Nutrition Profile

District Thatta

Geography[1]

Tehsils/ Talukas:	4
Union Councils:	29

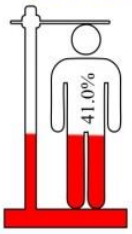
Demography[1]

Population 1998:	625,369
Population 2016(est):	935,062
Average Household Size:	5.1
Population Growth Rate:	2.26%

Urban/ Rural Population[1]

89 out of 100 persons settled in villages.

Stunting Prevalence[2]

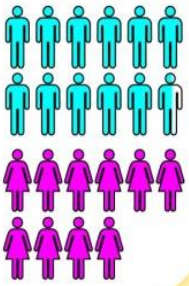


41.0% population lied under severe stunting prevalence.

Sex Ratio[1]

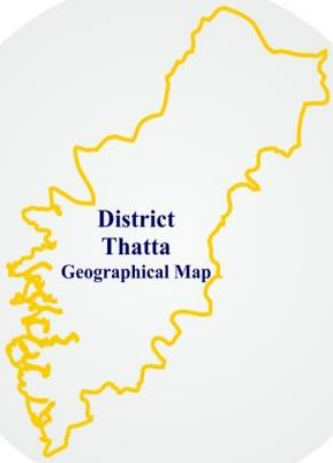
Male 113

Female 100



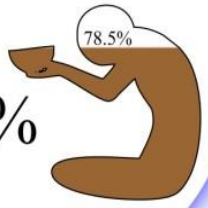
Wasting Prevalence[2]

4.7% population lied under severe wasting prevalence.



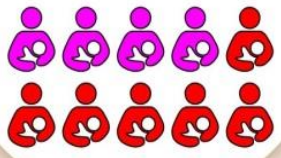
Poverty Rate[3]

78.5%



Breast Feeding[2]

4 out of 10 children are exclusively breastfed.

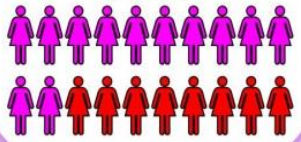


WASH[2]

86.1% population uses improved sources of drinking water.

MDD-W[4]

Only 12 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. Thatta District

Thatta district comprises four talukas (namely Thatta, Mirpur Sakro, Keti Bunder and Ghorabar). The district has a total geographical area of 9,348 square kilometres and has Thatta city as its capital. It shares its borders with the districts of Jamshoro, Hyderabad, Tando Muhammad Khan, Sajjawal and Karachi. The geographical position of the district is depicted below in Figure 1:

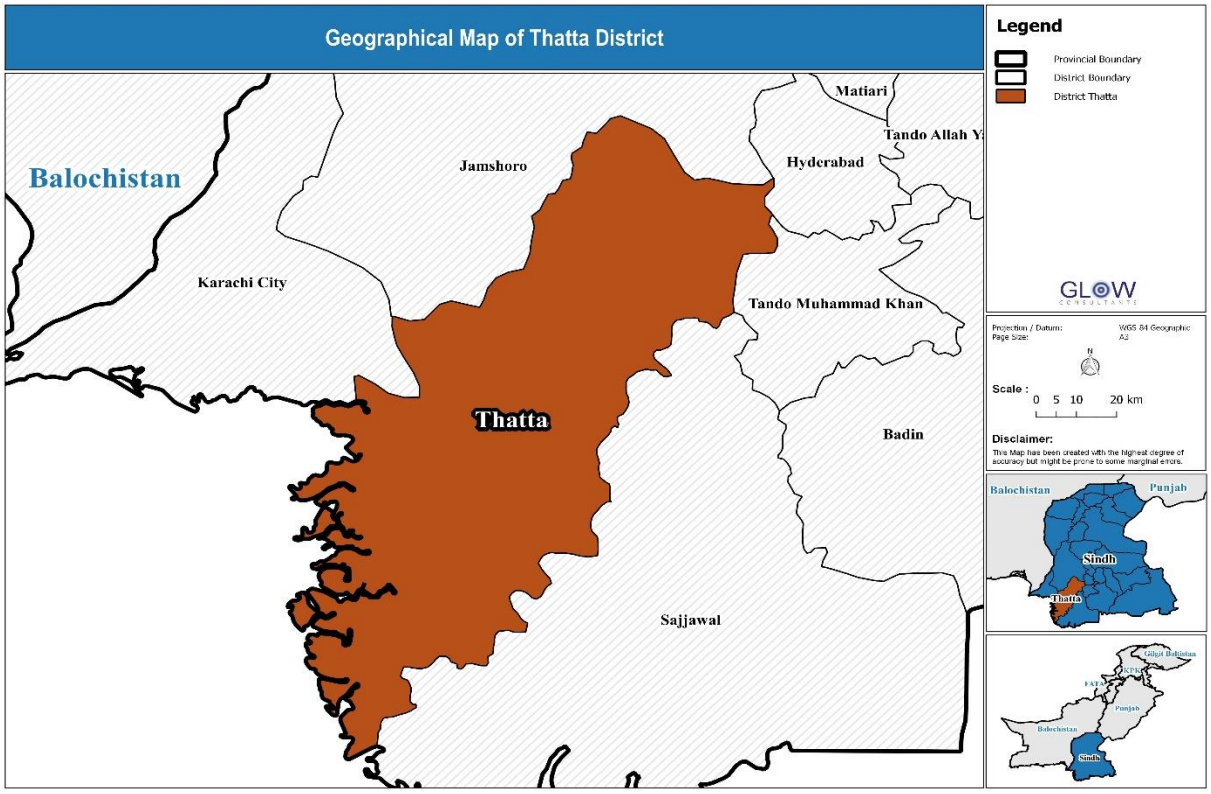


Figure 1: Geographical Map of Thatta District

2. Overall Development Situation in Thatta District

According to the Human Development Index (HDI) of 2013, Thatta is an underdeveloped district with a value of 0.41, 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, Thatta appears to be in joint last place as reflected in Figure 2 below[i]. Thatta and all of its neighbours except Karachi (which is in the Medium Human Development Category) are in the underdeveloped district category.

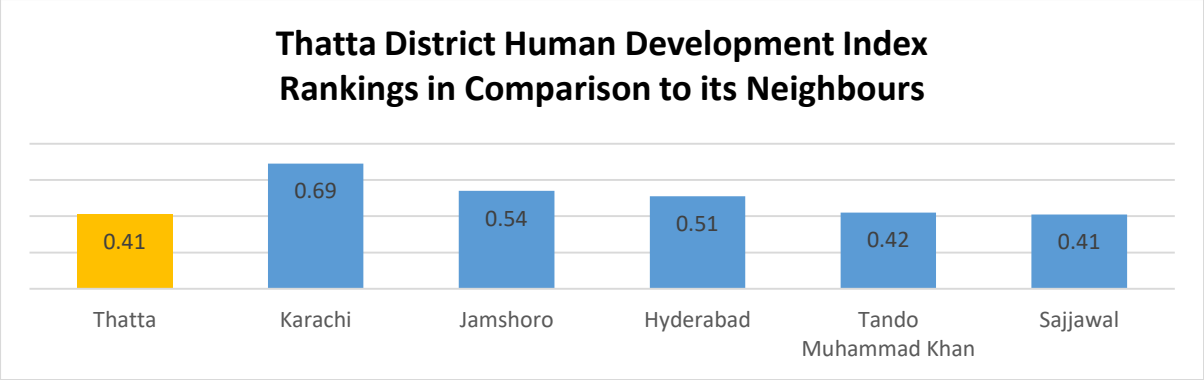


Figure 2: HDI Ranking of Thatta District and its Neighbours

3. Demographics

According to a 2016 estimate, Thatta district has an estimated population of 935,062 individuals (with an annual population growth rate of 2.26%). In 1998, the current area constituting Thatta had a population of 625,369. The 1998 census reported the Male-to-Female ratio to be 53:47 while the EU Programme for Improved Nutrition in Sindh (PINS) survey in the district gave a ratio of 51.1:48.9.

