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Algorithmic Clinical Credibility: Credential Opacity, Professional Visibility and Misinformation Risk on Short Form Video Platforms in East Africa

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ABSTRACT

Short form video has become a primary channel through which young East African populations encounter health information, yet platform architecture supplies no reliable signal of clinical credentialing. This narrative and critical review examines the resulting verification gap, in which licensed practitioners, unlicensed practitioners and commercially motivated wellness sellers occupy visually indistinguishable positions within the same feed. Evidence was drawn from peer reviewed literature on health misinformation and online credibility assessment, regulatory instruments and public notices issued by Kenyan statutory bodies, platform governance documentation and audience survey data reported by established research organisations. The review situates the phenomenon within regional patterns of digital health information seeking, describes the amplification logic of algorithmically curated feeds, and develops a typology distinguishing five categories of health content producer according to credential status, commercial orientation and regulatory reach. It then introduces the Algorithmic Clinical Credibility Model, an original framework proposing that perceived clinical authority online is assembled from four partially substitutable inputs, namely visual professional signalling, engagement volume, narrative relatability and formal credentialing, of which the first three are platform supplied and inexpensive to imitate while the fourth is platform absent and costly to verify. Regulatory instruments in Kenya already prohibit the conduct at issue, including the unauthorised use of the title doctor and influencer endorsement of health products, yet enforcement operates through mechanisms poorly matched to the speed and volume of algorithmic distribution. The review proposes a register linked audit protocol enabling systematic verification of high reach health accounts against national professional registers, and sets out corresponding regulatory, professional and platform level responses. No primary data were generated, and all statements concerning relationships between platform exposure and health outcomes are associative rather than causal.

Keywords:
health misinformation; social media; credibility; professional regulation; digital health; East Africa

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INTRODUCTION

Short form video has moved from entertainment to infrastructure across much of East Africa. Data published in advertising planning tools indicate that TikTok reached 18.4 million adults in Kenya in late 2025, equivalent to 56.1 per cent of the adult population and 78.5 per cent of the national internet user base, having grown by 4.72 million users in a single year (DataReportal, 2025). Regulatory data from Uganda place TikTok subscriptions at 10.8 million as of March 2026, ahead of every other tracked platform including messaging services that had previously dominated (Uganda Communications Commission, 2026). Platforms of this reach do not merely carry health information; they now constitute a principal environment in which health beliefs are formed.

This environment presents a structural problem that has attracted less analytical attention than the content it produces. Audience survey evidence indicates that 55 per cent of surveyed Kenyans identified the platform as a major source of misinformation, the highest proportion recorded for any platform in that market (Newman et al., 2025). Yet the more fundamental difficulty is not the presence of false claims, which is common to all information environments, but the absence of any mechanism through which a viewer can distinguish a licensed clinician from an unlicensed one. A registered physician, a nursing student, a herbal products vendor and an entirely fabricated persona can occupy visually identical positions within a single scrolling session.

Existing scholarship approaches several adjacent questions without addressing this one directly. Content analyses have quantified the prevalence of inaccurate health claims across clinical domains (Hudon et al., 2025; Loveland et al., 2024; Suarez-Lledo & Alvarez-Galvez, 2021). Credibility research has established that users evaluate online sources through cognitive heuristics rather than systematic verification (Metzger et al., 2010; Metzger & Flanagin, 2013). Regional communication research has documented motivations for sharing unverified information across sub–Saharan Africa (Madrid-Morales et al., 2021). None of this literature supplies a framework explaining how audiences construct clinical authority specifically, under conditions where the credentialing signal is architecturally unavailable.

This review pursues three objectives across the sections that follow. It characterises the verification gap as a structural property of platform design rather than a failure of individual discernment. It maps the regulatory instruments already applicable in Kenya and identifies why their enforcement mechanisms are poorly matched to algorithmic distribution. It then introduces the Algorithmic Clinical Credibility Model as an analytical framework, and proposes a register linked audit protocol through which the scale of the gap could be measured empirically.

DIGITAL HEALTH INFORMATION IN EAST AFRICA

Health information seeking in the region has shifted decisively towards digital channels, though the pattern is uneven and shaped by existing inequalities. A participatory study across Ghana, Kenya and Vietnam involving 174 young adults found that participants predominantly used search engines, social media and messaging groups for health information, and placed substantial reliance on trusted peer networks and on figures the authors describe as social media health champions (Davis et al., 2023). The same study documented barriers structured by gender, class, education and geography, alongside harms that participants themselves identified, including anxiety and concerns about surveillance.

The turn to digital sources is not solely a matter of preference. Health system access constraints, including cost, distance and waiting times, make an immediately available and free source of guidance attractive in ways that formal services frequently are not. Digital channels also afford privacy for topics carrying stigma, a factor documented in relation to sexual and reproductive health across the region. This combination means that platform sourced guidance is often sought precisely for conditions where the consequences of poor advice are most serious.

