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Report

Living Conditions among People with Disabilities in Lesotho

A National Representative Study

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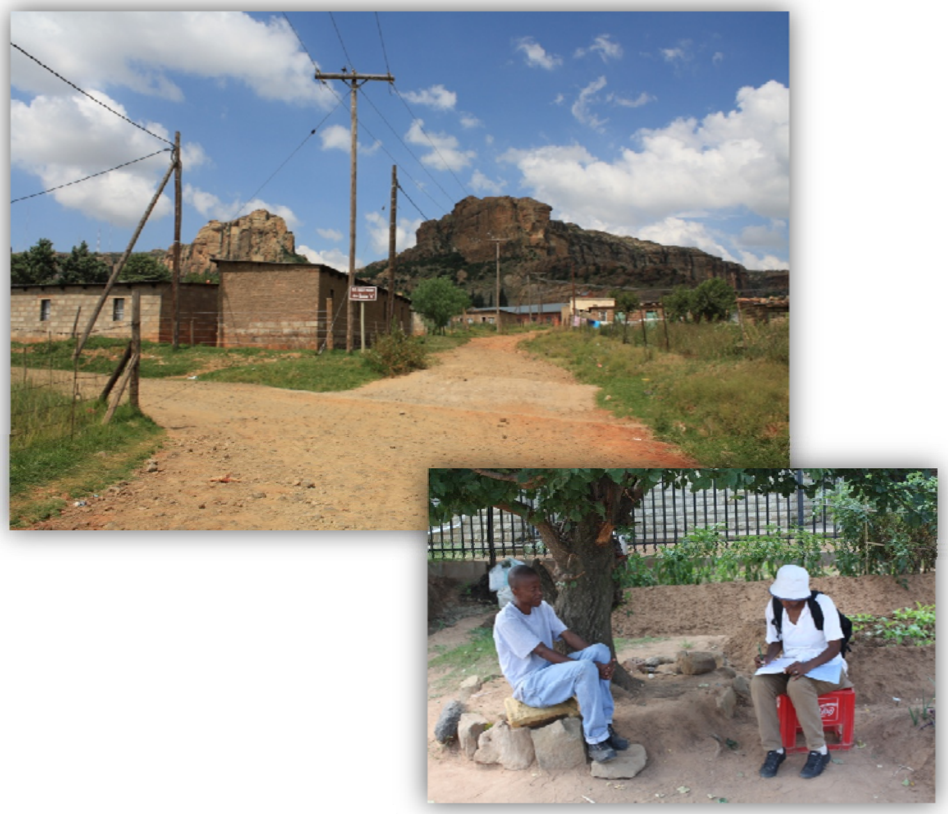
Arne H. Eide



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ABSTRACT

This research report provides results from the study of living conditions among people with disabilities in Lesotho. Comparisons are made between disabled and non-disabled in household level and individual level. Disability was defined as limitation to perform certain activities that was measured according to the Washington City Group questions. Results obtained in Lesotho are also compared to those obtained in earlier studies carried out in Mozambique, Zambia, Namibia, Zimbabwe and Malawi. The Lesotho study was undertaken in 2009-2010.

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1 Acknowledgements

This is a report from a National, representative household survey carried out in Lesotho in 2009 – 2010. A large amount of effort has been put into this two-year exercise until finally we can present the results of the combined efforts. First of all, this is a credit to Lesotho National Federation of the Disabled (LNFOD); to the Board for taking the decision to carry out and to support this study, to the Executive Director of LNFOD, Liau Motoko for his support and thorough follow-up as the administrative responsible throughout the whole exercise, to Mokome Monaheng for professionally handling all economic issues, and, not least, to the project co-ordinator at LNFOD, Relebohile Mabote for her professional and conscientious implementation of all steps in a comprehensive and complex process.

The Steering Committee for the survey comprised LNFOD Executive Director, Mr Liau Motoko, Research Officer, Mr. S Thoahlane, Mr T. Phafoli (Bureau of Statistics, BOS), Dr R. Leduka (Insititute of Southern Africa Studies – National University of Lesotho, ISAS-NUL) and Mrs L. Lesoetsa. They should all be thanked for their support and efforts to make this survey a useful tool for disabled people in Lesotho in the years to come.

A number of disabled individuals have contributed in different roles. Not least has this been an exercise that has proven the capabilities of disabled people, either in the Steering Committee, as enumerators or as supervisors. This report and this

study had not been possible without their enthusiastic participation. You have all contributed tremendously, not least to change the role of disabled people from objectives for research to actors and decision makers in research. This is a remarkable achievement, given the difficult situation for many individuals with disabilities in Lesotho and in the region.

Lastly, the Lesotho Bureau of Statistic and National University of Lesotho have both offered institutional support as well as having representatives at different levels in the project, including the Steering Committee.

With such a broad support for this project, it has been a pleasure being involved in this and we congratulate all stakeholders in this field with the establishment of new knowledge about the situation for disabled in Lesotho.

Oslo, 1 December 2010

Prof. Arne H. Eide, PhD	Yusman Kamaleri, PhD
Chief Scientist	*Research Scientist*

2 Summary

AH Eide & Y Kamaleri

Introduction:

This representative study on living conditions among people with disabilities in Lesotho is the result of an international co-operation between Southern Africa Federation of the Disabled (SAFOD), Lesotho National Federation of the Disabled (LNFOD), and Norwegian Federation of Organisations of Disabled People (FFO). The Lesotho Bureau of Statistics and the National University of Lesotho (ISAS) has played important roles in the study. The study has been funded by the Atlas Alliance on behalf of Norwegian Agency for Development Co-operation (NORAD).

Forming part of a Regional initiative to establish baseline data on living conditions among people with disabilities in Southern Africa, the study in Lesotho is the sixth to be published. The report is designed to provide both an overview of the situation for people with disabilities in Lesotho today and a comparison to the situation for those of the population without disabilities both at household and individual levels.

Methods:

The study design was developed in close collaboration with a broad range of stakeholders. Organisations of people with disabilities and individuals with disabilities have played a particularly active role during development of the design and the collection of data. Based on the previous studies, the research instrument comprises a study on living conditions among households with and without disabled members, a screening instrument (for disability), a section with specific questions to individuals with and without disabilities, and a matrix that represents an operationalisation of core concepts from the International Classification of Functioning, Disability and Health (ICF).

A two-stage sampling strategy was applied, comprising first a screening procedure, followed by full interviews of selected households and control households. The sample was drawn from the master sample developed by the Lesotho Bureau of Statistics for the 2006 Population and Housing Census, covering all provinces in the country. A total of 1220 households were sampled, with approximately half having at least one member with disability.

The study design allows for the following types of comparisons: between households with and without disabled family members, and between individuals with and without disabilities.

Results:

In general, the patterns observed (both similarities and differences) between people with and without disabilities demonstrated in the preceding studies in the region were replicated in Lesotho.

With regards to demographics, households with disabled members were found to have higher mean age. The household size was larger, primarily having more family members than did control households. In addition, disabled households had a tendency to have more dependent individuals compared to control households. The difference with higher proportion among disabled household was also elucidated in those with lower socioeconomic status and lower dietary diversity.

Systematic gender differences were less evident in the Lesotho sample, although females had a higher school attendance as well as literacy rate. The latter puts these results in contrast with other studies in the region. School attendance is clearly lower among persons with disabilities. The percentage of school attendance among individuals with disabilities over 5 years of age was approximately 72% as compared to 90% among non-disabled. A similar trend was found with regards to employment: approximately 70% of individuals with disability reported to be unemployed, while the corresponding figure for non-disabled was around 30%.

There were six disability types (i.e. core domains) registered in the study. These include vision, mobility, hearing, remembering, self-care and communicating. Around one third of those with disabilities have either a self-reported mobility disability or sensory disability (i.e. vision or hearing). These figures are somewhat lower than in the previous studies. The proportions for other disability core domains were; “remembering” (27%), “self-care” (19%), and “communicating” (16%). More than half of the disabled respondents had one severe disability domain, while almost one forth had two or three severe disability core domains. The major causes of disability were reported to be either the result of illness, congenital, and accident. This corresponds to previous studies. Generally, an early onset of disability, e.g before the age of 5 years indicates a serious challenge to health services for mothers and children in the country.

The gap between the need and receiving health and welfare services was found to be relatively similar in other countries. Health services, health information and traditional healers were received by most individuals with disabilities. At the other end of the scale, the most noticeable shortcomings with regards to service provision for those who were aware of the existence and needed were welfare services, legal assistance, vocational training and educational services. For those aged 15 years and above, the proportion of control respondents who received formal primary education was 23% higher than the disabled respondents.

An overview of accessibility to different services, facilities and institutions primarily shows that many individuals with disabilities do not access such services. An example here can be public transport which is inaccessible for close to one third of disabled persons. More than half reported on accessibility problem in banks and hotels. The general impression is that a potential exists for improving accessibility for people with disabilities.

An assessment of various forms of assistance that may be needed by individuals with disabilities in performing daily life activities showed that a large majority of respondents claimed to need emotional support, surpassing all other types of assistance required. Economic support, or assistance with finances, was the second most often mentioned form of assistance needed.

The results indicate certain problems of social exclusion which should not be overlooked. About 16% reported that they had experience of being discriminated in public services. A relatively high rate of discrimination within the family and society was also reported. However, looking more closely at what takes place in their daily life, there are clear indications that many individuals with disability are sidelined in important daily life activities. Among these problems the most pronounced concern is not taking part in one's own traditional ceremonies, and not making important decisions about one's life. These, and other indicators of social exclusion, imply that awareness creation, information and education directed at the society, including public services, and families of individuals with disabilities is urgently needed. Combining this information with the relatively large proportion of individuals with disabilities who report mental health problems, we argue that this study indicates that individuals with disabilities are struggling in their daily life and that assistance is needed at this level.

A very clear “mobility bias” was found with regards to distribution of assistive devices, in that more than 80% of the devices in use were for mobility purposes. A minority of those surveyed (13.9%) claimed to use assistive devices. It is interesting to note that this figure equals more or less the figure in Zambia (13 %) but otherwise is lower than in the other countries surveyed; Malawi (17%), Namibia (18%) and Zimbabwe (26%). Among those who used assistive devices in Lesotho, about one third were not satisfied with the devices.

Redundancy in activity limitation and participation restriction score among disabled and non-disabled respondents illustrated the challenge to define disability dichotomously only based on impairment. Defining disability as a range of limitation and restriction reflects the diversity of disability in the society. This indicates that being disabled is not a singular, two-dimensional phenomenon but rather a complex process that deserves to be understood as part of the human condition and not as something that represents a deviation from the norm.

Conclusion:

The baseline data and results produced through this study can be applied directly as documentation of the living standards among people with disabilities and their families, and as a basis for comparison with both non-disabled individuals and families without a disabled family member. Furthermore the results can be applied later for monitoring purposes. This information is potentially useful when decisions are made on utilisation of meagre resources, as documentation and evidence to prospective donors or other funding sources, and as a tool for organisations of disabled people in setting priorities, educating their own members and the population in general, and as a basis for advocacy.

It is recommended that the results from this study are considered, together with other relevant sources, as a basis for dialogue between authorities, professionals and organisations of people with disabilities, for developing policies, setting priorities, and for developing concrete measures within selected areas of priority.

3 PREFACE

Alexander M. Phiri – Director General, SAFOD

In 2000, at the Millennium Summit (in New York), the World leaders committed themselves to "spare no effort to free our fellow men, women and children from the abject and dehumanizing conditions of extreme poverty". This commitment was translated into what later on became to be known as the eight Millennium Development Goals (MDGs) whose main purpose is to halve world poverty by the year 2015.

Interestingly, at the time the Millennium Declaration of 2000 was being enunciated, the disability movement in Africa had just successfully lobbied with its African leadership for an important initiative on the implementation of the African Decade of Persons with Disabilities which was to run from 2000 to 2009. On the sidelines of these global developments, and initiatives, the Southern Africa Federation of the Disabled (SAFOD) and its Norwegian Partner, FFO (Norwegian Federation of Organisations of People with Disabilities), agreed to work on a number of joint activities which among other things would include building the capacity of organizations of people with disabilities and undertaking studies on the Living Conditions among people with Activity Limitations in SAFOD member countries.

It was further agreed that these studies would be carried out from country to country during the Decade period to collect disability data which would then be used to raise awareness on disability in respective countries. Thus, between 2000 and 2009, the Living Conditions Studies were carried out in Malawi, Mozambique, Namibia, South Africa, Zambia and Zimbabwe.

In 2009 – 2010 it was agreed to do national representative studies in Lesotho and Swaziland simultaneously as these countries were found to be relatively smaller and much easier to handle than other SAFOD member countries. Having done these two countries, it means that there are now only two countries remaining to do the studies, i.e. Angola and Botswana.

Over the years it has been SAFOD's desire to see governmental and non – governmental organizations utilizing the study findings to improve the quality of life of people with disabilities in the region. Indeed some governments and local authorities are finding the data from these studies useful in designing their development plans. The completion of the study reports in Lesotho and Swaziland have coincided with the debate and adoption by world leaders at the UN of an annual report on "Assessing Progress in Africa towards the Millennium Development Goals (MDGs) 2010". The report presents an African continent that has made progress in a number of key areas such as equality in primary education, political empowerment of women, access to safe drinking water, and reducing the spread of HIV / AIDS and TB. Incidentally, 2010 marks the 10th year of the MDGs and 2015 is only five years away. SAFOD's critical question is around the reality of achieving the MDGs when disability is silent in this global poverty reduction strategy.

Perhaps the data from the Living Conditions Studies may be used by governments, the UN itself, and other stakeholders to assess future progress (if any) on the implementation of the MDGs. As SAFOD we are more than happy to work with the MDGs implementers in this area.

Thanks to our Norwegian partner, FFO, for providing the resources that enabled our two member organizations, LNFOD and FODSWA, to carry out these studies under the supervision of another important Norwegian partner, SINTEF Health Research. Our thanks also go to Universities, Government Ministries, Central Statistical Offices, DPOs, individuals and other stakeholders in Lesotho and Swaziland for making these studies a success!

4 INTRODUCTION

Relebohile Mabote

4.1 Background of Lesotho

Lesotho is a small mountainous country located at 29º 30´ S and 28 º 30´ E south of the equator. It is completely surrounded by South Africa and is thus extremely vulnerable to political and economic changes in South Africa. More than 80% of the country is found at altitude exceeding 1,800 meters above sea level. Lesotho has a land area of 30 355km^2, of which 9% is suitable for crop farming. 91% of the total land area comprises of mountain ranges and foothills suitable for livestock farming. Lesotho is one of the least developed economies in the SADC region and is extremely dependent on South Africa. The economy is dependent on agriculture though there has been a decline in productivity over the past few years due to prolonged periods of drought. Other sectors contributing towards the economy of Lesotho include diamond exports, sale of water to South Africa, remittances and export of wool, mohair and garments.

Lesotho is divided into ten administrative districts each headed by a district administrator. The districts are further subdivided into 80 constituencies which consist of 129 community councils. Lesotho has a population of 1,880,661 and is ranked 156th on the Human Development Index (United Nations Development Programme, 2009). It has an infant mortality rate of 94 and life expectancy at birth is estimated at 42.9 and 39.7 for females and males respectively (Bureau of Statistics, 2010). 77% of the population resides in the rural areas while 23% resides in the urban areas. According to the 2006 Population and Housing Census males comprise 48.6 percent of the total population, while females represent 51.4 percent.

