

AMERICAN CIVIL LIBERTIES UNION FOUNDATION

OLGA AKSELROD (NY Bar No. 4132825) (Appearance *Pro Hac Vice*)

oakselrod@aclu.org

VERA EIDELMAN (CA Bar No. 308535)**

veidelman@aclu.org

RACHEL MEEROPOL (NY Bar No. 4100954) (Appearance *Pro Hac Vice*)

rmeeropol@aclu.org

ALEXIS AGATHOCLEOUS (NY Bar No. 4227062)*

aagathocleous@aclu.org

125 Broad Street, 18th Floor

New York, NY 10004

Telephone: (212) 549-2659

Attorneys for Plaintiffs

(Additional Counsel on Following Page)

**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
ANDREA ROSSO**

* Application for *Pro Hac Vice* Admission Forthcoming

** Out-of-State Licensee Renewal Pending

(Additional Counsel on Behalf of Plaintiffs)

**AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF NORTHERN CALIFORNIA**

GRAYCE ZELPHIN (CA Bar No. 279112)

gzelphin@aclunc.org

CHESSIE THACHER (CA Bar No. 296767)

cthacher@aclunc.org

NEIL K. SAWHNEY (CA Bar No. 300130)

nsawhney@aclunc.org

39 Drumm Street

San Francisco, CA 94111

Telephone: (415) 621-2493

PROTECT DEMOCRACY PROJECT

SHALINI AGARWAL (DC Bar No. 990963) (Appearance *Pro Hac Vice*)

shalini.agarwal@protectdemocracy.org

2020 Pennsylvania Avenue, NW, Suite 163

Washington, DC 20006

KENNETH PARRENO (TX Bar No. 24130477)*

kenneth.parreno@protectdemocracy.org

15 Main Street, Suite 312

Watertown, MA 02472

Telephone: (202) 579-4582

CENTER FOR SCIENCE IN THE PUBLIC INTEREST

LISA S. MANKOFSKY (DC Bar No. 411931) (Appearance *Pro Hac Vice*)

lmankofsky@cspi.org

OSCAR HEANUE (DC Bar No. 90036939) (Appearance *Pro Hac Vice*)

oheanue@cspi.org

1250 I Street, NW, Suite 500

Washington, DC 20005

Telephone: (202) 777-8381

JACOBSON LAWYERS GROUP PLLC

DANIEL F. JACOBSON (DC Bar No. 1016621)*

dan@jacobsonlawyersgroup.com

LYNN D. EISENBERG (DC Bar No. 1017511) (Appearance *Pro Hac Vice*)

lynn@jacobsonlawyersgroup.com

STEPHEN K. WIRTH (DC Bar No. 1034038) (Appearance *Pro Hac Vice*)

stephen@jacobsonlawyersgroup.com

5100 Wisconsin Avenue, NW, Suite 301

Washington, DC 20016

Telephone: (301) 823-1148

* Application for *Pro Hac Vice* Admission Forthcoming

1 I, Andrea Rosso, declare:

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

4 2. My name is Andrea L. Rosso.

5 3. I am offering this declaration in my individual capacity and not on behalf of my
6 employer.

7 4. I am a tenured Associate Professor in the Department of Epidemiology at the University
8 of Pittsburgh, where I also lead the Brain, Environment, Aging, and Mobility (BEAM) lab. My research
9 aims to improve the physical and cognitive function of older adults, reduce disability, and help
10 individuals stay independent in their communities.

11 5. I earned my MPH (2007) and PhD (2012) in Epidemiology from Drexel University. I
12 completed postdoctoral work from 2012-2014 in Epidemiology of Aging/Neuroepidemiology at the
13 University of Pittsburgh.

14 6. I have published widely in my field, including over 100 peer-review articles in
15 publications such as *Neurology*; *Alzheimer's & Dementia*; *American Journal of Epidemiology*;
16 *NeuroImage/NeuroImage: Clinical*; *Journal of Gerontology: Medical Sciences*; and *Journal of the*
17 *American Geriatrics Society*.

