

ASIAN ADOLESCENT EXPERIENCES OF HEALTH-RELATED STIGMA DURING THE COVID-19 PANDEMIC

ASIAN ADOLESCENT EXPERIENCES OF HEALTH-RELATED STIGMA DURING THE
COVID-19 PANDEMIC

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A THESIS SUBMITTED TO THE FACULTY OF GRADUATE STUDIES IN PARTIAL
FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE
IN NURSING

GRADUATE PROGRAM IN NURSING
YORK UNIVERSITY
TORONTO, ONTARIO

April 2024

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Abstract

Background: The COVID-19 pandemic, which took place between March 2020 and May 2023, has significantly impacted people's lives. Individuals with COVID-19, like other infectious diseases, are at risk for stigmatization related to their health status. As a group, Asian Canadians faced increased racism and discrimination during the pandemic in relation to prejudicial attitudes on spread and contagion of the disease.

Methods: This study used Interpretive Descriptive methodology to explore the experiences of Asian Canadian adolescents who have had COVID-19 through one-on-one interviews virtually and in person. Prior to the interview, participants filled out informed consent forms and demographic forms to obtain background information. The interviews were conducted between February 2023 and August 2023. Afterwards, the data was analyzed into codes and themes.

Results: The sample consisted of eleven Asian Canadian adolescents between the ages of 16 and 19-years old living in Ontario. Seven participants identified as female, three identified as male and one participant identified as non-binary. The participants reported facing stigmatization related to their positive COVID-19 status, their Asian identity, and their age. The findings were organized using the Health Stigma and Discrimination Framework (HSDF), which conceptualizes health-related stigma into drivers and facilitators, intersecting stigmas, manifestations, and outcomes. Drivers and facilitators included attitudes about people with COVID-19, Anti-Asian racism, the media and social media and time of infection. The intersecting stigmas were ageism and racism. Manifestations included negative reactions from others, anti-Asian experiences, and internalized stigma. Lastly, outcomes included the mental health consequences of racism and worsened academic performance. Challenges while isolating included difficulties keeping up with

schoolwork and isolation. Positive mediators included peer and familial support and being able to access information about COVID-19

Conclusions: Asian Canadian adolescents faced complex experiences and challenges during the pandemic related to their intersecting identities including stigmatization due to their COVID-19 status, as well as racism due to their Asian background and ageism from older individuals. Understanding these experiences can better inform the services provided to this population and decrease the risks and effects of stigmatization.

Dedication

This thesis is dedicated to the loving memory of Husen Hasan Ahmed and Abshiro Ismail Dirir
(may Allah have mercy on them).

Acknowledgement

Above all, I thank Allah, the most merciful, the most kind, for his blessings throughout the completion of this thesis.

I would like to acknowledge the great support I received from my thesis supervisor Dr. Nazilla Khanlou who has been a guide throughout the entire process of this project. I would also like to acknowledge my committee members Dr. Iris Epstein and Dr. Lisa Seto Nielsen who provided feedback and insight through the various edits of this paper. My gratitude extends to the York University Faculty of Graduate Studies Academic Excellence Fund for funding my study. Thank you as well to my colleagues at Toronto Public Health who have provided emotional support and encouragement, as well as my colleagues at the Office of Women's Health. I would also like to send my gratitude and thanks to all the participants who participated in this study, without their openness and candor, this study would not have been possible.

Last but certainly not least, I could not get through this process without the support of my parents (Mohamud Dirir and Zeinab Dahir), my siblings (Hodan, Ismail and Abdirasheed) and my friends who have always believed in me, in every endeavour I have attempted.

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List of Abbreviations

CDI	Communicable Disease Investigator
CID	Chinese Immigration Act
HRS	Health-Related Stigma
HSDF	Health Stigma and Discrimination Framework
ID	Interpretative Description
IPAC	Infection Prevention and Control
NML	National Microbiology Lab
PHU	Public Health Unit
RAT	Rapid Antigen Test
WHO	World Health Organization

1.0 Chapter One: Introduction

This section provides a broad overview related to the experiences of Asian Canadians and COVID-19 stigma. The background for this paper will discuss the COVID-19 pandemic, which was first declared in March 2020, the Ontario COVID-19 experience, schooling during the pandemic, the Asian Canadian context, and an overview of Health-related Stigma.

1.1 Background

The global COVID-19 pandemic that began in March 2020 has had profound and wide-reaching effects on society and individual health and well-being. One issue is the stigma directed at those suspected of having the disease, which often occurs historically during infectious pandemics (Fischer et al., 2019). The term stigma, studied by sociologist Erving Goffman refers to “an attribute that links a person to an undesirable stereotype, leading other people to reduce the bearer from a whole and usual person to a tainted, discounted one” (Goffman, 1963, p. 11). Goffman (1963) argued that most people experience stigma at some phase of their life and that stigmas can be related to various attributes and identities, including but not limited to race, gender, sexual orientation, conditions like blindness and diseases like leprosy. The stigma that results from a communicable disease can also fuel xenophobia and racism by erroneously associating certain nationalities and ethnicities with a disease. Additionally, fear of morbidity drives the public to identify and blame a scapegoat; in the case of the COVID-19 pandemic, the scapegoat was individuals of Asian descent (Rodriguez et al., 2022). The SARS pandemic that took place in 2003, which also originated in China, saw increased anti-Asian stigmatization, and the H1N1 Influenza pandemic in 2009, which originated in Mexico, saw a rise in anti-Latino sentiments (Van Daalen et al., 2021). Similar to past pandemics, the 2019-2021 COVID-19 pandemic has also resulted in increased stigmatization and discrimination towards COVID-19 survivors (Lohiniva et al., 2021),

healthcare workers (Do Duy et al., 2020) and individuals of Asian descent (Mamuji et al., 2021). Individuals of Asian descent in Canada have faced discrimination including verbal and physical assaults leading them to feel less integrated in their communities and more unsafe. This lack of security resulted in remaining constantly alert for possible harms which caused increased distress and exhaustion (Leigh et al., 2022) The rise in anti-Asian sentiments during the pandemic were due to a perceived belief that Asians were more likely to contract and spread COVID-19. This notion is incorrect and was fueled by the fact that the first known case of COVID-19 was reported in Wuhan, China (Misra et al., 2020). During the pandemic, racial discrimination towards East and Southeast Asians in Canada intensified significantly, with hate crimes against these two groups rising from 67 incidents in 2019 to 269 incidents in 2020, a 301% increase (Statistics Canada, 2022)

1.11 COVID-19 Pandemic

In late December 2019, a cluster of patients with viral symptoms was identified in Wuhan, China. The pneumonia of unknown origins was caused by a novel coronavirus later known as SARS-COV-2 (Khanna, et al., 2020). As cases spread to neighbouring countries worldwide, governments scrambled to contain the virus within their borders, enacting travel restrictions. To minimize stigmatization of the disease, The World Health Organization (WHO) renamed the disease COVID-19, CO referring to Corona, VI referring to virus, D referring to disease and 19 referring to 2019, the year in which the virus was identified. This new nomenclature reflected a protocol in which all newly identified diseases would avoid referencing a specific country, animal or individual. The WHO would go on to declare COVID-19 a pandemic on March 12, 2020.

1.1.2 COVID-19 in Ontario

The first Canadian case of COVID-19 was identified in Toronto, Ontario on January 25, 2020, in a traveller returning from Wuhan, China. In response to possible increased cases in the province, the Ontario Ministry of Health established case definitions for testing the disease, as well as guidance for its mitigation (Ontario Ministry of Health, 2023). Initially, during the pandemic, presumptive cases were tested via a PCR test at a local hospital. Cases were then followed up by their local public health unit by case disease investigators (CDIs) urging cases to be isolated for the mandatory quarantine period, initially 14 days. Later in the pandemic take home Rapid Antigen Tests (RAT) were widely available to the public and by February 2022, all Ontarians had access to free RATs (Government of Ontario, 2022).

Due to the worsening pandemic world-wide and rise in cases in the province, the Ontario Government declared a state of emergency and initiated a lockdown involving the closures of public services including, restaurants, gyms, schools, theatres, and all other non-essential services. Throughout the pandemic, patterns of alternating closures and openings occurred, coinciding with surges of cases in the province. The city of Toronto, the largest and densest city in the province, was subjected to the longest lockdown.

Epidemiology

As of September 6, 2023, there have been 1,633,000 cases in Ontario. Specifically relevant to this study, 238,914 cases were in individuals under 20 years old (Public Health Ontario, 2022). COVID-19-related data indicates that most cases were among those in the 20–39-year-old age group with most fatalities in the 80 and older age group. Although the province of Ontario did not collect socioeconomic data related to COVID-19 cases, the city of Toronto, along with age and gender, collected data regarding race and income status. This indicated that the majority of

COVID-19 cases were shown to be of Latin American, Southeast Asian, and South Asian descent and fell in the lower income bracket. Interestingly, East Asians had the lowest COVID-19 rates of any racial group (2591 cases per 100,000) compared to the public rate of 5245 cases per 100,000 people) (City of Toronto, 2022).

1.1.3 Schools in Ontario during the Pandemic

All schools across Ontario were closed by the provincial government on March 13th, 2020, including public, private, and post-secondary schools. They remained closed for the rest of that school year, during which time, online virtual school was conducted (Gallagher-Mackay et al., 2021). The following school year saw schools reopened with infection prevention controls in place for those students whose parents agreed to in-person schooling. Schools then remained open until the winter holiday break, but due to a rise in cases in the community, schools were once again closed for the first few weeks of the new year.

Structure of Schooling during the COVID-19 Pandemic

During the Summer of 2020, parents were consulted by their local school boards to decide whether they wished to send their children to in-person schooling for the 2020-2021 school year. Those students who did not return to in-person learning were placed in online remote learning. In secondary schools located in areas with high COVID risk (for example, in Toronto and the Greater Toronto Area), schools were initially operated using a part-time model with an alternating in-person and online learning schedule. The school year was divided into “quadmesters” which consisted of 4 intensive terms lasting roughly nine weeks in which students took 2 courses. Some schools and school boards also utilized a hybrid model in which teachers would instruct some students in-person and other students virtually within the same course.

Mitigation of COVID in Schools

The government of Ontario created the document *Operational Guidance: COVID-19 Management in Schools* to outline the roles and responsibilities of school administrators and the local public health units (PHUs) in ensuring schools remain safe amid the COVID-19 pandemic (Ontario Ministry of Education, 2020). School administrators were encouraged to consult with their local PHU if they had concerns regarding the implementation of the guidelines. The provincial government provided additional funding to PHUs to create specific COVID-19 response school liaison teams to better support schools with Infection Prevention and Control (IPAC) measures. Some of the requirements that schools were expected to follow included:

- Reporting confirmed cases associated with the school to the PHU.
- Maintaining accurate enrollment and attendance records for the school at all times.
- Communicating with parents and the wider school community regarding cases identified at the school, ensuring that confidentiality is maintained.

Post-Secondary Institutions and COVID-19

Like K-12 schools, Ontario colleges and universities were subject to closures during the pandemic as well. Although each school had their own policies and timelines for opening, the vast majority of post-secondary institutions remained closed for longer periods than K-12 schools and opened slowly throughout the 2020-2021 school year. During the 2020-2021 school year, most courses were offered via virtual and distanced learning, however, some universities opened their campuses for courses that required in-person instruction (for example labs). With the widescale availability of vaccines in the spring of 2021, most schools began planning for more in-person options for the 2021-2022 school year (El Masri & Sabzalieva, 2020). For example, York University began gradually reopening its campus in the fall of 2021 (York University, 2021), and

two of the largest universities in the province, the University of Toronto and Toronto Metropolitan University, began a full return to in-person courses in Fall 2022, while still offering virtual options as well (Toronto Metropolitan University, 2022; University of Toronto, 2022).

1.1.4 Asians in Canada

Current Context

Canada has one of the most diverse and multicultural populations in the world. More than one in five Canadians were born outside the country (Statistics Canada, 2023). More specifically, many of those immigrants trace their backgrounds to Asia. Immigration to Canada from Asia has had a steady rise since the mid-1960s. By 2016, half (52.5%) of all Canadian immigrants migrated from the continent of Asia, including East Asia, Southeast Asia, the Middle East, and the Indian subcontinent (StatsCan, 2016). Immigrants, including first, second and third-generation immigrants are one part of the larger Asian Canadian population which encompasses Asians whose families have lived in Canada for multiple generations. Currently 7,013,835 Asian Canadians live in Canada making up 19.3% of the Canadian population (Statistics Canada, 2023).

Historical Context

Asian Canadians have had a long history in Canada and their presence has been met with xenophobia and racism from nearly the beginning. Asian immigration to Canada dates to the 1850s when Chinese immigrants came to British Columbia to take advantage of the Gold Rush (Thobani, 2017). Between 1881 and 1885, many individuals were brought to Canada as indentured servants to work on the Canadian Pacific Railway (CPR). After the railway was completed in 1885, the government passed the Chinese immigration Act (CID), which was a bill enacted to restrict Chinese immigration to the country. This act also required a head tax of \$50 CAD for every Chinese person entering Canada. The tax quickly rose to \$100 in 1900 and \$500 in 1903. The CID

was followed in 1923 by the Chinese Exclusion Act (Thobani, 2017). These acts created an environment in Canada filled with distrust and hatred towards those of Asian descent who were viewed as a “yellow peril” to Canadian society.

Conversely, Japanese immigrants first came to Canada in the 1870s to work in sawmills, and mining and fishing industries, albeit in smaller numbers than Chinese migrants. Due to their relatively small population, hostility towards Japanese Canadians did not reach a peak until World War II, following the bombing of Pearl Harbor. At that time, twenty-three thousand Japanese people were placed in internment camps, even though the vast majority were Canadian Citizens (Thobani,2017).

As time passed, Asians continued to be viewed as the other when juxtaposed to the more desired Western European immigrants. Until the 1960s, immigration of non-white peoples continued to be minimized and it was not until 1971, that large-scale immigration from a wide range of Asian countries occurred due to the updated Canadian Immigration Act (Thobani, 2017). The 1970s and 80s saw large groups of people migrating to Canada from countries including China, the Philippines, Vietnam, Korea, and Thailand (Statistics Canada, 2016).

Asian Experience during the Pandemic

East Asians and Southeast Asians living in Canada have had unique challenges during the pandemic. Due to the origins of the virus beginning in China, many Asians have experienced increased incidences of anti-Asian racism and stigma. During the pandemic, the percentage of reported anti-Asian racism increased with 1150 cases of racist attacks being reported between March 2020 and February 2021 (Kong et al., 2021). It is also important to note that anti-Asian racism intersects with other identities, and it has been observed that female-identifying Asians are more at risk for anti-Asian Racism and individuals under 18 and over 65 were also at greater risk

(Kong et al., 2021). Additionally, some subgroups of Asians are highly represented among healthcare workers and nurses' aides, i.e., Filipino Canadians, and were therefore disproportionately affected by the COVID-19 pandemic and were more at risk for falling ill (Statistics Canada, 2023).

1.1.5. Health-Related Stigma

Health-related stigma (HRS) refers to the stigmatization experienced due to a health condition or disease (Scrambler, 2009). Individuals who differ from their peers or occupy a marginalized identity risk experiencing stigma and prejudice. Individuals can be deemed different based on race, gender, sexual orientation, class, ability, or appearance. Although the two terms are similar and connected, stigma and prejudice are distinct concepts. Prejudice is “an aversive or hostile attitude toward a person who belongs to a group, simply because he belongs to that group, and is therefore presumed to have the objectionable qualities ascribed to the group,” as defined by psychologist Gordon Allport in his seminal work (1958, p. 7). Stigma and prejudice share overlapping features, including negative attitudes and the potential for violence and discrimination (Stuber et al., 2008). Since Allport’s work on prejudice, more research has emerged on prejudice related to race and racialization, for example research conducted by Carl James about racialized youth living in Canada (James, 2019).

