

Supplement to: Earle-Richardson G, Nestor C, Prue CE. Progressive development of a new tool for rapid thematic analysis of community perceptions and concerns during health emergencies. *Glob Health Sci Pract.* 2025;13(2):e2400281. <https://doi.org/10.9745/GHSP-D-24-00281>

SUPPLEMENT 1. Tool Case Study: Hybrid In-Person/Zoom “Town Hall” Meeting for Ugandans in The U.S. During a Sudan Ebola Virus Disease (SEVD) Outbreak in Uganda

Background: CDC hosted a hybrid townhall meeting on Saturday, November 19, 2022, with Ugandan travelers or those who identify as members of the Ugandan diaspora within the U.S. through the Ugandan North American Association. Audience participants and those joining the meeting via Zoom were able to submit questions for CDC subject matter experts in attendance. The goals of the event were to: provide information on the Ebola virus; give an update on CDC’s response and U.S. preparedness efforts; and describe the process of point-of-entry screening at 5 funneling U.S. airports and answer questions.

Town Hall Community listening purpose: Listening objectives included identifying frequently asked questions that might form the basis for future public communications, understanding participant’s level of concern about Ebola, and identifying any concerns about Ebola screening activities at U.S. airports. We were also interested to know what opportunities might exist for further community engagement and collaboration.

Town Hall Methods – The analytic design was to systematically derive themes based on observer notes as well as comments and questions posted to the Zoom call chat. Thus, the text included both direct quotes from participants and note taker paraphrasing of participant comments. Note takers sat in different parts of the room and spoke informally with different people. However, during the main meeting, some comments were likely captured by more than one note taker. Notes and transcripts were imported into the tool. Because it was a single listening event with a short (60 minutes) discussion and comment period, analysts anticipated a relatively small body of text. Therefore, they created a simple coding scheme using the “action flags” coding tool, starting first with codes that directly related to the listening objectives above: *Questions to answer; Misinformation/ false information; SEVD testing/diagnosis; SEVD PPE/ self-protection; SEVD Screening/ points of entry; Possible resources (person/ group); Actionable suggestions; and Other.* As additional content was identified that didn’t fit these codes, the following

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codes were added: *Stigma, discrimination, inequity; Need for training of public health officials; Making comparisons to COVID response; Concern: people left without having their question answered; and Appreciation for having the event.* Once the text was segmented and coded, the analyst developed themes from the coded text. Codes and themes were then reviewed and confirmed by the second analyst. Both analysts were also note takers at the event.

Town Hall Results – Out of a total of 36 coded text segments, the most frequently applied codes were: *Questions to answer* (13); *Appreciation for having the event* (4); and *Actionable Suggestions*:(4). Table S.1 shows the 4 major themes identified with codes shown underneath, each with a text quote representative of that coded group.

1. Information needs and clarifications - The largest type of feedback from participants were questions (n=13). Questions were grouped into 4 topical areas: 1) about SEVD and how it's transmitted; 2) about travelling to and from Uganda; 3) where to get SEVD treatment in the U.S.; and 4) about the government response (both in the U.S. and Uganda). Some participants were concerned about what they need to do differently when traveling to or from Uganda, and what to do if they got sick in the U.S. Several requested a pre-recorded brief presentation that they could watch and share through their network- something that addressed the 4 main question areas (shown in Table S.1). There was concern that the amount of time dedicated to answering questions was not long enough to get to all of them. CDC addressed this by assuring the group that "this is just the beginning of a dialogue," which created an expectation of future public communications.

2. Appreciation for the event, curiosity with modest level of concern about SEVD - There were several comments viewing SEVD as less serious or even over-blown relative to COVID. One participant commented, "*COVID was a bigger deal than Ebola. Family back in Uganda are living a normal life (attending social gatherings, no restrictions on movements), not really worried about the Ebola.*"

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3. Possible early signals of mistrust and concern - There were a few comments that suggest that some anger or mistrust was beginning to emerge. For example, one participant remarked, “*Is the priority to protect people or to protect people from black diseases?*” Further, the comment, “*Public fear is being stoked by placement of Ebola screening stations at airports.*” is suggestive of mistrust.

4. Opportunities for collaboration: Resource (person/ group) to assist with SEVD information dissemination - This last theme relates to trying to identify new partners and to reinforce existing community partners. We don’t have to be limited to thinking of the Ugandan diaspora as the *recipients* of information, but as clients that can also be *sharers of information*. Beyond even participating in another Zoom question and answer session, they could talk to community members informally and understand their questions and concerns.

