DOES ENGAGING IN PEER-TO-PEER AWARENESS-RAISING HAVE ANY EFFECT ON RETURNEE MIGRANTS' MENTAL HEALTH AND PSYCHOSOCIAL STATUS ? A PILOT STUDY FROM WEST AFRICA

IOM
UN MIGRATION

The opinions expressed in this publication are those of the authors and do not necessarily reflect the views of the International Organization for Migration (IOM). The designations employed and the presentation of material throughout the publication do not imply expression of any opinion whatsoever on the part of IOM concerning the legal status of any country, territory, city or area, or of its authorities, or concerning its frontiers or boundaries.

IOM is committed to the principle that humane and orderly migration benefits migrants and society. As an intergovernmental organization, IOM acts with its partners in the international community to: assist in meeting the operational challenges of migration; advance understanding of migration issues; encourage social and economic development through migration; and uphold the human dignity and well-being of migrants.

This publication was made possible through support provided by the Ministry of Foreign Affairs of the Netherlands. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the donors.

Publisher: IOM Regional Office for West and Central Africa, Zone 3, Route des Almadies
Dakar - Senegal BP 16 838
Tel: (+221) 33 869 62 00
Fax: (+221) 33 869 62 33
Email: iomrodakarmedia@iom.int
Website: www.rodakar.iom.int

Authors: Maggie Zraly, Marilena Crosato, Oumarou Hebie, Emily Cholette
Layout: Sidi Mohamed Sougou

This publication was issued without formal editing by IOM.

Cover photo: MaM Volunteer who participated in a storytelling workshop. © IOM 2022/Sidi M. SOUGOU

Required citation: Zraly, M., M. Crosato, O. Hebie and E. Cholette (2022): *Does engaging in peer-to-peer awareness-raising have any effect on returnee migrants' mental health and psychosocial status ? A pilot study from West Africa.* International Organization for Migration, Dakar.

ISBN 978-92-9268-500-3 (PDF)
ISBN 978-92-9268-501-0 (print)

© **IOM 2022**

Some rights reserved. This work is made available under the Creative Commons Attribution-NonCommercial-NoDerivs 3.0 IGO License (CC BY-NC-ND 3.0 IGO).*

For further specifications please see the Copyright and Terms of Use.

This publication should not be used, published or redistributed for purposes primarily intended for or directed towards commercial advantage or monetary compensation, with the exception of educational purposes, e.g. to be included in textbooks.

Permissions: Requests for commercial use or further rights and licensing should be submitted to publications@iom.int.

* https://creativecommons.org/licenses/by-nc-nd/3.0/igo/legalcode

PUB2022/149/R

DOES ENGAGING IN PEER-TO-PEER AWARENESS-RAISING HAVE ANY EFFECT ON RETURNEE MIGRANTS' MENTAL HEALTH AND PSYCHOSOCIAL STATUS ? A PILOT STUDY FROM WEST AFRICA

Maggie Zraly
Marilena Crosato
Oumarou Hebie
Emily Cholette

December 2022

IOM UN MIGRATION

Ministry of Foreign Affairs of the Netherlands

ACKNOWLEDGEMENTS

The Migrants as Messengers (MaM) project is at the heart of this pilot study report. The project was a peer-to-peer awareness-raising campaign developed by the Media, Communications and Awareness-raising Unit (MCAR) at the International Organization for Migration (IOM) Regional Office for West and Central Africa (RO WCA). The MCAR Unit oversaw the implementation of the project in Côte d"Ivoire, the Gambia, Guinea, Liberia, Nigeria, Senegal, and Sierra Leone.

The design, planning and implementation of the pilot study was led by the MCAR Unit and IOM"s Global Migration Data Analysis Centre (GMDAC). MCAR Unit and GMDAC oversaw the study, implemented by IOM offices in Côte d"Ivoire, the Gambia, Guinea, Liberia, Nigeria, Senegal, and Sierra Leone.

Maggie Zraly – IOM consultant and co-author of this report – joined the team in June 2022 and developed the literature review and methodology for the data analysis. She worked in close coordination with the other authors to develop this report. Marilena Crosato and Oumarou Hebie – co-authors of this report and respectively community engagement officer at the MCAR Unit and impact evaluation officer at GMDAC – co-led the study design. They led the coordination, implementation and report writing. Oumarou Hebie led the data collection, cleaning and analysis process of the report. Emily Cholette – co-author of this report – operated as the Project Manager for the campaign in West Africa and contributed to report writing.

The authors would like to thank Mia Barrett, Head of the MCAR Unit, Jasper Tjaden (Professor of Applied Social Research & Public Policy at the Faculty of Economic and Social Sciences at Potsdam University, Germany) and Guglielmo Schininà, Head of the Global Section for Mental Health Psychosocial Response and Intercultural Communication Section at IOM for their guidance. Special thanks to MaM teams in IOM Côte d"Ivoire, IOM the Gambia, IOM Guinea, IOM Liberia, IOM Nigeria, IOM Senegal, IOM Sierra Leone and to Blandine Bruyère (IOM consultant) for assisting with field implementation, as well as to Aboubacar Hema, Oumarou Ouedraogo, Amani Dieudonné Konan, Mawugnon Fidele Eric Sessou and Felix Ndashimye (GMDAC team at IOM RO WCA) for data collection, cleaning and analysis support. Thank you also to Gaia Quaranta (IOM RO WCA) for study design support in the initial phase, Pablo Cordova Bulens (M&E Officer at IOM) for his contribution to the baseline data cleaning and analysis, Alexandra Shearn (Project Officer at IOM) for her contribution to report writing and to Sidi Mohamed Sougou for the graphic design of the report. The authors are immensely grateful to the reviewers: Heide Rieder (IOM MHPSS Global), Claire Laroche (IOM RO WCA), Evans Binan and Muhammed Touray (IOM the Gambia) and Rosamond Erica Johnson (MaM Volunteer in the Gambia).

The authors thank the donor – the Ministry of Foreign Affairs of the Netherlands – for its support and trust in this innovative pilot study.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

LIST OF BOXES

LIST OF ABBREVIATIONS

CB MHPSS	Community-based mental health and psychosocial support
CSO	Civil society organization
FGD	Focus group discussion
GMDAC	Global Migration Data Analysis Centre
IASC	Inter-Agency Standing Committee
IOM	International Organization for Migration
MaM-1	Migrants as Messengers Phase 1
MaM-2	Migrants as Messengers Phase 2
MHPSS	Mental health and psychosocial support
MOV	Means of verification
PFA	Psychological First Aid
SBCC	Social change and behaviour change communication
ROWCA	Regional Office for West and Central Africa as per IOM"s usage.

EXECUTIVE SUMMARY

BACKGROUND

Migrants as Messengers is a peer-to-peer awareness-raising campaign that supports the empowerment of young people in West and Central Africa to make informed decisions about migration. In the second phase of Migrants as Messengers (MaM-2), peer messengers at the centre of the campaign comprised youth and adult returned migrants who came back from irregular migration pathways to their countries of origin. Known as MaM-2 Volunteers, they develop and coordinate campaign communication strategies in seven countries across the region: Côte d"Ivoire, the Gambia, Guinea, Liberia, Nigeria, Senegal and Sierra Leone.

The MaM-2 campaign is theoretically grounded in social and behaviour change communication (SBCC), whereby the community of MaM-2 Volunteers engage across multiple levels of the social ecology – individuals, groups, social networks, communities, organizations and societies. Results from an impact evaluation during an earlier phase of the MaM campaign in Senegal showed a small yet positive effect on the social perception of returned migrants among people in their communities who were considering migration. International Organization for Migration (IOM) staff also observed that peer messengers" continuous interaction, peer-to-peer communication, and community engagement activities resembled critical components of the IOM community-based mental health and psychosocial support (CB MHPSS) approach.

Little research has been conducted on the linkage between SBCC and CB MHPSS. And the possible role of participation as a peer messenger in MaM-2, or any peer-to-peer awareness-raising campaign, to improve mental health and psychosocial well-being among youth and adult returned migrants has not yet been assessed.

IOM has conducted an exploratory pilot study to assess the possible effects of being a returned migrant peer messenger in the MaM-2 campaign on their mental health and psychosocial well-being. The pilot study focused on a cross-cutting component of the MaM-2 campaign, namely MHPSS mainstreaming, which drew on the IOM CB MHPSS approach to integrate MHPSS principles and considerations throughout the peer-to-peer awareness-raising campaign pillars.

STUDY DESIGN

IOM conducted a mixed-method quantitative panel study with qualitative semi-structured interviews and focus group discussions (FGDs) to explore associations and trends in involvement in MaM-2 campaign activities and mental health and psychosocial well-being among MaM-2 Volunteers.

All MaM-2 Volunteers from across the seven countries where the campaign was implemented were invited to become participants in the quantitative panel study. The panel study dataset consisted of approximately 1,000 questionnaires with 314 MaM-2 Volunteers surveyed up to four times across a period of 18 months. MaM-2 Volunteers in Côte d"Ivoire who were available and easily accessible were also invited for qualitative interviews before the start-up of the quantitative panel study and for qualitative FGDs after its completion.

KEY RESULTS

The exploratory pilot study provides evidence that intensity of involvement in MaM-2 campaign activities had small yet significant possible effects on Volunteers" mental health and psychosocial well-being. It also provides evidence that Volunteers possibly perceived or experienced peer interactions, peer-to-peer communication and community engagement as sources or resources for mental health and psychosocial well-being. There was evidence that these peer-to-peer awareness-raising activities had small yet significant possible effects on Volunteers" mental health and psychosocial well-being. These findings contributed to validating the MaM-2 MHPSS mainstreaming strategy.

Among the MaM-2 Volunteers who participated in the panel study:

- Slight yet significant positive-trending "distress intensity" was a possible effect of significant positive-trending intensity of MaM-2 involvement.

- Significant positive-trending supportive peers were found in MaM-2 (peer interaction perceived as social support) was a possible effect of significant positive-trending intensity of MaM-2 involvement.

- Slight yet significant positive-trending "social support" was a possible effect of significant positive- trending supportive peers were found in MaM-2 (peer interaction perceived as social support), as well as a possible association with higher frequency of community engagement being perceived as a source of personal well-being.

- Slight yet significant positive-trending "personal well-being" was a possible effect of significant positive-trending supportive peers were found in MaM-2 (peer interaction perceived as social support), as well as a possible association with higher frequency of community engagement being perceived as a source of personal well-being.

According to theoretical approaches to multilevel (multiple socioecological levels of) social capital and mental health and well-being:

Volunteers" membership of and participation in community and social structures (strengthened or developed by the MaM-2 campaign), such as Volunteer community, returned migrant civil society organizations, community-based and social media-based social networks and peer support structures had some positive effects at the individual level. Mobilizing community and interpersonal level social support and peer support helped enable individual coping strategies, decreasing distress and increasing personal well-being at the individual level.

Insights from the exploratory pilot study were consolidated to inform future work:

- Development of technical guidance for mainstreaming MHPSS in peer-to-peer awareness-raising campaigns and SBCC.

- Rigorous and conclusive studies of the mental health and psychosocial well-being impacts of MaM-2 or other peer-to-peer awareness-raising campaigns.

RECOMMENDATIONS

- There is a need for leadership in MHPSS in the awareness-raising and SBCC space. Awareness-raising and MHPSS programmes and actors should work in close collaboration to advance MHPSS integration into peer-to-peer migration awareness-raising and SBCC.
- Participation in a peer-to-peer migration awareness-raising campaign, integrated with MHPSS, had positive possible effects on the mental health and psychosocial well-being of returned migrant peer messengers.
- Social ecology is a key linkage between SBCC and CB MHPSS to support MHPSS mainstreaming into awareness-raising.
- MHPSS mainstreaming is important for maximizing positive mental health and psychosocial well-being impact in peer-to-peer migration awareness-raising campaigns and preventing harm.

- The mixed-method research design, quantitative panel study and qualitative methods were feasible, even during the challenging COVID-19 pandemic context.

This MaM-2 MHPSS pilot study aims to be promoted and disseminated widely to communicate the promising possible effects of involvement in MaM-2 campaign activities on Volunteers" mental health and psychosocial well-being, as well as the innovation of MHPSS mainstreaming in peer-to-peer migration awareness-raising.

INTRODUCTION

Peer-to-peer migration awareness-raising campaigns that situate returned migrants as peer messengers at the centre of community engagement, ideally support their empowerment and "mental health and psychosocial well-being".[1]

IOM works on return migration – the act or process of migrating persons going back or being taken back to the point of departure (IOM, 2019a) – to facilitate safe and dignified return, readmission and sustainable reintegration. IOM (2021a) uses a holistic, rights-based and sustainable development-oriented approach to return migration, guided by a policy on the full spectrum of return, readmission and reintegration (see Box 1).

BOX 1. IOM POLICY ON THE FULL SPECTRUM OF RETURN, READMISSION AND REINTEGRATION

In 2021, IOM released the policy on the full spectrum of return, readmission and reintegration. At its core, it focuses on the well-being of returnees and the protection of their rights, placing individuals at the centre of all efforts and empowering persons making informed decisions to participate in assisted voluntary return programmes.[a] It also recognizes that States have a sovereign prerogative to determine their national migration policies and to govern migration within their jurisdiction, in accordance with international law.

Note: [a] Support to migrants unable or unwilling to remain in a host or transit country and who decide to return to their country of origin.
Source: IOM, *Return and reintegration key highlights 2021*, Geneva (2022).

IOM support to migrants and communities includes addressing the challenges of irregular migration – movement of persons that takes place outside the laws governing regular migration channels (IOM, 2019a). Migration awareness-raising plays an essential role in ensuring the effectiveness of programmes focused on the prevention of irregular migration. In general, the aims of IOM migration awareness-raising campaigns (IOM, 2016) are to:

- Inform and engage young people with a desire to migrate about the risks and complex realities of irregular migration;
- Raise public awareness about migrants and migration to counter misinformation and prejudice;
- Communicate available services and assistance to displaced persons;
- Combat and prevent human trafficking and other protection risks;
- Increase knowledge of safe alternatives to irregular migration, such as regular migration procedures and available local opportunities;
- Encourage behaviour change to improve health and well-being and to prevent harm.

Throughout its migration programmes, IOM provides "mental health and psychosocial support"[2] (MHPSS) through direct assistance to migrants going back to countries of origin and through mainstreaming MHPSS into migrant protection (IOM, 2019b). MHPSS is also prioritized as a key area of IOM assistance in migration crises (IOM, 2021b). The combination of IOM prevention of irregular migration programming and MHPSS prioritization foregrounds the rationale to build understanding of the mental health and psychosocial support impacts of migration awareness-raising campaigns among returned migrant peer messengers.

This report presents an exploratory pilot study on the effects of engaging as a peer messenger in the "Migrants as Messengers" peer-to-peer awareness- raising campaign on mental health and psychosocial well-being among returned migrants in West and Central Africa (referred to as the MaM-2 MHPSS pilot study

[1] The terms "mental health" and "psychosocial well-being" overlap. This report uses the combined term "mental health and psychosocial well-being" to reflect the combined goal of IOM and other diverse agencies working on mental health and psychosocial support. See IASC, The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: With Means of Verification (Version 2.0) (Geneva, 2021).

[2] The term mental health and psychosocial support refers to any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder. See IASC, Guidelines on Mental Health and Psychosocial Support in Emergency Settings (Geneva, 2007).

for convenience). The MaM-2 MHPSS pilot study explored the potential effects of participation in a multi-country, peer-to-peer migration awareness-raising campaign in West and Central Africa (i.e. Migrants as Messengers – Phase 2 (MaM-2)) on the mental health and psychosocial well-being among youth and adult returned migrants who were peer messengers, called "Volunteers", in the campaign. The purpose of this exploratory pilot study was to search for possible associations and try out methods to inform future impact studies. The MaM-2 MHPSS pilot study generated a quantitative panel dataset on mental health and psychosocial well-being indicators among a self-selected sample of Volunteers who participated in the campaign from April 2019 to July 2022 and qualitative semi-structured interview and FGD data from Volunteers in one country (Côte d"Ivoire) on MHPSS integration into the campaign. Exploratory data analysis resulted in showing slight yet significant associations between select mental health and psychosocial well-being indicators and a measure of intensity of involvement in the MaM-2 campaign. The findings from this pilot study provide insights to inform future studies on the mental health and psychosocial well-being impacts among returned migrant peer messengers in migration awareness-raising campaigns and to develop approaches for mainstreaming MHPSS in awareness-raising programming.

The following sections of the report provide relevant background information and literature to contextualize the study, describe the exploratory methodology and mixed-methods research strategy, present quantitative results supplemented with qualitative results, discuss the study findings and limitations, outline recommendations and offer conclusions on the feasibility of the methodology and possible effects that may be worth following up in future studies.

MaM Volunteers participate in a hands-on workshop to learn how to edit videos on smartphones. © IOM 2021/Amanda NERO

BACKGROUND OF THE STUDY

There is mounting evidence that many migrants and people with a desire to migrate in the future, including those in West and Central Africa, are not well-informed or are misinformed about the contexts, risks and dangers involved in migration, particularly irregular migration to Europe (Tjaden and Gninafon, 2021). In response, IOM develops and conducts evidence-based awareness-raising campaigns in the region to enable community access to information and tools that support migrants and people with a desire to migrate to make decisions about their own lives, such as information on:

- Risks of irregular migration;
- Regular migration pathways;
- Alternative livelihood opportunities;
- Linkage to MHPSS services available in countries of origin, transit, and destination.

The field of migration involves addressing humanitarian, development and human rights issues. IOM is the leading global organization focusing on orderly and humane migration management. The IOM mission is to uphold the dignity and human rights of all migrants.

"MIGRANTS AS MESSENGERS"

The first phase of the Migrants as Messengers peer-to-peer messaging campaign (MaM-1) was implemented by IOM in Guinea, Nigeria and Senegal from November 2017 to March 2019. A rigorous impact evaluation study was conducted in Dakar, Senegal to measure the causal impacts of campaign activities led by returned migrant Volunteers, such as townhall events, among people with a desire to migrate in the future. Data were collected on study participants" perceptions, information levels, knowledge and intention to migrate irregularly to Europe. The results of the impact study showed that people who participated in MaM-1 events were more likely to feel well-informed about the risks and opportunities associated with irregular migration, more likely to be aware of the risks and less likely to report intention to migrate irregularly. These results suggest that returned migrant Volunteers were a trusted source of information for people with a desire to migrate, and that peer-to-peer messaging has a sizable impact on risk perception and reducing intention to migrate irregularly (Dunsch et al., 2019).

Results from the MaM-1 impact evaluation study also showed positive effect on the social perception of returnees among people in their communities who were considering migration (ibid.). This is an important finding, particularly for the MHPSS field, given the detrimental effects of discrimination on the mental health and psychosocial well-being of returned migrants, which were heightened during the COVID-19 pandemic (Spiritus-Beerden et al., 2021). It also suggests that migration awareness-raising campaigns may be especially well-suited to influence and contribute to "social outcome" constructs of mental health and psychosocial well-being (Ubels et al., 2022), such as enhancing environments that promote and protect the mental health and psychosocial well-being of returned migrants (IOM, 2019b; WHO, 2022).

MAM-2 THEORY OF CHANGE

Building on the promising results of MaM-1, MaM-2 expanded its geographic scope to cover a total of seven countries, adding Côte d"Ivoire, the Gambia, Liberia and Sierra Leone to the original three sites of Guinea, Nigeria and Senegal from April 2019 to December 2022. Countries were selected based on current migration trends, patterns of high numbers of assisted voluntary returns and synergies with existing activities at the national level. The design of MaM-2 was guided by the results of the MaM-1 impact evaluation and insights that emerged during a pilot phase of the campaign. The project continued to be led by returned migrant Volunteers who participated in multiple trainings on storytelling, community engagement, digital engagement, audiovisual content production and more.

The campaign theory of change explains how MaM-2 aims to achieve positive behavioural change through an interactive process whereby communities of individuals (i.e. Volunteers) develop communication strategies appropriate to particular settings that emerge from dialogues with the audience, undergo constant improvement through evaluation and adjust to changes in context (see Annex 1. MaM-2 theory of change). This theory of change draws on social behaviour change communication (SBCC) theories and concepts, including rational choice theories, theory of planned behaviour and socioecological models in relation to social cognitive theories, social network theory and social learning theory. SBCC aims to inhibit or encourage certain individual and social behaviours through the successful implementation of multiple interventions across levels of a socioecological model to bring about sustainable social, cultural and/or policy changes (Christofides et al., 2013; Davis et al.2014).

Migration awareness-raising campaigns that are informed by SBCC coordinate messaging along different communication channels using different types of media to reach different audiences across multiple levels of the social ecology (IOM, 2019c). Throughout MaM-2, Volunteers were continuously interacting to develop and strengthen the communication of messages.

The MaM-2 design strategies and theory of change nurtured the ultimate aim of developing a sustainable migrant-centred approach to the replication and scaling of the media platform led by networks of Volunteers. By August 2022, there were more than 400 MaM-2 Volunteers, who had produced more than 1,100 videos that generated more than 4 million digital engagements and led more than 1,000 community engagement and youth outreach activities that engaged more than 400,000 people.[3]

MHPSS MAINSTREAMING IN MAM-2

A strategy for MHPSS mainstreaming was designed for MaM-2. The strategic aims of mainstreaming MHPSS into MaM-2 were to:

- Deepen understanding and awareness of the mental health and psychosocial challenges of return migration;
- Facilitate empowering forms of bottom-up psychosocial support and build more supportive community networks;
- Identify people who may need more focused psychosocial support and ensure accessibility to front-line psychosocial support and linkage and referrals to available, appropriate MHPSS services;
- Protect and promote MaM-2 Volunteers" psychosocial well-being and promote increasing self-awareness, confidence and empowerment;
- Prevent potential harm in peer-to-peer interactions.

However, there is currently a gap in the technical guidance for integrating MHPSS into SBCC programming[4] and into awareness-raising more generally. Grounded in the recognition that SBCC and community-based approaches to MHPSS (CB MHPSS) are both deeply informed by the principle that individuals are part of a multilevel socioecological system (see Annex 2). The socioecological system in CB MHPSS), an MHPSS mainstreaming approach for MaM-2 was developed to overcome this gap. For SBCC, socioecological models enable: (a) understanding of the dynamic interrelations among family, peers, community and society; (b) considerations of the entire socioecological system and context in which human behaviour occurs; (c) learning on how some people can overcome barriers to change; and (d) understanding how communication can change underlying social and structural determinants (Kincaid et al., 2020). Likewise, CB MHPSS understands communities as interrelationships and interactions among clusters of individuals, families, groups and associations that can be drivers for their own care and agents, to varying degrees, of their own individual and collective well-being (Inter-Agency Standing Committee (IASC), 2019; IOM, 2021c).

The MaM-2 MHPSS mainstreaming approach[5] drew on CB MHPSS and was applied as a cross-cutting strategy to each awareness-raising campaign pillar, briefly illustrated in Figure 1. (For details on MHPSS integration into MaM-2, see Annex 3. Integration of IOM CB MHPSS approach into MaM-2 areas of intervention and Annex 4. MHPSS component in MaM-2 trainings: capacity-building as an empowerment process among returnees.)

[3] An impact evaluation study of MaM-2 was conducted in the Gambia, Guinea, Nigeria and Senegal. It is one of several large-scale impact evaluations done on information campaigns in the West and Central Africa region. Results will be available in early 2023.

[4] UNICEF has initiated a workplan to develop a field guide for programming at the intersections of SBCC and MHPSS.

[5] The MaM-2 MHPSS mainstreaming approach is online in its entirety at: www.migrantsasmessengers.org/sites/g/files/tmzbdl246/files/2022-03/MaM_MHPSSv07_en.pdf. IOM 2021e, Mainstreaming Mental Health and Psychosocial Support into Migrants ss Messengers Phase 2 (MaM-2), 2021.

Figure 1. MHPSS mainstreaming across MaM-2 pillars

Three types of peer-to-peer awareness-raising activities that were identified as similar to CB MHPSS activities were areas of focus for MHPSS integration (see Table 1).

Table 1. Peer-to-peer awareness-raising activities identified as similar to CB MHPSS activities

Socioecological levels	Peer-to-peer awareness-raising activities	CB MHPSS activities
Interpersonal (Microsystem, Mesosystem)	Constant engagement in peer interactions	Peer support
Interpersonal/Community (Mesosystem, Exosystem, Macrosystem)	Peer-to-peer communication to improve the perception of returnees: capturing and sharing stories through social media networks and giving public testimony	Community-based testimony methods and storytelling
Community (Exosystem, Macrosystem)	Community engagement: development of awareness-raising activities (such as public testimony) and facilitation of peer-support mechanisms and systems	Community engagement: activate or restore community supports and promote inclusion in community mobilization

RETURN MIGRATION IN WEST AND CENTRAL AFRICA

Migration in the West and Central Africa region involves large numbers of international migrants moving both within and out of the region. Intra-regional movement is the dominant pattern, with more than five out of eight migrants from West Africa continuing to stay within the region (UN DESA, 2020). However, more and more migrants are moving out of the region to different destinations in Africa and to Europe (McAuliffe and Triandafyllidou, 2021). Nearly half of all West African migrants are women (ILO, 2021), an increasing number of whom are skilled, independent, and/or pursuing their personal and economic well-being (Setrana and Kleist, 2022).

Irregular migration towards Europe from West and Central Africa is characterized by a fast-changing landscape of routes, including the prominent Central Mediterranean route that involves travelling through Libya, Tunisia or Algeria and crossing the Sahara Desert and the Mediterranean Sea (IOM, 2020a). An increasing number of people from West and Central Africa, including youth, are undertaking the dangerous irregular migration journey via the Central Mediterranean route (Fargues et al., 2020). In many cases, migrants decide to take these high-risk journeys with awareness that they may encounter protection incidents (UNDP, 2019), which studies show are strongly patterned by gender (MMC, 2020; Vammen et al., 2021). The COVID-19 pandemic crisis has had wide-ranging impacts on migration in West and Central Africa – more migrants searched for new ways to cross borders during the pandemic and a greater proportion of migration was irregular (IOM, 2021d).

Return migration in West and Central Africa is thought to be slightly increasing over recent years (Teye, 2022), with a growing number of migrant returns comprised of women (IOM, 2020b). While some migrants have been returning to the region after achieving the objectives of their migration projects, the assisted voluntary return of tens of thousands of migrants, including those in vulnerable situations, have been supported by various programmes.[6] From 2019 through 2021, West and Central Africa was the main region of origin among voluntarily assisted returnees or voluntary humanitarian returnees (IOM 2020a, 2021d; 2022) (see Figure 2).

Figure 2. West and Central Africa region highlights: IOM assisted voluntary return programmes from 2019–2021

2019

West and Central Africa was the main region of origin among voluntary humanitarian returnees (49.1%).

Among migrants assisted to return within the same region, the majority were in West and Central Africa (64.4%).

Worldwide, Niger was the main destination country from where assisted voluntary returns took place.

2020

West and Central Africa was the main region of origin among voluntarily assisted returnees (35.9%).

Among migrants assisted to return within the same region, the majority were in West and Central Africa (65%).

COVID-19 pandemic border closures effected a decrease from 2019 in the overall number of assisted returns, globally.

2021

West and Central Africa was the main region of origin among voluntarily assisted returnees (45%).

Worldwide, Guinea had the highest increase from 2020 in number of assisted returns (67%).

COVID-19 vaccination campaigns enabled an increase from 2020 in overall number of assisted returns, globally.

The process of return and post-return life is often associated with going back to one"s own culture, family and home (IOM, 2020a). For migrants who return through assisted voluntary return programmes to countries of origin in West and Central Africa, the experience of return is often characterized by uncertainty (Bisong, 2022). Returnees may re-face situations of vulnerability like those that originally drove their migration, and they may have debts, require assistance with daily life, and/or encounter stigma and discrimination (Kleist, 2020; Setrana and Kleist, 2022).

[6] To learn more about IOM return work, visit: https://www.iom.int/return-and-reintegration.

MENTAL HEALTH AND PSYCHOSOCIAL WELL-BEING AMONG RETURNED MIGRANTS IN WEST AND CENTRAL AFRICA

Promoting and protecting the mental health and psychosocial well-being of return migrants, their families, their communities and the multisectoral systems that serve them requires inclusive, participatory action on the social determinants of health and well-being (IOM, 2017a). The determinants that affect the mental health and psychosocial well-being among return migrants from irregular routes are the same as those that affect the rest of humanity. However, the experience of migration itself is a determinant of health and well-being, adding a layer of complexity shaped by experiences in one"s country of origin, migration journey, and experiences in transit/host countries. The prevalence of mental health conditions, distress and suffering among migrants is highly variable, dependent on social and environmental factors, such as social support (IOM, 2021c) and barriers to accessing general health services, mental health services and inclusive and accessible MHPSS promotion and prevention programmes. In addition, both return and mental health issues are stigmatized in many contexts, and self-stigmatization can be higher among migrant groups. The global evidence base indicates that depression, anxiety and psychoses can be higher among migrant populations, which could be due to the impact of suboptimal determinants of health (WHO, 2022).

Mental health and psychosocial well-being among returned migrants in West and Central Africa have received little research attention. Evidence from other geographical settings shows that return migrants are often unaware of the psychosocial re-adjustment challenges faced during and upon return, and planning for return rarely involves their mental health and psychosocial well-being (Vathi, 2017). Yet, access to mental health and psychosocial support services was found to be one priority in a recent study with West African migrants and returnees (Vammen et al., 2021). Research on return migration following prolonged forced internal displacement has found that not all returns are traumatic, yet the process of return can be a distressing or potentially traumatic experience for some migrants under certain circumstances (Siriwardhana and Stewart, 2013).[7] For example, a mixed-methods exploratory study in the Niger that found that migrants" encounters with hardship and deprivation in host countries was potentially associated with decreased subjective well-being, and that a sense of failure and despair upon returning home was likely higher among migrants without resources to support themselves and their families (Veronese et al., 2020).

The COVID-19 pandemic, however, exacerbated existing inequalities among irregular migration populations and disrupted health services, which deepened social and structural vulnerabilities faced by many migrants (WHO, 2022). The pandemic has been widely recognized, moreover, as a global mental health crisis due to its deleterious impact on social support structures across the individual, family, community and national system environments, which disproportionately affected migrants (Save the Children et al., 2021). Insightful studies from the West and Central Africa region show that the populations in Nigeria and Senegal experienced psychological distress during the height of the pandemic (Mansouri et al., 2022; Olaseni et al., 2020). Migrants especially, as shown by a mixed-method study with focus in Guinea and the Niger, faced increased likelihood of suffering psychosocial impacts during the pandemic, including fear and mistrust that resulted in discrimination and stigma against returnees (IFRC, 2021a).