During an infectious pandemic, HRS poses significant harm to individuals and society. One issue with stigma is that it can hinder the broader control of infectious outbreaks because stigmatized people may be less likely to report their illness for fear of backlash, making it difficult to receive information necessary to comply with public health measures (Fischer et al., 2019). Stigma can also have negative consequences on the mental health of a person, their families, and significant others (Sahoo et al., 2020). Throughout the pandemic, COVID-19 survivors faced

stigma and were often viewed as responsible for not adhering to prevention measures (Sahoo et al., 2020). The perception of stigma by others can also lead an individual to self-stigmatize, manifesting a negative sense of self and hesitance to engage publicly (Lohiniva et al., 2021). Some adolescents who contract COVID-19 may face stigmatization from their peers, school officials, and other parents. Based on the stigmatization statistics of Asians identified above, Asian adolescents were at greater risk for health-related stigma as they were already more predisposed to stigmatization based on their race (Misra et al., 2020; Statistics Canada, 2022). Therefore, this study focused on East and Southeast Asian adolescents who have had COVID-19. This population has a unique experience due to intersecting oppressions of race and health status associated with the COVID-19 pandemic.

1.2 Aims/Purpose

The aim of this study is to explore Asian Canadian adolescents' experiences of COVID-19-related stigma during the pandemic and how it intersects with their ethnic identity as well as identifying interventions to mitigate stigma. The study is needed due to the unique challenges the pandemic brought up for those who contracted the disease, among the prejudicial social environment experienced by Asian Canadians. Additionally, due to COVID-19 being an emerging and ongoing issue, the literature is limited in the experiences of Asian Canadian adolescents and their experiences of COVID-19 stigma.

1.3 Outline of Thesis and Chapter Sections

Moving forward, I have organized this thesis into five chapters. In the first chapter, I have provided an overview of the background related to the COVID-19 pandemic, health-related stigma, and Asian Canadian experiences both historically and during the pandemic. In the second chapter, I will provide a review of the literature. In the third chapter, I will discuss my

methodology, frameworks, research questions, positionality, and study rigour. The fourth chapter will present participant demographics and findings from the study guided by the HSDF framework and the final chapter will provide a discussion connecting to the literature and research questions, as well as implications of the research and limitations. Appendix A summarizes definitions for terms in the thesis.

1.4 Summary

The COVID-19 pandemic had a profound impact on the lives of Canadians, both due to the emergence of the disease and the provincial government's mitigation response. In Canada's diverse populations, Asian Canadians have figured heavily throughout history. Although Asian Canadians were always subject to racism and discrimination, Asian Canadians experienced increased challenges and hostility after the onset of the COVID-19 pandemic. Additionally, health-related stigma is observed in response to many diseases and can impact accessing care, the mental health of those experiencing the disease and communicable disease containment.

2.0 Chapter Two: Review of the Literature

Although there is growing research on the mental health effects of the COVID-19 pandemic, there is limited research about COVID-19-related stigma, especially from a Canadian perspective. Additionally, little research has been conducted on the experiences of COVID-19-related stigma among Asian adolescents, explicitly using an Interpretative Description research approach. Much of the previous literature on health-related stigma before the pandemic focused on adult populations and infectious diseases like Human Immunodeficiency Virus (HIV)/AIDS or mental health disorders like Schizophrenia (Jenerette, 2010). Additionally, there is nursing research studying COVID-19-related stigma experienced by nurses during the COVID-19 pandemic-related stigma, (Lee et al., 2021; Manik & Natalia, 2021; Passay-An et al, 2021; Simeone et al, 2021, Tsukuda, Kayano & Yoshiyasu, 2022). In terms of children and adolescents, research has been conducted on the HRS associated with HIV (Boyes & Cluver, 2015) and for non-infectious diseases, including Sickle Cell Disease (Jenerette, 2010) and allergies (Dean et al., 2015). Some research on COVID-19 stigma was related to racial stigma toward Asians who were perceived as having a predisposition to contracting the disease (Cheah et al., 2021, Misra et al., 2020, Pan et al., 2021, Wu et al., 2020). Other research has studied the stigmatization of health care workers (Do Duy et al., 2020). Research on the stigma experienced by COVID-19 survivors has been exclusive to adult populations (Chew et al., 2021, Lohiniva et al., 2021, Omri et al., 2021, Sahoo et al., 2020, Ugidos et al., 2022, Yuan et al., 2021).

2.1 Literature Search Guidelines

I conducted a literature search using CINHALL and PubMed with the keywords “COVID-19, Health-Related Stigma, AND children AND adolescents AND Asians”. Using these search terms between January 2020 to December 2022, 1530, articles were found. When limited to Full-

Text articles written in English and published in Academic Journals, 313 articles were yielded. The search was further narrowed to 29 articles after excluding studies on specialized populations that vastly differed from the target population, such as healthcare workers, sex workers and individuals with specific disease comorbidities (see Appendix B). The research focusing on COVID-19-related stigma was conducted in a wide range of countries, including China (Yuan et al., 2021), Tunisia (Omri et al., 2021), and Spain (Ugidos, 2022) and Finland (Lohiniva et al., 2021). The research pertaining to the racial stigmatization of Asians was mainly conducted in the United States and Canada (Pan et al., 2021; Wu et al., 2020). Most studies were conducted at the beginning of the pandemic between March – October 2020.

2.2 Anti-Asian Stigma during the Pandemic

Research that studied COVID-19-related stigma among individuals of East-Asian descent revealed experiences of racially motivated stigmatization, regardless of whether they had previously tested positive for COVID-19 (Mamuji et al., 2019). A study by Mamuji et al. (2019) examined 83 adult members of the Chinese community in Toronto; the study focused on identifying the counter-stigmatization methods rather than describing or interpreting the experiences of stigma faced by the participants. Pan et al. (2021) examined the survey results of 6707 Asian and Non-Asian American adults from the Understanding America Survey (UAS) conducted in March 2020. They found that Asians were disproportionately more likely to report facing discrimination than non-Asians, and this stigma manifests as psychological distress. Wu et al. (2020) surveyed Canadians in March and April 2020 and found that East Asian Canadians experienced more significant mental health impacts during the pandemic, due to increased racial stigmatization. Lastly, some research focused on Asian adolescents and their experiences of anti-Asian racism during the pandemic but did not study Asian adolescents who previously had

COVID-19. For example, Cheah et al. (2021) studied 211 Chinese American adolescents between the ages of 10 to 18 to identify the discrimination they faced during the pandemic related to their racial identity. Cheah et al. (2021) found that the adolescents faced COVID-19-related racial discrimination during the pandemic and subsequent internalizing behaviours and identity issues. However, the study did not explore the effects of testing positive for COVID-19 in addition to racial stigma.

2.3 COVID-19-related stigma of COVID-19 patients

Lohiniva et al. (2021) studied 64 child, adolescent, and adult participants in Finland. The participants comprised of previously COVID-19 positive individuals and their household members and were asked about the stigma they faced surrounding their contraction of COVID-19. The authors found that participants experienced stigma post-infection and were blamed for their infection. This led to a reluctance to disclose their coronavirus status to others. Self-stigma developed from conflicting information and reluctance to meet people after quarantining (Lohiniva et al., 2021). In a qualitative study by Sahoo et al. (2020), two individual COVID-19 survivors and one family were interviewed as case studies. The participants, living in India (45M, 23M and a couple 35M and 32 F) identified experiences of stigmatization related to their COVID-19 infection. These experiences resulted in internalized stigma and feelings of guilt and shame, especially if they had infected others close to them. These negative emotional responses to stigma contributed to a deterioration of mental health.

Similarly, Yuan et al. (2021) found that 154 adult male and female COVID-19 survivors and healthy controls over 18 years old with a mean age of 35.7, living in China reported higher levels of stigma in comparison to healthy controls and experienced social rejection, financial insecurity, internalized shame, and social isolation. Chew et al. (2021) studied 18 adults aged 18-

65 in Malaysia who had previously tested positive for COVID-19 and asked about their experiences of stigma. They found that the participants experienced stigmatization due to their positive status. The participants described feeling isolated, labelled, and blamed by others for contracting the virus. Omri et al. (2021) studied 277 adult participants between November and December 2020 in Tunisia and their experiences of stigmatization during the COVID-19 pandemic. The researchers found that previously testing positive for COVID-19 correlated with increased stigmatization, discrimination, and verbal and physical assaults (Omri et al., 2021). Lastly, Ugidos et al. (2022) studied 562 adults in Spain between 18-80 years old in a longitudinal study throughout the pandemic. The sample was primarily female (80%) and between 30-60 years old. The results indicated that individuals with COVID-19 experienced discrimination due to their COVID-19 status and began to internalize the stigma leading to feelings of depression and anxiety.

2.4 Adolescents and HRS Related to Other Diseases

Other studies on HRS experienced by children and adolescents focused on diseases other than COVID-19. These studies suggest that children and adolescents may face unique forms of stigmatization related to having a disease or illness (Boyes & Cluver, 2015; Dean et al. 2015, Jenerette et al., 2020). Boyes and Cluver (2015) studied HRS experienced by HIV-positive adolescents living in South Africa and found that due to their infection, they experienced bullying and victimization from their peers and ostracization which in turn led to increased anxiety and depressive symptoms. In a study by Dean et al. (2015), HRS was noted in school settings in which children with severe allergies experienced teasing, bullying, discrimination, physical threats, and harm. Jenerette et al. (2010) identified that children and adolescents with Sickle Cell Disease self-reported feeling stigmatized by peers and teachers, resulting in low self-esteem and embarrassment. These feelings of stigmatization were exacerbated by racial and ethnic minority

status. There is a great need for more research on the COVID-19 stigmatization of Asian adolescents. Most of the health research available focuses on adults who experience stigma due to contracting COVID-19 or adults who are stigmatized due to identifying as Asian. This study provides a unique intersection that focuses on adolescents who have not been extensively studied and, more specifically, Asian adolescents.

2.5 Summary

In summary, this section discussed the findings of my literature review. The main findings revolved around the stigmatization experienced by COVID-19 survivors, anti-Asian racism and the stigmatization faced by children and adolescents with other diseases. The subsequent section will review the methodology I used in the study.

3.0 Chapter Three: Methodology

In this section, I will discuss the methods and methodology used for this study including the theoretical frameworks that influenced it, the research methods, data collection tools, data analysis and timeline.

3.1 Theoretical Perspective

3.1.1 Health Stigma and Discrimination Framework (HSDF)

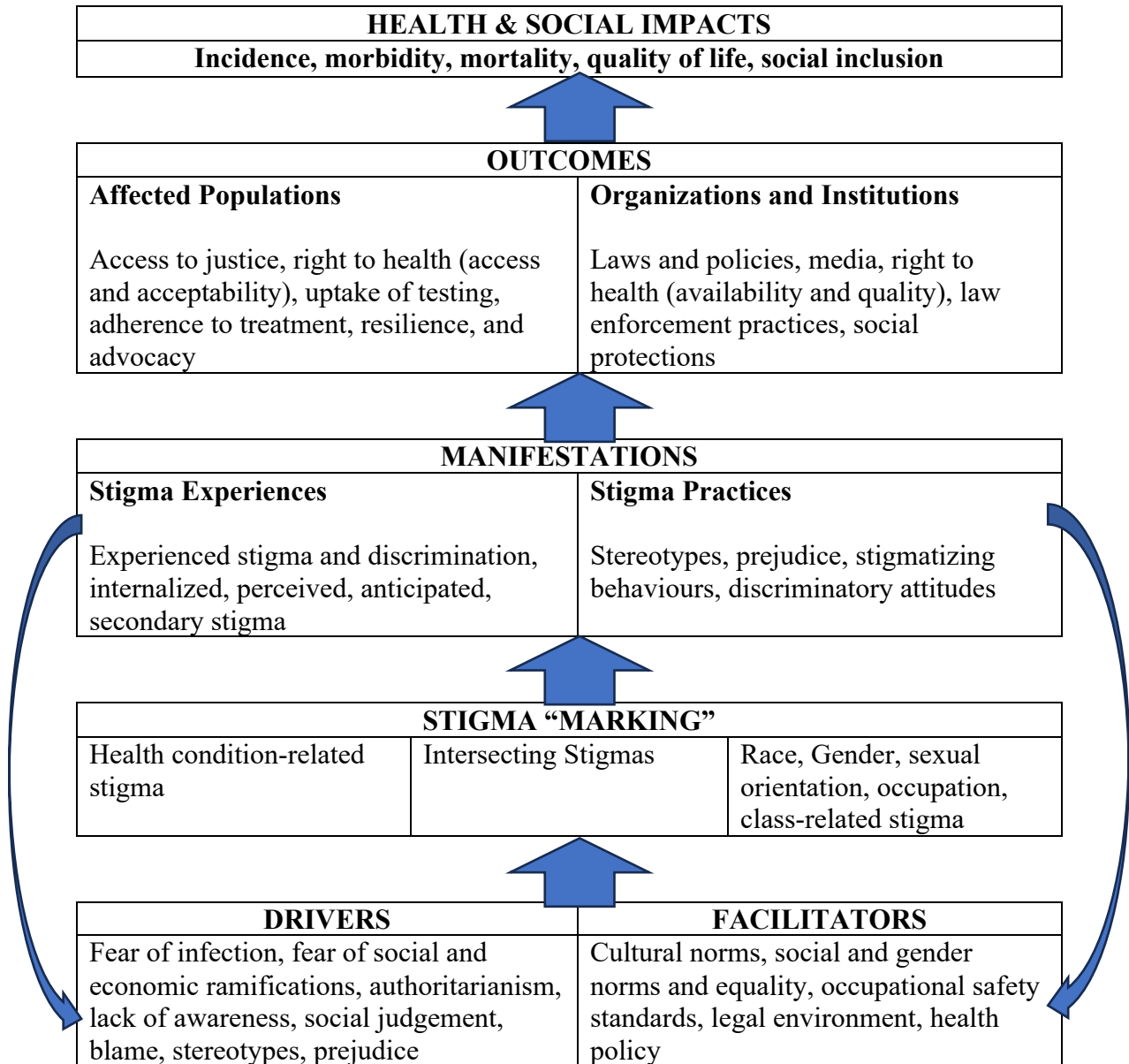
The Health Stigma and Discrimination Framework (HSDF) was developed by Stangl et al. (2019). The framework describes the stigmatization process related to health and illness. The HSDF discusses stigmatization across a socio-ecological spectrum using four domains: stigma drivers and facilitators, stigma marking, stigma manifestations and outcomes (see Appendix C). The HSDF attempts to indicate that stigma results from interconnections between power and vulnerabilities. Stangl et al. (2019) also point out that “all individuals can anticipate, perceive, internalize, experience, or perpetuate health-related stigma while acknowledging unique outcomes for affected populations” (Stangl et al., 2019, p. 4). One advantage of the framework is that it can be applied to various health conditions, including infectious diseases, chronic diseases, mental illnesses, and disabilities.

The framework has already been used in COVID-19-related stigma research by Lohiniva et al. (2021) in Finland and Ransing et al. (2020) in 30 different countries. Stangl et al. (2019) also provided suggestions for how their framework could be utilized in various health conditions such as Leprosy, Tuberculosis, and mental health conditions. Other studies in the literature used the framework to study non-COVID-19 related health conditions like HIV (Andersson et al., 2020) and mental illness (Kohrt et al., 2020). The HSDF guided me in designing interview questions for the study and my thematic analysis after coding. This framework was appropriate for this study

because it assisted with understanding the experiences of COVID-19 stigmatization while considering the intersection of racial oppression.

Figure 1

Health Stigma and Discrimination Framework (Stangl et al., 2019)



3.1.2 Intersectionality

Additionally, in the framework, HRS can co-occur with and is facilitated by other intersecting stigmas, including; sexual orientation, gender, race, occupation, and poverty (Stangl et al., 2019). In the HSDF, Stangl et al. (2019) identify how some individuals may be more vulnerable to being disadvantaged by HRS due to other intersecting stigmas, which relates to the concept of *Intersectionality*. Scholar Kimberle Crenshaw coined the word Intersectionality to “denote the various ways in which race and gender interact to shape the multiple dimensions of Black women’s employment experiences” and that the “intersection of racism and sexism factors into Black women’s lives in ways that cannot be captured wholly by looking at the women, race, or gender dimensions of those experiences separately.” (Crenshaw 1989, p 139)”. Although Crenshaw focused on Black American women, the concept has been extrapolated to other individuals who occupy multiple positions of oppression (Abrams et al., 2020). Human experience cannot be understood through one independent social identity but instead must consider how multiple identities and positions interact. In this study, I applied an intersectional perspective because the target population experienced stigma due to their Asian identity, COVID-19 status, and age.

