



Social construction of HIV/AIDS risk and Medicalization of social space: Critical view from Foucault Bio-Politics

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Abstract

Risk is not an objective reality, instead, 'the perception of risk is a social process' – where HIV/AIDS related risk or security issues can often be more suitably seen as a way of maintaining social solidarity than as reflecting health related concern. Burries (2000) attempted to reframe the construct of social risk, which he defines as the danger that an individual will be socially or economically penalized should be identified with an expensive, which comprises both the objective threat of harm and the subjective perception of risks for harm. Social construction of risk like HIV surveillance, therefore, should be understood in the ongoing process of social construction of HIV/AIDS illness. Whereas, medicalization as the process by which social aspects of human life or social-spatial position come into consideration as medical problems, before they were not considered pathological issues. Simultaneously, Foucault (1976) considered the process of indefinite medicalization to be one of the main features of society. He also stressed that, concept of bio-power is literally having power over others' bodies through the medicalization, 'an explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of population.'

Keywords: risk, medicalization, social space, bio-power

Introduction

The concept of risk has become a central characteristic of contemporary society and the writing on high/late modernity. As Beck's 'Risk Society' thesis suggests 'risk may be defined as a systematic way of dealing with the hazards and insecurities induced and introduced by modernisation itself' (1992: 21). To put it as simply as Young (2007: 59) we now live in a society where 'anything might happen'. As the dominance of risk discourses specific to science and technology (as Beck begins) filter into the public domain (predominantly via the media, Furedi 1997) the preoccupation with this concept widens. Such a preoccupation now stretches in breadth to include associated concepts (hazard, fear, harm, uncertainty; concepts used now interchangeably, Chadee, Austen, Ditton 2006) and diversifies into most areas of social life. Thus, today's increased concern with safety and risk has little to do with the advance of technology and science. After all, it is not just the outcome of technological and scientific developments which provokes anxiety and fear. (Furedi 1997: 7) The apparent realist position of Beck would seem to place risks and hazards at odds with subjective feelings of anxiety and fear. This contradiction, noted by Beck himself, (Flynn 2006) highlights the directions of alternative risk theorists, such as Mary Douglas *et al.* (1966, 1980, 1992) who promote the appreciation of socially constructed risk agendas. Furthermore, there are those who suggest that the separation of actual (objective) and appraised (subjective/perceived) risk is 'illusory' (Chadee, Austen, Ditton 2006). Therefore, by accepting this premise, it is the social construction of living at risk and taking risks which becomes the focus for investigation. The apparent risk-chic environment has become more diverse, not just as part of our everyday lives, but

embedded within political rhetoric and policy initiatives. Grand theories on the topic of risk have infiltrated many discourses of which the risk management of young people is one example. In the years since the 'Risk Society' thesis was delivered its influence on late modern theorising is to be admired. However, in recent years scholars have become critical of the term risk first appeared in the English language in the seventeenth century (Giddens 1990: 30). Furthermore, historians also relate the traditional use of the term to the religious notion of sin and an explanation of misfortune (Luhmann 1993: 8). The incline towards negative consequences, distinguishes a specifically biased outcome (Furedi 1997: 57). Adams' particular description of risk highlights the creation of such via a mathematical calculation. a numerical measure of expected harm or loss associated with an adverse event...the integrated product of risk and harm is often expressed in terms such as cost in pounds, loss in expected years of life or loss of productivity. (Adams 1995: 8) In light of such biased definitions, it is unsurprising that a society preoccupied with risk should be theorised by Beck in such a negative light suggesting 'one is no longer concerned with attaining something good, but rather with preventing the worst (Beck 1992: 49). As Wilkinson suggests 'he [Beck] seeks to draw a firm analytical distinction between an industrial society which was hitherto blind to the uninsurable risks of modernisation, and an emergent 'Risk Society' which is being forced to negotiate with a future which imposes the threat of self-annihilation upon our lives' (1997: 3). There are those who have chosen a distinctly different interpretation, opting instead to reflect on risk as the 'double edged character of society' (Giddens 1990: 7), in which a world enriched with opportunities can also harbour danger and insecurity. Or rather

there are those academics, such as Wildavsky who simply state that the negative assumptions of Beck are exaggerated or not evidenced (Adams 1995: 195). This most prominent criticism stems from the over-interpretation of the negativity of risk, in a thesis which repeatedly stresses danger, harm and uncertainty. It is to this extent that Adams reflects on such work as 'one-sided' in favour of 'its doom-laden view' (1995: 182). Adhering to this distinctive approach the suggestion of Short (1984: 711) seems appropriate; that the definition of risk need not be negative so that 'a more neutral definition simply specifies that risk is the probability of some future event'. Does it follow then that society has adopted Beck's pessimism and has a distinctly negative connotation of risk? Lupton suggests that the negative relationship between risk and pleasure can be conceptualised by the response of academic literature and expert opinion, and that of popular culture (1999: 149). To take unnecessary risks is commonly seen as foolhardy, careless, irresponsible, and even 'deviant', evidence of an individual's ignorance or lack of ability to regulate self. (Lupton 1999: 149) Academic discourse and theoretical debate in the 1960s and 1970s did much to strengthen this negative image, specifically using the phrase 'problem behaviour' to relate to concepts now aligned with the term risk. [ii] For example, Goffman conceptualised such behaviour as 'action, consequential for the individual, that has problematic outcomes, and that is undertaken for its own sake' (1967 cited in Lyng 1990: 862). Examples used include 'high risk occupations and leisure activities, combat experience, drug use and the like' (ibid). The media also play a significant role in the problematisation and demonisation of youth, by which many in society equate 'problem youth' with drugs, alcohol, violence and anti social behaviour (Miles 2000: 71). The media are challenged for creating 'youth' at a time of negative behaviour, and young people, particularly young males (Pearson 1994 in Croall 1998: 132, Loader 1996: 24), are often stereotyped as doing the same. Thus it is noted that in many situations 'to be young in itself constituted a reason for being regarded as one of the 'usual suspects' (Pearson 1994 in Croall 1998: 123). In recent years some risk researchers have started to acknowledge a division. For example, Benthin *et al.* (1993), separate their list of adolescent activities into 'problem behaviours' (such as drugs, alcohol, binge eating, and sex) and 'other behaviours' (riding motorcycles and bicycles, skiing and sunbathing), which shows at least an acknowledgement of a possible distinction. However, the preoccupation within risk discourse with the 'governance of risk' (Rothstein 2006) has meant that the terminology is now applied to most spheres of daily life, including the full range of children's daily 'play' and outdoor activities (Jenkins 2006). Thus, although academia is starting to acknowledge the functions of adolescent risk taking (see Parker and Stanworth 2005), or potential problems of over-regulating 'exposure to adversity' (Jenkins 2006: 380), it may be overshadowed by the perceptions of the lay population. The negativity of the 'Risk Society' suggests that society is inherently worried about the proliferation and negotiation of 'actual' risks. Such an outlook aligned with 'preventing the worst', stressed by the discussion on the negativity of risk, is now an accepted part of contemporary society. If we think negatively, or that the worst could happen, then it follows that we become anxious. The

