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Community health workers for mental health care in refugee camps: a scoping review

Rasha Istaiteyeh^{1*} and Wael K. Al-Delaimy²

Abstract

Objectives In recent years, countries in the Middle East and North Africa (MENA) region have seen a rise in immigration, driven by global conflicts, leading to increased prevalence of physical and mental health issues among refugees. This places significant demands on both refugees and healthcare professionals encountering them in various situations. The analysis considers the social and psychological implications of relying on specialized trainers versus the refugees themselves to determine the most effective and sustainable method for providing mental health support in challenging refugee camp environments.

Methods This article uses a scoping review methodology to compare the impact of two approaches for addressing mental health needs in refugee camps. Drawing upon previous studies, the research investigates the effectiveness and sustainability of recruiting external experts versus empowering refugees as mental health trainers within their communities.

Results The analysis suggests that in refugee camps, empowering refugees as mental health trainers within their communities yields more sustainable and culturally appropriate mental health support compared to recruiting external experts. This approach fosters community resilience and addresses the unique social and psychological needs of refugees in challenging camp environments.

Conclusion Ultimately, this analysis demonstrates the context-specific nature of health interventions in refugee camps. Empowering refugees as mental health trainers emerges as a promising approach to addressing mental health needs sustainably and effectively within these environments.

Keywords Community Health Workers, Refugee camps, Mental health, Health inequality, STROBE Approach, MENA, SDGs

Introduction

The mental health of refugees has become a critical concern during global crises and forced displacements. Refugees are more likely to suffer from mental health

issues. Mental health is a critical issue in Low- and Middle-Income Countries (LMICs), and particularly in humanitarian crises. Refugees, often among the most marginalized groups, experience poorer health outcomes compared to host populations [41], necessitating tailored and comprehensive health interventions. Among the most impacted by such situations, refugees face an increased risk of psychological disorders due to forced migration and prolonged insecurity. Despite this high prevalence, there is still a low engagement in seeking mental health assistance among these populations [22]. Although statistics show a high prevalence of mental health conditions among refugees, they often fall

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short in capturing the lived experiences and personal narratives behind these numbers. This underscores the importance of complementing quantitative findings with context-sensitive approaches. Satinsky et al. [20] conducted a systematic review of 27 studies on mental health and psychosocial support services (MHPSS) in Europe revealing that refugees and asylum seekers receive insufficient MHPSS for their needs. Refugees are exposed to a range of psychological and psychosocial issues, including rumination, ethnic conflict, and child abuse. Furthermore, there is international consensus on the significance of conducting needs and resource assessments to inform potential mental health and psychosocial support interventions [15]. Prioritizing community health workers is associated with the attainment of the third and fourth Sustainable Development Goals (SDGs): Good Health and Well-being & Quality Education. However, these communities face significant structural and cultural barriers, making access to mental health services difficult [10]. In response to these challenges, two contrasting approaches have emerged for delivering mental health support in refugee contexts. The first approach involves bringing in specialized trainers from abroad to address the psychological traumas and conditions prevalent in refugee camps. However, a paradigm shift is gaining interest, emphasizing the empowerment of refugees as mental health trainers in their communities. "Mental health training of non-specialized staff in complex humanitarian settings is feasible and can lead to increased competency of providers" [21]. Silove et al. [18] highlights the urgent psychological needs of displaced populations, and this scoping review study responds by examining how Community Health Workers can help bridge mental health service gaps in refugee camps.

Furthermore, this shift is consistent with the principles of community-driven interventions and the goals of sustainable development. LMICs are facing multiple challenges to achieving Sustainable Development Goals (SDG) health targets and the Universal Health Coverage (UHC) [58]. These constraints encompass infrastructure limitations, healthcare and political systems, and their interaction with individuals' mental bandwidth, cognition, and executive function [55, 65]. Empowering refugees to become mental health trainers not only addresses immediate mental health needs, but also lays the groundwork for long-term community resilience, which will make refugees heard and seen. It is not a zero-sum game; these community health workers can potentially bridge cultural gaps and provide a more nuanced understanding of the psychological challenges faced by their fellow refugees by adopting a curriculum tailored to the specific cultural context of each camp. In qualitative interviews with

mental health professionals providing services to refugees in Jordan, participants highlighted various obstacles to delivering effective care in refugee settings [19]. These challenges encompassed financial constraints, a shortage of mental health professionals, uneven geographic accessibility, pervasive stigma, clinician burnout, insufficient visibility of services, and inadequate or non-existent screening protocols [19]. An illustrative example arises from a report by Dajani and Makri [11] on empowerment, where the quantitative tool failed to reveal impact. However, a deeper examination of women's narratives revealed the profound impact, emphasizing the importance of capturing and valuing local narratives over standardized survey methodologies based on Western perspectives.

On the other hand, the traditional method of bringing in foreign mental health trainers has its advantages. This method frequently brings a wealth of expertise and experience in dealing with a wide range of psychological conditions. However, their vices have to be amplified. It does come with its own set of challenges, such as the high financial costs associated with international travel, lodging, and specialized training. Furthermore, there may be a cultural divide between the external trainers and the refugee population, which could reduce the effectiveness of the intervention. "Poor refugee community acceptance of the CHWs impaired their effectiveness, and was attributed to age, sex and socioeconomic barriers" [24]. It is critical to recognize that some of these studies are clearly out of date, emphasizing that healthcare worker training is not a new concept, highlighting its enduring importance.

To improve the effectiveness of mental health interventions in the MENA region, it is critical to learn from CHWs' experiences elsewhere. By learning from the solutions proposed by *Promotoras de salud* (Spanish term commonly used to describe community health workers) [56], the region can devise strategies to assist CHWs in managing work-life balance, navigating cultural nuances, and addressing mental health challenges in the Middle East and North Africa. In doing so, this effort aims to bridge the gap between available services and the growing need for mental health care.

