

Stigma Watch

A study on experiences of stigma
in survivors of sex-trafficking

2015

Preface

To all the girls and young women,
who have sometimes said and often not –
“...it’s like a long dark corridor
where I am walking alone...
never knowing when the light will go on...”
This study is an attempt to understand
your darkness...

The distance between the brothel/red light area where a girl is rescued from, and her home in the village community, generally can be traversed by many means of transport. But this conventional form of transportation masks the real distance the survivor of sex-trafficking must travel, from incarceration to a successful reintegration into her community. Survivors face many hardships once they return into their communities and, being stigmatized as a ‘loose, dirty, immoral and dangerous woman’ is often implicated as a major barrier to successful community reintegration. In our experience, survivors are one of the most stigmatized groups in rural communities, yet in the large body of research on stigma, we did not find any mention of them. Hence, this study.

In our work with survivors of sex trafficking over the last three years, there were experiences and suspicions that rehabilitation services – including case planning and management services which include facilitating linkages to

services, supporting survivors to identify rehabilitation and recovery challenges and exploring ways of removing those challenges, etc. – were not being able to sufficiently address the stigma. Even though social work services were regularly being offered to some of the survivors (and they did prove to be beneficial at times), our assumptions that the sheer service of being heard, attended to and supported would break isolation & alienation and help the survivors build resources to combat the stigma and discrimination in her family, community and in public spaces and institutions, needed to be checked. Hence, this study.

We would like to thank all the young girls and women who have participated in this study and taken the courage to share their experiences with us. They have been generous with their time and in the effort they have put into answering complex questionnaires and schedules.

Chandrani Dasgupta as the principal researcher and my colleague Pompi Banerjee

as the research assistant, are the two people who have put the entire rigor behind this study – methodology, tools and analyses. This would not have happened this way if we had not been able to share our thoughts, biases, experiences, frustrations and arguments with each other as easily as we did.

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...so they keep looking at me, staring at me... their eyes are everywhere... you know, like a hair in your mouth. You cannot see it, you cannot find it easily with your fingers, but you keep trying to throw it out and get rid of it... because it bothers you, irritates you, discomforts you...

Executive Summary

Sanjog has been engaged in working with survivors of trafficking in West Bengal for over a decade. During this period, it conducted two very important studies on the lives of survivors of sex trafficking^{1&2} that pointed towards the presence of stigma in the lives of survivors after they returned and also showed the way it affected their daily lives, their choices and their situations. Learning from their field experiences, Sanjog began conducting its Caring Connections³ program with survivors of sex trafficking in North 24-Parganas, West Bengal. However, due to lack of funds, this program was interrupted for a short period during which three survivors committed suicides. This created an urgent need to understand why such deaths occurred and what made other survivors who participated in this program view Sanjog's anxiety over the deaths with such surprise. What was that aspect of a survivor's life that we as practitioners were unable to understand and address directly?

The hunch with which this research began was that the missing link was stigma. Several studies have been conducted on stigma in the context of mental illness, HIV/AIDS, leprosy, disability, *etc.*, however, none were found to be directly based on stigma experienced by survivors of sex trafficking. The question of how stigma affected survivors needed to be preceded by what the nature of stigma in the lives of survivors of sex trafficking was. With the necessary financial support from 'Supporting children affected by sexual exploitation and trafficking: a learning grant supported by Oak Foundation and implemented by TdH foundation, the present extremely-focused study on stigma was, therefore, conducted.

Available theories and evidence shows that stigma has an extremely debilitating impact on the lives of the stigmatized person. It is a complex phenomenon because it can be generated from outside (public stigma and structural stigma) and inside (anticipated stigma and internalized stigma). Interventions that do not consider this extremely important and significant aspect in the lives of people who live with a devalued social identity, often fail to address the root causes that maintain the levels of distress in a stigmatized person's life. Moreover, initial evidence from studies conducted on survivors of sex trafficking in North 24-Parganas indicated the presence of psychological distress and prejudices amongst service providers. There was also evidence that survivors did not access welfare services and often remained invisible for the system. Therefore, the situation demanded an urgent and rapid assessment of stigma in the lives of survivors of sex trafficking.

OBJECTIVES

The broad objective of this research was to understand the nature of stigma in the lives of survivors of sex trafficking, in order to develop interventions that can enable them to deal with stigma more effectively. The specific objectives of the research were:

1. Identify type and nature of stigma experienced by survivors of sex trafficking
2. Identify stigmatizers from family, community and institutions
3. Understand impact of stigma
4. Understand how survivors cope with stigma
5. Explore innate attitudes in social workers towards survivors that are stigmatizing

METHOD

A mixed methods design was adopted to conduct an exploratory study of stigma in the lives of survivors of sex trafficking who had returned to their homes in North 24-Parganas, post rescue. Thirty survivors and twenty-one social workers were selected to participate in this study.

¹ *Where have all the flowers gone*: Research on sex trafficking in India; Sanjog, 2010

² *Bringing it all back home*: A research on reintegration of survivors of trafficking in their families and communities; Sanjog, 2014

³ Caring Connections is a field action project based on principles of restorative care and aims at rehabilitation of reintegrated survivors.

The study was conducted in North 24-Parganas, since Sanjog has been working in this area for several years now and the Caring Connections program is also conducted with survivors from this area. With a very robust network of social workers and community based organizations, it was deemed to be the best area to conduct a study with severe paucity of time and money.

The universe of survivors was not known. However, there was a list of 107 survivors living in North 24-Parganas with the community-based organizations working in the field of anti-trafficking. An ideal scenario would be to interview as many survivors till nothing new emerged with respect to the objectives, known as theoretical sampling. But given the paucity of time and resources, it was decided to do a random selection of 30 survivors who consented to participate in the study and conduct interviews with them.

All the 30 survivors had the following things in common: 1. *Had been rescued from sex work.* 2. *Had been trafficked.* 3. *Had been in bondage and servitude when they were rescued.* 4. *May have been either rescued by police raids or they may have arranged their own rescue, either with help of a client, or by running away, or by any other means.*

The 21 social workers who participated in this study were part of the network who had been working on the principle of case management with survivors of sex trafficking in this geographical area.

Data was collected in Kolkata where the participants stayed for two days. Survivors were interviewed, while social workers filled in their responses. FGDs were conducted with social workers.

RESULTS

1. Type and nature of stigma

- More than one-third survivors experienced enacted, anticipated and internalized stigma in their lives.
- Social workers consistently perceived higher presence of stigma and greater distress due to stigma in the lives of survivors as compared to survivors, though the overall trend was similar to that of a survivor's perception. This difference was largely because social workers spoke from the point of view of several cases they worked with. That social workers might be over-estimating the actual presence of stigma in individual cases, is a significant point to be included in training of social workers for such interventions.
- **Enacted stigma** – was primarily in the form of ridicule, bad words, isolation from family, and abandonment by friends. Around 27% reported others were sexually abusive as well. And 40% reported their families were abandoned because of them. There was a strong presence of stigma by association due to which close others often experienced stigma because of the survivor.

This was true even for social workers who experienced harassment because of their involvement with survivors of sex trafficking.

- **Anticipated stigma** – Fear of disclosure was very strong and more than 60% survivors believed that stigma would increase if others knew of their identity related to sex work. Around 67% also feared that their marital families would abandon them if they found out. Almost 80% believed that close others experienced stigma by association because of them.
- **Internalized stigma** – The feeling of alienation was very high among survivors who experienced shame and disappointment due to their involvement in sex work. The humiliation

on account of being trafficked was firmly rejected by survivors who did not accept enacted stigma in the form of bad words, ridicule, beating and other forms of public display of anger towards them. The feeling that they had been wronged by being trafficked was very strong and appeared to be dividing their internalized distress into shame of sex work that they owned and humiliation of being trafficked that they disowned.

2. Stigmatizers

- **In the family** – most stigmatizing were aunts and uncles, brothers and brothers-in-law.
- **In the community** – friends, other girls and boys of similar age and married women in the neighborhood.
- **In institutions** – *Panchayat* and police.
- **How did they stigmatize** – they abused, isolated, restricted and were un-cooperative.
- **Why did they stigmatize** – extremely negative attitude towards sex work and sexuality of a woman, blamed the survivor and her family for being greedy, to further oppress due to social disadvantages such as poverty, lack of property, settle past scores, afraid of the negative influence of the survivor on other young people and to displace anger of being stigmatized because of them.

3. Impact of stigma on participation

- **Level of participation restriction** – 73% survivors in urgent need of an anti-stigma intervention based on their levels of participation restrictions.
- **Areas of restrictions** – mobility, both physical and social (status loss), social interaction, personal care and employment opportunities.
- **Low participation restriction** – faced difficulties in only opportunities of employment and in participation in social events.
- **High participation restriction** – faced difficulties in moving around the house and neighborhoods, participating in social events, interacting with others and taking care of self.

4. Coping with stigma

- Avoidance of people and places that were stigmatizing was the most common form of coping.
- Survivors tried to make sense of others' reactions. However, most of them were disturbed by thoughts and emotions generated by stigmatizing experiences.
- Reaction to stress of being stigmatized was primarily in the form of anger and crying, though some social workers also mentioned suicidal ideation.
- Thinking about stigmatizing conditions was quite common as reported by both survivors and social workers.
- Use of denial and problem-solving requires further studies as there was a big difference between the responses of social workers and survivors on these items.

5. Innate attitudes of social workers

- Social workers appeared to be in a dilemma between blaming and not blaming the survivor for her trafficking. They considered the condition of survivors to be quite severe and requiring assistance.
- In several instances, social workers' perception of frequency and intensity of stigma was far greater than that of the survivors'.

- The social workers seemed to be endorsing the society's negative attitude towards sex work, sex workers and female sexuality. This seemed to be affecting the stance they took while protecting survivors and trying to reform them, so that they could gain more acceptance all long, letting the attitudes around sexuality remain unchallenged.

CONCLUSION

Stigma in the lives of survivors of sex trafficking is complex and multi-layered. It is complex because it emanates from deeply held socio-cultural beliefs surrounding sexuality and gender roles. The complexity has just been touched upon by this study; several aspects remain unrecognized.

It is multi-layered because stigma is present not just in actions of others, but also in the fears held within a survivor's mind and her own self concept. The reason why existing case-work is not addressing stigma is because it is restricted to that which is enacted and visible. A major source of stigma remains undetected as it is inside the survivor – which does not mean that it is self-created. Herein lies the complexity of stigma, because though it lies within the survivor's self-concept and fears, it is maintained by the socio-cultural milieu surrounding the survivor.

Such a milieu is formed of social actors and social norms. In fact, the main target of intervention by social workers during their case-work happens to be institutions and its office bearers such as *Panchayat* member, nurse, doctor, police, teacher, *etc.* Though these individuals play a role in stigmatizing the survivor, the relative importance of their attitude on the survivor's perception of stigma seems to be far less than that of people closer to a survivor. The institutional actors appear to be far removed from the circle of stigma surrounding a survivor of sex trafficking as indicated by her responses.

This indicates a need to rethink present practices and develop strategies that enable social workers to include a survivor's immediate family and physically closer networks (friends, neighbors, extended family living close by) in their interventions. There is also need for social workers to address their own deep-set attitudes and work on their own emotions, while working with conflicting personal and professional belief systems.

Chapter One

INTRODUCTION

Once a girl is rescued from a brothel, she is sent to a shelter home and from there, she goes back to her family if the family is willing to take her back. This is a general practice, only changed in case the girl's family is unwilling to take her back. Up until the last decade, families were mostly unwilling to take back their daughters when she was rescued from a red light area, though the situation has changed to the extent that most girls are sent back home now. The entire process of rescue and family reunification takes on an average, a year to two years. During this time, the survivor lives in a shelter home. Once a girl goes missing from her home in a rural agrarian community in parts of West Bengal, the village and family usually fear trafficking because of its widespread prevalence. The recent report of United Nations Office on Drug and Crime (UNODC), titled 'Anti Human Trafficking, 2013', revealed that out of 19,000 women and children reported missing in West Bengal in 2011, only 6000 could be traced. West Bengal heads the list of states from where women and children are trafficked regularly. 90% of this trafficking occurs within the national borders (Hameed, Hlatshwayo, Tanner, Turker and Yang, 2010). Therefore, when a girl goes missing from home, the community is more likely to believe that she was sold into prostitution. Prostitution or sex work elicits an extremely negative reaction from almost everybody in such communities, which

have conservative and traditional sexual norms and are patriarchal in nature. Therefore, from the moment a girl goes missing, her social status begins a downward descent with people openly expressing their disdain when she returns. That she might have tried to migrate runs the risk of being construed as evidence of her greed by others, who do not consider the fact that she is a victim of a crime of trafficking. What ensues in the form of trafficking is often viewed as retribution for her transgressing boundaries within which a girl is expected to live in society. People's reaction towards a survivor appear to be shaped by their anxiety over her having pre-marital sex with multiple men. Basically, a survivor of sex trafficking returns with attributes that are considered undesirable and unacceptable in a society governed by conservative moral standards.

Currently, at a policy level, rehabilitation of survivors of sex trafficking is expected to be over by the time a survivor leaves a shelter home and is 'handed over' to her family. There are no special schemes or policies that can ensure that a survivor receives support after returning home. Studies, on the other hand, have highlighted the need for rehabilitation services during the period of reintegration into her community and family. *Bringing it all back home* – a study conducted by Sanjog in 2014, interviewed survivors, caregivers and service providers and recommended immediate introduction of rehabilitation services to

ensure that survivors can access health, education, welfare and livelihood options. That Sanjog (2014) study identified deep-set prejudices within a survivor's community and within service providers due to which survivors were stigmatized and denied equal opportunities. Concern over stigma in the lives of people living with HIV/AIDS, mental illness and leprosy has been prominent as evident from the amount of literature on it. However, in the case of sex trafficking, stigma seems to be accepted by everybody and this kind of collusion has led to lack of any studies.

The present study was envisaged to develop anti-stigma interventions to assist survivors and social workers in dealing with its negative effects on their lives during the reintegration period. However, when a literature search was conducted, we found no such interventions or systematic studies on stigma experienced by survivors of sex trafficking. The literature was replete with studies on stigma and mental illness, HIV/AIDS, leprosy and cancer, but none on sex trafficking. Therefore, the present study was designed to make a beginning into documenting and analysing the nature of stigma in the lives of survivors of sex trafficking. However, in order to draw out research questions in line with stigma research conducted with other populations, a detailed review of literature was conducted to understand current conceptualization of stigma, types of stigma, impact of stigma and coping with stigma and interventions.

CONCEPTUALIZING STIGMA

According to Link and Phelan (2001), “research since Goffman’s seminal essay has been incredibly productive, leading to elaborations, conceptual refinements, and repeated demonstrations of the negative impact of stigma on the lives of the stigmatized” (pg. 363). Goffman defined stigma as an, “attribute that is deeply discrediting” and that reduces the bearer “from a whole and usual person to a tainted, discounted one” (Goffman, 1963; pg. 3). Since 1963, the concept of stigma has been refined to take into considerations several challenges and developments. Link and Phelan (2001) summarize the transition in definition in their article and suggest that stigma has been defined to indicate –

- Contrariness to a norm of a social unit (Stafford and Scot, 1986) • Possession of a devalued social identity (Crocker, *et al.*, 1998) • A mark that links a person to undesirable characteristics (Jones, *et al.*, 1984)

Challenges to these concepts are –

- Social scientists who do not belong to stigmatized groups, study stigma and do so from the vantage point of theories that are uninformed by the lived experience of the people they study (Kleinman, *et al.*, 1995; Schneider, 1988)
- Studies have been with an individualistic focus – as elaborated by Oliver (1992), research has focused on perceptions of individuals and the consequences of such perceptions on micro-level interactions.

Therefore, stigma is being viewed more in terms of attributes or stereotypes in a person rather than discrimination. The stigma (or mark) is seen as something in the person rather than a designation or tag that others affix to the person. In this respect, the term stigma directs our attention differently than a term like “discrimination.” In contrast to “stigma,” “discrimination” focuses the attention of research on the producers of rejection and exclusion – those who do the discriminating – rather than on the people who are the recipients of these behaviors (Sayce, 1998).

Based on their analysis of the above challenges and conceptions of stigma, Link and Phelan (2001) define stigma in the convergence of interrelated components. Thus, they say that stigma exists, “when elements of labeling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them” (pg. 377). It can also be summarized as an adverse reaction to the perception of a negatively evaluated difference (Susman, 1994). According to this conceptualization of stigma, first culturally created categories arise taking the form of labels, which accentuate differences that are deemed to be important. For example, in the case of sex trafficking, labels such as ‘whore’, ‘fallen’ and ‘spoiled’ (*noshto*) become attached to the survivor, because she has been involved in sex work. Such labels indicate that she has certain attributes that are different from others of her age and gender. This is known as stereotyping, or linking a devalued social identity to a person. Therefore, a person is labeled and linked with a set of undesirable characteristics that form a stereotype. A survivor labeled as ‘spoiled’ is affixed with stereotypes of being sexually promiscuous, a bad influence on others, greedy, not concerned about family’s status in the society, *etc.* Once a person is labeled and stereotyped, the next process of stigmatization is separation of ‘us’ from ‘them’. Therefore, a survivor is no longer like her peers, but is irrevocably different from others, since now she embodies her labels. Such separation perhaps helps in being unreasonably cruel to the stigmatized, since now she cannot be like the rest of ‘us’. The impact of labeling, stereotyping and separation is most visible in the form of status loss and discrimination. Status loss refers to devaluation and downward placement of an individual in a social hierarchy. Discrimination

occurs at an individual level – where one behaves differently with the stigmatized person and at a structural level – where institutions and structures around the stigmatized person are so affected that it works to the disadvantage of the person.

It is important to note that these cultural stereotypes become culturally salient over time. Once in place, it can affect the labeled person in ways that do not involve obvious forms of discrimination. Thus, survivors who return home are not needed to be told by someone always that they are 'spoiled' or 'fallen', they know of such cultural labels applicable to women who are sexually promiscuous. Once in place, cultural stereotypes become a lay theory about what it means to be in sex work, a phenomenon known as 'stigma consciousness' – thus, a survivor begins expecting stigma that in itself is debilitating enough.

Finally, according to this conceptualization, it takes power to stigmatize. Almost everybody engages in stereotyping. We all make sense of the world and people around us by drawing generalizations, however, all of us do not stigmatize the people whom we consider different from us. Those who engage in such discrimination are the ones who have social, economic, cultural and political power to infuse negative consequences to such perceptions and beliefs. Therefore, a significant aspect of stigma is the presence of power difference.

TYPES OF STIGMA

Stigma takes on various forms. Based on our literature review, we have chosen to present the conceptual model by Pryor and Reeder (2011), which in itself is based on previous theories. This model is depicted in the following *Figure 1* and includes four dynamically inter-related manifestations of stigma –

Public stigma – is the core of the model and represents people's psychological and social reactions to someone they perceive to have a stigmatizing condition. It is a consensual understanding that a social attribute is devalued.

Self stigma – refers to the social and psychological impact of possessing a stigma and it includes both, the apprehension of being exposed to stigma and internalization of negative beliefs and feelings associated with the stigmatizing condition.

Stigma by association – refers to social and psychological reactions to people associated with a stigmatized person, as well as people's reactions to be associated with a stigmatized person, and

Structural stigma – refers to legitimization and perpetuation of a stigmatized status by society's institutions and ideological systems.

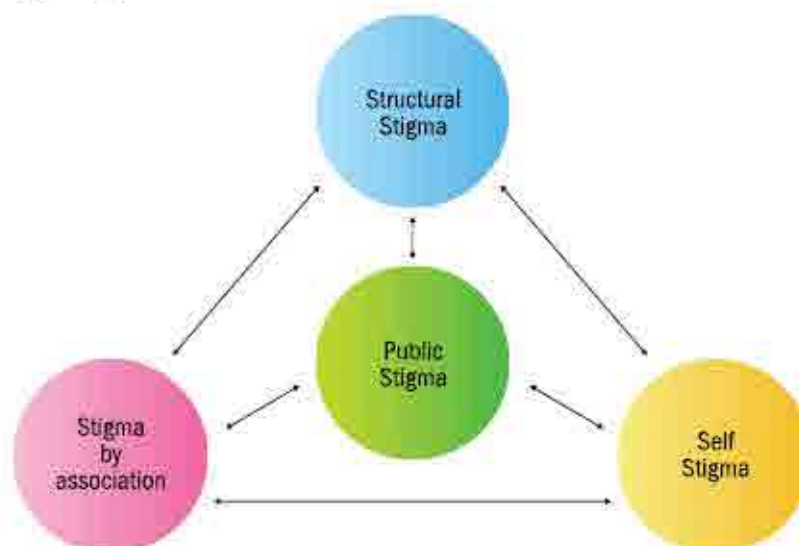


Figure 1 *Types of stigma model by Pryor and Reeder, 2011*

Public stigma impacts the self in three ways –

1. **Enacted Stigma** – This refers to the negative treatment of a person who possesses a stigmatized condition. One way of measuring this type of stigma is to ask about the experiences and negative reactions or actions by other people because of their stigmatized condition (ILEP, 2011).
2. **Anticipated Stigma** – refers to anticipation of stigmatizing experience by the person with a stigmatized condition. People with a stigmatized condition can fear that other people will react to them in a certain negative way. To avoid this negative reaction, people with a stigmatized condition may change their own behavior. For diseases that are concealable, such as HIV/AIDS, or conditions such as being a survivor of sex trafficking, this can manifest itself by choosing not to tell others about the condition that may set them apart (no self-disclosure). For diseases with visible manifestations, this can result in withdrawing from social interactions, such as avoiding places of worship and hiding in their own homes.
3. **Internalized Stigma** – refers to reduction of self worth and accompanying psychological distress experienced by people with a stigmatized condition. Feelings of fear, shame and guilt are commonly experienced as part of internalized stigma.

IMPACT OF STIGMA

Stigma has large and varied effects on people's life outcomes (Quinn and Chaudoir, 2009). Researchers have also stressed that stigma and its inter-relations with various aspects of self and society are complex and multi-layered. To attempt a linear correlation between variables is simplistic and incomplete. It is too simplistic to draw out how each type of stigma impacts an individual separately. That is to say that one will feel anxious when ridiculed, but depressed when afraid of being ridiculed. Such clear distinctions do not exist while understanding the impact of stigma on people's lives. Instead, a more cogent way of making sense of impact would be to identify various ways in which it changes a person's life when it is present.

IMPACT ON PSYCHOLOGICAL WELL-BEING

When a person experiences and anticipates stigma from others and becomes aware of one's own devalued status, it creates a stigma perception. Stigma perception has a powerful impact on people's psychological well-being, since the negative reactions they have experienced or anticipated, plus their own awareness of their devalued social identity contributes to creating negative assessment of oneself and symptoms of distress and social withdrawal (Berger, *et al.*, 2001; Miller and Major, 2000). Different studies have confirmed these facts since they have revealed that stigma perception is positively associated with depression, anxiety, hopelessness and loneliness (Berger, *et al.*, 2001; Bunn, *et al.*, 2007).

For mental illness, the effect of perceived stigma on psychological distress occurs over and above any positive effects of mental illness treatment and continues long after the initial labeling of a mental illness disorder (Link, Struening, Rahav, Phelan, & Nuttbrock, 1997; Markowitz, 1998).

IMPACT ON SELF

One way in which stigma affects self-concept is through labeling. Self-identity can be negatively affected by the labels associated with a particular condition. For example, in the case of mental illnesses – a label of schizophrenia is attached to a person when she is called schizophrenic. Which means that her identity is now defined by the diagnostic criteria of schizophrenia. When the person begins believing this label, she may inadvertently act in a way that endorses the label,

thereby firmly entrenching herself within something that is reductive. When this stigmatized identity becomes central to the self identity, it can cause much distress as studied by Quinn and Chaudoir (2009). That study showed that anticipated stigma, centrality (how central is the stigmatized identity to the self) and cultural stigma (culturally constructed levels of devaluation of stigmatized identities) each independently relate to greater psychological distress among people who live with concealable stigma. The authors stress that similar to identity threat, stigma has an insidious and undermining effect even in the absence of actual discrimination. According to them, the worry and concern about possible devaluation in itself can lead to negative outcomes. Their study showed that for people living with concealable stigma, centrality of stigmatized identity can render them vulnerable to distress. In other words, the more people think of their stigmatized identity, the more distressing the identity becomes. Cultural stigma, on the other hand, appeared to be directly impacting health well-being in the sense that people who possessed identities that were more culturally devalued, reported greater illness symptoms.

Impact of stigma on self is most directly observed in a person's self esteem and self-efficacy. People who agree with stigma and apply to it themselves may feel unworthy or unable to tackle the demands of life. Phelan, *et al.* (stigma as a barrier to recovery: the consequences of stigma for the self esteem of people with mental illnesses) found that stigma associated with mental illness harms the self-esteem of people who have serious mental illness.

IMPACT ON LIFE WITHIN SOCIETY

Stigma processes have a dramatic and probably under-recognized effect on the distribution of life chances such as employment opportunities, housing and access to medical care, write Link and Phelan in their article on Stigma and its public health implications, (2006). This is corroborated by Rosenfield and Neese-Tood who showed that specific domains of life – satisfaction with work, housing, health and finance were associated with self stigma as well as self-esteem. In a qualitative study of victims of trafficking in Albania, experienced difficulties in finding and keeping employment couldn't get reintegrated because of lack of money or jobs, experienced higher amount of violence than other vulnerable groups and rejection in society amounted to them being victimized twice (Marion, 2012). Amnesty International Ireland conducted research into the experience of discrimination as reported by people with mental health problems and found that 95.4% participants reported some level of unfair treatment as a result of mental health problems. More than 70% concealed their mental health problems from others. Three out of five stopped working. More than half stopped themselves from having a close relationship and more than 40% of people stopped themselves engaging in education.

There is evidence that despite the negative impact of stigma on a person's self-esteem, body image, life satisfaction, well-being and health, sometimes negative social perceptions may be rejected. A study of women with long-term mental illness found that these women did not accept negative social perceptions as relevant to them. They attributed it to deficiencies among those who stigmatized them and did not passively accept labels and negative identities placed upon them. These women avoided social interactions where they anticipated feeling different and excluded, formed new social groups in which they felt accepted and understood (Camp, Finlay and Lyons, 2002). This brings us to the concept of coping with stigma, or processes the underlie how stigmatized people deal with the negative outcomes of stigma – enacted, anticipated and internalized.

COPING WITH STIGMA

As a stigmatized person, living in the community can be extremely stressful since it creates huge

demands on resources to negotiate and adjust with negatively pre-disposed people and situations. Looking at stigma and reactions to it from a stress-coping framework (Miller and Kaiser, 2001), one can place stigmatization as a stress variable, while impact of stigma on well-being, status, participation as an outcome variable. It is well established that coping with stress can reduce or increase the effects of adverse situations on psychological well-being and health (Lazarus and Folkman, 1984). Coping with stigma can be viewed as a mediating variable that has an impact on the way stigmatization affects the stigmatized and it can clarify partial reasons for variations in stigma reactions in different survivors.

A theoretical model of coping

For the present study, we have followed Miller and Kaiser's (2001) adaptation of Compas *et al.*'s (2001) model of coping, which is empirically coherent and according to Miller and Kaiser, fits the way people deal with stigma in their lives. The model is represented in Figure 2.

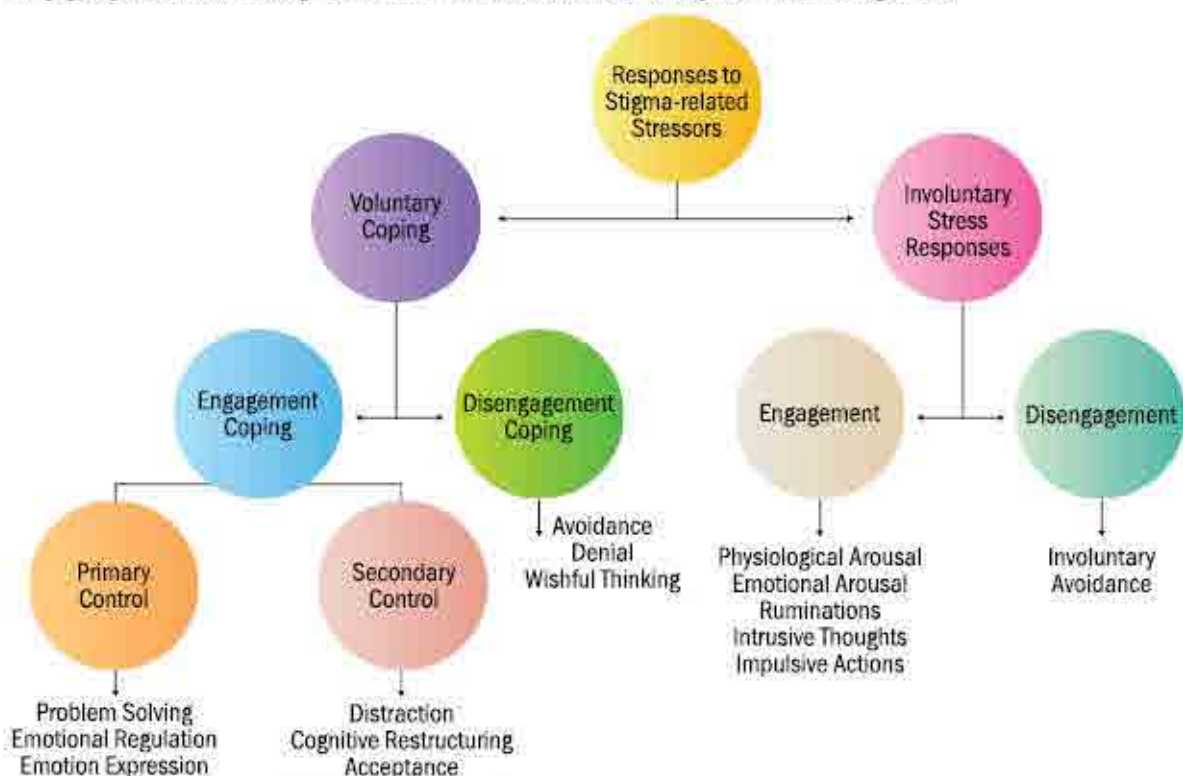


Figure 2 Coping with stigma model adapted by Miller and Kaiser

According to this model, stress responses can be divided into voluntary coping responses and involuntary stress reactions. This means that not every reaction to stress constitutes coping. Coping behaviors are only those that are volitional. Such behavior can be divided into two styles – engagement and disengagement styles. Even involuntary stress responses can be divided in the same way. Engagement is akin to ‘fight’ responses and disengagement is similar to ‘flight’ responses. Voluntary efforts of coping can be further divided in terms of control: primary control aims at gaining control over the stressor and one’s reactions while secondary control aims to control the way one feels about the situation. The basic assumption of this model is that people make several responses to stress, some are coping responses, while some are involuntary cognitive, behavioral and emotional responses. Though responses have been categorized in the model, there can be overlaps and the categories are useful for theoretical understanding primarily.

