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Living in Camps Impacts on the Mental Health and Quality of Life of Displaced People in Northwest Syria

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Abstract: The research aimed to study the impact of living in displacement camps on mental health and Quality of life among Syrians in Northwest Syria. A descriptive and analytical approach was utilized, where two scales of mental health (SCL – 90 - R) and Quality of life (WHOQOL – BREF) were applied, with (306) participants. Results show that symptoms of mental health disorders appear at different levels, where the most common disorder is Depression, and the least common is Psychoticism. Quality of life results show that the most common issue was General Health, and the least common was environmental health. Differences between educational status and gender were statistically significant when studying the presence of mental health disorders, where it was lower in males than in females. Quality of life results showed significant differences between all demographic characteristics except the duration of stay in the camp. It was higher in females than in males. It was higher among the employed than the unemployed, and the age (under 18 years) had the highest Quality of life .Regarding marital status, it was highest in the (single and widowed). The Quality of life was highest among the university degree holders. There was a moderate and inverse correlation between Symptoms of mental health disorders and Quality of life, where the correlation coefficient was (-0.382), and this indicates a lower level of mental health with increasing deterioration in Quality of life. The results showed that Quality of life contributes to interpreting the variance in Symptoms of mental health disorders. The beta value (β = - 0.391) means that whenever Quality of life improved by one unit, Symptoms of mental health disorders decreased by (0.391) unit . To conclude, quality of life statistically significantly contributes to explaining mental health disorders among Syrians in displaced camps.

Keywords: Mental health, Quality of life, Displacement, Displaced people

Introduction

The Syrian war began in March 2011 and has rapidly developed into an ongoing public health crisis and humanitarian disaster (Erum, 2021). Violence and displacement have led to a noticeable increase in the prevalence of trauma and severe mental health problems among Syrians inside and outside the country (Alhaffar & Janos, 2021). This requires the provision of mental health care in war zones, refugee camps, and internally displaced people. Syria suffered from one of the most significant humanitarian and displacement crises worldwide due to the 2011 uprising and its escalation into an armed revolution by the summer of 2012. About 15.3 million Syrians need humanitarian support (Aburas et al., 2018; Barkil-Oteo et al., 2018; Ocha, 2018). More than a million internally displaced people reside in camps, and many more live in overcrowded and poor conditions, including exposure to traumatic events and ongoing stressors such as unemployment, impoverishment, social disintegration, and loss of social support (Lindert et al., 2017). Forced displacement harms displaced people's safety, existence, health, and psychological well-being (Ozkaleli, 2018).

The impact of living in displacement camps on displaced peoples' mental health and quality of life is an important topic (Riyadh & Al-deen, 2022), focusing on the positive aspects of individuals' mental health and ability to withstand psychological stress. Studies have shown that forced displaced people face severe psychological and physical stress before, during, and after displacement (Knappe et al., 2023). Displacement camps significantly impact displaced peoples' mental health and quality of life (Rizzi et al., 2022). Studies have shown that displacement can lead to mental disorders such as depression, anxiety, and post-traumatic stress disorders (Schäfer et al., 2023).

In recent years, several studies and research have focused on these camps to better understand the effects of displacement and improve the physical and psychological well-being of the displaced. These initiatives yielded essential results, revealing details and clear concepts concerning the effects of displacement on mental health. Despite the valuable insights provided by past studies, there are still several knowledge gaps in our understanding of the mental health and quality of life of displaced people in camps, notably in Syria. Current research considers conducting studies to investigate the long-term impact of displacement and the role of social determinants on mental health and quality of life among displaced persons in camps, as well as understanding the contribution and impact of quality of life on mental health among Syrian displaced people. Despite the numerous research undertaken, studies specializing in mental health are nearly non-existent, prompting us to examine this topic to contribute to the lack of studies in this field. Further research is needed to understand the social factors that contribute to the impact of displacement and to address the specific psychological needs of displaced people.

