The Determinant Factors Influencing Immunization Clinics- There Is Nothing in Mr. Prafi Regency Manokwari

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ABSTRACT

Immunization against measles and Rubella Immunization, better known as Measles Rubella (MR), the year 2017 is nothing 82.1% of measles Immunization, Measles Immunization is nothing 2018 Year January to December 2018 20.8% province of West Papua, Advanced 13.4%, Measles 27%, very low nationwide. Measles Immunization Clinics close to Prafi in January to October 2018 72% and measles Advanced 0% of the 370 Babies in the workplace Puskemas Prafi Regency Manokwari. The purpose of the research: to find out the factor of determinants that affect immunization Clinics there is nothing in MR. Prafi Regency Manokwari. Research methods: Analytic observational study design with cross sectional. The research was carried out on 11 September to 30 October 2018 in Clinics with population of Prafi children aged 9 months s/d 15 years as much as the Child should be at 4,525 Immunization MR. and the number of respondents as much as 98 Children in purposive sampling. Data obtained using questionnaires and analyzed using Chi Square test with a significant α gained 0.005 < that significant socio-cultural (0.102), education (0.563), knowledge (0.963), income (0.398), attitude (0.856), family support (0.166), jobs (0.000), affordability to the place of service (0.831) and social media (0.904). That affect immunization is nothing MR. is job in determining Close Immunization Clinics in the Prafi District of MR. Manokwari.

Keywords: Immunization Clinics, Job, MR. Prafi, In The District Of Manokwari

1. INTRODUCTION

From the results of previous studies, there were some researchers who said there was a relationship between knowledge, education, attitude, and immunization (Tri Aulia Rahayu, 2017). Referring to RI Minister of Health Regulation No.1501 of 2010 concerning certain types of infectious diseases that can cause epidemics, Article 4 paragraph 1 contains 17 types of diseases & Article 2 mentions certain other infectious diseases that can cause epidemics. (Permenkes RI, 2010).

Indonesia has committed to achieving elimination of measles and rubella control / Congenital Rubella Syndrome (CRS) in 2020. Based on the results of surveillance and immunization coverage, routine measles immunization is not enough to achieve the measles elimination target. Whereas for rubella / CRS control acceleration, additional immunization campaigns need to be carried out before the introduction of the MR vaccine into routine immunization. For this reason, a MR vaccine immunization campaign is required for children aged 9 months to <15 years.

The MR immunization campaign activity will be carried out in two phases, namely phase I in August - September 2017 throughout Java and phase II in August-September 2018 throughout Sumatra, Kalimantan, Sulawesi, Nusa Tenggara, Maluku and Papua. (Indonesian Ministry of Health, 2017). The incidence of CRS in regions that have introduced the rubella

vaccine during 1996-2008 has decreased. In Indonesia, rubella is a public health problem that requires effective prevention. Surveillance data over the past five years shows that 70% of cases of rubella occur in the age group <15 years. In addition, based on a study of the estimated disease burden of CRS in Indonesia in 2013 it was estimated that there were 2767 cases of CRS, 82 / 100,000 occurred at the age of mothers 15-19 years and decreased to 47 / 100,000 at the age of 40-44 years. (Indonesian Ministry of Health, 2017). While the Modeling calculation in East Java is estimated at 700 babies born with CRS every year. (Indonesian Ministry of Health, 2017)

In the Global Vaccine Action Plan (GVAP), measles and rubella are targeted to be eliminated in the 5 WHO regions by 2020. In line with the 2012-2020 GVAP, The Global Measles & Rubella Strategic Plan maps out the strategies needed to reach the world target without measles, rubella or CRS. One of the five strategies is achieving and maintaining a high level of community immunity by giving two doses of vaccines containing measles and rubella through routine and additional immunizations with high coverage (> 95%) and evenly distributed.

Based on surveillance data and immunization coverage, routine measles immunization is not enough to achieve measles elimination targets. Whereas for rubella / CRS control acceleration, additional immunization campaigns need to be carried out before the introduction of the MR vaccine into routine immunization. For this reason, a campaign for the provision of MR immunization is needed for children aged 9 months to <15 years. Provision of MR immunization at the age of 9 months to <15 years with high coverage (minimum 95%) and evenly expected to form group immunity (Herd Immunity), so as to reduce the transmission of the virus to a more mature age and protect the group when entering reproductive age (Indonesian Ministry of Health, 2017).

