62nd Meeting of the National Institutes of Health (NIH) Advisory Committee on Research on Women's Health (ACRWH) Office of Research on Women's Health (ORWH) Bethesda, MD December 9, 2024

Members Present
Garnet L. Anderson, Ph.D.
Irene Aninye, Ph.D.
Arthur Arnold, Ph.D.
Ayush Giri, Ph.D.
Stephen Higgins, Ph.D.
Hendrée Jones, Ph.D.
Rosalyn E. Maben-Feaster, M.D.
Thelma Mielenz, Ph.D.
Alexandra Noël, Ph.D.
Melissa Simon, M.D.
Kimberly J. Templeton, M.D.

ORWH Leadership Present
Janine A. Clayton, M.D., FARVO
ORWH Director
Vivian Ota Wang, Ph.D., FACMG, CGC
ORWH Deputy Director
Victoria Shanmugam, M.B.B.S., M.R.C.P., FACR, CCD
Director, NIH Office of Autoimmune Disease Research (OADR-ORWH)
Sarah Temkin, M.D., FACS
Associate Director for Clinical Research
Xenia Tigno, Ph.D.
Associate Director for Careers

Special Guests
Sheila P. Burke, M.P.A., R.N., FAAN
Senior Public Policy Advisor and Chair, Government Relations and Policy Group, Baker Donelson; and Co-Chair, Committee on the Assessment of NIH Research on Women's Health, National Academies of Sciences, Engineering, and Medicine (NASEM)
Susan Cheng, M.D., M.M.Sc., M.P.H.
Erika J. Glazer Chair, Women's Cardiovascular Health and Population Science; Director, Institute for Research on Health Aging; Director, Public Health Research; Professor and Vice Chair of Research in Cardiology, Smidt Heart Institute, Cedars-Sinai; and Member, Committee on the Assessment of NIH Research on Women's Health, NASEM
Alina Salganicoff, Ph.D.
Senior Vice President and Director, Women's Health Policy, Kaiser Family Foundation; and Co-Chair, Committee on the Assessment of NIH Research on Women's Health, NASEM
Crystal Schiller, Ph.D.
Clinical Psychologist; Tenured Associate Professor of Psychiatry, Associate Director, Center for Women's Mood Disorders; Director, School of Medicine Clinical Psychology Internship Program; University of North Carolina at Chapel Hill; and Member, Committee on the Assessment of NIH Research on Women's Health, NASEM

Call to Order

Vivian Ota Wang, Ph.D., FACMG, CGC, ACRWH Executive Secretary, and ORWH Deputy Director, called the virtual ad hoc meeting to order at 1:04 p.m. ACRWH members introduced themselves. Dr. Ota Wang thanked Irene Aninye, Ph.D., and Garnet Anderson, Ph.D., for their continued service.

ORWH Director's Opening Remarks

Dr. Ota Wang introduced Janine A. Clayton, M.D., FARVO, ORWH Director, and NIH Associate Director for Research on Women's Health. Dr. Clayton reviewed the agenda, noting that the main topic is the

"Assessment of NIH Research on Women's Health" from the National Academies of Sciences, Engineering, and Medicine (NASEM). As background, she explained that in the Consolidated Appropriations Act of 2023, Congress called for an assessment of NIH's research on women's health to (1) explore the proportion of research on conditions that are common and/or unique to women; (2) establish how the conditions are defined, considering lifespan, sex differences, and health disparities; (3) determine the appropriate level of funding that is needed to address the gaps in women's health research (WHR); and (4) establish measurable metrics to ensure accurate tracking of the goals.

On December 5, 2024, NASEM released its assessment, *A New Vision for Women's Health Research: Transformative Change at the National Institutes of Health*, at a public briefing.

Dr. Clayton introduced the speakers from the NASEM Committee on the Assessment of NIH Research on Women's Health: Co-Chairs Sheila P. Burke, M.P.A., R.N., FAAN, Senior Public Policy Advisor and Chair, Government Relations and Policy Group, Baker Donelson, and Alina Salganicoff, Ph.D., Senior Vice President and Director, Women's Health Policy, Kaiser Family Foundation, as well as Committee members Susan Cheng, M.D., M.M.Sc., M.P.H., Erika J. Glazer Chair, Women's Cardiovascular Health and Population Science at Cedars-Sinai, and Crystal Schiller, Ph.D., Associate Professor of Psychiatry at the University of North Carolina (UNC) and Associate Director of the UNC Center for Women's Mood Disorders. Dr. Clayton thanked the entire Committee for its hard work on the report.

