IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

ISIS BENJAMIN; FANTASIA HORTON; NAEOMI MADISON; BRYNN WILSON; and JOHN DOE;

on behalf of themselves and all persons similarly situated,

Plaintiffs,

v.

COMMISSIONER TYRONE OLIVER, in his official capacity; ASSISTANT COMMISSIONER RANDY SAULS, in his official capacity; STATEWIDE MEDICAL DIRECTOR DR. MARLAH MARDIS, in her official capacity; and CENTURION OF GEORGIA, LLC,

Defendants.

Civ. Case No. 1:25-cv-04470-VMC

DECLARATION OF DR. JEEHEA SONYA HAW, M.D.

I, Dr. Jeehea Sonya Haw, M.D., hereby declare as follows:

1. I am a clinical endocrinologist with expertise in the diagnosis, treatment and long-term management of gender dysphoria. I am an Associate Professor of Medicine at Emory University and the Co-Founder and Medical Director of the Gender Center, a multidisciplinary center of care for gender expansive patients founded in 2017. I have extensive training and experience treating transgender and

gender diverse adults in my clinical practice and engage in research, medical education and quality improvement programs on this topic.

2. I have been retained by Plaintiffs' counsel to provide the Court with my expert evaluation and opinion regarding the expected effects of the implementation of GA SB185 in the Georgia Department of Corrections. The opinions outlined in this declaration are based on (i) scientific information and standards of care for gender diverse individuals; and (ii) summative knowledge and clinical experience based on my 10+ years of providing health care for gender diverse patients. I have actual knowledge of the matters stated herein and could and would so testify if called as a witness.

I. QUALIFICATIONS

3. I am a licensed physician in the state of Georgia, board certified in Internal Medicine and Endocrinology, Diabetes & Metabolism. My areas of specialty are in transgender medicine and diabetes care. I received my Medical Degree from the Medical College of Wisconsin in 2008 and completed residency in a joint Internal Medicine & Pediatrics program at the University of Minnesota in 2012. I then furthered my training with a fellowship in Endocrinology, Metabolism and Lipids at Emory University, which I completed in 2014.

4. I have been a practicing physician for 11 years. As the co-founder and medical director of a multidisciplinary center of care for underserved gender diverse adults

in Atlanta, I have diagnosed, and managed or continue to manage the treatment of, hundreds of individuals with gender dysphoria. Throughout this time, I have gained expertise in gender affirming care and have been asked to give lectures and presentations on the diagnosis and treatment of gender dysphoria at medical schools, medical residency programs, and regional and national scientific society conferences.

5. I have served as a primary investigator on a grant-awarded research study focusing on best practices for providing care to transgender individuals in the Atlanta area. I have also participated as an investigator on several National Institutes of Health-awarded multicenter clinical research studies examining risk and incidence of HIV acquisition among transgender adults. Resulting from this work, I have published several articles in reputable peer-reviewed journals as can be reviewed in **APPENDIX A**.

6. I have worked as an expert witness on a prior court case, *Jane Doe v. Georgia Department of Corrections* (GDC), from 2023-2024. This case involved a transgender woman incarcerated at a GDC prison who was seeking appropriate medical care and treatment for her gender dysphoria including hormone therapy, surgery, material provisions for adequate gender expression, and mental health services. I provided both a written report and in-person testimony. *Jane Doe v. Ga. Dep't of Corrs.*, No. 1:23-cv-05578-MLB (N.D. Ga. 2023).

7. A true and accurate copy of my Curriculum Vitae providing a comprehensive summary of my education, training and career-related experiences in addition to my lectureships, grant awards and publications is attached as **APPENDIX A.**

II. COMPENSATION

8. My consulting fee for this case is $400.00 per hour for remote work such as record review and drafting of this report; and $500.00 per hour for any in-person work such as participation in depositions or live testimony related to this case. My compensation does not depend on the outcome of this case, the opinions I express, or the testimony I may provide.

III. DATA REVIEWED

9. In addition to my extensive clinical experience, my opinions are based on the medical and scientific literature on gender dysphoria. This includes national and international medical society guidelines, such as the *Endocrine Treatment of Gender Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline* (2017) and the World Professional Association of Transgender Health (WPATH) guidelines, *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8* (2022). I have also relied on data from relevant peer-reviewed scientific papers.

10.I also received several documents concerning SB185, GDC's healthcare policies prior to SB185, and GDC's enforcement and implementation of SB185.

Attached as **APPENDIX B** is a list of all the materials I considered in connection with my expert declaration, inclusive of relevant literature I consulted.

IV. GENDER DYSPHORIA: TREATMENT AND MANAGEMENT

11. Gender dysphoria is defined as the distress and unease experienced by individuals whose gender identity is incongruent from their designated sex assigned at birth. People with gender dysphoria identify as gender diverse or transgender, though people who are gender diverse and psychosocially supported in their gender identity may not necessarily have dysphoria. Understanding the expansive terminology surrounding gender dysphoria and gender diversity is central to the following report. I have reviewed the expert declaration of Dr. Randi C. Ettner, Ph.D., dated August 1, 2025, for this matter, and agree and hereby adopt and incorporate by reference here in my report the definitions and explanations of gender dysphoria as a diagnosable medical condition and the physiological and biological bases for gender dysphoria, provided in Dr. Ettner's expert declaration.

12. Gender dysphoria is recognized by the American Psychiatric Association 5th edition of the DSM-5, which added "gender dysphoria" as a diagnosis in 2013 and explicitly states that "gender non-conformity is not in itself a mental disorder."

13. The 11th edition of the International Classification of Diseases and Related Health Problems ("ICD-11") redefined gender identity-related health conditions, replacing "gender identity disorder" with "gender incongruence," and moved gender

incongruence out of the "Mental and behavioral disorders" chapter into the "Conditions related to sexual health" chapter. This move acknowledges that gender diverse identities are not a mental illness; rather, they are part of a normative spectrum of human experience that requires individualized medical care.

14. The *Endocrine Treatment of Gender Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline* (2017), authored by the Endocrine Society ("Endocrine Society Guidelines"), and the World Professional Association for Transgender Health (WPATH) *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8* (2022) ("SOCv8"), are accepted as the standard-of-care clinical guidelines for the treatment of Gender Dysphoria that have been endorsed and adopted by reputable medical and scientific organizations nationally and internationally, including the American Medical Association, American Psychological Association, American Academy of Pediatrics, American Psychiatric Association, American Academy of Family Physicians, American Public Health Association, American College of Obstetrics and Gynecology, American Society of Plastic Surgeons, and the World Health Organization. The Endocrine Society Guidelines and SOCv8 align in their approach to the treatment of gender dysphoria in adults. SOCv8 heavily references the Endocrine Society Guidelines throughout but especially in regard to guidance on hormone and surgical therapies.

15. The treatment and management for gender dysphoria as set forth in the Endocrine Society Guidelines and SOCv8 clearly state the following general remarks regarding healthcare professionals:

a. Healthcare professionals who assess and treat gender dysphoria should be qualified, have the expertise, and be knowledgeable in the care of transgender and gender diverse people by participating in trainings and educational learning opportunities related to gender dysphoria; evaluating and treating individuals with gender dysphoria; and/or studying and/or researching the care and treatment of transgender people with gender dysphoria. And if this is not possible, healthcare professionals should seek out and work closely with a professional who is experienced in gender dysphoria.

b. Healthcare professionals treating gender dysphoria should undergo continuing education on transgender health, become members of relevant professional bodies, attend professional meetings and seminars and consult with other healthcare professionals with relevant experience and engage with the transgender community.

c. Healthcare professionals should liaise with professionals from different disciplines within the field of transgender health for consultation and referral. These may include mental health professionals,

endocrinologists, primary care providers, surgeons, and voice and communication specialists. (SOCv8, Stmt. 5.1-5.2).

16. Transgender individuals have individualized needs with respect to gender dysphoria treatment. Similar to the management of chronic diseases, the treatment of gender dysphoria relies on several considerations regarding risks versus benefits of various interventions, individual comorbidities, prior surgical history, and underlying reproductive anatomy, among other factors.