The core objective of our study is to compare the advantages and disadvantages of two models of deploying Community Health Workers (CHWs) in refugee camps: those recruited from within the refugee community versus those deployed by external organizations (e.g., NGOs and international agencies). To achieve this, we conducted a comprehensive scoping review relevant to each model.

Methods

Study design and information sources

To address the objectives of this study, a scoping review methodology was employed to systematically search for relevant articles. The search process involved exploring databases such as PubMed and Google Scholar. Keywords included "mental health," "refugee camps," "community health workers," "health inequality," "STROBE approach," "SDGs" and "MENA". The listed keywords are exhaustive and were selected to ensure the inclusion of a wide range of studies on mental health interventions in refugee camps across the MENA region and globally. The objective was to gather comprehensive information about mental health interventions in refugee camps, with an emphasis on studies conducted in various countries around the world, including those in the MENA region. The search strategy was comprehensive in order to obtain the full range of published literature.

Inclusion criteria (37 articles included)

1. Studies conducted globally to enable cross-cultural and contextual comparisons.
2. Research focusing on direct mental health interventions in refugee camps, specifically examining the advantages or disadvantages associated with training refugees or the introduction of external expertise.
3. Articles published within the last fifteen years were considered to ensure relevance, with a few older studies deemed important and therefore included.
4. Articles published in English to ensure consistency in language interpretation and understanding.
5. Studies conducted in host countries of refugees or migrants were included, focusing on their unique contextual challenges and mental health interventions.

Exclusion criteria (20 articles excluded)

1. Studies not related to mental health interventions in refugee camps.
2. Articles not published in English, as language consistency aids in the comprehensive analysis of findings.
3. Studies that do not specify the host country of the refugees were excluded.
4. Studies were excluded if they did not provide substantial insights into the effectiveness of mental health approaches in refugee settings.

Data extraction

The data extraction process was systematically organized, involving the selection of studies based on predetermined inclusion criteria. The initial phases included keyword usage and title scrutiny, as well as filtering studies relevant to the investigation's focus. A comprehensive review of chosen research applied inclusion criteria, ensuring alignment with study objectives. The Refugee Training perspective guided a straightforward approach, emphasizing the selection of studies addressing positive or negative aspects of appointing refugees within the camp, as well as appointing external experts. It was ensured that external experts were recruited from outside the camp, with all staff and experts sourced externally considered eligible for inclusion in the comparison. The process facilitated a nuanced evaluation of internal and external appointments, providing insights into mental health intervention effectiveness in the refugee context. Variables extracted included host country, home country if specified, and outcomes, enhancing the depth of understanding. The careful review of studies meeting inclusion criteria ensured the extraction of pertinent information. Studies that did not meet these criteria were excluded.

Justification

By adopting a global perspective and including studies from various refugee camps worldwide, this approach, based on the retrieval of 57 articles, aims to facilitate a scientific comparison between the efficacy of interventions led by refugees and those involving external experts. The comprehensive search yielded a diverse set of literature, enabling an in-depth exploration of mental health interventions. The utilization of English-language publications among the retrieved articles ensures clarity and consistency in the analysis, promoting a comprehensive understanding of the diverse experiences and practices across different regions. This rigorous approach, considering 57 articles, establishes a robust foundation for the subsequent comparative analysis of mental health interventions in refugee camps. To provide a clear overview of the study selection process, Fig. 1 illustrates the number of articles identified, duplicates removed, studies excluded, and those ultimately included in the final analysis.

STROBE approach

The study adhered to the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) approach. STROBE provides a structured framework for reporting observational studies, enhancing transparency and rigor. The utilization of STROBE facilitated comprehensive and standardized reporting of the research methods, ensuring clarity and replicability.

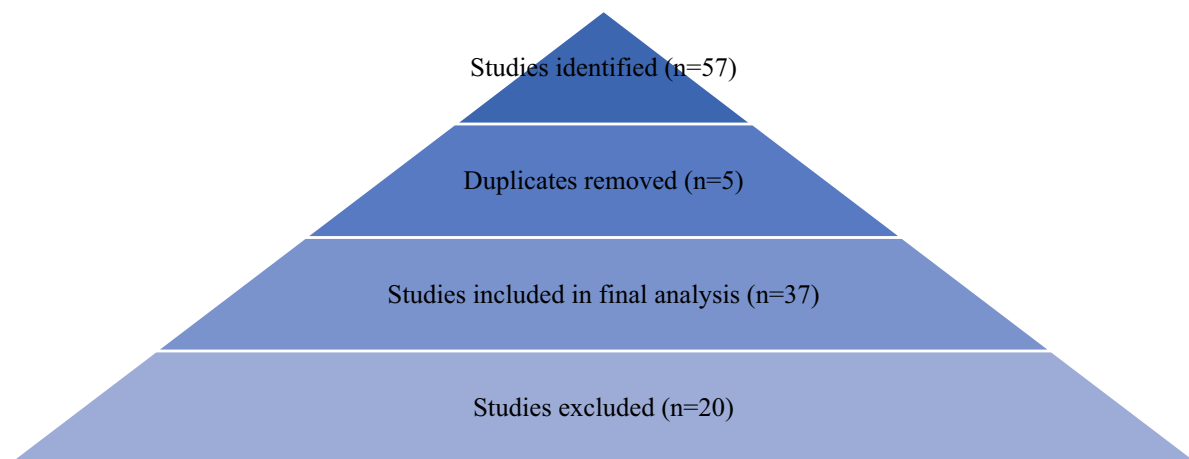


Fig. 1 Flow diagram of study selection process

In the forthcoming section, Table 1, named "STROBE Framework Table," will be presented. This table summarizes the scoping review's key findings, providing insights into the comparative analysis of mental health interventions in global refugee camps. It outlines the study design, objectives, participants, variables, data sources, and statistical methods used. Additionally, the table highlights inclusion criteria, potential bias, and key findings, offering a concise overview of the study's methodology guided by the STROBE approach.

