EXHIBIT 2

Department of Defense Personnel Policies Regarding Members of the Armed Forces Infected with Human Immunodeficiency Virus: Report to the Committees on the Armed Services of the Senate and House of Representatives August 2018

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

AUG 27 2018

The Honorable William M. "Mac" Thornberry
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This report is in response to House Report 115-200, pages 148-149, accompanying H.R. 2810, the National Defense Authorization Act for Fiscal Year 2018, which requests that the Department of Defense submit a report on its personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV).

The enclosed report includes the following: (1) a description of policies addressing the enlistment or commissioning, retention, deployment, discharge, and disciplinary policies regarding individuals with this condition; (2) an update on the status of the Department of the Army's HIV policy; (3) an assessment of these policies, with reference to medical experts and literature, which includes how the policies reflect an evidence-based, medically accurate understanding of how this condition is contracted, how this condition can be transmitted to other individuals, the risk of transmission, and treatment regimens available; and (4) the feasibility of allowing an individual who is currently serving as an enlisted member of the Armed Forces to become a commissioned officer of the Armed Forces, and what restrictions are different for an officer.

Thank you for your continued support of our Service members. A similar letter is being sent to the Chairman of the Senate Committee on Armed Services.

Sincerely,

Stephanie Barna
Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

AUG 27 2018

The Honorable John McCain
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This report is in response to House Report 115-200, pages 148-149, accompanying H.R. 2810, the National Defense Authorization Act for Fiscal Year 2018, which requests that the Department of Defense submit a report on its personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV).

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Stephanie Barna
Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member

Department of Defense Personnel Policies Regarding Members of the Armed Forces Infected with Human Immunodeficiency Virus:

Report to the Committees on the Armed Services of the Senate and House of Representatives

August 2018

The estimated cost of this report or study for the Department of Defense is approximately $18,000 for the 2018 Fiscal Year.
This includes $100 in expenses and $18,000 in DoD labor.
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EXECUTIVE SUMMARY

INTRODUCTION: House Report 115-200, pages 148-149, accompanying H.R. 2810, the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2018, requested that the Department of Defense (DoD) submit a report to the Committees on Armed Services of the Senate and House of Representatives on its personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV). Specifically, the Committee requested DoD provide the following in its report:

(1) A description of policies addressing the enlistment or commissioning, retention, deployment, discharge, and disciplinary policies regarding individuals with this condition.

(2) An update on the status of the Department of the Army's HIV policy, which was under review during the issuance of a 2014 report.

(3) An assessment of these policies, with reference to medical experts and literature, which includes how the policies reflect an evidence-based, medically accurate understanding of how this condition is contracted; how this condition can be transmitted to other individuals; the risk of transmission; and treatment regimens available.

(4) The feasibility of allowing an individual who is currently serving as an enlisted member of the Armed Forces to become a commissioned officer of the Armed Forces, and what restrictions are different for an officer.

DATA COLLECTION: This report follows the Department's interim response submitted to the Committees on Armed Services of the Senate and House of Representatives on March 19, 2018, and includes DoD- and Service-level policies and assessments addressing the requirements specified in House Report 115-200. Service-level information was obtained from each of the Military Departments at the request of the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)).

PERSONNEL POLICIES PERTAINING TO HIV:

1. Enlistment and Commissioning (i.e., Accession): Grounded in statutory requirements for accessions of able-bodied and physically qualified individuals, recently reissued Department of Defense Instruction (DoDI) 6130.03, "Medical Standards for Appointment, Enlistment, or Induction into the Military Services," May 6, 2018, establishes DoD policy to ensure that individuals considered for appointment, enlistment, or induction into the Military Services are:

- Free of contagious diseases that may endanger the health of other personnel.
- Free of medical conditions or physical defects that may reasonably be expected to require excessive time lost from duty for necessary treatment or hospitalization, or may result in separation from the Military Service for medical unfitness.
- Medically capable of satisfactorily completing required training and initial period of contracted service.

- Medically adaptable to the military environment without geographical area limitations.
- Medically capable of performing duties without aggravating existing physical defects or medical conditions.

That instruction also establishes a specific policy to allow applicants who do not meet the specified physical and medical standards to be considered for a medical waiver. The instruction addresses 29 body systems, and lists for each of those a number of conditions that do not meet medical accession standards. Under the heading "Systemic Conditions," there are 19 such conditions, including presence of HIV infection. Thus, HIV infection is a disqualifying medical condition for entry into the military service. Both prior service and non-prior service applicants undergo screening for HIV prior to entrance. As with all other disqualifying medical conditions, applicants may be considered for a medical waiver.

2. Retention and Discharge: DoD and Service policies restrict involuntary separation of a Service member solely due to being HIV positive. Service members who acquire HIV after joining the military are ensured access to appropriate medical care: DoD policy requires they receive counseling and treatment consistent with the standard of care, evidence-based HIV clinical practice standards, and medical management guidelines. HIV positive Service members receive a referral for medical evaluation of fitness for continued service in the same manner as a Service member with other chronic or progressive illnesses. Service members with HIV may continue their service as long as they are able to perform their military duties, taking into account the nature of their position. If they develop a disability, HIV-positive Service members undergo evaluation of fitness for continued service by the same process as those who are HIV-negative. Active duty (AD) and Reserve Component (RC) Service members with laboratory evidence of HIV infection who are determined to be unfit for further duty undergo separation or retirement. Military Departments and Combatant Commands (CCMD) limit assignments of HIV-infected individuals based on expert medical review, determination regarding the individual's fitness for duty, and the nature and location of the duties performed, in accordance with operational requirements.

3. Deployment: DoD policy establishing deployment-limiting medical conditions sets the minimum standard for all deploying and deployed DoD personnel. Military Department policy guidance, Service-specific readiness requirements, or Combatant Commander needs may involve additional restrictions. HIV antibody positive status is a deployment-limiting medical condition precluding contingency deployment.

DoDI 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," Enclosure 3, dated February 5, 2010, provides that individuals with a diagnosis of "human immunodeficiency virus (HIV) antibody positive with the presence of progressive [HIV related] clinical illness or immunological deficiency" shall not deploy unless a waiver is granted. All Service policies preclude HIV positive Service members from deploying to combat areas or in support of contingency operations due to the potential lack of access to needed medical care or medications in austere environments, as well as the military risks inherent in the mission assigned that could lead to illness exacerbation and compromise unit readiness and mission completion. For purposes of this report, a contingency deployment is one that is outside the continental United States (OCONUS), more than 30 days in duration, and in a

location with medical support from only non-fixed (temporary) military medical treatment facilities. A contingency deployment also includes the relocation of forces and materiel to an operational area in a situation requiring military operations in response to natural disasters, terrorists, or as otherwise directed.

All Services currently permit HIV positive Service members to deploy for purposes other than combat or a contingency operation, or to be assigned for duty in certain overseas locations, subject to receipt of a waiver. In view of this, members with HIV infection may be considered deployable with limitations. A waiver may be recommended on a case-by-case basis after review of the individual Service member's health and consideration of factors including the climate, altitude, rations, housing, nature of the duty assignment proposed, and medical services available in the location to which deployment or assignment is proposed. Further, the condition must not pose a significant risk of substantial harm to the individual or others, taking into account the condition of the deployed environment. The following table outlines the Service-specific policies for grant of a waiver to permit an HIV positive Service member to deploy for other than combat or a contingency, or to be assigned for duty in an overseas location:

Army	Waivable?	Yes
	By Whom?	Combatant Commander
	Under what conditions?	Soldier is determined to be fit and free of HIV-related illness.
	Host nation rules apply?	Yes, but deployments may be permitted ***only*** to Europe and Korea.
Navy/ Marine Corps	Waivable?	Yes
	By Whom?	Sailors: Treating HIV Evaluation and Treatment Unit (HETU), Navy Bloodborne Infection Management Center, PERS-82, and receiving command. Marines: Deputy Commandant. Manpower & Reserve Affairs and receiving command.
	Under what conditions?	Agreement by all organizations/officials listed above and receiving command (including the CCMD, as appropriate). Sailors/Marines who have no viremia (i.e., there is no virus present in the bloodstream), do have an established history of medical compliance, and possess a professional attitude, may be considered on a case-by-case basis for large ship platform tours and OCONUS deployment/assignment.
	Host nation rules apply?	Yes
Air Force	Waivable?	Yes
	By Whom?	Air Force Medical Support Agency, with favorable coordination from receiving commander and CCMD approval.
	Under what conditions?	No HIV-related illness.
	Host nation rules apply?	Yes

DoD has recently issued a new policy, DoDI 1332.45, "Retention Determinations for Non-Deployable Service Members," July 30, 2018, for implementation October 1, 2018. The overarching policy is that to maximize the lethality and readiness of the Joint Force, all Service members are expected to be deployable. Service members who are considered non-deployable for more than 12 consecutive months will be evaluated for a retention determination by their respective Military Department, and, as appropriate, referral into the Disability Evaluation System (DES) or initiation of processing for administration separation, with the normal policies and procedures, including due process procedures, of those systems continuing to apply. The Military Departments will determine the deployability status of Service members and will make retention determinations for Service members who have been non-deployable for more than 12 consecutive months. They may retain such members if determined to be in the best interest of the Military Service. Under this DoDI, "non-deployable" and "deployable with limitations" are two separate categories; the retention determination process applying to the former but not the latter. The Military Departments have authority to determine the specific dividing line between the two categories most appropriate for the operational circumstances applicable to their respective Services.

4. Disciplinary: DoD policy provides that a HIV positive status is not a punishable offense and cannot be used as a sole basis for disciplinary action against an individual. DoD policy also prohibits the use of information obtained as a result of an epidemiologic assessment interview to support any adverse personnel action against a Service member. However, Service members with laboratory evidence of HIV infection may be subject to disciplinary action if they disobey an order to inform current or potential sexual partners of their infected status or do not engage in safe sex practices.

ARMY POLICY STATUS UPDATE: Initiated in 2015, a working group has reviewed Army Regulation (AR) 600-110, last updated in April 2014, to assess any need for changes to reflect an evidence-based, medically accurate understanding of HIV infectivity, transmission, and treatment. This process is expected to be completed in the near future.

MEDICAL ASSESSMENT OF PERSONNEL POLICIES: Currently, no vaccine exists to prevent HIV infection, and no treatment exists to cure it. Broad consensus regarding published medical evidence supports the notion that people living with HIV on antiretroviral therapy (ART) who have an undetectable viral load in their blood, have a "negligible risk" of sexually transmitting HIV. Depending on the ART drugs used, it may take as long as six months for an individual's viral load to reach an undetectable level. Thus, with the advent of ART, HIV infection has evolved from a once terminal condition to a chronic illness requiring regular management and strict adherence to treatment protocol. As a result, the Department's policies have evolved over time. They currently focus not only on minimizing risks of HIV exposure, but also on providing evidence-based care and support for Service members living with HIV, with the goal to maintain a Service member's fitness for duty, optimize retention and quality of life, and help avoid disease progression of HIV-positive Service members into potential disability. Recognizing the risk factors for HIV infection and transmission, DoD- and Service-level personnel policies intend to reflect current knowledge of: how HIV is contracted and transmitted to HIV-naïve individuals; the ability of an HIV-positive individual to continue service without exacerbating his or her condition or risking the military mission; the effect of

infected personnel on commands; and the safety of military blood supplies. Medical literature pertaining to HIV medicine rapidly evolves. Subject matter experts across the Military Services are aware of and have access to all available contemporary medical literature, practice guidelines, medications, and treatment modalities based on emerging and published evidence-based studies or expert opinion.

FEASIBILITY OF ALLOWING ENLISTED SERVICE MEMBERS TO BECOME COMMISSIONED OFFICERS AND RESTRICTIONS DIFFERENT FOR OFFICERS: DoD policy has long maintained a difference between accession medical standards and retention medical standards. The rationale for this difference is that once a member has been fully trained and has experience in performing the duties of his or her position, whether as an enlisted member or officer, the needs of the Service incline decidedly toward allowing the member to continue to perform those duties and return the investment the Service has made in the member. At the accession stage, the needs of the Service incline toward selecting members in whom to make the training and mentoring investment who minimize any risk of inability due to medical conditions to complete an initial period of service and potentially a longer military commitment. Longstanding DoD policy under DoDI 6130.03 has also held that in the case of an enlisted member seeking appointment as a commissioned officer, the accession standards are the appropriate ones to apply because it is a new position, involving a whole new set of duties and responsibilities and new training and mentorship. The needs of the Service do not necessarily favor an officer applicant with prior enlisted service compared to one without such service, in minimizing any risk of inability to perform satisfactorily in the commissioned officer position due to medical conditions. Yet, it is appropriate to note that a review of two individual officer candidates, one with and one without prior enlisted service, requesting a medical waiver for the same condition, the candidate with prior service may well have the advantage of a record of successful military service in the enlisted ranks. However, regarding which set of standards to apply to the initial medical screening, the accession medical standards are the more appropriate standards for all applicants, including applicants for enlistment or commissioning. This is long-established DoD policy for all medical conditions; there is no special or different rule for individuals with HIV infection.

DISCUSSION: The Department has a responsibility to ensure the health and well-being of Service members, and through its policies, aims to minimize the risk of Service members' exposure to HIV, while ensuring that those infected with HIV have access to appropriate care and management of their illness and are able to continue service. Military unique considerations; the rapidly evolving nature of medical evidence and understanding pertaining to the nature of HIV transmission, infectivity, associated risks, and treatment; evolving mission requirements; and Service member needs pertaining to health information privacy protections, as well as opportunities for career advancement, are key factors that influence personnel policy pertaining to HIV-infected members of the Armed Forces. Current DoD- and Service-level personnel policies pertaining to HIV-infected members of the Armed Forces:

- Are established to maintain military readiness and optimize lethality of the Armed Forces.

- Are instituted to ensure military applicants can successfully complete rigorous military training and deploy to austere environments to accomplish the demanding missions of the military, including combat against enemy forces, without jeopardizing their health, the health of their unit, or the military mission, as well as to respect host Nation laws where our forces are deployed.

- Support retention of Service members infected with HIV, unless there is evidence of deteriorating health or other factors that render the individuals unable or unfit to perform their duties.

- Require the same procedures for medically evaluating Service members who develop disability due to chronic illness to determine fitness for continued service, regardless of whether the Service member is HIV-positive.

- Aim to ensure that, except for assignment limitations, HIV-infected personnel are treated no differently than other Service members.

- Ensure that a Service member infected with HIV but able to fully perform duties is not retired or involuntarily separated solely based on being infected.

- Direct the protection of health information and privacy of HIV-infected personnel.

- Reflect existing evidence and adhere to current nationally-accepted, evidence-based guidelines, and assess evolving medical evidence and scientific understanding of the nature and risk of HIV transmission, available treatment regimens, and the latest HIV management approaches and practices.

- Stipulate clinical management to be consistent with standard of care, evidence-based HIV clinical practice standards, and medical management guidelines.

