Received: 8 March 2024 | Revised: 21 May 2024 | Accepted: 10 June 2024

DOI: 10.1002/casp.2840

RESEARCH ARTICLE

WILEY

Health citizenship reveals ‘extra’ work managing biopolitical risk for immigrants in Canada during COVID-19: A qualitative study

Doris Y. L. Leung[1] | **Sepali Guruge**[2] | **Angel H. Wang**[2] | **Charlotte Lee**[2]

[1]School of Nursing, The Hong Kong Polytechnic University, Kowloon, Hong Kong

[2]Daphne Cockwell School of Nursing, Toronto Metropolitan University, Toronto, Ontario, Canada

Correspondence
Doris Y. L. Leung, School of Nursing, The Hong Kong Polytechnic University, Kowloon, Hong Kong.
Email: doris.leung@polyu.edu.hk

Sepali Guruge, Daphne Cockwell School of Nursing, Toronto Metropolitan University, 350 Victoria Street, Toronto, ON M5B 2K3, Canada.
Email: sguruge@torontomu.ca

Funding information
Toronto Metropolitan University

Abstract

One's health security (i.e., the ability to minimize risks and respond to public health threats) is a conferred right of citizenship but individuals construct identities during the process of securing their health. However, how this occurs, in relationship to the state, remains largely implicit or taken-for-granted. The Coronavirus Disease 2019 (COVID-19)' provided a unique opportunity to explore the relationship between oneself and governing social norms of health citizenship. We drew on secondary analysis of data from a previous (published) qualitative descriptive study that was conducted during May to September 2020 of COVID-19, to explore 72 immigrants' experience (from 21 countries) of health security in the Greater Toronto Area, Canada. Data were collected through semi-structured interviews and analysed using critical realism. The majority of participants were women. We demonstrate how individuals implicitly engaged in ‘extra’ work—gendered and driven by mechanisms of good citizenship—connected to the will to health, against ethopolitical work to regulate risks, of and for themselves, in public discourse. Public discourse tended to follow racialized hegemonic norms, which also reproduced systemic cultural racism. We argue that empathetic understanding of this process is conducive to enhancing one's resistance to stereotypes, and to bolstering immigrants' resilience to seeking health security during public health emergencies.

KEYWORDS
citizenship, COVID-19, critical realism, health security, human rights, immigrants, qualitative approaches

1 | INTRODUCTION

In this article, citizenship is defined as a performative social construct of how one's rights and entitlements play out in everyday lives (public and private) in relationship to the states' ethical principles of access, equality, and responsibility of participation (Jauho & Helén, 2022). Within this discourse, common goods of health are broadly grounded in governing the biological as well as the social citizen (Jauho & Helén, 2022). This occurs through 'rationale and practices of modern government that attempt to juggle the tensions between the freedom of the economic market and the need to solve social problems and provide social security' (Jauho & Helén, 2022, p. 3).

Netz, Lempp, Krause, and Schramm (2019) define biological citizenship as a 'kind of social governance' whereby 'one's body itself becomes the grounds of claiming rights,' in accordance to principles of distributive justice, that is, socially just or fair allocation of resources (Netz et al., 2019, p. 641). Hence, in this article, health citizenship refers to socially constructed responsibilities (including, roles to enact responsibilities) in the pursuit of public value and mitigating risks, to deserve the state's common goods of health. Indeed, citizens are judged against 'ethopolitics', in reference to:

> self-techniques by which human beings should judge themselves and act upon themselves to make themselves better than they are…coalescing around a kind of vitalism: disputes over the value to be accorded to life itself: 'quality of life', 'right to life' or the 'right to choose', euthanasia, gene therapy, human cloning, and the like (Rose, 2001, p. 18).

Our changing bodies and evolving laws (such as public health policies) transform our rights, responsibilities, and roles for claiming and accessing healthcare in encounters with state institutions (Komporozos-Athanasiou, Fudge, Adams, & McKevitt, 2018; Netz et al., 2019). However, how this occurs, to shape one's experiences of health (in) security remains largely implicit or taken-for-granted.

2 | HEALTH CITIZENSHIP AND A WILL TO HEALTH

Based on these premises, our research aims were to explain mechanisms of citizenship connected to the identity of immigrant groups, and to their self-determination and agency to access common goods of health during the first wave of the Coronavirus Disease 2019 (COVID-19). Spoel, Lacelle, and Millar (2023) suggest public health discourse in British Columbia, Canada, during the COVID-19 pandemic (first wave) compelled a 'communal ethos' that 'increased the burden of personal responsibility for health beyond norms of self-care'; moreover, presumptions of this identity excluded citizens who lacked the means to fulfil the expectations of 'good covid citizenship' (p. 770). Aligned with this, we suggest immigrants engaged in ethopolitics to make sense of public health discourse and engage in, what Rose (2001) describes as, a 'will to health.'

Specifically, Rose (2001) refers to a will to health as seeking health, not as an avoidance of sickness or premature death, but overall 'well-being' through 'self-health' (i.e., beauty, success, happiness, etc.). Organizations (e.g., pharmaceutical companies) and communities (e.g., self-help groups) govern 'at a distance', numerous ways individuals can understand and enact this freedom (Rose, 2001, p. 6).

For this article, we draw on Ellermann (2020) to define immigrants/migrants as individuals that maintain identification with, or belonging to, their ancestral homeland, even after living outside their country of origin, regardless of whether they are born in Canada or spent many years outside their ancestral country of origin. This definition acknowledges how immigration and citizenship policy continues to create precarities and loss of status among migrants, of whom are socially mapped onto group identities of gender, race/ethnicity, nationality, religion, and class (Ellermann, 2020, p. 2463). Indeed, how one negotiates group-based distinctions, such as, language acquisition, civic knowledge, financial savings, and full-time employment, are integral parts of societal social structures, which are converted into social capital, and demarcates our belonging (or not) as a citizen (Ellermann, 2020).

Social structures of health citizenship, in principle, grant access to common goods of health dependent on one's agency (partially embodied in pre-existing identity markers, such as language and religion; Ellermann, 2020) and how persons are situated (i.e., social determinants of health) (Komporozos-Athanasiou et al., 2018). In what follows, we will provide the context of the Canadian healthcare system, define terms of common goods of health for health (in) security, and review past literature about the work to access common goods of health. This combined understanding provides readers the context (and presuppositions) for the authors' approach to the key constructs in the research.

3 | THE CANADIAN HEALTHCARE SYSTEM

The Canadian healthcare system is publicly funded and known for principles valuing equity, to allow all citizens and permanent residents to access 'medically necessary' hospital and physician services free at the point of delivery (Allin, Marchildon, & Peckham, 2020). However, healthcare services often exclude: dental care, home care, psychological assessments, and certain outpatient prescription drugs (Allin et al., 2020). The latter services are dependent on access and knowledge of private or employment health insurance, affordability, health literacy, trust in public or private healthcare services, English language fluency, geographical proximity to services, and one's cultural orientation to overcome stigmatization and discrimination (Niraula et al., 2023).

