Nutrition Profile

District Qambar Shahdadkot

Geography[1]

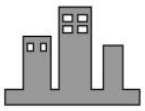
Tehsils/ Talukas:	7
Union Councils:	40

Demography[1]

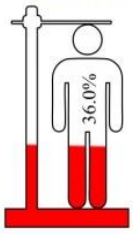
Population 1998:	900,507
Population 2016(est):	1,503,849
Average Household Size:	5.7
Population Growth Rate:	2.89%

Urban/ Rural Population[1]

71 out of 100 persons settled in villages.



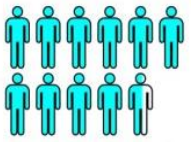
Stunting Prevalence[2]



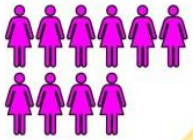
36.0% population lied under severe stunting prevalence.

Sex Ratio[1]

Male
106



Female
100

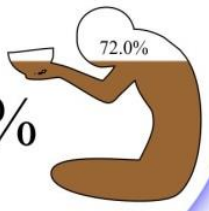


Wasting Prevalence[2]

3.8% population lied under severe wasting prevalence.

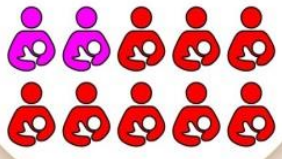
Poverty Rate[3]

72.0%



Breast Feeding[2]

2 out of 10 children are exclusively breastfed.

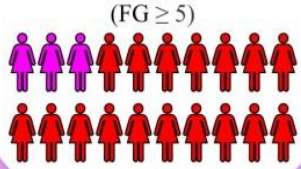


WASH[2]

86.3% population uses improved sources of drinking water.

MDD-W[4]

Only 3 out of 20 women of reproductive age take adequate amount of diversified food groups. (FG ≥ 5)



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. Qambar Shahdadkot District

Qambar Shahdadkot district, founded in 1713, comprises seven talukas (namely Warah, Qambar, Kubo Saeed Khan, Shahdadkot, Sujawal Junejo, Mir Khan and Nasirabad). The district has a total geographical area of 5,675 square kilometres[1] and has Shahdadkot city as its capital. It shares a border with the districts of Jacobabad, Larkana and Dadu. The geographical position of the district is depicted below in Figure 1:

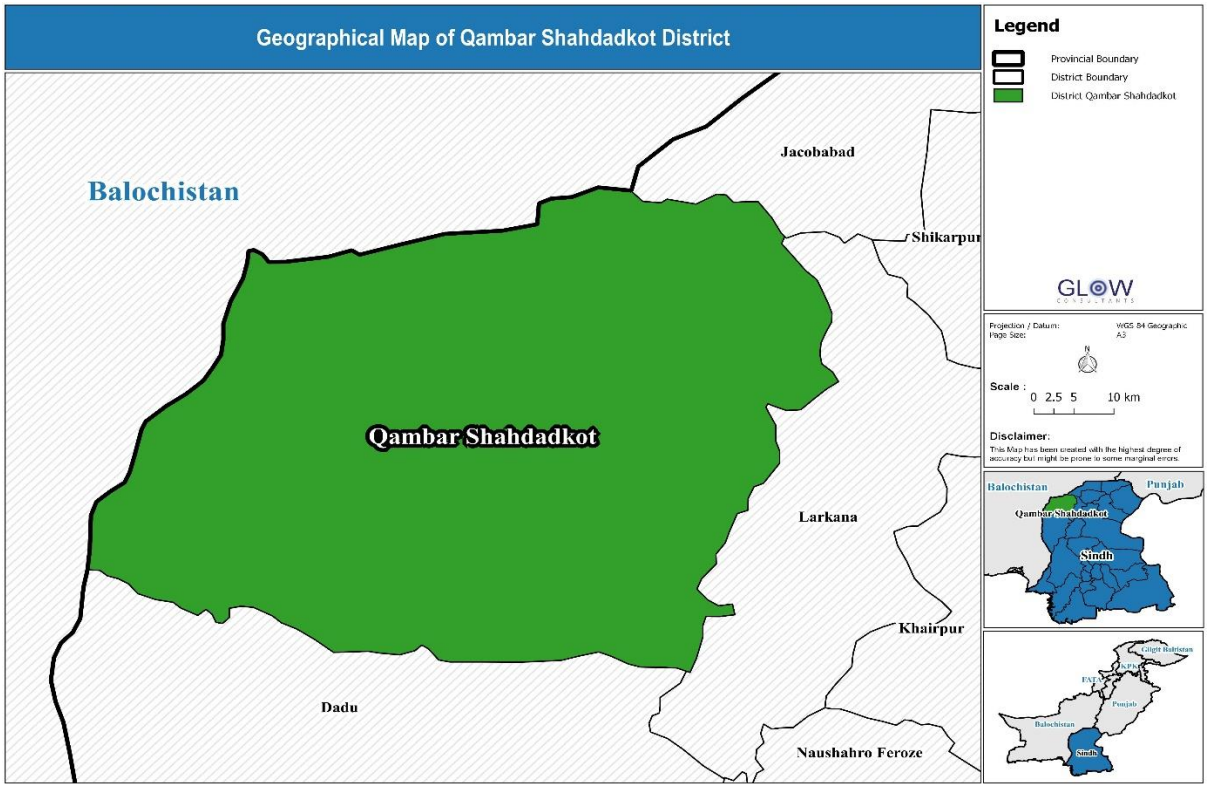


Figure 1: Geographical Map of Qambar Shahdadkot District

2. Overall Development Situation in Qambar Shahdadkot District

According to the 2013 Human Development Index (HDI), Qambar Shahdadkot is an underdeveloped district with a value of 0.35, 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 a rank below 0.555 signifies Low Human Development.

When compared with the neighbouring districts, Qambar Shahdadkot appears to be in last place as shown in Figure 2 below[i]. Qambar Shahdadkot and all of its neighbours are underdeveloped districts.

[1] USAID/IMMAP Pakistan Emergency Situation Analysis - District Qambar Shahdadkot, August 2014 Page i

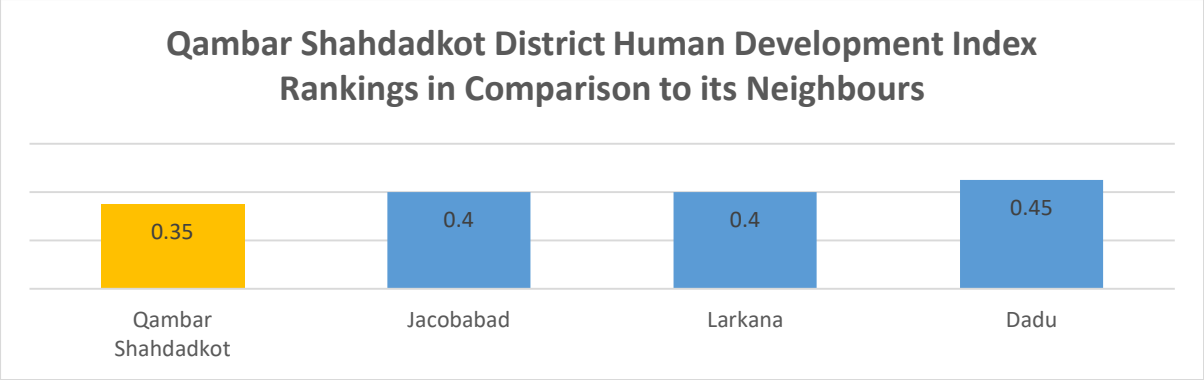


Figure 2: HDI Ranking of Qambar Shahdadkot District and its Neighbours

3. Demographics

According to a 2016 estimate, Qambar Shahdadkot district has an estimated population of 1,503,849 individuals (with an annual population growth rate of 2.89%). In 1998, the current area constituting Qambar Shahdadkot had a population of 900,507. The 1998 census reported the Male-to-Female ratio to be 51.5:48.5, which is also the figure reported by the EU Programme for Improved Nutrition in Sindh (PINS) survey in the district.

