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ARTICLE

'The voice of that boy is still trickling in my ears': Ethnography and the epidemiology of compassion

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Abstract: There is growing interest in understanding compassion not only as an individual feeling but as something that circulates through communities and institutions, shaping decisions, relationships, and commitments over time. Recent calls for an epidemiology of compassion suggest that compassion be treated as a population-level phenomenon, with its own patterns of emergence, transmission, and lasting effects (Addiss et al., 2022). Yet there is little empirical research showing how compassion actually works in practice, especially within global health policymaking.

This paper draws on an ethnographic study (2020–2025) of people within global health networks working on neglected tropical diseases (NTDs), to explore how compassion arises, spreads, and endures. Using in-depth interviews, participant observation, and creative anthropological methods, the study examines how compassion becomes 'catching' in certain moments. Vignettes include: a boardroom silenced by a woman's tears recalling classmates with podoconiosis; a long-held memory of a suicidal teenager shaping advocacy decades later; and a foot washing involving Ethiopian patients and UK parliamentarians.

These emotionally charged moments are fleeting, but their effects are not. They act as exposure events, shaping motivating memories, disrupting hierarchies, and sustaining long-term motivation. The study suggests that compassion can, perhaps, be thought of as behaving epidemiologically: with triggers (first-hand or second-hand exposure), vectors (stories, touch, shared rituals), patterns of distribution, and protective effects (re-energising slow advocacy work).

This work supports calls for an epidemiology of compassion by showing how compassion is felt, transmitted, and remembered across people, places, and time. It also argues for integrating more qualitative, sensory, and story-based methods into global health research to help trace the emotional energies that may underpin collective change.

Keywords: Ethnography, Global Health Policy, Epidemiology of Compassion, Neglected Tropical Diseases, skin-NTDs, SDG3: good health and wellbeing, podoconiosis

1. Introduction

In the middle of a biographical in-depth interview 'Dawit'[1], an Ethiopian surgeon turned national policy advisor for neglected tropical diseases now in his sixties, interrupted one of my [first author's] questions about his career trajectory with**:** 'Just let me first share with you one experience.'

[1] Names and some identifying details have been altered to protect participant anonymity, in accordance with the research protocol approved by the BSMS Research Governance and Ethics Committee.

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His tone of voice had changed, subtly but noticeably, and I sensed something significant was about to be said. So I replied, 'Yes please'. And Dawit went on to tell me this:

> 'So one day, while I was doing my round [in a leprosy hospital in Ethiopia]—you know, in those days we didn't have separate wards for children. And while I was doing my round, this child was like, "Eh!" And he asked me one question, **which is still trickling in my ears**, you know. He said, "Oh, Doctor, am I going to look like those individuals, those old guys, when I am older like them?", he asked me. Ohhhh, you know, this was very shocking for me! I knew the answer. Because of our health system's negligence, I think that he is going to go downhill. But I lied to him. I confronted him. I said, "No way, you'll be fine! You'll be okay in this." I just talked to him in good words. And then I think I left the hospital in Ethiopia and I joined AMREF in Kenya[2]. And you know, his - his level of insight, **his sound - still clicks in my ears**. Because I have the feeling that I lied to this boy, actually. I really lied. And with the level of care in the national setting, I don't know how he is now. But I wish I'd seen him, that I'd made some attempts to really follow him and meet him up sometime. But I failed. And my conscience tells me that I have really lied to this guy, this boy, so much. And that makes me really unhappy. So this is a scenario, a true scenario.'

As Dawit told me his story, I realised I was listening more intently—with more purpose—than before. I was cast into the scene in the hospital he described, imagining a bright boy, not yet disabled nor worn down by the stigma leprosy brings, looking directly into Dawit's eyes as he lied. I 'caught' a little bit of Dawit's emotional intensity and unspoken feelings conveyed through his storytelling. And just like the boy's 'sound' continued to 'trickle' around Dawit's ears throughout his life, Dawit's sound has continued to trickle around mine. For this was the first example of finding what other research participants later called a 'goosebumps' moment of palpable emotion in my anthropological research project exploring perspectives on how policymaking on neglected diseases happens.

In recent years, global health scholarship has increasingly turned toward the emotional and 'moral' dimensions of policy, recognizing that compassion—once sidelined as 'soft', private or personal—is central to sustaining health work (Addiss et al., 2022). Building on this shift, the notion of an epidemiology of compassion has emerged, calling for the systematic study of compassion as a population-level phenomenon: how it arises, spreads, and endures within networks of policy and practice. This reframing asks epidemiology to consider not only pathogens and morbidity but also emotional energies, like that conveyed by Dawit.

Despite this conceptual turn, empirical work on compassion in global health remains limited. Much existing research has conceptualized compassion as an individual personality trait, rooted in clinical psychology, and measured through psychometric instruments such as the Compassion Scale (Pommier et al, 2020), the Compassionate Love Scale (Sprecher & Fehr, 2005), or scales assessing compassion satisfaction and fatigue within clinical caregiving relationships (Figley, 1995; Stamm, 2010). These tools assess dispositional compassion or burnout among professionals but rarely capture the contextual and relational dynamics of compassion as experienced in practice. In contrast, this study examines compassion as it emerges and spreads within policy networks and advocacy ecosystems. It considers compassion not as a static disposition but as a

[2]African Medical and Research Foundation, one of the largest NGOs in Africa, first known as the Flying Doctors of East Africa.

dynamic exposure: arising unexpectedly, travelling through stories, art, and ritual, and leaving enduring traces in the form of emotional, motivating memories.

Policy processes themselves are often imagined as discompassionate; as governed by technocratic rationality or, more critically, as necropolitical (Mbembe, 2003, Wilson, 2023), with bureaucratic practices rendering suffering populations faceless and abstract. A concrete example of discompassionate policymaking can be found in policies of deliberate state indifference/ inaction to the health and wellbeing of refugees in the Calais encampment (e.g. Davies et al 2017). Or in Gupta's ethnographic analysis of bureaucracy, which shows how routine administrative practices and polices normalise poverty by turning people into files (Gupta 2012). Whilst vital and insightful, these critical views overlook the relational, embodied moments through which compassion sometimes breaks into policy spaces *in some contexts*; brief but potent encounters that can rehumanize patients in the eyes of policymakers, transforming abstract categories of disease into real people.

This paper addresses these gaps through a five-year (2020–2025) anthropological study of people within disease-specific global health networks advocating for the recognition and elimination of neglected tropical diseases (NTDs). The project concentrated on NTDs affecting the skin (Skin-NTDs), which are particularly stigmatised conditions. These included scabies (a contagious skin condition caused by tiny mites that burrow under the skin), mycetoma (a destructive infection of the skin and underlying tissues) and podoconiosis (a progressive, disabling form of leg swelling seen in barefoot farmers). The project aimed to explore different perspectives on how policy change related to Skin-NTDs actually happens, revealing that—in addition to more formal processes—individual determination, community, happenstance and, most interestingly for this special issue, *love or compassion*, were also perceived to be central elements.