The literacy rate in Lesotho is estimated at 87.0%. The constant rise in this figure can be attributed to the take-off of the Free Primary Education which was called for by the Prime Minster of Lesotho in the year 2000 *in lieu* of the Millennium Development Goal on Education. The free primary education initiative is on the 10th year of its operation. Majority of the orphans (estimated at 221, 403) are benefiting directly in this initiative.

The Integrated Labor Force Survey conducted by the Bureau of Statistics in 2008 indicates that 22.7% of the economically active population aged 15 years and above was unemployed. The unemployment rate was higher for females at 24.6% than the 21.2% displayed by males (Bureau of Statistics, 2009). It is estimated that 49% of the population lives below the poverty line which hovers around M149.91 (Bureau of Statistics, 2010).

Lesotho is one of the countries hard hit by HIV and AIDS and the pandemic was declared a national disaster by His Majesty King Letsie III in 2003. The National AIDS Commission (NAC) was established in September 2005 as a national coordinating body mandated to develop and coordinate strategies for combating HIV and AIDS; to provide policy guidance to implementing agencies in the country; to provide technical and financial support to the implementing partners; and to facilitate implementation, monitoring and evaluation of programmes. HIV prevalence is currently estimated at 23.6% of the total population (National AIDS Commission, 2010). HIV and AIDS is a major factor causing orphan hood and vulnerability to 68% of all orphans and vulnerable children (National AIDS Commission, 2010). The National AIDS Commission estimated adult new infections and annual AIDS deaths in 2008 at 21, 000 and 11, 000 respectively (National AIDS Commission, 2009). In order to address the pandemic NAC focuses on four thematic areas; Prevention, Treatment, Care and support, Impact mitigation and Leadership, Management & Coordination.

For a long time Lesotho did not have any data on disability. Several institutions such as the Ministry of Education and Training and Ministry of Development Planning have undertaken studies in the early 2000s to estimate the population of people with disabilities in Lesotho. The two ministries estimated the population of people with disabilities at 5.2% (Ministry of Health and Social Welfare, 2008) and 4.2% (Bureau of Statistics, 2002) respectively. For the first time in census history the Bureau of Statistics included questions on disabilities during the 2006 Population and Housing Census. The results of the census were presented for the first time to stakeholders in December 2009. The results of this census indicate that 3.7% of the total population of Lesotho has some form of disability of which 2.1% constitute males and 1.6% females. The census further indicates that 28.6% of people with disabilities have had disability for more than 20 years and 6.0% for less than one year.

4.2 General view of disability

The term disability is often a subject of debate among scholars. There are two major models that are often put forward when defining disability; the medical model and the social model. According to the medical model, disability is viewed as a problem directly caused by disease, trauma or any other health condition which therefore requires sustained medical care in order to ensure cure of the individual concerned (World Health Organization, 2002). The social model on the other hand views disability as a socially created problem and not at all an attribute of an individual. This model regards disability as a complex collection of conditions which are created by the social environment. The social model calls for restructuring of the physical environment and a change in attitudes in order to accommodate people with impairments so that they can be fully integrated into the society.

The World Health Organization (WHO) has developed the International Classification of Functioning, Disability and Health (ICF) as a conceptual basis for the definition, measurement and policy formulations for health and disability (World Health Organization, 2002). The ICF defines disability as the outcome of the interaction between a person with impairment and the environmental and attitudinal barriers he/she may face. ICF is a tool for measuring functioning in society regardless of one one's impairments.

Article 3 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) defines people with disability as "*including those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others*" (United Nations, 2006:4). The CRPD is an international instrument that is aimed at promoting, protecting and ensuring the full and equal enjoyment of all human rights and fundamental freedoms of persons with disabilities, and to promote respect for their inherent dignity. The CRPD follows several attempts made by international organizations to emphasise the right of persons with disabilities to the same opportunities as other citizens and to an equal share in the improvements in living conditions resulting from economic and social development. Some of the initiatives include the World Programme of Action Concerning Disabled Persons (United Nations, 1993) and the Standard Rules on the Equalisation of Opportunities for Persons with Disabilities (Resolution 48/96) (United Nations, 1994) approved by the General Assembly in 1993.

4.3 Disability in Lesotho's context

Basotho have historically imposed barriers that subject people with disabilities to isolation and exclusion from the society and extreme dependency on their families and the society at large. The barriers are two-fold; attitudinal and institutional (Silverstein, 2000). Attitudinal barriers are those imposed by the non-disabled which are often characterized by beliefs and sentiments held by the non-disabled. People with disabilities are often called mockery names and are often viewed as objects of charity and passive recipients of rehabilitation services. The institutional barriers include physical barriers such as those caused by infrastructure, policies, practices and procedures adopted by various entities that constitute the society.

Lesotho ratified the Convention on the Rights of Persons with Disabilities on December 2nd 2008. Article 4 of the Convention calls for countries that have joined the Convention to engage in the development and implementation of policies, laws and administrative measures aimed at securing the rights of people with disabilities and to abolish laws, regulations, customs and practices that constitute discrimination towards people with disabilities. Hence, the Convention requires states that are party to it to engage in the formulation of legislative tools aimed at domesticating the Convention. To date Lesotho has not adopted any pieces of legislation that promote protection of people with disabilities and their full inclusion in the society despite the early ratification of the Convention.

There is currently a draft National Disability and Rehabilitation Policy which is yet to be presented before the Cabinet. The primary objective of the policy is to protect the rights of people with disabilities and ensure full enjoyment of their fundamental human rights as enshrined in the Constitution of Lesotho. The policy will be used as a guiding document for designing, implementing and evaluating disability-specific policies and programmes that will ensure meaningful inclusion of people with disabilities into the mainstream society (Ministry of Health and Social Welfare, 2008).

4.3.1 DPOs in Lesotho and their achievements

In their fight against discrimination, people with disabilities have established four Disabled Peoples Organizations (DPOs) and an umbrella body Lesotho National Federation of Organizations of the Disabled (LNFOD). The four DPOs are Lesotho Society of Mentally Handicapped Persons (LSMHP), Lesotho National Association of Physically Disabled (LNAPD), Lesotho National League of Visually Impaired Persons (LNLVIP), and National Association of the Deaf-Lesotho (NADL). These five institutions are working together to represent the needs of people with disability to both the government and development partners. They have collectively achieved commendable results towards promotion of inclusion of people with disabilities in the society.

LNFOD and its affiliates have embarked on a number of initiatives targeted at inducing change at both the policy and grass roots levels. In partnership with the Norwegian Association of the Disabled and the Government of Lesotho, LNFOD is using the multi-sectoral approach of Community-Based Rehabilitation (CBR) to empower and enhance participation of people with disabilities at the community level. The various government departments are working together with LNFOD and its affiliates to ensure that people with disabilities have access and benefit from education, employment, health and social services. On a similar note, LNFOD and its affiliates embark on a number of advocacy initiatives to promote the inclusion of people with disabilities in the society. Through these two programmes a number of achievements have been realized.

At the policy level, the Government of Lesotho ratified the Convention on the Rights of Persons with Disabilities on the 2nd December 2008. The draft disability policy has also been developed in consultation with DPOs, though it is yet to be presented to the Cabinet.

LNFOD and its affiliates have developed alliances with other NGOs in Lesotho which are mainly used to solicit support from the civil society. To date a number of NGOs have undertaken programmes where they include issues of people with disabilities. For example, the Transformation Resource Centre engaged on a dialogue in June 2010 with parliamentarians where issues of people with disabilities and the importance of adopting the national disability policy were highlighted. Development for Peace Education (DPE) is also involved in activities where they train people with disabilities at the community level on livelihoods, governance and democracy.

The support obtained is not only limited to civil society organizations but also extends to government ministries. The Ministry of Forestry and Land Reclamation did not involve people with disabilities in the poverty alleviation projects on the basis that they are sick and can therefore not cope with the labour intensive methods used in the projects. Following the awareness raising initiatives undertaken by LNFOD there has been a tremendous change in this practice. There is now a requirement that each group of the labour force in these projects include a number of people with disabilities. On a similar note there has been a positive change in accommodating people with disabilities in the education sector. There is generally an increase in the enrolment of people with disabilities in the mainstream schools. The Lesotho College of Education and the Faculty of Education at the National University of Lesotho have introduced the Special Education Programme following the advocacy efforts by LNFOD and its affiliates.

Despite these achievements, people with disabilities continue to face discrimination, ill-treatment and are generally segregated by the society. A lot has to be done to ensure inclusion of people with disabilities at all societal levels. It is therefore important that policies and disability-specific legislations are defined in a way that protect people with disabilities and ensure their integration in the mainstream society. However, for these to be achieved wholly, there should be a thorough research on the living conditions of persons with disabilities and the challenges they face in different aspects of life. Such a research will form a foundation on which LNFOD and its affiliates base their advocacy. The research will also provide the much needed disability statistics which is a cornerstone in the formulation of disability legislation.

5 CONCEPTUAL UNDERSTANDING

Arne H. Eide

Disability and living conditions are core concepts to the study presented in this report. Our own understanding of these concepts has progressed in unison with some interesting developments in recent years. Both concepts are open to interpretation and can be perceived in different ways. In addition, it is important to be aware that the understanding and application of these concepts will vary from one socio-cultural context to another (Whyte & Ingstad, 1998). As the concepts are important for the design of the study as well as for the analyses and understanding of results, some clarifications are necessary.

5.1 Disability

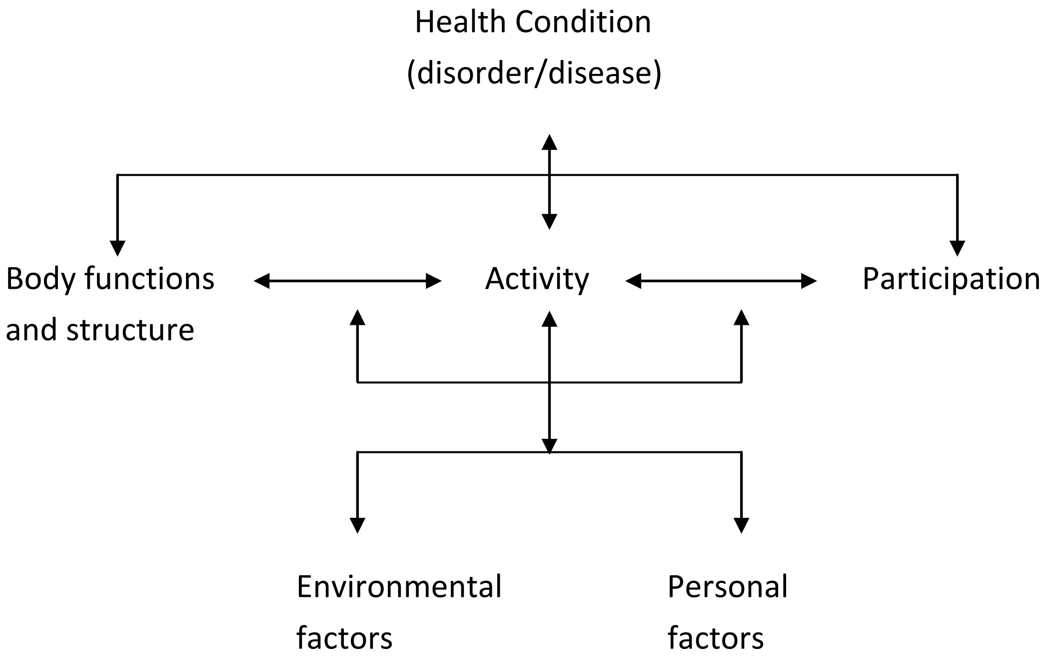
During the 1970s there was a strong reaction among representatives of organisations of persons with disabilities and professionals in the field of disability against the then current terminology. The new concept of disability was more focused on the close connection between the limitations experienced by individuals with disabilities, the design and structure of their environments and the attitude of the general population. Recent development has seen a shift in terminology and an increasing tendency towards viewing the disability complex as a process (the disablement process), involving a number of different elements on individual and societal levels. The recently adopted UN Convention on Rights of People with Disabilities (CRPD) (UN, 2006) defines disability as:

> “Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (Article 1)

5.2 International Classification of Functioning, Disability and Health (ICF)

The adoption of the World Health Organisation's International Classification of Functioning, Disability and Health (WHO, 2001) represents a milestone in the development of the disability concept. From 1980 and the first classification (The International Classification of Impairments, Disabilities and Handicaps (ICIDH) (WHO, 1980)), a 20 year process has resulted in shift in the WHO conceptual framework from a medical model (impairment based) to a new scheme that focuses on limitations in activities and social participation. Although not representing a complete shift from a strictly medical to a strictly social model, the development culminating with ICF nevertheless implies a much wider understanding of disability and the disablement process.

Figure 1: The ICF Model of Functioning, Disability and Health (WHO, 2001)



5.3 Application of ICF in the current study

The conceptual development from ICIDH to ICF is important here as this shift also has a methodological parallel. The classification forms a basis for the collection of statistical data on disability. The current study does not represent an application of ICF, and it has not been the intention to test the new classification as such. Rather, the study is inspired by the conceptual basis for ICF and has attempted to approach disability as activity limitations and restrictions in social participation. This is pronounced in the screening procedure and in the inclusion of a matrix on activity limitations and social participation restrictions developed particularly for this study. The current study does, none the less, provide a unique possibility for applying some core concepts from the ICF and testing some aspects of the model statistically.

An understanding of disability as defined by activity limitations and restrictions in participation within a theoretical framework as described in Figure 1 underlies this study. The term “disability” is, with this in mind, a problematic concept since it refers to, or is associated with, an individualistic and impairment-based understanding. As a term, it is nevertheless applied throughout this text since it is regarded as a commonly accepted concept, and its usage is practical in the absence of any new, easy to use terminology in this sector.

5.4 Environmental factors

Environmental factors are important elements in the ICF model, and it is fundamental to the present understanding of disability that activity limitations and restrictions in participation are formulated in the exchange between an individual and his/her environment. In the current study, environmental factors are included in an activity and participation matrix (Appendix 1 & 2). It is however acknowledged that studies like the current one traditionally focus on the individual and that this is also the case here.

5.5 Living conditions

The concepts of “level of living” or “living conditions” have developed from a relatively narrow economic and material definition to a current concern with human capabilities and how individuals utilise their capabilities (Heiberg & Øvensen, 1993). Although economic and material indicators play an important role in the tradition of level of living surveys in the industrialised countries, an individual’s level of living is currently defined not so much by his or her economic possessions, but by the ability to exercise choice and to affect the course of his or her own life. The level of living studies have been more and more concerned with such questions and are currently attempting to examine the degree to which people can participate in social, political and economic decision-making and can work creatively and productively to shape their own future (UNDP, 1997).

A number of core items can be regarded as vital to any level of living study: Demographics, health, education, housing, work and income. Other indicators may comprise use of time, social contact, sense of influence, sense of well being, perceptions of social conflict, access to political resources, access to services, social participation, privacy and protection, etc. The choice of which indicators to include will vary according to the specific requirements of each study and the circumstances under which the studies are undertaken.

