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How health mediation can function effectively on the fostering of healthcare utilization? : a realist qualitative study

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Abstract

Background Health mediation practices are multiform—as they constantly adapt to the context—and multilevel, making any study of health mediation complex. Given this background, some authors in interventional health research working on the complexity of interventions highlighted the need for a solid conceptual framework-upstream of any evaluation-that considers all the specificities of the intervention and the context. The present realist qualitative study aimed to deepen our understanding of how health mediation could foster healthcare utilization.

Methods We conducted a realist qualitative study from May 2021 to September 2022 in France using eighteen semi-structured interviews of professionals implementing health mediation. The themes investigated were their professional framework, activities, and perception of factors facilitating and limiting the effect of health mediation on the fostering of healthcare utilization by underserved populations. Data was analyzed to develop a taxonomy of health mediation activities and to hypothesize initial middle-range theories necessary to explain the effect of health mediation on healthcare utilization. Results were amended and adjusted at four consensus seminars in February 2023.

Results The taxonomy comprised 59 activities grouped into standardized categories into three dimensions: the territorial structuring of health mediation, the coordination and steering of response actions, and healthcare system navigation. We identified three initial middle-range theories that could explain how health mediation might foster healthcare utilization among underserved populations. Specifically, these theories suggested two prerequisites for effective health mediation. The first would be the need for a community of practice to help the healthcare system adapt to the problems and needs of underserved populations. The second would be the need to foster the intention to use the healthcare system, based on the targeted populations' perceived and unperceived health needs. In turn, this could encourage effective healthcare utilization for these populations.

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Discussion Health mediators might complement the work of all other healthcare and social workers to respond proportionately to the needs and different vulnerabilities of underserved populations. In this way, health mediation promotes the right to good health and fosters healthcare utilization.

Keywords Underserved populations, Health mediation, Complex intervention, Realist approach

Contributions to literature

- Health mediation practices are multiform—as they constantly adapt to the context—and multilevel. This makes any study of health mediation a complex task.
- Given this background, some authors in the field of interventional health research working on the complexity of interventions, highlighted the need for a solid conceptual framework—upstream of any evaluation—that takes into account all the specificities of both the intervention and the context.
- Our research proposes the first health mediation taxonomy and framework of health mediation understanding how the process of health mediation could foster healthcare utilization.

Background

Underserved populations primarily belong to the most socially excluded population groups in society [1]. They are also more likely to perceive that they have limited control over their lives [2]. In France, universal interventions to combat inequalities in healthcare utilization have been implemented, such as universal social protection, medical aid, and complementary health insurance (C2S), to facilitate financial access to healthcare services. However, as there are still many obstacles[1] to accessing healthcare services, more targeted interventions are needed for underserved populations.

Several interventions have been developed to improve access to healthcare for underserved populations. Case management [3] focuses on providing personalized, continuous support to people with complex needs by coordinating services across multiple sectors. This approach aims to ensure that patients receive holistic and efficient care, especially for those requiring long-term follow-up [3]. Similarly, navigation systems guide people through the complexities of the healthcare system, addressing barriers such as administrative processes, scheduling, and accessing appropriate services. These systems are particularly effective for populations who are unfamiliar or excluded from formal healthcare structures [4]. Community health workers (CHWs) and cultural mediators act as intermediaries, facilitating access to healthcare services while reducing cultural and social barriers [5, 6]. In the European setting, these interventions may be named health mediation. Health mediators also act as an interface between vulnerable populations and healthcare professionals. Unlike simple navigation or service coordination as case management, health mediation also seeks to raise awareness among professionals about the obstacles faced by underserved populations, fostering more inclusive and tailored interactions [7].

Peer support programs [8] and patient advocacy initiatives [9] enhance patient engagement by offering personalized guidance and practical advice throughout their healthcare journey. Integrated care models [10] coordinate health and social services to comprehensively address patients'complex needs, while mobile health clinics [11] overcome geographical barriers by delivering care directly to remote areas. While these approaches share common goals in different contexts, their methods and levels of involvement differ in supporting underserved populations and transforming professional practices.

As mentioned above, health mediation is one of the promising interventions to foster healthcare utilization in these populations. It is defined as a temporary process of 'going towards' and 'bringing to' the healthcare system and 'doing with' the person [1]. It acts as an interface between underserved populations and the professionals dealing with their problems (social and health care workers, government service agents, elected representatives, etc.). Health mediation aims to facilitate access to rights and care for vulnerable populations and raise awareness among the professionals concerned regarding the obstacles these people encounter [1]. This intervention can either be one of the roles performed by a professional in the health, social, or medico-social sector, or a dedicated individual can embody it, the health mediator. Based on the needs identified in the territory, health mediators implement individual and/or collective actions for information, communication, and skills-building (i.e., 'doing with'), healthcare system navigation (i.e., 'going to' and 'bringing to'), and strengthen coordination of collaborations through'third-party mediation,'by mobilizing, engaging, and bringing together local professionals (i.e., 'being together') who collaborate with local populations (i.e., 'doing together') [7]. So, a health mediator acts as an

[1] Geographical, familial, or social isolation, risky practices, unfavorable legal and health environment, precariousness, lack of knowledge of the French health system, difficulties linked to the French language or a low level of health and digital literacy.

interface in close proximity between underserved populations and the health or social professionals dealing with their problems (e.g., social and healthcare workers, government service agents, elected representatives, etc.) [1]. Most importantly, health mediation is an intervention which adapts existing practices to a socially shifting context. This makes any study of health mediation complex. To our knowledge, except for a few pioneering studies [12–14], no study has demonstrated health mediation's effectiveness in an experimental setting.

