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The economy of suffering during the mpox crisis

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ABSTRACT

This study examines the ethical dimensions of health communication during the 2022 mpox outbreak, focusing on the interplay between social media and public health officials in shaping stakeholder responses. Based on semi-structured interviews, findings reveal that social media played a crucial role in information dissemination for months during the crisis, while public health officials were slow to offer clear guidance. While social media empowers advocacy and the sharing of personal stories, it also raises ethical concerns, particularly regarding how vulnerable communities may become entangled in an economy of suffering, where their experiences of pain are validated and interpreted by stakeholders through a selective mechanism rooted in cultural codes and power dynamics. Moreover, systemic inequities render the suffering of marginalized groups, particularly those with intersecting identities, less visible and intensify the consequences of inadequate outreach. This creates a disparity where the suffering of those in more privileged positions is more readily recognized and addressed. The theoretical advancement lies in reconceptualizing the platformization of pain to include narrative resistance, highlighting that marginalized groups actively contest and reshape suffering narratives rather than passively experience them. This expanded framework also deepens the concept of an economy of suffering by integrating hermeneutical injustice, which emphasizes how power dynamics shape not only the visibility of suffering but also the interpretive frameworks that validate certain narratives while marginalizing others.

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Health; communication; mpox; ethics

To the friend who left me behind.

Life doesn't know what to do with the burden of suffering. But suffering can become writing – never consuming, always vital, leaving behind not just scars, but the memory of what once mattered. Not who.

– October, 2024

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Introduction

The 2022 mpox outbreak in the UK presented a complex challenge for public health communication, requiring a balance between the urgent need to disseminate information and the ethical imperative to avoid stigmatizing vulnerable populations, particularly men who have sex with men (MSM) (Choi & Fox, 2023; Roy, 2024). The legacy of the HIV/AIDS crisis underscores the importance of achieving health equity through public messaging (Taggart et al., 2021) while avoiding targeted messaging that could reinforce harmful stereotypes (Aquino et al., 2022). Additionally, the evolving understanding of mpox transmission and severity has complicated communication efforts, as public health authorities have had to manage transparency while minimizing undue public concern (Guttman & Lev, 2021). The outbreak highlighted broader ethical dilemmas in public health communication, including the tension between using fear-based messaging to ensure compliance and the potential erosion of public trust, as well as the need to respect individual autonomy while delivering urgent health guidance (El Dine et al., 2024; Toebes, 2020; Zimmerman, 2017).

These ethical challenges were exacerbated by the rapid spread of misinformation during the outbreak, which often outpaced accurate updates from official sources and contributed to the stigmatization of vulnerable communities (Edinger et al., 2023; Farahat et al., 2022). While social media can amplify misinformation, it also serves as a crucial tool for disseminating essential health information, allowing for collaboration and advocacy (Jackson et al., 2021), and tackling stigma (Garcia-Iglesias et al., 2023, p. 2). Hong's (2023) analysis shows how the Reddit platform facilitated the rapid dissemination of health promotion and vaccination information, enabled efforts to address the stigma associated with contracting mpox, and supported collaboration among various stakeholders in developing and sharing messaging. However, Garcia-Iglesias et al. (2023) contend that social media has become problematic due to users' reliance on pre-existing networks, patterns of exclusion and the proliferation of inaccurate or misleading information.

Social media campaigns around mpox predominantly reached individuals who were already integrated into well-served communities, such as urban, white, middle-class, gay men, while marginalized groups including minoritized ethnic communities, rural populations, migrants, and homeless individuals were largely excluded (Garcia-Iglesias et al., 2023, p. 5). This digital divide reflects broader inequalities, with studies from the US demonstrating lower mpox awareness among rural and lower-income populations due to limited media access, thereby intensifying their vulnerability (Owens & Hubach, 2023). Conversely, higher socioeconomic status correlated with greater access to critical health information (Abu-Farha et al., 2023). Helsper and Reisdorf (2017, p. 1267) characterize this intersectional exclusion as the emergence of a digital underclass whose marginalization extends beyond technological deprivation to broader exclusion from essential health knowledge.

These patterns of exclusion point to a deeper epistemic condition that extends beyond visibility. By shifting the analytical focus to the terms of interpretability, we ask not only who becomes visible through digital platforms, but whose suffering is rendered institutionally legible, according to which standards, and with what consequences (Chouliaraki, 2006, 2013, 2024). Narrative value, we argue, is not intrinsic but produced at the intersection of user practices, platform affordances, and institutional methodologies that define what counts as credible knowledge. This process is shaped by what Fricker

(2009) calls hermeneutical injustice: the structural exclusion of marginalized groups from the interpretive resources required to understand and articulate their own experiences. Building on this, the problem is not merely one of interpretive absence but of epistemic exclusion more broadly. It is not just that certain groups lack access to digital infrastructures; they are systematically denied the epistemic agency (Benjamin, 2019) to define and communicate their health realities on their own terms (Carel & Kidd, 2014), reinforcing their marginalization within public health discourse.

This epistemic exclusion is further reinforced within digital environments, where platform logics and evidence-based public health methodologies share underlying assumptions about what constitutes credible and actionable knowledge (Lalumera, 2024). Platform algorithms preferentially amplify content that adheres to institutional standards of credibility, emphasizing concise, standardized, and depersonalized presentation (Gillespie, 2017; van Dijk, 2020). Similarly, evidence-based public health, rooted in neo-positivist epistemology, privileges knowledge validated through statistical abstraction and generalizable findings (Chirkov & Anderson, 2018; Park et al., 2020).

This methodological orientation presumes neutrality, constraining ethical reflexivity regarding the implicit normative commitments that shape what is considered valid knowledge. Consequently, narratives based on lived experiences, affective testimonies, or community-generated frameworks (Okoroji et al., 2023) are systematically marginalized within dominant epistemic frameworks. As a result, structural inequities, although theoretically measurable, become obscured because the complex social and interpretive contexts from which they emerge are rendered invisible or irrelevant by neo-positivist methodologies. Thus, already marginalized communities experience compounded exclusion as their narratives are reshaped or dismissed to fit institutional expectations, reinforcing hierarchies of legitimacy and further silencing structurally vulnerable voices within public health discourse.

This article contributes to debates within *Information, Communication & Society* on the politics of digital platforms and information infrastructures by introducing two interrelated concepts, *platformization of pain* and *economy of suffering*, as analytical tools for examining how suffering is produced, circulated, and made institutionally meaningful within digital communication environments. We conceptualize *platformization of pain* as the structuring of digital visibility through affective economies, and *economy of suffering* as the institutional processes that determine whose pain is recognized as actionable. Together, these concepts provide a framework linking digital media studies, critical epistemology, and public health ethics, emphasizing how epistemic hierarchies shape communicative legitimacy and reinforce existing inequalities.

