The ongoing SARS-CoV-2 (COVID-19) pandemic demonstrates both the commitment to protecting life at all costs and the paradoxical determination of politicians to keep the economy "open" and productive. At the beginning of the pandemic, the rallying cry of "whatever it takes" (Al Jazeera English, 2020) was related to the economic price the European Union, and other countries such as Canada were ready to pay to "flatten the curve" (Fraiman, 2020). Physicians, activists, and some politicians declared that the pandemic was a "humanitarian disaster" (Gupta, 2020) and lobbied governments to save as many lives as possible. To this end, civil rights have been suspended and we are currently living in societies of imposed states of (health) emergency in the name of saving life (Foucault et al., 2020).

Governments claim that the virus does not discriminate and that we all are vulnerable, but the pandemic has made clear this is simply not the case (The UN Refugee Agency, 2020). It is widely acknowledged that COVID-19 has laid bare global social and racial inequalities that stem from the racist foundations of settler colonial capitalist societies and decades of systematic defunding of social, health, and welfare services according to a neoliberal rationale (Chomsky, 2020; Urie, 2020). Furthermore, the global capitalist agro-industrial modes of production have led to systematic deforestation and destruction of natural habitats that kept viruses "in check" (Latour, 2020; Wallace, Liebman, Bergmann, et al., 2020; Wallace, Liebman, Chaves, et al., 2020). Coupled with the ongoing climate crisis, this ruthless exploitation of resources has engendered the spread of zoonotic infectious diseases and viruses at an alarming rate.

Despite the promise to save every life, the COVID-19 pandemic has exposed social and racial inequalities, precarious living conditions, and engendered an exponential increase in overdose deaths. Although some lives are considered sacred, others are deliberately sacrificed. This article draws on the theoretical work of Foucault and scholars who further developed his concept of biopolitics. While biopolitics aims to ameliorate the health of populations, Foucault never systematically accounted for the unequal value of lives. In the name of saving the biological lives of people who use drugs (PWUD) during the pandemic, the harm reduction movement has emphasized the need for safe supply, decriminalization, and housing; governments have started implementing these measures, which were previously rejected as utopian and unrealistic. Paradoxically, the use of drugs itself, and therefore the increased risk of death from overdose or other medical sequelae, is the only way PWUD can achieve enough visibility to be recognized as a life worth saving. The humanitarian rationale of harm reduction concerns itself with the biological life and stipulates social and political rights in the name of its sacredness. This is what anthropologist Fassin and others called biolegitimacy—the recognition of life reduced to its physiological, biological essence.
rate in areas never exposed to them before (e.g., SARS, Zika virus, West Nile virus; Hupert, 2017; Napier, 2017). The current pandemic makes explicit, and worsens, the exaggerated vulnerability and precarity of certain groups which are expendable in the name of capital accumulation (Butler, 2020; Wade, 2020). Thus, the pandemic demonstrates that there exists a hierarchy of lives; some are able to safeguard their relatively comfortable quality of life, which is necessarily on the backs of those who can be sacrificed (Butler & Yancy, 2020). In addition to unmasking already existing inequalities, the response to COVID-19 maintained, perpetuated, and even created new inequalities. Many of these inequalities cannot be apprehended as they are the hidden consequences of the imposed lockdowns; the invisible inequalities, invisible suffering, and invisible deaths of despair (Case & Deaton, 2020b; Polychroniou, 2020). In other words, although we are counting the numbers of infection cases and deaths linked directly to the virus, we are not yet aware of the lives we will lose due to the economic consequences.

The emphasis on saving lives is not something new. According to Fassin (2018), the value of life in societies of the global North is deeply rooted in religious and philosophical traditions. From this perspective, life cannot be evaluated in financial terms; it has no price. This sacrosanctness of life is a specific form of power that characterizes society as such, a way of life as such, what theorists like Benjamin and Arendt called naked life (Arendt, 1973; Benjamin, 2004), meaning life reduced to its physiological, biological essence. Reduced in such a way, every life can be treated “equally.” For Foucault (2003), life itself is the focus of biopolitics, which is a non-disciplinary form of power that characterizes our contemporary societies, which is what Fassin (2009) terms biolegitimacy. Biolegitimacy is the power of life itself, what theorists like Benjamin and Arendt called naked life (Arendt, 1973; Benjamin, 2004), meaning life reduced to its physiological, biological essence. Reduced in such a way, every life can be treated “equally.” For Foucault (2003), life itself is the focus of biopolitics, which is a non-disciplinary form of power directed toward humans as a species and human beings as living beings. The management of the COVID-19 pandemic is a paradigmatic example of biopolitics in action (Esposito, 2020; Hannah et al., 2020). Foucault understood biopolitics as a new way of governing that emerged in the 18th century when governments increasingly characterized the lives of their citizens in terms of biological processes, a perspective which became the underlying rationale for decision-making. By imposing strong sanitary and population control measures to prevent the spread of COVID-19, governments have used population management techniques aimed at protecting the living forces of the population (Foucault et al., 2020). However, if we want to understand why in our societies, and in the pandemic, some lives count more than others, we need to include another dimension. This other dimension is what Fassin (2009, 2018) calls life as such, which refers to the biographical dimension of life or life how it is actually lived and experienced (Fassin, 2009, 2018). This perspective allows us to analyze how societal, economic, and political contexts, and discourses devalue some lives by increasing their precarity. This perspective broadens Foucault’s concept of biopolitics because it acknowledges that biopolitics engenders inequalities—an aspect Foucault never systematically developed (Fassin, 2009, 2018).