Through participant observation and biographical interviews, I (first author) encountered repeated, small but palpable moments of compassionate emotion that punctuated otherwise bureaucratic spaces. In one boardroom, Zara, a Rwandan non-governmental organization (NGO) representative, broke into tears recalling childhood classmates she shunned for their podoconiosis—a moment that transformed a previously listless meeting into one of renewed urgency. In an in-depth interview, Joy, a UK-based researcher and advocate, recounted the enduring memory of Lydia, a 16-year-old Ethiopian girl who had attempted suicide upon recognizing early symptoms of the disease, her voice breaking decades later in the telling. Similarly, as outlined above, Dawit an Ethiopian physician, described the voice of a young boy with leprosy asking if he too would one day 'look like those old men,' disfigured by the disease, a question that still 'trickled' in his ears years after he left clinical work to focus on policymaking. During a field visit in Ethiopia, UK parliamentarians engaged in a ritual foot-washing with podoconiosis patients, a small moment that nevertheless served to briefly collapse hierarchies and evoke biblical metaphors of shared humanity. Across these vignettes, compassion surfaced unexpectedly—quiet yet palpable—reverberating through advocacy networks and, seemingly, motivating long-term commitments to change.

1.1 Situating the study: Toward an epidemiology of compassion

These ethnographic moments resonate with emerging scholarship on the epidemiology of compassion which argues that compassion, like disease, can be examined epidemiologically by tracking its determinants, patterns of emergence, and pathways of spread (Addiss et al., 2022). Addiss and colleagues highlight compassion's risk factors (e.g., proximity, shared suffering, personal history) and its potential protective effects (e.g., sustaining advocacy, preventing

burnout). Yet they also identify critical gaps: little is known about the contexts and mechanisms through which compassion arises in real-world policy processes, or how brief encounters might produce enduring motivational trajectories. Complementary work in anthropology (Hollan & Throop, 2008), psychology (Lomas, 2023), and moral philosophy (Murdoch, 1959) underscores compassion's cultural mediation, its multisensorial nature, and its capacity to invite 'unselfing', understood here as a temporary decentring of the self towards others. Yet few studies have yet to bridge these insights with the structural and networked focus of epidemiology.

This study, therefore, brings these literatures into conversation by offering an ethnographic case study account of compassion-in-practice within global health policy. It argues that moments of compassion could be seen to function as emotional vectors: events that disrupt routine bureaucratic flows, spread affect across actors, and reconfigure advocacy networks. By situating compassion within epidemiological frames of person, place, and time, the paper shows how compassion can be 'caught', memorialized, and even transmitted across years, geographies, and institutions, quietly underpinning policy change.

1.2 Research aims and questions

This paper pursues two interrelated aims:

1. Descriptive: To document how compassion emerges, is experienced, and circulates in the everyday practices of NTD policymaking, focusing on its palpable, multi-sensorial qualities.
2. Conceptual: To explore the implications of these findings for a nascent epidemiology of compassion—specifically, how ethnographic insights can inform the development of frameworks and methods for tracing compassion's determinants, spread, and long-term effects in global health policy.

In following how compassion arises, moves, and lasts within these policy spaces, we aim to contribute to wider debates on compassion in global health. Our hope is to show how anthropology's close attention to lived moments can sit alongside epidemiology's broader concern with scale and patterns. It is, however, important to note that this study is limited to a small case study or *exploratory* ethnography, intended to open new questions and methods for future work, rather than provide definitive answers.

2. Background

2.1 The rise of compassion in global health discourse

Over the past decade, compassion has appeared with increasing frequency in global health scholarship, moving from the margins of individual clinical care into (some) discussions about policy and systems-level responses (Addiss et al., 2022). For example, in the 2025 World Health Organisation's (WHO) Skin-Neglected Tropical Disease Global Meeting compassion was, unusually for such forums, foregrounded in the opening speeches, where Dr Shams Syed, the Head of Policy and Partnerships in the WHO Special Programme on Primary Health Care, described compassion as comprised of the awareness of human suffering, combined with emotional resonance with that suffering, and action to alleviate it. Compassion, he argued, underpins the 'central question we should be asking ourselves: why are we [as a collective] doing what we are doing?'

In this framing, compassion is not merely an interpersonal virtue but a population-level phenomenon signposting a sense of shared humanity, the presence or absence of which shapes the trajectories of entire communities and practices.

The call for the development of a specific epidemiology of compassion reflects this shift. Rather than asking only *who* is compassionate, it asks *how* compassion emerges, travels, and endures within systems; what triggers it; and what protective or mobilising effects it might generate at scale. This reframing has resonance in the contexts of NTDs, where long-standing bureaucratic neglect combine with profound stigma, and where advocacy requires sustained energy over decades of slow policy progress.

2.2 Psychological and clinical foundations

Compassion research in psychology and clinical sciences provides crucial foundations for the epidemiology of compassion. Instruments such as the Compassion Scale (Pommier, 2020) and the Compassionate Love Scale (Sprecher & Fehr, 2005) have enabled some quantitative study of compassion as an individual trait, while measures of compassion fatigue (Figley, 1995) and compassion satisfaction (Stamm, 2010) explore its costs and benefits among caregivers. Intervention studies, notably Compassion-Focused Therapy (Gilbert, 2010), indicate that compassion can be cultivated deliberately, improving mental health and prosocial behaviour.

Yet these approaches largely remain intrapersonal: they measure what compassion *is* in individuals, rather than what compassion *does* in collectives or systems. They do not address how compassion is sustained across policy networks, or how it could spread through storytelling, art, and ritual—key dynamics in this ethnography.

2.3 Anthropological and philosophical perspectives on compassion and love

Anthropology—the study of what it means to be human in the broadest sense—has been surprisingly quiet on matters of compassion and love (Venkatesan, 2009). However, insights from moral and sensory anthropology offer important entry points. Scholars such as Throop (2010) and Hollan and Throop (2008) explore how 'moral' emotions like compassion are experienced and expressed in culturally specific ways, warning against assuming universality. Philosopher Iris Murdoch's (1959) concept of 'unselfing'—the moral shift from self-centredness to perceiving the other as fully real—and anthropologist Turner's (1969) notion of communitas—a transformative sense of solidarity produced in liminal ritual moments—are both crucial to interpreting the vignettes in this study (e.g., foot-washing as provoking recognition of shared humanity), as will be discussed later in the findings. Murdoch describes 'unselfing' as 'the extremely difficult realisation that something other than oneself is real' (Murdoch 1959, p. 51). This moment, she suggests, is not simply about recognising others intellectually, but about a shift in perception, a moral and emotional reorientation in which the self is momentarily decentred, allowing the presence, pain, or dignity of another to come into full view. It is a quiet but radical act of attention that opens the possibility for love, compassion, and ethical responsibility.