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

Table 1: Age of the Population in Thatta District

Age Group	Male (%)	Female (%)	Total
0-5	11.00%	8.50%	19.50%
6-14	12.94%	12.22%	25.16%
15-18	5.46%	5.06%	10.52%
19-49	**18.65%**	**20.15%**	**38.80%**
50-59	2.63%	2.26%	4.89%
60+	**0.49%**	**0.64%**	**1.13%**
Total	51.17%	48.83%	100.00%

Thatta, like most districts in Sindh, can be characterised as rural since 88.79% of the population resides in rural areas as compared to the 11.21% that resides in urban areas[ii]. According to census data, the average household size is 5.1 members but based on the profiling survey, the average household size is 6.2 members. The Sindhi language is spoken by 93% of the population followed by Urdu (2.1%), Punjabi (1.5%), Balochi (1.2%) and Pashto (1.2%). The remaining 1% of the population speaks other languages (see Table 2 for key population and demographic figures for the district).

Table 2: Key Figures for Thatta District

Population 1998	625,369
Estimated Population 2016	935,062
Males	495,583 (53%)
Females	439,479 (47%)
Urban	104,820 (11.21%)
Rural	830,242 (88.79%)
Languages Spoken	Sindhi (93.0%)
	Urdu (2.1%)
	Punjabi (1.5%)
	Balochi (1.2%)
	Pashto (1.2%)
	Others (1.0%)
Population Annual Growth Rate (1981-1998)	2.26%
Total Households (est. 2016)	183,345
Average Household Size	5.1 persons per household
Population Density	100.03 persons per km^2
Total Area	9,348 km^2

4. Poverty Status

The Multidimensional Poverty Report1 of 2014/15 reports that Thatta has witnessed an improvement over the years. In 2004/05, 84.1% of the population of the district was living below the poverty line whereas in 2014/15, the district registered a poverty rate of 78.5% (a slight increase of 2 percentage points on 2012/13)[iii].

5. Economy and Agriculture

According to the EU PINS Survey, in Thatta district 73% of the households had an income of PKR 10,000 or below, 17% had an income of PKR 10,001-15,000 and 10% had an income of PKR 15,001 or above as can be seen from the pie chart in Figure 3 below. The average income for the surveyed households is PKR 9,397 per household per month.

[1] 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.

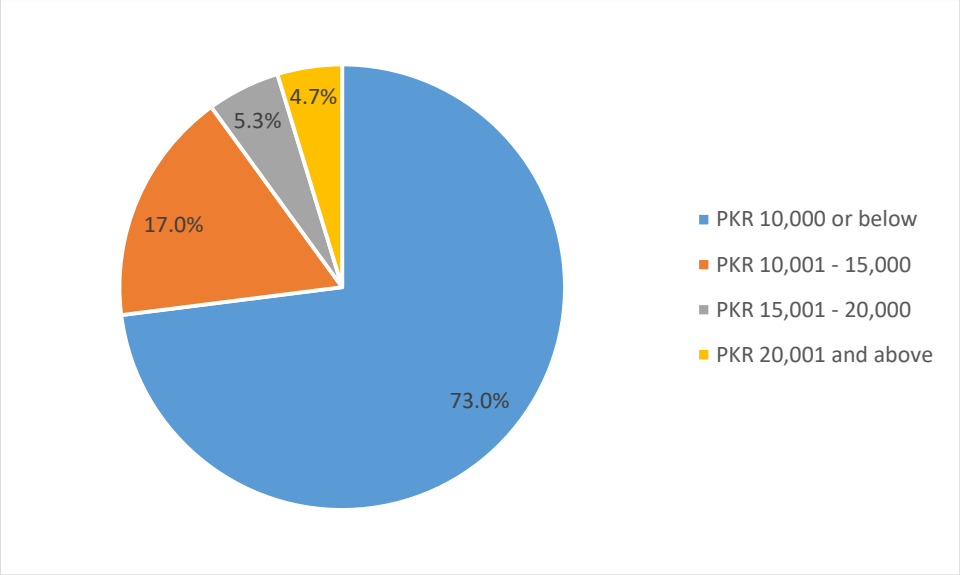


Figure 3: Household Income

In Thatta district 78.2% of the households had a monthly expenditure of PKR 10,000 or below, 15.5% 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. On average, household expenditure is PKR 7,561 per household per month in Thatta. Food constitutes by far the most important item of household expenditure followed by health. Almost 10% of the households are making regular payments with regard to debt (the amount of debt being below PKR 10,000 in 100% of cases).

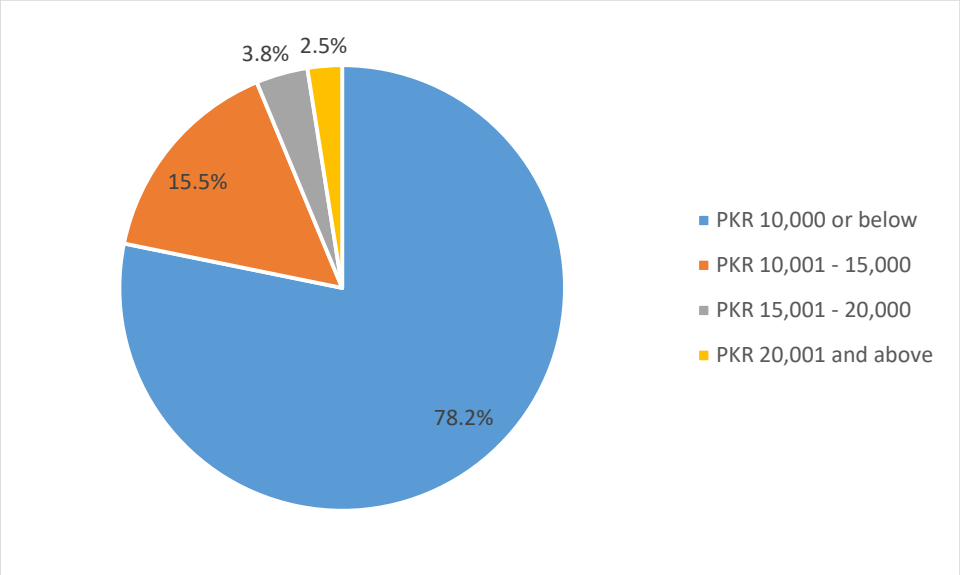


Figure 4: Household Expenditure

In 79.4% of households in Thatta, there is only one earner while 15.2% of households have two earners. Of all the households in Thatta, 67.2% are earning below PKR 10,000 per month and 28% 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, Thatta District

Income (PKR)	Number of Earners					Total
	1	2	3	4	5 or more	
< 10,000	61.6	5.6	-	-	-	**67.2**
10,000 – 20,000	15.4	9.3	2.3	0.5	0.5	**28.0**
20,001 – 30,000	1.6	0.3	1.0	-	0.3	**3.2**
30,001 – 40,000	0.8	-	0.8	-	-	**1.6**
40,001 – 50,000	-	-	-	-	-	**0.0**
> 50,000	-	-	-	-	-	**0.0**
% of all households	**79.4**	**15.2**	**4.1**	**0.5**	**0.8**	**100.0**

Data Source: CARDNO PINS Survey 2017

Paid skilled non-agricultural labour (44.1%), paid skilled agricultural labour (14%), paid unskilled non-agricultural labour (10.3%) and paid unskilled agricultural labour (7.3%) are the main sources of income as can be seen in the pie chart in Figure 5 below.

