

Nutrition Profile

District Matiari

Geography¹

Tehsils/ Talukas: 3
Union Councils: 19

Demography¹

Population 1998: 529,925
Population 2016(est): 795,147
Average Household Size: 5.7
Population Growth Rate: 2.28%

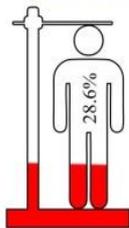
Urban/ Rural Population¹



85 out of 100 persons settled in villages.

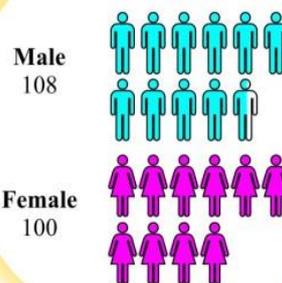


Stunting Prevalence²



28.6% population lied under severe stunting prevalence.

Sex Ratio¹



Male
108

Female
100

Poverty Rate³

62.1%



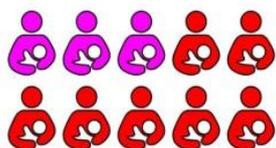
Wasting Prevalence²



2.6% population lied under severe wasting prevalence.

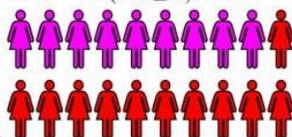
Breast Feeding²

3 out of 10 children are exclusively breastfed.



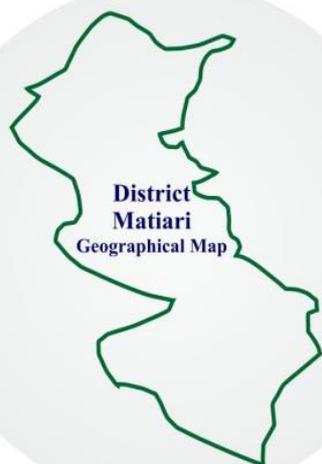
MDD-W⁴

Only 9 out of 20 women of reproductive age take adequate amount of diversified food groups. (FG ≥ 5)



WASH²

99.1% population uses improved sources of drinking water.



District Matiari Geographical Map

References

1. Pakistan Emergency Situation Analysis (PESA) 2014.
2. Sindh Multiple Indicator Cluster Survey (MICS) 2014.
3. Multidimensional Poverty in Pakistan.
4. Programme for Improved Nutrition in Sindh (PINS) Survey.

1. Matiari District

Matiari district was created in May 2005 (having previously been a taluka of Hyderabad district), comprises three talukas (Matiari, Hala and Saeedabad) and has a total geographical area of 1,458 square kilometres¹. It shares its border with the Districts of Shaheed Benazirabad, Sanghar, Tando Allahyar, Hyderabad and Jamshoro. The geographical position of the district is depicted below in Figure 1:

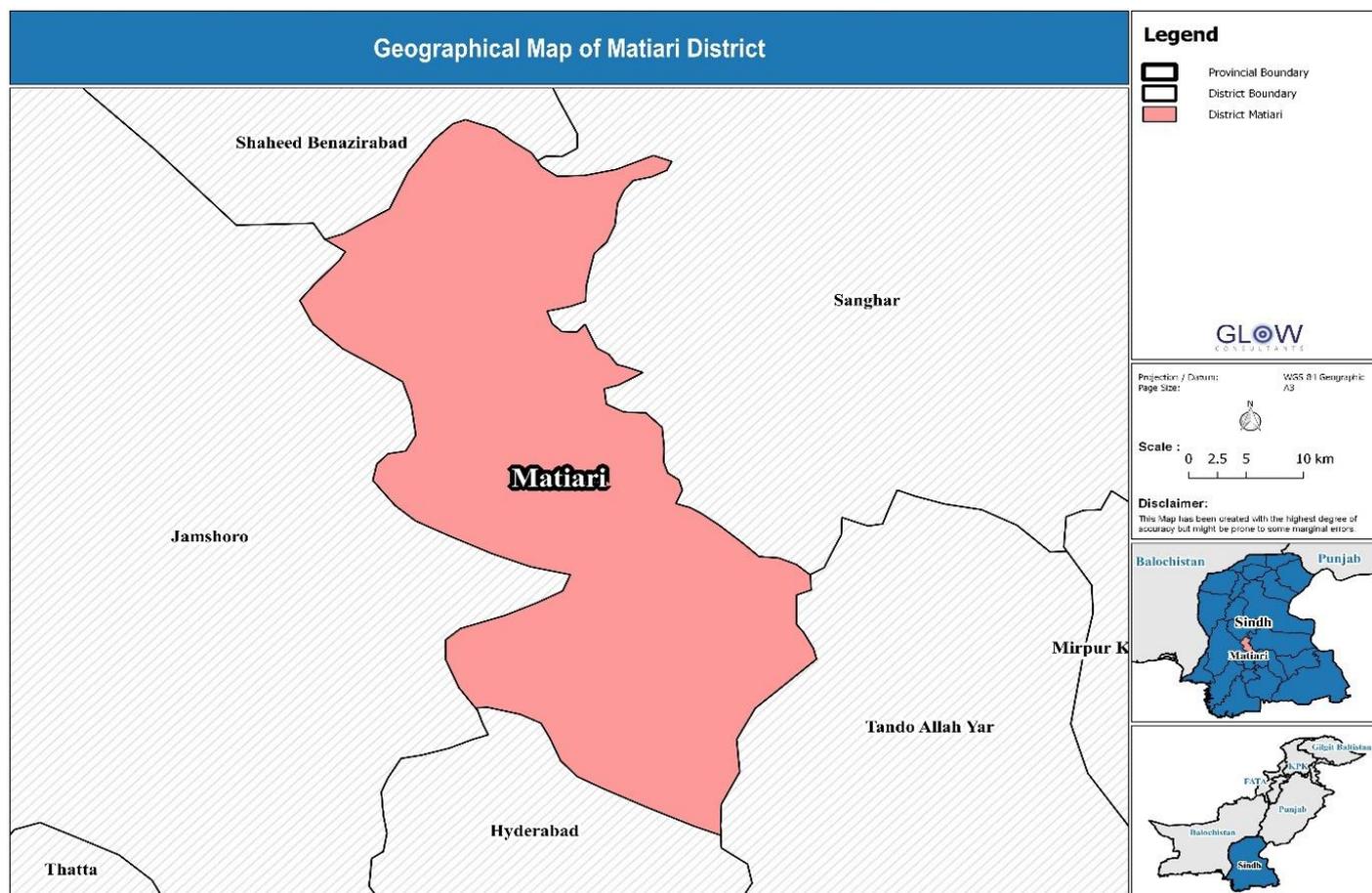


Figure 1: Geographical Map of Matiari District

2. Overall Development Situation in Matiari District

According to the Human Development Index (HDI) of 2013, Matiari is an underdeveloped district with a value of 0.46, which is lower than the gross HDI value of Sindh province (0.59). The index reflects a composite statistic used to rank life expectancy, education and *per-capita* Gross National Income in the area to judge the level of “human development” where Medium Human Development ranges from 0.555 to 0.699 and any score below 0.555 signifies Low Human Development.

When compared with the neighbouring districts, Matiari appears to be in last place along with Tando Allahyar as reflected in Figure 2 below¹. Matiari and all neighbouring districts are underdeveloped according to the HDI.

¹ USAID/IMMAP Pakistan Emergency Situation Analysis - District Matiari, August 2014 Page i

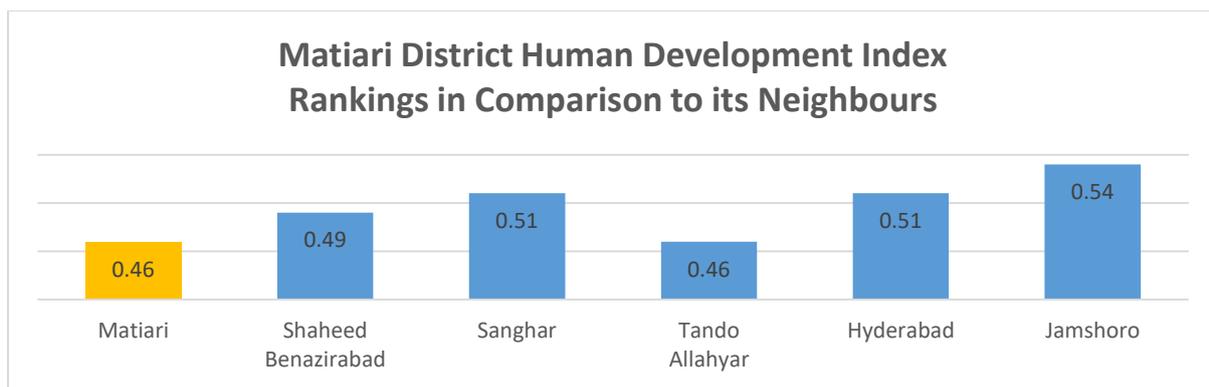


Figure 2: HDI Ranking of Matiari District and its Neighbours

3. Demographics

According to a 2016 estimate, Matiari has an estimated population of 795,147 individuals (with an annual population growth rate of 2.28%). In 1998, the current area constituting Matiari had a population of 529,925. The 1998 census reported the Male-to-Female ratio to be 52:48 while the EU Programme for Improved Nutrition in Sindh (PINS) survey in the district gave a ratio of 49:51.

Based on the EU profiling exercise for Matiari, the distribution of age groups by percentage of the district population is shown in Table 1.

