From AI detection to community resilience: rethinking the response to health misinformation in low-resource settings

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To the Editor:

We read with interest the Letter by Omar and colleagues describing AI-generated health misinformation in Somalia as a neglected crisis and calling for stronger digital health literacy, surveillance, and AI governance.[1] Detection remains useful for surveillance and moderation, but it cannot by itself establish whether misleading content is believed and acted upon. The central task for public health is to prevent false claims from driving health decisions; this depends on community resilience.

Throughout, misinformation denotes inaccurate health content regardless of intent and disinformation its deliberate manipulation. Generative AI has lowered the cost of producing convincing health misinformation, and current detection tools remain unevenly evaluated.[2] Whether a claim is machine-generated matters less than whether it is believed and acted upon: persuasion often rests on perceived expertise, familiar wording, and repetition rather than provenance. Nor is digital health literacy a sufficient safeguard: eHealth literacy was not significantly associated with health misperceptions or misinformation sharing, whereas situational motivation predicted both.[3]

In an audit of five widely used chatbots, each given ten adversarial designed questions in each of five misinformation-prone categories and rated against predefined criteria, 49.6% of responses were problematic, with poor referencing and fabricated citations.[4] Because of this targeted design, the finding should not be read as typical of routine use. Experiences documented in Pakistan, where media amplified COVID-19 and vaccine-related rumours,[5] and in Somalia,[1] illustrate context-specific challenges rather than a uniform pattern across low- and middle-income countries (LMICs), which differ in language, digital access, infrastructure, health-system capacity, and regulation.

We therefore propose an LMIC-focused operational synthesis rather than new components, extending the actions Omar and colleagues outline.[1] Four layers merit operational attention: early-warning surveillance, with AI supporting monitoring while consequential responses receive human review; rapid-response communication delivering verified information in locally relevant languages, recognizing that correction effectiveness varies with context; trusted intermediaries, including community health

workers and religious and community leaders, who help communities interpret evidence; and accountable governance that protects privacy and keeps responses proportionate to demonstrated harm. Implementation should be locally adapted and assessed through outcomes such as beliefs, care-seeking, trust, and acceptability rather than detection accuracy alone.[2]

Detection and community resilience are complementary: in low-resource settings, combining appropriately evaluated detection tools with locally adapted communication and trusted intermediaries may ad-dress both the circulation of misleading content and the social conditions that shape its influence.

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