3.2 Positionality

Before discussing the study's structure, I would like to express my positionality on the subject matter. In the spirit of reflexivity, it is crucial for researchers to reflect on their own positions and how it may impact their approach to the research and interpretation of the findings. As a registered Public Health nurse who was working in school health during the COVID-19 pandemic; I have had many experiences professionally with adolescents who have had COVID-19 and with school staff in implementing COVID-19 IPAC protocols. While interviewing the

adolescents in this study about their experiences with COVID-19-related stigma, I would nonetheless be unconsciously affected by my experiences as a Public Health nurse. Also, as a racialized individual, I am dedicated to research related to cultural sensitivity and health equity.

3.3. Research Question

Based on the literature review, the questions of interest focused on the experiences of Asian adolescents' stigmatization during the pandemic related to their positive COVID-19 status and racial identity. It was also helpful to understand how the participants experienced this stigma, how it manifested in social settings like school and what other factors affected this experience.

The research questions are:

- 1) "What are the lived experiences of Asian adolescents living in Toronto who have had COVID-19 during the COVID-19 pandemic, and the facilitators of their experiences?"
- 2) "Do Asian adolescents experience stigma from their peers and community as a result of their COVID-19 infection and other intersecting identities?"
- 3) What strategies did the Asian adolescents use to cope with stigmatization surrounding their COVID-19 status, and what do they identify as helpful interventions from parents and other adults?

3.4 Research Methodology

For this study, I utilized Interpretative Description (ID) (Thorne, Kirkham & MacDonald Emes, 1997). Interpretative Description methodology is a grounded approach to articulating patterns and themes related to clinical phenomena. In the literature, limited research utilizes this methodology to study HRS, however there is research using ID focused on stigma, disabilities, and ableism (Neely-Barnes et al., 2010). Additionally, the methodology has been used in nursing

research to research individuals' understanding and perception of their illness and subsequent treatment (Thorne, Kirkham & MacDonald Emes, 1997). For example, Thorne et al. (2004) studied 12 participants with Multiple Sclerosis (MS) and how they described communications surrounding their healthcare. To recruit participants for this study, I utilized, purposive sampling which involves intentionally selecting participants who will help to illustrate a theme and achieve a representative sample of the phenomena being studied (Thorne, 2016). The participants in this study shared the same experiences of being Asian adolescents living in Toronto who tested positive for COVID-19 during the pandemic. I chose to use Interpretative Description in my study because I was attempting to explore the experiences that Asian adolescents have regarding the stigma related to their COVID-19 diagnosis. Using Interpretative Description, I first obtained descriptive data based on the interviews conducted and afterwards, I created interpretations from the descriptive data, guided by both my research questions and the HSDF framework. Thorne (2016) offers a flexible approach to conducting research, so I used Interpretative Description methodology to roughly guide the research development process, from creation of the study to recruitment and sampling, and data analysis.

3.4.1 Ethics

I sought ethics approval from the York University Research Ethics Board, and I obtained informed consent from the participants through a consent form outlining the study's purpose and any benefits and risks (see Appendix F). All participants were made aware that they had the right to decline participation after beginning the study and would still receive the compensation. I took steps to safeguard confidential personal health information by ensuring that all participants were provided a unique ID number, and that all data was stored digitally, and password protected.

3.4.2 Study Timeline

The study took place between September 2022 and August 2023. Once research ethics approval was granted in January 2023, I began recruiting participants and conducted the interviews with the participants between February 2023 and August 2023.

3.4.3 Sampling strategy.

The sample I studied were adolescents living in Toronto between 16 and 19 years old who are of East Asian and Southeast Asian descent and had previously tested positive for COVID-19. Statistics Canada (2017) classifies individuals of East and Southeast descent as having family origins in the following countries: Cambodia, China, Indonesia, Japan, Korea, Laos, Malaysia, the Philippines, Singapore, Taiwanese, Thailand, Tibet, and Vietnam. Inclusion criteria for the study included being of East Asian or Southeast Asian (including those who are mixed-race). Exclusion criteria included a lack of fluency in English and participants who were virtual learners at the time of infection. I continued to recruit participants until information power was reached, which is when the sample holds enough information relevant to aim of the study (Malterud, Siersma & Guassora, 2016). Per the Interpretative Description methodology, I purposefully selected participants to help elicit broader interpretations (Thorne, 2016). I recruited individuals by posting recruitment flyers in community spaces in diverse neighbourhoods as well as on university campuses. I also utilized the assistance of community organizations to help recruit adolescents and the networks of my thesis committee. I also utilized a snowball method in which participants shared the study with other individuals in their social circles both virtually and in-real-life (IRL) who may fit the desired sample inclusion criteria. I had initially intended for 10 participants to be recruited and in the end 11 participants completed the study.

3.4.4 Data Collection

In the study, I used semi-structured interviews adapted from the study by Lohiniva et al. (2021) to collect data. Interpretative Description provides guidance for conducting interviews to obtain qualitative data (Thorne, 2016). Thorne (2016) suggests allowing participants to tell their stories in a linear fashion, to have a good introduction to the interview, to allow for adequate time, and to provide a summary for the interview. For my study, I asked the participants to fill out a demographic form via email. The interview guide consisted of both closed and open-ended questions about their experience during the COVID-19 pandemic and their experiences of stigma from their peers and others at their school and community. After completion of the interview, I provided the participants \$20 for participating in the session. I recorded the interviews using the Zoom recording features for virtual interviews and an audio recorder for in-person interviews. I transcribed the in-person interviews by hand and used the transcription feature embedded in Zoom to transcribe the Zoom interviews.

Interviews

The interview questions I used were guided by the Health Stigma and Discrimination Framework (Stangl et al., 2019) and were initially developed by Lohiniva et al. (2021). I felt the questions were relevant to my study because they fit the qualitative research design of the study, and the questions were specifically designed to study HRS in those who tested positive for COVID-19. Additionally, Lohiniva et al. (2021) used the questions to interview a broad sample, including children, adolescents, and adults, so that they would be age-appropriate for the proposed sample. For my study, I adapted the questions to capture relevant information to the experiences of Asian Canadian adolescents with COVID-19 (See Appendix E). The interviews took 20-60 minutes to complete. To transcribe the virtual interviews, for efficiency, I utilized the transcription

feature on Zoom, and I edited the transcriptions for accuracy. For in-person interviews, I transcribed the interview myself while listening to the audio recording. For each interview, I reviewed the recording an average of 3 times, initially to listen to audio, second to transcribe (in the case of in-person interviews) and lastly to review and correct the transcription created by myself or Zoom. From then on, I read and referred to the written transcriptions along with the field notes that I had created for each interview.

3.4.5 Data analysis

The qualitative data analysis of the study used the Interpretative Descriptive methodology developed by Sally Thorne (2016). My data analysis was influenced by Thorne's guidance (Thorne, 2016) in Interpretative Description, as she is flexible in her approach to data collection and analysis, I focused on determining themes and codes that emerged in the study. Thorne (2016) advises that after describing the data, to further interpret the meaning of the descriptions. To do this, I utilized the HSDF framework Stangle (2019) and the initial research questions. For the first three interviews, my supervisor, Dr. Nazilla Khanlou, and I analyzed the data separately and met to discuss our results. After my supervisor deemed the first three instances of data analysis to be satisfactory, I was able to continue coding the subsequent interviews independently.

For this thesis, I coded the data by hand and did not use any statistical software to support the analysis. Thorne (2016) suggests analyzing transcripts and field notes in a tactile manner by highlighting with colours for different thematic themes. Initially, to determine the descriptive results, I read the transcripts using notes in the margins and highlighted features to capture notable points and passages. For similar codes, I highlighted using the same colour code. I then began listing similar and related codes together, which were then grouped together as a theme. Once I began capturing important points in the transcripts and identifying recurring possible themes, I

was able to look for all instances of a particular theme I wanted to capture. Thorne (2016) also suggests reflecting on your own prior knowledge and clinical experience before generating themes and codes. Prior to coding, I reflected on my prior clinical experience, the theoretical framework and understanding of the literature to be more attuned to themes identified in the participant interviews. To organize my work, I utilized a table in which I identified larger thematic categories and subsequent themes. I identified direct quotes from the interviews that represented the theme and I continued to read the transcripts of each additional interview, and either added data to the existing themes or created new themes if they were substantial. After completing the descriptive analysis of the data, I performed an interpretative analysis of the interview transcripts. For this, Thorne (2016) suggests going beyond descriptive groupings of data and determining what relationships the groupings might have to one another. This is by using an iterative reasoning process which involves gradually coming to understand the implications of organizing your ideas in a certain way (Thorne, 2016). Ultimately, Thorne provides flexibility in the analytic process and technique, but interpretative description requires the researcher to know their data intimately and spend significant time thinking about the patterns they create (Thorne, 2016). To interpret my descriptive data, I considered the varying characteristics of the participants and the issues that emerged in the interviews. I then created themes from the patterns that I observed. The HSDF and Intersectionality frameworks provided a guide for the organization and contextualization of the themes that I found through my data analysis and coding.

3.4.6 Study rigor

One concept to keep in mind while conducting qualitative research is rigor, which refers to “the authoritative evaluation of good research and the unspoken standard by which all research is measured” (Davies & Dodd, 2002, p 280). To analyze the rigor of this study, I will be guided by

the four-dimension criteria developed by Lincoln and Guba (1985). For qualitative research findings to be rigorous, Lincoln and Guba posit that the concept of trustworthiness must be met. Trustworthiness assesses the quality of a study to determine how closely it meets the aims of the study (Alexander, 2019). Furthermore, the criteria to determine trustworthiness in a study fall under four dimensions; credibility, dependability, confirmability, and transferability (Alexander, 2019). Of the four criteria, I tried to maintain credibility, confirmability, and transferability.

Credibility refers to the level confidence in the truth of the data and involves two steps; carrying out the study to enhance believability and conveying that to the reader. To ensure there is credibility in the findings, I tried to minimize bias in tools and methods used, so as not to create artificial results. For this study, the interview questions were mostly open-ended and were not predicated on assumptions about the participants. For example, I asked, “How did you feel about yourself during quarantine?” instead of “Did you feel negative about yourself during quarantine?”

Confirmability refers to the congruency between two or more individual’s interpretation of data and its meaning. I ensured confirmability in the study by analyzing the first three interviews with my supervisor to determine that we both identified similar themes in the data. Our findings were in many ways similar but differed slightly due to our different lived experiences. Lastly, *transferability* refers to the ability to generalize the data to other settings and populations. I will attempt to maintain transferability by employing a “thick description” while discussing the implementation and context of the study design. This will allow any future researchers to attempt to apply the results while working with other similar groups.

3.5. Summary

In summary, this study chapter discussed the theoretical frameworks utilized, the research methods used and the timeline of the study. The study took place between September 2022 and

August 2023 and data was collected from the participants via interviews and a demographic form. The data was then analyzed utilizing Interpretative Descriptive Methodology (Thorne, 1997).

4.0 Chapter Four: Results

This chapter will explore the rich themes elucidated from the interviews conducted with participants. Using the demographics and information from the interviews, I have organized the results into themes and subthemes. I will describe the themes, and further support them using direct quotes from the participant interviews. The themes reflect the Health Stigma and Discrimination Framework (HSDF) (Stangl, 2019). I will review 1) the drivers and the facilitators of stigma identified by the participants, 2) the intersecting stigmas, 3) the manifestations of stigma and finally 4) the outcomes. Participants will be identified by their participant ID using the following format (Participant Number-Age-Gender).

4.1. Participant Characteristics and Demographics

4.1.1. Age and Gender

Participants were adolescents of East and Southeast Asian descent aged 16–19 years old (*average age*: 18.0) residing in the province of Ontario. Most of the participants were recruited from the Greater Toronto Area. Eleven adolescents participated in the study. Of those participants, 3 identified as male, 7 identified as female and 1 identified as non-binary (See Table 1 for details).

Table 1

Basic Demographic Profile of Participants

	Female		Male		Non-Binary		Total	
	n	%	n	%	n	%	n	%
	7	63.6	3	27.3	1	9.1	11	100
Age								
16 years	0	0.0	1	9.1	0	0.0	1	9.1
17 years	1	9.1	1	9.1	0	0.0	2	18.2
18 years	2	18.2	0	0.0	1	9.1	3	27.3
19 years	4	36.4	1	9.1	0	0.0	5	45.5

4.1.2. Familial Country of Origin

Participants were asked about their family of origin through the demographic form (See Appendix D). The recorded family place of origin for participants were China (including Hong Kong), The Philippines, China, and Vietnam, as well as one individual with a background from Vietnam, Bangladesh, and Poland. Most participants were of Chinese origin (See Table 2 for details).

Table 2

Familial Country of Participants

	n	%
	11	100
Family Country of Origin		
China	5	45.5
Philippines	3	27.3
China + Vietnam	2	18.2
Vietnam + Bangladesh+ Poland	1	9.1

4.1.3. Date of Infection and Number of Times Infected

Among the participants, the dates of infection were scattered throughout the pandemic, spanning a three-year period from March 2020 to June 2023. The majority of participants (9 of 11) contracted COVID-19 once, while 2 participants contracted the virus twice. Those participants who contracted the virus early in the pandemic (in 2020), were among those who contracted the virus a second time. Date of infection during the pandemic had significant effects on their experiences of quarantine and stigma and will be further discussed below.

4.1.4. Attendance in School during the Pandemic

Participants were asked if they attended school in-person during the pandemic. All participants attended in-person schooling for at least one of the academic years (2020-2021 and 2021-2022). All participants attended in-person school for the 2021-2022 school year. Due to the range of ages at participation and at infection, some participants had contracted COVID-19 while in high school and some in university or post-secondary studies. It was important to identify whether participants had attended school during the pandemic, as the research question attempted to elucidate participant’s experience at school both generally and related to COVID-19 stigma.

Table 3

School Attendance During the Pandemic (2020-2021 and 2021-2022 School Year)

	n	%
	11	100
School Year		
2020-2021 Only	0	0
2021-2022	1	9.1
Both Year	10	90.9

4.2. Drivers and Facilitators

In the HSDF, drivers and facilitators refer to the factors that contribute to the creation and perpetuation of stigma and as the names suggests, factors that “drive” or “facilitate” stigmatization (Stangl, 2019). Although the two factors are similar, drivers are inherently negative, while facilitators can be positive, negative, or neutral in nature. The participants in this study identified drivers of stigmatization to be stereotypes of individuals with COVID-19 as being reckless and irresponsible, fear of contracting the disease and existing anti-Asian racism. Facilitators of

stigmatization were the news coverage, accessibility of information, and the evolving seriousness of the pandemic.

4.2.1. Attitudes regarding Individuals with COVID-19

Some of the drivers of stigma identified in the interviews were related to attitudes and beliefs about COVID-19 and those who test positive for the disease. More specifically, fear of the disease and negative judgements about COVID-19 positive people drove stigmatization. I asked participants what they thought individuals in their city (i.e. Toronto) believed about those who got COVID-19, and they expanded both on the statements and sentiments they heard from others as well as internalized feelings they held. Participants discussed that the public would be afraid of those who contracted the disease due to worries about contracting it and as a result would avoid those individuals. This was especially common earlier on in the pandemic. Two of the adolescent participants were understanding of this view as they could relate to the initial unknowns of the disease.

“It’s definitely something that people are scared of, and generally like, wanna stay away from kind of like, you know, back out from again. There’s the whole fear factor with COVID. So I think you know in general, like, if you cough, even though it’s not COVID or you sneeze, or whatever right people sort of like get a little bit freaked out from the whole situation, and you know, so I think the general, you know population is scared for sure.”
(P1-17M).

Secondly, many participants believed that those with COVID-19 were viewed as reckless, irresponsible and were to blame for their disease: “...they’d say that they’re irresponsible in a way. I’m not really unsure, just like irresponsible for not taking care of themselves” (P5-19F). This perception and judgment regarding the contraction of the disease fueled negative sentiments

towards those who had COVID-19. This became more of the case later in the pandemic when vaccines and other disease mitigations were available, and individuals chose not to be vaccinated.