Ways in which people cope with stigma

Engagement Coping – primary control and secondary control type behavior

A lot of research work has been conducted in studying secondary control coping with stigma in which people try to adapt to stigma rather than confront or change the situation. Distraction is one of the most common secondary control type behaviors in which one adapts by engaging in some other activity that takes their mind away from stress created by stigma. Studies have shown that it effectively prevents ruminative thinking and intrusive thoughts (Nolen-Hoeksema and Morrow, 1993), which is linked with negative psychological outcomes. This implies that stigmatized people may be better off distracting their thoughts than suppressing them. Cognitive restructuring is another form of adapting to the situation, rather than changing the situation, which is useful when the situation cannot be controlled. It has been linked with better outcome in stress-coping literature and forms the basis of cognitive-behavioral techniques (Gottlieb, 1997 as cited in Miller and Kaiser, 2001). According to a review of coping with stigma by Crocker *et al.*, 1998, stigmatized people cope by reframing their thoughts through self-protective attributions and changing the value they place on domains in which their group fares poorly. Studies show that secondary control type coping behaviors are adaptive, especially when stressors cannot be controlled (Kohn, 1996).

Engagement coping styles (primary)

- Problem solving
- Emotion regulation
- Emotion expression
- Emotional arousal
- Rumination

Engagement coping styles (secondary)

- Distraction
- Cognitive restructuring
- Acceptance

Primary control type engagement coping is characterized by behavior aimed at controlling the situation or one's reaction to the situation. The most common way in which stigmatized people exert primary control over prejudice and discrimination is through individual or collective action (Wright *et al.*, 1990 as cited in Miller and Kaiser, 2001). Another method is through compensation by disconfirming stereotypes by behaving in a socially skilful manner that goes contrary to prejudices against a stigmatized group identity.

Gaining primary control over self and situation will also involve emotion regulation (controlling anger, anxiety and fear) as well as emotional expression (sharing feelings of dissatisfaction and grief). Though there is a focus of collectivizing stigmatized people to form groups that can engage in activism for advocacy of rights, there is evidence that suggests that whether a stigmatized person will respond individually or collectively to oppression will depend on whether prejudice and discrimination are perceived as group level or individual level stressors (Wright *et al.*, 1990 as cited in Miller and Kaiser, 2001). There may be situations where individual coping responses of compensation and emotion regulation may clash with group ideology, if that is of overt rejection of prejudices. According to Miller and Kaiser (2001), problem solving techniques used by stigmatized people have been understudied, though generally they are related to adaptation.

Disengagement style coping

Two main forms of disengagement coping are social and physical avoidance of stigmatizing situations and denial or minimization of prejudice and discrimination. Interestingly, avoidance may be a starting point for other forms of coping – in studies conducted by Cohen and Swim, 1995 and Pinel, 1999, women who expected to be stigmatized and who were low in self-confidence avoided stigmatizing situations and they also sought prejudice-free alternatives. Similarly, in Camp, Finlay and Lyons' (2002) study, women with long-term mental illness not just avoided social interactions where they anticipated feeling stigmatized and excluded, they also

formed social groups in which they felt accepted and understood. Though it has its short-term benefits, avoidance in the long-term may prove to be detrimental. For example, being enmeshed in a group and avoiding out-group comparison in which one avoids comparison to how they fare against non-stigmatized people, may lead to maintaining the status quo and not challenging one's devalued status (Miller and Kaiser, 2001). Another way of disengaging with stigmatizing conditions and people is by denying the existence of discrimination. The belief that other people behave discriminately makes a stigmatized person feel they are not socially accepted, and in order to avoid such unsettling perceptions, one might deny the presence of discrimination and even engage in wishful thinking in order to minimize the effects of prejudice.

Overall, disengagement style coping has been well-studied and largely related to negative outcomes – psychological distress and physical effects, though Miller and Kaiser stress that it would be impossible to not use this form of coping, especially in situations where there is little hope for change or where there is nothing to gain.

Involuntary responses to stigma-related stress

Involuntary responses to stigma may include physiological arousal such as heightened blood pressure, emotional arousal such as feeling anxious and cognitive arousal in the form of unbridled thoughts by ruminating about stigmatizing conditions, confirming stereotypes, anticipating stigma and intrusive thoughts on experiences of stigma. Impulsive acts can also be a form of involuntary reactions. These are engaged forms of involuntary stress reactions, as they engage with the stigma, for example ruminating means engaging with the stressful stimuli by means of continuous thinking. However, any disengaged form of involuntary stigma can be a type of avoidance that occurs at a pre-attentional level as observed by Mogg, Bradley and Hallowell, 1994 (as cited in Miller and Kaiser, 2001). Thus, stigmatized people who can successfully tune-out daily slights and hassles that arise from prejudice may be better able to maintain equilibrium in the face of stigma (Miller and Kaiser, 2001).

STIGMA INTERVENTIONS

Batson, *et al.*, (1997) conducted three experiments that demonstrated that feeling empathy towards a member of a stigmatized group can improve attitudes towards the whole group.

The 3 stigmatized groups studied were people living with HIV/AIDS, homeless people and convicted murderers.

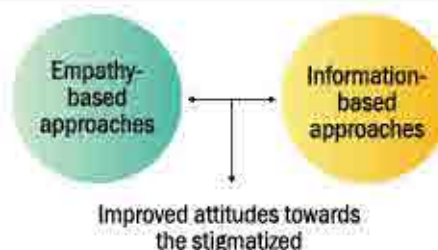


The results held true for men as well as women and regardless of whether the person for whom empathy was induced, was or was not held responsible for her/his plight. The study had two very compelling conceptual implications:

1. It was possible to evoke empathy for a victim who was responsible for her/his own plight if the empathy induction occurred before participants learned about the victim's responsibility and

2. Positive empathetic feelings induced towards an individual stigmatized group member generalized towards the group as a whole.

Therefore, interventions that aim to use an empathy-based approach along with an information-based approach may have higher chances of successfully improving attitudes towards the marginalised



However, despite such studies, actual interventions in the field do not reflect synthesis between research and action.

A review of interventions for reducing stigma of people living with HIV/AIDS (PLWHA) in 2001 conducted by Brown, Trujillo and Macintyre for Population Council Inc. showed that though eliminating stigma may be unrealistic, reduction is possible by using a variety of strategies – information, counseling, coping skills acquisition and contact. The review identified a lack of studies on long-term impact of intervention on stigma reduction; therefore, whatever reduction is achieved by intervention, seems to suggest that stigma can be reduced at least in short-term and short scale. Inducing empathy by direct contact with PLWHA to reduce stigma was not found in any interventions in developing countries, though this strategy has been found to be successful in the United States. The review also showed that relatively few interventions to reduce AIDS stigma were being conducted or were perhaps, not being rigorously evaluated, documented and published in developing countries. In fact, authors were surprised to find only one truly national level campaign against AIDS in India.

A review of stigma related to substance use disorder showed that self-stigma can be reduced through therapeutic interventions such as group-based acceptance and commitment therapy. Effective strategies for addressing social stigma include motivational interviewing and communicating positive stories of people with substance use disorders. For changing stigma at a structural level, contact-based training and education programs targeting medical students and professionals (*e.g.* police, counselors) are effective (Livingston, Milne, Fang and Amari, 2012).

In another review of interventions to reduce stigma related to depression, anxiety and suicide, Reavley and Jorm (2013) found sufficient evidence of effectiveness of psycho-education and school-based interventions to reduce stigmatizing attitudes of peers. Their review revealed significant gaps in knowledge in research on stigma intervention in the field of depression, anxiety and suicide prevention.

Link and Phelan (2001) suggest that one needs to focus on two principles in considering how to change stigma. The first is that any approach **must be multi-faceted and multi-level** – that is it should address the various mechanisms that lead to disadvantaged outcomes and it should address it at both individual and structural levels. The second is that an approach to change **must address the fundamental cause of stigma** – either by changing deeply held attitudes and beliefs of power groups that lead to cultural acceptance of stigma or change circumstances that limit the power of such groups to make their beliefs the dominant ones.

Overall, the literature suggests that interventions for reduction of stigma lack sound theory and methodology and it is recommended that interventions identify specific areas in which change is being targeted – public stigma, self stigma, stigma by association or structural stigma and include appropriate measures to evaluate these components. One will also need to establish what works best at all levels of intervention be it intra-personal, inter-personal, community or institutional levels (Bos, Pryor and Reeder, 2013).

The review of literature therefore, suggests that –

- 1. Stigma affects a person in multiple ways, and the mechanisms are complex.** Various socially disadvantageous factors can be reasons for stigma, instead of just one. Therefore, stigma towards a particular condition is always replete with interaction effects between that particular stigmatizing condition and other factors that place the stigmatized person in a less powerful situation. For example, it would be very difficult to say whether the reactions of people is purely towards a person having HIV/AIDS or because the person has HIV/AIDS and is a woman, is poor, belongs to a backward class and has been abandoned by her husband. Therefore, as Link and Phelan (2001) caution, studies on stigma must accept that a full assessment of the impact of stigma on such an outcome must recognize that many stigmatizing circumstances contribute to that outcome and not just the one selected for the particular study in question. However, the one selected for study plays a major role in sanctioning negative behavior that otherwise could have remained implicit or less dominant.
- 2. Stigma impacts different people in different ways or, in other words, there is individual difference in stigma impact.** There are several reasons that can underlie such individual differences in outcome, one of which could be the way one voluntarily copes with stigma and the way one involuntarily reacts to stress of stigma. Such coping mechanisms vary in their effectiveness and adaptability, which depends on various factors, such as the cultural context in which coping is occurring, the nature of stigma and the stigmatizing condition. However, the presence of coping shows that the stigmatized is not a passive victim, who is always acted upon, rather the stigmatized has ways of resisting stigma. These ways of dealing with stigma need to be studied and its correlation with positive and negative outcomes measured to identify protective and vulnerability factors.
- 3. Stigma interventions lack systematic evaluation and documentation because of which it appears that there aren't many interventions to combat stigma.** Such interventions need to take into account the multi-faceted and multi-level nature of stigma – that is stigma is of different forms and that it is individual and structural. Interventions also need to be empathy inducing in nature, instead of just being information driven.

RATIONALE

The present study emerged out of two types of needs – one from direct field experiences and the other from the literature review present before this section. Direct experience was a result of an ongoing practice that was in place in North 24-Parganas till 2014. In that year, there was a gap in intervention due to completion of a project and lack of funds. In this gap of around 9 months, three survivors committed suicide. This was a jolt to the practice team as well as Sanjog, as it demanded urgent introspection into what could have led to such drastic actions. It eventually became clear that something was missing in the program and its interventions. The gap during which no interventions or case work was performed seemed to have revealed a lack of anti-stigma component in the program. The assumption that case work in which each social worker followed up rehabilitation needs of around 5 to 7 survivors was proved to be not enough to counter-act the

impact of stigma. Moreover, during a discussion with survivors, they asked why Sanjog was so shocked about the conditions leading to suicides. This gave us an impression that survivors were dealing with far more stigma and distress than what was apparent through the case work data. Since there was already an ongoing program on health rights of survivors funded by Anesvad, the component of stigma needed to be assessed rapidly and with very restricted and specific objectives of identifying the nature of stigma and its impact. This couldn't be treated as a separate project in itself, as there was not enough data to build large scale and long-term intervention. The phenomenon of stigma by itself had been encountered in a previous study – '*Bringing it all back home*' by Sanjog, in 2014 but its components had not been delineated.

'*Bringing it all back home*' revealed the conditions in which survivors lived after their return home. The findings of that study set the direction for the present study. The need to learn more about stigma in the lives of survivors and develop an anti-stigma intervention was felt because:

1. Rehabilitation of survivors of sex trafficking after they returned home to their communities is challenged due to shaming and blaming from the community. The experiences of ridicule, abuse, discrimination and humiliation make it difficult for them to recover from the trauma of their experiences and places further pressure on their ability to cope. Stigma after return is present and debilitating.
2. Stigma emanates from the family, community and service providers; thus, it is present in the entire eco-system of a survivor. The presence and expectation of stigma makes it more difficult for survivors to disclose their identity or to share their problems – engagements that will necessitate disclosure.
3. Stigma and shame prevents survivors from accessing services as they do not like disclosing their past and hence, avoid asking for help in which they would have to explain why they need help or why they are eligible for services meant for survivors of sex trafficking.
4. As a result of stigma and pre-occupation with disclosure, girls are married off as soon as possible, or they are taken to traditional healers when they feel sick or uneasy. This leads to domestic violence, when their husbands or in-laws find out about their past and health suffers due to lack of proper treatment. There is high level of anxiety, depression, low mood and sexual and reproductive health problems among survivors that remain largely untreated.

Thus, it was increasingly clear that an anti-stigma intervention for survivors of sex trafficking who returned back to their families in their community, was extremely necessary. The health impact of their traumatic experiences was being exacerbated by the presence of stigma and was quite alarming and required a well-founded intervention. In order to do so, it was important to measure levels of stigma, identify the nature of stigma, and glean some data to give direction to the intervention. Hence, the study was conceived to answer the following questions.

Chapter Two

METHODOLOGY

STUDY DESIGN

The study framework was mixed method design with the main aim of exploring extent of stigma and identifying stigmatizers in the lives of survivors of sex trafficking living in North 24-Parganas in West Bengal. By mixed method, we meant that both qualitative and quantitative tools of data collection were used to collect data to best suit our research purpose and questions.

The goal of this research was to develop an anti-stigma intervention enabling survivors to manage the intensity of different types of stigma that they experienced in their daily lives. The anti-stigma intervention was also expected to enable survivors while they negotiated social interactions in the most positive manner, to reduce the intensity of harmful stigmatizers in their ecosystem (family, community and institutions).

The ontological assumption was that stigma was a subjective experience, which could be measured on the basis of how the respondents (survivors and social workers) reported their perceptions, experiences, thoughts and feelings in response to the interview questions. Therefore, epistemologically, the valid 'truth' being sought in this framework was a social

construction that did not require objective consensus for its validity. In that sense, there were no verifying mechanisms of either direct observation or data collected from other stakeholders to test the veracity of experiences reported by the participants. Based on this study design and the research questions, the objectives of the study were as follows:

RESEARCH QUESTIONS

1. What were the main types of stigma that survivors experienced?

Stigma has different forms. The study was interested in identifying the nature of stigma experienced by survivors. The type of difficulties they faced, the feelings it generated, the importance such stigmatizing behavior had in their lives were a part of the question.

2. What was the impact of stigma on survivors?

We were aware that stigma made it difficult for them to disclose their identity and access services, however, now we were interested in measuring all the areas in which they faced that difficulty and how important was the difficulty arising as a result of stigma in their lives.

3. How do survivors cope

with stigma?

Given the fact that stigma was present for all and yet several survivors appeared to be resilient and functioning effectively, the natural question was to ask how did they cope.

4. Who were the stigmatizers?

We were aware that stigma emanated in family, community and institutions, however, we knew very little about the stigmatizers, their relationship with the survivors, possible power dynamics and chances of resolution therein.

5. How did social workers understand stigma?

The change agents who were expected to operationalize an anti-stigma intervention were the community-based social workers. These social workers belonged to the same community that stigmatized. So the question was, how did they perceive the nature of stigma experienced by survivors and what were some of their own innate attitudes towards survivors of sex trafficking.

OBJECTIVES

1. To identify the type and nature of stigma impinging on survivors of sex trafficking after they are reintegrated.

Through this objective, the study aimed to map the frequency and intensity of enacted, perceived and internalized stigma. Knowing this would enable us to design a relevant intervention that can help build skills that can tackle the issues in a hierarchical manner. This could ensure that the intervention did not assume that the researcher and interventionist knew what was most painful or difficult for the survivor, instead the aim was to let the survivors inform us of what was most painful and difficult for them.

2. To identify who are the stigmatizers within the family, community and organizational levels and analyse their relationship with the most stigmatizing person from these three contexts.

Knowing who stigmatizes the most in the primary, secondary and tertiary levels of the ecosystem surrounding a survivor will be important while designing a community-level anti-stigma program. However, the underlying relationship dynamics between the survivor and the most stigmatizing agents in her primary, secondary and tertiary ecosystem will be more relevant in terms of the real reasons why such stigma perpetuates. Insights from this were expected to be useful while designing interventions to develop a survivor's skills in dealing with inter-personal stigma with such stigmatizers. It was assumed that knowing the nuances of the relationship a survivor shared with the most stigmatizing agents would reveal the power dynamics that lay at the root of stigma.

3. To understand the impact of stigma on survivors.

This would reveal the ways in which stigma affected a survivor's life. Having a clear idea of the myriad ways in which stigma impinged on their lives would help focus the goals of intervention. For example, one of the most apparent impacts of stigma is loss of access to resources. However, such impaired access can have varying levels of intensity, or negative meaning in a survivor's life. We intended to identify this negative valence of the different ways in which stigma strained a survivor's life chances, again in order to make the intervention as meaningful and effective as possible.

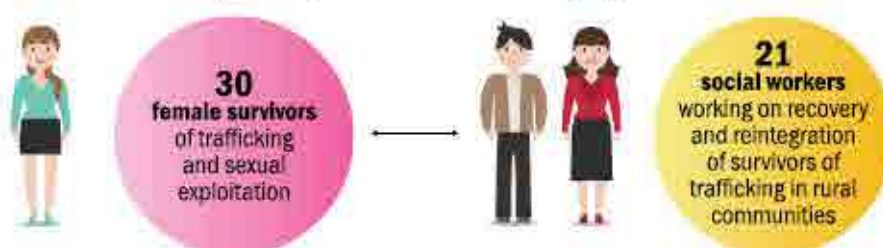
4. To understand existing coping mechanisms used by survivors to deal with stigma.

Survivors coped with stigma in the best possible way they could, though it may not be the most effective way. However, in order to develop an intervention that enabled them to deal with stigma, it was important to know how they were dealing with it by themselves. Only culturally salient methods could be built in the intervention to make its application successful. Therefore, knowing existing coping mechanisms would help in gaining insight into emic ways of dealing with stigma. Moreover, the tacit assumption was that coping mediates the way stigma affects a person. Positive coping techniques, by that logic, would increase the chances of reducing the intensity of stigma and its impact. Also knowing what came naturally to survivors in certain situations and customizing such natural reactions to best suit their own interests, would be important from the health goals of the intervention.

5. Identifying innate attitudes related to stigma present in social workers dealing with survivors of sex trafficking.

Community-based social workers are a part of the social milieu where the stigma manifests itself and also belong to the social order that perpetuates stigma. However, the very nature

of their profession demands having a positive attitude and repressing their culturally salient ways of reacting to the phenomenon of prostitution. Despite their explicit positive beliefs, it was possible that there were innate stereotypes present that could be making it difficult for them to be optimally efficient. The aim of identifying such innate and prejudicial attitudes in social workers was to include inferences drawn from there into the training program for social workers. Such insights could also be used in the professional development for social workers and in creating a care-giver stress resistance program in future.



PARTICIPANTS

Survivors: 30 female survivors of sex trafficking from 16 blocks of North 24-Parganas.

Sampling:

The universe of survivors was not known. However, there was a list of 107 survivors living in North 24-Parganas with the community-based organizations working in the field of anti-trafficking. It would have been ideal to interview as many survivors till nothing new emerged with respect to the objectives, known as theoretical sampling. But given the paucity of time and resources, it was decided to do a random selection of 30 survivors who consented to participate in the study and conduct interviews with them.

Therefore, all the 107 survivors were sent an invitation to participate in the research. Out of 107, only 45 consented. Which means that 58% survivors did not consent to participate in this research for various reasons. Finally, 30 survivors were selected in a randomized manner and consent letters explaining their rights during the research and the nature of research and nature of their participation were sent to these 30.

Profile of survivors:

The age of survivors ranged from 15 years to 25 years, with the mean age of the sample being 19 years ($SD = 2.85$). Out of 30, 14 girls were unmarried (47%) and 16 girls were married (53%). Out of the 16 girls who were married, 10 had been abandoned and only 5 were still married and lived with their husbands, while one was widowed (she was included in the married population, for further analysis). Only one survivor had a complicated marital set-up as she lived with her parents and her husband visited her from time to time. She identified herself as separated; hence, she was considered so in the analysis.

Assumptions about the survivor sample:

1. That all of the 30 had been rescued from sex work, since this was a research on survivors of sex trafficking – the survivors were contacted through NGOs providing services to survivors of sex trafficking who had returned home.
2. That all had been trafficked – cases of migration where the woman chooses to enter sex work were assumed not to be present in this sample – it is very difficult to verify whether a girl was rescued from a brothel where she had been taken by force after that girl returned home. It is possible that some survivors may have tried to escape vulnerabilities present at home and entered sex work and then later, been rescued and returned back home. How does one verify

this and what is the value of such verification in a study on stigma? If stigmatizing behavior was based on facts surrounding a girl's disappearance, it would have become non-existent.

3. That all had been in bondage and servitude when they were rescued, the assumption is that none were working on their own will, and that they were all being made to do sex work out of bondage.
4. That they may have been either rescued by police raids or they may have arranged their own rescue, either with the help of a client, or by running away or in any other means – this was not verified, either because again such information is not a part of the conceptualization of stigma and how it occurs.

Social workers: 21 who were from community-based organizations and had experience of case management of survivors of sex trafficking in North 24-Parganas.

Sampling:

These social workers were the ones who would eventually be trained to use anti-stigma interventions with survivors. Therefore, they were selected in total to measure their perceptions of stigma experienced by survivors and to measure their own innate attitudes towards survivors.

Profile of social workers:

The sample of social workers was mixed and included 6 female social workers and 15 male social workers with varied years of experience in working with survivors of trafficking. All the social workers except for one, had participated in a series of training programs conducted by Sanjog.

TOOLS OF DATA COLLECTION

1. Rating scales to measure Enacted, Anticipated/Perceived and Internalized stigma for survivors:

Three Likert type scales were prepared to measure frequency and intensity of enacted, anticipated/perceived and internalized stigma in survivors of sex trafficking. The scale measuring enacted stigma was adapted for survivors of sex trafficking from Berger HIV stigma scale (Berger, Ferrans and Lashley, 2001 and Working Report Measuring HIV Stigma: Results of a Field Test in Tanzania, USAID, 2005). The anticipated/perceived scale was contextually adapted from Exploratory Model Interview Catalogue Stigma Scale for Affected People, while the internalized stigma scale was adapted from the Internalized Stigma of Mental Illness Scale. Slight changes were made in the rating pattern since we were interested in both frequency and intensity of stigma. The responses ranged from 1 (never), 2 (sometimes) and 3 (always) to measure frequency and if the answer was 2 or 3 they were asked to indicate how intense the problem was by rating it on 1 (no problem), 2 (small problem), 3 (medium problem) and 4 (large problem). Two other response categories were also provided in case they felt it was not applicable marked as 0 and no answer marked as blank. High sum scores indicated high frequency and high intensity of that particular form of stigma. This was administered in the form of a structured interview.

2. Participation Scale version 6, 2012 to measure Impact of Stigma:

This was an 18 item interview-based instrument to measure perceived problems in major life domains. The scale allowed quantification of participation restrictions experienced by people affected by stigmatizing conditions. The initial work on development of this scale was undertaken in Nepal. It covers 8 out of 9 major life domains defined in the International Classification of Functioning, Disability and Health (ICF) published by WHO, 2001. Most

of the questions asked the respondent to compare herself with an actual or hypothetical peer; someone who she perceives is similar to her except for the stigmatizing condition. Two levels of responses were elicited. The first level provided 5 options – not specified, sometimes, no and irrelevant. If ‘yes’ or ‘sometimes’ on the first level, then the second level problem assessment over 4 options – no problem (1), small problem (2), medium problem (3) and large problem (5) was done. A high sum score indicated high levels of participation restriction. Cut-off score was found to be 12 for several different countries. Since we also collected data from social workers to measure their perception of impact of stigma on survivors, the wordings of the instrument were changed and it was administered as a self-reporting questionnaire for social workers. According to the manual, a score between 0-12 indicated no significant restriction, 13-22 indicated mild restriction, 23-32 indicated moderate restriction, 33-52 indicated severe restriction and 53-90 indicated extreme restriction.

3. Coping with stigma interview schedule:

This interview schedule listed 10 possible coping mechanisms (avoidance, denial, distraction, attributions, distraction, acceptance, problem solving, emotional arousal and regulation, rumination, emotional expression) with stigma based on the theoretical model of coping with stigma by Compas, *et al.*, 2001 (as cited in Miller and Kaiser, 2001). Survivors were asked to indicate which coping technique they used. The response categories were 1 – strongly agree, 2 – agree, 3 – undecided, 4 – disagree, 5 – strongly disagree. Respondents were also asked to describe, with examples, which coping mechanism they used to deal with most frequently and intensely experienced enacted, anticipated and internalized forms of stigma.

4. Distance and relation with stigmatizers interview schedule:

The aim of this tool was to identify the most stigmatizing person in a survivor’s family (primary context), community (secondary context) and institutions (tertiary context). For this, the survivor was asked to list the three most stigmatizing persons in each context and then rank them.

The tool also aimed to identify the relationship between the survivor and stigmatizer on four domains – nature of stigma, attributions, stigma by association and power to stigmatize. An open-ended interview schedule was used to elicit responses on these domains by asking the survivor to answer keeping in mind the most stigmatizing person in each context separately.

5. Innate attitude of social workers:

This tool was prepared to measure attitudes that were not in the conscious realm of mind. Paucity of time and technique led us to attempt this through a paper-pencil test instead of the commonly used computer-based Implicit Association Test (Greenwald *et al.*, 1998)⁴. Based on theoretical underpinnings of public stigma explained in Bos *et al.*, (2013) four perceptual lenses explaining public reactions to a stigmatizer person were identified as – perceived onset controllability, perceived dangerousness, perceived severity and perceived norm violation. A total of 12 items (3 items per domain) were drawn up to measure these four types of perceptual lens through which people view survivors. Each item was constructed in such a way that it could be applicable to either or all of the four stigmatized groups – people with mental illness, people with leprosy, people with HIV/AIDS and survivors of sex trafficking. Respondents were asked to rate each of the items on the basis of its applicability to each of the four stigmatized groups by using numbers 1 to 4, showing descending order of applicability (1 = very applicable and 4 = least applicable). They were given only 10 minutes to complete the rating, in order to control the tendency to think and answer and in expectation of eliciting the most innate response. The ratings were totalled for each of the perceptual lens domains and item-wise mean

⁴See Fazio, H.R. and Olson, M. A., 2003, Implicit Measures in Social Cognition Research: Their meaning and use, in *Annu. Rev. Psychol.*, 54 (297-327) for a detailed discussion on various measures.

ratings were calculated for responses marked under ‘survivors of sex trafficking’. Percentage of 1 and 2 ratings were also calculated to give us an idea of applicability to survivors of sex trafficking.

6. Focus group discussions to understand implicit stigma:

Focus group discussions were held with social workers in two groups comprising of 10 and 11 members. These discussions followed a guideline with an intention of understanding their attitudes towards survivors of sex trafficking, better. The discussions revolved around what they considered an easy to manage case and what they considered a difficult to manage case. Indicators of such cases were drawn out during analysis. The FGDs also probed into their responses on the Innate Attitude Scale – their mean scores on each of the four perceptual lens domains were discussed. This led to several interesting explanations and findings. FGD data were analysed qualitatively to support and better explain the findings of Innate Attitude Scale.

METHOD OF DATA COLLECTION

Ideally, as mentioned earlier, it would have been best to visit as many survivors as possible till a theoretical saturation was reached. However, paucity of time and resources and urgency of completing this study necessitated bringing the survivors out of their community and in a common space. The data was, therefore collected from survivors by inviting them to Kolkata. The total sample was divided into two groups. Each group stayed in Kolkata on designated days (two consecutive days) and participated in the research. Data was collected over a period of four days.

Though contrary to regular and ideal practice, this methodology had its advantages as it provided the survivors a relatively similar space for participation. Often, interviews conducted in homes have been affected by the presence of parents, neighbors, peers and other people from the community in close vicinity, at times even within the same room. In such situations, conducting an interview on stigma may yield very little data. Such interferences were ruled out by having the survivors come to Kolkata.

Each of the two data collection phases began with an overview to the research and the role of participants in it. Then each survivor was interviewed by a single interviewer in private. Three to four such interviews were held simultaneously in the four corners of a large hall by trained interviewers. The rest of the survivors were asked to relax and interact with each other. The survivors who completed their interviews were asked to spend time in a separate room, in order to avoid internal discussion and sharing of response between those who had been interviewed and those who were yet to be interviewed.