17. Therefore, it is important for healthcare professionals to understand the specific needs of each patient to better individualize their care. Additionally, treating gender dysphoria with a "one-size-fits-all" approach would be medically inappropriate and contrary to accepted standards of medical and other professional care, putting the patient potentially at risk of undue harm from conditions like osteoporosis, vasomotor dysregulation, and severe mental health exacerbation.

18. The medical treatment of gender dysphoria is similar in approach to the medical treatment of other chronic conditions like diabetes or hypertension, where the individual's medical and surgical history and pertinent social drivers of health guide and inform medical management of the diagnosis. In addition, careful assessment of an individual's reproductive organs and their desire for reproductive preservation heavily inform nuanced management of gender dysphoria.

19. Available treatments for gender dysphoria are currently categorized into hormone therapy, surgical therapy, and social transition. Medical transition (with hormone therapy and/or surgery) facilitates social transition and has been shown to improve overall safety in public. (Rood et al., 2017). The extent to which any or all therapies are necessary for effective treatment of gender dysphoria depends on the individual goals of each patient, their body's response to hormone therapies, and their personal health status. (van Velzen et al. 2020).

20. To the extent not otherwise addressed below in this section of my report, I agree with and hereby adopt and incorporate by reference here in this report Dr. Randi C. Ettner, Ph.D.'s explanation of the specific modalities of the medical treatment for gender dysphoria set forth in The Endocrine Society Guidelines and SOCv8.

21. Hormone Therapy: The Endocrine Society Guidelines, amongst others, clearly state the various options, safety, risks and benefits of feminizing and masculinizing hormone therapy regimens to treat gender dysphoria. Generally, feminizing hormone therapy includes estrogen, either via parenteral (injections), transdermal (patches) or oral (pills) routes. Some may also desire a "testosterone blocker" to lower endogenous testosterone effects. The first line and most used agent for this purpose in the U.S. is spironolactone. Masculinizing hormone therapy involves the administration of testosterone, which can be given either via parenteral,

transdermal or oral routes as well. Subcutaneous implantation of testosterone pellets is also possible but requires a medical provider specially trained to do this clinic-based procedure. (Hembree et al. 2017).

22. In my clinical experience, the provision of medically necessary hormone therapy is consistently correlated with improved quality of life and decreased depression and anxiety for patients with gender dysphoria. These clinical observations are corroborated by the growing number of peer-reviewed studies demonstrating improvement in depressive and other symptoms after initiating gender affirming hormone therapy. (Colizzi et al. 2014, Nguyen et al. 2018, Nolan et al. 2023, Reisner et al. 2025, Tordoff et al. 2022, White et al. 2016).

23. Surgical Therapy: Surgical treatment for transgender individuals is highly individualized, taking into consideration the heterogeneity of individuals and their medical needs. Certain surgeries to treat gender dysphoria can be done before starting on hormone therapy (e.g., mastectomy for those assigned female at birth), while others require a certain length of exposure to hormones prior to the surgery (e.g., breast augmentation for those assigned male at birth).

24. This depends on how and if hormone therapy affects different parts of the physical body. For example, testosterone will not reduce breast tissue, so transgender men will often desire chest surgery/mastectomy early on in their transition, while estradiol will cause breast growth, so transgender women are advised to wait until

the full effect of estradiol therapy is manifested (about 2-3 years) before pursuing breast augmentation. For gonadectomy (i.e., surgical removal of reproductive organs), it is recommended that transgender adults have tolerated at least 6 months of hormone therapy.

25. Surgical treatments are deemed medically necessary once the diagnosis of gender dysphoria is made and the specific surgery is aligned with the individual's treatment plan. (SOCv8, Hembree et al. 2017). This is because some transgender persons may only need hormone therapy to treat their gender dysphoria, whereas others may need only gender-affirming surgery, and yet others may need both hormone therapy and surgical treatments to fully treat their gender dysphoria.

26. For example, a patient's treatment plan may require a decision whether hormone therapy is required prior to surgery, as detailed above, or whether currently provided hormone therapy or another treatment option is not sufficiently managing their gender dysphoria, thus warranting surgery.

27. In circumstances where surgery is not available to treat gender dysphoria, hormone therapy can provide some, albeit not complete, alleviation of gender dysphoria, depending on the specific triggers of gender dysphoria. And on the flip side, if hormone therapy is not available, some surgical treatments can replicate the physical changes expected from hormone therapy, though careful consideration is needed to ensure no harm ensues for those without reproductive organs. (SOCv8).

28.In my experience, the most effective treatment for gender dysphoria for many transgender adults involve both hormone and surgical treatments. Studies report that individuals who have undergone gender-affirming surgeries demonstrate marked improvement in both depression and anxiety scores.

29.Social Transition: Gender-related social transition refers to the process by which an individual has the opportunity to live publicly in their gender identity. What specific processes are needed for social transition is individualized but can include the following: name change, pronoun change, and changes to clothing and grooming/personal expression such as use of gender-affirming clothing and undergarments, chest binders, wigs, prosthetics, padding and make-up. Some may also require hair removal procedures like electrolysis if hormone therapy itself is inadequate for body hair reduction.

30.Thus, it is particularly important to readily provide supplies needed for social transition in institutionalized settings, such as prison systems, as it may alleviate symptoms of gender dysphoria in a context where access to hormone and surgical therapy to treat gender dysphoria may be limited and delayed, and where a transgender person is unlikely to be affirmed in their identified gender through the use of names and gender congruent pronouns consistent with the SOCv8. (SOCv8, Stmt 11.5 at pS107).

31. The degree to which an individual's appearance conforms to their gender identity is the best predictor of quality of life and mental health outcomes following medical transition (Austin & Goodman, 2017; To M., *et al.* 2020). Therefore, social transition plays an integral role in the overall well-being of transgender adults. Providing access to the supplies needed for social transition will support the medically necessary care and treatment of gender dysphoria.

32. Access to the above-mentioned medically necessary care to treat gender dysphoria of transgender persons has been associated with significant reduction in the risk of suicide attempts, depression, and other mental health disorders. (Colizzi et al. 2014, Nguyen et al. 2018, Nolan et al. 2023, Reisner et al. 2025, Tordoff et al. 2022, White et al. 2016).

33. *Mental Health Therapy as a Supplement*: Mental health services can support transgender individuals with gender dysphoria as a supplement to hormone therapy and surgical therapy. However, mental health therapy on its own is not a sufficient treatment for gender dysphoria. Additionally, transgender individuals who been fully supported in their transition by their family and social environment may not need any mental health support. (SOCv8, Hembree et al. 2017).

V. TREATMENT OF GENDER DYSPHORIA IN CARCERAL SETTINGS

34. The SOCv8 has set forth guidelines recommended for health care professionals (or who are associated with institutions or agencies) who are

responsible for providing gender-affirming care to transgender individuals who are housed in institutions, including correctional facilities such as prisons. (SOCv8. Stmt. 11.1).

35. These guidelines are the standard of care used by medical professionals who provide care for gender diverse adults in institutional environments. These recommendations underscore that incarcerated persons do not have the access that non-institutionalized persons do to obtain medically necessary gender-affirming care on their own. And as such, incarcerated persons must be supported in being able to receive the medically appropriate standard of care for treating gender dysphoria.

36. The SOCv8 recommend, among other principles, that:

a. **Statement 11.3**. Medical professionals charged with prescribing and monitoring hormones for transgender individuals living in institutions who need gender affirming hormone therapy do so without undue delay and in accordance with the SOC-8.

b. **Statement 11.4.** Staff and professionals charged with providing health care to transgender individuals living in institutions recommend and support gender-affirming surgical treatments in accordance with the SOC-8 when sought by the individual, without undue delay.

c. **Statement 11.5.** Administrators, health care professionals, and all others working in institutions charged with the responsibility of caring

for transgender individuals allow those individuals who request appropriate clothing and grooming items to obtain such items concordant with their gender expression.

d. **Statement 11.6**. We recommend all institutional staff address transgender individuals by their chosen names and pronouns at all times.

37. Based on my experience and the scientific literature that I have consulted for this report, and as detailed in Dr. Ettner's August 1, 2025 expert declaration, without proper treatment in accordance with these accepted clinical guidelines, gender dysphoria can present severe and disabling physical and psychological symptoms.

