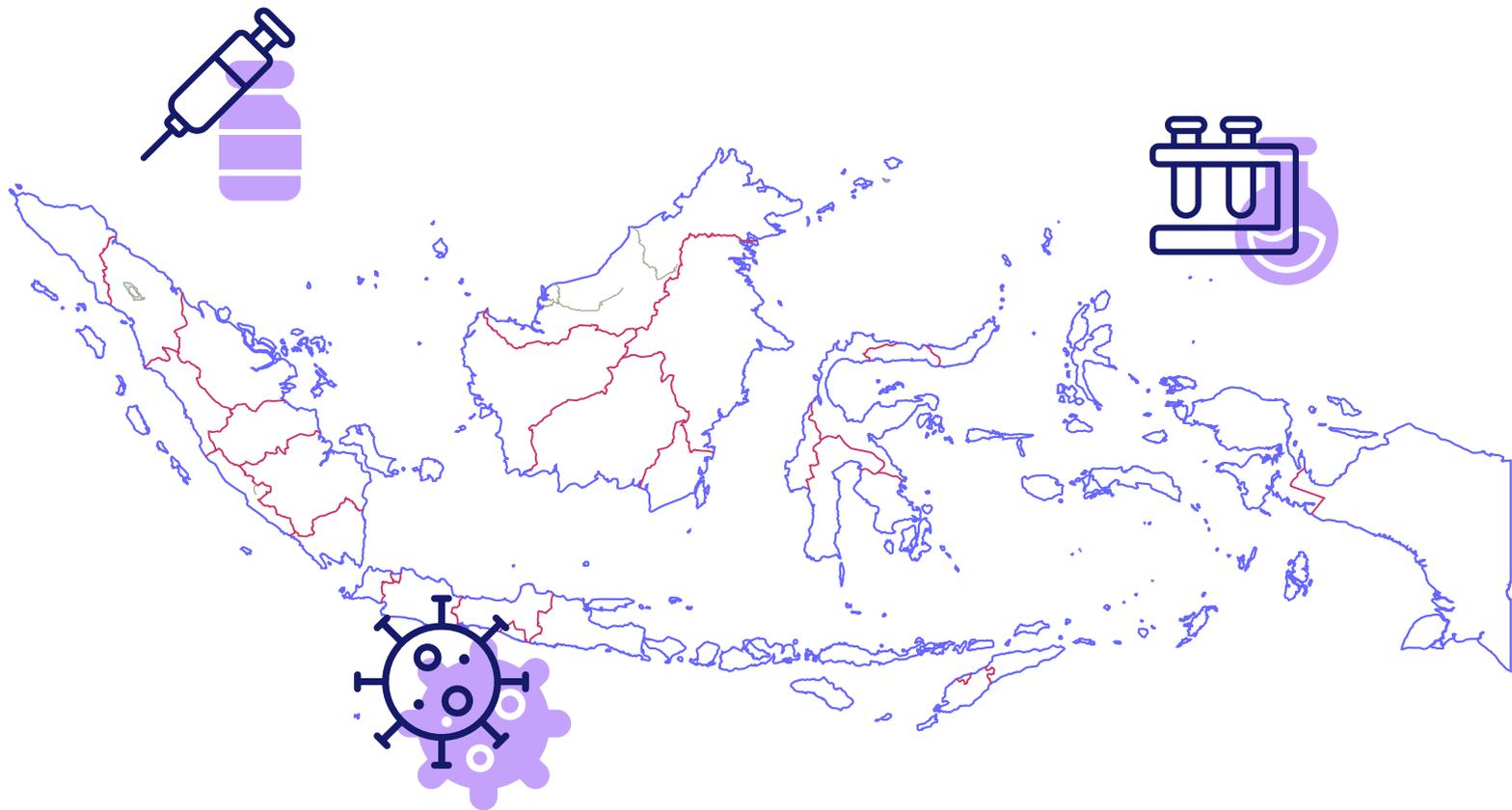
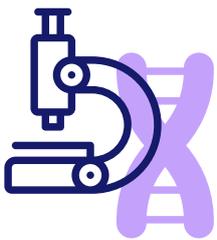


COVID-19 Vaccine Acceptance Survey in Indonesia



November 2020



Background

As in other countries across the world, since the pandemic was first declared in March 2020, the protracted COVID-19 outbreak has had a devastating effect on the Indonesian health sector and economy. The country has made extensive efforts to address challenges:

- The President of the Republic of Indonesia (ROI) formed a national team for the acceleration of the development of COVID-19 vaccines. The Presidential Decree no. 18/2020 issued on 3 September 2020 stipulates the formation of a COVID-19 vaccine development team which is supervised by the Coordinating Minister of Economic Affairs.¹ Additionally, the Indonesian Ministry of Research and Technology is responsible for reporting to the President on the day-to-day work of the team.²
- The President signed and issued a Presidential Decree on 6 October 2020 on the provision of a vaccine and the implementation of vaccination program to combat the COVID-19 pandemic. It stipulates that the government will arrange for COVID-19 vaccine provision, distribution and vaccination. The Decree assigns a state-owned pharmaceutical company, PT Bio Farma, to procure the vaccine in cooperation with several international institutions. It also assigns the Indonesian Ministry of Health (MoH) to manage vaccine distribution and the national vaccination programme.³
- The Ministry of Health (MoH) and UNICEF have signed a memorandum of understanding (MoU) that will enable the procurement of vaccines at affordable prices. The signing was part of Indonesia's commitment to COVAX Facility, the Gavi and WHO-led Access to COVID-19 Tools (ACT) Accelerator, which was established to ensure the procurement and equitable distribution of COVID-19 vaccines to all countries. The Government of Indonesia (GOI) expects to receive 30 million doses of vaccine through a bilateral arrangement with different vaccine manufacturers by the end of 2020 and an additional 50 million doses at the beginning of 2021. As mandated by the Presidential Decree issued in early October, the GOI intends to begin the vaccination process once a safe vaccine is available.⁴
- The National Immunization Technical Advisory Group (NITAG) conducted a situation assessment regarding COVID-19 vaccination and has made recommendations for access to priority groups. The MoH, with support from NITAG and development partners, has developed a standard operating procedure and road map for COVID-19 vaccination. These tools have been disseminated to all provinces and other necessary preparations, including the vaccine introduction readiness assessment tool (VIRAT). All processes have commenced simultaneously.
- Upon a request from NITAG, the MoH with support from UNICEF and WHO, conducted an online survey in Indonesia to understand the public views, perceptions, and concerns about COVID-19 vaccination.

1 <https://www.hukumonline.com/pusatdata/detail/lt5f5719c109642/nprt/lt50ed19c5aced0/keputusan-presiden-nomor-18-tahun-2020>

2 <https://jdih.setneg.go.id/viewpdfperaturan/P18937/Salinan%20Keppres%20Nomor%2018%20Tahun%202020>

2 <https://jdih.setneg.go.id/viewpdfperaturan/P18959/Peraturan%20Presiden%20Nomor%2099%20Tahun%202020>

4 <https://covid19.go.id/p/berita/ketua-komite-kpcpen-airlangga-hartarto-30-juta-dosis-vaksin-tiba-akhir-tahun-2020>

Methodologies and characteristics of respondents

The online survey took place from 19 to 30 September 2020. More than 115,000 respondents from all 34 provinces completed the survey. The distribution of respondents varied by question and province. Almost of all the 514 districts in the country (nearly 99 per cent) participated in the survey; six districts did not have any respondents (two in West Papua and four in Papua province). About 69 per cent of the total respondents were from Java and 13 per cent from Sumatra, where Approximately 75 per cent of the country's population resides.

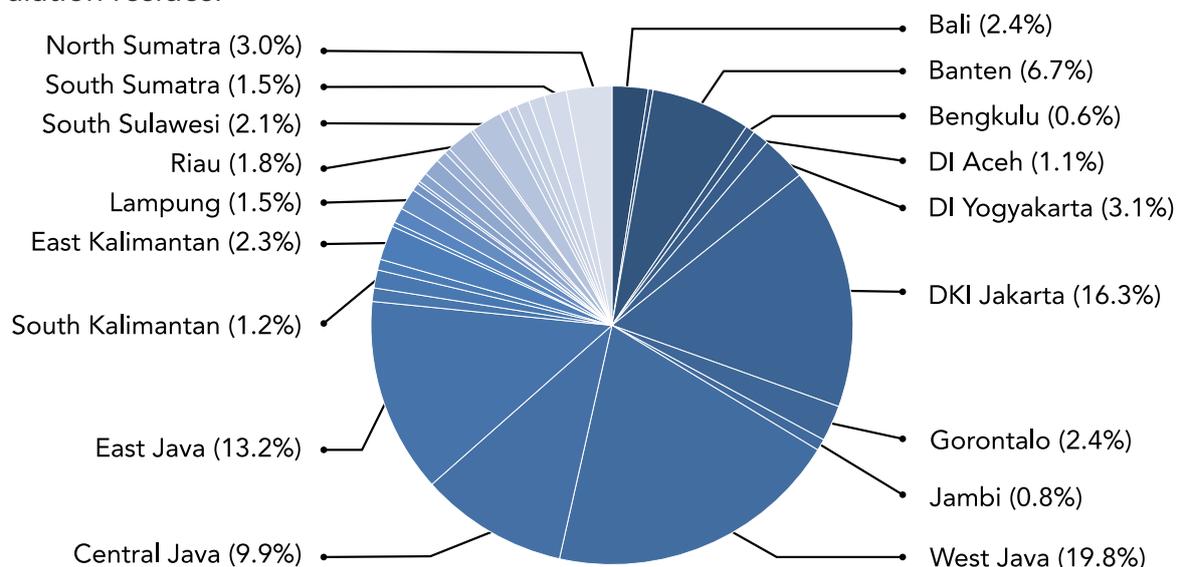
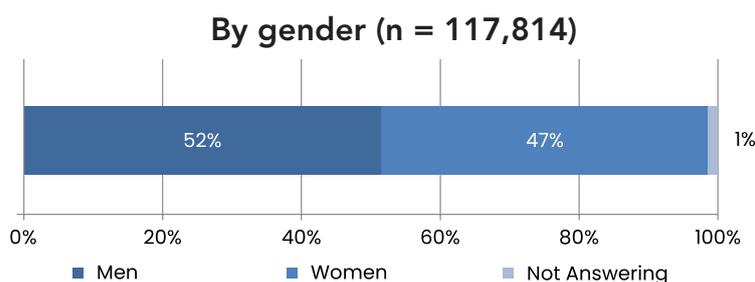
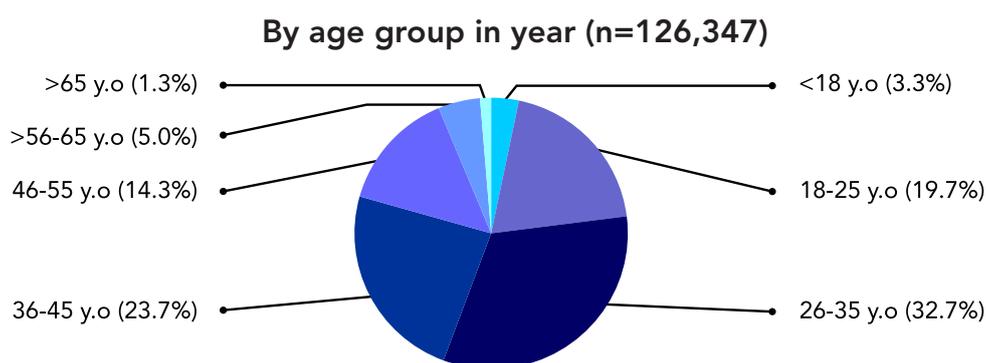


