

## Attitudes and practices related to malaria vaccine acceptability in Bo, Sierra Leone

### Questionnaire

Survey #	
Interviewer	
Neighborhood	

#### Getting Started *(to be filled out by the interviewer)*

Has the consent form been completed?	<input type="checkbox"/> Yes
What is the gender of the study participant?	<input type="checkbox"/> Female <input type="checkbox"/> Male

#### Demographics

1	<b>What is your age in years?</b>	<i>Enter a whole number, like 19 or 75.</i>	<input type="checkbox"/> _____
	<i>Is the individual age 18 or older?</i>	<i>If the age in years is less than 18, the participant is <u>not</u> eligible for the study.</i>	<input type="checkbox"/> Yes
2	<b>Are you currently married (or partnered), or are you single?</b>	<i>Check only one box.</i>	<input type="checkbox"/> Married / partnered <input type="checkbox"/> Single / divorced / separated / widowed
3	<b>Do you have any children (of any ages, including adult children)?</b>	<i>If the answer to this question is YES, then ask the follow-up question about the age of the children.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3a	<b><i>If YES</i>, do you have any children who are less than 10 years old?</b>	<i>If the answer to this question is YES, then the child questions will be asked at the end of the interview.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	<b>How many years of formal education did you complete?</b>	<i>Enter a whole number, like 19 or 75.</i>	<input type="checkbox"/> _____
5	<b>What is your religion, if any?</b>	<i>Check only one box.</i>	<input type="checkbox"/> Christian <input type="checkbox"/> Muslim <input type="checkbox"/> Christian and Muslim <input type="checkbox"/> None <input type="checkbox"/> Other: _____

			<input type="checkbox"/> Prefer not to respond
6	<b>As of today, how would you rate your general health?</b>	<i>Check only one box.</i>	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Don't know / no answer
7	<b>Would you say that your health is better, worse, or about the same as most people your age?</b>	<i>Check only one box.</i>	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> About the same <input type="checkbox"/> Don't know / no answer

### Malaria Risk

8	<b>Have you ever had malaria in your lifetime?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
9	<b>Have you had malaria in the past year?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
10	<b>How would you rate your likelihood of becoming ill with malaria during the next 12 months: very high, high, moderate, low, or very low?</b>	<i>Check only one box.</i>	<input type="checkbox"/> Very high <input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Very low
11	<b>Do you feel that your risk of malaria is present all of the time, most of the time, some of the time, rarely, or never during the year?</b>	<i>Check only one box.</i>	<input type="checkbox"/> All of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Rarely <input type="checkbox"/> Never

### Malaria Diagnosis and Treatment

12	<b>Have you had a fever at any time in the past month?</b>	<i>If the answer to this question is YES, then ask <u>ALL</u> of the follow-up questions about testing and diagnosis. If no, then skip to the next section.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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12a	<b><i>If YES</i>, did you go to a hospital or clinic because of your fever?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
12b	<b>Did you consult with a doctor, nurse, pharmacist, or other health worker about your fever?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
12c	<b>Did you have your blood tested at a laboratory during your illness?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
12d	<b>Did you take any medications, pills, herbs, or other treatments for your fever?</b>	<i>If yes, then ask the follow up question about types of treatments.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
12d2	<b><i>If YES</i>, what did you take?</b>	<i>Check or list <u>ALL</u> treatments mentioned. Many individuals will have taken 5 or more different treatments. All should be listed here.</i>	<input type="checkbox"/> Paracetamol <input type="checkbox"/> ASAQ (artesunate-amodiaquine) <input type="checkbox"/> moringa <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____

### Malaria Prevention

13	<b>What is the most common way for malaria to be transmitted</b>	<i>Do NOT read the list. Just check the 1 answer provided by the participant as the MOST common.</i>	<input type="checkbox"/> Mosquito bite <input type="checkbox"/> Close contact with someone who has malaria <input type="checkbox"/> Dirty water <input type="checkbox"/> I don't know <input type="checkbox"/> Others ( <i>write replies</i> ): _____
14	<b>Which types of people have given you helpful information about how to prevent malaria?</b>	<i>Check or list <u>ALL</u> items mentioned, but do NOT read the list out loud.</i>	<input type="checkbox"/> Doctors / nurses / health workers <input type="checkbox"/> Malaria control teams <input type="checkbox"/> Family members <input type="checkbox"/> Neighbors <input type="checkbox"/> Friends <input type="checkbox"/> Teachers <input type="checkbox"/> Religious leaders