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The scale of the workforce constraint gives this substitution considerable force. Health worker density across much of the region remains below the levels associated with adequate service coverage, and the consultation time available to each patient is correspondingly compressed. A platform video imposes no waiting time, no transport cost and no consultation fee, and it may be replayed until it is understood. Measured against these attributes, the informational advantages of a clinical encounter are not always decisive from the standpoint of the person making the choice.

Language shapes the comparison in a further and underappreciated way. Much authoritative health information circulates in English or in technical registers that presuppose extended formal education, whereas platform content is frequently produced in Kiswahili and in other widely spoken vernaculars. Content produced in the language a person thinks in carries advantages of comprehension and of perceived proximity that formal materials rarely match. This is a genuine strength of the medium and explains part of why platform content is actively preferred rather than merely tolerated. It also implies that interventions conducted only in English will systematically fail to reach the audiences most exposed.

Systematic review evidence confirms that social media use for health purposes has expanded across a wide range of populations and health domains over the past decade (Chen & Wang, 2021). The regional literature adds an important qualification to that general picture. Scholarship on information disorder in African contexts has cautioned against importing analytical frames developed elsewhere without adaptation, noting that the political economy of information, the structure of media trust and the history of state communication all differ in ways that shape how audiences receive health claims (Wasserman, 2020).

Regional research on misinformation provides important context for how such information circulates. A comparative focus group study across six sub–Saharan African countries identified civic duty and entertainment as the two dominant motivations for sharing information that participants themselves suspected might be false (Madrid-Morales et al., 2021). Related work examined audience perceptions of who bears responsibility for stopping the spread of misinformation across the same countries, finding that expectations are distributed across governments, platforms and individuals without settled consensus (Tully et al., 2022). Earlier comparative work established that media trust and perceived exposure to false information vary substantially across Kenya, Nigeria and South Africa (Wasserman & Madrid-Morales, 2019).

A structured review of the health infodemic on social media in Africa identified six recurring factors shaping information environments during health emergencies, including the socio-economic context of audiences, the circulation of conspiracy narratives, the identity of information sources, government responses and the availability of verification mechanisms (Hove & Cilliers, 2023). The final factor is directly pertinent to the present analysis, since verification mechanisms in this context refer principally to fact checking of claims rather than to authentication of the people making them. Institutional responses across the region have tended to follow the same analytical emphasis. The Africa Infodemic Response Alliance, convened by the World Health Organization Regional Office for Africa with partner organisations, operates through identification of information gaps, simplification of technical knowledge, amplification of accurate information and quantification of intervention impact (WHO, 2026).

The concept of the infodemic entered mainstream public health discourse during the coronavirus pandemic, framing the problem as an overabundance of information within which accurate guidance becomes difficult to locate (Zarocostas, 2020). That framing has been productive, but it directs attention towards claims and away from claimants. A viewer who cannot evaluate a claim on its technical merits, which describes most viewers for most clinical claims, must instead evaluate the person advancing it.

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Where the information environment supplies no reliable means of doing so, the infodemic framing describes the symptom rather than the mechanism.

METHODS AND EVIDENCE BASE

This paper is a narrative and critical review incorporating documentary analysis of regulatory instruments. Systematic review methodology was not employed, and no claim is made that the literature search was exhaustive. The design was selected because the analytical contribution lies in conceptual synthesis and framework development rather than in the aggregation of effect estimates, and because the specific phenomenon under examination has not yet generated a body of empirical literature amenable to synthesis.

Four distinct streams of evidence were assembled for the purposes of this review. The first comprised peer reviewed scholarship on health misinformation, online credibility assessment, digital health information seeking and professional conduct on social media, identified through targeted searching of major journal platforms and citation tracing from key articles. The second comprised regulatory and professional instruments, including Kenyan statutory provisions governing medical and pharmaceutical practice, advertising guidelines issued by the medicines regulator and public notices issued by professional councils and societies. The third comprised platform governance documentation and audience measurement data published by established research organisations. The fourth comprised reporting from recognised news organisations, used to document specific enforcement episodes.

A deliberately conservative evidentiary rule was applied throughout the analysis presented here. Specific enforcement episodes are reported only where documented in a primary regulatory communication or corroborated by established reporting, and named individuals are not discussed. Audience measurement figures derived from platform advertising tools are reported as such, since these instruments estimate potential reach rather than verified unique users and may overstate population penetration. Survey based figures are attributed to the sampling frame from which they derive, and the limitations of online panels recruited from more educated and more urban populations are noted where relevant.

No primary data of any kind were generated for the purposes of this review. The audit protocol presented later in this paper is a proposed research design and not a completed study, and no findings from any such audit are reported or implied. Because the evidence base is documentary and descriptive, associative rather than causal language is used throughout, and no claim is advanced that exposure to any category of content produces any health outcome.