Table 1: Age of the Population in Matiari District

Age Group	Male (%)	Female (%)	Total
0-5	10.5%	9.2%	19.7%
6-14	11.2%	12.6%	23.8%
15-18	8.6%	9.5%	18.1%
19-49	14.6%	16.6%	31.2%
50-59	3.6%	2.4%	6.0%
60+	0.6%	0.6%	1.2%
Total	49.1%	50.9%	100.0%

Matiari, like most districts in Sindh, can be characterised as rural since 85% of the population resides in rural areas as compared to the 15% that resides in urban areasⁱⁱ. According to both census data and the profiling survey, the average household size is 5.7 members. The Sindhi language is spoken by 92% of the total population followed by Urdu (3.6%). The remaining 4.4% speaks other languages (see Table 2 for key population and demographic figures for the district).

Table 2: Key Figures for Matiari District

Population 1998	529,925
Estimated Population 2016	795,147
Males	413,476 (52%)
Females	381,671 (48%)
Urban	119,272 (15%)
Rural	675,875 (85%)
Languages Spoken	Sindhi (92.0%)
	Urdu (3.6%)
	Others (4.4%)
Population Annual Growth Rate (1981-1998)	2.28%
Total Households (est. 2016)	139,499
Average Household Size	5.7 persons per household
Population Density	545 persons per km ²
Total Area	1,458 km ²

4. Poverty Status

According to the Multidimensional Poverty Report (MPR) of 2014/15, Matiari is among the few districts to have witnessed some improvements improvement over the years.² In 2008/09, 70.7% of the district population was living below the poverty line whereas in 2014/15, the district registered a poverty rate of 62.1%.ⁱⁱⁱ

The poverty scorecard survey conducted by the Rural Support Programme Network (RSPN) under the Sindh Union Council and Community Economic Strengthening and Support (SUCCESS) project reports that Matiari has a poverty rate of 57.2%. This survey collected and analysed data against various indicators^{iv}.

56.7% of the households in Matiari do not own any durable goods, 25.8% do not own any productive assets and 90.7% do not own any cultivable land. Across all districts profiled by SUCCESS, 56.2% of the households do not own any durable goods, 35.8% do not own any productive assets and 83.9% do not own any cultivable land³. Approximately 6.3% of the population consists of widows/widowers, 0.3% is divorced and 0.5% is separated⁴.

5. Economy and Agriculture

According to the EU PINS Survey, in Matiari district 42% of the households had an income of PKR 10,000 or below, 30.4% had an income of PKR 10,001-15,000 and 27.6% had an income of PKR

² The MPR includes the Multidimensional Poverty Index (MPI) which is based on the Alkire-Foster methodology and has 3 dimensions: education, health and living standards. To tailor the measure to Pakistan's context and public policy priorities, 15 indicators were used for this national measure instead of the 10 employed for the global measure. Of these 15 indicators, 3 are included under the dimension of education (years of schooling, child school attendance and educational quality), 4 under health (access to health facilities/clinics/Basic Health Units, immunisation, ante-natal care and assisted delivery) and 8 under living standards (water, sanitation, walls, overcrowding, electricity, cooking fuel, assets and a land/livestock indicator specifically for rural areas). All these elements are directly related to nutrition as better education, health and income leads to improved nutrition status within the district.

³ RSPN-Sindh Union Council and Community Economic Strengthening Support (SUCCESS) Programme Page 11

⁴ RSPN-Sindh Union Council and Community Economic Strengthening Support (SUCCESS) Programme Page 7

15,001 or above as can be seen from the pie chart in Figure 3 below. The average monthly income across the surveyed households is PKR 13,651.

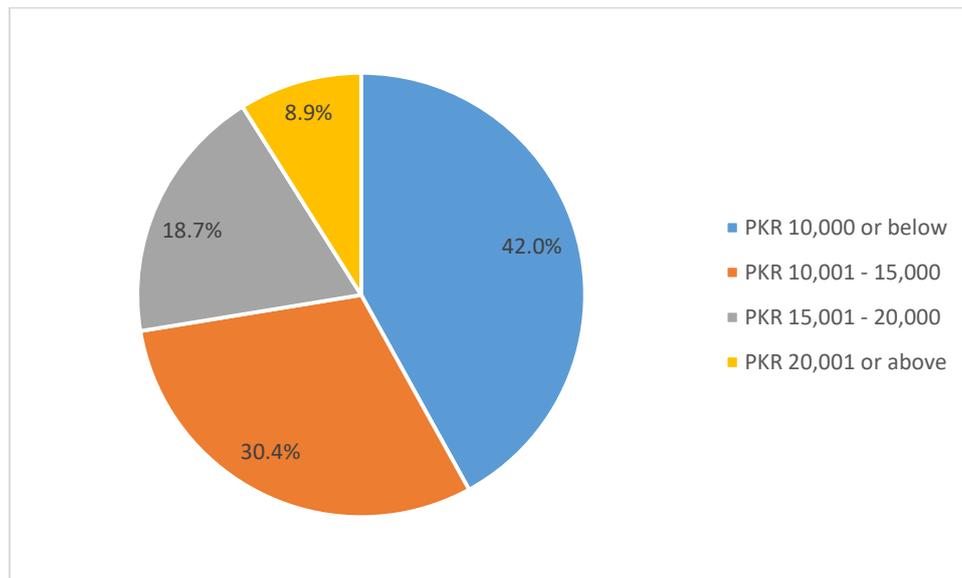


Figure 3: Household Income

In Matiari district 64.7% of the households had a monthly expenditure of PKR 10,000 or below, 13.7% had a monthly expenditure of PKR 10,001-15,000 and the remainder had an expenditure of PKR 15,001 or above as can be seen from the pie chart in Figure 4 below. On average, household expenditure is PKR 10,735 per household per month in Matiari. Food constitutes by far the most important item of household expenditure followed by health. Almost 28% of the households are making regular payments with regard to debt (the amount of debt being below PKR 10,000 in 57% of cases).

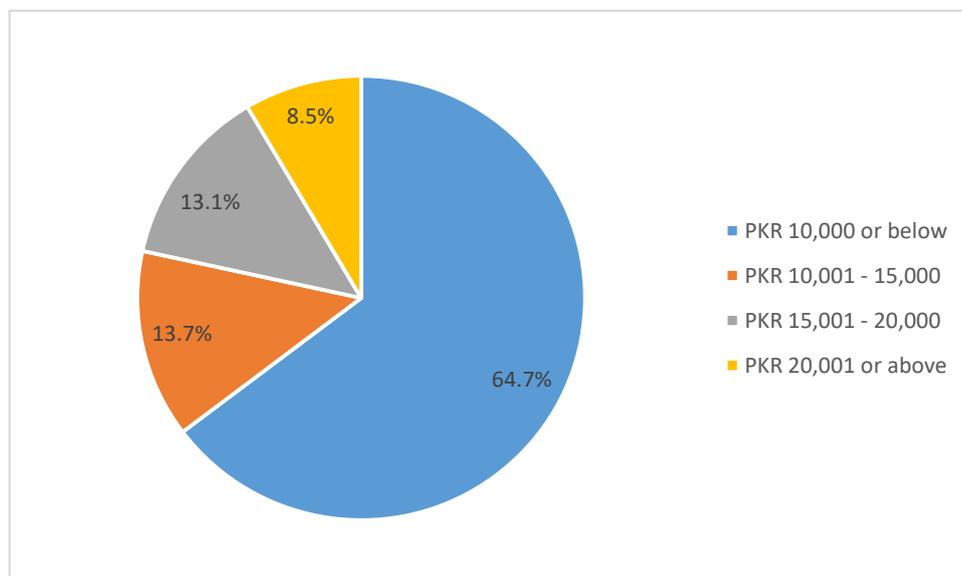


Figure 4: Household Expenditure

In 82.3% of households in Matiari, there is only one earner while 12.4% of households have two earners. Of all the households in Matiari, 28.9% are earning below PKR 10,000 per month and 61.8% are earning between PKR 10,000 and 20,000 per month. Table 3 shows the percentage of all households in each income bracket by number of earners.

Table 3: % of Households in Each Income Bracket by Number of Earners, Matiari District

Income (PKR)	Number of Earners					Total
	1	2	3	4	5 or more	
< 10,000	23.2	3.5	1.0	0.6	0.6	28.9
10,000 – 20,000	51.0	8.3	1.3	0.6	0.6	61.8
20,001 – 30,000	5.6	0.3	-	-	-	5.9
30,001 – 40,000	1.6	0.3	-	0.3	0.3	2.5
40,001 – 50,000	0.6	-	-	-	-	0.6
> 50,000	0.3	-	-	-	-	0.3
% of all households	82.3	12.4	2.3	1.5	1.5	100.0

Data Source: CARDNO PINS Survey 2017

Paid skilled agricultural labour (19.6%), paid skilled non-agricultural labour (12.1%), small business/self-employed (9.6%) and paid unskilled non-agricultural labour (8.8%) are the main sources of income as can be seen in the pie chart in Figure 5 below.