5.6 Disability and living conditions

Research on living conditions is comparative by nature. Comparison between groups or monitoring development over time within groups and populations are often the very reasons for carrying out such studies. The purpose is thus often to identify population groups with certain characteristics and to study whether there are systematic differences in living conditions between groups – or to study changes in living conditions within groups over time and to compare development over time between groups. Population sub-groups of interest in such studies are often defined by geography, gender, age – or the focus of the current research, i.e. people with disabilities vs. non-disabled. Research in high-income countries has demonstrated that people with disabilities are worse off along the whole spectre of indicators concerning living conditions, and that this gap has also remained during times with steady improvement of conditions for all (Hem & Eide, 1998). This research-based information has been very useful for advocacy purposes, for education and attitude change in the population, as well as for planning and resource allocation purposes.

These same patterns of systematic differences are also at work in low-income countries, as has been documented in our studies in other countries in the region (Eide, van Rooy & Loeb, 2003a; Eide, Nhiwatiwa, Muderezi & Loeb, 2003b; Loeb & Eide 2004, Eide & Loeb 2006; Eide & Kamaleri 2009).

When the stated purpose of the research is to study living conditions among people with disabilities, it is essential, at the onset, to decide upon a working definition of disability in order to identify who is disabled and who is not. This is a more complex issue than choosing between a "medical model" on one side and a "social model" on the other. How this is understood and carried out has major impact on the results of research, and consequently on the application of results (refer to chapter 3.1 on the disability concept).   The ICF may to some extent be viewed as an attempt to combine a broad range of factors that influence the "disability phenomena".

The authors behind this research report support the idea that disability or the disablement process is manifested in the exchange between the individual and his/her environment. Disability is thus present if an individual is (severely) restricted in his/her daily life activities due to a mismatch between functional abilities and demands of society. The role of the physical and social environment in disabling individuals has been very much in focus during the last 10 – 20 years with the adoption of the Standard Rules, the World Programme of Action, ICF, and lately the UN Convention (CRPWD). It is logical that this development is followed by research on the mechanisms that produce disability in the meeting between the individual and his/her environment.

It is true that studies of living conditions among people with disabilities in high-income countries have been criticised for not evolving from an individualistic perspective. Data are collected about individuals and functional limitations are still in focus. It is a dilemma that this research tradition has not yet been able to reflect the relational and relative view on disability that most researchers in this field would support today. While we agree to such viewpoints, we nevertheless argue that a “traditional” study is needed in low-income countries to allow for a description of the situation as well as comparing between groups and over time. In high-income countries such studies have shown themselves to be powerful tools in the continuous struggle for the improvement of living conditions among people with disabilities. In spite of an individualistic bias in the design of these studies, the results can still be applied in a critical perspective on contextual and relational aspects that represents important mechanisms in the disablement process.

5.7 Combining two traditions and ICF

The design that has been developed and tested here aims at combining two research traditions: studies on living conditions and disability studies[1]. Pre-existing and validated questionnaires that had been used in Namibia (on general living conditions – NPC, 2000) and in South Africa (on disability – Schneider et. al., 1999) were combined and adapted for use in the surveys. A third element, on activities and participation, was included to incorporate the conceptual developments that have taken place in connection with development of ICF. By combining the two traditions, a broader set of variables that can describe the situation for people with disabilities are included as compared to the traditional disability statistics. Secondly, a possibility is established for comparing the conditions of disabled people (and households with disabled people) with non-disabled (and households without any disabled members). It is argued that such comparative information is much more potent in the struggle for improvement of the situation for disabled people, reflecting the developmental target for the current study.

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[1] By "disability studies" we understand a broad specter of different studies that have generated knowledge about the situation of people with disabilities.

6 DESIGN AND METHODOLOGY

Relebohile Mabote

6.1 Introduction

The national study on the living conditions of persons with disabilities is aimed at establishing the living conditions of persons with disabilities so that the information obtained can be used to inform the formulation and implementation of policies and programmes that are inclusive of people with disabilities. Given the nature of the study, a census would have been appropriate to source out this kind of information. However, due to resource constraints a sample was drawn in which the study would be implemented.

This chapter therefore provides a description of the methodological approach adopted in undertaking the study.

6.2 Sampling Design

The sample was drawn from the master sample developed by the Bureau of Statistics for the 2006 Population and Housing Census. The master sample consists of enumeration areas (EAs) as the primary sampling units (PSUs). The sample was selected using a two-stage stratified cluster design. The sample frame was stratified into urban and rural. Rural was further divided into 4 strata namely; lowlands, foothills, mountains and senqu river valley. During the first stage, a total of 110 EAs was selected across all the 10 districts. In the second stage a complete households listing and screening in each of the selected EAs was carried out and thereafter households were systematically selected. A household was the unit of analysis in this survey. The survey did not include individuals who live in collective institutions such as homes for persons with disabilities, old age homes, schools, hospitals, prisons as well as people who are homeless.

6.3 Sample Size Determination

The number of primary sampling units in each stratum was determined using power allocation to ensure representation of all strata. This was done using the

$$n = \frac{(\sqrt{\text{Number of households in the stratum}})\ (\text{Total Number of EAs required/district})}{\sum\sqrt{\text{Number of households in the stratum}}}$$

A total sample of 11 Enumeration Areas was allocated to each district.

6.4 Selection of Enumeration Areas

The specific EAs in which sampling was undertaken in each stratum were selected as follows:

1. Calculation of the sampling interval (K) of the stratum using the formula

   $K=N/n$

   Where **K** is the Interval

   N is the Total number of household within a specific stratum

   n is the number of EAs required in the stratum
2. Calculate the sampling number as follows K + R where R is the Random Number between 0 and 100.
3. Compare each sampling number with the size of cumulative household numbers.

The first EA selected was the one whose cumulative household count is greater or equal to the sampling number calculated. The subsequent EAs were selected by adding the interval (K) to the cumulative sampling numbers until the required number of EAs was selected in each stratum.

The number of EAs allocated to the respective ecological stratum in each district is as shown in Table 1 below.

Table 1: Sample allocation

District	Stratum	Total households in the stratum	Number of selected EAs
Butha Buthe	Urban Lowlands	7761	4
	Rural Mountains	1944	2
	Rural Foothills	9575	5
Leribe	Urban Hlotse	4395	2
	Urban Maputsoe	8983	3
	Rural Foothills	9170	3
	Rural Mountains	6023	3
Berea	Rural Lowlands	30219	4
	Rural Foothills	10294	3
	Rural Mountains	133	0
	Urban	18456	4
Maseru	Rural Lowlands	34944	4
	Rural Foothills	13441	2
	Rural Mountains	6142	1
	Urban	60292	4
Mafeteng	Urban	27414	5
	Rural Lowlands	7228	3
	Rural Foothills	9068	3
Mohale's Hoek	Rural Lowlands	12304	3
	Rural Foothills	3976	1
	Rural Mountains	4936	2
	Rural Senqu River Valley	10983	3
	Urban	6415	2
Quthing	Rural Mountains	7166	3
	Rural Senqu River Valley	14710	5
	Urban	3661	3

Qacha's Nek	Rural Mountains	8058	5
	Rural Senqu River Valley	4246	3
	Urban	2765	3
Mokhotlong	Rural Mountains	18880	7
	Urban	5136	4
Thaba Tseka	Rural Mountains	22286	5
	Rural Senqu River Valley	3798	3
	Urban	7077	3
TOTAL			**110**

6.5 Household Listing and Screening

During the households listing and screening exercise enumerators used maps developed by the Bureau of Statistics during the 2006 Population and Housing Census to locate the EAs and identify their boundaries. The enumerators visited all households that were found within each EA for listing and screening purpose. The listing exercise was done using a listing form whose questions were designed based on the International Classification of Functioning (ICF) based attributes on activity limitations. All households listed on the screening form were classified as either cases (households with has at least one member with disability) or controls (households without members with disabilities).

6.6 Selection of households

The household listing and screening exercise yielded a household sampling frame of cases and controls in each Enumeration Area. Following the screening exercise, a maximum of 20 households was selected using systematic sampling from each EA. 50% of these households were cases and the remaining 50% were controls. Questionnaires were then administered to these households. In households where the number of persons with disabilities was more than one, the questionnaire for people with disabilities was administered to all individuals with disabilities.

6.7 Data collection tools

Data was collected by way of face-face interviews using the following tools:

- Household screening and listing form which was used to identify households with members with disabilities within a selected EA.
- Individual Case questionnaire. This was aimed at soliciting specific information on the living conditions of persons with disabilities. This questionnaire was administered to all members with disabilities within a household. The number of the individual questionnaires administered in each household depended on the number of members identified as having disabilities in that particular household.
- Household questionnaire which was aimed at determining the living conditions of the selected households.
- Control questionnaire which was aimed at determining the living conditions of people without disabilities. This was mainly to compare the living conditions of persons with disabilities to those of their non-disabled counterparts.

The household questionnaire covers the following topics:

- Demographics
- Education and literacy
- Economic activity of household members aged 15 years or above
- Reproductive health of female household members aged 12-49 years
- Income and expenditure
- Household assets and housing
- Transport and communication

The Individual Case questionnaire covers the following topics:

- Activity limitation and participation restriction
- Environmental factors
- Cause of impairment and discrimination experiences due to impairment
- Services needed and received
- Education and employment
- Accessibility in the home and surroundings
- Assistive devices
- Inclusion in family and social life
- Health and general wellbeing

The Control questionnaire covers the following topics:

- Activity limitation and participation restriction
- Environmental factors
- Education and employment
- Inclusion in family and social life
- Health and general wellbeing

6.8 Disability screening in the context of this survey

For the purposes of this research disability screening was done using questions based on the International Classification of Functioning (ICF) based classification of functional limitations. The screening questions were phrased as follows:

The next questions ask about difficulties you may have doing certain activities because of a HEALTH PROBLEM:

	No	Some	A lot	Unable
Do you have difficulty seeing, even if wearing glasses?	1	2	3	4
Do you have difficulty hearing, even if using a hearing aid?	1	2	3	4
Do you have difficulty walking or climbing steps?	1	2	3	4
Do you have difficulty remembering or concentrating?	1	2	3	4
Do you have difficulty with self-care such as washing all over or dressing?	1	2	3	4
Using your usual (customary) language, do you have difficulty communicating for example understanding or being understood?	1	2	3	4

An individual was considered to have a functional limitation if the answer to at least one of these questions was ‘A Lot’ or ‘Unable’ or if an answer to at least two questions was ‘Some’.

6.9 Research Teams

The survey was conducted by 11 teams each comprising of 1 supervisor, 3 enumerators and 1 driver (Appendix 3). Due to the rugged terrain of Lesotho, each team was transported in a 4X4 vehicle to enable access to the remote mountain areas. This mode of transport was complemented by use of horses where the terrain could not allow for further movement of a vehicle.

7 Results

Yusman Kamaleri

The results are presented in two sub-sections:

1. **Household section:** Results from comparative analyses between households with at least one member with disability and households without a member with disability. Head of household or someone knowledgeable about the household was the main informer. Data on every member in the household were also collected.
2. **Individual section:** The results are based on a detailed survey specifically addresses the situation of persons identified with disability. The disabled person or a proxy was the informer. This section also includes some comparisons on level of living conditions between persons with and without disability.

Throughout this chapter, the term ‘Disability’ and ‘Control’ will be used interchangeably with household or individuals with or without disability. Here, the term ‘Disability’ refers to individuals with functional limitations (i.e. disabled person) or households with member(s) with functional limitations (i.e. disabled household). The term ‘Control’ refers to individuals without functional limitation (i.e. control person) or households without any member with functional limitation (i.e. control household).

Sampling weight was implemented in the analyses to account for the differences in the population and households in the different provinces. Data from the Lesotho Statistical Yearbook 2008 (National Statistical System of Lesotho 2009) was used for weighting. In the presentation of the results, 95% confidence interval (CI) is provided whenever necessary to give an estimated range of values which is likely to include an unknown population parameter based on the study sample. Particular care has also been taken during the analyses to control for both gender and regional (districts) differences. Whenever these potential confounders have revealed significant differences, these are commented in the text, otherwise not. It should be noted that the total number of households or individuals included in the different analyses might be different than the overall total due to some missing data in any of the variables included in the analyses.

7.1 Household Section

In general, a household consists of a man, his wife, and their children with or without other relatives, domestic servants, boarders and lodgers. In other words, it refers to persons who *live and eat together*. A person who lives alone and caters for herself/himself forms a one-person household. The main unit of the survey is the household as defined above. Further we are interested in information about only the permanent members of the household – that is visitors were *excluded* and temporarily absent members were *included*. Those at boarding schools or those away for seasonal work are considered as members of the household while those in long-term institutions are not considered as members of the household. Family members living and/or working abroad are not considered as permanent household members.

A total of 10 256 households were screened using the Washington City Group (WCG) (CDC, 2010) questions on disability primarily to identify households with member(s) with disability for detailed interview. The head of the household or someone who were knowledgeable about the household was the key informer. He or she was also asked a general question on disability by asking "*If there is any member with disability in the household*". The table below presents the results from the screening.

Table 2: Results from households screening (n=10 256)

	n	%
Disability[1]	1036	10.1
Severe disability[2]	587	5.7
General disability[3]	762	7.4

[1]At least two questions answered with “some difficulty” in WCG questions

[2]At least one questions answered with “a lot of difficulty” or “unable” in WCG questions

[3]General question on ‘if anyone in the household has disability’

Based on our operational definition of *disability* with at least two disability domains in WCG questions were answered with “some difficulty”, the prevalence of households having at least one member with disability was 10.1% with a confidence interval of 9.5% – 10.7%. *Severe disability* with at least one of the six WCG questions was answered with “a lot of difficulty” or “unable” had a prevalence rate of 5.7% with confidence interval of 5.3% - 6.2%. The prevalence rate of the general question on *general disability* was higher than severe disability rate, 7.4% and 5.7% respectively. This contradicts with the common assumption that disability is often defined as only related to severe disability or impairment. Probably, the participation of people with disability in the data collection has increased the threshold and willingness to report on household member(s) with disability.

Results from the household screening were used as population frame to select households and individuals with and without disability for detailed interview. A general overview on number of households and individuals in the households is presented in the Table 3.

Table 3: Total study sample: Households and Individuals in the households

	Number of:	
	Households	Individuals
Disabled	589	639
Control	631	5255
Total	1220	5894

The total number of individuals living in the selected households for detailed interview was 5894 persons. Among them, 639 (10.7%, 95% CI 10% - 11.5%) persons were reported with disability. The total number of members in households with at least one member with disability was also higher compared to control households, 3019 persons and 2875 persons respectively.

The table below presents the proportion of households included in the detailed interview according to the different districts in Lesotho. Maseru district had the highest number of households that participated in the study (16.7%) while Makhotlong district had the lowest (4.3%).

Table 4: Sample of households by districts

	Households			
Districts	Disabled	Control	Total	
	n	*n*	*n*	(%)
Butha-Buthe	74	75	149	(12.2)
Leribe	55	72	127	(10.4)
Berea	73	74	147	(12.1)
Maseru	94	110	204	(16.7)
Mafeteng	75	76	151	(12.4)
Mohale's Hoek	47	51	98	(8.0)
Quthing	33	36	69	(5.7)
Qacha's Nek	29	28	57	(4.7)
Makhotlong	28	24	52	(4.3)
Thaba Tseka	81	85	166	(13.6)
Total	589	631	1220	(100)

The distribution of household members with disability according to different districts is presented in the table below. However, this distribution is not meant to be indicative of prevalence. These are derived from a selected sub-population based on a screening procedure that identified households with and without a disabled family member.