Figure 1. Distribution of the respondents (n=117,814)

Respondents aged below 18 years of age made up 3 per cent of the total respondents. These respondents were asked about their interest in and sources of information about COVID-19 vaccines and their preferred channels of communication. Most of the respondents (76 per cent) were 18 to 45 years of age, and more than 1 per cent of respondents were over 65 years of age. A little over half of the respondents were male.



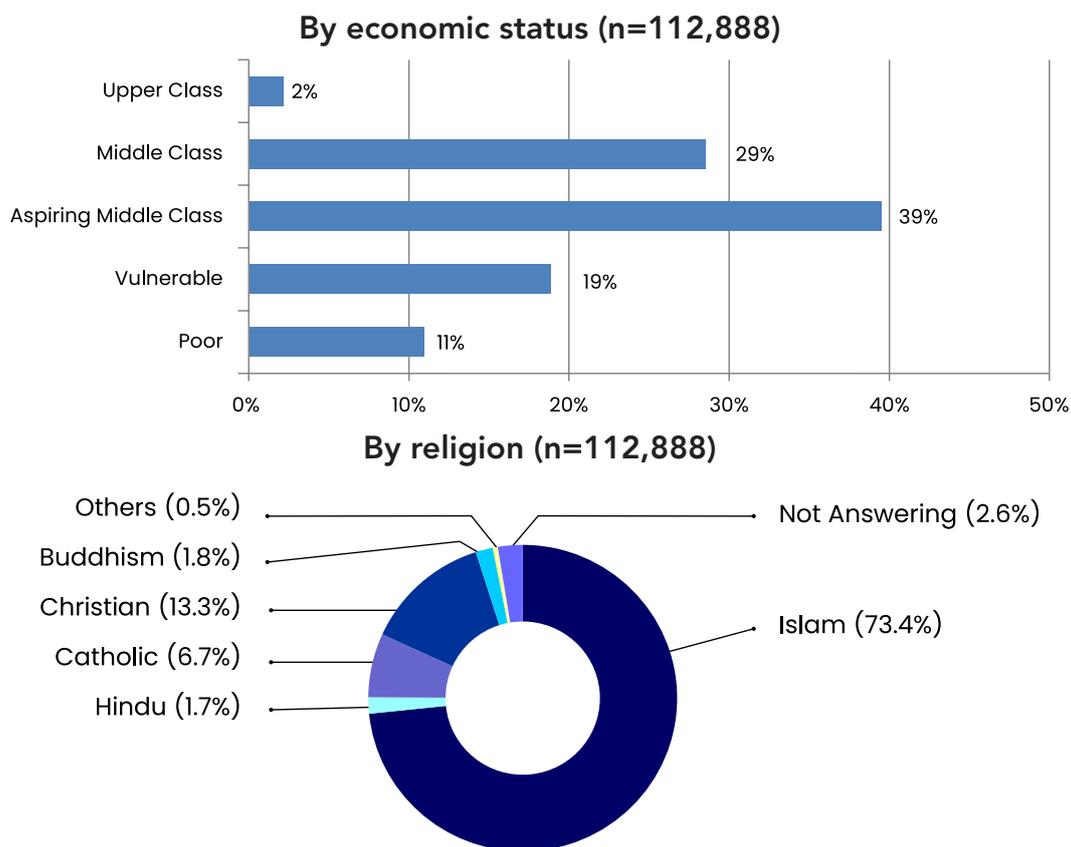


Figure 2. Characteristics of the respondents

A wide range of the respondents (51 per cent) were in formal employment, 10 per cent were self-employed or entrepreneurs and the rest were other professions, unemployed and students. The survey found that over 12 per cent of respondents worked in health sectors such as hospitals, clinics, and pharmacies.

Middle class respondents, including those who identified as 'aspiring middle class', represented nearly 70 per cent of total respondents; while poor, vulnerable, and upper class respondents represented 11 per cent, 19 per cent and 2 per cent respectively.⁵ The majority of respondents were Muslims (73 per cent), followed by Christians (13 per cent), Catholic (7 per cent), followed by others of different religious faiths. About 97 per cent of the respondents who responded to the survey claim to have completed senior high school, an equivalent educational qualification, or higher education.

Sixteen per cent of the respondents reported they do not have health insurance, whereas 64 per cent claim to have health insurance from the Health Care and Social Security Agency (*Badan Penyelenggara Jaminan Sosial/BPJS*). Only 5 per cent of the respondents reported having to have private health insurance and 15 per cent of the respondents said they hold both insurances - BJPS and private. This indicates that about 79 per cent of respondents were insured under the BPJS scheme. Respondents' economic status was analysed and it is found that 35 per cent of poor respondents and 23 per cent of vulnerable respondents do not have health insurance. The possession rate of health insurance increased gradually from poor to upper class respondents; however, a different trend was also reported; 11 per cent of upper class respondents reported not having health insurance.

⁵ Economic status was calculated based on household expenses using the World Bank's definition. Detailed information is provided in Annex B.

People's perceptions and acceptance

Approximately 74 per cent of the respondents reported some knowledge of the GOI's intention to deploy COVID-19 vaccines in the country. The percentage varied between provinces. About 61 per cent of respondents in Aceh report knowledge of the GOI's intention regarding COVID-19 vaccine distribution, whereas in several provinces in Sumatra, Sulawesi and Lesser Sunda Islands, 65–70 per cent of respondents were familiar with similar information. The provinces of Java, Maluku, Kalimantan Islands, along with Papua and few other provinces, reported a higher level of information (above 70 per cent). This survey did not explore the reasons for such variation and further studies are required to understand the factors.

Do you know that the Government of Indonesia has planned to offer COVID-19 vaccine?

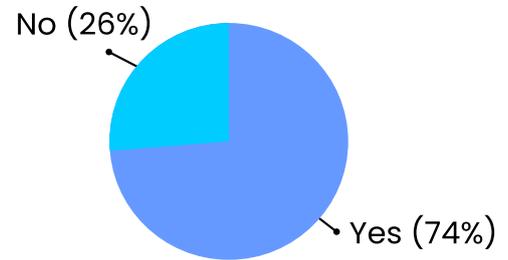


Figure 3. Respondents whether heard of COVID-19 vaccine or not (n=112,888)

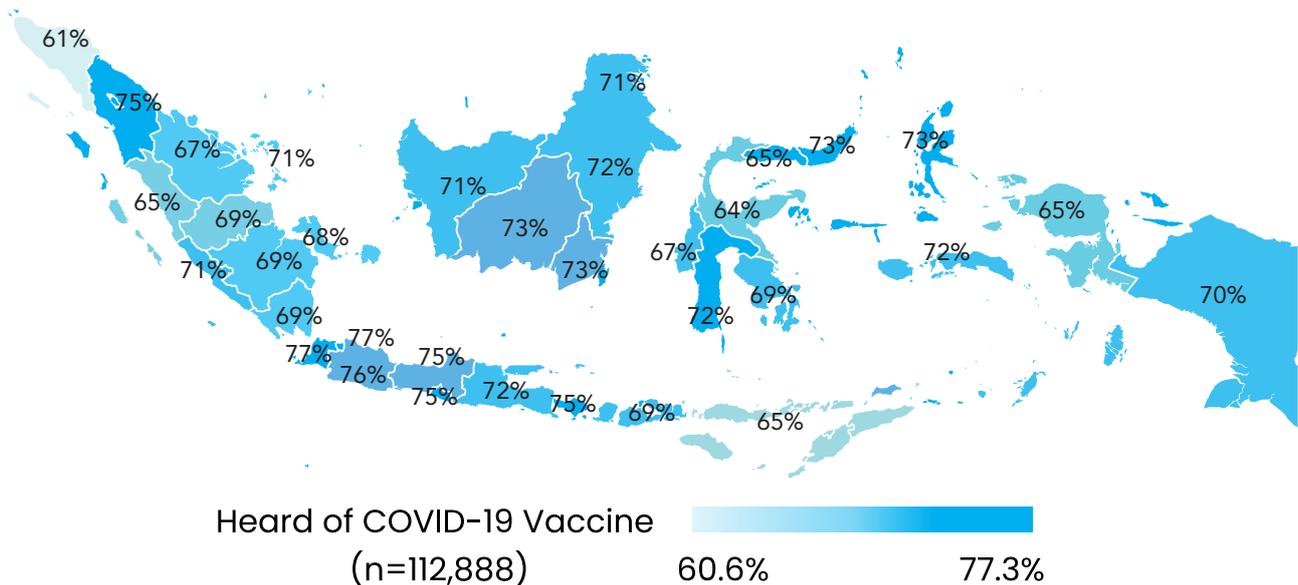


Figure 4. The percentage of respondents who know information related to COVID-19 vaccine

Respondents with low income levels report the lowest levels of knowledge. The level of information known tends to increase according to respondents' higher economic statuses. This may be due to better access to information among wealthier respondents. However, there was a marginal difference among male and female respondents' knowledge regarding the existence of COVID-19 vaccines and the GOI's intention to distribute the vaccine.