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

Table 1: Age of the Population in Qambar Shahdadkot District

Age Group	Male (%)	Female (%)	Total
0-5	11.1%	10.8%	21.9%
6-14	13.8%	11.7%	25.5%
15-18	7.8%	7.6%	15.4%
19-49	**17.0%**	**17.0%**	**34.0%**
50-59	1.6%	1.3%	2.9%
60+	**0.2%**	**0.1%**	**0.3%**
Total	51.5%	48.5%	100.0%

Qambar Shahdadkot, like most districts in Sindh, can be characterised as rural since 71% of the population resides in rural areas as compared to the 29% that resides in urban areas[ii]. According to census data, the average household size is 5.7 members but based on the profiling survey, the average household size is 5.8 members. The Sindhi language is spoken by 95.08% of the total population followed by Urdu (3.57%), Punjabi (0.5%) and Balochi (0.5%). The remaining 0.35% of the population speaks other languages (see Table 2 for key population and demographic figures for the district).

Table 2: Key Figures for Qambar Shahdadkot District

Population 1998	900,507
Estimated Population 2016	1,503,849
Males	774,482 (51.5%)
Females	729,367 (48.5%)
Urban	436,116 (29%)
Rural	1,067,732 (71%)
Languages Spoken	Sindhi (95.08%)
	Urdu (3.57%)
	Punjabi (0.5%)
	Balochi (0.5%)
	Others (0.35%)
Population Annual Growth Rate (1981-1998)	2.89%
Total Households (est. 2016)	263,833
Average Household Size	5.7 persons per household
Population Density	255 persons per km^2
Total Area	5,675 km^2

4. Poverty Status

According to the Multidimensional Poverty Report (MPR) of 2014/15, Qambar Shahdadkot has witnessed an improvement over the years.[2] In 2008/09, 83.4% of the population of the district was living below the poverty line but this fell to 72% in 2014/15[iii].

According to the poverty scorecard survey conducted by the Rural Support Programme Network (RSPN) under the Sindh Union Council and Community Economic Strengthening Support (SUCCESS) project, Qambar Shahdadkot has a poverty rate of 50.2%. This survey collected and analysed data against various indicators[iv].

55.8% of the households in Qambar Shahdadkot do not own any durable goods, 32% do not own any productive assets and 78.9% 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 land[3].Around 4.4% of the population consists of widows/widowers, 0.1% is divorced and 0.2% is separated[4].

[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

5. Economy and Agriculture

According to the EU PINS Survey, in Qambar Shahdadkot district 81.5% of the households had an income of PKR 10,000 or below, 16.3% had an income of PKR 10,001-15,000 and 2.2% had an income of PKR 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 9,150.

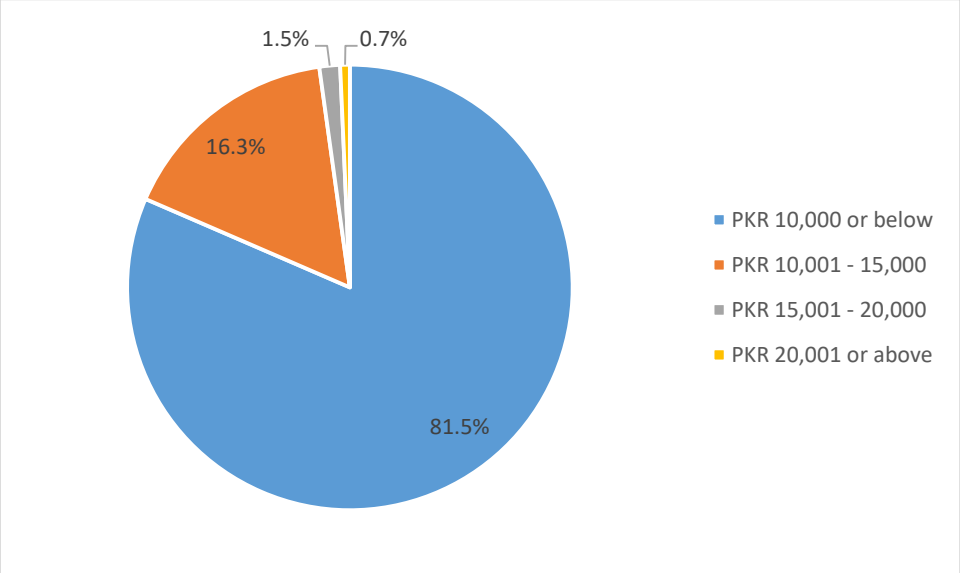


Figure 3: Household Income

In Qambar Shahdadkot district 83% of the households had a monthly expenditure of PKR 10,000 or below, 11.3% 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 8,245 per household per month in Qambar Shahdadkot. Food constitutes by far the most important item of household expenditure followed by health. Almost 3% of the households are making regular payments with regard to debt (the amount of debt being below PKR 10,000 in 100% of cases).

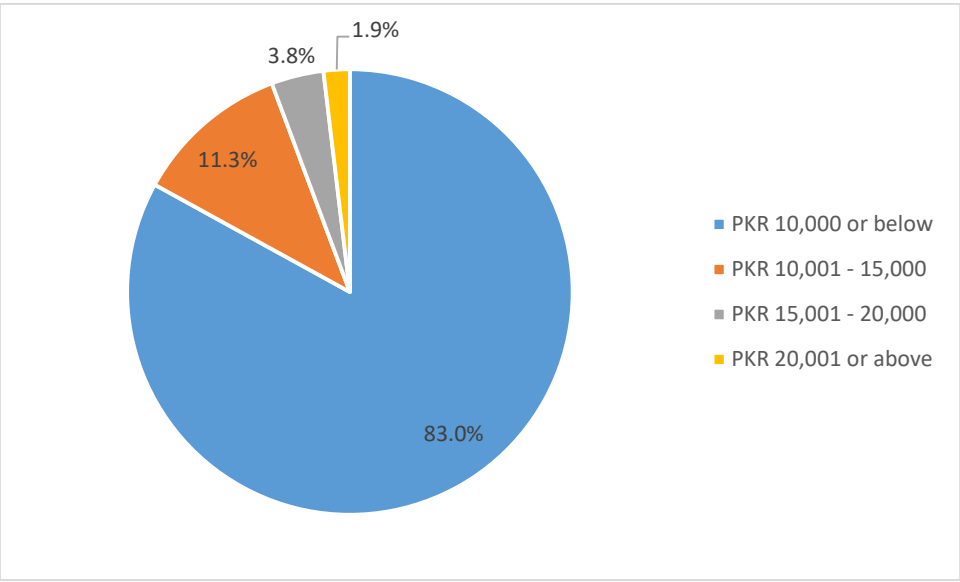


Figure 4: Household Expenditure

In 97.4% of households in Qambar Shahdadkot, there is only one earner while 2.6% of households have two earners. Of all the households in Qambar Shahdadkot, 46.3% are earning below PKR 10,000 per month and 53% 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, Qambar Shahdadkot District

Income (PKR)	Number of Earners					Total
	1	2	3	4	5 or more	
< 10,000	45.6	0.7	-	-	-	**46.3**
10,000 – 20,000	51.1	1.9	-	-	-	**53.0**
20,001 – 30,000	-	-	-	-	-	**0.0**
30,001 – 40,000	-	-	-	-	-	**0.0**
40,001 – 50,000	-	-	-	-	-	**0.0**
> 50,000	0.7	-	-	-	-	**0.7**
% of all households	**97.4**	**2.6**	**0.0**	**0.0**	**0.0**	**100.0**

Data Source: CARDNO PINS Survey 2017

Paid unskilled non-agricultural labour (50%), paid skilled non-agricultural labour (32.1%), skilled agricultural labour (2.3%) and small business/self-employed (1%) are the main sources of income as can be seen in the pie chart in Figure 5 below.

