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ARTICLE

Organizational features associated with compassion in two primary healthcare centres in Kenya and Uganda

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Abstract: To alleviate and prevent suffering, healthcare systems require collective action through organizational design and management. Therefore, healthcare organizations are appropriate contexts for studying the epidemiology of compassion – an emerging science that seeks to understand individual and systemic factors that foster compassion. Most research on compassion in healthcare settings has been conducted in high-income countries, focused on individual attributes that facilitate the giving of compassion. Less attention has focused on compassion in low- and middle-income country settings, or on organization- and system-level conditions that often determine whether compassion flourishes or falters. Epidemiology is a quantitative science, yet qualitative research can identify characteristics that warrant further testing and quantitative assessment. We conducted qualitative case studies of two primary healthcare organizations in Uganda and Kenya to examine how compassion is cultivated and sustained at the organizational level. Using the five components of the social architecture framework (network structures, organizational culture, roles, routines, and leaders) we discuss characteristics of these organizations that may enable compassionate responses to suffering among staff. Qualitative research in healthcare settings, framed by principles of organizational science, offers a pathway to sustaining healthcare workers and improving patient care. Increased attention to organizational and system-level compassion is needed, particularly in low- and middle-income countries where suffering is profound and complex.

Keywords: organizational compassion, social architecture, primary healthcare, epidemiology of compassion

1. Introduction

Healthcare systems require unique forms of collective action through organizational design and management to deliver services that prevent and alleviate suffering both for patients and the workers who care for them. The healthcare working environment heightens worker exposure to suffering through caring for the sick and dying (Pestian et al., 2023), and healthcare contexts have long been acknowledged as significant sources of worker suffering (Thienprayoon et al., 2022). Compassion is widely venerated as a cornerstone of healthcare, yet these workplaces are often physically, culturally, and psychologically unsafe for many employees (Simpson et al., 2020; Sinclair et al., 2016). In such an environment where the sources of suffering are 'recurrent and foreseeable,' organizations should strive to anticipate and prevent distress to the greatest extent

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possible (Gilbert, 2014; Pestian et al., 2023). Healthcare organizations may therefore be especially appropriate for studying coordinated responses to suffering and the epidemiology of compassion – an emerging science of the distribution of compassion by person, place, or time. In the healthcare literature, compassion has been conceptualized in diverse ways — as an identity, a value, an obligation, a finite resource, or a performed action (Martimianakis et al., 2020). While this range of interpretations can be viewed as conceptual ambiguity, it also highlights the multiple avenues through which compassionate action may occur, from individuals to organizations and systems (Stergiopoulos et al., 2019).

An organization can be defined as "a social system composed of patterned relationships among individuals and groups, designed to coordinate activities and achieve collective goals" (Scott, 2003: 16). If individual-level compassion is defined as noticing, interpreting, feeling, and acting to ease suffering, then organizational compassion can be understood as a *collective pattern* of these same processes realized across the organizational social system (Worline & Dutton, 2017). Drawing on Dutton, Workman, and Hardin (2014), we use a definition of compassion that highlights these four key processes and differentiates it from related concepts, such as empathy. First, compassion requires recognizing the presence of suffering, whether in an individual or within an organization, since it "always unfolds in relation to suffering" (Worline & Dutton, 2017: 5). Second, it involves interpreting this suffering in a way that motivates a desire to help. Third, compassion entails experiencing empathic concern for those who are suffering. Finally, compassion involves the commitment to take concrete action to alleviate or reduce the suffering in some way. When considering organizations, this definition includes dyadic compassion, group-level compassion, and system-level compassion (Simpson et al., 2020).

Individual-level characteristics, personal experiences, and behaviors influence one's ability to give and receive compassion, both to oneself and to others (Addiss et al., 2022). Although individual-level compassion interventions such as mindfulness and empathy training have been shown to be effective (Addiss et al., 2022), underlying organization- and system-level issues can aid or hinder compassion from flourishing within these social systems (Cometto et al., 2022; Ozawa-de Silva & Mascaro, 2026; Pedersen & Roelsgaard Obling, 2019). For example, strains on staff resulting from rigid funding structures (e.g., over-extending the number of patients seen by a clinician in a single day), or frustrating administrative burdens related to electronic medical record maintenance, can quash compassionate care in healthcare organizations despite individual-level affects and intentions (Wodnik & Rowland, 2024).

Human suffering is an inevitable part of the human experience (Powell, 2003). Workplace suffering can stem either from sources within the organization (e.g., bullying, unsafe work conditions) or from the aspects of personal life that cannot be disentangled from one's work life (e.g., the suffering of loss, death, or illness) (Dutton et al., 2014). The field of organizational compassion was largely sparked by the work of Peter Frost (Rynes et al., 2012; Simpson et al., 2024) when he proposed that compassion and attention to humanity do not contradict organizational efficiency and performance, but rather enhance them (Frost, 1999). Frost draws on an account he witnessed, while himself receiving cancer treatment, of a nurse who provided deeply compassionate care to a patient who had had a dehumanizing, frustrating, and humiliating morning while recovering from esophageal and stomach surgery. He deftly demonstrates how the nurse's compassionate actions benefitted both the individual patient and the organization – and even the author himself for being "moved into the flow of such palpable compassion" (Frost, 1999: 396). This example highlights that while organizations and workplaces may often be depicted as sources of pain and suffering, they can also be the sources of healing, caring, compassion, and love (Frost et al., 2000; Kanov et al., 2004).

