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Critical Public Health

ISSN: 0958-1596 (Print) 1469-3682 (Online) Journal homepage: www.tandfonline.com/journals/ccph20

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To cite this article: Harriet Dwyer, Luisa Enria, Nadine Beckmann & Julie Leask (2025) Trust and the infodemic: reframing information threats in the realm of public health, Critical Public Health, 35:1, 2535084, DOI: 10.1080/09581596.2025.2535084

To link to this article: https://doi.org/10.1080/09581596.2025.2535084

Published online: 18 Jul 2025.

Elevate Series

CRITICAL PUBLIC HEALTH
2025, VOL. 35, NO. 1, 2535084
https://doi.org/10.1080/09581596.2025.2535084

ARTICLE COMMENTARY

Trust and the infodemic: reframing information threats in the realm of public health

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ABSTRACT

Amidst polarisation, public health threats and economic uncertainty, there is a concern around the impact of an overabundance of information: *the infodemic*. In this paper we argue that:

- information threats are a symptom of eroded trust, not the cause. Instead of viewing the overabundance of information as the primary problem, it should be understood as a reflection of wider trust processes;
- focusing on rebuilding trust offers a more effective approach than simply managing the infodemic. This includes promoting transparency and accountability from decision makers and fostering genuine community engagement when designing policy and
- vaccine confidence serves as an example of how trust, rather than information alone, drives public health decision making.

We conclude that through understanding and rebuilding trust, rather than problematising information and individual consumption of information, we can strengthen community level public health responses.

ARTICLE HISTORY
Received 22 April 2025
Accepted 14 July 2025

KEYWORDS
Misinformation; infodemic; vaccines; public health; trust

Introduction

In January 2024 at the World Economic Forum in Davos, United Nations (UN) Secretary-General, Antonio Guterres reflected on the systematic undermining of principles and standards globally, arguing that there is 'little wonder that people everywhere are losing faith in governments, institutions and financial and economic systems' (Guterres, 2024).

This 'lost faith' is evident in our information ecosystems (defined as the ways in which people interact with and behave around information (Internews, 2021)). Online, echo chambers are shrinking our information ecosystems as people largely interact with information confirming their own world view, while social media has enabled the acceleration and proliferation of (mis/dis)information (Törnberg, 2018). Rapidly developing generative AI tools risk increasing misinformation, producing novel and personalised content that is difficult to fact-check and verify (Monteith et al., 2024; Raman et al., 2024; Zagni & Canetta, 2023).

In public health, the challenges posed by an overabundance of information have been formalised through terms such as *infodemiology*, coined by Professor Gunther Eysenbach in 2002. Eysenbach originally defined *infodemiology* as the 'study of the determinants and distribution of health information and misinformation', later modifying it to 'the science of distribution and determinants of information in an electronic medium, specifically the internet, with the ultimate aim to inform public health and policy' (Eysenbach, 2002; Zielinski, 2021). This earlier work established the foundational academic framework for understanding information dynamics in health. While Eysenbach's work focused on the study of such a phenomenon, the specific term *infodemic*, gained prominence when first used by Rothkopf during the

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severe acute respiratory syndrome (SARS) epidemic. In a Washington Post Op Ed, Rothkopf argued that we were facing an 'epidemic of information' that was contributing to profound new threats to social cohesion and economic efficiency, with opportunities for the irresponsible to practice new forms of manipulation (Rothkopf, 2003). The infodemic risks social cohesion by exposing people to conflicting and untrusted information, making it difficult to have shared understandings (WHO, 2020). The erosion of this shared understanding can lead to polarisation and make it more challenging to make widely accepted public policy.

The term infodemic, since then, remained dormant but was reinvigorated by the World Health Organization (WHO) during the COVID-19 pandemic, when the Director General declared: 'We're not just fighting an epidemic; we're fighting an infodemic. Fake news spreads faster and more easily than this virus and is just as dangerous' (El Mikati et al., 2023; Ghebreyesus, 2020). Initially referring to an over-abundance of information both accurate and not, the term has now become a catch-all metaphor that applies the 'lens of epidemic management' to information threats faced in the realm of public health and beyond (Briand et al., 2021; Simon & Camargo, 2023). WHO currently defines an infodemic as too much information, including false and misleading content, that spreads in digital and physical environments during disease outbreaks (WHO, n.d). It notes that infodemics cause confusion, risk-taking behaviours and mistrust in health authorities (WHO, n.d).