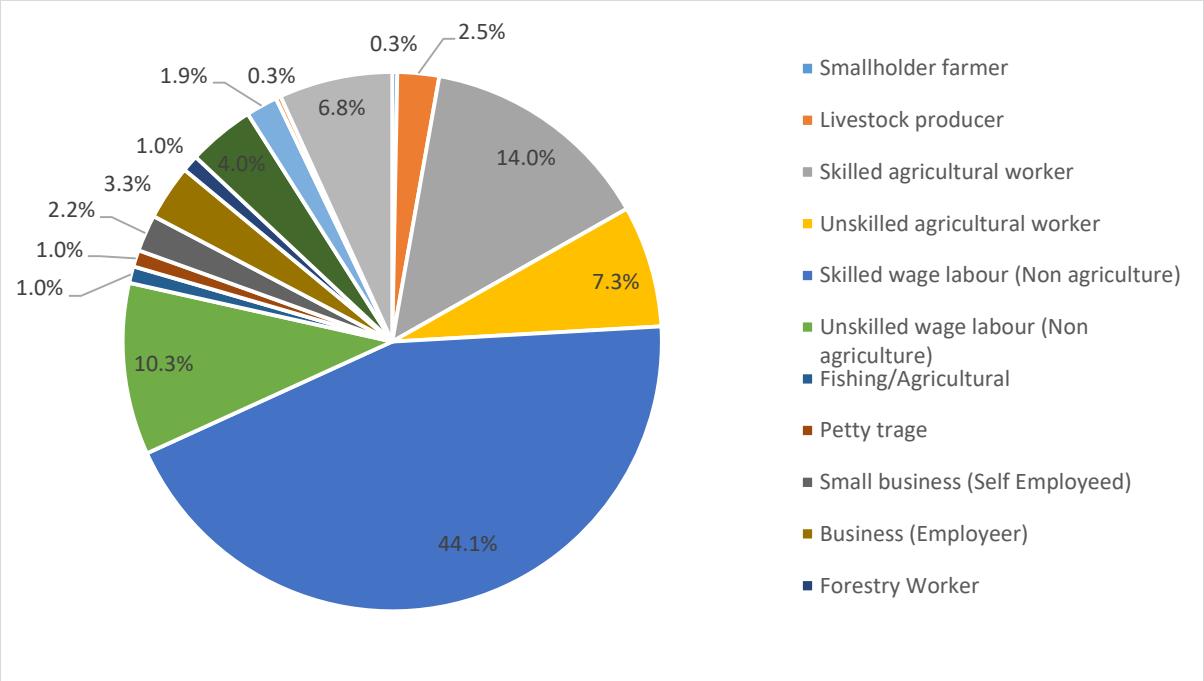


Figure 5: Sources of Household Income

The rainy season in Thatta 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[iv].

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				
Millet (rain-fed)				Planting				Harvest				
Chilli peppers		P					Harvest					
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 reports that almost 78% of the women in Thatta had consumed fish at least once in the last 12 months prior to the survey, while those who did not consume it mentioned religion, health and affordability as the main reasons. 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 the women participating in the survey consumed fish at least once in the last one month. Average fish consumption across 71% of the respondents was 100-150g per person per meal. Fish is eaten twice as often in winter (despite prices being 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 Thatta 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 Thatta.

6. Water and Sanitation

According to the Sindh Multiple-Indicator Cluster Survey (MICS) of 2014, 86% of the population in Thatta has access to improved sources of drinking water. 20.5% of people are using piped water, 57.8% are using drinking water from protected wells, 6% are sourcing their drinking water from hand pumps and 0.3% are collecting rainwater for drinking purposes (see Figure 6 below).

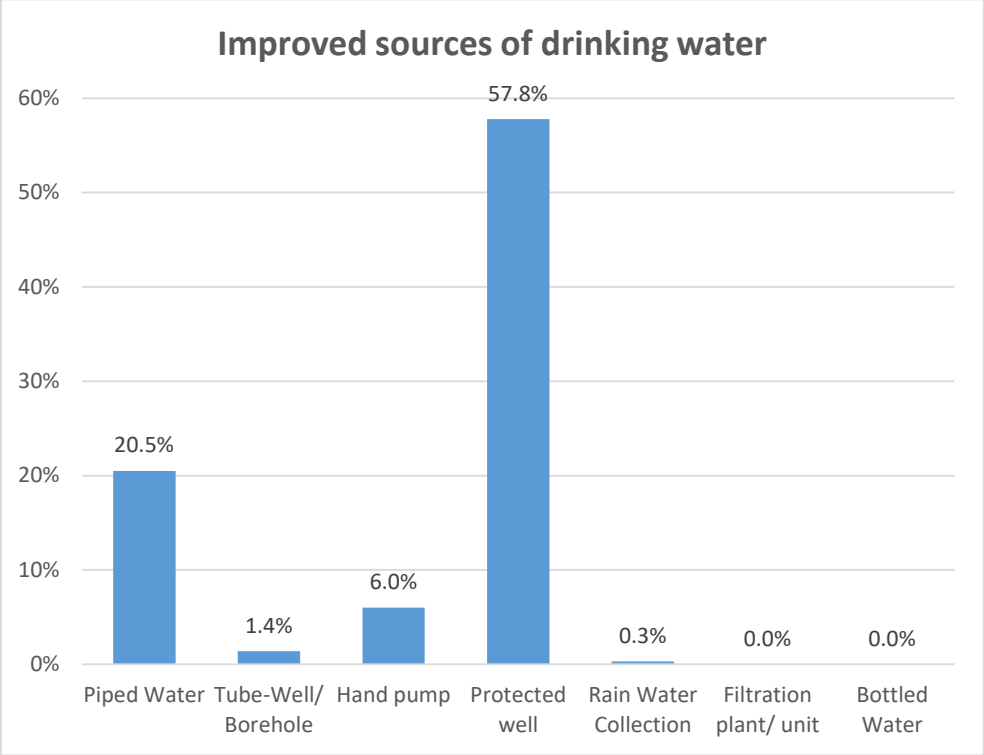


Figure 6: Improved Sources of Drinking Water

In Thatta, 11.1% of households have water piped directly to their dwelling while 2.4% have piped water in their yard/plot. A further 57.8% have access to a protected well and 6% 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	11.1%
		Into yard/plot	2.4%
		To neighbour	3.3%
		Public tap/stand-pipe	3.7%
	Tube-well/Borehole		1.4%
	Hand pump		6.0%
	Protected well		57.8%
	Rainwater collection		0.4%
	Filtration plant/unit		0.0%
	Bottled water		0.0%
Percentage Using Improved Sources of Drinking Water (A)			86.1%
Unimproved Sources	Tanker truck		1.6%
	Unprotected well		0.0%

Main Sources of Drinking Water	Percentage of the population	
	Cart with small tank/drum	0.0%
	Surface water	11.3%
	Bottled water	0.2%
	Other	0.8%
Percentage Using Unimproved Sources of Drinking Water (B)		13.9%
Total A + B		100.0%

77.3% of households in Thatta 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
77.3%	1.1%	0.1%	20.5%	0.1%	0.9%	2.2%	0.2%	0.0%

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

37% of people in Thatta district are using improved sanitation facilities, 8% are using unimproved sanitation facilities and 55% are still practising open defecation as shown in Figure 7 below[v].

