Caring Within Platform Capitalism: Community Health Workers' Perspectives on Social Media for Health Promotion and Advocacy

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Abstract

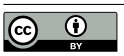
Community health workers (CHWs) play a key role in public health communication and outreach. With rising interest in social media for community health work and advocacy, we investigated its possible roles centering CHWs' perspectives. We conducted interviews and focus group discussions with CHWs and CHW allies in a southeastern U.S. state to understand how they currently use or envision using social media, and what informs their practices, views, and hesitations. While CHWs have limited activity posting online in an official capacity, we highlight how they do use social media in various other ways that are often less widely visible, attending to different phases of caring for their communities and caring with other CHWs. In so doing, they experience tensions between presenting a professional versus personal identity, and aspiring towards at-scale social marketing versus building up from local relationships. Our research contributes towards visibilizing a broader spectrum of social media use by community care workers, and making sense of the challenges they face online that parallel those in their broader work. We thus point towards alternative approaches to strategizing social media use and reimagining social media platforms that embrace pluralism and solidarity for caring within and across communities.

CCS Concepts

• **Human-centered computing** → **Empirical studies in HCI**; **Social media**; **Empirical studies in collaborative and social computing**.

Keywords

community health workers, care work, social media, public health



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1 Introduction

Despite the U.S.'s massive healthcare industry, the American public health system operates in its margins, chronically underfunded and stitched together across a web of public, non-profit, and private service providers [38]. In recent years, the COVID-19 pandemic brought newfound attention to this fragmented system and the importance of community-based outreach especially in historically marginalized communities. At the same time, the pandemic hastened the turn towards more digital communications including on social media for public health work, especially given concerns about the proliferation of health misinformation online [43]. Yet, researchers and practitioners question whether these often fragmented efforts to use social media manage to foster sufficient public engagement that reaches diverse communities in an equitable manner [41, 74].

Within this public health work and information ecosystem, community health workers (CHWs) play a key role in on-the-ground outreach and communication. A CHW is, as defined by American Public Health Association, a "frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served" and serves as a "liaison/link/intermediary between health/social services and the community" [3]. Various countries employ CHWs, with many large-scale CHW programs in the Global South tracing their histories to early post-colonial years in the 1960s and 70s [57]. In the U.S., which does not have a centralized national program, CHWs encompass a diverse set of workers with a range of job titles, roles, and employers. With the COVID-19 pandemic, there had been a wave of funding to support CHWs, recognizing their value in doing culturally sensitive community-based

outreach, and encouragement for CHWs to leverage social media. Yet, CHWs remain generally low-paid, precariously employed, and less publicly visible than other health workers. As such, in many states as well as nationally [52], CHWs have been organizing in order to strengthen and advocate for themselves as a workforce.

Researchers in human-computer interaction (HCI) have studied the design and use of technologies in supporting the work of CHWs and other frontline health workers globally, including messaging apps for health education and communication [31], computer-mediated peer support for workers [60], and social media as a platform for communication and organizing [28]. However, researchers have also demonstrated how technologies designed and deployed within ultimately neoliberal health systems can fail to support frontline workers, further invisibilizing, devaluing, and marginalizing their care work in the name of standardization and scale [31, 46, 61, 65]. In this paper, we investigate the place of social media—that is, large-scale commercial platforms for which public health actors are not a significant stakeholder—in the work of CHWs in the U.S. state of Georgia. We conducted interviews and focus group discussions with CHWs and CHW allies in the public health ecosystem to understand their perspectives on **how they currently (do or do not) use or envision using social media as related to their work**, and **what informs their goals, practices, and hesitations in using social media**.

We characterize CHWs' self-described actual and envisioned use of social media for promoting community health information and promoting community health workers themselves, using as an analytical framework the phases of caring introduced by Berenice Fisher and Joan Tronto [20] and expanded by Tronto [69]. While CHWs may have only peripheral involvement in posting health information on social media in an official capacity—which is what they mostly thought of first as active social media use "for work"—we highlight how they are actually using social media in various other ways that are often less widely visible, attending to different phases of care for their communities and caring with other CHWs. In so doing, they experience challenges and tensions between maintaining a professional versus personal presentation, and aspiring towards at-scale social marketing while building up from local grassroots relationships, paralleling tensions in their broader work and advocacy as CHWs. Our research contributes towards visibilizing a broader spectrum of social media use by community care workers, and making sense of the challenges they face within the context of neoliberalism in the public health system and digital platforms. We thus point towards alternative approaches to strategizing and evaluating social media use and reimagining social media systems that embrace pluralism and solidarity for caring within and across communities.

2 Related Work

2.1 Care and Professional Community-Based Work

Feminist scholars Berenice Fisher and Joan Tronto define caring at a high level as "a species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web" [20]. They further lay out four phases of the caring process, along with their associated ethical qualities:

(1) Caring about – attentiveness: paying attention to what needs care and selecting what we choose to attend to;
(2) Taking care of – responsibility: assuming responsibility to care for something and finding the resources to do so;
(3) Care giving – competence: doing the "hands-on" work of maintenance and repair; and
(4) Care receiving – responsiveness: responding with feedback to care received from the caregiver.

Tronto, in her work on caring democracy, added a fifth phase of care [69]:

(5) Caring with – plurality, communication, trust and respect; solidarity: caring for each other and valuing care in democratic society in a manner that upholds justice and equity.

We thus understand the work of CHWs as caring for the wellbeing of communities, encompassing aspects beyond clinical healthcare that also include caring for the various social determinants of health that impact community members. HCI researchers have used this framework of the phases and ethic of care to examine the work of other actors including grassroots neighborhood activists [42], aged care home staff [78], an immigrant-serving municipal organization [7], and Latino house-cleaners [58].

Fisher and Tronto also trace a historical trend of the professionalization of care work, with care provision moving out of the private sphere of the home and into the public sphere of the marketplace and bureaucracies [20]. While they point out how having a professional status can help care workers cut through red tape and hierarchies, it simultaneously reinforces unequal hierarchies within carers that marginalize supposed "low-skill" workers like CHWs. In their study of technology-mediated peer support for home care workers in the U.S., Poon et al. showed how the workers came together to provide peer emotional support and to build a collective professional identity as skilled practitioners, yet feared over-sharing information related to patient care that could endanger their jobs [59]. Sociologist Allison Pugh also identifies how neoliberalism exerts pressures on professional care work "in the private sector with the goal of extracting profit [and] in the public sector with the goal of managing austerity," ultimately resulting in lesser time, resources, and emotional bandwidth to provide high-quality human connection [61]—issues relevant to CHWs who in the U.S. are employed across public, non-profit, and private sectors. In the context of a community health system in the U.S. facing such structural socioeconomic and political challenges, Kaziunas et al. characterize the significant labor required to maintain technological interventions to support ecologies of care [33].

While a capitalistic, market-based approach to efficiency and scale is in many ways at odds with providing quality care, Fisher and Tronto warn against imagining the private middle-class home or self-contained community as the idyllic site of care work [20], which Helms and Fernaeus also echo in their problematizing of domestic care technologies [26]. Instead, Tronto calls for a whole-of-society valuing and arranging for the provision of care that moves past the private/public division of spheres—what she terms a caring democracy [69]. In such a society, care work is valued, and

all citizens recognize their own needs for care, are able to care well for themselves, and exercise their right to care for what is dear to them. We examine here how CHWs use social media to connect with community members, other social sector professionals, and other CHWs, providing community care while also receiving care with promoting CHWs as a workforce.