Social workers, who also accompanied the survivors during the two-day workshops, were asked to fill out the questionnaires in a separate space. For the Innate Attitude Scale, a researcher was present to instruct them on rating method and to time their response. The FGDs were conducted on the second day of data collection and was moderated by two of the researchers. These were recorded and later transcribed.

LIMITATIONS

- 1. Overemphasis on the context at the cost of the individual** – A common methodological issue of process-oriented studies; this refers to the lack of representativeness of the pre-determined number of sample. However, as mentioned earlier, since this is a mixed methods study, qualitative data collected from each of the 30 respondents will ensure some degree of person-based data to emerge and be meaningful in the analysis.
- 2. Limited generalizability** – Since this is essentially an exploratory study aiming to document

the nature/type of stigma, its impact and coping responses to it by survivors of sex trafficking, the purpose is not that of generalizing the results to a large population. In fact individual psychotherapy designs personal intervention plans for each individual. However, given the nature of research questions, the study will definitely give indicators of stigma towards survivors of sex trafficking, especially in the context of West Bengal.

- 3. Subjective data** – The debate between subjective and objective data will remain unresolved with this study as it relies on memory of stigma and even on perceived stigma, for which there is no objective test. However, the study aims to understand experience of stigma in the words of survivors and epistemologically condones subjective interpretive data. The interest is not in ‘discovering’ an objective ‘reality’ out there, but it is in understanding the ‘reality constructed’ by the respondent within the research set-up, assuming that this construction is what motivates the survivor to be what she is.
- 4. Cross-sectional data** – This is not a longitudinal study nor does it have a longitudinal design which limits its ability to capture the process of stigma as it unfolds over time. It takes a slice of life approach to present stigma and its impact in the same point in time. As an exploratory study, this is a valid limitation and a longitudinal study would be best suited for an explanation of how stigma affects survivors over time and its impact therein.
- 5. Biased data** – The survivors were expected to travel to Kolkata, accompanied by social workers and stay over for two days. In a cultural and social context of a survivor of sex trafficking, where we had assumed that there was presence of stigma, psychological distress and restricted mobility, it led to selection of a biased sample. This methodology only captured stigma experienced by survivors who were relatively more mobile and enjoyed enough support from family or with enough self-confidence to participate. This limitation had implications on the inferences drawn from the data. It was also a concern raised by social workers in one of the dissemination workshops. This was an unintended bias, but yet one that has impacted all our interpretations and one that needs to be considered by any reader of this research. The sample can act as a yardstick or representation of such survivors who were ‘allowed’ or who themselves agreed to participate in this research, that required an overnight stay in Kolkata. Meaning that the inferences drawn from this data may be more severe for a significant percentage of survivors who had much greater mobility or other restrictions and at the same time, the inference would be much less severe for survivors who had gained autonomy and were the elusive rehabilitated ones. Moreover, the demographic profile of this sample was complex enough to provide a mélange of variables such as religion, marriage, age, time since rescue, nature of exploitation, pre-trafficking vulnerabilities, health impact of trauma, and so on. It was assumed that their varied contexts were inconsequential to the stigma they experienced as a theoretical whole.
- 6. Non-standardized instruments** – The questionnaires constructed for this study were not standardized, nor were they pilot-tested due to paucity of time. Therefore, some questions appeared to be irrelevant once data collection began and some questions did not make the same sense when translated in Bengali. It is highly recommended to do a reliability and validity testing of the tools used in this study in case a research aims at generalizing the findings. Even without, it is important the scales and schedules are reviewed and edited based on responses from participants and researchers, observations.
- 7. Lack of resources – time and money**
The present study was conducted in a quasi lab setting, by inviting survivors to Kolkata and collecting data from them in a controlled environment instead of visiting them in their communities and collecting a more grounded data. This is due to lack of resources and paucity of time. The study was designed with a very limited and restricted budget and only a rapid assessment was possible in the given circumstances.

ETHICAL CONSIDERATIONS

- 1. Tool construction** – All the tools were constructed keeping in mind the sensitivity of the areas being probed through the questions. Though the tools were validated only by the research team comprising of three mental health professionals, since they were adapted from well documented and widely used instruments in stigma research, it was considered to be safe.
- 2. Informed consent** – All the survivors who participated in this research were given all information on their roles and responsibilities. Consent was taken from them and their parents/guardians.
- 3. Voluntary participation** – The participation of survivors and social workers was voluntary. They had the right to withdraw from participation or refuse to answer any question as per their will. This was clearly explained to each participant before each interview.
- 4. Confidentiality** – All data collected was coded and no personal data was discussed in the report or shared with anyone outside the research team. Confidentiality and its meanings were also explained to the participants before every interview and also before anything was audio recorded.
- 5. Debriefing** – Each of the two data collection phases ended with a debrief session in which participants were encouraged to voice their experiences, difficulties and feelings during the data collection process.
- 6. Dissemination** – Once the initial results were analysed, the trends and findings were disseminated with survivors and social workers separately. This was done to ensure that the participants had a chance to review the way the researchers had understood their responses and clarify or suggest changes in case of discrepancy in what they said and what was interpreted.

DATA ANALYSIS

Quantitative data obtained through scales and questionnaires was analysed by using Microsoft Excel software. Since the purpose of the study was exploratory and the sample was selected purposively, we did not perform any parametric tests. Descriptive statistics were restricted to calculating percentage of response and means where applicable. The sample size and nature of sample selection was not fit for further tests to compare means. Moreover, the study was not designed in such a way to compare groups based on independent variables.

Qualitative data obtained during interviews and FGDs was analysed at three levels. The first level was done by the principal investigator, by open and axial coding and the second was done by co-construction by all the researchers discussing the interpretations with an aim of adding richness and reducing subjective bias. Finally, the third level of analysis included the respondents – social workers and survivors. The findings and interpretations were presented to the groups separately and their response to the interpretations was also factored in the final inferences. While presenting the findings, both qualitative and quantitative analysis were fused together, to develop a nuanced description of data.

The inferences presented at the end of the report should not be confused with inferential statistics. These are theoretical inferences and do not intend to imply any causal inference drawn from the sample about the population. The study is limited in its generalizability which, as explained in the rationale, was never its purpose. Inferences drawn from the data were based on analysis and theory building. In this, the study provides the first categories of variables that appear to be important and that can be then taken up for further research aimed at identifying moderating and mediating effects of variables.

Chapter Three

RESULTS AND TRENDS – SURVIVORS

TYPE AND NATURE OF STIGMA

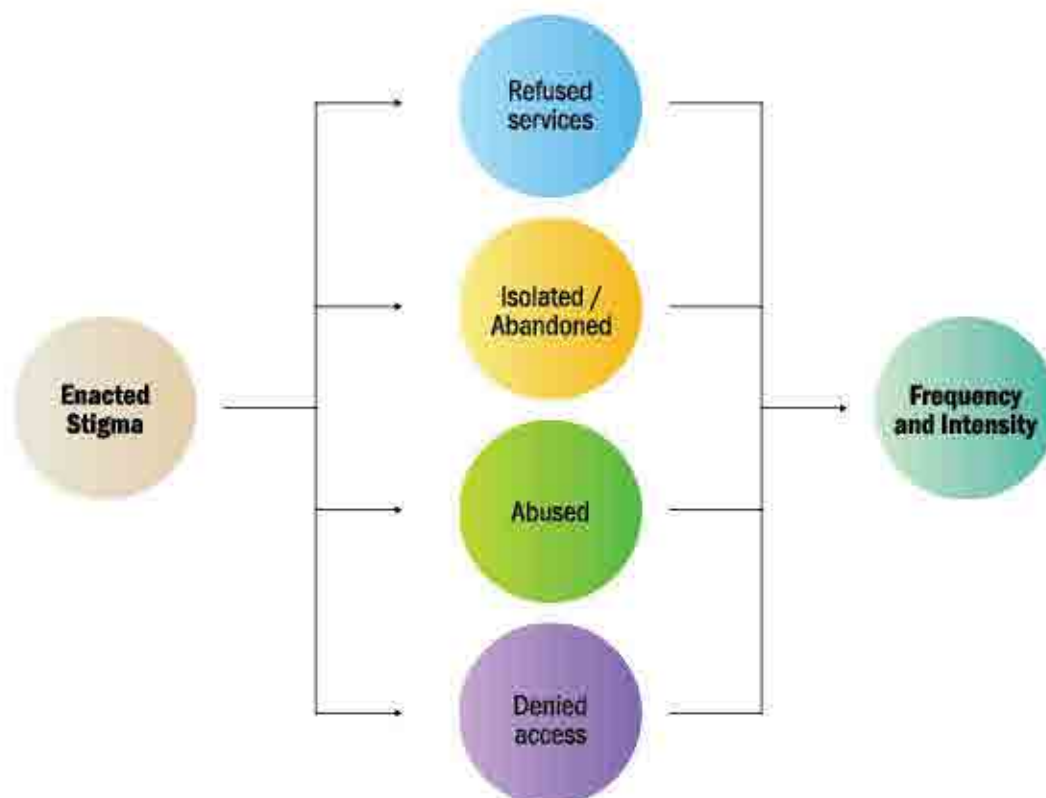
Three types of stigma were studied – enacted, anticipated and internalized. The nature of stigma was measured in terms of how frequently they experienced it and the intensity of distress it caused them. Descriptive statistics for each of the three stigmas are presented next. Frequency

was measured in terms of whether a particular form of stigma was experienced – never, sometimes or always (frequency). While, if the response was either sometimes or always, intensity was measured in terms of whether it was not a problem, a small problem, a medium problem or a large problem (intensity).

Enacted stigma

Frequency of enacted stigma

Enacted stigma was operationalized as stigmatizing behavior of other people that was observed in instances where the survivor was refused certain services, isolated, abandoned, abused and denied access to opportunities of various kinds.



There were four items measuring whether survivors were refused services in the areas of – health, education, *Panchayat* and religion. Results showed that 30%

survivors reported that they experienced refusal of services from *Panchayat* always. On an average, 15% survivors always experienced refusal of services, while 5%

experienced it sometimes. On the other hand, 53% survivors reported that they never experienced refusal of services. In fact, 73% survivors reported that they

never experienced refusal of medical services. The higher percentage of survivors reporting that they never experienced refusal of services needs to be interpreted keeping in mind that very few survivors actually try to access these services. In our scale, we had a response category of 'not applicable' and around 47% survivors reported that the question of 'refusal of service on education' was not applicable to them. Similarly, about 27% survivors reported refusal of service by *Panchayat* was not applicable to them. Only 7% survivors reported that refusal of medical services was not applicable to them. It appears that those who reported 'not applicable' are those who never tried to access the service, then it would follow that very few survivors tried to access educational services after they returned and almost all survivors accessed medical services. It needs to be mentioned that quality of service was not enquired on in this question.

Around 60% survivors reported that their families were isolated (sometimes, or always) because of them. While 52% survivors reported that they were isolated in social gatherings (sometimes, or always). On an average, 37% survivors always experienced isolation of self and family.

Isolation is closely associated with abandonment. About 57% survivors reported that their friends cut off relationships (sometimes, or always) when they found out about their trafficking experience. This occurs usually because parents of other girls do not allow their daughters to interact with the stigmatized survivor and, at times, other peers also reflect society's stigmatizing attitudes in their behavior. The stigma is mostly spurred by fear of stigma by association and fear of contamination. While 40% survivors reported that their paternal and marital families abandoned them after their trafficking experience as they asked them to leave the house. This was reflected in responses on paternal family such as, '*when others say bad words, my mother says you shouldn't have come back*', or, '*my father brought me back, but now he often says you have ruined me*'. There was evidence of possible violence in marital families in responses such as, '*they were so bad, they used to beat me so much, that I had to come away*'.

Such abandonment is usually preceded by gradual decline of relationships taking the form of abuse. More than 70% survivors reported that others sometimes, or always, used bad words at them (83%), found character flaws (80%), ridiculed them (76%) and ignored their positive points (70%). Around 66% also reported they were unnecessarily scolded and 43% reported being beaten as well. If we assume that these experiences occurred both outside as well as within their homes, it shows the nature of decline in their social relationships. Not being appreciated and always being scolded without any reason could be the starting point of feeling abandoned by their families. About 27% reported they had experienced some form of sexual abuse as well. On an average, therefore, about 37% survivors always experienced abuse from others after they returned to their homes.

The nature of abuse is further qualified in the following qualitative responses –

"my brother would beat me if I asked for some money"

"my brothers and sisters-in-law always scold me"

"they look at me in a way that makes me uncomfortable"

"was beaten in marital home; elder brother has beaten her since she returned"

"bad girl (baajemey), dirty girl (nongramey), how do you show your face, better you die..."

Box 1 Experiences of abuse

Enacted stigma has a very strong impact on a survivor's ability to access opportunities in different areas of life such as recreation, hobbies, social and religious participation, nutrition, health, employment and education. On an average, about 20% survivors were always denied access to these opportunities. The most commonly denied opportunity was with respect to recreation. About 43% survivors, sometimes or always, couldn't access recreational opportunities. Recreation is closely related to social relationships in a rural set-up. Usually, girls hang out with other girls or women of the neighborhood. High levels of ridicule and bad words being used against the survivors and experiencing abandonment from friends, could be resulting in loss of access to recreational activities. It also appeared that survivors had very little opportunity for developing any romantic relationships, even when they wished to. This got reflected in a response: *"I feel like meeting other men... I don't have a husband also... but they will beat me if I do that. I want to, but do not have any opportunity"*. About 33% survivors also reported that they were denied access to participate in social and religious events.

Overall, enacted stigma impacted a survivor's social life immensely. The impact was most visible in terms of various forms of abuse from others, which were most likely related to their feelings of abandonment, isolation and took the form of being denied access to interact with others for recreation. Areas of health, education and employment do not seem to be affected by enacted stigma, though these are areas that survivors require maximum support. Interestingly, these are areas that require interaction with a tertiary eco-system – service providers based in institutions. It could mean that survivors have very little direct interaction with duty bearers and service providers at the tertiary level, thus experiencing very little rejection or stigma from this group of people. What has emerged, is their experience of enacted stigma from their primary context – family, and secondary context – community.

Intensity of enacted stigma

Table 1 Mean scores of types of enacted stigma

	Forms of Enacted Stigma				
	Refusal of Services	Isolation	Abandonment	Abuse	Denial of Access
Intensity	.725	2.03	1.66	2.323	.93

A higher mean score on the intensity scale would indicate greater distress caused by enacted stigma. Table 3.1 shows that most distressing forms of enacted stigma were – abuse (M=2.32) and isolation (M=2.03).

When survivors were subjected to bad words and teasing, it caused them most distress (M=3.26). The other two forms of abuse causing high distress were when people always found flaws in their character (M=3.03) and when their good points were ignored (M=2.8). Out of the 8 survivors who reported having experienced some form of sexual harassment (boys leching at them, following them and more that remained unqualified), all the 8 reported feeling extreme amount of distress (percentage of '4' response was 100). Out of the survivors who experienced ridicule from others, 95% reported feeling extremely distressed (response '4') on such occasions. Similarly, 95% of those who experienced it, were extremely distressed when ridiculed by others because of being trafficked.

Survivors felt equally distressed on being isolated in social gatherings and also when others

isolated their families because of them (M=2.03). Out of the 16 survivors who reported being isolated in social gatherings, 81% felt extremely distressed and out of the 18 survivors who reported that others isolated their families, 76% felt extremely distressed.

Across other forms of enacted stigma, the ones in which almost all survivors reported feeling extremely distressed on experiencing it were – being refused religious services (100%), refused access to education (100%) and being abandoned by their paternal family (91%).

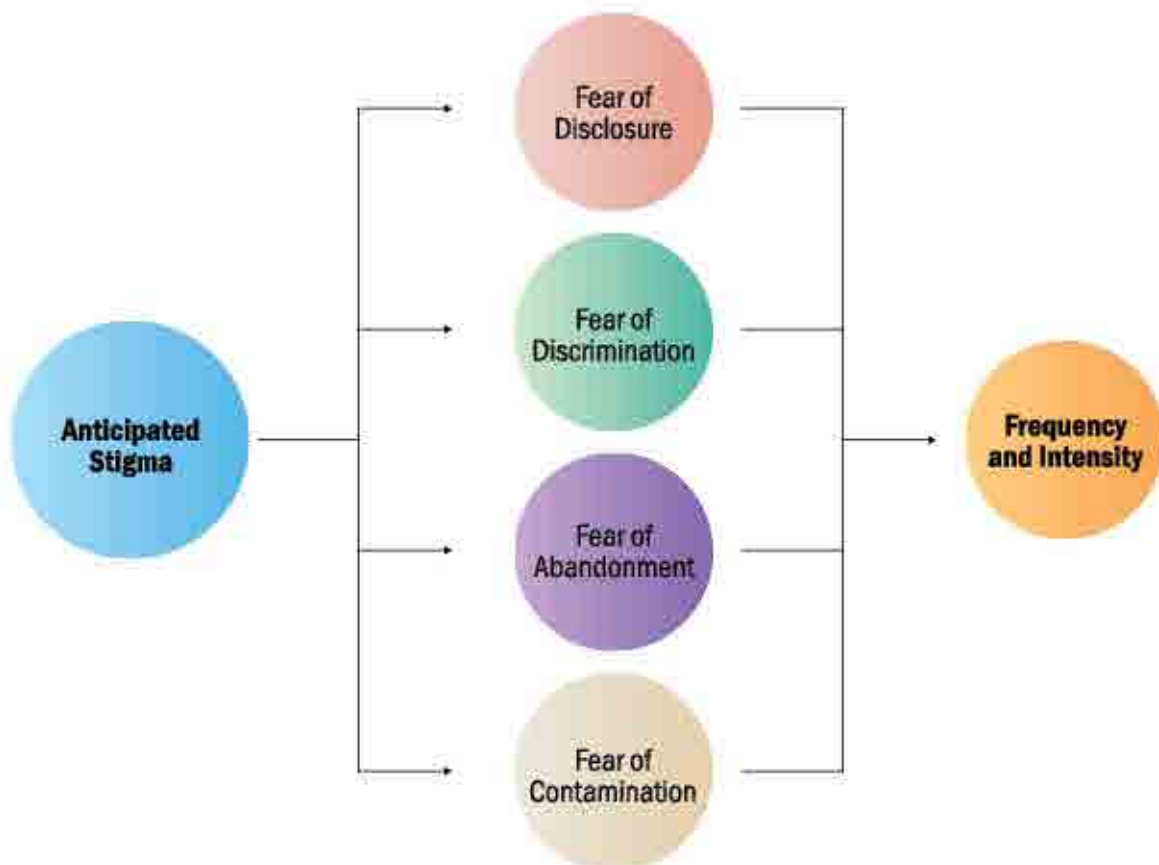
Therefore, discriminatory behavior in the form of abuse, isolation, abandonment by own family, refusal of access to education and religious services were the most distressing forms of enacted stigma experienced by survivors.

Anticipated stigma

Frequency of experiencing anticipated stigma

Anticipated stigma develops as a result of direct experience of enacted stigma and, at times, from secondary stigma – hearing about others' stigmatizing experience. As a result of anticipated stigma, a person, with a stigmatizing condition, comes to expect and perceive stigma even in the absence of actual events. This, therefore, takes the form of fear of stigma and is debilitating as it restricts a person's ability to be fully functional.

In the present study, anticipated stigma was operationalized in terms of fear of disclosure, fear of discrimination, fear of abandonment and fear of contamination.



Some of the responses by survivors given during the interviews illustrate the nature of anticipated stigma better. Please see *Box 2*.

"They will somehow get to know and then this will be repeated."

"I feel very very ashamed and scared."

"There is no chance of me getting married anymore."

"I keep feeling that others will taunt me, say something - may be they won't but I just imagine that they will."

Box 2 Qualitative data on anticipated stigma

Disclosure of one's trafficking experience is a very sensitive event. Most survivors try to hide their experiences and very few share it with people who are close to them. At times, experiences after sharing or disclosure shapes their ability to disclose to a wider number of people. Around 63% of survivors reported that they believed their stigma would be lower if less people knew about their experience. Similarly, 60% survivors reported that they would share it with somebody close. On average, 43% survivors reported fear of disclosure. Fear of disclosure arises out of concern over people's reaction to their identities. In societies that are rigid about their norms, fear of disclosure will tend to be higher as compared to societies that are permissive and more accepting of differences within its members. Also, survivors are aware of the stereotypes attached to sex work in their communities, hence they would prefer not to disclose their experiences to avoid devaluation and labels attached with sex work.

Fear of discrimination was measured by asking survivors how often (never, sometimes, always) they thought they would be subjected to various forms of discriminatory behavior such as – treated differently by service provider, be ridiculed, considered a bad influence, wouldn't be allowed to be carefree, would be subject of gossip, *etc.* About 83% survivors reported they feared (sometimes, or always) others would gossip about them and think they were different from the rest if they found out. About 80% survivors also feared (sometimes, or always) that they would not be allowed to move around freely if others found out about their trafficking experience. On average, 69% of survivors feared being discriminated if others found out about their experience. This fear is probably because of their actual experiences of discrimination as reflected in their experiences of enacted stigma.

Fear of abandonment was closely related to fear of being discriminated, as it indicated (in a way) an outcome of being discriminated. About 69% survivors believed that if others found out about their trafficking experience, they would be avoided by them – isolated and eventually abandoned by people who found out. Similarly, 67% survivors believed that if their marital family found out about their past, they would send them back, while 57% believed that their husbands would leave them if they knew. On average, 64% survivors feared being abandoned by others if they found out.

Finally, being afraid of causing stigma to others who associated with them was measured under the category of fear of contamination. Majority (80%) of survivors believed (sometimes, or always) that 'others who were close to them faced difficulties because of the stigma associated with them'. In other words, almost all survivors feared that their closest ones were contaminated by stigma associated with them. About 57% survivors reported that their families would be directly affected as they might be avoided/isolated by others in the society and they might be discriminated by service providers. This finding resonates with findings presented above that

showed that about 60% survivors reported that their families were isolated because of them. Therefore, on average, almost 65% survivors experienced fear of contamination.

Intensity of anticipated stigma

Table 2 Mean scores of types of anticipated stigma

Forms of Anticipated Stigma				
	Disclosure	Discrimination	Abandonment	Contamination
Intensity	2	2.48	2.4	2.4

Almost all the four forms of anticipated stigma caused similar levels of distress. Fear of being discriminated caused the highest levels of distress. Out of those who experienced fear of being discriminated, almost 90% reported feeling extremely distressed (response category '4') when they thought that others would consider them to be different from the rest of the society. About 85% survivors reported feeling extremely distressed when they thought about the difficulties they would face in getting married.

Fear of being abandoned by husband (89% marked '4') and by marital family (85% marked '4') caused extreme distress under the category of fear of being abandoned.

While around 74% survivors experienced extreme distress when thought they had to keep their experiences and identities a secret. About 65% survivors experienced extreme distress when they thought of their families being affected on account of stigma by association.

Therefore, what we observed in terms of intensity of anticipated stigma was that distress caused by anticipated stigma was extremely personal. Fears about oneself being negatively judged by others, including her husband and marital family, caused a lot of unhappiness and was considered a 'large' problem. Distress caused by fear of stigma by association caused relatively lesser distress. We can assume that anticipated stigma that is related to actual enacted stigma causes greater distress, as was the case in fear of discrimination and abandonment. If actual events occur that corroborate a person's negative expectations, then such expectations will tend to be maintained over time and even become resistant to change in the face of positive events. Anticipated stigma has been related to poor psychological well-being (Quinn and Chaudoir, 2009) and it has also been related to lower access of services when in need of it (Earnshaw and Quinn, 2012). Thus, the reason why a lot of survivors do not access services could be because they anticipate discrimination from service providers. Fear of discrimination from *Panchayat* based on personal experience or perceptions therefore, could be restricting them from accessing any services from them. Moreover, survivors might even not feel motivated to seek help, new relationships or opportunities for work because of their anticipation of discriminatory behavior from others.

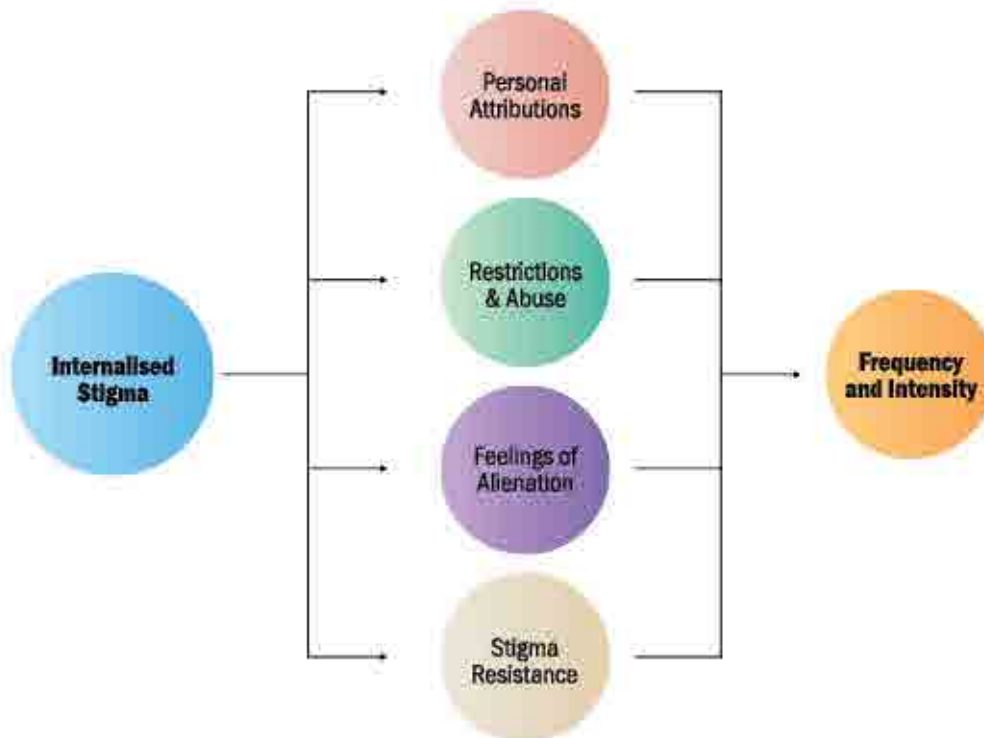
Internalized stigma

Frequency of internalized stigma

When stigma occurs through discriminatory behavior and prejudicial attitudes of others and when one develops a generalized expectation of stigma, it can also lead to changes in the way one perceives one's self. Just as our identities develop as a result of social construction, based on others' opinion and feedback, a stigmatized identity formation takes place when people around us tell us we are different from them, in a negative, deviant manner and we start believing them.

This identity formation is a result of internalizing stigmatizing beliefs of self or by endorsing stereotypes formed by stigmatizers.

We measured internalized stigma as stereotype endorsement of beliefs on personal attributions, restrictions and abuse, feelings of alienation and stigma resistance.



Some of the responses during the interviews given in *Box 3* illustrate how internalized stigma gets entrenched in a survivor's mind.

"Sometimes I feel maybe it's true."

"When others say it, then I believe it - especially my mother."

"May be I am bad, that's why they don't mix with me."

"I am always anxious about what will people say - I love going out but I can't."

"I want to be happy, did, but it will never happen"

"He will (beat) and I think it is natural that finally he will throw me out."

Box 3 Qualitative response on internalized stigma

Very often, one hears a service provider claim that the girl who is greedy and wants to earn more money leaves home and gets trafficked (Sanjog, 2014). Implicit in this theory is that the girl is responsible for being trafficked, her greed, ambition, over-confidence are to be blamed. Often in public discourse, the fact that a trafficker plays the most important role in the process of trafficking gets overshadowed by concerns over a girl's digressions from normative behavior. These stereotypes are transmitted to the survivor in the form of direct and indirect ridicule and admonishments. We tried to measure the frequency with which such thoughts of stereotypical personal attributions entered a survivor's mind. The results showed that the most frequently

occurring stereotypical thought on personal attribution was that after their experience of being trafficked, they were morally corrupt. About 43% survivors felt this way 'always' and 10% felt it 'sometimes' – therefore, a little more than half of the respondents thought they were morally corrupt as a result of their trafficking experience. About 43% survivors, sometimes or always thought that they were responsible for being trafficked and one-third survivors agreed with all the negative things others said about them. Contrastingly, only 6% survivors thought they were a bad influence on others.

Stereotypical restrictions are also present in the form of not allowing a survivor to be like other girls of her age – restricting her recreational activities, restricting her ability to be happy and restricting her from visiting religious places. Our results showed that 80% girls sometimes or always thought that they couldn't be as carefree as their peers. Similarly, 53% survivors (sometimes, or always) thought that they couldn't expect to be happy anymore. Very few, 20% girls (sometimes, or always) thought that they couldn't visit places of worship anymore.

Stereotypical abuse can take the form of beatings, ridiculing, discrimination by service providers and throwing her out of the house. Results showed that survivors rejected internalizing abusive behavior. Most of them did not accept such thoughts – around 80% survivors reported that it was never alright if they were beaten and mistreated by their husbands or sent back by their marital families or mistreated by service providers because of their trafficking experience. Similarly, about 73% survivors reported that it was never alright to be beaten, ridiculed and not taken seriously because of their trafficking experience.

Alienation, or the feeling that one is alone and different from others, with very little support, can occur when one begins internalizing the shame of being trafficked. It can lead to feeling worthless, ashamed, disappointed, and inferior and resigning to a fatalistic way of explaining discriminatory behavior meted out by others. Results showed that almost 80% survivors (sometimes, or always) felt disappointed with themselves because of being trafficked. Similarly, 76% survivors felt ashamed or embarrassed in social gatherings and 72% survivors felt they were inferior to others because they were trafficked. About 66% survivors felt that they couldn't be loved by anyone because they had been trafficked.