VI. EXPERT OPINIONS RE SB185 & THE CONSEQUENCES OF BANNING GENDER AFFIRMING CARE IN PRISON

38. Georgia SB185 is a bill signed into law on May 8, 2025 that bans the treatment of gender dysphoria with hormone therapy, surgical therapy, or cosmetic/prosthetic supplies used for gender identity expression in Georgia state prisons.

39. For the purposes of offering my expert opinion in this matter, I have been asked to assume the statute has the following effect:

a. The law prohibits the state provision of the aforementioned treatments to all incarcerated persons with gender dysphoria, even when the treatment was previously provided to patients as medically necessary by correctional healthcare officials;

b. The law prevents anyone newly diagnosed with gender dysphoria from being evaluated for, or initiating, care;

c. The law includes no exceptions for patients already receiving hormone therapy as treatment for their gender dysphoria; instead, the law provides for the tapering off of hormonal therapy that was initiated prior to the law's effective date for those incarcerated patients, only to facilitate permanent discontinuation.

40. For the purposes of offering my expert opinion in this matter, I have also been asked to assume the following to be true about GDC's plan to implement SB185:

a. The plan to implement SB185 provides for the forced termination of hormone therapy for patients with gender dysphoria over a four-to-eight-week period or, at a maximum, a three-month period.

b. Under the plan, all patients with gender dysphoria who previously received hormone therapy will be notified that their hormone therapy is being terminated sometime in July 2025.

c. Under the plan, a medical provider will obtain "informed consent" for one of two options, both of which result in the termination of a patient's prescribed hormone therapy for non-medical reasons. Under the first option, patients' hormone therapy will be immediately terminated.

Under the second option, patients will have their hormone therapy gradually terminated over a four-to-eight-week period.

d. Thereafter, all patients with gender dysphoria will have their hormone therapy care terminated by October 3, 2025, with many projected to have their hormone therapy terminated earlier.

e. The plan to implement SB185 calls for "increased access to counseling" for those whose hormone therapy is terminated.

f. The plan to implement SB185 calls for four mental health follow-up appointments and three physical health follow-up appointments throughout the hormone therapy termination process.

g. Consistent with SB185, the plan to implement SB185 includes no exceptions to termination of hormone therapy for those previously receiving hormone therapy due to a gender dysphoria diagnosis.

41. Based on these assumptions about the implementation of SB185, I offer the following opinions:

A. <u>Discontinuation of Hormone Therapy Under SB185</u>

42. To the extent that individuals who are currently receiving hormone therapy as medically necessary treatment for their gender dysphoria have their treatment discontinued under SB185, it will undoubtedly cause physical and psychological changes and put them at imminent risk for severe mental health symptoms such as

depression, anxiety and suicidality, in addition to the physiological risks I report on below. It is therefore medically unjustifiable to involuntarily discontinue hormone therapy in these individuals for non-medical reasons, as it will result in undue yet foreseeable risks of severe harm.

43. In my clinical experience, when transgender adults have their hormone therapy interrupted for any length of time, there is almost 100% of the time worsening of their depression, anxiety and other mental health and comorbidities. In some instances, this lack of hormone therapy has caused suicide attempts and attempts at self-castration. Furthermore, the worsening depression and mental health outcomes that result from the absence of such care cannot be adequately treated by mental health services alone. Nor can gender dysphoria itself be treated by mental health therapy alone, when hormone therapy, social transition, and/or surgical therapy is indicated.

44. Accordingly, mental health services by themselves—which SB185 prescribes in place of gender dysphoria treatment—will not treat the underlying cause of gender dysphoria or its related symptoms of depression, anxiety, suicidality, and systemic stress that will result from lack of adequate treatment and care.

45. In addition, SB185's plan to slowly taper people off of their hormone replacement therapy and other forms of treatment and care solely with the provision

of mental health services will not stop or reverse these severe and foreseeable symptoms of gender dysphoria.

46. Discontinuing hormone therapy in individuals who have been taking hormones for any amount of time, as SB185 requires, will also have a number of significant psychological side effects. Among these are the reversal of the many positive physical, emotional, and mental outcomes brought about by hormone therapy, such as the masculinization or feminization of the body and secondary sex characteristics in a manner that reduces gender incongruence and alleviates clinically significant distress, muscle and fat redistribution, facial/body hair growth or disappearance, and improvements to mood, and energy level. (Charlton et al. 2024).

47. Hormone therapy suppresses the body's endogenous hormone production and secretion, assuming reproductive organs are intact. Once hormone therapy is stopped, the rate at which the body starts to again make and secrete its endogenous sex hormones will vary dramatically person to person. (Kinnear et al. 2023, Rodriguez et al. 2025, Chan et al. 2024.).

48. Individuals who no longer have their reproductive organs will not be able to make any sex hormones. Some individuals who have reproductive organs may not make their own physiologic hormones for over a year, while others may do so in a few months. Emerging data report this variance may depend on duration of and

potency of hormone therapy, though currently there are no predictive calculations used clinically. (Kinnear et al. 2023, Rodriguez et al. 2025, Chan et al. 2024).

49. Based on my experience as an endocrinologist and emerging research data, discontinuing hormone therapy for transgender individuals who have previously been on hormone therapy also places the human body at risk of the following:

a. **osteoporosis**: brittle bones and high risk of fragility fracture (Frenkel et al.);

b. **vasomotor dysregulation**: heat intolerance, night-sweats, dizziness, and headaches (Charlton et al. 2024, Hamoda et al. 2024);

c. **metabolic changes**: rapid weight changes (either gain or loss) which can pose risk to other conditions like gallbladder disease, diabetes, hyperlipidemia (high cholesterol) and hypertension; changes to distribution of lean muscle mass and adipose tissue which can also increase risk of insulin sensitivity (and diabetes risk) and obesity (Weidlinger et al, 2024); and

d. **mental health symptoms**: depression/anhedonia, anxiety, suicidality, sleep disturbances (insomnia or hypersomnia), inability to concentrate, and dementia (Noachtar et al. 2023).

These symptoms can range from mild to severe and can significantly impact quality of life, ability to perform activities of daily living, and overall disease risk and well-being.

50. Stopping hormone therapy in someone with gender dysphoria is like stopping effective treatment for someone with hypertension. When medications are withheld for someone with hypertension, their blood pressure will revert back to being elevated, which puts them at risk of strokes and heart attacks. Forced discontinuation of treatment for gender dysphoria will also cause the symptoms of gender dysphoria to resurface, which can lead to severe mental health concerns.

51. This will be particularly crucial in the case of coerced discontinuation of gender affirming treatment, as the toll on the patient's mental health will be much more severely impacted compared to those who freely choose to stop hormone therapy.

52. To the extent that the research on medical and mental health outcomes of transgender individuals after forced discontinuation of hormone therapy is lacking, in my professional opinion, it is because creating such a study protocol would be deemed unethical by any Institutional Review Board due to the overt harm posed by forced discontinuation of hormone therapy on transgender individuals, as well as the likely impossibility of securing informed consent from subjects for such a study.

B. Discontinuation of Evaluations for Hormone Replacement Therapy and Bans on Other Treatment for Gender Dysphoria

53. As set forth above, SB185 bans all forms of healthcare that may be medically necessary for the treatment of gender dysphoria in patients in GDC: hormone therapy, surgical therapy, and the provision of items and care needed for social transition for incarcerated adults, including hair removal treatment. Thus, the statute's withholding of any and all treatments and care for gender dysphoria indicates evaluation for the same will also be withheld under SB185.

54. It is medically necessary to 1) formally evaluate symptoms of gender dysphoria and 2) provide patients with gender dysphoria with individualized treatment consistent with the accepted standards of care, including hormone therapy and/or surgery, as well as social transition. (Hembree et al. 2017, SOCv8).

55. Transgender individuals in GDC prisons seeking initial evaluation for gender dysphoria, however, will no longer be able to receive such evaluation and, thus, the diagnosis and initiation of treatment under SB185. Like the law's prohibition on treatment of gender dysphoria, this prohibition of initial evaluation contravenes applicable standards of care and violates basic standards for the practice of medicine that require readily available treatment—including hormone therapy, surgery, and/or social transition care provided by GDC before SB185's passage.