The study's goal is to determine the level of mental health and quality of life among the displaced, as well as the differences in symptoms of mental health disorders and quality of life caused by variables such as gender, age, marital status, duration of stay in the camp, working status, and educational status among the camps in northwest Syria. This focuses researchers' attention on the issues that society needs to address. By conducting this research, we aim to improve the understanding of this field and contribute to enhancing the quality of life of displaced persons while also providing them with the support they need to overcome the mental challenges they experience. Psychosocial support programs and community-based interventions may be used to improve resilience and well-being. Encourage collaboration among researchers, humanitarian organizations, and policymakers to ensure that research findings are turned into effective policies and actions. This would make it easier to apply evidence-based practices while also improving the mental health and quality of life outcomes for the Syrian displaced. Three camps in northwest Syria were chosen to implement this study based on the study's goals.

Literature Review

The displacement of individuals due to conflict and humanitarian crises has become a global concern (Troup et al., 2021). Large and sudden waves of displacement that occur in a short period put enormous pressure on the displaced, as well as on host communities and various organizations working in the field of mental health (Vito et al., 2015). Displaced people living in camps often face numerous challenges that can significantly impact their mental health and quality of life (Cogo et al., 2022). The literature synthesizes the existing research findings on the mental health and quality of life among displaced people in camps, explicitly focusing on the situation in Syria. A study was conducted on the mental health, quality of life, and life satisfaction of internally displaced persons (IDPs). The findings revealed that IDPs experienced high levels of psychological distress and a lower quality of life compared to the general population (Zelenska, 2022). The studies highlighted the need for mental health interventions and support services for IDPs to improve their well-being and overall quality of life (Getanda et al., 2015; Mandishekwa, 2021). Findings from various studies underscore the importance of addressing the specific needs and experiences of refugee women to improve their mental health and overall well-being (Jesuthasan et al., 2018). IDPs who leave their homes are exposed to severe distress factors during and after the migration and displacement process (UN Refugee Agency (UNHCR), 2015). These factors significantly affect mental and physical health and greatly increase the likelihood of experiencing mental health problems (Porter & Haslam, 2005) because the effects of displacement can be severe in the long term (Jbour & Sammour, 2016).

Internally displaced people are among today's most vulnerable individuals (Vito et al., 2015). Cardozo's study showed high levels of symptoms of depression and anxiety among displaced people in camps. The study showed that the primary psychological and social risk factors that contribute to and weaken the psychological health and social interaction of displaced people include poor nutrition, an increased number of traumatic incidents, previous psychological illnesses, and landmine and war injuries. Cardozo recommended the need to

implement innovative programs in the field of mental and psychosocial health and carefully monitor and evaluate them to ensure their effectiveness (Cardozo et al., 2004). Post-traumatic stress disorder, depression, and anxiety disorders are among the most common psychological problems among displaced people affected by war trauma and who have negative experiences in their lives (Morina et al., 2018). By prioritizing mental health services and implementing community-based interventions, it is possible to improve the psychological well-being of displaced people in camps and help them recover from the trauma and psychological stress resulting from displacement (Miller & Rasmussen, 2017; Nouri, 2019). As noted by mental health researchers at SAMS, many Syrians were suffering from Symptoms of mental health disorders associated with disorders such as anxiety, depression, and post-traumatic stress disorder (PTSD) (Aburas et al., 2018; Hughes et al., 2016). Available data strongly indicate that both war-related trauma and post-displacement stress factors significantly affect mental health (Tadese et al., 2022). A study showed that there is an increase in levels of depression among displaced Syrians residing in displacement camps in Jordan. She explained that the conditions of war and displacement to which they were exposed have significantly affected their psychological health, as many of them suffer from anxiety and severe depression. This is due to social and economic instability and constant anxiety about an unknown tomorrow (Susan Brown, 2018). Miller's studies have shown that the mental health of displaced people and refugees is affected not only by exposure to violence and loss associated with war but also by ongoing stressors associated with the displacement experience itself (Miller & Rasmussen, 2017).