Finally, it is possible that survivors develop or internalize beliefs that are opposite to what a stigmatizing society wants them to believe. In such cases, they would try to resist stigma by building certain positive self-concepts as a result of their overall experiences. We called this stigma resistance and measured it as being able to live as one pleases, feeling stronger and confident, believing that she has rights to be happy and enjoy her life like others and believing that she was trafficked because the trafficker cheated and exploited her. Results showed that almost all survivors (97%) sometimes, or always felt that they were trafficked because the trafficker cheated them and exploited their trust. Similarly, 80% survivors felt that they had all rights to be happy and enjoy life like others. About 60% survivors reported that they felt stronger and more confident because of their experiences and 57% reported they were able to live life the way they wanted to.

Findings on frequency of internalized stigma showed that survivors were not passively accepting and internalizing others' stigmatizing behaviors or thoughts. They were able to reject any internalization of abusive behavior and they were also able to carve out stigma-resistant beliefs of self, despite their experiences and fears. On the other hand, despite such positive trends, survivors were becoming more and more alienated from others. Most of them were disappointed

in themselves and felt alone and ashamed. There was a definite disconnect between the survivor and her eco-system. There seemed to be an evolution of a self-concept that allowed co-existence of a morally depraved self alongside a self that had all rights to be happy and enjoy life. A self that was not like the peers – carefree; a self that was disappointed and ashamed, but yet stronger and confident.

Table 3 Mean scores of types of internalized stigma

	Forms of Internalized Stigma				
	Personal Attributions	Restrictions	Abuse	Alienation	Stigma
Intensity	1.42	1.63	.85	2.44	1.3

Feeling alienated was related to feelings of distress among all other forms of internalized stigma (Table 3.3). A mean of 2.44 showed that overall, the survivors who reported feeling alienated also reported extreme distress upon feeling that way. Out of the 23 survivors who reported that they felt 'ashamed or embarrassed in social gatherings because of her trafficking experience', 78% of them also reported feeling extreme distress on feeling that way (response of '4'). Similarly, from those who reported feeling disappointed in themselves, and those who believed they deserved the bad behavior of other people, 75% reported extreme distress on feeling that way.

Apart from this, out of the 16 survivors who felt that their experience had left them 'morally corrupt' (somebody who had transgressed the moral boundaries set by society and was now unlikely to fit into the normative expectations set by society), about 88% reported feeling extremely distressed because of this. About 76% of survivors out of the 12 who reported feeling responsible for being trafficked, also reported extreme distress when they felt that way.

More than 80% survivors also reported extreme distress on account of condoning abusive behavior by their husbands and service providers.

Similarly, about 75% of survivors felt extreme distress when they thought they did not have all the rights to be happy and enjoy their lives like others.

Therefore, what emerged is a pattern of guilt and shame that was causing extreme levels of distress in survivors who internalized these feelings. It appeared that the pattern of internalization that caused most distress was whenever survivors took responsibility for their trafficking, by feeling that they were not as good as their peers, that they were to be blamed and hence, were not in any position to expect happiness but were destined for bad behavior from people (both from family and from institutions; therefore, primary as well as tertiary contexts). Such self-blame also led to feelings of embarrassment and shame in social situations, implying that it could be causing them harm in forming new relationships or stopping them from nurturing social connections.

Marriage and stigma

Often, it has been observed that parents and survivors believe that getting married would end a lot of their social isolation (Sanjog, 2014). Once the girl is rescued and returns to her family, the family begins its preparations to ensure that she is married off before disclosure occurs or before neighbors and the community begin stigmatizing the family and the girl. However, things do not move so fast and often survivors are married after several alliances are broken by neighbors interfering and informing the boy's family about the survivor's sexually deprecated status.

The hypothesis we tried to test here was whether marriage really had an impact on the nature

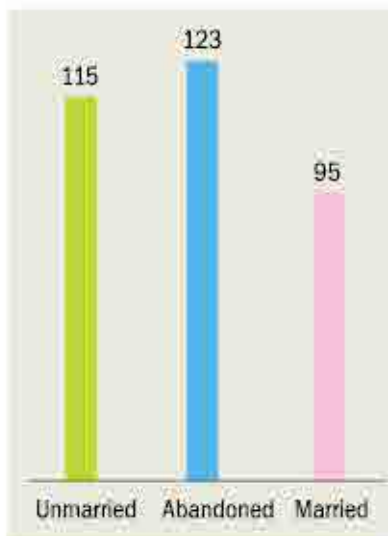


Figure 3 Comparison of stigma as a function of marriage

trends –

1. Distress due to anticipated stigma was the highest in all three groups.
2. The intensity of enacted and anticipated stigma increased considerably for abandoned survivors; which means that they experienced high levels of distress due to their enacted and anticipated stigma.
3. Unmarried survivors experienced greater distress due to anticipated stigma than enacted or internalized.
4. Married survivors experienced lowest distress due to enacted stigma and very low distress due to internalized stigma.
5. Generally, distress due to internalized stigma was lower than frequency of experiencing internalized stigma. While overall distress scores were higher than frequency scores for the abandoned group, the trend was reversed for the married group, who reported more frequency of stigma, but lower corresponding distress.

Table 4 Mean scores of intensity of stigma with frequency in parentheses

	Enacted	Anticipated	Internalized	Total
Unmarried	37 (37)	47 (42)	30 (36)	114 (115)
Abandoned	50 (43)	55 (43)	35 (37)	140 (123)
Married	15 (25)	38 (35)	25 (35)	78 (95)

Marriage, therefore, appears to be an important theme in the lives of survivors. It also appears to be a variable that seems to have an impact on the way stigma touches their lives. The difference in distress levels between the groups and within the three types of stigma give an indication that married survivors seem to have some protective influences that reduce the distress of enacted stigma and internalized stigma. High levels of anticipated stigma in all the three groups predict poor psychological well-being and difficulties in forming new relationships, which will need further qualification through qualitative studies.

of stigma experienced by survivors. Did married survivors experience greater stigma or lower stigma than unmarried survivors?

Based on the sample's marital status information, we divided them in three groups – married, unmarried and abandoned (the assumptions were that if they had replied 'sometimes' or 'never' to a question on being abandoned by their marital family, it would indicate abandonment being the reason for separation). The *Figure 3* shows that survivors who were married and then abandoned by their husbands faced maximum amount of stigma. However, married survivors not abandoned by their husbands, included those who were married and living with their husbands and one whose husband had died, fared much better than unmarried survivors and abandoned survivors.

In order to understand the nature of difference in experience of stigma, we compared the intensity of these three types of stigma as shown in *Table 4*. We found several interesting

IMPACT OF STIGMA ON PARTICIPATION

Restriction on participation was measured by using a standardized scale called the P-Scale in short. The developers of this scale have defined participation as a person's involvement and participation in wider aspects and areas of daily community living or life situations. Problems experienced in participating in any of these 'life situations' which are fairly common to every person regardless of their health, gender, age or caste, is referred to as 'participation restriction' (P-Scale Manual, v.6.0). This scale is especially useful for identifying rehabilitation needs. The total score can range between 0 and 90. In the study sample with which the scale was originally constructed, the cut-off score was 12, as 95% of control group scored 12 or less. We shall use 12 as the cut-off for this study, though a normative study would be best to determine a contextually relevant cut-off score.

Table 5 Levels of participation restriction

	Score ranges	Interpretation	Survivors
1	0-12	No significant restriction	26.7
2	13-22	Mild restriction	10
3	23-32	Moderate restriction	16.7
4	33-52	Severe restriction	30
5	53-90	Extreme restriction	16.7



Figure 4 Levels of participation restriction (responses in percentage)

About 73% survivors scored above the cut-off of 12, indicating an urgent need for an anti-stigma rehabilitation. Five survivors scored in the highest restrictions category, with scores ranging between 53 and 90. They reported extremely high levels of distress on facing restrictions, especially in mobility and social interaction areas. This group of high restriction survivors also reported extreme distress when they felt they were not respected as much as their peers in the community.

Compared to them there were 8 survivors who were in the 'no restrictions' level scoring between 0 and 12. The survivors in the highest participation restriction group reported restrictions in all 16 items of the scale, while those in the no restriction group indicated only two areas that caused them distress.

The no restriction group experienced some restrictions, but the nature of these restrictions was very different from that of the high restriction group. While the higher restriction groups experienced severe distress due to curtailed mobility, recreation opportunities, limited social interaction and not feeling respected, the no restriction group reported restrictions in finding employment and opportunities to contribute economically to their families.

If one were to consider the P-Scale as being an instrument to identify rehabilitation needs, the findings showed variation in rehabilitation needs of survivors at different stages. It can be speculated that survivors who experience greater stigma do not consider employment and education as distressing areas, rather for them social relationships, mobility, not feeling devalued would make more sense, at least in the beginning of any anti-stigma intervention. However, this scale also showed that survivors have different needs. Therefore, those who are showing 'no restrictions' would probably find very little meaning and value in an intervention designed for the

'highest restriction group'. In that sense, this finding can increase specificity and sensitivity of interventions.

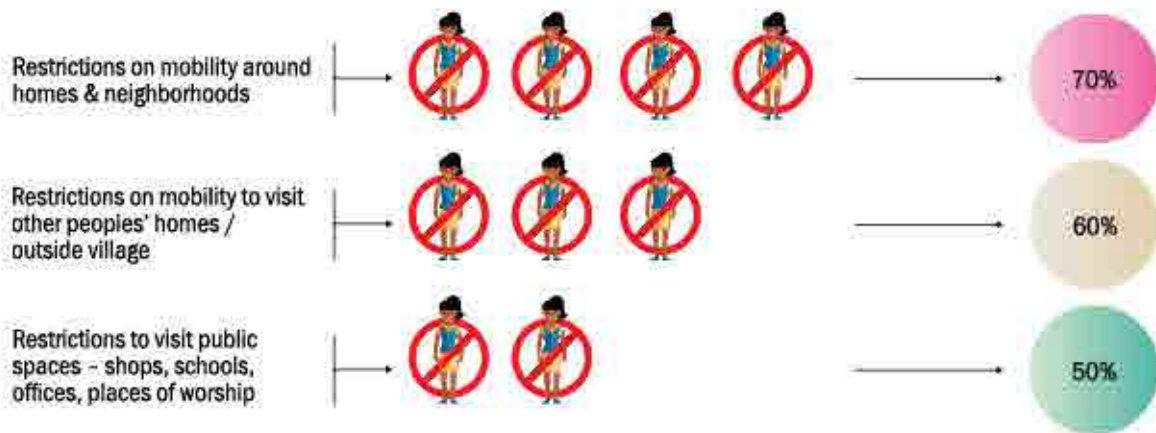
Frequency of restrictions

Overall, the P-Scale could be divided into broad life domains – work and education participation, mobility restrictions, loss of status, social and individual activities and growth related to restrictions.

Table 6 Participation restriction in different life domains

	Mobility	Social and Individual	Status Loss	Work and Employment	Growth
Average % Reporting Restriction	59%	51%	47%	34%	28% (65%)

The most frequently experienced restrictions were those on mobility of a survivor. Overall, 59% survivors experienced some form of mobility restriction – sometimes, or always. About 70% reported they could not move around their homes and neighborhoods, like their peers. Around 60% reported they couldn't visit other people in the community or travel outside their villages. Less than 50% survivors reported that they couldn't visit public places such as shops, schools, offices and places of worship, as their peers.



The next category was that of taking part in social and individual pursuits such as attending major festivals, being socially active, participating in recreational activities and engaging in self-care. Overall, a little more than half of the survivors reported they (sometimes, or always) couldn't participate in these activities. About 60% reported they couldn't participate in major festivals and rituals and 57% reported they were not as active as their peers. About 47% survivors reported they couldn't participate in recreational activities as their peers and 40% reported they couldn't take care of themselves.

Overall, 47% survivors reported a loss in status or devaluation as compared to their peers. However, 77% survivors reported that they were not as respected as their peers in the community. Within their homes, 70% survivors could participate in household chores and 43% could participate in family discussions.

About 34% survivors reported that they experienced difficulties in participating in income generation or educational pursuits. Around 47% survivors reported they did not have equal opportunities to find work and 33% survivors reported they couldn't contribute to their household income as their peers. Only 23% survivors reported they did not get equal opportunity to study.

Experiencing growth or positive outcomes despite restrictions was measured by asking survivors if they felt comfortable meeting new people or they felt confident in trying out new things. These items also measured their preparedness to participate, if given an opportunity. Interestingly, only 28% survivors overall reported they did not feel any positive growth, whereas 65% reported feeling confident and comfortable. About 83% survivors reported they felt confident in trying out new things and 50% survivors reported they felt comfortable meeting new people.

These findings showed that restriction on participation among survivors of sex trafficking was primarily in mobility. This restriction was similar within and outside the house. It is possible that as a result of this restriction and in conjunction with feeling devalued and disrespected, survivors did not or could not participate in social activities. Loss of status was primarily felt in the community; while within their homes, the levels of participation was quite high – indicating that stigma was enforced more outside the home. The most revealing finding was that of ‘personal belief’ – most survivors were prepared to participate and engage in ‘life situations’ and felt confident.

Intensity of restrictions

Table 7 Mean of distress scores as a function of participation restrictions

	Mobility	Social and Individual	Status Loss	Work and Employment	Growth
Average Score	2.42	2.2	1.83	1.42	1

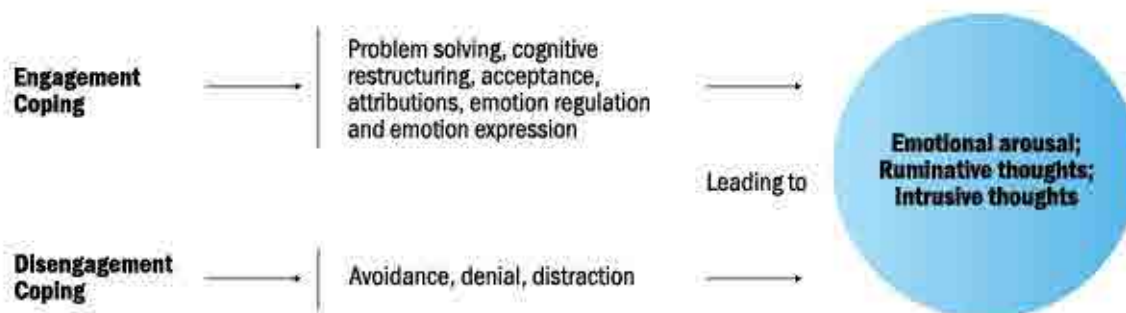
Higher scores would indicate higher distress upon facing that particular form of restriction. As expected, mobility restrictions caused most distress. Out of those who reported experiencing restrictions in moving around their homes and neighborhoods, 89.5% felt extremely distressed on being restricted.

About 83% survivors – who experienced restrictions in participating in major festivals and rituals, reported that not being able to participate caused them extreme distress. Similarly, 8 out of 12 participants (83%), who experienced restrictions in personal care, experienced extreme distress when they were not allowed to take care of their appearance, health and nutrition, as well as their peers. Though only 7 survivors reported that they sometimes, or always did not get equal opportunity to attend school or college; 5 out of them, which is 71%, reported feeling extremely distressed because of this.

Therefore, overall survivors of trafficking experienced varied forms of restrictions, mobility being the most common and most stressful, among all. We found that such restrictions were most likely not due to a survivor's own inability to overcome fears or social anxieties and that within their homes, they were treated as well as their peers. Most of the restrictions came to matter outside and in interactions at a community level. Those survivors who experienced very little restrictions, felt they did not have enough employment opportunities. Therefore, even when social stigma reduces, opportunities for employment remain a problem.

COPING WITH STIGMA

Coping was measured by using a scale prepared on the lines of conceptualizations by Compass, *et al.*, (2001) – an explanation has been presented in Chapter One. The types of coping could be broadly categorised as engagement and disengagement:



Under disengagement coping, we measured – avoidance, denial and distraction. Under engagement, we measure – problem solving, cognitive restructuring, acceptance, attributions, emotion regulation and emotion expression. Two types of stress reactions measured along with coping were – emotional arousal, ruminative and intrusive thoughts. The five point Likert type scale ranged from 1 – meaning strongly agree and 5 – meaning strongly disagree. Therefore, the percentage of strongly agree and agree (response category 1 and 2) would give an idea of how many survivors used that particular type of coping method. Since the intervention was supposed to help survivors deal with stigma, an idea of how they presently dealt with stigma was expected to give a direction to the program design.

	Disengagement Coping		Engagement Coping				Stress Reactions		
	Avoidance	Denial	Attributions	Distraction	Problem Solving	Emotional Expression	Cognitive Restructuring	Acceptance	Rumination & Emotional Arousal
Avg %	73.5%	46.5%	80%	70%	70%	71%	64.75%	60%	77%

Table 8 Coping and stress reactions

Disengagement coping is characterized by a tendency to withdraw from stigma related stressors. When stress caused by stigma cannot be managed or controlled, a person may avoid the situation and the people who stigmatize, altogether. Such avoidance may take the form of physically withdrawing from interactions with stigmatizing people or situations or in the form of denying presence of discrimination. Our results showed that 90% survivors avoided people who discriminated and stigmatized them. 57% survivors tried to attend events where others did not know of their trafficking history. This shows that survivors were trying to deal with enacted and anticipated stigma by avoiding physical sources of stigma. We also asked whether they only attended events where other survivors like them are present, to which we found only 27% did so. This was because there are hardly any such provisions or events that take place exclusively for survivors. However, responses such as, “*I just want an opportunity to feel happy, like I am happy now after meeting you all*” indicate that having such exclusive spaces for survivors would serve to help them cope with internalized stigma, by inducing feelings of self-worth and happiness. Overall, therefore, 73% survivors used avoidance mechanisms (avoiding people and avoiding situations).

Another form of disengagement coping is denial – characterized by wishful thinking. In this, the stigmatized person tries to minimize prejudice by denying the existence of the problem. About 46.5% survivors (Table 3.8) seem to be using this form of coping. Half of the survivors (50%) believe that their family may be discriminating against them, but yet the family loved and cared for them. Around 43% survivors believed that other people discriminated against them – not because they were trafficked, but perhaps because of other reasons. This pattern of thinking suggests a self-preservative way of thinking that the person who is being stigmatized is socially accepted and if not accepted, the problem was not trafficking but something else – gender, poverty, poor relationship, *etc.* This could be a mechanism of trying to cope with internalized stigma or even attempting to wish away internalized stigma.

Engagement coping, on the other hand, refers to the tendency to accept and deal with the stressors. This can either be of primary control type, where the person tries to change the stressful situation by controlling the situation or self, or it can be of secondary control type, where the stigmatized person tries to adapt to the stressful situation. Three types of secondary control type engagement coping are – distraction, acceptance and cognitive restructuring.

Distraction methods draw the person’s attention away from stress inducing events or thoughts. According to Stuart and Wegner (1999, as cited in Miller and Kaiser, 2001) the key to understand the beneficial effects of distraction is that it involves substitution of other thoughts and activities for stress-related ones, rather than an effort to stop thinking about them or denying them. Therefore, when 70% survivors report that they engage in an activity that they like doing to take their minds off a stigmatizing situation or experience, it means that they are engaging in a protective activity and distancing themselves from stigma-related stressors, rather than suppressing the presence of stress. Survivors mentioned that they engaged in activities like listening to music, sitting by the river, talking to friends over the phone and even tailoring.

About 60% survivors reported that they believed that being discriminated and stigmatized was in their fate. This suggests that they accepted injustice as their destiny because of the way people perceived sex work in their communities. Since stigmatizing conditions are pervasive, this form of coping can be detrimental to health and well-being of the stigmatized person; however, when one cannot control situations and others’ reactions, acceptance can be the only method of moving on and finding solace. Perhaps, the fact that survivors were aware of labels and stereotypes attached to sex work in their communities, they were able to accept the presence of stigma. Acceptance could be related to their levels of anticipated and internalized stigma, though.

Cognitive restructuring is another interesting form of adaptive coping technique. It is a mechanism that involves re-defining the meaning of stressful events. In our study, we measured the extent to which survivors redefined the value of certain stigmatizing conditions – participation in social and religious events and certain stigmatizing contexts – respect from family and community. So about 53% survivors agreed that it wasn’t important to participate in social events, while 53% survivors felt it was important to participate in religious events. About 83% survivors reported that respect from family was important and 93% survivors reported respect from community as important. Often, stigmatized people devalue the importance of a domain in which they fare poorly – social events, religious events, earning respect from family and community were examples of such domains. We found that there was no presence of dis-identification with such domains. Rather, such domains were deemed to be important and valued. The only domain that seemed to be less important was that of participating in social events, which probably was a way of coping with enacted stigma in the form of social isolation, ridicule and the fear of being discriminated.

Another form of cognitive restructuring is attributing the cause of stigma on something. This is known as attribution to prejudice and when it is externalized, which is how it should be, it can protect a person's self-esteem (Crocker *et al.*, 1998, as cited in Miller *et al.*, 2001). Almost all survivors (90%) reported that those who stigmatized them because of their trafficking experience were being unfair and rude. Similarly, 70% reported that people who treated them differently did not know the reasons why they were trafficked.

The primary control type engagement coping types studied were – problem solving and emotional regulation and expression. On average, about 70% survivors reported using problem solving skills. One type of problem solving skill in a stigmatizing condition that was studied, was that of compensation, in which a person tries to change one's social interaction strategies to suit the expectations of people who might be prejudiced. Around 70% survivors reported that they tried to please a person when they knew that the other person would be judging them. Survivors know of how others would judge them in a particular situation because they share a cultural identity with their stigmatizers. However, in institutions where they need to interact with duty bearers, it is the social workers who prepare survivors on how to talk and behave, so as to avoid conforming to stereotypes. Around 73% survivors reported that they tried to be nicer to their families, even when their families behaved rudely with them, which could be their way of coping with enacted stigma from the family. Behaving nicely with one's family even in face of discrimination and stigma could also be a way of avoiding confrontations.

Another common form of problem solving among stigmatized people is when they form a collective or a shared identity to improve the group's status. About 83% survivors reported that they felt it was important to belong to a group of survivors and 60% felt that belonging to such a group would not accentuate their stigma. Thus, there was a readiness in survivors for collectivisation, though spaces for such collective action were limited.

Another and most fundamental form of problem solving is when one expresses one's fears and is able to share it with someone else. Around 63% survivors reported that they could share their fears and feelings of being stigmatized with someone close. Another form of emotional expression measured was whether survivors could express their anger on being discriminated and found that 60% reported they could. Few respondents explained that they could shout back and express their anger at people outside their homes, with whom they were not close. However, they couldn't express anger at people close to them, when such people discriminated them or stigmatized them (maybe that is why they tried to be nicer to people closer to them, despite the stigma). About 83% survivors reported that they felt better when they could talk about their stigma related problems with other survivors. This indicated a mechanism of gaining in-group support.

Finally, stress reactions that occur involuntarily were measured in terms of emotional arousal and intrusive and ruminative thoughts. We found that 83% survivors reported feeling anxious, restless and unable to concentrate on a task after experiencing or feeling discriminated. Similarly, 90% or almost all survivors, reported that when somebody stigmatized them, they felt angry and could feel their heart beating faster.



These fall in the category of generalized stress response and may serve the purpose of alerting the person of impending stress, that needs to be dealt with by choosing an appropriate coping mechanism.

The not-so-effective forms of stress reaction – ruminative and intrusive thought, were also present in about 63% survivors who reported that they couldn't forget experiences of being stigmatized very easily and 73% survivors reported that at times, they felt anxious when memories of being stigmatized crept into their minds. These are known to be the most debilitating forms of stress reaction as they indicate that the person is unable to rid herself of thoughts around stigma and negative experiences. These reactions indicate the presence of stress despite being implicit. Therefore, the survivor may appear to be fine from the outside and to other people around, but internally, she may be experiencing symptoms that would then take the form of physical ailments such as aches, pains, hypertension, sleeplessness, loss of appetite, *etc.*

Overall, it appeared that the survivors were trying different types of mechanisms to cope with stigma. The anti-stigma intervention would be best designed by building these skills, by differentiating its impact on a survivor's ability to deal with enacted, anticipated and internalized stigma at both, individual and structural levels. The key to design an anti-stigma intervention would be to identify resilience inducing coping mechanisms and also identifying stage-specific coping skills. Therefore, certain coping skills that may serve a protective function in the primary stages of stigma or in dealing with higher participation restriction, may not be useful when the survivor makes a transition into different stigma contexts. The picture is very complex and layered, a rapid and exploratory quantitative study – as this has only managed to identify broad trends, but several other rigorous studies will be needed to determine such interaction effects between various variables.

STIGMATIZER IDENTIFICATION AND RELATIONSHIP

Who stigmatized?

Table 9 Stigmatizers within family

Stigmatizers within family	% who reported
Aunt	47
Uncle	40
Cousin brother	23
Sister-in-law	20
Brother-in-law	13
Brother	
Mother	
Father	10
Grandmother	
Cousin sister	7
Sister	3
Husband	
Mother-in-law	1
Husband's other wife	

The most commonly reported stigmatizers within the family were aunts and uncles according to the figures in *Table 9*. From the data, it appeared that more than immediate family members such as mother, father, sister, husband or mother-in-law, extended family members were more hurtful and prejudiced. Relationship-wise, therefore, extended family members appeared to be most stigmatizing.

Table 10 *Stigmatizers within community*

Stigmatizers in the community	% who reported
Peers (boys and girls of similar age)	43
Neighborhood married women	36
Neighborhood boys	27
Far relations in neighborhood	17
Neighborhood 'aunts'	13
Neighborhood 'uncles'	13
Neighborhood 'brothers'	10
Neighborhood 'grandmothers'	10
Trafficker's allies	

Within the community 'peers' who comprised of friends, girls and boys of similar age in the neighborhood, schoolmates and ex-schoolmates were the most stigmatizing (43%). *Table 10* also shows that neighborhood married women, mostly referred to as '*bhabhi, boudi or pararbou*' were also reported to be stigmatizing by more than one-third of the sample. The lines between extended family and relations living in the neighborhood were not very clear. Therefore, several mentioned 'aunts', 'uncles', 'grandmothers', 'brothers' who lived close by. Since these 'relations' were mentioned while asking about stigmatizers in the community, it is safe to assume that they lived in separate households, while the aunts and uncles who were mentioned when asked about stigmatizers within the family, may be sharing the same household.

Table 11 *Stigmatizers within institutions*

Stigmatizers within institutions	% who reported
<i>Panchayat</i> (<i>Panchayat, Pradhan, member</i>)	33
Police	20
Doctor/Hospital	13
BDO	7
Teacher	
CBO	
Lawyer	3
Shopkeeper	

Within institutions, *Panchayat* was mentioned as the most stigmatizing with more than one third respondents reporting various members of the *Panchayat* when asked who stigmatized them most in institutions. This was followed by police (20%) and doctor (13%). *Table 11* corroborates the findings of enacted stigma in terms of services refused, in which also more survivors reported being refused services by the *Panchayat*.

Table 12 Nature of relationship with stigmatizer

	Family	Community	Institutions
Nature of stigma	<p>Verbal abuses – bad words, insults, ridicules, blames</p> <p>Social isolation – gossip spreads rumours; discourages others from talking to her</p> <p>Physical abuse – beaten</p> <p>Psychological abuse – asked to kill herself, leave home, no security</p> <p>Restrictions – doesn't let her leave home, stopped her schooling</p>	<p>Verbal abuses – bad words, insults, ridicules for example 'village is ruined because of her', 'her family lives on her earnings from Sonagachi'</p> <p>Social isolation – avoids, cannot stand her sight, unhelpful, broke marriage proposal</p>	<p>Uncooperative – make them wait, police weakens the case by not submitting report on time</p> <p>Corrupt – police took money to travel to rescue her</p> <p>Verbal abuse – bad words, nurse says, 'Why are you feeling pain now; didn't you think about it while doing it?', shop-keeper behaves badly</p> <p>Sexual abuse – doctor propositions to have sexual relations</p>
Attributions (why they stigmatize)	<p>Sex work – prostitution, did dirty things with numerous people, corrupted, bad, spoiled</p> <p>Blame – blame survivor, blame parents for letting her go, blame trafficker</p> <p>Personal reasons – to take our house and land, because we are poor, to get back at us for past reasons, for bringing them disrespect</p>	<p>Sex work – morally corrupt (<i>charitranoshta</i>), bad things while in prostitution, bad influence on others</p> <p>Personal reasons – we are poor, they support the stigmatizer within our family</p> <p>Blame – blames survivor, blames trafficker</p>	<p>Personal reasons – because we are poor</p> <p>Sex work – because I was in prostitution, I am bad; did bad things with other men</p>
Stigma by association	<p><i>'my brother-in-law hears a lot of things, and then comes and hits me and my sister'</i></p> <p><i>'...women around her tell her about the bad name I have brought... she comes back and scolds me'</i></p> <p><i>'people say bad things to him when he walks down the road'</i></p> <p><i>'they abuse my family because they have taken me back'</i></p> <p><i>'others have behaved badly with chacha'</i></p> <p><i>'she feels angry that I stay with them and the whole family suffers'</i></p> <p><i>'uncle had beaten my mother because of me'</i></p>		

	Family	Community	Institutions
Power to stigmatize	<p>'others follow his behavior'</p> <p>'others say bad things just like him, they are his friends'</p> <p>'others support my bhabhi and say she is correct and they ridicule me'</p> <p>'everyone accepts, ridicules me'</p> <p>'others protest'</p> <p>'my neighbors love me and trust me'</p> <p>'others don't get influenced as even they have daughters whose husbands have left them'</p>	<p>'they have a lot of influence as they belong to the local club'</p> <p>'no one stops them'</p> <p>'others support them if there is a conflict in the neighborhood'</p> <p>'many people accept, many people don't'</p> <p>'no one pays attention to her'</p> <p>'others question them, protest against them'</p>	

Nature of stigma

Table 12 shows that the nature of stigma was somewhat similar in the family and in the community. The nature of stigma was mainly in the form of verbal abuse and social isolation.