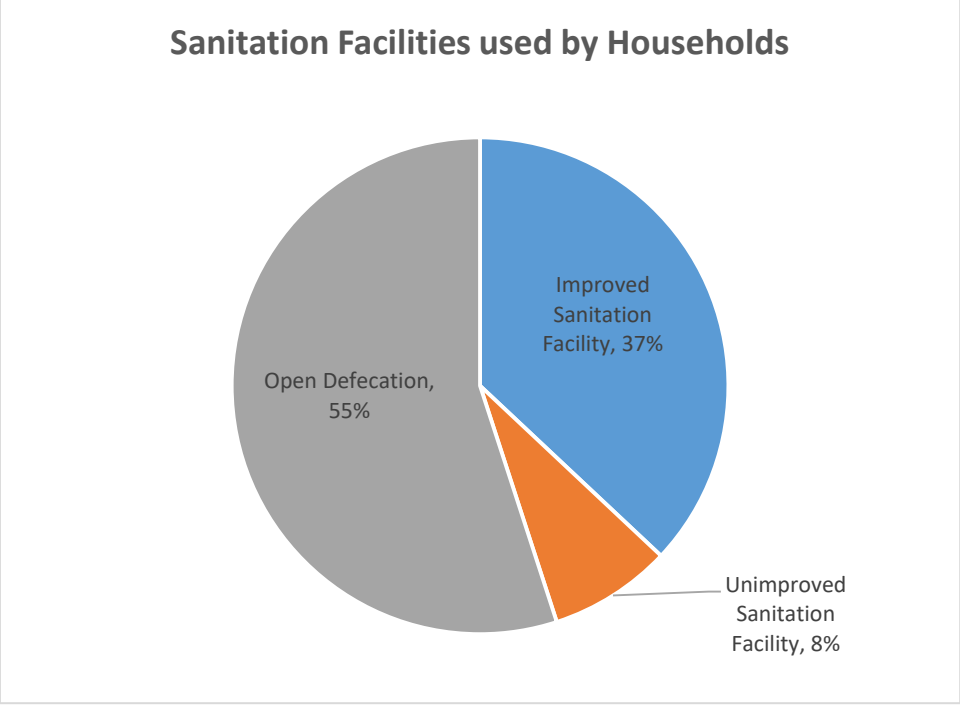


Figure 7: Household Use of Sanitation Facilities

Figure 8 shows that 20% of people in Thatta are using pour flush latrines and 9.4% use ventilated improved pit latrines. 5.2% use pit latrines with slabs and 2% use composting toilets. This totals 36.6% of people using improved sanitation facilities (rounded up to 37%).

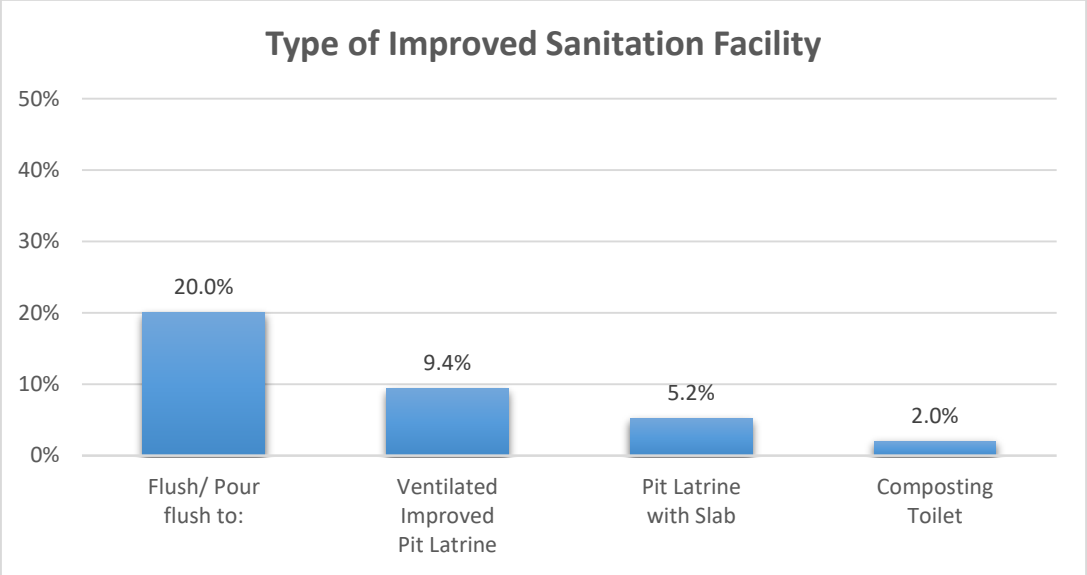


Figure 8: Improved Sanitation Facilities

6.1. Diarrhoea Treatment

Of the total number of children suffering from diarrhoea, 30.1% consulted public doctors or other health service providers and 50.4% 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 26.4% of the children and this reflects the need for increased access to and awareness of health services among the communities in Thatta.

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:					No advice or treatment sought
Health facilities or providers			Other source	A health facility or provider	
Public	Private	Lady health worker			
30.1%	50.4%	0.0%	1.0%	73.0%	26.4%

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

7. Literacy and Education

In Thatta district there are a total of 1,515 government schools, of which 93.9% are primary schools. Of these, 13.4% are exclusively for girls, 50.2% are for boys and 36.4% are mixed schools. 24.1% of teachers in Thatta district are female while the remaining 75.9% 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[2].

[2] Sindh Educational Profile 2014/15

Table 8: Number and Type of Government Schools

Level of Schooling	N° of Schools	%
Primary	1,422	93.9%
Middle	43	2.8%
Elementary	5	0.3%
Secondary	38	2.5%
Higher Secondary	7	0.5%
Total	1,515	100%

In Thatta district 44% of boys and 28.6% of girls attend primary school. At secondary level the attendance ratio is 15.4% for boys and 6.8% for girls[vi]. Moreover, 15.1% 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. For every 100 boys attending primary school, 86 girls are also attending. This falls to 81 girls for every 100 boys attending secondary school. 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	44.0%	15.4%
Female	28.6%	6.8%

8. Access to Mass Media

As shown in Table 10 below, 1.1% of women aged 15-49 in Thatta have access to all three types of mass media (newspapers, radio and television) at least once a week. These are important means of communicating nutrition messages to the masses (including women), especially in the context of areas like Thatta.

Table 10: Exposure to Mass Media

Exposure to Mass Media among Women aged 15-49 at least once a week	
Newspapers	6.6%
Radio	11.4%
Television	38.6%
All Three Media	1.1%
Any of the Three Media	44.4%

9. Infant and Young Child Nutrition and Health

9.1 Infant and young child mortality

The infant mortality rate in Hyderabad division which includes Thatta 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[vii]. These figures reflect a generally worrisome situation around children's health in the district and are shown in Figure 9.