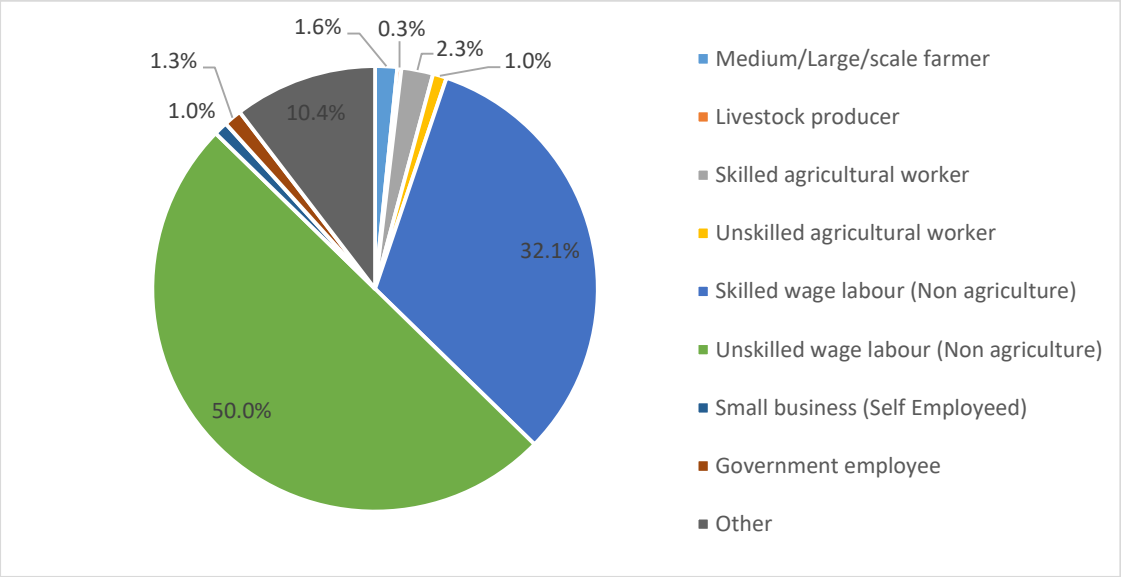


Figure 5: Sources of Household Income

The rainy season in Qambar Shahdadkot district 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				
Guava					H	H						
Chilli peppers		P					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 99% of the women in Qambar Shahdadkot had consumed fish at least once in the 12 months prior to the survey, while those who did not consume it mentioned religion, health and affordability as the 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 95% of the women participating in the survey consumed fish at least once in the last one month. Average fish consumption across 73% 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 Qambar Shahdadkot 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 Qambar Shahdadkot.

Guava, mango, banana and papaya are the main fruits produced in the district and chilli, turnip, pea, carrot, 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. Guava is a fruit of high nutritive value produced in the district which has five times the vitamin A content of an orange and also contains protein, fibre, folic acid and vitamin C.

6. Water and Sanitation

According to the Sindh Multiple-Indicator Cluster Survey (MICS) of 2014, 86.3% of the population in Qambar Shahdadkot has access to improved sources of drinking water. 8.3% of people are using piped water, 76.5% people are using drinking water from protected wells, 0.1% are sourcing their drinking water from hand pumps and 0.2% are collecting rainwater for drinking purposes (see Figure 6).

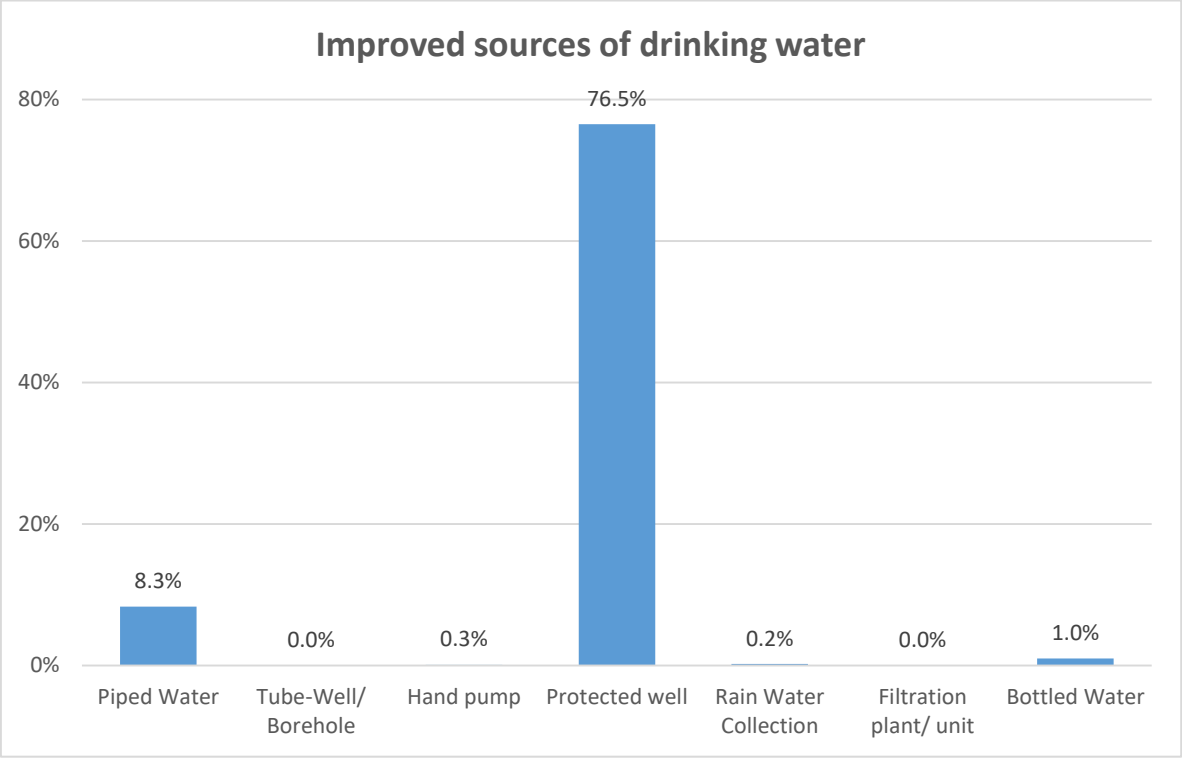


Figure 6: Improved Sources of Drinking Water

In the case of Qambar Shahdadkot, 2.3% of households have water piped directly to their dwelling while 3.3% have piped water in their yard/plot. A further 76.5% have access to a protected well. 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	2.3%
		Into yard/plot	3.3%
		To neighbour	0.8%
		Public tap/stand-pipe	1.9%
	Tube-well/Borehole		0.0%
	Hand pump		0.3%
	Protected well		76.5%
	Rainwater collection		0.2%
	Filtration plant/unit		0.0%
	Bottled water		1.0%
Percentage Using Improved Sources of Drinking Water (A)			86.3%
Unimproved Sources	Tanker truck		0.1%
	Unprotected well		1.0%
	Cart with small tank/drum		6.7%
	Surface water		4.3%
	Bottled water		0.1%
	Other		1.5%
Percentage Using Unimproved Sources of Drinking Water (B)			13.7%
Total A + B			100.0%

90.3% of households in Qambar Shahdadkot 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
90.3%	1.1%	0.0%	8.1%	0.0%	0.0%	0.6%	0.2%	0.0%

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

58% of people in Qambar Shahdadkot district are using improved sanitation facilities, 23% are using unimproved sanitation facilities and 19% are still practising open defecation as shown in Figure 7 below[vi].