2.2 CHWs and Technology Design and Use

Computing researchers as well as public health researchers and practitioners have long engaged CHWs to conduct technology-based interventions to improve community health [9], largely in the Global South across South Asia, Africa, and Latin America. Earlier research looked especially at mobile health (mHealth) interventions, such as digital media-based health education [48, 49, 73] and mobile data collection [55]. Researchers have emphasized the importance of substantively engaging CHWs in the study and participatory design of these technologies [19, 49], with much recent work centering CHWs' perspectives in the understanding and design of AI systems [29, 30, 53, 54, 67]. In this paper, we look at American CHWs' health communication and outreach work, and what it means to center CHWs' perspectives in the use of commercial social media platforms that they have little agency in shaping the design of compared to custom-built applications.

HCI researchers have also recognized how implementation of technological systems can result in the overburdening and further marginalization of CHWs, questioning the extent to which technologies intended to optimize efficiency actually prioritize frontline workers as stakeholders [30]. Karusala et al.'s study of a patient education program delivered through WhatsApp mobile messaging described the overburdening of medical support workers operating within inequitable health systems [31], drawing on feminist scholar Murphy's concept of unsettling care work in the context of hegemonic structures [51]. Researchers have also studied how technologies for tracking and compensating frontline health labor can serve to render their work invisible and thus underpaid [46, 47] or entangle them in uncaring bureaucratic systems [65]. Much of this work can be seen through the lens of considering the challenges of designing pro-labor technologies within the context of capitalism, as elaborated by Wolf et al. [79]. Our study examines how the challenges and tensions CHWs experience in using social media are shaped not only by the structure of a neoliberalized public health ecosystem, but also by capitalistic social media platforms and dominant narratives of proper and effective use.

To mitigate these challenges in technology deployment while addressing deeper-seated issues, researchers have examined how frontline workers can draw on their intersectional identities and community resources for empowerment and resiliency [28, 32]. Researchers have also explored technologies that directly support frontline health workers as a workforce, for example for skills training [80], to facilitate collective action [45], and for peer support and collective identity building [60]. Our study considers CHWs' leveraging of social media platforms to also form a collective identity as CHWs and engage in peer learning and support.

2.3 Social Media Use for Community Advocacy

Enthusiasm for using social media for health communication has taken off in public health research and practice, especially with the COVID-19 pandemic and persisting spread of health misinformation online [39, 43]. Researchers have studied social media use by government agencies [25, 77], community-based organizations [63], community leaders including CHWs [14], and scientists [1] to promote public health messages. Of particular interest has been having individuals become social media "influencers" for health [6, 22, 44], including providing training and support for them [2, 50]. HCI and social computing researchers have studied how popular social media influencers often cultivate a parasocial sense of closeness with followers to increase their appeal [15, 24], usually for financial gain, though sometimes also for more personal or altruistic goals [81]. Such purported influencers for good can be seen as practicing social marketing, or "the use of marketing to design and implement programs to promote socially beneficial behavior change" [23]. Social marketing has been widely popular in public health practice (including before social media), though has also attracted critique for its "narrow focus on individual behavior change and the potentially manipulative techniques" [11].

HCI and social computing researchers have considered alternative approaches to using social media for community-based health communication and other social action. Individuals may build and leverage bonding and bridging social capital [34] across both online and offline spaces to influence the thinking and actions of those in their communities, though may face tensions being in these interstitial roles. Studies have examined how various situated community-based actors leverage their positions to address online misinformation with those close to them, including community health workers and leaders [68, 72] and young adults [13, 56]. Beyond health promotion, researchers have studied social media use for other community-based organizing and advocacy, and the tensions in doing bridging work between community-based organizations and the public [27, 76]. HCI researchers have also studied social media in building distributed social movements, such the formation of collective identity by sharing and interacting with personal stories about gender-based harassment [35] and other diverse issues in social activism on TikTok [36], and the management of collectives by social movement organizations coordinating diverse coalitions [37]. Our study considers CHWs as advocates both for their communities and for the CHW workforce, and examines how they use social media in this advocacy.

3 Method

3.1 Study Setting and Background

Our study was conducted as part of the broader research agenda of a community-engaged research coalition to address health disparities in the southeastern U.S. state of Georgia, with an initial focus on addressing COVID-19 vaccine hesitancy in Black and Latinx/Hispanic communities. Convened in 2020 by a historically Black medical school, with the third author as principal investigator, the coalition includes academic researchers across several disciplines, including the first and last authors who are computing researchers; community health educators including the second author; and representatives of various community partners including local public

health agencies, community health centers, and community-based organizations.

Recognizing the community outreach needed to boost COVID-19 vaccine confidence and uptake, our coalition's work has involved engaging and empowering CHWs across the state. Indeed, many public health efforts across the U.S. engaged CHWs during the pandemic, with over $500 million of federal funding put towards employing and training CHWs [70, 71]. Despite the demonstrated benefit of CHWs in addressing ongoing health needs especially in marginalized communities, this pandemic funding has begun to wane [5], galvanizing efforts nationwide to advocate for the CHW workforce. In Georgia, various CHW initiatives have existed for over two decades, driven by the state public health department along with other organizations working in community health across the state [40]. Most recently, the Georgia CHW Advocacy Coalition was established in 2018, led by an advocacy non-profit and bringing together representatives of various partner organizations; and in 2021 the Georgia CHW Network launched to be a professional network constituted and led by CHWs [21]. Recent advocacy efforts in Georgia have included advocating for state legislation to standardize a CHW definition and certification process in the state, which would allow for employers to reimburse CHWs' services through health insurance providers and thus provide a more stable source of funding [4]. The second author is a member of the CHW Advocacy Coalition, and the first author (starting in 2023) and second author have attended events held by the state CHW Network and the CHW Advocacy Coalition to observe and engage in these conversations.

In light of COVID-19 misinformation spread on social media, as well as the turn towards digital communications with physical distancing during the pandemic, our research coalition has also investigated the role of social media and social computing tools in health communication efforts [13]. To begin exploring this topic with CHWs, the first and second authors co-led two interactive webinars for CHWs with other coalition members in August 2023 on social media and misinformation, and in December 2023 on social media and advocacy.

3.2 Participants and Data Collection

Our study protocol was approved by the research coalition lead institution's institutional review board. We conducted 10 semi-structured individual key informant interviews with experienced CHWs and (non-CHW) allies, and 4 focus group discussions with 32 total CHWs currently working in the state. Both the interviews and focus groups discussed participants' current work as or with CHWs, current or potential use (or non-use) of social media as related to their work or community health more broadly, and their attitudes towards social media as CHWs and personally as individuals. Interviews were conducted in February-April 2024 by the first author, and lasted approximately 1 hour. Focus group discussions were held in late March 2024 and led by the first author and co-facilitated by the second author, with another research coalition member aiding with notetaking and technical support, and lasted approximately 1.5 hours. All sessions were conducted and recorded using Zoom video conferencing. A brief online survey to collect self-reported demographics was sent to participants after each session. Participants were compensated with $50 in gift cards.

