Supporting Materials:

Susceptibility to Misinformation about COVID-19 Vaccines:

A Signal Detection Analysis

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Predicting Acceptance of False Information via Truth Sensitivity and Belief Bias

Anti-COVID-19-vaccine belief bias is captured by the following equation:

$$\text{Anti-vaccine bias} = [-0.5 \times [z(H_{pro}) + z(FA_{pro})]] - [-0.5 \times [z(H_{anti}) + z(FA_{anti})]]$$

In this equation, "pro" represents pro-COVID-19-vaccine information and "anti" represents anti-COVID-19-vaccine information. This equation can be transformed to:

$$\text{Anti-vaccine bias} = 0.5 \times [z(H_{anti}) + z(FA_{anti}) - z(H_{pro}) - z(FA_{pro})]$$

Overall truth-sensitivity is captured by the following equation:

$$\text{Truth sensitivity} = [[z(H_{anti}) - z(FA_{anti})] + [z(H_{pro}) - z(FA_{pro})]] / 2$$

This equation can be transformed to:

$$\text{Truth sensitivity} = 0.5 \times [z(H_{anti}) - z(FA_{anti}) + z(H_{pro}) - z(FA_{pro})]$$

The transformed equations for anti-COVID-19-vaccine belief bias and overall truth-sensitivity "illustrate that the two indices are based on the same input data and equal treatment of data" (Gawronski et al., 2023, p. 2225), the only difference being whether $z(FA_{anti})$ and $z(H_{pro})$ "enter the equation in an additive or subtractive manner" (Gawronski et al., 2023, p. 2225). Anti-COVID-19-vaccine belief bias increases with false-alarm rates for anti-COVID-19-vaccine statements and decreases with hit rates for pro-COVID-19-vaccine statements. Truth sensitivity decreases with false-alarm rates for anti-COVID-19-vaccine statements and increases with hit rates for pro-COVID-19-vaccine statements.

Analyses Controlling for Demographics

To exploratively control for demographic variables, we ran the SPSS *mixed* command with either truth sensitivity *d'* or acceptance threshold *c* as the outcome variable and participant attitude (Experiments 1 and 2: favorable vs. unfavorable vs. neutral; Experiment 3: favorable vs. unfavorable), statement slant (pro-COVID-19-vaccine vs. anti-COVID-19-vaccine), country of residence (United Kingdom vs. United States), gender, and racial or ethnic identity as categorical

predictors and political orientation (liberal vs. conservative), age, and education as continuous predictors. In addition to the main effects, we also included the Participant Attitude × Statement Slant interaction in the model. In Experiment 2, we additionally included Cognitive Elaboration (low vs. high) as a categorical main effect as well as the interaction terms for Participant Attitude × Cognitive Elaboration, Statement Slant × Cognitive Elaboration, and Participant Attitude × Statement Slant × Cognitive Elaboration. For all experiments, racial or ethnic identity was treated the same as for the analyses examining demographic differences in truth sensitivity and COVID-19-vaccine belief biases. For gender, we combined the two categories *other* and *I prefer not to answer*.

Acceptance Threshold Comparisons for Each Pair of Participant Groups Separately for Pro-Vaccine versus Anti-Vaccine Information

Pro-COVID-19-Vaccine Information

For pro-COVID-19-vaccine information, participants with favorable attitudes had a lower acceptance threshold than participants with unfavorable attitudes [Experiment 1: $t(231) = -18.76$, $p < .001$, $d = 2.46$; Experiment 2, favorable and low-elaboration vs. unfavorable and low-elaboration: $t(117) = -15.79$, $p < .001$, $d = 2.90$; Experiment 2, favorable and low-elaboration vs. unfavorable and high-elaboration: $t(127) = -14.45$, $p < .001$, $d = 2.55$; Experiment 2, favorable and high-elaboration vs. unfavorable and low-elaboration: $t(128) = -15.53$, $p < .001$, $d = 2.74$; Experiment 2, favorable and high-elaboration vs. unfavorable and high-elaboration: $t(138) = -14.26$, $p < .001$, $d = 2.41$; Experiment 3: $t(288) = -20.60$, $p < .001$, $d = 2.44$].