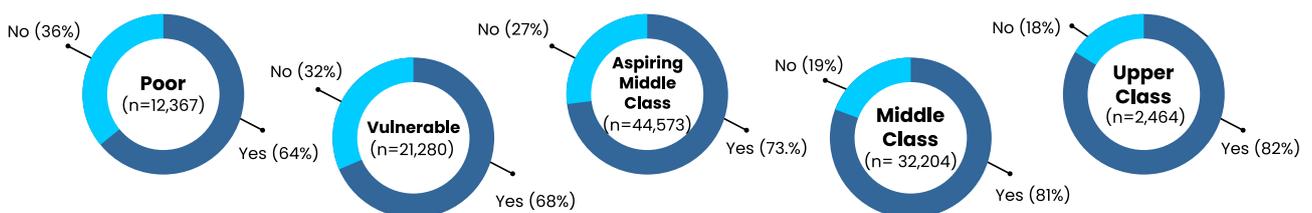


Figure 5. The number of respondents who heard about COVID-19 vaccines by economic status (n = 112,888)

Approximately 65 per cent of the respondents expressed their willingness to accept COVID-19 vaccination if provided by the GOI while about nearly 8 per cent said that they would not to take it. The remaining respondents (more than 27 per cent) expressed hesitation towards GOI's intention to distribute COVID-19 vaccines; this group is critical for a successful vaccination program. ***This should be interpreted cautiously; people may have varying trust levels towards COVID-19 vaccines due to limited information on the type of vaccine, its date of availability, and safety profiles. Furthermore, since NITAG, UNICEF, WHO, and MoH supported the survey, respondents might have been reluctant to entirely disclose their intent.*** According to this survey, vaccine acceptance was reported to be highest in provinces in Papua, Java, and Kalimantan Islands. Several provinces in Sumatra, Sulawesi and Maluku reported a lower level of acceptance. West Papua province reported the highest level (74 per cent) of acceptance among all provinces while Aceh reported the lowest level of acceptance (46 per cent).

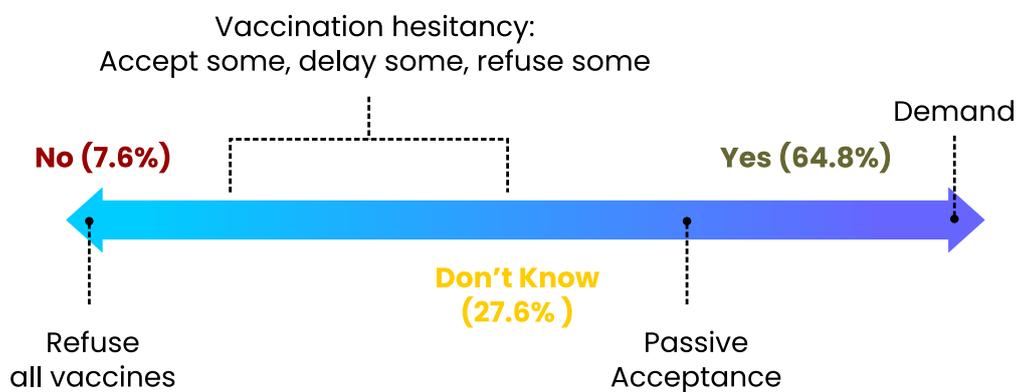


Figure 6. COVID-19 vaccine acceptance status (n=112,888)

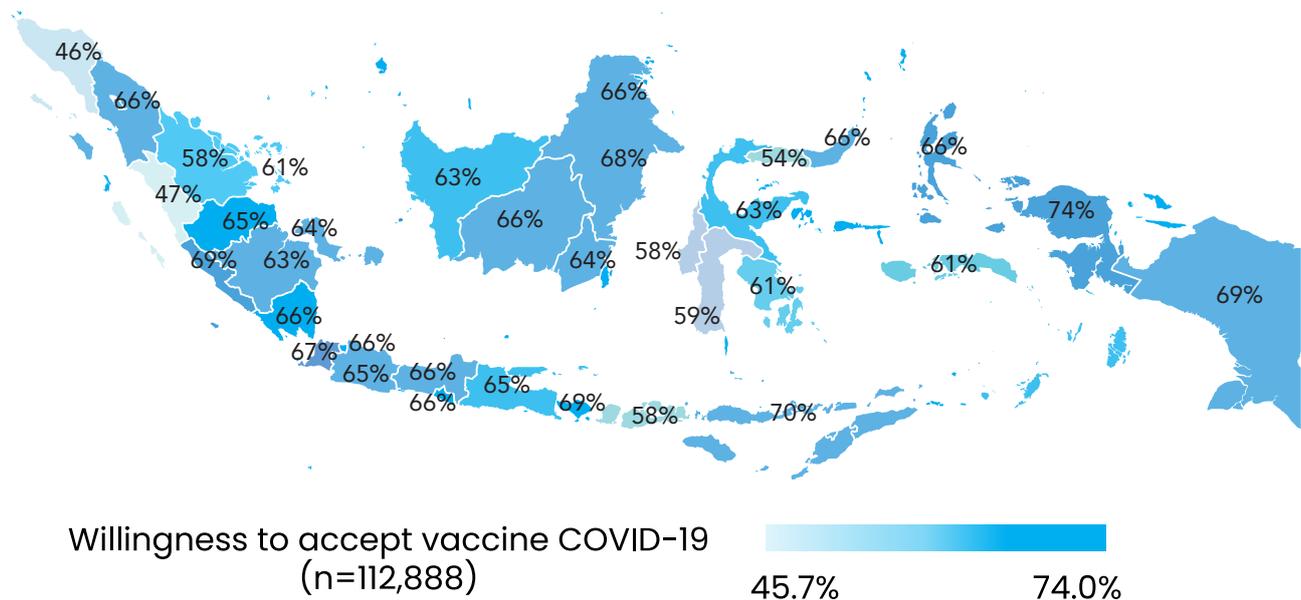


Figure 7. COVID-19 vaccine acceptance by province

The highest reported rate of vaccine acceptance (69 per cent) was reported by respondents of middle class economic status, and the lowest (58 per cent) by respondents of poor economic status. Generally, the higher the economic status, the higher the acceptance rate. However, the wealthiest respondents reported the highest refusal rate (12 per cent), whereas middle class respondents reported the lowest (7 per cent). One third of the respondents of poor economic status had yet to make their decision, and the level of hesitancy tends to decrease as economic status increases.

COVID-19 vaccine acceptance by economic status (n=112,888)

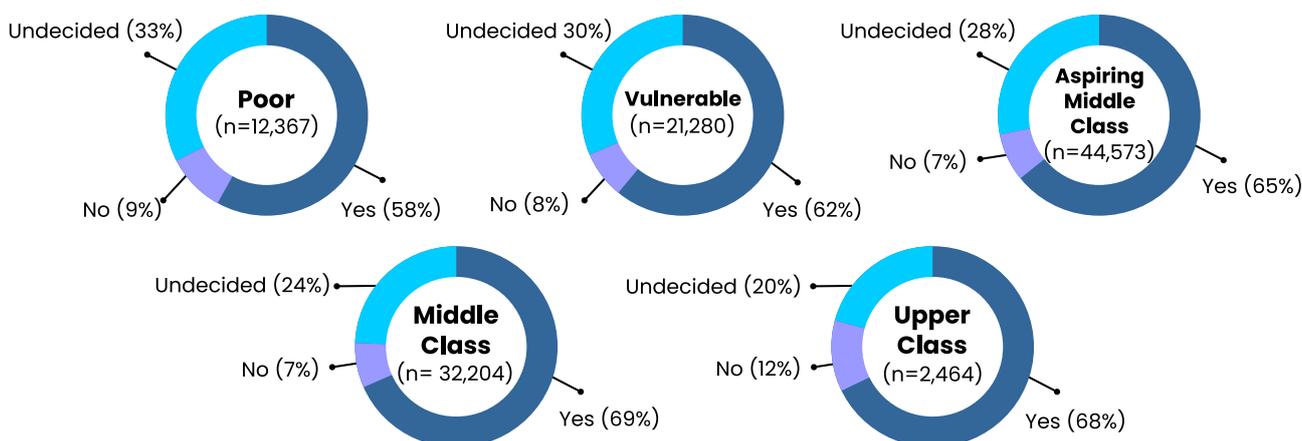


Figure 8. COVID-19 vaccine acceptance by economic status

The highest level (75 per cent) of acceptance was reported among the Catholic and Christian respondents and the lowest (44 per cent) among those who did not disclose their religious beliefs, then by followers of Confucianism, animism and other religious beliefs (56 per cent). About 63 per cent of the Muslim respondents would accept a vaccine, and about 29 per cent had yet to make their decision.

COVID-19 vaccine acceptance by religious beliefs (n=112,888)

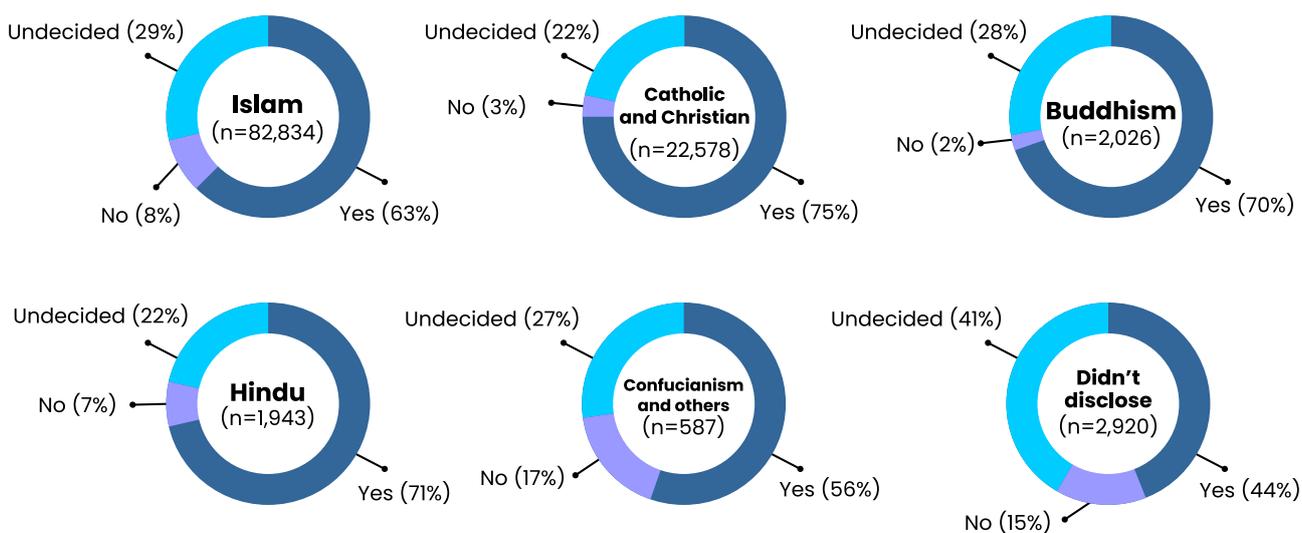


Figure 9. COVID-19 vaccine acceptance by religious beliefs

COVID-19 vaccine acceptance among male and female respondents was almost the same. However, 10 per cent of male respondents reported they would refuse a vaccine while less than 5 per cent among female respondents did so. Additionally, female respondents seem to be more hesitant than male respondents.

