Transformative Investment for Health and Economic Prosperity in Lesotho

A Case for Ending Preventable Maternal, Newborn, and Child Deaths, Unmet Need for Family Planning, Gender-Based Violence, and Child Marriage

Strategic Report

2026– 2030

Government of Lesotho

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Foreword

It is an honour to present this Investment Case for Lesotho, which outlines a strategic pathway to end preventable maternal, newborn, and child deaths, address the unmet need for family planning, and eliminate gender-based violence and child marriage.

While Lesotho has made progress in improving health outcomes, significant challenges remain. High maternal and neonatal mortality, persistent gender inequalities, and limited access to essential reproductive health services continue to affect the well-being of our people, particularly women, adolescents, and vulnerable populations.

This Investment Case provides compelling evidence that investing in these priority areas is both a moral obligation and an economic necessity. It demonstrates that targeted, high-impact interventions can save lives, strengthen our health system, and generate substantial economic returns for the country. The analysis clearly shows that every dollar invested yields multiple benefits, contributing to human capital development and sustainable national growth.

The scenarios presented offer practical options for scaling up interventions based on available resources, while highlighting the significant gains that can be achieved through increased investment. This evidence equips us to make informed decisions, prioritize effectively, and mobilize resources towards interventions that deliver the greatest impact.

I commend the Ministry of Health technical teams and our partners, particularly UNFPA and the Investment Case Reference Group, for their dedication to developing this important document.

The Government of Lesotho calls upon all stakeholders, development partners, the private sector, and civil society to work collaboratively in implementing this Investment Case. Together, we can build a healthier, more equitable, and prosperous nation.

Thank You

M Monyobi

Mrs Mants'oanelo Monyobi
Acting Principal Secretary - Health

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Executive Summary

The United Nations' Sustainable Development Goals (SDGs) include specific and broader objectives to end maternal, newborn and child (MNC) mortality, address unmet need for family planning (FP), and prevent gender-based violence (GBV). These priorities align closely with Lesotho's national strategies for leveraging its demographic dividend. While effective interventions exist for maternal, newborn and child health (MNCH), FP, and GBV, the scaling up of these efforts remains impeded by insufficient investment. Successful implementation of these interventions requires a significant increase in funding at all levels of the health system. Moreover, such investments also yield substantial health and economic returns. This investment case (IC) presents compelling evidence to inform potential investors about the considerable advantages of supporting high-impact interventions, emphasizing that each dollar invested produces far-reaching benefits that extend well beyond immediate health outcomes. The executive summary provides an overview of the costs and impacts associated with scaling up these interventions across different scenarios, with further details available in the report and appendix.

Ending preventable MNC mortality

This investment case was developed using multiple scale-up scenarios, each based on different assumptions about the level of intervention coverage.

- *Modest:* this scenario targets reducing maternal, neonatal, and child mortality from 530, 26, and 54 to 458 (per 100,000 live births), 19 (per 1,000 live births), and 44 (per 1,000 live births), respectively.
- *Achievable:* all interventions were scaled up to target a reduction in maternal, neonatal, and child mortality to 359, 16, and 38, respectively.
- *Ambitious:* targets scaling up interventions to reach Maternal, neonatal, and child mortality of 277, 14, and 35, respectively.

Expected costs and benefits of scaling up MNC health interventions (2026-2030)

Modest scenario	Achievable	Ambitious
Investment required: o US$63.5 million total investment.	**Investment required**: o US$98.9 million total investment.	**Investment required**: o US$142.6 million total investment.
Averts (Health benefits): o 472 **maternal deaths** o 4,561 **neonatal deaths** o 1,707 **child deaths** o 13.5%, 26.6%, and 18.1% decline in maternal, neonatal and child mortality.	**Averts (Health benefits)**: o 1,188 **maternal deaths** o 6,987 **neonatal deaths** o 3,535 **child deaths** o 32.3%, 40%, and 30.4% decline in maternal, neonatal and child mortality.	**Averts (Health benefits)**: o 1,861 **maternal deaths** o 8,488 **neonatal deaths** o 4,182 **child deaths** o 47.7%, 47.8%, and 36.1% decline in maternal, neonatal and child mortality.

Ending unmet need for family planning

This IC was developed under three scale-up scenarios that target an increase in the modern contraceptive prevalence rate (mCPR).

- *Business-as-usual*: the mCPR is projected to increase from 53.2% to 55.2% by 2030.
- *Achievable*: this target increases the mCPR from 53.2% to 55.4% by 2030.
- *Ambitious*: the mCPR is projected to increase from 53.2% to 56.5% by 2030.

Expected costs and benefits of scaling up family planning interventions (2026-2030)

Increasing mCPR to 55.2% by 2030…	Increasing mCPR to 55.4% by 2030…	Increasing mCPR to 56.5% by 2030…
Investment required: o US$1.06 million total investment.	**Investment required**: o US$1.60 million total investment.	**Investment required**: o US$1.87 million total investment.
Averts (Health benefits): o 331.8 thousand unintended pregnancies o 1.32 thousand **maternal deaths** o 22.3 thousand **unsafe abortions**	**Averts (Health benefits)**: o 339.0 thousand unintended pregnancies o 1.35 thousand **maternal deaths** o 22.8 thousand **unsafe abortions**	**Averts (Health benefits)**: o 344.8 thousand unintended pregnancies o 1.37 thousand **maternal deaths** o 23.2 thousand **unsafe abortions**

The combined economic benefit (discounted at 3% per annum) of scaling up MNC and FP interventions varies from US$213 million in the model's scenario to US$1.04 billion in the ambitious scenario. This translates to economic return on investment between US$3.6 and US$7.9 for every dollar invested.

Ending gender-based violence

The investment case was developed under three distinct scenarios: the business-as-usual, achievable, and ambitious. The interventions for each scenario are selected based on their respective unit costs and effectiveness in reducing GBV cases.

Expected costs and benefits of scaling up GBV interventions (2026 - 2030)

Business as Usual (BAU) scenario	Achievable	Ambitious
Investment required: o US$10.7 million total investment	**Investment required**: o US$17.7 million total investment	**Investment required**: o US$20.9 million total investment
Averts (Health benefits): o 21 thousand GBV cases	**Averts (Health benefits):** o 38 thousand GBV cases	**Averts (Health benefits)**: o 49 thousand GBV cases
Cost per case: o US$511 per case averted	**Cost per case:** o US$473 per case averted	**Cost per case:** o US$431 per cse averted

Ending child marriage

The investment case was developed under two scenarios. Scenario 1 considers a strict set of community and policy interventions that are locally relevant and validated by stakeholders. Scenario 2 includes life intervention to scenario 1, while scenario 3 includes two education interventions (i.e., rural schools supply and improve school infrastructure). While the full implementation year was set at 2035, economic benefits are assumed to be realized by 2050. This gives the intervention beneficiaries enough time to complete their education and reap the benefits thereof.

Expected costs and benefits of scaling up Child Marriage interventions

	Modest	**Achievable**	**Ambitious**
Child Marriage Interventions	**Investment required**: ● US$3.5 million to 2030 ● US$25.8 million to 2040 ● US$50.2 million to 2050	**Investment required**: ● US$5.1 million to 2030. ● US$37.5 million to 2030 ● US$72,9 million to 2030	**Investment required**: ● US$7.9 million to 2030. ● US$58.2 million to 2040 ● US$113.1 million to 2050
	Averts (benefits): ● 3,530 CM cases by 2030 ● 22,310 CM cases by 2040 ● 40,900 CM cases by 2050	**Averts (benefits)**: ● 4,270 CM cases by 2030 ● 26,560 CM cases by 2040 ● 48,570 CM cases by 2050	**Averts (benefits)**: ● 7,010 CM cases by 2030 ● 36,890 CM cases by 2040 ● 65,780 CM cases by 2050
	Economic Benefits (discounted): ● US$0.3 million by 2030	**Economic Benefits (discounted):** ● US$0.3 million by 2030	**Economic Benefits (discounted):** ● US$1.1 million by 2030

	• US$53.2 million by 2040 • US$290.3 million by 2050	• US$56.6 million by 2040 • US$311.4 million by 2050	• US$106.8 million by 2040 • US$569.3 million by 2050

1. Introduction

With the expiration of the Millennium Development Goals (MDGs) and the failure of many countries to achieve the set targets for Reproductive, Maternal, Newborn, and Child Health (RMNCH), the Sustainable Development Goals (SDGs) were introduced to drive progress on key population-related indicators[1]. Within Goal 3, which focuses on ensuring healthy lives and promoting well-being for all at all ages, three key targets relate to maternal health, newborn, children under 5 years and FP: Target 3.1 aims to reduce the global maternal mortality ratio to fewer than 70 per 100,000 live births, while Target 3.2 seeks to end preventable deaths among newborns and children under five. Target 3.7 promotes universal access to sexual and reproductive health services. Similarly, Goal 5, which seeks to achieve gender equality, addresses sexual and reproductive health and rights. Specifically, Target 5.3 calls for the elimination of all forms of violence against women and girls, and Target 5.6 emphasizes ensuring universal access to sexual and reproductive health[1].

The potential contribution of population-related indicators to achieving demographic dividends is evident. As the SDGs deadline approaches, increasing investment in key interventions has become important[2]. This report outlines investment cases designed to guide advocacy and promote greater investment in three transformative results. It highlights strong evidence that investing in maternal, newborn, and child health, family planning, and interventions addressing GBV and child marriage is not wasteful but rather a strategic investment with substantial health and economic benefits for individuals and the broader economy in Lesotho.

1.1 Context

Lesotho is a small country located in Southern Africa, surrounded by South Africa, with a population of approximately 2.3 million people. The country has a youthful population, with over 50% under the age of 25.[3] It suffers from high unemployment rates and widespread poverty, particularly in rural areas. Socially, Lesotho grapples with entrenched gender inequalities and a high burden of HIV, with a national prevalence of 21.1% among adults aged 15-49, the second highest in the world.[4] Health indicators reflect ongoing challenges, including high maternal and neonatal mortality, low contraceptive use among adolescents, and persistent gender-based violence (GBV). These challenges are compounded by hard-to-reach mountainous terrain, limited health infrastructure and workforce shortages. A heavy reliance on donor support points to an urgent need for strategic investment to strengthen health systems and address the social determinants of health. Classified as a lower-middle-income country, Lesotho faces significant economic constraints, with a Gross Domestic Product (GDP) per capita of $916 as of 2023.[5] Economic growth has been

[1] United Nations. (2015). Transforming our world: The 2030 Agenda for sustainable development, 21 October 2015. A/RES/70/1. https://www.refworld.org/docid/57b6e3e44.html

[2] Tsintsadze, A., Glonti, V., & Ghoghoberidze, T. (2024). Impact of Mutual Determining Factors of Demographic Dividend and Education on the Well-being of the Population. The International Journal of Health, Wellness and Society, 14(3), 67

[3] UNFPA. (2022). *Lesotho Population Dashboard*. https://lesotho.unfpa.org

[4] UNAIDS. (2023). *Country Factsheet: Lesotho*. https://www.unaids.org/en/regionscountries/countries/lesotho

[5] World Bank. Lesotho Country Data. https://data.worldbank.org/country/lesotho

sluggish, declining from 4% annual GDP growth (2000-2010) to 2% (2015-2019).[6] The country's economic growth has remained subdued in recent years, with average annual GDP growth hovering around 1.5% between 2019 and 2023, largely impacted by the COVID-19 pandemic.[7] The country relies heavily on external trade with South Africa, from where it imports over 80% of its goods. Furthermore, public debt has increased to nearly 60% of GDP, posing challenges to sustainable social spending.[8] Structural constraints, external shocks, and limited economic diversification have contributed to vulnerabilities in public service delivery, including healthcare. Key barriers to health service access include high out-of-pocket healthcare costs, a shortage of skilled health personnel, and inadequate infrastructure. Lesotho must identify and prioritise cost-effective, high-impact interventions that can deliver measurable improvements in population health and well-being.[9]

A cross-cutting concern across all four investment case areas, MNCH, FP, GBV, and child marriage, is the absence of a program-based budgeting and expenditure tracking framework. This limits the government's ability to assess value for money, align expenditures with strategic priorities, and ensure equity in resource distribution. Moreover, Lesotho's heavy reliance on external financing for reproductive, maternal, and gender-related health services poses long-term sustainability risks, especially in light of anticipated declines in donor funding. Funding constraints underscore the need for innovative financing strategies, improved budget tracking systems, and increased domestic resource mobilisation to ensure equitable and resilient service delivery for women, girls, and vulnerable populations.

