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歸國的柬埔寨移工之心理健康相關風險因素的量性和質性調查

A Quantitative and Qualitative Investigation of Risk Factors Associated with Mental Health Among Returned Cambodian Migrant Workers

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本論文係_建杉博（ D05849017）在國立臺灣大學_環境與職業健康科學研究所完成之博士學位論文，於民國 114 年 6 月 25 日承下列考試委員審查通過及口試及格，特此證明。

The undersigned, appointed by the Institute of Environmental and Occupational Health Sciences on 25th -June-2025 have examined a Doctoral Dissertation entitled above presented by **SAMPHOAS CHIEN** （**D05849017**） candidate and hereby certify that it is worthy of acceptance.

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摘要

背景：移工的心理健康近年來備受關注，尤其是那些在國外遭逢艱困甚至剝削壓迫性工作條件，返國後仍持續面臨身心挑戰的勞動者。本論文旨在探討 COVID-19 疫情期間，自泰國返回之柬埔寨移工的心理健康風險因素。研究採用混合方法研究，以全面探索影響其心理健康與職業風險之複雜脈絡。本論文整合大規模問卷調查所得量化資料與深度訪談質性見解，深入分析影響此弱勢族群心理健康問題的關鍵因素。

方法：本論文的量化研究部分採橫斷式調查，對象為來自班迭棉吉省、馬德望省、暹粒省及貢布省之 392 名返國柬埔寨移工。研究方法使用已驗證之病患健康量表第四版（PHQ-4）作為資料蒐集工具，以評估焦慮與憂鬱症狀。本研究旨在確定心理健康問題的盛行率，並檢驗其與職業健康風險因素之間的關聯性，包括長工時、不安全工作環境，以及暴露於具風險之作業情境等。另外質性研究部分則進行 25 份深度訪談，涵蓋 8 位返國移工與多位移工議題相關者。質性資料探討移工的個人經歷，重點關注其心理健康問題、職業風險以及 COVID-19 疫情對其生活的影響。質性資料以主題分析法進行，藉以採取反覆出現之主題與趨勢，並為量化資料提供更豐富的背景解釋分析。

結果：量化分析 PHQ-4 結果顯示，近半數受訪移工呈現心理健康相關症狀，其中 42% 有焦慮症狀，35% 出現憂鬱症狀。研究亦發現不良的職業衛生狀況與心理健康風險之間具高度相關性。具體而言，自我報告長時間工時、缺乏安全措施或暴露於危險環境的移工，較易出現焦慮與憂鬱症狀。此外，性別差異亦為重要因素，女性移工的壓力與焦慮程度顯著高於男性，突顯考慮性別差異對預防介入措施之必要性。

質性結果支持量化分析結果，受訪移工普遍描述艱困工作環境、文化孤立感以及疫情期間跨國處境所造成的複合心理負擔。受訪移工提及遭遇剝削、恐懼與不確定性的經驗，這些因素均加劇其身心脆弱性。疫情更使情況惡化，許多移工面臨失業、收入減少，以及難以取得醫療與支持服務等問題。此外，返國後的心理困難並未立即消失，部分移工仍持續面臨重新融入社會的挑戰及海外經歷所造成的長期影響。

結論：本研究凸顯柬埔寨返國移工在 COVID-19 疫情期間所面臨之重大顯著心理健康風險，特別是自泰國返國者。透過量化與質性並行之混合研究方法，本研究提供對此議題更全面的理解，並為政策制定者與實務工作者提供重要洞見，以期改善此弱勢群體之心理衛生。研究結果強調，應採取整體性且具性別敏感度的策略，以有效因應返國移工所面臨的心理健康挑戰。

關鍵字：心理健康、職業衛生、返國移工、柬埔寨、泰國、COVID-19 大流行、PHQ-4、量化研究、質性研究、性別差異、焦慮、憂鬱。

ABSTRACT

Background

The mental health of migrant workers is a growing concern, particularly for those who return home after working under demanding and often precarious conditions abroad. This study examines the occupational and psychosocial factors influencing mental health among Cambodian migrant workers who returned from Thailand during the COVID-19 period. The quantitative and qualitative approach was used to develop a comprehensive understanding of how prior work environments, economic pressures and reintegration challenges shape psychological well-being after return. By integrating quantitative findings from a cross-sectional survey with qualitative insights from in-depth interviews, the study provides a nuanced analysis of the determinants of mental health among this vulnerable population.

Methods

The quantitative component employed a cross-sectional survey of 392 returned Cambodian migrant workers from four provinces (Banteay Meanchey, Battambang, Siem Reap and Kampot). Mental health symptoms were assessed using the Patient Health Questionnaire-4 (PHQ-4), a validated screening tool for anxiety and depression. Occupational health risk factors such as long working hours, unsafe working conditions and exposure to hazardous environments were examined to determine their association with psychological outcomes.

The qualitative component consisted of in-depth semi-structured interviews with eight returned migrant workers (n = 8) to explore personal experiences of migration, emotional challenges after return and coping processes during reintegration. Interviews were conducted in Khmer, transcribed, translated into English and analyzed using reflexive

thematic analysis which provided contextual depth and elaborated the mechanisms underlying the quantitative trends.
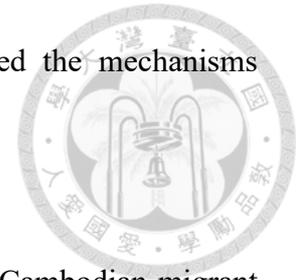
Results

The quantitative analysis revealed that nearly half of the surveyed Cambodian migrant workers reported anxiety symptoms showed symptoms of mental health issues with 42% showing signs of anxiety and 35% presenting symptoms of depression, as measured by the PHQ-4. The study found strong associations between poor occupational health conditions and elevated mental health risks. Specifically, workers who reported long working hours, a lack of safety measures and exposure to hazardous environments were more likely to experience anxiety and depression. Gender differences were also apparent, with female workers reporting higher levels of stress and anxiety compared to their male counterparts, highlighting the need for gender-sensitive interventions.

The qualitative findings supported the quantitative results, with interviewees frequently describing the psychological burden of harsh working conditions, cultural isolation and the compounded stress of navigating the COVID-19 pandemic while abroad. Workers detailed experiences of exploitation, fear and uncertainty, all of which contributed to a heightened sense of vulnerability. The pandemic exacerbated these challenges, as many workers faced job losses, reduced income and difficulty accessing healthcare and support services. The interviews also revealed that returning to Cambodia did not necessarily alleviate these mental health challenges, as many workers continued to struggle with reintegration and the long-term impacts of their experiences abroad.

Conclusion

This study demonstrates that the mental health of returned Cambodian migrant worker is closely shaped by their occupational conditions abroad and the challenges they encounter during reintegration. By integrating quantitative findings with qualitative insights, the

study highlights how job insecurity, financial pressure and cultural expectations contribute to psychological distress among returnees from Thailand. The results underscore the need for reintegration strategies that combine livelihood support with accessible, community-based mental health services and emphasize the importance of gender- and sector-sensitive approaches to promoting well-being among returned migrant workers.

Keywords: Mental Health, Occupational Health, Returned Migrant Workers, Cambodia, Thailand, COVID-19 Pandemic, PHQ-4, Quantitative Research, Qualitative Research, Gender Differences, Anxiety, Depression.

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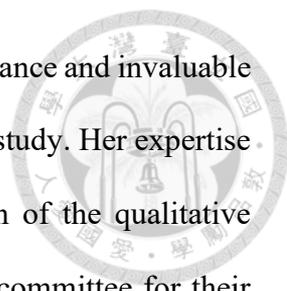
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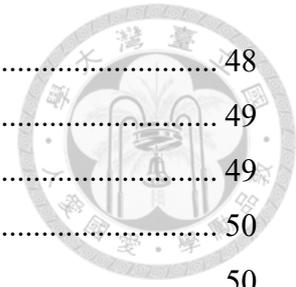
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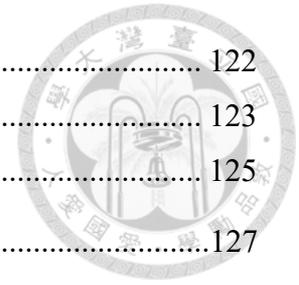
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LIST OF ABBREVIATIONS

AOR	Adjusted Odds Ratio
BTB	Battambang Province
BMC	Banteay Mean Chey
CI	Confidence Interval
CDHS	Cambodia Health Demographic System
CGDP	Cambodia's Gross Domestic Product
COVID-19	Coronavirus Disease 2019
CPH	College of Public Health
DHS	Demographic Health System
HRQOL	Health Related Quality of Life
HIS	Health Information System
IDI	In-Depth Interview
IOM	International Organization for Migration
ILO	International Labor Organization
MOH	Ministry of Health
MOI	Ministry of Interior
MLVT	Ministry of Labor Vocational and Training
NTU	National Taiwan University
OSH	Occupational Safety and Health
OMHI	Occupational Medicine and Industrial Hygiene
PHQ-4	Patient Health Questionnaire-4 items
PTSD	Post-Traumatic Stress Disorder
RDS	Respondent Driven Sampling
SDG	Sustainable Development Goal
SES	Socioeconomic Status
SPSS	Statistical Package for the Social Sciences
STATA	Stata is statistical software for data science
WHA	World Health Assembly
WHO	World Health Organization

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CHAPTER 1. INTRODUCTION

1.1 Contributions and Impacts of Migration

Migration is a multifaceted social and economic phenomenon that is influenced by factors such as the desire for upward mobility, economic prospects and job opportunities (de Haas, 2021). Many people, especially those from poor countries, migrate to find better ways to make a living. There are many positive aspects about migration but also a lot of negative aspects, especially for low-skilled workers in fields such as agriculture, construction and domestic work (Embrace, 2022). While migration offers significant economic and social benefits, it also exposes workers to employment risks, mental health concerns and social dislocation (Alegría et al., 2017). Migration entails a dynamic interplay of social and economic forces, prompting individuals to cross borders in pursuit of enhanced livelihoods, political security, or environmental stability (Alston et al., 2009). Overseas employment frequently provides migrant workers with greater income, supporting their families' financial needs, elevating living conditions and contributing to economic growth, poverty alleviation and community development in their home countries. Moreover, they gain valuable skills and experience, enhancing their employability upon return (ILO, 2005). As well as exposure to different work environments, it can lead to the adoption of better practices in various industries (World Bank, 2023). Over and above that, migration helps individuals escape unemployment in their home countries and both migrants and their families benefit from improved healthcare and education. Additionally, countries of origin see a reduction in unemployment rates as extra workers find jobs abroad (OECD, 2024).

A significant portion of the global workforce is made up of migrant workers, especially in low-skilled occupations including domestic work, construction and agriculture (Bustamante et al., 2018). Many migrant workers face hazardous work environments,
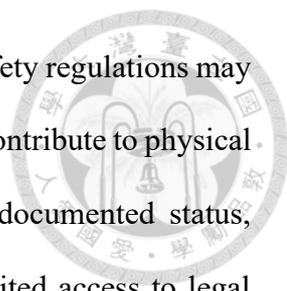
particularly in agriculture, construction and domestic work, where safety regulations may be weak, long hours of work, low wages and a lack of work stability contribute to physical and mental stress. Many migrants work under documented or undocumented status, making them vulnerable to exploitation, arrest, or deportation. Limited access to legal protections, healthcare and social services increases their vulnerability (Hargreaves et al., 2019). Still and all, the psychological impact of migration can lead to stress, anxiety, depression and post-traumatic stress disorder. Upon return, migrant workers often struggle to reintegrate into society, facing economic hardship and social discriminations. Workers in Southeast Asia regularly put up with unstable job conditions, such as low pay, unsafe working environments and restricted access to medical care (ILO, 2020).

Migration is a major force that shapes the socio-economic environment in Southeast Asia. Millions of people move within and outside of the area to find work, safety, and greater opportunities. According to the International Organization for Migration's (IOM) Asia Pacific Migration Data Report 2023, Southeast Asia remains a significant hub for labor migration, disaster-induced displacement and complex mixed migration flows (IOM, 2023).

Countries such as Thailand, Malaysia and Singapore continue to serve as major destinations for migrant workers within the subregion (IOM, 2022). Conversely, nations like the Philippines and Vietnam are prominent sources of emigrant populations, with the Philippines receiving over USD 38 billion in remittances in 2022, accounting for 9.4% of its GDP (IOM, 2022). Southeast Asia is notably vulnerable to natural disasters, leading to significant internal displacements. In 2022, the Philippines experienced over 5.4 million internal displacements due to events such as typhoons and tropical storms, marking the second-highest figure globally after Pakistan. The Southeast Asia region also faces challenges related to mixed migration flows (irregular migration and human
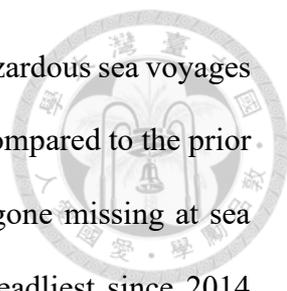
trafficking). In 2022, approximately 3,500 Rohingya embarked on hazardous sea voyages in the Bay of Bengal and the Andaman Sea, marking a notable rise compared to the prior year. It is reported that nearly 350 individuals have either died or gone missing at sea during these journeys, indicating that this year ranks among the deadliest since 2014 (UNHCR, 2023).

1.2 Mental Health Challenges in Migrant Workers

Migration offers considerable economic and social advantages for individuals and their families; however, it also poses various challenges that may affect the mental health of migrant workers. The mental health of migrant workers is a significant concern, as these individuals frequently encounter distinct stressors that may lead to psychological distress (McKenzie et al., 2022). A study by Virupaksa provides an overview of the mental health challenges faced by migrant workers, referencing key studies and literature to identify contributing factors and implications for health policy and practice (Virupaksha et al., 2014). Compared to non-migrant populations, migrant workers face heightened psychological distress. According to the World Health Organization, migrant workers constitute a vulnerable population with elevated risks of mental health problems due to their unique living and working conditions (WHO, 2023). Among migrant groups, the incidence of anxiety, depression and post-traumatic stress disorder is correlated with factors like social isolation, exploitation and difficulties adjusting to new surroundings (Lindert et al., 2009; Kirmayer et al., 2011).

Research in Cambodia suggests that Cambodian migrant workers, especially those in Thailand, frequently encounter considerable mental health issues (Kiss et al., 2015). These issues are associated with stringent working conditions, extended hours and the psychological effects of isolation from family and community. The discrimination surrounding mental health concerns in both the host nations and Cambodia
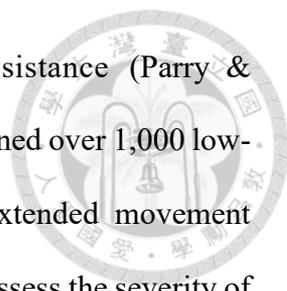
exacerbates the situation, deterring migrants from seeking assistance (Parry & Wilkinson, 2020). A cross-sectional study by Saw et al. (2021) examined over 1,000 low-wage male migrant workers in Singapore's dormitories during extended movement restrictions. Using the 21-item self-report questionnaire designed to assess the severity of depression, anxiety and stress symptoms (DASS-21) tool, the study found that complete lockdowns were strongly associated with elevated depression and stress symptoms, while COVID-19 diagnosis was linked to increased anxiety. Moreover, subjective health concerns, fear of job loss and high exposure to misinformation were key predictors of mental distress. Notably, although prevalence rates were comparable to the general population, these findings underscored critical vulnerabilities within a subset of the migrant workforce, emphasizing the need for culturally sensitive, context-specific mental health interventions (Saw et al., 2021). The importance of mental health issues for migrant workers around the world is becoming more widely acknowledged. Studies have repeatedly demonstrated that migrant workers are disproportionately impacted by mental health conditions like stress, anxiety and depression (Acharya et al., 2022). Because of the particular stressors connected to migration, migrant workers frequently have a higher frequency of mental health disorders than their non-migrant counterparts. The International Labor Organization (ILO) claims that socioeconomic constraints, unsafe working environments and limited access to healthcare services are the main causes of mental health issues that migrant workers commonly face (ILO, 2015).

In Southeast Asia, where millions of people travel to meet employment demands in industries including domestic work, construction and agriculture, the prevalence of mental health issues among migrants is particularly concerning. In addition, because of their unequal working conditions and fear of deportation, Cambodian and Myanmar employees in Thailand frequently express significant levels of stress and depression. The
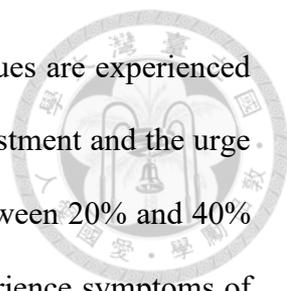
study from Win and colleagues found that similar mental health issues are experienced by Cambodian employees in South Korea as a result of cultural adjustment and the urge to send money home to help their families. Studies indicate that between 20% and 40% of Myanmar and other low-wage migrant workers in Thailand experience symptoms of anxiety and depression due to unfavorable working conditions and uncertainty about their future. Although prevalence estimates for Cambodian workers vary across studies, similar patterns of psychological distress have been documented among Cambodian migrants in Thailand and Malaysia, where demanding work environments, job insecurity and restrictive living conditions heighten their vulnerability to mental health problems. (Win et al., 2024).

According to Hasan and colleagues, a significant number of workers express stress as a result of financial strains, irregular immigration status and exploitative tactics such as wage theft or denial of legal rights. A mix of structural, social and personal variables impacts the reasons for mental health issues that migrant workers confront. Among the major causes of these mental health issues are experiences of migrant workers with regard to their mental health that are significantly influenced by their gender (Hasan et al., 2021)

Due to their roles and expectations in both their home and host countries, female migrants in particular are more vulnerable. Women frequently perform caring or household duties, which are marked by loneliness, lengthy workdays and a lack of legal protections. Their susceptibility to mental health issues like anxiety and sadness is heightened by this seclusion (Novotney, 2019). Further exacerbating their mental health issues is the increased likelihood that female migrants would encounter gender-based violence, such as harassment, assault and exploitation (Tan & Kuschminder, 2022). In addition to facing tremendous pressure to fulfill their role as the principal source of money, male workers are less likely to endure gender-based violence. Because of cultural expectations for male

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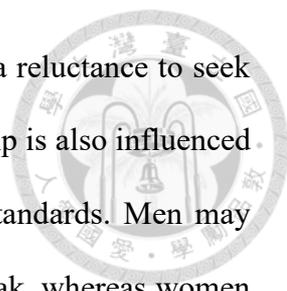
migrant workers, this pressure can lead to high levels of stress and a reluctance to seek mental health support (Brandt et al., 2022). The chance of getting help is also influenced by cultural challenges associated with mental health and gender standards. Men may suppress their emotional problems out of a fear of coming out as weak, whereas women appear more willing to talk about their mental health issues yet encounter more obstacles when trying to get help (Sheikh et al., 2024). Complex issues that call for all-encompassing and gender-sensitive methods are revealed by migration and mental health (Chatmon, 2020). Risk factors that have a substantial impact on migrant workers' mental health outcomes include stress, loneliness, exploitation and gender dynamics. Improving the general well-being of migrant communities requires addressing these problems, especially in areas like Southeast Asia, where migration is a major socioeconomic occurrence (Rice et al., 2021).

While qualitative interviews examined individual experiences with reintegration, healthcare access and economic obstacles, several studies concentrated on quantitative data that offered statistical insights into mental health issues among migrant workers (Blackmore et al., 2020). Prevalence rates of anxiety and depression were examined in one intriguing study and qualitative interviews recorded individual experiences of stressors such as social reintegration and financial strains (Abas et al., 2013). Insights into the socio-economic and psychological reintegration experiences of returned female migrant workers in Asia were provided by one of the studies on the reintegration experiences of female migrant workers in Asia that combined survey data and in-depth interviews. The study also revealed that women returnees faced disproportionately higher burdens, including persistent financial insecurity, greater caregiving responsibilities, and elevated symptoms of anxiety and depression. These gender-specific stressors indicate that reintegration is not experienced uniformly across groups and highlight the need for

comprehensive, gender-responsive reintegration programs that address women's economic vulnerability, psychosocial well-being, and access to supportive services. (Tittensor & Mansouri, 2017).

1.3 Occupational Health Risks in Migrant Workers

Workers who move abroad for jobs often encounter patterns of occupational risk that are not typically experienced by non-migrants in similar sectors. The risks can be affected by many factors, including the characteristics of the employment that migrants generally take on, their legal status and cultural status, as well as the circumstances related to their living and working conditions in the countries of destination (Porru & Baldo, 2022). In the industries of construction, agriculture and domestic work, migrant workers frequently take on demanding and dangerous professions. Labor migration introduces unique occupational health challenges, setting migrant workers apart from their local counterparts in terms of workplace risks. (1) Employment in the construction workers are particularly vulnerable to injuries from heavy machinery, pollution exposure and unsafe chemical exposure, as well as falls from high places (Moyce & Schenker, 2024). Insufficient training and inadequate safety procedures exacerbate these risks, frequently leading to chronic health issues or disabilities. (2) Agricultural workers are subjected to pesticide exposure, extreme weather conditions and extended periods of physically demanding employment. Extended exposure to agrochemicals may result in respiratory issues, dermatological conditions and potential long-term neurological effects (de-Assis et al., 2021). (3) Domestic workers frequently encounter risks, including musculoskeletal injuries due to heavy lifting and repetitive tasks, along with psychological stress caused by isolation and emotional abuse. Numerous domestic workers, especially women, encounter exploitative working conditions and lack adequate legal protection (IOM, 2024).

The risks faced by migrant workers are exacerbated by inadequate safety equipment, restricted access to healthcare and insufficient enforcement of employment rights in their home countries (Boonchalaksi et al., 2012). For those living in developing countries, migration has long been acknowledged as a means of both upward mobility and economic survival. Still, low-skilled employment migration carries major and well-documented occupational health hazards. Some studies have shown the dangerous working conditions migrant workers in industries including manufacturing, agriculture and construction endure (Cho et al., 2024). Physical strain, exposure to dangerous drugs and a great risk of work injuries define these areas. Occupational injuries (e.g., chronic pain and long-term illnesses) are common among migrant workers due to exposure to unsafe working environments.

Migrant workers experience significant psychological stress related to their working conditions, which poses important physical risks associated with stress and mental health issues. Migrants experience occupational stressors including long working hours, low pay, work insecurity and limited control over work tasks. These factors are associated with chronic stress, anxiety, depression and other mental health issues (Hovey & Magaña, 2000). Migrant workers in low-wage positions experience greater job strain and diminished job satisfaction relative to native workers (Landsbergis et al., 2014). Occupational stress is intensified by insufficient social support, language barriers and discrimination, which further aggravate mental health issues. The study emphasizes how work-related stress contributes to the development of psychosomatic diseases among migrant workers, including headaches, stomach problems and chronic feeling worn out (Nakao, 2010; Sartor et al., 2015).

Strict working conditions, coupled with long hours and low wages, contribute to high levels of stress and anxiety among migrant workers. The fear of job loss, deportation, or wage theft creates an additional psychological burden. The lack of social support and the
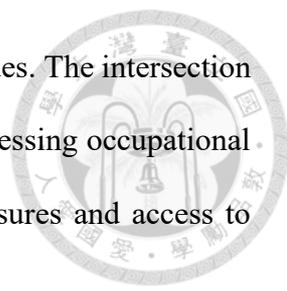
inability to access mental health services further compound these issues. The intersection of physical and mental health risks highlights the importance of addressing occupational health as a comprehensive issue that includes both preventive measures and access to healthcare for migrant workers (Aktas et al., 2022).

1.4 Socio-demographics and Economy in Cambodia

Southeast Asia's Cambodia is a fast-growing nation renowned for its vigorous socioeconomic changes and rich cultural heritage.
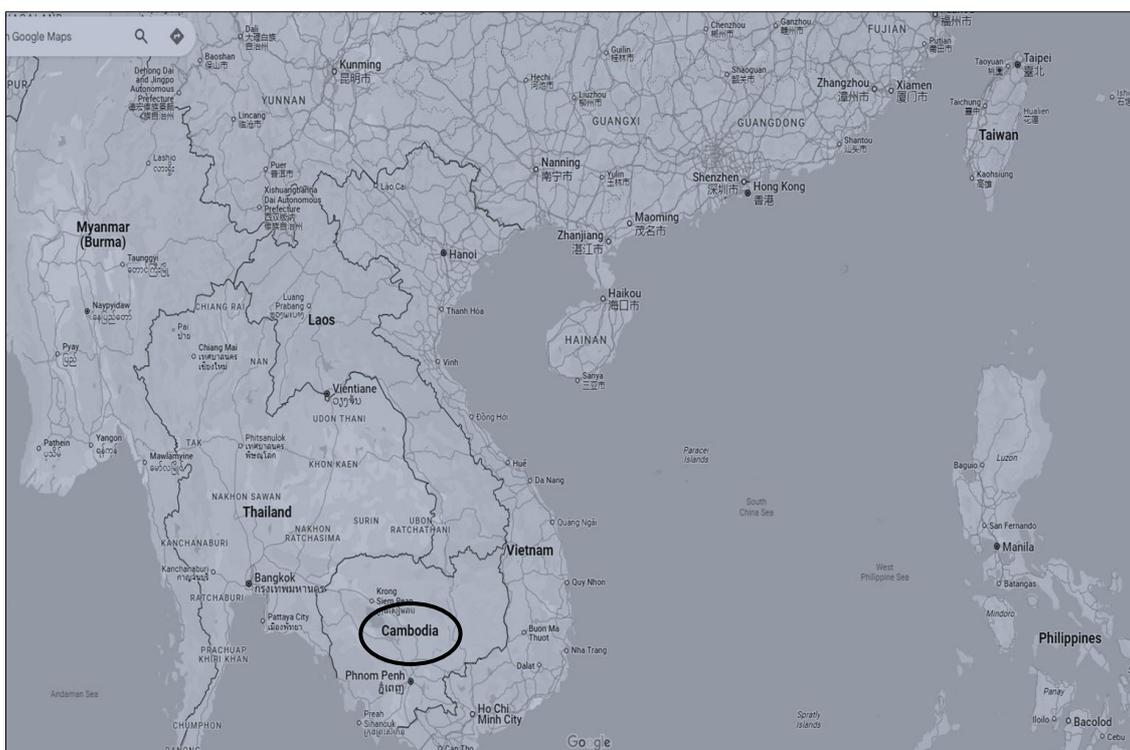
Figure 1. Location of Cambodia in Southeast Asia

Cambodia's population is estimated at 17.2 million in the year of 2024. The country of Cambodia is divided into 25 provinces including the capital city of Phnom Penh. Each province has its own unique characteristics, geography and cultural significance.

Each province is led by a governor appointed by the central government of Cambodia. The provinces are divided into districts and each district has a capital district, which is known as a city or town. The districts are further divided into communes and then villages. Moreover, in these subdivisions there are also cities and towns that take
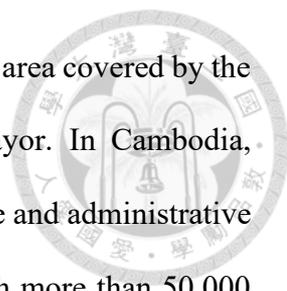
over some of the responsibilities of the districts and communes in the area covered by the municipality. All these have an elected board and an elected mayor. In Cambodia, municipalities are classified into three levels based on population size and administrative function. The highest level is city which refers to urban centers with more than 50,000 residents. The second level is also called town, typically referring to towns with over 10,000 residents or those designated as provincial capitals, regardless of population. The third level consists of communes in rural areas and wards in urban areas which function as subdivisions within districts or municipalities and are further divided into villages. (Ministry of Interior, 2023; National Institute of Statistics, 2023).

Cambodia's population pyramid generally has a pyramid shape reflecting its status as a developing country. It has a wide base, indicating a high birth rate and tapers towards the top, suggesting a lower life expectancy. However, the pyramid is starting to show signs of a slight bulge in the middle which indicates an increase in the number of people in their reproductive years. This is a positive trend for the country's future growth. The pyramid displays a high dependency ratio, meaning a large number of dependents (children and elderly) compared to the working-age population. This can put a strain on the economy and social services. Cambodia has a predominantly young population, with about two-thirds of its people under the age of 30. This youthful demographic offers a valuable opportunity to boost economic growth and social development. Many young Cambodians are attending school or pursuing higher education but there are gaps in skill levels, particularly in rural areas. Vocational training and digital skills programs are being emphasized to enhance employability. The youth make up a significant portion of the workforce, particularly in sectors like manufacturing, agriculture and services.

The geographical landscape of Cambodia is categorized into four distinct regions, each characterized by its own unique attributes and economic pursuits. The initial area under
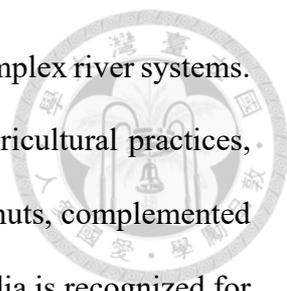
consideration is Eastern Cambodia, notable for its rolling hills and complex river systems. The economic landscape in this region is mainly centered around agricultural practices, with a significant emphasis on the cultivation of rubber and cashew nuts, complemented by an emerging sector in ecotourism. The northern region of Cambodia is recognized for its profound historical importance and its collection of archaeological sites. This region encompasses a combination of lowland plains and wooded areas. The economic landscape is fundamentally influenced by the sectors of tourism, agriculture and trade. The Mekong lowlands represent the most densely populated and agriculturally prolific area within Cambodia. The region derives significant advantages from the rich agricultural soils adjacent to the Mekong River, where essential economic pursuits encompass rice farming, fishing and a range of service sectors. In conclusion, the region characterized by the Cardamom and Elephant Mountains is notable for its rugged topography, lush tropical forests and coastal landscapes. The economy of this region is significantly dependent on ecotourism, coastal industries and agricultural practices, with specific provinces exhibiting a specialization in the extraction and production of resources like gemstones and pepper (MoFA, 2025).

Figure 2. Map of Cambodian regions

The gross domestic product (GDP) of Cambodia in 2022 was approximately $28.5 billion, reflecting steady growth driven by exports, tourism and agriculture. Cambodia has been one of the fastest-growing economies in Asia, with GDP growth averaging around 7% annually from 2010 to 2019. However, growth was disrupted during the COVID-19 pandemic but has been recovering steadily. The post-pandemic recovery has been supported by garment exports, construction and agriculture alongside a recovery in tourism. Per capita of gross domestic product (GDP) is approximately $1,700, placing Cambodia in the lower-middle-income (LMI) category. The per capita income in Cambodia is estimated to rise from $1,917 in the year 2022 to $2,071 in 2024, reflecting moderate economic development but still lagging behind neighboring countries like Thailand and Vietnam. Cambodia has seen improvements in income levels; inequality remains a significant issue. The poverty rate fell from 47.8% in 2007 to below 18% in the year 2020, though many remain vulnerable to economic shocks. In urban areas,

particularly Phnom Penh, there are higher income levels and better job opportunities compared to rural areas where agriculture is the dominant livelihood.

Urbanization is increasingly an important pushing force of the population, while the economy still relies on agriculture as a primary livelihood. Agriculture in Cambodia remains a cornerstone of Cambodia's economy, culture and livelihoods. It employs a significant portion of the population, particularly in rural areas and contributes substantially to the country's gross domestic product. Understanding the agricultural sector is critical for addressing mental health and occupational challenges faced by returned Cambodian migrant workers employed in this sector. Over 70% of Cambodia's population is engaged in agriculture, with rice farming being the dominant activity. Other key crops include maize, cassava, sugarcane and fruits. Agriculture accounted for approximately 20% of Cambodia's gross domestic product in recent years, making it a vital sector for rural development and food security. Cambodia exports rice, rubber and other agricultural products, with rice being the flagship commodity. Many Cambodian workers migrate to neighboring countries, particularly Thailand, to work in the agricultural sector due to limited opportunities at home. Upon their return, these workers often struggle to reintegrate into Cambodia's agricultural system. Returned workers frequently cite a lack of resources, skills transfer opportunities and financial capital as barriers to restarting or improving their agricultural activities. Mostly, women play a crucial role in Cambodia's agricultural workforce, often managing small farms or engaging in subsistence farming. However, they face unique challenges, including limited access to resources, increased caring responsibilities and gender-based disparities in wages and land ownership.

The construction industry in Cambodia has become a pivotal sector driving economic growth and urbanization over the past two decades. Its rapid expansion has created
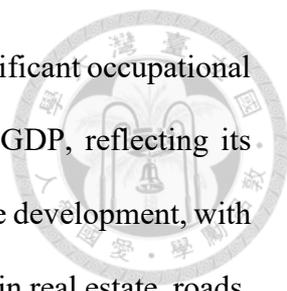
numerous employment opportunities but also exposed workers to significant occupational risks. Construction contributes approximately 11% to Cambodia's GDP, reflecting its importance in economic development. Urbanization and infrastructure development, with rapid urbanization coupled with government and private investments in real estate, roads, bridges and other infrastructure projects, have fueled demand for construction workers. Cambodia has received significant foreign direct investment in the construction sector, primarily from China, South Korea and other nearby countries (Ali, 2024). Women working in construction are often relegated to lower-paying, physically demanding roles such as carrying materials and face additional risks of harassment and exploitation. It is less likely that female workers will have access to formal contracts and safety preventative measures as compared to their male coworkers (Lo Bue et al., 2022).

Domestic work is a significant sector for employment, especially for Cambodian women both locally and abroad; it offers economic opportunities and often involves challenges such as low wages, lack of legal protections and social isolation. Addressing the vulnerabilities and mental health issues experienced by returned Cambodian migrant workers working in this industry requires an understanding of the domestic work context (Jesperson et al., 2022).

Domestic work is a primary source of income for many Cambodian women, particularly in rural areas with limited employment options. A significant number of Cambodian women migrate to countries like Thailand, Malaysia and South Korea for domestic work, where demand for caring and household help is high and remittances from domestic workers abroad contribute substantially to household income and the national economy. Domestic work is highly gendered, with women comprising the majority of workers. Female workers often face additional vulnerabilities, including gender-based violence, discrimination and the burden of unpaid caring responsibilities upon returning home.
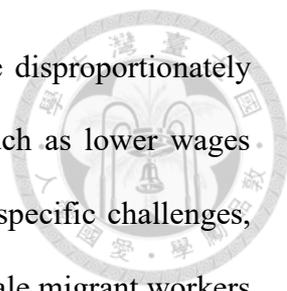
Women make up a significant proportion of the workforce but are disproportionately employed in lower-income and riskier jobs. Many face barriers such as lower wages compared to men and limited access to social protections. Gender-specific challenges, including violence and discrimination, are particularly acute for female migrant workers . The demand for Cambodian workers abroad, especially in Thailand and South Korea (NIS, 2021), remains high due to economic disparities and limited local opportunities. Common sectors include construction, domestic work and agriculture. However, these jobs often involve long hours, low pay and inadequate employment protections.

1.5 Occupational & Mental Health Challenges Among Cambodian Migrant Workers

Many Cambodian migrant workers employed abroad, mainly in Thailand and South Korea, engage in construction due to high demand for employment and relatively better wages. In 2024, approximately 1.38 million Cambodians were employed abroad, with a significant number working in Thailand. Collectively, these overseas workers sent home an estimated $2.95 billion in remittances, marking a slight increase from $2.94 billion in 2023. The Cambodian Ministry of Labor and Vocational Training has implemented measures to support these migrant workers. This includes signing memorandums of understanding with eight banks to facilitate access to official loans, thereby reducing interest rates for migrant workers from 18% to 8.5% annually (MLVT, 2024). Additionally, the ministry collaborated with Thai authorities to reduce the cost of applying for and renewing work visas, aiming to alleviate financial burdens on Cambodian workers in Thailand.

Cambodian migrant workers are due to their major influence on the country's economy and citizen welfare. Migrant workers, particularly those who work in low-skilled and high-risk occupations abroad, contribute substantially to Cambodia through remittances,
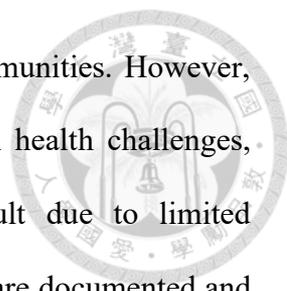
which help improve the living standards of their families and communities. However, these workers face numerous occupational health risks and mental health challenges, especially upon their return, when reintegration can be difficult due to limited employment options and support systems (WHO, 2020). Job losses are documented and there is limited research on the psychological effects of rapid unemployment and financial instability, particularly among returning migrant workers. Migrant workers were disproportionately affected by job losses due to the economic downturn during the pandemic. In Thailand, many Cambodian workers in sectors like construction and hospitality were laid off due to lockdowns and travel restrictions. Cambodian migrant workers, who frequently go to Thailand and South Korea in search of work are made aware of comparable difficulties that may have long-term effects on their physical and emotional well-being (IOM, 2019).

Research by Cambodianess in 2020 indicates that Cambodian migrant workers are often employed in informal or vulnerable jobs, where safety regulations are either absent or inadequately enforced (Cambodianess, 2020). The absence of protection increases the risk of accidents and injuries while concurrently reducing workers' access to healthcare and compensation. The lack of legal status or documentation frequently intensifies these vulnerabilities, as undocumented migrants are less inclined to pursue medical assistance due to fears of deportation or other legal consequences (Paitoonpong, 2011).

1.6 Migration Dynamics and Return Movement During the COVID-19 Pandemic

The World Health Organization's declaration of the COVID-19 pandemic had an impact on migration trends and presented difficulties for migrant workers. The COVID-19 pandemic significantly changed global migration patterns due to extensive movement restrictions, border closures and lockdown measures. Due to job loss, lockdowns and border closures, a sizable portion of Cambodian workers were compelled to return from
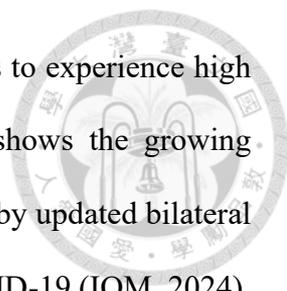
countries like Thailand (United Nations, 2021). Cambodia continues to experience high labor migration to Thailand. However, recent data (2023-2025) shows the growing migration to other countries such as Japan and Malaysia, influenced by updated bilateral migrant workers agreements and economic recovery following COVID-19 (IOM, 2024). The following section outlines how the COVID-19 pandemic influenced migration dynamics and public-health conditions in three key countries relevant to this study Cambodia, Thailand and South Korea.

Cambodia: The COVID-19 pandemic created major disruptions for Cambodian migrant workers, ultimately shaping large-scale return migration. As infections increased, Cambodia introduced strict lockdowns, border closures and other public-health controls. By the end of 2022, national records indicated approximately 137,000 cases and around 3,000 deaths. Vaccination coverage reached nearly 90% by mid-2022, among the highest in Southeast Asia. In total, more than 260,000 Cambodian migrant workers returned home during the pandemic, primarily due to job losses and mobility restrictions in host countries. Challenges included unemployment, financial instability and limited reintegration support, the total number of cases and deaths as shown in Appendix 2 (Worldometer, 2024).

Cambodia was moving from the acute phase of the COVID-19 epidemic to a period of slow reopening and economic recovery during the period of the questionnaire survey for this study (done in 2022). The nation had already seen multiple waves of COVID-19 infections; the most severe one fell between mid-2021 and early 2022. Driven by the Delta variant, which caused a notable increase in cases, this period was characterized by social disturbances and public health actions.

Early in 2022, the Cambodian government started to relax many of the strict policies, including travel bans, curfews and lockdowns, that had been in place all through 2021.
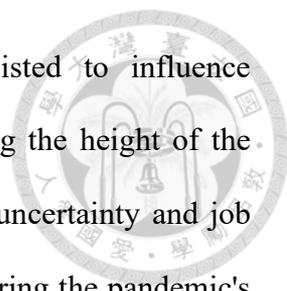
Still, the social and financial effects of past lockdowns persisted to influence underprivileged groups, including returned migrant workers. During the height of the epidemic, many had suffered limited access to healthcare, income uncertainty and job losses (OHCHR, 2022). Cambodia enforced stringent lockdowns during the pandemic's peak, especially from April to May 2021 and in specific high-risk areas throughout 2021. The lockdowns consisted of (1) Interprovincial travel restrictions, (2) curfews and stay-at-home orders in urban centers like Phnom Penh, (3) Closure of markets, factories and public spaces, (4) Mandatory quarantine for returning migrants, see Appendix 2 (CCC Cambodia, 2022).

Thailand: The pandemic profoundly affected Thailand's labor sectors, particularly those dependent on migrant workers. Strict lockdowns and curfews disrupted employment in construction, agriculture and domestic work. By mid-2022, Thailand had reported around 4.7 million confirmed COVID-19 cases and approximately 33,000 deaths, illustrating the scale of the crisis faced by both the population and the workforce. There was a lack of employment opportunities for Cambodian migrant workers in Thailand as a result of limitations placed on sectors and corporations. Migrant workers faced discrimination and limited healthcare access, leading to heightened mental health challenges, see the appendix 2 for the total number COVID-19 ceases and total number of deaths in Thailand (Thailand National Statistics Office, 2020; *Worldometer Thailand*, 2024).

Thailand was recovering from several waves of COVID-19 infections during the 2022 questionnaire survey, the most notable of which were the Delta wave in 2021 and the Omicron wave, which peaked in early 2022. While the number of daily cases remained high in early 2022, the Thai government's pandemic strategy had shifted from strict containment to coping with COVID-19, particularly as vaccination coverage increased, see Appendix 3 (Newsroom, 2022).
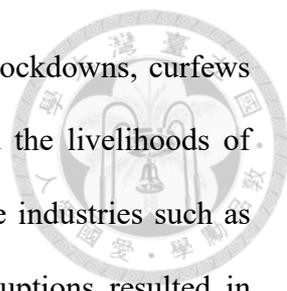
To prevent the virus from spreading, Thailand implemented strict lockdowns, curfews and travel restrictions in 2021. These measures severely disrupted the livelihoods of migrant workers, many of whom worked in informal and low-wage industries such as construction, agriculture, fisheries and domestic work. These disruptions resulted in widespread job losses, limited access to healthcare and social services and increased vulnerability for migrant workers, including those from Cambodia. During the peak periods of the pandemic in 2020 and 2021, Thailand enforced lockdowns, with the most stringent measures taking place from July to September 2021. The following were included: (1) Curfews at night and bans on public gatherings; (2) Businesses, markets and construction sites that are not needed will have to close; (3) Moves between provinces and into migrant worker camps are limited; (4) Mandatory quarantine for migrants coming back and controls at the borders.

South Korea: For migrant workers in South Korea, the COVID-19 pandemic created significant disruptions in employment, mobility and wellbeing. Outbreaks in factories and farms triggered quarantine measures and movement restrictions that reduced work availability. By mid-2022, national records indicated approximately 17.5 million confirmed cases and 23,000 deaths. These impacts were compounded by broader economic slowdown, which increased job insecurity for those working under the Employment Permit System (EPS). Social isolation, cultural barriers and limited access to information heightened the psychological stress experienced by Cambodian migrant workers. Additional epidemiological details are included in Appendix 3 (WorldometterS.Korea, 2024; Jihye et al., 2024).

South Korea was handling the consequences of the Omicron variant surge, which had resulted in unprecedented daily case numbers earlier in the year. In light of the considerable caseload, the South Korean government upheld its approach of harmonizing

public health priorities with economic stability by enacting targeted restrictions instead of resorting to comprehensive national lockdowns (Maresca, 2022).

Throughout the pandemic, South Korea refrained from implementing nationwide lockdowns. Rather, it depended on a strong framework of testing, contact tracing, quarantine and digital surveillance. Between 2020 and early 2022, the government implemented different degrees of social distancing measures based on the local case numbers. These comprised (1) Limitations on business operating hours and public gatherings, (2) Mask requirements in indoor and densely populated outdoor areas (3) Remote work guidelines and school shutdowns during peak waves. The quarantine protocols for incoming travelers and individuals in close contact (Ki-il, 2022).

Early in 2022, when the Omicron variant spread quickly, South Korea had its biggest wave of infections. In March, there were over 600,000 new cases every day. But by the middle of 2022, these numbers had dropped by a lot. The government started to loosen rules about social distance, such as removing restrictions on gatherings and business curfews. However, they still told people to get vaccinated and wear masks.

For Cambodian migrant workers in South Korea, this meant that there were not any complete lockdowns, but they did have long periods of being unable to move around, losing their jobs and being alone, especially in manufacturing, agriculture and fisheries. Some migrant workers had trouble getting accurate health information or support services because of problems with language and legal status, which made them even more vulnerable during the pandemic. Even though there was not a formal lockdown, migrant workers still had to deal with psychological and occupational stress. Many of them said they felt uncertain, afraid of getting sick, had little money and did not have enough support, all of which increased their mental health risks when they returned to Cambodia.

1.7 Disruption of Migrations and Labor Market Dynamics

The study demonstrates that the COVID-19 pandemic significantly affected labor migration market dynamics, and these disruptions were closely tied to the strict border closures and quarantine measures implemented during this period. Such restrictions limited cross-border mobility and directly reduced opportunities for new migrant workers to enter destination countries, particularly in high-demand sectors such as agriculture and healthcare. The pandemic influenced employment demand, heightening the necessity for healthcare and logistics personnel while reducing demand in sectors such as hospitality and tourism. This led to the necessity for migrant workers to moving to new industries to avoid unemployment. The changes in migration patterns underscore the susceptibility of migrant workers to global crises and the structural dependence of numerous industries on migrant workers (Murzakulova et al., 2021).

The pandemic made it even more risky for foreign workers, which was awful for their health, their employment and their social lives. Because they had hard times living and didn't have easy access to health care or protection measures at work, migrant workers were more likely to be exposed to COVID-19. Many workers couldn't get tested, vaccinated, or treated because they weren't legal or didn't have the legal documentation. Due to job insecurity and fear of infection, mental health problems like worry, sadness and stress also got worse (Uansri et al., 2023).

Migrant workers and their families experienced financial hardship as a result of the pandemic's prevalent contribution fraud and job losses (ILO, 2021; IOM, 2021). While others lost their savings as a result of unplanned unemployment or repatriation, many workers found it difficult to repay debt (World Bank, 2021). The financial sectors of the countries of origin, especially Cambodia, were also impacted by the drop in remittances (World Bank, 2022). Between 2020 and 2022, about 260,000 Cambodian migrant

workers repatriated because of health issues, job losses and the closure of the country's border (MLVT, 2022; IOM, 2022). These workers' entry was accompanied by social discrimination, economic hardship and a great deal of uncertainty (UNICEF, 2022; IOM, 2021). Migrant workers encountered significant challenges in numerous countries that enacted repatriation programs or compelled migrants to return home due to job losses or the expiration of work permits (ILO, 2020; IOM, 2021).

This resulted in a significant increase in return migration, placing considerable strain on origin countries facing reintegration challenges (IOM, 2022; UNDP, 2021).

1.8 Emerging Mental Health and Occupational Health Issues

During the epidemic, migrant workers faced increased discrimination and often were mistakenly assumed responsible for the disease's spread. Families and communities experienced severe strain by the rapid return of workers, which resulted in problems like overcrowded homes and restricted access to social services (Loganathan et al., 2024). Essential workers in low-income sectors experienced significant health and economic vulnerabilities during COVID-19, largely due to unstable employment and limited protections. Due to their working conditions, many migrant workers have had both increased exposure to the disease and financial difficulties, making them particularly impacted by the pandemic (Kluge et al., 2020). A study by the International Organization for Migration, 2020, emphasizes the disparate impact of the pandemic on migrant workers, many of whom experienced unemployment, financial instability and increased health hazards. The pandemic in Southeast Asia resulted in the rapid, large-scale repatriation of migrant workers, particularly Cambodians returning from Thailand and South Korea. Many returnees traveled under unsafe and unstable conditions, including overcrowded transportation, insufficient access to personal protective equipment, inconsistent health screening, and limited accommodation during quarantine. These factors heightened their

vulnerability to infection, increased psychological distress, and underscored systemic gaps in cross-border migrant protection during public health emergencies (IOM, 2020). The first major change in the pattern of access that affects the psychological health of returning migrant worker is the epidemic. The epidemic made this preexisting weakness more severe because the returning migrant workers were faced with unemployment, financial hardship and uncertainty about the future (adbheadhoncho, 2022). Migrant workers' access to necessary services and mental health support is restricted by the nation's lockdown, border closure and restrictive laws. Due to job loss, family separation and challenges adjusting to life in their home country, many returning migrant workers reported higher levels of stress, anxiety and depression (Hintermeier et al., 2024). Along with financial hardships and strained social ties, those returned migrant workers may have mental health issues like stress, anxiety and despair. The problem has gotten worse and has grown to be a major concern for Cambodian returnees as a result of the neglect of mental health, which is an essential aspect of welfare for many migrants. Research indicates that among regular migrant workers, anxiety, sadness and stress may be exacerbated by relocation attachment separation or unfulfilled economic demands (Qiu et al., 2011). Many workers who are migrants find significant changes when they return home, including increased unemployment, debt from going home, social discrimination and pressure to adjust. In addition, women are more susceptible to mental health problems and gender-based violence. Apart from unstable finances, social discrimination and psychological crises brought on by the COVID-19 pandemic, migrant workers' recovery upon return suffers further difficulties.

The epidemic caused by COVID-19 made these mental health concerns substantially more difficult to manage. The pandemic resulted in the loss of jobs for migrant workers, prolonged lockdowns and restricted access to health services for these individuals. On the
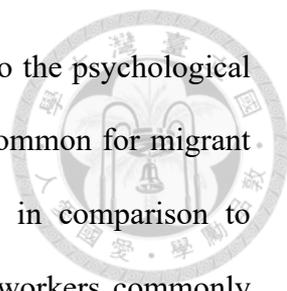
other hand, the challenges of being viewed as virus carriers added to the psychological load that individuals who were coming home were carrying. It is common for migrant workers to face an increased number of mental health concerns in comparison to communities that exclude migrants. Research shows that migrant workers commonly experience anxiety, depression and stress due to the unique challenges they encounter during migration, employment and reintegration (Saraceno & Almeida, 2022). Moreover, a study by the International Labor Organization indicates nearly 30 to 50 percent of migrant workers globally report moderate to severe symptoms of mental health disorders, underscoring the scale of the issue (Bureau international du travail, 2021).

Research done during the epidemic found that stress, anxiety and depression among migrants had increased. This was particularly prevalent for those migrants who had lost their employment or were unable to return home because of travel restrictions (Garcini et al., 2021). These mental health problems have been made worse by the social isolation brought on by restrictions and the challenges attached to being a migrant during the pandemic (Liem et al., 2020). Research by Doshi and colleagues found that the rise in anxiety and depression among migrant workers during the COVID-19 pandemic was strongly associated with economic stressors such as job loss, sudden loss of income, and uncertainty about future employment. These psychological impacts were further exacerbated by the breakdown of social support networks, mobility restrictions, and the challenges of reintegrating into home communities after long periods abroad, particularly in contexts where stigma and limited mental health resources were present (Doshi et al., 2020; Acharyya et al., 2022).

Given these factors, mental and physical health of foreign workers has experienced a substantial decline during the pandemic. As they sought to get back to their countries of origin during and after the pandemic, returned foreign workers faced special problems:
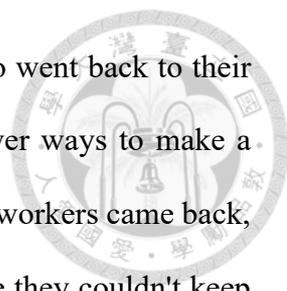
Due to the financial crisis caused by COVID-19, many workers who went back to their home countries had a hard time finding stable work. They had fewer ways to make a living because there was not any job training or help services. When workers came back, they often felt bad about themselves and criticized by others because they couldn't keep their career goals (Irudaya Rajan & Arcand, 2023). Losing independence and economic security also made mental health problems like worry and sadness even worse. Many times, people who came back to work could not get healthcare services like tests or treatment for COVID-19. Individuals who got the virus while they were moving would have long-term health problems if they didn't get appropriate care. A lot of returnees had trouble getting government help or reintegration programs because of documentation or organizational complications. The COVID-19 epidemic had a big impact on the life of workers from other countries. It affected how people get about and made health, economic, and social concerns worse (WHO, 2020).

The COVID-19 pandemic has highlighted and increased the occupational health risks encountered by migrant workers. Migrants are overrepresented in essential sectors, including agriculture, healthcare and logistics, where they face an increased risk of virus exposure. Many migrant workers face an increased risk due to restricted access to personal protective equipment and adequate healthcare, which further puts at risk their health. The pandemic has resulted in heightened stress and anxiety among migrant workers due to job insecurity, income loss and the risk of deportation. The pandemic's economic impact has been particularly severe for migrants, many of whom cannot access government support or unemployment benefits because of their legal status (Askari et al., 2020).

Upon returning, many workers re-enter Cambodia's construction workforce, facing challenges reintegrating due to the sector's informal nature and inconsistent job opportunities. In Cambodia, the return of large numbers of migrant workers has placed
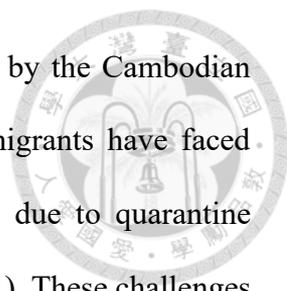
additional strain on an already limited healthcare system. Research by the Cambodian Ministry of Health and the World Bank indicates that returning migrants have faced difficulties accessing healthcare, including mental health services, due to quarantine requirements, challenges and resource constraints (World Bank, 2021). These challenges highlight the urgent need for policies and programs that address mental health needs of returning migrants in the context of the pandemic (Ministry of Health, 2024). For Cambodian migrant workers, these challenges were further compounded by the country's limited healthcare infrastructure and economic opportunities (Xiong et al., 2020; Clemente-Suárez, Martínez-González, et al., 2021).

1.9 Research Gaps

Despite growing global interest in the intersection of migration, mental health and occupational risks, several critical research gaps remain, particularly within the Cambodian context. This study addresses these voids by focusing on returned Cambodian migrant workers who were significantly affected by the COVID-19 pandemic. The key research gaps are outlined below:

1.9.1 Limited Country-Specific Research (Cambodia)

Most existing studies on migrant mental health are situated in high-income countries or neighboring transit countries like Thailand and Malaysia, with Cambodia often excluded from in-depth analysis (IOM, 2021). There is a dearth of empirical research specifically focused on returned Cambodian migrant workers, especially those who have experienced abrupt reintegration due to COVID-19. "Most studies concentrate on host countries, leaving gaps in origin-country contexts like Cambodia, where reintegration issues are pronounced" (ILO, 2022).
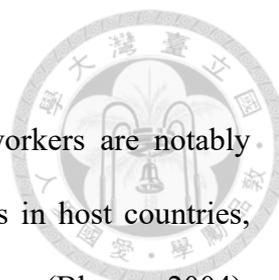
1.9.2 Lack Population

Mental health and occupational well-being of returned migrant workers are notably under-researched. While migration studies often center on migrants in host countries, little attention has been paid to those who return under crisis conditions (Bhugra, 2004). This is especially relevant during pandemics, where job loss, discrimination and uncertainty compound psychological stress upon return (Silove et al., 2017).

There remains a lack of integration between occupational health risks and mental health outcomes in migration literature. Studies frequently examine one or the other, but few explore how workplace exposure, sector-specific stressors (e.g., agriculture, construction, domestic work) and reintegration dynamics together affect migrant mental well-being (Chen et al., 2015; IOM, 2022).

Migration and mental health research in Southeast Asia have primarily relied on either cross-sectional surveys or anecdotal qualitative studies. Very few studies apply a qualitative and quantitative methods design to capture both statistical trends and lived experiences. This study's combination of quantitative (PHQ-4 tool) and qualitative (in-depth interviews) fills that gap and provides a nuanced understanding (Creswell & Plano Clark, 2017). In addition, a 2022 study in Greece validated the PHQ-4 for use in the general population, demonstrating its reliability in screening for symptoms of anxiety and depression. However, no comparable validation studies have been conducted in Cambodia. This raises important considerations regarding the use of non-validated mental health tools in Southeast Asian contexts, where cultural perceptions of mental illness, help-seeking behaviors, and symptom expression may differ significantly. A 2020 study on the development of mental healthcare in Cambodia highlights persistent cultural and structural barriers to mental health assessment, underscoring the need for locally validated screening instruments (Christodoulaki et al., 2022).

1.9.3 Insufficient Gender-Specific Analysis

There is an urgent need to explore gendered dimensions of mental health in migration research. Women migrant workers face unique challenges, including caregiving burdens, social discrimination and heightened exposure to gender-based violence (UN Women, 2021). Yet, disaggregated analyses remain scarce in Cambodian migration literature. This study addresses this by comparing male and female experiences using both survey and interview data.

Lack of policy translation and evidence-based recommendations: While various development partners and NGOs have published assessments, there remains a gap in studies that translate evidence into actionable policy insights for the Cambodian government or regional frameworks (IOM, 2021; UNDP, 2021). This dissertation's findings offer data-driven recommendations for reintegration programs, gender-sensitive mental health services and sector-specific protections.

The COVID-19 pandemic has underscored significant policy gaps in safeguarding Cambodian migrant workers, especially during crises. A 2020 scoping review on community-based healthcare for migrant communities suggests that peer mentorship and culturally responsive services can be adapted for Cambodian migrant workers and the UNICEF Cambodia (2022) highlights the experiences of migrant workers who faced heightened vulnerabilities due to limited access to healthcare services and vaccinations while working abroad. Their situation reflects a broader systemic issue where migrant workers are often excluded from essential health services in host countries, exacerbating their risk during health emergencies. The absence of comprehensive bilateral agreements and inclusive health policies contributes to this marginalization, leaving migrant workers without adequate protection or support mechanisms during global crises. This case exemplifies the urgent need for evidence-based policy reforms that ensure the inclusion

of migrant workers in national and international health strategies (Riza et al., 2020; UNICEF, 2022).

Table 1. Research Gaps in Mental Health and Occupational Risks

Gap	Identified Research Gaps
Specific Context (Cambodia)	There is little information available on mental health of migrant workers from Cambodia who have returned home after COVID-19, especially in rural areas like Banteay Meanchey, Battambang, Siem Reap and Kampot.
Target Population	Lack of studies focusing on returned migrant workers, especially gender-specific analysis (male vs. female) and high-risk subgroups.
Gender Analysis	There is a lack of emphasis on gender-specific vulnerabilities, including increased anxiety and depression. Migration related mental health challenges.

1.10 Study Objectives

Cambodia has experienced sustained labor migration to neighboring countries over the past two decades, particularly to Thailand, driven by limited domestic employment opportunities and the need for stable household income. For many migrant workers, employment abroad provides temporary financial relief; however, it also exposes them to physically demanding labor, low job security and varying degrees of social isolation and employer control. Upon returning to Cambodia, migrant workers often encounter difficulty re-establishing livelihoods, meeting family expectations and adapting to new or uncertain roles, which can place substantial strain on their psychological well-being. These challenges highlight that mental health among returnees is shaped not only by

individual emotional experiences, but also by broader occupational, economic and sociocultural conditions. Understanding these dynamics is essential for designing reintegration support that addresses both livelihood stability and mental well-being. Therefore, this study focuses on examining the links between occupational experiences and mental health outcomes, as well as the social and cultural factors influencing coping and access to support services among returned Cambodian migrant workers.

This study aimed to understand the occupational and mental health experiences of Cambodian migrant workers who returned to Cambodia after employment abroad. The focus was on examining how past work conditions and current reintegration challenges influenced psychological well-being upon return. The study also sought to identify the social, cultural and structural barriers that shape access to mental health support. The findings are intended to contribute evidence that can inform reintegration programs and policy strategies to strengthen the well-being and livelihood stability of returned migrant workers. The specific objectives of this study are as follows: (1) To describe the prevalence and patterns of anxiety and depression symptoms among returned Cambodian migrant workers and to evaluate the psychometric validity of the PHQ-4 screening tool within the Cambodian context. This objective responds directly to the lack of country-specific mental health study and the absence of validated screening tools for Cambodia. By examining both symptom distribution and the performance of the PHQ-4 screening tool, the study provides foundational evidence for mental health assessment among returned migrant populations. (2) To examine how occupational health risks and working conditions experienced abroad including long working hours, unsafe environments and sector-specific exposures are associated with mental health outcomes upon return. This objective addresses the limited integration of occupational and mental health research in migration studies. It aims to clarify how pre-return workplace exposures contribute to
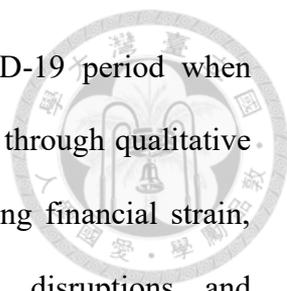
psychological distress after return, particularly during the COVID-19 period when employment instability and exploitation intensified. (3) To explore, through qualitative inquiry, the lived experiences of returned migrant workers regarding financial strain, psychosocial stress, workplace exploitation, pandemic-related disruptions and reintegration challenges. This objective fills the methodological gap in Southeast Asian migration literature by integrating qualitative insights with quantitative findings. It provides contextual depth into how returned migrants navigate emotional, social and economic pressures. (4) To identify gender differences in occupational exposures, psychosocial challenges and mental health outcomes among returned migrant workers. Given the scarcity of gender-disaggregated analyses in Cambodian migration research, this objective seeks to uncover how men and women experience vulnerabilities differently, including variations in stress, coping and exposure to gender-specific risks. (5) To identify the social, cultural and structural barriers that limit access to mental health and psychosocial support services among returned migrant workers in Cambodia. This objective responds to evidence showing that migrant workers often remain excluded from essential health and support systems. It focuses on discrimination, service gaps and structural constraints that shape help-seeking behaviors and coping strategies. (6) To develop evidence-based recommendations that strengthen reintegration policies and mental health support mechanisms for returned migrant workers, incorporating occupational, psychosocial and gender-specific needs. This objective addresses the gap between research and policy translation. It ensures that study findings inform practical, context-appropriate strategies for government agencies, NGOs and development partners.

1.11 Study Framework

The study structure shown in the figure below examined the relationship between health risks at work, mental health effects and how the COVID-19 pandemic affected
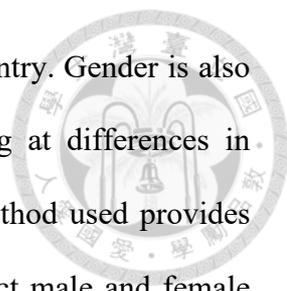
Cambodian migrant workers who migrated return to their home country. Gender is also used as a moderating variable in the framework for investigating at differences in experiences and results between male and female workers. The method used provides certain the research investigation focuses at how these factors affect male and female workers differently by using gender as an influencing variable. This presents a more comprehensive understanding of the problem.