COVID-19 vaccine acceptance by gender (n=111,397)

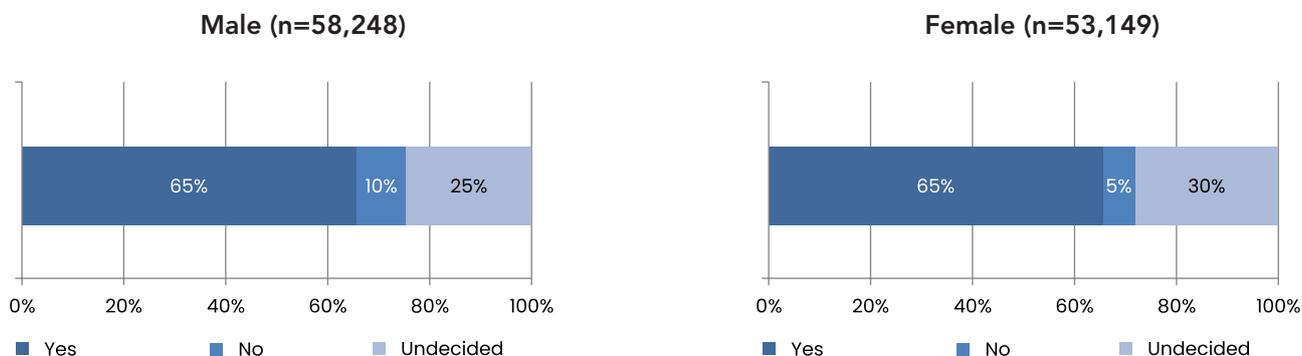


Figure 10. COVID-19 vaccine acceptance by gender

Vaccine acceptance was reported being higher among insurance holders. Almost 12 per cent of respondents without health insurance reported they would refuse a vaccine while around 6 per cent of the respondents with dual insurance reported a similar perception; one quarter to one third of respondents with insurance reported hesitancy.

COVID-19 Vaccine acceptance by insurance users (n=112,888)

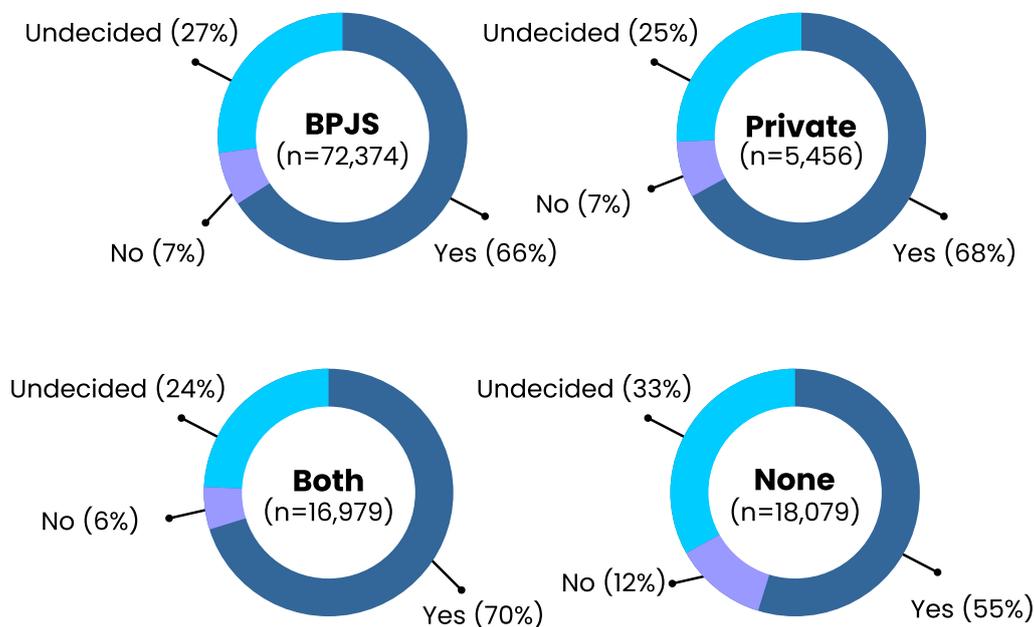


Figure 11. COVID-19 vaccine acceptance by insurance users

About 30 per cent of respondents reported that they or their close contacts such as family members, friends or neighbours had contracted COVID-19 infection and these respondents were found to be more willing to accept a vaccine.

Respondents raised significant concerns about vaccine safety and effectiveness, expressed their lack of trust toward a vaccine and raised concerns about the *haram-halal* category of the vaccine. The most common reasons for not accepting COVID-19 vaccine were concerns about vaccine safety (30 per cent); uncertainty about the effectiveness of the vaccine (22 per cent); lack of trust towards the vaccine (13 per cent); fear of side effects such as fever and pain (12 per cent); and religious beliefs (8 per cent).

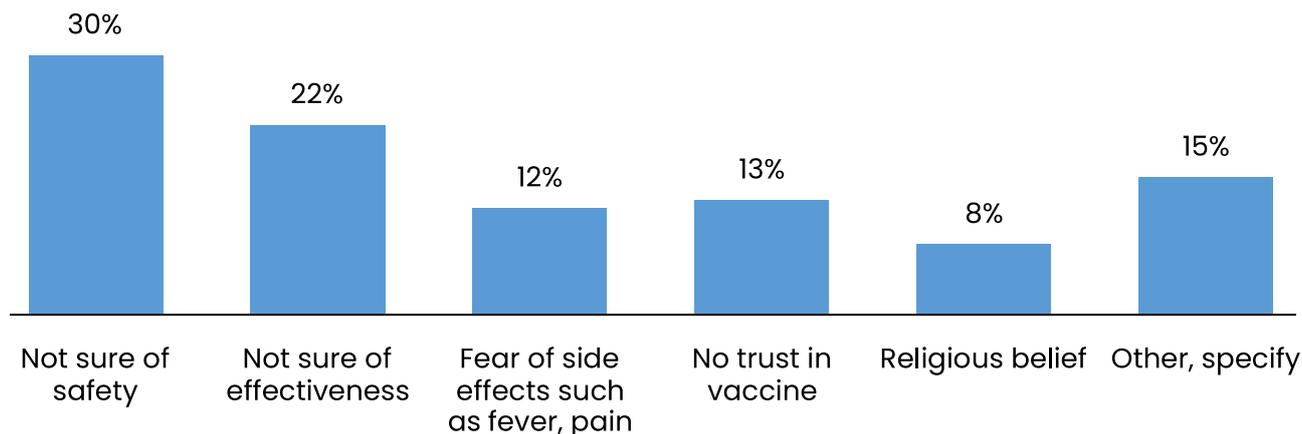


Figure 12. Common reasons for not accepting vaccines (n=16,686)

"We don't know the side effects of the vaccine, or if it is efficient." – Respondent.

"Vaccine needs one year of testing at minimum and 10 years of research completion. I never received immunization since I was an infant. I refuse to be vaccinated. I think it is more viable for the elderly." – Respondent

"If there are side effects, no one will take responsibility for the medical cost incurred." – Respondent

Those who were afraid of needles and those who had previously experienced side effects following immunisation expressed hesitancy. Several respondents questioned the vaccine clinical trial process and safety. Reliable sources of vaccine supply were also considered critical, and many stated they would welcome a vaccine if Indonesia produces it. Respondents also expressed their wish to see political leaders set an example, such as by being the first people to receive a vaccine before mass deployment. Many respondents neither believed in the existence of COVID-19 (SARS-CoV-2) nor its transmissibility and the vulnerability of the public. Several respondents claimed the pandemic was a product of propaganda, conspiracies, hoaxes, and/or an intentional attempt to spread fear through the media for profit.

People's perceptions towards health and disease prevention also played an important role with many considering spirituality as a way to maintain health and deal with disease. Other common contextual factors such as religious beliefs, perceptions of pharmaceutical companies and socio-cultural-economic conditions were also crucial for vaccine acceptance. Some also argued that the advice to wear masks, wash hands and apply social distancing (3M) is enough. Those who reported having been diligently following the 3M advice [("menggunakan masker" (mask-wearing), "mencuci tangan" (hand-washing) and "menjaga jarak" (social-distancing)] saw the benefits of this approach and questioned the risk-to-benefit of adding a vaccine.

- Approximately 74 per cent of respondents have heard about potential COVID-19 vaccines, although the information varied by geographical regions and the economic status of respondents.
- Respondents with poor economic status had the least information about the vaccine and upper class respondents had the most.
- About two-thirds of the respondents are likely to accept a vaccine and the respondents who hesitated were critical about several factors involving a vaccine.
- Acceptance varied by geographical regions; lowest in Aceh and highest in West Papua.
- Acceptance is highest among the middle-class respondents and lowest among the poor respondents.
- Muslim respondents have lower acceptance than other religious followers such as Hindu, Christian and Catholic.
- Respondents without health insurance were found to have the lower acceptance compared to those with insurance.
- There were significant concerns regarding vaccine safety and effectiveness; lack of trust towards a vaccine, and issues regarding the vaccine *haram-halal* category.

Willingness to Pay

Among those who wished to receive a COVID-19 vaccine, 35 per cent of them were willing to pay; approximately 38 per cent were unwilling to pay and the remaining 27 per cent of respondents were undecided.

Willingness to pay for a COVID-19 vaccine varied by province. The highest level of willingness was reported in DKI Jakarta (41 per cent) followed by Papua (40 per cent) and Banten (39 per cent); and the lowest willingness was reported in West Sumatra and Gorontalo (both 23 per cent). Generally, the provinces in Papua, Kalimantan, Maluku, and Lesser Sunda Islands showed a higher willingness to pay and the provinces in Sulawesi and Sumatra Islands showed the lowest willingness to pay. The willingness to pay for the vaccine in Java varied between 32 to 41 per cent.