Similar to trends in other sectors, compassion initiatives within healthcare organizations frequently focus solely on individual healthcare workers, often promoting 'self-care' programs. While well-intentioned, these efforts can inadvertently add to staff burdens and overlook deeper organizational and systemic factors that influence the cultivation of compassion (Cometto et al., 2022; Martimianakis et al., 2020). Placing the responsibility for improving well-being and fostering compassion entirely on individual workers shifts accountability away from the organization and the broader healthcare system and policy context in which it operates (Pedersen & Roelsgaard Obling, 2019). There is a psychological cost for caregivers to constantly show compassion (Cocker & Joss, 2016), so expecting caregivers to show compassion to one another as a remedy for workplace suffering may overly tax caregivers and sidesteps organizational accountability. The World Health Organization recently released a report on compassion and primary health care that reinforces the importance of measuring compassion as a key part of understanding the performance of healthcare organizations and systems (World Health Organization, 2024). How organizational and systemic determinants affect the flow of compassion in healthcare organizations remains a key area for future research (Addiss et al., 2022; Kirby, Sherwell, & Hsieh, 2026).

Healthcare settings in low- and middle-income countries are underrepresented in the compassion and organizational science literatures. The scope and nature of suffering in these settings is arguably greater than in high-income countries, given the greater prevalence and severity of disease as well as systemic issues beyond the health system that contribute to 'surplus' or 'social' suffering, defined as suffering beyond that which is an inevitable part of the human experience (e.g., the suffering of loss, death, illness, or old age) (Powell, 2003). This paper reports initial findings from a qualitative study of organizational learning and compassion in two healthcare organizations in Kenya and Uganda, and examines how these empirical findings from an organizational context contribute to the epidemiology of compassion.

2. Methods

2.1 Study design

The empirical evidence is sourced from a forthcoming qualitative multiple case study that explores the role of organizational learning in facilitating or disrupting the expression of compassion among colleagues in two healthcare centres in lower-middle income countries (Wodnik et al., forthcoming).

2.2 Case selection

The two case study organizations are Nama Wellness Community Centre (NAWEC) in Mukono, Uganda and Safari Doctors in Lamu, Kenya. NAWEC is a primary healthcare facility of about 35 staff that focuses on maternal and child health and supports a cadre of community health workers, serving an estimated 65,000 patients annually. Safari Doctors is an organization of about 18 staff providing free healthcare and veterinary services to rural, marginalized communities of the Lamu archipelago in northeast Kenya, many of which are only accessible by boat, and serves approximately 15,000 patients per year. Both organizations are based in English-speaking regions.

These organizations were selected from a pool of healthcare organizations that currently receive funding through the IZUMI Foundation. The directors of each organization applied to receive an additional sub-grant to enhance compassion at their organizations, selected by a panel of 6 independent reviewers based on directors' self-assessment of compassion within their

organizations. Reviewers selected these organizations because they articulated compassion in their mission and values statements, requested support to further integrate compassion into their programs, perceived challenges in providing compassionate care to patients, and had no previous experience participating in formal compassion cultivation activities or programs. The IZUMI Foundation funds organizations that are driven by "compassionate heart" and serve hard-to-reach populations, particularly in sub-Saharan Africa, Latin America, and the Caribbean (IZUMI Foundation, 2025).

Our research primarily focuses on organizational components that foster compassion among staff, rather than between staff and patients or self-compassion, though these are undoubtedly important aspects and outcomes of organizational compassion in healthcare. Previous research has demonstrated that empathic fatigue in healthcare providers negatively affects compassion towards patients (Sinclair et al., 2017). Clinicians who experience compassion at work benefit from a buffer against workplace stresses, and report higher levels of wellbeing (Barsade & O'Neill, 2014; McClelland et al., 2018) and greater ability to provide compassionate care for their patients (Barron et al., 2017; Dewar & Nolan, 2013; Jones et al., 2016; Singh et al., 2018). Research interest in compassion for and among healthcare workers and teams has been increasing in recent years (Pestian et al., 2023).

2.3 Within-case sampling

Using purposive sampling (Patton, 1990), we invited providers and staff within each of the two organizations to participate in qualitative key informant interviews. Individuals were selected using a maximum variation approach (Sandelowski, 2000) to actively seek out diversity in factors that may influence compassion and organizational learning, including gender, religious identity, and role within the organization. We also used theoretical sampling to conduct additional interviews to "follow clues from the analysis, fill gaps, clarify uncertainties, check hunches and test interpretations" (Chun Tie et al., 2019).

2.4 Data sources

Data for this study include key informant interviews with staff, review of documents (e.g., meeting notes, annual reports), and in-person observations at both organizations. Data were collected between April 2023 and February 2025. Observations at each organization included daily activities, community outreach visits, team lunches, staff and departmental meetings, and staff trainings, for a total of 15.5 days of in-person observation time (NAWEC=9.5 days; Safari Doctors=6 days). We conducted 31 interviews (NAWEC=19; Safari Doctors=12). Twenty-eight were conducted in-person in private rooms at the healthcare facilities, and three were conducted via Zoom and recorded with participant permission. In-person interviews were recorded with participant permission; eight interviewees declined audio-recording, in which case the interviewer took detailed notes. All interviews were conducted in English.

