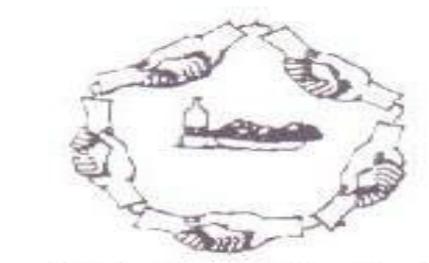




**LESOTHO FOOD AND NUTRITION POLICY (LFNP)
2016 - 2025**



**Prepared By
Food and Nutrition Coordinating Office
Maseru, 2016**

Foreword

The Lesotho Food and Nutrition Policy (LFNP) is intended to shape and guide planning and implementation of nutrition interventions in the country. The Government of Lesotho is aware of the important role nutrition plays in shaping the health and productivity of its population. This commitment is demonstrated by the existence of the Food and Nutrition Coordinating Office, which was established by Cabinet Memorandum No. 38 of 1978. Food and Nutrition interventions are promoted and implemented by key line ministries, namely Health, Agriculture and Food Security; Trade and Industry; Small Business Development; Cooperatives and Marketing; and Education and Training. However, levels of malnutrition have remained high among vulnerable groups.

Both under-nutrition and over-nutrition are of concern to the Government of Lesotho and need to be addressed as a matter of urgency. The LFNP is therefore intended to guide operations of various players by designing and implementing nutrition programmes and interventions that will avert the consequences of malnutrition. These actions will go a long way toward minimising losses related to national socio-economic development arising from the consequences of malnutrition.

The development of the LFNP is largely based on the understanding that nutrition is not only an outcome of socio-economic factors, but also a foundation for socio-economic development. The role of good nutrition to human capital formation and development is unequivocal. With this understanding, it is anticipated that the LFNP will contribute to poverty reduction by boosting productivity and improving education performance and outcomes. It will further help in reducing morbidity and mortality and improving maternal nutrition, which are essential to human capital formation. The policy will also promote appropriate healthy lifestyles that lead to lowered risk of diet-related chronic diseases.

The LFNP is intended to create an appropriate environment for planning and implementing nutrition programmes and interventions. It is anticipated that the key players and stakeholders will operate within the confines of this policy to ensure maximum benefit from the limited resources at the disposal of the Government of Lesotho.

Malnutrition results from multiple causes; therefore, in developing this policy the Food and Nutrition Coordinating Office held consultative processes with key stakeholders, particularly at national and district levels. I therefore implore all relevant stakeholders who participated in these processes to embrace the LFNP as their own. The commitment of policy-makers, technocrats, the private sector and civil society to its implementation will greatly assist in achieving a well-nourished, healthy and economically productive nation. This will be in line with the Government of Lesotho's commitments, including the Constitution of Lesotho, Vision 2020, the National Strategic Development Plan (NSDP) and all national development agendas.

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Minister to the Office of the Prime Minister

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Principal Secretary
Office of the Prime Minister

ACRONYMS

ANC	Ante-natal care
ARI	Acute respiratory infections
ARNS	Africa Regional Nutrition Strategy
ART	Anti-retroviral therapy
AU	African Union
AUC	African Union Commission
BMI	Body mass index
BoS	Bureau of Statistics
CAADP	Comprehensive African Agriculture Development Programme
CMAM	Community-based Management of Acute Malnutrition
CSNAP	Cross-Sectoral Nutrition Action Plan
DHMT	District Health Management Team
DMA	Disaster Management Authority
DSQA	Department of Standards and Quality Assurance
EC	European Commission
ECCD	Early Childhood Care and Development
ECSA-HC	East, Central and Southern Africa Health Community
EPI	Expanded Programme on Immunization
FAO	Food and Agriculture Organization
FANR	Food, Agriculture and Natural Resources Department
FMU	Food Management Unit
FNCO	Food and Nutrition Coordinating Office
FNSS	Food and Nutrition Security Strategy
GDP	Gross domestic product
GoL	Government of Lesotho
HDI	Human Development Index
HIV/AIDS	Human Immuno-Deficiency Virus / Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
ICN	International Conference on Nutrition
ICT	Information and communication technology
IDD	Iodine Deficiency Disorder
IEC	Information, Education and Communication
IECCD	Integrated Early Childhood Care and Development
IMAM	Integrated Management of Acute Malnutrition
IMCI	Integrated Management of Childhood Illnesses
IYCF	Infant and Young Child Feeding
IQ	Intelligence Quotient
LDHS	Lesotho Demographic Health Survey
LFNC	Lesotho Food and Nutrition Council
LFNPS	Lesotho Food and Nutrition Policy and Strategy
LVAC	Lesotho Vulnerability Assessment Committee
M&E	Monitoring and evaluation
MAFS	Ministry of Agriculture and Food Security
MAM	Moderate acute malnutrition
MCH	Maternal and child health
MDG	Millennium Development Goals

MDP	Ministry of Development Planning
MoF	Ministry of Finance
MoLG	Ministry of Local Government
MoET	Ministry of Education and Training
MoFLR	Ministry of Forestry and Land Reclamation
MoH	Ministry of Health
MoGYSR	Ministry of Gender, Youth, Sports and Recreation
MoNR	Ministry of Natural Resources
MoSD	Ministry of Social Development
MTCT	Mother-to-child transmission (of HIV)
MTI	Ministry of Trade and Industry
MUAC	Mid upper-arm circumference
NAC	National AIDS Commission
NACS	Nutrition Assessment Counselling and Support
NAPFS	National Action Plan for Food Security
NCDs	Non Communicable Diseases
NEPAD	New Partnership for Africa's Development
NGO	Non-governmental Organization
NPAN	National Plan of Action for Nutrition
NSDP	National Strategic Development Plan
OVC	Orphans and vulnerable children
OVCY	Orphans, vulnerable children and youth
PLHIV	People living with HIV/AIDS
PLW	Pregnant and Lactating Women
PMTCT	Prevention of mother-to-child transmission of HIV/AIDS
RAP	Regional Agricultural Policy
RED	Reaching Every District
SADC	Southern African Development Community
SAFEX	South African Futures Exchange
SAM	Severe acute malnutrition
SCN	Standing Committee on Nutrition of the United Nations System
SDG	Sustainable Development Goals
SUN	Scaling-Up Nutrition Movement
TB	Tuberculosis
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VAD	Vitamin A deficiency
VIP	Ventilated improved pit
WASH	Water, sanitation and hygiene
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organisation

DEFINITION OF TERMS

Care: provision of time, attention and support to meet the physical, mental and social needs of different family members in the household and the community

Complementary food: any food manufactured or locally prepared, suitable as a complement to breast milk or to infant formula.

Dietician: An expert in diets with particular skills in translating dietary knowledge into practical advice for provision of food suitable for maintaining good health in different health states.

Evaluation: A process that attempts to determine relevance, effectiveness and impact of activities as systematically and objectively as possible.

Food Fortification: The addition of one or more essential nutrients to food to correct or prevent a deficiency.

Food and Nutrition Security: When all people at all times have physical, social and economic access to food, which is consumed in sufficient quantity and quality to meet their dietary needs and food preferences and is supported by an environment of adequate sanitation, health services and care, allowing for a healthy and active life.

Food Security: When all people at all times have physical and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences, to allow for an active and healthy life.

Food insecurity: Inadequate intake of nutritious food, which can be transitory (when it occurs in times of crises), seasonal, or chronic (when it occurs on a continuing basis).

Health: A state of complete physical, mental and social well-being; not merely absence of disease.

Indicators: Used to help describe an existing situation, and can be used to track changes in the situation over time. Indicators are usually quantitative (i.e. measurable in some way), but they may also be qualitative.

Iodine Deficiency Disorders (IDD) refers to all of the consequences of iodine deficiency in a population that can be prevented by ensuring that the population has an adequate intake of iodine in the diet. Lack of iodine is shown by the enlargement of the thyroid gland (goitre), amongst other indicators.

Malnutrition: A physiological condition resulting from inadequacy or imbalance in food intake or from poor absorption of nutrients from food consumed.

Micronutrient deficiency: A lack of essential vitamins and minerals resulting from unbalanced food intake and specific problems of absorption of foods consumed.

Monitoring: The process of intermittently collecting and analysing information about a programme for the purpose of identifying problems, such as non-compliance, allowing corrective action so as to meet stated objectives.

Nutrition: Processes that encompass accessing food, and the consumption and utilization of nutrients by the body.

Nutritional status: The physiological state of the body resulting from food intake, utilization of essential nutrients, care practices and health and sanitation.

Nutritional surveillance: The regular collection and analysis of nutrition information that is used for making decisions about actions or policies that will affect nutrition.

Over-nutrition: The result of excessive food intake. Manifestations include overweight, obesity and poor health status.

Orphan: A child under 15 years who has lost either one or both parents.

Short-term emergency: Crises that may involve loss of life and injury as a result of calamities such as severe droughts, floods, famine, pest infestation, disease or acts of war.

Stunting: Having a low height for a given age, usually reflecting a sustained episode or episodes of under-nutrition.

Supplementary Feeding: Provision of extra food, along with the normal household diet, in order to satisfy an individuals' nutritional requirements.

Under-nutrition: The result of prolonged low level of food intake and/or poor absorption of food consumed; manifestations include wasting, stunting, underweight, reduced cognitive ability, poor health status and low productivity.

Underweight: Having a low weight for a given age, reflecting a current condition resulting from either inadequate food intake, past episodes of under-nutrition or poor health conditions.

Vulnerability: Refers to exposure to contingencies and stress and difficulties coping with risk, shock and stress.

Wasting: Having a low weight for height, generally the result of weight-loss associated with a recent period of starvation or severe disease.

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1. LESOTHO NATIONAL CONTEXT

1.1. Rationale for Lesotho Food and Nutrition Policy

The nutritional well-being of a population is a reflection on the performance of its social and economic sectors. A well-nourished, healthy workforce is a precondition for sustainable development. It is therefore important that the majority of the population is in good health and has good nutritional status, which permits them to participate actively and contribute effectively to national development. Better nutrition outcomes are essential for attainment of the Lesotho Vision 2020 and the global Sustainable Development Goals (SDGs). Therefore, strong advocacy and programming space is required in the area of nutrition. Commitment and leadership on nutrition by the government, donors and partner agencies needs to be increased. There is a need to prioritise nutrition on the development agenda and to negotiate for appropriate space and resource allocation to address undernutrition and its underlying factors.

Despite the existence of a number of food and nutrition programmes and interventions in Lesotho, the nutritional status of vulnerable groups (young children, pregnant and lactating mothers, adolescents and youth, orphans and the elderly) remains below international standards. In particular, chronic malnutrition (stunting) remains persistently prevalent in Lesotho, with devastating consequences. There is a clear need not only to address dietary intake and diseases, but also to consider measures for increasing the purchasing power of households.

Lesotho needs a framework of comprehensive, evidence-based national guidelines on nutrition, accompanied by effective coordination mechanisms, including a system of regular monitoring and evaluation (M&E) of nutrition activities.

It is for this reason that the Food and Nutrition Coordinating Office, mandated to coordinate nutrition programmes in the country, decided to develop a comprehensive Lesotho Food and Nutrition Policy (LNFP), to update earlier nutrition policies and national plans.¹ The LNFP will involve and guide all stakeholders involved in nutrition in Lesotho to ameliorate current nutrition problems and put in place appropriate intervention measures. It provides a framework for implementation of multi-sectoral programmes with set targets and clear, measurable nutrition objectives.

The decision to put in place such a framework to guide action on nutrition was based on the following considerations:

- Nutrition problems, including macronutrient and micronutrient (hidden hunger) deficiencies, are greatly affecting the poor and vulnerable population in Lesotho.
- Under-nutrition results in poor growth among young children, leading to impaired cognitive development, reproductive difficulties and impaired capacity for physical work among adults.
- Over-nutrition causes other diet-related non-communicable diseases (NCDs) such as diabetes, hypertension, and heart diseases, and also affects work productivity and national development efforts.
- Poor dietary intake as a result of food insecurity or inadequate knowledge and time to prepare nutritious meals. Mothers and caregivers are often overburdened by extra

¹ The Lesotho National Plan of Action for Nutrition (1997) and Lesotho Nutrition and Poverty Program (2002).

workloads of collecting firewood and water for preparation of meals and agricultural activities.

- The causes of malnutrition are multiple and complex, requiring action by multiple partners/players, which in turn demands an effective coordination mechanism.
- Evidence across the world has demonstrated that improvements in nutrition will bring benefits in several ways. Good nutrition is fundamental for better health, human development, human capital formation and economic growth.
- The Government of Lesotho (GoL) has robust policies and strategies in place for reducing poverty and food insecurity and improving access to quality health care and social services. These initiatives take into consideration gender and community participation issues. However, realising desired nutrition outcomes demands strengthened coordination and planning of interventions.

1.2. Geography and Social Economic Profile

Lesotho is a relatively small landlocked country with a population of 1.88 million (Census 2006), over 60 per cent of whom live in the western corridor (four districts in the Lowlands ecological zone and the Foothills), where there are better opportunities for agriculture and better developed physical infrastructures. About 30 per cent of the population resides in the other two ecological zones (Mountains and Senqu River Valley). Urbanisation rates are relatively low, at 25 per cent². The country is administratively delineated into ten districts. Lesotho is vulnerable to a range of natural disasters and climate change impacts, in particular droughts and heavy rains and flooding.