PLATFORM ARCHITECTURE AND CONTENT AMPLIFICATION

Short form video platforms differ from earlier social media architectures in ways that bear directly on health information. Distribution is governed primarily by algorithmic recommendation rather than by social graph, so that a video reaches audiences who have no relationship with its creator and no prior basis for assessing them. Reach is therefore decoupled from reputation in a manner that did not obtain when circulation depended on existing social ties.

The optimisation target of the recommendation system compounds this effect considerably. Recommendation systems are tuned towards sustained attention, measured through completion, replay and interaction, and these signals correlate imperfectly with accuracy. Content that is confident, surprising, emotionally resonant and simply expressed performs well against such measures, whereas content that is appropriately hedged, conditional and attentive to individual variation performs poorly. Clinical communication is characteristically hedged, conditional and attentive to individual variation, which places accurate health content at a structural disadvantage within the distribution mechanism.

Platform policy has responded to these dynamics, though principally at the level of claims rather

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than claimants. Documentation reviewed in a systematic review of the platform and digital health literacy indicates that content containing misinformation capable of causing moderate harm may be rendered ineligible for the principal recommendation feed, that warning labels may be applied to content assessed by fact checking partners and found unverifiable, and that users may be prompted to reconsider sharing such content (Merga, 2025). These measures address the accuracy of statements rather than the standing of speakers. They do not address the identity or qualification of the person making them.

Kenya illustrates the resulting concentration of attention with unusual clarity. Survey data place the proportion of Kenyan respondents using the platform for news at 38 per cent, the highest figure recorded across the markets surveyed in the Global South, while 55 per cent of the same respondents identified it as a major source of misinformation (Newman et al., 2025). The sampling frame requires explicit statement, since the Kenyan component of that survey was fielded principally in English, restricted to respondents aged eighteen to fifty, and is representative of younger English speaking online news consumers rather than of the national population (Newman et al., 2025). These two findings are not in tension with one another. A population may recognise that a channel carries unreliable material and continue to rely upon it, particularly where the available alternatives are less accessible, and this combination of dependence and distrust is precisely the condition under which peripheral credibility cues carry greatest weight.

The commercial layer of platform operation introduces a further consideration. Analysis of the social media industry as a commercial determinant of health argues that platform business models generate systematic incentives that shape health information environments independently of any individual actor intent (Zenone et al., 2022). Creators monetising health content face incentives aligned with engagement rather than accuracy, and product affiliation offers a revenue stream that rewards confident endorsement. These incentives operate on licensed and unlicensed creators alike, which is a point of some importance for the analysis developed below.

It should be acknowledged that these architectures also deliver substantial public health benefit. Analysis of influencer led health communication in Africa documents successful campaigns addressing vaccination and mental health awareness, and notes that influencers can reach young audiences that conventional campaigns struggle to engage (Simba & Girma, 2025). The same analysis reports survey findings from Kenya and Nigeria indicating that the overwhelming majority of 1,466 respondents actively follow social media influencers, which establishes both the opportunity and the exposure. The argument advanced here is not that the channel is inherently harmful but that it currently lacks a functioning credentialing signal.

A TYPOLOGY OF HEALTH CONTENT PRODUCERS

Analysis of the verification gap requires a clearer specification of who occupies the health content space. The typology proposed here distinguishes five categories according to three attributes: whether the producer holds a verifiable registration with a statutory professional council, whether the content carries a commercial orientation, and whether the producer falls within the enforcement reach of a health professional regulator.

Two features of this typology warrant particular emphasis in the present context. The first is that credential status and content accuracy are correlated but not equivalent. Content analyses across clinical domains have found that material produced by qualified professionals is generally more accurate than material produced by other creators, yet professional status does not guarantee accuracy and its absence does not guarantee error (Suarez-Lledo & Alvarez-Galvez, 2021). Registration functions as a probabilistic indicator and as an accountability mechanism rather than as a warranty of correctness.

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Table 1: Typology of health content producers on short form video platforms

Category	Credential status	Commercial orientation	Regulatory reach
Registered practitioner communicator	Verifiable registration with a statutory council	Usually absent or modest	Full, through professional conduct provisions
Registered practitioner promoter	Verifiable registration with a statutory council	Central, through product affiliation	Full, though enforcement is infrequent
Trainee or allied claimant	Partial, in training or registered in an adjacent cadre	Variable	Partial and cadre dependent
Wellness and lifestyle seller	Absent	Central, through product sales or affiliation	Limited, principally via advertising and medicines law
Fabricated clinical persona	Absent and misrepresented	Variable, often fraudulent	Nominal, since identity is concealed

Note. Categories are analytical constructs developed by the author from the regulatory and scholarly sources reviewed in this paper. They are not mutually exclusive in practice, and individual accounts may migrate between categories over time.