The infodemic *has* been a helpful way to frame concerns within evolving information landscapes during the COVID-19 pandemic. It moved away from a polarised framing of 'fake news' and provided a means to define the need for accurate information during health crises (Tangcharoensathien et al., 2020). However, the concept has also been critiqued for its lack of definitional clarity (El Mikati et al., 2023), often conflating the overabundance of information with the spread of falsehoods. Scholars have also noted that the epidemic metaphor underpinning the term obscures the political and relational nature of information, and that the concept remains undertheorized (Simon & Camargo, 2023).

In the wake of the COVID-19 pandemic, and with the increasing politicisation of public health, this article argues that we should reframe the infodemic as a symptom of eroded trust. Solutions should focus on connecting with people and communities instead of just the content, volume and mode of information messages. We begin this article by discussing the naming and framing of the infodemic agenda and presenting the perspective of (mis)trust. We then provide the example of vaccine confidence to illustrate this dynamic before suggesting strategies for building trust.

The infodemic: naming to frame the problem and solutions

Naming is a powerful practice because it shapes what needs attention and funding and, by implication, what does not. Scholars of social movements describe 'diagnostic framing' as the naming of a problem and its cause (Snow et al., 2018), from which 'prognostic framing' often emerges, suggesting solutions and tactics (Snow & Benford, 1988). In this case the naming of the *infodemic* suggests the problem is the volume of information (Calleja et al., 2021) and the solution lies in improving information quality and reducing information abundance.

Solutions to tackle the infodemic have given rise to the field of Infodemic Management (IM), defined as the systematic use of evidence-based risk analysis, and communications to manage infodemics and reduce their negative health impacts (Abuhaloob et al., 2024; Lewandowsky et al., 2022). This transdisciplinary approach integrates various scientific disciplines and has included the delivery of new toolkits, dedicated personnel, and investment in social listening services which aim to understand conversations online (Abuhaloob et al., 2024; Calleja et al., 2021; Tangcharoensathien et al., 2020). The narrative around the scale of infodemics and associated threats to public health has also found receptive audiences among academics and policy makers, with many funding opportunities seeking to address this issue (Scheufele et al., 2021).

This 'infodemic response agenda' re-enlivens the hypodermic needle model of influence, where information is 'injected' into passive minds of individuals (Bineham, 1988). For example, the UN's 'Verified' campaign, launched during the pandemic, aimed to 'flood the internet with facts and science' through information volunteers (UN DoGC, 2020), while WHO's 'MythBusters advice for the public' addressed misinformation messages (WHO, 2022b). These approaches are built around the deficit model, which assumes

that providing 'facts' will counter misinformation because the audience is merely lacking access to the facts, or indeed has too many facts (Goldenberg, 2016). However, this ignores the context from which the infodemic grows.

Information consumption is not isolated and must be situated within historical, social, political, and economic contexts (Goldenberg, 2016; Lewandowsky et al., 2022). Even historical examples remind us that health-related media have long reflected wider societal tensions, not simply served as a neutral carrier of biomedical advice (Yang & Southwell, 2004).

To situate this process of information interpretation, we propose Hall's encoding/decoding theory (Hall, 1980). This theory is relevant because it looks at how information is produced (encoding) and consumed (decoding) with the understanding that individuals actively make meaning from the information they receive within their own specific context (Ross, 2011; Vanderslott et al., 2021). Southwell et al. (2019) argue that misinformation should not be related as a simple matter of incorrect facts, but as a symptom of deeper systemic conditions that require structural and relational solutions. Building on this Southwell et al. (2023) emphasise how exposure to health misinformation is unequally distributed, shaped by structural inequities, historical marginalisation and systematic disparities in media access. Rather than focusing solely on correcting falsehoods, they call for interventions that prioritise relationships, institutional responsiveness and equity (Southwell et al., 2023). Our approach aligns with these insights, emphasizing that efforts to understand information must account for the broader social and political conditions in which information is consumed.

From a perspective of (mis)trust

Instead of focusing on the overabundance of information, we propose viewing it through a lens of trust, situating the infodemic within wider contexts of inequality, injustice, the politicization of public health, and the evolving media landscape (Enria et al., 2024; Goldenberg, 2021).