Table 5: Members of household by districts

	Household member		
Districts	Disabled	Total	% disability
Butha-Buthe	83	711	11.7
Leribe	56	604	9.3
Berea	73	683	10.7
Maseru	108	969	11.2
Mafeteng	88	708	12.4
Mohale's Hoek	48	469	10.2
Quthing	39	424	9.2
Qacha's Nek	30	297	10.1
Makhotlong	29	255	11.4
Thaba Tseka	85	774	11.0
Total	639	5894	10.7

The distribution of head of households and disability status is presented in the table below. About one-fifth of the household heads were persons with disability. In households with and without disabled member, 42.9% of the household heads were female. There was no significant difference in gender distribution between households with and without disabled member. This is presented in Table 6.

Table 6: Head of household by disability status

	Head of household	
	n	%
Disabled	248	20.2
Control	972	79.8

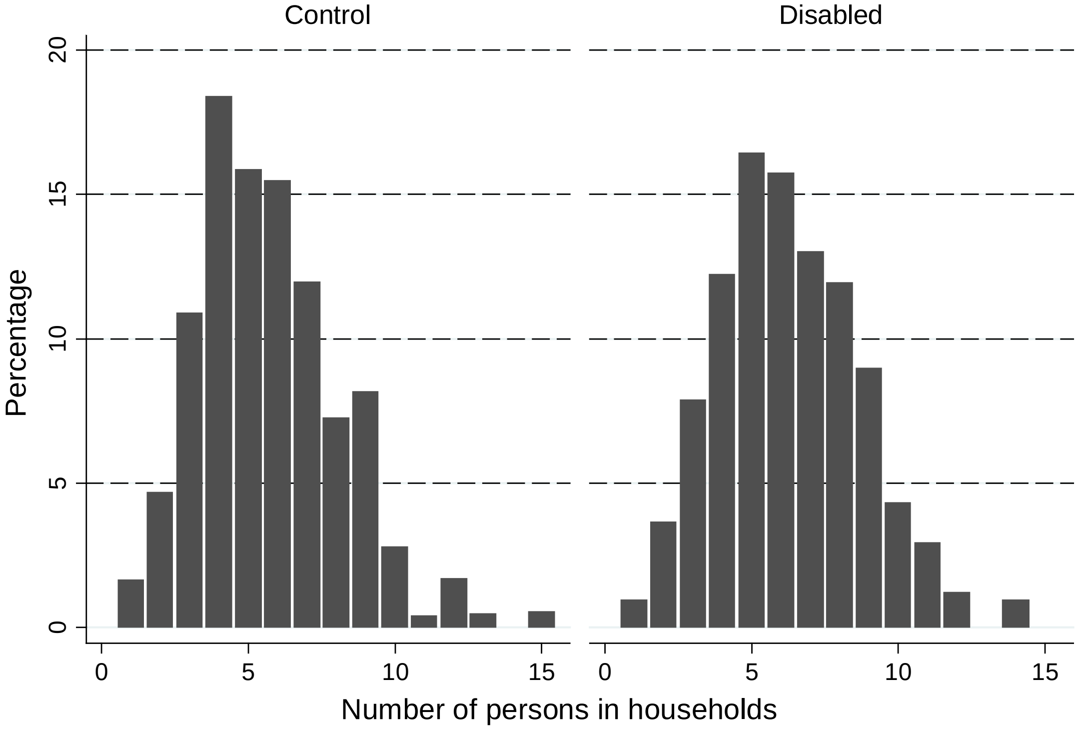
Table 7: Head of household by gender and disability status

Head of household	Disabled	Control
	%	%
Female	20.6	79.4
Male	20.4	79.6
Base = 100%	248	964

7.1.1 Household size

Household size refers to the number of individuals living in a household. Household size in this study has a range from one person to 15 persons. The distribution of household members according to disabled and control households is presented below (Figure 2):

Figure 2: Distribution of number of persons in a household



In general, households with at least one disabled member have significantly more household members than control households. The mean household size for disabled households is 5.1 (95% CI: 4.9 – 5.3) while control households have mean size of 4.6 (95% CI: 4.4 – 4.8). However, despite the tendency that mean household size is higher in households with at least one member with disability compared to control household, detailed analyses of different districts revealed that the difference is only significant in three districts. These districts are Butha-Buthe, Berea and Thaba Tseka.

Table 8: Number of disabled members in the households

	n	%
None	631	51.72
1 person	547	44.84
2 persons	37	3.03
3 persons	3	0.25

4 persons	1	0.08
5 persons	1	0.08
Total disabled individuals	639	
Total disabled household	589	

Table above shows that some households contained more than one disabled member. Therefore, the number of disabled households is less than the number of disabled individuals, at 639 persons.

7.1.2 Age of members

The analyses excluded 119 persons because they had missing data on age. Comparison of mean age in the households between disabled and control households as a whole shows that the mean age in disabled households was higher than the mean age of control households. Disabled households have mean age of 33.5 years (95% CI: 32.1 – 34.8) while control households have mean age of 31.6 years (95% CI: 30.4 – 32.9). Analyses of different districts however revealed that despite the tendency of higher mean household age in disabled households compared to control households, statistical significant difference was only found in Mafeteng district; mean age of 34.3 years old for disabled households and 29.1 years old for control households.

Distribution of age groups in the households is presented in the table below. There were 3692 persons who were 30 years old or below. This group represents more than half (64%) of the total individuals in the households. The table also illustrates that reporting with disability increases with age.

Table 9: Age groups of all members in the household

Age Group	Disabled person %	Total %
0 – 10	4.7	21.4
11 – 20	6.2	25.2
21 – 30	8.1	17.5
31 – 40	10.6	9.9
41 – 50	15.8	7.6
51 – 60	16.5	7.5
61 – 70	25.7	6.1
71 and above	35.0	4.9
Total	10.7	100

The table below presents the distribution of age groups among individuals with disability in the household. Despite the trend that disability increases with age, this study represents almost equal number of people with disability in the all age groups.

Table 10: Distribution of age groups among disabled members of households (n=628)*

Age Group	n	%
0 – 10	59	9.3
11 – 20	97	14.5
21 – 30	83	13.2
31 – 40	62	9.8
41 – 50	71	11.1
51 – 60	71	11.5
61 – 70	90	14.6
71 and above	95	16.1

* n is different than the overall total individuals due to missing data on age

7.1.3 Dependency ratio

Another measure of the structure of households is the dependency ratio. This is a measure of the portion of a population which is composed of dependents (people who are too young or too old to work). Here, we defined dependents as those who were below 15 years or over 65 years, while working-age is defined by those aged 15 to 64 years. Therefore, the dependency ratio is equal to the number of dependents divided by the number of individuals in working-age[2]. A rising dependency ratio is of concern to countries with quickly aging populations, since it becomes difficult for pensions systems to provide for this older, non-working population. A rapidly growing population with a high fertility rate implies that a relatively large proportion of the population consists of children who are dependent on their families for sustenance.

A dependency ratio of 0 means that the household consists of only individuals between 15 to 64 years old (i.e. working-age), while dependency ratio of 1.0 means there is one working-age person for each dependent in the family (e.g. a family of four with two adults and two children). Dependency ratio under 1.0 is indicative of less burden on the wage earners in the family and dependency ratio over 1.0 indicates a burden. It illustrates the economic responsibility of those economically active in providing for those who are not.

Analysis of the overall data shows that disabled households have significantly higher dependency ratio than control households; 0.90 and 0.76 respectively. The figure below presents the difference of dependency ratio between disabled and control households according to districts. Even though a significant different is

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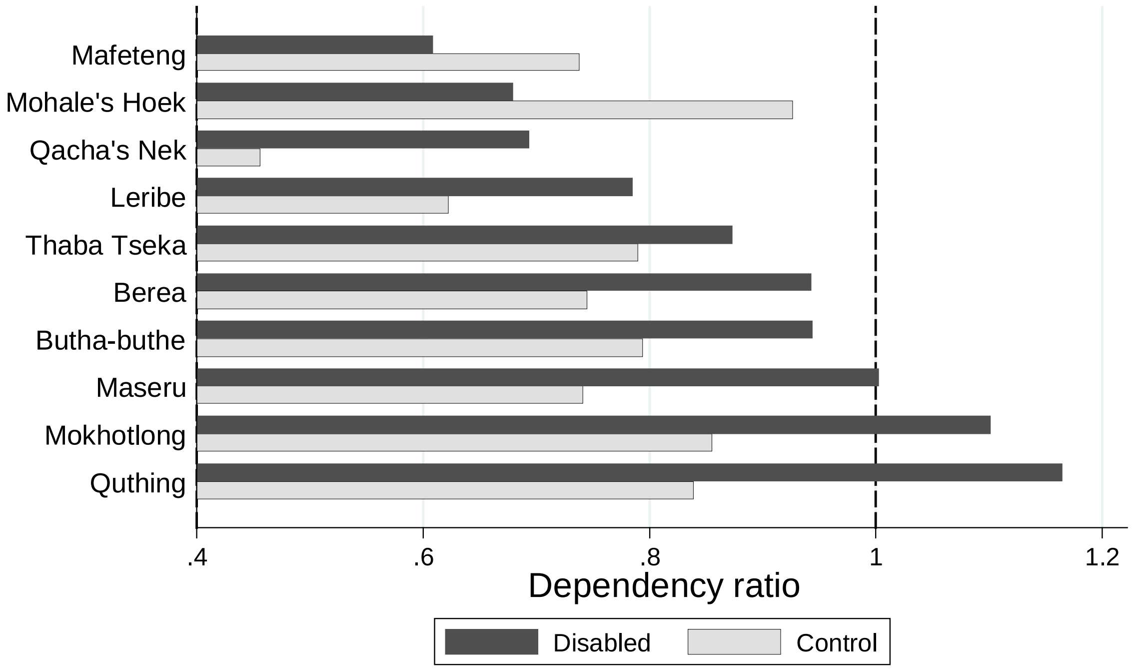
[2] Dependency ratio (*d*) = $\frac{N_{\leq 14} + N_{\geq 65}}{N_{15-64}}$

only found in Maseru district, the pattern shows that disabled households have a tendency to have more dependent individuals compared to control household.

Figure 3: Mean of dependency ratio by household type and districts



7.1.4 Gender

Concerning gender distribution, there was no significant difference in number of female members in disabled and control households. In disabled households, 52.2% (n=1574) were females, while control households had 51% (n=1482). However, analysis of gender proportion according to districts shows that Mohale’s Hoek district had more females in disabled households compared to control households; 61% and 39% respectively. On the other hand, in Quthing, there were more females in the control households compared to disabled households; 69% and 31% respectively. However, the result should be interpreted with caution due to the small household sample in these two districts.

An overview of the proportion of total females and males included in the detailed household survey is presented in the Table 11.

Table 11: Total number of individuals in the households, by sex

	Female		Male	
	n	(%)	n	(%)
Disabled	315	(10.3)	324	(11.2)
Control	2741	(89.7)	2499	(88.8)
Total	3056		2823	

There were 3056 females and 2823 males included in the total households selected for detailed interview. 15 persons have missing data on sex. The proportion of females and males with disability in this study was not significantly different, 10.3% and 11.2% respectively.

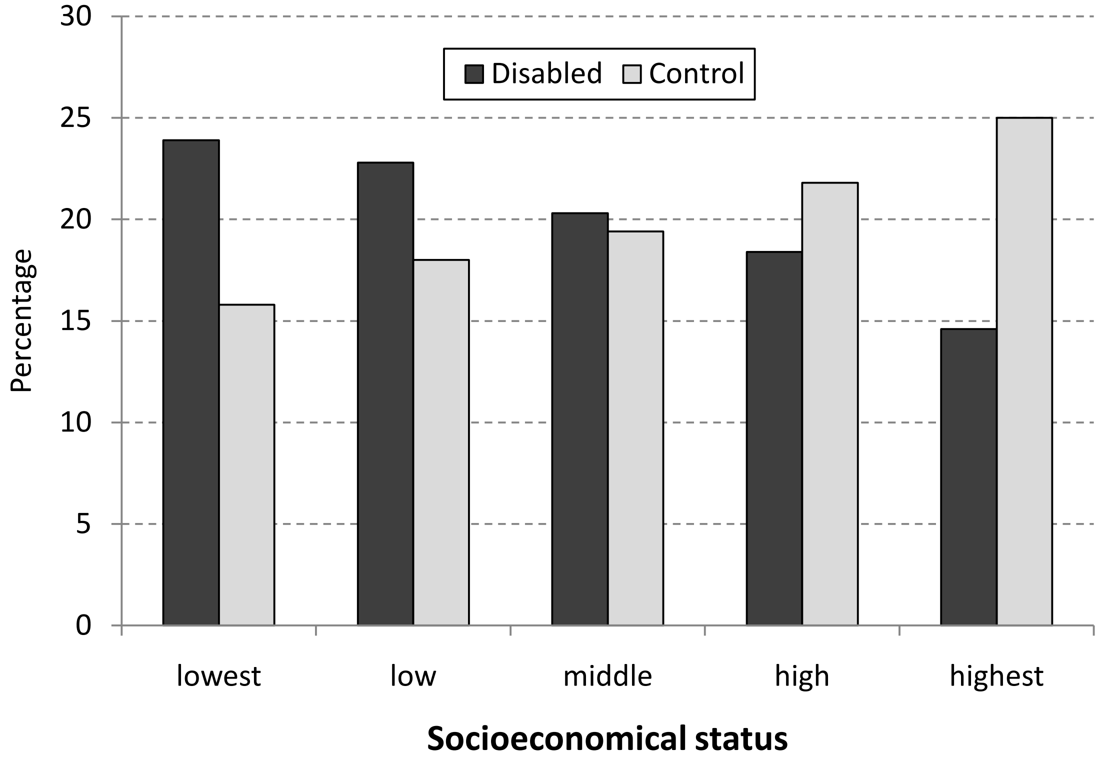
- Disabled households have more members compared to control households
- Average age of disabled household members is higher than control households
- There was a tendency that disabled households have more dependents than control

7.1.5 Socioeconomic status

Socioeconomic status (SES) was measured by asking questions on household possession of different items in the household. The questions ranged from items such as bed or radio to expensive items such as refrigerator, washing machine or car. There were 26 items being asked with “yes-no” answer. Principle Component Analysis (PCA) was used to aggregate these items into a single score. The score is then categories into five categories to represent 20% highest SES to 20% lowest SES in the study population.

Figure 4 illustrates the SES between disabled and control households. In general, disabled households had significantly lower SES compared to control. For instance, 24% of disabled households had lowest SES compared to 16% among control households. However, 25% of control households had highest SES compared to 15% among disabled households. There is also a tendency that the proportion of disabled households decreases as the SES increases. The opposite pattern was shown among the control households.

Figure 4: Socioeconomic status by household types



With regards to primary source of income in the households, 18.6% (95% CI: 15.4 – 22.1) of the disabled households reported “wage or salary work” as the main household income compared to 33.2% (95% CI: 29.3 – 37.3) among control households.

