Journal of Refugee & Global Health

Original Research

Barriers to Health among IDPs in Kabul, Afghanistan: A Qualitative Study

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Abstract

Background: Forced displacement is a significant problem for regions experiencing prolonged humanitarian crises due to armed conflict. Afghanistan, having experienced over four decades of conflict, has an estimated 1.2 million internally displaced persons (IDPs), a majority of which are concentrated in urban centers. IDPs have limited resources and face challenges accessing health services through traditional channels, leading to a disproportionate burden of morbidity and mortality. Health care facilities created for and existing within IDP camps also face numerous challenges. This study aimed to understand the structural factors that negatively impact health and the specific barriers to healthcare access for IDPs using qualitative methods.

Methods: An exploratory qualitative study was done to identify the barriers to health faced by IDPs and to understand the experience of providers caring for IDPs. Open-ended interviews were conducted using a semi-structured interview guide across three IDP camps in Kabul, Afghanistan between May and June 2017. Participants were interviewed in focus groups, interviewing a total of 37 IDP age 18 and older. In addition, two former health care providers were interviewed. A grounded theory approach was utilized to code interviews using a priori and emergent coding, from which several themes and sub-themes emerged. Two independent readers coded the data and discrepancies were resolved by consensus.

Results: Human security, water access, limited livelihood and employment, poor housing infrastructure and environmental factors significantly impacted IDP health. Closure of clinics within the camps caused substantial limitations to healthcare service access. Accessing existing health care infrastructure was limited by cost, distance, discrimination, and limited access to medication and vaccinations, particularly for children. Key informant interviews identified healthcare funding and vaccination delivery to be priority problems. Across all focus groups and key informant interviews, there appeared to be a solid and trusted patient-provider relationship.

Conclusion: Structural factors that negatively impact health coupled with new barriers to healthcare access for IDPs in Kabul are a source of serious concern. This study identified structural factors that exacerbate poor health and new challenges to healthcare access resulting from the discontinuation of in-camp health services. Further research could elucidate the barriers and facilitators of transition from emergency humanitarian response to long-term care for IDPs, as well as on the ability of local health systems to absorb vulnerable populations after humanitarian crises.

DOI: 10.18297/rgh/vol2/iss2/8
Submitted Date: January 11, 2019
Accepted Date: June 24, 2019
Website: https://ir.library.louisville.edu/rgh
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Recommended Citation:
Parwak, Yagana; Dandu, Madhavi; and Haar, Rohini J. (2019) "Barriers to Health among IDPs in Kabul, Afghanistan: A Qualitative Study," *Journal of Refugee & Global Health*: Vol. 2 : Iss. 2 , Article 8.

Background

Internally displaced persons (IDPs) are individuals that experience forced migration within the borders of their own country, generally resulting from armed conflict or natural disasters. In 2015, 27.8 million people were displaced in 127 countries. Of these, 8.6 million displacements were attributed to conflict and violence. [1] Of all IDPs worldwide, 70% are women and children highlighting the vulnerable nature of this population. [2] While refugees cross international borders and receive certain legal protections, IDPs do not have access to many of the resources provided by international refugee agencies. [3] This limits them to the resources allocated by their home government which may be unable or unwilling to provide for this population. Addressing health concerns remains a difficult task; IDPs do not have a designated organization that is responsible to provide or to advocate for their needs. Rather, each state holds primary responsibility for their IDP population with the international community playing a complementary role in an effort towards a "collaborative approach". [4] Although it does not fall within its mandate, the United Nations High Commissioner for Refugees (UNHCR) has been attempting to address some of the basic needs of this population. [5] In the 1990s the UN Human Rights Office of the High Commissioner set out the Guiding Principles on Internal Displacement, stating that individuals displaced within their country have a broad base of rights. Guiding

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principles 10 to 23 discuss access to basic needs such as food, shelter and medicines in the form of humanitarian assistance, as well as economic, educational and political opportunities and rights. [6] Nations and national law are the primary actors required to provide IDP provisions and protections, but in conflict and post-conflict states, it is particularly difficult to develop, implement and enforce such standards.