Given this background context, some authors in the field of interventional health research working on the complexity of interventions, highlighted the need for a solid conceptual framework—upstream of any evaluation—that takes into account all the specificities of both the intervention and the context [15]. As mentioned above, health mediation practices are multiform—as they constantly adapt to the context—and multilevel [7]. They constitute an interventional system (i.e., "a set of interrelated human and non-human contextual agents within spatial and temporal boundaries generating mechanistic configurations – mechanisms – which are prerequisites for change in health" [16]). The realist paradigm seeks to understand the interactions between the external context components in which the intervention is implemented (i.e., the components that influence both intervention activities and mechanisms), the intervention components (i.e., activities), and the mechanisms (i.e., agent reaction that produces a change) [17]. More specifically, it aims to understand what components are necessary to create a beneficial effect of an intervention, as well as this effect's transferability to other contexts. According to Pawson and Tilley [17], generative causality is based on three postulates [10]: i) an intervention does not work in itself and is not what produces an effect, ii) every intervention triggers a mechanism or a set of mechanisms that enables a reaction to be produced, and iii) every intervention is situated in a specific context. The question is not "Does this intervention work?" but "How, for whom, and in what circumstances does this intervention work?" [17].

We previously proposed mapping a health mediation conceptual framework within the conditions needed to influence both health mediation (in terms of feasibility and success) and its effect on healthcare utilization [7] (supplementary material 1). These conditions are external (i.e., conditions that influence health mediation activities and mechanisms) and internal (i.e., activities) to a health mediation intervention. In realist evaluation, 'mechanism' means"an element of reasoning and reactions of agents in regard to the resources available in a given context to bring about changes through the implementation of an intervention and evolves within an open space–time and social system of relationships"[18]. The present realist qualitative study aimed to deepen our understanding of how health mediation could foster healthcare utilization. The secondary objectives are to explore in detail the activities that define this mediation, to enhance the health mediation conceptual framework using field experiences in France, and to refine which health mediation hypotheses might be required to foster healthcare utilization by underserved populations.

Methods

Theoretical approach: the realist paradigm

From a methodological point of view, a realist evaluation seeks to identify middle-range theories (MRTs), that is to say CMO configurations, which explain what is at stake between an intervention, a context and mechanisms [17]. From a practical point of view, like any theory-based evaluation, MRTs need to be first hypothesized (i.e., 'initial MRTs' or 'a priori CMO configurations') and then confirmed (i.e., 'MRTs' or 'CMO configurations') or disconfirmed by quantitative or qualitative data collection. We identify them when they recurrently appear in data analysis [19].

In the realist paradigm, mechanism (M) corresponds to an agent's reaction [18]. This agent can be individual (e.g., a person) or collective (e.g., an organization, a group) in nature. Contextual components (C) can be defined as "elements located in time and space that can affect the intervention and the results produced" [16]. To clarify contextual components in MRTs, Cambon et al. proposed distinguishing between the 'intervention-related context' (Ci) and 'intervention-external context' (Ce).

Accordingly, CMO configurations become CeCiMO configurations which provide even greater analytical detail [20, 21]. Mirroring our work developing the health mediation conceptual framework [7], in the present study, we defined a priori CeCiMo configurations to explain the effect of health mediation on the fostering of healthcare utilization by underserved populations. In other words, we created hypotheses for how this intervention (i.e., health mediation) can function effectively.

In this context, conditions influencing health mediation activities and mechanisms are Ce, health mediation activities are Ci, and healthcare utilization by underserved populations is the outcome (O).

Study design

To define initial MRTs, we proceeded in two steps: i) a qualitative realist study conducted from May 2021 to September 2022 in France aimed at developing a taxonomy of health mediation activities and identifying a priori CeCiMO configurations (Step 1); ii) four consensus seminars aimed at validating and adjusting both the

taxonomy and the a priori CeCiMO configurations identified in Step 1 (Step 2).

In both steps, the study population comprised professionals who implement health mediation. In order to ensure that a diverse set of field health mediation activities were included, we selected participants according to the following criteria: i) the level of implementation of health mediation (national, regional, local), ii) the level of political commitment of the French health regional agency to integrate health mediation in the territory; we created three categories reflecting this level of commitment as follows: *acquired* (i.e., health mediation politically and financially supported since the start of the French Program for Access to Prevention and Care for the most Disadvantaged Populations (PRAPS) in 2018), *incipient* (i.e., health mediation politically and financially supported during PRAPS but not since the beginning of the program), *complicated* (i.e., health mediation politically and financially supported but its implementation remains sub-optimal)), and iii) participants with diverse profiles and initial training (e.g., health workers, social workers, public health engineers, sociologists) working in public administration, a local authority, a research organization, an association-based structure or a health center.

Step 1 – Realist qualitative study

This realist qualitative study aimed to identify i) the health mediation activities (Ci) and ii) the potential CeCiMO configurations required to explain the effect of health mediation on fostering healthcare utilization by underserved populations.