Trust is a complex concept, often defined as a relationship in which one party accepts a position of vulnerability, assuming the best interests and competence of the other (Larson et al., 2018; Mühlfried, 2018; Schiocchet, 2018). It is not just a phenomenon between individuals, it also operates at an institutional level, where people's trust in organisations, governments and systems influence their behaviour and response to the policies that affect them (Goudge & Gilson, 2005). Trust is hard to articulate. It is often referred to as a 'leap of faith', especially concerning individual health decisions; where we are particularly vulnerable (Beckmann, 2015; Goldenberg, 2016). This is particularly true in the relationship between patients and health workers, which is shown to be one of the most trusted relationships (Gallup, 2019), and is shaped by prior experiences, cultural expectations and systematic inequalities (Gilson, 2003; Goudge & Gilson, 2005). Because this relationship of trust is so strong, information (including misinformation) shared by health workers may be readily accepted.

Trust quickly erodes when systems, including governance structures and social policies, are perceived to be failing (Guterres, 2024; Wells & Scheibein, 2022). Recent executive actions in the United States, for example, such as the withdrawal from WHO, disbanding of USAID and restructuring of public health leadership, have realigned the global health ecosystem, with the potential to reshape long-standing norms and destabilise trust in multilateral health governance (Thomas et al., 2025). These political shifts underscore how institutional decisions, particularly by powerful actors, can have cascading effects on global trust dynamics.

Yet despite these visible ruptures, understanding how trust has eroded is not straightforward. The Edelman Trust Barometer, for example, attempts to articulate shifts in public trust globally through survey data. In 2023, it showed that public trust in the UN, traditional media, and government institutions declined (Institute ET, 2023). However, the Barometer has been criticised because of Edelman's commercial relationships with autocratic regimes and potential bias (Lowenstein, 2023). Beyond opinion surveys, other methods to quantify trust range from analysing voter turnout to even measuring consumption of bottled water as a proxy for reduced trust in water supplies (Perry, 2021). Organisations like the International Federation of Red Cross and Red Crescent Societies (IFRC) uses its Community Trust Index to track trust in humanitarian aid (IFRC, 2024). The WHO has also embarked on a global initiative on trust and pandemic preparedness (WHO, 2023). These examples reflect nascent efforts. Trust is still ambiguous, hard to define, investigate and address (Goudge & Gilson, 2005).

With information, trust or mistrust can relate to the source, message and messenger within the wider context present at the time (Larson, 2018). This complexity may explain why there is persistent emphasis placed on the information in the infodemic. By avoiding the nuance, we may miss critical opportunities to strengthen public health responses.

Vaccine confidence as an example

No clearer is this dynamic at play as during the decision to vaccinate. Confidence in vaccines, therefore, provides a suitable lens through which we can explore new framings and propose solutions. We draw here on Larson's framing of vaccine confidence as trust in the safety and efficacy of vaccines, the system that delivers them and the motivations of policy makers behind them, an approach that highlights confidence as a multi-dimensional, relational construct (Larson et al., 2015). WHO have since operationalised a measure of vaccine confidence as the 'belief that vaccines are effective, safe, and part of a trustworthy medical system' (WHO, 2022a).

While misinformation is often cited as a driver of vaccine hesitancy, the extent to which information alone influences vaccination decisions remains inconclusive (Ruggeri et al., 2024) and many studies fail to establish causality. Instead, research shows that vaccine refusal is shaped by deeper factors, such as parenting beliefs, core values, traumatic experiences in health care and broader socio-political dynamics (Amin et al., 2017; Christou-Ergos et al., 2022; Enria et al., 2024; Wiley et al., 2020). Vaccination decisions can cause anxiety, creating a demand for information within a context of (mis)trust (Eagan et al., 2023; Enria et al., 2021).

In Sierra Leone, for instance, trust in vaccines during Ebola vaccine trials was shaped not only by biomedical reasoning but also power dynamics, and political and historical interpretations of disease and intervention (Enria et al., 2016). In Guinea, grounded ethnographic research revealed that healthcare workers often expressed concerns about COVID-19 vaccines in private (backstage), while promoting them in public (frontstage) highlighting a gap between professional expectations and personal apprehension (Heyerdahl et al., 2023). Perceptions of being used as 'guinea pigs' for vaccine experimentation, shaped by historical inequities and geopolitical dynamics, contributed to persistent mistrust (Heyerdahl et al., 2023). In Nigeria, vaccine refusal during polio campaigns was historically rooted in deep-seated political and religious mistrust, driven by local memories of exploitation and marginalisation (Obadare, 2005). In Brazil, COVID-19 vaccine hesitancy was entangled with geopolitical tensions and domestic political narratives; then-President Jair Bolsonaro's vocal opposition to China led many Brazilians to reject the Sinovac vaccine, framing it as a foreign political imposition rather than a public health solution (Gramacho & Turgeon, 2021). Taken together, these cases show that vaccine confidence can serve as an indicator of wider systematic mistrust, rather than a mere consequence of misinformation (Cooper et al., 2024).