MHPSS MAINSTREAMING

MHPSS mainstreaming consists of integrating a psychosocial approach with an intervention in any sector across the humanitarian-development-peacebuilding nexus inclusive of migration programming. Mainstreaming MHPSS entails considering an intervention"s psychological and social elements, their interrelation and incorporating the principles of MHPSS: human rights and equity, participation, do no harm, building on available resources and capacities, integrated support systems and multilayered supports (IASC, 2007). MHPSS

[7] Guidance for supporting the mental health and well-being among people on the move translates this evidence into the recommendation that it is important not to assume that all returnees are traumatized nor to assume that return migrants who may be engaging in resilience or coping need no support. Save the Children et al. (2021).

mainstreaming aims to ensure that the mental health and psychosocial well-being impact of a programme is maximized, resulting in reduced suffering and improved mental health and psychosocial well-being (IASC, 2021).

In general, an MHPSS mainstreaming approach requires tailoring to contexts and taking into consideration issues such as the resources and needs of the community and the capacity of the organizations providing services (Horn et al., 2016). MHPSS mainstreaming, or integration, is increasingly well-developed across the health, protection and education sectors (Nemiro et al., 2022; Harrison et al., 2020; Tol et al., 2015) and in humanitarian and migration crisis response programming, where there is growing awareness that all staff involved should know the basics of MHPSS (Weissbecker et al., 2019). Mainstreaming MHPSS in specific organizational and community contexts increasingly involves the monitoring and evaluation of MHPSS impacts and outcomes in parallel to the integration of MHPSS considerations in the phases of design and implementation. When MHPSS is integrated into a programme, it is recommended that the MHPSS indicators be designed together with the community (IASC, 2021).

MHPSS IN MIGRATION AWARENESS-RAISING PROGRAMMING

Literature and guidance at the intersections of awareness-raising campaigns and MHPSS is scant, even more so in the context of migration programming. [8] A competency framework for social science interventions, community engagement and risk communication in health emergencies includes listening skills to understand and account for mental health impacts on affected communities (WHO/Europe, 2020). Ripoli et al. (2019) advise that MHPSS should be integrated into all risk communication, community engagement, and behavioural change interventions, with clear articulation on how MHPSS is included. In non-migration programmes, MHPSS has previously been integrated into: an awareness-raising campaign for disaster management in the Caribbean (PAHO, 2019); risk communication and community engagement during epidemic emergencies (Ripoli et al., 2019); training and supervision of refugee volunteers involved in information-sharing (Weissbecker et al., 2019); and camp management trainings (Schininá et al., 2016). In migration programming, psychosocial support workshops were an option in a migration awareness-raising campaign in Pakistan (Hahn-Schaur, 2021).

The evidence-base for using SBCC approaches to support mental health and psychosocial well-being across humanitarian, development, peacebuilding, and migration contexts is likewise nascent yet promising. A handful of studies have found: improvements in stress and mental well-being related to participation in awareness-raising campaigns that covered GBV-related issues embedded in a cash transfer campaign among Syrian refugee families in Jordan (IRC, 2012); positive outcomes for behaviour change among informal care providers through a mental health awareness-raising and community engagement programme in Sierra Leone (Adams et al., 2020); beneficial behaviour change and improved mental health and psychosocial well-being outcomes using a complexity-informed communication intervention approach with a large Jordanian healthcare organization supporting Syrian refugees (Parrish-Sprowl et al., 2020); and suggestions to implement awareness-raising campaigns among Syrian refugees in Jordan to improve utilization of MHPSS services (Bawadi et al., 2022).

Another promising direction starts with the IOM (2021c) CB MHPSS approach of restoring and developing community structures that create a supportive environment of trust, social connection and social cohesion among community members, enabling support for individuals through a wider social network.[9] Links through the IASC (2021) *Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: with means of verification (Version 2.0)*, Outcome 3: Family, community and social structures promote the well-being and development of all their members, Indicator 3.5: Level of social capital, both cognitive (level of trust and reciprocity within communities) and structural (membership and participation in social networks, civil

[8] There is an interdisciplinary body of social and political science research on the nature, mechanisms, and intended and unintended effects of awareness-raising in migration programming, including the Migrants as Messengers campaign itself (e.g. Maâ et al., 2022; Vammen, 2021; Vammen et al. 2021; Van Dessel, 2021; Williams, 2020). Though outside the scope of this literature review, this work may have insights to offer to the development of MHPSS considerations for returnees who engage in peer communications.

[9] This content is also included in the community engagement section below.

or community groups). This leads to an incredibly strong and accelerating literature on community social capital, associated in robust and nuanced ways with mental health and psychosocial well-being, and multi-level social capital interventions (Kawachi and Subramanian, 2006; Villalonga-Olives et al., 2018; Wind et al., 2021). Social capital has been defined in many ways and this current in the literature generally defines it as resources – including psychosocial resources – that can be drawn on through social networks and the value individuals ascribe to these resources. Thomson et al. (2015) provide an excellent overview of the important linkages between peer support, awareness-raising activities and social capital in a breastfeeding programme in England. MHPSS information campaigns in humanitarian and emergency settings also offer foundations and best practices, such as developing culturally and linguistically appropriate ways to communicate (Alem et al., 2021; Schininà and Popp, 2019), that migration awareness-raising campaigns can build on. Such campaigns have been used to raise awareness among migrant returnees about mental health issues related to the COVID-19 pandemic (IOM, 2020c) and among people facing internal displacement in South Sudan about coping strategies, self-care and peer-to-peer support (IOM South Sudan, 2019).

COMMUNITY-BASED MHPSS ACTIVITIES SIMILAR TO PEER-TO-PEER AWARENESS-RAISING ACTIVITIES

Peer support

Peer support, or peer-to-peer support, brings people with similar lived experiences together to share challenges, explore solutions and feel supported. Peers are conceptualized as equal, supporting each other"s empowerment and having a shared lived experience (for example, shared suffering, recovery, challenges and successes) (PAHO, 2020). Peer support processes are well-recognized in SBCC literature to have the ability to influence and help people sustain behaviour change (Sokol and Fisher, 2016).

Peer support is often conceived of as a specific subcategory of "social support," distinguished by its specific source, namely peers (Solomon, 2004). Social support has been defined in different ways, but definitions typically involve the idea of actual and/or perceived access to informational, material/financial, practical and/or emotional support through social interactions or involvement in social networks (Albrecht and Goldsmith, 2003). There is robust evidence that social support is extremely important when coping with distress, yet it is also complexly associated with additional stressors such as social obligations and dependencies (Hobfoll, 2001) and exacerbation of distress when talking about potentially traumatic experiences with people in the same situation (Spiritus-Beerden et al., 2021).

Informal models of peer support operate like peer-to-peer networks, mutual self-help groups or mutual aid (Ho et al., 2022). People with similar lived experiences may naturally connect or they may be facilitated to connect and to define how they will interact (i.e. created social network). Informal peer support does not require specific education, training or supervision. More focused peer support models may involve a peer supporter (or mentor) applying basic helping skills or delivering evidenced-based MHPSS interventions, either in a one-on-one or group setting or through a peer-to-peer network. Focused models require training and supervision for peer supporters, as appropriate to the specific skillsets and/or interventions (Fortuna et al., 2020; OPSIC, 2016). The literature on peer support and social support among migrants recognizes the importance of access to such support from informal social networks. MHPSS and other health interventions with migrant populations have involved strengthening informal and formal peer support structures across dyads, networks, groups and communities (Hernández-Plaza et al., 2006; Ho et al., 2022).

Peer-to-peer support has been identified as a strategic intervention priority for MHPSS integration in some humanitarian settings (Elshazly et al., 2022; Dickson and Bangpan, 2018) as well as a key intervention for CB MHPSS approaches (IOM, 2021c; UNICEF, 2021). IOM (2021c) provides practical steps for mentoring and for structured peer support in CB MHPSS and promotes trained mentors and supervision. Focused peer support interventions and resource packages are becoming more available for a wide range of populations, such as young peers (IFRC, 2021b), children, adolescents and their friends (UNICEF et al., 2021), non-specialist peer-refugee helpers (de Graaf et al., 2020) and refugee volunteers (UNHCR, 2017).

The results of a recent systematic review of the appropriateness, acceptability and effectiveness of peer support approaches (Peersman and Fletcher, 2019) concluded that:

a. Augmenting the social relationship that is at the heart of peer support can influence results positively and minimize harm. Its implementation needs to be supported by competency building, supportive supervision and appropriate reflective practice.
b. The role that experiential knowledge plays in the implementation of a peer support intervention depends on whether an empowerment model or a behaviour change model is used, which will have different implications for mental health and psychosocial well-being and risk of harm.

Community-based testimony methods and storytelling

In areas with few mental health resources, community-based testimony methods have been used as a form of MHPSS support (Esala and Taing, 2017; Igreja et al., 2004). Testimonies expressed using the primary channel of storytelling can be seen as universal human practices, a creative or expressive activity that supports psychosocial well-being or a therapeutic intervention modality that may have mental health and psychosocial well-being benefits as well as limitations and risks (Bangpan et al., 2019; IOM, 2021c). By telling one"s story, testimony creates linkages with culture, community and political activism (Theisen-Womersley, 2021) and has the ability to activate healing as well as individual and collective transformation (IOM, 2021c). Community-based testimony methods and storytelling are amenable to contextualization and successfully implementable as part of diverse programmatic initiatives (Dickson and Bangpan, 2018; Kienzler at al., 2019). For example, an MHPSS awareness-raising and communication campaign in the Caribbean used video testimonials to promote effective coping and reduce stigma associated with mental health conditions (Gray et al., 2020). Community sharing of stories in groups in Rwanda has demonstrated reliable mental health and psychosocial well-being outcomes, such as a sense of belonging, prosocial behaviour and trust (King, 2014).

Community engagement

Community mobilization and support is a core domain in the matrix of interventions for MHPSS in emergencies (IASC, 2007) and community engagement is a critical component of CB MHPSS. IOM (2021c) identifies three interrelated objectives for community engagement in CB MHPSS, namely informing decisions, building capacity and strengthening relationships. Seven levels of community engagement in MHPSS programmes have been further elaborated by IOM, with the highest level being "empowerment".

Interventions that engage participation by the community help to restore people"s sense of self-agency and competence to meet challenges and are more likely to be meaningful and sustainable (UNICEF, 2018). When meaningful community engagement is lacking, interventions can fail (Guta et al., 2013). The restoration and development of community structures creates a supportive environment that builds trust, social connection and social cohesion among community members, enabling support for individuals through a wider social network (IOM, 2021c).

OBJECTIVES OF THE PILOT STUDY

The MaM-2 MHPSS pilot study was designed to explore the possible effects that participation in MaM-2 had on the mental health and psychosocial well-being among youth and adults who returned from irregular migration journeys to countries of origin in West and Central Africa and became MaM-2 Volunteers. The study had the following general and specific objectives:

General objective:

Identify potential factors that improved the mental health and psychosocial well-being of MaM-2 Volunteers and assess the feasibility of undertaking a more extensive future study.

Specific objectives:

- Provide basic information about the demographic characteristics, migration experiences, extent of MaM-2 participation, and mental health and psychosocial well-being among MaM-2 Volunteers.
- Discover patterns of variation in mental health and psychosocial well-being and extent of MaM-2 participation among MaM-2 Volunteers over time.
- Highlight potential relationships between mental health and psychosocial well-being and extent of MaM-2 participation among MaM-2 Volunteers over time.
- Surface insights to support the potential deeper integration of MHPSS into the MaM-2 theory of change, specifically intersections with SBCC and awareness-raising.
- Surface insights to help clarify the conceptualization and methodology of more conclusive potential future study.

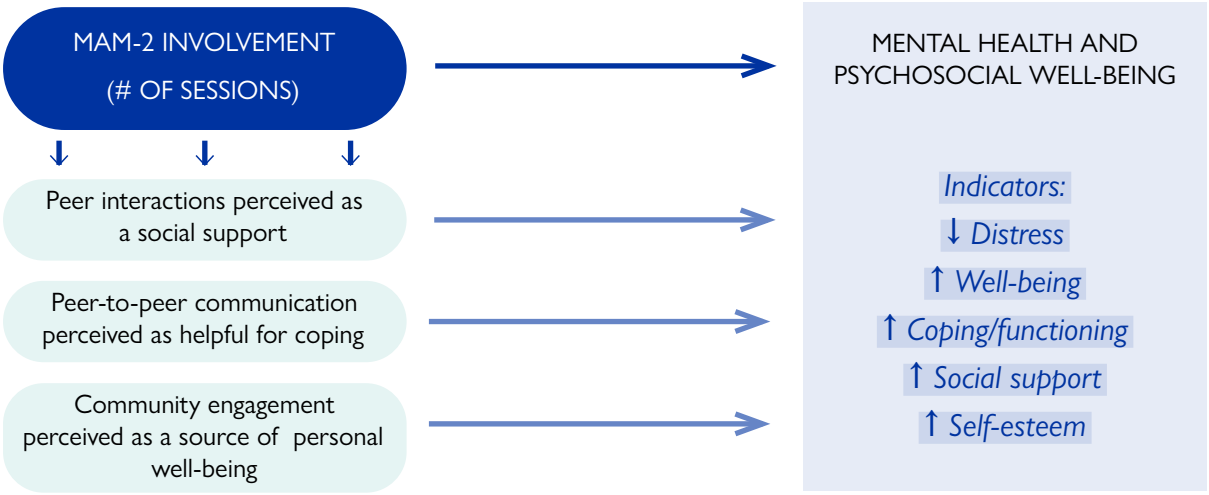
EXPLORATORY METHODOLOGY

Exploratory research is open to discovery of something new, and exploratory studies are useful when very little prior research has been conducted on a subject and a first analysis is being attempted (Swedberg, 2020). Exploratory methodology lends itself well to developing a better understanding of a relatively new phenomenon or problem, clarifying existing concepts and establishing future research priorities (Trochim and Donnelly, 2001). Exploratory studies do not aim to generate conclusive evidence to answer a research question and the aims of pilot studies are generally limited to assessing the feasibility of a study design and providing an estimation of a potential effect size to inform a future impact study (Thabane et al., 2010). An exploratory research methodology, therefore, is well-suited for the MaM-2 MHPSS pilot study, which is likely the first-ever study to explore the topic of possible mental health and psychosocial well-being effects among returned migrant youth and adults West and Central Africa, in relation to their participation as peer messengers in a migration awareness-raising campaign.

The exploratory pilot study researched possible:

- Effects of intensity of MaM-2 involvement on Volunteers" mental health and psychosocial well-being;
- Effects of MHPSS-integrated peer-to-peer awareness-raising activities on Volunteers" mental health and psychosocial well-being, including:
  - Peer interactions perceived as social support (peer support);
  - Peer-to-peer communication perceived as helpful for coping with painful memories (community-based testimony and storytelling);
  - Community engagement perceived as a source of personal well-being (community engagement in CB MHPSS).
- Associations between the intensity of MaM-2 involvement and MHPSS-integrated peer-to-peer awareness-raising activities.

Figure 3. MaM-2 MHPSS exploratory pilot study research



The exploratory mixed methods design, participant sampling strategy, quantitative and qualitative data collection methods, processes and data analysis strategy are described below.

EXPLORATORY MIXED-METHODS DESIGN

The MaM-2 MHPSS exploratory pilot study employed a sequential mixed methods research design (Creswell and Plano Clark, 2011) that centered around a quantitative panel study comprising four waves of data collection using questionnaires (see Figure 4).

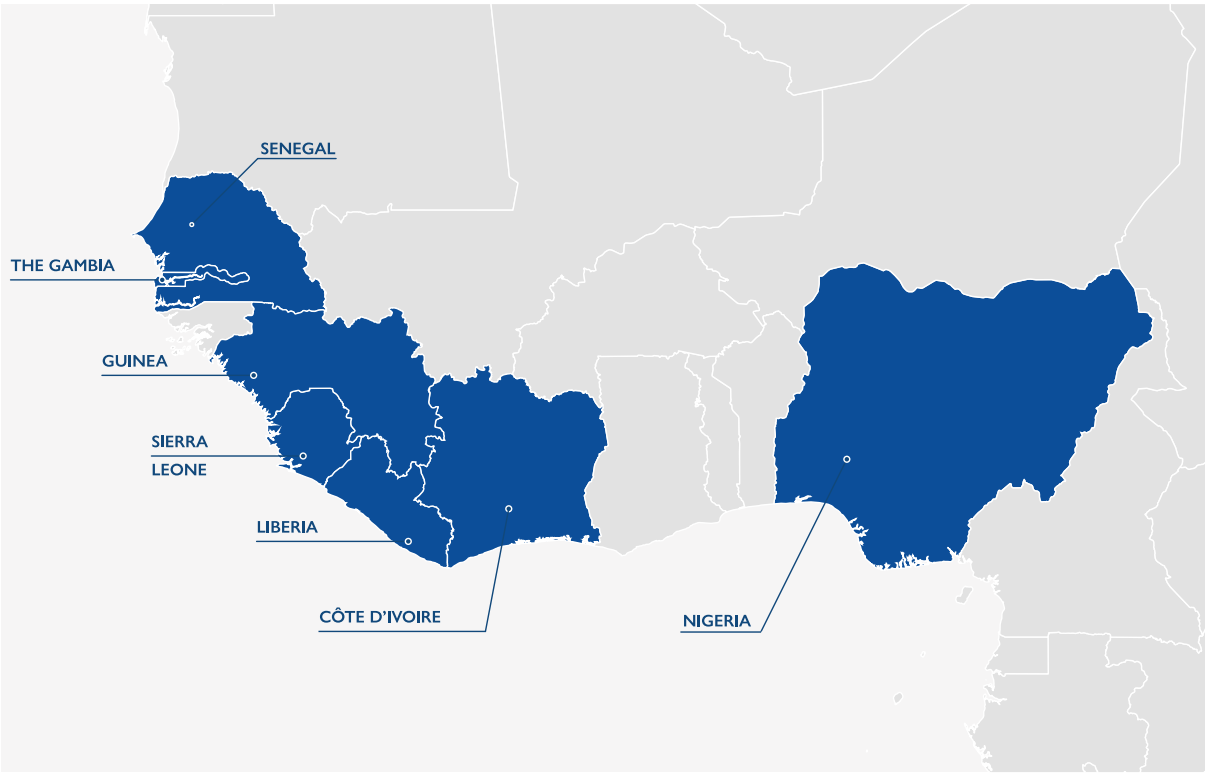
The quantitative panel study was supported by a one-country case study involving two qualitative methods with independent sampling strategies deployed at two separate timepoints: semi-structured interviews before the panel study and FGDs after it (see Yin (2003) on single case studies with embedded units).

Figure 4. Sequential mixed-methods research design

SAMPLING STRATEGIES AND PARTICIPANTS

QUANTITATIVE PANEL STUDY SAMPLING AND PARTICIPANTS

All MaM-2 Volunteers across the seven countries who were registered with the MaM-2 campaign between October 2020 and March 2021 were systematically invited to participate in the quantitative panel study. A total of 314 MaM-2 Volunteers self-selected to participate in the panel study and very few Volunteers declined to participate.[10]



Note: This map is for illustration purposes only. The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the International Organization for Migration.

Table 2 presents the variation among the self-selected sample of panel study participants by country, stratified by three programmatically meaningful variables: gender, age and MaM-1 Volunteer history. Gender mainstreaming was an important feature of MaM-2, and data disaggregation by gender is best practice for awareness-raising and MHPSS programming in migration crisis settings. Youth of all genders, from 18 to 30 years, who have the desire to migrate were the primary audience of MaM-2. For inter-agency harmonization purposes, however, this pilot study opted to align with the United Nations definition of youth as persons aged 15 to 24 years. Because MaM-2 Volunteers must be at least 18 years old, the effective age range of youth for this pilot study was 18 to 24 years. Data disaggregation by age that is attentive to young people is best practice for awareness-raising and MHPSS programming in migration crisis settings.

[10] It is unknown how many MaM-2 Volunteers there were in total between October 2020 and March 2021 or how many declined to participate in the study, however there were an estimated 400 Volunteers as of July 2022.

Table 2. Self-selected sample of panel study participants: country, gender, age group and MaM-1 Volunteer history

Country / Age group[11] / gender	Côte d"Ivoire	The Gambia	Guinea[a]	Liberia	Nigeria[a]	Senegal[a]	Sierra Leone	Total*
Youth/female	0	2	3 (*1*)	4	4 (*3*)	2 (*1*)	6	21 (*5*)
Youth/male	6	9	7 (*4*)	3	2 (*1*)	7 (*5*)	5	39 (*10*)
Adult/female	12	12	9 (*0*)	9	17 (*12*)	17 (*9*)	14	90 (*21*)
Adult/male	24	35	21 (*14*)	16	24 (*19*)	24 (*14*)	20	164 (*47*)
Total	**42**	**58**	**40 (19)**	**32**	**47 (35)**	**50 (29)**	**45**	**314 (83)**

Note: [a] Where applicable, counts of the number of study participants who had also been MaM-1 Volunteers are presented in parentheses as sub-sets of overall cell counts.

The number of panel study participants from each country ranged between 32 in Liberia to 58 in the Gambia. The total panel study sample of 314 MaM-2 Volunteers consisted of 111 (35.4%) females and 203 (64.6%) males, inclusive of 60 (19.2%) youth among all genders. Over half (164, 52.2%) of the panel study participants were adult males, and there were at least three-and-a-half times more adult males than young female participants in each country. While 100 per cent of panel study participants were MaM-2 Volunteers, a little over a quarter of the sample (83, 26.4%) had also been MaM-1 Volunteers.

All 314 study participants completed a baseline questionnaire (see Table 3). Most baseline questionnaires (89.8%, 282 participants) were carried out in October 2020 at Wave 1. Only 32 (10.2%) study participants completed baseline questionnaires at Wave 2 in March 2021. Study participation rates at each data collection wave ranged between a high of 94 per cent at Wave 2 (284 participants) and a low of 70 per cent at Wave 3 (220 participants).[12] The "completer" response rate – the proportion of sample members who participated in every data collection round among those who were eligible for all rounds – was just over half (51.0%), with 160 participants completing the baseline questionnaire at Wave 1 and all three follow-up questionnaires.

Table 3. Study participation across four quantitative data collection waves

Data Collection Waves	Participants (N = 314)	Baseline Questionnaires	Follow-up Questionnaires
Wave 1 (October 2020)	*n* = 282	282	0
Wave 2 (March 2021)	*n* = 284	32	252
Wave 3 (October 2021)	*n* = 220	0	220
Wave 4 (April 2022)	*n* = 227	0	227
Completers of all waves	**n = 160**	**Total baseline questionnaires: 314**	

[11] One of the 314 study participants" records in the database does not contain age data.

[12] Due to logistical challenges, data collection did not take place in Senegal during Wave 3.

For the purposes of this report:

- "At baseline" refers to the data collected from the first questionnaire that a participant completed. For most, this was at Wave 1, but for a small minority this was at Wave 2;
- Mention of specific waves in the following sections refers to the data collected for the *n* at that wave.

COUNTRY SAMPLING AND PARTICIPANTS FOR QUALITATIVE INTERVIEWS AND FOCUS GROUP DISCUSSIONS

Côte d"Ivoire was selected for the country case study based on a blend of logistical and MHPSS mainstreaming considerations.

- For the semi-structured interviews in July 2020: MaM-2 Volunteers were accessible and available by phone during the early months of the COVID-19 pandemic and IOM staff were willing and able to conduct them and transcribe the data.
- For the FGDs in July 2022: Some MaM-2 Volunteers, particularly women, had expressed meaningful experiences with the "Body acceptance" CB MHPSS activity used in the MHPSS mainstreaming approach,[13] MaM-2 Volunteers were accessible and available on short-term notice to participate, and the IOM Côte d"Ivoire office had the capacity to conduct the FGDs and transcribe the data in a timely manner.

Twenty-four MaM-2 Volunteers (8 women and 16 men) in Côte d"Ivoire, ages 25-41 years, participated in the semi-structured interviews. Recruitment took place after IOM had provided assistance with return to many of them through assisted voluntary return and reintegration programming. At the time of the interviews, participants were residing in 11 different neighbourhoods across the urban areas of Abidjan (70%) and Daloa (30%).

Thirteen MaM-2 Volunteers in Côte d"Ivoire participated in the FGDs. Two FGDs – the first with seven participants and the second with six participants – were conducted on the same day. FGD participants were selected by IOM staff in collaboration with two associations of MaM-2 Volunteers. Sampling was shaped partly by convenience and feasibility considerations and partly based on programmatic reasons.

Sample recruitment for the panel study, the semi-structured interviews, and the FGDs were done independently of each other, therefore it is not known how many MaM-2 Volunteers from Côte d"Ivoire participated in two or all three of these data collection activities. Based on the per-country participant totals in the panel study sample (presented above in Table 1), coupled with the understanding that all panel study participants had entered the study at the latest by Wave 2 in March 2021, it can be inferred that by March 2021 there were no less than 42 MaM-2 Volunteers from Côte d"Ivoire in the panel study sample. This provides an approximation of the minimum size of the potential participant pool for the qualitative methods.

DATA COLLECTION METHODS

QUANTITATIVE QUESTIONNAIRES

A baseline questionnaire was developed for use in the quantitative panel study (see Annex 5. Baseline questionnaire) to collect data from participants on:

- Demographic characteristics
- Migration experience
- Intensity of MaM-2 involvement
- Mental health and psychosocial well-being indicators, including distress, "personal well-being", capacity for functioning/coping, perceived social support, and "self-esteem"
- MHPSS-integrated peer-to-peer awareness-raising activities.

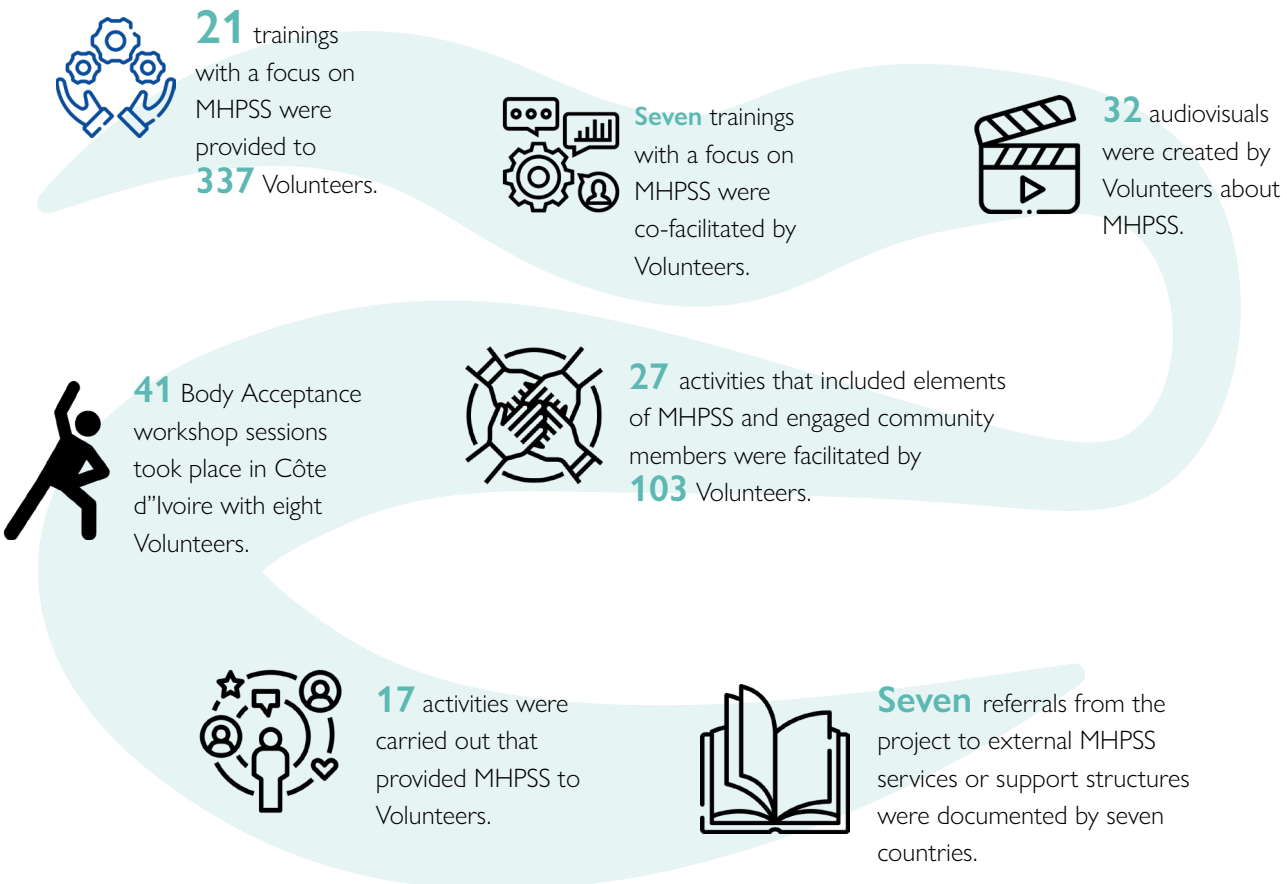
[13] A description of the activity is included in Migrants as Messengers and Psychosocial Support: A selection of evidence-based activities for psychosocial support with returned migrants.

Follow-up questionnaires conducted during Wave 2 (except for 32 participants – see above), Wave 3 and Wave 4 of the panel study did not include questions on demographic characteristics or migration experience, except for a few items on social media use and job skills.[14]

Intensity of MaM-2 involvement indicator

MaM-2 involvement was measured based on how many MaM-2 sessions participants reported having attended. The term "sessions" broadly referred to any of the trainings, workshops, content development sessions, MaM-2 meetings with IOM staff and Volunteers, or activities in the MaM-2 campaign. The estimated number of sessions "ever attended" was how intensity of MaM-2 involvement among panel study participants was operationalized from wave to wave. Figure 5 illustrates the scope of MHPSS mainstreaming activities at the session level and the extent and nature of Volunteer engagement in those sessions. It also includes information on use of the MaM-2 MHPSS referral pathways.