Crucially, this study also draws on sensory anthropology (Pink, 2015; Stoller, 1989; Classen, 1997; Howes, 2003), which foregrounds how life is lived through the senses. Compassion understood in this way is not only an idea or an ethical stance; it is palpable—experienced in goosebumps, shared silences, trembling voices, and tears that ripple through a room. Theoretical contributions from affect studies further support this framing: Brennan (2004), for example, explores how affect is transmitted between bodies, while Ahmed (2004) shows how emotions 'stick' to objects and policies, shaping public life. This approach allows us to trace compassion epidemiologically as both felt and transmitted, capturing how embodied responses become contagious and travel across networks. The metaphor of the *'voice that still trickles around my ears'* evokes precisely such a sensory memory: a fragment of sound that lingers in the body and continues to animate advocacy long after the original encounter, reminding us that compassion's

life course is as much about memory, embodiment and the act of retelling and sharing it as it is about immediate emotion.

A key insight from the ethnography described in this paper is compassion's temporal dimension. Participants' advocacy was often fuelled by core memories that act as emotional 'vectors': haunting recollections of formative encounters (e.g., Joy's Lydia; Dawit's boy) that resurfaced at later stages of their careers. This aligns with Hollan and Throop's (2008) work on moral emotions as remembered and reactivated, and with Farmer's (2005) notion of pragmatic solidarity: compassion as not just feeling but as enduring commitment to address structural injustice.

2.4 Organisational compassion and network dynamics

Research in organisational studies adds another dimension, showing how compassion can emerge and become routinised within collectives. Kanov et al. (2004) and Dutton et al. (2014) demonstrate how compassion unfolds in workplaces: noticing suffering, feeling empathic concern, and acting to alleviate it, processes that can be institutionalised and scaled. This study extends those insights into transnational policy ecosystems, tracing how compassion travels across ministries, NGOs, research institutions, and donor forums.

2.5 Critiques of compassion

Compassion is often celebrated as an unquestionable good, yet several scholars have challenged this assumption. Bloom (2016) warns against what he calls 'unexamined empathy,' arguing that compassion can be biased, parochial, and prone to moral error—directing care only toward identifiable individuals while neglecting broader structural solutions. Similarly, Grubner (2017) observes that emotions labelled as compassion can sometimes reinforce rather than alleviate suffering. Ethnographic studies provide powerful illustrations of this tension. Fassin's Humanitarian Reason (2012) and Ticktin's Casualties of Care (2011) show how compassion is mobilised and withheld in aid and migration policies, often reinforcing hierarchies between 'giver' and 'receiver' and producing selective moralised economies of who is deemed 'deserving.' Compassion, they argue, is never neutral; it is entangled with power and can justify both action and inaction. Barak Kalir's ethnography of Dutch immigration caseworkers offer a vivid example: enacting what he terms 'repressive compassion,' immigration caseworkers expressed personal care for deportable migrants even as they facilitated their expulsion, a process Kalir situates as an illustration of the banality and administration of evil (2019; 2023). However, in these cases, it seems that compassion is being selectively staged, rather than spontaneously and emotionally experienced.

These critiques underscore why it is crucial to examine compassion in specific contexts: rather than assuming its inherent virtue, we must ask how, when, and for whom compassion operates, and with what consequences.

2.6 Gaps addressed by this study

Despite growing interest in an epidemiology of compassion, several key gaps remain.

- Systemic dynamics: Few studies trace compassion's emergence and spread across policy networks rather than 'inside' individuals.
- Temporal trajectories: There is limited understanding of how compassion persists and reactivates over careers and life stages.

- Sensory dimensions: Epidemiological frameworks rarely capture the multi-sensorial markers—silence, touch, goosebumps—that ethnography can reveal.
- Ethical complexities: Little work examines the ethics of deliberately evoking compassion (e.g., through art installations) in policy settings.
- Disciplinary bridging: There is scant integration of anthropology's narrative depth with epidemiology's population-level focus.

What we try to do here, therefore, is to think about compassion itself as something we might trace epidemiologically—what sparks it, how it spreads, and what it protects against—using the messy, multi-sensory tools of ethnography to follow it through the everyday work of NTD advocacy.

3. Methods

3.1 Study design and rationale

This study employed a multi-sensorial ethnographic design to investigate compassion within global health policy networks advocating for NTDs. Essentially, this meant paying close attention to 'feeling' in the research, trying to (as far possible) feel along with others, what Laplantine calls 'sharing in the sensible' (Laplantine 2015).

3.2 Setting and context

Fieldwork conducted by the first author (2020–2025) followed advocacy networks for three stigmatizing skin NTDs—including podoconiosis—across Ethiopia, Rwanda, Sudan, and the United Kingdom. These global health networks linked researchers, NGO leaders, health ministry staff, donor representatives, and parliamentarians. Their advocacy efforts spanned campaigns for WHO recognition, integration into national health strategies, and securing sustained overseas development assistance.

Policy work is understood in its very broadest sense and unfolded in a variety of settings: WHO meetings, NGO conferences, UK parliamentary receptions, and field visits to treatment centres. Far from sterile, these spaces were sometimes punctuated by small moments of emotional rupture—tears interrupting technical presentations, silences settling over boardroom tables, or ritual foot-washing. These moments disrupt images of the "rule of desks" (the perception of policy as faceless and purely technocratic) and revealed the palpability of compassion beneath bureaucratic surfaces.

3.3 Participants

Twenty-nine participants were engaged through biographical interviews, focus group discussions and informal conversations, alongside participant observation. Participants included: academic researchers (epidemiologists, geneticists, anthropologists), NGO directors and frontline staff, Ministry of Health officials in NTD-endemic countries, and representatives of WHO and donor agencies. This diversity reflects the networked nature of NTD policy advocacy: compassion was not confined to frontline health workers or those in direct advocacy roles but surfaced among funders and scientists—actors often assumed to be detached.

3.4 Data collection

3.4.1 Ethnographic observation

Participant observation was conducted in both physical and virtual spaces: e.g., online meetings, seminars and conferences, WHO meetings, NGO annual conferences, strategic advisory board sessions. The observations that this paper focuses on concern palpable moments, affective shifts signalled by silence, tears, or embodied resonance (e.g., goosebumps). These moments were recorded in detailed fieldnotes, including researcher reflexive responses.

3.4.2 Biographical interviews

Interviews explored participants' biographies, including formative encounters with suffering, enduring memories, and how these experiences shaped their professional commitments. A significant number of interviews revealed emotional, formative memories, moments of compassion that lingered for decades, resurfacing at key life stages and sustaining advocacy.

3.4.3 Analytic approach

Analysis for this paper combined affect theory, anthropology and philosophy of compassion, and sensory ethnography. Therefore, reading through fieldnotes and interviews, the first author was attuned to affective markers (silence, tears, goosebumps), narrative motifs (moments of unselfing, 'moral' awakening) and any temporal dynamics (memories resurfacing over decades).