The study framework shown in the figure below illustrates how the research examined mental health effects and the broader impacts of the COVID-19 pandemic on Cambodian migrant workers who returned to their home country. The study originally recruited 25 participants for the qualitative component and 392 participants for the quantitative component. After applying the inclusion and exclusion criteria, a total of 8 qualitative interviews and 392 quantitative cases were included in the final analysis. Gender was incorporated as a moderating variable to explore differences in experiences and outcomes between male and female returned migrant workers. By integrating gender into the analytical framework, the study provides a more comprehensive and nuanced understanding of how the pandemic affected individuals differently, enriching the overall interpretation of the findings.
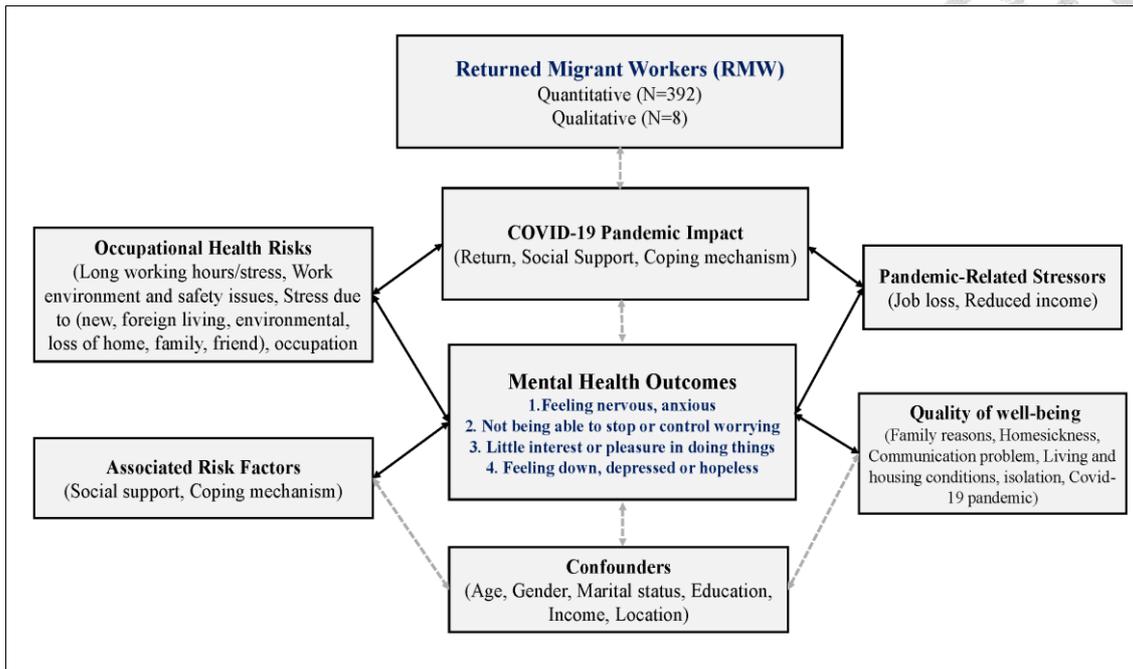
Figure 3. Study framework

The study framework guiding this study shows how multiple factors interact to influence mental health and overall well-being of returned Cambodian migrant workers. Central to the framework is the experience of COVID-19 pandemic impacts, including repatriation, changes in social support and coping mechanisms, which directly shape mental health outcomes after return. Alongside these pandemic-related influences, pandemic-related stressors such as job loss and reduced income, further intensify psychological distress among returnees.

The framework also incorporates occupational health risks previously encountered abroad such as long working hours, workplace stressors, safety concerns and environmental or social pressures associated with migration. Although these factors were explored during data collection, only those aligned with the study's inclusion criteria were retained for analysis.

Two additional domains, associated risk factors (including social support and coping strategies) and quality of well-being (such as family issues, homesickness, communication barriers, living conditions, isolation and pandemic-related concerns), contribute to shaping

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return migrants' post-migration mental health. These components help contextualize the broader reintegration environment in which mental health changes occur.

At the center of the framework are the four key mental health outcomes assessed in this study: (1) Feeling nervous or anxious; (2) Being unable to stop or control worrying; (3) Having little interest or pleasure in doing things; (4) Feeling down, depressed or hopeless. To ensure accurate interpretation, the analysis accounts for a range of confounding variables, including age, gender, marital status, education, income and residential location. These factors help distinguish whether observed mental health differences arise from COVID-19-related experiences or from underlying demographic characteristics.

In addition, the framework of the study demonstrated the link between multiple variables that significantly influence mental health outcomes of Cambodian migrant workers who have returned home. It integrates both occupational health risks and contextual factors such as the COVID-19 pandemic to examine how these essentials contribute to mental health issues with an emphasis on identifying potential gender differences. The study elements are listed as follows: Independent variables in this study represent the factors or characteristics that may influence mental health consequences (dependent variables) among returned Cambodian migrant workers. The demographic characteristics including gender (male and female), age (age categories or mean age), marital status (single, married with/without certificate, separated, divorced, windowed), education level (no formal schooling, primary incomplete, secondary, high school, bachelor's degree). The employment and migration-related factors including employment Sector (agriculture work, construction work and domestic work); legal status (legal or illegal migrant worker), type of employment of work destination, duration of stay in destination country is the time since return to Cambodia.
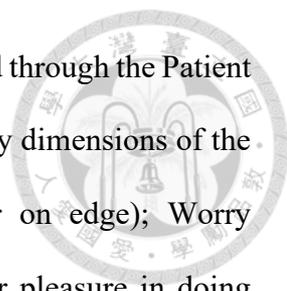
Dependent variables in this study are mental health outcomes assessed through the Patient Health Questionnaire-4 items, this questionnaire focusing on four key dimensions of the Nervousness/Anxiety (Frequency of feeling nervous, anxious, or on edge); Worry (Inability to stop or control worrying); Interest (Loss of interest or pleasure in doing things); Depression (Feeling down, depressed or hopeless). Also, categories these variables into: No/Mild Symptoms (Reflecting minimal or manageable mental health concerns. Moderate/Severe Symptoms (Reflecting more serious mental health conditions requiring attention or intervention).

Occupational roles and responsibilities including gender may influence the type of work that migrant workers are involved with female potentially facing different types of occupational health risks compared to male. For example, female might be more likely to work in domestic work whereas male might work in more physically demanding sectors like construction. Gender specific stressors, female might face additional stressors related to gender-based violence or harassment while male might face pressures related to providing financial support to their families. Gender-specific stresses can have varying effects on mental health outcomes. Cultural norms and gender roles may influence the willingness and ability of male and female workers to seek mental health support. For example, women may face greater challenges or practical barriers such as caring responsibilities that limit their access to services.

CHAPTER 2. RESEARCH METHODOLOGY

2.1 Study Areas and Setting

Banteay Meanchey, Battambang, Siem Reap and Kampot were the four provinces in Cambodia where the study was conducted. This sampling selection was based on the significance in migration patterns, their proximity to international borders and the socio-economic profiles of the study populations.

These areas were chosen because they have a lot of returned foreign workers, mostly from Thailand. The Banteay Meanchey, Battambang and Siem Reap are located along the Thai-Cambodia border, making them frequent points of return for migrants from Thailand. Kampot was selected to represent a non-border province with growing labor migration. In addition, Banteay Meanchey, Battambang and Siem Reap are located along the Thai-Cambodian border and are key migration hubs with high numbers of workers traveling to and returning from Thailand. These provinces are important for understanding the insights and experiences of migrant workers who mainly engage in agriculture and construction. On the other hand, Kampot province does not border Thailand but was selected in this study because of its significant population of returned workers from Thailand with unique occupational profile, including fisheries and domestic work. The selection of these provinces confirms a geographically diverse and representative sample with capturing a range of migration and reintegration dynamics that are important to understanding mental health and occupational risk factors faced by returned Cambodian migrant workers. Furthermore, it offers an in-depth geographic, economic and demographic analysis of the experiences of returned migrant workers, especially during the COVID-19 pandemic and allows a thorough understanding of the risk factors linked to mental health among Cambodian returned migrant workers (MLVT, 2021).
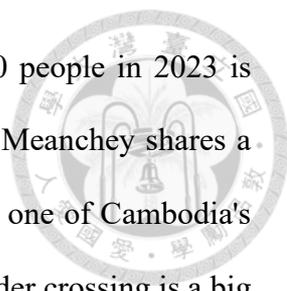
Banteay Meanchey province's population of approximately 891,500 people in 2023 is mainly engaged in agriculture and small-scale occupation. Banteay Meanchey shares a major land border with Thailand, Banteay Meanchey also making it one of Cambodia's most important provinces for cross-border migration. The Poipet border crossing is a big key entry and exit point for migrant workers between Cambodia and Thailand. This province has a high number of returned migrant workers due to its proximity to Thailand and a history of labor migration. Many returnees in Banteay Meanchey face reintegration difficulties, including limited job opportunities and social support.

Battambang is one of the potential places where Cambodian migrant workers travel across to Thailand. In 2023, the population of Battambang province is about 1,036,500 people, with a significant portion engaged in rice farming and agricultural work. The province has a strong agricultural foundation, which leads many people to migrate to Thailand during off-seasons or times of low local employment. Additionally, there was a notable increase in returning migrant workers during the COVID-19 pandemic.

Siem Reap province is also one of the potentials, with a population of around 1,004,200 people in the year 2023 and many people employed primarily by tourism and agriculture for income. With the economic downturn, migration increased as people sought livelihoods elsewhere and returned workers are a significant number, especially from Thailand, since the residents migrated mainly for jobs in the construction and hospitality occupation.

Kampot province has an estimated population in 2023 of about 627,800 people, with the main industries being agriculture (pepper and salt production) and fishing zones. Unlike other provinces, Kampot province is not close to the Thai border but we chose this province to capture the investigation of workers migrating to South Korea under the Employment Permit System (EPS). This province has a high rate of migration workers

from Thailand. Immigrants from Kampot often work in fishing, agriculture and construction. It provides a broader perspective on the migration experience.
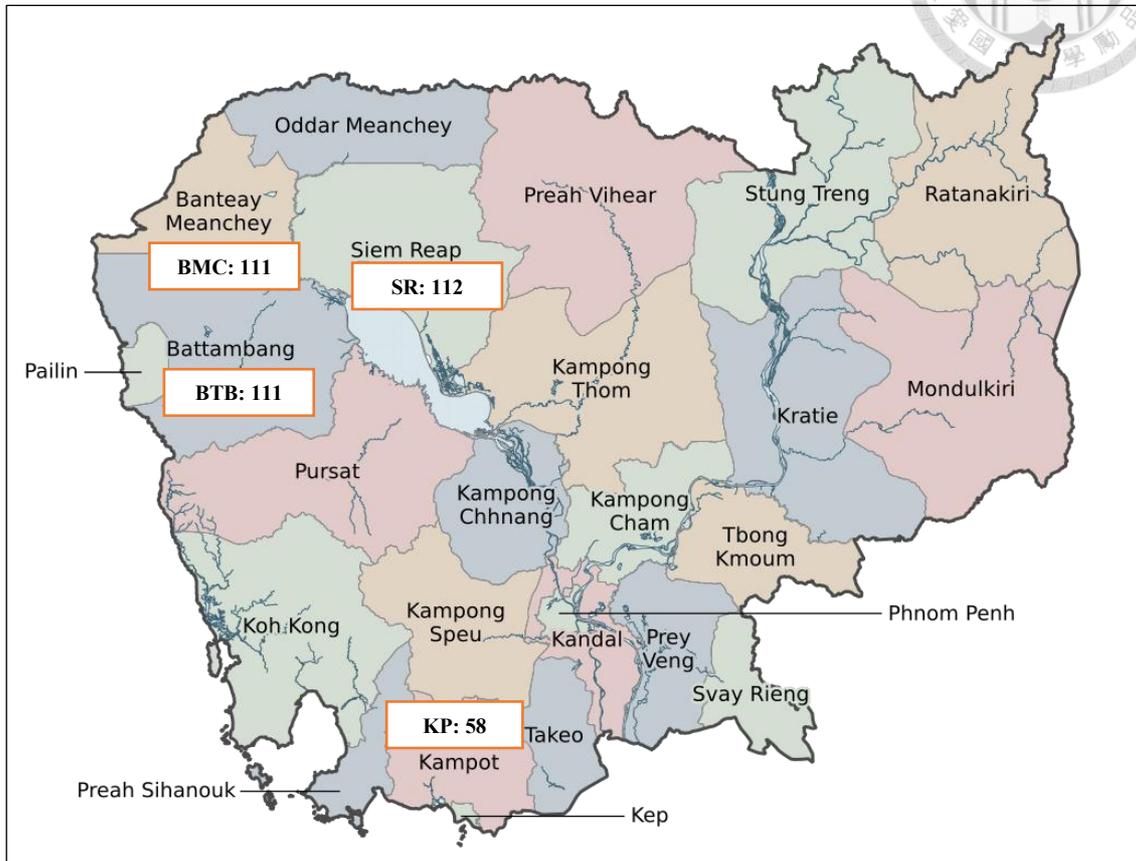
Figure 4. Study provinces included in the sample

2.1.1 Study Period

The study was conducted in August 2022, during a significant phase of the COVID-19 pandemic's aftermath, with a meticulously planned approach to both quantitative and qualitative data collection to ensure accuracy and safety. The study period defined the methodology for data collection, providing specifics on the total COVID-19 cases and mortality numbers. The study period was crucial for obtaining real-time data on the immediate effects of the COVID-19 pandemic on returned Cambodian migrant workers. This study offers important insights into mental health risks, occupational health challenges and reintegration difficulties came across by vulnerable populations during the COVID pandemic.
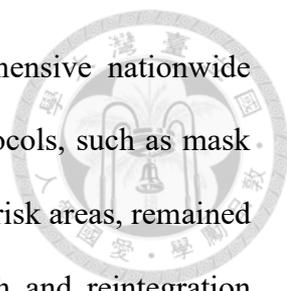
During the time of survey, in Cambodia there were no comprehensive nationwide lockdowns in place; however, localized restrictions and health protocols, such as mask mandates, vaccination requirements and movement controls in high-risk areas, remained in effect. The residual effects persisted in affecting mental health and reintegration experiences of returned migrant workers, rendering the timing of the survey especially pertinent for assessing post-pandemic stress and coping strategies. Additionally, Thailand had loosened up on most of these lockdown rules by the time of the survey. The country was slowly reopening to international travelers. It was also promoting domestic tourism and letting vaccinated people enter without being quarantined. Under bilateral agreements, migrant workers were allowed to go back home, but many still had troubles adjusting because of the socioeconomic effects of the earlier lockdowns. This changing situation in Thailand during the survey period is very important for understanding mental health and job risks that Cambodian returned migrant workers faced, since many of them had been unemployed, afraid of being deported, alone and unable to get help during the worst of the pandemic.

2.1.2 Study Subject

The study population included returned Cambodian migrant workers (aged 18 years and above) who had worked in Thailand and returned to Cambodia within the past 24 months and the key informants, including government officials, NGO staff, healthcare providers and representatives from the International Organization for Migration. When conducting this study on Cambodian returned migrant workers, selected a sample size to achieve statistically significant insights while ensuring practical feasibility through the COVID-19 pandemic. The decision to use a total quantitative sample size was driven by a balance of statistical accuracy and logistical feasibility. The sample size for the quantitative methods of this study involved 392 returned Cambodian migrant workers, which were

distributed across four provinces: Banteay Meanchey, Battambang, Siem Reap and Kampot. The selection process followed a convenient sampling method which intended to include varieties of returned workers based on provincial population data and migration trends.

This study employed a convenience sampling strategy to recruit returned Cambodian migrant workers who had migrated to Thailand for employment and subsequently returned to Cambodia during or after the COVID-19 pandemic. Convenience sampling was selected due to the practical challenges of identifying and accessing returned migrants across multiple provinces, particularly in the context of mobility restrictions, limited registry systems and the absence of a comprehensive list of returnees. This approach enabled the researcher to recruit participants who were readily available, willing to participate and met the study's eligibility criteria.

For the quantitative component, a total of 392 returned migrant workers were recruited from four provinces (Banteay Meanchey, Battambang, Siem Reap and Kampot) which are known to have high concentrations of returning migrants. Data collectors collaborated with local authorities, community leaders and migrant support organizations to identify individuals who met the inclusion criteria. Eligible participants were approached at community centers, local migrant offices, village meeting points and households. Although recruitment locations varied by province, the same set of inclusion and exclusion criteria was applied to ensure consistency across all sampling sites.

For the qualitative component, the study initially approached 25 potential participants, from which 8 individuals were selected based on their availability, willingness to participate and eligibility under the inclusion criteria. The qualitative sample aimed to capture diverse personal experiences related to migration, employment abroad, challenges during the pandemic and reintegration after return. While not intended to be

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statistically representative, this purposive aspect of convenience sampling allowed the study to gather rich, in-depth narratives that complemented the broader quantitative findings.
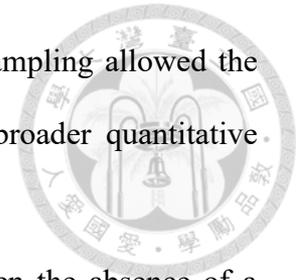
Overall, convenience sampling was appropriate for this study given the absence of a complete sampling frame of returned migrants, the logistical constraints of fieldwork and the study's objective of understanding lived experiences and mental health risks among returnees. This sampling strategy enabled efficient recruitment while maintaining relevance to the research objectives and ensuring the feasibility of data collection during a period of ongoing pandemic-related challenges (Braun & Clarke, 2021).

A total of eight returned migrant workers participated in in-depth semi-structured interviews. Participants were diverse in terms of gender, age, geographic origin, type of employment abroad and duration of stay overseas allowing variation in how migration and return were experienced. Ages ranged from 18 to 65 years with both male and female returnees represented. Employment sectors abroad included construction, manufacturing, agriculture, domestic work and service work, reflecting the common labor patterns among Cambodian migrants to Thailand (ILO, 2022a). Time since return to Cambodia ranged from 6 months to 3 years which enabled exploration of both immediate and longer-term reintegration challenges.

All participants were Cambodian nationals who had previously migrated to Thailand for employment and had subsequently returned to Cambodia either voluntarily or due to COVID-19–related disruptions. To be eligible, individuals had to be 18 years of age or older at the time of the interview and capable of providing informed consent. Additionally, participants needed to be able to take part in an interview conducted in the Khmer language, ensuring full comprehension of the study procedures and questions.

Participants were recruited through community networks, local health centers, village chief and commune chief and village health support groups (VHSG) in the selected target provinces. The recruitment process emphasized voluntary participation and confidentiality. No government officials, NGO personnel or stakeholders were included in the qualitative sample, ensuring that the qualitative findings reflected the perspectives and voices of returned migrant workers themselves rather than organizational or policy actors.

The qualitative sample size is 8 was sufficient for analytic depth and thematic saturation because the intention of the qualitative phase was not to generalize to all Cambodian migrant workers but to illuminate common patterns, social meanings and psychological dynamics across diverse return experiences (Creswell & Poth, 2018). This was confirmed during analysis when no new core themes were emerging and thematic patterns had stabilized across participant accounts.

2.2 Data Collections

Data collection utilized both quantitative and qualitative approaches to provide a comprehensive understanding of mental health risk factors experienced by Cambodian migrant workers who returned from Thailand. Before initiating data collection, secured ethical approval from the National Ethics Committee for Human Research under the Ministry of Health in Cambodia. To ensuring this study adhered to all institutional and public health guidelines. Protocols were established to protect participants and data collectors, including social distancing, mask-wearing and handwashing hygiene. As required by the NECHR, approval letters were obtained from all provincial governors.

Quantitative tools: A recognized screening tool for evaluating mental health, particularly anxiety and depression, is the Patient Health Questionnaire-4 (PHQ-4). It was chosen for this study based on a number of important factors, which made it a good fit
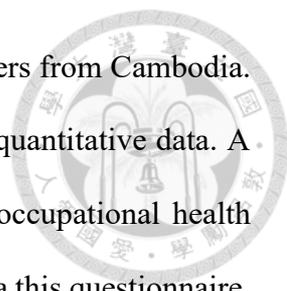
for the setting and objectives of the study on returning migrant workers from Cambodia. A structured survey questionnaire was the main tool used to gather quantitative data. A wide range of data, such as demographic traits, migration history, occupational health hazards and mental health outcomes, were intended to be collected via this questionnaire. The Patient Health Questionnaire-4 items serve as a validated instrument for evaluating mental health status of individuals, specifically by quantifying levels of anxiety and depression (Stein, 2004). The PHQ-4 screening tool consists of four questions, each rated on a scale from 0 to 3, with total scores ranging from 0 to 12 (Kroenke et al., 2010). In this study, the PHQ-4 screening tool was utilized in order to assess mental health conditions of Cambodian migrant workers who had returned home after working in Thailand during the COVID-19 pandemic (Renovanz et al., 2019). Given the stressful conditions associated with migrant work and the added challenges posed by the pandemic, assessing the levels of anxiety and depression among these workers was crucial to understanding mental health risks they face (Löwe et al., 2010a).

Four items measure depression symptoms by asking how often the person has been disturbed by them in the last two weeks. (1) Little interest or pleasure in doing things, (2) Feeling down, depressed, or hopeless. These items focused on assessing symptoms of anxiety by asking how often over the past two weeks the participant have been bothered by: (3) Feeling nervous, anxious or on edge, (4) Not being able to stop or control worrying. The responses from the survey were recorded using a digital data collection platform (e.g., tablets with data entry software) to minimize errors and facilitate immediate data entry. This method ensured that the data was captured accurately and efficiently, reducing the need for later transcription and minimizing the risk of data loss. Several measures were implemented to ensure the quality of the quantitative data. These included pilots testing the survey instrument, conducting regular training and supervision of data collectors and

performing random checks on completed questionnaires to identify and rectify any inconsistencies or errors.

The KOBO Toolbox was used to make this quantitative survey which used the PHQ-4 screening tool and other tests. The platform made it easy to add different types of questions, like multiple-choice, Likert scales and open-ended questions (Nampa et al., 2020).

Qualitative tools: The qualitative component of this study was designed to explore the lived experiences, emotional challenges and reintegration processes of Cambodian migrant workers who returned from employment in Thailand during the COVID-19 pandemic. A qualitative approach was selected because it allows for a deeper understanding of how individuals perceive, interpret and respond to the social and structural conditions shaping their mental health and occupational experiences (Creswell & Poth, 2018; Palinkas et al., 2015).

Data were collected through in-depth semi-structured interviews with eight returned migrant workers. The semi-structured format provided a balance between guiding the conversation and allowing participants to describe their experiences in their own words, ensuring both depth and flexibility (Flick, 2024). This approach enabled the study to capture personal narratives surrounding migration decisions, work environments abroad, emotional and psychological stressors and challenges during reintegration into Cambodian communities.

An interview guide was first developed in English and subsequently translated into Khmer to ensure both linguistic accuracy and cultural relevance. All interviews were conducted in Khmer, audio-recorded with participants' permission and later transcribed and translated into English for analysis. The interviews explored a range of topics, including participants' motivations for migration and their employment experiences

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abroad, their mental health and emotional challenges during migration and after returning to Cambodia, as well as their access to support systems, coping strategies and reintegration needs.

Each interview was conducted in a private and confidential setting, lasted approximately 45 to 60 minutes and was scheduled at a time and location chosen by the participant to ensure comfort and autonomy. This process allowed participants to speak openly about sensitive experiences, including financial stress, discriminations and emotional strain associated with return.

2.2.1 Data Collection Process

The data collection process for this study, focusing on returned Cambodian migrant workers, was carefully structured to navigate the ongoing challenges and restrictions associated with the COVID-19 pandemic. Conducted in August 2022, when COVID-19 risks and precautionary measures remained significant, the data collection team collaborated with local community leaders and organizations to identify and engage eligible participants, recognizing the limitations on face-to-face recruitment. These local partnerships supported outreach efforts and facilitated the identification of participants who met the study's eligibility criteria. Data collection was conducted face-to-face where conditions permitted, following strict COVID-19 safety protocols. Surveys and interviews were conducted in outdoor or well-ventilated spaces, with social distancing and mask usage rigorously maintained to minimize health risks.

Interviews were conducted in person at locations chosen for the participants' convenience, ensuring both privacy and comfort. Each session lasted approximately 60 to 90 minutes, providing ample time for an in-depth exploration of the study topics. With participants' consent, interviews were audio-recorded and subsequently transcribed verbatim for analysis purposes only.
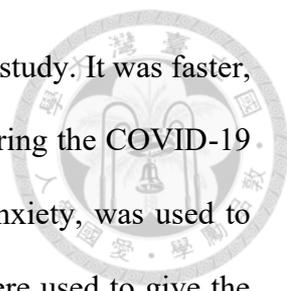
The Kobo Toolbox tool was used to collect quantitative data for this study. It was faster, more accurate and easier to access, which was especially helpful during the COVID-19 pandemic. The PHQ-4, a short screening tool for depression and anxiety, was used to check mental health of the participants. Standardized procedures were used to give the PHQ-4, which made sure that results were the same and accurate whether the data collection took place in person or via the internet.

The interviews were continued until data saturation was reached, that is, until no new themes or insights emerged from additional interviews, ensuring that the data collected was comprehensive and representative of the population's experiences for the data saturation. Adapting to Changing COVID-19 Conditions: As COVID-19 conditions and public health restrictions fluctuated, the data collection team remained flexible, adjusting data collection methods as necessary. For example, if an area experienced a spike in cases, remote data collection was prioritized and in-person activities were temporarily suspended. In addition, also built participant trust and comfort.

To address these concerns, the data collection team provided clear communication regarding the safety measures implemented and reassured participants about the protection of their health and privacy. The data collection process was conducted with considerable flexibility and a strong emphasis on the safety of both participants and data collectors. The researchers used a combination of methods to deal with the problems caused by the COVID-19 epidemic. This led to a complete dataset that accurately demonstrates mental health and working experiences of Cambodian migrant workers who returned.

Additionally, photographs were captured during the data collection process, with participants' consent, to document the study environment and contextual conditions in which both the quantitative surveys and qualitative interviews were conducted. These images illustrate the physical settings encountered by returned migrant workers such as housing, community
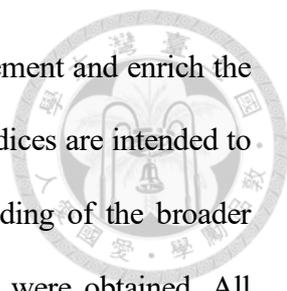
spaces, and interview locations and provide visual insights that complement and enrich the interpretation of both datasets. The photographs included in the Appendices are intended to support the qualitative narratives and enhance the reader's understanding of the broader fieldwork context in which survey responses and interview accounts were obtained. All identifiable information was removed to ensure participant privacy and confidentiality. (Appendix 8. Data Supplements Information of the study).

Quantitative data collection: Data were collected through structured interviews using a questionnaire programmed into the Kobo Toolbox (Harvard Humanitarian Initiative, 2024), a digital tool used for field surveys. The questionnaire covered the following: (1) Socio-demographic and migration history, (2) Occupational details, (3) Mental health screening using the PHQ-4 screening tool (measuring depression and anxiety). Enumerators conducted face-to-face interviews while adhering to COVID-19 safety protocols, which included mask-wearing and social distancing measures.

Qualitative data collection: Interviews were conducted in Khmer by trained researchers who were familiar with local dialects and cultural contexts. Each interview was held in a private and comfortable setting to ensure confidentiality and participant comfort. With permission, all interviews were audio-recorded to preserve accuracy and detail. Interviews typically lasted between 45 and 75 minutes and followed a semi-structured format guided by key questions focusing on participants' migration histories, reasons for migrating, working conditions abroad, challenges experienced during the COVID-19 pandemic, mental health experiences during and after return, access to support systems, coping strategies and reintegration challenges. This format allowed participants to share their experiences openly while ensuring that all core topics relevant to the study were systematically explored (Appendix 7).

2.2.2 Data Quality Assurance and Monitoring

The reliability and validity of both quantitative and qualitative findings were guaranteed through the prioritization of data quality assurance and monitoring. The data collection team received two days of training that included field experience from the expert (trainer) to ensure the capacity of the data collectors to conduct the interview and be familiar with the questionnaire and method of selection of interviewees. The pilot test was conducted in Phnom Penh and experiences and knowledge among the team members were collected before the data collection by performing mock interviews and role plays by administering the study instruments, the field pilot of the questionnaire and revision if necessary. Data cleaning persists during both the data entry and analysis stages. Validation was conducted on the two sets of data entries to pinpoint errors. Corrections are made according to the filled-out questionnaires. The following highlights how quality control was implemented in this study: the fieldwork supervisor/group leader continued to do accompanying checks on the first 50% of interviews, at least one for each interviewer, to reconfirm. In addition, fieldwork group leaders were required to do one random backcheck and one random spot-check every day to check and maintain interviewer quality. Team leaders were in charge of accompanying or back-checking interviewers. They could request that interviewers re-ask unclear questions during accompaniment, or they could request that interviewers revisit respondents if they find any inconsistency in their answers during the debrief. Moreover, during the accompanying check of the group, the leader checked both ways of asking questions and the materials to be used, including the showcard and/or photo card, if any. The quality control included an outdoor 100 percentage check on the completeness and logic of the completed questionnaires from all interviewers every day. Regarding the qualitative assurance aspect, all interviews were audio-recorded with proper consent to ensure precise transcription and thorough analysis. Furthermore, the transcriptions were
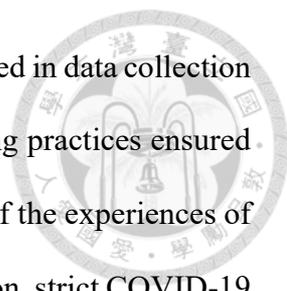
meticulously cross-verified by myself and additional members involved in data collection to ensure their accuracy. These data quality assurance and monitoring practices ensured that the findings of the study were reliable, valid and representative of the experiences of returned Cambodian migrant workers. During in-person data collection, strict COVID-19 health and safety protocols were followed to ensure participant comfort and minimize disruptions. Participants were clearly informed about the study's objectives and they provided written or verbal consent to confirm their voluntary participation. To ensure confidentiality and encourage open dialogue, all data was anonymized and securely stored. Interviews with participants' consent were audio-recorded and transcribed verbatim to ensure the accuracy and completeness of qualitative data collection.

2.2.3 Study Inclusion Criteria

The inclusion criteria defined the characteristics that participants were required to meet in order to be eligible for this study. To participate, individuals must have previously worked as migrant workers in Thailand and must have returned to Cambodia at the time of the interview. Eligible participants were also required to reside in one of the four selected provinces and to be at least 18 years of age. In addition, participants needed to be willing to participate in the study and able to provide informed consent. These criteria ensured that the study captured the experiences of returned Cambodian migrant workers who met the demographic and contextual parameters relevant to the research objectives.

2.2.4 Study Exclusion Criteria

This study identified the characteristics that would disqualify a participant from the study. These criteria helped to refine the sample and prevent confounding variables that could distort the study's findings. For this study, the following criteria were used for individuals who have not worked abroad as migrant workers: Those who have never worked as migrant workers in Thailand were excluded. This study focused specifically on the
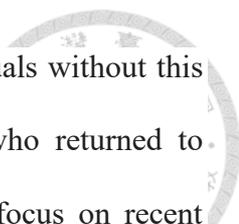
experiences of returned Cambodian migrant workers including individuals without this experience who would not provide relevant data. The participants who returned to Cambodia before COVID-19 were excluded to maintain the study's focus on recent experiences. This criterion contributed to understanding the influence of more recent occurrences, like as the COVID-19 pandemic on mental and occupational health of migrant workers. Individuals who did not live in Banteay Meanchey, Battambang, Siem Reap or Kampot during the interview were omitted. The study focused on these provinces to investigate regional disparities and ensure a reasonable scope for data gathering and analysis. Finally, people who did not agree to participate in the study or were unable to offer informed consent are omitted. This includes those who didn't completely comprehend the study's goal or who refused to participate freely. Ensuring voluntary participation was critical to maintaining the study's ethical standards.

2.3 Data Analysis

2.3.1 Quantitative Data Analysis

In order to provide a solid understanding of the mental health risk factors that influence occupational health among returned Cambodian migrant workers, the study data was analyzed using a combination of statistical and thematic methods. While thematic analysis offered a deeper understanding of individual experiences and contextual factors, statistical analysis shed light on relationships and predictors of mental health outcomes. When combined, these techniques guaranteed a thorough and sophisticated interpretation of the study's conclusions. To find trends, connections and important conclusions about mental health outcomes and occupational health risks among returned Cambodian migrant workers, the quantitative data gathered via the structured survey questionnaire was examined using a variety of statistical techniques.
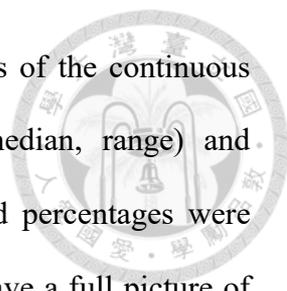
Descriptive statistics were applied to summarize key characteristics of the continuous variables, using measures of central tendency (mean, mode, median, range) and dispersion (standard deviation, range). Frequency distributions and percentages were used to figure out categorical variables. The descriptive statistics gave a full picture of the sample's age, gender, level of education and history of migration, as well as the number of people who had mental health problems as measured by the PHQ-4. For managing and analyzing the data for this study, the statistical packages SPSS version 27 and STATA version 15 were utilized (StataCorp LLC, 2017; IBM Corp, 2020). This study employs chi-square tests in its inferential statistics to evaluate the relationships between categorical independent variables, specifically gender and employment sector and mental health outcomes. Significance levels were established at $p < 0.05$.

A Confirmatory Factor Analysis (CFA) was conducted to evaluate the construct validity and internal structure of the mental health measurements used in this study. Because the assessment of mental health included multiple indicators specifically symptoms of anxiety, inability to control worry, lack of interest and depressive feelings CFA was employed to confirm whether these items appropriately reflected the latent constructs they were designed to measure. This analytical approach ensured that the mental health variables used in the subsequent regression models were psychometrically sound and theoretically consistent with prior research.

A confirmatory factor analysis was performed prior to the inferential analyses to verify that each mental health indicator demonstrated acceptable factor loadings, internal consistency and model fit. The analysis specifically examined whether the four observed indicators aligned with the underlying mental health construct based on the PHQ-4 framework. Standard fit indices were used to assess model adequacy, including the Comparative Fit Index (CFI), Tucker–Lewis Index (TLI), Root Mean Square Error of

Approximation (RMSEA) and Standardized Root Mean Square Residual (SRMR). Factor loadings above recommended thresholds and satisfactory model fit indices provided evidence that mental health items reliably captured the intended construct within the context of returned Cambodian migrant workers.

This validation step was particularly important given that mental health scales are often developed and tested in populations with different socioeconomic and cultural characteristics. By conducting CFA, the study ensured that the instrument performed reliably within this population, thereby strengthening the credibility of the mental health measurements. The results of the CFA provided the psychometric foundation for the binary logistic regression models used to explore associations between sociodemographic, occupational and migration-related factors and mental health outcomes.

Quantitative data were analyzed using binary logistic regression, following analytical approaches described by Roman and Goschin (2012) and Ghimire et al. (2023). This method was used to examine the associations between selected sociodemographic, economic and occupational variables and four key mental health outcomes (Roman & Goschin, 2012; Ghimire et al., 2023). Each mental health indicator was treated as a binary dependent variable (yes/no), reflecting the presence or absence of symptoms. For each model, Adjusted Odds Ratios (AORs) and 95% Confidence Intervals (CIs) were calculated to determine the strength and significance of associations between the independent variables and the mental health outcomes.

A total of four logistic regression models were constructed, corresponding to the following mental health indicators: (1) feeling nervous or anxious, (2) being unable to stop or control worrying, (3) having little interest or pleasure in doing things, and (4) feeling down, depressed or hopeless.
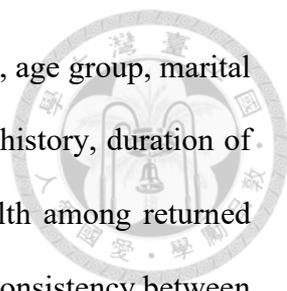
These models were used to assess how characteristics such as gender, age group, marital status, education level, employment status, income level, migration history, duration of foreign employment and current occupation influenced mental health among returned Cambodian migrant workers. The use of logistic regression ensured consistency between the methodological approach and the outcomes reported in the results, providing a clear examination of the factors associated with mental health risks in the context of post-migration and COVID-19 related experiences (Newman et al., 2013; Watson et al., 2020; Koseoglu Ornek et al., 2022a; Chand & Marwaha, 2025).

2.3.2 Qualitative Data Analysis

All collected questionnaires were verified, coded and securely stored after each phase of data collection to ensure confidentiality and data integrity. Access to all study materials, including the audio recordings and the final datasets, was strictly restricted. Only the Principal Investigator (PI) had authorization to access the tape recorder, audio files and all corresponding research data. The data is entered into Microsoft Excel and/or Microsoft Word (D. Meyer & Avery, 2009) format for additional data analysis. The Taguette software (Gilgun, 2020) was used for qualitative data outcomes analysis, thematic analysis and coding. Additionally, notes taken are used to control and ensure the main data analysis. The transcripts identify similarities and differences leading to the extraction of themes and the development of categories. The note sheet was obtained from the documents and materials associated with the data collector. The data is analyzed and synthesized by developing initial sections and integrating them into overarching themes. The qualitative data obtained from in-depth interviews with returned migrant workers underwent thematic analysis to identify and interpret patterns and themes within the data. All interviews were audio-recorded and transcribed verbatim. The transcripts were reviewed for accuracy and any identifying information was removed to ensure
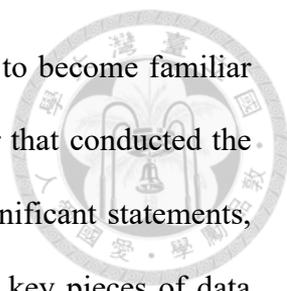
confidentiality. The PI of this study read and reread the transcripts to become familiar with the content and gain an initial understanding of the data. After that conducted the data coding by initial coding; open coding was used to identify significant statements, phrases and concepts within the transcripts. This involved labeling key pieces of data related to mental health challenges, occupational risks and personal experiences. The codebook was developed to categorize and organize the codes into broader themes. Codes were refined and adjusted as new insights emerged during the analysis process. Moreover, this identified the themes of the patterns and commonalities identified across the coded data, leading to the development of main themes and sub-themes. The themes were based on recurring issues, experiences and perceptions reported by participants. The themes were reviewed and refined to ensure they accurately reflected the data and were relevant to the research questions. Each theme was defined and described in detail, including illustrative quotes from participants to support the analysis.

Integration with quantitative data provides a comprehensive understanding of the research problem by combining quantitative findings with qualitative insights. In addition, qualitative themes were compared with quantitative results to explore how personal narratives and experiences supported or explained statistical patterns. This integration helped to contextualize the quantitative data and provided a richer interpretation of the mental health and occupational health issues faced by migrant workers.

2.4 Ethical Considerations and Approval

This study was approved by Cambodia's National Ethical Committee for Health Research (NECHR Ref. 269-IRB00003143), which authorized the data-gathering technique and all participants provided written informed consent prior to enrollment in the study (Appendix 2: Approval Letter from the NECHR Cambodia) (Ministry of Health, 2025) and the RHAC approval letter for the data used. In order to successfully achieve and maintain
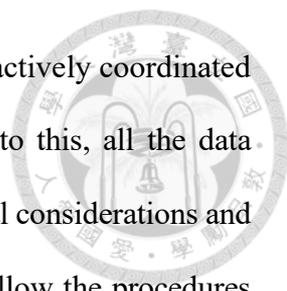
data collection in compliance with ethical guidelines, the researcher actively coordinated with local authorities to facilitate a seamless process. In addition to this, all the data collectors and supervisors were trained on the research protocol, ethical considerations and the specific tools. Data collection team members were required to follow the procedures and sign a confidentiality and ethical guidelines form.

Moreover, the data collection team worked closely with local health authorities to remain informed about any new developments or restrictions related to COVID-19. This also included gaining approvals for any necessary travel to reach participant locations.

CHAPTER 3. RESULTS

3.1 Descriptive Analysis

This chapter presents the quantitative findings from survey conducted among 392 returned Cambodian migrant workers. The analysis aimed to examine the prevalence of mental health symptoms specifically anxiety and depression using the PHQ-4 scale and to explore their associations with key sociodemographic, occupational and migration-related characteristics.

Descriptive statistics are first presented to summarize the distribution of participants. The data is categorized by gender, age, marital status, education level, income, employment status, and migration history. Next, bivariate analyses (cross-tabulations with chi-square tests) are used to explore gender differences across these variables. Finally, multivariate logistic regression models identify significant predictors of anxiety and depressive symptoms, adjusting for potential confounders. The results highlight key factors contributing to mental health outcomes in this vulnerable population and inform the basis for targeted reintegration and mental health interventions.

3.2 Socio-Demographics

The sample was composed primarily of female respondents (63.52%), while males represented 36.48% of the sample. The mean age of participants was 35.68 years (SD = 9.39), with ages ranging from 18 to 62 years and a median of 35. In terms of age distribution, the majority of participants were in the 25-35 age group (42.35%), followed by 36-45 years (31.12%) and 18–24 years (10.97%). Only a small proportion were aged 46-55 (12.76%) or 56-65 (2.81%). Participants were recruited from four provinces: Battambang (28.57%), Banteay Meanchey (28.32%), Siem Reap (28.32%) and Kampot (14.80%), with the first three provinces nearly equally represented.

Regarding marital status, most participants were either married without a legal certificate (48.72%) or married with a certificate (39.29%). A smaller proportion were single (8.16%), divorced (2.30%) or widowed (1.02%). No participants identified as separated and two participants (0.51%) did not provide a response. The vast majority of participants reported not having children (89.97%), while only (10.03%) had at least one child.

Table 2. Sociodemographic Characteristics of the Participants (N = 392)

Variable	Category	Frequency (n)	Percentage (%)
Gender	Female	249	63.52
	Male	143	36.48
Age-Group	18–24 years	43	10.97
	25–35 years	166	42.35
	36–45 years	122	31.12
	46–55 years	50	12.76
	56–65 years	11	2.81
	Age-Summary		
	Mean (SD)	35.68 (9.39)	
	Median (Range)	35 (18–62)	
Study location	Siem Reap (SR)	111	28.32
	Banteay Meanchey (BMC)	111	28.32
	Battambang (BTB)	112	28.57
	Kampot (KP)	58	14.80
Marital status	Single	32	8.16
	Married (with certificate)	154	39.29
	Married (without certificate)	191	48.72
	Separated	0	0.00
	Divorced	9	2.30
	Widowed	4	1.02
	No response	2	0.51
	Yes	38	10.03
Children			
	No	341	89.97
	No formal education	66	16.84
Education level			
	Primary (partial)	175	44.64
	Primary (completed)	33	8.42
	Secondary (partial)	68	17.35
	High school graduate	46	11.73
	Bachelor's degree	4	1.02

In terms of educational achievement, (44.64%) of participants had partially completed primary education and (17.35%) had partially completed secondary education. A further

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(16.84%) had no formal education, while (11.73%) were high school graduates, (8.42%) had completed primary education and just (1.02%) held a bachelor's degree.
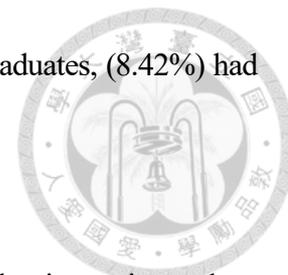
3.3 Employment and Migration Characteristics

The majority of returned Cambodian migrant workers reported having migrated to Thailand (91%), followed by Malaysia (4.3%), South Korea (2.3%) and other countries (2.4%). These findings reflect Thailand's continued dominance as a labor migration destination due to its geographic proximity and demand for low-skilled labor.

Table 3 below presents participants' current and past employment situations, monthly income, visa status, recruitment methods and job-related risks experienced abroad. Current Occupation in Cambodia: At the time of the survey, a substantial portion of respondents were unemployed (41.84%), while (25.51%) were engaged in agriculture and 13.78% operated small businesses. Other occupations included construction workers (7.40%), manufacturing/industry/services (4.59%) and employment in private companies (2.81%). Employment in the fishing sector, food factories and seasonal work (including Thailand) was reported by only a small fraction. No participants identified as students and two participants (0.51%) provided no response.

Occupation in Destination Countries: While abroad, the most commonly held occupations were in agriculture (38.27%) and construction (31.12%), followed by manufacturing (16.84%) and domestic work (10.46%). Employment in hospitality, fishing and seafood processing was rare. No participants reported working as drivers in the destination countries.

Monthly Income of Returned Migrant Workers in Cambodia, the largest proportion of participants (44.13%) reported earning between $200 and $500 per month, followed by 17.86% earning between $100 and $200. A total of (20.41%) reported having no income, while (9.18%) earned less than $100 per month and (8.42%) earned more than $500. The

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mean monthly income was $258.41 (SD = 284.95), with a median income of $250, ranging from $0 to $2,500.

Return From Abroad and Legal Status: A majority of participants (62.24%) had returned from abroad within the past 24 months, suggesting recent migration experience. Regarding visa status during their time abroad, (74.74%) had a working visa, (22.96%) worked without a legal work visa and (1.28% held a tourist visa. No participants reported entering on student visas and (1.02%) were unsure of their visa status.

Employment Contracts and Awareness: Only (28.32%) of participants had a formal working contract while abroad, while (71.68%) reported not having one. Of those who had contracts, only (17.35%) indicated that they understood their employment agreement, compared to (82.65%) who did not.

Job acquisition and decision-making: The most common pathway to securing work abroad was through family members already in the destination country (50.26%), followed by friends (28.32%). A smaller portion relied on government-registered agencies (6.63%), private or unclear-status agencies (3.83%), or private brokers/human smugglers (9.44%). Additionally, (23.98%) reported finding the job independently and less than 1% secured jobs through individual job placement contacts.

In terms of decision-making, the majority (85.71%) decided independently to take the job abroad, while (5.87%) made the decision with family input. The remaining decisions were influenced by employers (6.12%), relatives (1.28%), or recruiters/brokers (0.51%). Notably, 0.51% of participants reported being sent by a previous employer without their consent.

Occupational Injuries and Illness: Work-related injuries or illnesses were reported by a considerable majority of participants (59.18%), indicating high exposure to occupational risks. The remaining (40.82%) had not experienced such incidents.

Table 3. Employment and Migration Characteristics of Participants (N = 392)

Variable	Category	Frequency (n)	Percentage (%)
Current occupation in Cambodia			
	Unemployed	164	41.84
	Construction worker	29	7.40
	Fishing sector	2	0.51
	Food factories	3	0.77
	Manufacturing/Industry/Services	18	4.59
	Seasonal work (incl. Thailand)	9	2.30
	Small business	54	13.78
	Private company	11	2.81
	Agriculture	100	25.51
	No response	2	0.51
Occupation in destination Country			
	Fisher (offshore)	3	0.77
	Seafood processing	1	0.26
	Agriculture	150	38.27
	Construction	122	31.12
	Domestic work	41	10.46
	Hospitality	9	2.30
	Manufacturing	66	16.84
	Driving	0	0.00
Monthly income in Cambodia			
	No income	80	20.41
	< $100 (400K Riel)	36	9.18
	$100–$200 (400–800K Riel)	70	17.86
	$200–$500 (800–2000K Riel)	173	44.13
	> $500 (2000K Riel)	33	8.42
Income Summary			
	Mean (SD) $258.41 (284.95)		
	Median (Range) $250 (0–2500)		
Returned within 24 months			
	Yes	244	62.24
	No	148	37.76
Type of Visa used abroad			
	Working visa	293	74.74
	Tourist visa	5	1.28
	No work visa	90	22.96
	Don't know visa status	4	1.02
	Student visa	0	0.00
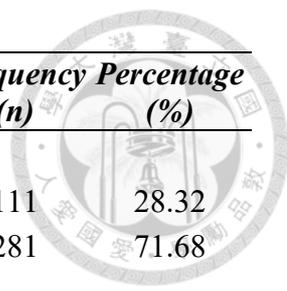
Variable	Category	Frequency (n)	Percentage (%)
Had a working contract abroad			
	Yes	111	28.32
	No	281	71.68
Understood the working contract			
	Yes	68	17.35
	No	324	82.65
How the job was obtained			
	Family member already there	197	50.26
	Friend already there	111	28.32
	Government-registered agency	26	6.63
	Private (unregistered) agency	8	2.04
	Unsure if registered agency	7	1.79
	Individual job placement contact	3	0.77
	Found job independently	94	23.98
	Private broker/human smuggler	37	9.44
Who made the job decision			
	Myself, alone	336	85.71
	Myself, with family	23	5.87
	Relative	5	1.28
	Recruiter/broker	2	0.51
	Employer	24	6.12
	Previous employer (without consent)	2	0.51
Suffered work injury or illness			
	Yes	232	59.18
	No	160	40.82

3.4 Distribution of Socio-Demographics by Gender

3.4.1 Gender Differences in Sociodemographic and Migration Characteristics

To better understand the demographic and migration profiles of the study population, gender-disaggregated analyses were conducted to explore potential differences across key socio-demographic and migration-related variables.

The analysis revealed no significant association between gender and age group [χ^2 (1, N = 392) = 1.53, p = 0.216]. A greater percentage of younger participants were female

(62.46%) compared to males (37.54%); however, this difference was not statistically significant (95% CI: 0.77-3.12).

A statistically significant gender difference in married status was reported [χ^2 (1, N = 392) = 7.95, p = 0.005]. Among unmarried individuals, (65.56%) were female, whereas among married participants, the majority were male (59.38%). The probability of being female was markedly reduced among married participants (95% CI: 0.17-0.75).

Gender differences in educational attainment were significant [χ^2 (1, N = 392) = 6.50, p = 0.011]. Female respondents exhibited a higher likelihood of never having attended school (77.27%) in contrast to males (22.73%), supported by an odds ratio confidence interval that suggests a significant effect (95% CI: 0.24-0.84).

In the context of current employment in Cambodia, a significant gender disparity has been identified [χ^2 (1, N = 392) = 15.99, p < 0.001]. Employment rates indicated that males had a higher likelihood of being employed at 52.34% compared to females at (47.66%). Conversely, among the unemployed population, females represented a significant majority at (71.21%), while males accounted for (28.79%). The likelihood of being female was notably greater among those who were unemployed (95% CI: 0.23-0.56).

Income level: although not statistically significant, the data indicated that a higher percentage of females had low income (71.25%) in comparison to males [(28.75%), p = 0.107; 95% CI: 0.37-1.10].

The analysis of return status within 24 months revealed a significant association between gender and return recency, [χ^2 (1, N = 392) = 6.83, p = 0.009]. In the past 24 months, the likelihood of returning was higher for females (68.44%) compared to males (31.56%), with a 95% confidence interval of (1.14-2.66).

Years of work abroad: no significant difference was observed in gender distribution by years of employment abroad [p = 0.827, 95% CI: 0.62-1.45].

Occupation type: There was a significant difference between men and women in their job status [χ^2 (1, N = 392) = 17.35, p < 0.001]. (75.61%) of the jobless returnees were women. On the other hand, the working participants were more evenly split (54.82% were women and 45.18% were men). The chances of being jobless were much higher for women (95% CI: 0.25-0.60). The analysis revealed notable gender differences across several employment sectors. In agricultural work, women were significantly more likely than men to be engaged in this sector, with 71.33% of agricultural workers being women compared to 28.67% men, [χ^2 (1, N = 392) = 6.41, p = 0.011, 95% CI: 1.13–2.71]. In contrast, employment in the construction sector showed no meaningful gender variation, as indicated by a non-significant association (p = 0.733; 95% CI: 0.69–1.68). A pronounced gender disparity was observed in domestic work, where women accounted for 80.49% of workers compared with 19.51% men, [χ^2 (1, N = 392) = 5.71, p = 0.017, 95% CI: 1.15–5.74]. Meanwhile, participation in the hospitality sector did not differ significantly by gender (p = 0.616; 95% CI: 0.18–2.69). These findings highlight substantial gendered patterns in certain types of employment, particularly agriculture and domestic work, while other sectors showed relatively equal representation.

Work contract status [χ^2 (1, N = 392) = 19.86, p < 0.001] showed a significant gender difference with regard to formal work contracts. Women made up (71.53%) of those without a contract. On the other hand, men made up (56.76%) of those with contracts. Those without a formal contract had significantly higher odds of being female (95% CI: 0.19-0.48).

Education, employment, marital status, domestic work and legal employment conditions all showed gender differences. According to these findings, female migrant workers from Cambodia who return home may be more vulnerable physically and socioeconomically, including having fewer contracts, having less education and being unemployed, all of which could have a negative impact on their reintegration and mental health.

Table 4. Gender Differences by Demographic, Economic and Employment Characteristics (N=392)

Category	Male n (%)	Female n (%)	95% CI	**p-value
Age Group				
18-24 Years old (Young)	131 (37.54)	218 (62.46)	0.77-3.12	0.216
25-65 Years old (Adult)	12 (27.91)	31 (72.09)		
Marital status				
Not married	124 (34.44)	236 (65.56)	0.17-0.75	**0.005****
Married	19 (59.38)	13 (40.63)		
Education Level				
No Schooling	15 (22.73)	51 (77.27)	0.24-0.84	**0.011***
Some Schooling	128 (39.26)	198 (60.74)		
Currently working in Cambodia				
No	76 (28.79)	188 (71.21)	0.23-0.56	**0.000****
Yes	67 (52.34)	61 (47.66)		
Income Level				
Low	23 (28.75)	57 (71.25)	0.37-1.10	0.107
High	120 (38.46)	192 (61.54)		
Returned within 24 months				
No	66 (44.59)	82 (55.41)	1.14-2.66	**0.009****
Yes	77 (31.56)	167 (68.44)		
Years of work experience				
Less than 2 Years	88 (36.07)	156 (63.93)	0.62-1.45	0.827
2 Years or More	55 (37.16)	93 (62.84)		
Occupation type				
Unemployed	40 (24.39)	124 (75.61)	0.25-0.60	**0.000****
Employed	103 (45.18)	125 (54.82)		
Agriculture job				
No	100 (41.32)	142 (58.68)	1.13-2.71	**0.011***
Yes	43 (28.67)	107 (71.33)		
Construction job				
No	100 (37.04)	170 (62.96)	0.69-1.68	0.733
Yes	43 (35.25)	79 (64.75)		
Domestic job				
No	135 (38.46)	216 (61.54)	1.15-5.74	**0.017***
Yes	8 (19.51)	33 (80.49)		
Hospitality job				
No	139 (36.29)	244 (63.71)	0.18-2.69	0.616
Yes	4 (44.44)	5 (55.56)		
Work contract				
No	80 (28.47)	201 (71.53)	0.19-0.48	**0.000****
Yes	63 (56.76)	48 (43.24)		
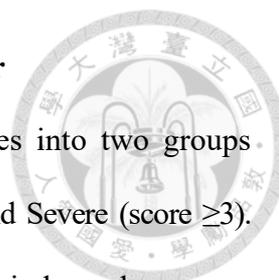
3.4.2 Distribution of PHQ-4 Mental Health Symptoms by Gender

In the analysis method, a binary outcome of the PHQ-4 categories into two groups specifically (Group 0: Normal (score 0-2), Group 1: Mild, Moderate and Severe (score ≥3). According to table 4 below, the results from a chi-square test of independence was conducted to examine the association between gender and the presence of mental health symptoms as measured by the PHQ-4 screening tool. Participants were categorized as having either no symptoms or some symptoms (including mild, moderate, or severe). The results revealed a statistically significant association between gender and PHQ-4 screening tool symptom status [$\chi^2 (1, N = 392) = 10.63$, $p = 0.001$]. Specifically, a greater proportion of males (69.08%) reported having PHQ-4 screening tool symptoms compared to females (30.92%). In contrast, the distribution among participants with no symptoms was more balanced (52.31% male and 47.69% female). The 95% confidence intervals indicated that the true population proportion of individuals with symptoms is likely between (48% and 64%), whereas the proportion of those without symptoms is likely between (67% and 78%).

Table 5. Distribution of PHQ-4 Mental Health Symptoms by Gender (N = 392)

PHQ-4 Category	Male n (%)	Female n (%)	Total n	**p-value
No symptoms	68 (52.3)	62 (47.69)	130	0.001**
Have symptoms	181 (69.08)	81 (30.92)	262	
Total	249	143	392	

Note. PHQ-4 = Patient Health Questionnaire-4. Symptom categories are based on total and subscale score cut-offs. Elevated scores on the anxiety or depression subscales suggest clinically relevant symptoms

3.5 The PHQ-4 Validity and Factors Associated with Mental Health outcomes

3.5.1 Distribution of the Mental Health Symptoms (PHQ-4)

The PHQ-4 has been categorized the symptom severity based on standard cutoffs points (0–2 "normal"; 3–5 "mild"; 6–8 "moderate"; 9–12 "severe"). In addition, 0=No or normal symptoms; 1=mild symptoms; 2=Moderate symptoms; 3=Severe symptoms.

The severity of psychological distress among participants was measured using the patient health questionnaire 4 items. The results revealed that approximately one-third of participants reported no symptoms of anxiety or depression (n = 130, 33.16%). A similar proportion experienced mild symptoms (n = 129, 32.91%), while 22.70% (n = 89) reported moderate symptoms. Notably, 11.22% of participants (n = 44) were categorized as having severe symptoms, indicating a potentially high level of psychological distress requiring clinical attention.

In the Table 6 below, findings suggest that while a significant portion of the sample was symptom-free, more than two-thirds (66.84%) experienced at least mild symptoms of mental health challenges, with a considerable proportion experiencing moderate to severe distress (33.92%).

Table 6. Distribution of Participants by PHQ-4 Mental Health Symptom (N = 392)

PHQ-4 Screening Tool	Frequency (n)	Percentage (%)
No symptoms	130	33.16
Mild symptoms	129	32.91
Moderate symptoms	89	22.70
Severe symptoms	44	11.22
Total	392	100.00

3.5.2 The PHQ-4 Total and Subscale Scores (N = 392)

Total score is determined by adding together the scores of each of the 4 items. Scores are rated as normal (0-2), mild (3-5), moderate (6-8) and severe (9-12). Total score ≥3 for first 2 questions suggests anxiety. Total score ≥3 for last 2 questions suggests depression (Apputhurai, Palsson, et al., 2024; Obeid et al., 2024).

Returned Cambodian migrant workers reported, on average, low overall distress (PHQ-4 = 2.13). Anxiety symptoms (Mean = 0.96) and depression symptoms (Mean = 1.17) are both well below their respective mid-points (3), indicating that clinically relevant distress is confined to a minority of the sample. The standard deviations (1.3-1.4) suggest substantial between-person variability, supporting further analyses of correlates and predictors of mental-health outcomes in this population

Table 7. Symptom Severity Categories of PHQ-4 Total and Subscale Scores

PHQ-4 Metric	Score Range	Mean ± SD	n (%)
Total score	0-12	2.13 ± 2.24	- None (0–2): 130 (33.2)
			- Mild (3–5): 129 (33.2)
			- Moderate (6–8): 89 (22.7)
			- Severe (9–12): 44 (11.2)
Anxiety sub-scale	0-6	0.96 ± 1.36	- None (0–1): 243 (62)
			- Elevated (2–6): 149 (38)
Depression sub-scale	0-6	1.17 ± 1.32	- None (0–1): 229 (58)
			- Elevated (2–6): 163 (42)

Note. N = 392 returned Cambodian migrant workers. Severity cut-points follow Kroenke et al. (2009).
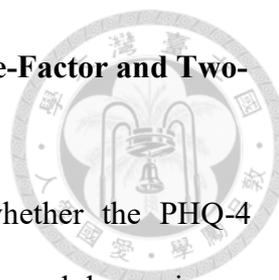
3.6 Confirmatory Factor Analysis of the PHQ-4: Comparing One-Factor and Two-Factor Models

Confirmatory factor analysis (CFA) was conducted to verify whether the PHQ-4 screening tool reflects its proposed two-dimensional structure anxiety and depression as distinct but related constructs, ensuring the measure's validity in the target population. Model Fit Comparison for PHQ-4 screening tool: one vs. two-factor structures, this study also used a confirmatory factor analysis to assess the two-factor model of the PHQ-4, reflecting latent anxiety and depression dimensions. The two-factor model demonstrated excellent fit [SB χ^2 (6) = 33.53; CFI = 0.99; TLI = 0.99; NFI = 0.99; RMSEA = 0.04]. Standardized loadings ranged from 0.59 to 0.71, all statistically significant ($p < .001$). Items "Nervousness" and "Worries" loaded on the Anxiety factor ($\lambda = 0.71, 0.68$), while "Loss of interest" and "Depressive mood" loaded on the Depression factor ($\lambda = 0.62, 0.59$).

In contrast, the one-factor model showed poorer fit [SB χ^2 (1) = 1960.34; CFI = 0.94; TLI = 0.83; RMSEA = 0.23], with a significant [χ^2 (1) = 938.24; p < 0.001]. These results support the two-factor solution over the one-factor model, suggesting that anxiety and depression are different but related constructs in the PHQ-4.

Table 8. Model Fit Indices for One-Factor and Two-Factor CFA Models

Model	SB χ^2	df	CFI	TLI	NFI	RMSEA	χ^2	p-value
One-factor model	1960.34	1	0.94	0.83	0.94	0.23	938.24	< 0.001
Two-factor model	33.53	6	0.99	0.99	0.99	0.04	—	—

Note. *SB χ^2 = Satorra-Bentler scaled chi-square; df = degrees of freedom; CFI = Comparative Fit Index; TLI = Tucker-Lewis Index; NFI = Normed Fit Index; RMSEA = Root Mean Square Error of Approximation. A lower RMSEA (< 0.06); and higher CFI/TLI (> 0.95), indicate good model fit. The Δχ² test compares the nested models.*

Table 9. Item Loadings on Two-Factor Structure of Anxiety and Depression

Item	Factor 1 (Anxiety)	Factor 2 (Depression)
Nervousness	0.71	—
Worries	0.68	—
Loss of interest	—	0.62
Depressive mood	—	0.59

Note. Factor loadings are standardized estimates from the two-factor confirmatory factor analysis (CFA) of PHQ-4. All loadings are significant at p < .001.

3.7 Aggregated Factors of Mental Health Issues

3.7.1 One-factor Model

Exploratory factor analysis (ML extraction) forced to one factor indicated that all four items loaded positively ($\lambda = 0.59$-0.71). The single factor accounted for 61 % of the total variance (eigenvalue = 2.44). Uniqueness values ranged from 0.49 to 0.65. Although the model explains a majority of variance, subsequent model-fit indices (from a two-factor CFA) suggested that a two-factor structure provided superior fit (see figure 5) (Gierk et al., 2014).