The National Gender and Development Policy serves as a guiding national framework that reinforces gender equity across all four thematic areas with a focus on gender-responsive budgeting and planning.[10] The National Strategic Development Plan II (NSDP II) recognises poor health and gender inequality as major development bottlenecks.[11] It prioritises improvements in maternal health, access to family planning, and prevention of GBV and child marriage as critical pathways to enhance human capital and inclusive growth. Developing an investment case for MNCH, FP, GBV prevention, and child marriage reduction will enable the country to align its limited resources with national priorities and global commitments, including the Sustainable Development Goals (SDGs).

2. Methodology

This section presents a summary of the tools and methods used in estimating the investment cases. Detailed descriptions of the methods and tools are provided in Appendix A.

2.1 Estimating costs and health impacts of ending preventable MNC deaths

The UNFPA recommended toolkit provides a standard stepwise approach, including models for estimating the health and economic impact of scaling up MNCH interventions. These tools are housed in the Spectrum policy software (version 6.42), developed by Avenir Health at Johns

[6] African Development Bank. (2021). Lesotho Economic Outlook. https://www.afdb.org/en/countries/southern-africa/lesotho
[7] World Bank. (2024). *Lesotho Economic Update: Recent Economic Developments and Outlook*. Available at: https://www.worldbank.org/en/country/lesotho/publication/economic-update
[8] IMF. (2023). Lesotho Public Debt Report. https://www.imf.org/en/Countries/LSO
[9] Ministry of Health, Lesotho. (2021). *Lesotho Health Sector Strategic Plan 2021-2026*. Government of Lesotho. lesotho_revised_nhsp_2017-22_final_draft1.pdf
[10] Ministry of Gender and Youth, Sports and Recreation (MGYSR). (2018). *National Gender and Development Policy 2018–2030*. Maseru, Lesotho: Government of Lesotho.
[11] Government of Lesotho. *National Strategic Development Plan II 2018/19–2022/23*

Hopkins Bloomberg School of Public Health and funded by the Bill & Melinda Gates Foundation to support decision-making in the health sector[12,13]. The Spectrum programme consists of several modules that interact with each other to address a variety of issues in demography and population health.

The demographic projection module (DemProj) forms the basis for any projection in Spectrum and requires inputs on demographic characteristics of a country. Population projection data from the 2016 Lesotho population and housing census were used to populate this tool. The tool then interacts with the Lives Saved Tool (LiST) module to estimate the cost and impact of selected high-impact MNCH interventions. We modeled alternative projection scenarios (described later in this report) for ending preventable MNC mortality. The intervention costs were computed as a product of the estimated number of users and the cost per user per year. Intervention impacts were estimated as a product of the population in need, intervention coverage per year, and the intervention effectiveness. A detailed description of the methods is presented in Appendix A.

2.2 Estimating the cost and impact of ending unmet need for family planning

To model the impact and cost of interventions towards ending unmet need for family planning, the FamPlan and LiST models in Spectrum were used. While the FamPlan model allows for baseline and targets to be set for all family planning-related interventions, the interventions can be costed using the LiST module. The FamPlan module allows one to identify the preferred family planning method mix appropriate for the country context. We adjusted the method mix to allow a shift towards the use of long-acting modern methods in line with the method mix reported in the Lesotho Demographic and Health Survey (LDHS). The model also requires baseline inputs, including the total fertility, contraceptive prevalence, as well as the proximate determinants of fertility, including the proportion of women of reproductive age married or in a sexual union, duration of postpartum insusceptibility, and abortion rates[13]. The intervention costs were computed as a product of the estimated number of users and the cost per user per year. Intervention impacts were estimated as a product of the population in need, intervention coverage per year, and the intervention effectiveness. A detailed description of the methods is presented in Appendix A.

2.3 Estimating the impact and cost of Gender based violence

To estimate the costs and impact of GBV prevention, we used the Impact40 tool[14]. The model was developed using the RESPECT framework proposed by the World Health Organization in collaboration with the United Nation (UN) Women. The RESPECT framework has categories and sub-categories of interventions considered to have high impact on the prevention of violence (see Table 1 for the definition of main categories). The cost and impact of specific interventions under

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[12] Spectrum Suite. (2014). Spectrum Suite of Modelling Software [Computer software]. http://idfive.jhsph.edu/departments/international-health/centers-and-institutes/institute-for-internationalprograms/current-projects/lives-saved-tool/spectrum-overview/

[13] Stover, J., McKinnon, R., & Winfrey, B. (2010). Spectrum: A model platform for linking maternal and child survival interventions with AIDS, family planning and demographic projections. International Journal of Epidemiology, 39(suppl_1), i7–i10. https://doi.org/10.1093/ije/dyq016

[14] https://www.impact40.org/

this framework, as well as response interventions for survivors, were estimated. The intervention costs were computed as a product of the coverage and unit cost for each intervention. The coverage is defined as the population that receives the intervention divided by the target population in need. The impact is then computed as the number of cases averted due to the interventions. A detailed description of the methods is presented in Appendix A.

Table 1: RESPECT Women Framework

R	Relationship skills strengthened
E	Empowerment of women
S	Service ensured
P	Poverty reduced
E	Environments made safe
C	Child and adolescent abuse prevented
T	Transformed attitudes, beliefs and norms

Source: (UN Women & WHO, 2020)[15]

3. Cost-benefit analysis of scaling up interventions

3.1 Ending Preventable maternal, newborn, and child deaths

3.1.1 The MNCH situation

Lesotho's MNCH landscape is shaped by strong policy intent, albeit persistent challenges, including a reliance on external support for implementation. With a maternal mortality ratio (MMR) of 530 per 100,000 live births and a neonatal mortality rate (NMR) of 26 per 1,000 live births,[16] the country continues to face one of the highest burdens in Southern Africa. Key contributors to maternal mortality include haemorrhage, hypertensive disorders, and sepsis, while neonatal deaths are predominantly caused by birth asphyxia, prematurity, and infections. Health insurance coverage is limited, and out-of-pocket payments, though relatively low, can still deter rural women from seeking facility-based care.[17]

According to the 2023-24 DHS, 95% of women had at least one antenatal care (ANC) visit, and 82% had four or more ANC visits, showing improvement since multiple indicator cluster survey (MICS) 2018.[18] However, disparities remain across rural areas, especially in mountainous districts, where transport and facility access continue to pose challenges. The DHS also reports 94% of births were assisted by skilled health personnel, a significant improvement from the 83% institutional delivery rate reported in MICS 2018.[19]

[15] UN Women & WHO (2020). RESPECT Women: Preventing violence against women – Implementation package. https://www.unwomen.org/en/digital-library/publications/2020/07/respect-women-implementation-package

[16] Ministry of Health [Lesotho] and ICF. (2024). Lesotho Demographic and Health Survey 2023–24: Final Report. Maseru, Lesotho, and Rockville, Maryland, USA: Ministry of Health and ICF.

[17] Ministry of Health & ICF. (2024). *Lesotho Demographic and Health Survey 2023–24: Key Indicators Report*. Maseru, Lesotho: Ministry of Health and ICF. Available at: https://dhsprogram.com/pubs/pdf/PR150/PR150.pdf

[18] Lesotho Bureau of Statistics and UNICEF. (2020). *Lesotho Multiple Indicator Cluster Survey 2018: Survey Findings Report*. Maseru, Lesotho: BoS and UNICEF. Available at: https://mics.unicef.org/surveys

[19] Ministry of Health & ICF. (2024). *Lesotho Demographic and Health Survey 2023–24*

The Ministry of Health (MOH) leads the national MNH response through the RMNCAH strategy, aligned with the National Health Strategic Plan 2023-2027 and global frameworks such as Every Newborn Action Plan (ENAP) and Ending Preventable Maternal Mortality (EPMM). These strategies aim to reduce maternal and newborn deaths through interventions like skilled birth attendance, emergency obstetric and neonatal care (EmONC), and antenatal and postnatal services. However, implementation is uneven across districts due to resource constraints, limited infrastructure, and human resource shortages, particularly midwives and anesthetists.

3.1.2 Projection scenarios

The investment case for ending preventable MNC deaths was conceptualized as reaching women, newborns, and children in need with a core subset of high-quality interventions spanning across the continuum of care from periconceptual to postpartum, breastfeeding to curative, and routine care to inpatient care. In line with these, three scenarios were created as follows (see Appendix A for a list of interventions and targets for each scenario).

- **The modest scenario** targets reducing MNC mortality from 530, 26, and 54 to 458 (per 100,000 live births), 19 (per 1,000 live births), and 44 (per 1,000 live births), respectively.
- **For the achievable scenario**, all interventions were scaled up to reduce MNC mortality to 359, 16, and 38 births, respectively.
- **The ambitious scenario** targets scaling up interventions to reach MNC mortality of 277, 14, and 35, respectively.

3.1.3 Health impact of scaling up MNC interventions

Achieving the targets set in the scenarios translates to substantial gains in the MMR by 2030. The MMR reduces by 14% under the modest scenario, 32% under the achievable scenario, and 48% under the ambitious scenario.

Table 2: Expected changes in Maternal Mortality Ratio

Scenario(s)	2025	2026	2027	2028	2029	2030	Reduction in MMR
Modest	530	515	500	485	471	458	14%
Achievable	530	486	447	414	384	359	32%
Ambitious	530	453	391	343	305	277	48%

In Table 3, the most significant decline in neonatal mortality rate occurs under the ambitious scenario, where scaling up all interventions reduces the NNR from 26 to 14 per 1,000 live births by 2030, representing approximately a 48% reduction within six years. If investment is scaled up above the modest scenario to levels described as an achievable scenario, NNR would reduce over the 6 years by about 40% from 26 to 16 per 1,000 live births by the endline.

Table 3: Expected changes in Neonatal mortality rate

Scenario(s)	2025	2026	2027	2028	2029	2030	Reduction in NNR
Modest	26	25	23	22	20	19	27%
Achievable	26	24	21	19	17	16	40%

Ambitious	26	23	20	18	16	14	48%

In Table 4, the expected changes in child mortality are reported. The estimates show that child mortality reduced by 18% under the modest scenario. However, if investment is scaled up beyond the modest scenario to the level defined as the achievable scenario, child mortality reduces by about 30% over the 6-year period from 54 to 38 per 1,000 live births by 2030. In the ambitious scenario, investments above the achievable scenario result in a reduction in child mortality by about 36% over the 6 years to achieve a child mortality rate (CMR) of 35 per 1,000 live births by 2030.

Table 4: Expected changes in Child mortality rate

Scenario(s)	2025	2026	2027	2028	2029	2030	Reduction in CMR
Modest	54	51	50	48	46	44	18%
Achievable	54	50	47	43	40	38	30%
Ambitious	54	49	45	41	38	35	36%

Scaling up maternal interventions under the three scenarios could save an additional 472 to 1,861 maternal lives. In the initial year of implementation of the high-impact interventions, 29 additional maternal lives are saved, which will rise to 163 in 2030 for the modest scenario. However, the number of additional lives saved is expected to increase from 82 in 2026 to 388 in 2030 if investments are scaled up in accordance with the achievable scenario. Under the ambitious scenario, with relatively more resources committed, the number of additional lives saved increases from 143 in 2026 to 573 in 2030.

Table 5: Additional maternal deaths averted by scenario

Scenario(s)	2025	2026	2027	2028	2029	2030	Total
Modest	-	29	60	93	127	163	472
Achievable	-	82	162	241	315	388	1,188
Ambitious	-	143	272	387	486	573	1,861

Between 4,561 and 8,488 additional neonatal lives could be saved as a result of scaling up interventions under the three scenarios. In the first implementation year of the high-impact interventions, 283 additional neonatal lives were saved, increasing to 1,568 in 2030 for the modest scenario. However, if investments are scaled up as outlined in the achievable scenario, the number of additional lives saved is expected to increase from 451 in 2026 to 2,359 in 2030. Under the ambitious scenario, the number of additional lives saved increases from 1,301 in 2026 to 2,818 in 2030.

Table 6: Additional neonatal deaths averted by scenario

Scenario(s)	2025	2026	2027	2028	2029	2030	Total
Modest	-	283	583	900	1,227	1,568	4,561
Achievable	-	451	914	1,392	1,871	2,359	6,987
Ambitious	-	567	1,134	1,706	2,263	2,818	8,488

Scaling up child interventions across the three different scenarios could save between 1,707 and 4,182 child lives. In the modest scenario, 46 additional child lives could be saved in the first year of implementing the high-impact interventions. This number could rise to 683 by the year 2030. If investments are scaled up as outlined in the achievable scenario, the number of additional lives saved is expected to increase from 104 in 2026 to 1,367 in 2030. Under the ambitious scenario, the additional lives saved could increase from 127 in 2026 to 1,594 in 2030.

