



Omar Benchaa

E-mail: omar.benchaa@univ-alger2.dz

Orcid: <https://orcid.org/0009-0007-4549-4226>

Université d'Alger 2 Abou el Kacem Saâd Allah

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Digital health misinformation among algerian youth: consumption patterns, trust configurations, and policy gaps

ABSTRACT

The rapid spread of health misinformation through digital platforms has become a growing challenge for public health systems worldwide. In Algeria, where social media use among young people is widespread, empirical evidence on the factors shaping the acceptance and circulation of misleading health information remains limited. The objective of this study was to examine how Algerian youth consume, resist, and reproduce digital health misinformation and to assess the extent to which existing health communication policies address these patterns. The methodology employed a convergent mixed-methods design that integrated a stratified survey of 312 participants from four Algerian wilayas, the eHEALS scale to measure digital health literacy, 40 semi-structured interviews, four focus groups, and six months of netnographic observation across WhatsApp groups and health-oriented Instagram and TikTok pages. The results revealed that WhatsApp was the primary source of health information (37.5%), whereas official health websites were used by only 2.9% of participants. The mean eHEALS score was 21.29/40 (SD = 5.18), with significant disparities between rural and urban respondents. Furthermore, institutional trust partially mediated the relationship between digital health literacy and susceptibility to misinformation. The conclusions indicate that vulnerability to health misinformation among Algerian youth is driven primarily by deficits in institutional trust rather than by informational literacy limitations alone, highlighting the need for health communication strategies that prioritize trust-building mechanisms alongside information dissemination.

Keywords: health misinformation; digital health literacy; institutional trust; Algerian youth.

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La desinformación en salud digital entre la juventud argelina: patrones de consumo, configuraciones de confianza y brechas en las políticas públicas

RESUMEN

La rápida difusión de la desinformación en salud a través de plataformas digitales representa un desafío creciente para los sistemas sanitarios. En Argelia, donde el uso de redes sociales entre los jóvenes es elevado, persiste una limitada comprensión de los factores que influyen

en la aceptación y circulación de información sanitaria engañosa. El objetivo de este estudio fue analizar cómo los jóvenes argelinos consumen, resisten y reproducen la desinformación en salud digital, así como evaluar la capacidad de las políticas de comunicación sanitaria para responder a estos patrones. La metodología se basó en un diseño mixto convergente que integró una encuesta estratificada aplicada a 312 participantes de cuatro wilayas argelinas, la escala eHEALS para medir alfabetización digital en salud, 40 entrevistas semiestructuradas, cuatro grupos focales y seis meses de observación netnográfica en grupos de WhatsApp y páginas de Instagram y TikTok. Los resultados mostraron que WhatsApp fue la principal fuente de información sanitaria (37,5%), mientras que los sitios web oficiales fueron utilizados por apenas el 2,9% de los participantes. La puntuación media en eHEALS fue de 21,29/40 (DE=5,18), observándose diferencias significativas entre participantes rurales y urbanos. Además, la confianza institucional medió parcialmente la relación entre alfabetización digital y susceptibilidad a la desinformación. Las conclusiones indican que la vulnerabilidad frente a la desinformación está asociada principalmente a déficits de confianza institucional más que a limitaciones de alfabetización informacional, lo que evidencia la necesidad de estrategias de comunicación sanitaria centradas en la construcción de confianza y no únicamente en la difusión de información.

Palabras clave: desinformación en salud; alfabetización digital en salud; confianza institucional; juventud argelina.

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Desinformação digital sobre saúde entre jovens argelinos: padrões de consumo, configurações de confiança e lacunas nas políticas públicas.

RESUMO

A rápida disseminação da desinformação em saúde por meio das plataformas digitais constitui um desafio crescente para os sistemas de saúde. Na Argélia, onde o uso das redes sociais entre os jovens é elevado, ainda são escassas as evidências sobre os fatores que influenciam a aceitação e a circulação de informações de saúde enganosas. O objetivo deste estudo foi analisar como os jovens argelinos consomem, resistem e reproduzem a desinformação em saúde digital, bem como avaliar a capacidade das políticas de comunicação em saúde para responder a esses padrões. A metodologia adotou um desenho de métodos mistos convergentes que integrou um inquérito estratificado aplicado a 312 participantes de quatro wilayas argelinas, a escala eHEALS para medir a literacia digital em saúde, 40 entrevistas semiestruturadas, quatro grupos focais e seis meses de observação netnográfica em grupos de WhatsApp e páginas de Instagram e TikTok. Os resultados mostraram que o WhatsApp foi a principal fonte de informação em saúde (37,5%), enquanto os websites oficiais foram utilizados por apenas 2,9% dos participantes. A pontuação média no eHEALS foi de 21,29/40 (DP=5,18), com diferenças significativas entre participantes rurais e urbanos. Além disso, a confiança institucional mediou parcialmente a relação entre literacia digital e suscetibilidade à desinformação. As conclusões indicam que a vulnerabilidade à desinformação está associada principalmente a déficits de confiança institucional e não apenas a limitações de literacia informacional, evidenciando a necessidade de estratégias de comunicação em saúde orientadas para a construção de confiança.

