BMC Infectious Diseases

RESEARCH Open Access

The role of social circle COVID-19 illness and vaccination experiences in COVID-19 vaccination decisions: an online survey of the United States population

Mark Skidmore*

Abstract

Background Around the world, policymakers have clearly communicated that COVID-19 vaccination programs need to be accepted by a large proportion of the population to allow life return to normal. However, according to the Center for Disease Control, about 31% of the United States population has not completed the primary vaccination series as of November 2022.

Aims The primary aim of this work is to identify the factors associated by American citizens with the decision to be vaccinated against COVID-19. In addition, the proportion of fatal events from COVID-19 vaccinations was estimated and compared with the data in the VAERS database.

Methods An online survey of COVID-19 health experiences was conducted. Information was collected regarding reasons for and against COVID-19 inoculations, experiences with COVID-19 illness and COVID-19 inoculations by survey respondents and their social circles. Logit regression analyses were carried out to identify factors influencing the likelihood of being vaccinated.

Results A total of 2840 participants completed the survey between December 18 and 23, 2021. 51% (1383 of 2840) of the participants were female and the mean age was 47 (95% CI 46.36–47.64) years. Those who knew someone who experienced a health problem from COVID-19 were more likely to be vaccinated (OR: 1.309, 95% CI 1.094–1.566), while those who knew someone who experienced a health problem following vaccination were less likely to be vaccinated (OR: 0.567, 95% CI 0.461–0.698). 34% (959 of 2840) reported that they knew at least one person who had experienced a significant health problem due to the COVID-19 illness. Similarly, 22% (612 of 2840) of respondents indicated that they knew at least one person who had experienced a severe health problem following COVID-19 vaccination. With these survey data, the total number of fatalities due to COVID-19 inoculation may be as high as 278,000 (95% CI 227,360–332,608) when fatalities that may have occurred regardless of inoculation are removed.

Conclusion Knowing someone who reported serious health issues either from COVID-19 or from COVID-19 vaccination are important factors for the decision to get vaccinated. The large difference in the possible number of fatalities due to COVID-19 vaccination that emerges from this survey and the available governmental data should be further investigated.

*Correspondence:
Mark Skidmore
mskidmor@msu.edu
Full list of author information is available at the end of the article

Keywords COVID-19, Return to normal, SARS-CoV-2, Survey, Vaccination

Introduction

Around the world, policymakers have made clear to their fellow citizens that the SARS-CoV-2: severe acute respiratory syndrome coronavirus (COVID-19) vaccination programs need to be accepted by a large proportion of the population to allow life return to normal. However, according to the Center for Disease Control (CDC) as of November 2022 about 31% of the United States (US) population had not completed the primary vaccination series, and a portion of the US population is resistant to being vaccinated. Recent studies that have examined the issue of vaccine hesitancy in the context of COVID-19, have highlighted concerns about vaccine safety as the main contributor to vaccine hesitancy [1–4]. A variety of factors such as age, education, political leaning, and misinformation have also been examined. Older people are at greater risk of severe disease and death from COVID-19 and thus may be more inclined to accept treatments such as the COVID-19 inoculation. Given the history of medical experimentation on African American populations [5], African American respondents may be less likely to be vaccinated. Information sources about COVID-19 may also influence the decision to be vaccinated.

A largely unexplored factor is the degree to which serious health problems arising from the COVID-19 illness or the COVID-19 vaccines among family and friends influences the decision to be vaccinated. Serious illness due to COVID-19 would make vaccination more likely; the perceived benefits of avoiding COVID-19 through inoculation would be high. On the other hand, observing major health issues following COVID-19 inoculation within one's social network would heighten the perceived risks of vaccination. Previous studies have not evaluated the degree to which experiences with the disease and vaccine injury influence vaccine status. The main aim of this online survey of COVID-19 health experiences is to investigate the degree to which the COVID-19 disease and COVID-19 vaccine adverse events among friends and family, whether perceived or real, influenced inoculation decisions. The second aim of this work is to estimate the total number of COVID-19 vaccine induced fatalities nationwide from the survey.

Methods

Design of the national survey of COVID-19 health experiences

The survey instrument and recruitment protocol of the National Survey of COVID-19 Health Experiences were approved by the Institutional Review Board (IRB) of the Michigan State University Human Research Protection Program (file number: STUDY00006960, date of approval: November 17, 2021). All methods were carried out in accordance with relevant guidelines and regulations. The sample was obtained by Dynata, the world's largest first-party data platform, and is representative for the US American population [6]. The sampling using Dynata is based on opt-in sampling, respondents deliver high quality data, they are diverse and have community norms of honesty and accuracy [7]. The survey was opened to the Dynata panel until the required number of responses was obtained from each category of the stratification variables age, sex, and income, as required for a balanced response set. With opt-in sampling there is no response rate as classically defined in survey research.

Development of questionnaire and pre-test

The questionnaire was developed in November 2021. A team that included a medical doctor and survey research specialist helped to validate the survey. The survey design was based on Shupp et al. [6]. Of relevance are questions that ask respondents about the health status of people in their social circles. Shupp et al. [6] included a similar question in their survey but in the context of prescription drug abuse. A pre-test was conducted with 1110 respondents December 6–9, 2021. The questionnaire was finalized using the responses from the pre-test.

The questionnaire is composed of five sets of questions: (1) questions about respondents' experiences with COVID-19 illness, (2) questions about respondents' experiences with COVID-19 inoculation, (3) questions about experiences with COVID-19 illness in respondents' social circles, (4) questions about experiences with COVID-19 vaccination in respondents' social circles, and (5) questions to obtain standard socioeconomic information, political affiliation, and views on COVID-19 policies, such as lockdowns and vaccine mandates. The questionnaire is provided in Additional file 1.