An immunization program is a health service program that must be provided and administered by the government. The mandatory term arises because an immunization program is a service that has a low domain and has a large impact on others (externality). Thus, availability means that the government must provide sufficient and reliable personnel in conducting, immunizing, adequate equipment in accordance with technical standards, sufficient funds (investment, operations, and maintenance), and adequate vaccines. (Muhllil R, 2005). The latest UNICEF report stated that 27 million infants and 40 million pregnant women worldwide still did not receive routine immunization services. As a result, the disease that can be prevented by this vaccine is estimated to cause more than two million deaths each year. This figure includes 1.4 million babies who were taken away by their lives (UNICEF, 2000).

Immunization must be given many times with a certain period of time, parents often forget and must record in child health documents that are usually given by midwives, either in the practice or in the hospital. If parents are careless, health documents might be tucked away (Ministry of Health, 2005). The success of immunization programs in Indonesia is influenced by several factors, including, maternal age, maternal education level, maternal employment status, level of maternal knowledge and birth order of children. Rubella Measles Immunization which is better known as MR Phase II Immunization in 7 Provinces namely Sumatra, Kalimantan, Sulawesi, Nusa Tenggara, Maluku, Papua and West Papua. MR Immunization in West Papua starts on August 1 to September 30, 2018.

West Papua carried out MR immunization in 12 districts and 1 city, namely Tambrauw Regency, Raja Ampat Regency, Wondama Bay Regency, Bintuni Bay Regency, Fak-Fak Regency, Sorong Regency, South Sorong Regency, South Manokwari Regency, Maybrat Regency,

Manokwari Regency, Manokwari Regency, Kota Sorong, Arfak Mountains Regency, and Kaimana Regency. Since the beginning of the implementation of MR immunization there were many obstacles so that the implementation of MR Immunization could not run as planned. Since August 1, 2018, the rejection of MR immunization has been evenly distributed in Manokwari Regency. Based on the description above, the researcher was interested in taking the title "Determinant Factors Affecting Measles Rubella Immunization in Prafi Health Center, Manokwari Regency in 2018"

2. MATERIALS AND METHODS
2.1. Type and Design of Research
This study is an observational analytic study which aims to determine the effect of two or more variables (Sogiyono, 2013). This study explains the relationship affects and is influenced by variables - variables to be studied. Using the Cross Sectional approach with data collection done simultaneously at one time (Sugiyono, 2013).

2.2 Place and Time of Research
Location is where the research is conducted, while time is the period of time needed by researchers to obtain data (Notoatmodjo S, 2012)

2.3. Place and Time
The place for conducting the research was conducted at the Prafi Health Center in Manokwari Regency. This research was conducted on September 11 to October 30, 2018

2.4 Population and Samples
1. Population
Population is the overall research subject (Arikunto, 2010). The population in this study were 9 months to 15 years old children as many as 4,525 MR children immunized.

2. Sample
According to (Notoatmodjo S, 2012) sample is a portion of the population that is considered representative. The sample size is obtained by the following formula:

$$n = \frac{N}{1 + N\,(d)^2}$$

Where :
n   : sample size
N   : population
d   : Deviations by population by the degree of health used, i.e. 0,1

n =	4.525
	$1 + 4.525\,(0,1)^2$
n =	4.525
	$1 + 4.525\,(0,1)^2$
n =	4.525
	1 + 45,25
n =	4.525
	46,25

n = 97,83 rounded up to 98 samples

Sampling is done by Purposive Sampling, which is a sample taken based on certain considerations with the following criteria:
a. Inclusion criteria
The inclusion criteria were the criteria for the sample that met the requirements to be used as samples, namely 1) Mothers who were willing to be respondents, 2) children aged 9 months - 15 years by random sampling, 3) Mothers who lived in the Prafi Health Center area.
b. Exclusion criteria
Exclusion criteria are criteria for samples that meet the requirements to be sampled, such as 1) Children who are not present during MR immunization, 2) Mothers who are not willing to be respondents, 3) Children who are sick, 4) Mothers who cannot read and write.

