

**Sexual and Gender Minority Health Research Listening Session  
Virtual Meeting  
November 19, 2020, 1:00 p.m.–2:30 p.m. EST**

[MEETING START TIME: 1:00 P.M. EST]

**DR. KAREN PARKER:** Welcome to the second annual NIH SGM Health Research Listening Session. I'm so happy to be here. My name is Karen Parker, and my pronouns are she and her. I currently serve as director of the Sexual & Gender Minority Research Office at NIH. The primary goal of today's listening session is for NIH leaders and staff to hear from community stakeholders about what issues are on their mind regarding SGM-related research and related activities at the National Institutes of Health. Selection of these organizations invited today is based on the diversity of organizational missions and efforts. This year, we will have 11 organizations presenting to us. Before we began listening to comments from these stakeholders, we will hear remarks from several senior NIH leaders. We also have several colleagues in attendance from across the different Institutes, Centers, and Offices at the agency, and we are all excited to hear from them. I will be serving as moderator for today's session, and we will be prompting speakers, both NIH leaders and invited organizational representatives, to turn your audio and video on when it is your time to provide remarks. Please be sure to mute your audio and video feed when you are not speaking. To members of the public who are joining in today to listen, welcome. This session is being recorded, and both a captioned video and transcription document will be posted to the SGMRO website in the coming weeks. Please note, members of the public will not be able to provide comments during this session. If you would like to submit comments to the Sexual and Gender Minority Research Office, you may do so after the session via email by emailing [sgmro@nih.gov](mailto:sgmro@nih.gov). So, now I'd like to get started. We'll begin by hearing opening remarks from NIH senior leaders, each of whom have approximately 2 minutes or so to speak. So, first, we have Dr. Alison Cernich, who serves as deputy director of the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development. So, Allison, if you'd like to turn your video on, welcome.

**DR. ALISON CERNICH:** Thank you, Karen, and thanks to all of you for welcoming us here today. I'm the deputy director of NICHD, as noted by Karen, and I just want to highlight that NICHD remains committed to issues facing individuals of sexual/gender minority groups. We really do look at those from a developmental perspective, including the development of gender beliefs, identity, and cognition in children. We also have large studies on early intervention used for care, including hormone treatment in sexual gender minority children and their impact on brain and bone development. We also do quite a bit of work in behavioral aspects of this, including identification of risk and resilience factor. We work a great deal in terms of demography and population health on issues facing this community. Specifically, we look at a very large study—the Generations study—which has been a longitudinal study that we had funded to look at the health and wellbeing of lesbians, gay men, and bisexuals across three generations, as well as the U.S. Transgender Population Health Survey, TransPop, which is the first national survey to accurately represent and affect the health of related issues in transgender individuals in the United States. We fund a great deal of research in differences of sex development, including chromosomal conditions and other issues related to anatomy that may be different at birth. Finally, we do a great deal of work in prevention and interventions for HIV and AIDS in sexual gender minority youth and adolescence. So, what I really look forward to today is hearing from you and what your concerns are and being able to understand how we can better position the research of our Institute to serve the needs of this community. So, thanks, Karen, for welcoming us today.

**DR. KAREN PARKER:** Great, thanks so much, Alison. Next, we are going to hear from Dr. Wilson Compton, who is deputy director of National Institute on Drug Abuse.

**DR. WILSON COMPTON:** Good afternoon. It's a pleasure to be with you, and thank you for inviting the National Institute on Drug Abuse to join this important listening session. When we think about the issues of sexual gender minority status and substance use, this has been a major concern. We see over-representation of persons from virtually all subgroups within the SGM population and addiction issues, whether that's use of various licit and illicit substances or the more serious addiction issues faced by persons that use these substances. Understanding the reasons for this health disparity has been a part of our epidemiology program going back now a number of years, and we're proud to continue that and to try to unravel these important associations so that we can develop interventions that can help prevent and ameliorate the impact of excess substance use by SGM populations. The other main theme I'd highlight, as far as NIDA's portfolio is concerned, would be our HIV program. About a quarter to a third of the NIDA budget is focused on HIV/AIDS-related research, and, of course, a major component of that will have to do with men who have sex with men and the other issues related to how drug use and drug use patterns overlap with sexual behavior in the transmission and progression of HIV/AIDS. So, that remains a major concern and a major area for interest for our portfolio. I'm particularly excited to be listening today, though, because while we have a robust program that builds on SGM issues, I know that there's a lot more that we could be doing, and I look forward to bringing back some new ideas from the groups participating today. Thanks very much.

**DR. KAREN PARKER:** Thank you, Wilson. So now, we're going to have Dr. Josh Gordon. Dr. Gordon is director of the National Institute of Mental Health.

**DR. JOSHUA GORDON:** Thanks, Karen, and thanks to everyone for joining the call today. I'm also equally honored and pleased to be here today and looking forward to hearing your input, so I'm going to keep my remarks brief. The National Institute of Mental Health recognizes that more mental health research involving SGM populations is essential, both to gain a better understanding of the complex factors impacting the wellbeing and mental health needs of individuals in the SGM community and also to develop interventions and approaches that reduce mental health disparities experienced by many in the SGM community. To that end, NIMH staff are tirelessly working to expand our knowledge base of SGM mental health and mental wellbeing to remove barriers to planning, conducting, and reporting NIMH-supported research on SGM mental health and to strengthen the community of researchers who conduct mental health research relevant to SGM populations. We have a broad portfolio of SGM mental health research. In the past year alone, we've focused on a range of topics, including but not limited to suicide prevention, to policy research related to health care access, and intervention research on SGM populations, with a focus on youth and minority populations. In addition, as was mentioned by Dr. Compton for DAR—sorry, for NIDA—the NIMH has a Division of AIDS Research that is very robust; about 10 percent or so of our budget goes to that. And the Division of AIDS Research at NIMH is focused on behavioral approaches to stemming the HIV epidemic and neuroscience approaches to understanding the effects on brain and behavior of HIV infection. There's a strong emphasis in both those areas on SGM populations in the U.S. and abroad. I would add, in particular, that there's been a number of research projects that are aimed at understanding the very high rates of both mental illness and—more importantly for the current conversation—HIV in transgender populations and trying to understand how to reach this challenging-to-reach population for care in both these areas. The NIMH sponsored its own annual ... sorry, the first what will become an annual SGM mental health research webinar in July. And program staff convened two workshops on SGM mental health research at scientific

meetings in the past year. So, we have an active program in this area. And I would just mention, in addition, that both the mental health and HIV-related SGM work is taking place in the U.S. but also as part of our global mental health research efforts, particularly in lower- and middle-income countries. We work closely in all this with the NIH Sexual & Gender Minority Research Office, with the National Institute on Minority Health and Health Disparities, as well as other Institutes and Centers. And, again, I'm really pleased to be here and to hear your input.