Table S.1. Themes identified in comments from “town hall” event for Ugandans in the U.S., supporting text codes and frequencies (n), followed by representative quotes (italics)

[November 2022]

1. Information needs and clarifications
<p>Questions to answer (13) – 4 types of questions:</p> <ul style="list-style-type: none"> • About travelling to and from Uganda (4) - <i>Thank you for holding this meeting. I will be traveling to Uganda next month and i was wondering if i should cancel my travel plans.</i> • About the government response (both in the U.S. and Uganda) (4) - <i>Are there any efforts going on in Uganda to stop the outbreak?</i> • About SEVD (disease facts) (3) - <i>Can the vaccine for the other EVD prevent SEVD?</i> • Where to get SEVD treatment in the U.S. (2) - <i>Where would someone be treated in the US if they had EVD?</i>
<p>Actionable suggestions - Immediate need for training (PPT or recording) for diaspora (4) - <i>Is this deck available to share with community organizations so community leaders can share the information? More of a mild “train the trainer” format for information sharing purposes?</i></p>
<p>Need for further training of public health officials (2) - <i>Also, I can attest that at least some local officials who are following up with interviews are not well educated on this issue. I hope that at least this level of education can be provided to local health officials.</i></p>
<p>Concern: people left without having their question answered (2) - <i>There were also comments expressing disappointment that the session ended before all of the questions were answered.</i></p>
<p>Misinformation/ false information (1) - <i>Just a suggestion. Since Atlanta is one of the airports where testing is done on arrival, and is the headquarters of the CDC, I suggest that a hospital is set up here as well and cases reported directly to the CDC.</i></p>
2. Appreciation for the event, curiosity, and modest level of concern about SEVD
<p>Appreciation for having the event (4) - <i>Thank you for your service and today's presentation</i></p>
<p>Making comparisons to COVID response [that minimize SEVD] (3) - <i>COVID was a bigger deal than Ebola. Family back in Uganda are living a normal life (attending social gatherings, no restrictions on movements), not really worried about the Ebola.</i></p>
<p>Other: Level of concern about SEVD is low (1) - <i>I asked one participant what the general level of concern about Ebola is among Ugandans here and she said that people are aware of it but there is not a really high level of concern.</i></p>
3. Possible early signals of mistrust and concern
<p>Stigma, discrimination, inequity (2) - <i>Is the priority to protect people or to protect people from black diseases?</i></p>
<p>SEVD Screening/ points of entry (2) - <i>Public fear is being stoked by placement of Ebola screening stations at airports... These screening areas need to be placed in private. Otherwise, you are simply adding to the stigma as it just looks like all the Africans on a flight have to be additionally and publicly screened.</i></p>
4. Opportunities for collaboration: Resource (person/ group) to assist with SEVD information dissemination
<p>Possible resource (person/ group) for SEVD information dissemination (2) - <i>...how can the diaspora help future domestic preparedness?</i></p>

Discussion and Implications – Because this event occurred near the end of the outbreak, we didn’t have the opportunity to see action taken by the response following up on this information. However, the analysis provided some key lessons that could be acted upon. Specifically, we were able to document a

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strong interest in more technical information (that could be shared more widely), more explanations about how airport screening was being conducted and why, some initial signs that a lack of this information was beginning to have a negative effect, and lastly, a clear invitation for public health officials to engage further with the Ugandan community in the U.S. These are all important pieces of information that can be used for successful community engagement going forward.

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SUPPLEMENT 2. Thematic Analysis of Media Portrayal of Mpox¹ outbreak and its causes, New

York State, June 26-August 8, 2022

CDC Mpox Response

Background: According to the U.S. CDC, the first U.S. case of West African clade of mpox was identified on May 10, 2022⁴⁸. Cases were subsequently identified in 9 states. On May 17, 2022, CDC, in coordination with state and local jurisdictions, initiated an emergency response to identify, monitor, and investigate additional mpox cases in the United States⁴⁹. Coming on the heels of the COVID-19 pandemic, lessons about the important role that active and early community engagement plays in an emergency response situation were critical in the early days of the mpox outbreak⁵⁰. Much of public sentiment being identified in social media related to concerns about misinformation being spread and stigmatization of the gay community.⁵¹ For example, an edited BBC News Graphic was posted to social media on July 23, 2022 that claimed CDC had classified the disease as airborne and suggested those with symptoms remain isolated for 2-4 months.⁵² In response to these concerns messages about mpox were adjusted to combat misinformation and stigma and vaccination campaign strategies were adapted using feedback from community based partner organizations.⁵³⁻⁵⁵