Taking as our starting point the exponential increase of overdose deaths during the pandemic (Public Health Agency of Canada, 2020b), and the accompanying humanitarian campaigns by HR advocates for saving the lives of people who use drugs (PWUD; e.g., Alliance for Healthier Communities, 2020), we will apply Fassin’s theoretical considerations to discuss how HR is an example of how biolegitimacy operates in the hierarchization of lives in biopolitical governmentality. Using the concept of biolegitimacy, we will think through the contradictory logic of biopolitical governmentality which emphasizes the value of life itself yet does not treat all lives equally. We will show how HR advocates use the suffering of PWUDs’ physical body, the life itself, as the foundation for political action. Advocating in the name of life itself strengthens the neoliberal rationale; advocacy no longer seeks to fight against a society that systematically renders some lives precarious, and it only advocates for the alleviation of suffering (Foth, 2020). Thus, the humanitarian logic of HR forecloses radical changes of life as such.

In the first section, based on Fassin’s work, we will develop our theoretical considerations around biolegitimacy and the different value of lives. Furthermore, we will discuss Foucault’s concept of biopolitics; using examples from the COVID-19 pandemic, we will delineate the practical implications of biopolitics and demonstrate that it does not provide the tools to fully grasp the production of inequalities in our neoliberal societies. Next, in order to contextualize the current state of HR for PWUD, we will provide a short overview of how HR transformed criminalized drug use into a public health concern, how it developed into the movement we see today, and how the pandemic has emboldened and transformed the HR movement. What strikes us most in the HR movement is the fact that PWUD are only visible and recognizable as suffering human beings—someone in need of help and support in order to physically survive (Foth, 2020). Paradoxically, the use of drugs itself, and therefore the increased risk of death from overdose or infection from unhygienic consumption practices, is the only way for PWUD to achieve a certain degree of visibility and be recognized as a life worth saving. A PWUD is recognized as a life itself, but never as a life as such. Harm Reduction is an example of how biolegitimacy changes the way we understand politics—as fighting for justice and equality we try to reduce suffering in the name of humanitarianism (Foth, 2020). Thus, in the last section, we contend that HR is not only a biopolitical technology aimed at managing drug use in such a way that it can be integrated into a public health approach, but that HR’s irrefutable humanitarian imperative privileges the biologic self and implies moral judgements which lead to a hierarchization of lives.

### 2 | BIOLEGITIMACY AND THE VALUE OF LIFE

Life as the supreme good is the Christian idea of the sacrosanctness of life and philosophies of natural rights define life as an absolute good (Fassin, 2018). In other words, life understood as the bare fact of being alive is recognized as a supreme value above all others in our societies; all lives have equal value and thus lives cannot be hierarchized. However, beginning at the end of the 19th century, economists introduced the idea that life has a relative value that can be quantified and represented in monetary values (Rose, 2001).
Economic calculations were an important precondition for insurance schemes and planning in the context of public health because they could be used to determine how many, and whose, lives could be saved through particular public health interventions (Foucault, 2014a, 2014b). Once the value of life could be calculated, public health experts and governments could determine how much these interventions would cost and if an investment is “worth” it (Fabre et al., 2021). Thus, economists transformed life understood as an absolute value into a relative worth. What is important in the context of our discussion is that life understood as biological entity can be calculated. Demographers and epidemiologists construe life in this sense by calculating, for example, life expectancy, potential years lost, or mortality rates.

Foucault introduced the concepts of biopower and biopolitics at the end of the 1970s to describe a form of power over life itself that emerged in the mid-18th century. This form of power is based on a new rationality which focuses on human beings as a particular species characterized by the interplay of complex processes stemming from mortality and birth or fertility rates (Foucault, 1978, 2003). In turn, these processes can be linked to economic and political considerations. It is at this historical moment that the population became intertwined with medicine. As a scientific and biomedical entity, the collective phenomena that influence the population must be managed because these collective phenomena have an influence on the economy. Thus, populations are composed of living beings that produce phenomena that appear random and unpredictable on the individual level but generate constants at the level of the population. From this perspective, these phenomena develop over long periods of time and Foucault called them *phenomena of series* because they are essentially “aleatory events that occur within a population that exist over a period of time” (Foucault, 2003, p. 246). Biopolitics uses statistical surveys and quantifiable dimensions to implement regulatory technologies that try to indirectly influence these phenomena of series to achieve a certain kind of equilibrium.