2.5 Ethics

Ethical approval for this study was obtained through the University of Toronto Research Ethics Board (Protocol #46586).

2.6 Analysis

Recorded interviews were transcribed verbatim, and handwritten notes were typed. All interview and observational data were coded and analyzed using Atlas.ti (Version 24.2.1). We

employed a constructivist grounded theory analytic approach, which uses inductive open-coding to stay close to participants' meanings before shifting toward focused theoretical coding (Charmaz, 2006). The first author kept a reflexivity journal and regularly wrote memos throughout the analytic process (Nowell et al., 2017; Tong et al., 2007). Participants were invited to review and provide feedback of analytic interpretations to ensure that they accurately reflected their experiences.

The full grounded theory empirical findings, including comparative results across the two organizations, are reported elsewhere (Wodnik et al., forthcoming).

3. Results

We present our empirical findings using five components of the social architecture framework, which can facilitate or inhibit compassionate response within organizations: 1) social network structures, 2) organizational culture, 3) work roles, 4) routines, and 5) leaders (Dutton et al., 2006).

3.1 Social network structures

Compassion is an interpersonal, collective, and co-constructed process (Dutton et al., 2014; Kanov et al., 2004). The social ties between people working in organizations form a network structure that may (or may not) allow staff and leaders to support one another.

Qualitative interviews and organizational charts highlighted that both NAWEC and Safari Doctors have flat, non-hierarchical structures that break down communication silos and lessen power differentials among staff. Staff described their colleagues as family and expressed a sense of freedom that they feel in communicating with peers and managers alike. The organizations accomplish this through informal processes, such as daily team lunches and tea breaks and via established formal structures, such as open-door policies for managers. All team members, regardless of position, also support one another socially in non-work aspects of life including personal moments of celebration, sickness, or family crises.

> "*The working environment that is here at Safari Doctors - it is very, like a very open relationship with your co-workers, with your bosses. It's sometimes hard to tell who is the bosses. It is very... like one-on-one interactions, very, very friendly, which is very good for the workplace.*" – Non-clinical staff, Safari Doctors

> "*[Breakfast and lunch breaks], that's when we get to interact with everyone. Because this is family, you know, like my friend likes saying that your workplace, you spend more of your time at work than at home, because this is where you spend all your time. So those people are your family, like you have to figure out way of being in touch with them, like getting a link with them.*" – Non-clinical staff, NAWEC

These network structures can be activated in times of suffering. In one powerful example, a long-time NAWEC team member was diagnosed with a terminal illness, and his network of colleagues came together in a time of suffering to share his burden and ease his pain. Although his family was local, team members noticed that "the weight of his illness was too heavy for his family to carry on their own," so NAWEC staff supported them by taking shifts to check on him at home and bringing him meals. They communicated to coordinate efforts, and pooled and spent their own money to purchase comfort items for him. Their ill colleague was also diabetic, so clinical team members also helped him manage his sugar levels and medication.

Strong social networks were already in place because the organization regularly provided space and opportunity to foster community through lunches and other activities. These active organizational design decisions ensured that the social capacity to respond to suffering existed

prior to their colleague falling ill, allowing for a swift, coordinated, and tailored compassionate response to his suffering. Sharing in a coordinated compassionate response also strengthened the social network for grief support after their beloved colleague passed away. The ability to come together over this non-work incident brought meaning and healing to staff in their ability to respond (Worline & Dutton, 2017).

3.2 Organizational culture

Organizational culture has been defined as "a pattern of shared basic assumptions learned by a group... which has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel" (Schein, 2010: 17). A compassionate culture within an organization cannot be simplified to mission or value statements, but must be demonstrated in consistent action and visible processes that legitimize compassion (Simpson et al., 2024).

A compassionate workplace culture is apparent both in written policies, as well as in long-term and day-to-day action at our two case-study organizations. Policy measures that allow for flexible work hours, account for child and elder caregiving arrangements, and allow for job sharing when needed are present at both, reflecting deliberate decisions and actions by staff and leaders to normalize a culture of compassion.

> *"I have been so supported by the team here ever since I had my baby four months ago. My teammates came for me at that time - they brought gifts, food, they were really supportive. They are like family."* – Clinical staff, Safari Doctors

> *"The other day, we were having our Monday meeting… and one of the exercises we had to do is we were asked to write down our comfort zones. The reason I wrote Lamu and this organization being my comfort zone is that I feel like I get all the bonuses around personal, I get enough time to be with my family. I get enough time to be in Lamu and to give back to the community that I came from."* – Non-clinical staff, Safari Doctors

Informants from our case study organizations discuss both personal and professional challenges with colleagues at every level of the organization, freeing space for action to alleviate suffering. Such openness reflects a relational climate that allows concerns to surface without fear of judgement or repercussion.