18 7. I have been recognized with several honors in my field at the national level. I was named
19 a fellow of the Gerontological Society of America in 2024, was inducted as a member of the Delta
20 Omega Honors Society in Public Health in 2022, and was awarded multiple Loan Repayment Program
21 awards from the National Institutes of Health. I have also received awards for research and mentoring
22 from the University of Pittsburgh and for excellence in peer reviewing from the *Journal of Gerontology:*
23 *Medical Sciences*.

24 8. I have served as the Principal Investigator, Multiple Principal Investigator, or Program
25 Project Director on multiple grants from the National Institutes of Health, specifically the National
26 Institute on Aging (NIA), including:

- 27 • R01 AG057671: *Restoring Central Motor Control to Improve Community Mobility of*
28 *Older Adults*;

- K01 AG053431: *Environmental Challenges and the Aging Brain: Implications for Community Mobility*;
- R21 AG054666: *Cognitive Decline, Brain Aging, Physical Environment, and Mobility*; and
- KL2 TR000146: *Neural Mechanisms of Community Mobility in Older Adults*.

9. I have been conducting research on neighborhood conditions and aging since my PhD training. Through this work, it became apparent to me that due to the legacies of racist practices such as redlining, White flight, and blockbusting that studies of neighborhood quality in relation to health outcomes in the US are inextricably linked with racial inequities in health. I have been committed to ensuring that my research includes those from under-represented backgrounds, such as those living in lower-income, African American neighborhoods, as this is critical for meeting the principle of justice as outlined in the Belmont report on ethical research involving human subjects and in the validity of research findings as applied to these communities. Without representative samples, we risk producing scientific findings with limited usefulness in the real world. I was approached by a team of other researchers in 2017 to expand an ongoing NIH-funded study in two African American neighborhoods in Pittsburgh to assess cognitive aging and dementia outcomes. I saw this as an important opportunity to expand the scope of cognitive aging research where this population has been underrepresented.

10. NIH grant applications are incredibly demanding. Preparing one can take months or even years. Proposals are lengthy and must make a compelling case that the health issue being studied is urgent and scientifically significant. Applicants must prove that their proposed methods are the best possible approach to solve the problem. They must also demonstrate that their team is uniquely qualified. Every application undergoes rigorous peer review by experts, and funding rates are low—especially for R01 grants, where many researchers apply multiple times before ever being funded. Securing a grant is not just about money—it indicates a project’s scientific importance, methodological rigor, and real-world potential to improve public health. In addition, grant cycles are 5 years long and don’t always align with a single administration. It is impossible to predict future agency priorities at the time of grant submission or even earlier at the time of idea conception and development.

11. In 2022, my institution was awarded a five-year R01 NIA grant for which I am a multiple principal investigator, along with two other researchers. The grant is titled *Longitudinal Examination of Neighborhood Disadvantage, Cognitive Aging, and Alzheimer's Disease Risk in Disinvested, African American Neighborhoods* (5R01AG072652), which had a project term of Feb. 15, 2022 through January 31, 2027, and built upon our research team's previous NIH-funded studies.

12. African Americans (AAs) have significantly higher rates and earlier onset of Alzheimer's Disease and related dementias (ADRD) relative to White Americans; however, we lack a thorough understanding of how the individual lived experience of being AA, including exposures stemming from structural racism, contributes to elevated ADRD risk. This project focused on two predominantly AA neighborhoods in Pittsburgh and included cognitive assessments, additional assessments of blood pressure and sleep, assessments of life and residential history, and qualitative interviews to reveal opportunities and barriers experienced by AAs in achieving optimal cognitive health in late life. This project built upon the team's existing, community-based research infrastructure to examine the impact of changing neighborhood conditions and the role of risk and protective factors, including biomedical factors such as hypertension, poor sleep and depressive symptoms, in the lived experience of AAs and their influence on cognitive function and ADRD risk.

13. Attached hereto as **Exhibit 1 is a true and correct copy of this** R01 grant's initial Notice of Award (i.e., NOA).

14. Based on findings from our early data, we published nearly a dozen articles about our research in journals including *Journal of Racial and Ethnic Health Disparities*, *Journal of Community Psychology*, *Sleep Health*, *Sleep Medicine*, *Housing Policy Debate*, *The Journals of Gerontology: Medical Sciences*, *Alzheimer's & Dementia*, *Journal of Urban Health*, *BMC Public Health*, and *Journal of Alzheimer's Disease*.