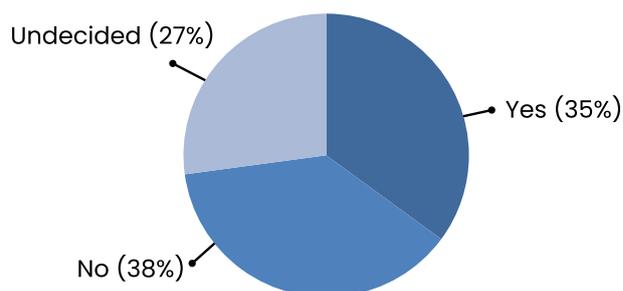


Figure 13. Willingness to pay for COVID-19 vaccine (n=72,795)

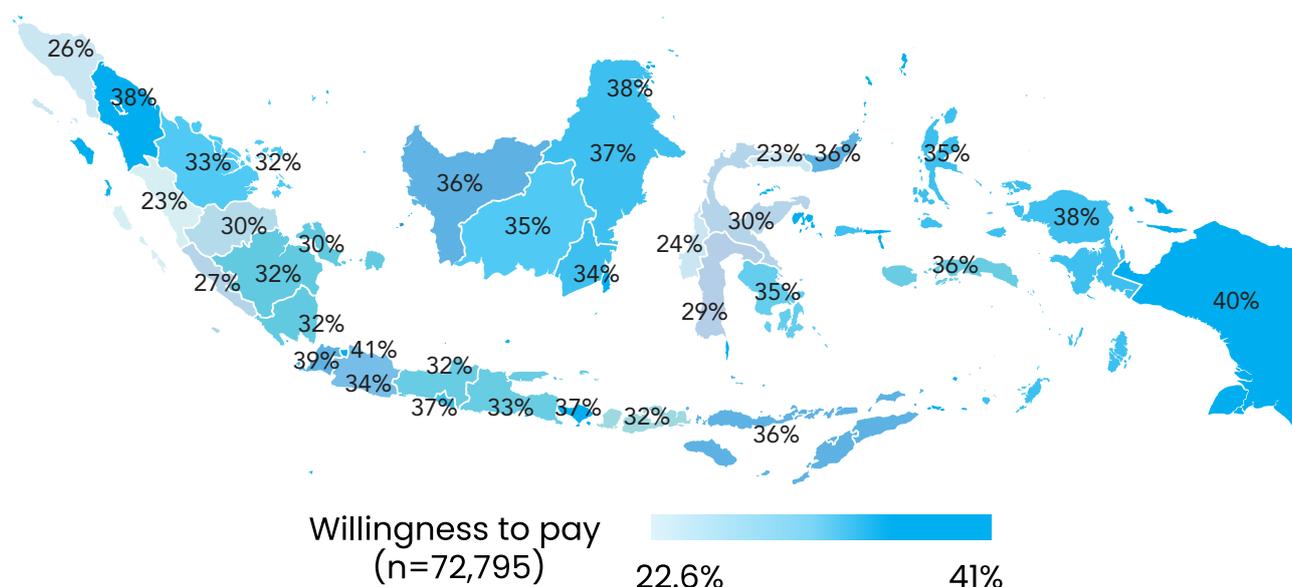
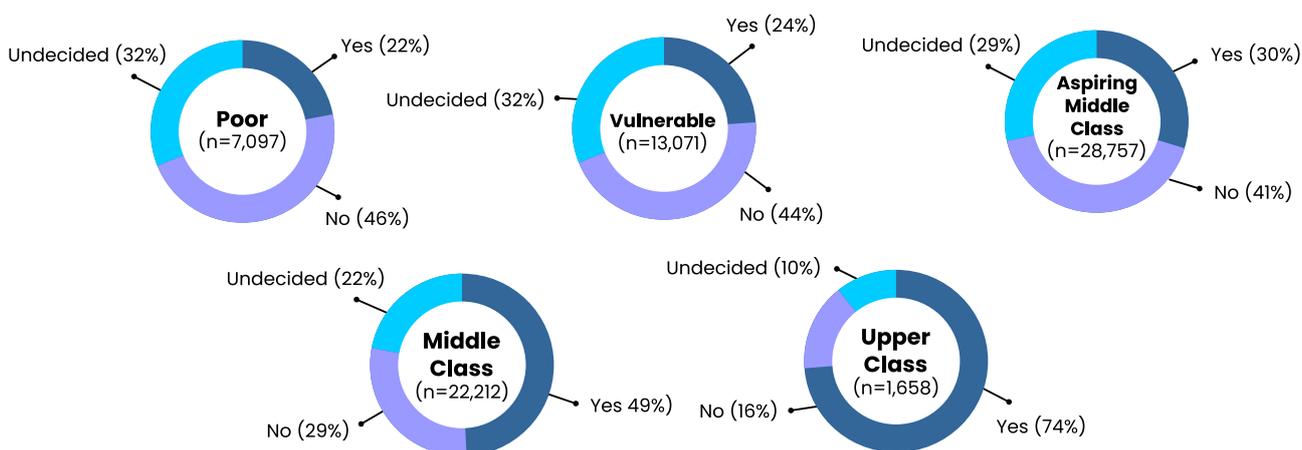


Figure 14. Willingness to pay by provinces

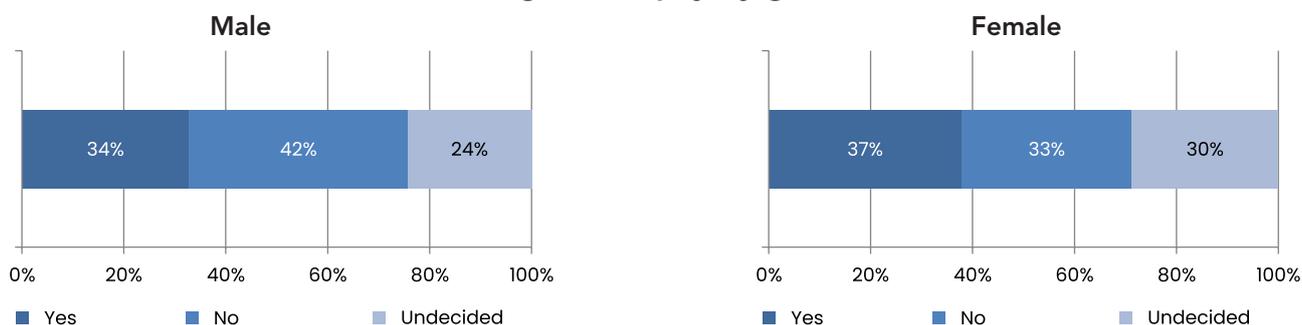
Willingness to pay for a COVID-19 vaccine was the lowest (22 per cent) among the respondents with poor economic status and the highest (74 per cent) among the respondents with high economic status. Willingness gradually increased according to the respondent's economic status. Female respondents reported more willingness to pay compared to male respondents; however, almost one-third of females and one-quarter of male respondents were still undecided. Generally, the level of understanding of how a COVID-19 vaccine might work and a willingness to accept and pay for a vaccine increased by age, from the youngest to oldest. The respondents among the oldest age group (>65 years) were more informed about COVID-19 vaccination (85 per cent) and more willing to accept and pay compared to younger age groups.

Respondents who worked as civil servants (PNS/army/police/SEO staff/regional government-owned enterprises staff) had heard more about COVID-19 vaccine (80 per cent) and had the highest level of acceptance of a vaccine (70 per cent) as well as the highest willingness to pay (43 per cent), followed by respondents who were entrepreneurs and those from the private sectors. The lowest level of willingness to pay was reported by the daily workers, drivers, and domestic helpers (12 per cent) although 60 per cent of them were willing to accept a vaccine.

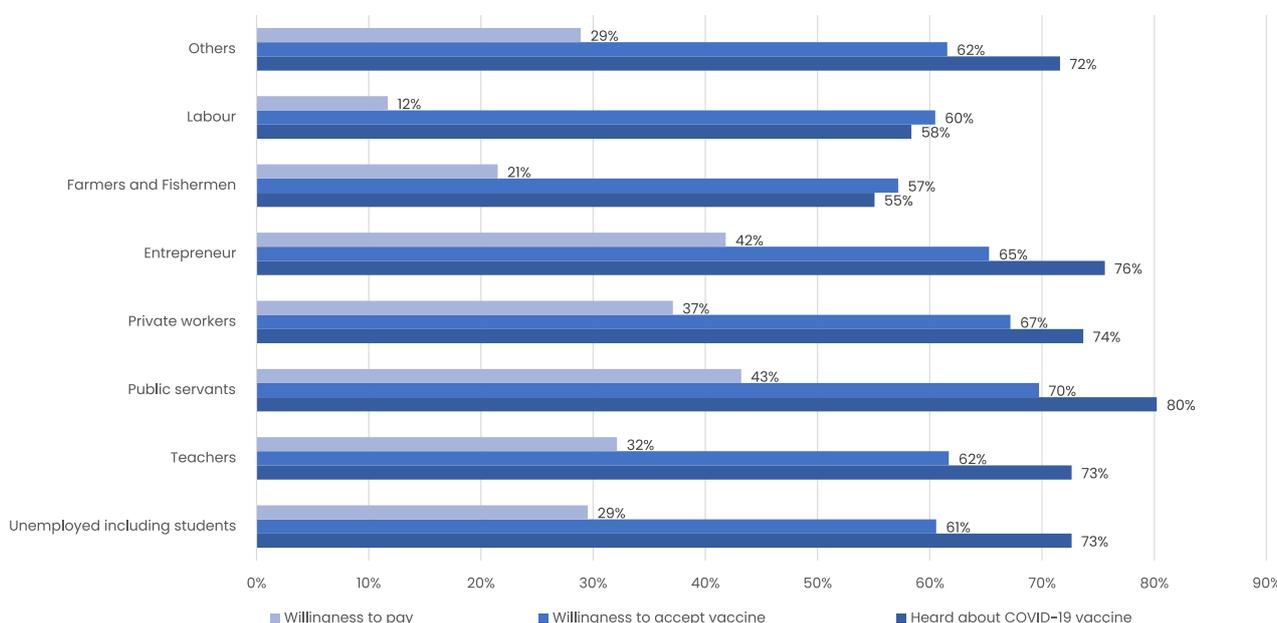
Willingness to pay by economic status of the respondents (n=72,795)