Figure 5: Volunteer involvement in MHPSS mainstreaming activities at the session level



[14] Data on select items from the questionnaires were not reported here, though they would be of interest in future analyses, including: job skills, motivation for volunteering with MaM-2, country most time spent in during migration journey, experience of a major event in the past six months, and things that help one to deal with stress and worry. While predominantly quantitative, the questionnaires did include some open-ended questions, including at least two stand-alone items that elicited local terms for feeling "well" and "not well". These data were not essential to addressing the objectives for this exploratory pilot study, and they are not reported here, however they are considered a good practice to be applicable and analysed in potential future studies that involve developing culturally-contextualized measures of mental health and psychosocial well-being. Minor additions were made to the follow-up questionnaire on constructs not included in this report, such as types of social media used in addition to Facebook and WhatsApp.

Mental health and psychosocial well-being indicators

Five indicators of mental health and psychosocial well-being were measured at each quantitative panel study data collection wave. The selection of these indicators for the pilot study was informed by preliminary analysis of the qualitative data gathered through the semi-structured interviews. A scale for each indicator was incorporated in the questionnaire. Scales for the indicators were developed by starting with scales recommended by the MHPSS research and technical literature, followed bysome of them being adapted, as needed, to better fit the pilot study. The face validity of the scales was determined by country offices in the region, and the content validity of the scales was determined by a MHPSS technical expert review as satisfactory.

For each of the five mental health and psychosocial well-being indicators, Table 4 presents: names and citation information for the original scales that inspired those in the MaM-2 MHPSS pilot study questionnaire, a description of the scale used in the questionnaire, the scoring of the scale used in the data analysis, alignment of indicator and scale with IASC MHPSS monitoring and evaluation guidance, and other relevant notes.

Table 4. Mental health and psychosocial well-being indicators and scales used in the pilot study

Indicator	Initial scale in the literature	Scale in the questionnaire and scoring	Alignment with IASC Monitoring and Evaluation Common framework for MHPSS	Additional notes
Personal well-being	Personal well-being section (nine Likert items) of IFRC (2017) sample well-being questionnaire, with the instruction that questions can be deleted, changed or added, and to pilot test it. Five of the items on this scale were taken from the Warwick Edinburgh Mental Well-Being Scale (WEMWBS) (Taggart et al., 2016; Tennant et al., 2007).	All nine Likert items from the section used. Cumulative scoring adapted from the WEMWBS, with each item scored from 1–4 (Rarely, Sometimes, Most of the time, Always), for a range of 9–36. 1. Two questions added. The transitional distress item discussed above, and an MHPSS-integrated peer-to-peer awareness-raising activities item discussed in the following sub-section. These two questions were not included in the scoring.	Alignment with goal impact indicator: Subjective well-being.	This scale comes from the same source as the "capacity for functioning and coping" scale. Ideally, this scale was designed to be adapted with a brief exploration of local concepts of well-being. The resulting scale would not be "validated", but it could serve to indicate changes in indicators of well-being during programme implementation.

Distress (intensity)	Patient Health Questionnaire (PHQ-9) (Kroenke and Spitzer, 2002) inspired some of the items. PTSD Checklist for DSM-5 (PCL-5), past month (Weathers et al., 2013) inspired some items and the response scales and items.	2. A transitional Likert item, "I have been feeling distressed," was added to the preceding scale. 3. Based on a participant"s affirmative response, they were prompted to describe the feelings of distress and the enumerator recorded the descriptions using a checklist and blank fields. 4. Regardless of the responses to the two questions above, all participants were asked to rate their "distress intensity". "How severe was this feeling?," on a scale from 0–4 (Not at all, Manageable, Bad, Very bad, Extreme) The one-item, ordinal distress intensity score (#3) was analysed for this report.	Alignment with goal impact indicator: Disabling distress and/ or presence of mental disorder. Alignment with recommended quantitative means of verification (MoV): PHQ-9, PCL-5.	PCL-5 measures Post Traumatic Stress Disorder as a clinical construct that captures only some aspects of distress. There may have been another scale that inspired this one that was not documented with the project.
Capacity to function and cope	Capacity (to function and cope) section (nine Likert scale items) of IFRC (2017) sample well-being questionnaire, with the instruction that questions can be deleted, changed or added, and to pilot test it. Three of the items on this scale were taken from the WEMWBS (Taggart et al., 2016; Tennant et al., 2007).	All nine Likert items from the section used. Cumulative scoring adapted from the WEMWBS, with each item scored from 1–4 (Rarely, Sometimes, Most of the time, Always), for a range of 9–36. One question added. An MHPSS-integrated peer-to-peer awareness-raising activities item discussed in the following subsection. This question was not included in the scoring.	Alignment with two goal impact indicators at the same time: Functioning and ability of people with mental health and psychosocial problems to cope.	This scale comes from the same source as the personal well-being scale.
Social support	Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet et al., 1998).	All 12 Likert scale items from the scale used. Mean scoring, summing all 12 items then dividing by 12. Items scored from 1–7 (Very Strongly Disagree, Strongly Disagree, Mildly Disagree, Neutral, Mildly Agree, Strongly Agree, Very Strongly Agree).	Alignment with goal impact indicator: Social connectedness. Alignment with recommended quantitative MoV: MSPSS.	Contains significant other, family and friends sub-scales.
Self-esteem	Rosenberg self-esteem scale (Rosenberg, 1965),	All 10 Likert items from the scale used. Cumulative scoring, with each item scored from 0–3 (Strongly Agree, Agree, Disagree, Strongly disagree), with reverse scoring on five items, for a range of 0–30.		Developed from research in 1965 with a sample of 5,024 high school students in New York State.

MHPSS-integrated peer-to-peer awareness-raising activities

One item was included on the questionnaire for each of the three MHPSS-integrated peer-to-peer awareness-raising activities:

- Peer interactions perceived as social support (peer support)
  - The stand-alone item included on the questionnaire was dichotomous:
    - "Through your involvement in MaM, have you found peers that support you?"
- Peer-to-peer communication perceived as helpful for coping
  - The additional item included on the questionnaire was a Likert item, scored from 1–4 (Rarely, Sometimes, Most of the time, Always). It was added to the end of the "capacity for functioning

and coping" scale but was not included in the scoring of that indicator:
  - "Talking about my personal experiences helps me to cope with painful memories."
- Community engagement perceived as a source of well-being
  - The additional item included on the questionnaire was a Likert item, scored from 1–4 (Rarely, Sometimes, Most of the time, Always). It was added near the end of the personal well-being scale but was not included in the scoring of that indicator:
    - "My community engagement gives me a sense of personal well-being."

QUANTITATIVE DATA COLLECTION PROCEDURES

The COVID-19 pandemic impacted quantitative data collection in a myriad number of ways, including logistical challenges. For these reasons, it was not possible for Wave 1 data collection, which was when most of the baseline questionnaires were administered, to be done before the start of the implementation of the project. This meant that many participants had started engaging in MaM-2 sessions before completing the baseline questionnaire. In some circumstances, participants were not available when data collection was happening, and in other cases it was not possible for an enumerator to travel to meet with the participant (or vice versa). Provisions were made to conduct the surveys by phone to ease the strain on travel and risk, and to mitigate potential panel data loss, however questionnaire-by-phone was considered a last resort.

The surveys were conducted in collaboration with the IOM country offices. Instructions during Wave 1 specified that, before engaging in data collection, enumerators should be briefed by a qualified MHPSS officer on: the study rationale, the timing of the administration of the questionnaire in relation to both returned migrants" enrollment as MaM-2 Volunteers and their first MaM-2 training session, the survey protocol, MHPSS considerations for administering questionnaires on sensitive topics, and COVID-19 safety measures. Consent to participate was sought at the start of each questionnaire for all waves.

Before the beginning of Wave 2, the technical quality of the enumerator briefing procedure was strengthened to include a mandatory briefing and training session. The session offered a supportive space to practice using the survey tool and updates to content on the topics of MHPSS, research ethics, enumerator role and relationship to focal points/supervisors, the study rationale, the consent process and the questionnaire protocol.

QUALITATIVE TOOLS

Semi-structured interview guide

The semi-structured interview guide consisted of open-ended questions and key word prompts to elicit "life story" conversational data on the themes of migration journeys, experiences of return, voluntary participation in the MaM-2 campaign and psychosocial situation upon return (see Annex 6. Semi-structured interview guide). The semi-structured interviews were conducted by phone and lasted between 25 to 45 minutes in duration.

Focus group discussion guide

The FGD guide consisted of suggested welcoming and closing scripts, open-ended questions and prompts (see Annex 7. Focus group discussion guide: questions and prompts) to facilitate the participant groups to discuss and share opinions, thoughts, perceptions and experiences on:

- Community and social aspects of MaM-2 MHPSS mainstreaming activities, including peer-to-peer interaction, sharing testimonies/stories about MHPSS in content creation and community engagement;
- Technology use for well-being promotion;
- Lay theories or lived experience of how MaM-2 participation may or may not have influenced Volunteers" mental health and psychosocial well-being.

EXPLORATORY DATA ANALYSIS STRATEGY

QUANTITATIVE ANALYSIS

Following data cleaning, initial data analysis (Baillie et al., 2022) proceeded systematically by using descriptive statistics to examine means and variation of data across each variable on its own, by gender and age, and across all waves of data collection, where applicable. Visual inspection of tables and graphs confirmed key variables of interest to work toward meeting the study objectives and to explore the research topics.

Following the initial data analysis, exploratory analysis proceeded using a flexible approach to applying descriptive and correlational statistical methods to analyse relationships between repeated measures of mental health and psychosocial well-being impact indicators, intensity of MaM-2 involvement, and MHPSS-integrated peer-to-peer awareness-raising activities.

Whole-wave missing data was non-random. IOM country offices shared the following insights about sources of missing data:

- COVID-19 restrictions.
- Participants were sometimes unreachable by phone, travelling, not feeling well, unavailable due to family/social commitments, or had missed the appointment.
- Staff and Volunteer time was limited due to scheduling challenges around other activities.
- The COVID-19 pandemic impacted the study timeline, which needed to be rigorous, as well as the timeline of project implementation (recruitment and trainings of Volunteers), which further impacted the coordination of the study timeline.
- Participants joined the Volunteer network after Wave 1, new Volunteer recruitment and training occurred at multiple times and was not closely coordinated with the study timeline.
- Participants did not fully understand the purpose/objective of the study and how it would benefit them.
- Some participants dropped out of MaM-2 for various reasons including to return to school.

There was also some uncertainty about the degree of data quality due to:

- Complexities of distributed data collection activities across multiple countries, teams and enumerators.
- Learning curve in enumerator training.
- Challenges to prioritization of data collection monitoring for an exploratory pilot study in relation to more rigorous and higher-stakes adjacent activities.

Based on these factors, a strategy was used that consisted of descriptive, correlational and trend analyses that did not require modeling, imputation of missing variables, or estimating unknown parameters (i.e. no regressions). Exploration focused on:

- Description of results at baseline for most variables.
- Variation across gender, age group and other demographic variables of interest at baseline.
- Trends in the mental health and psychosocial well-being indicators, intensity of MaM-2 involvement, and the MHPSS-integrated peer-to-peer awareness-raising activities.
- Variation in trends by gender and age group.
- For each wave, associations between:
  - Intensity of MaM-2 involvement and mental health and psychosocial well-being indicators;
  - MHPSS-integrated peer-to-peer awareness-raising activities and mental health and psychosocial well-being indicators;
  - Intensity of MaM-2 involvement and MHPSS-integrated peer-to-peer awareness-raising activities.

As the MaM-2 MHPSS exploratory pilot study was not intended to achieve generalizable findings, and approximations were sufficient to identify possible associations and effects, analyses proceeded with the spirit of discovery and without excessive concern regarding: (a) the differentials between the number or characteristics of participants at baseline (N=314), at each wave (Wave 1: *n*=282; Wave 2: *n*=284; Wave 3: *n*=220; Wave 4; *n*=227), and who completed all waves (n=160), (b) low cell counts when analyzing relationships between categorical variables with contingency tables larger than 2x2, (c) approximating the use of ordinal Likert scale data as continuous, or (d) minimal amounts (>5 cases) of occasional missing data for a few items.

For analyses at baseline or within a single wave (i.e. non-paired analyses):

- Chi-square tests of independence were performed to assess the relationship between categorical variables, and adjusted residuals were used for post hoc analysis, where appropriate.
- Independent samples t-tests were performed to assess the relationship between means across two independent groups.
- One-way analyses of variance (ANOVAs) were performed to assess the relationship between means across more than two independent groups, and Tukey"s honestly significant difference tests were used for post hoc analysis, where appropriate.

For trend analyses (i.e. paired analyses), the subset of 160 completers (participants with data at all four waves) was used. Friedman tests were performed to explore trends in categorical variable data. Where appropriate, post hoc analysis with Wilcoxon signed-rank tests were conducted with a Bonferroni correction applied, resulting in a significance level set at p<.013. The exception to this was for the dichotomous "have you found peers that support you" variable, for which Cochran"s Q test was performed and post hoc analysis was done using McNemar"s tests with a Bonferroni correction applied, also resulting in a significance level set at p<.013. Repeated-measures ANOVAs were performed to explore trends in ordinal approximations of continuous variables, and Scheffé tests for multiple comparisons were used for post hoc analysis where appropriate.

QUALITATIVE ANALYSIS

A robust and comprehensive stand-alone thematic content analysis of the semi-structured interview data was undertaken and completed in November 2021.[15] Select themes were prioritized for further analysis and refinement through iterative reflection in the context of the development of the exploratory quantitative analytic strategy described above. Initial criteria for prioritization included the illumination of something new or exemplary, confirmation of programmatic or study assumptions, historical informing of questionnaire development, or background contextualization for panel study and FGD data interpretation.

The FGD transcripts were translated from French to English using translation software and read through once in their entirety, while open-coding with multicoloured digital highlighter and noting comments in Microsoft Word. This initial pen-coding was performed by one white, cisgender, woman-identifying, MHPSS technical/mixed-method researcher/American medical anthropologist working from home, based in Vermont, United States of America. Approximately six weeks later, the same person re-read through the previously coded transcripts in relation to interim quantitative data analysis results. This allowed for a rapid qualitative analysis that generated themes and exemplar quotes for presentation, alongside quantitative findings to highlight divergences and convergences across the methods.

RESULTS

This section presents the quantitative results of the panel data analysis, supplemented with qualitative findings from the FGDs. The data patterns, significance of associations, themes, and mixed-method triangulations should be interpreted as potential rather than definitive (Westlund and Stuart, 2017). The presentation of results includes: demographic characteristics and migration experience at baseline, trends in mental health and psychosocial well-being indicators, trends in intensity of MaM-2 involvement and MHPSS-integrated peer-to-peer awareness-raising activities, along with associations with mental health and psychosocial well-being indicators for each wave, and associations between MaM-2 involvement and MHPSS-integrated peer-to-peer awareness-raising activities.

[15] Unpublished, internal IOM ROWCA report.

Age

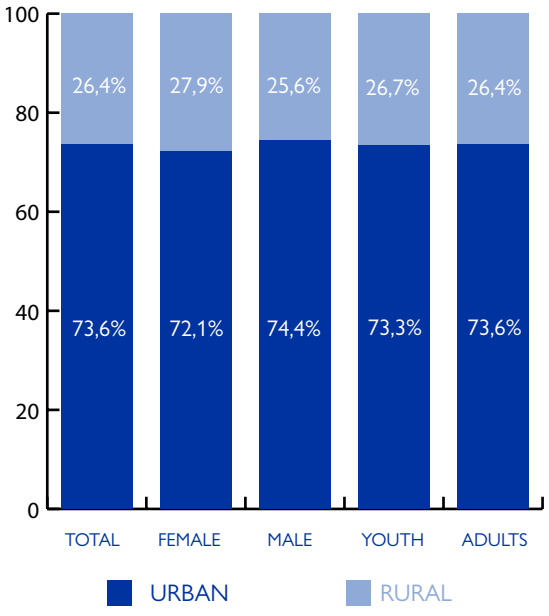
The mean age of all participants was 29 years with no difference across gender. The mean age of youth was 22 years, which was significantly lower than 31 years for the mean age of adults. This difference was not unexpected because the age group categories of youth and adult were defined according to age.

Table 5. Age in years				
Gender	Min	Median	Max	Mean
Female	20	28	43	29
Male	18	28	57	29
Age group	Min	Median	Max	Mean
Youth	18	23	24	22
Adults	25	30	57	31
Total	18	28	57	29

Geographic area

Nearly three-quarters (73.6%) of study participants resided in an urban area, while 26.4 per cent resided in a rural area. There were no significant differences across gender or age group.

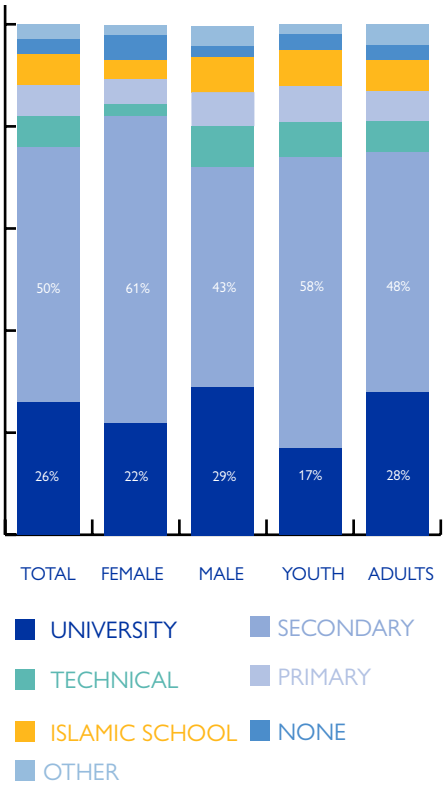
Figure 6. Geographic area



Education

Secondary school was the highest level of education attained by half (50%) of all study participants. Level of education significantly differed across gender but not age group. More women in the study had attained secondary education (61%) or had no school at all (5%), while more men had attained university education (29%), technical training (8%), primary school (6%), Islamic school (7%), or something else (4%).

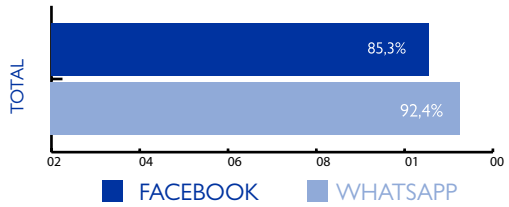
Figure 7. Education



Social media use

WhatsApp (92.4%) and Facebook (85.3%) were used by most participants with no significant differences across gender or age group.

Figure 8. Social media use



MIGRATION EXPERIENCE

Migration duration

The duration of migration journeys among participants ranged from 1 to 264 days. The mean duration of migration among all participants was 26 days. Youth"s mean duration of migration was 17 days, which was significantly less than the 28 days among adults.

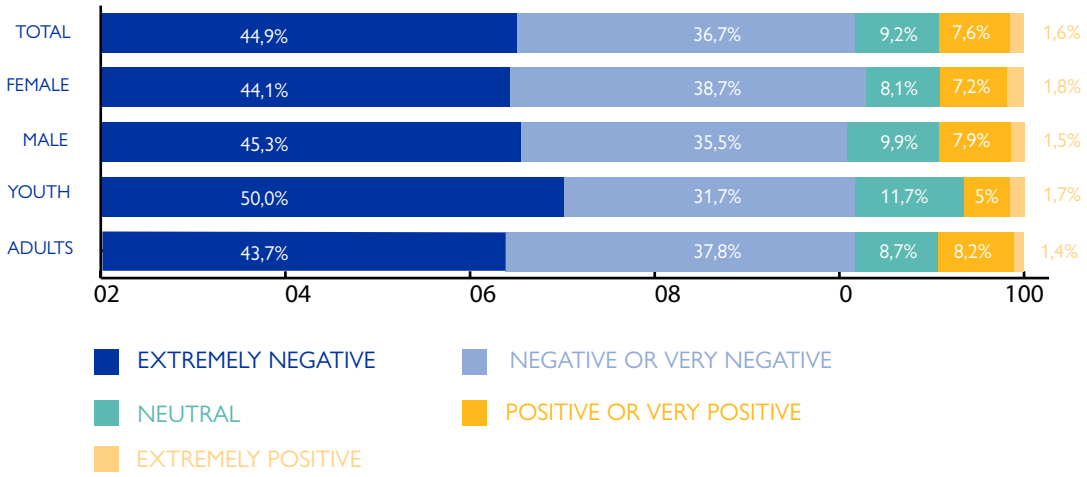
Table 6. Migration duration in days

Gender	Min	Median	Max	Mean
Female	1	26	120	22
Male	1	18	264	27
Age group	**Min**	**Median**	**Max**	**Mean**
Youth	1	14	120	17
Adults	1	18	264	28
Total	**1**	**18**	**264**	**26**

Quality of migration experience

Overall, many more participants rated their migration experience on the negative end of the spectrum as "extremely negative" (44.9%) or "negative or very negative" (36.7%) compared to "neutral" (9.2%), "positive or very positive" (7.6%) or "extremely positive" (1.6%). The were no significant differences across gender or age group.

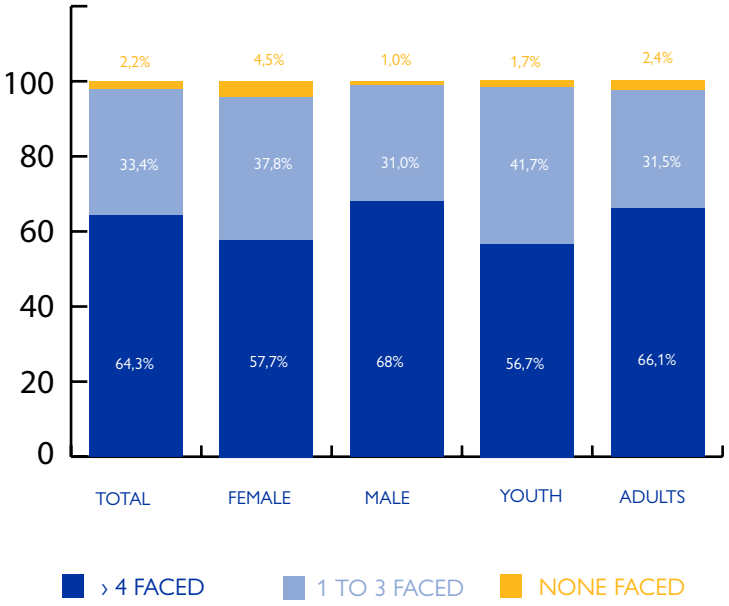
Figure 9. Migration experience rating



Protection risks during migration

Overall, most participants (64.3%) faced at least four protection risks during migration. The number of protection risks significantly differed across gender but not age group. A higher percentage of men (68.0%) reported facing more than four protection risks compared to women (57.7%).

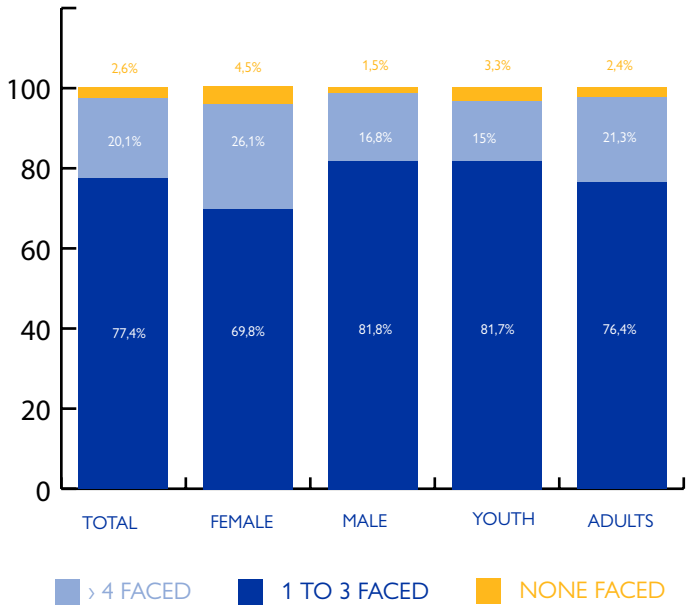
Figure 10. Protection risks



Challenges upon return

Overall, the number of challenges that most participants (77.4%) reported facing upon return was one to three. The number of challenges faced upon return significantly differed across gender but not age group. A higher percentage of females (26.1%) faced more than four challenges compared to males (16.8%).

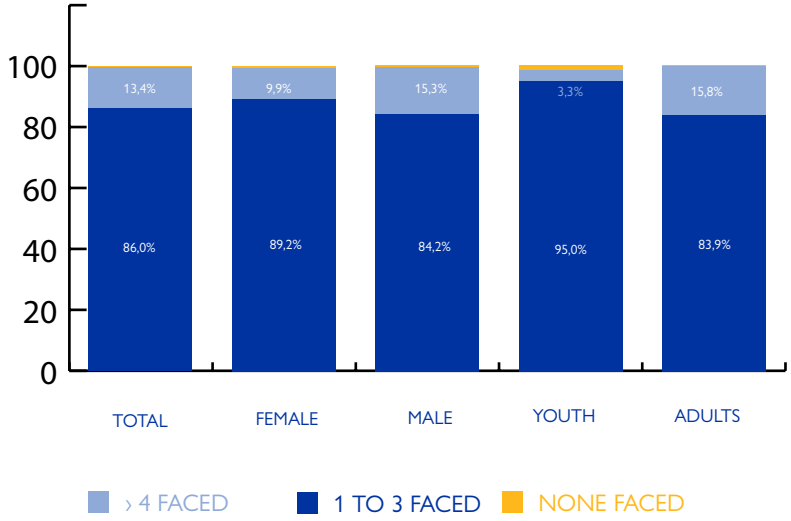
Figure 11. Challenges upon return



Opportunities upon return

Overall, the number of opportunities that most participants (86.0%) reported facing upon return was one to three. The number of challenges faced upon return significantly differed across age group but not by gender. A lower percentage of youth (3.3%) saw more than four opportunities compared to adults (15.8%).

Figure 12. Opportunities upon return



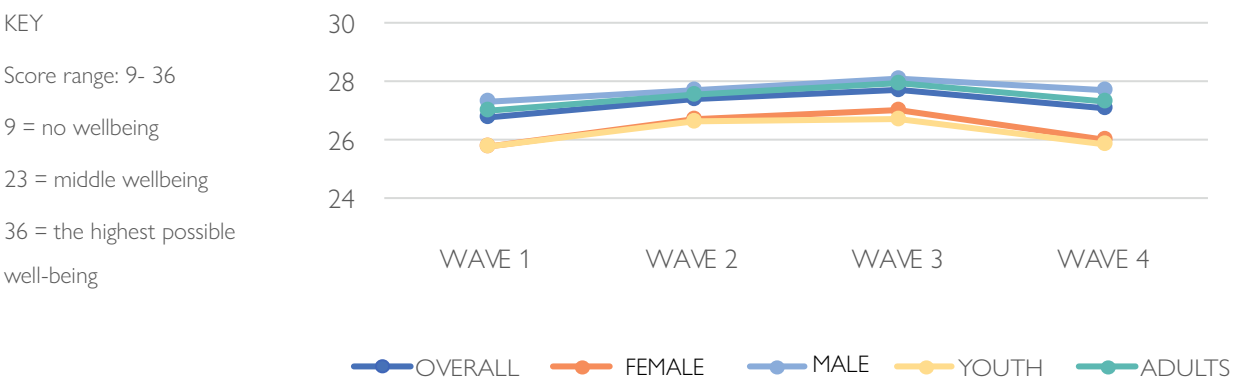
Additional baseline results of associations of MHPSS indicators by demographic variables (Table 12) and intensity in MaM-2 involvement, supportive peers and MaM-1 Volunteer by gender and age (Table 13) can be found in Annex 8 and Annex 9, respectively.

TRENDS IN MENTAL HEALTH AND PSYCHOSOCIAL WELL-BEING

PERSONAL WELL-BEING

The mean overall well-being score at Wave 1 was 26.8 and at Wave 4 was 27.1, with 9 being the lowest and 36 being the highest possible well-being score. Mean well-being scores across waves, gender and age groups were all in the 25 to 29 range. During Waves 1 and 4, there was a slight yet significant difference in the mean well-being scores across gender, where women's scores (25.8 and 26.0, respectively) were lower than men's (27.3 and 27.7, respectively). There was also a slight yet statistically significant difference in mean overall well-being score between Wave 1 (26.8) and Wave 3 (27.7).

Figure 13. Personal well-being trends

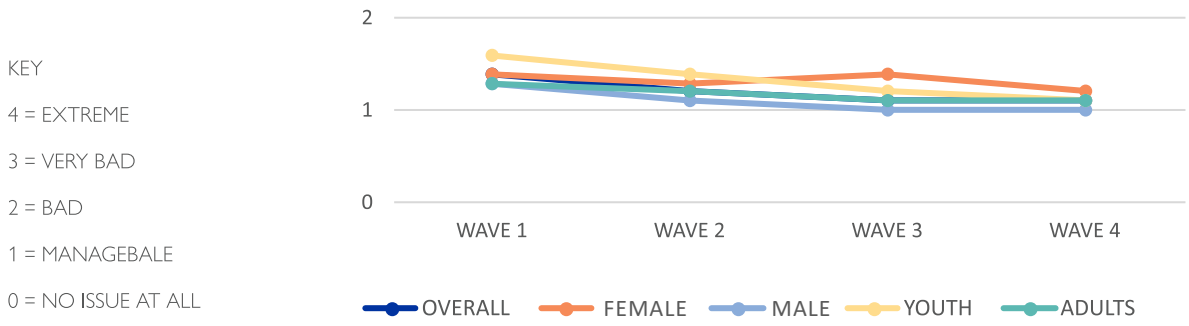


These data indicate that on average most participants entered MaM-2 with a relatively moderate[16] level of well-being that trended positively during the first year of the campaign. Most women and youth participants entered MaM-2 with lower levels of "personal well-being" compared to men and adults, respectively. While the gender and age gaps in well-being lessened and were insignificant by Wave 2 and Wave 3, women and youth lost more of their well-being than men and adults during the negative trend from Wave 3 to Wave 4. Furthermore, the gendered differences in well-being scores at Waves 1 and 4 were larger than the significant positive change in trend in well-being scores for participants overall.