These stressors include social isolation, unemployment, poverty, discrimination, domestic violence, and lack of safety in displacement camps (Riyadh & Al-deen, 2022). In addition, displacement-related stressors can range from chronic, low-intensity stressors to potentially traumatic events, increasing the risk of psychological disorders (Miller & Rasmussen, 2017). The post-displacement housing environment plays a crucial role in either enhancing or hindering the process of recovery from trauma and grief resulting from war (Askar et al., 2019; Valle & Romania, 2019). Additionally, ongoing stressors related to displacement, such as personal safety concerns, war-related loss, material loss, and personal hardships, are positively related to Symptoms of mental health disorders severity (Thomas et al., 2022). The Getanda study showed that IDPs who are younger, married, and receive health, social, and government care are more protected against poor mental health. In general, the IDPs studied have poor mental health and well-being. The results indicate that forced displacement has a significant negative impact on mental health (Getanda et al., 2015). Therefore, urgent support and assistance must be provided to IDPs in these circumstances to improve their health and psychological well-being in the long term, especially for internally displaced people who are concerned about the well-being of their families, lack social support, and suffer from Symptoms of mental health disorders (Kim et al., 2022; Romanova et al., 2023). This poses a major challenge to mental health and social services in such contexts, which witness significant and complex health and social care needs, further complicated by lack of resources, stigma, and lack of awareness in society in general (Bucy & Cross, 2023; Kariotis et al., 2019).

Alaiwi's study showed the exposure of the displaced to many heart and chronic diseases and Symptoms of mental health disorders. The emergence of deviance and crime in displacement camps, the increase in divorce and family disintegration, and the loss of many families of their children. These results highlight the significant challenges faced by displaced people and indicate the impact of forced displacement on the mental health, social relations, and level of education of these individuals (Ulaiwi, 2020). In a study that dealt with psychological distress among internally displaced persons showed that most displaced people are male and aged 50 years or over, most have primary education, and most people had a job before displacement. Displaced people suffer from a moderate level of psychological distress. There are significant relationships between psychological distress, age, level of education, profession, monthly income, and the period of displacement (Hussein et al., 2018). Providing temporary housing during the disaster recovery phase is critical for ensuring comfort, protection, privacy, and a gradual return to normal life activities, according to "The Role of Local Building Systems in Enhancing the Sustainability of Post-Disaster Temporary Housing," 2022. Quality of life is found to be associated with symptoms of mental health disorders (Sagayadevan et al., 2018; Snoek et al., 2018). The depressive disorder group had the lowest quality of life and the highest level of depressive and anxiety symptoms (Colovic et al., 2017). Depressive symptoms were found to have the most significant impact on the quality of life impairment in stress-related disorders. These findings suggest that quality of life contributes to explaining variation in symptoms of mental health disorders, with depressive symptoms having a powerful impact. In this study, we will look at the impact and contribution of quality of life on mental health, emphasizing understanding the correlation between the two.

Methods

Study Design

This prospective cross-sectional study was conducted in the camp area of northwestern Syria, notably the northern region of Idlib and Aleppo, where camp gatherings are concentrated due to their proximity to the Syrian-Turkish border. The study focused on displaced Syrians in three northern Syrian camps: the olive camp outside Azaz, the new Al-Hayat camp on the borders of Al-Bab, and the town of ATAA village in Atama in Idlib. According to data from camp administration, administrative authorities, and official local councils, there were approximately (10108) displaced individuals in the three camps. This investigation was conducted from July to November 2023. Before beginning the study, the Institutional Ethics Committee from the camp management provided approval. This analysis was performed in adherence to The Belmont Report.

Participants

The study includes displaced people living in northern Syrian camps as participants. The study sample was selected using the random sampling approach. The researchers conducted personal interviews with all sample participants (n = 306). A total of 300 persons volunteered to participate. According to the MORGAN equation, it accounted for 3 percent of the study community. The questionnaire, Symptom Checklist (SCL - 90 - R), and Quality of Life (WHOQOL - BREF) were all explained thoroughly. The specialist completed the questionnaires appropriately after resting for at least 15 minutes in a quiet place free of visual and auditory disturbances. Two teams from the Ataa Humanitarian Relief Organization, Department of Mental Health and Psychosocial Support, who are in the study region in northwestern Syria, have been working to administer questionnaires to camp residents, where all of the experienced and specialized personnel were.

Participants who needed to finish all the questions were excluded (N = 6). All participants provided informed consent. The investigation was conducted utilizing a structured questionnaire. The questionnaire consisted of three sections. In the first section, the subjects' sociodemographic information was included. The participants were queried regarding their mental health in the subsequent segment (Derogatis & Unger, 2010). In the final section, they were asked about the quality of life (Malibary et al., 2019; Skevington et al., 2004). Participants were requested to answer all questions.

