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Are IDPs satisfied with the quality of public health and education services they receive?

A long-term perspective from urban areas in the post-socialist countries

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Background paper to the main report

UWE Bristol | University of the West of England

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I. INTRODUCTION AND MOTIVATION

The recent refugee crisis has drawn immense public attention - becoming one of the most pressing international policy issues of our times. Fleeing conflict and violence and continuing to put their lives at risk, refugees embark on perilous cross-border journeys in hope of finding safety abroad. However, *international* refugees represent only the tip of the iceberg. Conflict and violence displace millions of people *within their own countries*. In 2017, among the 68.5 million people forcibly displaced worldwide, 40 million were internally displaced persons (IDPs) – people fleeing conflict, violence or persecution, but staying in their own country (UNHCR, 2018). New conflict- and violence-related displacement reached 11.8 million in 2017, almost double the figure of 6.9 million in 2016 (IDMC, 2018a).

It has been widely recognised that the overwhelming majority of IDPs live in non-camp, dispersed settings (Beyani, 2013; World Bank, 2016). It is also acknowledged that IDPs gravitate to urban areas[1] in an attempt to find jobs and sustain livelihoods, replenish physical, human and social capital lost during conflict and displacement, and obtain a degree of anonymity, safety and freedom that may not be offered by rural and camp setting (IDMP, 2018b; Jacobsen, 2006; Landau, 2014, Monteith and Lwasa, 2017). Getting to a town or city may well be part of a longer journey abroad – many of today's IDPs are tomorrow's international refugees and vulnerable migrants (Rushing and Sydney, 2018). Crucially, the survival, livelihoods and well-being of IDPs depend on the provision of basic public services, such as health, education and registry, the access and quality of which are usually better in urban areas and large cities.

Against this backdrop, the objective of this study is to provide the first quantitative evidence on the satisfaction with public services among IDPs in urban areas. This question is policy-relevant as any disadvantage experienced by IDPs in terms of their access and satisfaction with public services may translate into a greater likelihood of poverty and marginalisation, as well as a greater willingness to move abroad. Identifying and acting on the sources of disadvantage experienced by IDPs in the domain of public services can improve lives of hundreds of thousands of people across the globe.

It is well documented that IDPs have inferior socio-economic outcomes, for example poorer physical and mental health (Daoud et al., 2012; Mowafi, 2011; Porter and Haslam, 2005; Spiegel et al., 2010; Steel et al., 2009), unequal opportunities to access education and lower school performance (Das et al., 2016; Ferris and Winthrop, 2010; Gómez Soler, 2016), greater likelihood to be unemployed and work informally (Ivlevs and Veliziotis, 2018; Kondylis, 2010; Torosyan et al., 2018), and issues with obtaining/renewing identification and other documents (IDMC, 2015; UNHCR, 2007). As these outcomes can typically be enhanced through an adequate provision of public services, one could presume that IDPs are disadvantaged in terms of the quality of public services that they receive. However, it also cannot be excluded that IDPs are actively seeking, demanding, and as a result getting, good quality public services that help them rebuild their lives. Specifically, in most conflict and displacement contexts IDPs incur losses or damages to their material assets – housing, land and livestock (Engel and Ibáñez, 2007; Fiala, 2015; Ibáñez and Moya, 2010a; Ivlevs and Veliziotis, 2018). The loss in these possessions may lead the forcibly displaced to invest in mobile human capital – in particular education – in an attempt to reduce the socio-economic disadvantage that they or their children are likely to experience as a result of displacement.

[1] Despite a frequent mention of 60 to 80% of IDPs residing in urban areas, there are no global-level data to support these numbers (IDMC, 2018b).

Becker et al. (2018) provide long-term evidence to support this hypothesis, showing that, in Poland, people with a family history of post-WWII forced displacement are significantly more educated today and that forced displacement leads to a shift in preferences from material possessions (lost/damaged/immobile assets) to education (a mobile asset); these effects persist over three generations. Further evidence is provided by Ivlevs and Veliziotis (2018), who document a greater willingness of IDPs to acquire extra education and training 10-15 years after conflict took place. From this perspective, one may expect IDPs to actively seek, and obtain, adequate public education services and, as a result, be no less satisfied with the quality of received education services compared to people not affected by conflict.