Table 7: Additional child deaths averted by scenario

Scenario(s)	2025	2026	2027	2028	2029	2030	Total
Modest	-	46	165	318	495	683	1,707
Achievable	-	104	366	678	1,020	1,367	3,535
Ambitious	-	127	440	813	1,208	1,594	4,182

The results show that in general, while about 472 maternal lives could be saved under the modest scenario, this increases to 1,188 in the achievable scenario and 1,861 in the ambitious scenario.

3.1.4 Estimated financial investment required

Between 2026 and 2030, a total of US$63.5 million, US$98.9 million, and US$142.6 million will be required under the modest, achievable, and ambitious scenarios, respectively. The majority of these resources go into health system investments. The annual incremental cost by scenarios is presented in Appendix B.

Table 8: Summary of Total resources required to scale of maternal, newborn and child health interventions (2026-2030)

	Modest	Achievable	Ambitious	Modest (%)	Achievable (%)	Ambitious (%)
Total Intervention costs (US$)	$48,184,182	$74,969,192	$107,581,386	75.9	75.7	75.4
Programme Related Activity costs (US$)	$15,307,058	$24,015,359	$35,060,890	24.1	24.3	24.6
Total Investment Required (US$)	$63,491,241	$98,984,551	$142,642,276	100.0	100.0	100.0

3.2 Ending unmet need for Family Planning

3.2.1 The FP situation

Family planning is a critical component of Lesotho's reproductive health agenda, contributing to reductions in maternal and child mortality, prevention of unintended pregnancies, and promotion of gender equality. Lesotho has made moderate progress in expanding access to FP services, with a modern contraceptive prevalence rate (mCPR) up to 53.2% in 2023 from 34.9% in 2009 among all

women. Unmet need for FP is estimated at 12.6% for all married women but is as high as 21% among married adolescents aged 15-19, varying by district from 8% in Butha-Buthe to 17% in ThabaTseka[19]

The unmet need for family planning contributes significantly to high maternal mortality rates by increasing the risk of unintended and closely spaced pregnancies, which are more likely to result in complications such as haemorrhage, unsafe abortions, and inadequate recovery between births. Limited access to contraception disproportionately affects adolescents and women in vulnerable settings, leading to higher rates of maternal death due to unsafe abortion and overburdened health systems. Lesotho has a total fertility rate of 2.5 children per woman, with rural areas seeing higher rates of childbearing (2.8 children) than urban areas (2.1 children). Teenage pregnancies are common, with 17% of adolescent girls, aged 15-19, having ever been pregnant[19].
Lesotho's FP service delivery is primarily public-sector-led, with support from development partners and limited engagement from private providers. Services are integrated within primary healthcare facilities and include a mix of short-acting and long-acting reversible contraceptive methods (LARCs), though access to permanent methods and emergency contraception is limited in some areas. Barriers to FP uptake include stock-outs, stigma around adolescent use, provider bias, cultural norms, and lack of privacy in service settings.

3.2.2 Projection scenarios

The investment case for ending unmet need for family planning was conceptualized as increasing the use of modern contraceptives and shifting the method mix towards long-acting modern methods among women and men of reproductive ages. Against this backdrop, we defined three projection scenarios as follows.

- **Business as usual (BAU) scenario**: the mCPR is projected to increase from 53.2% to 55.2% by 2030.
- **Achievable scenario**: this target increases the mCPR from 53.2% to 55.4%.
- **Ambitious scenario**: the mCPR is projected to increase from 53.2% to 56.5% by 2030

3.2.3 Health impact of scaling up FP interventions

Figure 1 reports the annual trend in the number of FP users. In the BAU scenario, the results show an increase from 140 thousand in 2025 to approximately 158 thousand by 2030 (the final year of implementation). Under the achievable and ambitious scenarios, the number of users is estimated at 140 thousand in 2025 in both scenarios, and is expected to increase to 165 thousand and 171 thousand by 2030, respectively.

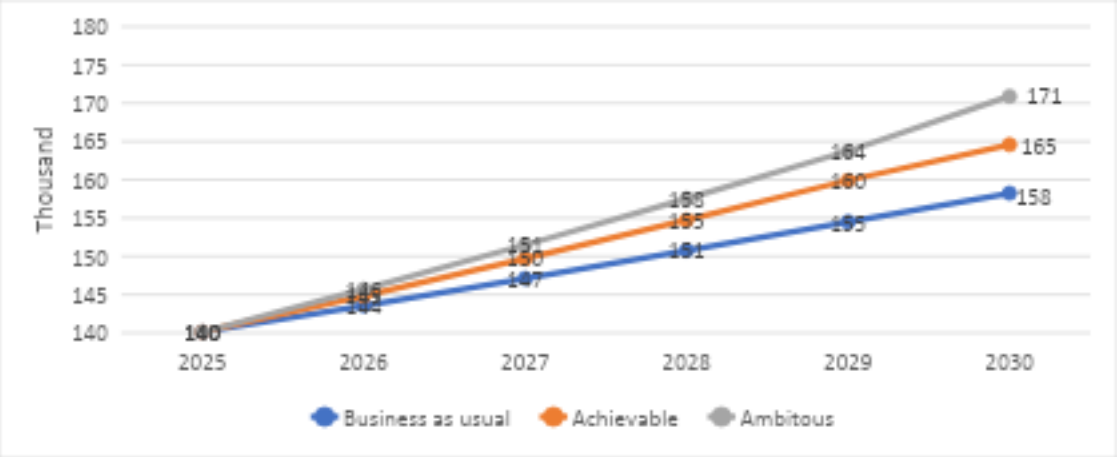

Figure 1: Annual trend in FP users

Figure 2 reports the annual trend in unintended pregnancies averted. Under the BAU scenario, the number of unintended pregnancies averted increased from about 52 thousand in 2025 to about 59 thousand by 2030. In the achievable and ambitious scenarios, the number of unintended pregnancies averted is estimated at 52 thousand (for both scenarios) in 2025, increasing to 61 thousand and 63 thousand by 2030, respectively.

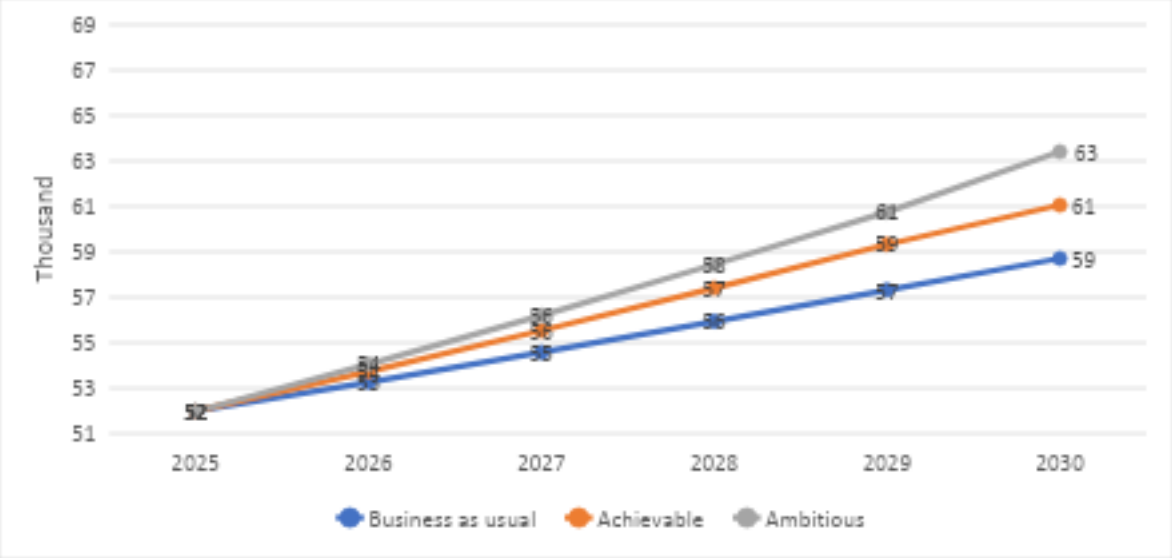

Figure 2: Annual trend in unintended pregnancies averted

Figure 3 shows the trend in the number of maternal deaths averted. Under the BAU scenario, maternal deaths averted increase from 207 in 2025 to 233 by 2030. In the achievable and ambitious scenarios, the number of maternal deaths averted rises from 207 for both scenarios in 2025 to 243 and 252 by 2030, respectively.

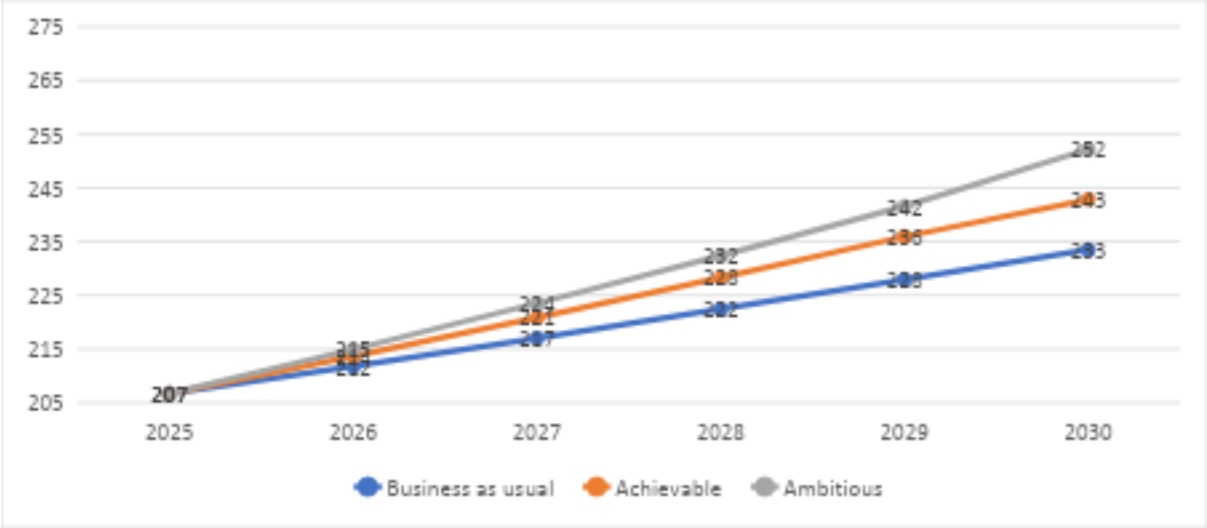

Figure 3: Annual trend in maternal deaths averted

The trend in the number of abortions averted shows a consistent increase in the number of abortions averted from 3,501 in 2025 to 3,954 by 2030 under BAU. In the achievable and ambitious scenarios, the number of abortions averted increases from 3,501 (for both scenarios) in 2025 to 4,112 and 4,270 by 2030, respectively.

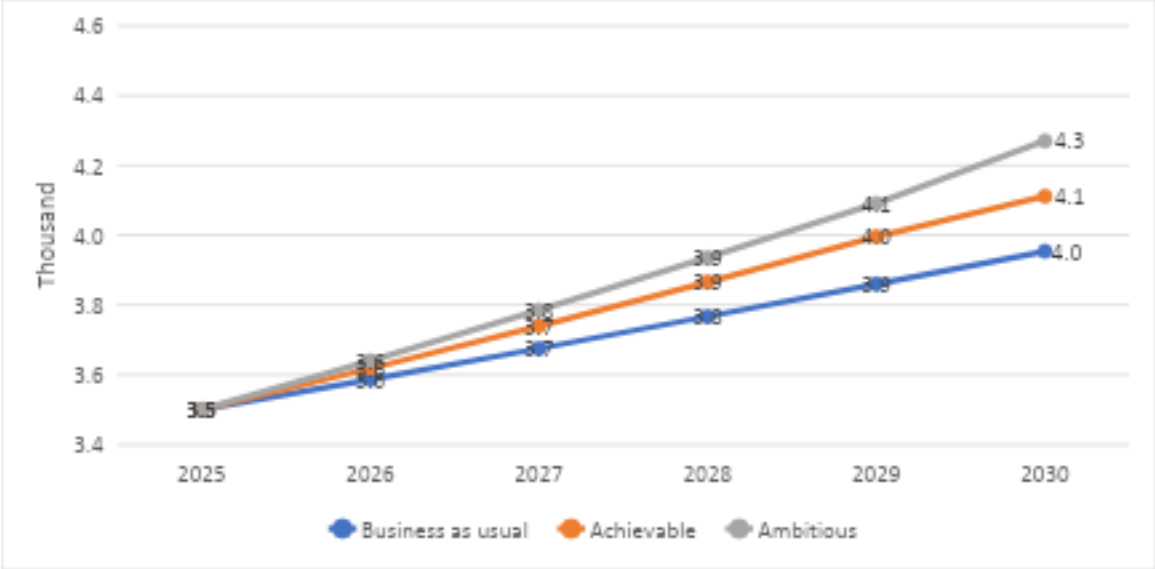

Figure 4: Annual trend in abortions averted

Figure 5 presents the expected increase in modern contraceptive rate by scenarios. In the BAU, mCPR is expected to increase from 53.2% to 55.2% (Business-as-usual). In the Achievable and ambitious scenarios, mCPR is expected to increase from 53.2% (for both scenarios) to 55.4% and 56.5% respectively.