Community listening purpose: Given the signals being received by the response from monitoring of social media channels, we wanted to know how the outbreak was portrayed by media outlets and whether news articles reflected the same sentiments being expressed from the public through social media. We posed two analytic questions: 1) What information about mpox is being communicated by the media in the New York area and is it accurate?; and 2) How is the mpox response being portrayed by the media? New York State was chosen as it had the highest number of cases when the project initiated in early Summer 2022.

¹(formerly monkeypox)⁴⁷

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Methods: A selection of news articles related from the CDC Daily Media Clips email summaries were chosen based on the following criteria: 1) they were primarily related to the 2022 U.S. mpox outbreak and 2) the news source for the article was in New York State. For the period of 6/27/2022 to 8/8/2022 this resulted in 11 articles. Six articles came from news sources located in New York City and 1 article each came from Albany, Buffalo, Elmira, Long Island, and Westchester, respectively. These 11 articles were coded using the epidemic coding scheme from the tool and the coded text was analyzed for themes using the steps outlined in the tool.

Results: Of 203 total codes applied to the 11 articles, 43% (87) were related to information about the disease, 32% (65) about government led control efforts, 18% (36) about the epidemic, 4% (8) about medical treatment and experience of the ill, 2% (4) about people dealing with the epidemic, and 2% (3) about other community issues.

Analytic question #1: The information about mpox being communicated by the media was almost exclusively that it posed a particular risk to the gay community, specifically on men who have sex with men. A few sources acknowledged that everyone is susceptible, but others specifically said that the risk to the general public was low. For example, 1 outlet said, “Anyone can get and spread monkeypox, though the current cases are primarily spreading among social networks of gay, bisexual and other men who have sex with men, so this community is currently at greater risk of exposure.” The symptoms most mentioned were flu-like symptoms, with suggestions to see a healthcare provider for unexplained skin rashes or lesions. Only 1 source provided actionable steps people infected with mpox could take to avoid infecting others (isolating while symptomatic and wearing a mask), while 1 other source provided information on how people could protect themselves outside of vaccination. While there was nothing identified as inaccurate in the coverage, the focus was on men who have sex with men as the group at greatest risk with awareness about potential concerns around avoiding stigmatizing this community. The following quote gives an example of the heightening focus concern about stigmatization, “*With few cases locally,*

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fears about effects on the gay community and knowledge that the public may resist warnings, officials walk a fine line between informing and alarming the community.”

Analytic question #2: A good deal of the media coverage was related to vaccine access, particularly criticism focused on the disconnect between the high number of mpox cases in New York compared to the low number of vaccine doses available. For example, “*New York makes up about one-third of the nation's 1,500 infections but has only received only 15% of the country's vaccine supply.*” and “*We have a population that wants the vaccine, that should be a good thing,*” said State Senator Brad Hoylman.”

Most coverage of the response was positive, though some articles did compare early missteps in vaccine availability and testing during the mpox response to similar issues during the COVID-19 pandemic. While some sources mentioned that there was a need for expanded testing capacity, there was little criticism of testing capacity compared to how much criticism was aimed at failure to meet vaccine demand.

Discussion and Implications

This analysis was done rapidly with the aim of informing the behavioral science task force of the mpox response about what type of messages were being transmitted through the news media in an area of the country that was most impacted in the early days of the outbreak. Findings confirmed that the misinformation being circulated on social media was not repeated by mainstream media sources.

However, the exclusive focus of media articles on the risk to the gay populations may have contributed to concerns about stigmatization during the outbreak. It is also useful to know that news media coverage, while generally accurate, was not providing the public with frequent and clear messaging about self-protection or treatment. This kind of messaging would need to be actively promoted through public health channels. Characterizing the media coverage of mpox in New York State was facilitated by using the tool in several different ways. First, having a preprogrammed coding scheme cut down on analysis time significantly, while we could still add codes as needed. Next, the tool provides an extremely

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transparent process of analysis that makes sharing the methods with others and validating the process very easy. Not only is the process transparent, but it is also quite easy to pull out specific quotes and how they were coded to answer any further questions regarding what specifically was said, or what might be a nuance to a comment. For example, responding to follow-up questions from communicators who received the results about specific concerns about testing was done easily by filtering the pivot tables and providing specific quotes from the articles that mentioned concerns about testing.

