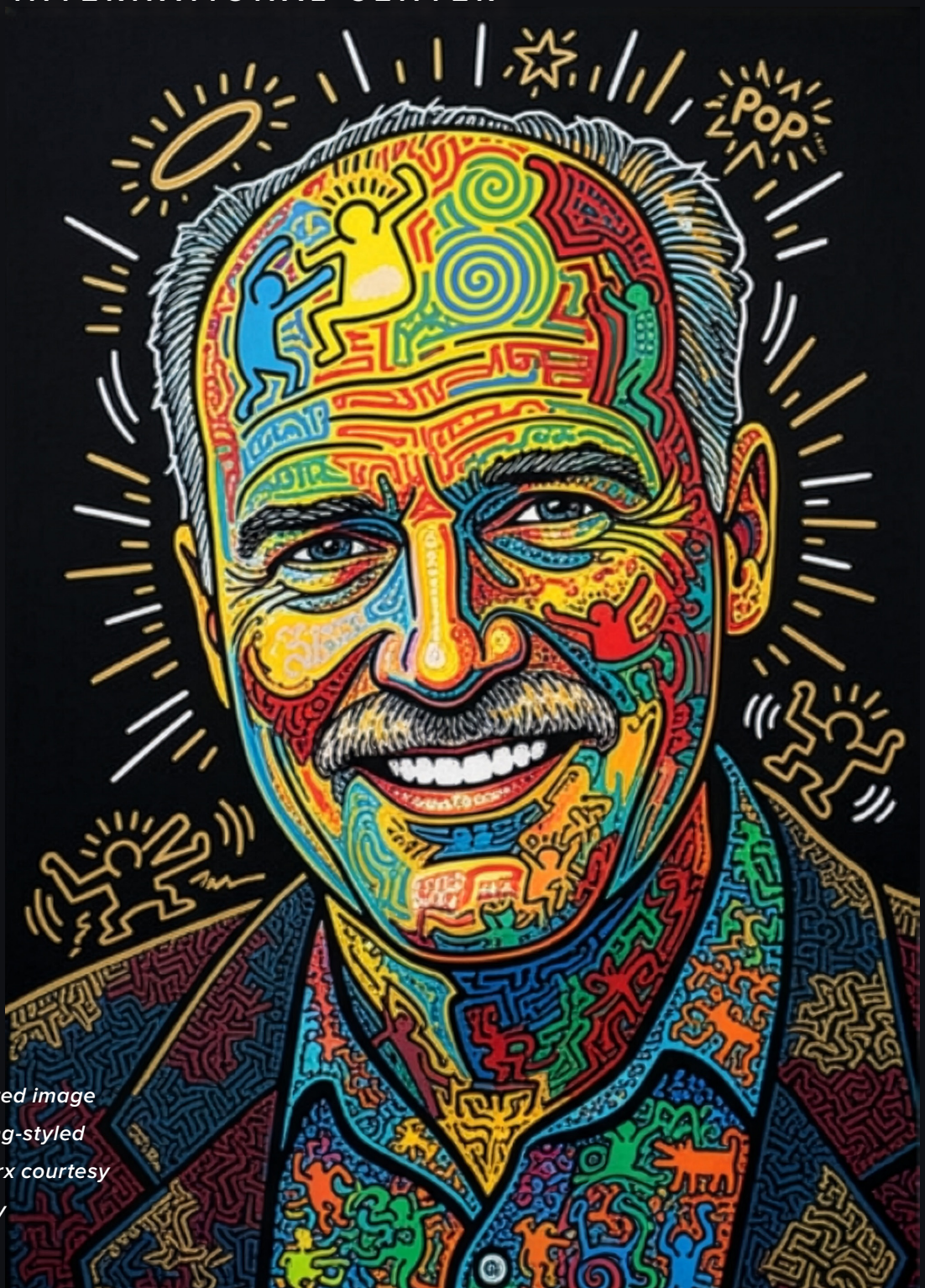
NATIONAL INSTITUTES OF HEALTH • DEPARTMENT OF HEALTH AND HUMAN SERVICES

Global Health Matters

FOGARTY INTERNATIONAL CENTER



This AI-generated image of a Keith Haring-styled Dr. Peter Kilmarx courtesy of Adobe Firefly

MAY/JUNE 2026 | ISSUE 3

Adapting to a changing global health landscape

LEADERSHIP TRANSITIONS provide an opportunity to reaffirm an institution's core values while embracing new perspectives. At the Fogarty International Center, we are undertaking a leadership transition at a time when international biomedical research and global health are experiencing profound transformations. During this period of change, our commitment to advance global health research through capacity building and partnership remains steadfast.

Fogarty has been truly fortunate to have Dr. Peter Kilmarx as Acting Director. Fogarty's mission is to support global health research conducted by U.S. and international investigators, to build partnerships between health research institutions in the U.S. and abroad, and to train the next generation of scientists to address global health needs. Dr. Kilmarx's longstanding commitment to scientific excellence, collaboration, mentorship, and sustained investment in people has reinforced Fogarty's role as a trusted partner in the global scientific community. NIH's international programs have helped position the United States as a global leader in biomedical research.

> "OUR COMMITMENT TO ADVANCE GLOBAL HEALTH RESEARCH THROUGH CAPACITY BUILDING AND PARTNERSHIP REMAINS STEADFAST."

Fogarty has developed an extensive network of trainees and grantees who strengthen scientific capacity and expand the global health workforce. Scientists supported by Fogarty have played critical roles in groundbreaking research supported by the NIH. The enduring value of Fogarty's investments is evident not only in scientific discoveries, but also in the capacity to respond to new challenges. The individuals and institutions supported by Fogarty are constantly responding to emerging global priorities.

Fogarty's initiatives promote both scientific excellence and responsible stewardship of U.S. resources. Fogarty and NIH international collaborations strengthen global capacity to detect, prevent, and respond to emerging health threats, thereby supporting U.S. health security. Research conducted across diverse populations also informs the development of vaccines, therapeutics, and diagnostics used in the United States. In this way, global health research and international partnerships yield benefits both abroad and at home.

New Leadership for a Changing Global Landscape

Dr. Steven Schiff, MD, PhD, will serve as the 9th Director of the Fogarty International Center and the NIH Associate Director for International Research. A pediatric neurosurgeon and scientist with decades of experience, Dr. Schiff has made significant contributions to global health, including research on

infectious diseases, neurological disorders, and sustainable health technologies. He has played a key role in advancing global neurosurgery and interdisciplinary research collaborations, and he is a recipient of NIH Director's Pioneer and Transformative Research Awards.

Dr. Schiff will assume the position of Fogarty's director at a time when global health research is evolving in significant ways. Global burdens of disease are shifting with many low- and middle-income countries experiencing rising rates of noncommunicable diseases alongside persistent infectious threats, requiring more integrated and multidisciplinary approaches. Advances in data science, genomics, and digital technologies are transforming how research is conducted and how quickly findings can be translated into practice. The global health funding landscape is also evolving, while research institutions in many countries are becoming stronger and making substantial contributions to scientific knowledge.

These shifts underscore the importance of global health capacity building. Training the next generation of scientists remains essential. The skills required are expanding from expertise in traditional biomedical research to competencies in advanced data analytics, implementation science, cross-sector collaboration, and cost-effectiveness. Strengthening institutions alongside individuals is critical to ensure sustainable and locally driven research capacity. To be most effective, sustained commitment is needed. Progress in global health depends on long-term investment in people, institutions, and partnerships.

As we look ahead, there are exciting new opportunities for global health research. Emerging technologies offer new tools for understanding disease and improving health outcomes. An increasing recognition of local expertise is helping to shape more effective and enduring solutions. The future for Fogarty will require flexibility to respond to new challenges while maintaining focus on enduring priorities based on collaboration across borders, disciplines, and sectors.

Welcome to Fogarty, Dr. Schiff!

BUILDING ON A STRONG FOUNDATION, THE FOGARTY INTERNATIONAL CENTER AND OUR NEW DIRECTOR ARE WELL POSITIONED TO ADAPT TO A CHANGING LANDSCAPE AND TO CONTRIBUTE TO A FUTURE IN WHICH SCIENTIFIC DISCOVERY CONTINUES TO IMPROVE HEALTH FOR PEOPLE AROUND THE WORLD AND AT HOME.

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The Fogarty International Center is dedicated to advancing the mission of the National Institutes of Health by supporting and facilitating global health research conducted by U.S. and international investigators, building partnerships between health research institutions in the United States and abroad, and training the next generation of scientists to address global health needs.

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profile

Manavalan's research team, from left to right: Godfrey Kweka, Preeti Manavalan, Pankrasi Shayo, Lisa Wanda, Jerome Mlangi, Kelvin Haukila

Preeti Manavalan
MD

Fogarty Global Health Fellow
2018-2019

Foreign Institute
Kilimanjaro Christian Medical Center in Moshi, Tanzania

U.S. Institute
Duke University

Project
Investigate and address hypertension among people living with HIV in Moshi, Tanzania

Current affiliation
Assistant Professor of Medicine in the Division of Infectious Disease and Global Medicine at the University of Florida

To become an independent researcher, this former fellow innovates at home and abroad

A year before she began her Fogarty fellowship, Preeti Manavalan, MD, had the opportunity to travel to Moshi, Tanzania, thanks to her mentors, Melissa Watt, PhD, Professor at the University of Utah and adjunct Professor at Duke University, Blandina Mmbaga, MD, PhD, Director of Research at Kilimanjaro Clinical Research Institute and Professor of Pediatric and Child Health at KCMC, and Nathan Thielman, MD, Director of Duke's Global Health Pathway program and Professor of Medicine at Duke. "I worked very closely with Drs. Watt and Mmbaga's team on a research project, got to learn more about the community and to meet with different clinical and community partners," says Manavalan.

