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HIV /AIDS BODY AND ISSUES OF SOCIAL SECURITY: CRITICAL VIEW FROM PUBLIC HEALTH GOVERNANCE

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Abstract
Body in general and HIV/AIDS related bodies in particular re-configuration within the framework of 'power mechanism' which is operating in society. The body also symbolized the concentration of a centralized power: which is reproduced and reproduced. From the Foucault point of view: Individuality was not simply an idea but it is concrete realization in the facility of the body. HIV/AIDS and its lentil property, has become a powerful infectious disease that are remain non-curable. Its non-curable and devastating characteristic has to be pronounced to be security issues that pose stability and security risk if left unchecked. Nevertheless, HIV/AIDS securitizing moves are demand to have been generated at the international level since 1990. Arguably , HIV/AIDS related risk wants the international institutional engagement and related initiative that would be play a very significant role in providing normative and technical support to sure social conformity and social stability through the public health governance framework. Socio-cultural character of the HIV/AIDS and related health issues is intrinsic the redefinition and claims upon the state and non-stat participation in framing HIV/AIDS related programmers and policies; it also embedded with the newly prosperous theoretical investigation within social sciences arenas.

***Keywords: Body, HIV/AIDS, Risk, Security, State and non-state engagement, public health Governance*.**

Nothing in man, not even his body, is sufficiently stable to serve as the basis for self-recognition or for understanding other man. The traditional devices for constructing a comprehensive view of history and for retracing the past as a patients and continuous development must be systematically dismantled. Necessarily, we must dismiss those tendencies that encourage the consoling play of recognitions.

Introduction

The body often appears to be a passive medium that is signified by an inscription from the socio-cultural sources. However the body is a culturally constructed through the suspected of generality when it is characterized as passive , non-productive and prior to dominant discourse .From the precedent of word from Christian and Cartesian , understand the body as so much inert matter , signifying no\thing or specifically , signifying a profane void , the fallen state as a deception , sin and premonition metaphoric of hell and eternal problematic , prior to the emergence from the nineteenth century vitalistics biology and socio-physic tic intervention .work of Beauvoir about the body where is figured out as a mute facticity that which anticipating the socio-cultural meaning that can be attributed only transcendent consciousness that would be signification itself as the act of a radically disembodied consciousness .

Whereas from the words of Mary Douglas in her Purity and Danger suggested that:
The body is established through marking that seeks to established specifics code of cultural coherence. Any discourse that established the boundaries of the body serves the purpose of instating and naturalizing certain taboos regarding the appropriate limits , postures , and modes of exchange that define what it is the constituted the bodies .

Her analysis however suggested that the limits of the body in never merely material, but that the surface, the skin, is systemically signified to manifest by the social taboo and anticipated transgression; indeed, the boundaries of the body become limit of the social per se. In this contingence, Simon Watney has been identified the contemporary social construction of HIV/AIDS identity through the notion of ''the polluting person'' as the person who have living with HIV/AIDS. not only this illness characterized as a gay disease , but rather interpellation as a illness of homophobic response there have been tactical construction of continuity between the polluted status of the homosexual by virtue of the boundaries between homosexuality and the disease as a specific modality of homosexual pollution (Butler, 1990). Because HIV/AIDS is transmitted through the exchange of bodily fluids that suggested within the sensationalist pictographic as a homophobic signifying systems the danger that permeable bodily boundaries to social order to social conformity. In this regards, Douglas remarks that,

The body is a model that can be stand for any bounded system. Its boundaries can represent any boundaries which are threaten or precarious. HIV/AIDSS body represent certain kind of bodily permeability's that can be unsanctioned ed by the hegemonic normatively, that constituted certainty of risk and social security, prior to and regardless of the cultural presence of HIV/AIDS. Douglas alludes to say that: A kind of sex pollution which express a desire to keep the body (physical and social) intact.

Significantly, Kristeva suggested that from the structuration notion of boundary constituting taboo for the purpose of constructing a discrete subject of exclusion. (Butler, 1990) . The abject designates that which has been expelled from the body, discharge as a excrement, literally render as a others. This notion of others (HIV/AIDS Infected People) designated as a an expulsion of alien elements, but the alien is strongly rooted in expulsion. An expulsion followed by the repulsion that found and consolidated through the socio-cultural hegemonic identities along with social acceptation or rejection . Kristeva argues that repulsion consolidated the identities through the operation of exclusion and domination. Which execrated through the distinction between us and them social world that signified the subject of border and boundaries tenuously maintained and surveillance for the purpose of social regulation and control?

Where Foucault suggested that from the very theme of genealogy, the body is figured as a surface and the scene of a cultural inscription and the body is the inscribed surface of events. In a situation , for Foucault , as for Nietzsche , cultural values of the body emerged as a product of inscription on the body ,understood as way of medium , indeed , for values inscription to identify , however, the medium must itself as destructed the sublimated values of cultural and transfigured in order for cultural construction .