The study compared two different approaches: one that involved recruiting specialized trainers from other countries, and another that empowered refugees to become mental health trainers in their own communities. The analysis, following STROBE guidelines, with careful attention to methodological rigor and transparency, considered various factors, including study design, participant characteristics, and outcome measures. The goal was to assess the social, psychological, and cultural implications of each approach to determine their efficacy and sustainability in addressing mental health needs in challenging refugee camp settings.

The data synthesis included a qualitative analysis of the selected articles to identify common themes and patterns regarding the impact of the two approaches on mental health outcomes. In conclusion, the scoping review methodology, guided by the STROBE approach, enabled a thorough examination of the effectiveness and sustainability of mental health interventions in refugee camps, contrasting the recruitment of external experts with empowering refugees as mental health trainers within their communities. The comparisons are presented in the following section, providing insights into the different

implications of these approaches on mental health outcomes in challenging camp settings.

Findings

This section presents the key outcomes of the comparative analysis of mental health interventions in refugee settings. Based on the studies reviewed, it looks at the ways different training strategies certified by external experts, or developed to empower refugees already, impact availability and accessibility of mental health services, their cultural compatibility, and the existence of community outcomes. These tables consolidate and compare the pros and cons of these modalities, providing evidence for the pragmatics and social consequences of each approach.

Table 2 presents a comprehensive overview of the advantages and disadvantages associated with various approaches to utilizing refugees as trainers to address mental health needs across diverse host countries. Cutts [12] highlights the flexibility and resourcefulness of employing refugees as trainers, particularly in countries facing shortages of experienced personnel. However, Simmonds et al. [4] note challenges such as the absence of community spirit and insufficient financial support in host countries. Nunnery and Dharod [2], along with Uitterhaegen [7], emphasize the benefits of shared backgrounds and community familiarity among refugee community health workers (CHWs) in fostering collaborative operations. Conversely, Black et al. [10] underscore technological constraints and recruitment issues in host countries. Additionally, Karaman and Ricard [38], as well as Eluka et al. [25], highlight the cultural compatibility of service providers with refugees as a significant advantage. Overall, Table 2 reveals a predominance of advantages over disadvantages in

Table 1 STROBE framework

Section/topic	
Title and Abstract	Title: Community Health Workers in Refugee Camps: A Scoping Review Abstract: This socioeconomic study compares mental health interventions in global refugee camps, contrasting the recruitment of external experts with empowering refugees as mental health trainers. The analysis explores social and psychological implications to determine effective and sustainable methods
Methods	
Study Design and Objectives	Research Question: Assess the effectiveness and sustainability of mental health interventions in refugee camps Study Design: Comparative cross-sectional analysis Sampling: Randomized selection of global studies on mental health interventions in refugee camps
Setting and Participants	Setting: Various refugee camps worldwide Participants: Refugees engaged in mental health interventions Inclusion Criteria: Studies with a clear host country specification
Variables	Exposure Variables: Socioeconomic status indicators, income, education Outcome Variables: Mental health outcomes, community resilience Measurement: Utilized standardized scales and surveys
Data Sources/Measurement	Data Sources: The study draws from a range of global sources, including studies, surveys, and interviews embedded within the selected studies conducted in various regions Measurement Tools: Given the scope of this review, specific standardized measurement tools were not employed. To achieve a comprehensive overview of the literature, the methodology focused on mapping and summarizing a diverse range of global sources, including studies, surveys, and interviews
Bias	Potential Bias: Selection bias Bias Minimization: Rigorous study design, standardized measurement tools
Statistical Methods	Data Analysis: Given the scoping nature of the review, no statistical analysis was conducted. The study focused on mapping and summarizing the existing literature without employing quantitative statistical methods." Adjustments: Controlling confounding variables and socioeconomic stratification Sensitivity Analyses: While the study did not conduct specific sensitivity analyses, the scoping review inherently considered variations in the literature, acknowledging, and addressing the diverse sources and perspectives included in the mapping and summarization process
Results	
Key Findings	Empowering refugees to become mental health trainers provides long-term and culturally appropriate support
Effect Estimates	Positive associations with community resilience
Discussion	
Interpretation	Findings aligned with existing literature on community-driven approaches
Implications	Advocating for policies and practices that promote refugee-led mental health initiatives
Limitations	Potential bias in the selection process
Conclusion	
Main Findings	Empowering refugees enhances mental health support in global refugee camps
Recommendations	Support for community-driven mental health interventions, further research on scalability and long-term effectiveness, and conducting interviews with stakeholders directly involved with refugees

utilizing refugees as trainers to address mental health needs across various host countries. This, in turn, suggests a potential reduction in health inequalities, as refugees take an active role in addressing mental health challenges within their communities. Where empathy depends on privilege, training these marginalized individuals not only empowers them but also fosters a deeper sense of understanding and compassion within society as a whole. Their attitudes will change, leading to a more inclusive and supportive environment for all.

Table 3 provides a comprehensive overview of the advantages and disadvantages associated with

introducing external community health workers (CHWs) to address mental health needs in refugee camps. The advantages highlighted include increased access to clinic-based services for highly disengaged individuals, promotion of personal and community growth by external psychotherapists, advancement in health promotion outcomes, and enhanced social capital. However, the disadvantages outlined indicate significant challenges, including cultural barriers such as mental health stigma and language proficiency, which are among the most important and most frequent defects. Additionally, structural barriers like financial strain and unstable housing,

Table 2 Advantages and Disadvantages for embracing training by *refugee camps people themselves* to be Community Health Workers(CHW)