Conclusions and Recommendations from the New National Academies Report, *A New Vision for Women's Health Research: Transformative Change at the NIH*

Ms. Burke provided an overview of the Committee on the Assessment of NIH Research on Women's Health and its process. She shared the complete list of Committee members, composed of leaders from a variety of fields, including obstetrics/gynecology, cardiovascular disease, neurology, bone health, autoimmune disease, female-specific cancers, and other medical specialties, as well as nursing, social sciences, health policy, population health, behavioral health, health disparities, and, especially, data and measurement.

The wide-ranging charge to the Committee was to (1) analyze the proportion of research that NIH funds on conditions that are female specific, more common in women, or that differently impact women; (2) establish how these conditions are defined and ensure that the definition captures conditions across the lifespan; (3) define women's health for the purpose of the report; (4) determine the appropriate level of funding that is needed to address gaps in WHR at NIH; (5) provide recommendations on NIH research priorities and NIH training and education efforts needed to build, support, and maintain a robust WHR workforce, NIH structure, systems, and review processes to optimize WHR, and the allocation of funding needed to address gaps in WHR at NIH; and (6) identify metrics that would ensure that the research is tracked and meets the continuing health needs of women over time.

The assessment was requested by Congress as part of the Consolidated Appropriations Act of 2023, as noted by Dr. Clayton, and funded by ORWH. The Committee used a robust process to inform its deliberations, including a literature review that enabled it to build on previous and ongoing work. The Committee held six information-gathering and deliberative meetings with a broad range of stakeholders, including patients, advocates, and clinicians, whose personal experiences are frequently referenced in the report. Information gathering ended in May 2024. Since then, NIH has continued to take steps to improve WHR that are not included in the report. The Committee also undertook a novel analysis to determine the impact of the grant funding spent by NIH Institutes and Centers (ICs) and of women's health conditions in terms of years of lives lost due to premature mortality and years lived with

disability. The Committee prepared a nine-chapter report with 15 conclusions and 8 recommendations, which underwent a rigorous external peer review by 17 expert reviewers.

Context. Dr. Schiller reported that an early step in the process was the establishment of needed definitions. Building on and adapting existing definitions where possible, the Committee adopted the following key definitions:

> **Women's Health** includes physical, biological, reproductive, psychological, emotional, and cultural/ spiritual health and wellness across the life course. It includes the experiences and needs of those assigned female at birth or identify as a woman, girl, female, nonbinary, transgender (men or women), genderfluid, or Two-Spirit.
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> **Women's Health Research** is the scientific study of the range of and variability in women's health as defined and the mechanisms and outcomes in disease and non-disease states across the life course. It considers both sex and gender, disease risk, pathophysiology, symptoms, diagnosis, and treatment, and addresses interacting concerns related to women's bodies and roles and social and structural determinants and systems.

A full list of definitions is included in the report.

Dr. Schiller provided further contextual information, noting that the U.S. is a leader in research innovation and health discoveries. However, scientific enterprises have not yielded the anticipated breakthroughs to improve health and well-being for over half the population—women and girls—because most research has been conducted on men. Thus, there is a lack of baseline understanding of basic sex-based differences in physiology (e.g., chromosomal and hormonal) and a lack of attention and support for research into conditions specific to, more common among, or that affect women and girls differently. This has been especially true for racially and ethnically minoritized women, many of whom suffer or die from female-specific conditions such as fibroids, endometrial and uterine cancer, and other conditions such as heart disease and stroke. WHR advances are critical to overall scientific progress and innovation.

Healthy women are vital to a healthy society and a growing economy. Women spend more years living with disability and poor health—on average, nine years, or 25% longer than men, significantly impacting their quality of life and productivity. Historical exclusion of women from research has led to persistent gaps in the evidence base on women's health that still impact research today. Women face intersecting barriers to care, including economic, geographic, institutional, social, and cultural barriers, discrimination and bias, lack of education and health literacy, and stigma. This intersection has led to a lack of health care knowledge, preventative approaches, diagnostic tools, and treatments for many women's health conditions. Breakthroughs in women's health improve understanding of health not only for women but also for men. For example, research on osteoporosis in women has contributed to guidance on men's bone health, and research on breast cancer in women has improved care for prostate cancer in men.