From his genealogy attempts to suggested that in the realms of bodies, power and spaces:
Once knowledge can be analyzed in terms of region, domain, implantation, displacement, transposition, one is able to capture the process by which knowledge functions as a form of power. It has been suggested that, from the work of Foucault:
Power and knowledge operates in the space of the body, not of geography … space is fundamental in any exercise of power because control of bodies as fundamental.''

On January 10 of that year (2000), at the behest of U.S. Ambassador Richard Holbrook and Vice- President Al Gore, the United Nations Security Council officially designated HIV/ AIDS as a threat to international peace and security in Africa. It was an immensely symbolic occasion because this was the first meeting of the Council in the new millennium and because it was the first time in the Council's history that it had designated a health issue as a threat to international security. In his position as president of the World Bank, James Wolfensohn (2000) argued on this occasion that:
"[m]any of us used to think of AIDS as a health issue. We were wrong. ... Nothing we have seen is a greater challenge to the peace and stability of African societies than the epidemic of AIDS. ... We face a major development crisis, and more than that, a security crisis."

From the logic of the Austinian Speech-act theory HIV/AIDS being securitized when the securitizing actors involve to utter s "HIV/AIDS is a security threat "However, securitizing actors may not always use the exact "security words" of the securitization concepts through the words 'security' and threat' in attempting to bring the issues in the realm of social security. From the words of, Huysmans, as that:There exists cultural specificities of the rhetorical structure of the speech act and thus securitizing agents can be motivated by the political and cultural factors.

Prior to the long history about the Health-security linkage implied the sense of urgency in responding to anticipated and forecasted threat, which justified the securitizing the infectious disease rather than chronic disease. However , , like others infectious disease HIV/AIDS first infectious disease to be frame as a national and social all in all global security threaten issues since 1990. While some scholar cited that absence of any direct causalities linkage between HIV/AIDS and social security but where as others acclaimed that collective impact of the disease on social structure and internal strength of the state are obviously undeniable.

Health is vital because it determine the survivals of the human race and constitutes a key dimension of soci-economic development In this regards Chen (2004) elaborately said that human security and health are closely linked because good health is intrinsic to human security , since human survival and good health are at the core of security ; good health is also instrumental to human security as it enables the full range of human functioning '' .So , good health should be attained prior to advocating others aspects of human security. As Orbinski remarked that:

''Is global health simply a security concern . . . or is global health best conceptualized as pursuing equity , and fairness , justice , and as fundamentally considering public health measures and access to health care and healthcare technologies, such as drugs , as a basic human entitlements" .

Although human security discourse offers a good start for developing the health-security linking and it has lacks a substantive conceptual and analytical framework for understanding health issues within the security discourse. This inadequacy is countered by the analytical framework in securitization theory.

Securitization Theory and HIV/AIDS

How, then, does one begin such a normative debate? Even though there has been an immense resurgence in normative theorizing in international relations over the. These arguments closely parallel those in Dewdney (1990). " For more general reflections on the normative questions the AIDS pandemic gives rise to, see Harris and Siplon (2001), and the special section on "Health and Global Justice" in Ethics and International Affairs 16 (2), Fall 2002. Should HIV/AIDS Be Securitized? Past decade (Brown 1992, 2002; Nardin and Mapel 1993; Bonanate, Puchala, and Kegley 1995; Frost 1996; Keim 2000; Seckinelgin and Shinoda 2001; Odysseos 2002, 2003), there has been markedly less engagement with the particular ethical tradeoffs involved in bringing the language of international security to bear on wider social issues. For those interested in such questions, the locus classics has quickly become the influential study by Barry Buzan, Ole Waever, and Jaap de Wilde (1998) entitled Security: A New Framework for Analysis Not only is the "securitization" theory presented in this framework widely considered to be among the most important, original, and controversial contributions to the field of security studies in recent years (Huysmans 1998:480), it also remains the only systematic scholarly study of the ethical implications of widening the security agenda to include an array of non-military issues-making it a natural starting point for a more sustained normative debate about the securitization of HIV/AIDS. Although securitization theory is not exclusively concerned with normative questions, and also has important analytical interests in tracing the detailed social processes through which security threats become constructed by political actors, it is predominantly this normative dimension of the framework that remains indispensable for opening up a wider ethical debate about framing HIV/AIDS as an international security issue. Indeed, securitization theory can address these normative questions more readily than many longer standing neorealist or neoliberal approaches to international security, because its constructivist account of security remains highly sensitive to the inter subjective and per formative nature of portraying social issues as security concerns, that is, of "speaking" security. Securitization theory forms part of a growing body of literature bringing the insights of speech act theory-as pioneered by J. L. Austin (1962) at Harvard University in the 1950s and subsequently developed by several other prominent philosophers and linguists (Searle 1969)-to bear on social and political analysis. Austin (1962:1) famously argued that the point of speech act theory was to challenge the assumption that "the business of a 'statement' can only be to 'describe' some state of affairs, or to 'state some fact,' which it must do either truly or falsely." Even though language certainly encodes information, speech act theory illustrates that language can also do much more than just convey information, and that even when it is used primarily to convey information, language often conveys more than just the literal meaning of the words.. By way of extension, for Buzan, Waever, and de Wilde, labeling an issue a security issue also constitutes such a performative speech act. For them (1998:26) security "is not interesting as a sign referring to something more real; it is the utterance itself that is the act. By saying the words, something is done (like betting, giving a promise, naming a ship)." Security is thus not viewed by these three scholars as something that exists independently of its discursive articulation,"' but rather as a particular Wxever (1995) and Williams (2003). A more comprehensive analysis of the securitizing actors, agendas, and strategies has already been under- taken by Sheehan (2002). In this way, their study forms part of a larger research effort to view security issues as being socially constructed. See, for example, Wendt (1992, 1999), Finnemore (1996), Katzenstein (1996), Adler (1997), Hopf (1998), Barnett and Finnemore (1999). 13 On this point see also Hansen (2000:288).

