IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 24-2079

ISAIAH WILKINS, et al.,
Plaintiffs-Appellees,

v.

PETE HEGSETH, in his official capacity as Secretary of Defense, and DANIEL P. DRISCOLL, in his official capacity as Secretary of the Army,
Defendants-Appellants.

BRIEF OF AMICI CURIAE CENTER FOR HIV LAW AND POLICY, NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS, AMERICAN CIVIL LIBERTIES UNION, AMERICAN CIVIL LIBERTIES UNION OF VIRGINIA, WHITMAN-WALKER CLINIC, INC., COMMUNITY RESOURCE INITIATIVE, AND SERO PROJECT IN SUPPORT OF APPELLEES AND AFFIRMANCE

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INTRODUCTION[1]

The Department of Defense ("DoD") has long been a leader in the field of HIV treatment and research. Although, like most federal responses, its initial endeavors were limited, ultimately—due to the incredible capacity for advancing science for which the U.S. military is well-known—the DoD came to be designated with key responsibilities under a whole-government approach to ending the HIV/AIDS pandemic. The question presented squarely falls within those current responsibilities delegated to the DoD. There is no question that a military accessions bar for people living with HIV ("PLWHIV") is arbitrary, capricious, irrational, and contrary to the DoD's responsibilities of improving HIV-related health outcomes of PLWHIV and reducing HIV-related stigma and discrimination for PLWHIV. To do otherwise would not only be contrary to science and further entrench de jure discrimination against PLWHIV, but would relieve the DoD of its federal role in ending the epidemic.

STATEMENT OF IDENTITY AND INTEREST OF AMICUS CURIAE

The Center for HIV Law and Policy ("CHLP") is a national, abolitionist legal and policy organization fighting to end stigma, discrimination, and violence

[1] No counsel for a party authored this brief in whole or in part, and no one other than the *amici*, their members, or their counsel contributed money toward the brief's preparation or submission. In addition, all parties have consented to the filing of this brief. *See* Fed. R. App. P. 29(a).

against people living with and vulnerable to HIV and other stigmatized health conditions. CHLP utilizes legal advocacy, high impact policy and research initiatives, and the creation of multi-issue partnerships, networks, and resources to support its communities. CHLP operates within and around criminal, legal, and public health systems at the state and federal levels to craft policies that amplify the power of mobilizations for systemic change guided by racial, gender, and economic justice. CHLP collaborates with PLWHIV, organizers and base builders, direct service providers, and national organizations to identify, create, and share expertly crafted, intersectional legal and policy resources and advocacy strategies.

The National Alliance of State & Territorial AIDS Directors ("NASTAD"), founded in 1992, is a leading nonpartisan nonprofit association representing public health officials who administer HIV and hepatitis programs in the U.S. and internationally. NASTAD's mission is to end the intersecting epidemics of HIV, viral hepatitis, and related conditions. A national leader in health department mobilization, NASTAD encourages the use of applied scientific knowledge and community engagement as a method of reducing the incidence of HIV and hepatitis. NASTAD's programmatic teams interpret and influence policies, conduct trainings, offer technical assistance, and provide advocacy mobilization for health departments to improve health outcomes for people living with and at risk for HIV and hepatitis.

The American Civil Liberties Union ("ACLU"), with more than four million members, activists, and supporters nationwide, is a non-partisan, non-profit organization that works with its 52 affiliates, including the ACLU of Virginia, to defend and advance the individual rights and liberties guaranteed by the Constitution and the laws of the U.S. Through the ACLU LGBTQ & HIV Project, founded in 1986, the ACLU has participated as counsel or an amicus in numerous cases addressing the constitutional and statutory rights of PLWHIV and to ensure that the governmental response to the HIV epidemic is supported by accurate information, rather than fear, prejudice, or stereotypes.

Whitman-Walker Clinic, Inc. ("Whitman-Walker"), is a nonprofit, community-based health organization serving the Washington, D.C. metropolitan area, including Northern Virginia. Whitman-Walker provides healthcare services for more than 18,000 individuals annually, including primary medical care; HIV and transgender specialty care; mental health and substance abuse treatment; dental care; nurse case management; legal services; and HIV and sexually transmitted infection testing, counseling, and prevention services. It is a national model for HIV care and healthcare for LGBT persons.

Community Resource Initiative ("CRI") leads the fight against HIV and other infectious diseases. CRI is a public health nonprofit that provides access and support through drug assistance, insurance support, prevention, and research—all

to make Massachusetts a healthier place for every resident of the Commonwealth. CRI conducts life-changing clinical research and has contributed critical research data resulting in the FDA approval of nearly all the currently available HIV medications and closely aligns its efforts and focus with statewide and national HIV/AIDS prevention and treatment strategies.

The SERO Project centers PLHIV leadership to end HIV criminalization, mass incarceration, racial and social injustice by supporting inclusive PLWHIV networks to improve policy outcomes, advance human rights and promote healing justice. SERO is focused on ending inappropriate criminal prosecutions of PLHIV by facilitating the creation and strengthening of PLWHIV networks, including those that are oriented toward advocacy, education, treatment access, prevention, recreation or for social purposes.

ARGUMENT

After careful reflection on a marred past of federal government inertia in protecting public health in the AIDS crisis, as compared to the relative successes of community-driven responses from smaller U.S. jurisdictions and abroad, in 2010, the U.S. finally committed to a whole-government approach to ending the HIV epidemic. That year, the federal government put forth its first coordinated National HIV/AIDS Strategy ("NHAS"), which delegates significant responsibilities toward

ending the HIV epidemic to the DoD.[2] Anything less, and the nation will risk a regression from hard-earned advances in public health. The matter before the court today—whether PLWHIV should once again be barred from enlistment and appointment in the military—falls squarely within the NHAS and DoD's responsibilities therein. And the question presented is no more complex than those presented in *Roe v. Department of Defense* in 2020.[3] As in *Roe*, considering a ban on deployment, a similar bar to entry at enlistment or appointment

> may have been justified at a time when HIV treatment was less effective at managing the virus and reducing transmission risks. But any understanding of HIV that could justify this ban is outmoded and at odds with current science. Such obsolete understandings cannot justify a ban, even under a deferential standard of review and even according appropriate deference to the military's professional judgments.[4]

Thus, it would be irrational, arbitrary, and capricious to reverse the lower court's order enjoining the DoD from enforcing its prior de jure discrimination against PLWHIV.[5] To hold anything less than that line on the important underlying

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[2] Jeffrey Crowley, *Announcing the National HIV/AIDS Strategy*, THE WHITE HOUSE (July 13, 2010), https://obamawhitehouse.archives.gov/blog/2010/07/13/announcing-national-hivaids-strategy.

[3] 947 F.3d 207, 211 (4th Cir. 2020), *as amended* (Jan. 14, 2020).

