

HIV/AIDS as a National Security Threat: Narrative Construction and the Limited Empirical Basis of Global Security Policy

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ABSTRACT

This study examined how HIV/AIDS was constructed as a national and international security threat and assessed whether the resulting security claims were proportionate to the available empirical evidence. A qualitative document-review design was used, combining purposive literature selection with critical content analysis of policy documents, United Nations materials, global health reports, and peer-reviewed research. The analysis operationalized securitization through the identification of securitizing actors, referent objects, audiences, threat claims, and policy consequences. The findings showed that the security framing of HIV/AIDS was driven particularly by concerns about state stability, military readiness, and peacekeeping operations. However, the empirical relationship between HIV/AIDS and state failure or international insecurity was indirect, context-dependent, and frequently mediated by poverty, conflict, governance capacity, and health-system resilience. Securitization increased political attention and resources, but it also risked threat inflation, stigma, and policy displacement. The study concluded that security considerations should remain subordinate to evidence-based, rights-sensitive, and public-health-oriented HIV policy.



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INTRODUCTION

The end of the Cold War widened the conceptual boundaries of security. Security was no longer understood exclusively as the protection of territorial sovereignty against military attack; it increasingly incorporated non-traditional threats whose consequences could disrupt social order, economic performance, state capacity, and transnational stability. Infectious disease became one of the most prominent issues in this broader agenda because pathogens cross borders, impose large social and fiscal costs, and can expose weaknesses in public institutions. The historical trajectory of HIV/AIDS is especially important in this regard. The disease emerged first as a severe public-health crisis, but by the late 1990s it was also being discussed through the vocabulary of national security, international peace, military readiness, and state fragility. More recent scholarship continues to show that the health-security nexus is politically consequential because the decision to label a health problem as a security threat can reorder priorities, redistribute resources, and authorize exceptional forms of intervention (Wenham, 2019; Zhou, 2024).

The securitization of HIV/AIDS did not arise only from the epidemiological magnitude of the epidemic. It was produced through interaction between disease burden, institutional authority, policy narratives, and broader geopolitical concerns. In January 2000, the United States National Intelligence Council issued National Intelligence Estimate 99-17D, The Global Infectious Disease Threat and Its Implications for the United States. The document treated infectious disease as a non-traditional security problem and considered possible consequences for political stability, socioeconomic development, military forces, and United States interests abroad (National Intelligence Council, 2000). Later that year, the United Nations Security Council adopted Resolution 1308, which connected HIV/AIDS to peacekeeping personnel and expressed concern about the potential implications of the epidemic for peace and security (United Nations Security Council, 2000). These interventions gave the HIV-security linkage exceptional political visibility and helped institutionalize a vocabulary in which an epidemic could be discussed as a security problem rather than only as a health and development problem.

Nevertheless, the movement from public-health concern to security threat should not be treated as evidence that the underlying causal claims were empirically established. A central problem in the HIV-security literature is the tendency to move too quickly from association to causation. High HIV prevalence has often coexisted with poverty, weak health systems, conflict, inequality, labor-market vulnerability, and limited institutional capacity. These conditions can reinforce one another, but their coexistence does not prove that HIV/AIDS independently causes state failure, military collapse, or international conflict. Kearns and Tucker (2023) emphasize the geopolitical work performed by AIDS securitization, while earlier studies found that the security linkage was often partial, contested, or highly dependent on institutional context (Rushton, 2010; McInnes & Rushton, 2013). The continued global burden of HIV confirms the seriousness of the disease, but contemporary epidemiological evidence also demonstrates that treatment expansion, prevention, institutional capacity, and social policy substantially modify outcomes (Tian et al., 2023; Lu et al., 2025).

A second issue concerns the relationship between security framing and policy effectiveness. Securitization may elevate an issue on the political agenda, accelerate resource mobilization, and bring actors from outside the health sector into the response. In the HIV field, such visibility contributed to attention within defense institutions, peacekeeping operations, diplomatic forums, and international financing initiatives. Shadyab et al. (2017) argued that securitization generated both opportunities and continuing challenges for military and uniformed services. At the same time, a security frame can privilege state interests over individual rights, encourage surveillance or coercive responses, and intensify stigma toward populations already exposed to discrimination. Elbe (2006) identified this ethical dilemma early in the debate, and later health-security scholarship has warned that an overexpanded security vocabulary can make exceptional responses appear normal even where ordinary public-health tools are more effective (Wenham, 2019).