Statistical analysis of the survey data

Means and standard deviations are provided for continuous variables, and absolute numbers (percentages in parenthesis) for categorical variables. Socioeconomic characteristics of survey participants were compared with those from the United States (US) Census and the US American Housing Survey [8–10] after adjustment for age and sex.

Logistic regression was used to identify factors associated with the chance of being vaccinated with at least one shot. The two primary independent variables of interest were: (1) knowing someone who suffered from the COVID-19 disease; and (2) knowing someone who has been injured by the COVID-19 vaccine. Adjustments were made for the following confounders: age, sex, political affiliation (Democrat, Republican, Independent), degree of urbanization using respondents' self-assessment of whether they live in urban, suburban or rural areas, race (Caucasian, African American, Hispanic, Asian, Native American/Pacific Islander, Other), educational attainment as defined by the US Census [11], sources of information about COVID-19 (mainstream news, alternative news/other, peer-reviewed scientific literature, official government sources), COVID-19 illness problems in social circles, and COVID-19 inoculation problems in social circles. Social circles, as defined in the survey, include "family, friends, church, work colleagues, and social networks". Among those in social circles who experienced health problems, respondents were asked to provide a description of the person they know best.

Comparing serious adverse events between publicly available data and the survey

Several steps are required to compare data on COVID-19 vaccine adverse events from the survey with publicly available government data. In the first step, public data on COVID-19 fatalities from the CDC [12] is combined with COVID-19 vaccine-related adverse events from VAERS [13] to create the ratio of COVID-19 vaccine-related fatalities to fatalities from the COVID-19 illness. The same ratio from the survey data is calculated so that a comparison can be made. To examine differences, the null hypothesis (H_0) is defined such that the True Ratio, X, is equal to the CDC ratio which is in turn equal to the survey ratio: X = CDC Ratio = Survey Ratio. The alternative hypothesis, H_a, is X = CDC Ratio < Survey Ratio. This hypothesis is tested using state-by-state VAERS data on reported COVID-19 vaccine fatalities and CDC data on COVID-19 illness fatalities. If there is a statistically significant difference, the two ratios can be used to estimate nationwide COVID-19 vaccine fatalities under the assumption that the survey is accurate:

$$\text{Survey Ratio} = \frac{\textit{Survey COVID-19 Vaccine Fatalities}}{\textit{Survey COVID-19 Illness Fatalities}} \qquad \text{Pop.Ratio} = \frac{y}{\textit{CDC COVID-19 Illness Fatalities}}$$

Solving for y generates the estimated number of nationwide vaccine fatalities. Through the end of 2021, reported COVID-19 vaccine fatalities from VAERS [13] for the US states and the District of Columbia was 8023, and the CDC [12] reported 839,993 fatalities attributed to COVID-19. These data were downloaded on January 16, 2022. The ratio of vaccine-associated fatalities to COVID-19 fatalities is $\frac{8023}{839{,}993} = 0.0096$, or about 1%. A bootstrap method is used to obtain the 95% confidence interval, which is a non-parametric approach that does not assume an underlying distribution of the data. The procedure is as follows. First, resample the original dataset with replacement to obtain the same number of "pseudo-observations" where some of the original observations are counted multiple times. The new dataset serves as a pseudo-survey sample, which is used to recalculate the point estimate. This process is repeated 1000 times to compute the 95% confidence interval.

In the second step, the fatality calculation from above is used to estimate the number of non-fatal adverse events. The ratio of estimated population-wide fatalities to reported fatalities in the survey is used to calculate nationwide adverse events, *a*, as per the two equations below. "Severe" and "less severe" adverse events are calculated separately.

$$\text{Fatality Ratio} = \frac{\textit{Estimated Pop. COVID} - 19\ \textit{Vaccine Fatalities}}{\textit{Survey COVID} - 19\ \textit{Vaccine Fatalities}} \qquad \text{Adverse Event Ratio}$$
$$= \frac{a}{\textit{Survey Adverse Events}}$$

Results

Characteristics of survey participants representativeness of the survey

The National Survey of COVID-19 Health Experiences was administered online between December 18 and 23,

Table 1 Demographic characteristics of survey participants compared to the US Census and the American Housing Survey 2020

Variable	Adjusted survey	US Census/AHS
Age in adult population (years)	46.9	47.6
Sex (male)	48.7%	49.2%
Political affiliation		
Democrat	32.7%	33%
Republican	32.1%	29%
Independent	35.3%	34%
Race		
Caucasian	68.3%	71.0%
African American	15.4%	14.2%
Urbanization		
Urban	30.8%	27%
Suburban	46.7%	52%
Rural	22.5%	21%
Education		
Some college/2-year degree	35.4%	27.6%
College degree	18.9%	22.1%
College above bachelors	14.2%	12.7%

2021. A total of 2840 participants completed the survey after removing the 216 respondents (6.5%) who opted out of the survey by not consenting to participate, 60 missing responses on age which is used to weight the data (1.9%), and 105 incomplete surveys (3.2%). Twenty-seven additional respondents did not answer the question about race; in portions of the evaluation where race is considered, there are 2813 observations. Item non-response for the following variables is considered negligible: age 1.9% (age), 0.9% (race), and 0.28% (number of people in social circles). The other questions used in this evaluation did not have a single missing item.