Once she returned home, Manavalan met with her mentors to develop her research question and proposal. She asked herself, What can I bring to the table to help the community? Her answer: A medical background in primary care combined with a passion for improving care for people living with HIV. Next, she considered, What are the needs in the community? Here she thought about the fact that people living with HIV have a twofold increased risk of cardiovascular disease, such as heart attack or stroke, compared to individuals without HIV.

These thoughts led to her decision to examine hypertension in people living with HIV in Moshi, Tanzania, for her Fogarty LAUNCH project. "One of the best ways to reduce the risk of cardiovascular disease is by addressing hypertension," says Manavalan.

Pilot study

Returning to Tanzania for her fellowship year, Manavalan, who currently works as an Assistant Professor of Medicine in the Division of Infectious Disease and Global Medicine at the University of Florida, immediately set to work accomplishing the three aims of her study. Her first objective was figuring out the prevalence of hypertension among people living with HIV. "I spent time going to one HIV clinic, in particular, and screening as many people as I could. In a two-month period, we screened more than 550 people. We found a prevalence of about 20%."

Her team also administered a survey to get more information about hypertension care and the entire continuum of hypertension care for patients living with HIV.

During the second phase of her study, Manavalan talked to clinical and general providers and interviewed about 30 people living with both HIV and hypertension and their medical providers to learn about the barriers and facilitators to hypertension care.

Finally, Manavalan used the gathered quantitative and qualitative data to fulfill the third aim of her study to develop an intervention to improve hypertension care for people living with HIV. "I integrated the intervention into an HIV clinic and conducted a small six-week pilot study," she explains. Her analyses described feasibility, fidelity, and acceptability of the intervention from both patient and provider perspectives.

Sobering results

"We found that more than half of the people with both HIV and hypertension had never had their blood pressure measured before, and only about 10% were currently on any sort of treatment. So no one had a controlled blood pressure," says Manavalan. On a positive note, the study results proved that a community health worker-delivered educational intervention could be integrated into existing HIV care. The work led to the publication of five manuscripts and provided preliminary data for a larger-scale Fogarty project on which Manavalan currently serves on a multi-principal investigator team along with her previous mentors, Drs. Mmbaga and Thielman and Dr. Julian Hertz, an emergency medicine physician, Associate Professor at Duke University. Their new project is: "Adapting and piloting an evidence-based intervention to improve hypertension care among Tanzanians living with HIV."

The HIV clinic in Moshi that was the main study site for Manavalan's Fogarty fellowship project.

For this new project, Manavalan and her colleagues decided to adapt the Control of Blood Pressure and Risk Attenuation program (COBRA) using lessons learned from her pilot study and then integrate it into a Tanzanian context. COBRA is an evidence-based hypertension intervention developed over decades and studied in more than 30 clinics in three countries in Southeast Asia. Though her pilot study shares similarities with COBRA, it had too few participants to qualify as evidence-based. Manavalan notes, "One of the things that I learned during my Fogarty year was implementation science, which taught me that it's really important for whatever you're adapting to be actually efficacious."

The team adapted the intervention over a year using participatory design methods, and then rolled it out in HIV clinics. One hundred people living with HIV enrolled in the six-month study. "At the beginning, nobody had controlled blood pressure. At the end of the study, we were able to achieve 75% hypertension control; there was a 30-point reduction in systolic blood pressure and close to a 15-point reduction in diastolic blood pressure."

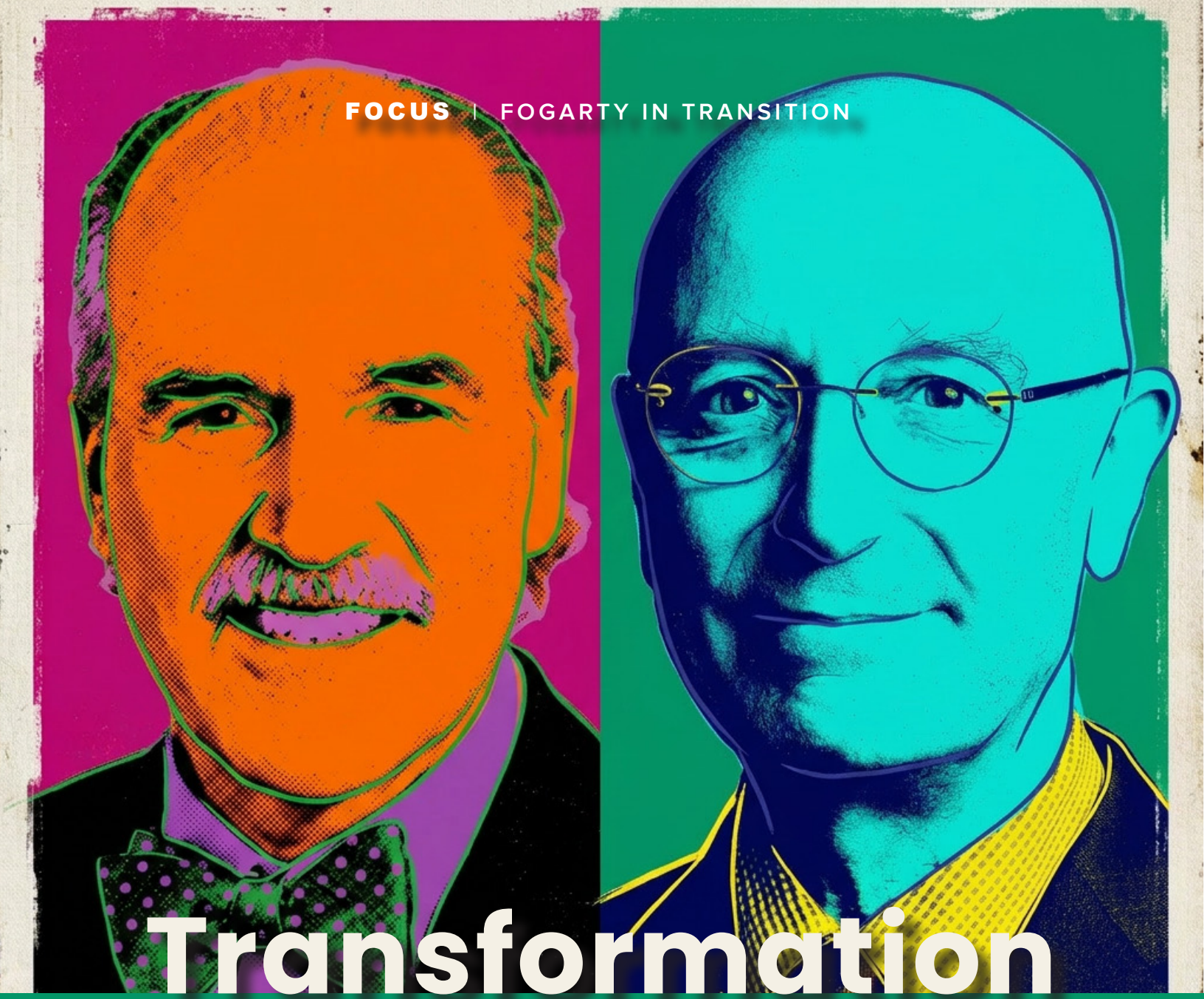
She adds that 96 out of the 100 participants completed all components of the intervention over the six-month period, and data analysis shows both high feasibility and high acceptability.

Based on these very positive outcomes, her team is hoping to scale up the intervention in Tanzania. "One of the clinics has actually decided to implement it on their own, which is exactly what we could hope for," says Manavalan. Another welcome result is that the study contributed to the building of local sustainable research and capacity. "We have the same research team as we did in 2018, and hopefully, as we continue to submit more applications, we'll continue to build on this research infrastructure." She is also thinking about how to translate lessons learned to the United States, where she's already working on a project funded by the National Institute of Mental Health.

A global health researcher needs to think of new ideas to help the community, says Manavalan. With the right mentorship, collaborators and research team, a Fogarty fellow will be successful because at the end of the day, it is all about the people. "Community members and clinic partners are the experts, and can provide invaluable insight and feedback. My success today is largely due to the relationships I forged during my training."

Manavalan's areas of focus are HIV/AIDS and Preventive Health Care.

Photo's courtesy of Preeti Manavalan



Transformation AT FOGARTY

June, 2026, will be remembered as a month of transformation for the Fogarty International Center. In that month Dr. Peter Kilmarx, acting director since 2025 and deputy director since 2015, resigned from government service, and Dr. Steven Schiff became Fogarty's ninth Director.

This Warhol-inspired rendering of Drs. Kilmarx and Schiff is courtesy of Adobe Firefly.

Schiff also assumed the duties of Associate Director for International Research at the National Institutes of Health (NIH), the nation's medical research agency, on that date.

Schiff will lead Fogarty in its mission of supporting and facilitating global health research conducted by U.S.-based and international investigators, building partnerships across the globe, and training the next generation of scientists to address global health needs. He'll oversee the center's annual budget of approximately $95 million, the majority of which is distributed through grants. In his role as an NIH associate director, he will provide planning and advice for basic, clinical, and translational medical research supported by NIH programs and conducted across international sites.