The contemporary policy environment makes a reassessment particularly necessary. Global HIV governance has increasingly moved toward evidence-based, people-centered strategies that emphasize prevention, antiretroviral treatment, community engagement, health-system strengthening, and protection from discrimination. The World Health Organization's 2022-2030 strategies place HIV within a framework of universal health coverage, primary health care, and health security, but they prioritize evidence-based services and equity rather than military-style threat management (World Health Organization, 2022). The 2024 progress report similarly emphasizes gaps in service access and sustainability, while UNAIDS reports in 2024 and 2025 highlight both substantial long-term progress and persistent inequalities, financing pressures, and prevention gaps (UNAIDS, 2024, 2025; World Health Organization, 2024). These developments suggest that the policy question is not whether security is entirely irrelevant, but how much explanatory and policy weight the security frame should carry relative to public health, development, and human rights.

This article therefore addresses two related questions. First, how was HIV/AIDS constructed as a national and international security threat by authoritative actors, particularly the United States intelligence community and the United Nations Security Council? Second, to what extent were the principal security claims supported by empirical evidence concerning state stability, military capacity, and peacekeeping operations? The research gap lies in the separation that often exists between studies of securitizing discourse and studies of empirical health or institutional outcomes. Many accounts explain how HIV/AIDS entered the security agenda, while other studies assess disease burden or program effectiveness. Fewer analyses systematically place the security claims and the available empirical evidence side by side.

The novelty of the article lies in combining a securitization framework with an explicit evidence test. Securitization is operationalized through five analytical elements: the securitizing actor, the referent object claimed to be threatened, the audience whose acceptance matters, the securitizing move through which the threat is articulated, and the policy consequences that follow from that framing. These elements are then compared with empirical indicators relevant to the claims being made. This approach distinguishes political success in constructing an issue as a security concern from empirical validity in demonstrating that the issue produces the predicted security outcome. Such a distinction is important because a narrative may be institutionally powerful without being causally sufficient. By separating these two dimensions, the article seeks to contribute to a more proportionate, evidence-based understanding of the relationship between HIV/AIDS and security.

RESEARCH METHOD

This study employed a qualitative document-review design using library research and critical content analysis. The design was appropriate because the research question concerns the construction of policy narratives, the authority of institutions that promoted those narratives, and the relationship between those narratives and evidence reported in academic and policy literature. The study did not attempt to estimate a pooled epidemiological effect or conduct a statistical meta-analysis. Instead, it treated official documents and peer-reviewed studies as texts that could be examined for claims, assumptions, evidence, and policy consequences. The core analytical period extended from the emergence of the HIV-security debate around 2000 to the contemporary policy context through 2026. Foundational theoretical works published before that period were retained when necessary to define securitization and to interpret later debates.

Source selection was purposive and transparent. The revised analytical corpus consisted of core official documents, global health reports, and peer-reviewed literature directly relevant to the HIV-security nexus. Priority documents included National Intelligence Estimate 99-17D, United Nations Security Council Resolution 1308, World Health Organization strategy and progress documents, and recent UNAIDS global AIDS updates. Peer-reviewed sources were selected when they addressed at least one of four domains: securitization theory and health security; HIV/AIDS and national or international security; military or peacekeeping implications; or contemporary HIV epidemiology and policy. Sources that discussed unrelated economic or development questions without a direct analytical link to HIV/AIDS and security were excluded from the revised manuscript. This criterion removed material that was peripheral to the central argument and strengthened the coherence of the evidence base.

The literature search for the revised manuscript used combinations of terms such as 'HIV/AIDS securitization', 'HIV national security', 'HIV military readiness', 'HIV peacekeeping', 'global health security', 'United Nations Security Council Resolution 1308', and 'HIV empirical evidence state stability'. Relevant materials were located through academic indexing services, publisher repositories, PubMed records, and official repositories of the United Nations, World Health Organization, UNAIDS, and United States intelligence institutions. Recent sources were prioritized for epidemiological and policy claims, while older sources were retained only when they were foundational to the securitization debate or constituted primary historical documents. This procedure was designed to improve reproducibility without representing the study as a systematic review conducted under PRISMA or similar protocols.