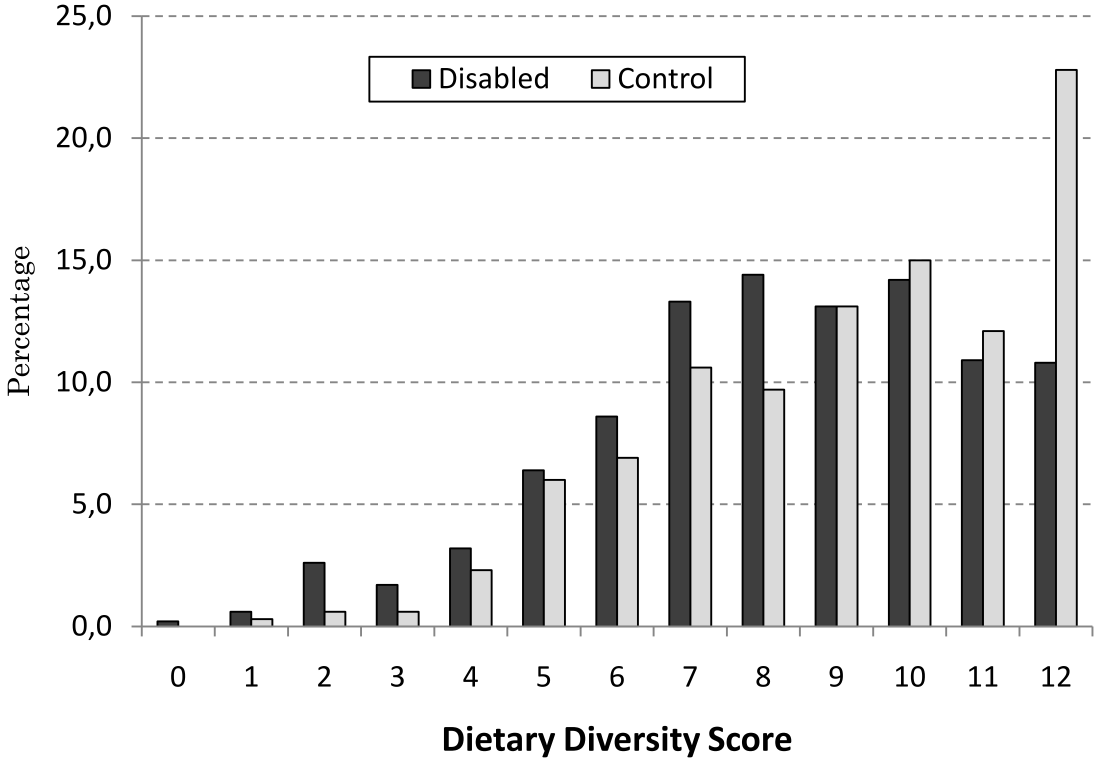
7.1.6 Dietary diversity

Household dietary was assessed by Household Dietary Diversity Score (HDDS) (Swindale 2006). The assessment was based on 12 different food groups consumed in the household in the past two weeks during the day and night. A sum score of 12 represent the highest food diversity. These food groups include:

a. Cereals
b. Root and tubers
c. Vegetables
d. Fruits
e. Meat, poultry, offal
f. Eggs
g. Fish and seafood
h. Pulses/legumes/nuts
i. Milk and milk products
j. Oil/fats
k. Sugar/honey
j. Miscellaneous

Overall, disabled households had lower dietary diversity compared to control households; 8.2 (95% CI: 8.0 – 8.5) and 9.1 (95% CI: 8.9 – 9.3) respectively. The figure below illustrates the distribution of HDDS between disabled and control households. The proportion of disabled households was more than threefold the proportion of control households with lowest HDDS (ie. 0 – 3). On the other hand, control households were twice the proportion of disabled households with highest HDDS (i.e. 12).

Figure 5: Dietary diversity by household types



7.1.7 Education

The percentage of school attendance among disabled members aged 5 years old and above was lower compared to members without disability; 71.6% (95% CI: 67.8 – 75.2) and 90% (89.0 – 90.8) respectively (n=5265). The distribution was almost similar among persons aged 15 years and above (n=3956).

The table below presents the distribution of school attendance for those who were between 5 years old and 60 years old (n=4638). Among disabled persons aged 5 to 10 years, almost 40% were not attending school. This was more than twofold the proportion of non-disabled members of the same age group. For disabled persons aged 11 to 20 years, almost 23% of them were not attending any educational institutions. This was more than seven times higher than the proportion of non-disabled of the same age group who were not attending school, college or university.

Table 12: School attendance by age groups (5 to 60 years old) and disability status

Age group	Disabled %	Control %	Total %
5 – 10	61.1	85.1	83.5
11 – 20	77.4	97.2	95.9
21 – 30	76.9	94.6	93.2
31 – 40	62.8	89.1	86.2
41 – 50	71.5	87.9	85.4
51 – 60	78.4	81.3	80.8
Base = 100%	432	4206	4638

Analysis of school attendance among females and males aged 5 to 60 years old shows that more females were attending or had attended school, college or university. The trend was the same in disabled and non-disabled persons. However, gender difference in school attendance among persons without disability was slightly less than among disabled persons; approximately 7% and 12% respectively. This is presented in the table below.

Table 13: School attendance by gender who were aged 5 to 60 yrs and disability status

Gender	Disabled %	Control %	Total %
Female	79.3	94.6	93.3
Male	66.6	88.2	86.0
Base = 100%	432	4206	4638

There were 12.7% of those aged five years old and above recorded as “never attended school”. The household head or main informer in the household was asked the reasons that household member(s) had never attended school. The results are presented in the table below. Lack of money was the main reason that they had never attended school in both disabled and non-disabled persons.

However, lack of money explained almost half of the reasons for not attending school among people without disability. Among disabled persons, shortage of money explained one fourth of the reasons. Nevertheless, more than 20% of people with disability aged five years old and above had never attended school because of their disability. Furthermore, 16.7 % of persons with disability stated illness as a reason for non-attendance, as compared to 1.9 % of non-disabled. Bearing in mind that health and disability often are associated, close to 40 % of disabled non-attendees stated their own functional/health status as the reason.

Table 14: Reasons for never attend school by disability status

Reasons	Disabled %	Control %	Total %
Not enough money	25.8	43.6	38.9
Illness	16.7	1.9	5.8
Because of disability	22.4	0.1	6.5
Lack of interest	9.6	21.7	18.5
Other	25.5	32.7	30.3
Base = 100%	475	172	647

7.1.8 Literacy

The question on literacy addresses the issue of individual’s ability to read and write in any language. The data recorded was based on the evaluation given by the head of the household or main informer on behalf of every household member. The analyses include only members aged 10 years old and above with complete data on age and literacy (n=4602). The prevalence of illiteracy among persons belonging to this age group was 17.7% (95% CI: 16.6 – 18.8). Among people without disability, 14.8% (95% CI: 13.7 – 15.9) was illiterate while the proportion was more than twofold among disabled people (38.6%, 95% CI: 34.4 – 42.9). The distribution of illiteracy status among disabled and non-disabled persons according to gender is presented in the table below.

Table 15: Illiteracy rate according to gender and disability status

	Disabled %	Control %	Total %
Female	29.0	11.6	13.6
Male	48.3	18.3	22.2
Base = 100%	565	4037	4602

The results from the table above show that among those aged 10 years old and above, the proportion of illiteracy among females and males who were disabled was more than twice the proportion of their counterparts who were non-disabled. In addition, in both disabled and control household, the proportion of males who were illiterate was significantly higher compared to females.

7.1.9 Employment

The table below gives the distribution of employment status among economically active persons aged 15 to 65 years old. The employment status concentrated only on four types: paid work, self-employed, unemployed because of health reasons and unemployment because of other reasons. Other types of employment statuses such as homemaker, student, volunteer, retired and others would not be included in the analyses. Therefore, the results are not meant to provide a statement on unemployment rate in the country as this information will be easily accessible from the Demographic Study or National Census (Lesotho Bureau of Statistic 2008). The results will only illustrate the situation of people with disability compared to people without disability on these four employment statuses.

Table 16: Employment status among disabled and non-disabled people

Work status	Disabled %	Control %	Total %
Paid work	5.7	17.9	16.6
Self employed	2.3	6.5	6.1
Unemployed (health reasons)	45.0	3.4	7.9
Unemployed (other reasons)	23.9	30.1	29.5
Base = 100%	380	3069	3449

The results presented in Table 15 clearly demonstrate the difference between disabled and non-disabled. The proportion of individuals with paid work is more than three times higher among non-disabled. Also the proportion of self-employed is three times higher among non-disabled. Unemployment for health reasons is on the other hand more than 40 % higher among disable.

Table 17: Employment status according to gender and disability status

Work status	Disabled %	Control %	Total %
Female			
Paid work	3.0	14.3	13.2
Self employed	3.1	4.2	4.1
Unemployed (health reasons)	36.2	3.2	6.5
Unemployed (other reasons)	27.6	26.6	2673
Base = 100%	186	1631	1817

Male			
Paid work	8.3	21.9	20.4
Self employed	1.4	9.1	8.2
Unemployed (health reasons)	53.4	3.7	9.4
Unemployed (other reasons)	20.3	34.0	32.5
Base = 100%	194	1438	1632

Table 17 shows that the difference in work status demonstrated in Table 16 is more pronounced for females as compared to men when it comes to paid work, while it is the other way around for self-employment. This is especially true among the disabled household members. In addition, unemployment for health reasons is clearly higher among disabled men than disabled women, both in numbers and with regards to the ratio between disabled and non-disabled.

7.1.10 Stillbirth among females aged 15 years old and above

The head of households were asked about incidence of at least one pregnancy that ended before term (ie. stillbirth) among all female members aged 15 years and above. This included 2038 females. Among them, 319 persons had had at least one pregnancy ended before term. This constituted 14.9% incidence rate with 95% CI between 13.3% and 16.5%.

Table 18: Proportion of stillbirth by disability status

Stillbirth	%	n
Disabled	21.3	56
Control	13.9	263

The table above shows that incidence of stillbirth among disabled females aged 15 years old and above was 53% higher compared to females without disability of the same age. Unfortunately, there is limited information in this study that could explain the difference.

7.1.11 Distance to school and health facility

Every households head was asked to estimate the distance to the nearest school and health facility from their house. The distance was measure by estimating the time taken to walk one way to these facilities. Estimated distance from home to the nearest school and health facility is presented in Table 19 and 20 respectively. There was no difference in the distance to school and health facility between disabled and control household because they were selected from the same area. More than half of the informant households lived close to a school. Nevertheless, almost 40% of all informant households were located quite far from the closest a health facility (i.e. more than one hour to walk one way).

Table 19: Time needed to walk one way to the nearest school

Time	Disabled %	Control %	Total %
5 – 30 min	58.8	55.7	57.2
31 – 60 min	13.3	14.5	13.9
> 1 hour	12.8	10.0	11.3
Don’t know	15.2	19.9	17.7
Base = 100%	604	544	1148

Table 20: Time needed to walk one way to the nearest health facility

Time	Disabled %	Control %	Total %
5 – 30 min	29.1	32.8	31.0
31 – 60 min	22.7	21.4	22.0
> 1 hour	41.4	35.3	38.2
Don’t know	6.8	10.5	8.7
Base = 100%	569	618	1187

7.2 Individual section

Every individual identified with disability during the household interview was invited to participate in detailed individual interview. Of the 639 persons identified, 633 of them participated. One person has missing answers on disability assessment (WGQ) and was excluded from the analyses. This gave total respondents to be 632 persons and a response rate of 98.9%. For a comparative purpose, 585 persons from the control households were invited to participate in detailed individual interview. The detailed interview for control individuals comprised only a short version of the questionnaire used for interviewing persons with disability.

One person identified as disabled during the household interview was a false positive (ie. identified as disabled but non-disabled). This was also the same in control individuals with one false negative. In the following analyses, however, they were grouped into their respective disability status. In addition, respondents aged less than five years (seven disabled and six non-disabled) were excluded from further analysis. This gives total sample for analyses to be 625 persons with disability and 579 persons without disability.

In about 51% of the cases the person with disability responded themselves, whereas proxy reporters answered in 42%. The remaining 7% was when the proxy responded together with the disabled persons.

7.2.1 Demographic

The table below presents demographic information about persons with and without disability. The information includes the proportion of disabled and non-disabled persons according to age group, gender and districts. The mean age for disabled persons was 44 years old with a standard deviation of 24 years. Among individuals without disability (i.e. control), the mean age was 42 years old with a standard deviation of 21 years. The difference in age between the two groups was not statistically significant. Moreover, no statistical significant difference was found in gender distribution according to districts.

Table 21: Demographic information by disability status

	Disabled %	Control %	Total %
Age			
5 – 10	8.0	6.9	7.4
11 – 20	14.7	13.7	14.2
21 – 30	14.8	15.2	15.0
31 – 40	10.8	13.4	12.1
41 – 50	10.1	14.1	12.0
51 – 60	11.5	15.1	13.3
61 – 70	15.1	12.5	13.9
71 and above	15.0	9.1	12.2
Gender			
Female	49.7	53.3	51.4
Male	50.3	46.7	48.6
Districts			
Butha-Buthe	5.5	5.8	5.7
Leribe	16.7	17.7	17.2
Berea	14.1	15.0	14.5
Maseru	24.9	23.3	24.1
Mafeteng	10.4	11.0	10.7
Mohale’s Hoek	8.6	8.5	8.6
Quthing	4.8	4.8	4.8
Qacha’s Nek	3.5	3.6	3.6
Makhotlong	4.7	4.3	4.5
Thaba Tseka	6.8	6.1	6.4

Comparison of demographic data among disabled and non-disabled primarily reveals that demographic differences between the two groups are marginal.

7.2.2 Distribution of disability core domains

Out of 625 individuals identified with disability, 537 persons (85.9%) answered *a lot of difficulty* or *unable to do* (i.e. severe disability) in at least one of the six disability core domains in the WGQ. The distribution of the different core domains among those reported with severe disability according to gender is presented in the table below. Overall, disability related to *mobility* was prominent followed by *remembering*. The prevalence of disability related to vision, hearing, self-care and communicating was almost equal. With regards to gender, even though there was no significant difference between females and males in the different disability core domains, there was a tendency that males had higher prevalence in the different disability core domains except self-care.

Table 22: Distribution of severe disability according to disability core domains and gender

Disability core domain	Female %	Male %	Total %
Vision	14.4	18.5	16.4
Hearing	15.1	19.9	17.5
Mobility	38.5	31.0	34.7
Remembering	28.0	26.3	27.2
Self-care	19.5	17.6	18.6
Communicating	12.0	19.1	15.6
Base = 100%	298	303	601

Despite gender difference was not statistically significant due to the marginal difference, results from Table 20 reveals a tendency that; disability related to vision, hearing and communication were more prevalent among disabled male respondents, while disability related to mobility, remembering and self-care are somewhat more prevalent among disabled female respondents.

Table 23: Distribution of number of disability core domains reported simultaneously, by gender

No. of disability core domain	Female	Male	Total	
	%	%	%	n
0[1]	12.8	8.8	10.8	83
1	59.7	64.9	62.3	368
2 – 3	24.8	23.0	23.9	134
4 – 6	2.7	3.4	3.1	16

[1] Persons who answered only *some difficulty* in at least two of the core domains

The majority of disabled respondents reported severe disability in one disability core domain. This represented with 64.9% among males and 59.7% among females. Having two or three disability core domains was also relatively common in this data material. Gender difference was small and was not statistically significant.