Across both interview and focus group participants, CHWs and allies worked at a variety of organizations, including community health centers, county and state health agencies, hospitals, community-based organizations, and academic medical schools. Interview participants (Table 1) were recruited through the authors' networks including the research coalition, relationships the first author built through the above described activities, and the second author's connections from her decades-long involvement in CHW training efforts in the state. Interviewees were purposively sampled to gather perspectives from knowledgeable individuals at different vantage points in the community health ecosystem with respect to CHWs, and included people who work as CHW employers, supervisors, and educators or are otherwise involved in CHW-related policy and advocacy work. All interview participants were women, with seven Black women, one Hispanic woman, and two non-Hispanic white women; and had a median of 8.5 years working as or with CHWs (as self-defined), though they each had years if not decades of experience doing other health- or community-related paid or volunteer work.

Focus group participants (Table 2) were recruited from webinar participants, CHW network email listservs, and snowball sampling as participants were encouraged to share about the study with others in their own networks. We sought to recruit a diversity of CHWs across the state in terms of personal background, community context, and professional situation. 28 focus group participants were women and four men, and most were Black with one Hispanic, one white, and three South Asian participants. Most primarily served urban communities (including a major metropolitan area and other smaller cities), three served rural communities, and seven focused on refugee and immigrant communities. Their years of experience working as a CHW ranged from several months to 18 years (median of 3 years), though several had prior experience working in health-related fields or doing other community-based work.

3.3 Analysis

All sessions were video recorded, with transcripts generated automatically by Zoom and manually corrected by the first author while relistening to session recordings. Coding and qualitative analysis was led by the first author, using a grounded approach of inductive reflexive thematic analysis [10]. Codes generated in a first round of open coding identified different uses of social media as described by participants, such as "sharing health-related information" and "following other health organizations." Overlapping *in vivo* codes also attended to the language participants used to describe particular qualities of their work and social media use, such as "the numbers" of social media engagement metrics or having a "go where they are" approach to community outreach. Further iteration involved discussing initial analyses with the other authors, and renaming and rearranging codes into groups that highlighted contrasting narratives around CHWs' work and different purposes for social media use, such as "professional vs. personal identity as a CHW," and "social marketing of health" and "health promotion as community organizing." Finally, codes that described processes of CHW work or social media use were revisited using the lens of Fisher and Tronto's theory of care, regrouping them to identify different phases of care being done for the communities and for CHWs.

Table 1: Interview Participants

Interview Participant	Position	Communities Served	Years of Experience as/with CHWs
PI-1	CHW, CHW supervisor	Rural	5
PI-2	Health advocacy	Statewide	3
PI-3	Health administration, CHW supervisor	Urban	13
PI-4	CHW, CHW Network leadership	Urban	9
PI-5	Health administration	Statewide	10
PI-6	CHW, CHW Network leadership	Urban	2
PI-7	CHW, health administration, CHW Network leadership	Urban	7
PI-8	CHW trainer	Urban	10
PI-9	CHW, CHW trainer, CHW Network leadership	Statewide	16
PI-10	Health administration, CHW supervisor	Statewide	8

Table 2: CHW Focus Group Composition. Though not listed individually here, focus group participants will be identified in the paper with their focus group letter followed by a number, e.g. FG-A1.

Focus Group	Number of Participants	Gender	Communities Served	Years of Experience as a CHW (median)	
FG-A	6	5 F, 1 M	Urban	2-8	(6)
FG-B	8	7 F, 1 M	Urban, refugee/immigrant, rural	0.5-18	(2)
FG-C	8	8 F	Urban, refugee/immigrant	0.5-10	(3)
FG-D	10	8 F, 2 M	Urban, refugee/immigrant, rural	0.5-8	(2)

3.4 Positionality

In conducting this study, we recognize how our positionalities influence our perspectives and interpretations. Of the four authors, three identify as women of color and one as a white man. All of us have extensive experience in conducting community-engaged research, two with decades of work in preventive health research and education in the state, and two on technology design and use in public health and other socially-oriented sectors in the U.S. and in the Global South. In engaging with workers who are themselves from and serve marginalized communities, we acknowledge the responsibility of researchers to recognize the power dynamics both within the particular research engagement as well as the broader social context of the research, and strive to center CHWs' perspectives in this study. Though none of the authors on this paper have worked as CHWs, our broader research coalition engages CHWs as both community coalition board members directing our overall research goals and as health educators conducting some of the coalition's interventions, and we continue to engage CHWs in the translation of these findings for the coalition and for a broader audience in public health research and practice.

4 Findings

Much of the interest in social media for CHWs is driven by the belief that *"social media is very, very effective in our type of work that we do, because you can help and spread news and also educate people"* (FG-D6)—that is, as a large part of CHWs' work is about direct community outreach and communication, it makes sense to leverage social media platforms as another means of reaching more people. This is all the more so given the importance that participants ascribed to social media in the modern-day information landscape:

> *"Well, this is the [air quotes] 'era of social media.' And I think we need to take advantage of it, because seem like to me, everything is about social media. I mean, you got TikTok, there is Instagram, there's all these different platforms. And why not utilize it? Because that's what they're into these days. Followers, likes."* (FG-B1)

Yet, many CHWs and allies, even those who more actively used social media, felt that they did not see as many CHWs promoting health information online as they would hope for—something we also consistently heard earlier at different CHW-related events and our webinars, which partly motivated this study. Our findings delve into why some CHWs might not be as visibly active on social media, as well as ways in which they already are, even if they may not immediately consider it as using social media "for work" as a CHW. We detail how CHWs and allies use and envision using social media for two related purposes: caring for the health and wellbeing of their communities, through finding and sharing information about health issues and resources to community members; and caring with other CHWs, through visibilizing CHWs in the community health ecosystem and peer connecting.

4.1 Caring for Community Health Online

4.1.1 Engaging Peripherally with Formal Communications. When we asked CHWs and CHW allies how they used social media "for work," often this was interpreted as whether or not they regularly posted content on social media platforms in their formal capacity as CHWs (or CHW allies) employed with their organizations—which

most of them said they did not do. Specifically, most of them did not post content on their organizations' official websites and social media pages, which shared information about their health programming and resources available. Typically, these official accounts are managed by the organization's marketing or communications team, or for smaller organizations, their one communications person or an external consultant—that is, marketing and organization communications were treated as a distinct function from the community outreach and health communication work of CHWs. These specialized professionals were responsible for maintaining the organizations' online presence and making the social media content attractively polished and on brand. One participant, the director of a unit of the state's Department of Public Health (DPH), described their communications team's objective to *"make sure that it meets DPH's standards and is representing DPH in the most positive light"* (PI-10).

While they mostly did not directly manage their organizations' social media posting, some CHW participants contributed in the hands-on offline work of collecting, adapting, and distributing content. One participant who recently started working as a CHW at a community health center shared that *"I personally work hand in hand with the marketing department. So I get brochures from them, and then I also take the pictures or make a flyer and hand it off to them"* (FG-C4). As a CHW, she plays a key role in the creation of these materials such as by taking pictures when doing on-the-ground work, and in actually getting the marketing department's content to community members. Some CHWs adapted materials for their communities: for example, a Latina CHW working at a community-based organization serving various refugee and immigrant communities estimated that she and her colleagues spoke a total of 23 languages, and would collectively *"do the translation for each flyer [which] is important for the community"* (FG-D2).