The present study aims at shedding more light on the IDPs' direct experiences of using public services. Specifically, it analyses IDPs' self-reported satisfaction from using two major public services – health and education – in urban areas of post-socialist countries of Central and Eastern Europe that experienced violent conflict in 1990s and 2000s. There are several reasons why such investigation is important, both from the policymaking and academic points of view. First, health and education are two major forms of transferrable human capital that is key for rebuilding lives after conflict and displacement. Given that IDPs tend to have inferior mental and physical health outcomes compared to people not affected by conflict (Daoud et al., 2012; Mowafi, 2011; Porter and Haslam, 2005; Spiegel et al., 2010; Steel et al., 2009) and the fact more than half of the forcibly displaced are children (UNCHR, 2018), investment in education and health and an adequate provision of the underlying public services are of key relevance for the well-being of IDPs, and especially so in urban areas where the majority of IDPs tend to end up. Second, we know relatively little about how IDPs fare in the post-socialist countries that witnessed some of the worst military conflicts of modern history; much of the existing literature has concentrated on the experiences and outcomes of IDPs in Latin American, African and Middle East countries. Finally, while it is routinely argued that IDPs lack access to adequate public services, studies drawing on the IDPs' self-reported experiences of using public services are rare and this paper fills this knowledge gap. Longer-term perspective – 10-15 years after the conflict – is also of particular interest here, as it allows to test whether IDPs experience a lasting disadvantage in terms of access, quality and satisfaction with received public services.

The analysis draws on a large, representative survey, Life in Transition-II, conducted by the European Bank and Reconstruction and Development and the World Bank in 2010. The survey is well suited for the research question of this study as it contains information on whether respondents previously had to move because of a specific conflict (this information will be used to identify IDPs) and a battery of questions on satisfaction with health and educational services. Overall, more than 1,000 IDPs were interviewed across the countries that were affected by conflict, representing 9% of total sample size; about 60% of the formerly displaced live in urban areas. A relatively large number of respondents displaced by a conflict and residing in urban areas allows conducting a meaningful statistical analysis of the public service satisfaction of IDPs. In particular, I conduct multiple regression analysis, where different outcomes related to satisfaction with public services are regressed on the displaced-person status variable, controlling for a number of socio-demographic characteristics and region-specific influences. In this way, I effectively compare the outcomes of urban dwellers who were and were not displaced by conflict, and isolate the impact of displacement from other relevant characteristics.

The remainder of the paper is organised as follows. Section 2 reviews the parameters of conflicts that the post-socialist countries experienced in the 1990s. Section 3 describes the data, variables and empirical model. Section 4 reports and discusses the results, following by a conclusion.

II. CONTEXT

Table 1 provides information about conflict and forced displacement in the nine post-socialist countries that I focus on in this paper. The wars and violent conflicts that took place during the 1990s across the former Yugoslavia and in the several former USSR republics (Armenia, Azerbaijan, Russia and Tajikistan) cost thousands of human lives and led to the displacement of millions of people. It is important to highlight two features that are common to these wars/conflicts. First, they unfolded in parallel with the breakdown of former Yugoslavia and USSR, the emergence of new nation-states, and a transition from planned to

market economy. These transformations were accompanied by an initial economic shock (sharp falls in GDP, hyperinflation, surge in unemployment), subsequent economic depression, contraction of the welfare state, and weak governance. In these times of economic, political and social turmoil, the needs of the forcibly displaced rarely emerged as a top priority for policymakers.

Second, besides hosting large populations of the internally displaced people, various countries (Armenia, Azerbaijan, Croatia, and Serbia) received large numbers of the forcibly displaced from the neighbouring states, which were affected by related conflicts. For the most part, these people – technically, cross-border refugees – belonged to the ethnic majority of the host country (for example, ethnic Croats moving from Bosnia and Herzegovina to Croatia) and would, therefore, be somewhat different from typical cross-border refugees moving between developing countries or from developing to developed countries. It should also be noted that only shortly before the conflicts, both Yugoslavia and the USSR were single national entities with fluid internal borders, meaning that the distinction between IDPs and incoming international refugees at that time would be less than clear-cut.