Participants with favorable attitudes also had a lower acceptance threshold than participants with neutral attitudes [Experiment 1: $t(205) = -8.60$, $p < .001$, $d = 1.21$; Experiment 2, favorable and low-elaboration vs. neutral and low-elaboration: $t(95) = -5.69$, $p < .001$, $d = 1.20$; Experiment 2, favorable and low-elaboration vs. neutral and high-elaboration: $t(112) = -$

5.11, $p < .001$, $d = 0.96$; Experiment 2, favorable and high-elaboration vs. neutral and low-elaboration: $t(106) = -5.10$, $p < .001$, $d = 1.04$; Experiment 2, favorable and high-elaboration vs. neutral and high-elaboration: $t(123) = -4.42$, $p < .001$, $d = 0.80$].

Participants with unfavorable attitudes had a higher acceptance threshold than participants with neutral attitudes [Experiment 1: $t(204) = 8.52$, $p < .001$, $d = 1.20$; Experiment 2, unfavorable and low-elaboration vs. neutral and low-elaboration: $t(92) = 6.93$, $p < .001$, $d = 1.47$; Experiment 2, unfavorable and low-elaboration vs. neutral and high-elaboration: $t(109) = 9.48$, $p < .001$, $d = 1.80$; Experiment 2, unfavorable and high-elaboration vs. neutral and low-elaboration: $t(102) = 6.02$, $p < .001$, $d = 1.24$; Experiment 2, unfavorable and high-elaboration vs. neutral and high-elaboration: $t(119) = 8.43$, $p < .001$, $d = 1.54$].

Anti-COVID-19-Vaccine Information

For anti-COVID-19-vaccine information, participants with favorable attitudes had a higher acceptance threshold than participants with unfavorable attitudes [Experiment 1: $t(231) = 14.81$, $p < .001$, $d = 1.94$; Experiment 2, favorable and low-elaboration vs. unfavorable and low-elaboration: $t(117) = 12.55$, $p < .001$, $d = 2.30$; Experiment 2, favorable and low-elaboration vs. unfavorable and high-elaboration: $t(127) = 12.90$, $p < .001$, $d = 2.27$; Experiment 2, favorable and high-elaboration vs. unfavorable and low-elaboration: $t(128) = 14.63$, $p < .001$, $d = 2.58$; Experiment 2, favorable and high-elaboration vs. unfavorable and high-elaboration: $t(138) = 15.12$, $p < .001$, $d = 2.56$; Experiment 3: $t(288) = 17.33$, $p < .001$, $d = 2.05$].

Participants with favorable attitudes also had a higher acceptance threshold than participants with neutral attitudes [Experiment 1: $t(205) = 6.27$, $p < .001$, $d = 0.88$; Experiment 2, favorable and low-elaboration vs. neutral and low-elaboration: $t(95) = 4.27$, $p < .001$, $d = 0.90$; Experiment 2, favorable and low-elaboration vs. neutral and high-elaboration: $t(112) = 3.02$, $p = .003$, $d = 0.57$; Experiment 2, favorable and high-elaboration vs. neutral and low-elaboration:

$t(106) = 5.44$, $p < .001$, $d = 1.11$; Experiment 2, favorable and high-elaboration vs. neutral and high-elaboration: $t(123) = 3.81$, $p < .001$, $d = 0.69$].