DISTRESS INTENSITY

Overall, mean "distress intensity" scores slightly dropped over the course of the study, from 1.4 to 1.1. Youth had the largest reduction from 1.6 to 1.1, and the mean youth "distress intensity" score was significantly different from adults at Wave 1. There was also a slight yet significant difference between the scores for women and men during Wave 3 (1.4 and 1.0, respectively) and Wave 4 (1.2 and 1.0, respectively). For the mean overall "distress intensity" score, there was a slight yet statistically significant difference between Wave 1 and Wave 3 and also between Wave 1 and Wave 4.

Figure 14. Distress intensity trends



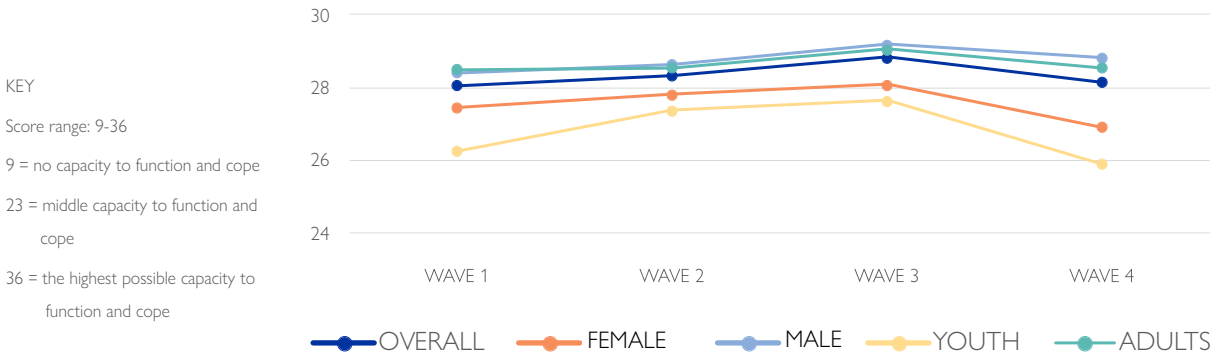
The quantitative "distress intensity" data indicate that on average participants entered MaM-2 with a nearly "manageable" level of distress that moved closer to a "manageable" level over time. Youth participants had the largest positive change in "distress intensity" level over time, which shifted from closer to "bad" towards "manageable". Notably, mean "distress intensity" among women elevated at Wave 3, reaching the level where it started at Wave 1, then reduced at Wave 4. Wave 3 was simultaneously when men"s mean "distress intensity" score reached its low, which continued at Wave 4.

CAPACITY FOR FUNCTIONING AND COPING

The mean "capacity for functioning and coping" score at Wave 1 for the overall sample 28.1, and the mean "capacity for functioning and coping" scores across waves, gender and age groups were all in the 26 to 30 range. At Waves 1 and 4, there was a slight yet significant difference in the mean "capacity for functioning and coping" score across age groups, where youth"s scores (26.3 and 25.9, respectively) were lower than adults" (27.3 and 27.7, respectively), with the initial difference nearly doubling by Wave 4. At Wave 4, there was also a slight yet significant difference in the mean score across gender: women"s mean score (26.9) was lower than men"s (28.2). There was not a statistically significant difference in mean overall "capacity for functioning and coping" score across any waves.

[16] Moderate is used broadly as there is no standard other than the range of the scale itself by which to qualitatively evaluate the score. However, the distress intensity and social support scales have more guiding experiential qualifiers and suggested thresholds built into them, however they have not been piloted or validated with returned migrant populations in West and Central Africa.

Figure 15. Capacity for functioning and coping trends

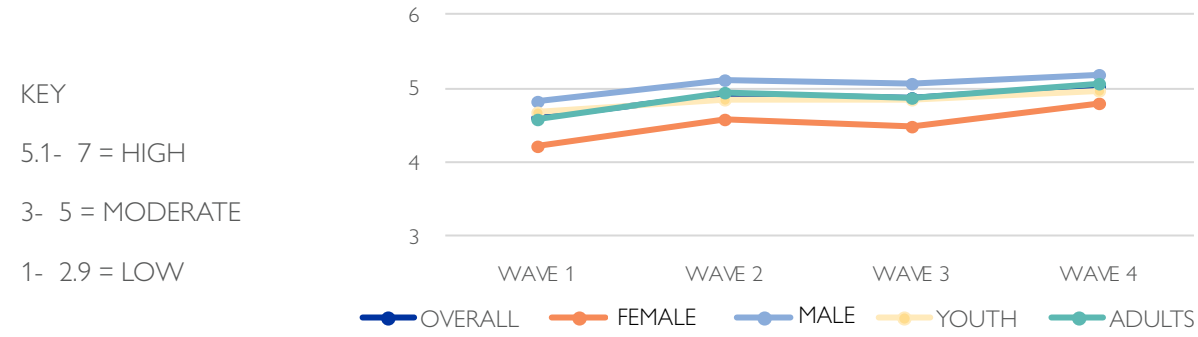


These data can indicate that the overall sample participants entered MaM-2 with a relatively moderate mean level of "capacity for functioning and coping" that positively trended through Wave 3, though the trend was not statistically significant. Men and adults had higher scores at Wave 4 compared to Wave 1, while women"s and youth"s scores were lower than where they started. The gender and age differences in "capacity for functioning and coping" scores at Wave 4 were larger than the positive change in trend in "capacity for functioning and coping" scores for participants overall.

SOCIAL SUPPORT

The mean overall "social support" score at Wave 1 was 4.6 and at Wave 4 was 5.0, with 5 being a suggested threshold between "moderate" and "high" "social support" scores. Mean scores among women were slightly yet significantly lower than those among men for all waves, with both women and men reaching high scores of 4.8 at 5.2, respectively, at Wave 4. There was a slight yet statistically significant difference in mean overall "social support" score between Wave 1 and each of the other waves.

Figure 16. Social support trends



During the FGDs, participants talked about linkages and influences of families:

> *"You have to see the families of the migrants. If we involve the families a little, it will be very interesting because the family also has an influence."*

> *"Visit our respective families in order to further strengthen the link between Volunteers and the IOM MaM-2 team."*

They also emphasized the importance of creating civil society associations:

> *"Overall, everything was good because it allowed us to have more training for ourselves, our personal activities, our different communities and for the association that we are going to set up."*

> *"Without collaboration, the association will not be able to advance. If we get along, we can move forward better."*

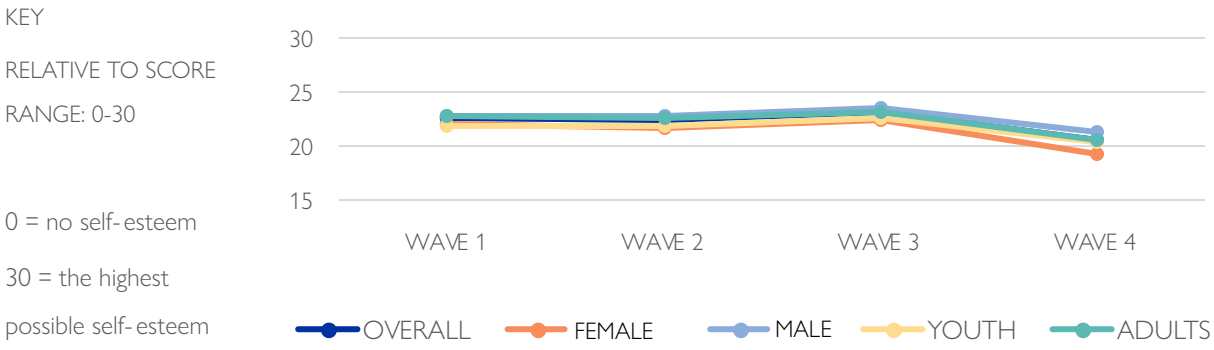
These qualitative data revealed that themes of strengthening family connections and setting up civil society associations of Volunteers were among the most important topics to discuss among participants.

These quantitative data show that, on average, participants entered MaM-2 with moderate levels of perceived social support from family, friends and significant others. Because the "social support" scale has items specific to family, friends, and "a special person", these scores reflect relationships external to the campaign as well as with peers in MaM-2. The significant positive trend in "social support" continued to slowly climb to a mean "high" level of "social support" for the overall sample by Wave 4. Between Waves 3 and 4, "social support" trended distinctly positively among participants. Women"s rate of mean score increase was faster than men"s between Wave 3 and Wave 4. This same time frame is also when women made their largest increase in "social support" scores. This is an interesting pattern, since women had the lowest mean "social support" score across all waves and their mean "social support" score at Wave 4 had not yet reach the level of men"s Wave 1 mean score.

SELF-ESTEEM

For overall "self-esteem", the mean score at Wave 1 was 22.6 and at Wave 4 was 20.1, out of a possible range of 0 to 30. The lowest mean "self-esteem" score for any group was 19.2 among women at Wave 4, which was slightly but significantly lower than the mean score among men (21.6) at the same timepoint. There was a statistically significant difference in mean overall "self-esteem" scores between Wave 2 and Wave 4 and between Wave 3 and Wave 4.

Figure 17. Self-esteem trends



Overcoming shyness, having confidence and strength, and feeling useful were possible experiences of MaM-2 involvement, among participants.

> *"The little training we had during the MaM project allowed us to get over our shyness and have the strength to accomplish our goal."*

"It allowed me to get out of myself and have confidence in myself because when I arrived, I felt useless, but now I feel useful in many different areas."

Participants" mean "self-esteem" scores were moderate at Wave 1, without differences across gender or age, and remained stable through Wave 3. This was followed by a significant negative trend between Waves 3 and 4, affecting women"s scores more than men"s. The qualitative data, gathered a few months after Wave 4, included themes of confidence and usefulness that participants could experience in relation to MaM-2 involvement, which mapped onto items in the "self-esteem" scale, as well as the "capacity for functioning and coping" scale. These qualitative data contrast with the quantitative data trends of stable and decreasing self-esteem among participants.

PATTERNS ACROSS THE MENTAL HEALTH AND PSYCHOSOCIAL WELL-BEING INDICATOR TRENDS

All initial levels of mental health and psychosocial well-being indicators for participants at Wave 1 were at "moderate" (or possibly "mid-high", though difficult to assess with relative scales) or "manageable" ranges. This also held for all gender and age groups, except the "distress intensity" score for youth, which was slightly closer to the "bad" than "manageable" level.

Four out of the five mental health and psychosocial well-being indicators trended slightly positively, for participants overall, between Waves 1 and 2, while the fifth ("self-esteem") was stable. Three out of the five mental health and psychosocial well-being indicators continued to trend positively for participants overall between Waves 2 and 3, while the other two ("self-esteem" and "social support") were stable. The positive trends between Waves 1 and 3 were significant for "personal well-being", "distress intensity" and "social support".[17]

Overall, the trends between Waves 3 and 4 for participants changed for each of the mental health and psychosocial well-being indicators: trends for "personal well-being", "capacity for functioning and coping", and "self-esteem" went from positive or stable to negative; the trend for "distress intensity" went from positive to stable; and the trend for "social support" went from stable to positive. The negative trend between Waves 3 and 4 was significant for "self-esteem". These changes in score trends from Wave 3 to 4 for all mental health and psychosocial well-being indicators could possibly have been related to MaM-2 involvement, which is explored in the next section. There were significant differences in mean scores across gender for at least one wave for each of the mental health and psychosocial well-being indicators and all gendered significant differences were patterned with women having worse scores than men. Mean scores were significantly different across gender at Wave 4 for each of the mental health and psychosocial well-being indicators. At Wave 3, mean scores were significantly different across gender for "distress intensity" and "social support". Mean scores were significantly different across gender for "personal well-being" and "social suppor"t at Wave 1. At Wave 2, mean scores were significantly different across gender for "social support" (mean "social support" scores were significantly different by gender at all waves).

There were significant differences in mean scores across age groups for at least one wave for two of the mental health and psychosocial well-being indicators – "distress intensity" and "capacity for functioning and coping" – and all significant differences by age were patterned with youth having worse scores than adults. Mean scores were significantly different across age groups for "distress intensity" and "capacity for functioning and coping" at Wave 1 and for "capacity for functioning and coping" at Wave 4.

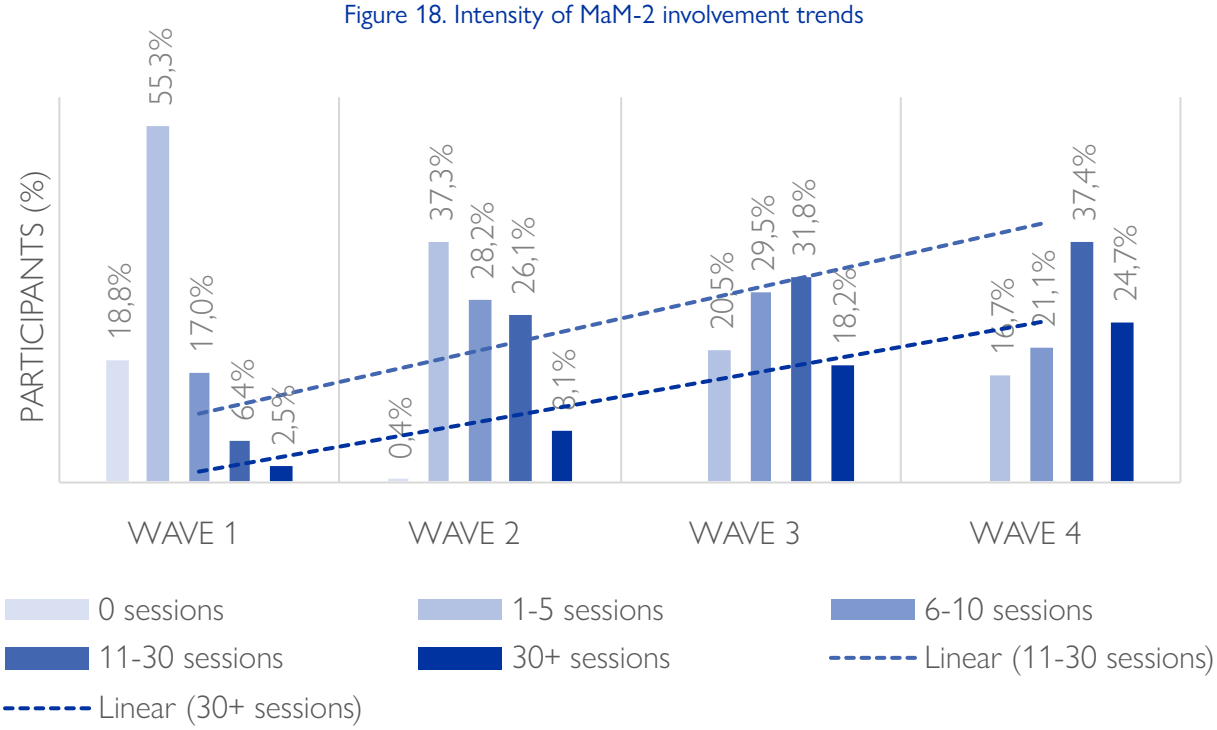
These findings ((a) positive and stable Wave 1 to 3 trends for each mental health and psychosocial well-being indicator, (b) initial scores of moderate psychosocial well-being and manageable distress, (c) differences by gender and age in mean mental health and psychosocial well-being indicator scores) could possibly have been related to MaM-2 involvement, as explored in the next section.

[17] It is unknown how large a significant difference in scores would need to be for it to be expected to represent an experiential difference among participants. It is reasonable that a 1-point difference on the distress intensity scale, such as the different between "manageable" and "bad" levels of distress, would be experientially meaningful, but probably not so on the personal well-being, "capacity for functioning and coping", or self-esteem scale.

TRENDS IN INTENSITY OF MAM-2 INVOLVEMENT AND ASSOCIATIONS WITH MENTAL HEALTH AND PSYCHOSOCIAL WELL-BEING INDICATORS

During Wave 1, most participants (55.3%) had attended between one and five MaM-2 sessions, with a little more than a quarter of the sample (25.9%) having already attended more than five sessions. At the other end of the spectrum, 18.8 per cent had attended no sessions at all before completing their first questionnaire. It is not surprising that some participants reported having attended upwards of six sessions during Wave 1 because 83 (26.4%) MaM-2 Volunteers had also been Volunteers during MaM-1[18] and because the start-up of sessions preceded Wave 1 data collection due the COVID-19 pandemic.

Figure 18. Intensity of MaM-2 involvement trends



Over the course of the data collection waves, progressively more participants reported having attended 11 to 30 sessions and 30 or more sessions. By Wave 4, most participants (62.1%) were reporting having attended these higher numbers of sessions. This increase in the intensity of MaM-2 involvement over time was found to be statistically significant from Wave 1 to Wave 3. Most participants attended one to two MaM-2 sessions or more, per month, over the course of at least a year.

At Wave 4, intensity of MaM-2 involvement was significantly different across gender, with a higher percentage of women reporting having attended 1–5 sessions and a lower percentage of women reporting having attended more than 30 sessions.

Higher levels of intensity in MaM-2 involvement were not significantly associated with any mental health and psychosocial support indicators at Wave 1 (see Table 7), indicating that initial scores of moderate psychosocial well-being and manageable distress among participants at Wave 1 were not likely the effect of MaM-2 involvement before Wave 1.

[18] No significant differences were found across age group or gender among the participants who were previous MaM-1 Volunteers. However, at Wave 1, the intensity of MaM-2 involvement among participants who had previously been a MaM-1 Volunteer, was significantly different than those who had not, with higher proportions of the MaM-1 alumni reporting already having attended 6 to 10 sessions, 11 to 30 sessions, and more than 30 sessions.

Table 7. Intensity of MaM-2 involvement and mental health and psychosocial well-being by wave

	Wave	Personal well-being	Distress intensity	Capacity for functioning/coping	Social support	Self-esteem
Intensity of MaM-2 involvement	1	Not significant	Not significant	Not significant	Not significant	1–5 sessions > 6–10 sessions
	2	1–5 sessions < 6–10 sessions	1–5 sessions -more "Bad", 11–30 sessions - more "Not at all"	1–5 sessions < 6–10 sessions	Not significant	Not significant
	3	Not significant	1–5 sessions -more "Bad", 30 or more sessions - more "Not at all"	Not significant	Not significant	Not significant
	4	Not significant	Not significant	Not significant	Means increase from 1–5 sessions through 30 or more sessions	6–10 sessions > 11–30 sessions and 30 or more sessions

Higher intensity in MaM-2 involvement was significantly associated with higher mean overall scores in "personal well-being" and "capacity for functioning and coping", in addition to lower mean overall score in "distress intensity" at Wave 2, as well as lower mean overall score in "distress intensity" at Wave 3. These associations indicate that the positive trends in "personal well-being" and "capacity for functioning and coping" among participants between Waves 1 and 2 and the positive trend in "distress intensity" among participants between Waves 1 and 3 could have been the effect of the significant trend of increasing intensity in MaM-2 involvement between Waves 1 and 3.

The positive "distress intensity" trend could also have been an effect of elevation bias, a pattern of participant reports of internal negative states being higher at initial measure, and/or attenuation effect, a pattern of participant reports of internal negative states being lower upon repeated measurement (Shrout et al., 2017).

In addition, the negative trends in "personal well-being" and "capacity for functioning and coping" and the stabilizing of the "distress intensity" trend at Wave 4 could have been the effect of lack of significantly increasing intensity in MaM-2 involvement between Waves 3 and 4.

Unexpectedly, higher levels of intensity in MaM-2 involvement were significantly associated with lower overall mean scores in "self-esteem" at Waves 1 and 4. This could indicate that the negative trend in "self-esteem" among participants between Waves 3 and 4 could have been the effect of increasing intensity in MaM-2 involvement.

The significant difference in mean scores across genders in all MHPSS indicators between Waves 3 and 4, with women having worse scores than men, could have been the effect of the significant difference by gender in intensity of MaM-2 involvement at Wave 4, at which women had a higher percentage of 1–5 sessions and a lower percentage of more than 30 sessions.

In addition, the significant association between higher intensity in MaM-2 involvement and in higher mean overall scores in "social support" at Wave 4, combined with the significant gender difference in intensity of MaM-2 involvement at Wave 4 could indicate that the positive trend in "social support" between Waves 3 and 4 may have been the effect of a significantly increasing trend in intensity of MaM-2 involvement between Waves 3 and 4 among women (or among men, even though it wasn"t significant for the overall sample). Without doing a regression, this cannot be tested. A visual comparison of means and standard deviations in "social support" across intensity in MaM-2 involvement levels at Waves 3 and 4 by gender (see Table 8) can offer insights into the relationships.

Table 8. Mean "social support" across intensity in MaM-2 involvement at Waves 3 and 4 by gender

Mean (s.d.) "social support" and difference in means						
	Female Wave 3	Female Wave 4	Female mean difference	Male Wave 3	Male Wave 4	Male mean difference
1–5 sessions	4.50 (0.96)	4.47 (1.23)	-0.03	5.07 (0.95)	4.91 (0.87)	-0.15
6–10 sessions	4.54 (1.18)	4.98 (1.01)	0.44	5.20 (1.14)	4.97 (1.19)	-0.23
11–30 sessions	4.68 (0.81)	4.95 (0.99)	0.27	5.04 (1.06)	5.23 (0.77)	0.19
30 or more sessions	4.02 (1.37)	4.79 (0.97)	0.77	4.91 (0.99)	5.47 (0.80)	0.56

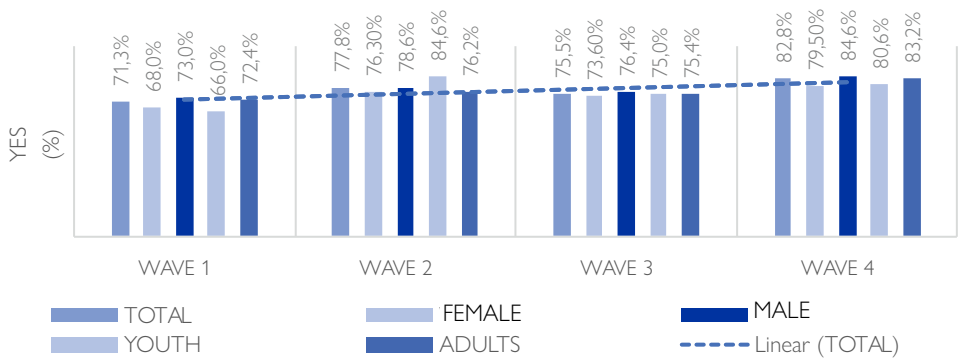
Women had greater increases and/or smaller decreases in mean "social support" scores between Waves 3 and 4 than men for all levels of intensity in MaM-2 involvement. Women"s mean "social support" score at the 30 or more sessions level was, however, lower than the 6–10 and 11–30 session levels at Wave 4, while men"s mean "social support" score at the 30 or more sessions level was higher than any other level at Wave 4. This pattern coupled with women"s higher percentage of having attended 1–5 sessions and lower percentage of having attended more than 30 sessions at Wave 4, compared to men"s, suggests that the positive trend in "social support" between Waves 3 and 4 could have been the effect of a significantly increasing trend in intensity of MaM-2 involvement between Waves 3 and 4 among men more than among women.

TRENDS IN MHPSS-INTEGRATED PEER-TO-PEER AWARENESS-RAISING ACTIVITIES AND ASSOCIATIONS WITH MENTAL HEALTH AND PSYCHOSOCIAL WELL-BEING INDICATORS

PEER INTERACTIONS PERCEIVED AS SOCIAL SUPPORT

The percentage of participants who reported finding supportive peers through MaM-2 during Wave 1 was 71.3 per cent, which increased to 82.8 per cent by Wave 4. This increase in the proportion of participants who found supportive peers between Wave 1 and Wave 4 was seen for all gender and age groups. There was a statistically significant increase between Wave 1 and Wave 4 in the percentage of Volunteers who found peers who support them.

Figure 19. Supportive peers in MaM-2 trends



Having a supportive friend in MaM-2 was significantly associated with higher mean overall scores in "personal well-being" and "social support" across all four waves, lower mean "distress intensity" scores at Wave 2 and higher mean "capacity for functioning and coping" scores at Wave 4 (see Table 9).

Table 9. Peers in MaM-2 as supportive and mental health and psychosocial well-being by wave

	Wave	Personal well-being	Distress intensity	Capacity for functioning/coping	Social support	Self-esteem
Peer interactions as social support (Supportive peers in MaM-2)	1	"Yes" has higher mean score	Not significant	Not significant	"Yes" has higher mean score	Not significant
	2	"Yes" has higher mean score	"Yes" has less Bad	Not significant	"Yes" has higher mean score	Not significant
	3	"Yes" has higher mean score	Not significant	Not significant	"Yes" has higher mean score	Not significant
	4	"Yes" has higher mean score	Not significant	"Yes" has higher mean score	"Yes" has higher mean score	Not significant

These associations indicate that the positive significant trend in "social support" between Waves 1 and 4 could have been an effect of the significant increase in the rate of participants having supportive peers in MaM-2 between Wave 1 and Wave 4. The positive significant trend of "personal well-being" between Waves 1 and 3 and the positive trend in "distress intensity" between Waves 1 and 2 could have been an effect of the increase in rate of participants having supportive peers in MaM-2.

In the FGDs, peer-to-peer interaction and support in MaM-2 was a rich topic of discussion. Participants explained how Volunteers could experience peer relationships as seeming like family:

> *"Every time I tell people I am family with all the Volunteers, I am family but there are exceptions. There are people who have taken me as their blood… so today I don"t see myself as someone who is rejected. We say that a family is not necessarily the same blood, but when someone accepts you as you are, it becomes more than a family, so the bond that I share with certain people in the Volunteer network goes beyond the word friendship."*

> *"We don"t have the same father or mother but we are sisters, even if we are not from the same family. That"s part of what the project brought me. I really liked the way we work together."*

Family-like relationships with peers in MaM-2 could be experienced by participants as characterized by social acceptance, belonging and cooperation. Participants could also possibly experience social bonding with, empathy for and acceptance of other Volunteers during structured monthly support meetings.

> *"These meetings are important because they create bonds between us although we don"t have the same experiences. We really try to put ourselves in the shoes of others and that makes us stronger."*

> *"Meetings lead us to accept others as they are. By being with each other, if you thought badly of the other person your idea of them gradually changes."*

Participants also explained that being a supportive peer could be an experience of providing mentoring:

> *"I say to myself that my peers and I form a family, so when you exchange with a peer and you see their psychological limits, it is up to you to adapt your way of bringing them up morally, to bring them to places to allow them to forget or to have exchanges that enable them to evacuate certain things. Personally, this is how I proceed. It often happens that we talk with a person, and we know that at some point they are psychologically affected, so we find a strategy to help them."*

> *"When migrants come back, I listen to them and after that I guide them in their decision-making because they are people who have not yet forgotten the way. And beyond that, I take the opportunity to reframe them by trying to become their friend."*

Providing mentoring among peers in MaM-2 could be an experience consisting of coaching, offering basic psychosocial support and befriending. Discussion of MaM-2 also related to the possible experience of expansion of social networks among participants:

> *"[MaM-2] allowed me to increase my number of friends and some have become my business partners."*

> *"[MaM-2] allowed me to know a lot about collaboration between us MaM Volunteers. It allowed me to know many Volunteers in Abidjan and Daloa. Before the project I didn"t know that I had so many colleagues."*

Expanding social networks could be experienced by participants as increasing numbers of friends among peer Volunteers relationships, some of whom could become business and/or collaboration partners.

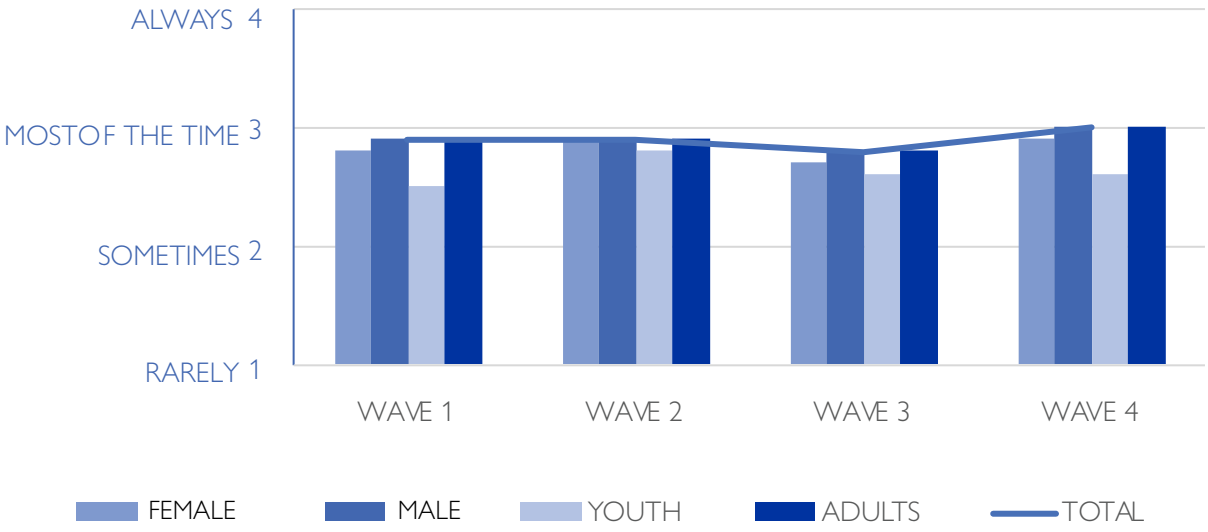
The qualitative data on peer-to-peer interactions indicate that MaM-2 offered participants experiences to get to know more returned migrant Volunteers. New peer relationships and friendships could be supported by empathy and acceptance of others, confer a sense of belonging and cooperation that felt almost familial, could find expression as caring mentorship and/or could lead to partnerships. These data help to qualify that support among peers in MaM-2 could be made possible through the created social networks of Volunteers and through structured support provided to groups of peer Volunteers. Furthermore, support could involve emotional, informational and practical, confirming that peer interactions could be perceived as social support, or the CB MHPSS activity of peer support.

The quantitative data indicate that most participants had found supportive peers in MaM-2 by Wave 1, and this percentage increased significantly by Wave 4. This could have been an effect of MaM-2 sessions starting before Wave 1, as well as the increasing intensity of MaM-2 involvement from Waves 1 to 3, providing opportunities for Volunteers to meet each other (this will be explored in the next section). The increasing development of such supportive peer-to-peer relationships with other MaM-2 Volunteers among participants likely contributed to the positive significant trend in "social support" across all waves and could have also contributed to the positive significant trends in "personal well-being" and "distress intensity" across shorter timeframes.