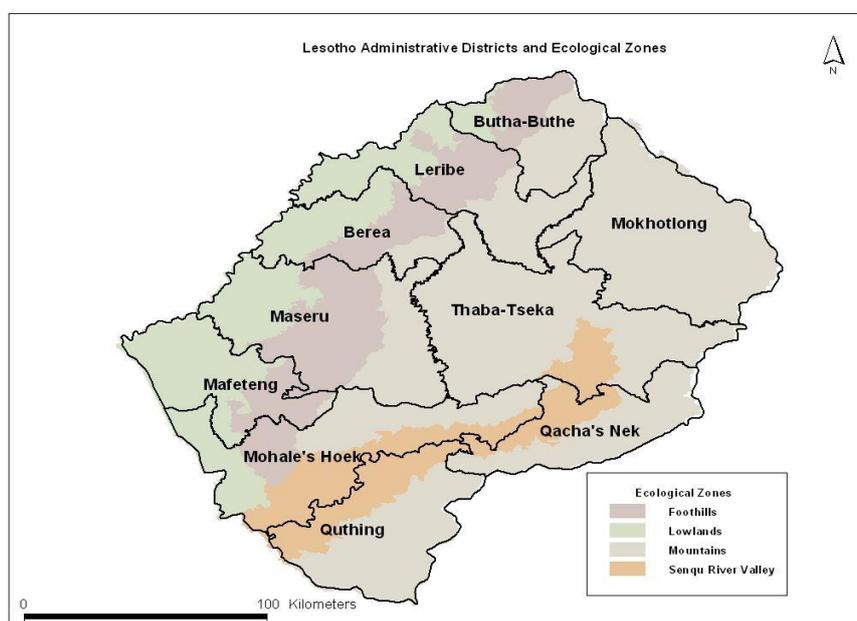


Figure 1: Map of Lesotho

Lesotho is undergoing a rapid demographic transition, due to a declining fertility rate combined with a substantially increased death rate in the past two decades as a result of high HIV prevalence³. This

² In particular there are many women who moved to urban areas due to the proliferation of the textile industry.

³ The Lesotho Demographic Health Survey (LDHS) 2009 estimated that 26.7 per cent of women aged 15-49 years and 18.0 per cent of men in the same age group were HIV positive. The figures for 2014 are somewhat

has led to a high proportion of children under 15 years (41 per cent) – of whom many are orphaned⁴ – and a significantly increased segment of the population over 60 years of age. The average household size is relatively low for Southern Africa, at 3.6 persons.

The **economy of Lesotho** is framed by its central location in Southern Africa. Lesotho is a member of the Southern African Customs Union, the Common Monetary Area and the Southern African Development Community (SADC). South Africa remains the largest trading partner and export market. Since the early 1980s Lesotho's Gross Domestic Product (GDP) has grown by 4 per cent per year, but growth was offset by reduced remittances from Basotho migrant workers in South Africa⁵ and a 1 per cent net population growth per year. In real terms, national disposable income per capita has remained unchanged.

Within Lesotho's economy manufacturing has been the main driver of growth. Agriculture's contribution to the national economy (still engaging over half of the population, mainly for subsistence farming⁶) has declined from around 20 per cent 30 years ago to around 8 per cent in recent years. Mining, quarrying and agriculture together in 2012/13 only accounted for 13.3 per cent of GDP. Inequality is significant in Lesotho, where the wealthiest quintile secures 60 per cent of the national income while the lowest quintile only receives 2.8 per cent⁷. The wealthier households tend to reside in the lowland areas and half of the poorest households live in the mountains. Poverty prevalence is similar in rural and urban areas.

In rural Lesotho, **food security conditions** are linked to seasonal agricultural patterns. During the winter months (May to July), the supply of maize (the main crop) is at its maximum while in the summer months (November to January), access to cereals is usually more restricted. This is why the summer months are sometimes called the 'hungry months', although other foods, like fruits and vegetables, are actually more abundant in the summer. In this respect, it is relevant to refer to the annual Lesotho Vulnerability Assessment Committee (LVAC) reports that provide information on the estimated number of people in need of humanitarian assistance during the summer months. As can be seen in the figure below the number varied between 200,000 in 2010/11 (a particularly good harvest year) to a high of 725,519 in 2012/13. Generally, the most affected zones are the southern lowlands, mountains and peri-urban areas.

down at 23.4 per cent (15-49 years) with 310,000 People living with HIV (PLHIV) in total (<http://www.unaids.org/en/regionscountries/countries/lesotho>). Lesotho remains among the top three in the world in terms of HIV prevalence.

⁴ The 2006 Census found that there were 221,000 single or double orphans (28.5 per cent of all children 0-17 years).

⁵ After abolition of Apartheid, the options for Basotho to engage in mining in South Africa have more than halved.

⁶ Most rural households cultivate around one hectare only. Around 30 per cent of the population in Lesotho is landless.

⁷ Figures cited in the NSDP II (from the African Peer Review Mechanism, Country Report No. 12, June 2010).

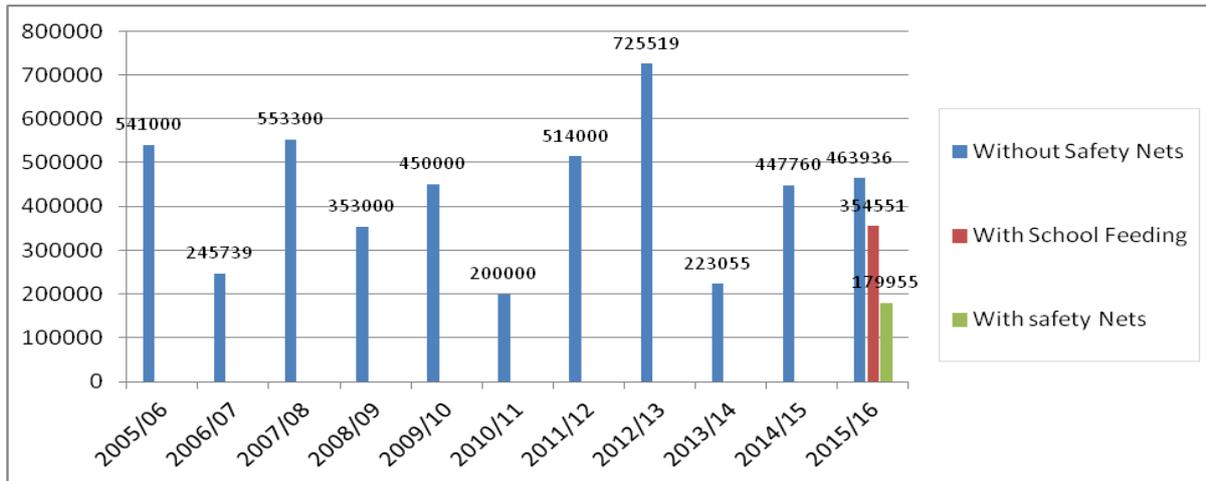


Figure 2: 2005/2006 – 2015/2016 LVAC estimates on number of people in need of humanitarian assistance

Lesotho’s performance along the ‘Continuum of Care’ for young children indicates that achievements are moderate, but are unacceptably weak on: promotion of good infant and young child feeding (IYCF), Vitamin A supplementation and care for infants and children affected by HIV/AIDS.

In terms of **gender**, it is to be noted that 36 per cent of households are headed by females in both urban and rural areas. This is attributed to the migration of many women to urban areas due to the proliferation of the textile industry, which predominantly employ women, and to the fact that a significant number of Basotho men live in South Africa as migrant workers⁸. It is noteworthy that in Lesotho half of all married women and 85 per cent of married men aged between 15-49 years are employed (LDHS, 2009). Most people in Lesotho work either in the informal sector (both in rural and urban areas) or in the private sector. Of the employed women, two-thirds are paid cash and 4 per cent are paid in kind, while 27 per cent do not receive payment for their work. Among men, the proportion who work for cash stands at 60 per cent while 32 per cent do not receive any pay. Low and sometimes irregular incomes have major implications for food security, resulting in reduced purchasing power and less investments in agricultural inputs. There is a need to link the women involved in income-generation activities coordinated by the Ministry of Agriculture and Food Security (MAFS) with sustainable markets for their products, and to empower them with entrepreneurial skills that equip them to gain competitive edge in the markets.

Over the past 30 years Lesotho’s **Human Development Index (HDI)**, a composite indicator measuring progress on health, education and income) has remained stagnant. Lesotho’s HDI value for 2014 was 0.497, placing the country in the ‘low human development’ category, and positioning it at 161 of 188 countries and territories (as calculated by the 2015 Human Development Report).

1.3. National Development Framework for Lesotho Relevant to Nutrition

In the **National Strategic Development Plan for Lesotho (NSDP)**, covering the period 2012/13 to 2016/17, the main indicator for success is that economic growth translates into sustained

⁸In the past the majority of the Basotho men used to work in the mining industries in South Africa. Nowadays it is a lower number but still about 20 per cent of the men. There is an increasing number of Basotho women who (seasonally) migrate to South Africa to work on agricultural farms and as domestics.

employment opportunities. In order to achieve National Vision 2020, the NDAP articulates six strategic goals to serve as guidance for political and budgeting decision-making⁹:

1. Pursue high, shared and employment-creating economic growth
2. Develop key infrastructure (water, transport, energy, information and communication technology, property, urban planning)
3. Enhance the skills base, technology adoption and foundation for innovation
4. Improve health and nutrition services, combat HIV and AIDS and reduce social vulnerability
5. Reverse environmental degradation and adapt to climate change
6. Promote peace, democratic governance and build effective institutions.

Many of the NSDP strategic objectives and actions under the fourth goal (on health, nutrition and social welfare) are relevant to the promotion of good nutrition in Lesotho. They form the core of this Food and Nutrition Policy. Under the first and third NSDP goals, action areas are listed that specifically relate to nutrition. The table below provides an overview of all action areas in the NSDP that provide the foundation for this LFNP, and includes references to other related national policies and strategies.

Objectives	Actions	Related national Policies and Strategies
AGRICULTURE (under Goal 1)		
Reduce vulnerability and manage risks	Promote conservation farming	National Action Plan for Food Security (2006); Lesotho Food Security Policy and Strategic Guidelines (2005); Agriculture Sector Strategy (2003)
	Promote community gardens, household food production or homestead gardens	
	Provide training on food preservation, storage, processing and preparation at community level	
	Promote animal exchange programmes	
	Promote orchard development and diversification	
WATER & SANITATION (under Goal 2)		
Expand water and sanitation distribution services to households and other institutions	Develop water infrastructure for communities that have no access to water, including installation of communal taps, well protection and water harvesting techniques	National Water and Sanitation Policy (2007)
	Enforce standards for construction of VIP latrines Encourage community-lead sanitation initiatives Encourage proper washing of hands using different mechanisms	
EDUCATION (under Goal 3)		
Improve access and quality of education	Improve children's development through ECCD based on multi-sectorial approach (nutrition, immunisation, socialisation, education support)	National Policy for integrated Early Childhood Care and Development (2013); National School Feeding Policy; LGSCCE curriculum for Food and Nutrition
	Extend nutrition support in reception classes	
	Strengthen curriculum and quality of teachers (primary, secondary and high school levels) and reduce dropout, especially in rural Lesotho	
HEALTH (under Goal 4)		
Reduce	Implement Essential Nutrition Actions (ENA) with	National Guidelines on Infant

⁹ The Government's Medium-Term Expenditure Framework – MTEF – and the NSDP Part II, the Public Sector Investment and Development Programme.

malnutrition (stunting, wasting, underweight)	emphasis on first 1,000 days	and Young Child Feeding (2013); MoH Nutrition Strategy 2012/13-2018/19 (2013); Lesotho National Guidelines for Integrated Management of Acute Malnutrition (2016); Lesotho Nutrition and Poverty Programme (2002); Lesotho National Plan of Action for Nutrition (1997); Expanded Program on Immunisation (EPI) Policy
	Improve management of acute malnutrition	
	Promote community health and nutrition	
	Develop national nutrition policy	
	Develop national food fortification legislation	
	Integrate nutrition monitoring into the Health Management Information System (HMIS)	
	Enhance capacity of the national nutrition coordinating body and Nutrition section at large	
Reduce maternal mortality rates	Improve antenatal care services, including the essential nutrition package for pregnant and lactating women	Health Sector Strategic Plan 2012/13 – 2016/17
HIV / AIDS (under Goal 4)		
Increase coverage and quality of treatment	Integrate nutrition support	HIV and AIDS Policy (2006); National HIV and AIDS Strategic Plan 2011/12-2015/16
Improve efficiency and sustainability of mitigation programmes	Provide support and empowerment mechanisms for orphans and vulnerable children (OVC)	
SOCIAL DEVELOPMENT (under Goal 4)		
Increase capacity of able-bodied persons to deal with vulnerability	Promote food and cash-for-work programmes	National Social Protection Policy (2014)
	Promote sustainable livelihood strategies to assist able-bodied vulnerable persons to graduate from social grants	

1.4. Nutrition and MDG Achievements

While the national frameworks for the new **Sustainable Development Goals for 2030** are yet to be developed, it is obvious that improving nutrition will make a strong contribution to achieving the SDGs. Nutrition has direct links with poverty, hunger, health, education, gender, work, growth, inequalities and climate change. Nutrition is captured as an explicit implementation target under SDG2 (hunger, food security and nutrition, and sustainable agriculture).

In Lesotho, achievement of the **Millennium Development Goals (MDGs)** was moderate to stagnant, with some exceptions¹⁰:

- In 2013, 57 per cent of people in Lesotho were still living below the **poverty** line, only a marginal decrease from the 1990 baseline (67 per cent). Many of these people live in rural areas, where the effects of mining retrenchments in South Africa have hit hardest.