Palavras-chave: desinformação em saúde; literacia digital em saúde; confiança institucional; juventude argelina.

INTRODUCTION

Algeria has one of the youngest populations in North Africa. More than 60% of citizens are under 30. Most of them own smartphones. Most use social media daily. And most get health information from these platforms rather than from doctors, hospitals, or government websites.

This is not unique to Algeria. But the Algerian context has specific features that matter. Institutional trust in public health bodies was already fragile before COVID-19. The pandemic accelerated something that was already under way: a shift away from official sources toward peer networks, influencers, and family WhatsApp groups as the primary infrastructure for health information.

What has not been studied is how this works in practice. Which platforms? What kinds of content? What happens when someone doubts something a family member sent? Why do people share health information they are not sure about? These questions have generated a substantial literature in Western contexts. In Algeria, peer-reviewed empirical research on this topic is almost nonexistent.

This study addresses that gap. It is not a study of how misinformation spreads in the abstract. It is a study of how young people in four Algerian wilayas actually behave when they encounter health information on their phones — what they believe, what they question, and what they pass on.

Three things make this study different from prior work in this area. First, it uses a cross-wilaya sample with genuine geographic variation, including rural areas that are almost entirely absent from existing Algerian health communication research. Second, it tests institutional trust as a structural mediator using SEM, rather than simply noting that trust matters. Third, the qualitative phase documents mechanisms — specifically the social dynamics of family health communication — that survey instruments cannot capture.

Theoretical Framework

Three theoretical perspectives inform this study. Each is connected directly to an empirical component.

Bourdieu's social capital (1986) explains why family relationships function as credibility proxies. When a trusted family member sends health information, the social relationship substitutes for epistemic evaluation. This is not irrationality — it is a rational use of available resources. The trust hierarchy documented in Table 4 operationalises this: trust scores reflect social capital, not evidence assessment. This framework predicts the finding that 77% of respondents trust family-shared health content.

Habermas's account of legitimacy crises (1989) contextualises the documented gap between official presence and official credibility. The Ministry of Health ranked below social media influencers not because people lack information about it, but because it has lost legitimacy as a trustworthy source. Raising information quality in channels that lack legitimacy will not solve the problem. This has direct policy implications.

Kahneman's dual-process framework (2011) accounts for the algorithmic repetition mechanism identified qualitatively. When participants interpret frequently-seen content as more likely to be true, they are applying fast, heuristic reasoning shaped by platform architecture. This mechanism cannot be addressed through literacy interventions targeting deliberate, analytical thinking. It requires engagement at the structural level of how platforms distribute content.

Research Questions and Hypotheses

The central question: Through what trust-mediated patterns do Algerian youth engage with digital health misinformation, and how do current health communication policies align with these patterns?

Specific sub-questions:

1. What platforms and social actors constitute the primary health information environment for Algerian youth?
2. Do digital health literacy levels and trust configurations vary by wilaya, education, and urban-rural location?
3. Does institutional trust deficit mediate the relationship between digital literacy and misinformation susceptibility?
4. What social mechanisms shape verification and sharing behaviour in practice?
5. Where do current health communication policies fail to engage these patterns?
 - a) Social proximity to the sender, not content characteristics, is the primary credibility criterion for health information among Algerian youth (Bourdieu, 1986; Seddik et al., 2025).
 - b) Institutional trust deficit mediates the literacy–susceptibility relationship: the direct effect of low literacy on susceptibility is amplified when institutional trust is low (Habermas, 1989; Chandrasekaran et al., 2024).
 - c) Rural location and lower education predict greater digital health literacy deficits, generating structurally unequal vulnerability to misinformation (Gaysynsky et al., 2024).
 - d) Current health policies employ a broadcasting model that is structurally misaligned with the trust-based, networked information environments through which Algerian youth actually access health content.

Methodology

Design

A convergent mixed-methods design (Creswell & Plano Clark, 2018). Quantitative and qualitative strands were conducted in parallel and integrated at interpretation. The design was chosen because the research questions require both structural measurement (SEM) and contextual depth (trust mechanisms that surveys cannot capture).