PEER-TO-PEER COMMUNICATION PERCEIVED AS COPING

During Wave 1, the mean score among all participants on the questionnaire item related to the activities of peer-to-peer communication to improve the perception of returnees, "talking about my experiences helps me to cope with painful memories," was 2.9 out of a possible 0.0 to 4.0 range. This score had very little fluctuation over the data collection waves and was 3.0 at Wave 4. At Waves 1 and 4, youth scores were slightly yet significantly lower than adult scores (youth: 2.5 and 2.6, respectively; adults: 2.9 and 3.0). There were no statistically significant differences over time.

Figure 20. "Talking about my personal experience helps me to cope" trend



Higher levels of peer communication to improve the perception of returnees ("Talking about my personal experience") as helpful for coping with painful memories among participants was associated with all five mental health and psychosocial well-being indicators but in varying patterns across the waves (see Table 10).

Table 10. Talking about personal experience helps coping and mental health and psychosocial well-being by wave

	Wave	Personal well-being	Distress intensity	Capacity for functioning/coping	Social support	Self-esteem
Peer communication as coping ("Talking about my personal experiences helpful for coping")	1	Rarely and Sometimes < Always	Not significant	Rarely and Sometimes < Always; Sometimes < Most of the time	Sometimes < Always	Sometimes and Most of the time < Always
	2	Not significant	Always has less Manageable and more Not at all	Sometimes and Most of the time < Always	Sometimes < Most of the time	Sometimes and Most of the time < Always
	3	Rarely < Always	Not significant	Means increase from Rarely through Always	Not significant	Not significant
	4	Sometimes < Always	Not significant	Rarely and Sometimes < Always; Sometimes < Most of the time	Rarely < Sometimes, Most of the time and Always; Sometimes < Always	Not significant

Higher levels of perceiving that talking about one"s personal experience was helpful for coping with painful memories was associated with higher levels of:

- "Capacity for functioning and coping" in all four waves, with shifts in the pairs of means at levels of talking about my personal experiences were significant. At Waves 1 and 4, where overall mean scores for "capacity for functioning and coping" means were lowest, the "rarely" level of talking about my personal experiences was involved in significant pairs. At Wave 3, where overall mean "Capacity for functioning and coping" score was highest, no pairs of levels in talking about my personal experiences were significant.
- "Personal well-being" at Waves 1, 3 and 4, with the "always" level of talking about my personal experiences involved in all the significant pairs, including for Waves 1 and 3, between which there was a statistically significant difference in mean overall well-being score.
- "Social support" at Waves 1, 2 and 4, with shifts in which pairs of means at levels of talking about my personal experiences were significant, and the most pairs occurring at Wave 4.
- "Self-esteem" at Waves 1 and 2, with the same set of significant pairs of means at levels of talking about my personal experiences: "sometimes" and "most of the time" were significantly less than "always".
- "Distress intensity" at Wave 2, with "talking about my personal experiences helps with coping with painful memories", "always" level having a lower percentage of participants with "manageable" distress but a much higher percentage of participants with distress being "no issue at all".

Looking at the coping aspects in the FGD data, telling one"s migration story could be a joyful, positive or even peak experience of MaM-2 involvement for participants.

"My best memory is the awareness-raising where we talk about our experience of the migration process."

"I feel joy in sharing my story, witnessing and saying what is in my heart - I feel good."

Self-awareness, self-acknowledgement, re-making of the self and having the courage to continue living could be part of an experience of discovery and the revelation that one has lived the same story as other participants in MaM-2.

> *"It"s the first time with people that we had the same stories…it served me to know who I am and to meet people with whom we had the same stories, so since that project, I know who I am… We know each other without even talking."*

> *"I tell my story after having listened to the peer in front of me. Just to let him know that we have lived through difficult situations, it is not a fatality, we can remake ourselves and we have to find the courage to go forward."*

Community-based testimony or storytelling could possibly be part of the experience among participants of having a life-saving mission.

> *"Whenever I have the opportunity to give a testimony, I do it with my heart because I tell myself that I am saving lives. As far as content creation is concerned, I do it for other associations without expecting anything in return, I tell myself that I got this knowledge through the projects, so I have to put it at the disposal of the different communities I belong to. In any case, it is in a fulfilling way that I do it."*

> *"One day I found out that my comrade was in Tunisia - I told her that it"s not worth going there, that it"s not good. She said no, it"s because you were afraid, that"s why you turned back. One day, when I learned that she had died, that"s when I decided to commit myself voluntarily."*

Relief, pride and confidence could be part of possible community-based testimony experiences for participants, as well as an emotional learning curve during which MaM-2 supportive structures were potentially appreciated.

> *"Being MaM Volunteers gives us the possibility of expressing ourselves... and this allowed us to release what was inside us and what was eating away at us. When you give your testimony, it"s as if you made a vacuum, you got rid of everything that was preventing you because it"s not easy to forget a misadventure, to forget all the atrocities that we have suffered, but MaM came and allowed us to do so, although it"s not easy to tell our stories."*

> *"During the activities, I didn't want to testify to avoid people feeling sorry for me, so I preferred to make videos because I felt sad and scared at the same time. As time went by, I managed to overcome all these difficulties and today I testify without any effort."*

This qualitative data indicates that telling one's migration story or testifying in the context of community could involve a wide variety of self, emotion and identity experiences among participants, ranging from peak positive emotions to emotional release and from living with purpose to being engaged in everyday processes of self-development. Emotions including joy, courage, relief, pride and confidence could be part of participants' talking about their experiences. These data also help to qualify that coping with painful experiences by talking about them could be made possible through MaM-2-facilitated opportunities for participants to use communication skills to express painful experiences. They can experience uplifting emotions by sharing stories through social media networks and giving public testimonies, confirming that peer-to-peer communication could be perceived as helpful to coping, similar to CB MHPSS community-based testimony methods and storytelling.

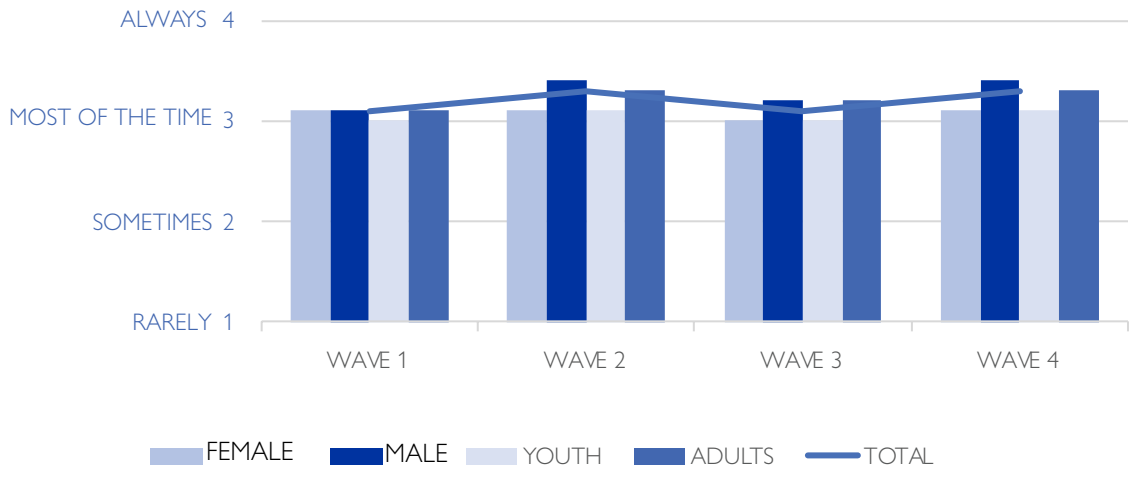
These quantitative data indicate that most participants perceived that telling one's own migration story, including as public testimony in the MaM-2 campaign, was "most of the time" helpful for coping, and that this perception was stable from Wave 1 until Wave 4. This could have been an effect of MaM-2 sessions starting before Wave 1, as well as the increasing intensity of MaM-2 involvement from Waves 1 to 3 creating opportunities for Volunteers to consistently receive this message (this will be explored in the next section). These data can also indicate that the baseline level of perception that "talking about my experiences helps me to cope with painful memories" was at a "most of the time" level among participants before MaM-2 sessions started, and so naturally remained stable. The perception could also possibly have been reinforced through participants' lived experienced of being able to cope with painful memories from engaging in telling their story to share on social media and/or through public testimony.

Higher levels of "capacity for functioning and coping' across all waves, as well as the significantly lower levels among youth, compared to adults, at Waves 1 and 4, could have been the effect of higher levels of perceiving that "talking about experiences helped one to cope with painful memories" across all waves, as well as significantly lower levels among youth, compared to adults, at Waves 1 and 4. Higher levels of "social support" at Waves 1, 2 and 4 could have been the effect of telling stories, listening to and recognizing shared stories among Volunteers. Lower levels of "distress intensity" at Wave 2 could have been the effect of higher levels of perceiving that talking about experiences helped one to cope with painful memories at Wave 2. Higher levels of "personal well-being" at Waves 1, 3 and 4 could have been the effect of joy, courage and relief, which could be part of telling one's story in the context of peer-to-peer communication. Higher levels of "self-esteem" at Waves 1 and 2 could have been the effect of confidence and pride in developing the capacity to engage in public testimony.

COMMUNITY ENGAGEMENT PERCEIVED AS WELL-BEING

During Wave 1, the mean score among all participants on "community engagement gives me a sense of well-being" was 3.1 out of a possible 1.0 to 4.0 range. By Wave 4, it had risen slightly to 3.3. The mean scores on this item, disaggregated by age and gender, all followed a similar pattern. At Waves 2 and 4, women were found to have scores of 3.1 and 3.1 respectively, which were slightly yet significantly lower than men's (3.4 and 3.4). No statistically significant differences over time were found.

Figure 21. "Community engagement gives me a sense of well-being" trends



Higher levels of perceiving community engagement as a source of well-being among participants was associated with all five mental health and psychosocial well-being indicators in varying patterns across the waves (see Table 11), with associations at all four waves for "personal well-being", "capacity for functioning and coping", and "social support" and associations at three of the four waves for "self-esteem". Higher levels of community engagement, perceived as a source of well-being, were not associated with lower "distress intensity" levels at Wave 1 and were associated with mixed levels of "distress intensity" at Wave 3. Unexpectedly, the highest mean of "self-esteem" at Wave 3 was associated with the lowest, "rarely", level of community engagement perceived as a source of well-being.

Table 11. Community engagement as sense of well-being and mental health and psychosocial well-being by wave

	Wave	Personal well-being	Distress intensity	Capacity for functioning/coping	Social support	Self-esteem
Community engagement as well-being	1	Rarely, Sometimes and Most of the time < Always	Not significant	Rarely, Sometimes and Most of the time < Always	Rarely and Sometimes < Always	Rarely, Sometimes and Most of the time < Always
	2	Rarely < Always; Sometimes < Most of the time < Always	Always has less Bad and more Not at all, Most of the time has less Very Bad	Rarely < Always; Sometimes < Most of the time < Always	Rarely and Sometimes < Most of the time and Always	Sometimes and Most of the time < Always
	3	Sometimes < Always	Always has less Bad but more Very Bad, Most of the time has more Not at All	Rarely and Sometimes < Always	Rarely < Sometimes, Most of the time and Always; Sometimes < Always	Means increase from Sometimes through Always, but highest mean is Rarely
	4	Sometimes < Most of the time and Always	Rarely has more Extreme	Sometimes < Most of the time and Always	Rarely and Sometimes < Most of the time and Always	Sometimes < Most of the time and Always

The qualitative data from the FGDs related to community engagement centered around possible experiences for participants when engaging in "Body Acceptance," a community-based psychosocial activity, in Côte D"Ivoire. Self-acceptance, self-expression and emotional expression were possible experiences related to this activity.

> *"It's a good thing because it allows us to express what we feel, even if it's indirectly. So for me, it's something to encourage."*

> *"Body Acceptance helped me to accept myself, to express myself, to believe in myself."*

Healing, growth, and self-knowledge could also be part of participants" experience. "Body Acceptance" opened possibilities for participants to experience a bi-directional relationship between freeing oneself and developing the ability to tell one's migration story as public testimony.

> *"Body Acceptance … really helped me a lot, it"s since that moment last year that I started to heal and started to grow."*

"For me, it was something very beneficial, because I didn"t know myself well before I came to Body Acceptance. The first time, I started to discover myself during the word draws and I started to heal."

"It"s a very good thing, as long as it served us first, ourselves, because stepping in front of an audience and telling your misadventure is not an easy thing, but at the same time, by doing it, you free yourself, it"s true… And frankly, it freed me today. I became manioc wood – everywhere you plant me I grow."

"MaM has positively influenced Volunteers because, at the beginning of the project, some Volunteers could not speak in public and now they can do it. And from that, I think it affects their well-being."

These qualitative data indicate that community engagement giving a sense of well-being could involve a wide variety of possible experiences of self, emotion and sociality processes among participants including self-acceptance, self-expression, self-knowledge, emotional expression, freeing oneself, healing, growth and becoming able to participate in public testimony. These data also help to qualify that receiving a sense of well-being from engaging with community could be promoted through MaM-2 activities designed to support the Volunteer community"s empowerment by participants organizing, leading and/or participating in community-based psychosocial activities, confirming that community engagement could be perceived as a source of well-being in MaM-2, like community engagement activities in CB MHPSS.

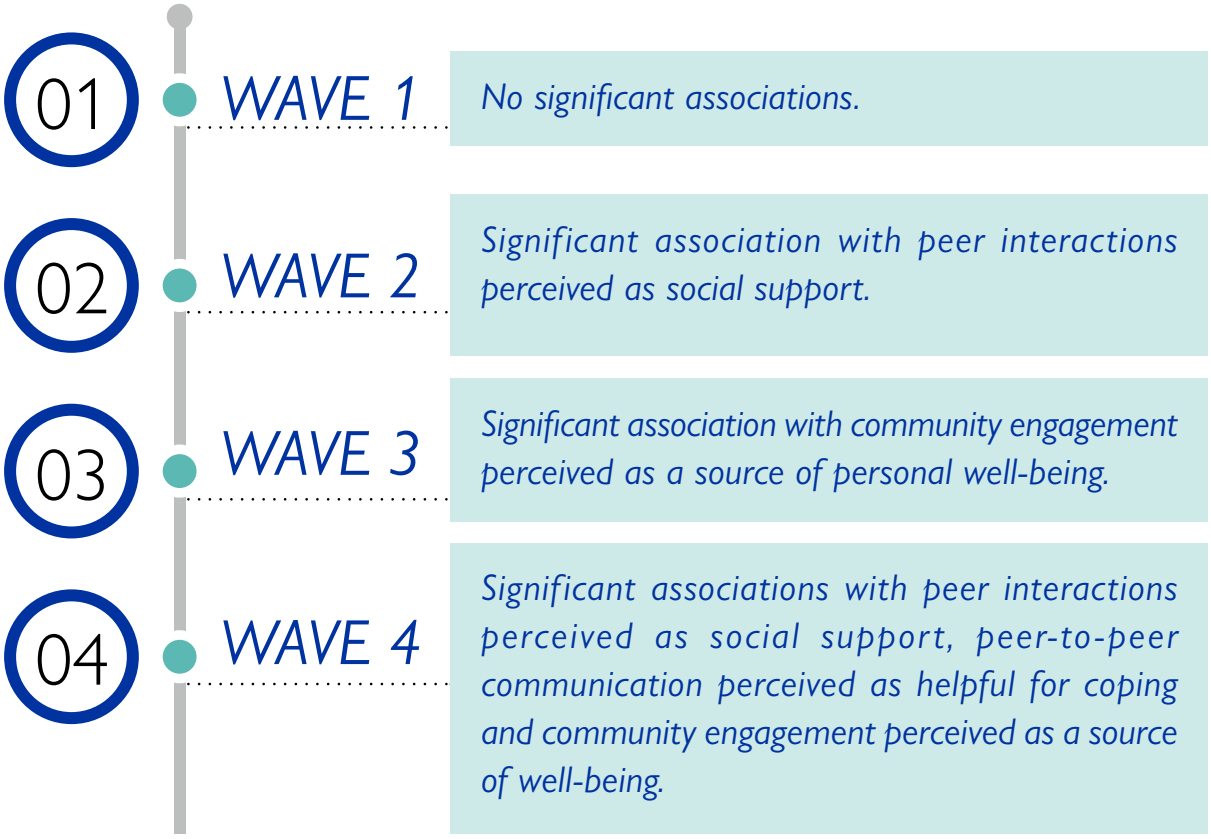
These quantitative data indicate that most participants perceived that community engagement was "most of the time" a source of well-being in the MaM-2 campaign and that this perception was stable from Wave 1 until Wave 4. This could have been an effect of MaM-2 sessions starting before Wave 1 as well as the increasing intensity of MaM-2 involvement from Wave 1 to 3 creating opportunities for Volunteers to consistently receive this message (this will be explored in the next section). These data can also indicate that the baseline level of perception that community engagement gives a sense of well-being was at a "most of the time" level among participants before MaM-2 sessions started up, and so naturally remained stable. The perception could also possibly have been reinforced through participants" lived experienced of community engagement through various community-based psychosocial support activities (like Body Acceptance), developing community-based testimony and storytelling opportunities for Volunteers, strengthening supportive structures for peer-to-peer engagement among Volunteers and directly engaging in community-based testimony.

Significant differences in mean scores across gender for all mental health and psychosocial well-being indicators at Wave 4 could have been an effect of lower mean scores in community engagement perceived as a source of well-being among women compared to men at Wave 4 along with its association with all five mental health and psychosocial well-being indicators at Wave 4. The significant positive trend of mean "personal well-being" scores between Wave 1 and 3 could have been an effect of association with significantly higher community engagement perceived as a source of well-being scores, and potential associated processes of self-acceptance, healing, freeing oneself and growth, from Wave 1 to Wave 3. The significant positive trend of mean "social support" scores between Wave 1 and 4 could have been an effect of association with significantly higher community engagement perceived as a source of well-being scores from Wave 1 to Wave 4. The stable mean "capacity for functioning and coping" scores from Wave 1 to Wave 4 could have been an effect of association with the stable mean scores in community engagement perceived as a source of well-being, and potential associated processes of becoming able to participate in public testimony and self and emotional expression, from Wave 1 to Wave 4. The stable mean "self-esteem" scores from Wave 1 to Wave 2 could have been an effect of association with the stable mean scores in community engagement perceived as a source of well-being, and potential association with self-knowledge, from Wave 1 to Wave 2.

ASSOCIATIONS BETWEEN INTENSITY IN MAM-2 INVOLVEMENT AND MHPSS-INTEGRATED PEER-TO-PEER AWARENESS-RAISING ACTIVITIES

Each of the three MHPSS-integrated peer-to-peer awareness-raising activities were explored in relation to intensity of MaM-2 involvement at each of the four waves.

Figure 22. Intensity of MaM-2 involvement associations with MHPSS-integrated peer-to-peer awareness-raising activities



- At Wave 1, there were no significant associations. This indicates that initial levels of peer interactions perceived as "social support", peer-to-peer communication perceived as coping and community engagement perceived as a source of well-being at Wave 1 were likely not an effect of participants" involvement in MaM-2 sessions before Wave 1. It also indicates that associations between MHPSS-integrated peer-to-peer awareness-raising activities and mental health and psychosocial well-being indicators at Wave 1 were not likely an indirect effect of MaM-2 involvement.
- At Wave 2, there was a significant association between peer interactions perceived as "social support" and intensity of MaM-2 involvement. This indicates that the significant associations between having a supportive peer in MaM-2 and higher levels of "personal well-being" and "social support" and lower levels of "distress intensity" at Wave 2 could be an effect of higher levels of intensity of MaM-2 involvement. Higher levels of intensity of MaM-2 involvement were independently associated with higher levels of "personal well-being" and lower levels of "distress intensity", so it is the association between having a supportive peer in MaM-2 and higher level of "social support" that intensity of MaM-2 involvement could be additionally affecting. This is unlikely given the strong conceptual and significant trend associations between peer interactions perceived as social support/peer support and social support in MaM-2.

- At Wave 3, there was a significant association between community engagement perceived as a source of well-being and intensity of MaM-2 involvement. This indicates that the significant associations between higher levels of community engagement being perceived as a source of well-being and higher levels of "personal well-being", "capacity for functioning and coping" and "social support" at Wave 3 could be an effect of higher levels of intensity of MaM-2 involvement. It also indicates that the significant associations between higher levels of community engagement being perceived as a source of well-being and mixed levels of "distress intensity" and "self-esteem" at Wave 3 could be an effect of higher levels of intensity of MaM-2 involvement. Higher levels of intensity of MaM-2 involvement were independently associated with lower levels of "distress intensity" at Wave 3. Because community engagement perceived as a source of well-being does not have a significant trend and intensity of MaM-2 involvement does have a significant trend that ends at Wave 3 with the highest levels of MaM-2 session intensity among participants, the association between "capacity for functioning and coping" and "social support" and community engagement at Wave 3 could be likely to be influenced by MaM-2 involvement. The association with personal well-being may be less likely due to the conceptual link between personal well-being and community engagement perceived as a source of well-being.
- At Wave 4, there was a significant association between each of the three MHPSS-integrated peer-to-peer awareness-raising activities and intensity of MaM-2 involvement. This indicates that:
    - Significant associations between having a supportive peer in MaM-2 and higher levels of both peer-to-peer communication being perceived as helpful for coping and community engagement being perceived as a source of well-being with higher levels of "personal well-being", "capacity for functioning and coping" and "social support" at Wave 4 could be an effect of higher levels of intensity of MaM-2 involvement.
    - Significant associations between higher levels of community engagement being perceived as a source of well-being with higher levels of "self-esteem" and lower levels of "distress intensity" at Wave 4 could be an effect of higher levels of intensity of MaM-2 involvement.
    - Significantly different scores among women and men across all mental health and psychosocial well-being indicators at Wave 4 could be at least a partial effect of higher levels of intensity of MaM-2 involvement.
- This also indicates that the:
    - Significant positive trend in peer interactions perceived as "social support" between Wave 1 and 4 could have been partially but not entirely an effect of the significant positive trend in intensity of MaM-2 involvement from Wave 1 to 3.
    - Stable trend in peer-to-peer communication as a perceived source of coping between Wave 1 and 4 was not likely an effect of the significant positive trend in intensity of MaM-2 involvement from Wave 1 to 3.
    - Stable trend in community engagement as a perceived source of well-being between Wave 1 and 4 could have been partially an effect of the positive trend in intensity of MaM-2 involvement from Wave 2 to 3.

MaM Volunteers participate in a hands-on workshop to learn how to edit videos on smartphones. © IOM 2021/Amanda NERO

One participant summarized the connections between involvement in MaM-2 with awareness-raising activity/ MHPSS mainstreaming variables and mental health and psychosocial well-being among Volunteers thusly:

> *"There is a mechanism that is put in place to allow the Volunteers to meet, exchange and share pleasant moments, all this has brought positive changes for all the Volunteers. Also by sharing our experiences we feel free and we reinforce our self-esteem. At the beginning of the project, most of those who made their testimonies public would start crying, but today this is no longer the case. So there has been a constant improvement."*

Overall, these data indicate that intensity of MaM-2 involvement could slightly yet significantly influence all mental health and psychosocial well-being indicators and gender differences in levels of mental health and psychosocial well-being indicators, especially at Wave 4. In addition, while MaM-2 sessions made access to the MHPSS-integrated peer-to-peer awareness-raising activities possible, they were perceived of by participants and operated as CB MHPSS activities. Thus, they could influence specific mental health and psychosocial well-being indicators and gender and age group differences in levels of mental health and psychosocial well-being indicators independently, and not just as indirect effects of MaM-2 involvement. This demonstrates that the MHPSS mainstreaming strategy could have been effective. Participants" increasing involvement in MaM-2 sessions over time and their experiences with MHPSS-integrated peer-to-peer awareness-raising activities together could have slightly yet significantly influenced all mental health and psychosocial well-being indicators and gender and age group differences across all waves of the panel study.

In Senegal, MaM Volunteers lead Street Art Together activities. © IOM 2021/Amanda NERO

PILOT STUDY STRENGTHS AND LIMITATIONS

By drawing on academic literature, MHPSS technical guidance, MaM-2 programmatic documentation, quantitative panel study dataset and qualitative FGD data, the MaM-2 MHPSS pilot study provides new insights into the potential effects of:

- MaM-2 involvement on Volunteers" mental health and psychosocial well-being;
- MHPSS-integrated peer-to-peer awareness-raising activities on Volunteers" mental health and psychosocial well-being;
- MaM-2 involvement and MHPSS-integrated peer-to-peer awareness-raising activities.

These insights can inform the strengthening MHPSS integration into future phases of the project and the development of technical guidance for mainstreaming MHPSS into awareness-raising and SBCC.

The study also provides insights into the feasibility of undertaking a future MaM mental health and psychosocial well-being impact study (or similar studies), which can inform the conceptualization and methodology of future mental health and psychosocial well-being impact studies of peer-to-peer migration awareness-raising campaigns more generally.

Despite these strengths, this study had several limitations. To make the study feasible, IOM staff participated in pilot study data collection, introducing social desirability bias as participants" responses to the administration of data collection tools could have potentially been influenced by their impression management in the context of IOM both implementing the MaM-2 campaign and carrying out the study. Because it was conceivable that very nearly all MaM-2 Volunteers would potentially want to participate in the study, a self-selected sampling strategy was used for the panel study, introducing selection bias that could potentially impact the representativeness of all MaM-2 Volunteers. The qualitative methods also did not use representative sampling, as it was outside the pilot study objective, which could further impact the representativeness. About half of the panel study participants completed less than all four waves of repeated measures, introducing whole-wave missingness bias, which is virtually inevitable in pilot longitudinal studies and can potentially impact the estimation of trends and potential effects. Though this pilot study aimed to test out various aspects of the methods, including the panel study, it was beyond the pilot study objective and scope to use statistical methods address the potential errors that can arise from repeated measures, introducing the potential risk of mischaracterizing changes across the data collection waves.

DISCUSSION

Understanding the effects of awareness-raising campaigns is critical to the well-being of youth and adult returnees in migration settings. There is evidence of harm experienced by migrants along irregular routes from West and Central Africa to Europe, and most studies have focused on the challenge of building the evidence base on campaigns" effectiveness to facilitate safe migration decisions (Tjaden and Gninafon, 2021). The MaM-2 MHPSS pilot study, alternatively, centered attention on the innovative field of investigating the possible mental health and psychosocial well-being effects among returned migrants who participated in the MaM-2 campaign as peer messengers, examining their involvement in campaign activities inclusive of peer-to-peer awareness-raising activities linked to community-based MHPSS approaches through MHPSS mainstreaming.

MaM-2 Volunteers who participated in the pilot study were a diverse group: 35.4 per cent were women, 19.2 per cent were youth, 26.4 per cent had been Volunteers during the MaM-1 campaign, and between 10.1 and 18.5 per cent were from each of the seven countries in West and Central Africa where MaM-2 was implemented. Most participants had negative experiences of migration (81.6%), had faced at least four protection risks during their migration journey (64.3%), and had faced at least one challenge upon return to their country of origin (97.5%). By the end of the four-wave, 18-month quantitative panel study, most participants had attended 11 or more MaM-2 sessions (62.1%), most had found supportive peers in MaM-2 (82.8%) and, on average, participants perceived that "most of the time" talking about their personal experiences helped them to cope with painful memories and their community engagement gave them a sense of personal well-being.

EFFECTS OF MAM-2 INVOLVEMENT ON VOLUNTEERS" MENTAL HEALTH AND PSYCHOSOCIAL WELL-BEING

Increased intensity of MaM-2 involvement was significantly associated with slightly better mental health and psychosocial well-being at 6, 12 and 18 months into the study although these associations were detected by different indicators or sets of indicators at each timepoint: "personal well-being", "distress intensity" and "capacity for functioning and coping" at Wave 2; "distress intensity" at Wave 3; and "social support" at Wave 4. All but the social support association occurred while the trend in intensity of MaM-2 involvement was significantly increasing for the overall sample between Wave 1 and Wave 3.

Intensity in MaM-2 involvement among participants was also significantly associated with specific MHPSS-integrated peer-to-peer awareness-raising activity variables at specific waves, indicating that it could have had an indirect effect on the slight but significant positive trends in "personal well-being" and "social support" at Waves 1, 2 and3, and "social support" also (and again) at Wave 4.

According to theoretical approaches to multilevel (multiple socioecological levels) social capital and mental health and well-being (Villalonga-Olives et al., 2018; Wind et al., 2021), participants" membership and participation in the community and social structures of the MaM-2 campaign – the Volunteer community, the returned migrant CSOs, the community-based and online-based social networks, the peer support structures – might mobilize social support and peer support and enable individual coping strategies, decreasing distress and increasing "personal well-being" at the individual level. Direct psychosocial support through participation in monthly supportive supervision sessions and community-based psychosocial activities as well as possible use of more focused or specialized MHPSS services through the strengthened linkages and referral pathways might also decrease distress and increase "personal well-being". From this perspective, the MaM-2 campaign might be understood as a multilevel social capital intervention, whereby increases in session attendance among Volunteers provides increased access to social capital (resources – including psychosocial resources – that can be drawn on through social networks and the value individuals ascribe to the resources) and its related mental health and psychosocial well-being (Kawachi and Subramanian, 2006).

These results on trends and associations in intensity in MaM-2 involvement with mental health and psychosocial well-being indicator variables and their positive trends are somewhat consistent with Parrish-Sprowl et al. (2020) findings on improved mental health and psychosocial well-being outcomes using a behaviour change and communication intervention approach with a Jordanian health-care organization supporting Syrian refugees, and studies on effects of cash transfer programmes, some of which have awareness-raising components, among refugees, which found mental health and psychosocial support effects (Hagen-Zanker et al., 2018; IRC, 2012).

Increased intensity of MaM-2 involvement was also associated with the lower "self-esteem" at Wave 4. Similarly, the lowest level "community engagement as a source of well-being" was associated with the highest mean "self-esteem" at Wave 3 but not Wave 4. This could make sense if higher levels of "self-esteem" decreased some participants" willingness to engage in MaM-2 sessions and with the community. However, considering the qualitative themes on "self-esteem", feelings of confidence and pride, and increasing self-knowledge, the marked decrease in "self-esteem" trend from Wave 3 to Wave 4 could also indicate a measurement issue.