56. Thus, similar to the consequences of withholding treatment for a serious medical diagnosis like gender dysphoria that I explain above, the consequences of

withholding evaluation, including initial assessments—particularly in the carceral context of GDC prisons, where healthcare is already limited—will manifest in severe mental health symptoms, such as major depression, anxiety, suicidality, and attempts at self-harm.

57. Under SB185, a patient within GDC will also be put at foreseeable risk for severe physical harm, including the endangerment of the patient's life through suicide, self-harm, and self-castration attempts, as set forth above.

58. Withholding an evaluation for medically necessary treatment for gender dysphoria is akin to withholding an evaluation for medically necessary treatment for other medical conditions, like diabetes. If an individual has Type 1 Diabetes for which the medically necessary treatment is insulin, but an evaluation for the diagnosis of diabetes and any other medically necessary care for the same is withheld, the individual will be at severe risk of decompensation or death due to their untreated hyperglycemia.

59. Applying this same logic to SB185 in GDC, withholding medically necessary treatment for gender dysphoria will cause similar risks of physical harm that I note above.

VII. CONCLUSION

60. The consequences of SB185 on transgender people with gender dysphoria in the Georgia Department of Corrections will undoubtedly be grave.

61. Gender dysphoria requires individualized medical treatment, and for many patients, hormone therapy and/or surgical therapy, as well as social transition. Withholding medically necessary treatment for gender dysphoria or treatment evaluations, as SB185 requires, will cause severe and foreseeable physical and psychological harm for those incarcerated within GDC already on therapies for gender dysphoria, as well as those with a diagnosis, or who meet the criteria for diagnosis, and are awaiting treatment to address their dysphoria symptoms. Thus, SB185 goes against the oath that all physicians take: to do no harm.

62. SB185 also puts people with gender dysphoria in Georgia custody at a substantial and foreseeable risk of physical injury or death from self-harm, self-castration, and suicide attempts—harms that could readily be prevented through the provision of medically necessary and readily available treatments for gender dysphoria. Tapering patients off hormone therapy does nothing to minimize or alleviate these risks. Nor does it neutralize the many negative sequalae and withdrawal symptoms associated with the forced discontinuance of hormone therapy.

63. Mental health services, on their own, are not a treatment for gender dysphoria. Thus, the mental health therapy services alone that SB185 purports to offer—as the only option for incarcerated transgender persons with gender dysphoria within GDC—will not meaningfully alleviate the symptoms of gender dysphoria that are

surely to come once hormone therapy and other treatments are discontinued or withheld. Nor are mental health services by themselves sufficient to treat the underlying cause of gender dysphoria or to reduce the harms associated with treatment denial or discontinuation.

64.I hold each of the opinions expressed in this declaration with a reasonable degree of scientific certainty, based on the materials I have reviewed and on my education, experience and knowledge. I reserve the right to supplement, amend, or modify my opinions upon review of further information, including, but not limited to, testimony, documents and reports I receive after the date of this declaration.

I declare under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the foregoing is true and correct.

Executed on August 6, 2025

J. Sonya Haw

JEEHEA SONYA HAW, M.D.

APPENDIX A

EMORY UNIVERSITY SCHOOL OF MEDICINE
CURRICULUM VITAE

Revised: July 2025

1. **Name:** Jeehea Sonya Haw, MD

2. **Office Address**: Emory University School of Medicine
Division of Endocrinology, Metabolism and Lipids
69 Jesse Hill Jr Drive S.E.
Glenn Memorial Building, [redacted]
Atlanta, GA 30303
[redacted] [redacted]

3. [redacted]

4. **Current Titles and Affiliations**:

a. Academic Appointments:

i. Primary Appointments:

Associate Professor of Medicine, Division of Endocrinology, Metabolism and Lipids, Emory University, School of Medicine; 2022 – present

b. Clinical Appointments:

Medical Director, Gender Center, Grady Memorial Hospital; 2017—Present

c. Other Administrative Appointments:

Associate Program Director, Endocrinology Fellowship Program; Emory University, School of Medicine; 2020 –2023

Program Director, Endocrinology Fellowship Program; Emory University School of Medicine; 2023- present

5. Previous Academic Appointments:

Instructor, Division of Endocrinology, Metabolism and Lipids, Emory University, School of Medicine; 2014-2016

Assistant Professor of Medicine, Division of Endocrinology, Metabolism and Lipids, Emory University, School of Medicine; 2016 – 2022

6. Licensures/Boards:

Georgia State Board of Medical Examiners, Issued 2014

7. Specialty Boards:

Internal Medicine, American Board of internal Medicine (ABIM) 2015
Endocrinology, Diabetes, and Metabolism Board Certification (ABIM) 2017

8. Education:

B.S., B.A. Texas Christian University 1999-2004
M.D., Medical College of Wisconsin 2004-2008

9. **Postgraduate Training:**

Internship and Residency in Internal Medicine and Pediatrics, University of Minnesota, Minneapolis, Minnesota, Bradley Benson (Program Director), 2008-2012

Clinical Fellowship, Endocrinology, Metabolism and Lipids, Emory University, Atlanta, Georgia, Vin Tangpricha (Program Director), 2012-2014

Chief Fellow, Endocrinology, Metabolism and Lipids, Emory University, Atlanta, Georgia, Vin Tangpricha (Program Director), 2013-2014

10. Continuing Professional Development Activities:

Junior Faculty Development Program, 2015-2016
Learning to be Better Teachers Workshop, 2016
Mentoring Workshop, Department of Medicine, 2018 (DEI section lead and speaker 2022)
Woodroof Health Educators Academy Teaching Fellowship , 2021-2022
Stanford Faculty Development Clinical Teaching Program, 2023

11. Committee Memberships:

a. National and International:
   1. Member, NIH: NIDDK and JDRF Preventing Early Renal Loss (PERL) Study Steering Committee, 2014 – present

   2. Elected Advisor, American Diabetes Association, Public Health and Epidemiology Interest Group, 2020 –2022

   3. Member, Type 1 Diabetes Exchange Quality Improvement Collaborative, Data Governance Committee, 2021 –present

   4. Member, Association of Program Directors in Endocrinology, Diabetes and Metabolism, Diversity, Equity, and Inclusion Subcommittee, 2021- 2022

   5. Member, Association of Program Directors in Endocrinology, Diabetes and Metabolism, Health Equity Committee, 2021-2022

6. Member, Association of Program Directors in Endocrinology, Diabetes and Metabolism, Curriculum Committee, 2022 –present

7. Co-Chair, Association of Program Directors in Endocrinology, Diabetes and Metabolism, Health Equity Committee, 2024- present

b. Institutional:

1. Chair, Fellowship Program Evaluation Committee, Division of Endocrinology, Metabolism and Lipids, 2015 – present; Chair 2019- 2023

2. Endocrinology Fellowship Core Faculty, 2016- 2023

3. Internal Medicine Residency Core Faculty, Division of Internal Medicine, 2016-2022

4. General Internal Medicine Residency CCIC, 2016- 2021

5. Department of Medicine, Mentoring Subcommittee, 2017-2021

6. Department of Medicine, Diversity, Equity and Inclusion Council, 2019-present

12. Peer Review Activities:

a. Grants:

1. Regional:
   1. Grant Application Reviewer, Georgia Center for Diabetes Translational Research, P30 Pilot Grant Award Program, 2019-2020

b. Manuscripts:

i. Vascular Health and Risk Management, 2014
ii. Journal of Clinical and Translational Endocrinology (JCTE), 2014-2020
iii. Endocrine Practice, 2014-2015
iv. Population Health Metrics, 2016
v. British Medical Journal (BMJ) Open Diabetes, Research & Care, 2017-2020
vi. Journal of General Internal Medicine (JGIM), 2018
vii. Pediatrics, 2019
viii. Acta Endocrinologica, 2020
ix. The Journal of the American Medical Association (JAMA), 2020
x. PLOS One, 2021
xi. Nature Communications, 2023
xii. Nature Medicine, 2023

c. Conference Abstracts:

1. National and International:

American Diabetes Association 76th Scientific Sessions, New Orleans, LA, Abstract Reviewer, 2016

American Diabetes Association 77th Scientific Sessions, San Diego, CA, Abstract Reviewer, 2017

American Diabetes Association 79th Scientific Sessions, San Francisco, CA. Abstract Reviewer, 2019