In Afghanistan, IDPs have had a particular challenge in navigating chronic conflict and insecurity, changing funding structures for health services, and poor baseline public health systems. Access to healthcare is significantly affected by violence, maldistribution of healthcare facilities, and high cost. 71.8% of individuals experienced difficulty accessing healthcare. For one in five people, this resulted in a death of a loved one. [7] Afghanistan's leading causes of death and disability are diarrhea, lower respiratory and other common infectious diseases which mostly affect children, followed by cardiovascular disease and violence related deaths from war and disaster. Since 2013, Afghanistan has adopted a Basic Packages of Health Care Services as a comprehensive set of requirements for providing healthcare. [8] However, there is inadequate research on health care provision, quality, and outcomes for particularly vulnerable populations such as IDPs. IDPs experience a disproportionate health burden such as excess mortality, worse mental health, and unfavorable social determinants of health. [9, 10, 11] For example, IDPs have an increased burden of communicable diseases due to living in close quarters- namely acute respiratory infections (ARIs). [12]

Afghanistan has been experiencing conflict for over four decades and has an estimated 1.2 million IDPs as a result of conflict, more than double the estimate in 2013. [13] Increased displacement led to a population influx for urban centers such as Kabul, a city that has experienced rapid population increase - from 1.5 million in 2001 to an estimated 3.7 million in 2016, with upper estimates at 5 million people. [14] The Afghan Ministry of Refugees and Repatriation (MoRR) developed the National Policy on Internally Displaced Persons, a document that went into effect in November of 2013. The policy recognized the government's role and responsibility for this population and provided a framework for providing basic needs. [15, 16] The World Bank and UNHCR assessed the basic needs of IDPs in three urban settings in Afghanistan, focusing particularly on housing, infrastructure and food security. Though not the primary focus of the study, approximately 15% of the population reported access to healthcare services as one of their top three problems. [17] There remains a gap in knowledge specifically regarding the health needs of this population. The objective of this study was to identify the barriers and facilitators to accessing healthcare among IDPs and providing healthcare to IDPs in Kabul, Afghanistan.

Methods

Methods

A qualitative study was used to identify the barriers and facilitators to health and healthcare access among IDPs in Kabul in May and June 2017. Additionally, interviews with health care providers allowed for identification of barriers and facilitators to providing healthcare for this population. Experiences of the IDP population were evaluated using open-ended semi-structured interviews with camp residents and health providers in three camps. Development of the initial questionnaire was informed by previous questions on surveys from multi-cluster needs assessment of IDPs in Iraq and research on IDPs in Afghanistan's urban settings. [18, 17] Specifically, questions around health were used as a starting point for creating new open-ended questions.

Sampling, Settings and Participants

Purposive and cluster sampling approach was used to reach a broad population of IDPs with diverse geographies, genders, ages, and causes for displacement. Kabul was chosen because it is the capital and has experienced an increase in IDPs. There are an estimated 52 IDP camps in the Kabul. The camps from which this study sampled were chosen based on accessibility and security considerations. Working with local NGOs allowed for identification of camps that were closer to the urban center, would be open to being sites for interviews, and perceived to be safer based on the organization's experience. The NGO formerly known as Serve Health Relief and Development Organization (SHRDO) is an Afghan NGO that ran healthcare clinics in 28 camps, serving a total of 41,407 individuals. The final camps chosen included one of the largest and longest standing camps, one of the smaller camps located in a very busy area near a Ministry of Public Health clinic, and a final camp with a mid-range population. The population of interest was individuals living in IDP camps in Kabul. Inclusion criteria were that individuals must be residing at the camp at time of study participation and time availability to participate. Those who did not live within the camps or were under the age of 18 were excluded. The study aimed to interview at least 30 IDPs within the camps. Two healthcare providers were interviewed to gain a broader perspective. The target number of interviews was determined based on the goal of reaching theoretical saturation. [19]

Data Collection

Interviews were conducted within the camps, based on accessibility and convenience. Qualitative semi-structured interviews were conducted in focus groups to account for cultural considerations. Based on discussions with camp residents and staff, it became evident that participants felt more comfortable in group settings. Focus groups were based on camp residence.