CONCLUSIONS: DoD- and Service-level personnel policies pertaining to members of the Armed Forces infected with HIV are evidence-based in accordance with current clinical guidelines and are reviewed and updated to align with evolving medical capabilities, technologies, evidence-based practices, and current scientific understanding of the nature of HIV infection, transmission, and management. Maintaining the health of military personnel is essential for force readiness. It is a strategic objective of the Military Health System (MHS) to sustain the health of Service members and restore the health and return to duty of Service members who become ill or injured, whenever possible. Once a Service member completes training, the goal is to retain members who acquire HIV and who are still capable of performing their duties in the rigorous military environment. Personnel policies aim to balance the need of the Services (e.g., readiness, resilience, deployability, mission accomplishment, retention) with the needs of Service members infected with HIV (e.g., access to quality care, counseling, support and educational services, privacy protections, option to continue service, if desired). As such, existing DoD- and Service-level personnel policies intend to maximize the lethality, readiness, and operational effectiveness of the Armed Forces, as well as help ensure the health and well-being of Service members, while mitigating the risk of HIV transmission.

INTRODUCTION:

In House Report 115-200, page 148-149, to accompany H.R. 2810, NDAA for FY 2018 (Public Law 115-91), the Committee on Armed Services of the House of Representatives requested that the DoD submit a report to the Committees on the Armed Services of the Senate and House of Representatives on its personnel policies regarding members of the Armed Forces infected with HIV. Specifically, the Committee requested that DoD provide the following in its report:

(1) A description of policies addressing the enlistment or commissioning, retention, deployment, discharge, and disciplinary policies regarding individuals with this condition.

(2) An update on the status of the Department of the Army's HIV policy, which was under review during the issuance of a 2014 report.

(3) An assessment of these policies, with reference to medical experts and literature, which includes how the policies reflect an evidence-based, medically accurate understanding of how this condition is contracted; how this condition can be transmitted to other individuals; the risk of transmission; and treatment regimens available.

(4) The feasibility of allowing an individual who is currently serving as an enlisted member of the Armed Forces to become a commissioned officer of the Armed Forces, and what restrictions are different for an officer.

The Committee indicated that the Department's previous report, submitted to Congress in response to section 572 of the NDAA for FY 2014, did outline the current DoD policies; however, it failed to include how current policies reflect the evidence base and medical advances in the field of HIV. The Committee also stated the report fell short in describing the criteria guiding the implementation of these policies throughout different branches and among commanding officers.

DATA COLLECTION: This report follows the Department's interim response submitted to the Committees on Armed Services of the Senate and House of Representatives on March 19, 2018, and includes DoD- and Service-level policies and assessments addressing the requirements specified in House Report 115-200. Service-level information was obtained from each of the Military Departments at the request of the OASD(HA).

PERSONNEL POLICIES PERTAINING TO HIV:

1. Accession (Enlistment or Commissioning)

Accession standards require healthy recruits who are free of communicable diseases or medical conditions that will likely endanger the health of other personnel, require excessive time lost from duty for necessary treatment or hospitalization, or likely result in separation from service due to medical unfitness. DoDI 1304.26, "Qualification Standards for Enlistment, Appointment,

and Induction," provides basic entrance qualification standards "designed to ensure that individuals under consideration for enlistment, appointment, or induction are able to perform military duties successfully, and to select those who are the most trainable and adaptable to Service life." Recruits must also be capable of functioning in the demanding military environment without aggravation of existing medical conditions. DoDI 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," states that individuals under consideration for appointment, enlistment, or induction into the Military Services must be:

- Free of contagious diseases that probably will endanger the health of other personnel.
- Free of medical conditions or physical defects that may require excessive time lost from duty for necessary treatment or hospitalization, or probably will result in separation from the Service for medical unfitness.
- Medically capable of satisfactorily completing required training.
- Medically adaptable to the military environment without the necessity of geographical limitations.
- Medically capable of performing duties without aggravation of existing physical defects or medical conditions.

DoDI 6130.03 also establishes a specific policy to allow applicants who do not meet the specified physical and medical standards to be considered for a medical waiver. This instruction addresses 29 body systems and lists for each a number of conditions that do not meet medical accession standards. Under the heading "Systemic Conditions," there are 19 such conditions, including presence of HIV infection. DoDI 6485.01, "Human Immunodeficiency Virus (HIV) in Military Service Members," June 7, 2013, reiterates that individuals with laboratory evidence of HIV infection are denied eligibility for appointment, enlistment, pre-appointment, or initial entry training for military service pursuant to DoDI 6130.03. All applicants for appointment, enlistment, or individuals being inducted into the Military Services are screened for laboratory evidence of HIV infection. Applicants do not meet accession standards if they present with HIV or serologic evidence of infection, or false-positive screening test(s) with ambiguous results on confirmatory immunologic testing. Thus, HIV infection is a disqualifying medical condition for military service, and persons infected with HIV are neither enlisted nor commissioned into military service. As with all other disqualifying medical conditions, applicants may be considered for a medical waiver pursuant to DoDI 6130.03.

Additionally, DoDI 6485.01 requires applicants to the U.S. Service Academies, the Uniformed Services University of the Health Sciences, and other officer candidate programs undergo testing for laboratory evidence of HIV within 72 hours of arrival to the program, and denies entry to the program if the test result is positive. Reserve Officer Training Corps program cadets and midshipmen must be tested for laboratory evidence of HIV no later than during their commissioning physical examination, and are denied a commission if they test positive.

Applicants for active and reserve enlisted service undergo HIV testing typically at U.S. Military Entrance Processing Command Military Entrance Processing Stations (MEPS) or other authorized locations. Applicants not tested at the MEPS undergo testing as part of the physical examination conducted prior to accession.

Service accession policies comply with DoDI 6130.03 and DoDI 6485.01. Applicable Service policies are set forth in the following: AR 600-110 and AR 40-501for the Army; Secretary of the Navy Instruction (SECNAVINST) 5300.30E for the Navy and Marine Corps; and Air Force Instruction (AFI) 48-123 for the Air Force.

DoD medical accession standards are reviewed periodically by the Accession Medical Standards Working Group (AMSWG), which evaluates and recommends updates to maintain the currency and validity of those standards. The AMSWG is co-chaired by representatives from the Office of the Assistant Secretary of Defense for Manpower and Reserve Affairs (M&RA) and OASD(HA). It includes a voting representative from each of the five Military Services, with additional support from the following DoD components/offices: Joint Staff Surgeon; Surgeons General of the Army, Navy, and Air Force; medical officers of the Coast Guard and National Guard Bureau; and personnel chiefs of the Army, Navy, Air Force, Marine Corps, Joint Staff, and National Guard Bureau. Among the functions of the AMSWG are to perform evidence-based assessments of the accession standards and provide direction in research initiatives for the Accession Medical Standards Research Activity, including evidence-based research in support of medical standards assessments.

Supported by the work of the medical and personnel experts of the AMSWG, the DoDI 6130.03 disqualification for accession for HIV infection does not reflect disagreement with the medical consensus that modern medication management of HIV infection produces very positive results. However, in the context of the extraordinary challenges of many aspects of military service, including potential mission needs under highly stressful combat conditions or in extremely austere and dangerous places worldwide, even well-managed HIV infection carries risks of complications and comorbidities, possibly with latent effects, immune system dysregulation, neurocognitive impairments (NCI) (discussed further below), disrupted medication maintenance and necessary monitoring for potential side-effects, possible military vaccination adverse effects, and potential communicability, including in circumstances of buddy-aid to a seriously injured member in combat and emergency whole blood battlefield transfusions. In view of these risks, the needs of the Service incline toward maintaining the longstanding medical standard disallowing accession of HIV infected individuals.

2. Retention/Discharge

Once a Service member completes initial training, the policy is to retain members who acquire HIV and are still capable of performing their duties in the rigorous military environment. Clinical management of an AD Service member and an RC Service member on AD for a period of more than 30 days with laboratory evidence of HIV infection is conducted consistent with standard of care, evidence-based HIV clinical practice standards, and medical management guidelines.

DoDI 6485.01 specifically addresses HIV in Service members, and prescribes procedures for the identification, surveillance, and management of members of the Military Services infected with HIV and for prevention activities to control transmission of HIV. An AD Service member with laboratory evidence of HIV infection is referred for appropriate treatment and a medical evaluation of fitness for continued service in the same manner as a Service member with other chronic or progressive illnesses, in accordance with DoDI 1332.18, "Disability Evaluation System." AD Service members with laboratory evidence of HIV infection determined to be fit for duty are allowed to serve in a manner that ensures access to appropriate medical care.

A RC Service member with laboratory evidence of HIV infection is referred for a medical evaluation of fitness for continued service in accordance with Service regulations, and in the same manner as an RC Service member with other chronic or progressive illnesses. Eligibility for AD for a period of more than 30 days is denied to those RC Service members with laboratory evidence of HIV infection (except under conditions of mobilization and on the decision of the Secretary of the Military Department concerned). RC Service members, either who are not on AD for a period of more than 30 days or who are not on full-time National Guard duty, and who show laboratory evidence of HIV infection, are transferred involuntarily to the Standby Reserve only if they cannot be used in the Selected Reserve.

In accordance with DoDI 6485.01, the privacy of a Service member with laboratory evidence of HIV infection is protected consistent with DoD 5400.11-R, "Department of Defense Privacy Program" and DoD 6025.18-R, "DoD Health Information Privacy Regulation."

A Service member infected with HIV but able to fully perform their duties is not retired or separated solely based on being infected. However, Service members, including those infected with HIV, whose condition deteriorates or otherwise interferes with their ability to perform their military occupation successfully, may be referred to the DES. The DES provides for the member to have a fair and full review to determine fitness for duty. The following DoD issuances establish policy for determining fitness for duty, and for retiring or separating Service members due to physical disability: Department of Defense Manual (DoDM) 1332.18, Vol 1, "Disability Evaluation System (DES) Manual: General Information and Legacy DES (LDES) Time Standards;" DoDM 1332.18, Vol 2, "Disability Evaluation System (DES) Manual: Integrated Disability Evaluation System (IDES);" and DoDM 1332.18, Vol 3, "Disability Evaluation System (DES) Manual: Quality Assurance Program (QAP)."

A medical evaluation is the first step in the disability evaluation process. A Medical Evaluation Board (MEB) documents a Service member's medical conditions and full clinical information. A summary of clinical information includes a medical history; appropriate physical examination; indicated medical tests and their results; medical and surgical consultations as necessary; diagnoses; ongoing or recommended treatment; and prognosis. The medical evaluation documents the medical status and duty limitations of Service members (subject to Service departmental regulations).

If the Service member cannot perform the duties of her or his military occupational specialty (MOS), the MEB refers the case to the DES. Criteria for referral of Service members into the DES include:

- Having one or more medical conditions that may, individually or collectively, prevent the Service member from reasonably performing the duties of his or her office, grade, rank, or rating, including those duties remaining on a Reserve obligation for more than one year after diagnosis;

- Having a medical condition that represents an obvious medical risk to the health of the member or to the health or safety of other members; or

- Having a medical condition that imposes unreasonable requirements on the military to maintain or protect the Service member.

A Service member is considered unfit when the evidence establishes that the member, due to physical disability, is unable to perform the duties of her or his office, grade, rank, or rating reasonably, to include duties during a remaining period of Reserve obligation. AD and RC Service members with laboratory evidence of HIV infection who, because of their disease progression, are determined to be unfit for further duty are medically separated or retired pursuant to DoDI 1332.18.

Service retention and discharge policies comply with the retention and discharge DoD policies described above.

Retention/Discharge - Army:
AR 600-110 stipulates that individuals confirmed to be HIV infected will be treated with dignity and understanding. Guidance for dealing with the psychosocial aspects of the disease may be obtained from command medical authorities and chaplains. Every effort will be made to ensure that, except for their assignment limitations, HIV infected personnel are treated no differently than other Soldiers. Commanders must ensure that information about the HIV infected Soldier's medical condition is provided only to those whose duties require knowledge of that information.

In AR 600-110, there is no medical reason for HIV-infected Soldiers' duties to change solely because of their infection (except in certain instances for health care providers). In instances where a Soldier performs duties as a member of a flight crew, or other position requiring a high degree of alertness or stability (for example, explosive ordnance disposal), a case-by-case determination is made by a MEB as to the Soldier's fitness to perform his or her duties. In the case of HIV-infected health care providers, their duties may be restricted if they present a risk of transmitting HIV to their patients. An expert medical review committee designated by the deputy commander for clinical services makes this determination. This committee makes recommendations on a case-by-case basis to the Medical and Dental Activity/United States Army Medical Center (MEDCEN)/Dental Activity commander per AR 40–68, "Clinical Quality Management," regarding the restriction of duties of HIV infected health care providers. The restriction may only apply until the risk is eliminated. In all other instances, HIV infected

Soldiers are utilized in their primary MOS, per normal utilization criteria contained in Army personnel regulations and the assignment limitations specified in AR 600-110.

Infectious disease specialists medically evaluate HIV-infected Soldiers at a participating MEDCEN supporting the health service region to determine their infection status. HIV infected Soldiers who meet medical retention standards outlined in AR 40-501, and who do not demonstrate progressive clinical illness or immunological deficiency during periodic evaluations (every six months or as directed), are not involuntarily separated solely based on HIV status.

HIV-infected RC Soldiers who wish to continue to serve in the RC must prove fitness for duty per medical retention standards of AR 40–501 and be found fit for duty. RC Soldiers are required to obtain the fit for duty medical examination from the civilian medical community at no expense to the Government. The required medical procedures are provided to the Soldier to give to his or her physician. This examination must be repeated at least annually after the initial evaluation. Medical follow-up and evaluation are conducted every six months and as directed by the infectious disease physician for all HIV infected Soldiers.

Except for those identified during the accession testing program, HIV infected AD Soldiers able to perform duties fully who do not demonstrate progressive clinical illness or immunological deficiency during periodic evaluations are not involuntarily separated solely because they are HIV infected. HIV infected Soldiers who demonstrate rapidly progressive clinical illness or immunological deficiency may not meet medical retention standards under AR 40–501, and are evaluated for physical disability processing under AR 635–40, "Disability Evaluation for Retention, Retirement, or Separation." AR 600-110 specifies procedures for officers (paragraph 6-13) and for enlisted personnel (paragraph 6-14). In accordance with AR 40-501, HIV-infected Soldiers who demonstrate progressive clinical illness or immunological deficiency are referred to a MEB. For Active Army Soldiers and RC Soldiers on AD for more than 30 days (except for training under 10 U.S.C. § 10148), a MEB must be accomplished and, if appropriate, the Soldier must be referred to a Physical Evaluation Board (PEB) under AR 635–40. For RC Soldiers not on AD for more than 30 days or on AD for training under 10 U.S.C. § 10148, referral to a PEB will be determined under AR 635–40. Records of official medical diagnoses provided by civilian medical providers concerning the presence of progressive clinical illness or immunological deficiency in RC Soldiers may be used as a basis for administrative action under, for example, AR 135–133, "Ready Reserve Screening, Qualification Records System, and Change of Address Reporting," AR 135–175, "Separation of Officers," AR 135–178, "Enlisted Administrative Separations," or AR 140–10, "Assignments, Attachments, Details, and Transfers," as appropriate. Additionally:

- Soldiers identified as HIV infected within 180 days of initial entry on AD are separated under the provisions of AR 635–200 for failure to meet accession medical fitness standards.

- HIV infected Army National Guard (ARNG) Soldiers who demonstrate progressive clinical illness or immunological deficiency, as determined by medical authorities, and who do not meet medical retention standards are processed under AR 40–501 and

National Guard Regulation (NGR) 600–200, "Enlisted Personnel Management," or NGR 635–101, "Efficiency and Physical Fitness Boards," as appropriate.