The unit of analysis was the explicit or implicit security claim. Each source was read for statements about what or who was threatened, how the threat was expected to operate, and what response followed. Coding was organized around five securitization categories derived from the Copenhagen School and subsequent health-security literature: securitizing actor, referent object, audience, securitizing move, and policy consequence (Buzan et al., 1998; McInnes & Rushton, 2013). A second coding layer classified the empirical claim being made into three principal outcome domains: state stability, military or institutional capacity, and international peace or peacekeeping. The coded security claim was then compared with evidence reported in empirical studies and institutional assessments.

Analytical validity was strengthened through source triangulation. Assertions originating in policy discourse were not treated as empirical findings merely because they appeared in authoritative documents. Instead, official security claims were compared with peer-reviewed studies, later institutional assessments, and contemporary epidemiological evidence. Contradictory findings were retained rather than harmonized. For example, evidence that HIV/AIDS can create personnel-management burdens in military institutions was distinguished from the stronger claim that it necessarily causes military incapacity or state collapse. Likewise, the political significance of Resolution 1308 was separated from the empirical question of whether peacekeeping operations were demonstrably impaired by HIV/AIDS. This distinction between narrative authority and causal evidence constituted the central methodological principle of the study.

RESULTS AND DISCUSSION

From a Public-Health Problem to a Security Issue

HIV/AIDS was initially governed primarily through the institutions and practices of public health. The main policy concerns were transmission prevention, clinical care, treatment development, epidemiological surveillance, health education, and the reduction of stigma. The disease had profound social and economic effects, particularly in countries with high prevalence, but these effects did not automatically place HIV/AIDS within the conceptual field of national security. The movement toward security occurred as the post-Cold War agenda widened and policymakers became more receptive to the idea that non-military phenomena could threaten the functioning of states. Infectious disease became especially salient because it combined cross-border mobility, uncertainty, demographic effects, fiscal pressure, and potential disruption of essential services. In this environment, HIV/AIDS became one of the earliest and most influential examples of health securitization.

The securitization framework clarifies why epidemiological severity alone cannot explain this shift. Buzan et al. (1998) conceptualized securitization as a political process through which an issue is presented as an existential threat to a valued referent object and is accepted by a relevant audience as requiring exceptional priority. Applied to HIV/AIDS, the principal securitizing actors included officials in powerful states, intelligence institutions, security organizations, and high-level international bodies. The referent objects varied: the state, military effectiveness, socioeconomic stability, peacekeeping personnel, and international order. Audiences included national policymakers, Security Council members, donor governments, defense establishments, and the wider international policy community. The securitizing move consisted of authoritative claims that the epidemic could undermine these referent objects. The policy consequences included greater political attention, military-sector prevention programs, dedicated financing, and incorporation of HIV into peace and security discussions.

This process was not uniform across countries or institutions. Lo (2018), for example, showed that HIV securitization in China interacted with state-society relations and global health initiatives in ways shaped by domestic political structures. Kearns and Tucker (2023) similarly stress that securitizing AIDS is not simply a technical response to disease burden; it reflects geopolitical assumptions and normative beliefs about risk, rights, and responsibility. These findings support the view that securitization is context-dependent. The same epidemiological condition can be framed as a public-health problem, a development challenge, a human-rights issue, or a security threat depending on who speaks, which audience is addressed, and what institutional response is sought.

Contemporary epidemiology further demonstrates why a purely security-based interpretation is inadequate. HIV remains a major global health burden, yet the trajectory of the epidemic is strongly shaped by access to testing, antiretroviral treatment, prevention, health-system performance, social inequality, and sustained financing. Recent burden estimates and projections show substantial variation between regions and countries rather than a uniform security effect (Tian et al., 2023; Lu et al., 2025). The 2025 UNAIDS update reported major reductions in new infections and AIDS-related deaths since 2010 while also documenting continuing prevention gaps and financing vulnerabilities (UNAIDS, 2025). These patterns are more consistent with a model in which HIV/AIDS interacts with institutional and social conditions than with a model in which disease prevalence alone determines security outcomes.

Constructing the Threat Narrative: U.S. Intelligence and the United Nations Security Council

A decisive moment in the construction of infectious disease as a security issue occurred in the United States intelligence community. The 2000 National Intelligence Estimate on the global infectious disease threat was often popularly associated with the Central Intelligence Agency, but it was formally produced under the auspices of the National Intelligence Council. This distinction matters because the document represented a coordinated national intelligence assessment rather than the institutional position of a single agency. The estimate argued that infectious diseases could have consequences for social stability, economic development, military forces, and United States strategic interests. HIV/AIDS featured prominently because of its scale, concentration in working-age populations, and severe burden in parts of sub-Saharan Africa (National Intelligence Council, 2000).