Participants with unfavorable attitudes had a lower acceptance threshold than participants with neutral attitudes [Experiment 1: $t(204) = -7.91$, $p < .001$, $d = 1.11$; Experiment 2, unfavorable and low-elaboration vs. neutral and low-elaboration: $t(92) = -7.32$, $p < .001$, $d = 1.55$; Experiment 2, unfavorable and low-elaboration vs. neutral and high-elaboration: $t(109) = -8.73$, $p < .001$, $d = 1.66$; Experiment 2, unfavorable and high-elaboration vs. neutral and low-elaboration: $t(102) = -7.25$, $p < .001$, $d = 1.50$; Experiment 2, unfavorable and high-elaboration vs. neutral and high-elaboration: $t(119) = -8.69$, $p < .001$, $d = 1.59$].

Across Cognitive Elaboration Conditions

In Experiment 2, participants with favorable attitudes in the low-elaboration condition did not differ from participants with favorable attitudes in the high-elaboration condition for pro-COVID-19-vaccine information [$t(131) = -0.95$, $p = .345$, $d = 0.17$] and anti-COVID-19-vaccine information [$t(131) = -0.36$, $p = .718$, $d = 0.06$]. Participants with unfavorable attitudes in the low-elaboration condition also did not differ from participants with unfavorable attitudes in the high-elaboration condition for pro-COVID-19-vaccine information [$t(124) = 1.07$, $p = .287$, $d = 0.19$] and anti-COVID-19-vaccine information [$t(124) = -1.07$, $p = .286$, $d = 0.19$]. The same was true for participants with neutral attitudes in the low-elaboration versus high-elaboration condition for both pro-COVID-19-vaccine information [$t(87) = 1.12$, $p = .265$, $d = 0.24$] and anti-COVID-19-vaccine information [$t(87) = -1.07$, $p = .286$, $d = 0.23$].

Demographic Differences

To explore if and to what extent participants of different political orientations (liberal vs. conservative), education levels, ages, racial or ethnic identities, genders, and countries of residence (United Kingdom vs. United States) differ in their truth sensitivity and anti-COVID-

19-vaccine belief bias, we conducted non-preregistered exploratory multiple-regression analyses with the aforementioned demographic variables as simultaneous predictors and overall truth-sensitivity *d'* and anti-COVID-19-vaccine belief bias as outcome variables, respectively. For racial or ethnic identity, the multiple-choice response options *American Indian or Alaska Native*; *Asian (e.g., Chinese, Asian Indian, Vietnamese)*; *Black (e.g., African, African American, Jamaican, Haitian)*; *Hispanic, Latino, or Spanish origin (e.g., Mexican, Mexican American, Colombian)*; *Middle Eastern or North African (e.g., Lebanese, Syrian, Moroccan, Algerian)*; *Native Hawaiian or Pacific Islander*; *White*; *Other* were all entered into the multiple regression as separate variables, coded as 1 for selected or 0 for not selected. If a response option was not selected by any participant, it was omitted from the analysis. This included *Native Hawaiian or Pacific Islander* in Experiments 2 and 3. For gender, we collapsed the two response options *other* and *I prefer not to answer,* and used a dummy-coding scheme to create two dummy variables which compared *Female* to *Male* and *Female* to *Other*/*I prefer not to answer*. In Experiment 3, we additionally ran a multiple-regression analysis predicting belief-congruency bias with the same aforementioned set of demographic variables.

Demographic differences in truth sensitivity and COVID-19-vaccine belief biases are depicted in Table S1. Exploratory demographic analyses revealed that conservative political ideology was significantly associated with both a poorer ability to discern true from false information about COVID-19 vaccines ($-.32 < \beta s < -.34$) and a stronger anti-COVID-19-vaccine belief bias ($.29 < \beta s < .46$). In Experiment 3, conservative political ideology was also significantly associated with a stronger belief-congruency bias ($\beta = .20$). Higher levels of education showed a significant positive association with truth sensitivity ($.12 < \beta s < .18$). In Experiment 2, education additionally showed a significant negative association with anti-COVID-19-vaccine bias ($\beta = -.12$), but this association was not statistically significant in