Data collection

We used semi-structured interviews. Studying participants' discourses enabled us to identify the relationships that they made between Ce, Ci, M, and O in their health mediation activities.

We built an interview guide exploring the following dimensions: field of activity, initial training and function within the employing structure, the populations to whom the professional provided health mediation, level of experience in the structure and in health mediation, activities carried out (i.e., Ci), perception of factors (i.e., conditions (Ce) and mechanisms (M)) facilitating and limiting health mediation's feasibility and success in fostering healthcare utilization (O). The interviews lasted approximately an hour and were conducted either face to face or by videoconference. They were recorded and transcribed verbatim for analysis.

Analysis

We performed a thematic content analysis following our health mediation conceptual framework (suplementary material 1), using Nvivo® software. Each interview was coded independently by two researchers. Divergent codings were subsequently discussed until consensus was reached.

Data analysis was both inductive and hypothetico-deductive. The inductive component aimed to draw up a list of activities that health mediators could perform (Ci) and to identify the links between Ce, Ci, M and O. The hypothetico-deductive component aimed to confirm and complement the health mediation conceptual framework with conditions that influence both health mediation activities and mechanisms (Ce) and the mechanisms (M). Recurring links became a priori CeCiMO configurations required to explain the effect of health mediation on the fostering of healthcare utilization by underserved populations.

Step 2: Consensus seminars

The four consensus seminars aimed to elaborate a Taxonomy and the initial MRTs (i.e., a priori CeCiMO configurations) identified in Step 1. We organized three two-hour participatory seminars and one-day participatory seminars with professionals implementing local, regional and national health mediation. None of these people participated in Step 1, and all participated in all four seminars. We also invited the director of France's national health mediation program and three researchers specializing in knowledge mobilization, two were also involved in research using realist evaluation. The three two-hour seminars were dedicated to elaborating the Taxonomy, while the one-day seminar was dedicated to validating and adjusting the a priori CeCiMO configurations.

In the first three seminars, participants were asked to select activities (Ci) and to explain the form they might take in different contexts. Each activity was discussed to ensure that it was i) clearly identifiable, ii) currently implemented, and iii) specific (i.e., each activity had only one objective). The activities were amended, complemented, and reorganized where necessary to provide a consensually agreed list of health mediation activities. After identifying the health mediation activities, we created a taxonomy of health mediation activities with the health mediation stakeholders, which described them all. We first grouped activities into standardized categories (i.e., activities contributing to the same mesoscopic objective). Then we grouped the latter into dimensions (i.e., standardized categories with the same macroscopic objective).

In the fourth seminar, for each dimension of Taxonomy V1, participants were asked to identify its effect (i.e. mechanisms) according to their local context of implementation. To do this, we divided participants into

groups, each one representing a dimension of Taxonomy V1. This made it possible to establish, through consensus, the a priori health mediation CeCiMO configurations required to explain the effect in fostering healthcare utilization.

Results

Characteristics of the study population

Eighteen interviews were conducted. Half of the participants implemented health mediation locally, a quarter at the regional level, and a quarter nationally. Ten, five, and three participants indicated that the French health regional agency's political and financial commitment to health mediation in their region was, respectively, *acquired*, *incipient*, and *complicated*.

Initial professional training was heterogeneous: Nine participants were health workers, five social workers, two public health engineers, and two sociologists. Three were elected representatives, two health mediation researchers, four directors of associations implementing health mediation, five health mediators, and four were public health engineers working in health mediation, health promotion or the PRAPS program (see above). Three worked in public administration, two in a local authority, and two in a research organization, while eleven worked in an association or a health center.

Taxonomy of health mediation activities

Through the qualitative study, we identified 50 health mediation activities. Following the consensus seminars, 29 activities were amended, one was deleted, 19 changed wording, and 11 were added. The health mediation taxonomy comprised 59 activities grouped into 12 standardized categories (Table 1), which in turn were grouped into three dimensions: territorial structuring of health mediation (Ci D1-A1-26), coordinating and steering response actions (Ci D2-A27-34), and healthcare system navigation (CiD3-A35-59).

Adaptation of the health mediation conceptual framework developed by Richard et al.

The realist qualitative study (step 1) confirmed the majority of the elements present in the health mediation conceptual framework (supplementary material 1) of our previous studies [7]. However, some adjustments were necessary, all concerning the meso-systemic Ce. The most significant changes were:

– At the meso-systemic level, Ce were added based on the notion of a 'community of practice'. The latter can be defined as"a group of people who share a common concern, a set of problems or an interest in a subject, and who come together to achieve individual and collective objectives gathered around a common issue"[14]. Effectively, health mediation is implemented within a community of practice in which the individual health mediator plays an active part. The Ce specific to the community of practice which were added were as follows: i) a knowledge of the specificity of the needs and problems of underserved populations, ii) a knowledge of the territorial context, including the actors of influence and negotiation, and iii) an attitude of patience, perseverance and commitment to the community of practice, which fosters trust and equality of power.
– At the microsystemic level, our analyses revealed a new mechanism: the perception of the collective ability to overcome obstacles in order to adapt the system to welcome and support underserved populations (i.e., collective self-efficacy). Figure 1 presents the modified health mediation conceptual framework.