Audio recordings and notes were transcribed into English. Participants provided verbal consent and no identifying data was collected. A total of four focus groups were conducted with each group consisting of nine to ten participants. Each focus group lasted between 1 to 1.5 hours. There were a total of 37 IDP participants- 15 men and 22 women- all of whom were displaced as a result of active violence between the government, Taliban and/or ISIS. Their ages ranged from: 20 to 60 years old. The majority of focus group participants were displaced from the same region of Afghanistan and experienced initial displacement within short time frame (6 months to 1 year) of each other. Their average length of stay in the IDP camp at the time of the study was 8 years.

Two past healthcare providers were interviewed as key informants. They worked with Serve Health Relief Development Organization for Afghanistan (SHRDO) which is now Organization for Rapid Health Response to Emergency (ORHRE) for over ten years, as physicians within the camp and various project management positions within the organization. Both were men who were born, raised and completed medical school in Afghanistan and both had Master of Public Health degrees. Interviews were audio-recorded, transcribed, and

Table 1 Focus Groups

Focus group and camp site	Total in focus group	Number of men	Number of women	Origin of displacement	Average years of displacement
Nasaji Bagrami (1) (Tapa Bagrami), Kabul City	9	9	N/A	Kandahar, Helmand	10+ years
Nasaji Bagrami (1) (Tapa Bagrami), Kabul City	9	N/A	9	Tagab, Kohgani, Jalalabad (Nangarhar)	8-10 years
Behind Habibia High School, Kabul City	10	3	7	Parwan (Ghorband), Qarabakh	8-10 years
Dewan Begi, PD 5, Kabul City	9	3	6	Jalalabad, Kunduz, Nangarhar	10 years

translated by the research team.

Analysis
Analysis was done through identification of pre-determined codes based on research objectives, as well as emergent coding based on grounded theory approach. [20] Basic demographic information as well as the responses to open-ended questions were coded.

Ethical Approval
Ethical approval was granted by the University of California San Francisco Committee on Human Research as well as the Afghanistan Ministry of Public Health Institutional Review Board.

Results

Two major themes emerged: (1) social and structural factors negatively impact health and (2) there are several barriers to healthcare access. The two key-informant interviews revealed decreased funding and discontinuation of vaccination services as primary areas of concern. Across all focus groups and key-informant interviews the theme of solid and trusted patient-provider relationship emerged.

Social and Structural Factors
Participants identified several factors associated with ill and worsening health. These factors include human security, water access, limited livelihood and employment, poor housing structure and environmental factors.

i. *Human Security*
Participants recounted varying levels of threats to human security. In this study, human security is defined as physical safety and the absence of physical or verbal threats. Two focus groups reported severe clashes with governmental officials and different unofficial organized crime members. One participant recalled how in the middle of the night, two officers dressed in civilian clothing came into the camp and killed his brother and the subsequent effect that had on the camp:

> *"We are all scared now. I am scared that they will come in the middle of the night just like they did when they killed my brother. They killed him, I am scared that they will come and kill us too. There is that fear in us."* – Male, mid 50s

Another IDP mentioned his own experience:

> *"They beat me- the way they were beating me, my God. They beat four, five other people. First they hit us like this [jab to the head], then another one comes and hits you like this [jab to the face]."* – Male, 32 year-old

The physical altercations resulted in negative health outcomes- injury, disability and death. One participant recalled about his nephew:

> *"It's been one or two months [since the incident] that injured his nose- he cannot breathe that well. It hurts him."* – Male, 47-year-old

ii. *Water Access*
Participants described inaccessibility of a water supply as a major source of concern. Even when wells were available, the water was too salty or the water pump was broken. Participants related this to children frequently getting diarrhea. Obtaining water by other means was a challenge, and the quality of obtained water was poor.