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SUPPLEMENT 3. Mixed Methods Survey Analysis of Public Awareness and Attitudes During a U.S. Mpox Outbreak, August 2022

Social and Behavioral Science Team, Community Engagement Task Force

While CDC and other governmental and non-governmental public health agencies were providing information about the outbreak and recommending self-protection measures, little was known about public awareness or actions to take to protect oneself. To gauge public awareness, CDC obtained public opinion survey data on public perceptions of mpox and infection prevention through a subscription license with a commercial market research company (Porter Novelli, Inc).

Between August 8-10, 2022, the public opinion survey company asked two open-ended questions: “What have you heard about monkeypox?” and “What do you think are the most important things people can do to prevent from becoming infected with the monkeypox virus?” Respondents were given a blank text box where they could write a response in their own words. This approach was chosen because offering a list of possible response options might influence participants’ answers. Also, without knowing how widely the responses might vary, leaving the response open-ended would provide more robust data.

Analysts used the tool (blank coding scheme) to code the responses. The analyses of these two questions required the development of two separate coding schemes specific to the questions being asked. First, the lead analyst reviewed 100 survey responses and made brief notes next to each one describing the essence of the response in her own words. As she continued, she used the same annotation as was previously used whenever appropriate. When all 100 responses were annotated, the analyst copied the notes to a separate spreadsheet and grouped similar notes together. She gave each group a brief title, which became a draft “broad code” and shortened and revised her annotations, which became draft “specific codes.” Two analysts then coded 50 responses using the coding scheme developed by the first analyst. When complete, the two analysts met and compared their codes, and reached a consensus coding scheme and protocol. At

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this point, the second coder coded the remaining open-ended responses. The senior analyst then reviewed all the codings and discussed any disagreements with the second coder.

Because the survey data was quantitative in the sense that responses were associated with individuals, this is a slightly different use of the tool than those presented above. When coding was complete, frequency tables were created for both questions, however, no thematic analysis was conducted. Instead, verbatim responses were used as examples of certain specific codes of interest. This mixed methodology was able to report response frequencies as one would with a closed-ended survey question but also share the thinking and perspectives of respondents much more fully, as one is able review all of the respondents speaking in their own words.

Results: A total of 946 respondents of a survey sample of 1006 (94%) responded that they had heard about mpox. As shown in table S.3.1., responses that fit the broad code of *mpox disease characteristics* were the most frequent (36%), with *mpox outbreak characteristics* and *mpox transmission* the second and third most frequent, respectively. When coded more specifically, the increasing number of mpox cases, its infectiousness and appearance (blisters, rash, etc.) were most mentioned. It is important to note that both specific codes and broad codes, when summed, will be greater than the total number of respondents, since responses were sometimes coded more than one way. Table S.3.2 shows the most frequent specific codes among all responses, along with a selected verbatim quote that is representative of the specific code. These quotes give a sense of how symptoms are thought of as well as how people think about risk and the gay community.

Table S.3.1. Broad and specific response code frequencies* for “What have you heard about monkeypox?” N=944, U.S. August 2022

Broad code and specific codes (indented)	N	%
Mpox disease characteristics	342	36%
Mpox infectiousness: contagious (very contagious; infectious; transmissible; exposure to virus)	141	15%
Mpox severity: deadly (incurable, dangerous, serious, worrisome)	58	6%
Mpox is a virus	50	5%
Relation to other diseases: similar to [smallpox, chicken pox, pox, other]	41	4%
Negative emotion related to mpox: horrible (awful, nasty, bad, sucks, gross, ugly)	32	3%