A final stark example of how institutional dynamics shape confidence is the recent appointment of Robert Kennedy Jr. as U.S. Health Secretary. Known for publicly questioning vaccine safety, Kennedy has advanced policies that challenge scientific consensus, illustrating how vaccine confidence can be actively undermined from within public institutions, reinforcing mistrust and elevating individualist framings over collective health responsibilities (Gardner & Gardner, 2025). These developments carry global consequences, as the U.S. has long served as a standard bearer for public health policy; shift in leadership and messaging can influence institutional norms and weaken multilateral cooperation (Thompson & Badizadegan, 2024; Yang, 2025).

A trust agenda

The year 2024 was one of unprecedented elections, occurring against a backdrop of deepening polarisation and the further politicisation of public health (Enria et al., 2024; Newman, 2024). As communities have sought to make sense of events, we propose looking beyond problematising information abundance, particularly in public health. Despite challenges around identifying, articulating and measuring trust, shifting efforts from managing the infodemic to understanding and rebuilding trust may improve community level public health programmes like vaccination. The efforts we propose include:

A socio-ecological model for trust that contextualises the infodemic

The infodemic frame currently places the responsibility on the individual, missing wider institutional, political and social challenges that fuel mistrust. However, a socio-ecological model for trust (Figure 1), which explores how individuals, communities, institutions and their politics interact, may help public health practitioners understand trust processes and improve community engagement efforts (Petit, 2019). This model moves beyond the individual by examining trust across multiple levels including individual beliefs, community norms, institutional practices (official and unofficial) and the broader political context (Dwyer et al., 2025; Enria et al., 2024). Tools like IFRC's community trust index, and qualitative interviews can help us assess individual trust in public health programmes (IFRC, 2024). At the community level, data like participation in decision making (voter turnout) and vaccination rates can serve as proxy indicators (OECD, 2017; Thompson & Badizadegan, 2024). Furthermore, political and historical analyses can reveal the root causes of mistrust, such as experiences of exclusion, historical oppression and structural violence (Enria et al., 2024). This is a complex and nuanced approach that, when operationalising, may be difficult to measure and evaluate. These dynamics evolve, so practitioners will face ongoing challenges (Mühlfried, 2018; Schiocchet, 2018).

Stronger and more genuine community engagement approaches

Public health institutions can enhance trust by learning from successful approaches that connect communities with decision makers within democratic processes. This can be achieved through initiatives that encourage greater dialogue. Building coalitions with communities, particularly through engagement with community and religious leaders, has demonstrated success in strengthening vaccine uptake, especially in humanitarian contexts (Thompson & Badizadegan, 2024; Underwood et al., 2023). Investing in platforms that support citizen journalism; where ordinary people report the news, fosters accountability from decision