			<input type="checkbox"/> Others ( <i>write replies</i> ): _____
15	<b>What media sources (if any) have given you helpful information about how to prevent malaria?</b>		<input type="checkbox"/> Radio <input type="checkbox"/> Television <input type="checkbox"/> Newspapers <input type="checkbox"/> Internet <input type="checkbox"/> Billboards / outdoor banners <input type="checkbox"/> Others ( <i>write replies</i> ): _____
16	<b>What actions do you take to prevent yourself from getting malaria?</b>	<i>Check or list ALL items mentioned, but do NOT read the list out loud.</i>	<input type="checkbox"/> Mosquito nets <input type="checkbox"/> Close doors and windows <input type="checkbox"/> Screens on doors and windows <input type="checkbox"/> Insecticides in or around home <input type="checkbox"/> Mosquito coils <input type="checkbox"/> Covering clothing <input type="checkbox"/> Others ( <i>write replies</i> ): _____
17	<b>Does your household have any mosquito nets?</b>	<i>If yes, then ask the 2 follow up questions about bednet use.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
17a	<i>If YES, how many mosquito nets does your household have?</i>	<i>Enter a whole number</i>	<input type="checkbox"/> _____
17b	<b>Did you sleep under a mosquito net last night?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No

### Vaccination

18	<b>Have you ever been vaccinated against any diseases (recently or in the past)?</b>	<i>Ask the follow up questions even if the answer to this question is 'NO'.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
19a	<b>Have you ever been vaccinated against ... measles?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
19b	<b>... polio?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
19c	<b>... tetanus?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No

			<input type="checkbox"/> I don't know
19d	... yellow fever?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
19e	... hepatitis A virus?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
19f	... malaria?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
19g	... Ebola?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
20	<b>In the past 5 years, has a doctor, nurse, public health worker, or someone else recommended that you receive a vaccine?</b>	<i>If yes, then ask the follow up question about the vaccine.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't remember
20a	<i>If YES, did you receive that vaccine?</i>	<i>If no, then ask the follow up question about not getting the vaccine.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't remember
20b	<i>If NO, why not?</i>	<i>Check or list <u>ALL</u> items mentioned, but do NOT read the list out loud. You may need to write several responses on the lines at the end of the list.</i>	<input type="checkbox"/> I did not think the vaccine was needed <input type="checkbox"/> I use other methods to protect myself from the disease <input type="checkbox"/> I did not think the vaccine would be safe <input type="checkbox"/> I was worried about side effects <input type="checkbox"/> I did not think the vaccine would be effective <input type="checkbox"/> I thought the vaccine would cost too much <input type="checkbox"/> I did not know where to get the vaccine <input type="checkbox"/> I heard or read bad things about the vaccine <input type="checkbox"/> I don't like needles <input type="checkbox"/> I was too busy / I could not leave work or home to get the vaccine

			<input type="checkbox"/> I did not know where to get reliable information about the vaccine <input type="checkbox"/> I don't remember <input type="checkbox"/> Others ( <i>write replies</i> ): _____
21	<b>Do you think that vaccines are just for children or are for both children and adults</b>	<i>Check only one box.</i>	<input type="checkbox"/> Only children <input type="checkbox"/> Only adults <input type="checkbox"/> Both children and adults <input type="checkbox"/> I don't know / No opinion
22	<b>Do you believe vaccines are safe?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other: _____
23	<b>Do you trust the health staff who give out vaccines in your area?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other: _____
23	<b>If a safe and effective malaria vaccine was available for adults, would you want to be vaccinated</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
24	<b>Would you be willing to <u>pay</u> to receive a malaria vaccine?</b>	<i>If yes, ask the follow-up question about price.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
24a	<i>If YES, how much would you be willing to pay?</i>	<i>Enter a number.</i>	<input type="checkbox"/> _____
25	<b>Would you be willing to receive a malaria vaccine if you had to be vaccinated every year rather than just one time?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
26	<b>A traditional vaccine would keep you from getting malaria from a mosquito. Would you be willing to get a vaccine that would prevent you from getting malaria from a mosquito?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
27	<b>A different type of vaccine would keep people who already have malaria parasites in their blood from passing the parasites to mosquitoes that bite them. This would slow or stop transmission in a community, if enough people were vaccinated. Would you be willing to be vaccinated</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know