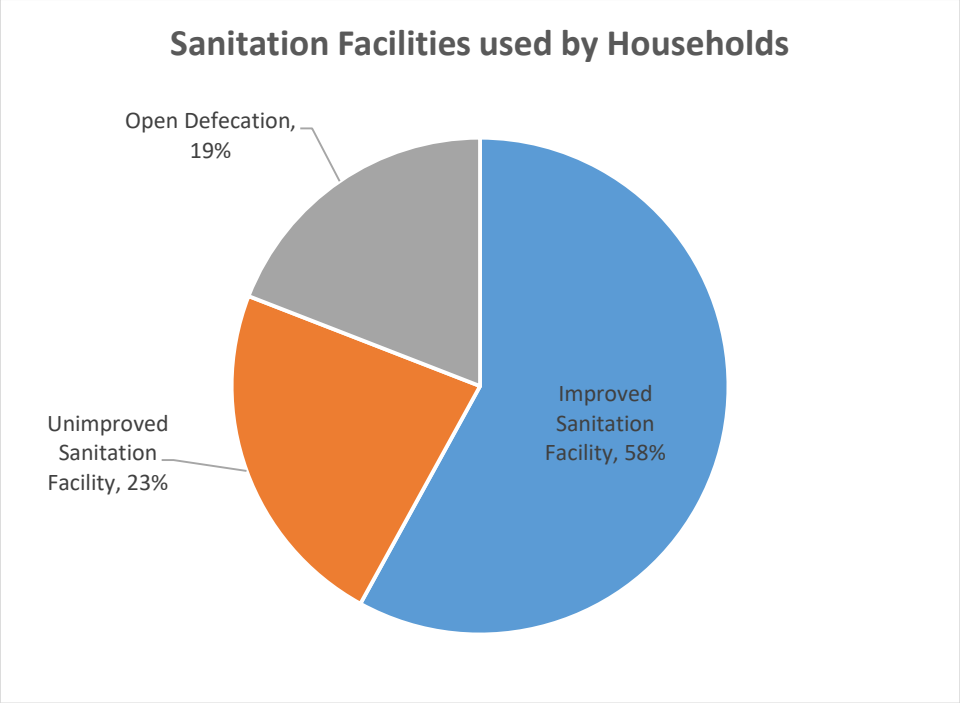


Figure 7: Household Use of Sanitation Facilities

Figure 8 shows that 42% of people in Qambar Shahdadkot are using pour flush latrines, 13.6% use pit latrines with slabs, 2.3% use ventilated improved pit latrines and 0.1% use composting toilets.

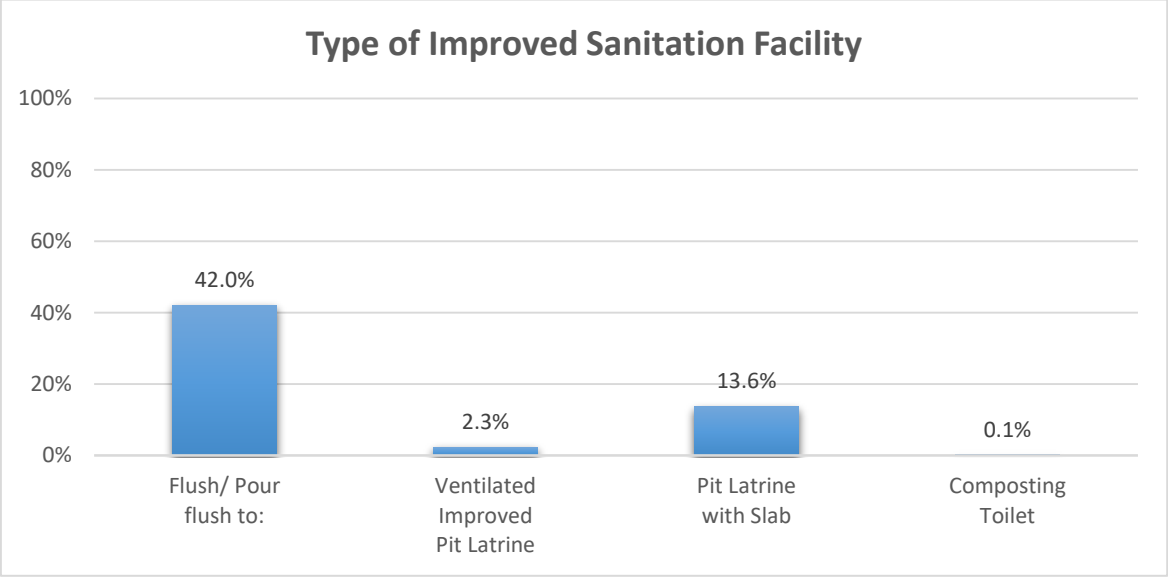


Figure 8: Improved Sanitation Facilities

6.1. Diarrhoea Treatment

Of the total number of children suffering from diarrhoea, 5.4% consulted public doctors or other health service providers and 68.1% 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 26.2% of the children and this reflects the need for increased access to and awareness of health services among the communities in Qambar Shahdadkot.

Table 7 shows the percentage of children with diarrhoea for whom advice or treatment was sought from health facilities or other 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			
5.4%	68.1%	0.0%	0.6%	72.6%	26.2%

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

7. Literacy and Education

In Qambar Shahdadkot district there are a total of 1,631 government schools, of which 93% are primary schools. Of these, 18% are exclusively for girls, 33.1% are for boys and 48.9% are mixed schools. 20.9% of teachers in Qambar Shahdadkot district are female while the remaining 79.1% 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 students[5].

Table 8: Number and Type of Government Schools

Level of Schooling	Nº of Schools	%
Primary	1,516	93.0%
Middle	55	3.4%
Elementary	4	0.2%
Secondary	46	2.8%
Higher Secondary	10	0.6%
Total	1,631	100%

In Qambar Shahdadkot district 38% of boys and 26.2% of girls attend primary school. At secondary level the attendance ratio is 28.7% for boys and 16.8% for girls[vii]. Moreover, 29.4% 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	38.0%	28.7%
Female	26.2%	16.8%

8. Access to Mass Media

As shown in Table 10 below, 0.7% of women aged 15-49 in Qambar Shahdadkot have access to all three types of mass media (newspapers, radio and television) at least once a week. These are

[5] Sindh Educational Profile 2014-15

important means of communicating nutrition messages to the masses (including women), especially in the context of areas like Qambar Shahdadkot.

Table 10: Exposure to Mass Media

Exposure to Mass Media among Women aged 15-49 at least once a week	
Newspapers	8.6%
Radio	7.9%
Television	57.9%
All Three Media	0.7%
Any of the Three Media	61.9%

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 Larkana division which includes Qambar Shahdadkot is 109 deaths per 1,000 live births and the under-five mortality rate is 142 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.