American Diabetes Association 80th Scientific Sessions, (virtual due to COVID-19). Abstract Reviewer, 2020

American Diabetes Association 82nd Scientific Sessions, New Orleans, LA, Abstract Reviewer, 2022

American Diabetes Association 83rd Scientific Sessions, San Diego, CA, Abstract Reviewer, 2023

ENDO Society National conference 2025, San Francisco, CA, Abstract Reviewer 2025

13. Honors and Awards*:*

a. Standing Ovation Award, Medical College of Wisconsin, 2008
b. Presidential Poster Award, Endocrine Society Annual Conference, 2013
c. Emory University, Endocrinology Fellows Faculty Teaching Award, Best at Grady, 2016
d. Emory University, Endocrinology Fellows Faculty Teaching Award, Best at Grady, 2018
e. Emory University, Endocrinology Fellows Faculty Teaching Award, Overall Best 2019
f. Emory University, Endocrinology Fellows Faculty Teaching Award, Best at Grady 2019
g. Emory University, Woodruff Health Educators Academy Teaching Fellowship, 2021-2022
h. Emory University, Endocrinology Fellows Faculty Teaching Award, Best at Grady, 2021
i. Emory University, Endocrinology Fellows Faculty Teaching Award, Overall Best, 2021
j. Emory University, Endocrinology Fellows Faculty Best Mentor Award, 2021
k. Emory at Grady Team-Based Award, 2021
l. Emory School of Medicine Educator Appreciation Day Recognition, 2022
m. Emory University, School of Medicine Hidden Gem Award, 2022
n. Emory University, Endocrinology Fellows Faculty Teaching Award, Best at Grady, 2022
o. Emory University, Endocrinology Fellows Faculty Teaching Award, Overall Best, 2022
p. Emory University, Endocrinology Fellows Faculty Teaching Award, Best at Grady, 2023
q. Emory University, Endocrinology Fellows Faculty Teaching Award, Overall Best, 2024
r. Emory University, Endocrinology Fellows Faculty Teaching Award, Best at Grady, 2024
s. Emory University, Endocrinology Fellows Faculty Teaching Award, Most Dedicated Faculty, 2025

14. Society Memberships:

a. American Diabetes Association, 2012 – present
b. Endocrine Society, 2012 – present
c. American Association of Clinical Endocrinology, 2012 – 2018, 2020, 2022—present
d. World Professional Association for Transgender Health, 2016- 2021, 2024—present
e. Academy of Health, 2019- 2020
f. Association of Program Directors in Endocrinology, Diabetes and Metabolism, 2020 – present

15. Clinical Service Contributions:

a. Medical Director, Co-Founder, Gender Center at Grady Memorial Hospital, 2017 – present;
   i. Clinical director for a multidisciplinary clinic focused on providing gender-affirming care for transgender and gender-diverse individuals.
   ii. As part of this effort, we provided cultural competency training for clinical staff and created a novel residency curriculum that was implemented in 2018 for the Internal Medicine Residency.

b. Physician Lead, Diabetes Prevention Program (DPP), Grady Health Systems, Diabetes Center, 2019 –2021;
   a. Certified as a national DPP Lifestyle Coach
   b. Grady has built the DPP program within the Diabetes Center at Grady for adults with pre-diabetes, working to implement broadly (curtailed by COVID-19 in 2020-2021).

c. Primary Investigator, Type 1 Diabetes (T1D) Exchange Quality Improvement (QI) Collaborative, 2021—2023
   a. Leading a QI team at Grady to improve the care of adolescents and adults with Type 1 Diabetes
   b. Type 1 Diabetes Exchange QI Collaborative is a national collaborative of 50+ institutions working together to implement data sharing and QI initiatives to improve outcomes for pediatric and adult patients with T1D.

d. Primary Investigator, Type 2 Diabetes (T2D) Exchange Quality Improvement (QI) Collaborative, 2023—Present
   a. Leading a QI team at Grady to improve the care of adolescents and adults with Type 2 Diabetes (expansion of T1D Exchange)

16. Community Outreach:

a. General:
   1. Camp Kudzu, Camp for kids with Type 1 Diabetes, Medical/Clinician volunteer, 2016
   2. Emory University, undergraduate faculty-in-residence program on transgender care, 2018
   3. Clarkston Community Health Clinic, organized an Endocrine Clinic for this free clinic for immigrants and refugees in Clarkston, GA, 2019 –present

4. ENDO Cares, co-lead the organization of a community health fair in Clarkston, GA as part of the national scientific conference with Endocrine Society, June 2022.

17. **Formal Teaching:**

a. Graduate Programs:

i. Medical Student Teaching:
1) Lecturer, School of Medicine, MS1 Human Developmental Section, Emory University, 2016- present, 2hr/year
2) Small Group Moderator, MS2 Diabetes Section, Emory University School of Medicine, 2018- present, 2hr/yr
3) Lecturer, MS4 Capstone lecture on Transgender health, Emory University School of Medicine, 2019, 1hr/yr

ii. Residency Programs:
1) Internal Medicine, core lecture series, 2015 – 2017, 1hr/yr
2) Guest Speaker, Emergency Medicine Core Conference, 2016, 1hr/yr
3) Internal Medicine Ambulatory Rotation, Transgender Health lectures, 2019 – present, 2hr/yr
4) Internal Medicine Ambulatory Rotation, topic-based lecture, 2020- present, 3-5hrs/yr

iii. Fellowship Programs:
1) Endocrinology, Metabolism and Lipids, core lecture series, 2014 – present, 1hr/yr
2) Develop and organize endocrinology fellows' core didactics each year, 2020 – present, 10hr/yr
3) Implemented Health Equity Curriculum for endocrinology fellowship, 2022—present, 10hr/yr

b. Other Categories:

i. Lecturer, Physician Assistant Endocrinology lecture series, Emory University 2014–2015, 1hr
ii. Guest Lecturer, HLTH 320 Nutrition and Chronic Disease class, Emory University, 2019, 1.5hr

18. Supervisory Teaching/Mentorship:

a. Fellowship Program:
1. Farah Kahn, 2014-2018; Assistant Professor, Division of Endocrinology, University of Washington, Seattle WA

2. Kristina Cossen, 2016—2018; Assistant Professor, Pediatric Endocrinology, Emory University

3. Jacqueline Reyes Diaz, 2018- 2021; Pediatric Endocrinology Fellow, Research Committee

4. Shirley Hao, 2021-2023; Pediatric Endocrinology Fellow, Research Committee

b. Residency Program:

1. Karen Sayad, Emory Internal Medicine Residency Coaching Program, 2017-2019, Pulmonary Critical Care Fellow

2. Caitlin Taylor, Emory Internal Medicine Residency Coaching Program, 2018-2019, Hematology/Oncology Fellow

3. Austin Rim, Emory Internal Medicine Residency Coaching Program, 2019- 2022, Cardiology Fellow

c. PhD and Graduate Dissertation Committees:

1. MK Findley, 2016—2018; PhD candidate, Nell Hodgson Woodruff School of Nursing, Dissertation Committee

2. Rachel Wolf, 2017- 2021; PhD candidate, Nell Hodgson Woodruff School of Nursing, Dissertation Committee

3. Ashley Fischer, 2022- 2023; MA candidate, Department of Nutrition, Byrdine F. Lewis College of Nursing and Health Professionals, Georgia State University, Thesis Advisor

d. Other:
Supervision of visiting medical students/residents:

1) Prachi Jain, 2015, postdoctoral research associate at NIH,
2) Santosh Kale, 2015, Internal Medicine Resident
3) Diba Debnath, 2016, medical student, King's College London, UK
4) Dhatri Malipeddi, 2017, Internal Medicine Resident
5) Siddhartha Kancharla, 2017, Internal Medicine Resident
6) Ashruta Patel, 2017, Internal Medicine Resident
7) Sreevatsan Kalangi, 2018, medical student,
8) Karthik Chamarti, 2019, medical student,
9) Chany Damian Ozuna, 2019, Geriatrics Fellow
10) Tania Ramos, 2020, Endocrinologist at Clinique Saint Michel, Paris, France

19. Lectureships, Seminar Invitations, and Visiting Professorships:

a. Regional:

1) "Emory Latino Diabetes Education Program," Southern Regional Dietetic Internship Program, Georgia State University, 2015

2) "Prevention of Type 2 Diabetes," Georgia Department of Public Health, webinar series for healthcare providers in Georgia, 2015

3) "Combatting Clinical Inertia: A Stepwise Approach to Diabetes Management," CME lecture for primary care providers at Mercy Care Clinic and Four Corners Clinic, 2015 – 2016

4) "Disparities in Diabetes Care," CME webinar lecture for primary care providers, 2017

5) "Endocrine Pearls," ABIM Board Review Course, Emory University, 2018, 2019

b. Institutional:

1) "Teaching Patients about Hyperglycemia and Hypoglycemia," Diabetes Education Course, as part of Emory Diabetes Education and Training Academy, Emory University, 2013 – 2020

2) "Diabetes Prevention; Past, Present and Future," Endocrine conference, Endocrinology, Metabolism and Lipids, School of Medicine, Emory University, 2015

3) "Race, Class and Genes: The Fates of Health Disparities in Diabetes," Endocrine Conference, Endocrinology, Metabolism and Lipids, School of Medicine, Emory University, 2017

4) "Transgender HealthCare; the Nexus of Health, Education, and Advocacy," Endocrine Conference, Endocrinology, Metabolism and Lipids, School of Medicine, Emory University, 2018

5) "Type 1 Diabetes: General overview of diagnosis and treatment," CME Webinar (for primary care in Georgia), Emory Diabetes Education and Training Academy, Emory University, 2019

6) "Obesity Pathophysiology," Hubert Department of Global Health, Guest Lecture for HLTH 320 Nutrition and Chronic Disease, Emory University, 2019

7) "Caring for Transgender and Gender non-conforming patients: What you need to know about sex hormones" Department of Obstetrics and Gynecology Grand Rounds, Emory University, Jan, 2020

8) "Approaches to Gender Affirming Care" Stephanie V. Blank Center for Safe and Healthy Children, Children's Healthcare of Atlanta, Joint Meeting, October, 2020.

9) "Caught in the Political Crosshairs: The Current State of Gender-Affirming Care in the U.S" Department of Medicine Grand Rounds, 2024

10) "Caught in the Political Crosshairs: The Current State of Gender-Affirming Care in the U.S" Department of Medicine, Professional Faculty Development Lecture Series, 2025

20. Invitations to National/international, Regional and Institutional Conferences:

a. National and International:

i. "Transgender Health, what a gynecologist needs to know," 125th Annual Meeting and Scientific Assembly of the National Medical Association, Obstetrics and Gynecology Section, (Virtual due to COVID-19), August 2020 (CME activity)

ii. "Social Determinants of Health," Type 1 Diabetes Exchange Collaborative Learning Session, (Virtual due to COVID-19), June 2021 (CME activity)

iii. "Introducing Health Equity Curriculum: Association of Program Directors of Endocrinology and Metabolism," American Academy of Clinical Endocrinology Annual Meeting, San Diego, May 2022.

iv. "Transition of Pediatric to Adult Care in Transgender Kids," American Academy of Clinical Endocrinology Annual Meeting, San Diego, May 2022 (CME Activity).

v. "How Faculty Bias Impacts the Evaluation of Learners." ENDO 2022, Atlanta, June 2022.

vi. "Let's get it right! Real Conversations with the Transgender Community—A panel discussion." Association of Women's Health, Obstetric and Neonatal Nurses, Denver, June 2022.

b. Regional:

i. "Caring for Transgender and Gender non-conforming patients," American Association of Clinical Endocrinology (AACE) Georgia Chapter Annual Meeting, 2020

ii. "Diabetes and Blood Glucose Management in the Hospital: Standards and What's New?" 21st Annual Southern Hospital Medicine Conference, October 2020 (*cancelled due to COVID-19*)

iii. "Feminizing Gender Affirming Care Overview" Trans Ally Health Symposium, August 2023

21. Abstract Presentations at National/International, Regional, and Institutional Conferences:

a. <u>National and International:</u>

1) ***JS Haw,** SL Jackson, DE Olson, MK Rhee, Q Long, D Barb, AV Mohan, AM Tomolo, PI Watson-Williams, LS Phillips. *Chronic poor diabetes control in a large*

integrated healthcare system. Endocrine Society Annual Meeting, San Francisco, California, June 2013 (poster)

2) ***JS Haw**, MK Findley, ES Cha, MS Faulkner, F Khan, S Markley, AS Alexopoulos, S Paul, MK Ali. *Hyperglycemic emergencies in young adults with diabetes in an inner-city county hospital.* American Diabetes Association 76th Scientific Sessions, New Orleans, Louisiana, June 2015 (poster)

3) Karla I. Galaviz, Audrey N. Straus, Mary Beth Weber, Jingkai Wei, Alysse Kowalski, **J. Sonya Haw**, K. M. Venkat Narayan, and Mohammed K. Ali. *Individual- vs. community-level diabetes prevention: which approach is more effective for weight loss in the real world?* International Diabetes Federation-World Diabetes Congress, Vancouver, Canada, December 2015 (poster)

4) Karla I. Galaviz, Audrey N. Straus, Mary Beth Weber, Jingkai Wei, Alysse Kowalski, **J. Sonya Haw**, K. M. Venkat Narayan, and Mohammed K. Ali. *Preventing diabetes in the real world: Global evidence on the effectiveness of weight loss interventions,* International Diabetes Federation-World Diabetes Congress, Vancouver, Canada, December 2015 (poster, with discussion)

5) Karla I. Galaviz, Audrey N. Straus, Mary Beth Weber, Jingkai Wei, Alysse Kowalski, **J. Sonya Haw**, K. M. Venkat Narayan, and Mohammed K. Ali. *Do lifestyle interventions to prevent diabetes in real-world settings reduce fasting blood glucose globally?* International Diabetes Federation-World
6) Diabetes Congress, Vancouver, Canada, December 2015 (poster, with discussion)

7) ***J. Sonya Haw**, Limin Peng, Francisco, J. Pasquel, Priyathama Vellanki, Maya Fayfman, Georgia Davis, Guillermo E. Umpierrez. *Racial and Socioeconomic Disparities in Meeting Goals of Care in Adults with Type 1 Diabetes*. American Diabetes Association 78th Scientific Sessions, Orlando, FL, June 2018 (Oral Presentation, *presenter)

8) Priyathama Vellanki, Limin Peng, Neil Dhruv, Clementina Ramos, **J. Sonya Haw**, Rodolfo J. Galindo, Georgia Davis, Maya Fayfman, Francisco J. Pasquel, Guillemro E. Umpierrez.Characteristics and Mortality of Recurrent Diabetic Ketoacidosis (DKA) in Adults and Children with Type 1 Diabetes (T1D). American Diabetes Association 78th Scientific Sessions, Orlando, FL, June 2018 (Poster)

9) Saumeth Cardona, Rodolfo J. Galindo, Katerina G. Tsegka, Maria A. Urrutia, Priyathama Vellanki, Maya Fayfman, **J. Sonya Haw**, Francisco J. Pasquel, Limin Peng, Guillermo E. Umpierrez. Simplified Transition Algorithm from Intravenous to Subcutaneous Insulin in Nondiabetic Cardiac Surgery Patients with Stress Hyperglycemia. American Diabetes Association 78th Scientific Sessions, Orlando, FL, June 2018 (Poster)

10) Rodolfo J. Galindo, Francisco J. Pasquel, Katerina G. Tsegka, Saumeth Cardona, Neil Dhruv, Priyathama Vellanki, Maya Fayfman, **J. Sonya Haw**, Alexandra Migdal, Shailesh Nair, Heqiong Wang, Guillermo E. Umpierrez. Clinical Characteristics and Outcomes in Patients Admitted with Diabetic Ketoacidosis (DKA) and End-Stage Renal Disease (ESRD). American Diabetes Association 78th Scientific Sessions, Orlando, FL, June 2018 (Poster)