- HIV infected United States Army Reserve Soldiers who demonstrate progressive clinical illness or immunological deficiency, as determined by medical authorities, and who do not meet medical retention standards under AR 40–501 are processed in accordance with AR 135–178 (enlisted) or AR 135–175 (officer).

The Army National Guard implements guidance as prescribed by the AR 600-110 and AR 40-501 with regard to HIV positive personnel. AR 600-110 is administered by the G1 (Army Personnel) section; however, Army National Guard – Office of the Chief Surgeon (ARNG-CSG) has oversight with regard to monitoring the implementation of laboratory testing and re-testing of HIV positive Soldiers). HIV positive Soldiers are retained in current MOS/Area of Concentration, as long as medical fitness standards are maintained in accordance with AR 40-501. ARNG-CSG relies highly on the input of Army Directives, the U.S. Army Public Health Center, and the Centers for Disease Control and Prevention (CDC) when considering medical retentions.

Retention/Discharge - Navy and Marine Corps:
If an AC Sailor or Marine tests HIV antibody positive during routine screening, he or she is directed by the Chief, Bureau of Medicine and Surgery to an appropriate medical facility for evaluation and determination of fitness for duty, like all Service members with a chronic medical condition, in accordance with SECNAVINST 1850.4E, "Navy Disability Evaluation Manual," and Chapter 18 of Naval Medical Command (NAVMED) P-117, "Manual of the Medical Department," which pertains to DES. Members with HIV undergo additional evaluation in accordance with DoDI 6485.01. If found fit for full duty (i.e., physically qualified to remain on AD), they are referred, evaluated, treated, and followed by an HETU, and are subsequently retained, deployed, and returned to their unit for duty. Further, they are eligible for reenlistment following normal reenlistment procedures. RC Sailors undergo evaluation by their civilian providers, and are also evaluated for fitness for duty in the same manner as all RC members with a chronic medical condition. Marine Corps Order (MCO) 1300.8, "Marine Corps Personnel Assignment Policy," is in accordance with SECNAVINST 5300.30E regarding the referral for medical evaluation for continued service, appropriate treatment, and determination of fitness for duty.

In SECNAVINST 5300.30E, if a Sailor or Marine is found unfit for continued service, he or she is processed for medical separation through the physical disability system and discharged. Sailors and Marines who have tested HIV positive also have the option to undergo voluntary separation, and are afforded the option of requesting a voluntary discharge under honorable conditions, unless there are other factors involved. Retention or discharge decisions are based on the determination of competent medical authority regarding fitness of service. SECNAVINST 5300.30E is currently under revision.

MCO 1900.16 Chapter 1, "Separation and Retirement Manual," refers to SECNAVINST 5300.30E for voluntary separation of Marines who have tested positive for HIV. In MCO 1001R.1L, "Reserve Administration Manual," Reserve Marines identified as HIV positive and

who, although deemed medically fit for duty, are unable to fill an appropriate billet within the Selected Reserve and are placed in the Standby Reserve-Inactive Status List. Under this status, such Marines are not eligible to participate, receive pay or retirement point credit, are not eligible for promotion consideration, and are not accountable for purposes of end strength or controlled grades.

SECNAVINST 5300.30E and DoDI 6485.01 permit members of the Marine Corps Ready Reserve who are HIV positive to continue to serve within the Marine Corps Reserve, barring any medically assessed unfitting conditions, such as immunologic deficiency, neurological deficiency, progressive clinical or laboratory abnormalities associated with HIV, or diagnosis of Acquired Immune Deficiency Syndrome (AIDS)-defining conditions.

Retention/Discharge - Air Force:
AFI 44-178, "Human Immunodeficiency Virus Program," instructs that "members with laboratory evidence of HIV infection who are able to perform the duties of their office, grade, rank and/or rating, may not be separated solely on the basis of laboratory evidence of HIV infection." AFI 48-123 stipulates that HIV is potentially a cause for denying continued service and requires a retention decision through a MEB or similar review."

AFI 44-178 guides the management of AD Service members with HIV and screening protocol routinely employed by the Air Force. In accordance with AFI 44-178, all AD Airmen with asymptomatic HIV are seen annually at the Air Force HIV Medical Evaluation Unit (MEU) in San Antonio. The MEU completes a narrative summary (NARSUM) for each Airman with HIV infection, which is forwarded to the Air Force Personnel Center (AFPC) for adjudication regarding retention.

In an effort to treat every Airman equitably and with dignity and respect, the Air Force refers Airmen with asymptomatic HIV infection into the DES in the same manner and process as any other Airman with a chronic medical condition. As outlined above, current Air Force policy requires that all Airmen with HIV have a NARSUM reviewed annually by AFPC. AFPC is the only entity that can assign Airmen an Assignment Limitation Code-C (ALC-C), which restricts permanent and temporary duty assignments to areas where appropriate medical care is available to the HIV-positive Service member. The intent of the ALC-C is to protect such members from being placed in environments where adequate medical care is not available. The benefit of assigning an ALC-C is that it ensures visibility at all levels that an Airman will require a waiver for OCONUS assignment or deployment.

3. Deployment
DoDI 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," includes HIV antibody positive diagnosis with the presence of progressive clinical illness or immunological deficiency as a medical condition that usually precludes contingency deployment. In all instances of HIV seropositivity, the policy requires that the cognizant CCMD surgeon be consulted before medical clearance for deployment. The Combatant Commander is the final approval authority for waivers. The medical standards in DoDI 6490.07 are mandatory for contingency deployments, and permissible for any other deployment, based on the commander's decision.

Medical evaluators must consider climate, altitude, rations, housing, duty assignment, and medical services available in theater when deciding whether an individual with a specific medical condition is deployable. DoD personnel with existing medical conditions may deploy based upon a medical assessment, if the following conditions are met:

(1) The condition is not of such a nature or duration that an unexpected worsening or physical trauma is likely to have a grave medical outcome or negative impact on mission execution.

(2) The condition is stable and reasonably anticipated by the pre-deployment medical evaluator not to worsen during the deployment in light of physical, physiological, psychological, and nutritional effects of the duties and location.

(3) Any required, ongoing health care or medications anticipated to be needed for the duration of the deployment are available in theater within the MHS. Medication must have no special handling, storage, or other requirements (e.g., refrigeration, cold chain, or electrical power requirements). Medication must be well tolerated within harsh environmental conditions (e.g., heat or cold stress, sunlight) and should not cause significant side effects in the setting of moderate dehydration.

(4) There is no need for routine evacuation out of theater for continuing diagnostics or other evaluations. (All such evaluations should be accomplished before deployment.)

DoDI 6490.07 sets the minimum standard for all deploying and deployed DoD personnel. Military Department policy guidance, Service-specific readiness needs, or CCMD requirements may involve additional deployment restrictions. Additionally, DoDI 6485.01 instructs compliance with host-nation requirements for screening and related matters for Service members. As outlined below, all Services currently permit HIV positive Service members to deploy for purposes other than combat or a contingency operation, or be assigned for duty in certain overseas locations, subject to receipt of a waiver. In view of this, members with HIV infection may be considered deployable with limitations.

Deployment - Army:
AR 40-501, paragraph 5-14, "Medical fitness standards for deployment and certain geographical areas," states a general rule that "all Soldiers considered medically qualified for continued military status and medically qualified to serve in all or certain areas of the continental United States (CONUS) are medically qualified to serve in similar or corresponding areas outside the continental United States (OCONUS)." However, the policy acknowledges, "because of certain medical conditions, some Soldiers may require administrative consideration when assignment to combat areas or certain geographical areas is contemplated. Such consideration of their medical conditions would ensure these Soldiers are used within their functional capabilities without undue hazard to their health and well-being as well as ensure they do not produce a hazard to the health or well-being of other Soldiers."

AR 40-501, paragraph 5-14, lists medical conditions requiring careful review prior to recommending whether the Soldier can deploy to duty in a combat zone or austere isolated area

where medical treatment may not be readily available. In accordance with AR 40-501, HIV infected Soldiers are not permitted to deploy into the combat theater of operations. Additionally, in accordance with AR 600-110 and AR 614-30, "Overseas Service," Soldiers confirmed to be HIV infected while stationed overseas are reassigned to the United States.

However, if found fit by a PEB, HIV infected Soldiers may be considered for overseas deployment to Europe or Korea (host Nation permitting), in accordance with AR 40-501. HIV infected AD Soldiers, including Active Guard and Reserve, are otherwise limited to duty within the United States (including Alaska, Guam, Hawaii, Puerto Rico, and the U.S. Virgin Islands). In the United States (including Alaska, Hawaii, Guam, Puerto Rico, and the U.S. Virgin Islands), HIV infected Soldiers are not assigned to:

- Any table of organization and equipment or modified table of organization and equipment unit. Installation commanders may reassign any HIV infected Soldier in such units to table of distribution and allowances (TDA) units on their installation, provided the Soldier has completed a normal tour in that unit (a normal tour for these purposes is three years from reporting date to the unit). After completion of a normal tour, reassignment to TDA units may be made, provided assignment can be made according to normal personnel management and assignment criteria in AR 614–100, "Officer Assignment Policies, Details, and Transfers," and AR 614–200, "Enlisted Assignments and Utilization Management." Reassignment must be to an authorized position for the Soldier's grade and primary or secondary MOS. Installation commanders unable to make appropriate reassignments report the names of HIV infected Soldiers to the Commander, Human Resource Command (HRC), Army Human Resource Command (AHRC)–EPD–I (enlisted), or Total Army Personnel Command (TAPC)–OPD–M (officer).

- Military-sponsored educational programs, regardless of length, but which would result in an additional service obligation. These programs include, but are not limited to, advanced civilian schooling, professional residency, fellowships, training with industry, and equivalent educational programs, regardless of whether the training is conducted in civilian or military organizations. HIV infected Soldiers assigned to these programs are disenrolled at the end of the academic term in which HIV infection is confirmed and may be reassigned without regard to Permanent Change of Station restrictions. Any financial support received by the Soldier may be retained through the end of the current term of enrollment and will not be subject to any recoupment. In addition, any additional service obligation incurred as a result of attendance at military sponsored educational programs is waived. Not included in this restriction are military schools required for career progression in a Soldier's MOS, branch, or functional area (such as, Noncommissioned Officer Education System schools, Captains Career Course, or intermediate level education).

- U.S. Army Recruiting Command, Cadet Command, MEPS, ARNG full time recruiting force, or ARNG full time attrition/retention force, if a Soldier's medical condition requires frequent medical follow-up (as determined by medical authorities), and if the Soldier's projected duty station is geographically isolated from an Army military treatment facility capable of providing that follow-up. These organizations report HIV-

infected Soldiers who cannot be assigned under this policy to the Commander, HRC, AHRC–EPD–I (enlisted) or TAPC–OPD–M (officer), for assignment instructions.

AR 600-110 stipulates that commanders may not change the assignment or use of HIV-infected Soldiers solely because of their infection, unless required by that regulation or the Soldier's medical condition. Grouping all HIV infected Soldiers within a command into the same subordinate unit, duty area, or living area is prohibited unless no other unrestricted units, positions, or accommodations are available.

HIV infected Service members may transfer to the Active Army from another Armed Force (inter-Service transfer), if they meet medical retention standards in AR 40–501. However, Service members who are HIV infected may not be transferred to the Army from another Armed Force, if they are required to meet accession medical standards in AR 40–501, except as specifically permitted in the Accession Testing Program, as described in AR 600-110.

Deployment - Navy/Marine Corps:
Deployment determinations for HIV-infected Service members are based on guidance articulated in DoDI 6490.07 and in CCMD Area of Responsibility specific Force Health Protection policies. SECNAVINST 5300.30E permits certain personnel on a case-by-case basis to be considered for OCONUS or large ship platform tours, in consultation with the treating HETU, Navy Bloodborne Infection Management Center, and PERS-82 (Temporary Disability Retirement List] (for Sailors), or the United States Marine Corps M&RA (for Marines). These cases apply to personnel with controlled HIV disease (as manifested by a reconstituted immune system, no viremia, an established history of medical compliance, and a history of professional attitude). This placement requires the receiving command's acceptance. These personnel are not considered for overseas individual augmentee tours, given the austere environments in which they potentially could be placed. This policy is based on the following considerations:

- There is no demonstrated risk of transmission of disease in normal daily activities.
- An investment in training of these members has been made.
- The previous policy of denying deployments has made this subset of personnel less competitive in achieving career milestones or warrior qualifications.

MCO 1300.8 is in accordance with SECNAVINST 5300.30E regarding assignment of HIV infected personnel.

Deployment - Air Force:
AFI 48-123 indicates, "conditions, which may seriously compromise the near-term well-being if an individual were to deploy, are disqualifying for mobility status or deployment duty." In accordance with DoDI 6490.07, AFI 48-123 also indicates, "medical evaluators must consider climate, altitude, rations, housing, duty assignment, and medical services available in theater when deciding whether an individual with a specific medical condition is deployable." However, AFI 48-123 also states, "in general, a member must be able to perform duty in austere environment with no special food, billeting, medical or equipment support for up to 179 days."

DoD has recently issued a new policy, DoDI 1332.45, "Retention Determinations for Non-Deployable Service Members," July 30, 2018, for implementation October 1, 2018. The overarching policy is that to maximize the lethality and readiness of the Joint Force, all Service members are expected to be deployable. Service members who are considered non-deployable for more than 12 consecutive months will be evaluated for a retention determination by their respective Military Department, and, as appropriate, referral into the DES or initiation of processing for administration separation, with the normal policies and procedures, including due process procedures, of those systems continuing to apply. The Military Departments will determine the deployability status of Service members and will make retention determinations for Service members who have been non-deployable for more than 12 consecutive months. They may retain such members if determined to be in the best interest of the Military Service. Under this DoDI, "non-deployable" and "deployable with limitations" are two separate categories; the retention determination process applying to the former but not the latter. The Military Departments have authority to determine the specific dividing line between the two categories most appropriate for the operational circumstances applicable to their respective Services.

4. Disciplinary

In and of itself, being HIV positive is not a punishable offense and cannot be used as a basis for disciplinary action against the individual. DoDI 6485.01 directs that information obtained during or primarily as a result of an epidemiologic assessment interview, (which is defined in DoDI 6485.01 as the "questioning of a Service member who has been confirmed by DoD to have laboratory evidence of HIV infection for purposes of medical treatment or counseling or for epidemiologic or statistical purposes"), cannot be used to support any adverse personnel action against the Service member, in accordance with section 705(c) of Public Law 99-661, "National Defense Authorization Act for Fiscal Year 1987," November 14, 1986. DoDI 6485.01 defines "adverse personnel action" as "a court-martial, non-judicial punishment, involuntary separation for other than medical reasons, administrative or punitive reduction in grade, denial of promotion, an unfavorable entry in a personnel record (other than an accurate entry concerning an action that is not an adverse personnel action), or a bar to reenlistment other than for medical reasons."

DoDI 6485.01 also requires aggressive disease surveillance and implementation of health education programs for Service members. A Service member with laboratory evidence of HIV infection receives training on how to prevent further transmission of HIV infection to others, and the legal consequences of exposing others to HIV infection. In compliance with this policy, the Services provide counseling and training to Service members with HIV infection regarding the prevention of disease transmission to others and the legal consequences of intentional exposure to others, or failure to disclose status to sexual partners or blood donation centers.