**DR. KAREN PARKER:** Great, thank you so much, Josh. Next, we have Dr. Jennifer Alvidrez, who is a program official at the National Institute on Minority Health and Health Disparities.

**DR. JENNIFER ALVIDREZ:** Hi, thank you, Karen. As Karen said, I'm Jennifer Alvidrez, pronouns she and her. I'm from NIMHD, and we appreciate the invitation to be part of this listening session. Our mission at NIMHD is exclusively focused on supporting research related to help disparity populations, which, of course, includes sexual and gender minorities. We have a primary interest in research on the social determinants of health from the individual to the societal level that contribute to health disparities for SGM populations across a broad range of health conditions. And we're also especially interested in intersectionality, how SGM status—in combination with race/ethnicity, socioeconomic status, and rural or urban residents—is related to health and health disparities. So, I'm excited to hear your comments today, and thank you very much for your participation. Thank you.

**DR. KAREN PARKER:** Thank you, Jennifer. Now I'd like to invite Dr. Maureen Goodenow, who serves as director of the Office of AIDS Research in the Division of Program Coordination, Planning, and Strategic Initiatives to make some comments.

**DR. MAUREEN GOODENOW:** Thanks, Karen, and thank you, all, for the invitation to be a part of this listening session today. The Office of AIDS Research—or OAR—coordinates the HIV research agenda across the NIH and, in that capacity, assures that the overarching research goals for the NIH HIV research program are addressed and achieved, and those include ending the HIV pandemic and improving the health of people with, at risk for or affected by HIV. OAR develops the strategic plan and scientific agenda for HIV for the NIH and deploys HIV resources across a number of Institutes, Centers, and Offices, including—I'm happy to say—all of the partners—federal partners—who are here today and have already spoke with you. In terms of background, in 2018, more than a million persons in the United States were living with diagnosed HIV infection. Gay, bisexual, and other men who have sex with men are the population most afflicted and infected by HIV in the United States. In 2018, gay and bisexual men made up 69 percent of the approximate 38,000 new HIV diagnoses in the United States. The percentage of transgender people who received new HIV diagnosis was three times the national average, and an estimated 14 percent of transgender women have HIV. By race/ethnicity, an estimated 44 percent of African American transgender women, 26 of Hispanic transgender women, and 7 percent white transgender women have HIV. These are higher rates of HIV among underrepresented minority groups and in the southern part of the United States. So, the comprehensive HIV research agenda at the NIH, the fact that it covers and includes almost every single Institute, Center, and Office ... and, as you already heard from the other NIH partners today, virtually everyone has a significant research portfolio in sexual and gender minority research, particularly affected by ... focused on HIV. So, thank you, again, for coming together and allowing us to sit in and listen on to your conversation today.

**DR. KAREN PARKER:** Thank you, Maureen. And then, finally, we'll hear from Dr. Charlene Le Fauve, who serves as a senior advisor in the Scientific Workforce Diversity Office in the Office of the Director at NIH. Charlene?

**DR. CHARLENE LE FAUVE:** Thank you very much, Karen, and thank you for all of you who are joining today and for the opportunity for our Office to participate in this very informative listening session. The mission of the Scientific Workforce Diversity Office, which was established in 2014 by Dr. Collins, is mainly to diversify the biomedical research workforce by developing a vision and comprehensive strategy to expand recruitment and retention and promote inclusiveness and equity throughout the biomedical research enterprise. The vision is to create cultures of inclusive excellence, establishing and maintaining scientific environments that can cultivate and benefit from a full range of talents at NIH and at NIH-funded institutions. To that end, we partner closely with Offices in the Office of the Director, with the Institutes and Centers at NIH in a trans-NIH way. And we also use data to drive most of what we do and inform most of our policies, recommendations, and programming. We also have a chief officer for scientific workforce diversity, who was appointed in 2014, and have an acting in place right now, Dr. Marie Bernard. And we oversee the Advisory Committee to the Director Working Group on Diversity, which informs the Advisory Committee to the Director for Dr. Collins. And then our functions are to promote diversity in the biomedical and behavioral research workforce—which, of course, includes sexual gender minority populations—as we think of the workforce contributing to the research agenda for solving complex medical problems. We also promote our recruitment and retention of underrepresented minorities—people with disabilities, people from disadvantaged backgrounds, and that includes, where applicable, sexual/gender minorities. And we want to also make sure that we have a mentoring focus, a career development focus, and a sponsorship focus for underrepresented minorities students and early career investigators. We also have a focus on addressing threats to inclusivity inside NIH and outside NIH in relation to reducing bias and encouraging a very broad perspective to capitalize on the excellent workforce out there to compete for biomedical research positions and to enter and retain their commitment in a biomedical research career trajectory. To that end, I just want to say that I sat in a listening session a previous year, and it was tremendously informative. I will be briefing our acting chief officer for scientific workforce diversity on these deliberations, and I work very closely with her and with Karen Parker and our partners across the OD to ensure that this mission related to SGM research is achieved. Thank you so much, and I look forward to hearing all of your thoughts.

**DR. KAREN PARKER:** Thank you, Charlene. And I would just like to, once again, thank all the folks from NIH who are here today. Our job truly is to listen, so you won't be hearing from NIH folks anymore until my closing remarks. I'd also like to thank everybody for staying to their time limit, which is remarkable. So, now we are ready to start listening to the folks who we would like to hear from. So, first, I'd like to invite Alexandra Bolles, who is a board member at large from the Bisexual Resource Center, to start your video and unmute yourself and please let us know what's on your mind.

**MS. ALEXANDRA BOLLES:** Hi, everyone. My name is Alexandra Bolles. My pronouns are she and her, and I'm a board member at large for the Bisexual Resource Center, the country's oldest nationally focused bisexual+ organization. Thank you to the NIH for welcoming the Bisexual Resource Center to today's listening session, and thank you to all who are tuning in. It is an honor to speak alongside so many respected community leaders today. At the BRC, we serve the entire bisexual+ community: That means bisexuals, pansexuals, and anyone attracted to more than one gender, regardless of label. While bi+ people may use different terms to identify ourselves, we share common hurdles in the movement for full equality, acceptance, and wellness. Some of the commonalities are bisexual+ people make up the majority of the LGBTQ community and have been at the forefront of the LGBTQ equality throughout history. The first Pride march was even organized by a bisexual woman named Brenda Howard, so our roots run