Chouliaraki's (2024) work on *platformization of pain* provides a foundational critique of how suffering becomes content in emotional capitalism, selectively amplified through algorithmic systems that reward visibility and emotional resonance. She identifies the platform as a moral-technological apparatus that confers value on suffering in ways that reproduce existing hierarchies of race, proximity, and affective legibility. However, Chouliaraki's approach remains oriented around affective spectatorship (2006, 2013) and the cultural hierarchies of visibility, offering less analytical traction for understanding the epistemic infrastructures and discursive conditions that govern how suffering becomes intelligible and institutionally actionable.

Marginalized communities are further silenced and excluded from shaping the collective knowledge that guides public health responses. Additionally, as Chouliaraki (2024,

p. 30) critiques, the platformization of personal pain within emotional capitalism (Illouz, 2007; Lazzarato, 2014) transforms suffering into a currency, privileging certain narratives – often those of white, Western victims – over others. This not only constructs a hierarchy of suffering but also reinforces existing social orders by weaponizing claims to victimhood (Chouliaraki, 2024, p. 35). The result, we argue, is an economy of suffering where marginalized groups are doubly silenced: first, by their exclusion from knowledge production, and second, by the commodification and overshadowing of their experiences in public discourse.

We expand this line of inquiry by reframing the *economy of suffering* not as a metaphor for commodification – an argument often made but rarely evidenced in material terms – but as a political economy of discursive value. Our use of 'economy' refers to a structuring logic that governs how suffering is produced and rendered intelligible as information within digital infrastructures. This includes how suffering becomes recognizable within platform ecologies and operationalized by institutional actors, including public health agencies or advocacy groups. It is not suffering itself that circulates but suffering as information, codified and filtered through differential levels of epistemic legitimacy. Our argument is that these infrastructures do not simply determine which stories circulate, but how suffering is *transformed into information* that can be routed through institutional pathways whether for health policy, media coverage, or philanthropic response.

By articulating these dynamics, we situate the economy of suffering within a broader concern with the social and political implications of Information and Communication Technologies (ICTs). In this sense, ICT systems are not neutral channels of communication; rather, they constitute environments that encode and reproduce existing inequalities by selectively enabling or constraining epistemic recognition (Napoli, 2024; van Dijk, 2020). Our framework addresses how suffering is not simply mediated but transacted within digital infrastructures by being attached to informational value and organized through hierarchies of visibility that reflect institutional logics (Akpinar & Fazelpour, 2024). In doing so, we offer a vocabulary for analyzing how suffering operates as a contested form of knowledge within platform society, expanding current understandings of information practices to include not only circulation and access, but also contestation, exclusion, and recognition (Räisä & Stocchetti, 2024).

To complement this structural critique, we introduce the concept of *narrative resistance*. This term captures the ways users contest dominant epistemic frameworks through strategic uses of platform affordances by reframing suffering, challenging stigma, and asserting interpretive authority. During the 2022 mpox outbreak, for instance, MSM users deployed platforms not only to share their experiences but to challenge the dominant medicalized and stigmatizing narratives that circulated across official channels. These practices complicate the idea of passive subjects of platform governance, highlighting instead how marginalized communities engage in active forms of epistemic counter-production within the constraints of platform infrastructures.

Building on these concepts, this study examines the ethical stakes of health messaging during the mpox outbreak by investigating, first, how shifting public discourse shaped stakeholder decision-making and institutional responses; and second, how stakeholders themselves interpreted the ethical implications of public messaging, particularly in relation to the reproduction or mitigation of socioeconomic and identity-based health inequities. Drawing on content analysis of mainstream press coverage and social media narratives, alongside semi-structured interviews with key stakeholders involved in the UK outbreak response, this research explores how the economy of suffering structured the visibility, legibility, and institutional uptake of suffering. In doing so, it seeks to inform the development of more equitable and reflexive communication practices for future public health crises.

The critical importance of this research is underscored by the recent resurgence of mpox in central Africa, culminating in the World Health Organization's declaration of a global public health emergency (WHO, 2024). This alarming development highlights the persistent challenges in containing mpox and emphasizes the urgent need for ethically sound and culturally sensitive communication strategies to combat this and future health crises, particularly in vulnerable populations and resource-limited settings.

The economy of suffering: ethical visibility and marginalized voices

The concepts of *platformization of pain* and *the economy of suffering* are central to understanding how social media platforms shape the representation and visibility of suffering. While these platforms provide spaces for advocacy and the sharing of personal stories, they also present significant ethical challenges. *Platformization of pain* refers to how social media platforms enable and amplify the sharing of personal suffering narratives, often transforming them into commodities that drive engagement (Chouliaraki, 2024, pp. 30–35). However, this visibility is unevenly distributed, with certain groups' suffering amplified while others are marginalized. This selective amplification is shaped by algorithmic dynamics that prioritize content based on engagement metrics, often reflecting systemic social inequalities (Beer, 2017; Gillespie, 2017; Pasquale, 2016). As a result, the suffering of privileged groups tends to receive more attention and resources, while the experiences of marginalized communities are frequently overlooked or minimized. The unequal distribution of visibility reproduces existing social hierarchies, leading to an imbalance in the recognition of suffering.

Expanding on this, we have elaborated the concept of the *economy of suffering* to broaden the analysis from the commodification of pain to include how social media platforms shape the processes of knowledge production and dissemination. In this expanded framework, stakeholders – such as public health officials, activists and media professionals – play a pivotal role not only in determining which narratives of suffering gain prominence but also in influencing how these narratives are framed, circulated and interpreted. This refined concept emphasizes that suffering is not just commodified, but actively negotiated and shaped by power dynamics within public discourse, making the role of stakeholders critical in either reinforcing or challenging systemic inequalities.

Chouliaraki's (2024) theorization of platformization of pain remains central for understanding how suffering is algorithmically rendered visible through media infrastructures designed to prioritize affect, circulation, and moral legibility. Nieborg and Poell's (2018) analysis likewise positions suffering within the political economy of platform governance, where content becomes a contingent commodity shaped by monetization logics and content moderation protocols. Yet both frameworks tend to emphasize structural overdetermination, risking a depiction of users as passively subjected to the circulation of their pain.

The concept of *narrative resistance* helps capture this agency. It foregrounds the ways users mobilize platform affordances to disrupt dominant framings and assert counter-narratives. This expands the theorization of platformization beyond a one-way logic of exposure, toward a more dialectical understanding that includes user-led strategies of disruption, resignification, and refusal. This account aligns with Velkova and Kaun's (2021) notion of *algorithmic resistance*, highlighting how users actively engage in tactical interventions to subvert platform-driven narrative hierarchies. Rather than treating platforms as totalizing, this reframing positions them as contested terrains where the visibility of suffering is not just imposed, but actively negotiated.