The survey instrument is available in Additional file 1. Table 1 provides descriptive statistics for the survey sample with comparison to data from the US Census [10, 14] and the American Housing Survey [15]. 49% of both the survey participants and the US population were male. Age of participants is 46.9 (CI 95% ± 0.640) years. There were also some minor differences in political affiliation, race, degree of urbanization and education. The data on urbanicity are comparable to data from the American Housing Survey [15] with small differences in percent urban (30.8% vs. 27%), percent suburban (46.7% vs. 52%), and percent rural (22.5% vs. 21%). For educational attainment, the survey had a higher percentage with "some college" (35.4% vs. 27.6%) but a lower percentage of "college graduates" (18.9% vs. 22.1%), and a higher percentage with "more than a college degree" (14.2 vs. 12.7).

Though a person may report that someone they know experienced a COVID-19 vaccine adverse event, it does not mean that vaccination was the cause of injury. As shown in the Table 4 and Additional file 3, some respondents indicated that a person they know had a heart attack after being vaccinated, though the heart attack could have been unrelated to the inoculation. To address this issue, an estimate of the number of people within respondent social groups who are expected to die regardless of inoculation is calculated and subtracted from reported COVID-19 vaccine fatalities. Three commonly reported vaccine adverse events are heart attacks, strokes and other manifestations of blood clots. The average age of a person in the survey dataset who experienced these conditions after being vaccinated is about 40 years of age, and the average age of death is 48. The incidence of heart attacks (myocardial infarction) for people of age 48 is about 1 per 1,000, and the incidence of strokes and blood clots for this age group is very low, near zero [12]. Heart attacks, strokes and blood clots are also commonly reported causes of COVID-19 vaccine death in VAERS. From the survey, about 51% of respondents reported being vaccinated. It is assumed that same proportion applies to those in respondents' social circles. The estimated total number of people in respondents' social circles is about 28,000. To calculate an estimated number of fatalities that might have occurred regardless of inoculation status, 17 is multiplied by the proportion of people who are vaccinated (0.51) and the proportion of people in social circles out of 100,000 (0.28). The estimated number of fatalities that might have occurred regardless of vaccination status is $17 \times 0.51 \times 0.28 = 2.43$ people.

Direct respondent experiences regarding the COVID-19 illness or the COVID-19 vaccine are informative but incomplete because potential respondents who are very ill or died due to COVID-19 illness or the COVID-19 vaccine could not participate in the survey. For this study, the most important information comes from the questions about the experiences of those within respondents' social circles because all these health experiences can be reported by survey respondents.

Descriptive statistics for primary endpoints

Table 2 presents summary statistics for the relevant questions answered of respondents with differences and p-values between those who had the COVID-19 illness and not, and those who were vaccinated and not. The survey questionnaire is provided in Additional file 1. 23% of respondents report have had the COVID-19 illness, of which 28% experienced lingering health issues; most indicated they had ongoing respiratory/breathing or taste/smell issues. About 8.6% of those who had

Table 2 Key summary statistics for COVID-19 health survey

	Obs.	Overall mean	COVID-19 illness				Vaccinated			
			Yes mean	No mean	Diff.	P-value	Yes mean	No mean	Diff.	P-value
Question/variable										
Have you had COVID? (yes = 1, no = 0)	2840	0.230	0.230				0.208	0.253	− 0.046	0.005
Health issues after COVID-19 (yes = 1, no = 0)	690	0.284	0.284				0.341	0.236	0.105	0.004
Severe health issues after COVID (yes = 1, no = 0)	1[illegible]	0.086	0.086				0.080	0.093	− 0.013	0.759
Vaccinated against COVID? (yes = 1, no = 0)	2840	0.[illegible]	0.461	0.526	− 0.064	0.005	0.511			
Health issues after vaccine (yes = 1, no = 0)	1365	0.1[illegible]	0.258	0.116	0.142	0.000	0.146			
Severe health issues after vaccine (yes = 1, no = 0)	205	0.1[illegible]	0.145	0.128	0.017	0.752	0.134			
Average income	2840	60,[illegible]52	63,957	59,014	4943	0.033	70,919	48,903	22,015	0.000
Gender (male = 1, female = 0)	2840	0.487	0.507	0.481	0.026	0.253	0.510	0.463	0.047	0.017
Social circle—# people respondents know	2,432	10.601	[illegible].598	10.602	− 0.004	0.997	12.487	8.443	4.044	0.000
Social circle health issues after COVID (yes = 1, no = 0)	2840	0.338	0.416	0.314	0.101	0.000	0.353	0.322	0.031	0.097
Social circle health issues after vaccine (yes = 1, no = 0)	2840	0.216	[illegible].286	[illegible].195	0.091	0.000	0.157	0.277	− 0.121	0.000
Education										
Less than high school (yes = 1, no = 0)	2840	0.038	0.047	0.035	0.012	0.198	0.016	0.061	− 0.045	0.000
High school/GED (yes = 1, no = 0)	2840	0.276	0.247	[illegible]5	− 0.038	0.054	0.217	0.338	− 0.121	0.000
Some college (yes = 1, no = 0)	2840	0.242	0.269	[illegible].234	[illegible].035	0.079	0.232	0.253	− 0.022	0.201
2-year college degree (yes = 1, no = 0)	2840	0.112	0.096	0.[illegible]	− 0.021	0.129	0.109	0.114	− 0.005	0.684
4-year college degree (yes = 1, no = 0)	2840	0.189	0.173	0.195	− [illegible].22	0.217	0.248	0.128	0.121	0.000
Master's degree (yes = 1, no = 0)	2840	0.097	0.103	0.095	[illegible]008	0.583	0.123	0.070	0.054	0.000
Doctoral degree (yes = 1, no = 0)	2840	0.019	0.022	0.018	0.004	[illegible]52	0.024	0.014	0.010	0.069
Professional degree (JD, MD) (yes = 1, no = 0)	2840	0.026	0.044	0.021	0.02[illegible]	[illegible]010	0.030	0.022	0.008	0.226
Race										
White/Caucasian (yes = 1, no = 0)	2813	0.683	0.662	0.690	− 0.028	0.192	[illegible].755	0.608	0.147	0.000
African American (yes = 1, no = 0)	2813	0.154	0.127	0.162	− 0.035	0.0[illegible]0	0.11[illegible]	0.193	− 0.078	0.000
Hispanic (yes = 1, no = 0)	2813	0.071	0.116	0.057	0.059	0.000	0.051	0.092	− 0.041	0.000
Asian (yes = 1, no = 0)	2813	0.035	0.033	0.036	− 0.003	0.722	0.[illegible]2	0.038	− 0.006	0.388
Native American/Pacific Islander (yes = 1, no = 0)	2813	0.024	0.030	0.023	0.007	0.341	[illegible].018	0.031	− 0.013	0.026
Other/more than one race (yes = 1, no = 0)	2813	0.033	0.032	0.033	− 0.001	0.948	0.028	[illegible].037	− 0.009	0.179
Urbanicity										
Urban (yes = 1, no = 0)	2840	0.308	0.320	0.305	0.015	0.475	0.299	0.318	− 0.019	0.294
Suburban (yes = 1, no = 0)	2840	0.467	0.459	0.469	− 0.010	0.664	0.504	[illegible].427	0.077	0.000
Rural (yes = 1, no = 0)	2840	0.225	0.221	0.227	− 0.005	0.786	0.197	0.25[illegible]	− 0.0[illegible]8	0.000
Information sources about COVID-19										
Mainstream news sources (yes = 1, no = 0)	2840	0.603	0.540	0.621	− 0.081	0.000	0.700	0.501	[illegible]198	0.000