4.2.2 Attitudes Towards Asians and Chinese Origin of COVID-19

Another driver of stigmatization was the existing racist attitudes and beliefs about Asians, particularly related to disease transmission. After the onset of the pandemic, the participants noticed overt racist attitudes towards Asians increasing. These attitudes emerged from more covert beliefs that existed about Asians previously, for example, one participant discussed how before the pandemic, people incorrectly believed that Asians had unconventional culinary habits and ate exotic meats; this incorrect belief fueled the racist rhetoric that Asians harbored diseases like COVID-19 and were more likely to spread it to others:

“I think there is, along with all of those things, a lot of like stigma around, like the things that East Asian people eat, cause I think there was something about like someone contracting it from like a bat or something like that, and I do remember hearing a lot of things about like East Asian people, you know, like eating weird things or people making comments about like them eating, you know, like dogs, or something like that. It’s like, ‘Oh, it’s because they keep eating like all these weird things that they keep contracting...” (P3-18N)

The rise in anti-Asian hate and negative attitudes towards Asians was something that most of the participants identified after the onset of the pandemic. The participants believed that the negative attitudes and beliefs about Asians were a result of the pandemic and its origins in China. Attitudes identified included feeling that Asians were blamed for the pandemic and fear of contracting the disease. Much of these sentiments were further fueled by racist messaging online and in the media. The consensus was that the pandemic had merely heightened attitudes that were

likely already present: *“In terms of during the pandemic, there was certainly an up burst of racial profiling towards Asian and East Asian cultures and populations for sure. I 100% noticed that. I'm just grateful I didn't experience it myself.” (P11-16M)*

4.2.3. Pandemic Timeline

Another facilitator of stigma was the point in the pandemic when the virus was contracted. At the beginning of the pandemic, stigmatization of those with COVID-19 was more related to fear and lack of knowledge of the disease and resulted in avoidance and fear of those with COVID-19. As the pandemic continued, the nature of stigmatization evolved. In some ways, health-related stigmatization decreased as more people contracted COVID-19 and there was knowledge of the disease and effective treatment options.

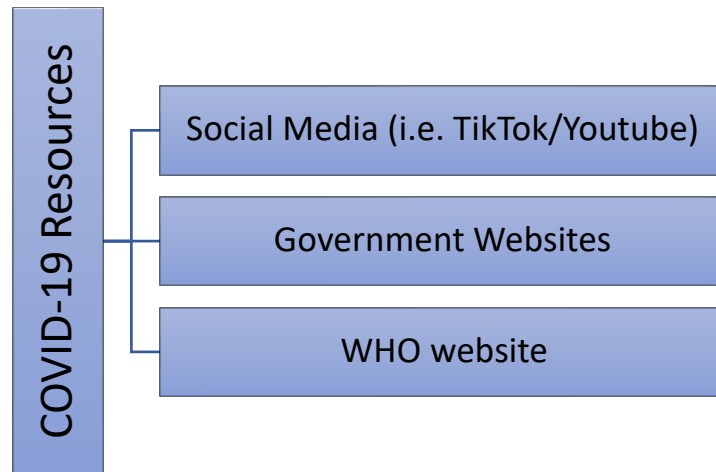
“...when the pandemic was when it first started back in March. I think people were still like really scared about it. And like, you know, if someone heard that like someone around them had Covid. They probably get really like freaked out more...but I think as time went on, people just kind of got like desensitized to it...And I think now it's just kind of like normal. It's like, “Oh, you have, Covid, oh that sucks. I hope you feel better soon” (P3-18N).

Conversely, after vaccines were widely accessible, those who contracted COVID-19 and were unvaccinated were viewed harshly and deemed responsible for their illness and selfish for not using available preventative measures. *“...after the vaccines started rolling out there was a bit of a...what's the word for this? If you were unvaccinated and you got it, people were not as surprised. They'd be like, you kinda did this yourself” (P11-16M).*

4.2.4. News and Social media

One facilitator of stigma identified by the participants was the media, both traditional news media and social media. Throughout the pandemic, news reports may have fueled fear of the disease due to constant reporting of hospitalizations and fatalities during the pandemic which may have caused people to worry excessively about the severity and the long-lasting effects of the disease which in turn lead to avoidance and stigmatization of people with COVID-19. For example, one participant worried about requiring more intensive medical care initially when her symptoms were severe due to news reports: *“Yeah, like the first few days the symptoms were pretty bad so I was kind of afraid that I would need to go to hospital because I’ve seen all these news reports of people on those like ventilation machines and I had heard about like the long-lasting effects as well so I was kind of concerned”* (P5-19F).

Additionally, social media could potentially be a source of misinformation and breed anti-Asian racism. This was mostly due to the sheer volume of information available online and challenges accessing reliable information. Participants identified the following venues for accessing information: social media, news media, websites of trusted sources (i.e., the WHO), information sent from their school and public health CDI following their case (See Figure 3). Although participants found the information available regarding COVID-19 to be mostly credible, one participant did express concern about the amount of misinformation about the disease due to the ease of publishing information online: *“Maybe there were a few websites like the very official ones...But then, again, like I said, there were just so many things spreading around social media, and the news at the time that it was almost hard to...it was...you couldn’t get that information unless you went out of your way to look for it kind of thing”* (P2-18F)

Figure 2*Sources of COVID-19 Information*

Social media was also responsible for perpetuating incorrect and racist stereotypes of Asians and many participants described witnessing anti-Asian racism during the pandemic on social media. Due to the anonymity of virtual spaces, more overtly racist rhetoric was expressed online than offline. Much of the sentiments focused on blaming Asians for the pandemic as well as hurtful stereotypes and othering of Asians. *“I have seen the comments to like other Asian influencers and stuff “Like all your people did this, go back to where you came from, stuff like that. But nothing to like me or like the people that I know personally.” (P7-19F).* Conversely, online spaces were also avenues to counter anti-Asian racism and social activism. Many participants discussed also witnessing Asian Canadians and Americans pushing back against stereotypes and prevailing narratives about Asians, particularly through the online hashtag #StopAsianHate.

4.3. Intersecting Stigmas

Drivers and facilitators will lead to stigma ‘marking’ (Stangl, 2019). A stigma marking is when the stigma is applied to groups of people connected to health condition or other perceived difference such as race, class, gender, sexual orientation, or occupation. Intersecting stigmas occur when people are ‘marked’ with multiple stigmas that intersect with one another. The participants in this study faced stigmatization related to their health status, their age, and their ethnic identity.

4.3.1 Racialization

As the participants were of Asian descent, they were at risk of stigmatization as a result of their racialization, which worsened during the pandemic. Racist stereotypes about Asians that already existed, and the fact that the pandemic originated in China, resulted in intersecting stigmas related to both their COVID-19 positive status and their ethnic identity. Many participants discussed the stigma they experienced due to having COVID-19, which included, hesitancy in disclosing, fearful reactions from others and distancing from others. At the same time, participants also disclosed experiencing racism and discrimination directly linked to their identity as Asian Canadians. Utilizing an intersectional lens, it is possible to understand how experiences of health-related stigma differed for those with an Asian background. A few participants expanded on the ways in which having COVID-19 would have been different if they had not been Asian. Due to attitudes about Asians during the pandemic, the participants felt that Asians are assumed to have COVID-19 and to be the cause of the spread. For that reason, one participant believed that Asians had to be extra cautious in following public health guidelines to avoid contracting COVID-19 to combat the assumption:

“A lot of Asian students stayed pretty safe during the pandemic. I mean, if you looked around you would notice that they are the ones who are always wearing the masks. They’re

the ones who are always, you know, keeping up with the safety procedures. And it. It was the kids of other races that were kind of, you know saying, you know we don't need or not wearing masks, or like coughing class, and not covering their mouths. The Asian kids, I think they knew like subconsciously, that if they did do what, for example, the white kids were doing by not wearing their masks, that they would be targeted and made fun of. So, I think in kind of to counter that they would be the masks, and, you know, stay to themselves as much as they could, just to avoid that whole situation, even happening. Right. And I guess, be even extra careful" (P2-18F).

4.3.2. Age

As Asian Canadian Adolescents, the participants also faced unique experiences and stigmas related to their age and status as a young person, including dealing with incorrect judgments from others after they contracted COVID-19. Two participants expressed dismay that others, particularly older adults, viewed young people as reckless and irresponsible. They felt that society often had a narrative that young people contracted COVID-19 because they were not being careful and chose to socialize instead of observing the necessary precautions. On top of being viewed as irresponsible for contracting COVID-19 and dealing with racial stereotypes about their ethnicities, the adolescents also faced blame for their illness rather than sympathy or understanding.

"...the assumption would be that the younger people are the ones who are being rowdy and going out and being irresponsible because they don't know what's good for them. But yeah, I think it was quite the opposite in that the young people were the ones who were following all the rules, and for the most part, and keeping up with the recommendations from the health departments and it was the older people who weren't complying with mask mandates

who just did whatever they wanted, because, you know, they don't have a lot to lose.” (P2-18F)

4.4. Manifestations

The next domain Stangl et al. (2019) labeled in their framework related to stigma was manifestations which refers to experiences of stigma which relates to their lived reality and stigma practices which includes the individual’s beliefs, attitudes, and actions. The experiences of stigma the participants discussed included negative reactions from others and experiences of racism. The stigma practices included internalized stigma, hesitancy to disclose and behavioural changes.

4.4.1. Negative Reactions to COVID-19 Status

Most of the participants chose to tell those who were close to them about their illness (i.e., family and friends) as well as those they were mandated to tell (i.e., school officials and possible close contacts). Participants were selective of who they told and focused on telling those they trusted to be non-judgemental and those they felt obligated to tell. Some discussed that it became easier to tell others if they contracted the disease later in the pandemic because by that point most of their social circles had already contracted the disease as well. Experiences disclosing their status varied from participant to participant and depended on the individual told and the relationship type. Some reactions were supportive while others were stigmatizing.

Classmates and teachers were sources of COVID-19-related stigma for four participants. As stated previously, most of the adolescents interviewed were careful with whom they disclosed their COVID-19 status and did not tell their classmates unless they were close friends. However, the participants who contracted COVID-19 while attending school in person were required to notify their school of their positive status. Although schools were obligated to maintain confidentiality and keep a student’s personal health information private, participants expressed

that most of the time, other classmates were able to determine that their absence from school was related to COVID-19. In all these instances, the reactions from others when returning to school was mixed. In some cases, the participants received neutral responses from their teachers who expressed sympathy and asked how they could support them (P6-17F). One participant whose classmates were aware of their positive COVID-19 status, reported that classmates would physically distance themselves from them upon their return (P5-18F).

Those participants in university or in virtual school at the time of their illness felt that the risk of stigma from classmates was lower as it was usually harder to notice if someone may be missing classes for possible health reasons due to larger class sizes, less frequent classes, and weaker social connections. However, one participant discussed how after telling his professors that he tested positive for COVID-19, he noticed a change in their behaviour towards him when he returned after isolating. Prior to disclosing his illness, the professors did not wear masks in class or during office hours, after the disclosure they began to wear a mask. The participant felt the action was a direct result of his disclosure.:

“I emailed only a few of my profs. So, the profs that I emailed were Like I was closer to them more because I would always attend their office hours. So, then I told them like, oh, I got COVID that’s why I’m not going to be at your office hours...Because of that I think they started wearing masks during classes. Yeah, so after that. Because I saw on the recordings, they started wearing a mask after. And then like whenever people approached them, they’d kind of be scared of everyone. Yeah, like things like that.” (P10-19M)

Participants also reported negative reactions and stigmatization from family and relatives as well. Seven of the participants contracted COVID-19 along with, or directly from their family did not need to inform or disclose their status. Others who contracted the virus first were required

to inform those with whom they cohabited, with mixed results. Some participants stated that their families were understanding and accepting. However, two were afraid to notify their family due to worries they would be blamed for contracting the virus. *“I felt worried about telling my parents, though, because I was worried what they would think of me, more so because I thought at that point, we didn’t know that we were all sick, and I guess my body was the first one to react to it. I thought maybe they would think that I was going out. And you know, being irresponsible”* (P2-18F). Sometimes this type of reaction was also connected to being viewed as an irresponsible young person who did not heed the advice of their elders:

“Mainly from family members and older adults that were friends of my parents. They kind of. They weren’t surprised when I got Covid, because they assumed that young adults would go out more during lockdown and because of that they’re more likely to catch Covid, and they assumed that that younger adults were less cautious with Covid, and with wearing masks and other enforcements.” (P4-19F)

Participant’s experiences interacting with healthcare workers depended on when in the pandemic they had contracted COVID-19. Those who contracted COVID-19 earlier in the pandemic would have tested at a COVID-19 assessment center located in a hospital and were followed up by their local Public Health Unit (PHU). Conversely, those who contracted COVID-19 later in the pandemic had access to RATs to test remotely in their homes. By utilizing a RAT, the participant may not have had to interact with any healthcare workers unless their health state deteriorated enough to require medical care. In Ontario, PCR testing was available to those who qualified at assessment centers, many of which were in hospital sites. Reactions from hospital workers experienced by the participants were mixed. For the most part, most participants felt hospital workers (nurses, doctors, etc.), were professional, non-judgemental, and efficient: *“At that*

time, they didn't make the rapid tests as available, so we didn't have one at home. So, I actually went to, to a clinic to get it, tested...I thought the staff were professional. I mean, they're healthcare professionals, so yeah, I didn't have any issue. They were pretty good.” (P5-18F) and “It was very good actually. They had to deal with a lot of these people, so they had a dedicated room, they had a dedicated line system” (system” (system” (P11-16M). However, even in the case of supportive healthcare workers, the experience was brief and hurried due to the volume of patients and time constraints. One participant who contracted COVID-19 early in the pandemic described a more harrowing experience of getting tested in which he felt dehumanized and unassured by the staff.

“Oh yeah, I had to go to the hospital to get tested.... I guess it was like a movie to me. Like we were like toxic radioactive aliens to them because they had like have Hazmat suits and everything. And they would just be like, okay, hurry up, let's go line up, sit down, Lift up your head. To them, it was just because they wanted to do things faster, but to us it was like we were just in a camp or something.” (P10-19M)

Similarly, another participant who tested at a hospital worried about what the nurses there thought of her, especially due to her Asian background.

“Actually, now that I think about it, I feel like when I went to get tested, it was in a hospital. I don't think back then they had the kits, so I didn't try it myself, I actually went to the Hospital itself. And I did kind of feel maybe those, nurses who did the swab testing on me, I was I was worried if they thought like I went to China or anything like that and like contracted the virus there like I was that I was spreading the virus from coming to the hospital. I did have those thoughts, but I think, I was just like worrying. They still treated me very nicely. I think it was just my own thoughts. And my own anxiety just overtaking the situation” (P9-19F).

Participants who were officially tested, were also followed up by a CDI from their local health department. Follow up calls involved, identifying symptom date of onset, close contacts and providing quarantine information. Participants described mostly positive interactions with CDIs with a common complaint being the frequent calls from multiple investigators. In some cases, participants had already accessed their positive test results while in other cases, the CDI notified the participant of their positive status. In the case that the CDI notified the participant, it was crucial for the investigator to remain non-judgmental and empathetic. Some participants had empathetic and caring responses from their assigned investigators and felt comfortable asking questions and receiving support. While other participants felt that the investigators were rushed for time and did not express any sympathy or warmth. A participant who spoke with their local CDI, described the experience as similar to interacting with a customs officer:

“...like when you cross the border and there's people asking questions, they're like, what are you here for? How long are you staying... there's no like sympathy in their voice. It's just like, here's my script. I'm reading it to you...it was just like “Oh hello, is your name ___ and then they were like, oh. Do you live here? You have COVID” and then yeah, like it was just like that instead” (P10-19M).

4.4.2. Experiences of Racism

Participants were also asked about their experiences with racism related to their ethnic identity during the COVID-19 pandemic. Most of the participants expressed that they had been fortunate to not have experienced direct and overt racism but nevertheless, they had observed a rise in anti-Asian hate around them during the pandemic. Some of these experiences happened to them directly and others happened to those around them. The interviews also touched on the impacts of racism experienced in online spaces and witnessing media coverage of hate crimes

against Asians. The common spaces in which racist experiences for participants occurred during the pandemic were at school and out in the community. In terms of community spaces, participants identified riding on public transit as frequent opportunities for racist encounters.

As stated above, school and education settings were identified as spaces for racist experiences among the adolescent participants. The participants that did disclose witnessing racist incidents in school did not experience them directly from their classmates, instead, there was a noticeable increase in anti-Asian sentiments felt in the school population. For example, one participant discussed that in her high school, there had been slurs aimed at Asians vandalized onto school property and the school administration blocked off access to those restrooms.