These dynamics have profound ethical implications as, in addition to reinforcing power imbalances, they contribute to what Fricker (2009) terms *hermeneutical injustice* – when marginalized groups are denied the ability to fully articulate and understand their own experiences. Platforms, while facilitating the amplification of suffering, are not neutral actors; their algorithms prioritize narratives that align with dominant epistemic frameworks, further marginalizing the voices of those already disenfranchized. Thus, the economy of suffering calls for a critical reflection on how public discourse is shaped by the selective amplification of pain, urging stakeholders to adopt more inclusive and equitable communication strategies.

We propose the *ethical responsibility of visibility* (Scalvini, 2024) as a normative obligation to ensure that structurally marginalized groups are not only seen but are able to participate meaningfully in the production of knowledge that informs public health communication. Visibility, in this context, is not reduced to representational inclusion or algorithmic reach; it entails enabling interpretive agency and narrative authority, particularly within crisis communication. This concept emphasizes the distributive question: who is allowed to be legible, legible to whom, and on what terms? As theorists like Honneth (1996) and Taylor (1992) argue, recognition goes beyond the passive acknowledgment of suffering, it requires affirming the dignity and humanity of marginalized individuals, thereby positioning them as active participants in shaping the discourse.

This level of recognition is crucial in public health communication because the failure to adequately recognize and include marginalized groups exacerbates existing inequities, and these communities are often the most vulnerable during a health crisis. Thus, recognition is not only a matter of justice but is very much a practical necessity. When the experiences and needs of all affected groups are acknowledged and integrated into health communication strategies, it fosters a sense of inclusion and respect (Siegrist & Zingg, 2014). Inclusivity builds trust between communities and public health authorities (Cairns et al., 2013), which is critical for securing compliance with health measures and encouraging cooperation in managing crises (Majid et al., 2021). Conversely, when certain groups feel that their suffering is ignored or dismissed, it can lead to alienation and resentment, further complicating public health efforts (Davies, 1999; Gray, 2001). Therefore, recognition is central to creating more equitable, effective and responsive public health initiatives that meet the diverse needs of all populations.

Moreover, recognition is intertwined with the politics of justice insofar as empathy and compassion must be grounded in equity and fairness. As Nussbaum (2001) argues, compassion must be paired with justice to ensure that all individuals are treated with equal respect. This requires realizing why some forms of suffering are recognized while others are ignored, which is crucial to addressing structural inequalities that perpetuate suffering. This aligns with the principle of equity, which asserts that addressing inequalities involves more than just redistributing resources; it means enhancing individuals' capabilities to achieve well-being (Sen, 2009, p. 231). For marginalized groups like the LGBTQIA + community, who face barriers such as stigma, distrust in healthcare, and lack of culturally competent care, public health communication that acknowledges and addresses these challenges – through targeted, inclusive messaging – can significantly enhance their ability to protect their health.

To summarize, the expansion of platformization of pain to an economy of suffering provides a valuable theoretical framework for analyzing issues of justice and recognition within public discourse. This approach not only highlights the selective amplification of certain narratives of suffering, but also critically examines the interpretive processes that determine which narratives are validated and which are marginalized. By focusing on these dynamics, the economy of suffering framework emphasizes the importance of inclusive communication strategies in public health, ensuring that all voices, particularly those from marginalized communities, are heard and contribute meaningfully to knowledge production. This recognition is essential for fostering social solidarity, addressing systemic inequalities, and ensuring that public health responses are both equitable and effective.

Methodology

This study employed a qualitative methodology, utilizing semi-structured interviews to gather in-depth insights from key stakeholders involved in the frontline response during the summer 2022 mpox outbreak in the UK. The research protocol received approval from the ethical committee of the [anonymized].

Four distinct stakeholder categories were identified, reflecting the diverse roles and experiences in the outbreak response: activists and individuals from third-sector organizations engaged in mpox efforts; clinicians and medical professionals working directly in mpox-related healthcare; policy actors involved in local or national governmental responses; and journalists who covered the early stages of the outbreak. While snowball sampling is inherently non-probability-based and may introduce bias, we made a deliberate effort to ensure representation across all stakeholder categories and to include participants from various geographical regions of the UK (England, Scotland and Wales). This approach aimed to capture a wide range of perspectives and experiences related to the mpox outbreak and its management (Table 1).

We intentionally excluded the category of patients directly affected by the infection to avoid potentially re-traumatizing those with lived experiences of mpox. Instead, their perspectives were inferred through data collected from social media platforms. However, one participant in the first category (activists and third sector) shared their personal

Table 1. Stakeholder interviews.

Stakeholder Category	Number of Participants	Geographic Location (UK)
Activists/Third-Sector	3	England (2), Scotland (1)
Clinicians/Medical Professionals	4	England (4)
Policy Actors/Government	2	England (1), Wales (1)
Journalists (early outbreak coverage)	2	England (2)
Total	11	

experience of contracting mpox, including hospitalization. We chose not to exclude this interview from the sample, as their experience had already been made public through both mainstream and social media platforms.

Semi-structured interviews, guided by a pre-written protocol, lasted between 60 and 75 minutes each. This approach provided the flexibility to explore emerging topics and ideas while maintaining consistency across all interviews. Initially, 15 participants were scheduled for interviews; however, data saturation was reached after interviewing 10 stakeholders (Saunders et al., 2018, p. 1983). While this was somewhat unexpected, it can be attributed to the brief duration of the crisis in the UK (June-August 2022) and the limited resources allocated to address it. In total, 11 expert interviews were conducted in the spring of 2023, approximately twelve months after the mpox outbreak. This time frame allowed for sufficient reflection and a more measured assessment of the events that transpired.

Triangulation was essential for extending our analysis across multiple stakeholder perspectives, allowing us to cross-validate findings and minimize potential bias. To achieve this, we incorporated two additional datasets: 1) press coverage from UK outlets such as *The Telegraph*, *The Guardian*, *Daily Mail* and *The Times* (19 articles collected between May and August) and a dataset from a sample of 55 videos from platforms like TikTok and YouTube. These videos were selected based on two key criteria: popularity (measured through viewership) and the relevance of the content creator, aligning with the same stakeholder categories interviewed. This triangulation allowed us to reconstruct public discourse and verify both the influence of mainstream media on stakeholders and the specific role of social media in shaping public perceptions and stakeholder actions.