Willingness to pay by gender



Willingness to accept and pay by profession



Understanding and willingness to accept and pay by age groups

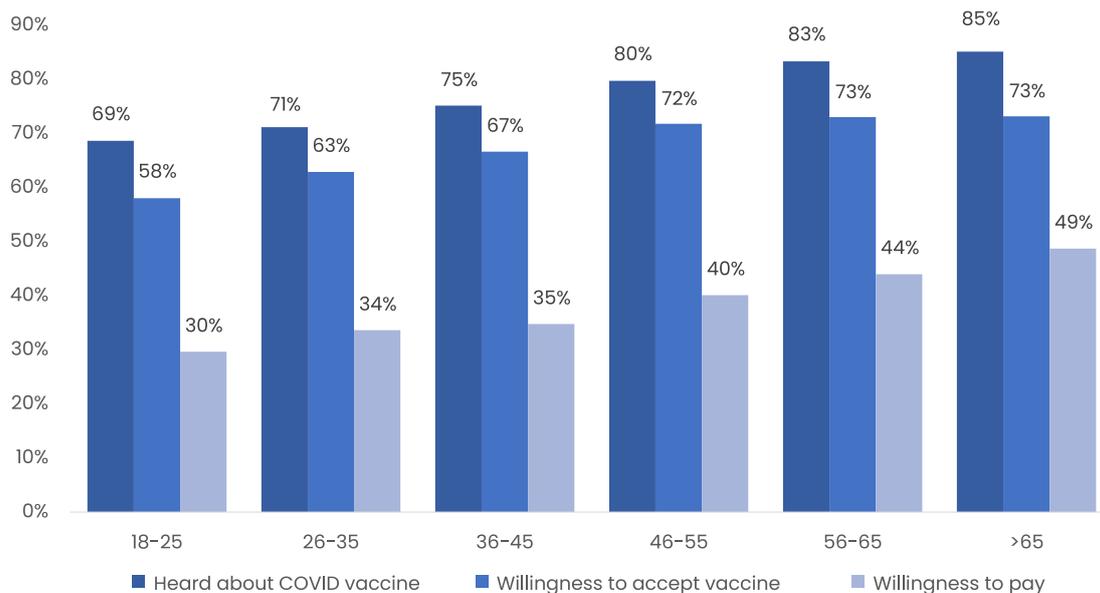
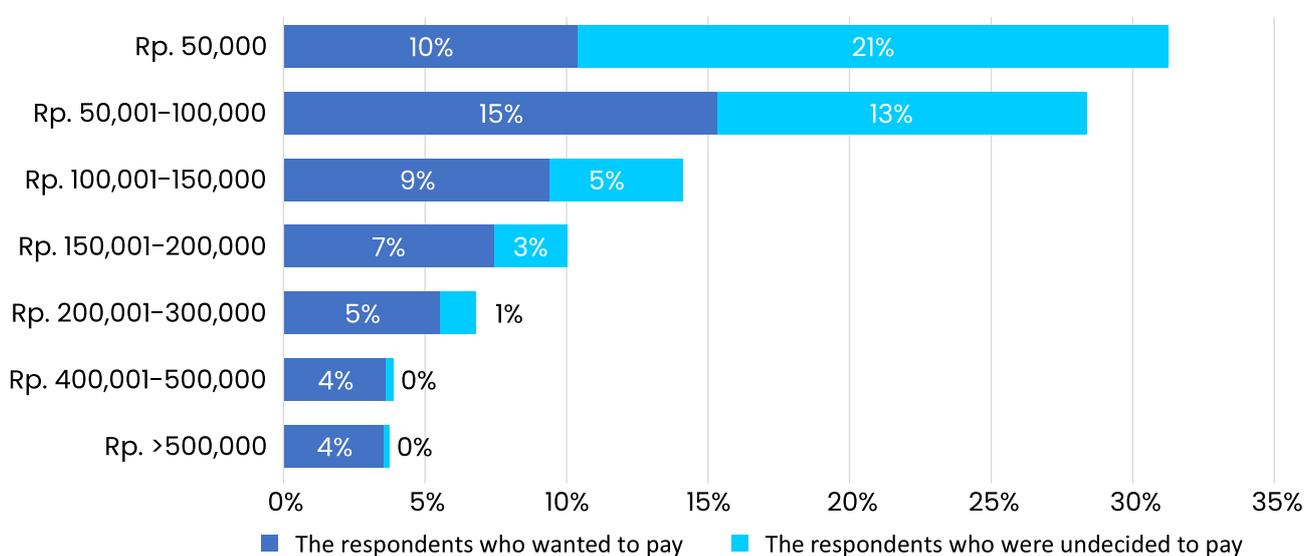


Figure 15. Willingness to pay by economic status, gender, profession and age

Respondents, who were willing to accept a vaccine - and pay for it - were asked to let the GOI know about their maximum ceiling price for a COVID-19 vaccine. More than 31 per cent of respondents mentioned that they would pay up to Rp. 50,000; 28 per cent of respondents would pay up to Rp. 100,000; and about 4 per cent of respondents would pay more than Rp. 500,000. The survey results typically reflect a connection between affordability and the socioeconomic status of the respondents. The willingness to pay for a COVID-19 vaccine to the utmost ceiling of Rp500,000 gradually increased from the poorest (1 per cent) to the richest (21 per cent) respondents. While 60 per cent of respondents with poor economic status were willing to pay up to Rp. 50,000; about 80 per cent of respondents of upper class economic status were willing to pay more than Rp. 100,000 for a vaccine. The most acceptable cost range of vaccine was Rp. 50,000-100,000 among the respondents who wanted (27 per cent) to pay for vaccine and ≤ Rp 50,000 among who were undecided (48 per cent) to pay.

Willingness to pay with a ceiling (n=44,759)



Payment ceiling by economic status (n=44,759)

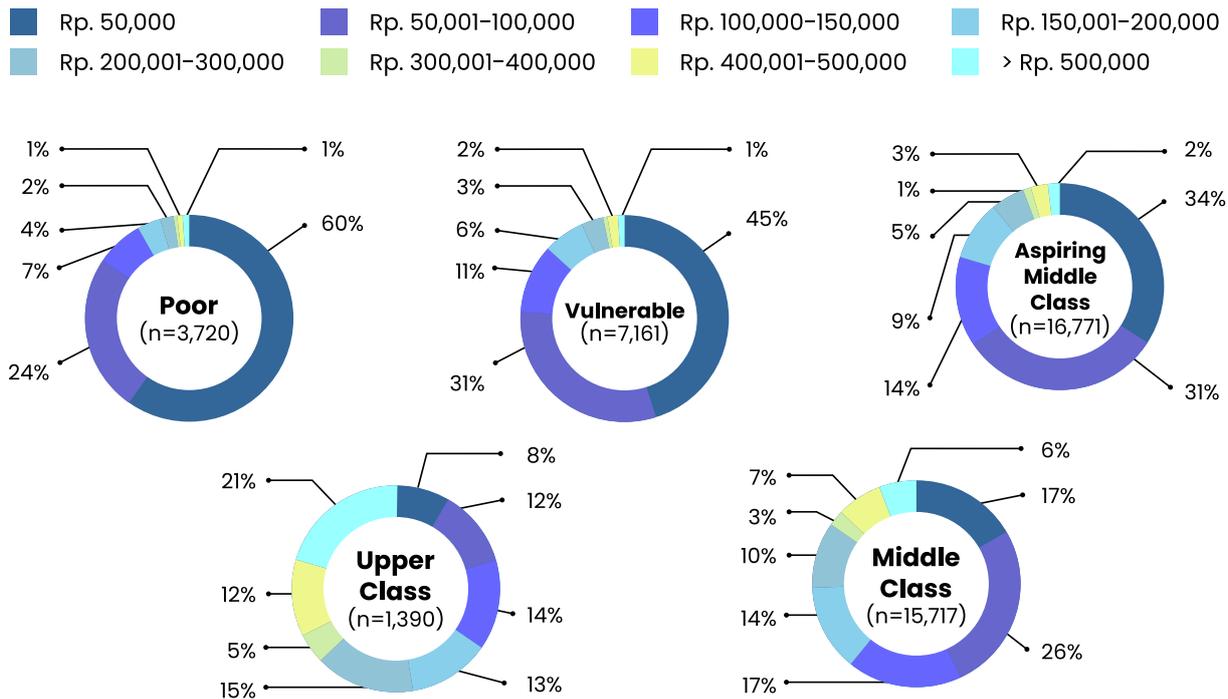


Figure 16. Payment options

- 65 per cent of respondents were not willing to pay for a COVID-19 vaccine.
- Varying across regions, the lowest willingness to pay is in West Sumatra and Gorontalo and the highest is in DKI Jakarta.
- Lowest willingness to pay is among the poor and vulnerable, and the highest is among upper class respondents.
- Respondents over 65 years of age had the highest level of information about potential COVID-19 vaccines and the highest willingness to accept and pay for the vaccine.
- Civil servants, then self-employed and entrepreneur respondents were the most willing to accept and pay for a vaccine.
- The majority respondents may not pay for or cannot afford a vaccine if it costs more than Rp.100,000.

Access to vaccine based on preferred places of vaccination

More than one-third (35 per cent) of respondents wished to get a vaccine at a Community Health Centre (*Pusat Kesehatan Masyarakat/puskesmas*). Private doctors, midwives or hospitals were regarded as the second preferred source (33 per cent) for receiving a COVID-19 vaccine. About 20 per cent of respondents wanted to be vaccinated at their offices or workplaces. There was also a high demand for vaccination at other places, such as private houses, apartments, shopping malls, private laboratories, village meeting halls and places of worship like mosques or temples.

