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Barriers to Public Health Trust-Building Using Social Media: A Qualitative Analysis

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Original Research

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Abstract

Objective: To combat declining trust in public health and effectively communicate during public health emergencies, it is critical for the public health workforce to engage with their communities through social media. Little is known about factors that influence the degree to which public health practitioners use social media for information sharing and bidirectional communication. This study aimed to examine perspectives on barriers to incorporating social media use into efforts to rebuild trust in public health.

Methods: 31 semistructured interviews were conducted with public health practitioners and subject matter experts. Common themes and barriers to using social media were identified using rapid thematic analysis and analyzed by levels of the socioecological framework.

Results: Barriers to public health practitioner social media use included lack of training, time, and fear (individual-level); limited online and offline relationships (interpersonal); lack of resources and supportive policies (organizational); and politicization of public health (societal).

Conclusions: This study identifies modifiable factors that could be intervened upon to strengthen the public health workforce's social media communication and highlights existing efforts to address barriers. Sustained investment is required to ensure that public health communicators are maximally supported to effectively use social media for trust-building and communication during public health emergencies.

Introduction

Trust in public health science, institutions, and officials has been declining in the United States, making it more difficult to promote lifesaving behaviors and information.[1] To rebuild trust after the COVID-19 public health emergency, there have been increased calls to reevaluate how public health officials communicate and engage with the public.[2–4] Social media is one crucial avenue for public health communication, with the potential to rapidly and widely distribute information.[5,6] Discussions on strengthening communication efforts and trust in public health must therefore consider the unique aspects of social media outreach and interactions.

Trust is a complex, multidimensional construct that operates at interpersonal and organizational levels. Interpersonal trust can be described as the extent to which an individual user views another individual to be reliable, honest, credible, qualified, influential, and ethical.[7–11] Organizational trust describes the extent to which an organization is seen to possess those same qualities, as well as if the organization is seen as effective and efficient.[9] These qualities can also be used to describe "trustworthiness," with individuals and organizations that are seen as trustworthy being more likely to engender trust.[7] Trust is dynamic, context-dependent, and event-dependent, meaning that it takes a long time to build but can be lost in an instant. Furthermore, trust and distrust act in a feedback loop: effective public health messaging can combat misinformation and strengthen trust, while trust-eroding misinformation can undermine the effectiveness of public health messaging.[6,12] As public health practitioners attempt to be trustworthy communicators and ensure life-saving information is received, they must be aware of the effort and complexities required to both earn and maintain trust.

Trust in the online context is influenced by unique dynamics. Online trust is affected by characteristics of the messenger, whether an individual or an organization, the recipient and their relationship to social media, the content being shared, and the platform on which it is shared.[10,12] Trust is also uniquely affected by social media's ability to accelerate the spread of information. In social media environments in which practitioners have built trust, these platforms can ensure information is received in a timely manner.[6] However, social media also accelerates the speed of misinformation.[12,13] In particular, algorithms that rely on engagement can amplify controversial content and create spaces of self-reinforcing discourse curated to individuals' existing beliefs.[14] These characteristics make it especially important but difficult for public health practitioners to earn trust and prevent or address misinformation through social media.

While the importance of social media for communication and trust is increasingly recognized, less is known about public health practitioners' on-the-ground experiences using social media for

trust-building, especially during public health emergencies. Previous research describing public health departments' use of social media is generally focused on the extent of use and type of content, rather than barriers or impact.[15–18] Existing research has analyzed limitations and challenges of social media-based public health campaigns but does not fully address the use of social media for more general information-sharing and trust-building.[19] Furthermore, this research on public health messaging often focuses on characteristics of the message itself, rather than the organizational, relational, and contextual factors needed to support social media-based trust-building.

This study aimed to better understand the multilevel factors influencing the degree to which public health organizations use social media to share evidence-based information about public health topics and engage in bidirectional communication with the public. Perspectives on barriers to incorporating social media use into trust-building, particularly in relation to COVID-19 and other public health emergencies, were examined through semi-structured interviews with 31 public health practitioners and experts. This study describes these barriers, and their implications, across levels of the socioecological framework.