presentation of risk information, predominantly via media discourse, has been criticised for promoting negativity and contributing to an increased sense of anxiety. The influential work of Kasperson *et al.* regards this situation as the 'social amplification of risk', providing an account for how expert risk assessment can be amplified [iii] within society (Kasperson *et al.* 2003: 15). Such transformations can increase (...) the volume of information about an event, heighten the salience of certain aspects of a message, or reinterpret and elaborate the available symbols and images, thereby leading to particular interpretations and responses by other participants in the social system. This most common association with amplified anxiety or worry in contemporary society is the emotive response of fear. The promotion of fear and the propagandist manipulation of information is often justified on the grounds that it is a small price to pay to get a message across to the public ...rather than provide people with the information to make an informed choice, everyone is warned that they are at risk. (Furedi 1997: 25) The above rationale applies to young people who must be, and are, educated about the risks inherent to their life stage. There are essentially more risks applicable to them, thus the intensity of education is much greater, and stems from a variety of sources. But does it follow then that such anxiety or worry is found within the younger generation? This question will be directly addressed by the findings presented in this paper. Integral to the negotiation of risk is society's debated exposure to hazards, and a feeling that "suddenly everything becomes uncertain" (Beck 1992: 109). Uncertainty can be understood as the cause of worry, coupled with negative thinking. Uncertainty creates feelings of worry via the thought that the outcomes of hazards are unknown, coupled with the preoccupation that these outcomes will be predominantly negative. Marris (1996) suggested that the way society deals with uncertainty is to constantly search for answers (knowledge) not just from our own private emotions, but within the public sphere (health warnings etc.). Such a search for information helps us deal with possibly uncertain consequences. Considering notions of calculation and probability, Marris also suggests that however small or large, the notion of uncertainty is always uncomfortable. It is not unsurprising then that Burgess notes 'the sociological interest in mistrust and uncertainty appears in much contemporary risk analysis and has been absorbed into the language of official scientific reports and institutions' (2006: 332). In a society which is preoccupied with risk, the discourse of risk information creates a considerable challenge for the lay person. Which risks should we take, which should we avoid, who is presenting the 'facts', and who is going to protect my interests? Beck's conclusion to such questioning is a state of anxiety, scepticism of expert opinion, and diminished trust in both professionals and established institutions (1992). Given that the 'Risk Society' stresses the negativity of risk situations, it follows that we would critique our risk knowledge and ask; how certain are we that we know the worst that could happen? Experts, and expert systems, whether labelled or socially constructed, are synonymous with ideas of knowledge, skills, problem solving and application. The perspective of the experts when it comes to risk is often taken at its word, reinforced by statistical assessments. The layperson, without the means of actuarial investigation, is led

to believe the ‘actual’ risks involved in for example, smoking, drinking and drug use. As Lupton comments “in the ‘Risk Society’, the assessment of risk is subject to a high degree of ambivalence, due to the complexity of scientific and technical knowledge” (1999: 64). It is hardly surprising, given the tensions between protecting children and permitting their autonomy, that parents should look to ‘experts’ for a set of rules which, having external authority, may lend a sense of certainty to decisions parents make...Such guidelines tend to bureaucratise decisions in relation to children, producing standardised responses without regard for the social context or life experience of individual children. (Jackson & Scott 1999: 94) However, studies involving the psychometric paradigm show that ‘ordinary people...use a broader definition of ‘risks’ than experts when making judgements about which ones are of most concern to them’ (Marris 1997). Experts rely on statistics such as fatalities whilst lay people consider a host of qualitative characteristics. Yet we seem to have a reliance on this expert knowledge, even if our judgement, and more importantly our experience, tells us otherwise. Natalier (2001) claims Beck and Giddens argue that ‘we live in an age where we rely on experts to manage and make sense of risks that are unknowable through lay knowledge’ (2001: 66). And yet, as Giddens (1990: 91) proposes, experts in many fields, (including health and safety policy) continue to fail to control and regulate the possibility of negative outcomes. Due to expert disagreements, resulting in a loss of authority, society begins to question the validity of assessments, a concept Giddens referred to as ‘doubt’ (1991: 3). Doubt, Giddens suggests, leads to contestability, revision and possibly abandonment. Consequently, knowledge overlaps with experience as people, especially adolescents, accept these warnings but search for their own alternative knowledge base – that of trial, and possibly error. In many cases as Luhmann (1979 in Boyne 2003: 86) suggests, trust, rather than dealing with the complexities of mistrust, is the easier option. How does one cope with the insecurities of the ‘Risk Society’, coupled with the impossibility of analysing every shred of information? The answer is we couldn’t and we don’t. Therefore such management demands that all our relationships (with individuals or systems) start with trust (ibid.), a concept which is debated specifically by Beck’s social theory.

Ulrich Beck and the Risk Society Ulrich Beck, the German sociologist and a key writer on the sociological theory of risk, distinguishes three types of risk: preindustrial risks, industrial-age risks and the enormous risks of late modernity (Beck 1988: 120–121). Preindustrial risks are not caused by technological and economic behaviours and decisions, they are extrinsic with respect to society and rooted in natural phenomena and the dealings of the gods. A typical example are natural disasters and epidemics. Little can be done to prevent them and although we can stave them off or minimise their consequences if we take sufficient pains to do so, their existence is not contingent on anything we humans do. They are usually unpredictable and incalculable (floods of the century could take place every year). However, their scope is temporally and spatially limited. Industrial age risks are a product of social behaviour and human decisions. Unlike preindustrial risks, “we ourselves are responsible” for industrial age risks and we factor in the anticipated benefits