Several measures were implemented to enhance the reliability of the study's findings (Seale, 1997; Spiers et al., 2018). First, triangulation was utilized by including multiple stakeholder groups, capturing a broad range of perspectives on the mpox outbreak, thus reducing the risk of bias inherent in any single viewpoint (Farmer et al., 2006). Second, each interview transcript was coded independently by two researchers, and the final coding process was iterative, involving a team of six researchers (one principal investigator and five research assistants). Third, to further ensure accuracy, participants were given the opportunity to review and provide feedback on the manuscript and the transcript of their own interview. This review process helped validate both the data and the interpretations derived from the analysis. Therefore, although the sample size is relatively small, the use of data saturation, triangulation and participant validation strengthens the reliability of the findings within the specific context of this study.

This research employed critical thematic analysis (Braun & Clarke, 2022) and utilized software for data management and coding. The analysis followed an iterative process, allowing us to move between inductive and deductive approaches. Initially, an inductive approach was used to identify emerging topics based on the interview protocol. We then applied deductive reasoning to connect these topics to existing theoretical frameworks, refining our understanding of the data and organizing it into coherent themes. Both datasets – (1) press coverage and (2) social media platforms – were coded and integrated into the thematic analysis to further validate the robustness of the identified themes. For transparency and accountability, the resulting Thematic Analysis Coding Table, along with the interview protocol and datasets, has been deposited on Harvard Dataverse (Scalvini, 2024), allowing others to examine the research process.

In conducting this research, we were mindful of the ethical responsibility to avoid perpetuating the power hierarchies that our study seeks to problematize. While we intentionally excluded individuals directly affected by mpox from the interview process to avoid re-traumatization, this decision raised concerns about the potential silencing of those with lived experience. To mitigate this risk, we integrated their perspectives through secondary data collection, analyzing social media content where people with lived experience had publicly shared their stories. By using these publicly available narratives, we ensured that their voices were still part of the discourse without subjecting them to the potential emotional burden of direct participation. This approach allowed us to reflect their experiences in our analysis while remaining ethically responsible and avoiding complicity in their silencing.

Finally, one member of the research team was hospitalized during the mpox crisis, which could have introduced a bias into the study. Their personal experience with the outbreak may have influenced their interpretation of the data, particularly in relation to how the healthcare system and public health messaging were perceived. While every effort was made to ensure objectivity through collaborative analysis and cross-validation with other team members, it is important to acknowledge that lived experiences, especially those involving personal hardship, can shape one's perspective on the crisis and the conclusions drawn from the research. To address this, we employed rigorous peer-review and triangulation methods to neutralize the influence of personal bias on the study's findings.

Findings: public discourse and ethical dimensions in the 2022 mpox outbreak

To answer the first research question – *How did evolving public discourse around the mpox outbreak influence stakeholder decision-making and institutional responses?* – our findings reveal that social media narratives shaped institutional responses in ways that both enabled and constrained ethical communication. Public health officials, activists, and media professionals were compelled to navigate rapidly shifting online narratives, where both accurate information and misinformation circulated at scale. These dynamics influenced not only public perception but also the *economy of suffering* – the structural logic through which certain forms of pain gained narrative value and institutional traction, while others remained illegible or ignored. As suffering became visible through particular discursive frames, it was selectively authorized for intervention. Stakeholder decisions were therefore not only guided by epidemiological data but shaped by the narrative terms under which suffering was rendered actionable, revealing how public discourse operated as a filter for institutional attention and public health response.

Theme 1: influence of public discourse on stakeholder decision-making

Media narratives

Mainstream media coverage of the mpox outbreak consistently foregrounded high-affect and emotionally charged narratives, often disconnected from the epidemiological evidence. An article from the *Daily Mail* on 13 May provides a paradigmatic example of this tendency, referring to mpox as ‘deadly’ and, later in the same piece, as ‘potentially deadly,’ while stating a mortality rate of ‘up to one in ten.’ These rhetorical shifts introduce epistemic instability, making it difficult for the public to discern reliable information. As Guttman and Lev (2021, p. 2) note, such communicative contradictions are more than stylistic excess; they actively facilitate the spread of misinformation by destabilizing trust in institutional knowledge.

The affective charge of these articles was not incidental – it functioned as a mechanism for narrative traction. Mpox was framed less as a public health concern requiring targeted, evidence-based intervention and more as a source of moral anxiety. This represents a core mechanism in the economy of suffering: the conversion of suffering into discursive value through its capacity to circulate affectively, regardless of epidemiological centrality. The most visible narratives were not the most urgent, but the most resonant within dominant cultural codes.

This was further illustrated in *Daily Mail* (6 July) and *The Times* (6 August) coverage that centered the risk to pregnant women and children – groups who were not, by that point, epidemiologically significant. Such narratives did not merely misrepresent risk; they reoriented public concern away from MSM. The focus on maternal and child vulnerability, despite being statistically peripheral, offered a more culturally intelligible form of suffering, rendering it institutionally actionable. This selective amplification is emblematic of how the economy of suffering prioritizes certain identities as legible victims while relegating others – queer, racialized, migrant – to the periphery.

Stigmatizing representations also played a central role. A *Times* article (11 June) described mpox transmission in terms of ‘unsafe sex,’ invoking a moralizing frame that echoes earlier public health panics. Similarly, the *Sunday Telegraph* (22 May) referred to a Spanish sauna as a ‘superspreader event,’ reproducing sexualized tropes of queer irresponsibility. These framings not only pathologized queer sexual cultures but attached stigma to public health messaging itself, complicating engagement. As one activist noted in the interviews, these portrayals ‘made it harder to convince people that the response wasn’t just moral policing.’

Even progressive outlets reproduced problematic associations. *The Guardian*’s efforts to draw parallels with HIV/AIDS – though well-intentioned – risked reactivating the same moral frameworks they sought to critique. These media strategies, taken together, reflect what we call an ethical failure of visibility: not a lack of representation, but the misrecognition and misframing of suffering through culturally familiar, morally loaded narratives. What is missing is an ethical responsibility of visibility – a stakeholder obligation to ensure that visibility is not allocated according to pre-existing symbolic hierarchies, but redistributed in ways that enable interpretive inclusion.

Platform amplification, and the selective recognition of suffering

Social media platforms, while often posited as corrective spaces, largely reproduced existing structures of authority and exclusion, though not without moments of contestation. On YouTube, Dr. John Campbell, a retired UK-based nurse educator with a substantial following, uploaded a video titled ‘Monkeypox homosexual spread,’ in which he framed the outbreak as a consequence of sexual practices within the MSM community and drew a reductive parallel with HIV. His framing relied on moral judgment, recasting public health discourse through stigmatizing tropes. What gave this content particular traction was the interplay between Campbell's professional identity and the platform's algorithmic systems. His credentialed status as a 'doctor' was not only rhetorically persuasive to viewers but also algorithmically functional: YouTube's recommender systems prioritize content tagged with medically coded language and associated with users who routinely publish health-related content. As a result, his videos were circulated more widely, indexed as both credible and authoritative. This dynamic reflects what we term *performative epistemic authority*: a convergence of professional status and platform design that amplifies certain voices under the guise of neutrality, even when the content reinforces stigma and misinformation.