Initial health mediation middle-range theories

After Step 1, we were able to identify the health mediation mechanisms fostering healthcare utilization: collective self-efficacy (M1), perceived health needs (M2), trust in a resource person—in this case the health mediator (M3) – and, finally, a set of individual capabilities (M4). At the end of Step 2, the participants adjusted and validated the above-mentioned mechanisms. Two new mechanisms perceived as key to health mediation emerged: reducing barriers to the use of health services perceived by underserved people (M4.2.3), and having a set of collective capabilities[2] (M5).

As indicated above, the three health mediation dimensions identified as influencing these mechanisms were: i) the territorial structuring of health mediation (Ci D1-A1-26), ii) the coordination and steering response actions (Ci D2-A27-34), iii) healthcare system navigation (Ci D3-A35-59).

The Ce identified as influencing both health mediation activities and mechanisms at the macro-system and meso-system levels, were:

– At the level of the macro-system, political and financial commitment (Ce1), the possibility of acting on structural and intermediate determinants of health (Ce2), and ensuring that the role of health mediators

[2] "Capacity and real power that a person possesses and what he or she is capable of doing and achieving in terms of choices that he or she values"(33) for and within his or her community.

Table 1 Taxonomy V1 of health mediation activities that health mediators can perform

Dimension	Activity category	N°	Activities	Shared with coordinator
1. Health mediation territorial structuring	Ongoing territorial diagnostics function	1	Observe the living conditions (housing, social, employment, economic, etc.) of the people we support	
		2	Exchange ideas with people on informal subjects at informal times and places	
		3	Identify the living conditions (housing, social, employment, economic, etc.) of the people we support	
		4	Identify people's needs and resources, wherever possible (living space, association premises, partner premises, public space, internet, etc.) by conducting interviews (using active listening) to assess the situation (administrative procedures already underway, organization of procedures to be continued or started), whatever the nature of these needs	
		5	Carefully identify the intermediaries, trusted by the person who can be mobilized to respond to the needs/issues identified	
		6	Identify potential partners* concerned by the issues identified in the area	X
		7	Meet partners likely to be concerned by the issues identified in the	X
		8	Identify partners'difficulties and the needs required to resolve problems, through exchanges on the current situation (steps already taken, organization of steps to continue or begin)	X
		9	Analyze people's living conditions, needs and resources with a view to formalizing integrated expertise within the territory	X
		10	Analyze the difficulties, needs and resources of partners that are affected by the problems which have been identified in the territory	X
		11	Keep up to date on what programs and interventions are available in the area	X
		12	Target the services that can be called upon to solve people's problems in the area	X
		13	Modulate/adapt existing systems to respond to problems identified in the area	X
		14	Recommend the adaptations needed to solve the problems identified in the area, based on an analysis	X
	Alert function	15	Alert team leaders or coordinators to issues identified as negatively affecting the health of the people we support	
		16	Alert partners to problems identified as having a negative impact on the health of people receiving support	X
		17	Alert institutions to issues identified as having a negative impact on the health of people receiving support	X

Table 1 (continued)

Dimension	Activity category	N°	Activities	Shared with coordinator
		18	Bring issues identified as having a negative impact on people's health to the attention of resource people likely to be able to resolve them: ombudsman, health agency, doctors'association, nurses in the event of patient refusal of care, courts for situations of concern or reports, hospital managers, etc	X
	Third-party expert function	19	Share feedback with partners by various means (telephone, meetings, notes, etc.)	X
		20	Discuss the problems encountered by the people we support at meetings organized by our partners (requested on an emergency or routine basis)	X
		21	Participate in knowledge-sharing/exchange of practices on issues encountered by individuals, between all partners concerned at the local level with a view to optimizing interventions—feedback—establishing local best practices—procedures	X
	Third-party leader function	22	Organize/facilitate meetings on the problems encountered by people (either on an emergency or routine basis) with partners to formulate proposals for action	X
		23	Organize/lead meetings with partners to determine joint action objectives for resolving problems (health or social) encountered by individuals	X
		24	Organize/facilitate routine knowledge-sharing forums around the problems encountered by people between all partners concerned at the local level with a view to optimizing interventions—feedback—establishing local best practices—procedures	X
	Formalization	25	Formalize a reciprocal commitment to collaboration and exchange with partners (partnership agreement, etc.)	X
		26	Organize and implement the monitoring of these commitments over time	X
2. Coordination and management of health mediation	Coordinating resources around response actions**	27	Organize/lead/participate in the coordination of actions, within a community of practice, with the aim of solving problems identified as influencing health: networking of players, assessment/monitoring, communication, etc	X
	Implementation of response actions	28	Monitor/encourage/support the development and adaptation of response actions in light of the diagnosis of the area's needs	X
		29	Co-construct and implement actions that respond to issues identified as having an impact on health, with partners and individuals, based on the diagnosis of the area's needs	X
		30	Co-construct/create/adapt, with partners and individuals, communication, awareness-raising and guidance tools, as needed and according to local resources and the diagnosis of the area's needs	

Table 1 (continued)