Table 1. Conflict and forced displacement in the post-socialist countries, 1990s and 2000s

Country	War/conflict	Number of the forcibly displaced
Armenia	Armenia-Azerbaijan conflict over Nagorno-Karabakh (1988-1994)	77,000 IDPs and 334,000 incoming refugees (mainly ethnic Armenians from the Nagorno-Karabakh region in Azerbaijan)
Azerbaijan	Armenia-Azerbaijan conflict over Nagorno-Karabakh (1988-1994)	778,000 IDPs and 230,000 incoming refugees (mainly ethnic Azeris from Armenia)
Bosnia and Herzegovina	Bosnian War (1992-1995)	1,100,000 IDPs
Croatia	Croatian War of Independence (1991-1995); Bosnian War (1992-1995)	200,000 IDPs and 187,000 incoming refugees (ethnic Croats fleeing ethnic cleansing in Bosnia and Herzegovina)
Former Yugoslav Republic of Macedonia	Violent conflict between ethnic Macedonians and ethnic Albanians; 2001	74,000 IDPs and 97,000 outgoing refugees to neighbouring countries; most forcibly displaced were able to return subsequently.
Kosovo	Kosovo-Serbia conflict (1998-1999); NATO airstrikes forcing the withdrawal of Yugoslav troops from Kosovo (1999)	260,000 IDPs before 1999; 800,000 ethnic Albanians fleeing to neighbouring countries (Montenegro, FYR Macedonia, and Albania) after the airstrikes, most returned subsequently.
Russia	1994 and 1999 Wars in Chechnya (1994 and 1999)	800,000 IDPs
Serbia	Croatian War; Bosnian War (1992-1995); NATO air strikes forcing the withdrawal of Yugoslav troops from Kosovo (1999)	650,000 incoming refugees (ethnic Serbs from Croatia and Bosnia) and 210,000 IDPs from Kosovo.
Tajikistan	Civil War (1992-1997)	520,000 IDPs

Source: Ivlevs and Veliziotis (2018), based on data from UNHCR (2000) and the UNHCR Statistics Database.

III. METHODS

a. DATA

The data for this study come from the *Life in Transition-II* survey, conducted by the European Bank of Reconstruction and Development and the World Bank in 2010. The survey covered 29 post-socialist countries of Central and Eastern Europe and Central Asia, Turkey, and five Western European countries (France, Germany, Italy, Sweden and the UK). Our focus is on nine post-socialist countries, which, in the 1990s, were affected by a major military conflict (see Table 1 above) that generated large flows of forcibly displaced people: Armenia, Azerbaijan, Bosnia and Herzegovina, Croatia, Former Yugoslav Republic of Macedonia, Kosovo, Russia, Serbia, and Tajikistan.

The nationally representative samples consisted of 1,000 face-to-face interviews in each country (1,500 respondents in the case of large countries: Russia and Serbia). In each country, households were selected according to a two-stage clustered stratified sampling procedure. In the first stage, the frame of primary sampling units was established using information on local administrative units. In the second stage, a random walk fieldwork procedure was used to select households within primary sampling units. Respondents within households were selected randomly using a selection grid. In addition, the interviewer asked the head of the household, or another knowledgeable person, a series of questions about the household composition, housing and expenses. A detailed account of survey design and implementation, as well as information on how to access the dataset, is provided on the survey's website.[2]

b. VARIABLES

This section outlines the variables that I will use in our empirical analysis, the main objective of which is to estimate the effects of forced displacement (main regressor) on variables capturing quality of public service use (outcome).

Outcome variable(s). All respondents were asked if, in the 12 months prior to the interview, their household used public health services and public education (primary, secondary, further) services. If the response was affirmative, follow-up questions were asked about the experience/issues with using these services. The users of health services had to indicate if they encountered the following issues: 1) frequent and unjustified absence of doctors; 2) treated disrespectfully by staff; 3) no medication/drugs available; 4) long waiting lists/lines; 5) facilities not clean; 6) payments required for services that should be free. The users of education services had to indicate if they encountered the following issues: 1) no textbooks or other supplies that should be provided free of charge; 2) poor teaching; 3) frequent and unjustified absence of teachers; 4) overcrowded classrooms; 5) facilities in poor condition; 6) payments required for services that should be free. For each of the 12 issues we create a dichotomous variable taking the value of 1 if the issue was encountered and 0 otherwise.

Main regressor. With reference to the conflicts listed in Table 1, respondents were asked: "Did your household have to move as a result of the conflict?" I use this question to create a dichotomous variable *forcibly displaced*, which is equal to 1 if the answer was 'yes' and 0 if the answer was 'no'. This is the main regressor of interest. Given that the interviews were conducted in the countries where the conflicts took place, it captures some form of internal displacement.[3] Overall, in our sample of nine countries, 9% of the respondents said they had to move as a result of the conflict; 60% of the forcibly displaced live in urban areas.

[2] See http://microdata.worldbank.org/index.php/catalog/1533/.

[3] Unfortunately, the survey does not contain information about any onward and return moves (including to and from other countries, as well as returns to the conflict zone) that the forcibly displaced might have undertaken between the first move and the time of the survey; what we know is that they were displaced by a particular conflict at least once and currently reside in the country where the conflict took place.