Other participants did not see themselves as being relevant or able to contribute to their organization's official communications work. An older CHW, who had also been with her organization for two decades in other roles, quipped when asked about her organization's social media use, *"Honey, I am not on that team. But I can tell you, that's a team of younger employees that do that"* (PI-1)—belying a sense that she felt apart from those operations run by who she perceived as social-media-savvier younger people, despite her deep experience with the organization. Another experienced CHW now working in an administrative position described the competencies she felt CHWs often lacked for this type of communication:

> *"Professional communication is a skill, right? [. . .] What I found is that you have community health workers who are really great at communicating with their community members. They know the language, they speak the language. But when it comes to doing professional writing and communication, it may not always be as strong. [. . .] So the feedback that I would receive sometimes is that, Oh, let's make sure we proofread it so that we make sure that there's no grammatical errors, or that it aligns with the organization's branding."* (PI-7)

For social media in particular, there were other tasks that she saw as necessary, such as being *"able to curate a social media calendar"* for scheduled posts and *"get things in Canva,"* a popular online graphic design platform that "makes it easy to create professional designs" [12]. While she proactively developed these skills over time, these were things that many CHWs may not know how to do, or have the time to do given their many responsibilities.

Some CHWs and allies faced more formal institutional barriers to posting on social media in their official capacities. Notably, those working at government agencies had stricter policies, such as requiring approval of content from the communications team for posts on agency accounts and not being allowed to post to personal accounts about their official work. Even lacking formal policies, some CHWs nonetheless felt it more appropriate to defer to their organizations' accounts to represent the work they do, such as one CHW who worked especially with young immigrants:

> *"Well, personally, I seldom make posts about my organization. [. . .] So what I simply do is direct them to the social media handles of the organization [. . .]. When you give them your own personal one, they might think that you're probably just making things up, you know, since it's yours. But, when you have our verified social media handles with a blue tick and all, you're able to trust us, and you feel that yeah, this is something credible."* (FG-D9)

These various factors contributed to CHWs being relatively marginalized from or less visible in their organizations' formal social media communications. However, many still engaged with their organizations' social media accounts more peripherally. As discussed more in the next section, many CHWs followed their organizations' accounts in order to reshare relevant information from there with others. Several CHWs also paid attention to the public responses to content on their organizations' accounts, such as one participant who said that *"I'm not the one handling it [...] But I make sure I tend to look at content that is posted from time to time, go through comments, and [...] engagement on the comment section"* (FG-D8). In these ways, CHWs contributed to or leveraged official organizational social media accounts not just to provide information to community members, but also pay attention to engagement with the information provided to be more responsive to their concerns.

4.1.2 Finding and Sharing Information Online in Alternative Capacities. CHWs also discussed being or wanting to be on social media moreso in a personal capacity to promote community health-related information and engage directly with community members. Sometimes, these activities blurred the line or otherwise drew a tension between their professional and personal spheres and identities. Some, though, saw their social media activity as part of a more holistic identity of being community health advocates that encompassed and went beyond their formal roles as employed CHWs.

Some CHWs discussed sharing health-related resources from their organizations' to their personal social media accounts, so that friends and family following them on social media could benefit from the information. Often, this meant just directly re-posting content from their organization's social media page, for ease and convenience. On the other hand, one CHW, a younger Black woman working at a community health center, described how she reframed such content to make it a more personal message:

> *"I don't necessarily share my organization's— Well, it's true, and it's kinda not true. Like, if we're having an event, I will post it on my story and be like, 'This is why I love my job' type of thing. […] Like, 'catch me at a health fair!' But it's not as professional as it would be on our social media. It's a little bit more like inviting your friends [than] like, inviting the masses. But either way, I'm trying to get engagement and pull people out to come. I really want my age range to come."* (FG-C4)

For her, posting about her organization's activities served several purposes: sharing about an event that would provide health services and resources for the community, celebrating the CHW work she does as a part of her life, and doing her part to encourage younger people to take care of their health (having usually an older clientele).

Participants also shared other health-related information that they found from other sources on social media. This included information about health issues and how to take care of them, such as blood pressure management tips (FG-B5) or articles about mental health (FG-C1), and sharing about other social services, like free grocery provision by other organizations in town (FG-A1), reflecting their interest in promoting community health and wellness beyond clinical physical health. Even if they did not post much content themselves, many participants said they kept abreast of community-health related content on social media for their own knowledge and so that they could share up-to-date and relevant information with their clients or community members off social media. PI-8 further described how she took advantage of the platforms' suggestions to find CHW-related content and accounts to follow, as *"I feel that, you know, the algorithm does sense if you repeatedly like particular types of posts"* (PI-8).

Three of the participants who said they were very active in using social media for health-related purposes were CHWs who owned their own health-related businesses or non-profits—an uncommon though interesting case to consider. One participant who worked as a CHW specializing in care for chronic health conditions for a community-based non-profit health provider also ran her own business as a certified fitness nutritionist, and discussed how she used her multiple social media accounts to post health-related information:

> *"When I share, I'm sharing as a community health worker from my personal social media accounts, but I'm also sharing it as a business owner of a non-profit from my business account as well, so that those community members on both sides are getting that information. […] Clients that see me within my personal business can get those benefits as well as sharing that information along with their family and friends."* (FG-A1)

In contrast, another CHW in the same focus group who also ran his own non-profit organization said that he did not make this same distinction of keeping a separate work-related account because he was *"doing it from the heart"* in starting his own non-profit, though added *"if I was working for another non-profit organization, it would be separate"* (FG-A3).

4.1.3 Caring for the Information Ecosystem: Being an At-Large Health Influencer? Much of the CHW participants' interest in sharing community health information was focused on those who they felt an immediate responsibility towards: their own friends and family, clients, and the communities they served. However, they also felt a sense of responsibility towards the broader health information ecosystem. When we asked participants what concerns they had about social media overall, by far the top concern was misinformation and the real health consequences of it. Participants discussed misinformation related to COVID-19 as well as other health issues, such as one CHW focusing on maternal health sharing that *"I see and hear a lot of things on social media with regards to pregnancy and what I do, and this and that, and take this and take that. I'm just like, whoa"* (FG-A2). More broadly, they were concerned about feeling overwhelmed and without confidence in the credibility of information online, hearing from community members and feeling themselves sometimes that *"we really don't know what kind of information to believe"* (FG-B3).

Several participants were especially frustrated that some individuals on social media with huge followings but little health expertise would spread misinformation indiscriminately, questioning *"what is their background?"* (FG-A1) and their shallow motivations:

> *"I feel like now when you go on there, it's more like everybody's selling something. Everybody's an expert in this, and everybody has their own podcast […]. So you do have people that may not be the most—like we are—educated in these fields. But people are really chiming in and listening to them, and really taking their advice because they're popular, they're entertaining, they may look a certain way, I don't know."* (FG-A2)

These participants described a kind of monetized social media influencer: people they felt did not share the same sense of responsibility towards community health nor have the same competence and credibility as CHWs, yet succeeded in attracting attention for their own gain.