Funding. Dr. Cheng noted that the Committee was tasked with analyzing the proportion of research funding that NIH spends on women's health. The Committee could not use published grant analyses or the specific NIH definition of women's health used by NIH's Research, Condition, and Disease Categorization (RCDC) system, which is not publicly available. Therefore, the Committee developed its

own approach to analyze funding from Fiscal Years (FY) 2013 to 2023 using information on more than 800,000 grants from NIH Reporter. However, it was unable to access the content of research grant proposals. The Committee adopted a multimethod and multistage approach in its analyses, including the use of empirical models and a final large language model that was iteratively tested (see report appendix for a detailed description). The Committee found that total grant funding for WHR between FY13−FY23 equaled 8.8% of all NIH research grant funding. In FY23, the last year analyzed, WHR funding amounted to 7.9% of all funding. A similar pattern of low funding may be found for NIH intramural research. Limitations to the Committee's analyses include an inability to distinguish among maternal health grants, some of which focused primarily on infant health outcomes. Such limitations may have led to overestimating the share of funding attributed to WHR.

Overall, the Committee found that while NIH grant funding steadily increased from FY13–FY23 in both dollars spent ($26.3 billion to $43.7 billion) and the number of projects funded, the proportion of funding for research related to women's health remained low and decreased during the same period (9.7% to 7.9%).

The Committee analyzed grant funding by NIH Institutes, Centers, and Offices (ICOs) and found a small amount of funds spent on WHR across all three groups. The *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD) had the largest proportion of WHR funding at 37%, although many of its grants were focused on fetal or infant health; other ICOs spent less than 20%, and many less than 10%. Of the $33 billion NIH spent on WHR grants between FY13–FY23, the National Cancer Institute spent the most at $9.2 billion, followed by NICHD ($5.3 billion), and the National Institute of Allergy and Infectious Diseases ($4.1 billion). Other ICOs had WHR budgets of about $2 billion or less.

Grants funded to study conditions relevant to women's health favored certain conditions, especially breast cancer, which received more than twice as much funding as the next most-favored condition. Other top 10 conditions included some female-specific cancers, pregnancy and infertility, and perimenopause and menopause, as well as conditions that also affect men (e.g., HIV/AIDS, diabetes, and depressive disorders). There were low levels of funding for many female-specific conditions, including endometriosis, fibroids, pelvic floor disorders, polycystic ovary syndrome (PCOS), postpartum depression, uterine cancer, vulvodynia, and others. Yearly funding has been flat over the past decade for many of these conditions.

Main Findings. Dr. Salganicoff reviewed the main findings of the Committee. Its overarching conclusions were that (1) A comprehensive approach is needed to develop a robust WHR agenda and establish a supportive infrastructure at the NIH. Augmented funding for WHR, while crucial, needs to be complemented by enhanced accountability, rigorous oversight, prioritization, and seamless integration of WHR across NIH; (2) NIH is underspending on women's health; and (3) The current NIH organizational structure limits its ability to address gaps in WHR. There is inadequate oversight and limited ability for ORWH to incentivize ICs to prioritize research, and many women's health conditions and female-specific life stages do not easily align within the purview of the 27 existing ICs despite the millions of women who experience the burdens of these conditions.

To address these structural issues, the Committee recommended that the NIH Director provide oversight for WHR activities across all ICs. Simultaneously, all NIH ICs should have responsibility for tracking, transparency, and accountability in WHR funding. To improve WHR at NIH, the agency should (1) create new pathways to facilitate and support innovative and transformative research for women's

health; (2) strengthen oversight, prioritization, and coordination for WHR across NIH; (3) expand, train, support, and retain the WHR workforce; (4) increase NIH investment in women's health; and (5) optimize existing NIH programs and policies to support WHR. Adopting these action items, accelerating breakthrough science on women's health, and increasing the research workforce with women's health expertise, should lead to measurable improvements in the health and well-being of women.

Chapter 9 in the NASEM report contains the Committee's recommendations to improve WHR.

NIH Organizational Structure. Dr. Salganicoff emphasized that no progress in WHR can be made without change. Referencing the first action step to create new pathways to facilitate and support innovative and transformative research for women's health, she detailed the Committee's Recommendation #1: Congress should (1) elevate ORWH to an Institute with primary responsibility to lead, conduct, and support research on female physiology and chromosomal differences, reproductive milestones across the life course, and female-specific conditions that do not fall under the purview of other ICs and (2) establish a new fund for WHR in the Office of the Director. Further, the NIH Director should assume oversight and responsibility for the WHR portfolio and implementation of priorities and policies relevant to women's health; IC directors should increase support for WHR that falls under their purview; and the National Institute on Minority Health and Health Disparities (NIMHD) should expand its role to include women, girls, and females among the populations that experience disparities. Congress should allocate enough funding to support these recommended changes.