[4] *Id.* at 228.

[5] Department of Defense Instruction 6130.03 §§ 1.2(d), 6.23 (disqualifying from appointment, enlistment, or induction PLWHIV who are not "covered personnel"—*e.g.*, "Military Service Academy cadets and midshipmen, contracted SROTC cadets and midshipmen, and other participants in in-service commissioning programs") ("DoDI 6130.03").

questions of science, health care, and national policy would ignore: facts, the incredible and worthwhile return on DoD investment, and the DoD's responsibility to uphold its delegated duties under NHAS and President's Emergency Plan for AIDS Relief ("PEPFAR"). Permitting the DoD to ignore its responsibility—one that here, it has enacted and operated under for nearly a year since the permanent injunction ordered in August 2024,[6] would be to allow the most technologically advanced arm of the American government to regress and retrench toward our more shameful days of past ignorance towards HIV.

The opportunity presented to the military is to continue accounting for those past errors. Affirmance of the trial court order enjoining Defendants-Appellants to revise policies that are "outmoded and at odds with current science"[7] and to refrain from "irrational, arbitrary, and capricious" discrimination[8] is necessary to fully implement and maintain[9] the over-due progress of the last eleven months.

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[6] *Wilkins v. Austin*, 745 F. Supp. 3d 375, 399 (E.D. Va. 2024) (granting plaintiffs' motion for summary judgment and granting relief to immediately enjoin the military from denying enlistment and appointment based on HIV-diagnosis).

[7] *Roe*, 947 F.3d at 228.

[8] *Wilkins*, 745 F. Supp. 3d at 387.

[9] *See, e.g.*, Trent Straube, *People With HIV Report Roadblocks to Joining the Military, Despite Court Rulings in Their Favor*, POZ (Jan. 17, 2025), https://www.poz.com/article/people-hiv-report-roadblocks-joining-military-despite-court-rulings-favor.

I. A Whole-Government Approach Is Necessary to End the HIV Epidemic.

A. Disordered and Slow Federal-Government Action Is Well-Understood to Have Led to Catastrophic Domestic Harm in the Past.

The HIV/AIDS epidemic began in 1981,[10] with the federal government mounting a trickle of piecemeal, disorganized responses months and years after the crisis gained a foothold in our nation.[11] By 1986, a contagious, then deadly, and poorly understood virus, unchecked by a federal response, wreaked havoc on the populous having precipitated at least 16,458 deaths with diagnoses in 1985 having increased by 89% over the prior year.[12] Also by then, there was a disparate impact on historically marginalized communities including people of color,[13] gay and bisexual men,[14] and injection-drug users.[15] Despite the high mortality rate, high

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[10] CDC, MORBIDITY AND MORTALITY WEEKLY REP., Vol. 30, No. 21 at 250-51 (June 5, 1981), https://stacks.cdc.gov/view/cdc/1261.

[11] *A Timeline of HIV and AIDS*, HIV.GOV, https://www.hiv.gov/hiv-basics/overview/history/hiv-and-aids-timeline [https://perma.cc/G73W-ZEHV] (last visited July 15, 2025) ("*Timeline of HIV and AIDS*").

[12] Boyce Rensberger, *AIDS Cases in 1985 Exceed Total of All Previous Years*, WASHINGTON POST (Jan. 16, 1986), https://www.washingtonpost.com/archive/politics/1986/01/17/aids-cases-in-1985-exceed-total-of-all-previous-years/38c933d7-260c-414b-80f7-0dd282415cc6/ (noting that, at the time, the death rate following diagnosis was over 50%).

[13] *See Acquired Immunodeficiency Syndrome (AIDS) among Blacks and Hispanics*, MMWR WEEKLY (Oct. 24, 1986), https://www.cdc.gov/mmwr/preview/mmwrhtml/00000810.htm.

[14] *Timeline of HIV and AIDS.*

[15] *Id.*

infection rate, and the disparate impacts, the federal government, for years, failed to mount a strong response consistent with its capabilities with infectious disease whether as compared to the past[16] or the future.[17] The relative political powerlessness of those communities and stigma played a significant role in "deter[ing] any proactive federal response,"[18] in part due to the misinformed idea that HIV targeted these groups in a cabined way and that HIV would not impact the general, heterosexual population.[19] This misinformed notion led to continued,

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[16] *See, e.g.*, Donald P. Francis, *Toward a Comprehensive HIV Prevention Program for the CDC and the Nation*, 268 JAMA 1444, 1444 (1992) (comparing the "woefully inadequate" federal HIV/AIDS response to the "enormous" mobilization after a single importation of smallpox or Lassa virus).

[17] *See, e.g.*, Hope Campbell et al., *The (Contrasted) Ethics of Covid-19 and HIV*, IX J. HEALTHCARE SCI. HUMAN. 107, 109, 117 (2021) ("Despite the global threat that both [HIV and COVID-19] cause, the governmental response to the two diseases have been vastly different and so has the outcome").

[18] Tasleem J. Padamsee, *Fighting an Epidemic in Political Context*, 33 SOC. HIST. MED. 1001, 1004 (2018) ("The social conservatives who helped [President Reagan] recoiled from a disease publicly associated with gay men—a strongly marginalised and stigmatised social group."); *see also* ALBERT JONSEN & JEFF STRYKER, THE SOCIAL IMPACT OF AIDS IN THE UNITED STATES, 7 (1993) (same); *but see* MITCHELL KATZ, *The Public Health Response to HIV/AIDS* 90, 91 *in* THE AIDS PANDEMIC (2005) (as compared to the nation's demographics and AIDS-response-resources as a whole, "[t]he political power of the gay community led to a very proactive approach towards AIDS by the San Francisco Health Department").

[19] *Roe*, 947 F.3d at 212 ("by th[e] time" researchers discovered HIV infection did not discriminate, "many Americans already believed the cause of the disease to be a deviant lifestyle"); *see also* Campbell et al., at 111.

sprawling harm, systemically addressed so late that HIV shaped the public health outcomes of the entire nation.[20]

Prior to federal government involvement in the public health policy response to the HIV/AIDS crisis, community aid networks, non-profits, and municipal and state governments created a patchwork of services to meet the dire health care crisis need.[21] The slow, agency-by-agency federal response, necessarily deploying each agency's own skillsets and resources,[22] were stifled in their efficacy by

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[20] *See* Campbell et al., at 111 (discussing that in a culture that "associated morality with medicine and healthcare," less resources were invested than necessary early on due to HIV-related stigma); *see also* Joseph Bennington-Castro, *How AIDS Remained an Unspoken—But Deadly—Epidemic for Years*, HISTORY.COM (last updated May 28, 2025), https://www.history.com/articles/aids-epidemic-ronald-reagan (describing multiple failings by the government to dispel misinformation in the early 1980s including that "Washington leaders ultimately rejected" the CDC's first AIDS prevention plan in 1985 allegedly due to agency interest in downplaying the epidemic, which came to have tallied 47,000 diagnoses by 1987 when the federal government began to catch up with other nations' responses).