Within the family, stigma also took the form of restrictions, physical abuse and psychological abuse.

In the case of service providers, stigma took the form of delayed service delivery, corruption and verbal/sexual abuse. However, it is difficult to say whether such service providers were being discriminatory, or were they the same with other socially disadvantaged people as well.

Attributions

One way of making sense of stigma is to understand why a stigmatizer behaves in a certain manner that discriminates and devalues. Therefore, we asked the survivors about their opinion on why their stigmatizers behaved badly with them.

According to the survivors, the primary concern was about the kind of work the girl did after being trafficked. Prejudice stemmed from perception of sex work being bad, morally corrupting and dirty. Even among themselves, survivors and social workers call prostitution as '*kharapkaaj*', meaning bad work. The implication of this bad work is directly reflected in the way others perceived them – which is as defiled, fallen, dirty and bad; which got enacted through verbal abuse in the form of calling them bad words, ridiculing them, gossiping about them and isolating them in social events. Concerns surrounding the norms that the girl had broken with respect to sexuality, seemed to be at the crux of the forms of stigma meted out to her.

Closely following concerns about sexual depravation was her blameworthiness in the entire event. Mostly, others felt the survivor was responsible for being trafficked. Some also blamed her family and trafficker, but even when blame was shared with others, the survivor was never spared from taking responsibility of the events that followed.

Another interesting factor that emerged as a reason for being stigmatized was poverty. It appeared that poverty made it easy for others from the family, the community and institutions to stigmatize the survivor. Some even did it to get back or settle past scores with the family of the survivor, some to remove them from their house and land.

Stigma by Association

At times, the stigma associated with a survivor gets transmitted to her family or even neighbors, known as stigma by association. The hypothesis here was that perhaps people who stigmatize are the ones who experience stigma themselves due to the survivor. Their stigmatizing attitude therefore, is partly a type of displacing their anger on the cause for them being ridiculed and called names. Hence, we asked the survivors whether the person who stigmatized them also experienced stigma from others, because of her.

The data in *Table 12* shows that the theory found some resonance in practice. Some survivors reported the ways in which their stigmatizers experienced stigma because of them. One of the survivors, who identified her elder brother as the most stigmatizing person, reported that when he (the brother) walked down the street, he had to hear bad words. Another survivor who identified her elder sisters as most stigmatizing and one of the brothers-in-law as the second most stigmatizing person in her family, reported, *'My brother-in-law hears a lot of things, and then he comes and hits me and my sister'*. In another case who identified her aunt as the stigmatizer, the aunt, it appears, had to hear from others that *'they could not keep their girl good'*. Thus, numerous incidents were reported, where the survivors felt that the people who stigmatized them in the family also had to experience stigma themselves.

The data also supports that survivors perceived a change in their stigmatizer and their relationship after their return. This indicated that previously, most of the stigmatizers within the family and some in the community had a good relationship with the survivor, which changed after she returned from sex trafficking. For example, one of the survivors said, *'...today I think she (aunt) feels angry that I stay with them and the whole family suffers because of me'*. This sums up the impact that stigma by association has on the survivor and her relations with her primary context. The pervasive nature of stigma in the lives of survivors therefore, does not remain restricted to them, but affects them indirectly as well, through their family members.

We couldn't find any strong evidence suggesting that stigmatizers in the community or institution could be facing any stigma by association. The link between stigma by association and the stigmatizer was most evident only in the case of stigmatizers in the family.

Power to stigmatize

The stigmatizer can do a lot of damage to a survivor's chances of ever getting out of the cycle of devaluation and prejudice, if she/he has the power to influence others' opinions about her as well. For example, an aunt who is also very influential in the family and neighborhood, can spread rumors about a survivor's character and habits to a large circle of people. To test this hypothesis, we asked the survivor whether their stigmatizer's behavior and attitude influenced others.

The data in *Table 12* shows that only some such connections of influence and the power to stigmatize could be established, and we also found that there was some resistance to stigma within a survivor's eco-system as well. For example, one of the survivors pointed out that others did not copy the stigmatizer because even they had daughters whose husbands had left them. This was an interesting point as it indicated that social vulnerability, when shared, could be protective. In other words, if people around are of similar socio-economic conditions, then their tendency to copy stigmatizing attitudes could be lower. In one case, we also see that others in the neighborhood protest against the stigmatizer, indicating protective mechanisms within the community that can help build a survivor's stigma resistance.

Chapter Four

RESULTS AND TRENDS – SOCIAL WORKERS

INNATE ATTITUDES

By social workers, we mean *community level case managers who work with survivors of trafficking after they return to their homes*. These social workers are not necessarily people with degrees in social work, but are so by virtue of their work. The reason why we collected data from these community-based social workers is because they represent a strata in the survivor's community that is resistant to stigmatizing and instead is exhibiting pro-social behavior towards a girl, who according to all norms of society in North 24-Parganas, is eligible for a devalued social status. Does the social worker reject cultural stereotypes associated with prostitution and sex work? Or does the social worker feel sympathy towards a girl who prostituted because she was forced and tricked? Is the shame associated with prostitution and sex work maintained by social workers or do they manage to question it? These were a few of the questions that led to studying innate attitudes held by social workers towards survivors of sex trafficking. It has been noticed that though people may display positive behavior towards a stigmatized person, they might hold deep, set beliefs and culturally formed meanings that get reflected in some ways masked within an apparently supportive

behavior. It is needed to unravel such innate beliefs as they might be detrimental to the health of both the social worker and the survivor.

The relation between attitudes and behavior is well-established, though it is based mostly on studies of explicit attitudes. In the case of mental illness, it has been shown that **positive attitudes increase the desire to help the stigmatized person** (Bateson, *et al.*, 2002), doctors and nurses engage in positive therapeutic interaction with suicidal patients (Demirkiran and Eskin, 2006). In contrast, negative attitudes predict whether mental health professionals assign more diagnoses and poorer prognoses to consumers portrayed through clinical vignettes (Peris *et al.*, 2008) and, when a mental condition is perceived as controllable, tend to elicit decreased pity, increased anger, and an unwillingness to assist (Weiner *et al.*, 1988). Though most of these studies are based on explicit attitudes, researchers believe that explicit measures might under-estimate stigma (Hinshaw and Stier, 2008) as compared to implicit measures. While explicit attitudes are self reported and in our conscious realm, implicit attitudes operate in the realm that is outside of conscious control, they

represent thoughts that the person might not want to reveal or endorse.

Stull *et al.*, (2013) studied explicit and implicit biases among the staff in a mental health treatment group with the purpose of exploring the extent to which biases predicted the use of treatment control mechanisms. This treatment is called the Assertiveness Community Treatment (ACT) and is based on an intensive case management evidence-based practice that has shown to increase in housing stability, and decrease in hospital use, among people with mental illness. It utilizes control mechanisms (for example, monitoring medications), which have been critiqued by proponents of recovery model because ACT often adopts a paternalistic attitude that limits a person's chances of autonomy and complete integration into a community. This is where we can draw a parallel between ACT staff's attitude and social workers' attitude towards survivors of sex trafficking. There is **anecdotal evidence that social workers adopt a paternalistic attitude stemming from their desire to protect their 'cases' and try to control their behavior and beliefs by constant coaching and being very anxious on any signs of waywardness by the survivor**.

In the present research, we measured innate attitudes in social workers towards survivors of sex trafficking by using a specifically designed rating scale.⁶ Bos *et al.*, (2013) have indicated that origin of stigmatization lies in the way people perceive the person with a deviant condition. Certain cognitive representations of a stigmatized condition translate into negative emotional and behavioral responses. Analysis of the data will help us unravel the four cognitive representations that have been associated with stigmatization. The rating scale measured innate stigma in terms of how social workers perceived – *onset controllability, severity, dangerousness and norm violation* with respect to trafficking. Ratings ranged from 1 – indicating high applicability of the statement for the particular group, while 4 indicated least applicability. Each statement had to be rated against a person with mental illness, a survivor of trafficking, a leprosy patient and a person living with HIV/AIDS. The data was analysed to obtain mean ratings appropriated to survivors of trafficking and percentage of 1 and 2 ratings given to survivors, as these would indicate higher levels of applicability. Therefore, a lower mean value would indicate a rating closer to 1, which in turn meant that the respondents agreed with the stigmatizing perception of a particular stigmatized group.

ONSET CONTROLLABILITY

Table 13 Showing responses on onset controllability of stigmatized condition

Number	Items measuring onset controllability	Mean	Percentage of 1 and 2 rating
1	She can't help it as it is caused by uncontrollable factors	1.38	90%
2	She could have averted the occurrence of her condition	1.9	76%
3	She is to be blamed for her condition	1.9	80%

Onset controllability as a construct measured a respondent's perception of how controllable was the onset of the condition. In this case, 'the condition' referred to sex trafficking. Our aim was to understand the presence of a commonly held belief that the survivor was in some way responsible for being trafficked. The belief underlying this perception could be that the survivor could have avoided falling the trap by being more restrained and not falling in love, less ambitious and not agreeing to migrate for better work opportunities, more obedient and not going out with friends, and so on.

The data showed that almost all social workers (90%) felt that being trafficked was caused by uncontrollable factors. At the same time, a large number of respondents (80%) felt that the survivor is to be blamed for her present condition and similarly 76% of social workers felt that she could have averted the occurrence of her condition. If we compare the data from an item on internalized stigma scale asking whether survivors felt responsible for being trafficked, we see similar responses, as 84% social workers believed that survivors felt responsible for being trafficked. However, 57% survivors reported never feeling responsible for being trafficked.

This finding suggests that social workers blamed survivors for their condition and, at the same time, believed it occurred due to uncontrollable factors. The question is, what were these uncontrollable factors that the social workers felt caused a girl to be trafficked?

When asked in the FGDs what these uncontrollable factors were, the participants answered that mostly traffickers lured girls with love and romantic relationships. This act of trusting someone

⁶ See Chapter Two – Methodology for detailed description of the scale.

or falling in love was the uncontrollable factor. For instance, one social worker says, *'...it would be wrong to think she will have control. The girl is going with the boy thinking he loves her, he is saying he loves her. She can't know he will sell her'*. Social workers also felt that cases that involved romantic relationships with the trafficker or first procurer were the most difficult to handle, as a survivor was very reluctant to blame the person and thus prosecute him even after being rescued.

Then why were they blaming the survivor and reporting that she could have avoided being trafficked? Probing further, we found that social workers felt that the survivor had been impulsive in deciding to leave with the person; that if she had confided in someone else, she could have avoided falling in the trap. At this point, during the FGD, there was a discussion on how practical it is to expect adolescents to listen to warnings by parents about trusting others. It emerged that adolescence had its own vulnerability and that older girls could be expected to be more decisive and less impulsive (hence, more worthy of blame for being trafficked) than younger girls (who could be excused for being immature and going through a difficult developmental stage). This was reinforced by a participant who said, *'age is an important factor; older girls getting trafficked can avoid falling in the trap as compared to younger girls...'*

What emerged, is an interesting dilemma between blaming and not blaming the survivor. The onus of trafficking was very clearly on the person luring the girl by some means, the promise of love being the most common and most damaging. However, the survivor wasn't exempted from blame for being *'impulsive'*, *'not responsible'*, *'not listening to her parents'* and being *'over confident'*. This dilemma will need to be resolved or at least accepted by social workers being trained to use the anti-stigma intervention.

Feeling that the survivor could have averted being trafficked and shares the blame for what befalls on her need not be denied but explained, deconstructed and finally, accepted within the self-concept of a social worker.

According to Bos *et al.*, (2013) high levels of attributed personal responsibility for the onset of the deviant condition evoke anger and stigmatizing behavior. Since social workers usually do not get a chance to acknowledge their innate attitudes, such negative feelings or anger could be suppressed and may get expressed in ways which could be detrimental for the survivor as well as for the mental health of the social worker.



SEVERITY

Table 14 Responses on severity of stigmatized condition

Number	Items measuring severity of stigmatized condition	Mean	Percentage of 1 and 2 rating
1	She is in a hopeless situation now	2.48	57%
2	Her situation can only become worse	2.19	62%
3	She needs all the help that she can get	1.86	76%

The construct of severity measured the perception of impact of a particular condition on a person. Therefore, one can expect greater perception of severity for the other stigmatizing conditions being compared – mental illness, leprosy and HIV/AIDS since these are defined medical conditions. In the case of sex trafficking, the survivor is also dealing with the trauma of sexual exploitation, but her condition is not defined by her medical needs, her condition is likely to be defined by her social devaluation and as a victim of crime. Unlike other conditions, the distress experienced by survivors is internal and thus, may not be perceived to be a severe situation. The perception of severity is an important factor determining stigmatizing attitudes as the extent to which the person with a stigmatizing condition has been damaged, is often related to feelings of sympathy and anxiety (Van Alphen *et al.*, 2012). Greater perception of damage would, in that way, be related to higher levels of sympathy.

The results in Table 14 showed that perceived severity was medium, with around 57% and 62% of social workers feeling that a survivor of trafficking was in a 'hopeless situation or that her situation could only become worse'. The mean scores on these two items were also above 2, indicating a lower applicability of such perceptions to survivors of trafficking. However, around 76% of respondents felt that survivors needed 'all the help that she can get'. Therefore, the quantitative data again showed a dichotomy as on one hand, the survivor was not perceived to have a serious condition, but on the other hand, there was sympathy towards her. Was the sympathy a result of their professional role only? What was the reason for the sympathy?

The FGDs indicated that social workers felt that there is an overall deterioration of conditions around her in terms of her health, social relationships and opportunities to work or study once the survivor returns, indicating social devaluation and loss of status on return. The hopelessness of her situation was in the inability to overcome stigma and identity of having being trafficked for sexual exploitation. As a social worker puts it, 'attempts at hiding the incident (of sex trafficking) and marrying off the girl doesn't work and when the husband or marital family finds out that she is a victim of acute domestic violence and abuse... which worsens her condition'. The social workers also felt that survivors needed all the help that could be extended to them, since they lose their previous relationships with friends upon return. One of the respondents said, 'Although life and death is not in our hands but still, at times, we think that if help was not given, then we would not have seen some of the survivors alive...':

Social Workers' Report



- Deterioration in Health (physical & mental) conditions
- Social devaluation
- Hopelessness of her situation and the inability to overcome stigmatized identity
- Increase in domestic violence
- Loss of friendships and relationships
- Increase in suicidal tendencies

Perceiving a severe outcome of a situation can elicit sympathy and anxiety. Perception of severity of the condition of a survivor of sex trafficking was explained in terms of the impact trafficking had on a survivor's social identity and her life opportunities. The social workers talked about difficulties faced by survivors while seeking admission in schools or trying to find work. They mentioned presence of stigma from the society and difficulty in arranging a survivor's marriage. What emerged is what we expected – severity of a survivor's condition was perceived in terms of social deficits and not personal distress despite the fact that most survivors experienced depression, anxiety and reproductive health issues upon return (Sanjog, 2014).

Other studies show that perception of severity of the condition is supposed to cause anxiety and sympathy, and this, in turn leads to emotional ambivalence and awkward social interaction (Dijker and Koomen, 2012) and according to Pryor *et al.*, 2009, it can also lead to pro-social behavior towards the stigmatized person. It is, therefore, possible that a survivor's level of mental and physical distress caused emotional ambivalence and awkwardness in social workers since they are not equipped to deal with these conditions. On the other hand, social problems were something that social workers were comfortable in dealing with and hence, they believed that survivors needed help in restoring their devalued identities.

DANGEROUSNESS

Table 15 Responses on dangerousness of a survivor.

Number	Items measuring dangerousness of a survivor	Mean	Percentage of 1 and 2 rating
1	Being close to her can influence others to be like her	2.62	52%
2	Associating with her can harm a person's reputation	1.67	86%
3	She can cause damage to others by her emotional outbursts, anger, impulsive behavior	1.62	81%

One way of dealing with a stigmatizing attitude is by identifying fears related to the stigmatized person. For example, people might avoid social interactions with a person with severe mental illness out of fear of violence associated with that condition. Fear of being contaminated with the disease could be responsible for isolating people with HIV/AIDS. Various types of fears emanating from different belief patterns underlie the attitudes and behavior one adopts towards a stigmatized person. This fear is related to perceived dangerousness of the stigmatized person. Several researches have shown that others hold beliefs about certain groups of people in terms of their potential to harm. For example, in a national survey, 61% of Americans believed that adults who have schizophrenia are likely to act violently and perceiving someone to be dangerous was related to desiring greater social distance from them (Link *et al.*, 1999 as cited in Pryor *et al.*, 2009). While mental illness has been linked with violent behavior, the dangerousness that we examined was more akin to what Rozin, Markwith and McCauley (1994) theorized as a superstitious sense that mere contact with a stigmatized person is sufficient to transmit all sorts of properties, including personal characteristics and moral standing. This construct of dangerousness thus measured fear of stigma by association and fear of negative influence by contact.

The data in *Table 15* shows that there is a strong belief among social workers supporting the

notion of stigma by association. Two items measuring this construct were endorsed by more than 80% of the respondents, while one item measuring fear of being influenced by a survivor was endorsed by more than half (52%) of the social workers. This indicated that social workers were anxious about a survivor's behavior. They seemed to expect a survivor to behave in a way that would endanger herself and others around her. Why were social workers endorsing this view that associating with survivors could harm another's reputation? What was the reason behind their belief that survivors could cause harm to others by their emotional outburst and impulsivity?

FGD data revealed that social workers were responding to this on the basis of what they had observed occurring with survivors and their peers. For example, some of the responses were, *'in many cases it has been observed that other girls learn by seeing the survivors... they pick up addictions from survivors... other girls associating with a survivor experience stigma...'* So while explaining how stigma by association occurs, the social workers cited examples of what they have observed. At this level, their attitude is based on observations; however, certain sentences revealed a deeper set of beliefs. Such as when one respondent said, *'...just like when a bad boy influences a good boy into becoming bad... so when another girl associates with a survivor, she may also get influenced by her.'* This could mean that in the minds of a social worker, who also belongs to the same stigmatizing community, a survivor who has been in prostitution carries the danger of polluting others. This allusion to 'bad' and 'bad work' is a repeated theme in such discourses. For example, another social worker said, *'...just because she had been bad, it is not that she will remain bad or that her mind will always stay the corrupted way... it may also happen that if my daughter is friends with her, it may influence the survivor's mind and change the bad aspects in her mind'*. While trying to measure dangerousness, we also captured the essence of 'degradation' or 'badness' in a survivor.

The data revealed some very interesting sets of beliefs. That the survivor is different and has something that is deviant, became apparent from the FGD excerpts. That she needs to be reformed from a negative state to a positive state, also emerged. The data also revealed the 'paternalistic' or 'reformist' attitude within social workers who expressed their desire to bring a positive change in a survivor. For example, one of them said, *'...not all girls who are rescued are getting services from a social worker. Now, it has been seen that those girls who are not getting service, there is no scope in them of change of character, change of mind, etc. These girls mostly become traffickers'*. The belief that once a girl experiences life as a prostitute/sex worker it changes her moral values, emerged very strongly from these sentences. Also present was a sense of anxiety that if the girl who had been rescued from sex work was not reformed, she may contaminate the society. Anecdotal evidence of survivors, further trafficking other girls from their community, reinforced this anxiety.

NORM VIOLATION

Table 16 Responses on norm violation by a survivor:

Number	Items measuring norm violation	Mean	Percentage of 1 and 2 rating
1	Some parts of her behavior will never be accepted in our society	1.9	71%
2	Her sexual needs are not similar to girls of her age	1.7	81%
3	Her behavior was always different from what was expected by the society	1.6	86%

Deviance is violation from norms. A stigmatized person is perceived to have deviated from

certain norms that set her/him apart from others who follow or create these norms. Goffman (1963) traced back the origins of stigma to Greeks who cut or burned marks into the skin of criminals, traitors slaves in order to identify them as tainted or immoral people to be avoided. In contemporary times, stigma has come to be associated with similar loss of social identity associated with perception of difference and devaluation (Dovido, Major and Crocker, 2000). However, it must be pointed out that this difference and devaluation is context dependent and is a product of social creation. Which means that it is not an attribute in a person, but a perception that others affix on the stigmatized.

While designing the construct measuring norm violation, the focus was on indicating a sense of difference without making the devaluation explicit. Hence, the three items measuring norm violation shows a certain difference between the stigmatized person and 'others'. Sexuality, being the vortex of the tension surrounding norm violation for at least people living with HIV/AIDS and survivors of trafficking, was also included in the construct.

The data in *Table 15* shows that most respondents felt that survivors of trafficking violated certain norms, to the extent that they were different from 'others'. More than 80% of social workers felt that sexual needs of survivors were different from girls of her age and that her behavior was always different from what was expected by the society. According to Bos *et al.*, (2013) perception of norm violation by a stigmatized person evokes anger and social exclusion and does not evoke sympathy. They have cited the example of how the perception of norm violation plays a fundamental role in stigmatization of people with HIV/AIDS, as traditionally HIV has been associated with promiscuity, prostitution, homosexuality and drug abuse, which are forms of deviant behavior. Similar lines can be drawn between sex trafficking and violation of the norm of chastity and morality. Here, it needs to be clarified that the norm violation is not hinged upon trafficking, though it is a crime and therefore, the survivor is someone who should have been perceived as the 'violated' and not the 'violatee'. On the contrary, in this case, the survivor's identity of a victim is surpassed by her sexual behavior during the trafficked period.

The FGD showed that social workers felt that having been in a profession involving and demanding sexual promiscuity, sex turned into a need for some survivors. The girls were mostly in their youth – a time when most young people become interested in sex. However, the stigma lies in marking out the need for sex in a survivor as something that is worthy of attention without considering it as a normal part of her developmental stage; one that gets accentuated by her sexual experiences under such traumatic conditions.

One social worker said, '*...this need makes them marry or get in and out of relationships so often... it is as if the impulse to have a sexual relationship drives them from one man to another... survivors seem to lose the reserve that other girls of their age seem to have*'.

While explaining how survivors differ from others, the respondents said that expectations of survivors change after being used to a certain lifestyle while in a brothel. The essence of norm violation got articulated well during the FGD. One of the respondents said, '*society wants a girl should be calm, composed, civilized. When she deviates from that societal boundary, maybe she wants to be independent... many girls go on their own because they get tempted by materialistic gains... they have high ambition...*'. There were some social workers who were opposed to the opinion that it is only because of ambition or temptation that girls leave home, that they have a need to support their families financially, which makes them leave home or migrate. The discussion on norm violation therefore, strengthened the fact that stigma against survivors of

sex trafficking mainly emanated from society’s beliefs about a female’s chastity being directly dependent on her sexual behavior. Having sex outside marriage was taboo; however, even when a girl was forced to perform sexual acts, it was considered to be shameful for the victim. Sex, which is a basic human need – one that becomes important during the period starting from adolescence, is considered a deviant need and survivors of trafficking are assumed to be deviant because they express their need for sex after they return. This expression of sexual desire is contrary to norms that decree that women shouldn’t express such desires openly.

Thus, survivors of trafficking are perceived to have violated the norm by being corrupted by their experiences during trafficking. That girls who have not been trafficked may also have similar sexual needs, was never mentioned. What emerged is a belief that survivors develop a different – deviant set of expectations from life, after being exposed to life in a big city and within a brothel. The ‘reform’ by social workers would need correcting this deviant expectation from life and relationships.

PERCEPTION OF SOCIAL WORKERS ABOUT THE NATURE OF STIGMA AND STIGMATIZERS

Nature of stigma

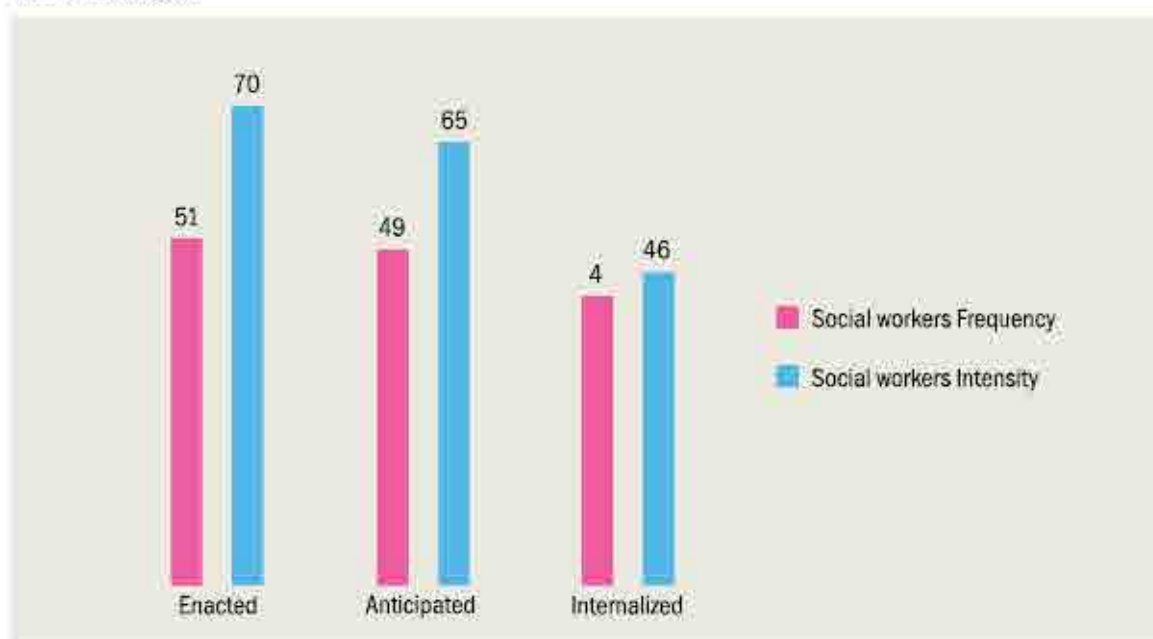


Figure 5 Comparing responses by social workers on three types of stigma experienced by survivors

At the outset, *Figure 5* shows that social workers perceived enacted stigma to be highest, followed by anticipated stigma and internalized stigma, respectively. The data presented in this figure are scale total scores. Typically, social workers use a case management approach to work with survivors. They identify a survivor’s needs and then go about approaching service providers for fulfilment of such needs. The *Panchayat* refused services to survivors (sometimes, or always) according to 86% social workers. While the service providers of education refused services according to 57% social workers and 47% social workers reported that survivors were refused health services. Around 66% social workers reported that survivors were refused religious

services after they returned. One of the social workers described the case of survivors who are not allowed to perform *Namaz* (prayer) or read the *Koran*, and had been refused the right to be buried after death in the community burial grounds. Religious leaders can have a very high impact on a survivor's social identity, especially in communities where everyday life is prescribed according to religion.

One of the social workers described the interaction with service providers very lucidly. He said, *'The service providers know that if they refuse service, they will be in trouble, so they don't refuse, but the way they look at you, it's akin to neglecting you. Superficially, their words are like spreading knowledge, but they feel like taunts: "Why do you go with whoever? Listen to your parents. Now you will see how many problems you'll have to face..., there are so many girls in the country, they don't get trafficked! You were itching to go... Delhi return, Bombay return..., if we give you jobs, then everyone will start going to Bombay".'*

Some of their responses are presented in *Box 4*

Qualitative responses by social workers on refusal of services

Panchayat, at times, says that we have no schemes for survivors of trafficking, so how can we help them?

In case of one survivor, the school authority as well as the headmaster forbade her from coming to the school. They said for this girl, the other girls of the school will also get spoilt. But later, after talking to them, they readmitted her.

In case of M, one of the school authorities was the trafficker. So she was not enrolled in the school, neither was she given a TC showing her older age as a reason for refusal. In case of many other girls, they say if the girl is enrolled in the school, the guardians will create a pressure, the school's credibility would be spoilt, these girls' studies are over anyway, what's the point of enrolling them, etc.

When RK was taken to the sub health center to get her Copper T removed, she was asked, *"Why these things for unmarried girls?"* They told us that they couldn't treat her at the sub center and were told to go to the BMOH.

R came back pregnant. The sub center had refused to give the Polio card (*Janani Suraksha Card*) for her baby. We went and spoke to the BMOH, then he gave her the card directly.

At times, doctors don't want to treat the survivors because they have on-going court cases, and they may have HIV/AIDS and the doctors may get infected.

When survivors go to a religious place, the religious leaders tell them not to go, they say those girls are ruined, unholy; hence they cannot be accommodated in such holy places, as that place will become unholy too.

Box 4 Social workers' data on refusal of services

Since enacted stigma is easier to observe and report, social workers could present qualitative data on this aspect much more than anticipated and internalized stigma. However, quantitative data showed that around 90% social workers reported that survivors most frequently thought about – being the subject of gossip and being a bad influence on others, and of the difficulty they would

face while finding a groom and being negatively perceived by others. All these fears were rooted in the kind of behavior they experienced from others. For example, one social worker said, *'When marrying a girl off seems difficult, her family members blame the girl, calling her names; they imply that if the girl leaves home, that'll be better'*. Talking about a case, one social worker said, *'She was married four times... all four times, she was thrown out by the marital family. She has even attempted suicide once'*.