3. RESULTS
3.1 Bivariate Analysis
a. Relationship between Socio-Culture and MR Immunization

Table 1. Relationship between Socio-Culture and MR Immunization in Prafi Health Center, Manokwari District in 2018

			MR Immunization					
			Yes	%	No	%	Total	%
Socio-cultural	Acceptance	Number	17	60,7	11	39,3	28	100
	No accept	Number	28	40	42	60	70	100
	Total	Number	45	45,9	53	54,1	98	100
P-Value = 0,102; RP = 1.518; CI 98% (1.004-2.295)								

In table 1, shows that of the socio-cultural variables that received MR immunization as many as 17 people (60.7%) and those who did not receive MR immunization as many as 28 people (40%). The results of the chi square statistical test at a meaningful value of 98% (α = 0.05) were obtained p-value 0.102 or P> α (0.05). This means that there is no socio-cultural relationship with MR immunization at the Prafi Health Center in Manokwari District. The results of the value of RP = 0.910; CI98% (1,004-2,295) more than 1, so social culture is not a risk factor with MR immunization.

b. Relationship between Education and MR Immunization

Table 2. Relationship between Education and MR immunization in the Community Health Center Prafi Manokwari District in 2018

			MR Immunization					
			Yes	%	No	%	Total	%
Education	High > SMA	Number	28	43,1	37	56,9	65	100
	Low < SMA	Number	17	51,5	16	48,5	33	100
	Total	Number	45	45,9	53	54,1	98	100
P-Value = 0,334; PR = 0.836; CI 98% (0.542-1.290)								

SMA; Senior high school

Table.2 shows that of 28 people (43.1%) who were highly educated there were 37 people (56.9%) who did not want their children to be immunized by MR. Whereas from 17 people (51.5%) respondents who had low education there were 16 people (48.5%) who did not want their children to be immunized by MR.

The results of the chi square statistical test at a meaningful value of 98% (α = 0.05) were obtained p-value 0.719 or P> α (0.05). This means there is no relationship between education and MR immunization at the Prafi Community Health Center in Manokwari Regency. Test Results Prevalence ratio (RP) = 0.836; CI98% (0.542-1,290) indicates that education is not a risk factor for MR immunization.

c. Relationship between Knowledge and MR Immunization at the Prafi Health Center in Manokwari District

Table 3. Relationship of Knowledge with MR immunization in the Prafi Health Center in Manokwari District in 2018

			MR Immunization					
			Yes	%	No	%	Total	%
Knowledge	Know	Number	32	45.1	39	54.9	71	100
	Not	Number	13	48.1	14	51.9	27	100
	Total	Number	45	45.9	53	54.1	98	100
P-Value = 0.963; PR = 0.936; CI 98% (0.586-1.495)								

Table 3 shows that respondents' knowledge about MR immunization was 32 people (45.1%) and those who did not have knowledge about MR immunization were 13 people (48.1%). The results of the chi square statistical test at a meaningful value of 98% (α = 0.05) were obtained p-value 0.963 or P> α (0.05). This means that there is no significant relationship between knowledge and MR immunization in the Prafi Community Health Center, Manokwari Regency. Prevalence ratio test results (RP) = 0.936; CI98% (0.586-1,495) more than 1, so knowledge is not a risk factor for MR immunization.

d. Relationship between Family Income and MR Immunization

Table 4. Relationship between Family Income and MR Immunization at the Prafi Community Health Center in Manokwari District, 2018

			MR Immunization					
			Yes	%	No	%	Total	%
Family income	High	Number	26	51	25	49	51	100
	Low	Number	19	40,4	28	59,6	47	100
	Total	Number	45	45,9	53	54,1	98	100
P-Value = 0.398; PR = 1.261; CI 98% (0.813-1.956)								