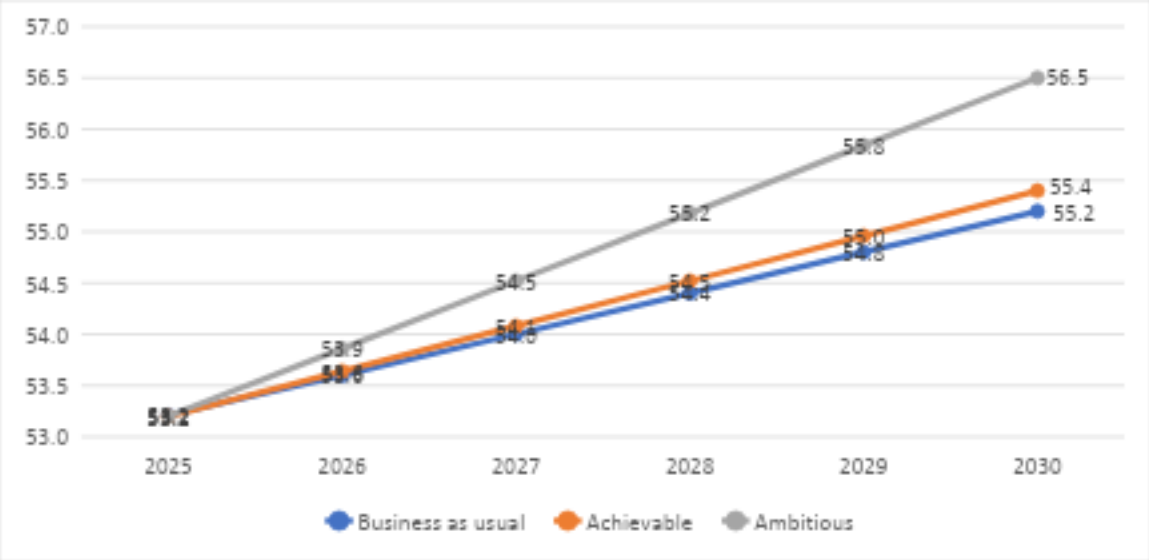

Figure 5: Expected increase in mCPR

In Figure 6, the annual expected reduction in unmet need is reported by scenarios. In the Business-as-usual scenario, the unmet need is expected to reduce from 12.6% in 2025 to 11.9% in 2030, representing a 5.6% reduction from 2025 to 2030. The unmet need is, however, expected to reduce from 12.6% in 2025 to 11.3% in 2030 in the achievable. This represents a 10.3% reduction over the entire period. For the Ambitious scenario, a 17.5% reduction in unmet need is expected between 2025 and 2030.

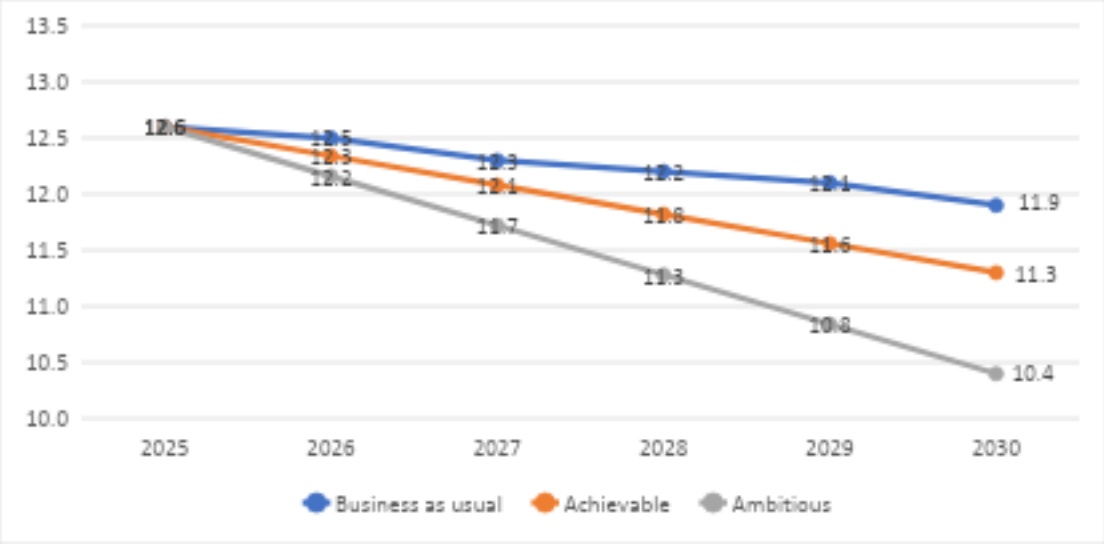

Figure 6: Expected reduction in unmet need

3.2.4 Estimated financial investment required

The total resources required to achieve these health benefits increase from $1.1 million under the BAU scenario to $1.6 million under the achievable scenario and $1.8 million under the ambitious scenario (see Table 9). These costs translate to spending about $1.2, $1.8 and $2.0 for each new modern method user under the three scenarios, respectively.

Table 9: Summary of resources required to scale of modern FP methods (2026 – 2030)

	Business as usual	Achievable	Ambitious
Total intervention cost (US$)	479,912	614,296	724,585
Total Programme Related Activity cost (US$)	580,204	986,457	1,148,803
Total investment required (US$)	1,060,116	1,600,753	1,873,387
Investment per user ($)	1.2	1.8	2.0

3.3 Economic benefits of investing in family planning and MNCH interventions

Investing in family planning services also has economic benefits beyond the immediate health benefits[20]. Three main benefits were identified, including social, workforce participation, and labour force productivity. The social benefits accrue through averted lost years of life and maternal years lived with disability. While workforce participation is related to increased years of life, labour force productivity is related to increased school years completed, hence raising productivity and lifetime earnings. Figure 7 reports the total economic benefits of scaling up interventions to meet the family planning needs and MNCH interventions in Lesotho from 2026 to 2030. These benefits result in benefit-cost ratios (BCR) of approximately $3.6, $6.3, and $7.9 for every dollar invested for the three scenarios, respectively (see Figure 8). The positive BCRs indicate that these investments offer significant economic returns for the country, beyond the health benefits and contributions to human rights.

[20] UNFPA (2022). Expanding choices, ensuring rights in a diverse and changing world: UNFPA Strategy for Family Planning 2022–2030. https://www.unfpa.org/expanding-choices-ensuring-rights

Figure 7: Total discounted economic benefits and costs (2026 – 2030)

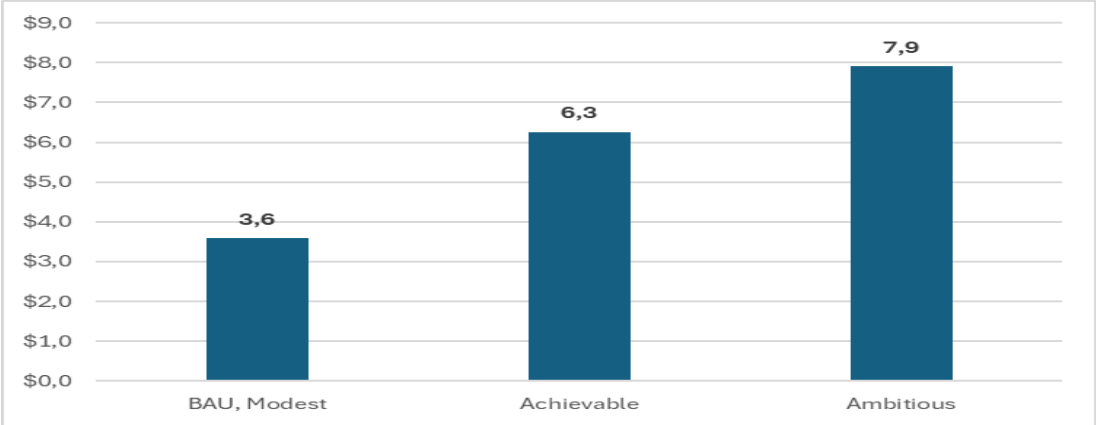

Figure 8: Benefit-cost ratio (BCR)

The economic benefit is disaggregated to reflect benefits accruing to education, social, and workforce participation. Under the BAU scenario, the total work benefits amount to $73,089,110, the total education benefits amount to $116,203,240, and the total social benefits amount to $172,092,673, leading to a cumulative benefit of $213,567,835. For the achievable scenario, work, education, and social benefits are $116,203,240, $22,879,839, and $431,784,742, respectively. The highest benefit was realized under the ambitious scenario, with work, education, and social benefits of $172,092,673, $24,030,849, and $843,979,711, respectively.

Table 10: Disaggregation of FP/MH Economic Benefit

	Business as usual	**Achievable**	**Ambitious**
Total work benefits	73,089,110	116,203,240	172,092,673
Total education benefits	22,421,426	22,879,839	24,030,849
Total social benefits	118,057,300	431,784,742	843,979,711

Total	$213,567,835	$570,867,821	$1,040,103,233

3.4 Gender Based Violence

3.4.1 The GBV situation

Gender-Based Violence (GBV) remains a pervasive and deeply rooted issue in Lesotho, affecting women, girls, and other vulnerable groups across all districts. An estimated 36% of women have ever experienced violence (physical, sexual, or emotional) from their current or most recent husband or intimate partner.[21] Intimate partner violence is the most prevalent form, while sexual violence, including rape and coercion, also remains widespread, particularly among adolescent girls. GBV in Lesotho is closely linked to gender inequality, harmful social norms, poverty, and substance abuse. A GBV Indicator Study conducted in 2014 reported only 22% of survivors of sexual violence seeking help from formal institutions, primarily due to shame, lack of awareness, and mistrust in the justice system.[22] The low levels of reporting appear to have persisted a decade down the line, with only 26% of survivors seeking help in the 2023-2024 DHS suggesting enduring systemic issues.

The Lesotho Violence Against Children Survey (2020) highlights alarming rates of sexual violence and intimate partner violence (IPV) experienced by children, particularly adolescent girls.[23] Approximately 10% of girls reported experiencing sexual violence before the age of 18, with perpetrators most commonly being intimate partners, relatives, or authority figures such as teachers. Nearly 7 in 10 children who experienced sexual violence did not tell anyone or seek support, largely due to stigma, fear of retaliation, or the normalisation of such acts within the community context.

Lesotho ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1995, committing to eliminating GBV and discrimination against women. This has led to key reforms, including the Counter Domestic Violence Act (2022), which defines domestic violence, strengthens survivor protections, and aligns with international standards. Earlier, the Legal Capacity of Married Persons Act (2006) advanced women's legal rights. National policies such as the Gender and Development Policy (2018–2030), Health Policy, and Social Protection Strategy (2021–2031) integrate GBV prevention, survivor support, and multi-sectoral coordination. However, implementation remains uneven due to low awareness, weak coordination, limited resources, and persistent cultural barriers, particularly in rural areas.

3.4.2 Projection scenarios

The GBV investment case considers three scenarios as outlined in Table 11 below. The interventions for each scenario are selected based on their respective unit costs and effectiveness in reducing GBV cases.