> "*We are very free with our bosses and our colleagues. We can discuss anything from personal to professional*." – Clinical staff, Safari Doctors

> "*For me in particular, I think… I try my best. Like, if there is something, an issue that I need to talk to you about, I will go and talk to you about it. So for me, there is no one among the leaders that I say I fear to approach or I fear to talk to about certain issues. No. From my immediate supervisor to the top boss. I feel free. I feel free.*" – Non-clinical staff, NAWEC

While all components of the social architecture framework are amenable to change, organizational culture is perhaps the slowest to transform (Worline & Dutton, 2017). The cultures of work-life balance and open dialogue that exist at the two organizations are built on years of consistent policy backed by action, and the compassionate cultures have also touched networks of collaborators beyond internal staff, in a clear scaling of compassion beyond the organizations. Years of annual reports demonstrate the commitment of both organizations to training and supporting professionalized community health workers (NAWEC) and youth health ambassadors (Safari Doctors) who extend the compassionate missions of each organization to the communities they serve.

3.3 Roles

Organizational roles outline the patterns of behavior and actions expected of people in different positions within the organization. Wrzesniewski & Dutton (2001) contrast between 'role taking' and 'role making' in fostering compassion in the workplace. Role taking involves adhering to formally defined responsibilities through training and structured onboarding, while role making emphasizes creative adaptation or "job crafting" to embed purpose in existing roles.

Staff at Safari Doctors and NAWEC report a sense of heightened fulfilment at work because flexibility allows them to hold diverse roles, which benefits clinical and non-clinical staff alike. This flexibility creates opportunities for staff to expand their skills, participate in a wider range of organizational activities, and contribute meaningfully beyond the boundaries of their formal positions. Interviewees describe this not only as professional growth but also as a relational experience, in which colleagues supported one another across tasks and responsibilities. Such cross-role collaboration fosters a sense of shared purpose and collective efficacy, reinforcing the organizations' "family-like" environments and enhancing staff members' overall sense of contribution to organizational mission.

> "*I have different roles in Safari Doctors - as the office's assistant, the job of cleaning and moving stuff, going to deliver things. I also help the vet [veterinarian]. It's a big experience, and the way that the vet really helps me out personally, and even at work – sometimes if I'm overwhelmed, she will even help me do like the cleanings and all that stuff.*" – Non-clinical staff, Safari Doctors

> "*So there's a lot of opportunity, and we learn a lot here. And so far here, I've developed more skills, getting to know how even to do some of the medical thing there. And during Covid, we helped a lot. Because of shortage of manpower, we people down here in security, we are helping to triage people who come to the facility. Before reaching the facility, we have made a tent in front here so all people entering have to pass through us. We have to triage them, check their body temperature and record everything, then isolate them according to their body temperature. We are working together as a family. So I got to know how to handle some of the patients.*" – Non-clinical staff, NAWEC

Organizational systems can be designed to favor individualist approaches that emphasize competition and disincentivize collaboration, or design can favor collectivist approaches that support and nourish teamwork towards common goals (Simpson et al., 2024). These design decisions influence how compassion is regarded in staff roles within the organization. Employees at Safari Doctors and NAWEC share their experience with role flexibility that emphasizes lending a hand to one's colleagues whenever possible.

> "*So for us, compassion just looks like tailor-made realities for our team. You know, there's a meeting happening and you're like, the office assistant is the one who's responsible for this. It's a big meeting. How are we all chipping in or bringing an extra hand? You know, are you all carrying your own dishes and cleaning your plate kind of thing? So for us compassion, it just means being your brother and your sister's keeper, basically.*" – Management team, Safari Doctors

Organizations can design formal 'role taking' in a way that offers more agility, enables self-organizing teams united by a common purpose, and elevates a sense of service (Madden et al., 2012; Simpson et al., 2024). For example, NAWEC requires all new team members – including highly trained clinicians – to shadow *all* positions in the organization during their onboarding to get a better understanding of the flow and workloads of each team. The organization also encourages all staff to attend the weekly continuing professional development (CPD) sessions,

and the topic rotates by department so that CPD topics range from biohazardous waste disposal (janitorial team) to triaging (reception and nursing team). Likewise, Safari Doctors often blurs the lines in terms of cross-training and siloed departments to promote shared responsibility in a way that staff understand the work of all their colleagues and feel empowered to assist when and where help is needed.

> *"I interact with everyone. So at some point I'm involved with each and everything they get. Like, I think earlier on this month, there was a training program with the Youth Ambassadors. So like, there's some topics that involve me more, so I'll have to be concerned about that and see how we can support them. It's like I'm the primary service provider, so I have to turn up to everyone. So you can see I tend to understand what most people are doing, since I'm all around."* – Clinical staff, Safari Doctors

3.4 Routines

Routines can include patterned organizational practices around hiring, onboarding and training, meetings, decision-making, performance review, systems of reward and recognition, and budget development – and each of these presents an opportunity to embed compassion within them (Simpson et al., 2024; Worline & Dutton, 2017).

At NAWEC, the team begins each workday with a routine they call Powerful Beginnings (Figure 1). It is a time set aside from approximately 8:00am to 8:30am for all available team members to come together in prayer and song, set intentions for the day ahead, connect with their colleagues, and share important work announcements. Interviewees noted that this routine makes them feel 'in-the-know' about what's happening in the organization, connects them to colleagues outside their department who they wouldn't normally get to see, and feel part of the overall compassionate mission of the healthcare organization regardless of their work role.