In response, several participants shared a desire *"to learn more and educate people on social media that has a misunderstanding concerning certain health topics"* (FG-D6). FG-C in particular enthusiastically discussed the idea of being credible *"health influencers"*: that *"we need somebody who truly knows what they're talking about, health-wise"* (FG-C4) and can rise to the scale of impact of an influencer:

> *"Influencers are very impactful. Their following can range in the thousands, if not millions. […] Having someone saying, you know, that you should have this [health] screening or that screening […]—[that] would definitely be impactful, to masses."* (FG-C8)

FG-C8 also referenced influencers' *"ability to market,"* the kind of skills that another participant elaborated on, saying *"when you follow people on TikTok, they have this stuff down to a science. It's like it's already programmed. […] Every day, they have different times of the day they're posting. You could tell it's already put together"* (FG-C3).

However, putting in this effort to maintain a social media presence akin to an influencer—comparable to what participants described for formal organizational marketing—seemed daunting to

participants. Some CHWs and allies emphasized for example that *"it can be challenging to build a big enough following so that it's impactful, and that you get engagement"* (PI-7), and that they would need *"training to understand what type of mode [...] needs to be for that particular population, like, how do they need to post?"* (PI-8)

Given these anticipated challenges, CHWs expressed a certain nervousness even with their enthusiasm:

> *"I'm a little shy. So being on social media, like, mm [sounding skeptical]. But being a health influencer, yes. 'Cause I mean, that's why I went into public health, was to be an influencer, to be a changer. So, yeah. I mean if it takes social media to be able to do that, I'm all for it."* (FG-C2)

Another participant painted a more vivid image of the risks she saw of being an influencer and what you would have to do to mitigate them:

> *"It is a downside now to being an influencer, because people deep dive on you. [...] If you're posting other things of you going out and actually having a personal life, you would have to make it like a finsta. [...] Just kind of separating your life and kind of being a split person. Because when you influence people, they wanna make sure you're walking what you say. [...] You can't be [...] always eating out, and you're eating very unhealthy, but you're in a partnership with the American Heart Association."* (FG-C4)

While this illustrated a heavier-handed approach of separating profiles on social media (with FG-C4 defining a "finsta" as *"a fake Insta that only your friends and family follow"*), it echoed apprehensions that other CHWs also voiced regarding receiving backlash or mockery for sharing health information on their personal social media. Several CHWs also noted being discouraged by what they saw as the negative and *"combative"* (PI-4) nature of social media, like seeing *"derogatory and malicious remarks"* in comments for popular pages (FG-C8). Some thus chose to distance themselves from social media on the whole, with one participant sharing that *"I kinda stepped away from it just because I do believe there are benefits to social media, but oftentimes I feel like I get sucked into the toxicity of it"* (FG-B3). That is, while not quite the same as maintaining work-life separation as a professional, these participants felt that becoming an "influencer" would require some separation between private and public presentation—or else, choosing to step away from the particular public sphere of market-driven social media.

4.1.4 Caring for More: Being a Full-Time Community Advocate. While participants were apprehensive about how using social media as a "health influencer" could become overwhelming, intruding into private personal life in an undesirable way, they also shared how *"especially with community health work, [...] I'm so much more out there, just doing more things that put me out there"* (PI-6). One experienced CHW, who actually used social media very little due to privacy concerns, shared how this manifested for her:

> *"When you become a community health worker, [...] it's sorta hard to break away from that role, if you will. Because once someone asks you about a resource or whichever, you're back into that role. [...] Being a community health worker, you jump right back into, you know... that mindset. But you know how to—well, you should know how—to bring it back to reality. [...] It's not just work, but we offer ourselves as well."* (FG-B7)

Here, she describes a deep sense of responsibility for caring for her community, one that extended past her formal work responsibilities. However, she was also conscientious about not overextending herself, not so much out of concern for professional bounds or privacy, but rather to sustain and care for herself in order to care for others.

Many CHWs voiced that having a passion to serve their communities was a primary motivation for both their formal work as CHWs, as well as other community caring they did beyond it. One participant who was part of the CHW Network leadership team shared her personal story, as a white woman who moved to the state years ago, and motivation to be an outspoken community advocate on social media:

> *"My personal thing became a platform. For example, what happened to my son? In a corrupt, racist town. Okay? My son was African American. And so, just the things that I went through through the judicial system, were things that I was able to utilize on social media, to make people aware, to draw attention."* (PI-9)

While she acknowledged the difficulty that she *"had to go through all that severe loss,"* she chose to frame it as how *"my path is what God—what my higher power I choose to call, had for me. [...] And it's just about giving hope. But you gotta know what to share, and when to share"* (PI-9).

While this perhaps seems less ambitious in scale than the idea of being an influencer, they believed their position in their communities and the trust others placed in them would help with their reach, with one CHW for example sharing how *"I have some community leaders on my group, so they can see the information, and they can share on the different groups"* (FG-D2).

4.1.5 Evaluating Reach and Response on Social Media. Part of the attraction to participants of using social media to spread information was its promise of speed, scale, and prominence. As such, participants often referred to wanting higher quantitative metrics of "engagement"—*"the numbers"* (PI-3)—like the number of followers on an account, or likes and clicks on a post, especially for their organizations' formal social media accounts (even though they mostly were not involved in monitoring these metrics). Some participants lamented that very few posts of theirs would ever have very high engagement numbers. However, some also shared instances of pleasant surprise when they learned even posts with seemingly low online metrics could have real impact, for example:

> *"I didn't realize that I was even making any type of impact until after once the COVID restrictions had started to be lifted, then we all started getting out and socializing [...] and people would come up to me. Some of my friends on Facebook would say, my husband got the vaccine because of you."* (PI-5)

PI-5 did not realize the impact that she had had, as her message-recipients had not visibly responded to her on social media, though she later learned in person that they did indeed respond positively to her post by taking positive health action. Ultimately, CHWs' and

allies' goals for communication were not to rack up views for the sake of it, but rather to improve health in their communities. PI-10, the state public health official, articulated her distinction between marketing, to get out the message of *"come and buy something"* where *"we may highlight a program, but we don't give you resources afterwards,"* and their approach of health communication:

> *"Every time we do something, we have to have a call to action, right? [...] Whatever we do, there has to be somewhere to link them back to for services. Even if they don't come to the workshop, or the class, or for more information, there has to be something to link them to a resource. So I definitely will say, from my lens, it's definitely a heavy base [of] health communication, [as] opposed to a marketing campaign."* (PI-10)

However, participants also noted ways in which they thought social media was limited in how it could reach their populations of interest—after all, *"not everybody is on social media, so [...] most of the content we post on social media will not get to everyone"* (FG-D8). Participants pointed to barriers related to discomfort with using social media, which they associated mostly with older age. One CHW who worked with older adults noted that *"most of my seniors have no clue how to even do Facebook, Instagram, Twitter. They have enough problems just trying to log in on their phone for Internet service"* (FG-D1). Another CHW who worked with refugee and immigrant communities also noted that she *"kind of stepped back from using it [social media], just because it wasn't working out for my community. They preferred more direct kind of contact through WhatsApp or, you know, texting, calling"* (FG-B3). Participants also brought up issues with people not having broadband or otherwise regular internet access. PI-1, who covered patients across a large rural region, did not consider social media as relevant for reaching her clients, and described how poor connectivity affected especially *"the lower socioeconomic patients, you know, they might have the phones, but when their minutes are out that's allotted to them, their minutes are out. And if they do not have Wi-Fi connectivity in the home, you kind of lose contact with them, until—you hope that they'll answer you the next month"* (PI-1).