Women's Health Research Workforce. Dr. Schiller presented the Committee's conclusions and recommendations about expanding, training, supporting and retaining the WHR workforce. The Committee found that opportunities to retain and grow the WHR workforce are insufficient. Key conclusions included (1) a robust infrastructure for research in women's health and sex differences at NIH is needed to cultivate a vibrant women's health workforce; (2) inadequate funding of WHR has led to an insufficient number of WHR investigators; (3) current grant mechanisms are inadequate to support career trajectories in WHR; (4) mentorship and career development are vital to the development of the WHR workforce; (5) gender-based bias and sexism persist, including in health and research systems, which affect the grant review and award-making process; and 6) in addition to sexism, bias related to race and ethnicity has been identified as independent and intersectional contributors to gaps in health research generally and WHR specifically.

Based on these conclusions, the Committee recommended that NIH should augment existing programs and develop new initiatives to attract researchers and support career pathways for scientists throughout all stages in the careers of women's health researchers (Recommendation #4, Career Pathways). Specifically, NIH should (1) create a new subcategory within the Loan Repayment Program for investigators conducting research on women's health or sex differences; (2) allow financial support of up to 10% for mentors on all mentored grants that support careers of early and midcareer investigators in women's health and sex differences research; (3) create new and expand existing early and midcareer grant mechanisms to grow and expand the WHR workforce (e.g., the K24, R35, UP, Administrative Supplement, and other mechanisms could be expanded or new mechanisms developed); and (4) support early career mentored institutional K-awards for up to five years. Creating more early career mechanisms for women's health research can be modeled on existing mechanisms, such as the Stephen I. Katz Early Stage Investigator Research Project Grant and Grants for Early Medical/Surgical Specialists' Transition to Aging Research (GEMSSTAR).

In Recommendation #5, Expand Workforce Development Programs, the Committee recommended that NIH should augment existing programs and develop new grant initiatives designed to promote interdisciplinary science and career development related to women's health. Specifically, NIH should expand ORWH's signature programs, Building Interdisciplinary Research Careers in Women's Health (BIRCWH) and Specialized Centers of Research Excellence (SCORE) on Sex Differences, as well as Women's Reproductive Health Research (WRHR) and the Research Scientist Development Program (RSDP). For example, NIH should double the number of BIRCWH Centers and increase the amount of funding per Center to $1.5 million annually. The Committee also recommended that NIH fund additional multi-project program grants and prioritize and promote the participation of women and investigators from underrepresented communities. Any expansion should include additional funding to ensure that research budgets are not reduced. Training efforts should be distributed geographically across the country, and grantees should collaborate with other disciplines within their institutions to offer mentees comprehensive and multidisciplinary research experience.

Increase NIH's Investment in Women's Health Research. Ms. Burke summarized the Committee's recommendations for increased spending on WHR to fill the WHR gaps. Overall, the Committee recommended that a five-year investment of $15.71 billion, reaching ~$3.87 billion/year in new funding in Years 4–5, be made. This investment does not include additional funds needed to support increased operational costs, increased oversight by the NIH Director, and other related costs.

The recommended investment in WHR should be allocated to (1) a new WHR Fund to support and foster interdisciplinary research on women's health and sex differences with recommended funding levels of $900 million in Year 1, $1.5 billion in Year 2, and $3 billion annually in Years 3−5; (2) a new WHR Institute on female physiology and chromosomal differences, reproductive life course, and female-specific conditions not under the purview of other ICs, funded at $800 million per year; and (3) expanded workforce development programs (as detailed above) with recommended funding of $42.8 million in Year 1, $56.8 million in Year 2, $66.8 million in Year 3, and $74.3 million annually in Years 4−5.

At the end of the five-year period, funding levels needs should be re-assessed. However, Ms. Burke emphasized that funding is only part of the overall issue; the other is restructuring, improved focus, and clear responsibilities.

Strengthened Oversight, Prioritization, and Coordination of WHR at NIH. Dr. Cheng stated that NIH's RCDC is inadequate for monitoring and reporting WHR at NIH. Therefore, the Committee made three recommendations to strengthen oversight and prioritize and coordinate WHR at NIH.