¹⁰ Ref: <http://www.ls.undp.org/content/lesotho/en/home/library/mdg/lesothomdgreport2013.html>

- **Food security** conditions in Lesotho have been rather static. The major problem faced by poor households in rural areas is limited food availability, while the urban poor have limited purchasing power due to lack of employment and high prices of foods¹¹. Although the South African Futures Exchange (SAFEX) prices for white maize have stayed relatively stable over the past five years, the price of maize and other staple foods in Lesotho have been rising due to inflationary pressures¹². According to the Livelihood Vulnerability Assessment (LVAC) report of 2014, crops performed poorly in most parts of the country as a result of the late onset of rains and the occurrence of hail storms in some areas. Regional cereal availability is good, as other countries in Southern African registered cereal production substantially above average¹³.
- Very limited advances were made toward reducing **underweight among children** under the age of five years (MDG 1). The baseline figure was 15.8 per cent and the current rate still stands at 13.2 per cent – far from the 2015 target of 8 per cent.
- The reduction of **maternal and child mortality** is completely off track. Under-five mortality stands at 85/1000, while the 2015 target was 37 (MDG 4), and the maternal mortality ratio stands at 1,024/100,000 while the 2015 target was set at 93 (MDG 5).¹⁴ This can be explained as a result of the combination of several factors: (a) high prevalence of HIV/AIDS (see under MDG 6 below); (b) limited access to health services, due to weak decentralization of health services¹⁵ and weak implementation of the Health Sector Strategic Plan (HSSP) and key health policies and programmes (e.g., Integrated Management of Childhood Illnesses (IMCI),¹⁶ EPI, the Infant and Young Child Nutrition and the Reaching Every District (RED) initiative; (d) insufficient environmental sanitation¹⁷; (e) early pregnancies; (f) poor child feeding and care practices and poor health-seeking behaviour; and (g) overall poverty.

The MDG target for **measles vaccination** was set at 100 per cent. According to the Preliminary 2014 LDHS report, measles immunisation (sub-indicator under MDG 4) now stands at 90.1 per cent, which is a positive achievement and well above the rate of 69.9 per cent reported in the 2009 DHS¹⁸. Measles vaccination forms part of the Expanded Programme on Immunization.

¹¹ The Bureau of Statistics (BoS) reported an annual inflation rate for December 2014 of 5.2 per cent for food and non-alcoholic beverages while the overall rate for all items was 3.6 per cent.

¹²The price of maize meal has increased to an average of M8.00 (M7.00 to 8.60) per kg compared to M3.00 during the baseline period in 2009/10.

¹³ Ref: <http://www.fews.net/southern-africa/food-security-outlook-update/september-2014>

¹⁴ The 2014 Lesotho Demographic Health Survey (LDHS) indicate that under-five Mortality Rate currently stands at 85 per 1000 live births (about 70 per cent occurring in the first year of life) which is a substantial decrease from the 2009 level which was still 117. LDHS 2014 shows that Maternal Mortality ratio is 1,024 per 100,000 live births lower than in 2009 at 1,243 per 100,000 live births. These high levels are to be explained by the cumulative effects of the high HIV/AIDS prevalence, overall high disease burden, the lack of access to health services, and poor care and feeding practices. Other contributing factors are poor environmental sanitation, lack of human resources, and early pregnancies and marriages.

¹⁵District health management teams (DHMT) should avail themselves of sufficient human resources with adequate skills and of sufficient logistics and other means to reach out to health units and possibly community levels.

¹⁶ IMCI is focused on treatment of the main childhood diseases such as acute respiratory illnesses, diarrhoea and Gastro-intestinal diseases like intestinal worms.

¹⁷ Leading to high incidence of diarrheal episodes which directly affects nutritional status and is also closely related to child mortality.

¹⁸ The WHO recommendation is to achieve at least 90 per cent coverage in urban and 80 per cent in rural areas.

The Figure below illustrates that malnutrition, pneumonia and diarrhoea are among the 10 leading causes of childhood mortality in Lesotho

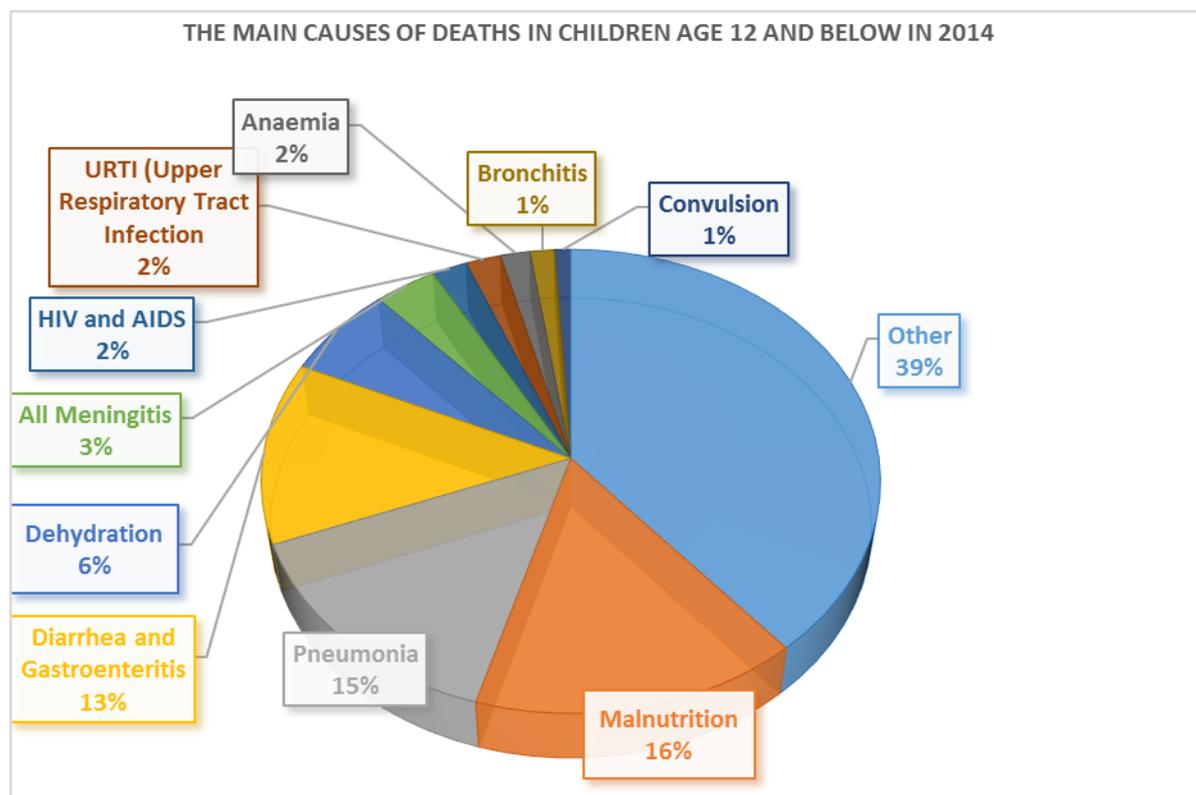


Figure: 10 leading causes of Childhood in Lesotho¹⁹

- In relation to MDG 6 on **HIV/AIDS and TB** – which are both major threats to Lesotho’s development²⁰ – substantial progress has taken place on HIV treatment coverage, both for anti-retroviral treatment (ART) and prevention of mother-to-child transmission (PMTCT), but very slow for other HIV-related indicators and stagnant on TB reduction.

A range of prevention, treatment and care interventions for HIV/AIDS. Lesotho’s AIDS effort is guided by the National HIV and AIDS Strategic Plan 2011/12 - 2015/16. The government intends to reverse the epidemic by reducing new HIV infections by 50 per cent, strengthening coping mechanisms for vulnerable people and providing ART for all those in need. More specifically, the strategy encompasses: (a) universal HIV testing; (b) various prevention measures (educational campaigns, workplace prevention, condom distribution, targeting high-risk groups, and PMTCT); (c) provision of ART treatment; and (d) care for

¹⁹ Source: AJR 2014 MOH (2011), Annual Joint Review

²⁰ The HIV prevalence rate in Lesotho is the second highest in the world and in 2014. Overall prevalence of HIV and AIDS among the population 15-49 years of age in Lesotho is 25 per cent (LDHS, 2014). The HIV pandemic has complicated food production, availability and household earnings. It has further increased the burden of providing adequate nutrition to vulnerable groups in households. The disease has significantly affected productivity and efficiency levels due to high absenteeism and mortality. In rural areas HIV and AIDS is the major hindrance to food security.

orphans. In 2012, ART coverage for those who need it stood at 58 per cent, while PMTCT coverage was 52 per cent.²¹

TB is a contagious disease related to poverty, undernutrition and poor immune function. It is one of the 10 leading causes of morbidity and mortality in Lesotho, and a major public health problem. About 20 per cent of TB cases are pulmonary, but the rest are extra-pulmonary and transmission is mainly airborne. There is a strong connection between HIV and TB, with a co-infection rate of 76 per cent; approximately 80 per cent of new TB patients test positive for HIV. Even though 95 per cent of the population have heard about TB, very few people are familiar with the symptoms (12 per cent of women, 13 per cent of men). Women are more likely than men to seek treatment for illness.

Access to basic sanitation has substantially improved in recent times, but remains low. The main forms of human waste disposal in Lesotho are pit latrines²² and the water/sewerage system. Figures for improved water supply are significantly better. However, about 16 per cent of households still lack access to clean drinking water (MDG 7)²³. Potable water is required for food preparation, cleaning of utensils and personal hygiene, and is thus essential to ensuring good nutrition and health.

²¹ Ref. to <http://www.avert.org/hiv-aids-lesotho.htm> for an update of results achieved.

²² Ventilated Improved Pit (VIP) latrines or simple latrines.

²³ Households with access to improved sanitation facilities have increased from 26 per cent baseline value (in 2009?) to 41 per cent in 2014, whereas the percentage of households with access to improved water has only risen slightly from 79 per cent to 84 per cent in 2014.

1.5. Causes of Malnutrition in Lesotho (Using Conceptual Models)

The **UNICEF conceptual model** developed in the 1980s is still the main framework for explaining the causative factors and links at different levels of operation that need to be addressed by any initiative directed at curtailing the vicious cycle of poverty, malnutrition and disease. It also demonstrates the interdisciplinary and transdisciplinary principles to be applied for the success of any nutrition programme. As shown in the diagram, individual nutrition status is directly related to both diet and health²⁴. For this reason nutrition security is tied to both access to and utilisation of food. Lesotho, like many other countries in Sub-Saharan Africa, is facing a double burden of malnutrition, meaning that both high levels of under-nutrition and high levels of over-nutrition are present within the population.

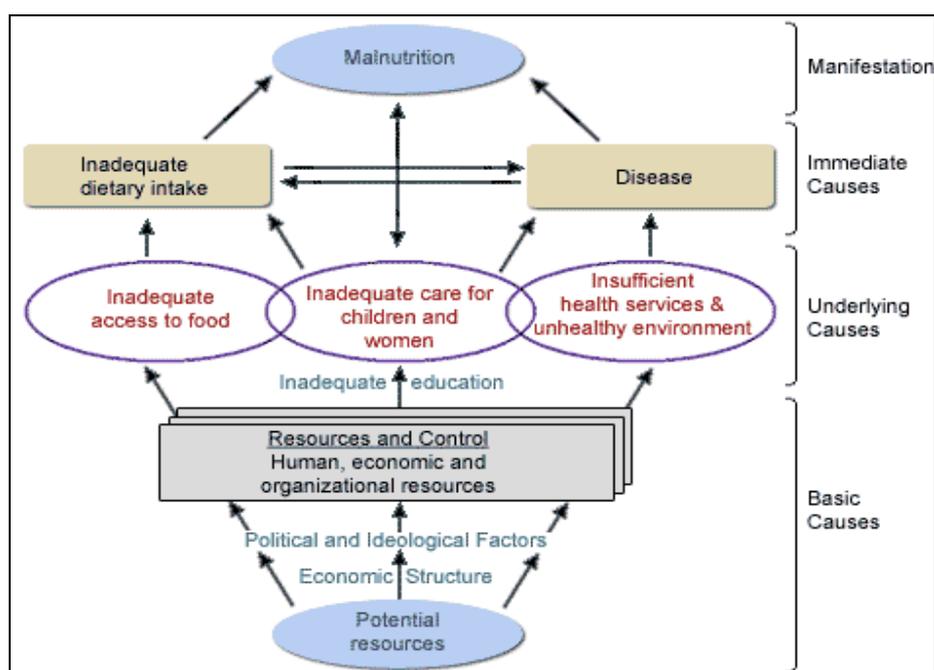


Figure: UNICEF Conceptual Framework on Nutrition

Since the early 1990s, awareness of the importance of nutrition as a key factor for ensuring healthy and productive lives has increased considerably at both the global and national levels. A series of key events and publications demonstrate how nutrition has come to be a core policy issue over the years (for further details, refer to Annex 1).

1.6. Food Consumption Patterns in Lesotho

An **essential dietary nutrient** is a substance that a person needs to consume in order to live, grow and be healthy. Nutrients are required to regulate body processes and build and repair tissues, thereby promoting health and preventing disease. The two main types of nutrients are macronutrients and micronutrients. Macronutrients (protein, carbohydrates and fat) are generally consumed in large amounts. Carbohydrates and some fats are converted to energy, while protein and some fats are used to build the structural and functional components of human tissue.

²⁴See Annex 3 for more information on the specific links between HIV and TB and nutrition which is of particular relevance for Lesotho due to the high HIV and TB prevalence.

Micronutrients (vitamins and minerals) are consumed in smaller amounts and are essential for metabolic processes. Macronutrients and micronutrients work together to contribute to tissue regeneration and cellular integrity.