deep. Statistically, we are abundantly intersectional, with many races, gender identities, and abilities represented. Civil rights, trans rights, and disability rights are bisexual+ rights. Compared to our gay and straight peers, we faced higher rates of physical, mental, social, and sexual abuse. This includes interpersonal violence, suicidality, substance misuse, anxiety, isolation, homelessness, poverty, and more. Bi+ people are often excluded from both straight and gay spaces, with few places to turn to meet our unique and pressing needs. Another vital experience those of us in the bisexual+ community share is perhaps the most important. When bisexuals have the tools we need, we exhibit great resilience. We successfully cope with and conquer our adversities, but we need your help to make this happen. We will never achieve full LGBTQ equality if bi+ peoples' need are not intentionally met. The three biggest, most urgent, most systemic things the bisexual+ community needs in order to survive and thrive are (1) money, (2) research, and (3) inclusion. Of course, money seems like an obvious ask, but I really mean it. Unlike our gay and trans peers, there are no bisexual+ organizations with paid full-time staff, and there are no staff members at major LGBTQ organizations dedicated solely to the bi+ community. Overall, bi-specific issues receive the least amount of money compared to L-, G-, and T-specific issues. Let me be clear: Bisexuals make up more than half of the LGBTQ community and face some of the highest health risks but receive the least resources to combat them. Ideally, a good chunk of that money goes towards research that disaggregates the bisexual+ community from the rest of the LGBTQ community. Because bisexual+ wellness rates are so much lower than the gay populations, aggregating our experiences together inflates the number we have about overall LGBTQ health without earmarking proportional funds towards bi+ people. In order for our specific and dire needs to be met, research needs to dig deeper into and offer policy solutions for our unique hurdles. That brings us to why inclusion, both dedicated and casual, is necessary for our community to thrive. Many of the hardships we face are rooted in misconceptions about who bi+ people are. False claims that bisexuals are inherently deceptive, disloyal, greedy, and hypersexualized are used to justify the exclusion we face from life-saving resources, the physical and sexual violence we face from our partners, the bullying from our peers, and more. You are less likely to see us represented in media, shaping policy, and holding positions at well-funded LGBTQ organizations. This erasure breeds harmful antagonism. While bisexuals make up most ... much of ... excuse me. While bisexuals make up so much of the overall LGBTQ community, we are less likely to be out to our loved ones because of the antagonism we'll face. So, the mainstream opinion of our community is often rooted in uncontested stereotypes. While the earmarked funding and research may take some time, everyone on this call today can commit to being better at including bisexual+ people in your work. Reach out to organizations like the Bisexual Resource Center, amplify the work of bi+ organizers, and pass the mic to bi+ people with intersecting, marginalized identities so we can tell our stories in our own words. Hear us, hire us, and help us become resilient. Thank you for your time.

**DR. KAREN PARKER:** Thank you very much. Now I'd like to invite Scott Nass, who is president of GLMA: Health Professionals Advancing LGBTQ Equality. So, if you'd like to turn on your video and unmute?

**DR. SCOTT NASS:** Hello, everyone. Thank you, Dr. Parker, and thank you to the Sexual & Gender Minority Research Office for inviting us here today and to the other NIH leaders taking part in this session. My name is Scott Nass—he/him—and I am a family physician located in Palm Springs, California. My clinical and advocacy work focus on LGBTQ health, and I am proud to serve as president of GLMA: Health Professionals Advancing LGBTQ Equality, an association of LGBTQ health professionals of all disciplines committed to ensuring LGBTQ health equity and equality for LGBTQ health professionals through policy, advocacy, and education. You can learn more about us at [glma.org](http://glma.org). GLMA would like to take a moment to

highlight four broad priority areas for your consideration today. We are grateful for the work that NIH is already doing in each of these areas, and we ask that NIH expand its efforts based on our recommendations today. First is LGBTQ inclusion in health policies and programs. As the largest biomedical research agency in the world, NIH has a unique role in supporting research initiatives. We wholeheartedly support the SGMRO's strategic goal to prioritize LGBTQ health research, and we hope this will result in increased funding for projects that evaluate LGBTQ health inequities, as well as an increased support for researchers through their research project grant program. Importantly, health inequities can be discovered only if the LGBTQ people are included in clinical research, so we ask that efforts be implemented to recruit sexual and gender minority participants to clinical trials and that requirements for demographic variable collection be expanded to ensure that the full breadth of diversity among LGBTQ communities is captured adequately. Second and related is, improve the data collection in nonclinical projects. The SGMRO has been leading inclusivity efforts, and this year's publication by the National Academies of the report *Understanding the Wellbeing of LGBTQI+ Populations* demonstrates the potential for establishing a baseline level of inclusion for LGBTQ people in national population surveys. Until we reach a point of broad inclusion of sexual orientation and gender identity in these surveys, we will not be fully equipped to address LGBTQ health inequities. Third, nondiscrimination in health care is foundational to ensuring health equity for LGBTQ people. Research continues to show that discrimination negatively impacts health and leads to inequitable health outcomes. The NIH surely has a role to play in supporting nondiscrimination in health care. This may not be a traditional role for the NIH, but we hope to see innovative leadership in this area. True health equity will never be achieved until we eliminate discrimination against all sexual and gender minority people. Finally, we ask that the NIH address training at all levels in LGBTQ health by taking an equity-in-all-programs approach to staff education and training. Staff within all Institutions and Divisions within NIH should have some knowledge of LGBTQ populations and their unique health needs, which would then position staff to understand how sexual and gender minority people fit within their particular scope of work. LGBTQ health equity reliably would be a consistent theme no matter the institution or division. For example, this can help ensure that research conducted NIH-wide accounts for sex not as a binary but as rather inclusive of transgender, nonbinary, and gender-nonconforming communities. Looking across these four priorities, we appreciate that specific communities have been included in today's session—communities that frequently are omitted from generalized health equity efforts, such as bi+, intersex, and BIPOC communities, particularly Black LGBT and Two-Spirit. We recognize, particularly in this year, that we need to be much more proactive around how we address the health of communities of color. We have much work to do highlight and center the health of these communities in discussions of health equity, especially given that our work around LGBTQ health particularly impacts communities and individuals at the intersection of sexual and gender minority identity and race. As an organization, GLMA is trying to do more to be responsive to these communities, and we need institutions to recognize the importance of inclusion and take action, as well, such as the invitations to important groups to this meeting today. GLMA certainly will be listening intently to the remaining recommendations shared by these groups for actionable items we can implement. We see this as a unique opportunity for NIH, as well. Finally, as we collect data on sexual orientation and gender identity, we need to have ways to analyze that data across BIPOC communities. We aren't going to get to a place where we can impact the health needs of Black LGBTQ people unless that data is intersectional. We ask NIH to take on this charge and promote data collection and analysis that ultimately will enable achieving success in the four priority areas we identified. Thank you for your time today.

**DR. KAREN PARKER:** Thank you, Dr. Nass. Next, we'll be hearing from David Ernesto Munar, who is president and CEO of the Howard Brown Health Center.