Experiments 1 and 3. Age showed no significant association with truth sensitivity or belief biases in any of the three experiments. Identification as being racially or ethnically *White* yielded a positive association with truth sensitivity in Experiments 1 and 2 ($.19 < \beta s < .32$), but this association was not statistically significant in Experiment 3. Participants who reported identifying as female did not differ in truth sensitivity and belief biases from participants who reported identifying as male. In Experiment 2, participants who selected *other* or *I prefer not to answer* in response to the gender question showed higher truth sensitivity than participants who reported identifying as female ($\beta = .17$), but this association was not statistically significant in Experiments 1 and 3. Compared to participants from the United Kingdom, participants from the United States showed higher truth sensitivity in Experiment 3 ($\beta = .16$) and a stronger anti-COVID-19-vaccine belief bias in Experiment 2 ($\beta = .20$), but these differences were not statistically significant in the respective other two experiments.

Integrative Analyses

In addition to the analyses of the individual experiments, we pooled the data of all experiments and exploratorily reran the analyses that showed diverging results across the experiments over this combined dataset (Curran & Hussong, 2009).

Consistent with the results of Experiment 2, education showed a significant negative association with anti-COVID-19-vaccine bias in the analysis of the pooled data ($\beta = -.090$, $p = .002$). Moreover, consistent with the results of Experiments 1 and 2, identification as being racially or ethnically *White* yielded a positive association with truth sensitivity ($\beta = .224$, $p < .001$). In the analyses of the pooled data, participants who selected *other* or *I prefer not to answer* in response to the gender question did not show higher truth sensitivity than participants who reported identifying as female ($\beta = .053$, $p = .079$). Compared to participants from the United Kingdom, participants from the United States showed higher truth sensitivity ($\beta = .070$, $p =$

.029). Country of residence was not significantly associated with anti-COVID-19-vaccine bias (β = .031, p = .331).

Associations of Truth Sensitivity and Belief Bias with Attitude Change

Following our preregistered analysis plan, our main analyses excluded participants who reported inconsistent attitudes toward COVID-19 vaccines in Prolific's prescreening survey and the demographic survey in our experiments. Although the number of participants whose attitudes had changed between the two measurements was very small, we also conducted non-preregistered exploratory analyses to examine truth sensitivity and belief bias among participants who had changed their attitudes toward COVID-19 vaccines.

Participants who changed their attitude toward COVID-19 vaccines from neutral to favorable (Experiment 1: n = 29, Experiment 2: n = 35) showed higher truth sensitivity and a lower anti-COVID-19-vaccine belief bias than participants who changed their attitude from neutral to unfavorable (Experiment 1: n = 11, Experiment 2: n = 11) [truth sensitivity: Experiment 1: $t(38) = 3.39$, $p = .002$, $d = 1.20$; Experiment 2: $t(44) = 4.39$, $p < .001$, $d = 1.52$; anti-COVID-19-vaccine belief bias: Experiment 1: $t(38) = -4.03$, $p < .001$, $d = 1.43$; Experiment 2: $t(44) = -6.44$, $p < .001$, $d = 2.23$]. Moreover, participants who changed their attitude from unfavorable to neutral (Experiment 1: n = 14, Experiment 2: n = 20, Experiment 3: n = 18) showed higher truth sensitivity than participants who did not change their unfavorable attitude (Experiment 1: n = 116, Experiment 2: n = 126, Experiment 3: n = 126) [Experiment 1: $t(128) = -3.63$, $p < .001$, $d = 1.03$; Experiment 2: $t(144) = -4.48$, $p < .001$, $d = 1.08$; Experiment 3: $t(142) = -3.51$, $p = .001$, $d = 0.88$]. A similar pattern emerged for anti-COVID-19-vaccine belief bias, in that participants who changed their attitude from unfavorable to neutral showed a lower anti-COVID-19-vaccine belief bias than participants who did not change their unfavorable attitude, but this difference did not reach statistical significance in Experiment 1 [Experiment 1: $t(128) =$