From a securitization perspective, the intelligence estimate operated as a securitizing move. The actor was the United States intelligence community, the principal referent objects were national interests and state capacity, and the immediate audience consisted of senior policymakers and security

institutions. Its authority derived not only from epidemiological information but also from the institutional prestige of intelligence assessment. By locating infectious disease within a document designed to evaluate threats to national interests, the report changed the policy meaning of disease. It encouraged readers to interpret epidemics not solely as humanitarian or medical problems but as factors capable of producing strategic consequences. Importantly, however, many of the report's strongest claims were prospective and scenario-based. They described plausible pathways rather than demonstrating that HIV/AIDS had already caused the predicted outcomes.

The United Nations Security Council provided a second, globally visible securitizing platform. Resolution 1308, adopted unanimously on 17 July 2000, expressed concern about the potentially damaging impact of HIV/AIDS on peacekeeping personnel and encouraged education, prevention, voluntary and confidential testing, counselling, and treatment as part of peacekeeping preparation (United Nations Security Council, 2000). The resolution was symbolically important because it was the first Security Council resolution devoted to HIV/AIDS. Its adoption signaled that a health issue could enter the institutional space normally associated with war, peace, and collective security.

Yet the text of Resolution 1308 was more cautious than later summaries sometimes imply. The resolution did not establish a general doctrine that HIV/AIDS constituted an existential threat to every state or to international peace in all contexts. Its operative provisions concentrated on prevention, training, and the health of peacekeeping personnel. Rushton (2010) subsequently demonstrated that HIV/AIDS never achieved an uncontested security status across the wider United Nations system. Development, public health, and human rights remained powerful alternative frames. McInnes and Rushton (2013) therefore characterize HIV securitization as multi-level and partial rather than a simple binary transition from non-security to security.

The difference between a securitizing move and successful securitization is analytically crucial. A powerful actor can identify a threat, but the durability and scope of securitization depend on audience acceptance and institutional follow-through. In the HIV case, the Security Council's intervention generated significant visibility, but it did not displace other policy frames. This limited institutionalization is consistent with the broader evolution of global HIV policy, which has increasingly emphasized treatment, prevention, inequality reduction, community participation, and human rights. The current World Health Organization strategy links HIV to health security but does so through evidence-based services, resilient health systems, and universal health coverage rather than through exceptional security measures (World Health Organization, 2022).

Testing the Security Claims Against Empirical Evidence

The first major security claim concerns state stability. Early securitization narratives suggested that high HIV prevalence could erode the productive population, increase dependency burdens, reduce public-sector capacity, intensify social stress, and ultimately contribute to state fragility. These mechanisms are plausible, particularly where an epidemic is severe and institutions are already weak. The empirical problem lies in moving from plausibility to independent causation. States with high HIV prevalence have differed markedly in political stability, and many of the variables associated with serious HIV epidemics - poverty, conflict, weak health systems, inequality, and limited administrative capacity - are themselves determinants of fragility. Consequently, HIV/AIDS is more accurately understood as a stress multiplier than as a sufficient cause of state failure.

The distinction can be expressed in causal terms. If HIV/AIDS were a direct and broadly generalizable cause of state failure, comparable levels of prevalence should generate relatively consistent effects on state capacity after controlling for other factors. The historical record does not show such uniformity. Instead, institutional resilience, fiscal capacity, access to treatment, external support, and governance quality substantially modify outcomes. The major contribution of the AIDS, Security and Conflict Initiative was precisely to challenge deterministic predictions and to show that the links among HIV, conflict, security institutions, and state fragility were more complex than early narratives assumed. This does not make the epidemic politically irrelevant; it means that the causal chain must be demonstrated rather than presumed.

The second claim concerns military readiness. HIV/AIDS can have genuine consequences for armed forces, including medical costs, personnel attrition, recruitment constraints, deployment restrictions, and the need for long-term treatment. Heineken (2009) documented such institutional challenges in the South African armed forces, and Shadyab et al. (2017) reviewed continuing military

and uniformed-service implications. These findings support a limited security claim: HIV can impose measurable burdens on military organizations. They do not, however, establish the stronger proposition that high prevalence necessarily produces military collapse or decisive strategic weakness. Military effects depend on force structure, age distribution, treatment access, testing policy, confidentiality practices, replacement capacity, and institutional management.