Control variables. The following control variables, potentially correlated with forced displacement, public service use, or both, will be included in the multiple regression analysis: gender, six age groups, three education levels (primary, secondary, tertiary), household consumption level (lower, middle, upper), labour market status and ethnic minority status. In addition, region-fixed effects (dichotomous variables for each region within each country; altogether 99 regions in nine countries) will be included to capture all region-specific (and, automatically, country-specific) influences on both the likelihood of being forcibly displaced and satisfaction with public services.

c. EMPIRICAL MODEL TO BE ESTIMATED

A relatively large number of respondents displaced by a conflict and residing in urban areas allows conducting a meaningful statistical analysis of the problems encountered by IDPs while using public services. Specifically, I conduct multiple regression analysis, where different outcomes capturing different public service use problems are regressed on the displaced-person status variable, controlling for mentioned-above socio-demographic characteristics and region-fixed effects. In this way, I effectively compare the outcomes of urban dwellers who were and were not displaced by conflict, and are living in the same region, and isolate the impact of displacement from other relevant covariates. Formally, we will estimate the following models:

$$\begin{aligned} Outcome_{ij} = \quad & \alpha * forcibly\ displaced_{ij} + \\ & \Gamma * individual\text{-}level\ controls_{ij} + \\ & \Delta * region\text{-}fixed\ effects_{j} + \\ & random\ error\ term_{ij} \end{aligned} \qquad (1)$$

where, for individual i in country j, *outcome* stands for a specific problem while using public services, individual-level controls are as described above, and α, β, Γ and Δ are parameters (or parameter vectors) to be estimated.

Given that information on a specific public service issue was only provided by respondents who had a contact with relevant public service (education or health) and that the outcome variables are binary (0/1), we estimate all models with the Heckman probit approach, which corrects for possible selection biases stemming from the fact that people may self-select into contact with public officials (see, e.g., Ivlevs and Hinks, 2015) and also accounts for the binary nature of the outcome. The identification variables in the selection stage are having children in the household for education outcomes and reporting poor subjective health for health outcomes.

IV. RESULTS

Here and in what follows I report the results of the Heckman probit outcome equation estimations (specifically, I report the marginal effects, which show by how much the likelihood of the outcome changes when the regressor changes by one unit; for example, in the case of the forced displacement variable, by how may percentage points the forcibly displaced are more or less likely to report a particular issue – absence of doctors, maltreatment in hospitals etc. – than people not affected by conflict). The results of the selection stage are not reported for space saving purposes; I note, however, that the two identification variables always turn out to be strong predictors ($p<0.001$) of selection into contact with the relevant public service.

Table 2 reports the individual-level determinants of issues encountered while using public health services. IDPs are more likely than people not affected by conflict to raise all the issues associated with the use of public health services except frequent and unjustified absence of doctors. Specifically, controlling for individual-level characteristics and all region-level influences, people who were displaced 10-15 years prior to the interview are 7.8 percentage points more likely to report that they were treated disrespectfully by medical staff, 4.1, 9.7 and 4.3 percentage points more likely to complain about the lack of

medication/drugs, long waiting lists/lines, and not clean facilities, as well as 8.6 percentage points more likely to report that that they were asked for unauthorised payments for medical services that should be free (Columns 2-6 of Table 2). These are large effects relative to the overall likelihood of reporting the respective issues (the full-sample shares of respondents reporting the issues in columns 2-6 of Table 2 are 22.6, 28.6, 48.5, 16.0 and 24.3%); for example being forcibly displaced 10-15 years prior to the interview increases the likelihood of maltreatment and unauthorised payment requests by medical staff by more than one third (7.8/22.6 and 8.6/24.3).

Table 2. Individual-level determinants of issues associated with the use of public health services