A one-factor confirmatory factor analysis (CFA) was conducted on the four-item PHQ-4 scale, hypothesizing that all items reflect a single latent construct representing general psychological distress. The model showed adequate to good fit based on common indices [CFI = 0.97, TLI = 0.95, RMSEA = 0.055, 90% CI: 0.00 – 0.11, SRMR = 0.028]. All items loaded significantly on the latent factor, with standardized loadings ranging from 0.59-0.71. Specifically, "Nervousness" ($\lambda = 0.71$) and "Worries" ($\lambda = 0.68$) had slightly stronger loadings compared to "Loss of interest" ($\lambda = 0.62$) and "Depressive mood" ($\lambda = 0.59$). The latent factor accounted for approximately)49%-65%) of the variance in individual items, as indicated by residual error variances. The overall internal consistency of the

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scale was acceptable (α = 0.83). These findings support the interpretation of PHQ-4 as a unidimensional measure of general emotional distress in this sample.
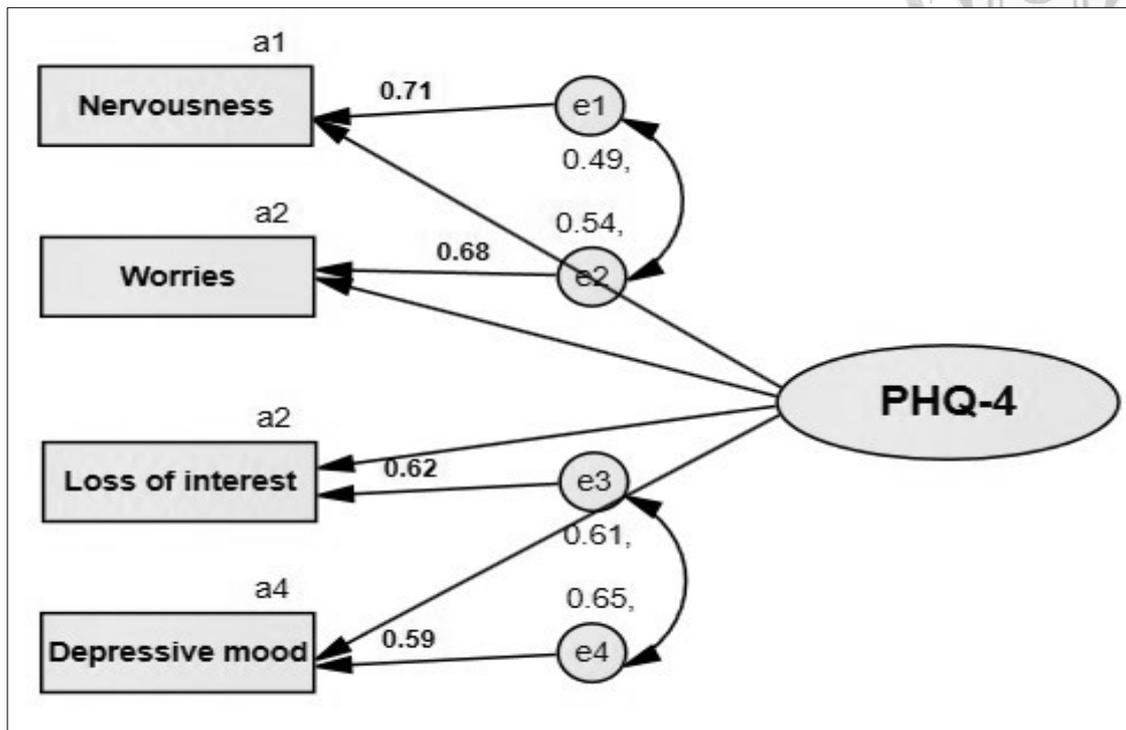
Figure 5. One factor Confirmatory Factor analysis (CFA)

3.7.2 Two-factor Model

A confirmatory factor analysis (CFA) was conducted on four items. A two-factor model showed good fit [$\chi^2(1)$ = 2.11; p = 0.15; CFI = 0.99; TLI = 0.97; RMSEA = 0.045, 90% CI: 0.00-0.12, SRMR = 0.021]. Factor 1 included items q501cfa1_r and q501cfa2_r (loadings = 0.68-0.72). Factor 2 included items q501cfa3_r and q501cfa4_r (loadings = 0.77-0.81). The latent factors were positively correlated [r = 0.51, p < 0.001] (figure 6).

A two-factor confirmatory factor analysis (CFA) was conducted to examine the dimensional structure of the PHQ-4, specifying separate but correlated latent factors for anxiety (measured by "Nervousness" and "Worries") and depression (measured by "Loss of interest" and "Depressive mood"). The model demonstrated excellent fit to the data based on the following indices [CFI = 0.99, TLI = 0.98, RMSEA = 0.035, 90% CI: 0.00 – 0.09), SRMR = 0.016].

Standardized factor loadings were all strong and statistically significant ($\lambda = 0.68$–0.81). The anxiety items loaded onto their factor as follows: "Nervousness" ($\lambda = 0.71$), "Worries" ($\lambda = 0.68$); and the depression items: "Loss of interest" ($\lambda = 0.62$), "Depressive mood" ($\lambda = 0.59$). The two latent factors were strongly correlated, [$r = 0.79$, $p < 0.001$], indicating substantial overlap between symptoms of anxiety and depression.

Residual error variances ranged from (0.35-0.51), suggesting that each latent factor accounted for approximately (49%-65%) of its indicators' variance. Internal consistency was high for both subscales ($\alpha = 0.83$ for anxiety; $\alpha = 0.80$ for depression).

These results support a two-factor structure of the PHQ-4 screening tool, consistent with its original conceptualization. This model may offer better construct precision than a unidimensional structure, particularly in analyses aiming to differentiate anxiety from depression symptoms (Staples et al., 2019).
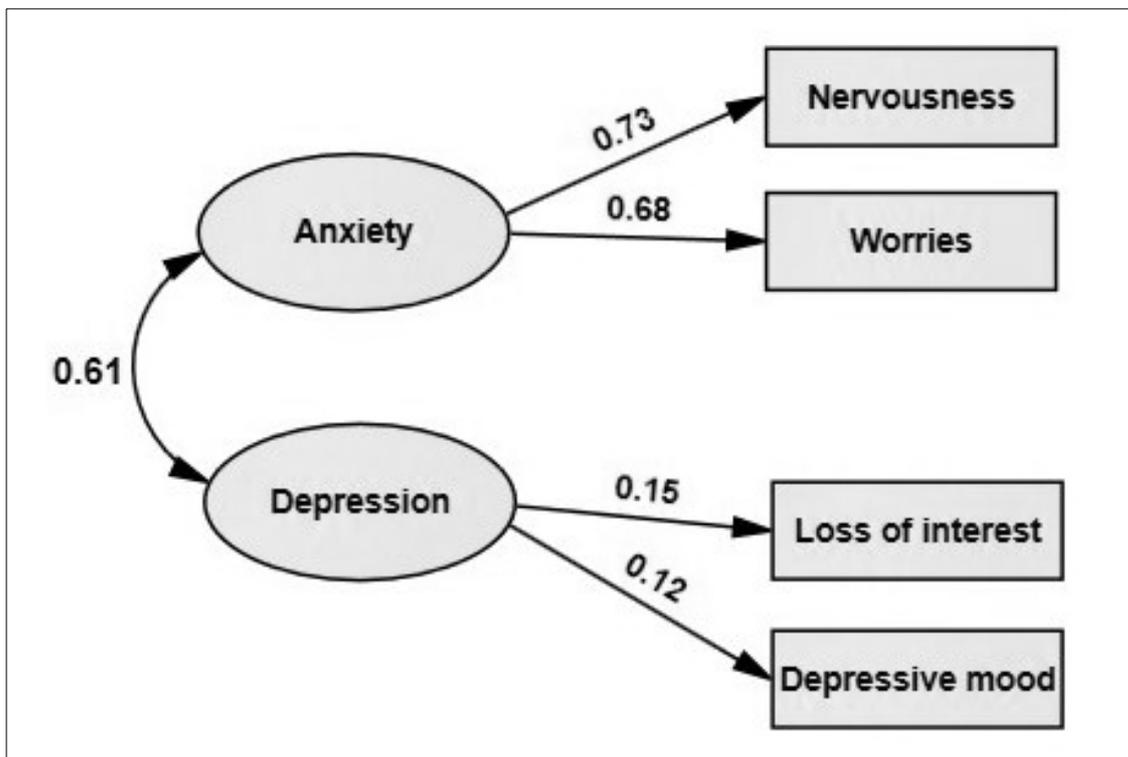
Figure 6. Two factor Confirmatory Factor analysis (CFA)

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3.7.3 Conclusion of the Psychometric Validation of the PHQ-4

The PHQ-4 demonstrated strong psychometric properties in this sample of returned Cambodian migrant workers (N = 392). Descriptive analysis showed low mean distress (M = 2.13, SD = 2.24), with most participants falling into the "none" or "mild" severity categories. A two-factor confirmatory factor analysis (CFA) revealed excellent model fit (CFI = 0.99, TLI = 0.99, RMSEA = 0.04) and clearly differentiated between anxiety (e.g., "nervousness," λ = 0.71) and depression (e.g., "loss of interest," λ = 0.62) dimensions. These findings support the theoretical structure proposed by Kroenke et al., (Kroenke et al., 2009), who originally validated the PHQ-4 as a brief, two-dimensional screening tool for emotional distress. Moreover, the internal consistency in this sample was high (α = 0.83 for anxiety; α = 0.80 for depression), consistent with findings from other cross-national studies (Löwe et al., 2010a). From the finding of Kroenke and Villiams (2009) found that the PHQ-4 screening tool is a reliable and efficient screening tool for identifying potential cases of anxiety and depression in primary care settings. It performs comparably to longer measures in terms of construct validity and effectively identifies patients who may require further evaluation for clinical disorders (Kroenke & Williams, 2009). Another evidence from by Löwe et al in 2020, found that the PHQ-4 screening tool is a psychometrically robust, ultra-brief screening tool for depression and anxiety, validated in a large German general population sample. Its high internal consistency (α = 0.82), construct validity and associations with known risk factors (gender, age, education, income, partnership status) support its use in clinical settings (Löwe et al., 2010).
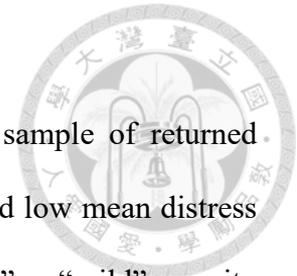
3.8 Analysis of Mental Health Outcomes in Returned Cambodian Migrant Workers

In this part of analysis, a binary logistic regression analyses examine the associations between selected sociodemographic, economic and occupational variables and four key indicators of mental health among returned Cambodia migrant workers, it included (Anxious, Inability to control worrying, lack of interest or doing things, depress or hopelessness), a total sample of 392 participants was included in the data analysis.

Each mental health outcome was treated as a binary dependent variable (yes/no) and ten independent variables were included in each regression model: gender, age-group, marital status, education-level, employment status, income-level, recent return from migration, years of foreign employment, current occupational engagement and occupational sector. For the Reference group such as male gender, younger age (18–24 years), non-married status, lack of formal education, unemployment, lack of income, no recent return, less than five years of foreign employment, no current occupation and various sector-specific groups were used as reference categories in the analyses.

3.8.1 Feeling Nervous, Anxious or on Edge

A binary logistic regression analysis was conducted to examine the association between various sociodemographic, economic and migration-related variables and the likelihood of experiencing anxiety. The model revealed that gender and education level were statistically significant predictors of anxiety status, while other variables showed no significant associations.

Participants identifying as female were significantly more likely to report anxiety symptoms compared to males (B = 0.51; AOR = 1.67; SE = 0.43; 95% CI: 1.00-2.77; p = 0.04). This finding suggests that being female increased the odds of reporting anxiety by approximately 67% relative to males.

Having attended school was associated with significantly lower odds of anxiety symptoms compared to those who had never attended school (B = –0.65; AOR = 0.52; SE = 0.15; 95% CI: 0.29-0.93; p = 0.02). This indicates a 48% reduction in the likelihood of anxiety among educated individuals.

However, employment in specific occupational sectors (agricultural, construction, domestic, manufacturing) was not significantly associated with anxiety levels. For instance, individuals in agricultural jobs had increased odds of anxiety (AOR = 1.64, *p* = 0.16), but this finding did not reach statistical significance.

In short, female gender and lack of formal education emerged as significant risk factors for anxiety in the adjusted model, whereas no significant associations were found for other sociodemographic or migration-related characteristics.

Table 10. Multivariate Logistic Regression Predicting "Anxious" Among Returned Cambodian Migrant Workers (N = 392)

Independent Variable	n	% Anxious	AOR	Std. Error	95% CI	**p-value
1.Gender						
Male [Ref.]	143	23.08			–	–
Female	249	38.55	**1.67**	0.43	[1.00-2.77]	**0.04*
2.Age Group						
18–24 years [Ref.]	43	32.95			–	–
25–65 years	349	32.56	1.12	0.45	[0.52-2.45]	0.76
3.Marital Status						
Non-married [Ref.]	32	34.17			–	–
Married	360	18.75	0.44	0.22	[0.15-1.21]	0.11
4.Education						
Never attended [Ref.]	66	48.48			–	–
Attended school	326	29.75	**0.52**	0.15	[0.29-0.93]	**0.02*
5.Occupation						
Unemployed [Ref.]	264	34.85			–	–
Employed	128	28.91	0.96	0.29	[0.53-1.75]	0.91
6.Income						
Without income [Ref.]	80	36.25			–	–
With income	312	32.05	1.17	0.39	[0.60-2.28]	0.62
7.Returned in Last 24 Months						
No [Ref]	148	30.41			–	–
Yes	244	34.43	1.07	0.27	[0.68-1.78]	0.78
8.Years of Foreign Employment						
<5 years [Ref]	224	34.43			–	–
≥5 years	148	30.41	0.80	0.19	[0.50-1.28]	0.36
9.Current Occupation						
No [Ref]	164	29.75			–	–
Yes	228	38.00	0.75	0.16	[0.49-1.15]	0.64
10. Occupational Sectors						
[Ref] Other jobs	242	29.75			–	–
Agricultural Jobs	150	38.00	1.64	0.58	[0.80-3.50]	0.16
[Ref] Other jobs	270	32.59			–	–
Construction Jobs	122	33.61	1.37	0.53	[0.64-2.94]	0.41
[Ref] Other jobs	351	33.05			–	–
Domestic Jobs	41	31.71	1.20	0.58	[0.47-3.17]	0.66
[Ref] Other jobs	383	32.90			–	–
Manufacturing Jobs	9	33.33	1.70	1.41	[0.32-8.66]	0.52

Note. AOR = Adjusted Odds Ratio; CI = Confidence Interval; Ref. = Reference category. p < 0.05 indicates statistical significance.

3.8.2 Not Being Able to Stop or Control Emotions

Table 10 presents the results of a binary logistic regression that examined the relationship between multiple independent variables and the likelihood of participants reporting an inability to control their emotions or reactions. Adjusted odds ratios (AORs), standard errors, 95% confidence intervals (CIs) and *p*-values are reported as below:

Gender was a significant predictor of reported inability to control. Participants identifying as female had significantly higher odds of reporting inability to control compared to males (B = 0.72, AOR = 2.06, SE = 0.56, 95% CI: 1.20-3.52, p < 0.001). This suggests that females were approximately twice as likely to experience this outcome than their male counterparts.

Income status was also significantly associated with the outcome. Individuals with income had significantly lower odds of reporting inability to control compared to those without income (B = –0.94, AOR = 0.39, SE = 0.12, 95% CI: 0.15-0.64, p < 0.001). This indicates that having income reduced the odds of inability to control by 61%, pointing to a protective effect of economic stability.

However, the type of occupational sector (agricultural, construction, domestic, manufacturing) did not yield statistically significant associations with inability to control, though some trends were observed. For example, participants in domestic jobs and manufacturing jobs had nearly double the odds of reporting inability to control (AOR = 1.98 and 2.05, respectively), but these results were not significant (p = 0.15 and 0.37), likely due to small sample sizes, especially in the manufacturing category.

The results identified that gender and income as significant predictors of depression. These insights emphasize the disparities in being unable to control worrying were linked to gender and income among migrant workers.

Table 11. Factors Associated with Inability to Control Emotions Among Returned Cambodian Migrant Workers (N = 392)

Independent Variable	n	%Unable to Control	AOR	Std. Error	95% CI	**p-value
1.Gender						
Male [Ref.]	143	19.58			–	–
Female	249	34.14	**2.06**	0.56	[1.20-3.52]	**0.00**
2.Age Group						
18–24 years [Ref.]	43	29.51			–	–
25–65 years	349	23.26	0.75	0.32	[0.32-1.76]	0.52
3.Marital Status						
Non-married [Ref.]	32	29.72			–	–
Married	360	18.75	0.84	0.44	[0.30-2.39]	0.75
4.Education						
Never attended [Ref.]	66	36.36			–	–
Attended school	326	27.30	0.89	0.27	[0.50-1.62]	0.71
5.Occupation						
Unemployed [Ref.]	264	28.79			–	–
Employed	128	28.91	1.34	0.42	[0.72-2.49]	0.35
6.Income						
Without income [Ref.]	80	42.50			–	–
With income	312	25.32	**0.39**	0.12	[0.15-0.64]	**0.00**
7.Returned in Last 24 Months						
No [Ref]	148	26.35			–	–
Yes	244	30.33	1.06	0.27	[0.68-1.78]	0.80
8.Years of Foreign Employment						
<5 years [Ref]	224	27.46			–	–
≥5 years	148	31.08	1.16	0.28	[0.72-1.88]	0.52
9.Current Occupation						
No [Ref]	164	30.49			–	–
Yes	228	27.63	1.61	0.28	[0.76-3.40]	0.21
10. Occupational Sectors						
[Ref] Other jobs	242	26.86			–	–
Agricultural Jobs	150	32.00	1.75	0.67	[0.82-3.73]	0.14
[Ref] Other jobs	270	28.52			–	–
Construction Jobs	122	29.51	1.65	0.65	[0.76-3.57]	0.20
[Ref] Other jobs	351	28.21			–	–
Domestic Jobs	41	34.15	1.98	0.96	[0.77-5.13]	0.15
[Ref] Other jobs	383	28.72			–	–
Manufacturing Jobs	9	33.33	2.05	1.68	[0.41-10.24]	0.37

Note. AOR = Adjusted Odds Ratio; CI = Confidence Interval; Ref. = Reference category. p < .05 indicates statistical significance.

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3.8.3 Little Interest or pleasure in doing things

According to the Table 11 below, the relationship between selected independent variables and the likelihood of having little interest in activities. AOR, standard errors, 95% CIs and *p*-values are reported for each predictor. The predictor results found the following below: Participants who had attended school were significantly more likely to report having little interest in activities than those who had never attended school (B = 0.69, AOR = 1.99, SE = 0.65, 95% CI: 1.04-3.81, p = 0.03). This finding suggests that education was associated with a 99% increase in the odds of reporting disinterest. Though somewhat counterintuitive, this may indicate greater psychological awareness or reporting bias among educated individuals.

In terms of income, those with income were less likely to report having little interest than those without (B = –0.67, AOR = 0.51, SE = 0.17, 95% CI: 0.26-0.99, p = 0.04). This implies a 49% reduction in the odds of low interest among individuals with financial resources, underscoring the protective role of economic stability.

Regarding occupational sectors, participants working in domestic jobs were significantly more likely to report low interest compared to other sectors (B = 0.82, AOR = 2.28, SE = 0.99, 95% CI: 1.26-4.68, p < 0.001). This suggests that individuals in domestic work were over twice as likely to experience symptoms of low interest, possibly due to job-related stress, isolation, or poor working conditions. The manufacturing sector also showed a marginally significant effect, with a notably high odds ratio (B = 1.37, AOR = 3.93, SE = 2.81, 95% CI: 0.96-16.00, p = 0.05). Although on the threshold of significance, the wide confidence interval suggests instability due to small sample size (n = 9) and requires cautious interpretation.

The results identified that education, income and occupation sectors (especially in domestic and manufacturing sectors) as significant predictors of depression. These

insights emphasize the disparities in lacking interest or pleasure were linked to education, income and job type among migrant workers.

Table 12. Factors Associated with Having "Little Interest in Activities" Among Returned Cambodian Migrant Workers (N = 392)

Independent Variable	n	% Little Interest	AOR	Std. Error	95% CI	**p-value
1.Gender						
Male [Ref.]	143	30.07			–	–
Female	249	36.95	1.22	0.31	[0.73-2.02]	0.43
2.Age Group						
18–24 years [Ref.]	43	34.10			–	–
25–65 years	349	37.21	1.21	0.48	[0.55-2.67]	0.62
3.Marital Status						
Non-married [Ref.]	32	35.56			–	–
Married	360	21.88	0.44	0.22	[0.15-1.21]	0.11
4.Education						
Never attended [Ref.]	66	25.76			–	–
Attended school	326	36.20	1.99	0.65	[1.04-3.81]	**0.03***
5.Occupation						
Unemployed [Ref.]	264	36.36			–	–
Employed	128	30.47	1.13	0.35	[0.62-2.09]	0.67
6.Income						
Without income [Ref.]	80	47.50			–	–
With income	312	31.09	**0.51**	0.17	[0.26-0.99]	**0.04***
7.Returned in Last 24 Months						
No [Ref]	148	36.49			–	–
Yes	244	33.20	0.69	0.17	[0.42-1.14]	0.15
8.Years of Foreign Employment						
<5 years [Ref]	224	34.02			–	–
≥5 years	148	35.14	0.98	0.23	[0.62-1.57]	0.96
9.Current Occupation						
No [Ref]	164	40.85			–	–
Yes	228	29.82	0.68	0.24	[0.34-1.35]	0.27
10. Occupational Sectors						
[Ref] Other jobs	242	34.71			–	–
Agricultural Jobs	150	34.00	1.12	0.37	[0.58-2.17]	0.71
[Ref] Other jobs	270	37.41			–	–
Construction Jobs	122	27.87	0.78	0.27	[0.39-1.54]	0.47
[Ref] Other jobs	351	32.19			–	–
Domestic Jobs	41	53.66	**2.28**	0.99	[1.26-4.68]	**0.00****
[Ref] Other jobs	383	33.68			–	–
Manufacturing Jobs	9	34.44	**3.93**	2.81	[0.96-16.00]	**0.05***

Note. AOR = Adjusted Odds Ratio; CI = Confidence Interval; Ref. = Reference category. p < .05 indicates statistical significance.

3.8.4 Feeling down, depressed or hopeless

In Table 12, a binary logistic regression was conducted to assess the relationship between various sociodemographic, economic and occupational factors and the likelihood of reporting depressive symptoms among migrant workers.

Gender was a significant predictor. Female participants were twice as likely to report symptoms of depression compared to their male counterparts (B = 0.69, AOR = 2.00, SE = 0.49, 95% CI: 1.24-3.23, p < 0.001).

Participants who returned within the past 24 months had significantly lower odds of reporting depression compared to those who had not returned recently (B = –0.58, AOR = 0.56, SE = 0.13, 95% CI: 0.35-0.91, p = 0.01). This suggests that recent return from migration may have a protective effect against depression. Regarding differences across occupational sectors, the analysis showed that workers employed in agriculture were significantly more likely to report symptoms of depression compared with individuals in other sectors (B = 0.42, AOR = 1.52, SE = 0.31, 95% CI:1.01–2.30, p = 0.04). The likelihood of depression was even higher among those engaged in domestic work, who exhibited more than twice the odds of reporting depressive symptoms relative to their counterparts in other occupations (B = 0.90, AOR = 2.46, SE = 0.85, 95% CI: 1.25–4.86, p < 0.001). In contrast, individuals working in the construction sector were significantly less likely to experience depressive symptoms, as reflected in the negative association observed (B = –0.65, AOR = 0.52, SE = 0.11, 95% CI: 0.33–0.80, p < 0.001). These findings highlight clear variations in mental health risk across occupational roles, with agriculture and domestic work presenting elevated vulnerabilities, while construction appears comparatively protective.

These findings highlight occupational context as a key determinant of mental health, particularly indicating that domestic and agricultural work may pose mental health risks, while construction work appears protective.
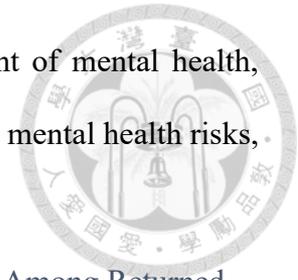
Table 13. Multivariate Logistic Regression Predicting "Depression" Among Returned Cambodian Migrant Workers (N = 392)

Independent Variable	n	% Depression	AOR	Std. Error	95% CI	**p-value
1.Gender						
Male [Ref.]	143	35.66			–	–
Female	249	52.21	**2.00**	0.49	[1.24-3.23]	**0.00**
2.Age Group						
18–24 years [Ref.]	43	45.56			–	–
25–65 years	349	51.16	1.53	0.59	[0.72-3.26]	0.26
3.Marital Status						
Non-married [Ref.]	32	46.67			–	–
Married	360	40.63	0.86	0.38	[0.36-2.07]	0.75
4.Education						
Never attended [Ref.]	66	51.52			–	–
Attended school	326	45.09	0.81	0.23	[0.45-1.43]	0.47
5.Occupation						
Unemployed [Ref.]	264	45.83			–	–
Employed	128	46.88	1.12	0.32	[0.64-1.97]	0.67
6.Income						
Without income [Ref.]	80	48.75			–	–
With income	312	45.51	0.65	0.21	[0.33-1.25]	0.20
7.Returned in Last 24 Months						
No [Ref]	148	52.70			–	–
Yes	244	42.21	**0.56**	0.13	[0.35-0.91]	**0.01***
8.Years of Foreign Employment						
<5 years [Ref]	224	45.49			–	–
≥5 years	148	47.30	1.09	0.24	[0.70-1.70]	0.68
9.Current Occupation						
No [Ref]	164	45.12			–	–
Yes	228	46.93	1.25	0.41	[0.65-2.41]	0.49
10. Occupational Sectors						
[Ref] Other jobs	242	42.15			–	–
Agricultural Jobs	150	52.67	**1.52**	0.31	[1.01-2.30]	**0.04***
[Ref] Other jobs	270	51.11			–	–
Construction Jobs	122	35.25	**0.52**	0.11	[0.33-0.80]	**0.00**
[Ref] Other jobs	351	43.87			–	–
Domestic Jobs	41	65.85	**2.46**	0.85	[1.25-4.86]	**0.00**
[Ref] Other jobs	383	46.21			–	–
Manufacturing Jobs	9	44.44	0.88	0.65	[0.20-3.80]	0.87

Note. AOR = Adjusted Odds Ratio; CI = Confidence Interval; Ref. = Reference category. p < .05 indicates statistical significance.

The results identified that gender, recent return from migration and occupation sectors (especially in domestic, agricultural and construction sectors) as significant predictors of depression. These insights emphasize mental health disparities linked to gender and job type among migrant workers.

CHAPTER 4. QUALITATIVE RESEARCH FINDINGS

4.1 Socio-demographics of qualitative findings

The qualitative findings provide deeper insight into how returned Cambodian migrant workers make sense of their experiences abroad and during reintegration. The narratives reveal how emotional distress is shaped by economic strain, shifting social roles and the challenges of rebuilding livelihoods after migration. This section presents the central themes that emerged from participant interviews, illustrating the meanings and interpretations that workers attach to their experiences.

Table 14. Demographic Characteristics of Returned Migrant Workers

Province	Gender	Age	Returned From
BMC	Female	26 years	Thailand
BMC	Male	38 years	Thailand
BTB	Female	37 years	Thailand
BTB	Female	36 years	Thailand
SR	Male	37 years	Thailand
SR	Female	29 years	Thailand
KP	Male	36 years	South-Korea
KP	Male	29 years	Thailand and Korea

Note: BMC= Banteay Meanchey, BTB=Battambang, Sr=Siem Reap, KP=Kampot

The findings provide nuanced insights into the emotional, social and economic realities of returnees, emphasizing how migration, return and reintegration a cross with mental well-being, family obligations and structural barriers. Through in-depth interviews with eight Cambodian returned migrant workers (RMW1 to RMW8) from

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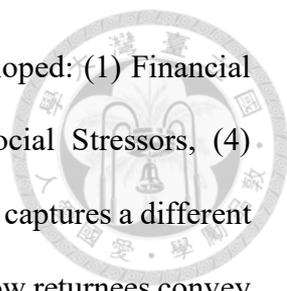
Thailand, there are five main themes and multiple sub-themes developed: (1) Financial Stress, (2) Psychological Health Problems, (3) Structural and Social Stressors, (4) Migration-Related Challenges and (5) Coping Strategies. Each theme captures a different but interconnected extent of the post-return experience, illustrating how returnees convey financial insecurity, emotional strain, social judgment and the absence of formal support mental health systems.

Participants consistently described how economic uncertainty exacerbated by unemployment, debt and family dependency served as a major source of psychological distress. Feelings of sadness, anxiety and helplessness were combined by the loss of social status and purpose that many migrant workers experienced upon returning their home country. In several cases, respondents reported physical symptoms include headaches, fatigue or insomnia linked to persistent stress they have. Despite these difficulties, most respondents demonstrated resilience through adaptive coping strategies such as engaging in household activities, farming or psychological practices to manage emotional tension. These coping responses, although limited in addressing root causes reflect the personal and cultural mechanisms by which returned migrants struggle to maintain emotional balance and dignity in the face of hardship.

Generally, the qualitative findings extend understanding of how migration and return processes influence the psychological and social well-being of Cambodian returnees. The following sections present each theme in detail which supported by participants' quotations to show the complexity of their post-return adjustment and the socio-economic contexts influential their experiences.

4.2 Overview of Thematic Findings
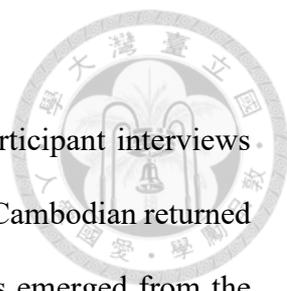
A total of 634 coded references were identified across the eight participant interviews (RMW1–RMW8), representing the full series of experiences among Cambodian returned migrant workers. Five main themes and their associated sub-themes emerged from the analysis: Financial stress, psychological health problems, Structural and social stressors, Migration-related challenges and coping strategies. The occurrences of coded segments are presented in Table 15. As shown and found, psychological health problems and financial stress emerged as the two most commonly mentioned sources of stress, highlighting the centrality of emotional distress and economic insecurity in participants' post-return experiences from Thailand. Migration-related challenges, Structural and Social Stressors were moderately represented reflecting concerns related to exploitation abroad, uncertainty during return and community-level discrimination. For the coping strategies looked less frequently but provided essential insight into participants' resilience, self-regulation and faith-based coping behaviors among Cambodian returned migrant workers.

These frequencies indicate the relative importance of each theme rather than general statistical conclusions. As qualitative coding aims to capture depth and emphasis in participants' narratives. The proportional distribution underscores that while returned migrants faced diverse challenges, their stories were subject by psychological and economic struggles with comparatively fewer expressions of coping and adaptation.

Table 15. Distribution of Major Themes Across Participant Narratives

Themes	Frequency	Description
Financial Stress	205	Economic hardship, debt, family obligations
Psychological Health Problems	223	Sadness, anxiety, depression, loss of purpose
Structural and Social Stressors	71	Discrimination, lack of services, social pressure
Migration-Related Challenges	82	Exploitation, uncertainty, job insecurity
Coping Strategies	53	Emotional regulation, problem-solving, spiritual coping
Total	634	

Note: Frequencies indicate the relative emphasis of each theme across coded data segments and do not imply statistical generalization (Braun & Clarke, 2021; Nowell et al., 2017).

4.3 Financial Stress

4.3.1 Financial Pressure after Return

Financial stress occurred as one of the most leading and cross-cutting themes among the returned Cambodian migrant workers from Thailand. Nearly all participants described the period following their return to Cambodia as one of heightened financial insecurity characterized by joblessness, debt and pressure to provide for family members. These conditions created persistent worry and emotional distress, often described as "burden" or "anxiety" or "feeling helpless". This is suggested that the financial strain experienced by returnees is not only an economic issue but also a profound psychosocial challenge that shapes their self-perception, family dynamics and mental well-being among returnees. Many participants highlighted that the loss of regular income after returning home represented a major source of stress and depression. Those who had relied on stable wages in Thailand now faced irregular or nonexistent employment opportunities in Cambodia.

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As one participant reflected that: *"Now I am jobless and no work, no income. It's hard to support my family"* (RMW1). Similarly, another participant stated: *"I haven't had steady work since I came back and it's hard to cover basic expenses"* (RMW2). These accounts reflect the transition from predictable earnings abroad to unstable or informal livelihoods at home country which significantly undermined feelings of security and self-worth.

Several returnees described how financial uncertainty was intensified by existing debts or loans taken before migration. For some, the inability to repay these debts upon return led to shame and continued anxiety. As one respondent shared that: *"I borrowed money to travel abroad and now I have to repay it without income"* (RMW5). The recurring concern about debt repayment underscores the recurrent nature of economic stress where migration intended to improve poverty often results in new forms of financial burden upon return to home country.

4.3.2 Family Financial Dependency

Another recurrent concerned the burden of family financial dependency. Several participants described feeling obligated to support elderly parents, spouses or children left behind despite lacking a stable income. This sense of obligation was intertwined with traditional expectations of family responsibility and social identity as a provider. One participant was explained that: *"My parents rely on me for their needs but without work, I feel helpless and cannot help them at all"* (RMW2). The financial obligation to provide the role strain of being unable to fulfill provider duties, the absence of a steady income and the resultant helplessness.

Although only one respondent obviously framed their experience as "family dependency", one of the participants was noted that: *"Every day, I feel anxious about money and how I'm going to provide for my family. It feels like a heavy weight that never goes away"* (RMW2*)*. These statements highlight how economic strain meets with emotional well-

being and family roles, revealing the deep relational aspect of financial stress among returnees.

4.4 Psychological Health Problems

4.4.1 Sadness, Anxiety and Depression

Emotional distress was the most pervasive dimension of psychological health problems among returned migrant workers. Most participants described persistent sadness, worry and hopelessness linked to unemployment and economic uncertainty. Several reported "thinking too much" a locally common expression of distress reflecting rumination and anxiety. One participant was stated that: *"Honestly, when I was abroad, I had goals. But now, I just wait"* (RMW6). Another participant was added that: *"Every day, I feel anxious and unsettled… my mind starts racing with worries about money and how I'm going to provide for my family"* (RMW4).

These highlighted the overlapping symptoms of anxiety and depression caused by disruptions in livelihood and social reintegration. The intensity and continuity of these emotions reflect what Kleinman (1982) called *somatopsychic distress*, in which economic hardship transforms into persistent psychological strain. The findings align with previous studies showing that financial instability is a strong predictor of depressive symptoms among Southeast Asian return migrant workers.

4.4.2 Discrimination and Social Withdrawal

A second sub-theme concerned the discrimination attached to returning home "empty-handed". Many participants described withdrawing from community activities to avoid gossip or humiliation. One of participant has stated that: *"I don't want to join the village gatherings… people will ask why I'm back and not working"* (RMW1). Another remarked that: *"I avoid going to the market because people will ask what I'm doing now"* (RMW2).
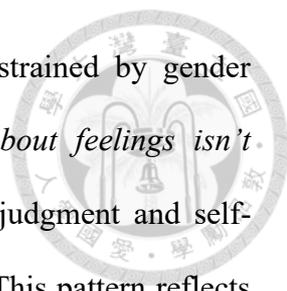
For male participants, emotional expression was particularly constrained by gender expectations. One participant noted that: *"As a man, talking about feelings isn't encouraged"* (RMW8). The social withdrawal shows how social judgment and self-blame contribute to isolation and reduced access to social support. This pattern reflects evidence that returnees in Cambodia often face marginalization related to the perception of migration "failure", such social experiences not only involve external criticism but also internal feelings that reinforce silence and loneliness.

4.4.3 Perceived Failure and Social Judgment

Many participants interpreted their economic struggles as personal failure rather than structural limitation. They expressed feelings of guilt toward their families and embarrassment within their communities. As one of returnee explained: *"People think I failed because I came back with nothing"* (RMW3). Another participant added: *"It hurts my pride… I feel like I've lost the role I used to have in the family"* (RMW8).

This perceived failure and social judgment are inadequate align with the collectivist social norms in Cambodian society, where fulfilling familial and financial obligations signifies virtue and success. When returnees cannot meet those expectations, self-blame intensifies psychological suffering. Similar findings have been observed among migrant workers in Thailand and Myanmar, where return without financial gain is equated with shame and loss of social standing.

4.4.4 Physical Symptoms of Stress

Emotional exhaustion was commonly described through physical symptoms such as headaches, chest tightness, fatigue and disturbed sleep. Several returnees shared experiences that reflected this connection between emotional distress and bodily discomfort. One participant stated, *"My sleep is not good… I think too much at night"* (RMW1); *"I get headaches almost every week now"* (RMW4); *"Sometimes my chest*
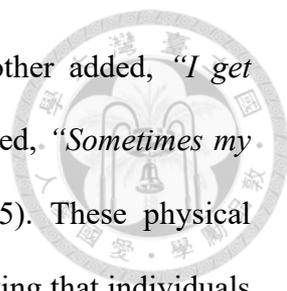
feels heavy, almost like I can't breathe properly" (RMW5). Another added, *"I get headaches almost every week now"* (RMW4), while a third explained, *"Sometimes my chest feels heavy, almost like I can't breathe properly"* (RMW5). These physical expressions of distress align with evidence from other contexts showing that individuals in low-resource settings often communicate emotional strain through bodily sensations. Limited access to mental health services further reinforces this pattern, as many returnees interpret physical pain as a normal part of life hardship rather than a sign of psychological overload.

4.4.5 Comparison to Peers

Social comparison emerged as a significant source of emotional distress with comparing oneself to others doing better financially or socially. Many participants compared themselves with peers who seemed more successful after returning from migration. One woman shared, *"It's harder when I see other women who have managed to start small businesses"* (RMW3). Another added, *"When I hear from friends still in Thailand and doing well, I feel left behind"* (RMW6). These reflections highlight feelings of relative deprivation and lowered self-esteem, which contributed to sadness and hopelessness. In closely connected rural communities, such comparisons are easily observed and carry social meaning, intensifying emotional distress when reintegration outcomes differ among households.

4.4.6 Unmet Expectations

The unmet expectation sub-theme highlighted the disappointment associated with unmet expectations after returning home. Many participants had anticipated greater stability and improved livelihoods following their time abroad but instead encountered ongoing uncertainty and financial hardship. As one returnee explained, *"I thought coming home would be easier, but I face the same problems that made me leave"* (RMW4). This sense

of disillusionment reflects a gap between aspiration and reality where the contrast between expected progress and actual struggle generated frustration and hopelessness. The finding aligns with previous studies indicating that unfulfilled migration expectations can lead to reverse culture shock and extended psychological distress among Southeast Asian returnees.

4.5 Structural and Social Stress

4.5.1 Skill Mismatch

Several participants expressed frustration about their inability to find employment that matched the skills and experience they had gained abroad. Although many had developed useful abilities in manufacturing, food processing, agriculture, or caregiving, these competencies were rarely recognized or applied upon return. One participant shared, *"I learned how to work with machines and follow strict production schedules, but here no one asks about that. The jobs are mostly casual or day labor"* (RMW3). This mismatch between skills and opportunities led to feelings of wasted potential and discouragement about the future. It also reinforced the belief that migration remained the only realistic path to economic stability. As another returnee explained, *"Even after returning, I feel like I have to leave again because there's no job that fits my skills in my country"* (RMW7).

This was highlighting a structural disconnection between the labor market and the skills returnees bring home. The absence of vocational reintegration programs or local enterprises that can absorb semi-skilled labor leads many to consider re-migration, perpetuating a cycle of economic dependency and instability. This mismatch also mixes the emotional consequences discussed earlier, as participants experience reduced confidence and self-worth when their efforts abroad are not socially or economically authorized at home. The skill mismatch highlights a structural gap between the local labor
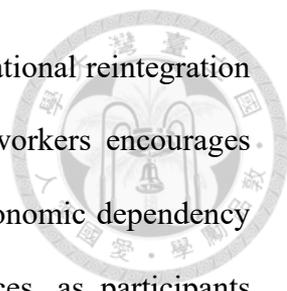
market and the skills that returnees bring home. The absence of vocational reintegration programs or local enterprises capable of absorbing semi-skilled workers encourages many to consider migrating again, thereby sustaining a cycle of economic dependency and instability. This mismatch also carries emotional consequences, as participants reported feelings of diminished confidence and self-worth when their experiences and efforts abroad were not socially or economically recognized upon return. Notably, limited institutional pathways for skill recognition and certification contributed to returnees' underemployment and psychosocial distress. As one participant explained, *"What I learned abroad doesn't matter here. People think I just did simple work"* (RMW5). This mismatch not only hindered economic reintegration but also deepened feelings of personal inadequacy and social exclusion.

4.5.2 Lack of Mental Health and Psychosocial Support Services in Cambodia

Another recurring concern was the limited access to mental health services and the general lack of awareness about available psychosocial support. Most participants reported never having engaged with professional mental health services after returning home, citing both the absence of such services and the belief that seeking help was culturally inappropriate. One participant shared: *"No, I didn't even know that was possible here. I've never seen anyone talk about getting emotional support. People expect you to just deal with your problems"* (RMW2).

In the absence of formal support systems, participants relied on informal coping strategies such as self-distraction or spiritual practices. While these methods offered temporary comfort, they did not address underlying emotional distress. The shortage of trained mental health professionals particularly in rural areas further reinforced the invisibility of psychological suffering and prevented timely intervention.
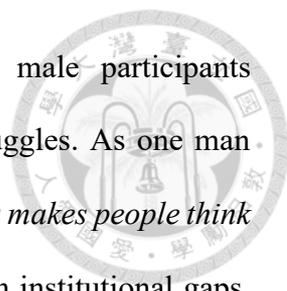
Gender norms also influenced help-seeking behaviors. Several male participants described pressure to remain strong and silent about emotional struggles. As one man stated, *"As a man, you are supposed to be strong. Talking about stress makes people think you are weak"* (RMW8). These gendered expectations intersect with institutional gaps, resulting in unaddressed distress and the normalization of emotional suffering. Without accessible psychosocial services, many returnees internalized their challenges, leading to prolonged stress and delayed reintegration.

4.5.3 Language Barriers

Participants among this population also mentioned ongoing challenges related to language barriers and navigating institutional systems both abroad and upon return. While abroad, limited proficiency in Thai constrained their ability to communicate effectively with employers, access legal protection or seek health care. Upon return, the same participants reported difficulty understanding administrative procedures related to reintegration or employment registration. One respondent reflected *"In Thailand, I couldn't really speak Thai, so I always depended on others to explain things. Here, when I went to ask about support programs, I also didn't understand the forms or where to go"* (RMW5). This dual-layered communication barrier experienced first as a migrant and later as a returnee supports systemic exclusion. Language limitations also constrained access to public information campaigns, vocational training and reintegration assistance. One participant explained *"I heard there are trainings for returnees but I never knew how to join. No one came to explain in our community"* (RMW6). The absence of clear, locally delivered communication channels spreads inequalities between urban and rural returnees, leaving many unaware of the limited services that do exist. This highlights the broader issue of institutional accessibility, where even existing government or NGOs programs

may fail to reach those who need them most due to communication gaps and administrative complexity.
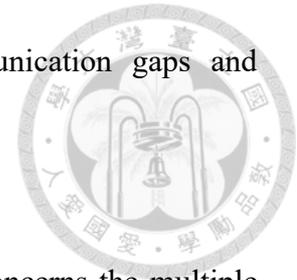
4.6 Migration-Related Challenges

Migration related to challenges from the qualitative data concerns the multiple encounters participants experienced during and immediately after migration. These migration-related challenges include exploitation in the workplace abroad, uncertainty during the return process and the loss of physical and emotional security. While migration was initially pursued as a livelihood strategy to improve poverty and family welfare, participants' stories reveal that the journey often exposed them to precarious working conditions, legal vulnerability and psychosocial strain. The period of return particularly during the COVID-19 pandemic and subsequent border restrictions further intensified these vulnerabilities. This was highlighted that the stressors experienced by Cambodian returned migrant workers cannot be separated from their earlier experiences abroad. These pre-return hardships continued to outline post-return adjustment and mental health, demonstrating the continuum of migration stress that begins with departure, peaks during employment abroad and extends into reintegration at home country.

4.6.1 Homesickness and Emotional Strain During Migration

Some participants described persistent homesickness while working in Thailand. Separation from family, language barriers and unfamiliar routines contributed to feelings of loneliness and sadness. One participant recalled, *"Homesickness was one. I cried quietly at night sometimes. And there were days when wages were delayed, or work was canceled due to bad weather"* (RMW6). Another added, *"Being far from family, with no one to talk to, that's not easy"* (RMW5).

Some returnees found comfort in informal peer networks formed among Cambodian workers. As one explained, *"We quickly formed a close-knit group. We would share our*

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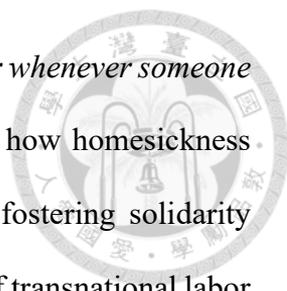
meals, talk about our families back home and look out for one another whenever someone was feeling down or homesick" (RMW4). These accounts illustrate how homesickness functioned both as an emotional burden and as a social catalyst, fostering solidarity among co-workers while revealing the ongoing psychological costs of transnational labor migration. Consistent with previous research prolonged family separation can intensify depressive symptoms and strengthen the desire to return home prematurely.

4.6.2 Workplace exploitation abroad

Another recurring sub-theme concerned exploitative and unsafe working conditions. Participants described long working hours, limited rest and frequent verbal or physical intimidation from supervisors. As several returnees shared, *"We worked under the hot sun for long hours and there wasn't much time to rest"* (RMW2, RMW3, RMW6, RMW7, RMW8).

Many participants also emphasized how their undocumented status left them vulnerable and unable to challenge mistreatment or wage deductions. One participant explained, *"Because I didn't have proper documents, I couldn't say anything when they underpaid me"* (RMW6). These accounts reveal structural power imbalances between employers and migrant workers, where precarious legal status facilitates routine exploitation and silences resistance.

Even after returning home, some participants reported lingering anxiety and mistrust toward authority figures, reflecting the long-term psychosocial consequences of workplace abuse. These findings align with regional studies indicating that weak labor protections and unregulated recruitment practices expose Southeast Asian migrant workers to persistent occupational risks.

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4.6.3 Exploitation and Precarious Work Abroad

Some participants recounted experiences of labor exploitation, low wages and unsafe or unfair working conditions while employed in Thailand. Many reported excessive working hours, verbal abuse or lack of access to healthcare and legal protection. As one participant stated: *"We worked for long hours without proper breaks and if we complained, the supervisor would threaten to cut our pay"* (RMW4).

Others emphasized the lack of formal contracts and job security, noting that undocumented status made them vulnerable to exploitation. One respondent shared that: *"Because I didn't have proper documents, I couldn't say anything when they underpaid me"* (RMW6). This exploitation abroad shows how systemic inequalities between migrant workers and employers perpetuate fear. These experiences of exploitation left lingering emotional effects. Even after returning home, participants continued to experience anxiety and mistrust toward authority figures or potential employers.

4.6.4 COVID-19 Disruptions

The global COVID-19 pandemic caused severe disruptions to migration patterns and had profound effects on participants' mental health. More than half of the returnees reported losing employment, facing delayed wages, or being unable to return home due to border closures. As some participants explained, *"The COVID-19 made my factory close... I had no choice but to return"* (RMW1); *"The pandemic delayed my return and cost me my job"* (RMW7); and *"The COVID-19 made things even more complicated... I was constantly worried about getting sick"* (RMW8).

The sudden instability intensified economic insecurity and anxiety about family safety. Several participants described fear of infection while traveling in crowded transport or staying in quarantine centers, as well as uncertainty regarding changing border regulations. These experiences illustrate how global health crises intersect with migration

precarity when structural protections fail, migrant workers shoulder disproportionate psychosocial burdens. Consistent with WHO (2021) guidance and regional evidence, pandemic-related disruptions heightened emotional distress, hindered safe reintegration and deepened feelings of abandonment among returnees.
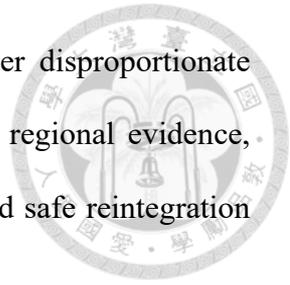
4.7 Coping Strategies

Coping Through Distraction or Keeping Busy as a Coping Strategy: amid economic hardship and psychological distress, many participants described keeping themselves busy as a primary way of coping. Rather than confronting emotional pain directly, they engaged in constant activity such as housework, farming, or helping others in their community to distract themselves from sadness, anxiety and uncertainty. This approach reflects to describe as *emotion-focused coping*, where individuals manage distress through distraction rather than direct problem-solving. Participants shared various examples*: "I try to keep myself busy with housework so I don't think too much"* (RMW1); *"I take care of my children all day to keep busy"* (RMW3); *"I help my neighbors on their farms when they need an extra hand"* (RMW5); *"I help out on the family farm whenever there's work to do"* (RMW6) and *"I work in the fields and help out around the house"* (RMW8).

These were illustrating how daily routines served as emotional buffers. Staying physically occupied helped reduce rumination ("*thinking too much*") and provided temporary relief from stress. Farming, in particular, was viewed as both economically practical and psychologically soothing, reconnecting participants with familiar rhythms of rural life and restoring a sense of control.

For many, this coping approach carried deep cultural meaning. Remaining industrious was seen not only as a means of survival but also as a moral and social responsibility. As one participant explained, *"If I stay idle, I start overthinking. Working helps me feel useful*

again" (RMW4). This highlights how distraction-based coping also functioned as a form of identity restoration, allowing returnees to regain a sense of dignity after perceived migration "failure". While this strategy supported short-term emotional balance, it also reflected structural limitations. The lack of accessible mental health and reintegration services left participants with few options beyond self-reliance and avoidance. As noted in other Southeast Asian studies "keeping busy" often conceals deeper distress rather than resolving it, serving as a culturally accepted yet constrained response to ongoing hardship. Ultimately, coping through distraction demonstrates both the resilience and endurance of returned migrant workers. It also underscores systemic neglect, revealing how personal and cultural coping practices can partially compensate for the absence of institutional support enabling emotional survival amid persistent socio-economic precarity.

CHAPTER 5. DISCUSSIONS

5.1 Overview of key findings

The findings of this study align closely with the aims of the study to examine the mental health outcomes and occupational experiences of returned Cambodian migrant workers. The findings indicate that mental health outcomes among returned Cambodian migrant workers were closely linked to their occupational experiences, particularly where work abroad involved low autonomy, heavy labor demands or unstable income. Although the COVID-19 pandemic shaped the broader migration and return context, its influence in this study can only be interpreted narratively, as it was not measured directly in the quantitative data. The discussion also highlights several barriers to mental health support during reintegration, including discrimination, limited-service availability and cultural expectations to endure distress independently. Together, these insights support the need for reintegration strategies that integrate livelihood stabilization with accessible, community-based psychosocial support. The following sections need to be discussed are: (1) Mental health outcomes and their link to occupation; (2) COVID-19 influence (contextual, partially addressed); (3) Barriers to mental health service access; (4) Policy-relevant evidence for reintegration support.

This quantitative and qualitative approach study examined the psychological well-being, occupational stressors and coping experiences of Cambodian migrant workers who had returned from employment in Thailand. The quantitative and qualitative approach design allowed for both breadth and depth quantitative data quantified the prevalence and determinants of anxiety and depression, while qualitative narratives captured the lived meanings, emotions and coping processes embedded within cultural, social and economic contexts. By integrating quantitative survey data (N = 392) and qualitative interviews (n

= 8), the study sought to provide a comprehensive understanding of post-migration adjustment and the factors influencing mental health outcomes among this population. Quantitative results from the Patient Health Questionnaire-4 (PHQ-4) indicated that approximately two-thirds of respondents exhibited at least mild symptoms of anxiety or depression, revealing a substantial mental-health burden among returnees. Regression analyses further identified significant factors like gender and occupational disparities, women were twice as likely as men to report depressive symptoms and those working in domestic and agricultural sectors had notably higher odds of psychological distress compared to construction workers. The findings reveal that structural factors, such as occupation, education and income, impact emotional outcomes, suggesting that post-migration mental health should not be viewed merely as an individual issue but must be contextualized within broader socioeconomic contexts.

In qualitative analysis, five interconnected themes emerged from the in-depth interviews included: financial stress, psychological health problems, structural and social stressors, migration-related challenges and coping strategies. Returnees vividly described economic pressure, unemployment and family financial dependency as dominant sources of anxiety, while social stress, skill mismatch and inadequate mental-health support further compounded their distress. Emotional symptoms such as sadness or thinking too much and insomnia were common, often accompanied by physical fatigue and social withdrawal. Thus far, within these hardships returnees also demonstrated resilience through coping behaviors such as keeping busy, seeking comfort in spirituality and relying on family solidarity. These insights provide texture and cultural depth to the numerical findings, revealing how Cambodian returnees interpreted and navigated distress within everyday life.
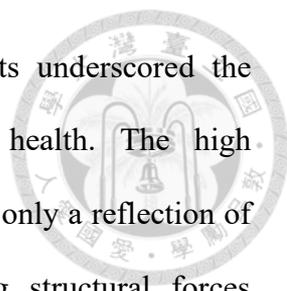
Collectively, the integration of quantitative and qualitative results underscored the multifactorial, context-bound nature of post-migration mental health. The high prevalence of psychological distress observed in the survey was not only a reflection of individual vulnerability but also a manifestation of intersecting structural forces economic precarity, gendered expectations and limited institutional support. The qualitative data enhanced this understanding by identifying the mechanisms through which these factors influenced emotional well-being, hence converting abstract statistics into tangible human experience. In doing so, the study contributes to growing evidence that migration and return are not discrete events but ongoing social processes marked by adaptation, loss and resilience. The findings hold important implications for developing gender-sensitive, culturally grounded reintegration and mental-health programs that recognize both the economic and psychosocial dimensions of migration. The combined quantitative and qualitative findings directly addressed the study's objectives by identifying the prevalence and predictors of post-migration mental health problems and explaining the contextual and psychosocial mechanisms underlying these patterns. The integration of both strands followed a convergent the quantitative and qualitative approach rationale, where qualitative insights enriched statistical results by illustrating how economic hardship, social expectations and gendered norms jointly shaped returned migrant workers' distress and coping experiences.

5.2 Contribution and Impact of Migration

International labor migration has long shaped Cambodia's socioeconomic landscape, particularly as a coping strategy for rural households facing limited employment opportunities. National statistics show that over 1.3 million Cambodians approximately eight percents of the labor force work abroad, primarily in low-skilled sectors such as construction, agriculture, domestic service and manufacturing (IOM, 2019). Remittances
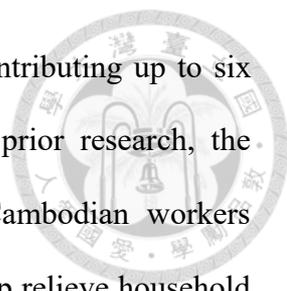
play a central role in household survival and debt management, contributing up to six percents of national GDP (World Bank, 2023). Consistent with prior research, the quantitative findings confirm migration's economic centrality. Cambodian workers typically migrate to Thailand to secure more stable earnings that help relieve household financial pressure, particularly through remittances (Maltoni, 2010; Hing et al., 2011; Bylander, 2017; IOM, 2019).

However, the qualitative narratives revealed the inconsistency of migration's dual role, which is simultaneously empowering and precarious. While migration improved short-term financial situations, many returnees described debt accumulation, unstable employment and social dislocation upon return. These patterns repeat the migration development nexus described by de Haan (2010) and the ILO (2022), wherein labor mobility functions as both an engine of rural transformation and a mechanism that reproduces vulnerability through exploitative labor regimes and cyclical indebtedness (de Haan, 2010; ILO, 2022).

Recent policy frameworks, such as Cambodia's National Labour Migration Policy 2024-2030, issued by the Ministry of Labour and Vocational Training (MLVT, 2024) and ASEAN's Declaration on the Protection of Migrant Workers, emphasize safer recruitment, reintegration and social protection measures but implementation gaps remain, particularly for low-skilled returnees in informal sectors. These structural tensions between empowerment and precarity create the context for the psychological vulnerabilities and reintegration stressors discussed in the subsequent sections.

Within the global and Cambodian migration contexts, the experiences of Cambodian migrant workers are consistent with global patterns of labor migration in which economic necessity drives movement into precarious low-wage sectors characterized by limited labor protections and high psychosocial vulnerability. Internationally, migrant workers
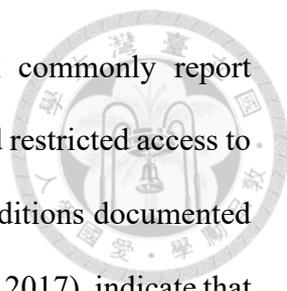
in sectors such as construction, agricultural and domestic work commonly report excessive working hours, wage withholding, hazardous worksites and restricted access to healthcare or legal recourse (ILO, 2021, 2023). These structural conditions documented across diverse regions including Southeast Asia (Farmer, 2004; Piper, 2017), indicate that exploitation and emotional strain are not unique to Cambodian migrants but reflect systemic inequalities embedded in global labor markets.

However, the Cambodian context is distinct in several ways. Firstly, migration often occurs within debt-financed or family-obligation frameworks, where migrants carry moral responsibility to financially uplift their households, intensifying guilt and psychological burden upon return (Derks, 2010; Chan & Higgs, 2020; Phuong et al., 2021). Secondly, Cambodia's reintegration systems, while improving, remain fragmented with limited access to community-based mental-health care and with inconsistent coverage under the National Social Security Fund (NSSF) (WHO, 2021; MLVT, 2024). Thirdly, the cultural idiom of thinking too much or "*Kuet Chreun*" in Khmer, suggested that the financial insecurity after return was found to be one strongest driver of psychological distress, often substitutes for psychiatric category, obscuring mental-health needs and delaying treatment (Hinton et al., 2012). Thus, while Cambodian migrants share many global risk exposures, the interaction of economic precarity, moral family expectations, cultural idioms of distress and limited reintegration services have shaped a particularly heightened and context-specific mental-health landscape.

5.3 Mental health challenges and risk factors

Across Southeast Asia, migrant workers experience disproportionately high rates of psychological distress due to social isolation, language barriers, job insecurity and restricted access to healthcare (S. R. Meyer et al., 2014; Harkins & Aylward, 2016; WHO, 2021). In quantitative analysis, 66.8 percent of respondents reported at least mild anxiety

or depression (PHQ-4 score ≥ 3), consistent with prior findings among Myanmar and Lao workers in Thailand (ILO, 2021; Apputhurai, Nguyen, et al., 2024).

Quantitative findings based on the PHQ-4 indicated a high prevalence of psychological distress among returned Cambodian migrant workers. A majority of participants showed symptoms consistent with mild to moderate anxiety and depression, suggesting that emotional strain is widespread during the reintegration period (Hing, Lun, & Oeur, 2011; Hinton et al., 2012; Bylander, 2017). Female returnee scored significantly higher than male counterparts, aligning with gendered vulnerability patterns observed in other Southeast Asian migration studies (Piper, 2017). This prevalence far exceeds pre-pandemic mental-health estimates (approximately 20 percent) in the general Cambodian population (WHO, 2023), underscoring returnees' disproportionate post-migration burden. Compared to studies in Thailand and Indonesia, where post-migration distress rates range from 35-45 percent (Soeparno et al., 2018; Apputhurai, Nguyen, et al., 2024), the findings suggested that Cambodian returnee workers faced increased psychosocial risks due to economic precarity, disrupted family roles and limited access to community-based mental-health services.

Gender discrepancies were striking: female returnees were twice as likely to experience depression. Some qualitative data explained this imbalance through narratives of guilt, social stress and familial obligation, consistent with the research by Derks (2010) and Phuong et al. (2021), who identified "moral failure" as a culturally gendered source of psychological distress among women who "return empty-handed." These findings reinforce the WHO recommendations for gender-responsive reintegration and psychosocial care needed (WHO, 2021).

The qualitative data expanded these statistics by identifying local idioms of distress, like thinking too much (*Kuet Chreun*), which express rumination, insomnia and fatigue. Such
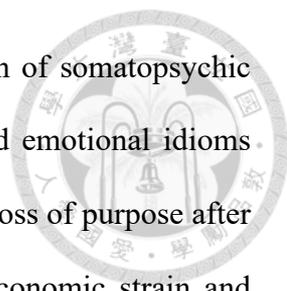
culturally embedded forms of suffering mirrored Kleinman's notion of somatopsychic distress, in which psychosocial stress manifests through bodily and emotional idioms (Kleinman, 1982). Many returnees described persistent sadness and loss of purpose after migration, consistent with previous research that post-migration economic strain and disrupted social roles heighten risk for depressive (Soeparno et al., 2018; Chan & Higgs, 2020).

5.4 Occupational and Economic Determinants of Mental Health

Occupational sectors have emerged as a critical determinant of mental health. Quantitative results showed higher odds of depression among domestic and agricultural workers, while construction workers had reduced the odds of depression. These disparities correspond with international data that domestic and agricultural sectors expose migrants to hazardous environments, long hours and limited legal protections (ILO, 2021; IOM, 2023).

The quantitative analysis also highlights the significant association role of economic and occupational conditions in determining mental health outcomes among returned Cambodian migrant workers. Income emerged as a protective factor with higher-earning returnees experiencing lower odds of anxiety and depression symptoms. This suggests that financial stability provides an important psychological buffer during reintegration. Conversely, returnees facing income instability or unemployment reported higher levels of psychological distress, indicating that economic precarity remains a central stressor following return. These patterns align with evidence that Cambodian households often rely on labor migration as a strategy to improve financial pressure, stabilize consumption and manage household debt (Maltoni, 2010; Hing et al., 2011; Bylander, 2017; IOM, 2019). When income security reduces after returning, previously suppressed stressors may reemerge, heightening mental health vulnerability.
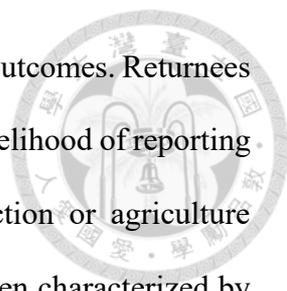
Occupational history also contributed meaningfully to mental health outcomes. Returnees who were previously employed in domestic work showed a higher likelihood of reporting depressive symptoms compared to those who worked in construction or agriculture (Harkins & Aylward, 2016; ILO, 2021, 2022). Domestic work is often characterized by low sovereignty, social isolation and limited worker protections conditions that may contribute to persistent psychological burden even after returning home (Maltoni, 2010; IOM, 2019). In contrast, those who worked in construction sectors demonstrated comparatively lower levels of psychological distress, possibly reflecting a stronger sense of skill transferability and employment re-entry potential (Bylander, 2017; Phuong et al., 2021). These occupational differences were resonated in the qualitative results, where participants described how work environments abroad shaped their self-worth, stress tolerance and coping strategies upon return (Chan & Higgs, 2020).