Dimension	Activity category	N°	Activities	Shared with coordinator
		31	Organize meetings and exchanges between people and partners, in associations' premises or in the community	X
	Follow-up/review of response actions	32	Fill in monitoring tables (standardized indicators) and patient monitoring software (DPI: computerized patient record) as required	
		33	Participate in or write reports on activities undertaken	
		34	Distribute and/or circulate activity reports to funders and supervisory bodies	x
3. Navigating the healthcare system	Informal or formal support meetings****	35	Provide emotional and/or informational support to people in the health structure's premises or in the places where they frequent	
		36	Facilitate access to material support for people, in the health structure's premises or in the places where they frequent (condoms, syringes, pregnancy tests, masks, food, blankets, etc.)	
		37	Participate in welcoming people to the healthcare structure's premises (providing coffee, etc.)	
		38	Informing people and partners of people's rights with regard to problems identified as having a negative impact on health	
		39	Inform people and partners about the measures in place to solve problems identified as having a negative impact on health	
		40	Informing people and partners about the players available according to needs and the issues identified as influencing health	
		41	Facilitating understanding and helping to fill in the documents needed to solve the problems identified as influencing health, by drawing on people's resources	
	Orientation	42	Refer people and partners to the appropriate institutions/organizations/associations/internal departments according to the needs expressed and the issues identified as negatively influencing health	
		43	Transmit, to the actor who will receive the referred person, the information necessary to deal with their problem (by phone, mail or email) within the legal framework of sharing personal information. cf: law n°2016–996 of July 20, 2016	
	Support activities	44	Facilitate telephone appointments with healthcare professionals, social workers or institutions (prefecture, town hall, etc.)	
		45	Make it easier to book appointments on online platforms (AMELI, CAF, Doctolib, etc.)	
		46	Organize/facilitate the presence of an interpreter in interactions between the person and resource players	

Table 1 (continued)

Dimension	Activity category	N°	Activities	Shared with coordinator
		47	Explain/rephrase thoughts and ensure good understanding between people and resource players (health professionals, CAF, CPAM, etc.)	
		48	Physical support for appropriate resources (health professionals, CAF, CPAM, etc.) to resolve problems and meet expressed needs	
		49	Create/adapt tools to promote continuity in the healthcare pathway (appointments, taking medication, list of healthcare professionals, etc.)	
		50	Facilitate coordination of care pathways (complementary tests, laboratory, pharmacy) and complex care (hospitalization, liaising with the hospital's social assistant to request LHSS, DSUV, etc.)	
		51	Use tools to remind people of upcoming appointments (medical or social)	
		52	Anticipate and organize transportation to the appointment with the people involved	
	Capacity building	53	Communicating with people on health topics (cancer, mother and child health, environmental exposure, chronic illness, strengthening psycho-social skills, etc.)	
		54	Preventive education and health promotion initiatives with partners on themes such as digital technology, cancer, mother-and-child health, environmental exposure, chronic illnesses and strengthening psycho-social skills, aimed at the people we support	
		55	Participate in training or awareness-raising initiatives organized by partners or within the association, on the obstacles people encounter when accessing healthcare	
		56	Raise awareness within the association and among partners and future professionals about the obstacles people face in accessing healthcare	
		57	Support for new health mediator by more experienced staff	
		58	Sharing complex situations within a formal team (surprise report, situation report)	
		59	Participate in professional exchanges between health mediators (for example, regarding the official recognition of this work as a profession)	

[*] All those concerned by the problems of the target population: Volunteers, social-health professionals, prefectures, etc.

[**] Actions/interventions/programs to respond to the problems encountered by the target population

[***] Always based on people's resources

[****] At the place of residence (camp, squat, hostel, migrant workers'hostel, independent housing, or prison) of a targeted individual, at the association's premises, at the premises of a partner (hospital or other institution), hair salons, festive places, on the internet