FOGARTY WISHES PETER KILMARX THE FONDEST OF FAREWELLS

PETER KILMARX, MD, AN EXPERT ON INFECTIOUS DISEASE RESEARCH AND HIV/AIDS PREVENTION, RETIRED FROM GOVERNMENT SERVICE ON MAY 30. He served as acting director of the Fogarty International Center and acting associate director for international research at the National Institutes of Health during two periods: from April 2025 through May 2026 and from January 2023 to May 2024. He originally joined Fogarty in 2015 to serve as deputy director.

Among his numerous awards, Kilmarx received the USPHS Presidential Unit Citation for "extraordinary courage and the highest level of performance in action throughout the United States Government's response to the Ebola outbreak." He's also a recipient of the U.S. Public Health Service Distinguished Service Medal based on his response to HIV/AIDS and other infectious diseases as well as his work building health research capacity worldwide.

During a fireside chat shortly before his retirement, Kilmarx's comments about his career often surprised his audience.

Advocating for Fogarty

"What's been most rewarding is this last year and being in this role of acting director," said Kilmarx. During a period of uncertain funding, he spent "a good amount of time" with NIH Director Dr. Jay Bhattacharya, other NIH leaders, and Fogarty supporters discussing why NIH and Fogarty conduct global health research and the impact it has. This period has been "kind of an unintended career path… to try to preserve this work."

As an example, Kilmarx highlighted the recent trials and tribulations of the Health in Extreme Weather Initiative for which he was co-chair of the steering committee and its executive committee. The initiative's original title referred to 'climate change,' a research topic that is no longer a priority under the current administration, and so the reason the initiative had come under fire. Kilmarx said that he responded to critics by explaining that "we're not meteorologists, we're not actually studying climate change, we're looking at hurricanes and forest fires; we're not studying what's causing them—we're not focused on

Dr. Peter Kilmarx and Dr. Paul Farmer, co-founder of Partners in Health.

the relationship between smokestacks and weather. We're studying the weather and health." By refocusing and renaming the initiative, he and other committee members were able to help continue the work.

"I'm optimistic by nature," said Kilmarx. "Many people from across NIH are really committed to [global health research] and I think we have a mutual understanding of its importance." When others have misconceptions about Fogarty's work and threaten to withdraw support, he recommends "taking the time to explain." Kilmarx has met with NIH leadership accompanied by Barbara Sina, PhD, acting director of Fogarty's Division of International Training and Research, to clarify the center's programs and mission. "And

they said, 'Okay, that sounds fine, go ahead and continue,'" he said.

Even when a political appointee was embedded within Fogarty for a few weeks—ostensibly to cut programs—Kilmarx felt hopeful. "This is actually better. It could have been someone coming down and saying, 'Stop, stop, stop, stop, stop.' We can talk to the appointee." And talk Kilmarx did, energetically and effectively, which resulted in most of Fogarty's programs being spared. "With all that we know about the importance of our work for science, for research, for health, including for Americans' health, if we just keep up this messaging, we will continue."

John T. Monahan, JD, Professor, Senior Lecturer in Law, Senior Fellow, Public Policy, and Senior Advisor in Office of the President at Georgetown University, said of Kilmarx's extraordinary stewardship during this period of uncertainty and transition: "Peter Kilmarx's legacy is far more than a long and distinguished career of accomplishment in public health and science. Peter has repeatedly demonstrated character, commitment, and passion when assuming leadership roles during times of change. When called upon, Peter has always led with a steadfast commitment to improving the health of people at home and around the world." Fogarty Program Director Laura K. Povlich, PhD, added that Kilmarx's "perseverance, support, and encouragement as acting director will be remembered and appreciated well beyond his time here."

Helping secure Fogarty's future may be Kilmarx's greatest achievement while serving the international center, but it's certainly not his only contribution. During his tenure, Kilmarx spearheaded various analyses of NIH global health activities, built coalitions with high-level NIH and external stakeholders, and represented Fogarty and the NIH in national and international forums. He also co-led the African Postdoctoral Training Initiative (APTI), which brings African postdoctoral fellows to NIH, and other programs to transform health professional education and research in Africa. Additionally, he worked to build global capacity for pandemic preparedness and encouraged the use of data, metrics and AI to increase impact and strengthen capacity.

Dr. Peter Kilmarx in Thailand.

Life before Fogarty

In the earliest years of his government service, Kilmarx frequently responded to outbreaks of two infectious diseases: HIV and Ebola. He joined the Epidemic Intelligence Service (EIS) at the Centers for Disease Control and Prevention (CDC) in Atlanta in 1994 and led household surveillance efforts during the 1995 Ebola outbreak in Kikwit, DRC. University of Washington's Dr. Judy Wasserheit, an internationally recognized leader in infectious disease research and a former Fogarty Advisory Board member, recalls: "Peter Kilmarx was an EIS officer in CDC's Division of STD Prevention when I was the division director and the seeds of the exceptional leadership and management skills that Peter has consistently exhibited were clear even then—the insightful analytic intelligence based on data; the integrity; the ability to listen to

Photos courtesy of Peter Kilmarx

Dr. Madhukar Pai, Director of McGill Global Health Programs and Director of the McGill International TB Centre, alongside Dr. Peter Kilmarx.

Dr. Jean Nachega, associate professor at the University of Pittsburgh and Director of the Centre for Infectious Diseases at Stellenbosch University, Cape Town; Dr. Peter Kilmarx; and Dr. Jean-Jacques Muyembe-Tamfun, general director of Institut National pour la Recherche Biomedicale, Democratic Republic of Congo.

Dr. Peter Kilmarx and Dr. Linda-Gail Bekker, a professor of Medicine and Chief Executive Officer of the Desmond Tutu Health Foundation, University of Cape Town.

what's said, and, equally important, to what is not said and to respond with the honesty, transparency, and empathy that are the cornerstones of trust; the perseverance and resilience that I think have served all of us especially well recently; and the creativity and style."

Kilmarx next directed CDC's northern Thailand HIV/STD prevention research field station from 1996 to 2002. Dr. Timothy Mastro, Director of CDC Thailand at that time and now board chair of the North Carolina Global Health Alliance, notes, "I would call Peter the 'Swiss army knife of epidemiology.' He could pretty much do it all. We had Peter up in Chiang Rai, Thailand, where we had cohort studies looking at the natural history of HIV while we were trying to develop an intervention and do prevention research. And Peter was perfect. He was very personable, quickly learned how to speak Thai quite respectfully. He fit in with the Thai staff, engaged with the ministry officials, and the medical societies there. He was very good at data analytics, writing protocols. We had a lot of data, so we needed somebody that could crank out those articles, and Peter did that quite a lot."

Focus on Africa

Following Thailand, Kilmarx directed CDC's Botswana office from 2002 to 2005. During the latter post, he implemented the President's Emergency Plan for AIDS Relief (PEPFAR) and conducted HIV and TB prevention research. He observed, "West Africa circumcises so they have a low prevalence of HIV infection—because circumcision is very effective at preventing female-to-male transmission of HIV. By contrast, southern and eastern Africa, which doesn't circumcise, had very high HIV rates." This observation was borne out by the completion of three randomized controlled trials, between 2005 and 2007, of voluntary medical male circumcision to prevent female to male HIV transmission, which showed a greater than 50% reduction in HIV acquisition in the circumcised men. At the CDC, Kilmarx next became Chief of the Epidemiology Branch from 2006 to 2010. During that time, he initiated the CDC response to the Ebola outbreak in Kasai Occidental, formerly a province of DRC. Next at CDC, he became Senior Advisor to the Director for Health Reform from 2010 to 2011 and then oversaw its Zimbabwe office from 2011 to 2015. There he provided oversight for 30 staff members who managed the implementation of U.S. efforts to reduce HIV/AIDS, tuberculosis (TB), and malaria. During this busy period, he led the "building of a laboratory specimen transport system and a health information system. All 1,200 districts had a flip phone that they could send in reports on rabies

In the earliest years of his government service, Kilmarx frequently responded to outbreaks of two infectious diseases: HIV and Ebola.

Dr. Peter Kilmarx with his colleagues at the U.S. Public Health Service Epidemiology Branch, Division HIV/AIDS Prevention, CDC in 2010.

Dr. Peter Kilmarx with former Botswana President Festus Mogae

Left to right: Dr. Peter Kilmarx, former NIH Director Dr. Francis Collins, and former Fogarty Director Dr. Roger Glass

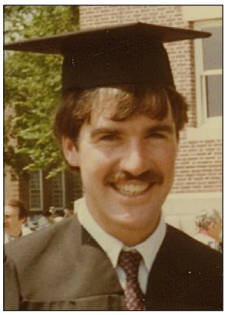
cases and diptheria cases and the numbers of mothers and children treated and those kinds of things."

The 2014–2016 Ebola outbreak, the largest to date (with more than 28,600 cases reported), occurred during his time in Zimbabwe. He was deployed to Sierra Leone, where he served as the CDC Ebola response team leader during September and October, 2014. In Sierra Leone, Kilmarx's responsibilities included standing up "all these different new capacities…with essentially unlimited resources from the CDC Foundation." (Importantly, the foundation accepted "a big donation from Mark Zuckerberg" following a media appeal from Kilmarx.) "We started a public health laboratory system. We started a behavioral research program, a communications system, a dead body management system," says Kilmarx. He even helped engage the British Army to help with logistics and security.