However, infected Service members retained on AD who fail to comply with the directives given during preventive medicine counseling are subject to appropriate disciplinary actions for their disregard or disobedience. All Services hold HIV infected members accountable under the Uniform Code of Military Justice if they ignore orders to warn and protect others whose health might be jeopardized by sexual contact or other types of high-risk exposures. Commanders may recommend that personnel who violate such guidance be considered for involuntary discharge or separation.

STATUS UPDATE ON THE DEPARTMENT OF THE ARMY'S HIV POLICY:
Initiated in 2015, a working group has reviewed AR 600-110, last updated in April 2014, to assess any need for changes to reflect an evidence-based, medically accurate understanding of HIV infectivity, transmission, and treatment. This process is expected to be completed in the near future.

MEDICAL ASSESSMENT OF POLICIES:
Currently, no vaccine exists to prevent HIV infection, and no treatment exists to cure it. As such, the Department takes every effort to protect the health and well-being of Service members to minimize the risk of exposure to HIV through regular HIV screening and surveillance efforts. DoDI 6485.01 requires that the Secretaries of the Military Departments report HIV test results to the Defense Medical Surveillance System, pursuant to Department of Defense Directive (DoDD) 6490.02E, "Comprehensive Health Surveillance," and directs health care personnel providing medical care to follow the recommendations issued by the CDC for preventing HIV transmission in health-care settings.

DoD health surveillance policy also requires that medical surveillance systems continuously capture data on occupational and environmental exposures to potential and actual health hazards, and link with medical surveillance data to monitor the health of DoD's population and identify potential risks to health. Thus, this policy enables timely implementation of interventions to prevent, treat, or control disease and injury, and reinforces the provision of optimal medical care.

Impact of Antiretroviral Therapy on Disease Management

Viral suppression and AIDS are two ends of the spectrum of HIV infection. Virally-suppressed HIV infection usually requires an individual to take ART, alternatively referred to as combination Antiretroviral Therapy, regularly and to see an infectious disease specialist annually. ART consists of a combination of antiretroviral (ARV) drugs to suppress the HIV virus to undetectable levels and stop HIV disease progression. AIDS is usually the result of long-term non-adherence with medications and can be associated with impairment and disability (e.g., opportunistic infections, cancer, weakness).

There is broad consensus on evidence published in the medical literature to support the notion that people living with HIV on ART with an undetectable viral load in their blood have a "negligible risk" of sexually transmitting HIV. Depending on the ART drugs used, it may take as long as six months for the viral load to become undetectable. "Continued and reliable HIV suppression requires selection of appropriate agents and excellent adherence to treatment. HIV viral suppression should be monitored to assure both personal health and public health benefits."[1]

However, it is important to emphasize that despite undetectable viral loads, HIV transmission still can occur. According to the U.S. Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis, "exposure to a source patient with an undetectable serum viral load does not eliminate the possibility of HIV transmission or the need for (post-exposure prophylaxis) PEP and follow-up testing. While the risk of transmission from an occupational exposure to a source patient with an undetectable serum viral load is thought to be very low, PEP

should still be offered. Plasma viral load (e.g., HIV RNA [ribonucleic acid]) reflects only the level of cell-free virus in the peripheral blood; persistence of HIV in latently infected cells, despite patient treatment with ARV drugs, has been demonstrated, and such cells might transmit infection even in the absence of viremia. HIV transmission from exposure to a source person who had an undetectable viral load has been described in cases of sexual and mother-to-child transmissions."[2] It is also important to underscore that an "undetectable" viral load that confers a "negligible risk" of HIV transmission has no application in the setting of blood transfusion or needlestick (occupational) exposures.

Thus, with the advent of ART, HIV infection has evolved from a once terminal condition to a chronic illness requiring regular management and strict adherence to treatment protocol. As a result, the Department's policies have evolved over time. They currently focus not only on minimizing risks of HIV exposure for HIV-naïve individuals, but also on providing evidence-based care and support for Service members living with HIV, with the goal to retain and maintain a Service member's fitness for duty, optimize quality of life, as well as avoid any disability that might arise as a result of HIV infectivity.

Recent Findings Signifying Impairments Despite Viral Suppression and Asymptomatic HIV: Potential Impact on Future Policy

Despite virological suppression, long-term treated patients may experience memory difficulties, mental slowing, attention deficits, and other neurological impairment symptoms. Moreover, neurocognitive damage can occur without HIV-infected individuals experiencing related symptoms or interference in their daily functioning. The impact of HIV-associated neurocognitive disorder and asymptomatic NCI on fitness for duty, including resilience and readiness, is currently unknown.

According to a Department of Defense Infectious Disease Clinical Research Program cross-sectional study of 200 HIV-infected and 50 HIV-uninfected military beneficiaries including AD members, retirees, or dependents, HIV positive patients diagnosed and managed early during the course of HIV infection had a low prevalence of NCI. This is comparable to matched HIV-uninfected persons.[3] Based on these data, the early recognition and management of HIV infection may be important in limiting NCI.

Yet effective ART resulting in viral suppression and asymptomatic infection does not imply absence of HIV-associated injury or impairment. Some HIV-infected, virally suppressed patients on ART will develop illnesses associated with premature aging (e.g., cardiovascular disease, osteoporosis). As the HIV-positive population ages, there is greater recognition that cerebrovascular disease risk factors such as hypertension, diabetes, and hypercholesterolemia are becoming risk factors for cognitive impairment in HIV-positive patients on ART.[4]

Common neurocognitive symptoms experienced by HIV-infected patients potentially include changes in memory, concentration, attention, and motor skills, may present challenges for accurate diagnoses and assessments of functional capacity, and often require prolonged observation or reporting.[5,6] Some patients may experience a fluctuating course of NCI over time, including symptom normalization; however, it is unknown whether these changes reflect

biologic alterations induced by responses to (or failures) of ART, or occur independently of viral load and changes to ART regimens.[7] Despite effective systemic viral suppression among HIV-positive individuals on ART, scientific studies have indicated that a small subset of individuals show neurocognitive deterioration with evidence of persistent laboratory and neuroimaging abnormalities in the central nervous system.[8] A longitudinal cohort observation study found that numerous patients with asymptomatic NCI, even with a suppressed plasma viral load, eventually developed symptomatic NCI.[9] The impact of these potential NCIs on a Service member's readiness, resilience, and/or retention is currently unknown.

As the HIV-positive population on ART ages, there is greater recognition that cerebrovascular disease risk factors such as hypertension, diabetes, and hypercholesterolemia may become risk factors for cognitive impairment.[10] The future impact of HIV as a chronic disease on readiness, resiliency, and retention, as well as treatment and management approaches, are a part of ongoing DoD health surveillance efforts.

As stipulated in DoDD 6490.02E, DoD requires comprehensive, continuous and consistent health surveillance to enable continuous capture of individual and population data, including health status, occupational exposures, disease, and medical interventions (such as immunizations, treatments and medications), in order to implement early intervention and disease control strategies and reinforce provision of optimal medical care. As such, the policy enables DoD to be well-positioned to update policies and practices to appropriately identify and manage HIV infection among Service members as the HIV-positive population on ART ages.

Military-Unique Considerations

According to the Military Infectious Diseases Research Program (MIDRP), HIV "remains a significant threat to Service members deployed overseas, and is a major source of regional instability in areas of US force protection."[11] Additionally, the MIDRP also recognized that infectious diseases can also impose "a significant burden on the medical logistical system for people requiring treatment" and "loss of personnel to infectious diseases reduces operational readiness and effectiveness by requiring replacement troops." Therefore, the MIDRP indicates, preventing disease is "a force multiplier by keeping people healthy and by enhancing readiness," and DoD must protect its forces from diseases that may compromise its ability to complete missions and to prevent troops from acquiring illnesses. As such, preventing disease through limiting risk of exposure to infectious disease is a key component to enhance military readiness and effectiveness.

It is important to note that DoD HIV screening policy is population-based, and accounts for unique operational military requirements. For example, protecting the safety of the U.S. military blood supply or health of potential donors and recipients (i.e., Service members) is of critical importance to DoD and therefore a central issue. Combat-related injuries, especially during mass casualty situations, require large supplies of blood for transfusions. The need for screening the blood supply is therefore critical. In certain cases, "battlefield transfusions" may be required to resuscitate casualties in life-threatening situations when the inventory of U.S. Food and Drug Administration (FDA)-compliant blood products is depleted in combat zones due to austere operating conditions and irregular resupply. In these cases, the U.S. Army Institute of Surgical

Research Joint Trauma System Clinical Practice Guideline on Fresh Whole Blood indicates that Service members may receive an emergency transfusion of fresh whole blood in life-saving or limb-sparing situations.[12] This Joint Trauma System Clinical Practice Guideline also indicates that even though fresh whole blood undergoes rapid testing for HIV to the greatest extent possible prior to transfusion, the potential risk for HIV transmission remains in battlefield circumstances. HIV infection is among a number of medical conditions that preclude blood donation. Early CDC data demonstrate that the highest risk of transmission of HIV infection is via blood transfusion (92.50 percent transmission rate, or 9250/10000 exposures).[13] Even though this data included cases involving transmission of very high viral loads as well as lower levels of viremia, it is conceivable that a unit of whole blood (as utilized used in a "walking blood bank" scenario) would pose a very high risk of transmission of HIV infection, even if from an HIV-infected Service member with an undetectable viral load.[14] To the extent possible, DoD adheres to FDA blood-borne pathogen screening guidelines requiring all donated blood products be tested for HIV types I and II.[15] DoD ensures the safety of the blood supply through policies of the Armed Services Blood Program Office and the accreditation requirements of the American Association of Blood Banks. However, in emergency battlefield circumstances it is impossible to eliminate all risk of communicability through blood transfusion.

Service Policies

Service policies accurately reflect current medical literature and expert opinion (consensus standards) regarding transmission and treatment of HIV. The U.S. Air Force (USAF) management of Airmen with HIV is highly structured and achieves viral load suppression in over 90 percent of patients. AFI 44-178 is the underpinning of the USAF's HIV management success. AR 600-110, "Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus," and Headquarters, Department of the Army medical and personnel policies on HIV reflect current knowledge of the natural progression of HIV infection; the risks to the infected individual incident to military service; the risk of transmission of the disease to non-infected personnel; the overall impact of infected personnel in Army units and on readiness posture; and the safety of military blood supplies. The Assistant Secretary of the Navy (M&RA) established SECNAVINST 5300.30E to reflect current knowledge of the natural history of HIV; the risks to the infected individual incident to military service; the risk of transmission of HIV to non-infected personnel; the effect of infected personnel on commands; and the safety of military blood supplies. The Services are currently reviewing and updating several policies, to include SECNAVINST 5300.30E, AFI 44-178, AR 600-110, to reflect changes as medical capabilities, technologies, and evidence-based practices have evolved.

Medical literature pertaining to HIV medicine rapidly evolves. MHS subject matter experts are aware of and have access to all available contemporary medical literature, practice guidelines, medications, and treatment modalities based on emerging and published evidence-based studies or expert opinion, referenced in, but not limited to the following:

- "National HIV/AIDS Strategy for the United States." U.S. Department of Health & Human Services. Available at: https://www.hiv.gov.

- Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV. Department of Health

and Human Services. Available at: http://aidsinfo.nih.gov/contentfiles/lvguidelines/AdultandAdolescentGL.pdf.

- Primary Care Guidelines for the Management of Persons Infected with HIV, issued by expert panel of the HIV Medicine Association of the Infectious Diseases Society of America. Update issued in: Aberg JA, Gallant JE, Ghanem KG, et al. Primary care guidelines for the management of persons infected with HIV: 2013 update by the HIV medicine association of the Infectious Diseases Society of America. Clin Infect Dis. 2014;58(1):e1-34. Available at: https://www.ncbi.nlm.nih.gov/pubmed/24235263/.

- CDC. "Integrated prevention services for HIV infection, viral hepatitis, sexually transmitted diseases, and tuberculosis for persons who use drugs illicitly: summary guidance from CDC and the U.S. Department of Health and Human Services." MMWR Recomm Rep. 2012;61(RR-5):1-40. Available at: https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6105a1.htm.

FEASIBILITY OF ALLOWING ENLISTED MEMBERS TO BECOME COMMISSIONED OFFICERS OF THE ARMED FORCES AND RESTRICTIONS DIFFERENT FOR OFFICERS:

DoD policy has long maintained a difference between accession medical standards and retention medical standards. The rationale for the difference is that once a member has been fully trained to perform, and has experience in performing the duties of his or her position, whether as an enlisted member or officer, the needs of the Service incline decidedly toward allowing the member to continue to perform those duties and return the investment the Service has made in the member. At the accession stage, the needs of the Service incline toward selecting members in whom to make the training and mentoring investment, who minimize any risk of inability due to medical conditions to complete an initial period of service and potentially a longer military commitment. Longstanding DoD policy under DoDI 6130.03 has also held that in the case of an enlisted member seeking appointment as a commissioned officer, the accession standards are the appropriate ones to apply because it is a new position, involving a whole new set of duties and responsibilities and new training and mentorship. The needs of the Service do not necessarily favor an officer applicant with prior enlisted service, compared to one without such service, when it comes to minimizing any risk of inability due to medical conditions to perform satisfactorily in the commissioned officer position. However, it is appropriate to note that a review of two individual officer candidates, one with and one without prior enlisted service, requesting a medical waiver for the same condition, the candidate with prior service may well have the advantage of a record of successful military service in the enlisted ranks. However, regarding which set of standards to apply to the initial medical screening, the accession medical standards are the more appropriate standards for all applicants, including applicants for enlistment or commissioning. This is long-established DoD policy for all medical conditions; there is no special or different rule for individuals with HIV infection.

DISCUSSION:

The Department has a responsibility to ensure the health and well-being of Service members, and through its policies, aims to minimize the risk of Service members' exposure to HIV, while ensuring that those infected with HIV have access to appropriate care and management of their illness and are able to continue service. Military unique considerations; the rapidly evolving

nature of medical evidence and understanding pertaining to the nature of HIV transmission, infectivity, associated risks, and treatment; evolving mission requirements; and Service member needs pertaining to health information privacy protections, as well as opportunities for career advancement, are key factors that influence personnel policy pertaining to HIV-infected members of the Armed Forces.

Current DoD- and Service-level personnel policies pertaining to HIV-infected members of the Armed Forces:

- Are established to maintain military readiness and optimize lethality of the Armed Forces.
- Are instituted to ensure military applicants can successfully complete rigorous military training and deploy to austere environments to accomplish the demanding missions of the military, without jeopardizing their health, the health of their unit, or the military mission, as well as to respect host Nation laws where our forces are deployed.
- Support retention of Service members infected with HIV, unless there is evidence of deteriorating health or other factors that render the individuals unable or unfit to perform their duties.
- Require the same procedures for medically evaluating Service members who develop disability due to chronic illness to determine fitness for continued service, regardless of whether the Service member is HIV-positive.
- Aim to ensure that, except for assignment limitations, HIV-infected personnel are treated no differently than other Service members.
- Ensure that a Service member infected with HIV is not retired or involuntarily separated solely based on being infected.
- Recognize that in the unique circumstances of military combat operations, there remain significant risks that individuals with even well-controlled HIV infection may suffer adverse health effects and create additional mission risks for the military command.
- Direct the protection of health information and privacy of HIV-infected personnel.
- Reflect existing evidence and adhere to current nationally accepted, evidence-based guidelines, and assess evolving medical evidence and scientific understanding of the nature and risk of HIV transmission, available treatment regimens, and the latest HIV management approaches and practices.
- Stipulate clinical management to be consistent with standard of care, evidence-based HIV clinical practice standards, and medical management guidelines.