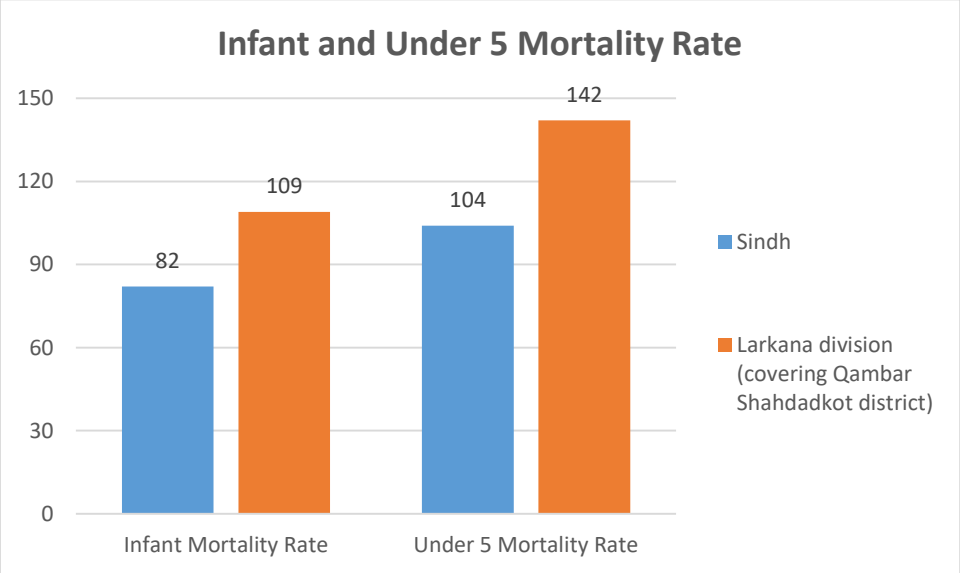


Figure 9: Infant and Under-5 Mortality Rates (per 1,000 live births)

9.2 Nutritional status

26.6% of children aged 0-5 in Qambar Shahdadkot are moderately underweight while 22.2% are severely so (with 48.8% of all children aged 0-5 being of a less-than-healthy weight overall). 24.2% of under-fives are moderately stunted and 36% severely so (with 60.2% of all children aged 0-5 being stunted to some degree overall). 13.7% of under-fives are wasted overall (with 9.9% of all children of this age group showing moderate wasting and 3.8%, 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 Qambar Shahdadkot district. These statistics are sourced from the MICS of 2014/15[ix] and are shown in Figure 10.

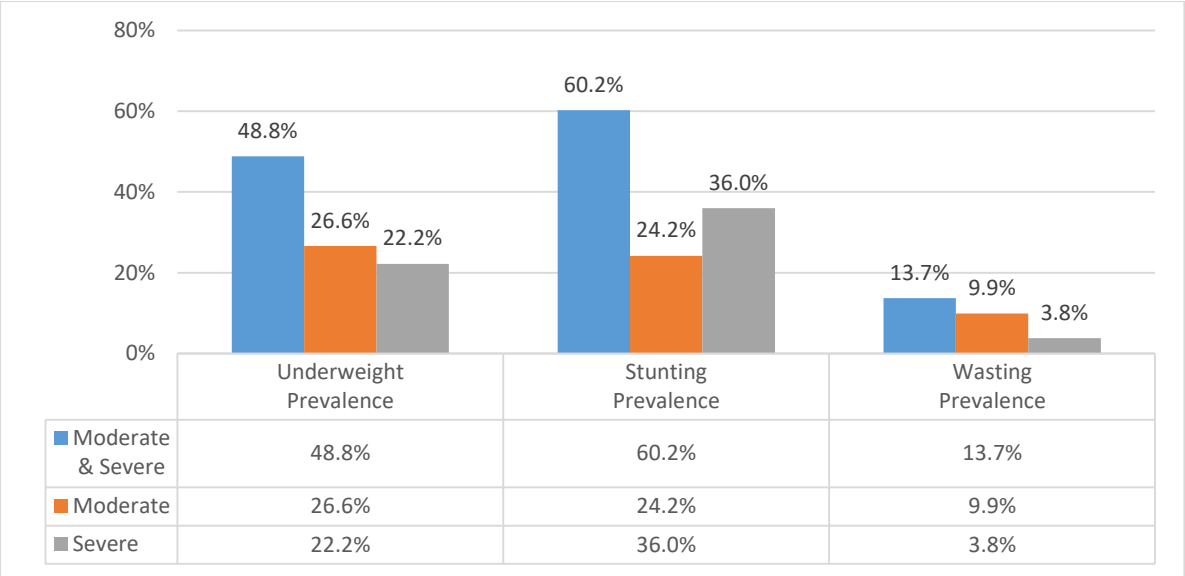


Figure 10: Prevalence of underweight, stunting and wasting

9.3 Breastfeeding and complementary feeding

28.9% of women in Sindh province and 15.9% in Qambar Shahdadkot district practise exclusive breastfeeding during the first six months of life. In Sindh, 56% and in Qambar Shahdadkot 50.8% 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 province overall, only 20.7% of women initiate breastfeeding within one hour of birth. This is even less widely practised in Qambar Shahdadkot district where 17.2% of women initiate breastfeeding within one hour of birth according to MICS 2014/15 data (see Figure 11).

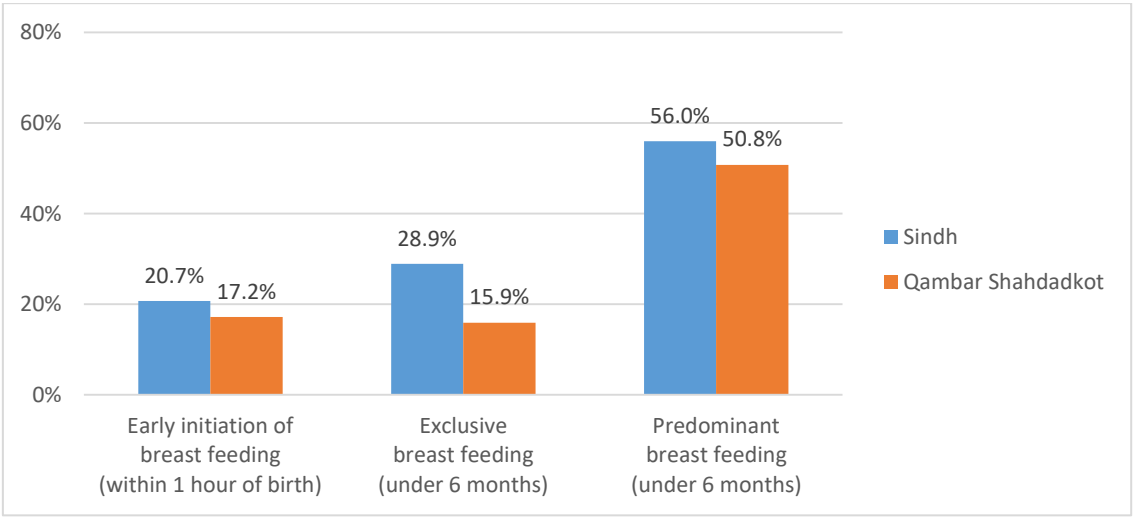


Figure 11: Early-initiation, exclusive and predominant breastfeeding

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 Qambar Shahdadkot, 43.8% are achieving Minimum Meal Frequency (MMF) and 5.7% are achieving Minimum Acceptable Diet (MAD). These figures 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 Qambar Shahdadkot district are presented in Figure 12[xiii].

