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Truth, Trust and Child Health: How can we win against misinformation?

Parents, child health and misinformation in an AI-mediated information ecosystem.



FREUDS · REPUBLIC · Future Health Research · Ipsos · netmums

Contents.



EXECUTIVE SUMMARY 4

PARENTAL TRUST IN HEALTH INFORMATION 10

THE CHALLENGES FACING PARENTS 14

WHEN IS IT A PARTICULAR ISSUE, AND FOR WHOM? 18

THE CHANGING INFORMATION LANDSCAPE 22

HOW CAN WE ADDRESS IT? FROM TRUSTED INFORMATION TO TRUSTED PRESENCE 26

CALL TO ACTION AND FURTHER RESEARCH 34

ANNEX 38

Executive Summary.

Is the effort to address misinformation about children's health winnable, and if so, how?

Misinformation in health has long been identified as a problem by policymakers: the World Economic Forum's Global Risks Report has placed misinformation and disinformation among the most severe global risks for several years running.[1,2] But when it comes to children's health, the question is not simply how much misinformation exists. It is how it reaches parents, what happens when they encounter it and, crucially, what could help.

New research for this report, combining a survey of 627 UK parents, in-depth interviews with mothers, behavioural data on where parents spend their time online and a review of the published evidence, gives us a much clearer picture. And it shows the stakes are real.

A third of parents have believed something about their child's health that later turned out to be misleading, inaccurate or false.[3,4] Of those parents, half say it affected a decision they made.[5] One in ten parents say information led them to delay a health decision, 5% to miss or postpone an appointment or event such as a vaccination, and 4% to decide not to follow a professional's advice.

Among parents who use social media for child health information, 13% have decided not to follow professional advice, and among AI users 19% have changed their mind on a child's health issue.[6]

These findings do not establish that misinformation caused each behaviour, and not every change or delay is harmful. But they demonstrate why the information environment around parents matters: what they encounter can shape not only what they believe, but what they do.

The good news is that our research also points to an answer. **For most parents, most of the time, the effort is winnable. And perhaps the most important finding is that this is not primarily a crisis of trust. It is a gap in presence.**

96% of parents trust healthcare professionals and 94% trust the NHS. When advice conflicts, most turn to an NHS source or a healthcare professional.[7] **Parents are not turning away from professional expertise. The problem is that the sources they trust most are not always there in the moments and places they are looking for answers.**

The answer, therefore, is not simply to produce more trusted information, but to build trusted presence.



Much of the child health information journey happens either side of clinical contact. **Nearly half of parents have gone online because they wanted reassurance quickly, one in five because they could not get professional advice fast enough, and 17% because they did not want to trouble the NHS or call 111.[8]** Parents are not replacing professional expertise; they are supplementing it in the gaps around it.

In those gaps, parents are left to make sense of a crowded and sometimes conflicting information environment. Forty-three per cent often encounter conflicting advice and more than half (52%) find it hard to know who to trust when that happens. Most search further or turn back to a professional, but the burden of interpreting and reconciling different advice falls heavily on parents.

AI makes closing this presence gap more urgent. **Twenty-nine per cent of parents have used an AI platform for child health questions, rising to 44% among 25–34-year-olds.**

Trust is particularly high among those already using AI for this purpose: 72% trust it, compared with 43% of parents overall. Crucially, nearly one in five AI users say information they encountered has led them to change their mind about a child health issue (19%), underlining AI's growing influence on health decision-making. For parents using AI, child health information can now be compressed into a single, confident answer, potentially reducing the extent to which parents compare credible sources before making decisions.

Parents themselves point towards what would help: **easier access to NHS advice, clearer explanations of risks and benefits, better signposting and more time with professionals.** But access alone cannot close the gap. Trusted expertise also needs to become more present, useful and recognisable across the wider information environments parents already use.

Six principles for building trusted presence

Our research points to six principles for building trusted presence. Together, they shift the focus from simply producing accurate information to making sure trusted expertise is recognisable, useful and available where and when parents need it:

1. **Start with what matters to parents:** Understand the need behind the search, whether that is reassurance, understanding a risk or knowing what to do next, and connect trusted information to the question or concern that matters in that moment.
2. **Make complex information easier to navigate:** Give parents enough context to understand what is known, what remains uncertain and, when guidance changes, what has changed and why.
3. **Make credibility visible:** Make it easy to see who information comes from, the expertise behind it, how current it is and what evidence it draws on, whenever it is encountered.
4. **Bring authority and relatability together:** Combine professional expertise with voices, experiences and formats that make that expertise feel relevant and human, and build familiarity with trusted information before moments of uncertainty arise.
5. **Provide a clear next step:** Information should not simply leave parents better informed; it should help them decide what to do next, where to go and when to act.
6. **Design for how information travels:** Create trusted information with its own journey in mind, adapting language, format and creative expression for the different places parents encounter it while keeping the underlying guidance consistent.

Building trusted presence is a shared task. The NHS and public bodies cannot, and should not, be present in every AI answer, messaging group, parenting platform or social feed. But parenting platforms, professional bodies, charities, employers, regulators, companies with a stake in child health, and the platforms and AI developers shaping what parents see, all reach parents in places and moments that public health bodies do not.

The opportunity is to build on the trust that already exists and extend its reach: to make trusted expertise more present where parents are, when they need it and, where possible, before uncertainty or misinformation takes hold.

The evidence gives us reason for optimism. Parents are not turning away from trusted expertise; they are looking for it in new places and at different moments. The challenge now is to make sure it is there to meet them. Because addressing misinformation is not only about correcting what is false; it is about making sure what is trusted, useful and true is already there.





A NOTE ON METHODOLOGY AND TERMINOLOGY

Methodology:

The research in this paper combines the expertise of Freuds Group, Future Health Research, Ipsos, Netmums and Republic.

Research approach:

- **Stage one:** Evidence and literature review conducted by Future Health.
- **Stage two:** An online survey of 627 UK parents of children under 18, conducted between 28 August and 1 September 2026 by Ipsos.
- **Stage three:** Online behaviour mapping, a snapshot of where parents spend their time online over the course of a month using Ipsos iris.
- **Stage four:** In-depth interviews with 10 mothers conducted by Republic*.
- **Stage five:** Analysis and development of recommendations and communications principles led by Freuds and Future Health.

*** A detailed methodology and additional audience data can be found in the annex, including a note on the qualitative approach.**

Terminology:

- ***Misinformation*** is a term that is used in a range of different ways. A 2023 review identified 20 different definitions of misinformation and 19 of disinformation, which helps to explain why estimates of prevalence vary so widely: one systematic review found estimates of how much health content on major platforms is misinformation ranging from 0.2% to 28.8%.[9, 10] This report uses the distinction drawn by Wardle and Derakhshan for the Council of Europe, which separates misinformation (false information shared without intent to harm) from disinformation (false information intended to deceive).[11] Our research is primarily concerned with misinformation, and that is the term used from here on.
- Rather than restating that misinformation exists and that parents are exposed to it, this research set out to understand how it reaches parents, who it reaches, and what the sources parents already trust and the wider set of organisations that reach parents could do differently. That starts with understanding where parents go for information about their child's health, and how far they trust what they find there.
- ***"Trusted sources"*** means the sources parents themselves say they trust, which in this research are overwhelmingly healthcare professionals and the NHS.
- ***"Official sources"*** means the NHS and government bodies and the guidance they publish. Survey differences cited are statistically significant at the 5% level unless stated and describe associations rather than causes.

Parental trust in health information.

Parents trust the NHS and healthcare professionals most, but can't always reach them when they need answers.

> **"It can be really overwhelming and confusing as a first-time parent. There's so many different pieces of advice.**
>
> PARENT, QUALITATIVE RESEARCH[12]

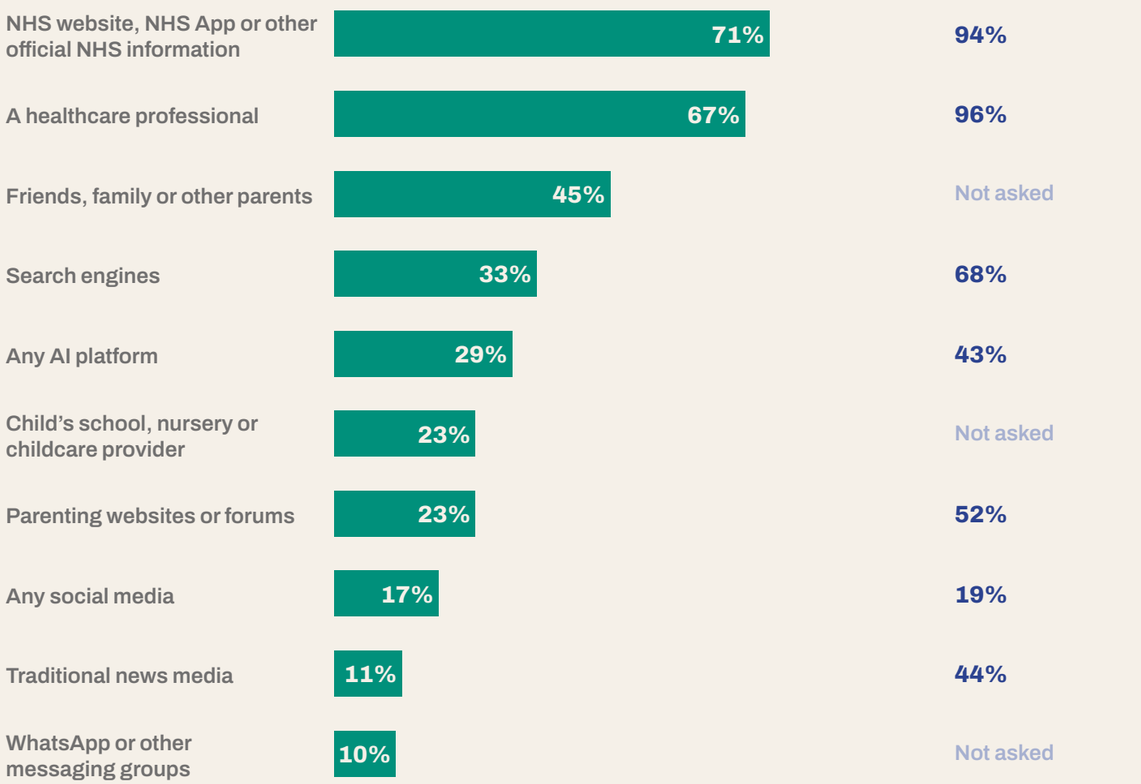
Thirty years ago, a parent who wanted to know whether a rash was serious had a few options: the GP, the health visitor, a family member, or perhaps a copy of a baby book. Today, the same parent has thousands of options, most of which are available instantly. **As the volume of information has grown, so has the amount that parents judge to be misleading.**