The qualitative narratives substantiate these risks of returnees recounted unsafe workplaces, physical exhaustion and exploitation by employers, especially among undocumented migrants. These accounts reflect prior research results of widespread wage theft and intimidation in Thailand's agricultural labor markets (Harkins & Aylward, 2016). The constrained power of migrants, along with the fear of deportation, creates persistent stress and legitimizes exploitation, a process referred to as "structural violence" (Farmer, 2004). Beyond physical risk, occupational precarity intersects with psychosocial health. Many returnees reported lingering anxiety and mistrust toward employers, indicating that occupational trauma persists beyond the migration (Derks, 2010; IOM, 2023). This reinforces the ILO's call for integrating occupational safety with psychosocial support in reintegration policy (ILO, 2022).

Additionally, returnees often entered informal or unstable employment upon return, regardless of the skills they had acquired abroad. This "deskilling" or mismatch between

prior experience and local labor opportunities has been documented in Cambodian and regional studies (Chan & Higgs, 2020; Phuong et al., 2021). The inability to adapt migration experience into stable employment further perpetuated psychological distress and economic vulnerability, reinforcing the cyclical nature of precarious labor.

5.5 Gendered and Sociocultural Dimensions

Gender and sociocultural context emerged as central determinants of post-migration mental health in this study, shaping both the experiences of distress and the possibilities for coping among returned Cambodian migrant workers. Quantitatively, female returnees were found to be twice as likely to report depressive symptoms (AOR = 2.00, p < 0.001) than men, showing a significant gender disparity consistent with regional evidences that women experience disproportionate psychosocial vulnerability following migration (ILO, 2022; WHO, 2021). Qualitative narratives elaborated these disparities by revealing how profoundly gendered expectations, social norms and moral economies influence emotional well-being. Female returnees described guilt, shame and anxiety stemming from perceived failure to fulfill familial and social obligations particularly the expectation to remit money and enhance family prestige. One returnee explained: *"My parents relied on me, but I came back with nothing; it's shameful."* This moralized experience of "returning empty-handed" echoes Derks's description of the moral economy of migration in which success is evaluated not only by income but also by the fulfillment of gendered duties of care and provision (Derks, 2010).

For female returnees, distress was compounded by intersecting burdens of economic pressure and relational responsibility. Many continued to bear primary caregiving roles while also striving to repay debts and support extended family members. This dual strain aligns with broader Southeast-Asian research on "feminized migration" which underscore how women's migration decisions are often framed within patriarchal family structures
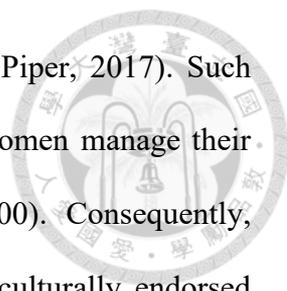
that valorize sacrifice and endurance (Harkins & Aylward, 2016; Piper, 2017). Such expectations produce what is termed "emotional labor", wherein women manage their own stress silently to sustain family harmony (Hochschild, 2000). Consequently, emotional suppression, rather than free expression, emerged as a culturally endorsed coping mechanism, aligning with Hinton et al. (2012), who observed that Cambodian women frequently embody distress through somatic symptoms such as headaches and chest pressure (Hinton et al., 2012).

Male returnees, in contrast, reported fewer depressive symptoms statistically, yet qualitative insights suggested that this may reflect under-reporting rather than resilience. Men described feeling "useless" or "stuck" when unable to secure employment but often avoided discussing emotional pain due to cultural expectations of masculine stoicism. As one male returnee remarked, *"As a man, I must be strong; if I talk about stress, people think I'm weak."* This remark aligns with Kleinman's (1982) argument that cultural scripts govern the articulation of distress: silence becomes a performative marker of masculinity. Similar patterns were identified by Harkins and Aylward (2016) in Thai and Cambodian contexts, where men's self-worth is closely tied to economic provision. Thus, the apparent gender difference in PHQ-4 screening tool scores may partly reflect differing norms of emotional disclosure rather than absolute resilience differences in suffering (Harkins & Aylward, 2016).

The study findings also highlighted broader sociocultural dimensions that intersect with gender, including discrimination, social comparison and community judgment. Returnees, especially women, spoke of gossip and social exclusion upon returning home without visible success, a phenomenon that is termed "spoiled identity" (Goffman, 1963). This adverse social judgment reinforces feelings of inadequacy and limits returnees' connection to support networks that could otherwise buffer distress. Phuong et al. (2021)

similarly found that Cambodian return migrants' reintegration is often hindered by community perceptions that conflate migration failure with personal weakness (Phuong et al., 2021). The qualitative data, thus, contextualize the quantitative gender disparity within a cultural system that values endurance, humility and family obligation over self-care or emotional expression.

At the same time, gendered sociocultural norms shaped coping behaviors. Female returnees frequently applied emotion-focused coping to keep busy with housework, or community activities to distract themselves from anxiety, consistent with Lazarus and Folkman's (1984) stress-coping framework and Meyer et al.'s (2014) findings among female garment workers in Phnom Penh (Lazarus & Folkman, 1984; S. R. Meyer et al., 2014). Male returnees, meanwhile, relied more on problem-focused coping, such as seeking new employment or engaging in physical labor to restore a sense of agency. Yet both genders described turning to spiritual practices and family rituals for solace, reflecting the enduring role of Buddhism and collectivist values in Cambodian psychosocial resilience (WHO, 2021). Although these culturally grounded coping strategies provide temporary relief, they may inadvertently mask the need for professional mental health services, which continue to be limited and socially disfavored nationwide (S. R. Meyer et al., 2014; UNDP, 2020).

In sum, gendered and sociocultural dimensions are not peripheral but foundational to understanding post-migration mental health. They influence how distress is experienced, expressed and managed and they reveal that the psychological burden of return migration cannot be divorced from moral expectations and social identity. The integration of quantitative survey and qualitative narrative data underscores that female returnee's higher risk of depression was driven not only by economic hardship but also by the invisible emotional labor of maintaining familial and moral legitimacy. Male returnee's

lower reported distress, conversely, reflected socially enforced silence rather than resilience. Addressing these patterns requires culturally sensitive, gender-responsive mental-health interventions that acknowledge both the structural inequities and the cultural logics through which suffering is lived and narrated.
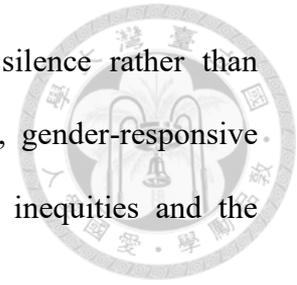
5.6 Impact of COVID-19 on Return Migration

The COVID-19 pandemic profoundly disrupted migration dynamics. Border closures in 2020–2021 triggered mass returns, job loss and social stress for migrant workers across the Mekong Subregion (UNDP, 2020; ILO, 2022). Qualitative testimonies confirm these regional patterns: returnees described chaotic border crossings, lack of information and prolonged unemployment. Many reported fear and confusion during quarantine, mirroring IOM (2023) reports of inadequate repatriation protocols (IOM, 2023).

Economic disruption compounded psychological distress. Returnees faced debt repayment without income, while community stress against "returnees from disease-risk countries" exacerbated social isolation (WHO, 2021). Despite these hardships, some returnees described renewed family cohesion and spiritual coping as sources of resilience findings aligned with studies from Lao PDR and Myanmar that highlight collectivist coping under crisis (Apputhurai, Nguyen, et al., 2024).

Quantitatively, the regression model identified recent return (< 24 months) as modestly protective against depression, possibly reflecting short-term emotional relief upon reunion. Yet qualitative insights revealed that such optimism was transient while distress resurged as debts and unemployment persisted, which are consistent with research by Chan and Higgs (2020) and WHO (2021). Thus, pandemic-related return magnified preexisting vulnerabilities rather than resolving them (Chan & Higgs, 2020; WHO, 2021).

5.7 Methodological Implications of the Convenience Sampling Approach

The study employed a convenience sampling strategy to recruit returned Cambodian migrant workers, which was shaped by the practical realities of conducting research with a highly mobile and hard-to-reach population. Convenience sampling is commonly used in migration studies where no complete sampling frame exists, participants are geographically dispersed and researchers rely on accessible networks to identify eligible individuals (Etikan et al., 2016). In this study, the absence of a national registry of returnees, combined with post-pandemic mobility restrictions and limited administrative data, made probabilistic sampling approaches impractical. Similar limitations have been documented in other studies involving migrant workers and irregular or transient populations, where convenience sampling provided the most feasible means of recruitment (Bloch, 2007; Tyldum & Johnston, 2014).

While convenience sampling allowed for timely data collection and provided meaningful insights into the lived experiences of returnees, it also introduces limitations related to representativeness. Individuals who were more visible in community networks or who had stronger connections to local authorities may have been more likely to participate, whereas those living in remote areas, individuals experiencing severe distress or those with limited social ties may be underrepresented. These biases are well-recognized in migration research, where accessibility often shapes participant inclusion (Faugier & Sargeant, 1997). As a result, the findings of this study cannot be generalized to all returned Cambodian migrant workers; instead, the results should be interpreted as reflective of the experiences of those who were reachable and willing to participate during the data collection period.

Despite these limitations, convenience sampling remains a methodologically defensible choice in contexts where migrant populations are fluid, undocumented or dispersed. As
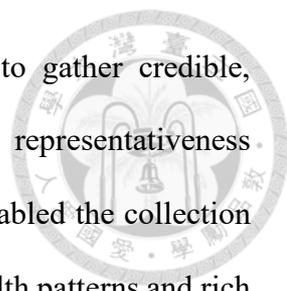
scholars have highlighted, the priority in such settings is often to gather credible, contextually grounded data rather than to achieve statistical representativeness (Mackenzie & Ssewakiryanga, 2010). In this study, the approach enabled the collection of both quantitative and qualitative data that captured key mental health patterns and rich personal narratives during a critical post-pandemic recovery phase. Future studies may complement this approach by employing respondent-driven sampling or mixed recruitment strategies to improve representativeness and reach more hidden segments of the migrant population.

Validating the PHQ-4 Using Confirmatory Factor Analysis (CFA)

In this study, Confirmatory Factor Analysis (CFA) was conducted to validate the structure of the PHQ-4 screening tool before using it as the primary measure of anxiety and depression among returned Cambodian migrant workers. Although the PHQ-4 has been widely validated in many settings, its performance can vary across cultural and linguistic contexts (Kroenke & Williams, 2009; Löwe et al., 2010). Mental health instruments developed in Western populations may not always capture emotional distress similarly in Southeast Asian or migrant populations, where somatic expressions, idioms of distress and cultural interpretations of mental illness can differ substantially (Hinton & Lewis-Fernández, 2010). Therefore, validating the PHQ-4's latent structure was necessary to ensure that it accurately represented anxiety and depression among Cambodian returnees. The CFA results confirmed the established two-factor structure of the PHQ-4, with anxiety and depression emerging as distinct but related constructs. This aligns with previous international research demonstrating that the PHQ-4 consistently provides a good fit for a two-factor model (Kroenke & Williams, 2009; Zuithoff et al., 2010). Validating the scale within this population not only ensured psychometric reliability but also strengthened the interpretability of the regression findings by confirming that the

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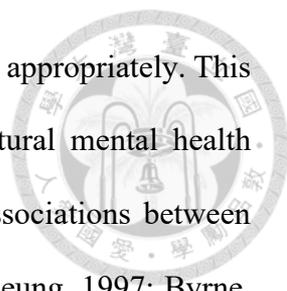
four mental health symptoms were measuring the intended constructs appropriately. This validation step is especially important when conducting cross-cultural mental health research, as measurement errors can introduce bias and weaken associations between exposure variables and psychological outcomes (Van de Vijver & Leung, 1997; Byrne, 2016). Furthermore, confirming the PHQ-4's factor structure supports the credibility of the study's mental health prevalence estimates, ensuring that anxiety and depression scores are based on a valid and stable measurement model. This enhances confidence in the study's broader conclusions about the mental health vulnerabilities of returned migrant workers and strengthens the evidence base required for policy recommendations and intervention planning. By demonstrating acceptable factor loadings and strong model-fit indices, the CFA provided empirical support that the PHQ-4 screening tool was suitable for use among Cambodian migrant workers a population that has been understudied in mental health research.

5.8 Integrated Analyses in Migration and Labor Issues

The integration of quantitative and qualitative analyses provides more nuanced understanding of post-migration mental health among returned Cambodian migrant workers. Quantitative analysis established broad statistical relationships high prevalence of anxiety and depression, gender and occupational disparities and the predictive effects of income and employment status while qualitative analysis revealed the subjective meanings and mechanisms underlying these patterns. Together, the two strands converge on three interlinked domains: economic insecurity and role strain, temporal dynamics of reintegration and coping and resilience mechanisms.

5.8.1 Economic Insecurity and Role Strain

For both methods, financial precarity emerged as the most powerful determinant of distress. Quantitatively, unemployment and low income were strongly associated with

elevated PHQ-4 scores, affirming that economic adversity is a key predictor of both anxiety and depression. This statistical relationship echoes the findings from regional studies indicating that economic instability is the principal driver of post-migration psychological symptoms in Southeast (ILO, 2022; Apputhurai, Nguyen, et al., 2024). Quantitative and qualitative analyses converged to highlight economic insecurity and family role strain as central drivers of post-migration mental distress. Quantitative results showed that lower monthly income and unstable employment status were significantly associated with elevated PHQ-4 scores. Binary logistic regression also confirmed that returnee workers earning the national median income had nearly twice the odds of reporting anxiety or depressive symptoms compared with those in stable work. Qualitative findings deepened this interpretation: the returnees described being "the only provider" yet unable to meet family needs reflecting the psychosocial burden of financial obligation and responsibility. The analytical integration highlights how economic vulnerability and disrupted role identity jointly produce emotional strain, echoing prior studies linking labor precarity to depression among returned migrants in Southeast Asia (Soeparno et al., 2018; Chan & Higgs, 2020).

Qualitative narratives expanded this notion by illustrating that economic stress covers not only financial aspects but also moral and relational dimensions. Returnees expressed sentiments of obligation, powerlessness and reduced self-esteem while failing to fulfill familial expectations, especially when returning without financial savings. One returnee stated that: *"My parents relied on me, but now I cannot help them; what use am I?"* This diction of distress aligned with Derks's notion of the moral economy of migration, wherein self-esteem and social value are tethered to financial contribution (Derks, 2010). The "economic insecurity" is inseparable from "role strain" the internal conflict between provider identity and structural limitation. While regression models quantified the

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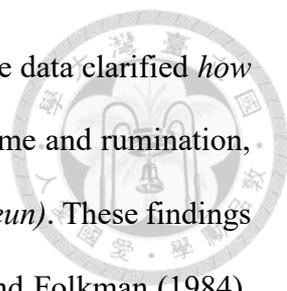
association between income and depressive symptoms, the qualitative data clarified *how* this strain operates psychologically: loss of role identity triggers shame and rumination, expressed through local idioms such as thinking too much (*Kuet Chreun*). These findings corresponded the stress-coping framework established by Lazarus and Folkman (1984), which contextualizes emotional distress within perceived loss of control and appraised inability to fulfill valued roles (Lazarus & Folkman, 1984). As in similar Cambodian and Filipino studies, the economic precarity becomes both a socioeconomic condition and a psychosocial burden, reinforcing the need for livelihood-linked mental-health interventions (S. R. Meyer et al., 2014; IOM, 2023).

5.8.2 Time-based Reintegration

Integrated Analyses also highlights that reintegration is a dynamic, evolving process rather than a single event. Quantitative regression indicated that recent returnees ($\leq$ 24 months) exhibited slightly lower odds of depression (AOR = 0.56, p = 0.01), This suggests that the early stage of return may provide emotional relief through family reunion and homecoming but this optimism often reduces as financial obligations resume and savings are exhausted. However, qualitative analysis revealed that this emotional respite was often temporary. Returnees initially experienced happiness at reuniting with family, but distress resurfaced as savings dwindled, debts accumulated and employment prospects remained limited.

The process of reintegration unfolded as a time-bound and psychologically adaptive trajectory with stress levels decreasing gradually as returnees rebuilt livelihoods and social belonging. Quantitative analysis found that the length of time since return inversely correlated with anxiety scores which suggesting progressive adjustment over months of readaptation. Returnees initially felt disoriented and "purposeless", but many regained stabilities through renewed family and community engagement. Drawing on Festinger's
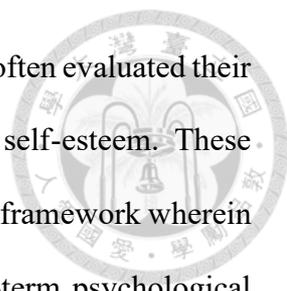
(1954) social-comparison theory, the analysis revealed that returnees often evaluated their progress relative to peers which influenced both motivation and self-esteem. These dynamics also align with Berry's (1997) acculturation and adaptation framework wherein cognitive reappraisal and community connectedness facilitate long-term psychological resilience. Thus, reintegration is not a fixed endpoint but a continuous process of meaning-making and self-redefinition following return migration.

The time-based pattern reflects the post-migration deterioration hypothesis observed in broader migration research (Chan & Higgs, 2020; WHO, 2021), where initial adjustment gives way to cumulative strain when structural support is lacking. Over time, social comparison with more "successful" peers intensified feelings of failure a theme consistent with Festinger of social-comparison theory. This integrated analyses thus captured a longitudinal path, the first stage of return relief, followed by a second stage of reintegration fatigue (Festinger, 1954).

Moreover, time-based dynamics intersected with the factors of gender and occupation. The qualitative results suggest that gender shaped the emotional impact of return migration. Women reported rapid emotional exhaustion due to immediate caregiving demands, whereas men experienced delayed frustration tied to prolonged unemployment (Hing et al., 2011; Bylander, 2017). Similar patterns were identified by Phuong et al. (2021), who found that Cambodian returnees' psychological well-being declines sharply within two years of return unless livelihood stability is achieved. The integration of time-sensitive quantitative indicators with longitudinal qualitative accounts therefore reveals that the "window of recovery" after return is brief and fragile, underscoring the importance of sustained reintegration programs beyond initial repatriation (Phuong et al., 2021).

5.8.3 Coping and Resilience Mechanisms

While the quantitative study did not directly measure coping behaviors, the relatively moderate mean PHQ-4 screening tool score. However, that widespread adversity suggests the presence of adaptive mechanisms mitigating severe psychopathology. The qualitative data explicated these mechanisms, identifying three dominant coping pathways included behavioral distraction, social support and spiritual endurance.

Qualitative analysis provided crucial insight into emergent sub-themes of coping and resilience derived from the eight in-depth interviews. Returnees applied three primary strategies: problem-focused coping, emotional regulation and social coping to navigate distress. These sub-themes, identified through thematic analysis, complimented quantitative analysis that lower PHQ-4 scores among returnees with high perceived family support. The integration suggested that while material stressors remained persistent, psychosocial resources, especially religious trust and collective belonging, served as protective factors against chronic anxiety and depression. This coherence between quantitative and qualitative analyses reinforced the methodological rigor of the quantitative and qualitative approach design and affirms that resilience among Cambodian returnees is rooted in culturally embedded coping systems, emphasizing adaptation rather than avoidance (Lazarus & Folkman, 1984; Hinton et al., 2012).

Many returnees described "*keeping busy*" through farming, household chores, or community activities as a means of avoiding intrusive thoughts. This reflected an emotion-focused coping strategy, functioning to regulate distress rather than resolve its cause (Lazarus & Folkman, 1984). Such "coping through distraction" parallels the research by Meyer et al. (2014) and Hinton et al. (2012), who find similar behavioral avoidance among Cambodian garment and refugee populations. Social connectedness also featured prominently; returnees drew comfort from family and neighbors, confirming

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WHO (2021) evidence that collective belonging is a key protective factor in post-migration contexts (Hinton et al., 2012; S. R. Meyer et al., 2014; WHO, 2021).

Spiritual and cultural practices further reinforced resilience. Returnees frequently mentioned prayer, merit-making and Buddhist reflection as grounding rituals. This spiritual coping resonates with findings from Lao and Thai migrant studies (ILO, 2022; Apputhurai, Nguyen, et al., 2024), suggesting that Buddhist frameworks of karma and endurance help normalize suffering as transient rather than pathological. However, these culturally congruent coping forms also risk masking deeper distress and delaying professional help-seeking, especially in contexts where mental-health stress remains pervasive (UNDP, 2020).

Integrating both data strands, the evidence portrays resilience not as recovery but as endurance within structural limitation. Quantitatively, moderate symptom levels may conceal significant suffering managed through cultural suppression rather than clinical resolution. Qualitatively, resilience emerges as relational and spiritual rather than psychological a mode of survival rooted in community, morality and faith. These findings affirm the need for culturally sensitive psychosocial interventions that strengthen community-based coping resources while normalizing access to professional support.

5.8.4 Synthesis of quantitative and qualitative analyses

Collectively, the integration of economic, temporal and coping dimensions demonstrated that Cambodian returnees' mental-health trajectories were shaped by intersecting structural, cultural and temporal forces. Economic insecurity triggered the role strain. Delayed reintegration amplified this stress and coping mechanisms, though adaptive often obscure continuing vulnerability. The quantitative and qualitative approach thus provided a holistic picture: the quantitative statistics quantified the prevalence, while qualitative narratives humanized the process. Aligning with the research by Braun and Clarke (2021)

and Carling and Eriksen (2019), this study emphasized that migration and return should be understood as cyclical experiences of adaptation, loss and resilience rather than discrete transitions (Braun & Clarke, 2021).

These insights underscore the imperative for policy frameworks that extend beyond immediate reintegration to encompass long-term psychosocial accompaniment, skill recognition and culturally informed mental-health support particularly for those facing compounded gendered and economic constraints (Carling & Eriksen, 2019).

These findings suggest that interventions should not replace, but rather strengthen, existing cultural coping systems by integrating family, religious institutions and community-based psychological support (UNDP, 2020; WHO, 2021).

5.9 Alignment of Findings with Research Objectives

The study's findings align closely with the original research objectives, demonstrating coherence between the study's aims and the empirical evidence generated through both quantitative and qualitative analyses.

Objective 1, sought to identify and assess the occupational health risks faced by Cambodian migrant workers during employment abroad. This objective was addressed through both quantitative and qualitative findings. The quantitative results indicated that workers in domestic work and agriculture experienced significantly higher odds of anxiety and depressive symptoms compared to those in the construction sector, suggesting that the occupational sector influenced vulnerability differently. These patterns are consistent with international employment research indicating that domestic and agricultural works is characterized by low bargaining power, hazard exposure and social isolation (IOM, 2019; ILO, 2021). Qualitative narratives supported this by detailing unsafe work environments, wage withholding, employer control and fear of deportation forms of exploitation embedded within what Farmer (2004) conceptualizes

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as structural violence (Farmer, 2004). Thus, the first objective was fully supported of the occupational risk profiles abroad materially contributed to psychosocial stress in this study.

Objective 2, which aimed to explore mental health outcomes among returnees and their association with occupational experiences, which was also fully addressed from the analysis of this data. Quantitative analysis showed that 66.8 percent of respondents showed mild to moderate anxiety or depression (PHQ-4 ≥ 3), with domestic workers and unemployed returnees reporting the highest distress levels. Income acted as a protective factor, while unemployment increased vulnerability. These findings align with previous Cambodian research showing that migration is often undertaken as a household financial survival strategy and psychological stress strengthens when returnees are unable to fulfill expected provider roles (Hing et al., 2011; Bylander, 2017; Phuong et al., 2021). Qualitative interviews illuminated this mechanism, revealing emotional strain tied to debt, shame, self-worth and disrupted identity, confirming that mental health outcomes during reintegration are socially and economically embedded.

Objective 3, aimed to investigate the effects of the COVID-19 pandemic on migration and mental health experiences. However, this study did not collect direct COVID-19 data related indicators (for example: lockdown severity, quarantine trauma, pandemic-period employment history) in the quantitative survey. Therefore, while some qualitative accounts referenced pandemic-related return disruption the available data cannot support an efficient analysis of COVID-19 effects. This limitation is consistent with the broader literature which emphasizes the need for COVID-specific stress, exposure and economic impact variables when evaluating pandemic effects (UNDP, 2020; ILO, 2022). As such, Objective 3 was only partially addressed.
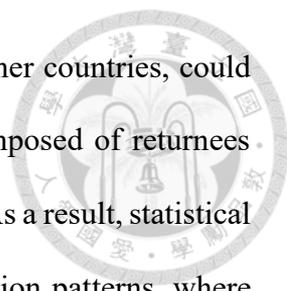
Objective 4, which proposed comparing returnees from Thailand other countries, could not be fully achieved because the sample was overwhelmingly composed of returnees from Thailand, with only minimal representation from South Korea. As a result, statistical comparison was not feasible. This reflects broader structural migration patterns, where Thailand remains the dominant destination for Cambodian workers due to geographic proximity and lower recruitment barriers (Maltoni, 2010; IOM, 2019). Therefore, Objective 4 is acknowledged as unmet and should be reframed in future research.

Objective 5, identifying barriers to accessing mental health services, was addressed qualitatively. Returnees described discrimination, lack of mental-health literacy, limited availability of community services and cultural norms favoring emotional strength as barriers. These align with WHO (2021) and Meyer et al. (2014), who describe mental health care in Cambodia as structurally under-resourced, socially discrimination and culturally filtered through somatic idioms such as "thinking too much" or "Kuet Chruen in Khmer" (Hinton et al., 2012). The findings suggest that reintegration support should include community-based psychosocial outreach, not solely clinical referral.

Finally, Objective 6 aimed to generate policy-relevant evidence. The study contributes directly to this goal by indicating that mental health after return is shaped not just by individual emotional response but by labor protections, income precarity, gender norms and access to services. Therefore, reintegration support must integrate livelihood stability, gender-responsive care, community-based counseling and targeted occupational protections consistent with Cambodia's National Labour Migration Policy 2024–2030 (MLVT, 2024) and ASEAN labor standards.

5.10 Theoretical and Policy Implications

5.10.1 Theoretical Implications

The findings of this quantitative and qualitative approach study contribute to migration and mental-health scholarship by advancing theoretical understanding of how structural, cultural and temporal dimensions interact to shape the well-being of returned Cambodian migrant workers. Three major theoretical implications have emerged.

First, the results reinforce and expand the stress-coping transactional model (Lazarus & Folkman, 1984) by demonstrating that stress among returned migrants was not merely individual but relational and moral. Economic insecurity and unmet family expectations created enduring *role strain*, which intensified distress even in the absence of acute trauma. The qualitative narratives showed that coping was mediated through collective and spiritual logics such as maintaining social harmony or fulfilling karmic duty rather than purely psychological regulation. Hence, this study extends classical stress coping theory into a culturally embedded framework that recognizes moral economy (Derks, 2010) and social identity (Goffman, 1963) as central to stress appraisal (Goffman, 1963; Derks, 2010).

Secondly, the integration of quantitative and qualitative analyses supports a socioecological model of migrant mental health, situating individual symptoms within nested layers of social and structural determinants. High PHQ-4 scores were linked not only to gender and occupation, but also to macro-level factors of labor policies, informal employment and limited access to health services. This multi-level perspective resonates with Bronfenbrenner's (1994) ecological systems theory and aligns with recent frameworks emphasizing the interaction of economic, social and cultural systems in shaping migrant well-being (Bronfenbrenner, 1994; WHO, 2021).
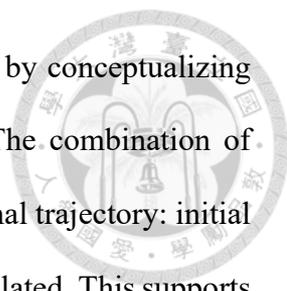
Thirdly, the temporal findings contribute to return-migration theory by conceptualizing reintegration as a dynamic process rather than a fixed outcome. The combination of quantitative regression and qualitative narratives revealed an emotional trajectory: initial optimism followed by deterioration as reintegration pressures accumulated. This supports Carling and Eriksen's (2019) "circulation of care" model and challenges traditional linear migration frameworks that treat return as closure. Instead, the results corresponded to that return migration constitute a continuum of vulnerability, a cyclical movement between hope, obligation and adaptation (Carling & Eriksen, 2019).

Together, these theoretical insights enrich the interdisciplinary field of migration studies by bridging sociological, psychological and anthropological approaches. They underscore that post-migration mental health in Cambodia must be interpreted not simply as a health issue but as a culturally and structurally situated social process.

5.10.2 Policy Implications

The study findings also deliver direct implications for policy and program design within Cambodia's health, labor and social-protection sectors:

Integrating mental health into reintegration programs: Given that two-thirds of returnees exhibited at least mild anxiety or depression, psychosocial support must be mainstreamed into the reintegration services administered by the Ministry of Labor and Vocational Training (MLVT) and provincial labor offices. This aligns with the WHO recommendations to incorporate mental-health screening, counseling and referral systems into migrant resource centers. Community health workers could be trained to recognize common symptoms such as *"thinking too much"* and provide culturally attuned first-line support (WHO, 2021). (WHO, 2021)

Strengthening economic and livelihood interventions: Quantitative analysis showed that unemployment and unstable income were the strongest predictors of psychological
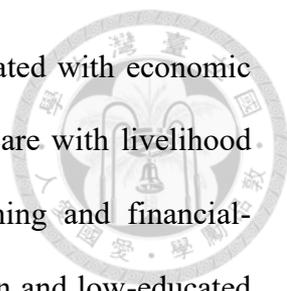
distress, while qualitative narratives emphasized moral guilt associated with economic failure. Reintegration policies should thus combine mental-health care with livelihood restoration; for example, micro-enterprise grants, vocational training and financial-literacy programs. These initiatives should particularly target women and low-educated returnees, who were most vulnerable in this study (UNDP, 2020; ILO, 2022b).

Promoting gender-responsive and family-centered support: The gendered patterns of distress and coping underscore the need for interventions that address women's emotional labor and caregiving burden. Programs could establish peer-support groups or "women's returnee networks" to facilitate collective healing and empowerment. For men, awareness campaigns should challenge norms equating silence with strength and encourage emotional openness.

Enhancing cross-border coordination and occupational protections: The association between occupational sector and mental health highlights the importance of safe-migration frameworks. Bilateral agreements between Cambodia and Thailand should be expanded to ensure fair working conditions, social security portability and pre-departure training that includes psychosocial preparedness. Integrating occupational health and mental-health promotion into labor-migration policy aligns with the ILO's (2022) decent-work agenda (ILO, 2022).

Building community-based and faith-sensitive mental-health services: Given the centrality of spiritual coping and Buddhist practices, local pagodas and village leaders can play important roles in fostering greater openness toward mental health care. Partnerships between the Ministry of Health and monastic communities could facilitate culturally acceptable referral pathways that bridge traditional and biomedical healing systems (Hinton et al., 2012). Collectively, these implications called for a multisectoral and culturally grounded policy response that addresses both the structural and

psychosocial dimensions of migration. Effective reintegration requires not only economic rehabilitation but also recognition of the human emotional costs borne by returned workers.
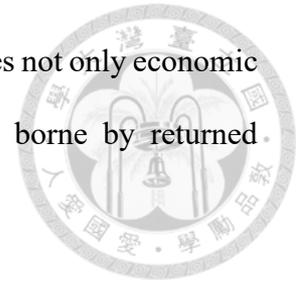
5.11 Limitations and Future Directions

While this study offers valuable insights, several methodological and contextual limitations should be acknowledged.

The cross-sectional nature of the quantitative survey precludes causal inference. Although associations between unemployment, gender and mental health were strong, temporal directionality cannot be established poor mental health may both result from and contribute to joblessness.

The PHQ-4 screening tool, though validated internationally, may not fully capture Cambodian idioms of distress such as thinking too much or (Kuet Chreun) in Khmer or somatic manifestations like headaches and fatigue. Cultural adaptation of standardized instruments remains essential for accurate measurement (Hinton et al., 2012).

The use of convenience sampling limits the representativeness of the sample and restricts the generalizability of the results to all returned Cambodian migrant workers. Individuals who were more accessible or connected to local networks may be overrepresented. The study's cross-sectional design prevents establishing causal relationships between migration experiences, COVID-19 impacts and mental health outcomes. The findings reflect associations rather than directionality or temporal effects.

All data were based on self-reported measures, which may be subject to recall bias, social desirability bias or underreporting of sensitive experiences such as psychological distress or working conditions abroad. Fourth, although the PHQ-4 screening tool demonstrated acceptable validity through confirmatory factor analysis, it remains a brief screening tool, which may not capture the full spectrum or severity of mental health conditions. Finally,

the qualitative sample size was modest and derived from participants willing to share their experiences, which may not fully reflect the diversity of returnees lived realities.

Despite these limitations, the study provides valuable and timely insights into the mental health challenges of returned migrant workers and offers evidence to inform policy and future research.

Qualitative data were derived from a relatively small sample of eight, which limits representativeness. Nonetheless, data saturation was achieved and the narratives provided rich contextual understanding complementing the survey results. Future research should expand the qualitative sample to include more diverse occupations and provinces.

Self-reporting in the study may be influenced by social desirability bias, particularly given cultural norms discouraging open discussion of emotional distress among men. Triangulation with observational or clinical data could improve validity.

Finally, the study focused solely on Cambodian migrant workers returning from Thailand. Consequently, the results should not be generalized to returnees from other migration destinations, as labor arrangements, recruitment pathways and reintegration contexts may vary.
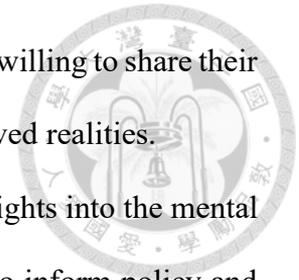
CHAPTER 6. CONCLUSIONS AND RECOMMENDATIONS
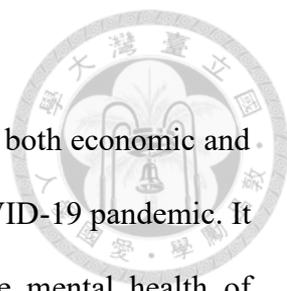
This study highlights the urgent need for support systems that tackle both economic and psychosocial challenges, especially during global crises like the COVID-19 pandemic. It provides an in-depth examination of the risk factors affecting the mental health of Cambodian migrant workers who returned from Thailand during this period. Through the quantitative and qualitative approach, the research highlights the interconnected challenges of migration, occupational risks and reintegration faced by this vulnerable population as follows: Mental health outcomes: High prevalence of anxiety, depression and stress among returned workers, with significant associations between mental health and factors such as gender, education level, income and occupational sector. Female workers were particularly vulnerable, facing higher rates of mental health issues due to gender-based violence, caregiving burdens and societal expectations. The impact of the COVID-19 pandemic has exacerbated pre-existing vulnerabilities, leading to job losses, social isolation and financial instability. Returned workers reported heightened stress and discrimination, particularly during reintegration into their communities. Workers in sectors like agriculture, construction and domestic work faced significant physical and psychological hazards, contributing to poor mental health outcomes. Unemployment, lack of social support and strained family dynamics emerged as key barriers to successful reintegration.

Based on the findings from the study, the following recommendations include the critical need for targeted interventions to address the complex mental health and reintegration challenges faced by returned Cambodian migrant workers. The successful implementation of these recommendations requires collaboration among NGOs, governmental ministries, host countries and international organizations. By addressing mental health and socio-economic needs of returned Cambodian migrant workers, these
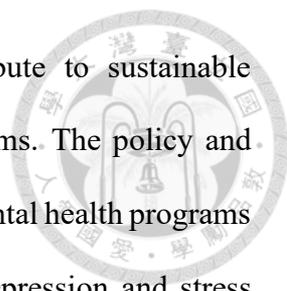
actions will not only improve their well-being but also contribute to sustainable development in Cambodia and strengthen regional migration systems. The policy and institutional support to develop accessible and culturally sensitive mental health programs for returned migrant workers, with specific support for anxiety, depression and stress management, including reintegration programs to implement comprehensive reintegration programs that address employment opportunities, financial stability and social reintegration and gender-sensitive interventions to adapt support programs to address the unique challenges faced by female workers, including protection against gender-based violence and access to mental health services.

The policy recommendations should be centered on the importance of a collaborative approach. The existing initiatives all highlighted the inter-ministerial collaboration with the Ministry of Health (MoH), the Ministry of Labor and Vocational Training (MLVT), the Ministry of Interior and the General Department of Immigration should be working together to: (1) integrate mental health screenings into routine checkups for returned migrants at health centers, drop-in centers or checkpoint centers; (2) train the MLVT staff to identify potential mental health issues during job placement consultations and (3) develop referral pathways to culturally sensitive mental health professionals within the MoH or through partnerships with NGOs.

Recommendations to close partnerships and collaborations with local NGOs can also help address resource limitations and offer additional support. NGOs can provide culturally appropriate mental health interventions and peer support groups at the community level (as suggested by the provincial health department). On the other hand, the IOM's capacity-building expertise in the country can be leveraged to train local service providers, including those affiliated with NGOs and ministries, in collaboration. With these recommendations, stakeholders can work toward improving mental health services for

returned Cambodian migrant workers, addressing their unique needs and promoting their overall well-being and successful reintegration into society.

The recommendations to collaboration partners are as follows: the relevant ministries, host countries and stakeholders/NGOs:

Relevant Ministries

Ministry of Labor and Vocational Training (MLVT): (1) Strengthen pre-departure orientation programs to include mental health awareness, coping strategies and information on labor rights in host countries and (2) Establish dedicated reintegration centers to support returned workers with employment assistance, mental health services and financial counseling.

Ministry of Health (MoH): (1) Integrate mental health services into primary healthcare facilities, ensuring returned workers can access affordable care and (2) Train healthcare workers to identify and treat common mental health issues such as anxiety and depression.

Ministry of Interior (MoI): (1) Enhance data collection systems to monitor the migration and reintegration of workers, enabling targeted interventions; and (2) Facilitate partnerships with NGOs and international organizations to address the needs of undocumented and irregular migrants.

Ministry of Women's Affairs (MoWA): Implement programs that empower female workers through vocational training, leadership opportunities and access to legal and psychological support.

Ministry of Interior (MoI): (1) Enhance data collection systems to monitor the migration and reintegration of workers, enabling targeted interventions and (2) Facilitate partnerships with NGOs and international organizations to address the needs of undocumented and irregular migrants.

Stakeholders/International Organizations

Provide technical and financial support to the Cambodian government and local NGOs to scale up mental health services and reintegration programs. Conduct regional studies to monitor the long-term impact of migration and reintegration on workers' mental health. Advocate for the inclusion of migrant workers' needs in global development agendas, and facilitate partnerships between governments, NGOs and host countries to develop holistic solutions addressing both migration and reintegration challenges.

These study recommendations further research to investigate long-term mental health outcomes among returned workers to assess the effectiveness of reintegration programs and policy interventions and explore the intersection of mental health and occupational risks in other sectors and regions to broaden the evidence base. Future research should consider longitudinal studies to explore the long-term mental health outcomes of returned migrant workers and the effectiveness of interventions designed to support them. In addition, to continue to explore the complex relationship between migration, with a particular focus on the long-term effects of migration and reintegration. Further studies could also investigate the role of social support networks and cultural factors in shaping mental health outcomes among migrant workers. By doing so, this can better understand the needs of migrant workers and develop effective interventions to support their well-being. Based on the findings of this study, it is recommended that the National Taiwan University (NTU), in collaboration with local and international NGOs in Cambodia (RHAC) organization, relevant ministries and other key stakeholders, develop and conduct more comprehensive nationwide studies on mental health and reintegration experiences of returned and pre-departure migrant workers. Expanding the scope of research beyond the selected provinces would help capture broader patterns and region-specific challenges, as well as provide more robust evidence to inform national policy

and intervention strategies. Such a collaborative effort would be instrumental in shaping targeted, culturally appropriate and sustainable mental health and social support services for vulnerable migrant populations across Cambodia.
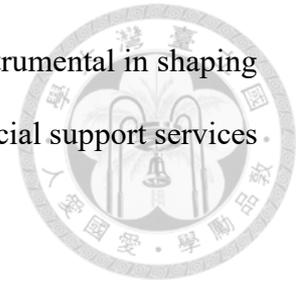
Directions for Future Research

Building on these limitations, several avenues for future inquiry are recommended.

Longitudinal design: Future studies should apply the longitudinal or panel design to track psychological well-being across migration stages pre-departure, employment abroad, return and long-term reintegration. Such designs would clarify causal pathways and temporal patterns of resilience or deterioration (Chan & Higgs, 2020).

Culturally grounded measurement: Developing and validating Khmer-language mental-health instruments that incorporate local idioms of distress would enhance diagnostic accuracy. Collaborations between psychologists, anthropologists and Buddhist scholars could generate culturally sensitive tools aligned with community perceptions (Hinton et al., 2012; WHO, 2021).

Intersectional and comparative approaches: Further research should examine how gender intersects with other factors such as age, education and migration history to shape mental-health outcomes. Comparative studies across originating provinces or destination countries could identify context-specific risk and protective factors.

Evaluating intervention effectiveness: Rigorous evaluation of psychosocial and livelihood programs, including randomized or quasi-experimental designs, is essential to determine which reintegration strategies most effectively reduce distress and improve well-being. Collaboration with MLVT and NGOs could facilitate such applied research (ILO, 2022; IOM, 2023).

Incorporating family and community perspectives: Future qualitative studies should include not only returnees but also family members, community leaders and employers

to capture the relational ecosystem influencing reintegration. This aligns with socioecological models emphasizing the family and community as key determinants of migrant well-being (Bronfenbrenner, 1994; WHO, 2021).

Therefore, future research should adopt multi-level, longitudinal and participatory designs that capture both the structural realities and cultural meanings of migration and return. By deepening empirical evidence and theoretical refinement such work can guide the creation of inclusive and sustainable reintegration systems in Cambodia and across the Lower Mekong region.
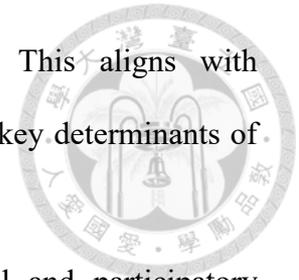
Bibliography

Abas, M., Tangchonlatip, K., Punpuing, S., Jirapramukpitak, T., Darawuttimaprakorn, N., Prince, M., & Flach, C. (2013). Migration of Children and Impact on Depression in Older Parents in Rural Thailand, Southeast Asia. *JAMA Psychiatry (Chicago, Ill.)*, *70*, 226–233. https://doi.org/10.1001/jamapsychiatry.2013.271

Acharya, S. R., Moon, D. H., Chun, J. H., & Shin, Y. C. (2022). COVID-19 and mental health: Anxiety disorders among immigrants due to the COVID-19 outbreak in South Korea. *International Journal of Psychiatry in Medicine*, *57*(4), 323–337. https://doi.org/10.1177/00912174211042695

Acharyya, B. C., Dutta, M., Meur, S., Das, D., & Acharyya, S. (2022). Acute Pancreatitis in COVID-19-associated Multisystem Inflammatory Syndrome of Children-A Single Center Experience. *JPGN Reports*, *3*(1), e150. https://doi.org/10.1097/PG9.0000000000000150

adbheadhoncho. (2022). *Greater Mekong Subregion Border Areas Health Project* (Cambodia) [Text]. https://www.adb.org/projects/53290-001/main

Aktas, E., Bergbom, B., Godderis, L., Kreshpaj, B., Marinov, M., Mates, D., McElvenny, D. M., Mehlum, I. S., Milenkova, V., Nena, E., & Glass, D. C. (2022). Migrant workers occupational health research: An OMEGA-NET working group position paper. *International Archives of Occupational and Environmental Health*, *95*(4), 765–777. https://doi.org/10.1007/s00420-021-01803-x

Alegría, M., Álvarez, K., & DiMarzio, K. (2017). Immigration and Mental Health. *Current Epidemiology Reports*, *4*(2), 145–155. https://doi.org/10.1007/s40471-017-0111-2
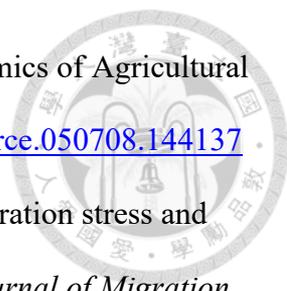
Alston, J., Pardey, P., James, J., & Andersen, M. (2009). The Economics of Agricultural R&D. *Agribusiness*, *1*. https://doi.org/10.1146/annurev.resource.050708.144137

Apputhurai, P., Nguyen, T., Somchai, K., & Lee, J. (2024). Post-migration stress and psychological outcomes among Southeast Asian workers. *Journal of Migration and Health*, *8*(2), 145–159. (PDF) The Relationship Between Post-Migration Stress and Psychological Disorders in Refugees and Asylum Seekers

Apputhurai, P., Palsson, O. S., Bangdiwala, S. I., Sperber, A. D., Mikocka-Walus, A., & Knowles, S. R. (2024). Confirmatory validation of the patient health questionnaire—4 (PHQ-4) for gastrointestinal disorders: A large-scale cross-sectional survey. *Journal of Psychosomatic Research*, *180*, 111654. https://doi.org/10.1016/j.jpsychores.2024.111654

Askari, S., Montazerin, N., & Zarandi, M. H. F. (2020). Modeling energy flow in natural gas networks using time series disaggregation and fuzzy systems tuned by particle swarm optimization. *Applied Soft Computing*, *92*, 106332. https://doi.org/10.1016/j.asoc.2020.106332

Blackmore, R., Boyle, J. A., Fazel, M., Ranasinha, S., Gray, K. M., Fitzgerald, G., Misso, M., & Gibson-Helm, M. (2020). The prevalence of mental illness in refugees and asylum seekers: A systematic review and meta-analysis. *PLoS Medicine*, *17*(9), e1003337. https://doi.org/10.1371/journal.pmed.1003337

Bloch, A. (2007). Methodological Challenges for National and Multi-Sited Comparative Survey Research. *Journal of Refugee Studies*, *20*(2), 230–247. https://doi.org/10.1093/jrs/fem002

Boonchalaksi, W., Chamratrithirong, A., & Huguet, J. W. (2012). Has Permanent Settlement of Temporary Migrant Workers in Thailand Begun? *Asian and*
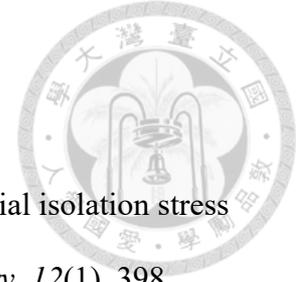
Pacific Migration Journal, *21*(3), 387–404.

https://doi.org/10.1177/011719681202100306

Brandt, L., Liu, S., Heim, C., & Heinz, A. (2022). The effects of social isolation stress

and discrimination on mental health. *Translational Psychiatry*, *12*(1), 398.

https://doi.org/10.1038/s41398-022-02178-4

Braun, V., & Clarke, V. (2021). *Thematic Analysis: A Practical Guide*. SAGE.

https://uk.sagepub.com/en-gb/eur/thematic-analysis/book248481

Bronfenbrenner, U. (1994). Ecological models of human development. In T. Husen &

T. N. Postlethwaite (Eds.), *International Encyclopedia of Education* (pp. 1643–

1647). Pergamon.

https://www.sciencedirect.com/referencework/9780080448947/international-

encyclopedia-of-education

Bureau international du travail (Ed.). (2021). *ILO global estimates on international*

migrant workers: Results and methodology (3rd ed). International labour

organization. https://www.ilo.org/publications/ilo-global-estimates-

international-migrant-workers-%E2%80%93-results-and-1

Bustamante, L. H. U., Cerqueira, R. O., Leclerc, E., & Brietzke, E. (2018). Stress,

trauma, and posttraumatic stress disorder in migrants: A comprehensive review.

Revista Brasileira de Psiquiatria, *40*(2), 220–225. https://doi.org/10.1590/1516-

4446-2017-2290

Bylander, M. (2017). Credit and the Migration Experience: Evidence from Cambodia.

Population Research and Policy Review, *36*(4), 527–552.

https://doi.org/10.1007/s11113-015-9367-8

Byrne, B. M. (2016). *Structural Equation Modeling with AMOS: Basic Concepts,*

Applications, and Programming. Routledge.

https://www.routledge.com/Structural-Equation-Modeling-with-AMOS-Basic-Concepts-Applications-and-Programming/Byrne/p/book/9781138797031
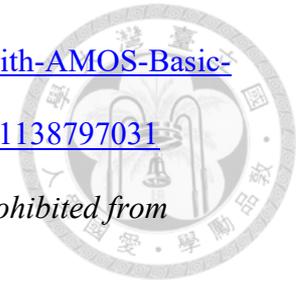
Cambodianess. (2020, July 13). *Cambodian migrant workers are prohibited from returning to their jobs abroad*. Cambodianess. https://cambodianess.com/article/cambodian-migrant-workers-are-prohibited-from-returning-to-their-jobs-abroad

Carling, J., & Eriksen, T. (2019). Return migration and the transnational circulation of care. *Migration Studies*, *7*(3), 323–340. https://doi.org/10.1093/migration/mnz004

CCC Cambodia. (2022). Cambodia's position paper on the COVID-19 pandemic and vaccination. Civil Society Platform for COVAX (CCC Cambodia). https://gcap.global/wp-content/uploads/2023/03/Cambodia-Country-Position-Paper-on-COVID-19-Vaccines-2022.pdf

Chan, S., & Higgs, E. (2020). Reintegration stress among Thai return migrants. *Asian Population Studies*, *16*(3), 278–295. https://www.ilo.org/sites/default/files/wcmsp5/groups/public/@asia/@ro-bangkok/@sro-bangkok/documents/publication/wcms_733917.pdf

Chand, S. P., & Marwaha, R. (2025). Anxiety. In *StatPearls*. StatPearls Publishing. http://www.ncbi.nlm.nih.gov/books/NBK470361/

Chatmon, B. N. (2020). Males and Mental Health Stigma. *American Journal of Men's Health*, *14*(4), 1557988320949322. https://doi.org/10.1177/1557988320949322

Chen, W., Hall, B. J., Ling, L., & Renzaho, A. M. (2015). Pre-migration and Post-migration Factors Associated with Mental Health in Humanitarian Migrants in Australia and the Moderation Effect of Post-migration Stressors: Findings from
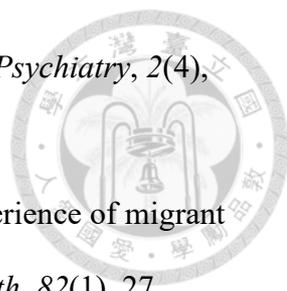
the First Wave Data of the BNLA Cohort Study. *The Lancet Psychiatry*, *2*(4), 296–306. https://doi.org/10.1016/S2215-0366(15)00033-1

Cho, H.-J., Kang, K., & Park, K.-Y. (2024). Health and medical experience of migrant workers: Qualitative meta-synthesis. *Archives of Public Health*, *82*(1), 27. https://doi.org/10.1186/s13690-024-01254-z

Christodoulaki, A., Baralou, V., Konstantakopoulos, G., & Touloumi, G. (2022). Validation of the Patient Health Questionnaire-4 (PHQ-4) to screen for depression and anxiety in the Greek general population. *Journal of Psychosomatic Research*, *160*, 110970. https://doi.org/10.1016/j.jpsychores.2022.110970

Clemente-Suárez, V. J., Martínez-González, M. B., Benitez-Agudelo, J. C., Navarro-Jiménez, E., Beltran-Velasco, A. I., Ruisoto, P., Diaz Arroyo, E., Laborde-Cárdenas, C. C., & Tornero-Aguilera, J. F. (2021). The Impact of the COVID-19 Pandemic on Mental Disorders. *A Critical Review. International Journal of Environmental Research and Public Health*, *18*(19). https://doi.org/10.3390/ijerph181910041

Creswell, J. W., & Plano Clark, V. L. (2017). *Designing and Conducting Mixed Methods Research* (3, Ed.). SAGE Publications. https://us.sagepub.com/en-us/nam/designing-and-conducting-mixed-methods-research/book241842

de-Assis, M. P., Barcella, R. C., Padilha, J. C., Pohl, H. H., & Krug, S. B. F. (2021). Health Problems in Agricultural Workers Occupationally Exposed to Pesticides. *Revista Brasileira de Medicina Do Trabalho*, *18*(3), 352–363. https://doi.org/10.47626/1679-4435-2020-532

de Haan, A. (2010). The migration and development relationship revisited. *Journal of International Development*, *22*(2), 276–292. https://doi.org/10.1002/jid.1687

de Haas, H. (2021). A theory of migration: The aspirations-capabilities framework. *Comparative Migration Studies*, *9*(1), 8. https://doi.org/10.1186/s40878-020-00210-4

Derks, A. (2010). Migration and morality: The economy of migration in Cambodia. *Asian Journal of Social Science*, *38*(6), 835–855. https://doi.org/10.1163/156853110X531826

Embrace. (2022). *The pros and cons of migration*. https://www.embraceni.org/migration/the-pros-and-cons-of-migration/

Doshi, T., Gupta, R., Singh, A., & Sharma, N. (2020). *Assessing the psychological impact of COVID-19 on migrant workers: A cross-sectional study from India.* Journal of Migration and Health, 1, 100005. https://doi.org/10.1016/j.jmh.2020.100005

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of Convenience Sampling and Purposive Sampling. *American Journal of Theoretical and Applied Statistics*, *5*(1), 1–4. https://doi.org/10.11648/j.ajtas.20160501.11

Farmer, P. (2004). An anthropology of structural violence. *Current Anthropology*, *45*(3), 305–325. https://doi.org/10.1086/382250

Faugier, J., & Sargeant, M. (1997). Sampling Hard-to-Reach Populations. *Journal of Advanced Nursing*, *26*(4), 790–797. https://doi.org/10.1046/j.1365-2648.1997.00371.x

Festinger, L. (1954). A theory of social comparison processes. *Human Relations*, *7*(2), 117–140. https://doi.org/10.1177/001872675400700202

Garcini, L. M., Daly, R., Chen, N., Mehl, J., Pham, T., Phan, T., Hansen, B., & Kothare, A. (2021). Undocumented immigrants and mental health: A systematic review
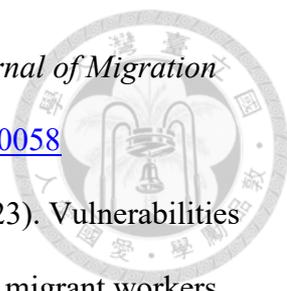
of recent methodology and findings in the United States. *Journal of Migration and Health*, *4*, 100058. https://doi.org/10.1016/j.jmh.2021.100058

Ghimire, J., Nepal, R., Crowley, J., Ghimire, D., & Guragain, S. (2023). Vulnerabilities and risk perceptions of contracting COVID-19 among Nepali migrant workers. *Social Sciences & Humanities Open*, *7*, 100486. https://doi.org/10.1016/j.ssaho.2023.100486

Gierk, B., Kohlmann, S., Kroenke, K., Spangenberg, L., Zenger, M., Brähler, E., & Löwe, B. (2014). The Somatic Symptom Scale–8 (SSS-8): A Brief Measure of Somatic Symptom Burden. *JAMA Internal Medicine*, *174*(3), 399–407. https://doi.org/10.1001/jamainternmed.2013.12179

Gilgun, J. (2020). *Deductive Qualitative Analysis and Grounded Theory: Sensitizing Concepts and Hypothesis-Testing* (pp. 107-122.). https://doi.org/10.4135/9781526485656.n7

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice-Hall. https://archive.org/details/stigmanotesonman00goff

Hargreaves, S., Rustage, K., Nellums, L., McAlpine, A., Pocock, N., Devakumar, D., Aldridge, R., Abubakar, I., Kristensen, K., Himmels, J., Friedland, J., & Zimmerman, C. (2019). Occupational health outcomes among international migrant workers: A systematic review and meta-analysis. *The Lancet Global Health*, *7*. https://doi.org/10.1016/S2214-109X(19)30204-9

Harkins, B., & Aylward, L. (2016). *Managing labour migration in ASEAN: Protecting migrant workers through origin and destination country collaboration*. International Labour Organization. https://www.migratingoutofpoverty.org/documents/harkins-labour-migration-in-the-asean-region.pdf

Harvard Humanitarian Initiative. (2024). *KoboToolbox for window*. KoboToolbox. https://www.kobotoolbox.org/

Hasan, S. I., Yee, A., Rinaldi, A., Azham, A. A., Mohd Hairi, F., & Amer Nordin, A. S. (2021). Prevalence of common mental health issues among migrant workers: A systematic review and meta-analysis. *PLOS ONE*, *16*(12), 0260221. https://doi.org/10.1371/journal.pone.0260221

Hing, V., Lun, P., & Oeur, I. (2011). *Irregular Migration from Cambodia: A Study of Recruitment Channels and Working Conditions of Cambodian Migrants in Thailand*. Cambodia Development Resource Institute (CDRI). https://www.researchgate.net/publication/254441862_Irregular_Migration_from _Cambodia_Characteristics_Challenges_and_Regulatory_Approach

Hintermeier, M., Gottlieb, N., Rohleder, S., Oppenberg, J., Baroudi, M., Pernitez-Agan, S., Lopez, J., Flores, S., Mohsenpour, A., Wickramage, K., & Bozorgmehr, K. (2024). COVID-19 among migrants, refugees, and internally displaced persons: Systematic review, meta-analysis and qualitative synthesis of the global empirical literature. *eClinicalMedicine*, *74*. https://doi.org/10.1016/j.eclinm.2024.102698

Hinton, D. E., Pich, V., Chhean, D., Safren, S. A., & Pollack, M. H. (2012). Somatic-focused trauma interventions for traumatized refugees: A case study. *Transcultural Psychiatry*, *49*(3–4), 367–388. https://doi.org/10.1037/0033-3204.43.4.491

Hochschild, A. R. (2000). Global care chains and emotional surplus value. In W. Hutton & A. Giddens (Eds.), *On the Edge: Living with Global Capitalism* (pp. 130–146). Jonathan Cape. https://www.penguin.co.uk/books/353/35355/on-the-edge/9780224064752.html
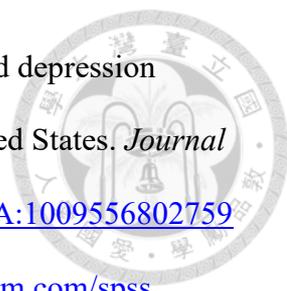
Hovey, J. D., & Magaña, C. (2000). Acculturative stress, anxiety, and depression among Mexican immigrant farmworkers in the midwest United States. *Journal of Immigrant Health*, *2*(3), 119–131. https://doi.org/10.1023/A:1009556802759

IBM Corp. (2020). *IBM SPSS Statistics for Windows*. https://www.ibm.com/spss

ILO. (2005). Migration and Development. In *International Organization for Migration*. https://www.iom.int/migration-and-development-2005

ILO. (2015). *ILO global estimates on migrant workers | International Labour Organization*. https://www.ilo.org/publications/ilo-global-estimates-migrant-workers

ILO. (2020). *Safety and health for migrant workers | International Labour Organization*. https://www.ilo.org/resource/safety-and-health-migrant-workers

ILO. (2021). *ILO Monitor: COVID-19 and the world of work (7th edition)*. International Labour Organization. https://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/documents/briefingnote/wcms_767028.pdf

ILO. (2021). *Risks and rewards: Outcomes of labour migration in South-East Asia | International Labour Organization*. https://www.ilo.org/publications/risks-and-rewards-outcomes-labour-migration-south-east-asia

ILO. (2022). *Migrant reintegration in Cambodia and Thailand: Policy review and recommendations*. International Labour Organization. https://www.ilo.org/sites/default/files/wcmsp5/groups/public/%40asia/%40ro-bangkok/%40sro-bangkok/documents/publication/wcms_733917

ILO. (2022). *Regional Study on Return and Reintegration of Migrant Workers in ASEAN Member States*. https://www.ilo.org/asia/publications/WCMS_844390/lang--en/index.htm

ILO. (2023). *ILO Monitor: COVID-19 and the world of work (7th edition)*. International

Labour Organization.

https://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/documents/briefingnote/wcms_767028.pdf

IOM. (2019). *Cambodian Labour Migrants in Thailand: IOM Study*. International

Organization for Migration. https://www.iom.int/news/cambodian-labour-migrants-thailand-iom-study

IOM. (2019). *Migration in Cambodia: Internal and Cross-Border Movement*.

International Organization for Migration (IOM).

https://www.iom.int/news/cambodian-labour-migrants-thailand-iom-study

IOM. (2020). World Migration Report 2020. *IOM.Int*.

https://worldmigrationreport.iom.int/wmr-2020-interactive/

IOM. (2021). *COVID-19 Impact on Returning Migrants in Cambodia*.

https://cambodia.iom.int/resources/covid-19-impact-returning-migrants-cambodia

IOM. (2022). *Labour Migration and the Health of Migrant Workers in the ASEAN*

Region. https://publications.iom.int

IOM. (2023). *Asia–Pacific Migration Data Report*.

https://publications.iom.int/books/asia-pacific-migration-data-report-2023

IOM. (2023). *Return and reintegration in Southeast Asia: Country assessment*.

International Organization for Migration.

https://publications.iom.int/books/return-and-reintegration-key-highlights-2023

IOM (Ed.). (2024). *Migration in the Kingdom of Cambodia: A country profile 2023*.