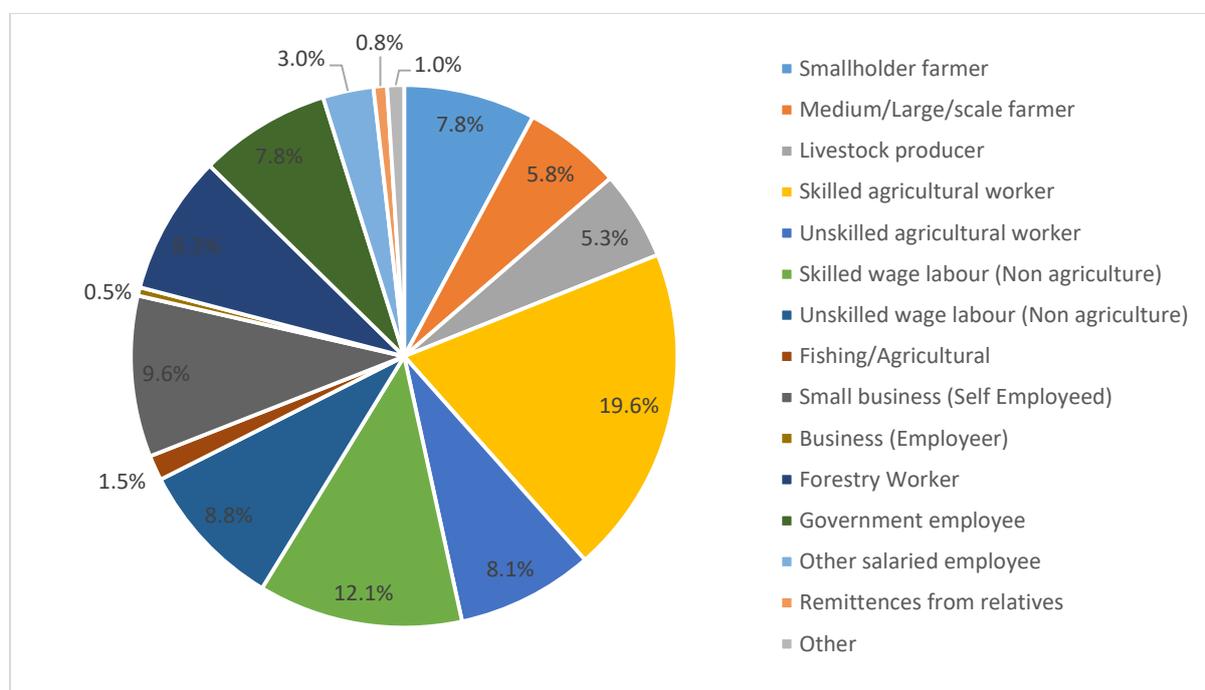


Figure 5: Sources of Household Income

The rainy season in Matiari lasts from June/July to September and the cropping calendar is divided into two seasons: the Rabi and the Kharif. Men and women have distinct productive activities and responsibilities in agriculture, with both men and women actively involved on the family farm although women are considered to play a more supportive role in agricultural work. Both men and women carry out paid local agricultural labour and in situations where a family migrates in search of work, both men and women will take on paid farm labour. Both men and women are also engaged as casual labourers on farms.

One difference is that the decision-making responsibility rests entirely with men. In sharecropping arrangements for example, landlords only deal with the male sharecropper. Livestock production is also gender-divisive; women rear small stock and men rear large stock, but decisions about all types of livestock sales rest with men. Another difference is that only women fetch water for domestic or livestock use and only men are involved in market-based activities, including buying supplies and selling produce at the market^v.

Table 4: Seasonal Calendar

Agricultural Season (including gender roles)	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
	Rabi	Kharif						Rabi				
Rainy season												
Crops (women having key role both in harvesting and planting season)												
Wheat, winter (irrigated)	Harvest							Planting				
Onions						Planting			Harvest			
Livestock (women being the primary care taker of livestock)												
Cattle milking peak												
Buffalo milking peak												
Goat milking peak												
Livestock sales peak												
Other Income												
Agricultural labour peak												
Construction labour peak (mostly men)												
Labour migration peak (most men leaving home and women taking over their roles at home)												
Firewood sales												
Stress/High Expenditure Periods												
Livestock diseases												
High staple prices												
Human diseases												
Festivals												
Hunger season / Lean period (irrigated zones)												
Hunger season / Lean period (rain-fed zones)												
Migration to Urban Centres												

The EU PINS profiling survey reported that almost 91% of the women in Matiari had consumed fish at least once in the 12 months prior to the survey, while those who did not consume it mentioned religion and health as the two main reasons why. Some minority communities simply do not eat fish while others associate it with the development of white patches on the skin (a condition known as vitiligo or leucoderma) or miscarriage during the first trimester in expecting mothers. Over 86% of all women who participated in the survey had eaten fish at least once in the last one month. Average fish consumption across 56% of the respondents was 100-150g per person per meal. Fish is eaten twice as often in winter (even though prices are higher) with portion sizes staying the same. Thus, there is no direct correlation between the price of fish and its consumption with the season apparently having the biggest influence.

Children and pregnant women in Matiari are given fish, although it is only given to children under the supervision of an adult and is not generally given to breastfeeding women. People in general avoid consuming milk and fish without any significant variation among gender or age group. Better information on the utility of fish and the facilitation of fish farming are among the key factors that may promote fish consumption in Matiari.

Mango, lychee, citrus, jammon, banana and papaya are the main fruits produced in Matiari district and chilli, onion, tomato, okra, cauliflower, bitter gourd, coriander and cucumber are the main

vegetables and herbs. Rural households grow their own vegetables (most commonly onion and chilli) for home consumption and sale on the market. Access to fruit is not universal even among farming families and fruit is too expensive to buy from the market, even during the peak season. Where households do produce fruit, they do so for their own consumption. Mangoes and bananas are two fruits of high nutritive value that are produced in the district. Mangoes contain over 20 different vitamins and minerals and bananas are a good source of dietary fibre, vitamin C, potassium and manganese.

6. Water and Sanitation

According to the Sindh Multiple-Indicator Cluster Survey (MICS) of 2014, 99.1% of the population in Matiari has access to improved sources of drinking water. 31.7% are using piped water, 63.9% are using drinking water from protected wells and 3.4% are sourcing their drinking water from hand pumps (see Figure 6).

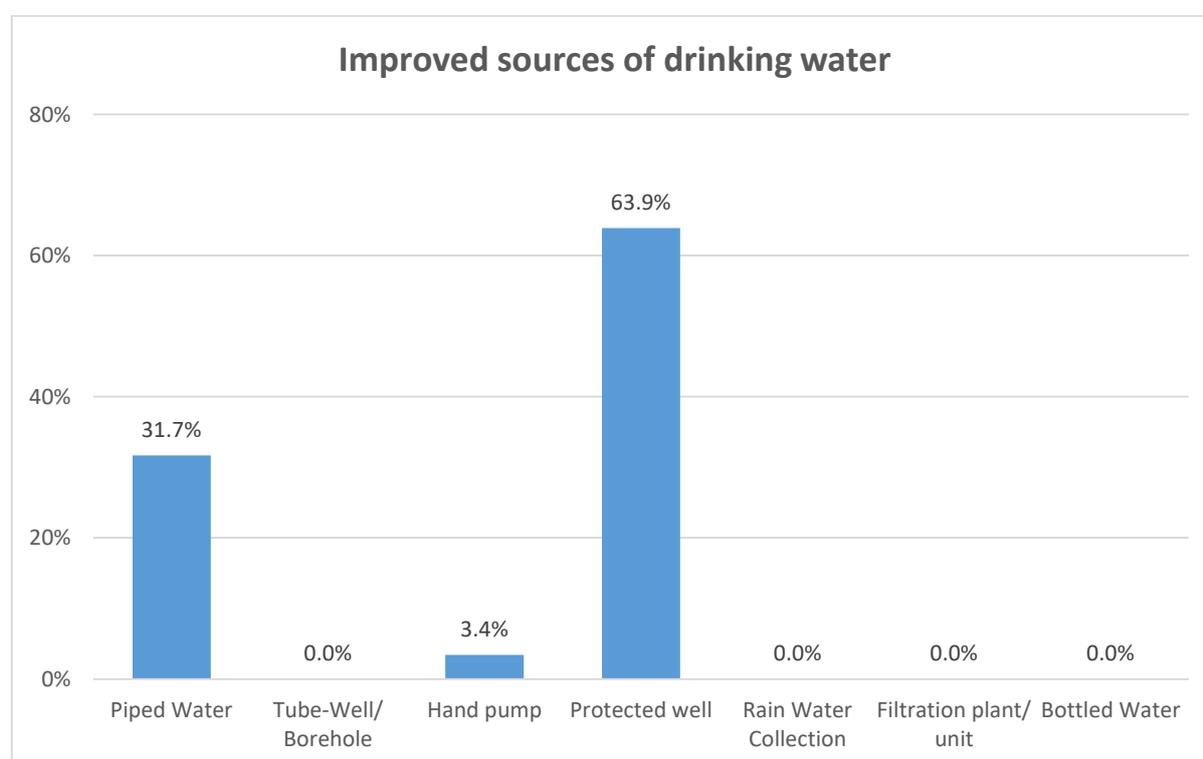


Figure 6: Improved Sources of Drinking Water

In the case of Matiari, 22.3% of households have water piped directly to their dwelling while 2.3% have piped water in their yard/plot. A further 63.9% have access to a protected well and 3.4% have access to a hand pump. Access to clean drinking water has a direct link with nutritional status. Detailed data are given in Table 5 below.

