Survivor Experiences and Perceptions of Stigma:
Reintegrating into the Community

Thematic Paper

The Butterfly Longitudinal Research Project

A Chab Dai study on (Re-)integration: Researching the lifecycle of sexual exploitation & trafficking in Cambodia

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សម្ព័ន្ធចាប់ដៃ
**CHAB DAI
COALITION**

Because life is very important… And because I saw what happened in front of my eyes and I know how much it hurt. That is why I don't want the people whom I love, especially my daughter, to experience being hurt as I did.

STIGMA: SURVIVOR EXPERIENCES AND PERCEPTIONS

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Discourse Regarding Definitions

HUMAN TRAFFICKING

Defined by the UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, Article 3

"…the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum. The exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs."

SEXUAL EXPLOITATION
"Child sexual exploitation" is when a child (under the age of 18) is involved in a situation or a relationship where they are being used sexually, and the child, or a third party, receives a reimbursement for this activity (money, gifts, affection or favors – e.g. alcohol, food or shelter). There are thought to be three main forms of sexual exploitation: prostitution, pornography, and trafficking for sexual exploitation. In this research we are interested in trafficking for the purposes of prostitution, the movement of children from one place to another, within a country or across a border, for the purposes of prostitution, and the exploitation of children through prostitution.

RE-INTEGRATION

There are no universally accepted definitions of 'integration' or 're-integration' (COMMIT, 2010), the discussion on a common definition of re-integration has evolved over time within various contexts:

In 'Monitoring Anti-Trafficking Re/Integration Programs: A Manual' (Surtees, 2010), successful (re-) integration is defined in the *Trafficking Victims Re/Integration* (TVRP) as:

"Recovery and economic and social inclusion following a trafficking experience. This includes settlement in a stable and safe environment, access to a reasonable standard of living, mental and physical wellbeing, and opportunities for personal, social and economic development, and access to a social and emotional support. It may involve returning to one's family and/or community of origin; it may also involve integration in a new community and even in a new country. TVRP criteria for determining if an individual has been successfully (re-) integration includes: 1) safe and affordable accommodation, 2) legal status, 3) [professional and employment opportunities, 4) education and training opportunities, 5) security and safety, 6) healthy social environment (including anti-discrimination and anti-marginalization), 7) social wellbeing, 11) access to services and opportunities, 12) motivation and commitment to (re-) integration [process, 13) legal issues and court proceedings, and 14) wellbeing of secondary beneficiaries."

TYPES OF ASSISSTANCE PROGRAMS partnering in the Butterfly Longitudinal Research[1]

'Shelter' refers to assistance a participant receives whilst residing in the shelter. 'Community Program' refers to assistance on the form of employment and possibly in addition psychosocial/ spiritual support/ further training. 'Transition home' and 'Family group home' refers to assistance at some level in a group accommodation. 'Training program,' refers to any participant who is undergoing a type of skills training. The participant can be out in the community or in any type of residential program whilst receiving this training.

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[1] The majority of the Assistance programs partnering in the Butterfly Longitudinal project describe themselves as Christian Faith Based ministries or non-government organizations.

EXECUTIVE SUMMARY

Objective: The Butterfly Longitudinal Research Project is an ongoing ten-year longitudinal study following the (re-) integration of a select group of survivors of sexual exploitation and trafficking in Cambodia. As research progresses, the focus of the project has included the development of thematic assessment from the vast data sets. The purpose of this thematic paper is to document and describe the stigmas and discrimination survivors of sexual exploitation and trafficking must contend with in the community. This paper also seeks to identify persistent issues surrounding stigma among survivors as well as highlight positive coping strategies and mechanisms survivors discuss as they confront stigma in Cambodia.

Methods: The thematic assessment draws from a subset of participants within the larger pool of data collected in the Butterfly Longitudinal Research Project. The assessment groups included, 33 individuals in Female SP/RC [females that stayed in shelter programs (SP) and have (re-) integrated in the community (RC)] and 27 individuals in Female RC [females that did not stay in shelter programs and have (re-) integrated in the community].

Results: The majority of respondents (65%) contended with stigma at least once during the four-year assessment. Overall, participants talked more frequently about stigma related to gender inequality in marriage (25% of all respondents), current or past work in the sex industry (23.3% of all respondents), and lower socioeconomic levels (23.3% of all respondents). Most respondents that described stigmatizing experiences also identified the person or group of people involved, with 61.7% of all respondents identifying one or more stigmatizing groups over the four years included in the assessment.

Survivors discussed many forms of public discrimination during the four-year assessment. The three discrimination practices respondents in both groups discussed most included, verbal abuse and cursing identified by 31.7% of individuals (19 individuals; n=60), social isolation from the community and/or family identified by 30% of individuals (18 individuals from two categories combined; n=60), and domestic violence identified by 25.7% of respondents in marriage/partner relationships (nine individuals out of 35 individuals married/with partners).

Survivors reported multiple forms of stigma and discrimination in some cases multiple forms over multiple years during the assessment. Overall, 40% of survivors talked about contending with multiple forms of discrimination (24 individuals; n=60). Of these 24 respondents, 14 individuals described multiple forms of discrimination over multiple years (23.3%; n=60). Survivors also talked about self-stigmatizing thoughts along with multiple forms of public stigma and discrimination (21.7%; n=60).

Conclusions: Survivors must wrestle simultaneous with self-stigmatizing thoughts along with trauma during trafficking and exploitation. At some point during trafficking or exploitation survivors realize that their life situation has changed and it now fits within a different social construct, a construct containing negative labels and stereotypes. As survivors become "stigma conscious", they must contend with self-stigma and self-discrimination. These situations are clearly evident in the voices' of survivors:

⇒ *I felt empty with myself because they already abused me one time. That is why I agreed with this person to go to work (in a brothel) after they abused me.*

In general, findings in this assessment suggest that stigma increases in degree and intensity as multiple discriminating experiences converge and remain in place over multiple years. The intensity and degree of stigma can also increase as survivors locate fewer and fewer trusted social resources (e.g. friends or family members) and safe places in the community (e.g. relatives and neighbors homes or places of business).

There are multiple lines of evidence indicating stigma is a persistent issue in the lives of survivors. The assessment includes a broad range of stigmata, some that survivors undoubtedly faced before being trafficked such as poverty and gender discrimination in families. In many cases, survivors still contend with these forms of stigma in addition to stigma resulting from trafficking and exploitation.

Based on the discussions among survivors, most survivors are highly stigma conscious regarding their "ability" to get married, divorced, or for some, remarried. The vast majority if not all of the survivors that are single discuss wrestling with stigma related to marriageability at some time during the assessment. Survivors that find themselves in an abusive or violent relationship struggle with gender based stigma as well as cultural stigma associated with options such as divorce. Even the decision to leave a relationship involving domestic violence can be stigmatizing, given the vast majority of Cambodians believe wives should be patient and endure (i.e. keep silent) domestic violence in order to keep a family together. Presently, there are survivors contending with multiple forms of stigma as they cycle between abusive relationships with spouses, divorce/separation, and re-marriage into yet another abusive relationship.

Most survivors that enter into relationships with spouses choose not to legally register their marriages at the civil registry. This is a disturbing trend among the cohort group; there is only one in 36 respondents considered married/with a partner that has legally registered their marriage. Women that do not obtain legally registered marriages are not assured rights to marital assets, property acquired during marriage and registered in the name or their partner, partner alimony, and child support. They effectively have no power to negotiate conflicts and stigma arising from gender inequality in the marriage without fear of violence, financial repercussions, physical abandonment, or forced eviction.

Keeping the past a secret can be a significant strain mentally and physically. Survivors talk about concerns that someone might recognize them or that friends or family might decide to look on the internet for the organization where they lived or now work. In one example, a highly stigma conscious survivor describes linking health problems with the stresses of contending with stigma. She describes this stress as the greatest worry in her life:

⇒ *I think the most is about this issue; I really focus on it. I don't know what to do if my parents in law know my story.*
(When asked if it affects her health?) -Yes! I can't sleep well, can't eat much and feel exhausted, as you have seen now

It is clear in this assessment that survivors contend with stigma. They are not passive helpless victims but instead they challenge stigma through various strategies and mechanisms. Some survivors undoubtedly learn coping mechanisms in aftercare programs and work training programs and are now employing them in the community. The assessment does not identify any

one strategy that was more effective; instead the survivors choosing to "think through situations more" often found effective ways to deal with stigma.

A group of survivors in this assessment have overcome many of the stigmatizing situations they faced in life. This group collectively shares several important resilience attributes and characteristics including interconnected relationships, mental strength, the willingness to work hard and struggle, the perseverance to learn a skill or trade and excel at work, and the sense of having "earned honor" through life choices. One survivor describes this in the following statements:

⇒ *Frankly speaking, if the young girls have any problems like me I want them to be strong and calm. .... If you have problems don't be too afraid. If you face any problems you have to be strong and struggle. When you face that problem doesn't think that your life is over and that you cannot improve it. Our life is longer than this so doesn't finish it there or destroy it more and more. I always think positive like that.*

This study has identified a range of stigma intensity and degree among survivors. Additional evaluation of forms of social- and self-stigma and mental and physical health indicators in survivors during the years following (re-) integration would further understandings of these interactions. Cooperation between researchers that focus on resiliency in children and young adults, stigma concepts and scalar assessment, and mental and physical health fields would allow for the exchange of concepts, a discussion in overlapping terminologies, and the development of cooperative studies. These types of cooperative studies would benefit a range of stakeholders, not least of which, survivors themselves.

1.0 Introduction

The Butterfly Longitudinal Research Project (BLR Project) is an ongoing ten-year longitudinal study following the (re-) integration of a select group of survivors of sexual exploitation and trafficking in Cambodia. The study began in 2010 and is now in its sixth year. The central theme of BLR Project is to listen to the 'voice' of survivors and in so doing gain an understanding of their perspectives and experiences as they (re-) integrate into society. Through disseminating their 'voice' and the research findings locally, regionally and globally, Chab Dai believes (re-) integration programming and policy will be informed and advanced, thereby directly improving the quality of life for survivors of sexual exploitation and trafficking.

The purpose of this thematic paper is to document and describe the stigmas and discrimination survivors of sexual exploitation and trafficking must contend with in the community. This paper also seeks to identify persistent issues surrounding stigma among survivors as well as highlight positive coping strategies and mechanisms survivors discuss as they confront stigma in Cambodia.

2.0   Stigma – Working Definition

The field of stigma research is broad, containing a well-developed body of literature. Areas of research span conceptual understandings of stigma to qualitative and quantitative study of a stigma in a vast array of situations to clinical observations, scaling, and linkages with mental and physical health. Stigma is well researched among select people groups in areas such as ethnic minorities (James et al. 1984; Steele and Aronson 1995; Major and O'Brien 2005), gender inequality (Witvliet et al. 2014), gender and sexuality (Rebhen 2004; Fick 2005; Tomura 2009; Kokun 2012), and health related topics such as mental illness, addictions, and more recently HIV (Link et al. 1989; Link et al. 1997; Van Brakel 2006; Yang et al. 2007; Hatzenbuehler et al. 2013; Link and Phelan 2013). As with many fields of study in social science, stigma research is broadly represented and established in many western cultures, while at best, selectively represented and slowly progressing in other regions such as South East Asia.

Erving Goffman's (1963) book *Stigma: Notes on the Management of Spoiled* is largely seen as the inspiration for much of the present day field of stigma research. Conceptually recent literature has focused on stigma as a sum of its components. Link and Phelan (2001) have expanded on Goffman's work by suggesting stigma is comprised of the co-occurrence of negative labels and stereotypes, separation (us and them), loss of status, and discrimination. Stigma then exists if all four components are present and grounded in a situation of power inequality. Power inequality exists when one group has less access to resources, less influence over others, and less control over their own destiny.

The majority of stigma research is focused around two main constructs, 1) Social stigma or public stigma, defined as stigma contained in the community or society; the public outward fostering of stereotypes, separation, and discrimination and 2) Self-stigma, defined as the inward understandings and self-perceptions of stigma (Corrigan et al. 2009).

2.1   Concepts of Stigma

Conceptually stigma spans physical, emotional, social, and cultural domains. In this way, stigma not only impacts a person's emotional states, it also impacts their physical states (Yang et al. 2007). Stigma occurs among interpersonal and intrapersonal communication as well as through other forms of natural communication, such as body language and physical gestures. What makes stigma particularly dangerous is that it threatens what is "most at stake" in an individual's life (Yang et al. 2007), their close personal relationships and their personal life values (also termed "identity threat"; Major and O'Brien 2005). In other words, two people may experience the same stigma but have two very different and personal reactions toward it.

Self –Perceptions of Stigma

Stigma consciousness and stigma self-awareness or self-perception are terms researchers use to explain an individual's level of understanding regarding cultural labels and stereotypes that separate people in society (Link and Phelan 2001). Self-stigma and discrimination arises when an individual is aware of the negative labels and stereotypes, is in general agreement with these negative beliefs and attitudes, and chooses to apply these negative labels and stereotypes to their "self" thereby impacting thought processes and decision making (Link and Phelan 2001).

Several theories have developed around self-stigma including modified labeling theory (Link et al. 1989). Modified labeling theory suggests that through the growth and maturity of a person, he or she learns and adopts cultural worldviews containing positive and negative labels. As a person's life develops situations and experiences can cause these labels to become activated and

subconsciously applied, modifying behavior in everyday life situations. The authors have suggested that amongst people with mental illness this form of self-stigmatization leads to behaviors such as expecting or fearing rejection. Research has shown that people hospitalized for mental illness tend to be less confident and more defensive in approaching primary care-givers about their condition, often choosing to avoid potentially threatening situations. The authors argue that self-stigma affects decision-making and alters life chances and opportunities (Link et al. 1997; Link and Phelan 1989; 2001).

In a similar theory, authors have researched stereotype threat (Steele and Aronson 1995). This theory is defined as the subconscious self-concern people have about a particular stereotype being applied to them in a life situation. The theory is illustrated in the following example.

Authors described research to evaluate the stereotype that African-American students have lower intellectual abilities than Caucasian-American students in the United States (Steele and Aronson 1995). The study developed a sample group of student respondents, both African-American and Caucasian-American and controlled for SAT scores (Scholastic Aptitude Test). A research test was then administered to respondents but before the test began each group was told the test measured "intellectual ability". Test results showed African-American students scored lower as compared to Caucasian-American students. However, when the same test was administered and no notice was given that the test measured "intellectual ability", both groups of respondents had equivalent scores. The researchers concluded that the mere threat of the stereotype subconsciously impacted test scores among African-American students (Steele and Aronson 1995; Major and O'Brien 2005).

Stigma consciousness, labeling theory, and stereotype threat all deal with self-discrimination and self-stigmatizing thoughts. The subconscious realization of stigma can and does trigger powerful self-discriminating thoughts, including expectations of rejection and shame (Link et al. 1997). These thoughts can demoralize a person's self-esteem, impact relationships and impair social functioning. Researchers have taken these theories further and suggested a continuum of personal responses to self-stigmatizing thoughts. One end of the continuum includes personal responses that demoralize individuals lowering self-esteem and self-value. On the other end of the continuum individuals are empowered almost "energized" by the stigmatizing message. In these cases individuals react with confidence often setting and pursuing goals to affect the situation (Corrigan et al. 2009).