Stigmatizers

Survivor's family and community

According to responses by social workers, survivors had to deal with stigma from their own paternal family. This stigma was expressed in the form of various types of restrictions placed on the survivor to 'protect' her from further deprecation. For example, one social worker said, *'A lot of girls' parents don't let them watch TV; they say as it is they are in such a state, and if they watch TV, it'll get worse!'* When asked to identify stigmatizers within the family, out of the 21 social workers, 14 reported it was an aunt, 11 reported it was a sister-in-law, 11 also reported it was a brother and 10 reported it was an uncle who stigmatized the survivor most. Out of 21, 5 social workers reported the stigmatizer could be the mother and 6 reported it could be the father. About 46% social workers reported that a survivor's family sometimes, or always abandoned them. At times, things become so difficult that some survivors refuse to stay with their families. Around 84% of social workers reported marital families abandoned survivors, 71% reported that survivors thought it was okay for their husbands to beat them and 65% reported that survivors thought that their marital families could send them back, if they found out about their trafficking history. However, while identifying the most stigmatizing people within one's family, out of 21 social workers, 2 identified 'husband' and 1 each identified 'mother-in-law' and 'father-in-law' as the stigmatizer within the family. Most social workers are requested not to visit a girl after she is married. Marriage is treated as redemption of a survivor's social identity and a true sign of rehabilitation, according to the family of the survivor. The only married survivors with whom social workers engage, are the ones who have been sent back, divorced or abandoned by their marital families or husbands. This explains why very little is known by the social workers about the nature of stigma emanating from husbands and in-laws.

From the community, married women who lived near by, friends, boys in the neighborhood, and neighborhood 'aunts' and 'uncles' were identified by social workers as stigmatizers within the community.

Nature of stigma from family and community

Verbally abuses them, threatens them with isolation, stops them from doing anything. Even their own parents don't take them to any social gatherings or entertainment events, and don't allow them to even watch television.

They think - she was outside, has been with many men; so the family members feel their pride is being lowered, she won't be able to get married and then she will have to suffer life-long.

They say - *"Because of your shame we are not respected."* *"Why don't you die?"* *"You chose that half dead guy; you couldn't find anyone else?"* *"Was I bad?"* *"She has a bad character!"* *"All our difficulties are due to you!"*

Box 5 Social workers' data on stigma from family and community

Stigmatizers in institutions

The data suggested that social workers adopted a protectionist attitude and engaged directly with

service providers and duty bearers on behalf of survivors. Therefore, it was meaningful to identify who were the most stigmatizing people in institutions. Apparently, according to the findings, social workers identified all duty bearers and service providers associated with health, welfare, education and religion as stigmatizers. This indicated an urgent need for advocacy of rights for survivors and legitimacy for social workers. It is possible that service providers do not wish to comply with social workers, since they go without the actual right holder – the survivor.

Nature of stigma from service providers

The police tell the girl – “Were you not feeling ashamed when you slept with them?” They think they will also take advantage; they leer at the girls.

Tough to meet them, even when we are able to meet them, they try to avoid. They make ignorant comments – “Bombewali... they are like that, again they will go; what’s the point of helping them?”

Box 6 Social workers’ data on nature of stigma from service providers

Why do others stigmatize?

The question that arises from these findings is what, according to social workers, motivates people to stigmatize one amongst them? How does the devaluation actually occur in the home and outside? Is there any difference in the way social workers perceive stigmatizers within the family and those in institutions?

Qualitative responses on attributions of why people stigmatize

It is in the structure of our society that it finds comfort in wrongly stigmatizing and ridiculing the girls... What is most unfortunate, is that girls themselves become enemies of other girls and stigmatize them.

Because they despise her, they think she is bad that is why. Because they don’t know. People criticize poor people, because they are insulted by others because of her.

It is easy for these people to stigmatize the survivors because of the stain on the survivors’ names, some people do this out of old grudges, most girls do not protest or cannot be that vocal. Some accept this as their destiny, their luck. Those who stigmatize are trying to look after their selfish motives.

They stigmatize her due to several reasons – as revenge, to not to give her a share of land, or because they’ll have to deal with costs for her marriage, etc.

No one likes sex workers, they think she is spoilt, so many people have used her, people think bad of these girls, they don’t know what happened actually

Other people in the village tell the family members that the girl was in a brothel, so she is spoilt now.

They think other boys and girls in the village or neighborhood will be ruined too. They think she has come back from a bad place so she must have been with a lot of men.

Prejudices against survivors, not knowing all the facts about them, believing the survivors to be spoilt.

Since she was out of their sight, they don’t know what has happened. They always think being outside of family means she was involved in some bad work, so they stigmatize her.

Box 7 Social workers’ data on why people stigmatize

The reasons for stigmatizing a survivor are several and are complex. There is a clear indication of sex work being the crux of the tension instigating others to be prejudicial. However, other vulnerabilities such as gender and socio-economic conditions seem to mediate public reaction. The survivor becomes a burden for the family and the community since her stigma permeates to people associated with her as well. The birth of a daughter in an agrarian society marks the beginning of preparation for her marriage, which may involve dowry. In the case of a survivor of sex trafficking, this marriage becomes even more difficult, an added stress for the family, which could be dealing with several other vulnerabilities. The survivor seems to be the scapegoat who is blamed for all misfortunes befalling the family and in some context, the community. She is blamed for other girls going awry as if she has a magical influence of ‘polluting’ innocent people around her.

The survivor and, in some cases, her parents are blamed for her misfortune. Often, allusions of greed and incompetent parenting are made. Therefore, the blame of a crime committed by a trafficker is shifted neatly upon the survivor and her family.

Power to influence and displacing stigma

Often, in the case of family members who stigmatized, there is presence of displacing the anger on the survivor. This happens because the family member experiences stigma due to the survivor. For example, one social worker said, *‘Yes. If anything happens, they have to hear “your sister/sister-in-law is Bombewali. How dare you talk?”’* According to social workers, *‘other people in the village also ridicule them’ (ie. the family)*. Therefore, it seems that the survivor experiences stigma at two levels – directly aimed at her and one that reaches her as a result of displaced anger because of stigma experienced by her family members.

Finally, it also emerged that social workers believed that people ganged up against a survivor. Repeated stigma by someone influential could change attitudes of others who begin buying into the negative propaganda.

Interestingly, none of the social workers mentioned any sympathetic relations or people who would try to counter others’ stigma. Survivors mentioned this when they answered the same question; the results are presented in Chapter Three.

IMPACT OF STIGMA ON SURVIVOR

The impact of stigma was measured by studying restrictions on a survivor’s participation in various domains of life. Social workers were asked to rate how frequently survivors experienced restrictions and how intense was the restriction. The ratings on intensity were totaled to identify how many social workers perceived different levels of restrictions. The levels of restrictions ranged from none (score of less than 12) to extreme restriction (score ranging between 53 to 90).



Figure 6 Levels of participation restriction

The data in *Figure 6* shows that more than half of the social workers reported that survivors experienced extreme levels of participation restriction. Participation restriction scores ranged from 0 to 90, with higher scores representing greater restrictions. It appears that more than 50% social workers perceived extreme participation restrictions for a survivor. Since this tool can be used to identify rehabilitation needs, we identified those areas which were rated as most intense by the social workers. These areas were:

- 1) Economic opportunities – cannot contribute to the income and doesn't get opportunities
- 2) Recreational activities – not enough opportunities
- 3) Mobility – cannot move around freely inside and outside her home and cannot visit others, which also indicates isolation
- 4) Respect and status – doesn't have the same respect as her peers in the community and status within her family is deficient, as her opinions do not count in family discussions.

Thus, it appears that social workers feel that stigma restricts a survivor's chances of finding work and earning. This has implications for rehabilitation. As observed by some social workers, getting some engagement was very important for survivors after they returned. The most sought-after engagement was work, as it brought economic benefits; money that the survivor and her family needed. However, public stigma would make it very difficult for such girls to find acceptance in work opportunities around their homes, thus necessitating that they move outside their community for work. Here, they faced another barrier in the form of mobility restrictions. Parents often restricted mobility out of fear of stigma, attracting negative attention and also because they might be afraid of the trafficker. As mentioned in *Box 5*, parents also restricted them from watching TV, which is the most common recreational activity available inside the home. Therefore, it seemed that according to more than half of the social workers, survivors experienced isolation outside, as well as inside their homes.

HOW DO SURVIVORS COPE, ACCORDING TO SOCIAL WORKERS

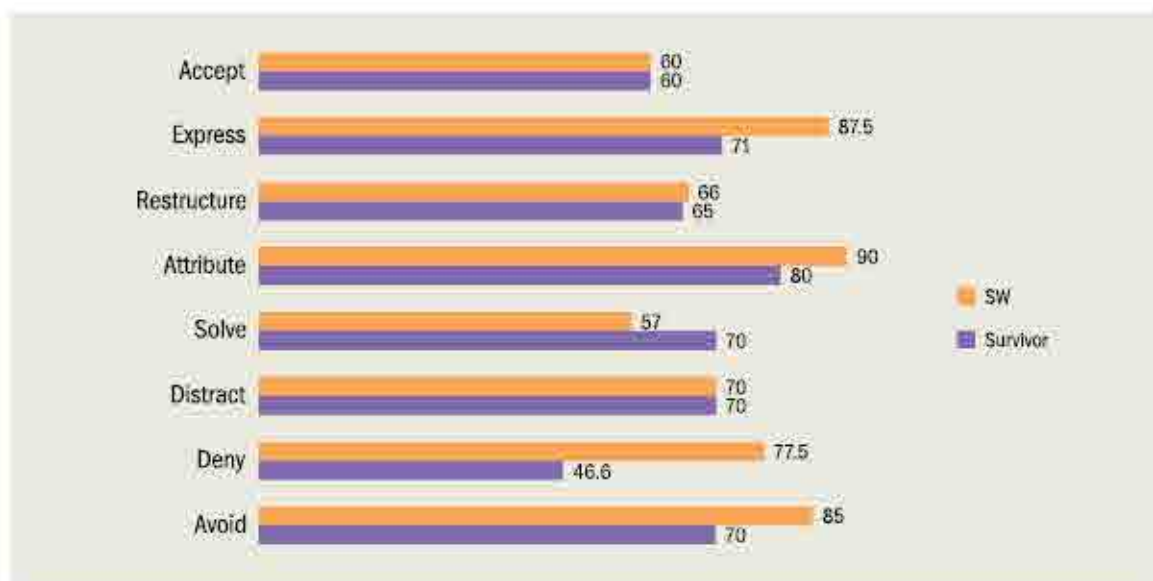


Figure 7. Types of coping compared in percentage

Figure 7 shows a comparison between responses by social workers and survivors on coping mechanisms. A larger percentage of social workers seem to believe that survivors deny the presence of stigma. Almost all social workers believe that survivors use attribution as a coping mechanism. Comparatively, less percentage of social workers believed that survivors used problem-solving methods to cope with stigma. Further, enquiry into the way survivors coped using problem-solving and denial therefore, needs to be conducted to understand why a discrepancy exists in the way the two groups have perceived it.

Qualitative responses of social workers about coping mechanisms used by survivors

They stay silent, cry, injure themselves bodily to express their anger, abuse other verbally, express the anger on others, break down in despair, blame others for trafficking as well as threaten with going back there in order to stop people from abusing her. When angry, they go to those relatives who support them.

Many stop trying to get services or to complain, they kill off their needs in fear of being rejected. Fraught with guilt they stop eating and sleeping, refuse treatment. They find the pain of the past experiences less tolerable than the illness. They often feel desperate, contemplate suicide, or returning to RLA.

Many stop trying to understand, they pretend not to give attention to whoever is saying what, some spend time with children, don't go to anyone's house, watch TV, cry when alone, tries to convince people that she is not at fault, many also contemplate suicide.

Faced with stigmatizing behaviors from neighbors, the girls prefer to stay home because they think if do not go outside then I won't have to listen to such comments and therefore I won't feel bad. They won't even talk to the neighbors for the same reason. Many girls have told me that if anyone asks about them, to tell those people that she stays in a home where children go for studying.

When the girls are faced with enacted stigma from duty bearers, they feel, if educated people behave this way, where shall we go. They bear it all silently; think that it's their fault. They think that they will never go back to these people (service providers) even if it is a matter of life and death. They become stubborn. They wonder why they even went there in the first place. To cope with it, they go somewhere to feel free.

Box 8 Social workers' data on how survivors cope with stigma

The qualitative data presented in *Box 8* corroborated what social workers reported in their questionnaires, to measure coping mechanisms used by survivors. According to the survey data, 100% social workers believed that survivors avoided people who stigmatized them to cope with stigma. According to the excerpts presented in *Box 8*, it appears that survivors avoided getting ridiculed and insulted by withdrawing from social contact and from accessing services. In fact, when asked why social workers approach service providers on behalf of survivors, instead of ensuring that the survivor speaks up for her rights, the social workers respond that survivors are afraid of meeting service providers, fearing insulting behavior, ending with rejection. Avoidance was also qualified as staying indoors, not talking to neighbors, not trying to access services and avoiding responding to people who are stigmatizing them.

The other mechanism that emerged by triangulating qualitative and quantitative data, was that

of distraction. Distraction refers to diverting attention to less harmful situations in the face of imminent threat. For example, survivors visit relatives who are sympathetic and supportive, spend time with kids, or go somewhere to 'feel free'.

The qualitative responses also qualified the nature of emotional expression that survivors engage in (85% social workers reported survivors express anger). It seems that survivors express their emotions in the form of angry outbursts, crying, refusing treatment, harming themselves and with suicidal thoughts. This indicated that undiagnosed depression could be present in this population.

Thus, it appeared that though survivors were trying to cope with their situation, most of the coping mechanisms identified by social workers seemed to be counter-productive. For example, avoiding service providers would end up depriving the survivor of her rights and entitlements and not change a service provider's attitude or behavior. In the same way, suicidal thoughts and self harm were extremely risky stress reactions, endangering the survivors' lives and making them appear weak and unhinged in the eyes of others; thereby accentuating differences, devaluing their social identities further and creating greater stigma.

Chapter Five

INFERENCES AND RECOMMENDATIONS

The study on stigma of survivors of sex trafficking reaffirmed certain beliefs about the relationship between a survivor and her family and community, after she returned home. It also brought out the complex ways in which people's attitudes, beliefs and cultural norms get entrenched in the ways they react, confront, accept and adapt. The inferences we drew from the results that were presented in Chapter Three are based on experiences of working with survivors over several years. These inferences have led to certain recommendations for interventions to reduce, mitigate and, someday, eradicate stigma towards survivors of sex trafficking, 'sex' being the operative term here. We have presented first the inferences and then the recommendations.

NATURE OF STIGMA IN THE LIVES OF SURVIVORS

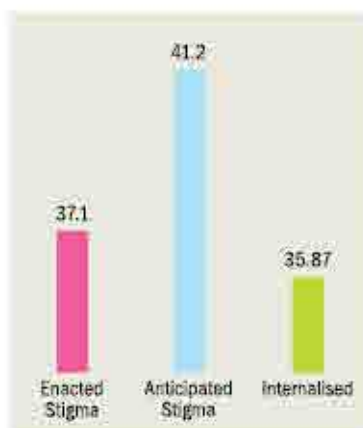


Figure 8 Overall stigma levels

1. There is a definite presence of all three types of stigma in the lives of survivors, with anticipated stigma being the highest among all three. Before drawing inference on this overall trend, we must first concede that stigma is complex and not a linear process. It affects in different ways and it gets reflected in numerous *avatars*. Cultural meaning making is an important aspect to be withheld while understanding stigma, as the origins of people's beliefs about devalued social identity exists in the way a culture justifies it. This is especially true in the case of stigma that emanates for social reasons, like stigma towards sex work, since it reflects a society's conflicts, fears and anger towards sex and women who perform sex work.
2. Overall, around 37% survivors reported presence of enacted stigma in their lives. Presence of enacted stigma has a number of implications in a stigmatized person's life. As per Link and Phelan's (2001) model, the social consequence of enacted or public stigma is exclusion, status loss, structural discrimination and lower life choices. The high levels of isolation and abuse reported by the survivors stand testimony to the fact that they were experiencing constant devaluation and loss of status within their families and community. Social isolation can lead to lack of personal control, negative body image and low self esteem (Fife and Wright, 2000). Therefore, at an individual level, there is clear presence of enacted stigma in the form of discrimination, isolation, abandonment and abuse. The level and degree to which each survivor experiences these stigmas from others varies and could be driven by class, gender, economic and social factors.
3. The findings related to structural stigma need to be interpreted with respect to contextual realities under which services are accessed and the manner in which services are delivered. Our results showed that very few survivors were able to access services directly. Inability to access services due to actual experience of stigma or fear of discrimination could be the reasons inhibiting this behavior. Fear of disclosure also inhibits a survivor's access to services. When a survivor hesitates or avoids going to a duty bearer or service providers, a social worker

usually steps in to help her receive what she needs. Therefore, it is possible that in most cases, social workers approach service providers to get services on behalf of survivors and it is social workers who experience refusals on behalf of them. The fact that social workers approach service providers indicates a protectionist attitude, which results in lower injury from structural stigma (indicated in such high percentage of never refused services) and, at the same time, it results into lower direct engagement with the state, lower visibility, lower participation in decisions affecting self and generation of perception, that the demand for services catering to survivors is NGO-created than an actual people's demand.

4. The survivor who wants to cope by avoiding direct confrontation with situations that can be stigmatizing feels safe in such an arrangement. But is this good or bad? Does it serve some purpose? Does it really protect a survivor from stigma? There is an unequivocal correlation between avoidance as a coping mechanism and greater psychological distress in the literature of stress and coping. Moreover, presence of anticipated and internalized stigma in the present data suggests that protecting survivors from public stigma emanating from service providers, is not serving to reduce their distress from fear of stigma and beliefs held about the self. Instead, it could be letting the devalued self-image go unchallenged. In protecting a survivor from a service provider's discrimination, a social worker could be reinforcing the shame associated with her devalued social identity. And, it also leads to statistical misrepresentation of actual facts – meaning it masks structural discrimination and does not even allow it to be counted, as it doesn't exist in the lived experiences of a survivor, who has been shielded.
5. The trigger of anticipated stigma starts much before she comes back, as she begins fearing stigma from the moment she realizes she will return home from the brothel. The collective consciousness that she shares with her community members reminds her of the norms surrounding a girl's sexuality in her culture. She is aware of the labels used in her society for girls who violate that norm, and so anticipated stigma and even internalized stigma perhaps begins much before the first experience of any enacted stigma. A number of factors therefore, impinge on the anticipated and internalized stigma reported in the present study. Therefore, it emerges that work with anticipated and internalized stigma needs to begin much before the survivor returns home. It needs to be addressed in shelter homes and some level of coping needs to be present before a survivor returns home.
6. When enacted stigma in the form of abuse, isolation, abandonment, denial of access and refusal of services become personally relevant, it will strengthen the already present fear and shame within a survivor. Such anticipation does not require direct experience of a certain form of discrimination. The survivor usually copes with this by withdrawing from situations that are perceived to be threatening. Coupled with this, a work force that belongs to the same community shares the survivor's collective consciousness and has deep-set attitudes towards sexuality and sex work, and we can expect protectionism, welfare-oriented care giving that strengthens an identity that is shamed and devalued, that is in need of emancipation because it has fallen from the norm. This attitude came out quite strongly during the FGDs with social workers and hence, it explains why a rights-based approach may take time in finding acceptance and relevance in these contexts.
7. When survivors begin anticipating labels and stereotypes and when they rationalize others' stigmatizing behavior, they end up endorsing stereotypes about themselves. Internalized stigma is characterized by such endorsements or acceptance of labels and negative stereotypes, leading to sometimes, permanent changes in self-concept. This is especially true for people who depend on external reinforcements for their internal sense of worthiness, often seen

in adolescents. Such people are more prone to internalize stigmatizing beliefs of others in their self-concept. Diminished sense of self is related to lack of satisfaction with life and, at times, limits a person's ability to take opportunities even when they arise. Our results showed that survivors experienced a sense of alienation as a form of internalizing negative beliefs about themselves. Devalued self-concept was revealed in their feelings of disappointment in themselves, feelings of shame and inferiority. The danger lies in the importance a survivor places on her stigmatized identity. If this stigmatized identity, which is disappointing and shameful for the survivor, is at the centre of her self-concept, then she may experience greater psychological distress (Quinn and Earnshaw, 2013; Quinn and Chaudoir, 2009).

8. Among the three types of stigma reported by survivors however, internalized stigma was lowest. If internalized stigma is defined only in terms of negative self image and not in terms of stigma resistance, as we have done in our measurement tool, then the percentage would not have been so low. However, the very presence of stigma resistance shows that survivors seem to have created a split in the way they were internalizing stigma. Our data showed that though shame and disappointment was very high in survivors, that though they had endorsed stereotypes of being morally corrupt and devalued, they resisted being abused because they had been trafficked by someone. The defence against internalizing or accepting abuse and discrimination was their firm belief in victimhood. That the trafficker who betrayed their trust, cheated them, was a belief that fuelled their resistance to stigma. Their anger at being trafficked, their frustration with others not knowing of how they were cheated into sex work and the element of force and exploitation involved in getting her to do sex work, all act as protective elements of her identity. While others may blame the survivor for having left home, she accepts no blame for it herself. Where she accepts blame is for having sinned in prostitution that remains unchallenged through her rehabilitation services. This has two main implications – one is that she is able to feel resilient, whereby she feels she cannot be cheated so easily anymore and another is a sense of maturation as she now sees through deceptions in her primary systems.
9. However, despite stigma, some people can succeed in resisting its negative effects by rejecting such stereotypes as observed by Camp, Finlay and Lyons (2002) among women with long-term mental illness. Within internalized stigma, we found that despite presence of stigma, survivors reported feeling confident and willing to learn new things. Also, they strongly believed that they had been cheated when they were trafficked. Self-concept of survivors who participated in this study appeared to be in the process of integrating two intertwined aspects. One was shame for having performed sexual acts outside the sanctity of marriage with many men. This shame was owned by survivors and internalized. The other aspect was humiliation for having done what they had done. This the survivors rejected as they were clear they couldn't own humiliation for a crime that had been committed on them. Therefore, this implied that a sense of victimhood was protecting her from accepting acts meant to humiliate – bad words, ridicule, abandonment, physical violence and restrictions. The presence of belief in oneself and one's ability to learn new things and meet new people could be a result of interventions by social workers. The constant dialogue on rights and entitlements between social workers and survivors appeared to be containing and minimizing the negative self-image. However, the danger was that in containing and minimizing her negative identity, the social workers were not challenging it. The negative identity based on sexual depravity was being accepted and avoided. It was in turn turning into a tacit, yet salient part of a survivor's identity. Rationalizing it on the basis of dominant cultural meaning was letting this shame remain untouched. Hence, the internalization of shame and rejection of humiliation.

10. We found indications of marriage being related to nature of stigma experienced by survivors. Lending support to a popular belief held among survivors and their families, was the data that married survivors experienced lower levels of stigma, and lowest distress levels due to enacted stigma. However, the quality of marriage mattered a lot, because survivors who had been married and abandoned, fared the worst. They had highest levels of stigma when compared to the married and unmarried group. It is difficult to reach conclusions based on this trend, as marriage is a very complex phenomenon in the contextual backdrop of sex trafficking and imminent stigma. However, it appears that there is some wisdom in getting the survivor married as soon as possible. The reasons why some work and some don't are not known, though there is indication that when survivors choose their husbands and share their trafficking identity, marriages survive. Though contrary to a feminist ideologue, the idea that marriage can be seen as a solution seems like the best way to mitigate her loss of social status in resolving the tension surrounding her sexual contraventions. This tension creates fear and anger in others towards the survivor. The fear is of contamination, threat and her perceived ability to seduce any and every man. The anger is towards her unbridled sexuality, mostly perceived. Marriage helps in reigning in this being who seems capable of disturbing society's carefully laid rules around a woman's sexuality. Stigma between married survivors (Mean = 34) and unmarried and abandoned survivors (Mean = 44) indicated the beneficial impact of supportive relationships and improved social status in a patriarchal society.

IMPACT OF STIGMA ON PARTICIPATION

1. The participation scale is a valid instrument to identify rehabilitation needs of people in distress due to stigma. Our findings showed that majority of survivors fell in the range above the cut-off score, indicating an urgent need for intervention. Areas of intervention that appeared to be most salient for those experiencing greater restrictions on participation were related to mobility and social acceptance. On the other hand, the survivors who were experiencing very low levels of restrictions, required intervention in accessing enabling opportunities for education and work. These findings can be very useful in designing interventions specific to level of stigma.
2. In order to understand nature of participation restriction, we need to identify what were the factors that restricted mobility and induced social isolation in survivors with high restriction. Taking the case of a survivor with highest participation restriction scores, we traced her responses on experience of stigma. A snapshot of her qualitative responses is presented in *Box 9* on the following page.

Qualitative responses from a case with highest participation restrictions and highest levels of stigma

Social isolation and discrimination

"I had gone to a wedding once and the elderly ladies said horrible things about me going to Mumbai... I don't go any more - I feel scared"

"People taunt my parents; I just can't sleep."

"Bajemeye, nongrameye! How do you show your face, better you die!"

"I also met my trafficker in the marketplace and he also threatened to traffic me again."

Family relationship

"My father and elder sister threw me out, my mother brought me back... She loves me a little."

"My own 'mama' often threatens me for bringing the family a bad name and tells me that he will kill me."

Marital relationship

"My husband used to beat me every time after drinking. This happened even before I went."

"My husband never comes back - he has left me and got married again."

Rehabilitation needs

"I don't want to study."

"Never went to school after being back."

"I have been taken by (social worker's name)da, done blood tests and given medicines. Had high fever and bad headaches."

"I feel like meeting other men, I don't have a husband also. But they will beat me if I do that. I want to, but there is no opportunity."

Box 9 Qualitative responses of highest participation restriction case

The responses in *Box 9* illustrate the possible nature of how stigma engulfs the life of a survivor after return. This case shows that higher levels of stigma can be predicted by studying family relationships and pre-trafficking history of a survivor. Domestic violence, strained family relationships, proximity to trafficker in the community and abandonment by husband are probable red-flags that need to be taken into consideration before arranging a survivor's family reunification, post rescue. In this case, enacted stigma in the form of social ostracism seems to be strong and such ostracism appears to be supported from within the family as well. It becomes clearer how it would be immature to banish the protectionist attitude by social workers completely. Cases with very high stigma need social workers to begin their intervention by being protectionist, as it almost appears that in high stigma contexts, a social worker is more than just a service provider. In situations where the survivor is without any support in her home and community, a social worker may need to play the role of a quasi parent, a friend and a counselor. Therefore, it appears that mobility is restricted by enacted stigma in the form of verbal abuse and humiliation. It becomes reinforced when family relationships are weak and there are additional stigmatizing conditions such as marital discord, possible poverty, abandonment and lack of skills. As stigma becomes personally relevant and as the survivor imbibes socially constructed beliefs about herself, shame, fear and worthlessness spur anticipated and internalized stigma. Therefore, stigma becomes pervasive

even if there are no actual enactments of discrimination.

4. In order to capture the entire spectrum of stigma, it is important to present the case of a girl who reported 0 restrictions. Naturally, she also had the lowest overall stigma score. Some of her qualitative responses are presented in *Box 10* below:

Qualitative responses from a case with lowest participation restriction

"I'm studying in class 10 now."

"Abasanyojana (welfare scheme for housing) from Panchayat."

"I go if I want to." (to social events)

"I have friends. They all know about this. They have been friends for very long. They were happy to see me, especially my friend who lives next door."

"...usually no one...once in a fight, a neighbor had called me by a dirty word. I also fought back. Since then, no one says anything."

"After I finish my studies..." (contribute by working)

Box 10 Qualitative responses of lowest participation restriction case

5. A survivor who experiences low levels of stigma must have a web of protective factors that shield her against the harmful effects of stigma or that mitigate the presence of stigma around her. From the excerpts presented in *Box 10*, it appears that lowest levels of stigma and no participation restriction draws its influence from very little enacted stigma, presence of social support from family and friends, positive welfare experiences, capabilities to enhance skills that create a future orientation. Just like risks accumulate and accrue stress, in the same way protective factors build resilience and help a survivor gain external and internal strength to fight negativities. One interesting trend observed from the scores of this case, was that though she did experience some forms of enacted, anticipated and internalized stigma (total frequency of stigma was 71), the intensity of distress on experiencing stigma was 14. Therefore, the level of stress created by the presence of stigma was very little, also indicated in the fact that this case has lowest responses on coping scale as well.

COPING WITH STIGMA

1. Survivors were using both engaged as well as disengaged forms of coping. Almost all survivors tried to avoid people who discriminated against them or stigmatized them and they felt that people who stigmatized them were being unfair and rude. Also almost all felt it was important to belong to a group of survivors and it was important to be respected in their families and communities. Therefore, the ways of coping were diverse and included almost all forms of coping measured, indicating presence of both traditionally effective (problem solving, distraction, cognitive restructuring) and ineffective forms (avoidance, denial). Involuntary stress reactions were also present in the form of emotional arousal (feeling angry and agitated) and being disturbed by thoughts around stigma (ruminative and intrusive thinking).
2. Studies have shown that people use disengagement coping mostly when they perceive their stressors to be insurmountable and uncontrollable. When survivors use avoidance to cope with stigma, it suggests that they have appraised that particular stigmatizing context as threatening to their self. A perception of threat according to Lazarus and Folkman's (1984) transactional model of stress and coping, eventuates in expectation of harm. In such situations therefore, the proclivity is to use disengagement forms of coping. When the situation is perceived as challenging the tendency is to find a solution by engaging with the stressor. This

oversimplification fails to capture the nuances of coping as it occurs and the variations in the final outcome, though it provides a preliminary explanation as to why survivors use avoidance techniques or problem-solving techniques.