Table 4 shows that high family income is 26 people (51%), there are 25 people (49%) who want to be immunized by MR. And as many as 19 people (40.4%) whose family income is low and not immunized as many as 28 people (59.6%). The results of the Chi Square statistical test at a meaningful value of 98% ($\alpha = 0.05$) were obtained p-value 0.398 or P> α (0.05). This means that there is no relationship between family income and MR immunization at the Prafi Community Health Center in Manokwari Regency. Prevalence ratio test results (RP) = 1,261; CI98% (0813-1,956) more than 1, so that family income is not significant with MR immunization.

e. Relationship between Attitudes and MR Immunization

Table 5. Relationship between Attitudes with MR Immunization in the Prafi Health Center in Manokwari District in 2018

			MR Immunization					
			Yes	%	no	%	Total	%
Attitude	Accept	Number	17	48,6	18	51,4	35	100
	Refuse	Number	28	44,4	35	55,6	63	100
	Total	Number	45	45,9	53	54,1	98	100
P-Value = 0.856; PR = 1.093; CI 98% (0.705-1.695)								

Table.5 shows the attitude of the respondents 17 people (48.6) who want to receive MR immunization and 28 people (44.4%) who refuse to be immunized with 18 people not accepting MR immunization (51.4%), while the attitude that refused and did not want MR immunization was 35 people (55.6%).

The results of the Chi Square statistical test at a meaningful value of 98% ($\alpha = 0.05$) were obtained p-value 0.856 or P> α (0.05). This means that there is no relationship between attitude and MR immunization at the Prafi Community Health Center in Manokwari Regency. Prevalence ratio (RP) = 1,093; CI98% (0.705-1,695) more than 1, so attitude is not a risk factor for MR immunization.

f. Relationship between Family Support and MR Immunization

Table 6. Relationship between Family Support and MR Immunization in Prafi Health Center, Manokwari District in 2018

			Imunisasi MR					
			Yes	%	No	%	Total	%
Family support	Yes	Number	8	32	17	68	25	100
	No	Number	37	50,7	36	49,3	73	100
	Total	Number	45	45,9	53	54,1	98	100
P-Value = 0.166; PR = 0.631; CI 98% (0.341-1.167)								

Table 6 shows family support for MR immunization as many as 45 people (45.9%) with those who are willing to get MR immunization as many as 8 people (32%) and those who are not willing to get MR immunization as many as 37 people (50.7%) while without support family but were willing to get MR immunization as many as 37 people (50.7%) and those without family support were still unwilling to immunize MR 36 people (49.3%). The results of the chi square statistical test at a meaningful value of 98% ($\alpha = 0.05$) were obtained p-value 0.166 or P >α (0.05). This means that there is no relationship between family support and MR immunization at the Prafi Community Health Center in Manokwari Regency. Prevalence ratio test results (RP) = 0.631; 98% CI (0.341-1.167).

g. Employment Relations and MR Immunization

Table 7 Job relationships with MR immunization in the Prafi Community Health Center in Manokwari District in 2018

			MR Immunization					
			Yes	%	No	%	Total	%
Occupation	Working	Number	37	62,7	22	37,3	59	100
	No work	Number	8	20,5	31	79,5	39	100
	Total	Number	45	45,9	53	54,1	98	100
P-Value = 0.000; PR = 3.057; CI 98% (1.599-5.847)								

Table 7 shows the number of respondents working and their children immunized as many as 37 people (62.7%) and those not immunized by 22 people (37.3%) with respondents who did not work and immunized as many as 8 people (20.5 %). The results of the chi square statistical test at a significant value of 98% (α = 0.05) were obtained p-value 0.000 or P <α (0.05). This means there is a relationship between work with MR immunization at the Prafi Community Health Center in Manokwari Regency. Prevalence ratio (RP) = 3.057; 98% CI (1,599-5,847), so work is a risk factor for MR immunization.

h. Relationship to Affordability to the place of service and MR Immunization

Table 8 Relationship of Affordability to the service location with MR Immunization in the Prafi Community Health Center in Manokwari District in 2018

			MR Immunization					
			Yes	%	No	%	Total	%
Affordability to the service location	Far	Number	27	44,3	34	55,7	61	100
	Nes	Number	18	48,6	19	51,4	37	100
	Total	Number	45	45,9	53	54,1	98	100
P-Value = 0.831; PR = 0.910; CI 98% (0.589-1.405)								