4 | COMMON GOODS FOR HEALTH AND HEALTH (IN)SECURITY

The World Health Organization (WHO, 2021) defines *common goods for health* as access to 'core population-based functions or interventions requiring collective financing, such as disease control policies and strategies', (p. 1) to protect and promote individuals' 'will to health' (Rose, 2001). In other words, citizens are granted right to access health, as 'a state of physical, mental, and social well-being, irrespective of disease or infirmity' (WHO, 2011). Common goods of health provide access to essential medicines, procurement of personal protective equipment (e.g., masks, eye protection, gloves), equitable distribution of information and surveillance (e.g., disease testing and tracing), and public health goods and services (e.g., health promotion education, infrastructure to access healthcare) (United Nations, 2020).

The means by which common goods of health are procured depends on the political community's prejudices and assumptions (at all levels of government), which include fundamental (dominant) 'assumptions of justice, the authority to rule, personhood, and other fundamental considerations' (Atterbury & Rowe, 2017, p. 274). Historically, these conceptions have been socially produced by political powers to exclude women, people of colour, persons with mental illness, and others (Atterbury & Rowe, 2017). As such, common goods of health may be denied to those who are perceived as outside the dominant group(s) or not meeting the roles and responsibilities of civic participation by those who rule (Atterbury & Rowe, 2017; Spoel et al., 2023).

> Determinations of the common good are often constructed and organized to exclude the needs, interests, and choices of citizens deemed to be dependent (Atterbury & Rowe, 2017, p. 274).

Therein lies a prejudice towards those deemed ‘dependent’ (e.g., older persons, ill persons, children), or engaged in unpaid labour, as paid labour is assumed to be part of being an ‘active’ citizen (Cunningham-Burley, Backett-Milburn, & Kemmer, 2006).

We argue that the essential work of non-healthcare domestic labour (i.e., those in transport, food production, and distribution work, or engaged in unpaid household cleaning, childcare, eldercare) during the first wave of COVID-19 was a prominent concern; particularly if one lacked, or was limited to, engaging in domestic labour; or were engaged in paid domestic labour but were unable to procure common goods of health (e.g., janitors, homecare workers for the elderly) (Pandey, Parreñas, & Sabio, 2021). Common goods of health were crucial when persons could not sustain social measures, for which they were reliant on, to reduce exposure to COVID-19 when COVID-19 vaccines were not available in Canada during December 2019 to mid-December 2020 (Semenza et al., 2021).

5 | AGENCY AND CITIZENSHIP AS DETERMINANTS OF HEALTH

The very act of making claims to citizenship necessitates legal membership of the nation state (a ‘right-bearing subject’); not to be conflated with health citizenship, in reference to performing expected standards of liberal (i.e., productive and able-bodied) responsibilities and roles (Netz et al., 2019). Hence, in this article, we refer to health citizenship as the ways it is embodied in a will to health, and socially constructed in a relationship between the state and the individual (Jauho & Helén, 2022).

According to Jauho and Helén (2022), international events shape how one's relationship and resources are constructed, based on economic and cultural globalization and transnational migration. As a result, health citizenship can be characterized as, ‘citizenship by vitality’.

> Vitality refers to characteristics and capabilities of individuals and groups of people, which are biologically elementary, crucial for their viability, and often seen as congenital. Examples include physical health, mental abilities, hereditary characteristics, reproductive capacities, fitness for work, etc. (Jauho & Helén, 2022, p. 2).

Jauho and Helén (2022) argue that health citizenship in affluent western societies is a ‘double-edged sword’—bound to uphold principles of the nation-state and society through responsibilities to manage their vitality (e.g., lifestyle choices, self-monitoring), while also actively ‘entitled to, and demanding of personal protection, care, and even improvement of their vital capacities from public authorities’ (p. 14). Altogether, the performative work of accessing common goods of health, and its self-management, is universally assumed to be part of one's ‘civic duty’ (Andreouli & Brice, 2022).

5.1 | The work to access common goods of health

Citizenship is ‘civically minded’ performative work (Ellermann, 2020). Citizens construct their right to health, beginning with how one (bodily) identifies with (or differentiates the self from) the dominant group(s), such as their age group, their ethnic community, or a subculture with whom they share characteristics (e.g., disabilities) (Ponce &

Rowe, 2018). In doing so, individuals embody how they do (or do not) conform to normative cultural practices and intentionally construct identities of citizenship during the process of securing their health (Bauder, 2008). Specifically,

> every citizen must now become an active partner in the drive for health, accepting their responsibility for securing their own well-being (Rose, 2001, p. 6).

Drawing on Cunningham-Burley et al.'s (2006), citizenship is the labor to actively manage social and cultural meanings of health and sickness; these are characterized by one's values, and played out in the social production of everyday life in public and private practices, whether at home or at work. Hence, one's own self-conceptualization is assigned an understanding of citizenship, and may mean that some individuals regard themselves as belonging to a marginalized collective in domestic affairs; thus, as (dis)empowered to claim their 'will to health' and, by extension, to attain health security.

Health security is defined as the individual's agency (embodied in belonging to a collective) to prevent, detect, respond to, and prepare oneself for public health emergencies (Kandel, Chungong, Omaar, & Xing, 2020). In principle, health security does not *only* include an ability to access health services, according to liberal rights-based policies; rather, health security is shaped by historical configurations classifying groups 'according to their vital capacities and …different citizenship trajectories depending on these classifications' (Jauho & Helén, 2022, p. 9). For example, in a study in Edinburgh, Scotland, women who were engaged in domestic work portrayed themselves as 'reliable workers'; though their construction as such, conflicted with needs for 'sick leave' when workplace culture deterred taking absences for illness or caregiving (Cunningham-Burley et al., 2006). Hence, historical values in intersections of gender and class shape decisions of how one is prepared and responds to risks of health security.

Indeed, during the COVID-19 pandemic, the salience of historical antecedents of identity based on structural inequities, such as gender, socioeconomic status, and ethnicity, appeared to drive social constructions of how citizens were part of a larger 'whole'; and through health communication compelled to 'fulfil our part' of a commodification in how 'we were all (or all not) in it together' (Bowleg, 2020). This kind of ubiquitous health communication guided how one was responsible, and could or could not access common goods of health (e.g., health information of vaccination, disease testing); in other words, a commodification of how we were responsible to appraise our vitality enabling us to fulfil citizenship responsibilities to 'flatten the curve' (Bowleg, 2020).

Aligned with Bowleg (2020), we argue that health communication, during the first wave of COVID-19, highlighted the power differentials in how some groups were 'not in it together', through disproportionate risk to some based on their identification with intersections of gender, racial/ethnicity minority status, and class. We argue that the implicit association to one's identity was conveyed in health communication making apparent that: 'the riskiest and most stressful frontline jobs, deemed essential, were occupied by low pay, and the most marginalized persons in intersections of race/ethnicity, women, and undocumented workers' (Bowleg, 2020, p. 917). Hence, for marginalized groups, their agency was socially constructed in work in negotiat their health security against COVID-19 contagion—work defined as biopolitics—as part of enacting health citizenship (Jauho & Helén, 2022).

6 | BIOPOLITICS OF HEALTH CITIZENSHIP DURING COVID-19 (2020)

Biopolitics refers to the politicization of individuals' vital capabilities (i.e., autonomy/self-management, and competence) to act as productive members of society; through assessment of one's vitality (i.e., social, mental, and health hygiene), to claim membership to a nation or society (Jauho & Helén, 2022). Indeed, politics of one's life instills ideas of 'deservingness', creating a differential in the construction of access to health benefits (Horton, 2004) and limits the quality of one's citizenship when one's vital capabilities (e.g., genetics, ancestry, socio-economics) are rendered explicit (Jauho & Helén, 2022).