3. Dealing with prejudice has been noted to be a difficult task. An important feature of successfully protecting oneself and achieving desired goals in the face of stigma would be the ability to regulate one's emotions. Emotional arousal in the form of anxiety, anger and frustration are natural in stigmatizing conditions, however effective regulation of one's emotions to disconfirm stereotypes is most necessary. Problem-solving would involve adapting one's social interaction strategies, changing one's behavior and regulating emotions to achieve desired goals in prejudicial situations. Survivors can learn to predict certain outcomes, and then use this to shape their behavior to elicit positive as against negative outcomes in a social interaction. For example, behaving in a stereotype disconfirming fashion, by being vocal when expected to be meek, or being socially skilful in interactions, when least expected to.

STIGMATIZER AND SURVIVOR RELATIONSHIP

1. Aunts and uncles were most stigmatizing within the family. Brothers and brothers-in-law were also identified to be stigmatizing. Peers, or girls and boys of similar age who were schoolmates or friends, were most stigmatizing in the community and the *Panchayat* and its functionaries were most stigmatizing among service providers.
2. Norm violation, especially sexual norm violation and controllability or being responsible for her trafficking, were the most commonly reported reasons underlying the motivations to stigmatize. It also appeared that social vulnerabilities in the form of poverty, conflicts within the family were also responsible for others behaving badly with the survivor. Stigma was not just used to target the survivor for her perceived ill-conduct or sexual deprivations, but also used to get even with the family and try to gain control over the family's resources (land and house).
3. Most of the stigmatizers within the family were also subjected to stigma from others outside, because of the survivor. Stigma by association was present and has been shown to be related to lower self-esteem and psychological distress in the stigmatized person because she takes blame for bringing misfortune for the family (Bos *et al.*, 2013). When stigma by association is present, it can also lead to concealment advice, or efforts to not disclose survivor status, trying to keep the survivor isolated by distancing from her and displacing anger of being stigmatized on the survivor.
4. Very few stigmatizers within the family or neighborhood seemed to have the power to stigmatize by influencing others' attitudes towards the survivor. Also, no explicit connections were found that showed that the stigmatizers had much to do with decisions impacting a survivor's life. Some evidence was found about stigma resistance from others in the family and community to diminish the power of stigmatizers. In cases where the stigmatizer was influential, it clearly created greater problems for the survivor by creating an overall oppressive condition of living. It is possible that family members did not oppose an influential one either because they agreed with the stigmatizing attitude or because they were themselves overcome with shame associated with the survivor. In both cases, there would be a tacit acceptance of stigma, which in itself can be viewed as support.
5. From the results on identification of stigmatizers and relationship between survivor and stigmatizer, it appears that families are vulnerable. Once the survivor returns to such contexts,

it adds to their vulnerability and strains already strained relationships. There is evidence of pre-trafficking vulnerability in families from which girls are trafficked (*Change Mantras*, 2015, in press). How else would one explain brothers-in-law and aunts trafficking a girl? Poverty, strained relationships, domestic violence and a host of other vulnerabilities exist in the families of some girls that remain even when they return. Stigma that perpetuates to the family because of the survivor adds on to the already strained conditions and, thereby creates a web of inter-related vulnerability factors that maintain a stigmatizing environment. The findings showed that when relationships are good; for example, girls who were married and not abandoned, stigma was lower. Thus, our study corroborates what Goffman initially proposed: Studying stigma needs to use the ‘language of relationships and not attributes’ (1963, Pg. 3).

RECOMMENDATIONS

Several recommendations can be drawn from these inferences. These recommendations are multi-pronged as they are targeted at the system, as well as the survivor.

1. Synchronic skill development

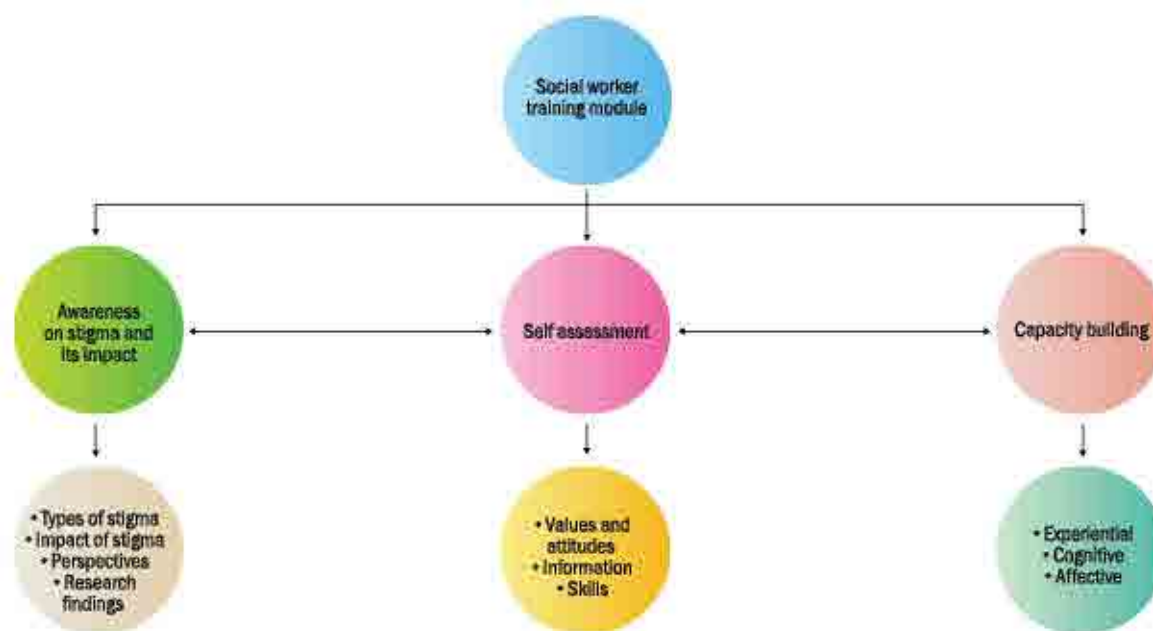


Figure 9 Synchronic skill development model

Social workers based out of communities who are expected to use anti-stigma interventions for survivors of sex trafficking, lack capacities to do so. These capacities are specific to identifying, mitigating and maintaining stigma resistance and do not refer to their capacity of conducting basic case work. The assumption here is that community-based social workers would be aware of case work and case management. This assumption needs to be checked and ensured that case work is not being confused with maintaining a file for each survivor only. Once this basic skill is present the synchronous skill development model can be utilized to build capacities to deal with stigma. This model is based upon the principle of synchronicity of skill development. This means that it supposes that skills to deal with stigma cannot be taught in a hierarchical manner, rather each

component needs to be linked with the other and neither can be assumed to be complete ever. Therefore, 'awareness on stigma and its impact' needs to be accompanied by 'self assessment' and 'capacity building'. It can never be assumed that a social worker knows everything that is to be known about stigma – as and when new knowledge emerges from the field or from research, it needs to be imbibed by the team of interventionists. Similarly, self assessment which has three sub-components – values and attitudes, information and skills need to be an ongoing process. The study showed that social workers might carry residual stress, anger and complex emotions about themselves and about the survivor. Such inner processes need to be identified and resolved in order to avoid perpetuating stigma or converting an innate negative attitude into a behavior. This component of the module also aims towards care for social workers – only through self-assessment can they be aware of their own mental health and knowledge needs. It is important to include a care for care-givers component in interventionists in the anti-stigma field. Finally, capacity building will need to be primarily experiential – inducting reasoning needs to be encouraged to avoid pre-conceived notions and stereotypes from restricting a social worker's approach. Affective skills in terms of ability to listen and identify nuances that are often not vocalized will play an important role in the way a social worker identifies and addresses internalized and anticipated stigma. The capacities need to be built in such a way that the social worker is able to be creative in its application at different levels – intra-personal (stigma from within the survivor), inter-personal (stigma between survivor and others) and structural (power relations, institutional practices).

2. Case management approaches to identify stigmatizers and family work

The study made it increasingly clear that case management approaches used by community-based social workers would need to include two very important elements. One is that social workers would have to work with the survivors to identify stigmatizers in a survivor's family, community and tertiary level – institutions. Second, the social worker would need to at least visit the survivor twice a month; the frequency of such visits will depend on the intensity of problems identified. These bi-monthly visits will need to be structured in a way to include a considerable amount of time in which the survivor can talk about how she is feeling, what are her worries, what are the thoughts that are continuously on her mind and so on. Survivors need to be equipped to access services, raise concerns about lack of services, complain about poor quality of services and advocate for stigma free service delivery by their own. The protectionist attitude with which social workers shield a survivor seems to be counter-productive. However, some amount of hand-holding will be needed, especially in the initial stages, the progress of a case must be monitored in terms of how independent the survivor becomes with time and not just with the outcome of service access only. That means, that even if a survivor doesn't get services on account of trying to access it herself, instead of letting the social worker do it on her behalf, it should be considered a progress and strategies need to be found to deal with barriers that prevent her from receiving services.

2. Developing interventions that include working with families of survivors

The present study has clearly indicated that the most easily identifiable stigma emanates from the family. However, in order to leverage power to work with the family to reduce stigma, a social worker will need support from the state. This is because at present, if a family refuses to allow a social worker access to the survivor, nothing can be done. In that sense, a social worker has lower power than the family, which will prevent any interventions targeted at addressing stigma emanating from the family. If the state gives power to a social worker to check on a survivor without the family's permission, only then will there be some scope for working on contentious

issues with the survivor's family. Public-private partnership models can be used to confer legitimacy to community-based organisations so as to indicate that CBOs are acting on behalf of the state in protecting survivors from public stigma.

A pilot phase of operationalizing such a public-private partnership for anti-stigma intervention needs to be carried out as there will be situations where the family will be hostile and strategies of managing their hostility need to be worked out. As of now, a social worker needs to be mindful that the highest form of stigma is from the family and her ability to resist stigma from the family is lower. Therefore, family axis is important.

One of the reasons why the ongoing model of intervention in North 24-Parganas is not working to reduce stigma could be that it is externally focused. Social workers are geared towards increasing acceptability in institutions, rather than working on building relationships within the family and community. According to this research, stigma is highest at the family and community level. Based on the data on stigmatizers, it appears that aunts, brothers, sisters-in-law are most common stigmatizers. Social workers will need to have the skills to analyze why these groups stigmatize most often. What is the source of the hostility? The intervention needs to be planned taking into account the nature of affect and ambivalence generating in the dyadic relationship as well as its place in the larger context. For example, in the case of a sister-in-law, the real reason for stigmatizing may not be sex work, it may be displacement of anger and frustration towards the weakest member. This anger and frustration of the sister-in-law may not be directly related to the survivor, but could be an indication of domestic violence in her life or any such stressor. Instead of trying to work at the surface, social workers now need to adopt a holistic approach. Families may themselves be victims of stigma and therefore, will benefit from interventions that make them feel that their stigma is shared. However, fundamentally social workers will need to have legitimacy to intervene in families and community, without being denied access and they will need skills and resources to make long-term changes.

3. Collectivisation – mobilizing social action

Social action in the form of collectives of stigmatized people that aims to solve problems together by creating a collective identity, is a common way of coping with stigma as a group. Such collectives can serve several purposes. Survivors who usually do not find any space to express their feelings, vent their emotions, and find support will get a safe and secure place to do so in such collectives. So such collectives will have a therapeutic purpose. Next, such collectives can be platforms to launch social action against stigma. Collectives can be mediums through which survivors identify stigma and take steps to improve the group's status in the society and advocate for their rights. Therefore, a collective can service the purpose of advocacy, problem solving and activism. Finally, distraction is an effective coping technique to deal with stigma. But opportunities for distraction available to a survivor are very few. There is evidence that peer support may be related to positive adaptation with stigma, and that peer support decreases as a result of enacted stigma. Participation in collectives can provide survivor avenues for distraction and developing peer relations and social capital. Such collectives need to avoid becoming instruments that strengthen discrimination or separation of a survivor from her community. Therefore, collectives need to have mixed memberships, which means that some collectives need to be open to all young people, or all married people. Collectives need not necessarily be in the same village but can be organized at a block or district level, so as to constantly expand the social network of the girl. The anti-stigma agenda of such collectives can be overarching and include stigma against anybody in the community. This will ensure that collectives help de-rationalize beliefs and structures that maintain stigmatizing attitudes within the community and culture,

rather than work at a superficial level of only raising voice against acts of stigma.

4. Anti-stigma policy

There needs to be policy level interventions to create intolerance towards stigma. Stigmatizers need to receive a strong message from community governance bodies such as the *Panchayat* and police in the form of public shaming of stigmatizers. Just as in any social event, stigmatizing contexts too have stigmatizers, bystanders and sympathetic people. Such people need to be identified within institutions and sympathetic people need to be motivated to build empathy towards survivors. There needs to be a clear guideline issued by DWCD (Department of Women and Child Development) on anti-stigma and discrimination which has policy legitimacy that can be used by social workers and the *Panchayat*. Adopting an anti-stigma stance through policy formulation can be especially useful in inhibiting institutional stigmatizers.

Policy level intervention would, therefore, entail:

- Advocate for an anti-stigma law encompassing the rights of all socially devalued identities, thereby ensuring there is a mechanism to punish the stigmatizer
- Lobbying with the Government to build this into a much more public-private partnership model
- Co-management, closer monitoring, and joint accountability.
- Integrate it with existing schemes; such as in West Bengal an anti-stigma component can be a part of the existing *MuktirAlo* scheme.
- In states that lack schemes or policy, build awareness on the impact of lack of reintegration services on survivors and impact of stigma on reintegration.
- Institutional legitimacy that will ensure greater leverage and higher accountability.
- Chain of information needs to flow from social workers to DSWO (District Social Welfare Officer), DCPU (District Child Protection Unit) and need to reach the DWCD (Department of Women and Child Development).

7. Anti-stigma messaging

Anti-stigma communication can be developed around the objectives of:

1. **Appeal** – tools that can show the impact of stigma on a person's life. The appeal needs to be affective and needs to be built taking cultural meanings into consideration. For example, in a patriarchal agrarian community, short-films showing how the survivor actually feels disappointed in herself and alienated and needs help and support from others who are more powerful and are traditionally supposed to be the 'protectors' may work better than a film simply asking people to support the 'poor girl'.
2. **Empathy** – such tools will need to contextualize a stigmatized person's life – campaigns around how controllable was the event that led to her being trafficked, deconstructing vulnerability pre-trafficking, deconstructing her potential dangerousness, normalizing her life, *etc.* can build empathy towards a survivor. The survivor's data in this study showed, that they wished others knew of what really happened.
3. **Information** – posters, ad campaigns, films, songs, street plays and other creative means can be used to disseminate information on traffickers, stigma and policy, and schemes for the affected.
4. **Threat** – assuming that there has been sufficient lobbying with law enforcement agencies and policy level changes, threat can be used to prevent enacted stigma.

SUGGESTIONS FOR FUTURE RESEARCH

Every research in the course of answering questions, gives rise to several other questions that need further explanation. In our present study too, we arrived upon several questions that couldn't be answered and that we feel need immediate research. These are:

1. Longitudinal research on identifying variables that moderate the relationship between stigma and well-being and social identity of a survivor. There are a host of variables that impact the way stigma affects a survivor's life conditions. Identification of such variables and their effects can lead to better understanding of resilience in survivors. Possible variables to be included

in such a study or series of such studies could be – pre-trafficking living conditions, relationship with a trafficker, experience of exploitation, nature of rescue, nature of rehabilitation in shelter home, impact of time on stigma, reasons for migration and nature of services on return.

2. In-depth qualitative research on identifying the community's ways of responding to and mitigating stigma towards other vulnerable groups such as unwed mothers, abandoned women, pre-marital sex, sex work and so on, need to be conducted to understand

the origins of anticipated stigma in survivors of sex trafficking. This will capture the multi-faceted nature of stigma.

3. In-depth qualitative study on marriage of survivors of sex trafficking. Such a study can be conducted on survivors who are married to men from the same community that stigmatizes. How the tension gets resolved within the marriage can be answered by finding out how they deal with similar questions that the rest of the community reacts to negatively.

EPILOGUE

When we began this study, we had a rapid assessment design in mind. We needed data to get an overview of stigma in the lives of survivors living in North 24-Parganas. Now that we have completed it, the study has evolved beyond our primary conceptions.

It was like opening a crack and being flooded with light, a lot of which couldn't even be contained by our limited framework. In the lives of survivors of sex trafficking, stigma appeared to be all pervasive and fluid. It was present in the way people behaved with survivors and it was present in the way survivors perceived themselves and others.

It was not very linear, one that emanates from a point and moves to another. At times, it was created outside the survivor, at times within.

We realized that anticipation of stigma began much before a survivor returned home and we recommended, therefore, that stigma as a theme would need a psycho-social frame of reference as against a purely activism and rights perspective.

We learned that stigma was primarily towards sexuality and violation of norms around it. That even within a survivor's mind, sexual norm violation created shame but being trafficked created anger. This shame was a part of a collective consciousness that was shared by the survivor, her supporters as well as her stigmatizers, which was resulting in rationalization of the very foundation of stigma both from outside and within. Without deconstructing this shame, anti-stigma

interventions would be restricted to superficial improvements only. However, deconstruction of shame is not simple and nor is it something that can be achieved in a short span of time. Often, generations pass before the culture gives up a deeply held shame, but it does occur and we are hopeful that in this case too, there will be change. A psycho-social perspective would induce questioning beliefs of all stakeholders involved in meaning making. Therefore, from a language of 'oughts' it would move towards a language of 'cans', thereby reducing guilt in not fitting into the limits drawn by 'oughts' and forcing others to expand their frame of reference and make space for multiple outcomes.

I have never earned any good name even after trying so hard. I am "opaya" (unlucky)... I have no qualities.

If I try to join any young girls' group, they make fun - both, the married and unmarried women. Maybe I am bad, that's why they don't mix with me... I wonder then, am I?

STIGMA

He (the doctor) did not refuse to treat me, but he verbally abused me, humiliated me while touching me.

We are an isolated family - no one comes to our house.

I am not like other girls. My social worker has helped me, but there is no one else who treats me like other girls... I am a 'bad' different.

Appendix

TOOLS FOR DATA COLLECTION

Enacted stigma scale for survivors of sex trafficking

Instruction for the interviewer

You can say this:

We are going to understand forms of enacted stigma that you have experienced. Enacted stigma means the way people behave with you because of their beliefs about a person who has been trafficked or sexual exploitation. It can happen in other cases as well, for example, if someone has a mental illness, sometimes people make fun of that person. That is enacted stigma. I will be asking you some questions about such enacted stigma, you need to indicate how frequently this occurs with you. You can also give me examples of such situations that have occurred with you. We are trying to understand what are the types of negative behaviour that you experience when people know of your trafficking experience. Do you have some questions? Please let me know if you do not understand my questions.

তোমাকে কী কী ধরনের বৈষম্যমূলক আচরণ এবং নিন্দা সহ্য করতে হয় আমরা সেটা বোঝার চেষ্টা করছি। যারা পাচার থেকে ফিরে আসে, তাদের ব্যাপারে কিছু কিছু মানুষের মনে খারাপ ধারণা থাকে, যার ফলে এই মানুষরা পাচার থেকে ফিরে আসা মেয়েদের সঙ্গে বিভিন্ন রকম ভাবে খারাপ ব্যবহার করে, তাদের নিন্দা করে। এই ধরনের ব্যবহারগুলিকেই বৈষম্যমূলক আচরণ বলা হয়। এই ধরনের ব্যবহার অন্যান্য কিছু মানুষদের সঙ্গেও হয়। যেমন, কেউ যদি মানসিক ভাবে অসুস্থ হন, অনেক সময় অনেকে তাকে নিয়ে মজা করে। এটাও একধরনের বৈষম্য করা। আমি তোমাকে এই ধরনের নিন্দা এবং খারাপ ব্যবহারের কিছু উদাহরণ দেবো, তুমি আমায় বলো যে এই ধরনের ব্যবহার তুমি কখনো পেয়েছো কি না, বা কতবার পেয়েছো। তুমি আমায় এই ধরনের ঘটনা বা তোমার সঙ্গে হয়েছে তার উদাহরণও দিতে পারো। আমরা এটা বোঝার চেষ্টা করছি যে যখন কেউ তোমার পাচার হওয়ার ব্যাপারে জানতে পারে, তার পর তারা কি ধরনের নিন্দা করে তোমার ব্যাপারে, অপবাদ দেয় বা বাজে ব্যবহার করে তোমার সাথে। যদি তুমি কোনো প্রশ্ন না বুঝতে পারো তাহলে আমাকে জানিও।

No	People who know of my sex trafficking history - যারা আমার পাচার হওয়ার ঘটনার সম্পর্কে জানে, তাদের মধ্যে কয়েকজন -	NA/ Irr	কখনো হয়নি Never	কয়েক বার হয়েছে Sm	সবসময়েই হয় Always	NP 1	S 2	M 3	L 5
A	Refused services (কোনো সেবা বা সার্ভিস দিতে চায় নি)		1	2	3				
1	Have refused me Medical services আমার চিকিৎসা করতে চায় নি। Ask for incident (কি ঘটেছিলো?) <i>If sometimes or Always, how big a problem is it to you?</i> যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?								
2	Have refused me Education services আমায় স্কুলে বা ক্লাসে নিতে চায় নি।								

<p>Ask for incident(কি ঘটেছিলো?)</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>										
<p>Have refused me Panchayat services</p> <p>আমাকে পঞ্চায়েতের কোনো সার্ভিস দেয় নি।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>										
<p>Have refused me religious services</p> <p>আমাকে ধর্ম সম্পর্কিত কোনো সেবা দেওয়া হয় নি, বা আমার ধর্ম পালন করতে দেওয়া হয় নি।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>										
<p>Any other অন্য কিছু</p>										
<p>Isolation আলাদা করে রেখেছে</p>										
<p>Have isolated me in a Social gathering</p> <p>আমায় কোনো সামাজিক অনুষ্ঠানে সবার সঙ্গে থাকতে দেয় নি বা আলাদা করে রেখেছে।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>										
<p>Have Not visited my family</p> <p>আমার বা আমার বাড়ির লোকের সঙ্গে দেখা করতে আসেনি।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>										
<p>Any other অন্য কিছু</p>										
<p>Abandonment</p> <p>ছেড়ে দিয়েছে / তাড়িয়ে দিয়েছে</p>										
<p>Have abandoned me (paternal family)</p>										

	<p>বাবা-মা বাড়ী থেকে তাড়িয়ে দিয়েছে, বা আমায় বাড়ী ছেড়ে চলে যেতে বলেছে।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>							
10	<p>Have abandoned me (marital family)</p> <p>শুভ্রবাড়ী থেকে তাড়িয়ে দিয়েছে, বা আমায় বাড়ী ছেড়ে চলে যেতে বলেছে।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>							
11	<p>I have lost friends when they found out about my sex trafficking experience</p> <p>আমার বন্ধুরা যখন জানতে পেরেছে তখন আমার সাথে আর বন্ধুত্ব রাখে নি।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>							
12	Any otherঅন্য কিছু							
C	Abuse অপমান করা, খারাপ ব্যবহার করা							
13	<p>Have sworn at and teased me</p> <p>আমায় গালাগালি দিয়েছে, উত্যক্ত করেছে।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>							
14	<p>Have scolded me unnecessarily and made me feel responsible for unrelated things</p> <p>আমায় বিনা কারনে বকা দিয়েছে, এবং যা করিনি তার জন্য আমাকে দায়ী করেছে।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>							

15	<p>Have beaten me আমায় মেরেছে।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i> যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>																			
16	<p>Have sexually harassed, abused, teased me আমার উপর যৌন অত্যাচার করেছে, হয়রানি করেছে।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i> যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>																			
17	<p>Have ridiculed me আমায় নিয়ে ঠাট্টা তামাসা করেছে।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i> যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>																			
18	<p>Have threatened to harm me আমার ক্ষতি করবে বলে হুমকি দিয়েছে।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i> যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>																			
19	Any other... অন্য কিছু																			
D	Access প্রবেশাধিকার বা সুযোগ																			
20	<p>Have denied me access to recreation আমায় বিনোদনের সুযোগ নিতে দেয় নি।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i> যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>																			
21	<p>Have denied me access to education আমায় পড়াশোনা করার সুযোগ নিতে দেওয়া হয় নি।</p>																			

	<p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>										
22	<p>Have denied me access to health services and medicines</p> <p>আমাকে স্বাস্থ্য পরিসেবার সুযোগ নিতে দেয় নি।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>										
23	<p>Have denied me access to employment</p> <p>আমায় চাকরি পাওয়ার সুযোগ নিতে দেওয়া হয় নি।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>										
24	<p>Have denied me access to food</p> <p>আমায় খাবার বা রেশন পাওয়ার সুযোগ থেকে বঞ্চিত করা হয়েছে।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>										
25	<p>Have denied me access to participation in social and religious activities</p> <p>আমাকে সামাজিক বা ধার্মিক অনুষ্ঠানে অংশগ্রহণ করতে দেওয়া হয় নি।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>										
26	<p>Have denied me access to hobbies and interest</p> <p>আমায় আমার শখের বা আগ্রহের, ভালোনাগার কাজ করার সুযোগ নিতে দেওয়া হয় নি।</p> <p><i>If sometimes or Always, how big a</i></p>										

<i>problem is it to you?</i> যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?									
Have ignored my good points আমার ভালো দিক এবং গুন গুলিকে অবজ্ঞা করা হয়েছে। <i>If sometimes or Always, how big a problem is it to you?</i> যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?									
Have looked for flaws in my character আমার চরিত্রে দোষ খুঁজে বের করার চেষ্টা করেছে। <i>If sometimes or Always, how big a problem is it to you?</i> যদি কয়েকবার হয়ে থাকে বা সবসময়েই হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?									
Any other... অন্য কিছু									
Comment মন্তব্য									Total

Not answered, Irr - Irrelevant, Sm - sometimes, NP - no problem, S - small, M - medium, L - large

Anticipated/perceived stigma scale for survivors of sex trafficking

Instructions: "I will read out some statements that describe some of the thoughts that occur to survivor of sex trafficking at times. These statements and thoughts may or may not occur to you. I would like to know if these thoughts occur to you. Please indicate the frequency with which these thoughts occur to you using these numbers: 1 = Never, 2 = Sometimes, and 3 = Always. If these thoughts occur to you sometimes or always, then how much of a problem it is to you: NP - no problem, S - small, M - medium, L - large.

There is no right or wrong answer. Think what is applicable to you and let me know. Usually the first reply that comes to your mind is the most applicable one."