1.82, $p = .071$, $d = 0.52$; Experiment 2: $t(144) = 5.09$, $p < .001$, $d = 1.23$; Experiment 3: $t(142) = 2.09$, $p = .039$, $d = 0.53$]. Participants who changed their attitude from unfavorable to either neutral or favorable (Experiment 1: $n = 16$, Experiment 2: $n = 28$, Experiment 3: $n = 27$) showed higher truth sensitivity and a lower anti-COVID-19-vaccine belief bias than participants who did not change their unfavorable attitude [truth sensitivity: Experiment 1: $t(130) = -3.15$, $p = .002$, $d = 0.84$; Experiment 2: $t(152) = -5.47$, $p < .001$, $d = 1.14$; Experiment 3: $t(151) = -3.66$, $p < .001$, $d = 0.78$; anti-COVID-19-vaccine belief bias: Experiment 1: $t(130) = 2.29$, $p = .023$, $d = 0.61$; Experiment 2: $t(152) = 6.94$, $p < .001$, $d = 1.45$; Experiment 3: $t(151) = 4.45$, $p < .001$, $d = 0.94$].

Table S1

Political Orientation, Education, Age, Race, Gender, and Country Predicting Truth Sensitivity and COVID-19-Vaccine Belief Biases

	N	Truth Sensitivity		Anti-Vaccine Belief Bias		Belief-Congruency Bias	
		β	*p*	β	*p*	β	*p*
Political Orientation							
Experiment 1	323	-.323	< .001	.458	< .001		
Experiment 2	348	-.332	< .001	.299	< .001		
Experiment 3	290	-.331	< .001	.419	< .001	.198	.002
Education							
Experiment 1	323	.172	.002	-.053	.308		
Experiment 2	348	.129	.011	-.118	.021		
Experiment 3	290	.144	.008	-.098	.069	-.113	.058
Age							
Experiment 1	323	-.052	.359	.075	.170		
Experiment 2	348	.044	.396	.023	.658		
Experiment 3	290	.103	.074	.010	.868	-.028	.661
Racial or Ethnic Identity							
American Indian or Alaska Native versus Not							
Experiment 1	4 vs. 319	-.028	.588	.015	.772		
Experiment 2	1 vs. 347	.015	.780	-.014	.799		
Experiment 3	7 vs. 283	-.075	.163	-.083	.122	-.081	.170
Asian versus Not							
Experiment 1	18 vs. 305	.043	.548	-.018	.794		
Experiment 2	21 vs. 327	.168	.133	.063	.573		
Experiment 3	18 vs. 272	.087	.312	-.112	.198	-.094	.324
Black versus Not							
Experiment 1	25 vs. 298	.074	.323	.014	.839		
Experiment 2	14 vs. 334	.145	.098	.079	.369		
Experiment 3	19 vs. 271	-.135	.155	.083	.385	-.079	.450
Hispanic, Latino, or Spanish origin versus Not							
Experiment 1	16 vs. 307	-.092	.108	.018	.741		
Experiment 2	8 vs. 340	.018	.783	-.011	.870		
Experiment 3	19 vs. 271	-.073	.362	.011	.889	-.030	.737
Middle Eastern or North African versus Not							
Experiment 1	7 vs. 316	.041	.438	-.020	.690		
Experiment 2	2 vs. 346	.048	.427	.017	.774		
Experiment 3	3 vs. 287	.048	.368	-.054	.315	-.048	.414