when calculating the risk. This type of risks is individual, local, temporally and spatially limited, and predictable. Industrial age risks come closest to the classical meaning of the word “risk,” i.e., the probability of appearance of a loss of specified magnitude adopted, e.g., by insurance companies. Vehicle accidents, illness due to tobacco smoking or extreme sports are some examples. Major dangers of the postmodern era are what Beck is most interested in (a fact which did not keep him from using the term “risk” to describe them) and they are the dialectical synthesis of preindustrial risks and industrial age risks. They resemble the former in that they are difficult to predict and control and are supraindividual. Like preindustrial risks, we do not choose them ourselves, they are inflicted on us from without. They resemble the latter in that their origins are intra-systemic, i.e., they are the product of technological progress. Ecological, chemical, nuclear and genetic dangers are examples of industrial age risks. According to Beck, although contemporary dangers (risks) are produced by the system itself, they are the most real and obvious ones of the lot (Beck 1988: 155). This does not stop them from being the object of the social “defining relations” which take the place of power relations in risk societies. The power to define and say what is harmful and what is not, to what extent and beginning from what amounts, how to behave in the face of possible dangers, and how to control and regulate them, is one of the most fundamental political resources. This is because of the nature of the dangers themselves which are always symbolically mediated and can therefore only be cognised indirectly. As Beck wrote in *Risk Society: Towards a New Modernity* (1992: 27): That which impairs health or destroys nature is not recognizable to one’s own feeling or eye, and even where it is seemingly in plain view, qualified expert judgment is still required to determine it ‘objectively.’ Many of the newer risks (nuclear or chemical contaminations, pollutants in foodstuffs, diseases of civilization sensitization of society to risk. Sects are in opposition to the market and the hierarchy and their ways of classifying risk. All three types of organization refer to a schema created by Mary Douglas called grid & group (for a more detailed discussion see Douglas 1970; Sojak 2004: 53–60; see also Adams 1995). The second pillar on which Douglas and Widavsky’s theory rests is the anthropological theory of the relation between ideas of purity and danger developed by Mary Douglas (1969). According to this theory, what society decides to view as pure and impure is relative to the social order. Dirt and pollution, according to Douglas, are defined in terms of interference with the social order which constitutes a given group. Anything which is not in its proper place or violates the accepted order of things is impure. This is what the British anthropologist says in *Purity and Danger* (1969: 35): If we can abstract pathogenicity and hygiene from our notion of dirt, we are left with the old definition of dirt as matter out of place. This is a very suggestive approach. It implies two conditions: a set of ordered relations and a contravention of that order. Dirt then, is never a unique, isolated event. Where there is dirt there is the system. Dirt is the by-product of a systematic ordering and classification of matter, in so far as ordering involves rejecting inappropriate elements. If something does not fit into the existing classification system on which social order is founded, it is

thought to be impure and polluted and therefore taboo. Douglas mentions this in the context of “taxonomic anomalies.” One example of such an anomaly is perception of pork as impure meat in Jewish culture: this perception allegedly originated in the inability to classify pigs unequivocally because they have two mutually incompatible features: they belong to the artiodactyla family (like cattle) but do not ruminant. Anomalies such as these threaten the social order maintained by appropriate classification systems which help to organize and systematize reality and therefore the eating of pork must be forbidden (taboo). Risk too is defined by checking whether and how it threatens the group’s moral, political or religious order and whether or not it fits the accepted system of classification of reality. The group’s dominant way of life and the fact that the risk threatens to jeopardise this way of life determines whether the risk will be recognised or rejected. In *Risk and Culture* (Douglas & Wildavsky 1982: 8) we read: [T]he choice of risks to worry about depends on the social forms selected. The choice of risks and the choice of how to live are taken together. Each form of social life has its own typical risks portfolio. Common values lead to common fear (and, by implication, to a common agreement not to fear other things). According to the culturalist approach, risk is socially constructed within each type of group even though certain objective threats are at its roots (ibid.: 7). Society has no direct access to them, however, except within the categories and selection filters supplied by the group: all social institutions perceive and select risk subjectively. Douglas and Wildavsky point out that this social perception of risk has two aspects: “each social arrangement elevates some risks to a high peak and depresses others below sight” (1982: 8). Selection of certain threats and attribution of social forms to these threats is just one side of the coin; the flip side is society’s tendency to ignore and marginalise potential threats. “What needs to be explained is how people agree to ignore most of the potential dangers that surround them and interact so as to concentrate only on selected aspects” (ibid.: 9). Douglas and Wildavsky point directly to the need to pursue two different lines of research on risk: its social selection and construction and its ignoring and denial. Meanwhile, as we said before, most researchers concentrate on the first aspect and remain immune to the problem of ignoring risk. Douglas and Wildavsky’s theory could serve as a good analytic instrument for such research but it also has its weaknesses. These largely flow from the anthropological nature of the theory and its focus on cultural features as the basic explanation of risk selection processes. As such, it can only embrace some of the mechanisms whereby threats are made invisible but, as we shall try to argue further on, these mechanisms go beyond the culturally determined ways of living which are typical for various social groups. Risk and Threat-Between Objectivism and Constructivism? According to the classical, dictionary definition, risk means prediction of the probability of occurrence of certain losses and can be presented by means of the following formula: $R = P \times S$ where P is the assumed probability and S is the anticipated magnitude of harm. In this sense, risk is a measure of danger (Bechmann 1993: 240). We may say that it is a “conceptual cover” which society uses to tame danger cognitively. Danger is translated into the universal and precise language of

mathematics and the task of evaluating risk is left to the scientists. If we refer to the “risk construction axis,” reconstructed on the basis of Beck’s works, which connects the factual and objective state of threat with the appropriate model of risk resulting from the social processes of risk definition, negotiation and construction, then we may assume that the concept of threat (or danger) applies to the objective, real possibility of occurrence of specific harm whereas the concept of risk applies to a conceptual construct which describes this threat. The mathematical model of risk was a popular way of coping cognitively with dangers in the industrial era. Most writers on uncertainty in the context of technological progress admit that the concept of risk became useless in the second half of the twentieth century (cf. Bechmann 1993; Krohn & Krücken 1993; Evers & Novotny 1987; Bonß 1995). This is because the two pillars of the classical risk concept collapsed due to the acceleration of innovations in contemporary western societies: as far as contemporary hazards are concerned, we are unable to foresee the possible nature of the harm, not to mention its probability. In this sense, this resembles the extreme type of ignorance where we do not know what we do not know. Uncertainty no longer applies to the probability of occurrence of a hazard, it applies to the nature of the hazard itself. All this has considerably broadened the field for the processes of social risk construction which are less strongly related to and limited by references to the intangible objective danger. This is attested to by the increasing number of controversies where it has not been possible to reach consensus concerning the reality and nature of the threat in question (e.g., the connection between so-called mad cow disease (BSE) and Creutzfeldt-Jacob’s disease, the human contribution to global warming or the adverse consequences of bioengineering). On the other hand, the scope of reverse processes is also broadened. Here, danger is not conceived according to the risk model in order to make it cognitively accessible. It is rendered invisible by means of various methods, beginning with science’s denial of certain types of danger, through negation of certain consequences and marginalisation and exclusion from discourse and ending with concealment in the strict sense. This ‘securitization’ of HIV/AIDS was inaugurated symbolically on 10 January 2000 when the United Nations Security Council temporarily abandoned its traditional concern with regulating the deployment of armed force in international politics, and considered instead the growing impact of HIV/AIDS on peace and security in Africa. The meeting was deliberately timed to coincide with the first gathering of the Security Council in the new millennium, rendering the meeting both deeply symbolic and also historic in that the Council had never before considered a disease to pose a threat to international peace and security. In light of the wider securitization of HIV/AIDS that has since ensued, the AIDS pandemic now constitutes an important site in which the languages of risk and security intersect in contemporary world politics, and in relation to which various conceptualizations of this risk-security nexus can be usefully explored. This article identifies and evaluates three concepts of risk - as a ‘danger of modernization’ (Beck), as a ‘neologism of insurance’ (Ewald), and as a ‘biopolitical technology’ (Foucault) - that can serve as the basis for

conceptualizing this emerging risk-security nexus.