The availability of effective antiretroviral therapy has further changed the empirical basis of this claim. As treatment has improved, HIV infection has become increasingly manageable as a chronic condition for people who have reliable access to care. Contemporary military and public-sector institutions can reduce risk through prevention, testing, treatment continuity, occupational-health protocols, and anti-discrimination policies. This means that security assessments based on the epidemiological and therapeutic conditions of the late 1990s should not be mechanically projected into later periods. The relationship between disease and military capability is dynamic, and policy capacity is itself part of the causal explanation.

The third claim concerns peacekeeping operations and international security. Resolution 1308 reflected concern that peacekeeping environments could create risks for personnel and local populations. Such environments may indeed involve mobility, separation from family, unequal power relations, sexual exploitation risks, and limited access to services. These are legitimate public-health and protection concerns. Yet evidence that HIV risk exists in peacekeeping settings is not equivalent to evidence that HIV/AIDS has caused peacekeeping missions to fail or has independently destabilized international peace. The appropriate empirical question is therefore narrower: whether HIV materially degrades mission readiness or generates transmission patterns at a scale that undermines operational objectives.

The policy response of the United Nations itself suggests a more proportionate interpretation. Resolution 1308 emphasized training, prevention, counselling, testing, and treatment rather than emergency security coercion. These are conventional public-health and personnel-management measures. Their use demonstrates that the identified risks were governable through institutional adaptation. The absence of strong evidence connecting HIV directly to peacekeeping failure weakens the strongest security claims, while the persistence of prevention programs supports a more limited conclusion that HIV is an operational health risk deserving structured mitigation.

The fourth claim concerns broader international instability. Security narratives sometimes implied that demographic losses, weakened institutions, and economic stress could interact to increase the likelihood of conflict. Once again, the mechanism is possible but difficult to isolate empirically. Conflict can increase HIV vulnerability through displacement, disrupted health services, sexual violence, and economic insecurity; HIV can simultaneously impose additional burdens on conflict-affected institutions. The relationship is therefore potentially bidirectional. Treating HIV as a single-direction cause of conflict obscures this complexity and may lead policymakers to overstate the explanatory power of disease while understating political, social, and institutional drivers.

Recent global HIV reports reinforce the importance of contextual variables. UNAIDS and the World Health Organization identify inequality, service access, financing, prevention coverage, stigma, legal environments, and health-system resilience as central determinants of epidemic outcomes (UNAIDS, 2024, 2025; World Health Organization, 2024). This evidence does not negate a security dimension, but it shifts the analytic center of gravity. Security effects appear most plausible where severe disease burden interacts with pre-existing institutional vulnerability. In such cases, HIV/AIDS is one component of a compound risk environment rather than an autonomous threat with a predictable security outcome.

Table 1 Security Claims and Empirical Assessment

Domain	Core security claim	Empirical assessment	Overall evaluation
State stability	High prevalence weakens productive populations and state capacity, potentially producing fragility or failure.	Effects are indirect and mediated by poverty, governance, conflict, treatment access, and institutional resilience.	Partially supported; insufficient for a universal causal claim.
Military readiness	HIV reduces recruitment, retention, deployability, and force effectiveness.	Institutional burdens are documented, but effects vary and can be mitigated through prevention, testing, treatment, and personnel management.	Supported as an institutional risk, not as automatic military collapse.

Peacekeeping	HIV threatens peacekeepers, local populations, and mission effectiveness.	Health risks justify prevention and training, but evidence of systematic mission failure caused by HIV is limited.	Operational health concern; stronger security claim is weak.
International peace	The epidemic generates instability with cross-border security consequences.	Causal pathways are complex and often bidirectional; conflict and weak institutions also increase HIV vulnerability.	Context-dependent and not independently demonstrated.
Policy consequences	Security framing increases urgency and resources.	Agenda elevation occurred, but securitization can also create stigma, militarization, and policy displacement.	Mixed: political benefits must be weighed against rights and public-health costs.