"The biggest challenge was actually then going to Guinea, which was, in contrast, the most frustrating professional experience I've ever had," said Kilmarx. In Guinea, he served as the CDC's principal deputy team leader for the same ongoing Ebola epidemic during January and February 2015. He found Guinea to be very different from Sierra Leone for "a long list of reasons," through primarily due to it being a Francophone country. While the British Army helped in Sierra Leone, due to their history, "it was not as easy to have the French and Guineans work together."

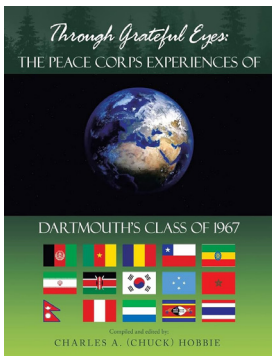
Despite this, the Ebola epidemic dissipated and eventually disappeared in both Sierra Leone and Guinea around the same time. Kilmarx believes that, in Guinea, the indigenous leaders were responsible for this positive outcome. As he imagines it, they told their people "this is how it is transmitted, and you have to stop washing your face with the water that you use to wash the dead bodies, and we're going to fine you a chicken if you're hiding a sick person in your house—those are the kinds of things that ultimately ended it. It was the people taking care of themselves."

The original spark



Kilmarx, a proud Rhode Island native, is a graduate of Dartmouth College. After earning his MD from Dartmouth-Brown's Combined Program in Medicine, he completed both his internal medicine residency and infectious disease clinical fellowship at Johns Hopkins Hospital in Baltimore. He's co-authored papers that use data to track metrics to measure national health research capacity as well as numerous peer-reviewed journal articles and book chapters. He's a fellow of the Infectious Diseases Society of America and serves on the editorial board of Sexually Transmitted Diseases. In retirement, he plans to live in Thailand near his wife's family, where he will garden and raise fish.

Tracing the origins of his vocation for global health research inevitably leads back to the two-year period Kilmarx spent as a Peace Corps volunteer, when he helped develop fisheries in the DRC (then Zaire)—fisheries, by the way, that are still productive today.



In his foreword to "Through Grateful Eyes: The Peace Corps Experiences of Dartmouth's Class of 1967," Kilmarx explains his own decision to join in 1983: "I had fulfilled the premed requirements but was not feeling sufficiently mature to begin medical

school. I thought the Peace Corps would give me an opportunity for service, for adventure, and to know myself better."

Recurring themes in 'Grateful Eyes' echo his own ideas and impressions, Kilmarx notes. "The descriptions of culture shock, loneliness, austerity, adventures, and professional and health challenges will resonate with readers who have lived and worked immersed in the culture of a developing country … the writers, like me and most volunteers, grew up during their service to learn about themselves, their role in society, and their potential to make a difference." After Zaire, he returned home "instilled with the motivation and mindset to complete medical school with honors and embark on an exciting career in global health and government service. And I've been privileged to remain involved in various ways with both Dartmouth and the Peace Corps."

Dr. Peter Kilmarx and Dr. Patty Garcia, former Minister of Health of Peru and professor, School of Public Health at Cayetano Heredia University in Peru.

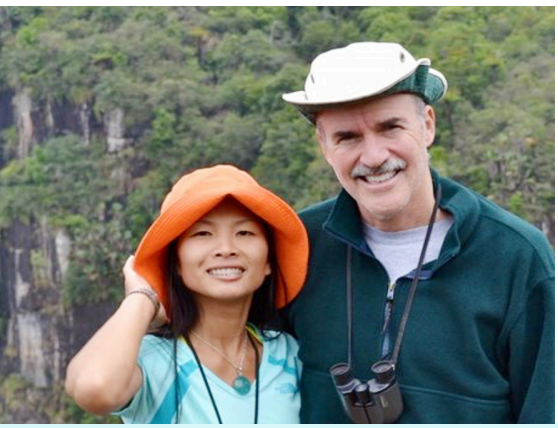
In 2025, when Jody Olsen, a former director of the Peace Corps, visited NIH to discuss her memoir, 'A Million Miles,' Kilmarx introduced her to the assembled guests. He said then, "You never say 'former' Peace Corps volunteer, you say 'returned' Peace Corps volunteer, because it's a lifelong commitment." For Kilmarx, it undoubtedly has been.

Dr. Peter Kilmarx and Marco Antonio Zago sign a new cooperation agreement between São Paulo Research Foundation and the NIH to strengthen connections between scientists in São Paulo and the U.S.

Courtesy of Daniel Antônio/Agência FAPESP

"PETER'S GREATEST CONTRIBUTIONS TO PROGRESS IN GLOBAL HEALTH HAVE BEEN THE WAYS IN WHICH HE HAS CONSISTENTLY HELPED CATALYZE OR ACCELERATE PARADIGM CHANGES IN GLOBAL HEALTH RESEARCH." – DR. JUDY WASSERHEIT

Peter Kilmarx and his wife, Nicha.



"YOU NEVER SAY 'FORMER' PEACE CORPS VOLUNTEER, YOU SAY 'RETURNED' PEACE CORPS VOLUNTEER, BECAUSE IT'S A LIFELONG COMMITMENT." FOR KILMARX, IT UNDOUBTEDLY HAS BEEN.

FOGARTY WELCOMES ITS NEW LEADER, STEVEN SCHIFF

HIS GROUNDBREAKING WORK ON DEVELOPING THE CONCEPT OF PREDICTIVE PERSONALIZED PUBLIC HEALTH WILL BRING A CUTTING-EDGE SCIENTIFIC MIND TO THE NIH LEADERSHIP TEAM.

Steven Schiff, MD, PhD, joined the Fogarty International Center as its ninth Director in June. He has also been appointed Associate Director for International Research at the National Institutes of Health (NIH).

A pediatric neurosurgeon, Schiff currently serves as the Harvey and Kate Cushing Professor of Neurosurgery, Vice Chair for Global Health, Department of Neurosurgery, and Professor of Epidemiology and of Electrical and Computer Engineering at Yale University.

NIH Director Dr. Jay Bhattacharya said of him: "Dr. Schiff brings nearly 40 years of experience in global health, epidemiology of microbial diseases, and pediatric neurological disorders to NIH. His groundbreaking work on developing the concept of predictive personalized public health will bring a cutting-edge scientific mind to the NIH leadership team."

Schiff founded the Center for Neural Engineering at Penn State University and has worked to develop the Center for Global Neurosurgery at Yale. He received the NIH Director's Pioneer and Transformative Awards in 2015 and 2018, respectively. He has worked toward the sustainable control of infant infections in the developing world, and this has evolved into an exploration of what he calls 'predictive personalized public health.' He also led the discovery of a highly lethal infant brain disease, known as neonatal paenibacilliosis, which is an invasive infection caused most commonly by the bacterium P. thiaminolyticus, and is increasingly recognized as an underdiagnosed cause of neonatal sepsis, particularly in resource-limited settings as well as recently recognized in U.S. infants.

After receiving his undergraduate degree in Biology from MIT, Schiff earned his MD and completed his general surgery internship, PhD, and neurosurgery residency at Duke Uni-versity. He completed his pediatric neurosurgery fellowship at Children's Hospital of Philadelphia. He is a fellow of the American Association for the Advancement of Science, American College of Surgeons, American Association of Neurological Surgery, American Physical Society, and the American Epilepsy Society. He serves on the U.S. Food and Drug Administration's Medical Devices Advisory Committee and as a member of the Executive Committee, Topical Group on Medical Physics of the American Physical Society. He has published nearly 250 scientific papers across a variety of topics, including neural control engineering, sustainable health engineering, and global health.

"DR. SCHIFF BRINGS NEARLY 40 YEARS OF EXPERIENCE IN GLOBAL HEALTH, EPIDEMIOLOGY OF MICROBIAL DISEASES, AND PEDIATRIC NEUROLOGICAL DISORDERS TO NIH."

— DR. JAY BHATTACHARYA

Workshop in Lviv focuses on advancing ethical research in Ukraine

Jack DeHovitz

Fogarty's training programs in Ukraine face profound challenges due to the ongoing war. Yet in late March, Ukrainian Catholic University (UCU) hosted a three-day workshop in Lviv on HIV and mental health research, epidemiology, and bioethics. The meeting brought together Fogarty trainees, faculty, and other partners who remain dedicated to building rigorous, ethical, and local research capacity in the embattled country.

"The Lviv workshop stands as a powerful example of sustained global partnership—advancing science, strengthening capacity, and supporting the next generation of researchers," says Jack DeHovitz, MD, Distinguished Service Professor at SUNY Downstate Health Sciences University and Director of the Special Treatment and Research (STAR) Program.

Three Fogarty-funded programs jointly coordinated and provided instruction for the Lviv conference.

Emily Anderson

Loyola University Professor Emily E. Anderson, PhD, presented on behalf of the *Loyola-Ukrainian Catholic University International Bioethics Research Training Program.* Both Adam Levine, MD, Director of Brown University Center for Global Health Equity, and Brown University Professor Timothy Flanigan, MD, represented the *Building Capacity in HIV/TB and Mental Health in Ukraine's Humanitarian Crisis* program.

"As the newest Fogarty research training program in Ukraine, it was incredibly helpful for our recently recruited trainees to have an opportunity to interact and network with more senior trainees and faculty mentors from across Ukraine as they begin to develop their research projects and career interests," says Levine.

Finally, DeHovitz and David Odegaard, MPH, Director of Training and Education for the STAR program, led activities provided by the *New York State International Training and Research Program.*

A grounded practice

Each of the three programs met individually on the first day. The programs from SUNY Downstate University and Brown University both focused on orientation for new trainees. Meanwhile the Loyola program highlighted the various achievements of alumni and advanced trainees.