	Frequent and unjustified absence of	Treated disrespectfully by staff	No medication/ drugs available	Long waiting lists/queues	Facilities not clean	Payments required for services that
	(1)	(2)	(3)	(4)	(5)	(6)
Forcibly displaced	0.063	0.078***	0.041*	0.097***	0.043**	0.086***
Female	0.011	0.006	-0.015	0.003	0.008	-0.011
Age group (reference: 35-44)						
18-24	0.037	0.010	0.025	0.045*	-0.027	0.028
25-34	0.015	0.047**	0.017	-0.012	-0.003	0.060***
45-54	-0.031	-0.013	-0.012	-0.040	-0.042*	0.013
55-64	-0.045	-0.049**	0.011	-0.059**	-0.057*	-0.022
65+	-0.059	-0.076***	0.018	-0.088***	-0.085*	-0.056**
Education (reference: secondary)						
Primary	-0.004	-0.007	0.008	0.004	0.001	-0.010
Tertiary	0.007	0.009	-0.005	0.023	0.023	-0.001
Income level (reference: middle)						
Low income	-0.025	-0.005	-0.004	-0.036*	-0.030*	-0.002
High income	-0.014	-0.008	0.002	-0.005	0.018	0.000
Employed	0.017	0.011	0.007	0.043***	0.002	0.008
Linguistic minority	0.006	-0.009	-0.047**	-0.021	-0.008	-0.048**
Region-fixed effects	Yes	Yes	Yes	Yes	Yes	Yes
Total observations	5,862	5,862	5,862	5,862	5,862	5,862
Uncensored observations	4,137	4,137	4,137	4,137	4,137	4,137
Chi^2	555.6	487.0	911.7	837.2	1089	1215
$p > Chi^2$	0.000	0.000	0.000	0.000	0.000	0.000

*Note: The table reports estimations of six Heckman correction model outcome equations, each showing the determinants of being dissatisfied with a specific aspect of using public health services. *** p<0.01, ** p<0.05, * p<0.1.*

Overall, these results suggest that, within urban areas of the post-socialist countries, IDPs are disproportionately more likely to be dissatisfied with the quality of received public health services 10 to 15 years after displacement. It is possible that, even in the relatively long term, IDPs are only able to settle in poorer localities with inferior provision of health services – either by personal choice/necessity (for example, because they have limited incomes and housing rents in such areas are lower) or because they are provided accommodation in such areas by local authorities. In addition, as our sample of the forcibly displaced included those who have returned to the former conflict zone, the results may also reflect the fact that the medical services infrastructure was damaged or destroyed during the conflict (hence the lack of medication/drugs) and hospitals in such areas may be less able to attract and retain doctors (hence longer waiting lists/lines). Particularly disturbing are the findings that former IDPs are more likely to be treated disrespectfully and asked for unauthorised payments by staff in public health institutions. Again, this could reflect the concentration of IDPs in areas where such malpractices are more prevalent (for

example, in poorer areas) or prejudice and discrimination against IDPs (Feijen, 2005; Hill et al., 2006; Holland, 2004; López et al., 2011; Sundal, 2010; World Bank, 2016) which puts them in a vulnerable position.

Table 3. Individual-level determinants of issues associated with the use of public education services

	No textbooks or other supplies that should be provided	Poor teaching	Frequent and unjustified absence of teachers	Overcrowded classrooms	Facilities in poor condition	Payments required for services that should be free
	(1)	(2)	(3)	(4)	(5)	(6)
Forcibly displaced	0.001	0.045	0.034	0.026	0.064	-0.008
Female	0.009	-0.011	0.005	0.023*	0.007	-0.014
Age group (reference: 35-44)						
18-24	-0.011	0.064	0.035	0.039**	0.013	0.023
25-34	0.032	0.007	0.028	0.012	-0.005	0.028
45-54	-0.009	0.003	0.010	0.004	-0.023	-0.009
55-64	-0.040	-0.010	-0.009	-0.040	-0.047	-0.069
65+	-0.042	-0.040	-0.010	-0.053*	-0.165	-0.049
Education (reference: secondary)						
Primary	-0.039	-0.027	0.014	0.005	0.009	-0.011
Tertiary	-0.013	0.011	0.026	0.012	-0.005	0.002
Income level (reference: middle)						
Low income	0.020	-0.013	-0.017	0.005	-0.007	0.015
High income	0.007	0.021	0.002	0.011	0.019	0.014
Employed	0.012	0.030	0.001	-0.004	0.017	0.030
Linguistic minority	0.061	-0.043	-0.036	0.001	0.052	0.026
Region-fixed effects	Yes	Yes	Yes	Yes	Yes	Yes
Total observations	5,890	5,890	5,890	5,890	5,890	5,890
Uncensored observations	2,104	2,104	2,104	2,104	2,104	2,104
Chi^2	324.4	463.8	237.4	342.7	378.8	492.3
$p > Chi^2$	0.000	0.000	0.000	0.000	0.000	0.000

*Note: The table reports estimations of six the Heckman correction model outcome equations, each showing the determinants of being dissatisfied with a specific aspect of using public education services. *** p<0.01, ** p<0.05, * p<0.1.*

Table 3 reports the individual-level determinants of the issues encountered while using public education services. Other things equal, the forcibly displaced no different from people not affected by conflict in reporting the six issues associated with the use of public education services: the coefficients of the forcibly displaced variable are statistically insignificant in all six specifications. This means that, in the long terms, IDPs living in urban areas are not necessarily disadvantaged (although there is no advantage either) in terms of satisfaction with public education services. This set of results contrasts with the significant IDPs disadvantage identified earlier for public health services (Table 2). The relatively good outcomes for the education domain, however, are not entirely surprising: as discussed in the introductory section, the forcibly displaced may be particularly keen to compensate the loss of material possessions with gains in education – a transferable human capital.