[21] *See, e.g.*, Padamsee, at 1005 (discussing New York City's Gay Men's Health Crisis, the Los Angeles Gay and Lesbian Center, and San Francisco's AIDS and KS (Kaposi's Sarcoma) Foundation as well as the municipal investments of San Francisco's health department); *40 Years of AIDS*, UCSF (June 4, 2021), https://www.ucsf.edu/news/2021/06/420686/40-years-aids-timeline-epidemic#:~:text=Congress%20passes%20the%20Ryan%20White,HIV/AIDS%20in%20the%20U.S. (discussing San Francisco's 1982 efforts to develop a standardized model of care for AIDS, development of the first outpatient clinic in 1983, and closure of public accommodations linked to transmission); *Reagan's Legacy*, SFAF (Feb. 10, 2011), https://www.sfaf.org/collections/status/reagans-legacy/ (the "AIDS budget for the City of San Francisco was bigger than . . . [the federal] AIDS budget . . . in the mid-1980's. In fact, Reagan's proposed federal budget for 1986 actually called for an 11 percent reduction in AIDS spending").

[22] *See, e.g.*, LAUREN LEVETON, HAROLD C. SOX, JR., & MICHAEL A. STOTO, *History of the Controversy* 57, 70-74, *in* HIV AND THE BLOOD SUPPLY (1995) (discussing

inefficiency, without endorsement and accountability of an executive mandate to coordinate.[23]

B. Decades of Independent DoD Action Led to Significant Innovations Impacting Domestic and International Public Health.

The first interagency-response of the federal government was not until 1986, when the CDC was designated as the lead agency to educate the public about HIV/AIDS.[24] As with prior domestic and international communicable disease public health crises, a multifaceted approach from those many agencies of varying

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that in the early years, the CDC largely served as a recording and reporting entity of diagnoses and deduced means of transmission without delegated power to require inter-agency coordination to prevent treatment and establish care strategies and instead held meetings—to "enlist" other public health agencies to assist with those problems—that could result in "a great deal of debate but no consensus on specific action;" for example, at such a meeting the FDA reported out on its research regarding blood products and "tried to establish a time frame for action" for which the "FDA's Blood Products Advisory Committee would agree to take action to implement donor screening policies," but "lack of consensus about the nature and magnitude of the threat . . . and uncertainty about the costs, risks, and benefits of the proposed control strategies" limited responses and recommended safety measures from such collaborations).

[23] *See* Padamsee, at 1004-06 ("Federal agency leaders expressed mounting frustrations . . . as the administration blocked congressional appropriations for AIDS-related program[s] and impeded the CDC's attempts to mount prevention campaigns," while the Institute of Medicine/National Academy of Sciences' critical report highlighted "extreme fiscal strains mounting at hospitals in hard-hit cities and advocating a strong, coordinated response to the disease").

[24] *The AIDS Epidemic in the United States, 1981-early 1990s*, CDC, https://www.cdc.gov/museum/online/story-of-cdc/aids/index.html [https://perma.cc/8MR5-XCNC] (last visited July 15, 2025).

expertise was necessary,[25] and the critical massive power of the DoD was key to turning a corner in the epidemic.[26]

Although the military system's response arguably came years too late for the full-weight of its scientific and resource bandwidth to curb the epidemic before it evolved to a pandemic, the DoD's first initiative—the HIV Natural History Study ("NHS"), a longitudinal study beginning in 1986—yielded early results "critical to understanding the impact of HIV infection among active-duty service members and military beneficiaries, as well as producing insights that are broadly relevant," including, crucially "the first broad surveys of HIV prevalence and patterns across the USA" and "development of one of the first highly predictive HIV clinical staging and classification systems."[27] Overtime, "[f]rom early descriptions of the natural history of infection, helping to establish laboratory testing practices, and development of the highly predictive Walter Reed system of staging clinical disease, the [military] has provided benefit to the clinical care of HIV-infected

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[25] Francis, at 1444.

[26] Richard Shaffer, *Military Medicine's Contribution to an AIDS-free Generation*, HIV. GOV (Nov. 27, 2012), https://www.hiv.gov/blog/military-medicines-contribution-to-an-aids-free-generation ("The U.S. military medical community has been a consistent leader in solving international health problems, particularly in the area of infectious diseases . . . such as yellow fever, malaria, and dengue fever [that] have had a major negative impact on the readiness of our U.S. Armed Forces going back to before World War I.").

[27] Brian Agan et al., *The US Military HIV Natural History Study*, 184 MIL. MED. 6, 7-8, 14 (2019).

individuals," which contributed to inter-agency advancements and nationwide windfalls in fighting HIV.[28] Today, as part of its responsibilities under the NHAS, the military's own researchers credit its ongoing study of service members living with HIV as critical to continuing our nation's understanding of the epidemic.[29]

Through the 1990s and 2000s, the patchwork and cross-purposes efforts between the White House, agencies, and Congress continued,[30] with DoD still playing a key role, including establishing a standard of medical practice for service members living with HIV ("SMLWHIV") and maintaining undetectable viral loads.[31]

[28] *Id.* at 14.
[29] *Id.*
[30] *See* Padamsee, at 1011-22.
[31] *See, e.g.*, Agan et al., at 7, 14 (citing primary sources).

In the wake of domestic advancements, in 2003, the President assembled experts to address the ongoing international HIV/AIDS crisis[32] and introduced PEPFAR legislation.[33] It passed on a bi-partisan basis[34] with the stated purpose:

> [T]o strengthen United States leadership and the effectiveness of the United States response to certain global infectious diseases by—
> (1) establishing a comprehensive, integrated five-year, global strategy to fight HIV/AIDS that encompasses a plan for phased expansion of critical programs and improved coordination among relevant executive branch agencies and between the United States and foreign governments and international organizations;
> (2) providing increased resources for multilateral efforts to fight HIV/AIDS;
> (3) providing increased resources for United States bilateral efforts, particularly for technical assistance and training, to combat HIV/AIDS, tuberculosis, and malaria;
> (4) encouraging the expansion of private sector efforts and expanding public-private sector partnerships to combat HIV/ AIDS; and
> (5) intensifying efforts to support the development of vaccines and treatment for HIV/AIDS, tuberculosis, and malaria.[35]

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[32] *See* Eric Goosby et al., *The United States President's Emergency Plan for AIDS Relief*, 60 JAIDS S51, S51 (2012), https://journals.lww.com/jaids/fulltext/2012/08153/the_united_states_president_s_emergency_plan_for.2.aspx (In the early 2000s, an "estimated . . .34 million people worldwide were living with HIV, with more than 20 million in sub-Saharan Africa."); *PEPFAR's Five-Year Strategy*, PEPFAR, at 2 (Dec. 2022), https://2021-2025.state.gov/wp-content/uploads/2022/11/PEPFARs-5-Year-Strategy_WAD2022_FINAL_COMPLIANT_3.0.pdf (In, 2000, the U.N. issued an unprecedented resolution declaring "a health issue should be considered a national security threat.").