During COVID-19 worldwide, biopolitics gave rise to ethical tensions, and in response, to feelings of powerlessness, which generated scapegoating or ‘othering’, evidenced by rising events and experiences of racism (i.e., inherent superiority based on racialized status and cultural differences) and xenophobia (i.e., fear of foreigners) (Ristić & Marinković, 2022). These were reproduced in social media and applied to immigrants and refugees to legitimize biopolitical actions and/or measures against ‘foreign entities’, irrespective of whether or not these impinged on self-determined freedoms, and health citizenship rights (Gover, Harper, & Langton, 2020; Ristić & Marinković, 2022).

Specifically, tensions were from a public communal struggle to bodily express oneself as a part of the solution ‘flattening the curve’ (e.g., staying home, physical distancing in public spaces, limiting travel), versus a private experience of ‘othering’, when one's will to health was impinged by their identification with a marginalized community (e.g., one with a ‘sick’ body, engaged in essential, yet devalued, domestic labour, or due to physical confines of limited space, whether at work or home). This highlighted the significance of the ‘biopolitics of othering’, a link that is often overlooked between immigration policy and intersections of economics and identity (Ellermann, 2020).

We drew on ‘the biopolitics of othering’ as a ‘series of complex social practices’ that demarcates ‘how one actively identifies with social boundaries’ as an ‘a priori ingredient’ to ‘processes of group dynamics and identity formation’ (Ristić & Marinković, 2022, p. 2). Ristić and Marinković's (2022) qualitative study of 27 academic articles during 2020/2021 of the COVID-19 pandemic found that the social and political arenas during COVID-19 constructed discourses of ‘Othering’ to make sense of the spread of the virus, including in Canada, ‘Virus-as-Other, lower socioeconomic groups, and migrant workers/strangers’. This study concluded that a global need to find stereotypical ‘villains’ played out in the everyday ‘politics of naming’ others for the cause of COVID-19; this was reflected in political discourse of the ‘Chinese flu’ or the ‘Wuhan virus’, depending on the social and cultural context (Ristić & Marinković, 2022). Moreover, in Canada, fear and anxiety of the foreign ‘other’ legitimatized discourse to create restrictive policies that reinforced social vulnerability of migrant workers (Larios & Paterson, 2021). Hence, we posited that in Canada, exploring experiences of migrant groups might be helpful in that they represent social actors, not only experiencing ‘biopolitics of othering’, but in how they may be resisting ‘othering’, and redefining their identities in social boundaries of citizenship.

7 | PURPOSE

COVID-19 provided a unique opportunity to explore the relationship between one's identity (intersections of socioeconomic status, ethnicity, and gender etc), and governing social norms of health citizenship. In particular, the authors aimed to reveal one's descriptions enacting a right to access health; an exchange assumed with governing authorities, to enable capacities to attain common goods of health to protect oneself from COVID-19 contagion.

This study involved a secondary qualitative data analysis from a qualitative descriptive study of the challenges immigrants faced while conforming to public health social measures during COVID-19 in the Greater Toronto Area (GTA), Canada (published elsewhere). Results of this study revealed systemic challenges beyond the intrapersonal; all study participants reported how their sense of belonging to their host country and communities were challenged. This raised new study questions of how participants constructed a sense of belonging, which was amenable to a different study purpose: To reveal mechanisms of immigrants' health (in)securities during the first wave of COVID-19 in 2020, beyond mere access to health services, but to represent a capacity to have a will to health, that is, to access common goods of health, as citizens in Canada. The two study questions were:

1. How are the identities of immigrants and refugees socially constructed as part of their performance of health citizenship, during the COVID-19 pandemic?
2. How do immigrants and refugees construct their identities to enable them to maintain and/or seek common goods of health, including those for mental health problems?

8 | METHODOLOGY

We employed critical realism, a post-positivist paradigm, and meta-theoretical orientation, introduced by the British philosopher, Bhaskar (Elder-Vass, 2010). Unlike most other qualitative approaches, this lens has the potential to go beyond description and explain causal factors of personal agency interacting with socio-cultural structures (Harwood & Clark, 2012).

The ontology of critical realism is founded on paradigmatic assumptions of ‘social reality’ that are stratified and emergent in three domains: (a) the ‘empirical’, which comprises experiences and observations of what we tell each other happened; (b) the ‘actual’, which reveals tangible or intangible events that one may or may not subjectively discern (e.g., physiological changes in our body due to stress); (c) the ‘real’, which comprises an ensemble of causal mechanisms (objects or structures) that are not objectively discernible, yet influence events at the empirical level to occur or not occur (Elder-Vass, 2010; Fletcher, 2017). While experiences reveal knowledge across all three domains (i.e., the empirical, the actual, and the real), causal mechanisms are not objectively discernible in the domain of the ‘real’ (Elder-Vass, 2010). Hence, critical realism was chosen to reveal mechanisms at play, which are implicit, and not necessarily realized or actualized in all contexts (Elder-Vass, 2010). We chose methods of thematic analysis using Fryer's (2022) process, which is aligned to critical realism (details to follow under data analysis).

8.1 | Study setting

The study took place in the GTA, Ontario, between May 2020 and September 2020 (during the first wave of COVID-19). The GTA, with a population of 6,372,000, had the highest level of permanent resident admissions of any Canadian city just prior to the COVID-19 pandemic (Toronto Public Health, 2023). Further, 47% identified as immigrants in Toronto, and 56% identify as belonging to a racialized group (Toronto Public Health, 2023). Of these, recent immigrants (i.e., landed immigrants or permanent immigrants up to 5 years) self-identified their country of birth as India (20%), Philippines (13%), China (9%), Pakistan (3%), Iran (3%), United States (3%), Bangladesh (2%), Syria (2%), Nigeria (2%), and Brazil (2%) (Toronto Public Health, 2023). In the GTA, 71% of those hospitalized during the first wave of the pandemic were from racialized groups, particularly Black and South Asian communities (Brar & Jimenez, 2021).

8.2 | Recruitment and data collection

Recruitment of participants occurred through: emails to and advertisements at business associations, social media targeting immigrants/refugees, and snowball sampling. Further, a non-profit community organization that provides outreach to people of East Toronto facilitated recruitment. Inclusion criteria were: (a) self-identifying adult immigrants (including refugees); (b) living in apartment complexes in the GTA (including Toronto's city core); and (c) willing to participate in an interview in their preferred language. Beyond these, there were no exclusion criteria. As researchers anticipated a large diversity of immigrants/refugees (from at least 10 racialized groups), a larger sample size was sought to reach sampling saturation, taking into consideration constraints (e.g., recruitment during the pandemic) to accessing participants for interviews.

Data were collected by phone, Zoom, or Skype (audio only). Interviewers used a short questionnaire to collect socio-demographic information, followed by an interview, using a semi-structured guide. Questions focused on how participants minimized the risk of COVID-19. Prompts were used to gather more information, following the participant's lead. All interviews were audio-taped and transcribed verbatim. Transcripts were translated (and back translated for verification) into English for analysis. The research team determined that data saturation (redundancy of codes and patterns) occurred after 72 interviews, and so data collection ended at that time. Interviews lasted between 5 and 46 min, for an average of 17 min each.