CONCLUSIONS:

DoD personnel policy for HIV-positive Service members is evidence-based, in accordance with state-of-the-art clinical guidelines, reviewed for currency, and updated accordingly as medical capabilities, technologies, and evidence-based practices evolve.

DoD accession policies align with the military's requirements to recruit healthy personnel who are able to complete demanding military training and to deploy to austere environments without exacerbating their health or compromising operational effectiveness and mission accomplishment.

For those who acquire HIV after accession, DoD policy emphasizes retention if the medical condition is stable with appropriate treatment and the Service member is found fit for duty. Service members with laboratory evidence of HIV infection who are able to perform the duties of their office, grade, rank and/or rating, cannot be separated solely based on laboratory evidence of HIV infection. Service members with medical illnesses or conditions that might limit their ability to perform military duties (including HIV infection) may undergo evaluation for either duty limitations or medical discharge.

A waiver is required for HIV-positive Service members to deploy; medical evaluators must consider climate, altitude, rations, housing, duty assignment, and available medical services in theater when deciding whether an individual is deployable. However, current Service policies do not permit HIV-infected Service members to deploy to combat theaters of operation or in support of other contingency operations, given the austere environment, potential exacerbation of illness and lack of access to needed medical care, as well as risk of compromising unit readiness and successful mission completion. Army policy currently allows deployment to Europe and Korea for HIV-infected soldiers found fit by a PEB (host Nation permitting). Navy policy currently permits case-by-case consideration for non-combat OCONUS or large ship platform tours for HIV-infected personnel with controlled HIV disease (as manifested by a reconstituted immune system, no viremia, an established history of medical compliance).

DoD policy prohibits adverse personnel actions based solely on HIV status, assuming ability to perform duties fully. However, as with any direct order, a Service member who violates the order to inform sexual partners of their HIV status or fails to use safe sexual practices, as instructed during face-to-face consultation, may be subject to disciplinary action.

Maintaining the health of military personnel is essential for force readiness. It is a strategic objective of the MHS to sustain the health of Service members, restore the health, and return to duty of Service members who become ill or injured, if possible. Once Service members complete training, the goal is to retain members who acquire HIV who are still capable of performing their duties in the rigorous military environment. Personnel policies aim to balance the need of the Services (e.g., readiness, resilience, deployability, mission accomplishment, retention) with the needs of Service members infected with HIV (access to quality care, counseling, support and educational services, privacy protections, and option to continue service, if desired). Existing personnel policies intend to maximize the lethality, readiness, and operational effectiveness of the Armed Forces, as well as to help ensure the health and well-being of Service members, while mitigating the risk of HIV transmission.

ACRONYMS:	
AD	active duty
AFI	Air Force Instruction
AFPC	Air Force Personnel Center
AHRC	Army Human Resource Command
AIDS	Acquired Immune Deficiency Syndrome
ALC-C	Assignment Limitation Code-C
AMSWG	Accession Medical Standards Working Group
AR	Army Regulation
ARNG	Army National Guard
ARNG-CSG	Army National Guard – Office of the Chief Surgeon
ART	antiretroviral therapy
ARV	antiretroviral
CCMD	Combatant Command
CDC	Centers for Disease Control and Prevention
CONUS	continental United States
DES	Disability Evaluation System
DoD	Department of Defense
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoDM	Department of Defense Manual
FDA	U.S. Food and Drug Administration
FY	Fiscal Year
HETU	HIV Evaluation and Treatment
HIV	human immunodeficiency virus
HRC	Human Resource Command
IDES	Integrated Disability Evaluation System
IMR	individual medical readiness
LDES	Legacy Disability Evaluation System
M&RA	Manpower and Reserve Affairs
MCO	Marine Corps Order

MEB	Medical Evaluation Board
MEDCEN	United States Army Medical Center
MEPS	Military Entrance Processing Stations
MEU	Medical Evaluation Unit
MHS	Military Health System
MIDRP	Military Infectious Diseases Research Program
MOS	military occupational specialty
MQA	medical quality assurance
NARSUM	narrative summary
NAVMED	Naval Medical Command
NCI	neurocognitive impairment
NDAA	National Defense Authorization Act
NGR	National Guard Regulation
OASD(HA)	Office of the Assistant Secretary of Defense for Health Affairs
OCONUS	outside the continental United States
PEB	Physical Evaluation Board
QAP	Quality Assurance Program
RC	Reserve Component
SECNAVINST	Secretary of the Navy Instruction
TAPC	Total Army Personnel Command
TDA	table of distribution and allowances
USAF	U.S. Air Force

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EXHIBIT 3

Excerpts from the March 15, 2019 Deposition of Kevin Cron

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
ALEXANDRIA DIVISION
NO. 1:18-CV-00641-LMB-IDD

NICHOLAS HARRISON and
OUTSERVE-SLDN, INC.,

Plaintiffs,

vs.

JAMES N. MATTIS, in his official capacity as Secretary of Defense; MARK ESPER, in his official capacity as the Secretary of the Army; and the UNITED STATES DEPARTMENT OF DEFENSE,

Defendants.
_____/

201 North Franklin Street
Tampa, Florida
9:00 a.m. to 3:41 p.m.
March 15, 2019

VIDEO-RECORDED DEPOSITION OF KEVIN CRON

Taken on behalf of the PLAINTIFFS before Kim Auslander, RPR, CRR, Notary Public in and for the State of Florida at Large, pursuant to Notice of Taking Deposition in the above cause.

coming ashore. Their float operations are managed separately.

Then the Marines, they just -- they have fewer, but they have a much smaller force footprint within the AOR.

Q Is it safe to say that the total number of waiver applications for deployments to CENTCOM since June of 2015 is over 30,000?

A I believe so, but I cannot -- I cannot commit to that, but I believe that's true.

Q Okay. And do I understand from your testimony earlier this morning that in no case has a waiver been granted to allow an HIV positive service member to deploy?

A That's correct; to the CENTCOM AOR.

Q I'm sorry?

A I'm sorry. To the CENTCOM area of operations.

Q Tell me, what type of waiver applications come to you, as opposed to one of the service waiver application officers?

MR. NORWAY: Objection. Asked and answered. You may answer.

THE WITNESS: The -- we officially, we handle behavioral health waivers, which are generally reviewed by the service components first in order

Additionally, for very complicated medical conditions, once again, those 100-page files we get, a lot of times you will end up with a very equivocal case, and you will need more information, so you just say no, rather than, if you request more information, that's more information, and you will go back and forth. Meanwhile, that file is still sitting there unanswered, and then the -- it can take a long time to finalize that process. So, we will just say no; here's what we want, send it back in when it's complete, and we will move on to the next.

And those appeals usually come to us as well when the case is complete, so it's a mixture of updates, and I disagree with your decision, I would like somebody else to render a decision, please.

Q And is there any appeal from your decision if someone wants to take one?

A So, within the CENTCOM surgeon's office itself, this is not in our written policy, but it's just kind of our unspoken policy.

I recognize my limitations as a single provider. If somebody were to appeal a case from the service component to us and I issue a decision based on what I find out in my own experience, and they say, we still disagree with that, then it goes directly to the

CENTCOM surgeon, who is the senior ranking medical officer in the headquarters, and I will staff it with him and basically be; here's the situation, here's what the service component said, here's what I said.

He is the Combat and Commander's direct representative; we all operate under his authority, so he may turn around and say, well, I disagree, let's do this instead. It is his prerogative. That's an informal process.

Because, honestly, if it was that equivocal a case to begin with, I would have already talked with him about it --

Q Okay. And --

A -- and after that, if it goes past that level, then you can appeal to our chief of staff, who is a two star general, and basically at that point, once you reach that level, you've basically -- what you are saying at that point is the senior medical officer of the Combat and Command is going to what is functionally the executive officer of the Combat and Command and saying, we have a gentleman or a lady who wishes to go here to do this, the component doesn't think it's a good idea -- and when I say "component," they are usually talking to the people who are actually in the theater who would be taking care of them, so they are speaking

on behalf of the deployed force -- so they're saying the forces don't think it is a good idea, the medical officers here at CENTCOM don't think it is a good idea, however, is there some reason we should take this guy in anyway.

And, so, you're basically saying, there is an operational imperative to have this individual that supersedes the risk that they represent, and where -- and of course we all work under the Combat and Commander's authority, and the chief of staff is literally one step below the commander.

He could say, in his capacity; I see what you guys are saying, I agree with everything you are saying, we need this guy there, take him anyway, make it as safe as you can. We have done that --

Q Okay.

A -- and if he issues that order, we will comply, which comes back around to that our original HIV statement, where could they deploy; yes.

If General Votel came to me or General Perilla, and said, Doc, I understand your concerns, we need this guy to go in, make it as safe as you can, we will comply. We consider that a lawful order. We will execute it to the best of our abilities. We will do what we can to mitigate the risk we have identified.

Barring that, however, then we -- it's very rare that they will go out on a limb like that. In my time at CENTCOM, it's happened only once.

Q Only one time that the chief of staff has overruled the medical officers; is that right?

A Correct.

Q And am I correct that the Combat and Commander surgeon is a physician?

A He is. It is a nominative position, so basically each service nominates a candidate to serve in that role; not just in our Combat and Command, but at the other geographic Combat and Commands.

Then the command team of the Combat and Command will go through the files and select the one that they wish, or pick somebody else at their discretion. It's not a position to which you are accidentally placed. It is not a position where you just happen to be the guy available. You have to be very well qualified to serve in that capacity.

Q Okay. And the chief of staff, though, is not a medically trained person?

A No. Our chief of staff is a combat arms general, different backgrounds. These are two star generals at our Combat and Command. I believe they are at the others as well.

of the 100 waivers I have seen this week, so I'm just going to disapprove the other 50 percent --

Q Which is not what I'm suggesting. I am suggesting, historically, of the 15,000 that you have reviewed, what percentage have you granted?

A Seems like probably about 70 to 80 percent, but within that are a lot of those waivers which I just alluded to where there are technicalities, or there are things -- for instance, we require waivers for all controlled substances, because we identified at the outbreak of the opioid crisis that we also had an opioid issue, and while we were at it, we would have to have the other controlled substance categories, because our pharmacist theater were identifying that we were using an awful lot of, particularly stimulants; the Adderall, Vivant, that type of medication.

We wanted to have a mechanism to look closely at those meds and make sure they were being used appropriately so we required a waiver for all of them.

Most of those waivers are granted, because most of the healthcare providers are prescribing them appropriately, so it kind of pulls that percentage of approved over to the right a little bit.

Other conditions are very -- for instance, epilepsy we have a fairly low approval rate on because

MR. NORWAY: Objection, scope. You may answer.

THE WITNESS: So, we have two -- this embodies two separate approaches.

The first approach -- once again, this entire appendix is a listing of conditions which generally preclude deployment, so it basically identifies a diagnosis of HIV. HIV antibody positive would indicate a positive HIV test.

You could just as easily say an HIV positive individual with the presence of progressive clinical illness or immunologic deficiency should be considered to be generally non-deployable to any contingency deployment, would be my interpretation of that.

This would deliberately exclude, as I said, those individuals with a positive HIV test who were determined on subsequent testing to not have HIV positive antibodies, so, a key distinction.

So, basically, an HIV positive individual with clinical illness or immunologic deficiency should not deploy on a contingency deployment.

The second --

BY MS. BAUER:

Q Let me stop you there.

original intent of the waiver or not.

Q Of the approximately 15,000 waiver applications that you have reviewed, what number of those have been for HIV positive?

MR. NORWAY: Objection, vague. You may answer. Objection, scope, to the extent that you're asking as a representative DoD. You may answer.

THE WITNESS: So, for CENTCOM, very few. Perhaps ten -- eight to ten. Most of those are actually not for service members.

The services themselves have policies about deploying with HIV that usually remove consideration even for a waiver before they prepare to deploy, so most of our HIV waivers have been for contractors and civilians.

BY MS. BAUER:

Q The ones that you've reviewed?

A Yes, ma'am, the ones I have reviewed.

Q For the service-specific waiver authorities, do you know how many HIV positive waiver applications they've reviewed?

A I honestly don't know. We asked them. We requested to know if any had been approved, and they said none had been approved. Unfortunately, I didn't

have active tuberculosis, we have not approved a waiver for that.

Q If they have active tuberculosis?

A If they have current or recent active tuberculosis. It's poor wording on our part.

Q Is an inability to donate blood in itself disqualifying for deployment to CENTCOM?

A Potentially.

Q What do you mean by "potentially?"

MR. NORWAY: Vague. You may answer.

THE WITNESS: As a global requirement, no. If you said, if they can go anywhere, do any job, in any place, for any time, it's fine, because there's going to be exceptions. If they are on a small team operating in a remote location, then yes, it would be.

There are -- we have operations where the ability to serve as a blood donor is a requirement to go on that mission.

BY MS. BAUER:

Q So, would it depend on what they're being deployed for, essentially?

A It would. It would be heavily dependent not only on their occupation, but also the operational environment to which they are going, what we anticipate

as the level of risk associated with that, and then what else they have around them, who else they have around them, the parent nation, do they have a blood capability we can rely upon.

Once again, outside of our AOR -- this is a crucial discussion in Africa, where the host nation blood capability is extremely unreliable, and the walking blood bank becomes a vital component of your health support plan.

So, potentially. It could be a potential discriminator. For those individuals for which it is a requirement, we would not grant a waiver, though, in fairness, that's not going to be the answer for everyone going to our entire AOR.

Q And what about individuals who have a chronic medical condition that requires them to take medication, if the daily medication is not itself disqualifying for deployment to CENTCOM?

A What is the question?

Q Sure. Whether an individual who requires daily medication to manage a chronic medical condition.

A Is --

MR. NORWAY: Objection, vague. You can answer.

THE WITNESS: So, are you asking if that

We often turn down chemotherapy patients for this reason, where their oncologist has said, as long as they stay on their regiment they will be just fine and their tumor will stay under control. It is the "as long as" statement which we have to draw concern about.

So, if the therapy is required, if the underlying condition is severe, it all has to go into the risk that that condition represents, either in a controlled or an uncontrolled state. It's very individualized.

So, we don't require a waiver for it, per se, because if I did, I would literally get everybody who's on any medication for anything. Our waivers would go from thousands to hundreds of thousands. It's challenging to find an individual these days who's not on some kind of medication for something, so that standard would be too difficult for us to write out and to enforce.

Q Directing your attention to the first page of Cron Deposition Exhibit 7, which is Tab A to Mod 13, I am at paragraph 1D. It starts on the first page.

A Sorry.

Q That's okay. I'm jumping around.

A Go ahead, please.

Q Paragraph D says:

Q And was Captain Via in agreement that a waiver should not be granted for the HIV positive service member that you were discussing with him?

A He was.

Q Continuing on with that paragraph, it reads:

"It's highly unlikely that either Service Member Rowe or Vo would be granted a waiver to deploy to the CENTCOM AOR."

Do you see that?

A Yes.

Q And when you executed this declaration on January 25 of 2019, what did you know about Service Member Rowe?

A I knew that they were presented to me as an HIV positive individual with no mitigating circumstances or features.