[33] Goosby et al., at S51-52.

[34] H.R. 1298, 108th Cong. (2003); *see also* Katie Coester et al., *PEPFAR Is A True Bipartisan Success With An Uncertain Future*, HEALTHAFFAIRS (Apr. 14, 2023), https://www.healthaffairs.org/content/forefront/pepfar-true-bipartisan-success-uncertain-future.

[35] 22 U.S.C. § 7603 (2003).

DoD is one of many departments tasked with carrying out PEPFAR. DoD HIV/AIDS Prevention Program ("DHAPP") is the DOD implementing agency for PEPFAR and "is responsible for assisting foreign military partners with the development and implementation of culturally focused, military-specific HIV/AIDS prevention, care, and treatment programs in more than 55 countries around the globe."[36] And, as PEPFAR supports UNAIDS 95-95-95 goals ("95 percent of people with HIV diagnosed, 95 percent of those diagnosed on antiretroviral treatment (ART), and 95 percent of those on ART virally suppressed *by 2020*"), "DHAPP's responsibility is to ensure that military populations can also achieve targets at a similar pace to their civilian counterparts."[37] This includes "providing and expanding HIV prevention, care, and treatment support for active-duty military personnel, dependent family members and surrounding civilian communities."[38] In over two decades of programming and billions of dollars invested, PEPFAR has "had a crucial impact abroad," with "HIV infection rates hav[ing] fallen in 33 countries—22 of them in sub-Saharan Africa, the region most

[36] *Department of Defense HIV/AIDS Prevention Program*, DHAPP, https://cms.dhapp.global/ (last visited July 15, 2025) ("*DHAPP*").
[37] *Id.* (emphasis added).
[38] *See* Shaffer.

affected by the AIDS pandemic."[39] Yet in the same period domestically, the rate of new infections had held steady from the 1990s.[40]

C. Decades of Uncoordinated Federal Agency Action Left the U.S. Behind Other Wealthy Nations in Ending the Epidemic.

Although the federal agencies had demonstrated collaborative, nimble leadership internationally through PEPFAR, contemporaneous domestic efforts lacked similar coordination and strategic focus.[41] While other nations were managing to reduce transmission rates and improve health outcomes as they developed whole-government, responses to the virus, the U.S. saw less progress.[42]

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[39] Azmat Khan, *What Is President Obama's Track Record on HIV/AIDS?,* FRONTLINE (July 19, 2012), https://www.pbs.org/wgbh/frontline/article/what-is-president-obamas-track-record-on-hivaids/; *see also PEPFAR Latest Global Results*, DEPARTMENT OF STATE (Dec. 1, 2024), https://www.state.gov/pepfar-latest-global-results-factsheet-dec-2024/ (PEPFAR is credited with providing lifesaving treatment to 20.6 million PLHIV and over 83.8 million people with HIV testing services).

[40] *See* Khan.

[41] *See, e.g.*, Padamsee, at 1012-15.

[42] *See id.* at 1006 ("the US government's slow response and halting incrementalism contrasted sharply with events in Britain, where Margaret Thatcher's Conservative government had already assumed proactive leadership on HIV/AIDS by th[e] point" when the U.S. federal government began to inch forward in the late 1980s); *and see* Michael Hobbes, *Why Did AIDS Ravage the U.S. More Than Any Other Developed Country?*, THE NEW REPUBLIC (May 12, 2014), https://newrepublic.com/article/117691/aids-hit-united-states-harder-other-developed-countries-why#:~:text=Here's%20where%20the%20differences%20come,a%20heroin%20addict%20that%20day (explaining that "[g]raphs of AIDS deaths in almost every developed country look [a]like . . . [s]tarting from zero, deaths rise steadily through the '80s, a bit faster in the '90s, then suddenly, around 1995 or 1996, plummet

Thus, after three decades of HIV/AIDS, on World AIDS Day in 2009, the President announced a commitment to develop a NHAS.[43]

II. The U.S. Is Committed to a Whole-Government Approach to Ending the HIV Epidemic.

A. The NHAS Was Developed to Foster Coordination, Collaboration, and Accountability Between Agencies.

The NHAS was America's first comprehensive, coordinated domestic blueprint for confronting the HIV epidemic.[44] Its emergence came at a critical moment in the epidemic's history. The NHAS was developed to address persistent gaps in HIV prevention, inconsistent access to care, and significant health disparities among marginalized populations, particularly communities of color and LGBTQ+ individuals.[45] This coordinated approach marked a significant shift in domestic HIV policy, emphasizing evidence-based interventions and measurable outcomes.[46] As of 2010, more than half a million Americans had died of AIDS-

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downward" with the implementation of HAART treatment, then, "[t]he next thing you notice about those graphs is that death rates in the United States didn't fall to the same lows as the rest of the developed world." And new infections continued to climb domestically at a disproportionate rate: "In 2010, the United States had 47,500 new HIV infections. The entire European Union—with a population more than one and a half times that of the United States—had just 31,400.").

[43] *World AIDS Day, 2009*, 74 Fed. Reg. 63,269, 63,269 (Dec. 1, 2009).

[44] ONAP, *National HIV/AIDS Strategy for the United States* (2010), https://obamawhitehouse.archives.gov/sites/default/files/uploads/NHAS.pdf.

[45] *Id*. at 7-10.

[46] Baligh Yehia & Ian Frank, *Battling AIDS in America: An Evaluation of the National HIV/AIDS Strategy*, 101 AM. J. PUB. HEALTH 9, e4-e7 (2011).

related complications, and approximately 1.1 million people were living with HIV in the U.S.[47] The UNAIDS vision for "getting to zero"—zero new infections, zero AIDS-related deaths, and zero discrimination—influenced the development of the strategy.[48]

The NHAS developed as a significant domestic policy innovation inspired by earlier international efforts like PEPFAR, emphasizing coordinated, cross-agency collaboration.[49] DoD's substantial contributions through research, domestic healthcare standards, and global partnerships remain central to the Strategy's ongoing effectiveness.[50] Through successive updates and implementation plans, NHAS continues to evolve to address changing needs and incorporate scientific advancements in the fight against HIV/AIDS, with the ultimate goal of ending the epidemic domestically by 2030.[51]

Its deeply collaborative development process—ensuring that those most affected by HIV had a voice—distinguished NHAS from previous public health

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[47] *Id.* at e4.