Stigma Degrees and Persistence

Qualitative and quantitative studies both demonstrate that stigma varies in intensity and degree (Link and Phelan 2001; Major and O'Brien 2005; Van Brakel 2006). The major components of stigma themselves have ranges in levels of importance and strength of connection. Negative labels can carry more or less prominence in a given situation and be connected with one or many stereotypes. There can be differing degrees of separation between groups and differing losses of social status. Further, two people can have two very different reactions to the same stigma based on an individual's resilience and the perceived strength of the stigma threat.

Stigma Persistence

Stigma is persistent because the mechanisms of discrimination that reinforce it are adaptable and extensive. Link and Phelan (2001) described three general mechanisms of discrimination, individual discrimination, systemic discrimination, and forms of self-discrimination originating from a person's thoughts, beliefs and behavior. The authors state: "there are many ways to

achieve structural discrimination, many ways to directly discriminate, and many ways in which stigmatized persons can be encouraged to believe that they should not enjoy full and equal participation in social and economic life" (Link and Phelan 2001; pp. 379-380).

Stigma is considered a persistent dilemma because the stigmatizing process encompasses a broad field of domains, physical, emotional, social, and cultural domains (Link and Phelan 2001; Yang et al. 2007; Hatzenbuehler et al. 2013). There are many possibilities and many possible outcomes among stigmatized people. Another researcher suggests stigma can negatively impact people by restricting function within any combination of life domains including: learning and applying knowledge, general tasks and demands, communication, mobility, self-care, domestic life, interpersonal interactions and relationships, major life areas and community, social and civic life (life domains developed by World Health Organization; Van Brakel 2006). Coping with stigma is stressful and there are ranges of unintended consequences when a person tries to avoid discrimination or a stigmatizing situation. For example one study has shown unintended consequences among African-Americans who work hard to avoid being labeled as lazy and unproductive only to suffer physically from high levels of hypertension (James et al 1984).

Cultural Contexts

Stigma is culturally dependent in that negative labels, separation, loss of social status, and discrimination manifest through cultural contexts (language, customs, mannerisms, and norms of behavior). Yet researchers looking at mental illness and HIV stigma have found similarities in domains of life affected by stigma and in the types of discrimination and self-stigmatizing thoughts that occur among individuals in Asian, European, and North American contexts (Van Brakel 2006 and Yang et al. 2007). Yang et al. (2007) have argued that these types of similarities do not provide the complete picture regarding stigma in Asian countries such as China that place a culturally high value on family and community support. The authors suggest that studies regarding stigma must take into account cultural aspects of high value because these aspects most often embody what matters most in an individual's life and therefore, these aspects are under the greatest threat from stigma.

2.2   Roots of Social Stigma in Cambodia

Social Status and Honor

In Cambodian society relationships are organized in a hierarchical configuration (Gorman and Kheng 1999; UNIFEM 2004; Ministry of Women's Affairs 2008). The concept of status and honor are central to this hierarchy and applied among relationships, to positions in a family, and to a family's position in the community. There are many societal components that determine hierarchy; the main one being gender followed by others such as age, financial resources, marital status, whether a family has children, family reputation, individual character, political position, education, employment and religious practice (Gorman and Kheng 1999; UNIFEM 2004). In practice, the group or community determines the social status or position of an individual or family. This position is not static and therefore concepts such as codes of conduct and "saving face" are necessary to gain or preserve honor and status among individuals and families within the community. Researchers point out that even children understand the importance of honor and clearly consider it an enabling or disabling factor for future life (Reimer et al. 2007).

Gender Codes of Conduct

Chbab Srei, or "The Rules of the Lady," is a widely known and traditionally followed code of conduct for Cambodian women. It touches on many aspects of what a "respectable" women looks

and acts in society, including how to dress, how to act, how to speak, what work she should or should not do, and how she should address and respond to others. While many forms of gender bias are presently being challenged in Cambodia (Ministry of Women's Affairs 2008), various aspects of this code of conduct are still relevant in society. In fact, Chbab Srei was taught in public primary schools up until 2007, suggesting that various age groups in Cambodia are more or less familiar with code itself (Ministry of Women's Affairs 2008).

In order to focus on the issues relevant to survivors, the BLR Project conducted focus group discussion with survivors. In these groups, survivors have personally described their understandings of Chbab Srei and the aspects they feel are most relevant to their lives. The following exhibit is taken from a BLR Project final report to illustrate survivor's self-perceptions of gender roles, negative labels and stereotypes, and ultimately sources of stigma in Cambodia (Miles et al. 2012).

Exhibit 1: Survivor Focus Group Discussions Regarding Chbab Srei

Select participants were asked to discuss in Focus Groups their understanding of Chbab Srei and how it related to them in Cambodia today. This group generally described Chbab Srei as a code of correct conduct for women and girls. They said it was important because it brought honor to one's husband, family, and society in general. They described many types of behavior such as the importance of respecting and obeying one's husband in all circumstances, even if he is in the wrong. They spoke about the importance for girls and women to maintain their virginity until marriage and then to be monogamous thereafter, regardless of their husband's sexual practices. They spoke about the woman's responsibility to manage the household and ensure that it runs smoothly, to refrain from drawing attention to themselves by loud behavior or by expressing strong opinions, to restrict their movements by remaining at home and not spending unnecessary time away from the household, and by not going out at night, not sleeping heavily in order to always be ready to serve one's husband and family, and to avoid slandering and gossiping about others.

In a group activity, participants ranked what they thought were the most important tenants of Chbab Srey.

1. Do not go out at night
2. Do not walk loudly
3. Do not speak ill of others
4. Do not speak or laugh loudly
5. Do not curse others
6. Do not sleep like a log
7. Do not play long hours at another's house
8. Help with the household chores
9. Respect older people
10. Do not curse husband
11. Wear suitable clothing
12. Do not be arrogant
13. Save your virginity

Participants were asked to consider how their views on Chbab Srey pertained to them personally in their contexts. Many younger participants did not seem overly concerned with following the codes of Chbab Srey, and had vague knowledge about the specifics of the code. Older participants answered they hoped their own children would abide by this code so as to bring honor to their own families. Many of the older female participants felt they had lost their chance to truly be Chbab Srey women because of their past, but still wanted the code to be applied to their own female children.

Participants were asked to discuss their perceptions of what they thought Cambodian society valued regarding how Cambodian people should behave and conduct themselves. Their responses ranged, with an emphasis on the importance of showing respect towards the elders of society and to one's parents, and the importance of obedience and heeding their advice. They also spoke about the importance of being a person who was adaptable to whatever situations should arise. They spoke about how society values people who are able to control their emotions and in particular not display anger or rage. They spoke about the importance of being reliable, being honest, and owning up to mistakes. They spoke about how society values women who are physically pretty but does not value women who are sex workers.

Stigma in Cambodia occurs when an individual's behavior or situation deviates from cultural norms and codes of conduct leading to negative labels, separation, losses of social status, and discrimination. For example, age can be a source stigma if a woman remains single for a longer time period than the community deems normal. Further, there is often higher degrees of societal stigma when an individual's behavior or situation deviates from cultural norms and affects multiple determinants of hierarchy in a community; for example a women's loss of virginity

before marriage (whether by choice or exploitation) may impact societal components such as individual character, family reputation, and marital status in the community.

There are concrete examples of women's losses of honor and social status as a result of behaviors or life situations that deviate from cultural norms and codes of conduct in Cambodia. For women involved in sex work (including survivors of human trafficking and sexual exploitation), divorced, or from a divorced family, and in some cases, her children, it is culturally understood that these groups are not invited to take part in the blessings of a newly wedded couple in specific ceremonies such as:

1. ពិធីហែរជំនួន *"Pi Ti Hae Chum noun"* - Fruits ceremony in the front of the line

2. ពិធីកាត់សក់ *"Pi Ti kat sok"* - Blessing by cutting hair for groom and bride

3. ពិធីបង្វិលពពិល *"Pi Ti bang vil po pil"* - Candle blessing

4. ធ្វើជាអ្នកកំដរកូនកម្លោះកូនក្រមុំ *"Nak Kam dor Koun Kam laos neung Koun Kra mum"* - To be the groom or bride's mate of honor

Gender Based Stigma and Discrimination

Gender inequality is a primary source of stigma and discrimination among women in Cambodia. Women are traditionally prescribed a lower status than men in Cambodian society. The separation of status and traditional power differences between men and women have resulted in deeply ingrained and persistent forms of stigma and discrimination among women (Gorman and Kheng 1999; USAID 2010). There are many reports that document and describe aspects of gender based stigma (i.e. gender bias and inequality) and discrimination (Amnesty International 2010; USAID 2010; ADHOC 2011). The following points serve to underscore the main issues surrounding gender-based stigma in Cambodia.

- There are multiple persistent underlying factors and attitudes contributing to domestic violence among women (Yount and Carrera 2006; Eng et al. 2010; Amnesty International 2010; ADHOC 2011),
- There are persistent forms of family discrimination toward female children and wide gaps between male and female children's' access to education (Khun 2006; USAID 2010),
- There are multiple forms of systemic stigma and discrimination in the legal system regarding marriage and divorce among women (Van Der Keur 2014),
- There is a higher poverty index among women and women headed households represent the poorest of the poor (UNIFEM 2004),
- There are wide gaps between male and female representation in the legal system and government (USAID 2010),
- There are persistent barriers for women accessing health care (USAID 2010),
- There are persistent economic barriers and wage discrimination among women in the work force (USAID 2010), and
- There are disproportionate levels of crime committed against women (domestic violence, land grabbing, trafficking) and high levels of impunity for these crimes (ADHOC 2011).

Ethnic Stigma

Racial prejudice, discrimination, and stigma are deeply rooted global problems that span countries, people groups, and continents. Cambodia is no different in this regard. There are long standing racial tensions between Cambodia and neighboring people groups. The Vietnamese and

Khmer people have a long history of violence, discrimination, and prejudice (Berman 1996). The Vietnamese people comprise the largest minority group in Cambodia. Racial stigma and discrimination is particularly strong against Vietnamese communities and many choose to live together isolated from Khmer society. Reports suggest that Vietnamese and those of mixed decent face numerous form of systemic and individual discrimination (Berman 1996).

2.3   Stigma and Survivors of Human Trafficking

Across the globe, children and young people have reported they often face stigma and discrimination due to their involvement, or perceived involvement in sexual exploitation. Studies by Simkhada (2008), Chaulagai (2009), and Richardson et al. (2009) have identified stigma as a continuing problem for returning girls in South Asia, namely in Nepal. Simkhada (2008) found that survivors, upon (re-) integration, often face severe public stigma due to perceptions of lost family honor among families and even the community itself. Family repudiation leaves them with "*no hope for a dignified life*", especially when they return home indebted, sick or without money to help their family (Simkhada 2008: 243-246). Crawford and Kaufman (2008) have described the stigma surrounding prostitution in Nepal as so strong that the presence of a survivor in the community is perceived as bringing shame not only upon her family, but also the whole community. Gjermeni et. al (2008) based in Eastern Europe have concluded that in male-dominated societies there is little understanding of trafficking, or the view that women and girls are 'victims' rather than 'prostitutes'. In contrast to these views, Rende-Taylor (2005) and Montgomery (2007) in discussing girls' experiences of involvement in commercial 'sex work' have noted that in some rural areas in Northern Thailand there is little social stigma for women returning to live in the community.

Stigma and discrimination among sex workers has been qualitatively researched over many years and in many countries (Rebhen 2004; Fick 2005; Tomura 2009; Kokun 2012), including Cambodia (Freed 2004; Jenkins 2006; Sandy 2006; 2009). However, there have been few quantitative studies examining forms of stigma among sex workers in South East Asia. There are no studies that directly quantify stigma among survivors of human trafficking and sexual exploitation.

Yan et al. (2010) and Hong et al. (2009) used scalar survey methods to evaluate self-perceived stigma and mental health indicators among female sex workers in China. These studies found significant positive correlations between heightened levels of self-perceived stigma and poor mental health among female sex workers. Another recent study in the greater Mekong Sub-region used qualitative survey methods to assess aspects of self-stigma among repatriating survivors. Zimmerman et al. (2014) surveyed male and female survivors of human trafficking following repatriation from five countries including Cambodia (survivors had received post-trafficking services for less than ten days). Participants were asked a series of questions regarding common concerns about the future and if they were worried about how their families would receive them when they arrived home. The results showed 43.1% of all participants (men, women, and children) had feelings of guilt and shame and more specifically, 75% of female survivors who reported sexual violence while in a trafficking situation indicated they were worried about how they would be treated by people upon arrival at home.

Bolton et. al (2008) conducted surveys with select survivors in Cambodia in order to better understand how survivors view their problems. The authors developed several categories of concerns raised by survivors based on free list survey responses. These included: mental health issues [e.g. anxiety, depression, and PTSD (Post Traumatic Stress Disorder)], severe stigma (i.e.

being hated by society and rejected by their friends and families), loss of education (due to time spent in sex work and not in school; older aged survivors that have tried to go back to school are also met with stigma), and loss of future (losses of social status such as traditional marriageability status and loss of relationships that irreversibly alter expectations for the future). It was evident from the categories of responses provided in the study that stigma and components of sigma (i.e. loss of social status) were important concerns among survivors.

Survivors, Stigma, and (Re-) Integration

Stigma is addressed in many reports and studies involving (re-) integration of survivors of human trafficking (Derks, 1998; Arensen et. al, 2004; Reimer et al. 2007; Brunovskis and Surtees 2012; Surtees 2013). In most cases these reports reference stigma, highlighting it as a concern for survivors during (re-) integration. Many reports also suggest that program managers account for stigma or look for ways to potentially reduce stigma for survivors during (re-) integration into family settings. Brunovskis and Surtees 2012 describe stigmatizing events in which survivors are publically discredited (their story or history is revealed) and self-stigmatizing situations where survivors are fearful that their story will be known and therefore distance themselves from the community. The authors go on to discuss stress as a physical side effect of contending with stigma and identify certain coping mechanisms for stigma, suggesting disclosure of the past contributes to well-being in survivors, provided social support networks are in place. The authors also suggest some survivors may decline assistance from organizations because they distrust the assistance that is proposed to them, fearing stigma and exclusion once they are identified as trafficking victims (Brunovskis and Surtees 2012). To date there are few studies that provide more details regarding stigma and no longitudinal studies that have examined stigma and its components in the lives of survivors following (re-) integration.

A study conducted in Nepal by Crawford and Kaufman (2008) has shown that it is possible to facilitate stigma-reducing change within the socio-cultural environment and thereby support (re-) integration of survivors. The authors suggest that three quarters of the survivors in their sample experienced a successful family reintegration, due in part to stigma-reducing efforts by a local NGO operated entirely by Nepalese women who had extensive experience, local knowledge, and cultural insight. Survivors were also notably equipped with skills to generate an income, which gave them the ability to provide for themselves and their family, a source of status and honor in the culture (Crawford and Kaufman 2008). The authors conclude that by strengthening skill sets and reducing stigma, survivors were well positioned to regain community acceptance and support.