Figure 1. The Powerful Beginnings morning routine at Nama Wellness Community Centre in Uganda. Photo courtesy of NAWEC.

Unlike many Western organizational routines that tend to prioritize cognitive coordination, the participants in Powerful Beginnings also engage in embodied and relational dimensions of compassion through touch, movement, and song. The practice enhances staff connection and supports a collective readiness to notice and respond to suffering.

NAWEC has also recently incorporated a routine to ensure the continuity and further nurture compassion through a monthly Compassion Heroes Award, in which staff submit and vote on stories of compassionate action they witness among their colleagues. This routine of recognizing and celebrating exemplary acts of compassion among staff cultivates positive and collaborative interpersonal relationships among colleagues, reifies the organization's stated value of compassion, and fosters a compassionate culture at the workplace.

The team at Safari Doctors embarks on monthly outreach missions to bring medical staff and supplies to isolated communities across the Lamu archipelago. These medical outreaches often last several days, during which the team is traveling by boat and staying overnight in the communities. These trips are noted by staff as the most energizing part of their jobs. But they are also challenging because of the strenuous conditions and the weight of witnessing such poverty and need. The routine of debriefing after each trip as a full team, discussing what went well and what was challenging, introduces important opportunities for learning and for staff to better support one another.

> Interviewer: "*How did you feel about getting kind of the opportunity to talk about those challenges and then address them as a team?*"
>
> Interviewee: "*It was very... first, it was very, very nice, because then you feel heard. Because sometimes you put these things in a report, and maybe they are not followed up with. But the moment that you have, you discuss them as a group, then nobody can ignore it. They will get addressed. So as like the people who go out to the field during the outreach, we felt heard, and we felt like this is something that is going to be dealt with, and it is not going to happen again. It will make our life easier.*" – Non-clinical staff, Safari Doctors

3.5 Leaders

Leaders have agency and a particular kind of role permission for reshaping structures to enable compassion to 'flow' among staff through meaning-making of events, mobilizing resources for enabling compassion in the workplace, modeling compassion, and supporting and sustaining existing patterns of compassion (Czarniawska-Joerges & Wolff, 1991; Simpson et al., 2020).

One staff member of Safari Doctors recalled a time when his father was going through a health crisis, and both the health issues and the resulting financial burdens were causing a strain on his wellbeing. Though he didn't say anything at work, the executive director noticed a change in his demeanor from his usual vibrant, smiling self. As the executive director would be out of the office for the coming weeks, she asked managers to continue to check in on this team member in her absence. Because she knew this staff member so well, she was better positioned to recognize the subtle shifts in his behavior and energy, and to respond early in a way that felt personalized and authentic rather than procedural. In the staff's own words:

> "*In other working areas, you won't get the boss coming to you like, what's wrong with you, are you okay? You've changed, you don't smile much. But after a while, once [I began feeling better], she's on the [virtual] call greeting everyone, going round. I took the phone and I was like, 'Hi', with a smile. And she was like, 'Wow! Hi too, I'm happy to see you!' So then I was like, so it was not just like a bluff, like, she really meant it, and I really felt happy.*" – Non-clinical staff, Safari Doctors

Compassionate leadership can also mean holding space for 'generous interpretations' – in other words, approaching staff challenges with a curiosity mindset rather than a blaming mindset – which involves holding a "positive default assumption" that people are inherently good and worthy of compassion (Worline & Dutton, 2017). This mindset, for leaders and staff alike, is bolstered by a recognition of shared humanity and a sense of connection or an 'ecosystem' at work, where all team members are seen as collectively striving towards a shared goal (Worline & Dutton, 2017).

> "*You have clear strategic directions you need to achieve. But you can do this while also being compassionate and what you do when someone comes late, you know that the person is supposed to be at the facility by 8 AM. But the person who reports at nine? Before you rush and start saying you are late, you need to understand what could have been the problem. You listen to their perspective. It may be that the person got even an accident on the road and delayed. Maybe the kid was sick, and that's what delayed the person to report to work. But he has tried his or her best to make sure that he's at the workplace amidst all these challenges. So you need to understand people's perspective first before even you rush to conclusion.*" – Management team, NAWEC

Leadership in the two organizations is embedded in community-based and relational worldviews, as they are dependent on their relational knowledge of staff. As a leader at Safari Doctors emphasized, compassion is fostered not through technical checklists but through culturally rooted practices of checking in, encouraging conversation, and modeling shared values.

> *"The nuance is, for me, what are your values that you're living out. We're always encouraging, you know, you can always talk to someone. Being intentional about creating these spaces and a vibe. How is leadership able to identify that and encourage you know, we haven't heard what your feedback is. Or sending someone indirectly to check in. It's just also a cultural thing. I think if you look at the East versus the West, and as far as compassion, you know, even the labeling of compassion and the check boxes... it's good to be intentional about it, but at the same time, it's not about making it a technical thing."* – Management team, Safari Doctors

4. Discussion

The qualitative research identified several organizational characteristics of these two healthcare centres that support the 'flow' of compassion within the organization and into the surrounding communities. While prior research has emphasized the conditions that allow compassion to emerge in workplaces, our findings reveal several extensions to existing theory, showing how organizational elements not only facilitate compassionate responses but also distribute responsibility for addressing suffering, embed compassion into everyday practices, and cultivate collective capacities that endure over time. Together, these insights illustrate how compassion has become an organizing logic rather than an episodic reaction in the case study organizations, offering new conceptual insights for the study of compassionate work systems in low- and middle-income country contexts, and for the study of the epidemiology of compassion by establishing formative understandings of how compassionate practices originate and spread across persons, places, and time within complex social systems.