GENDER AND EFFECTS OF MAM-2 INVOLVEMENT

Results showed that the significantly lower scores for all mental health and psychosocial well-being indicators among women compared to men at Wave 4 could have been, at least in part, an effect of significantly higher levels of intensity of MaM-2 involvement among men but not women. In addition, the significant difference across gender in "distress intensity" scores at Wave 3 could have been the effect of the significant positive trend in intensity of MaM-2 involvement.

Return migrants" mental health and psychosocial well-being is highly dependent on social and environmental factors (IOM, 2021c) and highly shaped by the social determinants of health, including gender (WHO, 2022). MaM-2 endeavored to address potential gender inequities through a gender mainstreaming approach, focused inclusion of women in all aspects of MaM-2. The gender difference in mental health and psychosocial well-

being scores could reflect that despite the gender mainstreaming, wider sociocultural patterns of gender inequity could not be prevented from affecting the MaM-2 community and social structures through which men might have consolidated more access to social capital than women.

EFFECTS OF MHPSS-INTEGRATED PEER-TO-PEER AWARENESS-RAISING ACTIVITIES ON VOLUNTEERS" MENTAL HEALTH AND PSYCHOSOCIAL WELL-BEING

Results from the mixed quantitative and qualitative data analysis validated that the three MHPSS-integrated peer-to-peer awareness-raising activities were perceived by most Volunteers to be resources for mental health and psychosocial well-being and were functioning like components of CB MHPSS. While there is growing recognition that MHPSS mainstreaming should be a norm in any area of the migration field (DRC, 2021; IOM, 2019b; Schininà et al., 2016; Weissbecker et al., 2019) and MHPSS information campaigns are becoming more common in migration and humanitarian settings (e.g. Alem et al., 2021; IOM, 2020c; IOM, 2019e; PAHO, 2019; Schininà and Popp, 2019), it is unknown if there are other examples of MHPSS integration into migration awareness-raising campaigns. These findings support the case for mainstreaming MHPSS in peer-to-peer migration awareness-raising campaigns.

Peer interactions were perceived by most participants as a source of social support, which is consistent with peer support and social support literature generally and prioritizing migrant populations (Albrecht and Goldsmith, 2003; Hernández-Plaza et al., 2006; Ho et al., 2022; Solomon, 2004). Peer support helps to build social connections (UNICEF, 2018) and social capital (Thomson et al., 2015). Finding a supportive peer in MaM-2 was associated with social support at all four waves, and they both significantly increased from Wave 1 to Wave 4, throughout the duration of the study.

Peer-to-peer communication (talking about my experience) was perceived as helpful for coping "most of the time" among participants. It"s similarity to community-based testimony methods and storytelling in CB MHPSS and relationship with coping is consistent with IOM CB MHPSS programming approaches (2021c) and literature on community-based testimony and storytelling (Igreja et al., 2004; King, 2014; Theisen-Womersley, 2021). "Talking about my experience helps me to cope" was associated with "capacity for functioning and coping" at all four waves, and they both remained stable at an above-mid, moderate level throughout the study.

Community engagement was perceived as a source of well-being "most of the time" among participants and was associated with "personal well-being" at all four waves. "Community engagement as a source of well-being" remained stable at an above-mid, moderate level throughout the study, while "personal well-being" slightly yet significantly increased between Wave 1 and 3. IOM (2021c) sees one objective of community engagement in CB MHPSS to be strengthening relationships, which facilitates the development of community structures and social networks, contributing to a supportive environment.

Each of the MHPSS-integrated peer-to-peer awareness-raising activity variables also showed significant associations with multiple mental health and psychosocial well-being indicators across multiple waves, meaning their effects could have been broadly supportive of participants rather than narrowly interacting with the single mental health and psychosocial well-being indicator named in their questionnaire item.

There were no significant trends for either talking about my experiences as helpful for coping or "community engagement as a source of well-being" – this seems likely to stem from the design of their questionnaire items not including an explicit linguistic reference to a tangible participant experience in MaM-2 (like the intensity in MaM-2 involvement and peer interactions perceived as supportive items both did) and an unknown number of participants being confused if either of these activities were experienced more like the feelings of another mental health and psychosocial well-being indicator.[19]

[19] Recall that these two scales are sub-sections of the same original adaptable well-being scale and also both include a few items from the same psychometrically strong well-being scale.

While the results of the data analysis suggest that trends in the MHPSS-integrated peer-to-peer awareness-raising activity variables and their significant associations with mental health and psychosocial well-being indicators could have been, at least partial, effects of intensity in MaM-2 involvement, they were not entirely its effects. Therefore, the MaM-2 MHPSS mainstreaming strategy and the MHPSS-integrated peer-to-peer awareness-raising activities contributed to ensuring that the mental health and psychosocial well-being impact of the MaM-2 campaign was maximized (Horn et al., 2016; IASC, 2021).

INSIGHTS FROM THE MAM-2 MHPSS PILOT STUDY TO INFORM MHPSS MAINSTREAMING IN AWARENESS-RAISING

The results of the MaM-2 MHPSS pilot study showed that MHPSS can be successfully integrated into a peer-to-peer migration awareness-raising campaign with returned migrants as peer messengers to optimize mental health and psychosocial well-being outcomes. Because very little technical guidance is available to support practitioners in designing, implementing, and evaluating MHPSS mainstreaming in awareness-raising and SBCC, insights from the study can be leveraged as a source of information to support integration of MHPSS into peer-to-peer migration awareness-raising campaigns that are theoretically grounded in SBCC and the systematic development of global guidance. Initial top-line insights were consolidated with select MaM-2 MHPSS mainstreaming strategy components and are presented here:

- MHPSS is understood to be a specialized and integral part of multisectoral programming across the humanitarian-development-peacebuilding nexus along with migration, including awareness-raising.
- Awareness-raising and MHPSS programmes and actors should work in close collaboration to advance MHPSS integration into peer-to-peer migration awareness-raising.
- The IASC (2007) MHPSS intervention pyramid (see Annex 10) is the foundational framework for multilayered MHPSS interventions in emergency and humanitarian settings, the IOM CB MHPSS approach, and the MaM-2 MHPSS mainstreaming strategy. It should guide MHPSS mainstreaming in awareness-raising.
- The integration of MHPSS and SBCC strategies can work synergistically to:
    - Change knowledge, attitudes, beliefs, perceptions (including stigma) and behaviours of community members, families and/or service providers towards people with mental health and psychosocial conditions[20] and returned migrants
    - Change social norms to create social contexts that lead toward youth having increased ability and autonomy to make informed migration-related decisions and the mental health and psychosocial well-being of all members of a society to be prioritized[21]
    - Generate wider participation and local ownership, and increased social capital,[22] among family, community and social structures that influence youth around migration-related decisions and influence well-being promotion among all their members
    - Generate active support, resources, and political-social commitment that create an enabling environment for sustaining increased ability and autonomy among youth to make informed migration-related decisions and increased prioritization of mental health and psychosocial well-being of all members of society among community members, families and/or service providers
    - Increase the percentage of migrants and returnees who are actively involved in participation in needs assessments, programme design, implementation and monitoring and evaluation for MHPSS-integrated peer-to-peer migration awareness-raising activities[23]

[20] See: IASC, *The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: with means of verification (Version 2.0)*, Geneva (2021).

[21] See: Compton, M.T. and R.S. Shim, The social determinants of mental health, *Focus* (2015).

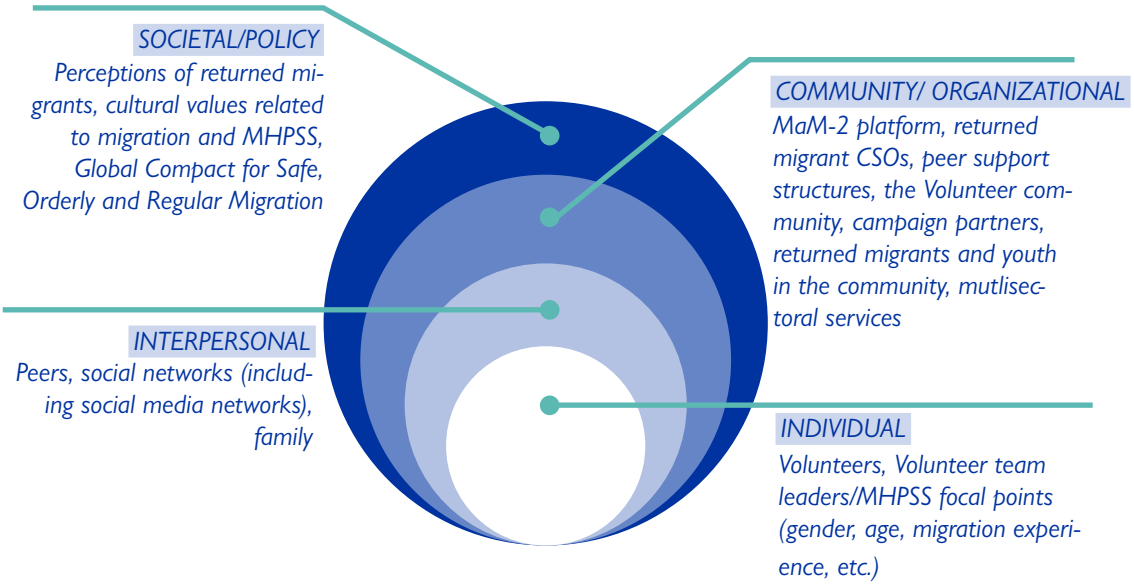
[22] See: IASC, *Common M&E Framework for MHPSS* (2021).

[23] Ibid.

- Increase the percentage of peer-to-peer migration awareness-raising staff and Volunteers who are trained and following MHPSS guidance on how to avoid harm[24]
- Increase the percentage of migrants and returnees who receive accessible information on self-help approaches for positive coping/well-being.[25]

- The socioecological model is common to both CB MHPSS and SBCC. A multi-level approach using the socioecological model is an effective framework for the integration CB MHPSS and SBCC-based peer-to-peer awareness-raising as it understands that both mental health and psychosocial well-being and social behaviour are affected by the interaction between individuals, groups, networks, communities, organizations and social, cultural and political contexts (see Figure 23).
  - Individual level: At the centre are individual returned migrant Volunteers and Volunteer team leads/MHPSS focal points and the characteristics of their identities, such as age, education and migration experiences, which can influence how a person behaves and their access to health, protection and other social and care resources.
  - Interpersonal level: Individuals are surrounded by interpersonal relationships with family, significant others, peers, friends and social networks, including social media networks, which have great potential to influence behaviours and be resources for health and well-being.
  - Community/organizational level: This level focuses on organizations and structures, such as multisectoral services (e.g. health services, social services), schools, religious organizations, neighbourhoods, local politics, mass media, and businesses and industry, and the networks between them that influence and determine the behaviour, health and well-being of community populations through institutional regulations, community customs, and the dissemination of information and knowledge as well as opportunities for returned migrants. The Volunteer community, returned migrant CSOs, peer support structures, campaign partners (journalists, civil society actors, influencers, artists, other migration stakeholders), returned migrants and youth with a desire to migrate in the community, and mutlisectoral services.
  - Societal/policy level: At the broadest level of the model are the cultural attitudes and ideologies, as well as policies (local, national, global), that have the potential to impact behaviour, health and well-being of community populations long-term, such as perceptions of returned migrants, cultural values related to migration and MHPSS, and MHPSS and migration policies.

Figure 23. Socioecological model in IOM CB MHPSS adapted for peer-to-peer awareness-raising migration



[24] Ibid.

[25] Ibid.

- MHPSS integration into peer-to-peer migration awareness-raising campaigns should support mental health and psychosocial well-being among migrating and returned children, youth, and adults of all genders; migrating and returned people"s families; migrating people"s communities and communities where people are thinking about irregular migration.
- MHPSS can contribute to:
  - Conducting a participatory, community-based psychosocial needs assessment in return migration settings to understand local patterns of coping with adversities, which kinds of coping skills are working and not working among individual returnees and communities, visions for MHPSS mainstreaming in peer-to-peer migration awareness-raising campaigns (see IOM, 2021c for a list of recommended MHPSS assessment tools; Kühhas et al., 2017).
  - Designing MHPSS indicators for the outcomes and impacts of peer-to-peer migration awareness-raising campaigns together with the community (Bragin, 2005; IASC, 2019) that align with the global guidance (!ASC, 2021). Consider including social impacts and outcomes for MHPSS such as communication, social connectedness, peer support, stigma reduction and community structures (Ubels et al., 2022).
  - Considering the psychosocial aspects of all awareness-raising activities and incorporating the principles of MHPSS: human rights and equity, participation, do no harm, building on available resources and capacities, integrated support systems and multilayered supports (IASC, 2007).
  - Raising public awareness about migrants, especially since return from irregular migration journeys and mental health issues are both stigmatized in many contexts, and self-stigmatization can be higher among migrant groups (see WHO, 2020). This includes increasing awareness of the mental health and psychosocial needs of returnees at the community level.
  - Raising MHPSS awareness among returned migrants, especially since people planning for return migration are often unaware of psychosocial re-adjustment challenges that can be faced during and upon return and rarely include mental health and psychosocial well-being in planning (Vathi, 2017).
  - Mainstreaming MHPSS considerations into capacity-strengthening activities with non-specialist MHPSS providers and peer messengers to support participants" understanding of how MHPSS is a priority for awareness-raising (see Schininà et al., 2016).
    - Training in basic psychosocial skills, such as psychological first aid, can enable Volunteers to provide returned migrants in the community and youth in the community thinking about migration with appropriate front-line support and linkage/referrals to more focused or specialized MHPSS services as appropriate.
  - Improving community capacity for rights-based, equitable, accessible, quality MHPSS service delivery for migrant children, youth and adults, and non-migrants, across multisectoral systems and structures (Schininà and Zanghellini, 2021).
  - Strengthening multisectoral MHPSS referral pathways. Effective MHPSS referral systems may be required to enable return migrants to equitably access high-quality focused psychosocial supports, mental health care in primary care, and/or specialized MHPSS services (IOM, 2017b, 2019d).
  - Strengthening peer interactions and informal peer networks to become a source of safe, meaningful, effective peer support (Hernández-Plaza et al., 2006; Ho et al., 2022).
    - Consider that, as a specific form of social support, peer support is an important resource for coping with distress, but it can also introduce additional stressors such as social obligations and dependencies, and exacerbation of distress among peers discussing shared situations of potentially traumatic experiences (Hobfoll, 2001; Spiritus-Beerden et al., 2021). Provide peer support training and supportive supervision to mitigate this risk (Peersman and Fletcher, 2019).
  - Strengthening peer-to-peer communication, such as public testimony and storytelling for campaign content production, to become a source of safe, meaningful, effective community-based testimony and storytelling (IOM, 2021c).
    - Consider that sociocultural activities and creative expression of migration experiences can support returned migrants" coping with distress or suffering, create opportunities for interaction with other returnees who share similar experiences, offer a sense of relief (Ahmad et al., 2018) and/or mobilize social support and

solidarity (Greene et al., 2022). However, talking about painful experiences can also inadvertently exacerbate distress for people in some contexts (Hechanova and Waelde, 2017).

  - Conduct a context analysis (or draw on needs assessment findings) to understand if and how talking about one"s irregular migration experience, or hearing peers" experiences, may or may not be a potential source of relief and/or distress in the specific cultural context. Given the mandate to "do no harm", it is essential that community-based testimony and storytelling facilitation methods avoid inappropriate exploration of distressing events (IOM, 2010).
  - To maximize mental health and psychosocial well-being and minimize the risk of harm, ensure that Volunteers and other returned migrants in the community are empowered to make informed decisions about whether or not to voluntarily opt in to tell one's migration story to create awareness-raising campaign content or offer testimony at community awareness-raising events (Peersman and Fletcher, 2019), mainstream MHPSS considerations into peer-to-peer interviews, and provide supportive accompaniment to return migrants giving testimony at community events.

- Strengthening community engagement to support mental health and psychosocial well-being:
  - Mainstreaming MHPSS considerations into group discussions, dialogues, and debates with returned migrants and community members, caravans, townhalls and youth outreach.
  - Guiding the design and implementation of community-based psychosocial activities.
  - Supporting Volunteer team leads/MHPSS focal points to develop peer support structures.
- Ensuring that MHPSS-integrated peer-to-peer awareness-raising activities are gender- and age-sensitive (IASC, 2019; Schininà & Popp, 2019).

INSIGHTS FROM THE MAM-2 MHPSS PILOT STUDY TO INFORM FUTURE STUDIES

Findings from the MaM-2 MHPSS pilot study showed that slight yet significant improvements in mental health and psychosocial well-being among returned migrant peer messengers at the centre of an MHPSS-integrated peer-to-peer awareness-raising campaign in the West and Central Africa region could be the effects of involvement in campaign activities and that demographic variables (i.e. gender and age group) as well as peer support, community-based testimony methods and storytelling, and community engagement could shape and contribute to these effects. It also showed that a quantitative panel study and qualitative semi-structured interviews and FGDs were feasible to conduct despite logistical challenges, and that a mixed-methods approach was valuable for providing grounded information about the mental health and psychosocial well-being of peer messengers to inform the design of the quantitative tool as well as broader and deeper information about participants" experience of involvement in campaign activities to add rigour to the data analysis.

FEASIBILITY

- The panel study recruitment strategy of IOM country offices inviting all MaM-2 Volunteers to participate resulted in a self-selected sample consisting of all but a small number of Volunteers. Though self-selection does not systematically produce a representative sample, the 314-participant sample in the pilot study was probably very nearly representative of MaM-2 Volunteers since it was almost a total population sample. The qualitative methods used convenience sampling from one country and representativeness could not be assumed for either Volunteers in Côte d"Ivoire or in all seven countries. Because future impact study designs will likely call for sample(s) to be representative, different recruitment and sampling strategies will probably be required.
- Most of the panel study participants had data for at least three of the four waves of repeated measurement and retrospective feedback on reasons for whole-wave missing data by IOM country offices pointed to logistical

challenges much more often than formal attrition. Real-time monitoring of data completeness and a sample refreshment approach, where additional participants are selected using the same criteria as the initial participants to respond to attrition and missing data (Mazen et al., 2019), can address this in future panel studies.

- Even though only 160 participants, just over half of the sample, completed all four data collection waves, there was enough power to test statistical significance on small changes across repeated measures using correlational techniques. More rigorous future panel studies with the objective to answer research questions with definitive, conclusive findings would be expected to have a planned data analysis pathway inclusive of regression analyses and a plan for statistically handling list-wise, pair-wise and whole-wave missing data to determine a sample size to produce enough power.
- Enumerator training was reinforced after Wave 1, however questions about data quality remained. To make an MHPSS impact study feasible, adequate dedicated time, budget and support are needed for staff training and mentoring needs, including ongoing support during data collection from study leads.
- The quantitative and qualitative tools appeared to be generally feasible since they generated a reasonable data set, although the distress scale linkage between asking about experiencing any distress, prompting for distress symptoms, and asking a global "distress intensity" rating may not have worked entirely well. An extremely small number of participants out of the 160 completers reported any signs of distress by Wave 4, which seems unlikely for any population, yet they all provided a rating of their "distress intensity" with a mean score of manageable, which is difficult to interpret.
- The mapping of MHPSS services available to participants and dissemination of information for linkage and referral was important for ensuring that participants had access to MHPSS services. These efforts required time, staff and budget. For feasibility, future studies can build MHPSS mapping and referral pathways strengthening into timelines to be completed before data collection begins.

RESEARCH DESIGN

- Consider convening a research advisory board for future MHPSS impact studies of migration awareness-raising campaigns, comprising an MHPSS technical research adviser, an awareness-raising technical research adviser, and representatives from the peer messenger community and other organizational stakeholders. This is a new area of study that can benefit from technical research advisory and community engagement.
- To enhance community engagement and empowerment, assess the possibility and fit of increasing participatory methodologies, such as the participatory development of mental health and psychosocial well-being indicators (Bragin, 2005), community engagement and co-learning through research (Wood and Kallestrup, 2021) and consultation with children and youth in the research design (IASC, 2014).
- Hypotheses for more rigorous future studies can be linked to a CB MHPSS/SBCC model to consider mental health and psychosocial well-being impact indicators beyond the individual level, investigate how SBCC supports MHPSS impacts and outcomes and how MHPSS mainstreaming supports awareness-raising outcomes, broaden indicators for peer-to-peer awareness-raising campaign involvement beyond the number of sessions to better reflect the suspected mechanism(s) of CB MHPSS, and clarify and refine existing MHPSS-integrated peer-to-peer awareness-raising activity indicators.
- Methods are driven by research questions. A panel study design may be appropriate for future MHPSS impact studies of multi-year awareness-raising campaigns, especially if implementation data can be systematically collected. Mixed methods helped to generate insights during the MaM-2 MHPSS pilot study. Expanding the scope of qualitative methods can be done in ways that help build narratives that are true to returned migrants" voices, be done in alignment with global MHPSS guidance (IASC, 2021), and possibly conceptually or practically bridge with peer communication/community-based testimony and storytelling activities in MHPSS-integrated campaigns. Mixed methods data analysis planning can enhance the rigor of future study approaches.
- Budgeting and planning can include a phased dissemination of findings, such as from early qualitative components and baseline analyses, formatted in multiple ways for different audiences and for communication with migrant stakeholders.

RESEARCH ETHICS

- Timelines for future studies can build in review of the research protocol by an ethics committee.
- Future studies can consider the role of research funders in influencing or setting research agendas, as funding connected to donor goals. Donor-researcher partnership approaches can be developed to assess and address risks of inadvertent research constraints and steering that could be an effect of donor policy agendas.

Bintou, MaM Volunteer from Guinea. © IOM 2021

RECOMMENDATIONS

1. Co-lead further into the MHPSS in awareness-raising/SBCC space.
2. Support the empowerment of returned migrants to collaborate on developing co-leadership models for MHPSS mainstreaming in peer-to-peer migration awareness-raising.
3. Increase MHPSS technical workforce capacity in migration awareness-raising at country and regional levels.
4. Cultivate technical specialty in MHPSS mainstreaming.
5. Prevent and reduce harm by acknowledging and accounting for power relations between groups across all levels of the CB MHPSS/SBCC-based migration awareness-raising social ecology.
6. Increase appreciation of the Volunteer peer messengers, their time, lived experience and voices as well as the participatory devices that sustain their engagement in the Volunteer community over time.
7. Innovate with Volunteers to develop and test new forms of content creation.
8. Co-create a participatory MaM-2 MHPSS mainstreaming workshop with Volunteers to reflect together on the pilot study findings and outline empowering decisions for MHPSS next steps.
9. Strengthen the selection and measurement of mental health and psychosocial well-being goal and outcome indicators and MoV based on the guidance provided in the IASC (2021) common monitoring and evaluation framework for MHPSS and Ubels et al. (2002) article on social outcomes of psychosocial support.[26]
10. Conduct rapid follow-up exploratory studies with the MaM-2 MHPSS pilot study dataset focusing on: migration experience, gender, urban/rural, youth; calling back study participants to recover missing data and re-analyse.

CONCLUSION

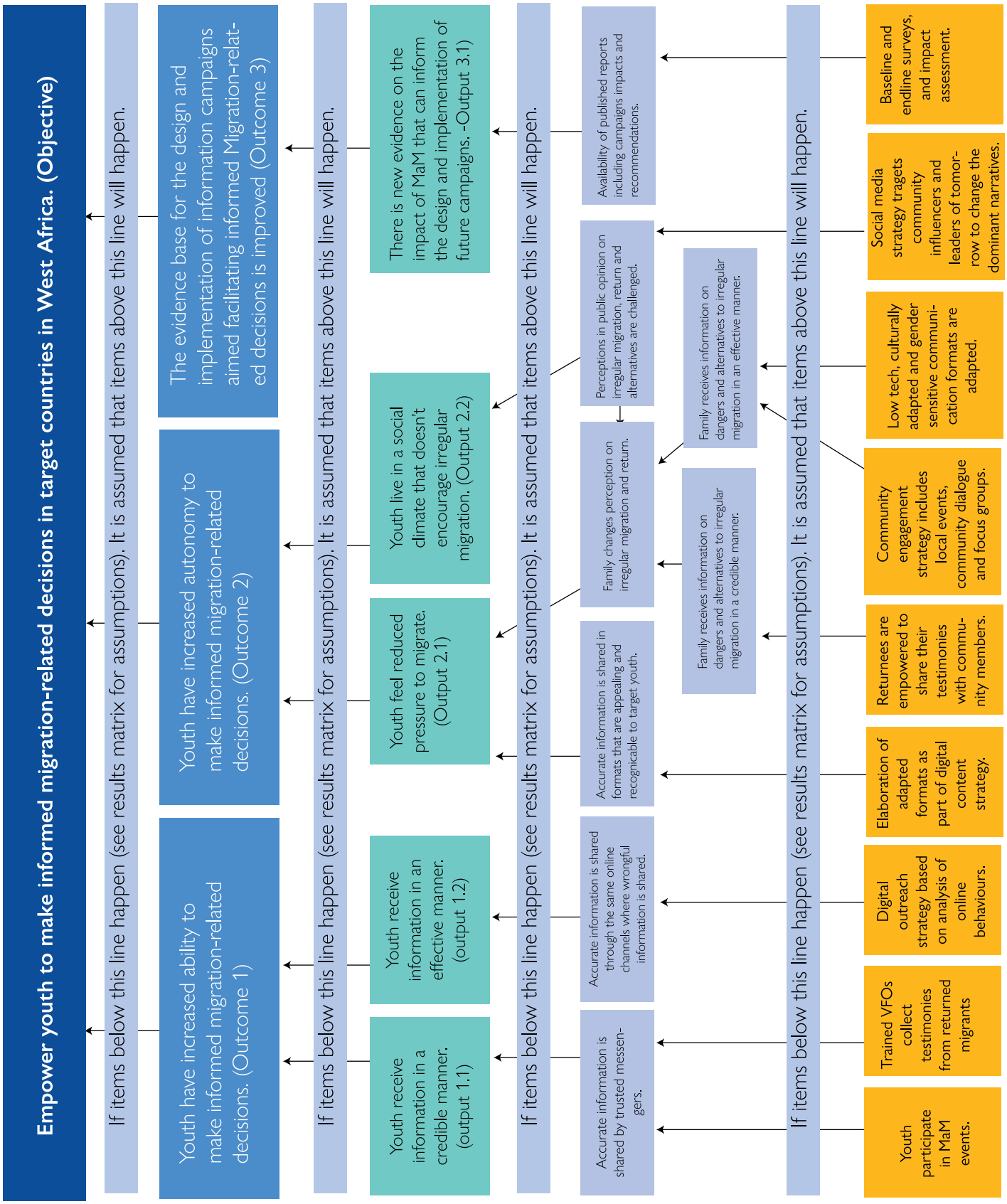
The purpose of the MaM-2 MHPSS pilot study was to explore the possible effects of being in the MaM-2 campaign on the mental health and psychosocial well-being among returned migrant MaM-2 Volunteers in West and Central Africa and the feasibility of the pilot study methodology. The quantitative focus was on variables of increased intensity in MaM-2 involvement, gender, age group, and MHPSS-integrated peer-to-peer awareness-raising activities in relation to five indicators of mental health and psychosocial well-being, The qualitative focus supplemented the results of the quantitative panel study with FGD data on perceptions and experiences of being peer messengers in MaM-2, peer interactions, peer-to-peer communication and community engagement. Likely small but significant effects of intensity of MaM-2 involvement and MHPSS-integrated peer-to-peer awareness-raising activities were identified including positive trends in personal well-being, "social support" and "distress intensity" among a sample of MaM-2 Volunteers that was nearly a total population sample. The mixed-method research design, quantitative panel study and qualitative methods were feasible. These conclusions may help inform the development of MHPSS mainstreaming guidance for awareness-raising and SBCC in migration settings and future MHPSS impact studies of peer-to-peer migration awareness-raising campaigns.

[26] Recommendation details: Maintain the social support indicator and scale; Add a qualitative MoV for social support; Select at least one of the "increase the percentage …" outcomes referenced in the "insights… to inform MHPSS mainstreaming in awareness-raising" section (above) and a qualitative or quantitative MoV to measure it; Select at least one mental health and psychosocial well-being impact indicator for each level of the CB MHPSS/peer-to-peer awareness-raising socioecological model (individual, interpersonal, community, societal) and select a quantitative or qualitative MoV for each; If the personal well-being, distress, coping and functioning indicators at the individual level are maintained, select new MoV"s for each of them aligned with the IASC common framework; Review the content on adapting existing MoVs to local contexts or creating new ones (pp. 4, 57-59, and 118) and apply as appropriate.