“...but my school there was a point when one of the washrooms was closed because someone had written a slur I think targeted towards the Asian community. This happened a couple of times, targeting various groups, but like around the pandemic it was targeting like the Asian community” (P6-17F).

For those who noticed an increase in racist attitudes at school (mostly among classmates), they did not feel school staff were equipped to address the issue. One participant decided to try and combat anti-Asian racism in his high school by creating an Asian Student Association that had not previously existed to increase awareness regarding Asian culture and Asian hate. He partly felt compelled to create the group along with other Asian students at his school because he felt teachers were unaware of the experiences of Asians,

“But the staff didn't really...I don't know if they noticed or not, and that's kind of part of it, or if they did notice, they just kind of like, you know, swept it under the rug, or whatever. But we certainly didn't have help and that's why we've had to make this Student Association.

It's a student-run student operated so that we can, you know, help with the problems that we've noticed because, again, there is not much being done by others.” (P1-17M)

As touched on previously, public spaces in the community were another common location for racist experiences by participants as multiple adolescents discussed negative reactions and even verbal harassment by strangers on the street, at stores and on public transit. The experiences ranged from targeted looks to more overt racist attacks. Milder experiences posed a challenge for participants as it was unclear whether the experiences were related to their racial background or another unknown reason.

“But I've always felt like, even in like in the deep of the pandemic, because sometimes I would need to commute to school on the subway. On the subway, specifically like I would sit down, and then I'd notice, like a group of people kind of move away from me, or if I'm walking on the sidewalk, I'll notice that they'll, you know, go out of their way to like to avoid me. But I'm, I know a lot of people do that to people regardless of their race. So, I mean, it could be happening to me more so because I'm Asian.” (P2-18F)

Since social distancing was necessary during the pandemic, some participants interpreted some of these reactions as other individuals attempting to limit the spread of the disease and not a direct attack on Asians. However, one participant was able to discern the intention behind strangers distancing themselves when she and her mother noticed a stranger only maintaining distance from Asian people in public:

“My mom went to Canadian Tire, and I believe she told me she was in line, and she sneezed. And like a man like behind her like just walked all the way back and her kind of looked at her like in disgust. And it was weird because another gentleman also sneezed, he wasn't the same background as us, he wasn't an Asian descent, he also sneeze, but the man who

was close to him, the man didn't move or look at him, weirdly or anything like that. So, my mom kind of knew it was a little bit obvious that he was, the man was a little bit, you know reluctant or hesitant in being close to my mom because she was of Asian descent (P9-19F).

In terms of more serious incidents identified by the participants, it was undeniable that the act was connected to their ethnic identity and the COVID-19 pandemic. One adolescent was yelled at by a stranger while walking in Chinatown with her grandmother and was blamed for spreading the virus: *“When I was like, I was with my grandma in Chinatown, there's just like a guy and then he was just like literally yelling at every Asian person he saw like “Oh, you're going to pay. This is all your fault!” (P7-19F).* Another participant described experiencing similar events frequently in the shared spaces of his condominium, including comments and others visibly disengaging from him: *“Yeah, it was mostly from strangers. I live in a condo. So, we like when we ride the elevator is like people will literally lean away from me. Yeah, or like when I'm grocery shopping, like people will like. I'll have like my own bubble of space. And everyone's just going to try not touching me or whatnot” (P10-19M).*

4.4.3. Internalized Stigma

Internalized stigma was another stigma experience that emerged from the interviews, while quarantining, many participants began to have negative feelings towards themselves for having contracted COVID-19. Participants discussed experiencing emotions including “anger” and “disappointment” with themselves. Most of the internalized feelings stemmed from the belief that they should have been more careful and feelings of guilt for spreading the disease to others, this was heightened when they were worried about medically compromised family members. One participant discussed feeling guilty for going to an overnight trip for school and contracting COVID-19 shortly after:

“...I feel like I should have been more responsible because that was when like mask mandates had lifted, because I remember not wearing a mask for most of it. And then like just being in close contact with the people. So, I was kind of hard on myself for making the decision to like still to go, even though I knew that it was going to be kind of a health risk if I did get COVID.” (P8-18F)

4.4.4 Changes in Behaviour

Another stigma practice included changes in individual behaviour due to experiences of stigma, both perceived and actual. Due to concerns about being stigmatized, participants avoided disclosing beyond family, close friends, and those they were mandated to disclose to. The hesitation stemmed mostly from being unsure how others they would react, fear of stigma and having the disease define them in other people’s eyes:

“...I think. I guess it was the stigma around it because I don't know, people kind of treated others, like the disease, when COVID was a thing. I don't want to be like pushed out because of something that wasn't really...I don't know, like I didn't want it to affect my relationships.” (P8-18F)

Additionally, concerns about experiencing anti-Asian racism made two participants worry about wearing a mask in public. During the pandemic, it was a common misunderstanding that individuals wore masks in public when they had COVID-19, but in reality, many people who did not have COVID-19 also wore masks to protect themselves from contracting the virus. As Asians were already viewed suspiciously and thought to be carrying the disease, wearing a mask publicly could result in increased animosity and negative interactions, particularly when masks were not mandated by the government. Furthermore, non-Asians who wear masks for their own protection did not face the same assumptions as Asians. This difference in perception led some

participants (P7-19F, P10-19M) to be cautious about wearing a mask in public as an Asian Canadian and decided to forgo wearing it. *“But I feel like if they saw a Chinese person wearing a mask outside. They'd purposely like avoid them. Yeah, so that's why now, whenever my family and I go out, we tend to just not wear a mask at all. So, then people don't like fear us, I guess.”* (P10-19M)

4.5 Outcomes

Manifestations of stigma lead to a range of outcomes for the stigmatized population as well as consequences for society. The participants discussed in their interviews some outcomes of their stigmatization including the negative effects to their mental health and academic achievement.

4.5.1 Lasting effects of Racism

Participants discussed how the racist experiences had negative effects on their mental health. One participant described feeling demoralized after witnessing individuals moving away from her due to her identity. *“It feels very uncomfortable. It feels like sometimes you'll see. I mean a lot of younger people are probably better at hiding it if they are racist, but a lot of older people like to be like to act out more on their thoughts and feelings because they have nothing to lose or something”* (P2-18F). All participants who experienced racism personally described being affected in some way by the experience and participants who encountered racism indirectly through witnessing it also were mentally affected by the presence of anti-Asian racism. One other male participant disclosed that they experienced anti-Asian attacks so frequently that over time, they had become numb to it:

“I guess. I guess like at one point I just felt numb to the hate, if that makes sense, like whenever people would be like, Oh, like “Go back like, like, oh, be careful like they're

Chinese, like, they might, they might give you COVID”, Like I just shrug it off and I’ll be like, okay, fear me I guess like it didn’t really matter to me as much...” (P10-19M)

On the other hand, for some participants, the pandemic raised their awareness regarding social justice and helped them gain confidence and motivation in tackling the racism experienced by Asian Canadians. Prior to the pandemic, many were shielded from overt racism due living in communities with higher percentages of Asians. Experiencing racist incidences exposed them to the racism experienced by Asians and other marginalized groups. This increased awareness led participants to learn more about Asian issues and Asian activism and began combatting it in their lives, one example was a participant who started a “Stop Asian Hate” club in his high school (P1-17M)

4.5.2. Academic Consequences

One other consequence of contracting COVID-19 for the participants was lowered academic performance due to lack of support and inequitable treatment from teachers while isolating. Participants faced challenges both in terms of keeping up with their studies due to prolonged absence from school while quarantining and adjusting to returning to school. However, schooling while isolating for COVID-19 was not an issue for those participants who contracted the virus during school breaks (in the summer or Christmas holidays). According to participants, some schools and teachers were very supportive and ensured that they remained on track while in quarantine and were accommodating and lenient if they were too ill to complete course work: “...they had a kind of process and protocol in place and I wasn’t kind of the first person in the whole school to get COVID so they were like they were pretty supportive” (P6-17F). However, four participants described their school and teachers as “unsupportive” and did not enable them to

follow along with their classes while at home, even if their symptoms were mild enough to study at home:

“The measures that they that a lot of my teachers had in place for students who got Covid and were subpar, to say the least. I basically missed an entire week and a half of school again, and there was nothing I can do about it other than attempt to catch up. And unfortunately, it was an extremely heavy semester for me, so it took a lot of time to sort of recover from that position” (P1-17M).

Limitations with technology was cited as a reason some teachers were not able to support students with COVID-19 to navigate course work while isolating:

“It was a bit difficult, not being at school, I think, because, like some teachers, like some teachers, aren't as good with technology. And so, when they set up like Zoom Meetings and things like that, they don't really pay attention to it as much or like they don't navigate it as easily as in-person class so that was definitely a challenge, trying to get things done by myself” (P3-N18).

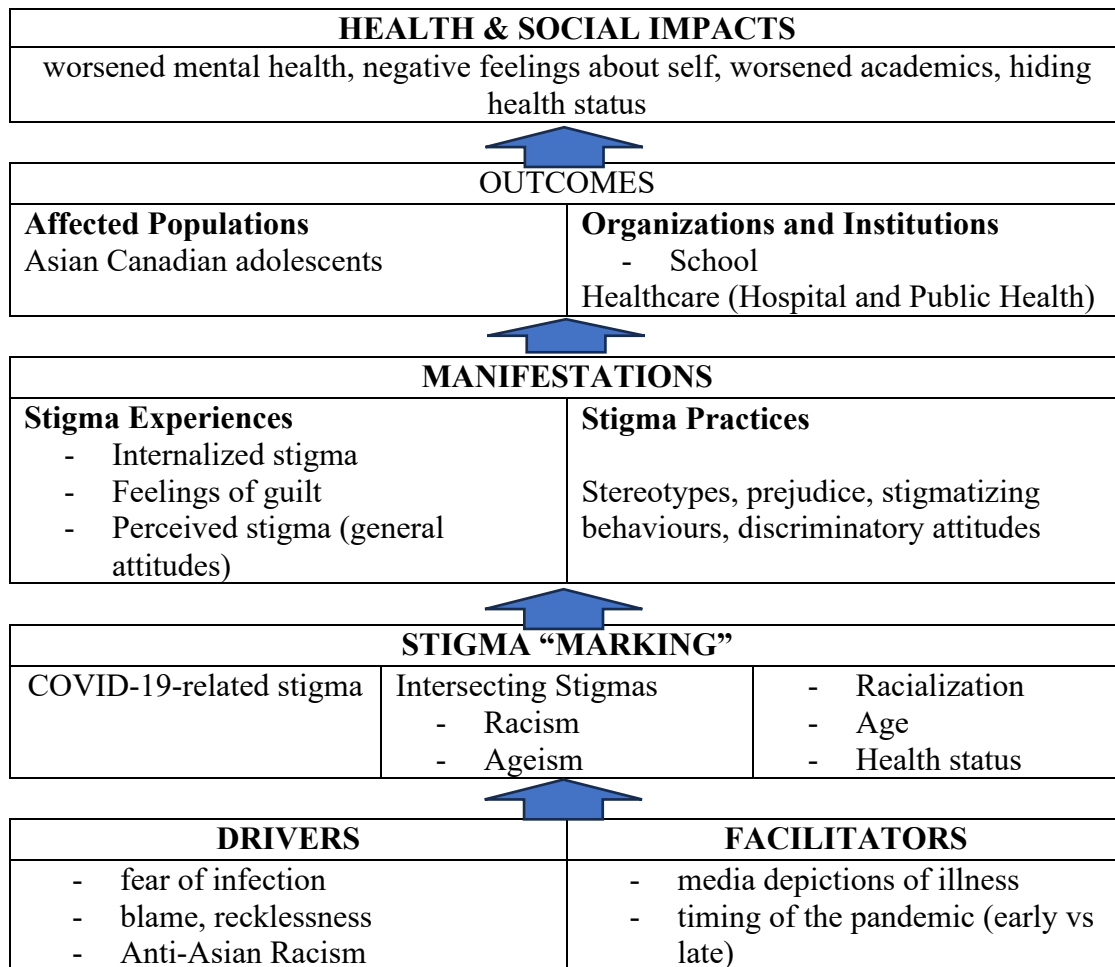
For those participants who were in post-secondary school at the time they contracted COVID-19 had increased difficulties in keeping up with coursework compared to those in high school. As universities require students to be more independent and proactive with their studies, some participants found their school administration to be unaccommodating in ensuring that students stayed afloat: *“I feel like they didn't do anything particularly to make me feel better about it I guess like the exams were still going...like I still had to go to school even with COVID to take an exam. Which was not good because I had a fever at that time too.” (P10-19M).*

In the figure below (Asian Canadian Youth COVID-19-related stigma Framework), I recreated the Health Stigma and Discrimination framework chart created by Stangl et al (2019) to

summarize and capture the drivers and facilitators, intersecting stigmas, manifestations, and outcomes of health-related stigma experienced by Asian Canadian adolescents during the COVID-19 pandemic.

Figure 3

Asian Canadian Youth COVID-19-related stigma Framework (adapted from Stangl et al., 2019)



4.6 Summary

In summary, this section discusses the findings that emerged from the interviews of the adolescent participants. The chapter that follows will provide a discussion of the study guided by the research questions and the existing literature.

5.0 Chapter 5: Discussion

This chapter will provide further discussion of the results and contextualize the themes using the research questions and theoretical frameworks. I will discuss reinterpretations of the data in relation to extant knowledge as outlined by the Interpretive Descriptive methodology and provide key takeaways regarding the experiences of Asian Canadian youth of COVID-19-related stigma. My findings provide insight into the research questions as the participants discussed their experiences during the pandemic, their experiences of health-related stigma in different settings, including school and supports utilized. The discussion is organized in such a way to illustrate the answers to the research questions. Lastly, I will also discuss some implications for practice, particularly in a nursing context. This chapter will also provide a conclusion to the report and discuss the limitations of the study and dissemination of the findings.

The previous chapter showed a thorough display of the data obtained from the interviews, this section will attempt to examine and reflect on the findings to determine meaning and relevance in relation to the existing literature. With the interpretation of the results, I will return to answer the research questions that this study aims to answer and summarize the understanding of COVID-19-related stigma and the Asian Canadian experience.

5.1. Experiences of Asian Canadian Adolescents with COVID-19

The first research question was related to the experiences of Asian Adolescents that had COVID-19, and the factors that facilitated their experiences. The experiences varied depending on factors related to participants. The greatest influencer regarding experiences of COVID-19 was related to when in the pandemic the participants tested positive. Participants who tested positive earlier in the pandemic had a very different experience from those who tested later. As discussed in the background, the Government of Ontario enacted varying levels of responses to COVID-19

cases throughout the pandemic based on evolving scientific evidence about the disease. Individuals who tested earlier in the pandemic, experienced greater amounts of stigma and fear from others and were also subjected to longer quarantine periods and were more likely to interact with healthcare workers. Those individuals who tested later in the pandemic, were more likely to simply take an at-home RAT and therefore not interact with healthcare workers and they may have been isolated for a shorter period. Many of the participants discussed how attitudes towards people who had COVID-19 and attitudes towards the disease itself lightened throughout the pandemic, with most of the public being less fearful of the disease and by extension those who had it as the pandemic progressed. Once most of the public had contracted COVID-19, the disease was more normalized and less stigmatized. This poses interesting information for researchers and practitioners that suggests considering time as a variable affecting the nature and experience of stigma. Although I was unable to find specific research regarding changes of stigma during the COVID-19 pandemic, Earnshaw et al (2022) similarly suggest that stigma is not static and waxes and wanes over time depending on the social perceptions of the disease. Additionally, one protective factor that helps decrease stigma towards a disease is knowing an individual with the disease, as it increases compassion towards those that have the disease and knowledge of the disorder (Rössler, 2016). The COVID-19 pandemic occurred over a long period (three years), and overtime, this allowed a larger percentage of the population to contract the disease or encounter someone who had been positive, decreasing stigma.

Another area of influence on experiences while isolating was who they lived with during the time of illness. As young people, most of the participants acknowledged they may not have been at great risk for severe complications, but those participants living with an elderly relative or a medically compromised family member, had to be extra careful to not contract COVID-19 and

keep their loved ones safe when they did contract COVID-19. This concern for other household members contributed to more worries about the disease as well as guilt and internalized stigma when they did contract the disease. Worries among youth can have negative effects on their mental health; a Norwegian study by Lehmann et al (2021) surveyed many youths and found that worrying among the youth resulted in increased feelings of stress and trouble sleeping (Lehmann et al, 2021).