**MR. DAVID ERNESTO MUNAR:** Thank you, Dr. Parker, and the SGM Research Office for this opportunity. My name is David Ernesto Munar. I'm president and CEO at Howard Brown Health, and I use he/him pronouns. Howard Brown Health is the largest LGBT organization in the west and medical home for 40,000 patients and clients who receive care through 12 clinical locations across Chicago. Today's remarks build on work led by Howard Brown Center for Education, Research, and Advocacy over the past year, including two community-based participatory research projects. We lead with national and local cohorts of transgender and nonbinary leaders in community efforts. Drawing on community input, we have expanded our understanding of transgender health research needs, particularly the need to continue to examine the long-term effects of hormone replacement therapy, including interactions, side effects, long-term outcomes, delivery methods, and dosing, as well as the impact these can have on gender-affirming surgery. The community members we've met with through the community participatory research are also very interested in research to better understand and address mental health needs and trauma experienced by TGNCB people. We also are really interested in more research that focuses on the interventions and understanding around our reproductive health needs, fertility and family-planning needs of the transgender community, as well as the ways to better engage clinical providers to support shared decision-making with their patients. Finally, we'd like to recommend that there be additional research looking at population-specific needs of the transgender community, particularly understanding the needs—the unique needs—of nonbinary people, transgender people with disabilities, and transgender people of color. Other research topics that the Howard Brown Center for Education, Research, and Advocacy is concerned about underscore comments made by Alexandra from the Bisexual Resource Center to expand research focusing on bisexual and bi+ people, including best practices in primary care and other interventions to better serve this population. We'd like to see a greater focus on research on the health needs of lesbians to better understand disparities in the health care access, cancer interventions, and other health topics. Our experience with community-engaged researchers has really expanded our understanding of how rich the community-engaged process can be, and we'd like to see NIH continue to expand its portfolio, particularly with underrepresented LGBTQ communities. Because of the pandemic that we're all living through, there are so many enormous research needs to understand the impact of COVID-19 on LGBTQ communities, particularly communities of color, as well as engagement strategies and messaging around vaccine uptake. Community-level interventions are needed to address the social determinants of health of diverse LGBT communities and better understand the impact of stigma, housing insecurity, food insecurity, and employment needs of the LGBT community. And then, thank you, Charlene, for your comments, because they echo our interest in seeing NIH continue to support early-career LGBTQ investigators of color and trans-identified researchers to increase pathways for future research in areas of the NIH portfolio. Thank you for this opportunity.

**DR. KAREN PARKER:** Thank you so much, David. Next, we will hear from Sean Saifa Wall, cofounder and strategist of the Intersex Justice Project.

**MR. SEAN SAIFA WALL:** Oh [inaudible].

**DR. KAREN PARKER:** Yeah, we can hear you.

**MR. SEAN SAIFA WALL:** Okay, great. Alright. Okay. Just wanted to make sure. Thank you for this invitation. Again, my name is Sean Saifa Wall. I am cofounder and strategist with the Intersex Justice Project. I'm coming to you today just to share a little bit about IJP's work, as well as sort of the landscape for intersex research and just an ask. So, the Intersex Justice Project was founded in 2016, with the goal of ending intersex surgery in the United States. We

believed that intersex people of color would lead that initiative to end this surgery. After 3 years of campaigning through online campaigning, as well as building alliances and coalitions with trans allies and other allies in other movements, we were able to pressure Lurie Children's Hospital to end surgeries. They issued an apology in July 2020 of this year, as well as saying that they would stop doing surgeries at their hospital—medically unnecessary, harmful surgeries on intersex children—for 6 months, and that's huge. That is so huge. And we're hoping that that trend can continue. The thinking behind it was that if we can get one hospital to stop these practices, maybe other hospitals, especially the leading hospitals, would agree to do this. Maybe we can actually create healthy alternatives in health care for intersex children, as well as adults. Thanks to the work led by InterACT, which is a legal and policy organization, Boston Children's Hospital said that they would stop doing cliteroplasties and vaginoplasties on intersex children. Mind you, this is happening on intersex girls—intersex little girls. So, what I'm asking for the NIH ... from the NIH is that we fund research that is driven by intersex people, that we fund research driven by intersex activists, and that we trust intersex activists to deliver the work. For people on this call who don't know, there was a study that was ... the study results were released this year ... Suegee Tamar-Mattis—who is an intersex doctor based in California—Jason Flatt, who is at UCSF, and some other authors contributed to the first national intersex study in the U.S. that documented the mental health and the physical health of intersex people—intersex adults. From that survey, they found—it was online—from that survey, they found that over 50 percent of the people have mental health issues ... of the people who were respondents had mental health issues. Also, the sample was overwhelmingly young. A lot of the people were between the ages of 18 and 39. I bring that up ... is that we actually need more research that's based in the United States, because a lot of the research is based outside the U.S.—in Europe, where I am right now. I'm in England. I'm doing a fellowship—Marie Curie fellowship—by the European Commission to look at intersex rights in this context. They funded 10 research posts, and I'm doing one of the posts to become an intersex researcher, right? Because there is a dearth of knowledge, and for a community that is marginalized, that is harmed by the medical establishment—namely pediatric urologists—we need intersex people to be driving the research, and we actually need to remove intersex as a category from the sort of medical gaze and from the medical establishment. And so, I would ask ... like, right now, I'm in England, and the National Health Service is doing a consultation on intersex. As an American, I believe that we can actually do the same. I think we can actually pressure ... put pressure to actually end medically unnecessary, cosmetic surgeries on intersex infants and children. We can do this. So, this is my ask. And finally, what I would ask of Howard Brown is that, as a community partner, that you would also take a stand as far as creating comprehensive health care for intersex young people who receive services at your institution. So, thank you for your time. Thank you for listening, and I look forward to the remaining presentations and from my other panelists. Thank you.

**DR. KAREN PARKER:** Thank you so much for joining today, Sean. So, next, we'll hear from Chloe Opalo, who is a research coordinator at the Los Angeles LGBT Center.

**MS. CHLOE OPALO:** Hi, everyone. My name is Chloe Opalo. I work as a research coordinator at the Los Angeles LGBT Center. I wanted to thank you so much for inviting me today into this listening session. Today, since we're talking about research, I wanted to focus with this platform that I'm being given today. I wanted to talk about trans health and trans health in research. I wanted to talk about what we'd like to see more. So, we would like to see more trans research that's unrelated to HIV research. It would be wonderful to see more research focus on HRT and the interaction it has on our minds and bodies over time; trans-related research that focuses on our mental health, self-care, and wellbeing; research that is focused on support groups and their impact on our community; and more studies that focus on housing, education, and employment.