3.4.4 Paintings

Large-scale paintings were co-created with Kenyan artist Johnson Ondiek, depicting some of the scenarios described by participants, and becoming dissemination and advocacy artefacts (used in a policy event, for example). Several of these were selected for inclusion in the 'Black Box of Policy', an immersive travelling installation (contained in a tent) of sounds, art and lights inspired by the research with the aim of encouraging users to share in the stories and feelings of people affected by neglected diseases, and researchers, policy advisors and others trying to make change. Paintings were accompanied by music and audio-clips from interviews. Reactions to the Black Box, ranging from tears to confusion, provided insights into compassion's uneven legibility: not everyone "caught" compassion in the same way.[3]

3.5 Reflexivity and ethics

Ethical clearance for this piece of research was obtained from the Research Governance and Ethics Committee of Brighton and Sussex Medical School. All study participants were adults. For interviews and focus group discussions, participants provided informed consent in audio-recorded verbal form after reading an information sheet. Pseudonyms (e.g., Zara, Joy, Dawit) are used to protect identities. Gatekeeper permission was obtained for observations at conferences and meetings.

In the course of this research, the first author found herself also emotionally touched by listening to the stories of others and started to take on a dual role as both researcher and researcher and policy advocate (chairing the UK Coalition Against NTDs Influencing Working Group). Her own embodied responses (tight throat, goosebumps) were recorded as analytic data. While anthropology values such reflexivity, it can challenge epidemiological norms of 'objectivity' and replicability, and it is important to bear this in mind.

[3] A short video showcasing the Black Box can be viewed here: https://youtu.be/kHjTZOFEeS8?si=Ys93iN_hphTPcDZu

3.6 Limitations

Ethnography, the bedrock of anthropological research, relies heavily on (usually) a single researcher who interprets findings through their mind and body. The deep immersion of an ethnographer offers nuance but does limit replicability, a challenge for epidemiological generalisation. It is difficult to know, therefore, whether the first author's attentiveness to moments of love or compassion is a particular feature of her, as a researcher and person, or whether other researchers would have also produced these findings, with this focus. For example, her experience is shaped by a visual condition that makes her rely more on voice, atmosphere, and other non-visual cues. Therefore, it is important to consider the findings discussed below as exploratory, offering starting points for further research, rather than definitive.

4. Findings

Findings are presented below as a series of ethnographic vignettes (written by the first author in first person) that trace how compassion emerged, moved, and lingered within global health policy spaces—not as a stable trait, but as a sensory and relational force that was intermittently palpable, sometimes contagious, and occasionally transformative. Four key themes are identified: compassion as a palpable moment, compassion as an enduring trace, compassion as a traveller, and finally, compassion arising invisceral recognitions of structural violence

4.1 Theme 1: Palpable moments—compassion in the room

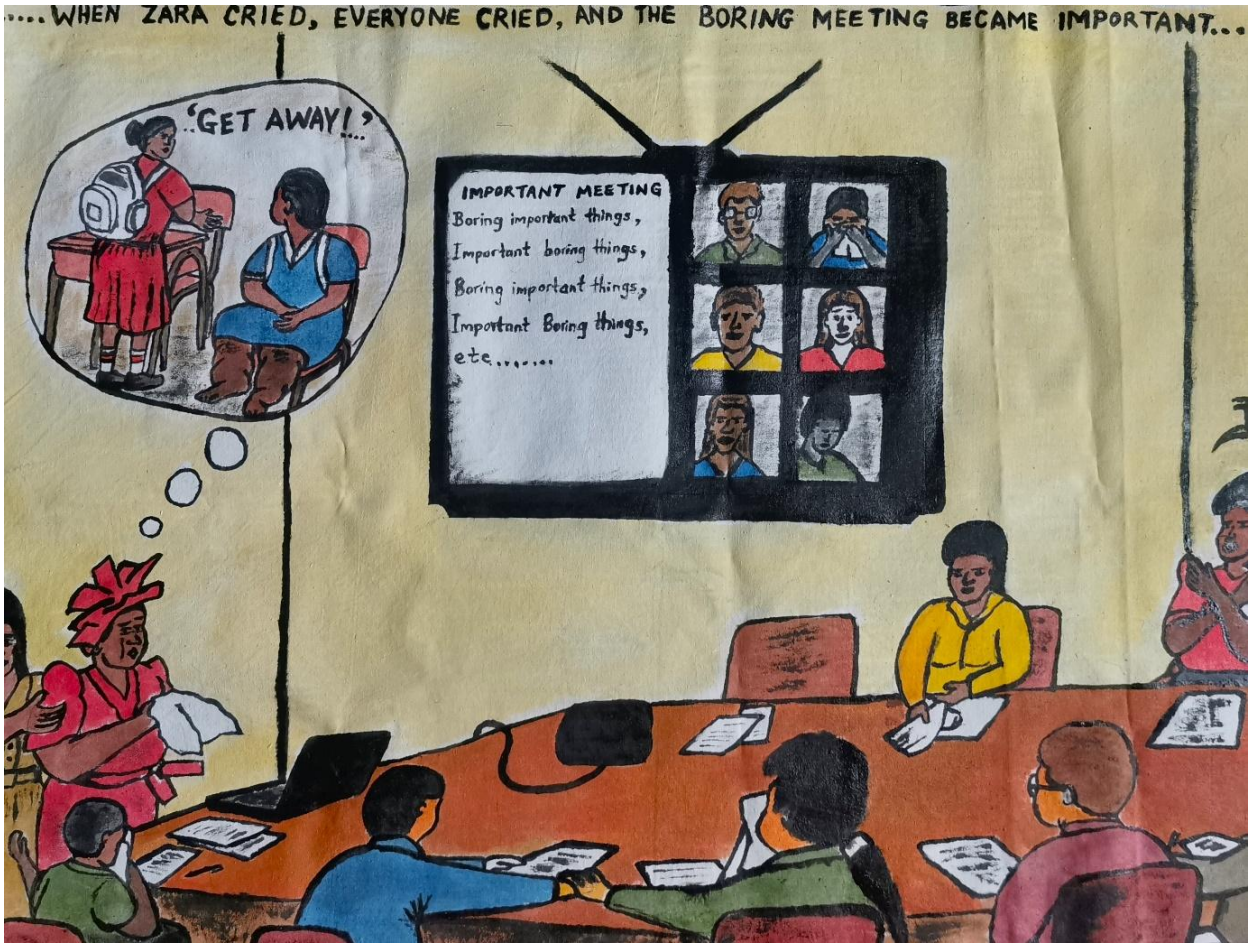

Figure 1. 'When Zara cried, everyone one cried. And the boring meeting became important' (Illustration by Johnson Ondiek with Gemma Aellah, 2022)

4.1.1 Before: A mundane meeting in an unusual place

It is the third day of an annual strategic advisory board meeting for a transnational applied medical research programme in the UK. The venue is striking: a glass-fronted room in a Premier League football stadium. Outside, the immaculate pitch glows under soft wintery light; inside, the energy is waning. Laptop lids open and close. Coffee cups cluster. The hum of air conditioning and faint crowd noise from a distant tour of the stadium form the soundtrack to technical updates: PhD milestones, risk registers, agenda items about data harmonisation.

The first author sits behind the main table, her fieldnotes already thick with acronyms and procedural decisions. Nothing in the atmosphere signals what is about to happen.