11) Maya Fayfman, Dara Mize, Daniel Rubin. Isabela Anzola, Maria Urrutia, Clementina Ramos, Francisco Pasquel, **Sonya Haw**, Priyathama Vellanki, Heqiong Wang, Katherine Joyce, Abhijana Karunakaran, Bonnie Abury, Rita Weaker, Lavanya Viswanatha, Shuchie Jaggi, Rodolfo Galindo, Guillermo Umpierrez. *Safety and Efficacy of Exenatide Therapy for the Management of Hospitalized Patients with Type 2 Diabetes—Exenatide Hospital Trial.* American Diabetes Association 78th Scientific Sessions, Orlando, FL, June 2018 (Poster)

12) *Karla I. Galaviz, Mary Beth Weber, Unjali Gujral, Jingkai Wei, Kara Suvada, **J. Sonya Haw,** K.M. Venkat Narayan, Mohammed K. Ali. *Do Diabetes Prevention Treatments Promote Regression to Normal Glucose Regulation? A network meta-analysis.* American Diabetes Association 80th Scientific Sessions, June 2020 (Oral Presentation, *presenter)

13) *M. Agustina Urrutia, M. Citlalli Perez-Guzman, Yi Guo, M. Florencia Scioscia, K. Walkiria Zamudio, Isabel Anzola, Bonnie Albury, Saumeth Cardona, **J. Sonya Haw**, Rodolfo Galindo, Maya Fayfman, Georgia Davis, Alexandra Migdal, Priyathama Vellanki, Guillermo E. Umpierrez, Francisco J. Pasquel. *Home diabetes regimen and admission HbA1c as predictors of hospital glycemic control: A pooled analysis of inpatient clinical trials.* American Diabetes Association 80th Scientific Sessions, June 2020 (Oral Presentation, *presenter)

14) S. Hafeez, **J.S. Haw**, *A Catecholamine Secreting Tumor in a Pregnant Patient with Von-Hippel-Lindau: A Case Report.* EMBRAACE 2020, the AACE 29th Annual Scientific & Clinical Congress, (Poster)

15) John O-Connell Knight, Priyathama Vellanki, **J. Sonya Haw**. *Primary Hyperparathyroidism Presenting as Acute Necrotizing Pancreatitis and Diabetic Ketoacidosis in Type 2 Diabetes.* Endocrine Society Annual Scientific Meeting, ENDOOnline 2020 (Poster)

16) Teg Uppal, Gail Fernandes, **J. Sonya Haw**, Megha Shah, Sara Turbow, Swapnil Rajpathak, K.M. Venkat Narayan, Mohammed K. Ali. *Association of Demographic Factors with Emergency Department Use Among Adults with Diabetes, 2009-2017*. American Diabetes Association 80th Scientific Sessions, June 2020 (Poster)

17) Teg Uppal, **J. Sonya Haw**, Megha Shah, Sara Turbow, K.M. Venkat Narayan, Mohammed K. Ali**.** *Preventable and Other Emergency Department Use in Adults with and without Diabetes, 2009-2017.* American Diabetes Association 80th Scientific Sessions, June 2020 (Poster)

18) Clemetina Ramos, Rodolfo J. Galindo, Saumeth Cardona, Bonnie S. Albury, Omolade Oladejo, Francisco J. Pasquel, Priyathama Vellanki, Maya Fayfman, Alexadnra Migdal, Georgia Davis, **J. Sonya Haw**, Limin Peng, Guillermo Umpierrez. *A Randomized Study to Evaluate the Efficacy of Insulclock Pen Device in Insulin-treated Patients with Uncontrolled Type 2 Diabetes.* American Diabetes Association 80th Scientific Sessions, June 2020 (Poster)

19) Teg Uppal, Gail Fernandes, **J. Sonya Haw**, Megha Shah, Sara Turbow, Puneet Chehal, Swapnil Rajpathak, K.M. Venkat Narayan, Mohammed K. Ali. *Variation in*

Ambulatory Care Sensitive Condition-Related Emergency Department Use Among Adults with Diabetes between 2008-2014. American Diabetes Association 81st Scientific Sessions, June 2021 (Poster)

20) Nudrat Noor, Halis K. Akturk, Marisa Desimone, Marina Basina, Nicole Rioles, Saketh Rompicherla, Jeehea Sonya Haw, Lauren Golden, Osagie Ebekozien, *The Effect of Obesity on HbA1c Among Adults with Type 1 Diabetes: A U.S. Based Multi-Center Study.* American Diabetes Association 81st Scientific Sessions, June 2022 (Poster)

21) Emma Ospelt, Nudrat Noor, J. Sonya Haw, Georgia Davis, Susan Hsieh, Ruth S. Weinstock, David W. Hansen, Kristina Cossen, Kathryn L. Fantasia, Ines Guttmann-Bauman, Vandana Raman, Berhane Seyoum, Osagie Ebekozien, *Food Insecurity in People with Type 1 Diabetes and Glycemic Outcomes*, American Diabetes Association 82nd Scientific Sessions, June 2023 (Poster)

22) Khemaporn Lertdetkajorn, J. Sonya Haw, Jamie Elizabeth Paysour, *Atypical Presentation of Birt-Hogg-Dube Syndrome with poorly differentiated follicular thyroid cancer and paraganglioma,* Endocrine Society Annual Scientific Meeting, 2023 (Poster)

23) Susan Thapa, PhD, Dhruvi Vora, BS, Nicole Rioles, MA, Sandra Tsai, MD, Ruth S. Weinstock, MD, PhD, Margaret Zupa, MD, Sonya J. Haw, MD, Francisco Pasquel, MD, Thaer Idrees, MD, Osagie Ebekozien, MD, MPH. *HBA1c Improvement with the Addition of Continuous Glucose Monitoring to GLP-1 Agonist Therapy in people with Type 2 Diabetes,* American Diabetes Association 85th Scientific Sessions, June 2025 (Poster)

24) Bol, T, Odugbesan, O, Wright, T, Rioles, N, Fantasia, K, Zupa, M, Haw, JS, Ebekozien, O. *T1D Exchange Multicenter Study: Increasing CGM Adoption in Type 2 Diabetes,* American Diabetes Associoation 85th Scientific Sessions. June 2025. (Oral)

25) Rachel Wolf, J. Sonya Haw, Priyathama Vellanki, Alexander F. Hudgins, Joshua I. Barzilay, Mackenzie Crawford, Lawrence Fisher, Laura M. Gonzalez Paz, Ilana Graetz, Courtney McCracken, Teaniese L. Davis, *StreamLine: A 5-Step Toolkit for Blood Sugar Management for Young Adults with T1D,* Association of Diabetes Care & Education Specialists 2025. (Poster)

26) Rachel Wolf, J. Sonya Haw, Priyathama Vellanki, Alexander F. Hudgins, Joshua I. Barzilay, Mackenzie Crawford, Lawrence Fisher, Laura M. Gonzalez Paz, Ilana Graetz, Courtney McCracken, Teaniese L. Davis, *Diabetes Distress, Management And Psychosocial Needs Among Black Young Adults With Type 1Diabetes From Two Healthcare Systems: An Integrated Care System And Public Safety-Net Hospital,* American Diabetes Association 85th Scientific Sessions, June 2025 (Poster)

b. <u>Institutional:</u>

1) *JS Haw, SL Jackson, DE Olson, MK Rhee, Q Long, D Barb, AV Mohan, AM Tomolo, PI Watson-Williams, LS Phillips. *Chronic poor diabetes control in a large integrated healthcare system.* Emory University 6th Annual Department of Medicine Research Day, Atlanta, Georgia, October 2013 (poster)

2) S Rahman, S Wishloff, A Emmanuels, A Murphy, C Njoku, JS Haw, J Schneider, *Creating an Online Community Resouce Guide to Support Transgender and Non-binary Patients*, Emory University Department of Medicine Health Equity Day, 2025 (Poster)

22. **Research Focus:**

My research interest is to understand the causes of health inequities, particularly racial and socioeconomic disparities, in order to mitigate gaps in care and outcomes. I have focused on two populations; 1) adolescents and adults with diabetes and 2) transgender, gender non-binary and gender expansive adults.