Medicalization

Sociologists are interested in researching the medicalization phenomena but there is no definitive meaning of the concept. What is not in dispute regarding the definition of medicalization is that it means the expansion of medical jurisdiction and its use as a mechanism of social control through the medical gaze and surveillance (Brubaker and Dillaway, 2009). Christiaens and van Teijlingen (2009: 123) distinguish three meanings within the first generation of medicalization theories. Namely, the origin of the medical model, which refers to the origin of medical knowledge; medical imperialism, suggesting a growing number of life domains and social problems within social space defined in terms of health and illness; iatrogenesis, in which medicalization is interpreted as an exaggeration of medical control. The second generation medicalization theory added a new meaning to the concept: the optimization of normal characteristics or processes. Hence, normal phenomena become problematic and a new consumer market is created (Christiaens and van Teijlingen, 2009: 123). The term “medicalization” was first used in the 1970s, when the American sociologist Irving K. Zola (1972) pointed out the influence of medicine as an institution of social control and thus its increased influence on the everyday life of individuals. Zola went so far as to suggest that medicalization is capable of affecting, even excluding, more traditional institutions such as religion and law, claiming that it was becoming the new repository of truth, the place where absolute and often final judgments are made by supposedly morally neutral and objective experts. And these judgments are made not in the name of virtue or legitimacy but in the name of health. To Zola, this was happening in such a way that medicalization had begun intruding into the everyday life of individuals; medicine and labels such as “health” and “disease” were acquiring broader social meaning (Zola, 1972: 487). That is where Zola saw the biggest problem of medicalization: he and his acolytes thought that medicine exceeded its acceptable jurisdiction. Accordingly to Abbott (1988), professions do not operate individually but rather as a system. As he explains it, various professions are always in competition with one another. Their goal is to secure their own position in the marketplace, to control valuable jurisdictions and enlarge them. The latter is clearly associated with legitimate social power and control (Freidson, 1988). Davis (2006) points out that medicalization was initially based on a specific social process, the expansion of the jurisdiction of medicine as a profession, whereas the use of the term medicalization today implies the use of medical terminology for every definition or description of a problem or treatment via medical intervention. After four decades, the concept of medicalization still remains highly disputable. According to White (2002), medicalization has increasing consequences because more and more areas are exposed to expanded medical control; the border between the desired and undesired or, rather, normal and pathological, is supposed to be drawn by experts based on socially and culturally neutral biological/physiological criteria. That seemingly objectifies measurements and criteria for classification and, at the same time, minimizes the connection

between definition and social factors. Peter Conrad (1992: 210–211), one of the most important authors describing medicalization, asserts that it is a process by which non-medical problems become defined and treated as medical problems, usually in terms of illnesses or disorders. Medicalization consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to treat it. It is also a sociocultural process that may or may not involve the medical profession, leading to medical social control or medical treatment, or be the result of an intentional expansion by the medical profession. In his opinion, medicalization can happen on various levels: (1) conceptual, using medical terminology, with which we describe a problem, (2) institutional, using a legitimate medical approach to explore a problem or (3) an interactional level with doctor-patient interaction, whereby the doctor specifies the problem as medical and begins treatment. Davis (2006) objects to Conrad’s definition of medicalization partly because he claims that today’s use of medical terminology and the medical model are not limited only to the medical profession.³ Any group or individual’s use of such terms/frameworks represents an instance of medicalization. Conrad and Barker (2010: 74) claim that medicalization has expanded beyond medical professionals, social movements and organizations to biotechnology, consumers and the insurance industry. There is evidence that the pharmaceutical industry plays a pivotal role in the shaping and disseminating of medical knowledge to promote their products (Williams and Calnan, 1996; Conrad and Leiter, 2004; Bezenšek and Barle, 2007; Conrad and Barker, 2010). Like Conrad (1992, 2007) and Zola (1972), Reissman (1983: 4) claims that medical practice becomes a vehicle for eliminating or controlling problematic experiences that are defined as deviant, for the purpose of securing adherence to social norms. In this context, Conrad (1992: 216), based on the work of Foucault, distinguishes among four types of medical social control: (1) medical ideology, (2) collaboration, (3) technology and (4) medical surveillance. Medical ideology imposes a medical model primarily because of accrued social and ideological benefits; medical cooperation presents doctors in the role of informants, gatekeepers, institutional agents and technicians; medical technology suggests the use of medical technological means for social control, especially drugs, surgery and genetic or other types of screening; medical surveillance as a form of medical social control suggests that certain conditions or behaviours become perceived via a “medical gaze” and that physicians may legitimately lay claim to all activities concerning the condition. Helman (2007) suggests that the process of medicalization has undoubtedly been successfully assisted by advances in medical technology, which serve further to reinforce peoples’ dependence on the medical profession for the solutions of their problems.

Social space

Social space is an invisible set of relationships which tends to retranslate itself, in a more or less direct manner, into physical space in the form of a definite distributional arrangement of agents and properties (e.g. opposition between downtown and suburbs). [This means that all the distinctions proposed about

physical space can be found in reified social space (or, what amounts to the same, in appropriated social space) defined, to speak like Leibniz, by the correspondence between a certain order of co-existence of agents and a certain order of co-existence of properties. Each agent may be characterized by the place where he or she is situated more or less permanently, that is, by her place of residence (those who are "without hearth or home," without "permanent residence", domicile fixe, have almost no social existence -see the political status of the homeless) and by the relative position that her localizations, temporary (as for instance with the regulated placings of protocol in official ceremonies) and permanent (her private and professional addresses), occupy in relation to the localizations of other agents. It is also characterized by the place it legally occupies in space through properties (houses and apartments or offices, land for cultivation Of residential development, etc.) which are more or less congesting or, as we sometimes say, "consuming of space" (the ostentation of appropriated space being one of the *bonn par excellence* of the ostentation of power).] It follows that the locus and the place occupied by an agent in appropriated social space are excellent indicators of his or her position in social space. [One may also note in passing that part of the inertia of the structures that make up social space results from the fact that they are inscribed in physical space and can be modified only at the cost of a painful work transplantation, by moving things and by uprooting or deportating persons.] The structure- of social space thus manifests itself, in the most diverse contexts, in the form of spatial oppositions, inhabited (or appropriated) space functioning as a sort of spontaneous metaphor of social space. There is no space, in a hierarchical society, which is not hierarchized and which does not express social hierarchies and distances in a more or less distorted or euphemized fashion, especially through the effect of naturalization attendant on the durable inscription of social realities onto and in the physical world: differences produced by social logic can then seem to arise out of the nature of things (think of the notion of "natural frontier" or that of "natural area" dear to the early Chicago school).