The table below shows the distribution of severe disability in the different disability core domain according to age groups. Mobility was prominent among those aged 41 years old and above. Disability core domain related to mobility had the highest proportion among disabled respondents aged 51 – 60 years old. Problem with remembering and concentrating core domain was higher among younger respondents (i.e. aged 40 years old and below). Respondents age 61 and above reported more problem with vision.

Table 24: Distribution of severe disability according to disability core domain and age groups

Disability core domain	Age groups							
	5 – 10 %	11 – 20 %	21 – 30 %	31 – 40 %	41 – 50 %	51 – 60 %	61 – 70 %	> 70 %
Vision	10.5	5.5	10.7	8.4	11.9	12.3	28.4	33.2
Hearing	32.2	23.7	11.3	15.5	15.9	11.6	15.6	18.8
Mobility	21.8	19.2	24.5	24.3	44.3	57.2	33.0	49.7
Remembering	33.5	49.8	45.9	31.9	23.6	11.6	10.2	13.5
Self-care	24.2	22.4	10.5	29.2	9.4	18.1	15.8	22.5
Communicating	35.3	34.7	20.1	22.3	7.8	4.6	5.8	4.7

7.2.3 Disability onset

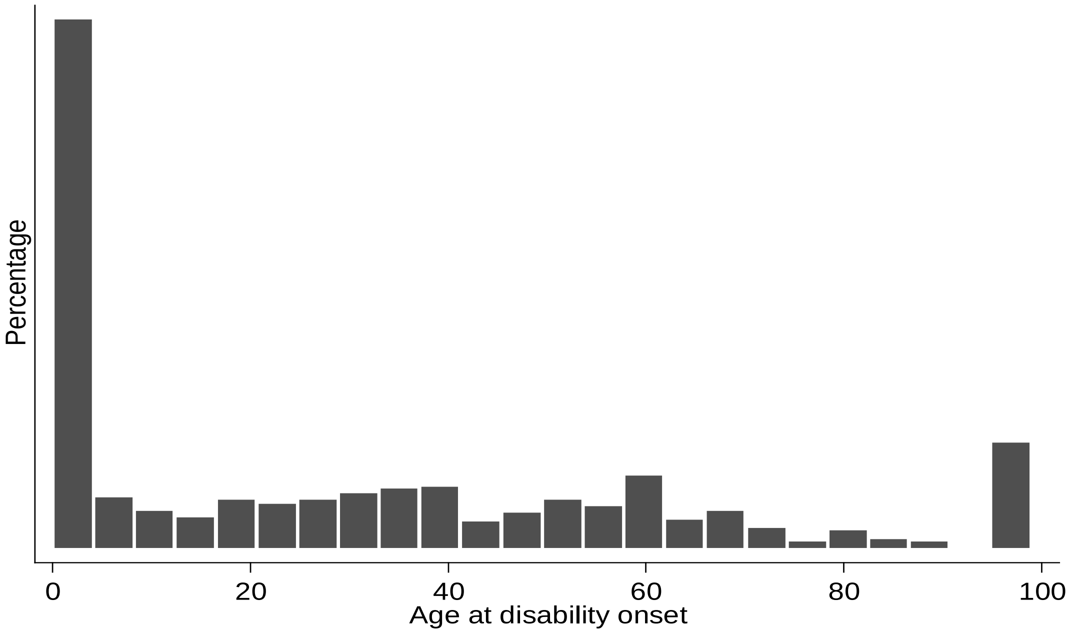
Personal opinion on the cause of their disability was also recorded. No attempt was made to acquire a medical verification of causes of disability. The different causes are listed in the table below. Disability because of disease or illness was reported as the highest cause followed by congenital disability. They represent 35.4% and 32.6% of the disability causes respectively. About 13% of them were disabled due to accident. Witchcraft and stress related causes explained slightly more than 3%.

Table 25: Causes of disability

Causes of disability	n	%
From birth/congenital	204	32.6
Accident	79	12.6
Fall	13	2.1
Burns	6	1.0
Disease/illness	221	35.4
Beaten by family	4	0.6
Violence outside home	7	1.1
War related	3	0.5
Animal related	1	0.2
Stress related	20	3.2
Witchcraft	23	3.7
Other reasons	14	2.2
Don't know/refused	23	3.7
Missing data	7	1.1
Total	625	100.00

They were also asked about when was the onset of the disability. The figure below illustrates the distribution of disability onset. The figure illustrates that the majority of disability onset in our data material took place very early in the life span. Other than congenital and old age, the majority of the disability onset occurred at 40 years old and below.

Figure 6: Age at disability onset



7.2.4 Discrimination: personal experience

An attempt was made to recode personal experience of being discriminated both in the family and society among disabled respondents who were 15 years old and above (540 persons). Three questions were asked to assess the experience of being discriminated and they could answer either *yes*, *no* or *don't know.* These questions are:

1. Experience of being beaten or scolded by family members or relatives
2. Experience of being beaten or scolded by others
3. Experience of being discriminated in any public services ie. hospital, clinic, police station, bank etc.

The results are presented in the table below. There was no gender difference with regards to personal experience of being discriminated. Experience of being discriminated was mostly related to discrimination executed by others (i.e. society).

Table 26: Distribution of personal experience of being discriminated, by gender

Context of discrimination	Female	Male	Total
	%	%	%
Family	16.7	16.1	16.4
Society	20.1	23.4	21.7
Public services	15.5	16.9	16.2

7.2.5 Welfare and Health Services: Needed, Aware of or Received

An attempt was made to record the need of people with disability of several welfare and health services and at the same time determine whether they are aware of the services. The table below lists the different welfare and health services and the proportion of people with disability who were in need of and aware of the services. The analyses included only people with disability who were either interviewed directly face-to-face or together with the proxy (361 individuals).

Table 27: Gap I: Proportion of people who needed but were not aware of services

Type of services	Needed	Aware of	Gap I[1]
	%	%	%
Medical rehabilitation	63.6	46.7	34.5
Assistive devices	58.1	49.4	25.4
Educational	40.6	34.2	28.1

Vocational	49.7	42.2	29.6
Counseling	63.9	49.4	29.1
Counseling for parent/family	61.4	47.8	28.5
Welfare	64.2	47.2	30.7
Health	81.7	73.6	11.6
Health information	66.9	58.6	17.4
Traditional/faith healer	54.4	49.4	18.9
Legal	40.6	30.6	32.2

[1] All disabled respondents who needed the service but were not aware of

The results show that there was a discrepancy between need of services and awareness of the services (Gap I). In all of the services, the expressed need was greater than the awareness of the services. The biggest gap between the need and awareness of services was found in medical rehabilitation, legal and welfare services with each represented over 30% gap. The least gap was shown by health services (11.6%).

Analyses of the discrepancy between disabled people who needed the different welfare and health services and the actual acquisition of the services revealed a wider gap between the two (Gap II). There were less than 20% of disabled respondents who actually received most of the services they needed except for health, health information, traditional/faith healer and counseling for family/parent. The pattern of the gap was almost similar for respondents who did not receive the services despite that they needed as well as were aware of the services (Gap III). This is presented in the table below.

Table 28: Gap II & III: Proportion of people who needed but did not receive the services

Type of services	Received %	Gap II[1] %	Gap III[2] %
Medical rehabilitation	13.6	82.5	78.0
Assistive devices	12.5	81.3	77.6
Educational	6.7	87.0	83.8
Vocational	6.7	89.4	85.7
Counseling	10.3	86.1	80.4
Counseling for parent/family	17.2	75.6	67.1
Welfare	5.0	93.1	90.6
Health	47.9	42.9	36.9
Health information	35.2	51.9	43.7
Traditional/faith healer	23.3	61.7	54.7
Legal	3.9	92.5	90.9

[1] All disabled respondents who needed the service but did not receive

[2] Disabled respondents who needed and were aware of the service but did not receive

7.2.6 Education

Analyses included only respondents aged 15 years old and above. There was a significant gender difference with regards to receiving a formal primary education with a higher percentage among females; 84.3% vs. 71.4%. Analysis of the difference in receiving a formal primary education between disabled and non-disabled respondents revealed that the proportion of non-disabled respondents who received the education was higher compared to disabled respondents. Among non-disabled, 86.1% (95% CI: 82.8 – 88.9) received formal primary education compared to 70.2% (95% CI: 66.0 – 74.0) among disabled persons.

The table below presents detailed analyses of receiving a formal primary education between females and males according to their disability status. The difference between proportion of females and males among disabled respondents was slightly higher compared to the non-disabled.

Table 29: Received a formal primary education, by gender and disability status

	Disabled %	Control %	Total %
Female	78.9	89.2	84.3
Male	62.3	82.0	71.4

Among disabled respondents who at least received formal primary education, the type of schools attended during different levels of education was also recorded. This is presented in the table below. At each level of education, the majority went to mainstream or regular school. About one-fifth attended pre-school while attendance in the secondary school was about one-forth. Among disabled respondents who were 18 years old and above, only 7% received tertiary education.

Table 30: Type of school attended among disabled respondents who attended at least a formal primary education

	Type of school attended	
	Mainstream/regular %	Special[2] %
Pre-school/early childhood	21.5	1.1
Primary school	96.3	2.6
Secondary school	23.0	1.6
Tertiary education[1]	7.1	1.3
Vocational training[1]	5.1	2.4

[1] Include only those aged 18 years old and above

[2] Include special school or special class in a regular school

Respondents with and without disability were asked if they studied as far as they had planned. This is presented in the table below. Even though the proportion was slightly higher among non-disabled respondents who studied as far as they had planned, this difference was not statistical significant. Almost 90% in both groups claimed that they did no study as far as they planned. However, the reason for not studying as far as planned was not sought. Nevertheless, this could explain the decline in attendance of the different level of education.

Table 31: Study as far as planned among disabled and control respondents

Studied as far as planned	Disabled	Control	Total
	%	%	%
Yes	4.6	5.2	4.9
No	89.2	89.0	89.1
Still studying	6.2	5.8	6.0
Base = 100%	433	363	796

7.2.7 Employment

Respondents with and without disability aged 15 years and above were asked if they were currently working. Currently working includes casual laborers, part-time work and those who were self-employed. There were 12.1% of the respondents who were currently working. It is important to note that this rate should not be used as a national employment rate but a comparison between disabled and non-disabled respondents.

The results from the table below show that the proportion of respondents with disability who were currently working were threefold less than the proportion of non-disabled respondents, 6.0% (95% CI: 4.1 – 8.6) and 18.5% (95% CI: 15.1 – 22.5) respectively.

Table 32: Current employment status, by disability status

Currently working	Disabled %	Control %	Total %
Yes	6.0	18.5	12.1
No, but have been employed previously	32.6	27.7	30.2
No, never been employed	59.8	49.9	55.0
Homemaker	1.7	3.8	2.8
Base = 100%	**479**	**510**	**989**

Detailed analyses according to gender revealed that among disabled respondents, 4.6% females and 7.8% males were currently working. On the contrary, 17.1% females and 21.2% males of the non-disabled respondents were currently working.

Among those who were not working but have been employed previously, 32.6% of the non-disabled respondents stopped working because they had been retrenched while 16% of the disabled respondent stopped working because of the same reason. The low percentage could be explained by the low employment rate among the disabled people. On the other hand, 51% of the disabled respondents stopped working due to illness or disability. Interestingly to note that one-fourth of the non-disabled respondents reported that they stopped working because of similar reason.

7.2.8 Accessibility

Disabled respondents were asked if their home has different rooms or facilities such as kitchen, bedroom, living room, dining room and toilet. They were also asked if these rooms were accessible to them and that they can get there easily and use the facility most of the time. Availability of these rooms or facilities and their accessibility are listed in the table below. Generally, it can be claimed from the data presented that the majority of those who owned these facilities or rooms in their home could access them as well. Regarding ownership, less than half of the disabled respondents had a living room in their home (36.5%), while half of the respondents (50.6%) had a dining room in their home. Almost one-third of the disabled respondents claimed that they did not have their own toilet at home.

Table 33: Accessibility at home and ownership

Room/facility	Accessible %	Total[1] n	Have none %
Kitchen	93.7	573	8.2
Bedroom	94.7	602	3.5
Living room	87.7	228	63.5
Dining room	90.2	315	49.4
Toilet	88.2	407	34.8

[1] Total respondents who owned the room/facility in their home

The table below presents the distribution of accessibility of different places or facilities among disabled persons who had used them or where these places or facility were available in their area. Among all the places and facilities, banks and hotels were the least accessible. More than half of the respondents who had been to these places reported that these places were not accessible, 53.6% and 55.1% respectively. About 41% claimed that the hospitals were not accessible, while 33.3% stated that the primary health care clinics were not accessible.

Table 34: Accessibility from home

Place/facility	Accessible %	Total[1] *n*	Not Applicable[2] %
▪ Workplace	87.5	48	92.3
▪ School	87.9	107	82.8
▪ Shops	67.2	515	17.3
▪ Place of worship	75.1	542	13.0
▪ Recreational facilities	57.0	249	60.0
▪ Sports facilities	70.2	372	40.3
▪ Police station	54.9	479	23.1
▪ Magistrates office/ traditional courts	55.2	413	33.7
▪ Post office	52.2	364	41.6
▪ Bank	46.4	319	48.7
▪ Hospital	58.7	513	17.7
▪ Primary health care clinic	66.7	570	8.5
▪ Public transportation	68.8	568	8.7
▪ Hotels	44.9	178	71.4

[1] Total respondents who used the places or facilities

[2] Percentage that did not use or the places or facilities were not available

7.2.9 Assistive devices

Disabled respondents were asked if they used assistive devices – 86 persons (13.9%) responded 'yes'. There were no difference between males and females who were using assistive devices. 13.7% of disabled male respondents and 13.5% of disabled female respondents were using assistive devices. Every individual that used assistive devices were also asked the type of device(s) he or she was using. All devices were recorded if the respondent was using multiple devices. This is presented in the table below. The devices were categorized into:

i. Information – eg. Eye glasses, hearing aids, magnifying glass, telescopic lenses, enlarge print, Braille
ii. Communication – eg. Sign language interpreter, fax, portable writer, computer
iii. Personal mobility – eg. Wheelchairs, crutches, walking sticks, white cane, guide, standing frame
iv. Household items – eg. Flashing light on doorbell, amplified telephone, vibrating alarm clock
v. Personal care & protection – eg. Special fasteners, bath & shower seats, toilet seat raiser, commode chairs, safety rails, eating aids
vi. For handling products & goods – eg. Gripping tongs, aids for opening containers, tools for gardening
vii. Computer assistive technology – eg. Keyboard for the blind

Table 35: Proportion of disabled respondents, by type of device(s) in use

	Type of device	% of persons using the device
i.	Information	22.5
ii.	Communication	1.5
iii.	Personal mobility	81.9
iv.	Household items	4.4
v.	Personal care & protection	4.4
vi.	For handling products & goods	2.9
vii.	Computer assistive technology	1.5

The majority of disabled persons who used assistive device(s) were using personal mobility device (81.9%). Detailed analyses of people who answered *a lot of difficulty* and *unable to perform*, to the question on mobility and vision disability core domain, showed that 84.4% were using assistive device(s) related to personal mobility. However, among all disabled persons using any type of assistive devices, 40% reported that the device was not in a good working condition.