To check further if former IDPs are actively seeking better-quality public education services, I looked at how likely they are to file a complaint if dissatisfied with the service; information on that is also available in the

LITS-II survey. Table 4 reports the results of the probit model, where the outcome is a binary variable capturing the fact that a respondent had filed a complaint about a public service (either education or health) before. As the model is estimated on the sample of respondents who were not satisfied with a particular service, the sample size is relatively low and the estimation with region-fixed effects becomes too demanding; this is why I used the county-fixed effects. The results suggest that, relative to people who were not affected by conflict, the IDPs are 4.2 percentage more likely to file a complaint if dissatisfied with the public education service (Column 1 of Table 4). The effect is substantively large relative to the overall likelihood of filing a complaints in education (6.2%): being a former IDP increases this probability by more than two thirds (4.2/6.2). Regarding the public health services, I do not find that former IDPs are any different from people not affected by conflict in their likelihood of filing complaints: the estimate of the forcibly displaced variable is statistically insignificant (Column 2 of Table 4). Taken together, these findings suggest that former IDPs are more active in ensuring they receive a good quality public education service than public health service, and support the conjecture that the forcibly displaced are particularly keen to invest in education – probably because gains in this type of transferable human capital are believed to compensate for losses of physical possessions experienced during conflict and displacement.

Table 4. Individual-level determinant of filing complaints when dissatisfied with public services

	Have you filed a complaint when you were dissatisfied with:	
	Public education services	Public health services
Forcibly displaced	0.042*	0.028
Female	-0.009	-0.002
Age group (reference: 35-44)		
18-24	0.024	0.039*
25-34	0.017	0.022
45-54	0.001	0.006
55-64	-0.006	0.041**
65+	0.007	0.017
Education (reference: secondary)		
Primary	-0.042	-0.010
Tertiary	0.024	-0.004
Income level (reference: middle)		
Low income	-0.035	0.010
High income	-0.028	-0.005
Employed	-0.004	-0.008
Linguistic minority	-0.027	-0.040
Country-fixed effects	Yes	Yes
Number of observations	880	1,601
Pseudo R^2	0.048	0.040

*Note: The table reports the marginal effects after the binary probit estimations. *** p<0.01, ** p<0.05, * p<0.1.*

d. LIMITATIONS AND FUTURE RESEARCH

This study provides the first evidence on the former IDPs' satisfaction with public health and education services in the urban areas of post-socialist countries. However, it is not without limitations – which open directions for future research. First, as the study provides a combined perspective from nine post-socialist countries (which I was confident to pool together as they share similar historical, political and social backgrounds, as well as the timing and nature of conflicts), future research could look at whether these results are driven by a particular country or even a city/region with a large concentration of IDPs. While the sample size of the survey used in this study does allow to conduct a high-quality statistical analysis of the

differences between IDPs and non-IDPs at a very disaggregated geographical level (countries and especially cities), Tables 1A and 1B of the Appendix show the averages in satisfaction with public health and education services for IDPs and non-IDPs for individual countries included in the survey, as well as their capital cities (the averages for other cities, which in our case are generally smaller than capital cities, are not reported because of the relatively low number of respondents interviewed in each of them). With the small sample size caveat in mind, there is little indication that the health services results are driven by a particular or capital city: IDPs tend to be less satisfied with the public health services across the board. As to education, the picture is more mixed, with the IDPs being more dissatisfied in some countries and cities but not others. This would explain the insignificant coefficient of forced displacement obtained for the whole sample and also provide a rationale for future research to explore the role of national and local context for determining the disadvantage of IDPs in terms of satisfaction with public education services.