15. I have also presented our findings in oral presentations at national and international conferences including the Gerontological Society of America, the Alzheimer's Association International Conference, and an invited plenary session at the Interdisciplinary Association for Population Health Science.

1 16. In 2025, I became aware of a number of grants terminated by NIH on the basis that they
2 were not aligned with the agency's new priorities insofar as they promoted DEI, gender identity, and
3 other concepts disfavored by the administration. Based on the types of grants that were terminated, I
4 became concerned that NIH might determine that our project—which studied Alzheimer's disease risk
5 in a predominantly African American neighborhood—would be deemed by NIH to promote DEI.

6 17. As we approached the fifth year of grant funding and had to submit an annual report on
7 the progress of the grant, in order to ensure that funding for our work was not disrupted, we reached out
8 to our NIH program officer to submit revised language as to the aims of the grant to preemptively try to
9 more clearly align with NIH priorities. While we kept language about the elevated risk of Alzheimer's
10 Disease and related dementias for African Americans, we changed the framing from talking about
11 structural racism to talking about socioeconomic disadvantage. We included this revised language in our
12 annual report that was submitted to NIH.

13 18. We never received a response to the modified aims we proposed.

14 19. When the funds from NIH for the fifth year of our grant which we were supposed to
15 receive by February 1, 2026 were delayed, we became concerned that our grant was being held up
16 because of the agency's process of re-evaluating grants for alignment with new priorities. When we
17 reached out to our NIH program officer in February and April of 2026, they confirmed that our grant
18 was still under review by the grants management office. We also learned from a conversation with the
19 grants management specialist that the PO and grants management office had already signed off on our
20 grant but that it was nonetheless being held.

21 20. Then, on May 27, through our institution, we submitted revised language for our title,
22 abstract, and narrative—the public-facing parts of our grant—that we believed would align with NIH's
23 new priorities and survive its censorship screening. Specifically, we removed references to African
24 Americans, discrimination, lived experiences, disinvested communities, neighborhood segregation,
25 racial disparities, and structural racism, replacing these with language about low-socioeconomic status
26 and economic disadvantage. So, for example, we proposed changing our title from *Longitudinal*
27 *Examination of Neighborhood Disadvantage, Cognitive Aging, and Alzheimer's Disease Risk in*
28 *Disinvested, African American Neighborhoods* to *Longitudinal Examination of Neighborhoods,*

1 *Cognitive Aging, and Alzheimer's Disease Risk*. And we changed language in the abstract similarly,
2 from "Although prior research has made significant contributions to our understanding of racial
3 disparities in ADRD, we still lack a comprehensive understanding of how the individual lived
4 experience of being AA, including cumulative exposure to structural racism, contributes to elevated
5 ADRD risk and the potential mechanisms underlying those risks" to "Although prior research has made
6 significant contributions to our understanding of socioeconomic differences in ADRD, we still lack a
7 comprehensive understanding of how individual risk factors contribute to elevated ADRD risk and the
8 potential mechanisms underlying those risks." Although we had misgivings about these changes and
9 how they distorted the characterization of what we were actually studying, we proceeded with them in
10 order to ensure our grant funding continued.

11 21. However, NIH staff never responded substantively to our requests to renegotiate the
12 language of the grant.

13 22. Instead, we received a response the following day that the award was under
14 administrative review at NIH, that there was no update or timeline for completion, and that there was no
15 further action required from us.

16 23. The following month, on June 20, 2026, we received a new NOA which included
17 language that had not been in our prior NOAs indicating that the award "may also otherwise be
18 terminated, to the extent authorized by law, if the agency determines that the award no longer effectuates
19 program goals or agency priorities." Attached hereto as **Exhibit 2 is a true and correct copy of this**
20 updated NOA.

21 24. This was alarming as we had the suspicion that NIH would conclude our award was not
22 currently in alignment with agency priorities because of its focus on individuals in disinvested African
23 American neighborhoods and use of terms such as "structural racism" throughout the grant and in the
24 public facing language. We were aware of other grants being terminated in 2025 with similar focus and
25 others being asked to renegotiate language. Indeed, that was why we had made several efforts to update
26 the grant language, without success.