[48] Cynthia I. Grossman & Anne L. Stang, *Global Action to Reduce HIV Stigma and Discrimination*, 16 J. INT'L AIDS SOC. 18881, 18881 (2013).

[49] *Id.*; *see also* Yehia & Frank, at e6.

[50] *Department of Defense HIV/AIDS Prevention Program*, HEALTH.MIL, https://www.health.mil/Military-Health-Topics/Health-Readiness/Public-Health/DHAPP (last visited July 15, 2025).

[51] ONAP, *National HIV/AIDS Strategy for the United States 2022–2025*, at 1 (2021) https://files.hiv.gov/s3fs-public/NHAS-2022-2025.pdf ("*NHAS 2022-2025*").

initiatives.[52] The White House Office of National AIDS Policy ("ONAP") led the effort.[53] Stakeholders included multiple federal agencies, healthcare providers, researchers, state and local governments, community organizations, and importantly, PLWHIV.[54] This inclusive approach led to increased collaboration among federal agencies; people with or at risk for HIV; state, local, and Tribal governments; health care providers; researchers; faith communities; and many other community partners.[55]

B. NHAS Development, Goals, and Metrics.

Building on bipartisan foundations of HIV/AIDS programs like PEPFAR, NHAS continued a growing federal commitment—across multiple administrations—to addressing HIV/AIDS. NHAS's four primary goals were and are:

> 1) reducing the number of people who become infected with HIV;
> 2) increasing access to care and improving health outcomes for people living with HIV;
> 3) reducing HIV-related health disparities; and
> 4) and achieving a more coordinated national response to the epidemic.[56]

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[52] *Implementation of the National HIV/AIDS Strategy*, 75 Fed. Reg. 41,687, 41,687 (July 16, 2010) ("*NHAS 2010 Implementation Plan*").
[53] *Id*.
[54] *See* Crowley.
[55] *See NHAS 2022-2025*, at 12.
[56] *National HIV/AIDS Strategy for the United States,* at vii.

Since its inception, the NHAS has undergone several updates to reflect evolving scientific knowledge, shifting policy landscapes, and changing epidemiological dynamics.[57] The 2015 update extended its goals through 2020, incorporating new insights in HIV prevention and care.[58] This update included revised steps, recommended actions, and quantitative progress indicators.[59]

Each iteration of the NHAS has been accompanied by detailed implementation plans that translate broad strategic goals into concrete actions across federal agencies, including DoD.[60] These Federal Implementation Plans assign responsibilities to agency officials, designated reporting structures, and identified actions to advance the Strategy and include steps to strengthen coordination in planning, budgeting, and evaluating domestic HIV/AIDS programs within and across agencies.[61]

A distinguishing feature of NHAS has been its emphasis on data-driven approaches and measurable outcomes to track progress and refine strategies over

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[57] ONAP, *National HIV/AIDS Strategy: Updated to 2020*, at 1-4 (2015), https://files.hiv.gov/s3fs-public/nhas-update.pdf ("*NHAS 2015 Update*").
[58] *Implementing the National HIV/AIDS Strategy for the United States for 2015-2020*, 80 Fed. Reg. 46,181 (July 30, 2015) ("*NHAS 2015-2020 Implementation"*).
[59] *NHAS 2015 Update,* at 49-54.
[60] *NHAS 2010 Implementation Plan*, at 41,688; *Accelerating Improvements in HIV Prevention and Care in the United States Through the HIV Care Continuum Initiative*, 78 Fed. Reg. 43,057 (July 15, 2013); *NHAS 2015-2020 Implementation*.
[61] *See, e.g.*, *NHAS 2015-2020 Implementation*.

time.[62] NHAS results have been measured using defined metrics including rates of new HIV infections, linkage to care, retention in care, viral suppression, and progress in reducing disparities among targeted populations.[63] Regular progress reports refine strategies and ensure the continuous alignment of initiatives with stated goals.[64]

C. The NHAS Federal Implementation Plan Has Assigned Specific HIV-Related Research, Health Outcome Improvement Goals, Prevention Actions, and Awareness Initiatives to DoD.

The first implementation plan of the NHAS called upon the DoD to participate in a multi-disciplinary research agenda setting technical consultations to identify scientific opportunities, priorities, and gaps in HIV prevention and treatment.[65] And, a revised NHAS in 2015 ("to reflect substantial advancements in AIDS science and to note progress on goals made to date"[66]) designated DoD as a lead agency of the NHAS,[67] tasked with "[i]ncreas[ing] the coordination of HIV

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[62] *See, e.g.*, ONAP, *National HIV/AIDS Strategy 2024 Progress Report*, at 2-3 (2024), https://files.hiv.gov/s3fs-public/2024-NHAS-Progress-Report.pdf ("*NHAS 2024 Report*").

[63] *Id.*

[64] *See, e.g.*, National HIV/AIDS Strategy Federal Interagency Workgroup, *National HIV/AIDS Strategy 2017 Progress Report*, at 13 (2017), https://d15z5zmc2jt7n3.cloudfront.net/s3fs-public/NHAS_Progress_Report_2017.pdf ("*NHAS 2017 Report*").

[65] *NHAS 2010 Implementation Plan*, at 41,688-89.

[66] Padamsee, at 1026.

[67] *NHAS 2015-2020 Implementation*, at 46,181.

programs across the Federal government and between Federal agencies and State, territorial, Tribal, and local governments."[68]

The 2017 updates to the NHAS produced the most robust and itemized responsibilities to DoD across 2 key goals: (1) reducing new HIV infections and once again (2) achieving a more coordinated response to the HIV epidemic,[69] including a portion of an overall interagency strategy to "[i]ntensify HIV prevention efforts in communities where HIV is most heavily concentrated" with a focus on high-risk populations including "gay, bisexual, and other men who have sex with men; Black and Latino women and men; people who inject drugs; youth aged 13 to 24 years; people in the Southern United States; and transgender women,"[70] utilize "evidence-based approaches" for educating SMLWHIV and to disseminate those by 2018,[71] and continue DoD vaccine research.[72] Although the inter-agency promise of the NHAS was dramatically impaired after the 2017 update with removal of key leaders, advisors (including ONAP), and public

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[68] *NHAS 2015 Update*, at 44-45.
[69] *NHAS 2017 Report*, at 37, 39, 43, 65.
[70] *Id.* at 37.
[71] *Id.* at 39, 43.
[72] *Id.* at 39; *see also* Nicos Karasavvas et al., *The Thai Phase III HIV Type 1 Vaccine Trial (RV144)*, 28 AIDS RSCH. HUM. RETROVIRUSES 1444, 1445 (2012) (a U.S.-military funded HIV vaccine study demonstrating the first effective prevention in humans.).