> *"There is no water. Currently we do not have water. This building behind us, when they feel bad for us they throw a pipe over and give us water. When they do not, then we have to go into the city and ask at different people's houses."* – Female, late 30s

> *"All the neighbors have water pumps. We must beg- we have to beg that our children are thirsty, that they are dying. Most of them don't give us water, they make excuses like the cost or something. This or that."* – Male, 40-year-old

iii. *Livelihood and Employment*
Employment was an issue across all camps. Participants discussed how unemployment affects their ability to eat properly or cover health-related costs, particularly for medications.

> *"They do this or that, try to find 100 or 200 [equivalent to 1.45 USD to 3 USD] Afghanis. They go to the store and buy some bread if they can, but there is no other thing they can do."* – Male, early 20s

Table 2 Two major themes emerging from the interviews.

Social and structural factors	***Barriers to healthcare access***
Human security: physical safety; the absence of physical threats	*Cost and distance: physical distance and monetary cost (for travel to facility and treatment of care)*
Water: access to clean and safe water source	*Logistical issues: barriers to accessing care even when cost and distance not an issue*
Employment: source of income and livelihood	*Discrimination: experienced differential care because of IDP status*
Housing infrastructure: physical construction of living quarters	*Medicines and Vaccinations: prescribed and needed medications and vaccinations*
Burning of plastic: use of plastic as fuel for a fire	

iv. *Poor Housing Structure*

IDP camps have regulations against building any permanent structure or laying bricks within the informal settlements. Therefore, most IDP homes are tents or abode-style houses. Participants highlighted that this limited infrastructure does not protect against the cold winters or hot summers.

> *"A tablet [pill] won't do anything because of how we live. A blanket, a place to sleep, a pillow, some wood to heat up the house. These things won't be fixed with a pill. The cold is a problem here, how we live."* – Male, 36-year-old

Limited housing infrastructure further affects young children in the home. One respondent recounted how his neighbor's roof caved in under the weight of snow- killing their infant.

> *"You see my neighbor there [points]. This past winter, a few months ago the snow was too much and the roof caved in. The baby was in the house only a few months old, the snow killed her."* – Female, mid 30s

v. *Environmental Factors*

Due to unemployment and lack of housing infrastructure, participants noted that they collect and burn plastic to cook and keep warm. Collection and burning of plastic was a universal practice across all three camps. While participants understood that burning wood was more optimal and less harmful, they felt they did not have a choice. Children begin collecting plastic at a young age. Reported uses of the plastic and other scraps collected was as fuel for cooking, warming up water to shower, and heat during the harsh winters. Burning of plastic occurs within or in very close proximity to the homes. The fumes mostly impact women and young children who spend more time at home relative to men.

> *"A lot of people go [to collect plastic]. This elderly woman. This one [points] he goes, he is three years old, this one is four years old. If they find one piece of wood they get so happy, we can cook our food."* – Female, early 40s

vi. *Education*

The number of children enrolled in schools from the three camps was inconsistent. Participants in one camp reported that a non-governmental organization (NGO) came and registered children at the local schools. Participants from another camp reported:

> *"There are maybe 700 or 800 children here at the camp, but only 100 of them go to school. 50 boys and 50 girls… They go to every second house, third house or fifth house to randomly choose which child is enrolled. It's based on house number.* – Male, mid 30s, father of three

> *"There is one class [grade]. My son is 12 years old now but he has stayed in the same class with all the other kids. We are thankful that at least they are learning something. [The teachers] try their best."* – Female, early 40s

In the third camp, school was not a ready option for children:

> *"In this whole camp you can't name five people, not a boy here that studies or goes to school on their own."* – Male, mid 20s

Barriers to Healthcare Access

Common themes under barriers to healthcare access emerged. Namely barriers associated with cost, distance, discrimination, obtaining medicine and vaccinations.

i. *Cost and Distance*

Cost and distance proved a significant barrier to accessing healthcare. Participants described traveling long distances and explained that illness made it more difficult to make the trip to a facility.