Participants from all three programs congregated during the second two days, which boasted a full-day research symposium. There, presentations highlighted the work of UCU faculty members as well as Fogarty trainees and faculty, including Texas A&M University's Israel Liberzon, MD, who leads an NIH-funded program focused on psychologic aspects of trauma care. Sessions created space for peer exchange, reflection, and the strengthening of professional networks, an essential component of the Fogarty program's long-term impact.

Many of the Lviv attendees are at the earliest stages of their research careers, with limited, prior experience in manuscript writing or study design. All the sessions, then, aimed not only to provide technical knowledge, but also to inspire trainees to begin developing their own proposals and collaborations. For example, one general workshop for HIV epidemiology trainees—designed for early-stage investigators, including trainees from Ukraine's Ministry of Health and community-based HIV organizations—emphasized building foundational skills in implementation science and research development.

Alumni and advanced bioethics trainees led the conference's well-attended core session, *Responsible Conduct of Research (RCR).* Structured around the lifecycle of a research study—from developing a research question to publication and peer review—the curriculum highlighted ethical principles at every stage. Topics included bias and source verification, IRB review and participant protections, informed consent, data integrity, and authorship practices. Small-group discussions of case studies helped to reinforce lessons in ethical decision-making.

Adam Levine

Photos courtesy of Jack DeHovitz

Throughout the Lviv conference, participants presented their ideas, received mentorship, and spoke about pressing public health challenges in Ukraine. Discussions highlighted critical areas of inquiry, including the impact of conflict on HIV transmission and care continuity, disruptions to treatment systems, and the mental health needs of civilians and members of Ukrainian armed forces. All conversations underscored the importance of research that is responsive to rapidly evolving conditions while remaining grounded in the lived experiences of affected populations. Finally, a tour of UCU's new clinical facilities offered insight into how care delivery and training are integrated within the local context.

Across the conference, across an array of presentations, one consistent theme emerged: ethical research is not simply a set of rules, but a practice grounded in integrity, mentorship, and community.

"By combining scientific training with case-based learning and collaborative exchange, the Lviv workshop exemplified Fogarty's mission in funding both research and bioethics training—to equip researchers not only to generate evidence, but to do so responsibly," concludes Anderson.

Cheryl Moyer. PHD, MPH

Q&A

Bridging Barriers to Care

by Mariah Felipe-Velasquez

Cheryl Moyer, PhD, MPH, is a Professor of Learning Health Sciences, Obstetrics and Gynecology, and Health Management and Policy at the University of Michigan Medical School. She is also Associate Director for Education and Mentorship at the University's Center for Global Health Equity. Moyer has served as an investigator for the Northern Pacific Global Health Leadership, Education, and Development for Early-Career Researchers (NPGH LEADERs) consortium since 2011. NPGH LEADERs is one of six consortia that currently make up Fogarty's LAUNCH Global Health training program, which supports one year of mentored training for researchers from the United States and low-and-middle income countries.

Why child and maternal health research in Ghana?

My first public health job focused on breast cancer screening in rural eastern North Carolina, where we saw huge challenges in the way providers and patients communicated. There wasn't always a language barrier, but there were profound gaps in understanding on both sides. When I moved to Michigan, I was pulled into work that was underway in Ghana. One of my mentors, Dr. Tim Johnson, led a program to help establish in-country OB-GYN training, with the goal of increasing the number of practicing OB-GYNs in Ghana. Through the relationships Dr. Johnson and others at Michigan cultivated in Ghana, I got connected to Ghanaian colleagues doing maternal and newborn health research, and the rest is history. I think the thing that is interesting to me now is that when I began my public health career, I had no intention of working globally. Yet in hindsight, the work I began domestically has had a huge impact on the work I do globally. Bridging the gap between patients and providers is a universal challenge.

How do Ghanaian researchers and their western partners relate?

Even early on, our work in Ghana tried to focus on finding the "win-win", where projects were designed for mutual benefit. Yet structurally, global health has often been driven by western institutions writing grants and then bringing in partners. Today, we're seeing a growing effort to change that dynamic and support Ghanaian colleagues in leading the research.

For my own projects, I try to make sure my partners are the ones driving the agenda, while I contribute where my expertise adds value. I think Fogarty's approach to capacity building and programs like LAUNCH have really helped shift the culture and established long-term networks that are allowing for this shift to stronger and more sustainable partnerships.

Does your current project in Ghana translate to the United States?

My current project is focused on early detection of neonatal jaundice, which is a condition that develops in the first few days after a baby is born. As a baby's blood cells break down, a bright yellow waste product is created called bilirubin. Too much bilirubin in the blood, which can cause a newborn's skin and eyes to look yellow, can cause brain damage and even death. If identified early, treatment can be relatively simple. Most hospitals in Ghana have access to phototherapy, the technology used to treat neonatal jaundice. Yet many cases go undetected for a variety of reasons.

To mitigate this, we're studying a low-cost tool called a "Bili-Ruler" to see if it can reliably help identify babies who need further testing, specifically in children with darker skin tones. The Bili-Ruler allows mothers, healthcare providers, and researchers to compare a baby's underlying skin tone to a series of increasingly yellow color blocks on the ruler. Lighter colors indicate lower levels of bilirubin, and darker colors indicate higher levels of bilirubin. We are testing to see if mothers' scores align with healthcare provider scores, as well as if Bili-Ruler scores align with other ways to identify jaundice. Other ways to identify jaundice require expensive equipment (such as using skin-based light refraction via transcutaneous bilirubin assessment, or TCB), or invasive

blood tests that may take 12-24 hours to process given laboratory limitations. Our hope is that if mothers' scores align with healthcare providers' scores, and if the Bili-Ruler approximates other measures of jaundice, it might be possible to send the Bili-Ruler home with mothers and families to monitor their newborns and improve the chances of early detection in the week after birth.

Even though this study is happening in Ghana, we deal with challenges in accessing health care in the U.S. as well, especially in rural areas. In my state of Michigan, our upper peninsula has very few healthcare providers compared to the rest of the state, and many residents need to drive for hours to seek basic healthcare. We are also aware of how many of the devices that we use in the U.S. might not work as well among dark-skinned patients. Our study is exploring how well this low-tech, low-cost device works in Ghana, but this information is likely to be useful in the United States as we seek to find tools that work across diverse populations. So, while the context may seem vastly different on the surface, we have a lot more in common than not.

Moyer (right) guides trainees through the procedure using a medical manikin.

Moyer (right) demonstrates a technique for trainees using a doll.

Photos courtesy of Cheryl Moyer

Why is mentorship so important to you?

My focus is always to try and meet people where they are. We all bring different life experiences to our work, and we are all at varying stages of growth. I work to create space for people to process their experiences, especially because in global health research trainees are often navigating unfamiliar environments. If someone isn't feeling well mentally or physically, they won't be able to do their best work.

My personal metric for 'good mentorship' is if it transcends that initial relationship of mentor and mentee and ultimately helps both of us see the world a little differently. If I can help someone grow, I hope they'll pay that forward to others. Watching mentees go on to lead their own work is one of the most rewarding parts of my career.

What is your advice for future global health researchers?

Recognize that this work isn't glamorous. It's hard. You'll be far from home, dealing with challenges you didn't anticipate while simultaneously trying to do complex research sometimes for the first time. Even so, trainees should know that these experiences, whether or not they choose to stay in global health research, will shape them both personally and professionally. Even when it seems like systems are working against you, you can still show up every day, bringing rigor, authenticity, and integrity to the inevitable challenges. For those who stay in global health, the trick is seeing each new challenge as an opportunity to learn something new.

"IN HINDSIGHT, THE WORK I BEGAN DOMESTICALLY HAS HAD A HUGE IMPACT ON THE WORK I DO GLOBALLY. BRIDGING THE GAP BETWEEN PATIENTS AND PROVIDERS IS A UNIVERSAL CHALLENGE."

CUGH 2026 CONFERENCE: How one researcher and practitioner translated lessons learned in Zambia to North Carolina

WHAT IS THE FUTURE OF GLOBAL HEALTH? In April, attendees of the 2026 annual conference for the Consortium of Universities for Global Health (CUGH) explored possible answers to this question. The Washington, DC meeting, which assembled leaders from academia, government, the private sector, and other organizations, reflected CUGH's commitment to strengthening global health through partnership and scientific rigor.

The 2026 annual program featured more than 40 panels, 500 abstracts, and 200 speakers, including Michael Herce, MD, MPH, Associate Professor of Medicine and Associate Director of International Operations at the University of North Carolina (UNC) Institute for Global Health and Infectious Diseases.

Herce—a recipient of both Fogarty's Launching Future Leaders in Global Health (LAUNCH) Research Training Program and its International Research Scientist Development Award—described how he implemented lessons learned in Zambia for North Carolina.

Innovation inspiration

"Going all the way back to 2020, my colleagues and I at UNC were caring for COVID-19 patients in the ICUs," says Herce. It was an "inescapable" fact that most of the severely affected patients early in the pandemic were from predominantly Black, Latino, and other medically underserved communities in rural areas outside of Chapel Hill. This imbalance reminded Herce of battling HIV in Zambia, where his team had worked for over a decade with communities on the fringes of the medical system. Could Herce and his team bring services for COVID-19, including testing and monitoring, and later vaccination and treatment, to communities in North Carolina just as his team had done for HIV in Zambia?

