

July 15, 2024

In making these recommendations we point to recent consensus studies and reports from the National Academies of Sciences, Engineering and Medicine that identify priorities as well as specific recommendations for research on sexual and gender minority (SGM) populations:

National Academies of Sciences, Engineering, and Medicine. (2020). *Understanding the Well-Being of LGBTQI+ Populations*. Washington, DC: The National Academies Press.

National Academies of Sciences, Engineering, and Medicine. (2022). *Reducing Inequalities Between Lesbian, Gay, Bisexual, Transgender, and Queer Adolescents and Cisgender, Heterosexual Adolescents: Proceedings of a Workshop*. Washington, DC: The National Academies Press.

National Academies of Sciences, Engineering, and Medicine. (2022). *Measuring Sex, Gender Identity, and Sexual Orientation*. Washington, DC: The National Academies Press.

1. Support Research on SGM Life Course Exposures and Aging

Tremendous growth in research on sexual and gender minority (SGM) health over the past decade has delivered essential breakthroughs in understanding and ameliorating SGM health disparities. However, nearly all of this work has focused on younger people. Just 7.6% of all NIH funded SGM-related projects examine aging or age-related health conditions despite 23% of SGM people being age 50 or older. Among NIH funded aging projects, inclusion of midlife and older SGM adults is even more rare. Less than 0.35% of aging projects identify SGM populations even though midlife and older SGM adults comprise 2.5% of the population aged 50 and older (there are an estimated two to four million who identify as LGBTQ, and this population is expected to double by 2030). Based on limited data sources, we know that midlife and older SGM adults experience significant disparities in age-related conditions and outcomes: sexual and reproductive health (e.g., maternal health and menopause); cognitive decline and Alzheimer's disease and related dementias (ADRD); and earlier mortality. To address these gaps, NIH should prioritize high-quality aging projects that are SGM inclusive and provide opportunities and incentives for major population-level data resources to incorporate SOGI data collection and SGM expertise. Additionally, to better understand the unique lives, aging trajectories, and exposures of SGM people across the life course, NIH should invest in longitudinal studies of SGM populations that expand coverage of the full life course of SGM people.

2. Support Research Using and Developing New & Innovative Sources of SGM Health Data Beyond Survey Data:

Survey data are critical to SGM health research, and the President's Evidence Agenda to expand federal collection of data about sexual orientation, gender identity, and sex characteristics is very important and should be prioritized and expanded. However, the challenges of survey data in the modern environment (e.g., protest or fraudulent responses, low response rates, respondent burden, declining trust in government and associated surveys) must also be acknowledged. The

NIH should support research that leverages complementary sources of data, including population registers (e.g., in other countries), administrative data (e.g., tax records), and health claims data; the NIH should also support innovative data linking efforts within the US and across the world to expand the scope and focus of SGM health research. To do so, NIH should encourage data accessibility and linking while supporting innovation in data privacy and security.

3. Support Research Focused on Policy and Health Economics to Study SGM Health:

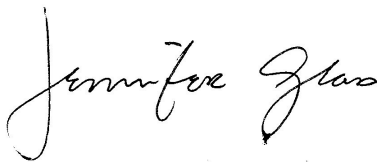
The policy environment surrounding LGBTQ+ rights has changed enormously, and continues to change with new state laws, court rulings (including Supreme Court decisions), and administrative interpretations of existing policy. Given the large role of local, state, and federal policy in contributing to SGM health, the NIH should invest in research to understand the causes and consequences of LGBTQ-related public and private policies relating to education, employment nondiscrimination, gender affirming care, health insurance coverage, marriage equality, and others.

4. Enhance Capacity Building by Funding Research Centers focused on Promoting and Disseminating SGM Health Research:

NIH should develop focused calls for Program Project Grants/Center Grants (P) or a similar mechanisms focused on SGM Health Research. While there has been an increase in Individual Investigator Awards (F, K, R) focused on SGM health research in the past several years, a gap is the limited number of NIH-funded research centers that focus specifically on SGM populations, methods, and health outcomes. Even within institutions, researchers studying SGM health are often siloed into disciplinary departments which can thwart innovation. Center grants specifically focused in this area will bolster institutional capacity to support interdisciplinary scholars to build capacity in the area of SGM health research and provide visible institutional and field leaders in this space. An excellent model for such an approach focused on SGM health research centers would be the NIMH Practice-Based Suicide Prevention Research Centers.

5. Bolster Research & Training Focused on SGM Workforce Development:

NIH should prioritize funding opportunities to support workforce development and training pipelines in SGM health research. First, the NIH can promote T32 Institutional Research Training Grants focused on Advancing SGM Health Research to formalize training pipelines for pre-doctoral and post-doctoral fellows to obtain skills in SGM Health Research. Second, the NIH can develop SGM-specific workforce diversity funding and training opportunities focused on advancing research related to SGM workforce diversity (e.g., enhancing inclusive data collection practices, studying gaps in NIH funding by sexual orientation and gender identity).



Jennifer Glass
President, Population Association of America