Derks (1998) has suggested that in Cambodia shame is related to departures from norms of social behavioral in situations where young women migrate from their village, work in the sex industry (either by choice or through exploitation), and provide little or no financial support to their family (negative family contribution). If the young woman returns with illness her family sees her as having brought shame upon it. Because of survivors' awareness of the perceptions regarding prostitution, even when it has been forced, they feel shame and therefore, do not discuss their experience much with their family after their return. And even when families have suspicions, they usually do not ask questions. This is seen as facilitating a return to normalcy and preserving the perceived honor of the family, but leaves survivors isolated and without support.

In Cambodia, service providers have spoken of warmer receptions for girls that come home with money, goods or skills to allow them to earn a living, lessening the stigma and rejection (Derks, 1998; Arensen et. al, 2004; and Reimer et. al, 2007). Surtees (2007) has also suggested that

assistance organizations could consider helping survivors purchase small gifts for their family members when returning home, which may help ease some of the negative associations of returning home empty-handed.

3.0   Methods

The BLR Project is the first longitudinal study to follow children and adult survivors of sexual exploitation and trafficking. The design and approach of the project is unique in that participants in the study are survivors themselves, describing their perceptions and experiences of (re-) integration in real time. The longitudinal component of the study addresses a significant limitation identified in cross sectional studies involving survivor (re-) integration (Derks et al. 2006; Reimer et al. 2007; Surtees 2013). The project began formulating a cohort group in Cambodia from 2010 and 2011, with a goal to follow individual cohorts for a span of ten consecutive years.

Overview of BLR Project Methodology

The BLR Project has used a mixed method approach over the past five years (see Miles and Miles 2010; Miles and Miles 2011; Miles et al. 2012; Miles et al. 2013, Miles et al. 2014). The research team has used survey tools, which combined asking both closed and open-ended questions. The team has also utilized a number of qualitative data collecting activities such as focus group discussions, in-depth interviews, informal interviews, play, art projects and participant observation. To continue collecting information on participants that migrate (e.g. Thailand) or move to inaccessible locations in Cambodia, the team has conducted phone interviews. The mixed method approach has allowed the BLR Project research team to establish a broad overview of participants' lives.

In 2014, at the midway point in the longitudinal study, the team conducted a baseline case study analysis on each participant. Four-plus years of quantitative and qualitative data were compiled and summarized to document what is known, contradictory, and missing from each participant's story. The case study analyses resulted in detailed narrative summary data for each participant in the BLR Project. Subsequent to these narratives, qualitative surveys have been conducted, adding to the longitudinal data for most participants.

The thematic assessment draws from a subset of participants within the larger pool of data collected in the BLR Project. Further details regarding BLR Project study methods, changes in methods from year to year, ethically standards followed, specific data collection tools and techniques, and strengths and weakness of the methodologies chosen are outlined in Appendix A (see also Miles and Miles 2010; Miles and Miles 2011; Miles et al. 2012; Miles et al. 2013, Miles et al. 2014).

Thematic Assessment Scope

The thematic assessment included 60 female participants divided into two groups (see Table 1). The thematic assessment focused on female cohort responses to stigma in the community. Only cohorts that had been (re-) integrated were chosen for the assessment. Female cohorts were included if the case study showed at least four visits for a cohort spanning at least two calendar years. Participants were grouped based on whether or not they lived in a shelter program (for more information on shelter programs see Discourse Regarding Definitions) for at least 4-months prior to re-entry in the community. The groups included:

1. Female SP/RC - females that stayed in shelter programs (SP) and have (re-) integrated in the community (RC) and
2. Female RC - females that did not stay in shelter programs (< 4-months) and have (re-) integrated in the community (RC)

Relevant longitudinal data were compiled in the assessment as they related to several basic themes involving self-stigma and public stigma (see Figure 1). These included participants' responses, attitudes, perceptions and experiences relating to 'stigma', 'stigmatizing groups', 'discrimination practices', and 'survivor responses and coping strategies to stigma'. Narrative responses from individual participants were combined into the year the interview was conducted. In this way, individual assessment years were constructed for participants over four calendar years in which data were collected (2011-2014). These yearly data sets were then used in the thematic assessment.

Table 1: Statistics for Cohort Groups Included in the Assessment, 2011-2014

Assessment Groups	Starting Ages		Total Number of Individuals	Total Number of Years Assessed	Count of Individuals by the Number of Years Included in Longitudinal Assessment						
	Range	Average			Shelter			Community			
					1	2	3	1	2	3	4
Female RC	16-36	24.7	27	100				0	0	8	19
Female SP/RC	13-21	16.9	33	50/75	18	13	2	4	16	13	0

Notes: RC - (Re-) integrated into Community

  SP/RC - Shelter Program then (Re-) integrated into Community

Longitudinal data generally spanned three to four consecutive years for each group. Individual assessment years for Female RC participants were exclusively in the community, while data for Female SP/RC participants were spilt with the majority of survivors spending one to two years in a shelter program and two to three years in the community (Table 1). The total number of years assessed included 100 individual years for Female RC participants and 75 individual years for Female SP/RC participants in the community.

A team of researchers conducted the thematic analysis. Qualitative data were coded using inductive methods combined with theory and research regarding stigma and culturally relevant understandings of stigma components in Cambodian society. Team members included expatriate and Khmer staff and advisors, both men and women. The team worked collaboratively throughout the data assessment process to identify and describe stigma in the Cambodian society. Narrative summaries compiled by year were reviewed along with recent qualitative surveys conducted in 2014. Team members reviewed data separately and then collectively to identify specific situations, key words, and phrases involving stigma and its components. In this way, the team worked by consensus to document and describe culturally important aspects of stigma and stigmatizing interactions between survivors and their community.

Figure 1: List of Research Survey Questions Used in the Assessment

Q10. In past four months, do you feel a person/some people (anyone) have discriminated against you?

Q10a. Who discriminated against you?

Q11a. Who has treated you respectfully in the past four months?

Q11b. Why do you to feel some people have been respectful towards you?

Q12. Over the last four months, have you had someone in your life that you feel you can trust?

Q12a. Who do you feel you can trust the most?

Q13a. Who(m) has/have been you physically violent towards you?

Q13b. Please describe more about this situation when you experienced physical violence towards you

Q14a. Who (whom-can be more than one person) was emotional violent to you?

Q14b. Please describe more about this situation when you experienced physical violence towards you.

Q39. How do you feel relations between yourself and people in your community *(outside of the shelter)* have changed in the past year overall?

Q40. Do you feel generally accepted by the community *(outside of the shelter)* where your household is located at this present time?

Q41. Do you agree with the following statement? In the past year, 'I feel I am (re-) integrating well into my community where my residence *(outside of the shelter)* is located.'

Q42. In past year, have you experienced discrimination?

Q43a. From whom have you experienced discrimination in past year?

Q43b. If yes, what do you think is the reason this person discriminated against you?

Q44. From whom did you access help to deal with discrimination in this past year?

Q45. How did the experience of being discriminated against make you feel?

Q62. How have you felt emotionally during the past four months compared to the same time period last year?

Q63. Have you felt generally happier or sadder during this past year?

Q64. Have you generally felt more contented or more worried during this past year?

Q65. Have you had 'other' feelings (other than happy, sad, contented and worried) during this past year?

Q80a. Do you feel you have been pressured to have sex when you did not want to in this past year?

Q81c. Do you feel you have been sexually exploited in the past year?

Figure 1: List of Research Survey Questions Used in the Assessment

4.0   Results

Cohort Group Characteristics

The thematic assessment included 60 female participants divided into two groups, 27 individuals in the Female RC group and 33 individuals in the Female SP/RC group (see Table 1). Participants' average age at the beginning of the longitudinal assessment (in 2011) differed by almost eight years between groups. The average age in the Female SP/RC group was 16.9 years old, while the average age in the Female RC group was 24.7 years old. Generally, the groups included participants that started in the assessment as teenagers transitioning to young adults (Female SP/RC) and young adults to adults (Female RC). The Female RC group had the widest age range of 20 years, although most participants within this group were between the ages of 18-24 years old (44.4%) and 24-35 years old (48.1%) at the beginning of the assessment. In contrast, the majority (57.6%) of Female SP/RC participants were children at the beginning of the assessment. Participants starting ages in the Female SP/RC group included 24.2% between 10-14 years old, 33.3% between 15-17 years old and 42.4% between 18-24 years old.

Most participants described their ethnicity as Khmer (44 out of 60 total individuals), although there were a variety of responses (see Table 2). Separately, ethnic Khmer comprised 63.6% of the participants in Female SP/RC and 85.2% of participants in Female RC. Participants also indicated other ethnic backgrounds such as Vietnamese (4), Khmer/Vietnamese (7), and Khmer/Thai (2). Three participants with ethnic Khmer/Chinese backgrounds were aggregated with Khmer at several stages in the assessment due to the history of Khmer and Chinese intermarriage and assimilation into Khmer culture (Willmott 2011).

Table 2: Ethnicity and Marital Status Counts and Frequency for Survivors Among Female SP/RC (n=33)

Marital Status in 2014*	Female SP/RC				Female RC		
	Khmer**	Vietnamese	Khmer/ Vietnamese	Khmer /Thai	Khmer**	Khmer/ Vietnamese	Khmer/ Thai
No Previous Marriage/Partner							
Single	9 (27)	3 (9)	4 (12)	1 (3)	3 (11)	1 (4)	
New Partner/Married***	7 (21)	1 (3)	1 (3)		1 (4)		
Partner / Married > 1-Year	5 (15)				10 (37)		1 (4)
Divorce / Separated							
Single					4 (15)		
New Partner/Married***	2 (6)						
Partner / Married > 1-Year					6 (22)	1 (4)	

Notes: RC - (Re-) integrated into Community
    SP/RC - Shelter Program then (Re-) integrated into Community
    * - Marital status in 2013 is used for survivors with no data in 2014
    ** - Khmer includes Khmer / Chinese; 2 participants in Female SP/RC and one individual in Female RC
    *** - New Partner/Married for less than 1-Year
    Blank - No observations
    Total counts (*Percent of Sample Group*)

Participants' marital status often shifted throughout the assessment time period as participants married, found partners, or divorced and then married again. All participants in Female SP/RC entered (re-) integration single and none had previous marriages' or long-term partners. By 2014, 16 participants were married or with partners and 17 were still single (see Table 2). The vast majority of these relationships were newly formed and in 2014 only five of the 16 individuals had been in relationship with their spouse or partner for a year or longer.

In contrast, eleven individuals in the Female RC group were already married or with partners at the beginning of the assessment in 2011. By 2014, the number of individuals married or with partners climbed to 19 participants. Further, 18 of these 19 respondents in the Female RC group had been married or with partners for longer than one year in 2014 (see Table 2). The Female RC group also had substantially more divorced or separated respondents (nine individuals in 2011 and eleven individuals in 2014) than the Female SP/RC group. In 2014, respondents that had at least one divorce or separation comprised nearly 41% of the Female RC group. Of all the new marriages and survivors with long term marriages in both groups (i.e. Female RC and Female SP/RC), only one respondent and their spouse legally registered the marriage[2].

Survivor education levels showed similar ranges in both assessment groups (see Table 3). All respondents in the Female RC group dropped out of school. Among Female SP/RC respondents, 23 of the 33 individuals attended school in Shelter Programs. Within this subgroup, 61% (14 of 23 individuals) dropped out of school after (re-) integrating into the community. As of 2014, nine respondents were still in school and no participant had successfully graduated from secondary school (i.e. completed grade 12 and passed the graduate exam).

Table 3: Count and Frequency of the Highest Education Level Studied by Survivors Among Female SP/PC (n=33) and Female (n=27), 2011-2014

	Still in School? (Y/N)	Primary School		Secondary School*	
		< Grade 4	Grades 4-6	Grades 7-9	Grades 10-12
Female RC	N	7 (*26*)	3 (*11*)	14 (*52*)	3 (*11*)
Female SP/RC	N	8 (*24*)	5 (*15*)	10 (*30*)	1 (*3*)
	Y		4 (*12*)	4 (*12*)	1 (*3*)

Notes: RC - (Re-) integrated into Community
 SP/RC - Shelter Program then (Re-) integrated into Community
 Blank - No Observations
 * - As of 2014, no survivor has graduated from Secondary School.
 Highest education level studied but not necessarily completed
 Total counts (*Percent of Sample Group*)

Stigma and Negative Labels

Survivors discussed having to contend with a diversity of stigma throughout the longitudinal assessment. These stigmatizing situations were evaluated by the research team and compiled into categories that best described the situations survivors reported in the community (see Table 4). Examples of negative labels were developed based on these conversations with survivors and the research team's knowledge and understanding of culturally relevant slang, curses, insults, and negative labels. Survivors often talked about a stigmatizing situation or experience within their home or community along with some of the negative labels associated with the various stigma categories. Survivors also discussed negative labels that overlapped and connected various stigma categories.

⇒ *Friends at school made me feel unhappy because they mocked me and say bad words about me. I felt they were discriminating against me because they know that I used to live in a shelter. They say that shelter children were sexually exploited and raped until they got pregnant without a husband.*

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[2] Participants described celebrating a traditional Buddhist marriage ceremony. This ceremony is considered by society/friends/family to represent the act of marriage and couples are then considered husband and wife (Van Der Keur 2014).