> *"My nephew was sick they took him all the way to [Facility]. The child was so sick. He had severe diarrhea. He was sick and his child was sick but they had to take him very far – how do we get him there? What do we do if we don't?"* – Female, 35-year-old

Traveling longer distances also came with an associated cost which participants found difficult to pay.

> *"Any hospital you go to- to go to the hospital it takes 4,000 to 5,000 bucks (equivalent to 58 to 72 USD). [21] Some people can make that type of money, most people can't. We can get sick really bad and we have to take them. We do our best to find a way."* – Male, 42-year-old

> *"We must find a way to pay it. We must find a way or we are left with nothing. We cannot walk – it is too*

far, especially when we are sick." – Female, 25-year-old

Even when they did find the money and means to travel to a facility, participants faced barriers in accessing specialist care advised by their primary provider.

> *"The other day they told me to go to the private [specialty] clinic, but I did not have even one Afghani to get to a private clinic or the money to pay to be seen when I get there."* – Male, 42-year-old

Prior to the closure of clinics and discontinuation of services by the local NGO, emergency cases had a voucher system for transportation. A telephone number and voucher was provided to patients, and the patient would be transported via taxi.

ii. <u>*Logistical Issues*</u>

Even when a clinic was located close to the camp, logistical issues proved a barrier. Logistical issues included the time and conditions in which the participants were able to be seen. Participants described the process of taking a "number" which corresponded to an appointment with the provider. However, their number would never be called and they would be turned away and asked to show up even earlier the next day. Multiple participants described leaving the camp to go to the facility at 3AM.

iii. <u>*Discrimination*</u>

IDPs faced discrimination based on their displaced status. They faced this despite shared nationality, ethnicity and religious beliefs with the local populations. Participants recalled negative experiences from public facilities.

> *"That governmental clinic does not let us come. They say you are from the camp you guys should not come here. We will not treat you. All of these women go, they don't let them get to the door. There is a guard by the door of that government clinic that I yelled at. I said we are from this country too. We are from Afghanistan too. The clinic has free care because it is governmental but they do not let us come? Why?"* – Male, mid 20s

Participants also reported negative interactions with providers and most participants experienced explicit discrimination.

> *"The providers say that they are for the people of the area [not displaced persons], they look down on us. They try to stop us for coming. They hit us. They chase us away. We are left without care."* – Female, 30-year-old

iv. <u>*Medicine and vaccination*</u>

Participants described challenges associated with obtaining prescribed medications. Prior to the closure of the clinic system within the camps, all major medications and vaccinations were administered free of charge. Barriers to obtaining proper medication included uncertainty of availability and cost.

> *"We put it [prescriptions] in our pockets. If there is no money how can we get the medication? …. If we have money, we will go to the store. If there is no money, then no."* – Female, 60-year-old

IDPs frequently reported difficulty obtaining vaccinations for children. Participants expressed concern over lack of ability to vaccinate, particularly for newborn children. There were also high rates of vaccine dropout, where individuals – especially children – got an initial round of vaccines while the clinic was open, but are unable to receive subsequent doses after the in-camp clinics closed.

> *"My child is four months and I cannot get a single vaccine for her. They say come back tomorrow, come back the next day. They have been doing this to me, they keep doing this to me."* – Female, 25-year-old

> *"My daughter is two months here, has no vaccines. She has gone six times to get the vaccines and no one will help her. She has not had the BCG vaccine."* – Female, 21-year-old

> *"The government said the clinics provide it [vaccines]. But the clinics, we have gone six times and they do not see us."* – Female, 32-year-old

Key Informant Interviews

I. Funding

Funding sources have been a serious concern over the past ten years. Key informants expressed that funding was provided by international agencies, mostly international organizations like the WHO/Health Cluster and private non-governmental organizations such as Corodaid. Funding would be provided in the form of 3-month, 6-month or 9-month grants but much of the health funding was discontinued on April 15, 2017.