Table 2 (continued)

	Obs.	Overall mean	COVID-19 illness				Vaccinated			
			Yes mean	No mean	Diff.	P-value	Yes mean	No mean	Diff.	P-value
Alternative news sources (yes = 1, no = 0)	2840	0.350	0.385	0.34	0.045	0.041	0.270	0.434	− 0.165	0.000
Peer reviewed scientific literature (yes = 1, no = 0)	2840	0.182	0.195	[illegible]	0.016	0.368	0.177	0.188	− 0.010	0.485
Official gov't sources such as the CDC (yes = 1, no = 0)	2840	0.382	0.361	0.388	− 0.027	0.222	0.458	0.302	0.156	0.000
Political affiliation										
Democrat (yes = 1, no = 0)	2840	0.327	0.300	0.335	− [illegible]35	0.091	0.389	0.261	0.128	0.000
Republican (yes = 1, no = 0)	2840	0.321	0.360	0.309	0.051	0.021	0.300	0.342	− 0.042	0.024
Independent/other (yes = 1, no = 0)	2840	0.353	0.341	0.356	− 0.015	[illegible]75	0.311	0.397	− 0.086	0.000

health problems experienced more severe health problems resulting from COVID-19. 51% of respondents indicated that they had been vaccinated of which 15% indicated that they experienced a health issue after vaccination, and 13% of those indicated that a severe adverse event had occurred. The respondents' comments describing the nature of the COVID-19 illness and health issues and COVID-19 vaccine adverse events are available from the author upon request. There are statistically significant differences across groups, with notable differences across the vaccinated/unvaccinated groups in income ($70,919 vs. $48,903), knowing someone who experienced a vaccine adverse event (0.157 vs. 0.277), as well as with the education, race, information sources, and political affiliation categorical variables.

Factors related to vaccination decision and vaccine injury

The Logit regressions for vaccination and knowing someone who experienced a vaccine adverse event are shown in Table 3, which reports the odds ratios with confidence intervals. All regressions are estimated using the unweighted data due to the inclusion of socio-economic controls used by Dynata to recruit a balanced sample. Starting with socioeconomic factors, age is positively associated with inoculation (OR: 1.025, 95% CI 1.019–1.031), but negatively associated with knowing someone who has been injured from inoculation (OR: 0.979, 95% CI 0.973–0.985). Higher income is also positively associated with inoculation (OR: 1.000005, 95% CI 1.000004–1.000007). Relative to Democrats, those who self-identify as Republican have lower odds of being vaccinated (OR: 0.595, 95% CI 0.477–0.742) and have greater odds of knowing someone who has experienced an adverse event (OR: 1.388, 95% CI 1.089–1.769). Those who identify as Independent also have lower odds of being vaccinated (OR: 0.631, 95% CI 0.511–0.773). There is evidence of an urban-rural divide, where rural residents have lower odds of being vaccinated (OR: 0.744, 95% CI 0.587–0.943). Race is an important factor in vaccination status. African Americans (OR: 0.655, 95% CI 0.513–0.835), Hispanics (OR: 0.647, 95% CI 0.469–0.893), and Asians (OR: 0.599, 95% CI 0.387–0.927) have lower odds of being vaccinated relative to the White population. African Americans are also more likely to know someone who has experienced a health problem post-vaccination (OR: 1.376, 95% CI 1.066–1.776). Educational attainment is positively associated with inoculation. Those with doctoral (OR: 3.835, 95% CI 1.759–8.358) or professional degrees (OR: 3.2821, 95% CI 1.601–6.729) have higher odds of being inoculated. Those with doctoral (OR: 4.263, 95% CI 2.009–9.043) or professional degrees (OR: 3.525, 95% CI 1.755–7.079) also have higher odds of reporting that they know someone who has experienced a health problem after inoculation, respectively. Information sources are also associated with inoculation status. Those who report reliance on mainstream news and official government sources have higher odds of being vaccinated (OR: 1.394, 95% CI 1.165–1.669). However, use of alternative news sources reduces the odds of inoculation (OR: 0.669, 95% CI 0.557–0.802). Also, reliance on alternative news (OR: 1.481, 95% CI 1.217–1.801) and peer reviewed scientific publications (OR: 1.430, 95% CI 1.143–1.789) increases the odds that a respondent knows someone who experienced a health problem post-vaccination.