They were also asked if they were give any information or help/training on how to use the device they were using. Out of 81 disabled persons who answered, 30% claimed that they got complete information while 16.1% got only some information. Nevertheless, almost half of them reported that they didn't get information or help/training on the device they were using (46.9%).

Level of satisfaction with the device(s) in meeting their needs was also measured, ranged from *not satisfied* to *very satisfied*. This is presented in the table below. More than half of them (57.9%) were either not satisfied or less satisfied with the device(s) they were using.

Table 36: Level of satisfaction with assistive device

Level of satisfaction	Female %	Male %	Total %
Not satisfied	30.3	42.1	35.5
Less satisfied	21.2	26.3	22.4
Satisfied	39.4	15.8	29.0
Very satisfied	9.1	13.2	11.8
Don't know	0	2.6	1.3
Base = 100%	33	38	76

Table 35 further demonstrates the differences between males and females in that males tend to be less satisfied with their assistive device than their females counterparts.

7.2.10 Assistance in daily life activity

The results presented under this topic are obviously dependent on numerous factors; among them the sex and age of the disabled persons and the severity of their disability. The analyses are based on the proportion of the sample that did not classify the activity as *not applicable*; the basis, or denominator, for the calculations is the number of persons with disability who answered either *yes*, *no,* or *sometimes* on the different types of assistance they needed in daily life activity. The results are presented in the table below.

Table 37: Assistance needed in daily life activities

Activity	Yes %	Sometime %	No %
Dressing	23.6	22.5	53.8
Toileting	19.6	10.0	70.4
Bathing	24.9	18.5	56.6
Eating/feeding	10.8	7.1	82.1
Cooking	51.1	21.4	27.5
Shopping	48.3	28.8	22.9
Moving around	43.5	28.0	28.5
Finances	51.9	24.3	23.8
Transport	46.9	22.1	31.0
Studying	36.1	18.4	45.5
Emotional support	57.7	22.7	19.7

The range of percentages of assistance needed for the different daily life activities lies between 10.8% - 57.7% for *yes* and 7.1% to 28.8% for *sometimes*. The majority of the disabled persons claimed that they needed emotional support (57.7%). Detailed analyses revealed that emotional support were equally needed in the different age groups.

Gender difference was only found in cooking with more males needed help to cook compared to females. This might have cultural explanation in the male dominated societies where one may expect women to do the cooking.

7.2.11 Involvement in family, social life and social activities

Involvement in family life activities was also analyzed and results are presented in the tables below. While the majority of the questions involved activities that were not regular in the aspect of family life, it is worth noting that about 30% of disabled respondents answered that they were not included with the family to events such as family gatherings or social events. The proportion was more than four times higher than the proportion among non-respondents. In addition, about 25% claimed that the family did not involve them in conversation compared to only 7.1% among non-disabled respondents. This is presented in Table 38.

In general, comparison of involvement in family life between disabled and control respondents show that involvement of the disabled respondents in all four family life activities was considerably less compared to the non-disabled respondents. However, taking into account of these differences, it should be noted that the majority of the respondents felt that they were involved and part of the family.

Among respondents aged 15 years old and above, questions on involvement in making decision in the family and participation in local community meetings were also asked. The difference between disabled and non-disabled respondents on the two involvement measures is presented in Table 39. About one-fourth of the respondents with disability claimed that they were not involved in family decision making and about half did not participated in local community meeting. Among the non-disabled respondents, involvement rate in the family and social life was more than 80%; family life (87.3%) and social life (83.1%).

Table 38: Involvement in family life, by disability status

Measure of involvement	Disabled				Control			
	Yes %	No %	Sometimes %	Total n	Yes %	No %	Sometimes %	Total n
▪ Go with the family to events such as family gatherings, social event etc.	50.2	30.1	19.7	588	83.0	7.2	9.8	556
▪ Feel involved and part of the household or family	85.5	9.2	5.3	582	96.5	1.9	1.6	565
▪ Family involves you in conversations	59.5	25.5	15.0	573	84.6	7.1	8.3	540
▪ Take part in your own traditional practices	27.7	65.6	6.7	566	48.4	50.1	1.5	553

Table 39: Involvement in family and social life among those aged 15 years old and above, by disability status

Measure of involvement	Disabled				Control			
	Yes	No	Sometimes	Total	Yes	No	Sometimes	Total
	%	%	%	n	%	%	%	n
▪ Consulted about making household decisions?	57.9	24.9	17.2	501	87.3	6.4	6.4	491
▪ Participate in local community meeting	34.8	50.2	15.0	513	83.1	8.7	8.2	495
▪ Make important decision about your own life	58.0	13.9	24.6	539	86.2	0.9	12.7	503

A significant difference was also shown when asked if they make important decisions about their own life. Only 58% of respondents with disability answered *yes* to the question compared to 86.2% among respondents without disability. It is worth to note that 13.9% of disabled respondents stated that they *never* made important decisions about their own life compared to only 0.9% among non-disabled respondents.

Relationship with and knowledge about the disability movement was used as an indicator for involvement in society, and is presented in Table 40. Less that 10% reported to be a member of a disability organization (DPO, disabled peoples' organization), while only 12% said that they were aware of such organizations. Among those who were aware, slightly more than half were member of a DPO.

Table 40: Involvement in society, 15 years old and above

Measure of involvement	Yes %	No %
▪ Aware of any DPO	12.3	87.7
▪ Member of a DPO	8.2	91.8
▪ Aware of and member of a DPO	53.3	46.7

Persons with and without disability aged 21 years old and above were asked if they voted in the 2007 election. Among disabled persons, less than half of them (49.1%) voted while among non-disabled, 82.6% reported that they voted during the last election. Of those disabled persons who did not vote, 44.8% claimed that disability was the reason that they did not vote.

7.2.12 General health

Assessment of general well-being was done using a standardized General Health Questionnaire 12-item (GHQ-12) (Goldberg & Williams, 1988). In addition, a general question of personal assessment on mental health status at present was also used. A standard Likert scoring procedure was implemented in GHQ-12, with scores for each question ranging from 0 to 3. Higher score represents higher psychological distress. All respondents aged 15 years old and above were asked these questions. The results are presented in the Table 41.

Table 41: GHQ-12 score, by disability status

	Disabled		Control	
	Mean	95% CI	Mean	95% CI
Female	14.1	13.2 – 15.1	9.2	8.5 – 9.9
Male	12.7	11.7 – 13.8	7.7	7.1 – 8.3
Total	13.4	12.8 – 14.1	8.6	8.1 – 9.0

Overall, disabled respondents scored higher in the GHQ-12 assessment compared to non-disabled respondents; 13.4 and 8.6 respectively. This illustrated that respondents with disability had lower general well-being status compared to respondents without disability. Significant difference was also found in gender where females reported to have lower general well-being compared to males.

The respondents were also asked to rate their *overall mental health status at the present time*. The results are presented in Table 42. The proportion of disabled respondents who answered that their overall mental health status was *poor* or *not very* good was almost five times higher than the proportion of non-disabled respondents. Only 5.7% of disabled respondents stated that their current mental health was *very good* compared to 16.2% among non-disabled respondents.

Table 42: Overall mental health at present, by disability status

	Disabled		Control	
	%	(95% CI)	%	(95% CI)
Poor	11.1	8.8 – 14.0	2.2	1.3 – 3.5
Not very good	34.4	30.6 – 38.5	7.4	5.4 – 10.1
Good	48.6	44.5 – 52.9	74.2	70.3 – 77.8
Very good	5.7	4.0 – 8.0	16.2	13.3 – 19.6

7.3 Towards a revised understanding of disability

By altering society's notion of disability – from the concept of physical impairment to one based on activities and participation – it is hoped to shift also the focus of demands set by society while at the same time empowering people with disabilities. Research on living conditions among people with disabilities must ultimately be directed towards the integration, participation and enfranchisement of people with disabilities into society.

Social movements associated with changes in paradigms can influence research, and vice versa, as is evident in the table below whereby the increased emphasis on the role of the environment (both physical and social) has affects on the subject matter under study – in this case persons with disability.

- Among those aged 15 years and above, receiving formal primary education among non-disabled was 23% higher than the disabled.
- Disabled respondents who were currently working were threefold less than the proportion of non-disabled respondents.
- Generally, the majority of disabled respondents who owned different facilities or rooms in their home could access them as well.
- About 41% of disabled respondents claimed that the hospitals were not accessible, while 33.3% reported accessibility problem in the primary health care clinics.

Table 43: Contrasting disability paradigms for research

Characteristic	*Old paradigm*	*New paradigm*
Definition of disability	An individual is limited by his or her impairment.	An individual with an impairment requires an accommodation to perform functions required to carry out life activities
Strategy to address disability	Fix the individual, correct the deficit	Remove the barriers, create access through accommodation and universal design, promote wellness and health
Method to address disability	Provision of medical, psychological, or vocational rehabilitation services	Provision of supporters (e.g. assistive technology, personal assistance services, job coach)
Source of intervention	Professionals, clinicians, and other rehabilitation service providers	Peers, mainstream service providers, consumer information services
Entitlements	Eligibility for benefits based on severity of impairment	Eligibility of accommodation seen as a civil right
Role of people with disabilities	Object of intervention, patient, beneficiary, research subject	Consumer or customer, empowered peer, research participant, decision maker
Domain of disability	A medical "problem" involving accessibility, accommodations and equity	A socio-environmental issue

Source: Brown 2001 : derived from DeJong and O'Day (1999)

Several of these paradigm 'shifts' have been realized through the research we have conducted in Lesotho. Most notably perhaps the definition of disability used in the survey and the role of people with disabilities in the research process, where significant number of the supervisors and enumerators employed were people with disabilities.

International standards are important for setting guidelines and establishing routines as much as for quantifying differences among nations, cultures and societies. But, at the same time, it is important not to become too restricted by these same international standards. A certain degree of flexibility must be allowed to be incorporated into these constructs. We are ultimately left with the following challenge: to acknowledge and integrate cultural anomalies and differences when making and interpreting international comparisons.

From the data analysis perspective, the research challenge, we believe, lies in a shift in the dependent variable from a dichotomous outcome measure (disabled, not disabled) to a continuous measure of activity limitation/participation restriction – mirroring the range of disability we see in society. Figure 6 and 7 below present such a scenario presenting a comparison of activity limitation and participation restriction among disabled respondents and respondents WITHOUT disability.

These figures clearly indicate that there is an overlap; that is, even people without disabilities live with certain limitations in their daily life activities and restrictions in their ability to participate in all levels of social interaction and some people with disabilities are able to function in society with little or no problem. Also the range of scores on both activity limitations and participation restrictions reflects the diversity of disability in society – and clearly indicates that being disabled is not a singular, two-dimensional phenomenon but rather a complex process that deserves to be understood as part of the human condition and not as something that represents a deviation from the norm.

Finally, these measures of activity limitations and participation restrictions must be interpreted as relevant to the environment, society and culture from which they are derived. This will require an expanded view of disability data and effect substantially greater measurement challenges. We have in this research attempted to meet these challenges through the development of a matrix, based on the concepts inherent in the ICF and have thus taken a step in the direction of a new paradigm, defining a new concept. Disability research can no longer afford to be restricted to counting impairments, handicaps or even people with disabilities – but using a better definition to identify a population based on activity limitations and participation restrictions and ensure that they are enfranchised.

Figure 7: Distribution of Activity Limitation score, by disability status

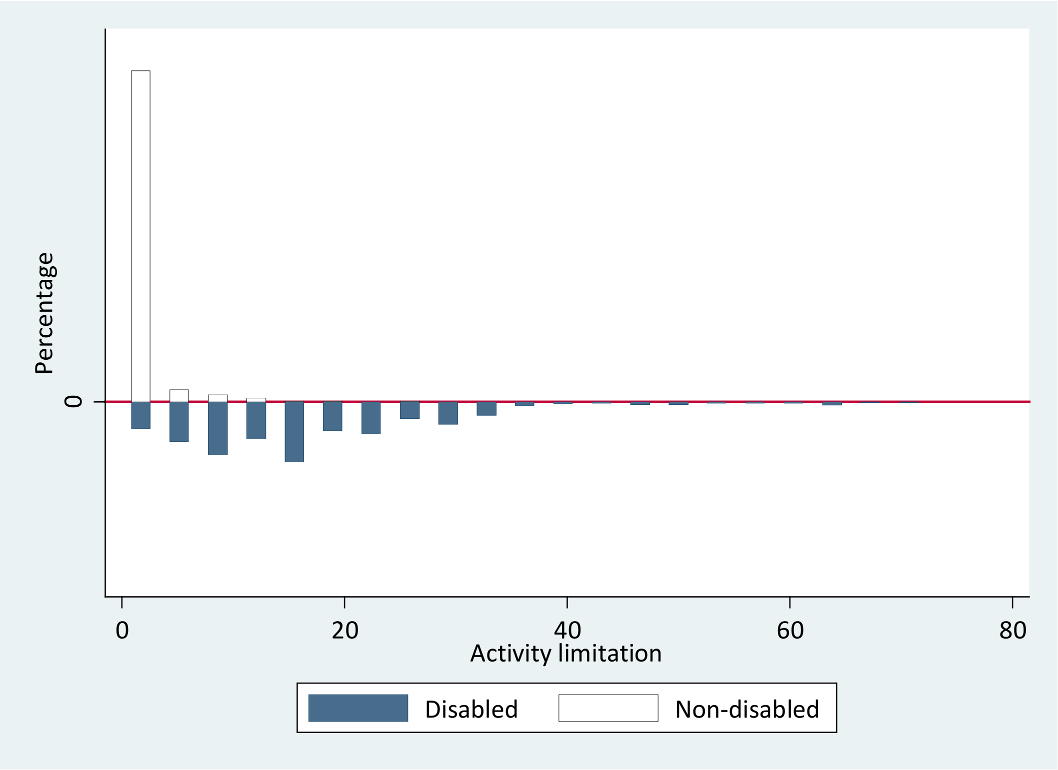
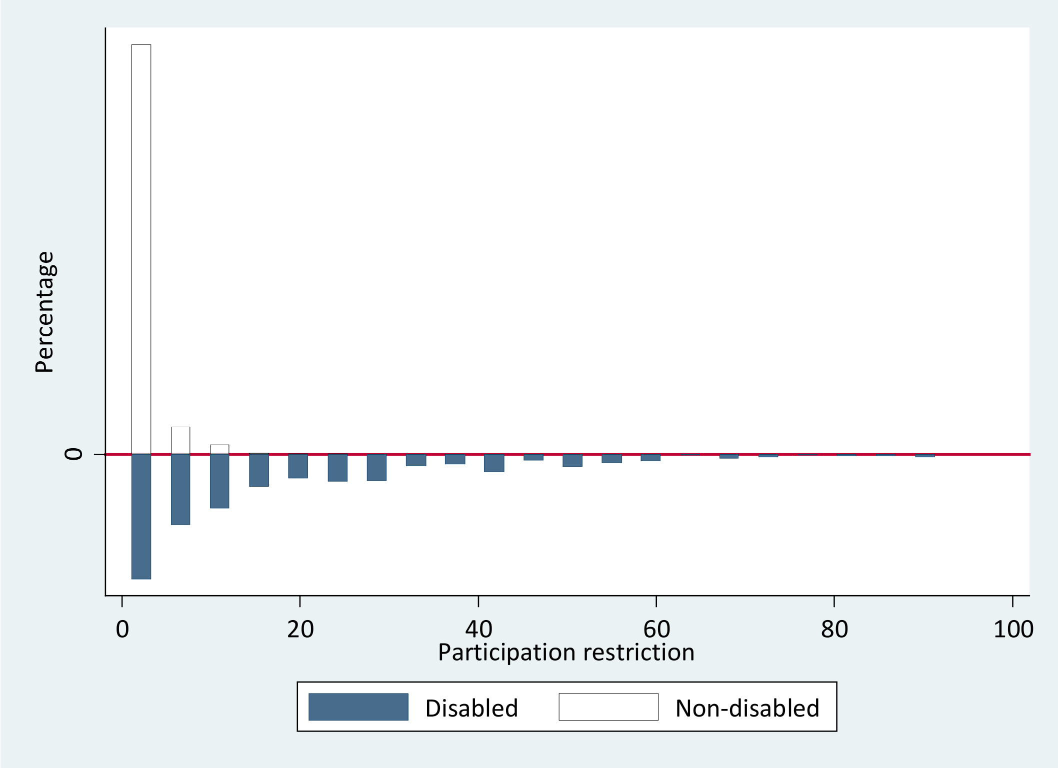


Figure 8: Distribution of Participation Restriction score, by disability status



- One third of disabled respondents had either mobility or sensory disability.
- Disability related to mobility was prominent among disabled respondents aged 51 – 60 years old.
- Congenital, illness and accident were the main causes of disability.
- More than one sixth had experience of being discriminated in public services.