Form of per formative speech act; security is a social quality political actor, such as intelligence agencies, government officials, and international organizations, inject into issues by publicly portraying them as existential threats (Buzan, Wever, and de Wilde 1998:204). Whereas more traditional approaches to security operate within a specific definition of security, revolving for example around the deployment of armed force in world politics, and then seek to ascertain empirically whether an issue genuinely represents a security threat, for securitization theory the designation of an issue as a security threat is primarily an inter subjective practice undertaken by security policy makers. "It is a choice to phrase things in security ... terms, not an objective feature of the issue . . . ." (Buzan, Waever, and de Wilde 1998:211); or, as Weaver (1995:65) put it elsewhere, the "[u]se of the security label does not merely reflect whether a problem is a security problem, it is also a political choice, that is, a decision for conceptualization in a special way."

The leader of a political party, for example, can choose whether to portray immigration as a security issue or as a human rights issue. Similarly, leaders of international organizations can choose whether they portray HIV/AIDS as a health issue, as a development issue, or, as they have done more recently, as an international security issue. According to the framework of Buzan, Waever, and de Wilde, the determination of which issues end up on the international security agenda cannot consequently be made solely on the basis of empirical criteria. Much security analysis entails making speculative predictions about future developments, necessitates prioritizing between competing claims with imperfect information, and, especially when it comes to wider social issues, requires deciding about whether an issue is best addressed under the heading of security rather than another competing framework.

Inevitably, there is a considerable element of politics involved in determining how a social issue is presented in public debate. An issue can either remain non-politicized if it is not made an issue of public debate or decision, or it can become politicized if it is successfully made part of public policy and subject to a public decision. Finally, in the extreme case, an issue can become "securitized," by which Buzan, Waever, and de Wilde (1998:23-24) mean very specifically that it is "presented as an ex-istential threat requiring emergency measures and justifying actions outside the normal bounds of political procedure." The security quality of an issue thus does not reside for them in the nature of the issue itself or in the anticipated empirical effects of a particular phenomenon, but it derives from the specific way in which an issue or phenomenon is presented in public debate. Buzan, Waver, and de Wilde provide their framework with a high degree of analytical focus by further specifying the precise conditions that collectively make up this "security" speech act. Rather than addressing all instances in which the word "security" is used, or all wider calls for the adoption of emergency measures, securitization theory applies only to those issues that are presented according to the particular logic or grammar of the security speech act (Buzan, Waever, and de Wilde 1998:25).

The four constituent components of this security speech act (Buzan, Wever, and de Wilde 1998:24, 36) are presence of the following: (i) securitizing actors (such as political leaders, intelligence experts, etc.), declaring (ii) a referent object (such as a state)' to be (iii) existentially threatened (e.g., by an imminent invasion), Referent objects of security do not necessarily have to be states or militaries, but more generally "things that are seen to be existentially threatened and that have a legitimate claim to survival" (Buzan, Wxever, and de Wilde 1998:36). Examples of this security grammar can thus be found operating both in regard to military issues and throughout the wider security agenda. For example, it is just as possible for non-governmental organizations (securitizing actors) to declare humanity or the biosphere (referent objects) existentially threatened by greenhouse gases, requiring drastic social changes. Of course, Buzan, Waever, and de Wilde are aware that, in practice, there are important constraints on which actors can successfully securitize issues. Although it remains a theoretical possibility, they find that individuals and small groups of people are rarely able to establish a wider security legitimacy in their own right. Nevertheless, this flexibility in their framework in principle allows it to be applied to the wider security agenda, including HIV/AIDS, without losing analytic focus as a result.

3.However, associating with the health and security ought not be imply ignorance the basic understanding rather offer a linking retains the core valued embedded in public health, while strengthen the idea of security related strategies and tactics, which is the core values of the public health securitism. In broad terms, public governance can be defined as the actions and means adopted by a society to promote collective action and deliver collective solutions in pursuit of common goals. This a broad term that is encompassing of the many ways in which human beings, as individuals and groups, organize themselves to achieve agreed goals. Such organization requires agreement on a range of matters including membership within the co-operative relationship, obligations and responsibilities of members, the making of decisions, means of communication, resource mobilization and distribution, dispute settlement, and formal or informal rules and procedures concerning all of these. Defined in this way, governance pertains to highly varied sorts of collective behaviour ranging from local community groups to transnational corporations, from labour unions to the UN Security Council. Governance thus relates to both the public and private sphere of human activity, and sometimes a combination of the two. Importantly, governance is distinct from government.