Turning to the primary hypothesis, a respondent's observations within his/her social circles have a significant influence on the decision to be vaccinated. Those who know someone who experienced a significant health problem from the COVID-19 illness have higher odds of being vaccinated (OR: 1.309, 95% CI 1.094–1.566). Conversely, those who know someone who had a health problem following inoculation have lower odds of being vaccinated (OR: 0.567, 95% CI 0.461–0.698). The impact of COVID-19 vaccine injury is larger than the impact of COVID-19 illness.

Comparison of serious adverse events between publicly available data and the survey

An unexpected result of the survey is that many participants who decided not to be vaccinated reported that an event among friends or family members, which they recognized as adverse vaccination event, was a reason for their hesitance to be vaccinated. If COVID-19 vaccine adverse events are rare, then they would not be captured in the survey and would not influence inoculation decisions. The high proportion motivated a closer examination of data from the CDC Vaccine Adverse Events Reporting System (VAERS) [13].

Table 4 presents a summary of COVID-19 illness and COVID-19 vaccine health experiences among respondents' social circles. 34% (959 of 2840) of respondents indicated that they knew at least one person who had experienced significant health problems from COVID-19, including 165 people who had died from COVID-19. Additional file 2 provides a word-cloud of respondent descriptions of COVID-19 illness experiences in social circles along with respondent comments. 22% (612 of 2840) of respondents indicated that they knew at least one person who experienced a health problem after COVID-19 vaccination. Fifty-seven people indicated that among the people they knew who had experienced a vaccine adverse event, the person they knew best had died. Additional file 3 provides respondent descriptions of COVID-19 vaccine health problems in social circles in a word-cloud along with respondent comments. Respondents report a variety of problems including heart

Table 3 Logit regression on COVID-19 inoculation and social circle inoculation adverse events

	Have you been inoculated against Covid-19?					**Has anyone in your social circles experienced a significant health problem after they received the Covid-19 vaccination?**				
	OR	**SE**	**95% CI**		**p**	**OR**	**SE**	**95% CI**		**P**
Age	1.025	0.003	1.019	1.031	0.000	0.979	0.003	0.973	0.985	0.000
Combined income	1.000005	0.000001	1.000004	1.000007	0.000000	0.999999	0.000001	0.999997	1.000001	0.229544
Democrat	REF	REF	REF	REF	REF	REF	REF	REF	REF	REF
Republican	0.595	0.067	0.477	0.742	0.000	1.388	0.172	1.089	1.769	0.008
Independent/other	0.631	0.066	0.514	0.773	0.000	1.098	0.129	0.872	1.381	0.426
Urban	REF	REF	REF	REF	REF	REF	REF	REF	REF	REF
Suburban	0.967	0.096	0.797	1.175	0.738	1.004	0.110	0.809	1.245	0.973
Rural	0.744	0.090	0.587	0.943	0.015	1.255	0.167	0.967	1.630	0.088
White	REF	REF	REF	REF	REF	REF	REF	REF	REF	REF
African American	0.655	0.081	0.513	0.835	0.001	1.376	0.179	1.066	1.776	0.014
Hispanic	0.647	0.106	0.469	0.893	0.008	1.115	0.193	0.794	1.565	0.531
Asian	0.599	0.133	0.387	0.927	0.022	0.666	0.179	0.393	1.129	0.131
Native American/Pacific Islander	0.803	0.212	0.479	1.345	0.405	1.244	0.340	0.728	2.126	0.425
Other/more than one	0.760	0.174	0.485	1.191	0.232	0.811	0.213	0.485	1.357	0.425
No high school completion	REF	REF	REF	REF	REF	REF	REF	REF	REF	REF
HG/GED	1.700	0.420	1.047	2.760	0.032	1.083	0.275	0.659	1.781	0.754
Some college	2.133	0.533	1.308	3.480	0.002	1.248	0.321	0.754	2.067	0.389
2-year CD	2.208	0.589	1.309	3.726	0.003	1.827	0.499	1.070	3.121	0.027
4-year CD	3.535	0.918	2.125	5.880	0.000	1.355	0.365	0.800	2.296	0.259
Master's	2.941	0.827	1.695	5.102	0.000	2.028	0.579	1.143	3.536	0.015
Doctoral	3.835	1.524	1.759	8.358	0.001	4.263	1.636	2.009	9.043	0.000
Professional (JD, MD)	3.282	1.202	1.601	6.729	0.001	3.525	1.254	1.755	7.079	0.000
No news source	REF	REF	REF	REF	REF	REF	REF	REF	REF	REF
Mainstream news sources	1.394	0.128	1.165	1.669	0.000	1.026	0.105	0.840	1.254	0.800
Alternative/other news sources	0.669	0.062	0.557	0.802	0.000	1.481	0.148	1.217	1.801	0.000
Peer reviewed scientific literature	1.069	0.117	0.862	1.326	0.544	1.430	0.165	1.140	1.789	0.002
Official government sources such as CDC	1.594	0.140	1.341	1.894	0.000	0.845	0.085	0.694	1.028	0.092
Female	REF	REF	REF	REF	REF	REF	REF	REF	REF	REF
Male	1.172	0.101	0.990	1.387	0.065	1.006	0.096	0.833	1.213	0.954
Social circle-no health problem	REF	REF	REF	REF	REF					
Social circle-health problem after Covid-19	1.309	0.120	1.094	1.566	0.003					
Social circle-health problem after vaccine	0.567	0.060	0.461	0.698	0.000					
Constant	0.135	0.039	0.076	0.238	0.000	0.354	0.106	0.197	0.634	0.001