Misinformation in health has long been identified as a problem by policymakers: the World Economic Forum's Global Risks Report has placed misinformation and disinformation among the most severe global risks for several years running.[13, 14]

Our findings provide some reassurance. **The NHS and healthcare professionals are both the most used and the most trusted sources: 71% of parents have used NHS information and 67% a healthcare professional, and 96% trust healthcare professionals and 94% the NHS, with fewer than one in twenty saying they do not.**[15, 16]

Few institutions in public life could expect trust at this level, and nothing in this research suggests parents are turning away from professional expertise. Asked which single source has the biggest influence on what they eventually do, **44% name a healthcare professional and 27% the NHS; no other source reaches 10%.**[17] **Faced with conflicting advice, 38% would check an NHS source and 24% would follow a healthcare professional.**[18]

SOURCES USED FOR INFORMATION OR ADVICE ABOUT CHILD HEALTH AND DEGREE OF TRUST IN SELECTED SOURCES



Source: Ipsos survey, Q20: Which of the following would most help you feel confident making decisions about your child's / children's health? Base: all parents (627). Multiple responses allowed. Table 78.

But the range of sources is wide, and trust quickly drops. **Search engines are trusted by 68%, parenting forums by 52%, traditional media by 44%, AI by 43% and social media by 19%.**

The picture becomes more complicated when parents are asked where they go first.

The NHS (34%) and healthcare professionals (27%) remain the most common answers to that single-choice question, but one in ten start with friends and family, 7% with an AI platform, and 12% say it depends on the issue.[19]



Mothers interviewed described an information journey with several stages rather than a single step:

- Before contacting the NHS, they consult a range of sources, to work out how worried to be and to prepare to advocate for their child.
- After the appointment, many go back online to find out more about what they were told and to hear from parents who have been through a similar experience.
- The NHS or the professional usually informs the final decision, but much of the journey takes place either side of that contact, in spaces official sources do not always reach.[20]

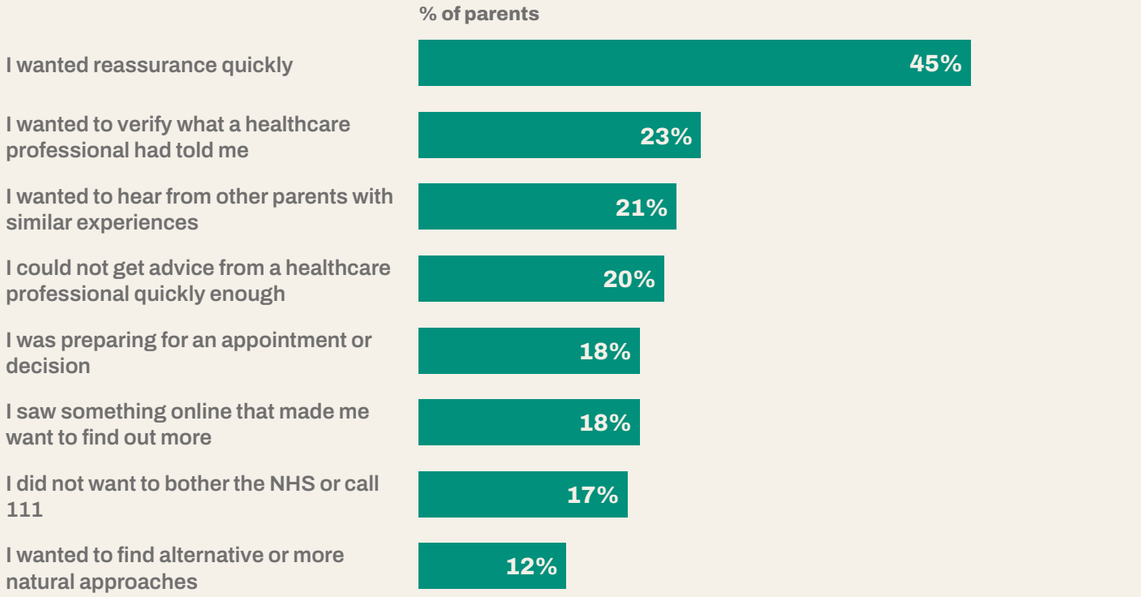
> “We need to trust ourselves as parents, but we’re not necessarily always right.”
>
> MOTHER, QUALITATIVE RESEARCH[21]

> “If I don’t go in there [GP appointment] with medical terms, nobody’s listening to me.”
>
> MOTHER, QUALITATIVE RESEARCH[22]

The reasons parents give for looking beyond the NHS are mostly about need rather than doubt.

Wanting reassurance quickly is by far the most common, followed by wanting to verify what a healthcare professional had said and wanting to hear from other parents with similar experiences.[23]

REASON FOR LOOKING FOR CHILD HEALTH INFORMATION ONLINE



Source: Ipsos survey, Q6: Which of the following, if any, have led you to look for child health information online? Base: all parents (627). Multiple responses allowed. Table 11.

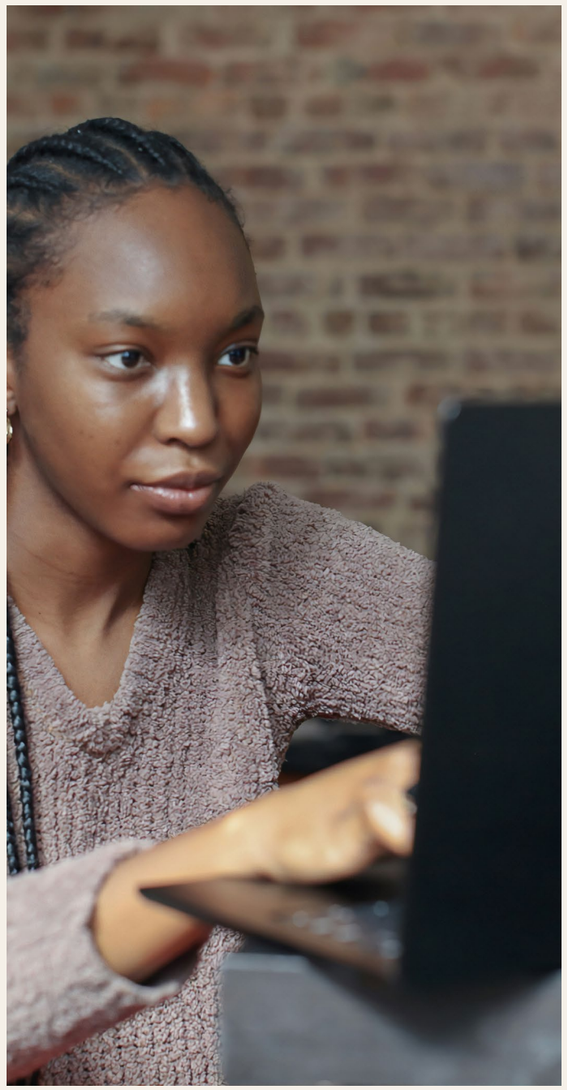
These reasons, and the qualitative research, suggest parents turn to AI, digital and peer sources because they are **immediate, personal and accessible, and that NHS content, by comparison, can feel generic and is not always easy to find at the moment it is needed.** Where parents look beyond official sources, the causes are practical and relational: difficulty getting access, concerns that do not meet a service threshold, fear of being judged, and moments when no professional support is available. This is very rarely driven by ideological distrust of the NHS. Parents are using different sources for different jobs, supplementing the sources they trust rather than replacing them.[24]

This makes the current parental information environment one defined as much by the abundant availability and accessibility of information, as by concerns about misinformation. Much of it is positive: parents can reach information, and other parents’ experience, in ways that were impossible a decade ago. But it also leaves them to distinguish credible information from less credible information, in an environment that makes such judgements difficult. **The gap this report is focused on is not a gap in trust. It is a gap in presence:** the sources parents trust most are not reliably there in the moments and places where parents are actually looking.

The challenges facing parents:

Conflicting advice leaves parents to work out what to believe on their own.

39% OF PARENTS SAY THEY OFTEN COME ACROSS CHILD HEALTH INFORMATION THEY THINK IS MISLEADING, INACCURATE OR FALSE.[25]



High trust in healthcare expertise does not remove the difficulty of navigating everything around it. The survey and the interviews identified five pressures that follow from this, and the first, the burden of interpretation, runs through all of the others.