information regarding the NHAS;[73] it is clear from the related, underlying litigation (*Roe v. Austin*), during that time, the military met and exceeded goals around treatment as prevention of transmission, given evidence produced in that litigation showing a consistent, undetectable viral load rate of 99.8% or more amongst SMLWHIV.[74]

In 2021, ONAP was re-established and built upon the HIV National Strategic Plan released in January 2021 (without the leadership of ONAP).[75] The 2022-2025 Strategy, in its most expansive and delineated form yet, placed a strong emphasis on equity and integrated responses across government sectors.[76] DoD-delegated responsibilities, focusing on treatment and care, spanned all four NHAS Goals: (1) Preventing New Infections, (2) Improving HIV-Related Health Outcomes of PLWHIV, (3) Reducing HIV-Related Disparities and Health

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[73] *National HIV/AIDS Strategy*, AMERICAN ACADEMY OF HIV MEDICINE, https://aahivm.org/national-hivaids-strategy/ [https://perma.cc/ZAY5-VQAL] (In 2017, "President Trump fired all the members of the President's National HIV Advisory Council . . . [and] the White House removed all references to the National HIV/AIDS Strategy from all federal websites. President Trump [did] not appoint a new Director for the [ONAP], the entity formerly overseeing implementation of the NHAS.") (last visited July 15, 2025).

[74] Dkt. 257, Memo. Supp. Pls.' Mot. Summ. J., *Roe et al. v. Austin*, 1:18-cv-00641, at ¶¶ 57, 65 (E.D. Va., May 4, 2020).

[75] *NHAS 2022-2025*, at 67.

[76] *Id.* at 1-10.

Inequities, and (4) Achieving Integrated, Coordinated Efforts that Address the HIV Epidemic Among All Partners and Stakeholders.[77]

Specifically, DoD is responsible for preventing new infections by increasing awareness of HIV,[78] increasing the rate of people who know their status through screening,[79] and increasing uptake of prevention measures by "[e]xpand[ing] and improv[ing] implementation of safe, effective prevention interventions, including treatment as prevention . . . and develop[ing] new options."[80] DoD is also delegated responsibility for improving health outcomes for PLWHIV through mandates to link diagnosed persons to care,[81] increasing adherence to treatment for better health outcomes including reaching and maintaining undetectable viral

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[77] ONAP, *National HIV/AIDS Strategy for the United States 2022–2025: Federal Implementation Plan*, at 17, 21, 25-27, 30, 38, 40, 46-47, 50, 52 (2022), https://files.hiv.gov/s3fs-public/2022-09/NHAS_Federal_Implementation_Plan.pdf ("*NHAS Implementation Plan 2022-2025*").

[78] *Id.* at 9.

[79] *Id.* at 10-11.

[80] *Id.* at 13-14; *see also DHAPP* (military policies "address HIV testing strategies, chain of command notifications, deployments, and antiretroviral treatment initiation and retention to reflect changes in international normative guidance"); Joseph S. Cavanaugh et al., *The Purpose and Impact of the U.S. Military HIV Research Program*, 110 JOINT FORCE QUARTERLY 69 (2023), https://ndupress.ndu.edu/Portals/68/Documents/jfq/jfq-110/jfq-110_69-74_Cavanaugh-et-al.pdf?ver=FovGNZ_qXG_DaFSSh9yECg%3d%3d.

[81] *NHAS Implementation Plan 2022-2025* at 21; *see also U.S. Military HIV Research Program (MHRP)*, NIAID, https://www.niaid.nih.gov/research/military-hiv-research-program [https://perma.cc/7JJX-YNL7] (last visited July 15, 2025).

loads,[82] and increasing capacity of public health networks to support the same.[83] And critically, the DoD is responsible for addressing "social determinants of health"[84] and for working to address HIV "in the context of social and structural/institutional factors including stigma, discrimination, and violence." [85]

D. DoD's Implementation of NHAS Directives to Reduce HIV-Related Stigma and Discrimination and Improving HIV-Related Health Outcomes of PLWHIV.

In recent updates, DoD has identified two specific implementations to meet its NHAS-delated responsibilities. First, towards Goal 3: "Reduce HIV-Related Disparities and Health Inequities," the DoD reported the following in 2023:

> DOD issued a memo updating its policies on HIV-positive personnel serving within the Armed Forces in view of significant advances in the diagnosis, prevention, and treatment of HIV since the policy was established. Under the updated policies, "individuals who have been identified as HIV-positive, are asymptomatic, and who have a clinically confirmed undetectable viral load will have no restrictions applied to their deployability or to their ability to commission while a Service member solely on the basis of their HIV-positive status. Nor will such individuals be discharged or separated solely on the basis of their HIV-positive status."[86]

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[82] *NHAS Implementation Plan 2022-2025* at 25; *see also DHAPP*.

[83] *NHAS Implementation Plan 2022-2025* at 27.

[84] *Id.* at 40.

[85] *Id.* at 50.

[86] ONAP, *National HIV/AIDS Strategy 2023 Interim Action Report* at 7 (2023), https://files.hiv.gov/s3fs-public/2023-12/National-HIV-AIDS-Strategy-2023-Interim-Action-Report.pdf.

This first and only stigma- or discrimination-reducing advancement reported by the DoD followed the U.S. District Court for the Eastern District of Virginia ordering DoD to change its unconstitutional and unlawful policy towards SMLWHIV and reflected the subsequent change in DoDI regulations.[87]

And second, toward Goal 1: "Prevent New HIV Infections," the DoD reported the following in 2024:

> DOD's Defense Health Agency updated policy in March 2024 to optimize use of PrEP, supporting the health and readiness of service members. PrEP and lab services are available for all military and nonmilitary beneficiaries who are at high risk for HIV. Standardized training for health care providers and resources for patients were developed to support implementation of this policy, including provider tool kits, fact sheets, and a PrEP resource app.[88]

This recommendation is in keeping with DoD medical professional leaders' guidance for efficacy and cost-effectiveness: PrEP service delivery, immediately followed by a campaign to improve services "provides the best value . . . and it makes the most substantial contribution to the national objective of 90% reduction in HIV incidence by 2030."[89]

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[87] Memorandum from Secretary of Defense Lloyd Austin to Senior Pentagon Leadership at 1 (June 6, 2022), https://media.defense.gov/2022/Jun/07/2003013398/-1/-1/1/POLICY-REGARDING-HUMAN-IMMUNODEFICIENCY-VIRUS-POSITIVE-PERSONNEL-WITHIN-THE-ARMED-FORCES.PDF.

[88] *NHAS 2024 Report*, at 6.