The Security-Public Health Tension

The empirical assessment has direct normative and policy implications. Securitization can be politically productive because security issues are difficult for senior decision-makers to ignore. Elevating HIV/AIDS to the security agenda helped communicate the scale of the crisis and supported cross-sectoral engagement. For uniformed services in particular, security framing created incentives to develop prevention programs, testing policies, treatment pathways, and institutional data systems. In this limited sense, securitization can function as an agenda-setting mechanism that mobilizes authority and resources that might otherwise be unavailable.

The same mechanism, however, can distort policy if the label 'security threat' becomes detached from the evidence. Elbe (2006) warned that securitization can shift the center of policy from the rights and needs of people living with HIV toward the protection of the state. Wenham (2019) later described the broader problem of oversecritization in global health: once security language becomes routine, it can normalize military participation, emergency governance, and threat-based policy pathways. In HIV policy, such a shift is especially sensitive because the epidemic has long been associated with stigma, moral judgment, criminalization, and discrimination against marginalized groups.

Threat inflation is therefore a substantive risk. When policymakers describe a disease as a threat to national survival, they may create incentives for restrictive or coercive interventions even when voluntary, community-based health measures are more effective. A security frame may also narrow attention toward populations regarded as risks to the state rather than people entitled to care. This is not only an ethical problem; it can undermine epidemiological effectiveness. Fear of surveillance, punishment, or disclosure can discourage testing and treatment, reduce trust in public institutions, and push affected populations away from health services.

A more defensible approach is to distinguish among levels of security relevance. HIV/AIDS can pose an individual health threat, an institutional operational risk, a development challenge, and, under specific conditions, a contributor to broader instability. These categories should not be collapsed. The evidence required to justify a military-readiness claim differs from the evidence required to claim that HIV threatens state survival or international peace. Clearer distinctions reduce the temptation to use the political force of the word 'security' as a substitute for causal analysis.

Implications for Evidence-Based Global HIV Policy

The findings support an evidence-based policy model in which security considerations are retained but subordinated to measurable outcomes. The primary objective of HIV policy should remain the reduction of transmission, prevention of AIDS-related morbidity and mortality, universal access to testing and treatment, and protection of the rights and dignity of people living with HIV. Security institutions may participate when they possess relevant capabilities or when HIV measurably affects their personnel, but their involvement should support rather than replace civilian public-health systems.

Contemporary global strategies provide a practical foundation for this approach. The World Health Organization's 2022-2030 strategy calls for high-quality, people-centered services, the use of data for decision-making, stronger systems and partnerships, community engagement, and innovation (World Health Organization, 2022). The 2024 progress report emphasizes that service gains coexist with major gaps and that sustainability planning is essential (World Health Organization, 2024). These priorities align more closely with the empirical drivers of HIV outcomes than broad claims of national insecurity do. They also provide indicators against which policy can be evaluated: treatment coverage, viral suppression, incidence, prevention access, mortality, equity, and continuity of care.

Recent UNAIDS reporting reinforces this point. The 2024 Global AIDS Update described a global response at a crossroads, emphasizing that inequality and political choices shape whether progress can be sustained. The 2025 update highlighted both long-term reductions in new infections

and AIDS-related deaths and a serious funding crisis that could reverse gains (UNAIDS, 2024, 2025). From a security perspective, these reports suggest that financing instability and institutional disruption may be more immediate threats to HIV outcomes than the disease is to state security. The policy implication is to strengthen resilience in health financing, supply chains, workforce capacity, community systems, and access to prevention technologies.

Evidence-based policy also requires temporal sensitivity. The security claims formulated around 2000 emerged when treatment access was limited and the future course of the epidemic was highly uncertain. Since then, antiretroviral therapy, prevention technologies, epidemiological surveillance, and institutional experience have changed the risk environment. A claim that may have been plausible under conditions of uncontrolled mortality can become less accurate when effective treatment is widely available. Security framing should therefore be periodically reassessed rather than treated as a permanent label.

Context sensitivity is equally important. The security implications of HIV are unlikely to be identical in a high-capacity state with broad treatment coverage and in a conflict-affected setting with disrupted health services. Policy should therefore be based on specified mechanisms and indicators. If the concern is military readiness, the relevant evidence includes prevalence in the force, treatment continuity, deployability, absenteeism, and replacement capacity. If the concern is state stability, analysis should examine fiscal pressure, public-service continuity, governance indicators, and the independent contribution of HIV relative to conflict and poverty. If the concern is peacekeeping, the relevant evidence concerns personnel health, transmission risk, mission readiness, conduct, and access to prevention. Such specificity prevents broad security rhetoric from substituting for measurement.