4.1.2 During: Zara speaks

Zara, a new board member representing a Rwandan NGO, is asked to introduce herself and rises to do so. Her posture is tentative, her voice quiet. Rather than listing credentials as would be usual convention, she spontaneously begins with a memory:

> 'I really appreciate the importance of this project, because these patients have been really neglected for a long time… I grew up in a rural area, I know what you are talking about. My classmates who had parents or siblings with podoconiosis… we could not even eat together. It's really sad. When I think about it now, I feel guilty, and I do not even have a chance to say sorry to them. Because they have died.'

Her voice cracks. A silence falls, thicker than any ordinary pause. Pens hover midair. Screens lower. The hum of air conditioning becomes suddenly audible. Goosebumps rise on my arms. I (first author) register my own breathing slowing, in sync with others. A funding representative's eyes well; another researcher quietly reaches across the table to rest a hand on Zara's arm.

4.1.3 After: A meeting transformed

When the meeting resumes, something in the atmosphere has shifted. Technical updates feel newly urgent. Immediately after the meeting, I turned to one of the project's funding representatives sitting near me and ask them if they felt something. 'Yes,' they told me, 'It was a 'goosebumps' moment. I was crying, you were crying. It was a reminder not to sweat the small stuff.'

This was compassion as acute exposure—a sudden, unplanned, rupture in bureaucratic routine. In epidemiological terms Zara's story became an index case, triggering affective contagion that spread silently across the room, altering its emotional temperature. The moment was all the more compelling, perhaps, because it was not staged. Despite it's 'smallness' the atmosphere felt more potent in comparison to other more rehearsed moments of personal storytelling designed to invoke compassion, such as observed on a formal stage during the launch of the 2022 Kigali Declaration on NTDs at the Malaria and NTDs Summit in Rwanda. The first author was present in person during this event, in which Chimamanda Ngozi Adichie spoke about her experience of losing childhood friends to malaria. Yet, despite the poetics of her storytelling and drama of the stage lighting, the felt experience of a 'goosebumps' was much less (for this ethnographer, at least) than when Zara spoke more casually in the small administrative meeting.

4.1.4 Afterlife: From meeting to painting

Months later, Zara's moment was captured in a painting: 'When Zara cried, everyone cried, and the boring meeting became important' (Ondiek & Aellah, 2022). The artwork travelled inside the

Black Box of Policy immersive installation described above, accompanied by a recording of Zara's voice repeating the story she had shared in the meeting. I observed people entering the box and their reactions. Some cry and seem visibly moved. But I noticed that not everyone responded in the same way. Compassion, I realised, doesn't 'catch' in everyone the same way. Yet for those who resonate, the painting reactivates the moment: a booster exposure, reigniting moral urgency long after the fact, even for people several degrees removed from the original event.

4.2 Theme 2: Emotional core memories—enduring traces of encounter

Figure 2. 'Somebody's child, everybody's child' (Illustration by Johnson Ondiek with Gemma Aellah, 2024)

4.2.1 Joy and Lydia: A memory that haunts and sustains

Joy, a UK-based NTD researcher and advocate, sits across from me in a quiet corner of a research institute for an in-depth interview. She recounts her first encounter with podoconiosis decades ago, when she was working in Ethiopia. She says that the 'memory of seeing the first patients has never left me.' And then tells me about Lydia, a teenager who was brought to meet her during her first visit to a rural podoconiosis clinic in Ethiopia and who had been stopped from jumping from a tree because:

> '…she had noticed her leg swelling and knew what that would mean. And she had seen what effect it had on her family. And she tried to kill herself. Thankfully someone had brought her down, and there she was—really depressed, clearly. You never forget that… when your own children reach that age, you think: why are there still places where a sixteen-year-old girl can want to kill herself because of a condition that's completely preventable?'

As she speaks, I feel my own throat tighten. Time seems to slow. This is compassion not as sudden eruption but as chronic, latent exposure—a memory etched deep, resurfacing when Joy's own daughters reach sixteen, reactivating advocacy decades later.

This moment is immortalised in '*Someone's Child, Everyone's Child'* (Ondiek & Aellah, 2023), later incorporated into the Black Box of Policy installation. The painting's title echoes the epidemiological logic of contagion: one child's suffering reframed as universal moral concern.

Joy is not the only person who tells me a story like this. For example, James, a scabies researcher and advocate shares with me the moment he truly realises why tackling scabies was something worthwhile dedicating himself to. In a small clinic on a tropical island, he found himself witnessing the treatment of a small child suffering dreadfully from scabies, a treatable skin disease that his own small daughter would never suffer from in such a way. The contrast between the child in front of him and his healthy child back at home provoked a moment of deep and significant compassion. Desta, an Ethiopian dermatologist also shares with me his core memory: of returning to an NGO where he did voluntary work to visit a patient with podoconiosis, ready to commence a simple foot washing care regime after doing some research on how to effectively treat the condition, but instead finding it was too late:

> 'I could not find my patient. And then I went to this room. And I found him lying there and his leg was already amputated. Because the orthopaedic physician at that time thought that there was no solution for this kind of foot. That one—oh, I really became sad and upset with myself…'

4.2.2 Dawit: The voice that clicks in his ears

And of course, Dawit, once a clinician, now a policy advisor, who in the vignette that opens this paper describes a boy from his hospital days:

> 'This child asked me, 'Doctor, am I going to look like those old guys?' And I knew the answer. Because of our health system's negligence, I thought he is going to go downhill. But I lied. I said, 'No way, you'll be fine.' And his voice still clicks in my ears. I really lied to this boy, and that makes me unhappy.'

The phrase 'still clicks in my ears' conveys how such retellings are not just memories but auditory haunting—a sound that reverberates years later, shaping career choices and policy commitments. In epidemiological framing, these could be described as latent infections: exposures long past that resurface as potent motivators.

4.3 Theme 3: Transmission and transformation—how compassion travels

As part of this project's dissemination activities, I participated in several activities that produced insight into how these small moments of compassion could travel or extend outwards beyond the individual. In both examples, as in the meeting where attendees 'caught' some of Zara's feelings towards her classmates, compassion travels, but here it is through art and through touch. In all cases, as it moves it leaves its original setting and creates small moments of connection between people who might never have met. In this way, and in epidemiological terms, compassion could be thought of moving through 'emotional vectors.'

Figure 3. 'Touching feet and hearts: A ritual foot washing' (Illustration by Johnson Ondiek with Gemma Aellah, 2024)

4.3.1 The black box of policy: Mediated contagion

As described above, the Black Box of Policy is an immersive installation that combines Joy's (and others) audio testimony with paintings like *'Someone's Child, Everyone's Child.'* Inside the darkened space, visitors hear Joy's real breaking voice while confronting vivid imagery. The effect is visceral: some cry openly; others stand motionless; a few leave quietly to compose themselves.

Here, compassion can be seen to spread secondarily—transmitted not by direct witnessing but by mediated encounter. The artwork functions as a vector, carrying core memory across time and geography, from rural Ethiopia to a policy forum or university room, and allowing others the chance to feel something of the emotions another felt when witnessing suffering first hand. It is difficult to know, however, (within the confines of this specific research project) the enduring impact of this—whether the effect provokes transformative action or remains at the level of providing a moment of contemplative reflection that may, or may not, have any diffuse effects later on in the life and actions of those entering the Black Box.