⇒ *Some rich kids in school treat me badly because I am poor. They think they are better than poor children. I told the teacher but she is powerless against the rich. Rich children have rich parents who don't have to follow any rules.*

⇒ *I am illiterate. My brother told me to study but how can I do this? My brother laughs at me. Everyone will curse and blame me because I am an adult and cannot read or write. Now I have given up trying to learn to read and write.*

⇒ *I am a girl that worked at night but the neighbors and wider community said my job was bad. They said 'the girls who work at night are not good'. Before I worked at the Karaoke place, I had a good relationship with my neighbors but when they found out I was working at Karaoke they stopped being friends with me and stopped treating me respectfully.*

Table 4*: Categories of Stigma and Commonly Used Negative Labels*

Stigma	Examples of Commonly Used Negative Labels
Current or Past Work in the Sex Industry	- ស្រីខារ៉ាអូខេ "Srey Karaoke" - **Karaoke girl/KTV girl** - ស្រីខូច "SreyKouch"/ស្រីរកស៊ី "srey roksi"/ស្រីសំជើង "sreysampeung"(strong insult) - **Broken girl** - ដើរលេងផ្តេសផ្តាស "Deur leng yub pdes pdas"/ដើរហាច់ "Deur Hach" (insult)- **You go out and walk at night** - ធ្វើការងារអាក្រក់ "Tver ka ngear a krok" - **You do the bad work**
Associated with Shelter (Aftercare) Programs	- ក្មេងអង្គការ "Kmeng Angka"-**NGO girl** - ស្រីខូច "SreyKouch"/ស្រីរកស៊ី "srey roksi"-**Broken girl** - អ្នកក្រ "Nak Kro"-**Poor person**
Pregnant Without a Husband Child Without a Husband	- ដើរលេងយប់ផ្តេសផ្តាស "Deur leng yub pdes pdas" -**You go out and walk at night** - កូនអត់ខាន់ស្លា "Kon ort Khan sla"/កូនអត់ឪ "kon ort ov" -**Illegitimate child** - ដើមព្រៃ "Pheum Prey"/ដើមអត់ប្ដី "Pheum ort bdey"/ពោះធំអត់ប្ដី " Pos thom ort bdey" -**Pregnant without husband/ don't who child's father is**
Partnership and Second Wife	- ប្រពន្ធអត់ខាន់ស្លា "Propun ort khansla"/ប្រពន្ធអត់ស្របច្បាប់ " Propun ort srob Chbab" -**Illegal wife** - ប្រពន្ធចុង "Propun Jong" -**Second wife** - ស្រីកំណាន់ "Srey Kamnan"/ស្រីល្ងចលាក់ "Srey louch lak" -**Mistress** - សង្សារ " Sangsa"/ស្រីរបស់គេ "Srey bos ke" - **Girlfriend** - ប្ដីច្រើន "bdey chreun"/ប្រុសច្រើន "bros chreun" - **Multi partners**

Divorce	- បាក់ម្តែកបាក់ធាង "Bak mek bak theang"/ប៉ែកបាក់ "bek bak" - **Breaks relationship** - ស្រីមេម៉ាយ "Srey mae may"/ស្រីលែងប្ដី "srey leng bdey" - **Divorced woman**
Marriageability	- ស្រីអត់គ្រប់លក្ខ "Srey ort krub leak"/ស្រីអភ័ព្ "srey ak phoub" /បាក់ម្តែកបាក់ធាង "Bak meik bak theang"- **Unfit woman** - ស្រីអាក្រក់ "Srey a krok" /ស្រីអត់ល្អ "srey ort la or"/ស្រីថោក "Srey thouk" (strong insult) - **Messy woman** - ស្រីក្រីក្រ "Srey krey kro" / ស្រីរហោមរហាម "srey ro hem ro harm" /ស្រីថោកទាប "Srey thouk teap" (putting them into a very low status) - **Poor girl**
Gender Inequality in Marriage	- គ្រាន់តែជាប្រពន្ធទេ "Kran te jea propun te" - **You are just a wife** - ប្រពន្ធប្ដីវាយ "Propun bdey vai"/សាច់កម្ម "sach kam" - **The wife who is beaten**
Socioeconomic status	- ចាស់ហើយ "Jas heuy"/អាយុច្រើន "Ayu chreun" -**Too old for school** - ពួកអ្នកក្រ "Pouk nak kro"/ពួករហោមរហាម "pouk ro hem ro harm" -**Poor person** - រហោមរហាម "ro hem ro harm" /គោកយ៉ាក "Touk yak" -**The have-nots**
Ethnicity	- ស្រីយួន "Srey Youn"/ស្រីខ្វូច "srey Koch" - **Vietnam girl**
Mental Health	- មនុស្សល្ងង់ "Monus la ngung"/ភ្លើភ្លើ "Pli Pleu"/ស្ទុក "Stuk" – **Stupid person** - មនុស្សឆ្កួត "Monus chhkout" -**Crazy person**
Physical Health e.g. HIV	- ស្រីខ្វូច "Srey Koch"/ស្រីកើតអេដស៍ "Srey keut aid"/ស្រីរកស៊ី "Srey roksi" - **Broken woman**

Stigma in Cohort Groups

The majority of respondents (65%) contended with stigma at least once during the four-year assessment (see Table 5). Overall, participants talked more frequently about stigma related to gender inequality in marriage (25% of all respondents), current or past work in the sex industry (23.3% of all respondents), and lower socioeconomic levels (23.3% of all respondents). These categories also included the highest number of participants that reported multiple years of stigma. Given the ethnic groups represented in the data, one category that was conspicuously missing in the assessment was ethnic stigma.

There were substantial differences in the prevalence of stigma between assessment groups. The percent of individuals reporting stigma was considerably higher among the Female RC group, 81.5%, compared to 51.5% in the Female SP/RC group (see Table 5). In addition, there were over twice as many respondents that reported the same stigma(s) over multiple years in the Female RC group when compared with the Female SP/RC group. Total counts for stigma were also higher among Female RC respondents with 75 incidences of stigma described as compared to 40 incidences in the Female SP/RC group. Normalizing total counts by the number of (re-) integration years assessed for each group (100 for Female RC and 75 for Female SP/RC; see

Table 1) also showed higher incidence of stigma among Female RC; 0.75 incidence per year for Female RC compared to 0.53 incidences a year in Female SP/RC). In the Female SP/RC group, six respondents (18.2% of the group) reported stigma associated with shelter programs, while only one individual talked about this stigma among the Female RC group.

Table 5: Prevalence of Stigma Categories Discussed by Survivors Among Female SP/RC (n=33) and Female RC (n=27), 2011-2014

Survivors talk about stigma related to:	Female SP/RC				Female RC			
	n*	%	Total Count	Individuals w/ Multiple Years	n*	%	Total Count	Individuals w/ Multiple Years
Gender inequality in marriage	4	12.1	7	2	11	40.7	19	6
Current or past work in the sex industry	4	12.1	8	2	10	37.0	19	5
Lower socioeconomic levels	6	18.2	8	1	8	29.6	15	5
Pregnant without a husband Child without a husband	3	9.1	4	1	6	22.2	7	1
Marriage "Fitness"	3	9.1	3		3	11.1	3	
Divorce	0	0	0		2	7.4	4	1
Mental health	1	3.0	2	1	1	3.7	2	1
Physical health	0	0	0		1	3.7	1	
Religious beliefs	1	3.0	1		1	3.7	3	1
Associated with Shelter (Aftercare) Programs	6	18.2	6		1	3.7	1	
Partnership and second wife	1	3.0	1		1	3.7	1	
Total**	17	51.5	40	5	22	81.5	75	11

Notes: RC - (Re-) integrated into Community

SP/RC - Shelter Program then (Re-) integrated into Community

Blank - No Observations

* - Number of Individuals

** - Individuals talk about multiple stigma; therefore, counts are not additive.

The relative frequency cohort groups discussed stigma was assessed by (re-) integration year. Data were aggregated by groups and years spent in shelter programs (combined), then yearly after (re-) integration (see Table 6). Respondents living in shelter programs rarely discussed stigma, with just two instances observed for all Female SP/RC respondents overall years spent in shelter programs. Both groups showed comparable frequencies of stigma in Year 1, 27.3% and 22.2% in Female SP/RC and Female RC, respectively. In contrast, stigma rates were almost twice as high among Female RC than Female SP/RC in Years 2 and 3. Year 1 following (re-) integration had the lowest relative frequency of stigma in both groups. While the relative frequency of stigma showed the greatest increase from Year 1 to Year 2 among both groups, climbing in Female SP/RC from 27.3% in Year 1 to 34.5% in Year 2 and in Female RC from 22.2% to 66.7% in Years 1 and 2, respectively. Relative frequencies of stigma remained comparatively steady in Years 2 and 3 for Female SP/RC and Years 2 through 4 for Female RC.

Table 6: **Frequency Survivors Discuss Stigma Among Female SP/RC and Female RC by (Re-) integration year**

Year	Female SP/RC				Female RC			
	No Stigma		Stigma		No Stigma		Stigma	
	n*	%	n*	%	n*	%	n*	%
SP **	48	96.0	2	4.0	--		--	--
RC Year 1	24	72.7	9	27.3	21	77.8	6	22.2
RC Year 2	19	65.5	10	34.5	9	33.3	18	66.7
RC Year 3	8	61.5	5	38.5	11	40.7	16	59.3
RC Year 4					7	36.8	12	63.2

Notes: RC - (Re-) integrated into Community
   SP/RC - Shelter Program then (Re-) integrated into Community
   * - Total Number of individual observations (Individual Assessment Years)
   ** - Shelter Programs (SP); Stigma frequency assessed for all years survivors stayed in SP
   "--" - No long-term stay in SP
   Blank - No observations

The assessment also considered ethnicity and stigma for survivors (re-) integrated and living in community (see Table 7). While there were far fewer observations for Vietnamese, Khmer /Vietnamese, and Khmer/Thai, the relative frequency of stigma among these groups was substantially less than the Khmer. When evaluated collectively, these groups accounted for 24.5% of the "No stigma" observations (24 of 98 total "no stigma" observations) but just 5.2% of the "Stigma" observations (four of 77 total "Stigma" observations) in the data set. The majority of respondent, nine of the thirteen that comprised these ethnic groups (i.e. Vietnamese, Khmer/Vietnamese, and Khmer/Thai), had a marital status of single. Further, ten out of thirteen respondents in these ethnic groups were part of the Female SP/RC group (see Table 2).

Table 7: **Frequency Survivors Discuss Stigma by Ethnicity While Living in the Community All Years Combined**

Ethnicity	Female SP/RC and Female RC			
	No Stigma		Stigma	
	n*	%	n*	%
Khmer**	74	50.3	73	49.7
Vietnamese	7	100		
Khmer / Vietnamese	12	75.0	4	25.0
Khmer / Thai	5	100		

Notes: RC - (Re-) integrated into Community
   SP/RC - Shelter Program then (Re-) integrated into Community
   * - Total Number of individual observations in community (Individual Assessment Years)
   ** - Khmer includes Khmer / Chinese
   Blank - No observations

Building on the previous results, marital status and stigma was assessed among (re-) integrated Khmer survivors in the two cohort groups (see Table 8). The results showed that relative frequency of stigma among "Single, No Previous Marriage/Partner" grouping was similar between Khmer SP/RC and RC cohorts (38.2% for Female SP/RC and 36.8% for Female RC). The relative frequency of stigma among "New Marriage/Partners, No Previous Marriage/ Partner" grouping in Female SP/RC was the lowest of all categories at 28.6%. In contrast, Female RC with "Divorce/Separated" marital status reported higher frequencies of stigma when

compared to the counterpart group (among "No Previous Marriage/Partner", categories with more than ten observations). Finally, Female RC Partner/Married > 1-Year reported the highest relative frequency of stigma (among categories with more than ten observations). This trend was similar in Female SP/RC that were married or in partnerships for longer than 1-year, although there were few observations (n=6).

Table 8: Frequency Survivors Discuss Stigma Among (Re-) integrated Khmer Survivors by Marital Status and Cohort Group, 2011-2014

	Female SP/RC				Female RC			
	No Stigma		Stigma		No Stigma		Stigma	
Marital Status	**n***	**%**	**n***	**%**	**n***	**%**	**n***	**%**
No Previous Marriage/Partner								
Single	21	*61.8*	13	*38.2*	12	*63.2*	7	*36.8*
New Partner/Married**	10	*71.4*	4	*28.6*	1	*20.0*	4	*80.0*
Partner / Married > 1-Year	2	*33.3*	4	*66.7*	13	*44.8*	16	*55.2*
Divorce / Separated								
Single	1	*50.0*	1	*50.0*	6	*42.9*	8	*57.1*
New Partner/Married**	1	*50.0*	1	*50.0*	2	*40.0*	3	*60.0*
Partner / Married > 1-Year					5	*31.3*	11	*68.8*

Notes: RC - (Re-) integrated into Community
SP/RC - Shelter Program then (Re-) integrated into Community
* - Total Number of individual observations in community (Individual Assessment Years) for all Khmer survivors
** - New Partner/Married for less than 1-Year
Blank - No observations

Stigmatizing Groups

Most respondents that described stigmatizing experiences also identified the person or group of people involved, with 61.7% of all respondents identifying one or more stigmatizing groups over the four years included in the assessment (see Table 9). Overall:

- 35% of survivors contended with social stigma from neighbors in their community (n=60),
- 51.4% of survivors that were married/with partners contended with social stigma from their husband/partner and/or parents-in-law (n=35; see Table 2), and
- 22% of survivors that attended school described contending with social stigma from their classmates (n=23; see discussions for the Female SP/RC group on p.7).

Table 9: Prevalence of Stigmatizing Groups Discussed by Survivors Among Female SP/RC (n=33) and Female RC (n=27), 2011-2014

Survivors talk about discrimination from:	Female SP/RC				Female RC			
	n*	%	Total Count	Individuals w/ Multiple Years	n*	%	Total Count	Individuals w/ Multiple Years
Neighbors / Community	8	24.2	10	1	13	48.1	20	5
Partner/Husband	3	9.1	5	2	11	40.7	20	7
Partner/Spouse's Parents	3	9.1	4	1	10	37.0	18	4
Family	2	6.1	6	1	5	18.5	9	2
Co-workers and/or Clients	1	3.0	1		5	18.5	9	3
Workplace Supervisor	2	6.1	2		2	7.4	2	
Community Leader	1	3.0	1		1	3.7	1	
Classmates	5	15.2	5		0	0	0	
Total**	16	48.5	34	4	21	77.8	79	12

Notes: RC - (Re-) integrated into Community
SP/RC - Shelter Program then (Re-) integrated into Community
Blank - No Observations
* -Number of Individuals
** - Individuals talk about multiple stigmatizing groups; therefore, counts are not additive.

Similar to the results for stigma categories in Table 5, there were substantial differences in the prevalence of stigmatizing groups between Female SP/RC and Female RC. The total counts and percent of individuals reporting stigmatizing groups were higher among Female RC than Female SP/RC. The percent of individuals reporting stigmatizing groups was 77.8% for Female RC compared to 48.5% in the Female SP/RC (see Table 9).

Partners/husbands and their parents played a substantial role in the long-term stigma among survivors. Multiple year stigma and discrimination from partners/husbands and their parent's accounted for three of four individuals in Female SP/RC and ten of twelve individuals in Female RC (see Table 9).

Survivor's described stigmatizing groups in the following ways:

⇒ *Some people think I am a bad girl. Some people mistreat me... I heard them say (neighbors who live next door) that all of the children in the NGO are bad. They stereotyped us without understanding the feelings of the children living in the center.*

⇒ *My mother in law and I, we always fight with each other. I remember one time she cursed me and called me a prostitute girl and later she called my daughter the same name. When I heard what she said, it was so painful. ..... I cried, there was (so much) pain in my heart and I almost could not walk. I wanted to kill myself by hitting my head against the wall.*

⇒ *If you were a wife and I was a husband, and if I spent money only for myself when I got my salary and looked down my wife as rubbish. How would you feel? Then he said, "I do not know about that feeling because I am a man. You are the wife and it happened to you only. I do not know about that hurt feeling, so do not talk about this with me anymore."*

Discrimination Practices

Survivors discussed many forms of public discrimination during the four-year assessment (see Table 10). The three discrimination practices respondents in both groups discussed most included, verbal abuse and cursing identified by 31.7% of individuals (19 individuals; n=60), social isolation from the community and/or family identified by 30% of individuals (18 individuals from two categories combined; n=60), and domestic violence identified by 25.7% of respondents in marriage/partner relationships (nine individuals out of 35 individuals married/with partners; see Table 2).