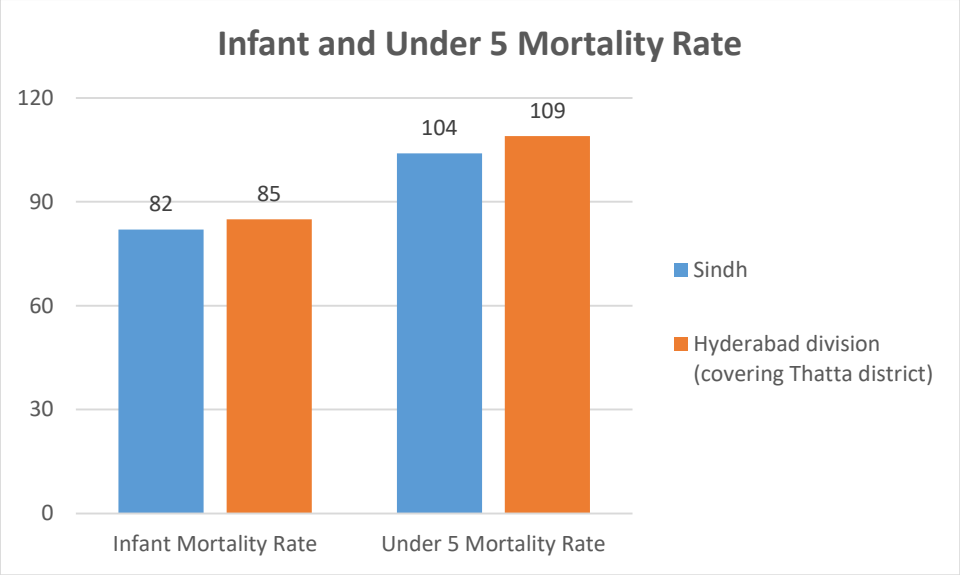
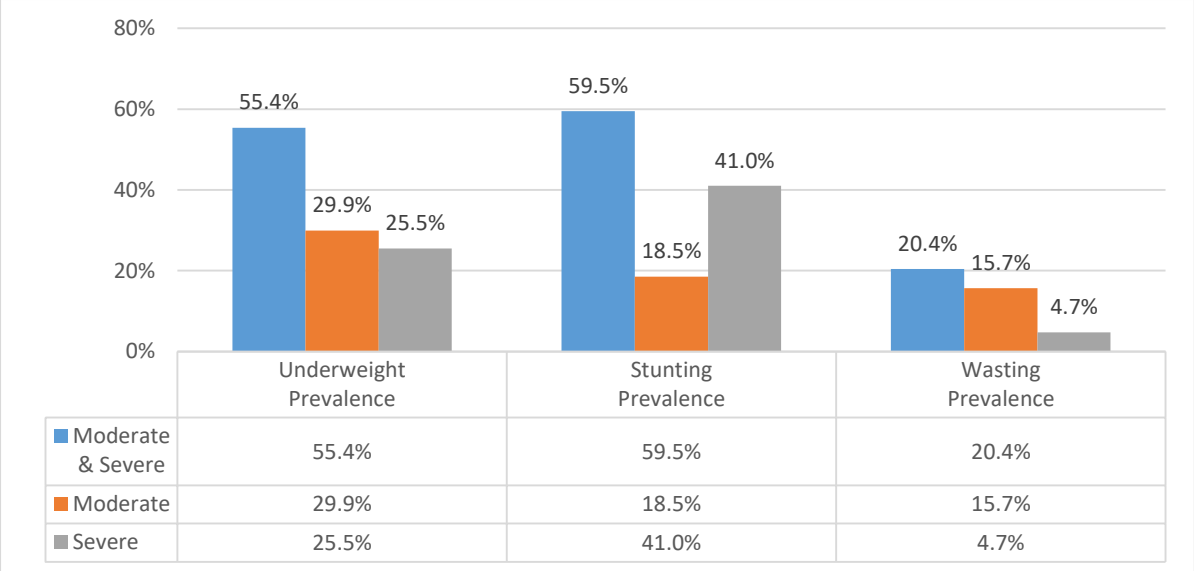


Figure 9: Infant and Under-5 Mortality Rates (per 1,000 live births)

9.2 Nutritional status

29.9% of children aged 0-5 in Thatta are moderately underweight while 25.5% are severely so (with 55.4% of all children aged 0-5 being of a less-than-healthy weight overall). 18.5% of under-fives are moderately stunted and 41% severely so (with 59.5% of all children aged 0-5 being stunted to some degree overall). 20.4% of under-fives are wasted overall (with 15.7% of all children of this age group showing moderate wasting and 4.7%, 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 just 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 Thatta district. These statistics are sourced from the MICS of 2014/15[viii] and are shown in Figure 10.



	Underweight Prevalence	Stunting Prevalence	Wasting Prevalence
Moderate & Severe	55.4%	59.5%	20.4%
Moderate	29.9%	18.5%	15.7%
Severe	25.5%	41.0%	4.7%

Figure 10: Prevalence of underweight, stunting and wasting

9.3 Breastfeeding and complementary feeding

28.9% of women in Sindh province and 44.9% in Thatta district practise exclusive breastfeeding during the first six months of life. In Sindh province, 56% and in Thatta district, 71% of women report predominantly breastfeeding their infants until six months of age[ix]. 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[x]. In Sindh province overall, only 20.7% of women initiate breastfeeding within one hour of birth. This is much more widely practised in Thatta district where 47.4% of women initiate breastfeeding within one hour of birth according to MICS 2014/15 data (see Figure 11).

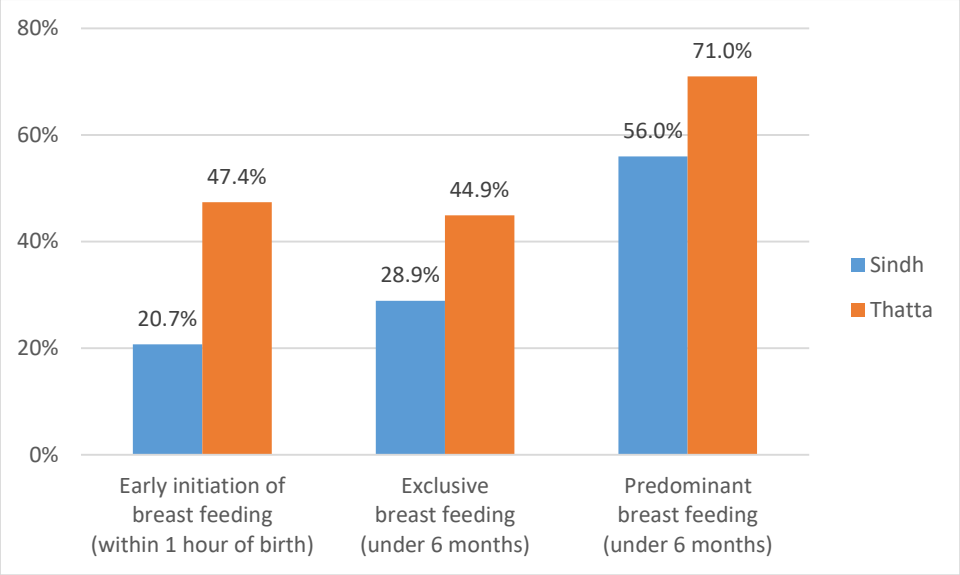


Figure 11: Early-initiation, exclusive and predominant breastfeeding

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

According to MICS 2014/15 estimates, 13.1% of children aged 6-23 months are achieving Minimum Dietary Diversity (MDD) in Thatta district, 47.7% are achieving Minimum Meal Frequency (MMF) and 4.5% 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[xi].

MICS 2014/15 estimates of achievement of MDD, MMF and MAD in Thatta district are presented in Figure 12[xii].

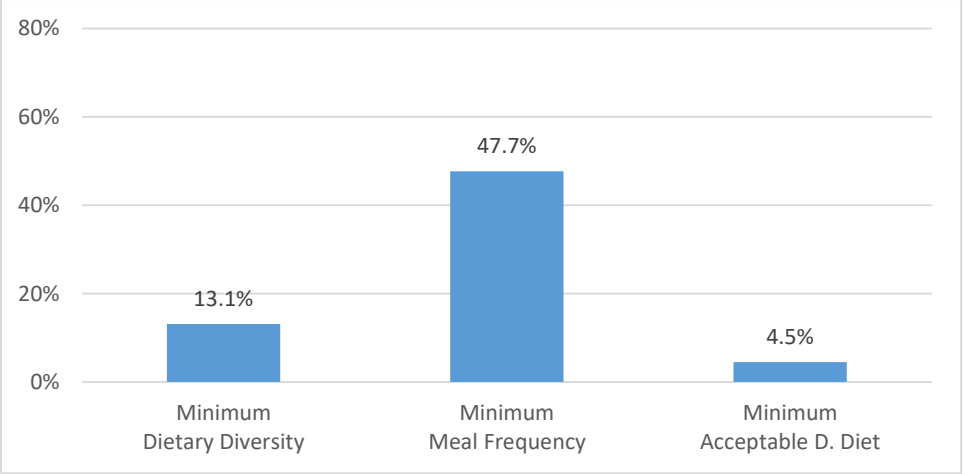


Figure 12: Achievement of Minimum Acceptable Diet, Minimum Meal Frequency and Minimum Dietary Diversity in Thatta district