So, all these studies should be incentivized generously so they can help trans people who do not have regular sources of income and depend on incentives from research studies and support groups. A lot of trans and nonbinary folks depend on the compensation that is given to them through research, so not only do we need more trans-related research to help improve our society's knowledge of trans health, but we need these research studies to give back to the trans community with these incentives that help them live and thrive. It would be amazing to see more generous compensations for the trans community and incentives that help them with transportation, as well. So, a lot of trans people that participate in research have to take public transportation, where they can encounter discrimination, so it would be great to have studies that help them get to and from their appointments—be it car services like Uber or Lyft or a more permanent solution would be a study that would provide bicycles or other reliable modes of transportation that they could use to get to their other appointments, aside from research—so, the other appointments that they have for food banks, support groups, possible employment, etc. We'd also like to see more research on post-op trans women—that would be trans women who have gone through gender confirmation surgery, also known as vaginoplasty. For the most part, we know it's a safe procedure, but more research needs to be done on what happens after the surgery—what changes can they expect to their mental health, their mood, libido, and what are the long-term effects of the surgery? How much does their life change afterwards? The social impact it has on them? The long-term effects of dilation or lack of dilating? And with this surgery becoming more accessible through health insurance in the recent years, we think this is something that the community really needs more information on. We'd also like to see more research on trans masculine people all around. So trans masculine people usually take the back seat when addressing the trans community, and it would be great to see them represented more in research by having studies focus on them and their health—mental health and all of those things. We'd also like to ... sorry. We also think there needs to be more research on what can be done for trans women of color to have long and healthy lives. Trans women of color have a shorter life expectancy than the other populations, so perhaps implementing a study that helps trans women move forward in life. Besides their sexual health, how else can we help them access education, employment, and housing? Possibly developing a study that helps them with all of these aspects. Usually if someone is needing help with housing, they are also in need of employment, as well. And if you step back and see the bigger picture, you notice that it's a cycle where one barrier has a major effect on the other, and usually all of these barriers need to be addressed for them to have access to these services. And of course, when working with a trans and nonbinary population, there needs to be trans representation on the research side, as well. So, there needs to be trans and nonbinary people doing the outreach to the community. They need to have someone who is trans explaining and consenting them for the studies as a research coordinator. Having trans and nonbinary people working on these research studies will prevent the participants from feeling like an exotic other, and instead they will see someone who is a part of their community or has endured the same or similar life experiences that only trans and nonbinary people can understand. And most importantly of all, all future studies should have a trans and nonbinary advisory board that would filter out any studies that would be doing a disservice to the community. And if we focus on HIV research, we'd like to see more research on sex work. And also, if it's HIV research—which a lot of it right now seems to be HIV prevention—it would be great to see more HIV-positive inclusion for participants in these studies. Like I mentioned before, a lot of the community depends on these compensations for their survival, and a lot of the HIV positive community seems to be left out from the research. So, yes, that's what I would like share today. Thank you.

**DR. KAREN PARKER:** Great, thank you so much for your comments. Next, we have Mary Anne Adams, who is founder and executive director of ZAMI NOBLA, the National Organization

of Black Lesbians on Aging. And so, Mary Anne, I'm not sure if you are on video or if you just want to unmute your phone.

**MS. MARY ANNE ADAMS:** I am unmuting my phone. I am having some problem with my video.

**DR. KAREN PARKER:** Great, we can hear you perfectly.

**MS. MARY ANNE ADAMS:** Great, thank you. Thank you, Dr. Parker and the Sexual & Gender Minority Research Office, for this important listening session. “Those of us who stand outside the circle of the society’s definition of acceptable women, those of us who have been forced in the crucibles of difference, those of us who are poor, who are lesbians, who are Black, who are older know that survival is not an academic skill”—Audre Lorde. Deeply rooted in the state of Georgia with a national reach, ZAMI NOBLA: National Organization of Black Lesbians on Aging is committed to building a base of power, amplifying Black lesbians 40 and older through service advocacy and community-engaged research. As the only organization in the country expressly focused on older Black lesbians, with members ranging in age from 40 to 85 and living in such geographically diverse places as rural Alabama and Harlem, New York, we aim to create new paradigms for conscious aging. We offer needs-based community programming, support groups, social networking, houses, housing and food justice initiatives, educational activities, scholarships for lesbians over 40, skills-based training, public policy advocacy work, and community-based participatory research. Health and wellbeing, economic security, and social connections are among the cornerstones of successful aging, yet these are areas in which many LGBTQ elders face substantial barriers stemming from current inequities, as well as the accumulation of a lifetime of legal and structural discrimination, social stigma, and isolation. A 2014 study on Black Lesbians and Aging: Understanding Health Care Needs conducted by ZAMI NOBLA in partnership with Dr. Tonia Poteat at John’s Hopkins School of Public Health found there was an urgent need to address physical health and mobility, as well as mental health preventative and therapeutic care. What we don’t know and need data to better understand are the ways in which community impacts isolation and fosters coping and resilience through social support mechanisms. We need funding to investigate and test innovative, holistic care models based in the community with links to culturally competent facility-based services. Are increased opportunities for networking and social support through online as well as in-person interactions that focus on spiritual expression and stress reduction techniques—including music, dance, yoga, laughter, and sexual expression—beneficial for older Black lesbians? We don’t know. Will a support network of Black lesbians in multiple generations positively impact the aging process? We don’t know. We need funding to collect the data to develop the interventions and to evaluate the effectiveness to find out. We also need additional research with aging Black lesbians in rural areas and other regions of the country where the aging experiences of mature Black lesbians may look different than that of lesbians in rural and suburban centers. In a 2018 research study, ZAMI NOBLA, in partnership with Dr. Tonia Poteat and Dr. Lori Dean of Johns Hopkins School of Public Health, looked at exploring interactions between Black sexual minority women and health care providers for breast cancer screening and care. And the findings suggest that Black sexual minority women face challenges in the health care system for breast cancer screening and follow-up care because health care environments and health care providers may be less likely to support them. We need better collection of sexual orientation and racial identity data in electronic medical records and other databases essential for building the evidence base to understand disparities for those at the intersection of marginalized racial and sexual identities. The experiences of Black sexual minority women during breast cancer screening and follow-up care captured in this study speak to a larger need to fund interventions and training programs that address individual-

and structural-level biases that hinder quality of care for Black sexual minority women. Once such intervention could be funding programs to train Black lesbian breast cancer survivors as peer navigators to counsel other Black sexual minority women to encourage engagement and retention in care and support services. ZAMI NOBLA is currently partnering with Dr. Tonia Poteat and UNC Chapel Hill collecting qualitative data on meeting the pandemic needs of Black lesbian elders. And this data would inform a rapid COVID-19 response intervention. Does social isolation of older Black lesbians in a pandemic affect their mental, physical, and nutritional health and fears about aging? We don't know. But we are collecting the data, exploring their knowledge of and access to material in psychosocial support. Unfortunately, when we complete the qualitative dataset with these 100 Black lesbians, we will have to put the quantitative component with the 300 lesbian sample size, both accessing health impacts and psychosocial measures, on hold because we simply don't have the necessary funding to continue this important and necessary research. Thank you for listening.