23. Grant Support:

a. Active Support:
   1. Federally Funded:

      Site Co-I, NIH-NIMH/NIAID/NICHD, *Enhanced COhort methods for HIV Research and Epidemiology (ENCORE) among transgender women in the United State (PI: Andrea Wirtz),* R01AI172092, $176,398; 07/01/2022 – 06/30/2027

   2. Privately Funded:

      Site Co-I, *Expanding T1DES pilot to a public hospital setting at Grady,* Helmsley Foundation (PI: Tina Davis), $323,392.00, 4/1/2023- 3/30/2025, *NCE*

b. Completed Research Support:
   i. Federally Funded:

      Co-I, NIH-NIMH/NIAID/NICHD, *American Cohort to Study HIV Acquisition among Transgender Women in High Risk Areas*, 1UG3AI133669-01, $1,458,347; 07/01/2017 – 06/30/2022

      Co-I, NIH-NIDDK and JDRF, *Preventing Early Renal Loss in Type 1 Diabetes (PERL)*, UC4, $531,970; 11/01/2014 – 6/30/2019

   ii. Private Foundation Funded:

      M-P.I., Emory Medical Care Foundation, *Improving access to and quality of care for transgender patients in the Grady Healthcare System,* $30,000; 2016-2018

      Co-I, Merck, *Health Disparity in Healthcare Resource Utilization in Diabetes*, VEAP 8234, $389,045; 08/02/2019 – 08/01/2021

Site PI, *Type 2 Diabetes Exchange Quality Improvement Collaborative*, T1D Exchange Collaborative (PI: Osagie Ebekozien), $50,000; 01/15/2023- 01/14/2025

2. **Bibliography:**

a. Published and Accepted Research Articles (clinical, basic science, other) in Refereed Journals:

1. **Haw JS**, Narayan KM, Ali MK: Quality improvement in diabetes--successful in achieving better care with hopes for prevention. Annals of the New York Academy of Sciences 2015;1353:138-151

2. **Haw JS**, Farrokhi F, Smiley D, Peng L, Reyes D, Newton C, Pasquel FJ, Vellanki P, Umpierrez GE: Comparison of Basal Insulin Regimens on Glycemic Variability in Noncritically Ill Patients with Type 2 Diabetes. Endocr Pract 2015;21:1333-1343

3. Pasquel FJ, Gomez-Huelgas R, Anzola I, Oyedokun F, **Haw JS**, Vellanki P, Peng L, Umpierrez GE: Predictive Value of Admission Hemoglobin A1c on Inpatient Glycemic Control and Response to Insulin Therapy in Medicine and Surgery Patients With Type 2 Diabetes. Diabetes care 2015;38:e202-203

4. Olson DE, Zhu M, Long Q, Barb D, **Haw JS**, Rhee MK, Mohan AV, Watson-Williams PI, Jackson SL, Tomolo AM, Wilson PW, Narayan KM, Lipscomb J, Phillips LS: Increased cardiovascular disease, resource use, and costs before the clinical diagnosis of diabetes in veterans in the southeastern U.S. Journal of general internal medicine 2015;30:749-757

5. **Haw JS**, Tantry S, Vellanki P, Pasquel FJ: National Strategies to Decrease the Burden of Diabetes and Its Complications. Current diabetes reports 2015;15:65

6. Reyes-Umpierrez D, Davis G, Cardona S, Pasquel FJ, Peng L, Jacobs S, Vellanki P, Fayfman M, **Haw S**, Halkos M, Guyton RA, Thourani VH, Umpierrez GE, Cde: Inflammation and Oxidative Stress in Cardiac Surgery Patients Treated to Intensive vs. Conservative Glucose Targets. J Clin Endocrinol Metab 2016:jc20163197

7. Fayfman M, Vellanki P, Alexopoulos AS, Buehler L, Zhao L, Smiley D, **Haw S**, Weaver J, Pasquel FJ, Umpierrez GE: Report on Racial Disparities in Hospitalized Patients with Hyperglycemia and Diabetes. J Clin Endocrinol Metab 2016;101:1144-1150

8. Alexopoulos AS, Fayfman M, Zhao L, Weaver J, Buehler L, Smiley D, Pasquel FJ, Vellanki P, **Haw JS**, Umpierrez GE: Impact of obesity on hospital complications and mortality in hospitalized patients with hyperglycemia and diabetes. BMJ Open Diabetes Res Care 2016;4:e000200

9. **Haw JS**, Galaviz KI, Straus AN, Kowalski AJ, Magee MJ, Weber MB, Wei J, Narayan KMV, Ali MK: Long-term Sustainability of Diabetes Prevention Approaches: A Systematic Review and Meta-analysis of Randomized Clinical Trials. JAMA internal medicine 2017;177:1808-1817

10. Cha E, **Haw JS**, Faulkner MS: 20 Things You Didn't Know About Type 2 Diabetes in Emerging Adults. J Cardiovasc Nurs 2017;32:317-320

11. Umpierrez GE, Cardona S, Chachkhiani D, Fayfman M, Saiyed S, Wang H, Vellanki P, **Haw JS**, Olson DE, Pasquel FJ, Johnson TM, 2nd: A Randomized Controlled Study Comparing a DPP4 Inhibitor (Linagliptin) and Basal Insulin (Glargine) in Patients With Type 2 Diabetes in Long-term Care and Skilled Nursing Facilities: Linagliptin-LTC Trial. Journal of the American Medical Directors Association 2018;19:399-404 e393

12. Rhee MK, Safo SE, Jackson SL, Xue W, Olson DE, Long Q, Barb D, **Haw JS**, Tomolo AM, Phillips LS: Inpatient Glucose Values: Determining the Nondiabetic Range and Use in Identifying Patients at High Risk for Diabetes. The American journal of medicine 2018;131:443 e411-443 e424

13. Galaviz KI, Weber MB, Straus A, **Haw JS**, Narayan KMV, Ali MK: Global Diabetes Prevention Interventions: A Systematic Review and Network Meta-analysis of the Real-World Impact on Incidence, Weight, and Glucose. Diabetes care 2018;41:1526-1534

14. Davis G, Fayfman M, Reyes-Umpierrez D, Hafeez S, Pasquel FJ, Vellanki P, **Haw JS**, Peng L, Jacobs S, Umpierrez GE: Stress hyperglycemia in general surgery: Why should we care? Journal of diabetes and its complications 2018;32:305-309

15. Magee MJ, Salindri AD, Kyaw NTT, Auld SC, **Haw JS**, Umpierrez GE. Stress Hyperglycemia in Patients with Tuberculosis Disease: Epidemiology and Clinical Implications. Current diabetes reports. 2018;18(9):71.

16. Magee MJ, Salindri AD, Gujral UP, Auld SC, Bao J, **Haw JS**, Lin HH, Kornfeld H. Convergence of non-communicable diseases and tuberculosis: a two-way street? Int J Tuberc Lung Dis. 2018 Nov 1;22(11):1258-1268. doi: 10.5588/ijtld.18.0045. PMID: 30355404; PMCID: PMC6281291.

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b. Manuscripts Submitted:

Srinidhi Bharadwaj, Sagarika Das, MPH, Jason S. Schneider, MD, Limin Peng, PhD, J. Sonya Haw, MD, A comparative analysis of sociobehavioral outcomes among transgender women living with and without HIV.

c. Review Articles:

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d. Book Chapters:

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2. Choi, E., Gupta, P., Besse, J., **Haw, JS.** Care of Transgender and Gender Diverse Youth. In: Pediatrics for High-Risk Populations, American Academy of Pediatrics, *Submitted.*

e. Published Abstracts:

1. **Haw, JS**, Phillips LS. Chronic Poor Diabetes Control in a Large Integrated Healthcare System. Endocrine Reviews. Vol 34. June 2014.

3. Contributions Not Otherwise Noted:

a. Ambulatory clinic and Inpatient consult service schedule organizer for Endocrinology faculty at Grady, Emory University, 2019 –present

b. Internal Medicine Residency Y-block rotation in Endocrinology schedule organizer, Emory University, 2020 –2025

APPENDIX B

APPENDIX B - REFERENCES

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OTHER MATERIALS

Declaration of Dr. Randi C. Ettner, August 1, 2025.

Email from Gerald Wynne, Centurion Georgia Statewide Medical Director, to Marlah Mardis, GDC Statewide Medical Director, Sallie Barker, GDC Director of

Health Services, and Randy Sauls, GDC Assistant Commissioner, related to SB 185 implementation (June 9, 2025).

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