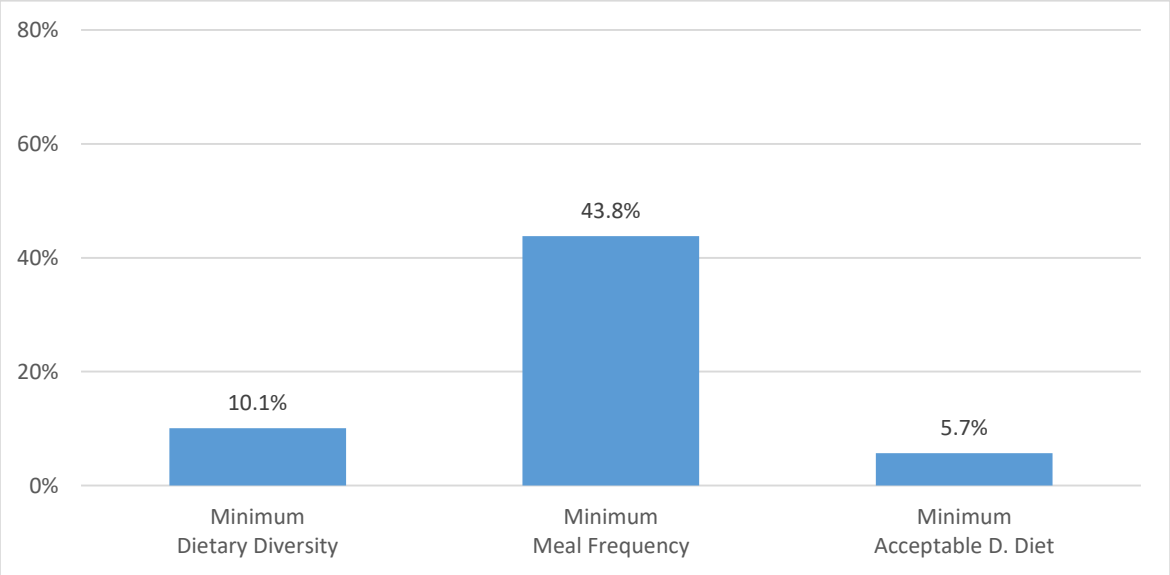


Figure 12: Achievement of Minimum Acceptable Diet, Minimum Meal Frequency and Minimum Dietary Diversity in Qambar Shahdadkot district

9.5 Minimum Dietary Diversity of Women (MDD-W)

Only 16.9% of women of childbearing age (15-49 years) in Qambar Shahdadkot 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 8 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 Qambar Shahdadkot

Food groups consumed	Overall	Agricultural households
Less than 5	83.1%	70.0%
5 or more	16.9%	30.0%

Data Source: CARDNO PINS Survey 2017

The table shows that significantly more women aged 15-49 in agricultural households achieve their MDD-W than in the overall population. Almost 5% of people in Qambar Shahdadkot district are involved in agricultural and/or food production and it would seem that women in these households

are in a better position to maintain a diversified diet than those not involved in agriculture. Agricultural households eat a greater variety of foodstuffs because they grow their own food and are not reliant on markets. 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 Qambar Shahdadkot

Number of food groups consumed	Overall	Agricultural households
At least 1	100%	100%
At least 2	85.9%	90.0%
At least 3	56.4%	75.0%
At least 4	34.6%	45.0%
At least 5	16.9%	30.0%
At least 6	3.6%	30.0%
At least 7	1.5%	5.0%
At least 8	0.3%	0.0%
At least 9	0.0%	0.0%
All 10	0.0%	0.0%

Data Source: CARDNO PINS Survey 2017

In Qambar Shahdadkot district, grains and related foodstuffs have a significant presence in the diet of both agricultural and non-agricultural households and among families of both high and low income. More meat, poultry and fish are consumed in agricultural households than non-agricultural households as reflected in Table 13.

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

Nº	Food Group	Overall	Agricultural Households
1	Grains, white roots and tubers, plantains	100%	100%
2	Pulses (beans, peas, and lentils)	50%	60%
3	Nuts and seeds	1%	0%
4	Dairy	71%	55%
5	Meat, poultry and fish	7%	20%
6	Eggs	32%	45%
7	Dark-green leafy vegetables	12%	5%
8	Other Vitamin A-rich fruit and vegetables	22%	30%
9	Other vegetables	3%	20%
10	Other fruits	3%	15%

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 ther 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 Qambar Shahdadkot.

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

Nº	Food Group	Overall	Agricultural Households
1	Grains, white roots and tubers, plantains	100%	100%
2	Pulses (beans, peas, and lentils)	41%	43%
3	Nuts and seeds	1%	0%
4	Dairy	66%	50%
5	Meat, poultry and fish	5%	21%
6	Eggs	20%	21%
7	Dark green leafy vegetables	6%	0%
8	Other Vitamin A-rich fruit and vegetables	10%	14%
9	Other vegetables	2%	14%
10	Other fruits	2%	7%

Data Source: CARDNO PINS Survey 2017

Those with adequate food diversity in Qambar Shahdadkot eat significantly more fruit, vegetables (including dark green leafy vegetables) and eggs than those without. There are some variations among these food groups, but this can probably be attributed to the fact that some families are substituting food from one group with another food group. As shown by a comparison of Tables 13 and 14, there are major 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 Qambar Shahdadkot (i.e. those with 5 food groups or more in their diet)

Nº	Food Group	Overall	Agricultural Households
1	Grains, white roots and tubers, plantains	100%	100%
2	Pulses (beans, peas and lentils)	92%	100%
3	Nuts and seeds	3%	0%
4	Dairy	95%	67%
5	Meat, poultry and fish	18%	17%
6	Eggs	89%	100%
7	Dark green leafy vegetables	38%	17%
8	Other Vitamin A-rich fruit and vegetables	79%	67%
9	Other vegetables	8%	33%
10	Other fruits	9%	33%

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 Qambar Shahdadkot, indicating poor maternal and newborn health and nutrition. 30% of babies born in Sindh and 31.2% of those born in Qambar Shahdadkot 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.

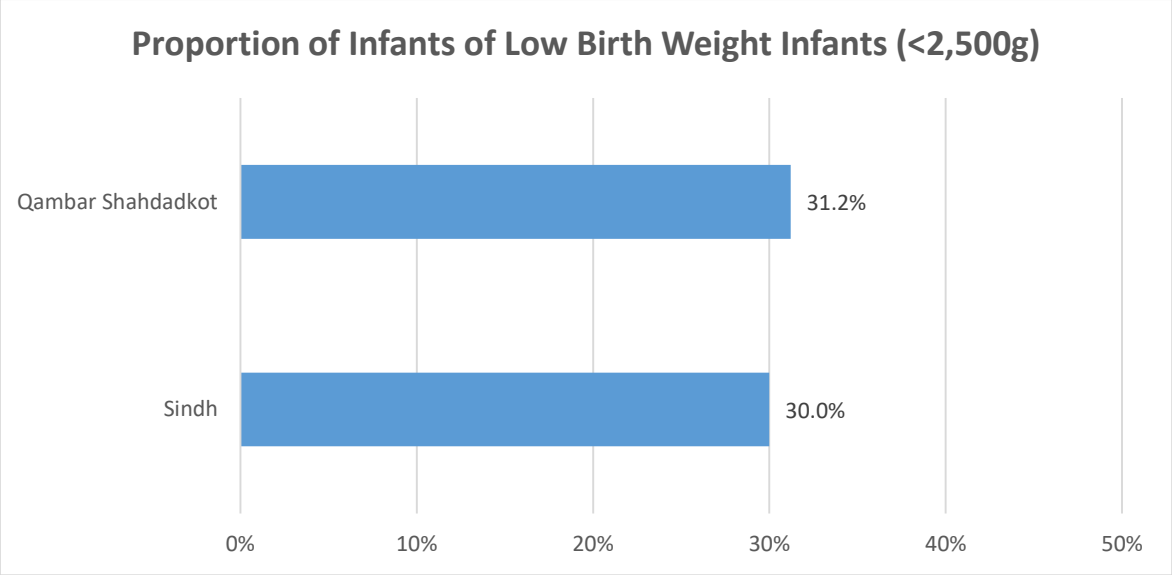


Figure 13: Proportion of Infants of Low Birth Weight (<2,500g)

9.7 Child immunisation

In Qambar Shahdadkot district 22.6% of children aged 12-23 months had received all recommended vaccinations by 12 months of age. 27.8% of children had been vaccinated against measles and 58.1% 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.