[89] James Mancuso et al., *Improving HIV PrEP Implementation to Help End the HIV Epidemic in the U.S. Military*, HEALTH.MIL (Oct. 1, 2024),

III. Denying Accession to Civilians Living with HIV Irrationally Impairs Military Interests and is Arbitrary and Capricious.

Where, as here, a government department is charged with meeting outcomes that are inhibited by its own policies and practices, those polices are arbitrary, capricious, and irrational.[90] As discussed above, Defendants-Appellants are charged with various responsibilities to reduce stigma, increase access to care, increase HIV-related health-outcomes, and address historical discrimination and violence. It is at odds with those duties to uphold a policy or practice that inscribes discrimination against this historically marginalized group.

Denying accession to civilians living with HIV is contrary to ending HIV-related stigma and discrimination. As acknowledged by NHAS, "HIV rates . . . disproportionately affect[] African Americans, Latinos, people who live in the American South, and, increasingly, those who are 25 to 34 years old—all groups highly represented in the military."[91] A reinstitution of the appointment and

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https://health.mil/News/Articles/2024/10/01/MSMR-HIV-PrEP-Guest-Editorial?type=Fact+Sheets.

[90] *See Wilkins*, 745 F. Supp. 3d at 398-99 (describing the HIV accessions bar as "puzzling" and "irrational, arbitrary, and capricious," and that "[e]ven worse, [the bar] contribute[s] to the ongoing stigma surrounding HIV-positive individuals while actively hampering the military's own recruitment goals."); *see also Univ. of Texas M.D. Anderson Cancer Ctr. v. United States Dep't of Health & Hum. Servs.*, 985 F.3d 472, 475 (5th Cir. 2021) (under arbitrary-and-capricious review an agency must "examine [] relevant data" and not "entirely fail[] to consider an important aspect of the problem that it seeks to address" (internal citations omitted)).

[91] Cavanaugh et al., at 71.

enlistment bar would frustrate the NHAS goal of addressing those disparities, and would arbitrarily, capriciously, and irrationally deprive the military of otherwise qualified service members to meet its readiness goals.[92] It is similarly arbitrary, capricious, and irrational, and reeks of retrenchment to ages past of discrimination on the basis of misinformed notions that only certain populations are at risk,[93] for the DoDI 6130.03 to treat accessions candidates living with HIV distinctly from each other based on whether they are "covered personal."[94] When SMLHIV have served honorably and taken substantial risks to do so, it is arbitrary, capricious, and irrational to mark similarly situated persons unfit for enlistment and appointment.[95] Further, it would establish another instance in which the U.S. military policy is out-of-step with that of other wealthy nations regarding HIV policy,[96] namely the U.K., France, Israel, and Australia.[97]

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[92] *Wilkins*, 745 F. Supp. 3d at 298-99.

[93] *Supra* at 8-9.

[94] DoDI 6130.03 §§ 1.2, 6.23.

[95] *See Roe*, 947 F.3d at 231 (discussing SMLWHIV who had "served their country, collectively earning accolades, promotions, the trust of their commanding officers, and the respect of their fellow servicemembers" to underscore "the public interest in their continued service," which was supported by former-military-official amici who stated "[i]t is more damaging to military readiness to deny those service members the opportunity to deploy where they are needed.").

[96] *See supra* at 15.

[97] *See* Ministry of Defense, *Final barriers removed for Armed Forces personnel with HIV*, GOV.UK (June 21, 2022), https://www.gov.uk/government/news/final-barriers-removed-for-armed-forces-personnel-with-hiv; *Defence minister says HIV-positive people are now allowed to*

Denying accession to civilians living with HIV is contrary to science and improving HIV-related health outcomes of PLWHIV and people at risk for HIV. This Court has acknowledged the advances in HIV medical science—since the time the underlying policy was implemented[98]—which demand a continuation of the eleven months of open accessions for PLWHIV. The DoD's ability to meet its NHAS treatment responsibilities and its own mandates for SMLWHIV indicate that accepting new recruits living with HIV will enhance goals of increasing knowledge of one's status, maintaining treatment, maintaining viral suppression, and reducing stigma[99]—which is known to positively impact all treatment and prevention measures.[100] The coordinated, whole-government response and interdependent accountability under the NHAS is key to our nation ending the epidemic. The DoD mustn't be permitted to regress its scientifically-supported steps toward improving the health care outcomes of PLWHIV and reducing HIV-

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join French army, RFI (Sept. 5, 2023), https://www.rfi.fr/en/france/20230509-defence-minister-says-hiv-positive-people-are-now-allowed-to-join-french-army; Tia Goldenberg, *Israel to begin enlisting HIV-positive soldiers*, AP (Dec. 1, 2015), https://apnews.com/article/-----e94161065968408194ff02ace6990d28; *Statement on Australian Defence Force HIV Policy Reform*, NAPWHA (June 13, 2024), https://napwha.org.au/statement-on-australian-defence-force-hiv-policy-reform/.

[98] *Roe*, 947 F.3d at 228 (describing the same scientific arguments put forth in this matter as "obsolete understandings" "at odds with current science.")

[99] *Supra* at 20-25.

[100] Julie Pulerwitz, et al. *Reducing HIV-Related Stigma*, 125 PUB. HEALTH REP. 272, 279 (2010).

related stigma and discrimination, when it has been delegated responsibility for those very outcomes.

CONCLUSION

In reviewing the district court's permanent injunction and order, the Court should take account of DoD's delegated responsibilities in a whole-government approach to ending the HIV epidemic and reducing stigma, as well as the advances in medical science this court has already held outweighed rationale behind other military policy barring service by otherwise qualified people living with HIV and affirm.

Dated: July 16, 2025

Respectfully submitted,

/s/ Kara N. Ingelhart
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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 6,487 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Word for Microsoft 365 in Times New Roman 14-point font, a proportionally spaced typeface.

/s/ Kara N. Ingelhart
Kara N. Ingelhart

UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

DISCLOSURE STATEMENT

- In civil, agency, bankruptcy, and mandamus cases, a disclosure statement must be filed by **all** parties, with the following exceptions: (1) the United States is not required to file a disclosure statement; (2) an indigent party is not required to file a disclosure statement; and (3) a state or local government is not required to file a disclosure statement in pro se cases. (All parties to the action in the district court are considered parties to a mandamus case.)
- In criminal and post-conviction cases, a corporate defendant must file a disclosure statement.
- In criminal cases, the United States must file a disclosure statement if there was an organizational victim of the alleged criminal activity. (See question 7.)
- Any corporate amicus curiae must file a disclosure statement.
- Counsel has a continuing duty to update the disclosure statement.

No. 24-2079 Caption: Wilkins et al. v. Hegseth et al.