4.3.2 Ritual foot washing: Collapsing hierarchies

For the final dissemination meeting our research programme held, a group of UK parliamentarians travelled to Ethiopia. The parliamentarians had asked to visit a treatment centre to see podoconiosis care in action. I saw an opportunity to move beyond passive observation; to create a moment where they might *feel* something of the embodied, relational compassion that seems to sustain many NTD advocates over time. Watching patients demonstrate self-care routines would provide information, but I wanted to shift the encounter from seeing to sensing. Drawing on the

idea that compassionate love begins when being extends beyond the skin, I suspected that literal touch might be key.

Because it would have been politically fraught—and visually problematic—for a Global South health worker to wash the feet of a Global North policymaker, I arranged instead to be trained myself in washing a parliamentarian's feet. The night before the visit, as we drove back from a cultural dinner, the parliamentarians chatted mostly about the football match they were planning to watch from their hotel. It didn't feel like the beginning of a transformative moment.

At the treatment centre the next day, patients were initially hidden behind a canvas wall while officials gave formal speeches. When the curtain was pulled aside, the patients were suddenly revealed, sitting quietly with their feet in plastic basins. At first, the gap between them and the visiting delegation felt unbridgeable. And then—gradually—there was movement. A few MPs began sitting beside patients, exchanging questions through translators. The atmosphere shifted.

In the painting that later captured one of the day's key moments, I'm crouched, learning to wash a parliamentarian's foot. A patient seated beside him steps in to help—offering guidance, laughing gently when I drop the soap. They didn't exchange names, but they laughed together. Something shifted. In that mix of awkwardness and intimacy, of seriousness and shared humour, I felt something open.

This was communitas in anthropologist Turner's (1969) sense: a fleeting collapse of social hierarchy in a liminal moment, where politicians dressed in suits moved from the formal space of the tent for speeches, to a space for care, breaking with formal protocols, sitting on simple benches alongside patients with their feet in buckets. It was not staged or sentimental, but tactile and sincere—a moment where touch carried moral weight. Compassion here travelled not through statistics or speeches but through contact. Holding the parliamentarian's vulnerable foot in my hands, I felt something physically soften between me and him, and more importantly, between him and the man with podoconiosis sitting beside him.

Later that afternoon, at our policy forum attended by senior Ethiopian stakeholders, one parliamentarian reflected:

> *'Some of us were reflecting this morning that there was something almost biblical about the washing of feet that we witnessed… How quickly could we make progress on the Sustainable Development Goals if we found ways to love others as we love ourselves? We share a common humanity, whatever our religious affiliation.'*

This ritual produced more than empathy. It produced a tactile exposure that briefly collapsed policy distance, allowing compassion to be felt, transmitted, and perhaps remembered. In the logic and terminology of an epidemiology of compassion, this moment might be read as a contact event—a brief, sensory exposure with the potential to alter the trajectory of motivation and memory.

4.3.3 Afterlives: Compassion as fuel

These moments reverberate beyond the events themselves. Compassion here functions as motivating fuel, sustaining advocacy through bureaucratic inertia and the slow grind of eradication campaigns. These memories seemed to work like wells that people could return to, stores of feeling that sustained them long after the original encounter.

4.4 Theme 4: The visceral recognition of structural violence

What Dawit, Joy, and the others interviewed in our research project had in common was that they worked in the health field, albeit in different capacities—positions that made them more likely to encounter compassion-triggering moments, since such exposures are unevenly distributed and often concentrated where structural violence and avoidable suffering are most visible. In other respects, they came from different backgrounds, countries, and genders, and the small scope of this research does not allow me to generalise much further about distribution.

However, we hypothesize that not every type of suffering provokes the same intensity of compassion. We wonder if these moments invoked intense compassionate love precisely because they revealed avoidable suffering—diseases that could have been prevented if the sufferer's life circumstances or the state of global policymaking had been different. We suspect that encounters with more 'natural' or 'unlucky' suffering would not elicit the same quality of activating compassion. In this sense, such experiences are patterned by inequity: they occur where structural violence has made some lives more vulnerable, more exposed, and more neglected. Structural violence is harm embedded in social and political systems that produces suffering and avoidable death, yet its diffuse, systemic nature makes it difficult to trace or blame, so its effects often remain unseen (Galtung, 1969; Farmer, 2005). In these examples, however, Joy, Dawit, Zara, and others were, for a moment, able not only to see but also to *feel* structural violence expressed through the damaged potential of a specific individual's life.

Interestingly, although these encounters were always about a specific person—vividly present in the moment—the individuals were never truly known again. Dawit cannot remember the boy's name; like Joy and Zara, he does not know what became of him. Nor do we know whether the other person (the sufferer) experienced the encounter as profound or lasting. For those on the observing side, compassionate love provoked a visceral, immediate response—goosebumps, tears, the urge to comfort—but rarely translated into direct action for that individual. Instead, the encounter became catalytic, shaping future commitments not toward the one person before them but toward all those who share their position within the unequal distribution of suffering. In the moment, Joy, Dawit, Zara, and others often felt powerless, unsure what could be done. Yet it is precisely this uncertainty, this confrontation with structural failure in which they had been complicit, that seems to propel their future selves to act.

Crucially, compassion here is entangled with power. Observers occupy positions within the health system that both enable exposure to suffering and constrain action. Their visceral responses—goosebumps, tears, the urge to comfort—reflect not a pure moral sentiment but an awareness of inequality and their own structural positioning. Often powerless to intervene directly, the experience redirects their energy toward broader commitments, highlighting the limits and possibilities of action within institutional and global hierarchies. In this sense, the compassion observed is both a response to vulnerability and a recognition of systemic inequities, complicity, and authority.

This framing offers a subtle counterpoint to Didier Fassin's important critique which emphasizes compassion as selective, performative, and morally partial. While our participants' compassion is indeed uneven and structured by power, it is not merely symbolic; it involves visceral recognition of structural violence and can catalyse sustained practical engagement with systemic inequities, extending beyond immediate, visible suffering.

4.5 Summary of findings: Compassion behaving epidemiologically

Across these vignettes, it might be helpful to think of compassion as behaving in ways akin to an epidemiological process. It seems to have determinants**:** proximity to suffering, personal

biography, sensory immediacy (touch, tears, silence) distribution (concentrated around avoidable suffering), and vectors: direct encounters (Zara's testimony), mediated storytelling (Black Box), ritual care (foot washing). It also has protective effects**:** sustaining advocacy, mitigating burnout, re-humanising policy spaces. And, finally, it exhibits temporal dynamics: brief exposures transforming into enduring motivating memories, reactivated across careers and networks.