Despite "obvious differences" between Zambia and North Carolina—very different pathogens, for one—Herce thought a similar approach of partnering with local organizations "who knew their communities better than anyone else" might be effective. In Zambia, his team and its collaborators had constructed health care delivery platforms that trained community health workers to offer HIV services in the places where people congregated and socialized, like bars, clubs, and community events. His aim in North Carolina, then, was to provide health services closer to where people lived and worked at "pop-up events and community venues, like churches and parks, to reach people affected by COVID-19."

Importantly, Herce had an unseen advantage when putting innovation into action. Over the past decade, he'd "naturally gravitated" towards

Fogarty's Dr. Peter Kilmarx (left) and CUGH Executive Director Dr. Keith Martin share a moment on the podium at the CUGH 2026 conference.

Courtesy of Robb Cohen Photography & Video

implementation science, a methodology that helps researchers rigorously consider "what lessons might be transferable across settings to improve population health worldwide."

Strategies

Implementation science offers frameworks—which are "really well thought out evidence-based playbooks"—to guide decision-making and to address contextual differences, barriers, and facilitators in order "to bring an evidence-based practice into a routine care setting," says Herce.

When translating insights from the HIV response in Zambia to the COVID response in North Carolina, Herce and his team began by determining which stakeholders could help implement a new community-based model of health service delivery. The team identified federally qualified health centers or "FQHCs" (outpatient clinics that qualify for Medicare and Medicaid reimbursements) as partners for healthcare delivery and local community-based organizations as leaders of the response. Use of participatory research and implementation science methods helped bring these different organizations together into a single

consortium capable of coordinating with government agencies, sharing resources, and articulating common goals and priorities to fight COVID-19. Next, implementation strategies refined in Zambia, such as creating mobile care teams, were adapted to overcome barriers when offering COVID-19 services in North Carolina.

Hurdles

The greatest challenge faced by Herce and his team was constant change. He says, "Different waves of COVID, different guidelines, different expectations, changing technologies… things were moving so fast, we had to constantly think about adaptation." Co-creation helped with this; Herce's team would sit down with community partners and think about how best to work together and identify workflows that would be feasible.

"We used focus groups and rapid appraisal methodology to test how we were doing and get an early sense of acceptability, feasibility, and appropriateness of what we'd co-created," says Herce. They reviewed the routinely collected data, which included the proportion of people accessing services at brick-and-mortar health centers or accessing services in the community. "We fed that data back to the group and then all the partners would meet to make iterative refinements to our model to make sure we adapted to the ever-changing situation during the pandemic."

"Another major challenge was overcoming bureaucratic and insurance-related barriers in the U.S. healthcare system," says Herce. "We also had several mass testing and vaccination events that were just far more complicated than anything we'd tried to do in Zambia, where you're trying to reach several hundred people in one go." A small phalanx of IT workers and healthcare administrators was needed to register patients, document services provided to patients in electronic records, and furnish instructions. This was "incredibly logistically complex to do, for example, at a farm site or in a school parking lot in a rural area."

Yet, the firm resolve of both partners and communities made overcoming hurdles easier than anticipated, says Herce.

Human resources

"There was such a clamoring for community-centered service within the organizations and the communities themselves," recalls Herce. One group working with the Latino community in central North Carolina, The Hispanic Liaison, trained community health workers to go door-to-door in the hardest-hit neighborhoods and take a household inventory of needs, distribute COVID-19 self-test kits and educational materials, and schedule people for appointments. "In 10 months, a team of about eight community health workers conducted almost 1,200 home visits and distributed over 4,700 self-test kits. So this cultural and civic engagement organization pivoted to create a community health worker program … just amazing."

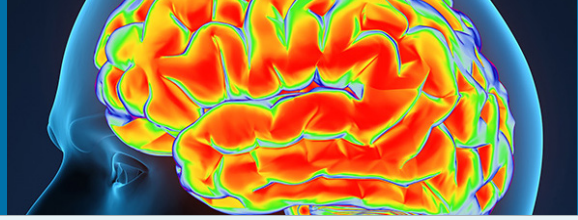
Kristen Weymouth (left) and Janelle Cruz at the Fogarty International Center exhibitor table at the CUGH 2026 conference.

Dr. Michael Herce giving a shot at the COVID-19 community health fair in Central North Carolina.

Courtesy of Michael Herce

The community responded favorably overall, says Herce. "On average, three out of four participants liked or really liked and approved of our model." This was echoed in focus groups where his team heard "over and over again" that delivery of COVID-19 services by "trusted" community and healthcare organizations in the spaces where people live and work made them more appealing.

Herce believes a legacy of his work is organizational transformation for community partners and FQHCs in North Carolina. Today, they're all much better positioned to deliver community-based health services, he says. "Investments in global health can change policy and practice in beneficial ways in the United States—in ways that we can't always predict. If you had asked me a decade ago whether aspects of my work in Zambia could address a pandemic in my home country, I would have struggled to imagine it. But it absolutely helped save American lives."



Could solving a medical mystery help explain complex brain diseases?

A medical mystery on the island of Guam has perplexed investigators for more than half a century.

In a recent National Institutes of Health lecture, Daniel Perl, MD, posits that renewed investigations of cases of amyotrophic lateral sclerosis (ALS) and dementia on Guam could lead to therapies or cures for patients with related neurological disorders.

Interdisciplinary science, international collaboration, and contemporary technologies, including AI, just might solve this long-standing mystery, suggests Perl, a professor at Uniformed Services University of the Health Sciences.

Singular backstory

Perl begins his lecture with some necessary historical context. In 1898, Spain ceded Guam, an island 30 miles long and 4-12 miles wide, along with the Philippines, Puerto Rico, and Cuba to the United States. Shortly thereafter, the U.S. Navy began to rule this U.S. territory in the Western Pacific. On December 8th, 1941—the day after the attack on Pearl Harbor—Japan invaded Guam, which surrendered three days later. The Japanese occupied the island until the summer of 1944, when U.S. troops reclaimed it and began staging the Western Pacific theater of World War II there.

To better understand the island's endemic diseases (and prevent troop infections), the U.S. Navy set up the 'Naval Medical Research Laboratory 2' (later renamed 'US Naval Institute of Tropical Medicine'). Scientists recruited for the island lab included Harry Zimmerman, a pathologist at Yale University, and Albert Sabin, a virologist at the Cincinnati Children's Hospital. The two shared a tent while working together in the hospital and research facilities (essentially, a series of Quonset huts). Notably, Zimmerman and Sabin developed a vaccine against Japanese encephalitis during their time on Guam.

In June 1945, Zimmerman submitted a monthly report that noted how Guam's civilian medical wards had admitted seven or eight patients, all Chamorro natives, with ALS (also called 'Lou Gehrig's disease'). A devastating neurological condition, ALS destroys the nerve cells that control movement, eventually leading to paralysis and death. Guam's population at the time of Zimmerman's report was about half of the current count of 169,000 people, with native Chamorro inhabitants comprising half of that total.

Worldwide incidence of ALS is only about 2 cases per 100,000 people, so several cases on Guam would indicate an unusually high prevalence, explains Perl.

Surveys and surprises

After the war ended, the NIH sent two neurologists, Drs. Leonard Kurland and Donald Mulder, to investigate this Guam anomaly. In 1953, they conducted a door-to-door survey of the entire island and discovered the Chamorro population were dying from ALS at a rate 50 to 100 times higher than anywhere else in the world. Their survey documented more than 350 cases in a single village of 700 people.

In some patients, Kurland observed rigidity, bradykinesia (slowed movements),

Daniel Perl, MD

Courtesy of Uniformed Services University of the Health Sciences

resting tremor, the classic Parkinsonian gait, and a progressive dementia similar to Alzheimer's disease. Notably, these same patients showed a poor response to Levodopa (L-dopa is commonly used to treat Parkinson's disease movement symptoms). Scientists began referring to this condition as Parkinsonism dementia complex (PDC), with some believing PDC constituted a separate disorder from ALS in Guam. Based on his own research, Perl argues that "it looks much more like a spectrum of disease rather than two separate diseases."

In 1961, Asao Hirano, MD, a neuropathologist practicing at Montefiore Medical Center in the Bronx, published a series of papers on the Guam ALS cases. His postmortem findings showed prominent upper motor neuron degeneration with lateral cortical spinal degeneration. Kurland sent Hirano's slides to other neuropathologists, asking, "Is there anything different here?" Perl notes that Nathan Malamud, PhD, a neuropathologist at the Langley Porter Institute at UCSF,

"WORLDWIDE INCIDENCE OF ALS IS ONLY ABOUT 2 CASES PER 100,000 PEOPLE, SO SEVERAL CASES ON GUAM WOULD INDICATE AN UNUSUALLY HIGH PREVALENCE."

answered: “Yes. There are neurofibrillary tangles… and a lot of them.”

Following Malamud’s observation, Hirano looked more closely at his samples and found neurofibrillary tangles in the motor neurons of the spinal cords of virtually all Guam ALS cases. In comparison, he analyzed 50 cases of ALS from his New York laboratory and found no neurofibrillary tangles. Another feature of the tangles in Guam patients is they appeared in the superficial layers of the cortex as opposed to the deeper layers, which is the opposite of the distribution seen in Alzheimer’s disease. Perl himself has retested samples from this era and found that these tangles are not the beta amyloid deposits commonly seen in Alzheimer’s disease.

