

What Makes Vulnerable Urban Populations Hard to Reach in Indonesian cities?

Findings and Recommendations from a Diagnostic Immunization Assessment in Central Jakarta, South Jakarta and South Tangerang metropolitan areas



Many homeless people in Jakarta live in waste places and beside railroad tracks.

Like many other countries, Indonesia is experiencing rapid urbanization, especially in Jakarta, already the country's most populous city. The Jakarta Population and Civil Registry Office predicts a two percent annual increase in new arrivals to the city.¹ The high population density in urban areas may facilitate disease transmission, with children most at risk. In these settings, marginalized groups, such as temporary workers and homeless people, require special attention to meet their health and social needs. Due to their high mobility and lack of access to health services, including immunization, there is increased risk of outbreak for infectious diseases, including vaccine-preventable diseases (VPDs), in these urban centers.

Under the Gavi-supported Partners' Engagement Framework, JSI Research & Training Institute, Inc. (JSI) collaborated with the Centre for Health Research Universitas Indonesia from June to September 2019 to conduct a diagnostic assessment to identify the barriers contributing to low coverage in Jakarta municipalities and prioritize potential interventions to address the immunization needs of urban communities.

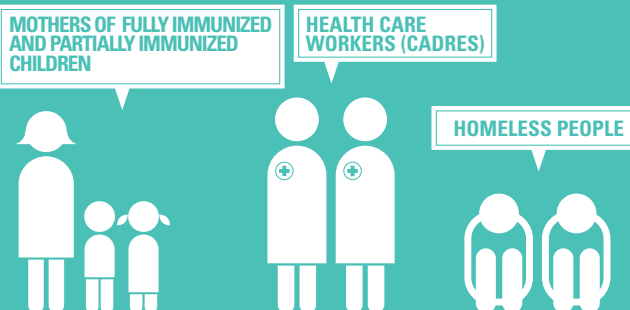
¹ al.kontan.co.id/news/pemprov-dki-jakarta-siapkan-langkah-antisipasi-peningkatan-arus-urbanisasi.

METHODS

This study used a mixed-method approach in three low-income settings within the Jakarta metropolitan area: South Tangerang, Central Jakarta and South Jakarta. The **quantitative** study reviewed basic immunization service² and coverage data by using a Lot Quality Assurance questionnaire, adapted from an existing UNICEF survey. This tablet-based questionnaire, which had been pre-tested before use, was given to 1,812 caregivers: 908 with children aged 12–23 months (for basic immunization), and 904 with children aged 24–35 months (for the booster dose). The survey followed two-stage sampling methods with hamlets (small settlements like villages) as clusters. Six teams of trained data collectors worked in 60 clusters.

The team also documented **observations** of the Expanded Programme on Immunization (EPI) services. Research teams observed a total of 22 public-service providers and 9 private providers in 31 health centers, including community health centers and posyandus (village health posts), using a supervisory checklist, to identify bottlenecks in services.

THE QUALITATIVE STUDY: FOCUS GROUP DISCUSSIONS (FGDs, 6 TO 8 PARTICIPANTS)



IN-DEPTH INTERVIEWS BY RESEARCHERS (14 IN EACH MUNICIPALITY, TOTAL OF 42 INTERVIEWS)



² Basic immunization includes bacillus Calmette-Guérin (BCG); Hepatitis; diphtheria/tetanus toxoid/pertussis (Pentavalent: DPT-HB-Hib); polio; and measles-rubella (MR).

Figure 1. Reason reported by caregiver for not fully immunized children and booster immunization in Central Jakarta

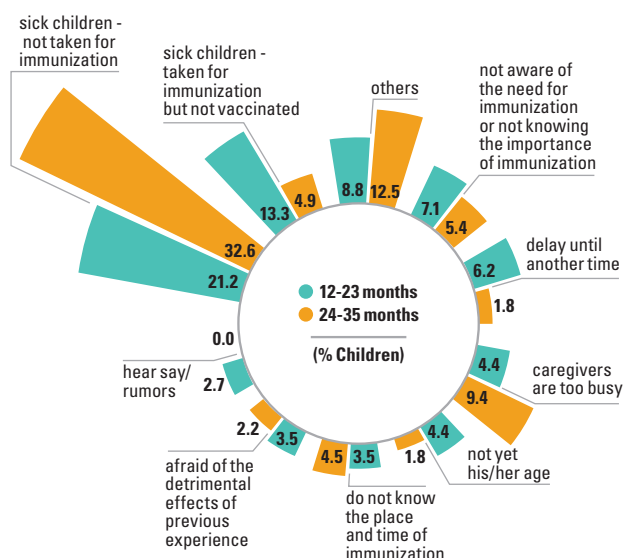


Figure 2. Reason reported by caregiver for not fully immunized children and booster immunization in South Jakarta