8 Discussion

Arne H. Eide

A nationwide representative study on living conditions among people with activity limitations has been carried out in Lesotho in 2009 – 2010. This report provides some of the key results from the study. Partners LNFOD and SINTEF Technology & Society, with good support from Lesotho Bureau of Statistics and representatives from other institutions in Lesotho, have together established the first generation of data about individuals with disabilities in the country. With this, they have established an important basis for promoting the rights of disabled people and better living conditions for people with disabilities in Lesotho. The study offers an opportunity for both monitoring the situation over time and assessing the impact of policies through later studies. Furthermore, a unique database has been created allowing for the comparison of living conditions between people with and without disabilities and between households with and without disabled family members. The study also adds to a growing body of information on living conditions among people with disabilities currently being collected in the southern African region. In the future, with data from Namibia (2003), Zimbabwe (2003), Malawi (2004), Zambia, Mozambique (2008) and possibly other SADCC member countries there will be possibilities not only for making national or regional comparisons but to share experiences and build capacity in the region to improve living conditions in general and specifically among people with disabilities.

A particular feature of the series of studies of living conditions in southern Africa is the inclusion of a control sample of households and individuals without disabilities. In the current study, this aspect has been taken further and now comprises larger sections of the study. In addition to unique data on the situation for individuals with disabilities, the study thus also provides a unique set of data on living conditions that may be useful for monitoring the general standard of living in the country. The study in Lesotho is based on the same core design as in the previous countries. There are however some new questions and topics included such as dietary diversity and psychological health. In addition, the survey on individual level included both individuals with and without disability for comparison.

A particular feature of this and the preceding studies is the broad inclusion of individuals with disabilities in all stages of the research process, and the position of disabled peoples' organizations (DPOs) in initiating and controlling the research and it's application. Our experience from other countries implies that this will yield a stronger, more experienced organization with increased standing in the respective countries. We also argue that involving individuals with disabilities as interviewers has reduced the threshold for individuals with disabilities and their families to come out with information sought in this study – and this has shown that individuals with disabilities are contributing members of society when given a chance to be so.

Socio-demographic differences between the two types of households (those with and without disabled family members) are similar in Lesotho as compared to the five studies that have so far been completed (Namibia, Zimbabwe, Malawi, Zambia and Mozambique). Households with disabled members are larger and mean age of family members is higher. Dependency ratio, a measure of the portion of a population which is composed of dependents individual compared to independent individuals (aged 15-64), was also shown to be higher among households with disabled members, reflecting more members at dependent age groups. The pattern seems to exist across the region. As there are few, if any, services to support families and individuals with disabilities living at home; practical, economic and other problems will have to be solved within the household itself. The studies of disability and poverty by Ingstad & Grut in Kenya provides some in-depth information about such coping mechanisms at the household level.

It is a main finding that households with disabled members and individuals with disabilities score lower on a number of indicators of level of living conditions as compared to households without disabled members or non-disabled individuals. Largely, the observed differences in levels of living conditions in the data material from Lesotho substantiate the pattern that was first observed in the Namibian, Zimbabwean, Malawian, Zambian and Mozambiquean studies. This study extends this comparison also to include dietary diversity and again demonstrates the difference in living conditions between the two types of households.

The results concerning school attendance and literacy also confirms previous studies and reveal as expected lower school attendance and literacy rates among disabled. One surprising result from Lesotho was however that females tend to have higher attendance and literacy rates than men, for both disabled and non-disabled. With regards to employment however, the expected gender difference appeared as in previous studies.

The disability component of the survey revealed a relatively even distribution of people with disabilities across age categories. This is very similar to the pattern in neighbouring countries, but deviates from the situation in more developed countries where age is closely and positively associated with disability. This could be due entirely to the particular age profile in the region, Lesotho included, with large proportion of the population being 20 years or less. Bearing in mind however that onset of disability for many of those surveyed is early in life, and that the causes of disability to a large extent are congenital or illness related, the results presented here demonstrates a different “causal profile” than in high-income countries. This should have bearings also on service development, rehabilitation, as well as preventive measures. One indication of problems related to the health services and how disability is handled may be the very high incidence of stillbirths among disabled females.

Previous experience has shown that using the disability screening procedure proposed by the Washington Group on Disability Statistics, will yield higher prevalence rates as compared to other less sensitive and impairment based questions. The results presented here confirm this, but also contribute to demonstrate that any prevalence reflects a given cut-off point and that different cut-of points serve different purposes. It is also interesting that a general disability question which uses the term “disability” produces a higher prevalence rate than might have been expected if we look at previous work on this in low-income countries. This may indicate one of two; either the prevalence of severe disability is higher in Lesotho as compared with other countries in the region, or the recruitment and training in this study has given a better basis for interviewing and thus identification of disabled in the households.

The results concerning discrimination imply that among individuals with disabilities, one in six have experienced discrimination and/or beating/scolding by family members or by employees at public services. When referring to “others”, the figure further increased to one in five. In itself, this is clearly problematic and an indication of negative attitudes and active discrimination and even abuse of individuals with disabilities in Lesotho. While the problems related to family and “other” in no way should be played down, we argue that the most surprising here is related to public services, as we may anticipate that the negative behaviour largely takes place publicly and thus also represent humiliation and transfer of negative attitudes. One may of course also put weight on the fact that 8 out of 10 do not report any experience in this direction, but we argue that the minority here is substantial and that this issue needs to be illuminated further. The results indicating that individuals with disabilities also face problems with being slighted at home further adds to this issue. Related to this is the weak penetration of the disability movement into the population of disabled.

Large gaps were observed in the provision of several types of services needed by individuals with disabilities. The largest gaps were found with regards to welfare services and legal assistance, but very high gaps were also identified for vocational training, educational services, counselling, medical rehabilitation, assistive devices, and counselling for parent/family. Such figures point directly to important challenges for service providers to improve services and accessibility, and not in the least to policy makers to review priorities in the area of service provision. Health services, health information and traditional healer on the other hand, are apparently available to larger groups of those with disabilities, although the identified gaps in Lesotho are for some of these services substantially higher as compared to other countries in the region.

When looking at assistance needed in daily life, it was found that need for emotional support surpassed all other types of support when asking for what type of assistance that was needed in daily life. Results further indicate that overall, self-reported mental health is clearly lower among individuals with disabilities as compared to those without. This is important to bear in mind when developing services for people with disabilities, as emotional needs will more readily be neglected when the focus of service delivery is generally in terms of practical help and economic and material needs. Developing mental health support programs at the local community level, for instance integrated in community based rehabilitation or similar service structures, is very relevant in this regard.

Accessibility at home appeared to be a relatively small problem. Outside of the house, accessibility however appears to be a much large problem for individuals with disability. Many public services and other services appear to be inaccessible for a large number of individuals.

A relatively small proportion of individuals with disabilities report that they have an assistive device. The distribution of assistive devices primarily reflects and confirms that this service has a “mobility” bias. Wheelchairs, crutches, walking sticks, etc, comprise the bulk of assistive devices used by the disabled population in Lesotho as in neighbouring countries. The results indicate clearly that there are problems with the quality of the devices as more than half were not satisfied with them.

9 Conclusions

Arne H. Eide

This study in Lesotho is the sixth in a series of studies that aim at mapping the situation for disabled people in the southern Africa region. It has produced unique data on living conditions among people with disabilities and a control sample of people without disabilities. Virtually no other information of this kind has been produced in, or for, Lesotho. This survey thus represents a first possibility to study different aspects of the lives of people with disabilities in the country. It also provides a basis for monitoring the situation in the future, and it links up to other studies that together is about to establish a Regional database.

The main finding is that there are systematic differences between those with and without disabilities in Lesotho, as it is in neighboring countries. Differences are also found between men and women, highlighting the multidimensionality of the resource distribution also in low-income countries. While this is in line with the previous studies, this survey showed that women seem to have better access to education than men. While a survey format does not explain this, the results invites further exploration of this interesting phenomenon.

It is hoped that this study and other similar studies can contribute to highlight systematic discrimination, inform the public, authorities and the disabled themselves about the situation, and thus create a consciousness and level of awareness that is necessary for action. A clear challenge will be to advocate and instigate for improvements in the living conditions of people with disabilities in the current context of a low-income country in Southern Africa.

It is recommended that the results from this study be considered, together with other relevant sources, as a basis for defining the situation for people with disabilities in Lesotho and agreeing upon a path for the future. Setting priorities, developing policy as well as specific measures will be necessary in order to achieve tangible improvements. A database on living conditions such as the one presented here is, in this regard, a potentially important tool for organizations of people with disabilities and relevant authorities. A first important step could be a dialogue between the Government of Lesotho including relevant ministries, LNFOD and other DPOs, as well as researchers and other resource persons, in order to agree on priorities and measures to improve the situation for individuals with disabilities in Lesotho.

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APPENDICES

10.1.1.1.1.1 ACITVITY LIMITATION

1. How difficult it is for you to perform this activity WITHOUT any kind of assistance at all?

[Without the use of any assistive devices – either technical or personal]

Read out the options

ACTIVITY LIMITATION ITEMS*	SCORE
a. watching/looking/seeing	
b. listening/hearing	
a. learning to read/write/count/calculate	
b. acquiring skills (manipulating tools, painting, carving etc.)	
c. thinking/concentrating	
d. reading/writing/counting/calculating	
e. solving problems	
f. understanding others (spoken, written or sign language)	
g. producing messages (spoken, written or sign language)	
h. communicating directly with others	
i. staying in one body position	
j. changing a body position (sitting/standing/bending/lying)	
k. transferring oneself (moving from one surface to another)	
l. lifting/carrying/moving/handling objects	
m. fine hand use (picking up/grasping/manipulating/releasing)	
n. hand & arm use (pulling/pushing/reaching/throwing/catching)	
o. walking	
p. moving around (crawling/climbing/running/jumping)	

Options: No difficulty, mild difficulty, moderate difficulty, severe difficulty, unable to carry out the activity or not applicable (NA). Score ranges from 0 – 4 and 9 for NA.

10.1.1.1.1.2 PARTICIPATION RESTRICTION

2. Do you have any difficulty performing this activity in your current environment?
[Current environment where you live, work and play etc for the majority of your time, and with the use of any assistive devices, either technical or personal]

PARTICIPATION RESTRICTION ITEMS*	SCORE
a. washing oneself	
b. care of body parts, teeth, nails and hair	
c. toileting	
d. dressing and undressing	
e. eating and drinking	
f. shopping (getting goods and services)	
g. preparing meals (cooking)	
h. doing housework (washing/cleaning)	
i. taking care of personal objects (mending/repairing)	
j. taking care of others	
k. making friends and maintaining friendships	
l. interacting with persons in authority (officials, village chiefs)	
m. interacting with strangers	
n. creating and maintaining family relationships	
o. making and maintaining intimate relationships	
p. going to school and studying (education)	
q. getting and keeping a job (work & employment)	
r. handling income and payments (economic life)	
s. clubs/organisations (community life)	
t. recreation/leisure (sports/play/crafts/hobbies/arts/culture)	
w. religious/spiritual activities	
x. political life and citizenship	

Option: No problem, mild problem, moderate problem, severe problem, complete problem (unable to perform) or not applicable (NA). Score ranges from 0 – 4 and 9 for NA.

10.1.1.1.1.3 Data Collection Team

Team	District	Supervisor	Names	DPO
1	Botha Bothe	‘Malako Nthulanyane	1. Mokheseng Ncheke	LNAPD
			2. Mots’oari Makhetha	LSMHP (volunteer)
			3. Senate Seutloali	
2	Leribe	Ntahli Tau (LSHMP)	1. ‘Matiisetso Monare	
			2. Kekeletso Maphathe	
			3. Mohau Masoabi	LSMHP (volunteer)
3	Berea Rural	Bokang Mokhothu	1. ‘Mamabina Mahlelebe	LNLVIP
			2. Nkoti Phello	LNAPD
			3. Lehlohonolo Mokhele	
4	Maseru Urban and Berea Urban	Malefetsane Nthoele	1. Pinki Khutlang	LNLVIP
			2. Aaron Moeti	LNLVIP (guide)
			3. Sr Angelina Rameno	LNLVIP
			4. Setsoto Molefi	LNLVIP (guide)
			5. Hlalefang Konka	LSHMP
5	Maseru Rural	Phoofolo Phoofolo	1. Moseli Moseli	NADL
			2. Mojabeng Moahloli	NADL
			3. Mary Mojaje	NADL
6	Mafeteng	Nkalimeng Makhube	1. John Mohale	LNAPD
			2. Bongiwe Buzi	NADL
			3. Mamello Lesoetsa	NADL
			4. Lipolelo Makhele	LNAPD
Team	**District**	Supervisor	**Names**	**DPO**

7	Mohale's Hoek	Thabelo Mahloane	1. Liteboho Challa	LSMHP (volunteer)
			2. Liakae Mafatle	
			3. 'Mapulane Makatisi	LSMHP (volunteer)
8	Quthing	Tholoana Sekotlo	1. 'Mateboho Jobo	NADL
			2. Tankiso Sekhankhe	NADL
			3. Renang Letsau	
9	Qacha's Nek	'Mafumane Makhele (LSMHP)	1. 'Malibiti Sehlahla	
			2. Tumisa Nkuatsana	
			3. George Mphunyetsane	
10	Thaba Tseka	Motsamai Talla	1. Thapelo Setenane	LSMHP, parent of a child with mental disability)
			2. Relebohile Marole	
			3. Lineo Moreki	
11	Mokhotlong	Phuthehang Mohai	1. Litaolana Mosuoe	LNAPD
			2. Angelina Mafika	
			3. 'Malefu Toeba	

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