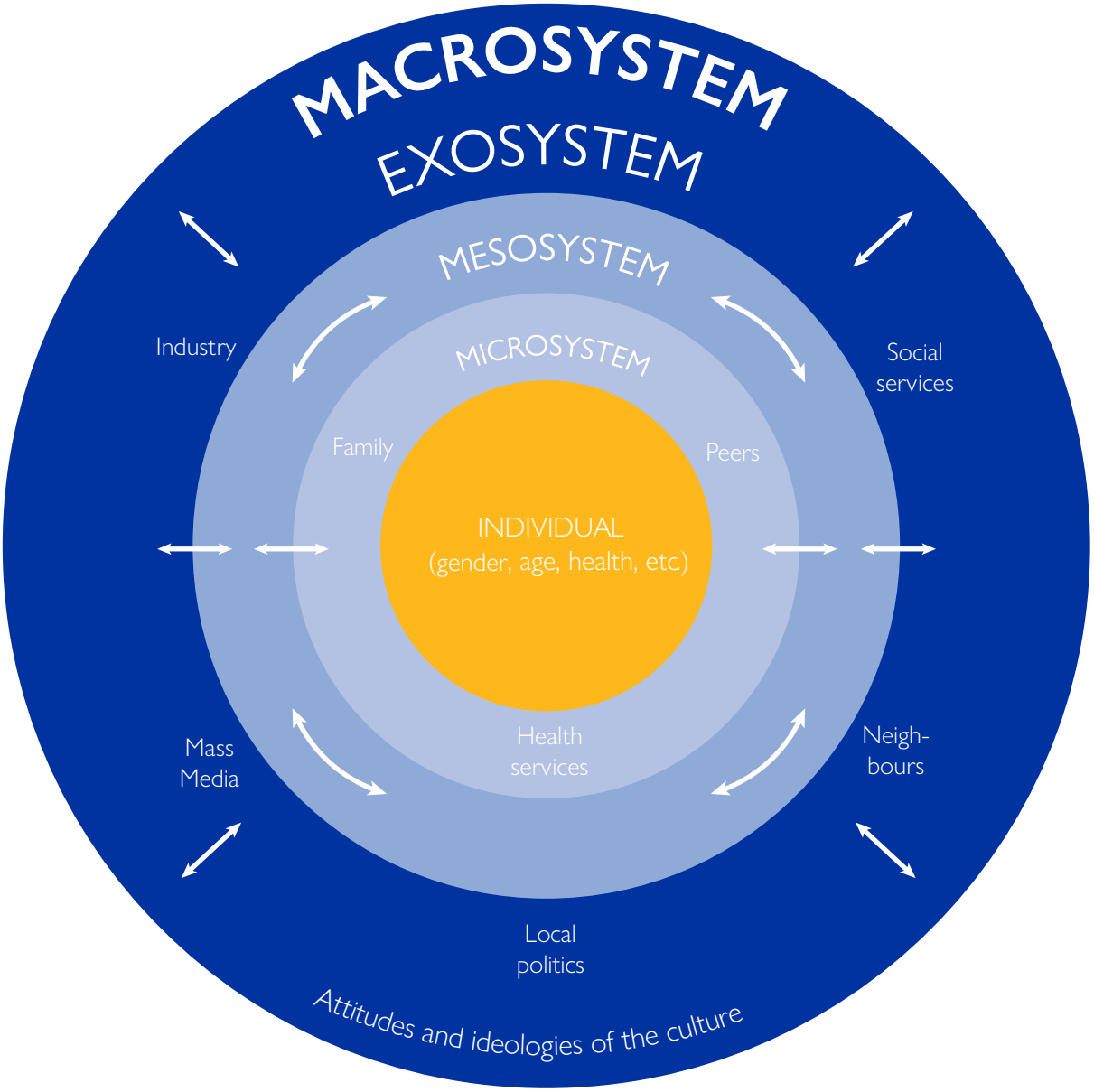
Annexes

ANNEXES

ANNEX 1. MAM-2 THEORY OF CHANGE



ANNEX 2. THE SOCIOECOLOGICAL SYSTEM IN CB MHPSS



Source: IOM, *Manual on community-based mental health and psychosocial support in emergencies and displacement*, Geneva (2021).

ANNEX 3. INTEGRATION OF IOM CB MHPSS APPROACH INTO MAM-2 AREAS OF INTERVENTION

The content below is excerpted from the MaM-2 MHPSS mainstreaming strategy document (IOM ROWCA, 2021:9–11).

The integration of IOM"s MHPSS approach into MaM-2 is implemented through the following identified areas of intervention:

1. PILOT STUDY AND SUSTAINABILITY

The MaM-2 awareness-raising team, working closely with the support of the Global Migration Data Analysis Centre (GMDAC), implemented a study (Annex 1 & Annex 2) to investigate further the linkages between participatory awareness-raising activities and community-based MHPSS approaches and to strengthen evidence-based programming in this innovative field. More specifically, the study assesses whether those returning migrants that participate in MaM-2 as messengers benefit from their engagement in terms of mental health and social-psychological well-being. Experience from the first phase of MaM has shown that returning migrants can find a community of peers through participating in MaM as Volunteers. In addition, talking about their migration experiences and journey may allow returnees to deal with trauma and to mitigate fears of being stigmatized by the community. The planned pilot study is designed to collect evidence of such effects through a longitudinal survey with all participating Volunteers.

The study was designed by MaM-2 regional awareness-raising team and GMDAC in consultation with IOM"s MHPSS. The questionnaire has been revised by the MHPSS expert for the next rounds of data collection. The survey is implemented in collaboration with the IOM country missions. Survey participants are interviewed in regular intervals over the course of their involvement in MaM which may range from 6 months to 3 years. In addition to collecting quantitative survey data, the team conduct focus groups with participating returnees to improve the survey and provide further qualitative information about changes in social-psychological well-being. MHPSS professionals based in each participating IOM mission should be involved as much as possible.

2. CAPACITY BUILDING ACTIVITIES (DETAILED IN ANNEX 4. MHPSS COMPONENT IN MAM-2 TRAININGS: CAPACITY BUILDING AS AN EMPOWERMENT PROCESS AMONG RETURNEES)

2.1 MHPSS capacity-building component included in MaM-2 Training"s toolkit-package addressed to all MaM-2 Volunteers

A MaM-2 Training Session addressed to all the Volunteers has been developed and includes practical modules on how to:

- Strengthen interpersonal, communication and interviewing skills with a focus on peer-to-peer interactions;
- Understand key aspects of peer-to-peer psychosocial support/community-based MHPSS intervention;
- Psychological First Aid[27] (PFA);
- Prevent harmful practices.

2.2 One-day MHPSS training included in the Training of Trainers for a selected number of MaM-2 Volunteers

A smaller group of MaM-2 Volunteers participated in a Training of Trainers (ToT) aimed at preparing the participants to provide support as co-facilitators in capacity-building activities for new Volunteers, as well as assume the role of MHPSS Focal Persons during on-the-ground activities.

[27] WHO, *Psychological First Aid: Facilitator"s manual for orienting field workers*, Geneva (2013).

A one-day training module is added to the ToT package, based on the model of the IOM MHPSS community-based interventions. Such training is optional but recommended and delivered by IOM MHPSS officers when available in MaM-2 country offices or by other identified qualified IOM staff or Partners (International non-governmental organizations and other UN agencies) involved in MHPSS services provision. All of them should also have received the PFA training and the ToT on PFA.

3. ACCESS TO INFORMATION ON MHPSS SERVICES AND PROGRAMMES

Key information on existing MHPSS services and programmes (including IOM"s) has been consolidated at the country office level whenever possible and disseminated through MaM-2 activities. A simple and practical guide containing key referral information has been developed and distributed to MaM-2 Volunteers, in case of identified psychosocial needs. Updated MHPSS service mapping information in the seven MaM countries has been uploaded on the WAKA Well platform.

4. CONTENT CREATION

MaM Volunteers, as members of their communities and people engaged in producing content for digital awareness campaigns, are invited to speak up about mental health in all its dimensions linked to migration. In most of the stories shared by migrants, they explained the challenges they face to feel fulfilled in their place of origin, hence they decided to leave, to find more self-development. This means mental health dynamics are a transversal component that needs to be considered in all the migration process, not only psychological distress as result of extreme violence faced on the road.

In migration, body and mind are engaged in the migration process and both are potentially submitted to a tough experience. IOM"s comprehensive approach integrates the body and mind"s considerations in the developed activities to support returned migrants to elaborate on their experience and re-discover their own and/or new resources. So basically, what the body undergoes, affects the mood, the way of thinking and feeling. A repetitive and stressful event which disturbed mind/mood can affect your body sensation. Following the "Do not Harm" principles, no one will be pushed to speak up. The whole process of MaM commitment is a way to support Volunteers in taking the ownership of their story and a way to share experience to raise awareness about the risk of irregular migration. As for all activities, it is only based on volunteering, even when it comes to selecting topics or conducting activities as a team.

In terms of content creation or production, it can consist of different element.

Interviews with the Volunteers with emphasis on:

- How they were/are affected (psychologically, morally, physically, spiritually), knowing that one area affects the others. Possible answers:
  - I felt I was not human anymore.
  - I believed that God had abandoned me.
  - I was afraid not to be able to walk anymore.

- How do they overcome from this?
  - I never prayed before but at that time I start praying.
  - I was talking to myself a lot.
  - I wanted to survive.
  - I was thinking about my family.
  - I had a good friend I could talk to.

- Where did they find support? And how did it work?
  - Another migrant I met helped me to adapt to the situation.
  - When I went to a doctor for the injuries, I met a nurse who took time to listen to me.
  - I found a place to play sports.
  - I was drawing (singing or anything else), small things, thinking
  - That at least I will leave my mark if I disappear.

- Interviews between the Volunteers, their peers and community members emphasizing:
  - What could they do to find some respite, some comfort during their migration journey?
  - What helped them to overcome difficulties, before leaving, during their migration, and upon return?
  - Has their migratory experience changed their

vision of the world, their relationship with religion and tradition?

- All people are not like me, the way they talk, eat, behave is different.
- Before I would never accept to do such job, in my country, but there, I had to do things to survive; now I can see differently.
- I never cooked before; it was a woman"s thing.

Digital campaigns around mental health, such as World Mental Health Day.

Elaborating more on the reasons for leaving (e.g., what is behind economic or social reasons) may allow us to talk differently about the conflicts (internal or family conflict) that occur in all migration stories and processes, but here, it is important to ensure consent to publish a private story.
These are sample questions that can be used to create content.

Different angles could be used and involve a larger network of friends, family and peers of the returned migrant (how they look at them, what do they imagine about their pain and suffering, how do they understand their choice to leave and then to come back...).

5. COMMUNITY-BASED INTERVENTIONS

While conducting some community-based activities, Volunteers may identify people in need of mental health and psychosocial support. Being informed/trained on mental health and knowing where basic MHPSS services can be found, can help Volunteers in increasing awareness and in deconstructing the stigmatization of psychological distress in a community and stigma towards migrants.

Awareness-raising activities/campaigns that include messages around mental health, stigma and migration can also be carried out. Each Volunteer group can think about developing mental health prevention materials, such as pamphlets or brochures presenting specific situations of migration and the understanding that one can have from a mental health point of view (e.g.: the effects on well-being of violence, loss of social ties and emotional distress, fear and anxiety).

These will have to be revised by a MHPSS expert to frame the right message. Community-based interventions, such as the ones included in the document on evidence-based MHPSS activities can be conducted to support psychosocial well-being.

6. MHPSS SUPPORT FOR THE VOLUNTEER

As mentioned above, on the entire migration process, the volunteering engagement in the MaM programme, might expose the returned migrants to different stressors. Speaking up could awaken difficult emotions and memories about their experience but talking is not always considered as a relief in some cultures.

Although, once expressed, they all acknowledge the benefit of talking and sharing their experiences. Group discussions with Volunteers show that talking about common knowledge during a campaign event or on video is easier than talking about more intimate subjects such as what really drives people to leave, or when singular experiences have affected people in their dignity and integrity. Based on this discussion, it will be relevant to propose a monthly group discussion (like a "clinical supervision" or InterVision) with the Volunteer, facilitated by a mental health professional (IOM or external consultant), as a private moment, insisting on the confidentiality of what is shared in the group.

ANNEX 4. MHPSS COMPONENT IN MAM-2 TRAININGS: CAPACITY BUILDING AS AN EMPOWERMENT PROCESS AMONG RETURNEES

The below is excerpted from pages 20-23 of the MaM-2 MHPSS mainstreaming strategy document (refer to Annex 3).

In the seven MaM-2 implementing countries, the project aims at building an organic community of more than 300 Volunteers, returned migrants engaged in civic engagement and awareness-raising initiatives. To support returnees" empowerment and the sustainability of the action, an articulated and flexible set of capacity-building opportunities has been designed.

The different types of trainings are all conceived around the key concepts of participatory approach and peer-to-peer communication; they will not only empower the participants to collectively shape the campaign and its content throughout the project, but also contribute to building a dynamic and autonomous Volunteer-based community of returnees.

AN OVERVIEW OF MAM CAPACITY BUILDING OPPORTUNITIES:

- Training of Trainers: MaM Volunteers having one year of practice-based experience in participatory awareness-raising will follow a 4 to 5 days train-the-trainer workshop during and assist IOM staff with the training of newly recruited Volunteers and other stakeholders.
- Training of new Volunteers: By the end of MaM-2, the Volunteer community is expected to count 315 MaM Volunteers across the seven participating countries. A total of 39 trainings will be organized for new Volunteers and co-facilitated by trainer Volunteers.
- Skills training workshops for (former and new) MaM Volunteers tailored to the needs and interest of the returnees and the campaign. During MaM-1, Volunteers expressed interest in receiving further training in public speaking, video editing, fundraising, project management and social theatre. These skills will be incorporated through the flexible formula of skills training targeting smaller group of Volunteers based on their common interests.
- Partner training: workshops for journalists, civil society actors, influencers, artists, and other stakeholders on key migration topics such as the Global Compact for Safe, Orderly and Regular Migration, terminology and balanced reporting, which a parallel objective of fostering collaborations to disseminate MaM content and create sustainable synergies between the Volunteers community and the local civil society.

MHPSS COMPONENT IN THE TRAINER OF TRAINERS OF MAM[28]

Sustainability is one of the reasons supporting the choice of working on a smaller group of experienced Volunteers with a ToT approach, it will allow 63 Volunteers to become team leaders and models for the new Volunteers joining the MaM community. The goal of the MaM ToT process is to give experienced Volunteers the background knowledge, skills and practical experience on community engagement, digital storytelling and digital engagement.

Nine MaM-2 Volunteers per country will participate in a ToT preparing the participants to provide support as co-facilitators in capacity-building activities for new Volunteers and to assume a role of team leaders in on-the-ground awareness-raising activities. The latter includes peer-to-peer interviews, FGDs with other returned migrants or community members, debate facilitation, caravans, townhalls and student outreach. Volunteers will maintain in-depth and dynamic contact with the community, especially with other returnees, establishing trusting relationships with target groups for awareness-raising activities.

[28] IOM, *Formation- Migration et Santé mentale*, Brussels (2021).

For this reason, within the process of MHPSS mainstreaming in MaM-2, experienced Volunteers attending the ToT have been identified as the best placed to act as MHPSS Focal Persons during on-the-ground activities.

Therefore, the four days ToT package is complemented by two additional modules based on the model of the IOM MHPSS community-based interventions and PFA. Such one-day training will be optional and delivered by IOM MHPSS officers when available in MaM-2 Country Offices or by other identified qualified IOM staff.

The module will aim to:

- Create a deeper understanding and awareness of the mental health and psychosocial challenges of return migration;
- Create a deeper understanding and awareness of the peer-support mechanism and how to avoid harmful practices;
- Strengthen interpersonal, communication and interviewing skills with a focus on peer-to-peer interactions;
- Provide participants with tools such as PFA and basic counseling skills to act as MHPSS Focal Persons, enabling them to (1) facilitate empowering forms of bottom-up psychosocial support, (2) build more supportive community networks, (3) use creative tools to increase awareness on the mental health and psychosocial needs of returnees at the community-level.

Ensure that MHPSS Focal Persons can provide first-line emotional support or referrals to specialized MHPSS services available to those who need a more focused psychosocial support.

Using a participatory and interactive methodology, the module will be focused on the peer-to-peer relationship and implications seen through different prisms. The training will leverage the participants" knowledge based on their existing capacities and it will build on what trainees already know thanks to their previous engagement as MaM Volunteers. Firstly, it will create a deeper understanding of the necessary self-awareness regarding the participant"s path. How their own story, sociocultural values and identity can be seen as an asset and how their life experiences can positively influence their interactions/relationships with their peers.

Processes and challenges that are common to the whole MaM Volunteers community, such as the identity transformations that take place all along the migration cycle, with a focus on return migration and social reintegration, will be analysed. This will aim not only at raising awareness on the related mental health and psychosocial challenges, but also at highlighting resilience and positive activation of resources as key aspects that the participants have likely already experienced throughout the Volunteer engagement.

Peer-to-peer dynamics will be seen then through the prism of interpersonal communication skills, necessary to prevent harmful practices in peer-to-peer interviewing, as well as to build and manage supportive relationships.

Then, the peer-support mechanisms will be explored as a form of bottom-up psychosocial support that can be applied through MaM awareness-raising community-based activities. MaM Volunteers, who will act as MHPSS Focal Persons, will be equipped to increase awareness of the mental health and psychosocial needs of returnees at the community level and contribute to building more supportive community networks. They will also be shown how to identify people who need a more focused psychosocial support and provide first line emotional support or referrals to specialized MHPSS services available.

MHPSS PARTNERSHIP, TRAINING AND COORDINATION

During the MaM project, local organizations were created in some of the countries to continue awareness-raising on irregular migration or to provide different types of support to returned migrants.

In the perspective to build their capacity and ensure more sustainability, Country Offices should coordinate with local or international organizations in-country that can contribute to trainings or sharing experiences.

To strengthen the capacity of the IOM MaM team, as well as the Volunteers, in improving psychosocial self-awareness, some coordination efforts and partnerships can be developed for this purpose. Within the IOM team, some skills could also be needed to develop and reinforce the capacity of returned migrants. This would mean a better internal and external coordination to increase the quality of the services and the level of knowledge shared. Hence, the Volunteers will be able to transmit their knowledge to their peers, using the buddy system.

ANNEX 5. BASELINE QUESTIONNAIRE

1	**Introduction**	Thank you for your time. This interview will approximately take 30 min. Your involvement in MaM-2 will help other people in the community to understand the migration life-experiences and challenges through your direct testimonies. Now, this interview is about you and how you can benefit mentally, psychologically and socially from being involved in the project. This questionnaire is part of one of the studies IOM is conducting within the Migrants as Messengers project. This study aims at supporting the MaM Volunteers throughout the three years of project implementation to outline the relationship that there is between your direct engagement as MaM Volunteers through activities as trainings, peer-to-peer interviews, community-based awareness-raising sessions and your own psychosocial well-being. Conducting this study will help us to better understand your psychosocial needs and help us to provide you appropriate support if needed. After today's interview, we will recontact you again in several months for a follow-up interview.	*Notes*
2	**Consent**	□ Yes □ No	
	Contact & Demographics		
3	**First name**		
4	**Last name**		
5	**Telephone**	**Under which number can we reach you?**	
6	**WhatsApp**	**Are you using WhatsApp?**	
7	**Facebook**	**Are you using Facebook?**	

8	**Residence**	**Where do you currently live?** Guinea □ Town:_____ □ Neighborhood: _____ Côte d'Ivoire □ Town:_____ □ Neighborhood: _____ Liberia □ Town:_____ □ Neighborhood: _____ Nigeria □ Town:_____ □ Neighborhood: _____ Senegal □ Town:_____ □ Neighborhood: _____ Sierra Leone □ Town:_____ □ Neighborhood: _____ The Gambia □ Town:_____ □ Neighborhood: _____	
9	**Age**	**How old are you?** _____	
10	**Gender**	**What is your gender?** □ Male □ Female □ Other	
11	**School**	**What is your school level?** □ Never attended school □ Primary □ Secondary □ University	
12		**Were you a Volunteer for MaM-1?** □ Yes □ No	
13	**Skills**	**Have you acquired particular job skills in the past?**	*Open text question*
MaM involvement			
14	**Motivation**	**What motivates you to volunteer with MaM2? (select multiple)** □ Financial support □ Meeting other returnees □ Preventing others from harm □ Nothing else to do □ Other	*Select all applicable* *Do not prompt*
14bis	**Other motivations**	**Please specify other reasons**	

15	**Intensity**	**How many MaM meetings have you attended so far?** □ This is my first session □ From 1 to 5 □ From 6 to 10 □ From 10 to 30 □ More than 30	*Select one* *Do not prompt*
16	**Friends**	□ Through your involvement in MaM, have you found peers that support you? □ Yes □ No	*Do not prompt* *[If needed, explain that a peer is a person who is of the same social status or close in age and/or share similar abilities or life experiences (e.g. youth, returned migrants, women)]*
		Migration experience	
17	**Time abroad**	**In total, how long did you stay outside of [your country] (in months)?**	
18	**Return date**	**When did you return to [country]?**	*Format month + year*
19	**Country**	**In which country did you spend most of your time during your migration journey?**	
20	**Experience**	**Overall, how would you describe your migration experience?** □ Extremely negative □ Very negative □ Negative □ Neutral □ Positive □ Very positive □ Extremely positive	*Do not prompt*
21	**Risks faced on migration journey**	**Have you experienced any of the following either before or during your migration process and/or upon return?** □ Violence (physical and psychological), □ Verbal harassment/racism, □ Exploitation, □ Abuse, □ Abduction, □ Threats, □ Captivity, □ Coercion, □ Witnessed violence/execution/gross human rights violations, □ Saw dead bodies/corpses, □ Other, □ Do not know, □ Refused	*Do not prompt* *Select all applicable*

21 bis	**Other risks**	**Specify other risks you faced**	
22	**Challenges upon return**	**Which challenges did you face upon return?** ◻ Unemployment, ◻ Rejection from family members, ◻ Rejection from community-members, ◻ Stigma, ◻ Violence, ◻ Lack of access to justice, ◻ Lack of access to education ◻ Lack of access to health care ◻ Other, ◻ Do not know, ◻ Refused	*Do not prompt* *Select all that apply*
22 bis	**Other challenges**	Specify other challenges	
23	**Challenges upon return**	**After your return home how would you rate the challenges you just mentioned?** ◻ Extremely challenging ◻ Very challenging ◻ Somehow challenging ◻ Easy ◻ Very easy ◻ Extremely easy	*Prompt* *Select one*
24	**Opportunities upon return**	**Which opportunities did you have upon return?** ◻ Study/training opportunity ◻ Civic engagement opportunity ◻ Access to justice ◻ Access to health care ◻ Reconnection with family members ◻ No opportunity ◻ Do not know ◻ Refused ◻ Other opportunity (not listed)	*Prompt* *Select all that apply*
24 bis	**Other opportunities**	**Specify other opportunities**	
25	**Major event**	**Have you experienced major event in your life (positive and/or negative) during the last six months?** ◻ Yes ◻ No ◻ Don't want to answer	
Psychosocial well-being			

26	**Well-being**	**When someone is "well" what words would you use to describe the way they feel? For example, what might be experiencing in their body, mind and heart?**	*Open text question* *[If needed, explain that you refer for instance to local description of hopefulness, optimism, self-esteem, thinking of the future; etc.]*
27	**Distress**	**When someone is "not well" what words would you use to describe the way they feel?**	*Open text question* *[If needed, explain that you refer for instance to local description of anger, despair, negative thoughts, physical symptoms]*
28	**Personal well-being**	**I am going to read a set of statement to you about your personal well-being. Please tell me if you agree or disagree with the statement based on how you have been feeling <u>over the past month.</u>** Circle the "1" for "rarely" Circle the "2" for "sometimes" Circle the "3" for "most of the time" Circle the "4" for "always" 1. I am able to have positive (good) feelings 1 2 3 4 2. Everyone has difficult feelings sometimes (feeling upset, sad, angry, anxious). I can manage my difficult feelings in healthy ways (without hurting myself or others) 1 2 3 4 3. I have been feeling cheerful 1 2 3 4 4. I have energy for the things I want to do 1 2 3 4 5. I have been feeling relaxed 1 2 3 4 6. I have been feeling optimistic about the future 1 2 3 4 7. I have been thinking clearly 1 2 3 4 8. I have been feeling good about myself 1 2 3 4 9. My community-engagement gives me a sense of personal well-being 1 2 3 4 10. I have been feeling interested in things that usually give me pleasure 1 2 3 4 11. I have been feeling distressed 1 2 3 4	*Prompt- select one*

29	**Feelings of distress**	**May you describe this feeling of distress?** ◻ Sleeping problems ◻ Tiredness/ Weakness ◻ Decreased concentration ◻ Constant worry /Anxiety ◻ Suicidal thoughts ◻ Nightmares ◻ Flashbacks ◻ Loss appetite ◻ Somatic complaints ◻ Irritable/angry ◻ Hyperactivity ◻ Fear ◻ Panic attacks ◻ Overwhelmed/unable to cope ◻ Low or sad mood ◻ Feeling worthless ◻ Hopelessness ◻ Cultural expression (please write down the words used to express distress, if any) ◻ Other, please specify bellow	*Do not prompt* *Select all applicable*
29bis		Please specify other cultural expressions	
29tri		Please specify other feelings of distress	
30	**Distress intensity**	**How severe is this feeling?** ◻ No issue at all ◻ Manageable ◻ Bad ◻ Very bad ◻ Extreme	*Prompt* *Select one*

31	**Capacity to function and cope**	**I am going to read a set of statement to you related to the coping strategies you use during difficult times. Please tell me if you agree or disagree with the statement based on how you have been feeling <u>over the past month.</u>** Circle the "1" for "rarely" Circle the "2" for "sometimes" Circle the "3" for "most of the time" Circle the "4" for "always" 1. I have the knowledge to take decisions in my life 1 2 3 4 2. I am able to meet the responsibilities in my life 1 2 3 4 3. I am able to adapt to challenges that arise in my life 1 2 3 4 4. I have been feeling useful 1 2 3 4 5. I have been dealing with problems well 1 2 3 4 6. I have been feeling confident 1 2 3 4 7. I have been able to make up my own mind about things 1 2 3 4 8. I have a voice in decisions that affect me 1 2 3 4 9. I can express to others the things that are important to me 1 2 3 4 10. Talking about my personal experience help me to cope with painful memories 1 2 3 4	*Prompt- select one*
32	**Coping**	**What helps you to deal with stress and worries?**	*Open text question*

33	**Perceived social support**	**Instructions: We are interested in how you feel about the following statements.** Read each statement carefully. Indicate how you feel about each statement. Circle the "1" if you **Very Strongly Disagree** Circle the "2" if you **Strongly Disagree** Circle the "3" if you **Mildly Disagree** Circle the "4" if you are **Neutral** Circle the "5" if you **Mildly Agree** Circle the "6" if you **Strongly Agree** Circle the "7" if you **Very Strongly Agree**	
		1. There is a special person who is around when I am in need.	1 2 3 4 5 6 7 SO
		2. There is a special person with whom I can share my joys and sorrows.	1 2 3 4 5 6 7 SO
		3. My family really tries to help me.	1 2 3 4 5 6 7 Fam
		4. I get the emotional help and support I need from my family.	1 2 3 4 5 6 7 Fam
		5. I have a special person who is a real source of comfort to me.	1 2 3 4 5 6 7 SO
		6. My friends really try to help me.	1 2 3 4 5 6 7 Fri
		7. I can count on my friends when things go wrong.	1 2 3 4 5 6 7 Fri
		8. I can talk about my problems with my family.	1 2 3 4 5 6 7 Fam
		9. I have friends with whom I can share my joys and sorrows.	1 2 3 4 5 6 7 Fri
		10. There is a special person in my life who cares about my feelings.	1 2 3 4 5 6 7 SO
		11. My family is willing to help me make decisions.	1 2 3 4 5 6 7 Fam
		12. I can talk about my problems with my friends.	1 2 3 4 5 6 7 Fri

34	**Self-Esteem**	**Instructions: Below is a list of statements dealing with your general feelings about yourself.** If you strongly agree, circle **SA**. If you agree with the statement, circle **A**. If you disagree, circle **D**. If you strongly disagree, circle **SD**. 1. On the whole, I am satisfied with myself. SA A D SD 2. At times, I think I am no good at all. SA A D SD 3. I feel that I have a number of good qualities. SA A D SD 4. I am able to do things as well as most other people. SA A D SD 5. I feel I do not have much to be proud of. SA A D SD 6. I certainly feel useless at times. SA A D SD 7. I feel that I'm a person of worth, at least on an equal plane with others. SA A D SD 8. I wish I could have more respect for myself. SA A D SD 9. All in all, I am inclined to feel that I am a failure. SA A D SD 10. I take a positive attitude toward myself. SA A D SD	

ANNEX 6: SEMI-STRUCTURED INTERVIEW GUIDE

The advantage of the semi-structured interview is that the interviewee is immersed in a conversation as opposed to a traditional question-and-answer session. It is the interviewer"s responsibility to prompt the interviewee at the right moment and to let them express themselves when necessary. A quick glance at the interview guide should help redirect the conversation if necessary.

THEMATICS	QUESTIONS/GUIDELINES	KEYWORDS
Introduction	Obtaining oral consent Background	N/A
Migratory Journey	GUIDING QUESTION: Can you tell us about your migration experience? Referrals if necessary: • Reason for departure • Family and community perception? • Misadventure on the road • Return experience	Journey, family, violence, purpose, perception of danger, stress, responsibility, information
Volunteering	GUIDING QUESTION: Why did you decide to volunteer as Migrants as Messengers? Orientation if necessary: • Family and community perception? • Personal goals • What impact? • Relationship with other Volunteers?	Solidarity, community, family, self-esteem, purpose, responsibility
Psychosocial well-being	GUIDING QUESTION: How do you feel mentally? Referrals if necessary: • Health • Social integration? • What challenges?	Stress, confidence, integration, family, community, trauma, self-esteem, employment status, feelings of shame
WHAT HAS THE MIGRANTS AS MESSENGERS EXPERIENCE BROUGHT TO YOU?		

ANNEX 7. FOCUS GROUP DISCUSSION GUIDE: QUESTIONS AND PROMPTS

MHPSS IN AWARENESS-RAISING FOCUS GROUP DISCUSSION GUIDE

BEGINNING QUESTIONS

- What did you think of the MaM project?
- When you think back about being a Volunteer with MaM, what is your fondest or most enjoyable memory?

TRANSITION QUESTION

- Tell us about positive experiences you had with connecting with migrant peers in MaM who support you?
- Tell us about any disappointments you had with connecting with migrant peers.

KEY QUESTIONS

- When you think about the testimony/storytelling you did in MaM, either for creating your own content or producing content other Volunteers or community members, how did you feel about speaking about mental health and psychosocial support (MHPSS)?
- How did you feel about the psychosocial support in the community engagement activities, for example like providing psychosocial support to others, raising awareness about psychosocial well-being or stigma and migration, or the body acceptance workshop?
- What did you think about the monthly focused group support meetings for Volunteers?
- Based on your experience in MaM, tell us about how you think using technology, like phones, for building migrant social networks can contribute to positive psychosocial well-being?
- Tell us about how you think using technology might detract from migrant psychosocial well-being?
- We are currently looking at the some of the MaM study results and it looks like when Volunteers first enter MaM many have feelings of both well-being AND sadness and distress. Overall, how do you think being in MaM influenced psychosocial well-being among Volunteers?

ENDING QUESTIONS

- Suppose that you had one minute to advise the head of IOM in West Africa on psychosocial well-being in awareness-raising activities on (irregular) migration. What would you say?
- Alternate question: Of all the things we discussed what is the most important?
- Thank you for all of those valuable thoughts. Have we summarized everything?
- The final question is, have we missed anything about how being in MaM might affect Volunteers' psychosocial well-being?