The second feature is that commercial orientation cuts across credential status. The literature on medical influencers identifies conflicts of interest as a principal ethical concern arising from the monetisation of clinical authority, noting that undisclosed financial relationships deny audiences information they require to weigh a recommendation appropriately (Ng et al., 2024). A registered practitioner promoting a product for compensation may present a greater risk to an individual viewer than an unregistered creator offering general advice without commercial motive, because the credential lends the endorsement authority that the underlying evidence may not support.

The fabricated clinical persona represents the category of greatest concern and the least tractability. Kenyan regulatory authorities have publicly reported an increase in individuals presenting themselves as qualified doctors and dentists on digital platforms, describing such conduct as both unlawful and dangerous to public health (KMPDC, 2026a). Where identity itself is fabricated, professional conduct provisions have no purchase, since the accountability mechanisms they establish presuppose a registrant to whom sanction can attach.

A further observation concerns movement between these categories over time. Accounts frequently begin as personal or lifestyle content and acquire a health orientation as engagement grows, since health topics reliably attract sustained attention. Commercial affiliation typically arrives after an audience has been established rather than before, which means that the account a viewer began following in one category may occupy a different category by the time a product recommendation appears. Drift of this kind is invisible to a viewer encountering a single video within a recommendation feed, and it is not captured by any cross-sectional assessment of the content ecosystem.

THE CREDENTIAL VERIFICATION GAP

The central analytical claim of this paper concerns an asymmetry in the cost and availability of credibility signals. Platforms supply, at no cost to the creator, a range of cues that audiences read as indicators of clinical authority. Platforms do not supply, at any cost, an authenticated indicator of professional registration. The signals that are cheap to produce are consequently the signals that audiences receive, and the signal that would be most diagnostic is the one the environment omits.

It is worth considering carefully what a viewer of such content observes. A creator may appear in clinical attire within what appears to be a clinical setting, may use a professional title within a display name or biography, may speak with fluency and confidence about a clinical topic, and may present follower counts and engagement figures that suggest widespread acceptance. Every one of these cues can be produced by a person holding no qualification whatsoever, and none of them can be produced by the platform in a form

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that carries authentication. Verification badges, where they exist, attest to identity or notability rather than to professional qualification, and are therefore not diagnostic of the attribute that matters.

The MAIN model supplies the most direct theoretical antecedent for the argument advanced here. It proposes that technological affordances, categorised as modality, agency, interactivity and navigability, function as cues that activate cognitive heuristics and thereby shape credibility judgements independently of message content (Sundar, 2008). The model was developed to explain how interface design influences credibility across digital environments generally, and its central insight transfers directly to the present case, since what an interface makes visible determines what audiences are able to use in judging. The extension proposed in this paper concerns what follows when an interface makes visible every attribute except the one that is actually diagnostic.

This point deserves emphasis because platform verification is frequently misread as addressing the problem. A verification badge attests that an account belongs to the person or entity it claims to represent, and in some implementations that the account has met thresholds of notability or activity. It makes no representation whatever about professional qualification, and a badged account presenting clinical advice carries no more assurance of competence than an unbadged one. The badge nonetheless functions as a credibility cue in its own right, so its presence on an account making clinical claims may increase perceived clinical authority without any corresponding increase in warrant.

Credibility research explains why an asymmetry of this kind produces substantial effects. Work on cognitive heuristics in online credibility assessment establishes that users faced with information abundance rely on rapid peripheral cues rather than systematic evaluation, and that these heuristics include reputation, endorsement, consistency and expectancy violation (Metzger et al., 2010; Metzger & Flanagin, 2013). The affordances of a platform accordingly function as credibility cues in themselves, independently of the content they carry. Where the available affordances signal popularity and presentation but not qualification, the heuristics available to the viewer will track popularity and presentation.

Verification friction compounds the problem in ways that accessible registers alone cannot resolve. Kenyan authorities have made professional registers publicly accessible, including through a short message service enabling members of the public to confirm whether a practitioner is registered and licensed, and through publication of a master registry of licensed practitioners and facilities (KMPDC, 2026b; Njaaga, 2025). These are meaningful measures deserving recognition as genuine improvements in public access. Their limitation is behavioural rather than technical: verification requires the viewer to suspend consumption, exit the platform, know that the register exists, know the practitioner name as registered, and complete a query. Each step imposes friction, and the aggregate friction is large relative to the few seconds a video occupies.

The asymmetry at the centre of this analysis can therefore be stated compactly. Producing the appearance of clinical authority costs a creator almost nothing. Verifying clinical authority costs a viewer real effort, and the cost is incurred separately for every account encountered. Under these conditions a rational viewer will not verify, and the credentialing signal will play little part in credibility formation regardless of how accessible the register is made.

DOCUMENTED AND PLAUSIBLE HARM PATHWAYS

Harm arising from this environment operates through several distinguishable pathways, and the evidence base supporting each varies considerably in strength.