	<b>as part of a community malaria control program?</b>		
28	<b>Do you have any concerns about vaccines for adults?</b>	<i>If yes, ask the follow-up question about price.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
28a	<i>If YES, what are your concerns?</i>	<i>List ALL items mentioned. You may need to write several responses on the lines.</i>	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
			<input type="checkbox"/>

### Wealth Assessment

Is there electricity in the home?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
What is the flooring material in the home?	<input type="checkbox"/> Earth, sand <input type="checkbox"/> Dung <input type="checkbox"/> Wood/planks <input type="checkbox"/> Palm/bamboo <input type="checkbox"/> Vinyl or asphalt strips <input type="checkbox"/> Ceramic tiles <input type="checkbox"/> Cement <input type="checkbox"/> Carpet <input type="checkbox"/> Other <input type="checkbox"/> No response
How many rooms in the home are used for sleeping?	<input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three or more <input type="checkbox"/> No response
Where does the household cook food?	<input type="checkbox"/> In the house <input type="checkbox"/> In a separate building <input type="checkbox"/> Outdoors <input type="checkbox"/> No food cooked in household <input type="checkbox"/> Other <input type="checkbox"/> No response
What type of cooking fuel is used?	<input type="checkbox"/> Electricity <input type="checkbox"/> LPH/natural gas/biogas <input type="checkbox"/> Kerosene

	<ul style="list-style-type: none"><li><input type="checkbox"/> Coal/lignite</li><li><input type="checkbox"/> Charcoal</li><li><input type="checkbox"/> Wood</li><li><input type="checkbox"/> Straw/shrubs/grass</li><li><input type="checkbox"/> Agricultural crop</li><li><input type="checkbox"/> Other</li><li><input type="checkbox"/> No food cooked in household</li><li><input type="checkbox"/> No response</li></ul>
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**FOR PARTICIPANTS WHO HAVE AT LEAST ONE CHILD LESS THAN 10 YEARS OLD...**

**Child Eligibility**

0a	<b>How many children do you have who are less than 10 years old?</b>	<i>Enter a whole number.</i>	<input type="checkbox"/> ____
0b	<b>How many of these children are less than 5 years old?</b>		<input type="checkbox"/> ____
0c	<b>How many of the children are 5 to 9 years old?</b>		<input type="checkbox"/> ____
		<i>Confirm that the sum of children &lt;5 and 5-9 is the total number of children &lt;10.</i>	<input type="checkbox"/> The sum is correct.

**Choose only 1 child to answer questions about...**

*If the participant has more than 1 child under 10 years of age, choose 1 child to answer these questions about using this priority list:*

- *If only one child is ages 5 to 9, use that child for the survey.*
- *If all the children are less than 5 years old, choose the oldest under-5 child.*
- *If more than one child is ages 5 to 9, select just one to answer the survey about.*

**Child Demographics**

1	<b>What is the age of the child you are going to answer the questions about?</b>	<i>Enter a whole number.</i>	<input type="checkbox"/> ____
2	<b>Is this child a boy or a girl?</b>		<input type="checkbox"/> Boy <input type="checkbox"/> Girl
3	<b>Does this child attend school?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No