However, Foucault did not mean that biopolitics replaced disciplinary power; on the contrary, disciplinary and even sovereign power are still part of biopower. Foucault called it the anatomopolitical axis of biopower that uses disciplinary mechanisms to train and target individuals and their bodies. In his chapter about the Panopticon, Foucault describes how disciplinary power emerged in the context of the plague (as opposed to leprosy) that served as the model of efficient disciplinary intervention in the fight against the highly contagious disease (Foucault, 1995). Although in the model of the leper the infected person was excluded and driven outside the town and left to themselves to die, the model of the plague enclosed the residents of the town subjecting them to a strict disciplinary regime—they were not allowed to leave their houses, they had to present themselves to the inspectors of the town, etc. These are the same mechanisms being employed today in the COVID-19 pandemic. Life in biopolitical terms is what Fassin (2009) terms the life itself; life itself is linked to life sciences and biomedical interventions on living matter and designates “the biological existence of the living and its political extension as population” (Fassin, 2009, p. 48).

However, life must be understood as part of a broader social context and political stake which Fassin (2009, 2018) terms life as such. Life as such grasps life as the course of events between birth and death as it is impacted by political or structural violence, health and social policies, cultural interpretations or moral decisions, or as Fassin puts it “life which is lived through a body (not only through cells) and as a society (not only as species).” (Fassin, 2009, p. 48). If we understand life from this perspective, it is not about the simple fact of being physically alive but rather about what qualifies as the life one can hope for—it is the social/political form of life (Fassin, 2018). This dimension of life is no longer quantifiable or measurable in terms of life expectancy because it is about living conditions that allow one to live a social or political life or to achieve a quality of life that goes beyond the simple fact of being alive in a physiological sense. The full meaning of life, and the diverse directions lives may take, is only comprehensible if life is not reduced to biological phenomena and living beings are not understood merely as populations. Therefore, Fassin (2018) introduces the concepts of physical/biological and social/political life. Life itself is thus the physical/biological form of life.

It is important to recognize that in our societies the pair physical/biological prevails over the social/political. Today, the sacredness accorded to biologic life takes precedence over the political life; in recognizing the universality of biologic life (life itself) suffering becomes the manifestation of “universal humanity,” and it is understood as beyond the political and the social (Ticktin, 2011, p. 212). Biolegitimacy imposes itself as something indisputable, whereas legal protection and social justice are increasingly questioned. The physical/biological life must be protected, and therefore, it commands the respect and particular attention of the state. It follows that states of emergency and the suspension of constitutional rights are justified in the name of saving biologic lives (preventing death; Agamben, 1998, p. 83). European countries and Canada have sacrificed public liberties and fundamental rights (including the right to a dignified death and dying) in the name of saving every single life in the “war against the virus.” (Haas, 2020). There is an obvious paradox between, on the one hand, the emphasis on the sacredness of life, and, on the other hand, sacrificing what Bauman (2004) calls surplus or wasted lives (a central characteristic of modern life); “[w]ho should live in the name of what is definitely a political question” (Fassin, 2009, p. 52). There is a linking of the living (the biological fact of being alive) with politics (citizenship and social rights; Greco, 2004). In contrast to biopolitics and governmentality, it is not only about tactics and strategies aimed to control life and the technologies to achieve these ends, but also about the question of how humans are treated and how lives are evaluated differently. Thus, biopolitics alone is insufficient to understand the way the COVID-19 pandemic, for example, has affected our lives so differently; this is what the pandemic made dramatically clear: that lives are not evaluated equally.

Therefore, while both dimensions must be included in our understanding of life, they must also both be problematized through a political and moral anthropology that analyzes how these dimensions shape life through political choices and moral economies. Moral
economies can also be called “regimes of living” (Collier & Lakoff, 2005); heterogeneous configurations founded on moral reasoning which is invoked and reworked as a guide for decisions and actions to solve situations deemed problematic. Thus, life is not something that is just a given, but it is formed and transformed through the interplay of discourses, programs, decisions, etc. To understand how different sections of the populations are differently impacted one needs to understand politics not just as an art of government, as in Foucault’s conceptualization of governmentality, but also about how lives are evaluated and treated differently (Bröckling et al., 2011; Foucault, 2009). Our current societies are less characterized by biopower but by a power of life or biopoliticity. Biopolitics is not only about populations but also about the inequalities in life that it engenders. It is not only about normalizing lives but also about what kind of life people are able and allowed to live; Fassin calls this dimension “bio-inequalities” (Fassin, 2009, p. 49). However, the decisive point in Fassin is that biopoliticity has become a foundation of the moral economy of contemporary societies. The politics around COVID-19 highlight particularly well that "the proclamation of a humanitarian rationale in the government of human beings" (Fassin, 2009, p. 49) has become the decisive rationale in the governing of populations. But "humanitarianism is not about human rights in general but about the right to live in particular: saving lives is its higher mission" (Fassin, 2009, p. 49). Thus, this humanitarian rationale reduces life to the physical/biological form.