Table 3 (continued)

	Have you been inoculated against Covid-19?				Has anyone in your social circles experienced a significant health problem after they received the Covid-19 vaccination?			
	OR	**SE**	**95% CI**	**p**	**OR**	**SE**	**95% CI**	**P**
Obs	2813				2813			
LR Chi^2	563.42				158.68			
Pseudo R^2	0.145				0.053			

Table 4 Summary statistics for health problems in social circles

Question/variable	Obs	# People	Mean
Social circle health issues after COVID-19 (yes = 1, no = 0)	2840	959	0.338
One person—health issue after COVID-19 (yes = 1, no = 0)	980	379	0.3[illegible]
Two people—health issue after COVID-19 (yes = 1, no = 0)	980	355	0.362
Three people—health issue after COVID-19 (yes = 1, no = 0)	980	156	0.159
≥ Three people—health issue after COVID-19 (yes = 1, no = 0)	980	91	0.092
Death after COVID-19 (yes = 1, no = 0)	980	165	0.168
Severe issues after COVID-19 (yes = 1, no = 0)	980	354	0.361
Less severe issues after COVID-19 (yes = 1, no = 0)	980	471	0.480
Average age of people with COVID-19 issues	980	–	44.95
Social circle health issues after vaccination (yes = 1, no = 0)	2840	[illegible]	0.216
One person—health issues after vaccination (yes = 1, no = 0)	649	268	0.413
Two people—health issues after vaccination (yes = 1, no = 0)	649	230	0.354
Three people—health issues after vaccination (yes = 1, no = 0)	649	[illegible]0	0.138
≥ Three people—health issues after vaccination (yes = 1, no = 0)	649	62	0.095
Death after vaccine (yes = 1, no = 0)	649	57	0.088
Severe health condition after vaccine (yes = 1, no = 0)	649	197	0.303
Less severe health condition after vaccine (yes = 1, no = 0)	[illegible]49	400	0.616
Heart condition after vaccine (yes = 1, no = 0)	64[illegible]	42	0.065
Blood condition after vaccine (yes = 1, no = 0)	649	22	0.034
Nervous condition after vaccine (yes = 1, no = 0)	[illegible]49	14	0.021
Covid related conditions after vaccine (yes = 1, no = 0)	649	45	0.069
Average age of people with vaccine adverse events	649	–	41.16

attacks and other heart related problem[illegible], blood clots and strokes, and neurological problems. Many of the descriptions such as "heart attack," "stro[illegible]" or "blood clot" are consistent with FDA [16] and Pfizer [17] documentation about the potential risks of the COVID-19 vaccine.

The ratio of COVID-1[illegible] vaccine deaths to COVID-19 illness deaths of the people respondents knew best who had health problem[illegible] is $\frac{57}{165} = 0.345$, whereas the ratio of vaccine-associated fatalities to COVID-19 fatalities from government sources is $\frac{8023}{839{,}993} = 0.0096$. The null hypothesis ($H_0$) that the true ratio, X, is equal to the CDC ratio which is also equal to the survey ratio: X = CDC Ratio = Survey Ratio.

This hypothesis is tested using state-by-state VAERS data on reported COVID-19 vaccine-associated deaths and COVID-19 illness fatalities. The alternative hypothesis (H_a) is: X = CDC Ratio < Survey Ratio. The mean (u) and standard deviation (σ) of the ratio of vaccine fatalities to COVID-19 fatalities from the state-by-state data are u = 0.0136 and σ = 0.0111. The probability that the Survey Ratio > CDC Ratio = X is P(CDC Ratio > 0.345). With P(CDC Ratio > 0.345) = 0 and a Z-score = 28.86; the null hypothesis is rejected.

Assuming the experiences captured in the survey represent the true ratio, the survey ratio is used to estimate nationwide COVID-19 vaccine fatalities: Estimated fatalities are 289,789 (95% CI 229,319–344,319). Estimated nationwide deaths combined with other survey data on adverse events are also used to estimate total adverse events. "Severe" adverse events are estimated to be about one million nationwide, and "less severe" adverse events are about 2.1 million. Estimated nationwide fatalities, "severe" injuries and "less severe" injuries tally to 3.4 million.

This evaluation is conducted under the assumption that the reported vaccine-related fatalities and injuries are caused by the COVID-19 vaccine but is now relaxed by reducing the number of reported fatalities by the fatalities due to other causes that would be expected to have occurred anyway. An estimated 2.43 fatalities might have occurred from heart attacks, strokes and blood clots within the survey sample regardless of vaccination status. Subtracting these fatalities from total estimated vaccine fatalities generates a nationwide estimate of 278,000 fatalities, which is 4.1% smaller. Estimated total adverse events are correspondingly reduced by 4.1%. Also, Additional file 4 provides analysis of respondent bias as reflected by political affiliation and vaccination status. Estimated nationwide COVID-19 vaccine fatalities based on the Democrat, Republican and Independent subsets are 109,564, 463,444 and 247,867, respectively. With

the vaccinated and unvaccinated subgroups, estimated COVID-19 vaccine fatalities are 110,942 and 659,995.