5. Discussion

This ethnography provides an in-depth account of compassion's dynamics within global health policy processes, demonstrating how compassion could potentially be conceptualised as an epidemiological phenomenon, with determinants, vectors of transmission, protective effects, and enduring impacts on advocacy networks. By bringing sensory ethnography into dialogue with epidemiology, the study responds directly to Addiss et al.'s (2022) calls to develop a transdisciplinary 'epidemiology of compassion.'

Compassion in this study behaves like contagion. A single exposure—Zara's tearful memory, Joy's haunting recollection, Dawit's 'clicking' voice—triggers affective resonance across a group, evident in collective silences, goosebumps, and subtle gestures (e.g., a hand on an arm). These moments function as index cases, sparking emotional shifts that spread quietly yet powerfully through policy networks.

Interestingly, transmission is not limited to direct witnessing. Compassion travels through mediated vectors: paintings (e.g., *When Zara cried*), installations (the Black Box of Policy), and ritual (foot washing). These artefacts allow compassion to reach secondary audiences, sustaining action far beyond the original encounter. Compassion thus could be seen as operating epidemiologically: arising under certain conditions, 'infecting' others through relational and sensory channels, and leaving behind potent memories that can persist for decades.

5.1 Motivating memory and temporal dynamics

A striking finding is compassion's temporal durability. Joy's memory of Lydia's suicide attempt—decades old yet emotionally vivid—continues to shape her advocacy and parenting. Dawit's recollection of the boy's fearful question ('Will I look like those old men?') 'clicks' in his ears years after leaving clinical work. And Desta finds ways to continue to support podoconiosis patients through setting up a clinic, as well as teaching his medical students. These are not fleeting empathic responses but recurrent prompts, enduring imprints that resurface at pivotal moments, guiding professional decisions and personal ethics.

This challenges prevailing views of compassion as transient or situational. Instead, compassion can be understood as an emotional reservoir of motivation: an affective resource drawn upon repeatedly in advocacy, sustaining commitment amid bureaucratic fatigue and slow policy progress. Importantly, this observation also addresses critiques of compassion itself: Bloom (2016), for example, argues empathy and compassion are parochial and biased, prone to moral errors. By this he means that empathy is biased and narrow in its focus on single, identifiable victims at the expense of addressing systemic inequalities. The cases here suggest otherwise, illustrating how compassion can extend beyond individual partialities, fostering broader solidarities. For, in this context, it is notable that although compassion is sparked by intimate encounters with single suffering others, those experiencing the moments as profound did not continue relationships with those particular people. Nor did it lead to direct action for that person. For example, Dawit cannot remember the name of the boy whose voice 'trickles' in his ears and, like Joy and Zara, does not know what happened to him after the encounter. Rather

these 'exposure events' trigger enduring action (like public health advocacy and policymaking) at a more 'population level', with the single person standing for a group of unknown others also suffering from NTDs. Dawit remarked on this when discussing why he decided to change from being a surgeon treating individual patient after individual patient to working on policy aimed at mass treatment and eradication: 'you realise that the task is endless, it will never stop. Unless a bigger solution is found.' Kirby et al. (2026) have highlighted the importance of attending to the 'flows' of compassion - compassion to others, compassion from others, and self-compassion. Our ethnographic project adds an additional direction to their 'flow of compassion' framework: the diffuse movement of compassion away from identifiable individuals toward non-named others, as affect generated in vivid, intimate encounters is redirected into commitments to populations who largely remain unknown.

5.2 Counterpoint to necropolitics

Global health policy is often critiqued as necropolitical (Mbembe, 2003): producing zones of neglect where certain populations are consigned to premature death. This study acknowledges those structural realities but also reveals a small quiet moral counter current: fleeting moments of compassion that can rupture bureaucratic indifference.

These compassionate ruptures do not erase structural injustice but create spaces of re-humanisation, moments when policy actors reconnect to the lived realities behind statistics. Compassion thus fuels potential resistance to necropolitics, sustaining actors in the long, grinding work of advocacy for neglected diseases.

5.3 Distribution and the personification of structural violence

An epidemiology of compassion must also consider its distribution. Encounters that trigger compassion are not random but patterned by inequity, arising where people meet personifications of structural violence and avoidable suffering—especially stark in NTDs that afflict the most marginalised. In such moments, people not only see but *feel* the enormity of injustice that usually remains hidden. What strikes hardest is the dissonance between the potential of the person before them and the reality of their preventable suffering, coupled with the unsettling recognition that the very systems they represent are complicit in this failure. Such exposures are concentrated in spaces of neglect. Some people, therefore, are more likely than others to find themselves in places where they experience this exposure (for example, some people working on policy-related activities may never, or less frequently, meet people with the diseases they target). Attending to distribution shows how compassion, like disease, follows social fault lines, its very emergence shaped by the uneven topography of suffering.

5.4 Anthropology's contribution to epidemiology of compassion

Anthropology enriches epidemiology by revealing compassion's relational and sensory textures. Murdoch's (1959) notion of embodied 'unselfing'—seeing the other as fully real—is evident in Zara's and Joy's vignettes. Turner's (1969) concept of communitas illuminates the transformative humility of ritual foot washing.

Epidemiology, in turn, offers scale: identifying patterns of exposure, mapping determinants (e.g., proximity to suffering, personal biography), and measuring outcomes (e.g., sustained advocacy, reduced burnout, enhanced wellbeing). A hybrid approach integrating qualitative and quantitative methods could capture compassion's complexity while enabling system-level insights.

5.5 Methodological implications

5.5.1 Multi-sensorial ethnography

This study demonstrates the value of multi-sensorial ethnography (Pink, 2015; Stoller, 1989) for compassion research. Attending to bodily responses—goosebumps, silence, tears—reveals affective dynamics invisible to standard policy analysis. Visual artefacts (paintings, installations) not only document but extend compassionate encounters, allowing them to travel and be studied across settings.

5.5.2 Reflexivity as data

The first author's dual role as researcher and advocate provided privileged access but required constant reflexive attention. Her own embodied responses (tight throat, goosebumps, awkward humility washing feet) became analytic signposts, alerting her to moments when compassion was 'in the room.' In anthropology, such reflexivity is integral; in epidemiology, it may be seen as bias. Yet recognising how compassion moved the ethnographer illuminates how it might move others—an insight vital to any epidemiology of compassion.

5.5.3 Bridging disciplinary silos

Bridging anthropology and epidemiology requires methodological innovation. Multi-observer ethnography, mixed-method designs, and integration of psychometric tools with sensory data could deepen understanding of compassion's spread. Importantly, such hybrid approaches must preserve compassion's lived texture rather than flattening it into metrics alone. This perspective aligns with Adiabu and Nkamgang Bemo's (2026) proposal for a compassionate epidemiology that centres relational knowledge and lived experience rather than standardised metrics.

5.5.4 Compassion, justice, and wellbeing

Farmer's (2005) concept of pragmatic solidarity—the moral imperative to accompany those suffering injustice—resonates strongly with this study. Compassion here is not passive pity but active solidarity: motivating advocacy, sustaining networks, and reorienting policy toward equity. By linking compassion to collective wellbeing, this study reframes success in global health: not solely expressed in metrics, but the cultivation of ethical, sustaining relationships that underpin enduring change, such as long-term equitable partnerships between institutions, practitioners and communities, networks with collective goals that persist beyond short-term funding cycles and siloed interests, or the small but growing practice of involvement of people affected directly as equal partners in policy and practice.