Percent of individuals reporting discrimination were consistent with the percent of individuals that identified stigmatizing groups as most respondents discussed these components of stigma together. Again, there were substantial differences in the prevalence of discrimination between Female SP/RC and Female RC. Percent of respondents reporting discrimination was 48.5% for Female SP/RC and 77.8% for Female RC (see Table 10). Both groups had individuals that talked about contending with discrimination over multiple years. Respondents reported multiple years of verbal abuse and domestic violence linked with husbands and parents in-law (see Table 9), three of the four respondents in Female SP/RC and nine of the 12 respondents in Female RC.

Table 10: Prevalence of Discrimination Practices Experienced by Survivors Among Female SP/RC (n=33) and Female RC (n=27), 2011-2014

Survivors talk about discrimination practices:	Female SP/RC				Female RC			
	n*	%	Total Count	Individuals w/ Multiple Years	n*	%	Total Count	Individuals w/ Multiple Years
Verbal abuse	7	21.2	13	4	12	44.4	27	9
Social isolation in the community	4	12.1	4		9	33.3	15	5
Domestic violence	4	12.1	9	4	5	18.5	10	3
Social isolation in the family	0	0	0		5	18.5	6	1
Sexual harassment	2	6.1	2		4	14.8	6	2
Gossip	6	18.2	6		4	14.8	7	2
Extortion / Corruption	1	3.0	1		4	14.8	4	
Sexual violence	1	3.0	2	1	3	11.1	3	
Abandonment	0	0	0		3	11.1	4	1
Collusion	0	0	0		2	7.4	2	
Workplace / Community violence	1	3.0	1		2	7.4	4	1
Sexual exploitation	3	9.1	4	1	1	3.7	2	1
Threatening physical harm	1	3.0	1		0	0	0	
Total**	16	48.5	43	4	21	77.8	90	12

Notes: RC - (Re-) integrated into Community
      SP/RC - Shelter Program then (Re-) integrated into Community
      Blank - No Observations
      * -Number of Individuals
      ** - Individuals talk about multiple discrimination practices; therefore, counts are not additive.

Respondents often attributed discriminatory practices to specific stigmatizing groups. In this way, survivors regularly described contending with:

- Social isolation and gossip from neighbors, co-workers, classmates, and their family,
- Verbal abuse and domestic violence from partners/husbands and parents in-law,
- Sexual harassment, exploitation, and violence while working in jobs in the sex industry (but not always working as a sex worker) and in some cases in their marriages, and

- Collusion, abandonment, extortion/corruption from a husband/partner and/or his family, particularly when the partner's family rejected her as a spouse.

Three examples of discriminatory practices discussed by survivors:

⇒ *They begin to stop talking with me when they know my story. They start to evaluate and think that I am not a good person. They consider me a simple person who is not in their group/level. Yes, they do not give me value. They also look down because they knew my story… I realize when they heard my story, they started not to have close relationship with me anymore… After they knew my story, they started to tell new people who come to work here. They told all my stories to them.*

⇒ *I was trying to work hard, to save the money, and sell the hair salon products to customers just before I gave birth to my child. He (my husband/partner) was cruel; he took all of my money that I saved for the birth and delivery and gave it to his mother to buy a motorbike for his brother. This happened just two days before I gave birth. On the night of the birth and delivery, I had only 10 thousand riels (about $2.50 USD)… I begged the doctors to please wait for tomorrow morning and I would pay them for the delivery fees… It was a really difficult birth because my child's head was big but my hips were small… If I could not give birth naturally, I would die because I did not have the money to pay for an operation.*

⇒ *It was difficult when my family in-law mistreated me like this. When I made a mistake during the daytime, he (my husband) just blamed me in front of everyone but when night-time came, he beat me and mistreated me a lot. He beat me until my eyes become black and blue; he broke my tooth and gave me bruises. There were bruises on my leg and all over my body because of his violence. It felt very painful but I thought I must bear/endure it because I am staying here (with her parents in-law) in this city alone; my parents don't live here. I do not have my own house.*

Multiple Forms of Stigma and Discrimination Over Multiple Years

Survivors reported multiple forms of stigma and discrimination in some cases multiple forms over multiple years during the assessment (see Table 11). Overall, 40% of survivors talked about contending with multiple forms of discrimination (24 individuals; n=60). Of these respondents, 14 individuals described multiple forms of discrimination over multiple years (23.3%; n=60). Survivors also talked about self-stigmatizing thoughts along with multiple forms of public stigma and discrimination (21.7%; n=60).

Table 11: Survivors that Identified Multiple Stigmas and Multiple Years Among Female SP/RC (n=33) and Female RC (n=27), 2011-2014

Assessment Groupings	Female SP/RC				Female RC			
	Multiple Categories		Multiple Categories Multiple Years		Multiple Categories		Multiple Categories Multiple Years	
	n*	%	n*	%	n*	%	n*	%
Stigma Categories	9	27.3	2	6.1	14	51.9	5	18.5
Stigmatizing Groups	7	21.2	1	3.0	15	55.6	6	22.2
Discrimination Practices	9	27.3	5	15.2	15	55.6	9	33.3
Self-Stigma and Public Stigma**	2	6.1	2	6.1	5	18.5	4	14.8

Notes: RC - (Re-) integrated into Community
P/RC - Shelter Program then (Re-) integrated into Community
Blank - No Observations
* - Number of Individuals
** - Survivors discuss self-stigmatizing thoughts along with multiple forms of public stigma and discrimination

General comparisons between groups showed higher numbers of Female RC individuals that identified multiple categories of stigma and discrimination and multiple categories over multiple years (see Table 11). At the end of 2014, all of the observations in which survivors with spouses or partners reported multiple discrimination practices over multiple years were attributed to verbal abuse and domestic violence by spouses/partners and/or parents in-law, three of five in the Female SP/RC group and six of nine in the Female RC group (see Table 11 and a further breakdown in Figure 2). The respondents that were single at the end of 2014 and talked about multiple discrimination practices over multiple years were either still working in the sex industry (n=2) or contending with verbal abuse and/or violence at home in the family (n=3).

Figure 2: Survivor Ethnic Groupings by Marital Status in 2014 and History of Experiences with Discrimination Following (Re-) Integration
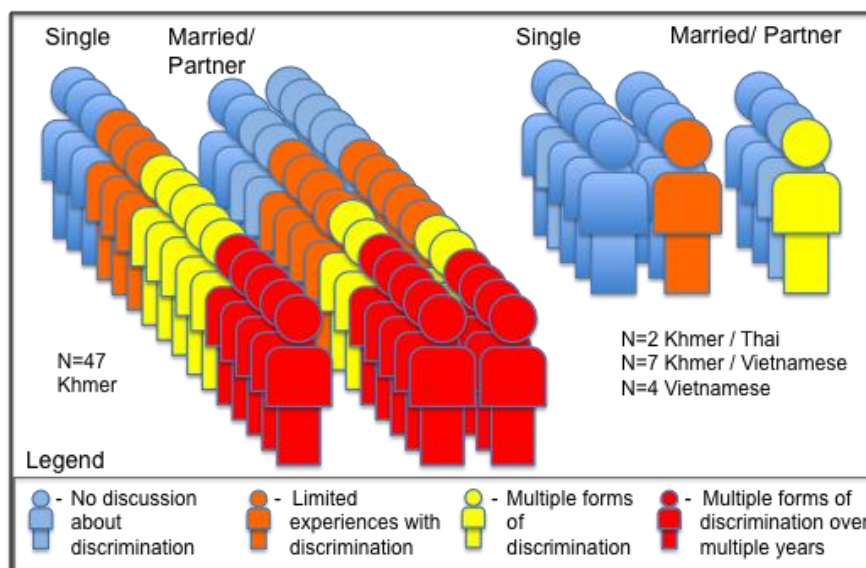
Strategies and Coping Mechanisms for Stigma

The majority of survivors described at least one strategy or coping mechanism to contend with stigma and discrimination (see Table 12). Within Female SP/RC and Female RC, 75.8% and

77.8% of individuals talked about coping mechanisms, respectively. These were also similar total counts between groups. The strategy of "keeping the past a secret" was most often identified in each assessment group, 13 individuals in Female SP/RC and eight individuals in Female RC.

Not all coping mechanisms employed to contend with stigma were considered helpful and constructive strategies. There were respondents who admitted using alcohol and drugs, anger and fighting, or self-harm practices (e.g. cutting) to cope with stigma and discrimination (see Table 12). Others chose not to develop close friendships or to leave school or well-paying jobs in hopes of avoiding stigma. Some respondents contended with stigma by trying to change their appearance; purchasing clothes, jewelry, and other things. Patience and endurance was often talked about in marriages and partnerships when respondents chose to stay for multiple years and contend with verbal abuse and domestic violence.

Table 12: Prevalence of Coping Mechanisms for Stigma and Discrimination Discussed by Survivors among Female SP/RC (n=33) and Female RC (n=27), 2011-2014

Survivors strategies for coping with stigma and discrimination:	Female SP/RC				Female RC			
	n*	%	Total Count	Ind. w/ Multiple Years	n*	%	Total Count	Ind. w/ Multiple Years
Keep the past a secret	13	39.4	14	1	8	29.6	13	4
Patience and endure	7	21.2	7		6	22.2	9	2
Careful and confident	3	9.1	3		5	18.5	7	2
Anger / Fighting	4	12.1	7	2	5	18.5	8	2
Share about past with spouse/partner	6	18.2	6		4	14.8	4	
Use alcohol/drugs	3	9.1	4	1	4	14.8	8	3
"Be strong"	4	12.1	4		4	14.8	4	
Stop work in the sex industry and move on	0	0	0		4	14.8	4	
Religious faith	4	12.1	4		3	11.1	3	
Move away (another home)	4	12.1	5	1	2	7.4	2	
Share with trusted family member / friend	2	6.1	3	1	2	7.4	2	
Develop no close relationships	0	0	0		2	7.4	2	
Get married or go back to previous partner	1	3.0	1		1	3.7	1	
Spend and buy things / pretend happy	2	6.1	2		1	3.7	1	
Suicidal thoughts / Self-harm	0	0	0		1	3.7	1	
Polite and respectful - "dutiful"	0	0	0		1	3.7	1	
Quit school or job	2	6.1	2		0	0	0	
Total**	25	75.8	62	4	21	77.8	70	7

Notes: RC - (Re-) integrated into Community
      SP/RC - Shelter Program then (Re-) integrated into Community
      Blank - No Observations
      * -Number of Individuals
      ** - Individuals talk about multiple coping strategies; therefore, counts are not additive.

Survivors employed positive coping strategies such as being careful and confident toward friends, family, and potential spouses or remaining emotionally and mentally strong as they navigated stigma and potentially stigmatizing situations (see Table 12). Other survivors chose to make a deliberate break from their past and found they were able to move on regardless of people around them. Sharing with trusted friends, family, or a potential spouse/partner was also helpful for some respondents. Keeping the past a secret was beneficial but at times it was linked with concerns by survivors that there was no person in their life that they could trust. Religious faith was also a positive coping strategy for stigma described by survivors.

Survivor's described strategies and coping mechanisms to contend with stigma in the following examples:

⇒ *I am changing myself a lot. I am strong and I don't cry easily like before. I try to make myself strong so that people won't look down me.*

⇒ *I still struggle and have difficulties like before but I want to solve problems on my own.*

⇒ *My faith really changed me, and I became more courageous. When I encountered obstacles, I prayed to God, and He answered me.*

⇒ *I decided to get married to my second husband in 2012. My husband actually pursued me all along. He never got married to another woman, he wanted to marry me, so I agreed to take him. In fact, we've known each other since we were very young because we lived in the same village. Although my husband knows about my past story, he still loves me and has compassion for me.*

⇒ *I am pregnant with my boyfriend. My boyfriend's family knows and they refused to accept our unborn baby and me. They wanted me to abort our child. I feel very broken-hearted and at the same time afraid of my parents. My parents will physically beat me if they know that I am pregnant (I keep it a secret). Moreover, if my neighbors know that I am pregnant they will look down on me because this brings shame to my family.*

⇒ *Every night I cannot sleep unless I drink alcohol because I feel depressed with my husband, as he often does not come home and when he does he is violent toward me.*

5.0   Discussion

The BLR Project is the first longitudinal study to follow children and adult survivors of sexual exploitation and trafficking, starting from the time they are in aftercare programs through (re-) integration. The longitudinal study design addresses a significant limitation identified in cross sectional studies involving survivor (re-) integration (Derks et al. 2006; Reimer et al. 2007; Surtees 2013). The project follows a select group of individuals in Cambodia and has already collected a wide array of data between 2011 and 2014.

This assessment documents various forms of stigma that survivors of sexual human trafficking must contend with living in Cambodia. Many studies highlight discrimination and to some degree address stigma as an important issue that survivors deal with during (re-) integration, however no studies have attempted to breakdown the magnitude and extent of stigma among (re-) integrated survivors long-term. The finding in this assessment systematically characterize the main components of stigma, documenting culturally germane stereotypes and negative labels, important stigmatizing groups, and the discrimination practices survivors confront long-term while living in the community. Survivors discuss their encounters with public stigma throughout the many changes they experience in life from year to year. This group lends their voice not only in protest to the stigma and inequality they so often confront but also to encourage others to contend with stigma and discrimination and struggle to overcome these adversities in life.

5.1   Experiences of Stigma Among Cohort Groups

Based on the findings, three central themes, gender inequality, marriageability, and socioeconomic status underlie the majority of stigma categories described by survivors. Certain aspects of gender identity are considered core tenets in traditional Khmer social culture: the virginity of the bride and the higher ranking of a man relative to a woman (Gorman and Kheng 1999). Marriage is a highly valued norm in Cambodian society and therefore gaining or loosing status in marriageability is of great importance not only among single individuals but also among their families (including extended family). The ability to increase an individual's socioeconomic status and therefore, the family's status is also a valued social norm that can and does affect marriageability.

The themes gender inequality, marriageability, and socioeconomic status are clearly evident in survivor stories as they discuss stigma, negative labels, and the gain and loss of social status and personal honor and value. Highly stigmatizing situations can and do arise when an individual perceives the loss of personal self-worth and family honor in marriageability and is seen by others as ineffective or unable to financially contribute to change in a family's socioeconomic status. Stigmatizing situations are not relegated solely to initial timeframes surrounding (re-) integration or even until a survivor is married. Instead, they can arise at any time, particularly as one considers the importance of family honor. Consequently, stigma can be an important issue for survivors not only as they (re-) integrate but also later in life as they interact in the community.

While each stigma category includes a set of unique traits or situations, negative labels and stereotypes in essence act as common threads that tie these categories back to socioeconomic status, marriageability, and gender inequality (see Table 4). This occurrence is quite logical given the complexity of life circumstances, the perceived intensity of stigma, and the range of knowledge stigmatizing groups do or do not have regarding a current situation and a survivor's past history. For example some survivors discuss contending with stigma regarding marriageability from potential parents in law because their family's standing in the community and not because of past experiences of sexual exploitation or sex work. In these instances,

knowledge of a survivor's past experiences would only serve to strengthen stigma overall in the given situation.

