



Development Research Centre

Development Studies Institute



Research Seminar Series

Lent Term 2005

Wednesday, 19th January 2005

Hidden Injuries of Displacement: Executive Summary

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This paper is concerned with Greek Cypriot villagers studied at three periods: 1968, as prospering citrus farmers and artisans, in 1975, as very recent IDPs, in 2004, their 30th year of exile, the focus of the paper.

Theme 1 – Economic Recovery:

The paper deals first with how the state dealt with a threatened economic meltdown by neo-Keynesian/New Deal methods, treating the refugees as “development resources”. The refugees responded by adapting their economic skills to new situations. Farmers switched from pre-war slow-yielding capital-intensive tree crops, to quick turn-around early vegetables, to intensive livestock rearing. Labourers found work in construction, both of refugee housing, roads, airports, and industrial sites. Women who were not wage-working pre-war entered the labour market either as home-based machinists, as packers in produce factories, as service workers in the expanding tourist sector.

Theme 2 – Assessing Social Disruption costs: technology change and the conservation of social capital.

Where early analysis had a focus on the compact highly-intermarried village as dominant social institution, the dispersal of 1500 villagers to more than 25 locations in Cyprus and abroad forced an analytic reconsideration of the functional importance of the village to the villagers. Loss of community features strongly in refugee narratives of deprivation. In fact, it comes third, after 1] land 2] homes. And the village-as-community is clearly second to the nuclear and extended family, as the key unit of livelihood, social solidarity, and life planning. In fact, although villagers did experience a very real loss of sociality after displacement, their dispersal coincided with rapid growth of telephone ownership, car ownership, road improvements, and economic wealth generation.

The boom in the Cypriot economy 1976 to 2000 meant that the social costs of dispersal were practically offset by new communication forms. That is ignored in how the refugees think.

Some attention is paid to weddings and funerals, because other analysts have supposed that the refugees are irrationally pre-occupied with commemorating the village at these events. My analysis argues that the wedding as rotating credit association, and opportunity to catch up with friends and relatives is in no way nullified by the loss of the physical village - : the village was a site where social relations were facilitated, not the ultimate purpose of life in and of itself. Social facilitation is just as valued in diaspora.

Theme 3: Health Costs of Displacement: a comparison of refugee and non-refugee cohort.

In 2000 the refugees explained deaths of their covillagers as due to displacement and exile. Literature on cardio-vascular disease suggested that this could be true, but as refugees tend to explain everything negative as due to “the situation” it might be that they were treating “normal” death as refugee-produced. No official statistics allowed a clear comparison of refugee/non-refugee death rates, and government statisticians could find no “spikes” in annual death rates since 1974. But refugee doctors had anecdotes of early deaths which suggested the idea should be examined.

The method we adopted was to start with the men and women recorded in village birth registers between 1930 and 1940 from Argaki [refugee] village, and those from nearby Astromeritis, [non-refugee]. We excluded all childhood deaths, all those who had migrated from either village before 1974, and overseas migrants post 1974.

Persons still “in the study” were cross-identified on electoral registers, which also provided us with contact addresses in the case of the refugees, and the non-refugees alike. We then interviewed everyone we could find. We found 80% of the non-refugees, and 73% of the refugees. The interview had four components

- 1] brief descriptions of all livelihood activities in adult life.
- 2] brief descriptions of the educational attainments, and employment of the children of the 1930 cohort – themselves now married adults.
- 3] The lifetime serious health problems of the 1930-40 cohorts.
- 4] We also tracked all known deaths post 1974 in the two cohorts from next of kin, and there is no significant difference in the death rates. We can see no obvious way in which we might have missed a large number of deaths in either cohort. So, the refugees’ narrative of “earlier refugee mortality” is not supported by our evidence.

5] However our data show that **the refugees have significantly higher rates of serious and moderate cardio-vascular disease**, in comparison with the non refugee village. [Chi Square $P = .01$] As the factors which complicate [“confound”] most studies of migrant/refugee health are absent in Cyprus, we suppose that if this finding applies to refugees in “failing states” illness rates might be much higher.

Our data do not allow us to offer a strong explanation for why this should be the case. There are three front-running “candidate” explanations, and there could be a mixture of several of these kicking in.

1] **Diet:** The refugee villagers may have had a richer meat diet in the 10 years prior to their displacement.

2] **Harder Working Lives:** Our data are not detailed enough to clear this up, and we have some more analysis to do. In the medical literature, hard work /lots of work is not as such a simple correlate of cardio-vascular disease. However, chronic fatigue can be a predictor of heart disease. As can “an irresolvable problem/loss”

3] **Workplace Control:** Persons experiencing strong workplace demands over which they feel they have little control have a higher risk of heart disease. It is possible the refugees have experienced their working lives in just such a way. The refugees had specific life goals –

education and marriage of their children, and much economic striving has gone to meet those goals.

Theme 4: Protective Factors: the [relative] Wellness of Refugees?

Our study did not find many cases of depression among the refugees, and of those we found, some were clearly pre-war in onset, and others were explained by the loss of a child.

And in comparison with the non-refugees, the refugees had more people with no serious illness, and more people with only one illness. So, **apart from heart disease**, the refugees were not obviously less healthy than the non-refugees.

Why not? What are the **protective factors** in the Greek Cypriot case?

1] State, Society, and Economic Development helped them get through the worst. Everyone found work, got a life, a home.

2] Their life goals were simple, clear, and achievable, They felt they transcended their displacement, at the price of very hard work.