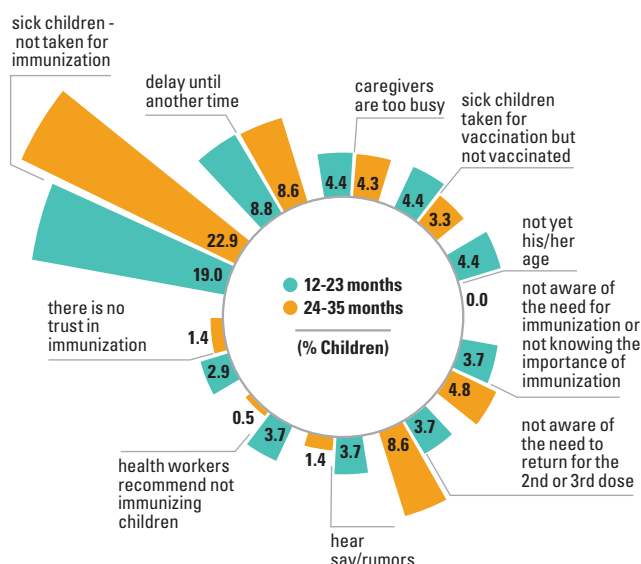
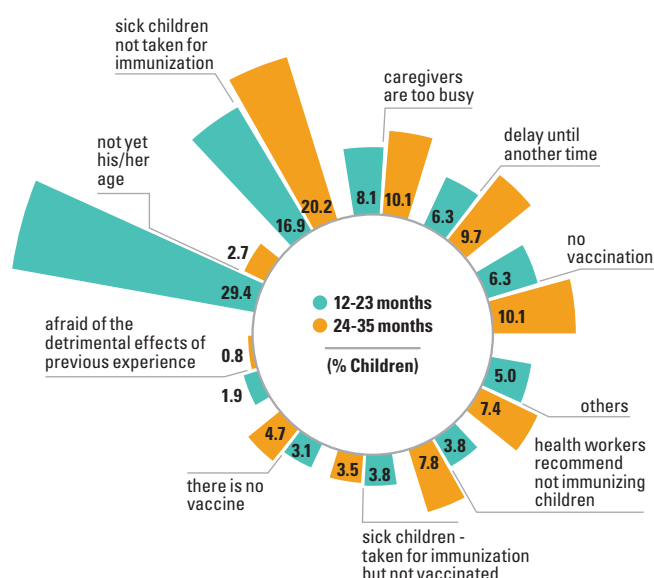


Figure 3. Reason reported by caregiver for not fully immunized children and booster immunization in South Tangerang



FINDINGS

Quantitative results: The average basic immunization coverage for these three areas was 55 percent (63% in Jakarta, 54% in South Jakarta, and 48% in South Tangerang), lower than the national level of 58 percent.³ The proportion of children receiving booster immunization was also low: 43 percent for DPT and 33 percent for MR booster. Dropout rates were below 10 percent, except in central Jakarta where they were as high as 18.5 percent.

The survey pointed to many causes for low immunization on the demand side. Overall, caregivers responding to the survey were aware of the need to immunize their children, but their knowledge of VPDs other than polio, measles, and hepatitis B was low. Caregivers most often sought immunization at pukesmas (community health centers), followed by posyandus and private midwives, though preferences differed from one district to another. The majority of caregivers believed that immunization is important for their child's health; but they also cited a range of barriers (see Box 1). The

Box 1. Caregivers' Reasons for Not Immunizing

- Sick child
- Limited knowledge about importance and/or location of immunization services
- Too busy
- Services not available
- Lack of trust in providers
- Belief that vaccination is not halal

most common reason for not fully immunizing a child was reluctance to bring a sick child for vaccination, suggesting the need for better communication with providers. More than half of caregivers across districts were reluctant to have their child receive multiple immunization shots in one visit, mostly due to fear of side effects such as fever.

“I want every immunization to be in posyandu, we are always got the news, got information. I want it to be like that, so the immunization is always available.”