Pursuant to FRAP 26.1 and Local Rule 26.1,

Center for HIV Law and Policy
(name of party/amicus)

who is amicus, makes the following disclosure:
(appellant/appellee/petitioner/respondent/amicus/intervenor)

1. Is party/amicus a publicly held corporation or other publicly held entity? ☐ YES ☑ NO

2. Does party/amicus have any parent corporations? ☐ YES ☑ NO
If yes, identify all parent corporations, including all generations of parent corporations:

3. Is 10% or more of the stock of a party/amicus owned by a publicly held corporation or other publicly held entity? ☐ YES ☑ NO
If yes, identify all such owners:

4. Is there any other publicly held corporation or other publicly held entity that has a direct financial interest in the outcome of the litigation? ☐YES ☑NO
If yes, identify entity and nature of interest:

5. Is party a trade association? (amici curiae do not complete this question) ☐YES ☑NO
If yes, identify any publicly held member whose stock or equity value could be affected substantially by the outcome of the proceeding or whose claims the trade association is pursuing in a representative capacity, or state that there is no such member:

6. Does this case arise out of a bankruptcy proceeding? ☐YES ☑NO
If yes, the debtor, the trustee, or the appellant (if neither the debtor nor the trustee is a party) must list (1) the members of any creditors' committee, (2) each debtor (if not in the caption), and (3) if a debtor is a corporation, the parent corporation and any publicly held corporation that owns 10% or more of the stock of the debtor.

7. Is this a criminal case in which there was an organizational victim? ☐YES ☑NO
If yes, the United States, absent good cause shown, must list (1) each organizational victim of the criminal activity and (2) if an organizational victim is a corporation, the parent corporation and any publicly held corporation that owns 10% or more of the stock of victim, to the extent that information can be obtained through due diligence.

Signature: /s/ Kara N. Ingelhart Date: 7/16/25

Counsel for: Center for HIV Law and Policy

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No. 24-2079 Caption: Wilkins et al. v. Hegseth et al.

Pursuant to FRAP 26.1 and Local Rule 26.1,

National Alliance of State & Territorial AIDS Directors ("NASTAD")
(name of party/amicus)

who is amicus, makes the following disclosure:
(appellant/appellee/petitioner/respondent/amicus/intervenor)

1. Is party/amicus a publicly held corporation or other publicly held entity? ☐ YES ☑ NO

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Signature: /s/ Kara N. Ingelhart Date: 7/16/25

Counsel for: NASTAD

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No. 24-2079 Caption: Wilkins et al. v. Hegseth et al.

Pursuant to FRAP 26.1 and Local Rule 26.1,

American Civil Liberties Union
(name of party/amicus)

who is amicus, makes the following disclosure:
(appellant/appellee/petitioner/respondent/amicus/intervenor)

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Signature: /s/ Kara N. Ingelhart Date: 7/16/25

Counsel for: American Civil Liberties Union

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No. 24-2079 Caption: Wilkins et al. v. Hegseth et al.

Pursuant to FRAP 26.1 and Local Rule 26.1,

American Civil Liberties Union of Virginia
(name of party/amicus)

who is amicus, makes the following disclosure:
(appellant/appellee/petitioner/respondent/amicus/intervenor)

1. Is party/amicus a publicly held corporation or other publicly held entity? ☐ YES ☑ NO

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Signature: /s/ Kara N. Ingelhart Date: 7/16/25

Counsel for: ACLU of Virginia

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No. 24-2079 Caption: Wilkins et al. v. Hegseth et al.

Pursuant to FRAP 26.1 and Local Rule 26.1,

Whitman-Walker Clinic, Inc.
(name of party/amicus)

who is amicus, makes the following disclosure:
(appellant/appellee/petitioner/respondent/amicus/intervenor)

1. Is party/amicus a publicly held corporation or other publicly held entity? ☐ YES ☑ NO

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Signature: /s/ Kara N. Ingelhart Date: 7/16/25

Counsel for: Whitman-Walker Clinic, Inc.

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UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

DISCLOSURE STATEMENT

- In civil, agency, bankruptcy, and mandamus cases, a disclosure statement must be filed by **all** parties, with the following exceptions: (1) the United States is not required to file a disclosure statement; (2) an indigent party is not required to file a disclosure statement; and (3) a state or local government is not required to file a disclosure statement in pro se cases. (All parties to the action in the district court are considered parties to a mandamus case.)
- In criminal and post-conviction cases, a corporate defendant must file a disclosure statement.
- In criminal cases, the United States must file a disclosure statement if there was an organizational victim of the alleged criminal activity. (See question 7.)
- Any corporate amicus curiae must file a disclosure statement.
- Counsel has a continuing duty to update the disclosure statement.

No. 24-2079 Caption: Wilkins et al. v. Hegseth et al.

Pursuant to FRAP 26.1 and Local Rule 26.1,

Community Resource Initiative
(name of party/amicus)

who is amicus, makes the following disclosure:
(appellant/appellee/petitioner/respondent/amicus/intervenor)

1. Is party/amicus a publicly held corporation or other publicly held entity? ☐ YES ☑ NO

2. Does party/amicus have any parent corporations? ☐ YES ☑ NO
If yes, identify all parent corporations, including all generations of parent corporations:

3. Is 10% or more of the stock of a party/amicus owned by a publicly held corporation or other publicly held entity? ☐ YES ☑ NO
If yes, identify all such owners:

4. Is there any other publicly held corporation or other publicly held entity that has a direct financial interest in the outcome of the litigation? ☐YES ☑NO
If yes, identify entity and nature of interest:

5. Is party a trade association? (amici curiae do not complete this question) ☐YES ☑NO
If yes, identify any publicly held member whose stock or equity value could be affected substantially by the outcome of the proceeding or whose claims the trade association is pursuing in a representative capacity, or state that there is no such member:

6. Does this case arise out of a bankruptcy proceeding? ☐YES ☑NO
If yes, the debtor, the trustee, or the appellant (if neither the debtor nor the trustee is a party) must list (1) the members of any creditors' committee, (2) each debtor (if not in the caption), and (3) if a debtor is a corporation, the parent corporation and any publicly held corporation that owns 10% or more of the stock of the debtor.

7. Is this a criminal case in which there was an organizational victim? ☐YES ☑NO
If yes, the United States, absent good cause shown, must list (1) each organizational victim of the criminal activity and (2) if an organizational victim is a corporation, the parent corporation and any publicly held corporation that owns 10% or more of the stock of victim, to the extent that information can be obtained through due diligence.

Signature: /s/ Kara N. Ingelhart Date: 7/16/25

Counsel for: Community Resource Initiative

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Pursuant to FRAP 26.1 and Local Rule 26.1,

SERO Project
(name of party/amicus)

who is amicus, makes the following disclosure:
(appellant/appellee/petitioner/respondent/amicus/intervenor)

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Signature: /s/ Kara N. Ingelhart Date: 07/16/2025

Counsel for: SERO Project

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