**Malaria Diagnosis and Treatment**

4	<b>Has this child had a fever at any time in the past month?</b>	<i>If the answer to this question is YES, then ask <u>ALL</u> of the follow-up questions about testing and diagnosis. If no, then skip to the next section.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4b	<b><i>If YES, did you take the child to a hospital or clinic because of the fever?</i></b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
4c	<b>Did you consult with a doctor, nurse, pharmacist, or other</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No

	<b>health worker about your child's fever?</b>		
4d	<b>Did you have your child's blood tested at a laboratory during your illness?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
4e	<b>Did you give your child any medications, pills, herbs, or other treatments for your fever?</b>	<i>If yes, then ask the follow up question about types of treatments.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4e2	<b><i>If YES, what did you give your child?</i></b>	<i>Check or list ALL treatments mentioned. Many individuals will have taken 5 or more different treatments. All should be listed here.</i>	<input type="checkbox"/> Paracetamol <input type="checkbox"/> ASAQ (artesunate-amodiaquine) <input type="checkbox"/> moringa <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____

### Child Disease Prevention

5	<b>Did your child sleep under a mosquito net last night?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
6	<b>Has your child ever been vaccinated against any diseases?</b>	<i>Ask the follow up questions even if the answer to this question is 'NO'.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
7a	<b>Has your child ever been vaccinated against: ... measles?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
7b	<b>... polio?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
7c	<b>... hepatitis B virus?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
7d	<b>... tetanus?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
7e	<b>... yellow fever?</b>		<input type="checkbox"/> Yes

			<input type="checkbox"/> No <input type="checkbox"/> I don't know
7f	... pneumococcus?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
7g	... rotavirus?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
7h	... malaria?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
7i	... Zika?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
8	<b>In the past 5 years, has a doctor, nurse, public health worker, or someone else recommended that your child receive a vaccine?</b>	<i>If yes, then ask the follow up question about the vaccine.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't remember
18b	<b><i>If YES, did your child receive that vaccine?</i></b>	<i>If no, then ask the follow up question about not getting the vaccine.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't remember
18c	<b><i>If NO, why not?</i></b>	<i>Check or list ALL items mentioned, but do NOT read the list out loud. You may need to write several responses on the lines at the end of the list.</i>	<input type="checkbox"/> I did not think the vaccine was needed <input type="checkbox"/> I use other methods to protect my child from the disease <input type="checkbox"/> I did not think the vaccine would be safe <input type="checkbox"/> I was worried about side effects <input type="checkbox"/> I did not think the vaccine would be effective <input type="checkbox"/> I thought the vaccine would cost too much <input type="checkbox"/> I did not know where to get the vaccine <input type="checkbox"/> I heard or read bad things about the vaccine <input type="checkbox"/> My child does not like needles

			<input type="checkbox"/> I was too busy / I could not leave work or home to get my child vaccinated <input type="checkbox"/> I did not know where to get reliable information about the vaccine <input type="checkbox"/> I don't remember <input type="checkbox"/> Others ( <i>write replies</i> ): _____
19	<b>If a safe and effective malaria vaccine was available for children, would you want to be vaccinated</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
20	<b>Would you be willing to <u>pay</u> for your child to receive a malaria vaccine?</b>	<i>If yes, ask the follow-up question about price.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
20b	<b><i>If YES</i>, how much would you be willing to pay?</b>	<i>Enter a number.</i>	<input type="checkbox"/> _____
21	<b>Would you be willing for your child to receive a malaria vaccine if he/she had to be vaccinated every year rather than just one time?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
22	<b>A traditional vaccine would keep your child from getting malaria from a mosquito. Would you be willing for your child to get a vaccine that would prevent your child from getting malaria from a mosquito?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
23	<b>A different type of vaccine would keep people who already have malaria parasites in their blood from passing the parasites to mosquitoes that bite them. This would slow or stop transmission in a community, if enough people were vaccinated. Would you be willing for your child to be vaccinated as part of a community malaria control program?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know

24	<b>Do you have any concerns about vaccines for children?</b>	<i>If yes, ask the follow-up question about concerns.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
24b	<i>If YES, what are your concerns?</i>	<i>List <u>ALL</u> items mentioned. You may need to write several responses on the lines.</i>	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____