8.3 | Data analysis

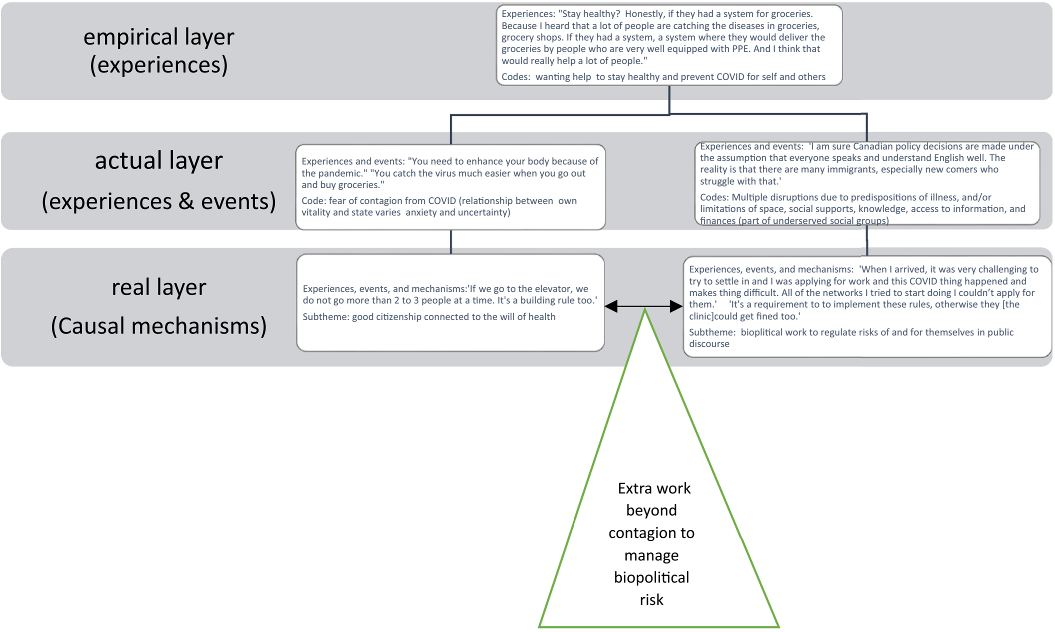
The analytical process moved back and forth between four levels of analysis following Fryer (2022): (a) familiarization of data (comprehension); (b) applying, developing, and reviewing codes for synthesis; (c) developing and reviewing themes for theorization; and (d) generating conclusions through reconceptualization and reporting them (Fryer, 2022). Exemplars of coding using stratified 'layers' of critical realism are illustrated in Table 1.

The lead author and one other research team member (AW) organized data using the computer software of NVivo12 to prepare and manage analysis (QSR International, 2020). Familiarization was conducted through reading through the interviews as a whole, and creating theoretical memos associated with the research questions. Coding was done by two researchers (DL and AW) by assigning a label/code to chunks of text representing descriptive meaning at the layer of the 'empirical' with the first set of 10 transcripts. All initial coding was done independently before all codes were discussed between the two researchers to establish consensus of labels. In doing so, this stage of familiarization/comprehension built the initial coding structure, which was used for comparison against every new code with subsequent transcripts.

Using the initial coding structure, the lead author continued to apply codes, develop new ones, and review emergent codes with one other research team member (AW), for confirmation and standardization (synthesis). Synthesis occurred in an iterative process along with (re)familiarization/comprehension. This involved grouping similar codes together for consolidation and to develop theoretical patterns or 'themes' (Fryer, 2022) that answered the research questions at the level of the 'actual'.

As analysis progressed to developing and reviewing themes for theorizing causation, we moved deeper into an inferential process of moving through critical realist devices of abduction to refine previous codes, and generate new ones using conceptual phrases, such as when the code: 'willingness to conform to public health guidelines' was refined to 'the will of health'. These phrases help us link theoretical patterns to underlying mechanisms (inductively) and to interacting structures (abductively), at the level of the 'real'. Finally, conclusions were drawn through a process of reconceptualization to posit explanations of what created 'actual' events or properties emerging from

TABLE 1 Exemplar coding of causal analysis using critical realism.



empirical layer
(experiences)

Experiences: "Stay healthy? Honestly, if they had a system for groceries. Because I heard that a lot of people are catching the diseases in groceries, grocery shops. If they had a system, a system where they would deliver the groceries by people who are very well equipped with PPE. And I think that would really help a lot of people."

Codes: wanting help to stay healthy and prevent COVID for self and others

actual layer
(experiences & events)

Experiences and events: "You need to enhance your body because of the pandemic." "You catch the virus much easier when you go out and buy groceries."

Code: fear of contagion from COVID (relationship between own vitality and state varies anxiety and uncertainty)

Experiences and events: 'I am sure Canadian policy decisions are made under the assumption that everyone speaks and understand English well. The reality is that there are many immigrants, especially new comers who struggle with that.'

Codes: Multiple disruptions due to predispositions of illness, and/or limitations of space, social supports, knowledge, access to information, and finances (part of underserved social groups)

real layer
(Causal mechanisms)

Experiences, events, and mechanisms:'If we go to the elevator, we do not go more than 2 to 3 people at a time. It's a building rule too.'

Subtheme: good citizenship connected to the will of health

Experiences, events, and mechanisms: 'When I arrived, it was very challenging to try to settle in and I was applying for work and this COVID thing happened and makes thing difficult. All of the networks I tried to start doing I couldn't apply for them.'   'It's a requirement to to implement these rules, otherwise they [the clinic]could get fined too.'

Subtheme: bioplitical work to regulate risks of and for themselves in public discourse

Extra work
beyond
contagion to
manage
biopolitical
risk

multiple mechanisms and structures (Fryer, 2022). Peer debriefing by the research team supported plausibility of the analytical ideas at all levels of analysis. Exemplars reflecting raw data of each theme are reported (below).

8.4 | Ethical considerations

Research Ethics Boards of the participating university and partnering community organization approved the study. A research member explained the purpose of the study, answered participants' questions, and obtained verbal and written consent prior to interviews. All data remained confidential within the research team, and identifiers (names, places) were redacted prior to analysis. Further, all data were password protected on researchers' computers, and virtual hard drives. All dissemination contains only participants' assigned numbers.

9 | RESULTS

9.1 | Participant demographics

Our data were collected from 72 participants born in 21 countries who spoke 15 languages: Roma, Russian, Spanish, Tagalog, Turkish, Urdu, Arabic, Hindi, Ibo, Malayalam, Cantonese, Mandarin, Farsi, Tamil, and English. In all, 44.5% had immigrated within the last 10 years, and 61.1% stated that they were Canadian citizens, while 27.8% reported that they were permanent residents. Approximately 1% identified themselves as refugees. The majority (71%) of participants in our study were women ($n = 51$) who had a mean age of 41.8 years and 65% were caregivers to children ($n = 47$); and/or 24% to extended family ($n = 17$). Approximately 68% ($n = 49$) of all participants stated that they were not working at the time of the study, 13% ($n = 9$) identified as essential workers, and 1% stated they were temporary workers. Most participants (65%) resided in rental apartments with areas of <1,000 square ft.

