Operationalizing Accompaniment: Reflections and Questions for Student Accompagnateurs

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INTRODUCTION TO THE ACCOMPANIMENT MODEL

The accompaniment model provides both moral orientation and pragmatic instruction for public health workers.

The concept of accompaniment, first identified through Catholic social teaching,[2] was popularized as a model for healthcare delivery by Dr. Paul Farmer, who co-founded the international non-profit Partners In Health, an organization committed to building systems that provide high quality healthcare to the medically underserved. In an address to the Harvard Kennedy School of Government, Farmer explained:

> *"To accompany someone is to go somewhere with him or her, to break bread together, to be present on a journey with a beginning and an end… We're not sure exactly where the beginning might be, and we're almost never sure about the end. There's an element of mystery, of openness in accompaniment: I'll go with you and support you on your journey wherever it leads."*

During the COVID-19 pandemic, I worked for Partners In Health to support the public health response, first in Massachusetts and later in Immokalee, Florida. We returned to this definition many times to ground our approach.

This paper offers reflections and questions borne out of the COVID-19 response, which I seek to extend as an invitation to discussion with other public health practitioners, especially those who, like me, may have recently embarked on the collective mission to operationalize accompaniment in community health.

Contact Tracing in Massachusetts: On an individual level, accompaniment is built on mutual trust.

In April 2020, after the COVID-19 pandemic had brought me back to my parents' home in Massachusetts, I sat on the floor of my childhood bedroom and punched in a ten-digit phone number.

I was a Contact Tracer, tasked with calling positive cases and their contacts to collect data on exposure, provide technical assistance for isolation and quarantine, conduct symptom monitoring, and refer to clinical and social services.

When I called Marie*, a mother who'd contracted COVID-19 along with her two children, she hadn't yet received their positive test results. As I delivered the news, she stated, "I can't isolate. I can't."

I looked at the script. This wasn't in it.

"I know this is really difficult, but our team is here to make it easier, however possible," I said. "Can you tell me more about why you can't isolate?"

Over the next thirty minutes, I learned that Marie was terrified of not being able to feed her children. She was terrified of losing her job and her home. Eviction felt like a disease worse than COVID-19 due to its well-known and devastating prognosis.

"What if we send a letter to your employer from the Department of Public Health that says you need to miss work? And what if we arrange daily food drop-offs?"

"Well, I guess that might work," she said.

As Marie and her children isolated, I called her every afternoon. We talked about symptoms (cough, sore throat, loss of taste and smell) and hand-washing games for kids (singing the ABCs), but we also discussed our mutual love for Dunkin' Donuts, our families, and our Massachusetts roots.

As Contact Tracers, we asked deeply personal questions about a disease that was heavily stigmatized and politicized - *who have you been in contact with for the past few days? Can you share their names and phone numbers? Do you have enough food to eat? Money to pay rent?* The questions on the script were hard to ask but even harder to answer, and the quality of our conversations depended on mutual trust.

The trust determination model of communication names four pairs of constructs important for building trust - honesty and openness, competence and expertise, dedication and commitment, and caring and empathy. To accompany patients, we had to establish trust by remaining *open* to understanding and addressing the barriers to following public health recommendations; we offered technical *expertise* on strategies for minimizing the spread of infection; we showed *commitment* by calling patients every day; and we demonstrated *empathy* by avoiding judgment and showing interest in each patient as a whole person.

Healthcare providers and public health practitioners can implement strategies for building trust to operationalize accompaniment in their own practices, which can improve adherence and healthcare outcomes.

Ten days later, Marie and her children had made it through isolation with significantly improved symptoms.

"Thank you," I said, "for all that you've done to accompany your family and community."

*Name changed to protect privacy

Coordinating a COVID-19 Response in Immokalee, FL: On a structural level, accompaniment requires shifting power and redistributing resources to advance health as a human right.

Disease is not randomly distributed, but is structured by the social, economic, and political fabrics of society. In few places has this been clearer than in Immokalee, Florida during the COVID-19 pandemic. Many members of this tight-knit community are farmworkers within an agricultural system that is rooted in slavery.[6] This history of economic inequality continues today: in 2020, the median yearly income in Immokalee was $33,249,[7] less than a third of that of nearby Naples ($118,141).[8]

During the COVID-19 pandemic, poverty, racism, and xenophobia were key drivers of infection.