Table.8 shows the affordability of services to the provision of far-reaching immunizations as many as 27 people (44.3%) and those not immunized as many as 34 people (55.7%), affordability to services that are close and unwilling in MR immunization as much as 19 people (51.4%) and those who had been immunized by MR were 18 people (48.6%). The results of the chi square statistical test at a meaningful value of 98% (α = 0.05) were obtained p-value 0.831 or P> α (0.05). This means that there is no relationship between Affordability to the service location and MR immunization at the Prafi Community Health Center, Manokwari Regency. Prevalence ratio test results (RP) = 0.910; 98% CI (0.589-1,405).

i. Relationship of Information Media with MR Immunization

Table 9. Relationship of Information Media with MR Immunization in Prafi Health Center, Manokwari District in 2018

			MR Immunization					
			Yes	%	No	%	Total	%
Information media	Know	Number	32	47,1	36	52,9	68	100
	Not	Number	13	43,3	17	56,7	30	100
	Total	Number	45	45,9	53	54,1	98	100
P-Value = 0.904; PR = 1.086; CI 98% (0.672-1.756)								

Table.9 shows that there was no relationship between information media on MR immunization as many as 45 people (45.9%) knew about MR immunization but were not in MR immunization, and who did not know information about MR immunization but wanted to be MR immunized as many as 53 people (54, 1%). The results of the chi square statistical test at a meaningful value of 98% (α = 0.05) were obtained p-value 0.904 or P> α (0.05). This means that there is no relationship between media information and MR immunization at the Prafi Community Health Center in Manokwari Regency. Prevalence ratio (RP) = 1.086; 98% CI (0.672-1.756). However, information media as a protective factor with the implementation of MR immunization.

3.2 Multivariate Analysis
Multivariate analysis was used to obtain answers to which factors had an effect on MR immunization, so bivariate analysis was needed, followed by multivariate tests. Bivariate modelling using the chi square test was seen from p <0.25 can be seen in table.18.

Table 10. Bivariate Modeling

No	Variables	p-value	Notes
1	Socia-culture	0.102	Not candidate
2	Education	0,563	Not candidate
3	Knowledge	0,963	Not candidate
4	Family income	0,398	Not candidate
5	Attitude	0,856	Not candidate
6	Family support	0,166	Not candidate
7	Occupation	0.000	Candidate
8	Distance	0,831	Not candidate
9	Information media	0,904	Not candidate

In the table 10 indicates that the variable entered as a candidate to be tested together or multivariate is a variable of employment. Test using logistical binary regression. Based on table 17 bivariate modelling, there is only one candidate variable, namely education. So it doesn't use multivariate tests.

4. DISCUSSION
4.1 Relationship between Socio-Culture and MR Immunization

The results showed that there was no relationship between socio-culture and MR immunization. Can be seen socio-cultural variables in MR immunization as many as 45 people (45.9%) and those not in MR immunization as many as 53 people (54.1%). It can be concluded that there are still many who have views in terms of beliefs, customs, and traditions not to be immunized by MR. Consideration because the MR vaccine is not halal. This socio-culture is protective of MR immunization. The active role of the government, cross-sectors, religious leaders, community leaders, agencies related to regional work units and health workers to be active in implementing MR immunization, especially in providing understanding of the importance of MR immunization.

4.2 Relationship of Education with MR Immunization

The results showed that there was no relationship between education and MR immunization. It was seen from 98 people (100%) who were highly educated there were 28 people (43.1%) who wanted their children to be immunized against MR, while 37 (56.9%) people those with low education are not immunized by MR. It can be

concluded that overall higher education and low education in MR immunization were 45 people (45.9%) and 53 people (54.1%) people whose children were not immunized by MR. This education is protective of MR immunization because most of them are highly educated in Senior High School and Higher Education but are highly educated, not always able to change one's perspective on MR immunization. Education is not only at school but the child's first education is at home or in the surrounding environment. All fields of education and health must play an active role in providing education about health and the importance of immunization especially early childhood immunization to children.