‘Unusual epidemiology’

Hirano’s findings prompted the NIH to establish a special Guam field office led by Kurland. His team established the mean age of onset for ALS as 46 years and for PDC as 53 years. Of adult Chamorro deaths, 13% were due to ALS, while 11% were due to PDC. At its peak, ALS and PDC together accounted for nearly a quarter of all adult deaths on Guam.

“Now it gets even more complicated,” says Perl. The field office had recorded these patterns between 1960 and 1985, but then “all of a sudden the pathology changes.” Beginning in the late 1980s, more than 61% of the PDC cases began showing amyloid plaques, similar to what is observed in brain specimens obtained from cognitively intact people of comparable age in New York City (and well below what is encountered in moderate or severe Alzheimer’s disease).

Adding to the complexity, scientists identified a second locus of ALS/PDC on Japan’s Kii Peninsula. In 1911, Dr. Kinosuki Miora had noted an unusually high prevalence of ALS there and in

Tumon Bay, Guam

Courtesy of U.S. Air Force

1975, Dr. Yoshiro Yase’s follow-up investigation found high incidence of ALS in two villages: Kozagawa had 15 cases per 100,000 people, while Hobara had 55 cases per 100,000. Though these incidence rates are below those seen in Guam, they are substantially higher than elsewhere. Unusually, Kozagawa and Hobara are 125 miles apart and incidence rates in the intervening villages are not high, observes Perl: “So very unusual epidemiology here, but appearing to be a similar phenomenon as Guam.”

Vanishing act

In the 1980s, incidence of ALS and PDC on Guam began decreasing, while the age of onset increased by 10 years, says Perl. Over time, no new cases appeared on the island, while long-term survivors now account for the few remaining cases. “Genetic diseases don’t just go away like that, and they also don’t change characteristics [age of onset],” says Perl.

Perl says that, despite recent advances in both genetic studies and potential therapies, Guam ALS continues to confound scientists.

Something in the environment caused this disease… and something in the environment—(either removal of a harmful agent or introduction of a protective one) made it stop, says Perl. Theory after theory has been pursued—in particular, a toxic plant called cycad, common on the island, has been extensively investigated as a possible cause—yet Perl and other scientists believe none of the explanations suffice. Adding to the mystery, new, high-tech imaging revealed that brain proteins in early Guam ALS samples match those found in chronic traumatic encephalopathy (CTE, the concussion disease most commonly seen in athletes).

Perl says the Guam cases show features of ALS, Parkinson’s, and Alzheimer’s—a “neurological triple threat” unlike anything seen elsewhere. If one or more environmental change can eliminate a fatal neurological disease in 30 years, that’s not just an oddity, it’s a blueprint. To that end, he’s spent decades collecting and preserving samples from Guam patients, which are available for international and interdisciplinary investigations. Perl believes that solving this medical mystery could create the “Rosetta Stone of neurodegeneration” and would lead to an improved understanding of brain disease with profound implications far beyond the island.

Community

Dieffenbach receives lifetime achievement award from CROI

The Conference on Retroviruses and Opportunistic Infections (CROI) presented Carl W. Dieffenbach, PhD, senior advisor to Fogarty's director, with its first-ever Lifetime Achievement Award. This award honors a distinguished senior investigator whose career spans decades of groundbreaking contributions to HIV research. To receive this award, an individual must have dedicated at least 25 years to advancing the understanding of the biology, prevention, or treatment of HIV, with a lasting impact on both science and the global research community. "Dieffenbach's career exemplifies these criteria through a sustained record of scientific leadership, innovation, and impact," the International Antiviral Society noted in a press release. During his tenure as director of the Division of AIDS (DAIDS) at the National Institute of Allergy and Infectious Diseases, he oversaw a global HIV/AIDS research portfolio exceeding $1 billion. Under his leadership, DAIDS-funded research played a pivotal role in the development of antiretroviral therapies and long-acting formulations for the treatment and prevention of HIV. Dieffenbach is a graduate of the University of Maryland who earned his PhD in biophysics, with a focus on virology and host immune responses to viral infection, including interferon biology, from Johns Hopkins University in 1984. Following postdoctoral research, Dieffenbach was appointed assistant professor at the Uniformed Services University of the Health Sciences, where he investigated influenza, coronavirus, and HIV. Dieffenbach originally joined DAIDS in 1992 as chief of the Preclinical Therapeutics Group.

Green tapped as CEO of NIH Clinical Center

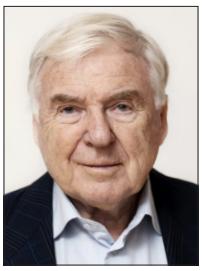
Jonathan M. Green, MD, MBA, is the NIH Clinical Center's new Chief Executive Officer (CEO). In this role, he will oversee the center's nearly $700 million annual operating budget and day-to-day operations of the 200-bed, 870,000-square-foot facility that saw more than 3,000 inpatient admissions and nearly 72,000 outpatient visits last year. The Clinical Center, the world's largest research hospital, is adding 570,000 square feet to the NIH's Bethesda campus footprint, an expansion that is expected to be completed in 2029. Green joined NIH in 2018 as Director of the NIH Office of Human Subjects Research Protections, where he led the consolidation of 12 Institute and Center-specific Institutional Review Boards (IRBs) into a single IRB serving the entire NIH intramural research program. Prior to NIH, he served as Professor of Medicine, Pathology, and Immunology and Associate Dean for Human Studies and Executive Chair of the IRB at Washington University School of Medicine in St. Louis. Green's research explored the molecular mechanisms of T cell activation. He received his medical degree from Wayne State University and then completed residency training at Boston City Hospital, a fellowship in pulmonary and critical care medicine at the University of Michigan Medical Center, and post-doctoral training at the University of Chicago. He continues to serve as an attending physician in the Medical Intensive Care Unit and Pulmonary Consult Service at the Clinical Center with board certification in internal medicine, pulmonary diseases, and critical care medicine.

Clemens, Holmgren named co-winners of 2026 Gairdner Global Health Award

John Clemens, MD, and Jan Holmgren, MD, PhD, are co-recipients of the 2026 John Dirks Canada Gairdner Global Health Award for advances in understanding cholera disease and immunity, and for the development and evaluation of safe, effective, and affordable inactivated oral cholera vaccines that have enabled cholera control worldwide. Clemens, an epidemiologist, and Holmgren, an immunologist, have worked together for over 40 years.

Clemens is Senior Scientific Advisor to the Director General, International Vaccine Institute (IVI) in Seoul, South Korea and Adjunct Professor of Epidemiology, UCLA Fielding School of Public Health in Los Angeles. He designs, conducts, and analyzes large population-based epidemiologic studies and vaccine field trials in low-income countries. A graduate of Stanford, he received his medical degree from Yale University. From 1983 to 1988, he served as a research scientist at the International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b). After returning to the United States, he held senior positions at the University of Maryland and the NIH. In 1999, he became the first Director-General of the International Vaccine Institute (IVI) in Korea, where he led the team that developed a killed oral cholera vaccine (Shanchol). In 2011, he moved to UCLA as Professor of Epidemiology and Founding Director of a new Center for Global Infectious Diseases.

From 2013 to 2021, Clemens served as Executive Director of icddr,b and since then he's worked at IVI. Clemens, who is credited with more than 500 peer-reviewed publications, received the 2010 Sabin Gold Medal.



Holmgren is a Senior Professor at the University of Gothenburg in Sweden. After completing his medical and research training, he served as a scientist at the Swedish Medical Research Council from 1970 to 1980. He's published more than 600 papers in microbiology, immunology, and vaccinology. Among his achievements with colleagues, Holmgren discovered the AB subunit structure and function of cholera toxin; identified the cholera toxin receptor; explained the key immune mechanisms and protective antigens in cholera; defined mucosal immunization routes for targeting immunity to specific sites; developed the first effective oral cholera vaccine, Dukoral; and aided the technology transfer that enabled local cholera vaccine production in Vietnam and later in India. Holmgren, an elected member of several scientific academies, has served on the boards of numerous national and international organizations, including Gavi, icddr,b, and IVI. He's received numerous scientific awards, including the Sabin Gold Medal.

Stuart, Wutich elected to National Academy of Sciences

The National Academy of Sciences elected 120 new members plus 25 new international members in recognition of their distinguished and continuing achievements in original research. Among its new members, the Academy recognized two researchers who work in the field of global health.

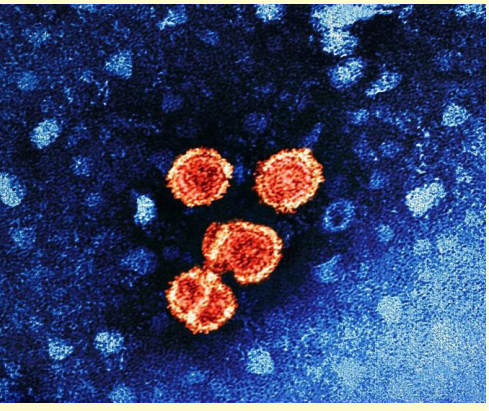
Kenneth Stuart, PhD, is a National Institute of Allergy and Infectious Diseases grantee who works in the area of malaria. Stuart is a Professor in the Departments of Pediatrics and Global Health in the Schools of Medicine and Public Health at the University of Washington. He also serves as a principal investigator in Seattle Children's Research Institute's Center of Global Infectious Disease Research and an affiliate investigator in the Vaccine and Infectious Disease Division at the Fred Hutchinson Cancer Center. A graduate of Northeastern University, he earned an MA in Biology from Wesleyan University and a PhD in Zoology from the University of Iowa. He conducted postdoctoral research at the National Institute for Medical Research in London and at SUNY Stony Brook before becoming an Assistant Professor of Biology at the University of South Florida. Later, he founded the Seattle Biomedical Research Institute that merged with Seattle Children's Research Institute. His expertise is in molecular and cell biology, immunology and host-pathogen interactions with a focus on protozoan pathogens.