In addition to barriers in reaching certain populations, participants also noted several topics that they thought were difficult to address on social media, like mental health challenges. One CHW who worked in hospice also shared about how she finds joy in palliative care as *"a lot of times, my clients, they just wanna smile for a day. Maybe partner with local community churches and have people volunteer just to come and sit with them, talk with them, pray with them, you know, ease their mind,"* yet said that *"I don't see any of that, as far as hospice and palliative care on social media"* (FG-A4). Another group participant added in response that *"that's kind of taboo, even for us people that are a little older. You know, you're like, Okay, I'm not getting on here to hear about people dying, or suffering, or anything like that"* (FG-A2)—that is, such topics were deemed too unpleasant for what people expected from social media.

With these limitations, participants saw social media as *"just another tool in the toolbox"* (PI-5), to be used as appropriate alongside other tried and tested channels for client and community outreach.

4.2 Caring With Community Health Workers Online

Despite the impactful work of CHWs, they remain underrecognized and precariously employed. Participants discussed how they experienced directly the lack of awareness of CHWs and the work that they did among others working in the health and social sectors, community members, and even other CHWs, with real implications for CHWs' employment, ability to work effectively, and career development. As such, CHWs and allies in the state have been engaging in advocacy efforts to promote awareness of CHWs and *"build a more sustainable and credible workforce"* (PI-2). We discuss here the motivation and efforts of our participants to engage in such promotion and their use of social media to doing so, ranging from coordinated campaigns to informal networking.

4.2.1 Garnering Attention and Recognition for CHWs. A key aspect of CHW advocacy efforts has been, first, to define CHWs. While this may seem trivial, CHWs in the state and across the U.S. have been labeled with a range of job titles, including peer specialists and patient navigators, and thus have been hard to identify together—or, as one long-time health administrator and CHW ally put it, *"they called them everything under the sun except for maybe a CHW sometimes"* (PI-3). This in part stems from inconsistent and decentralized resources for hiring CHWs, often cycling through grants that specify particular roles to work on a given health issue. PI-3 explained further:

> *"Historically, I feel like when folks would think about community health workers, it was more of a part-time, volunteer, low-pay type position. So the recognition and the respect even for the role wasn't there. It was almost like, those are just those folks that you call on, and if you give them a $200 stipend, they'll run around and do whatever you want them to do. A whole lot of work for a little bit of money, or no money."* (PI-3)

This stands in contrast to other health professions, such as registered nurses and medical assistants, which have standardized training and certification as well as broader public recognition. As such, formal efforts to promote CHWs include *"streamlining the term"* (PI-2) by enshrining an official definition for CHWs for people in the state to rally around and, more recently, supporting legislation to create standardized CHW training and certification.

Several participants noted a parallel disparity in visibility also playing out in social media: that they saw other health professionals getting recognition on social media, *"but in terms of like, just calling themselves community health workers or, you know, the career, the term community health worker? I don't see that so much on the social media platforms"* (FG-A2). PI-5 for example, a family medicine doctor by training, recalled seeing how *"there's even a little template that talks about Happy Doctor's Day, and then you put, the doctor has their little face in the little template that's posted all on social media."* This motivated the CHW Network to create Instagram and LinkedIn pages *"primarily for building awareness of the workforce, not necessarily sharing resources for patients. So it's more professional-facing than it is resource- or client-facing"* (PI-7).

Though CHWs' range of work in many ways resists definition, advocates have tried to embrace and showcase the diversity of

CHW roles, skills, and situations as one of the key hallmarks of the workforce. One way they try to achieve these goals is by telling the story of CHWs: who they are, where they work, what they do, and why they matter, and to *"tell those tear-jerking stories to incite emotion, to evoke emotion, that will incite change"* (PI-9). PI-2 believed in the impact of sharing specific stories with policymakers:

> *"So it's one thing to go to a policymaker and say, there are 20 community health workers in [small city] doing this work. And they're like, 'Okay, great.' But I could say, one of your constituents was diagnosed with diabetes and was in critical condition, blah blah blah, a community health worker got involved, and now this person, you know. […] So those types of stories help kind of put faces to the data and help make more of an influence."* (PI-2)

These are stories that she would gather by reaching out to CHWs via listservs and at in-person events held by the CHW Advocacy Coalition and encouraging them to share their stories, and using their quotes and video footage on paper flyers and social media content: an interweaving of offline and online organizing.

In addition to policymakers, CHW advocates also wanted to reach others working in the community health space: to make CHWs known to potential CHW employers, partners, and hopefully future allies. PI-3 for example encouraged CHWs she supervised to participate in their storytelling:

> *"For the most part, the CHWs are responsible for reporting out like, what event did you do? Tell us the details about the event and then share three to four pictures. We send it over to our social media person and she uploads it and then bam, now it's out there. We're telling the story as to what we're doing as an organization."* (PI-3)

The organization's posting of this content on their official social media accounts serves the dual purpose of promoting their programs (as described earlier), as well as visibilizing CHWs in doing that work to those who follow them online: members of the public, and other organizations and individuals working in community health.

Closer to the ground, CHW participants shared about experiences having to explain themselves and their work to confused or skeptical community members as well as other health professionals. The CHWs in FG-B exchanged stories with each other, with one younger CHW who works in refugee and immigrant communities sharing:

> *"I'm constantly having to just tell my community members again, like, who I am, what I do. […] At first, the beginning? Oh my god. [other participant laughing] We struggled with, 'What's your credentials? Like, are you a doctor? Are you a nurse? Like, who are you?' And so I didn't really have credentials at all. So I'm just like, 'I'm just a community health worker,' and they're just like, 'No, that just sounds like something you made up.' [laughing]"* (FG-B3)

Another CHW added, *"I'm in clinic on Mondays. And soon as I go in with the doctor, and they ask, 'are you the social worker?' I'm like, 'No, I'm not.' You know, I have to explain"* (FG-B1). When asked what they think could help, she offered one idea, laughing together with others in the group in agreement:

> *"I would like to see a commercial, with faces […]. They always have these paid actors and stuff, where they just say, 'Have you met your community healthcare worker?' You know. 'Not social workers, but we're community healthcare workers. We're not this, but we're community healthcare workers.'"* (FG-B1)

Here, she and the group were imagining leveraging the methods of commercial advertising via whatever means out there—*"I don't care, media, TV, radio"* (FG-B1)—to reach the broadest audience possible, their laughter suggesting that they perhaps thought it an audacious but intriguing idea to address the issue of their visibility and recognition.