4.1 Social network structures

Research in healthcare environments has shown that positive practices, such as celebrating team members' personal and professional milestones, collective decision making, and bounded play (e.g., decorating work environments), can foster high-quality social connections among staff and increase motivation to act compassionately towards one another in times of difficulty (Lilius et al., 2011). The social structures that exist within an organization determine individuals' power and influence, which is affected by who they know and how frequently they interact with others (Easley & Kleinberg, 2010; Worline & Dutton, 2017). Classic pyramidal bureaucracies "tend to reinforce power distance, obedience to rigid rule following, developing formality, and communication silos" (Simpson et al., 2024: 138).

The social networks in our two case study organizations appear to move beyond enabling compassion, to sharing in and redistributing the burden of suffering. Intentional cultivation of networks through organizational actions, such as daily shared meals and open-door norms, support a "family-like" sense of belonging. Beyond the established ideas that connections help enable compassionate response, organizational members participate in collective load-sharing over time, leading to compassion that is not just activated but sustained. The flattened organizational structures appear to distribute authorization of who feels responsible for and empowered to act on suffering. The efforts at NAWEC to care for their ill colleague were not led by organizational leaders only, but by team members in all roles, representing a conceptual extension of power structures in the compassion literature.

4.2 Organizational culture

An organization's culture can be expressed through its stated or lived-out goals and values, spanning the range from established policies to employees' understanding of 'the way things are here' (Schein, 2010; Worline & Dutton, 2017). Negative aspects of organizational culture have been identified as some of the biggest constraints to the provision of compassion within healthcare settings, for example bullying or implicit norms of excessive workloads (Malenfant et al., 2022). A compassionate workplace culture may be understood as employees' shared perceptions about how and whether their organization values and rewards compassionate acts (Schneider, 1990), including that acting compassionately makes one a good employee (Barsade & O'Neill, 2014).

Healthcare organizations in particular have been known to harbor and tolerate cultures that discourage engagement and open discussion, where emotional suppression is expected and even regarded as a strength (Leach et al., 2024; Lehmann et al., 2018), and where compassion is infrequently discussed or rewarded (McClelland & Vogus, 2021). This shadow side of healthcare cultures can normalize and pass down certain attitudes and practices, for example, failing to debrief after an emotionally challenging death of a patient (Lehmann et al., 2018). By suppressing communicative cues that suffering is occurring, healthcare staff limit the ability for others around them to act compassionately.

The two case study organizations have cultural norms that actively surface signals of suffering, rather than merely responding when they appear. While the healthcare literature often portrays the suppression of suffering at work as normal or inevitable, the established culture at these organizations appear to make suffering visible and enable members to be vulnerable with one another. The organizational cultures at both NAWEC and Safari Doctors – reinforced through leadership, policy, and action – make it clear to staff and collaborators that compassion has high social currency within the organization, which gives people a clear rationale for

behaving in alignment with compassionate action. This social currency provides a motivational dimension for acting compassionately at work.

4.3 Roles

Organizational approaches to role design, whether rigidly prescriptive or flexible and adaptive, significantly influence how compassion manifests by infusing daily tasks with deeper meaning. For example, a hospital case study found that janitorial staff who redefined their roles to include patient interaction and caregiving not only enhanced their sense of purpose, but also expanded their capacity for compassion beyond formal job requirements (Wrzesniewski et al., 2003).

Interviewees at both organizations described helping behaviors as a default expectation of every position, with compassion painted as a role norm. The description of compassion as "being your brother and sister's keeper" demonstrates the mindset that compassion is built into what it means to do the job correctly at Safari Doctors. We see an example of compassion being scaled because NAWEC staff had the role flexibility to jump in in new and supportive ways, such as triaging during the height of the COVID-19 pandemic, reconfiguring roles to respond quickly to emerging suffering.

4.4 Routines

Within and across organizations, routines can particularly frustrate compassion from flourishing. For example, clinicians in Canada report that the embedded routines stemming from rigid funding structures or introducing extensive administrative burdens represent a primary source of workplace suffering, burnout, and intention to leave (Canadian Academy of Health Sciences, 2023). Conversely, routines have great potential to provide the 'architecture' to build compassion into everyday actions, because they represent expected ways that day-to-day activities and processes will unfold. Routines are also highly amenable to change, adjustment, and readjustment.

In an important paradox, Simpson et al. (2024) note that the "routinization of compassion comes with some risks, as it may encourage compassionate behaviors aimed at simply managing impressions" (pg. 142). The recognition of the hazards of routines simply becoming 'performative compassion' was expressed by management teams at both case study organizations as they sought to strike a balance between elevating existing compassionate routines without becoming overly prescriptive in organizational action. By instituting routines such as post-outreach debriefs and normalizing raising challenges and emotional burdens faced at work, the organizations have created structural ways to counteract silence and suppression of staff suffering.