4.3 Relationship between Knowledge and MR Immunization

The results showed that there was a relationship between knowledge and MR immunization. Table 11 can be seen as many as 32 people (45.1%) who had knowledge about MR immunization and 13 people (48.1%) who did not have knowledge about MR immunization. Knowledge continues to grow and is very influential in the implementation of MR immunization, since the implementation of MR immunization is a lot of repelling due to knowledge about the obscurity of non-halal MR vaccines. All efforts have been made such as socialization, counseling and education so that the understanding and knowledge that develops is not in line with reality. The role of health workers, the government, cross-sectors, religious leaders, community leaders and community institutions to play an active role in dealing with a problem and resolving problems with health goals for all children of the nation.

4.4 Relationship between Family Income and MR Immunization

The results showed that of 51 people had high income and 47 people had low income. Those who were willing to be immunized by MR 45 people (45.9%) and those who were not MR immunized 53 people (54.1%) indirectly rejecting MR immunization were greater than those who

were willing to be immunized MR High and low income did not affect MR immunization, because most of the population in the Prafi Community Health Center area of Manokwari Regency are farming, gardening and entrepreneurship.

4.5 Relationship between Family Support and MR Immunization

The results showed family support for immunization as many as 8 people (32%) and those without supporting the family as many as 17 people (68%), while without family support as many as 37 people (50.7%) with those who support families get as many as 36 MR immunizations people (49.3%). It can be concluded that family support plays a role in MR immunization, without family support, MR immunization cannot be carried out. So, family support is a protective factor with MR immunization. Family support greatly influences MR immunization outcomes, without family support, MR immunization cannot run in accordance with the national target of 95%. All returned to the certification of halal MR vaccines, so that many families forbid children, grandchildren, relatives to be MR immunized. so that all government, private and community parties (cross-sectors) must be involved in the implementation of MR immunization. MR immunization is a new immunization and is a combination of measles and rubella immunization vaccine. So that the family needs more understanding of the way the cycle of making, distributing and using MR vaccines to children aged 9 months to 15 years.

4.6. Employment Relations with MR Immunization

The results showed that MR immunization was given to respondents who worked as many as 37 people (62.7%) with those not in MR immunization as many as 22 people (37.3%), while those who did not work and in MR immunization were 8 people (20.5 %) with those who were not in MR immunization as many as 31 people (79.5%). Based on existing data, it is clear that work is very influential on the implementation of MR immunization The work of someone who has a high position or position does not have the time to take the child to an immunization service to either the government or private health service center because it is busy with work and responsibilities in the office. Work also affects ordinary people because they require responsibility and work so they don't pay attention to immunization and children's health. So that it can be concluded whatever the work of a person or respondent greatly influences the implementation of MR immunization.

4.7 Relationship to Affordability to Service Sites with MR Immunization

The results showed that affordability to remote MR immunization service sites was 27 people (44.3%) with 34 people not immunized (55.7%), affordability to close service places as many as 18 people (48.6%).) those who were MR immunized and those who were not immunized were 19 people (51.4%). The distance between living quarters and the location of MR immunization services does not interfere with the implementation of MR immunization. Because distance does not affect respondents to bring children aged 9 months to 15 years to government and private health service centers to get MR immunization.

4.8 Relationship to Information Media with MR Immunization

The results showed that the information media was very instrumental in the implementation of 32 immunizations of MR (47.1%) who used information media to determine MR immunization and as many as 13 (43.3%) who did not use media information about MR immunization. Modern times greatly influence one's attitudes, views, education and knowledge. With the spread of information about the inadequacy of the MR vaccine, the side effects after injection of the MR vaccine even cause death after MR immunization; there is a prohibition against MR immunization causing the number of rejects against immunization. Conclusion there is

no relationship between information media and MR immunization.

Measles and Rubella immunization or Measles Rubella (MR) is a new immunization carried out in Manokwari Regency. The implementation of MR immunization is carried out on August 1 to September 31, 2018 with the target number of children aged 9 months to 15 years is 4,525 with a national target of 95%.

As a result of the rejection and rampant information from the mass media and electronics about halal vaccines, the effects arising from Mr immunization and deaths due to MR immunization. Respondents preferred not to give MR immunization to their children due to fear that their hot children could not work.