Q What do you mean by "no mitigating circumstances or features?"

A Once again, HIV, to us, is a disqualifying diagnosis. In order to approve a waiver for deployment, we have to demonstrate that there is adequate mitigation to offset whatever risk the condition represents. The default answer is no.

So, we were presented with an individual who was HIV positive with no additional circumstances or

information which we could use to mitigate that risk, so the answer was likely no. The reason that we equivolate on it is because it's certainly -- you could certainly come back and say, well, could information be provided, and information could be provided. I have no idea what that information would be. We would have to consider such information when and if it surfaced, and we could factor it into the conversation.

Q Okay. That was the information that you knew was the same for both Rowe and Vo; is that right?

A I believe so. I cannot distinguish between the two from memory.

Q And you didn't review their medical records, for example?

MR. NORWAY: It is a yes or no answer. It doesn't call for the disclosure of any attorney-client communications. You may answer yes or no.

THE WITNESS: I did not.

BY MS. BAUER:

Q Did you review the administrative record of their --

A I did not.

Q Do you know what jobs Rowe or Vo were currently serving in in the military?

A If I did, I don't recall.
Q Paragraph 12, you wrote:
"There are features of HIV which make it difficult to compare to other conditions."
Tell me what features you are referring to there.
A The features are listed further on in the paragraph.
Q Okay.
A Their medications are highly specialized and to the extent of often being individualized. They have to have a constant diligent compliance with therapy. This is a compliance which is absolutely rigid. It cannot waver. It has to be rigidly adhered to for the virus to remain adequately controlled.
One of the unique features of HIV is its ability to rapidly adapt to subtherapeutic levels of medication; so if an individual is not rigidly adherent to their regiment, not only will the virus return, it will likely become resistent to the entire class of medications with which it is being treated, and this is additionally compounded by subsequent resistence that's acquired on multiple -- if you were to try multiple regiments, it would continue to adapt and to adjust.
So, you asked earlier about daily medications

THE WITNESS: Simply its nature as a potentially infectious blood-borne agent similar to the other potentially infectious blood-borne agents.

BY MS. BAUER:

Q What about tattoo; does a service member with tattoos require a waiver to deploy to CENTCOM?

A Not for medical reasons. There are service policies governing tattoos as an administrative feature.

Q What do those policies provide?

MR. NORWAY: Objection, scope.

THE WITNESS: I am not up-to-date with them. However, they are geared around the proper military bearing. Usually tattoos that extend beyond the wrist or the neck such that they are visible when the traditional service uniform is worn, these are not health-related policies; they are geared towards appearance and military bearing.

BY MS. BAUER:

Q Okay. What about service members who have taken human growth hormone; do they require a waiver to deploy to CENTCOM?

A I would say yes. Those would be in the class of -- if you look at Tab A on the medications, we name androgens and anabolic steroids as one of our controlled

actual uniform services to ask for their input to make sure that we are basically more or less reaching a consensus.

Q Is there an average length of a deployment for a service member to CENTCOM?

MR. NORWAY: Objection, vague. You can answer.

THE WITNESS: So, the -- there is, but it's just that; it's a genuine average, in that there are those that go longer, there are those that go shorter, and the answer depends greatly on where in the AOR you want to go, and what operation you are supporting.

Typically, the answer would be nine months to a year, is the generic one size fits all answer. All that said, we do see a number of six-month deployments to certain locations, and we still see 15-month deployments.

BY MS. BAUER:

Q And is that true across services, or does the length of a deployment vary by the service?

MR. NORWAY: Objection, scope. You may answer.

THE WITNESS: It does vary by service; having more to do with operational factors than a genuine,

this is just how we do it mentality. It has to do with how rapidly we can push a force out.

There is significant disruption when we turn forces over in theater, so once we get a force successfully inserted and up and running, we like to leave them there as long as practical.

Additionally, while one unit is deployed, another unit is resting and refitting, so if you try to turn too quickly, you end up burning the candle at both ends, so to speak.

This is all operational and planning consideration. It's -- really, medical follows the rest of the force, so if the combat arms forces are moving in and out, the medical forces are moving in and out with them.

So to an extent, we don't really on the medical side have a say in that, although we will sometimes have to factor in the length of deployment, especially with surgeons with highly specialized medical personnel, as far as staffing those billets and providing those personnel to those capabilities.

BY MS. BAUER:

Q And the service members deployed to CENTCOM, do they get leave days during their deployment?

MR. NORWAY: Objection, scope. You may answer.

THE WITNESS: It's according to higher policy. Typically we like to give what we call R and R, rest and relaxation.

There are provisions; I am not familiar with the modern iterations of those provisions, and even then, it is an as allowing provision; if circumstances allow, you are supposed to do it.

If you are in sustained kinetic operations, then we're not going to cut somebody loose so they can go on leave. It's going to be -- it's really going to be up to the local commanders and more of a battlefield issue.

BY MS. BAUER:

Q And, as I understand, when a service member deploys to CENTCOM and is required to take a daily medication, they are told to take a 180-day supply with them on the deployment?

A With the exception of the controlled substances, yes.

Q And do they get one big bottle of the 180 days worth of medication or two bottles with 90 days?

MR. NORWAY: Objection, form. You may answer.

THE WITNESS: It depends on the filling

pharmacy. All of the above. It really depends on the pharmacy that's filling the script.

It's not uncommon, especially for some of our -- once again, the National Guard and reserve soldiers who are not going to a military pharmacy, you can imagine a civilian pharmacist, sometimes bulk if asked to fill a prescription like that.

So they will sometimes get one big bottle, sometimes they will get smaller ones. A lot of times they will just demonstrate that they have a provision in place to deliver their medications within a reasonable timeframe.

(Plaintiff's Exhibit 9 marked for identification.)

BY MS. BAUER:

Q Lieutenant Colonel Cron, I am handing you what's been marked as Cron Deposition Exhibit 9, which is a copy of an order that was entered in Rowe versus Shanahan on February 15, 2019.

Have you ever seen this document before, sir?

A I think so, but it looks like the other ones, so not sure.

Q You've seen some --

A I have seen many documents formatted like this.

if that information is readily available. We only do limited screening currently prior to deployment. This is one of the things we're also discussing in terms of modifying our deployment criteria.

BY MS. BAUER:

Q Are you familiar with the HHS' current guidelines on the treatment of HIV?

MR. NORWAY: Objection, scope. You may answer.

THE WITNESS: I am not. That's outside my typical scope of practice.

BY MS. BAUER:

Q Going back to deployment waivers; do men who have sex with men require a waiver to deploy to CENTCOM?

A Not unless they required it for some other reason. We don't -- that's not considered a medical condition, and therefore we would have no reason to know that unless it was part of a medical discussion of some kind.

Q It's not information that's asked for when deployment decisions are being made?

A Not that I'm aware of.

Q Are you aware of any documented case of the transmission of HIV through wound to wound contact, as you described earlier today?

A I am not.

MS. BAUER: I have nothing further.

MR. NORWAY: Sir, I just have a few followup questions.

EXAMINATION

BY MR. NORWAY:

Q Do you recall Julie asking you a few moments ago about status of forces agreements?

A I do.

Q And is there a reference in Tab A, which is marked as Exhibit 7 in this deposition, to agreements with other nations in paragraph C, subparagraph 2, concerning HIV infection?

A What was that page?

Q It is page 6, C2.

A What is your question again?

Q Is there a reference to agreements with other host nations in that subparagraph?

A That paragraph does not necessarily apply to agreements with host nations as much as the laws of the host nation, which would legitimately include Visa entry requirements, although a legal prohibition against entering a country that was part of a status of forces agreement would also be appropriately referenced in that.

that individual. Once again, we are talking about civilians as well as service members.

Q But do I understand correctly that that host nation law has never been the deciding factor in whether or not to grant a waiver to someone with HIV?

A You are correct.

Q I should have asked this earlier, but do I understand that you are expecting to deploy later this year?

A No, ma'am. I am actually -- I am expecting orders to go to one of our overseas labs.

Q And you don't know when those orders are coming through, though?

A Literally any day now. The Army is undergoing a transition within our medical system which has disrupted the normal sequence of things.

In a normal year I would already have them, but I've been told it's going to happen. When you're in the Army, you learn quickly that you're never quite sure what's going to happen until you have the orders in your hand. That's the case.

So I believe I will be going to Thailand probably in the June to July timeframe, though I don't have a date yet, and I don't have orders yet.

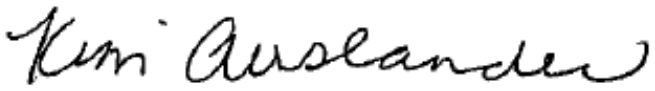
Q Okay. And will you continue to be the waiver

REPORTER'S DEPOSITION CERTIFICATE

I, KIM AUSLANDER, Registered Professional Reporter, certify that I was authorized to and did stenographically report the deposition of KEVIN CRON, the witness herein on March 15, 2019; that a review of the transcript was requested; that the foregoing pages numbered from 1 to 212 inclusive is a true and complete record of my stenographic notes of the deposition by said witness; and that this computer-assisted transcript was prepared under my supervision.

I further certify that I am not a relative, employee, attorney or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action.

DATED this 15th day of March, 2019.



KIM AUSLANDER

Registered Professional Reporter

EXHIBIT 4

Excerpts from the April 30, 2019
Deposition of Dr. Clinton Murray

UNDER SEAL

EXHIBIT 5

Excerpts from the March 7, 2019 Deposition of Sergeant Nicholas Harrison

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF VIRGINIA

NICHOLAS HARRISON, et al., Plaintiffs, v. PATRICK M. SHANAHAN, in his official capacity as Acting Secretary of Defense, et al., Defendants.	Civil Action No. 1:18-cv-641-LMB-IDD

Deposition of NICHOLAS HARRISON, a Plaintiff herein, at the offices of United States Department of Justice, 1100 L Street, N.W., Washington, D.C., commencing at 9:38 a.m. on Thursday, March 7, 2019 and the proceedings being taken down by stenotype and transcribed by Catherine B. Crump, a Notary Public in and for the District of Columbia.

Q. Did you graduate from the University of Oklahoma?

A. No, I did not.

Q. Did you transfer from the University of Oklahoma?

A. Yes, I did.

Q. Before that, do you remember, roughly, your GPA or rank at the University of Oklahoma?

A. I don't. It was pretty low. That's why I transferred.

Q. And where did you transfer?

A. I transferred to the University of Central Oklahoma.

Q. What years did you attend the University of Central Oklahoma?

A. '97 through 2000, roughly, was the first time and then I had a break for military service from 2000 to 2003. Then I came back and finished up my degree from 2003 to 2005.

Q. So from 1997 to 2000, you were at the University of Central Oklahoma?

A. Right.

Q. And this was before you joined the military?
A. That's correct.
Q. What were you studying at the time?
A. Political science.
Q. You did not graduate in 2000?
A. That's correct.
Q. Do you remember, roughly, your GPA or class rank at the University of Central Oklahoma?
A. I don't.
Q. Then you had a break from 2000 to 2003 for military service. Correct?
A. Correct.
Q. And then when you returned, did you again return to the University of Oklahoma?
A. That's correct.
Q. And what years was that again?
A. It would have been 2003 through 2005.
Q. Were you still studying political science?
A. Yes, I was.
Q. Any other major?

A. Not until the very end. At the very end, I ended up grabbing a general studies degree, because I had already secured admission to law school and didn't want to stay and take an extra capstone course. So it seemed easier just to go with that degree and move on.

Q. So you did not graduate with a degree in political science?

A. That's correct.

Q. You graduated with a degree in general studies?

A. That's correct.

Q. Because you did not want to take an extra capstone course; is that correct?

A. That's correct.

Q. Then you said you had already secured admission to law school. Correct?

A. That's correct.

Q. Which law school is that?

A. Oklahoma City University.

Q. What years did you attend Oklahoma City University?

A. That's my best estimate right now though.

Q. Okay. When did you begin at -- you said the University of Oklahoma?

A. That's correct.

Q. And when did you begin there?

A. I began in 2007.

Q. So immediately after your deployment?

A. That's correct.

Q. And am I correct that you said you had to repeat your 1-L course?

A. That's correct.

Q. I'm very sorry to hear that.

When did you graduate from the University of Oklahoma?

A. I graduated in 2011.

Q. So you were there for four years?

A. That's correct.

Q. Is that because you were in a joint degree program?

A. That's correct.

Q. What was your overall GPA or class rank

bar?

A. No.

Q. Okay. You said you also received an MBA. Correct?

A. That's correct.

Q. From the University of Oklahoma?

A. That's correct.

Q. What did you study in your MBA program?

A. In the MBA program, I took the entrepreneurial specialization.

Q. And did you also graduate in 2011?

A. Yes, I did.

Q. Do you have any other educational -- have you ever attended any other educational institution?

A. I've taken online courses at Champlain University, which is in New Hampshire, accounting courses. I'm working toward a CPA certification right now.

Q. When did you start the online courses?

A. Probably 2016, somewhere around then. I also took some project management courses through

Stanford University on line to get a PMP certification and earned that certification as well.

Q. Did you get that certification?

A. Yes, I did.

Q. How many courses did you take for that?

A. I believe I took two, maybe three.

Q. I'm sorry. When was that?

A. That would have been 2014, 2015.

Q. Any other online courses?

A. Not that I can think of.

Q. Any other education, generally?

A. No.

Q. Okay. Now I'm going to ask about your military background.

A. Okay.

Q. I believe you earlier said that you joined the military in 2000; is that correct?

A. That's correct.

Q. What service did you join?

A. The U.S. Army.

Q. Did you join as an active duty service member?

Military Occupation Specialty?

A. That's correct.

Q. You said you've had other billets. Correct?

A. That's correct.

Q. I believe you mentioned two, military police and contracting; is that right?

A. That's correct.

Q. But you were always infantry?

A. That's correct.

Q. When did you have the military police billet?

A. When I did an interstate transfer upon getting a job here in Washington, D.C., I moved from the Oklahoma National Guard to the D.C. National Guard. D.C. National Guard does not have infantry positions. So they transferred me first into a military police slot. So that would have been 2013, is when I started there.

Q. And how long were you in the military police billet?

A. Probably, about two years.

Q. Did you have any negative personnel actions taken against you at this time?
A. No.
Q. After finishing your assignment in Alaska, you said you left active duty. Correct?
A. That's correct.
Q. And if I remember correctly, 2003 is when you went to the University of Central Oklahoma. Is that right?
A. That's correct. That's when I returned.
Q. And you said that you joined the Army Reserves; is that correct?
A. Yeah. There was a concurrent enrollment program. I was released from active duty so I could go to the Army ROTC program at the University of Central Oklahoma, and while doing that, then have a concurrent enlistment or concurrent service program where I was serving in the Oklahoma National Guard at the same time.
Q. So after 2003, you were serving in the Oklahoma National Guard and simultaneously serving in the Army Reserves and simultaneously an ROTC cadet?

Q. And you said you graduated in 2005. Correct?

A. That's correct.

Q. And from 2003 to 2005, you were always in the Oklahoma National Guard. Correct?

A. That's correct.

Q. After graduation from college, you enrolled at the Oklahoma City University Law School. Correct?

A. That's correct.

Q. And that was in the fall of 2005?

A. That's correct.

Q. And you were still in the Oklahoma National Guard at that time?

A. That's correct.

Q. But I believe, earlier, you said you deployed to Afghanistan while attending the Oklahoma University Law School. Correct?