IOM. https://publications.iom.int/books/migration-kingdom-cambodia-country-profile-2023

IOM. (2024). *New rights for domestic workers in Thailand | International Labour Organization*. https://www.ilo.org/resource/article/new-rights-domestic-workers-thailand

Irudaya Rajan, S., & Arcand, J.-L. (2024). COVID-19 return migration phenomena: Experiences from South and Southeast Asia. *Journal of Ethnic and Migration Studies, 49*(20), 5133–5152. https://doi.org/10.1080/1369183X.2024.2268963

Jesperson, S., Alffram, H., Denney, L., & Domingo, P. (2022). *Labour migration in Cambodia, Laos, Thailand and Vietnam: Migrants' vulnerabilities and capacities across the labour migration cycle*. https://doi.org/10.1016/S0033-3182(09)70864-3

Ki-il, L. (2022). *Korean government announces new measures against Covid-19*. https://koreajoongangdaily.joins.com/2022/07/20/national/socialAffairs/Korea-Covid19-coronavirus/20220720135815673.html

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., Hassan, G., Rousseau, C., & Pottie, K. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *CMAJ: Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne*, *183*(12), 959–967. https://doi.org/10.1503/cmaj.090292

Kiss, L., Pocock, N. S., Naisanguansri, V., Suos, S., Dickson, B., Thuy, D., Koehler, J., Sirisup, K., Pongrungsee, N., Nguyen, V. A., Borland, R., Dhavan, P., & Zimmerman, C. (2015). Health of men, women, and children in post-trafficking services in Cambodia, Thailand, and Vietnam: An observational cross-sectional study. *The Lancet Global Health*, *3*(3), 154–161. https://doi.org/10.1016/S2214-109X(15)70016-1

Kleinman, A. (1982). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry*. University of California Press. https://www.ucpress.edu/book/9780520045118/patients-and-healers-in-the-context-of-culture
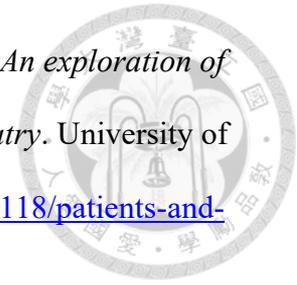
Kluge, H. H. P., Jakab, Z., Bartovic, J., D'Anna, V., & Severoni, S. (2020). Refugee and migrant health in the COVID-19 response. *Lancet (London, England)*, *395*(10232), 1237–1239. https://doi.org/10.1016/S0140-6736(20)30791-1

Koseoglu Ornek, O., Waibel, J., Wullinger, P., & Weinmann, T. (2022). Precarious employment and migrant workers' mental health: A systematic review of quantitative and qualitative studies. *Scandinavian Journal of Work, Environment & Health*, *48*(5), 327–350. https://doi.org/10.5271/sjweh.4019

Kroenke, K., Spitzer, R. L., Williams, J. B. W., & Löwe, B. (2009). An ultra-brief screening scale for anxiety and depression: The PHQ-4. *Psychosomatics*, *50*(6), 613–621. https://doi.org/10.1176/appi.psy.50.6.613

Kroenke, K., Spitzer, R. L., Williams, J. B. W., & Löwe, B. (2010). The Patient Health Questionnaire Somatic, Anxiety, and Depressive Symptom Scales: A systematic review. *General Hospital Psychiatry*, *32*(4), 345–359. https://doi.org/10.1016/j.genhosppsych.2010.03.006

Kroenke, K., & Williams, J. B. W. (2009). *An Ultra-Brief Screening Scale for Anxiety and Depression: The PHQ–4*. https://doi.org/10.1016/S0033-3182(09)70864-3

Landsbergis, P. A., Grzywacz, J. G., & LaMontagne, A. D. (2014). Work organization, job insecurity, and occupational health disparities. *American Journal of Industrial Medicine*, *57*(5), 495–515. https://doi.org/10.1002/ajim.22126

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. Springer.

Lee, J., & Kim, C. (2024). *Research finds 93.6% of migrant worker deaths in South Korea go unrecorded*. Business & Human Rights Resource Centre. https://www.business-humanrights.org/en/latest-news/s-korea-research-finds-936-of-migrant-worker-deaths-in-south-korea-go-unrecorded/

Liem, A., Wang, C., Wariyanti, Y., Latkin, C. A., & Hall, B. J. (2020). The neglected health of international migrant workers in the COVID-19 epidemic. *The Lancet. Psychiatry*, *7*(4), e20. https://doi.org/10.1016/S2215-0366(20)30076-6

Lindert, J., Ehrenstein, O. S. von, Priebe, S., Mielck, A., & Brähler, E. (2009). Depression and anxiety in labor migrants and refugees—A systematic review and meta-analysis. *Social Science & Medicine*, *69*(2), 246–257. https://doi.org/10.1016/j.socscimed.2009.04.032

Lo Bue, M. C., Le, T. T. N., Santos Silva, M., & Sen, K. (2022). Gender and vulnerable employment in the developing world: Evidence from global microdata. *World Development*, *159*, 106010. https://doi.org/10.1016/j.worlddev.2022.106010

Loganathan, T., Amirah Zafirah Zaini, Watinee Kunpeuk, Rapeepong Suphanchaimat, Huso Yi, Aysha Farwin, & Hazreen Abdul Majid. (2024). Challenges faced by migrant populations in complying with public health measures during the COVID-19 pandemic in Malaysia: A qualitative study. *BMJ Public Health*, *2*(2), e000923. https://doi.org/10.1136/bmjph-2024-000923

Löwe, B., Wahl, I., Rose, M., Spitzer, C., Glaesmer, H., Wingenfeld, K., Schneider, A., & Brähler, E. (2010). A 4-item measure of depression and anxiety: A validation and standardization of the Patient Health Questionnaire-4 (PHQ-4) in the general population. *Journal of Affective Disorders*, *122*(1–2), 86–95. https://doi.org/10.1016/j.jad.2009.06.019

Mackenzie, A., & Ssewakiryanga, R. (2010). *Researching hard-to-reach populations: Methodological reflections* (Working Paper No. 321). Overseas Development Institute (ODI). https://cdn.odi.org/media/documents/6083.pdf

Maltoni, B. (2010). *Migration in Cambodia: Internal vs. external flows*. International Organization for Migration (IOM). https://www.iom.int/sites/g/files/tmzbdl486/files/jahia/webdav/shared/shared/mainsite/policy_and_research/gcps/vietnam_internal_external_flows.pdf

Maresca, T. (2022). *South Korea to lift most COVID-19 restrictions next week—UPI.com*. UPI. https://www.upi.com/Top_News/World-News/2022/04/15/COVID-19-restrictions-lifted-mask-mandate/1141650018362/

McKenzie, S. K., Oliffe, J. L., Black, A., & Collings, S. (2022). Men's Experiences of Mental Illness Stigma Across the Lifespan: A Scoping Review. *American Journal of Men's Health*, *16*(1), 15579883221074789. https://doi.org/10.1177/15579883221074789

Meyer, D., & Avery, L. (2009). Excel as a Qualitative Data Analysis Tool. *Field Methods*, *21*, 91–112. https://doi.org/10.1177/1525822X08323985

Meyer, S. R., Roberts, B., & DeCamp, M. (2014). Labour migration and mental health in Cambodia: A qualitative study. *International Journal of Mental Health Systems*, *8*(1), 1–11. https://doi.org/10.1186/1752-4458-8-44

Ministry of Health. (2024). *Final Report*. https://moh.gov.kh/?lang=en

Ministry of Health. (2025). *MOH web portal*. https://hismohcambodia.org/public/contact-us.php?pid=9

Ministry of Interior, R. G. of C. (2023). *Administrative Divisions and Local Governance Structure of Cambodia*. Ministry of Interior. https://www.interior.gov.kh/en/law_and_regulation

MoFA. (2025). *Information for visitor—Ministry of Foreign Affairs and International Cooperation*. https://www.mfaic.gov.kh/informationforvisitor

MLVT. (2021). *Ministry of Labour and Vocational Training*. https://www.mlvt.gov.kh/

MLVT. (2024). *National Labour Migration Policy 2024–2030*. Royal Government of Cambodia. https://www.mlvt.gov.kh/index.php/en/policies-and-plan/

MLVT. (2024). *Remittances from Cambodians abroad hit $2.95 billion in 2024*. https://www.phnompenhpost.com/national/remittances-from-cambodians-abroad-hit-2-95-billion-in-2024

Moyce, S. C., & Schenker, M. (2024). Migrant Workers and Their Occupational Health and Safety. *Annual Review of Public Health*, *39*(1), 351–365. https://doi.org/10.1146/annurev-publhealth-040617-013714

Murzakulova, A., Dessalegn, M., & Phalkey, N. (2021). Examining migration governance: Evidence of rising insecurities due to COVID-19 in China, Ethiopia, Kyrgyzstan, Moldova, Morocco, Nepal and Thailand. *Comparative Migration Studies*, *9*(1), 44. https://doi.org/10.1186/s40878-021-00254-0

Nakao, M. (2010). Work-related stress and psychosomatic medicine. *BioPsychoSocial Medicine*, *4*(1), 4. https://doi.org/10.1186/1751-0759-4-4

Nampa, W., Mudita, I., Riwu Kaho, N., Widinugraheni, S., & Natonis, R. (2020). The KoBoCollect for Research Data Collection and Management (An experience in researching the Socio-Economic Impact of Blood Disease in Banana. *SOCA: Jurnal Sosial, Ekonomi Pertanian*, *14*, 545. https://doi.org/10.24843/SOCA.2020.v14.i03.p15

Nanjundeswaraswamy, D., & Divakara, S. (2021). DETERMINATION OF SAMPLE

SIZE AND SAMPLING METHODS IN APPLIED RESEARCH. *Proceedings*

on Engineering Sciences, *3*, 25–32. https://doi.org/10.24874/PES03.01.003

National Institute of Statistics, M. of P. (2023). *General Population Census of*

Cambodia 2023. National Institute of Statistics. https://nis.gov.kh/en/main-page-

2

Newman, M. G., Llera, S. J., Erickson, T. M., Przeworski, A., & Castonguay, L. G.

(2013). Worry and generalized anxiety disorder: A review and theoretical

synthesis of evidence on nature, etiology, mechanisms, and treatment. *Annual*

Review of Clinical Psychology, *9*, 275–297. https://doi.org/10.1146/annurev-

clinpsy-050212-185544

Newsroom, T. A. T. (2022). Thailand lifts nationwide COVID-19 restrictions with

immediate effect. *TAT Newsroom*. https://www.tatnews.org/2022/06/thailand-

lifts-nationwide-covid-19-restrictions-with-immediate-effect/

NIS. (2021). *National Institute of Statistics*. https://www.nis.gov.kh/index.php/km/

Novotney, A. (2019). *The risks of social isolation*. Https://Www.Apa.Org.

https://www.apa.org/monitor/2019/05/ce-corner-isolation

Obeid, S., Hemade, A., Malaeb, D., Sakr, F., Dabbous, M., Xu, J., Ying, Y., Jiang, C.,

Meng, R., Fekih-Romdhane, F., & Hallit, S. (2024). Psychometric properties of

the ultra-brief self-report Patient Health Questionnaire-4 (PHQ-4) to assess

anxiety and depression in Arabic-speaking adults. *BMC Psychiatry*, *24*(1), 537.

https://doi.org/10.1186/s12888-024-05978-8

OECD. (2024). Migration Outlook 2024. *OECD*.

https://www.oecd.org/en/topics/migration.html

OHCHR. (2022). *Legal Briefing: Cambodia's Law on Preventive Measures Against the Spread of COVID-19 and Other Severe and Dangerous Contagious Diseases as Applied Against Human Rights Defenders, Land Rights Defenders, and Other Citizens*. https://www.licadho-cambodia.org/reports/files/238Analysis_COVID-19_Law_20220929_ENG.pdf

Paitoonpong, S. (2011). *Different Stream, Different Needs, and Impact: Managing International Labor Migration in ASEAN: Thailand (Immigration)*. https://pidswebs.pids.gov.ph/CDN/PUBLICATIONS/pidsdps1128.pdf

Parry, S. J., & Wilkinson, E. (2020). Mental health services in Cambodia: An overview. *BJPsych International*, *17*(2), 29–31. https://doi.org/10.1192/bji.2019.24

Phuong, S., Chan, N., & Vuthy, C. (2021). Social reintegration of Cambodian migrants after return from Thailand. *International Journal of Environmental Research and Public Health*, *25*(2), 8–15. https://www.ide.go.jp/library/English/Publish/Reports/Ec/pdf/201902_02_ch03.pdf

Piper, N. (2017). Feminization of migration and the social dimensions of development. *Third World Quarterly*, *38*(5), 1127–1145. https://doi.org/10.1080/01436590802386427

Porru, S., & Baldo, M. (2022). Occupational Health and Safety and Migrant Workers: Has Something Changed in the Last Few Years? *International Journal of Environmental Research and Public Health*, *19*(15). https://doi.org/10.3390/ijerph19159535

Pourhoseingholi, M. A., Vahedi, M., & Rahimzadeh, M. (2013). Sample size calculation in medical studies. *Gastroenterology and Hepatology from Bed to Bench*, *6*(1), 14–17. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4017475
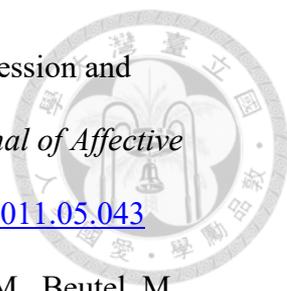
Qiu, P., Caine, E., Yang, Y., Chen, Q., Li, J., & Ma, X. (2011). Depression and associated factors in internal migrant workers in China. *Journal of Affective Disorders*, *134*(1–3), 198–207. https://doi.org/10.1016/j.jad.2011.05.043

Renovanz, M., Soebianto, S., Tsakmaklis, H., Keric, N., Nadji-Ohl, M., Beutel, M., Ringel, F., Wollschläger, D., & Hickmann, A.-K. (2019). Evaluation of the psychological burden during the early disease trajectory in patients with intracranial tumors by the ultra-brief Patient Health Questionnaire for Depression and Anxiety (PHQ-4). Supportive Care in Cancer. *Official Journal of the Multinational Association of Supportive Care in Cancer*, *27*(12), 4469–4477. https://doi.org/10.1007/s00520-019-04718-z

Rice, S., Oliffe, J., Seidler, Z., Borschmann, R., Pirkis, J., Reavley, N., & Patton, G. (2021). Gender norms and the mental health of boys and young men. *The Lancet Public Health*, *6*(8), e541–e542. https://doi.org/10.1016/S2468-2667(21)00138-9

Riza, E., Kalkman, S., Coritsidis, A., Koubardas, S., Vassiliu, S., Lazarou, D., Karnaki, P., Zota, D., Kantzanou, M., Psaltopoulou, T., & Linos, A. (2020). Community-Based Healthcare for Migrants and Refugees: A Scoping Literature Review of Best Practices. *Healthcare (Basel, Switzerland)*, *8*(2). https://doi.org/10.3390/healthcare8020115

Roman, M., & Goschin, Z. (2012). Romanian Immigrants Worldwide: What makes them Return Home? *Journal of Identity and Migration Studies, Volume 6, Number 2, 2012, Pp. 2-17, Http://E-Migration.Ro/Jims/Vol6_No2_2012/Articles/JIMS_Vol6_No2_2012_pp_2_17_ROMAN_GOSCHIN.Pdf*.
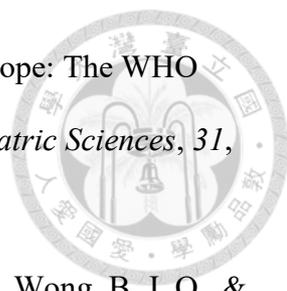
Saraceno, B., & Almeida, J. M. (2022). An outstanding message of hope: The WHO

World Mental Health Report 2022. *Epidemiology and Psychiatric Sciences*, *31*,

53. https://doi.org/10.1017/S2045796022000373

Sartor, O., Flood, E., Beusterien, K., Park, J., Webb, I., MacLean, D., Wong, B. J. O., &

Mark Lin, H. (2015). Health-related quality of life in advanced prostate cancer

and its treatments: Biochemical failure and metastatic disease populations.

Clinical Genitourinary Cancer, *13*(2), 101–112.

https://doi.org/10.1016/j.clgc.2014.08.001

Saw, Y. E., Tan, E. Y., Buvanaswari, P., Doshi, K., & Liu, J. C. (2021). Mental health

of international migrant workers amidst large-scale dormitory outbreaks of

COVID-19: A population survey in Singapore. *Journal of Migration and*

Health, *4*, 100062. https://doi.org/10.1016/j.jmh.2021.100062

Sheikh, A., Payne-Cook, C., Lisk, S., Carter, B., & Brown, J. S. L. (2024). Why do

young men not seek help for affective mental health issues? A systematic review

of perceived barriers and facilitators among adolescent boys and young men.

European Child & Adolescent Psychiatry. https://doi.org/10.1007/s00787-024-
02520-9

Silove, D., Ventevogel, P., & Rees, S. (2017). The contemporary refugee crisis: An

overview of mental health challenges. *World Psychiatry: Official Journal of the*

World Psychiatric Association (WPA), *16*(2), 130–139.

https://doi.org/10.1002/wps.20438

Soeparno, A., Huda, N., & Iskandar, T. (2018). Return migration and mental health

among Indonesian workers. *Asian Population Studies*, *14*(3), 293–310.

Staples, L. G., Dear, B. F., Gandy, M., Fogliati, V., Fogliati, R., Karin, E., Nielssen, O.,

& Titov, N. (2019). Psychometric properties and clinical utility of brief

151

measures of depression, anxiety, and general distress: The PHQ-2, GAD-2, and

K-6. *General Hospital Psychiatry*, *56*, 13–18.

https://doi.org/10.1016/j.genhosppsych.2018.11.003

StataCorp LLC. (2017). *Statistical software for data science | Stata*.

https://www.stata.com/

StataCorp. (2023). *Stata Statistical Software: Release 18*. College Station, TX:

StataCorp LLC | *Stata*. https://www.stata.com/

Stein, M. B. (2004). Public health perspectives on generalized anxiety disorder. *The

Journal of Clinical Psychiatry*, *65 Suppl 13*, 3–7. Public health perspectives on

generalized anxiety disorder - PubMed

Tan, S. E., & Kuschminder, K. (2022). Migrant experiences of sexual and gender based

violence: A critical interpretative synthesis. *Globalization and Health*, *18*(1), 68.

https://doi.org/10.1186/s12992-022-00860-2

Thailand National Statistics Office. (2020, October 11). *COVID-19 Impact on Thai

Labor Market—Open Development Thailand*.

https://thailand.opendevelopmentmekong.net/topics/covid-19-impact-on-thai-

labor-market/

Tittensor, D., & Mansouri, F. (2017). *The Feminisation of Migration? A Critical

Overview* (pp. 11–25). https://doi.org/10.1057/978-1-137-58799-2_2

Tyldum, G., & Johnston, L. (2014). *Applying Respondent-Driven Sampling to Migrant

Populations*. Palgrave Macmillan. https://doi.org/10.1057/9781137363619

Uansri, S., Kunpeuk, W., Julchoo, S., Sinam, P., Phaiyarom, M., & Suphanchaimat, R.

(2023). Perceived Barriers of Accessing Healthcare among Migrant Workers in

Thailand during the Coronavirus Disease 2019 (COVID-19) Pandemic: A

Qualitative Study. *International Journal of Environmental Research and Public Health*, *20*(10). https://doi.org/10.3390/ijerph20105781

UN Women. (2021). *Gendered Impact of COVID-19 on Women Migrant Workers in Southeast Asia*. https://asiapacific.unwomen.org

UNDP. (2020). *Socioeconomic impacts of COVID-19 on migrant workers: Evidence from Cambodia and Thailand*. UNDP. https://www.undp.org/cambodia/publications/covid-19-economic-and-social-impact-assessment-cambodia

UNDP. (2021). *Supporting Economic Recovery for Returned Migrants in Cambodia*. https://www.undp.org/cambodia/news/supporting-economic-recovery-returned-migrants-cambodia

UNHCR. (2023). *UNHCR: Urgent action needed to address dramatic rise in Rohingya deaths at sea*. UNHCR. https://www.unhcr.org/news/briefing-notes/unhcr-urgent-action-needed-address-dramatic-rise-rohingya-deaths-sea

UNICEF. (2022). *Providing protection and hope to Cambodian migrant workers | UNICEF Cambodia*. https://www.unicef.org/cambodia/stories/providing-protection-and-hope-cambodian-migrant-workers

United Nations. (2021). *Information Note #8: UN Cambodia's Support to Returning Migrant Workers in the COVID-19 Response | United Nations in Cambodia*. https://cambodia.un.org/en/132559-information-note-8-un-cambodia%E2%80%99s-support-returning-migrant-workers-covid-19-response, https://cambodia.un.org/en/132559-information-note-8-un-cambodia%E2%80%99s-support-returning-migrant-workers-covid-19-response

Van de Vijver, F. J. R., & Leung, K. (1997). *Methods and Data Analysis for Cross-Cultural Research*. Sage Publications. https://doi.org/10.1017/9781107415188

Virupaksha, H. G., Kumar, A., & Nirmala, B. P. (2014). Migration and mental health: An interface. *Journal of Natural Science, Biology, and Medicine*, *5*(2), 233–239. https://doi.org/10.4103/0976-9668.136141
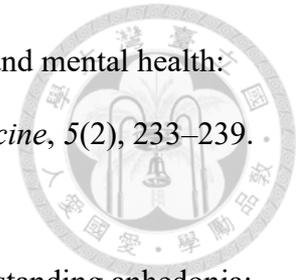
Watson, R., Harvey, K., McCabe, C., & Reynolds, S. (2020). Understanding anhedonia: A qualitative study exploring loss of interest and pleasure in adolescent depression. *European Child & Adolescent Psychiatry*, *29*(4), 489–499. https://doi.org/10.1007/s00787-019-01364-y

WHO. (2020). *Mental Health and Work: Impact, issues and good practices*. Mental Health. https://iris.who.int/items/0c630a18-2573-4eb6-9e73-2941b8fd6815

WHO. (2021). *Guidelines on mental-health promotion and care for refugees and migrants: Global evidence review*. World Health Organization. https://iris.who.int/bitstream/handle/10665/346743/9789240033108-eng.pdf

WHO. (2023). Advice for the public on COVID-19 – World Health Organization. *Www.Who.Int*. https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public?adgroupsurvey=

Win, N., Hounnaklang, N., Tantirattanakulchai, P., & Panza, A. (2024). The Impact of Stressors on Depressive Symptoms Among Youth Myanmar Migrant Workers in Thailand: A Cross-Sectional Study. *Psychology Research and Behavior Management*, *17*, 2653–2663. https://doi.org/10.2147/PRBM.S465535

World Bank. (2021). *Migration & Remittances Overview*. World Bank. https://www.worldbank.org/en/topic/migration/overview

World Bank. (2023). *Overview of migration [Text/HTML*. World Bank. https://www.worldbank.org/en/topic/migration/overview

Worldometer. (2024). Cambodia: COVID-19 coronavirus statistics. https://www.worldometers.info/coronavirus/country/cambodia/

Worldometer. (2024). South Korea: COVID-19 coronavirus statistics.

https://www.worldometers.info/coronavirus/country/south-korea/

Worldometer. (2024). Thailand: COVID-19 coronavirus statistics.

https://www.worldometers.info/coronavirus/country/thailand/

Xiong, J., Lipsitz, O., Nasri, F., Lui, L. M. W., Gill, H., Phan, L., Chen-Li, D.,

Iacobucci, M., Ho, R., Majeed, A., & McIntyre, R. S. (2020). Impact of COVID-

19 pandemic on mental health in the general population: A systematic review.

Journal of Affective Disorders, *277*, 55–64.

https://doi.org/10.1016/j.jad.2020.08.001

Zuithoff, N. P. A., Vergouwe, Y., King, M., Nazareth, I., de Wit, N. J., Geerlings, M. I.,

van Weert, H. C., van der Horst, H. E., Laurant, M. G. H., & Moons, K. G. M.

(2010). Predicting the risk of anxiety and depressive disorders in primary care:

The PHQ-4 score. Journal of Affective Disorders, 124(3), 270–278.

https://doi.org/10.1016/j.jad.2009.11.007

Appendix 1. Ethical Approval Documentation

This appendix contains official ethical approval documents relevant to the conduct of this study. The material is included for administrative completeness.

![RHAC logo] អង្គការថែទាំសុខភាពគ្រួសារកម្ពុជា (រ៉ក់)
Reproductive Health Association of Cambodia (RHAC)

Phnom Penh, 08 September 2022

Prof. H.E. Eng Huot
Chairman of the National Ethics Committee for Health Research (NECHR)
Secretary of State
The Ministry of Health (MoH), Cambodia
Royal Government of Cambodia
Ref: Request for the approval of the proposal

Dear H. E. Prof. Eng Huot,

I am writing to kindly request your expedited review and approval of the study on "A Survey on Harassment and VAW in the workplace: Situational Analysis of Harassment among garment factories' workers in 2022" which is scheduled to take place from September to December 2022. This study will be carried out by a team led by Dr. SAPHON SOMOLIREASMEY, and Dr. CHIEN SAMPHOAS under the RHAC's program Research & Advocacy Unit. Please be informed that the objectives of the assessment include:

(1) To determine the proportion of factory workers who have ever experienced related sexual harassment in the workplace or outside the workplace
(2) To explore the percentage of sexual harassment among garment factory employees
(3) To explore the percentage of sexual harassment among garment industry workers under RHAC's coverage
(4) To compare the proportion of factory knowledge and perception related to sexual harassment in Phnom Penh and the provinces
(5) To explore the knowledge of sexual harassment/abuse/ among peers and people at a higher position in the factory
(6) To identify the percentage of factory workers who know about RHAC's activities in the factory, clinic RHAC, clinic RHAC location, and clinic services
(7) Health seeking behavior: To determine the percentage of factory workers who get sick in the last six months and where they seek the services (and why).

We have enclosed the research protocol, study tools, informed consent, questionnaires, and other support documents for your review and approval. Please feel free to contact us if you need further information related to this proposal. Thank you very much for your support and collaboration in the efforts.

Yours sincerely,

VAR CHIVORN, MD/MPH
Executive Director, RHAC

House #05, Street 600, Sangkat Boeung Kok II, Khan Toul Kork, 120408 Phnom Penh, Cambodia
Tel: (855-23) 883 027 / (855-23) 882 046, Email: info@rhac.org.kh, Website: www.rhac.org.kh

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National Ethics Committee for Health Research

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Phnom Penh. September 19, 2022

Dr. Va Chivorn

Project: Demand and Minimum Humanitarian Settings for SRH for Migrants: A study for a better sexual and reproductive health among Cambodian Migrants (Mixed methods study). Version Nº 1, dated 11th August 2022.

Reference: 16th September 2022 NECHR meeting minutes

Dear Dr. Va Chivorn,

I am pleased to notify you that your study protocol entitled "Demand and Minimum Humanitarian Settings for SRH for Migrants: A study for a better sexual and reproductive health among Cambodian Migrants (Mixed methods study). Version Nº 1, dated 11th August 2022" has been approved by National Ethics Committee for Health Research (NECHR) in the meeting on 16th September 2022. This approval is valid for twelve months after the approval date.

NECHR also wish to remind the Principal Investigator that all research activities to be conducted during the COVID-19 pandemic must strictly follow the latest prevention measures set by the MOH and the relevant local authorities.

The Principal Investigator of the project shall submit following document to the committee's secretariat at the National Institute of Public Health at #80, Samdach Penn Nouth Blvd (289), Sangkat Boeungkok 2, Khan Tuol Kork, Phnom Penh. (Tel: 012 528 789, 086 762 113, 012 203 382. Email: nouthsarida@gmail.com, cheatasoft27@gmail.com):

- Annual progress report
- Final scientific report
- Patient/participant feedback (if any)
- Analyzing serious adverse events report (if applicable)

The Principal Investigator should be aware that there might be site monitoring visits at any time from NECHR team during the project implementation and should provide full cooperation to the team.

Regards,

Chairman

Prof. ENG HUOT
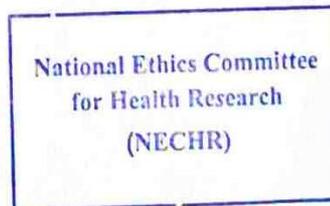
National Ethics Committee
for Health Research
(NECHR)

Date   : October 07, 2022
To   : **International Organization for Migration (IOM)**
Address   : #42, Sayon Building 3rd Floor Samdach Pan Ave (214 Phnom Penh, Cambodia)

Dear Ms. PARCO Kristin, IOM Cambodia Country Director,

Objective: Request for interview with a focal staff of the International Organization for Migration (IOM) who is in charge of health issues and Sexual and Reproductive Health and Rights in responding to the health among Migrant workers/Returning migrant workers.

I am writing this letter to request the International Organization for Migration (IOM), asking for collaborating to allow our staff to interview with a focal person of IOM who is in charge of health issues and especially sexual and reproductive Health and Rights among Migrant workers.

Currently, RHAC has been conducting a study on "The Demand and Minimum Humanitarian Settings for Sexual Reproductive Health and Rights (SRHR) among returned Migrant workers: A study for a better sexual and reproductive health among Cambodian Returning Migrant Workers (Mixed methods study)". The objective of this study are: (1) to understand access to services and the situation in the migrated country and home country (Cambodia); (2) to explore the challenges related to health issues, especially sexual health, reproductive health and the rights of reproductive and sexual rights among migrants; (3) to understand the minimum requirements for reproductive health services during migration and other urgent health needs; (4) to measure awareness of sexual health, reproductive health and rights, as well as sources of information among migrants; (5) to examine the effective mechanism of facilitating the provision of sexual and reproductive health services for returned migrants workers, particularly the National Working Group for Migrant Health. Therefore, your participation would be very essential for us to understand and explore further how the returning Migrant workers (RMW) access health services, perceptions, and attitudes toward sexual reproductive health and rights in Cambodia. The interview would be held either online or in person with the approximate time of 40 minutes. I would highly appreciate if you could confirm to us by 20, October 2022. Should you have any question and clarification, please contact to Dr. Somolireasmey Saphon, our Research and Advocacy Program Manager, at yhapm@rhac.org.kh or phone number 085 250 368.

Thank you very much for your collaboration.

Best regards,

Executive Director

Dr. Va Chivorn

House #05, Street 600, Sangkat Boeung Kok II, Khan Toul Kork, 120408 Phnom Penh, Cambodia
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Appendix 2. Permission Letter for Data Use and Collaboration

This appendix is provided for documentation and transparency purposes. The content is not part of the analytical text of the dissertation.

RHAC
អង្គការថែទាំសុខភាពគ្រួសារកម្ពុជា (រ៉ាក់)
Reproductive Health Association of Cambodia (RHAC)

Date: October 07, 2022
Objective: Formal Permission to Use RHAC Study Data for Mr. SAMPHOAS CHIEN

To Whom It May Concern:

Reproductive Health Association of Cambodia (RHAC) is pleased to confirm that Mr. Samphoas Chien served as Associate Project Manager for the RHAC study entitled: *"The Demand and Minimum Humanitarian Settings for Sexual Reproductive Health and Rights (SRHR) among returned Migrant workers: A study for a better sexual and reproductive health among Cambodian Returning Migrant Workers (Mixed methods study)"*.

Fieldwork for this mixed-methods study (quantitative survey and qualitative interviews) was carried out from **15 August to 30 September 2022** in the provinces of Banteay Meanchey, Battambang, Siem Reap, and Kampot. The research was funded by RFSU-Core fund, Sweden (The Swedish Association for Sexuality Education) and approved by the National Ethics Committee for Health Research (NECHR Approval No.269/NECHR/IRB00003143).

In his capacity as Project Manager, Mr. SAMPHOAS CHIEN:

- **Designed the study protocol**, designed study methodology, sampling framework, and data-collection instruments
- **Oversaw field operations**, including enumerator training, data quality assurance, and participant protection
- **Ensured compliance** with national ethical standards and RHAC data-governance policies.

Please accept this letter as formal documentation that Mr. SAMPHOAS CHIEN is fully authorized to employ the RHAC 2022 dataset in fulfillment of his doctoral requirements at National Taiwan University.

Should you need any further information, do not hesitate to contact us.

Sincerely,

Best regards,

Executive Director

Dr. Va Chivorn, MD/MPH

Appendix 3. Number of COVID-19 Cases and Deaths in three countries

This appendix is provided for documentation and transparency purposes. The content is not part of the analytical text of the dissertation.

3.1 COVID-19 Context in Cambodia
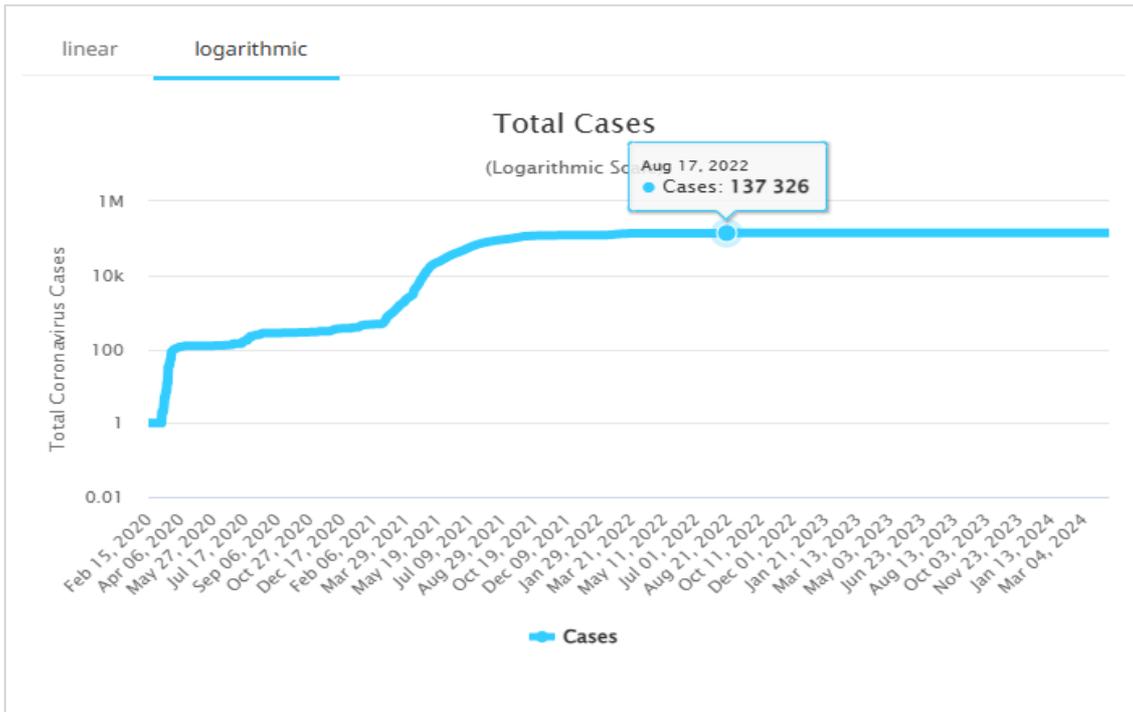
Figure 7. Total number of Cases in Cambodia from Feb 2020 to Mar 2024

Epidemic Curve of COVID-19 total deaths from Feb 2020 to Feb 2024
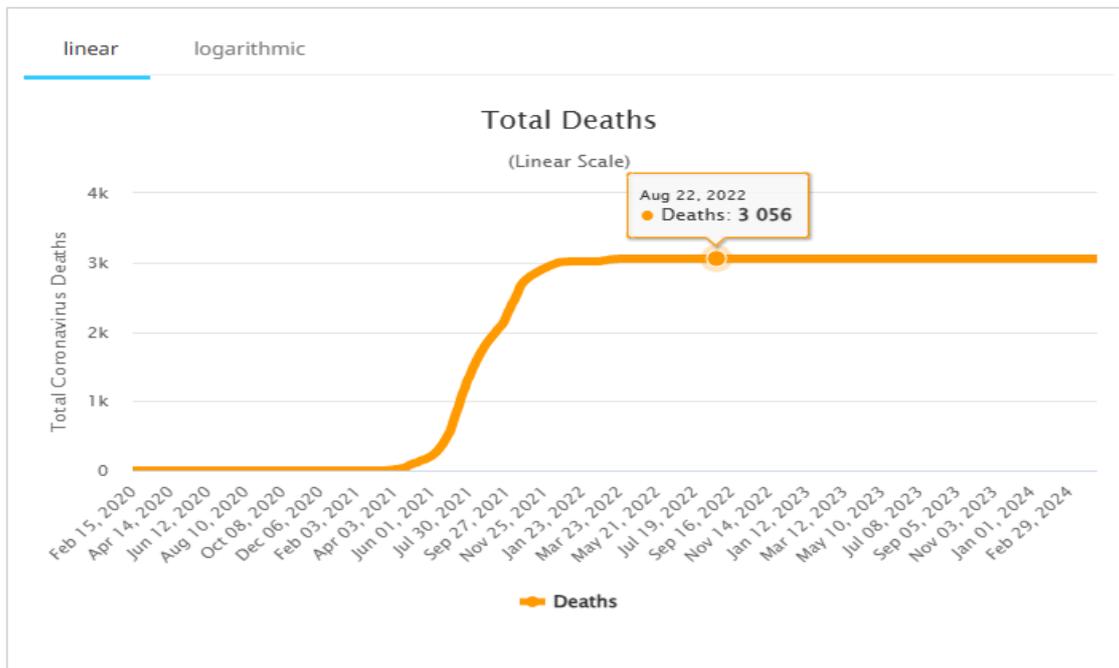
3.2 COVID-19 Context in Thailand
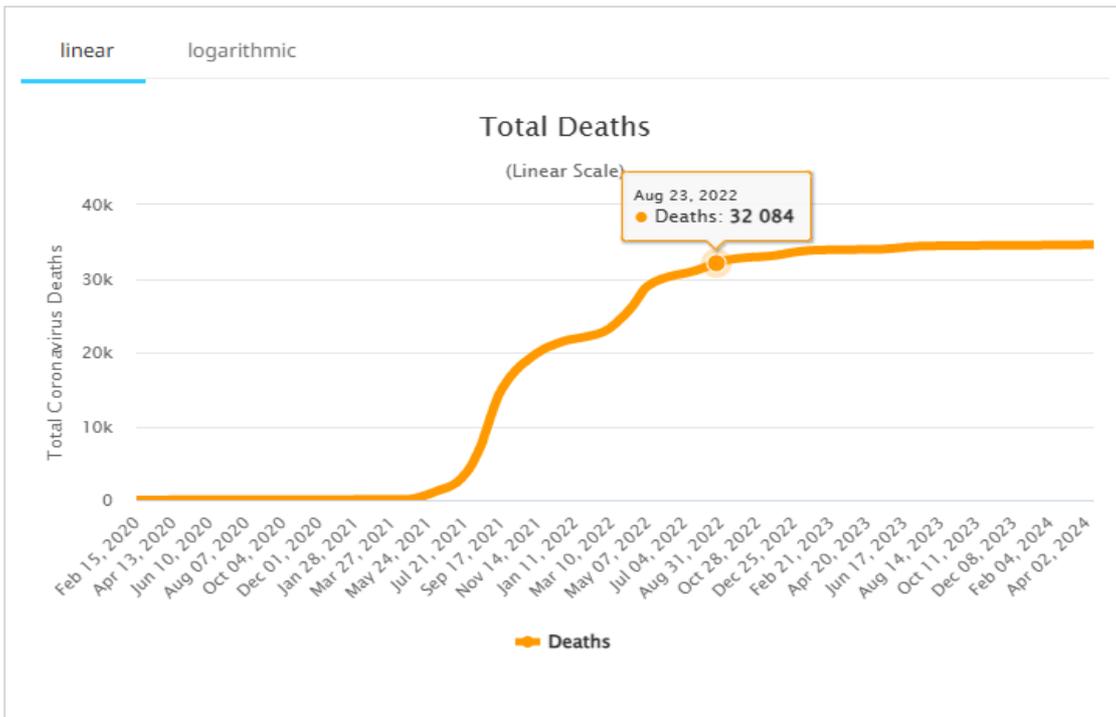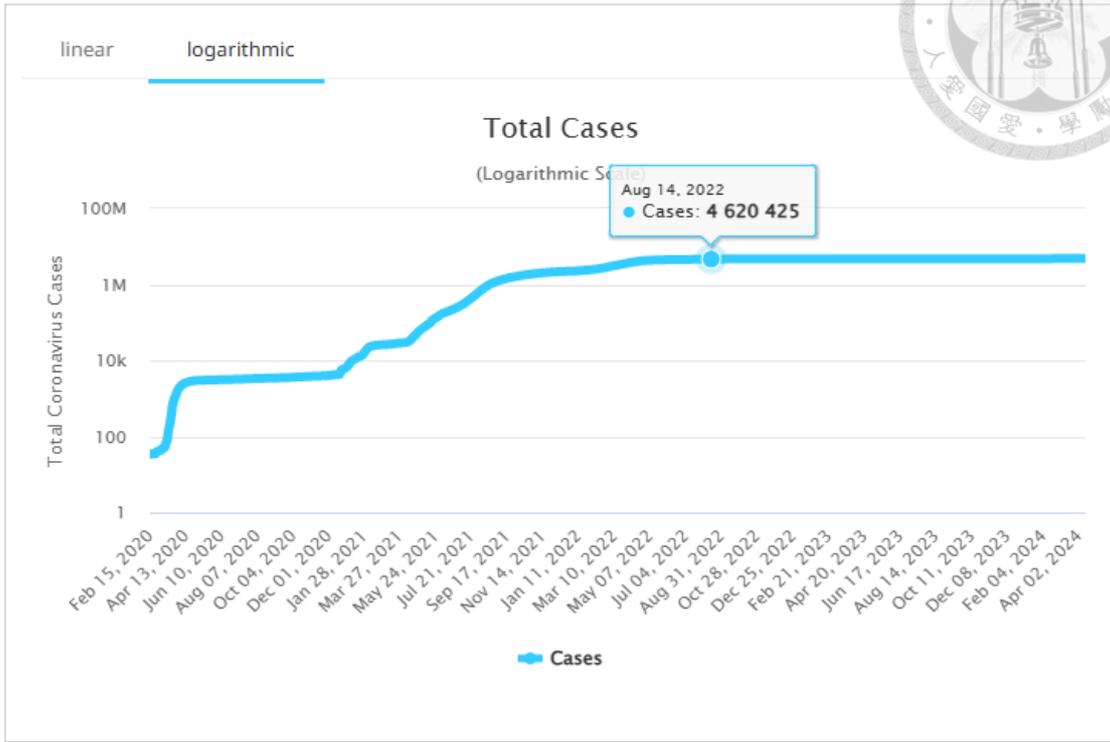
Figure 8. Total number of COVID-19 Cases in Thailand from Feb 2020 to Apr 2024

3.3 COVID-19 Context in Sout-Korea
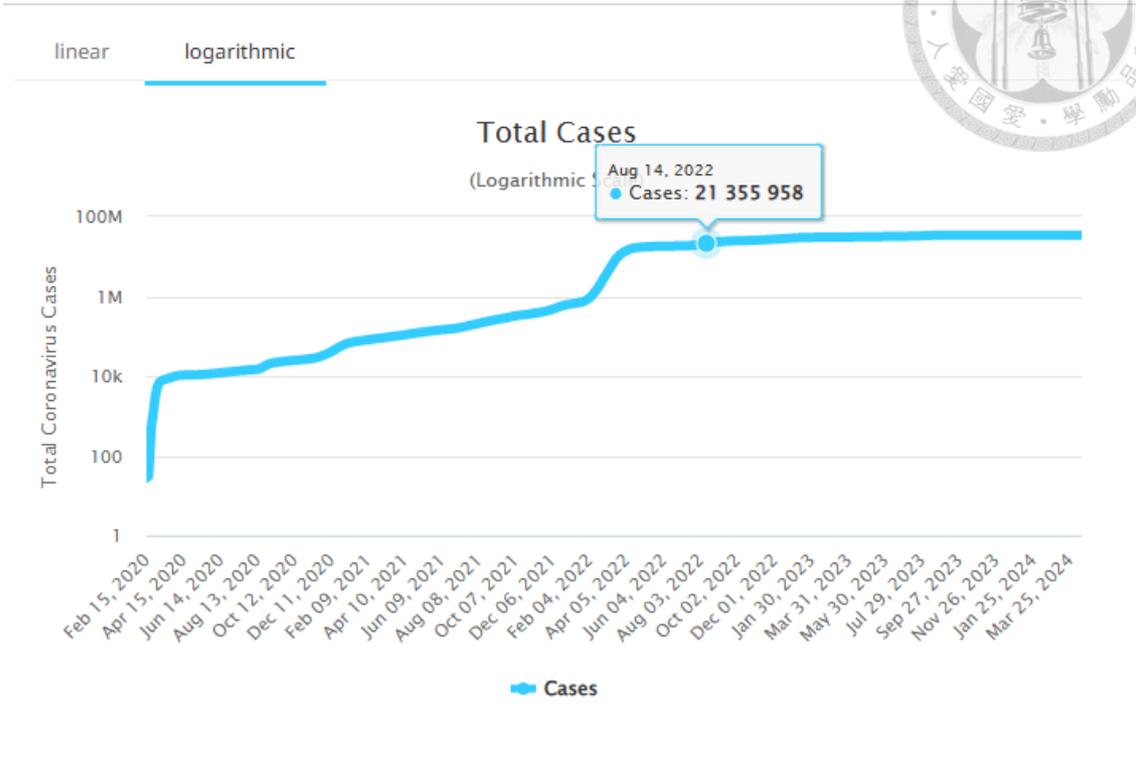
Curve total COVID-19 Deaths in South-Korea from Feb 2020 to Feb 2024
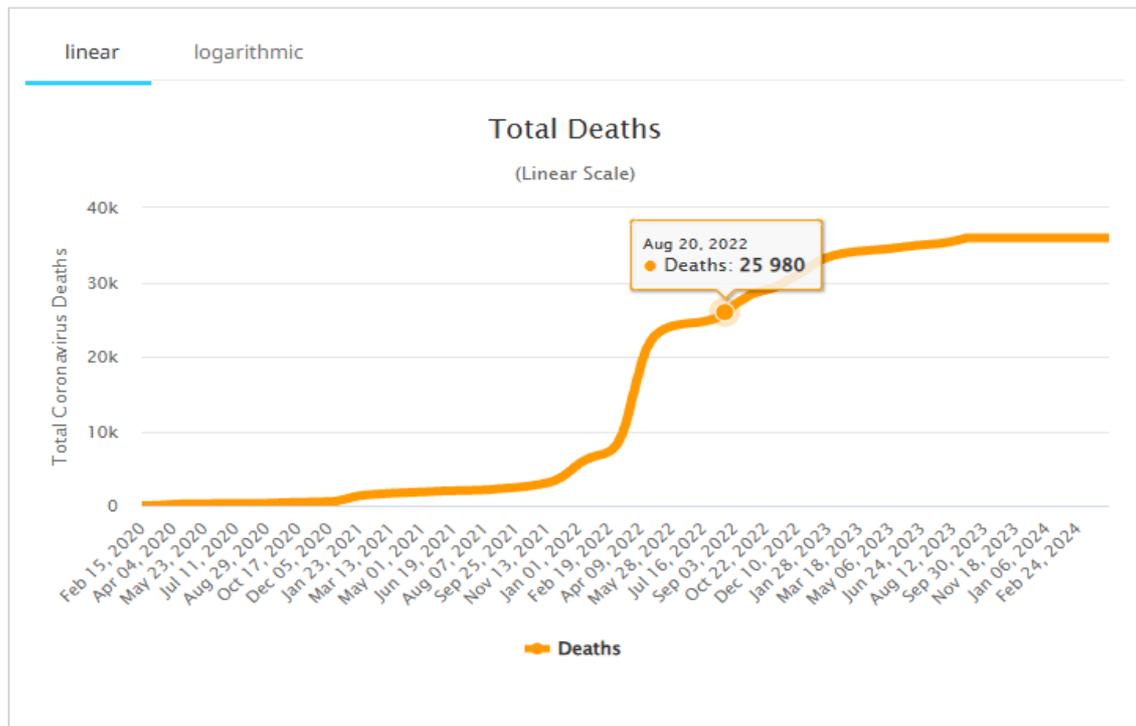
Figure 9. Total COVID-19 Cases in South Korea from Feb 2020 to Mar 2024

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Appendix 4. Author's Published Article Derived from This Dissertation

This article has been published by the author and is included here to document scholarly output derived from this dissertation. Any textual similarity reflects the author's own work and does not constitute plagiarism.
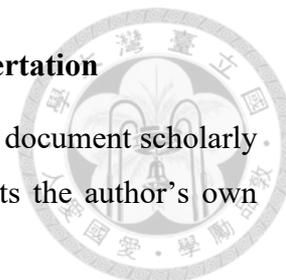
Accepted and published in the Asia Pacific Journal of Public Health (APJPH)

ORIGINAL MANUSCRIPT

Title: Gender Differences in Mental Health Among Returned Cambodian Migrant Workers During the COVID-19 Pandemic

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Gender Differences in Mental Health Among Returned Cambodian Migrant Workers During the COVID-19 Pandemic

Samphoas Chien, PhD[1,2] iD **, Kai-Lih Liu, PhD[2],
Huyleng Khov, MD[3], and Chang-Chuan Chan, PhD[1,2]** iD

Introduction

The phenomenon of international migrant workers holds significant importance for the growth and employment strategies of numerous countries, both those that send and receive migrant workers.[1] Migrant workers play a significant role in reducing unemployment and supporting economic growth.[2] They establish settlements, share information, and develop business and trade connections, which can help to alleviate labor shortages and increase human capital in countries facing workforce shortages and aging populations.[3] Working conditions, individual characteristics, socioeconomic status, and the structure of the health care system all influence worker health. These elements contribute to the usability and accessibility of the occupational health system.[4] This study aimed to provide a comprehensive understanding of the correlation between migration and mental health, focusing on returned Cambodian migrant workers repatriated during the post-COVID-19 pandemic. It examined the factors associated with the prevalence of mental health problems among returned migrant population. Additionally, the research investigated gender disparities and occupational stress, paying particular attention to gender inequalities, psychological distress, location of residence, and socioeconomic status.

Methods

The study sample was obtained from a cross-sectional study with 388 returned Cambodian migrant workers from Thailand, South Korea, and Japan. This study used the Patient Health Questionnaire-4 (PHQ-4) screening tool, which is a valuable instrument in research on mental health among returned Cambodian migrant workers during COVID-19. The data were collected in September 2022.

Results

The PHQ-4 Scale's Model Logistic Regression by Gender

The logistic regression analysis highlights a concerning gender disparity in mental health symptoms among returned Cambodian migrant workers. Females are nearly three times more likely than males to have moderate and severe symptoms of depression and anxiety (adjusted odds ratio [AOR] = 1-2.96). The factor appears to be associated with a higher risk of experiencing moderate and severe symptoms of depression and anxiety among returned Cambodian migrant workers (Table 1).

Model 1: Nervous/Anxious or on the Edge

Factors were associated with the variable of being nervous/anxious or on the edge. Females were significantly more likely to be nervous than males (AOR = 2.04), and migrant workers who attended any level of school were significantly more likely to be nervous, compared to those who never attended school (AOR = 2.1).

Model 2: Not Being Able to Stop or Control Worrying

Two significant factors were associated with being unable to control worrying. Females were 2.08 times more likely than males to struggle with controlling their worries. Migrant workers with current income were less likely to experience uncontrollable worrying compared to those without income. However, while having income seems positive, it may also introduce new financial pressures and responsibilities, contributing to increased worries.

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Table 1. The PHQ-4 Scale's Model Logistic Regression by Gender.

Variable	N	PHQ-4 (%)	AOR	95% CI	P-value
1. No and mild symptoms					
Male	109	42.58	1	0.92-2.49	.101
Female	147	57.42	1.50		
2. Moderate and severe symptoms					
Male	92	35.38	1	1.74-5.04	.000
Female	168	64.62	2.96		

Abbreviations: AOR, adjusted odds ratio, CI, confidence interval; PHQ-4, Patient Health Questionnaire-4 items.

Model 3: Little Interest or Pleasure in Activities

Migrant workers who attended school were significantly more likely to experience a lack of interest or pleasure in activities compared to those who never attended school (AOR = 1.91). Those with current income were also more likely to experience this lack of interest (AOR = 1.92). Additionally, working in construction was associated with a higher likelihood of experiencing little interest in activities (AOR = 1.62), and domestic workers were even more likely to face this issue (AOR = 2.92). These findings suggest that certain educational backgrounds, income levels, and occupations, particularly construction and domestic work, are linked to reduced interest or pleasure in activities.

Model 4: Feeling Down, Depressed, or Hopeless

The study found that female migrant workers were nearly twice as likely to feel depressed or hopeless compared to males (AOR = 1.98). Migrant workers who returned to Cambodia within the last 24 months were more likely to experience depression than those who had not returned recently. Additionally, workers in agriculture (AOR = 1.57), construction (AOR = 1.91), and domestic jobs (AOR = 2.61) were more prone to depression compared to workers in other sectors. These findings highlight significant associations between gender, recent return from migration, and specific occupations with the likelihood of experiencing depression or hopelessness (Table 2).

Discussion

This study reveals significant links between various risk factors and mental health outcomes among Cambodian migrant workers, with gender differences playing a critical role.[5]

Women were found to experience higher rates of depression and anxiety, largely due to greater exposure to gender-based violence and pandemic-related stressors like job loss and uncertainty.[6] The COVID-19 pandemic intensified these challenges, particularly for women, who faced increased stress and anxiety. Education and income levels also influence mental health, with higher education generally linked to better outcomes, while lower income is associated with greater anxiety and depression.[7] High-stress occupations such as agriculture, construction, and domestic work were found to significantly contribute to mental health issues, particularly among low-skilled workers.[8] Workplace stress, driven by job insecurity and lack of employer support, emerged as a major contributor to these problems, with women more likely to experience anxiety.[9] The findings highlight the urgent need for targeted mental health and psychosocial support for returned migrant workers, especially women, to address the long-term effects of the pandemic and occupational stress. Effective intervention is crucial to mitigate these challenges, improve well-being, and reduce the vulnerability of workers to occupational issues.[10]

Conclusion

This study underscores the urgent need for government and non-governmental organization interventions to address occupational stress and mental health issues among returned Cambodian migrant workers. Targeted mental health and psychosocial support programs, especially for women in high-stress occupations, are essential for successful reintegration. The research highlights gaps, such as the lack of data on pre-deportation conditions, and calls for further studies to explore the mental health impact of deportation and working conditions abroad. Future research should focus on understanding the relationship between occupational factors and mental health to develop effective interventions.

Table 2. Factors Associated With Mental Health Outcomes (Nervous/Unable to Control/Little Interest/Depression).

Variables	N	%	Model 1[a] Nervous			Model 2[b] Unable to control			Model 3[c] Little interest			Model 4[d] Depression		
			AOR	95% CI	P-value	AOR	95% CI	P-value	AOR	95% CI	P-value	AOR	95% CI	P-value
Gender of participants														
Male	140	36.08	1			1			1			1		
Female	248	63.92	2.04	1.28-3.26	.002	2.08	1.27-3.40	.003	0.73	0.46-1.13	.158	1.98	1.29-3.03	.002
Current occupation														
Unemployed	127	32.73	1			1			1			1		
Employed	261	67.27	1.31	0.48-1.19	.231	—	0.62-1.59	.997	0.77	0.49-1.21	.269	1	0.65-1.53	.986
Level of education														
Non-attending school	66	17.01	1			1			1			1		
Attending school	322	82.99	2.1	1.27-3.74	.004	0.66	0.38-1.16	.162	1.91	1.02-3.58	.045	0.78	0.45-1.32	.36
Current income														
Without income	79	20.36	1			1			1			1		
With income	309	79.64	0.95	0.49-1.38	.464	2.19	1.32-3.67	.003	1.92	1.16-3.18	.011	0.87	0.52-1.41	.552
Current marital status														
Non-married	32	8.25	1			1			1			1		
Married	356	91.75	2.29	0.91-5.70	.056	1.86	0.74-4.65	.178	1.98	0.83-4.70	.116	1.29	0.61-2.69	.495
Country of destination														
Thailand	350	90.21	1			1			1			1		
South Korea/Japan	38	9.79	1.68	0.77-3.66	.192	0.42	0.17-1.04	.057	0.98	0.48-1.99	.965	2	0.97-4.09	.058
Returned within 24 months														
No	145	37.37	1			1			1			1		
Yes	243	62.63	1.17	0.75-1.82	.475	1.19	0.75-1.88	.456	0.82	0.53-1.27	.387	1.54	1.01-2.32	.041
Type of occupation														
Other	142	36.6	1			1			1			1		
Agriculture	246	63.4	1.04	0.66-1.64	.858	0.28	0.06-1.32	.11	0.95	0.61-1.47	.832	1.57	1.03-2.38	.033
Other	121	31.13	1			1			1			1		
Construction	267	68.81	0.95	0.60-1.51	.858	0.95	0.59-1.53	.854	1.62	1.01-2.59	.044	1.91	1.22-2.97	.004
Other	22	5.67	1			1			1			1		
Domestic work	366	94.33	1.07	0.42-2.69	.884	0.46	0.19-1.12	.089	2.92	1.21-7.03	.017	2.61	1.03-6.55	.041
Other	26	6.7	1			1			1			1		
Hospitality	362	93.3	1.13	0.47-2.67	.781	1.39	0.54-3.58	.484	0.5	0.22-1.11	.091	0.72	0.32-1.61	.432
Other	61	15.72	1			1			1			1		
Manufacture	327	84.28	1.82	0.96-3.44	.063	1.82	0.93-3.57	.08	1.19	0.66-2.15	.545	1.19	0.69-2.08	.521

Abbreviations: AOR, adjusted odds ratio; CI, confidence interval.
[a] Model 1: adjusted odds ratio (AOR) for nervous, anxious, or on edge.
[b] Model 2: adjusted odds ratio (AOR) for the not being able to stop or control worrying.
[c] Model 3: adjusted odds ratio (AOR) for the little interest or pleasure in activities.
[d] Model 4: adjusted odds ratio (AOR) for feeling down, depressed, or hopeless.

Declaration of Conflicting Interests

Funding

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References

1. *Labor Migration in Asia: Impacts of the COVID-19 Crisis and the Post-Pandemic Future*. OECD Publishing; Asian Development Bank Institute; 2021.
2. Huynh HH, Vo DH. The effects of migration on unemployment: new evidence from the Asian countries. *Sustainability*. 2023;15(14):11385. doi:10.3390/su151411385
3. Martin P. Migrants in the global labor market, a paper prepared for the Policy Analysis and Research Programme of the Global Commission on International Migration. Published 2005. Accessed November 11, 2024. https://www.iom.int/sites/g/files/tmzbdl486/files/2018-07/TP1.pdf
4. Ravesteijn B, van Kippersluis H, van Doorslaer E. The contribution of occupation to health inequality. *Res Econ Inequal*. 2013;21:311-332. doi:10.1108/S1049-2585(2013)0000021014
5. Aberdein C, Zimmerman C. Access to mental health and psychosocial services in Cambodia by survivors of trafficking and exploitation: a qualitative study. *Int J Ment Health Syst*. 2015;9:16. doi:10.1186/s13033-015-0008-8
6. Sediri S, Zgueb Y, Ouanes S, et al. Women's mental health: acute impact of COVID-19 pandemic on domestic violence. *Arch Womens Ment Health*. 2020;23(6):749-756. doi:10.1007/s00737-020-01082-4
7. Rudenstine MS, Mcneal K, Schulder T, et al. Depression and anxiety during the COVID-19 pandemic in an urban, low-income public university sample. *J Trauma Stress*. 2020;34:1-11. doi:10.1002/jts.22600
8. Daghagh Yazd S, Wheeler SA, Zuo A. Key risk factors affecting farmers' mental health: a systematic review. *Int J Environ Res Public Health*. 2019;16(23):4849. doi:10.3390/ijerph16234849
9. Bhui K, Dinos S, Galant-Miecznikowska M, de Jongh B, Stansfeld S. Perceptions of work stress causes and effective interventions in employees working in public, private and non-governmental organisations: a qualitative study. *BJPsych Bull*. 2016;40(6):318-325. doi:10.1192/pb.bp.115.050823
10. Spiritus-Beerden E, Verelst A, Devlieger I, et al. Mental health of refugees and migrants during the COVID-19 pandemic: the role of experienced discrimination and daily stressors. *Int J Environ Res Public Health*. 2021;18(12):6354. doi:10.3390/ijerph18126354

ORIGINAL MANUSCRIPT

Full title: Psychological distress, financial strain and coping among returned Cambodian migrant workers: A qualitative study of reintegration challenges
Short title: Mental health of returned Cambodian migrant workers

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PLOS Mental Health

Psychological distress, financial strain and coping among returned Cambodian migrant workers: A qualitative study of reintegration challenges
--Manuscript--

Abstract:	Background
	Returned Cambodian migrant workers often experience significant psychological and socioeconomic challenges following employment in Thailand's low-wage sectors. While quantitative evidence indicates a high burden of anxiety and depression among returnees, limited qualitative research has explored the lived experiences and contextual factors shaping psychological distress after return. This study examined how financial strain, social expectations, occupational histories and reintegration challenges influence the mental health trajectories of Cambodian migrant workers.
	Methods
	Eight in-depth semi-structured interviews were conducted with Cambodian migrant workers who had recently returned from Thailand. Interviews were completed in Khmer, audio-recorded, transcribed and translated into English. Reflexive thematic analysis was conducted using Taguette software to identify patterns related to emotional well-being, stressors and coping during reintegration.
	Results
	Five interconnected themes emerged. Financial stress and economic insecurity were the most pervasive drivers of distress, linked to debt, limited income and heightened family obligations. Participants described emotional symptoms such as sadness, "thinking too much", insomnia, fatigue and loss of purpose. Structural and social stressors including stigma, unmet community expectations and unsafe or exploitative working conditions abroad exacerbated emotional strain. Reintegration was perceived as an ongoing process marked by uncertainty, declining well-being over time, and challenges in securing stable employment. Despite these pressures, returnees demonstrated resilience through behavioral distraction, social support, and culturally grounded spiritual coping practices.
	Conclusions
	Psychological distress among returned Cambodian migrant workers is shaped by intersecting economic, structural and sociocultural factors rather than individual vulnerability alone. Understanding these lived experiences underscores the need for

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	culturally grounded, gender-sensitive, community-based mental health and reintegration programs. These qualitative findings complement existing quantitative evidence and highlight the importance of addressing both economic and psychosocial conditions across the migration cycle.
Opposed Reviewers:	
Additional Information:	
Question	**Response**
Financial Disclosure Enter a financial disclosure statement that describes the sources of funding for the work included in this submission and the role the funder(s) played. This includes grants and any commercial funding of the work or authors. This statement will be typeset if the manuscript is accepted for publication. *Please review the [submission guidelines](#) and the instructions link below for detailed requirements and guidance.*	This research did not receive any dedicated external funding. The study was conducted using institutional resources. The funders had no role in the study design, data collection and analysis, the decision to publish, or the preparation of the manuscript.
Competing Interests On behalf of all authors, disclose any competing interests that could be perceived to bias this work. This statement will be typeset if the manuscript is accepted for publication. *Please review the instructions link below and PLOS Mental Health's [competing interests](#) policy to determine what information must be disclosed at submission.*	The authors have declared that no competing interests exist in this study.
Data Availability Before publication, Authors are required to make fully available and without restriction all data underlying their findings. Please see our [PLOS Data](#)	All data underlying the findings of this study are freely available in accordance with PLOS data policies. The de-identified dataset and supporting materials have been made accessible to other researchers. These data are provided without restriction and comply with the ethical approval granted by the National Ethics Committee for Health Research (NECHR No. 322).