This illustrates a key feature of the economy of suffering in platform environments: epistemic authority is often algorithmically and institutionally decoupled from lived experience. Those closest to the suffering in question – MSM individuals, particularly racialized and working-class – were rarely in a position to frame the discourse, unless they were already legible to the platform's attention economy. Suffering, here, becomes a content category – its uptake determined not by severity but by its alignment with existing interpretive codes.

Yet significant resistance emerged through user-led interventions. On TikTok, MSM users including Brian Thomas (POZ RN) and Matt Ford used the platform to share firsthand experiences of mpox, actively countering the sensationalism of both mainstream media and figures like Campbell. Their narratives foregrounded information accuracy, public health solidarity, and de-stigmatization. As Ford explained in one widely circulated post, 'This isn't a gay disease. This is about healthcare, about dignity, and about getting the right information out there.' These interventions did not merely supply alternative information – they enacted what we term narrative resistance, challenging dominant interpretive frames and asserting counter-epistemologies grounded in lived experience.

Thomas and Ford's approaches rejected moral judgment as a foundation for public health messaging. In contrast to Campbell's video, which implied behavioral correction through a cautionary tone, their content prioritized education and risk reduction without assigning blame. This distinction matters: it signals a shift from normative messaging toward the amplification of marginalized knowledge. Their interventions exemplify an ethical responsibility of visibility – not through spectacle or moral appeal, but through the deliberate redistribution of attention toward those most affected. Rather than exploiting personal narratives for engagement, they affirmed them as legitimate sources of knowledge.

As Sadler and LaPan (2023) argue in the context of Black women's alternative media practices, such interventions are vital for disrupting dominant framings and asserting control over how marginalized experiences are represented. Similarly, Vicari and Cappai (2016) show that patient organizations can leverage digital platforms for connective action that resists reductive public health narratives. Thomas and Ford's work aligns with this lineage of media activism, demonstrating how visibility can function not as exposure, but as a strategic and ethical act of reclamation.

However, this counter-visibility was entangled in the contradictions of the *platformization of pain*. While these interventions aimed to challenge dominant framings, they remained subject to platform dynamics that privilege content conforming to existing stereotypes or generating conflict. As a result, corrective messaging often struggled to gain traction or reach wider audiences. Rega and Medrado (2023) caution that visibility does not automatically translate into empowerment for marginalized communities; instead, it can increase exposure to harm and surveillance.

Participants echoed this ambivalence. One LGBTQ + activist explained, 'Social media was both a blessing and a curse. It allowed us to share vital information quickly, but it also became a breeding ground for misinformation and hysteria, which made it difficult to manage the public's reaction' (Interview 3). This dual function of platforms – as vectors of both stigma and resistance – replicates patterns observed in previous health crises, including autism (Parsloe & Holton, 2018) and COVID-19 (Yue et al., 2023), where digital visibility produced contradictory effects on public understanding and community self-representation.

Theme 2: ethical dimensions of visibility, recognition and communication

To answer the second research question – *How did stakeholders perceive the ethical dimensions of public messaging, particularly its potential to either reinforce or mitigate socioeconomic and identity-based health inequities?* – our findings suggest that platformization of pain and public health communication often exacerbated existing inequities rather than mitigate them. Stakeholders recognized that inadequate communication strategies, particularly those lacking cultural sensitivity, contributed to the stigmatization of marginalized communities and reinforced socioeconomic disparities. Additionally, the failure to address these issues through inclusive and transparent public health messaging created barriers to accessing care, undermining trust in public institutions and frustrating efforts to inspire cooperation in managing the mpox outbreak.

Public health messaging challenges

Public health messaging during the mpox outbreak was fraught with ethical challenges, particularly in balancing the need for accurate information with the avoidance of further stigmatization. As Aquino et al. (2022) caution, targeted public health campaigns may result in significant psychosocial harm to marginalized groups, particularly by stigmatizing these communities and associating them with specific diseases. Guttman and Salmon (2004) further highlight that targeted public health campaigns, while necessary for risk communication, often involve ethical risks such as labeling and stigmatizing certain populations, which was evident when MSM communities became the focal point of public health messaging during the outbreak. This reflects a deeper ethical challenge: finding a balance between raising public awareness and avoiding the reinforcement of harmful stereotypes.

These dynamics place public health professionals in a reactive posture: trying to correct misinformation while contending with the acceleration of partial truths and stigmatizing content. The activists of a gay and lesbian organization (Interview 8) critiqued the official response for prioritizing sex-positive messaging over epidemiological urgency. He noted that initial NHS and security team advice – aimed at being inclusive and non-stigmatizing – delayed necessary precautions. According to interview 8, this hesitancy, driven by ideological commitments rather than pragmatic public health considerations, left communities vulnerable: 'Gay organizations did not adequately protect the interests of the community.' His critique points to the consequences of overcorrecting for the stigmatizing narratives of the HIV/AIDS era: 'The lesson from AIDS should be to react quickly,' he says, suggesting that current public health discourse has become paralyzed by reputational anxiety (Interview 8).

Interview 8 does not explicitly frame his critique in terms of discrimination, but he challenges what he perceives as institutional reluctance to act decisively. In his view, gay organizations and public health authorities prioritized avoiding accusations of homophobia over implementing timely, evidence-based interventions. This hesitation, he argues, left communities vulnerable during the early stages of the outbreak.

Health professionals echoed this concern, though from a different vantage point. Interviews with clinicians revealed the difficulty of navigating communication strategies that were both accurate and non-stigmatizing. As one medical doctor observed, 'misinformation circulated on social media complicated efforts to communicate accurate public health information' (Interview 6). Public health officials had to strike a precarious balance: informing at-risk groups without reinforcing the very stereotypes they sought to dismantle. Yet the more explicitly they addressed the elevated risks within the MSM community, the more they risked reproducing stigma. This contradiction created a reactive environment, where fear – both of public backlash and of reinforcing historical prejudice – often displaced evidence as the primary driver of communication. The ethical dilemma lies not in the presence of false information, but in how even accurate messaging, if not carefully framed, can exacerbate social inequality and hinder trust in public health institutions.