Medicalization of social space

so, medicalization of Social space is constructed in such a way that medical agents or groups are distributed in it according to their position in the statistical distribution based on the two differentiation principles which, in the most advanced and complex societies, are undoubtedly the most efficient: economic capital and cultural capital. It follows that all agents are located in this space in such a way that the closer they are to one another, the more they share in those two dimensions, and the more remote they are from one another, the Social spaces are regarded as relational orders of (zoological) animals and social goods that are aggregated at common places (Löw/Steets/Stoetzer 2008, 63). Social spaces are relations between coincidental plural placements. Space is formed between objects and therefore is the embodiment of coincidences. There were two early spatial metaphors used for the description of social spaces: The model of the ecological zones by Bronfenbrenner/Baacke and the "island model" by Helga Zeiher. In the model of ecological zones, Dieter Baacke (1984; Figure 1) explained the social embeddedness of the

development of children within local social spaces by referring to a ecological model that was originally developed by Urie Bronfenbrenner (Bronfenbrenner 1979; Grundmann/Kunze 2008, 179). Baacke (1984, 84f.) altered this model to describe the following different forms of embeddedness.

Bio-political aspects of the of HIV/AIDS

The concept of biopolitics is most closely associated with the writings of Michel Foucault (1926–84), who intermittently deployed this idea in his researches from the mid-1970s until around 1980. Unfortunately Foucault's reflections on biopolitics remained largely fragmentary and cursory until his premature death, probably of AIDS-related illnesses, in 1984. Yet in retrospect it is clear that Foucault in fact deployed three distinct concepts to capture the growing preoccupation of modern power with the biological dimensions of human existence – *biopower*, *anatopolitics*, and *biopolitics*. Of the three, biopower is the most widely cast notion and generally designates that which 'brought life and its mechanism into the realm of explicit calculations and made knowledge-power an agent for the transformation of human life'. This new type of biopower, whose emergence Foucault located in 18th-century Europe, acted over persons as biological or living beings rather than as legal or political subjects; its emergence marked the 'acquisition of power over man insofar as man is a living being'. Henceforth politics would no longer be concerned merely with settling questions of war and peace, or with organizing society's material enrichment; it would additionally come to bear on people's physical well-being, health, and longevity.¹⁶ This last expansion in the domain of political power – whereby man's biological existence becomes the target of deliberate strategies of control and intervention – is summarily referred to by Foucault as 'biopower'. Within this broader category of biopower Foucault further distinguished between two of its distinct manifestations or 'axes' – anatomo-politics and biopolitics.

Foucault predominantly used the term anatomo-politics to designate political strategies targeting 'man-as-body' in the attempt to make individual human bodies more productive and docile. Biopolitics, by contrast, refers to political strategies aimed collectively at 'man-as-species'; it is the attempt to regulate aggregate biological occurrences at the *population* level, such as lowering a population's mortality rate, increasing its average life expectancy, stimulating its birth rate, decreasing its morbidity levels, and so on. In order to better measure and control these collective population dynamics, European societies needed to be subjected to detailed statistical surveillance, which is why the birth of the biopolitical age in 18th-century Europe also coincided historically with the vast explosion in the number of demographers evaluating these population dynamics in quantitative terms. The detailed knowledge produced by these demographers then formed the basis for a plethora of biopolitical interventions trying to regulate the observed population dynamics, ranging from health insurance systems and old-age pensions, through to rules governing public hygiene, and so forth. In the end Foucault could thus succinctly define the *biopolitical* dimension of biopower as 'the endeavour, begun in eighteenth-century Europe, to rationalize the problems presented to governmental practice

by the characteristic of a group of living human beings constituted as a population'. This biopolitical axis of biopower is extremely pertinent for understanding the deeper significance of the ongoing securitization of AIDS, for a crucial implication of the rise of European biopolitics was that henceforth disease would be rendered an important political and economic issue needing to be collectively resolved as a matter of overall policy. If one of the goals of biopolitics is to maximize the health of populations, then disease could no longer be left to the random fluctuations of nature, but would have to be brought under continuous political and social control, which, according to Foucault, is precisely what happened in 18th-century Europe. The 18th century, to be sure, did not invent health measures as such (there are many historical precedents for this), but it 'prescribed new rules and above all transposed the practice onto an explicit, concerted level of analysis such as had been previously unknown'. From this time onwards, the social, economic, and political problems posed by disease have occupied an expanding place in European politics. Today such biopolitical impulses can also be found resonating beyond the borders of Europe through practices such as the securitization of HIV/AIDS. The latter, after all, marks nothing other than a powerful international intervention targeted directly at the level of *population*. With the arrival of HIV/AIDS on the international security agenda, security is no longer confined to defending sovereignty, territorial integrity, and international law; but, as the unprecedented Security Council meeting demonstrates, population dynamics – including levels of 'disease' – have now become strategically significant as well. International political actors securitizing HIV/AIDS are effectively calling upon governments around the world to make the health and longevity of their populations a matter of highest governmental priority - echoing Foucault's earlier observation that in a biopolitical age 'the population now appears more as the aim of government than the power of the ruler'. The securitization of AIDS is also biopolitical, secondly, because of the manner in which international actors are trying to monitor and govern the health of populations. The detailed statistical monitoring of populations that formed such an integral component of 18th-century European biopolitics is today being replicated on a global level by international agencies eager to identify and forecast the population dynamics likely to be induced around the world by HIV/AIDS. The task of compiling these statistics has been assigned to the World Health Organization and the Joint United Nations Program on HIV/AIDS (UNAIDS). The latter prides itself on its efforts to provide 'strategic information' about HIV/AIDS globally, as well as '[t]racking, monitoring and evaluation of the epidemic and of responses to it'.²⁵ Indeed, it claims to be 'the world's leading resource for epidemiological data on HIV/AIDS'.²⁶ To this end, UNAIDS also provides - in a manner that recalls England's 19th-century 'Blue Books' - annual updates on the global state of the AIDS pandemic, and endeavours to keep up-to-date information on HIV prevalence amongst adult populations for every country. Crucially, UNAIDS does not restrict itself to providing data for collective populations; its surveillance techniques penetrate further and also generate new sub-populations by singling out specific risk groups that need to be targeted –