Advantages	Disadvantages
<p>(Cutts, [12]):</p> <ul style="list-style-type: none"> There is flexibility in utilizing refugees as trainers, particularly in terms of teaching hours When there is a shortage of experienced personnel in the host country within the fields of health and training, refugees can fill this gap In some countries, policies prohibit the utilization of international staff, leading to the use of refugees as trainers, aligning with such policies The training of refugees facilitates the training process as they belong to the same community and share the same language <p><i>Host country: Pakistan</i> <i>Home country: Afghanistan</i></p>	<p>(Simmonds et al., [4]):</p> <ul style="list-style-type: none"> Absence of a cohesive community spirit Insufficient financial support and incentives for primary healthcare workers <p><i>Host country: India, Somalia, Pakistan, Philippines, Honduras, Tanzania, and Thailand</i> <i>Home country: Tibet, Ethiopia, Afghanistan, Vietnam, Cambodia, and Laos</i></p>
<p>(Nunnery and Dharod, [2, 7]):</p> <ul style="list-style-type: none"> CHWs who are refugees share a common background and are familiar with the community, providing a conducive environment for collaborative operations with others <p><i>Host country: The United States; the Netherlands</i> <i>Home country: Bhutan, Liberia, and Vietnam; Different countries</i></p>	<p>(Black et al., [10]):</p> <ul style="list-style-type: none"> Technological constraints, stemming from a low level of digital literacy among refugees and the associated costs of education The recruitment and retention of participants pose intricate issues, as communities exhibit diversity in both their availability and willingness to engage <p><i>Host country: The United States</i> <i>Home country: Somalia</i></p>
<p>(Pratt et al., [13]):</p> <ul style="list-style-type: none"> Refugees will acquire problem-solving, stress reduction, and anger management skills through participation in the program <p><i>Host country: The United States</i> <i>Home country: Somalia</i></p>	<p>(Eluka et al., [25]):</p> <ul style="list-style-type: none"> Establishing and maintaining professional boundaries with clients poses inherent challenges Managing frustration and disappointment when confronted with unfavorable outcomes for their clients <p><i>Host country: The United States</i> <i>Home country: Central African Republic, Vietnam, Burundi, Myanmar, Eritrea, Rwanda, and Nepal</i></p>
<p>(Eluka et al., [25]):</p> <ul style="list-style-type: none"> They will employ widely understood cultural languages and encourage a sincere and empathetic internal dialogue with patience They will acquire English through formal or informal means <p><i>Host country: The United States</i> <i>Home country: Central African Republic, Vietnam, Burundi, Myanmar, Eritrea, Rwanda, and Nepal</i></p>	<p>(Simmelink and Shannon, [34]):</p> <ul style="list-style-type: none"> While community-based organizations led by refugees acknowledge mental health symptoms among refugees, they may be less inclined to evaluate these symptoms and make referrals for treatment <p><i>Host country: The United States</i> <i>Home country: Non-Western countries</i></p>
<p>(Salem-Pickartz, [26]):</p> <ul style="list-style-type: none"> Enhancing the knowledge and skills of participants for effective development Establishing practical benchmarks for individuals to manage the distress experienced by fellow community members Cultivating self-awareness in managing personal distress <p><i>Host country: Jordan</i> <i>Home country: Iraq</i></p>	<p>(Subedi et al., [47]):</p> <ul style="list-style-type: none"> There is no decrease in negative attitudes toward people with mental illnesses <p><i>Host country: The United States</i> <i>Home country: Bhutan</i></p>
<p>(McDonald et al., [33]):</p> <ul style="list-style-type: none"> Training leads to the restructuring of participants' pre-existing knowledge Training fosters empathy towards refugees Participants acquire new knowledge and perspectives <p><i>Host country: Sweden</i> <i>Home country: Different countries</i></p>	<p>(Mangeni et al., [50]):</p> <ul style="list-style-type: none"> "Unequal power dynamics and negative views of "incentive workers" (e.g., people who don't know what they are doing, they consider us inferior)" <p><i>Host country: Kenya</i> <i>Home country: Somalia</i></p>
<p>(Slewa-Younan et al., [36]):</p> <ul style="list-style-type: none"> Comprehending the life experiences, loss, and grief of older refugees, assessing the influence of their experiences in old age, and gauging their capacity to locate Accessing information to aid in the care of older refugees <p><i>Host country: Australia</i> <i>Home country: Different countries</i></p>	<p>(Bond et al., [52]):</p> <ul style="list-style-type: none"> A significant challenge faced by many young refugee individuals is their absence of formal education prior to arrival <p><i>Host country: Australia</i> <i>Home country: Different countries from Africa and the Middle East</i></p>

Table 2 (continued)

Advantages	Disadvantages
<p>(Karaman & Ricard, [38]): A group of trained mental health facilitators among refugees can address these issues fundamentally:</p> <ul style="list-style-type: none"> ▪ Cultural and Spiritual Challenges ▪ Challenges With Counseling Interventions ▪ Language Barriers <p><i>Host country: Turkey</i> <i>Home country: Syria</i></p>	<p>(Bajwa et al., [53]):</p> <ul style="list-style-type: none"> ▪ Informational barriers prevent students from navigating educational pathways, accessing professional supports, evaluating credentials, financing education, navigating immigration systems, using online resources, and advancing their education, causing mental health distress <p><i>Host country: Canada</i> <i>Home country: different countries from Central and South America, Africa, the Middle East, and Asia</i></p>
<p>(Subedi et al., [47]):</p> <ul style="list-style-type: none"> ▪ Refugees are demonstrating significant improvement in recognizing depression symptoms and are expressing treatment beliefs that align with those of mental health professionals <p><i>Host country: the United States</i> <i>Home country: Bhutan</i></p>	<p>(Salvo and Williams, [54]):</p> <ul style="list-style-type: none"> ▪ A significant number of refugees and asylum seekers have limited proficiency in English <p><i>Host country: UK</i> <i>Home country: Different countries from East Africa, Middle East, East Africa, and Eastern Europe</i></p>
<p>(Im and Swan, [48]):</p> <ul style="list-style-type: none"> ▪ Significant improvement in providers' understanding of the effects of trauma, cultural expressions of trauma and stress-related symptoms, and culturally responsive, trauma-informed care <p><i>Host country: the United States</i> <i>Home country: Afghanistan, Bhutan, Democratic Republic of the Congo, and Myanmar</i></p>	
<p>(Ehiri et al., [51]):</p> <ul style="list-style-type: none"> ▪ Enhancing service coverage, promoting awareness of disease symptoms and prevention methods, encouraging the adoption of improved behaviors related to seeking treatment and protection, boosting service uptake <p><i>Host country: Africa (Guinea and Tanzania), Central America (Belize), and Asia (Myanmar)</i> <i>Home country: Liberia, Sierra Leone, Myanmar, Thai-Myanmar border, and Democratic Republic of the Congo</i></p>	

and refugee-specific barriers such as immigration status and confidentiality concerns, present formidable challenges. Furthermore, concerns regarding the high expense of supervising lay health worker models suggest potential funding and interest gaps in refugee mental health initiatives. Coordination of care and reluctance to attend to refugees also pose significant obstacles. The table suggests that while external CHWs offer certain benefits, the challenges they face, particularly in terms of cultural and structural barriers, may outweigh the advantages in some contexts, potentially leading to increased health inequalities.