The burden of interpretation

Parents feel they are being asked to make difficult judgement calls. **43% say they often come across conflicting advice from different sources, 52% find it hard to know who to trust when that happens, and 46% sometimes feel overwhelmed by the amount of child health information available.** [26]

Conflicting advice is not confined to the online environment: **67% think expert recommendations seem to change over time,**[27] while mothers interviewed described inconsistencies between advice from family members, midwives and health visitors: *"older friends and family will tell you one thing, health professionals or midwives will tell you another, then the health visitor might say something completely different."*[28]

> "Everybody's a doctor now.
>
> MOTHER, QUALITATIVE RESEARCH[29]

Faced with that uncertainty, parents cross-check sources and look for patterns: "*I won't just read one link or one website. I will read other ones to see if there's a pattern of information.*"[30] Another mother, who works in health, said she still struggled to tell who was credible.

This creates a burden of interpretation: parents are not simply finding information; they are having to reconcile different advice and work out what it means for the decision in front of them.

The shifting baseline

Medical advice changes as evidence develops, and it should: updated guidance is the sign of a system that learns. The problem, as the mothers interviewed described it, is less that the advice changes and more how the change is communicated. The sense of shifting ground added to feelings of overwhelm, particularly for mothers comparing what they were told with a first child against a second.[31]

This creates an opening for misleading content. The qualitative research found that parents treat absolute claims as a warning sign, yet the moment official advice appears to move, a simple and unchanging answer has an appeal that measured guidance lacks.[32]

> "With my second baby, I had more confidence as a parent. So when I was told by a nurse some feeding advice, I knew it didn't make sense for my baby. Whereas the first time around, I would have done what I was told.
>
> MOTHER, QUALITATIVE RESEARCH[33]

Parents understand that guidance changes, **but they want the change to be explained.** A clearer explanation of risks and benefits is the second most chosen of the twelve things parents say would most help their confidence, behind easier access to NHS advice,[34] and **the qualitative research shows a preference for content that is nuanced and evidenced over content that is absolute.**[35]

The reassurance loop

That process does not always end once parents find an answer. Searching can generate further questions, and wanting reassurance quickly is the single most common reason parents go online.[36] What they want is often not a fact but a judgement: that this is normal, that they can wait, that they are not alone. The qualitative research suggests parents often find that reassurance in forums and among peer groups: *"if there's loads of people saying oh yeah my kid does that, then I'll calm down."*[37]

Confidence without certainty

A need for reassurance doesn't always mean a lack of confidence: **96% say they feel confident making decisions about their child's health, 84% say they know where to go for reliable information and 72% say they know how to check whether information is reliable.**[38]

But that confidence has limits: only 41% feel very confident, 42% worry very or fairly often about getting it wrong, and **a third (33%) have believed child health information that later turned out to be misleading, inaccurate or false.**[39, 40]

The qualitative research suggests confidence builds with experience and, in particular, with a second or third child. It falls away in the newborn weeks, when a symptom persists, and when an issue is unfamiliar, with development and behaviour mentioned most often. Parents do not expect certainty; what they want is to feel equipped, knowing what to do and where to turn: *"I'm more confident in terms of choosing what route to take to seek help, because I respect the opinions, knowledge and expertise of the professionals. I'm less confident, obviously, with knowing exactly what's wrong."*[41]

> "We need to trust ourselves as parents, but we're not necessarily always right."
>
> MOTHER, QUALITATIVE RESEARCH[42]

Concern about being judged, or dismissed

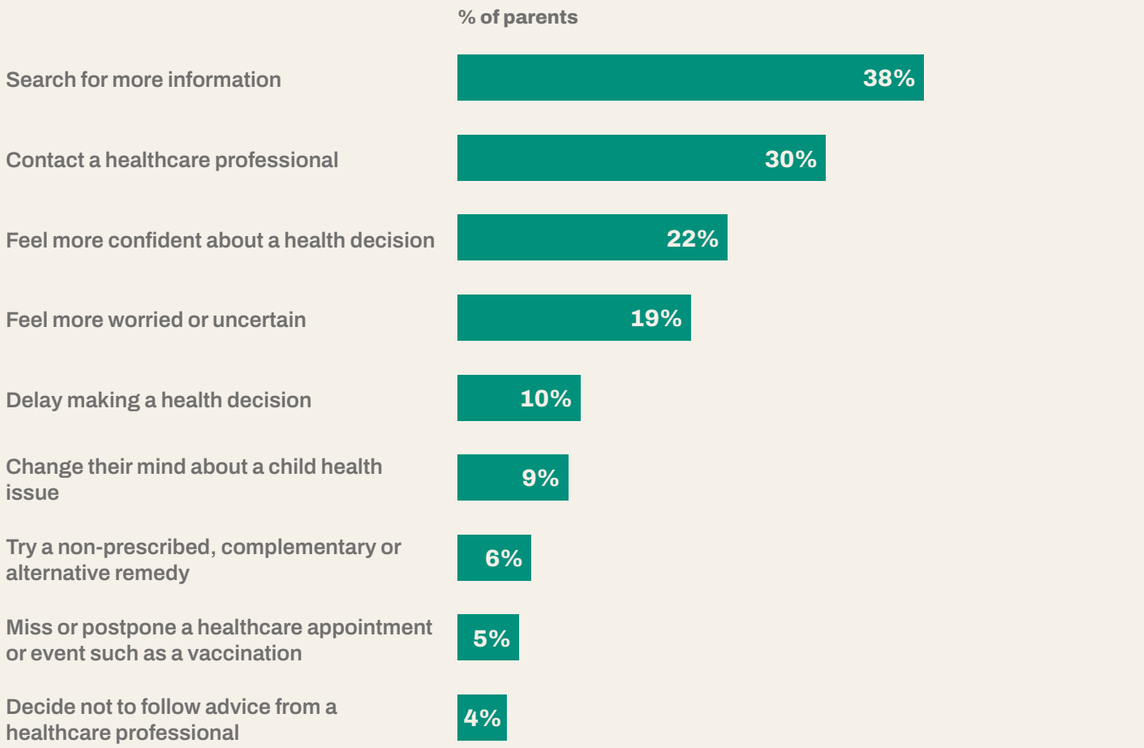
Availability of trusted sources does not make it easy to ask for help. 17% of parents have looked online because they did not want to trouble the NHS or call 111. For mothers it is 22%, for fathers 11%.[43] Behind that reluctance sits another concern: whether they will be taken seriously when they do ask for help. Several mothers described looking up medical terminology before an appointment so that they would be taken seriously. Another put it in terms of language: *"if you don't have that behind you, you can totally get dismissed and fobbed off."*[44]

> "If I don't go in there with medical terms, nobody's listening to me."
>
> MOTHER, QUALITATIVE RESEARCH[45]

What parents do as a result

The central question for policymakers is whether misinformation, and the wider difficulty of navigating uncertain and competing information about child health, is associated with parents delaying or avoiding care.

EFFECT OF CHILD HEALTH INFORMATION SEEN, READ OR HEARD



Source: Ipsos survey, Q17: Has information you have seen, read or heard about children's health ever led you to do any of the following? Base: all parents (627). Multiple responses allowed. Table 57.

To note, there are some considerations to take into account when using the data above, to find out more please see data considerations in the annex.

Further checking ranks top, followed by contacting a healthcare professional: most parents respond to what they read by seeking more information or professional advice, not by rejecting it.[46]

But worryingly, **of the third of parents who have believed something that later proved misleading (29% once or twice, 4% several times)[47], 50% say it affected a decision about their child's health to a great or some extent.**[48]

These are parents' own judgements, made after the event, of what was misleading; some will include advice that was sound but did not work for their child. **One in ten say information led them to delay a health decision, 5% to miss or postpone an appointment or event such as a vaccination, and 4% to decide not to follow a professional's advice.** Among parents who use social media for child health information, 13% have decided not to follow professional advice, and among AI users 19% have changed their mind on a child's health issue.[49]

It is important to state that not all delay is harmful. Waiting to see whether a symptom passes or deciding not to seek care that is not needed, can be exactly the right response, and reassurance in the gaps between contacts with the health service is one of the benefits the digital environment offers. The concern is delay driven by doubt rather than by judgement of credible information.[50] The literature describes vaccine hesitancy, and hesitancy about seeking care more generally, as an accumulation of small deferrals more so than an outright act of refusal.[51] Harmful delay is therefore the behaviour that matters most, and the hardest to observe. A parent who refuses a vaccination is visible to the system. A parent who postpones an appointment, waits to see whether a symptom passes, or quietly decides not to act is not. The measure of success for any intervention should include whether parents act in time, not only whether they hold accurate beliefs.

Pieces of content were shown to mothers interviewed; these were either misleading or inaccurate. The mothers interviewed readily dismissed misinformation that was extreme, such as a post claiming the MMR vaccine had caused a child's autism, as it contradicted existing beliefs rather than because they had checked it.