5.2. Stigma at the Intersections of Race, Age, Health Status, and Gender

The second research question was related specifically to stigmatization experienced by the participants in different social settings. In this study, I explored the different intersecting stigmas of health-related-stigma, ageism, and racism. The findings described in the previous chapter touched on experiences of stigma and oppression relating to the participants' multiple intersecting identities. The participants shared experiences of stigma based on their COVID-19 status, but also simultaneously experienced stigma related to their ethnic identity and age. Additionally, the experiences of isolating as an Asian Canadian adolescent are multifaceted and cannot be summed up by a singular position they occupy. Asian Canadian adolescents face similar challenges with navigating a COVID-19 diagnosis as other individuals, but additionally, they face unique challenges related to their racial identity and age.

Ethnic identity was exacerbated by the pandemic and perpetuated by the media. This stigmatization occurred in multiple settings including at school, online and in public spaces. As discussed in the background, Asian Canadians have always occupied a position as racial "other" and experienced racism in Canada. The COVID-19 pandemic combined the fear of the disease with anti-Asian prejudices (Leigh et al., 2022). For the participants, navigating both the stigma of being COVID-19 positive and the racial stigma was an important facet of their pandemic experience. These findings are in line with what the literature has shown about the experiences of

Asians during the pandemic, particularly those living in Western countries. Individuals of Asian descent experienced increased discrimination in the form of verbal harassment in public spaces and racist bullying online which was similar to the experiences of my participants (Leigh et al., 2022; Lu et al., 2023, Ma & Zhan, 2022)

Throughout the pandemic as cases increased, ageism towards young people increased as well (Werner, AboJabel, & Tur-Sinai, 2022). There was an incorrect assumption about younger individuals being irresponsible and reckless and contributing to the spread of the virus due to their need to socialize with their peers. This incorrect inference placed the adolescent participants I studied in a tenuous position in which they were facing ageism compounded with other intersecting oppressions. Cook et al (2021) posit that youth during the COVID-19 pandemic were subject to scrutiny from society and were simultaneously viewed as healthy and socially worthy, but also selfish individuals who deliberately put themselves and others at risk. Additionally, the stereotypes about young people during the pandemic were in congruence with the negative stereotypes about young people that already existed: that they were rebellious, irresponsible risk takers who were unreliable and required protection and discipline by society (Cook et al, 2021). Previous research on ageism against young people (de la Fuente-Núñez, et al., 2021) showed that ageism can impact confidence and self-esteem in youth and result in compensating behaviours, such as acting older, particularly in workplaces.

Furthermore, an adolescent's approach to dealing with quarantine and isolation may be different than adults. Based on theories of adolescent development, adolescents place great emphasis on relationships with peers and rely on these ties for support (Gadassi Polack et al, 2021). For the participants in this study, many described their friends as supportive and as the only individuals outside of their families they felt safe disclosing their status. Additionally, the

importance of friendships was displayed in the interviews, as a lack of connection with friends resulted in loneliness for some participants. Other participants made efforts to stay connected through social media sites like Discord.

There is previous evidence in the literature to suggest that an individual's gender may have impacted their experiences of the COVID-19 pandemic. However, in this study, issues related to gender did not come up in the participants' interviews, so I was unable to create correlations between gender and experiences of stigma during the pandemic. This may be related to one of the limitations of the study which is an unevenly distributed gender sample. Additionally, the interview questions and prompts did not specifically probe for discussions about gender. In the literature, gender inequalities during the pandemic mostly negatively affected women, including more psychological stress, increased domestic labour, greater risk of experiencing intimate violence as well as job insecurity (Fisher & Ryan, 2021).

5.3. Effects of Stigma

The literature suggests that experiences of stigmatization can have significant negative effects on the mental health and well-being of those experiencing the stigmatization. Individuals experiencing COVID-19-related stigma have reported low moods and feelings of anxiety as well as internalized stigma (Sahoo et al., 2020). Additionally, experiences of racism and discrimination have long been known to result in a myriad of negative effects on both mental and physical health due to exposure to chronic stress. For example, children and adolescents who are regularly exposed to racism over time are more likely to have worse mental health, poorer educational attainment, and worse health outcomes (Trent et al., 2019). Among the participants, those that experienced racism during the pandemic, already identified feelings of sadness and demoralization which can

result in poorer mental health. Among participants who experienced multiple compounding racist interactions discussed feeling numb and apathetic to the abuse.

In this study I also explored the effects of **health-related stigma** on the participants. The adolescents did express that they had negative feelings about themselves related to the stigma experiences. For instance, some participants felt angry at themselves for having gotten COVID-19 and were worried about being stigmatized by others. However, some other participants felt that they could understand others' fearful reactions towards them, as they would likely feel similar, therefore, they were not as emotionally affected. Similarly, for the adolescents in this study, experiencing **racism**, either directly or indirectly had negative effects on the participant's feelings about themselves and sense of belonging. The participants described feeling disheartened and upset after experiencing racist interactions with others. Furthermore, the experiences left some participants afraid enough that they worried for their safety and made changes to their behaviour to limit opportunities for attacks, for example, being mindful of where they wear a mask in public as an Asian person. The participants in this study experienced compounding effects of stigmatization due to the intersecting stigmas they faced which is consistent with the literature on interesting health stigmas. The co-existence of health stigma and other stigmatizations like racism are associated with worse health behaviors and outcomes like increased depression (Turan et al., 2019)

5.4. Strategies Identified and Supports while Isolating

The third research question that this study looked at was the strategies Asian adolescents used to cope with stigmatization surrounding their COVID-19 status, and what they identified as helpful interventions from parents and other adults. The supports identified by participants could be divided into socio-emotional supports as well as resource supports. Participants described their

close friends and families as being a source of socio-emotional support while isolating. With these social supports, it was easier to avoid loneliness while isolating and use of technology and social media made staying connected easier. With friends and family serving as sources of trust and non-judgement, participants had spaces to discuss and disclose their COVID-19 status without fear of possible stigma. Additionally, many participants felt that living in communities and attending schools that valued diversity and made attempts to combat Anti-Asian racism helped shield them from possible anti-Asian-related stigma they may have faced during the pandemic. In terms of resource support, easy access to simple, up-to-date, and clear information about COVID-19 is crucial to navigating quarantine and the disease. Similar to Lohiniva et al. (2021) finding accurate information was sometimes difficult for participants due to the abundance of misinformation, especially online. This is particularly important in mitigating COVID-19-related stigma, as providing accurate information to the public is correlated with decreased fear of the disease and stigmatization of those who have it (Lohiniva, et al., 2021). With the Asian Canadian adolescent population, it is important to have health education available in a way that can be understood by younger populations, is not fearmongering and is translated into other languages for their family members who may not speak English.

5.5 Limitations

This study contains several limitations to consider when reviewing the findings; they include 1) the small sample size, 2) the single interview format, 3) the uneven gender and age distribution of participants, and 4) the lack of socioeconomic discussion. The first two limitations included the small sample size of 11 participants and that the youth were only interviewed once. The small sample size was effective since information power was still reached. Information power indicates that the more information the sample holds relevant to the study, the smaller the sample

is needed (Malterud, Siersma & Guassora, 2016). The participants held a lot of information, and their characteristics were highly relevant to this study, therefore a smaller sample was adequate. A second interview may have provided more information, however in the first interviews, the youth provided extensive descriptions of their experiences, so a second interview may not have yielded a lot more information as the interview questions were able to be completed in the 1 hour offered. I tried to address this limitation, by allowing the participants enough time in the interview to speak and providing additional probing questions to encourage more reflection. The third limitation is that the sample did not have an even distribution of genders and most participants were older in age (average age=18). However, to ensure credibility in my findings, I designed the interview questions to be open-ended to elucidate more information from the participants. The fourth limitation of the study is that although the findings touched on the intersecting effects of age, racialization and gender, the study did not explore the socioeconomic differences among the participants, as the framework I used limited the questions I was able to ask about socioeconomic demographics. Any future studies conducted about this topic should include discussions on socioeconomic status and COVID-19-related stigma. Research suggests that those of lower socioeconomic status were disproportionately represented in COVID-19 cases and their experiences isolating included unique challenges (Mishra et al., 2022).

5.6. Implications for Practice, Research and Dissemination

The findings of this study offer multiple implications that may be relevant for those who work with Asian Canadian adolescents or similar diverse populations. The two groups of professionals to whom this research is most pertinent are those in education and healthcare. First, for school administrators and educators, it is important to provide students with the supports while isolating and after returning to school, so students do not fall behind in their studies and are able

to return to a safe, non-discriminating school environment. This will allow students to not feel penalized academically when they contract a disease that requires isolation and absence from school. It is also crucial for schools to ensure, to the best of their ability, that confidentiality is maintained regarding student's health information to limit opportunities for stigmatization at school. Furthermore, schools must acknowledge the increased racial stigmatization and anti-Asian racism that occurred during the pandemic and should be prepared to educate their school populations, promote inclusivity, and effectively address instances of hate crimes at school. School liaison public health nurses and multi-disciplinary health teams could support schools in addressing some of the health-related stigmatization as well as racial stigmatization related to COVID-19. The literature strongly supports schools as a source for combating stigma as they are frequently a setting in which stigmatization occurs (Akiba, 2020). School officials can reduce stigma related to health disorders among students through various awareness and education campaigns (Koller & Stuart, 2016, Link et al, 2020). More specifically to combat anti-Asian hate during the COVID-19 pandemic, the following interventions could be utilized (Akiba, 2020): school wide condemnation of Asia-phobia, reinforcement of existing anti-bullying policies, combating misinformation and increased education on the diversity of Asians and Asian culture.

For nurses and other healthcare workers, it is important to take steps to prevent further stigmatization of individuals with COVID-19 while in their care. CDIs in particular, play an important role in decreasing health-related stigma as they are tasked with informing people about their illness and enforcing isolation measures. This is particularly true for adolescents who may require additional sensitivity and support through their diagnosis. To decrease disease stigmatization, healthcare workers should aim to explain information in a straightforward and accessible way and take the necessary time to ensure adolescents feel heard and comfortable asking

questions. Healthcare workers should further maintain a non-judgemental and sympathetic attitude to improve the therapeutic relationship.

The main dissemination of these findings is through the submission as a Master of Nursing thesis at York University. An adapted version of the literature review of this study was presented at the Lilian Meighan Wright 9th annual conference on July 22, 2022. In the future, there are plans to further disseminate the findings through publications and presentations in nursing and health-related journals and academic conferences on public health. I will also attempt to present an abstract poster of the thesis at conferences and submit a shorter research report in smaller publications. I will also try to disseminate these findings to healthcare workers and other professionals who may be working with this population. Additionally, I will make efforts to present my research findings to other public health nurses at my public health unit and other Public Health Units through professional organizations comprised of community health nurses.

5.7 Conclusion

In conclusion, during the COVID-19 pandemic, Asian Canadian adolescents have experienced unique challenges when they have contracted COVID-19 due to the intersecting positions they occupy as both Asians and adolescents. The Asian Canadian adolescents interviewed in this study experienced stigmatization from school peers, school staff, and healthcare workers due to their COVID-19 status, as well as racism due to their Asian background and ageism from older individuals. Adolescents are highly aware of the prevailing attitudes towards those that have COVID-19 and those that are Asian and are therefore mindful of whom they disclose their positive status. Experiences of stigmatization have negative effects on the adolescent's feelings about themselves and can contribute to internalized stigmatization. Those professionals that work

with Asian adolescents can better support them by creating safe and supportive spaces in schools and in healthcare settings that are inclusive and adopt anti-discriminatory policies and protocols.

References

- Abrams, J. A., Tabaac, A., Jung, S., & Else-Quest, N. M. (2020). Considerations for employing intersectionality in qualitative health research. *Social Science & Medicine*, 258. doi: [10.1016/j.socscimed.2020.113138](https://doi.org/10.1016/j.socscimed.2020.113138)
- Akiba, D. (2020). Reopening America's schools during the COVID-19 pandemic: protecting Asian students from stigma and discrimination. *Frontiers in Sociology*, 5. doi: [10.3389/fsoc.2020.588936](https://doi.org/10.3389/fsoc.2020.588936)
- Allport, G. W., Clark, K., & Pettigrew, T. (1958). The nature of prejudice. Addison-Wesley
- Andersson, G. Z., Reinius, M., Eriksson, L. E., Svedhem, V., Esfahani, F. M., Deuba, K., ... & Ekström, A. M. (2020). Stigma reduction interventions in people living with HIV to improve health-related quality of life. *The Lancet HIV*, 7(2), 129-140.
- Boyes, M. E., & Cluver, L. D. (2015). Relationships between familial HIV/AIDS and symptoms of anxiety and depression: the mediating effect of bullying victimization in a prospective sample of South African children and adolescents. *Journal of youth and adolescence*, 44(4), 847-859.
- Cheah, C. S., Zong, X., Cho, H. S., Ren, H., Wang, S., Xue, X., & Wang, C. (2021). Chinese American adolescents' experiences of COVID-19 racial discrimination: risk and protective factors for internalizing difficulties. *Cultural Diversity and Ethnic Minority Psychology*. (4) 559-568. doi: 10.1037/cdp0000498.
- Chew, C. C., Lim, X. J., Chang, C. T., Rajan, P., Nasir, N., & Low, W. Y. (2021). Experiences of social stigma among patients tested positive for COVID-19 and their family members: a qualitative study. *BMC Public Health*, 21(1), 1-11. doi: 10.1186/s12889-021-11679-8.
- City of Toronto (2022). COVID 19: Ethno-Racial Identity & Income. Retrieved from:

<https://www.toronto.ca/community-people/health-wellness-care/health-programs-advice/respiratory-viruses/covid-19/covid-19-pandemic-data/covid-19-archived-dashboards/covid-19-ethno-racial-identity-income/>

- Cook, P. S., Curryer, C., Banks, S., Neves, B. B., Omori, M., Mallon, A. H., & Lam, J. (2021). Ageism and risk during the coronavirus pandemic. In D. Lupton & K. Willis (Eds.), *The COVID-19 Crisis: Social Perspectives* (pp. 207-218)
- Crenshaw, K. (1989). 1995. Mapping the margins: Intersectionality, identity politics, and violence against women of colour. *Critical race theory: The writings that formed the movement*, ed. K. Crenshaw, N. Gotanda, G. Peller, and K. Thomas, 357-83.
- Davies, D., & Dodd, J. (2002). Qualitative research and the question of rigour. *Qualitative health research*, 12(2), 279-289. doi: 10.1177/104973230201200211
- Dean, J., Fenton, N. E., Shannon, S., Elliott, S. J., & Clarke, A. (2016). Disclosing food allergy status in schools: health-related stigma among school children in Ontario. *Health & social care in the community*, 24(5), 43-52. doi: 10.1111/hsc.12244
- de la Fuente-Núñez, V., Cohn-Schwartz, E., Roy, S., & Ayalon, L. (2021). Scoping review on ageism against younger populations. *International journal of environmental research and public health*, 18(8), 3988. doi: 10.3390/ijerph18083988
- Do Duy, C., Nong, V. M., Van, A. N., Thu, T. D., Do Thu, N., & Quang, T. N. (2020). COVID-19 related stigma and its association with mental health of healthcare workers after quarantined in Vietnam. *Psychiatry and Clinical Neurosciences*, 74(10), 566-568. doi: 10.1111/pcn.13120
- El Masri, A., & Sabzalieva, E. (2020). Dealing with disruption, rethinking recovery: Policy