9.5 Minimum Dietary Diversity of Women (MDD-W)

Only 61% of women of childbearing age (15-49 years) in Thatta 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 6 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 Thatta

Food groups consumed	Overall	Agricultural households
Less than 5	39.0%	53.0%
5 or more	61.0%	47.0%

Data Source: CARDNO PINS Survey 2017

The table shows that significantly fewer women aged 15-49 in agricultural households achieve their MDD-W than in the overall population. In general, agricultural households eat a greater variety of foodstuffs because they grow their own food and are not reliant on markets (but this does not apply to all districts in Sindh). 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 Thatta

Number of food groups consumed	Overall	Agricultural households
At least 1	100%	100%
At least 2	97.5%	96.0%
At least 3	94.0%	93.0%
At least 4	78.0%	67.0%
At least 5	61.0%	47.0%
At least 6	46.5%	33.0%
At least 7	32.3%	22.0%
At least 8	18.3%	14.0%
At least 9	2.0%	0.0%
All 10	0.0%	0.0%

Data Source: CARDNO PINS Survey 2017

In Thatta district, grains and related foodstuffs have a significant presence in the diet of both agricultural and non-agricultural households. Significantly fewer fruits and vegetables are consumed in agricultural than in non-agricultural households as reflected in Table 14.

Table 13: Consumption of Food Groups in Thatta 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)	67%	56%
3	Nuts and seeds	23%	23%
4	Dairy	89%	85%
5	Meat, poultry and fish	60%	59%
6	Eggs	58%	51%
7	Dark green leafy vegetables	14%	9%
8	Other Vitamin A-rich fruit and vegetables	41%	28%
9	Other vegetables	33%	24%
10	Other fruits	47%	37%

Data Source: CARDNO PINS Survey 2017

The diets of women who eat from fewer than five food groups show a significant presence of dairy, eggs and pluses as part of their diet. Tables 13 and 14 provide a breakdown of the consumption of different food groups by those with adequate and inadequate food diversity in Thatta.

Table 14: Key Food Groups consumed by those with inadequate food diversity in Thatta (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)	56%	38%
3	Nuts and seeds	10%	13%
4	Dairy	76%	79%
5	Meat, poultry and fish	31%	43%
6	Eggs	20%	21%
7	Dark green leafy vegetables	6%	8%
8	Other Vitamin A-rich fruit and vegetables	10%	2%
9	Other vegetables	4%	4%
10	Other fruits	8%	9%

Data Source: CARDNO PINS Survey 2017

Those with adequate food diversity in Thatta eat fruit, vegetables (including dark green leafy vegetables) and eggs as part of their routine diet as can be seen in Table 15. 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.

Table 15: Key Food Groups consumed among those with adequate food diversity in Thatta (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)	74%	77%
3	Nuts and seeds	31%	34%
4	Dairy	96%	91%
5	Meat, poultry and fish	77%	77%
6	Eggs	82%	85%
7	Dark-green leafy vegetables	18%	11%
8	Other Vitamin A-rich fruit and vegetables	60%	57%
9	Other vegetables	51%	47%
10	Other fruits	72%	68%

Data Source: CARDNO PINS Survey 2017

9.6 Low birth weight

Low birth weight is witnessed for every third child born in Thatta, indicating poor maternal and newborn health and nutrition. 30% of babies born in Sindh and 30.1% of those born in Thatta 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.

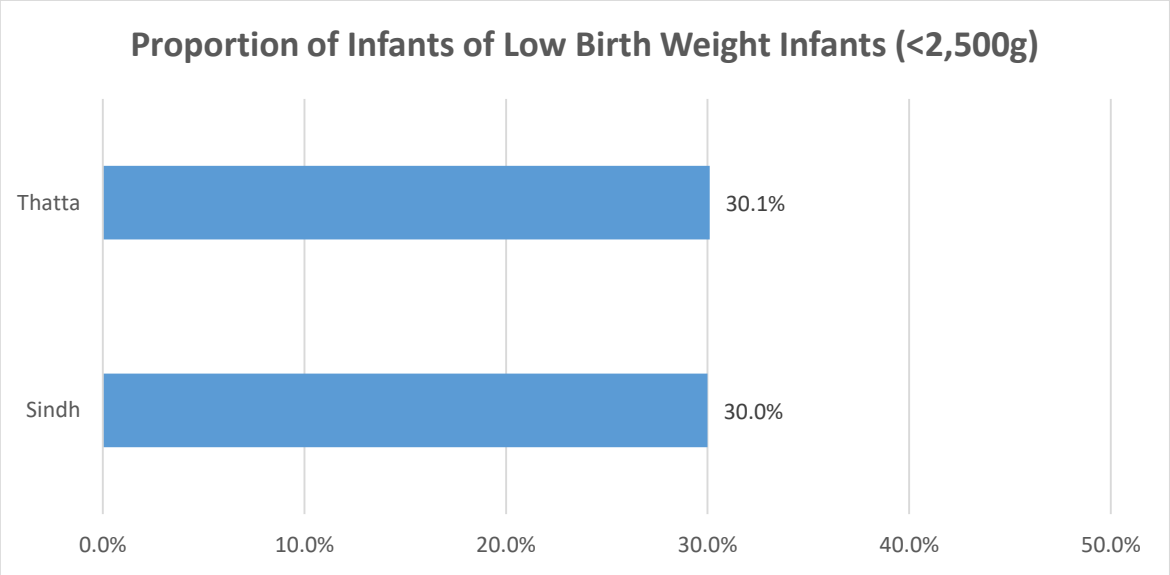


Figure 13: Proportion of Infants of Low Birth Weight (<2,500g)

9.7 Child immunisation

In Thatta district 37.4% of children aged 12-23 months had received all recommended vaccinations by 12 months of age. 57.3% of children had been vaccinated against measles and 82.2% 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.