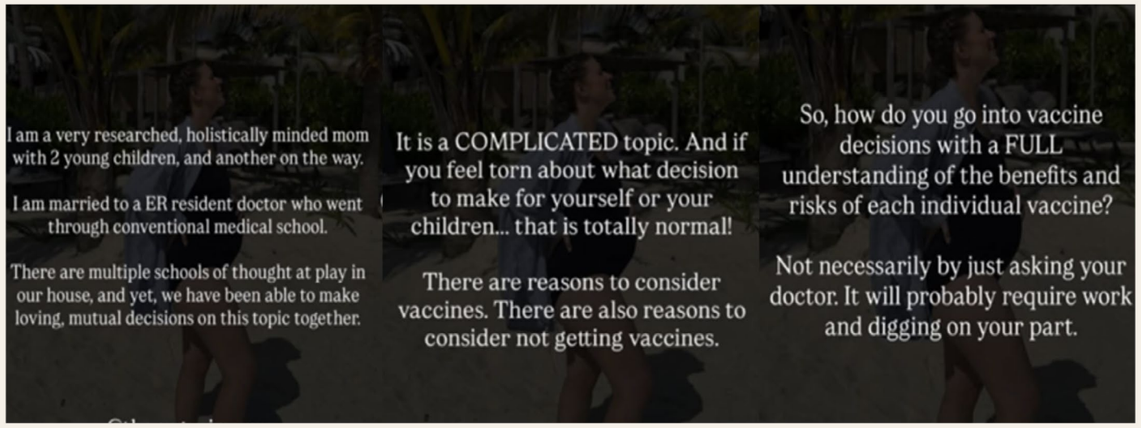


Image A: Misleading Instagram content weighing up childhood vaccination through a personal, holistic-parent perspective

However, misleading content that looked balanced was harder to spot: a post (image A) weighing up whether to pursue child vaccinations, from a self-described holistic mother, came across as credible and relatable to a few of the mothers interviewed.

This highlights an important tension: **extreme or familiar claims can be relatively easy to dismiss, but misleading content that looks balanced, relatable or evidenced can be much harder to judge.** The risk is not only that parents are persuaded outright, but that credible-looking content introduces enough doubt to make an established decision feel less certain.

These same cues of credibility recur in misleading content on social media: the appearance of evidence, relatable voices, apparent expert endorsement and significant reach.



Image B: Instagram content linking childhood vaccine doses and autism rates, shown with Full Fact's "missing context" assessment.

One example is content that borrows the visual language of evidence. In 2026, an Instagram post (Image B) presented selected figures on childhood vaccine doses alongside autism rates, inviting the viewer to infer a relationship between the two. Full Fact subsequently fact-checked the post, finding that the figures were presented without important context.

The example illustrates how misleading content can introduce doubt without making its central claim explicit. By presenting selected figures as a self-evident "pattern", it leaves the parent to make the connection themselves.

A second route is through relatability and apparent professional endorsement. A paid Facebook advertisement (Image C) for a children's supplement used the personal testimony of a mother of an autistic child alongside an apparent reference to a paediatrician. The Advertising Standards Authority (ASA) found that the advert implied the supplement could treat traits associated with autism and failed to make its commercial intent clear.



Image C: Paid Facebook advertisement for a children's supplement, subsequently found by the ASA to be misleading.

Reach and timing can add another layer. In 2025, following the death of a child from measles, a British influencer with more than 200,000 followers posted content criticising Liverpool's Alder Hey hospital:

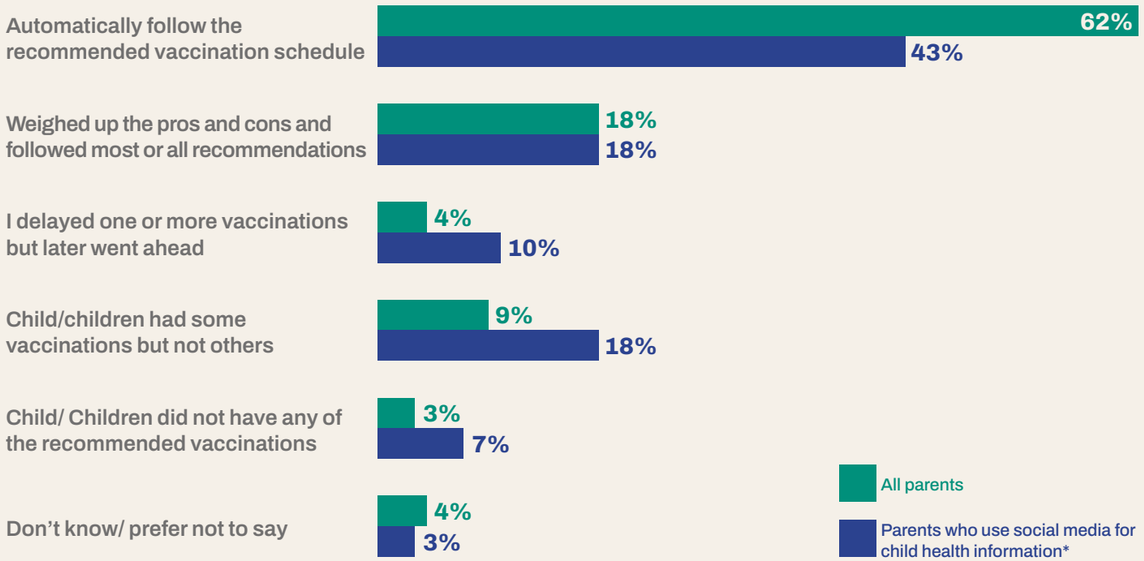
"Measles isn't this deadly disease… it's not dangerous… [in response to Alder Hey's official statement] really, really pushing and manipulating parents into getting the MMR vaccine."

Local health bodies responded to the claims, but the content had already entered the information environment at a moment of heightened anxiety. Trusted sources were present, but they were responding after the claim had begun to circulate.

Taken together, these examples show why vaccination is such a useful test of trusted presence. Most parents still follow recommended guidance, but they are making those decisions in an information environment where doubt can be introduced through content that looks evidenced, feels relatable or reaches them at a moment of heightened concern.

The survey cannot establish that social media use causes different vaccination decisions, but there is a clear association worth understanding: **among parents who use social media for child-health information, 43% automatically followed the recommended schedule, 10% delayed one or more vaccinations and 7% reported that their children had none of the recommended vaccinations.**

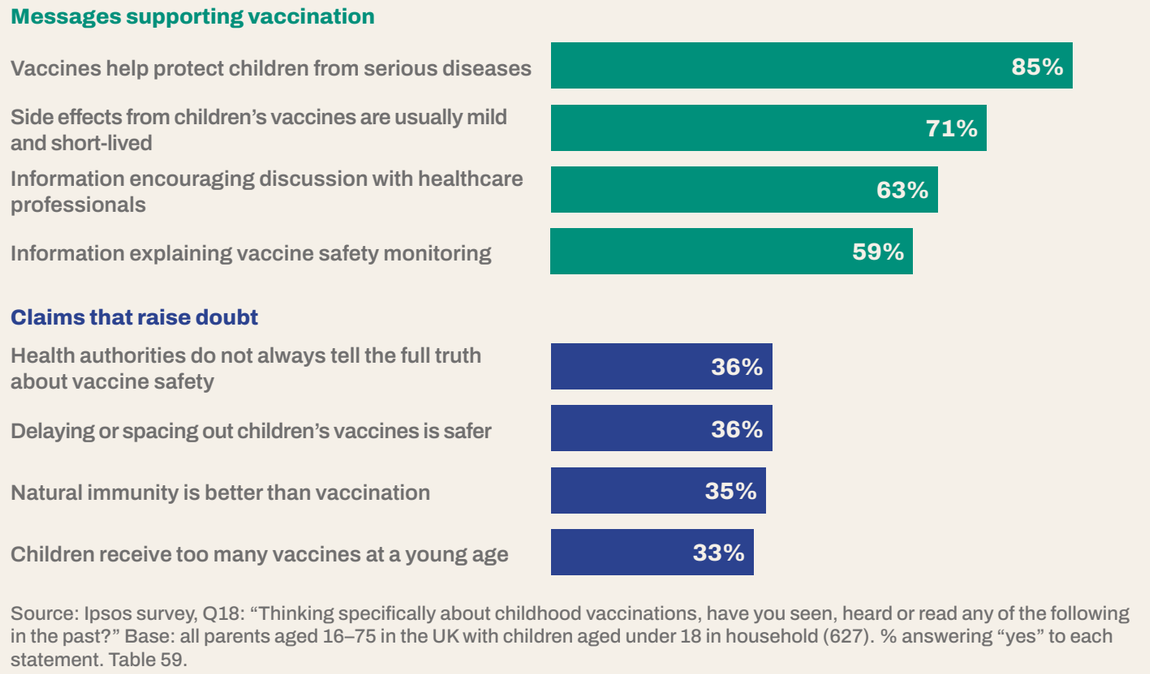
APPROACH TO CHILDHOOD VACCINATIONS



Source: Ipsos survey, Q19: "Thinking specifically about childhood vaccinations, which of the following best describes your approach for your child / children?" Base: all parents aged 16–75 in the UK with children aged under 18 in household (627); parents who use social media for child health information (113 unweighted, 105 weighted). Single response. Tables 76 and 77. *Small base: treat this column as indicative.

Parents have seen the arguments on both sides.

MESSAGES PARENTS HAVE SEEN, HEARD OR READ



Source: Ipsos survey, Q18: "Thinking specifically about childhood vaccinations, have you seen, heard or read any of the following in the past?" Base: all parents aged 16–75 in the UK with children aged under 18 in household (627). % answering "yes" to each statement. Table 59.

The risk appears less about widespread rejection of professional advice than the accumulation of doubt, delay and selective decision-making, with these behaviours particularly pronounced among parents who use social media for child-health information.

Balance is not the same as nuance

These pressures describe a parent who wants to feel capable, is surrounded by advice, but in many cases can end up more anxious than when they started. Part of the answer is to help parents navigate uncertainty and differing perspectives with confidence, rather than to promise a certainty that does not exist. Some of those interviewed asked for more balanced content to support decision making, but caution is needed here. Balance is a quality that misleading material readily imitates.