3 | BIOLEGITIMACY IN THE COVID-19 PANDEMIC

Social and economic inequalities are most visible in the COVID-19 case numbers and mortality rates. To understand the deadly consequences for some during the pandemic, deaths that are based on the differential value of lives, we need to broaden our analytical approach. Closely related to a dimension of Foucault's concepts of biopolitics and biopower is what he described as "reject into death" [this is the translation provided in Fassin (2009, p. 52)]. Fassin (2009) notes "that biopolitics has consequences in terms of inequalities, that governmentality conveys disparities in the quantity and quality of life, that subjectification might be distinct for the dominant and the dominated is almost absent from Foucault's work" (p. 53). Thus, most scholars focus on the idea that biopolitics is about fostering life and the technologies developed to achieve this end. However, in order to make life, it is necessary to also decide who shall live, what sort of life, and for how long (Fassin, 2009). Consequently, biopolitics is not only about life but also about death. Decisions such as these are unquestionably political and form the foundation of what Foucault calls societies of normalization (Foucault, 2003). In societies of normalization, state racism adopts a scientific (biomedical) approach to divide the population into subgroups and subsequently singling out subgroups that may pose a perceived biological danger for the population (as was the case in the Nazi regime: Foth, 2013). In doing so, decisions are made about which groups (or populations) are "biologically risky" or "a biological threat"; it follows then that these decisions also imply whom to "let die." Thus, we share Foucault's (2007) notion of critique; critique is about questioning the limits of our knowledge and taken-for-granted assumptions about the world in which we live (see, also, Butler, 2001). This form of critique questions the specific rationales involved in the governing of individuals and societies, and invites us to think about "how not to be governed." Thus, our argument aims to think about "how not to be governed like that, by that, in the name of those principles, with such and such an objective in mind and by means of such procedures, not like that, not for that, not by them." (Foucault, 2007, p. 79). The decisions about whom to "let die" are often hidden in health policies, educational policies, social policies, etc., but have a direct impact on life expectancy, and reflect the "value" ascribed to different lives (Butler & Yancy, 2020). To illustrate, we will discuss the impacts of the response to the COVID-19 pandemic in Canada on long-term care facilities (LTC), low-wage essential workers, women and sex and gender minorities, migrants and BIPOC, and PWUD.

3.1 | Long-term care

During this pandemic, saving the lives of the elderly has been declared as the noble motif for the lockdowns. However, in June 2020, the Canadian Institute for Health Information (CIHI) reported that 80% of COVID-19 deaths in Canada had occurred in LTC homes (CIHI, 2020a). Seen from the perspective of life as such, these deaths of seniors in LTC are a direct consequence of the ongoing neoliberal transformation of the Canadian healthcare system. In the late 1990s, under the guise of the "Common Sense Revolution," the LTC system in Ontario was progressively privatized (Murnighan, 2001). Today, 54% of these are privately owned, and 28% of these are for-profit (CIHI, 2020c). When the mortality rates in LTC led to public outcry, the government called in the Canadian military to try to "stabilize" the situation in these facilities. Described as "disturbing" by Canada’s Prime Minister (DeClerq, 2020), the Canadian Forces' report on the state of LTC homes, attributed the COVID-19 deaths to inadequate PPE and staffing, insufficient supplies, generally poor conditions (e.g., rotting food, seniors sitting in soiled briefs and bed linen), and physical and emotional abuse of patients and staff (CMFMAG Team, 2020). It is important to note that all of these conditions in LTC homes significantly predate the pandemic (Mckay, 2003; Ontario Health Coalition, 2001). Thus, the root causes for the unacceptable conditions and unjustifiable deaths in these facilities are the privatization of LTC and the economic precarization of nurses and personal support workers. In order to support themselves financially, this precarization forces these workers to work in multiple homes, enabling the spread of the virus across multiple sites and endangering their own families. However, the decisive point is rather than attacking these root causes, which have devastating consequences for both the staff and the residents fighting for their naked lives, critics only attacked the inhumane living conditions and the "right" of the residents to have their lives "saved." It is in the name of life itself that
political requests have been made—with little success as deaths in these facilities continue to increase at a steady pace.