The ethical dimension of evidence-based policy is also central. Endalamaw et al. (2023) show that social attitudes toward people living with HIV remain unequal and shaped by socioeconomic factors. Stigma can be amplified when people with HIV are represented as dangers rather than rights-bearing members of society. Policy should therefore incorporate confidentiality, non-discrimination, informed consent, community participation, and protection from coercive practices. These safeguards are not external to effectiveness; they are part of the conditions that enable people to seek testing, remain in treatment, and trust health institutions.

Finally, the analysis suggests a more balanced understanding of health security. The concept can be useful when it directs attention to resilience, continuity of essential services, preparedness, and the protection of institutions whose failure would have wide social consequences. It becomes less useful when it treats every serious health problem as an existential threat or privileges exceptional security instruments by default. HIV/AIDS demonstrates both sides of this tension. Security framing helped elevate the epidemic politically, but the most durable gains have come from public-health technologies, community mobilization, treatment expansion, evidence-based prevention, and sustained institutional commitment.

Synthesis of the Discussion

The overall findings show that the securitization of HIV/AIDS was a genuine political process but an incomplete empirical proposition. The political process is visible in the involvement of the United States intelligence community, the Security Council, defense institutions, and other high-level actors. These actors identified valued referent objects, articulated potential threats, and influenced policy agendas. In that sense, HIV/AIDS clearly acquired security meaning. Yet acquisition of security meaning does not establish that the strongest predicted security outcomes occurred.

Across the three central empirical domains, the evidence supports qualified rather than universal conclusions. HIV/AIDS can impose burdens on states and security institutions, but the magnitude of those burdens is mediated by governance capacity, treatment access, socioeconomic conditions, and institutional adaptation. Military organizations can be affected, but they can also mitigate the effects. Peacekeeping environments can create health and protection risks, but those risks do not amount to demonstrated systemic mission failure. State fragility may interact with severe epidemics, but the causal relationship is multidirectional and confounded by factors that independently affect both health and security.

This distinction clarifies the article's theoretical contribution. A securitizing move should be assessed on at least two axes: political-institutional uptake and empirical proportionality. The first asks whether influential audiences accepted the issue as sufficiently urgent to alter policy. The second asks

whether the scope and intensity of the security response were justified by evidence of the alleged threat. HIV/AIDS achieved significant political uptake in some institutions, especially around 2000, but the empirical proportionality of some claims was weaker. The result is best described as partial securitization accompanied by uneven evidentiary support.

The distinction also clarifies the article's policy contribution. Desecuritization need not mean ignoring institutional or strategic consequences. It can instead mean returning decision-making to ordinary, accountable, evidence-based policy when extraordinary measures are not justified. In HIV policy, a proportionate approach recognizes operational risks to militaries and peacekeeping institutions where data support them while keeping the primary response anchored in public health, rights, development, and resilient health systems.

CONCLUSION

This study finds that HIV/AIDS became a national and international security issue through a process of political and institutional construction rather than through epidemiological facts alone. The United States intelligence community and the United Nations Security Council were important securitizing actors because they connected the epidemic to state stability, military readiness, peacekeeping, and international order. Resolution 1308 and the 2000 National Intelligence Estimate gave the HIV-security linkage unusual authority and visibility, but neither document by itself proves that the strongest security consequences occurred.

The empirical evidence is more nuanced. HIV/AIDS can increase institutional burdens and aggravate existing vulnerabilities, particularly where poverty, conflict, weak governance, and limited health-system capacity are already present. It can affect military personnel management and create operational health concerns in peacekeeping settings. However, the evidence does not support a universal claim that HIV/AIDS directly causes state collapse, military failure, or international insecurity. The relationship is contextual, mediated, and capable of being reduced through prevention, treatment, institutional adaptation, and effective governance.

Accordingly, the most appropriate policy position is neither to reject the security dimension completely nor to treat HIV/AIDS as a permanent existential threat. Security analysis should be used selectively, with explicit indicators and periodic reassessment. The principal policy framework should remain evidence-based public health: prevention, treatment, health-system strengthening, community engagement, financing sustainability, stigma reduction, and protection of rights. This approach preserves attention to legitimate institutional risks while preventing security rhetoric from displacing the health needs and dignity of people living with HIV.

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