Methods

Recruitment and Population

To understand public health organization perspectives this study created a stratified sample of (1) individuals that were public health practitioners with a range of experience using social media, from those who were very active online to those who rarely or never used social media in their professional role; (2) individuals with known social media presence in the area of public health; and (3) individuals with research or practice expertise in the area of trust-building and social media for public health. The research team solicited names of potential interviewees from our Centers for Disease Control and Prevention project officer, the Public Good Projects and Public Health AmeriCorps project partners, and from recent webinars or panels on public health communication and trust (e.g., ABIM Foundation's Trust Building Initiative webinar series[20]). Overall, 42 individuals were invited to participate via email, which was hypothesized to be a sufficient sample size to achieve saturation across strata.[22]

Thirty-one of these individuals were interviewed. Thirteen participants were state or local public health practitioners, representing 10 US states (from across all 4 census regions). Twelve were subject matter experts on the topics of trust, public health communication, and the public health workforce, some of whom also had on-the-ground experience utilizing social media for public health communication and trust-building. The remaining 6 interview participants were federal public health practitioners in communications roles.

Data Collection

Interviews were conducted via Microsoft Teams between March and May 2023. A semistructured interview guide was used to ask about participants' experiences with using social media in their work, particularly during public health emergencies. The interview guide included questions on the extent of their experience using social media to communicate about public health and barriers to effective online public health engagement and trust-building. Content of the interview guide was informed by a literature review and environmental scan on how social media interactions shape trustworthiness of public health science and officials. Questions on barriers to use were also informed by the Consolidated Framework for Implementation Research (CFIR).[21] After obtaining verbal consent from the interview participant, interviews were conducted in pairs, with one team member leading the interview while the other took detailed notes. Interviews lasted approximately 45 minutes.

Analysis

A rapid thematic analysis[23] was conducted using a deductive approach to synthesize interview findings. Study team members abstracted summaries from the detailed interview notes into an Excel matrix, with direct quotations documented when relevant. Each row in the matrix represented a respondent, and each column corresponded to an interview question. Within cells, responses were further divided inductively into thematic subcategories to facilitate further analysis. We did not conduct formal double coding or inter-rater reliability tests as these steps are not typically part of rapid thematic analyses. The study team then reviewed the matrix to identify common themes across respondents, with a focus on barriers to using social media for trust-building. After reviewing all barriers that were identified, the team agreed on the socio-ecological model as an emergent organizing framework.[24]

RAND's Human Subjects Protection Committee approved this study (2022-N0520).

Results

Participants fell into 2 groups: those who were very engaged in public health trust-building on social media and those who hardly ever used social media, if at all. Most participants' experience with social media communication centered around the COVID-19 pandemic. While they uniformly endorsed the importance of social media for amplifying trust-building efforts that occur "in real life," they identified numerous barriers to using social media for trust building and expressed skepticism that many of them could be overcome. As described above, these barriers are categorized according to four levels of the socio-ecological framework (Figure 1).[24]

Individual-Level Barriers

Participants identified several barriers to social media trust-building at the individual level. One of the most mentioned barriers was a lack of time. Participants explained that competing public health priorities, especially during a crisis, limit the time that practitioners can spend using social media and staying up to date on the latest social media strategies, platforms, and trending topics. One participant described how practitioners often think, "I have to handle the issue [i.e., the public health emergency], why would I be on social media?" Participants also reported that public health practitioners lack training on how to use social media, employ culturally sensitive communication strategies, and translate complex science to a lay audience. For example, one practitioner noted that social media training is often only provided to communications teams, so staff on the epidemiology or nursing teams will defer to the communications team to engage on social media and not pick up the skills or gain experience themselves. Relatedly, participants mentioned a dearth of ready-made social media communications materials for public health practitioners such as social media toolkits. As one local practitioner described,