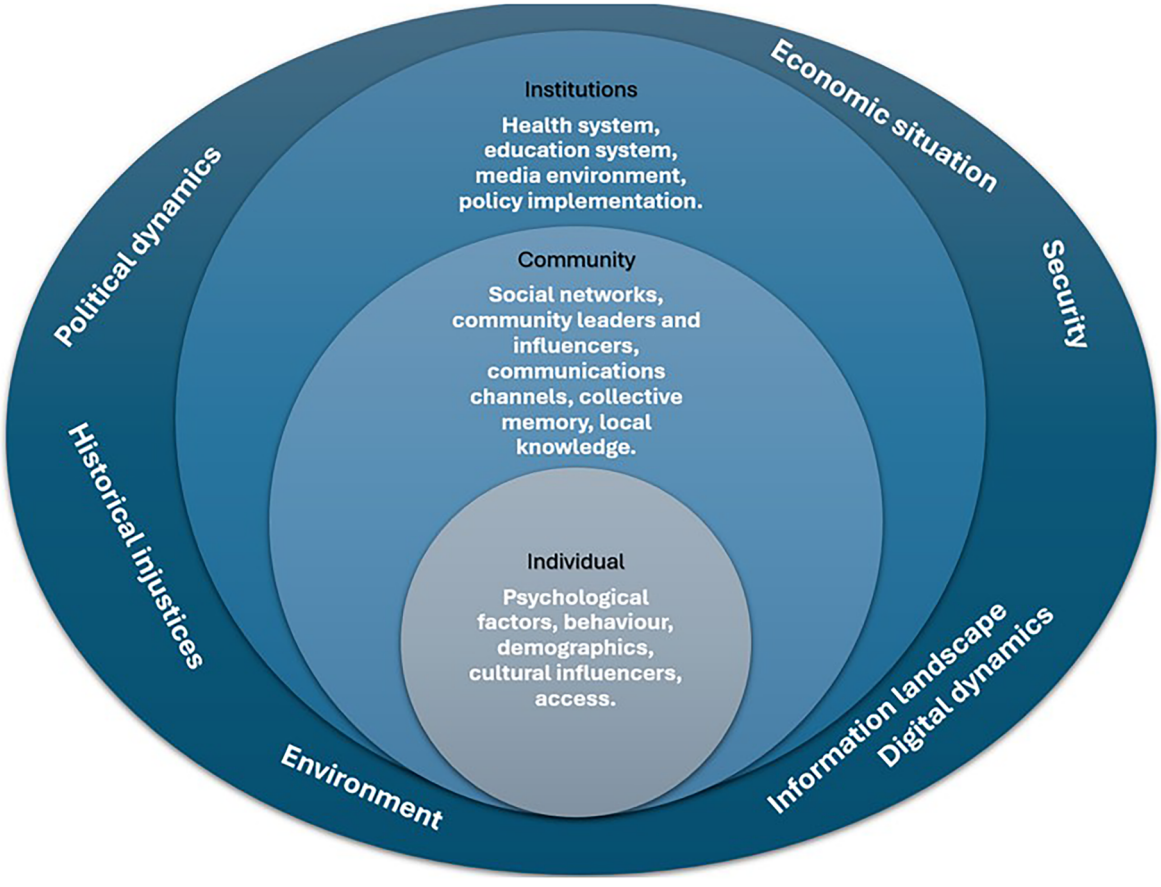

Figure 1. A socio-ecological model for trust.

makers (Enria et al., 2024). Facilitating public deliberation between citizens and decision makers on policies around health data or budget planning, has enhanced transparency, which can strengthen trust in decision making (Enria et al., 2024; London, 2020; Mena et al., 2023; Steinke & Hövelmann, 2021). However, it is important to note, that poorly planned or tokenistic engagement can undermine communities and replicate the flaw in the infodemic framing, ultimately diminishing trust (Reynolds & Sariola, 2018; Steinke & Hövelmann, 2021).

Greater transparency and accountability from government and institutional decision makers

The prism of trust does not necessarily fit within the current institutional system structures used for public health responses. To build trust, therefore, we need to break out of the technical and operational siloes that often grip institutions.

Greater accountability and transparency are needed from all policy makers (Vinck et al., 2019). Those with decision making power must include communities in policy making, publicly acknowledge policy errors and clearly communicate uncertainty. Public engagement efforts should gather citizens, inform them and seek their inputs into policies (Degeling et al., 2017). A focus on empathy and empowerment will have greater impact (Sandman, 2010).

Conclusion

We do not propose that all investigations and actions around the infodemic are futile. Indeed, (mis) information can have serious impacts in the right conditions. Work to document its salience and travel is useful for communications planning. Yet, we need to go beyond the focus on the information itself to a community-centred approach, that situates the impact of different kinds of information on the person receiving it, in their social, political and economic settings. We have outlined several elements for consideration towards building trust. For public health practitioners this includes robust and genuine community engagement approaches that move beyond perfunctory consultations and establish a meaningful dialogue between communities and decision makers. For governments and institutions this includes greater transparency in decision making processes and accountability for the communities they serve.

Author contributions

HD, a PhD candidate, co-conceptualised the paper, wrote the first draft and made critical revisions (writing- original draft, writing review and editing). LE and NB were involved in supervision and writing (review and editing.) JL co-conceptualised the paper and was involved in writing (review and editing). All authors approved the final version to be published.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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