As Rosenau (1990) writes, Governance is not synonymous with government. Both refer to purposive behaviour, to goal oriented activities, to systems of rule; but government suggests activities that are backed by formal authority…whereas governance refers to activities backed by shared goals that may or may not derive from legal and formally prescribed responsibilities and that do not necessarily rely on police powers to overcome defiance and attain compliance. Government, in other words, is a particular and highly formalized form of governance. Where governance is institutionalized within an agreed set of rules and procedures, regular or irregular meeting of relevant parties, or a permanent organizational structure with appropriate decision making and implementing bodies, we can describe these as the means or mechanisms of governance (Finkelstein 1995), of which government is one form. In other cases, however, governance may rely on informal mechanisms (e.g. custom, common law, cultural norms and values) that are not formalized into explicit rules.

Health governance concerns the actions and means adopted by a society to organize itself in the promotion and protection of the health of its population. The rules defining such organization, and its functioning, can again be formal (e.g. Public Health Act, International Health Regulations) or informal (e.g. Hippocratic oath) to prescribe and proscribe behaviour. The governance mechanism, in turn, can be situated at the local/sub-national (e.g. district health authority), national (e.g. Ministry of Health), regional (e.g. Pan American Health Organization), and international (e.g. World Health Organization) and, as argued in the global level. Furthermore, health governance can be public (e.g. National Health Service), private (e.g. International Federation of Pharmaceutical Manufacturers Association), or a combination of the two (e.g. Malaria for

Medicines Venture). Historically, the locus of health governance has been at the national and sub-national level as governments of individual countries have assumed primary responsibility for the health of their domestic populations. Their authority and responsibility, in turn, has been delegated/distributed to regional/district/local levels. Where the determinants of health have spilled over national borders to become international (transborder) health issues .

(e.g. infectious diseases) two or more governments have sought to cooperate together on agreed collective actions. Growing discussions of the need to strengthen health governance at national, regional, international and, more recently, the global level has, in part, been driven by a concern that a range of globalizing forces (e.g. technological change, increased capital flows, intensifying population mobility) are creating impacts on health that existing forms of governance cannot effectively address. This has led to debates about, for example, the appropriate balance among different levels of governance, what roles public and private actors should play, and what institutional rules and structures are needed to protect and promote human health.

This paper sees globalization as an historical process characterized by changes in the nature of human interaction across a range of social spheres including the economic, political, technological, cultural and environmental. These changes are globalizing in the sense that boundaries hitherto separating us from each other are being transformed. These boundaries – spatial, temporal and cognitive - can be described as the dimensions of globalization. Briefly, the spatial dimension concerns changes to how we perceive and experience physical space or geographical territory. The temporal dimension concerns changes to how we perceive and experience time. The cognitive dimension concerns changes to how we think about ourselves and the world around us (Lee 2000b). Many argue that globalization is reducing the capacity of states to provide for the health of their domestic populations and, by extension, intergovernmental health cooperation is also limited. The impact of globalization upon the capacity of states and other actors to co-operate internationally to protect human health is fourfold. First, globalization has introduced or intensified trans-border health risks defined as risks to human health that transcend national borders in their origin or impact (Lee 2000a). Such risks may include emerging and reemerging infectious diseases, various non-communicable diseases (e.g. lung cancer, obesity, and hypertension) and environmental degradation (e.g. global climate change). The growth in the geographical scope and speed in which trans-border health risks present them directly challenge the existing system of IHG that is defined by national borders.

The mechanisms of IHG, in other words, may be constrained by its state-centric nature to tackle global health effectively (Zacher 1999b). Second, as described above, globalization is characterized by a growth in the number, and degree of influence, of non-state actors in health governance. Many argue that the relative authority and capacity of national governments to protect and promote the health of domestic populations has declined in the face of globalizing forces beyond national borders that affect the basic determinants of health as well as erode national resources for addressing their consequences (Deacon et al. 1997). Non-state actors, including civil society groups, global social movements, private companies, consultancy firms, think tanks, religious movements and organized crime, in turn, have gained relatively greater power and influence both formally and informally. The emerging and potential role of civil society and private sector in global health governance are discussed is becoming more complex, with the distinct roles of state and non-state actors in governance activities such as agenda setting, resource mobilization and allocation, and dispute settlement becoming less clear. New combinations of both state and non-state actors are rapidly forming, in a myriad of forms such as partnerships, alliances, coalitions, networks and joint ventures. This apparent “hybridization” of governance mechanisms around certain health issues is a reflection of the search for more effective ways of cooperation to promote health in the face of new institutions. At the same time, however, it throws up new challenges for creating appropriate and recognized institutional mechanisms for, inter alia, ensuring appropriate representation, participation, accountability and transparency. Third, current forms of globalization appear to be problematic for sustaining, and even worsening existing socioeconomic, political and environmental problems. UNDP (1999), for example, reports that neoliberal forms of globalization have been accompanied by widening inequalities between rich and poor within and across countries.