> *"We had to use every connection we had to get this last round of funding. Funders say humanitarian crises and emergencies lasts a few months, maybe a couple of years- not 10 years. They wonder, for how long? When will this end?"* – Key Informant A

II. Vaccination Delivery

Key informant interviews identified discontinuation of preventative care – particularly lack of vaccinations as a source of serious concern. Vaccine drop-out is a concern for both IDP populations and the urban populations which they are situated in; disease will easily spread in densely populated urban centers.

> *"We tried to tell the government that health issues for this [IDP] population is bad for the people of Kabul too. There are 52 camps across Kabul and they all interact with everyone in the city. Sickness will spread too easily."* – Key Informant B

Patient-provider relationship

Across all focus groups and through the key informant interviews, participants shared solid and trusted patient provider relationships in contrast to discrimination experienced when attempting to access healthcare through facilities designed for the general population. Patients and providers had unique viewpoints.

Participants shared how doctors went above and beyond their obligations as healthcare providers.

> *"This doctor, he is our father, our brother, our friend. In the winter, he runs back and forth between the clinic and the tents, snow falling hard on his head. We have such good memories from him, I hope he has good ones from us as well."* – Male, 32-year-old

> *"We came here [to Kabul] because it was not safe at home. We cannot go back. Our loved ones, our kids are sick. Please write that down. The doctor, may God give him strength, has served us for so long. Many years, he would treat us. Now that he has left, the clinic has left we are not only sick, but deeply heartbroken."* – Male, mid 20s

Key informant interviews provided more context. It was revealed that relationships were initially strained.

> *"When I first started working on the camps, I would get threats. Threats that they [IDPs] would kill me and my family. They did not trust us – especially around contraception and vaccination. But they are pure-hearted people. Over time, now they come to us for health issues but also personal and family problems as well."* – Key Informant A

Discussion

Populations experiencing prolonged humanitarian crises are often the most vulnerable and most easily neglected once immediate conflict has subsided. IDP populations in Afghanistan are growing, but research on their health needs has remained limited. This research highlights the social and structural factors that impact health and challenges in accessing healthcare experienced by IDPs in Kabul in order to address this gap in literature. Furthermore, this research reports how inconsistent funding comes at a significant price for this already vulnerable population.

Social and structural factors that negatively burden this population may be ameliorated by a resettlement plan. Attempts to directly address issues discussed around human security, water access, livelihood and employment, poor housing structure and environmental stressors are necessary, but thus far, have been short-term. Forced displacement due to conflict creates a host of health challenges, with the average conflict-driven IDP being displaced for over an average 23 years. [22] This depicts the necessity to address concerns upstream.

Effective health system level and policy action has the power to remedy issues associated with the barriers to healthcare access, discontinuation of services and inconsistent funding. Prior to funding cuts, the healthcare barriers such as cost and distance, discrimination and limited access to medication and vaccinations were less prevalent, as clinics were located within camps and designed specifically for IDPs. These health system and policy actions can prioritize healthcare needs as well as allocate appropriate funding streams within the health system.

While the primary research objective was to identify health related barriers, symptoms of broader issues become apparent in the interviews. The lack of an effective transition from humanitarian crises to development initiatives had led to a funding and programmatic gap that constrained already limited resources. Humanitarian crises seldom follow a predicted timeline and often last far longer than initially predicted. In these camps, initial humanitarian funding was discontinued before other long-term programs were initiated, leaving these populations at a high risk for disease and death. With increasing magnitude of displacement, the transition between humanitarian crises and development must be safeguarded and further research is needed to explore the capacity of health systems to absorb marginalized populations after humanitarian crises.