Measures

The mental health scale (SCL - 90 - R) and the WHOQOL - BREF were employed following the American Psychiatric Association's DSM-V symptom criteria. The (SCL - 90 - R) is a set of 90 self-report items that test for nine symptoms of mental health problems (somatization, interpersonal sensitivity, obsessive-compulsive, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism). The WHOQOL-BREF comprises 26 self-report items assessing six aspects of quality of life (psychological, physical, environmental, social relationships, general health, and overall quality of life). Participants respond to the questions using a 5-point Likert scale (1 = not at all, 5 = excessively). The internal consistency validity of the mental health and quality of life scale dimensions has been established. The Lehman classification was used to estimate this study's degree of correlation coefficient (Lehman, 2005). According to the Cronbach Alpha method, the questionnaire is highly reliable (McHorney et al., 1992).

Statistical Analysis

The sample size was calculated to be 306 people. It was expected to have at least 330 participants with a 10% margin of error. The sample size was calculated using an online Morgan equation and calculator (https://clincalc.com/). The categorical variables are numbers and percentages (Krejcie et al., 1996). The variables were analyzed using both descriptive and analytical methods. The numerical variables are reported as mean ± standard deviation or median (interquartile range). The distribution of the groups was determined using the Kolmogorov-Smirnov test. The categorical variables were analyzed using the chi-squared test. The numerical variables were analyzed using the student t-test and the Analysis of Variance ANOVA test. Linear regression analysis was employed to examine the data. Pearson correlations were used to analyze the relationships between psychological factors. The statistical significance criterion was set as ($p < 0.05$). Lehman (2005) reported optimal item-intercorrelation (0.593) and excellent internal consistency (Cronbach's $\alpha = 0.921$). They indicated the suitability of the data for factor analysis. The statistical analysis was performed using SPSS® for Windows version 27.0 (IBM, Chicago, IL, United States) (SPSS, 2019).

Results

The study involved 306 participants, with six failing to complete the questionnaire (n=6). The final analysis comprised 300 participants. More than 32% of participants were above 40, with women accounting for 53.3%. The baseline demographic characteristics of the participants are shown in (Table 1).

Table 1. Basic demographic characteristics of participants and p-values

Variables	Values, n (%)	Mental health (p-value)	Quality of life (p-value)
Gender		**0.046**	**0.027**
Male	140 (46.7)		
Female	160 (53.3)		
Age		0.825	**<0.001**
Under 18 years old	28 (9.3)		
From 19 - 30 years old	87 (29)		
From 31 - 40 years old	88 (29.3)		
More than 40 years	97 (32.3)		
Marital status		0.378	**<0.001**
Single	44 (14.7)		
Married	236 (78.7)		
Widow	17 (5.7)		
Divorced	3 (1.0)		
Educational level		**0.008**	**0.004**
I don't know how to read and write	82 (27.3)		
High school or below	(62.3) 187		
Institute	(6.0) 18		
University	13 (4.3)		
Duration of stay in the camp		0.45	0.085
From 1-2 year	58 (19.3)		
From 3-4 year	82 (27.3)		
More than five years	160 (53.3)		
Working status		0.245	**0.027**
Employed	64 (21.3)		
Unemployed	236 (78.7)		

*The statistical significance at the 0.05 level (2-tailed).

The findings revealed that 64.6% of displaced persons living in camps had low levels of mental health disorders, 31% had moderate levels, and only 4.4% had high levels. By presenting the findings, we can conclude that displaced persons have poor mental health. Furthermore, the findings revealed that 44% of displaced individuals living in camps have a low quality of life, 47% have a moderate level, and only 9% have a reasonable level. The results show that the displaced have a moderate quality of life. This is illustrated in (Table 2).

Table 2. The level of mental health and quality of life among displaced people in camps

Variable	level	Values, n	Values, (%)
mental health symptoms	Low	194	64.6
	moderate	93	31
	High	13	4.4
Quality of life	Low	132	44
	moderate	141	47
	High	27	9

*The statistical significance at the 0.05 level (2-tailed).

Aspects of mental health disorders symptoms are present as reported by participants in the study sample, where depression ranks first with a prevalence of 57.2% and is classified as moderate on a five-point Likert scale. Psychoticism ranked lowest, with a prevalence of 36%. This is demonstrated in (Table 3).

Sample responses to questions about quality of life: General health ranks first, with a prevalence rate of 64.0%, indicating a moderate level on a five-point Likert scale. Environmental health scored last, with a prevalence rate of 40.2%, considered low on a five-point Likert scale. The data is presented in (Table 4).