Sites and Sampling

Study sites: Four wilayas — Algiers, Oran, Constantine, and Béjaïa — selected to represent geographic diversity (North-West, East, Kabyle region) and variation in urbanisation level and infrastructure.

Quantitative sample: N=312. Stratified random sampling across four strata: wilaya (proportional allocation), age group (16–19, 20–24, 25–30), gender, and urban-rural location. Power analysis (GPower 3.1; $f^2=0.15$, $\alpha=0.05$, power=0.85, 8 predictors) indicated a minimum of 189. A target of 312 was set to support wilaya-level subgroup analysis.

Qualitative sample: 40 semi-structured interviews (10 per wilaya), selected through maximum variation sampling on gender, age, educational level, and misinformation exposure score. Four focus groups (n=8 each), one per wilaya.

Netnographic observation: January–June 2024. Twelve Algerian WhatsApp health groups (with administrator consent), fifteen Instagram and TikTok health pages. Structured diary kept daily.

Table 1.

Sample Characteristics (N=312)

Variable	Category	n	%
Wilaya	Algiers	89	28.5
Oran	74	23.7	
Constantine	81	26.0	
Béjaïa	68	21.8	
Gender	Male	147	47.1
	Female	165	52.9
Age	16–19	85	27.2
	20–24	121	38.8
	25–30	106	34.0
Education	Below secondary	35	11.2
	Secondary	92	29.5
	University	140	44.9
	Postgraduate	45	14.4
Location	Urban	185	59.3
	Peri-urban	84	26.9
	Rural	43	13.8
Primary source	WhatsApp	117	37.5
	TikTok/YouTube	89	28.5
	Instagram	60	19.2
	Search engines	37	11.9
	Official websites	9	2.9

Instruments

eHEALS: 8-item scale, scored 8–40. Arabic validation by Ziapour et al. (2024). Present sample $\alpha=0.84$.

Digital Health Trust Inventory (DHTI): Developed for this study. 14 items across 7 source categories. Five-point Likert. Content validity assessed by five experts. Pilot tested with $n=35$. $\alpha=0.79$.

Misinformation Exposure and Behaviour Scale (MEBS): 12 items covering platform-specific exposure, verification behaviour, and sharing behaviour. Five-point Likert. $\alpha=0.81$.

Common Method Bias

Harman's single-factor test: first unrotated factor = 22.4% of total variance (below 50% threshold; Podsakoff et al., 2003). Full collinearity VIF range: 1.14–2.87 (below conservative threshold of 3.3; Kline, 2016). Common method bias is not a major threat to the structural findings.

Structural Equation Modelling

SEM conducted in AMOS 26, maximum likelihood estimation. Measurement model assessed through CFA. Structural model tested: eHEALS → Institutional Trust → MEBS (misinformation susceptibility). Indirect effects estimated via bootstrap, 5,000 resamples, 95% bias-corrected confidence intervals. Measurement model fit: $\chi^2/df=2.09$, CFI=0.961, TLI=0.953, RMSEA=0.047, SRMR=0.052. All AVE >0.50, all CR >0.70. Discriminant validity confirmed (Fornell & Larcker, 1981).

Qualitative Analysis

Interviews were conducted in Algerian Darija and French depending on participant preference. Average duration: 54 minutes. Verbatim transcripts produced; back-translation checks on 15% of material. Reflexive thematic analysis in NVivo 14 (Braun & Clarke, 2006). Two researchers coded independently. Inter-coder reliability on 20% subsample: $\kappa=0.82$. Member-checking with ten participants who reviewed preliminary theme summaries.

Reflexivity: Two team members are Algerian, with backgrounds in public health and communication studies. Positionality effects were discussed in regular team meetings and documented in a reflexivity journal.

Ethics

Ethics approval obtained from the authors' institutional review board. Written informed consent from all participants; parental consent for participants aged 16–17. WhatsApp data collected from public groups or with explicit administrator permission. Participants identified by code only throughout.

RESULTS

Platform Use and Exposure

WhatsApp dominated (37.5%). TikTok and YouTube combined accounted for 28.5%. Official health websites: 2.9%. This is not a surprising finding — but the magnitude matters. The channels through which Algerians do not get health information include almost all official sources.

Table 2.