Table 11: Scenarios for GBV intervention (%)

[21] Ministry of Health & ICF. (2024). *Lesotho Demographic and Health Survey 2023–24*

[22] Gender Links. (2014). *Lesotho Gender-Based Violence Indicators Study*. Maseru, Lesotho: Gender Links and Ministry of Gender and Youth, Sports and Recreation. https://genderlinks.org.za

[23] Lesotho Ministry of Social Development, Ministry of Health, Ministry of Education and Training, Bureau of Statistics, and UNICEF. (2020). *Lesotho Violence Against Children Survey: National Report 2020*. Maseru, Lesotho. https://www.unicef.org/lesotho/reports/vacs-2020

Interventions by RESPECT Category	2030 scaleup target		
	Business as usual	Achievable Scenario	Ambitious Scenario
Empowerment of women			
Empowerment training for women and girls, including life skills, safe spaces and mentoring	65.00	70.00	90.00
Environments made safe			
Bystander interventions	80.00	85.00	90.00
Child and adolescent abused prevented			
Life-skills/school-based curriculum, rape and dating violence prevention training	85.00	90.00	95.00
Transformed attitudes, beliefs and norms			
Community mobilization	90.00	95.00	99.00
Group education with men and boys to change attitudes and norms	75.00	78.00	85.00
Services Ensured: response interventions			
Medical care	35.00	35.00	35.00
Justice	35.00	35.00	35.00
Social Services	35.00	35.00	35.00
Policing	35.00	35.00	35.00

3.4.3 Expected reduction in GBV cases by scenario

The Business-as-usual scenario leads to a fall in the proportion experiencing GBV from 25.4% to 21.8% in 2030, with a total of 21 thousand cases averted. The achievable scenario leads to a fall in the proportion experiencing GBV from 25.4% to 18.8%, with a total number of cases averted of about 38 thousand by 2030. The ambitious scenario leads to a fall in the proportion experiencing GBV from a baseline of 25.4% to 17.8%, with a total number of cases averted of about 49 thousand by 2030.

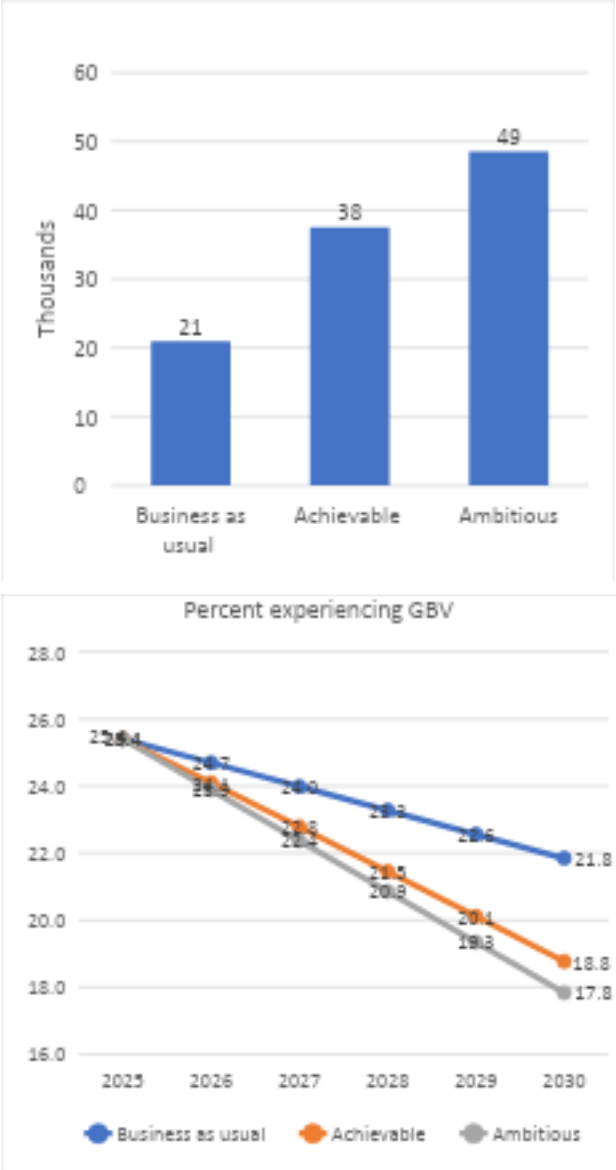

Figure 9: GBV cases averted and Percent of GBV and percent experiencing GBV

3.4.4 Additional Investment required to scale up GBV interventions

Table 12 reports the cost of scaling up GBV interventions for the three scenarios. The results show total incremental costs of the BAU, achievable, and ambitious scenarios to be $10.7 million, $17.7 million and $20.9 million, respectively, between 2026 and 2030.

Table 12: Total investment cost required to scale up GBV interventions (in US$)

Intervention	Business as usual	Achievable	Ambitious
Cost of responding to GBV survivors	4,531,981	4,123,979	3,845,404
Empowerment of women	287,740	431,610	1,726,438

Environments made safe	23,857	35,786	47,715
Child and adolescent abuse prevented	225,641	338,461	676,922
Transformed attitudes, beliefs and norms	5,646,046	12,809,010	14,638,868
Total	10,715,265	17,738,845	20,935,348

3.4.5 Expected cost per case

Figure 10 shows that cost per case averted declines as investment increases, suggesting potential economies of scale. Ambitious investment scenario was the most cost effective, providing more marginal benefit relative to costs. This highlights the health and economic impact of scaling up investment in GBV interventions.

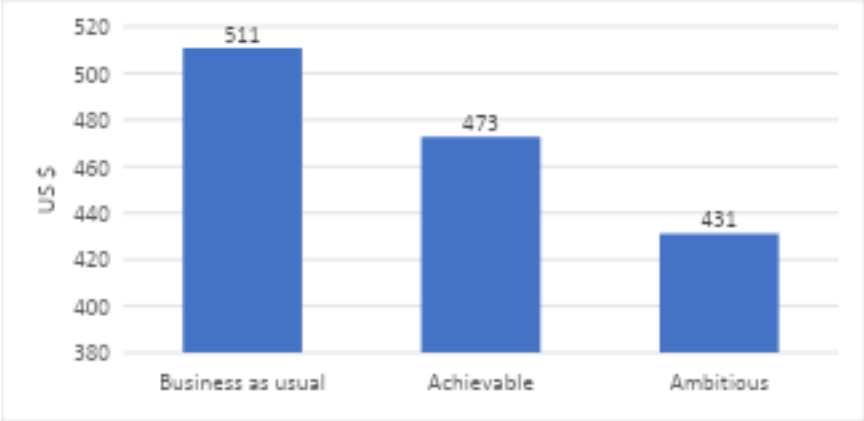

Figure 10: Cost per case averted

3.5 Ending child marriage (CM)

3.5.1 The CM situation

Child marriage remains a significant concern in Lesotho, particularly in rural and impoverished communities. While there has been a consistent decline in child marriage rates over the last two decades, approximately 16% of girls are married before the age of 18, with higher prevalence in hard-to-reach districts and among out-of-school girls[19]. While the legal minimum age for marriage is 18, customary practices, poverty, gender inequality, and limited educational and economic opportunities continue to drive early and forced marriages. These marriages place girls at heightened risk of early pregnancy, school dropout, GBV, and poor health outcomes, including maternal and neonatal complications.

Lesotho is committed to ending child marriage through laws and policies aligned with regional and global frameworks. The Children's Protection and Welfare Act (2011) sets 18 as the minimum marriage age and bans harmful practices. Policies such as the Gender and Development Policy (2018), Education Sector Strategic Plan (2016–2026), and Social Protection Strategy II (2021–2031)

promote girls' education, sexual reproductive health and rights (SRHR) access, and social support to prevent early marriage. Government efforts include awareness campaigns, school re-entry for pregnant girls, and community dialogues, while the Health Policy (2017) promotes multi-sectoral action to address harmful social norms.

Despite this progressive legal and policy framework, enforcement remains weak, particularly in rural areas where child marriage is often perceived as a cultural norm or economic coping mechanism. The lack of community-level awareness, limited access to legal recourse, and gaps in coordination between the child protection, education, and health sectors continue to hamper effective implementation. In addition, monitoring and data collection systems for child protection violations, including early marriage and abuse, remain weak. The absence of a central database and routine reporting mechanisms hampers evidence-based programming and policy enforcement.[24]

3.5.2 Projection Scenarios

The investment case on CM was developed under scenarios that differ in terms of effectiveness and costs of the set of interventions. Scenario 1 considers a set of community and policy interventions that are locally relevant and validated by stakeholders. Scenario 2 extends the set of interventions in scenario 1 to include life skills interventions, while scenario 3 includes education interventions (i.e., rural schools supply and improve school infrastructure). In all, 10 interventions were identified, and their distribution across the scenarios is summarized in Table 13.

Table 13: Child Marriage Interventions

Interventions	Business as usual	Achievable	Ambitious
Conditional Economic Incentives	Yes	No	No
Life Skills	No	Yes	Yes
Development of Laws and Policies, and Capacity	Yes	Yes	No
Advocate for Change of Community Norms and Values	Yes	Yes	Yes
Improve Safe School Environments	Yes	Yes	Yes
Improve Parent and Care Giver Support	No	No	Yes
Promote and strengthen a safe, secure, and enabling school environment and life-skills training in Lesotho.	No	Yes	No
Strengthen referral mechanisms for essential multi-sectoral services.	No	No	Yes
Promote functional helplines to support effective prevention and response to violence against children.	Yes	No	No
Enhance coordination mechanisms at all levels.	Yes	Yes	Yes
Create awareness on prevention and response on violence against children.	No	No	Yes
Rural School supply	No	No	Yes
Improve school infrastructure	No	No	Yes

[24]

3.5.3 Impact of scaling up child marriage interventions in Lesotho

The cases of CM averted range from 40,905 to 65,778 for the three scenarios across. Under scenario 1, approximately 40.9 thousand cases are expected to be averted. Similarly in scenario 2, about 48.6 thousand cases are expected to be averted. In scenario 3, the number of cases averted increases significantly to 65.8 thousand. The number of cases averted by 2030 range from 3,530 (Scenario 1) to 7,010 (Scenario 3).

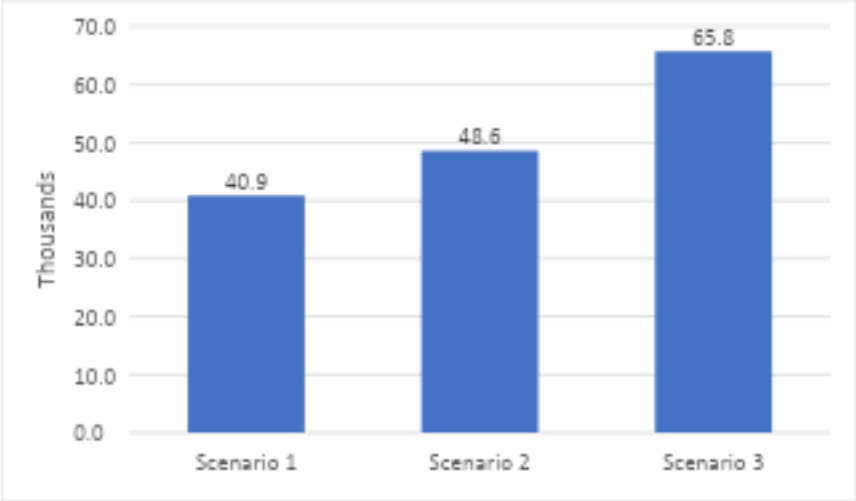

Figure 11: Cases averted as a result of child marriage interventions

3.5.4 Additional investment required for scaling up Child Marriage interventions

The total incremental costs are presented in terms of the three scenarios. The additional investment needed for the proposed child marriage interventions ranges between $50.2 million and $113.1 million by 2050. Table B17 in the Appendix presents details of the total costs across the years for the three scenarios.