Health inequities and access to resources

The mpox outbreak exposed stark health inequities, particularly for low-income and marginalized communities. Unlike the COVID-19 response, public health policies offered no financial support for those required to isolate. As one health officer noted, this created 'an ethical dilemma' (Interview 10), forcing individuals to choose between protecting their health and maintaining their income. An activist explained, 'Many people were not isolating because they were afraid of losing their jobs' (Interview 2). This policy gap not only increased transmission risk but also underscored how socioeconomic vulnerability shapes the uneven distribution of public health protections, deepening existing structural inequalities.

A similar tension emerged in the prioritization of vaccine distribution. Although the MSM community was rightly prioritized based on epidemiological risk, the lack of clear communication around this decision led to confusion and resentment among other at-risk groups (Interviews 9, 10). Without transparent messaging, the strategy was perceived by some as exclusionary. As one participant shared, 'They [my friends] stopped talking to me, like I [was] the decision maker or something' (Interview 2, Activist). This highlights the need for public health messaging to be both evidence-based and transparent – ensuring communities understand the rationale behind targeted strategies to prevent division and maintain trust.

As an activist explained, 'There was a clear disconnect between the official communication and what was actually reaching people on the ground' (Interview 8). He argued that this gap gave those with greater access to information and vaccines a false sense of security – leading some to engage in riskier behaviors under the mistaken belief that they were fully protected. While digital platforms like TikTok, WhatsApp or Grinder played an important role in vaccine advocacy and information sharing (Interview 4), they also reproduced broader systemic exclusions.

Those without consistent access to these digital channels – often the most vulnerable – were left without essential health information, placing them at greater risk. This disparity not only undermined the goals of public health messaging but also reinforced the very inequities it sought to reduce. As Ihm and Lee (2021) argue, access to social and media resources is critical for equitable health communication; without it, existing vulnerabilities are compounded. This creates an ethical paradox: communication designed to protect can, when unevenly distributed, deepen exclusion and worsen health outcomes for those already at the margins.

Cultural and identity-based disparities

Public health messaging encountered challenges in addressing the diverse needs of the population. Language barriers and inadequate outreach strategies significantly delayed the dissemination of vital health information to non-English speaking communities, limiting their access to vaccines and essential services. One healthcare professional emphasized the lack of foresight in translating public health materials into the languages spoken by local communities (Interview 5). This oversight left many marginalized groups uninformed about critical public health measures until it was too late, exacerbating existing disparities in healthcare access. Another medical doctor (Interview 9) reiterated that non-English speakers and individuals without digital access were disproportionately affected, often missing out on vaccination opportunities altogether. These communication failures signify a broader systemic issue: the assumption that uniform public health messaging could effectively reach all communities. Health promotion strategies that incorporate culturally grounded narratives are essential for effectively reaching marginalized populations, as they reflect the lived experiences of these communities (Larkey & Hecht, 2010). The mpox outbreak thus revealed that public health strategies need to actively engage with diverse cultural and linguistic contexts and ensure their communication is inclusive and responsive to the needs of local communities.

A significant ethical dilemma arises in addressing the needs of marginalized groups within the LGBTQ + community, particularly transgender individuals. Many faced barriers due to healthcare providers' limited understanding of the intersection between gender identity and sexual health, resulting in ineffective communication and exclusion from essential services. This reflects broader patterns of stigmatization, as individuals with intersecting identities reported negative healthcare experiences that hindered recovery and access (Smith et al., 2024). Trans women, especially those assigned male at birth, were particularly at risk of being overlooked. These failures reveal a critical gap in health equity and underscore the need for gender-sensitive public health strategies.

Similarly, people of color within the LGBTQ + community encountered compounded vulnerabilities at the intersection of race, sexual orientation and gender identity. These individuals often experienced double marginalization, and public health campaigns regularly failed to reach them effectively. As one medical professional noted, 'It is crucial to address health inequalities for less-heard groups like closeted individuals and those in different cultural communities. Love Tank did separate vaccination sessions for people of color and trans individuals' (Interview 9). The absence of demographic-specific outreach reinforced feelings of exclusion, neglect and alienation. Moreover, delays in providing accessible, targeted health information, particularly for individuals with insecure migration status or those not fully integrated into the MSM community, further deepened health disparities.

These identity-based disparities reflect the broader structural inequalities that Bowleg (2012) discusses through the lens of intersectionality. The failure of public health campaigns to provide accessible, targeted information for these groups underscores how the barriers to healthcare access are magnified by the experiences of those with intersecting marginalized identities. Bowleg's (2012) framework emphasizes that public health interventions must account for these overlapping systems of oppression to effectively address the compounded health disparities that arise in moments of crisis. This calls for a shift towards more inclusive, intersectional approaches in public health that actively target and support the most vulnerable communities.

Discussion: ethical reflexivity and practice

The findings refine the frameworks of platformization of pain and the economy of suffering by highlighting the discursive agency of marginalized users. Departing from structuralist accounts emphasizing algorithmic determinism (Flisfeder, 2021; Noble, 2018), this study shows how marginalized groups actively use communicative infrastructures to challenge and redefine the meanings assigned to their suffering. Far from passively experiencing the platformization of pain during the mpox outbreak, MSM communities strategically employed social media to counter stigmatizing narratives, repositioning their experiences within alternative epistemic frameworks (Garcia-Iglesias et al., 2023). Such narrative interventions underscore that suffering, once visible, is always subject to contested interpretation, and that users can actively resist pathologizing portrayals by asserting their own interpretive authority.

This reframing clarifies that the economy of suffering cannot be reduced to visibility alone (Chouliaraki, 2013). Visibility on digital platforms is always mediated by narrative frameworks, institutional logics, and algorithmic mechanisms that determine which forms of suffering circulate widely and gain legitimacy. As illustrated through Campbell's stigmatizing portrayal of mpox, algorithmic systems amplify narratives that align with established moral judgments, reinforcing existing symbolic hierarchies rather than challenging them. In contrast, marginalized users, such as MSM creators, must continually perform and strategically frame their pain to remain perceptible within these environments. Their interventions highlight how visibility becomes an unevenly distributed communicative labor: their narratives are repeatedly enacted not just as sources of knowledge, but as necessary counterpoints to stigmatizing discourses. As Bailey et al. (2017) emphasize, this recursive exposure constitutes a secondary form of exploitation, where visibility simultaneously functions as a mode of survival and a source of vulnerability. Digital platforms, therefore, do not merely circulate suffering neutrally; they actively mediate its perceived legitimacy, selectively amplifying narratives that fit dominant interpretive codes, while systematically marginalizing lived experiences that resist or complicate those codes.