### 3.2 Low-wage essential workers

In March 2020, when the virus began spreading in North America, sweeping restrictions against travel, public gatherings, and closing all but "essential" businesses to prevent the spread of the virus were enacted (Office of the Premier, 2020a, 2020b). Held up as "heroes" (Office of the Premier, 2020c), low-wage essential workers (such as retail and food service workers, transportation and sanitation workers, unregulated healthcare providers) risk their lives so that individuals who have the privilege of self-isolating can do so (e.g., those with a home, stable income). In Alberta, the outbreak stemming from the Cargill meat processing facility resulted in over 1500 cases of COVID-19 and the deaths of three employees (Rieger, 2020b). The low-wage workers in these facilities are mostly new migrants and temporary foreign workers (Graveland, 2020; Rieger, 2020a). Workers have described conditions in meat processing facilities as "elbow-to-elbow" (Dryden, 2020) and "filthy" (Dryden & Rieger, 2020). Driven by concerns regarding interruption in the supply of meat (Seskus, 2020), workers described how they were pressured, and even bribed, to return to work even after testing positive for COVID-19 (Dryden & Rieger, 2020). Further, many of these workers live together in small, low-income, multigenerational homes (Graveland, 2020), and family members described being "worried for [their] lives" (Croteau, 2020). The discourse about the need to find a balance between public health and the economy necessitates that wasted lives be rejected into death so that others can live on; the well-being of one part of the population necessarily restricts the well-being of others.

Following the 2008–2009 recession, there were demonstrably increased rates of suicide, severe mental health concerns, and morbidity and mortality associated with alcohol and other drugs, particularly among those of lower socioeconomic status prior to the recession (Cheung & Marriott, 2015; Dom et al., 2016); these are what economists Case and Deaton (2020a) call deaths of despair. Thus, it is reasonable to conclude that there will similarly be innumerable deaths and illnesses that will be a direct consequence of governments’ policies in response to COVID-19. These eradicated lives are people already living in very precarious conditions, who will be unemployed, left without sufficient protections, and find themselves in extremely desperate situations.

### 3.3 Women, children, and sex and gender minorities

The increase in violence, particularly domestic violence (DV) during COVID-19, is another consequence of public health measures (UN Women, 2020). Data from countries around the world are showing an increase in intimate partner violence (UN Women, 2020), sexual and gender-based violence (Johnson et al., 2020), and child abuse (Storz, 2020), particularly youth who identify as LGTBQ (Osman, 2020). Bradbury-Jones and Isham (2020) highlight how imposed lockdowns have resulted in isolation from social support networks and resources, and that “home is not always a safe place to live; […] home is often where physical, psychological, and sexual abuse occurs” (p. 2047). Compounded by job loss and economic strain, quarantine conditions can result in increased levels anger, symptoms of post-traumatic stress, and alcoholism (Brooks et al., 2020; Finlay & Gilmore, 2020; Sánchez et al., 2020). Thus, the loss of wage labor as a result of the measures taken to contain the pandemic has a dual effect—not only does it create and maintain economic precarity, but it also potentiates conditions that foster DV. Normative societal views of the family influence the underreporting of DV and make it impossible to fully grasp the extent of physical/sexual violence in the home (Bradbury-Jones & Isham, 2020). Women, children, and sex and gender minorities are hidden victims of the imposed quarantine. Unable to access any labor protections, sex workers are also hidden victims; “the loss of income that would result from such social distancing measures prevents [sex workers] from working, and makes the difference between affording basic needs such as food, medicine, childcare, rent” (Butterfly Asian and Migrant Sex Worker Support Network & Maggie's Toronto Sex Workers Action Project, 2020). The key message is this: We count the global number of cases and deaths from day to day, but we must acknowledge that there is very limited information or data about the effect of the economic shutdown on those who depend on wage labor, their families, and their communities.

### 3.4 Race-based inequalities

Rates of COVID-19 infections and mortality among groups such as black, Indigenous, and people of color, migrants, and the marginally housed outpace those of more privileged groups (Carman, 2020; Subedi et al., 2020). In October 2020, Statistics Canada reported that in British Columbia, age-standardized mortality rates in neighborhoods with a high proportion (>25%) of groups designated as visible minorities were 10 times higher than in neighborhoods with the lowest proportion; in Ontario and Québec, they were three times higher (Subedi et al., 2020). In all provinces, age-adjusted mortality rates among these groups outpace their white or upper-middle-class counterparts (Subedi et al., 2020). In Toronto, “more than 80 percent of cases [are] happening in visible minorities. And […] over 50 percent to 60 percent of the cases in low-income households” (Carman, 2020). Despite this evidence, and the publication of guidelines for the collection of race-based data by CIHI (2020b), most provinces still do not collect race-based data and there has been no federal mandate to do so; as of December 22, 2020, the Canadian Federal Government still does not report on race-based data (Government of Canada, 2020b). Given the overwhelming evidence of the disproportionate impact of COVID-19 on visible minorities, the refusal to collect race-based data on the part of certain provinces illustrates
the acceptability of systemic racism in Canadian health care and works to perpetuate these inequalities (Wiafe & Smith, 2020).