In a special issue of Development4, authors cite experiences of worsening poverty, marginalization and health inequity as a consequence of globalization. In some respects, these problems can be seen as “externalities” or “global public bads” (Kaul et al. 1999) that are arising as a result of globalizing processes that are insufficiently managed by effective health governance. As Fidler (1998a) writes, these deeply rooted problems “feed off” the negative consequences of the globalization of health, creating a reciprocal relationship between health and the determinants of health. Although many of these problems are most acute in the developing world, they are of concern to all countries given their transborder nature (i.e. unconfined to national borders). Fourth, globalization has contributed to a decline in both the political and practical capacity (see reading) of the national governments, acting alone or in cooperation with other states, to deal with global health challenges. While globalization is a set of changes occurring gradually over several centuries, its acceleration and intensification from the late twentieth century has brought attention to the fact that states alone cannot address many of the health challenges arising.

Infectious diseases are perhaps the most prominent example of this diminishing capacity, but equally significant are the impacts on non-communicable diseases (e.g. tobacco-related cancers), food and nutrition, lifestyles and environmental conditions (Lee 2000b). This decapitating of the state has been reinforced by initiatives to further liberalize the global trade of goods and services. The possible health consequences of more open global markets have only begun to be discussed within trade negotiations and remain unaddressed by proposed governance mechanisms for the emerging global economy. The fourth of the above points is perhaps the most significant because it raises the possibility of the need for a change in the fundamental nature of health governance. As mentioned above, IHG is structured on the belief that governments have primary responsibility for the health of its people and able, in co-operation with other states, to protect its population from health risks.

Globalization, however, means that the state may be increasingly undermined in its capacity to fulfill this role alone, that IHG is necessary but insufficient, and that additional or new forms of health governance may be needed.. This process of institutionalization of IHG, according to Fidler (1997), was a consequence of the intensified globalization of health during this period. Notably, these initiatives enjoyed the support of political and economic elites across European societies who believed that the cross border spread of disease would hamper industrialization and the expansion of international trade (Murphy 1995; Fidler 1998a). The first institution to be created during this period was the International Sanitary Conference, with the first conference held in 1851. The achievements of this meeting, and the ten conferences subsequently held over the next four decades, were limited. In total, four conventions on quarantine and hygiene practices were concluded, along with an agreement to establish an institution for maintaining and reporting epidemiological data, and coordinating responses to outbreaks of infectious diseases (Lee 1998). Importantly, however, the conferences formalized a basic principle that has defined subsequent efforts to build IHG, namely the recognition that acting in cooperation through agreed rules and procedures enable governments to better protect their domestic populations from health risks that cross national borders.

As such, the institutions adopted were envisioned as an extension of participating governments' responsibilities in the health field to the international (intergovernmental) level. Along with this emerging sense of an international health community, constructed of cooperating states, was a growing body of scientific knowledge that was beginning to be shared in a more organized fashion (1998a). Scientific meetings on health-related themes reflected substantial advances during this period in understanding the causes of a number of diseases, such as cholera and tuberculosis. Many medical practitioners and public health officials building national public health systems at the national level (e.g. Margaret Sanger) became closely involved in designing these early international health institutions. Many of attended international scientific conferences from the mid nineteenth century, bringing with them a strong belief that international The twelve health-related international institutions established compares with five on human rights, three on humanitarian relief and welfare, and ten on education and research (Murphy 1995). health cooperation should seek to provide health to as many people as possible. To achieve this vision of ‘social medicine’ required a strong emphasis on universality as a guiding principal, achieved through the inclusion of as many countries as possible in any international system of health governance that was formed. International Health Governance after the Second World.

The postwar period brought a significant expansion in IHG through the establishment of new institutions and official development assistance for health purposes. Within the UN system, the World Health Organization (WHO) was created in 1948 as the UN specialized agency for health. Other organizations contributing to health were the UN Relief and Rehabilitation Administration (UNRRA) in 1943, UN International Children’s Emergency Fund (UNICEF) in 1946 and UN High Commissioner for Refugees (UNHCR) in 1949. WHO was similar in a number of ways to the Health Organization of the League of Nations that preceded it. Above all, the ideal of universality was, and remains, central to its mandate and activities. As stated by the Constitution of WHO (1946), the overall goal of the organization is “the attainment by all peoples of the highest possible level of health”. Even in the face of skepticism at the attainability of such a mandate, and challenges to the appropriateness of social medicine (Goodman 1971), WHO was founded with a strong commitment to addressing the health needs of all people. The universalism of WHO has been reaffirmed on a number of occasions since 1948, most clearly during the 1970s with the Health for All strategy and Renewing Health for All Strategy in the 1990s (Antezana et al. 1998). WHO pledge to universality, however, has been strongly defined by the sovereignty of its member states? The working assumption of the organization has been that "health for all" can be achieved by working primarily, if not exclusively, through governmental institutions, notably ministries of health. Universality, in this sense, is measured by number of member states. Where a large number of countries participate, such as the World Health Assembly (WHA), it is assumed that the health needs of all peoples are represented.