Table 3. Analysis of the opinions of the study sample's responses on the dimensions of the mental health

The dimension	Mean	Std. Deviation	Prevalence rate %	Rank	level
Somatization	2.6	0.836	52	3	moderate
Interpersonal sensitivity	2.41	0.78	48.2	5	low
Obsessive-Compulsive	2.83	0.785	56.6	2	moderate
Depression	2.86	0.812	57.2	1	moderate
Anxiety	2.26	0.836	45.2	6	low
Hostility	2.1	0.814	42	7	low
Phobic anxiety	1.95	0.728	39	8	low
Paranoid ideation	2.53	0.946	50.6	4	low
Psychoticism	1.8	0.578	36	9	low
Total (mental health)	2.39	0.555	47.8		low

*The statistical significance at the 0.05 level (2-tailed).

Table 4. Analysis of the opinions of the study sample's responses on the dimensions of the quality of life

The dimension	Mean	Std. Deviation	Prevalence rate %	Rank	level
Psychological health	2.82	0.647	56.4	4	moderate
Physical health	3.11	0.775	62.2	3	moderate
Environmental health	2.01	0.733	40.2	6	low
Social relationships	3.15	0.728	63.0	2	moderate
General Health	3.2	1.302	64.0	1	moderate
Overall Quality of Life	2.43	1.121	48.6	5	low
Total (Quality of Life)	2.65	0.541	53.0		moderate

*The statistical significance at the 0.05 level (2-tailed).

The Pearson correlation coefficient test was used to investigate the association between mental health symptoms and quality of life, with a correlation coefficient -0.382. The Lehman classification was used to calculate the degree of correlation coefficient (Lehman, 2005). The results are presented in (Table 5). A linear regression model was used to investigate the impact of quality of life on displaced peoples' psychological health symptoms (Table 6).

Table 5. Pearson correlation coefficient test between mental health symptoms and quality of life

Dependent Variable	Correlation coefficient	p value
mental health	-0.382	0.00

*Correlation is significant at the 0.05 level (2-tailed).

Table 6. Results of linear regression analysis of quality of life with mental health

Dep Variable	Indep Variable	R	R^2	F (p value)	B	T (p value)	VIF
Mental Health	Quality of life	0.382	0.146	50.855(0.000)	-0.391	-7.131(0.000)	1.000

*The statistical significance at the 0.05 level (2-tailed).

A linear regression model was utilized to investigate the association between mental health symptoms and quality of life, with mental health symptoms as the dependent variable and quality of life as the explanatory variable. These findings emphasize the importance of psychosocial therapies and mental health services in meeting the mental health needs of those affected by displacement .

Discussion

According to our findings, indications of mental health disorders arise at varying levels, with a 47.8% prevalence rate among displaced people. The most frequent was moderate depression, with a prevalence rate of 57.2%, while the least common was low psychoticism, with a prevalence rate of 36%. These findings are consistent with several studies, including one (Weiss Becker & Leichner), which found that many displaced persons live in camps and lack necessities such as housing, food, education, and health care. In addition, they suffered from psychological symptoms and disorders, with a significant prevalence of anxiety and depression. Depression was the most common, accounting for 54%, whereas psychotic disorders accounted for only 11%. These findings are congruent with ours. Similarly, Miller's research revealed the incidence of depression, psychological problems, and psychosis among Syrian refugees and displaced people. Many studies have found a

significant frequency of depression among refugees and displaced persons living in displacement camps (Abas, 2018; Hamid & Musa, 2010; Kabunga & Anyayo, 2020; Lavdas et al., 2023; Llosa et al., 2014).

While the quality of life was moderate, with a prevalence rate of 53%, the most frequent was general health, with a prevalence rate of 64%, and the least widespread was environmental health, with a prevalence rate of just 40.2%. According to research, refugees living in cities are more satisfied with their overall environmental health than those living in camps (Behnke et al., 2020). Displaced people living in internal displacement camps are more sensitive to mental health problems due to the adverse effects of environmental change and other detrimental factors (Vossoughi et al., 2018). Environmental health measures such as water supply, excreta management, solid waste management, and disease vector control are critical during the emergency phase of displacement. However, there needs to be more research on environmental health conditions during the transitory phase of migration, which lasts six months to two years (Cooper et al., 2021). Despite the importance of environmental health, there remain barriers to change, including institutional, political, and implementation issues (Wardeh & Marques, 2021).