Inaccurate Clinical Content

The most direct pathway is exposure to inaccurate information. A systematic review of the prevalence of health misinformation on social

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media documented substantial proportions of inaccurate content across multiple clinical domains and platforms (Suarez-Lledo & Alvarez-Galvez, 2021). Subsequent domain specific analyses have reported comparable patterns, including in relation to liver disease, where a comparative analysis distinguished accurate from misleading content on the platform (Loveland et al., 2024), and in relation to psychiatric illness, where an observational study of platform videos found disinformation concentrated in discussion of neurodevelopment, personality disorders and treatment (Hudon et al., 2025). These studies were conducted predominantly in high income settings, and the extent to which their findings transfer to East African content ecosystems is unestablished.

Promotion of Prescription Only Medicines

A second and better documented pathway in the regional context concerns the promotion of medicines that may lawfully be supplied only on prescription. Kenyan reporting has documented influencers marketing glucagon like peptide receptor agonists for weight reduction on video and image platforms, including through discount framing more commonly associated with consumer retail, and has documented that such promotion continued after the medicines regulator issued a warning (Kanuri, 2025). The Pharmaceutical Society of Kenya subsequently issued a public advisory to a fitness influencer concerning content discussing prescription only weight reduction medicines, citing the applicable advertising guidelines and the professional code of ethics (Mwangi, 2025).

This pathway carries several distinct and compounding categories of risk. Medicines of this class require clinical assessment, dose titration and monitoring, and their promotion outside a clinical relationship removes each of these safeguards. Demand generated through such promotion also creates a market that unregulated supply channels may serve, and Kenyan authorities have previously issued alerts concerning falsely labelled products presented as these medicines. The commercial framing additionally reconstructs a therapeutic decision as a purchasing decision, which is a reframing that the applicable regulatory instruments were designed specifically to prevent.

Therapeutic Delay and Substitution

A third pathway concerns the substitution of platform sourced guidance for clinical assessment. Where a creator offers a confident explanation and a purchasable remedy, and where formal care carries cost, distance and waiting time, substitution is a rational response to the incentives a person actually faces. The consequences depend on the condition, and are most serious where early intervention materially alters prognosis. Direct evidence quantifying this pathway in East African settings was not identified during this review, and the claim is advanced as plausible rather than demonstrated.

Unregulated Supply and Counterfeit Risk

A further pathway concerns the supply channels that platform promotion opens. Content promoting a product frequently routes viewers towards sellers operating outside licensed pharmacy channels, through direct messaging, informal delivery arrangements or dedicated vendor accounts. Kenyan authorities have previously issued alerts concerning falsely labelled products presented as recognised weight reduction medicines, and have documented the repackaging of conventional pharmaceutical compounds as herbal preparations (Daily Nation, 2020; Kanuri, 2025). Purchases arranged through such channels bypass pharmacovigilance infrastructure entirely, since a product that never passed through a licensed outlet generates no dispensing record and no adverse event report attributable to an identifiable supplier.

Erosion of Institutional Trust

A fourth pathway operates at population rather than individual level. Where audiences repeatedly encounter contradictory health claims from sources they cannot differentiate, the rational response is generalised scepticism rather than improved discrimination. Qualitative work examining adolescent and parental responses to

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health misinformation has described precisely this orientation, characterising it as distrust applied by default rather than as targeted evaluation (Feijoo et al., 2023). Generalised scepticism degrades responsiveness to accurate public health communication as readily as to inaccurate commercial claims, which is a consequential outcome for outbreak response and routine immunisation alike.

PROFESSIONAL AND REGULATORY INSTRUMENTS

It is important to establish that the conduct discussed in this paper is not unregulated. Kenya possesses a reasonably comprehensive set of applicable instruments, and the difficulty lies in the fit between those instruments and the medium rather than in their absence. Statutory provisions governing medical and dental practice restrict the use of professional titles and the provision of services to registered and licensed persons, and attach substantial penalties to contravention, including fines and custodial sentences (Medical Practitioners and Dentists Act (Cap. 253), 2022). The regulator has invoked these provisions directly in relation to digital platforms, stating that it is unlawful for any person to use the title doctor unless registered or licensed as a practitioner or holding legitimate doctoral qualifications, and identifying an increase in individuals misrepresenting themselves online (Njaaga, 2025). Parallel legislation governs pharmaceutical practice and the supply of medicines (Pharmacy and Poisons Act (Cap. 244), 2012).

Advertising and promotion are addressed through guidelines issued by the medicines regulator, which set minimum requirements for the promotion of health products and technologies and were developed in response to a documented increase in advertisement of unregistered medicines and of products lacking adequate safety and efficacy data (Pharmacy and Poisons Board, 2022). Analysis of the current guideline indicates that only products available without prescription may be advertised to the public, that information concerning prescription only medicines must be restricted to healthcare professional audiences, and that influencer and celebrity endorsement of health products is not permitted. Responsibility is also placed on companies to monitor user generated content for exaggerated claims.