The role of WHO, in turn, is designed as supporting the efforts of governments to promote and protect the health of their populations. Beyond national governments NGOs have been allowed to apply for permission to enter into official relations with WHO since 1950 if it is concerned with matters that fall within the competence of the organization and pursues (whose

aims and purposes are in conformity with those of the Constitution of WHO). In 1998, there were 188 NGOs in official relations (WHO 1998) from such diverse fields as medicine, science, education, law, humanitarian aid and industry. In principle, therefore, NGOs are recognized as important contributors to achieving the goals of WHO. In practice, however, the actual role NGOs have played has been limited. Lucas et al. (1997), for example, found that WHO has engaged with NGOs in its support at country level in contrast with trends within agencies and other UN organizations such as UNDP and UNICEF. At the headquarters and regional levels, officially recognized NGOs have observed proceedings of the World Health Assembly or meetings of the regional committees, and have limited access to programme related meetings dealing with more specific health issues. However NGOs have not been routinely consulted despite their importance as channels of health sector aid since the 1980s (Hulme and Edwards 1997) increased. This traditional focus on member states and, in particular, ministries of health has been in a context of greater diversity of policy actors. By the mid 1990s, 12 the map of IHG was one of considerable uncertainty, as Zacher (1999bc) describes, fractured into an "organizational patchwork quilt". Alongside WHO has emerged a multiplicity of players, each accountable to a different constituency and bringing with them different guiding principles, expertise, resources and governance structures.

The World Bank maintains a prominent place because of its unrivalled financial resources and policy influence. Regional organizations, such as the European Union, and other UN organizations (e.g. UNICEF, UNDP, and UNFPA) retain health as an important component of their work but are more limited in membership and/or scope. The Organization for Economic Cooperation and Development (OECD) and World Trade Organization (WTO) approach health from an economic and trade perspective. Varied civil society groups, such as consumer groups, social movements and research institutions, also make substantial contributions to health development. Finally, the growth of the private sector actors in health, within and across countries, is notable. New fault lines and allegiances had emerged to form an increasingly complex milieu for health cooperation, with interests divided within and across countries and organizations. Undertaking a wide-ranging process of reform, WHO has sought to change some of its traditional governance features, notably its strong focus on ministries of health, by engaging other public and private sector actors, and creating new consultation mechanisms?

An Emerging System of Global Health Governance?

The precise origins of the term GHG are unclear, although many scholars and practitioners who use the term draw upon a number of different fields. These mixed origins mean that GHG can be difficult to define. This problem of definition is compounded by the fact that the term GHG is used widely in a number of different contexts. We can begin to overcome this problem of definition by breaking GHG into its component parts – global health and governance. International versus global health Globalization brings into question how we define the determinants of health and how they can be addressed. In principle, the mandate of WHO is based on a broad understanding of health. The Constitution of WHO defines health as "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. ''For example, Health for all in the 21st Century links the attainment of good health to human rights, equity, gender, sustainable development, education, agriculture, trade, energy, water and sanitation (Antezana et al. 1998). Similarly, the replacement of the Global Programme on AIDS by UNAIDS was in large part due to a desire to go beyond a narrow biomedical approaches to HIV/AIDS (Altman 1999). Globalization from the late twentieth century has emphasized even more poignantly the need for greater attention to the basic determinants of health including so-called non-health issue areas. In arguing for a reinvigoration of public health, McMichael and Beaglehole (1999) point to the need to address underlying socioeconomic (notably inequalities), demographic and environmental changes that global change is creating. Similarly, Chen et al. (1999) argue that globalization is eroding the boundary between the determinants of public (collective) and private (individual) health. For example, susceptibility to tobacco-related diseases, once strongly linked to, and blamed on, the lifestyle choices of individuals, is increasingly seen as attributable to the worldwide marketing practices of tobacco companies.

The distinction between global health and international health therefore is that the former entails a broadening of our understanding of, and policy responses to, the basic determinants of health to include forces that transcend the territorial boundaries of states. Global health requires a rethinking of how we prioritise and address the basic determinants of health, and engagement with the broad range of sectors that shape those underlying determinants. The need to address the basic determinants of health leads to the practical question of how to do so. Since at least the early 1990s, there has been a growing confusion of mandates among UN organizations that have substantial involvement in the health sector - WHO, UNICEF, UNDP, UNFPA and the World Bank. In large part, this has been due to efforts to develop multisectoral approaches to health and development, as well as key areas (e.g. reproductive health, environmental health) that bring together the activities of two or more organizations (Lee et al. 1996). Globalization invites a further widening of the net of relevant organizations, requiring engagement with actors that have little or no formal mandate in the health field. Notable have been efforts to establish greater dialogue between WHO and the WTO. While trade interests have historically defined, and in many ways confined, international health cooperation, officially the two spheres have been addressed by separate institutions. Nonetheless, the

multiple links between trade and health policy are well recognized (WHO 2002, Brundtland 1998; Brundtland 1999), resulting in high-level meetings between the two organizations since the late 1990s. At present, WHO holds official observer status on the Council of the WTO, and committees relating to Sanitary and Phytosanitary Measures (SPS) and Technical Barriers to Trade (TBT) agreements? However, the capacity to articulate public health concerns regarding, for example, the agreement on trade-related intellectual property rights (TRIPS), has been hampered by the framing of health among trade officials as a "non-trade issue", and as such the reluctance of certain countries to discuss health within the context of a trade negotiations. Moreover, the ability of WHO to influence the WTO has been hampered by the fact that states (many of which are members of both organizations) have accorded a higher priority to trade issues, rather than those relating to human health. As such, there remain considerable barriers to incorporating health as a legitimate and worthy concern on the global trade agenda. The different meanings of governance As described above, the ability of a society to promote collective action and deliver solutions to agreed goals is a central aspect of governance. The term governance has been used in a number of different ways, ranging from the relatively narrow scope of corporate and clinical governance, to the broader concept of global governance.