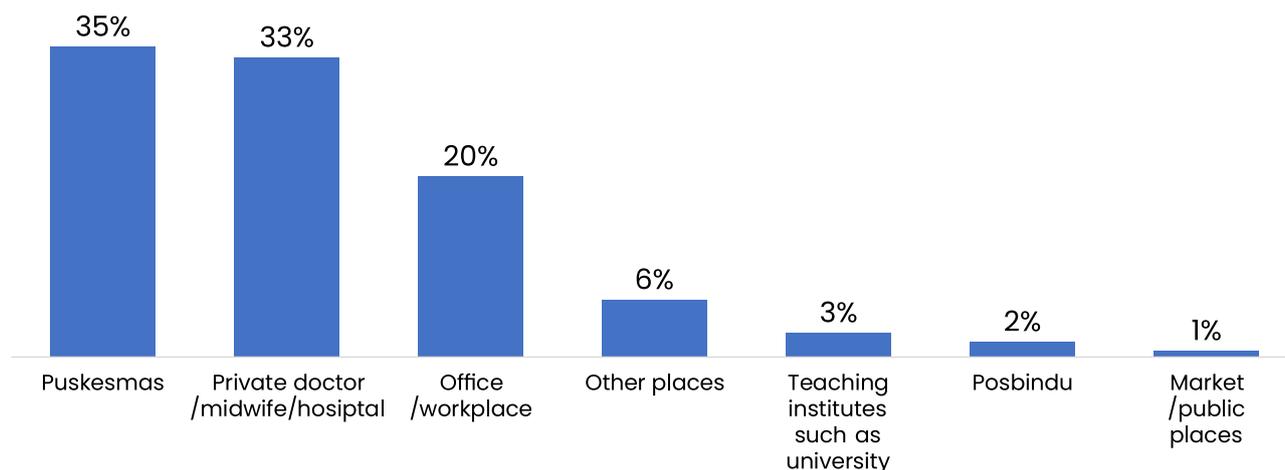
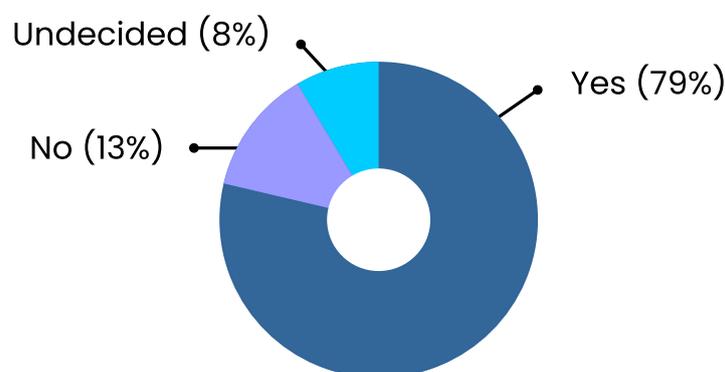


Figure 17. Preferred vaccination sites (n=72,058)

Demand for information

Approximately 79 per cent of respondents wanted to hear more information about potential COVID-19 vaccines. Although all age groups reported high demand for information, it was the highest (95 per cent) among respondents aged more than 65 years. However, reluctance and hesitancy to seek more information was highest (11 per cent) among the younger age group of 18–25-year-old.

Would you like to get further information about COVID-19 vaccine? (n=112,748)



Demand for information about COVID-19 vaccine by age group (n=11,2067)

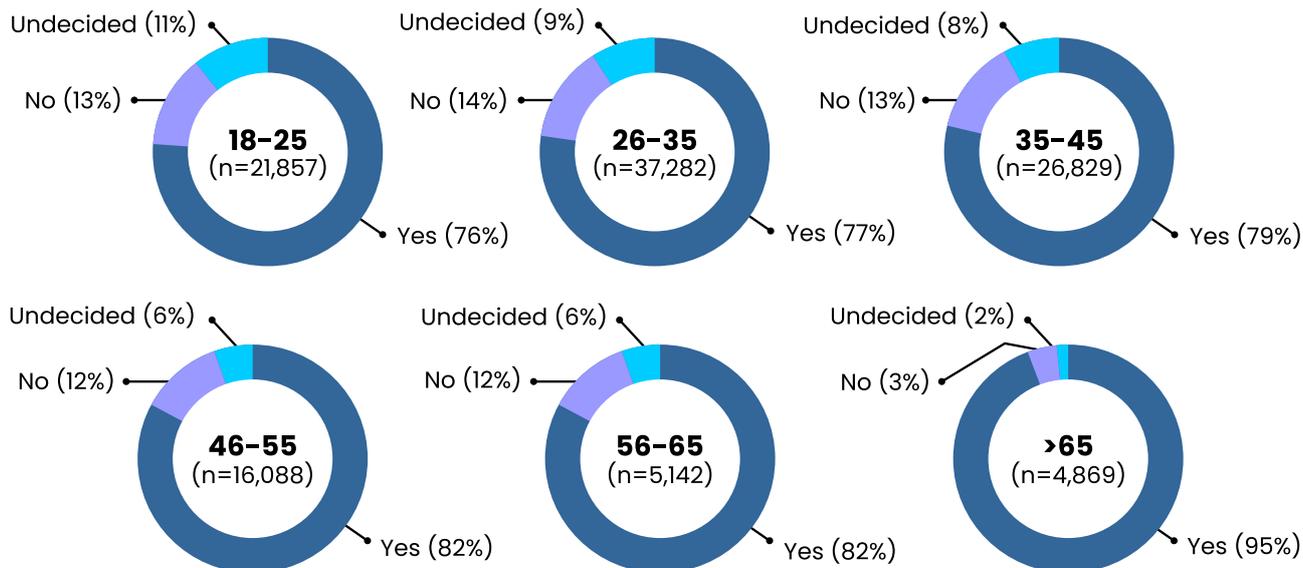
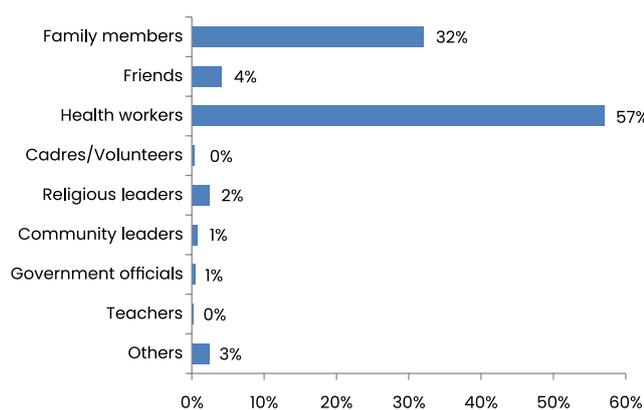


Figure 18. Demand for information

Health professionals and health workers were considered the most trustworthy (57 per cent) in guiding hesitant respondents in deciding whether to accept a COVID-19 vaccine. Family members were the second choice for respondents who would like to consult others. However, respondents also wanted to get more information about a vaccine's safety and efficacy through academics and scientists; medical journals and articles; social media and the internet; traditional healers; and volunteers who have received a COVID-19 vaccine as part of a clinical trial.

Who will you consult? (n=30,686)



How do you want to get more information? (n=112,748)

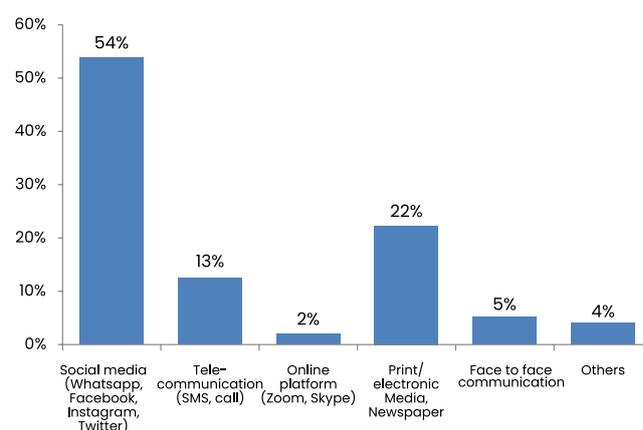


Figure 19. Respondents' preferred sources and channels of information

Approximately 54 per cent of respondents preferred social media - such as WhatsApp, Facebook, Instagram, and Twitter - to get more information about COVID-19 vaccines, followed by print and mass media such as television and newspapers. About 13 per cent of respondents wanted to receive information through telecommunication channels such as SMS and phone calls. Although social media was the most preferred channel for acquiring information among the respondents of all age groups, the preference for electronic and print media increased progressively by the age of the respondents. For example, the 18–25-year-old age group chose social media as their first choice (60 per cent) and electronic media as their second choice (15 per cent). For respondents more than 65 years of age, it was 48 per cent for social media and 29 per cent for electronic and print media. Amongst all channels for information, social media was the most preferred channel of information (57 per cent) among the respondents with poor economic status and the preference rate declined gradually by their improved economic status, from poor to rich.

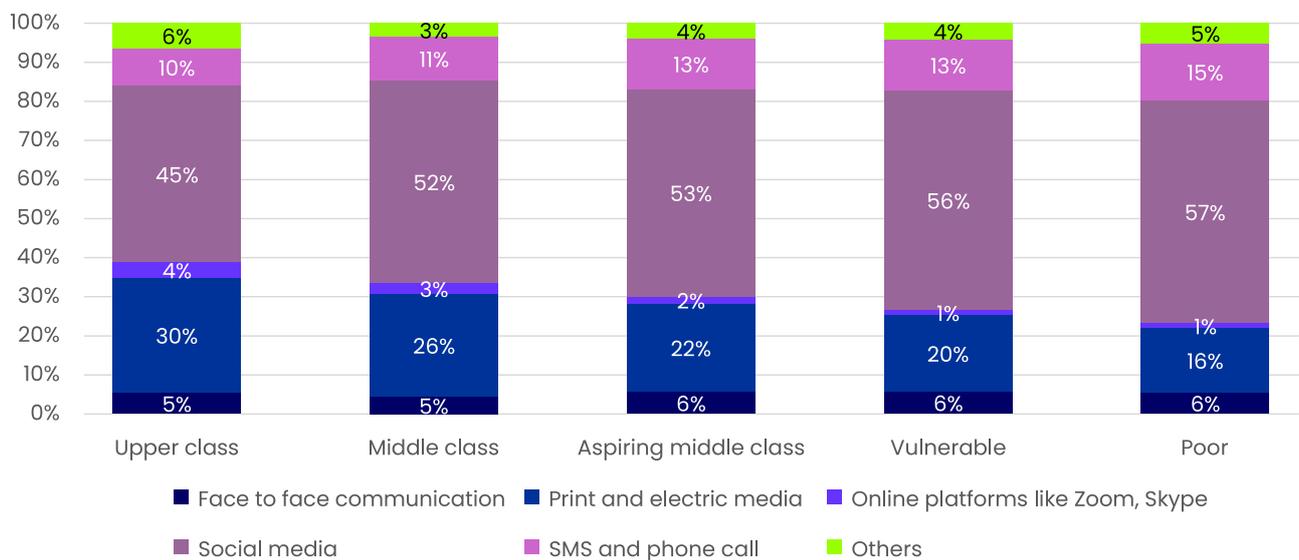


Figure 20. Preferred channels for the information of COVID-19 vaccine by economic status (n= 108,997)

- There is high demand for correct and accurate information about COVID-19 vaccination.
- Health workers are the most trusted source of information.
- Social media, as well as print and mass media, are the most preferred channels for information.