9.2 | Work of good citizenship against the biopolitics of othering, to regulate perceptions of risk

Our results suggest that participants' health insecurity was driven by work of good citizenship against the biopolitics of othering, to regulate perceptions of their risk: *good citizenship connected to the will to health against*, and *biopolitical work to regulate risks of (othering) and for themselves in public discourse*. We begin by describing the work of participants' biopolitics, in its two parts, which was generated in intersections of identity and citizenship exclusion.

9.2.1 | Work of good citizenship connected to the will to health

Our findings revealed that the majority of immigrants identified with responsibilities and roles conforming to a will to ‘stay healthy’ (prevent COVID-19 contagion). These social norms appeared to reflect ‘good citizenship’ as part of a responsibility to enact the ‘greater good’ of health security for themselves and others.

> You can almost interpret it [the performative act] as not wearing mask shows others that you are healthy and not infected. So, you see many Canadians who cannot understand why they [Asians] have to wear a mask. The concept of wearing a mask in public to protect yourself and others is very foreign to them. (Participant 1,300).

As the participant suggests, good citizenship appeared as a civic responsibility, connected to how guidance from public health authorities emphasized actions contributing to the greater 'good' of society, which immigrants experienced as 'foreign' to many others. Moreover, participants expressed concern, and even frustration, when others, not adhering to social measures of physical distancing and/or wearing masks, were perceived to impinge on their own agency to enact their civic responsibility:

> I am trying to apply social distancing whenever I can, and so do my friends and family. But some kids don't. They go out and party anyway. (Participant 1,659).

> People are not careful and a lot of people are walking around without masks. I fully cover myself when I go out. (Participant 1,215).

Meanwhile, around 25% of the participants expressed that the public health guidelines were problematic as public health discourse exacerbated a felt marginalization to their identified group of belonging, who had limited space and finances. For example, one participant that recently immigrated from Europe stated,

> Wearing those face coverings like we are all about to rob a bank or something. It's just plain stupidity, and it makes life much more complicated because we have no money, and the benefits are not enough (Participant 902).

In sum, while the majority of participants eventually found means of securing some personal protective equipment, such as masks, most reported some degree of biopolitical work to regulate risks of and for themselves in public health discourse due to financial and social strains generated from COVID-19 public health policies.

9.2.2 | Work to regulate risks, of and for themselves, in public biopolitical discourse

Immigrants expressed discourse of how they did, or did not, fit dominant norms as immigrants; situated with limitations that were economical, all of which disrupted their will to health by following public health guidelines.

> In the beginning, we were stunned at what is going on around us and what is this social distancing. In the beginning, staying home all the time was hard, I didn't have a job and still don't have one, so for me it's very hard. (Participant 1,015).

> Because we were newcomers, we were facing other challenges since we are temporary. People won't rent to us since our status will expire. Places were expensive and people asked for a lot of saving. People asking for us to be able to cover rent for at least a year which was a huge amount, especially because with COVID. Our budget lowered even more because the exchange rate changed dramatically. (Participant 1,415).

We suggest that discourse of biopolitics tended to silence participants' expressions of their vulnerability with respect to the government's ability to keep them—as immigrants—healthy and safe. This vulnerability emerged in three parts, as 'extra work' to regulate public perceptions of biopolitical risks, of and for themselves: (a) work to regulate a sense of (mis)trust of the government, (b) work to regulate resilience and minimize needs to access healthcare, and (c) work to regulate experiences of public stigma and fear surrounding COVID-19 contagion. As a result, all participants discussed strategies to safeguard their vulnerability belonging to more than one disadvantaged group (e.g., migrants with low socioeconomic status, caregivers to children, and/or extended families).

9.3 | 'Extra work' to regulate public perceptions of biopolitical risks, of and for themselves

9.3.1 | Work to regulate a sense of (mis)trust of the government

Some participants discerned themselves as disenfranchised from receiving government assistance during the COVID-19 pandemic. The structures, such as the Canadian Emergency Response Benefit (CERB) or rent deferral arrangements, generated participants to question whether the government was aware of the needs of immigrants of diverse cultures and their differing special circumstances. For example, one participant living in a shelter stated,

> All government funds go directly to administration. I will not get even a small amount (Participant 900).

Informal caregivers highlighted their needs in light of their low income and disabilities, and/or their inability to work during COVID-19:

> So, I think this this EI [Employment Insurance] should have some…needs some changes. So, I go appeal. I go in my wheelchair. My husband pushes me and the wheelchair to go. When I'm there, three people sit in front of me and tell me, they can't help. They need me to go to Ottawa to talk to them, to tell Ottawa to change the policy. Man, at that point, I was thinking I'm about to die, and I'm still to go to Ottawa to talk to them? (Participant 1,330).

Yet another participant stated that they did not know how to access information that was not in their language, and they were overwhelmed by the amount of translation required to make sense of what to do to keep themselves safe:

> I think it's the language barrier that causes us the biggest challenge. When information around social distancing and the pandemic is broadcasted, there is tremendous amount of information that overflows without me being able to understand them fully. (Participant 1,300).

In all circumstances, participants reported a growing mistrust and helplessness to access common goods of health due to the lack of government concern for marginalized groups that they belonged to, and the lack of financial support in government policies. The participants' sense of vulnerability appeared to shape a dialectic within themselves with respect to their exclusion, and consequent marginalization with regard to government concern and consideration for subsidies.

9.3.2 | Work to regulate resilience and minimize need to access healthcare

All participants expressed working to tolerate distress, both from their own mental health problems, and in interactions with their communities, to minimize needs to access healthcare. For some, performative citizenship was enacted by helping those in their community, who needed help to interpret information or to obtain supplies to cope with enforced isolation during COVID-19:

> Well, here I am talking about my own community, whoever is talking on my own language, people from my own culture. So, what we can do for them? We can discuss regarding social development. I

> am the member of two different organizations. The newcomer, who are on quarantine, we can help them by dropping off groceries. We need to make a plan. (Participant 1,100).

While for other participants, they expressed a vulnerability because of being recently hired and lacking income, or about meeting performance expectations when they were limited in building relational trust and rapport with their colleagues:

> If they need to get rid of someone, if they need to, like let go someone, I will be the first person, you know, as I'm a recent hire. So, you want to make sure that you're actually like working really hard. And even though working from home is like exhausting… like working really hard to show like that you're capable to do everything from home. (Participant 900).

Indeed, participants mentioned having experienced stress as a result of the 'extra work' required to engage not only in preventing COVID-19 contagion, but in preventing job loss and/or managing public stigma, as part of a marginalized group.

9.3.3 | Work to regulate experiences of public stigma and fear surrounding COVID-19 contagion

Public stigma is defined as 'a stereotypical view of an individual or a group of persons whose attributes are considered deviant from dominant societal norms' (Côté et al., 2020, p. 1154). Approximately 25% of participants reported having experienced public stigma either directly or indirectly—for example, in 'the ways in which they stare at us' (Participant 1,300), the ways in which they 'glance, mumble, and scold you' (Participant 1,400), or in expressions of prejudice towards them:

> You would feel that there is some stereotyping. They would ask us if we had recently travelled, because most of the people know that the virus came from Asia, right? But when white people pass security or the reception of the establishment, they will not be asked this type of questions (Participant 1,500).