"Global health governance" refers to the use of formal and informal institutions, rules, and processes by states, intergovernmental organizations, and nonstate actors to deal with challenges to health that require cross-border collective action to address effectively. This definition's relative simplicity should not obscure the breadth and complexity of this concept. Leading definitions of "health" conceptualize it in broad terms. The World Health Organization (WHO) defines health as "the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." New and unprecedented institutional arrangements have arisen to address specific problems, especially HIV/AIDS, international public health emergencies, and the pandemic in tobacco-related diseases. The HIV/AIDS pandemic has produced a multifaceted regime that involves UNAIDS (created in 1996), the Global Fund (established in 2002), initiatives by the G8, significant donor funding for treatment, and extensive NGO involvement. The pandemic of tobacco-related diseases led WHO to adopt in 2003 the Framework Convention on Tobacco Control (FCTC), the first time WHO adopted a treaty under the Article 13 of the WHO constitution. The FCTC launched an unprecedented global anti-tobacco movement. Threats of naturally occurring or man-made communicable diseases (such as Severe Acute Respiratory Syndrome, or SARS, influenza, and bioterrorism), along with the threat of trans-boundary chemical and radiological accidents or intentional releases, produced the revised International Health Regulations in 2005. The IHR 2005, which connects global health to security, economic, development, and human dignity interests, constitutes one of the most radical governance innovations since health diplomacy began in the mid-nineteenth century (Figure 1). States, IGOs, and no state actors also began to address wider aspects of global health governance. These efforts included acting on how health affects macroeconomics, economic development, and social determinants. In collaboration with governmental and nongovernmental partners, WHO focused more attention on non-communicable diseases, a push manifested in not only the FCTC but also strategies on obesity-related diseases, road traffic injuries, and harmful uses of alcohol? Global health governance also became more important in regimes designed to achieve non-health objectives. For example, "trade and health" controversies arose within the WTO, regional trade agreements, and bilateral trade accords, especially with respect to the effect of intellectual property rights on access to medicines. These controversies, combined with problems created by HIV/AIDS and other outbreaks, raised global health's profile within the human rights community and led to new attention on the right to health. Global health capabilities, such as surveillance and response capacities, emerged as significant in efforts to prevent development and use of biological weapons through the Biological Weapons Convention.

Global health policymakers also provided inputs into governance reform initiatives on the global economic, food, energy, and climate change crises. Finally, the eight Millennium Development Goals (MDGs) affirmed health as a focal point of global governance. Three of the MDGs target specific health objectives (HIV/AIDS, maternal health, and child health), and four others attempt to improve social determinants of health, namely poverty and hunger, education, gender equality, and environmental protection. For example, although both are communicable diseases, the approach to HIV/AIDS should not guide preparations for pandemic influenza. Preventing occupational injuries mandates different techniques than reducing the demand for tobacco. Similarly, the regulation of the application of sanitary and phytosanitary measures to trade in goods is not a template for preventing trans-boundary pollution. And the process of developing a new antibiotic for drug-resistant tuberculosis does not reduce poverty in the developing world. Although public health experts seek multipurpose surveillance and intervention capabilities where possible, surveillance and response interventions do not often support actions against multiple problems. Political interests help produce the multitude of regime clusters in global health. Consider the proliferation of efforts to address HIV/AIDS: activities began with the WHO Global Programme on AIDS, but have expanded to include UNAIDS, human rights bodies, the Security Council, the World Bank, WTO, the MDGs, the Global Fund, G8 initiatives, regional efforts, bilateral programs, and various NGOs. The HIV/AIDS regime cluster reflects how states, IGOs, and non-state actors have framed HIV/AIDS as a security, economic, development, and humanitarian issue. It also reflects how powerful actors and influential processes, such as the United States and the G8, created new initiatives (such as PEPFAR and the Global

Fund) to address specific concerns rather than strengthening efforts within UNAIDS and WHO. GLOBAL HEALTH PLAYERS The revolution in global health governance has increased the quantity and diversity of players (see Table 1). This development has intensified competition for leadership, influence, and resources. States, IGOs, and NGOs have long been involved in global health, but the participation of each type 10 of player has changed. In addition, public-private partnerships (PPPs) emerged as new actors. Global health governance has truly gone "multipolar," with many more players more deeply engaged than ever before. Donor states, especially the United States, have increased development assistance for health but have done so mainly through bilateral aid, such as the President's Emergency Preparedness for AIDS Relief (PEPFAR), or new mechanisms, such as the Global Fund, which bypass traditional institutions, such as WHO or the World Bank.30 These shifts reflect the growing importance of global health to powerful states, which are exerting greater control over resources they expend in this area. Established and emerging powers, such as the United States, China, and Brazil, increasingly view global health as a component of "soft" or "smart" power. 31 This heightened interest by major countries has elevated global health politically, but it also reveals how the divergent interests of states shape global health..