One respondent addresses this issue:

⇒ *I decided to marry with my husband because I do not want others to look down on me anymore, my husband proposed to marry me but I knew that he had many girls after he was engaged with me. I am a strong person, but I still think that my life has no value; sometime I think to myself that I still have half value... That's why I never told my husband about my past experiences because he would look down on me more than now.*

Participants' experiences with stigma are dynamic and complex, often shifting over time. One survivor's story illustrates these points.

An 18-year-old participant, who had (re-) integrated back to her family when she was 16 years old, relayed the following experience. She and her family were attending a wedding celebration of a relative near her home. Whilst the reception was proceeding, her older unmarried aunt arrived late, accompanied by two men. The older aunt and the accompanying men apparently had arrived already intoxicated with alcohol. According to the participant, the aunt and the two men were loud and physically affectionate in public. The grandfather of their family took offence to the aunt's behavior and publically accused her of 'flirting' and not acting in an honorable way for an unmarried woman. A loud argument ensued between the aunt and the grandfather. The participant relayed she did not enter into the debate, yet found herself made the center of attention, when her aunt turned toward her, and publically accused her of dishonoring the whole family because of her former experiences in the sex industry; "*everyone knows she was a sex worker.*" Following her aunt's public accusation, a number of uncles turned their attention toward the participant and threatened to kill her if she returned home. They did not want her to live in the village anymore because she had dishonored their wider family. "*I am afraid to sleep at my house because my aunt and uncles promise to kill me in my sleep.*" Since that visit the participant has lived with a number of different family members and moved to another part of the country.

In an interview in 2015, this survivor described her recent marriage and her excitement in being able to celebrate the "Fruit Walk Ceremony". She went on to talk about her promotion at work and thereby her gain in status in the family as "household head" explaining that, "*when my mom doesn't have money, she calls to borrow from me*". However, these gains in social status in the family were also tempered by the following discussion:

⇒ *Actually he (my husband) discriminated against me. He didn't know that I lived in the organization until after we got married. Now it feels like he doesn't like me. He said "Erh! If I had known that you were an organization child I would not have married you". When he said that I felt very hurt/difficult.*

This story is certainly not unique among survivors; the majority of survivors describe lives and experiences with stigma that are complex and changing.

Factors Influencing Stigma Among Cohorts

There are several factors identified in the assessment that potentially influence stigma among cohorts.

Aftercare and Shelter Based Programs - Respondents living in aftercare programs discussed few stigmatizing experiences, just 4% of the total number of assessment years (n=50; see Table 6). This was not to say that survivors didn't discuss conflicts or what some survivors felt were discriminatory actions by their shelter peers. Many survivors talked about relational conflicts, particularly when they first entered the program. In most instances, however, these conflicts were temporary in duration. While these situations were likely important in the lives of survivors at the time they occurred, they were not identified in the assessment as stigmatizing experiences. This was due to two reasons. First, shelter peers generally came from similar backgrounds and no real separation of power was apparent in these conflicts. Secondly, although aftercare programs were likely not free of all stigma, the core values in these programs included protecting survivors from conflicts and stigmatizing situations.

Evaluations of the stigma in the years following (re-) integration indicated the lowest prevalence of stigma in the first year; frequencies of stigma in Year 1 were 27.3% and 22.2% in Female SP/RC and Female RC, respectively (see Table 6). The prevalence of stigma increased in the following years for both cohort groups (substantially increased in the Female RC). These findings suggested the first year following reintegration might not be as difficult for survivors as the years that followed regarding stigma.

There are several possible reasons why survivors report fewer instances of stigma in Year 1, including well thought out (re-) integration plans, job training programs and immediate employment, and/or follow-up services and support in certain situations that act to alleviate stigma or potential stigma. Regardless, these findings have implications for program managers as they consider the scope of resources and the duration of follow-up programs for survivors once they (re-) integrate in the community.

Ethnicity – Ethnicity is an important factor in understanding potential stigma among survivors. In this assessment we evaluated stigma associated predominately with Cambodian culture and social norms. The Vietnamese survivors living in Cambodia are generally not assimilated in the Cambodian culture nor, it would appear, are many of the respondents with mixed ethnicities. Apart from one individual, these respondents generally did not share similar concerns and experiences regarding stigma. Other studies confirm these findings suggesting Vietnamese communities may have a more pragmatic view and therefore less stigmatizing view of sex work (Reimer et al. 2007). While these groups did not discuss racial stigma, it is a significant underlying theme, particularly between ethnic Khmer and ethnic Vietnamese people (Berman 1996). Further, most survey questions primarily focus on stigma within families and community settings and did not directly address potential underlying racial stigma or discrimination.

Marital status - Marital status is also an important factor in stigma among survivors. The data shows marital categories with single status had lower prevalence of stigma, while long-term relationships had the highest prevalence of stigma (Table 8). Stigma in the long-term relationships is primarily due to gender inequality and lack of acceptance by parent's in-law. Martial categories including divorce show the highest prevalence of stigma (Table 8). These results are consistent with the high degree of cultural stigma associated with marriageability, gender, and divorce.

5.2   Stigma Consciousness

Survivors must wrestle simultaneously with self-stigmatizing thoughts along with trauma during trafficking and exploitation. Zimmerman et al. (2014) alludes to this finding 75% of female

survivors who reported sexual violence while in a trafficking situation were worried about how they would be treated by people at home in their community. These responses suggest a conscious concern about stigma among the study participants. As discussed previously, respondents, particularly ethnic Khmer, grew up learning various aspects of Chbab Srei (Rules of the Lady) and labels surrounding "acceptable and unacceptable behavior" for girls and women in society (see discussions in Section 2.2, p.6). At some point during trafficking or exploitation survivors realize that their life situation has changed and it now fits within a different social construct, a construct containing negative labels and stereotypes. As survivors become "stigma conscious", they must contend with self-stigma and self-discrimination. These situations are clearly evident in the voices' of survivors:

⇒ *I felt empty with myself because they already abused me one time. That is why I agreed with this person to go to work (in a brothel) after they abused me.*

⇒ *When I faced that problem, I never thought to rescue myself to be better…In the past, I never think about how to make my life better, I always think that I am bad like other people said and even if I try to do good, other people will still think bad of me.*

⇒ *I got involved in a bad job and became a bad person.*

⇒ *I felt ashamed and I think of myself as not a good person.*

Response Continuum

Survivors' responses to negative labels and stereotypes span a continuum from demoralizing to empowering. Some survivors discuss changes in thinking that they attribute to counseling and other services provided by organizations. Two survivors demonstrate the range of these responses:

⇒ *After I divorced and returned to Cambodia the neighbors look down on me because of my failed marriage and because I returned poor. I had no money at all. Before I married I was a virgin and I hated the Karaoke girls and then after my divorce I didn't care anymore. I thought I should work as a Karaoke girl because I was no longer a virgin and everyone already blamed me because I was divorced. …… I already felt so ashamed by my neighbors for my divorce and because I was poor I decided to add to my shame by going to work in Karaoke.*

⇒ *Frankly speaking, if the young girls have any problems like me I want them to be strong and calm. …. If you have problems don't be too afraid. If you face any problems you have to be strong and struggle. When you face that problem doesn't think that your life is over and that you cannot improve it. Our life is longer than this so doesn't finish it there or destroy it more and more. I always think positive like that.*

5.3   Stigma Degrees

In this assessment, survivors discuss stigma in varying intensities and degrees based largely on the stigmatizing groups and forms of individual discrimination. Stigma is described, for the most part, as overt forms of public stigma directed toward an individual. For instance, one survivor may talk about dealing with social isolation from a neighbor because of past work in the sex industry, while another survivor may talk about dealing with social isolation from their family and a neighbor because of past work in the sex industry. In these instances stigma varies in intensity. In another example, one survivor may contend with verbal and domestic abuse by a

husband and parent's in-law (while living at their house) because of past work in the sex industry. In the third example stigma varies from the first two instances in both intensity and degree. In general, findings in this assessment suggest that stigma increases in degree and intensity as multiple discriminating experiences converge and remain in place over multiple years. The intensity and degree of stigma can also increase as survivors locate fewer and fewer trusted social resources (e.g. friends or family members) and safe places in the community (e.g relatives and neighbors homes or places of business).

The combination of multiple forms of individual discrimination and self-stigmatizing (or self-discriminating) thoughts also suggest varying intensity and degrees of stigma among survivors. During some interviews, survivors describe mounting levels of discrimination in combination with self-stigmatizing thoughts (21.7% of all survivors; see Table 11). These instances differ from introspective thoughts regarding past experiences with stigma; instead survivors are speaking to the present situation. It's important to note that not all survivors dealing with multiple forms of stigma share these types of thoughts, nor did survivors that identify limited or no experiences with public stigma. One survivor describes this combination of individual discrimination and self-stigmatizing thoughts in the following way:

⇒ *I felt discouraged and it broke my heart because my relatives look down on me because I used to have many men and got pregnant; I used to have abortions many times. Moreover, I have a husband but we did not get married (partner). Therefore, all my relatives discriminate and look down on me and the family of my husband does not accept me as well. It breaks my heart and makes me feel disappointed with myself very much. I feel like I have no value.*

5.4 Persistence of Stigma Among Survivors

There are multiple lines of evidence indicating stigma as a persistent issue in the lives of survivors. The assessment includes a broad range of stigmata, some that survivors undoubtedly faced before being trafficked such as poverty and gender discrimination in families. In many cases, survivors still contend with these forms of stigma in addition to stigma resulting from trafficking and exploitation. The following paragraphs outline some of the more substantial factors regarding stigma and its persistence.

Continual Reminders

There is a group of survivors that discuss being continually blamed for and harassed about their past involvement in the sex industry by family members. Other survivors describe similar experiences for being divorced. These persistent reminders target personal honor and the family's honor. They increase stigma intensity and create reoccurring conflict in relationships among neighbors, family members including husbands, and in other cases parents' in-law. These public forms of discrimination represent the most obvious types of continual reminders but there are other more subtle forms as well (e.g. exclusion from wedding ceremonies). Survivors talk about being continually reminded of their past:

⇒ *2012 - They (my family) stopped looking down badly like they did before; just sometimes they recall my bad background, which then hurts my feelings, when my sister blames me for going out at night….but in my mind I'm afraid of my brother-in-law who looks down on me, even now…. He blames me and looks down on me most of the time. Whenever he has a problem with my sister he blames me for being a prostitute and calls our family "prostitute family".*

2014 - Because when we have arguments he (my husband) always blames me and brings up the secrets about my family but he did not say anything about my story that I used to have another husband.

⇒ *2012 First Quarter - I feel like my cousin discriminates against me because she does not allow her daughter to come and have a relationship with me. Sometime she insults me, which hurts me the most.*

2012 Fourth Quarter - For this past 4 months, I think my cousin discriminated against me because she does not talk to me. She hates me and doesn't get along with me. She often teases me (about working in the sex industry in the past) and hurts my feelings.
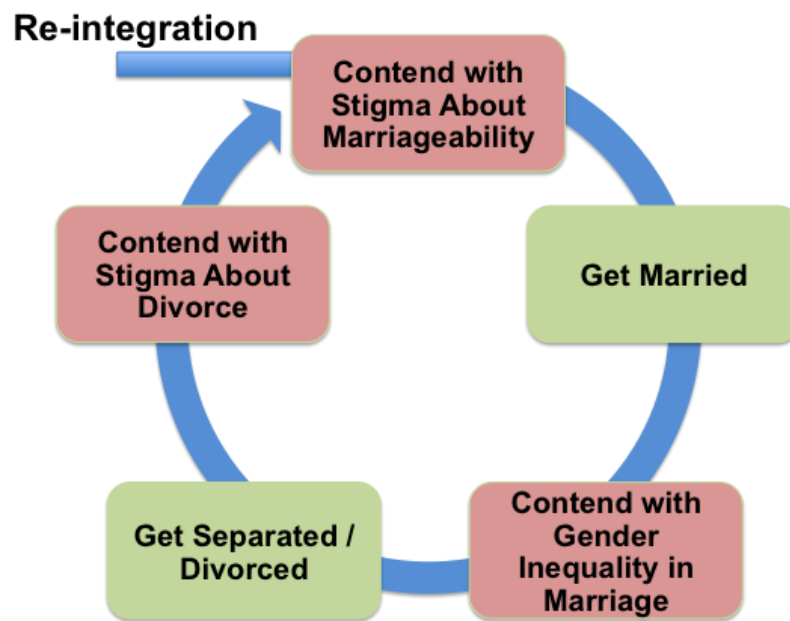
Marriageability Stigmata

Based on the discussions among survivors, most survivors are highly stigma conscious regarding their "ability" to get married, divorced, or for some, remarried. This is to be expected given the value and honor Cambodian society places on the institution of marriage. The vast majority if not all of the survivors that are single discuss wrestling with stigma related to marriageability at some time during the assessment. Survivors that find themselves in an abusive or violent relationship struggle with gender based stigma as well as cultural stigma associated with options such as divorce. Unlike many western cultures, divorce is highly stigmatized among women in Cambodia (Van Der Keur 2014) making the choice to leave a relationship a difficult decision. Even the decision to leave a relationship involving domestic violence can be stigmatizing, given the vast majority of Cambodians (75%) believe wives should be patient and endure (i.e. keep silent) domestic violence in order to keep a family together (Van Der Keur 2014). Presently, there are survivors contending with multiple forms of stigma as they cycle between abusive relationships with spouses, divorce/separation, and re-marriage into yet another abusive relationship (illustrated in Figure 3). Survivors describe their struggles and concerns with gender inequality and stigmata in marriage and divorce:

⇒ *She gossiped about me. The villagers felt very sorry for me (that I was "unfit" for marriage) and said to me if I didn't get married (to a particular person) there was no way another man would ask to marry me.*

⇒ *Husband and wife have to give value to each other. You are my husband but you have never given value to me as your wife, I said to him.*

⇒ *I thought I didn't have value anymore. I didn't care about my body. My husband can have a lot of girlfriends and so I have a lot of boyfriends (this survivor was just divorced and decided to start working as a sex worker in a Karaoke shop).*

Figure 3: Marriageability Stigmata Cycling

Survivors describe instances when marriageability stigmata impact their thinking and decision-making regarding relationships. The degree to which survivors modify their behavior consciously and subconsciously in seeking relationships was beyond the scope of this assessment. However, it is clear that survivors felt they had fewer opportunities and sometimes declined to pursue relationships because of the stigma associated with past experiences.

⇒ *Another man that I knew he was from wealthy family, he loved me and wanted me to meet his parents but I denied him because I was afraid they would look down on me as my background was not good.*

⇒ *You know, there was one young man that came to me and wanted to propose to share life with me. However, I could not do this because I am HIV positive; I am afraid to destroy his future.*

Some survivors also talk about starting long-term relationships with men they met by chance, despite spending little time getting to know their future spouse. One survivor started a relationship with a man after she noticed him on the street during an excursion from the shelter home; another started a relationship with a man she talked with on the phone after becoming intoxicated and calling the wrong number; yet another decided to enter into a long term relationship with a man she met while living with a stranger and despite being physically abused and pregnant with their child. In each outcome, survivors eventually found themselves in verbally and physically abusive marriages/partnerships. Although the role stigma played in these decisions is not fully known, the stories illustrate the difficulty some survivors have pursuing supportive and encouraging relationships following (re-) integration.