Table 5: Main Sources of Drinking Water at Household Level

Main Sources of Drinking Water		Percentage of the population	
Improved Sources	Piped Water	Into dwelling	22.3%
		Into yard/plot	2.3%
		To neighbour	6.3%
		Public tap/stand-pipe	0.9%
	Tube-well/Borehole	0.0%	
	Hand pump	3.4%	

	Protected well	63.9%
	Rainwater collection	0.0%
	Filtration plant/unit	0.0%
	Bottled water	0.0%
Percentage Using Improved Sources of Drinking Water (A)		99.1%
Unimproved Sources	Tanker truck	0.0%
	Unprotected well	0.0%
	Cart with small tank/drum	0.9%
	Surface water	0.0%
	Bottled water	0.0%
	Other	0.0%
Percentage Using Unimproved Sources of Drinking Water (B)		0.9%
Total A + B		100.0%

98% of households in Matiari are not using any form of water treatment while the remainder are mainly boiling water, straining it through a cloth or using other means as reflected in Table 6 below. A reduction in the consumption of untreated water leads to reduced incidences of diarrhoea and an improvement in nutritional status.

Table 6 shows the percentage of total households which use various methods of water treatment (with some households using more than one method).

Table 6: Water Treatment Methods Used in Households

Percentage of households using different water treatment methods								
None	Boiling	Addition of bleach/ chlorine	Straining through a cloth	Water filter	Solar disinfection	Letting it stand and settle	Alum (phitkari)	Other
98.0%	1.1%	0.1%	0.6%	0.2%	0.0%	0.0%	0.4%	0.0%

Data Source: Govt of Sindh / UNICEF Sindh MICS Survey 2014/15

60% of people in Matiari district are using improved sanitation facilities, 13% are using unimproved sanitation facilities and 27% are still practising open defecation as shown in Figure 7 below^{vi}.

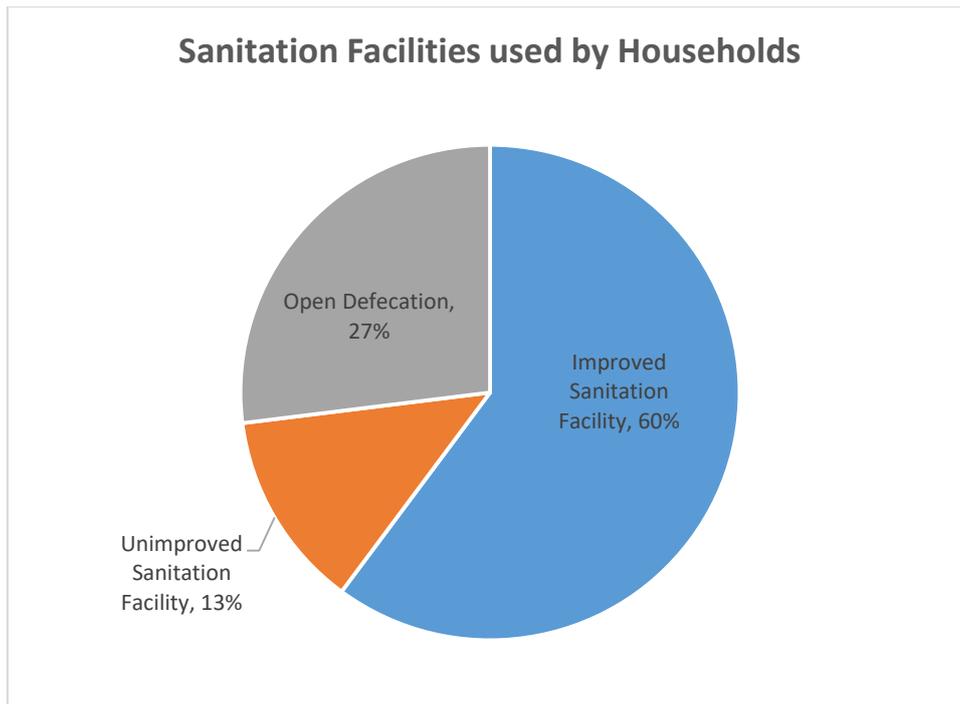


Figure 7: Household Use of Sanitation Facilities

Figure 8 shows that 50.4% of people in Matiari are using pour flush latrines, 5.2% use ventilated improved pit latrines and 4.6% use pit latrines with slabs.

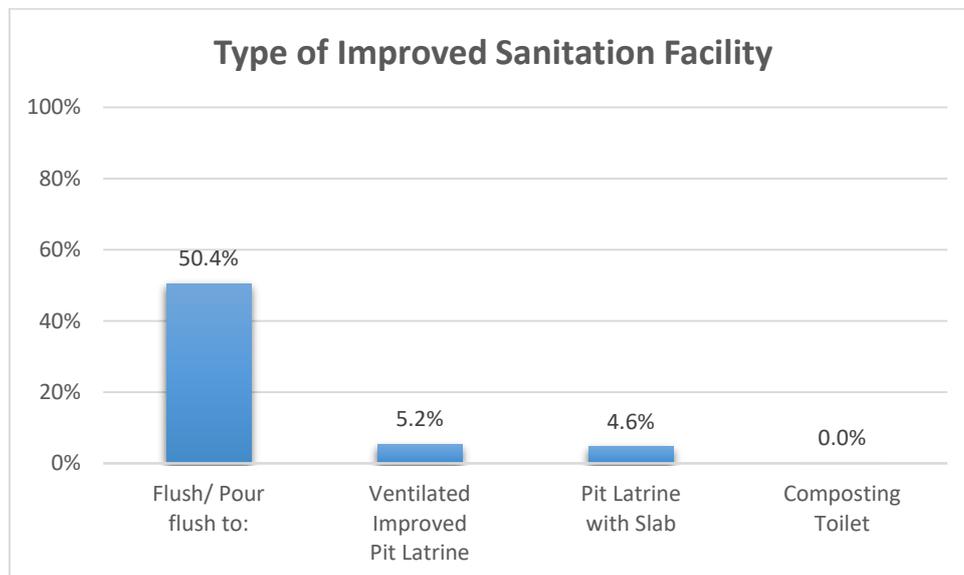


Figure 8: Improved Sanitation Facilities

6.1. Diarrhoea Treatment

Of the total number of children suffering from diarrhoea, 21.8% consulted public doctors or other health service providers and 52.4% consulted private health facilities or providers (although these figures are distorted by the fact that some children sought treatment from both public and private health facilities or providers). No treatment or advice was sought for 23.6% of the children and this reflects the need for increased access to and awareness of health services among the communities in Matiari.

Table 7 shows the percentage of children with diarrhoea for whom advice or treatment was sought from health facilities or other service providers.

Table 7: Percentage of children with diarrhoea who receive treatment

Percentage of children with diarrhoea for whom:					
Advice or treatment was sought from:					
Health facilities or providers			Other source	A health facility or provider	No advice or treatment sought
Public	Private	Lady health worker			
21.8%	52.4%	1.0%	2.8%	70.2%	23.6%

Data Source: Govt of Sindh / UNICEF Sindh MICS Survey 2014/15

7. Literacy and Education

In Matiari district there are a total of 926 government schools, of which 92.6% are primary schools. Of these, 14.5% are exclusively for girls, 10.6% are for boys and 74.9% are mixed schools. 19.6% of teachers in Matiari district are female while the remaining 80.4% are male. This highlights the need for more female teachers in order not only to effectively reach out to girls' schools but also to enable the more effective communication of nutrition-related messages to female students⁵.

Table 8: Number and Type of Government Schools

Level of Schooling	N ^o of Schools	%
Primary	857	92.6%
Middle	19	2.0%
Elementary	2	0.2%
Secondary	45	4.9%
Higher Secondary	3	0.3%
Total	926	100%

In Matiari district 39.4% of boys and 35.9% of girls attend primary school. At secondary level the attendance rate is 41.9% for boys and 26.5% for girls^{vii}. Moreover, 43.5% of young women aged 15-24 are literate. The low rate of literacy among both boys and girls is a challenge to increasing awareness of nutrition. The attendance ratio disaggregated by gender and level of schooling is shown in Table 9 below.

Table 9: School Attendance Ratio

Gender	Primary School net attendance ratio (adjusted)	Secondary School net attendance ratio (adjusted)
Male	39.4%	41.9%
Female	35.9%	26.5%

8. Access to Mass Media

As shown in Table 10 below, 1.4% of women aged 15-49 in Matiari have access to all three types of mass media (newspapers, radio and television) at least once a week. These are important means of

⁵ Sindh Educational Profile 2014/15

communicating nutrition messages to the masses (including women), especially in the context of areas like Matiari.

Table 10: Exposure to Mass Media

Exposure to Mass Media among Women aged 15-49 at least once a week	
Newspapers	5.7%
Radio	6.5%
Television	54.2%
All Three Media	1.4%
Any of the Three Media	57.8%

Data Source: Govt of Sindh / UNICEF Sindh MICS Survey 2014/15

9. Infant and Young Child Nutrition and Health

9.1 Infant and young child mortality

The infant mortality rate in Hyderabad division which includes Matiari is 85 deaths per 1,000 live births and the under-five mortality rate is 109 deaths per 1,000 live births. Sindh province overall has an infant mortality rate of 82 deaths per 1,000 live births and an under-five mortality rate of 104 deaths per 1,000 live births^{viii}. These figures reflect a generally worrisome situation around children's health in the district.