Discussion

Key comparative findings: benefits, barriers, and regional lessons

The study provides valuable insights into the contrasting approaches of utilizing refugees and external community health workers (CHWs) to address mental health needs in refugee camps. By employing a scoping review methodology, the research explores the advantages and disadvantages of each approach across diverse host countries. In research conducted by Nunnery and Dharod [2] aimed to identify key characteristics of Community Health Workers (CHWs) and delineate the pivotal role

of CHWs in engaging with and conducting health-based research among underserved refugee populations in the United States. Recruitment requirements for potential CHWs included individuals with the same background as the study community, who had resided in the research region for several years. CHWs demonstrated the highest effectiveness when possessing certain key attributes, such as a strong commitment to the community and study efforts. This approach aligns with the principles of empowerment and sustainability advocated by international organizations such as the World Health Organization (WHO) and the United Nations High Commissioner for Refugees (UNHCR). Murray et al. [16] has offered a succinct overview of refugee research, assessing therapeutic interventions in resettlement contexts. The study provides recommendations for best practices, urging further evaluation of diverse psychotherapeutic, psychosocial, pharmacological, and other approaches, emphasizing personal and community growth in resettlement countries.

One of the key findings is the prevalence of advantages over disadvantages in utilizing refugees as trainers to address mental health needs across various host countries. Using a model in which health workers from within refugee camps provide mental health services improves

Table 3 Advantages and disadvantages of introducing external Community Health Workers(CHW)

Advantages	Disadvantages
<p>(Miller, [6]):</p> <ul style="list-style-type: none"> ▪ Clinic-based services assist highly disengaged individuals in refugee communities in more effectively participating in community programs by reducing the intrusive symptoms of trauma and depression <p><i>Host country: Industrialized countries (USA in particular)</i> <i>Home country: Refugees from several different countries are mentioned, including Bosnia and Herzegovina and Guatemala</i></p>	<p>(Ryan and Epstein, [14]):</p> <ul style="list-style-type: none"> ▪ Cultural differences, Difficulty finding bilingual staff <p><i>Host country: The United States</i> <i>Home country: Cambodia and Vietnam</i></p>
<p>(Murray et al., [16]):</p> <ul style="list-style-type: none"> ▪ external experts of psychotherapists promote personal and community growth <p><i>Host country: The United States</i> <i>Home country: Different countries</i></p>	<p>(Murray et al., [16]):</p> <ul style="list-style-type: none"> ▪ More funding and training for those working with clients from refugee backgrounds <p><i>Host country: The United States</i> <i>Home country: Different countries</i></p>
<p>(Marsh, [30]):</p> <ul style="list-style-type: none"> ▪ Investigating the cultural attitudes of clinicians to enhance self-awareness across various levels, such as physiological, psychological, and interpersonal dimensions ▪ Enhancing clinicians' understanding of refugee resettlement ▪ Cultivating intervention skills among clinicians for effective work with this vulnerable population <p><i>Host country: United States and other Western countries, the Middle East including to Jordan, Lebanon, Syria, and Egypt</i> <i>Home country: Iraq</i></p>	<p>(Byrow et al., [22]):</p> <ul style="list-style-type: none"> ▪ Cultural barriers, such as mental health stigma and knowledge of dominant models ▪ Structural barriers, such as financial strain, language proficiency, unstable housing, and a lack of understanding of how to access services ▪ Refugee-specific barriers, such as immigration status, distrust of authority figures, and confidentiality concerns <p><i>Host country: Australia, Canada, Denmark, Greece, Italy, Norway, South Korea, Sweden, the Netherlands, the United Kingdom, the United States, Jordan, Kenya, Lebanon, and Turkey</i> <i>Home country: Albania, Afghanistan, Bhutan, Bosnia, Burma, China, Cote d'Ivoire, Democratic Republic of Congo, Djibouti, Eritrea, Ethiopia, Iran, Iraq, Liberia, Middle East, Pakistan, Serbia, Somalia, Southeast Asia, Sri Lanka, South Sudan and Tanzania</i></p>
<p>(Im and Rosenberg, [31]):</p> <ul style="list-style-type: none"> ▪ Advancement in hraealth promotion outcomes, encompassing heightened health knowledge and competence in accessing appropriate health resources ▪ Enhanced health practices, involving shifts in health behaviors and improved coping mechanisms ▪ Augmentation of health, manifested as alterations in perceived or subjective well-being ▪ Establishment and reinforcement of social capital as the foundation for a healthy lifestyle <p><i>Host country: the United States</i> <i>Home country: Bhutan</i></p>	<p>(Kohrt et al., [23]):</p> <ul style="list-style-type: none"> ▪ The expense associated with supervising a model led by lay health workers is excessively high <p><i>Host country: Brazil, China, Colombia, the Democratic Republic of Congo, Pakistan, Sri Lanka, Thailand, and Uganda, sub-Saharan Africa, South Asia, Mexico, Chile, Eastern Europe, India, Iran, South Africa and Turkey, Vietnam, and Malaysia</i> <i>Home country: Unspecified</i></p>
<p>(Shannon et al., [32]):</p> <ul style="list-style-type: none"> ▪ Coordination of active care, proactive resolution of obstacles, trust establishment & the provision of culturally responsive care <p><i>Host country: The United States</i> <i>Home country: Cambodia, Democratic Republic of the Congo, Eritrea, Ethiopia, French-speaking Africans, Hmong and Karen speakers, Laos, Liberia, Iraq, Russia, Somalia, Uganda, and Vietnam</i></p>	<p>(Keller and Mongkolpue, [24]):</p> <ul style="list-style-type: none"> ▪ The brevity of numerous expatriate contracts often leads to a mindset focused on short durations ▪ Training in interpersonal skills is essential for external CHW's ▪ Conflicts arise between educated, upper-class CHW's and the majority of the uneducated camp <p><i>Host country: Thailand</i> <i>Home country: Cambodia</i></p>
<p>(Bäärnhielm et al., [35]):</p> <ul style="list-style-type: none"> ▪ Training leads to an enhanced capacity among participants to comprehend the social vulnerability of recently arrived refugees experiencing mental distress <p><i>Host country: Sweden</i> <i>Home country: Finland, Iraq, Syria, Afghanistan, Somalia, and Stateless people</i></p>	<p>(Tarannum et al., [27]):</p> <ul style="list-style-type: none"> ▪ External participants require comprehensive training in conducting mental state examinations, delivering psychoeducation, and bolstering psychosocial support <p><i>Host country: Bangladesh</i> <i>Home country: Myanmar</i></p>
<p>(Orang et al., [44]):</p> <ul style="list-style-type: none"> ▪ External counselor-led sessions improved the resilience and perspective-taking of migrants and refugees <p><i>Host country: Germany</i> <i>Home country: Iran, Afghanistan, Syria, Guinea, Iraq, Lebanon, Burkina Faso, Egypt, Palestine, and Yemen</i></p>	<p>(Mattar et al., [28]):</p> <ul style="list-style-type: none"> ▪ Therapist training should prioritize establishing a secure and affirming therapeutic environment conducive to aiding patients in integrating their sense of self and life experiences ▪ Therapists' training should address interpersonal relational patterns, aiming to create a secure space for refugees to navigate trauma and integrate their sense of self <p><i>Host country: The United States</i> <i>Home country: Unspecified</i></p>