A. That's correct.

Q. When did you deploy to Afghanistan?

A. 2006 and 2007.

Q. Do you remember the month you started?

A. March, I believe is whenever we were mobilized.

Q. How long was that deployment?

A. It was about 18 months, I believe.

Q. What were your job duties in Afghanistan?

A. Job duties, I was still assigned as radio telephone operator, but over in Afghanistan, they put me in charge of the brigade tactical operations center, first at the base that I was at, at Fort Delaram or Camp Delaram, I guess is what they call it, and then they moved me over to Camp Phoenix and I was a radio telephone operator over there. In that capacity, I basically was in charge of establishing the entire sort of battle tracking system and training personnel, developing the system to manage critical information as it came in and respond to threats, coordinate medivacs and reinforcements and so forth.

Q. What was your rank during this time?

A. I was an E4 at the time.

Q. An E4?

A. That's correct.
Q. And you previously said you were an E5?
A. E5 in 2008 is whenever I was promoted to that.
Q. I see. Did you receive any awards in Afghanistan?
A. Yes, I did.
Q. What were they?
A. I received sort of a whole complement of awards that you get in Afghanistan, the campaign medal, the NATO medal. I also received an Army accommodation.
Q. Were there any negative personnel actions taken against you during your time in Afghanistan?
A. No.
Q. When did you return from Afghanistan?
A. 2007.
Q. Do you know, roughly, when in 2007?
A. I want to say May or June of 2007 is whenever I returned.
Q. And what did you do upon your return?

A. That's correct.
Q. Were there ever any other negative personnel actions taken against you during this time period?
A. No.
Q. What did you do following law school?
A. Immediately following law school, I was deployed again, this time to Kuwait, in 2011 and 2012.
Q. You deployed in 2011?
A. That's correct.
Q. Do you remember when you were mobilized, meaning which month?
A. They mobilized the unit sometime in March or April. They were nice enough to allow me to actually graduate this time. So they didn't mobilize me until May, after I graduated.
Q. You got a deferment until you graduated?
A. That's correct.
Q. And how long was that deployment?
A. That lasted until 2012, probably about May or June as well.

it could be whenever you've done something. I think it could also flag medical conditions, but you'd probably have to talk to a personnel person to get what the official response is, but it basically means that because of something having to do with your record, either personnel or readiness or whatever, you had been flagged as being ineligible for promotions, favorable personnel actions, etc.

Q. Have you ever been flagged?

A. No.

Q. Have you ever had any nonjudicial punishment?

A. No.

Q. As I foreshadowed, I'm now going to talk about your medical records. You are HIV-positive. Correct?

A. That's correct.

Q. When did you learn that you were HIV-positive?

A. Whenever I came back from my deployment from Kuwait, about two or three months after. I want to say July of 2012 was whenever I was diagnosed.

Q. Are you receiving treatment for your HIV status?

A. Yes, I am.

Q. Who is your medical provider?

A. My medical provider is Dr. Maggie Czarnogorski. I can't spell it off the top my head. She is an infectious disease specialist of the office of -- Department of Veterans Affairs.

Q. How often do you see Dr. Czarnogorski?

A. Usually, about every six months. There's a little bit of leeway there, because there's never really been an issue with my condition. It's always been well controlled.

We'll schedule something for six months, and she's always very comfortable that if she has something else going on, she's taking leave or whatever, she'll reschedule me later, sometimes seven months, sometimes eight months.

Q. How long have you been seeing Dr. Czarnogorski?

A. She's been my primary care provider since I moved to Washington, D.C. So that would have

Q. Do you know what the term "virally suppressed" means?
A. Yes, I do.
Q. What does it mean?
A. Virally suppressed is the sort of actual line that medical professionals draw whenever you are no longer able to transmit the virus because you've gotten the copies down so low. I believe it's like 200 copies per milliliter, is kind of that standard. It's slightly higher than undetectable, but it still has the net effect once you reach virally suppressed, it's impossible for you to transmit the disease.
Q. Have you been told by your medical provider that you viral load is undetectable?
A. I have.
Q. So I assume you've also been told at some point that your medical provider says you're virally suppressed?
A. Right.
MR. SCHOETTES: Objection. I'll withdraw that.
BY MR. ABBUHL:

requirement that I be in a non-deployable billet right now. I think that's the only thing right now.

As far as duty limitations and so forth, I mean, every time I talk to the state surgeon, he said your PULHES Code is straight across the board; you have no duty limitations; you can pretty much do anything.

There are no restrictions on the things that I can do in the military.

Q. For the record, PULHES Code is P-U-H-L-E-S Code?

A. Yes.

Q. And it's, generally speaking, a measure of physical fitness?

A. Well, it's a general of medical fitness. Your PULHES Code examines different areas of your body, like your extremities, your eyesight, your, cardio. Each of the letters stand for one of the areas.

So they give you a number, and each of them say what your limitations are. So if you have a PULHES Code of ones across the board, it's basically

a medical provider saying, you know, looking at you and looking at all the different areas, we evaluate you there's nothing wrong with you physically. There's nothing you can't do. There's no restriction on your duties or limitations on what you should be able to do.

It's kind of a numeric way of saying that for the military.

Q. Beside your doctors, is there anyone else in the military who knows that you're HIV-positive?

A. Yes.

Q. Who?

A. Probably, the general public at this point.

Q. Before the filing of this lawsuit, how many members of the military knew that you were HIV-positive?

MR. SCHOETTES: Objection, speculation, calls for speculation.

You can answer.

THE WITNESS: Initially, it was a very close

whatever until I got back or if I have to go through the whole process again or exactly what. It was just something that I really couldn't actively pursue while I was on my deployment. So it's difficult for me to characterize what happened with it.

Q. So you're not sure if it was held open?

A. Right. Right.

Q. When did you next apply to be a JAG officer?

A. I can't remember if I submitted anything through the central system again. I know shortly after I got back through -- back to Oklahoma, I did reach out to the Oklahoma National Guard and asked them about that whole process.

I took the California Bar exam, didn't pass that. I took the Oklahoma Bar exam, passed that. I think it was shortly after I passed the Oklahoma Bar again that I reached out to the Oklahoma National Guard.

I'm not sure if I made any other applications. I do think I submitted an application coming back from my deployment through the centralized system

BY MR. ABBUHL:

Q. Do you recognize this document?

A. Yes. It looks like the complaint that was filed in this case.

Q. It has your name at the top?

A. Yes, it does.

Q. If you could please turn to page 13 and look at Paragraph No. 49. This paragraph says that Colonel Elliott of the Oklahoma National Guard offered you a position as a JAG officer. Correct?

A. That's correct.

Q. When did that occur?

A. That was shortly after I returned from my deployment, after I passed the Bar examination. Colonel Elliott is the state JAG or he was at the time, and so the process I explained earlier where active duty is the centralized accessions procession and National Guard is more driven by the person who holds the slots, Colonel Elliott was the guy who controlled the slots in Oklahoma. He was the full bird colonel that was the state's Judge Advocate General.

and please look at paragraph 51, which starts on page 13 and goes on to page 14.

This paragraph says that while living in Washington, D.C. in 2013, you applied for a position in the Judge Advocate General' office for the D.C. National Guard. Correct?

A. That's correct.

Q. And this is the same application you had just referred to. Correct?

A. That's correct.

Q. And it was directly to the D.C. National Guard?

A. That's correct.

Q. This paragraph also states that you were chosen for an open position in the JAG Corps for the D.C. National Guard. Correct?

A. That's correct.

Q. What do you mean by "chosen for an open position"?

A. Back in 2013 -- I want to say the interview was November of 2013 -- I mean, I was talking to the different JAG offices. There's a JAG

other soldiers in the unit, for them to see somebody who's enlisted as a sergeant going from that rank to a captain. That's something that he wanted others to see as well.

Q. And the position was with the Legal Services Office. Correct?

A. Yes.

Q. How did they formalize the offer?

A. How did the office formalize the offer?

Q. Well, you said the offer was formalized after your commanding officer gave them his recommendation. Correct?

A. Correct.

Q. In what way was it formalized by the legal services office?

MR. SCHOETTES: Objection, mischaracterizes prior testimony.

You can answer.

THE WITNESS: I mean, they basically told me everything is set. They connected me with the specialty branch officer, who in the D.C. National Guard began building the packet. That was First

Lieutenant Ono.

So once they communicated to her that they wanted me for that slot, she started building the packet. That's basically been my experience in the National Guard, is that the recruiting -- specialty branch recruiting officers don't start building the packet until they get the approval or the, yes, this is the person we firmly want from that office.

They did that. So we started building the packet in D.C.

BY MR. ABBUHL:

Q. Did you ever receive a letter informing you that you had this slot with the legal services office?

A. They never sent me a letter anything like that.

Q. No E-mail?

A. I don't think there was an E-mail. I think it was a phone call.

Q. Nothing written?

A. That's correct.

Q. You said the Legal Services Office is in

that. Correct?

A. [Pause.]

Q. Let me rephrase. What's your understanding of why you cannot become a JAG office as a result of your 2013 JAG application process?

A. My understanding is I cannot become a JAG officer because DoD has a policy that says people with HIV cannot commission.

Q. What did you do when that policy became an issue in your application?

A. I went through the process of applying for a waiver and then an exception to policy. That's sort of laid out in the regulations.

Q. And what is a medical waiver?

A. A medical waiver is a process where, a lot of times, if you have some sort of condition that is not a bar for you to continue to serve, but is a bar for you to enlist or access, most of the time, the military, the U.S. Army, will waive that condition whenever you're moving from "E" to "O", and so a medical waiver is saying, Okay, you have -- yes, you have one of these conditions that's listed here,

Q. Who was it that -- excuse me.

Did someone tell you that you needed to submit a waiver request?

A. I guess it was just sort of mutual understanding. I've served so long in the military that it kind of came naturally to me that I knew that a waiver was sort of the next step in that process, and First Lieutenant Ono just kind said, Yes, sort of the next step is to put together a waiver and we'll send it up and see what happens.

Q. I'm trying to get a sense of what happened immediately before. Was your application denied and then you submitted a waiver or you submitted --

A. I mean, where it starting is they started building the application, and what she does is she sets up a medical examination, a commissioning medical examination at Walter Reed Hospital. There were two phases to it. One, you just go in and they start the blood tests and table exam, and then the second, you come and get the results from all the blood tests and follow up on any other items on your

a waiver, you go through that process, and then you come back and in Step 4 of the process, you have another condition or issue. It doesn't make sense for them.

So they have you do the entire medical examination, figure out what's your total shape, what's your fitness, what's your medical readiness. Then they say, You're good but for this, and then that's when they start the waiver process that says, Okay, well, let's examine this and delve into it and go forward.

Q. Did anyone assist you in preparing your waiver request?

A. First Lieutenant Ono. She actually put it together. It's more of a process, at least on the waiver side, that is put together by the specialty branch officer rather than the soldier. The specialty branch officer asks for documents, asks you to send them stuff, and then they submit everything collectively to -- I believe it was the surgeon at the National Guard Bureau who I ended up going to.

Q. Did anyone else help you prepare your

document, if I remember correctly, which was contrary their regulation, contrary to medical status and everything like that, and so I called those people up and I was like, Okay, what's the deal; why did you deny this?

I reached out first to some of the officers at bottom that were clinical. I found out very quickly that the officers that were listed on that document hadn't worked for that office for a while. So they had no idea why they were still listed on that document and that somebody else was really in charge now and they had no information for me.

I believe I contacted some of the administrative officers and got through to a contractor, and a contractor on the phone told me pretty point blank that, yes, I understand your condition, your physical, but he said, point blank, we don't give waivers for HIV; we don't do that.

So then I was pretty much told there are no waivers for HIV coming out of this offices, but I completed that step and sort of the next thing that came to mind that I found out about and pursued was

the exception to policy process. I started that whole thing.

Q. Before we get into that, have you submitted any other waiver requests concerning your HIV status?

A. No. That was only waiver request. That's the only waiver avenue that's out there.

I submitted correspondence to different people, like the Army Surgeon General and congressmen and things like this, but no. That's the only waiver process that was out there.

Q. Are you aware of any reasons why you might not be a good candidate for a waiver?

A. No.

MR. SCHOETTES: Objection, calls for speculation.

You can answer.

THE WITNESS: No.

BY MR. ABBUHL:

Q. All right. And you just mentioned an exception to policy. Right?

A. Right.

Q. What is an exception to policy?

A. So both of the policies that were put out for HIV, there is DoD policy that's perpetuated by a DoD instruction that comes from the Under Secretary for Personnel and Readiness at DoD. In implementing that policy, there is Army regulations, and the proponent of that is the deputy chief staff of the Army, G1; and if you go through both of those documents, it's not explicitly spelled out in the DoDI, but it's kind of implicit sort of in understanding that if put out that document, exceptions are listed. Then the person you have to go is the proponent of document, but the Army regulation is much more explicit about it. They actually have a section that says that exceptions to the policy shall be submitted to deputy chief of staff, Army G1.

So I put together a letter, memorandum, that is, basically, a justification memo for an exception to the policy where I outlined who I am, years of service, what my medical condition is, that I've denied, that I've gone through this process and,

basically, made the case, laying out that I should get a commission, that it was in the best interest of the Army because they made a considerable investment in me. I wanted to continue my years of service. The best billet for me is this position. It's sort of the natural career progression.

I sent that off to probably the Under Secretary at the time. I think I CC'd the chief of staff, because he was the highest ranking LGBT person serving in the Department of Defense at the time.

I think I also sent it to the Army G1, but I basically fired off this letter that asked for an exception to policy, not knowing or having seen or put together any exception policy packet myself ever before. So it all started with that memo.

Q. How was the memo acted upon?

A. At the Department of Defense, I got kind of a response back from somebody who's the director, I want to say, of military or personnel readiness or something like that. There was kind of a card stock response that said, yeah -- never explicitly denying the exception to policy, but I don't know. It's an

administrative bureaucratic way of brushing me off.

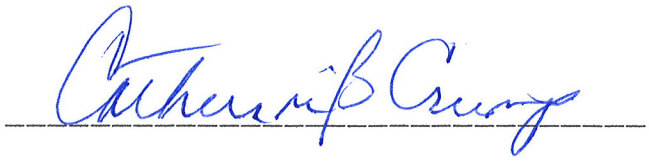
From the Department of the Army, though, Headquarters Department of the Army, I actually got a call back from a Colonel Williams, and she was the medical resiliency officer at Headquarters of the Department of the Army. She's the one that reached out to me and very sort of vague initially, like, Sergeant Harrison, I need to talk you about an issue on the phone, and that sort of thing, because it had to do with my HIV condition. So she didn't want to put anything in an E-mail or send a voicemail until she confirmed who I was.

She did that, and she talked about it and she say, Yeah, I got your memo; it's been referred to me; I'm Army Resiliency Officer G1; I work in this office. I got your memo and your memo is like awesome. I'm looking at it and I was laughing at it. I saw the part -- she was laughing at the part where it said I said that the Army's military policy was relative to the 1980s, because she absolutely agreed with that.

She had been serving on the board or committee

CERTIFICATE OF NOTARY PUBLIC

I, CATHERINE B. CRUMP, the officer before whom the foregoing deposition was taken, do hereby testify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness was taken by me stenographically and thereafter reduced to typewriting under my direction; that said deposition is a true record of the testimony given by said witness; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken; and further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto nor financially or otherwise interested in the outcome of the action.