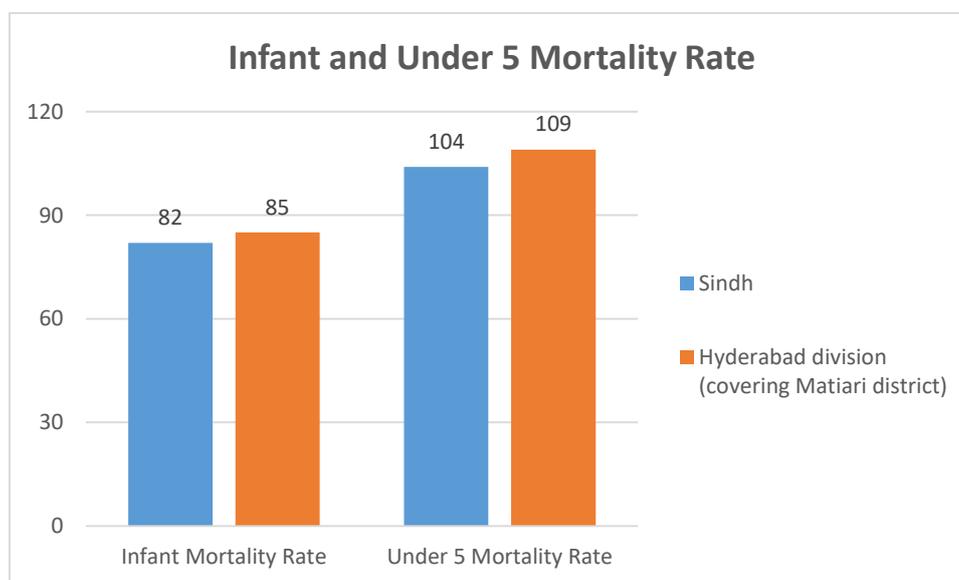


Figure 9: Infant and Under-5 Mortality Rates (per 1,000 live births)

9.2 Nutritional status

29.2% of children aged 0-5 in Matiari are moderately underweight while 22.4% are severely so (with 51.6% of all children aged 0-5 being of a less-than-healthy weight overall). 26.2% of under-fives are moderately stunted and 28.6% severely so (with 54.8% of all children aged 0-5 being stunted to some degree overall). 16% of under-fives are wasted overall (with 13.4% of all children of this age group showing moderate wasting and 2.6%, severe wasting).

In Sindh, more than four in ten (42%) of children under the age of five are underweight and 17% are classified as severely underweight. Almost half of children aged under five (48%) are stunted or short for their age and almost a quarter (24.4%) are severely stunted. 15.4% of these children are wasted or thin for their height and only 1% are overweight or too heavy for their height. This amounts overall to a crisis situation as regards the health of children under five in Matiari district. These statistics are sourced from the MICS of 2014/15^{ix} and are shown in Figure 10.

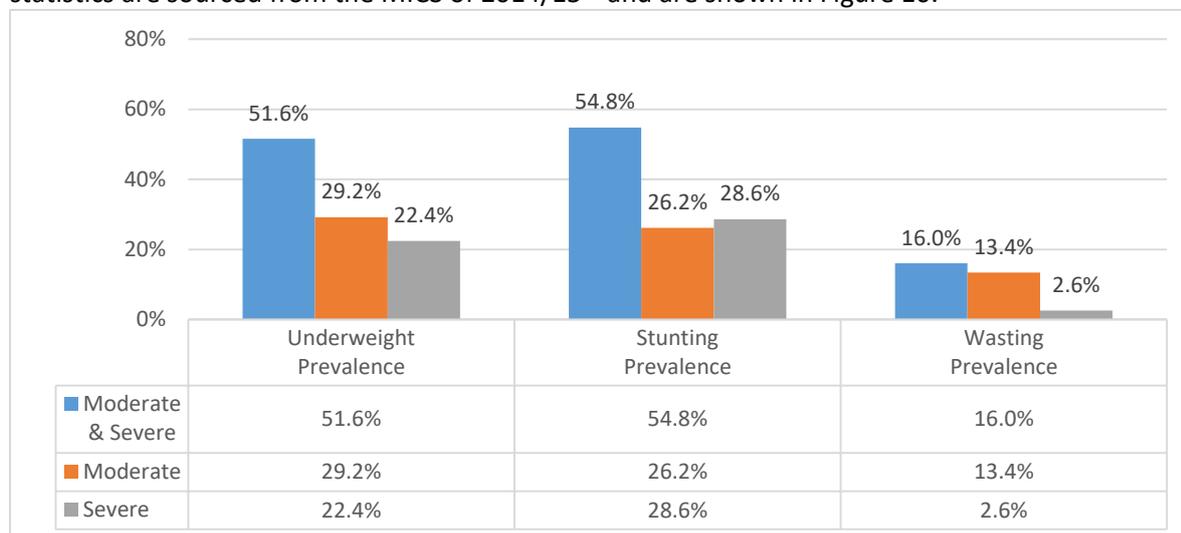


Figure 10: Prevalence of underweight, stunting and wasting

9.3 Breastfeeding and complementary feeding

28.9% of women in Sindh province and 34.6% in Matiari district practise exclusive breastfeeding during the first six months of life. In Sindh 56% and in Matiari 66.5% of women report predominantly breastfeeding their infants until six months of age^x. Feeding practices play a critical role in child development; poor feeding practices can adversely impact the health and nutritional status of children, which in turn has direct consequences for their mental and physical development. Duration and intensity of breastfeeding also affect a mother’s period of postpartum infertility and thus, the amount of time between births^{xi}. In Sindh overall, only 20.7% of women initiate breastfeeding within one hour of birth. This is more widely practised in Matiari district where 36.7% of women initiate breastfeeding within one hour of birth according to MICS 2014/15 data (see Figure 11).

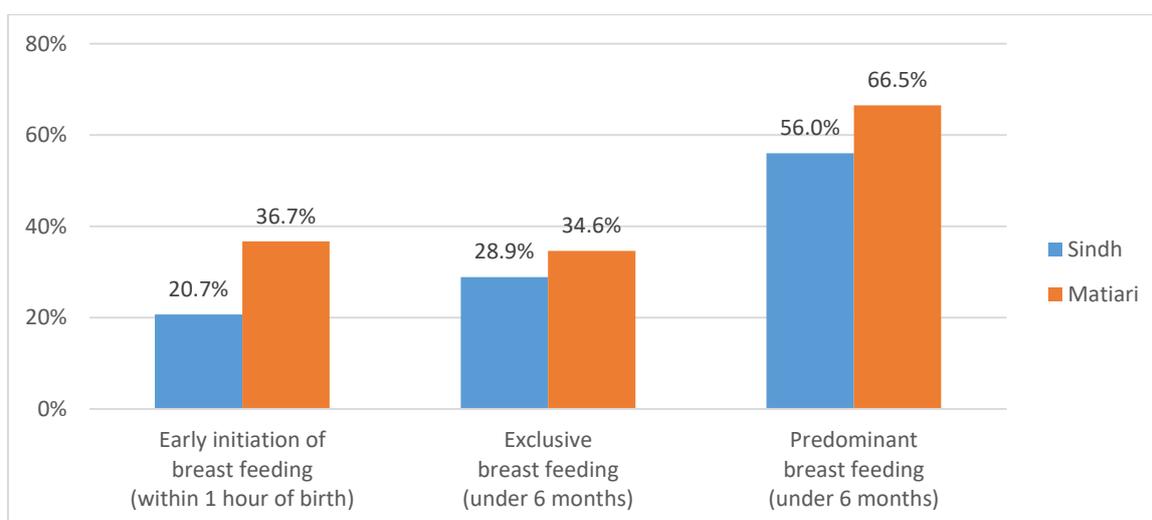


Figure 11: Early-initiation, exclusive and predominant breastfeeding

9.4 Dietary diversity and frequency of meals among children aged 6-23 months

According to MICS 2014/15 estimates, 10.1% of children aged 6-23 months are achieving Minimum Dietary Diversity (MDD) in Matiari district, 37.7% are achieving Minimum Meal Frequency (MMF) and 1.7% are achieving Minimum Acceptable Diet (MAD). These percentages are not encouraging as insufficient quantities and quality of complementary foods, poor child feeding practices and high rates of infection all have a detrimental effect on health and growth in children under 2 years of age. An estimated 6% of under-five deaths can be prevented by ensuring optimal complementary feeding among which MDD and MMF are the most important indicators^{xii}.

MICS 2014/15 estimates of achievement of MDD, MMF and MAD in Matiari district are presented in Figure 12^{xiii}.