27 25. Then, on August 4, 2026, we received a letter from the NIH stating that the grant had
28 been terminated "because the project no longer effectuates NIH's priorities, as reflected in the August

1 15, 2025, Director’s Priorities Statement.” Attached hereto as **Exhibit 3 is a true and correct copy of**
2 **this** termination letter.

3 26. Specifically, the letter highlighted the grant’s definition of “structural racism” as
4 “residential segregation, inequitable distribution of resources, and community disruption,” as “unclear.”
5 Our neighborhood measures which we characterize as a product of historical structural racism are drawn
6 from administrative and historical records—Census tract data, residential composition over time,
7 housing values, and related public records dating to 1940—which are objective, third-party, and
8 independently verifiable.

9 27. Further, the letter faulted the grant’s use of surveys and interviews to measure individual-
10 level discrimination as “subjective.” We use standardized, psychometrically validated survey
11 instruments which are an established scientific method for rendering subjective experience into a
12 reliable, quantifiable variable, and are not “amorphous,” but rather a critical person-oriented perspective.
13 These subjective experiences are impactful for health outcomes such as cognitive aging specifically
14 because they reflect both the occurrence of an event and the interpretation of that event by the
15 individual. This is standard practice in the field with subjective reporting of individual experiences
16 commonly being used in NIH-funded research on a variety of topics, including, just to name a few, pain,
17 sleep quality, social isolation, perceived cognitive function, and well-being.

18 28. In addition, the letter concluded that the “neighborhood stressors” assessed in the grant,
19 including “Neighborhood Reinvestment and Revitalization (e.g., housing tax credits), Lifecourse
20 Neighborhood Level Exposures (e.g., unemployment rate, median housing value, neighborhood racial
21 composition), Individual-Level Risk and Protective Factors (e.g., limited education opportunities,
22 perceived safety, neighborhood satisfaction)” “all fall outside of biomedical research’s sphere of
23 influence” and thus “will not lead to actionable healthcare interventions.” However, this award examines
24 the specific, modifiable, and treatable biobehavioral mechanisms (i.e., sleep and cardiometabolic risk)
25 through which neighborhood conditions are hypothesized to affect cognitive aging and dementia risk.

26 29. The letter states that the award cannot be renegotiated to bring it into alignment with
27 NIH’s priorities.
28

1 30. Two days later, on August 6, 2026, we received a new NOA moving up the end date from
2 the grant to August 7, 2026 and quoting extensively from the August 4 letter as the basis for the
3 termination. Attached hereto as **Exhibit 4** is a true and correct copy of this termination NOA.

4 31. Under the design of the study, the project team conducts two visits with cohort
5 participants: one with a data collector surveying a number of factors (including experiences of
6 discrimination using a validated measure, adverse childhood experiences, depressive symptoms, PTSD,
7 residential and educational history, height, weight, blood pressure, and objectively measured sleep
8 quality) and a second one with a cognitive assessment team testing for cognitive function, medical
9 history, and independence in activities of daily living. Between 2022 and when the grant was terminated
10 in August 2026, we had completed most of these visits. However, we had not yet had our clinical team
11 make a determination of whether each participant has dementia or not. We also have not completed
12 processing our most recent data and disseminating findings in scientific publications and directly to the
13 community.

14 32. Because we had already collected much of the data for the study, NIH's termination in
15 our fifth year jeopardizes the ability of our clinical team to review the data and determine whether
16 participants have dementia. Consequently, we may be unable to inform particular participants 1:1 whom
17 the data would indicate have dementia that they should follow up with their own physicians. We also
18 may not be able to provide community updates to participants to educate them about our findings. For
19 example, we had planned a community advisory board meeting at the end of September that we will no
20 longer be able to hold.

21 33. Beyond that, the termination threatens our ability to publish papers about our findings,
22 which seems perverse when NIH had already invested over \$8 million in the grant, just to cut off the
23 funding at the stage when we are nearly ready to disseminate our findings. We had planned to publish
24 papers about how mental health consequences of childhood adverse events impacts cognitive function
25 and providing evidence for potential targets for adults who have experienced adverse childhood events
26 to protect later life cognitive function. Another example is understanding how using simple cutoffs on
27 cognitive test scores compares to doing a comprehensive clinical assessment of likely dementia in this
28 sample. We suspect that due to systematic biases in standard cognitive tests that they will overdiagnose

1 cognitive impairment without considering the full clinical picture, which has important implications for
2 clinical diagnosis.