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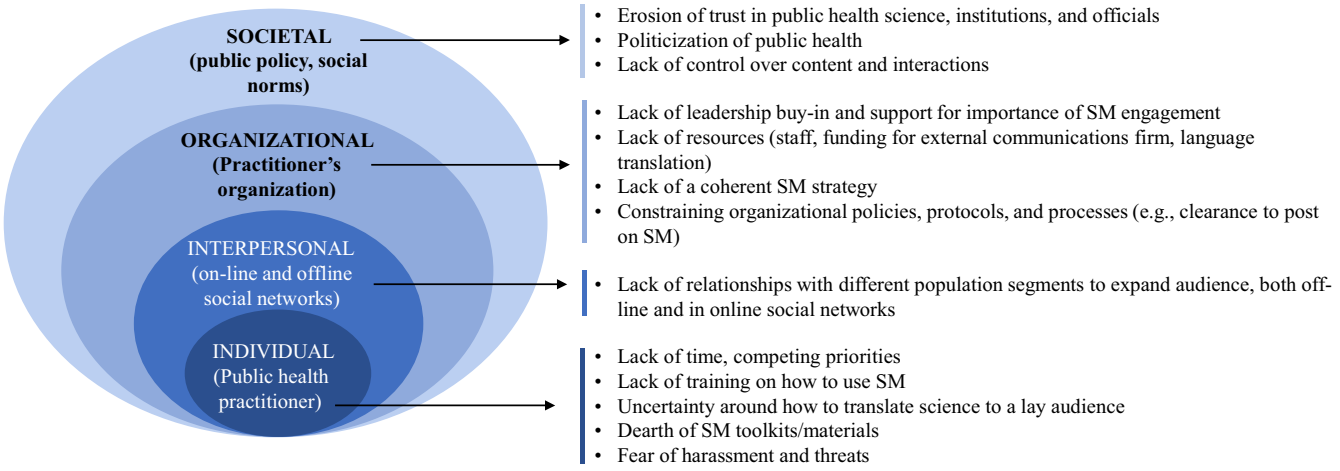

Figure 1. Barriers to using social media for public health trust-building, by socio-ecological framework levels.

If a health communicator wants to share vaping material in their community, they do a google search, see thousands of results of existing vaping materials but it's not immediately clear if [these materials are] evidenced-based, if [they have] worked in similar communities.

Several participants indicated that public practitioners were uncertain whether the time spent to learn and use social media would produce proportional benefits for trust-building, essentially—wondering whether "the juice would be worth the squeeze." However, participants who were actively engaged on social media acknowledged that this work is time-consuming and that it took some initial "start-up energy" to learn the nuances of different social media platforms, but they felt that the need to meet their community members where they are made it imperative to invest that time.

Some interviewees mentioned that public health practitioners feared harassment and personal threats from their use of social media. Indeed, one interviewee who developed a strong social media presence during the COVID-19 pandemic mentioned receiving multiple death threats. The few participants who had directly experienced online attacks noted that it was intimidating and stressful at times, but they felt that this was an expected consequence of being in public service during a pandemic and the benefits outweighed the risks for them on a personal level. Other who were less active online described being hesitant to engage on social media due to a general fear of backlash from the public. Another participant who infrequently used social media noted that in their organization, "the people who've been more active in putting out messages [got] a lot of coordinated pushback, often on email too. Seeing that didn't make me want to engage broadly on social media." To address this fear of online backlash, one participant described a need for online collaboration between public health professionals to support one another in efforts to combat misinformation, stating,

If there's misinformation happening in a different state and I don't think it impacts me I may not check it, I may not care as much. And that's a problem because that's lack of solidarity. One public health official is getting beaten up across the country by the negative forces, but I don't see a lot of people coming to the defense of that public health official.

Interpersonal-Level Barriers

At the interpersonal level, several participants noted that public health practitioners' lack of relationships and external partnerships, both online and offline, limits their ability to build trust over social media. For example, one participant shared that most of their organization's social media followers were employees, donors, and members of their board of directors, not the members of the public that they primarily aimed to reach through their social media accounts.

Some participants noted that partnerships with influencers or celebrities can be a powerful tool to expand online reach of public health messages, but that it is a challenge for public health practitioners to pick partners who will share consistent, accurate messages, serve as positive role models, and not do anything controversial that could discredit their message. One participant noted, "for us it would be a red flag if an influencer posted content supportive of tobacco use. There's a lot of nuances to working with [influencers] we have to flesh out." Additionally, participants indicated that public health practitioners need offline relationships with organizations and trusted messengers in their communities to ensure their online messaging (regardless of format or platform) was aligned with community concerns and questions. As one participant stated, "The digital landscape is best is when it's an amplifier for what's happening offline – or in line with what's happening offline."