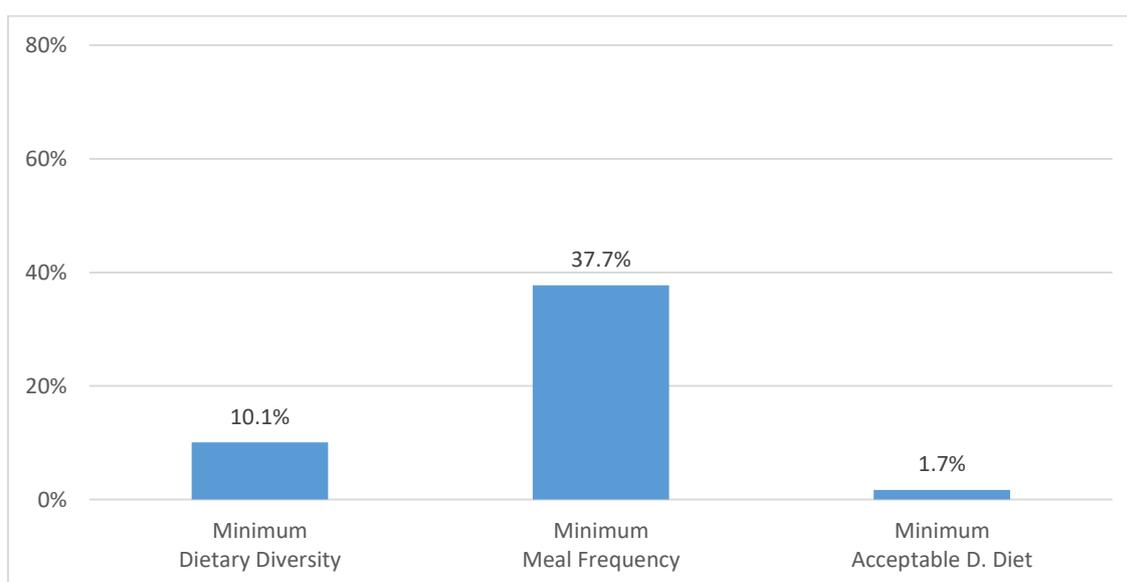


Figure 12: Achievement of Minimum Acceptable Diet, Minimum Meal Frequency and Minimum Dietary Diversity in Matiari district

9.5 Minimum Dietary Diversity of Women (MDD-W)

Only 43% of women of childbearing age (15-49 years) in Matiari district achieve their minimum dietary diversity (where this is interpreted to mean the consumption of at least 5 food groups and an adequate amount of micronutrients). In other words, almost 5 out of 10 women are not meeting minimum required dietary diversity criteria. MDD-W is an indicator of whether a woman receives enough nutrients through her diet. The percentage of women achieving their MDD-W by household type and income is presented in Table 11.

Table 11: Rate of achievement of Minimum Dietary Diversity of Women (MDD-W) in Matiari

Food groups consumed	Overall	Agricultural households
Less than 5	57.0%	55.5%
5 or more	43.0%	44.5%

Data Source: CARDNO PINS Survey 2017

The table shows that almost equal percentages of women aged 15-49 in agricultural households and the overall population achieve their MDD-W. Table 12 provides a more detailed breakdown of the achievement rate of MDD-W by household type.

Table 12: Breakdown of Achievement of MDD-W in Matiari

Number of food groups consumed	Overall	Agricultural households
At least 1	100%	100%
At least 2	98.0%	97.0%
At least 3	87.8%	86.4%
At least 4	59.8%	61.8%
At least 5	43.0%	44.5%
At least 6	26.0%	26.7%
At least 7	13.0%	15.7%
At least 8	5.7%	7.3%
At least 9	3.2%	4.2%
All 10	1.0%	1.0%

Data Source: CARDNO PINS Survey 2017

In Matiari district, grains and related foodstuffs have a significant presence in the diet of both agricultural households and the overall population. More meat, poultry and fish are consumed in agricultural households than among the general population as reflected in Table 13.

Table 13: Consumption of Food Groups in Matiari by household type and income

N°	Food Group	Overall	Agricultural Households
1	Grains, white roots and tubers, plantains	100%	100%
2	Pulses (beans, peas, and lentils)	71%	71%
3	Nuts and seeds	12%	16%
4	Dairy	67%	66%
5	Meat, poultry and fish	32%	39%
6	Eggs	28%	30%
7	Dark-green leafy vegetables	36%	37%
8	Other Vitamin A-rich fruit and vegetables	47%	46%
9	Other vegetables	27%	23%
10	Other fruits	18%	17%

Data Source: CARDNO PINS Survey 2017

The diets of women who eat from fewer than five food groups show a significant absence of nuts, seeds, meat, poultry, fish, eggs, dark-green leafy vegetables, Vitamin A-rich fruit and vegetables and other fruits and vegetables. Tables 13 and 14 provide a breakdown of the consumption of different food groups by those with adequate and inadequate food diversity in Matiari.

Table 14: Key Food Groups consumed by those with inadequate food diversity in Matiari (i.e. those with fewer than 5 food groups in their diet)

N°	Food Group	Overall	Agricultural Households
1	Grains, white roots and tubers, plantains	100%	100%
2	Pulses (beans, peas and lentils)	57%	56%
3	Nuts and seeds	5%	7%
4	Dairy	47%	44%
5	Meat, poultry and fish	14%	18%
6	Eggs	10%	14%
7	Dark-green leafy vegetables	13%	13%

N°	Food Group	Overall	Agricultural Households
8	Other Vitamin A-rich fruit and vegetables	27%	23%
9	Other vegetables	21%	20%
10	Other fruits	11%	8%

Data Source: CARDNO PINS Survey 2017

Those with adequate food diversity in Matiari eat significantly more fruit, vegetables (including dark-green leafy vegetables) and eggs than those without. There are some variations among these food groups. As shown by a comparison of Tables 13 and 14, there are some differences between the dietary intakes of women with adequate food diversity and those with inadequate food diversity (especially in the case of eggs and Vitamin A-rich fruit and vegetables).

Table 15: Key Food Groups consumed among those with adequate food diversity in Matiari (i.e. those with 5 food groups or more in their diet)

N°	Food Group	Overall	Agricultural Households
1	Grains, white roots and tubers, plantains	100%	100%
2	Pulses (beans, peas and lentils)	89%	91%
3	Nuts and seeds	21%	28%
4	Dairy	94%	94%
5	Meat, poultry and fish	57%	65%
6	Eggs	51%	49%
7	Dark-green leafy vegetables	67%	66%
8	Other Vitamin A-rich fruit and vegetables	74%	75%
9	Other vegetables	34%	27%
10	Other fruits	27%	28%

Data Source: CARDNO PINS Survey 2017

9.6 Low birth weight

Amongst the children who were weighed in the district at birth, low birth weight is witnessed for every third child born in Matiari, indicating poor maternal and newborn health and nutrition. 30% of babies born in Sindh and 29.2% of those born in Matiari have a low weight at birth. This reflects undernourishment *in utero* and increases the risk of a child's death in the early months and years of life. It also increases the risk that even those who survive will remain undernourished, with reduced muscle strength and cognitive capacity.

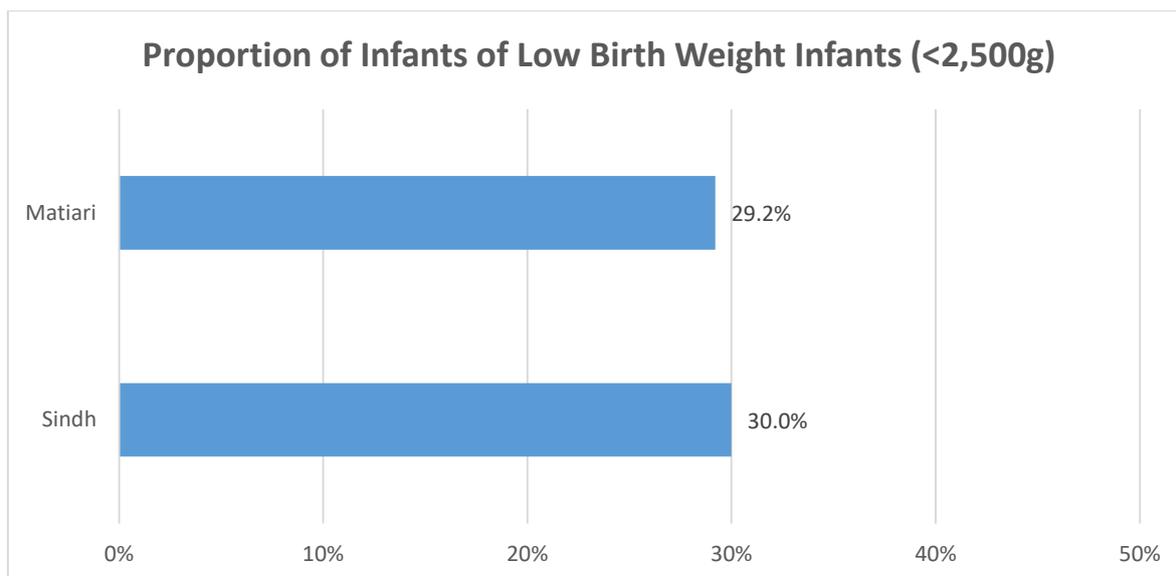


Figure 13: Proportion of Infants of Low Birth Weight (<2,500g)

9.7 Child immunisation

In Matiyari district 68% of children aged 12-23 months had received all recommended vaccinations by 12 months of age. 81% of children had been vaccinated against measles and 94.8% against TB. Immunisation is crucial to reducing child death from preventable diseases and is closely linked with nutrition-specific interventions. The chart in Figure 14 covers all required vaccination indicators.