- Immunization FGD mother of incompletely immunized child in Kramat, Central Jakarta

Factors on the service delivery or supply side also impeded full immunization. Providers would tell caregivers that the vaccination was not due yet, but did not set a date for receiving the services. Often, they did not follow up with the caregivers. Another factor was the practice, by some providers, of not vaccinating sick children. Overall, staffing for immunization services was sufficient, especially for midwives; but providers said that they had not received specialized training on immunization and none had received refresher training. None of the nurses, and fewer than 15 percent of the midwives, had received EPI training. Rapid staff turnover also reduced the number of trained providers.

“... the knowledge is not well-received ma'am, yes maybe it will not be our specialty, so when in the sub-district we have participated in the training, but if special training for immunization has never been done.”

- IDI, midwife in Central Jakarta

“ There is still lack of training, since 2011.”

- IDI, bidan di Jakarta Pusat

Qualitative Results (homeless communities): Homeless participants in FGDs and in-depth interviews were mainly migrants with limited education, working as waste collectors or laborers, living in parks or in unused, often unsuitable areas, and often returning to their home villages periodically. Their knowledge of immunization was good overall, especially for measles, polio, and BCG. Just over half (17 of 32) had obtained full basic immunization for their children. Some mothers said that their husbands, or other relatives, reminded them of the immunization schedule; and they also said that since they knew the health care cadres at the nearby posyandu (health posts), they had access to the services.

Those whose children were not fully immunized cited factors similar to those found in the survey. Some were reluctant to seek the services, being “outsiders.” Others said that they lacked the ID they needed for services at a posyandu, and feared that they would be refused the service and then have to pay for services at a private provider. A main reason for not immunizing was that the child was sick; in that case, caregivers said that midwives told them to postpone immunization. Also—though information on immunization was available from various sources—posyandus did not include the homeless during service planning and forecasting; and thus, did not include them in outreach services or take actions to communicate with them about immunization.

Observation results: In general, EPI management in the three districts was inadequate, especially in Central Jakarta. South Tangerang performed slightly better, where providers had recently received training through the U.S. Center for Disease Control’s Strengthening Technical Assistance for Routine Immunization Training (START) program. Immunization safety was good overall, with over 70 percent of procedures performed safely in all three districts.

The teams identified some gaps in EPI management across all three districts. Fewer than one-third of the 22 public-sector providers observed or understood the requirements for adequately stocking and supplying vaccines. Also, fewer than 60 percent of public health centers conducted standard supervision and met management standards (e.g., developing and updating microplans, vaccine forecasting, community outreach). Monitoring was mixed, with high performance in South Tangerang and much lower performance in the other districts. Except for South Jakarta, fewer than 60 percent of facilities had EPI, stock, or child registers available; and fewer than half of all facilities had job aids. Also, though providers treated patients well, their communication about contraindications and possible side effects was limited—possibly leading to misunderstandings about immunization, and thus missed opportunities.

Participating private providers showed good knowledge of maintaining vaccine quality, but their knowledge about temperature-sensitive vaccines and monitoring of vaccine use and supply was insufficient. Immunization safety was good overall, though soap and disinfectants were often unavailable. Provider-client communication was good overall, but discussion of contraindications and possible side effects was limited.

MAIN RECOMMENDATIONS

- **Immunization scheduling** should be clearly indicated, and should be organized in a way that reduces drop-out and avoids missed opportunities. Immunization services should be offered widely and regularly—preferably at every posyandu—and this should be made clear to vulnerable populations.
- Facilities and policy-makers should consider options for **ensuring universal vaccination**, such as outreach (including to migrant and other vulnerable populations) and waivers (to provide free immunization for those without ID cards). This should include planning and budgeting to cover services for all populations. .
- All providers who offer immunization services should receive regular **training**—including not only technical competency, but skills in communication (for example, on side effects and whether or not to vaccinate sick children).
- **Community leaders, influentials and caregivers** should be educated to provide accurate information about immunization, scheduling, booster doses and address concerns about multiple shots.
- Facilities should conduct **regular microplanning** for supply forecasting and outreach, and should include homeless and vulnerable populations in this planning.
- **Routine supportive supervision** is needed in both public and private facilities. This would help to identify and address challenges in the system—for example, the inadequate recording and reporting of immunization observed in this study.
- **Supply chain strengthening** is essential to ensure that vaccines are reliably available.
- **Private clinics** should be included in training and further studies to enable greater depth of understanding of immunization in Indonesia.

REFERENCES

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