For Canada’s Indigenous communities, the situation is increasingly dire. At the beginning of the second wave, the number of active cases in First Nations communities across the country began to increase exponentially (Indigenous Services Canada, 2020). For example, in Manitoba, First Nations individuals make up approximately 10% of the province’s population, but 23% of active COVID-19 cases and 38% of COVID-19 cases in the ICU (Fiddler, 2020). Located in northern Manitoba, at the Rod Mc Gillivary Care Home in Opaskwayak First Nation, all 28 residents, and almost half the staff, tested positive for the virus (Izri, 2020; Tsicos, 2020). Citing poor housing conditions, poverty, income insecurity, and the scarcity of health resources as factors increasing First Nations’ susceptibility to the virus and serious outcomes, the Physician Director of the Indigenous Physicians Association of Canada emphasized that “we can't deny the impacts colonization has had on Indigenous people, both historically and contemporary” (Gibson, 2020). In addition to the impact on First Nations communities, Nunavut reported its first confirmed active case of COVID-19 on November 6, 2020 (Savikataaq, 2020) and numbers swelled to top active cases by the end of November (CBC News, 2020b). Factors such as poverty, unemployment, food insecurity, and overcrowding, resulting from decades of colonial dispossession fundamentally underpin the rapid spread of the virus (George, 2020; Tranter, 2020). While the inadequacy of health services for Canada’s Indigenous is unconscionable (Toth, 2020), emphasizing this issue blurs the reality that systemic racism and ingrained colonialism within Canadian institutions and society underpins every aspect of the current situation faced by Indigenous people in Canada. What is particularly interesting is that similar trends among visible minorities and Indigenous people in Canada were observed during the H1N1 crisis in 2009 (Boggild et al., 2011; National Collaborating Centre for Aboriginal Health, 2016) and yet, in a decade, there has been little to no change to address the inequities underpinning these rates.

4 | HARM REDUCTION, PWUD, AND COVID-19

This brings us to the final and central considerations of this paper. PWUD have been particularly hard hit by the COVID-19 pandemic. In early- to mid-April 2020, civil society and community groups began sounding the alarm about the disproportionate impact of COVID-19 on PWUD. They noted an increase in overdose deaths (Government of Canada, 2020a) which was attributed to tainted drug supply (tainted because of border and travel interruptions; PHAC, 2020c), increased criminalization, and human rights violations (shelter, income, health; Canadian HIV/AIDS Legal Network, 2020). In the earliest stages of the pandemic, the Alliance for Healthier Communities wrote an open letter to the Deputy Premier of Ontario and minister of health Christine Elliott (April 3, 2020) in which they argued that immediately expanding the “Emergency Safe Supply” in Ontario could address both the opioid and overdose crisis, and the COVID-19 pandemic (Alliance for Healthier Communities, 2020). As a HR intervention, Safe Supply is defined as the “legal and regulated supply of mind- or body-altering substances” (Bonn et al., 2020, p. 557). In the context of the opioid and overdose crisis, safe supply most frequently takes the form of prescriptions for Hydromorphone (“dillys” that can be crushed, cooked, and injected) to ensure that the drug is “appropriately dosed and not adulterated,” reducing the risk of overdose (Bonn et al., 2020, p. 557). While the stated logic of safe supply is one of the right to consume drugs and respecting the agency and dignity of PWUD (Canadian Association of People Who Use Drugs, 2019), it has been transformed into a public health intervention that can “facilitate physical isolation by preventing a need to seek funds to purchase unknown substances from unregulated drug markets” (Bonn et al., 2020, p. 557). Other groups, such as the Manitoba Harm Reduction Network, also wrote to government leaders and advocated for the decriminalization of drugs, or a moratorium on pursuing PWUD during the pandemic (Manitoba Harm Reduction Network, 2020). In a similar vein, the HIV Legal Network (2020) launched their “#FlattenInequality #Policingthepandemic” campaign to bring attention to Human Rights violations in the time of COVID-19. They specifically emphasize that “criminalization is not an evidence-based response to public health issues” and that criminalization creates barriers to “prevention, testing, care and treatment” (p. 2). Here, the logic is that the decriminalization of drugs will make PWUD more visible to health professionals (particularly in public health and HR). Making visible is the first step in imposing the public health mandates necessary to “save” their lives. This also illustrates how the sacredness of life, the importance accorded to the biologic, is how HR has become an essential part of the public health solution for stopping the spread of the virus.