Second, the specific focus of the paper is on urban areas, which invites a comparative perspective on IDPs' experiences of using public services in urban *and* rural areas. Third, this study has revealed IDPs' satisfaction with using public services 10-15 years after conflict; subject to data availability, future research could look whether the effects is larger in shorter term and smaller in longer term, i.e. if any disadvantage experienced by IDPs in terms of public service use disappears over time. Finally, this study has focused on public health and education services – partly because of their importance for IDPs in helping rebuild their lives and partly because of data constraints. Future work could explore access to and satisfaction with other public services, in particular registry, as IDPs in many countries face challenges in obtaining, recovering and renewing documents even in the long term (IDMC, 2015; UNHCR, 2007).

V. CONCLUSION

This paper set out to determine whether IDPs in urban areas are disadvantaged in terms of satisfaction with public services. Adopting a long-term perspective (10 to 15 years after displacement), focusing on two major public services (health and education) and analysing data from a large representative survey, administered in 2010 in nine post-socialist countries that were affected by conflict in the 1990s and 2000s, I found that IDPs are more likely to be dissatisfied with the quality of received public health services than people not affected by conflict. Specifically, IDPs are more likely to report disrespectful treatment by staff, lack of medication, long waiting lists/lines, unclean facilities, as well as requests for unauthorised payment for services that should be free. Some of these findings can be explained by the concentration of IDPs in areas where health services are underfunded or were damaged by conflict, while others point to the discrimination and prejudice against IDPs. Overall, these results are disturbing, pointing to the long lasting vulnerability and disadvantage of IDPs in terms of access and satisfaction with public health services. Policymakers could make a particular effort to improve public health services in areas where former IDPs tend to live, and also set in place mechanisms which allow IDPs to report, in a confidential and non-threatening manner, maltreatment and bribe requests by public health staff.

A somewhat different – and more optimistic – picture emerged for public education services. First, I found that people who were displaced by conflict 10-15 years prior to the interviews were as likely to be satisfied with the quality of received public education services as people not affected by conflict; so contrary to the public health domain no IDP disadvantage (although also no advantage) was observed for education. Second, former IDPs are more likely than people not affected by conflict to file a complaint if they are not satisfied with the education service they receive; no such greater likelihood to file complaints was found for the public health services. These relatively better outcomes for public health services can be explained by the willingness of the forcibly displaced to invest in transferable capital – education – in order to compensate for the damage or loss of material possessions, as was recently highlighted in the literature (Becker et al., 2018). Despite an absence of adverse outcomes for IDPs in terms satisfaction with public education services, policymakers should continue to ensure that IDPs and their descendants receive good quality education services, enhancing their chances of socio-economic integration and successful rebuilding of lives after conflict.

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VII. APPENDIX

Table A1. Satisfaction with public health services, by country and capital city

	Frequent and unjustified absence of doctors		Treated disrespectfully by staff		No medication/ drugs available		Long waiting lists/queues		Facilities not clean		Payments required for services that should be free	
	Non-IDPs	IDPs	Non-IDPs	IDPs	Non-IDPs	IDPs	Non-IDPs	IDPs	Non-IDPs	IDPs	Non-IDPs	IDPs
Countries												
Armenia	0.08	0.17	0.11	0.25	0.20	0.42	0.18	0.42	0.06	0.25	0.28	0.42
Azerbaijan	0.06	0.13	0.06	0.08	0.31	0.42	0.25	0.34	0.12	0.11	0.57	0.74
Bosnia and Herzegovina	0.21	0.18	0.27	0.34	0.23	0.18	0.50	0.43	0.13	0.12	0.22	0.33
Croatia	0.05	0.09	0.13	0.21	0.06	0.15	0.50	0.45	0.07	0.06	0.06	0.06
Macedonia	0.31	0.56	0.33	0.67	0.47	0.33	0.53	0.89	0.41	0.44	0.29	0.33
Russia	0.11	0.27	0.25	0.47	0.22	0.33	0.68	0.87	0.06	0.13	0.17	0.33
Serbia	0.14	0.13	0.29	0.38	0.19	0.19	0.57	0.66	0.13	0.11	0.12	0.15
*Tajikistan**	0.11	0.00	0.17	0.00	0.38	0.00	0.26	0.20	0.15	0.20	0.45	0.33
Kosovo	0.17	0.36	0.29	0.29	0.60	0.74	0.38	0.50	0.32	0.41	0.13	0.14
Capital Cities												
*Yerevan**	0.11	0.00	0.13	0.20	0.26	0.40	0.22	0.40	0.07	0.40	0.37	0.60
Baku	0.10	0.29	0.08	0.14	0.28	0.36	0.29	0.50	0.16	0.07	0.44	0.64
Sarajevo	0.22	0.14	0.38	0.46	0.20	0.22	0.27	0.32	0.16	0.14	0.39	0.43
*Zagreb**	0.04	0.00	0.11	0.18	0.05	0.18	0.53	0.55	0.06	0.00	0.07	0.00
Skopje	0.35	0.43	0.45	0.57	0.47	0.14	0.62	0.86	0.44	0.43	0.24	0.14
*Moscow**	0.22	0.50	0.36	1.00	0.26	0.50	0.80	1.00	0.08	0.00	0.13	0.50
Belgrade	0.12	0.07	0.28	0.31	0.12	0.21	0.51	0.55	0.04	0.10	0.10	0.14
*Dushanbe**	0.18	0.00	0.23	0.00	0.34	0.00	0.26	0.00	0.21	0.00	0.38	1.00
Prishtina	0.13	0.32	0.13	0.30	0.45	0.81	0.34	0.58	0.28	0.52	0.07	0.10