Stigma generated extra distress and anxiety for those identifying with a stigmatized group, particularly Asians (∼25% of the study participants). Stress occurred in decisions of whether to leave their home ('feeling like I'm in jail or stuck at home'), while 10% admitted having experienced COVID-19 fatigue or depression. COVID-19 fatigue was expressed as being 'fed up or tired of the rules' or 'tired of staying in' (Participant 1,200).

All participants reported experiencing some degree of fear and anxiety perceived to be the result of experiencing health insecurity. At this point, we highlight results focused on managing the 'extra work', which exemplified participants' health insecurity during the first wave of COVID-19.

9.4 | Experiences of health insecurity during the first wave of COVID-19

Participants' perceptions of health insecurity, from 'extra work' regulating biopolitics, consisted of three parts, dependent on how participants were socially situated: (a) *dependent on social networks limiting their individualism*, (b) *financial and social strains limiting their perceived control*, and (c) *limitations of their home and public transportation hindering their freedoms*. Indeed, our results illuminated the intersecting nature of social stratifications beyond nationality, race, ethnicity, and gender to how they were situated in—their social networks, finances, limitations of space in their homes, and geographic neighbourhoods—all of which exacerbated historical experiences of exclusion in their capacity to perform ‘a will to health’.

9.4.1 | Dependent on social networks limiting their individualism/autonomy

All participants expressed concern about how to follow COVID-19 guidelines or misunderstanding public health restrictions owing to their limited access, comprehension, and proficiency in English. For instance, our study participants were prevented from keeping abreast of changing public health restrictions and guidelines by the lack of signage and limited mainstream social media communication in different languages. They relied on family, friends, and community workers who spoke the same language as they did to ‘spread this information to us’ (Participant 2,200). Or else they ‘look[ed] for healthcare providers who could understand’ their respective languages (Participant 1,300).

9.4.2 | Financial and social strains limit their perceived control

As stated earlier, the majority (71%) of participants self-identified as women ($n = 51$) who had a mean age of 41.8 years and 65% were caregivers to children ($n = 47$); and/or 24% to extended family ($n = 17$). We suggest that participants' experiences of financial and social strain were shaped by prior conditioning of gendered and racialized hegemonic norms (i.e., ascribed to gender-based work, and ruling or dominant norms of its value). For example, the participant's statement (below) reflects constraints of money associated with health policies limiting ability to obtain adequate financial assistance:

> Because to us, normally just to survive, to use our senior's pensions, it's already a very tight budget. If because of this Covid-19 situation they need us to take out more additional expenses, it's very difficult for us. (Participant 190,620)

9.4.3 | Limitations of their home and public transportation hinder freedoms

As 65% of participants rented apartments, <1,000 square feet, and relied on public transit, these factors posed a risk to experiencing freedom from the COVID-19 contagion, as they were unable to adhere to physical distancing guidelines within their confined spaces (Government of Canada, 2021b). Indeed, participants reported conscious awareness of the challenges in performing their everyday activities, such as whether or how they exercised, or how they could (or could not) take apartment elevators:

> In high rise buildings, it is extremely difficult, because we live in two- and three-bedroom apartments. So, there are so many people. Sometimes it is very difficult to use the elevator. (Participant 140,620).
>
> Yeah, but the problem is the elevator mostly, I mean, we wished we were staying in a house so that was the biggest problem. Even, we think 100 times before leaving the house because there's an elevator. And the elevator, as you know, is a closed environment so it keeps, of course, any virus or microbe in it. (Participant 1,400).

Some participants reported that disrupted activities impacted their quality of lives as a consequence of limited spatial freedom in their homes:

> I live in three-bedroom apartment with my brother and his family; 4 adults and 10 children. How can we do social distancing? (Participant 170,620).

Notably, all participants reported that the limited shared public space in their communities exacerbated their psychological distress; the latter a consequence of the loss of social support in everyday informal conversations:

> In fact, we South Asians are often very social culturally. We feel strong bonds with colleagues and other people we meet. Now, we are not going to anyone, and no one is coming to us.…It feels like some part of our social lives is missing, which causes mental distress. (Participant 170,620).

Specifically, COVID-19 related public health policies disadvantaged those reliant on shared public spaces, public transportation, financial subsidies, social services, and with limited social networks to obtain common goods of health. As a whole, these experiences culminated in participants experiencing health insecurity, which triggered some to isolate, rather than engage with public discourse generating extra work to regulate their sense of vulnerability.

10 | DISCUSSION

In summary, the vulnerability to health insecurity was made explicit by tangible COVID-19 events and experiences exacerbating historical discrimination of participants' autonomy, control, and freedoms; generating 'extra work' to attain a 'will to health'. The work was driven by mechanisms of good citizenship connected to accessing common goods of health against biopolitical work to regulate risks, of and for themselves, in public discourse. Public discourse was perceived to contain ethopolitical ideas following racialized hegemonic norms, which tended to reproduced systemic cultural racism.

Our findings support the past literature on systemic racism during pandemics: the relatively stable historical and social properties or relations, which condition group members' behaviours for 'othering' were evident during the COVID-19 pandemic as well (Spoel et al., 2023; Vieten, 2020). State policies reflecting dominant value norms (self-reliance) differentiated members that could not adhere to these norms (e.g., norms of working at home or physical distancing within their homes). This is reflected in earlier identity politics literature, whereby meanings of 'good' citizenship are embedded in how state policies grant some but not others a 'will to health', generating a comparison of how one fits the host's culture and its ethics (Petryna, 2004).

Many immigrants and refugees exhibited a tolerance for accepting new social norms as they worked to fulfil the neoliberal roles and responsibilities of good citizenship (i.e., self-management and responsibility for one's own lives; Andreouli & Brice, 2022), while others expressed work to overcome risks with respect to the discourse of biopolitics in public health guidance and policies. Indeed, the most vulnerable participants (i.e., those unable to work, retired, living in private apartments) experienced what Meza-Palmeros (2020) called a 'body precariousness' due to COVID-19 government structures disenfranchising them from receiving assistance from state services. Meza-Palmeros (2020) states,

> precarity refers to relations of domination that produce social hierarchies and a differential distribution of this precariousness upon the body of individuals (p. 114).

Specifically, COVID-19 demonstrated how vitality of one's body became a form of political control, regulation, and surveillance exercised over 'ill bodies' as a group (Meza-Palmeros, 2020). The emergence of participants' 'extra work' was in how they attempted to manage and tolerate a process of multiple breakdowns in obtaining common goods of health (i.e., dependency on their social networks to obtain resources, financial and social strains, and limitations of shared spaces in their homes and communities) and precarious work brought forth to survive COVID-19 (e.g., domestic work paid or unpaid). Altogether, by the end of the first wave of COVID-19, in Canada like in Eastern Europe and Australia, these factors culminated in immigrants experiencing reduced self-efficacy, weakened social integration, lowered social capital, and disproportionately magnified their health problems (Macmillan & Shanahan, 2021; Quinlan, 2021).