Experimental research on media coverage of the vaccine and autism controversy found that presenting "both sides" of a settled scientific question increased readers' uncertainty about vaccine safety, even though the evidence was clearly weighted to one side.[52] Parents in the qualitative research trusted content that was evidenced and honest about uncertainty, and treated absolute claims as a warning sign; what they did not need was equal weight given to unequal evidence.[53] **Nuance, not balance, is what trusted sources should offer.**

When is it a particular issue, and for whom?

Parents are most vulnerable to misleading information at moments of high anxiety, and some groups are more exposed than others.

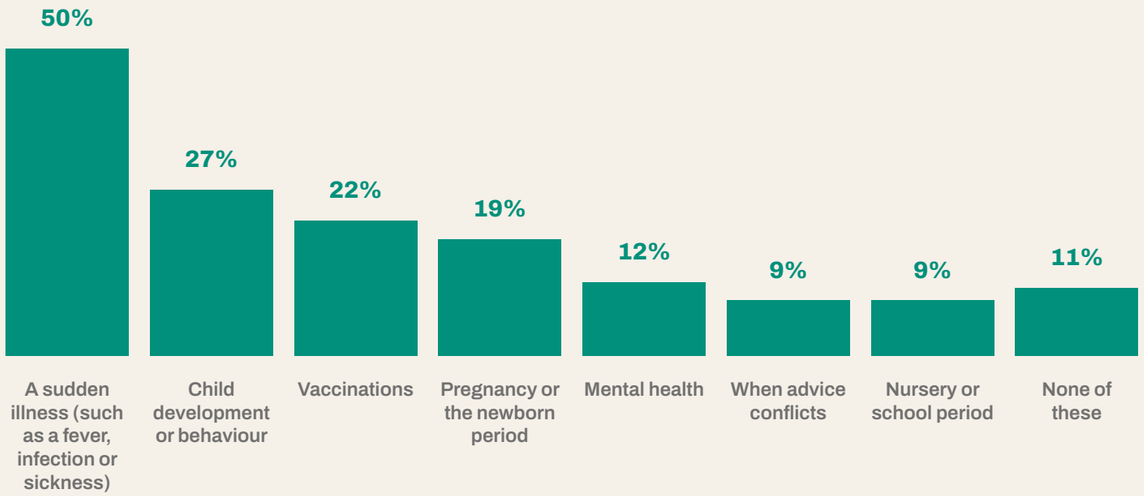


Parents' need for information about their children's health fluctuates over time, creating particular moments of heightened information need, when exposure to misleading content matters most. The literature offers some pointers on who is most susceptible and when, although the evidence on individual factors is contested. Lower digital and health literacy, low trust in institutions, motivated reasoning and a simple lack of reflection have all been associated with greater susceptibility.[54]

Timing matters as much as disposition: for parents of children under five, pregnancy and the months after birth, acute illness, immunisation appointments and transitions such as starting school are all periods when health anxiety is high and confidence is low.[55]

When: the moments of greatest need

WHEN PARENTS MOST NEEDED TRUSTED INFORMATION ABOUT THEIR CHILD'S HEALTH



Source: Ipsos survey, Q15: At which of the following times, if any, have you felt most in need of trusted information about your child's / children's health? Base: all parents (627). Multiple responses allowed. Table 42.

Half of parents (50%) say the time they most needed trusted information about their child's health was a sudden illness. After that comes development or behaviour (27%), vaccinations (22%) and pregnancy or the newborn period (19%).[56] The literature on parents of children under five singles out pregnancy and the months after birth, when anxiety, major decisions, low confidence and heavy online searching all arrive together.[57] The mothers interviewed described confidence wavering at parenting "firsts" such as weaning, with symptoms that would not go away, and with problems that seemed to fall between services.[58]

These moments are not always predictable for an individual parent, but many are predictable across the parenting journey. Pregnancy, the newborn period, vaccination appointments and transitions such as starting school create opportunities to build familiarity with trusted information before questions become urgent. **Trusted presence should therefore be anticipatory and proactive, as well as responsive.**

Who: the groups most exposed

The survey shows markedly higher exposure to misleading content, and higher rates of acting on it, among five groups of parents. A link to the full dataset, with bases and comparison figures, is in the annex. All of these are associations: the survey cannot show whether, for example, using AI or social media leads to these outcomes or reflects the needs and behaviours of the parents who use them.



PARENTS OF UNDER 5S

are the most likely to feel overwhelmed by the amount of child health information (55%, against 46% of all parents), the most likely to have needed trusted information at a moment when professional advice was not available quickly (27% against 20%), and more likely to have believed something that later proved misleading (39% against 33%).

PARENTS AGED 25 TO 34

are the heaviest users of AI (44%). They are also the most likely to report often coming across conflicting advice (55%) and misleading information (53%), and to have believed something that later proved false (52%).

PARENTS FROM ETHNIC MINORITY BACKGROUNDS

report markedly higher rates of acting on misleading information (10% have decided not to follow professional advice, against 2% of white parents; 17% have delayed a decision, against 9%) and rely more on closed channels such as WhatsApp groups (18%, against 7%).

PARENTS WHO USE SOCIAL MEDIA FOR CHILD HEALTH INFORMATION

show the strongest association with reported behaviour: more than half (56%) have believed misleading information, three quarters (74%) of those say it affected a decision, and fewer than half (43%) automatically followed the vaccination schedule.

MOTHERS

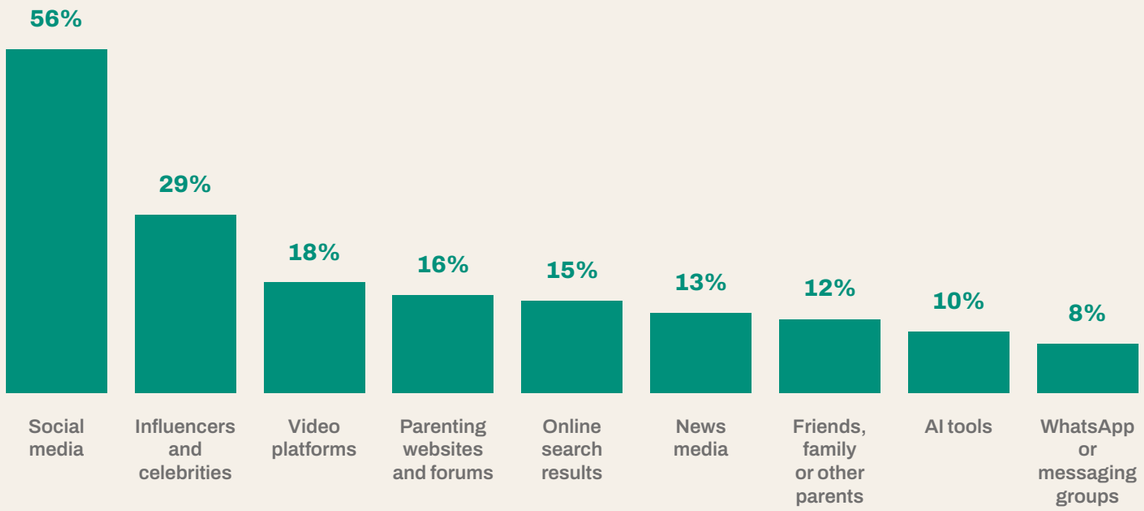
are more likely than fathers to hold back from contacting the NHS (22% against 11%) and to be left more worried by what they find (23% against 15%). This may say more about who carries day to day responsibility for children's health than about how mothers and fathers weigh information: both are equally likely to worry about making the wrong decision.[59] Parents in social grades C2DE are less likely to value a single online hub (14% against 24%).

Please note, there are some considerations with the data outlined above please see data considerations in the annex for more detail.

The changing information landscape:

AI and social media are changing where parents find health information and where they come across misleading content.

WHERE MISLEADING CONTENT IS MOST OFTEN ENCOUNTERED



Source: Ipsos survey, Q11: Where do you most often encounter information about children's health that you think may be misleading, inaccurate or false? Base: parents who have come across such information (528). Single response. Table 34. The NHS and healthcare professionals were not among the options offered.

Social media is, by some distance, where parents say they most often encounter misleading content, followed by influencers and celebrities.[60] The channels that carry the risk are also the channels where parents already are, and two trends stand out from the data: **the arrival of AI in the search habit, the way guidance changes land with parents, and the shift of content towards the places parents scroll rather than search.**

AI is becoming part of the search habit

For more than a decade, parents have been typing their child's symptoms into Google and scanning three or four results for a pattern. AI is becoming part of that habit, and for some parents is starting to replace it. **29% of parents have used an AI platform for child health information: 22% ChatGPT, 12% Google's AI summaries, 7% Gemini and 3% Claude.** Among parents aged 25 to 34 the figure for any AI use is 44%.[61] 7% of all parents now go to an AI platform first, and 13% of 25 to 34 year olds.[62]

The behavioural data suggests even those figures are conservative. Mapping of online parental behaviours found that 68% of parents with a child under 15 used an AI platform in August 2026, for any purpose rather than child health specifically, for an average of 128 minutes over the month, against 63% of all internet users. **Among parents who also use health websites it rises to 72%, and among 18 to 24 year old parents who use health websites to 79%, at nearly two and a half hours a month.[63]**

> **AMONG PARENTS WHO HAVE USED AI FOR CHILD HEALTH INFORMATION, HALF (50%) TRUST IT AS A SOURCE AND HALF (49%) DO NOT.** IPSOS SURVEY[64]

Parents are using AI platforms faster than they have come to trust them. 43% of all parents trust AI as a source and 53% do not, and even among those who use it for child health information the split is even. 55% agree that AI generated health information makes it harder to know what to trust.