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	N	Truth Sensitivity		Anti-Vaccine Belief Bias		Belief-Congruency Bias	
		β	*p*	β	*p*	β	*p*
Native Hawaiian or Pacific Islander versus Not							
Experiment 1	1 vs. 322	-.040	.451	.015	.771		
Experiment 2							
Experiment 3							
White versus Not							
Experiment 1	272 vs. 51	.192	.041	.028	.753		
Experiment 2	304 vs. 44	.318	.034	.093	.537		
Experiment 3	234 vs. 56	.169	.185	.005	.969	-.198	.159
Other versus Not							
Experiment 1	7 vs. 316	.039	.523	.114	.053		
Experiment 2	7 vs. 341	.048	.546	.123	.128		
Experiment 3	6 vs. 284	-.072	.274	.032	.632	.027	.710
Gender							
Female versus Male							
Experiment 1	198 vs. 119	-.039	.464	-.010	.849		
Experiment 2	236 vs. 110	-.009	.862	-.039	.444		
Experiment 3	147 vs. 135	.085	.114	-.041	.453	.060	.313
Female versus Other / I prefer not to answer							
Experiment 1	198 vs. 6	-.008	.886	-.028	.588		
Experiment 2	236 vs. 2	.166	.001	-.033	.510		
Experiment 3	147 vs. 8	.050	.375	-.054	.347	-.023	.717
Country (UK vs. US)							
Experiment 1	141 vs. 182	.003	.964	-.004	.936		
Experiment 2	299 vs. 49	-.062	.260	.200	< .001		
Experiment 3	158 vs. 132	.156	.009	.052	.385	.069	.290

Note. Results of multiple-regression analyses using political orientation, education, age, race, gender, and country as simultaneous predictors of truth sensitivity, anti-COVID-19-vaccine belief bias, and belief-congruency bias, respectively. Higher scores on the political-orientation index reflect a more conservative (vs. liberal) political ideology. For each racial or ethnic identity, participants who selected the respective identity (coded as 1) were compared to those who did not select this identity (coded as 0). For gender, female was used as reference group (always coded as 0) which was compared to either male (coded as 1 for this comparison) or

other/I prefer not to answer (coded as 1 for this comparison). For country of residence, UK (coded as 1) was compared to US (coded as 2).

Table S2

Statements Used as Stimulus Materials in Experiments 1 to 3

Statement	Truth status	Slant
Child Covid-19 hospitalizations in the United States rose amid Omicron, especially among children too young to be vaccinated.	true	pro-COVID-19 vaccine
COVID-19 death rate is considerably higher for unvaccinated people.	true	pro-COVID-19 vaccine
Pfizer's COVID booster greatly improves the antibody response to be able to fight off Omicron.	true	pro-COVID-19 vaccine
Vaccinated people clear the COVID-19 infection more quickly.	true	pro-COVID-19 vaccine
As of early December 2021, unvaccinated adults in the U.S. were 97 times more likely to die from COVID-19 than boosted adults.	true	pro-COVID-19 vaccine
Covid vaccines are safe in pregnancy.	true	pro-COVID-19 vaccine
There is no evidence of cancer due to COVID-19 vaccines.	true	pro-COVID-19 vaccine
Getting vaccinated for COVID-19 yourself also protects people around you.	true	pro-COVID-19 vaccine
There is no evidence that the COVID-19 vaccine affects puberty.	true	pro-COVID-19 vaccine
After the body produces an immune response, it discards all the COVID-19 vaccine ingredients.	true	pro-COVID-19 vaccine
COVID-19 vaccination causes a more predictable immune response than infection with the virus that causes COVID-19.	true	pro-COVID-19 vaccine
Getting vaccinated for COVID-19 reduces the risk of getting COVID-19.	true	pro-COVID-19 vaccine
Vaccines effectively protect against severe Covid-19 infection.	true	pro-COVID-19 vaccine
Pfizer’s Covid vaccine is effective in preventing kids from catching Omicron.	true	pro-COVID-19 vaccine
Getting a COVID-19 vaccine can provide added protection for people who already had COVID-19.	true	pro-COVID-19 vaccine