*Notes: The table reports the shares (raw averages) of IDP and non-IDP respondents, by country and capital city, raising specific issues while using public health services. Respondents who had not used public health services in the 12 months prior to the interviews are excluded. * indicates low size of the IDP sub-sample (n<10), and the results for these countries/capital cities should be interpreted with caution.*

Table A2. Satisfaction with public education services, by country and capital city

	No textbooks or other supplies that should be provided free of charge		Poor teaching		Frequent and unjustified absence of teachers		Overcrowded classrooms		Facilities in poor condition		Payments required for services that should be free	
	Non-IDPs	IDPs	Non-IDPs	IDPs	Non-IDPs	IDPs	Non-IDPs	IDPs	Non-IDPs	IDPs	Non-IDPs	IDPs
Countries												
Armenia	0.11	0.00	0.13	0.20	0.26	0.40	0.22	0.40	0.07	0.40	0.37	0.60
Azerbaijan	0.10	0.29	0.08	0.14	0.28	0.36	0.29	0.50	0.16	0.07	0.44	0.64
Bosnia and Herzegovina	0.22	0.14	0.38	0.46	0.20	0.22	0.27	0.32	0.16	0.14	0.39	0.43
Croatia	0.04	0.00	0.11	0.18	0.05	0.18	0.53	0.55	0.06	0.00	0.07	0.00
Macedonia	0.35	0.43	0.45	0.57	0.47	0.14	0.62	0.86	0.44	0.43	0.24	0.14
*Russia**	0.22	0.50	0.36	1.00	0.26	0.50	0.80	1.00	0.08	0.00	0.13	0.50
Serbia	0.12	0.07	0.28	0.31	0.12	0.21	0.51	0.55	0.04	0.10	0.10	0.14
*Tajikistan**	0.18	0.00	0.23	0.00	0.34	0.00	0.26	0.00	0.21	0.00	0.38	1.00
Kosovo	0.13	0.32	0.13	0.30	0.45	0.81	0.34	0.58	0.28	0.52	0.07	0.10
Capital cities												
*Yerevan**	0.19	0.00	0.12	0.00	0.07	0.00	0.11	0.00	0.09	0.00	0.12	0.00
Baku	0.19	0.30	0.41	0.40	0.07	0.50	0.07	0.00	0.23	0.50	0.38	0.80
Sarajevo	0.43	0.33	0.17	0.33	0.04	0.08	0.09	0.08	0.09	0.17	0.43	0.17
Zagreb	0.14	0.25	0.10	0.13	0.05	0.25	0.19	0.00	0.14	0.38	0.07	0.00
Skopje	0.26	0.14	0.19	0.14	0.14	0.00	0.22	0.43	0.27	0.43	0.18	0.00
*Moscow***	0.14	-	0.16	-	0.07	-	0.09	-	0.12	-	0.16	-
Belgrade	0.07	0.13	0.22	0.13	0.11	0.20	0.09	0.20	0.11	0.33	0.13	0.00
*Dushanbe**	0.43	0.00	0.26	0.00	0.10	0.00	0.24	0.00	0.29	0.00	0.19	0.00
Prishtina	0.16	0.19	0.12	0.30	0.18	0.30	0.44	0.48	0.26	0.19	0.00	0.09

*Notes: The table reports the shares (raw averages) of IDP and non-IDP respondents, by country and capital city, raising specific issues while using public education services. Respondents who had not used public education services in the 12 months prior to the interviews are excluded. * indicates low size of the IDP sub-sample (n<10), and the results for these countries/capital cities should be interpreted with caution. ** - the sample did not include any IDPs using public health services.*