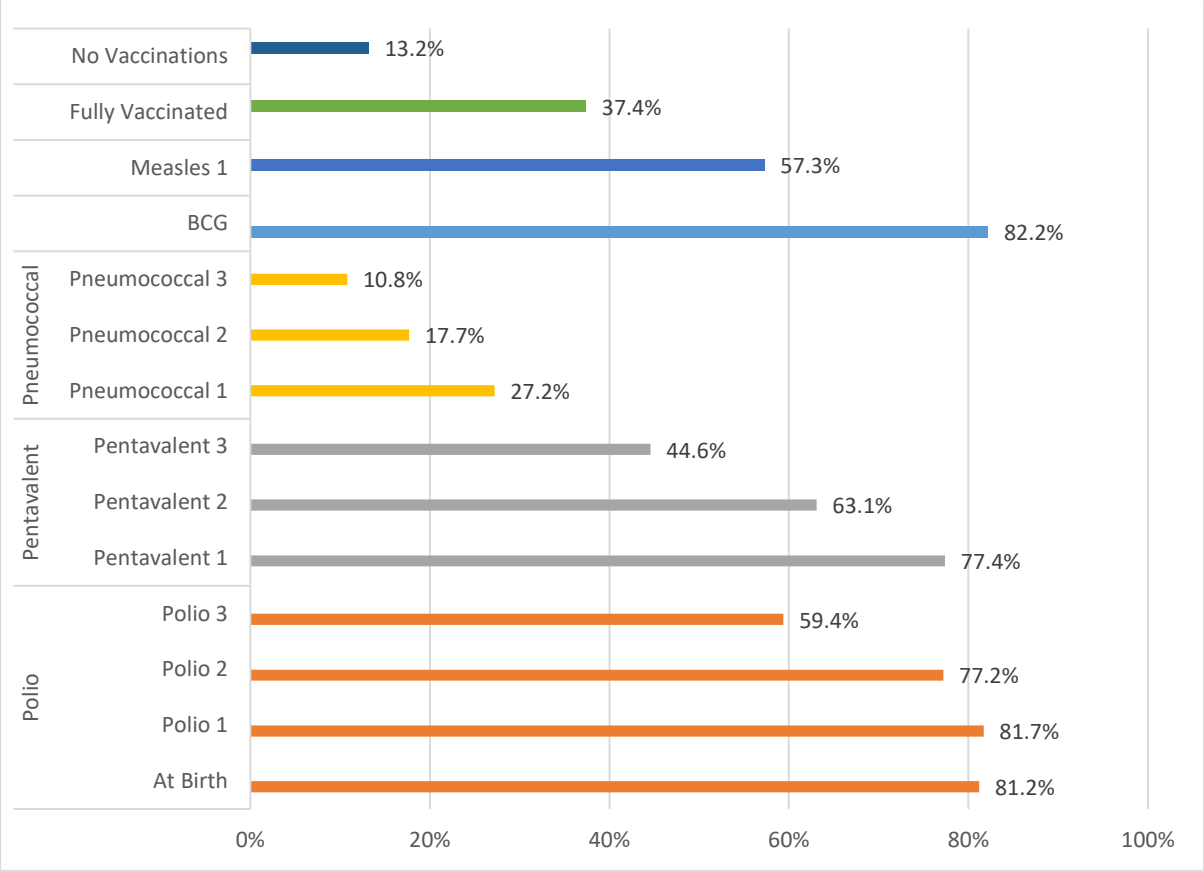


Figure 14: Vaccination of children aged 12-23 months

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

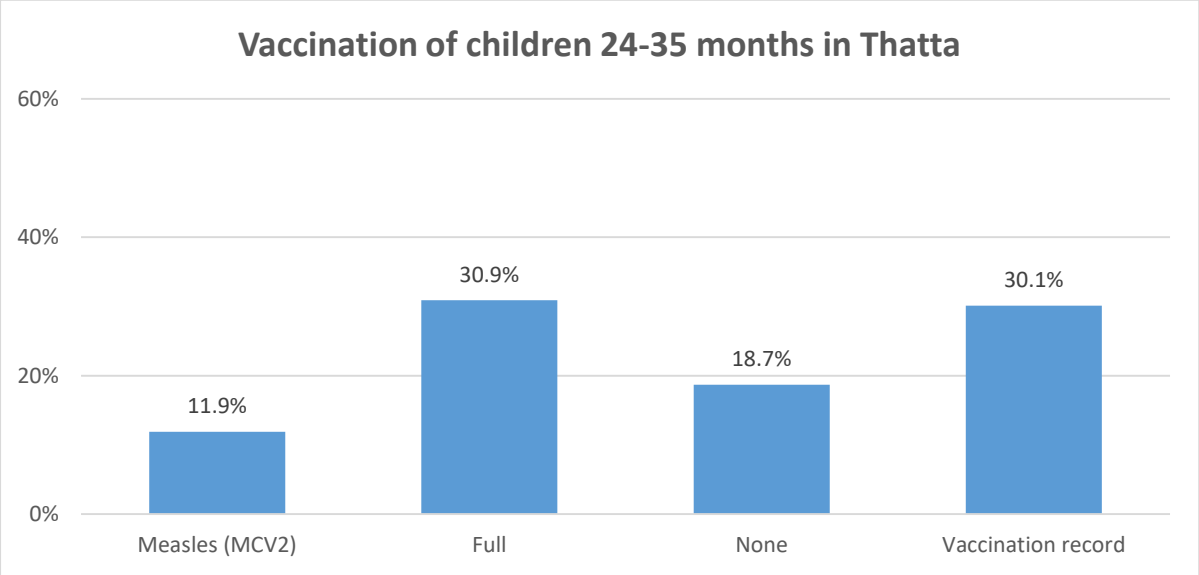


Figure 15: Vaccination of children aged 24-35 months in Thatta

10. Maternal Health and Nutrition

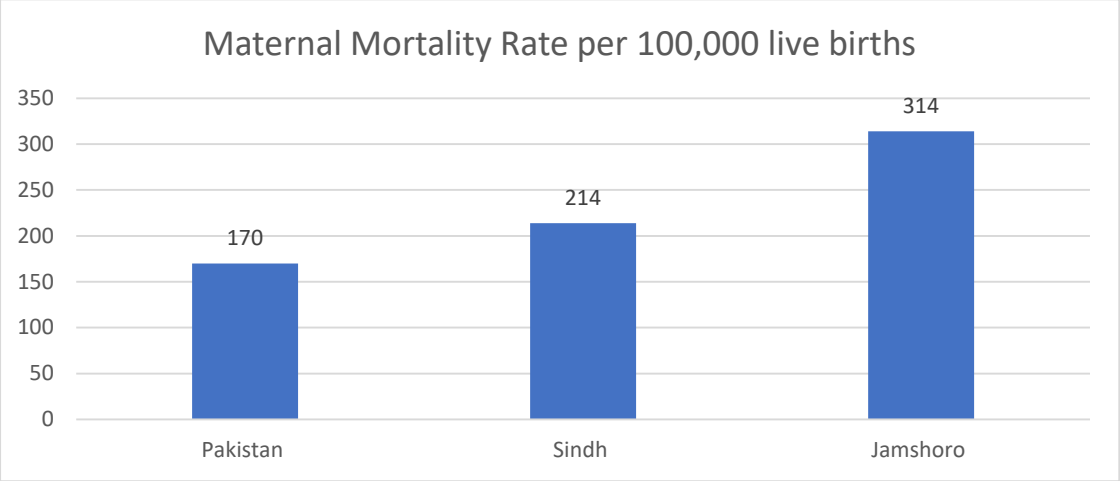


Figure 16: Maternal mortality rates in Pakistan, Sindh and Jamshoro

10.1 Reproductive health

The fertility rate in Thatta district is 4.4 children per woman. 19.7% of women in the district use some form of contraception with 15.9% using modern contraceptive methods[xiii]. The most common contraceptive method is female sterilisation which is currently used by 5.6% of ever-married women.

10.2 Maternal and neonatal health

76.2% of ever-married women in Thatta have received antenatal care. According to the MICS of 2014/15xiv, 59.5% of all deliveries in Thatta took place at a health facility with 15.8% occurring in state centres and 43.7% in private centres. The remaining 40.5% 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.

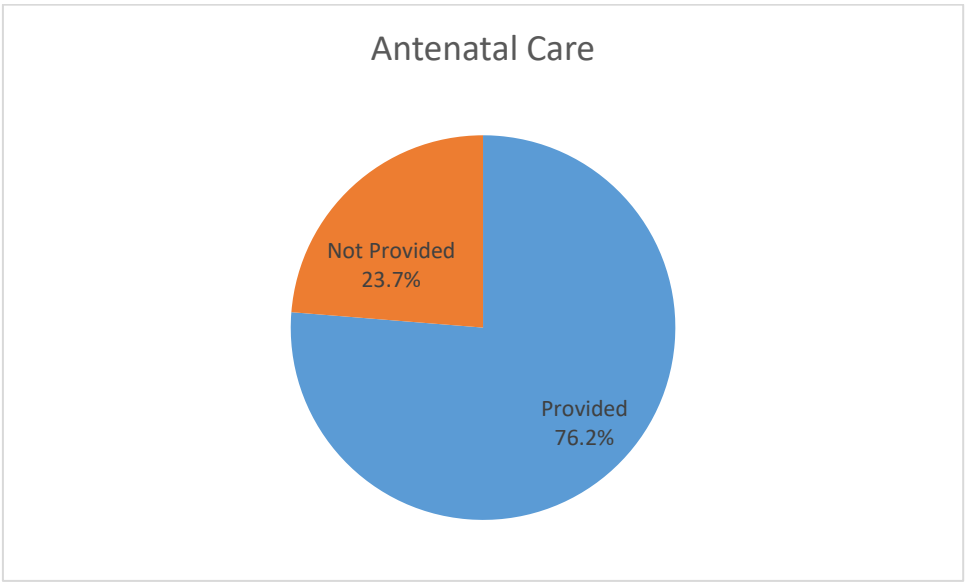


Figure 17: Provision of ANC in Thatta

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 Thatta 76.3% 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 Thatta district.