ANNEX 8: MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT INDICATORS BY DEMOGRAPHIC VARIABLES AT BASELINE

Table 12: Mental health and psychosocial support indicators by demographic variables at baseline

N = 314	Personal well-being	Distress intensity	Capacity for coping and functioning	Social support	Self-esteem
Overall sample	26.57	1.30	27.96	4.58	22.75
Age					
Youth	25.71	1.58	26.61	4.66	22.21
Adults	26.77	1.27	28.28	4.57	22.87
Gender					
Female	25.72	1.36	27.53	4.21	22.02
Male	27.03	1.31	28.20	4.79	23.14
Geographic area					
Rural	26.62	1.14	27.42	4.51	22.24
Urban	26.55	1.39	28.16	4.61	22.93
Education					
University	27.87	1.26	28.87	4.98	23.10
Secondary	25.98	1.35	27.32	4.37	22.18
Technical	28.05	1.10	29.70	4.60	23.95
Primary	24.44	1.61	26.55	4.33	22.55
Islamic schools	27.52	1.47	28.73	5.25	25.84
None	25.22	1.22	28.66	3.86	23.00
Other	25.40	1.20	27.50	4.51	20.50
Migration experience					
Negative	26.09	1.38	27.44	4.49	22.40
Neutral	28.08	1.08	28.91	4.88	25.08
Positive	28.82	1.10	30.63	5.03	24.08
Protection risks during migration					
>4 faced	26.26	1.31	27.79	4.52	23.03
0–3 faced	27.12	1.35	28.27	4.71	22.23
Challenges faced upon return					
>4 faced	25.44	1.44	26.98	4.18	22.00
1–3 faced	27.39	1.25	28.69	4.88	23.32
None faced	32.00	1.00	28.00	5.75	21.00
Intensity of MaM-2 involvement					
Low (0 ≤ 5 sessions)	26.60	1.27	28.22	4.69	23.60
High (6 ≤ 30+ sessions)	26.48	1.49	27.24	4.30	20.37

Significant associations filled in blue.

ANNEX 9: INTENSITY IN MAM-2 INVOLVEMENT, SUPPORTIVE PEERS AND MAM-1 VOLUNTEER BY GENDER AND AGE AT BASELINE

Table 13: Intensity in MaM-2 involvement, supportive peers and MaM-1 Volunteer by gender and age at baseline

	Overall N = 314	Women n = 111	Men n = 203	Youth n = 60	Adults n = 254
Intensity of MaM-2 involvement					
No sessions	54 (17.2%)	22 (19.8%)	32 (15.8%)	13 (21.7%)	41 (16.1%)
1 ≤ 5 sessions	177 (56.4%)	58 (52.3%)	119 (58.6%)	34 (56.7%)	143 (56.3%)
6 ≤ 10 sessions	52 (16.6%)	17 (15.3%)	35 (17.2%)	7 (11.7%)	45 (17.7%)
11 ≤ 30 sessions	23 (7.3%)	10 (9.1%)	13 (6.4%)	3 (5.0%)	20 (7.9%)
> 30 sessions	8 (2.6%)	4 (3.6%)	4 (2.0%)	3 (5.0%)	5 (2.0%)
Found supportive peers in MaM-2 (Yes)	222 (70.7%)	75 (67.6%)	147 (72.4%)	40 (66.7%)	182 (71.7%)
MaM-1 Volunteer (Yes)	83 (26.4%)	26 (23.4%)	57 (28.1%)	15 (25.0%)	68 (26.8%)

No significant associations.

ANNEX 10. IASC MHPSS INTERVENTION PYRAMID

The first layer of the pyramid refers to the protection of the well-being of all people through ensuring psychosocial and/or social considerations in the (re)establishment of basic services and security are taken. Security, adequate governance, and services that address basic needs, such as "food, shelter, water, basic health care and control of communicable diseases", should be provided in "participatory, safe and socially appropriate ways that protect local people"s dignity, strengthen local social supports and mobilise community networks." MHPSS responses in this level could include advocating for these services to be "put in place with responsible actors; documenting their impact on mental health and psychosocial well-being; and influencing humanitarian actors to deliver them in a way that promotes mental health and psychosocial well-being" (IASC, 2007).

The second layer refers to "Community and family supports" and draws attention to the importance of the role community plays in enabling the maintenance and improvement of the affected persons" mental health, specifying activities such as "family tracing and reunification, assisted mourning and communal healing ceremonies, mass communication on constructive coping methods, supportive parenting programmes, formal and non-formal educational activities, livelihood activities and the activation of social networks, such as through women"s groups and youth" (IASC, 2007). More specifically, the Guidelines recommend the facilitation of "conditions for community mobilization, ownership and control of emergency response in all sectors… community self-help and social support… conditions for appropriate communal cultural, spiritual and religious healing practices".

The third layer, focused supports, refers to support provided to people who "require more focused individual, family or group interventions by trained and supervised workers" (IASC, 2007).

The fourth layer, specialized services, refers to services provided to people who experience significant difficulties in basic daily functioning due to intolerable suffering, and to those who have severe mental disorders (IASC, 2007). Assistance should include psychological or psychiatric supports, "referrals to specialised services if they exist, or the initiation of longer-term training and supervision of primary/general health care providers" (IASC, 2007).

Source: IOM, 2021c, p. 26.

LIST OF REFERENCES

Adams, B., F. Vallières, J.A. Duncan, A. Higgins and J. Eaton.
2020 Stakeholder perspectives of Community Mental Health Forums: a qualitative study in Sierra Leone. Int *International Journal of Mental Health Systems*, 14(50).

Adler, N.
2019 People, heal thyselves: Nigeria"s new mental illness approach. *The Guardian*, Sept 25, 2019.

Afifi, R. A., Makhoul, J., El Hajj, T., & Nakkash, R. T.
2011 Developing a logic model for youth mental health: participatory research with a refugee community in Beirut. *Health Policy and Planning*, 26(6), 508-517.

Ahmad, A., L. Ahmad and J. Mannell.
2018 Responding to trauma during conflict: a case study of gender-based violence and traditional story-telling in Afghanistan. *Humanitarian Exchange*, 72:34-37.

Albrecht, T.L. and D.J. Goldsmith.
2003 Social support, social networks, and health. In: *The Routledge Handbook of Health Communication* (T.L. Thompson, A. Dorsey, R. Parrott and K. Miller, eds.). Routledge, New York.

Alem, M., S. Githaiga, E. Kiflom and L. Eloul.
2021 Programming to address suicidal behaviour among unaccompanied refugee minors in a camp setting: a field report from Ethiopia. *Intervention*, 19(2):233–241.

Baillie, M., S. le Cessie, C.O. Schmidt, L. Lusa, M. Huebner and Topic Group "Initial Data Analysis" of the STRATOS Initiative.
2022 Ten simple rules for initial data analysis. *PLOS Computational Biology*, 18(2):e1009819.

Bandura, A.
2001 Social cognitive theory: An agentic perspective. *Annual Review of Psychology*, 52(1):1–26.

Bangpan, M., L. Felix and K. Dickson.
2019 Mental health and psychosocial support programmes for adults in humanitarian emergencies: a systematic review and meta-analysis in low and middle-income countries. *BMJ Global Health*, 4(5):e001484.

Bawadi, H., Z. Al-Hamdan, Y. Khader and M. Aldalaykeh.
2022 Barriers to the use of mental health services by Syrian refugees in Jordan: a qualitative study. *Eastern Mediterranean Health Journal*, 28(3):197–203.

Bisong, A.
2022 Return, precarity and vulnerability in West Africa: evidence from Nigeria. In: *Migration in West Africa* (J.K. Teye, (ed.)). IMISCOE Research Series. Springer, Cham.

Bragin, M.
2005 The community participatory evaluation tool for psychosocial programmes: A guide to implementation. *Intervention*, 3(1):3–24.

Bronfenbrenner, U.
1979 *The ecology of human development: Experiments by nature and design*. Harvard University Press.

Christofides, N.J., S. Nieuwoudt, S. Usdin, S. Goldstein and S. Fonn.
2013 A South African university-practitioner partnership to strengthen capacity in social and behaviour change communication. *Global Health Action*, 6(1):19300.

Compton, M.T. and R.S. Shim.

2015 The social determinants of mental health. *Focus*, 13(4): 419–425.

Creswell, J. W. and V.L. Plano Clark.
2011 Choosing a mixed methods design. *Designing and Conducting Mixed Methods Research*, 2:53–106.

Danish Red Cross (DRC)
2021 Guidelines on mental health and psychosocial support in migration and displacement.

Davis, R., R. Campbell, Z. Hildon, L. Hobbs, and S. Michie.
2014 Theories of behaviour and behaviour change across the social and behavioural sciences: a scoping review. *Health Psychology Review*, 9(3):323–344.

de Graaf A.M., P. Cuijpers, D. McDaid, A. Park, A. Woodward, R. Bryant, D.C. Fuhr, B. Kieft, E. Minkenberg and M. Sijbrandij
2020 Peer-provided problem management Plus (PM+) for adult Syrian refugees: a pilot randomised controlled trial on effectiveness and cost-effectiveness. *Epidemiology and Psychiatric Sciences*, 29:e162.

Dickson, K. and M. Bangpan.
2018 What are the barriers to, and facilitators of, implementing and receiving MHPSS programmes delivered to populations affected by humanitarian emergencies? A qualitative evidence synthesis. *Global Mental Health*, 5:e21.

Dunsch, F., D. Tjaden and W. Quiviger
2019 *Migrants as Messengers: The impact of peer-to-peer communication on potential migrants in Senegal. Impact evaluation report*. International Organization for Migration, Geneva.

Elshazly, M., O. Rebolledo and S. Rosenbaum.
2022 Integration of mental health into emergency preparedness and response planning for the monsoon season in Bangladesh. *Intervention*, 20(1):114–118.

Esala, J.J., and S. Taking.
2017 Testimony therapy with ritual: a pilot randomized controlled trial. *Journal of Traumatic Stress*, 30(1):94–98.

Fargues, F., M. Rango, E. Börgnas and I. Schöfberger
2020 *Migration in West and North Africa and across the Mediterranean*. International Organization for Migration. Geneva.

Fortuna K.L., J.A. Naslund, J.M. LaCroix, C.L. Bianco, J.M. Brooks, Y. Zisman-Ilani, A. Muralidharan and P. Deegan
2020 Digital peer support mental health interventions for people with a lived experience of a serious mental illness: systematic review. *JMIR Mental Health*, 7(4):e16460.

Gray, B., F. Hanna and L. Reifels.
2020 The integration of mental health and psychosocial support and disaster risk reduction: A mapping and review. *International Journal of Environmental Research and Public Health*, 17(6):1900.

Greene, M.C., A. Bonz, R. Isaacs, M. Cristobal, C. Vega, L.S. Andersen, A. Angulo, A. Armijos, M.E. Guevara, L. Benavides, and A. de la Cruz.
2022 Community-based participatory design of a psychosocial intervention for migrant women in Ecuador and Panama. *Social Science and Medicine - Mental Health*, 2:100152.

Guta, A., S. Flicker and B. Roche.
2013 Governing through community allegiance: a qualitative examination of peer research in community-based participatory research. *Critical Public Health*, 23(4):432–451.

Hagen-Zanker, J., M. Ulrichs and R. Holmes.
2018 What are the effects of cash transfers for refugees in the context of protracted displacement? Findings from Jordan. *International Social Security Review*, 71(2):57-77.

Hahn-Schaur, K.
2021 Awareness-raising and information campaigns on the risks of irregular migration in Pakistan. Background Report. Budapest Process. Hungary.

Harrison, S., F. Hanna, P. Ventevogel, N. Polutan-Teulieres and W.S. Chemaly.
2020 MHPSS and protection outcomes: Why joint action to improve mental health and psychosocial wellbeing of people affected by conflict, violence and disasters should be a priority for all protection actors. Policy Discussion Paper. Global Protection Cluster and IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings: Geneva.

Hechanova, R. and L. Waelde.
2017 The influence of culture on disaster mental health and psychosocial support interventions in Southeast Asia. *Mental Health, Religion and Culture*, 20(1):31-44.

Hernández-Plaza, S., E. Alonso-Morillejo and C. Pozo-Muñoz.
2006 Social support interventions in migrant populations. *British Journal of Social Work*, 36(7):1151-1169.

Ho, K.H.M., C. Yang, A.K.Y. Leung, D. Bressington, W.T. Chien, Q. Cheng and D.S.K. Cheung.
2022 Peer support and mental health of migrant domestic workers: a scoping review. *International Journal of Environmental Research and Public Health*, 19(13):7617.

Hobfoll, S.E.
2001 The influence of culture, community, and the nested-self in the stress process: Advancing conservation of resources theory. *Applied Psychology: An International Review*, 50: 337-421.

Horn, R., M. Waade and M. Kalisky.
2016 Not doing more, but doing differently: Integrating a community based psychosocial approach into other sectors. *Intervention*, 14(3):245–256.

Igreja, V., W.C. Kleijn, B.J. Schreuder, J.A. Van Dijk and M. Verschuur.
2004 Testimony method to ameliorate post-traumatic stress symptoms: Community-based intervention study with Mozambican civil war survivors. *The British Journal of Psychiatry*, 184(3):251–257.

Inter-Agency Standing Committee (IASC)
2007 *Guidelines on Mental Health and Psychosocial Support in Emergency Settings,* Geneva
2014 *Recommendations for Conducting Ethical Mental Health and Psychosocial Research in Emergency Settings*
2019 *Community-Based Approaches to MHPSS Programmes: A Guidance Note.*
2021 *The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: With Means of Verification (Version 2.0),* Geneva.

International Federation of Red Cross and Red Crescent Societies (IFRC)
2017 *Monitoring and Evaluation Framework for Psychosocial Support Interventions. Toolbox,* Copenhagen.
2021a *Risks and Resilience: Exploring migrants" and host communities" experiences during the COVID-19 pandemic in West Africa.*
2021b *Psychological First Aid (PFA) for Young Peers.* Copenhagen.

International Labour Organization (ILO)
2021 A socio-economic integration strategy to turn migration into a factor for sustainable development. ILO News, 10 March.

International Organization for Migration (IOM)
2010 *Psychosocial Needs Assessment in Emergency Displacement, Early Recovery, and Return.*
2016 *Public Communication Campaign Toolkit.*
2017a *Health of Migrants: Resetting the Agenda.* Geneva.
2017b *Towards an Integrated Approach to Reintegration in the context of return.*
2019a *Glossary on Migration.*

2019b *Mental Health, Psychosocial Response and Intercultural Communication.* Geneva.
2019c *Handbook on Protection and Assistance for Migrants Vulnerable to Violence, Exploitation and Abuse.* Geneva.
2019d *Reintegration Counselling: A Psychosocial Approach*
2019e *MHPSS and Well-being Promotion Campaign: IDPs Well-being.*
2020a *Return and Reintegration Key Highlights 2019.* Geneva.
2020b *West and Central Africa: More women search for equality through migration. Press release, 13 March.*
2020c *Mental Health and Psychosocial Support (MHPSS) in the COVID-19 Response: Guidance and Toolkit for the use of IOM MHPSS Teams: Version III-Final.* Geneva.
2021a *Policy on the Full Spectrum of Return, Readmission and Reintegration.*
2021b *Addressing the Mobility Dimensions of Crises: IOM Migration Crisis Operational Framework – 2021 Addendum.*
2021c *Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement.* Geneva.
2021d *Return and Reintegration Key Highlights 2020.* Geneva.
2021e Mainstreaming Mental Health and Psychosocial Support into Migrants as Messengers Phase 2 (MaM-2).
2022 Return and Reintegration Key Highlights 2021. Geneva.
n.d. Migrants as Messengers and Psychosocial Support: A selection of evidence-based activities for psychosocialsupport with returned migrants. ROWCA
2022 *Return and Reintegration Key Highlights 2021.* Geneva.

International Organization for Migration, West and Central Africa (IOM)
Migrants as Messengers and Psychosocial Support: A selection of evidence-based activities for psychosocial support with returned migrants.
2021 n.d.*Mainstreaming Mental Health and Psychosocial Support into Migrants as Messengers Phase 2 (MaM-2).*

International Rescue Committee (IRC)
2012 *Assessment Report Cash Transfer Program to Syrian Refugees in Jordan.*

Kawachi, I. and S.V. Subramanian.
2006 Measuring and modeling the social and geographic context of trauma: a multilevel modeling approach. *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies*, 19(2):195–203.

Kienzler, H., C. Spence and T. Wenzel.
2019 A culture-sensitive and person-centred approach: understanding and evaluating cultural factors, social background and history when working with refugees. In: *An Uncertain Safety* (T. Wenzel and B. Drožđek, eds.). Springer, Cham.

Kincaid, D.L., M.E. Figueroa, D. Storey and C. Underwood.
2020 *A Socio-Ecological Model of Communication for Social and Behavioral Change: A Brief Summary.* Johns Hopkins Bloomberg School of Public Health.

King, R.U.
2019 The true healing is healing together: Healing and rebuilding social relations in postgenocide Rwanda. *Peace and Conflict: Journal of Peace Psychology,* 25(1):49–60.

Kleist, N.
2020 Trajectories of involuntary return migration to Ghana: forced relocation processes and post-return life. *Geoforum*, 116:272–281.

Kroenke, K. and R.L. Spitzer.
2002 The PHQ-9: A new depression and diagnostic severity measure. *Psychiatric Annals*, 32:509–521.

Kühhas, B., J. Taaka and M. Bragin.

2017 Development of participatory psychosocial well-being indicators for IOM-MHPSS programming in Wau, South Sudan.

Maâ, A., J. Van Dessel and I.M. Savio Vammen.
2022 Can migrants do the (border) work? Conflicting dynamics and effects of "peer-to-peer" intermediation in North and West Africa. *Journal of Borderlands Studies*, August:1–19.

Mansouri, F., L. Lahlou, M. Camara, S. Seck and M.H. Thiam.
2022 Assessing psychological, anxiety, depression and stress levels of Senegalese general population during COVID-19 pandemic. *Annales Medico-psychologiques*. September.

Mazen, J.A., X. Tong and L.K. Taylor.
2019 Evaluation of supplemental samples in longitudinal research with non-normal missing data. *Behavior Research Methods*, 5(3):1321–1335.

McAuliffe, M. and A. Triandafyllidou
2021 *World Migration Report 2022*. International Organization for Migration, Geneva.

Mixed Migration Centre (MMC)
2020 *A Sharper Lens on Vulnerability (West Africa): A statistical analysis of the determinants of vulnerability to protection incidents among refugees and migrants on the move in West Africa, MMC Research Report.*

Nemiro, A., Z. Hijazi, R. O"Connell, A. Coetzee and L. Snider.
2022 Mental health and psychosocial wellbeing in education: the case to integrate core actions and interventions into learning environments. *Intervention*, 20(1):36-45.

Olaseni A.O., O.S. Akinsola, S.F. Agberotimi and R. Oguntayo.
2020 Psychological Distress Experiences of Nigerians Amid COVID-19 Pandemic. SSRN.

Operationalising Psychosocial Support in Crisis (OPSIC)
2016 *The Comprehensive Guideline on Mental Health and Psychosocial Support (MHPSS) in Disaster Settings.*

Pan American Health Organization (PAHO)
2019 *Stronger Together - Building Individual and Social Resilience to Cope with the Impacts of Natural Hazard Events.*

Parrish-Sprowl, S., J. Parrish-Sprowl and S. Alajlouni.
2020 Innovations in addressing mental health needs in humanitarian settings: a complexity informed action research case study. *Frontiers in Communication,* 5.

Peersman, G. and G. Fletcher.
2019 Peer support approaches: To what extent are they appropriate, acceptable, beneficial? What is needed to implement them well? A systematic review of systematic reviews of international literature. The Australia and New Zealand School of Government, Melbourne.

Rayes, Diana
n.d. Barriers and Facilitators to Mental Health Service Utilization Among Refugees in Sweden Doctoral dissertation in progress. Johns Hopkins University.

Ripoll, S., I. Gercama, T. Jones A. and Wilkinson.
2019 *Social Science Lessons Learned from Ebola Epidemics*. Evidence Summary.

Rosenberg, M.
1965 Rosenberg self-esteem scale (RSE). *Acceptance and Commitment Therapy. Measures Package,* 61(52):18.

Save the Children, HIAS, IFRC, TdH, IASSW, and the MHPSS Collaborative

2021 *Mental Health and Psychosocial Support for People on the Move during COVID-19: A Revised Multi-Agency Guidance Note.*

Schininà, G.
2021 Migration governance and mental health. In Bhugra, D. ed., 2021. Oxford Textbook of Migrant Psychiatry. Oxford University Press, USA.

Schininà, G., N. Nunes, P. Birot, L. Giardinelli and G. Kios.
2016 Mainstreaming mental health and psychosocial support in camp coordination and camp management. The experience of the International Organization for Migration in the North East of Nigeria and South Sudan. *Intervention*, 14(3):232–244.

Schininà, G. and K. Popp.
2019 The mental health and wellbeing of migrants in the context of the 2030 sustainable development agenda. In: *The Routledge Handbook of International Development, Mental Health and Wellbeing* (L. Davidson, ed.) Routledge, London.

Schininà, G. and T.E. Zanghellini.
2021 Internal and international migration and its impact on the mental health of migrants. In: *Mental Health, Mental Illness and Migration. Mental Health and Illness Worldwide* (D. Moussaoui,, D. Bhugra, R.Tribe, and A. Ventriglio, eds). Springer, Singapore.

Schubert, J.
2018 Mental health & psychosocial support for Syrian refugees in Jordan–a capacity analysis of the national implementation of WHO"s mhGAP.

Setrana, M.B. and N. Kleist.
2022 Gendered dynamics in West African migration. In: *Migration in West Africa* (J.K. Teye, (ed.). IMISCOE Research Series. Springer, Cham.

Shrout, P.E., G. Stadler, S.P. Lane, M.J. McClure, G.L. Jackson, F.D. Clavél, M. Iida, M.E.J. Gleason,h , J.H. Xu and N. Bolger
2018 Initial elevation bias in subjective reports. *Proceedings of the National Academy of Sciences,* 115(1):E15–E23.

Siriwardhana, C. and R. Stewart.
2013 Forced migration and mental health: prolonged internal displacement, return migration and resilience. *International Health*, 5(1):19–23.

Sokol, R. and E. Fisher.
2016 Peer support for the hardly reached: a systematic review. *American Journal of Public Health*, 106(7):e1–e8.

Solomon, P.
2004 Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal*, 27(4):392–401.

Spiritus-Beerden, E., A. Verelst, I. Devlieger, N. Langer Primdahl, F. Botelho Guedes, A. Chiarenza, S. De Maesschalck, N. Durbeej, R. Garrido, M. Gaspar de Matos, E. Ioannidi, R. Murphy, R. Oulahal, F. Osman, B. Padilla, V. Paloma, A. Shehadeh, G. Sturm, M. van den Muijsenbergh, K. Vasilikou, C. Watters, S. Willems, M. Skovdal and I. Derluyn.
2021 Mental health of refugees and migrants during the COVID-19 pandemic: The role of experienced discrimination and daily stressors. *International journal of environmental research and public health*, 18(12). 6354.

Swedberg, R.
2020 Exploratory research. In: *The Production of Knowledge: Enhancing Progress in Social Science (Strategies for Social Inquiry)* (C. Elman, J. Gerring, and J. Mahoney, eds.). Cambridge University Press.

Taggart, F., S. Stewart-Brown and J. Parkinson.
2016 Warwick-Edinburgh mental well-being scale (WEMWBS). User Guide (Version 2). Edinburgh, NHS

Health Scotland, Warwick Medical School, University of Warwick.

Tennant, R., L. Hiller, R. Fishwick, P. Platt, S. Joseph, S. Weich, J. Parkinson, J. Secker and S. Stewart-Brown.
2007 The Warwick Edinburgh Mental Well-being Scale (WEMWBS): development and UK validation. *Health and Quality of Life Outcome*, 5:63.

Teye, J.K.
2022 Migration in West Africa: An introduction. In: *Migration in West Africa*. (J.K. Teye (ed.)) IMISCOE Research Series. Springer, Cham.

Thabane, L., J. Ma, R. Chu, J. Cheng, A. Ismaila, L.P. Rios, R. Robson, M. Thabane, L. Giangregorio and C.H. Goldsmith.
2010 A tutorial on pilot studies: the what, why and how. *BMC Medical Research Methodology,* 10(1):1–10.

Theisen-Womersley, G.
2021 Trauma and Resilience Among Displaced Populations: *A Sociocultural Exploration*. Springer, Cham.

Thomson, G., M.C. Balaam and K. Hymers.
2015 Building social capital through breastfeeding peer support: insights from an evaluation of a voluntary breastfeeding peer support service in North-West England. *International breastfeeding journal,* 10(1):1–14.

Tjaden, J. and H. Gninafon
2021 Raising awareness about the risk of irregular migration: quasi-experimental evidence from Guinea. *Population and Development Review*, 48(3):745-766.

Tol, W.A., M. Purgato, J.K. Bass, A. Galappatti and W. Eaton.
2015 Mental health and psychosocial support in humanitarian settings: a public mental health perspective. *Epidemiology and Psychiatric Sciences*, 24(6):484–494.

Trochim, W.M. and J.P Donnelly.
2001 *Research Methods Knowledge Base* (Vol. 2). Macmillan Publishing Company, New York.

Ubels, T., S. Kinsbergen, J. Tolsma and D.J. Koch.
2022 The social outcomes of psychosocial support: A grey literature scoping review. Social Science & *Medicine-Mental Health*, 100074.

United Nations Children"s Fund (UNICEF)
2018 *Operational Guidelines on Community Based Mental Health and Psychosocial Support In Humanitarian Settings: Three-Tiered Support For Children And Families (field test version).* New York.
2021 *Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children and Families Across Settings (field demonstration version).* New York.

United Nations Children"s Fund (UNICEF), Save the Children/MHPSS Collaborative and World Health Organization.
2021 *I Support My Friends Resource Kit: Equipping Children and Adolescents to Support a Friend in Distress.* UNICEF, New York.

United Nations Department of Economic and Social Affairs, Population Division (UN DESA)
2020 *International Migration 2020 Highlights* (ST/ESA/SER.A/452).

United Nations Development Fund (UNDP)
2019 *Scaling Fences: Voices of Irregular African Migrants to Europe.*

United Nations High Commissioner for Refugees (UNHCR)
2017 *Operational Guidance on Mental Health & Psychosocial Support Programming for Refugee Operations.* Geneva.

Vammen, I.M.S.
2021 "When migrants become messengers": affective borderwork and aspiration management in Senegal.

Geopolitics, April:1–20.

Vammen, I.M.S., S. Plambech, A. Chemlali and N.N. Sørensen
2021 *Does Information Save Migrants" Lives? Knowledge and Needs of West African Migrants en Route to Europe.* (No. 2021: 01). DIIS Report.

Van Dessel, J.
2021 Externalization through "awareness-raising": the border spectacle of EU migration information campaigns in Niger. *Territory, Politics, Governance*, October:1–21.

Vathi, Z.
2017 Introduction: the interface between return migration and psychosocial wellbeing. *In: Return Migration and Psychosocial Wellbeing: Discourses, Policy-Making and Outcomes for Migrants and Their Families* (Z. Vathi and R. King, eds.) Routledge: London.

Veronese, G., A. Pepe, L. Addimando, G. Sala and M. Vigliaroni
2020 "It"s paradise there, I saw it on TV": Psychological wellbeing, migratory motivators, and expectations of return among West African migrants. *Nordic Psychology*, 72(1): 33–50.

Villalonga-Olives, E., T.R. Wind, and I. Kawachi.
2018 Social capital interventions in public health: A systematic review. *Social Science & Medicine*, 212:203–218.

Weathers, F.W., B.T. Litz, T.M. Keane, P.A. Palmieri, B.P. Marx and P.P. Schnurr.
2013 The PTSD Checklist for DSM-5 (PCL-5) – Standard [Measurement instrument].

Weissbecker, I., F. Hanna, M.E. Shazly, J. Gao and P. Ventevogel.
2019 Integrative mental health and psychosocial support interventions for refugees in humanitarian crisis settings. In: *An Uncertain Safety* (T. Wenzel and B. Drožđek, eds.). Springer, Cham.

Westlund, E. and E.A. Stuart.
2017 The nonuse, misuse, and proper use of pilot studies in experimental evaluation research. *American Journal of Evaluation,* 38(2):246–261.

Williams, J.M.
2020 Affecting migration: public information campaigns and the intimate spatialities of border enforcement. *Environment and Planning C: Politics and Space,* 38(7-8):1198–1215.

Wind, T.R., I. Kawachi and I.H. Komproe.
2021 Multilevel social mechanisms of post-disaster depression. *International Journal of Environmental Research and Public Health*, 18(2):391.

Wood, B. and P. Kallestrup,
2021 Benefits and challenges of using a participatory approach with community-based mental health and psychosocial support interventions in displaced populations. *Transcultural Psychiatry*, 58(2):283-292.

World Bank Group
2016 Mental health among displaced people and refugees: Making the case for action at the World Bank Group.

World Health Organization (WHO)
2013 *Psychological First Aid: Facilitator"s manual for orienting field workers.* Geneva.
2021 *Mental Health and Forced Displacement.*
2022 *World Report on the Health of Refugees and Migrants.* Geneva.

World Health Organization and United Nations Children"s Fund (WHO and UNICEF)
2021 Mental Health and Psychosocial Support Minimum Service Package (Field-test version.)

World Health Organization, Regional Office for Europe (WHO/Europe)
2018 Mental health promotion and mental health care in refugees and migrants. Copenhagen: WHO Regional Office for Europe; 2018 (Technical guidance on refugee and migrant health).
2020 *White Paper and SocialNet Experience*. Copenhagen.

Yin, R.K.
2003 *Case Study Research: Design and methods*. Sage, Thousand Oaks, California..

Yuen, L.
2020 Towards the successful reintegration of returned migrants: IOM Niger"s trainings for migrants in transit. Migration in West and North Africa and across the Mediterranean, 330.

Zimet, G.D., N.W. Dahlem, S.G. Zimet and G.K. Farley.
1988 The multidimensional scale of perceived social support. *Journal of Personality Assessmen*t, 52(1):30–41.

IOM Regional Office for West and Central Africa
Zone 3, Route des Almadies
Dakar - Senegal BP 16 838
Tel: (+221) 33 869 62 00
Fax: (+221) 33 869 62 33
Email: iomrodakarmedia@iom.int
Website: https://rodakar.iom.int/