3 34. Even if we are able to publish our findings, I am fearful of negative impacts on my ability
4 to secure NIH funding in the future. If I speak or write about my work or present my findings using a
5 title that refers to any of the concepts to which NIH objected, such as discrimination or neighborhood
6 stressors and their impact on health, and list that title on my biosketch for future NIH grant applications,
7 that could well doom the prospects for those applications' success. But omitting such a title would
8 obscure my scholarship, making my application less competitive.

9 35. Further, members of our team spent over 10 years building trust with our community
10 participant cohort and partnering community organizations to conduct the assessments, which cover
11 sensitive topics, including childhood abuse, PTSD, and experiences of discrimination. The sudden
12 termination of the grant and our inability to follow up with participants is devastating to those in the
13 participant cohort, both for their trust in research generally and in us as researchers in particular.

14 36. The termination of this grant has impacted the way I approach my work, including both
15 the language I use to describe my research and the substance of my research itself. Because of NIH
16 flagging terms like "African Americans" and "racism" as misaligned with its priorities, I have reframed
17 the language of at least two other grant applications that might similarly communicate the disfavored
18 viewpoint that racial inequality can bear on health outcomes. Both proposed projects would use the same
19 cohort of predominantly African American neighborhoods in Pittsburgh as the terminated grant—I am
20 unsure whether this focus in itself will be disqualifying. One will examine how neighborhood conditions
21 impact mobility trajectories; I omitted reference to how racism might have factored into those
22 neighborhood conditions. The other determines the contributors for becoming homebound across
23 socioeconomic and rural/urban settings; I framed this proposal so that it focuses on socioeconomic
24 divides rather than racial disparities. While I have preemptively tried to structure these proposals to
25 avoid "problematic" language in accordance with NIH's censorship policies, I am concerned that the
26 proposals are not as strong and will not score as highly with peer reviewers as they would have
27 otherwise.

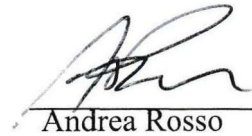
1 37. If this grant were restored, it would allow me to move forward with completing the
2 research that we had planned and with framing the research in the context of the current scientific
3 understanding, regardless of specific language usage. By focusing language solely on economic
4 disadvantage and not acknowledging the role of structural racism, we lose the context of why the
5 exposures and outcomes we are studying are more common in this population. As a consequence, we
6 may misattribute the reasons for risk or not account for important exposures such as discrimination.

7 38. NIH funding has and continues to be the primary way that I have funded my research
8 program. I am now considering whether I will have to pivot my research away from social factors to
9 focus exclusively on physiological factors, even though I know that social factors, including access to
10 medical and economic resources, can be incredibly important in determining people's risk for disease
11 outcome. Biomedical and behavioral interventions cannot be successful without considering the social
12 conditions in which those interventions occur. Further, interventions targeted at neighborhoods and
13 social conditions are possible and can have broad impact across populations, making them incredibly
14 powerful approaches to improve health. It is incorrect to say that neighborhood factors are outside of
15 biomedical research's sphere of influence and cannot lead to actionable healthcare interventions.

16 39. My research has largely focused on identifying how neighborhood characteristics and
17 social factors affect the health of older adults in order to understand how public health and policy
18 interventions could improve aging outcomes for all. Without the funding from this grant specifically or
19 from NIH funding for this area of research in the future, I will lose this direction of research that I have
20 been building for two decades. This will damage my career advancement if I need to pause and pivot my
21 research in a new direction. It may also negatively impact the prospects for my currently pending NIH
22 grant proposals that communicate a similar disfavored viewpoint.

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

1 I declare under penalty of perjury that the foregoing is true and correct, and that this declaration
2 was executed at Pittsburgh, Pennsylvania this 18th day of September 2026.

3
4 
5 _____
6 Andrea Rosso