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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

ARGHAVAN SALLES; ABIGAIL HATCHER; ANDREA ROSSO; ANN D. COHEN-WILSON; DOLORES ALBARRACÍN; HEIDI MOSESON; JADE PAGKAS-BATHER; JONATHAN KYLE DAW; KATIE EDWARDS; KELTON MINOR; MICHAEL D. GREEN; SARA JACKSON; SUZANNE BELL; JORDAN DOE 1; JORDAN DOE 2; JORDAN DOE 3; and JORDAN DOE 4, *on behalf of themselves and all others similarly situated,*

Plaintiffs,

v.

NATIONAL INSTITUTES OF HEALTH; JAY BHATTACHARYA, *in his official capacity as Director of the National Institutes of Health*; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY, JR., *in his official capacity as Secretary of the United States Department of Health and Human Services*; and UNITED STATES DOGE SERVICE,

Defendants.

Case No. 3:26-cv-10510-SK

DECLARATION OF JONATHAN KYLE DAW

* Application for *Pro Hac Vice* Admission Forthcoming
** Out-of-State Licensee Renewal Pending

(Additional Counsel on Behalf of Plaintiffs)

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* Application for *Pro Hac Vice* Admission Forthcoming

I, Jonathan Kyle Daw, declare:

1. I have personal knowledge of the facts set forth in this declaration, and if called to testify as a witness thereto, could do so competently under oath.

2. I am a Professor of Sociology and Demography at the Pennsylvania State University. Broadly speaking, my research focuses on how demographic, inequality, and biological processes combine to influence health and well-being. The main focus of my research currently is to study the causes of racial and ethnic disparities in kidney disease, kidney failure, treatments for kidney failure, and kidney failure patient mortality.

3. I offer this declaration in my individual capacity and not on behalf of my employer.

4. I earned a B.A. in Sociology and Government in 2005 at the University of Texas at Austin. I then earned my M.A. (in 2007) and Ph.D. (in 2011) in Sociology from the University of North Carolina – Chapel Hill.

5. Before working at Penn State, I was an Assistant Professor of Medical Sociology at the University of Alabama – Birmingham. Prior to that, I completed my postdoctoral fellowship at the Institute of Behavioral Science and the Institute for Behavioral Genetics at the University of Colorado – Boulder.

6. I am the author of over 40 peer-reviewed scientific publications, published in many top medical and sociology journals, including the *American Journal of Transplantation*, *Clinical Transplantation*, *Kidney Medicine*, *Transplant Immunology*, *Progress in Transplantation,* the *American Journal of Public Health*, the *American Journal of Preventive Medicine*, *Proceedings of the National Academies of Sciences,* the *American Journal of Sociology*, the *Journal of Health & Social Behavior*, and *Social Science & Medicine*.

7. My interest in the social determinants of kidney disease and transplantation research developed throughout my academic training. During that training, I realized that health research—and in particular, research around kidney transplantation—layered together my interests in things like family dynamics, genetics, and social outcomes. And what I observed throughout my time as a researcher is that there are huge disparities between racial and ethnic groups when it comes to kidney disease, kidney failure, kidney failure treatments, and kidney failure patient mortality.

8. Institutional grantees are the entities that host the research and receive award and funding from the National Institutes of Health (NIH), and are generally universities, hospitals, and sometimes non-profits and other entities. Awards also name one or more Principal Investigators, who are researchers directly responsible for proposing the projects, overseeing the design and implementation of studies, and managing the research from the application stage through the end of a grant. In 2022, the National Institute of Diabetes and Digestive and Kidney Diseases at the NIH awarded a four-year R01 grant for which I was the Principal Investigator. The grant number for that award is R01DK132953, and the project is titled, "The Impact of Structural Racism on Racial/Ethnic Disparities in End-Stage Kidney Disease from Healthy Population to Mortality."

9. The goal of this project was to understand why there are racial and ethnic disparities in kidney failure, kidney failure treatment receipt, and kidney failure patient mortality. Our hypothesis, based on decades of theoretical and empirical research by our team and many others, was that structural racism is a key driver of racial and ethnic disparities in these critical outcomes. In our view, structural racism is best measured by examining area racial/ethnic disparities in key life outcomes, such as earning a college degree, owning a home, being incarcerated, having health insurance, and living in poverty. A key goal of the project was to construct the most comprehensive database of structural racism indicators ever constructed, with the aim to construct a structural racism index comprised of 8 different race/ethnicity-specific indicators on five different racial/ethnic groups at the county level over a 30-year time span. Assembling and cleaning this database and using it to construct our structural racism indices for each racial/ethnic comparison in each time period has constituted the bulk of our efforts on this project to date, and the final steps in this process are currently finally being completed.