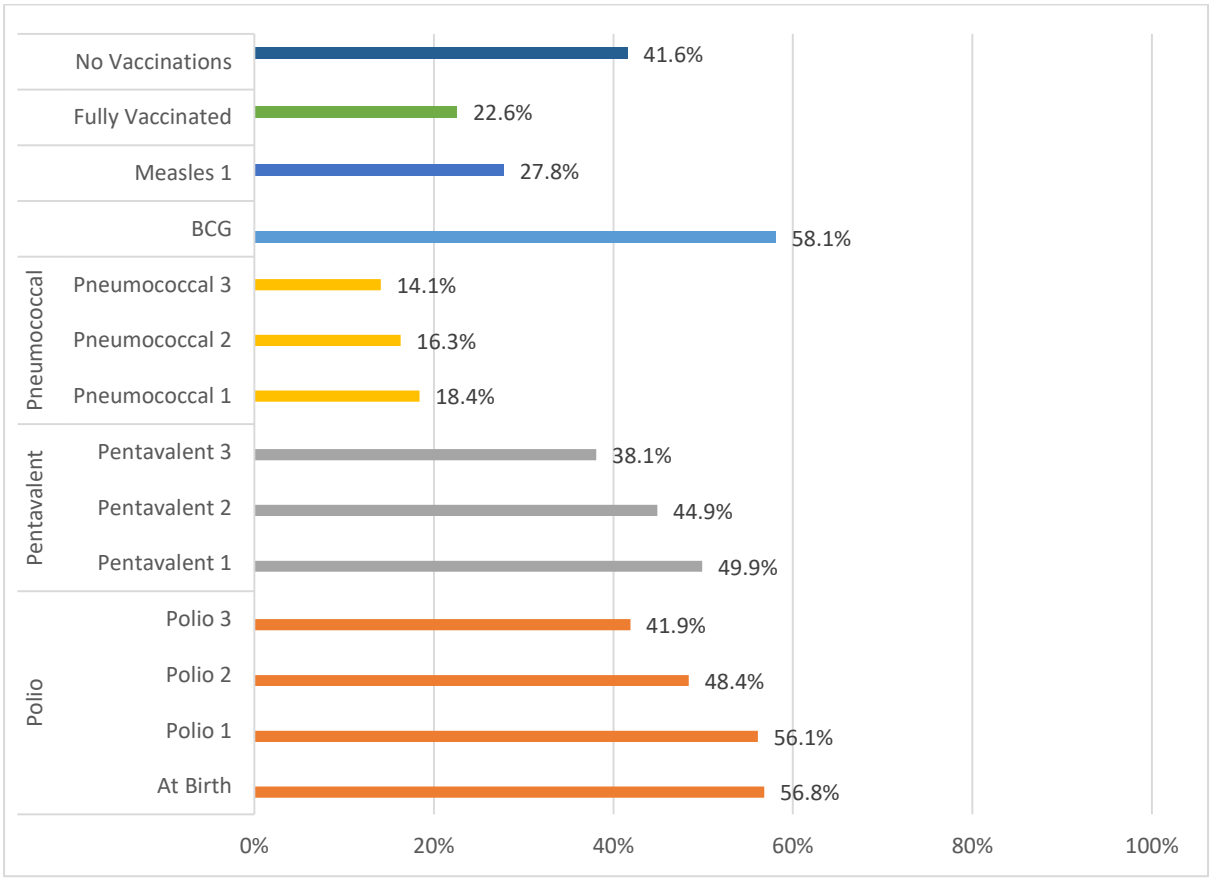


Figure 14: Vaccination of children aged 12-23 months

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

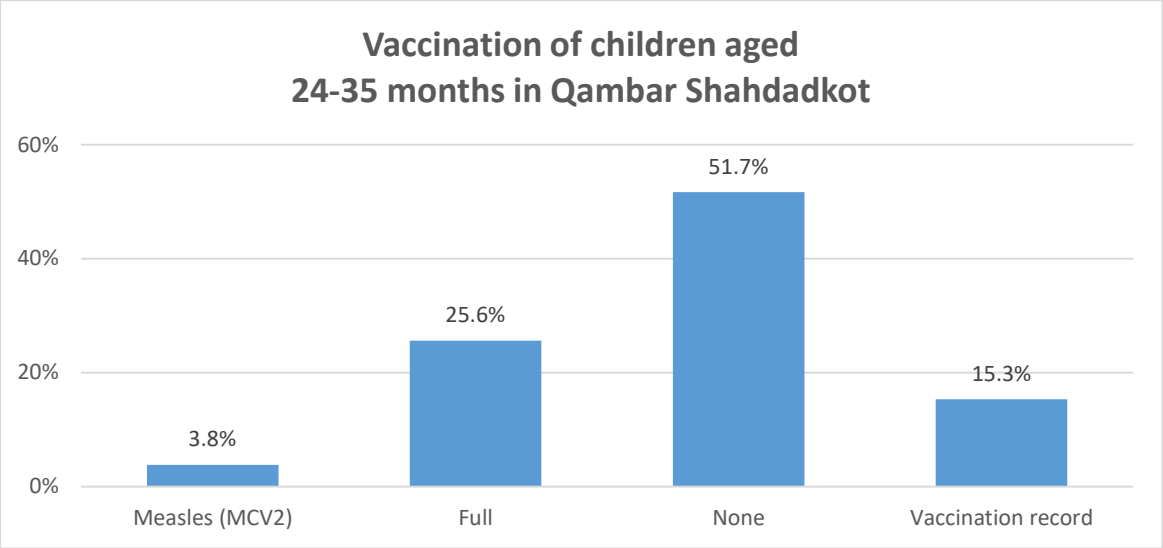


Figure 15: Vaccination of children aged 24-35 months in Qambar Shahdadkot

10. Maternal Health and Nutrition

10.1 Reproductive health

The fertility rate in Qambar Shahdadkot is 6.1 children per woman. 18.4% of women in the district use some form of contraception with 18.2% using modern contraceptive methods[xiv]. The most common contraceptive method is female sterilisation which is currently used by 8.9% of ever-married women.

10.2 Maternal and neonatal health

72.4% of ever-married women in Qambar Shahdadkot have received antenatal care. According to the MICS of 2014/15[xv], 51.1% of all deliveries in Qambar Shahdadkot took place at a health facility with 10.4% occurring in state centres and 40.7% in private centres. The remaining 48.9% 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.

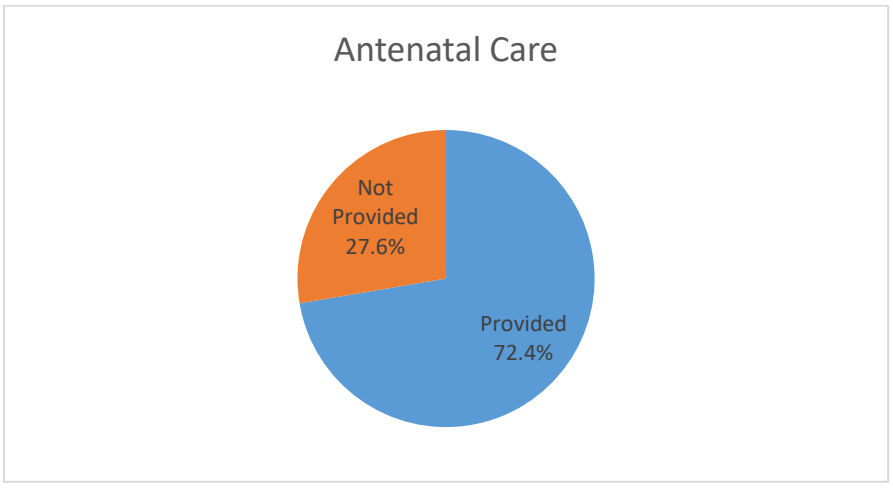


Figure 16: Provision of ANC in Qambar Shahdadkot

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 Qambar Shahdadkot 70.3% 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 Qambar Shahdadkot district.