**DR. KAREN PARKER:** Thank you so much for sharing. Next, we have Kia Darling-Hammond, who serves as director of education programs and research at the National Black Justice Coalition.

**DR. KIA DARLING-HAMMOND:** Can you all hear me?

**DR. KAREN PARKER:** Yes, we can.

**DR. KIA DARLING-HAMMOND:** Okay, thank you. My name is Kia Darling-Hammond; my pronouns are she/her. I'm the director of education programs and research at the National Black Justice Coalition, and I'm happy to join this conversation today. The National Black Justice Coalition is the nation's only civil rights organization working at the intersection of racial equity and LGBTQIA+ and same-gender-loving equality. Our north star is a society free of stigma, discrimination, and violence against Black LGBTQ and same gender-loving Americans. And our work includes crisis response, efforts around access to and increasing civic engagement, research, cultural competency training, and youth development. The populations we serve who represent multiple groups experiencing complex marginalization along the lines of race, sexuality, gender, and related challenges that result from being perceived as disposal and impossible experience social ills disproportionately. So, these include an increasingly visible lack of technology equity, also known as the digital divide; exposure to all forms of violence, including hate crimes, which you can see in a recent report from the FBI, which unfortunately noticed underreporting; every dimension of civil rights need, from housing to education to public space accommodation and jobs, and all of this impacts health. In addition, our populations experienced numerous health-confounding challenges across the landscape that disproportionately disadvantaged them, including disparities in research investment, which relate to disparities in representation across the entire health and health research field, and that relates to things like affordability and other compounded challenges to accessing completion of training among our population, funding of publication-driven decision making that's related to the kinds of investments that entities on this call make, and good old-fashioned discrimination. Another health-confounding challenge or suite of challenges include perpetual negative experiences with community-facing researchers and practitioners, including bias and discrimination, misinformation, ignorance and cultural incompetence, and disrespect. Again, going back to the comment on being treated as disposable or impossible, that trickles down of course into every facet of how we're experiencing the various aspects of health and health care and health research. I'd like to invite everyone on this call to revisit what sister Mary Anne Adams just said, because everything in her comments is something we cosign. And I would add that approaches to research about Black trans, queer, same-gender-loving, bisexual, lesbian,

and gay people need to be community grounded, community driven, holistic, and critically informed. And that means that they have to really take into account the way that systems and institutions that are grounded in ideas of body hierarchy and disposability function. There's also a profound lack of focus on thriving and flourishing and triumph. Most the research on our populations focuses on challenges and disparities, which is necessary, right? They are real. But there's a need to reframe the way that we think about and understand these groups of people also in relationship to our innovations and the ways that we've made a way out of no way and the ways that we can inform how to design a better world. Representation of practitioners, researchers, and stewards of resources needs to increase, and dramatically so. Collecting of SOGI data needs to include age groups under 13. We need to figure out how to measure our populations across the lifespan. And data needs to be readily available, granular, and disaggregated so that we know what we're talking about here. I just think that there's a clear connection between the kinds of belief systems that come into play in our society and the kind of health research that takes place and the kinds of investments that follow suit. All of those need to be reexamined to be inclusive and intersectional. Thank you.

**DR. KAREN PARKER:** Thank you very much. Next, we will hear from Koomah from the Houston Intersex Society.

**KOOMAH:** Hello, everybody. Can you hear me?

**DR. KAREN PARKER:** Yes, we can.

**KOOMAH:** Great. Hello, I'm Koomah from the Houston Intersex Society, and I use all pronouns. So, if ... particularly, if you're not familiar with what intersex is, intersex is when someone has anatomical, hormonal, chromosomal, and/or gonadal traits that are somewhere in between what is considered typical for male or female. And oftentimes what happens is when children like this are born, they rush and do an immediate surgery on them. These surgeries are medically unnecessary. They're painful. They're irreversible, and they're nonconsensual. And intersex ... a lot of times people are told that it's very rare. It's actually ... we're about 2 percent of the population, which is roughly about the same number of identical twin births. So, there's really only two instances where surgical intervention is necessary. The first is when someone is born with internal organs on the outside of their body, and the second is in order to create an opening for waste to leave the body, where one is underdeveloped or not present. Any other surgical procedures are cosmetic and can be safely deferred until the child can be involved in the decision-making process. So, up to 40 percent of these surgeries that are happening have complications; many require multiple follow-ups, and about 60 percent of the time, there's an incorrect sex assignment, where the person grows up to have a gender identity different than the sex that's been surgically assigned. And that information comes from the Statistic Manual of Intersex Disorders in 2006. So, one of the things that we really, really, really need is research. And a lot of these surgeries are being done referring to old research, and this old research was ... based their success outcomes solely on the appearance of the post-surgical genitals. They didn't really follow up with the individuals, and they didn't take into account the mental, physical, and emotional health and wellbeing of the individual as they got older. So, what we really need is more new data. So, similar to what Saifa had shared earlier—and I put a link to the research article in the chat box—is that we are the data, whereas before, we were kind of hidden away and in isolation. But we are the data, and we are speaking out now, and we are willing to participate and to lead this research. So, that research came out in October of this year and had roughly 200 participants, and it's considered the largest research sample of intersex people. So, some of the things that that research shows is that intersex individuals have ... specifically those who have been subjected to these medical unnecessary surgeries,