This study found that the challenges of a prolonged political and humanitarian crises, limitations in funding and disruptions between emergency and long-term programs and the overlying burden of social factors created multifaceted impediments to good health for these IDPs.

Completion of this research has provided more data and insights into the health and healthcare access of IDPs within Kabul-research that has been missing in displacement literature. In the case of IDP camps in Kabul, the medical clinics run by ORHRE (formerly SHRDO) have played a crucial role in addressing IDP suffering and have provided quality healthcare access to the world's most vulnerable populations. When organizations are able to gain community buy-in and provide effective care, it is crucial that they garner the necessary structural support to continue providing care sustainably.

Limitations of this study include methodology limitations; as a qualitative study, results may not be representative of all the Kabul IDP populations. Focus groups were conducted, as opposed to individual interviews, which may have been a source of additional bias. Individuals may have shared differently with respect to a group versus an individual setting. Lastly, the limited sample size and locations from which samples were selected could have skewed results. While further research will be required to more deeply explore these issues, this foundational research presents key issues faced by many IDPs in Kabul.

Conclusion

Due to funding limitations, the closure of healthcare facilities within the camps has created additional challenges to obtaining healthcare and maintaining health since April 2017 for IDPs. This paradigm of increased health risks and decreased health services threatens those living within camps and can also have potentially catastrophic effects on the rapidly urbanizing population in which these camps are situated.

Future research is needed to better understand the transition between humanitarian health emergencies and development. Humanitarian crises seldom subside on an anticipated timeline and therefore, it is essential to engage in multi- and inter-disciplinary conversations to determine sustainable solutions. Furthermore, research is needed on the capacity of health systems to absorb marginalized populations after humanitarian crises.

Contributors

YP and RH conceived and designed the study. YP conducted field work and wrote the initial draft of the manuscript. YP, RH and MD were involved in data analysis and revising the report. The corresponding author, YP, had full access to all the data in the study and had final responsibility for the decision to submit for publication.

Funding

No funding sources.

Acknowledgements

First and foremost, we are thankful to all the participants of this study for sharing their experiences and stories with us. Sincerest gratitude to our dedicated and inspiring on-the-ground partners Dr. Niaz Mohammad Faizi and Dr. Farooq Iqhbal, who were instrumental in accessing this population. The study would not have been possible without your support. Thanks to Dr. Sayed Murtaza Sadat Hofiani who provided guidance on conducting research in Afghanistan. Finally, we thank Dr. Rahman A. Zamani for his support in preparing and translating the interview guide.