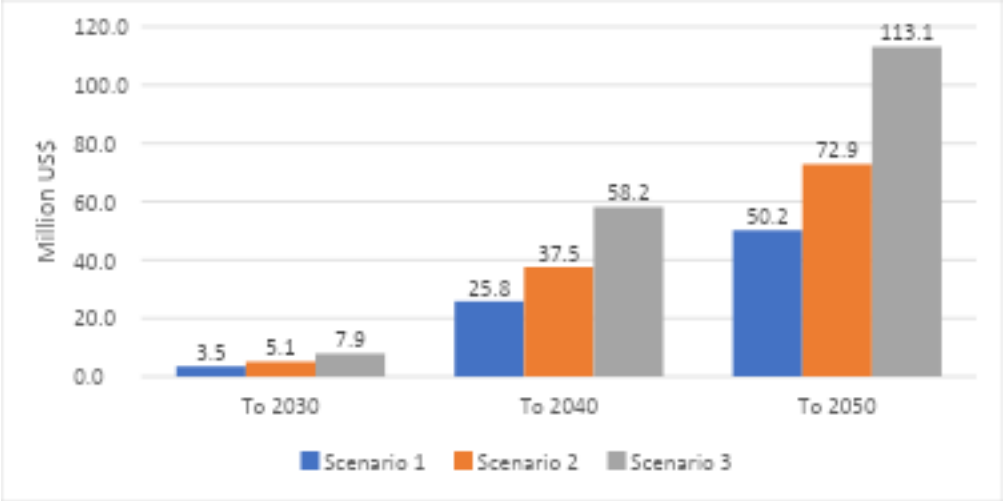

Figure 12: Total Costs of Child Marriage Interventions

3.6 Economic benefit of investing in CM interventions

The total economic benefits of child marriage interventions are estimated to be between $290.3 million and $569.3 million across the three scenarios (from 2026 to 2050). These have different benefit-cost ratios, with the ambitious scenario having the highest benefit-cost ratio. Specifically, scenario 1 has total economic benefits of $290.3 million, with a benefit-cost ratio of $10.0. Similarly, for scenario 2, the economic benefit is $311.4 million, with a benefit-cost ratio of $7.4. Scenario three follows a similar trend with economic benefits of $569.3 million and a benefit-cost ratio of 8.7. The benefit-cost ratios suggest that every dollar spent on child marriage interventions yields $10.0, $7.4 and $8.7 in return for scenarios 1, 2, and 3, respectively (see Figures 13 and 14).

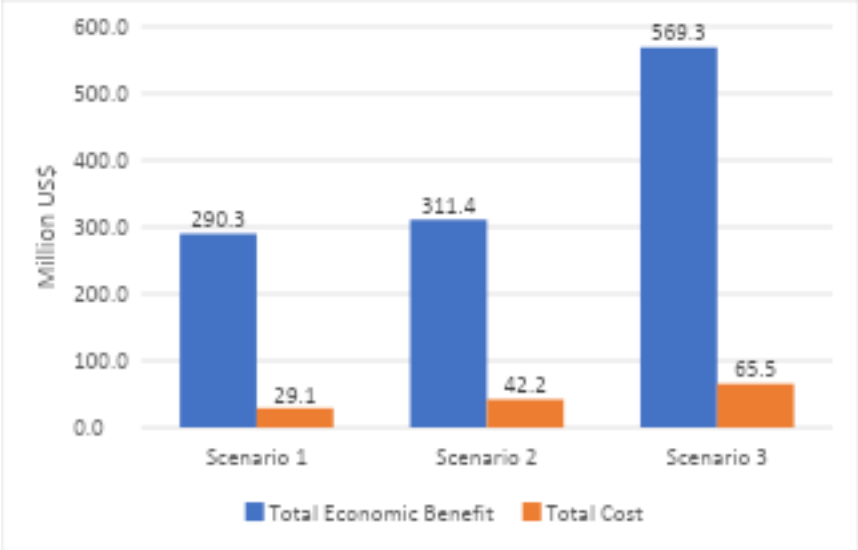

Figure 13: Discounted Economic Benefit and Cost of Child Marriage Interventions (2026-2050)

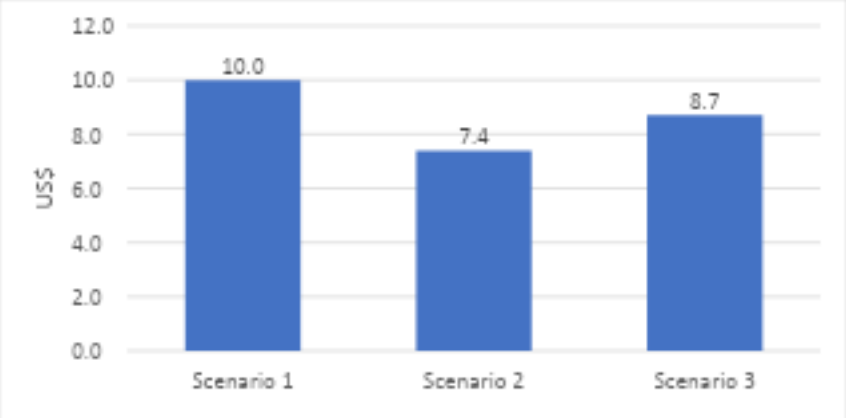

Figure 14: Benefit-Cost Ratios of Child Marriage Interventions

4. Conclusion

The report highlights the fact that investing in MNCH, FP, GBV, and CM is both a moral imperative and a sound economic decision. These transformative results remain major challenges in Lesotho and continue to limit the potential of the population, especially women and girls. Consequently, the nation's human capital, productivity, and social cohesion are undermined. Strengthening health and social sectors to provide equitable services towards MNC deaths, unmet need for FP, GBV and CM will yield far-reaching benefits across generations.

The evidence shows that for every dollar invested in these interventions, there are more than a dollar of economic returns to the country and individual families through reduced mortality, improved workforce participation, and enhanced educational attainment. Preventing GBV and CM will not only protect human rights but also contribute to national development by breaking cycles of poverty and dependence.

The policy and legal landscape in Lesotho shows a demonstration of commitment to tackling these challenges. However, sustained progress requires coordinated action and adequate financing. This can be achieved by prioritising these transformative areas within the national budget and attracting strategic partnerships. These will help accelerate progress towards Lesotho achieving the SDGs and adequately equipping the young population for future economic prospects.

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Appendix A

Methodology

Data

Multiple data sources were used to estimate the baseline situation for maternal health. First, the most recent round of Lesotho Demographic and Health Survey (LDHS) 2023-2024 was used. In addition to this, the 2016 Lesotho population and housing census was also used to collect demographic data. Various national reports and strategic documents were also reviewed along the transformative results to collect information on national targets and interventions.

Data validation workshop

To ensure that interventions and baseline data reflect the national context, a 5-day validation workshop was convened with respective stakeholders relevant to the transformative results under consideration. At this workshop, stakeholders were introduced to the tools used for the investment cases. All interventions considered for scale-up were then reviewed and validated. The baseline coverage of each of these interventions was revised as deemed appropriate and updated using national data.

Analytical tools

The modelling was conducted using Spectrum (version 6.42). This software houses several tools to estimate the costs and benefits of different health interventions. The demographic projection module (DemProj) forms the basis for any projection in Spectrum and requires inputs on demographic characteristics of a country. The tool then interacts with the Lives Saved Tool (LiST) and Family Planning (FamPlan) modules to estimate the cost and impact of a set of interventions towards ending the two transformative results. The specific interventions are presented next.

Ending Preventable Maternal, Newborn and Child Deaths

Interventions towards ending preventable maternal, newborn and child deaths

To ensure that the selected interventions are context relevant, major drivers of maternal, newborn and child mortality in Lesotho were identified. The list of specific interventions validated and included in this investment case is reported in Table A1.

Table A. 1: Maternal interventions included in the investment case

Periconceptual	**Pregnancy**	**Childbirth**	**Breastfeeding**	**Preventive/Neonatal**
Folic acid fortification/supplementation	TT-Tetanus toxoid vaccination	Clean birth environment	Exclusive breastfeeding	Vitamin A Supplementation
Safe abortion services	Syphilis detection and treatment	Immediate drying and additional stimulation	Predominant breastfeeding	Zinc supplementation
Post abortion case management	Calcium supplementation	Thermal protection	Partial breastfeeding	Basic Sanitation
Ectopic pregnancy case management	Iron supplementation in pregnancy	Delayed cord clamping		Piped water
Iron fortification	Multiple micronutrients supplementation in pregnancy	Clean cord care		Handwashing with soap
Zinc fortification	Hypertensive disorder case management	MgSO4 for eclampsia		Hygienic disposal for children's stools
	Diabetes case management	Antibiotics for preterm or prolonged PROM		BCG
	Fetal growth restriction detection and management	Antibiotics for maternal sepsis		Polio
		Assisted vaginal delivery		DPT
		Neonatal resuscitation		Pneumococcal
		Uterotonics for postpartum hemorrhage		Rotavirus
		Manual removal of placenta		Measles
		Removal of retained products of conception		Oral management of neonatal sepsis/pneumonia
		Induction of labour for pregnancies lasting 41+ weeks		Injectable antibiotics for neonatal sepsis

		Antenatal corticosteroids for preterm labour		Full supportive care for neonatal sepsis/pneumonia
		Cesarean delivery		ORS
		Blood transfusion		Antibiotics for treatment of dysentery
		KMC – Kangaroo mother care		Zinc for treatment of diarrhea
				Oral antibiotics for pneumonia
				Oxygen and pulse oximetry for pneumonia
				Vitamin A for treatment of measles
				SAM – Treatment for severe acute malnutrition
				MAM – Treatment for moderate acute malnutrition

Projection scenarios for preventable maternal, newborn and child death interventions

To allow for flexibility in the estimates, we modeled alternative projection scenarios for each of the interventions towards ending preventable maternal, newborn, and child deaths. The projection scenarios make assumptions about different coverage levels of the interventions by the target year of 2030. In all, three scenarios were projected. The baseline coverage and projected coverage for each of the interventions are presented in Table A2.

Table A. 2: Baseline and endpoint projections for Maternal, Newborn, and Child Health interventions coverage targets by Scenario, 2025 – 2030

S/N	Maternal, Newborn and Child Health Interventions	2025 **Baseline (%)**	2030 **Modest Coverage (%)**	**Achievable Coverage (%)**	**Ambitious Coverage (%)**
	Periconceptual				
1.	Folic acid fortification/supplementation	0.00	10.0	20.0	45.0
2.	Safe abortion services	0.9	10.0	30.0	65.0
3.	Post abortion case management	0.0	15.0	30.0	55.0
4.	Ectopic pregnancy case management	0.0	15.0	35.0	50.0
5.	Iron fortification	0.0	20.0	35.0	50.0
6.	Zinc fortification	0.0	20.0	35.0	50.0
	Pregnancy				
7.	TT-Tetanus toxoid vaccination	60.3	70.0	80.0	85.0
8.	Syphilis detection and treatment	47.7	80.0	85.0	95.0
9.	Calcium supplementation	0.0	30	40.0	55.0
10.	Iron supplementation in pregnancy	85.5	87.0	95.0	100.0
11.	Multiple micronutrient supplementation in pregnancy	80.0	20.0	40.0	60.0
12.	Hypertensive disorder case management	14.0	20.0	60.0	90.0
13.	Diabetes case management	14.0	20.0	50.0	55.0
14.	Fetal growth restriction detection and management	0.0	20.0	30.0	50.0
	Childbirth				
15.	Clean birth environment	82.0	85.0	90.0	98.0
16.	Immediate drying and additional stimulation	87.37	90.0	95.0	98.0
17.	Thermal protection	90.39	95.0	99.0	100.0
18.	Delayed cord clamping	0.0	30.0	45.0	55.0
19.	Clean cord care	89.0	90.0	95.0	100.0
20.	MgSO4 for eclampsia	79.04	80.0	85.0	90.0
21.	Antibiotics for preterm or prolonged PROM	80.42	84.0	88.0	95.0
22.	Antibiotics for maternal sepsis	80.42	85.0	88.0	95.0
23.	Assisted vaginal delivery	59.85	60.0	65.0	80.0
24.	Neonatal resuscitation	72.19	80.0	90.0	95.0
25.	Uterotonics for postpartum hemorrhage	86.45	90.0	95.0	98.0
26.	Manual removal of placenta	64.88	70.0	80.0	85.0
27.	Removal of retained products of conception	53.12	70.0	75.0	85.0

28.	Induction of labour for pregnancies lasting 41+ weeks	52.16	60.0	75.0	80.0
29.	Antenatal corticosteroids for preterm labour	0.0	40.0	50.0	60.0
30.	Cesarean delivery	23.5	30.0	45.0	55.0
31.	Blood transfusion	55.32	60.0	70.0	99.0
32.	KMC – Kangaroo mother care	19.9	30.0	30.0	90.0
33.	**Breastfeeding**				
34	Exclusive breastfeeding	67.0	70.0	75.0	80.0
35.	Predominant breastfeeding	5.64	5.0	4.0	2.0
36	Partial breastfeeding	14.9	13.0	10.0	5.0
	Preventive				
37.	Vitamin A supplementation	69.6	68.0	75.0	80.0
38.	Basic sanitation	46.3	50.0	60.0	80.0
39.	Piped water	38.0	45.0	50.0	98.0
40.	Hygienic disposal of children's stools	45.8	50.0	60.0	85.0
	Vaccines				
41.	BCG – single dose	98.8	99.0	100.0	100.0
42.	Polio – three dose	69.3	70.0	75.0	85.0
43.	DPT – three does	83.3	85.0	90.0	95.0
44.	Pneumococcal – three dose	76.2	80.0	84.0	85.0
45.	Rotavirus – two dose	83.4	85.0	85.0	85.0
46.	Measles	79.0	80.0	88.0	95.0
	Neonatal				
47.	Oral antibiotics for neonatal sepsis	0.0	40.0	50.0	70.0
48.	Injectable antibiotics for neonatal sepsis	80.42	88.0	90.0	95.0
49.	Full supportive care for neonatal sepsis/pneumonia	0.0	50.0	60.0	80.0
	Diarrhea				
50.	ORS	36.0	50.0	70.0	85.0
51.	Antibiotics for treatment of dysentery	26.12	50.0	60.0	80.0
52.	Zinc for treatment of diarrhea	12.80	20.0	35.0	50.0
	Other Infectious Disease				
53.	Oral antibiotics for pneumonia	53.71	60.0	70.0	80.0
54.	Oxygen and pulse oximetry for pneumonia	0.0	20.0	70.0	85.0
55.	Vitamin A for treatment of measles	19.0	30.0	60.0	80.0
56.	SAM – treatment for severe acute malnutrition	6.15	30.0	70.0	85.0
56.	MAM – treatment for moderate acute malnutrition	0.0	30.0	70.0	85.0