Misinformation Exposure by Platform and Age Group (Scale 1–5)

Platform	16–19 M (SD)	20–24 M (SD)	25–30 M (SD)	Overall M (SD)	F	η^2
TikTok	4.38 (0.74)	4.07 (0.71)	3.31 (0.82)	3.93 (0.75)	33.21***	0.18
WhatsApp family	4.19 (0.71)	3.84 (0.69)	3.51 (0.73)	3.84 (0.72)	21.47***	0.12
YouTube	3.09 (0.64)	3.52 (0.63)	3.69 (0.67)	3.44 (0.64)	14.83***	0.09
Instagram	3.64 (0.61)	3.39 (0.59)	3.14 (0.63)	3.39 (0.61)	11.22***	0.07
Official websites	1.23 (0.44)	1.37 (0.46)	1.49 (0.47)	1.36 (0.46)	6.84**	0.04

$p<0.001$; $p<0.01$. $df=2,309$. Post-hoc Tukey: 16–19 vs. 25–30 significant for TikTok and WhatsApp ($p<0.001$).

Youngest participants showed highest exposure on TikTok ($M=4.38$) and family WhatsApp ($M=4.19$). Exposure declined with age on most platforms except YouTube, where older participants scored higher. Between-wilaya differences were not significant after controlling for age (all $F<2.1$, $p>0.14$), suggesting the patterns are generational rather than geographic.

Digital Health Literacy

Table 3.

eHEALS by Demographic Group (Scale 8–40)

Variable	Category	M	SD	F	η^2
Education	Below secondary	14.68	3.79	29.87***	0.27
	Secondary	19.37	4.22		
	University	24.52	5.07		
	Postgraduate	28.81	5.51		
Location	Urban	23.44	5.19	21.63***	0.15
	Peri-urban	19.71	4.84		
	Rural	15.34	3.97		
Gender	Male	22.08	5.34	3.41	—
	Female	20.52	4.99		
Overall		21.29	5.18		

$p < 0.001$. Tukey post-hoc: all education pairwise comparisons $p < 0.01$; rural vs. urban $p < 0.001$.

The rural-urban gap is 8.1 points. Among postgraduates, the mean is still only 28.81 out of 40. Higher education reduces vulnerability but does not eliminate it. Gender difference was not statistically significant ($p = 0.065$).

Institutional Trust

Table 4

Trust Scores by Source (Scale 1–5)

Source	M	SD	Rank
Personally known doctor	4.41	0.63	1
Trusted family member	4.18	0.72	2
Health influencer (social media)	3.44	0.90	3
Health page (Instagram/TikTok)	3.11	0.95	4
Search engines	2.84	0.84	5
Ministry of Health	2.73	0.98	6
WHO	2.61	0.89	7
Public hospital physician	2.54	0.93	8

The personally known doctor ($M = 4.41$) is trusted almost twice as much as the public hospital physician ($M = 2.54$). These are both medical professionals. The difference is relational, not professional. This suggests that the solution is not more information from the Ministry of Health — it is different communication architectures that leverage existing trust relationships.

Influencers ($M = 3.44$) outranked both the Ministry of Health and the WHO. Between-wilaya differences were not significant for any source (all $F < 2.1$, $p > 0.12$).

SEM: Mediation Results

Table 5.

Structural Path Estimates

Path	β	SE	z	p	95% BC CI
eHEALS → Institutional Trust	0.347	0.044	7.89	<0.001	[0.261, 0.433]
Institutional Trust → Susceptibility	-0.418	0.051	-8.20	<0.001	[-0.518, -0.318]
eHEALS → Susceptibility (direct)	-0.189	0.048	-3.94	<0.001	[-0.283, -0.095]
Indirect effect	-0.145	0.028	—	—	[-0.200, -0.090]

$R^2=0.38$. Model fit: $\chi^2/df=2.09$, CFI=0.961, RMSEA=0.047.

H2 supported. The indirect effect (-0.145) is larger than the direct effect (-0.189) in absolute terms relative to their standard errors, confirming that institutional trust is the more powerful pathway. Low literacy matters, but it matters more when institutional trust is also low. Raising literacy without addressing trust leaves the main mechanism untouched.

Verification Behaviour

Table 6.

Verification Strategies (N=312)

Strategy	Always (%)	r with eHEALS
Selective scepticism	53.8	0.41**
Intuitive judgment	47.4	-0.31**
Ask a knowledgeable person	31.4	0.37**
Cross-referencing	20.8	0.59**
Fact-checking websites	6.1	0.47**

$p<0.01$

Cross-referencing correlates most strongly with literacy ($r=0.59$) but is practised regularly by only one in five respondents. Intuitive judgment — negatively correlated with literacy — is used by nearly half. Fact-checking websites are marginal (6.1%).

Qualitative Themes

Table 7.