CATHERINE B. CRUMP
Notary Public in and for the
District of Columbia

My Commission Expires: October 31, 2022

Exhibit 6 to Deposition of Sergeant Nicholas Harrison

9 June 2017 Memorandum

MEDICAL DETACHMENT
DISTRICT OF COLUMBIA ARMY NATIONAL GUARD
2001 EAST CAPITOL STREET
WASHINGTON, DC 20003-1719

NGDC-MED-DET 9 June 2017

MEMORANDUM FOR Land Component Commander, District of Columbia Army National Guard, 2001 East Capitol Street, Washington, DC 20003

SUBJECT: Recommendation Regarding Exception to Policy from SGT Harrison, Nicholas, SSN: [redacted]

1. After careful review of current DoD Regulations and Policies regarding personnel infected with the Human Immunodeficiency Virus (HIV), The Office of the State Surgeon, DCARNG recommends that the request for exception to policy of the above listed Soldier dated 22 April 2017, receive a non-concur endorsement from the Command Group regarding the request for organ donor approval consideration and for approval to receive an appointment as a Commissioned Officer in the JAG Corps.

2. Regarding the Soldier's request for consideration to receive approval to become an organ donor; IAW AR 600-110, Chapter 4-8, the Soldier received formal preventive medicine counseling's on 5 July 2012, 5 August 2016 and 26 February 2016, that specifically outline his individual responsibilities relating to continued military service; including that he is forbidden to donate blood, blood products, semen, sperm, eggs, breast milk, tissues or organs. The Human Immunodeficiency Virus (HIV) may be potentially transferred in any of these organ systems, and therefore DoD policy prohibits Service Members from donating the above listed items irrespective of the level of detectable virus in the individual's blood. Any failure to meet the individual's obligations outlined in the preventive medicine counseling could represent a risk of additional infections, and therefore may result in a recommendation for separation action.

3. Regarding the Soldier's request for consideration to receive an appointment as a Commissioned Officer in the JAG Corps, the Soldier fails to meet established medical standards for Commissioning as outlined in AR 40-501, Standards of Medical Fitness. Specifically, Chapter 2-30, which states that personnel who have tested positive for the Human Immunodeficiency Virus (HIV) are disqualified from entrance into military service, or receive appointment as a Commissioned Officer or Warrant Officer. IAW AR 40-501, Chapter 3-7, (h) Soldiers who acquire the Human Immunodeficiency Virus while in a military status can remain members of the military, as long as they remain medically stable and do not show evidence of progressive clinical illness or immunodeficiency. Chapter 3-7 (h) section of AR 40-501 is applicable to this Soldier. This Soldier has been informed on multiple occasions that he is disqualified from Commissioning due to his medical condition.

4. A consultation with the Chief of Preventive Medicine, Office of the National Guard Surgeon was made for the purposes of confirming established DoD regulations and policies relating to personnel infected with the Human Immunodeficiency Virus (HIV), and at no time was personally identifiable information shared during the consultation.

5. POC is the undersigned at 202 685-9670

GREGG A. VIGEANT
COL, SP, DCARNG
Deputy State Surgeon

HARRISON
EXHIBIT NO. 6
3/7/19
C. CRUMP

DISTRICT OF COLUMBIA ARMY NATIONAL GUARD
JOINT FORCE HEADQUARTERS
2001 EAST CAPITOL STREET
WASHINGTON, DC 20003-1719

REPLY TO
ATTENTION OF

NGDC-JFHQ

22 April 2017

Noted 10 Jun 17 NLM

MEMORANDUM THRU CPT NICOLAS MASON, Commander, Joint Force Headquarters, 2001 East Capitol Street SE, Washington, DC 20003

Noted 9 June 2017

THRU COL AARON DEAN, Commander, Land Component Command, 2001 East Capitol Street SE, Washington, DC 20003

WJW 16 June 2017

THRU BG WILLIAM WALKER, Acting Commanding General, DC National Guard, 2001 East Capitol Street SE, Washington, DC 20003

THRU LTG JAMES MCCONVILLE, Deputy Chief of Staff (G-1), US Army, 300 Army Pentagon, Washington, DC 20310

THRU MR. TONY KUTA, Acting Undersecretary of Defense for Personnel and Readiness, 4000 Defense Pentagon, Washington, D.C. 20301

FOR THE HONORABLE MR. JAMES MATTIS, Secretary of Defense, 1000 Defense Pentagon Washington, DC 20301

SUBJECT: Reconsideration of a Request for an Exception to Policy (DoDI 6485.01)

Executive Summary

1. My name is SGT NICHOLAS HARRISON. I am a member of the DC National Guard and I am writing in regards to an exception to policy request that I submitted so that I could receive a direct commission as a JAG officer.

2. I was interviewed by the DC National Guard and I was offered a slot in the Legal Services Office supporting the Director, Army National Guard in Arlington, VA. However, under DoDI 6485.01, I am not eligible for any form of a commission because I am HIV+.

3. Pursuant to current policy, I have spent the past three years going through the chain of command to request a medical waiver from the National Guard Bureau and an exception to policy from the Deputy Chief of Staff (G-1), US Army. These requests were denied by COL ERIC MORAN and MG JASON EVANS - both of whom cited DoDI 6485.01.

4. I submitted a request to the Acting Undersecretary of Defense for Personnel and Readiness, the proponent of DoDI 6485.01, on July 21, 2016. I received a letter from MS. STEPHANIE BARNA denying that request on July 26, 2016. In that letter, she notes:

"The policies enumerated in the DoDI, and in other DoD issuances establishing accession and commissioning standards, were reviewed and revalidated as recently as 2013. Accordingly, we are unable to grant favorable consideration of your request."

5. However, in the National Defense Authorization Act of 2014 (NDAA), Congress directed the Secretary of Defense to submit a report describing policies on the enlistment, commissioning, retention, deployment, discharge, or disciplining of individuals with HIV or Hepatitis B, and an assessment of whether the policies "reflect an evidence-based, medically accurate understanding of how these conditions are contracted, how these conditions can be transmitted to other individuals, and the risk of transmission."

6. Respectfully, I wish to assert that the previous Administration did not comply with that directive and DoD did not conduct a serious assessment of current policies.

7. Respectfully, I disagree with DoD's assertion that current policies are "evidence-based, medically accurate, reflect standard of care medical practices" or that these policies have been "reviewed regularly and updated as practices, guidelines, and standard of care have evolved." (Report to Congressional Defense Committees on Department of Defense Personnel Policies Regarding Members of the Armed Forces with HIV or Hepatitis B, September 22, 2014)

8. Respectfully, I assert that the current policy is not in line with the opinions of the medical community. And, I would like to resubmit my request for an exception to policy for reconsideration when a new Undersecretary of Defense for Personnel and Readiness is appointed by the President and confirmed by the Senate.

Background

9. I am a 40-year-old sergeant in the DC National Guard. I served 3 years on active duty as an airborne paratrooper stationed at Fort Richardson (Anchorage, Alaska). And, I served 13-1/2 years in the Army National Guard so far with 2 overseas tours of duty in Afghanistan (2006 - 2007) and Kuwait (2011 - 2012).

10. I completed my education by taking advantage of a variety of military benefits - loan repayment program, GI Bill, National Guard kicker, ROTC stipend, and tuition assistance. I graduated with a JD/MBA from the University of Oklahoma in 2011.

11. I was selected as an alternate during the JAG accessions process in 2011 – which carries with it an automatic slot in the National Guard/Reserves if I wanted it. However, I was deployed before I could take the bar exam and I wasn't able to follow through with it until I returned in 2012.

12. I was diagnosed with HIV shortly after I got back from my second deployment in July 2012. And, I am currently undetectable.

13. In 2013, I was selected as a Presidential Management Fellow and I took a job with the U.S. Small Business Administration. Upon relocating to the Washington DC area, I was interviewed by the Legal Services Office which supports the Director of the Army National Guard Bureau in Arlington, VA and I was offered a slot by them.

14. I completed my physical exam at Walter Reed Army Medical Center and I was advised that my HIV status constitutes a disqualifying condition which does not allow me to become a JAG officer. However, I have a PULHES code of 111111 - which indicates that I am considered to possess a high level of medical fitness and functional capacity in all categories and that I have no without medical, physical, or psychiatric duty limitations.

Argument

15. The current military policy prohibiting HIV positive personnel from becoming commissioned officers is a relic of the 1980s when people were dying of AIDS. Medical technology has evolved considerably over the past thirty-five years and HIV is more easily manageable than many other health conditions.

16. I have no significant duty limitations and there is no rational basis for the current policy. HIV positive personnel can work in health care or food service industries. There are no restrictions on taking federal law enforcement, foreign service, or DOD civilian positions. Even the U.S. Navy recently opened up overseas and large ship platform assignments.

17. DR. MICHAEL HORBERG, a board member and former chair of the HIV Medicine Association and a member of the President's Advisory Council on HIV/AIDS (PACHA) noted, "The notion that people with HIV cannot enlist and serve in any aspect of the military, or that their health status warrants special 'safe sex' orders or punishments for consensual sex, seems rooted in a 1980's understanding of HIV, and flies in the face of national efforts to get people with HIV tested and into treatment." (Positive Justice Project Press Release, December 23, 2013)

18. CATHERINE HANSSENS, Executive Director at the Center for HIV Law and Policy (CHLP) said, "Bringing existing military policies on the treatment of people living with HIV into the twenty-first century is long-overdue.... For too long, qualified individuals have been refused consideration for military service. And those who become HIV positive following enlistment are targeted with 'safe sex' orders, prosecutions, discharge and imprisonment on the basis of gross misinformation about how HIV is transmitted and the scientific and everyday realities of living with HIV." (Positive Justice Project Press Release, December 23, 2013)

19. TERRANCE MOORE of the National Alliance of State and Territorial AIDS Directors, stated "HIV criminalization can provide cover for lingering homophobic reactions to LGBT service members. Special penalties for otherwise legal conduct by those with HIV can reinforce stereotypes of LGBT people as predatory, dangerous and deviant. We need government agencies, including the Department of Defense, to show positive leadership

against ugly stereotypes, and to lead through the example of rational policies." (Positive Justice Project Press Release, December 23, 2013)

20. CAROLE TRESTON, RN, of the Association of Nurses in AIDS Care, added, "Nurses are in the business of counseling people with HIV, and part of that counseling is assuring those who are newly infected that they can lead a normal life that includes intimate relationships. It can be an uphill battle when government agencies are still telling people living with HIV that they are too dangerous to serve in the armed forces or too infectious to have a love life. That message is not just counterproductive; it's cruel." (Positive Justice Project Press Release, December 23, 2013)

21. The military has already decided that I cannot be discharged for my status. Indeed, current policy affords me with the opportunity to attend NCOES and other MOS-producing courses required for career progression. However, it makes little sense to keep me where I am. I am of limited use to the service in my current billet. The natural career progression for someone like me (upon graduating from law school and passing the bar exam) is to pursue a direct commission as a JAG officer.

22. I attained my education using military benefits. So, there's a case for giving the military a return on its investment. I also would incur no additional service obligation – having already fulfilled my statutory obligation during the past 16-1/2 years as an enlisted soldier.

23. The Legal Services Office supporting the Director of the National Guard Bureau wants me. They've told me that my previous combat experience in a line unit would be a real asset to their office. It suits the needs of the US Military. And, even if that slot is filled, I would respectfully request an exception to policy to pursue a commission through the Army Reserve.

Conclusion

24. While I respectfully disagree with the US Military's overall policy, this letter is a request for a narrow exception while the new Administration reevaluates that policy. I respectfully assert that DoDI 6485.01 should not be a bar to someone:

    (a) who is already in the service;
    (b) who has served long enough to fulfill his statutory obligation; and
    (c) who wishes to receive a direct commission into a specialty support branch for which he is well qualified, to serve out the remainder of his military career.

25. Thus, I ask you to grant my request for an exception to policy so that I can take a direct commission and finish out my military career as a JAG officer.

26. I also respectfully request a face-to-face meeting to discuss this matter further. The point of contact for this memorandum is SGT NICHOLAS HARRISON at [redacted].

Nicholas A Harrison

NICHOLAS A. HARRISON
SGT, DCARNG

DISTRICT OF COLUMBIA ARMY NATIONAL GUARD
JOINT FORCE HEADQUARTERS
2001 EAST CAPITOL STREET
WASHINGTON, DC 20003-1719

REPLY TO
ATTENTION OF

NGDC-JFHQ 22 April 2017

Noted 10 Jun 17 NCM

MEMORANDUM THRU CPT NICOLAS MASON, Commander, Joint Force Headquarters, 2001 East Capitol Street SE, Washington, DC 20003

Noted 9 June 2017

THRU COL AARON DEAN, Commander, Land Component Command, 2001 East Capitol Street SE, Washington, DC 20003

16 June 2017

THRU BG WILLIAM WALKER, Acting Commanding General, DC National Guard, 2001 East Capitol Street SE, Washington, DC 20003

FOR LTG JAMES MCCONVILLE, Deputy Chief of Staff (G-1), US Army, 300 Army Pentagon, Washington, DC 20310

SUBJECT: Request for an Exception to Policy (AR 600-110)

1. My name is SGT NICHOLAS HARRISON. I am a member of the DC National Guard. I am HIV+ and I am writing to request an exception to policy so that, upon my death, I can become an organ donor.

2. Pursuant to AR 600-110, HIV+ servicemembers are ordered by their commanders not to donate blood/blood products, sperm/semen or eggs, breast milk, tissues, or organs due to the risk of HIV transmission to recipients.

3. Like most of the policies that the US Military maintains regarding HIV+ servicemembers, this regulation is not evidence-based, it is not medically accurate, and it does not reflect standard of care medical practices. Nor has it been reviewed or updated as practices, guidelines, and standard of care have evolved.

4. In November of 2013, the President signed the HIV Organ Policy Equity Act (the HOPE Act) into law as PL 113-51 – revising a decades-old law that prevented patients from receiving organs from HIV+ people.

5. In February of 2016, John Hopkins performed the first HIV+ organ transplants in the United States.

6. I have been in contact with DR. DORRY SEGEV, MD PHD, Associate Vice Chair in the Department of Surgery and Director of the Epidemiology Research Group in Organ Transplantation at Johns Hopkins University. He confirmed that there was a need for organ donors. He seemed delighted that I wanted to volunteer and frustrated that the US Military maintains a policy which might bar HIV+ servicemembers from participating.

7. Although the US Military claims that it still values my service and respects my privacy, to become an organ donor I am required to tender this request through my chain of command up through NGB and HQDA to the Deputy Chief of Staff (G-1) in order to secure an exception to policy in accordance with AR 600-110.

8. Having previously put my life on the line to protect and defend others, I feel that it's in our nature as servicemembers to want to help save the lives of others.

9. Having also benefited from decades of medical research which now affords me the opportunity to live a long, healthy life as an HIV+ individual, I also feel a personal obligation to pay it forward.

10. Thus, I ask you to grant my request for an exception to policy so that, upon my death, I can become an organ donor.

11. I also respectfully request a face-to-face meeting to discuss this matter further. The point of contact for this memorandum is SGT NICHOLAS HARRISON at [redacted]

Nicholas A. Harrison

NICHOLAS A. HARRISON
SGT, DCARNG