Player category Examples States Great powers United States, China Emerging powers India, Brazil Developed states Britain, Canada, Germany, Japan, Norway Developing countries Bangladesh, Indonesia, Kenya, Venezuela Failing or failed states Congo, Haiti, Zimbabwe, Somalia IGOs Multilateral ILO, UN, UNAIDS, UNICEF, World Bank, WHO, WTO Regional African Union, ASEAN, European Union PPPs Mechanisms to increase access to health technologies AMCV; GAVI Alliance; Global Fund; IFFIm Drug and vaccine development partnerships Drugs for Neglected Diseases Initiative, International AIDS Vaccine Initiative, Medicines for Malaria Venture, Malaria Vaccine Initiative, TB Alliance Nonstate actors Philanthropic foundations Bloomberg Initiative, Carter Center, Clinton Foundation, Gates Foundation, Rockefeller Foundation NGOs and civil society groups Amnesty International, Doctors Without Borders, Human Rights Watch, Oxfam Multinational corporations Food and beverage, pharmaceutical, and tobacco companies IGOs remain central actors, but the revolution in global health governance has affected them in complex ways. On the one hand, IGOs have become more prominent as venues for analyzing problems, designing solutions, and facilitating negotiations. In this regard, WHO has never been more 11 important. Similarly, multilateral institutions, such as the World Bank and WTO, and regional organizations have also gained significance. On the other hand, the growth in bilateral initiatives, development of alternative diplomatic processes, and expanded influence of non-state actors have made the environment for IGOs more complicated, competitive, and difficult. These changes have challenged WHO's legacy as the central institution in global health and forced it to adapt in the face of declining influence.

Non-state actors have been important since health cooperation began, as illustrated by the pressure merchants put on governments to address national quarantine systems in the second half of the nineteenth century, the involvement of workers' associations in the development of international labor standards before and after World War I, and the public health achievements of the Rockefeller Foundation in the first decades of the twentieth century. But non-state actors now enjoy more influence on global health than ever before. The globalization of trade, commerce, and finance has expanded the impact of certain private enterprise sectors, including the pharmaceutical, tobacco, and food and beverage industries. MNCs now play a significant role in diplomacy on intellectual property, labor and product safety standards, and trade in tobacco, alcohol, and food and beverage products. In many cases, the WTO has bridged the gap between trade and health. The not-for-profit sector also has a higher profile now than in any other previous period. The impact of NGOs has increased partly because of their expanded use by states and multinational corporations as direct recipients of aid and in-kind contributions, such as donated medicines.34 Philanthropies have also helped transform global health, most notably through the efforts of the Carter Center, the Clinton Foundation, and the Gates Foundation. The Gates Foundation, in particular, has been a "game changer" because of the unprecedented resources it devotes to global health. Since its creation in 1999, the Gates Foundation has disbursed nearly $10 billion in global health grants. The scale of the foundation's resources has "resulted in almost every university department, think tank, civil society group and partnership working in this area, receiving funding from it directly or indirectly." After the United States and the United Kingdom, the Gates Foundation "is the third largest contributor to the WHO," and it participates in leading PPPs, including the Global Fund, the Global Alliance for Vaccines and Immunization (GAVI Alliance), the Malaria Vaccine Initiative, and AMCV. These and other PPPs are new players that have had widespread impact, especially in terms of resource availability for global health. Two of the biggest PPPs created in the past decade, the Global Fund and GAVI Alliance, "have attracted a growing share of funds, while the proportion of assistance going to UN agencies and development banks has decreased during this period." Other PPPs, such as the IFFIm, UNITAID, and AMCV, have raised new funds through innovative financing mechanisms. PPPs have also been active in developing new medicines and vaccines for HIV/AIDS, malaria, tuberculosis, and neglected communicable diseases.

Final Remarks

From sociological point of view to an understanding of HIV/AIDS knowledge and socio-cultural expression and symbolic meaning has been to map through the various theoretical transformation that made out to objectified human body since 12th centuries. The very formalization and institutionalization of knowledge of sociology and social security which around the turn of the evidence based explanation of socio-cultural meaning of contagious disease which enough to develop new kind of techniques for making the human bodies legible . Hence, body related health security linkage is not novel concept but a desirable political social intervention. HIV/AIDS related policies and programmes remains the core values of public health. Which is the fundamental value of public health securitism? With public health securitism incorporated into public health governance, issues that are likely to jeopardize the overall health of the society are securitized; resulting is an 'alternative', potentially more effective response mechanism. Nevertheless, although HIV/AIDS securitization is viewed as a desirable political reaction turned the problem of mankind and social security health issues.

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