That parents turn to a source they do not fully trust is one of the most important findings in this research, and the qualitative research suggests why: AI is immediate, it helps parents make sense of what they are seeing, and it helps them work out what to do next.

The mothers interviewed were using AI to put a name to a problem or to triage a photo of a rash, while worrying about leading the tool with their prompts, about alarmist answers, and about not knowing where the information came from. Some had learned to moderate how they described symptoms, to search and AI tools alike, so as not to frighten themselves with the reply: *"I'll moderate what I say to not panic anyone."* (Mother, qualitative research)[65]

Two survey findings sit uneasily together. **Only 10% of parents who encounter misleading content say they most often meet it in AI tools, although AI is also one of the less used sources, so a lower figure is to be expected. Yet 52% of parents who use AI for child health information have believed something that later proved wrong, against 33% of parents overall.**[66, 67] The survey cannot tell us whether what those parents believed came from AI, and there are four possible explanations it cannot separate:

1. AI users may simply search more and be exposed to more content of every kind.

2. AI answers draw on and summarise the same web content that carries misinformation, while stripping away the signals parents use to judge it, so that an AI answer does not resemble the provocative post parents have learned to distrust; it reads as authoritative and sourced.

3. Parents who are more anxious, or more sceptical of professional advice, may be more likely both to use AI and to be led astray.

4. AI users may simply be better at recognising, and therefore reporting, information that turned out to be wrong. Each explanation would call for a different response, which is why mapping the AI user journey is the first priority in the research agenda.

For the parents who use AI, the verification step they used to do themselves is now being done for them inside a single confident answer.

Those producing trusted guidance need to know how it is being summarised, sourced and sometimes distorted as a result. Demand for help is currently small: only 4% of parents say guidance on using AI safely for health questions would most help their confidence, rising to 10% of 25-34-year-olds and 9% of AI users.[68] **It seems clear that AI will be an important part of the information environment for parents, and that most will no more think to ask for guidance on using it than they would for a search engine.**

The gap between rapidly rising use and low demand for support is itself a finding, and it argues for building trusted presence into AI answers now rather than waiting for parents to ask. Some of this work has begun, led so far by the platforms rather than by health bodies – but more needs to be done.

Where parents scroll social media and messaging groups

Ofcom's 2025 data shows that younger parents are on TikTok and Instagram, and older parents in Facebook groups. WhatsApp is growing as a channel that is private and, in practice, self-moderated: because messages are encrypted, content shared within groups is not visible to the platform, and the only moderation is by group members themselves. **In our survey, messaging groups matter particularly for parents from ethnic minority backgrounds** (18%, compared with 7% of white parents).[69, 70]

The mothers interviewed described judging credibility through a mix of message, messenger, engagement, format and imagery, and being more careful when actively searching than when passively scrolling.[71] One described the algorithm at work:

> **"If [you have] a baby that really doesn't sleep well, and you're scrolling at 2am and looking at The Sleep Fairy and sleep coaching, and XYZ accounts, you're just going to get fed more and more of that content. And I think it probably just gets more and more stressful and confusing.**[72]

Another was dismissive of what she saw: *"There is a lot of divisive content online, which is very shouty and uses shock tactics. And I just don't give that any credibility."*[73]

The distinction between active searching and passive scrolling matters because the content a parent encounters while scrolling is selected by the platform rather than by the parent. Social media is the least trusted source of all (19%) and the place parents most often say they meet misleading content (56%), yet 17% of parents, and 22% of 25-34-year-olds, use it for child health information.[74] It follows, as an inference rather than a direct finding, that content reaching parents in the scrolling moment is less likely to come from an official source.

The implication, developed in section 5, is that trusted sources need to be present in the passive moment as well as the active one, and in a form that fits it. Appetite for trusted content in newer formats, such as short video, expert reviewed content on parenting platforms and prompts at decision points, is modest overall but higher among the groups most exposed to misleading content. Short videos from healthcare professionals appeal to 10% of parents overall, but to 16% of AI users, 18% of social media users and 17% of parents from ethnic minority backgrounds. Trusted parent platforms carrying expert reviewed content appeal to 11% overall and 20% of 25-34-year-olds.[75, 76]

How can we address it?

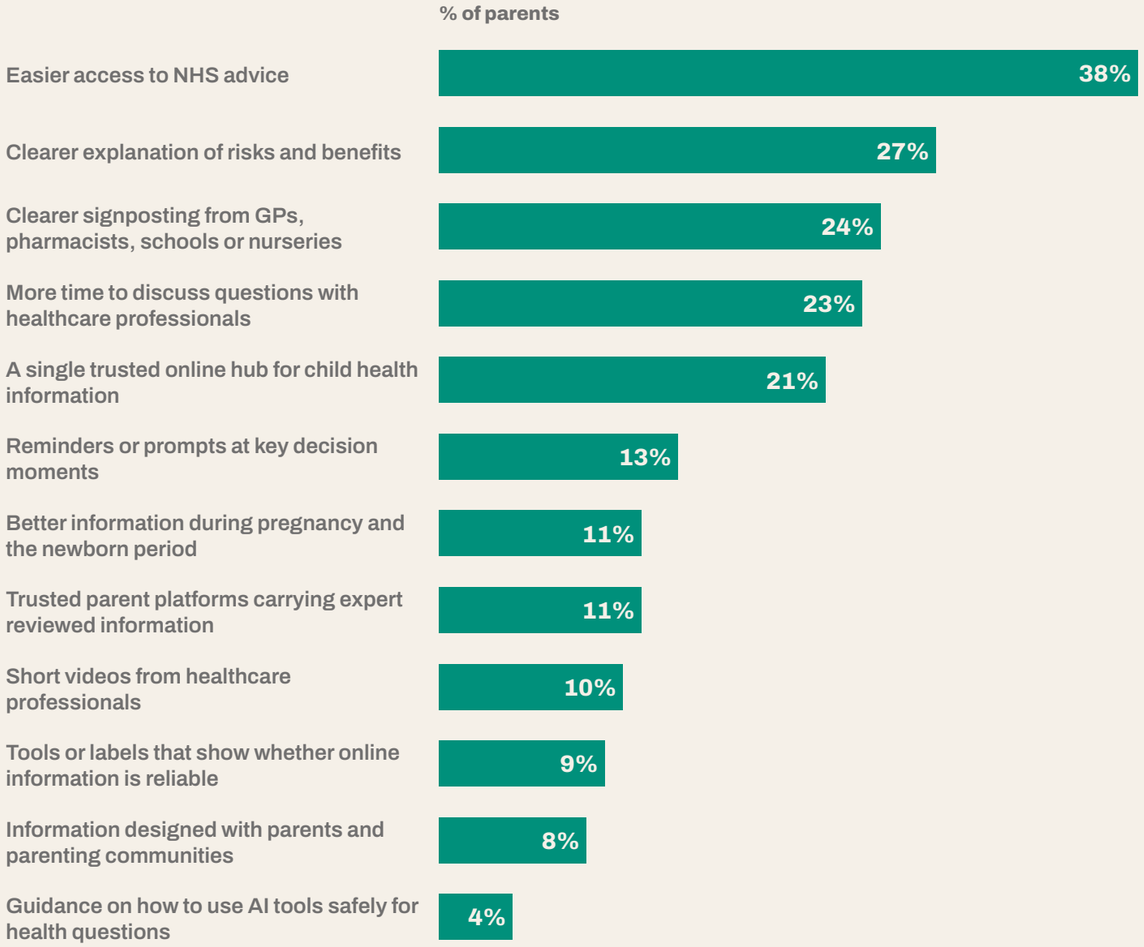
Trusted sources need to be present where and when parents are looking.



WHAT PARENTS SAY WOULD HELP

We asked parents what would most help them feel confident making decisions about their child's health. None of the top four answers is about content; they are about accessing a trusted person, and what happens when they do.[77]

WHAT WOULD MOST HELP PARENTS FEEL CONFIDENT MAKING DECISIONS



Source: Ipsos survey, Q20: Which of the following would most help you feel confident making decisions about your child's / children's health? Base: all parents (627). Multiple responses allowed. Table 78.

Read alongside the interviews, the data points to seven things parents need:

1. **Reassurance and resolution.** Reassurance is the main reason parents go online, and the need that official content is least designed to meet.[78] This is not a criticism of NHS content, which is written to help parents recognise when a child needs urgent care. But a parent asking, "is this normal?" who finds only an answer to "is this an emergency?" is left with an unresolved question and will take it somewhere else. The qualitative research found that parents' susceptibility to misinformation may rise when the motivation behind a search is not met by the source consulted.[79]
2. **Relatability alongside expertise.** Parents want a mix of information that threads relatability and expertise. A professional's recommendation makes information more trustworthy for 55% of parents and alignment with NHS guidance for 53%. Another parent's experience does the same for 17%.[80]
3. **Permission to ask, and to ask again,** without feeling they are wasting anyone's time. The 17% who held back from the NHS or 111, and the mothers who learned medical terminology before appointments in order to be listened to, both point to this need.[81, 82]
4. **Plain language and familiar prompts,** with some acknowledgement that the decision itself can be hard. 19% say information that is easy to understand is more trustworthy.[83] One mother described research that *"can be hard to read and not digestible. It uses jargon that nobody understands."*[84]
5. **Confidence in the decision making process** rather than certainty about the outcome. The mothers interviewed accepted that they would never be completely sure; what they wanted was to feel equipped.[85]
6. **A clear place to start.** 12% say where they go first depends on the issue,[86] and the gap between "not an emergency" and "worth an appointment" came up repeatedly as a source of anxiety: "Do I fill in the GP form, phone 111, or go to the chemist?"[87]
7. **Support in judging credibility online.** Parents are already trying to work this out for themselves, using a rough checklist of message, messenger, engagement, format and imagery, applied carefully when searching and loosely when scrolling.[88] The signals they rely on most are a professional's recommendation, alignment with NHS guidance, a reference to scientific evidence (28%) and the author's qualifications (23%).[89]

THE ANSWER IS TO BUILD TRUSTED PRESENCE

Our research shows that trust in the NHS and in healthcare professionals is high. What is missing is trusted presence in the moments when parents are seeking help. Those moments sit either side of clinical contact. They happen at night, at weekends, in the car outside nursery, and increasingly inside an AI answer or a WhatsApp group.