Our findings suggest that the COVID-19 pandemic exposed diverse degrees of inequity, particularly for those who experienced multiple breakdowns in social and economic capital, disproportionately exposing them to intensified work to regulate their risks. Members of the latter group reflect resistance to neoliberal social norms/bias by frequently advocating to transform the orientations by which common goods of health are attained into more inclusive publicly funded sources. In other words, the majority of participants in our study advocated to transform their relationship with the government to counter exclusionary notions, when they were unable to enact responsibilities and roles as citizens: self-regulating, entrepreneurial, and security-conscious subjects (Baker-Cristales, 2009; Komporozos-Athanasiou et al., 2018). Empathetic understanding of these mechanisms may take into account the potential impact of future political rhetoric on vulnerable groups amid public health emergencies.

10.1 | Strengths and limitations

We used critical realism (for our secondary analysis of data), which targets mechanisms triggering interactions between agency and social structures; both as a precursor and as having emergent properties and potential agential powers (Archer, 1995). Our study purposefully collected data from a diverse group of immigrants (from 21 countries), though data saturation for each group may not have reached, thus, for example, we did not examine intersections of identity based on religion as a potential axis of inclusion/exclusion (Ellermann, 2020). Lastly, as the COVID-19 pandemic continually evolves, findings may not be transferable to the current climate of "post" COVID-19, (Joli, Buck, Zipfel, & Stengel, 2022).

11 | CONCLUSIONS

In this article, we reconceptualise how individual agency is shaped by pre-existing structures (e.g., public health policies and health system structures created 'health as a site of citizenship'; Komporozos-Athanasiou et al., 2018), and its interaction with local social structures (e.g., social networks), generating 'extra' work to regulate agential powers of biopolitics (e.g., activism). In doing so, complex theorization of a phenomenon, like how health (in) security occurs for marginalized groups, may be realized. We argue that empathetic understanding of this process is conducive to enhancing immigrants' health security during public health emergencies.

Knowledge of the mechanisms that drive citizenship identity and politics of belonging can reveal the barriers that hinder adaptation to changing state policies (Ellermann, 2020). In our study, those groups that resided outside dominant norms appeared to experience greater struggles in their processes of adaptation to the public health guidelines aimed at mitigating the spread of COVID-19.

Existing literature suggests that health citizenship is most easily performed by immigrants who have economic capital and cognitive (including language) proximity to the (host) country's national norms, enabling them to better adapt to the changing situations and mitigate tension that enhances their health (Filion, Fenelon, & Boudreaux, 2018; Ng & Zhang, 2020). Our findings resonate with those of Andreouli and Brice (2022), which examined how a change in political rhetoric in the United Kingdom during the first 9 months of the COVID-19 pandemic restricted the average citizen in ways that dictated a passive rather than active role. Specifically, previous responsibilities of the average citizen did not apply, as citizens were asked to be 'passively confined, sacrificial, and unfree' (Andreouli & Brice, 2022). Similarly, in our study, immigrants who were limited to fulfil the neoliberal roles and responsibilities for one's own health and well-being, experienced extreme hardship following public health guidelines during the first wave of COVID-19. Hence, we suggest future research ought to take into account deeper individual mechanisms emerging from wider determinants of health, conducive to enhancing ones' resistance to stereotypes, and to bolstering their resilience to seeking health security during public health emergencies.

ACKNOWLEDGEMENTS

We would like to thank the study participants as well as the non-profit community organization that provides healthcare and social and community outreach services to the people of East Toronto that supported our participant recruitment efforts.

FUNDING INFORMATION

The Faculty of Community Services at Toronto Metropolitan University provided funding. The funders did not play any role in data collection, interpretation, or reporting of the study findings.

CONFLICT OF INTEREST STATEMENT

The authors declare no potential conflict of interest.

DATA AVAILABILITY STATEMENT

The authors confirm that the data supporting the findings of this study are available within the article.

ETHICS STATEMENT

Ethical approval was obtained through the respective Research Ethics Boards of the participating university and partnering community organization.

PARTICIPANT CONSENT STATEMENT

All participants provided written consent prior to data collection.

ORCID

Doris Y. L. Leung https://orcid.org/0000-0002-9636-3118
Sepali Guruge https://orcid.org/0000-0002-8459-2319
Angel H. Wang https://orcid.org/0000-0002-4467-0554
Charlotte Lee https://orcid.org/0000-0001-7115-5104

REFERENCES

Allin, S., Marchildon, G., & Peckham, A. (2020). *Health system overview*. Canada: InternationalCommonwealthFund.Org. Retrieved May 2, 2023, from https://www.commonwealthfund.org/sites/default/files/2020-12/2020_IntlOverview_CAN.pdf

Andreouli, E., & Brice, E. (2022). Citizenship under COVID-19: An analysis of UK political rhetoric during the first wave of the 2020 pandemic. *Journal of Community & Applied Social Psychology*, *32*(3), 555–572. https://doi.org/10.1002/casp.2526

Archer, M. (1995). *Realist social theory: The morphogenetic approach*. Cambridge: Cambridge University Press.

Atterbury, K., & Rowe, M. (2017). Citizenship, community mental health, and the common good. *Behavioral Sciences & the Law*, *35*(4), 273–287. https://doi.org/10.1002/bsl.2293

Baker-Cristales, B. (2009). Mediated resistance: The construction of neoliberal citizenship in the immigrant rights movement. *Latino Studies*, *7*(1), 60–82.

Bauder, H. (2008). Citizenship as capital: The distinction of migrant labor. *Alternatives*, *33*(3), 315–333. https://doi.org/10.1177/030437540803300303

Bowleg, L. (2020). We're not all in this together: On COVID-19, intersectionality, and structural inequality. *American Journal of Public Health*, *110*(7), 917.

Brar, A., & Jimenez, C. (2021, February 3). *Opinion*. Toronto Star. Toronto, Ontario, Canada. Retrieved March 30, 2021, from https://www.thestar.com/opinion/contributors/2021/02/03/1-in-4-COVID-19-cases-found-through-contact-tracing-in-peel-were-those-went-to-work-sick-data-reveals-how-ontarios-lack-of-paid-sick-legislation-fails-vulnerable-workers.html

Côté, D., Dubé, J., Gravel, S., Gratton, D., & White, B.W. (2020). Cumulative stigma among injured immigrant workers: a qualitative exploratory study in Montreal (Quebec, Canada), *Disability and Rehabilitation*, *42*(8), 1153–1166. doi:10.1080/09638288.2018.1517281.

Cunningham-Burley, S., Backett-Milburn, K., & Kemmer, D. (2006). Constructing health and sickness in the context of motherhood and paid work. *Sociology of Health & Illness*, *28*(4), 385–409.

Elder-Vass, D. (2010). *The causal power of social structures: Emergence, structure and agency*. New York: Cambridge University Press.