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Statement	Truth status	Slant
COVID-19 vaccine boosters can further enhance or restore protection.	true	pro-COVID-19 vaccine
With the rapid uptake in vaccinations in the months when vaccines first became widely available, COVID-19 deaths in the U.S. fell sharply.	true	pro-COVID-19 vaccine
All COVID-19 vaccines are free from metals.	true	pro-COVID-19 vaccine
COVID-19 vaccines can help prevent new variants from emerging.	true	pro-COVID-19 vaccine
There is no evidence that COVID-19 vaccines cause fertility problems in women or men.	true	pro-COVID-19 vaccine
COVID-19 vaccines become less effective at preventing severe illness over time.	true	anti-COVID-19 vaccine
Some breakthrough infections of people vaccinated against COVID-19 result in death.	true	anti-COVID-19 vaccine
Breakthrough cases prove that even if I get the vaccine, I might still get COVID.	true	anti-COVID-19 vaccine
Coronavirus vaccine protection was much weaker against Omicron.	true	anti-COVID-19 vaccine
All COVID-19 vaccines have the possibility of short-term side effects.	true	anti-COVID-19 vaccine
Guillain Barré syndrome has occurred in some people who have received Johnson & Johnson's COVID-19 vaccine.	true	anti-COVID-19 vaccine
Citing a rare blood clot risk, the U.S. Centers for Disease Control and Prevention discouraged Johnson & Johnson's vaccine.	true	anti-COVID-19 vaccine
Individuals who have had two COVID-19 vaccine doses can be just as infectious as those who have not been jabbed.	true	anti-COVID-19 vaccine
In October 2021, Scandinavians curbed Moderna shots for some younger patients due to an increased risk of heart inflammation.	true	anti-COVID-19 vaccine

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Statement	Truth status	Slant
Changes to the menstrual cycle do occur following COVID-19 vaccination.	true	anti-COVID-19 vaccine
Skin problems such as swelling, redness, and pain can occur after receiving a COVID-19 vaccine.	true	anti-COVID-19 vaccine
The COVID-19 vaccines do not generally prevent an infection.	true	anti-COVID-19 vaccine
The Delta variant impaired the protection provided by vaccination.	true	anti-COVID-19 vaccine
Like other versions of Omicron, BA.2 has infected many vaccinated people.	true	anti-COVID-19 vaccine
When the Seychelles had vaccinated more people per head against Covid-19 than any other country, it still experienced a spike in cases.	true	anti-COVID-19 vaccine
Studies confirmed waning immunity from Pfizer's vaccine against Covid-19 infection.	true	anti-COVID-19 vaccine
In fall 2021, the Delta variant continued to cause high Covid case numbers even in countries with high vaccination rates.	true	anti-COVID-19 vaccine
In October 2021, several members of a U.S. Food and Drug Administration advisory committee voiced concerns about recommending to vaccinate all children 5 to 11 for COVID-19.	true	anti-COVID-19 vaccine
Beginning of December 2021, COVID cases in the U.S. spiked even as it hit 200M vaccine milestone.	true	anti-COVID-19 vaccine
The Pfizer and Moderna vaccines are associated with an increased risk of myocarditis.	true	anti-COVID-19 vaccine
If you're vaccinated against COVID-19, you're not going to be hospitalized.	false	pro-COVID-19 vaccine
Getting three doses of an mRNA COVID-19 vaccine eliminates the risk of death from COVID-19.	false	pro-COVID-19 vaccine