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Date 03 December 2025

Editor-in-Chief
PLOS Mental Health
Public Library of Science

Dear Editor,

I am pleased to submit our manuscript entitled **"Psychological Distress, Financial Strain, and Coping Among Returned Cambodian Migrant Workers: A Qualitative Study"** for consideration in *PLOS Mental Health*.

This study explores the complex interplay of psychological distress, financial hardship, structural vulnerabilities, and coping strategies among Cambodian migrant workers who returned home during and after the COVID-19 pandemic. Using a rigorous qualitative design informed by the COREQ guidelines, we provide novel insights into how financial strain, migration-related trauma, and social expectations shape mental health outcomes among a highly vulnerable and understudied population.

To our knowledge, this is the first qualitative study that examines mental health distress within the broader socio-economic and migration context among returned Cambodian migrant workers. The findings have important implications for mental health policy, reintegration support programs, and migrant protection in Southeast Asia and beyond.

We believe our manuscript is well suited to *PLOS Mental Health* because: It addresses global mental health inequities among migrant workers, it contributes new qualitative evidence to strengthen public health and psychosocial interventions, it aligns with the journal's mission to amplify research that informs policy, practice and population-level mental health and it highlights vulnerable populations often underrepresented in global mental health literature.

We confirm that:

- The manuscript is original and has not been published elsewhere

- It is not under consideration by any other journal

- All authors have read and approved the final version

- Ethical approval was obtained from the **National Ethics Committee for Health Research, Cambodia (Ref. No. 322 NECHR)**.

- We have adhered to all PLOS guidelines, including ethical reporting, data availability and authorship requirements.

We respectfully request that our manuscript be considered for publication in *PLOS Mental Health*. We believe the findings will be of significant interest to researchers, policymakers, and practitioners working in mental health, migration, and global public health.

Thank you for your time and consideration. We look forward to the opportunity to contribute to your journal.

Sincerely,

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1 **Full title: Psychological distress, financial strain and coping among**
2 **returned Cambodian migrant workers: A qualitative study of reintegration**
3 **challenges**
4

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6 **Short title: Mental health of returned Cambodian migrant workers**

7

8

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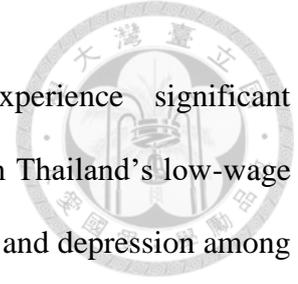
19 **Abstract**

20 **Background:** Returned Cambodian migrant workers often experience significant

21 psychological and socioeconomic challenges following employment in Thailand's low-wage

22 sectors. While quantitative evidence indicates a high burden of anxiety and depression among

23 returnees, limited qualitative research has explored the lived experiences and contextual factors

24 shaping psychological distress after return. This study examined how financial strain, social

25 expectations, occupational histories and reintegration challenges influence the mental health

26 trajectories of Cambodian migrant workers.

27 **Methods:** Eight in-depth semi-structured interviews were conducted with Cambodian migrant

28 workers who had recently returned from Thailand. Interviews were completed in Khmer,

29 audio-recorded, transcribed and translated into English. Reflexive thematic analysis was

30 conducted using Taguette software to identify patterns related to emotional well-being,

31 stressors and coping during reintegration.

32 **Results:** Five interconnected themes emerged. Financial stress and economic insecurity were

33 the most pervasive drivers of distress, linked to debt, limited income and heightened family

34 obligations. Participants described emotional symptoms such as sadness, "thinking too much",

35 insomnia, fatigue and loss of purpose. Structural and social stressors including stigma, unmet

36 community expectations and unsafe or exploitative working conditions abroad exacerbated

37 emotional strain. Reintegration was perceived as an ongoing process marked by uncertainty,

38 declining well-being over time, and challenges in securing stable employment. Despite these

39 pressures, returnees demonstrated resilience through behavioral distraction, social support, and

40 culturally grounded spiritual coping practices.

41 **Conclusions:** Psychological distress among returned Cambodian migrant workers is shaped by

42 intersecting economic, structural and sociocultural factors rather than individual vulnerability

43 alone. Understanding these lived experiences underscores the need for culturally grounded,
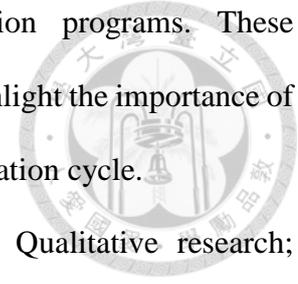
44   gender-sensitive, community-based mental health and reintegration programs. These

45   qualitative findings complement existing quantitative evidence and highlight the importance of

46   addressing both economic and psychosocial conditions across the migration cycle.

47   **Keywords:** Mental health; Returned migrant workers; Cambodia; Qualitative research;

48   Migration; Occupational health; Coping strategies.

49   **Introduction**

50   International labor migration remains a central livelihood strategy for Cambodian households

51   facing limited economic opportunities. More than 1.3 million Cambodians, representing

52   roughly eight percent of the national labor force work abroad, predominantly in Thailand's

53   construction, agriculture, manufacturing, and domestic service sectors (1). Remittances sent by

54   migrant workers play an essential role in household subsistence, debt repayment, and rural

55   economic stability, contributing nearly six percent of Cambodia's GDP (2). Despite these

56   economic benefits, Cambodian migrant workers frequently face exploitative working

57   conditions, occupational hazards, wage withholding, discrimination, and restricted access to

58   health or legal services. These vulnerabilities align with broader evidence linking migrant labor

59   to structural precarity and systemic power imbalances (3–5).

60   The process of returning home introduces additional challenges that can exacerbate

61   psychological stress. Previous studies in Cambodia and the wider Southeast Asian region show

62   that returning migrant workers often encounter unemployment, debt accumulation, unstable

63   income, and pressures to meet family expectations (6,7). These conditions may create

64   emotional strain as returnees attempt to rebuild their livelihoods and social identities. For many,

65   returning is not an endpoint but the beginning of a new cycle of uncertainty, and this transition

66   can be marked by feelings of shame, frustration, or self-blame when reintegration does not

67   align with the expected narrative of "successful migration".
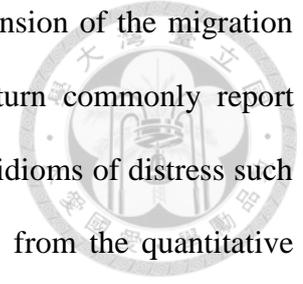
68   Mental health concerns are increasingly recognized as a critical dimension of the migration

69   experience. Cambodian migrant workers both abroad and upon return commonly report

70   anxiety, sadness, irritability, sleep disturbance, and culturally specific idioms of distress such

71   as "thinking too much" or Khmer word "kuet chruen" (8). Findings from the quantitative

72   component of the larger mixed-methods dissertation indicate that 42% of surveyed returnees

73   showed symptoms of anxiety and 35% showed symptoms of depression, as measured by the

74   PHQ-4 screening tool. These results point to a substantial mental-health burden requiring

75   deeper qualitative investigation (9).

76   Reintegration is also shaped by temporal dynamics. Research has shown that emotional relief

77   initially felt upon returning home often diminishes over time as financial savings are exhausted

78   and debts resurface, a phenomenon described as the post-migration deterioration hypothesis

79   (10). Recent longitudinal evidence from Cambodia suggests that psychological well-being

80   declines most sharply within the first two years unless livelihood stability is re-established (11).

81   These findings highlight that mental health trajectories are closely tied to shifting structural

82   conditions, economic uncertainty, and social comparison with peers who appear more

83   financially successful.

84   Despite this growing body of evidence, little is known about how Cambodian returnees

85   themselves interpret and make meaning of psychological distress, how these experiences

86   evolve over time during reintegration, and how coping strategies are shaped by structural and

87   cultural contexts. While quantitative studies document the prevalence and correlates of anxiety

88   and depression, qualitative evidence explaining the lived realities and sociocultural meanings

89   behind these symptoms remains limited. Qualitative inquiry is essential for capturing the social

90   meanings, cultural logics, and day-to-day experiences that shape mental health after migration,

91   especially within contexts where emotional expression is influenced by cultural norms, family

92   obligations, and collective identities.
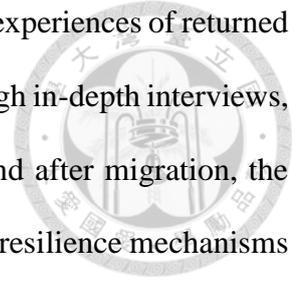
93   This qualitative study addresses these gaps by examining the subjective experiences of returned

94   Cambodian migrant workers who previously worked in Thailand. Through in-depth interviews,

95   the study explores the psychological challenges encountered during and after migration, the

96   structural and social factors contributing to distress, and the coping and resilience mechanisms

97   used to manage these pressures. By situating individual experiences within broader economic

98   and sociocultural contexts, the study provides a more holistic understanding of post-migration

99   mental health. While prior qualitative studies in Cambodia have documented economic and

100   social challenges, few have explored how psychological distress evolves over time during

101   reintegration or how structural and cultural factors interact to shape coping (7,12,13). This

102   qualitative study aimed to explore how returned Cambodian migrant workers experience

103   psychological distress during reintegration, how financial and structural factors shape these

104   experiences, and which coping strategies they use to manage distress.

105   **Materials and Methods**

106   **Study design and context**

107   This study employed a qualitative design nested within a broader mixed-methods design. The

108   qualitative component was developed to deepen and contextualize the quantitative findings on

109   mental health symptoms among returned Cambodian migrant workers. By using in-depth

110   interviews, this component explored how workers understood and experienced psychological

111   distress, the social and economic factors shaping these experiences, and the coping strategies

112   they used during reintegration. This qualitative approach provided depth and contextual

113   nuance, enabling a richer interpretation of the quantitative patterns and illuminating the lived

114   experiences underlying the numerical trends.

115   **Participants and sampling**

116   Eight Cambodian migrant workers who had returned from Thailand were purposively selected

117   to ensure variation in gender, occupation, and geographic location. Participants were drawn

118   from four provinces with high migration flows in Banteay Meanchey, Battambang, Siem Reap

119   and Kampot and represented diverse employment sectors including construction, agriculture,

120   manufacturing and domestic work. This sampling strategy was intended to capture a broad

121   range of post-migration experiences and mental health challenges among returnees. Thematic

122   saturation was reached when successive interviews failed to produce new codes or

123   meaningfully expand existing themes. After coding the eighth interview, the research team

124   observed that data patterns had become repetitive and that all key dimensions of psychological

125   distress, structural stressors, and coping patterns were well represented. Consistent with

126   qualitative methodological guidance, this point was considered sufficient to support conceptual

127   saturation and ensure analytical depth.

128   **Data collection**

129   Data were collected through semi-structured interviews conducted in Khmer. The interviews

130   explored participants' migration histories, occupational risks and working conditions abroad,

131   psychological challenges experienced both during employment and after returning home,

132   difficulties encountered during reintegration, and the coping strategies they used to manage

133   distress. Each interview lasted between 45-65 minutes and was audio-recorded with

134   participants' consent. All recordings were transcribed verbatim in Khmer and subsequently

135   translated into English for analysis. Khmer-to-English translations were checked by a bilingual

136   researcher to ensure cultural and linguistic accuracy.

137   **Data management and analysis**

138   Data were analyzed using reflexive thematic analysis following the approach outlined by Braun

139   and Clarke (14). The research team began by repeatedly reading the transcripts to achieve deep

140   familiarization with the content. Using Taguette software, initial codes were generated

141   inductively to capture meaningful patterns across participants' narratives (15). These codes

142   were then grouped into preliminary themes and refined through an iterative process of constant

6

143 comparison, revisiting transcripts, and maintaining analytic memos to ensure that themes

144 accurately represented the complexity of the data.

145 The final themes were synthesized into coherent interpretive narratives that illustrated the

146 emotional, social, and structural influences on returnees' mental health experiences. To

147 enhance analytic rigor, we employed multiple iterative coding cycles, collaborative code

148 checking, and systematic reflexive memoing to document positionality, analytic decisions and

149 potential biases throughout the coding process.

150 **Ethics statement**

151 This study received ethical approval from the National Ethics Committee for Health Research

152 (NECHR), (Approval No. 269-IRB00003143) All participants were informed about the study

153 objectives, procedures, risks and benefits, and their right to withdraw at any time. Written

154 informed consent was obtained prior to all interviews. All data were de-identified to protect

155 confidentiality.

156 **Reporting guideline notes**

157 This study was designed, conducted, and reported in accordance with the Consolidated Criteria

158 for Reporting Qualitative Research (COREQ) guidelines. The COREQ framework was used to

159 guide transparency in sampling, data collection procedures, researcher reflexivity and thematic

160 analysis. A completed COREQ checklist is available and can be provided as supplementary

161 material upon submission.

162 **Results**

163 Analysis of the eight in-depth interviews revealed five major themes that characterized the

164 psychological experiences of Cambodian migrant workers after returning from Thailand: (1)

165 financial stress and economic insecurity, (2) psychological distress and emotional burden, (3)

166 structural and social stressors, (4) migration-related challenges during and after return, and (5)

167 coping and resilience mechanisms. Together, these themes illustrate how returnees navigated

168 emotional hardship while drawing on culturally embedded and socially mediated forms of

169 resilience.
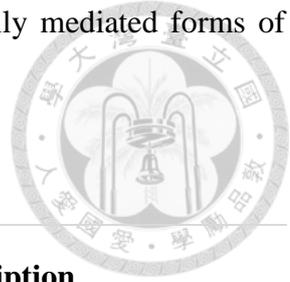
170 **Table 1. Distribution of major themes across participant narratives**

Theme	Frequency	Description
Financial stress and economic insecurity	205	Economic hardship, debt, family obligations
Psychological distress and emotional burden	223	Sadness, anxiety, loss of purpose
Structural and social stressors	71	Stigma, lack of services, social pressure
Migration-related challenges	82	Exploitation, uncertainty, job insecurity
Coping strategies	53	Emotional regulation, behavioral distraction, spiritual coping

171 **Note:** Frequencies represent coded segments and do not imply statistical generalization

172 **Financial stress and economic insecurity**

173 Financial pressure emerged as the most pervasive and immediate source of anxiety following

174 return. Many participants reported returning with limited savings, accumulated debt, or unmet

175 expectations regarding remittances and household support. The loss of a stable income created

176 persistent anxiety about daily expenses and family obligations. Participants commonly

177 described: "*Now I am jobless and no work, no income. It's hard to support my family*",

178 (*RMW1*). *Others highlighted how their financial responsibilities intensified soon after*

179 *returning: "I haven't had steady work since I came back and it's hard to cover basic expenses",*

180 *(RMW2).* Debt repayment was an especially common source of rumination and "thinking too

181 much", particularly among those who financed their migration through loans: "*I borrowed*

8

182   *money to travel abroad and now I have to repay it without income*", (*RMW5*). These narratives

183   demonstrate that financial insecurity rather than individual-level emotional vulnerability was

184   the central driver of psychological distress.

185   **Psychological distress and emotional burden**

186   Participants reported symptoms such as sadness, worry, hopelessness, irritability, sleep

187   disturbance, and a pervasive sense of purposelessness. Several described feeling emotionally

188   depleted, particularly when they struggled to find work after returning. Several of returnees

189   reflected on the dramatic shift in motivation: "*Honestly, when I was abroad, I had goals. But*

190   *now, I just wait*", (*RMW6*). Another participant described how emotional and financial stress

191   intertwined: "*Every day, I feel anxious about money and how I'm going to provide for my*

192   *family. It feels like a heavy weight that never goes away*", (*RMW2*).

193   The returnees commonly used the culturally embedded idiom in Khmer word "*kuet chruen*",

194   *meaning that* "*thinking too much*" to express psychological distress which indicates both

195   emotional and somatic strain. These expressions highlight the culturally specific ways distress

196   is conceptualized and communicated.

197   **Structural and social stressors**

198   Beyond financial worry, structural vulnerabilities and shifting social expectations contributed

199   to profound emotional distress. Participants recounted exploitative or hazardous employment

200   conditions abroad such as wage withholding, employer control, and unsafe work environments

201   experiences that lingered psychologically even after returning home. Although not all

202   narratives were captured through verbatim quotations, several participants explicitly linked

203   their distress to perceived social judgment and unmet community expectations. Male returnees

204   emphasized shame linked to unemployment: "*My parents rely on me for their needs, but*

205   *without work, I feel helpless…*", (*RMW2*).

9

206 Women, particularly those who returned to caregiving roles, felt emotionally overwhelmed by

207 immediate household responsibilities and the lack of recognition for their contributions abroad.

208 Social comparison also played a role, as returnees expressed frustration when others in the

209 community appeared more successful reinforcing feelings of inadequacy and failure.

210 **Migration-related challenges and reintegration pressures**

211 Reintegration was described as an ongoing and uncertain process. Initial relief upon returning

212 home often diminished as savings were depleted, debts resurfaced, and employment

213 opportunities proved scarce. Most participants stated: *"It's like starting over again every time*

214 *I come back. No job, no savings, everything begins from zero"*. Several participants

215 expressed regret when migration outcomes did not meet expectations, noting that the gap

216 between anticipated success and actual reintegration outcomes contributed to anxiety and

217 discouragement. These narratives underscored the emotional weight of social and economic

218 pressures that extend long after returning.

219 **Coping and resilience mechanisms**

220 Despite substantial hardship, returnees demonstrated resilience through adaptive coping

221 behaviors. Many relied on behavioral distraction through household tasks, farming or

222 community engagement to manage rumination and intrusive thoughts. Some of the

223 participants described that: "*Working outside or helping around the house helps me stop*

224 *thinking too much*".

225   Social support from family, neighbors and peers was a critical emotional resource.

226 Talking with trusted individuals helped alleviate loneliness and provided reassurance:

227 "*Talking with my relatives helps me feel less alone*." Spirituality played a central coping role

228 across narratives. Participants emphasized that prayer, visiting temples, and engaging in

229 Buddhist rituals helped restore a sense of calm and perspective during periods of uncertainty.

10

230 These coping mechanisms illustrate how cultural norms, social relationships and spiritual

231 practices intersect to shape resilience among returning migrant workers.

232

233 **Discussion**

234 This study highlights how Cambodian migrant workers experience psychological distress after

235 returning from Thailand and shows that reintegration is shaped by a combination of economic

236 hardship, structural vulnerabilities, and social expectations. Returnees described ongoing

237 anxiety, sadness and "*thinking too much*", driven largely by financial insecurity, renewed debt,

238 and difficulty securing stable income. Experiences of exploitation abroad, community stigma,

239 and gendered family pressures further intensified emotional strain. At the same time, returnees

240 demonstrated resilience through culturally rooted coping strategies such as spiritual practices,

241 social support, and engagement in daily activities. These findings underscore that post-

242 migration mental health is deeply embedded in broader socioeconomic and cultural contexts,

243 emphasizing the need for reintegration and mental-health support that is both community-based

244 and culturally grounded.

245 **Financial stress as a primary driver of emotional distress**

246 Consistent with studies from Cambodia and other Southeast Asian migration corridors,

247 financial insecurity emerged as the most salient source of psychological distress among

248 returnees. Participants described persistent anxiety related to debt, unstable income and unmet

249 family needs echoing prior research showing that economic strain is a central determinant of

250 post-migration stress (7,6,4). Many returnees viewed migration as an economic strategy, and

251 returning without sufficient savings or perceived success contributed to feelings of failure and

252 shame. These findings align with global evidence demonstrating that financial strain is a key

253 determinant of depression, persistent worry, and reduced well-being among migrant workers

254 (16,17).

11

255   The theme of "thinking too much" or in Khmer word "kuet chruen", a culturally embedded

256   idiom of distress was frequently linked to financial concerns. Previous research in Cambodia

257   has shown that rumination about economic hardship often manifests through such idioms,

258   which reflect both emotional and somatic aspects of suffering. The present findings reinforce

259   the importance of understanding local expressions of distress when designing mental-health

260   interventions (8).

261   **Psychological distress shaped by social and structural vulnerabilities**

262   In addition to financial stress, participants reported a range of emotional challenges, including

263   sadness, frustration, sleep disturbance, and loss of motivation. These symptoms mirror findings

264   from regional studies documenting the psychological consequences of migration-related

265   stressors such as hazardous work environments, wage withholding, employer control, and fear

266   of arrest or deportation (4,5). Structural vulnerability defined as the social, economic, political

267   and legal forces that constrain agency and heighten exposure to harm was evident both during

268   migration and throughout the reintegration period (3) .

269   Returnees' mental health was influenced not only by prior workplace exploitation but also by

270   the stresses of reintegration, including community stigma, shifting family expectations, and

271   gendered norms. Male returnees described pressure to fulfill provider roles, while women noted

272   increased caregiving responsibilities upon returning home. These gendered expectations reflect

273   broader literature showing that migration and reintegration burdens differ by gender and

274   contribute to unique patterns of emotional distress (18,19).

275   **Reintegration as a prolonged and challenging process**

276   The findings highlight that reintegration is not a discrete event but an ongoing process,

277   consistent with evidence from Cambodia and other migrant-sending countries (10,11).

278   Although participants initially felt relief upon returning home, emotional well-being often

279   declined as financial obligations resumed and employment proved difficult to secure. This

12

280   aligns with the "post-migration deterioration" hypothesis, which suggests that mental health

281   may worsen once migrants are back in environments where structural challenges persist (20).

282   Participants also expressed a lack of access to mental-health services during reintegration. This

283   is consistent with national reports indicating that Cambodia's mental-health system remains

284   severely under-resourced, with limited availability outside major urban centers. The absence

285   of support systems exacerbates distress among returnees facing significant socioeconomic

286   challenges (17).

287   **Coping strategies and resilience shaped by culture and community**

288   Despite significant adversity, participants demonstrated resilience through a variety of coping

289   strategies. Behavioral distraction (e.g., farming, community work), social support from family

290   and neighbors, and spiritual practices such as visiting temples and prayer were common. These

291   findings echo research highlighting the importance of collective coping, Buddhism, and

292   spiritual meaning-making in Cambodian communities (16,8,21). The use of avoidance,

293   cognitive reframing, and emotional regulation mirrors coping patterns documented among

294   Southeast Asian migrant populations, where maintaining composure and preserving social

295   harmony are culturally valued. These culturally grounded coping practices may buffer distress

296   but may also delay engagement with formal mental-health services, highlighting the need for

297   culturally adapted interventions (22).

298   **Implications for policy and practice**

299   The findings point to several practical implications. First, reintegration programs should

300   prioritize livelihood support, debt relief mechanisms and skills-based employment

301   opportunities to reduce financial strain. Second, mental-health interventions must be culturally

302   grounded, community-based, and sensitive to local expressions of distress. Integrating mental-

303   health services into existing social and economic support programs may be particularly

304   effective. Third, cross-border labor protections and pre-departure training addressing

13

305   psychological well-being should be strengthened to reduce risk factors associated with

306   migration.

307   **Strengths and limitations**

308   This study provides in-depth qualitative insights into the post-migration mental health

309   experiences of Cambodian returnees. The use of reflexive thematic analysis enhanced the rigor

310   of the findings, and the inclusion of men and women from diverse occupations and provinces

311   allowed for a broad range of perspectives. The study also captures nuanced cultural expressions

312   of distress and coping, offering valuable contextual understanding that is often missing from

313   existing migration research in Cambodia.

314   However, several limitations should be noted. The small sample size of eight participants limits

315   its representativeness of the findings and may not fully reflect the diversity of experiences

316   among all Cambodian returnees. Purposive sampling may have introduced selection bias, and

317   the reliance on self-reported narratives could be influenced by recall limitations or social

318   desirability pressures. Additionally, the findings are shaped by the specific cultural and

319   socioeconomic conditions of the provinces included in the study and may not be generalizable

320   to other migrant populations or geographic settings.

321   **Conclusion**

322   This study highlights the complex emotional challenges faced by Cambodian migrant workers

323   after returning from Thailand. Financial insecurity, structural vulnerabilities, and reintegration

324   pressures were key contributors to psychological distress, while culturally grounded coping

325   strategies and social support played important roles in fostering resilience. These qualitative

326   insights complement quantitative findings by illustrating how economic and social conditions

327   shape lived mental health experiences. Strengthening reintegration support systems, expanding

328   access to culturally responsive community-based mental-health services, and addressing

329   structural risks across the migration cycle are essential for improving the well-being of
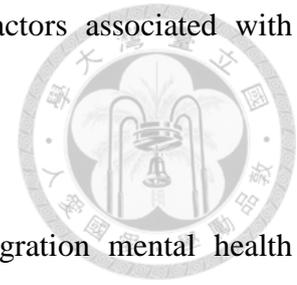
330 Cambodian returnees. These findings highlight the urgent need for coordinated migration and

331 mental health policies to support returnees more effectively.

332 **Acknowledgements**

343 **References**

344 1. International Organization for Migration (IOM). *Migration in Cambodia: Internal and*
345 *Cross-Border Movement* [Internet]. Geneva: International Organization for Migration;
346 2019. Available from: https://publications.iom.int/books/migration-cambodia-internal-
347 and-cross-border-movement

348 2. World Bank. *Cambodia Economic Update: Rebuilding after COVID-19* [Internet].
349 Washington, DC: World Bank; 2023. Available from:
350 https://documents.worldbank.org/en/publication/documents-
351 reports/documentdetail/099533205172332087/p17529804302bab050ad7101551b2f68a5f

352 3. Farmer P. An anthropology of structural violence. *Curr Anthropol*. 2004;45(3):305–325.
353 doi:10.1086/382250.

354 4. International Organization for Migration (IOM). Cambodian labour migrants in Thailand
355 [Internet]. Geneva: International Organization for Migration; 2019. Available from:
356 https://www.iom.int/news/cambodian-labour-migrants-thailand-iom-study

357 5. International Labour Organization (ILO), editor. *ILO global estimates on international*
358 *migrant workers: Results and methodology*. 3rd ed. Geneva: International Labour
359 Organization; 2021.

360 6. Bylander M, Hamilton E. Loans and Leaving: Migration and the Expansion of
361   Microcredit in Cambodia. *Popul Res Policy Rev*. 2015;34(5):687–708.
362   doi:10.1007/s11113-015-9367-8

363 7. Hing V, Lun P, Oeur I. *Irregular Migration from Cambodia: A Study of Recruitment*
364   *Channels and Working Conditions of Cambodian Migrants in Thailand* [Internet]. Phnom
365   Penh, Cambodia: Cambodia Development Resource Institute (CDRI); 2011. Available
366   from: https://cdri.org.kh/publication/irregular-migration-from-cambodia/

367 8. Hinton DE, Pich V, Chhean D, Safren SA, Pollack MH. Somatic-focused trauma
368   interventions for traumatized refugees: A case study. *Transcult Psychiatry*. 2012;49(3–
369   4):367–388. doi:10.1177/1363461511425093

370 9. Chien S, Liu KL, Khov H, Chan CC. Gender Differences in Mental Health Among
371   Returned Cambodian Migrant Workers During the COVID-19 Pandemic. *Asia Pac J*
372   *Public Health*. 2025;37(1):156–159. doi:10.1177/10105395241304077.

373 10. Chan S, Higgs ES. Reintegration stress among Thai return migrants. *Asian Popul Stud*.
374   2020;16(3):278–295. doi:10.1080/17441730.2020.1811769

375 11. Phuong S, Chan N, Vuthy C. Social reintegration of Cambodian migrants after return
376   from Thailand. In: *Economic Development in Asia: Studies on Social and Economic*
377   *Issues* [Internet]. Chiba, Japan: Institute of Developing Economies (IDE–JETRO); 2019.
378   Available from:
379   https://www.ide.go.jp/library/English/Publish/Reports/Ec/pdf/201902_02_ch03.pdf

380 12. Derks A. *Reintegration of Migrant Workers in Cambodia* [Internet]. Phnom Penh,
381   Cambodia: International Organization for Migration; 2008. Available from:
382   https://publications.iom.int/books/reintegration-migrant-workers-cambodia

383 13. Quesada J, Hart LK, Bourgois P. Structural vulnerability and health: Latino migrant
384   laborers in the United States. *Med Anthropol*. 2011;30(4):339–362.
385   doi:10.1080/01459740.2011.576725

386 14. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*.
387   2006;3(2):77–101. doi:10.1191/1478088706qp063oa

388 15. Rampin R, Rampin V, Bui AT. Taguette: Open-source qualitative data analysis. *J Open*
389   *Source Softw*. 2021;6(68):3768. doi:10.21105/joss.03768

390 16. Steel Z, Chey T, Silove D, Marnane C, Bryant RA, van Ommeren M. Association of
391   torture and other potentially traumatic events with mental health outcomes among
392   populations exposed to mass conflict and displacement: A systematic review and meta-
393   analysis. *JAMA*. 2009;302(5):537–549. doi:10.1001/jama.2009.1132

394 17. World Health Organization (WHO). *Refugees and migrants in times of COVID-19:*
395   *Mapping trends of public health and migration policies and practices* [Internet]. Geneva:
396   World Health Organization; 2021. Available from:
397   https://www.who.int/publications/i/item/9789240028906

398 18. Piper N. Feminization of migration and the social dimensions of development. *Third*
399   *World Q*. 2017;38(5):1127–45. doi:10.1080/01436597.2016.1205441

400   19. International Organization for Migration (IOM). *Inner Journeys: Mental Health and*
401   *Psychosocial Perspectives on the Migration, Return and Reintegration Experiences of*
402   *Ethiopian, Somali and Sudanese Migrants in Vulnerable Situations* [Internet]. Geneva:
403   International Organization for Migration; 2020. Available from:
404   https://publications.iom.int/books/inner-journeys-mental-health-and-psychosocial-
405   perspectives-migration-return-and-reintegration.

406   20. Zimmerman C, Kiss L, Hossain M. Migration and Health: A Framework for 21st Century
407   Policy-Making. PLOS Med [Internet]. 2011;8(5):1001034. Available from:
408   https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001034

409   21. Eisenbruch M. The Cultural Epigenesis of Gender-Based Violence in Cambodia: Local
410   and Buddhist Perspectives. *Cult Med Psychiatry*. 2018;42(2):315–349.
411   doi:10.1007/s11013-017-9563-6

412   22. Nguyen TP, Karney BR, Bradbury TN. When poor communication does and does not
413   matter: The moderating role of stress. *J Fam Psychol*. 2020;34(6):676–686.
414   doi:10.1037/fam0000643

415
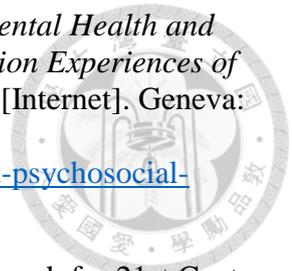
Appendix 5. Research Quantitative Questionnaire in English version
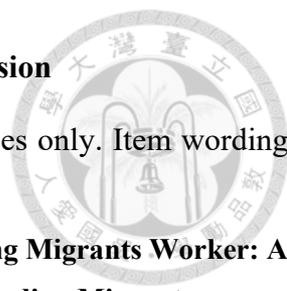
This questionnaire is reproduced for research documentation purposes only. Item wording follows standardized instruments where applicable.

Demand and Minimum Humanitarian Settings for SRHR for Returning Migrants Worker: A study for a better sexual and reproductive health among Cambodian Migrants

Interviewee's ID: ………...…………………………...………………

Interview place: Province: ……………............………… District / Khan: ………...………

Commune/Sangkat: …………………………...Village: …………………………………

Interviewer's ID: …………………Started: ……………Finished: ………………….

Field work supervisor's check: Yes……………No: ……………

No.	Questions & Instruction	Answer	Code	Skips
I.	**SECTION I: SOCIO-DEMOGRAPHIC INFORMATION**			
Q101	Type of respondent (Gender) *[Interviewer record this answer without asking respondent]*	Male Female Transgender	1 2 3	
Q102	How old are you? (Enter response in years. If DK, enter 88, if refuse to answer, enter 99)	Years……………		
Q103	What is the highest grade you completed?	No formal schooling Primary incomplete Primary complete Secondary incomplete Secondary complete Undergraduate Master level Others, Specify………………	0 1 2 3 4 5 6 99	
Q104	What is your current job?	No job Student Construction worker	0 1	

		Fishing sector	2	
		Food factories	3	
		Manufacturing, industries and services	4	
			5	
		Seasonal work (including Thailand)	6	
			7	
		Small business	8	
		Private company	77	
		DK/Not response	99	
		Others, Specify……………		
Q105	How much do you earn a month?	Less than $100/month (400K Riel)	1	
			2	
		$100-$200/month (400-800K Riel)	3	
			4	
		$200-$500/month (800-2000K Riel)	99	
		Over $500/month (2000K Riel)		
		Others, Specify……………		
Q106	What is the type of house you are living?	No home	0	
		Own house	1	
		Parent house	2	
		Relative house	3	
		Rent room alone	4	
		Rent room with friends	5	
			6	
		Work place	7	
		Public place	99	
		Others, Specify…………		

Q107	Marital Status	Single	0	
		Married (**with** Certificate)	2 3	
		Married (**without** certificate)	4 5	
		Stay with a spouse	6	
		Separated	7	
		Divorced	77	
		Widow	99	
		DK/Not response		
		Others, Specify……………… .		
Q108	Do you have children? **0 skip to Q109**	Yes	1	
		No	0	
Q109	If yes, how many?	One Child	1	
		2-3 Child	2	
		More than 3 Child	3	
		DK/Not response	77	
Q110	Have you returned from working abroad (that is, outside of Cambodia) in the last 24 months?	Yes	1	
		No	0	
Q111	How many years and/or months ago did you return to Cambodia from your most recent trip to work abroad?	Year:……………. Month:……………		
Q112	In which country was you most recently working?	Thailand	1	
		Malaysia	2	
		China	3	
		South Korea	4	
		Japan	5	
		Others, Specify……………	99	

167

Q113	What type of visa you were holding at the time?	Student visa	1	
		Working visa	2	
		Tourist visa	3	
		I was working without a work visa	4	
		Refused	88	
		Others, Specify…………	99	
Q114	In what industry was your most recent job?	Fishing (on a boat)	1	
		Seafood processing	2	
		Agriculture	3	
		Construction	4	
		Domestic work	5	
		Hospitality	5	
		Manufacturing	6	
		Driving	7	
		Refused	88	
		Others, Specify…………	99	
Q115	Did you have a written employment contract?	Yes	1	
		No	0	
		Don't know	88	
		Others, Specify…………	99	
Q116	Who was your contract with?	Recruiter	1	
		Employer	2	
		Don't know	88	
		Others, Specify…………..	99	
Q117	How did you obtain the job in [destination country]?	A family member already in [dest_country]	1	
		A friend already in [dest_country]	2	
			3	

		[A country which the respondent obtains in the last trip]	A government registered official job recruitment agency	4	
			A private recruitment agency (not registered with the government)	5	
			A recruitment agency (respondent unsure if it was registered or not)	6	
			An individual with connections of job placement in [dest_country]	7	
			I found it myself	8	
			Private broker/Human smuggler	88	
			Don't know	99	
			Others, Specify………………		
Q118		Did you pay a recruitment fee to a broker or recruiter in order to secure your job in [dest_country]? I am referring to a fee other than the costs of plane tickets, visas, health checks, etc.	No	0	
			Yes – paid a fee during recruitment/prior to starting job	1	
			Yes – paid a fee only after arriving and beginning job	2	
			Don't know – paid recruiter lump sum and unsure whether payment went towards recruitment fee or other expenses	3	
			Don't know	88	
				99	

		Others, Specify……………	
Q119	Who decided that you should take your job?	Myself, alone A relative Myself, with my family Recruiter/broker The employer My previous employer, who sent me here without my consent Don't know Others, Specify………………	1 2 3 4 5 6 88 99
Q120	Do you have any record documents such as the card/ ID/ to access the health care if you seeking health care? [at your destination country]	Yes No Don't know **If No skip to q123**	1 0 88
Q121	Have you ever used that card to benefit from insurance?	Yes No Don't know	1 0 88
Q122	Do you know the benefits of insurance?	Occupational Injury Insurance Maternal Health Benefits (Maternity) General health insurance Sexual reproductive health and rights I have never claimed benefits	1 2 3 4 5 99

		Others, Specify……………	
Q123	Did you know that your employer pays for workers' health insurance?	Yes No Don't know	1 0 88
Q124	Have you ever suffered an injury, work accident (that was an event that happened at work or related to your job and caused your personal injury or illness)?	Yes No Don't know Others, Specify…………… **If No skip to Q126**	1 0 88 99
Q124a	Did this accident happen when you were working?	Yes No Don't know	1 0 88
Q125	Have you been to a hospital or sought treatment or health care for an occupational accident?	Yes No Don't know	1 0 88
Q126	Do you think that illegal and legal workers have the same right to health care?	Similar Different Don't know	1 2 3
Q127	Did you know that every worker is eligible for the National Social Security Fund health insurance card?	Yes No Don't know **If don't know (88) skip to q128**	1 0 88
Q128	Do you have a health examination card, health insurance card, or poor health insurance card for health examination in our district?	Yes No Don't know	1 0 88

171

Q129	Do you know where you can get health insurance?	Yes	1	
		No	0	
		Don't know	88	

SECTION 2: KNOWLEDGE AND ATTITUDE ON SRHR

Q201	Have you ever heard about SRHR? **0 skip to q205**	Yes	1	
		No	0	
Q202	If you have heard or known, what do you know about sexual reproductive health and rights?	HIV/AIDS	1	
		Family planning	2	
		Gynecology/obs	3	
		Maternal and child health	4	
			5	
		Pregnancy	6	
		Gender and Violence	7	
		Communication and decision	8	
			9	
		Abortion and safe abortion	10	
		Health seeking behavior	88	
		STI/STD	99	
		Don't know		
		Others, Specify………………		
Q203	From who have you heard about this information?	Friends	1	
		Parents	2	
		School	3	
		HC staff	4	
		Private clinic	5	
		Co-workers	6	
		Reading IEC materials	7	
		Social media	8	
		TV / Radio	9	
		Others, Specify…………………	99	

Q204	Do you know where to go when you need a SRHR information or services	HC	1	
		Private clinic	2	
		Pharmacy	3	
		Governmental facilities (HC/RH)	4	
		NGOs clinic	5	
		Others, Specify………………	99	
Q205	Can you tell me how much you know about sexual violence? (SGBV)	Yes (Know it)	1	
		No	0	
Q206	Do you know what is the sexual violence is?	Forced Sex	1	
		Threats	2	
		Forced Pregnancy	3	
		Rape	4	
		Sexual exploitation	5	
		Harassment	6	
		Sex work	7	
		Forced prostitution	8	
		Don't know	88	
		Others, Specify………………	99	
Q207	How often have you heard, heard and seen advertisements about sexual violence?	Very often	1	
		Often	2	
		Sometimes	3	
		Never	4	
Q208	What sources of information do you hear about sexual violence education? (Mark all answers answered)			
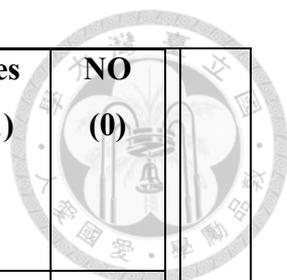
		What sources of information do you hear about sexual violence education? (Mark all answers answered)	Yes (1)	NO (0)	
		Radio			
		TV			
		Cassette			
		Billboard			
		Health professionals			
		Family			
		Friends			
		Through RHAC staff Or RHAC organization			
		Facebook			
		Other ……………………..			
Q209	Do you think you need to learn about SRHR?		Yes	1	
			No	0	
Q210	Do they think it is important for youth to learn about SRHR?		Yes	1	
			No	0	
Q211	Do you think young girl also needs to learn about SRHR or ASRH?		Yes	1	
			No	0	
Q212	The right age to begin sexuality education is:	Around 5 years old	1		
		Around 8 years old	2		
		Around 12 years old	3		
		Around 18 years old	4		
		None of the above	5		
		Others, Specify………………	99		
II. KNOWLEDGE RELATED TO ABUSE AND SEXUAL HARASSMENT					

Q213	Have you experienced sexual harassment?		Yes	1
			No	0
			Don't Know	88

Q214	Does your workplace have a sexual harassment policy?		Yes	1
			No	0
			Don't Know	88

Q215	If you experience sexual harassment, do you know how to report it?		Yes	1
			No	0
			Don't Know	88

q216 Have you ever seen or heard of any of the following happen to your co-workers?

Question	Yes	No	Don't know
Threatening them Or family by any violence			
Physical abuse			
Sexual abuse			
Send them to the authorities and police			

Section 2C: Knowledge related to HIV, AIDS, transmission and access to health services

| Q220 | Have you ever heard or heard about HIV / AIDS? | | Yes | 1 |
| | | | No | 0 |

Q221: I am now going to read you some statements about HIV/AIDS. Please tell me whether you think the statement is True, or False, or whether you don't know.

Question	Yes	No	D
It is possible to cure AIDS			
A person with HIV always looks unhealthy in some way			
They can know HIV status without taking HIV test			

Q222	Apart from HIV/AIDS, there are other diseases that men and women can catch by having sexual intercourse. Have you heard of any of these diseases?	Yes No	1 0	
Q223	And what are the signs or symptoms when a woman is infected?	Vaginal discharge Pain during urination Ulcers/sore in genital area Skinny body Abnormal bleeding Don't Know Other (specify)_.......................	1 2 3 4 5 88 99	
Q224	If a friend of yours needed treatment for a sexually transmitted disease, where could he or she obtain such treatment? PROBE Any other places?	Shop Pharmacy Government hospital Private clinic RHAC clinic Facility Indicated by health insurance	1 2 3 4 5 6	
Q225	Have you ever had a sexually transmitted disease?	Yes No	1 0	
Q226	Did you seek treatment?	Yes No **If No Skip to Q228**	1 0	
Q227	Where did you seek treatment?	Shop Pharmacy Government hospital Private clinic RHAC clinic	1 2 3 4 5	

		Facility Indicated by health insurance	6	
Q228	Did your sexual partner (any of your partners) seek treatment?	Yes No Don't Know	1 0 88	

Q228a **Where did you obtain information on HIV/AIDS or STD?**

Questions	Yes	No
Radio		
TV		
Newspapers		
Poster		
Health professional		
Family		
Friends		
RHAC staff/RHAC social media		
Tik Tok/Instagram/Line		
Other (specify)		

Q229	Have you heard of pill?	Pill IDU Implant Jelly/foam Female sterilization Condom Other (specify)_........................	1 2 3 4 5 6 99	If No skip to q232
Q230	Which method do you think is most suitable for young people?	Pill IDU Implant Jelly/foam Female sterilization Condom	1 2 3 4 5 6 99	

		Other (specify)_......................	
Q231	Which method do you think is most suitable for young people?	Pill IDU Implant Jelly/foam Female sterilization Condom Other (specify)_......................	1 2 3 4 5 6 99
Q232	Have you ever-used a modern contraceptive? If No skip to q234	Yes No	1 0
Q233	Have you ever-used a modern contraceptive?	Pill IDU Implant Jelly/foam Female sterilization Condom Other (specify)_......................	1 2 3 4 5 6 99
Q234	If no, why don't you use any modern contraceptives? Or do you have other options? (multiple answer).	Too young Wanted child Influenced from husband or partners Influenced from parent Unmet needs Using traditional method (e.g., calendar, withdrawal) Other (specify)…………	1 2 3 4 5 6 99
Q235	In your opinion, if you want to find a contraceptive service,	Shop Government hospital Private clinic Facility Indicated by health insurance	1 2 3 4

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doi:10.6342/NTU202504848

	where should you seek in the destination country?	Other (specify)........................	99
Q236	In your opinion, if you want to seek for the contraceptive services at destination country where should you seek from?	Shop Government hospital Private clinic Facility Indicated by health insurance Other (specify)........................	1 2 3 4 99
Q236a	Do you know how many times which pregnancy women should take the ANC should receive?	One time 2 to 3 times 4 to 5 times More than 6 times Don't know	1 2 3 4 88
Q237	Where do you think pregnant women in migration country should go for antenatal care (ANC)?	Government hospital Private clinic Facility Indicated by health insurance In their working place Other (specify)........................	1 2 3 4 99
Q237a	Why they chose that option?	There is other option Nearby their place Easy to access Know someone at the health facility Reliable on that health service Ever used and accessed service before Other (specify)........................	1 2 3 4 5 6 99
Q238	In your opinion, what about accessing health services in the country of	In the destination country is better than	1 2 3

	migration and in Cambodia?	In Cambodia is better than Similar health services in and outside Don't know	88
Q238a	If in the destination countries better than in Cambodia, why?	Quality of medical services Staff friendly Affordable prices for migrant workers Free of charge for migrant worker Same rights to the local people in receiving health services in destination country Have enough time Other (specify)…………	1 2 3 4 5 6 99
Q238b	If Cambodia is better than the destination country? Why?	Quality of medical services Staff friendly Affordable prices for migrant workers Free of charge for migrant worker Same rights to the local people in receiving health services in destination country Have enough time Other (specify)…………	1 2 3 4 5 6 99
	Part II. From your experiences, please let me know about your experience of abortion or safe abortion		
Q240	Do you know about abortion or safe abortion? If No skip to q243	Yes No	1 0

Q241	Can you tell me what are the consequences of unsafe abortion?	Bleeding Rupture of the uterus Mother death Infertility rate Infected Other (specify)…………	1 2 3 4 5 99	
q241a	Did you know that abortion is legal?	Yes No	1 0	
Q242	Do you have friends or relatives who have had abortions while working in a migrant country?	Yes No	1 0	
Q243	What do you think: Where did they seek abortion services? In the destination country?	Buy abortion pills from the stores Buy abortion pills from the pharmacy Seek at the public hospital or HC Went to private clinic Return to Cambodia to find service Facility Indicated by health insurance Other (specify)…………	1 2 3 4 5 6 99	
Q244	Do women have rights to make their own decision to receive safe abortion service?	Yes No Don't know	1 0 88	
Q246	Do you know that if you have any questions or would like to make appointment with a doctor	Yes No Don't know	1 0 88	

	for a safe abortion service?			
Q247	Have you or a friend of yours ever received cervical cancer related services in the destination country? If male respondent (imagine from their perception). If No skip to q250		Yes No	1 0
Q248	Where do you / your friend seek cervical cancer screening services?	Public Hospital (RH or HC) Private Clinic RHAC Clinic Facility Indicated by health insurance Shop Pharmacy Other (specify)…………		1 2 3 4 5 6 99
Q249	Why you or your friends chose that option?	No other option Nearby my place Easy to access Know someone at the health service Health service reliable Ever used health service before Other (specify)…………		1 2 3 4 5 6 99
Q250	Did you know that there is a vaccine to prevent cervical cancer?		Yes No	1 0
Q251	Do you think women should be vaccinated		Yes No	1 0

		against cervical cancer for every woman?		
Q252	If you want to seek advice and get vaccinated against cervical cancer, where can you find it?	Public Hospital (RH or HC)	1	
		Private Clinic	2	
		RHAC Clinic	3	
		Facility Indicated by	4	
		health insurance	5	
		Pharmacy	99	
		Other		
		(specify)…………		
	Part 2H. Knowledge related to RHAC Clinic			
Q253	Do you know an RHAC clinic or organization? If No skip to q301	Yes	1	
		No	0	
Q254	Can you tell me how to get to the RHAC clinic nearest to your place?	Yes	1	
		No	0	
Q255	Have you ever received services from any RHAC clinics?	Yes	1	
		No	0	
Q256	Can you tell me about available services at RHAC clinics?	STI	1	
		FP	2	
		Abortion	3	
		HIV	4	
		ANC/PNC	5	
		Laboratory	6	
		Other	99	
		(specify)_...................		
SECTION III: HEALTH SERVICES UTILIZATION (BEHAVIOR AND PRACTICE)				
Q301	Have you ever accessed to any health center to	Yes	1	

		receive information or ASRH services (e.g., contraception, pregnancy, abortion or sexually transmitted deceases) in the last 4 years? **1skip to q303**	No	0	
Q302	If no, what were the reasons?	Never get sick or health problems You don't have any health issues Don't trust privacy/confidentiality of HC Health service far from my place Don't feel comfortable talking to HC staff Lack of health staff professional Long waiting time Price too high, not affordable Other (specify)_........................	0 1 2 3 4 5 6 7 99	
Q303	If yes, what of the following information you had accessed for? [Multiple-answers]	Family planning Pregnancy Abortion STI service HIV service No answer Other (specify)_........................	1 2 3 4 5 88 99	

Q304	Thinking about your last visit, did you go to a government health center or hospital or a private clinic? If 3 skip to q305	HC Hospital Private clinic Other (specify)_........................	1 2 3 99	
Q305	How many times have you sought services or information from a doctor or a nurse for these services in the last 12 months?	Number of times ___|___ Did not seek care in last 12 months => **0**		
Q306	If more than one service, did you get all services are intended at once?	Yes No	1 0	
Q307	Did you feel satisfied with the service(s) provided?	Yes No So and so	1 0 3	
Q309	Did you feel comfortable enough to ask questions to the doctor or healthcare workers? **If No skip to 311a**	Yes No	1 0	
Q310	If you have not gone to HC or RH, have you gone to any private clinic?	Yes No	1 0	
Q311	If so, what would be the reasons (Please take 3 most suitable responses)	Short waiting time Trust on privacy and confidentiality Staff are friendly Has seen separate room for patient Has separate staff for patient	1 2 3 4 5 6 7	

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		Staff explain me about the issue in detail Has multiple services High quality services Reasonable cost Other (specify).........................	8 9 99	
	Part 3B: Do you remember: Did you receive any health, sexual, or reproductive health services when you were working abroad?	Yes No	1 0	
Q311	Q311a If ever, what are the health care services?	Family planning Pregnancy Abortion STI service HIV service Health service at my workplace Other (specify)_.......................	1 2 3 4 5 6 99	
Q312	Thinking about the last job you did abroad [in a migrant country], did you go to a public health center/ a public hospital or a private clinic? Overseas	Public health facilities Private facilities Never	1 2 0	
Q313	How many times did you seek sexual reproductive health and rights services or information from a nurse when you were working abroad?	Number ……………… 0=never seek for the service		

Q314	Do you feel satisfied with the health services your doctor provides to you [at the country of migration]?	Yes No So and so	1 0 3	
Q315	Are you comfortable enough to ask questions to your doctor or health care provider?	Yes No	1 0	
Q316	Have you ever request for your health care services related to sexual reproductive health and right (in the destination country)? **If No Skip q316a**	Yes No	1 0	
Q316a	If yes, what health services have you requested?	Family planning Pregnancy care Abortion STI service HIV service Home base care Fee of charge for health service Mental health care Digital health care Other (specify)_........................	1 2 3 4 5 6 7 8 9 99	
Q317	Do you know of any health care policies or services in [target country] for migrant workers (working outside of Cambodia)? If No skip to q319	Yes No	1 0	

Q318	Q318 If so, what are the health care policies for migrants [have you ever used or known]? In the country of migration!	All workers receive free medical examination and treatment	1	
		Workers have equal rights to health care	2	
		Migrant worker receiving health service the same local people	3 4 5	
		Special discount for migrant workers	6	
		Migrant workers are paid more than local people	99	
		Still get paid when they sick leave		
		Other (specify)........................		
Q319	Do you know of any health care policies or services in Cambodia for migrant workers? If No skip to q322M	Yes No	1 0	
Q320	Q320 If so, what is the health care policy for migrants [have you ever used or known]?	All workers receive free medical examination and treatment	1	
		Workers have equal rights to health care	2	
		Migrant worker receiving health service the same local people	3 4 5	
		Special discount for migrant workers	6	
		Migrant workers are paid more than local people	99	
		Still get paid when they sick leave		

		Other (specify).......................	
Q322F	Do you know what are the sexual reproductive health services and rights of migrant workers in the country they are most in need of (for the women)?	Open answer for this question	
Q322M	Do you know what are the sexual reproductive health services and rights of migrant workers in the country they are most in need of (for the women)?	Open answer for this question	
Q322SOGIE	Do you know what are the sexual reproductive health services and rights of migrant workers in the country they are most in need of (for the women)?	Open answer for this question	
III.	**COMMUNICATION AND INNOVATIONS (DIGITAL HEALTH SEEKING BEHAVIOR)**		

Q401. Apart from calling**,** most of the time, how do you <u>communicate</u> with the followings people with your relatives' siblings and other? **(√)** **(Select the most suitable 3 preferred)**

Code	Family (√)	Co-workers (√)	Close friends (√)	Partners (√)
1	Facebook	Facebook	Facebook	Facebook
2	Messenger	Messenger	Messenger	Messenger
3	ផ្ញើសារ SMS	ផ្ញើសារ SMS	ផ្ញើសារ SMS	ផ្ញើសារ SMS
4	Instagram	Instagram	Instagram	Instagram
5	Line	Line	Line	Line
6	Telegram	Telegram	Telegram	Telegram
7	What's App	What's App	What's App	What's App
8	Twitter	Twitter	Twitter	Twitter
9	TikTok	TikTok	TikTok	TikTok
10	YouTube	YouTube	YouTube	YouTube
11	WeChat	WeChat	WeChat	WeChat
12	Viber	Viber	Viber	Viber
13	Others	Others	Others	Others

Q402. Which of the means below have you used for seeking for health services related to sexual reproductive health and rights **(Select the most suitable 3 – for each column)**

Code	Family (√)	Co-workers (√)	Close friends (√)	Partners (√)
1	Facebook	Facebook	Facebook	Facebook
2	Messenger	Messenger	Messenger	Messenger
3	ផ្ញើសារ SMS	ផ្ញើសារ SMS	ផ្ញើសារ SMS	ផ្ញើសារ SMS
4	Instagram	Instagram	Instagram	Instagram
5	Line	Line	Line	Line
6	Telegram	Telegram	Telegram	Telegram
7	What's App	What's App	What's App	What's App
8	Twitter	Twitter	Twitter	Twitter
9	TikTok	TikTok	TikTok	TikTok
10	YouTube	YouTube	YouTube	YouTube
11	WeChat	WeChat	WeChat	WeChat
12	Viber	Viber	Viber	Viber
13	Others	Others	Others	Others

PART 5. MENTAL HEALTH SCALE					
PATIENT HEALTH QUESTIONNAIRE (PHQ-4)					
Over the **last two weeks**, how often have you been bothered by the following problems?					
Q501	Feeling nervous, anxious or on the edge?		Not at all	0	
			Several days	1	
			More than half the day	2	
			Nearly every day	3	
			Refused	88	
			Don't know	99	
Q502	Not being able to stop or control worrying		Not at all	0	
			Several days	1	
			More than half the day	2	
			Nearly every day	3	
			Refused	88	
			Don't know	99	
Q503	Little interest or pleasure in doing things		Not at all	0	
			Several days	1	
			More than half the day	2	
			Nearly every day	3	
			Refused	88	
			Don't know	99	
Q504	Feeling down, depressed or hopeless		Not at all	0	
			Several days	1	
			More than half the day	2	
			Nearly every day	3	
			Refused	88	
			Don't know	99	
Q505	Do you have any additional comments?		If you don't have, we can finish our session now!		

Thank you very much for your participation!

Appendix 6. Patient Health Questionnaires-4 (PHQ-4), English version

The PHQ-4 is a standardized mental health screening instrument. The scale is reproduced here for research reference and documentation only.

PHQ-4

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

<u>Scoring</u>

PHQ-4 total score ranges from 0 to 12, with categories of psychological distress being:
- None   0-2
- Mild   3-5
- Moderate   6-8
- Severe   9-12

Anxiety subscale = sum of items 1 and 2   (score range, 0 to 6)

Depression subscale = sum of items 3 and 4   (score range, 0 to 6)

On each subscale, a score of 3 or greater is considered positive for screening purposes

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The PHQ scales were developed by Drs. Robert L. Spitzer, Janet B.W. Williams, and Kurt Kroenke and colleagues. The PHQ scales are free to use. For research information, contact Dr. Kroenke at kkroenke@regenstrief.org

Kroenke K, Spitzer RL, Williams JBW, Löwe B. An ultra-brief screening scale for anxiety and depression: the PHQ-4 Psychosomatics 2009;50:613-621.

Patient Health Questionnaire-4 (PHQ-4), Khmer Version

This Khmer version of the PHQ-4 was translated and used for data collection in the present study. The content is included for transparency and methodological reporting.
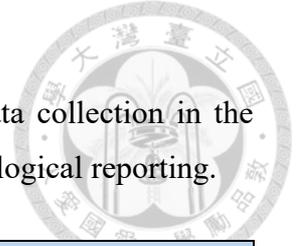
ផ្នែកសុខភាពផ្លូវចិត្តរបស់ពលករចំណាកស្រុកដែលវិលត្រឡប់មកវិញ				
ក្នុងរយៈពេលពីរសប្តាហ៍ចុងក្រោយនេះ តើអ្នកត្រូវបានរំខានដោយបញ្ហាខាងក្រោមនេះញឹកញាប់ប៉ុណ្ណាដែរ?				
1	មានអារម្មណ៍ភ័យ ជប់ជាម្ន	មិនដែលទាល់តែសោះ	0	
		កើតឡើងជាច្រើនថ្ងៃ	1	
		ច្រើនជាងធម្មតា	2	
		ស្ទើរតែរាល់ថ្ងៃ	3	
2	មានអារម្មណ៍ មិនអាចបញ្ឈប់ ឬគ្រប់គ្រងការព្រួយបារម្ភខ្លួនឯង	មិនមែនទាល់តែសោះ	0	
		កើតឡើងជាច្រើនថ្ងៃ	1	
		ច្រើនជាងពាក់កណ្ដាលនៃថ្ងៃ	2	
		ស្ទើរតែរាល់ថ្ងៃ	3	
3	មានចំណាប់អារម្មណ៍តិចតួច ឬ មិនរីករាយក្នុងការធ្វើអ្វីៗ	មិនមែនទាល់តែសោះ	0	
		កើតឡើងជាច្រើនថ្ងៃ	1	
		ច្រើនជាងពាក់កណ្ដាលនៃថ្ងៃ	2	
		ស្ទើរតែរាល់ថ្ងៃ	3	
4	មានអារម្មណ៍ធ្លាក់ទឹកចិត្ត ឬអស់សង្ឃឹម	មិនមែនទាល់តែសោះ	0	
		កើតឡើងជាច្រើនថ្ងៃ	1	
		ច្រើនជាងពាក់កណ្ដាលនៃថ្ងៃ	2	
		ស្ទើរតែរាល់ថ្ងៃ	3	

ការដាក់ពិន្ទុ៖

ពិន្ទុសរុប PHQ-4 មានចាប់ពី ០ ដល់ ១២ ជាមួយនឹងប្រភេទនៃទុក្ខព្រួយផ្លូវចិត្តគឺ៖

- មិនមាន៖ ០ ទៅ ២ ពិន្ទុ
- កម្រិតស្រាល៖ ៣ ទៅ ៥ ពិន្ទុ
- កម្រិតមធ្យម៖ ៦ ទៅ ៨ ពិន្ទុ
- កម្រិតធ្ងន់៖ ៩ ទៅ ១២ ពិន្ទុ

រង្វាស់លើជំងឺ ចប់បារម្ភ = ផលបូកនៃធាតុ ១ និង ២ (លំដាប់ពិន្ទុ ០ ដល់ ៦)
រង្វាស់លើជំងឺធ្លាក់ទឹកចិត្ត = ផលបូកនៃធាតុ ៣ និង ៤ (លំដាប់ពិន្ទុ ០ ដល់ ៦)

នៅលើរង្វាស់រងនីមួយៗ ពិន្ទុ ៣ ឬច្រើនជាងនេះ ត្រូវបានចាត់ទុកថាជាពិន្ទុវិជ្ជមានសម្រាប់
គោលបំណងពិនិត្យនេះ។

ទម្រង់សំណួរសម្ភាសអ្នកជំងឺ៤ទម្រង់នេះ គឺបានបង្កើតឡើងដោយ Drs. Robert L.
Spitzer, Janet B.W. Williams and Kurt Kroenke និងក្រុមការងាររបស់ពួកគាត់។
ទម្រង់សំណួរនេះ PHQ គឺអាចប្រើប្រាស់ដោយសេរី។ សម្រាប់ព័ត៌មានស្រាវជ្រាវ សូម
ទាក់ទងវេជ្ជបណ្ឌិត Kroenke តាមរយៈអ៊ីម៉ែល៖ kkroenke@regenstrief.org

Kroenke K, Spitzer RL, Williams JBW, Löwe B. An ultra-brief screening scale for anxiety and depression: the PHQ-4 Psychosomatics 2009;50:613-621.

Appendix 7. Semi-Structured Interview Guide

This interview guide outlines the thematic prompts used during qualitative data collection and is included for methodological transparency.

This appendix presents the qualitative component of the study, which involved in-depth interviews with eight returned Cambodian migrant workers. These interviews were conducted to explore participants lived experiences, including their migration motivations, working conditions abroad, challenges encountered during the COVID-19 pandemic and their reintegration experiences upon returning to Cambodia. The qualitative data comprising audio recordings, verbatim transcripts and coded analytic materials were collected and managed in accordance with ethical standards to ensure confidentiality and data protection. For reasons of privacy, the raw interview materials are not publicly included in this appendix. However, interested researchers or committee members may request access to the full qualitative dataset, including audio files, transcripts and related documentation, by contacting the Principal Investigator (PI), subject to ethical approval and data-sharing regulations.

Qualitative Interview Guide

Demand and Minimum Humanitarian Settings for SRHR for Returning Migrants Worker: A study for a better sexual and reproductive health among Cambodian Migrants

<u>Interview Guide for the Returned Migrant Worker</u>

This interview guide outlines the thematic prompts used during qualitative data collection and is included for methodological transparency.

Aims of project:

> This research assessment is led by the RHAC's & Advocacy Program in partnership with IPPF, under the 'Setting for SRHR Access for migrants: A better sexual and reproductive health among migrant Cambodian workers' project. Following the objectives of this assessment, this study aims to access the challenges related to sexual reproductive health and right among Cambodian returned migrant workers. Source of information and perceived urgent health needs.

The Objective of the Study

1. Explore the challenges related to health issues, especially sexual health, reproductive health and the exercise of reproductive and sexual rights among migrants

2. Understand the minimum requirements for reproductive health services during migration and other urgent health needs

3. Measure awareness of sexual health, reproductive health and rights, as well as sources of information among migrants

4. Examine the mechanism of facilitating the provision of sexual and reproductive health services for returned migrants workers

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Key In depth Interview (IDI)	Number
(1) Commune / Village Authorities	(1)
(2) Provincial health department staff	(2)
(3) Stakeholders or CSOs working with migrant workers	(3)
(4) The Cambodian returned migrant workers	(4)
(5) The UN Agency UNFPA and IOM)	(5)
(6) The Ministry of Labor and Vocational Training	(6)
(7) The Ministry of Health (MoH)	(7)

The interview discussion might subject to adjust based on the status of each target group. The interview should begin with a clear informed consent from the participants.