10. Attached hereto as Exhibit 1 is a true and correct copy of this R01 grant's original Notice of Award ("NOA").

11. The grant application did not come together overnight. I started developing the application for this grant back in 2018, collaborating with a graduate student in my department at the time. The work included a broad review of literature, assessing the data sources available to us, and preliminary data analysis. All that, along with collaborating with other researchers to draft and

repeatedly revise the application materials in preparation for submission, cumulatively took hundreds of hours over almost three years.

12. A few months after the grant was awarded, I applied for a diversity supplement to the award. The goal of this diversity supplement was to mentor and collaborate with a researcher whose background had been in public policy, so that she could assist with the research funded through the original grant and eventually propose her own kidney disease-related projects.

13. NIH awarded that diversity supplement on August 18, 2023. Attached hereto as Exhibit 2 is a true and correct copy of the original NOA of this diversity supplement.

14. Until May 2025, we submitted annual progress reports and sought non-competitive renewal for these grants without any concerns raised by NIH officials regarding this project.

15. But on May 1, 2025, a colleague at Penn State informed me by email that NIH had terminated the diversity supplement grant. NIH had issued a revised NOA for this grant, listing an end date of April 29, 2025. Attached hereto as Exhibit 3 is a true and correct copy of the revised NOA of this diversity supplement. Later that day, that same colleague informed me by email that NIH had terminated the parent R01 grant. NIH had issued a revised NOA for this grant, listing an end date of April 30, 2025. Attached hereto as Exhibit 4 is a true and correct copy of the revised NOA of this grant.

16. The revised NOAs provided no individualized explanation for why the grants were canceled, and both fail to discuss the grant application, progress reports, or other related materials. The project was proceeding well, and the project's annual progress reports had never prompted questioning or reduction in funds from the NIH prior to this termination.

17. Instead, NIH provided the following statement for the termination:

> It is the policy of NIH not to prioritize research programs related to DEI: Research programs based primarily on artificial and non-scientific categories, including amorphous equity objectives, are antithetical to the scientific inquiry, do nothing to expand our knowledge of living systems, provide low returns on investment, and ultimately do not enhance health, lengthen life, or reduce illness. Worse, so-called diversity, equity, and inclusion ("DEI") studies are often used to support unlawful discrimination on the basis of race and other protected characteristics, which harms the health of Americans. Therefore, it is the policy of NIH not to prioritize such research programs.

Ex. 3 at 6; Ex. 4 at 6.

18. Prior to the termination, we had made significant progress in this project. In addition to the work noted above constructing the structural racism database, we had regularly held meetings of a community advisory board based in Pittsburgh, Pennsylvania and Baltimore, Maryland, when we met with a group of community members to talk about our research findings, connect that research to the lived experiences of those individuals as patients and as community advocates, and learn from those experiences to inform our own research. This work has thus far resulted in two research manuscripts, one (Corradi *et al.*, "Development and Integration of Community Advisory Boards to Inform Research on the Impact of Structural Racism on Racial/Ethnic Disparities in End-Stage Kidney Disease") published in *Health Expectations*, and the other (Corradi *et al.*, "On the Back Burner: Lived Experiences of Structural Racism and End-Stage Kidney Disease") presently under review at a peer-reviewed journal. We also published descriptive analyses comparing the treatment histories of young kidney failure patients by race/ethnicity in *Kidney Medicine* (Pessin *et al.* 2026, "Kidney Replacement Therapy Sequences: Racial/Ethnic Disparities in End-Stage Kidney Disease Patients' 10-Year Treatment Histories"). Finally, we have presented several conference papers developed based on preliminary versions of the structural racism index and associated health disparities, including the following: "County-Level Structural Racism Predicts Black-White End-Stage Kidney Disease Patient Mortality Disparities" at the 2023 American Society of Nephrology conference, "County-Level Structural Racism and the Black-White Gap in End-Stage Renal Disease Incidence" at the 2024 Population Association of American conference, "County-Level Structural Racism Measures Beyond Black and White" at the 2025 Population Association of America conference, and "County-Level Structural Racism and Mortality Rates Among Non-Hispanic White, Non-Hispanic Black, and Hispanic Populations" at the 2025 Population Association of America conference. This work supports our project's hypothesis that racial/ethnic disparities in kidney disease incidence and mortality are worsened in counties characterized by higher levels of structural racism (as measured by our index).