Participants who were active on social media described how public health practitioners can integrate their social media activity with on-the-ground engagement through in-person town halls, frequent radio or local news media appearances, press briefings, and health-related events in their communities. One interviewee from a foundation noted success with combining social media with local news and radio, explaining that "diversifying messaging is really important for … the normalization [of a message] and just seeing it in multiple areas of your day-to-day really kind of helps bring the message [home]." Participants noted that online engagement cannot replace on-the-ground trust-building and has not yet become public health practitioners' "go to" mode of communication. One participant described an instance in which they shut down a viral post because there was a lot of back-and-forth in the comments, stating,

Social media is not a place for in-depth large conversations. If that [back-and-forth] starts happening, I invite the people on social media to come engage in person in another venue… [For example], 'come join our experts to speak more about this on Wednesday.' [It] gives more people an invitation to come engage more productively."

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Organizational-Level Barriers

Many respondents described barriers at the organizational level. Participants from public health agencies, nonprofits, and other health care organizations noted that their organizations often lacked support for social media engagement from leadership (although several felt that this was changing with time) and the resources to support such engagement. As one communication specialist described, "most people in leadership are 50 or older. Some of them don't understand the value of social media… the first year of me being in my position was convincing the director you need to be out here tweeting about stuff." Respondents mentioned that limited funding and staff inhibited their ability to expand social media outreach by translating materials, paying for advertisements, or having access to internal or external social media specialists. As one participant from a public health organization's communications department described,

We are hugely understaffed. It's shocking honestly. It's this problem I think that people who aren't responsible for communicating and using social media in particular think, 'my kid does it so it can't be that hard' … [Social media communication] takes time to do well and if you don't have the staff, you can't do that.

A few participants also noted that public health organizations' lack of a coherent social media strategy inhibited their ability to reach the public. Finally, some participants with low social media use described organizational policies or processes that slowed or limited their social media communications. One interviewee from a public health department noted that, by organizational policy, all social media messages had to be passed through several levels of leadership for approval, and that they were not allowed to respond directly to public questions on social media—they had to wait until members of the public emailed the organization with questions. In contrast, participants who were frequent users of social media often described supportive leadership and relatively streamlined processes that allowed them to directly communicate with the public in a timely fashion.

Societal Barriers

Finally, participants reflected on societal barriers to trust-building over social media, including the increasing polarization of public health viewpoints on social media platforms and overall negative views of public health institutions. Several participants discussed features that make the general social media environment difficult for public health practitioners to navigate, noting that social media interactions allow for two-way interactions. When anyone can comment or respond to a public health department's post, this can inadvertently create a forum for misinformation and backlash. Practitioners are then faced with the difficult choice of deleting comments, which in and of itself can fuel distrust and concerns of censorship, acknowledging and taking the time to craft sound responses to the comments, or not responding and allowing uncorrected misinformation to reach more people. One local public health practitioner described an online panel on vaccines in which the chat "was extremely negative and [felt] like a trap." This environment greatly differs from traditional media communications that practitioners have more experience with where communication is more structured and unidirectional from the public health practitioner to the public. As one participant noted,

For Facebook, unless we block everything, we can't control what people comment. So how do we respond to comments? Are we creating a forum for people to bash us? Versus if you put out a press release you control the message, reporters call you and you answer questions in the way you want to answer. It's a bit more controlled.

Another participant described how the social media environment can vary by platform, noting that those with more bots are much more challenging to have engaging dialogue on.

Overall, interviewees perceived that trust in public health institutions was declining, both online and more generally. Several participants who worked at local and state health departments commented on the political polarization of public health viewpoints and how that polarization has led to distrust in the government. For example, one participant noted, "we heard from primarily our conservative community … that when we only site CDC or use them as a reference, certain members of the public immediately distrust what we're sharing because there is a lack of trust in the CDC." Another participant described how they were not allowed to create a blog post about the harms of misinformation because their organizational leadership deemed it too political.

Discussion

The interviewed public health practitioners and experts discussed the importance of rebuilding trust in public health and the potential of effective social media communication to contribute to this effort. However, interview participants noted numerous barriers to trust-building and crisis communication using social media. These discussions highlight areas that can be intervened upon at each level of the socio-ecological framework to overcome identified barriers. They also highlight how individuals have, in some cases, successfully navigated these challenges in their professional roles.