Introduction and warm-up (5 minutes)

1. Facilitator introduces self and explains set-up, set-up and presence of observers

2. Explain the purpose of the discussion "We are going to talk mostly about your experience related to sexual reproductive health and right among migrant workers from Thailand". Our topic is about the humanitarian settings for SRH for migrants.

3. Assure confidentiality and privacy for the participant

4. Encourage candidness and that there are no right or wrong answers.

Respondent Basic Geographic Information/ Demographic characteristic

(1) Date and Time: …………………………………………………………………

(2) Interview Location (site): …………………………………………………………

(3) Name: …………………………………………………………………………..

(4) Sex: Male, Female: ………………………………………………………………

(5) Age: …………………………………………………………………………………

(6) Occupation/Position: ……………………………………………..	
(7) Address/Contact: ……………………………………………	
(8) Interviewer: ……………………………………………	
QUESTIONS ABOUT MIGRANT WORK EXPERIENCE	Okay, now I'm going to ask you some questions about your experiences migrating and working outside of Cambodia. For all these questions, I want you to focus on your *most recent* job outside of Cambodia. Your experiences workplace and tasks you completed particular related to health care services/your health information either physical or mental health issues.
	1. How many years and/or months ago since you returned to Cambodia from your most recent trip to work abroad? i. Probes: How do you remember that you returned to Cambodia on which date (dd/mm/yyyy)? How did you arrive at that answer? Was this question hard to answer? 2. In which country have you most recently worked? 3. How many times have you migrated abroad for work prior to this last time in past 10 years?
Could you let me know?	4. How long have you been working in this position (number of years working in this job)? [current & past at dest_country]?

	5. Could you let me know what sexual and reproductive health means to you? 6. Do you think that women and girls should have the rights and access to sexual and reproductive health? Why do you think so?
Migration and Returned background	7. Can you tell me about your journey and experience working abroad (in Thailand)? 8. What kind of work did you do while you were abroad? 9. What were the reasons for your return to Cambodia? 10. When did you return and how was the return journey during the COVID-19 pandemic? 11. Since returning, how have you been feeling emotionally or mentally? 12. Have you experienced stress, sadness, or anxiety since your return? Can you share more? 13. How does your current situation compare to your life before going abroad?
Opinion on Accessibility and Health Facility	14. What are the most common obstacles for people to access safe healthcare services? (Ex. Cost, distance, time, cultural discrimination, insurance . . . etc), especially for yourself as a migrant worker in a foreign country?

General Knowledge related to SRHR	15.Have you heard of sexual health, reproductive health, or reproductive health and rights? Can you ever explain what reproductive health and sexual health are? What do you think of yourself in terms of sexual and reproductive health? 16.Will you discuss the information or learn more about sexual and reproductive health with your partner/spouse?
Knowledge and perception related to abortion	17.What is your opinion on the abortion in Cambodian context? 18.Do you think that women should have access to safe abortion information and services? Where? 19.Do you think that the decision to have an abortion should be part of women's sexual and reproductive health rights? Why do you think this? 20.What are your opinions on how to create the access to safe and quality abortion information and service for female migrant workers? Any suggestion? 21.Do you think where should people get access to self-managed medical abortion *[abortion pill]? (Information and abortion service).*

Knowledge, ever-use and current use of contraceptive methods	22. Have you ever used any kind of family planning? Probe: IUD, Condom, Pill, Injection, Emergency pills, Implant, Jelly/foam, Probe: anything else you may know? If you or your family using, what are the contraceptive methods you use the most? Do you think it is safe for your and your partner?
Knowledge of pregnancy related	23. Can you tell me when should pregnant women seek for the antenatal care (ANC)? Where should they get the ANC? How old is the age that women should have a birth?
Knowledge on RHAC Clinic	24. Have you ever heard about the RHAC organization or the RHAC Clinic? Probe: why or why not? If so, have you ever used any particular health services from the RHAC clinic? 25. Have you ever sought for any health care service while you were in the foreign country? What services? Why or why not? If so, can you tell me the services healthcare/treatment you received there?
View on Improving Accessibility and Digital Health Care Innovation and Intervention	26. Do you have a smartphone? Have you ever checked or searched any information regarding healthcare-seeking behavior on web sites or social media (like Facebook)?

	27. Have you ever used the smartphone to seek for health care treatment in a foreign country you worked before, or in Cambodia now? If yes, what kind of service healthcare or treatment did you access? What was the quality of the service you received?
	28. In your view, which form of media do you think people are accessing most, such as the internet, Facebook, TV, radio, magazine, or newspaper? And how often, every day, once a week?
Health seeking behavior	29. Have you ever visited a health facility or doctor of any kind to receive health services or health information in a foreign country you worked before, or in Cambodia now? How often have you sought health services or health information from the health facility/doctor in the last twelve months? [How would you satisfy health service at your last destination country and in Cambodia]? Probe: Please mention clearly to the participant on their experience of health service accessing outside Cambodia and compare them in Cambodia.
Comments and recommendation *(Interviewer takes note and observes anything unusual or interest about the interview.)*	
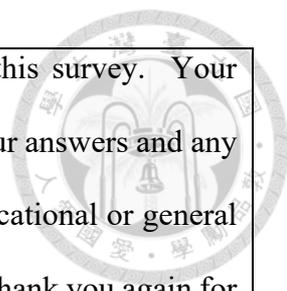
Thank you for taking the time to answer the questions in this survey. Your answers are very important to our research at the RHAC. Your answers and any personal information you provide is used exclusively for educational or general research purposes related to the improvement of the SRHR. Thank you again for your participation and your help in the Access for a better sexual and reproductive health among Cambodian migrant workers.

Quantitative Questionnaire in Khmer language

លេខកូដរបស់អ្នកឆ្លើយតបសម្ភាស: ....

ទីតាំងសម្ភាស: ខេត្ត: .... ស្រុក / ខណ្ឌ: ....

ឃុំ/សង្កាត់: .... ភូមិ: ....

លេខកូដអ្នកសម្ភាស: ....ម៉ោងចាប់ផ្ដើម: ....ម៉ោងបញ្ចប់

សម្ភាស: ....

ត្រួតពិនិត្យទម្រង់សំណួរនៃកិច្ចសម្ភាស: បាទ-------ទេ:-------

លេខទូរស័ព្ទរបស់អ្នកចូលរួម:.................

ល.រ	ទម្រង់សំណួរ	ការឆ្លើយតប	កូដ	វែង
ផ្នែកទី១៖ ព័ត៌មានសង្គមប្រជាសាស្ត្រ				
Q101	ភេទរបស់អ្នកចូលរួមសម្ភាស?	ប្រុស ស្រី	1 2	
Q102	អាយុរបស់អ្នកចូលរួមសម្ភាស?	ឆ្នាំ...................... សូមបញ្ចូលលេខជាឆ្នាំរបស់អ្នកតបសម្ភាស ហើយបញ្ចូលលេខ ៨៨ ប្រសិនបើអ្នកតបសម្ភាសមិនដឹងពីអាយុ និងលេខ៩៩ ប្រសិនបើ បដិសេដ ឬមិនឆ្លើយសំណួរនេះ		
Q103	ការសិក្សា(កម្រិតអប់រំ)របស់អ្នកតបសម្ភាស?	មិនបានចូលរៀន មិនបានបញ្ចប់ថ្នាក់បឋមសិក្សា បានបញ្ចប់ថ្នាក់បឋមសិក្សា មិនបានបញ្ចប់អនុវិទ្យាល័យ បានបញ្ចប់អនុវិទ្យាល័យ ថ្នាក់បរិញ្ញាបត្រ ថ្នាក់អនុបណ្ឌិត	0 1 2 3 4 5 6	

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Q104	មុខរបរចុប្បន្នរបស់អ្នកចូលរួមសម្ភាស?	គ្មានការងារធ្វើ	0	
		ជាសិស្ស និស្សិត	1	
		កម្មករសំណង់	2	
		ធ្វើការវិស័យនេសាទ	3	
		រោងចក្រកែឆ្នៃអាហារ	4	
		ផលិតកម្ម ឧស្សាហកម្ម និងសេវា	5	
		កម្ម	6	
		ការងារតាមរដូវ (រួមទាំងប្រទេស	7	
		ថៃ)	8	
		អាជីវកម្មខ្នាតតូច	77	
		ក្រុមហ៊ុនឯកជន	99	
		មិនដឹង/ មិនឆ្លើយឥប		
		ផ្សេងៗ, សូម		
		ញ្ញាក់_____		
Q105	តើចំណូលរបស់អ្នកក្នុងមួយខែទទួលបានប្រហែលប៉ុន្មានដែរ?	សរុបប្រាប់ខែគិតជាដុល្លារ អាមេរិក		
Q106	ប្រភេទផ្ទះដែលអ្នកកំពុងរស់នៅ?	គ្មានផ្ទះទេ	0	
		ផ្ទះផ្ទាល់ខ្លួន	1	
		ស្នាក់នៅផ្ទះឪពុកម្តាយ	2	
		នៅផ្ទះសាច់ញាតិ	3	
		បន្ទប់ជួលតែម្នាក់ឯង	4	
		ជួលបន្ទប់ជាមួយមិត្តភក្តិ	5	
		ស្នាក់នៅកន្លែងធ្វើការ	6	
		ស្នាក់នៅទីកន្លែងសាធារណៈ	7	
		ផ្សេងៗ សូមបញ្ញាក់	99	
Q107	ស្ថានភាពអាពាហ៍ពិពាហ៍?	នៅលីវ	0	
		រៀបការ (មានវិញ្ញាបនបត្រ)	2	
			3	

		រៀបការហើយ (គ្មាន វិញ្ញាបនបត្រ)	4	
			5	
		នៅជាមួយប្ដីឬប្រពន្ធ	6	
		ចែកផ្លូវគ្នា	7	
		លែងលះ	77	
		មេម៉ាយ ឬពោះម៉ាយ	99	
		មិនដឹង / មិនឆ្លើយតប		
		ផ្សេងៗ		
		បញ្ជាក់_____		
Q108	តើអ្នកមានកូនទេ?	បាទ/ចាំ	1	
		ទេ	0	
		0 វិលងទៅ Q110		
Q109	បើមាន តើមានប៉ុន្មាននាក់ ដែរ?	កូន១នាក់	1	
		២ ទៅ៣នាក់	2	
		លើសពី៣នាក់	3	
		មិនឆ្លើយតប	77	
Q110	តើអ្នកបានធ្វើការនៅ ប្រទេសគោលដៅចុង ក្រោយៗ រយៈពេលប៉ុន្មាន?	សូមបញ្ចូលចំនួនដែលគាត់បាន ធ្វើការងារគិតថាខែសរុប		
Q110a	តើអ្នកបានត្រឡប់មកពីធ្វើ ការនៅបរទេសវិញក្នុង អំឡុងពេល២៤ខែចុង ក្រោយនេះដែរឬទេ?	បាទ/ចាំ	1	
		ទេ	0	
		មិនដឹង	88	
		ផ្សេងៗ	99	
		បញ្ជាក់_____		
Q111	តើអ្នកបានត្រឡប់មក**កម្ពុ ជាប៉ុន្មានឆ្នាំ** និង/ឬប៉ុន្មាន ខែមុន ពីការធ្វើដំណើរទៅ ធ្វើការនៅបរទេសនាពេល ថ្មីៗនេះ?	ឆ្នាំ:............. ខែ:..............		

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Q112	ភាគច្រើនតើអ្នកទៅធ្វើ ការងារនៅប្រទេសណា ដែរ? **ការងារចុងក្រោយដែល គាត់ធ្វើការនៅបរទេស!**	ប្រទេសថៃ	1	
		ម៉ាឡេស្សី	2	
		ប្រទេសចិន	3	
		កូរ៉េខាងត្បូង	4	
		ប្រទេសជប៉ុន	5	
		ផ្សេងៗ	99	
		បញ្ជាក់_____		
Q113	តើទិដ្ឋាការប្រភេទណា ដែលអ្នកកំពុងកាន់នៅ ពេលនោះ? (ប្រភេទវីសា) ស្របច្បាប់ឬមិនស្រប ច្បាប់?	ទិដ្ឋាការសិស្ស	1	
		ទិដ្ឋាការការងារ	2	
		ទិដ្ឋាការទេសចរណ៍	3	
		ខ្ញុំបានធ្វើការដោយគ្មានទិដ្ឋាការ ការងារ	4	
			88	
		មិនដឹង/មិនឆ្លើយ ផ្សេងៗ	99	
		បញ្ជាក់_____		
Q114	តើអ្នកធ្វើការងារជាអ្វីដែរ នៅពេលអ្នកធ្វើការងារនៅ ទីនោះ?	នេសាទ (នៅលើទូក)	1	
		ការកែច្នៃអាហារសមុទ្រ	2	
		កសិកម្ម	3	
		សំណង់	4	
		ការងារក្នុងស្រុកផ្សេងៗ	5	
		បដិសណ្ឋារកិច្ច	5	
		រោងចក្រផលិតផលផ្សេងៗ	6	
		ជាអ្នកបើកបរ	7	
		មិនដឹង/មិនឆ្លើយ	88	
		ផ្សេងៗ	99	
		បញ្ជាក់_____		
Q115	តើអ្នកមានកិច្ចសន្យា ការងារជាលាយលក្ខណ៍ អក្សរទេ?	បាទ/ចាំ	1	
		ទេ	0	
		មិនដឹង	88	
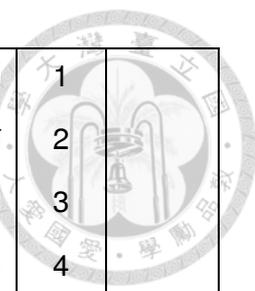
Q115a	គិតអំពីបទពិសោធនៃការធ្វើការងាររបស់អ្នកនៅក្រៅប្រទេសនោះ, តើអ្នកគិតជាអ្នកជាពលករស្របច្បាប់ឬមិនស្របច្បាប់?	ពលករស្របច្បាប់	1	
		មិនស្របច្បាប់	2	
		បដិសេធមិនឆ្លើយ	77	
		មិនដឹង	88	
Q116	តើអ្នកធ្វើកិច្ចសន្យារបស់អ្នកជាមួយអ្នកណា?	អ្នកជ្រើសរើសបុគ្គលិក	1	
		និយោជក	2	
		មិនដឹង	88	
Q117	តើអ្នកទទួលបានការងារនៅក្នុង **ប្រទេសគោលដៅ** ដោយរបៀបណា? ជម្រើសមានច្រើន	សមាជិកគ្រួសារដែលនៅទីនោះ	1	
		មិត្តភក្តិដែលកំពុងធ្វើការនៅទីនោះណែនាំ	2	
		រដ្ឋាភិបាលបានចុះបញ្ជីភ្នាក់ងារជ្រើសរើសការងារជាផ្លូវការ	3	
		ទីភ្នាក់ងារជ្រើសរើសបុគ្គលិកឯកជន (មិនបានចុះឈ្មោះបញ្ជីជាមួយរដ្ឋាភិបាល)	4	
			5	
			6	
		ភ្នាក់ងារជ្រើសរើសបុគ្គលិក (អ្នកឆ្លើយតបមិនប្រាកដថាវាត្រូវបានចុះឈ្មោះឬអត់)	7	
			8	
		បុគ្គលដែលមានទំនាក់ទំនងនៃការដាក់ស្នើការងារនៅក្នុងប្រទេសនោះ	88	
		ខ្ញុំបានរកវាដោយខ្លួនឯង	99	
		ឈ្មួញកណ្តាលឯកជន/មេខ្យល់នៃណាំ		
		មិនដឹង		
		ផ្សេងៗ		
		បញ្ជាក់_____		

Q118	តើអ្នកបានបង់ថ្លៃជ្រើស រើសបុគ្គលិកទៅឱ្យឈ្មួញ កណ្តាល ឬអ្នកជ្រើសរើស បុគ្គលិក ដើម្បីធានាបាន ការងាររបស់អ្នកនៅក្នុង ប្រទេសដែលអ្នកឆ្លប់ធ្វើ ការងារនោះដែរឬ ទេ? ខ្ញុំ ចង់សំដៅលើថ្លៃផ្សេងទៀត ក្រៅពីថ្លៃសំបុត្រយន្តហោះ ទិដ្ឋាការ ពិនិត្យសុខភាព ជាដើមៗ។	ទេ បាទ/ចាស – បង់ថ្លៃកំឡុងពេល ជ្រើសរើសបុគ្គលិក/មុនពេលចាប់ ផ្តើមការងារ បាទ/ចាស - បង់ថ្លៃតែបន្ទាប់ពី មកដល់ និងចាប់ផ្តើមការងារ មិនដឹង - ប្រាក់បុកសរុបអ្នក ជ្រើសរើសបុគ្គលិកដែលបង់ប្រាក់ ហើយមិនប្រាកដថាតើការទូទាត់ បានឆ្លោះទៅរកថ្លៃជ្រើសរើសបុគ្គលិក ឬការចំណាយផ្សេង ទៀតទេ មិនដឹង ផ្សេងៗ បញ្ជាក់_____	0 1 2 3 88 99	
Q119	តើអ្នកណាសម្រេចចិត្តថា អ្នកគួរទទួលបានការងារ ដែលអ្នកបានធ្វើនោះ?	ខ្លួនខ្ញុំជាអ្នកសម្រេច សាច់ញាតិរបស់ខ្ញុំ ខ្លួនខ្ញុំជាមួយគ្រួសាររបស់ខ្ញុំ អ្នកជ្រើសរើស/ឈ្មួញកណ្តាល និយោជកសម្រេចឲ្យខ្ញុំ និយោជកពីមុនរបស់ខ្ញុំ ដែលបាន បញ្ជូនខ្ញុំមកទីនេះដោយគ្មានការ យល់ព្រមពីខ្ញុំ មិនដឹង ផ្សេងៗ បញ្ជាក់_____	1 2 3 4 5 6 88 99	
Q119a	តើអ្នកឆ្លប់មានរបួសពេល កំពុងធ្វើការដែរឬទេ? របួសដែលធ្វើឲ្យអ្នក	បាទ/ចាំ ទេ	1 0	

	សម្រាកពីការងារ២ថ្ងៃ ឡើងទៅ ឬច្រើនជាងនេះ?		
Q120	តើអ្នកមានឯកសារកត់ត្រា ដូចជា កាត/បណ្ណ ប.ស. សពិនិត្យសុខភាព/ ដើម្បីពិ និត្យថែទាំសុខភាពដែលឬទេ ប្រសិនបើអ្នកស្វែងរកសេវា សុខភាពនៅក្នុងប្រទេស ដែលអ្នកធ្វើការងារនោះ?	បាទ/ចាំ ទេ ខ្ញុំចំណាយដោយខ្លួនឯង មិនដឹង	1 0 2 88
Q121	តើអ្នកធ្លាប់ក្លែមអត្ត ប្រយោជន៍ពីបណ្ណធានា រ៉ាប់រងដែលឬទេ? **(រំលងទៅផ្នែកទី១២៤)**	បាទ ទេ	1 0
Q122	តើអ្នកបានទទួលអត្ត ប្រយោជន៍អ្វីខ្លះពីការធានា រ៉ាប់រងនោះ?	កាធានារ៉ាប់រងរបួសទាក់ទងនឹង ការងារ អត្តប្រយោជន៍សុខភាពមាតា (មាតុភាព) ការធានារ៉ាប់រងសុខភាពទូទៅ សេវាសុខភាពផ្នែកធ្មេញ និងសុខ ភាពបន្ទព្វជ ខ្ញុំមិនដែលទាមទារអត្តប្រយោជន៍ ទេ ផ្សេងៗ បញ្ជាក់	1 2 3 4 5 99
Q123	តើថៅកែនៅកន្លែងធ្វើការ របស់អ្នកបានចំណាយថ្លៃ ធានារ៉ាប់រងដល់បុគ្គលិក ដែលឬទេ?	បាទ/ចាំ ទេ មិនដឹង	1 0 88
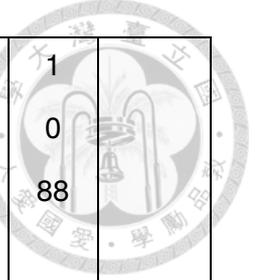
Q124	តើអ្នកធ្លាប់ឈឺចាប់ក្នុងគ្រោះថ្នាក់ការងារ (នោះជាព្រឹត្តិការណ៍ដែលមិននឹកស្មានដល់ដែលបានកើតឡើងនៅកន្លែងធ្វើការ ឬទាក់ទងនឹងការងាររបស់អ្នក ហើយដែលបណ្តាលឱ្យមានរបួស ឬជំងឺផ្ទាល់ខ្លួនរបស់អ្នក)?		បាទ/ចាំ	1	
			ទេ	0	
			មិនដឹង	88	
Q125	តើមានគ្រោះថ្នាក់នេះកើតឡើងក្នុងរយៈពេល ២៤ ខែចុងក្រោយនេះមែនទេ?		បាទ/ចាំ	1	
			ទេ	0	
			មិនដឹង	88	
Q126	តើអ្នកបានទៅមន្ទីរពេទ្យ ឬស្វែងរកការព្យាបាល ឬការថែទាំសុខភាពទេ?		បាទ/ចាំ	1	
			ទេ	0	
			មិនដឹង	88	
Q127	តើអ្នកបានទៅមន្ទីរពេទ្យ ឬស្វែងរកការព្យាបាល ឬការថែទាំសុខភាពទេសោយសារគ្រោះថ្នាក់ការងារនោះដែរឬទេ?		បាទ/ចាំ	1	
			ទេ	0	
			មិនដឹង	88	
Q128	តើអ្នកដឹង ឬស្គាល់អំពីបេឡាជាតិរបបសន្តិសុខសង្គម (បណ្ណ ប.ស.ស) ដែរឬទេ? តើអ្នកមានកាតនេះទេ? បើមិនដឹងសូមរំលងទៅសំណួរផ្នែកទី២អ		បាទ/ចាំ	1	
			ទេ	0	
			មិនដឹង	88	

Q129	តើអ្នកដឹងទេថា កម្មករ និយោជិតគ្រប់រូបមានសិទ្ធិ ទទួលបណ្ណធានាសុខភាព បេឡាជាតិរបបសន្តិសុខ សង្គមដែរឬទេ?	បាទ/ចាំ	1
		ទេ	0
		មិនដឹង	88
Q130	តើអ្នកដឹងថាកន្លែងណា ដែលអ្នកអាចទទួលបាន ធានារ៉ាប់រងសុខភាព/ប. ស.ស?	បាទ/ចាំ	1
		ទេ	0
		មិនដឹង	88
	ផ្នែកទី២A៖ ចំណេះដឹងទាក់ទងនិងសុខភាពបន្តពូជ សុខភាពផ្លូវភេទ និងសិទ្ធិ		
Q201	តើអ្នកធ្លាប់លឺអំពីសុខភាព ផ្លូវភេទ សុខភាពបន្តពូជ និងសិទ្ធិដែរឬទេ?	បាទ	1
		ទេ	0
		0 រំលងទៅ 209	
Q202	ប្រសិនបើអ្នកបានដឹង តើ អ្នកបានដឹងអ្វីខ្លះពីសុខ ភាពផ្លូវភេទ សុខភាពបន្ត ពូជ និងសិទ្ធិទាំងនេះ?	មេរោគអេដស៍/ជំងឺអេដស៍/កាម រោគ	1
			2
		ការពន្យាកំណើត	3
		សម្ពព និងរោគស្ត្រី	4
		សុខភាពមាតានិងទារក	5
		ការមានផ្ទៃពោះ	6
		ភេទ យេនឌ័រ អំពើហិង្សា	7
		ការប្រាស្រ័យទាក់ទង និងការ	8
		សម្រេចចិត្ត	9
		ការលូតដោយសុវត្តិភាព	88
		ការស្វែងរកសេវាសុខាភិបាល	99
		មិនដឹង	
		ផ្សេងៗ	
		បញ្ជាក់_____	

Q203	តើអ្នក ទៅរកសេវាសុខភាពបន្ទួជ សុខភាពផ្លូវភេទ តាមរយៈអ្វី? (ជម្រើសមានច្រើន)	មណ្ឌលសុខភាព	1	
		គ្លីនិកឯកជន	2	
		ឱសថស្ថាន	3	
		ទីតាំងសុខាភិបាលរបស់រដ្ឋ (មណ្ឌលសុខភាព និងមន្ទីរពេទ្យបង្អែក)	4	
			5	
		គ្លីនិករបស់អង្គការក្រៅរដ្ឋាភិបាលផ្សេងៗ	99	
		បញ្ជាក់_____		
Q204	តើអ្នកបានដឹង ឬ ព័ត៌មានទាក់ទង និងសិទ្ធិផ្លូវភេទ និងសិទ្ធិបន្តពូជ នេះពីប្រភពណាដែរ?	មិត្តភក្តិ	1	
		ឪពុកម្តាយ	2	
		ពីសាលារៀន	3	
		ពីបុគ្គលិកមណ្ឌលសុខភាព	4	
		គ្លីនិកឯកជន	5	
		មិត្តរួមការងារ	6	
		ដោយការអានខិតបណ្ណផ្សេងៗ	7	
		ប្រព័ន្ធផ្សព្វផ្សាយសង្គម	8	
		តាមរយៈទូរទស្សន៍ / វិទ្យុ	9	
		ផ្សេងៗ	99	
		បញ្ជាក់_____		
Q205	តើអ្នកអាចប្រាប់ខ្ញុំបានទេ តើអ្នកបានដឹងពីអំពើ ហិង្សាផ្លូវភេទបានប៉ុណ្ណា ដែរ?	ចាំ/បាទ (ច្រើន)	1	
		ចាំ/បាទ (ខ្លះ)	2	
		ចាំ/បាទ (តិចតួចណាស់)	3	
		ទេ (មិនអាចប្រាប់អ្វីបានទេ)	0	

Q206	តើអ្នកដឹងថាអំពីហិង្សាផ្លូវ អេទមានអ្វីខ្លះដែរឬទេ?	ការបង្ខំឲ្យរួមអេទ	1	
		ការគំរាមកំហែង	2	
		ការបង្ខំឲ្យមានផ្ទៃពោះ	3	
		ការរំលោភសេពសន្ថវៈ	4	
		ការកេងប្រវ័ញ្ចផ្លូវអេទ	5	
		ការបៀតបៀនកេ្ស្ខាស	6	
		ការធ្វើអាជីវកម្មផ្លូវអេទ	7	
		ការបង្ខំឲ្យមានផ្ទៃពោះ	8	
		ការបង្ខំឲ្យធ្វើជាស្ត្រីពេស្យាចារ	9	
		មិនដឹង/មិនឆ្លើយ	88	
		ផ្សេងៗ	99	
		បញ្ជាក់_____		
Q207	Q207 តើអ្នកបានស្តាប់ ដឹង លឺ និងបានឃើញការ ផ្សព្វផ្សាយអំពីអំពើហិង្សា ផ្លូវអេទញឹកញ្យាប់កម្រិត ណាដែរ?	ញឹកញ្យាប់ណាស់	1	
		មិនញឹកញ្យាប់ទេ	2	
		មួងម្ការ	3	
		មិនដែលលឺសោះ	4	
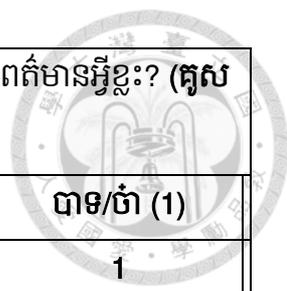
Q208	តើអ្នកដែលលឺអំពីការរអប់រំអំពីហឹង្សាផ្លូវភេទ តាមរយៈប្រភពព័ត៌មានអ្វីខ្លះ? **(គូស រាល់ចម្លើយដែលបានឆ្លើយ)**	

ប្រភេទព័ត៌មាន	បាទ/ចាំ (1)
a. វិទ្យុ	1
b. ទូរទស្សន៍	1
c. ការសែត	1
d. ផ្ទាំងផ្សព្វផ្សាយ	1
e. អ្នកជំនាញផ្នែកសុខភាព	1
f. គ្រួសារ	1
g. មិត្តភក្តិ	1
h. តាមរយៈបុគ្គលិកអង្គការរ៉ាក់ ឬអង្គការរ៉ាក់	1
i. តាមរយៈហ្វេសបុក	1
99. ផ្សេងៗ (បញ្ជាក់)_____	1

| Q209 | តើអ្នកគិតថាអ្នកគ្រូរៀន ឬ ស្វែងយល់បន្ថែមអំពី សុខ ភាពបន្តពូជ សុខភាពផ្លូវ ភេទ និងសិទ្ធិ ដែរឬទេ? | ចាំ/បាទ | 1 |
		ទេ	0

| Q210 | តើអ្នកគិតថាវាសំខាន់ សម្រាប់យុវជន និងអ្នក ផ្សាល់ក្នុង ការស្វែងយល់ អំពីសុខភាពបន្តពូជ សុខ ភាពផ្លូវភេទដែរឬទេ? | ចាំ/បាទ | 1 |
		ទេ	0

| Q211 | តើអ្នកគិតថាក្មេងស្រី ស្ត្រីវ័ យជំទង់ គួរស្វែងយល់ អំពីសុខភាពបន្តពូជ សុខ ភាពផ្លូវភេទ និងសិទ្ធិដែរ ឬទេ? | ចាំ/បាទ | 1 |
		ទេ	0

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Q212	តើអ្នកដឹងថា អាយុត្រឹមត្រូវ ដើម្បីចាប់ផ្ដើមស្វែងយល់ អំពីសុខភាពបន្តពូជ សុខ ភាពផ្លូវភេទដែលឬទេ?	អាយុប្រហែល ៥ ឆ្នាំ	1	
		អាយុប្រហែល ៨ ឆ្នាំ	2	
		អាយុប្រហែល ១២ ឆ្នាំ	3	
		អាយុប្រហែល ១៨ ឆ្នាំ	4	
		មិនដឹង/មិនឆ្លើយ	5	
		ផ្សេងៗ	99	
		បញ្ជាក់_____		
	ផ្នែកទី២B៖ ចំណេះដឹងទាក់ទងនឹងការរំលោភបំពាន និងការរៀបរៀនផ្លូវ ភេទ			
Q213	តើអ្នកធ្លាប់ជួប ឬដឹងអំពី ការរៀបរៀនផ្លូវភេទដែរ ឬទេ?	ចាំ/បាទ	1	
		ទេ	0	
		មិនដឹង	88	
Q214	តើកន្លែងធ្វើការរបស់អ្នក មានគោលនយោបាយ ទាក់ទងនិងការរៀបរៀន ផ្លូវភេទដែរឬទេ?	ចាំ/បាទ	1	
		ទេ	0	
		មិនដឹង	88	
Q215	ប្រសិនបើអ្នកជួបប្រទះការ រៀបរៀនផ្លូវភេទ តើអ្នក ដឹងពីរបៀបរាយការណ៍ ដល់អាជ្ញាធរ ឬសមត្ថកិច្ច ដែរឬទេ? ប្រសិនបើធ្លាប់ សូមរៀបរាប់	បាទ/ចាំ	1	
		ទេ	0	
		មិនដឹង	88	

| Q216 | តើអ្នកធ្លាប់**បានឃើញ** ឬឮអំពីការកើតឡើងខាងក្រោមនេះចំពោះអ្នកបម្រើការងារ ជាមួយអ្នកដែរឬទេ? **(គូសរាល់ចម្លើយដែលបានឆ្លើយ)** |||||

សកម្មភាព	1=បាទ/ ចាស	2=ទេ	88=មិន ដឹង
1.ការគំរាមកំហែងពួកគេ ឬក្រុមគ្រួសារ ដោយអំពើហិង្សាណាមួយ			
2.ការបំពានលើរាងកាយ			
3.ការរំលោភបំពានផ្លូវភេទ			
4.បញ្ជូនពួកគេទៅកាន់អាជ្ញាធរ សមត្ថ កិច្ច			

| | **ផ្នែកទី២C៖ ចំណេះដឹងទាក់ទងនិងមេរោគអេដស៍ ជំងឺអេដស៍ ការចម្លង ជំងឺ និងការស្វែងរកសេវាសុខាភិបាល** ||||

| Q220 | តើអ្នកធ្លាប់ដែលលឺ ឬដឹង អំពីមេរោគអេដស៍ ជំងឺអេដ ស៍ដែរឬទេ? | បាទ/ចាំ | 1 | |
| | | ទេ | 0 | |

| Q221 | ឥឡូវនេះ ខ្ញុំនឹងអានសំណួរ មួយចំនួនអំពីមេរោគអេដស៍/ជំងឺអេដស៍។ សូមប្រាប់ ខ្ញុំថាតើអ្នកគិតថាឃ្លាទាំងនេះ ពិត ឬមិនពិត ឬក៏អ្នកមិនដឹង។ |||

ទម្រង់សំណួរ	ពិត	មិនពិត
a. ជំងឺអេដស៍អាចមានលទ្ធភាពព្យាបាលជាសះ ស្បើយ?	1	0
b. អ្នកផ្ទុកមេរោគអេដស៍ គឺមានសុខភាពមិនល្អនោះ ទេ?	1	0
c. យើងអាចដឹងនរណាម្នាក់មានផ្ទុកមេរោគអេដស៍ ដោយពុំចាំបាច់ធ្វើតេស្តនោះឡើយ?	1	0

| Q222 | ជាផ្នែកមួយនៃមេរោគអេដ ស៍/ជំងឺអេដស៍ ក៏មានជំងឺ | បាទ/ចាំ | 1 | |
| | | ទេ | 0 | |

		ផ្សេងទៀតដែលបុរស និង ស្ត្រីអាចឆ្លងតាមរយៈការ រួមភេទ។ តើអ្នកធ្លាប់លឺពី ជំងឺទាំងនេះដែរឬទេ?			
Q223	បើសិនជាស្ត្រីម្នាក់មានការ ចម្លងជាតនោះ តើអ្នកដឹង ថាមានជាតសញ្ញាអ្វីខ្លះដែរ ឬទេ?	ការហូរទឹករំអិលទ្វារមាស ឈឺចាប់ពេលបត់ជើងតូច ដុំបៅ / ដុំបៅនៅតំបន់ប្រដាប់បន្ត ពូជ រាងកាយស្គមស្គាំង មានធ្លាក់ឈាមខុសធម្មតា មិនដឹង/មិនឆ្លើយ ផ្សេងៗ (បញ្ជាក់)_____	1 2 3 4 5 88 99		
Q224	ប្រសិនបើអ្នក មានមិត្តភ័ ក្តិរបស់អ្នកត្រូវការការ ព្យាបាលជំងឺកាមរោគ តើ គាត់អាចទទួលបានការ ព្យាបាលនៅឯណា?	តាមហាង ឱសថស្ថាន មន្ទីរពេទ្យរដ្ឋ/មណ្ឌលសុខភាព គ្លីនិកឯកជន គ្លីនិកឯកជន គ្លីនិកវ៉ាក់ ទីតាំងផ្តល់សេវាដែលដែលមាន សេវាធនាវ៉ាប់រង ផ្សេងៗ (បញ្ជាក់)_____	1 2 3 4 5 6 7 99		
Q225	តើអ្នកធ្លាប់កើតជំងឺកាម រោគទេ? **បើ ០ រំលងទៅ ២២៨**	ធ្លាប់កើតម្តង ច្រើនជាងម្តង មិនដែលកើតទេ	1 2 0		
Q226	តើអ្នកបានស្វែងរកការ ព្យាបាលដែរឬទេ?	បាទ/ចាំ ទេ មិនដឹង	1 0 88		
Q227	តើអ្នកបានស្វែងរកការ ព្យាបាលនៅឯណា?	តាមហាង ឱសថស្ថាន	1 2		

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		មន្ទីរពេទ្យរដ្ឋ/មណ្ឌលសុខភាព	3	
		គ្លីនិកឯកជន	4	
		គ្លីនិកឯកជន	5	
		គ្លីនិកវ៉ាក់	6	
		ទីតាំងផ្តល់សេវាដែលដែលមាន	7	
		សេវាធនាវ៉ាប់រង	99	
		ផ្សេងៗ (បញ្ជាក់)_____		
Q228	តើអ្នកមានដឹងថាៈ ដៃគូ របស់អ្នក (ដៃគូដែលអ្នក បានរួមភេទជាមួយ) បាន ស្វែងរកការព្យាបាលជំងឺ កាមរោគនេះដែរឬទេ?	បាទ/ចាំ	1	
		ទេ	0	
		មិនដឹង	88	

Q228a តើអ្នកទទួលបានព័ត៌មានអំពីមេរោគអេដស៍/ជំងឺអេដស៍ ឬកាមរោគនៅឯណា?

ប្រភេទព័ត៌មាន	បាទ/ចាំ (1)
វិទ្យុ	1
ទូរទស្សន៍	1
កាសែត	1
ផ្ទាំងផ្សព្វផ្សាយ	1
អ្នកជំនាញផ្នែកសុខភាព	1
គ្រួសារ	1
មិត្តភក្តិ	1
តាមរយៈបុគ្គលិកអង្គការវ៉ាក់ ឬអង្គការវ៉ាក់	1
តាមរយៈហ្វេសបុក	1
ផ្សេងៗ (បញ្ជាក់)_____	1

ផ្នែកទី២Dៈ ចំណេះដឹង បទពិសោធន៍ និងការប្រើប្រាស់ មធ្យោបាយពន្យាកំណើត			
Q229	តើអ្នកដឹងថាអ្វីជាការព្យា កំណើតដែរឬទេ?	បាទ/ចាំ	1	
		ទេ	0	

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Q230	តើអ្នកកំពុងប្រើវិធីពន្យារ កំណើតណាមួយដែរឬទេ? **បើ 0 រំលងទៅ២៣២**	បាទ/ចាំ	1	
		ទេ	0	

Q231	ប្រសិនបើកំពុងប្រើ, តើ អ្នកកំពុងប្រើវិធីពន្យារ កំណើតមួយណាដែរ?	ថ្នាំគ្រាប់ពន្យារកំណើត	1	
		ថ្នាំចាក់ពន្យារកំណើត	2	
		ចងបំពង់មេជីវិតឈ្មោល	3	
		កងដាក់ក្រោមស្បែក	4	
		ស្រោមអនាម័យ	5	
		ចងបំពង់មេជីវិតឈ្មោល	6	
		កងដាក់ក្នុងស្បូន	7	
		មិនដឹង/មិនឆ្លើយ	88	
		ផ្សេងៗ(បញ្ជាក់)_____	99	

Q232	សូមរៀបរាប់អំពីវិធីសាស្ត្រ នៃការធ្វើផែនការគ្រួសារ **(ការពន្យាកំណើត)**ឲ្យបាន ឫនចំណុចដែលអ្នកបាន ស្គាល់?	ថ្នាំគ្រាប់ពន្យាកំណើត	1	
		ថ្នាំចាក់ពន្យារកំណើត	2	
		ចងបំពង់មេជីវិតឈ្មោល	3	
		កងដាក់ក្រោមស្បែក	4	
		ស្រោមអនាម័យ	5	
		ចងបំពង់មេជីវិតឈ្មោល	6	
		កងដាក់ក្នុងស្បូន	7	
		ផ្សេងៗ(បញ្ជាក់)_____	99	

Q233	តើវិធីសាស្ត្រពន្យាកំណើត មួយណាដែលអ្នកគិតថា ស័ក្តិសមបំផុតសម្រាប់យុវ វ័យ ប្រសិនបើគេចង់ប្រើ? (ជម្រើសមានតែមួយ)	ថ្នាំគ្រាប់ពន្យាកំណើត	1	
		ថ្នាំចាក់ពន្យារកំណើត	2	
		ចងបំពង់មេជីវិតឈ្មោល	3	
		កងដាក់ក្រោមស្បែក	4	
		ស្រោមអនាម័យ	5	
		ចងបំពង់មេជីវិតឈ្មោល	6	
		កងដាក់ក្នុងស្បូន	7	

		ផ្សេងៗ(បញ្ជាក់)_____	99	
Q234	តើអ្នកកំពុងប្រើធីសាស្ត្រពន្យាកំណើតទំនើបណាមួយដែរឬទេ? **(បើ៎ រំលងទៅផ្នែកបន្ទាប់)**	បាទ ទេ	1 0	
Q235	ប្រសិនបើទេ ហាតុអ្វីបានជាអ្នកមិនប្រើវិធីសាស្ត្រពន្យាកំណើតណាមួយ? សូរដេញៈ តើមានអ្វីផ្សេងទៀតឬទេ? (ជម្រើសមានច្រើន)	នៅក្មេងពេកចង់បានកូនដោយសារមានគទ្ទិពលពីប្ដីឬប្ដែគួរដោយសារមានគទ្ទិពលពីឪពុកម្តាយមិនមែនជាតម្រូវការប្រើប្រាស់វិធីបុរាណ (ខ. វិធីប្រតិទិន ឬ ចាក់ទឹកក្រោៗៗង) ផ្សេងៗ (បញ្ជាក់)_____ _____	1 2 3 4 5 6 99	
	ផ្នែកទី២E៖ ចំណេះដឹង និងបទពិសោធន៍ទាក់ទង និងការមានផ្ទៃពោះ			
Q236	តើអ្នកដឹងទេថា យ៉ាងហោចណាស់ស្ត្រីមានផ្ទៃពោះគួរទទួលបានការថែទាំមុនសម្រាលប៉ុន្មានដងដែរឬទេ?	តែមួយដង ២ទៅ៣ដង ៤ទៅ៥ដង ច្រើនជាង ៦ដង មិនដឹង ផ្សេងៗ (បញ្ជាក់)_____ _____	1 2 3 4 88 99	
Q237	តើអ្នកធ្លាប់មានផ្ទៃពោះក្នុងរយៈពេលដប់ពីរខែចុងក្រោយនេះដែរឬទេ?	បាទ ទេ	1 0	

	(បើ វិលងទៅផ្នែកបន្ទាប់)		
Q238	តើអ្នកបានទៅកន្លែងណា ដើម្បីទទួលសេវាថែទាំផ្ទៃពោះមុនសម្រាល? **(ពិនិត្យពោះ)**	មន្ទីរពេទ្យរដ្ឋ ឬមណ្ឌលសុខភាព	1
		គ្លីនិកឯកជន	2
		គ្លីនិកវ៉ាក់	3
		នៅតាមទីតាំងសុខភាពដែលបានបង្ហាញតាមបណ្ណឋាន	
		រ៉ាប់រង	4
		ផ្សេងៗ (បញ្ជាក់)_____	99
Q239	ហាតុអ្វីបានជាអ្នកជ្រើសរើសជម្រើសនេះ?	មិនមានជម្រើសទេ	1
		ជិតទីតាំងខ្ញុំរស់នៅ	2
		ងាយស្រួលក្នុងការស្វែងរក	3
		ស្គាល់អ្នកផ្ដល់សេវាសុខភាព	4
		សេវាអាចទុកចិត្តបាន	5
		ធ្លាប់ប្រើសេវានៅទីនោះពីមុន	6
		ផ្សេងៗ (បញ្ជាក់)_____	99
	ផ្នែកទី២F៖ ចំណេះដឹងទាក់ទងនិងការរំលូត		
Q240	តើអ្នកដឹងទេថា ការរំលូតគឺស្របច្បាប់ដែរឬទេ?	បាទ/ចាំ	1
		ទេ	0
Q241	តើអ្នកអាចប្រាប់ខ្ញុំបានទេ ថាតើផលវិបាកនៃការរំលូតដោយគ្មានសុវត្ថិភាពមានអ្វីខ្លះ?	ផ្លាក់ឈាម	1
		រំហែកភ្នាសស្បូន	2
		ឆាំង/ ស្លាប់ម្ដាយ	3
		អគ្រាត្ថានកូន	4
		ឆ្លងមេរោគ	5
		ផ្សេងៗ (បញ្ជាក់)_____	99
Q242	តើអ្នកមានមិត្តភ័ក្ដិ ឬសាច់ញាតិដែលធ្លាប់រំលូត ក្នុងរយៈពេល១២ខែចុងក្រោយនេះដែរឬទេ?	បាទ ធ្លាប់មាន	1
		ទេ មិនធ្លាប់មានទេ	0

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	(បើ 0 សូមរំលងសំណួរ ខាងក្រោម)		
Q243	តើអ្នកគិតថា៖ តើពួកគេ បានស្វែងរកសេវាវិលូត នៅឯណា?	តាមហាង	1
		ឱសថស្ថាន	2
		មន្ទីរពេទ្យរដ្ឋ ឬមណ្ឌលសុខភាព	3
		គ្លីនិកឯកជន	4
		គ្លីនិកវ៉ាក់	5
		នៅតាមទីតាំងសុខភាពដែល បានបង្ហាញតាមបណ្ណធានា រ៉ាប់រង	6
		ផ្សេងៗ (បញ្ជាក់)_____	99
Q244	តើស្ត្រីមានសិទ្ធិធ្វើការ សម្រេចចិត្តដោយខ្លួនឯង ដើម្បីទទួលបានសេវាវិលូត ដោយសុវត្ថិភាពដែរឬទេ?	ចាំ/បាទ	1
		ទេ	0
Q245	តើអ្នកដឹងទេថា ក្នុងកាល៖ ទេស៖ណាខ្លះ ដែលស្ត្រី វិលូត អាចសុំការឈប់ សម្រាកឈឺពីកន្លែងធ្វើ ការ?	ចាំ/បាទ ខ្ញុំបានដឹង	1
		មិនដឹងទេ	
		មិនឆ្លើយ	0
			88
Q246	តើអ្នកដឹងទេថា ប្រសិនបើ អ្នកមានចម្ងល់ ឬចង់ ណាត់ជួបជាមួយវេជ្ជ បណ្ឌិត ដើម្បីទៅពិនិត្យការ វិលូត ដោយសុវត្ថិភាព តើ អ្នកអាចទូរស័ព្ទទៅអ្នក ប្រឹក្សារបស់ RHAC បាន ទេ?	ចាំ/បាទ	1
		ទេ	0
		មិនដឹង	88

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ផ្នែកទី២G៖ ចំណេះដឹងទាក់ទងនិងជំងឺមហារីកមាត់ស្បូន និងក្រពេញប្រូស្តាត			
Q247	តើអ្នក ឬមិត្តភ័ក្តិរបស់អ្នក ធ្លាប់ទទួលបានសេវា ទាក់ទងនឹងជំងឺមហារីក មាត់ស្បូនក្នុងរយៈពេល ១២ខែចុងក្រោយនេះ ឬទេ?	ចាំ/បាទ ទេ **បើ0 រំលងទៅ Q250**	1 0	
Q248	តើអ្នក/មិត្តរបស់អ្នកស្វែង រកសេវាពិនិត្យមហារីកមាត់ ស្បូននៅឯណា?	ពេទ្យរដ្ឋ (ពេទ្យបង្អែក ឬមណ្ឌល សុខភាព) គ្លីនិកឯកជន គ្លីនិកវ៉ាក់ ទីតាំងផ្តល់សេវាដែលដែលមាន សេវាធនាវ៉ាប់រង ផ្សេងៗ (បញ្ជាក់)_____	1 2 3 4 99	
Q249	ហាតុអ្វីបានជាអ្នក ឬមិត្ត របស់អ្នកជ្រើសរើសជ ម្រើសនោះ?	មិនមានជម្រើសទេ ជិតទីតាំងខ្ញុំរស់នៅ ងាយស្រួលក្នុងការស្វែងរក ស្គាល់អ្នកផ្តល់សេវាសុខភាព សេវាអាចទុកចិត្តបាន ធ្លាប់ប្រើសេវានៅទីនោះពីមុន ផ្សេងៗ (បញ្ជាក់)_____	1 2 3 4 5 6 99	
Q250	តើអ្នកដឹងថា មានវ៉ាក់ សាំងការពារជំងឺមហារីក មាត់ស្បូនដែរឬទេ?	ដឹង មិនដឹង	1 0	
Q251	តើអ្នកគិតថាស្ត្រីគ្រប់តែចាក់ វ៉ាក់សាំងការពារមហារី មាត់ស្បូនឲ្យបានគ្រប់គ្នា ដែរឬទេ?	បាទ ទេ	1 0	

Q252	ប្រសិនបើអ្នកចង់ស្វែងរកការពិគ្រោះ និងចាក់វ៉ាក់សាំងការពារជំងឺមហារីកមាត់ស្បូន តើអ្នកអាចស្វែងរកនៅឯណាបាន?	ពេទ្យរដ្ឋ (ពេទ្យបង្អែក ឬមណ្ឌលសុខភាព)	1	
			2	
		គ្លីនិកឯកជន	3	
		គ្លីនិកវ៉ាក់	4	
		ទីតាំងផ្តល់សេវាដែលដែលមានសេវាធនវ៉ាប់រង	5	
		តាមឌីសចស្តាន	99	
		ផ្សេងៗ (បញ្ជាក់)_____		
	ផ្នែកទី២H៖ ចំណេះដឹងទាក់ទងនិងគ្លីនិកវ៉ាក់ (RHAC clinic)			
Q253	តើអ្នកស្គាល់គ្លីនិកវ៉ាក់ ឬអង្គការវ៉ាក់ដែរឬទេ?	ចាំ/បាទ	1	
		ទេ	0	
		បំលងទៅផ្នែកបន្ទាប់		
Q254	តើអ្នកអាចប្រាប់ខ្ញុំពីរបៀបទៅគ្លីនិក RHAC ដែលនៅជិតកន្លែងរបស់អ្នកបំផុតបានទេ?	ចាំ/បាទ	1	
		ទេ	0	
Q255	តើអ្នកធ្លាប់ទទួលបានសេវាពីគ្លីនិកវ៉ាក់ណាមួយដែរឬទេ?	ចាំ/បាទ	1	
		ទេ	0	
Q256	តើអ្នកអាចប្រាប់ខ្ញុំពីសេវាសុខភាពដែលមាននៅគ្លីនិកវ៉ាក់បានដែរឬទេ? (ជម្រើសមានច្រើន)	ជំងឺកាមរោគ	1	
		សេវាពន្យាកំណើត	2	
		សេវារំលូត	3	
		ជំងឺអេដស៍	4	
		ថែទាំមុនសម្រាល/ក្រោយសម្រាល	5	
		សម្រាល	6	
		ពិសោធន៍វេជ្ជសាស្ត្រ	99	
		ផ្សេងៗ (បញ្ជាក់)_____		

	ផ្នែកទី៣A៖ ការស្វែងរកសេវាសុខភាព (គរុយោបទ និងការអនុវត្ត) និងបទ ពិសោធន៍ក្នុងការស្វែងរកសេវាសុខភាព និងកិច្ចអន្តរាគមន៍ផ្សេងៗ			
Q301	តើអ្នកធ្លាប់ទៅកាន់ មណ្ឌលសុខភាពណាមួយ ដើម្បីទទួលបានព័ត៌មាន ឬសេវា សុខភាពបន្តពូជ សុខភាពផ្លូវភេទ (ខ. ការពន្យាកំណើត ការមានផ្ទៃ ពោះ ការរំលូត ឬជំងឺកាម រោគ) ក្នុងរយៈពេល ៣ ឆ្នាំ ចុងក្រោយនេះដែរឬទេ?	ចាំ/បាទ	១	
		ទេ	០	
		(0 វិលងទៅ៣0៧)		
Q302	ប្រសិនបើទេ តើអ្វីជាហេតុ ផលខ្លះដែរ? (ជម្រើសមានច្រើន)	មិនដែលឈឺ	0	
		សុខភាពល្អមិនមានបញ្ហា	1	
		មិនទុកចិត្តភាពឯកជន/ការ សម្ងាត់របស់មណ្ឌលសុខភាព	2	
		មិនមានអារម្មណ៍ស្រួលក្នុងការ និយាយជាមួយបុគ្គលិកមណ្ឌល សុខភាព	3	
		ពេលវេលារង់ចាំយូរពេក	4	
		ផ្សេងៗ បញ្ជាក់_____	99	
Q303	ប្រសិនបើធ្លាប់ តើព័ត៌មាន អ្វីខ្លះដែលអ្នកទៅទទួល សេវាទាំងនោះ? នៅក្នុង រយៈពេល១២ខែចុងក្រោយ នេះ? (ចម្លើយមានច្រើន)	ដើម្បីធ្វើផែនការគ្រួសារ (ពន្យា កំណើត)	1	
		មានផ្ទៃពោះ	2	
		ទៅរកសេវារំលូតកូន	3	
		សេវាជំងឺកាមរោគ/រោគស្ត្រី	4	
		សេវាមេរោគអេដស៍	5	
		មិនដឹង/មិនឆ្លើយ	88	
		ផ្សេងទៀត (បញ្ជាក់) _____	99	

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Q304	គិតអំពីការទៅរកសេវាសុខភាពចុងក្រោយរបស់អ្នក តើអ្នកបានទៅរកសេវាសុខភាពរបស់រដ្ឋ ឬឯកជនិកឯកជន?	មន្ទីរពេទ្យ មណ្ឌលសុខភាព ឯកជនិកឯកជន	1 2
Q305	តើអ្នកបានស្វែងរកសេវាសុខភាព ឬព័ត៌មានអំពីសុខភាពពីផ្ទះបណ្ដេត ឬគិលានុបដ្ឋាយិកាប៉ុន្មានដងសម្រាប់សេវាសុខភាពទាំងនេះក្នុងអំឡុងពេល១២ខែចុងក្រោយនេះ?	**ចំនួនពេល.......................** **សូមបញ្ចូលលេខ 0 បើមិនបានស្វែងរកសេវាសុខភាពក្នុងអំឡុងពេល១២ខែចុងក្រោយនេះទេ!**	
Q306	ប្រសិនបើអ្នកទទួលសេវាសុខភាពច្រើនជាងមួយ តើអ្នកទទួលបានសេវាកម្មទាំងអស់ត្រូវបានផ្តល់ក្នុងពេលតែមួយទេ? (ឬត្រូវមកទទួលសេវាពេលវេលាផ្សេង១គ្នា)?	ចាំ/បាទ ទេ	1 0
Q307	តើអ្នកមានអារម្មណ៍ពេញចិត្តនឹងសេវាសុខភាពដែលបុគ្គលិកគេបានផ្តល់ជូនដែរឬទេ?	ចាំ/បាទ ទេ ធម្មតា១	1 0 2
Q308	តើអ្នកមានអារម្មណ៍ស្រណុកចិត្តដែរឬទេ នៅពេលដែលស្ងួសំណូរទៅកាន់ផ្ទះបណ្ដេត ឬអ្នកធ្វើការផ្នែកសុខភាព?	ចាំ/បាទ ទេ មិនដឹងដែរ	1 0 2

Q309	តើអ្នក ធ្លាប់ទៅ ស្វែងរក សេវានៅគ្លីនិកជនណា មួយទេដែរឬទេ? **(ឆ្លងទៅ៣១១)**	ចាំ/បាទ	1	
		ទេ	0	
Q310	បើធ្លាប់ទៅ តើអ្វីជាហេតុ ផលរបស់អ្នក សូមជ្រើស រើសចម្លើយបីដែលអ្នកគិត ថាសមម្បសម្រាប់អ្នក?	ពេលវេលាង់ចាំខ្លី	1	
		ជឿជាក់លើឯកជនភាព និងការ	2	
		សម្ងាត់	3	
		បុគ្គលិកមានភាពរួសរាយ	4	
		រាក់ទាក់	5	
		មានបន្ទប់ដាច់ដោយឡែក	6	
		សម្រាប់អ្នកជំងឺ	7	
		មានបុគ្គលិកដាច់ដោយឡែក	8	
		សម្រាប់អ្នកជំងឺ	9	
		បុគ្គលិកពន្យល់ខ្ញុំអំពីជំងឺយ៉ាង	99	
		លំអិត		
		មានសេវាសុខភាពច្រើនដែលខ្ញុំ		
		ចង់រក		
		សេវាសុខភាពមានគុណភាព		
		ខ្ពស់		
		ការចំណាយថវិការសមម្យ		
		ផ្សេងៗ (បញ្ជាក់) _____		
ផ្នែកទី៣B៖ បទពិសោធន៍ក្នុងការធ្លាប់ប្រើសេវាសុខភាពរបស់អ្នកនៅក្រៅប្រទេសកម្ពុជា				
Q311	តើអ្នកចាំទេថា៖ តើអ្នក ធ្លាប់ទទួលសេវាសុខភាព កាលពីពេលដែលអ្នកធ្វើ ការនៅប្រទេសក្រៅដែរ ឬទេ?	ចាំ/បាទ	1	
		ទេ	0	
		មិនដឹងដែរ	88	

Q312	បើមិនដែលឆ្លាប់ព្យាបាលក្រៅប្រទេស៖ តើមូលហេតុអ្វីខ្លះដែលអ្នកមិនបានទទួលការព្យាបាលសេវាសុខភាពនៅ ប្រទេសគោលដៅ្រ នោះ? Multiple answer	មិនដែលឈឺ ឬបញ្ហាសុខភាព	1
		ឡើយ	2
		មិនមានបញ្ហាសុខភាពណា	3
		ឡើយ	
		មិនទុកចិត្តភាពងកជន/ការ	4
		សម្ងាត់របស់មណ្ឌលសុខភាព	
		មិនមានអារម្មណ៍ស្រួលក្នុងការ	5
		និយាយជាមួយបុគ្គលិកមណ្ឌល	6
		សុខភាព	
		ពេលវេលាផ្ទាល់ចាំឈ្យ	99
		ទំនាក់ទំនងពិបាកជាមួយ	
		បុគ្គលិកសុខាភិបាល	
		កន្លែងធ្វើការរបស់ខ្ញុំមិនទាមទារ	
		ទេ	
		ផ្សេងៗ (បញ្ជាក់) _____	
Q313	តើអ្នកចាំទេថា តើអ្នកបានស្វែងរកសេវាព្យាបាល ឬព័ត៌មានពីវេជ្ជបណ្ឌិត ឬគិលានុបដ្ឋាយិកាប៉ុន្មានដងសម្រាប់សេវាកម្មទាំងនេះក្នុងរយៈពេល ១២ខែចុងក្រោយនេះនៅបរទេស?	ចំនួនពេល............................. បើមិនដែលស្វែងរកការព្យាបាលដាក់លេខ 0	
Q314	គិតអំពីការងារចុងក្រោយដែលអ្នកបានធ្វើនៅបរទេសនោះ ្រ[ប្រទេសគោលដៅ]្រ តើអ្នកបានទៅមណ្ឌលសុខភាពរបស់រដ្ឋ	មន្ទីរពេទ្យរដ្ឋ មណ្ឌលសុខភាពរដ្ឋ គ្លីនិកឯកជន	1
			2
			88
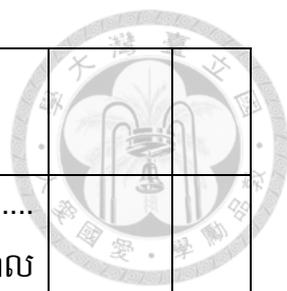
	ឬមន្ទីរពេទ្យរដ្ឋ ឬគ្លីនិកឯកជន?			
Q315	តើអ្នកចាំទេថា តើអ្នកបាន ស្វែងរកសេវា ឬព័ត៌មានពី វេជ្ជបណ្ឌិត ឬតិលានុបដ្ឋា យិកាប៉ុន្មានដងសម្រាប់ សេវាកម្មទាំងនេះក្នុងរយៈ ពេល ១២ខែចុងក្រោយ នេះ?	ចំនួនពេល................. បើមិនដែលស្វែងរកការព្យាបាល ដាក់លេខ ០		
Q316	តើអ្នកមានអារម្មណ៍ថា ពេញចិត្តនឹងសេវាសុខ ភាពដែលគ្រូពេទ្យបានផ្ត ល់ដល់អ្នក ប្រទេសគោល ដៅៗ ដែរឬទេ?	បាទ ទេ ធម្មតាៗ	1 0 2	
Q317	តើអ្នកមានអារម្មណ៍ស្រួល គ្រប់គ្រាន់ក្នុងការស្នើ សំណូមទៅកាន់គ្រូពេទ្យ ឬ បុគ្គលិកថែទាំសុខភាពទេ? **សេវាសុខភាពនៅប្រទេស គោលដៅដែលអ្នកបានធ្វើ ការៗ**?	បាទ ទេ	1 0	
Q318	តើអ្នកដឹងថាមានគោល នយោបាយថែទាំសុខភាព សម្រាប់ពលករចំណាក ស្រុកនៅក្នុងប្រទេសដែល អ្នកធ្ញើការងារៗចុង ក្រោយរបស់អ្នកដែរឬទេ?	ចាំ/បាទ ទេ មិនដឹងដែរ	1 0 88	

Q319	បើបានដឹង, តើសេវាថែទាំសុខភាពមានអ្វីខ្លះបូ ដឹង? **[ចម្លើយមានច្រើន]**	ផែនការគ្រួសារ(សេវាពន្យាកំណើត)	1	
			2	
		សេវាមានផ្ទៃពោះ	3	
		សេវាលួត	4	
		សេវាជំងឺកាមរោគ	5	
		សេវាមេរោគអេដស៍	6	
		ការថែទាំ និងព្យាបាលនៅកន្លែងធ្វើការ	99	
		ផ្សេងៗ (បញ្ជាក់) _____		
Q320	តើអ្នកធ្លាប់ស្តើសុំសេវាថែទាំសុខភាពរបស់អ្នកទាក់ទងនឹងសុខភាពបន្តពូជ សុខភាពផ្លូវភេទ និងសិទ្ធិ [នៅក្នុងប្រទេសដែលអ្នកធ្លាប់ធ្វើការ] ដែរឬទេ?	ចាំ/បាទ	1	
		ទេ	0	
		មិនដឹងដែរ	88	
Q321	បើធ្លាប់, តើមានសេវាសុខភាពអ្វីខ្លះដែលអ្នកបានស្នើសុំគេ?	ផែនការគ្រួសារ(សេវាពន្យាកំណើត)	1	
			2	
		ថែទាំការមានផ្ទៃពោះ	3	
		សេវាលួត	4	
		សេវាជំងឺកាមរោគ	5	
		សេវាមេរោគអេដស៍	6	
		ការព្យាបាលតាមផ្ទះ	7	
		សេវាមិនគិតថ្លៃថែទាំសុខភាព	8	
		សេវាថែទាំសុខភាពផ្លូវចិត្ត	9	
		សេវាថែទាំសុខភាពតាមរយៈឌីជីថល	88	
		មិនដឹង	99	
		ផ្សេងៗ (បញ្ជាក់) _____		