another historical hallmark of biopolitics.²⁸ The organization thus differentiates between adult and child populations and between urban and rural populations, and pays particularly close attention to sex workers and drug users. Where possible, UNAIDS even gathers data on sexual behaviour, such as the median age of first sexual intercourse and the rate of condom use, as well as a variety of other knowledge indicators. UNAIDS, in short, produces the 'vital' knowledge about the biological characteristics of the world's populations and sub-populations needed to rein in the pandemic. Finally, the linking of international security and HIV/AIDS is also characteristically bio political in that it is undertaken with the active and willing participation of a whole host of wider social and political actors. In his essay on 'The Politics of Health in the Eighteenth Century', Foucault observed how biopower and biopolitics were not merely deployed vertically downwards from the state into society, but were consentingly invoked by many social groups, including religious associations such as the Quakers, charitable organizations, and even scholars. The health of all, he noted, became a priority for all,²⁹ which is why Foucault insisted that bio power 'must be analysed as something which circulates, or rather as something which only functions in the form of a chain', and which 'is exercised through a net-like organisation'.³⁰ The unfolding of the securitization of AIDS follows such a net-like deployment of biopower, as it is being simultaneously driven by a plethora of actors ranging from: (i) predominantly Western governments including the United States; (ii) international organizations such as the World Health Organization, the United Nations, the European Union, ASEAN, and the African Union; (iii) a plethora of prominent multinational corporations working through the Global Business Coalition on HIV/AIDS; (iv) non-governmental organizations such as the Civil– Military Alliance to Combat HIV/AIDS and the International Crisis Group; (v) think tanks such as the Center for Strategic and International Studies and the Chemical and Biological Arms Control Institute; (vi) media organizations; and (vii) scholars in the academy.³¹ The net of the securitization of AIDS has thus been widely cast, corroborating Foucault's view that biopower is never solely the property of one agent; it is always plural, decentralized, and capillary in nature. 'Power', he reminded his readers, 'is everywhere; not because it embraces everything, but because it comes from everywhere.' In the end, these biopolitical dimensions to the securitization of HIV/AIDS also make it far less surprising that Foucault's influential description of the 18th-century biopolitical transformation in Europe could just as well be read as a penetrating commentary on the contemporary expansion of the international security agenda to include health issues such as AIDS: For the first time in history, no doubt, biological existence was reflected in political existence; the fact of living was no longer an inaccessible substrate that only emerged from time to time, amid the randomness of death and its fatality; part of it passed into knowledge's field of control and power's sphere of intervention. Power would no longer be dealing simply with legal subjects over whom the ultimate dominion was death, but with living beings, and the mastery it would be able to exercise over them would have to be applied at the level of life itself; it was the taking charge of life, more than the threat

of death, that gave power its access even to the body. In this case, however, the securitization of HIV/AIDS takes on particular significance for contemporary world politics not only because it is a novel way of framing the illness, but also because it illustrates how international security constitutes an important site for disseminating biopolitical strategies to the non-Western world – giving rise to novel normative dangers. Global biopolitics and the new racism Why does it matter that the securitization of HIV/AIDS is biopolitical? It matters because, their humanitarian appeals to ‘life’ and ‘health’ notwithstanding, biopolitical strategies have historically been Janus-faced. They have led to the construction of hospitals and the design of universal healthcare systems, but they have also led to the justification of eugenics and mass death. Some of those advancing the securitization of HIV/AIDS clearly do so in the hope that this will have important humanitarian benefits for persons living with HIV/AIDS around the world by bolstering international AIDS initiatives. Peter W. Singer argues that presenting HIV/AIDS as a security threat ‘strengthens the call for serious action against the menace of AIDS. It is not just a matter of altruism, but simple cold self-interest.’³⁴ Many policymakers agree, including the executive director of UNAIDS, who has similarly argued that framing HIV/AIDS as a security issue is not merely an academic exercise but ‘defines how we respond to the epidemic, how much is allocated to combating it, and what sectors of government are involved in the response’. Foucault’s historical analyses, however, point to the need for a greater degree of caution regarding these normative aspirations because biopolitical strategies have in the past also engendered serious dangers that continue to accompany recent efforts to think of security in terms of the health of populations. One of these dangers is that the biopolitical imperative of optimizing the health of populations effectively constitutes disease – and by extension the diseased – as a social and political problem that needs to be addressed, but without specifying exactly how this problem should be dealt with. Unfortunately the creation of universal healthcare programmes to treat the ill is just as compatible with a biopolitical logic as is the purging of populations of the diseased by more sinister means, such as killing them or letting them gradually die. As counter-intuitive and ironic as it may seem, a biopolitical society based on the enhancement of ‘life’ and ‘health’ can still sanction and justify instances of mass death. The European era of biopower, after all, coincided with 20th-century political projects demanding the deaths of millions. Foucault later came to understand this bizarre confluence only on the basis of a new racism that biopolitical orders can give rise to.³⁶ ‘Racism’, he contended from a biopolitical perspective, ‘is primarily a way of introducing a break into the domain of life that is under power’s control: the break between what must live and what must die.’³⁷ The reason biopolitical orders can still sanction mass death is because they can generate a powerful new form of racism that pits the ‘healthy’ members of the population against the ‘unhealthy’ who are deemed to sap the strength and vitality of the population as a whole. The underlying principle of this new biopolitical racism is thus not the primacy of cultural difference, as with many more traditional forms of racism, but rather the more subtle idea ‘*that the death of others makes one*