The available instruments are therefore reasonably adequate in their formal scope. Their limitation is one of operational fit, and four mismatches are identifiable. Enforcement is reactive, initiated after a complaint or an observation, whereas distribution is instantaneous and content may reach its full audience before any regulatory process begins. Enforcement is individualised, addressing one account at a time, whereas the phenomenon is distributed across very large numbers of accounts. Enforcement presupposes an identifiable and locatable respondent, which fabricated personas are constructed specifically to avoid. Finally, jurisdiction over the platform itself rests with the communications regulator rather than with health authorities, so that the body identifying a health harm is not the body able to compel platform action.

These mismatches are structural rather than remediable through greater diligence by regulators. A council operating a complaints-based process cannot match the throughput of an algorithmic distribution system, however well-resourced it becomes. The implication is that effective response requires mechanisms that operate at the same speed and scale as the phenomenon, which points towards platform level integration rather than towards individual enforcement alone.

Comparison with other jurisdictions is instructive without being directly transferable. Regulators in several high-income settings have moved towards requiring disclosure of commercial relationships within health-related content, and towards holding commissioning companies accountable for endorsements they arrange rather than pursuing individual creators alone. The Kenyan advertising guideline already contains the stronger provision, prohibiting influencer endorsement of health products outright rather than merely requiring that it be disclosed. The deficiency therefore lies not

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in the standard adopted but in the capacity to detect contravention at the volume at which it occurs, and detection at that volume is a computational problem before it is a legal one.

THE ALGORITHMIC CLINICAL CREDIBILITY MODEL

The preceding analysis indicates that existing frameworks address adjacent questions without capturing this one. Heuristic models of online credibility explain how users evaluate sources in general but do not address the specific structure of clinical authority. Infodemic frameworks address the accuracy of claims rather than the authentication of claimants. Professional conduct frameworks presuppose a registrant to whom sanction can meaningfully attach. The Algorithmic Clinical Credibility Model is proposed to fill this gap.

The model holds that perceived clinical authority within an algorithmically curated feed is assembled from four partially substitutable inputs, and that the substitutability of these inputs is the mechanism through which credential opacity produces harm. Substitutability means that a deficiency in one input can be compensated by strength in another, so that an account lacking any credential may achieve perceived authority equivalent to a registered practitioner through strength in the remaining three.

Visual Professional Signalling

This input comprises the visual and linguistic markers conventionally associated with clinical practice, including attire, setting, instruments, terminology and the use of professional titles within display names and biographies. These markers are inexpensive to reproduce and are not authenticated by any platform mechanism. Their diagnostic value is consequently low while their perceived diagnostic value is high, which is the defining property of a misleading signal.

Engagement Volume

This input comprises follower counts, view counts, interaction metrics and the algorithmic placement that these metrics generate. It operates through a consensus heuristic, in which widespread acceptance is read as evidence of validity. Engagement volume is partially endogenous, since prominence generates further prominence, and it is responsive to content characteristics that correlate weakly with accuracy. It is also subject to direct manipulation through purchased engagement.

Narrative Relatability

This input comprises the personal, conversational and vernacular qualities of the communication, including use of local languages, personal testimony and the sustained familiarity that repeated exposure generates. Relatability operates through mechanisms distinct from expertise and may in some circumstances substitute for it, particularly where formal health services are experienced as inaccessible or unwelcoming. Its influence is not inherently problematic and may be harnessed for accurate communication, as analysis of influencer led health campaigns in Africa demonstrates (Simba & Girma, 2025).

Formal Credentialing

This input comprises verifiable registration with a statutory professional council. It is the only input among the four that is diagnostic of professional qualification, and it is the only input that platforms do not supply. Its influence on credibility formation is therefore low, not because audiences discount it but because they cannot observe it. The model treats this as the central structural feature of the environment.

Verification Friction as Moderator

The model specifies verification friction as a moderating condition determining the weight formal credentialing can carry. Friction comprises the number of discrete actions required to authenticate a creator, the availability and searchability of the relevant register, the discoverability of the register to a non-specialist audience, and the interruption to consumption that verification imposes. As verification friction falls, the weight carried by formal credentialing correspondingly rises. The policy implication is that reducing friction, ideally to the point of integration within the platform interface, is the

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intervention most likely to shift credibility formation towards the diagnostic input.

Scope Conditions

The model carries scope conditions that limit the range of settings to which it applies. It assumes an information environment in which distribution is governed by algorithmic recommendation rather than by social connection, since the decoupling of reach from reputation is the condition that makes credential opacity consequential. It assumes a population in which formal registration exists and is maintained, so that a diagnostic signal is in principle available even where it is not observable. It assumes that audiences lack the domain knowledge required to evaluate clinical claims on their merits, which is the condition under which source evaluation substitutes for content evaluation. Where any of these conditions fails, the mechanism the model describes will operate weakly or not at all.