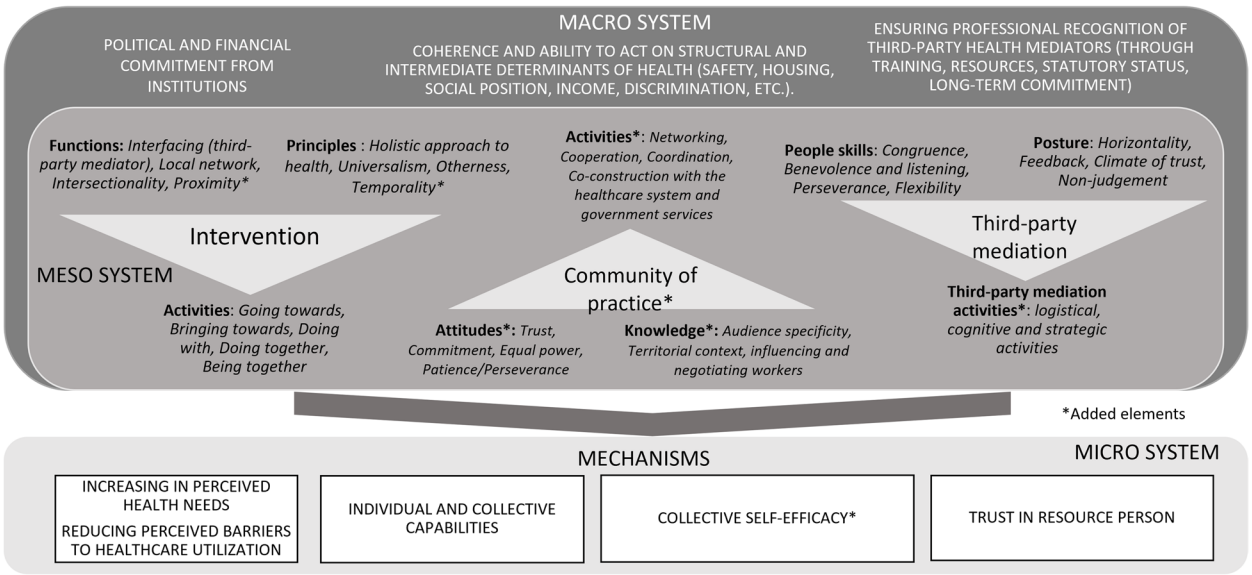


Fig. 1 Modified health mediation conceptual framework

is officially recognized (in terms of professional status, remuneration, training, etc.) (Ce3),

– At the meso-system level, the principles (Ce4) and functions (Ce5) of health mediation, the health mediator's posture (i.e., non-hierarchical, positive feedback in a climate of trust and non-judgment) (Ce6) and his/her soft skills (i.e., congruence, benevolence and listening, perseverance, mental flexibility) (Ce7), the attitudes of the community of practice (i.e., relationship of trust, commitment, equality of power, patience/perseverance) (Ce9), and the knowledge within this community of practice (Ce10).

Seminar participants amended the meso-systemic Ce and Ci identified as influencing these mechanisms. According to the participants, all the Ce influenced the activities specific to the health mediation intervention, the health mediator, and the community of practice. Our study explains this by considering all health mediation practices (e.g., non-peer, peer-based, etc.) for all underserved populations.

This study enabled us to formulate the following three initial health mediation MRTs (Table 2):

– Healthcare system navigation activities generate trust in a resource person and individual capabilities; this mechanism fosters the intention to use healthcare services for physical discomfort (cf. Theory 3 above).
– The territorial structuring of health mediation activities around a community of practice, and the coordination of response actions by the latter, generate collective self-efficacy within the community of practice, and a reduction in the perceived obstacles to using health services by underserved populations. These mechanisms help to adapt the healthcare system to welcome and support underserved people (see theory 1 above).
– The coordination of response activities within the community of practice and healthcare system navigation activities fosters underserved populations' perception of their health needs and collective capabilities. These mechanisms foster underserved populations' intention to use healthcare services for physical and mental well-being (cf. theory 2 above).

These three initial health mediation MRTs interlock chronologically (i.e., CeCiMO3 < -CeCiMO1 < -CeCiMO2 over time) to promote the effective healthcare utilization.

In summary, healthcare system navigation activities only foster healthcare utilization in the case of physical discomfort (O3). In order to promote healthcare utilization for physical and mental well-being (O2), it is necessary to:

– 1/coordinate response actions with the help of a community of practice (having benefited upstream from territorial structuring concerning health mediation) to adapt the healthcare system to welcome and support underserved populations (O1),

Table 2 Initial medium-range theories (MRTs) of health mediation: after the consensus seminars (modifications highlighted)

N°	Expected results and effect mechanisms	Intervention and non-intervention components influencing effect mechanisms
MRT 1	Adapting the system to welcome and support underserved people (O^1) and thus facilitate their effective use of the healthcare system (O) is facilitated if the community of practice perceives that it has the collective ability to overcome obstacles to adapting their work system/organization (M1) and if underserved people perceive a reduction in barriers to using healthcare services (M4.2.3)	These perceptions are facilitated by the territorial structuring of health mediation (Ci D-A1-26), particularly if health mediation benefits from political and financial commitment from institutions (Ce1) and if health mediators feel secure in their professional framework (Ce3), thereby facilitating the posture (Ce7) and adapted soft skills (Ce6) of the health mediator. They are also facilitated by mobilizing the functions (Ce5) and principles (Ce4) of health mediation These perceptions are facilitated by the coordination of resources, within a community of practice, around response actions to act on health determinants (Ci D2-A27), particularly when there is political and financial commitment from institutions (Ce1). Moreover, it is facilitated the community of practice's knowledge (Ce10) and attitude (Ce9). In addition, the health mediator's posture (Ce7) and soft skills (Ce6) enable him/her to act on the social determinants of health (Ce2)
MRT 2	The intention to utilize health services for physical and mental well-being (O^2), and thus to make effective use of the health system (O), is facilitated if underserved people perceive they have a health need (M2) and if a set of collective capabilities exist (M5)	These perceptions are facilitated by the coordination of resources, within a community of practice, around response actions to act on health determinants (Ci D2-A27), particularly with the presence of political and financial commitment from institutions (Ce1), thereby enabling health mediators and the community of practice to act on the social determinants of health (Ce 2), thanks to the presence, within the community of practice, of knowledge (Ce10) and an appropriate attitude (Ce9), and the posture (C7) and soft skills (C6) of the health mediator These perceptions are facilitated by healthcare system navigation activities (Ci D3-A35-59), particularly when the role of health mediators is officially recognized (in terms of professional status, remuneration, training, etc.) which in turn facilitates the posture (Ce7) and soft skills (Ce6) of the health mediator and the functions (Ce5) and principles (Ce4) of health mediation
MRTy 3	The intention to utilize healthcare services if physically inconvenienced (O^3) and thus the effective use of the healthcare system (O) is facilitated by trust in a resource person (M3) and if a set of individual capabilities exist (M4)	These perceptions are facilitated by the healthcare system navigation system (Ci D3-A35-59), particularly when the role of health mediators is officially recognized (in terms of professional status, remuneration, training, etc.), which in turn facilitates the posture (Ce7) and soft skills (Ce6) of the health mediator and the functions (Ce5) and principles (Ce4) of health mediation

– 2/foster underserved people's intention to use healthcare through the coordination of response actions and healthcare system navigation activities (i.e., CeCiMO3 < -CeCiMO1 < -CeCiMO2).