References

1. United Nations High Commissioner for Refugees. Global Trends Forced Displacement in 2015. 2016. UNHCR Global Trends 2015. https://www.unhcr.org/en-us/statistics/unhcrstats/576408cd7/unhcr-global-trends-2015.html. (Accessed July 2017).
2. Internal Displacement Monitoring Centre. Girl, disrupted. 2014. IDMC Briefing Paper. http://www.internal-displacement.org/sites/default/files/publications/documents/201403-global-girl-disrupted-pic-brief-en.pdf.
3. Odusanya OO. The health of internally displaced persons. Niger Postgrad Med J. 2016 Oct-Dec;23(4):159–60.
4. United Nations Human Rights Office of the High Commissioner. Questions and answers about IDPs. 1996-2019. OHCHR. https://www.ohchr.org/EN/Issues/IDPersons/Pages/Issues.aspx. (Accessed February 2017).
5. United Nations High Commissioner for Refugees. Global Trends Forced Displacement in 2016. 2017. UNHCR Global Trends 2016. https://www.unhcr.org/5943e8a34.pdf. (Accessed July 2017).
6. Deng FM. Guiding principles on internal displacement. International Migration Review. 1999 Jun;33(2):484-93.
7. Nic Carthaigh N, De Gryse B, Esmati AS, Nizar B, Van Overloop C, Fricke R, et al. Patients struggle to access effective health care due to ongoing violence, distance, costs and health service performance in Afghanistan. Int Health. 2015 May;7(3):169–75.
8. Hansen PM, Peters DH, Niayesh H, Singh LP, Dwivedi V, Burnham G. Measuring and managing progress in the establishment of basic health services: the Afghanistan health sector balanced scorecard. Int J Health Plann Manage. 2008 Apr-Jun;23(2):107–17.
9. Dixon-Woods M, Cavers D, Agarwal S, Annandale E, Arthur A, Harvey J, et al. Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. BMC Med Res Methodol. 2006 Jul;6(1):35.
10. Nidzvetska S, Rodriguez-Llanes JM, Aujoulat I, Gil Cuesta J, Tappis H, van Loenhout JA, et al. Maternal and Child Health of Internally Displaced Persons in Ukraine: A Qualitative Study. Int J Environ Res Public Health. 2017 Jan;14(1):54.
11. Heudtlass P, Speybroeck N, Guha-Sapir D. Excess mortality in refugees, internally displaced persons and resident populations in complex humanitarian emergencies (1998-2012) - insights from operational data. Confl Health. 2016 Jul;10(1):15.
12. Connolly MA, Gayer M, Ryan MJ, Salama P, Spiegel P, Heymann DL. Communicable diseases in complex emergencies: impact and challenges. Lancet. 2004 Nov;364(9449):1974–83.
13. Amnesty International. Afghanistan: Number of people internally displaced by conflict doubled to 1.2 million in just three years. 2016. Afghanistan Internally Displaced People. https://www.amnesty.org/en/latest/news/2016/05/afghanistan-internally-displaced. (Accessed January 2017).
14. Koser K. Internal Displacement in Afghanistan. Brookings Inst Semin Intern Displac South Asia; 2007. p. 8.
15. President of the Islamic Republic of Afghanistan and the Ministry of Refugees and Repatriation. The National Policy of the Islamic Republic of Afghanistan on Internal Displacement. 2013. National IDP Policy. http://www.internal-displacement.org/sites/law-and-policy/files/afghanistan/Afghanistan_national_policy_English_2013.pdf.
16. Samuel Hall Consulting. From Policy to Implementation: Engaging with national procedures, national and international stakeholders in 2015. 2015. Policy Brief – National IDP Policy Working Group. http://samuelhall.org/REPORTS/AfghanistanNationalIDPPolicyBrief.pdf. (Accessed July 2017).
17. World Bank. Afghanistan - Research study on IDPs in urban settings (English). 2011. Washington, DC: World Bank. http://documents.worldbank.org/curated/en/458151468153539693/Afghanistan-Research-study-on-IDPs-in-urban-settings
18. REACH Initiative. Multi-Cluster Needs Assessment of Internally Displaced Persons Outside Camps. 2015. Iraq Assessment Report. http://www.reachresourcecentre.info/system/files/resource-documents/reach_irq_multiclusterneedsassessment_idps_outside_camps_oct2014.pdf.
19. Guest G, Bunce A, Johnson L. How Many Interviews Are Enough? An Experiment with Data Saturation and Variability and a good number of journals in the. Morse Sandelowski Bluff Byrne; 1995. https://doi.org/10.1177/1525822X05279903.
20. Pandit NR. The Creation of Theory: A Recent Application of the Grounded Theory Method. Qual Rep. 1996;2:1–15.
21. XE Currency Converter. XE Currency Converter: 1 USD to AFN. 2019. http://www.xe.com/currencyconverter/convert/?Amount=1&From=USD&To=AFN. (Accessed July 2017).
22. Crawford N, Cosgrave J, Haysom S, Walicki N. Protracted displacement: uncertain paths to self-reliance in exile. 2015. Humanitarian Policy Group. http://www.odi.org/hpg. (Accessed March 2018).