As the pandemic progressed, some “life-saving” HR services were scaled down or suspended altogether, individuals experiencing homelessness became increasingly precarious, and overdose deaths continued to increase (Ferreira, 2020). On May 29, 2020, the Chief Public Health Officer of Canada described the trend of increased drug-related deaths since the onset of COVID-19 as “worrying” and asserted the importance of “never us[ing] alone” (PHAC, 2020b). Health and civil society groups identified a paradox in this messaging—PWUD are not able to socially distance if they must “never use alone” (Goodwin, 2020). This conflicting messaging underscores another HR intervention that has gained prominence during the pandemic: housing (Wills & Montgomery, 2020). Despite years of advocacy for HR to include a “housing-first” approach (Gaetz et al., 2013; Harm Reduction International, 2018; Moore, 2013), this was never addressed nor considered possible before the threat of the virus and the “life-saving” potential of physical and social distancing. Put simply, if the marginally housed, and by extension some PWUD, are provided with adequate shelter (housing, accommodations, or otherwise), they will be able to socially distance and therefore saved from the virus. This complements safe supply, which makes it “safe” to use drugs alone or socially distanced. In the context of COVID-19, the argument goes that PWUD should be able to use drugs but in a
very particular “safe” way. Seen from the perspective of life itself, the emphasis on “safe” use implements a biopolitical rationale in the managing of this particular “at-risk” group. Further, through strict prescribing guidelines, health practitioners are now recording and dictating the type of drugs that can and should be used, as well as the amount and the frequency of drug consumption. At Safe Injection Sites, staff must record information such as the substance being consumed, the route, the site, the amount of time spent in the site, and any interactions between themselves and the PWUD. We can see a larger project at play that has been intensified during the pandemic: every aspect of drug use can be scrutinized and measured, meaning that it can be evaluated and normalized.

But we want to demonstrate how biologitcimacy enables us to develop a critical perspective on the politics of HR during the pandemic. In October 2020, the British Columbia Coroners’ Report stated that there had already been 1200 drug-related deaths from Jan-Sep 2020, compared to 986 for the entirety of 2019 (CBC News, 2020a). In particular, drug-related deaths in September 2020 were more than double those in September 2019 (CBC News, 2020a). It is important to note that deaths in 2019 were already the outcome of an opioid crisis, which means that PWUD now find themselves at the intersection of two public health crises: an opioid crisis and the COVID-19 pandemic. The Chief Public Health Officer of Canada’s Report on the State of Public Health in Canada 2020 was released in October 2020. In the report titled From risk to resilience: An equity approach to COVID-19, tackling the “health inequities” created by “structural determinants of health” is the new motif for Canada’s public health project (PHAC, 2020a). In this new vision, virtually all aspects of society are now health problems (p. 21). The COVID-19 crisis has made increasingly visible underlying inequalities in our societies but it has also made it possible to medicalize these inequalities. Thus, these statements formulate what could be called a politics of care which is morally legitimated by reference to the suffering body and the notion of emergency. Under this politics of care, the pandemic has catalyzed the subsumption of a variety of social problems under the umbrella of HR and public health. The suffering body of PWUD and the emergency situation become the foundation of political action—“inequities” are identified as what hinders the ability of individuals to live healthier lives.

In the discourses around the opioid and overdose crisis and the COVID-19 pandemic, biological integrity clearly holds a sacred place. The production of PWUD as subjects takes place at the intersection of the neoliberal political economy and regimes of care—a subject that ironically has more rights and better chances for health care, human rights, and housing when it is diseased than when healthy. To be able to understand this paradoxical subject position, it is necessary to understand that with new humanitarianism, biological resources become commensurate with political resources. The problem therein is one particular aspect of humanitarian government: neutralizing the political element by supplanting it with the incontestable rationale of saving lives. It is no longer a question of political struggle, but of health “crisis” (Foth, 2020); we no longer need to fight for an amelioration in conditions, but we can concern ourselves simply with the question of keeping PWUD alive. Although veiled as social projects, the current discourse stipulates these projects insomuch as they pertain to the biologic condition, there is no question about the political dimension of PWUD’s quality of life. Human rights are stipulated through determinants of health, which are fundamentally about optimizing the biological and the physical, not challenging the status quo. It is as if the current discourse only leaves the possibility of advocating in the name of life itself. Everything is stipulated through the biologic.

5 | BIOSOCIALITY, BIOLOGICAL CITIZENSHIP, AND BIOCAPITAL

Rabinow (1996) introduced the concept of biosocial spaces that refer to social communities created by a shared diagnostic or illness and open possibilities to use biology as a flexible and social resource. Biology, as understood in biosociality, focuses on the materiality of the life processes of human beings or on life itself. Biosociality in the context of HR movement becomes the socially, politically, and economically framed choice to draw on one’s biology (i.e., addiction and medical sequelae) in order to advocate for political actions. Biosociality is closely linked to what Rose and Novas (2005) called biological citizenship, a concept first introduced by Petryna (2004) in her work about the victims of the Chernobyl disaster who were granted political status based on the proven physical consequences they suffered as a direct result of the radiation. Due to physical conditions of victims of the Chernobyl disaster, social rights were granted and compensation given. This further illustrates the linking of the living (or the biological, medical) with the meaning of politics (citizenship and social rights). The focus on the materiality of the life processes of human beings has become a signifier within the field of biomedicine—bodies are increasingly perceived and understood in biological terms on neurological, genetic, microbiological as well as other dimensions. According to Rose (2007), natural life is no longer something that must be accepted but is rather something that can be changed and “corrected” on the molecular level; “natural” life must be produced through the work of the self on the self. In neoliberalism, the self can optimize and adapt their body to the societal expectations by using psychopharmaceuticals, plastic surgery, etc. For the wealthy, in this new moral economy, it is an expectation to “optimize” their body; it is an active modeling of one’s biological resources that shapes one’s future. Naturally, the ability to manipulate one’s corporeality depends on where one is positioned in regard to circuits of capital and governance. For some, their ability to choose and manipulate their corporeality in the capitalist system makes their biology a biocapital. In contrast, in the context of humanitarian governance, biology is understood as immutable and biologically based suffering (in the case of PWUD, their risk of death or medical sequelae) is “legitimate” and treatable. These two dimensions imply different notions of hope and the limits and costs of malleability of biology and well-being. For the subject of humanitarianism, biology is understood as immutable because they are only visible through biology. In contrast with the liberal subject’s malleable biology, the
"victim's" biology is fixed; PWUD become intelligible only through their biological condition and thus, biology becomes their essence. As we see with the COVID-19 pandemic, only the legitimate risk of the virus to the health and life of PWUD becomes the fundamental justification for advocacy; only a "legitimate" threat (as opposed to the "choice" to consume drugs) can be the catalyst for change.