Table 3 (continued)

Advantages	Disadvantages
<p>(Sualp et al., [45]):</p> <ul style="list-style-type: none"> ▪ Mental health professionals assessed the personal and interpersonal development skills, trauma resilience, and adaptation of Syrian refugee children <p>Host country: Turkey Home country: Syria</p> <p>(Tribe, [46]):</p> <p>Community groups and clinicians may be able to provide services that are culturally and linguistically appropriate, accessible, and possibly less stigmatizing</p> <p>Host country: UK Home country: Unspecified</p>	<p>(Pejic et al., [29]):</p> <ul style="list-style-type: none"> ▪ Significance of supervision, cultural obstacles, requirement for additional resources, and impact on future practices <p>Host country: the United States Home country: Iraq</p> <p>(Shannon et al., [32]):</p> <ul style="list-style-type: none"> ▪ Cultural obstacles, absence of care coordination, reluctance to attend to refugees & system and language barriers <p>Host country: The United States Home country: Cambodia, Democratic Republic of the Congo, Eritrea, Ethiopia, French-speaking Africans, Hmong and Karen speakers, Laos, Liberia, Iraq, Russia, Somalia, Uganda, and Vietnam</p> <p>(Sualp et al., [45]):</p> <ul style="list-style-type: none"> ▪ Culture and language issues, access, intervention, organizational and system-related barriers, and barriers resulting from ongoing trauma and abuse of Syrian refugee children, as well as secondary trauma experienced by mental health professionals providing services <p>Host country: Turkey Home country: Syria</p> <p>(Franks et al., [49]):</p> <ul style="list-style-type: none"> ▪ Varied perceptions of mental health issues, insufficient recognition, discussion, and prioritization of such problems, social stigma, limited awareness of available services, apprehension towards authority, and a deficit of trust ▪ Resource constraints, absence of interpretation and translation assistance, as well as practical obstacles like transportation and appointment scheduling <p>Host country: UK Home country: Portugal, Eastern Europe, Africa and South America</p> <p>Salami et al. ([5]):</p> <p>linguistic barriers, cultural interpretations of mental health, and stigma surrounding mental illness</p> <p>Host country: Canada Home country: Unspecified</p>

access to these services and has a direct positive impact on refugees' livelihoods. It also stimulates the local camp economy by creating jobs, which may, in turn, contribute to the broader host country economy [71]. Also, SDGs are interconnected in a refugee camp placing [42]. These benefits contribute to SDG 3 (Good Health and Well-Being) in terms of increased access to and quality of mental health care as well as SDG 4 (Quality Education) through the capacity-building of refugee CHWs. As trainers, refugee providers provide culturally sensitive care, and receive a valuable educational experience to promote the resilience of the community and reducing health inequalities. The advantages identified include flexibility, resourcefulness, shared backgrounds, community familiarity, and cultural compatibility among refugee CHWs. These factors contribute to the effectiveness and sustainability of mental health interventions, highlighting the importance of community-driven approaches in refugee settings. However, the study also highlights significant challenges associated with introducing external CHWs to address mental health needs in refugee camps.

Additionally, coordination of care and reluctance to attend to refugees' present formidable obstacles, potentially limiting the effectiveness of external CHWs in providing mental health support. Moreover, training CHWs poses challenges, especially considering the lack of recognition in various cultures. Orpinas et al. [56] explored the challenges and solutions faced by CHWs or *Promotoras de salud* from their perspectives. *Promotoras de salud* identified eight key challenges, including balancing work with family commitments, addressing power imbalances, managing emotional impact, overcoming language barriers, navigating discrimination, coping with cultural beliefs, dealing with transportation issues, and handling the data collection burden related to research. These challenges complicate their prospects for securing employment readily. Furthermore, one of the major challenges identified is the recruitment of CHWs from within refugee populations. Refugees often face legal barriers to formal employment, lack prior health-related training, and experience high levels of psychological distress themselves, all of which complicate recruitment efforts

[66]. Additionally, training programs must be culturally adapted and trauma-informed, but they are frequently underfunded or implemented inconsistently by different NGOs. These challenges highlight the need for long-term investment in structured, certified CHW training programs that account for both the vulnerabilities and capacities of refugee communities.