- responses to the COVID-19 pandemic in higher education. *Policy Design and Practice*, 3(3), 312-333. doi: [10.1080/25741292.2020.1813359](https://doi.org/10.1080/25741292.2020.1813359)
- Earnshaw, V.A., Watson, R.J., Eaton, L.A., Brousseau, N. M., Laurenceau, J.P., & Fox, A.B. (2022). Integrating time into stigma and health research. *Nature Reviews Psychology*, 1(4), 236-247. Chicago.
- Fischer, L. S., Mansergh, G., Lynch, J., & Santibanez, S. (2019). Addressing disease-related stigma during infectious disease outbreaks. *Disaster medicine and public health preparedness*, 13(5-6), 989-994. doi: 10.1017/dmp.2018.157
- Fisher, A. N., & Ryan, M. K. (2021). Gender inequalities during COVID-19. *Group Processes & Intergroup Relations*, 24(2), 237-245. doi: [10.1177/1368430220984248](https://doi.org/10.1177/1368430220984248)
- Gadassi Polack, R., Sened, H., Aubé, S., Zhang, A., Joormann, J., & Kober, H. (2021). Connections during crisis: Adolescents' social dynamics and mental health during COVID-19. *Developmental Psychology*, 57(10), 1633. doi: [10.1037/dev0001211](https://doi.org/10.1037/dev0001211)
- Gallagher-Mackay, K., Srivastava, P., Underwood, K., Dhuey, E., McCready, L., Born, K., ... & Sander, B. (2021). COVID-19 and education disruption in Ontario: Emerging evidence on impacts. <https://doi.org/10.47326/ocsat.2021.02.34.1.0>
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Simon and Schuster.
- Guenther, L. (2019). Critical phenomenology. *50 concepts for a critical phenomenology*, 11-16.
- Government of Ontario (2022). Ontario Expanding Access to Free Rapid Tests for General Public [News Release]. Retrieved from: <https://news.ontario.ca/en/release/1001575/ontario-expanding-access-to-free-rapid-tests-for-general-public>
- James, C. E. (2019). Community, Schooling, and the education of racialized students: a

postscript. *Critical Schooling: Transformative Theory and Practice*, 327-338. doi:
[10.1007/978-3-030-00716-4_14](https://doi.org/10.1007/978-3-030-00716-4_14)

- Jenerette, C. M., & Brewer, C. (2010). Health-related stigma in young adults with sickle cell disease. *Journal of the National Medical Association*, 102(11), 1050-1055. doi: 10.1016/s0027-9684(15)30732-x
- Khanna, R. C., Cicinelli, M. V., Gilbert, S. S., Honavar, S. G., & Murthy, G. V. (2020). COVID-19 pandemic: Lessons learned and future directions. *Indian journal of ophthalmology*, 68(5), 703. doi: 10.4103/ijo.IJO_843_20
- Kohrt, B. A., Turner, E. L., Rai, S., Bhardwaj, A., Sikkema, K. J., Adelekun, A., ... & Jordans, M. J. (2020). Reducing mental illness stigma in healthcare settings: proof of concept for a social contact intervention to address what matters most for primary care providers. *Social Science & Medicine*, 250, 112852. doi: 10.1016/j.socscimed.2020.112852
- Koller, M., & Stuart, H. (2016). Reducing stigma in high school youth. *Acta Psychiatrica Scandinavica*, 134, 63-70. <https://doi.org/10.1111/acps.12613>
- Kong, J., Ip, J., Huang, C., & Lin, K. (2021). A year of racist attacks: Anti-Asian racism across Canada one year into the Covid-19 pandemic. *Toronto, Canada. Chinese Canadian National Council Toronto*.
- Lee, E. J., Cho, O. Y., Wang, K. H., & Jang, M. J. (2021). Corelation between nurses' posttraumatic stress disorder, depression and social stigma in nursing COVID-19 patients. *Journal of East-West Nursing Research*, 27(1), 14-21.
- Lehmann, S., Skogen, J. C., Haug, E., Mæland, S., Fadnes, L. T., Sandal, G. M., ... & Bjørknes,

- R. (2021). Perceived consequences and worries among youth in Norway during the COVID-19 pandemic lockdown. *Scandinavian Journal of Public Health, 49(7)*, 755-765. doi: 10.1177/1403494821993714
- Leigh, J. P., Moss, S. J., Tiifu, F., FitzGerald, E., Brundin-Mathers, R., Dodds, A., ... & Ng-Kamstra, J. (2022). Lived experiences of Asian Canadians encountering discrimination during the COVID-19 pandemic: a qualitative interview study. *Canadian Medical Association Open Access Journal, 10(2)*, E539-E545. doi: 10.9778/cmajo.20220019
- Link, B. G., DuPont-Reyes, M. J., Barkin, K., Villatoro, A. P., Phelan, J. C., & Painter, K. (2020). A school-based intervention for mental illness stigma: A cluster randomized trial. *Pediatrics, 145(6)*. doi: 10.1542/peds.2019-0780
- Lohiniva, A. L., Dub, T., Hagberg, L., & Nohynek, H. (2021). Learning about COVID-19-related stigma, quarantine and isolation experiences in Finland. *PloS one, 16(4)*, e0247962. doi: [10.1371/journal.pone.0247962](https://doi.org/10.1371/journal.pone.0247962)
- Lu, Y., Baumler, E., Wood, L., Le, V. D., Guillot-Wright, S. P., & Temple, J. R. (2023). Racial discrimination and interpersonal violence in Asian American adolescents during the COVID-19 pandemic. *Journal of Adolescent Health, 74(2)*, 246-251. doi: 10.1016/j.jadohealth.2023.09.016
- Ma, Y., & Zhan, N. (2022). To mask or not to mask amid the COVID-19 pandemic: How Chinese students in America experience and cope with stigma. *Chinese Sociological Review, 54(1)*, 1-26. doi: [10.1080/21620555.2020.1833712](https://doi.org/10.1080/21620555.2020.1833712)
- Malterud, K., Siersma, V.D., & Guassora, A.D. (2016). Sample size in qualitative interview studies: guided by information power. *Qualitative health research, 26(13)*, 1753-1760. doi: [10.1177/1049732315617444](https://doi.org/10.1177/1049732315617444)

- Mamuji, A. A., Lee, C., Rozdilsky, J., D'Souza, J., & Chu, T. (2021). Anti-Chinese stigma in the Greater Toronto Area during COVID-19: Aiming the spotlight towards community capacity. *Social Sciences & Humanities Open*, 4(1), 100232.
- Manik, M. J., & Natalia, S. (2021). Social stigma towards nurses taking care of patients with COVID-19 in Indonesia: A mixed-methods study. *Belitung Nursing Journal*, 7(2), 98. doi: 10.33546/bnj.1322
- Misra, S., Le, P. D., Goldmann, E., & Yang, L. H. (2020). Psychological impact of anti-Asian stigma due to the COVID-19 pandemic: A call for research, practice, and policy responses. *Psychological Trauma: Theory, Research, Practice, and Policy*, 12(5), 461. doi: [10.1037/tra0000821](https://doi.org/10.1037/tra0000821)
- Mishra, S., Ma, H., Moloney, G., Yiu, K. C., Darvin, D., Landsman, D., ... & Baral, S. D. (2022). Increasing concentration of COVID-19 by socioeconomic determinants and geography in Toronto, Canada: an observational study. *Annals of epidemiology*, 65, 84-92. doi: [10.1016/j.annepidem.2021.07.007](https://doi.org/10.1016/j.annepidem.2021.07.007)
- Omri, N., Mlouki, I., Sfar, H., Ben Youssef, F., Jandoubi, M., & El Mhamdi, S. (2021). Discriminatory attitudes against people tested for coronavirus in the region of Mahdia (Tunisia). *European Journal of Public Health*, 31(Supplement_3), ckab165-118.
- Ontario Ministry of Education. (2020). *Operational guidance: COVID-19 management in schools*. Retrieved from the Ontario Ministry of Education website: <https://www.ontario.ca/page/operational-guidance-covid-19-management-schools>
- Ontario. Ministry of Health; Ministry of Long-Term Care. *COVID-19: guidance for the health*

sector [Internet]. Retrieved from:

https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/2019_guidance.aspx#health

- Pan, S. W., Shen, G. C., Liu, C., & Hsi, J. H. (2021). Coronavirus stigmatization and psychological distress among Asians in the United States. *Ethnicity & health, 26*(1), 110-125. doi: [10.1080/13557858.2020.1849570](https://doi.org/10.1080/13557858.2020.1849570)
- Pasay-An, E., Alshammari, F., Mostoles Jr, R., Gattud, V., Cajigal, J., & Buta, J. (2021). A qualitative study on nurses' experiences with social stigma in the context of COVID-19. *Enferm. Clinica, 32*, 75-82.
- Public Health Ontario (2022). COVID-19 in Ontario: January 15, 2020 to June 14, 2022. Retrieved from: <https://www.publichealthontario.ca/-/media/documents/ncov/epi/covid-19-daily-epi-summary-report.pdf?la=en>
- Ransing, R., Ramalho, R., de Filippis, R., Ojeahere, M. I., Karaliuniene, R., Orsolini, L., ... & Adiukwu, F. (2020). Infectious disease outbreak related stigma and discrimination during the COVID-19 pandemic: drivers, facilitators, manifestations, and outcomes across the world. *Brain, behavior, and immunity, 89*, 555.
- Rössler, W. (2016). The stigma of mental disorders: A millennia-long history of social exclusion and prejudices. *EMBO reports, 17*(9), 1250-1253.
- Sahoo, S., Mehra, A., Suri, V., Malhotra, P., Yaddanapudi, L. N., Puri, G. D., & Grover, S. (2020). Lived experiences of the corona survivors (patients admitted in COVID wards): a narrative real-life documented summaries of internalized guilt, shame, stigma, anger. *Asian journal of psychiatry, 53*, 102187. doi: [10.1016/j.ajp.2020.102187](https://doi.org/10.1016/j.ajp.2020.102187)
- Scambler, G. (2009). Health-related stigma. *Sociology of health & illness, 31*(3), 441-455.

Simeone, S., Rea, T., Guillari, A., Vellone, E., Alvaro, R., & Pucciarelli, G. (2021, December).

Nurses and stigma at the time of COVID-19: A phenomenological study.

In *Healthcare* (Vol. 10, No. 1, p. 25). MDPI. doi: [10.3390/healthcare10010025](https://doi.org/10.3390/healthcare10010025)

Stangl, A. L., Earnshaw, V. A., Logie, C. H., van Brakel, W., C Simbayi, L., Barré, I., &

Dovidio, J. F. (2019). The Health Stigma and Discrimination Framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. *BMC medicine*, *17*(1), 1-13. doi: [10.1186/s12916-019-1271-3](https://doi.org/10.1186/s12916-019-1271-3)

Statistics Canada. 2017. *Canada [Country] and Canada [Country]* (table). *Census Profile*.

2016 Census. Statistics Canada Catalogue no. 98-316-X2016001. Ottawa. Released November 29, 2017. <https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E>

Statistics Canada. 2022. Asian Heritage Month 2022... by the numbers. Ottawa. Modified May

11, 2022. https://www.statcan.gc.ca/en/dai/smr08/2022/smr08_262

Statistics Canada (2023). Asian Heritage Month 2023... by the numbers. Retrieved from

https://www.statcan.gc.ca/en/dai/smr08/2023/smr08_272

Stuber, J., Meyer, I., & Link, B. (2008). Stigma, prejudice, discrimination and health. *Social science & medicine* (1982), *67*(3), 351.

Thobani, S. (2017). Nationals, Citizens, and Others.”. *Asian Canadian Studies Reader*, 29-48.

Thorne, S., Kirkham, S. R., & MacDonald-Emes, J. (1997). Interpretive Description: a noncategorical qualitative alternative for developing nursing knowledge. *Research in nursing & health*, *20*(2), 169-177.

Thorne, S., Con, A., McGuinness, L., McPherson, G., & Harris, S. R. (2004). Health care communication issues in multiple sclerosis: an interpretive description. *Qualitative health*

research, 14(1), 5-22. doi: [10.1177/1049732303259618](https://doi.org/10.1177/1049732303259618)

Thorne, Sally. *Interpretive Description: Qualitative research for applied practice*. Routledge, 2016.

Toronto Metropolitan University (2022). Update on the fall 2022 semester

Retrieved from: <https://www.torontomu.ca/news-events/news/2022/06/update-on-the-fall-2022-semester/>

Trent, M., Dooley, D. G., Dougé, J., Cavanaugh, R. M., Lacroix, A. E., Fanburg, J., ... & Wallace, S. B. (2019). The impact of racism on child and adolescent health. *Pediatrics*, 144(2). doi: [10.1542/peds.2019-1765](https://doi.org/10.1542/peds.2019-1765)

Tsukuda, M., Kayano, T., & Yoshiyasu, I. T. O. (2022). Experiences of COVID-19-Related Stigma: A Qualitative Study on Nurses Caring for Patients With COVID-19. *Journal of Nursing Research*, 30(6), e241. doi: 10.1097/jnr.0000000000000528

Ugidos, C., López-Gómez, A., Castellanos, M. Á., Saiz, J., González-Sanguino, C., Ausín, B., & Muñoz, M. (2022). Evolution of intersectional perceived discrimination and internalized stigma during COVID-19 lockdown among the general population in Spain. *International Journal of Social Psychiatry*, 68(1), 55-63. doi: 10.1177/0020764020975802

University of Toronto (2022). COVID-19 planning updates. Retrieved from:

<https://www.utoronto.ca/utogether/covid-19-planning-update>

Van Daalen, K. R., Cobain, M., Franco, O. H., & Chowdhury, R. (2021). Stigma: the social virus spreading faster than COVID-19. *J Epidemiol Community Health*, 75(4), 313-314. doi: 10.1136/jech-2020-214436

Weiss, M. G., Ramakrishna, J., & Somma, D. (2006). Health-related stigma: rethinking concepts

and interventions. *Psychology, health & medicine*, 11(3), 277-287. doi:

10.1080/13548500600595053

Werner, P., AboJabel, H., & Tur-Sinai, A. (2022). Ageism towards older and younger people in the wake of the COVID-19 Outbreak. *Maturitas*, 157, 1-6. doi:

10.1016/j.maturitas.2021.11.002

Wu, C., Wilkes, R., Qian, Y., & Kennedy, E. B. (2020). Acute discrimination and East Asian-white mental health gap during COVID-19 in Canada. *Available at SSRN 3626460*.

Yuan, Y., Zhao, Y. J., Zhang, Q. E., Zhang, L., Cheung, T., Jackson, T., ... & Xiang, Y. T. (2021). COVID-19-related stigma and its sociodemographic correlates: a comparative study. *Globalization and health*, 17(1), 1-9. doi: 10.1186/s12992-021-00705-4

Appendix A

Definitions:

Stigma: “an attribute that links a person to an undesirable stereotype, leading other people to reduce the bearer from a whole and usual person to a tainted, discounted one”

Prejudice: an aversive or hostile attitude toward a person who belongs to a group, simply because he belongs to that group, and is therefore presumed to have the objectionable qualities ascribed to the group

Health-Related Stigma: the stigmatization experienced due to a health condition or disease

Adolescent: For this study, an adolescent is a youth in their teenage years (13-19 years), but the participants will be at least sixteen years old.