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Statement	Truth status	Slant
Data suggest the boosted are fully protected against getting the BA.2 coronavirus variant.	false	pro-COVID-19 vaccine
Long COVID affects only the unvaccinated.	false	pro-COVID-19 vaccine
Evidence suggests that the fully vaccinated who catch Delta exhibit no symptoms.	false	pro-COVID-19 vaccine
There is no evidence that there have been any significant adverse reactions to the Covid 19 vaccines.	false	pro-COVID-19 vaccine
There is no evidence of death due to COVID-19 vaccines.	false	pro-COVID-19 vaccine
People vaccinated for COVID-19 do not spread the disease to anyone else.	false	pro-COVID-19 vaccine
COVID-19 vaccines are risk-free.	false	pro-COVID-19 vaccine
Studies have shown no side effects of COVID-19 vaccines for children.	false	pro-COVID-19 vaccine
Studies have shown no side effects of COVID-19 vaccines for people older than 60.	false	pro-COVID-19 vaccine
COVID-19 vaccines cure corona.	false	pro-COVID-19 vaccine
High COVID-19 vaccination rates successfully stopped the spread of the Delta variant.	false	pro-COVID-19 vaccine
Omicron does not infect vaccinated people.	false	pro-COVID-19 vaccine
If you had COVID-19 and then get vaccinated, the virus cannot infect you anymore.	false	pro-COVID-19 vaccine
The immunity from Pfizer's Covid-19 vaccine remains stable over time.	false	pro-COVID-19 vaccine
Countries with high vaccination rates no longer experience high Covid case numbers.	false	pro-COVID-19 vaccine
COVID-19 vaccines have been tested for over 10 years.	false	pro-COVID-19 vaccine
COVID-19 vaccines also protect against getting the flu.	false	pro-COVID-19 vaccine

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Statement	Truth status	Slant
There is no evidence that COVID-19 vaccines are associated with anaphylaxis, a severe type of allergic reaction.	false	pro-COVID-19 vaccine
Teens are more likely to be hospitalized with myocarditis from the COVID-19 vaccines than to be hospitalized with COVID.	false	anti-COVID-19 vaccine
Vaccine related deaths rival recorded COVID-19 deaths.	false	anti-COVID-19 vaccine
People vaccinated against COVID-19 are more likely to be infected than those without the jab.	false	anti-COVID-19 vaccine
Vaccinated people get sicker with COVID-19 than people who are not vaccinated.	false	anti-COVID-19 vaccine
An mRNA COVID-19 vaccine can make me sick with COVID-19.	false	anti-COVID-19 vaccine
The odds of having a serious adverse event are much higher than 50% with both the Pfizer and Moderna vaccines.	false	anti-COVID-19 vaccine
By early October 2021, more young active duty personnel in the U.S. had died from the vaccines than from COVID-19.	false	anti-COVID-19 vaccine
COVID-19 vaccines do not stop transmission of COVID, but instead increase it.	false	anti-COVID-19 vaccine
Pfizer's Covid-19 vaccine may cause vaccine-associated enhanced disease.	false	anti-COVID-19 vaccine
The COVID-19 vaccine affects sperm production.	false	anti-COVID-19 vaccine
A person’s immune system “tanks” after their second COVID-19 vaccine dose.	false	anti-COVID-19 vaccine
The COVID-19 vaccine booster might have a reverse effect, something called immune system fatigue.	false	anti-COVID-19 vaccine
The surge in COVID-19 cases in the U.S. in summer 2021 was caused by antibody mediated viral enhancement from the COVID-19 vaccines.	false	anti-COVID-19 vaccine

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Statement	Truth status	Slant
Data from around the world suggests that Omicron more likely infects the fully vaccinated.	false	anti-COVID-19 vaccine
People who have recovered from COVID-19 do not benefit from vaccination.	false	anti-COVID-19 vaccine
Pfizer, Moderna, and Johnson & Johnson are shipping jabs with varying ingredients and potency.	false	anti-COVID-19 vaccine
In winter 2021-2022, U.K. Health Security Agency data showed the rate of hospitalization and death was substantially greater in people vaccinated for COVID-19 compared with unvaccinated people.	false	anti-COVID-19 vaccine
COVID-19 vaccines are still in an experimental stage.	false	anti-COVID-19 vaccine
Airlines in the U.S. met to discuss the risks of carrying passengers vaccinated against COVID-19 due to the risk of clots and the liabilities involved.	false	anti-COVID-19 vaccine
Studies show that myocarditis produced by a COVID-19 infection tends to be mild, while myocarditis caused by the vaccine can be severe.	false	anti-COVID-19 vaccine

References

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