Kiselev et al. [3] investigated structural and sociocultural impediments to mental health care accessibility among Syrian refugees in Switzerland. Findings reveal significant socio-cultural barriers, prompting the suggestion to enhance overall service system agility and foster a proclivity for innovative approaches rather than tailoring mental health services to individual barriers and the needs of this new demographic. Providing culturally appropriate services for refugee populations, particularly in healthcare and social services, faces challenges due to ambiguous definitions and operationalization of cultural competence. Furthermore, the cultural competence literature inadequately addresses the distinct needs and priorities of individuals from refugee backgrounds [17]. From a regional perspective, in the MENA area, political factionalism, poor governance, and economic hardships have long caused fragility and instability. Particularly in addressing mental health issues, these structural problems directly affect the ability to meet refugee needs [69]. The ongoing refugee crisis poses significant and unforeseen health challenges for displaced individuals residing in camps [40]. Our research underscores the critical issue of health inequality within refugee camps, a key finding highlighted by previous studies. Comparing the advantages of employing refugees as mental health trainers versus external employees, we find that the former offers greater benefits, potentially leading to a reduction in health disparities among refugees. This underscores the importance for policymakers and healthcare providers to prioritize addressing health inequalities within refugee populations.

Advancing health justice in Jordan: policy, practice, and theory

Although most of the Arab world has underdeveloped and underused the more general concept of social justice, the idea of justice in health, defined as fair access, equal treatment, and the equitable distribution of health resources, remains vital, especially in underprivileged environments like refugee camps. As an example from the MENA region and one of the Low- and Middle-Income Countries, Jordan, is among the highest countries relative to population that host refugees; it is also an LMIC [68]. In 2023, almost 25% of Jordan's population registered with the United Nations (UN)-such as UNHCR (for non-Palestinian refugees) and UNRWA (for Palestinian

refugees)- underscoring the nation's central responsibility in managing displacement and its reliance on foreign aid to maintain refugee support systems [67]. Health equity is present in Jordan to a considerable extent. 76.8% of the Jordanian population is covered by some form of health-care insurance, including government, private, and other insurance schemes. Among non-Jordanians who are not classified as refugees, the coverage rate is 25.3% [60]. Furthermore, Jordan has integrated refugees into the national health system, granting those registered with the Ministry of Interior access to public healthcare in their area of residence, similar to uninsured Jordanians [61]. Jordan was also one of the first countries to provide the COVID-19 vaccine to Syrian refugees. On January 14, 2021, Iraqi and Syrian refugees in camps began receiving their first doses of the vaccine in accordance with government guidelines [62]. This model decentralizes health service provision, respects cultural and linguistic contexts, and redistributes health agency to marginalized groups. Justice in health can be practically advanced in the framework of Syrian refugee camps in Jordan by means of the deployment and empowerment of CHWs hired from among the refugee population. Theoretically, this aligns with Amartya Sen's Capabilities Approach, which views expanding people's real freedoms, including the ability to live a healthy life, as central to justice [63]. In the context of health, this means allowing every person, including refugees, to obtain the requirements for both physical and psychological well-being. Practically, models supported by UNHCR in Zaatari and Azraq camps offer early evidence of success in promoting equitable health outcomes, improving trust in health systems, and bridging the gap between formal health institutions and the camp population. Practically, models supported by UNHCR in Zaatari and Azraq camps offer early evidence of success in promoting equitable health outcomes, improving trust in health systems, and bridging the gap between formal health institutions and the camp population [64]. These localized solutions provide a basis for scaling justice in health throughout the Arab region. Particularly when combined with supportive policies and investment in refugee leadership and training.

Regional case studies and innovative delivery models

By visiting MENA countries, a study by Sagaltici et al. [1] delves into the identification of various traumatic experiences, as well as the determination of predictors influencing the severity of Post-Traumatic Stress Disorder (PTSD) among Syrian refugees residing in a camp in Turkey. Considering that a considerable portion of Syrian refugees has already integrated into various towns in the country, those residing in camps potentially represent a particularly vulnerable subgroup. For an extended

period, the Syrian crisis persists, exerting a significant social and economic influence on the nations hosting Syrian refugees. The prolonged Syrian crisis and displacement stressors have inflicted enduring mental health challenges on Syrian refugees in Jordan. Children and adolescents grapple with issues like depression, anxiety, post-traumatic disorders, racial discrimination, and emotional problems [59]. Non-governmental organizations primarily deliver Mental Health and Psychosocial Support (MHPSS) services, with 75% being provided by non-specialized staff and 20% by specialized national staff; despite these efforts, specialized services constitute only a fraction, with the focus mainly on non-specialist provision and integrating MHPSS into broader humanitarian aid sectors [59]. Declared the most severe humanitarian crisis by the United Nations, the Syrian refugee crisis places immense strain on neighboring nations like Jordan. Al-Rousan et al. [9] explored perspectives from Syrian refugees, Jordanian healthcare providers, and stakeholders. Cost emerged as a notable barrier to healthcare access for refugees, emphasizing the urgent need to allocate resources for chronic illness and mental health, a crucial aspect amid limited resources. The World Health Organization and collaborators developed a program to bolster mental health service delivery in an integrated healthcare model for refugees and displaced individuals. Furthermore, Karaman and Ricard [38] tackled the mental health requirements of Syrian refugees in Turkey, offering insights for counseling professionals aiding displaced individuals through a crisis intervention method rooted in humanistic mental health principles and perspectives. Kerbage et al. [37] utilized semi-structured and in-depth interviews with 60 policymakers and 25 Syrian participants in Lebanon's refugee mental health services. Refugees saw their distress as a normal response to adversity, contrasting with professionals who viewed it as indicative of mental illness. Practitioners cited Syrian culture as a care barrier, prioritizing mental health education for refugees. Policymakers justified short-term interventions due to the crisis, while refugees sought community-based interventions and resettlement for improved living conditions. Mistrust endangers the therapeutic relationship. In a study by Akhtar et al. [39], the research protocol is outlined for a trial of group problem management plus (gPM+), a group-based intervention devised by the World Health Organization. This intervention, consisting of five sessions, is designed to be administered by non-specialist providers in Jordan. The primary objective is to assess the reduction in levels of psychological distress in three months' post-treatment. The trial aimed to establish a framework for cost-effective and scalable psychosocial interventions suitable for implementation in refugee settings, benefiting both