Discussion

The primary contribution of this study is to examine the role that observed health experiences within social circles play in COVID-19 vaccination decisions. Findings indicate that knowing someone who experienced a major health problem from the COVID-19 illness as well as knowing someone who experienced an COVID-19 vaccine adverse event are important factors. The unexpectedly large number of respondents who reported that they knew someone who had experienced a vaccine adverse event motivated further examination of how many people nationwide may have experienced an adverse event from the COVID-19 vaccine. Estimates from the survey indicate that through the first year of the COVID-19 vaccination program there may be as many as 278,000 vaccine induced fatalities and up to a million severe adverse events. The analyses offer new evidence that the health experiences with the COVID-19 illness and vaccination within social circles play an important role in the decision to be vaccinated. Further, the reported COVID-19 vaccine adverse events within respondent social circles in the survey are substantial, suggesting that this effect is an important factor in vaccine hesitancy, whether perceived or real. Consistent with previous research, findings show that personal characteristics are also associated with vaccination status. As summarized in Nguyen et al. [18] and Prematunge et al. [19], a number of studies have examined vaccine hesitancy in the context of influenza outbreaks. Among the factors that influence vaccination status are perceptions of vaccine safety, effectiveness in the prevention of infection to self and others, and the seriousness of the illness. These studies highlight the importance of emphasizing the benefits of vaccination to improve vaccine uptake.

The research on COVID-19 vaccine hesitancy also shows the importance of perceptions and beliefs regarding the safety and effectiveness of the vaccines as well as concerns about the severity of the COVID-19 illness [18, 20–22] in vaccination decisions. Important factors also include vaccine-specific concerns, the need for more information, antivaccine beliefs/attitudes, and lack of trust, which are also correlated with lower educational attainment [23, 24]. In addition, there is a positive correlation between general trust in science and COVID-19 vaccination intentions [25]. As highlighted earlier, socioeconomic characteristics are also associated with vaccination status [1–4].

The findings confirm other research on vaccine hesitancy that show the importance of various personal characteristics [1–4] and builds on this earlier work by demonstrating that experiences with health problems from the COVID-19 illness and the COVID-19 vaccine in respondent social circles are also important factors. Knowing someone who had health issues with the COVID-19 illness increases the odds of vaccination, whereas knowing someone who experienced a vaccine injury reduces the odds of vaccination. This research suggests that those who know someone who is COVID-19 vaccine injured will be resistant to vaccination. Future research with a larger sample in a validated in a clinical setting is needed.

The strengths of this research are that it is based on a sample that closely matches the US population and that it provides new information regarding how experiences with the COVID-19 illness and COVID-19 vaccine adverse events, real or perceived, influence COVID-19 vaccination decisions. These findings increase our understanding of vaccine hesitancy. The limitations of the study are threefold: (1) The sample of 2840 respondents is small; (2) reported COVID-19 illnesses and COVID-19 vaccine adverse events are not diagnosed in a clinical setting; and (3) health survey responses are biased. For example, there are limitations with using a survey to collect COVID-19 health information, particularly for a politicized health issue. Respondents often interpret events with bias due to perceptions based on history, beliefs, culture and family background. For example, a respondent who self identifies as Republican may offer a report that is different than a person who identifies as Democrat. As discussed in "Results" section, we examine response differences across sub-samples based on reported political affiliation and vaccination status. These alternative calculations provide evidence of bias; Democrats perceived fewer vaccine adverse events than Republicans and Independents, and the vaccinated perceived far fewer vaccine adverse events than the unvaccinated. The latter finding suggests significant bias in the sense that each subgroup (vaccinated and unvaccinated) has an incentive to validate personal health decisions.

Conclusion

The survey provides useful information about the decision for or against getting vaccinated for COVID-19. The evaluation also showed that those who perceive that loved ones were harmed by the COVID-19 illness were more likely to be vaccinated, but the opposite was true for those who knew someone who had been injured by the COVID-19 vaccine. The large difference in the possible number of fatalities due to COVID-19 vaccination that emerges from this survey and the available governmental data should be further investigated.

Abbreviations

CDC	Centers for Disease Control
FDA	Food and Drug Administration
COVID-19/SARS-Cov-2	Severe acute respiratory syndrome coronavirus 2
US	United States
VAERS	Vaccine Adverse Events Reporting System

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12879-023-07998-3.

Additional file 1. National survey of Covid health experiences.

Additional file 2. Reported COVID-19 deaths and injuries in social circles.

Additional file 3. Reported COVID-19 inoculation deaths and injuries in social circles*.

Additional file 4. Examining bias based on respondent characteristics.

Acknowledgements
I thank Kathy Dopp, Catherine Austin Fitts, Sarena L. McLean, and Michael Palmer for valuable feedback on survey design and/or the draft paper. Fernanda Alfaro provided excellent research assistance.

Author contributions
The author read and approved the final manuscript.

Funding
Catherine Austin Fitts providing funding to cover the cost of the online survey.

Availability of data and materials
The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request. Once the paper is published, all data generated or analyzed during this study will be included in the published article and its Additional files. Please contact the author to request the survey data set and Stata code files.

Declarations

Ethics approval and consent to participate
The survey instrument and recruitment protocol of the National Survey of COVID-19 Health Experiences were approved by the Institutional Review Board (IRB) of the Michigan State University Human Research Protection Program (file number STUDY00006960, date of approval: November 17, 2021, name of IRB: Michigan State University Human Research Protection Program). All participants gave written informed consent via reading a written consent statement and clicking "I Agree" before being allowed to take the online survey. All methods were carried out in accordance with relevant guidelines and regulations.

Consent for publication
Not applicable.

Competing interests
The author declares that he has no competing interests.

Author details
[1]Department of Agricultural, Food and Resource Economics, Department of Economics, Michigan State University, 91 Morrill Hall of Agriculture, East Lansing, MI 48824-1039, USA.