The Committee addressed better oversight of NIH's investment in WHR in Recommendation #2 (Tracking WHR Investments): NIH should reform its process for tracking and analyzing its investments in research funding to improve accuracy for reporting to Congress and the public. Specifically, NIH should (1) improve the accuracy of grants coded as Women's Health, using large language models to analyze the content of grants; (2) update its process for reviewing, revising, and adding new RCDC categories; and (3) make transparent and accessible the process and data used for portfolio analysis.

In regard to priority-setting for WHR, the Committee concluded that ICs' strategic plans to inform their research priorities rarely mention women's health and lack elements of the NIH-Wide Strategic Plan for Research on the Health of Women. Variations in the timing of the IC plans complicate NIH's ability to set, implement, and oversee cohesive and cross-agency priorities for women's health research.

In Recommendation #3 (Priority-Setting), the Committee recommended that the NIH Director should develop and implement a transparent, biennial process to set priorities for WHR that is data-driven, includes input from the scientific and practitioner communities and the public, and responds to gaps in the evidence base and evolving women's health needs. Specifically, NIH should (1) employ data-driven methods to assess the public health effect of conditions that are female specific, disproportionately affect women, or affect women differently; (2) report this assessment publicly and use it to identify research priorities and direct funding for WHR; and (3) in addition to current funding activities, issue Requests for Applications, Notices of Special Interest, Program Announcement, and similar mechanisms to ensure that priorities for WHR are implemented.

The Committee's Recommendation #8 (Priority Research and Measurement) describes areas for prioritization needed to advance WHR across the research spectrum. Research on the role of sex, gender, gender identity, and sex beyond the binary within each type of research will improve understanding of how these factors play a role in disease prevention, development of health conditions, and treatment outcomes. The Committee also suggested measures to track progress on advancing women's health in Chapter 9.

Optimize NIH Programs and Policies to Support Women's Health Research. The Committee also made recommendations to optimize programs (e.g., peer review) and policies (e.g., Sex as a Biological Variable [SABV]) to support WHR.

***Peer Review*.** Dr. Schiller reported that the Committee concluded that representation of women's health expertise is essential during the NIH peer review process, including the expertise of the Center for Scientific Review staff, IC program officers, council members, and peer reviewers. Despite NIH efforts to expand the cadre of reviewers with WHR expertise, a large proportion of WHR-related grants are evaluated by special emphasis panels, not standing study sections, indicating that standing study sections do not yet have the required expertise to review WHR grants.

Therefore, in Recommendation #6 (Peer Review), the Committee recommended that NIH continue and strengthen its efforts to ensure balanced representation and appropriate expertise when evaluating grant proposals on women's health and sex differences research in the peer review process. Specifically, NIH should (1) employ data science methods and use professional networks to identify experts and recruit recently funded investigators; (2) expand the Early Career Reviewer program; and (3) work with NIH-funded institutions to identify qualified individuals with expertise in women's health. In the short term, special emphasis panels should be used more often.

SABV. Dr. Cheng summarized the Committee's conclusions about the SABV policy first implemented in 2016: SABV is not meaningfully factored into research designs, analyses, and reporting in vertebrate animal and human studies. The overall uptake and application of SABV in practice have not been optimal. Although guidance and training on the NIH SABV policy outline distinctions between sex and gender, language and implementation are not geared toward studies of gender, gender identity, and intersex status. No cross-agency mechanism exists at NIH to assess how SABV in grants is evaluated or to track the appropriateness and completeness of SABV implementation. Finally, there are no consequences for grantees if they do not implement plans for SABV, nor are there incentives to encourage implementation.

Therefore, in Recommendation #7 (SABV Policy), the Committee recommended that NIH revise how it supports and implements its SABV policy to ensure it fulfills its intended goals. NIH should (1) expand

and tailor education and training resources for investigators; (2) ensure that SABV is consistently and systematically reviewed in the grant review process; (3) expand the SABV policy in human studies to explicitly factor the effect of biological sex, gender, and gender identity in research designs, analyses, and reporting; and (4) exempt relevant studies from across-the-board budget cuts to protect sample sizes and analyses needed to study sex differences and have access to administrative supplements, among other actions.