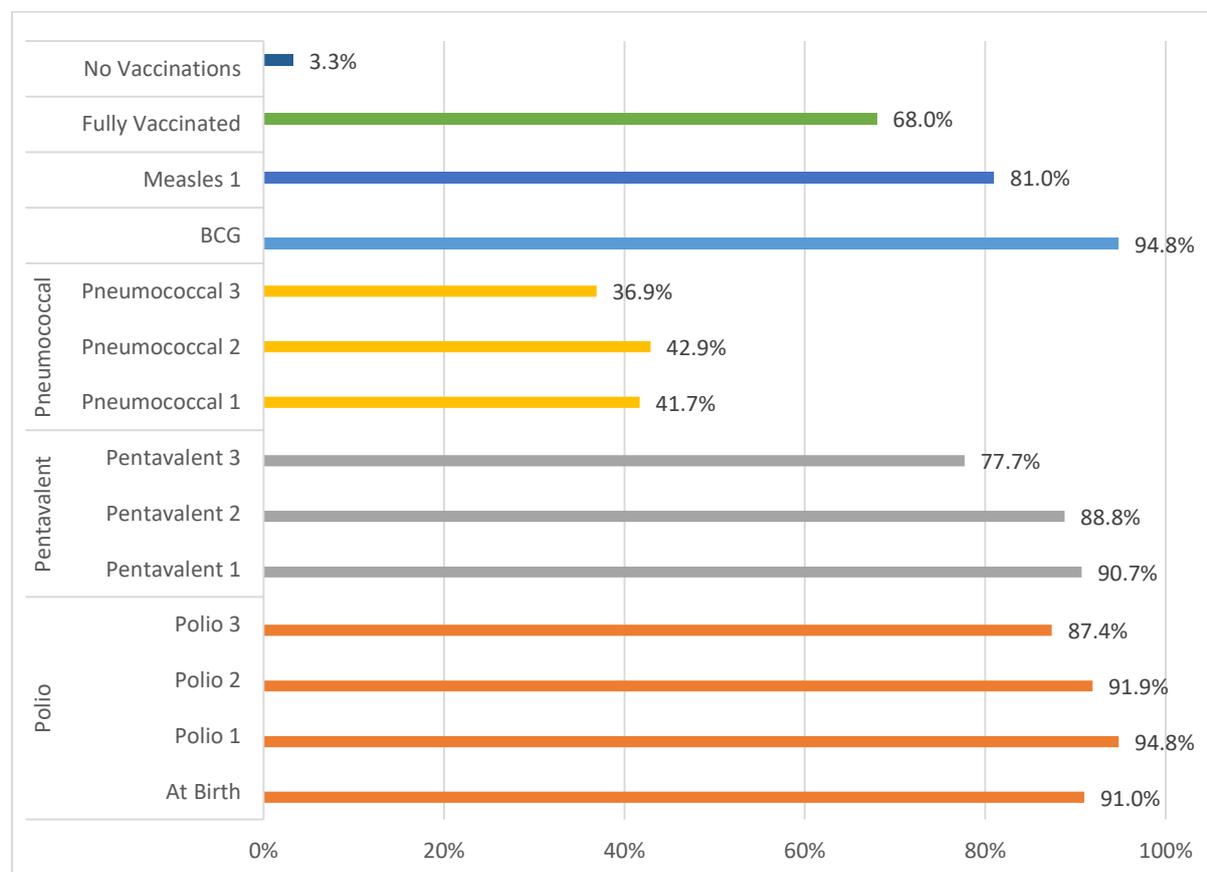


Figure 14: Vaccination of children aged 12-23 months

Figure 15 provides details on the vaccination of children aged 24-35 months.

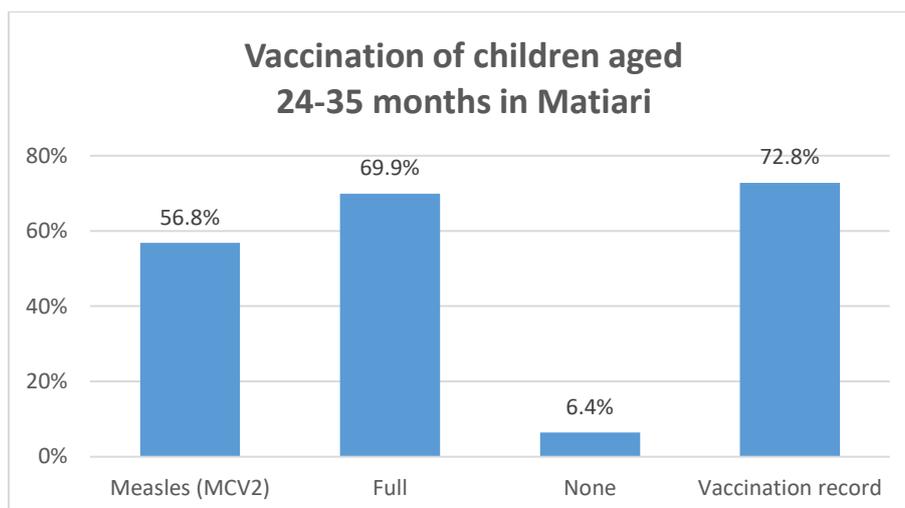


Figure 15: Vaccination of children aged 24-35 months in Matiari

10. Maternal Health and Nutrition

10.1 Reproductive health

The fertility rate in Matiari district is 4.2 children per woman. 32.4% of women in the district use some form of contraception with 30.6% using modern contraceptive methods^{xiv}. The most common contraceptive method is female sterilisation which is currently used by 11.9% of ever-married women.

10.2 Maternal and neonatal health

88.5% of ever-married women in Matiari have received antenatal care. According to the MICS of 2014/15^{xv}, 65.2% of all deliveries in Matiari took place at a health facility with 30% occurring in state centres and 35.2% in private centres. The remaining 34.8% of deliveries took place at home. Seeking antenatal care (ANC) during pregnancy is of significant importance as it identifies risk factors which minimise the chances of later maternal complications and can reduce the number of miscarriages and stillbirths.

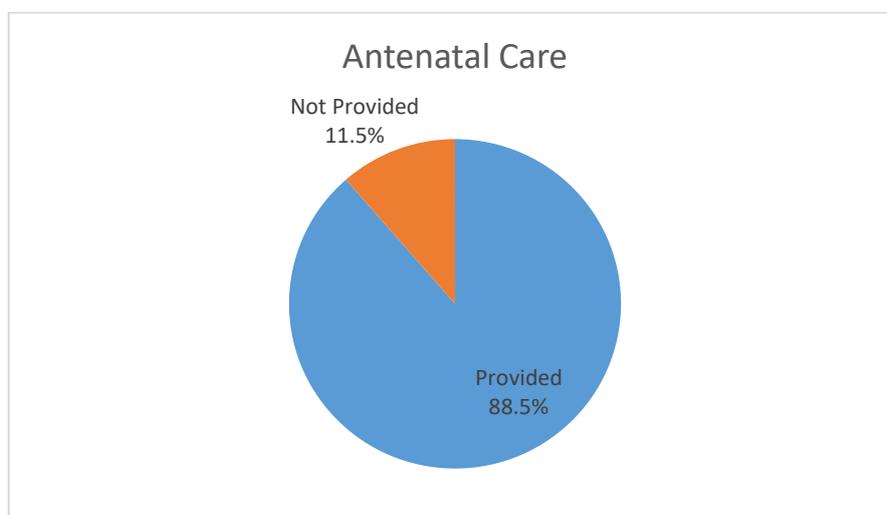


Figure 16: Provision of ANC in Matiari

In Sindh province overall, almost 79.6% of ever-married women have received antenatal care from a skilled provider (an improvement of almost 100% over the last decade as compared to the findings of the MICS 2003/04 when only 42% received ANC) while in Matiari 85.7% of ever married women have received antenatal care from a skilled provider. The percentage of deliveries taking place at a health facility also considerably increased from 42% (Demographic and Health Survey 2006/07) to 64% as reported in the Sindh MICS 2014. Figure 18 below presents these figures on ANC and place of delivery in both Sindh province and Matiari district.

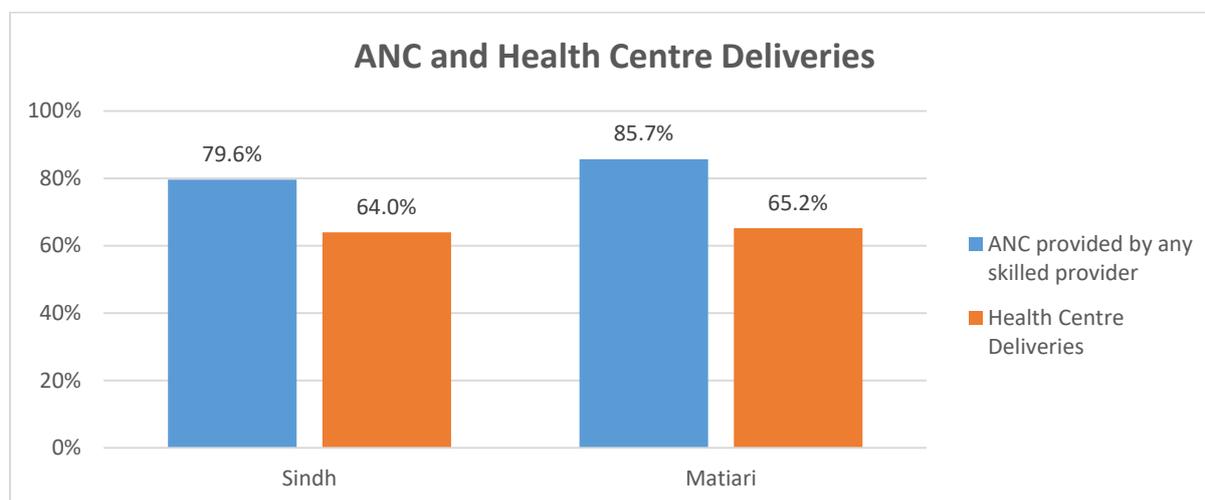


Figure 17: ANC and Health Centre Deliveries

As shown in Table 16, 84.5% of women receive ANC from doctors, 1.2% received it from nurses and/or midwives, 2.2% receive it from a lady health worker and 0.6% receive it from other service providers (total 88.5%). The remaining received no antenatal care.