participants and their children. WHO promotes using affordable technology to improve healthcare, especially at the primary level. The International Telecommunication Union has led mobile health (m-health) efforts in developing countries since 2002. These nations face challenges with diseases, limited funds, and a loss of skilled health workers [57]. The Hispano-American Health Link program initiated with a pilot project deploying 39 sets of m-health equipment to health posts and centers within a district health system. These m-health projects primarily aimed to extend essential primary health care services to rural communities previously underserved [57]. The findings of these studies can offer valuable insights for similar situations in developing nations like Jordan, presenting potential strategies to address healthcare challenges.

Recommendations and policy implications

The findings suggest the need for a comprehensive approach that takes into account the contextual factors and challenges specific to each host country. This includes addressing cultural and structural barriers, ensuring adequate funding and resources, enhancing coordination of care, and promoting community engagement in mental health interventions. Solving different trauma and mental health issues through CHWs from the same society could be related to human capital investment, as it represents a core but often overlooked component of human capital. Moreover, the study emphasizes the importance of understanding the narratives and perspectives of refugees themselves in designing and implementing effective mental health support programs. Overall, the study contributes to the ongoing discourse on optimizing mental health support in refugee camps by comparing the advantages and disadvantages of utilizing refugees and external CHWs. Consequently, dealing with data must be conducted efficiently. It highlights the potential of community-driven approaches in addressing mental health needs and underscores the importance of addressing contextual factors and challenges to ensure the effectiveness and sustainability of mental health interventions in refugee settings. Furthermore, emphasizing the importance of these programs is beneficial, as their continued implementation has the potential to reduce health disparities in MENA region. This aligns with the overarching global goal of reducing inequality within and among countries. Governments play a pivotal role in fostering these initiatives in line with Targets 10.2 and 10.4. The former urges the promotion of universal social, economic, and political inclusion, while the latter emphasizes the adoption of fiscal and social policies that actively foster equality. It is imperative that governments actively endorse and support these measures to propel progress towards achieving these significant targets.

Limitations

This study has several limitations. First, there is a potential for selection bias, as the scoping review included only studies published in English and those available in specific databases, which may have excluded relevant research conducted in Arabic or in grey literature sources from the MENA region. Second, while we aimed to provide a balanced synthesis of the findings, interpretation bias may have occurred due to differences in study quality, terminology, and intervention design across the included sources. Furthermore, there is a clear discrepancy in the availability of information on refugee training programs across the MENA region, which limits deeper analysis of their effectiveness and scope.

Conclusion

In conclusion, our research highlights the crucial role of Community Health Workers (CHWs) in contributing to the achievement of Sustainable Development Goals (SDGs), particularly in addressing mental health needs within refugee populations. By prioritizing the training and empowerment of CHWs, we not only promote access to quality healthcare but also advance progress towards SDGs related to health and well-being, such as Goal 3: Good Health and Well-being, and Goal 4: Quality Education. In terms of community-driven initiatives, understanding what drives the motivation and performance of community health workers (CHWs) in humanitarian emergencies is an important research gap in the field of human resources for health [8]. The Community Health Worker (CHW) model, the framework embedded within strong social capital, encourages local participation and builds internal solidarity. By leveraging trust, networks, and local knowledge, CHWs play a pivotal role in fostering bottom-up economic development for refugees' fosters self-reliance, and aligns with global calls to shift from aid dependency to development-oriented solutions (e.g., Global Compact on Refugees).

Looking ahead, we aim to expand our study to Syrian refugee camps in Jordan in the next stage of our research. However, this endeavor necessitates securing the necessary resources, primarily through fieldwork funding. In future studies, if new funding and stakeholder collaboration become available, in-depth field engagement will be possible. In particular, conducting interviews with stakeholders who are directly involved with refugees will be essential to enrich the analysis and validate the findings in real-world contexts. We are open to collaboration with organizations and stakeholders to ensure the successful implementation of our study. By conducting research in Syrian refugee camps in Jordan, we aim to further examine the effectiveness of different approaches to mental health support, contributing valuable insights

to the existing literature and informing future interventions. Despite the MENA region being one of the most affected by refugee challenges, there is still a noticeable lack of studies addressing refugee mental health in the region. Many previous studies have examined the prevalence of mental health disorders among large numbers of refugees and internally displaced persons due to exceptional events in recent years, but none have focused on the MENA region [70]. We are proud to be among the first studies to shed light on this critical issue. Furthermore, our research underscores the critical gap in mental health training for refugees in the Middle East, particularly in Jordan. "There is no long-term planning for refugees residing in camps in Jordan" [43]. The comparison of different approaches to mental health support highlights the importance of addressing this gap and implementing effective strategies to enhance mental health services for refugees in the region. By identifying the strengths and limitations of current approaches, we can inform policy and practice to better meet the mental health needs of refugees in Jordan and elsewhere.

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Authors' contributions

RI and WA designed the idea and analysis approach, analyzed the data, and drafted the manuscript. WA offered guidance on the data analysis and the drafting of the manuscript. All authors read and approved the final manuscript.

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Data availability

No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate

No human participants were involved in this study.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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