Estimating impact

The impact of scaling up the maternal, newborn and child health interventions was measured as the number of maternal, newborn and child lives saved. To estimate the number of lives saved by scaling up an intervention, the case-specific mortality from this intervention is multiplied by the coverage of the intervention and its effectiveness as presented in equation 1.

$$MNC\ lives\ saved = case\ specific\ mortality\ x\ intervention\ coverage\ x\ effectiveness \quad (1)$$

Unmet need for family planning

Interventions towards ending unmet need for family planning

In Table A3, the modern contraceptive interventions (methods) covered in this investment case is presented. These are based on evidence from the LDHS and cover all modern methods reported to be used in the country. The method mix at baseline as well as how we project it to change between 2025 and 2030 are also presented. The method mix is projected to change towards only modern methods by the endline of 2030.

Table A. 3: Modern contraceptive interventions and method mix

Method	2025	2030
Long-acting and permanent methods		
Female sterilization	2.93	3.02
Implant - Jadelle (5years)	8.96	9.25
IUD - Copper-T380-A IUD (10 years)	2.74	2.83
Short-term methods		
Condom - Male	27.24	28.11
Condom - Female	0.18	0.19
Injectable - 3 months (Depo Provera)	34.1	35.28
Pill - Standard Daily regimen	20.66	21.32
Traditional methods		
Withdrawal	2.56	0
Traditional (not specified)	0.63	0
Total (%)	100	100

Source: Baseline method mix are from LDHS. Endline method mix is projected

Projection scenarios for ending unmet need for family planning

The family planning estimations were done with a focus on reaching a goal for modern contraceptive use under three projection scenarios. The scenarios make assumptions about what mCPR could be achieved by the endline. The expected changes in the mCPR under each of the scenarios is presented in Table A4.

Table A. 4: mCPR projection scenarios

Senario	2025	2026	2027	2028	2029	2030
Business as usual	53.2%	53.6%	54.0%	54.4%	54.8%	55.2%
Achievable	53.2%	53.6%	54.1%	54.5%	55.0%	55.4%
Ambitious	53.2%	53.9%	54.5%	55.2%	55.8%	56.5%

Note: Annual projections are based on linear interpolation mCPR between baseline endline

Estimating impact

The health impact of scaling up family planning interventions was measured in three outcomes (i) number of unintended pregnancies averted (ii) number of abortions averted and (ii) number of maternal lives saved. To estimate the health impacts, the case-specific impact of the outcome indicators from an intervention is multiplied by the coverage of the intervention and its effectiveness.

Estimating intervention costs

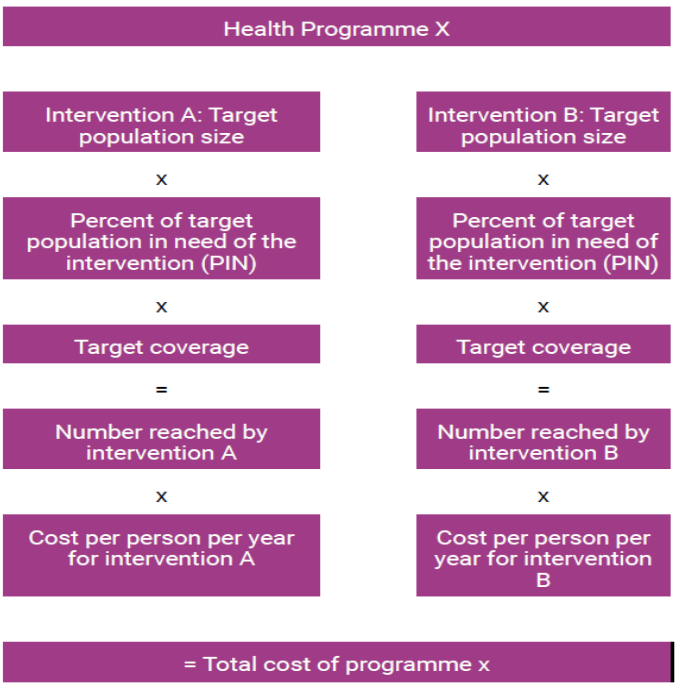
For each intervention included in the analysis, the total cost of scaling up the intervention in a particular year as a product of the target population, the population in need, the target coverage, and the cost per person per year was computed.

$$Total\ cost\ of\ intervention\ A = target\ population\ x\ population\ in\ need\ x\ target\ coverage\ x\ cost\ per\ p$$

(2)

The cost for each intervention includes the required drugs and consumable supplies (e.g., syringes, gloves), provider time, and the number of inpatient days and outpatient visits needed for the effective provision of the intervention. The resource requirement for each intervention therefore includes drugs and supplies, labour, capital, and other recurrent costs required to deliver the intervention per person. Assumptions about appropriate drug and labour are based on WHO's standard guidelines for delivering the intervention in question (Avenir Health, 2023). For instance, to cost the delivery of condoms, we followed the recommended 120 pieces of male condoms per person per year to be received by 95% of men in their reproductive age. We further assumed that a health worker would dedicate 35minutes (20 minutes for counseling and 15 minutes for resupply) per patient per year. Similar assumptions were made for female condoms except that 5% of women in their reproductive ages will be reached given the low uptake rate. In a similar fashion, we define the target population, coverage, and resource needs for each of the interventions considered for both maternal health and family planning (see Avenir Health, 2023 for details on all interventions). The first three components of equation (2) produce the number of services required for an intervention for a particular year. The product of the number of services and cost of service per person per year produces the cost of the intervention in question. Total intervention cost is therefore the sum of all individual intervention costs (see Box 1).

Aside from the intervention costs, other costs categories were computed to facilitate the implementation of the interventions through an improved health system. These are the programme costs and other health system costs. The cost of each of these items was computed as a proportion of the total intervention cost.



Box 1
Source: UNFPA (2020)

Ending Gender Based Violence (GBV)

Data and data source

The contextual data used for the GBV interventions were country default data information derived from literature and published sources by Avenir Health as well as data obtained from the Lesotho Demographic and Health Survey (LDHS) Report 2023-2024 and the Lesotho labour force survey 2024. The LDHS report specifically indicates percentage of victims of domestic violence in Lesotho. The population data used are the number of women and men between ages 15 to 49, and number of boys and girls between ages 10 to 14, all sourced from the LDHS. The macroeconomic data used include Gross National Income per capita (GNI per capita), Gross Secondary School enrolment rate, purchasing power parity conversion factor and female labour force participation rate.

Analytical tools and approaches for estimating impacts of scaling up GBV interventions

To estimate the costs and impact of GBV prevention, the impact40 model was used (www.impact40.org). The model was developed using the RESPECT framework proposed by the World Health Organization in collaboration with UN Women. The model, however, focuses on intimate partner violence (IPV) – considered to be the most prevalent form of GBV worldwide. The RESPECT framework has categories and sub-categories of interventions considered to have high impact on prevention of violence (see Table A5 for definition of main categories). However, interventions targeted at supporting victims of GBV are also considered. The tool defines IPV to include "the proportion of ever married/partnered women who reported that they had been subjected to one or more acts of physical or sexual violence, or both, by a current or former husband or male intimate partner within the 12 months preceding the survey".

Table A. 5: RESPECT Women Framework

R	Relationship skills strengthened
E	Empowerment of women
S	Service ensured
P	Poverty reduced
E	Environments made safe
C	Child and adolescent abuse prevented
T	Transformed attitudes, beliefs and norms

Source: UN Women (2020)[15]

Based on a comprehensive global literature review conducted at the London School of Economics, adjusted unit costs are reported for each of the interventions. The cost of each of the interventions is then computed as a product of the target population, the intervention coverage and unit price. While this assignment made use of the cost within the tools, we also make use of the costs contained in the costing and ME framework of Lesotho. It is also worth noting that some country-specific interventions outside of the RESPECT women framework were employed.

$$Intervention\ cost = target\ population\ x\ intervention\ coverage\ x\ unit\ cost \quad (3)$$

The target population is the population sub-group for whom the intervention is targeted. The intervention coverage at baseline is the proportion of the target population receiving the intervention at baseline. The total cost was computed as the sum of all intervention costs across all categories and sub-categories.

For each of the interventions, their effect on the percentage of women experiencing IPV was extracted from the literature. Only interventions that showed reduced impact on exposure or perpetration of sexual or physical GBV were included with their odds ratios to estimate impact. The odds ratios together with the target population was then used to compute percentage reduction in IPV cases due to the intervention as reduction in number of women experiencing IPV due to the intervention.

Projected scenarios

The analysis considers three scenarios for scale up with a mix of interventions. The scenarios are summarised in Table A.

Table A. 6**:** Interventions categories for the GBV Model

Interventions by RESPECT Category	2030 scaleup target		
Relationship skills strengthened	Business as usual	Achievable Scenario	Ambitious Scenario
Empowerment training for women and girls, including life skills, safe spaces and mentoring	65.00	70.00	90.00
Environments made safe			
Bystander interventions	80.00	85.00	90.00
Child and adolescent abused prevented			
Life-skills/school-based curriculum, rape and dating violence prevention training	85.00	90.00	95.00
Transformed attitudes, beliefs and norms			
Community mobilization	90.00	95.00	99.00
Group education with men and boys to change attitudes and norms	75.00	78.00	85.00
Services Ensured: response interventions			
Medical care	35.00	35.00	35.00
Justice	35.00	35.00	35.00
Social Services	35.00	35.00	35.00
Policing	35.00	35.00	35.00

Child marriage

Analytical tools and approaches for scaling up Child Marriage interventions

The investment cases for scaling up child marriage interventions used the Child Marriage Optimal Intervention (CMOI) model from the Impact40 tool kit. The CMOI enables us to compute the cost per participant reached (i.e., unit cost) for intervention based on the population group that receives the targeted interventions. The CMOI model estimates the cost of CM interventions using the target population for that intervention, the coverage of that intervention, effectiveness of the intervention, and the unit cost of that intervention for a given year. Specifically, the cost of each scale up is obtained as:

$$Cost\ of\ \text{CM} = target\ poplation \times coverage \times unit\ cost \qquad (4)$$

The target population is defined as the sub-population that will receive the intervention (e.g., women, students, women in the labour force, couples etc.). Coverage (%) is defined as the proportion of the sub-population that receives the intervention out of the population in need of the

intervention. The total annual intervention cost was extracted from the Costing and ME Framework of the National Response Plan on Violence Against Children in Lesotho. The unit cost was derived by dividing the total annual intervention cost by the target age group population (15 years). The intervention targets 15-year-olds because the greatest CM risk in Lesotho is reported among girls aged 15-17 years[25]. We therefore assumed that every cohort receiving the interventions would be equipped to avert CM in the future. Effectiveness data for local interventions were extracted from existing literature as described in Table A7.