The intake of sufficient nutrients can be ensured by consuming a diet with food items of sufficient nutritional quality and with sufficient variety from various food groups. Along with the need for sufficient quantities of food in line with a person's requirements for energy and macronutrients (carbohydrates, protein and fats) – according to age group and activity level – there is also a need for sufficient dietary diversification to ensure that all household members receive essential nutrients. Maize is still the staple food across Lesotho, although it has become more expensive and less accessible for poor households. Furthermore, food habits in urban areas in Lesotho have evolved away from traditional healthy foods towards more refined foods, which often are of lower nutritional quality and raise food safety issues. But Lesotho does not have a well-developed food standards infrastructure²⁵. According to a consumption study conducted in Berea and Thaba-Tseka districts, Basotho diets are monotonous, mainly comprised of cereal *papa* or maize meal porridge, *moroho* or *green leafy vegetables*, *lesheleshele* or *soft unfermented sorghum meal beverage* (sometimes with milk and/or sugar). Little animal protein is included.

In Lesotho, poverty and nutrition are inter-related; under-nutrition negatively affects the productivity of households. The poor segments of the population continue to carry the burden of malnutrition in all its forms. This perpetuates the cycle of poverty, morbidity and mortality, leading to reduced life spans. The poorest households are most vulnerable to food and nutrition insecurity²⁶ and insecure livelihoods.

Most rural households depend on the immediate environment for their livelihoods, including water for home use, food production, gathering wild foods and wood as a source of firewood for cooking. In Lesotho much of the land is grasslands, making it difficult for households to access firewood. Women are forced to walk long distances to fetch firewood, thereby increasing their workload. Accessing water, particularly in the highlands, is also a problem; households have to walk fairly long distances to water points. The terrain in some rural areas makes it difficult to produce crops, including much-needed cereals like sorghum, maize and wheat. Climate change has further aggravated this situation, impacting food production due to unpredictable weather patterns. Responsibility for providing care to the family lies heavily on women. Women can provide good care only if they are provided with sufficient resources and power to control them. In Lesotho, some positive initiatives for empowering women with means to generate family incomes have been undertaken. However women, particularly those from poor segments of the population, still face problems in accessing inputs for their income-generating activities. Women involved in income-generation activities coordinated by MAFS need to be better linked to sustainable markets for their products and to be empowered through training in entrepreneurship to equip them to gain a competitive edge in the markets.

²⁵ This refers to both the legal framework and the existence of clear mandates for the various institutions involved.

²⁶In 2013, the UN Standing Committee on Nutrition proposed the following definition: "Food and nutrition security exists when all people at all times have physical, social and economic access to food, *which is consumed in sufficient quantity and quality to meet their dietary needs and food preferences, and is supported by an environment of adequate sanitation, health services and care, allowing for a healthy and active life.* (Ref. http://www.unscn.org/files/Annual_Sessions/UNSCN_Meetings_2013/Wustefeld_Final_MoM_FNS_concept.pdf)

1.7. Anthropometrical Indicators²⁷

As shown in the Figure below, in Lesotho under-nutrition among children under five is primarily reflected in widespread **stunting** (also known as chronic malnutrition, measured by the **Height-for-Age** indicator). Once stunting has developed at a young age it is irreversible and has a lasting negative impact on physical and mental capabilities. Since the early 1990s the prevalence of stunting in Lesotho has remained at a high level, above the 'public health problem' threshold set by World Health Organization (WHO), which stands at 30 per cent. Stunting prevalence was close to this threshold in 2002 (30.7 per cent) but rose again in the years thereafter until 2007. Since 2007 the rate has gradually declined, reaching 33.2 per cent in 2014. This suggests that diet quality, child feeding practices and overall dietary diversity in households improved in recent years, although far greater efforts are required to further reduce stunting. Stunting is more prevalent in rural areas (35.1 per cent vs. 27.3 per cent in urban areas) and among boys (38.8 per cent vs. 28.1 per cent for girls).

Wasting (measured by **Weight-for-Height** and/or **Mid Upper-Arm Circumference -MUAC-**) is the indicator that is most sensitive to short-term lack of access to food and to occurrence of illnesses. In Lesotho the prevalence of wasting across the years has remained quite stable at around 3-to-4 per cent. It is not a problem of public health significance. Where wasting occurs, it is normally caused by chronic or recurrent illnesses related to hygiene and overall health conditions. If not treated, severe wasting is a condition with a high mortality risk.

Underweight (measured by **Weight-for-Age**) is an indicator that combines both short-term and long-term malnutrition and as such is more difficult to interpret. In many countries, including Lesotho, the indicator is still being used as the core measure within the growth monitoring programme. The prevalence of underweight has been relatively stable, but since 2007 has steadily declined to 10.3 per cent in 2014, clearly below the WHO threshold of 20 per cent.

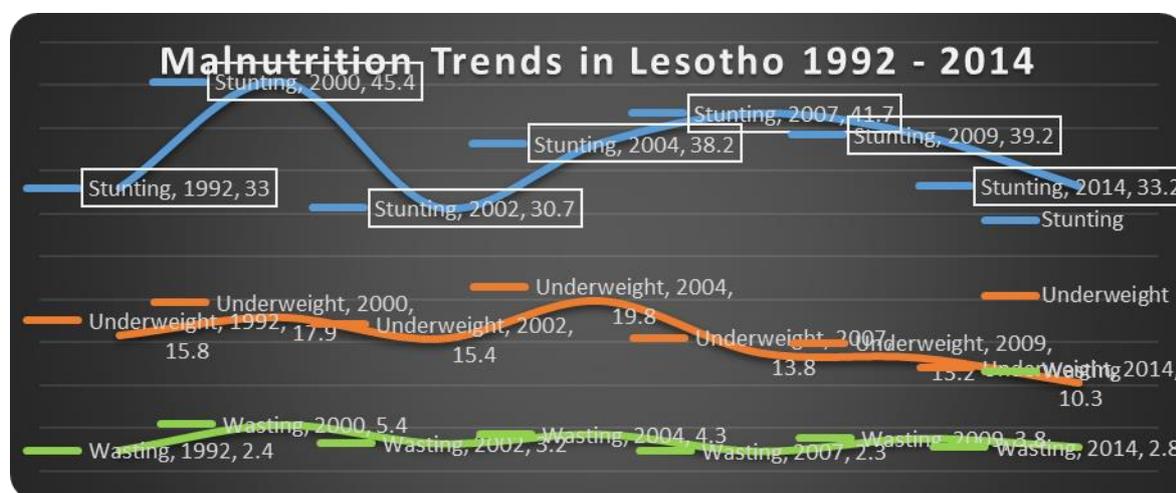


Figure: Stunting, underweight and wasting among children under five years of age

1.8. Micronutrient Deficiencies

Lesotho is still battling with diseases related to micronutrient deficiencies such as Vitamin A and iron, and to a lesser extent iodine deficiency disorders:

²⁷ Further information on trends in nutrition indicators at district level is provided in Annex 2.

- **Vitamin A Deficiency:** Unfortunately no recent data is available on Vitamin A Deficiency (VAD) in Lesotho²⁸. No information is available at all on sub-clinical forms of VAD (serum retinol levels) among women of childbearing age²⁹. In addition to its relation to (night) blindness, VAD increases the severity of infections and results in impaired physical growth. The main cause of VAD in Lesotho is low consumption of foods of animal origin and fruits and vegetables that are rich in carotenoids. For over 15 years, homestead gardening has been actively promoted in Lesotho, but supplementation for young children and post-partum women remains the main intervention required to fight VAD in Lesotho. As in many other countries, it is a standard programme implemented alongside the vaccination programme. However, its coverage stands at rather low levels (55 per cent in DHS 2004) and urgently needs to be increased.
- **Anaemia:** According to the preliminary 2014 LDHS results, overall 51 per cent of children aged 6-59 months in Lesotho present with some level of anaemia; 25 per cent are mildly anaemic, 25 per cent moderately anaemic and 1 per cent severely anaemic. The rate exceeds the threshold for a serious public health problem (40 per cent). Prevalence is highest among children aged 6-to-11 months of age (62 per cent) and lower among children aged 3-to-5 (42 per cent). Anaemia appears to be a nationwide problem that occurs in all districts (although with varying severity levels) and is present in both urban and rural areas. There is a slight inverse correlation with wealth status.

Information on anaemia among men and women aged 15-to-49 is provided in both the 2009 and 2014 LDHS reports. Among women, the prevalence of anaemia is stagnant at around 26-27 per cent. Higher rates are found in urban areas than in rural areas (32 per cent vs. 24.8 per cent), in the lowlands (30.6 per cent) and, rather surprisingly, among the higher wealth quintiles (all 2014 figures). Among men in the same age bracket, 14.6 per cent were found to suffer from some level of anaemia, which is a slight increase compared to 2009 data. The prevalence of anaemia in men varies little by urban-rural residence but greatly by district. For men there was an inverse relationship between anaemia prevalence and wealth levels.

The consequences of anaemia include reduced immunity to infections, low cognitive and concentration span and low productivity³⁰, among others. The high prevalence of anaemia among under-five children in Lesotho is related to low intake of iron-rich foods (meat, fish, dried beans, and green leafy vegetables), combined with lower intakes of dietary enhancers of iron absorption (such as Vitamin C) and higher intakes of iron absorption inhibitors (cereal bran and grain in general). Also, a considerable proportion of children are infected with soil-transmitted helminths (hookworm, etc.). Effective strategies for improving iron status are supplementation with iron-folate tablets for pregnant women³¹, regular deworming, multiple micronutrient supplements for infants and young children and fortification of staple foods³².

- **Iodine deficiency disorder (IDD)** used to be a serious public health problem in Lesotho. Iodine deficiency can result in irreversible impaired mental and physical development and

²⁸The last survey that included Vitamin A status dates from 1993 and found that VAD was a severe problem among preschool children, with 78 per cent prevalence of sub-clinical and clinical Vitamin A deficiency. However, these results should be interpreted with caution as the sample size was small.

²⁹ WHO (2009), Global Prevalence of Vitamin A Deficiency in Populations at Risk 1995–2005 (www.who.int/vmnis)

³⁰ A 1 per cent drop in iron status is associated with 1 per cent reduction in productivity.

³¹ The 2014 LDHS report that 27 per cent women were anaemic and it is higher in urban than rural areas.

³² In endemic countries reduction of the exposure to malaria is another measure to be taken.

hence low productivity³³. It has been brought under control since the late 1990s. High levels of IDD are related to the ecology of Lesotho; this is because in mountainous areas it is normal that soil iodine levels are low. Universal salt iodization has been in place in Lesotho since 1999. But close monitoring of the iodized salt quality is still necessary to avoid over-dosage³⁴.

1.9. Over-Nutrition

The 2014 LDHS also provides data on the prevalence of overweight (Weight-for-Height > two standard deviations) among children under five years of age. This condition appears to be present in 7 per cent of children (2014 LDHS), with the highest rates (around 10 per cent) in Moleleke's Hoek and Qacha's Nek and the lowest rates (around 4 per cent) in Berea. The highest prevalence is among very young children 0-6 months (25 per cent), but rapidly declines from nine months onwards. Hardly any differences exist between boys and girls, or urban and rural areas.

1.10. Nutrition Conditions of Adults

The 2014 LDHS report also offers information on the nutritional status of adults in Lesotho. While there was a high level of 'overweight' among women (45 per cent), this was not the case for men (12 per cent). For both men and women, the Body Mass Index (BMI) correlated positively with wealth level and living in an urban area. However it was not clear which factors were associated with undernutrition (thinness) among men.

Table: Nutritional status among adults in Lesotho, LDHS 2014

BMI	Thin	Normal	Overweight
Women	4 per cent	51 per cent	45 per cent
Men	14 per cent	74 per cent	12 per cent

An excessive intake of calories and fat causes obesity, which is associated with higher risk of chronic or non-communicable diseases such as diabetes, hypertension and cardiovascular disease. The 2014 DHS indicated a prevalence of overweight and obesity at 55 per cent among urban women, compared to 42 per cent in rural women. Lesotho evidently is undergoing a major nutrition transition, in which non-communicable diseases have become a major concern. These diseases not only reduce productivity and lifespan, but also strain an already overburdened health system.

³³ IDD is estimated to result in 1 per cent reduction in height which is equivalent to 1.3 per cent loss in productivity.

³⁴ The 2002 national cluster survey found a urinary iodine concentration of below 100µg/L in 22 per cent of school children but also a urinary concentration in excess of 300µg/L in 36 per cent of the children which poses a slight risk of iodine-induced hyperthyroidism.