Table 2: Inputs to the Algorithmic Clinical Credibility Model

Input	Observable cues	Cost to imitate	Supplied by platform	Diagnostic of qualification
Visual professional signalling	Attire, setting, instruments, titles, terminology	Very low	Yes, unauthenticated	No
Engagement volume	Followers, views, interactions, feed placement	Low, including purchased engagement	Yes, and algorithmically amplified	No
Narrative relatability	Personal testimony, vernacular language, familiarity	Low	Yes, and algorithmically rewarded	No
Formal credentialing	Statutory register entry and licence status	High, and unlawful to falsify	No	Yes

Note. The table sets out the four inputs specified by the model. Verification friction operates as a moderating condition on the weight the fourth input can carry and is therefore not represented as a separate row.

Five propositions follow from the model and are offered as testable claims rather than as established findings. The first proposition holds that perceived clinical authority will correlate more strongly with engagement volume than with registration status across a representative sample of high reach health accounts. The second holds that visual professional signalling will be observed at similar frequency among registered and unregistered creators, since the cost of producing it is equivalent. The third holds that reductions in verification friction will increase the weight of formal credentialing in credibility formation, with in interface integration producing larger effects than external register access. The fourth holds that commercial orientation will be associated with stronger visual professional signalling, since the signal carries commercial value. The fifth holds that sustained exposure to undifferentiated health content will be associated with generalised scepticism towards health authorities rather than with improved discrimination between sources.

A PROPOSED REGISTER LINKED AUDIT PROTOCOL

The propositions above are not currently testable because no instrument exists for systematically linking platform accounts to professional register entries. This section sets out a protocol through which such linkage could be undertaken. The protocol is a proposed research design, and no audit has been conducted or is reported in this paper.

1) Define the sampling frame using platform search and hashtag queries in English and Kiswahili across a specified set of clinical topics, restricted to accounts exceeding a stated reach threshold within the target market.
2) Extract account level attributes including display name, stated title, stated qualification, stated affiliation, follower count and a coded assessment of visual professional signalling based on a predefined rubric.

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3) Query the relevant statutory registers, including those maintained by the medical and dental council, the nursing council and the pharmacy regulator, using the stated name and any stated registration number.

4) Classify each account into one of four verification states: registration confirmed, registration not found, registration claim absent, or identity insufficiently specified to permit any query.

5) Code content characteristics for a defined sample of videos per account, including clinical claim type, presence of commercial promotion, disclosure of commercial relationship and alignment with current national clinical guidance.

6) Analyse the association between verification state, engagement metrics and content characteristics, reporting all findings descriptively given the observational design and the absence of random assignment.

Several methodological cautions attach to this design and should be stated explicitly. Name matching against registers is imperfect where creators use partial names, professional nicknames or transliterations, and a proportion of accounts will fall into the insufficiently specified category through ambiguity rather than concealment. Registers are updated at intervals and a recently registered practitioner may not appear. Platform search results are personalised, so that sampling frames constructed from search are not reproducible without documentation of account state and query conditions.

Ethical considerations are substantial and require explicit treatment in any protocol implementation. The audit examines public accounts but produces determinations about identifiable individuals, some of which carry legal implications. Findings should be reported in aggregate, individual accounts should not be named in publications, and the research should be positioned as an assessment of the information environment rather than as an enforcement instrument. Institutional ethical approval should be obtained notwithstanding the public nature of the data, and any referral of specific accounts to regulators raises questions of researcher role that should be resolved in advance rather than in response to findings.

IMPLICATIONS FOR PRACTICE AND POLICY

The analysis supports recommendations at three levels, ordered here by the strength of their expected effect on the mechanism the model identifies.

Platform Level

1) Integrate credential verification within the platform interface, so that accounts presenting clinical claims can display an authenticated indicator derived from a national register rather than a self-asserted title. This is the intervention that directly addresses verification friction and is therefore expected to produce the largest effect.

2) Establish an accessible reporting pathway for suspected misrepresentation of clinical qualification, distinct from general misinformation reporting, and route such reports to a review process that considers identity rather than claim accuracy alone.

3) Publish market level enforcement data disaggregated by category, so that regulators and researchers in East African markets can assess platform performance against health-related policy provisions rather than against aggregate removal counts.

Regulatory Level

4) Establish formal coordination between health professional councils and the communications regulator, so that determinations of unlawful clinical misrepresentation can be transmitted to a body possessing jurisdiction over the platform.

5) Modernise professional register interfaces to support programmatic query, enabling third party verification tools and reducing the friction that currently prevents the credentialing signal from operating.

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6) Extend advertising enforcement to the commissioning entity as well as the individual creator, since the commercial arrangements generating prohibited promotion originate with companies that are locatable and licensable in ways that individual creators frequently are not.