List of interventions and source of effectiveness

Interventions	Source
Development of Laws and Policies, and Capacity (Amendment of Childrens n and Welfare Bill)	• Duque V. Violence and children's education: Evidence from administrative data. J Confl Resolut. 2024;68(5):903–37. doi:10.1177/00220027231180114. • Grueso H. Heterogeneous effects of violence on student achievement: evidence from Colombia. J Int Dev. 2024;36(2):1535–69. doi:10.1002/jid.3875.
Advocate for Change of Community Norms and Values	• Pande R, Kurz K, Walia S, MacQuarrie K, Jain S. *Improving the reproductive health of married and unmarried youth in India: Evidence of effectiveness and costs from community based interventions*. Washington DC: International Centre for Research on Women; 2006. https://www.icrw.org/wp-content/uploads/2016/10/Improving-the-Reproductive-Health-of-Married-and-Unmarried-Youth-in-India.pdf. Accessed September 28, 2017. • Mehra D, Sarkar A, Sreenath P, Behera J, Mehra S. Effectiveness of a community based intervention to delay early marriage, early pregnancy and improve school retention among adolescents in India. *BMC Public Health*. 2018;18(1):732-745. doi:10.1186/s12889-018-5586-3 • Erulkar A, Medhin G, Weissman MA. *The impact and cost of child marriage prevention in three African settings*. New York: Population Council; 2017. https://www.popcouncil.org/uploads/pdfs/2017PGY_ChildMarriageAfrica_brief.pdf. Accessed August 7, 2018. • Sewall-Menon J, Bruce J. *The cost of reaching the most disadvantaged girls: Programmatic evidence from Egypt, Ethiopia, Guatemala, Kenya, South Africa and Uganda*. New York: Population Council; 2012. https://www.popcouncil.org/uploads/pdfs/2012PGY_CostOfReachingGirls.pdf.
Improve Safe School Environments	• Isokuortti, N., Aaltio, E., Laajasalo, T. and Barlow, J., 2020. Effectiveness of child protection practice models: a systematic review. *Child Abuse & Neglect*, *108*, p.104632. • Wilson, S.J. and Tanner-Smith, E.E., 2013. Dropout prevention and intervention programs for improving school completion among school-aged children and youth: A systematic review. *Journal of the Society for Social Work and Research*, *4*(4), pp.357-372.
Create awareness on prevention and response on violence against children.	• Wilson, S.J. and Tanner-Smith, E.E., 2013. Dropout prevention and intervention programs for improving school completion among school-aged children and youth: A systematic review. *Journal of the Society for Social Work and Research*, *4*(4), pp.357-372.

[25] https://data.unicef.org/wp-content/uploads/cp/child-marriage/Child-marriage-profile_LSO.pdf

Appendix B

Table B. 1: Annual cost of maternal, newborn and child health interventions – Modest scenario

	2025	2026	2027	2028	2029	2030	Total
Total Intervention costs (US$)	-	2,557,949	5,617,321	9,177,645	13,153,098	17,678,169	48,184,182
Programme Related Activity costs (US$)	-	819,996	1,795,675	2,922,788	4,174,624	5,593,975	15,307,058
Total Investment Required (US$)	-	3,377,945	7,412,996	12,100,433	17,327,722	23,272,144	63,491,241

Table B. 2: Annual cost of maternal, newborn and child health interventions – Achievable scenario

	2025	2026	2027	2028	2029	2030	Total
Total Intervention costs (US$)	-	3,869,795	8,593,385	14,159,395	20,514,500	27,832,116	74,969,192
Programme Related Activity costs (US$)	-	1,255,142	2,773,886	4,548,972	6,563,991	8,873,368	24,015,359
Total Investment Required (US$)	-	5,124,937	11,367,272	18,708,367	27,078,491	36,705,484	98,984,551

Table B. 3: Annual cost of maternal, newborn and child health interventions – Ambitious scenario

	2025	2026	2027	2028	2029	2030	Total
Total Intervention costs (US$)	-	5,618,986	12,394,737	20,335,081	29,406,420	39,826,161	107,581,386
Programme Related Activity costs (US$)	-	1,850,554	4,063,754	6,640,547	9,573,528	12,932,507	35,060,890
Total Investment Required (US$)	-	7,469,540	16,458,492	26,975,628	38,979,948	52,758,668	142,642,276

Table B. 4: Annual trend in Family Planning users by scenario

Scenario	2025	2026	2027	2028	2029	2030	Total
Business as usual	140,106	143,559	147,102	150,773	154,505	158,247	894,292
Achievable	140,106	144,816	149,677	154,732	159,914	164,577	913,822
Ambitous	140,106	145,698	151,489	157,522	163,734	170,907	929,456

Table B. 5: Annual trend in unintended pregnancies averted by scenario

Scenario	2025	2026	2027	2028	2029	2030	Total
Business as usual	51,981	53,262	54,576	55,938	57,323	58,711	331,792
Achievable	51,981	53,728	55,532	57,407	59,330	61,060	339,038
Ambitous	51,981	54,056	56,204	58,443	60,747	63,408	344,839

Table B. 6: Annual trend in maternal deaths averted by scenario

Scenario	2025	2026	2027	2028	2029	2030	Total
Business as usual	207	212	217	222	228	233	1,319
Achievable	207	214	221	228	236	243	1,348
Ambitious	207	215	224	232	242	252	1,371

Table B. 7: Annual trend in unsafe abortions averted

Scenario	2025	2026	2027	2028	2029	2030	Total
Business as usual	3,501	3,587	3,675	3,767	3,860	3,954	22,344
Achievable	3,501	3,618	3,740	3,866	3,995	4,112	22,832
Ambitious	3,501	3,640	3,785	3,936	4,091	4,270	23,222

Table B. 8: Annual cost of Family Planning interventions – Business-as-usual scenario

	2025	2026	2027	2028	2029	2030	Total
Total intervention cost (US$)	-	30,343	61,873	94,946	129,001	163,750	479,912
Total Programme Related Activity cost (US$)	-	12,303	65,964	117,633	165,374	218,929	580,204
Total investment required (US$)	-	42,646	127,837	212,579	294,375	382,679	1,060,116

Table B. 9: Annual cost of Family Planning interventions – Achievable scenario

	2025	2026	2027	2028	2029	2030	Total
Total intervention cost (US$)	-	38,866	79,462	122,194	166,527	207,248	614,296

Total Programme Related Activity cost (US$)	-	36,374	115,951	195,316	272,467	366,348	986,457
Total investment required (US$)	-	75,241	195,413	317,511	438,993	573,596	1,600,753

Table B. 10: Annual cost of Family Planning interventions – Ambitious scenario

	2025	2026	2027	2028	2029	2030	Total
Total intervention cost (US$)	-	44,868	91,857	141,425	193,053	253,381	724,585
Total Programme Related Activity cost (US$)	-	37,031	116,817	195,984	272,593	526,377	1,148,803
Total investment required (US$)	-	81,899	208,674	337,410	465,646	779,759	1,873,387

Table B. 11: Annual costs of GBV Interventions – Business as usual

	2025	2026	2027	2028	2029	2030	Total
Cost of Responding to GBV Survivors (US$)	-	327,273	635,780	925,400	1,196,014	1,447,514	4,531,981
Cost of Preventing GBV Cases (US$)	-	408,346	819,621	1,233,679	1,650,683	2,070,954	6,183,284
Total Investment Required (US$)	-	735,619	1,455,402	2,159,079	2,846,698	3,518,467	10,715,265

Table B. 12: Annual costs of GBV Interventions – Achievable

	2025	2026	2027	2028	2029	2030	Total
Cost of responding to GBV survivors (US$)	-	319,951	606,354	858,901	1,077,333	1,261,439	4,123,979
Cost of Preventing GBV Cases (US$)	-	899,251	1,804,797	2,716,429	3,634,547	4,559,842	13,614,866
Total Investment Required (US$)	-	1,219,203	2,411,151	3,575,330	4,711,880	5,821,282	17,738,845

Table B. 13: Annual costs of GBV Interventions – Ambitious

	2025	2026	2027	2028	2029	2030	Total

Cost of responding to GBV survivors (US$)	-	314,536	585,086	812,046	996,002	1,137,735	3,845,404
Cost of Preventing GBV Cases (US$)	-	1,129,384	2,266,329	3,410,394	4,561,966	5,721,871	17,089,943
Total Investment Required (US$)	-	1,443,919	2,851,415	4,222,440	5,557,967	6,859,606	20,935,348

Table B. 14: Annual Trend in Percentage Experiencing GBV

Scenario	2025	2026	2027	2028	2029	2030
Business as usual	25.4	24.7	24.0	23.3	22.6	21.8
Achievable	25.4	24.1	22.8	21.5	20.1	18.8
Ambitious	25.4	23.9	22.4	20.9	19.3	17.8

Table B. 15: Annual Trend in Number Experiencing GBV

Scenario	2025	2026	2027	2028	2029	2030
Business as usual	149,842	145,685	141,508	137,313	133,101	128,871
Achievable	149,842	142,425	134,958	127,446	119,893	112,305
Ambitious	149,842	140,015	130,225	120,493	110,842	101,292

Table B. 16: Annual Trend in GBV Cases Averted

	2026	2027	2028	2029	2030	Total
Business as usual	4,158	4,177	4,195	4,212	4,229	20,971
Achievable	7,417	7,467	7,513	7,553	7,588	37,537
Ambitious	9,827	9,790	9,731	9,652	9,550	48,550

Table B. 17: Cost in CM interventions by Scenarios

Scenario 1	**To 2030**	**To 2040**	**To 2050**
Advocate for change of community norms and valudes	318,599	2,342,117	4,551,462
Conditional Economic Incentives	1,901,658	13,979,640	27,166,786

Development of Laws and Policies, and capacity	120,844	888,357	1,726,353
Promote functional helplines to support efffective prevention and response to violence against children	99,582	732,059	1,422,618
Enhance coordination mechanisms at all levels	366,533	2,694,494	5,236,239
Improve safe school environment	706,490	5,193,615	10,092,809
Total	3,513,707	25,830,281	50,196,267
Scenario 2	**To 2030**	**To 2040**	**To 2050**
Advocate for change of community norms and valudes	319,107	2,349,196	4,565,725
Life Skills	2,869,374	21,123,709	41,054,496
Development of Laws and Policies, and capacity	121,036	891,042	1,731,763
Promote and strenghen a safe, secure, and enabling school environment and life-skills training in Lesotho	707,487	5,208,368	10,122,602
Enhance coordination mechanisms at all levels	367,117	2,702,637	5,252,649
Improve safe school environment	707,615	5,209,312	10,124,438
Total	5,091,737	37,484,263	72,851,674
Scenario 3	**To 2030**	**To 2040**	**To 2050**
Rural School supply	984,761	7,257,177	14,101,642
Improve School infrastructure	492,380	3,628,589	7,050,821
Advocate for change of community norms and valudes	320,985	2,365,495	4,596,465
Create awareness on prenvention and response on violence against children	193,881	1,428,807	2,776,357

Conditional Economic Incentives	1,915,898	14,119,178	27,435,404
Life Skills	2,886,263	21,270,270	41,330,909
Development of Laws and Policies, and capacity	121,749	897,224	1,743,423
Strengthen referral mechanisms for essential multi-sectoral service	267,595	1,972,038	3,831,928
Improve safe school environment	711,781	5,245,455	10,192,604
Total	7,895,293	58,184,233	113,059,552

Table B. 18: Trend in Child Marriage Cases Averted by intervention

Scenario 1	**To 2030**	**To 2040**	**To 2050**
Advocate for change of community norms and valudes	1,144	7,235	13,267
Conditional Economic Incentives	1,430	9,044	16,583
Development of Laws and Policies, and capacity	477	3,015	5,528
Improve safe school environment	477	3,015	5,528
Total	3,528	22,309	40,905
Scenario 2	**To 2030**	**To 2040**	**To 2050**
Advocate for change of community norms and valudes	1,126	7,004	12,811
Life Skills	2,206	13,717	25,088
Development of Laws and Policies, and capacity	469	2,919	5,338
Promote and strenghen a safe, secure, and enabling school environment and life-skills training in Lesotho	-	-	-
Enhance coordination mechanisms at all levels	-	-	-
Improve safe school environment	469	2,919	5,338
Total	4,271	26,558	48,574
Scenario 3	**To 2030**	**To 2040**	**To 2050**

Rural School supply	941	4,952	8,830
Improve School infrastructure	653	3,436	6,127
Advocate for change of community norms and valudes	922	4,851	8,650
Create awareness on prenvention and response on violence against children	384	2,021	3,604
Conditional Economic Incentives	1,152	6,064	10,813
Life Skills	1,806	9,500	16,940
Development of Laws and Policies, and capacity	384	2,021	3,604
Strengthen referral mechanisms for essential multi-sectoral service	384	2,021	3,604
Improve safe school environment	384	2,021	3,604
Total	7,011	36,889	65,778

"Strengthening health and social sectors for equitable ser- vices towards MNC deaths, unmet need for FP, GBV, and CM will yield far-reaching benefits across generations."

Contact Information

Address: Ministry of Health HQ, Maseru, Lesotho
Email: info@health.gov.ls
Website: www.health.gov.ls