1.11. Main international nutrition frameworks

- The **International Conference on Nutrition** in Rome in 1992 led to the Lesotho Government's commitment to prepare a National Plan of Action for Nutrition (NPAN)³⁵.
- This was followed by the adoption of the **Millennium Development Goals (MDGs)**, with MDG 1, 4 and 5 all having a strong association with nutrition.
- The next step was the global launch of the **Scaling-Up Nutrition (SUN)** movement in 2010, which focuses on reducing stunting through specific support during the first 1,000 days (pregnancy and the first two years of life).
- The SUN Movement builds on evidence presented in a **series of articles on maternal and child nutrition in The Lancet** in 2008, and a follow-up series published in 2013.
- At the **2012 World Health Assembly (WHA)**, a comprehensive implementation plan was adopted on maternal, infant and young child nutrition³⁶, which specifies a set of six global nutrition targets to be achieved by 2025.
- A **second International Conference on Nutrition** was held in Rome in November 2014. This led to the adoption of a voluntary Framework for Action that focuses on stunting, wasting, low birth-weight, breastfeeding, anaemia in children 6-59 months and child overweight and obesity.
- The **Africa Regional Nutrition Strategy (ARNS) 2015-2025** is intended to guide nutrition policies and programmes on the African continent. It stipulates that it is the responsibility of each African Union (AU) member state to fulfil their obligation to realise the right to nutrition security for all their citizens. In addition, the AU has well-established mechanisms to put in place accountability frameworks tailored toward nutrition. These frameworks aim to strengthen nutrition governance as a critical part of eliminating malnutrition, one of the perpetual obstacles to Africa's development.
- The **SADC Food and Nutrition Security Strategy (FNSS)** was developed to implement a wide range of SADC policies and programmes seeking to holistically address issues of food and nutrition security from a multi-sectoral perspective. More specifically, the FNSS implements the food and nutrition aspects of the SADC Regional Agricultural Policy (RAP); the SADC Health Policy Framework; Orphans, Vulnerable Children and Youth (OVCY) Strategy; and the Maseru Declaration on HIV and AIDS, among others. The FNSS also takes into account the AU African Regional Nutrition Strategy (2005-2015) and member states' national food and nutrition security policies and strategies.
- World leaders adopted the **2030 Agenda for Sustainable Development**, which includes a set of 17 **Sustainable Development Goals** to end poverty, fight inequality and injustice, and tackle climate change by 2030. These new SDGs, and the broader sustainability agenda, go much further than the MDGs, addressing the root causes of poverty and the universal need for development that works for all people.
- **Agenda 2063 Vision** - By 2063, African countries will be amongst the best performers in global quality of life measures. This will be attained through strategies of inclusive growth; job creation; increasing agricultural production; investments in science, technology, research and innovation; gender equality; youth empowerment and the provision of basic services including health, nutrition, education, shelter, water and sanitation.
- **CODEX Alimentarius Commission**. The Mandate of Codex is to establish international food standards to protect the health of consumers and to ensure fair practices in the food trade.

³⁵The Lesotho NPAN was adopted by Cabinet in 1995 and published in 1997.

³⁶ Ref: http://www.who.int/nutrition/publications/globaltargets2025_policybrief_overview/en/

1.12. Operational Bottlenecks and Challenges for Nutrition Programmes (Key Gaps for Nutrition Programmes)

Lesotho's experience with the MDGs demonstrates that the country is far from realising the set targets. The reasons are to a large extent tied to the specific country context, marked by high poverty levels combined with a high prevalence of HIV/AIDS and TB; weak social services in the areas of agriculture, education and primary health care delivery; and gaps in sanitation and availability of safe water. In addition, inadequate human resources within the health system, combined with poor utilisation of health and nutrition services, has led to low coverage for health and nutrition services.

Table: Key Challenges and Possible Solutions

Level	Challenges	Possible Solutions
Supply side	Insufficient guidelines, lack of clear national policies and standards, no job aids available on nutrition	Development of policies, guidelines and job aids (standardised counselling cards and other Information, Education and Communication (IEC) materials) for multi-sectoral nutrition interventions (including for prevention of Non Communicable Diseases; nutrition for PLHIV; Home Grown School Feeding programme).
	Lack of mechanisms for effective planning and management of nutrition programmes and interventions.	Establishment of clear structures that link all key players and stakeholders on nutrition at national and district levels so that activities are harmonised and duplication of efforts is avoided.
	Inadequate human and financial resources for nutrition programme implementation.	GoL to provide sufficient budgets for nutrition programmes and posting of well-qualified staff, at national and district levels.
	Significant weaknesses in reporting systems and coverage for nutrition indicators and systems	Incorporation of functional food and nutrition indicators in the HMIS and food security monitoring tools, so that surveillance information is available for appraisal of programme performance and to inform policy and strategy review.
	Poor infrastructure in mountainous areas, which limits people's access to health and other government services.	Provision of other means to reach remote communities, such as mobile clinics (possibly in collaboration with development partners and NGOs).
	Weaknesses in supply chain management (gaps in availability of critical supplies, including multiple micronutrient supplements)	Identify and address key constraints in supply chain planning, management and monitoring
	Inadequate nutrition counselling at health facilities and at community level	Clear messaging, information job aids, and objectives across the sectors
	Incomplete integration of IMAM into MoH system	Ensure all districts have implementation capacity on IMAM (technical guidelines, job aids, expertise, supplies)
	Lack of national Code on marketing of formula	Revise the draft Code of marketing on breast milk and submit for approval
	Limited fortification of foods with micronutrients	Partnership between government and industry to finalize regulatory framework and standards
	Inadequate monitoring and enforcement of salt iodization regulation so that imported non-iodised salt is still on the market	Reinforce standards and regulations on salt iodization
	Lack of regular monitoring of nutrition indicators	Periodic nutrition surveys
	Lack of advocacy to involve private sector	Advocate for private partnerships to advance nutrition.
Demand side	Limited utilization of available services	Undertake intensive community awareness campaign on nutrition
	Need to increase behavioural change tied to exclusive breastfeeding	Increase counselling and support initiatives
	Low levels of consumption of fortified foods	Advocate, regulate and support use of fortified foods for humans and animals
	Slow change in hygiene behaviour	Strengthen and broaden communication on WASH

Part 2 Lesotho National Food and Nutrition Policy

2. VISION, MISSION, GOAL, AND GUIDING PRINCIPLES

2.1. Vision

By 2025 Lesotho aspires to have a well-nourished, healthy and economically productive nation.

2.2. Mission

To advance a healthy life for all Basotho through a well-articulated Integrated Health, Food Security and Nutrition programme.

2.3. Goal

To attain optimal nutritional requirements for the improvement of health status among the population of Lesotho, enabling them to contribute effectively to national socio-economic growth and development.

2.4. Guiding Principles

Political commitment: The Government is committed to poverty reduction, with an emphasis on economic growth and social protection. This commitment will provide critical guidance in priority-setting and resource allocation. Commitment to this policy will be required at all levels of political, civil and cultural leadership.

Global and regional nutrition initiatives: Lesotho meets its national, regional and international obligations as set out in national laws and international conventions, treaties and resolutions on the right to food and nutrition, including reaching World Health Assembly targets and those of the Comprehensive African Agriculture Development Programme (CAADP) and as a member of the SUN global initiative.

Multi-sectoral approach/coordinated approach: As the causes and consequences of malnutrition are multi-dimensional, effectively addressing the problem requires an integrated approach with broad cross-sectoral political support. While cross-sectoral co-ordination increases the challenges of implementing effective programmes, these challenges are not insuperable, particularly with effective leadership.

Primary health care approach: In accordance with the Alma Ata declaration of 1979 and the Ouagadougou Declaration of 2008, the Government of Lesotho shall provide essential health care services that are universally accessible and affordable to all Basotho. Emphasis will continue to be put on effective application of its principles and elements, as well as on health systems strengthening.

Unified extension service provision on food and nutrition: Creating a mechanism to ensure that the entire food chain – from food production to food processing and consumption – is efficiently managed within the overall development strategy, through building capacities at all levels

(households, communities, local councils, districts) for adequate action to improve household food security.

Focused and targeted interventions: Available resources for nutrition are optimally used to implement priority interventions among vulnerable groups, with a particular focus on the most disadvantaged areas and districts.

Equity: In accordance with the Constitution of Lesotho, all Basotho shall have equal access to basic quality health care services. Particular attention shall be paid to resource distribution patterns in Lesotho to identify and accelerate the correction of disparities.

Gender balance: Gender sensitivity and responsiveness shall be applied in food and nutrition service planning and implementation. Special consideration shall be accorded to women due to their culturally constructed lower social status and their special role in reproduction. Where men have been disadvantaged, special efforts will be made to support them.

Accessibility and availability: Services shall be progressively extended to reach all communities in Lesotho. Special attention shall be given to the country's disadvantaged regions and underserved communities. Services shall be community-based, taking into consideration special socio-cultural circumstances.

Community involvement and empowerment: Communities shall be actively encouraged and supported to participate in decision-making and planning for food and nutrition services. Through ownership of community projects, communities will become masters of sustainable food and nutrition programmes in their own areas, embedded within local government structures. Families and communities will be empowered to adopt healthy lifestyles, sound nutritional practices and improved livelihoods that are culturally and gender sensitive.

Integrated approach along the continuum of care: Nutrition services are delivered in an integrated manner, linking community, extension services, primary health care and hospital services. Nutrition issues will be coupled holistically with hygiene and promotion of healthy lifestyles. The nutrition sector will use a lifecycle approach, focusing on the key 'window of opportunity'; namely pregnancy and the first two years of life (the first 1000 days).

Quality: Efforts will be made to ensure that all Basotho receive quality nutrition care services. National norms, guidelines and standards of services shall be reviewed, formulated and applied to ensure that good quality services are provided.

Efficiency of resources: As much as possible, resources shall be used where the greatest benefit to an individual or community is envisaged. Periodic analyses shall be carried out to identify cost-effective interventions.

Inter-sectoral collaboration and partnership: Government and non-Government sectors will be consulted and involved in planning, implementation, monitoring and evaluation of nutrition service provision using effective collaborative mechanisms. The policy emphasizes the cross-cutting nature of food and nutrition across the life cycle.

Ethics and human rights: Nutrition service workers shall exhibit the highest level of integrity and trustworthiness in performing their work. They will observe ethical conduct guided by ethical guidelines, which will be enforced by professional councils. The policy recognises that adequate food and nutrition is a human right and that food is treated as a national strategic resource.

3. FOOD AND NUTRITION POLICY OBJECTIVES AND TARGETS

The *Lancet* series conceptual framework was adapted to inform the organisation of Lesotho's National Nutrition Policy.

3.1. Policy Objectives

Objective I. Nutrition-Specific Programming

1. To ensure that women of child-bearing age and during the neonatal period consume a diet that provides adequate nutrients appropriate for their physiological needs
2. To ensure that all infants and young children 0-59 months of age in Lesotho are appropriately fed
3. To ensure optimal nutrition for school-age children and adolescents
4. To ensure prevention, treatment and management of acute malnutrition according to IMAM guidelines
5. To ensure prevention and control of diet-related non-communicable diseases and ensure a healthy lifestyle.
6. To ensure that all people in Lesotho have adequate micronutrient status
7. To ensure that nutrition aspects are strengthened in all TB and HIV and AIDS prevention, treatment and care programmes.

Objective II. Nutrition-Sensitive Programming

1. To achieve reliable production, supply and utilisation of a variety of safe, adequate, affordable and nutritious foods at all times, the Government shall aim to promote climate-smart technologies
2. To ensure that multiple micronutrients are added to staple and other regularly consumed foods
3. To enact and implement appropriate legislation and other regulatory frameworks to ensure that safe and high quality food is available at all times
4. To expand the coverage of social protection programmes, target nutritionally vulnerable groups and strengthen the quality of service provision
5. To ensure that all children in Early Childhood Care and Development (ECCD) centres and primary schools get adequate nutrition and that nutrition education is covered in curricula from ECCD to institutions of higher learning
6. To ensure that all households and other institutions in Lesotho can live in conditions of good environmental health.

Objective III. Enabling Environment

1. Nutrition **capacity building**
2. Nutrition **research**, to ensure coordinated, regulated and appropriately prioritised nutrition research that contributes to and supports policy objectives, poverty reduction and strategy reviews.
3. **Institutional framework**, to facilitate coordination and harmonisation of all nutrition-related policies and programmes in order to avoid duplication, ensure optimal use of scarce resources and ensure standardisation of operations by all public and private entities
4. **Budget** - Efficient allocation and use of resources for implementation of LFNP
5. **Common Results Framework** - Monitoring and evaluation of nutrition programmes.

3.2. National Nutrition Targets to be achieved by 2025

Lesotho's Food and Nutrition Policy should adopt the clear nutrition goals for 2025 set by the World Health Assembly. The policy covers the period 2015-2025, leaving 10 years for the realisation of the required changes in nutrition conditions and behaviours. The strategy that has been developed in principle covers five years (2015-2020), which leaves room for adjustment of the approach and possible reallocation of resources after the first five years of policy implementation.

Based on WHA global targets, the following **national targets**³⁷ have been formulated for the LFNP to be achieved by 2025:

1. Stunting among children 6-59 months of age will be reduced to a prevalence of 23 per cent or lower
2. Anaemia prevalence among women of reproductive age (15-49 years) will be reduced to 13 per cent or lower
3. Childhood overweight will not have increased and at most will affect 7 per cent of children under five years of age
4. The exclusive breastfeeding rate during the first six months will be maintained at a level of at least 50 per cent
5. Childhood wasting will be maintained at a level below 5 per cent.
6. Low birth-weight will be maintained at a level below 5 per cent.

Table: Baseline and target values for the LFNP indicators

Indicator		2009 DHS	2014 DHS	2025 Target
1	Stunting (Height-for-Age <-2SD) children 6-59 months	39.2%	33.2%	23%
2	Anaemia (Mild, moderate, severe) women 15-49 year ³⁸	26.3%	27.3%	13%
3	Overweight (Weight-for-Height >2SD) children 6-59 months	7.2%	7.4%	7%
4	Exclusive Breast Feeding children 0-5 months	53.5%	66.9%	> 50%
5	Wasting (Weight-for-Height <-2SD) children 6-59 months	3.8%	2.8%	< 5%
6	Low birth weight	2%	1%	<5%

The above table on current trends for these indicators and the target values, demonstrate that the **main challenges in Lesotho** are to make progress on reducing stunting among children 6-to-59 months of age and anaemia prevalence among women 15-to-49 years of age. The baseline figures for exclusive breastfeeding and wasting are already compliant with the 2025 targets. For overweight children the target is to ensure that during the ten-year period up to 2025 there is no increase in prevalence compared to the baseline.