to invasive examinations, and to childhood genital pictography—medical genital pictography—is that we have higher rates of depression, higher rates of suicidality, we have worse overall health than our non-intersex peers, and overall lower income. The other thing to note was that that research was very, very difficult to publish. Nobody really wanted to publish it, because it was ... everything that was presenting was counter to what is considered the common knowledge in the medical community. So, our organization, the Houston Intersex Society, we work closely with a lot of universities locally, such as Rice University, UT Medical Branch, Baylor College of Medicine, and we are educating the new generation of medical providers, but we're also assisting a lot of the student researchers with research. But the research is still lacking. While we do focus a lot on research in regards to surgery, there's really no comprehensive research on intersex people and STD/STIs, intersex people and HIV, intersex people and drug use. So, those are the things that we also need research about. Similar to what everybody else has said, we need funding, right? We need funding, not just for this research, but to also understand that intersex-specific funding is incredibly minute, not just in the U.S., but basically every intersex organization across the world is vying for the same limited funding that's available to us. And to be really clear is that our organization is 100 percent volunteer led. The majority of the work that we're doing is funded out of our own pockets. So, the reason that this research is important is ... and as individuals, not necessarily as an organization, we are a nonprofit, but myself and Mo Cortez are involved in legislative action, so we have been working on intersex protective legislation on the state level for the past few years—and that's in Texas—and we hope to soon be introducing legislation on the federal level. And this legislation is super important, because it would include a Standards of Care, and it would also dictate a deferring of these surgical interventions until the children could be involved in that decision-making process. So, a lot of the reasoning for doing this, they say that these are medical necessary, they're medical necessary, they're very urgent. But what we've noticed with COVID, right, when they put a cessation on medically unnecessary surgeries, they momentarily stop intersex surgeries, and that tells us that they're not as urgent as they are claiming that they are. But we really need the funding in order to do the research, in order to make movement happen in these communities. So, also if you remember what Saifa mentioned about Lurie Children's Hospital, they put a 6-month moratorium on surgeries as a result of pressure from activists within the intersex community. They also issued an apology. But it's important to remember that an apology is not admissible in court as evidence of wrongdoing. So, the apology is important from an emotional standpoint, but we need more than that in order to make change happen. And so, a lot of what we're doing is we're pushing for deferring of these surgeries and getting the children involved. One of our big concerns is, with any sort of comprehensive outright bans of these surgeries, we're concerned about medical tourism. So, we're concerned about little things like that, and so our research and our ... everything that we're doing all goes hand in hand. We're really paying attention to everything that is being put out there. One of the other things is that, recently, Boston Children's Hospital announced that they would be ending two specific types of surgeries—specifically cliteroplasty, which is either the embedment or excision of clitoral tissue that is deemed to be too large, and vaginoplasty on children. And there's no medical need whatsoever for an infant to have a vaginal canal. So, these are a lot of the things that our organization is focused on. We also provide a lot of patient advocacy; we provide scholarships, various other things. But our biggest reason for participating—and thank you for letting me be here to speak today—is to request support, specifically, funding for research and funding for our organizations in order to do the work to protect these intersex children, infants, but also because this research is imperative to making sure that adults who have been impacted ... that intersex adults are able to get quality, competent care for the rest of their lives. So, thank you again for this opportunity, and I will pass it onto the next person.

**DR. KAREN PARKER:** Thank you very much for those comments. So, unfortunately, Ash Stevens from the Transgender Law Center is unable to be with us today, so we will next hear from Harlan Pruden, who is a First Nations Cree scholar, Two-Spirit activist, and AI/AN Community Member.

**MR. HARLAN PRUDEN:** Thank you so much, Karen. Call you all hear me? [overlapping voices] Yay. Thank you so much, Karen, for hosting this important conversation. I'm Harlan Pruden. I am First Nations Cree. My mother is from the Beaver Lake Indian Reserve. My father is from the Saddle Lake Indian reserve—two different reservations of Treaty 6 territory; and I'm honored and humbled to be here. Today, we are broadcasting, Jessy and I, from the Coast Salish territory, the Musqueam, Tsleil-Waututh, and Squamish First Nations peoples on whose territory that we are on today, and I humbly thank my Coast Salish relatives for allowing me to be on their territory and tolerating my presence.

**MR. JESSY DAME:** Hello, everyone; my name is Jessy Dame; I use he/him/his pronouns. I am a Métis Two-Spirit registered nurse. My parents are from Treaty 1, Treaty 2 territory, which we now know as Winnipeg in Manitoba. I am the Two-Spirit program manager at the community-based research center, and I humbly thank CBRC for the opportunity to be the Two-Spirit program manager and the role that has been created. As a registered nurse, I have a background in sexual health, and I'm currently a master's student who focuses on protective factors in suicide. And I humbly urge and strongly recommend the creation of a Two-Spirit support program for Two-Spirit researchers like myself to create and support Two-Spirit research.

**MR. HARLAN PRUDEN:** So, I would like to first of all thank GLMA and the amazing leadership of GLMA for the inclusion and advocacy of standing with the Two-Spirit community. Thank you so much. It is so great to hear other folks that are standing with and advocating for our Two-Spirit people who live in the intersection of sex, gender, and minority, because we are indigenous people. The one thing I just want to contextualize is that Two-Spirit people must see themselves and be central to sex and gender minority research when it is appropriate. If you were doing a let and/or studying on African American or Asian American LGBT or some gender minority is ... that's essential to the city, we as indigenous people do not have to be a part of it. But if you are doing LGBT queer research, we as Two-Spirit people should be central, and we should actually begin that whole acronym of 2SLGBTQI+. Being first people, we should be listed first. And I often heard on my time in PACHA, what is measured is treasured. We must see ourselves in research. Now, for the overall why we need to see ourselves in research? And I go back to this as health researchers and someone who is a member of the health field and public health, the remedy must match the harm. Two-Spirit and indigenous people have historically been excluded from research or have been negatively impacted by discriminatory policies like the Indian Residential Boarding School, where literally our Indian-ness was beaten out of us. Or how it was illegal for us to practice our own traditional religions. Think back to your stories of your founding fathers of leaving some country for religious prosecution to only come here to ban our practices. Hmm. If Settler Colonizers had no issue to taking these actions that singled indigenous people out and did harm to us, the remedy should meet or exceed that harm, that you must then include us in a meaningful, targeted, and a singled-out way. The remedy must match the harm. But that also means that you all have to acknowledge the harm that you've done to our indigenous relatives. We humbly ask for the following: meaningfully inclusion of Two-Spirit people and communities in research. Currently, we are rendered invisible and erased when we are collapsed and classified as LGBTQI+ or some other western and colonial construct. We, as indigenous and Two-Spirit people, have always been here. And in that collapsing, I believe that there's a presumption of innocence, meaning that if you do not include