Discussion

Main results

In the present realist qualitative study, we identified three initial MRTs necessary for the effect of health mediation on the fostering of healthcare utilization by underserved populations. To do this, we drew on both theoretical and experiential knowledge and considered the different contexts in which health mediation is implemented in France. Health mediation would require a balance between, on the one hand, the use of a community of practice to implement necessary adaptions within the healthcare system to tackle the problems and needs of underserved people, and, on the other hand, fostering underserved people's intention to use the healthcare system according to their perceived health needs. Therefore, the collective dimension of health mediation would be an essential condition for the feasibility and success of the three initial MRTs. Other authors refer to this condition as"doing together"[22–24].

Health mediation: revealing systemic failures

An intervention that is proportionate to underserved populations' degree of need and of vulnerability

The present study helps us to reposition health mediation in the different health intervention approaches which characterize the health promotion interventions in France. To date, health mediation has been perceived by its supporters to be a targeted intervention (often reduced to simply outreach services) aimed at clearly defined groups (often those hard to reach). They see the scope of this intervention as being limited to encouraging people to utilize the healthcare system, without questioning the structural determinants at the root of the obstacles to this utilization. In this perspective, health mediation only focuses on the effects produced by health inequalities in terms of individual behaviors, rather than on the structural cause of these behaviors. In contrast, the findings from our present study highlight the need for a focus on structural determinants as a *sine qua non* condition for the success of health mediation in fostering healthcare utilization. Specifically, we found that i) one of the success mechanisms of health mediation is the reduction of obstacles to the use of health services (cf. theory 1 above), which in turn promotes perceiving health needs (cf. theory 2 see above), ii) the healthcare system navigation activities necessary for this awareness-raising require the coordination, by a community of practice, of solutions acting on the social determinants of health (cf. theory 2). In other words, there can be no effect of individual healthcare system navigation activities without first acting collectively on structural determinants through territorial collaboration. Coordination of territorial collaboration activities is not exclusive to health mediation but applies to any health promotion intervention. However, since health mediation can be considered a targeted intervention, it is important to view it as an intervention proportionate to the population's degree of need and of vulnerability (i.e., the principle of proportionate universalism aims to act on the whole of a population by adjusting the intensity, and/or degree of action and/or strategies according to this social gradient [25]). Therefore, strengthening the coordination of collaborations is essential to the success of health mediation.

A collective rather than individual-centric lever for intervention

Structural difficulties in the healthcare system constitute some the structural causes (i.e., structural determinants that determine the unequal distribution of other determinants) of professionals' failure to provide care. Indeed, the systemic understaffing and turnover of healthcare workers in France, their difficulty in accessing continuous training, the rigidity of care procedures, the biomedical vision of health in the French healthcare system organization, the compartmentalization of the healthcare system between private practices and hospitals, between hospital departments themselves, and above all, between the health and social sectors, all contribute to failures in the healthcare system [26].

Our results highlight that it is vital to adapt the healthcare system and practices to the needs and problems of underserved populations. There are many ways of doing this: extending opening hours, offering a walk-in service in private and/or hospital healthcare facilities which is open to everyone (i.e., open to people without health insurance), mobilizing professional interpreters, providing transport tickets free of charge, offering childcare solutions to make it easier to get to scheduled appointments or emergencies, organizing outreach actions and encouraging outreach in places frequented by the target population (food distribution points, schools, etc.), setting up a one-stop shop where all public services are represented in the same place and which is as close as possible to where people live, etc. [26]. Other adaptations are possible without necessarily performing the practices in parallel. These include changes to the structuring of systems—health, social and medico-social—by i) simplifying procedures and taking into account people's needs, ii) reinforcing accessibility to healthcare in an equitable way, and ensuring that access does not become dematerialized overnight, and iii) promoting intersectorality

rather than working in silos, introducing shared procedures to ensure continuity of healthcare pathways, and developing inter-knowledge between services and their fields of competence [26].

An intervention acting on determinants of social inclusion

The predominance of a structural determinant over an individual behavioral determinant echoes the propositions made in the Alma-Ata Declaration [27], in social science research [28, 29], and in social epidemiology [30], which demonstrate that socially-disadvantaged people cannot be held responsible for their health situation; instead, their exclusion is the result of society's inability to distribute its wealth equitably within the population [27, 28, 31]. Moreover, according to epidemiological studies, healthcare systems are responsible for between 15 and 40% of variations in the state of health of populations, while social determinants are responsible for between 45 and 60%. [32]. This finding advocates broadening the scope of public health interventions [21] and therefore acting on the social determinants of health [33]. Health mediation, insofar as it seeks to mobilize within the community of practice to act on the social determinants of health, is a step in this direction. It contributes to health promotion [17] and the reduction of certain health inequalities. However, our study findings suggest that—within the framework of public policies that support its deployment—it seems to be used mainly to promote access to care for underserved populations. It should not be limited to this objective. It should also be used to promote healthcare utilization (i.e., according to a holistic definition of health) and to tackle social inequalities in health.