³⁷The indicators that form the basis for the Lesotho national nutrition targets have been chosen in such a way that no additional data collection is necessary beyond regular DHS surveys repeated five-yearly. It is logical to use 2014 LDHS figures as the baseline as this is the last national survey before the WHA targets were set in 2012.

³⁸ The thresholds for each type of anaemia are different for pregnant and non-pregnant women. Refer to the DHS reports for the classification applied.

4. POLICY OBJECTIVE 1: NUTRITION-SPECIFIC PRIORITY ACTIVITY AREAS³⁹

This section focuses on nutrition-specific interventions related to child feeding and care-giving patterns and child health. Most of these interventions fall under the purview of the health sector, both at facility and community levels, including: promotion of appropriate infant and young child feeding, maternal nutrition, prevention and treatment of malnutrition, prevention and treatment of diet-related non-communicable diseases, prevention of micronutrient deficiencies, HIV and AIDS and TB. The strategies for each of these intervention areas are described in Annex 4.

4.1. Improving Maternal Nutrition

Science has shown that nutrition during the first 1,000 days (period between pregnancy and a child's second birthday) is essential to ensure optimum physical and cognitive development. Mothers' nutritional status is critical to support foetal development and lactation during this period. Inadequate weight during pregnancy is associated with low birth-weight, pre-term delivery and intra-uterine growth retardation. Women who gain too much weight during pregnancy are also at increased risk for complications and adverse outcomes.

Policy objective:

To ensure that women of child-bearing age and during the neonatal period consume a diet that provides adequate nutrients appropriate for their physiological needs.

Strategic objectives:

1. Integrate nutrition services into antenatal and postnatal care and family health packages.
2. Ensure routine iron folate supplementation and deworming.
3. Institutionalise universal maternity care.
4. Prevent malnutrition and mother-to-child transmission of HIV; ensure adherence to treatment through provision of nutrition services to women and infants.
5. Promote nutritional support for malnourished women of child-bearing age.

4.2 Promotion of Appropriate Infant and Young Child Feeding Practices

Appropriate IYCF practices are essential for the nutrition, growth, development and survival of infants and young children. In Lesotho, practices for feeding infants and young children show mixed trends. The 2014 LDHS preliminary results indicated that 67 per cent of children under six months are exclusively breastfed, which is well above the global target of 50 per cent. However, only 11 per cent of children under the age of five meet the minimum acceptable recommended dietary intake, down from 18 per cent in 2009. Given Lesotho's high HIV prevalence (23 per cent), counselling and support on infant feeding can improve child survival by promoting appropriate feeding practices, while minimising the risk of HIV transmission through breastfeeding. Initiatives to improve IYCF practices will be aligned with Lesotho's Infant and Young Child Feeding Policy.

Policy objective:

To ensure that all infants and young children aged 0-to-59 months in Lesotho are appropriately fed.

Strategic objectives:

1. Promote, protect and support exclusive breastfeeding and create an enabling environment that includes enforcement of the law on marketing breast-milk substitutes.

2. Promote efficient nutrition assessment and counselling.
3. Promote and create access to appropriate, diverse, nutritionally adequate complementary foods for children aged 6-to-24 months.
4. Support the monitoring of IYCF trends.
5. Provide essential nutrition services.
6. Advocate for the incorporation of IYCF into the curricula at all levels of formal and non-formal education systems.

4.3. Prevention, Treatment and Management of Malnutrition

This section describes the objectives for prevention and management of acute malnutrition at different levels. Acute malnutrition is a global health problem; in Lesotho the rate is 3.4 per cent (below the WHO threshold). Acute malnutrition can be moderate or severe; both forms have severe consequences and contribute to increased morbidity and mortality.

Policy objective:

To ensure prevention, treatment and management of acute malnutrition according to IMAM guidelines.

Strategic objectives:

1. Promote efficient early identification, management and follow-up of acute malnutrition patients at community and health facility level.
2. Ensure availability of specialised nutrition products to treat acute malnutrition.
3. Enhance monitoring, evaluation and management of acute malnutrition programmes.

4.4. Nutrition in the General Population

Policy objective:

To ensure optimal nutrition and healthy lifestyles amongst all age groups.

Strategic objectives:

1. Facilitate the prevention and control of nutritional deficiencies through micronutrient supplementation, food fortification, food-based approaches and disease-control measures.
2. Promote behavioural practices supportive of optimal nutrition and healthy lifestyles.

4.5. Preventing and Managing Diet-Related Non-Communicable Diseases

Non-communicable diseases (also known as chronic diseases) are not passed from one person to another. They are of long duration and generally slow in progression. The main types are cardiovascular diseases (such as heart attack and stroke), cancers and chronic diseases (such as asthma and diabetes). These diseases are driven by factors such as aging, rapid unplanned urbanisation and unhealthy lifestyles. Furthermore, the risk of acquiring NCDs is related to early foetal and childhood under-nutrition, followed by excessive weight gain later in childhood. Therefore, nutrition is an important component of NCD prevention and management.

Policy objective:

To ensure prevention and control of diet-related non-communicable diseases and ensure healthy lifestyles.

Strategic objectives:

1. Promote consumption of healthy foods and diets, physical activity and healthy lifestyles
2. Promote programmes on prevention and management of diet-related NCDs
3. Promote screening for NCDs

4.5. Preventing Micronutrient Deficiencies

The main micronutrient deficiencies encountered in Lesotho are Vitamin A, and iodine deficiencies and anaemia. Lack of iron contributes to anaemia, which is present among 51 per cent of under-five children, and 27 per cent of women of child-bearing age (2014 DHS). Solutions are being sought through routine micronutrient supplementation (Vitamin A for children under-five, iron folate for pregnant women), as well as fortification of staple foods (iodised salt established since early 1990s, multi-fortification of maize meal and wheat flour) and de-worming.

Policy objective:

To ensure that all people in Lesotho have adequate micronutrient status.

Strategic objectives:

1. Provide access to essential nutrition services, with a focus on vitamin A and iron supplementation and salt iodisation
2. Enforce micronutrient legislation
3. Support the implementation of appropriate micronutrient supplementation programmes for identified groups at risk (pregnant and lactating mothers, infant and young children, school-aged children and people living with HIV/AIDS and TB)
4. Promote the production, processing, preservation, packaging and consumption of foods rich in micronutrients
5. Develop new (and/or update existing) regulations and legislation on micronutrient fortification of both locally-produced and imported foods
6. Develop and implement a communication strategy on the importance of foods rich in micronutrients, to encourage behavioural change
7. Strengthen collaboration and linkages between communities, the GoL, NGOs and the private and informal sectors
8. Support the enforcement of food-fortification regulations and legislation
9. Advocate for the integration of routine de-worming for all populations at risk.

4.6. Nutritional Needs of Special Groups**4.6.1. Nutrition, HIV and AIDS and TB**

The HIV and AIDS pandemic continues to have a devastating impact on health, nutrition, food security and the overall socio-economic development of heavily affected countries. In Lesotho the HIV epidemic continues to impose a significant burden on the population, despite the country's achievements in prevention, treatment and care. Nutrition plays a critical role in comprehensive care, support and treatment of HIV-infected people. Complex interactions exist between nutrition and HIV and AIDS. HIV progressively weakens the immune system and leads to malnutrition. Malnutrition worsens the effects of HIV and contributes to a more rapid progression to AIDS. HIV also has a negative impact on food and nutrition security. In fact, HIV and AIDS and food security are

closely interlinked. For example, while chronic illness of a breadwinner can lead to food insecurity due to reduced income and livelihood options, food insecurity can also lead to HIV through risky behaviour or early marriage as a coping strategy to deal with food insecurity.

Policy objective:

To ensure that nutritional needs are met in all TB, HIV and AIDS prevention, treatment and care programmes.

Strategic objectives:

1. Integrate nutrition into TB, HIV and AIDS prevention, treatment and care programmes
2. Advocate for increased commitment at public, private, NGO and community levels to support nutrition, TB, HIV and AIDS programmes
3. Establish linkages between nutrition assessment care and support (NACS) in communities and livelihood programmes.

4.6.2. School-Aged Children and Adolescents

Childhood and adolescence are the growth periods from infancy to the beginning of adulthood and are marked by many physical changes. Nutritional concerns of childhood and adolescence can include poverty, lack of food, lack of child and adolescent friendly health services, poor body image resulting in eating disorders, obesity from overeating empty calories, insufficient exercise, skipping meals and adopting negative behaviours that could lead to early development of non-communicable diseases.

Policy objective:

To ensure optimal nutrition for school-age children and adolescents.

Strategic objectives:

1. Promote nutrition for optimal growth and development for school-age children and adolescents
2. Promote optimal nutrition composition of all school meals
3. Support school-based meals that contribute to improved daily attendance and reduction of dropout rates
4. Strengthen nutrition education.

5. POLICY OBJECTIVE 2: NUTRITION-SENSITIVE PRIORITY ACTIVITY AREAS⁴⁰

This chapter focuses on nutrition-sensitive programmes that address key underlying determinants of nutrition such as food safety and standards, fortification, social protection, early childhood development and water and sanitation. It is at this level where the Food and Nutrition Policy become multi-sectoral, entailing interventions on food and nutrition security, water and sanitation, early childhood care and development and social protection. Nutrition sensitive programmes, when

implemented at scale, enhance the coverage and effectiveness of nutrition specific interventions. Annex 5 provides an overview of the strategies for each of these intervention areas.

5.1. Food and Nutrition Security at National, Community and Household Level

Food security exists when all people at all times have physical, social and economic access to food, which is consumed in sufficient quantity and quality to meet their dietary needs and food preferences. **Nutrition security** is said to exist when food security is combined with education, sanitation, adequate health services and proper care and feeding practices to ensure a healthy life for all households.

The 2005 Lesotho Food Security Policy emphasises the importance of increasing production in order to ensure food availability, affordability and accessibility. In addition, the policy seeks to ensure that all citizens of Lesotho have adequate, safe and nutritious food. Lesotho's food production is characterised by subsistence farming, which contributes about 20 per cent of the country's cereal requirements, implying that most Basotho depend on food purchases. Seventy-seven to 80 per cent of the rural population relies on subsistence farming as their main livelihood source. The bulk of household food (45 per cent to 60 per cent) is from purchases. The data reveal that the population faces a considerable food security gap. Thus this policy area focuses on nutrition-sensitive food security.

Policy objective:

To achieve sustainable production, supply and utilisation of a variety of safe, adequate, affordable and nutritious foods at all times. The government shall aim to promote climate-smart technologies.

Strategic objectives:

1. Promote utilisation of diverse, safe and nutritious foods
2. Contribute to the diversification of sustainable food production and supply-base, considering climate-smart technologies
3. Promote community nutrition programmes that support income-generating, sustainable and resilient livelihoods
4. Promote climate-smart and labour-saving technologies.

5.2. Food Fortification

Food fortification is the addition of one or more essential nutrients to a food (whether or not it is already contained in the food) for the purpose of preventing or correcting a deficiency of one or more nutrients in the population or specific population groups. It is designed to build up micronutrient stores in people over time and without risk, as a safe and efficient way of improving nutrition without forcing people to change their eating habits. Currently in Lesotho two milling companies are fortifying maize meal and wheat flour. Furthermore, the Ministry of Agriculture and Food Security, through the Department of Agricultural Research, is piloting product development of bio-fortified bean seeds.

Policy objective:

To ensure that multiple micronutrients are added to staple and other regularly consumed foods.

Strategic objectives:

1. Promote the consumption of nutrient-enhanced foods.

2. Advocate for the provision of multiple micronutrient sachets for addition to a child's meal before consumptions and addition to milling machines used in the community each time a pre-measured portion of grain is added.

5.3. Food Safety and Standards

Food safety is a critical element of food production, storage, preparation and service. Safe and adequate food is not only essential for proper nutrition but also for trade. An effective food safety system throughout the food chain is necessary for improved nutritional wellbeing. About 80-to-90 per cent of imported food consumed in Lesotho and 20 per cent of food produced locally does not meet health and safety standards. The lack of operational food standards exposes the population to a hazardous food-safety environment, hence the need for a clear policy and enforcement tools.

Policy objectives:

To enact and implement appropriate legislation and other regulatory frameworks to ensure that safe, high-quality food is available to the population at all times.

1. Improve/ensure food standards, quality and safety.
2. Develop food standards guidelines.

5.4. Caring for the Socio-Economically Deprived & Nutritionally Vulnerable

The Government of Lesotho has introduced several social safety nets through the Ministry of Social Development (MoSD), including Bursaries for OVC, the Child Grant Programme, Public Assistance, Community Development (income generation projects) and the Old Age Pension. This set of social protection programmes is aimed at reducing vulnerabilities throughout the life-course to: provide support to those that are unable to construct a viable livelihood, protect the assets and improve the resilience of poor and vulnerable households and increase the productive capacity and asset-base of poor and vulnerable households, moving them above the poverty line. The Government will ensure targeting of underserved areas populated by the most vulnerable groups living in challenging circumstances for nutrition services, to meet their right to good nutrition. This includes all services delivered through the Health, Education, Agriculture and Finance sectors and civil society organisations.

Policy objective:

To expand the coverage of social protection programmes, target nutritionally-vulnerable groups and strengthen the quality of service provision.

Strategic objectives:

1. Promote social protection interventions for improved nutrition
2. Promote participation by men in the provision of nutritional care and support for their families
3. Support the creation of community-based livelihood and growth-promotion programmes
4. Build capacity for the provision of nutritional care to socio-economically deprived and nutritionally vulnerable household members
5. Advocate for food and nutrition programmes directed to vulnerable groups
6. Ensure that all food packages aimed at nutritionally vulnerable groups meet nutritional standards.