The mpox outbreak demonstrates the contingent and hierarchical structure of this economy. Early media coverage focused intensely on MSM individuals, but this hypervisibility functioned through tropes of deviance, irresponsibility, and risk, reinforcing stigma rather than enabling care (Aquino et al., 2022; Smith et al., 2024). Initially, MSM were visible but not recognizable as legitimate sufferers, a form of epistemic misrecognition that delegitimized their suffering and stalled care (Garcia Iglesias et al., 2022). As the outbreak progressed, media narratives shifted toward emphasizing maternal and child vulnerability, despite these groups being epidemiologically peripheral, reflecting their symbolic alignment with heteronormative ideals of innocence and protection (Roy, 2024). These narratives became discursively privileged, their suffering rapidly authorized for institutional response (Chouliaraki, 2024, p. 59, 69). In contrast, the suffering of queer, racialized, and migrant individuals, despite their statistical centrality to the outbreak, remained epistemically contested and ethically uncertain, mediated by culturally encoded hierarchies of worth (Benjamin, 2019; Bowleg, 2012; Choi & Fox, 2023).

This asymmetry underscores a central claim of the economy of suffering: recognition is unevenly distributed. Suffering gains visibility selectively, based on how closely it aligns with dominant symbolic frameworks; public discourse, operating across traditional media and digital platforms, functions as an evaluative mechanism that designates certain lives as deserving of empathy and care, while marginalizing others as morally or epistemically illegible. In this sense, the economy of suffering provides both an analytical lens to understand media power and a critical framework for interrogating the normative assumptions that determine whose pain becomes legible in public health contexts.

Importantly, this economy is structured through semiotic and affective hierarchies, but it is also actively contested. Acts of narrative resistance (Vicari & Cappai, 2016), exemplified by marginalized users during the mpox outbreak, directly challenge imposed moral scripts by asserting alternative frameworks for interpreting harm and vulnerability. These counter-narratives aim beyond mere visibility; they demand epistemic justice by questioning who holds authority over defining suffering and determining whose knowledge is legitimate within public discourse.

These dynamics demand a reorientation of ethical thought in public health communication, shifting from a liberal ideal of representational inclusion toward a critical interrogation of the structural and epistemic conditions under which suffering becomes communicable (Bowleg, 2012; Carel & Kidd, 2014; Fricker, 2009). This approach involves two distinct but complementary ethical commitments: an *ethical responsibility of visibility* (Anonymised, 2024; Chouliaraki, 2006, 2013; Honneth, 1996) and *ethical reflexivity* (Guttman & Salmon, 2004; Lalumera, 2024). Ethical responsibility of visibility refers to a normative obligation to redistribute interpretive legitimacy to ensure not merely more diverse representation, but that marginalized experiences are actively recognized and granted authority in public discourse (Akpinar & Fazelpour, 2024; Napoli, 2024).

Ethical reflexivity, by contrast, emphasizes continuous critical examination of communicative strategies (Beer, 2017; Gillespie, 2017; Nieborg & Poell, 2018). It questions who is authorized to speak, whose narratives achieve institutional recognition, and whose suffering remains illegible or misread (Benjamin, 2019; Chouliaraki, 2024; Parsloe & Holton, 2018). Thus, if ethical responsibility of visibility defines *what* should be made visible and *for whom*, ethical reflexivity interrogates precisely *how* visibility is constructed, legitimized, and circulated (Rega & Medrado, 2023; Velkova & Kaun, 2021).

This reflexive practice compels public health practitioners, media actors, and institutional stakeholders to scrutinize their assumptions, exclusions, and underlying political commitments, addressing the deeper power structures embedded within public health communication (Bailey et al., 2017; Guttman & Lev, 2021; Taggart et al., 2021).

As articulated in public health ethics (Guttman & Lev, 2021; Guttman & Salmon, 2004), ethical reflexivity resists the technocratic impulse to ‘target’ communities and instead asks what is presupposed by the very act of targeting – what forms of knowledge are privileged, what histories are silenced, and what hierarchies are reproduced? It refuses the fantasy that visibility is inherently reparative and insists, instead, on examining how legibility is allocated, who benefits from its distribution, and to what institutional ends it is put. In the context of mpox, where suffering was simultaneously spectacularized and disqualified, ethical reflexivity represents more than a gesture of care; it constitutes a call for structural accountability (Rubenstein, 2007; Young, 2006).

This concept emerges not as a normative ideal, but as an analytical reflection of the dilemmas stakeholders themselves encountered during the mpox outbreak (Choi & Fox, 2023; Roy, 2024). Practitioners were often compelled to respond to public fear, media framing, and misinformation against their own judgment (Aquino et al., 2022; Taggart et al., 2021). Several participants described how even factually accurate campaigns were recontextualized in ways that amplified stigma, particularly toward MSM communities. These accounts mirror the warning issued by Guttman and Lev (2021): that targeted health communication, when uncritically applied, risks reinforcing the very epistemic and structural inequalities it claims to address. Ethical reflexivity, in this context, refers to the ethical labor required to navigate a communication environment shaped by unequal narrative legitimacy, where experiences of harm are not merely represented but adapted to conform to established moral and institutional frameworks.

This reflexive orientation points toward a broader ethical challenge: how to communicate responsibly within digital environments shaped by platform logics and unequal hierarchies of visibility (Napoli, 2024; van Dijk, 2020). As Chouliaraki (2006, 2013) argues, visibility alone can be politically problematic, reinforcing symbolic hierarchies of suffering rather than challenging them. Ethical reflexivity thus demands recognition that communicative legitimacy is unequally distributed, requiring public health communication to actively acknowledge the unequal conditions under which certain narratives become visible and authoritative (Aquino et al., 2022; Rega & Medrado, 2023). It advocates for communicative practices that resist dominant institutional modes of knowledge production, creating spaces for alternative forms of expression that would otherwise remain marginalized (Fricker, 2009; Lalumera, 2024; Okoroji et al., 2023). Reflexivity therefore challenges habitual reliance on established epistemic frameworks and critically interrogates the supposed neutrality of neo-positivist approaches in public health (Chirkov & Anderson, 2018; Park et al., 2020). It encourages meaningful engagement with marginalized perspectives that institutions routinely overlook or dismiss precisely because they disrupt dominant expectations of credibility and legitimacy (Bailey et al., 2017; Benjamin, 2019; Noble, 2018).

Translating ethical reflexivity into public health strategy requires moving beyond one-way messaging toward participatory infrastructures. First, communication strategies must be co-designed with affected communities, not retrofitted through post-hoc consultation (Bowleg, 2012; Vicari & Cappai, 2016). Second, public health institutions should establish iterative feedback mechanisms – structured, ongoing engagements with community actors to assess how messages are being received, resisted, or reinterpreted (Garcia-Iglesias et al., 2023; Guttman & Lev, 2021). Third, institutional communicators must be trained in media ethics, with specific emphasis on avoiding the symbolic hierarchies of victimhood that continue to shape public discourse (Chouliaraki, 2006, 2024; El Dine et al., 2024). Fourth, partnerships with peer communicators – activists, patients, community voices – should be prioritized to bridge institutional language and community knowledge (Okoroji et al., 2023).