biologically stronger insofar as one is a member of a race or a population’.³⁸ The insistence on maximizing the health of populations can thus be dangerous for those who are deemed to be unhealthy. The Nazi movement demonstrated the extreme ends to which this darker side of biopolitics can be taken when it carved up the European continent using the dubious criterion of ‘blood’ for deciding which populations could be usefully ‘Germanized’ and thus spared, and which ones would have to perish.³⁹ It remains one of the most disconcerting testaments to the dangers of thinking security in biological terms, or on the basis of health and sickness. In Nazi Germany, moreover, this new biological racism was also projected internally to Jews who were no longer persecuted solely because of their Judaism, but also because their quasi-biologically defined ‘Jewishness’ was deemed to be undermining the purity and strength of the Aryan race. Enhancing the strength and vitality of the latter, by this logic, required the elimination of the former. In some ways this biopolitical racism is even more pernicious than a culturally defined one because, as Hannah Arendt once pointed out in her memorable phrase, whereas in the past ‘Jews had been able to escape from Judaism into conversion; from Jewishness there was no escape’.⁴⁰ A biopolitical society aimed at promoting ‘life’ and ‘health’ still has to make decisions about whose life is worth preserving and whose life will be allowed to perish, and the function of racism in a biopolitical age is to make this very distinction not necessarily according to the principle of cultural difference, but according to the maxim of whose survival will maximize the strength and wellbeing of the population, and whose will undermine it. By way of extension, the concomitant danger with the securitization of HIV/AIDS as a biopolitical strategy is that while it clearly dramatizes the need to address the problem of disease at the global level, it does so without specifying exactly how this is to be achieved. The securitization of HIV/AIDS may increase attention and resources for charitable and humanitarian global AIDS initiatives, and may lead to more universal access to treatment, but these, alas, are not the only outcomes that would be consistent with a security approach to the pandemic. Indeed, there are at least three more disconcerting ways in which the securitization of HIV/AIDS could – at least hypothetically – follow the path of earlier biopolitical strategies and give rise to a new biopolitical racism between the ‘healthy’ (HIV negative) and the ‘unhealthy’ (HIV-positive) segments of a population. First, if HIV/AIDS is exclusively responded to in a security framework, there is, strictly speaking, nothing to preclude some governments from concluding that the most effective way of meeting this biopolitical objective of ridding their populations of the problem of HIV/AIDS is by simply letting the infected die, rather than by providing universal treatment for them in the way many of those securitizing HIV/AIDS would want. Although this is at present only a hypothetical possibility (there is no documented proof that such thinking is going on), there is certainly evidence that analysts and policymakers do not shy away from pondering whether simply letting those infected with HIV/AIDS die could also have beneficial social consequences for the surviving population. In 1999 one former UN Population Fund (UNFPA) official reportedly joked that AIDS would be one way of controlling population

growth in Africa. Increased mortality, the official jibed, was one of three ways of controlling population growth, thereby implying that hypothetically letting those infected with HIV die could be beneficial for those surviving the pandemic.⁴¹ The initial reaction of one official at the National Intelligence Council in the mid-1990s, responding to an early demand for a project analysing the security implications of AIDS, was similarly: 'Oh, it will be good, because Africa is overpopulated anyway.'⁴² These are not isolated incidents. In a report by the World Bank from 1992 one can read from an economic perspective that '[i]f the only effect of the AIDS epidemic were to reduce the population growth rate, it would increase the growth rate of per capita income in any plausible economic model'.⁴³ More recently the president of Botswana also argued publicly that providing antiretrovirals (ARVs) to its citizens would have the undesirable effect of keeping persons living with HIV alive longer, thus increasing the chances of further transmission of the virus which was undesirable for the population as a whole.⁴⁴ What is striking about such sentiments is not just the sobering cost-benefit analysis they bring to bear on human life, but more importantly the *biopolitical* racism they evince by pitting the interests of those living without HIV/AIDS against those affected by the illness through implying, however erroneously, that the healthy ones would be better off without the latter. To reiterate, these kinds of arguments appeal directly to the core principle of biopolitical racism, namely 'that the death of others makes one biologically stronger insofar as one is a member of a race or a population'.⁴⁵ Especially in a context of material scarcity and competing pressure for limited funds, there is a danger with the securitization of HIV/AIDS in that some political leaders might conclude that in the long run the health and security of their population may be best served by simply letting the infected die. Although diametrically opposed to the intended consequences of the securitization of HIV/AIDS, the fact that such a (hypothetical) outcome would nevertheless be consistent with a security approach to HIV/AIDS must surely give pause for thought in terms of framing the global response to HIV/AIDS exclusively in the language of security. Short of this more drastic outcome, the securitization of HIV/AIDS could also bring such biopolitical racism between the population and the infected into play in a second way – by inadvertently justifying measures both to remove persons living with HIV/AIDS from the population, and by preventing new HIV-positive persons from other countries joining the population. Calls for quarantining people with HIV/AIDS because of their biological characteristics, subjecting them to various forms of violence, and attempting to bar such persons from serving in state institutions, are only a few of the examples in which persons living with HIV/AIDS have been ostracized and even persecuted by some states for their illness. These actions have all been justified, moreover, in the name of ensuring and enhancing the health of populations. In Colombia left-wing guerrillas of the Revolutionary Armed Forces of Colombia (FARC) did not hesitate in 2001 to order 30,000 inhabitants of Vistahermosa to take HIV tests, subsequently forcing those who tested positive out of their homes. The inhabitants of the region have now also been forced to carry an identity card that contains the result of the test.⁴⁶ Moreover, the securitization of HIV/AIDS

has already begun to fuel a similar purging of HIV-positive persons within many of the world's armed forces, where such persons are increasingly being excluded from military service because of the perception that they weaken the efficiency and effectiveness of the military population, and thus also undermine the protection of the civilian population as a whole.⁴⁷ Persons living with HIV/AIDS may also be prevented from joining other populations on 'health' grounds by refusing to issue them with visas. If HIV/AIDS is deemed to be a security threat, would states then not be justified in keeping HIV-positive persons out of their country? A characteristic headline from the British *Daily Telegraph* reads 'African AIDS: Deadly Threat to Britain'.⁴⁸ The portrayal of AIDS as being a disease that comes from foreigners, from outsiders, and especially from 'black' Africans, has been a perennial feature of the discourse on AIDS ever since the illness was first discovered. Nor are these examples confined to the dustbin of history. As recently as February 2003 the British government considered implementing compulsory HIV screening for prospective immigrants amid alleged worries that HIV-positive foreigners are travelling to the United Kingdom to seek treatment – a problem since found to have been grossly overstated.⁴⁹ As with Arendt's aforementioned observations about 'Jewishness', there seems to be no escape from one's HIV status when it comes to immigration. Rather than providing treatment for the ill, some leaders may simply be tempted to stigmatize, quarantine, or ban persons living with HIV/AIDS from their communities. Although clearly regrettable from a humanitarian standpoint, these outcomes too would be consistent with a security approach to HIV/AIDS, which must similarly give pause for thought. Finally, even where states do undertake efforts to make treatment available for some persons living with the illness, the securitization of HIV/AIDS also risks fanning a new biopolitical racism by potentially according the guardians of the populations – i.e. the elites and the armed forces – with privileged access to treatment. Within a security framework concern about HIV/AIDS may not revolve primarily around how HIV/AIDS affects the civilian population as a whole, but around how it affects the core institutions of the state, including the armed forces, charged with securing the population. In low-income countries in particular, where it is difficult to make universal treatment available because of lack of resources and infrastructure, this could mean that scarce resources for medicines are provided on a priority basis to the armed forces and state elites who are charged with protecting and defending the population rather than to all civilians, or, in the worst case, that these resources are diverted from civilian programmes to military programmes as a result of the portrayal of HIV/AIDS as a security threat. Examples of the latter have not yet been officially documented by NGOs or civil-society organizations, but there is certainly evidence that in many countries members of the armed forces routinely enjoy preferential access to medicines vis-à-vis the civilian population, or have at least moved to the front of the line in terms of receiving access to expensive ARVs. In Zambia members of the military have begun to argue that the armed forces should have priority access to more government funding for ARVs because the military and their families are more at risk due to the nature of their job and because this