The legitimacy of the suffering body is based on the acknowledged ubiquity of the sacred bare life (Ticktin, 2011). Suffering understood in biological terms is the bare, naked, minimal humanity that Agamben, Arendt, and Benjamin discussed (Agamben, 1998; Arendt, 1958; Benjamin, 2004). For this universal humanity, biology is the incontestable truth and the members of this naked minimal humanity are legitimated through biology's fixity; "bodies tell the truth; biological measures cannot dupe the system" (Ticktin, 2011b, p. 146). This illustrates the dual regime of truth at work. The liberal, wealthy subject can manipulate their biological capital as their biology is fluid and open to choice; through work on the self, they can improve their biocapital. For the suffering subject of new humanitarianism their biology is fixed—it is their essence. Therefore, they are unable to "work" on their biological fate and cannot be subjects or agents in the same manner as wealthy liberal subjects. They are victims of their desires and addiction despite humanitarian assertions to treat them as equals. These victims' choices are reduced to behaving in a responsible and "rational" way in order to avoid the consequences of their addiction, or contemporarily with the COVID-19 pandemic, to be on "safe" supply and socially distance (Ticktin, 2011a, p. 212; see also: Feldman & Ticktin, 2010; Redfield, 2008).

In this new humanitarianism, illness becomes political and the biological condition determines the social condition. One could even say that the biological life (life itself) becomes the foundation for social recognition and the prospect of death (overdose or COVID-19) ensures the social life of PWUD. What is impossible to achieve in this framework is a more comprehensive form of recognition. Drug use, and the biological risks associated with it, becomes one of the rare resources available to PWUD; their biology provides them with access to the circuits of relative wealth and privilege. For example, "peers" are employed (although precariously) in supervised injection sites to supervise injectors and are often held up as role models for what can be achieved through "responsible" drug use or sobriety (Gagne et al., 2018; Greer et al., 2020). However, despite the fact that their "biology provides hope for a better life, this politics of care refuses inclusion or recognition under conditions of equality" (Ticktin, 2011a, p. 217), they are still recognized as victims. With the concept of biologitimation, it becomes possible to analyze these constructions of meaning and values of life. In contrast to biopolitics and governmentalities, it is not only about tactics and strategies aimed to control life and the technologies to achieve these ends, but also about the question of how humans are treated and how lives are evaluated.

6 | CONCLUSION

Current discourses surrounding HR preclude any question about life as such; there is only recognition of the physical/biological despite the fact that it is often mentioned in the background of humanitarian HR campaigns. Under regimes of care, there is a linking of the political with the biological and a biopolitical critique cannot fully capture the unequal evaluation of lives in our societies. Using the concept of biologitimation, we have shown how the sacredness of life itself naturally engenders and maintains inequalities that result in a hierarchization of lives and that the worth of life is a political question. Using examples from the response to the COVID-19 pandemic, we have made explicit the paradox between the imperative to save lives, the unequal evaluation of those lives, and which can be "rejected" into death." (Fassin, 2009, p. 52). Thus, the decisive point that is missed in HR, advocacy, and public health is that we need to fight against the conditions resulting from the capitalist (and more specifically neoliberal) mode of production and rational that increasingly produces wasted lives. While the pandemic has made perfectly clear that there are deeply entrenched inequalities of biological lives, we need to act in regard to the inadequacies of the biographical life, the life as such, that reflects the larger social and political context. Instead of advocating for reducing the harm of this neoliberal ruthless exploitation and to safeguard the survival of biological life, we need a form of care that is not restricted to the individual, a form of care that is not performed by professionals like physicians and nurses, but rather we need to fight for care as the foundation of our society as a whole.

CONFLICT OF INTEREST

The authors have no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no datasets were generated or analyzed during the current study.

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