Our recommendations respond by advocating for practices that move beyond simply including marginalized voices to actively redefining the terms of inclusion. This involves co-creating messaging with affected communities (Ems & Gonzales, 2016; Taggart et al., 2021), prioritizing situated knowledge over generalized expert-led content (Fricker, 2009; Okoroji et al., 2023), and critically engaging with rather than passively relying on platform metrics as indicators of legitimacy (Akpinar & Fazelpour, 2024; Beer, 2017; Flisfeder, 2021). These recommendations are necessary to move beyond tokenistic inclusion and to propose communicative strategies that address epistemic inequality at its operational core (Benjamin, 2019; Napoli, 2024). In this sense, reflexivity becomes transformative not as an abstract ethical ideal but as a practical method for proactively designing communication that resists dominant epistemologies and enables narrative justice (Rega & Medrado, 2023).

Such communicative strategies were used during the mpox outbreak in grassroots communication efforts, particularly among MSM users who strategically disrupted official framings. As Jackson et al. (2021) note, while social media offers avenues for public health advocacy, its ethical potential lies in deliberate, user-driven practices that promote inclusion and resist representational closure. Vicari and Cappai (2016) similarly highlight the co-production of health knowledge by marginalized users as a mode of resistance against dominant discourse. In the mpox case, these practices reclaimed interpretive authority and created new affective publics. Viewed alongside stakeholder reflections, they clarify that ethical reflexivity must be paired with a broader structural orientation – one that links communication to redistribution, accountability, and epistemic justice.

Policymakers must also acknowledge that the visibility of suffering is never politically neutral. Communication that amplifies certain risks while silencing others does more than distort information; it reorganizes the conditions of trust and legitimacy that structure access to care. A commitment to the ethical responsibility of visibility requires that health messaging be evaluated not only for accuracy, but for its epistemic and distributive consequences. Who is allowed to narrate suffering? Who becomes intelligible within institutional frames? Who is left behind in the name of clarity?

Together, ethical reflexivity and ethical responsibility of visibility constitute a critical framework for public health communication, rejecting the assumption that communication is merely a neutral instrument for behavioral intervention. Instead, they recast communication as an agonistic space in which the terms of legibility are continuously contested and redefined through struggles over recognition and power. Public health, if it is to be ethical, must abandon the managerial fantasy of control and embrace the political task of listening otherwise (Table 2).

Table 2. Thematic analysis of public discourse and ethical dimensions in the 2022 mpox outbreak.

Research Question	Theme	Sub-themes	Revised Key Topics	Theoretical Concept
How did the evolving public discourse surrounding the mpox outbreak shape stakeholder decision-making and actions?	Influence of Public Discourse on Stakeholder Decision-Making	Media Narratives	Mainstream media operationalized moral frames and affective spectacle, producing epistemic instability and prioritizing legible victimhood over epidemiological relevance.	Economy of Suffering
		Platform Amplification and Public Perception	Platform actors and algorithms mediated selective recognition, producing both stigmatizing content and narrative counter-publics structured by visibility logics.	Platformization of Pain, Narrative Resistance
How did stakeholders perceive the ethical dimensions of public messaging, particularly its potential to reinforce or mitigate socioeconomic and identity-based health inequities?	Ethical Dimensions of Visibility, Recognition, and Communication	Public Health Messaging Challenges	Stakeholders negotiated competing imperatives: avoiding stigma, maintaining institutional credibility, and confronting the symbolic hierarchies embedded in targeted communication.	Hermeneutical Injustice, Ethical Responsibility of Visibility
		Health Inequities and Access to Resources	Absence of material support, uneven digital infrastructures, and ambiguous prioritization protocols compounded structural exclusion and distributive injustice.	Economy of Suffering, Platformization of Pain
		Cultural and Identity-Based Disparities	Public health communication erased intersectional experience, reproducing symbolic marginality for trans, migrant, and racialized individuals.	Intersectionality Hermeneutical Injustice

Conclusion: beyond crisis communication

Finally, the mpox outbreak underscores the need to expand the theoretical and practical scope of public health communication beyond episodic crisis response. Public health messaging must be reconceptualized not merely as the delivery of risk information, but as a sustained practice of structural intervention – one that confronts the systemic inequalities shaping whose suffering becomes visible, intelligible, and actionable. As this study has shown, suffering does not circulate neutrally; it is governed by what we term the *economy of suffering* – a process through which narratives acquire value via affective legibility, but one that can also be resisted, disrupted, or reconfigured by those whose pain has been misrecognized or excluded. Confronting this process demands a paradigm shift: from managing crises to addressing the socio-political conditions that render some communities persistently more vulnerable than others.

This theoretical reorientation challenges the notion of public health as technocratic or neutral, and instead positions communication as a political practice – one that can either reproduce or dismantle hierarchies of recognition. Within this framework, public health communication becomes a site of *ethical reflexivity*, where practitioners critically assess how their messages circulate; a space of *ethical responsibility of visibility*, where institutions must take active responsibility for redistributing interpretive authority; and a terrain of *narrative resistance*, where marginalized communities use digital platforms to contest dominant framings, reclaim agency, and assert alternative epistemologies. These practices reveal that public health narratives are not only produced by institutions but actively negotiated from below. Recognizing and supporting such counter-narratives is essential for fostering communicative environments that are not only inclusive but structurally responsive.

Practically, this shift requires public health institutions to adopt long-term, community-centered strategies: building sustained relationships with marginalized groups, co-producing health messaging, and embedding accountability mechanisms that reflect the lived experiences and epistemic authority of those most affected. It also demands that public health practitioners reimagine their roles – not simply as conveyors of neutral information, but as agents of structural change, accountable for how health narratives are constructed, circulated, and institutionalized.

In short, public health communication must be treated not as a temporary fix but as an enduring commitment to equity. This includes resisting the reductive logic of the *economy of suffering*, refusing platform-driven shortcuts to visibility, and investing in communication as a tool for transformation – not containment.

Open Scholarship

This article has earned the Center for Open Science badges for Open Data and Open Materials through Open Practices Disclosure. The data and materials are openly accessible at Scalvini, Marco, 2024, “Ethical Dimensions of Public Health Communication During the Mpox Crisis (Supplementary Material)”, https://doi.org/10.7910/DVN/KWIPTL, Harvard Dataverse, V1 and .

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