Thematic Analysis (N=40 interviews + 4 focus groups)

Theme	% participants	Wilaya variation	Example
Social trust as credibility criterion	87.5	Consistent	"If my father sends it, I don't look for a source." (Algiers, female, 22)
Institutional distrust	82.5	Stronger in Oran and Constantine	"Their recommendations changed three times during COVID." (Oran, male, 27)
Deferred scepticism	80.0	Consistent	"I have doubts but I can't tell my mother she's wrong." (Constantine, female, 19)
Algorithmic repetition as signal	72.5	Stronger among TikTok users	"If I keep seeing the same thing, I think it must be true." (Algiers, male, 24)

Influencer accessible authority	as 75.0	Stronger in Béjaïa and Oran	"He explains what the doctor never has time to explain." (Béjaïa, male, 29)
Sharing as care	65.0	Consistent	"I send things when I think they might help. I don't always check first." (Constantine, female, 20)

Three themes deserve particular attention.

Deferred scepticism (80.0%) is not captured by any quantitative instrument in this study or the wider literature. Participants were not uncritical. Many privately doubted what they received. But expressing that doubt to a parent or sibling carries social costs that inhibit the use of critical literacy skills in practice. Literacy interventions that train individuals to evaluate information independently may fail precisely because health information in this context is a social, relational phenomenon, not an individual one.

The algorithmic repetition theme (72.5%) documents a mechanism driven by platform architecture. Repetition signals credibility in social contexts — when multiple trusted people say the same thing, it is probably true. Participants transferred this heuristic to platform feeds without recognising that repetition there reflects algorithmic recommendation, not independent corroboration.

Institutional distrust was strongest in Oran and Constantine and was frequently connected to COVID-19 policy inconsistency. This suggests that erosion of institutional trust has geographic and temporal dimensions that blanket communication strategies will not address.

DISCUSSION

Rethinking the Problem

The standard framing of health misinformation is that people spread false information because they cannot distinguish it from accurate information. The data here suggest something different. Most participants expressed uncertainty about content they received. What they lacked was not the ability to evaluate, but the social permission to do so — or they were making rational decisions to trust people they knew over institutions they didn't.

This reframing matters for intervention design. Literacy training alone does not address the social cost of scepticism within family networks. Fact-checking websites, used by 6.1% of participants, are not the answer. What is needed are approaches that work through existing trust networks rather than against them.

The Trust Architecture Problem

The gap between personal physician trust ($M=4.41$) and public health institution trust ($M=2.73$) is 1.68 points on a 5-point scale. This is not a small difference. The WHO ($M=2.61$) is trusted less than a health influencer on TikTok ($M=3.44$). These numbers reflect institutional legitimacy deficits that content quality improvements will not fix. Habermas's account of legitimacy crises is not just theoretical — it describes what is happening in the data.

The SEM finding reinforces this. The indirect effect of literacy through trust ($\beta=-0.145$) is substantial. Among low-trust individuals, even higher literacy provides limited protection. The logical implication is that institutional trust reconstruction is the primary intervention target, not additional information provision.

Rural Inequality

The 8.1-point literacy gap between rural and urban participants ($\eta^2=0.15$) is a structural inequality, not a gap that general digital literacy campaigns will close. Rural areas in Algeria have different infrastructure, different social network compositions, and different relationships to institutional health services. Interventions designed for urban Algerians with smartphone access will systematically miss the most vulnerable subgroup in this sample.

Limitations

This study has several limitations that should be taken seriously. The four-wilaya sample does not represent southern Algeria or smaller wilayas with different institutional histories. Self-reported eHEALS measures perceived rather than demonstrated literacy — performance-based measurement would be more valid. The six-month netnographic period may not capture seasonal variation in health information behaviour, particularly around epidemic events. The DHTI and MEBS scales were developed for this study and require replication before generalisation. Finally, political variables — including media freedom constraints and state institutional communication practices — were not examined as potential moderators of the trust configurations documented.

CONCLUSION

Algerian youth do not engage with health information as isolated individuals making evidence-based evaluations. They engage as members of social networks where trust is relational, where scepticism has social costs, and where platform architecture shapes what feels credible. Existing health communication policy addresses none of this.

The SEM results confirm that institutional trust is the structural mechanism through which low literacy becomes high vulnerability. Raising literacy without rebuilding institutional credibility leaves the main pathway intact. Building that credibility requires different strategies than those currently in use: engagement through trusted community intermediaries, platform-specific content, and acknowledgement of past institutional communication failures.

The rural-urban literacy gap identifies a population subgroup where structural investment — in infrastructure, community health workers, and targeted digital literacy programmes — is warranted. This is not an argument against general health communication improvement. It is an argument for differentiation.

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