According to the results of the Symptoms of mental health disorders study, there were substantial disparities in gender and education level. Females averaged 2.45, whereas males averaged 2.32. Other demographic factors did not show significant variations. This suggests that females are more likely to experience stress and symptoms of mental health disorders than males. Women are noted for caring for their families, including children and the elderly. However, when they are displaced, the load of these tasks increases, causing psychological stress and symptoms of mental health conditions. Displacement can result in a loss of security, social support, income, and housing. This increased societal pressure causes symptoms of mental health issues. This is evident in a study conducted by N. Rizkalla on Syrian refugees in Jordan, which dealt with the significant psychological and social pressures that women face, as this additional pressure is a source of the emergence of symptoms of mental health disorders, which disproportionately affect women (Rizkalla et al., 2020). This is similar to the findings of Jarallah and Vromans, who discovered that refugee and displaced women suffer from more significant psychological diseases and illnesses than men (Jarallah & Baxter, 2019). Other Middle Eastern studies have found that refugee women experience higher levels of psychiatric symptoms (Tahir et al., 2022).

Quality of life results revealed substantial disparities between all demographic categories except the length of stay in the camp. The discrepancies were as follows: males and females averaged 2.58 and 2.72, respectively. This is congruent with a study on refugees in Greek camps, which found that female participants were more satisfied with their quality of life than males (Plakas et al., 2023). Regarding employment status, the average was 2077 for employed and 2.62 for unemployed people. The amount of money a person earns from his job significantly impacts his ability to improve his quality of life. Furthermore, when relocated men cannot provide for and defend their families, they may feel helpless and inept, resulting in a much lower quality of life (Affleck et al., 2018). The age group (under 18 years) had the highest average, at 2.90. This is similar to prior research, which found that age substantially affects quality of life, with younger people having more significant rates of healthy quality of life than older participants (Plakas et al., 2023). The variation in marital status is attributable to the disparity between (single/widower) and (married/widower), with an average of 0.668 and 0.384, respectively. Our findings that widows had significantly worse mental health than married IDPs, this situation can be explained by the fact that the death of a partner constitutes a significant loss in psychological and social support. It also raises the likelihood of additional trauma (Nickerson et al., 2014), depression (Gilman et al., 2012), and loneliness (Caserta et al., 2013). Other research has found that single people in refugee camps have more significant quality of life scores than married, divorced, and widowed people (Plakas et al., 2023). The variations in education level are attributable to those with a university degree, with a value of 2.96, followed by those who have completed secondary school or less, with a value of 2.71. This finding is consistent with earlier studies on the importance of education (Hui, 2022; Xu, 2022). According to research, displaced people in camps with greater levels of education live more fulfilled and quality lives than those with lower levels of education (Plakas et al., 2023).

There was a moderate inverse correlation between symptoms of mental health disorders and quality of life, with a correlation coefficient of -0.382 and statistical significance (p-value < 0.001). This suggests a poorer degree of mental health and a worsening quality of life, and vice versa. There was also a moderate and statistically significant negative connection between mental health condition symptoms and quality of life in both genders. The correlation coefficients for males and females were -0.432 and -0.379, respectively. Overall, mental health suffers as the quality of life declines, and vice versa. This test demonstrates the significance of prioritizing quality of life to obtain mental health. It is important to note that this link is not constant between individuals and can be influenced by social, economic, cultural, and environmental factors. This shows that men may suffer

more negative effects on their mental health as a result of quality of life issues than women (Hooper et al., 2023). According to (Cieślik, 2023). quality of life encompasses family conditions, stability, and other things that positively impact mental health. Therefore, mental health is strongly tied to quality of life. The findings revealed that quality of life contributes to approximately 14.6% of the variation in symptoms of mental health issues. (-0.391) was a statistically significant value of (β). This suggests that for every one-unit improvement in quality of life, symptoms of mental health issues decrease by (0.391) units. The regression equation can also be written as:

$$Y = 3.43 - 0.39*X + \varepsilon.$$

This finding complements recent research by Dana Bdier, which found that Quality of Life is inversely connected to symptoms of mental health issues (Bdier et al., 2023). The findings show promise for future research to understand better how the current study's factors are connected. This could help specialized mental health service providers develop suitable therapies to reduce the harmful consequences of camp living. Furthermore, it could improve the quality of life for displaced people and promote healthy coping mechanisms. Our findings demonstrated the importance of quality of life, as well as social and demographic determinants, in the symptomatology of mental health disorders among displaced people. These findings demonstrated that quality of life has a statistically significant impact on explaining heterogeneity in symptoms of mental health issues. This observation illustrates the beneficial influence that enhancing quality of life has on mental health, as ameliorating conditions and factors that impact quality of life can lead to a reduction in the symptoms of mental health disorders. According to Cohen's d effect size, the influence of quality of life on mental health was 0.29, which suggests that quality of life positively affects mental health (Bakker et al., 2019; Cohen, 1988).

Limitations

The current study has several limitations. It was a cross-sectional qualitative study, and the nature of surveys limits the responses. We invited displaced individuals to camps. Six of them declined to participate and fill out the questionnaire. Being the first to investigate mental health and its relationship to quality of life, this study will provide the framework for future research. Participants may have overestimated or underestimated their answers. More accurate demographic figures must be, and it is not easy to move about in northwest Syria. Because of the challenges caused by the man's absence at home, it is recommended that the questionnaire be administered at an opportune time.

Conclusion

We have obtained essential results that highlight the need to focus on providing psychological and social support to displaced people experiencing various stresses and obstacles due to displacement. We also provided several ideas for future research that can help advance understanding of the domains covered in this study. We recommend upgrading infrastructure, providing essential services such as water and sanitation, and transitioning from tent shelters to permanent housing units that provide adequate refuge for the displaced. Directing efforts towards addressing these characteristics can help improve the displaced people's quality of life and alleviate any psychological stresses caused by their living conditions. Because the study's participants' mental health and quality of life ranged from average to poor, we advocate creating mental health treatment and psychosocial support centers in displacement camps. This includes guidance, therapy, training, and awareness programs that help displaced individuals deal with the social challenges and psychiatric diseases they experience daily, allowing them to adjust and fully integrate into society. Given the significantly high unemployment rate and its significant impact on the quality of life of the displaced, we propose increasing the provision of psychological and social support and assisting in the search for job opportunities to improve their psychological and living circumstances. Due to the poor level of education, with roughly 28% of individuals illiterate, there is an urgent need to improve literacy programs in displacement camps. These programs are a critical step towards boosting reading and writing skills among displaced people.

As a result, we advocate creating personalized educational programs that consider the requirements and peculiarities of the displaced population. Based on the findings, which show that improving quality of life is an effective way to reduce symptoms of mental health disorders among displaced people, we recommend developing and enhancing programs and strategies to improve quality of life, particularly in contexts where displaced people face psychological and social stressors. We advocate performing additional studies and research that include other forms of mental diseases and levels of quality of life in displacement camps while

considering new advancements and changes. In conclusion, existing research sheds light on the mental health and quality of life of displaced persons in camps. However, more research is needed to fill knowledge gaps and provide comprehensive interventions and services that meet the unique needs of displaced people, notably in Syria.

Ethical approval

All participants were required to provide informed consent before proceeding to the questionnaires, whether online or in person. Contact information for the research team was given at the beginning and end of each study for any inquiries that may occur during the research. Participants could end questionnaires or interviews anytime without justifying and facing any consequences. Furthermore, participants had up to one week after completing the questionnaires or responses to contact the researcher if they wanted to remove their data. If a person withdraws, their data will be permanently deleted and not included in any analysis published in this research.

Authors Contributions

Study concept and design (D.B., M.H.), acquisition of the data (D.B., M.H.), analysis and interpretation of the data (D.B., M.H.), drafting of the manuscript (D.B., M.H.), critical revision of the manuscript for important intellectual content (D.B.).

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Authorship Contribution Statement

Dujana Baroudi: Writing—review and editing, Writing—original draft, Visualization, Supervision, Project administration, Methodology ,Investigation, Validation, Data curation, Conceptualization.

Muhammed Humeydi: Writing – review & editing, Writing – original draft, Visualization, Supervision, Methodology, Formal analysis, Data curation.

Scientific Ethics Declaration

The authors declare that the scientific ethical and legal responsibility of this article published in EPESS journal belongs to the author

Acknowledgments or Notes

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