Loss of Opportunities in Education

As a group, female survivors in the assessment struggled to complete their education. Literature has documented many obstacles female students face in finishing school in Cambodia, obstacles such as poverty, distances to high school and safety concerns for female students, gender bias in the family, and family conflicts. Survivors' face these obstacles along with other obstacles. Some

participants talked about the lost time during trafficking being too much to make up and others dropped out due to the public stigma they received from fellow students for being too old for the grade in which they were enrolled (Miles and Miles 2011). Through 2014, no study participant has yet completed Year 12 and passed the graduate exam. Of all the cohorts in this assessment, 85% have dropped out of school. The majority of survivors in the Female SP/RC group attended school (23 of 33) while living at the shelter facilities. Following (re-) integration, 61% of these survivors (14 of 23) had dropped out of school despite financial support for school from most of the aftercare programs.

Given the number of obstacles female survivors face and the directions most survivors take following (re-) integration, it is likely that few will go on to complete their education. These findings suggest most survivors will continue to face stigmata associated with the lack of education (e.g. gender inequality in marriage, socioeconomic status). Training programs have helped many survivors learn valuable job skills and find gainful employment but in certain circumstances these skills cannot compensate for the honor gained by women that have completed their education. Consider the following story as told by a survivor with job training but little education as compared to her husband/partner that graduated from college and now works as a loan manager in a microfinance company:

⇒ *Sometimes I asked him how and if he considers me. I asked him if he thinks that I have no heart, no ideas, and no brain and that is why I am able to receive whatever he does. Nowadays, does he know how I feel? I asked him if he knows about how I got sick and how our son got sick. Did he understand how I survived? He said nothing. Then he said with rude words that I did not have a brain, I didn't know (anything). And he told me not to talk to him because I do not have brain, I am like a dog, I do not know how to think.*

Legal Marriages

Most survivors that enter into relationships with spouses choose not to legally register their marriages at the civil registry. This is a disturbing trend among the cohort group; there is only one in 36 respondents considered married/with a partner that has legally registered their marriage. There are several reasons survivors state for not registering including time and/or distance to civil registry, resistance by the husband/or survivor, lack of knowledge regarding registration procedures, lack of knowledge regarding its importance, and divorce costs associated with terminating a marriage.

While survivors state many reasons for not registering their marriages, the overarching problem is primarily contained within systemic stigma surrounding divorce. Van Der Keur (2014) outlines many of the specific types of systemic discrimination females in particular must contend with in order to proceed with divorce in the civil justice system. Three main themes include the following:

- Couples with legally registered marriages must obtain legally registered divorces in order to pursue other relationship with impunity from the law
- Divorce law reflects the Cambodian social culture and the stigma on divorce by including numerous steps and obstacles to obtain a divorce judgment; these steps and obstacles are cost prohibitive for lower income couples
- Male dominated civil justice system (commune councils are 82% male and 91.5% of judges are male)

Cambodian marriage laws do not "*regulate the rights and the obligations of a couple who fail to legally register their marriage at the civil registry*." (Van Der Keur 2014; p. 2). Women that do not obtain legally registered marriages are not assured rights to marital assets, property acquired during marriage and registered in the name or their partner, partner alimony, and child support. They effectively have no power to negotiate conflicts and stigma arising from gender inequality in the marriage without fear of violence, financial repercussions, physical abandonment, or forced eviction. For example, consider the negotiating options available to the survivor in the aforementioned story and discussion (page 36) with her husband. They do not have a legally registered marriage and she is not assured rights to their marital assets nor financial support for her or their children should he decide to abandon the relationship. In this way, many survivors must contend with persistent stigma associated with gender inequality and potential divorce in relationships.

Health

Stigma has been shown to have enduring effects on mental health and well-being (Link et al. 1997; Pyne et al. 2004) . Link et al. 1997 concluded stigma had a "relatively strong and enduring effect" on men in study group one full year after treatment and recovery from mental illness and substance abuse. Despite positive life changes, stigma continued to complicate their well-being (Link et al. 1997). Yan et al. 2010 demonstrated a significant positive correlation between heightened levels of self-perceived stigma and poor mental health among female sex workers in China. Zimmerman et al. (2014) indicated that repatriating survivors whom reported feelings of guilt and shame (presumably associated with experiences during trafficking and exploitation) were more likely to have symptoms of depression. Survivors in this assessment also discussed feelings that are symptomatic of depression and suicide.

Keeping the past a secret can be a significant strain mentally and physically. Survivors talk about concerns that someone might recognize them or that friends or family might decide to look on the internet for the organization where they lived or now work. In one example, a highly stigma conscious survivor describes linking health problems with the stresses of contending with this stigma. The survivor is newly married and she discusses shedding stigma from her family due to marriageability but gaining it back by fearing her parent's in-law may someday find out her past history. Her husband knows about her past but she does not fully trust him. She describes this stress as the greatest worry in her life at the time:

⇒ *I think the most is about this issue; I really focus on it. I don't know what to do if my parents in law know my story.*
(When asked if it affects her health?) -Yes! I can't sleep well, can't eat much and feel exhausted, as you have seen now.

Situations involving stigma and discrimination can change rapidly but the impacts of stigma on mental and physical health may not respond in the same manner. This assessment suggests survivors contend with stigma in varying intensities and degrees. The potential mental and physical health impacts these ranges of stigma have on survivors are not fully known in this assessment. Further research would benefit program managers as they follow-up with survivors and assess potential care needs and services.

5.5   Coping Strategies for Stigma

It is clear in this assessment that survivors contend with stigma. They are not passive helpless victims but instead they challenge stigma through various strategies and mechanisms. Some

survivors undoubtedly learn coping mechanisms in aftercare programs and work training programs and are now employing them in the community. The assessment does not identify any one strategy that was more effective; not every survivor knew a trusted family member or husband and not every survivor had their choice to keep the past a secret. Instead the survivors choosing to "think through situations more" often found effective ways to deal with stigma.

In general, almost all survivor strategies included keeping the past a secret from certain groups of people (i.e. selective disclosure). Relatively high numbers of survivors in the Female SP/RC group employed this strategy and given the duration of time some spent in shelters (two to three years) not everyone in the community remembered them when they returned. These respondents essentially had the opportunity to start over with certain groups of people. Survivors that did not stay in shelter programs and did not move locations were not able to keep their past a secret in many instances.

Some strategies were aimed at self-stigma such as "be strong" and other such as "careful and confident" included both self-stigma and public stigma. Survivors that were careful and confident often thought through situations before making decisions and were empowered and proactive when they faced stigmas and obstacles. Other groups made a "clean break" from their ties to the sex industry, often moving to a new location and simply starting over, sharing little about their past history with friends and neighbors.

Survivors Overcoming Stigma

A group of survivors in this assessment have overcome many of the stigmatizing situations they faced in life. This group collectively shares several important resilience attributes and characteristics. These traits and characteristics are discussed in greater detail.

Interconnected – One of the more difficult aspects of stigmatizing situations is the separation it causes between people, "us and them". People with strong interconnections (i.e. encouraging and trusting relationships) are likely not "separated" to the same degree by the stigma they experience as compared to people who feel there is "no one they can trust".

Cross referencing results in this assessment with resilience attributes assessed in 2014 (see Morrison et al. 2014) shows survivors that overcome stigmatizing situations also talk about encouraging and trusting relationship(s) with their husband and/or family member(s). These survivors experience safe trusting relationships and are not continually reminded of their past experiences and difficulties. Gray (2012) describes features of resilience culturally distinct or unique to Cambodian youth identifying the aspects "family and community support" and "connection and support" as important components of resilience in Cambodian society. These aspects of resilience are culturally embedded in society and considered appropriate ways of coping with adversity. Survivors that are accepted in these situations find that stigma cannot threaten one of the most important cultural values in their lives.

Exhibit Forms of Mental Strength – There is a commonly used phrase in Cambodian society encouraging women to "be strong" in difficult life situations. The phrase has, perhaps in part, risen from traditional gender roles and expectations that married women are to "be strong" (Khun 2006). However, this phrase also exemplifies positive coping mechanisms survivors employ to contend with self-stigma. Researchers in social science may choose the term physiological resilience to describe these forms of mental strength.

There are studies that stress the importance of professional interventions in strengthening and positively influencing survivor physiological resilience and recovery from sexual exploitation and abuse (Gozdziak et al. 2006; Abu-Ali and Al-Bahar 2011; Gray et al. 2012; Sobon 2015). Gray et al. (2012) recommend interventions that increase mastery as a means of strengthening resilience to future adversity, adversity that would most certainly include stigma. These authors advise that interventions be implemented as early as possible to reduce traumatic symptoms and be "*age-appropriate methods of cultivating increased psychological functioning, mastery and competence, in addition to engendering overall resilience*" (Gray et al. 2012: 368).

Indeed many survivors express being grateful for the counseling they receive from organizations and trusted family members. Some survivors describe a process of change toward healthy patterns of thinking that have facilitated interconnection and carry over into their life in the community.

⇒ *Before I blamed myself a lot, but now I don't. I know more and I have new ideas and I don't dwell on my past problems.*

⇒ *My mom knows me. She said I should be strong. I didn't listen to her but now I know.*

⇒ *The first time that I face the court, I was afraid because I saw the offender in front of me but I tried to commit myself. Moreover, I tried to make a commitment to be strong so they cannot see my fear or my weakness. As a result, I am not afraid any more with the next meet up (court appearance).*

⇒ *Everybody has value even if they worked in Karaoke like 5 years, 10 years but they still are alive and they still have value. They are not from the dirt like people say. That is not truth. There are many people that say, you know now that I have worked in Karaoke, I cannot find the right guy. It is not truth. If you believe in yourself and you can be strong, you can still find many people that want to see you grow.*

Work hard and struggle – Survivors reflect on hard work and struggle when asked about what advice they would give to others. Other studies in Cambodia identify hard work as an important part of resilience for survivors of the Khmer Rouge (Overland 2012). Muco (2013) suggests a willingness to work hard demonstrates a motivation needed to succeed, an important trait for survivors dealing with self-stigma and potential stigma in the community. One survivor's explains the need to work hard and struggle with stigma in the following way:

⇒ *I want to tell them to keep going forward although we had this problem, but we have to struggle more. Our future is not finished yet because we still have life. We have to try and have hope. Believe and strengthen yourself to a good future. Although we had problems, we have crossed it already. Sometime we feel depressed, but we must remember that we have crossed it. It has gone, so please try harder again for your future.*

Learn a skill or trade and are growing (excelling) at work – Survivors that overcome stigma discuss a process of learning or training in a job skill, finding a "good job", and continuing to learn new skills. These survivors often talk about starting a job and later becoming a supervisor or trainer and beginning to teach others the same skills they learned. In some ways this characteristic is more of a process in survivors' lives than it is a single attribute. The process can be seen not only in the information that survivors share but also in changes in body language and the levels of confidence in responses that survivors provide to questions during interviews.

Feel that they have "earned honor" through life choices – This aspect is probably the most important characteristic survivors describe in overcoming stigma because it deals with self-perceptions of gaining or earning honor. Of equal importance, perceived gains in honor are made through or because of a survivor's life choices. When survivors talk about moving from no job or the "bad job" to a "good job" or in other situations "getting married" and thereby attaining the "ability to be married", they describe empowerment; they describe earned honor. Cambodian culture gives honor to people that are married, to those with financial means, and to those that are educated/skilled. Survivors of all ages and marital status talk about this concept:

⇒ *I would tell her that you have to try to learn, you should not go for a walk, you have to learn for your future, and work in the office, work in a good place.*

⇒ *I believe I can change my village neighbors' bad ideas about me by studying hard and finding a good job. This will stop their negative gossip about me, about my past sexual exploitation.*

⇒ *Now I become a household head (the most important financial earner in the marriage)…when my mom doesn't have money, she calls to borrow from me.*

⇒ *I plan to stay in school and graduate from college so that I can have a bright future and a good job. Then nobody will look down/underestimated me. And when I get married and have a family, I will feel proud of myself.*

⇒ *Honestly, the most significant thing that has changed is that I am working in a place that does not affect my relationships with the people around me. I work in a good job. And that's the most important thing. That we work in a good place. And so I like to work at the organization. And I left from the place that I should not work.*

Another survivor describes this concept by reflecting on changes in her employment and subsequent positions of honor in her second marriage as compared to her first marriage. During her first marriage she was paid a salary at a skilled job with an organization but now in her second marriage she receives no salary, yet still works in support of her parents in-law's business.

⇒ *If I compare the situation recently with the time when I was working in the NGO, I want that time back; I don't like the situation right now because I live with my husband and his family. His parents work to support my family, which causes other people in his family to look down on me and sometimes they use rude words that disappoint me. I said to my second husband that when I lived with my first husband, I was never afraid to say something to him. I had work (at the NGO) and I earned the money to support my children, but now I depend on everyone and I cannot say anything.*

Survivors that overcome stigma either speak with honor when they talk about their lives or they describe the process by which they believe they have "earned honor" through the choices they have made.

5.6   Study Limitations

There are several strengths and limitations in this assessment. The most prominent strength over the past four years is the increasing levels of 'trust' participants express towards the research team. Whilst this evolving trust and increasing 'truth' is welcomed and appreciated as a data asset, it is also challenging when participants' later contradict their earlier accounts. In addition,

assessment groups have unequal sample sizes and numbers of visits during a given year because not all participants were accessible every year (see Table 1). Further, participants sometimes provide inconsistent responses due to emotional states on different interview days, sexual trauma and its negative affect on memory, second guessing 'answers', and wanting to 'please' the interviewer.

The loss of data integrity during translation and cultural appropriate interpretation of data are also two potential limitations in the assessment. This assessment includes a compilation of surveys collected over four years throughout Cambodia. Data are first collected in Khmer and later translated into English. All records are crosschecked to ensure translation accuracy. Data analysis and preliminary findings are reviewed as a team to avoid cultural bias in translation and ensure that cultural perspectives are retained in data evaluations.

Discussions of racial stigma are conspicuously absent from surveys with Vietnamese survivors and others with mixed ethnic backgrounds. Vietnamese survivors, in particular, live together in ethnic communities separated from Khmer communities. Many of the survey themes and questions are directed toward family and community and as such survivors may not have engaged with racial stigma or discrimination. Among survivors with mixed ethnicities, answers to survey questions regarding ethnic background often shifted from year to year. These findings suggest survivors use selective disclosure about ethnicity and are therefore aware of racial stigma. The cultural prejudice in Cambodia, the separation of ethnic communities, and the selective disclosure of ethnicity by certain survivors suggest that racial stigma is most certainly a concern for some groups of survivors regardless of the findings in this assessment.

Our ability to quantify and describe stigma among survivors is directly related to a survivor's willingness and ability to trust the research team and recall stigmatizing situations. Stigma and discrimination are sensitive issues to recall and discussing these situations is in some ways counter-cultural. Further with persistent stigma and there are many ways to discriminate, both overtly and covertly, sometimes targeting, sometimes excluding a persons and/or their children and family members.