Table 16: Provision of Antenatal Care

Provision of Antenatal Care							
Medical Doctor	Nurse/ Midwife	Community Midwife	Lady Health Visitor	Traditional/ Skilled Birth Attendant	Lady Health Worker	Relative/ Friends	Other
84.5%	1.2%	0.0%	0.0%	0.0%	2.2%	0.0%	0.6%

Data Source: Govt of Sindh / UNICEF Sindh MICS Survey 2014/15

17.2% of women in Matiari receive or attend one ANC visit, 16.1% have two visits, 18.4% have three visits and 36.9% have four or more visits as shown in Figure 19.

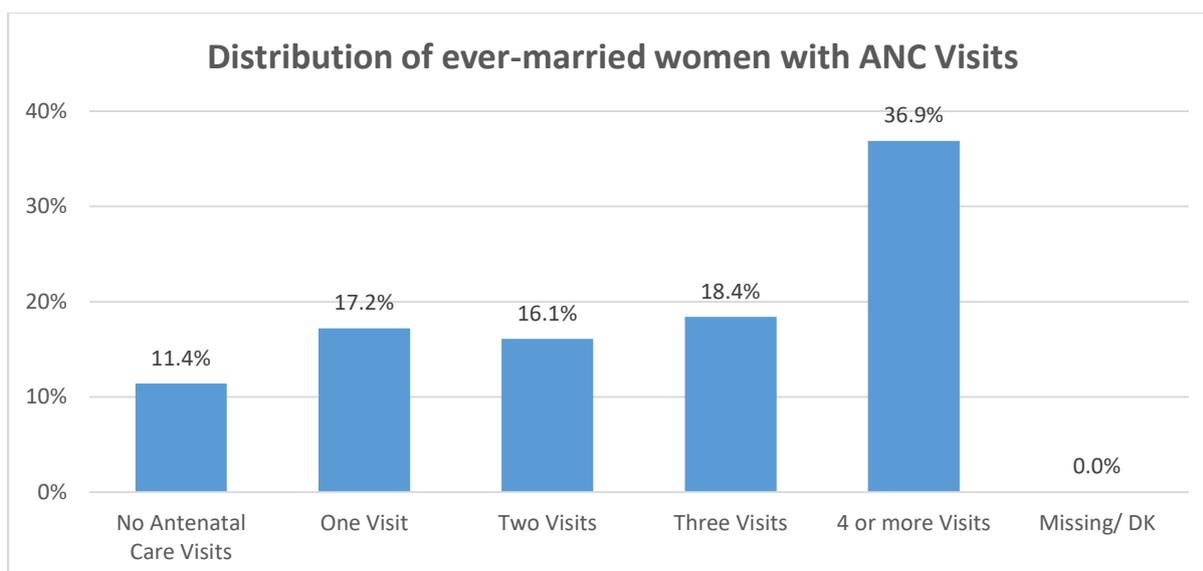


Figure 18: Distribution of ever-married women having ANC visits

In Matiari, 47.3% of pregnant women have their first ANC during the first trimester. 17.6% first attend at 4-5 months, 15% first attend at 6-7 months and 7.1% first attend at 8 months or later (see Table 17).

Table 17: Number of months of pregnancy at time of first ANC visit

Percentage distribution of ever-married women by number of months pregnant at the time of first antenatal care (ANC) visit					Median months pregnant at first ANC visit
First trimester	4-5 months	6-7 months	8+ months	Missing/DK	
47.3%	17.6%	15.0%	7.1%	1.5%	3

Data Source: Govt of Sindh / UNICEF Sindh MICS Survey 2014/15

10.3 Post-natal care of mothers and children

In Matiari, 79.8% of newborns and 71.6% of mothers receive a health check following birth in either a facility or at home^{xvi}. In Sindh overall, this figure is slightly lower at 77% of newborns. Such checks are important as they may take advantage of a critical window of opportunity to deliver life-saving interventions to both the mother and newborn if needed^{xvii}. This totals 87% of pregnant women (nearly all of those who receive ANC) with data on the remaining 1.5% missing.

10.4 Visits to women aged 15-49 by Lady Health Workers (LHWs)

In Sindh, 52.3% of women of childbearing age were visited by a Lady Health Worker during the three months prior to the MICS 2014 survey while this percentage was 83.2% in Matiari. In Sindh, 64% of ever-married women live in close proximity to an LHW while this figure is 97.4% in Matiari^{xviii}. With insufficient numbers of health managers, nurses, paramedics and skilled birth attendants, the national government created the Lady Health Worker Programme for family planning and primary healthcare in order to provide essential primary health services to the community and fulfil unmet health-related needs in rural and urban slum areas^{xix}.

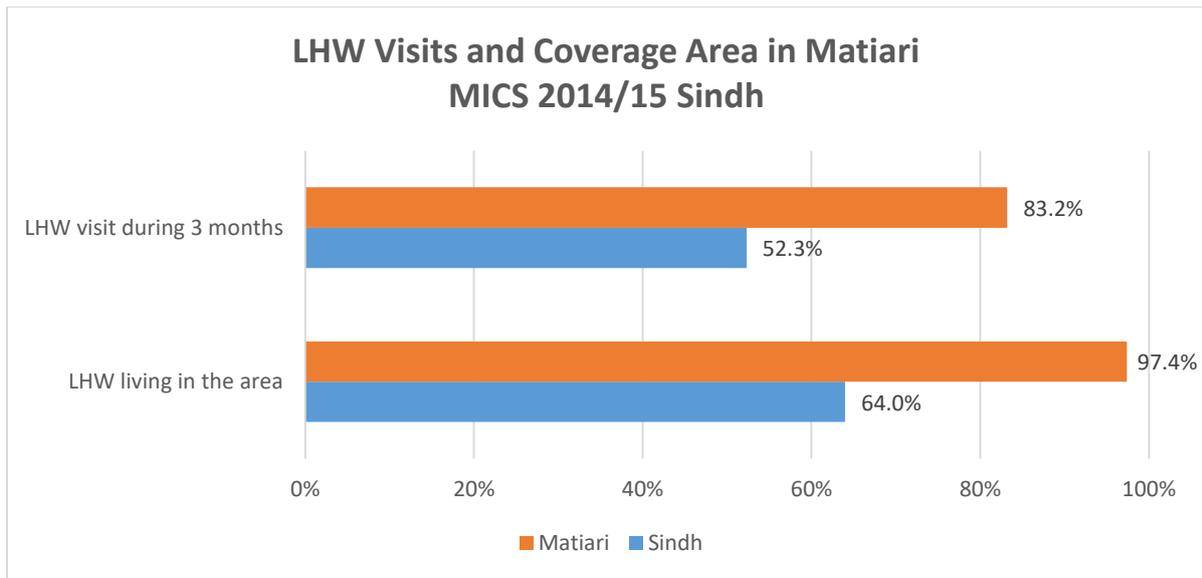


Figure 19: LHW Coverage in Matiari

REFERENCES

- <http://www.spdc.org.pk/Data/Publication/PDF/AR2014-15.pdf> page 135
- ii <http://www.alhasan.com/system/files/skim-magazine/PESA-DP-Jamshoro-Sindh.pdf>
- iii http://www.pk.undp.org/content/pakistan/en/home/library/hiv_aids/Multidimensional-Poverty-in-Pakistan.html
- iv <http://mis.rspn.org/SUCCESS/PSC/Index>
- v http://reliefweb.int/sites/reliefweb.int/files/resources/hea_drought_assessment_sindh_2015-final_2016_v2_0.pdf
- vi <http://sindhbos.gov.pk/wp-content/uploads/2014/09/01-Sindh-MICS-2014-Final-Report.pdf>
- vii <http://sindhbos.gov.pk/wp-content/uploads/2014/09/01-Sindh-MICS-2014-Final-Report.pdf>
- viii <http://sindhbos.gov.pk/wp-content/uploads/2014/09/01-Sindh-MICS-2014-Final-Report.pdf>
- ix <http://sindhbos.gov.pk/wp-content/uploads/2014/09/01-Sindh-MICS-2014-Final-Report.pdf>
- x <http://sindhbos.gov.pk/wp-content/uploads/2014/09/01-Sindh-MICS-2014-Final-Report.pdf>
- xi http://www.who.int/nutrition/publications/gs_infant_feeding_text_eng.pdf
- xii https://www.unicef.org/nutrition/index_24826.html
- xiii <http://sindhbos.gov.pk/wp-content/uploads/2014/09/01-Sindh-MICS-2014-Final-Report.pdf>
- xiv <http://sindhbos.gov.pk/wp-content/uploads/2014/09/01-Sindh-MICS-2014-Final-Report.pdf>
- xv <http://sindhbos.gov.pk/wp-content/uploads/2014/09/01-Sindh-MICS-2014-Final-Report.pdf>
- xvi <http://sindhbos.gov.pk/wp-content/uploads/2014/09/01-Sindh-MICS-2014-Final-Report.pdf>
- xvii https://www.unicef.org/health/index_maternalhealth.html
- xviii <http://sindhbos.gov.pk/wp-content/uploads/2014/09/01-Sindh-MICS-2014-Final-Report.pdf>
- xix http://www.who.int/workforcealliance/knowledge/case_studies/CS_Pakistan_web_en.pdf?ua=1