Key recommendations

The following recommendations were made by MoH, NITAG, UNICEF and WHO and may be considered to ensure successful deployment of a COVID-19 vaccine. Several actions are needed to be carried out urgently, such as providing information about COVID-19 vaccine safety and efficacy to the general public using clear, tailored communication approaches and channels. Detailed recommendations are as follows:

1. To increase vaccine acceptance:

- a. Develop a communications strategy that considers the diverse information needs of the audience before, during, and after vaccine introduction, especially those relating to the benefits of vaccine, safety, efficacy and equity issues.
- b. Continue strong messaging and policy support provision for other COVID-19 mitigation measures such as 3 M (mask use, hand washing and physical distancing) and promote them as a new social norm.
- c. Localise COVID-19 vaccine preparedness efforts as much as possible, including tailoring Risk Communication and Community Engagement (RCCE) approaches.
- d. Include front line health workers as the primary audience in communications planning and build their capacity.
- e. Conduct more in-depth research to understand concerns and perceptions toward a COVID-19 vaccine and how misinformation, disinformation or an 'infodemic' may contribute to these concerns.
- f. Find ways to reach the people who have the least access to information such as poor and vulnerable people.
- g. Include behavioural interventions in RCCE planning, not just communication messages
 - Consider including environmental "nudges" to address issues related to concerns about cost, complacency (low-risk perception), and convenience;
 - Consider building out user profiles of early target groups in a human-centered-design approach to ensure services provided are appropriate and acceptable to mitigate risk.
- h. Make confidence-building part of every public action related to COVID-19 vaccine development and rollout—ensuring strong visibility of this aspect.
 - E.g., live stream a plenary session of a national vaccine safety meeting outlining the general research and development and vaccine safety approaches employed by the government and experts.
- i. Speak with one consistent voice: choose a leading spokesperson.
- j. Plan for all contingencies and create a robust Vaccine-Related Events Response Plan that considers all possible scenarios and responses.
- k. Involve religious leaders, professional organisations and Civil Society Organisations.

2. To increase the affordability and accessibility and promote equity:

Further studies and discussions about costs and payment-related issues are needed to produce conclusive recommendations. GoI may provide vaccine free of cost to increase acceptance, especially among people of poor and vulnerable economic status. If the vaccine is not provided at free of charge, it should be priced at an affordable range so that everyone can afford it. The following aspects may be considered while finalising the price of the vaccine and payment options:

- How can poor and vulnerable groups without health insurance access a COVID-19 vaccine without having to face any financial barriers?
- How to ensure access for people above 65 years of age with comorbidities who are willing to accept vaccine?
- What are the financial costs to the government and repercussions on other health programs (including immunisation, maternal, newborn and child health programs) during the rollout of COVID-19 vaccination?

3. Additional recommendation:

Consider the vaccine acceptance rate, willingness to pay and access to services during vaccine forecasting exercises and continuously monitor vaccine needs depending on the ongoing COVID-19 pandemic transmission in Indonesia.

Disclaimer

This report was prepared based on the information provided by the respondents who voluntarily took part in the online survey. An online survey is a cost-effective platform, especially during this COVID-19 context where travel and face-to-face interactions may increase the risk of disease transmission. However, the opportunity for fair participation and data validation were fundamental limitations. This survey was conducted prior to the GoI's announcement about the deployment of the vaccine in January 2021 (or earlier). People's perception may also be influenced by the involvement of MoH, NITAG, UNICEF and WHO in the survey.

Acknowledgement

MoH, NITAG, UNICEF and WHO would like to express their gratitude to COVID-19 Task Force (<https://covid19.go.id>), telecom providers, PHOs, DHOs and all health facilities across the country. We also appreciate the respondents' active participation and valuable inputs.

Survey on the community acceptance of COVID-19 vaccine in Indonesia

Greetings! As you know that the Government of Indonesia has planned to offer vaccine for COVID-19 in tentatively early 2021 to combat the pandemic through increasing the population immunity. Vaccine could be available for the people with high risks, such as health workers, people with comorbidity, productive workforce and others.

In order to understand your views, perceptions and concerns about COVID-19 vaccine, the Ministry of Health, National Immunization Technical Advisory Group (NITAG), WHO and UNICEF are inviting all adults in Indonesia to participate in the survey.

The responses will be anonymous, and confidentiality will be maintained. Thank you very much.

1. Are you willing to join?

- A. Yes B. No

2. What is your **age**:

- A. <18 years B. 18-25 years C. 25-35 years
D. 35-45 years E. 45-55 years F. 55 to 65 years
G. >65 years

If age less than 18 years, excluded from the survey (use logic)

3. Which **province** do you live in?

4. Which **kabupaten/kota** do you live in?

5. Sex:

- A. Male B. Female C. Don't want to disclose...

6. What is your **marital status**?

- A. Married B. Single (unmarried/separated/widow)
C. Don't want to disclose

7. What do you do to live in (**occupation**)?

- › Unemployed including students
- › School and other teaching institutions
- › Civil Servant/Army/Police/State-owned enterprises/Regional-owned enterprises
- › Private employee
- › Self-employed/Entrepreneur
- › Farmer
- › Fisherman
- › Daily labor/driver/housemaid
- › Others

8. Do you work in the health sectors such as hospital, clinics, pharmacy?
A. Yes B. No
9. What is your household's monthly expense on an average?
 › <Rp. 1,416,000
 › Rp. 1,416,000-2,128,000
 › Rp. 2,128,001-4,800,000
 › Rp. 4,800,001-24,000,000
 › > Rp. 24,000,000
10. What **religion** do you believe in?
 A. Islam B. Hindu C. Christian D. Catholic
 E. Buddhist F. Kong Hu Cu G. Believer (penganut kepercayaan)
 H. Others I. Don't want to disclose
11. What is your highest **education**?
 › Never went to school
 › Did not finish elementary school/ MI
 › Graduated from elementary school/ MI
 › Graduated from Junior High School/ MTs
 › Graduated from Senior High School/ MA/ Vocational School
 › Graduated from Diploma/ Bachelor/Master/PhD/University level
12. Information about your **health insurance**?
 A. BPJS B. Private C. Both D. No insurance
13. Have you or any of your family members or others such as friends, colleagues, neighbors whom you interact closely had COVID-19?
 A. Yes B. No C. Not sure
14. Do you know that Government of Indonesia has planned to offer COVID 19 vaccine? (note: Vaccine could be one or two-dose or more, and in injection mode)
 A. Yes B. No
15. If Government of Indonesia offers you COVID 19 vaccine, will you take it for yourself and your family members?
 A. Yes B. No C. Not decided yet
16. If response to Q 15 is No, why will you not accept COVID vaccine (multiple choices):
 › Not sure of safety
 › Not sure of effectiveness
 › Fear of side effects such as fever, pain

- › No trust in vaccine
 - › Religious belief
 - › Other (specify)
17. If the response to Q 15 is not decided yet; Who would you like to consult if you are not decided yet?
- A. Family members B. Friends
 C. Health professionals (Doctors, nurses, midwives and others)
 D. Cadres E. Religious leaders F. Community leaders
 G. Government Officials H. Teachers I. Other (specify)
- If response to Q 15 is yes, ask the following questions, 18-19:
18. Are you willing to pay for the vaccine?
- A. Yes B. No C. Don't know.
19. If 17 is yes, how much will you pay utmost to get vaccine if there is such provision?
- A. Rp. 50,000 B. Rp. 50,001-100,000 C. Rp. 100,001-150,000
 D. Rp. 150,001-200,000 E. Rp. 200,001-300,000 F. Rp. 300,001-400,000
 G. Rp. 400,001-500,000 H. >Rp. 500,000
- (Note, this is neither the real price nor market survey, and it does not have any relationship with government plan)*
20. Where would you like to get vaccine?
- A. Puskesmas B. Posbindu
 C. Private doctor/Midwife/Hospital
 D. Office/workplace,Market/public places
 E. Teaching Institutes such as University F. Another place (specify)
21. Would you like to get further information about COVID-19 vaccine?
- A. Yes B. No C. Don't know
- (further information: please visit.....link.....)
22. How would you like to get more information about COVID-19 vaccine? *(most preferred, single option)*
- › Social media such as WhatsApp, Facebook, Instagram, Twitter
 - › Through telecommunication such as SMS and call
 - › Online platforms such as Zoom, Skype,
 - › Print and Electronic media: TV, newspaper
 - › Face to face communication
 - › Other

Thank you very much for your participation

Income Scale

	Poor (P)	Vulnerable (V)	Aspiring Middle Class (AMC)	Middle Class (MC)	Upper Class (UC)
	Those living below the national poverty line, or around Rp 354,000 per person per month (US\$2.20 per person per day in 2016 PPP-adjusted terms);	Those living above the poverty line but with a non-negligible risk of falling into poverty, or between Rp 354,000 and Rp 532,000 per person per month (US\$2.20-3.30 per person per day)	Those no longer living in poverty or vulnerability but who are not yet economically secure, or between Rp 532,000 and Rp 1.2 million per person per month (US\$3.30-7.75 per person per day)	Economically secure Indonesians with little chance of falling into poverty or vulnerability, or between Rp 1.2 million and Rp 6.0 million per person per month (US\$7.75-38 per person per day)	The wealthiest Indonesians who consume more than Rp 6 million per person per month (>US\$38 per person per day)
Consumption/ per person/ month	354,000.00	532,000.00	1,200,000.00	6,000,000.00	6,000,001.00
Average household (HH) members**	4	4	4	4	4
Total consumption/ HH/month	1,416,000.00	2,128,000.00	4,800,000.00	4,000,000.00	4,000,004.00
Suggested range for household expenses/ month	1,416,000.00	1,416,000-2,128,000	2,128,001-4,800,000	4800001-24,000,000	>24,000,000

Sources:

* World Bank: Aspiring Indonesia—Expanding the Middle Class, 2019

** United Nations Database of Household Size and Composition 2017