CHWs and allies also recognized that there was value in more targeted, relationship-focused advocacy work. Long-time CHW allies especially felt that *"we all know each other […] and so we connect through other organizations that we know are doing this similar type of work"* (PI-8), that *"we're all one big family in this ecosystem, so it's about that collective impact of everybody working together and us not siloing ourselves"* (PI-3). Pointing to the selective appropriateness of social media for doing this kind of work, PI-2 said that she would advise CHWs new to advocacy that *"if they're just trying to establish a relationship, I'd say pick up the phone or send them an email. If they're trying to advocate, then you might have to do that via social media and email."* Though, as an advocate who was relatively newer to CHW-focused advocacy herself, she also discussed how she used social media to deliberately build relationships with relevant stakeholders:

> *"You can't just, you know, slide in their DMs [direct messages] randomly. So I start engaging with them way ahead of [legislative] session and liking their posts. My senator posted that she and her son got COVID […] so I just like sent her a message like, 'Hey, I hope all is well with your son, I used Pedialite a lot when I had it, it really worked.' […] And now her and I have a really close relationship. […] Retweeting their events, […] just show support, so that when I do need a favor, or when I need them to pay attention to something we're doing policy-wise, they know who I am."* (PI-2)

Social media thus was used by various CHWs and allies to broadly visibilize CHWs to different audiences and help build targeted relationships through more strategic individual interactions, though its perceived effectiveness depended on the particular context of use.

4.2.2 Establishing CHWs' Own Collective Identity. In defining CHWs, the goal of CHW advocates is not just to garner external support for CHWs, but to form a collective identity and awareness amongst CHWs themselves as well. PI-10, who manages CHW programs at the state public health department, described how she saw this goal:

> *"This is such a wide range field, that it is imperative that people can see themselves in this role and be able to have a name to it. […] And if we get that momentum and people being able to identify themselves as such,*

> *it will help us have more power behind helping CHWs move further in the space across the state."* (PI-10)

Several CHW participants related how they had moments of realization that they were, in fact, CHWs, perhaps even before they first had a CHW job title. PI-7 for example, who has worked in community health for over 20 years and now in a more administrative role, described how her first job was working as a *"program coordinator, community navigator,"* but only identified herself as a CHW when she got a job seven years ago as a Community Health Worker Program Manager:

> *"It wasn't till I saw that job description that I really was like, okay, this is what a community health worker is. I am a community health worker. [...] Even now, working as an ally, I still see myself as a community health worker and jump at the opportunity to provide resources and assistance as needed."* (PI-7)

Others also had similar experiences, such as PI-6 who had only started as an employed CHW two years ago, but shared that *"honestly, I feel like I've been doing the work before I even knew what it was and as volunteer. I didn't even know. So it wasn't till I actually started working at [community health center] that I realized that I've been doing this for a while."*

In forming CHWs' individual and collective identities, social media has played a role in helping them stake out and take pride in their identities as CHWs in presentation to others. PI-6 for example has since become very active in CHW Network leadership, and though at first she felt shy sharing about her work as a CHW on social media, has come to fully embrace it:

> *"I really never talked about my job. [...] But I think, especially with community health work, [...] I'm just doing more things that put me out there. I was like, okay, let me just go ahead and start sharing. [...] My friends were just like, you do such great things that people just don't know about it and aren't sharing it. [...] It's like, you're not bragging, you're just sharing. So I had to look at it that way."* (PI-6)

By sharing posts about her work, PI-6 also said she hoped to inspire others to become CHWs. For promoting themselves, participants mentioned LinkedIn as the more *"professional-type platform"* to use, where *"you're with other professionals, a lot of people that you know you went to college with, or you worked with at other organizations or non-profits, or whatever [...] where you can load up your resume"* (FG-A2): that is, to present yourself, a CHW, as a professional in the community health space. Yet, some participants also felt it necessary to present CHWs as beyond just health professionals who share about going to formally organized health events and tout CHWs' impact on healthcare cost-effectiveness, as *"we cut ourselves short because we're only telling one minute part of what we do"* (PI-9).

4.2.3 Connecting With CHWs. CHWs valued being able to have opportunities and spaces to network with each other, especially when working at organizations with few CHWs or being distributed across different communities. This can happen spontaneously when *"just being out at events or in the community, you meet people that do this same type of work that you do"* (FG-B2), as well as at more formally organized events and spaces for CHWs and others working in community health, such as health worker-related trainings and CHW Network and Advocacy Coalition events. With CHWs' work being so community-based and thus localized based on community culture and specific resources available, there can be great value in place-based networking, such as one CHW working in a small city with diverse refugee and immigrant communities appreciating the establishment of a city "Hub" health coalition to bring together local organizations and groups (FG-B3).

Digital communications were especially used for connecting across geographies. This included formally organized virtual events, such as statewide CHW Network online meetings, or as one participant shared, her South Asian diaspora-focused program conducting online sessions for their CHWs as they began scaling up from a local to national level (FG-C6). Even during three of our four online focus group discussions, some CHW participants began on their own to put links to their own organizations or other resources they mentioned in the chat, and asked for each other's contact information (we allowed them to stay on the Zoom meetings after ending the focus group discussions and stopping video recording, to share such information with each other as they wished). Several especially more experienced CHWs and allies also mentioned how they kept a tab on CHW efforts across the country online, for example following other states' and national CHW associations on LinkedIn and staying aware of CHW policy-related developments *"because I want to see what people doing in other states, to see how it could benefit Georgia"* (PI-9).

Social media was also used for less formally organized networking, with one CHW describing how he thought *"it's a very good avenue to get to meet other people, because you can't just be confined to the community. You have to interact and talk to other community health workers. And this is another [way] for you to do that, social media"* (FG-D8). Several CHWs also brought up participating in CHW Facebook groups and pages. One newer CHW shared how she regularly visits three different ones, and the benefit she got from it:

> *"The first time I was just looking at comments, 'cause I was curious. [laughing] But as I got more comfortable, I started asking questions, and they started helping me with simple things. Like, 'Okay, if that person is about to move, then you might want to set up this, that, and the other with their utilities.' Or, 'hook them up with [organization], because that that agency may be able to give them more resources.' So those are avenues that I was not aware of at all."* (FG-D4)

On the other side of the table, a more experienced CHW shared how *"when I get information, I'll put it in the group to let other community health workers know about events that's going on"* (FG-B5). Information shared on these groups was often to help CHWs ultimately help each other's clients and communities, for example by answering questions about how to address certain situations with clients and spreading awareness about community health-related resources that could be shared onwards to them. Other information more directly benefitted the CHWs, such as information about trainings being offered. One participant (FG-B6) even noted that she found out about our study from a CHW Facebook group (which

the authors were not members of, did not post to themselves, and had not been aware of any such posts). While some of these online groups and connections were within-state due to the relevancy of local or state-based resources and policies, some CHWs also appreciated informally connecting across state lines on social media to learn from each other:

> *"Sometimes you even connect with community health workers in other states that have different perspectives, you know, 'cause we all live in different regions, and how they do it where they are that works, and then you can bring it back and implement in our [city], where we are, or you know, throughout rural [regions of the state]. So yeah, it's awesome."* (FG-A2)

5 Discussion

Our findings detail how CHWs currently use and envision using social media to care for the health of their communities, and to care with and for CHWs themselves within the community health ecosystem. Even though their social media activity may not be readily visible or considered as being for work, their many uses of social media that were often more informal effectively enacted various phases of care [20, 69]. In caring for their communities, they 1. were attentive to online updates related to their community's health as well as the degree of health misinformation online, 2. took care of finding resources online in the form of health-related information, 3. shared relevant information with community members that enabled them to improve their health, and 4. were responsive in adapting their approaches to what would best reach community members. In advocating for and connecting with other CHWs and allies online, they also 5. cared with each other, promoting the value of care work in society and building solidarity.