19. Unfortunately, the grant's termination substantially slowed and in some instances even stalled the project's progress. Following the termination, our research team sought replacement funding from the Pennsylvania State University Social Science Research Institute (PSU SSRI) and other potential funding sources, and applications for those alternative funding sources took dozens of hours

during that could not be used to conduct research related to this grant. Eventually, we did receive some funding from PSU SSRI, for which we were very grateful, but those funds were able to cover only a small percentage of the funds lost due to termination. In addition, leading up to the termination, we were pursuing further data collection, refinement, and analysis before submitting further publications. That takes a lot of time and labor. But because members of the research team lost funding from this grant to directly support this research, some of those members had to spend more of their time on responsibilities outside of the research itself, such as teaching more or taking on other non-research responsibilities at their institution. What's more, to gather and analyze data for our database, we needed a programmer dedicated to that task, but for one month prior to receiving the PSU SSRI funds we were unable to secure one because of a lack of funding resulting from this termination, and although we were eventually able to secure one, our work has been delayed as a result. As such, the research has continued at a much slower pace, meaning that the medical community and the broader public have been delayed in benefiting from the findings and recommendations of our research.

20. Prior to the grant termination, we had been scheduled to hold two more meetings of the Community Advisory Board, but those have not been held because of the termination. Due to this long period of disengagement, lost information sharing, and trust, it is unclear if we will be able to reconvene the same group in the future even if the funds are restored.

21. The delay in our research has slowed down our ability to demonstrate results from our research, limiting the competitiveness of future grant applications from my colleagues who are also working on this project and me. In addition, I have had to forego attending several medical conferences because of a lack of sufficient funding. Our team's inability to attend these important medical conferences limits our ability to keep up with the latest research presented at these conferences which is often not yet published, limits our ability to share our work with our peers working on similar topics, and limits our ability to network and establish new projects and collaborations with those peers, as conferences are often places where new ideas for grant applications or research collaborations germinate.

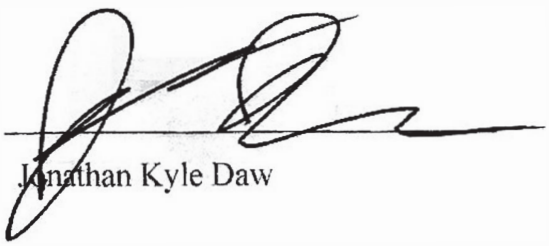
22. Given these terminations, and my understanding that research related to my grant is disfavored under NIH's current policies, I do not believe it is worthwhile to submit new grants studying

the impact of structural racism on racial/ethnic health disparities while the present administration is in power. This unfortunate situation is a loss not only for my team and myself, but also the broader medical community and for public health, as research like that supported by this grant—that is, trying to discern why different groups of people experience kidney disease and failure at different rates, with different treatments, and different mortality outcomes—is critical not only to achieving NIH's mission, but also to making sure we have a healthier society. As an expert in population health, I know that the large health disparities observed in our population by race/ethnicity, gender, socioeconomic status, and geography substantially account for the large gaps between U.S. life expectancy and disease burden and those of other wealthy and many middle-income countries, so this work could not be more essential to U.S. public health.

23. Restoring this grant would be a huge benefit to our research efforts and to the broader public health. That restoration would allow us to provide funding for our team members to spend more time on research relating to this project. That in turn would allow us to process and analyze data more quickly, as well as to produce publications at a faster rate, which would in turn allow us to distribute our findings more quickly than without this funding.

24. I understand that, as a class representative, I represent the interests of everyone in the class, and not just myself. I am prepared to stay informed about what is happening with my case and stay in touch with my attorneys to give them information they need. I am committed to being a class representative because I do not want other researchers to be subjected to the same unlawful policies and actions that I have experienced. I have never served as a class representative in any prior action.

I declare under penalty of perjury that the foregoing is true and correct, and that this declaration was executed at State College, Pennsylvania this 21st day of September 2026.



Jonathan Kyle Daw