us or acknowledge us, you can then now cop to the fact that it has been your forefathers that totally messed it over for us as Two-Spirit people and that it erodes a history that we, as Two-Spirit people, had full citizenship, full participation, and were honored by our folks within our respective nation. Why don't we look at that history and see if we can learn from that history? Looking to our northern residents in Canada, the NIH is equivalent to the Canadian Institute for Health Research and their commitment to increase their indigenous and Two-Spirit funding. Currently, it is at 4 percent. Aspirationally, they want to take that up to 11 percent—one in 10 dollars of research money going to indigenous and Two-Spirit research. Karen ... I shared with Karen our "meet the methods" of how ... what and who is Two-Spirit in health research and some methods on how to culturally, humbly collect Two-Spirit data within various research projects. I would like to see a question on all research proposals that are let from NIH that asks about a sex- and gender-based analysis and for that question to be inclusive of Two-Spirit people and to ask the researchers to account for why they're excluding Two-Spirit and indigenous people or how are they accounting and including Two-Spirit people within their SGBA. We must do better in research design, as well as in knowledge translation and dissemination. As a Two-Spirit person, when we see ourselves in research, we are often compared to nonindigenous publics that are often straight and male, so try as I might, as a Two-Spirit person, we are not going to be nonindigenous and we are not going to be straight. So then why am I being compared to them? When we do this, it messages that we are always going to be disproportionately impacted. We're going to die younger, die earlier, have greater disease impact. And at the same time, when we message that, if you are nonindigenous and non-Two-Spirit and you're—i.e., if you're white—you're going hear in the void that you're going to live longer, you're going to be less impacted. And so that positioning, I would argue, supports and models white supremacy. We are going to die younger, and you are going to be better off. We must do better. Secondly and finally, there needs to be a need for greater attentiveness in language and colonial structures and framings. I often see this at play when folks like Jessy and I, who are indigenous and gay-identified and Two-Spirit, are labeled as vulnerable or having a vulnerability, positing the problem on me and us. If it is our indigeneity and our sexual orientation that put us at a greater likelihood of having negative outcomes, be it health, social, political, and economic, what agency do I have to change my indigeneity and/or my sexual orientation? It is the systems of homophobia, settler colonialism, transphobia, racism that puts me at a greater chance or likelihood of having negative outcomes. And when we posit the problems on the systems, then we can work to change the systems. I and Jessy, we do not have to change; the system must change. These simple yet complex steps create an opportunity that may positively impact and redress the historical wrongs that will play out in policies and programs. As we collectively work for a better tomorrow for our Two-Spirit relatives, peoples, and communities, it is with the greatest honor and humility that I say thank you.

**MR. JESSY DAME:** Thank you.

**DR. KAREN PARKER:** Thank you so much for those comments. So, now we're going to move to Bianca Wilson, who is the Rabbi Barbara Zacky senior scholar of public policy at the Williams Institute.

**DR. BIANCA D.M. WILSON:** Hi. Can you hear me?

**DR. KAREN PARKER:** Yep, we sure can. Thank you.

**DR. BIANCA D.M. WILSON:** Okay, sorry. So, thank you for inviting us today. It's been very useful hearing everyone's comments, and I'll try to keep mine brief. I'd like the privilege of hearing the comments from the community groups. At the Institute, several of my colleagues

thank Karen Parker and the SGM Research Office for their efforts today. We would like to encourage the Institutes to continue trying to make it a priority to increase their SGM research portfolios. In particular—and I say this as one of the core investigators of the Generations Project—not to lose focus on stigma as a key component to understanding both development and resilience and wondering if some of the Institutes seem to be going backwards on their commitments on those issues. In terms of research, just a few areas that I'll add connected to some work that I've done. So, some areas of research that I think are especially significant on SGM groups ... I would have liked to have seen in the strategic plan naming weight-based bias or sizeism as one of the axis of oppression to examine in research on SGM health, especially among cis women—cis gay and bisexual women—and also would like to see the Office continue and encourage investigators to engage in community-based research on the lives and wellbeing of sex workers—again, a group that SGM folks are likely disproportionately a part of that subpopulation, even though we don't have great data on that. But nonetheless, encourage research on the lives and wellbeing of sex workers that moves beyond a pure HIV prevention focus and integrates an emphasis on experiences of victimization, police violence, and criminalization, as well as resilience. And then finally, I'll just add encouragement to investigators to test more interventions aimed at improving the social and economic conditions for Black sexual minority men as a way to address the HIV epidemic that really moved beyond behavioral and peer group changes, since we know that, in general, the epidemic—both in the U.S. and internationally—continue to follow economic conditions. And behavioral explanations have not worked when thinking about Black sexual minority men, and I would like to see more emphasis on testing interventions that are about improving economic conditions and stability. Thank you.

**DR. KAREN PARKER:** Okay, thank you very much. And now, we will hear from Vin Tangpricha, who is president of the World Professional Association for Transgender Health.

**DR. VIN TANGPRICHA:** Hi. Thank you very much for having us. My name is Vin Tangpricha—he/him pronouns—now the past president of the World Professional Association for Transgender Health. A little bit about WPATH—we're the largest interdisciplinary professional and educational organization devoted to transgender health. We are approximately 2,500 members strong around the globe. Our professional, supporting, and student members engage in clinical care and research to develop evidence-based medicine guidelines and strive to promote a high-quality of care for transgender and gender-diverse individuals around the world. We hold the largest international conference every 2 years focused on updates and research, clinical care, and public health issues related to transgender and gender-diverse people around the globe. And we publish the most authoritative and comprehensive guideline for delivering health care for transgender and gender-diverse people, entitled The WPATH Standards of Care. We'd like the NIH to support programs that examine, number one, the longitudinal health risks of gender-affirming therapies on transgender and gender-diverse people. We'd love to see more broad Institute support at the NIH in these research activities. We're also interested in research that supports medical guidelines and research on the dissemination of evidence-based guidelines. There are a number of guidelines in the published literature, but little is known how these are used in the medical setting. We'd also like the NIH to support more research on transgender and gender-diverse youth, especially on mental and medical health outcomes and fertility preservation. Also, there's very little known about gender-diverse people, specifically gender nonbinary people, and we'd like to see more research in this population. I think that would be very important. We'd like to see more grant initiatives that establish larger cohorts for biorepository studies in the United States to increase research collaboration and to allow connection of biomarkers to assess long-term health risks of gender-affirming therapy. And



finally, we'd like to see more studies in BIPOC transgender communities to understand their unique health concerns and needs. Thank you for having us.

**DR. KAREN PARKER:** Okay, thank you so much for your comments. So, that actually brings us to the end of the agenda, and I really would just like to thank all of the speakers and panelists who were here today. You've given NIH so much to think about as we think about our priorities moving forward. I would also like to thank members of the public for attending and for folks from the NIH community. If you do have comments that you'd like to submit, please do so via email. You can send those to [sgmro@nih.gov](mailto:sgmro@nih.gov). As a reminder, there will be a captioned video, as well as a transcription document, that will be posted to the Sexual and Gender Minority web page in the coming weeks, and, of course, stay tuned to other activities happening at NIH related to SGM health by subscribing to the NIH SGM listserv. If you don't want to go to this very long link, you can Google SGMRO, head to our website, scroll to the bottom, and there will be a place to subscribe just from our home page. So, I would like to thank everyone again for being here. And something that we say often in the SGMRO is, "There is much work to be done." And so, thank you for your comments today. I feel very inspired and reminded that, indeed, there is much work to be done. Thank you, and have a great day.

[MEETING END TIME: 2:21 P.M. EST]