would contribute to world peace.⁵⁰ In Rwanda, high-ranking officer increasingly have access to ARVs, but not the general population.⁵¹ This is part of a wider development in Africa whereby the soldiers of many countries now have greater or better access to healthcare and AIDS medicines than the civilian population.⁵² As Radhika Sarin notes: quite a few African militaries are committed to providing treatment for their soldiers, such as the Ugandan People's Defense Forces and Nigeria's Armed Forces. These militaries do try and work with military spouses and civilian communities to provide HIV prevention education. However, access to antiretrovirals is very low in many African nations.⁵³ The securitization of HIV/AIDS may thus inadvertently help to ensure that soldiers and elites who play a crucial role in protecting populations receive access to treatment, without being able to ensure that such treatment is also provided democratically and universally to all who need it. In this third way, too, the framing) of HIV/AIDS as a security issue could give rise to a biopolitical racism and thus have more detrimental consequences than the ones envisaged by those securitizing the illness. Its more progressive normative aspirations notwithstanding, then, the biopolitical nature of the securitization of AIDS risks fanning a more subtle biopolitical racism that could end up deciding who is allowed to live and who will be left to die – a criterion that assesses human beings not in terms of any intrinsic value, but on the basis of their relation to the objective of maximizing the health and well-being of the population. To be clear, the point here is not that the securitization of HIV/AIDS will invariably lead to these outcomes and therefore needs to be categorically resisted and abandoned, but rather it is to warn that it has the potential to generate these kinds of outcomes. These outcomes are not precluded from a security framing of HIV/AIDS in a way that they would be within a humanitarian or human rights framework. The mere fact that these outcomes could be consistent with a security framing of HIV/AIDS, moreover, in conjunction with the fact that – as the aforementioned examples illustrate – the seeds of such a biopolitical racism clearly do not lurk very far beneath the surface of the debate on HIV/AIDS and security, necessitates more sustained reflections on how to ensure that these dangers do not emerge in a more forceful manner in the years ahead.

Final Remarks

Presenting the AIDS pandemic as a security issue could ensure that they insist that it is not *exclusively* a security issue, but rather a security issue *in addition* to being a health issue, a development issue, an economic issue, a social issue, a political issue, a human rights issue, a gender issue, etc. In this way, highlighting the security implications of HIV/AIDS does not unreflectively reify the privileged status of the security sector and elites in terms of access to treatment, and makes it more difficult to simply write off the lives of ordinary civilians living with HIV/AIDS. This outcome could also be achieved, secondly, not just by using a national security framework when securitizing AIDS, but by complementing such an analysis with a human security framework as well. Although it has shortcomings of its own, the human security framework is by nature more comprehensive and better equipped to capture the importance of addressing the illness for the lives of ordinary individuals, and makes a stronger

claim for addressing the needs of the latter than just letting them perish. In so doing, the normative benefits that could accrue from adopting a security framework, such as increasing the level of attention and available resources for addressing HIV/AIDS, would not necessarily have to be sacrificed, while the less threatening language used would result in a lower risk of those living with HIV/AIDS being subjected to harsh measures in the name of security. The normalizing dangers accompanying the securitization of AIDS, in turn, might best be addressed by insisting that international AIDS policies do not privilege prevention and the prescription of specific norms of sexual behaviour at the expense of treatment. Averting the security implications of HIV/AIDS can only be achieved in the long run by also scaling up treatment programmes, which are less concerned with how persons became infected than with helping those already infected survive. International and bilateral AIDS initiatives launched through the securitization of HIV/AIDS thus need to be less moralistic and judgmental in tone, and need to focus more on providing treatment to those who want it. In this way addressing the pandemic would not necessarily have to involve heavily prescriptive practices about how and when people should engage in sexual behaviour, but could focus instead on procuring medicines and enhancing the infrastructure for their effective dispersal. Even if these precautions are taken, however, the securitization of HIV/AIDS nevertheless remains in the end a risky gamble on the ability of those presenting HIV/AIDS as a security issue to maintain control over the uses to which this language will be put – albeit a gamble that has perhaps become necessary due to the particular vicissitudes of contemporary world politics. Foucault once insisted that 'the ethico-political choice we have to make every day is to determine which is the main danger'.⁶⁰ In the case of the securitization of HIV/AIDS, this means deciding whether the potential dangers that derive from its biopolitical nature outweigh the dangers of not drawing upon whatever discursive and material resources are available today for addressing the global AIDS pandemic – including the dangerous language of security. Another way of putting this same point is to suggest that the risk-security nexus evident in the securitization of HIV/AIDS is performing what Foucault called normalizing practices, i.e. practices whereby populations are subject to continuous indirect surveillance and where those groups deviating from the desired biological norms (such as being HIV-negative) are targeted by a variety of political interventions. 'A normalizing society' Foucault argued, 'is the historical outcome of a technology of power centred on life'. Whilst penning these thoughts on biopower in the 1970s, Foucault had still believed, perhaps erroneously, that many parts of the non-Western world were outside this biopolitical sphere, noting, for example, how '*[o]utside the Western world famine exists, on a greater scale than ever; and the biological risks confronting the species are perhaps greater, and certainly more serious, than before the birth of microbiology.*' If Foucault were alive today, however, he may well have been struck by the fact that the ongoing securitization of AIDS is now in the process of globalizing such biopolitical considerations not least through extensive use of the language of risk. The securitization of HIV/AIDS thus marks an important mechanism through which the Western world can increasingly subject the rest of the world to

these same biopolitical strategies in the name of 'life' and collective 'health'. All of this gives rise to a deeper political trade-off. On the one hand, not to draw upon the language of risk and security in order to garner more international support and resources for persons living with HIV/AIDS would be to risk the lives of those who may otherwise perish. Yet to draw upon the language of risk and security in order to prevent this outcome would also be risking lives in the very different sense of encouraging international political interventions which, in the name of life itself, seek to inscribe various biopolitical and risk-based identities and subjectivities onto HIV/AIDS bodies.

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