A complementary intervention for professionals promoting access to mainstream healthcare services

To tackle health inequalities, the World Health Organization recommends: i) improving everyday living conditions (i.e., the circumstances in which people are born, grow up, live, work and age), ii) combating inequalities in the distribution of power, money and resources (i.e., the structural determinants on which everyday living conditions depend), and iii) measuring and understanding the problem of inequalities and evaluating the effectiveness of action taken [34]. As a result, the health mediator complements all the other professionals who have an impact on people's health and living conditions, by working to ensure that their right to health is recognized in macro-systemic contexts under strong territorial and political influence.

The implementation of the macro-systemic conditions we highlighted for feasible and successful health mediation (i.e., political and financial commitment, the possibility of acting on the social determinants of health, and ensuring that health mediators are officially recognized (in terms of professional status, salary, etc.)) is currently hampered by political incoherence dominated by the logic of profitability in the healthcare system, and governmentality based on the market economy [29]. Effectively, the current state of affairs is that public policy decision-makers ask health mediation professionals to fill the gaps left by other professionals (in the healthcare, social support and medico-social sectors, in particular, and in public services more generally), or to repair the consequences of political choices that undermine systems (in healthcare, but also in access to rights, housing, education, etc.). Moreover, this happens in a way that is sometimes deleterious to the health of the population, as neither healthcare professionals' workload nor the resources (human, financial, material) they need to effectively perform health mediation are taken into consideration. This situation also reflects a"philosophical"incoherence, since health mediators, who work in close proximity with the most vulnerable populations, are expected to respond effectively to the latter's needs. Health mediation cannot compensate for the healthcare system's structural difficulties in acting on social determinants, or for its inability to adapt to the characteristics of underserved populations. As a matter of fact, health mediation reveals the system's shortcomings. This is why any public policy that addresses the above-mentioned failings of the current healthcare system will facilitate the success of health mediation.

Study limitations

This study has several limitations. The first is the social desirability bias linked to interviewing. This bias was undoubtedly reinforced because health mediation is not yet legally or officially recognized as a profession in France. Supporters for this intervention are using activism as a valid tool to gain this recognition. This bias was most likely limited because the first question in the study interview was open-ended.

Second, the study does not provide a ready-to-use logical framework for health mediation. As suggested by the realist evaluation, we proceed to the first step of realist evaluation by identifying initial MRTs that must be confirmed or refuted through future empirical studies. So, using an evidence-based method, our findings offer insights into how health mediation works and how its multiple components work together, which must be confirmed.

Methodological contributions

Drawing on our previous work and the results from this study, we finalized a conceptual framework for analyzing

health mediation, something advocated by the Medical Research Council (MRC) [35, 36]. Indeed, the latest MRC guidelines emphasize the importance of a priori evaluations to understand the mechanisms of effect and the role of context and implementation on these mechanisms [35]. Some authors have also emphasized the importance of using theory in pilot studies [15] to not restrict them to classic trial feasibility studies. Specifically, they suggest that pilot studies be used not only to test the viability of interventions but also to establish the hypotheses of how they work, prior to any implementation or evaluation. It is in this spirit that we proceeded here, postulating that the lack of evaluation of the effects of health mediation lies partly in the inability to grasp the full complexity of this intervention modality [36]. Accordingly, the work described here can be likened to a pilot study by offering a large range of initial MRTs to be confirmed or refuted in future evaluation on the effectiveness of health mediation in fostering healthcare utilization. More specifically, this work attempted to provide the first health mediation framework for any health mediation evaluation approach (experimental, quasi-experimental, natural experimentation, etc.).

Conclusion

This study concludes the methodological development of the first framework for analyzing health mediation by combining theoretical and experiential knowledge. This first health mediation conceptual framework, which future empirical studies must confirm as planned in the realist evaluation, sets out the questions to be taken into account when implementing and evaluating health mediation (i.e., What works in health mediation, how, why, and with whom?).

Supplementary Information

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Supplementary Material 1.

Supplementary Material 2.

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Authors' contributions
ER conducted all the interviews and seminars, analyses data, and drafted the first version of the manuscript. LR double-checked the analyses coding. MC, MO, OS, VT, CU, CC, FQC, participate to seminar and bring their expertise of health mediation implementation during seminars. JMF brings her expertise in realist evaluation and supervise seminars. LC and SV supervise the study. ER drafted the final version of the health mediation conceptual framework. All the authors contributed to data interpretation. All reviewed the manuscript and approved the final manuscript.

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Data availability
The datasets used during the current study are available from the corresponding author on request.

Declarations

Ethics approval and consent to participate
All methods during this study were conducted in accordance with relevant guidelines and regulations. The study corresponds to the French MR004 reference methodology. An institutional review board approved the study protocol: the hospital of Bordeaux's data protection officer approved by French National Commission for Commission nationale de l'informatique et des libertés (CNIL – agreement 2228473 v 0). Informed consent was obtained from all subjects for the study.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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