Routines at both organizations (e.g., Powerful Beginnings and post-outreach debriefs) appear to support collective emotional processing that moves beyond enabling compassion, to sustaining the capacity to act compassionately over time. Future research could explore whether such collective processing events are preventive for empathic fatigue or burnout. The established routines also (re)connect employees to the compassionate mission of the organizations at regular intervals, supporting collective identity as a compassionate team.

4.5 Leaders

If organizations are architectural systems that do or do not lend themselves to compassion, then leaders can be thought of as the architects (Worline & Dutton, 2017). While conceptualizations of 'compassionate leadership' are still nascent, a recent systematic review identified six core

dimensions of compassionate leadership: empathy, openness and communication, support of physical and mental wellbeing, inclusiveness, integrity, and respect and dignity (Ramachandran et al., 2023). Leaders can set the tone for compassion within an organization (Mountford & Powis, 2017).

Organizational compassion need not be driven in a top-down manner. Beyond embodying aspects of compassion in their own actions, leaders can enable workplace compassion by supporting the organizational structures mentioned above (i.e., networks, culture, roles, and routines). Managers and staff play important roles in acting on (or not), customizing, and implementing the structures set forth by an organization's top leaders (Vogus & McClelland, 2020). Because compassion is emergent (meaning that it is a dynamic, context-dependent process between people and their environments) leaders can work with and embrace these emergent processes, using resources to amplify, expand, and mobilize compassion (Halifax, 2012). While traditional organizational leaders play important roles in modeling compassion, compassionate leadership and championship can come from anywhere in the organization (Worline & Dutton, 2017).

We see leaders at both case study organizations practicing proactive noticing, not just responsive compassion. While existing theory shows how leaders can mobilize resources when suffering has been made visible, these illustrative examples demonstrate how leaders noticed subtle behavioral cues even before suffering was voiced by staff and took anticipatory care actions. Proactive noticing appears to be an important leadership trait for enabling compassion at these organizations. We also see that the leadership actions are embedded in community-based and relational worldviews, as they are dependent on their relational knowledge of staff. This differs from Western leadership models which often center on an individual's emotional intelligence or fostering psychological safety. Relational and community-based leadership models could represent a major contribution to compassionate organizations in low- and middle-income country contexts.

5. Organizations and qualitative research as channels to studying the epidemiology of compassion

5.1 Organizations as opportunities to study compassion

Organizational science maps the landscape of communications, norms, processes, and dynamics within organizations, which provides a solid foundation for understanding how compassion manifests and 'flows' across groups of humans. As such, organizations provide concrete opportunities to study the epidemiology of compassion in several ways.

First, organizations act as defined communities bounded over time, allowing study of individual and systemic factors associated with compassion within a clearly defined population and space. Many studies have already examined the sources of workplace suffering within organizations (Sánchez-Hernández et al., 2022), and epidemiologic analysis might help identify which of these sources of workplace suffering are the most important and which are most amenable to intervention. As one example, our qualitative research found that flexible family care policies at the case study organizations allowed staff to more clearly express their needs at work and to show compassion more freely to their colleagues; future epidemiologic studies could explore the prevalence or distribution of compassionate actions across staff resulting from family care policies. The clear boundaries of organizations may also enable better structure of intervention studies.

Second, organizations and the individuals and groups operating within them are deeply influenced by their particular context. Compassion is an interpersonal, collective, and co-

constructed process (Dutton et al., 2014; Kanov et al., 2004). The ways that organizations differ in terms of location, size, type, aims, and bureaucratic structure could allow for exploring the ways that compassion flows or is stifled across groups of people. Organizations are also part of larger systems that exert external influence on decision-making and organizational behavior (Katz & Kahn, 1966), whether through obligations to investors and shareholders, economic influences, government policies, or market trends. For example, the case study organizations in Kenya and Uganda receive external funding that supports their operations, and both report that these funding organizations play an important role in supporting their compassionate missions. On the other hand, donors can restrict organizational and individual behaviors by directing their activities away from those that matter most to staff and the communities they serve (Abimbola et al., 2021; Wodnik et al., 2024). The case studies also highlight broader cultural factors that influence compassion among staff, including shared spirituality and the communal nature of the societies.

Third, the study of organizational compassion is already well-established, particularly in the field of management, providing research tools and approaches to draw from. Current collaboratives such as the Center for Positive Organizations (Center for Positive Organizations, 2025) and the Compassion Research Lab (Compassion Research Lab, 2025) continue to advance the science and practice of organizational compassion research. Many validated tools exist for assessing aspects of organizational compassion, including the Community Flourishing Measure (VanderWeele, 2019), the Compassionate Leadership Self-Report Tool (West & Chowla, 2017), the NEAR Organization Compassion Scale (Simpson & Farr-Wharton, 2017), and the Compassion Practice Scale (McClelland & Vogus, 2014). Organizational science frameworks, such as the social architecture framework (Dutton et al., 2006) we employed to organize our findings, provide structured ways to examine the organizational conditions that affect how, where, and why compassionate responses arise, spread, or collapse within a collective.