With this framing of the phases of caring, we discuss below tensions in navigating of professional and community identities online, and raise the question of doing community work at scale using social media in the context of platform capitalism.

5.1 Navigating Professional and Community Identities and Roles

CHWs, as community care workers operating in the context of the American public health system, constantly must navigate and visibilize themselves within the complex health and social sector ecosystem as well as within the communities they serve. In doing so, they experience tensions in defining themselves as both health professionals deserving of recognition, and whole-hearted community advocates. We find that this dynamic similarly carries over to the online spaces of social media, on the one hand maintaining professional profiles on platforms like LinkedIn and marginally engaging with their employing organizations' official social media presence, yet also doing a significant amount of informal information sharing and exchange with community members and other CHWs on what they consider to be more personal social media spaces.

Drawing on Tronto's conceptualization of caring democracy, we can see this challenge as one of trying to move past the traditional notion of separated public professional and private care spheres, and towards an alternative arrangement of care in society [69]. Relatedly, the modern concept of work-life balance can be seen as a construct of neoliberalism, where all human actions are conceived of in the context of the economics [79], and thus the need to define private personal "life" relative to public professional "work," which becomes especially ill-defined and problematized for care workers [17, 59, 64]. On social media, we can understand this playing out as CHWs both resisting while also leveraging context collapse, where various social networks are flattened into one audience online [8]. By managing their identities across social media platforms with different affordances (e.g., LinkedIn's resume-formatted profiles) and thus different popular reputations, some curate distinct "professional" and "personal" online spaces as a means of maintaining work-life separation. Yet, one social media post about their work can also serve multiple purposes, offering their care as a resource to community members while also showcasing themselves professionally in the community health sector. Other participants expressed identities as community advocates in a manner that further resists this separation, reflected in how their social media presentation and use blurred typical personal and work boundaries to connect with community members and within the community of CHWs themselves. This is not to deny, however, appropriately recognizing, compensating, and maintaining boundaries around the legitimate labor of CHWs.

In considering how to reframe social media use to promote care workers and advance towards a caring democracy, we consider the potential for collective identity formation and Wolf et al.'s call to build alternative institutions for pro-labor technology design within capitalism [79]. Dimond et al. studied how online storytelling can help in collective framing of identities and experiences towards building a social movement [18]—something which several participants described themselves as doing and encouraging others to do for CHW workforce advocacy, both organizing formally with the CHW Network and CHW Advocacy Coalition and informally in Facebook groups. However, the formation of these formal and informal institutions for CHW organizing is happening within the context of the fragmented U.S. public health system and commercial social media platforms [62], which are both ultimately neoliberal sociotechnical infrastructures within which CHWs have little structural power. While this poses challenges to collective action and the ability to shape these or other institutions as effectively alternative counter-institutions, echoing Wolf et al.'s suggestions [79], future work with CHWs to design strategies for social media use may simultaneously consider their urgent tactical needs within realistic current constraints, while at the same time centering CHWs' voices and actions in reworking longer-term strategies.

5.2 Platform Capitalism and Community Work at Scale

A primary appeal of social media to our participants was the promise of scale with "everyone" being on social media: of having posts online get hundreds of thousands of impressions, far more than the number of paper flyers that any CHW can physically hand out. Much of this ideal is couched in terms of social marketing, best expressed in community health organizations' adoption of marketing practices and evaluation metrics, and CHWs' aspirations of becoming individual "health influencers" marketing public health

at scale. However, these metrics measuring flat, viral scale are not necessarily reflective of their ultimate goals: the actual improvement of the health of individual community members and the social determinants of health in communities. Further, even if these marketing goals are seen as simply instrumental towards these ultimate community health goals, participants expressed ambivalence and discomfort at the perceived potential consequences of becoming health influencers, and indignance at the societal consequences of misinformation that they linked with monetized unqualified influencers. This logic of marketing is also heavily baked into capitalistic social media platforms themselves in terms of their affordances for users, businesses, and advertisers, and the algorithms behind how content is surveilled and promoted on them [62, 84].

While some CHWs felt they were rendered invisible by these marketing practices and platforms, they also already engaged in alternative forms of interaction online that leveraged existing platform affordances. They described for example following other community health-related accounts to show support for each other while tailoring their own social media feed algorithms, and conversing with each other on Facebook groups at local, statewide, and even national scales. What might supporting these modes of community-based scaling on social media look like, and how might we evaluate success? Sharma et al. point to post-growth philosophy to inform HCI design that is not rooted in capitalistic growth, but rather towards wellbeing [66]. Among their suggestions is to nurture pluralistic solidarities across cultures and communities, a concept which is also discussed by Vlachokyriakos et al. in studying the solidarity economy towards developing a vision for solidarity HCI [75]. Christian et al. specifically consider networked solidarity and, despite corporate social media platforms limiting the potential for such solidarity, examined how artists nonetheless engaged in alternative modes of presentation and interaction online to celebrate and platform intersectionality [16]. Thinking beyond social media platforms as they are now, technologists such as Zuckerman are considering alternative structures for social media platforms themselves, like decentralized networks with participatory governance to enact a more pluralistic social media infrastructure [85], with researchers unpacking the challenges that also lie with them [83]. The situated perspectives of diverse community builders, like CHWs, are essential in further exploring the sociotechnical design space of social media systems [82] to envision these and other alternatives.

6 Study Limitations and Future Work

Our study engaged CHWs and CHW allies in a southeast U.S. state in discussion about their perceptions about and their self-described usage of social media, which allowed us to examine their conceptualization of social media platforms and paradigms of use. We recognize that by recruiting participants through existing CHW-related networks for a study labeled as being about social media, our participants are likely to both be more in-the-know about CHW advocacy efforts in the state and more familiar with or interested in using social media. We do not take this study to be representative of CHWs and CHW allies in the state, and certainly not of CHWs in the U.S. or globally, and instead consider our participants to be particularly informed and interested experts who collectively offer valuable situated perspectives on and aspirations for social media and community health. Future work may more closely investigate actual social media use by community care workers in diverse contexts, as well as engage in co-design of alternative strategies for their social media use and reconceptualize how to evaluate such efforts.

7 Conclusion

CHWs are skilled and trustworthy community-based health communicators and advocates, playing a key role in the community health ecosystem. With rising interest in social media for health promotion, we studied its place in community health work and advocacy centering CHWs' perspectives. We conducted interviews and focus group discussions with CHWs and CHW allies about their perceptions of and use of social media as related to their work and community health. We investigated how they use social media to enact various phases of care for their communities and CHWs themselves, experiencing tensions in navigating professional and community identities and conflicting desires for scale. Our research contributes to the understanding of pro-social use of social media, in particular by community care workers, within the context of capitalism as reflected in the American community health sector and in social media platforms. As an alternative, we point to collective action and pluralistic solidarity to inform approaches to social media use and design to promote community wellbeing and caring democracy.

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