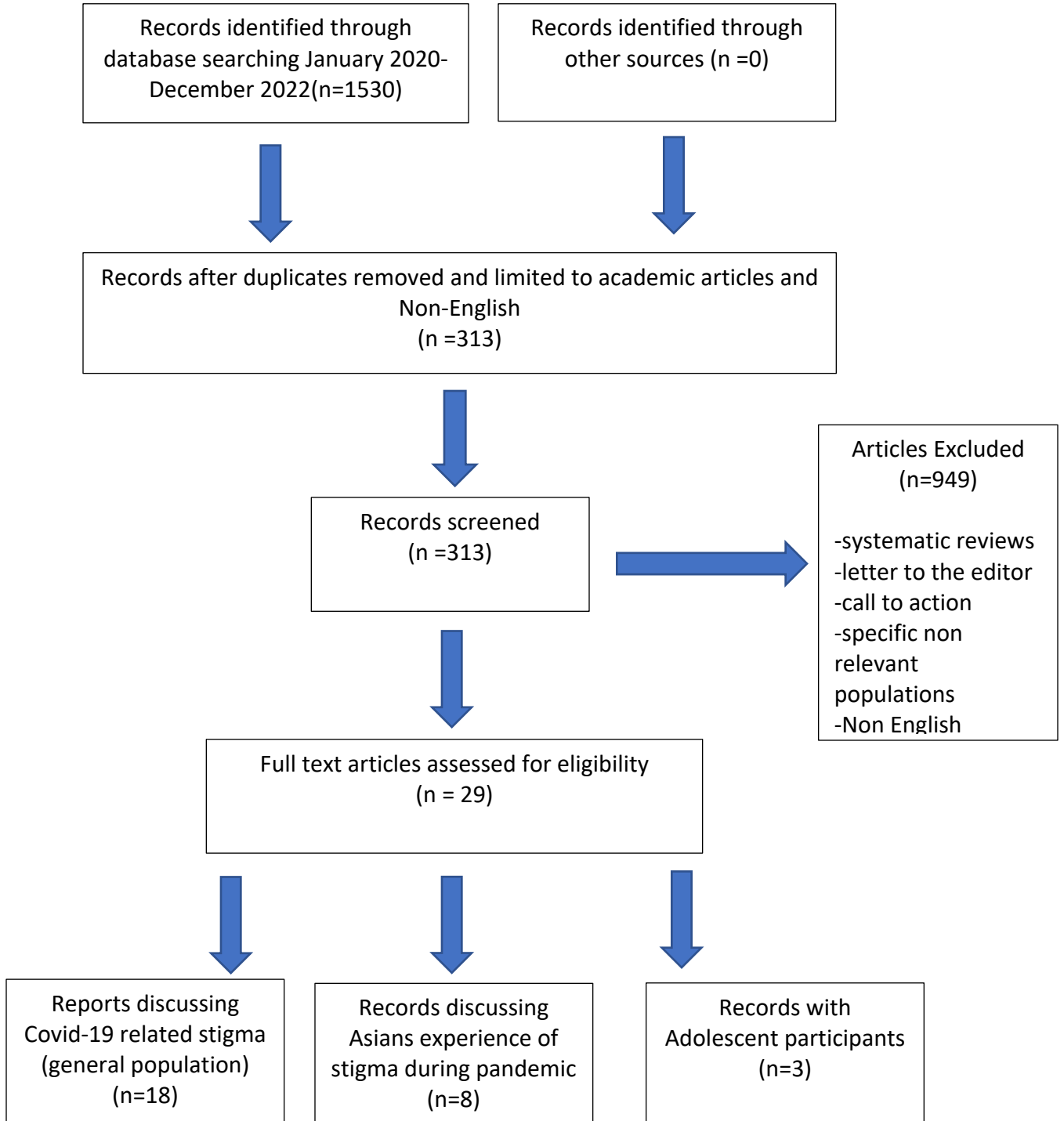
Covid-19

East Asian: For this study, East Asian refers to individuals with a family country of origin from the following countries: China (including Taiwan, Hong Kong), Korea and Japan

Southeast Asian: For this study, Southeast Asian refers to individuals with a family country of origin from the following countries: Cambodia, Laos, Malaysia, Myanmar, Nepal the Philippines, Thailand, Vietnam

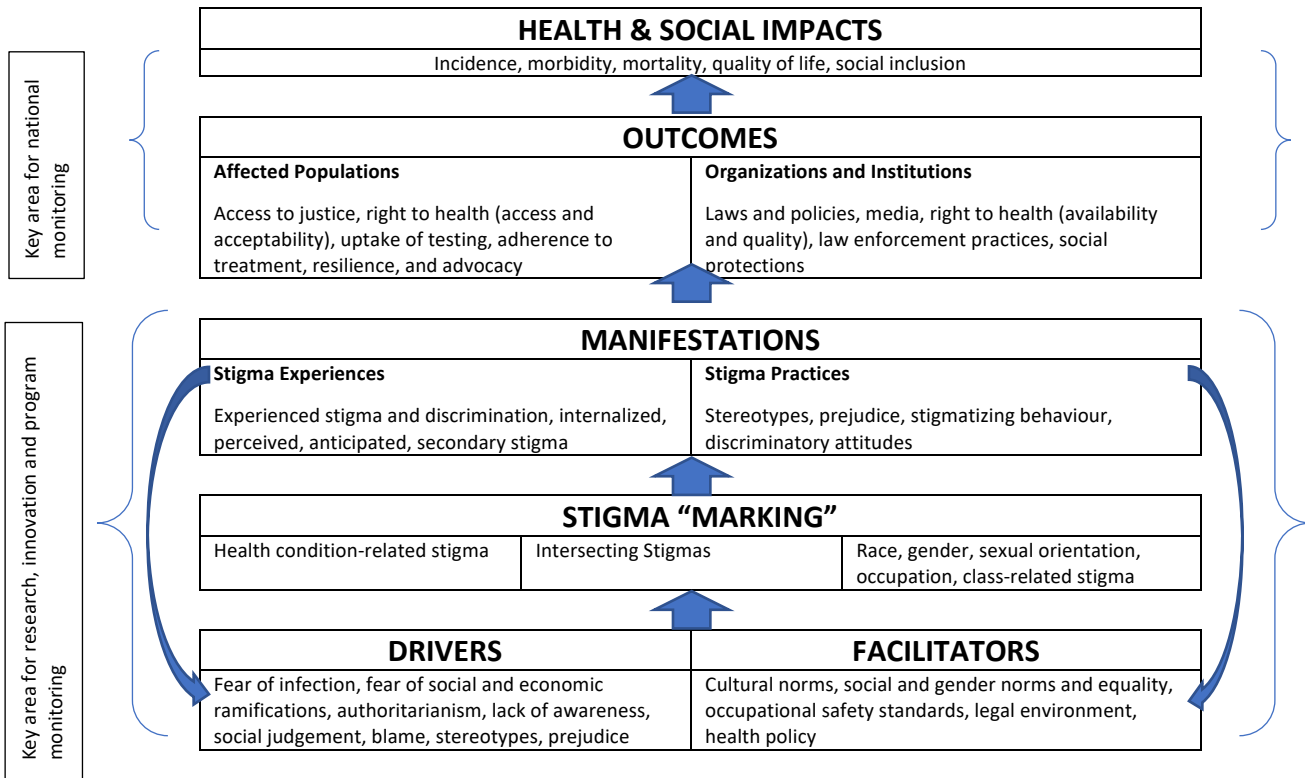
Appendix B

Literature Search Prisma



Appendix C

Health Stigma and Discrimination Framework (retrieved from Stangle et al., 2019)



Appendix D
Demographic Questionnaire

Please answer the following questions

1. How old were you on your last birthday?
_____ years old

2. To which gender identity do you most identify?"

- Male
- Female
- Transgender
- Gender Non-conforming/non-binary
- Not listed _____
- Prefer not to answer

3. What grade/year are you in?

4. How would you describe yourself (i.e. Chinese Canadian, Filipino Canadian, etc.)

5. When did you test positive for COVID-19?

6. How many times did you test positive?

7. Did you attend school onsite during the 2020-2021 school year

- Yes
- No

8. Did you attend school onsite during the 2021-2022 school year

- Yes
- No

Appendix E

Discussion Questions (Lohiniva et al., 2021)

Discussion with coronavirus quarantined or isolated family members

1. Let us start talking about your experiences with quarantine / isolation?
 - Probes: How did it all start? What happened next?
2. How did people treat you during your quarantine/ isolation?
 - Probes: Can you tell me some examples of situations in which you felt being treated negatively?
3. How was your experience at school after returning from quarantining?
 - Probes: any reactions from other students, staff?
4. How do you think these experiences impacted you?
 - Can you give me some concrete examples?
5. What do you think people in general think of people associated with coronavirus in Toronto/Canada?
6. Did you experience any interactions related to your racial background during the pandemic?
 - Probes: Can you tell me some examples of situations in which you felt being treated negatively?
7. What do you think people in general think of people of East/Southeast Asian descent in Toronto/Canada?
8. How did you feel about yourself during quarantine/isolation?
 - Probes: What kind of negative feelings and positive did you have towards self?
9. From where do you think these feelings came from?
10. How did these feelings impact you?
11. From where and how did you receive COVID-19 and quarantine/ isolation related information?
12. What can you tell me about your everyday life and routines during quarantine/ isolation?

- Probe: you make special arrangements to avoid contact with other household members?
13. Tell me about COVID-19 and quarantine/ isolation related information that you received during quarantine/isolation.
 14. What has been the most memorable or significant issue in your quarantine/isolation experience?
 15. Is there anything you would like to share with regards to health-related stigma and Asian identity that we haven't discussed?

Thank you very much for your participation!

Appendix F

In-Person Informed Consent Form

Date: March 8, 2022

Study Name: Asian Immigrant adolescent Experiences of Health-Related Stigma During the COVID-19 Pandemic

Researcher name: Nasteo Hasan, RN, MScN [Candidate], York University. nhasan28@yorku.ca. Nazilla Khanlou, RN. PhD, York University nkhanlou@yorku.ca, Iris Epstein, RN. PhD, York University, iepstein@yorku.ca

Purpose of the Research:

- The purpose of this study is to explore Asian-immigrant adolescents' experiences of health-related stigma after contracting COVID-19.

What You Will Be Asked to Do in the Research:

- Participants will complete a demographic survey questionnaire about themselves
- Participants will then be asked over the phone or in-person open-ended questions about their experiences with stigmatization after testing positive for COVID-19 and any Anti-Asian stigmatization they may have also felt
- The estimated total time commitment of the study is about one hour.

Risks and Discomforts: The interview discussion may bring up some uncomfortable conversations related to stigmatization and racism. Participants are able to take breaks if needed and are free to stop if unable to continue.

We do not foresee any risks or discomfort from your participation in the research.

Benefits of the Research and Benefits to You: This research will help learn more about how Asian Canadian adolescents have been experiencing stigma after testing positive for COVID-19. We will also learn more about the intersecting effects of race on health-related stigma. You will be able to provide some of your unique experiences during the pandemic.

Voluntary Participation and Withdrawal: Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer, to stop participating, or to refuse to answer particular questions will not influence the nature of the ongoing relationship you or your child may have with the researchers or study staff, or the nature of your relationship with York University either now, or in the future. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

Unless you choose otherwise all information you supply during the research will be held in confidence and unless you specifically indicate your consent, your name will not appear in any report or publication of the research. Some data will be collected through an online survey link (Survey Monkey). Signed consent forms will be safely stored in a locked location, and your research data will be safely stored in a secure password-protected electronic database, and only the researcher will have access to this information. The data collected from the study will be stored until December 31, 2027, and will be destroyed after the study. Confidentiality will be provided to the fullest extent possible by law.

The researcher(s) acknowledge that the host of the online survey (Survey Monkey) may automatically collect participant data without their knowledge (i.e., Internet Protocol (IP) addresses.) Although this information may be provided or made accessible to the researchers, it will not be used or saved without the participant's consent on the researcher's system. Further, "Because this project employs e-based collection techniques, data may be subject to access by third parties as a result of various security legislation now in place in many countries and thus *the confidentiality and privacy of data cannot be guaranteed during web-based transmission.*

Questions About the Research? If you have questions about the research in general or about your child's role in the study, please feel free to contact me at nhasan28@yorku.ca or my supervisor, Dr. Nazilla Khanlou, PHD at nkhanlou@yorku.ca and. You may also contact the Program in York University School of Nursing at nursing@yorku.ca and/or (416)-736-5271

This research has received ethics review and approval by the Delegated Ethics Review Committee, which is delegated authority to review research ethics protocols by the Human Participants Review Sub-Committee, York University's Ethics Review Board, and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, Kaneff Tower, York University (telephone 416-736-5914 or e-mail ore@yorku.ca).

Legal Rights and Signatures:

I, _____ consent to participate in *Asian Immigrant Adolescent Experiences of Health-Related Stigma During the COVID-19 Pandemic* conducted by Nastehe Hasan. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature _____
Participant

Date _____

Signature _____
Principal Investigator

Date _____

Appendix G

Zoom Informed Consent Form

Date:

Study Name: Asian Immigrant adolescent Experiences of Health-Related Stigma During the COVID-19 Pandemic

Researcher name: Nasteho Hasan, RN, MScN, Candidate [Principal Investigator], York University. nhasan28@yorku.ca. Nazilla Khanlou, RN. PhD, York University, Iris Epstein, RN. PhD, York University, Lisa Seto-Nielsen, RN, PhD

Purpose of the Research:

- The purpose of this study is to explore Asian-immigrant adolescents' experiences of health-related stigma after contracting COVID-19. The methodology will include a one-hour interview and the data and findings will be presented in a thesis. The findings may also be presented at conferences and in academic publications

What You Will Be Asked to Do in the Research:

- Participants will complete a demographic survey questionnaire about themselves
- Participants will then be asked over the phone or in-person open-ended questions about their experiences with stigmatization after testing positive for COVID-19 and any Anti-Asian stigmatization they may have also felt
- The estimated total time commitment of the study is about one hour.
- You will receive \$20 for your participation

Risks and Discomforts: The interview discussion may bring up some uncomfortable conversations related to stigmatization and racism. Participants are able to take breaks if needed and are free to stop if unable to continue.

Benefits of the Research and Benefits to You: This research will help learn more about how Asian Canadian adolescents have been experiencing stigma after testing positive for COVID-19. We will also learn more about the intersecting effects of race on health-related stigma. You will be able to provide some of your unique experiences during the pandemic.

Voluntary Participation and Withdrawal: Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer, to stop participating, or to refuse to answer particular questions will not influence the nature of the ongoing relationship you may have with the researchers or study staff, or the nature of your relationship with York University either now, or in the future. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible. If you decide to stop participating, you may withdraw without penalty, financial or otherwise, and you will still receive the promised inducement.

Confidentiality: Unless you choose otherwise all information you supply during the research will be held in confidence and unless you specifically indicate your consent, your name will not appear in any report or publication of the research. Some data will be collected through an online survey link (Survey Monkey). Signed consent forms will be safely stored in a locked location, and your research data will be

safely stored in a secure password-protected electronic database, and only the researcher will have access to this information. The data collected from the study will be stored until August 31, 2028, and will be destroyed after the study. Confidentiality will be provided to the fullest extent possible by law.

This study will use the platform Zoom to collect data, which is an externally hosted cloud-based service. When information is transmitted over the internet privacy cannot be guaranteed. There is always a risk your responses may be intercepted by a third party (e.g., government agencies, or hackers). Further, while York University researchers will not collect or use IP addresses or other information which could link your participation to your computer or electronic devices without informing you, there is a small risk with any platform such as this of data that is collected on external servers falling outside the control of the research team. If you are concerned about this, we would be happy to make alternative arrangements (where possible) for you to participate, perhaps via telephone. Please contact the researcher for further information. Recordings (audio/video) will be saved in a password-protected file to research team members' local computers, not the cloud-based service. Please note that it is the expectation that participants agree not to make any unauthorized recordings of the content of a meeting/data collection session.

The researcher(s) acknowledge that the host of the online survey (Survey Monkey) may automatically collect participant data without their knowledge (i.e., IP addresses.) Although this information may be provided or made accessible to the researchers, it will not be used or saved without the participant's consent on the researcher's system. Further, because this project employs e-based collection techniques, data may be subject to access by third parties as a result of various security legislation now in place in many countries and thus *the confidentiality and privacy of data cannot be guaranteed during web-based transmission.*

Questions About the Research? If you have questions about the research in general or about your role in the study, please feel free to contact me at nhasan28@yorku.ca or my supervisor, Dr. Nazilla Khanlou, PHD at nkhanlou@yorku.ca and. You may also contact the Program in York University School of Nursing at nursing@yorku.ca and/or (416)-736-5271

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Legal Rights and Signatures:

I, _____ consent to participate in *Asian Immigrant Adolescent Experiences of Health-Related Stigma During the COVID-19 Pandemic* conducted by Nasteho Hasan. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature _____
Participant

Date _____

Signature _____
Principal Investigator

Date _____

Additional consent

1. Audio recording

I consent to the audio-recording of my interview(s).

2. Video recording

I consent to the videorecording of my interview(s).

Signature _____
Participant Name:

Date _____

Appendix H

Recruitment Poster

Recruitment Flyer Volunteers Needed for Study on COVID-19 Stigma

Are you of East Asian or Southeast Asian descent between the ages of 16-19? Did you contract COVID-19 during the pandemic? You may be eligible to participate in a study to explore your experiences.

You May Qualify If You

- Are between 16 and 19 years old
- Are of East Asian or Southeast Asian descent
- Tested positive for COVID-19 during the pandemic
- Attended school onsite during the pandemic

Potential Benefits

Participating in this study will help us learn about the experiences of Asian Canadian adolescents after testing positive for COVID-19.

Participation Involves

- Completing an online demographic form
- Answering interview questions about your lived experiences from a researcher
- The Interview will take approximately 1 hour

Location: Virtually (via telephone or Zoom) OR in-person York University Toronto, Ontario

Participants will be compensated \$20 for their participation

To participate in this study please contact Nasteho Hasan at 647-575-2891 or email nhasan28@yorku.ca.

*Approved by York University's Research Ethics Board