Professional Level

7) Issue explicit guidance on digital communication within professional codes of conduct, addressing display of registration details, disclosure of commercial relationships and the boundary between general health education and individual clinical advice.

8) Support registered practitioners to communicate effectively within these formats rather than discouraging participation, since vacating the space concedes it to producers subject to no professional accountability whatsoever.

9) Incorporate digital health literacy into secondary and tertiary curricula, with specific attention to the distinction between authenticated credentials and self-asserted professional titles.

One further consideration concerns the sequencing of these three levels of intervention. Platform level integration of credential verification requires cooperation from companies headquartered outside the jurisdiction and operating across many markets simultaneously, and such cooperation is unlikely to be secured by any single national regulator acting alone. Coordinated approach through a regional body, whether a continental public health institution or a regional economic community, offers better prospects than bilateral engagement by individual authorities. The regulatory and professional measures set out above can proceed in the meantime, and their implementation would strengthen rather than weaken the case that any subsequent platform level request is reasonable and technically feasible.

The relative emphasis placed on these three levels matters considerably for effectiveness. Interventions directed at audience discernment, including public awareness campaigns and literacy programmes, are worthwhile but address the demand side of a supply side problem. So long as producing the appearance of clinical authority remains nearly costless while verifying it remains effortful, the environment will continue to reward misrepresentation regardless of audience sophistication. The structural intervention is the reduction of verification friction, and the remaining measures are complements to it rather than substitutes for it.

Limitations

Several limitations constrain the conclusions that may reasonably be drawn from this review. The empirical literature on health content quality on short form video platforms derives predominantly from high income settings, and the extent to which its findings transfer to East African content ecosystems, languages and clinical contexts is not established. No content analysis of East African health content was identified during this review, which is itself a finding but which also limits what can be claimed about the regional prevalence of the phenomena described.

Audience measurement figures reported in this paper derive from platform advertising tools and from online survey panels, and both instruments carry known limitations. Advertising tools estimate potential reach rather than verified unique users and may overstate penetration. Online panels recruited from more educated and more urban populations do not represent national populations, and the Kenyan survey data cited here derive from an English language instrument administered to respondents aged eighteen to fifty. Figures of this kind describe connected urban populations and should not be generalised to rural, older or non-English speaking groups, whose exposure patterns may differ substantially.

The framework advanced here was developed conceptually and has not been empirically validated. The propositions derived from it are testable but untested, the input weightings are

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unspecified, and no measurement instrument has been developed or piloted. The audit protocol is a proposed design and generated no data for this paper. Because the evidence base is documentary and descriptive, all statements concerning relationships between platform exposure and health outcomes are associative rather than causal, and alternative explanations grounded in health system access, educational attainment and prior trust in health institutions cannot be excluded on the evidence reviewed.

CONCLUSION

Short form video platforms have become a principal environment in which health beliefs are formed across East Africa, reaching a majority of the adult population in some national markets. The analysis presented here argues that the central difficulty in this environment is not the volume of inaccurate claims, which is a familiar problem admitting familiar responses, but the absence of any mechanism through which audiences can distinguish qualified from unqualified sources.

This absence is a structural property of platform design rather than a deficiency of audience judgement. Platforms supply, at negligible cost, the visual, metric and relational cues that audiences read as indicators of clinical authority. They do not supply an authenticated indicator of professional registration, which is the only cue diagnostic of the attribute that matters. Audiences relying on peripheral cues, as credibility research establishes, they routinely do, will therefore form judgements that track presentation and popularity rather than qualification.

The Algorithmic Clinical Credibility Model is offered as a framework for analysing this environment, specifying four partially substitutable inputs to perceived clinical authority and identifying verification friction as the condition determining how much weight the diagnostic input can carry. The model directs attention towards an intervention that current policy discussion largely neglects. Considerable effort is directed at correcting claims and at improving audience literacy, and comparatively little at making credentials observable within the environment where credibility judgements are actually made.

Kenya possesses regulatory instruments adequate in scope to address the conduct at issue, including restrictions on the use of professional titles and prohibitions on influencer endorsement of health products. Their limitation is operational fit, since reactive and individualised enforcement cannot match the throughput of algorithmic distribution. This mismatch will not be resolved through greater regulatory diligence, and it points towards platform level integration of verification as the response operating at the appropriate speed and scale.

Two research priorities follow directly from the analysis developed in this paper. The first is systematic linkage of high reach health accounts to national professional registers, for which a protocol is proposed in this paper, since the scale of the verification gap in East African markets is currently unmeasured. The second is examination of how audiences in these markets weight the inputs the model specifies, which would permit the framework to be refined or rejected on evidence rather than accepted on plausibility.

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Ethical approval: Ethical approval was not required for this review, which analysed publicly available documents and published literature and involved no human participants.

Data availability: All sources analysed in this review are publicly available and are listed in the reference list.

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