5.5. Early Childhood Care and Development

Malnutrition among children aged 0-5 years has been a problem in Lesotho. Stunting levels are a prominent form of malnutrition and remain in above the WHO threshold. When children are poorly nourished their cognitive and physical development is compromised. They become more prone to illness and death, productivity is impaired, and they may not achieve their full potential. Therefore optimal nutrition is essential at this stage.

Policy objective:

Ensure that all children in ECCD centres and primary schools receive adequate nutrition and that nutrition education is covered in the curricula.

Strategic objectives:

1. Improve the nutritional status of children in ECCD
2. Improve the nutritional status of children in primary schools
3. Reduce malnutrition in schools
4. Improve food and nutrition security
5. Increase knowledge on nutrition, food production and livelihood opportunities at all schools.

5.6. Water, Sanitation and Hygiene (WASH)

Access to and use of safe water, sanitation facilities and good hygiene have the potential to positively impact nutritional outcomes by addressing both the direct and indirect causes of malnutrition. In Lesotho access to improved drinking water is ensured for 82 per cent of the population. About 55 per cent of households have access to improved sanitation (mainly pit latrines). Lesotho also has high rates of open defecation, which can lead to repeated episodes of illness and waterborne diseases which contribute to poor nutrition outcomes. Therefore, the policy aims to link with the water and sanitation sector to advocate for WASH infrastructure and promote use and awareness of WASH practices. Essential WASH practices have been shown to effectively reduce the prevalence of diarrhoea, a major contributor to child malnutrition.

Policy objective:

To ensure that all households and other institutions in Lesotho can benefit from good environmental health conditions.

Strategic objectives:

1. Promote safety of drinking water, including commercially bottled water
2. Promote essential WASH practices (hand-washing with water and soap at critical times, treatment and safe storage of drinking water, and sanitary disposal of human faeces)
3. Promote water protection interventions
4. Advocate for water, sanitation and hygiene distribution services to households and other institutions.

5.7. Nutrition in Emergency Situations

Since 2006 Lesotho has experienced successive climate shocks – including recurrent droughts, dry spells and flooding – with serious consequences for the population's food and nutrition security. With a population 1.8 million people, the number of food-insecure people has ranged between 200,000 and 725,519 between 2006 and 2015. These levels indicate chronic food insecurity, with a serious negative impact on the nutrition status of the population. In an emergency situation timely

response programmes are required to increase the resilience of communities and their ability to access adequate food. The most commonly affected are children under the age of five and pregnant and lactating women, as well as people living with HIV/AIDS and TB. When addressing emergency situations the health and nutrition cluster, coordinated by the Disaster Management Authority, will provide appropriate nutrition programming support.

Policy objective:

To ensure timely access to adequately nutritious food for people affected by emergencies.

Strategic objectives:

1. Strengthen nutrition early warning systems by including a food security and nutritional assessment
2. Strengthen the capacity of Government, UN agencies and NGOs to respond to nutrition and nutrition-related early warning information related to potential shocks
3. Ensure availability of specialised nutrition products, supplementary food, therapeutic food, safe drinking water and water purification commodities
4. Support integration and linkage of emergency programmes to livelihood interventions and social safety nets/transfers
5. Support infant and young child nutrition emergency principles, including breastfeeding support, essential WASH actions and access to other critical services.

6. POLICY OBJECTIVE 3: CREATION OF AN ENABLING ENVIRONMENT

In Lesotho the most efficient and cost-effective way of strengthening nutrition are: addressing the first 1000 days of life (SUN approach), addressing malnutrition among children under five years of age, and addressing micronutrient deficiencies among women of childbearing age (15-49 years). These steps require the creation of an enabling environment that facilitates the programming, coordination and implementation of various nutrition-specific and nutrition-sensitive priority interventions.

The Food and Nutrition Coordinating Office is playing a key role in implementation of the LFNP, with responsibility for overall coordination, capacity building activities and action-oriented research. The FNCO also undertakes overall monitoring and evaluation that builds on data collection undertaken by the various line ministries. What is new in the LFNP approach is that GoL programmes are linked with those operated by other stakeholders (UN partners, NGOs and private-sector initiatives).

This approach needs to be based on **linking together and expanding existing relevant programming across sectors**. The only way that the LFNP can be effective and make a difference is by maintaining a clear and continuous focus on the need to effectively reach out to communities and households. The LFNP thus relies on maximising the impact of programming already taking place under the NSDP, rather than introducing additional lines of activity. Implementation will therefore not involve new, up-front funding for start-up in the course of 2016, beyond the budget for some staff, travel and equipment costs. It is hoped that the development actors present in Lesotho will be able to find these funds from within their discretionary budgets. Expansions from 2016 onwards will need to figure in each actor's own subsequent planning and funding arrangements.

Within the LFNP, **FNCO** is the designated agency for overall coordination, both horizontally (FNCO acting as the link between the various actors involved in the capital and district-based FNCOs doing

the same within their respective districts), and vertically (FNCO uses its district-outreach network of DFNCOs to ensure that national-level planning is translated into and builds on field-level activities). The coordination role for FNCO entails overseeing the preparation of annual cross-sectoral activity plans. These plans should be linked and build on the planning by each line ministry involved in the LFNP. Another key role for FNCO is to facilitate implementation of the plan. This implies a range of activities as described in the sections below. The strategies for each of these activity lines are further described in Annex 6.

The LFNP requires involvement of a range of stakeholders from various Government agencies and their partners at national, district and community levels. Annex 7 provides an overview of the key line ministries and other agencies relevant to the Food and Nutrition Policy and Strategy (Ministry of Health; Ministry of Agriculture and Food Security; Ministry of Trade & Industries; Ministry of Small Business; Ministry of Local Government; Ministry of Education and Training; Ministry of Social Development; Ministry of Finance and Development Planning; and Ministry of Gender, Youth, Sports and Recreation). The line ministries are the lead agency in their sector, each with its own budgeting, implementation and reporting processes. Each ministry should have one LFNP focal point who acts as the liaison with other ministries and the FNCO.

6.1. Research, Monitoring and Evaluation

Research, timely information and updated knowledge are vital for evidence-based programme planning, management, decision-making and enhanced public accountability at all levels. Monitoring is essential to assess the *process* of implementation of nutrition programmes, while evaluation will assess the *impact* of nutrition interventions.

Policy objective:

To ensure coordinated, regulated and appropriately prioritised nutrition research that contributes to and supports policy objectives, poverty reduction and strategy reviews.

Strategic objectives:

1. Develop a framework and plans for monitoring, evaluation and research on nutrition
2. Obtain timely data on the nutritional status of the population through nutritional surveillance, HMIS, periodic surveys and other routine and non-routine (early warning systems) information systems, for better programming and decision-making
3. Prioritise and support research-oriented activities and utilise evidence for regular monitoring and periodic evaluation of nutrition programmes
4. Build local capacity for undertaking nutrition research
5. Upgrade and publicise the nutrition resource center at FNCO
6. Support relevant nutrition research to guide policy review and implementation.

6.2 Institutional Structure and Financing of Nutrition Programmes

Nutrition programming is multi-sectoral in that it is implemented by different line ministries. Thus it is essential to have a comprehensive institutional structure that will assist in effective and efficient implementation of nutrition activities. The Government and institutional structures should ensure

that priority areas identified in the LFNP are allocated sufficient funding in the budget planning process.

Policy objective:

To facilitate coordination, harmonisation and financing of all nutrition-related policies and programmes, in order to avoid duplication and ensure efficiency.

Strategic objectives:

1. Ensure optimal use of scarce resources and standardisation of operations by both public and private sectors
2. Mainstream all nutrition-related policies and programmes
3. Strengthen institutional structures related to nutrition
4. Commit financial resources through the budgeting process to meet the goals of food and nutrition programmes in all line ministries
5. Facilitate development of a nutrition resource mobilisation strategy to ensure long-term and sustainable funding for implementing nutrition programmes.

6.3 Human Resources for Nutrition

The repositioning of nutrition as core to development, and its role as a major determinant of health and wellbeing, have increased the demand for nutrition services. Food insecurity, poverty, diet-related chronic diseases and the HIV pandemic have also contributed to an increased need to focus on nutrition. However, there is a shortfall of qualified personnel to manage and provide technical support for nutrition programmes among stakeholders.

Policy objective:

To facilitate the establishment of nutrition positions in key line ministries and NGOs, where necessary, at all levels.

Strategic objectives:

1. To scale up the employment and deployment of qualified personnel to manage nutrition programmes at all levels (national, district and community levels)
2. Support initiatives that will improve the skills of community volunteers involved in the promotion of food-based interventions, to promote good health and nutrition practices.

6.4 Training and Capacity Building on Nutrition

Personnel that are targeted to effectively implement food and nutrition programmes require empowerment in the form of training.

Policy objective:

To ensure that nutritionists and other related cadre are adequately trained on nutrition issues

Strategic objectives:

1. Ensure nutrition education of good quality
2. Establish a cadre for nutrition at all levels
3. Ensure the incorporation of nutrition in professional training
4. Support nutrition capacity-building in leadership and management skills for various nutrition positions.

7. COMMON RESULTS FRAMEWORK

7.1. LFNP Organising Principles

Substantial reduction of under-nutrition requires long-term efforts and can only be achieved through a **package of complementary interventions that reach out to large segments of the population**. As described in the previous chapter, the *Lancet* differentiates between two groups of activities: (a) nutrition-specific interventions that primarily have to be implemented through the health sector, and (b) nutrition-sensitive programmes and approaches that fall under the responsibility of a range of line ministries.

In summary, the **nutrition-specific interventions** through the health sector that have highest priority in terms of their potential contribution to reducing stunting and anaemia are:

- Strengthen nutrition within the **minimum health package**, through antenatal care and mother/child health clinics
- Adoption and enactment of **Infant and Young Child Feeding** Policy Guidelines and strategies
- Improve antenatal care services, including the **essential nutrition package for pregnant and lactating women (PLW)**
- Promotion of **dietary diversification** and nutrition
- **Food supplementation** programme to prevent chronic malnutrition (blanket feeding of PLWHIV and children 6-23 months in the most affected districts)
- **De-worming** for children 2-12 years
- Multiple micronutrient **fortification of staple foods** (including national legislation).

For **nutrition-sensitive programmes**, the highest priority interventions to reduce stunting and anaemia are:

- Increase **household-level food production** (conservation farming, community gardens, orchard development, animal exchange programmes)
- Community-level promotion of **dietary diversity**.

Some other interventions of high relevance for a true **cross-sectoral approach** to combating stunting and anaemia include:

- Promote enforcement of standards for construction of **VIP latrines**
- Support improvement of children's development through by incorporating nutrition into **ECCD**
- Strengthen nutrition in the **empowering mechanisms for OVC** (e.g. cash grants).

7.2. LFNP Coordination, Monitoring and Reporting Framework

Lesotho's National Food and Nutrition Policy will cover the 10-year period from 2016 to 2025, accompanied by a five-year strategic plan (2016 to 2020). The strategic plan specifies the strategic actions and means of verification. Coordination of the LFNP will be undertaken at both national and subnational levels in accordance with a common results framework aligned to the Scaling-Up Nutrition movement.

7.3. Legal Framework

The objective of the LFNP legal framework is to endorse and transform into law policies, strategic plans and guidelines governing the operations of the organisations mandated to address nutrition and nutrition-related issues.

8. LFNPS IMPLEMENTATION STRUCTURE

The objective of the institutional framework for the Lesotho Food and Nutrition Policy and Strategy (LFNPS) is to facilitate coordination and harmonisation of all nutrition-related policies and programmes in order to avoid duplication, ensuring optimal use of scarce resources and standardised operations by all public and private sector actors.

A three-layered coordination structure is envisaged at national level with an in-built cross-sectoral nature. The structure places the plan at the highest Government levels through the establishment of an LFNPS Executive Committee and a LFNPS Steering Committee. The LFNPS Coordination Committee should hold quarterly joint planning and review meetings, engaging a wide range of stakeholders on nutrition in Lesotho. The structure also provides for a series of technical working groups for more focused discussion of technical and programme matters and a district-level coordination mechanism.

8.1. Key Governmental Agencies for Inter-Sectoral Nutrition Programming

The Food and Nutrition Coordinating Office, under the Prime Minister's Office, is charged with overall coordination of food and nutrition programmes in the country. FNCO is mandated to provide visionary policy direction, technical guidance, oversight, monitoring and evaluation and resource mobilisation, among other functions. This office is also responsible for coordinating the implementation of the National Nutrition Policy.

Planning and implementation of food and nutrition activities will be carried out by various line ministries: the main ministries involved in nutrition programmes are the Ministry of Health (MoH) Behavioural Change Communication on Mother, Infant and Young Child feeding programmes (preventive), and Mother and Child Health services); the Ministry of Agriculture and Food Security (MAFS) for nutrition-sensitive programming of agriculture and food security programmes; the Ministry of Education and Training (MoET) for nutrition-sensitive ECCD and primary education; the Ministry of Trade and Industry (MTI) for fortification of staple foods and the MoSD, for social safety net programmes.