Received: 11 July 2022 Accepted: 9 January 2023
Published online: 24 January 2023

References

1. Dubé È, Ward JK, Verger P, Macdonald NE. Vaccine hesitancy, acceptance, and anti-vaccination: trends and future prospects for public health. Annu Rev Public Health. 2020;42:175–91.
2. Hyland P, Vallières F, Shevlin M, Bentall RP, McKay R, Hartman TK, et al. Resistance to COVID-19 vaccination has increased in Ireland and the United Kingdom during the pandemic. Public Health. 2021;195:116–9.
3. Kreps SE, Goldfarb JL, Brownstein JS, Kriner DL. The relationship between us adults' misconceptions about covid-19 vaccines and vaccination preferences. Vaccines. 2021;9(8):1–8.
4. Yoda T, Katsuyama H. Willingness to receive covid-19 vaccination in Japan. Vaccines. 2021;9(1):1–8.
5. Gamble V. A legacy of distrust: African Americans and medical research. Am J Prev Med. 1993;9(6):35–8.
6. Shupp R, Loveridge S, Skidmore M, Greenberg J, Albrecht D. Recognition and stigma of prescription drug abuse disorder: personal and community determinants. BMC Public Health. 2020;20(1):1–9.
7. Tsai J, Shen J, Southwick SM, Greenberg S, Pluta A, Pietrzak RH. Public attitudes and advocacy about posttraumatic stress disorder in US adults. J Anxiety Disord. 2015;35(February):63–9. https://doi.org/10.1016/j.janxdis.2018.02.002.
8. United States Census Bureau. QuickFacts United States. https://www.census.gov/quickfacts/fact/table/US/PST045221. Accessed 11 Apr 2022.
9. United States Census Bureau. National demographic analysis tables: 2020. https://www.census.gov/data/tables/2020/demo/popest/2020-demographic-analysis-tables.html. Accessed 11 Apr 2022.
10. Pew Research Center. What the 2020 electorate looks like by party, race and ethnicity, age, education and religion. https://www.pewresearch.org/fact-tank/2020/10/26/what-the-2020-electorate-looks-like-by-party-race-and-ethnicity-age-education-and-religion/. Accessed 11 Apr 2022.
11. United States Census Bureau. About educational attainment. 2021. https://www.census.gov/topics/education/educational-attainment/about.html. Accessed 16 June 2022.
12. Centers for Disease Control and Prevention (CDC). https://wonder.cdc.gov/ucd-icd10.html. Accessed 10 Apr 2022.
13. VAERS. VAERS summary for COVID-19 vaccines through 01/14/2022. 2022. https://vaersanalysis.info/2022/01/21/vaers-summary-for-covid-19-vaccines-through-01-14-2022/. Accessed 10 Apr 2022.
14. United States Census Bureau. Race and ethnicity in the United States: 2010 census and 2020 census. 2021. https://www.census.gov/library/visualizations/interactive/race-and-ethnicity-in-the-united-state-2010-and-2020-census.html. Accessed 16 June 2022.
15. Bucholtz S. Urban. Suburban. Rural. How do households describe where they live?. The Edge, PD&R's online magazine. 2020. https://www.huduser.gov/portal/pdredge/pdr-edge-frm-asst-sec-080320.html. Accessed 16 June 2022.
16. Anderson SCBER, plans for monitoring. COVID-19 vaccine safety and effectiveness. 2020. https://www.fda.gov/media/143557/download.
17. Pfizer. Cumulative analysis of post-authorization adverse event reports of Pf-07302048 (Bnt162B2) received through 28-Feb-2021. 2021. https://www.coletividade-evolutiva.com.br/2021/12/documentos-revelam-a-ocultacao-de-mortes-por-vacinas-da-pfizer-por-parte-da-fda.html?m=1.
18. Nguyen T, Henningsen KH, Brehaut JC, Hoe E, Wilson K. Acceptance of a pandemic influenza vaccine: a systematic review of surveys of the general public. Infect Drug Resist. 2011;4(1):197–207.
19. Prematunge C, Corace K, McCarthy A, Nair RC, Pugsley R, Garber G. Factors influencing pandemic influenza vaccination of healthcare workers—a systematic review. Vaccine. 2012;30(32):4733–43. https://doi.org/10.1016/j.vaccine.2012.05.018.
20. Bendau A, Plag J, Petzold MB, Str A. COVID-19 vaccine hesitancy and related fears and anxiety. Int Immunopharmacol. 2021;97:107724.
21. Luo C, Yang Y, Liu Y, Zheng D, Shao L. Intention to COVID-19 vaccination and associated factors among health care workers: a systematic review and meta-analysis of cross-sectional studies. Am J Infect Control. 2021;49:1295–304.
22. Guidry JPD, Laestadius LI, Vraga EK, Miller CA, Perrin PB, Burton CW, et al. Willingness to get the COVID-19 vaccine with and without emergency use authorization. Am J Infect Control. 2021;49(2):137–42. https://doi.org/10.1016/j.ajic.2020.11.018.

23. Fisher KA, Bloomstone SJ, Walder J, Crawford S, Fouayzi H, Mazor KM. Attitudes toward a potential SARS-CoV-2 vaccine: a survey of US adults. Ann Intern Med. 2020;173(12):964–73.
24. Alshurman BA, Khan AF, Mac C, Majeed M, Butt ZA. What demographic, social, and contextual factors influence the intention to use COVID-19 vaccines: a scoping review. Int J Environ Res Public Health. 2021;18(17):9342.
25. Agley J, Xiao Y, Thompson EE, Golzarri-Arroyo L. Factors associated with reported likelihood to get vaccinated for COVID-19 in a nationally representative US survey. Public Health. 2021;196:9–14. https://doi.org/10.1016/j.puhe.2021.05.009.

Publisher's Note