In addition, applications that rigorously examine sex, gender, or gender identity differences should (1) be exempt from across-the-board budget cuts to protect sample sizes and analyses needed to study sex differences; (2) have access to administrative supplements to ensure that sex, gender, and gender identity differences can be studied rigorously and with adequate sample size; (3) have priority for funding when such projects fall in the discretionary range of the payline; and (4) undergo a streamlined process for requesting higher budgets. NIH Intramural researchers also should factor SABV in research design, analyses, and reporting.

Conclusion. Ms. Burke concluded the presentation by stating that increased investment in WHR is only a first step and not a "one and done" effort. Improving quality of life and reducing morbidity and mortality from conditions that are female specific, disproportionately affect women, or affect women differently than men requires sustained commitment, additional funding, and accountability. The continued neglect of research on women's health ultimately impacts not only women but also society as a whole. Now is the time to act, because it will take a long time to achieve the results envisioned by the Committee and detailed in the new report.

Questions and Answers

Dr. Ota Wang facilitated a discussion with ACRWH members about the NASEM report. Key points included the following:

- The report represents a substantial amount of effort, and ACRWH members expressed their appreciation for the hard work that went into the report.
- There is a need to address training not only for study section members but also for a new generation of researchers who are being trained by those who did not regard sex differences as important or essential to research rigor and reproducibility. The cost of training researchers is substantial and outlined in Recommendation #7 in the report. Chapter 3 provides information on SABV training.
- The Committee recommended that funding increases be introduced over time to provide opportunities at NIH to build resources and capacity within the agency. At the end of five years, the Committee recommends an assessment to determine how effectively the funds have been used, whether additional funds are needed, or whether funds should be allocated differently. When funds are limited, WHR is often among the first topics to be eliminated. To counter this issue, the Committee recommended a multipronged approach that includes both a new WHR Institute and a new WHR fund.
- The Committee has submitted its report to NASEM and ORWH and briefed Congressional committees on its recommendations. The next steps in disseminating the report's findings and recommendations include publishing the report in whole or in part in academic journals and other publications. However, widespread dissemination of these ideas cannot be done without the participation of the broader research community. The Committee encourages ACRWH to amplify the message at professional conferences, in trainings, and in research applications.

- Because many conditions (e.g., osteoarthritis) affect both men and women, decisions about which conditions to assign to a new WHR Institute will require serious consideration. The new Institute can cover conditions that are not covered by another IC; however, areas of collaboration are important.
- The NIH Director is critical in working with each IC to develop and monitor its research agenda; the Director should also identify opportunities for collaboration between each IC and the new WHR Institute and Fund. Simply increasing IC funding for WHR from the current 8% level would be insufficient to address women's health needs, which are more comprehensive than can currently be addressed.
- The key factor in increasing the effective implementation of the SABV policy is accountability; NIH has a significant opportunity to improve how it holds Principal investigators accountable for SABV.
- Creating a new Institute or a significant increase in funding is a large challenge that will take time to implement. Committee recommendations that can be implemented more readily include better tracking and accountability from the Office of the Director to ensure that women's health care is part of NIH planning, changes in the peer review process, and improved WHR training; these areas could move forward without significant structural changes. More funding, however, is needed to support NIH in strengthening these processes.
- A new WHR Institute would house many conditions that currently do not have an IC home. Also needed is interdisciplinary collaboration, which is sometimes challenging when ICs are siloed.
- Establishment of an Institute with authority, funding, expertise, and accountability is a critical recommendation for expanding WHR at NIH. ORWH is not currently funded nor staffed with the necessary level of resources and expertise that is needed to expand WHR. Many of ORWH's current roles and responsibilities should be elevated to the new WHR Institute and the Office of the Director.
- NIMHD is an example of an Office that subsequently became an Institute.

Closing Statement

Dr. Clayton thanked the Committee leadership and members for their incredible work and thoughtful approach. She also thanked ACRWH members for their efforts, as well as ORWH staff and contractors for making the meeting possible. Dr. Clayton adjourned the meeting at 2:21 p.m.

Certification

We certify that the contents above are accurate and complete.

Janine A. Clayton -S Digitally signed by Janine A. Clayton -S Date: 2025.06.16 13:06:54 -04'00'

Janine Austin Clayton, M.D., Director
Office of Research on Women's Health

Date _____

VIVIAN OTA WANG -S Digitally signed by VIVIAN OTA WANG -S Date: 2025.06.16 11:45:31 -04'00'

Vivian Ota Wang, Ph.D., Executive Secretary
Advisory Committee on Research on Women's Health

Date June 16, 2025