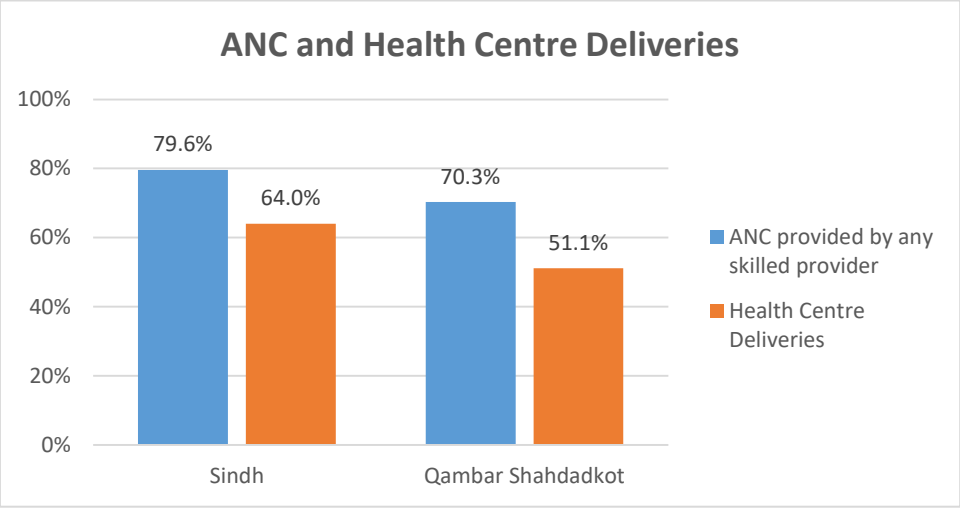


Figure 17: ANC and Health Centre Deliveries

As shown in Table 16, 67.4% of women receive ANC from doctors, 2.9% receive it from nurses and/or midwives, 0.5% receive it from traditional and/or skilled birth attendant and 1.6% receive it from other service providers (total 72.4%). The remaining 27.6% receive no antenatal care.

Table 16: Provision of Antenatal Care

Provision of Antenatal Care							
Medical Doctor	**Nurse/ Midwife**	**Community Midwife**	**Lad Health Visitor**	**Traditional/ Skilled Birth Attendant**	**Lady Health Worker**	**Relative/ Friends**	**Other**
67.4%	2.9%	0.0%	0.0%	0.5%	0.0%	0.0%	1.6%

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

19.5% of women in Qambar Shahdadkot receive or attend one ANC visit, 21.1% have two visits, 10.2% have three visits and 21.6% have four or more visits as shown in Figure 19.

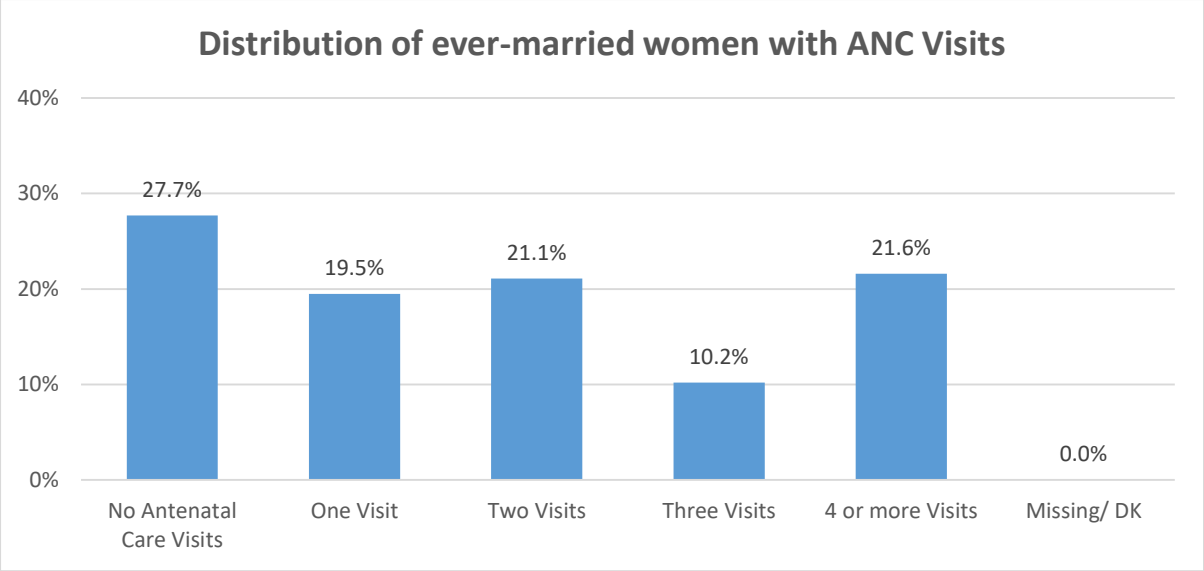


Figure 18: Distribution of ever-married women having ANC visits

In Qambar Shahdadkot, 19.1% of pregnant women have their first ANC during the first trimester. 15.4% first attend at 4-5 months, 22.6% first attend at 6-7 months and 14.9% first attend at 8 months or later (see Table 17).). Data on the remaining 0.4% who receive ANC are missing.

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	
19.1%	15.4%	22.6%	14.9%	0.4%	6

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

10.3 Post-natal care of mothers and children

In Qambar Shahdadkot, 62.9% of newborns and 41.6% of mothers receive a health check following birth in either a facility or at home[xvi]. In Sindh overall, this figure is considerably higher 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].

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 74.8% in Qambar Shahdadkot. In Sindh, 64% of ever-married women live in close proximity to an LHW while this figure is 80.5% in Qambar Shahdadkot[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].

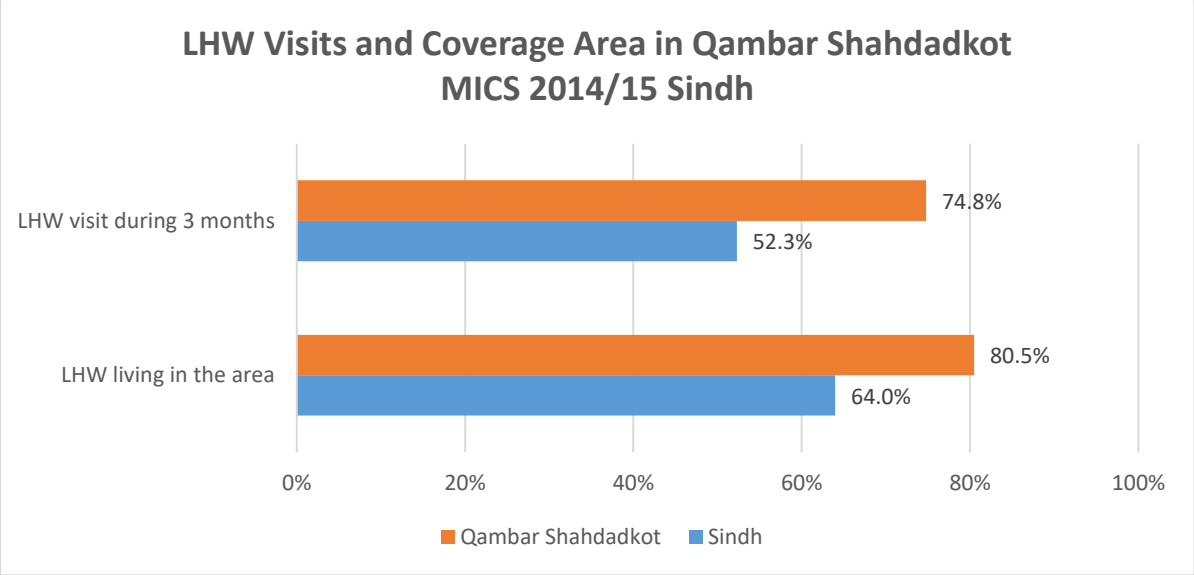


Figure 19: LHW Coverage in Qambar Shahdadkot

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