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Mpox severity: curable/treatable/not deadly (doesn't last long)/ rarely fatal	22	2%
Mpox origin: outside the country (Europe, China, Africa)	19	2%
Mpox is a new disease/variant	18	2%
All other specific codes combined*	26	3%
Mpox outbreak characteristics	291	31%
Number of cases: increasing (spreading, getting worse, coming back)	169	18%
Outbreak geography: U.S.	46	5%
Outbreak control efforts: declared health emergency / crisis	23	2%
Future epidemic/pandemic: new/ another	18	2%
All other specific codes combined	63	7%
Mpox transmission	209	22%
By physical contact: specifies contact with someone who has mpox	54	6%
By physical contact: skin to skin/ physical	50	5%
By intimate contact: sex /sexual / STD	48	5%
By contact with surfaces/objects: no further details	41	4%
Via body fluids	19	2%
By intimate contact: specifies homosexual sex	17	2%
All other specific codes combined	34	4%
Groups experiencing mpox most	189	20%
Sexual orientation: gay (homosexual) males	76	8%
Sexual orientation: gay /LGBTQ (not further specified)	56	6%
Sexual orientation: men who have sex with men	15	2%
All other specific codes combined	75	8%
Mpox Symptoms	133	14%
Appearance: warts/sores/blisters/blisters, bumps, pimples/acne/big spots/ rash)	95	10%
Sensory: pain	40	4%
All other specific codes combined	42	4%
Mpox Vaccine	82	9%
Vaccines: exist/ there is one	33	3%
Vaccine availability: short supply	32	3%
All other specific codes combined	23	2%
Public response to the outbreak	42	4%
Emotional response: fear /concern/scared/freaking out	10	1%
Belief: comparable to COVID	10	1%
All other specific codes combined	25	3%
Mpox effects	11	1%
Physical: scarring	7	1%
Physical: blindness	5	1%
Physical: brain injury	1	0%
Other	123	13%
None: no/nothing/NA/don't know/don't remember/not much	68	7%
Not codable: not enough detail to categorize	34	4%
Not codable: answering WHERE not WHAT heard	21	2%

*In cases where multiple specific codes had frequencies less than 2%, these codes were combined into a single row.

**The broad codes, "Relating to the news media" and "Use of medication" both had frequencies under 2.0% and were omitted from the table.

***Broad code counts may differ from the sum of specific code totals since a single response might be assigned more than 1 specific code.

****The total number of broad codings = 1422. 478 responses were coded into more than 1 broad code

Table S.3.2. Most frequently named specific response codes for “What have you heard about monkeypox?” and a representative verbatim response

Specific response code	n	%	Representative verbatim response
Number of cases: increasing (spreading, getting worse, coming back)	169	18%	<i>It is a growing concern about it becoming an emergency and looking at how it gets past [sic] to other people.</i>
Mpox infectiousness: contagious (very contagious, infectious, transmissible, exposure to virus)	141	15%	<i>A contagious, viral rash that spreads through personal contact.</i>
Appearance: warts/sores/blisters/blisters (bumps, pimples, acne, big spots, rash)	95	10%	<i>It can be a rash on your genitals or your chest, hands looks like blisters or pimples can have flu like symptoms...</i>
Sexual orientation: gay (homosexual) males	76	8%	<i>Is generally spread via the gay male community.</i>
Mpox Severity: deadly (incurable, dangerous, serious, worrisome)	58	6%	<i>It's a dangerous infectious disease that causes death.</i>
Sexual orientation: gay/ (not further specified)	56	6%	<i>It is spreading in the US mostly in the gay community.</i>

For the second survey question, “What do you think are the most important things people can do to prevent from becoming infected with the monkeypox virus?”, “practice hygiene” (mainly referring to hand hygiene), and “practice social distancing or avoidance” were the most identified measures. Table S.3.3 shows the distribution of broad and specific codes representing the responses. Table S.3.4 shows the most common specific codes, with an accompanying representative quote for each code group.

Table S.3.3. Broad and specific response code frequencies* responses to "What do you think are the most important things people can do to prevent becoming infected with the monkeypox virus?" U.S. Adults (N=946), August 2022

Broad code and specific codes (indented)	N	%
Practice hygiene including washing	257***	27.2%
Wash hands (frequently, appropriate times, constantly)	165	17.4%
Maintain personal hygiene/ general hygiene practice	74	7.8%
Disinfect (frequently, regularly, often)	21	2.2%
Use hand sanitizer	21	2.2%
Keep hands clean (clean and fresh)	5	0.5%
Practice social distancing or avoidance	225	23.8%
Social distancing/keep a distance from people	111	11.7%
Stay at home/indoors/avoid travel/isolate	71	7.5%
Avoid or be careful w/ public places or crowds	46	4.9%