Based on these lines of evidence it is likely that our assessment underestimates the multiple roles that stigma plays in the lives of survivors. Whether it is the number of choices a survivor makes to limit potential stigma, the total number of times family members choose to remind survivors of their past, or the role stigma and discrimination play in re-traumatizing experiences, stress, and mental fatigue, this assessment does not capture all the many ways stigma impacts the lives of survivors. Nevertheless this assessment does help define the depth and breadth of the problem at hand. Further, it functions as a much needed outlet for survivors to voice their concerns and self-understandings of stigma and discrimination.

5.7 Implications for Future Research

The Butterfly Research Project is an ongoing ten-year study. The data collected will provide a long-term understanding of survivor (re-) integration including what they experience and how their lives change over time. Additional data will provide an opportunity to evaluate stigma over a longer time scale and revisit some of the conclusions reached in this paper.

Research in Cambodia has implications to other ethnic groups in this region that share similar cultural norms regarding marriageability and divorce. These two forms of stigma are especially difficult for survivors to navigate as they contend with systemic, individual, and often self-

inflicted forms of discrimination. These forms of stigma vary by degree and intensity in the lives of survivors and for many they have profound effects on a wide range of choices regarding relationships. A carefully crafted study looking at stigma consciousness regarding marriageability and divorce along with decision-making in relationships may shed light on some of the core issues and tendencies surrounding these forms of stigma in survivors.

This assessment identifies persistent stigma in survivors following (re-) integration. Several studies have linked self-stigma and aspects of self-stigma with depression and suicidal ideation among people groups with similar stigmatizing situations and similar cultural norms (Yan et al. 2010; Zimmerman et al. 2014). This study has identified a range of stigma intensity and degree among survivors. Additional evaluation of forms of social- and self-stigma and mental and physical health indicators in survivors during the years following (re-) integration would further understandings of these interactions. It would also give program managers an assessment tools to better identify and aid individuals during program follow-up visits. Additional cooperation between researchers that focus on resiliency in children and young adults, stigma concepts and scalar assessment, and mental and physical health fields would allow for the exchange of concepts, a discussion in overlapping terminologies, and the development of cooperative studies. These types of cooperative studies would benefit a range of stakeholders, not least of which, survivors themselves.

6.0   Bibliography

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Appendix A

Appendix A
BLR Project
Methodologies

BUTTERFLY LONGITUDINAL RESEARCH DESIGN

This section will briefly review the reasons Chab Dai decided to conduct a longitudinal study on (re-) integration. It will define and describe longitudinal approaches, as well as highlight some of the challenges and advantages. Additional information regarding the longitudinal approach can be found in Miles and Miles (2010) and Miles et al. (2012).

Prospective Panel Longitudinal Research Design
According to Menard (2002), longitudinal design "is research in which (a) data are collected for each item or variable for two or more distinct time periods; (b) the subjects or cases analyzed are the same or at least comparable from one period to the next; and (c) the analysis involves some comparison of data between or among periods".

Although there are many excellent studies on (re-) integration of people who have been sexually exploited globally and in Cambodia, the research thus far has largely been cross-sectional or retrospective in design (Derks 1998; Reimer 2007; Velazco 2011). In fact, it is recognized globally and in Cambodia there is a paucity of longitudinal studies specifically examining the (re-) integration experiences of people who have been sexually exploited and trafficked for sexual exploitation. There has been recommendation for such research to be done in Cambodia (Derks et al. 2006; Reimer 2007). Therefore, in order to gain this long-term perspective, a longitudinal design and approach was intentionally chosen for the BLR Project.

A prospective panel longitudinal approach is employed in the BLR Project. In essence, a panel study examines the same set of people each time (Babbie 2007) and generates data on changes over time. The BLR team recognizes such prospective panel designs have special problems and challenges as outlined below (Babbie 2007).

Panel Attrition
A particular and fundamental challenge and limitation of panel studies is "panel attrition" (Babbie 2007). Panel attrition simply means participants leaving a study for any multitude of reasons.

Panel retention rate in the BLR Project was 84% in 2012 (Miles et al. 2012), 76% in 2013 (Miles et al 2013) and 69% in 2014.

Maintaining Contact
Maintaining contact with the participants and sustaining their motivation is difficult and costly (Rajulton 2001). This has been the case with some participants in the BLR Project. Some reasons for challenges in maintaining contact with participants include: phones getting lost, sold or stolen; incompatible work schedules, weddings and funerals, frequent relocations and household moves, migrating outside of Cambodia, and even imprisonment or being "on the run from the law". In order to maintain the database the team is available by phone 24/7, and the team keeps abreast of participants' and their key close contacts' by phone numbers.

Measurement Error
All research methods have the potential of measurement error; particularly, for longitudinal research, there is the unsolved problem of "how many times and when to measure the variables of interest to capture the change in process under study. It is possible to obtain measures that suggest change when actually there was no change at all or measures that suggest no change when actually there was change" (Rajulton 2001). It is hoped that by employing a mixed-methods approach that data generated will make more sense.

Related to measurement error are potential changes to the survey instrument as the year's progress. "In studies that carry even for a few years, new hypotheses will arise either from the study itself or from general advances in the relevant fields of social research" (Rajulton 2001). The government's paradigm shift regarding residential care is anticipated to affect the wider context of Cambodia. Therefore it is anticipated the framing of the survey questions will change accordingly. It is anticipated that new knowledge will create challenges since relevant data were not collected in the previous waves and thus have the potential to diminish the value of what has already been done (Rajulton 2001).

Panel Conditioning

Panel conditioning poses a threat to the validity of the longitudinal information gathered. This is because over time the potential for participants to answer questions in a way to which they have grown accustomed will potentially increase. Also, the longer the participants participate in the study, the greater the possibility they are less likely to report "socially unacceptable" situations (Rajulton 2001). For example, participants who end up returning to sex work may not want to disclose this to researchers as they may fear the latter will disapprove.

Alternatively it must be recognized that as time passes and participants feel researchers are trustworthy and continue to be interested in their lives, greater trust between participants and the research team will actually enhance relationships so that the team will hear more honest accounts. In light of these concerns and tensions the BLR team makes every attempt to be nonjudgmental and accepting of each participant.

Building Trust

Trauma destroys the trust relationship of victims with themselves and the world. This creates an inordinate amount of stress on the mental, emotional, and physical capacities of the victim whose coping behaviors and belief structures have been shattered by trauma. The victim no longer knows how to act or what to expect from the world to survive (Whitmer, 2001; cited in Harrison, 2006).

One difficulty in doing research with survivors of sexual exploitation is getting accurate information from survivors. In some ways, participants share only the surface story about themselves because they do not fully trust the research teams and because they are afraid to tell others about their past. In addition, some participants are very young. When asked specific questions, their answers are often unclear and change from visit to visit. Survivors sometimes also have issues of trust with their own caregivers and may feel they are not at liberty to express themselves when in the presence of someone other than the researcher whom they do not trust.

Often as the relationship with the researcher deepens, especially in a longitudinal study, research participants feel more at liberty to share their story and experiences. Doing research with these survivors requires flexibility and more time to establish trust. Trust can be gained from all participants once researchers have a relationship with them. Building trust with survivors of trafficking also must be done in the context of proper training and with a concern for keeping relationships built with research participants in an appropriate and ethical framework.

PARTICIPANT DEVELOPMENT

This section reviews methodology for participant development. Greater details are found in Miles and Miles (2010) and Miles and Miles (2011).

Partner Organizations

In order to have access to potential participants for this study the Chab Dai developed Memorandums of Understanding (MOUs) with interested and willing assistance/ assessment programs (APs) working with individuals who have been trafficked or sexually exploited. As part of the MOU agreement, the research team is given access to potential participants in their programs who meet the study's inclusion criteria, providing the opportunity to enquire about when and to where participants have referred, moved and/or (re-) integrated.

Ethics

The vulnerability of the participants is appreciated and every effort has been made to abide by high ethical standards, as found in Ethical Guidelines for Reaching Children and Vulnerable People (Ennew 2010) and Human Rights Counter Trafficking Research and Programming (UNIAP 2008). Harrison (2006) states it is the ethical responsibility of all researchers to identify and respond to risks associated with anti-trafficking research projects, and that researchers should be fully accountable for this process. The avoidance of harm to the participants in a research study should be the overriding ethical concern (Cwikel 2005).

The National Ethics Committee of the Royal Government of Cambodia Ministry of Health has granted annual approval for this Project (see Miles and Miles 2011; Miles et al. 2012; Miles et al. 2013). Resources useful to survivors has been compiled and distributed as needed to participants in their respective geographic areas.

Informed Consent/Assent

Participants were reminded upon each encounter about the voluntary nature of this research and their right to leave the study for any length of time and their right to return. Upon request by participants, the aims, methods/processes, topics, and intended purposes of the data and findings were reviewed. The research object and consent was reviewed with parents of younger participants who (re-) integrated over the past year, as guardianship shifted from the AP to the parents. Some parents have decided they do not wish their children to continue in the study for the time being.

Participant Inclusion Criteria

To participate in the study, potential participants must have:

- Experience of sexual exploitation and/or trafficking for sexual purpose, regardless of whether the participant also has any additional experiences of exploitation, trafficking for labor, sexual assault, domestic violence, etc.
- Be (re-) integrating within Cambodia borders to any province. If participants migrate outside of Cambodia after (re-) integrating from their assistance programs, the research team will maintain contact where possible and will communicate to participant that they are welcome to return to the study when they return to Cambodia.

To begin recruitment, APs were asked to allow all potential participants who fit our inclusion criteria to be allowed to attend the invitation and explanation field sessions. Limitations for inclusion were not placed in relation to age, sex or ethnicity/nationality. In addition, there were no limitations as to whether the participant was considered "assisted" or whether they ended up refusing assistance (for whatever purpose).

Cohort Panel Development

Upon embarking on the longitudinal phase of this research in early 2011 the research team wanted to have a reasonably large sample of participants. This is because 'attrition' of such participants over the ten year study will likely be one of the biggest challenges. Thus, throughout 2011 recruitment of participants was kept open until December 2011 in order to obtain as large a sample size as possible. The sample size grew accordingly at each field visit to 128 participants (Miles et al. 2012).

As part of the first field visit, the research team introduced and explained the research to potential participants who were not yet part of the study. The focus of this meeting was to allow each person ample time to consider whether or not he/she wanted to join the study. For those who decided to join the study we then had them sign consent and provide us with their contact information. This group did not do a survey at this initial field visit because we felt the explanation and consent process needed ample time. At a subsequent field visit several months later, those who previously provided consent joined with other study participants to complete the first scheduled questionnaire survey.

RESEARCH METHODS

This section briefly describes the research methods employed during the BLR Study. Additional detail regarding study methods, sampling approaches, research questions, and survey tool use can be found in the project annual reports (see Miles and Miles 2010; Miles and Miles 2011; Miles et al. 2012; Miles et al. 2013, Miles et al. 2014).

Study Years 2011 to 2013
Research methods from 2011 to 2013 were based on a mixed methods approach. The research team assessed the overall descriptive 'what' questions regarding participants' experiences and perceptions through several quantitative questionnaires. The team used a three-part questionnaire survey tool developed in the preliminary year (2010; see Miles and Miles 2010), which was administered in face-to-face interviews over four different sessions over the year in 2011. The number of face-to-face interviews was later reduced to three different sessions in 2012 and 2013. The general topic areas covered by the questionnaire included socio-economic issues, education and training issues, psychosocial and spiritual issues, and health and relationship issues, including that of stigma and discrimination.

Qualitative methods were used to explore questions of 'how' and 'why'. Methods included in this process were limited focus group discussions; in-depth interviews; informal interviews before and after times when the team was visiting them in their respective programs and communities; activities such as drawing and games; and observation of the participants in their contexts. Open-ended questions included in the quantitative surveys explored a number of the 'how' and 'why' questions as well.

Face-to face survey questionnaires were conducted in many settings, including in residential centers, community programs, participants' homes if they invited us, in private rooms in restaurants, on outings to parks and national heritage sites, etc. In each location the team was careful to assess and ensure the setting was private and confidential.

Study Years 2014 to Present
From 2011 to 2013 the BLR Project employed three revolving open and closed survey questionnaires each year in order to broadly focus on different areas of participant's lives. Though the surveys enabled the team to gain a broad understanding of participant's lives, the

quantitative components have not explained the deeper and more nuanced stories and experiences of the participants and nor have they captured the complexities and apparent contradictions of participants' evolving disclosure (Miles et al. 2014). Therefore, whilst initially the study utilized a mixed method (quantitative and qualitative) approach, beginning in 2014, the BLR Project focused on qualitative survey methods and thematic analysis (Braun and Clarke 2006).

Guiding questions for in depth interviews were constructed keeping the central themes from previous years including socio-economic issues, finances, education and training issues, psychosocial and spiritual issues, health and relationship issues, and stigma and discrimination. Starting in 2014, the research team began employing these qualitative interview methods with study participants.

The overall purpose of BLR Project is to listen to the perspectives and experiences of victim/survivors. Therefore, the team believes a stronger focus on a qualitative approach is more appropriate for capturing the nuances and complexity of people's lives.

Schedule
The field visits with participants were conducted four times per year in 2011, three times a year in 2012 to 2013, and twice per year in 2014. Meeting participants frequently at the start of the study was important in building trust with participants. However, the challenges of tracking and meeting with participants over a wide geographical area proved to be difficult over time as participants (re-) integrated in communities and dispersed across Cambodia. To address these challenges the team reduced the number of field visits during the study.

Data Management
The quantitative data and analysis is processed using Statistical Product and Services Solutions (SPSS).

LESSONS LEARNED & CHALLENGES FACED

This section briefly describes some of the lessons and challenges identified during the research. The annual reports also provide yearly assessments of lessons learned and challenges faced by the BLR Team (see Miles and Miles 2010; Miles and Miles 2011; Miles et al. 2012; Miles et al. 2013, Miles et al. 2014).

Practical Logistics
Maintaining contact with participants who are geographically located across Cambodia is obviously critical to this study and the research team anticipated it would require much effort to maintain an accurate database with each participant's current contact details. The team felt it was critical to the study that those currently living in the community have access to a phone. For those without any access to a phone, the BLR Project provided them with a mobile phone.

Diligence in Maintaining Confidentiality
Diligently maintaining confidentiality has meant the research team needed to be flexible and a bit creative in the various interview settings. In the shelter programs this meant finding private or enclosed areas. In the community where neighbors were close and privacy was not the norm, this posed an even greater challenge. With one particular (re-) integrated participant the research team

decided to forgo the interview because the close proximity of her extended family and neighbors meant the team could not ensure a confidential interview.

Accuracy in Translation

Face-to-face interviews were conducted in Cambodian (Khmer) language. With Vietnamese participants, the team used a Vietnamese translator who was fluent in Khmer, Vietnamese and English. Tapes were made of all interviews and all tapes were transcribed into Khmer and English, and then cross-checked so as to ensure accuracy of translation.