Trusted presence is not simply being findable when parents search. It means building familiarity with trusted expertise before the moment of uncertainty, being useful when that moment arrives, and remaining recognisable as information moves across the wider environment.

The research literature points the same way, though by a different route. Directly correcting a false belief has limited effect among people who hold it strongly. A growing body of evidence, drawing on inoculation theory, favours what the field calls prebunking: building resistance before exposure by helping people recognise the techniques of manipulation.[90] The Bad Vaxx game, which does this for vaccine misinformation, is the best known example.[91] Prebunking works best when it comes from a source people already trust, in a place they already spend time, at a moment when they are paying attention. The lesson is less that parents need training to spot falsehoods , and more that support to navigate a complex information environment has to come from the right source, in the right place, at the right time. In practical terms, that is a description of presence.

Public bodies cannot do this alone. **But nor can responsibility for intervention fall between organisations.** Too much of the current response relies on monitoring misinformation and reacting once it has gained traction. By then, misleading claims may already have travelled through the places parents spend time and begun to shape understanding and decisions.

The response therefore needs to shift from monitoring and correction alone towards anticipation: identifying moments of heightened information need, building familiarity with trusted guidance before misinformation takes hold, and being clearer about which organisations are responsible for acting.

The NHS, the Department of Health and Social Care (DHSC) and the UK Health Security Agency (UKHSA) cannot, and should not, be present in every private messaging group, AI answer or platform where parents scroll. But trusted information can be present there, if public bodies, platforms, AI developers, parenting communities, professional bodies and others are clearer about the role each can play in carrying it.

Nor is the field empty. Platforms and AI developers have begun to engage clinicians and to respond to criticism of their health content, but that work is being led from the technology side, is partial, and does not yet draw systematically on official health sources.[92, 93] **Building a trusted presence is therefore a shared task. Parenting platforms, professional bodies, charities, employers and companies with a stake in child health all reach parents in moments the state does not, and each can carry trusted information further and help build trusted presence.**

Principles for building trusted presence

Turning trusted information into trusted presence is a communications challenge as much as an information challenge. Accuracy is essential, but facts alone do not determine what people notice, remember or act on.

The principles below bring together the findings of this research with DETECT, Freuds' proprietary information integrity model, developed with leading academics and industry experts to understand vulnerable audiences, counter threats and identify opportunities to help ensure the truth travels. They apply that expertise to helping trusted information earn attention while retaining the credibility, nuance and authority that make it trustworthy.



1. Start with what matters to parents

The information people need, and the reason they need it, are not always the same. For parents, the underlying need may be reassurance, understanding a risk or knowing what to do next. Wanting reassurance quickly is the most common reason parents give for looking online.

Effective communication starts with that motivation. Stories, lived experience and creativity can connect evidence to situations parents recognise, making its relevance clear, without changing what it says. The evidence still leads, but the route into it should connect with the question, concern or experience that matters in the moment.

WHAT THIS MEANS IN PRACTICE: REASSURE FIRST

Official health information should answer "is this normal?", alongside "is this an emergency?". Red flags must remain prominent, but content should also help parents understand what they can reasonably expect, what they can do themselves and when they need to seek further help.

This matters particularly in moments of uncertainty, when information that feels clear in daylight may land differently at 2am with a crying baby. The aim is not to stop parents looking elsewhere, but to make sure trusted information has answered more of the question before they do.

Tangible actions:

- NHS.uk and NHS App pages for common childhood symptoms could set out what is normal and what to expect alongside red flags, as the existing NHS page on children's coughs and colds does.
- 111 online and out-of-hours services could be promoted as places to seek reassurance, not only urgent advice;
- Health visiting and community pharmacy teams could help answer "is this normal?" questions without an appointment.[94]

2. Make complex information easier to navigate

Parents are dealing with conflicting advice, changing recommendations and decisions that do not always have a single, certain answer. They value information that is evidenced and honest about uncertainty and can treat absolute claims as a warning sign.

Good communication helps parents find their way through that complexity. Clarity does not mean removing uncertainty; it means giving people enough context to understand what is known, what remains uncertain and what matters for the decision in front of them.

WHAT THIS MEANS IN PRACTICE: EXPLAIN SIGNIFICANT CHANGES

When guidance changes, trusted sources should make the change itself easy to understand, rather than simply replacing the old advice. Parents should be able to see what has changed, why it has changed and what, if anything, they need to do differently.

Where credible sources disagree, the role of trusted communication is not necessarily to provide a single definitive answer, but to help parents understand the difference and know what to look for when weighing the information in front of them.

Tangible actions:

- Changes to child health guidance should be accompanied by a short explanation of what has changed, why and what parents should do differently, distributed to the professionals parents meet (GPs, health visitors, midwives, pharmacists) as well as published online.
- Trusted sources should give parents simple cues for weighing conflicting information, rather than only correcting individual claims.[95]

3. Make credibility visible

Parents do not judge information on content alone. They look at who recommends it, whether it aligns with NHS guidance, the evidence behind it and the qualifications of the person responsible.

As health information moves further from its original source, those cues can become harder to see. Credibility therefore cannot be assumed from where information was first published; people need to be able to recognise why something is trustworthy wherever they encounter it.

WHAT THIS MEANS IN PRACTICE: SHOW THE SOURCE

Make the signals parents use to judge credibility explicit and easy to recognise. A parent encountering health information should be able to see who it comes from, the expertise behind it, how current it is and what evidence it draws on, without having to trace it back to the original source.

Tangible actions:

- NHS and professionally endorsed content would carry visible provenance (the author's role, the organisation, the date and the evidence base) in a form that survives beyond the original post.
- Health bodies could also publish structured, machine-readable guidance so AI tools can cite it accurately; and platforms and AI developers would surface that guidance, with its provenance visible, in the health answers they give parents.[96]

4. Bring authority and relatability together

Professional expertise remains the strongest source of trust and influence in this research. Parents also look to other parents and people with relevant experience for reassurance and recognition. These sources provide different forms of value and do not need to compete.

The strongest communications bring them together: expertise provides evidence, explanation and authority, while relatable voices, experiences and formats can help make that expertise feel relevant and human. The aim is not to replace professional authority, but to help it connect with parents through the people and experiences they recognise.

WHAT THIS MEANS IN PRACTICE: BUILD FAMILIARITY

Trusted information should become recognisable before the moment of need. Sufficient reach and repetition across the places parents encounter health information can build familiarity with credible sources, messages and cues before and when uncertainty arises.

This doesn't mean repeating the same execution. Core messages, sources and cues of credibility can remain consistent while the creative, voices and formats change around them.

Tangible actions:

- Build familiarity through consistent messages and trusted cues repeated across different channels, voices and formats.
- Pair professional expertise with relevant lived experience where it adds reassurance and recognition, while keeping the underlying guidance and source consistent.
- Plan communications proactively by anticipating moments of heightened information need, rather than relying on trusted information being found once uncertainty or misinformation has already taken hold.

5. Provide a clear next step

Information should leave parents better equipped, not simply better informed. The purpose of trusted information is not only to answer a question, but to help parents decide what to do with that answer.

A clear route forward can turn information into confidence and, where necessary, action. Success should therefore be judged not only by whether information was seen or understood, but by whether it helped parents make a better decision and act at the right time.

WHAT THIS MEANS IN PRACTICE: SIGNPOST CLEARLY

Many childhood health concerns are not emergencies but still need an answer, and parents are not always sure where to start. A quarter want clearer signposting from GPs, pharmacists, schools and nurseries, and the mothers described pathways that were too rigid for the problem in front of them.

Parents need a clear starting point and simple guidance on where to go next, whether that means waiting and monitoring, speaking to a pharmacist, contacting a GP or seeking more urgent support. The route should be easy to understand and consistent wherever parents encounter it.

Tangible actions:

- One consistent NHS guide to the common "is this worth an appointment?" problems, saying which service to use and when, repeated by schools, nurseries, pharmacies and parenting platforms so that parents meet the same answer wherever they look.[97, 98]

6. Design for how information travels

Health information rarely stays where it was first published. It is searched, shared, reposted, discussed in groups and increasingly summarised through AI. Parents may encounter the same information in very different contexts, often removed from the page, organisation or professional that originally produced it.

Trusted information therefore needs to be created with that journey in mind. The challenge is to make sure its meaning and essential guidance remain clear as it moves between different environments and formats.

WHAT THIS MEANS IN PRACTICE: DESIGN FOR THE CHANNEL

The same piece of health information will not necessarily work in the same way on an NHS page, in a short video, through a parenting platform, inside a messaging group or within an AI-generated answer. Format, language and creative expression should adapt to the environment, while the underlying guidance remains consistent.