Due to high rent prices and low wages, many people lived close together in trailers, which promoted susceptibility to infection. When individuals became sick, many lacked health insurance and other means for accessing medical care, which increased rates of morbidity and death. Within this context, a multi-stakeholder team formed to implement community-based interventions for stopping the spread of disease.

"It's the COVID-19 Team!" Our team knocked on the door of a trailer. Even though the paint was peeling and the window screen was caving in, a bed in this trailer could cost hundreds to a thousand dollars per month. A housing monopoly in the community left individuals seeking shelter with little choice but to spend most of their paychecks on rent.

"No one's home," declared my teammate. Sweating in the aggressive Florida humidity, we heaved our bags of masks and folders of informational pamphlets to the next door.

One of our coalition's first interventions was the use of health education, where we accompanied a team of Health Promoters from Immokalee to conduct household visits to share information about COVID-19 and strategies for "flattening the curve."

Very few people had access to masks, cleaning supplies, safe places to isolate, or other materials required to implement the CDC recommendations laid out on our colorful, multilingual flyers. When we returned to the clinic that day, we were sweaty and defeated.

"People can't stay home, even if they are sick," my colleague said. "I used to work in the packing houses - you go when you're called, and you don't get time off."

"What do you think we should do?"

Over the next few weeks, the team listened intently during household visits and community events and met regularly to discuss findings. Testing, we learned, was in settings that were inconvenient for the primarily-walking community, and many individuals never received

their results due to challenges with the online portal. Despite a strong sense of care for the community, and experienced ingenuity in navigating economically challenging conditions structured by immigration processes and agricultural labor, few people had the material resources to isolate if they did test positive.

In response to this feedback, the team developed a testing system, where rapid test events were hosted at convenient times in community-centered locations, bringing care to the people instead of forcing people to come to the care. Anyone who tested positive was assigned to a Health Promoter, who followed up through daily phone calls and food drop-offs. Individuals in isolation also received a cash transfer of $800-$1,200, based on two-week farmworker earnings during harvest season, to alleviate the economic precarity that was exacerbated by infection.

Within 15 months, 2,500 people had been supported to isolate, and over $900,000 had been disbursed throughout Immokalee.[9]

For me, this system demonstrated the importance of moving beyond the education-only approach - which operated at the individual level and put the responsibility on a person to act on public health recommendations, regardless of material circumstances - to incorporate structural competence, where the social, political, and economic structures that manifest as health and disease were considered.

The Health Promoters provided invaluable leadership in gathering input from the community to guide every intervention. Accompaniment, they demonstrated, calls us to de-center ourselves from the work to shift power to those we seek to accompany. As accompagnateurs, we must consider how we can be vectors in moving resources and agents in shifting power to address the social, political, and economic inequities underlying disease.

QUESTIONS ABOUT THE ACCOMPANIMENT MODEL

While my experiences in the COVID-19 response were transformative for my own understanding of accompaniment, they also left me with questions about the model:

- Multi-stakeholder initiatives in public health and community health often unearth opposing interests among partners. When working with multiple stakeholders during a conflict, who do we choose to accompany and how?
- One goal of accompaniment is to avoid the creation of parallel operations by accompanying public sectors to strengthen existing systems that were theoretically voted for by the people they serve. However, during crises in which governments may not be able to serve all their constituents immediately, how do we maintain this principle of public sector accompaniment while ensuring individuals have access to life-saving resources at the moment?
- To provide structural accompaniment, we must move resources and shift power to historically marginalized communities to

address the social, economic, and political inequities that structure poor health outcomes. How might we build healthcare systems that achieve this movement of wealth and influence on a larger scale?

CONCLUSION

The accompaniment model can be used to operationalize health as a human right at both the individual and structural levels. While questions surrounding accompaniment require further reflection, accompagnateurs can look to this model for philosophical orientation and practical instruction to guide their work in community health.

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