5.2 Conceptual foundations for studying compassion

A primary challenge in advancing the study of the epidemiology of compassion will be developing a clear definition of what compassion is within specific contexts (Boyd et al., 2026; Mascaro et al., 2020). Qualitative research is especially important for generating the formative insights needed to understand what compassion means in specific contexts, cultures, and organizations. Tools and frameworks from organizational science – e.g., the social architecture framework of networks, culture, roles, routines, and leaders – may point at least to some of the emergent elements that make up an environment in which compassion does or does not flourish. These tools may be especially helpful for research paradigms that view compassion as "composed of non-compassion elements" such as awareness, memory, and empathic concern (Addiss et al., 2022; Halifax, 2012). There is also a need to expand definitions of compassion to include more voices and conceptualizations, including from low- and middle-income countries. Interviewees in our study shared an array of interpretations of compassion, including putting oneself in someone else's shoes, treating all people with kindness and respect, and noticing if someone is sick or feeling down, which one interviewee framed as "social awareness". As one interviewee defined compassion, "I can't explain it, but I can understand it – it is about having that merciful giving heart."

Although epidemiology has been traditionally dominated by quantitative approaches, there are growing calls for the inclusion of qualitative data to explore the 'why' and 'how' questions of context and causation (Bannister-Tyrrell & Meiqari, 2020; Lane-Fall, 2023). Compassion is inherently contextual, so having a clearly defined unit of analysis (e.g., an organization),

supported by organizational science and qualitative research enables us to move beyond individual risk factors for compassion to better understand the features of compassion in complex social populations. Our research identified that potential 'risk factors' for compassion within organizations could include non-hierarchical organizational structures, flexible family- and self-care policies, role flexibility to lend a helping hand to colleagues, onboarding practices that expose newcomers to multiple roles and departments, and routines that strengthen personal relationships within teams. The evidence base for how compassion flows – or fails to – among people currently remains centered on individual-level experiences, while the state of compassion 'at scale' is underrepresented in research (Addiss et al., 2022).

5.3 Studying compassion in low- and middle-income country settings

Formative qualitative research is a necessary precursor to quantitative epidemiological studies of compassion, particularly in low- and middle-income country settings which have largely been understudied. Our research demonstrates why compassion and organizational research from high-income countries cannot be neatly transposed, given the contextual nature of compassion. Several of the characteristics identified in these organizations may be particularly cogent for organizations in low- and middle-income country settings: for example, the lack of sharp boundary between professional and personal concerns, the communal nature of the society, and spirituality as a unifying force and promoter of compassion (e.g., staff coming together in morning prayer for the daily Powerful Beginnings at NAWEC in Uganda).

5. Conclusion

There is no one-size-fits-all way to "create" compassionate organizations – rather, there are components that allow for the emergence of compassion and that lend legitimacy and attention to compassionate ways of working (Dutton et al., 2006), which together may open channels to studying the epidemiology of compassion. We have reflected on how this has emerged in two healthcare organizations based in low- and lower-middle income country settings. In the face of great suffering, staff at these healthcare organizations respond with extraordinary levels of compassion, and we have explored how the organizations enable the preconditions for compassion to flourish across persons, place, and time. Increased attention to organizational and system-level compassion is especially needed in low- and middle-income countries, where suffering is profound and complex.

Although epidemiology is a quantitative science, qualitative research can identify characteristics that warrant further testing and measurement. This study offers an example of a qualitative formative epidemiologic contribution, in which we have identified characteristics (potential "risk factors") that could be investigated quantitatively in future research, all oriented toward the outcome of a 'compassionate organization'. This could be a model of the role of qualitative research in establishing an epidemiology of compassion.

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Author contribution statement

BKW, HB, DA, JVL, and EDR contributed to the conceptualization and design of this study. BKW led data collection with assistance from HB, DC, PPK, PK, DN, JT, UO, AM, AO, and VW. BKW conducted the analysis; member checking was conducted with help from PPK, PK, DN, JT, UO, AM, AO, and VW. BKW wrote the original manuscript, and all authors revised and approved the manuscript.

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Conflict of interest statement

The authors report no conflicts of interest.

AI statement

AI was not used in study design, data analysis, interpretation, or manuscript writing.

Data availability statement

The qualitative interview transcripts collected and analyzed as part of this study are not publicly available due to the need to protect participant confidentiality. Even with identifiers such as names and places removed, the transcripts contain contextual and relational details that could enable participant identification, given the small organizational size at NAWEC and Safari Doctors. Data are therefore not shared in order to comply with ethical commitments made to participants and research ethics board approval. Please contact Breanna K Wodnik at breanna.wodnik@mail.utoronto.ca for specific inquiries.

Ethics statement

Ethical approval for this study was obtained through the University of Toronto Research Ethics Board (Protocol #46586). Interviewees were provided with a copy of the consent information, which outlined their rights to elect whether or not to participate, to stop participating at any time, or to refuse to answer any questions that they did not wish to respond to. Prior to beginning the interview, the interviewer reviewed the consent information with the participant, ensuring understanding and giving them time to ask any questions. Participants were verbally asked whether they consented to a) participate in the interview, and b) record the interview. All interview transcripts were de-identified and responses are anonymous.

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