"আমি তোমায় কয়েকটি শাইন পড়ে শোনাচ্ছি। এই কথাগুলি অনেক সময় পাচার থেকে ফিরে আসা মেয়েদের মনে হয়। এই ধরনের কথা তোমার নিজের সম্পর্কে মনে হতে পারে বা নাও মনে হতে পারে। তুমি আমাকে বলো যে এই চিন্তাগুলির কোনটা তোমার কতটা মনে হয় ১= কখনো মনে হয় না, ২ = মাঝেমধ্যে মনে হয়, ৩ = সবসময় মনে হয়। আর যখন এই চিন্তা গুলি তোমার মনে আসে, তখন তার জন্য তোমার কতটা কষ্ট হয় ১ - কোনো কষ্ট হয় না, ২ - অল্প কষ্ট হয়, ৩ - একটু বেশি কষ্ট হয়, ৪ - অনেকটা কষ্ট হয়।

এখানে কোনো ঠিক বা ভুল উত্তর নেই। তোমার যেটা মনে হয় সেটাই বলো।"

No	Items	NA/ Irr	Never 1	Sm 2	Always 3	NP 1	S 2	M 3	L 5	S
1	If possible I would keep others from knowing about my trafficking experience. যদি সম্ভব হয়, তাহলে আমি অন্যদেরকে আমার পাচার হওয়ার ঘটনার কথা জানতে দেবো না। If sometimes or Always, how big a problem is it to you when people come to know of your experience? যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তাহলে অন্যরা তোমার পাচার ঘটনার ব্যাপারে জানলে, তোমার কতটা সমস্যা হয়?									
2	I would share it with someone who is close to me, someone I trust. যারা আমার কাছের লোক, যাদেরকে আমি বিশ্বাস করি, একমাত্র তাদেরকে আমি এই ঘটনার কথা জানাতে পারি। If sometimes or Never, how big a problem is it to you? যদি কয়েকবার মনে হয়ে থাকে বা কখনই না মনে হয়, তার									

	ফলে তোমার কতটা কষ্ট হয়?												
3	<p>I think if others (family, neighbours, friends, colleagues) knew of my experience they would think I am different in a negative sense. আমার মনে হয় যদি আমার পরিবার, প্রতিবেশী, বন্ধু, সহকর্মী এরা আমার এই ঘটনার কথা জানতে পারে, তারা আমাকে নিজেদের থেকে আলাদা ভাবে।</p> <p>If sometimes or Always, how big a problem is it to you? যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তার জন্য তোমার কতটা কষ্ট হয়?</p>												
4	<p>I think less of myself now. Being a survivor of sex trafficking has reduced my sense of pride. আমার নিজে থেকে ছোট মনে হয় খুব। পাচার থেকে ফিরে আসার জন্য আমার আত্ম গর্ব এবং আমার আত্মসম্মান কমে গেছে।</p> <p>If sometimes or Always, how big a problem is it to you? যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তার জন্য তোমার কতটা কষ্ট হয়?</p>												
5	<p>I think service providers will not treat me like others if they knew about my experience. আমার মনে হয় সার্ভিস প্রভাইডাররা যদি আমার এই ঘটনার কথা জানতে পারে তাহলে তারা আমার সঙ্গে আলাদা রকম ব্যবহার করবে।</p> <p>If sometimes or Always, how big a problem is it to you? যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তার জন্য তোমার কতটা কষ্ট হয়?</p>												
6	<p>I think others will avoid me if they knew about my trafficking experience. আমার মনে হয় আমার পাচার থেকে ফিরে আসার কথা জানতে পারলে অন্যান্যরা আমায় এড়িয়ে চলবে।</p> <p>If sometimes or Always, how big a problem is it to you? যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তার জন্য তোমার কতটা কষ্ট হয়?</p>												

7	<p>I think If they knew, my neighbours, friends, relatives will stop visiting my family. আমার মনে হয় যদি আমার প্রতিবেশী, বন্ধু, আত্মীয়রা জানতে পারে, তাহলে ওরা আমাদের বাড়ীতে আসা বন্ধ করে দেবে।</p> <p>If sometimes or Always, how big a problem is it to you? যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তার জন্য তোমার কতটা কষ্ট হয়?</p>									
8	<p>I think because of this experience my chance of getting married is more difficult. আমার মনে হয় এই ঘটনার জন্য আমার বিয়ে হওয়া আরো কঠিন।</p> <p>If sometimes or Always, how big a problem is it to you? যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তার জন্য তোমার কতটা কষ্ট হয়?</p>									
9	<p>I think if my husband / future husband found out he will leave me. আমার মনে হয় যদি আমার স্বামি কখনো জানতে পারে, সে আমাকে ছেড়ে দিতে পারে।</p> <p>If sometimes or Always, how big a problem is it to you? যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তার জন্য তোমার কতটা কষ্ট হয়?</p>									
10	<p>I think my marital family / future marital family will send me back if they knew. আমার মনে হয় আমার শ্বশুরবাড়ীতে জানতে পারলে তারা আমায় ফেরত পাঠিয়ে দেবে।</p> <p>If sometimes or Always, how big a problem is it to you? যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তার জন্য তোমার কতটা কষ্ট হয়?</p>									
11	<p>I think this experience will cause difficulties for my family - in accessing services, in social gatherings, etc. আমার মনে হয় আমার এই ঘটনার জন্য আমার পরিবারের জন্য বিভিন্ন সামাজিক অনুষ্ঠানে বা বিভিন্ন পরিষেবা নিতে</p>									

	<p>পেলে সমস্যা হবে। If sometimes or Always, how big a problem is it to you? যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তার জন্য তোমার কতটা কষ্ট হয়?</p>								
12	<p>I think others become sexually abusive when they find out someone was trafficked. আমার মনে হয় অন্যান্যরা যখন জানতে পারে যে কেউ পাচার হয়ে গেছিল, তখন তারা মেয়েটির উপর যৌন অত্যাচার করে। If sometimes or Always, how big a problem is it to you? যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তার জন্য তোমার কতটা কষ্ট হয়?</p>								
13	<p>I fear others will ridicule me if I behaved like other girls of my age. আমার মনে হয় আমি যদি আমার বয়সী অন্যান্য মেয়েদের মতন আচরণ করি, তাহলে লোকে আমায় নিয়ে ঠাট্টা করবে। If sometimes or Always, how big a problem is it to you? যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তার জন্য তোমার কতটা কষ্ট হয়?</p>								
14	<p>I think because of this experience others think I am a bad influence. আমার মনে হয় এই ঘটনার জন্য অন্যান্যরা ভাবে আমার সঙ্গে মিশলে তারাও খারাপ হয়ে যাবে। If sometimes or Always, how big a problem is it to you? যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তার জন্য তোমার কতটা কষ্ট হয়?</p>								
15	<p>I think because of this experience others feel I shouldn't be happy and carefree. আমার মনে হয় এই ঘটনার জন্য অন্যান্যরা ভাবে আমার আনন্দে থাকা বা আমার মতন করে থাকা উচিত নয়। If sometimes or Always, how big a problem is it to you? যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়,</p>								

	তার জন্য তোমার কতটা কষ্ট হয়?								
16	<p>I think if others knew they would call me names and gossip about me. আমার মনে হয় যে অন্যান্যরা জানতে পারলে তারা আমার ব্যাপারে গুজব ছড়াবে, আমার নামে খারাপ কথা বলবে।</p> <p>If sometimes or Always, how big a problem is it to you? যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তার জন্য তোমার কতটা কষ্ট হয়?</p>								
17	<p>I think people who love me and care for me will stop loving and caring if they found out. আমার মনে হয় যারা আমাকে ভালোবাসে, আমার যত্ন নেয়, তারা এই ঘটনার কথা জানতে পারলে আমায় আর ভালোবাসবে না।</p> <p>If sometimes or Always, how big a problem is it to you? যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তার জন্য তোমার কতটা কষ্ট হয়?</p>								
	Comment মন্তব্য								টোটাল

NA - Not answered, Irr - Irrelevant, Sm - sometimes, NP - no problem, S - small, M - medium, L - large

Internalized Stigma Scale

Instructions: "I will read out some statements that describe some of the thoughts that occur to survivors of sex trafficking at times. These statements and thoughts may or may not occur to you. I would like to know if these thoughts occur to you. Please indicate the frequency with which these thoughts occur to you using these numbers: 1 = Never, 2 = Sometimes, and 3 = Always. If these thoughts occur to you sometimes or always, then how much of a problem it is to you: NP = no problem, S = small, M = medium, L = large.

There is no right or wrong answer. Think what is applicable to you and let me know. Usually the first reply that comes to your mind is the most applicable one."

“আমি তোমায় কয়েকটি লাইন পড়ে শোনাচ্ছি। এই কথাগুলি অনেক সময় পাচার থেকে ফিরে আসা মেয়েদের মনে হয়। এই ধরনের কথা তোমার নিজের সম্পর্কে মনে হতে পারে বা নাও মনে হতে পারে। তুমি আমাকে বলো যে এই চিন্তাগুলির কোনটা তোমার কতটা মনে হয় ১= কখনো মনে হয় না, ২ = মাঝেমধ্যে মনে হয়, ৩ = সবসময় মনে হয়। আর যখন এই চিন্তা গুলি তোমার মনে আসে, তখন তার জন্য তোমার কতটা কষ্ট হয় ১ - কোনো কষ্ট হয় না, ২ - অল্প কষ্ট হয়, ৩ - একটু বেশি কষ্ট হয়, ৪ - অনেকটা কষ্ট হয়। এখানে কোনো ঠিক বা ভুল উত্তর নেই। তোমার যেটা মনে হয় সেটাই বলো।”

No	Items	NA/ Irr	Never 1	Sm 2	Always 3	NP 1	S 2	M 3	L 5	S
1	I think I was responsible for being trafficked, like it was my own fault. আমার মনে হয় আমার পাচার হওয়ার জন্য আমি নিজেই দায়ী, এটাতে আমারই দোষ ছিলো। <i>If sometimes or Always, how big a problem is it to you?</i> যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?									
2	I think I am a bad influence on others because of my experience. আমার মনে হয় আমার এই অভিজ্ঞতার জন্য অন্যদের উপর আমি খারাপ প্রভাব ফেলি। <i>If sometimes or Always, how big a problem is it to you?</i> যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?									
3	I think my experience has left me morally corrupt.									

	<p>আমার মনে হয় আমার এই অভিজ্ঞতার জন্য আমি নষ্ট হয়ে গেছি।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>									
4	<p>I think I cannot be loved by anyone because of my experience.</p> <p>আমার মনে হয় আমার এই ঘটনার জন্য আমাকে কেউ ভালোবাসতে পারবে না।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>									
5	<p>I feel ashamed or embarrassed in social gatherings because of my trafficking experience.</p> <p>আমি যেহেতু পাচার হয়ে গেছিলাম তাই এখন কোনো সামাজিক অনুষ্ঠানে গেলে আমার খুব লজ্জা লাগে।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>									
6	<p>I feel disappointed in myself because of being trafficked.</p> <p>আমি যেহেতু পাচার হয়ে গেছিলাম তাই আমার খুব নিজের প্রতি হতাশ লাগে।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>									
7	<p>I feel I am inferior to others because of my trafficking experience.</p> <p>আমার পাচার হয়ে যাওয়ার ঘটনার জন্য আমার নিজেকে অন্যদের কাছে খুব ছোট মনে হয়।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p>									

	যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?									
8	<p>I agree with the negative things that others who know of my experience say about me. আমার পাচার হওয়ার ব্যাপারে যারা জানে তারা আমার ব্যাপারে যে খারাপ কথা বলে আমি সেগুলি বিশ্বাস করি।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>									
9	<p>Because of this experience I cannot be as carefree as other girls my age. আমার এই অভিজ্ঞতার জন্য আমি আমার বয়সি অন্য মেয়েদের মতো সহজ হতে পারি না।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>									
10	<p>Because I was trafficked I cannot expect any happiness now আমি পাচার হয়ে গেছিলাম, তাই এখন আমার কোনো রকম আনন্দ পাওয়ার আশা করা উচিত নয়।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>									
11	<p>Because of my experience I can be beaten, ridiculed and not taken seriously by my family আমার এই ঘটনার জন্য আমায় কেউ মারলে, আমায় নিয়ে মজা করলে, বা আমার মতামতের গুরুত্ব না দিলে সে ভুল করবে না।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>									
12	<p>Because of this experience I shouldn't visit religious places of worship</p>									

	<p>আমার এই অভিজ্ঞতার জন্য আমার কোনো ধর্মস্থানে যাওয়া উচিত নয়।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>									
13	<p>It is alright if service providers such as nurse, teacher, Panchayat, doctor, etc treat me badly because of my trafficking experience</p> <p>আমার এই অভিজ্ঞতার জন্য যদি নার্স, শিক্ষক, পঞ্চায়েত, ডাক্তার এরা যদি আমার সঙ্গে খারাপ ব্যবহার করে আমি পাচার থেকে ফিরে এসেছি বলে তাহলে ভুল করবে না।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>									
14	<p>I deserve the bad behaviour and fate because of being trafficked</p> <p>আমি যেহেতু পাচার হয়ে গেছিলাম তাই আমার এই খারাপ ব্যবহার আর এই ভাগ্যই প্রাপ্য।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>									
15	<p>It is alright if my husband beats me and mistreats me because of my trafficking experience</p> <p>আমার এই ঘটনার জন্য যদি আমার স্বামী আমায় মারে বা খারাপ ব্যবহার করে, তাহলেও ঠিক আছে।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>									
16	<p>It is alright if my marital family sends me back if they find out that I was trafficked</p> <p>আমার স্বভ্রাতৃবান্ধী থেকে যদি আমায় ফেরত পাঠিয়ে দেয় আমার পাচার হওয়ার কথা জানতে পেয়ে,</p>									

	<p>তাহলেও তারা ভুল করবে না।</p> <p><i>If sometimes or Always, how big a problem is it to you?</i></p> <p>যদি কয়েকবার মনে হয়ে থাকে বা সবসময়েই মনে হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>									
17 *	<p>I think I am able to live life like I want to.</p> <p>আমি যেমন ভাবে বাঁচতে চাই, তেমন ভাবেই বাঁচতে পারছি।</p> <p><i>If sometimes or Never, how big a problem is it to you?</i></p> <p>যদি কয়েকবার মনে হয়ে থাকে বা কখনো না মনে হয়, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>									
18 *	<p>I think I have become stronger and more confident because of this experience</p> <p>আমার এই অভিজ্ঞতার জন্য আমি আরো শক্ত এবং আত্মবিশ্বাসী হতে পেরেছি।</p> <p><i>If sometimes or Never, how big a problem is it to you?</i></p> <p>যদি কয়েকবার মনে হয়ে থাকে বা কখনো না মনে হয়,, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>									
19 *	<p>I think I have all rights to be happy and enjoy my life like others</p> <p>আমার অন্যদের মতই আনন্দে বাচার এবং জীবন উপভোগ করার অধিকার আছে।</p> <p><i>If sometimes or Never, how big a problem is it to you?</i></p> <p>যদি কয়েকবার মনে হয়ে থাকে বা কখনো না মনে হয়,, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>									
20 *	<p>I think I was trafficked because the trafficker cheated and exploited my trust</p> <p>আমার মনে হয় আমি পাচার হয়েছিলান কারণ পাচারকারী আমার সঙ্গে প্রতারণা করেছিল এবং আমার বিশ্বাসের খারাপ সুযোগ নিয়েছিলো।</p> <p><i>If sometimes or Never, how big a problem is it to you?</i></p> <p>যদি কয়েকবার মনে হয়ে থাকে বা কখনো না মনে হয়,, তাহলে তার ফলে তোমার কতটা কষ্ট হয়?</p>									
	Comment									Total

Participation Scale for assessing Impact of Stigma

No	Items	NA/ Irr	Yes	Sm	No	NP 1	S 2	M 3	L 5	S
1	Do you contribute to your household economically same as your peers do? <i>If sometimes or no, how big a problem is it to you?</i> তুমি কি তোমার সমবয়সি মেয়েদের মতো একই রকম ভাবে তোমার পরিবারে অর্থনৈতিক ভাবে সাহায্য করো? যদি না করো, বা কখনো কখনো করো, তাতে তোমার কতটা সমস্যা বা দুঃখ হয়?									
2	Do you have equal opportunity as your peers to find work? <i>If sometimes or no, how big a problem is it to you?</i> কাজ খুঁজে পাওয়ার ক্ষেত্রে কি তুমি তোমার সমবয়সি মেয়েদের মতো একই রকম সুযোগ সুবিধা পাও? যদি না পাও, বা কখনো কখনো পাও, তাতে তোমার কতটা সমস্যা বা দুঃখ হয়?									
3	Do you have equal opportunity as your peers to attend school/college? <i>If sometimes or no, how big a problem is it to you?</i> স্কুলে বা কলেজে পড়তে যাওয়ার ক্ষেত্রে কি তুমি তোমার সমবয়সি মেয়েদের মতো একই রকম সুযোগ সুবিধা পাও? যদি না পাও, বা কখনো কখনো পাও, তাতে তোমার কতটা সমস্যা বা দুঃখ হয়?									
4	Do you make visits outside your neighbourhood/village as much as your peers do? <i>If sometimes or no, how big a problem is it to you?</i> তুমি কি তোমার সমবয়সি মেয়েদের মতো একই রকম ভাবে তোমার পাড়া বা গ্রামের বাইরে যাও? যদি না যাও, বা কখনো কখনো যাও, তাতে তোমার কতটা সমস্যা বা দুঃখ হয়?									
5	Do you take part in major festivals and rituals as your peers do? <i>If sometimes or no, how big a problem is it to you?</i> তুমি কি তোমার সমবয়সি মেয়েদের মতো একই রকম ভাবে বড়ো উৎসব বা অনুষ্ঠানে অংশ নাও? যদি না নাও, বা কখনো কখনো নাও, তাতে তোমার কতটা সমস্যা বা দুঃখ হয়?									
6	Do you take as much part in casual/recreational activities as your peers do? <i>If sometimes or no, how big a problem is it to you?</i> তুমি কি তোমার সমবয়সি মেয়েদের মতো একই রকম ভাবে সাধারণ বা বিনোদনমূলক কাজে অংশ নাও? যদি না নাও, বা কখনো কখনো নাও, তাতে তোমার কতটা সমস্যা বা দুঃখ হয়?									
7	Are you as socially active as your peers are? <i>If sometimes or no, how big a problem is it to you?</i>									

	তুমি কি তোমার সমবয়সি মেয়েদের মতো একই রকম সামাজিক ভাবে সক্রিয়? যদি না হও বা কখনো কখনো হও, তাতে তোমার কতটা সমস্যা বা দুঃখ হয়?											
8	Do you have the same respect in your community as your peers? <i>If sometimes or no, how big a problem is it to you?</i> তুমি কি তোমার সমবয়সি মেয়েদের মতো একই রকম সামাজিক সম্মান পাও? যদি না পাও, বা কখনো কখনো পাও, তাতে তোমার কতটা সমস্যা বা দুঃখ হয়?											
9	Do you have opportunity to take care of yourself (appearance, nutrition, health, etc.) as well as your peers? <i>If sometimes or no, how big a problem is it to you?</i> তোমার নিজের খেয়াল রাখার দিক থেকে (তোমায় দেখতে কেমন লাগছে, পুষ্টিগত, স্বাস্থ্যগত দিক ইত্যাদি) তুমি কি তোমার সমবয়সি মেয়েদের মতো একই রকম সুযোগ সুবিধা পাও? যদি না পাও, বা কখনো কখনো পাও, তাতে তোমার কতটা সমস্যা বা দুঃখ হয়?											
10	Do you visit other people in the community as often as others do? <i>If sometimes or no, how big a problem is it to you?</i> তুমি কি অন্যান্যদের মতনই আশেপাশের লোকজনদের বাড়িতে যাতায়াত করতে পারো? যদি না পারো, বা কখনো কখনো পারো, তাতে তোমার কতটা সমস্যা বা দুঃখ হয়?											
11	Do you move inside and outside the house and around the village/ neighbourhood just as other people do? <i>If sometimes or no, how big a problem is it to you?</i> তুমি কি অন্যান্যদের মতনই নিজের বাড়ির ভেতরে - বাইরে, এবং গ্রাম বা পাড়ার ভেতরে - বাইরে একই রকম ভাবে যাতায়াত করতে পারো? যদি না পারো, বা কখনো কখনো পারো, তাতে তোমার কতটা সমস্যা বা দুঃখ হয়?											
12	In your village, do you visit public places (shops, schools, offices, place of worship, etc.) as often as others do? <i>If sometimes or no, how big a problem is it to you?</i> তোমার গ্রামে কি তুমি অন্যান্যদের মতনই বিভিন্ন সরকারি জায়গা এবং প্রকাশ্য জায়গায় যাতায়াত কর? যদি না করো, বা কখনো কখনো করো, তাতে তোমার কতটা সমস্যা বা দুঃখ হয়?											
13	In your home, do you do household work as your peers? <i>If sometimes or no, how big a problem is it to you?</i> তোমার বাড়িতে কি তুমি তোমার বয়সি অন্যান্য মেয়েদের মতনই বাড়ির কাজ করো? যদি না করো, বা কখনো কখনো করো, তাতে তোমার কতটা সমস্যা বা দুঃখ হয়?											

14	In family discussions, does your opinion count? <i>If sometimes or no, how big a problem is it to you?</i> পারিবারিক আলোচনায় কি তোমার মতামত নেওয়া হয়? যদি না নেওয়া হয়, বা কখনো কখনো নেওয়া হয়, তাতে তোমার কতটা সমস্যা বা দুঃখ হয়?																			
15	Are you comfortable meeting new people? <i>If sometimes or no, how big a problem is it to you?</i> তুমি কি নতুন মানুষদের সাথে দেখা করতে স্বস্তি বোধ করো? যদি স্বস্তি বোধ না করে, বা কখনো কখনো স্বস্তি বোধ করে, তাতে তোমার কতটা সমস্যা বা দুঃখ হয়?																			
16	Do you feel confident in trying to learn new things? <i>If sometimes or no, how big a problem is it to you?</i> তুমি কি নতুন কিছু শিখতে আত্মবিশ্বাস অনুভব করো? যদি না করে, বা কখনো কখনো করে, তাতে তোমার কতটা সমস্যা বা দুঃখ হয়?																			
	Comment																			Total

NA - Not answered, Irr - Irrelevant, Sm - sometimes, NP - no problem, S - small, M - medium, L - large,

Coping with stigma interview schedule

No	
1	<p>You have mentioned that you most frequently and intensely face the following types of Enacted stigma -</p> <ol style="list-style-type: none">123 <p>I would like to know how do you cope with them?</p> <p>তুমি বললে যে এই তিন রকমের কলঙ্ক দেওয়া ব্যাবহার তোমার সঙ্গে সব থেকে বেশী হয় এবং তোমায় সব থেকে বেশী কষ্ট দেয় -</p> <ol style="list-style-type: none">১)২)৩) <p>এগুলি হলে, তুমি নিজেকে সামলানোর জন্য কি করো?</p>
2	<p>You have mentioned that you most frequently and intensely face the following types of anticipated/perceived stigma -</p> <ol style="list-style-type: none">123 <p>I would like to know how do you cope with them?</p> <p>তুমি বললে যে এই তিন ধরনের কলঙ্ক বা নিন্দার আশঙ্কা তোমার সব থেকে বেশী হয় -</p> <ol style="list-style-type: none">১)২)৩) <p>এই চিন্তাগুলি যখন তোমার মনে হয়, তখন তুমি কি করো?</p>

3	<p>You have mentioned that you most frequently and intensely face the following types of internalized stigma -</p> <ol style="list-style-type: none">123 <p>I would like to know how do you cope with them?</p> <p>তুমি বললে যে তোমার নিজের ব্যাপারে এই ধরনের চিন্তা গুলি সবথেকে বেশী হয় -</p> <ol style="list-style-type: none">১)২)৩) <p>এই কথাগুলি যখন তোমার মনে হয়, তখন তুমি কি করো?</p>

	Please help me understand your coping a little better -	√√ 1	√ 2	? 3	X 4	XX 5
1	I avoid people who discriminate against me and stigmatize me. যারা আমার বিরুদ্ধে বৈষম্য করে আর আমায় কলক দেয় আমি তাদেরকে এড়িয়ে চলি।					
2	I only attend events where other survivors like me are present. আমি একমাত্র সেই সব অনুষ্ঠানে যাই যেখানে আমার মতো অন্যান্য পাচার থেকে ফিরে আসা মেয়েরা আসে।					
3	I try to attend events where people don't know of my trafficking history. আমি চেষ্টা করি সেই সব অনুষ্ঠানে যেতে যেখানে কেউ আমার পাচার হয়ে যাওয়ার কথা জানে না।					
4	I believe that even though my family discriminates against me they love and care for me. আমার বিশ্বাস যে আমার পরিবার আমার সঙ্গে বৈষম্যমূলক ব্যবহার করলেও তারা আমায় ভালোবাসে।					
5	I don't think those who discriminate against me do it because I was trafficked, even when they know of my experience. অন্যান্যরা আমার পাচার হওয়ার কথা জানলেও, আমার মনে হয় না যে তারা আমার সঙ্গে আলাদা রকম ব্যবহার করে তারা আমি পাচার থেকে ফিরে এসেছি বলে এরকম করে বলে।					
6	I engage in an activity that I like doing to take my mind off a stigmatizing situation/experience. কেউ যখন আমার সঙ্গে খারাপ ব্যবহার করে বা আমার নিন্দা করে, আমি নিজের মন থেকে সেটা সরানোর জন্য আমার ভালোলাগার কোনো কাজ করি।					
7	People who treat me badly because of my trafficking experience are being unfair and rude. যারা আমি পাচার হয়ে গেছিলাম বলে আমার সঙ্গে খারাপ ব্যবহার করে তারা অন্যায় এবং খারাপ করে।					
8	People who treat me badly because of my trafficking experience are unaware of the reasons why I was trafficked. যারা আমি পাচার হয়ে গেছিলাম বলে আমার সঙ্গে খারাপ ব্যবহার করে তারা জানে না যে আমি কেন পাচার হয়ে গেছিলাম।					
9	I don't think it is important to participate in social events. সামাজিক অনুষ্ঠানে যাওয়া খুব প্রয়োজনীয় বলে মনে হয় না আমার।					
10	I don't think it is important to participate in religious events. ধার্মিক অনুষ্ঠানে যাওয়া খুব প্রয়োজনীয় বলে মনে হয় না আমার।					
11	I think it is important to be respected in one's family. নিজের পরিবারে সম্মান পাওয়াটা আমার গুরুত্বপূর্ণ বলে মনে হয়।					
12	I think it is important to be respected in one's community. নিজের গ্রামে / পাড়ায় / সমাজে সম্মান পাওয়াটা আমার গুরুত্বপূর্ণ বলে মনে হয়।					
13	Being discriminated and stigmatized is in my fate.					

	এই কলঙ্ক আর বৈষম্যই আমার ভাগ্য।					
14	When I know I will be judged I try to please the other person. যখন আমি জানি যে মার ব্যাপারে বিচার করা হবে, আমি অন্যদেরকে সন্তুষ্ট করার চেষ্টা করি।					
15	I try to be nicer to my family even when they behave rudely with me. আমার পরিবার আমার সঙ্গে খারাপ ব্যবহার করলেও আমিই তাদের প্রতি ভালো ব্যবহার করার চেষ্টা করি।					
16	When I experience or feel discrimination it makes me angry and I express it. যখন কেউ আমার সঙ্গে বৈষম্য করে, মানে আলাদা রকম ব্যবহার করে, আমার রাগ হয় এবং আমি সেটা প্রকাশ করি।					
17	When I experience or feel discrimination it makes me anxious and I cannot concentrate on any activity, I become restless. যখন কেউ আমার সঙ্গে বৈষম্য করে, মানে আলাদা রকম ব্যবহার করে, আমার উতলা লাগে, আমি কোনো কিছুতে মন বসাতে পারি না, আমার অস্থির লাগে।					
18	I think it is important to belong to a group of survivors of sex trafficking. আমার মনে হয় পাচার থেকে ফিরে আসা মেয়েদের একটি দল থাকা দরকার।					
19	If I associate with people who have been trafficked or who work with survivors of trafficking, I will never be able to escape from stigma. আমি যদি তাদের সঙ্গে মিশি যারা পাচার হয়ে গেছিল বা যারা পাচার থেকে ফিরে আসা মেয়েদের সঙ্গে কাজ করে, তাহলে আমি কখনোই কলঙ্কের থেকে রেহাই পাবো না।					
20	I can share my fears and feelings of being stigmatized with someone close. আমি আমার কলঙ্কিত হওয়ার কথা বা ভয়ের কথা আমার কাছের লোকজনকে বলতে পারি।					
21	I feel better when I can talk about my stigma related problems with other survivors. আমার কলঙ্ক এবং নিন্দা সবকিছু আমি অন্যান্য পাচার থেকে ফিরে আসা মেয়েদের সঙ্গে কথা বলতে পারলে আমার ভালো লাগে।					
22	When someone stigmatizes me I start feeling very angry and can feel my heart beat faster. কেউ যখন আমার নামে নিন্দা করে আমার খুব রাগ হয়, আর আমার হৃৎপিণ্ডের গতি বেড়ে যায়।					
23	I can forget experiences of being stigmatized very easily. কেউ আমার নামে নিন্দা করলে বা কলঙ্ক দিলে আমি সেই ঘটনার কথা সহজেই ভুলে যেতে পারি।					
24	Sometimes while working or sitting quietly memories of being stigmatized disturb me and make me feel anxious. কখনো চুপচাপ কাজ করার সময় বা বসে থাকলে এই রকম কলঙ্ক দেওয়ার স্মৃতি আমায় নাড়া দিয়ে যায় আর আমার উতলা লাগে।					

- 1 - Strongly agree
2 - Agree
3 - Undecided
4 - Disagree
5 - Strongly disagree

Interview schedule to study survivor's relationship with stigmatizer

Guideline

This can be used with all the three stigmatizers from different context – family, community and institutional service provider. If the respondent says no, probe to ascertain that she has understood the question. Again for the 'power to stigmatize questions' if the respondent says no, ask whether it means no, or that she does not know.

Ascertaining the nature of stigma experienced from the stigmatizer

1. What does do to stigmatize you?

১) তোমাকে কীভাবে কলঙ্ক দেয় বা তোমার নিন্দা করে?

2. What makes you think 's behaviour is discriminatory and is because of your trafficking experience?

২) তোমার কি কারণে মনে হয় যে তুমি পাচার থেকে ফিরে এসেছো বলে তোমার সঙ্গে আলাদা রকম ব্যবহার করে?

3. Does behave differently with others (those who have not been trafficked/other family members/peers)?

৩) কি অন্যান্যদের সঙ্গে, (যারা পাচার হয় নি এরকম পরিবারের অন্যান্যরা, বন্ধুরা) আলাদা ব্যবহার করে?

4. How was 's behaviour towards before you got trafficked?

৪) তোমার পাচার হওয়ার আগে তোমার সঙ্গে কিরকম ব্যবহার করতো?

Attributions (কারণ)

1. Why do you think stigmatizes you?

১) তোমার কি মনে হয় কেন তোমার নামে নিন্দা করে বা তোমার কলঙ্ক দেয়?

2. Whom does hold responsible for your being trafficked?

২) তোমার পাচার হওয়ার জন্য কাকে দায়ী মনে করে?

Stigma by association

1. Has been treated differently by others because of you?

১) তোমার সঙ্গে সম্পর্কিত হওয়ার জন্য কি অন্যান্যরা এর সঙ্গে আলাদা রকম ব্যবহার করেছে?

2. Have there been any effects of your trafficking experience on? If yes, how?

২) তোমার পাচার হওয়ার জন্য কি এর উপর কোনো প্রভাব পড়েছে? কি প্রভাব?

Power to stigmatize

1. How do you think’s discriminatory behaviour influences the behaviour of others (in the same context) towards you?

১) তোমার প্রতি এর বৈষম্যমূলক ব্যবহার তোমার প্রতি অন্যান্যদের ব্যবহারের উপর কিরকম প্রভাব ফেলে?

2. Do you think others (in the same context) also accept’s opinion about you? If yes, how, what makes you think that way?

২) তোমার কি মনে হয় যে অন্যান্যরা তোমার ব্যাপারে এর মতামত মেনে নেয়? যদি হ্যাঁ হয়, তাহলে তোমার এরকম কেন মনে হয়?

3. Do you think’s behaviour has led others (in the same context) to treat you in a discriminatory manner, distance themselves from you? If yes, how, what makes you think so?

৩) তোমার কি মনে হয় যে এর তোমার প্রতি ব্যবহার দেখে অন্যান্যরাও তোমার প্রতি বৈষম্যমূলক ব্যবহার করেছে এবং তোমার থেকে দূরে সরে গেছে? তোমার এরকম মনে করার কারণ কি?

4. Does the decisions taken by affect your life in any way? If yes, which ways? How?

৪) এর বিভিন্ন সিদ্ধান্ত কি তোমার জীবনে কোনো প্রভাব ফেলে? কী রকম প্রভাব ফেলে?

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