Fortunately, several of the individual-level barriers to social media use for public health trust-building are beginning to be addressed. In recent years, spurred by challenges with communication during the COVID-19 pandemic, there has been a proliferation of webinars[25] and trainings[26,27] such as the Infodemiology Training Program and the World Health Organization's capacity-building tools[28,29] that aim to strengthen health and health emergency communications skills, including social media competency and storytelling, among the public health workforce. Burgeoning efforts to create ready-made public health communications materials exist.[30] Similarly, there have been efforts to support individuals experiencing personal attacks by building interpersonal connections of public health professionals to defend those experiencing online attacks.[31] Additionally, undergraduate programs and schools of public health are expanding their course offerings around communication strategies that incorporate social media.[32–36] Some of these advances will help build capacity among the public health workforce to use social media for trust-building, but rapidly changing platforms will require ongoing skill-building, and existing communications materials still require time and effort to tailor to specific populations or crises.

Interpersonal and organizational barriers will require more time and investment to address. Relationship-building between public health institutions and their community partners, ideally first "in real life," is an ongoing process that is built on inclusivity, bi-directional influence and information flow, and long-term commitment.[37,38] Furthermore, the observation that many public health-oriented organizations simply are not reaching their intended audiences on social media must be taken seriously. They

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may consider employing creative ways to encourage members of their community to "follow" and continue to engage with their social media accounts, such as monthly drawings for giveaways, "like this post and tag your friends" campaigns. Perhaps most importantly, relationship building should be used as a way to amplify offline connections, such as highlighting events held in the community and celebrating success stories related to their partnerships. At the organizational level, policies and protocols are needed to streamline social media processes and help staff most effectively use their limited time and communicate time-sensitive messages. These policies must also provide guidance on when it might be preferable to wait for additional information before posting on social media, as quickly pushing out inaccurate information can be counterproductive to trust-building and crisis communication. Finally, organizations should provide clear guidance to staff on how to respond to concerns or misinformation that come in via online comments. Even as they encourage social media outreach, organizations must respect and address individuals' concerns of backlash and fears for their own safety. Strategic plans that thoughtfully detail how social media will be used for trust-building are needed. This may include only using organizational accounts, protecting staff identities, and implementing policies for handling threats. Additionally, when limited resources allow, hiring dedicated health communications staff, and investing in training for current staff, can allow organizations to empower individuals and dissuade fears about engaging online.

Societal-level barriers will be the most difficult to overcome. Interviewees expressed concerns about whether, and how best, to respond to misinformation, noting a tension between correcting inaccurate information (debunking) and inadvertently amplifying bots or online trolls. Recent debates about social media platforms' responsibility to monitor and remove misinformation and litigation around the government's approach to misinformation have potential implications for how public health practitioners approach social media communication.[39–41] Because social media platforms have little incentive for self-governance, proposed solutions often rely on government regulation, whether at state, national, or international levels.[42] Such regulation faces significant challenges, but it is imperative for public health officials and researchers to remain engaged in these conversations. Relationship-building and collaboration efforts can also be employed at a societal level. As one interviewee described, individual fears of backlash are heightened by a "lack of solidarity." Societal-level collaboration among public health practitioners and cross-sector partnerships provide an opportunity to present a unified front against misinformation.[43] Finally, as multiple participants noted, rebuilding trust in public health and effectively managing public health emergencies requires long-term, consistent communication both on and offline.

Limitations

This study has some limitations. Interviews were conducted with 31 practitioners and experts in spring of 2023. Their perspectives may not represent experiences of other public health practitioners. There is also potential for recall bias as many participants spoke to their experiences during the height of the COVID-19 pandemic, months and years prior to our conversations. Still, with representation from 10 states and inclusion of practitioners and subject matter experts, our findings reflect a range of perspectives from a critical time for reflecting on public health trust-building.

Conclusions

Rebuilding trust is an urgent priority for public health emergency preparedness and response. This study identified potentially modifiable factors that could be intervened upon to strengthen the public health workforce's ability to use social media to engage in a trustworthy way with the communities they serve. These findings point to opportunities to intervene at all levels of the socioecological framework to improve the use of social media for public health communication: building workforce capacity through additional training, developing social media strategic plans, balancing speed and accuracy in communication protocols, and implementing organizational policies that allow for more effective online engagement. The field has begun to implement strategies to overcome some of the barriers identified in these interviews, and motivated individuals at public health institutions across the country have managed to demonstrate how to use this powerful tool despite various roadblocks. However, sustained investment and attention are required to ensure that public health communicators are maximally supported to integrate social media into their important trust-building work.

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