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Q322	តើអ្នកដឹងថាមានគោល នយោបាយថែទាំសុខភាព ឬសេវាសុខភាពណាមួយ នៅក្នុង ប្រទេសគោល ដៅ) សម្រាប់ពលករ ចំណាកស្រុក (ធ្វើការក្រៅ ប្រទេសកម្ពុជា) ដែរឬទេ?	ចាំ/បាទ	1	
		ទេ	0	
		មិនដឹងដែរ	88	
Q323	បើមាន តើគោល នយោបាយថែទាំសុខភាព បែបណាសម្រាប់ជនចំ ណាកស្រុក អ្នកធ្លាប់ប្រើ ឬបានដឹងនោះៗ?	កម្មករទាំងអស់មិនគិតថ្លៃទេ	1	
		កម្មករមានសិទ្ធិទទួលបានសុខ ភាពស្មើៗគ្នា ប្រជាពលរដ្ឋដូច ទទួលបានដូចកម្មករ	2	
			3	
			4	
		តម្លៃពិសេសសម្រាប់កម្មករ	5	
		កម្មករត្រូវបង់ប្រាក់ច្រើនជាង ពលរដ្ឋ	6	
		នៅតែទទួលបានប្រាក់ខែសម្រាប់ ការឈប់សម្រាកឈឺ	88	
			99	
		មិនដឹង		
		ផ្សេងៗ (បញ្ជាក់) _____		
ផ្នែកទី៤៖ ការស្វែងរកសេវាសុខភាពតាមរយៈប្រព័ន្ធឌីជីថល				

Q401. ភាគច្រើន តើអ្នកទាក់ទងជាមួយមនុស្សខាងក្រៅ សាច់ញាតិ បងប្អូន អ្នកដ៏ទៃ ដោយរបៀប ណា? សូមគូសសញ្ញា(√) (ជ្រើសរើសចម្លើយៗ ដែលអ្នកគិតថាសមស្របបំផុតសម្រាប់អ្នក)

កូដ	គ្រួសារ (√)	អ្នកធ្វើការជាមួយ (√)	មិត្តជិតស្និទ្ធ (√)	ដៃគូរ (√)
1	ហ្វេសបុក	ហ្វេសបុក	ហ្វេសបុក	ហ្វេសបុក
2	ឆាតហ្វេសបុក	ឆាតហ្វេសបុក	ឆាតហ្វេសបុក	ឆាតហ្វេសបុក
3	ផ្ញើសារ SMS	ផ្ញើសារ SMS	ផ្ញើសារ SMS	ផ្ញើសារ SMS
4	អ៊ីនស្តាក្រាម	អ៊ីនស្តាក្រាម	អ៊ីនស្តាក្រាម	អ៊ីនស្តាក្រាម
5	ឡាញ	ឡាញ	ឡាញ	ឡាញ
6	តេឡេក្រាម	តេឡេក្រាម	តេឡេក្រាម	តេឡេក្រាម
7	វ៉ាត់អាប់	វ៉ាត់អាប់	វ៉ាត់អាប់	វ៉ាត់អាប់
8	ធ្វីតធឺ	ធ្វីតធឺ	ធ្វីតធឺ	ធ្វីតធឺ
9	តិកតុក	តិកតុក	តិកតុក	តិកតុក
10	យូធូប	យូធូប	យូធូប	យូធូប
11	វីឆាត	វីឆាត	វីឆាត	វីឆាត
12	វ៉ាយប៊ី	វ៉ាយប៊ី	វ៉ាយប៊ី	វ៉ាយប៊ី
13	ផ្សេងៗ	ផ្សេងៗ	ផ្សេងៗ	ផ្សេងៗ

Q402. តើមធ្យោបាយណាខ្លះខាងក្រោមដែលអ្នកគិតថានឹងត្រូវបានប្រើ - ស្វែងរកព័ត៌មានទាក់ទង នឹងសុខភាព សុខភាពផ្លូវភេទ សុខភាពបន្តពូជ និងសិទ្ធិ ជាដើម។ (ជ្រើសជើសចម្លើយៗ ដែលសម ស្របបំផុតសម្រាប់ជួរឈរនីមួយៗ)

កូដ	គ្រួសារ (√)	អ្នកធ្វើការជាមួយ (√)	មិត្តជិតស្និទ្ធ (√)	ដៃគូ (√)
1	ហ្វេសប៊ុក	ហ្វេសប៊ុក	ហ្វេសប៊ុក	ហ្វេសប៊ុក
2	ឆាតហ្វេសប៊ុក	ឆាតហ្វេសប៊ុក	ឆាតហ្វេសប៊ុក	ឆាតហ្វេសប៊ុក
3	ផ្ញើសារ SMS	ផ្ញើសារ SMS	ផ្ញើសារ SMS	ផ្ញើសារ SMS
4	អ៊ីនស្តាក្រាម	អ៊ីនស្តាក្រាម	អ៊ីនស្តាក្រាម	អ៊ីនស្តាក្រាម
5	ឡាញ	ឡាញ	ឡាញ	ឡាញ
6	តេឡេក្រាម	តេឡេក្រាម	តេឡេក្រាម	តេឡេក្រាម
7	វ៉ាត់អាប់	វ៉ាត់អាប់	វ៉ាត់អាប់	វ៉ាត់អាប់
8	ធ្វីតធឺ	ធ្វីតធឺ	ធ្វីតធឺ	ធ្វីតធឺ
9	តិកតុក	តិកតុក	តិកតុក	តិកតុក
10	យូធូប	យូធូប	យូធូប	យូធូប
11	វីឆាត	វីឆាត	វីឆាត	វីឆាត
12	វ៉ាយប៊ី	វ៉ាយប៊ី	វ៉ាយប៊ី	វ៉ាយប៊ី
13	ផ្សេងៗ	ផ្សេងៗ	ផ្សេងៗ	ផ្សេងៗ

ផ្នែកទី៥៖ វ៉ាស់សុខភាពផ្លូវចិត្តរបស់ពលករចំណាកស្រុកដែលវិលត្រឡប់មកវិញ				

	កុងរយ:ពេលប៉ុនសប្តាហ៍ចុងក្រោយនេះ តើអ្នកត្រូវបានវ៉ិខានដោយបញ្ហាខាង ក្រោមនេះញឹកញ្យាប់ប៉ុណ្ណាដែរ?			
Q501	មានអារម្មណ៍ភ័យ ថប់ បារម្ម	មិនដែលទាល់តែសោះ	0	
		កើតឡើងជាច្រើនថ្ងៃ	1	
		ច្រើនជាងធម្មតា	2	
		ស្ទើរតែរាល់ថ្ងៃ	3	
		បដិសេធ	88	
		មិនដឹង	99	

Q502	មានអារម្មណ៍ មិនអាចបញ្ឈប់ ឬគ្រប់គ្រងការព្រួយបារម្ភខ្លួនឯង	មិនមែនទាល់តែសោះ	0	
		កើតឡើងជាច្រើនថ្ងៃ	1	
		ច្រើនជាងពាក់កណ្ដាលនៃថ្ងៃ	2	
		ស្ទើរតែរាល់ថ្ងៃ	3	
		បដិសេធ	88	
		មិនដឹង	99	
Q503	មានចំណាប់អារម្មណ៍តិចតួច ឬមិនរីករាយក្នុងការធ្វើអ្វីៗ	មិនមែនទាល់តែសោះ	0	
		កើតឡើងជាច្រើនថ្ងៃ	1	
		ច្រើនជាងពាក់កណ្ដាលនៃថ្ងៃ	2	
		ស្ទើរតែរាល់ថ្ងៃ	3	
		បដិសេធ	88	
		មិនដឹង	99	
Q504	មានអារម្មណ៍ធ្លាក់ទឹកចិត្ត ឬអស់សង្ឃឹម	មិនមែនទាល់តែសោះ	0	
		កើតឡើងជាច្រើនថ្ងៃ	1	
		ច្រើនជាងពាក់កណ្ដាលនៃថ្ងៃ	2	
		ស្ទើរតែរាល់ថ្ងៃ	3	
		បដិសេធ	88	
		មិនដឹង	99	
Q505	មតិយោបល់ចុងក្រោយបើសិនមាន?	បញ្ចប់បើសិនមិនមានអ្វីបន្ថែមទៀត		
		បើមាន សូមសរសេរបញ្ចូល		

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មគ្គុទេសក៍សម្ភាសបែបស៊ីជម្រៅ

តម្រូវការកញ្ចប់សេវាអប្បរមាមនុស្សធម៌សម្រាប់សុខភាពផ្លូវភេទ សុខភាពបន្តពូជ ចំពោះពេល ការទេសន្តរប្រវេសន៍ ៖ ការសិក្សា ដើម្បីលើកកម្ពស់សុខភាពផ្លូវភេទ សុខភាពបន្តពូជក្នុង ចំណោមពលការទេសន្តរប្រវេសន៍កម្ពុជា

មគ្គុទេសក៍សម្ភាសសម្រាប់ (ពលការចំណាកស្រុកកម្ពុជាដែលត្រឡប់មកវិញ)

គោលបំណងនៃគម្រោង៖	
ការវាយតម្លៃនៃការស្រាវជ្រាវនេះត្រូវបានដឹកនាំដោយអង្គការរ៉ាក់ **(RHAC's & Advocacy Program)** ក្នុងភាពជាដៃគូជាមួយក្រុម IPPF ស្ថិតនៅក្រោមការធ្វើឱ្យប្រសើរឡើងនូវ សុខ ភាពផ្លូវភេទ សុខភាពបន្តពូជ និងសិទ្ធិក្នុងចំណោមពលការចំណាកស្រុករបស់កម្ពុជា។ បន្ទាប់ពីគោលបំណងនៃការវាយតម្លៃ ការសិក្សានេះមានគោលបំណងដើម្បីឈានទៅរក បញ្ហាប្រឈមទាក់ទងនឹងសុខភាពបន្តពូជ សុខភាពផ្លូវភេទ និងសិទ្ធិក្នុងចំណោមពលការចំ ណាកស្រុកកម្ពុជាដែលត្រឡប់មកកម្ពុជាវិញ ជាពិសេសនោះគឺ ប្រភពនៃព័ត៌មាន និងការ យល់ឃើញអំពីគម្រោងការសុខភាពបន្ទាន់។	
គោលបំណងនៃការសិក្សាស្រាវជ្រាវ៖	
5. ស្វែងយល់អំពីបញ្ហាប្រឈមទាក់ទងនឹងបញ្ហាសុខភាព ជាពិសេស សុខភាពផ្លូវភេទ សុខ ភាពបន្តពូជ និងការអនុវត្តសិទ្ធិបន្តពូជ និងផ្លូវភេទ ក្នុងចំណោមអ្នកធ្វើចំណាកស្រុក	
6. ស្វែងយល់អំពីកម្រិតនៃគម្រោងការសេវាសុខភាព សុខភាពបន្តពូជជាអប្បរមាក្នុងអំឡុង ពេលនៃការធ្វើចំណាកស្រុក និងគម្រោងការសុខភាពបន្ទាន់ផ្សេង	
7. វាស់ផ្ទៃងអំពីការយល់ដឹងអំពី សុខភាពផ្លូវភេទ សុខភាពបន្តពូជ និងសិទ្ធិ ក៏ដូចជាប្រភពនៃ ការស្វែងយល់ ព័ត៌មានក្នុងចំណោមអ្នកធ្វើចំណាកស្រុក	
8. វិភាគអំពីយន្តការនៃការសម្របសម្រួល ការផ្តល់សេវាសុខភាពផ្លូវភេទ សុខភាពបន្តពូជ សម្រាប់អ្នកធ្វើចំណាកស្រុក	

ការណែនាំកិច្ចសម្ភាស

ការសម្ភាសបែបស៊ីជម្រៅ	ល.រ
(8) មេឃុំ មេភូមិ និងប៉ូលីសមូលដ្ឋាន	(8)
(9) បុគ្គលិកមន្ទីរសុខាភិបាលខេត្ត	(9)
(10) ភាគីពាក់ព័ន្ធ ឬអង្គការសង្គមស៊ីវិល ដែលធ្វើការជាមួយពលការចំ ណាកស្រុក	(10)
(11) ពលការចំណាកស្រុកខ្មែរត្រឡប់មកវិញ	(11)

(12) ទីស្នាក់ការអង្គការសហប្រជាជាតិ UNFPA និង IOM)	(12)
(13) ក្រសួងការងារ និងបណ្ដុះបណ្ដាលវិជ្ជាជីវៈ៖	(13)
(14) ក្រសួងសុខាភិបាល	(14)

ការសិក្សាស្រាវជ្រាវនេះអាចជាកម្មវត្ថុនៃការកែតម្រូវដោយផ្អែកលើស្ថានភាពនៃក្រុមគោលដៅនីមួយៗ។ ការសំភាសន៍គួរតែចាប់ផ្ដើមដោយមានការយល់ព្រមច្បាស់លាស់ពីអ្នកចូលរួម។

សេចក្ដីផ្ដើម និងសំណួរបំផុស (៥នាទី)

1) អ្នកសម្របសម្រួលណែនាំខ្លួនឯង និងពន្យល់ពីការរៀបចំ និងគោលមានរបស់អ្នកសង្កេតស្ថានការណ៍

2) ពន្យល់ពីគោលបំណងនៃការពិភាក្សា "យើងនឹងនិយាយភាគច្រើនអំពីបទពិសោធន៍របស់អ្នកទាក់ទងនឹងសុខភាពបន្តពូជ សុខភាពផ្លូវភេទ និងសិទ្ធិក្នុងចំណោមពលករចំណាកស្រុកមកពីបរទេស"។

3) ធានាការសម្ងាត់ និងឯកជនភាពសម្រាប់អ្នកចូលរួម

4) លើកទឹកចិត្តឱ្យមានភាពស្មោះត្រង់ ហើយមិនមានចម្លើយត្រឹមត្រូវឬក៏ខុសនោះ។

ព័ត៌មានប្រជាសាស្ត្ររបស់អ្នកចូលរួម/លក្ខណៈភូមិសាស្ត្រ

(๑) កាលបរិច្ឆេទ និងពេលវេលា៖ ....

(๒) ទីតាំងសម្ភាសន៍ (ទីកន្លែង)៖ ....

(๓) ឈ្មោះរបស់អ្នកចូលរួម៖ ....

(๔) ភេទ៖ ប្រុស/ ស្រី៖ ....

(๕) អាយុ៖ ....

(๖) មុខតំណែង៖ ....

(๗) អាស័យដ្ឋាន/ទំនាក់ទំនង៖ ....

(๘) អ្នកសម្ភាសន៍៖ ....

សំណួរអំពីបទពិសោធន៍ការងារជាពលករចំណាកស្រុក	តទ្បុរនេះខ្ញុំនឹងសួរអ្នកនូវសំណួរមួយចំនួនអំពីបទពិសោធន៍របស់អ្នកដែលធ្វើចំណាកស្រុក និងធ្វើការនៅក្រៅពីប្រទេសកម្ពុជា។ ចំពោះសំណួរទាំងអស់នេះ ខ្ញុំចង់ឱ្យអ្នកផ្ដោតលើការងារថ្មីៗចុងក្រោយបំផុតរបស់អ្នកនៅក្រៅប្រទេសកម្ពុជា។ បទពិសោធន៍របស់អ្នកនៅកន្លែងធ្វើការ និងកិច្ចការដែលអ្នកបានបញ្ចប់ ជាពិសេសទាក់ទងនឹងសេវាថែទាំសុខភាព/ព័ត៌មានសុខភាពរបស់អ្នក។
	1. តើអ្នកបានត្រឡប់មកកម្ពុជាបានប៉ុន្មានឆ្នាំមកហើយ ដោយគិតអំពីការធ្វើដំណើរទៅធ្វើការនៅបរទេសចុងក្រោយបង្អស់? **ស្ទូរដេញ៖** តើអ្នកចាំបានថា តើអ្នកបានត្រឡប់មកកម្ពុជាវិញនៅក្នុងឆ្នាំខែណាដែរ_____ ឆ្នាំ/ខែ?

	2. តើអ្នកបានធ្វើការនៅប្រទេសណាច្រើនដងជាងគេ?
	3. តើអ្នកបានធ្វើចំណាកស្រុកទៅក្រៅប្រទេសប៉ុន្មានដងមុនការធ្វើដំណើរលើកចុងក្រោយនេះក្នុងរយៈពេល ១០ ឆ្នាំកន្លងមកនេះ?
	4. តើអ្នកអាចទទួលបានការងាររបស់អ្នកដោយរបៀបណា?
	5. តើអ្នកបានចំណាយប្រាក់ប៉ុន្មានសម្រាប់ទទួលបានការងារនោះ?
	6. តើអ្នកបានធ្វើការក្នុងមុខតំណែងនោះរយៈពេលប៉ុន្មានឆ្នាំ (ចំនួនឆ្នាំធ្វើការក្នុងការងារនេះ)? បច្ចុប្បន្ន និងអតីតកាលនៅក្នុងប្រទេសដែលអ្នកធ្វើការ?
	7. តើអ្នកបានត្រៀមប្រាក់សម្រាប់ការព្យាបាលជំងឺរបស់អ្នកដែរឬទេ ក្នុងអំឡុងពេលធ្វើការរបស់អ្នកនៅបរទេស? បើបានត្រៀម ហាតុអ្វី? បើមិនបានត្រៀម ហាតុអ្វី?
ចំណេះដឹងទូទៅទាក់ទងនឹងសុខភាពផ្លូវភេទ សុខភាពបន្តពូជ និងសិទ្ធិ	8. តើអ្នកអាចប្រាប់ខ្ញុំបានទេថា អ្វីជាសុខភាពផ្លូវភេទ និងសុខភាពបន្តពូជមានន័យដូចម្តេច? តើសុខភាពផ្លូវភេទ និងសុខភាពបន្តពូជមានអ្វីខ្លះដែរ?
	9. តើអ្នកអាចប្រាប់ខ្ញុំបានទេថា អ្វីជាសិទ្ធិផ្លូវភេទ និងសិទ្ធិបន្តពូជ?
	10. តើអ្នកគិតថាស្ត្រី និងក្មេងស្រីគួរតែមានសិទ្ធិទទួលបាននូវសុខភាពផ្លូវភេទ និងបន្តពូជដែរឬទេ? ហាតុអ្វីបានជាអ្នកគិតបែបនេះ?
	11. តើអ្វីទៅជាសុខភាពបន្តពូជ និងសុខភាពផ្លូវភេទ ដែលអ្នកគិតថាវាមានសារៈសំខាន់ខ្លាំងសម្រាប់ស្ត្រី/ក្មេងស្រីក្នុងការទទួលបានសេវាសុខភាព? ហាតុអ្វី?
	12. តើអ្វីទៅជាសុខភាពបន្តពូជ និងសុខភាពផ្លូវភេទ ដែលអ្នកគិតថាវាមានសារៈសំខាន់ខ្លាំងណាស់សម្រាប់បុរស/ក្មេងប្រុសដើម្បីទទួលបាន? ហាតុអ្វី?
	13. តើអ្នកមានមិត្តភក្តិណាដែលពួកគេជាអ្នកស្រឡាញ់ភេទដូចគ្នាដែរឬទេ? ហើយតើអ្នកគិតថា សុខភាពផ្លូវភេទ សុខភាពបន្តពូជ និងសិទ្ធិវាមានសារៈសំខាន់ខ្លាំងយ៉ាងណាដែរសម្រាប់ពួកគេ? ហាតុអ្វី?
	14. តើអ្នកគិតថាសុខភាពផ្លូវភេទ សុខភាពបន្តពូជ និងសិទ្ធិមានសារៈសំខាន់សម្រាប់អ្នកដែរឬទេ?

	15. តើអ្នកនឹងពិភាក្សាអំពីព័ត៌មាន ឬស្វែងយល់បន្ថែមអំពីសុខ ភាពផ្លូវភេទ និងសុខភាពបន្តពូជជាមួយដៃគូររបស់អ្នកដែរឬទេ?
គំនិតលើភាពងាយស្រួលក្នុង ការស្វែងរកកន្លែងថែទាំសុខ ភាព	16. តើអ្វីជាខបសគ្គសម្រាប់មនុស្សក្នុងការទទួលបានសេវា ថែទាំសុខភាពប្រកបដោយសុវត្តិភាព? (ខ. ថ្លៃចំណាយ ធម្មាយ ពេលវេលា ការធើសអើងវប្បធម៌... ។ល។) សម្រាប់ខ្លួនអ្នកជា ពលករចំណាកស្រុក?
ចំណេះដឹង និងការយល់ ឃើញទាក់ទងនឹងការរំលូត	17. តើអ្នកមានទស្សន:យ៉ាងណាចំពោះការរំលូតក្នុងបរិបទនៃ ប្រទេសកម្ពុជាយើង?
	18. តើអ្នកគិតថាស្ត្រីគួរតែទទួលបានព័ត៌មាន និងសេវាកម្ម រំលូតដោយសុវត្តិភាពដែរឬទេ? ហើយរកបាននៅកន្លែងណា?
	19. តើអ្នកគិតថាការសម្រេចចិត្តរំលូតគួរតែជាផ្នែកមួយនៃសុខ ភាពបន្តពូជ សុខភាពផ្លូវភេទ និងសិទ្ធិរបស់ស្ត្រីដែរឬទេ? ហេតុអ្វី បានជាអ្នកគិតបែបនេះ?
	20. តើអ្នកមានយោបល់យ៉ាងណាដែរចំពោះវិធីដែលបង្កើនលទ្ធ ភាពទទួលបានព័ត៌មាន និងសេវាកម្មរំលូតប្រកបដោយសុវត្តិ ភាព និងគុណភាពសម្រាប់ពលករចំណាកស្រុកជាស្ត្រី?តើអ្នក មានគំនិតអ្វីបន្ថែមទៀត?
	21. តើអ្នកគិតថាកន្លែងណាដែលមនុស្សគួរទៅទទួលសេវា និង មានសិទ្ធិគ្រប់គ្រាន់ក្នុងការរំលូតដោយខ្លួនឯង? (ព័ត៌មាន និង សេវាកម្ម)
ចំណេះដឹង ការប្រើប្រាស់ និង វិធីសាស្ត្រក្នុងការប្រើប្រាស់ មធ្យោបាយពន្យារកំណើត	22. តើអ្នកធ្លាប់ប្រើប្រាស់សេវាពន្យាកំណើតប្រភេទណាដែរ ឬទេ? **ស្វ័រដេញៈ** កងដាក់ក្នុងស្បូន, ស្រោមអនាម័យ, ថ្នាំគ្រាប់, ការចាក់, ថ្នាំគ្រាប់ពន្យាកំណើតបន្ទាន់ (៧២ម៉ោងជាដើម), កង ដាក់ក្រោមស្បែក, ដាក់ដៃលជាដើម, **ស្វ័រដេញៈ** មានអ្វីផ្សេង ទៀតដែលអ្នកបានដឹង? ប្រសិនបើអ្នក ឬក្រុមគ្រួសាររបស់អ្នក ប្រើ តើវិធីពន្យារកំណើតបែបណាដែលអ្នកប្រើប្រើនជាងគេ? តើ អ្នកគិតថាវាមានសុវត្តិភាពសម្រាប់អ្នក និងដៃគូររបស់អ្នកដែរ ឬទេ?
ចំណេះដឹងទាក់ទងនឹងការ មានផ្ទៃពោះ	23. តើអ្នកអាចប្រាប់ខ្ញុំបានទេ តើស្ត្រីមានផ្ទៃពោះគួរតែស្វែងរក សេវាថែទាំមុនសម្រាលដែរឬទេ? តើពួកគេគួរទទួលបានសេវា

	ថែទាំមុនសម្រាលនៅឯណា? តើស្ត្រីគួរមានកូននៅអាយុប៉ុន្មាន ដែលល្អសម្រាប់គាត់?
ចំណេះដឹងអំពីគ្លីនិកវ៉ាក់	24. តើអ្នកធ្លាប់ញអំពីអង្គការវ៉ាក់ ឬគ្លីនិកវ៉ាក់ដែរឬទេ? សួរដេញៈ ហាតុអ្វីបានជាអ្នកស្គាល់ ឬហាតុអ្វីបានជាអ្នកមិនស្គាល់? បើ ដូច្នេះ តើអ្នកធ្លាប់ប្រើសេវាសុខភាពណាមួយពីគ្លីនិកវ៉ាក់ដែរ ឬទេ? ហាតុអ្វីបានជាអ្នកជ្រើសរើសជម្រើសសេវាសុខភាពនៅគ្លី និកវ៉ាក់?
ការធ្វើឱ្យប្រសើរឡើងនូវសេវា និងកិច្ចអន្តរាគមន៍សេវាសុខ ភាពតាមប្រព័ន្ធឌីជីថល	25. តើអ្នកមានស្មាតហ្វូនប្រើដែរឬទេ? តើសកម្មភាពមួយណា ដែលអ្នកកំពុងមើលច្រើនជាងគេ នៅពេលអ្នកមើលស្មាតហ្វូន របស់អ្នក? **សួរដេញៈ** មើលគេហទំព័រ ឬព័ត៌មានណាដែល ទាក់ទងនឹងការស្វែងរកការថែទាំសុខភាពដែរឬទេ?
	26. តើអ្នកធ្លាប់ប្រើស្មាតហ្វូនដើម្បីស្វែងរកការព្យាបាល ថែទាំ សុខភាពរបស់អ្នកដែរឬទេ? ប្រសិនបើធ្លាប់ តើសេវាថែទាំសុខ ភាព ឬការព្យាបាលប្រភេទណាដែលអ្នកទទួលបាននោះ? តើ គុណភាពនៃសេវាកម្មដែលអ្នកបានទទួលបាននោះល្អដែរឬទេ?
	27. តាមទស្សនៈរបស់អ្នក តើប្រព័ន្ធផ្សព្វផ្សាយមួយណាដែល អ្នកគិតថាមនុស្សចូលប្រើច្រើនជាងគេ ដូចជាអ៊ីនធឺណិត ហ្វេស ប៊ុក ទូរទស្សន៍ វិទ្យុ ទស្សនាវដ្ដី ឬកាសែត?
គំរិយាបទក្នុងការស្វែងរកសេវា សុខភាព	28. តើអ្នកធ្លាប់ទទួលឬប្រើប្រាស់សេវាសុខភាពបន្តពូជ សុខ ភាពផ្លូវភេទ នៅក្នុងប្រទេសដែលអ្នកធ្លាប់ធ្វើការនោះដែរឬទេ? ប្រើធ្លាប់ សូមស្ងួសំណួរ ២៩ ៣០ ៣១ បើមិនធ្លាប់ សូមរំលង ទៅសំណួរ៣២។
	29. តើអ្នកទទួលបានព័ត៌មានអំពីកន្លែងផ្តល់សេវាសុខភាព ដែលអ្នកបានទទួលសេវាព្យាបាលនៅទីនោះពីណាដែរ? តើ សេវាសុខភាពដែលអ្នកបានទទួលបាននោះវាយ៉ាងដូចម្តេច ដែរ?
	30. តើអ្នកគិតថាអ្នកទទួលបានសេវាសុខភាពគ្រប់គ្រាន់ ឬ ពេញចិត្ត នៅពេលដែលអ្នកត្រូវការសេវានេះ?
	31. តើការចំណាយទៅលើការព្យាបាលយ៉ាងដូចម្តេចដែរ?
	32. តើអ្នកធ្លាប់ទទួលសេវាសុខភាព សុខភាពផ្លូវភេទ សុខ ភាពបន្តពូជ និងសិទ្ធនៅក្នុងប្រទេសកម្ពុជាដែរឬទេ មុនពេល

និងក្រោយពេលត្រឡប់មកពីធ្វើការបរទេសវិញ? បើធ្លាប់ សូម
បន្តសំណួរ**៣៣ ៣៤ ៣៥** បើមិនធ្លាប់បន្តសំណួរ**៣៦**។

33. សូមប្រាប់ខ្ញុំពីសេវាសុខភាពអ្វីខ្លះដែលអ្នកទទួល?

34. តើអ្នកទទួលបានព័ត៌មានពីណាដែលអ្នកបានទៅទទួល
ព័ត៌មាននៅទីនោះ? តើសេវានៅទីនោះយ៉ាងដូចម្តេចដែរ?

35. តើការចំណាយថ្លៃសេវាដូចម្តេចដែរ? វាសមរម្យដែរឬទេ?

36. តើអ្នកគិតថាក្នុងពេលឆាប់ៗខាងមុខ អ្នកនឹងស្វែករកឬប្រើ
សេវាសុខភាពបន្តពូជ សុខភាពផ្លូវភេទ និងសិទ្ធដែរឬទេ? បើ
បាទ/ចាស តើសេវាកម្មប្រភេទណាដែលអ្នកប្រហែលជាចង់
បាន? បើមិនចង់ សូមប្រាប់ខ្ញុំពីមូលហេតុ?

37. តើអ្នកបានស្វែងរកសេវាសុខភាព ឬព័ត៌មានសុខភាពពី
មណ្ឌលសុខភាព/ឆ្នួបបណ្តាញឃើញកញ្ចប់ប៉ុណ្ណោះ? **ស្វរដេញៈ** សូម
បញ្ជាក់ឲ្យច្បាស់ទៅកាន់អ្នកចូលរួមអំពីបទពិសោធន៍របស់ពួក
គេនៃការទទួលបានសេវាសុខភាពនៅក្រៅប្រទេស ហើយប្រៀប
ធៀបសេវាសុខភាពនៅក្នុងប្រទេសកម្ពុជា តើមួយណាដែលអ្នក
គិតថាប្រសើរជាង? ហាតុអ្វី? បើនៅស្រុកគេប្រសើរជាង មូល
ហេតុអ្វី? បើនៅស្រុកយើងប្រសើរជាង មូលហេតុអ្វី?

38. តើអ្នកធ្លាប់ឮពីគោលនយោបាយណាមួយសម្រាប់ការ
ការពារពលករចំណាកស្រុកដែរឬទេ? ជាពិសេសគោល
នយោបាយទាក់ទងនិងសុខភាព?
តើអ្នកគិតថាការយល់ដឹងអំពីគោលនយោបាយថ្នាក់ជាតិមានសា
រៈសំខាន់ដែរឬទេ?

39. តើអ្នកដឹងអំពីគោលនយោបាយការពារសុខភាពរបស់អ្នក
នៅក្នុងប្រទេសដែលអ្នកបានទៅធ្វើការងារនោះដែរឬទេ? បើដឹង
តើអ្នកដឹងអំពីវាដោយរបៀបណា?

40. តើអ្នកត្រូវការការអន្តរាគមន៍ពីរដ្ឋាភិបាលក្នុងការទទួលបាន
សេវាថែទាំសុខភាព សុខភាពផ្លូវភេទ សុខភាពបន្តពូជ និងសិទ្ធ
ដែរឬទេ?បើត្រូវការហេតុអ្វី? បើមិនត្រូវការហេតុអ្វី?

41. តើអ្នកមានសំណូមពរអ្វីបន្ថែមដើម្បីពង្រឹងសេវាសុខភាព
បន្តពូជ សុខភាពផ្លូវភេទ និងសិទ្ធសម្រាប់ពលករចំណាកស្រុក
ដែរឬទេ? តើសេវាសុខភាពបន្តពូជ សុខភាពផ្លូវភេទ និងសិទ្ធ
សំខាន់បំផុតដែលពួកគេត្រូវការគឺជាអ្វី? បានដោយរបៀបណា?

	យោបល់ និងអនុសាសន៍

(អ្នកសម្ភាសន៍ត្រូវរក្សាចំណាំ និងសង្កេតមើលអ្វីដែលខុសប្រក្រតី ឬគួរចាប់អារម្មណ៍អំពីការសម្ភាសន៍)

សូមអរគុណចំពោះការចំណាយពេលឆ្លើយសំណួរនៅក្នុងការស្ទង់មតិនេះ។ ចម្លើយរបស់អ្នកមានសារៈសំខាន់ខ្លាំងណាស់ចំពោះការស្រាវជ្រាវរបស់យើងនៅក្នុងអង្គការរ៉ាក់នេះ។ ចម្លើយរបស់អ្នក និងព័ត៌មានផ្ទាល់ខ្លួនរបស់អ្នកដែលបានផ្តល់នឹងត្រូវបានប្រើទាំងស្រុងសម្រាប់តែគោលបំណងនៃការអប់រំប៉ុនោះ ឬការស្រាវជ្រាវទូទៅទាក់ទងនឹងការវិកលម្អរសុខភាពវឺភាគ សុខភាពបន្តពូជ និងសិទ្ធិ ។ សូមអរគុណម្តងទៀតចំពោះការចូលរួមរបស់អ្នក និងជំនួយរបស់អ្នកក្នុងការធ្វើឱ្យសុខភាពវឺភាគ សុខភាពបន្តពូជ និងសិទ្ធិកាន់តែប្រសើរឡើងក្នុងចំណោមពេលករចំណាកស្រុក កម្ពុជា។

<div align="center">សូមអរគុណសម្រាប់ការចូលរួមឆ្លើយរបស់អ្នក!</div>

ទម្រង់កិច្ចព្រមព្រៀងចូលរួមសម្ភាស

ជម្រាបសួរ ខ្ញុំបាទ/នាងខ្ញុំឈ្មោះ .... ខ្ញុំមកពីអង្គការថែទាំសុខភាពគ្រួសារវ៉ាក់ (RHAC)។ អង្គការវ៉ាក់ គឺជាអង្គការមិនមែនរដ្ឋាភិបាល ដែលត្រូវបានបង្កើតឡើងនៅក្នុងឆ្នាំ១៩៩៦ ជាមួយនឹងការប្តេជ្ញាចិត្តយ៉ាងមុតមាំក្នុងការនាំយកសេវាសុខភាពប្រកបដោយគុណភាពដល់សហគមន៍ ជាពិសេសដល់ជនក្រីក្រ និងជនងាយរងគ្រោះ។ អង្គការវ៉ាក់គឺជាដៃគូសហការយ៉ាងសកម្ម និងធ្វើការ យ៉ាងជិតស្និទ្ធជាមួយក្រសួងសុខាភិបាលក្នុងការគាំទ្រទៅដល់មណ្ឌលសុខភាពរបស់ខ្លួនក្នុងការលើក កម្ពស់គុណភាព លទ្ធភាពទទួលបាន និងការប្រើប្រាស់សេវាសុខភាព នៅកម្រិតសហគមន៍។ អង្គការវ៉ា ក់គាំទ្របណ្តាញអ្នកស្ម័គ្រចិត្តសុខភាពតាមសហគមន៍ ដើម្បីលើកកម្ពស់លទ្ធភាពទទួលបានសេវាសុខ ភាពរបស់មាតា និងទារកនៅតាមគ្រឹះស្ថានសាធារណៈ។ គោលបំណងនៅក្នុងការសិក្សានេះគឺផ្តោត សំខាន់ទៅលើ តម្រូវការកញ្ចប់សេវាអប្បរមាមនុស្សធម៌សម្រាប់សុខភាពផ្លូវភេទ សុខភាពបន្តពូជ ចំពោះ ពលករទេសន្តរប្រវេសន៍ ៖ ជាការសិក្សា ដើម្បីលើកកម្ពស់សុខភាពផ្លូវភេទ សុខភាពបន្តពូជក្នុងចំណោម ពលករទេសន្តរប្រវេសន៍កម្ពុជា។ ការសិក្សានេះនឹងផ្តោតសំខាន់តែចំពោះជនចំណាកស្រុកដែលត្រឡប់ មកកម្ពុជាវិញ យើងនឹងស្វែងយល់ពីការយល់ដឹង បទពិសោធន៍ និងការអនុវត្តរបស់ពលករចំណាកស្រុក ទាំងនោះទាក់ទងនឹងសុខភាពបន្តពូជផ្លូវភេទ និងសិទ្ធិ ជាពិសេសអាក្បប្បកិរិយាស្វែងរកសេវាសុខភាព តម្រូវការសេវាសុខភាពបន្ថាន់ផ្សេង និងប្រភពព័ត៌មានលើសុខភាពរបស់ពួកគេជាដើម។ អ្នកមានសិទ្ធិ មិនចូលរួមក្នុងការកិច្ចសម្ភាសនេះនៅពេលណាក៏បាន។ ប្រសិនបើអ្នកមានសំណួរណាមួយអ្នកអាច សាកសួរបាន? អ្នកអាចសាកសួរមកកាន់ លោកស្រីបណ្ឌិត សាធន សុម៉ាលីស្មី (០៦៩ ៧៧៧ ៩៥៥) និងលោក ជៀន សម្បស្ស (០៨៨ ៧៧៧៧ ២៨៣) ឬតាមរយៈអ៊ីម៉ែល rhac.ra.sro@gmail.com ។ អំឡុងពេលសម្ភាសខ្ញុំសូមសុំការអនុញ្ញាតិអ្នកដោយថតសម្លេងនៅពេលសន្ទនានេះ ដើម្បីទទួលបាន ព័ត៌មានគ្រប់ជ្រុងជ្រោយ ប៉ុន្តែយើងនឹងលុបសារសម្លេងនេះវិញបន្ទាប់ពីបញ្ចប់កិច្ចការស្រាវជ្រាវនេះ។ ខ្ញុំ សូមធានាអះអាងថារាល់ព័ត៌មានរបស់អ្នកគឺត្រូវបានរក្សាទុកជាការសម្ងាត់បំផុតសម្រាប់ការសិក្សា ស្រាវជ្រាវនេះ។

☐ តើអ្នកមានសំណួរអ្វីបន្ថែមដែរឬទេ?

☐ តើអ្នកយល់ព្រមចូលរួមនៅក្នុងការសិក្សានេះដែរឬទេ?

☐ តើអ្នកយល់ព្រមឱ្យក្រុមការងារយើងថតសម្លេងក្នុងការសម្ភាសនេះដែរឬទេ?

សូមគូសសញ្ញាធីកនៅក្នុងប្រអប់ខាងលើ។ សូមសរសេរឈ្មោះរបស់អ្នក និងចុះហត្ថលេខាខាងក្រោម នេះ។

_____ _____ _____ / កក្កដា /២០២២

ឈ្មោះ:   ហត្ថលេខា   ថ្ងៃ   ខែ   ឆ្នាំ

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Appendix 8. Additional Data information

This appendix is provided for documentation and transparency purposes. The content is not part of the analytical text of the dissertation.

Kingdom of Cambodia
Religion Nation King

Siem Reap Police Commissioner
Anti-Human Trafficking and Juvenile Protection office
Work Plan and Gender Work

Table of Cambodian Migration to work abroad
For June 2022 data from 17 May 2022-17 June 2022

Cities/provinces	Grant total				Documented				Undocumented			Returned Migrants			
	Total	Female	Juvenile		Total	Female	Juvenile		Total	Juvenile		Total	F	Juvenile	
			Total	F			Total	F		M	F			Total	F
Siem Reap	799	314	0	0	95	17	0	0	0	0	0	704	297	0	0
Chi Kreng	5236	1592	3	1	1291	248	0	0	0	0	0	3945	1444	13	7
Soth Nikom	5238	2363	63	46	2405	1190	0	0	63	48	15	2833	1173	32	5
Prasat Bakorng	2340	217	0	0	1961	59	0	0	0	0	0	379	158	0	0
Svay Lue	676	289	0	0	238	95	0	0	0	0	0	438	194	2	0
Banteay Srey	455	199	22	10	229	101	20	9	0	0	0	226	98	2	0
Angkor Thom	2788	919	11	9	2121	627	5	2	0	0	0	667	292	7	2
Angkor Chum	7255	2377	0	0	2481	255	0	0	0	0	0	4774	2122	0	0
Varin	2002	2219	0	0	497	654	0	0	0	0	0	1505	1565	3	0
Puk	8795	2590	0	0	3033	44	0	0	0	0	0	5703	2546	0	0
Kroa Lanh	9318	4857	0	0	1137	1145	0	0	0	0	0	8181	3712	0	0
Srey Snom	4775	2022	137	0	685	305	0	0	137	97	40	4090	1717	5	0
Total	49578	20053	236	66	16233	4740	25	11	200	145	55	33445	15318	60	12

ព្រះរាជាណាចក្រកម្ពុជា
ជាតិ សាសនា ព្រះមហាក្សត្រ

រដ្ឋបាលខេត្តបាត់ដំបង
លេខ: ៣៧២១/២២ សជណ ថ្ងៃសុក្រ ១៤កើត ខែទ្រុបថ ឆ្នាំខាល ចត្វាស័ក ព.ស ២៥៦៦
បាត់ដំបង ថ្ងៃទី ០៩ ខែ កញ្ញា ឆ្នាំ២០២២

ជម្រាបមក
លោកនាយកប្រតិបត្តិ អង្គការថែទាំសុខភាពគ្រួសារកម្ពុជា

កម្មវត្ថុ: ការឈ្លើយសំណើសុំការគាំទ្រ និងអនុញ្ញាតដល់ អង្គការថែទាំសុខភាពគ្រួសារកម្ពុជា (RHAC) ធ្វើ
ការប្រមូលទិន្នន័យសម្រាប់ការសិក្សា ស្តីពីតម្រូវការកញ្ចប់សេវាអប្បបរមាមានអនុស្សមទំសម្រាប់
សុខភាពផ្លូវភេទ សុខភាពបន្តពូជ ចំពោះពលករទេសន្តរប្រវេសន៍។ ការសិក្សាស្តីពីការលើកកម្ពស់
សុខភាពផ្លូវភេទ សុខភាពបន្តពូជក្នុងចំណោមពលករទេសន្តរប្រវេសន៍កម្ពុជា នៅខេត្តបាត់ដំបង។

យោង : - លិខិតលេខ ២២/១២៥ ចុះថ្ងៃទី១១ ខែសីហា ឆ្នាំ២០២២ របស់អង្គការថែទាំសុខភាពគ្រួសារកម្ពុជា
- ចំណារបស់ ឯកឧត្តមអភិបាលស្តីទី នៃគណៈអភិបាលខេត្ត ចុះថ្ងៃទី២៦ ខែសីហា ឆ្នាំ២០២២។

តបតាមកម្មវត្ថុ និងយោងខាងលើ ខ្ញុំសូមជម្រាបមក លោកនាយកប្រតិបត្តិ អង្គការថែទាំសុខភាព
គ្រួសារកម្ពុជា ប្រាបថា រដ្ឋបាលខេត្តមិនមានការយល់ទាស់ទេ លើការឈ្លើយសំណើសុំការគាំទ្រ និងអនុញ្ញាតដល់
អង្គការថែទាំសុខភាពគ្រួសារកម្ពុជា (RHAC) ធ្វើការប្រមូលទិន្នន័យសម្រាប់ការសិក្សា ស្តីពីតម្រូវការកញ្ចប់
សេវាអប្បបរមាមានអនុស្សមទំសម្រាប់សុខភាពផ្លូវភេទ សុខភាពបន្តពូជ ចំពោះពលករទេសន្តរប្រវេសន៍។ ការសិក្សា
ស្តីពីការលើកកម្ពស់សុខភាពផ្លូវភេទ សុខភាពបន្តពូជក្នុងចំណោមពលករទេសន្តរប្រវេសន៍កម្ពុជានៅខេត្ត
បាត់ដំបង។ ទន្ទឹមនេះ រដ្ឋបាលខេត្តស្នើ លោកនាយកប្រតិបត្តិ អង្គការថែទាំសុខភាពគ្រួសារកម្ពុជា ធ្វើការ
ទំនាក់ទំនង និងសហការជាមួយមន្ត្រីជំនាញពាក់ព័ន្ធ និងអាជ្ញាធរមូលដ្ឋានឱ្យបានល្អប្រសើរ។

អាស្រ័យហេតុនេះ សូម លោកនាយកប្រតិបត្តិ អង្គការថែទាំសុខភាពគ្រួសារកម្ពុជា ប្រាប និង
បាត់ចែងអនុវត្តតាមការគួរ។

សូម លោកនាយកប្រតិបត្តិ ទទួលនូវការស្រលាញ់រាប់អានអំពីខ្ញុំ។

ចម្លងជូន :
- មន្ត្រីសុខាភិបាល នៃរដ្ឋបាលខេត្ត
- មន្ត្រីជំនាញពាក់ព័ន្ធ
- រដ្ឋបាលក្រុង-ស្រុកទាំង១៤
"ដើម្បីជ្រាប និងសហការ
- ឯកសារ-កាលប្បវត្តិ

le 16-09-2022

តំណាង អភិបាលខេត្ត
អភិបាលរងខេត្ត
យ៉ឹម សេងគុណ

អាសយដ្ឋាន: ផ្លូវលេខ០១, ទល់មុខស្ពានចាស់, ទូរស័ព្ទនិងទូរសារលេខ: ០៥៣ ៧៣៩ ៩៩៩ / ៧៣៩ ៩៩៩ គេហទំព័រ: www.battambang.gov.kh
Address : Road 01, In front of old bridge, Telephone & Fax : 053 739 999 / 739 999 Website: www.battambang.gov.kh
Facebook Page : រដ្ឋបាលខេត្តបាត់ដំបង : www.Facebook.com.com: www.battambang.gov.kh

អង្គការវិថីទាំសុខភាពគ្រួសារកម្ពុជា (រ៉ាក់)
Reproductive Health Association of Cambodia (RHAC)

លេខ៖ ២៦៧/១៩២៥

សូមគោរពជូន
ឯកឧត្តមអភិបាល នៃគណៈអភិបាលខេត្ត បាត់ដំបង

កម្មវត្ថុ៖ សំណើសុំការគាំទ្រ និងអនុញ្ញាតដល់ អង្គការវិថីទាំសុខភាពគ្រួសារកម្ពុជា (RHAC) ធ្វើការប្រមូលទិន្នន័យ សម្រាប់ការសិក្សា ស្តីពីតម្រូវការកញ្ចប់សេវាអប្បរមាអនុស្សធម៌សម្រាប់សុខភាពផ្លូវភេទ សុខភាពបន្តពូជ ចំពោះ ពលករទេសន្តរប្រវេសន៍៖ ការសិក្សាស្តីពី លើកកម្ពស់សុខភាពផ្លូវភេទ សុខភាពបន្តពូជក្នុងចំណោមពលករ ទេសន្តរប្រវេសន៍កម្ពុជា នៅខេត្ត **បាត់ដំបង**។

យោង៖ លិខិតលេខ ១៩១៣/២០ ស.ជ.ណ ចុះថ្ងៃទី១១ ខែមិថុនា ឆ្នាំ២០២០ របស់រដ្ឋបាលខេត្តបាត់ដំបង ស្តីអំពីការគាំ ទ្រកម្មវិធីរបស់អង្គការវិថីទាំសុខភាពគ្រួសារកម្ពុជា (រ៉ាក់) បន្តសម្រាប់ឆ្នាំ២០២០-២០២២ដើម្បីចូលរួមបង្កើន សុខមាលភាពរបស់ប្រជាពលរដ្ឋក្នុងខេត្តបាត់ដំបង ។

សេចក្តីដូចបានចែងក្នុងកម្មវត្ថុខាងលើ ខ្ញុំបាទសូមជម្រាបជូន **ឯកឧត្តមអភិបាល** មេត្តាជ្រាបថា៖ អង្គការវិថីទាំ សុខភាពគ្រួសារកម្ពុជា (រ៉ាក់) បាននិងកំពុងរៀបចំតម្រោងសិក្សាមួយស្តីអំពី តម្រូវការកញ្ចប់សេវាអប្បរមាអនុស្សធម៌សម្រាប់សុខភាពផ្លូវ ភេទ សុខភាពបន្តពូជ របស់ពលករទេសន្តរប្រវេសន៍នៅប្រទេសកម្ពុជា ដែលការសិក្សានេះនឹងផ្តោតលើការប្រមូលទិន្នន័យនៅក្នុងខេត្តចំនួន៤ គឺ ខេត្តបាត់ដំបង ខេត្តបន្ទាយមានជ័យ ខេត្តសៀមរាប និងខេត្តកំពត។ គោលបំណងនៅក្នុងការសិក្សានេះ គឺដើម្បី៖ (ក)ស្វែងយល់អំពីបញ្ហា ប្រឈមទាក់ទងនឹងបញ្ហាសុខភាពសុខភាពផ្លូវភេទ សុខភាពបន្តពូជ និងការអនុវត្តទិទ្ធិបន្តពូជ និងផ្លូវភេទ ក្នុងចំណោមពលករចំណាកស្រុក កម្ពុជាដែលបានវិលត្រឡប់វិញ (ខ)ស្វែងយល់អំពីកម្រិតនៃតម្រូវការ សេវាសុខភាព សុខភាពបន្តពូជជាអប្បរមាក្នុងអំឡុងពេលនៃការធ្វើ ចំណាកស្រុក និងតម្រូវការសុខភាពបន្ទាប់ផ្សេងៗ (គ)វាស់វែងអំពីការយល់ដឹងលើ សុខភាពផ្លូវភេទ សុខភាពបន្តពូជ និងសិទ្ធិ ក៏ដូចជា ប្រភពនៃការស្វែងរក ព័ត៌មានក្នុងចំណោមអ្នកធ្វើចំណាកស្រុកកម្ពុជា (ឃ) វិភាគអំពីយន្តការនៃការសម្របសម្រួល ការផ្តល់សេវាសុខភាព ផ្លូវភេទ សុខភាពបន្តពូជជាសម្រាប់អ្នកធ្វើចំណាកស្រុក។ សម្រាប់ខេត្តនៃគោលដៅទាំងឡាយនេះ ក្រុមការងារប្រមូលទិន្នន័យ និងធ្វើការជ្រើសរើស មេក្រូមិ មេឃុំ អាជ្ញាធរមានសមត្ថកិច្ច ភាគីពាក់ព័ន្ធ សមាជិក គ.ក.ន.គ បុគ្គលិកមន្ទីរសុខាភិបាល ដែលធ្វើការងារពាក់ព័ន្ធនឹងពលករចំណាក និងពលករចំណាកស្រុកដែលវិលត្រឡប់មកវិញផងដែរ។

ខ្ញុំបាទសូមជូនភ្ជាប់មកជាមួយនូវ (១) ព័ត៌មានសង្ខេបនៃតម្រោងសម្រាប់ធ្វើការសិក្សា (២)កម្រងសំណួរសម្រាប់ សម្ភាសជាមួយពលករចំណាកស្រុកដែលត្រឡប់មកវិញ (៣)កម្រងសំណួរសម្រាប់សម្ភាសជាមួយអាជ្ញាធរភូមិឃុំ និងជនបង្គោល (៤)បញ្ជី តារាងឈ្មោះខេត្តទាំងបួន និង (៥)លិខិតបញ្ជាក់កិច្ចព្រមព្រៀងចូលរួមដែលនឹងត្រូវចុះហត្ថលេខាដោយសមាមីខ្លួនចូលរួមក្នុងការសម្ភាស។

អាស្រ័យដូចបានជម្រាបជូនខាងលើ សូម **ឯកឧត្តមអភិបាល** មេត្តាពិនិត្យលទ្ធភាព និងអនុញ្ញាតផ្តល់នូវលិខិតគាំទ្រ ដល់ក្រុមការងារអង្គការរ៉ាក់ ដើម្បីអនុវត្តន៍កិច្ចការទាំងឡាយ នៅក្នុងអំឡុងខែសីហា ដល់ខែកញ្ញា ឆ្នាំ២០២២ ដោយក្តីអនុគ្រោះ។

សូម **ឯកឧត្តមអភិបាល** ទទួលនូវការគោរពដ៏ខ្ពង់ខ្ពស់អំពីខ្ញុំបាទ។

ថ្ងៃព្រហស្បតិ៍ ១៤កើត ខែស្រាពណ៍ ឆ្នាំខាល ចត្វាស័ក ព.ស ២៥៦៦
រាជធានីភ្នំពេញ ថ្ងៃទី១១ ខែសីហា ឆ្នាំ២០២២

នាយកប្រតិបត្តិ

អៀ. ម៉ា ជីវ័ន

18/8/2022

ចម្លងជូន៖
- មន្ទីរសុខាភិបាលខេត្ត បាត់ដំបង
- មន្ទីរកិច្ចការ និងបណ្ណសារបណ្ឌិត្យសភាខេត្ត
- អគ្គនាយកដ្ឋាន អង្គការសង្គមស៊ីវិល និងវិទ្យុពាក់ព័ន្ធ

ប៉ារ ប៊ី 098 068007
099

ព្រះរាជាណាចក្រកម្ពុជា

ជាតិ សាសនា ព្រះមហាក្សត្រ

រដ្ឋបាលខេត្តបាត់ដំបង

លេខ: ២៣៧៦/២២ សជណ ថ្ងៃសុក្រ ០៤កើត ខែទ្រវបទ ឆ្នាំខាល ចត្វាស័ក ព.ស ២៥៦៦

បាត់ដំបង ថ្ងៃទី ០៩ ខែ កញ្ញា ឆ្នាំ២០២២

ជម្រាបមក

លោកនាយកប្រតិបត្តិ អង្គការរៃទាំសុខភាពគ្រួសារកម្ពុជា

កម្មវត្ថុៈ ករណីសំណើសុំការគាំទ្រ និងអនុញ្ញាតដល់ អង្គការរៃទាំសុខភាពគ្រួសារកម្ពុជា (RHAC) ធ្វើ ការប្រមូលទិន្នន័យសម្រាប់ការសិក្សា ស្ដីពីតម្រូវការកញ្ចប់សេវាអប្បបរមាមានុស្សធម៌សម្រាប់ សុខភាពផ្លូវភេទ សុខភាពបន្តពូជ ចំពោះពលករទេសន្តរប្រវេសន៍ៈ ការសិក្សាស្ដីពីការលើកកម្ពស់ សុខភាពផ្លូវភេទ សុខភាពបន្តពូជក្នុងចំណោមពលករទេសន្តរប្រវេសន៍កម្ពុជា នៅខេត្តបាត់ដំបង។

យោង ៈ - លិខិតលេខ ២២/១២៥ ចុះថ្ងៃទី១១ ខែសីហា ឆ្នាំ២០២២ របស់អង្គការរៃទាំសុខភាពគ្រួសារកម្ពុជា

- ចំណារបស់ ឯកឧត្តមអភិបាលស្ដីទី នៃគណៈអភិបាលខេត្ត ចុះថ្ងៃទី២៦ ខែសីហា ឆ្នាំ២០២២។

តបតាមកម្មវត្ថុ និងយោងខាងលើ ខ្ញុំសូមជម្រាបមក លោកនាយកប្រតិបត្តិ អង្គការរៃទាំសុខភាព គ្រួសារកម្ពុជា ជ្រាបថា រដ្ឋបាលខេត្តមិនមានការយល់ទាស់ទេ លើករណីសំណើសុំការគាំទ្រ និងអនុញ្ញាតដល់ អង្គការរៃទាំសុខភាពគ្រួសារកម្ពុជា (RHAC) ធ្វើការប្រមូលទិន្នន័យសម្រាប់ការសិក្សា ស្ដីពីតម្រូវការកញ្ចប់ សេវាអប្បបរមាមានុស្សធម៌សម្រាប់សុខភាពផ្លូវភេទ សុខភាពបន្តពូជ ចំពោះពលករទេសន្តរប្រវេសន៍ៈ ការសិក្សា ស្ដីពីការលើកកម្ពស់សុខភាពផ្លូវភេទ សុខភាពបន្តពូជក្នុងចំណោមពលករទេសន្តរប្រវេសន៍កម្ពុជានៅខេត្ត បាត់ដំបង។ ទន្ទឹមនេះ រដ្ឋបាលខេត្តស្នើ លោកនាយកប្រតិបត្តិ អង្គការរៃទាំសុខភាពគ្រួសារកម្ពុជា ធ្វើការ ទំនាក់ទំនង និងសហការជាមួយមន្ទីរជំនាញពាក់ព័ន្ធ និងអាជ្ញាធរមូលដ្ឋានឱ្យបានល្អប្រសើរ។

អាស្រ័យហេតុនេះ សូម លោកនាយកប្រតិបត្តិ អង្គការរៃទាំសុខភាពគ្រួសារកម្ពុជា ជ្រាប និង បាត់ចែងអនុវត្តតាមការគួរ។

សូម លោកនាយកប្រតិបត្តិ ទទួលនូវការស្រលាញ់រាប់អានអំពីខ្ញុំ។

ចម្លងជូនៈ
- មន្ទីរសុខាភិបាល នៃរដ្ឋបាលខេត្ត
- មន្ទីរជំនាញពាក់ព័ន្ធ
- រដ្ឋបាលក្រុង-ស្រុកទាំង១៤
      "ដើម្បីជ្រាប និងសហការ"
- ឯកសារ-កាលប្បវត្តិ

16-09-2022

អភិបាលខេត្ត
រងអភិបាល

យ៉ិន សែនកុណ

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ព្រះរាជាណាចក្រកម្ពុជា
ជាតិ សាសនា ព្រះមហាក្សត្រ

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រដ្ឋបាលខេត្តបន្ទាយមានជ័យ

លេខ៖ .... ផ.ផ.ក./......សរ.ខ.ស

ថ្ងៃពុធ. ៦ កើត ខែភទ្របទ ឆ្នាំខាល ចត្វាស័ក ព.ស ២៥៦៦
បន្ទាយមានជ័យ ថ្ងៃទី ១៤ ខែ កញ្ញា ឆ្នាំ ២០២២

ជ្រាបជូនដល់

លោកវេជ្ជបណ្ឌិត **វ៉ា ចំរ៉ន** នាយកប្រតិបត្តិអង្គការវ៉ែទាំសុខភាពគ្រួសារកម្ពុជា (RHAC)

កម្មវត្ថុ ÷ ករណីសំណើស្នើសុំការគាំទ្រនិងអនុញ្ញាតដល់អង្គការវ៉ែទាំសុខភាពគ្រួសារកម្ពុជា (RHAC) ដើម្បីធ្វើការប្រមូលទិន្នន័យសម្រាប់ការសិក្សា ស្តីពីតម្រូវការកញ្ចប់សេវាអប្បរមាមនុស្សធម៌ សម្រាប់សុខភាពផ្លូវភេទ សុខភាពបន្តពូជ ចំពោះពលករទេសន្តរប្រវេសន៍ ការសិក្សាស្តីពី លើកកម្ពស់សុខភាពបន្តពូជក្នុងចំណោមពលករទេសន្តរប្រវេសន៍កម្ពុជា នៅក្នុងខេត្តបន្ទាយ មានជ័យ ។

យោង ÷ លិខិតលេខ ២២/១២៦ ចុះថ្ងៃទី១១ ខែសីហា ឆ្នាំ២០២២ របស់អង្គការវ៉ែទាំសុខភាព គ្រួសារកម្ពុជា (RHAC) ។

សេចក្តីដូចមានចែងក្នុងកម្មវត្ថុ និងយោងខាងលើសូម លោកវេជ្ជបណ្ឌិត **វ៉ា ចំរ៉ន** ជ្រាបថា រដ្ឋបាលខេត្ត គាំទ្រ និងឯកភាពជាគោលការណ៍អនុញ្ញាតដល់អង្គការវ៉ែទាំសុខភាពគ្រួសារកម្ពុជា (RHAC) ធ្វើការប្រមូលទិន្នន័យសម្រាប់ការសិក្សាស្តីពីតម្រូវការកញ្ចប់សេវាអប្បរមាមនុស្សធម៌សម្រាប់សុខភាពផ្លូវភេទ សុខភាពបន្តពូជ ចំពោះពលករទេសន្តរប្រវេសន៍ ការសិក្សាស្តីពីលើកការកម្ពស់សុខភាពបន្តពូជក្នុងចំណោម ពលករទេសន្តរប្រវេសន៍កម្ពុជា ខេត្តបន្ទាយមានជ័យ ចាប់ពីខែសីហា ដល់ខែកញ្ញា ឆ្នាំ២០២២ ។

អាស្រ័យហេតុនេះ សូម លោកវេជ្ជបណ្ឌិត ជ្រាប និងចាត់ចែងតាមការគួរ ។

សូម លោកវេជ្ជបណ្ឌិត ទទួលនូវការរាប់អានអំពីខ្ញុំ ៕

ចម្លងជូន
-ក្រសួងមហាផ្ទៃ
-ក្រុមប្រឹក្សាខេត្ត
« ដើម្បីគោរពជូនជ្រាប »
-មន្ទីរសុខាភិបាល នៃរដ្ឋបាលខេត្ត
-រដ្ឋបាលក្រុង ស្រុក
« ដើម្បីជូនជ្រាប »
-ឯកសារ កាលប្បវត្តិ

អភិបាលខេត្ត

ផ្លុំ រាត្រី

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Appendix 9. Data Supplementary Information of the Study

This appendix is provided for documentation and transparency purposes. The content is not part of the analytical text of the dissertation.

9.1. Supplementary components of the data analysis in the study

Sample Size Calculation

The sample size for the quantitative component of this study was determined using a standard formula that is commonly used in survey research to estimate the number of participants needed to achieve reliable results (Pourhoseingholi et al., 2013) (Nanjundeswaraswamy & Divakara, 2021). The formula used is:

**Figure 10. Quantitative Sample Size Calculation**

Formula: $(n = z^2 * p * (1-p) / e^2)$

Where:

- Z=Confidence level at 95% (standard value of 1.96)

- P=Estimated prevalence or proportions of project

- e=Range of Confidence Interval (CI)

Where:

- **n** = **Sample size**: The number of participants required for the study to achieve sufficient statistical power.

- **z** = **Z-value (Z-score)**: The number of standard deviations from the mean that corresponds to the desired confidence level. Common Z-values include:

  - **1.96** for a 95% confidence level

  - **1.645** for a 90% confidence level

  - **2.576** for a 99% confidence level

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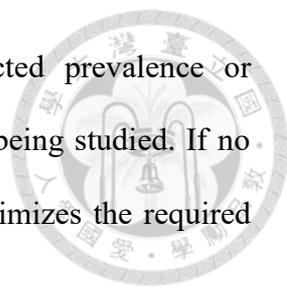
- p = Estimated proportion of the population: The expected prevalence or proportion of the population that exhibits the characteristic being studied. If no prior estimate is available, **0.5** is often used because it maximizes the required sample size, ensuring a conservative estimate.

- **e** = **Margin of error (precision)**: The desired level of precision, expressed as a proportion (e.g., 0.05 for ±5% precision). This represents the range within which the true population parameter is expected to fall, with the specified confidence level.

Explanation of the Sample size Calculation

- The Z-value represents the desired confidence level, reflecting how confident you want to be that the sample accurately represents the population. A higher confidence level requires a larger sample size.

- The proportion (p) indicates the anticipated prevalence of the outcome in the population. This could be based on previous research or estimated if no prior data is available.

- The margin of error (e) defines how close the sample estimate should be to the true population value. A smaller margin of error (higher precision) necessitates a larger sample size.

Thus, the required sample size would be 392 participants to achieve a 95% confidence level with a 5% margin of error, assuming a 50% prevalence rate.

9.2 Photos of Data Collection Field Work

Photo from Battambang province (Drop-in-center) at the Thai-Cambodia border

Photo taken before Migrant they drop the migrant workers from Thailand

Photo of the data collection team in the Komrieng operational district of Battambang province.

Photo from our interview with a male migrant worker who returned to Banteay Meanchey province.

Photo of our interview at the drop-in center while Cambodian migrants were pushed back from Thailand immediately.

Obtaining authorization from the Commune Hall in Battambang province.