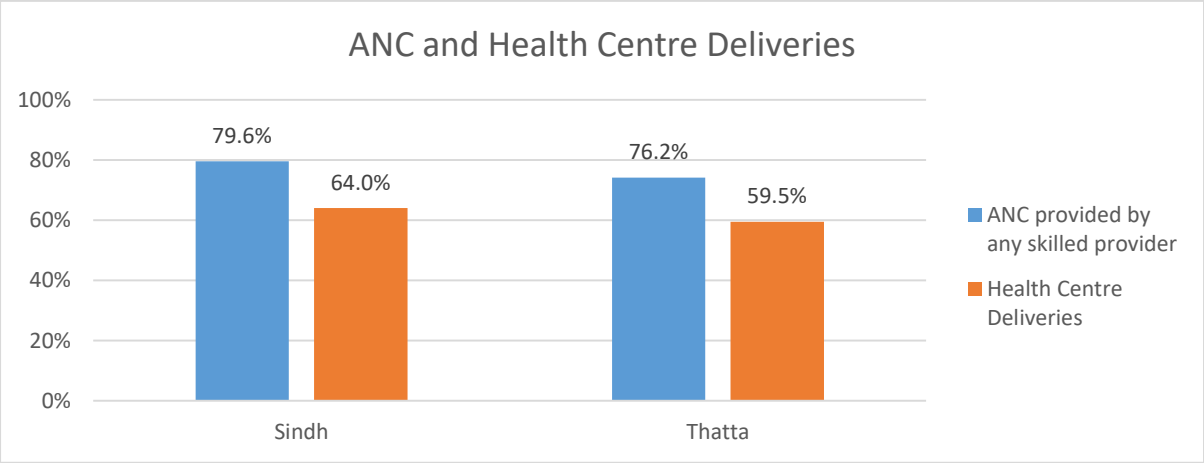


Figure 18: ANC and Health Centre Deliveries

As shown in Table 16, 68% of women receive ANC from doctors, 6.1% receive it from nurses and/or midwives, 1.5% receive it from lady health visitor and lady health worker and 0.6% receive it from other service providers (total 76.2%). The remaining 23.8% receive 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**
68%	6.1%	0.0%	0.8%	0.6%	0.7%	0.0%	0.0%

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

14.6% of women in Thatta receive or attend one ANC visit, 18.9% have two visits, 17.2% have three visits and 24.6% have four or more visits as shown in Figure 19 with 0.9% as missing numbers.

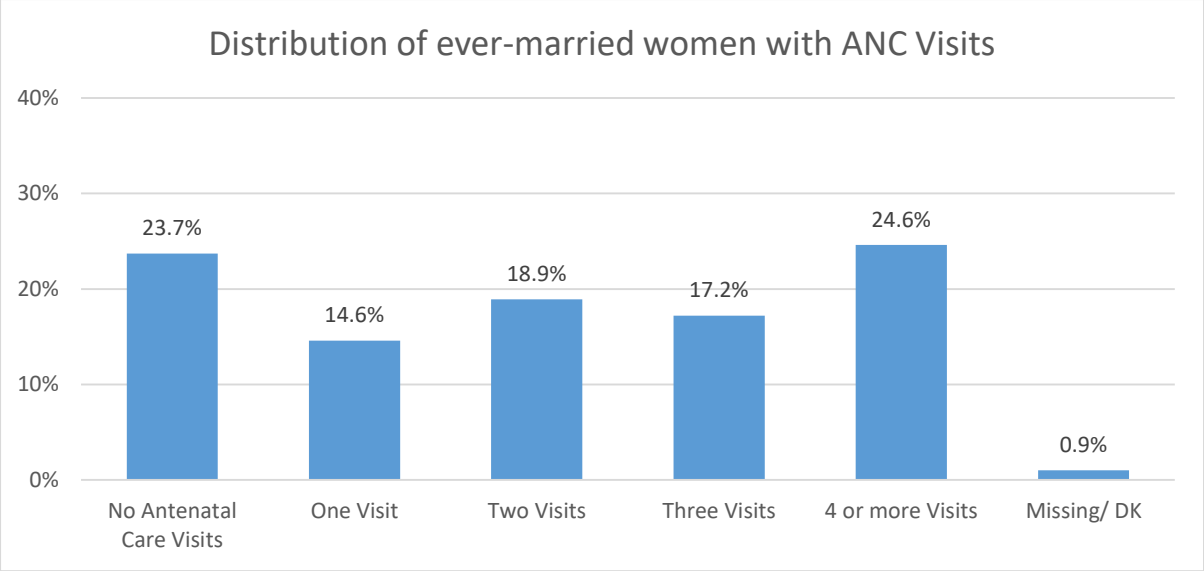


Figure 19: Distribution of ever-married women having ANC visits

In Thatta, 28.8% of pregnant women have their first ANC during the first trimester. 20.2% first attend at 4-5 months, 18.1% first attend at 6-7 months and 6.6% 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	
28.8%	20.2%	18.1%	6.6%	1.9%	4

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

10.3 Post-natal care of mothers and children

In Thatta, 64.2% of newborns and 56.7% of mothers receive a health check following birth in either a facility or at home[xv]. 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[xvi].

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 71.9% in Thatta. In Sindh, 64% of ever-married women live in close proximity to an LHW while this figure is 85.1% in Thatta[xvii]. 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[xviii].

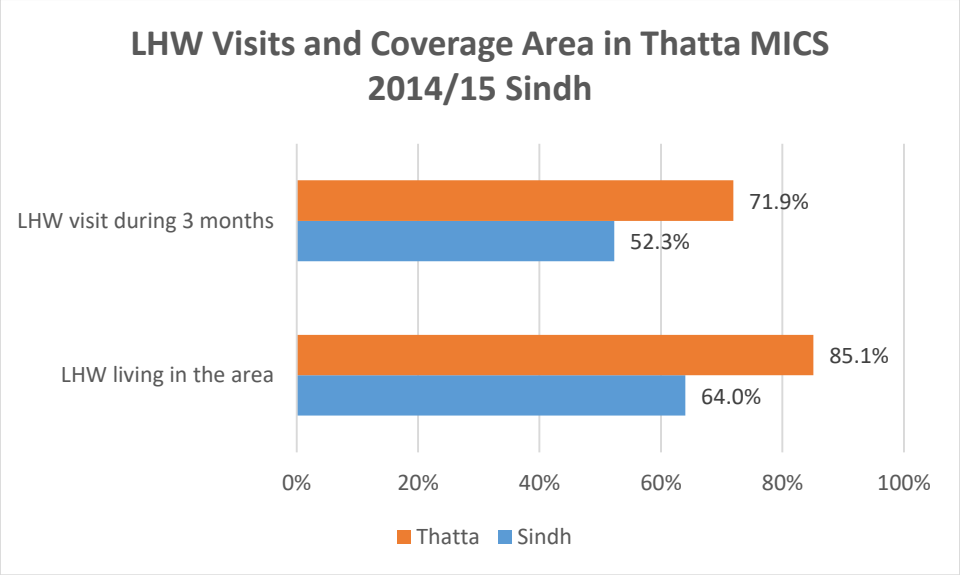


Figure 20: LHW Coverage in Thatta

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