This means thinking about distribution from the outset, rather than creating information for one destination and adapting it afterwards.

Tangible actions:

- Develop core health guidance in formats that can be readily adapted for short video, parenting platforms, social content and messaging environments.
- Create clear, shareable versions of trusted guidance that professionals, schools, nurseries, charities and parenting communities can use in the channels where they already reach parents.
- Consider how guidance will appear when surfaced or summarised by AI, rather than designing only for the original NHS or health body webpage.

Call to action and further research:

What public bodies, platforms and partners should do next, and the evidence still needed.



This research paper started with a simple question: is the effort to address misinformation about children's health winnable? The good news is that for most parents, most of the time, we think it is. The trust is there; what has to change is where and how trusted sources show up, so that they build a presence that equips and supports parents. The asks that follow are organised around that single question: how trusted expertise can become more present in the environments parents already use.

For the NHS, DHSC, UKHSA and other public bodies, treat the moments either side of clinical contact as part of the service. Build reassurance into NHS.uk and the NHS App alongside triage. Explain changes to guidance in plain terms as they occur. Make NHS content machine readable and clearly attributed so that AI tools surface it accurately. Best Start in Life already promises trusted information and support from pregnancy to age five.[99] The findings on the newborn period and on parents of under 5s suggest that promise should be specific about presence, format and channel, not only about content.

For platforms and AI developers - surface NHS and professionally recommended sources with visible provenance in health answers for parents, to work with health bodies on how changes in guidance propagate through their systems, and to support prebunking content in the formats parents actually consume.

For parenting platforms, charities and professional bodies - support the building of a trusted chain. Carry expert reviewed content where parents already gather. Give professionals short, shareable material. Make it easy for a health visitor, a pharmacist or a school nurse to hand a parent something they will recognise as credible.

For companies with a stake in child health - in consumer health, nutrition, digital health and technology, the evidence makes a case for engagement. These companies meet parents at exactly the moments this report describes. The ask is to adopt the six actions and to support the further research set out below.[100]

For regulators: keep pace with how child health information is promoted and distributed online. Ofcom and the ASA have different but complementary roles, from platform accountability and protecting children online to health claims in advertising and commercial influencer content. Existing regulatory levers should evolve alongside the formats, creators and technologies shaping what parents see.

FURTHER RESEARCH

Four pieces of research would take this agenda forward.

1. Map the user journey for child health: how parents prompt, interpret and act on AI answers, and how NHS content shows up inside them, distinguishing parents who meet AI passively in the summaries at the top of search results from those who actively ask a chatbot for a diagnosis or advice.
2. A longitudinal panel of first time parents followed through pregnancy and the first year, the window both the literature and this survey identify as most exposed. It would track which sources parents use at each decision point (the vaccination schedule, weaning, early sleep), where misleading content enters, and which forms of support (reassurance content, health visitor contact, peer platforms) change what they do.
3. Parents with low trust in institutions. The survey and the interviews reached few parents sceptical of the NHS itself, and the question of how the effort can be won cannot be answered without them.
4. A longitudinal behavioural study, for a funder such as the National Institute for Health and Care Research, linking information exposure to recorded immunisation uptake and service use, with a sample large enough to test differences by age of parent, age of child, ethnicity and information source, and testing whether a health information triage routine changes anything.

Alongside these, several groups deserve dedicated attention: parents from ethnic minority backgrounds, with community specific work on the higher reported rates of acting on misleading content and on the role of WhatsApp and community trust chains; fathers; and parents of children with long term conditions and parents in Wales, Scotland and Northern Ireland, where this survey's bases are too small to report.

Annex.

Methodology

Literature review: Future Health Research carried out a narrative literature review to map what is already known about child health misinformation and parents in March 2026.

- **Methodology note:** It started from a core set of studies and reports:
  - Hazards of Online Advice for Parents of Young Children: A Scoping Review from King's College London
  - Digital Misinformation/Disinformation and Children, a rapid analysis from UNICEF's Office of Global Insight and Policy
  - Fault Lines, the Council of Canadian Academies' expert panel report on the socioeconomic impacts of science and health misinformation
  - A 2025 commentary in The Lancet
  - UK Government publications
- Additional sources: Targeted searches of PubMed, Google Scholar, Oxford Academic, PMC and policy databases, covering 2018 to 2026 and favouring work published since the COVID-19 pandemic. The review also drew on Ofcom's Children and Parents: Media Use and Attitudes Report 2025 and the World Economic Forum's Global Risks Report 2025, as well as peer-reviewed research on why people believe and share misinformation and on what helps counter it.
- What was excluded: The review only covered sources published between 2018 and 2026. Within that window it gave most weight to work from 2020 onwards, because the COVID-19 pandemic changed how parents find and judge health information. International studies were included only where they offered theory, data or comparisons relevant to the UK.

Quantitative research: Ipsos interviewed 627 parents aged 16 to 75 in the UK with at least one child under 18 in the household, online, between 28 August and 1 September 2026. Data are weighted to be representative of UK parents. The full dataset can be found here.

- **Methodology note:** Differences cited in this report are significant at the 5% level unless stated and results for the full sample are subject to a margin of error of ±3.9 percentage points.
- Subgroups with unweighted bases under 30 are not reported. Base sizes for the groups cited: parents of under 5s 229, parents aged 25 to 34 190, social media users 113, AI users 212, ethnic minority backgrounds 104, white 512, women 330, men 294, C2DE 161, parents who have believed misleading information 210.

Qualitative research: Republic held ten in-depth interviews with mothers recruited via Netmums network, from across the UK. No fathers took part in the qualitative research: all of the parents who opted in to the in-depth interviews, recruited through Netmums, were mothers. Fathers are an area for further research.

- **Methodology note:** The sample is skewed towards parents who use online forums. Insights are indicative and are used to add depth to the survey findings. Quotations are anonymised and used with permission.
- Qualitative findings are used to add illustrative colour to the survey findings and are not representative.

Online Behaviour Mapping: Ipsos iris passive measurement of UK internet users aged 18 and over, August 2026.

Communications review: Freuds reviewed the communications and engagement landscape.

- **Methodology note:** The review was guided by DETECT. This is Freuds' own model for protecting information integrity, developed with leading academics and industry experts. It supports strategy and implementations of communications activity, from understanding audiences who are vulnerable to misinformation, to proactively and reactively countering threats and opportunities to ensure the truth travels.

Data considerations

Section Two: Data table, "Effect of child health information seen".

There are some limits to what the survey can say and should be stated wherever the figures are used:

- It asks parents to recall and attribute their own behaviour, and recall and social desirability affect responses in both directions.
- Some sub-bases are small: 113 social media users, 210 parents who believed misleading information, and roughly 25 parents who delayed a vaccination.
- The design is cross sectional, so it cannot show whether exposure to misleading content caused a behaviour or whether parents already inclined to that behaviour seek out content that supports it; the literature describes both directions.[101]
- The question wording captures any information, not misleading information specifically.

Section Three: The groups most exposed

- Parents from ethnic minority backgrounds are a broad group, spanning communities with very different histories and relationships with the health service, and the survey cannot distinguish greater exposure to misleading information from greater willingness to report it. What the data show is a pattern of information moving through closed channels, with this group reporting higher use of WhatsApp groups and of community leaders, which official sources rarely reach. It is presented as a signal that merits dedicated, community specific research.
- Parents aged 16 to 24 are an unweighted base of 25, too small for significance testing, so references to younger parents mean those aged 25 to 34. Ipsos iris data points in the same direction for the youngest parents, with 79% of parents aged 18 to 24 who use health websites or apps also using AI platforms, against 63% of all internet users.[102]

About the partners

Freuds is one of the UK's leading communications agencies, specialising in behaviour change, culture and social impact. Experts in its Health and Behaviour Change team led the partnership and developed the communications principles. These were informed by Freuds' proprietary DETECT methodology that combines narrative intelligence, behavioural science, audience insight and cultural fluency to identify emerging threats and opportunities, understand why they resonate, where they are travelling and when they are reaching a tipping point that demands action.

Future Health Research undertakes cutting edge public policy research, generating new insights and solutions. It seeks to shape the global healthcare policy debate and inform the decisions made by Governments and health systems to enable healthier and wealthier people, communities and nations.

Ipsos is a global leader in market research and public opinion polling. In healthcare, it is a global insight, evidence and advisory partner to the sector, working across the healthcare product lifecycle. Its health and social care research also supports government, the NHS and the wider public sector with evidence for policy and delivery. This study drew on that breadth of expertise, with agile quantitative fieldwork by Ipsos Observer and behavioural data from Ipsos iris, a privacy-first panel that passively measures real-world digital activity. Combining survey responses with observed online behaviour provided a robust evidence base for understanding exposure to and engagement with health information online.

Netmums is one of the UK's best-known parenting communities. Founded in 2000, it now welcomes millions of parents every month through its forum, expert content and local listings. Its founders were awarded OBEs for services to families.

Republic, Freuds' sister agency is an insight and strategy consultancy with a multilingual team, specialising in qualitative and quantitative methods, with a strong focus on analysis and storytelling. Together, they combine audience insight with communications expertise to understand what shapes attitudes and decisions, and how to turn that understanding into action.

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32. Republic, qualitative research for Freuds: ten in-depth conversations with mothers recruited via Netmums, UK, 2026. See the credibility checklist: parents cited absolute claims and miracle cures as red flags, and nuanced, evidenced content as a trust signal.

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