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Distance from /avoid suspected mpox cases	9	1.0%
Avoid touching people or objects	197	20.8%
Avoid contact (skin or other) w/ infected person or person with rash	87	9.2%
Avoid skin contact (or use caution)	64	6.8%
Avoid/limit contact with people (or people who are not family)	30	3.2%
all other specific codes combined*	30	3.2%
Practice safe or limited intimacy	136	14.4%
Practice safe sex	51	5.4%
Do not engage in homosexual sex	34	3.6%
No sex	19	2.0%
All other specific codes combined	42	4.4%
Use personal protection	96	10.1%
Wear a mask (doesn't specify when going out)	85	9.0%
All other specific codes combined	19	2.0%
Vaccination practices	86	9.1%
Get vaccinated	86	9.1%
Increase knowledge	33	3.5%
General awareness (be aware)	22	2.3%
All other specific codes combined	13	1.4%
Keep the Ill from infecting others	28	3.0%
Quarantine/isolate if the person has it or may have it	24	2.5%
All other specific codes combined	5	1%
Maintain and monitor general health	23	2.4%
Generally, keep healthy (incl. exercise, diet)	18	1.9%
All other specific codes combined	5	0.5%
Related to COVID	11	1.2%
Mentions COVID protection in response	11	1.2%
Other	170	18.0%
No response/NA/No/don't know	92	9.7%
Too little detail in text to code	64	6.8%
All other specific codes combined	14	1.5%

*In cases where multiple specific codes had frequencies less than 2%, these codes were combined into a single row.

**The broad codes, "Relating to the news media" and "Use of medication" both had frequencies under 2.0% and were omitted from the table.

***Broad code counts may differ from the sum of specific code totals, since a single response might be assigned more than 1 specific code.

Table S.3.4. Most frequently named specific response codes for "What do you think are the most important things people can do to prevent becoming infected with the monkeypox virus?" and a representative quote

Specific response code	n	%	Representative quote
Wash hands (frequently, appropriate times, constantly)	165	17%	<i>Clean yourself. Wash your hands before and after touching things or using the bathroom.</i>
Social distancing/keep a distance from people	111	12%	<i>Give other [people] their space. Don't go out into loads of people unless you have to and be conscious of your surrounding people</i>

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Avoid contact (skin or other) w/ infected person or person with rash	87	9%	<i>Avoid close, skin to skin contact with who have a rash look like monkeypox.</i>
Get vaccinated	86	9%	<i>Be careful with skin-to-skin contact, get the vaccine if you are in a high-risk area</i>
Wear a mask (going out or not unspecified)	85	9%	<i>Use facemask</i>

Discussion: Nearly all respondents had heard about mpox by August 2022, with the greatest number of responses focused on the growing outbreak, its transmissibility and symptoms. It’s not surprising with a new disease outbreak that responses reflected what was stated in news media coverage. There was also a relatively high level of awareness that some members of the gay community were at higher risk for infection, but not clear articulation as to who within the community that was. However, with the future possibility of spread to the wider public, these open-ended question responses provided the universe of self-protection beliefs and could be used to form quantitative evaluation measures in the future. Fewer respondents stated that there was a vaccine available. In response to the second question, “What should a person do to protect themselves from mpox?”, the unprompted responses included the correct recommendations and did not include any misinformation or dangerous home strategies (e.g., bleach or alcohol). Since protective recommendations had largely been communicated largely to high-risk groups, it is not surprising that the overall proportion of people reporting the CDC recommended steps was low. The fact that some measures more related to COVID-19 (social distancing and masking), which had recently been widely promoted were mentioned suggests that there are some “leftover” effects from those promotional efforts.

This analysis used the tool in a slightly different manner than the earlier examples. Text was coded, however, responses were attributed to individual participants and always kept within a single cell. This contrasts with the analysis of a focus group transcript or other unstructured text, where assignment of text to a single cell is done according to the concept represented in the text, not according to who said it. With truly qualitative text, there is no way to know who made a particular statement. In this analysis we were able to quantify the number of respondents who said a particular thing, rather than simply reporting which

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codes were used most frequently. This is key point that differentiates qualitative analysis from mixed methods. This “mixed methods” approach provides quantitative results but also preserves participants’ verbatim responses, which can be shared selectively as “representative quotes” for different responses. These can add a level of insight not often obtained with quantitative research alone.