8.2. UN agencies and the Main NGOs Relevant for Nutrition

UN agencies (such as UNICEF, WFP and WHO) and NGOs present in Lesotho (together with their partners) are engaged in the following activities:

- Advocacy for nutrition
- Provision of services and facilities for implementation of nutrition programmes
- Provision of technical and financial support for improvement of nutrition
- Support and technical assistance in the development and review of policies, strategic plans and guidelines

Government of Lesotho Institutions Relevant for Nutrition Programming

Ministry of Health

The MoH's mandate is to ensure that maternal and child health and nutrition services are prioritised and implemented in the health sector. The Ministry's Nutrition Unit implements the following activities: nutrition education; nutrition assessment care and support; nutritional needs for TB, HIV and AIDS patients; growth monitoring and promotion; IYCF programmes; and micronutrient supplementation, including food supplementation in health facilities. The Ministry conducts in-service training of health personnel in nutrition and dietetics. The Ministry also assists in the nutrition components of Safe Motherhood and Integrated Management of Childhood Illnesses (IMCI). In addition, the Ministry has a Dietetics division based in hospitals, which deals with nutrition education, providing therapeutic food and following-up cases discharged from hospitals, as well as food management services in hospitals. The Disease Control Unit also deals with diet-related non-communicable diseases. Through its public health division, the Ministry carries out water, sanitation and hygiene campaigns and ensures adherence to food safety standards and programmes for disease and infection prevention and control in public places, including schools and institutions, and in households. The Division of Public Health, because of its wide network, should also support the disease surveillance and response programme. Disease and infection burdens have both direct and indirect effects on the nutrition status of individuals. The Ministry provides technical guidance on health issues to other ministries and, through its HMIS system, generates and monitors nutrition indicators.

Ministry of Agriculture and Food Security

The main goal of the MAFS is to combat malnutrition through food-based interventions in order to improve the food and nutrition security and quality of life of the population. Given the central role that MAFS plays in nutrition advocacy and prevention activities, it is imperative that it be recognised as one of the lead ministries, alongside the MoH, for the implementation of nutrition programmes in the country. The Ministry undertakes activities aimed at creating and promoting awareness, and educating the public on nutrition, the role of nutrition in HIV and AIDS treatment, care and support and improved livelihoods. The ministry is also involved in monitoring and evaluating nutrition and home economics projects within the Nutrition Division. It additionally liaises and exchanges ideas with other institutions and NGOs that are involved in nutrition and home economics, and ensures that there are trained nutrition and home economics personnel at all levels of service delivery. The Ministry also pursues and conducts food and nutrition research and disseminates research findings to the public in order to improve nutrition awareness. The Ministry should empower farmers to create innovative projects that will add value to their products, so as to compete on the market for improved quality and enhanced earnings. In collaboration with partners and NGOs, the Ministry should also provide incentives and empower youth in rural areas with entrepreneurship skills that will motivate them to be involved in agricultural-based enterprises for increased productivity and creation of employment. One of the strengths of the nutrition department is empowering women in nutrition-related livelihood interventions. MAFS ensures adherence to phyto-sanitary standards.

Ministry of Trade and Industry

The Department of Standards and Quality Assurance (DSQA) of the MTI is charged with coordinating the formulation, adoption and harmonisation of food standards – guided by the Codex Alimentarius Commission and in collaboration with the Environmental Health Inspectorate Unit of the MOH, MAFS, FNCO and other stakeholders – to ensure that food safety and hygiene adhere to the Lesotho Standards Institute (LSI), enacted by Parliament in July 2014. At present there is no supportive legal framework on food standards and no modern legislation to facilitate effective implementation of

food control systems. The DSQA is also responsible for food quality infrastructure to establish mechanisms for verification, quality and safe fortified food products. The Consumer Section is mandated to promote and protect consumer rights, and is responsible for advocacy in favour of the consumption of safe, quality and fortified foods by the general public.

Ministry of Small Business Development, Cooperatives and Marketing

The Department of Marketing regulates the importation and exportation of essential food items, controls prices of staple foods and ensures the distribution of food from surplus regions to deficit areas. The Ministry, in conjunction with the MAFS, advocates for diversification and value-addition to local agricultural products for enhanced nutritional quality.

The Department of Cooperatives empowers small-hold farmers to form farmer groups that are actively involved in the design and management of their own agricultural development programmes, to ensure sustainable livelihoods. The private and public sector should facilitate the provision of manageable credit facilities to farmer groups, as well as link the farmers to markets through well-established and coordinated marketing systems. These will enhance the establishment of small- and medium sized enterprises (SME) for increased processing – and therefore availability and accessibility – of affordable food products, and improved incomes through job creation.

Ministry of Local Government

This Ministry of Local Government (MoLG) ensures that nutrition education is carried out efficiently at the community, district and national levels. It also ensures that land is available for food production, working closely with MAFS. These nutrition interventions are operating below expectation and need to be strengthened. The Ministry has the advantage of a wide network, covering the whole country. This could provide an opportunity to support the nutrition surveillance system, thus facilitating the tracking of trends and reporting on emerging issues requiring immediate attention. The MoLG is also well-placed to provide regular appraisal on nutrition programmes and interventions to the FNCO and to assist with community mobilisation.

Ministry of Education and Training

The Ministry of Education and Training is charged with ensuring that nutrition education is included and implemented efficiently in the curricula of all education institutions.

The Ministry is also responsible for implementing school feeding programmes, according to the 2015 School Feeding Policy. The MoET, in collaboration with MAFS, supports local agricultural production for school meals. The MoET recognises the importance of nutrition through its IECCD policy. In partnership with the MOH, MoET provides primary health care services to schools when needed to ensure the health and well-being of learners. Existing school feeding initiatives need to be reviewed to ensure that they provide adequate nutritious meals and to expand and sustain de-worming and Vitamin A supplementation interventions. Prevention and treatment of common illnesses based on IMCI guidelines should be monitored. School feeding programmes assist in attracting and keeping children in school, especially those from poor households (MDG 2), and enhance nutrition and health status to reduce mortality and morbidity among children (MDG 4), contributing to the attainment of universal primary education. Malnutrition decreases intelligence quotient. There is need to extend school nutrition programmes and interventions to early childhood education centres, since they cater for a nutritionally vulnerable age group.

Ministry of Social Development

The MoSD leads and facilitates the provision of sustainable development services that are universally accessible to vulnerable groups in Lesotho, in collaboration with other key stakeholders.

The Ministry achieves this through implementation of such programmes as public assistance, child grants programme, OVC bursaries and community development. The overall aim is to reduce the economic and social vulnerability of poor, vulnerable and marginalised groups and increase their inclusion in social and economic activities. This entails developing a comprehensive social security system on a progressive realisation basis, and building the capacity of the poor to emerge from poverty and enjoy their rights to life and all associated benefits. These initiatives assist with the acquisition of food and increase purchasing power to ensure nutritional wellbeing of beneficiaries. The MoSD developed the community-based targeting model that will be employed by all sectors working with the community.

Ministry of Water

The Ministry of Water is responsible for ensuring access to a sustainable supply of water and basic sanitation services for all Basotho. The Ministry, through rural water and sanitation departments, implements two distinct programmes to eliminate open defecation: a latrine subsidy programme and a community-led total sanitation programme.

Ministry of Finance

The Ministry of Finance is responsible for budgetary allocation, management and monitoring of government funds, in accordance with financial regulatory systems. The Ministry implements the old age pension programme, which increases the purchasing power of beneficiary households, allowing them to acquire food.

Ministry of Development Planning

The Ministry of Development Planning provides overall national strategic direction to ensure: economic growth, infrastructure development, enhanced skills base, innovation and technology adoption for accelerated development, improvement of health to combat HIV and AIDS and reduce vulnerability, reversal of environment degradation and adaptation to climate change, building of effective institutions and promotion of peace and democratic governance. Nutrition is embedded in the country's development agenda.

Ministry of Gender, Youth, Sports and Recreation (MoGYSR)

The Ministry works to advance gender equity and equality, as well as the enhancement of sporting excellence and the integration of youth in the country's socio-economic and political development. It ensures that development efforts have an equal impact on both genders.

The Departments of Gender and Youth will be more directly involved in implementing and scaling-up initiatives that build on the Lesotho National Nutrition Policy, including but not limited to strengthening the integration of nutrition-related actions into district planning processes.

The Food and Nutrition Coordinating Office (FNCO)

The mandate of FNCO is to ensure that good nutrition becomes a national development goal through guidance and coordination of food and nutrition programmes.

FNCO is also responsible for monitoring and evaluating nutrition programmes for effective implementation of nutrition activities such as nutrition surveys, nutrition research, surveillance and emergency response.

The Disaster Management Authority (DMA)

The Disaster Management Authority is mandated to manage disasters, risks and similar emergencies in the country through various multi-sectoral and multidisciplinary structures. Nutrition is an integral part of disaster management clusters and early warning systems.

Food Management Unit

The Food Management Unit is responsible for receipt, storage and control of logistics for the distribution of food commodities to beneficiaries, in collaboration with development and humanitarian partners and relevant government ministries.

The National AIDS Commission

The National AIDS Commission coordinates all national response initiatives on HIV and AIDS treatment, care and support through committees established at all administrative levels. Nutrition is an integral part of HIV and AIDS treatment, care and support programmes.

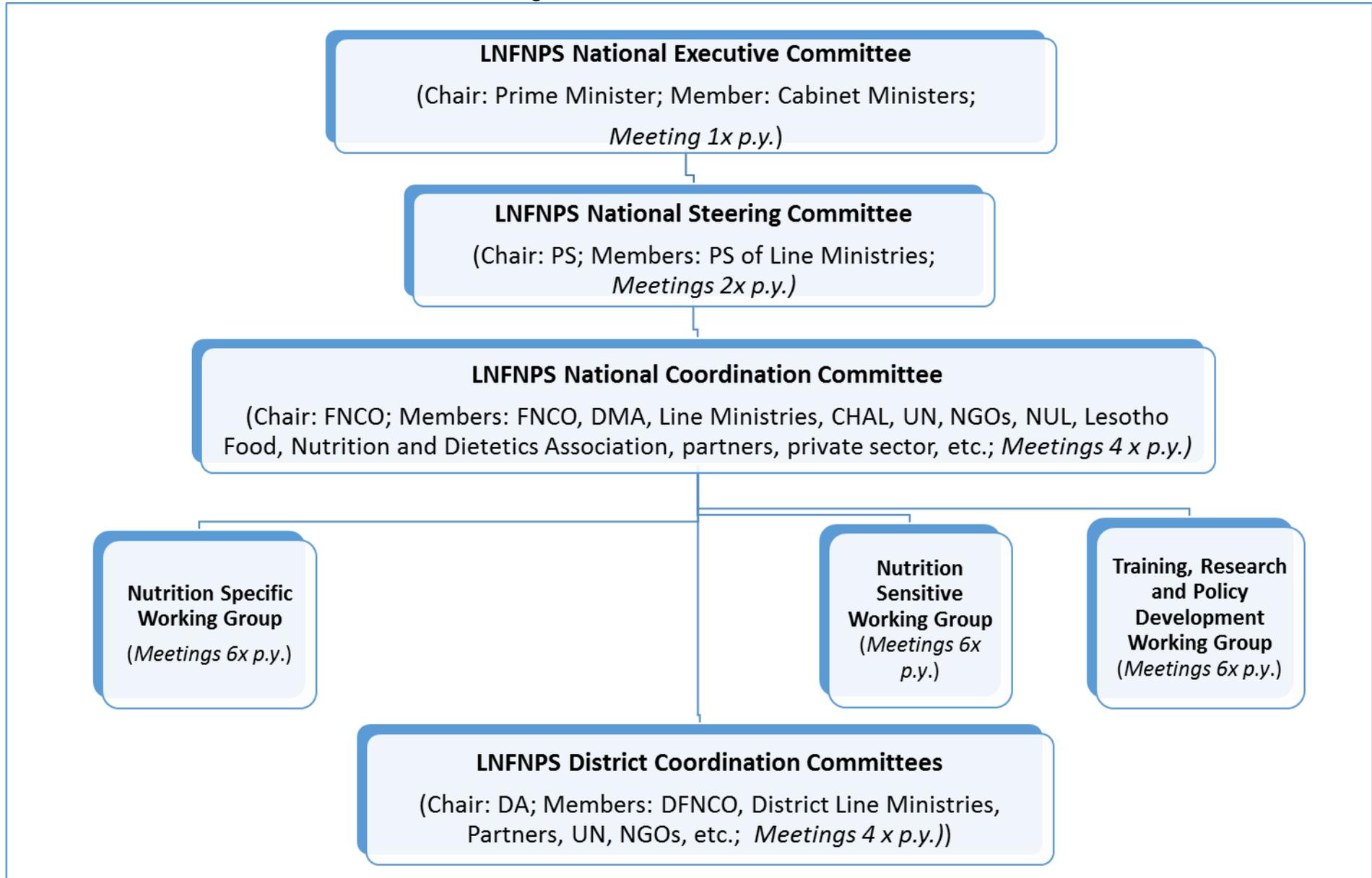
8.3. Role of the Private Sector

The private sector in Lesotho also plays a major role in improving nutrition, as it must follow guidelines established by the Government in the domain of nutrition. It can also engage in provision of quality nutrition services, such as assisting in food and nutrition related activities like the celebration of National Breastfeeding Week.

8.4. Operational Steps for Implementation of the Lesotho Food and Nutrition Policy

- Adopt and promulgate the national food and nutrition policy
- Adopt and implement the national food and nutrition strategic plan, protocols and guidelines
- Develop an operational food and nutrition action plan
- Advocate for the role of food and nutrition in national development, to ensure that the food and nutrition policy is well-integrated into the national development policy
- Evaluate training needs (pre and in-service)
- Develop training modules and other educational materials
- Strengthen capacities of nutrition service providers at all levels (training of trainers, in-service training and pre-service training of nutritionists)
- Mobilise and provide human and financial resources to support nutrition
- Ensure that the policy further seeks to provide a legal basis for existing food and nutrition structures, sectoral policies and action plans
- Support regular follow-up of nutritional data
- Undertake regular monitoring and evaluation of nutrition intervention strategies
- Carry out mid-term and long-term evaluation of outputs.

Figure 3: LNFNPS Institutional framework



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