Ellermann, A. (2020). Discrimination in migration and citizenship. *Journal of Ethnic and Migration Studies*, *46*(12), 2463–2479. https://doi.org/10.1080/1369183X.2018.1561053

Filion, N., Fenelon, A., & Boudreaux, M. (2018). Immigration, citizenship, and the mental health of adolescents. *PLoS One*, *13*(5), e0196859. https://doi.org/10.1371/journal.pone.0196859

Fletcher, A. J. (2017). Applying critical realism in qualitative research: Methodology meets method. *International Journal of Social Research Methodology: Theory & Practice*, *20*(2), 181–194. https://doi.org/10.1080/13645579.2016.1144401

Fryer, T. (2022). A critical realist approach to thematic analysis: Producing causal explanations. *Journal of Critical Realism*, *21*(4), 365–384. https://doi.org/10.1080/14767430.2022.2076776

Gover, A. R., Harper, S. B., & Langton, L. (2020). Anti-Asian hate crime during the COVID-19 pandemic: Exploring the reproduction of inequality. *American Journal of Criminal Justice*, *45*(4), 647–667. https://doi.org/10.1007/s12103-020-09545-1

Government of Canada. (2021). From risk to resilience: An equity approach to COVID-19. Chief Public Health Officer of Canada's Report on the State of Public Health in Canada 2020. Retrieved July 28, 2022, from https://www.canada.ca/en/public-health/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/from-risk-resilience-equity-approach-covid-19.html

Harwood, L., & Clark, A. M. (2012). Understanding health decisions using critical realism: Home-dialysis decision-making during chronic kidney disease. *Nursing Inquiry*, *19*(1), 29–38. https://doi.org/10.1111/j.1440-1800.2011.00575.x

Horton, S. (2004). Different subjects: The health care System's participation in the differential construction of the cultural citizenship of Cuban refugees and Mexican immigrants. *Medical Anthropology Quarterly.*, *18*(4), 472–489. https://doi.org/10.1525/maq.2004.18.4.472

Jauho, M., & Helén, I. (2022). Citizenship by vitality: Rethinking the concept of health citizenship. *Distinktion: Journal of Social Theory*, *24*, 1–21. https://doi.org/10.1080/1600910X.2022.2057561

Joli, J., Buck, P., Zipfel, S., & Stengel, A. (2022). Post-COVID-19 fatigue: A systematic review. *Frontiers in Psychiatry*, *13*, 1–20. https://doi.org/10.3389/fpsyt.2022.947973/full

Kandel, N., Chungong, S., Omaar, A., & Xing, J. (2020). Health security capacities in the context of COVID-19 outbreak: An analysis of international health regulations annual report data from 182 countries. *The Lancet*, *395*(10229), 1047–1053. https://doi.org/10.1016/S0140-6736(20)30553-5

Komporozos-Athanasiou, A., Fudge, N., Adams, M., & McKevitt, C. (2018). Citizen participation as political ritual: Towards a sociological theorizing of 'health citizenship. *Sociology (Oxford)*, *52*(4), 744–761. https://doi.org/10.1177/0038038516664683

Larios, L., & Paterson, S. (2021). Fear of the other: Vulnerabilization, social empathy, and the COVID-19 pandemic in Canada. *Critical Policy Studies.*, *15*(2), 137–145. https://doi.org/10.1080/19460171.2021.1927777

Macmillan, R., & Shanahan, M. J. (2021). Why precarious work is bad for health: Social marginality as key mechanisms in a multi-national context. *Social Forces*, *100*(2), 821–851. https://doi.org/10.1093/sf/soab006

Meza-Palmeros, J. A. (2020). Risk perception, coronavirus and precariousness. A reflection on fieldwork under quarantine. *Health Sociology Review*, *29*(2), 113–121. https://doi.org/10.1080/14461242.2020.1785321

Netz, S., Lempp, S., Krause, K., & Schramm, K. (2019). Claiming citizenship rights through the body multiple. *Citizenship Studies*, *23*(7), 637–651. https://doi.org/10.1080/13621025.2019.1651041

Ng, E., & Zhang, H. (2020). The mental health of immigrants and refugees: Canadian evidence from a nationally linked database. Government of Canada. *Statistics Canada. Health Reports*, *31*(8): 3–12. https://doi.org/10.25318/82-003-X202000800001-ENG

Niraula, A., Ratti, N., Colley, M., Rosenberg, M., Ghassemi, E., & Wilson, K. (2023). Negotiating precarity: Recent immigrants' perceptions of waiting for public healthcare in Ontario, Canada. *Health Policy*, *104843*, 104843.

Pandey, K., Parreñas, R. S., & Sabio, G. S. (2021). Essential and expendable: Migrant domestic workers and the COVID-19 pandemic. *The American Behavioral Scientist*, *65*(10), 1287–1301. https://doi.org/10.1177/00027642211000396

Petryna, A. (2004). Biological citizenship: The science and politics of chernobyl-exposed populations. *Osiris*, *19*(1), 250–265. https://doi.org/10.1086/649405

Ponce, A. N., & Rowe, M. (2018). Citizenship and community mental health care. *American Journal of Community Psychology.*, *61*(1–2), 22–31. https://doi.org/10.1002/ajcp.12218

QSR International. (2020). NVivo12. https://www.qsrinternational.com/

Quinlan, M. (2021). COVID-19, health and vulnerable societies. *Annals of Work Exposures and Health.*, *65*(3), 239–243. https://doi.org/10.1093/annweh/wxaa127

Ristić, D., & Marinković, D. (2022). Biopolitics of othering during the COVID-19 pandemic. *Humanities and Social Sciences Communications*, *9*(1), 1–8. https://doi.org/10.1057/s41599-022-01435-7

Rose, N. (2001). The politics of life itself. *Theory, Culture & Society.*, *18*(6), 1–30. https://doi.org/10.1177/02632760122052020

Semenza, J. C., Adlhoch, C., Baka, A., Broberg, E., De Cenciarelli, O., Angelis, S., et al. (2021). COVID-19 research priorities for nonpharmaceutical public health and social measures. *Epidemiology and Infection*, *149*(e87), e87. https://doi.org/10.1017/S0950268821000716

Spoel, P., Lacelle, N., & Millar, A. (2023). Constituting good health citizenship through British Columbia's COVID-19 public updates. *Health (London, England: 1997)*, *27*(5), 770–788. https://doi.org/10.1177/13634593211064115

Toronto Public Health. (2023). Toronto's Population Health Profile – Insight on the health of our city. https://www.toronto.ca/wp-content/uploads/2023/02/940f-Torontos-Population-Health-Profile-2023.pdf

United Nations (2020). *Policy brief: COVID-19 and universal health coverage*. New York, USA. Retrieved March 31, 2021, from https://www.un.org/sites/un2.un.org/files/sg_policy_brief_on_universal_health_coverage.pdf

Vieten, U. M. (2020). The "new normal" and "pandemic populism": The COVID-19 crisis and anti-hygienic mobilisation of the far-right. *Social Sciences*, *9*(9), 165. https://doi.org/10.3390/socsci9090165

World Health Organization (WHO). (2011). World Health Organization definition of health. Retrieved May 6, 2022 from: https://www.who.int/about/governance/constitution

World Health Organization [WHO]. (2021). *Financing common goods for health*. Geneva: License: CC BY-NC-SA 3.0 IGO. Retrieved December 16, 2022, from https://www.who.int/health-topics/common-goods-for-health#tab=tab_3

How to cite this article: Leung, D. Y. L., Guruge, S., Wang, A. H., & Lee, C. (2024). Health citizenship reveals 'extra' work managing biopolitical risk for immigrants in Canada during COVID-19: A qualitative study. *Journal of Community & Applied Social Psychology*, *34*(4), e2840. https://doi.org/10.1002/casp.2840