MR immunization is influenced by social culture, education, knowledge, income, family support, employment, affordability to service places, and information media. But it does not have a significant relationship. It is very difficult to be able to change the attitude that already exists, so it needs various ways to be able to change that attitude. So that the achievement of MR immunization can be achieved.

The implementation of MR immunization is carried out simultaneously from August to September 2018. The Prafi Health Center with a target number of children aged 9 months to 15 years is 4,525 with a national target of 95%. As a result of rejecting and increasing information from mass and electronic media about vaccine halalness, the effects of Mr. immunization and deaths from MR immunization. Respondents preferred not to give MR immunization to their children due to fear that their hot children could not work. Respondents did not bring their children immunization service posts because there was no transportation, respondents preferred to work to earn income. So that on September 31, 2018 Children aged 9 months to 15 years who received MR immunization at the Prafi Health Center from August to September were 3,428 children (75.8%). So

that there was an increase in the number of children injected by October 3,995 children (88.3%) the Prafi Health Center still could not reach the target. Due to the rejection and fear of parents, as well as families who forbid MR immunization, the government has extended the period of MR immunization until December 2018. All efforts have been made by issuing the Regent's Instruction in September 2018 mandatory MR immunization by involving all existing sectors, Fatma MUI no 33. Year 2018 concerning Mubah and Mandatory MR Immunization, Cross-Sector MR Socialization October 18 2018 (Central Government, West Papua Provincial Government, Manokwari District Government, Central Indonesian Ulema Council, Indonesian Papua Ulama Council, Manokwari District Ulema Council, The Department of Culture and Sports Education, Central Ministry of Religion, Ministry of Religion of West Papua Province, Ministry of Religion of Manokwari Regency, parents and children with measles and rubella) mobilized all health workers (Socialization, Counseling, Internal Meetings and formation of Fast Immunization Driving Teams), and involving the Su Institute Research Society. Prafi Community Health Center achieved the target on November 5, 2018 as many as 4,426 children (97.81%). Involving all cross sectors, government and community survey institutions through approaches, socialization and continuously trying to convince the community.

5. CONCLUSIONS
Based on the results of the discussion it can be concluded as follows:
1. There was no significant socio-cultural relationship with MR immunization in the Prafi district of Manokwari district. P-Value = 0.102; Rp = 1,518; 98% CI (1,004-2,295).
2. There is no significant relationship between education and MR immunization at the Prafi Community Health Center in Manokwari Regency. P-Value = 0.563; Rp = 0.836; 98% CI (0.542-1,290).

3. There is a meaningful relationship of knowledge with MR immunization at the Prafi Health Center in Manokwari Regency. P-Value = 0.963; RP = 0.936; 98% CI (0.586-1,495).

4. There is no significant relationship between family income and MR immunization at the Prafi Community Health Center in Manokwari Regency. P-Value = 0.398; Rp = 1,261; 98% CI (0813-1,956).

5. There was no significant relationship between attitude and MR immunization at the Prafi Community Health Center in Manokwari District. P-Value = 0.856; Rp = 1093; 98% CI (0.705-1,695).

6. There is no significant relationship between family support and MR immunization at the Prafi Community Health Center in Manokwari Regency. P-Value = 0.166; RP = 0.631; 98% CI (0.341-1.167).

7. There is a meaningful relationship of work with MR immunization at the Prafi Community Health Center in Manokwari Regency. P-Value = 0,000; Rp = 3.057; 98% CI (1,599-5,847)

8. There is no significant relationship of affordability to the service location with MR immunization at the Prafi Community Health Center in Manokwari Regency. P-Value = 0.831; RP = 0.910; 98% CI (0.589-1,405)

9. There is no significant relationship between Media Information and MR immunization at the Prafi Community Health Center in Manokwari Regency. P-Value = 0.904; Rp = 1,086; 98% CI (0.672-1.756)

It can be concluded that MR immunization is influenced by socio-cultural variables, education, knowledge, income, attitudes, family support, affordability to service places, and information media. But the most important and most influencing MR immunization is the Job Variable. The work of the respondent greatly influences because it cannot leave work due to duties and responsibilities to the work. Position The work of high and low responders is very influential because work that is dense and cannot be abandoned results in children of respondents whose parents are working not being immunized by MR.

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