5.6 Limitations and future directions

This study's scope, observed by a single ethnographer within a small group of participants, limits generalisability. Compassion's dynamics may vary across diseases, cultural contexts, and policy arenas. Therefore, future research could explore comparative studies across different health conditions (e.g., HIV, mental health, maternal mortality); mixed-method designs integrating ethnography, psychometrics, and physiological measures (e.g., heart rate, galvanic skin response). It would also be interesting to develop systematic network analyses mapping compassion's spread across policy actors and time, as well as intervention studies testing ethical ways to cultivate compassion in policymaking. Further, it would be important to explore whether there are 'antibodies' to compassion: why are some people moved and others not (and does this always matter?); how often does exposure actually lead to action and how would it be possible

to measure this, given what counts as 'action' could be difficult to observe or even define? How does 'burnout' or 'compassion fatigue' arise, and how can compassion be revived? Finally, reflecting on the felt difference between performative and more spontaneous storytelling, it is worth considering the potential for inadvertently encouraging cynicism when designing opportunities for exposure, for instance, by creating experiences that feel inauthentic or manipulative.

6. Conclusion

This ethnography demonstrates that compassion, often overlooked in policy analysis, quietly but profoundly shapes global health advocacy. Through thickly described vignettes—Zara's tears silencing a boardroom, Joy's memory of Lydia's suicide attempt, Dawit's haunting recollection of a boy's fearful question, and MPs humbling themselves in ritual foot washing—compassion emerges as a quiet motivating force within bureaucratic spaces.

Framed epidemiologically, these moments reveal compassion's determinants (personal biography, sensory immediacy, proximity to suffering), vectors (direct encounter, mediated storytelling, ritual care), and protective effects (sustaining advocacy, mitigating burnout, reframing neglected diseases as moral imperatives). Crucially, compassion displays temporal dynamics: brief exposures that evolve into moral memories, resurfacing across careers and reactivating ethical commitment at critical junctures. These moments are unevenly distributed, appearing where exposure to suffering is concentrated, and are easily overlooked if not attended to.

In many ways, compassion felt contagious. A single moment—Zara's tears, Joy's story—would linger in people's memories and resurface years later, shaping their choices and sustaining their commitment to eradication.

This study challenges prevailing framings of global health policy as purely technocratic or necropolitical. While structural neglect remains profoundly real, moments of compassion, often fleeting, easily missed if not observing closely, disrupt bureaucratic inertia, re-humanise statistics, and sustain those who labour toward seemingly impossible goals, such as the elimination of ancient diseases of poverty.

The findings underscore the value of multi-sensorial ethnography for global health research. Attending to goosebumps, silences, and tears, alongside words and numbers, enriches understanding of how compassion operates in networks and systems. Moreover, integrating these insights into an epidemiology of compassion offers a promising framework for bridging anthropology's attentiveness to lived texture with epidemiology's capacity for scale.

Finally, this work points toward wellbeing implications. Compassion not only alleviates suffering for those directly affected by disease but also nurtures relational wellbeing among policymakers, advocates, and health workers themselves. By cultivating conditions for compassion to emerge and travel ethically, global health systems can foster more humane, resilient, and ethically attuned responses to the world's most neglected health challenges.

6.1 Conceptual framework for an epidemiology of compassion in global health

Building on this ethnographic research into NTD policymaking, we propose some suggestions for a conceptual framework for an 'epidemiology of compassion' that considers compassion not only as a personal moral sentiment but as a structurally significant force, shaping advocacy, persistence, and policy transformation in global health.

Such an epidemiology of compassion could track several interrelated phenomena:

- Compassionate Encounters—A visceral recognition of 'the other#, echoing Iris Murdoch's notion of love as 'the extremely difficult realisation that something other than oneself is real.' Zara's confession exemplifies such an encounter, transforming a routine meeting into a moment of moral reorientation.
- Memorialization and Moral Trajectory—First-hand encounters (e.g., Joy meeting Lydia) persist as enduring energising touchstones, resurfacing across decades to guide advocacy careers and policy priorities.
- Communitas and Relational Extension—Shared experiences, such as the Ethiopian foot washing ritual, create temporary suspensions of hierarchy, fostering a sense of common humanity (Turner, 1969).
- Transmission of Compassion—Compassionate moments can 'travel' through storytelling, art, and ritual—evident in the Black Box installation that allowed others to feel, second-hand, what Joy felt in Ethiopia.

6.1.1 Methodological implications

Studying compassion requires moving beyond document analysis and semi-structured interviews toward ethnographic, sensory, and narrative methodologies: observing silence, tears, touch, and other embodied responses as legitimate policy data. Mapping how compassion flows across individuals, events, and timelines parallels the tracing of disease transmission revealing how emotional contagion shapes advocacy trajectories.

6.1.2 Ethical and critical considerations

This framework acknowledges compassion's dual potential. As Kalir (2019) warns, 'repressive compassion' can humanize oppressive systems without altering them. Any future epidemiology of compassion must interrogate who is moved, who is unmoved, and why, paying attention to the uneven distribution of exposure to suffering and compassion across different actors, contexts, and structural positions. Ensuring that compassion fuels structural transformation rather than symbolic comfort requires recognizing that some individuals encounter profound ethical stimuli while others are systematically shielded from them.

6.1.3 Implications for global health

Embedding compassion into global health practice has several implications:

- Training: Incorporating reflective and narrative practices into professional development for health workers and policymakers.
- Metrics: Complementing Disability Adjusted Life Years (DALYs) and Quality Adjusted Life Years (QALYs) with indicators of dignity, trust, and recognition of common humanity.
- Advocacy Design: Intentionally fostering compassionate encounters—through immersive storytelling, participatory art, and carefully structured field visits— while being attentive to the uneven distribution of who can access or witness such moments and avoiding instrumentalization or voyeurism.

6.2 Closing

An epidemiology of compassion reframes global health as not only a technical endeavour but also a profoundly human one. By systematically tracing where and how compassion arises—

moments of love quietly at work—we can better understand, and potentially cultivate, the energies that sustain movements to address neglected diseases, and broader inequities in global health.

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GA: Conceptualization, Methodology, Investigation (ethnographic fieldwork and data collection), Data curation, Formal analysis, Writing—original draft. GD: Funding acquisition, Conceptualization, Writing—review & editing.

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The authors report no conflicts of interest.

AI statement

AI tools were used for proof-reading (spelling and grammar).

Data availability statement

Due to ethical restrictions arising from the sensitive and personal nature of the ethnographic and qualitative data collected, including fieldnotes, the raw data underlying this study are not publicly available. In accordance with the approved ethics protocol, they are stored in a secure repository at the University of Sussex and cannot be shared beyond the research team. Extracts supporting the findings may be made available by the first author upon reasonable request, subject to ethical approval and controlled access conditions.

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