Amber Wutich, PhD, is a Regents Professor, President's Professor, and Director of the Center for Global Health in the School of Human Evolution and Social Change at Arizona State University in Tempe. An expert on water insecurity, Wutich directs the Global Ethnohydrology Study, a cross-cultural study of water knowledge and management in more than 20 countries. Her two decades of community-based fieldwork explore how people respond, individually and collectively, to extremely water-scarce conditions. She leads Action for Water Equity, a participatory convergence study that develops collaborative water solutions with water-insecure U.S. communities, and Arizona Water for All, a participatory study that works with Arizona's most water-insecure communities to improve household water security. An ethnographer and methodologist, Wutich has authored more than 200 papers and co-authored eight books. She also edits the journal *Field Methods* and directs the NSF Cultural Anthropology Methods Program. Wutich is a MacArthur Fellow, who has been recognized with awards such as Carnegie CASE Arizona Professor of the Year.

Kaplan wins Pierre Galletti Award

The American Institute for Medical and Biological Engineering (AIMBE) is proud to present its highest award, the Pierre Galletti Award, to David L. Kaplan, PhD, Stern Family Endowed Professor of Engineering, Distinguished University Professor, and Professor in the Department of Biomedical Engineering at Tufts University. The award recognizes his pioneering work in silk-based biomaterials, translational impact on the biomedical sciences, and for his advocacy on behalf of bioengineers across all aspects of human health. His research focuses on biopolymer engineering, tissue engineering, regenerative medicine, and cellular agriculture. He has published more than 1,000 peer-reviewed papers and serves as editor-in-chief of the journal *American Chemical Society's Biomaterials Science and Engineering*. The Pierre Galletti Award, named after AIMBE's Founding Member and Past President, recognizes a career-long commitment to advancing the field through transformative research, service, and advocacy.

Global HEALTH Briefs



Coalition will monitor infectious diseases at 2026 FIFA World Cup

The 2026 FIFA World Cup, jointly hosted by 16 cities across North America, expects 6.5 million soccer fans traveling from more than 100 countries. The National Center for Health Security and Resilience, a partnership of Georgetown University and MedStar Health, will operate the Health Security Operations Center (HSOC) to monitor infectious disease transmission across the host cities (11 in the United States, three in Mexico, and two in Canada) in the hopes of mitigating global health risks. HSOC plans to integrate wastewater surveillance, electronic health record (EHR) data, environmental monitoring, open-source intelligence, and international health alerts and then provide daily situation reports with actionable intelligence for state and local public health departments, health systems, and partner organizations. HSOC leads a coalition of more than 30 organizations, including Samsung Electronics America, University of Nebraska Medical Center's Global Center for Health Security, Verily Health, and the American Society of Tropical Medicine and Hygiene.

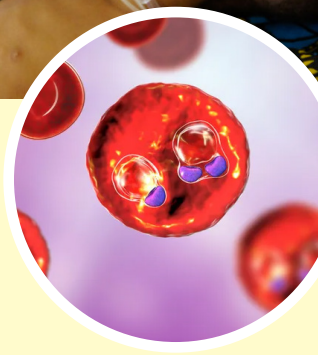
Ebola outbreak confirmed in DRC, Uganda

A total of 635 confirmed cases, 127 confirmed deaths and 119 suspected cases caused by Ebola virus disease have been reported in the Democratic Republic of the Congo (DRC) and 19 confirmed cases and two deaths in Uganda as of June 10, according to the DRC and Uganda Ministries of Health. The Africa Centers for Disease Control and Prevention is monitoring the outbreak and working with partners to coordinate and reinforce cross-border surveillance, preparedness, and response measures. Scientists have determined that this outbreak is caused by Bundibugyo virus, one of four types of ortho-ebolaviruses that cause illness. Ebola virus disease is contagious, spreading through contact with bodily fluids, such as vomit, blood, or semen, and with surfaces and materials, such as clothing contaminated with these fluids. Symptoms of this viral hemorrhagic illness include fever, vomiting, diarrhea, muscle pain, and, at times, internal and external bleeding. Medical personnel, trained by the NIH-Fogarty-funded Emerging and Re-emerging Pathogens Research Training Program, have been deployed to the epicenter of the outbreak. In an article published in *The Lancet*, Fogarty grantee Dr. Jean Nachega highlights the evolving epidemiology of the outbreak, the challenges posed by the absence of licensed Bundibugyo virus-specific vaccines and therapeutics, and the urgent need to strengthen surveillance, diagnostics, clinical care, community engagement, research preparedness, and regional and global coordination. Nachega, who holds faculty positions at University of Pittsburgh and Stellenbosch University, also discusses broader implications for epidemic preparedness and response in Africa and beyond.

Fogarty grantee to lead international Hepatitis B cure team

The National Institute of Allergy and Infectious Diseases awarded a five-year $24 million grant to a multinational Hepatitis B and HIV Cure Consortium led by Johns Hopkins Medicine with research groups in Brazil, India, Senegal, Uganda, and the United States. The consortium seeks a cure for hepatitis B, a lifelong, incurable viral infection that can cause both acute and chronic disease. Hepatitis B can be prevented by a safe and effective vaccine given shortly after birth. Scientists estimate that roughly 300 million people worldwide are already infected with hepatitis B virus, with more than a million new cases added each year. Sunil Solomon, MBBS, PhD, a former Fogarty trainee, will lead the 'Shared Resources Core,' a team within the consortium that is working to create a repository for human specimens (blood, liver tissue, and peripheral blood mononuclear cells) for use by project teams. Solomon is the recipient of several international awards, including a Fogarty Research Fellowship from Brown University and Johns Hopkins University.

Global HEALTH Briefs



Severe childhood malaria linked to continuing mental harm

Cerebral malaria and severe malarial anemia are the most severe and most prevalent manifestations of malaria, respectively. Together they affect more than one million children annually. Studies have linked these conditions to impairments in overall cognition one to two years after illness and diminished academic achievement up to five years later. The researchers asked: Do these negative effects continue as children become teens? They examined cognitive function and academic achievement in Ugandan children ages 4 to 15 years old for the study. The team evaluated overall cognitive ability, attention, reading and math skills of children who'd experienced an episode of severe malaria and compared these scores to those of matched children without a history of severe malaria. Results showed that childhood cerebral malaria and severe malarial anemia are associated with some cognitive impairment and decreased academic achievement in later childhood and adolescence. The *Journal of the American Medical Association* published the study, which was supported by a Fogarty Global Brain Disorders Research program grant. First author Paul Bangirana, PhD, is a former Fogarty Fellow, while senior author Chandy John, MD, is a former Fogarty advisory board member.

The impact of malaria vaccine in Ghana, Kenya, and Malawi

Scientists estimate that the RTS,S/AS01 malaria vaccine (Mosquirix) saved the lives of one in eight children who were eligible to receive the shot in Ghana, Kenya, and Malawi from 2019 to 2023. The international team, which included researchers from the U.S. Centers for Disease Control and Prevention, randomly assigned 158 groups (each with a birth cohort of roughly 4,000 children) to either roll out the vaccine in 2019 (79 areas) or to implement it at a later date (79 areas). The inoculation is administered according to a four-dose schedule. By 46 months, nearly 1.3 million children had received the first dose of Mosquirix, while 1.2 million had received the second dose, 1.1 million a third dose, and 436,527 a fourth. Use of the vaccine led to a 13.2% reduction in death, while severe malaria infections were reduced by 21.6%, according to the study published in *The Lancet*. GlaxoSmithKline and the U.S. Department of Defense's Walter Reed Army Institute of Research jointly developed the vaccine. Ghana, Kenya, and Malawi are the first three African nations to offer the shot.

Article features Fogarty-trained scientist leading Zambian HIV efforts

A recent *New York Times* article highlighted the work of Dr. Lloyd Mulenga, a former Fogarty grantee who leads Zambia's national HIV program. *The Times* notes that, following the closure of the United States Agency for International Development (USAID), the United States has continued to pay for a significant amount of the HIV care in Zambia through bridge funding. Zambia also has retained the support of the Global Fund to Fight AIDS, Tuberculosis and Malaria, yet that organization, which is reliant on U.S. support, plans to implement its own budget cuts. Meanwhile, the State Department is negotiating new health assistance agreements with countries that previously benefitted from USAID funding, and, in Zambia, it has tied support to U.S. access to Zambian minerals. The article outlines the necessary cuts to Zambian health systems made by Mulenga to address the reduced funding. While Mulenga acknowledges new infections and increased deaths, he told *The Times* that he believes the distribution of prevention drugs, including lenacapavir (a shot that provides protection from HIV for six months), may make up for expired programs and initiatives. Mulenga received support from Fogarty through the UNZA-Vanderbilt Training Partnership for HIV-NCD Research program and the AIDS International Training and Research Program. .

FUNDINGNEWS

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TO READ MORE

On behalf of the Fogarty International Center at the U.S. National Institutes of Health (NIH), the following funding opportunities, notices, and announcements may be of interest to those working in the field of global health research.

Funding Announcement	Deadline	Details
Global Infectious Disease Research (GID) Training Program (D43 Clinical Trial Optional)	August 6, 2026	https://www.fic.nih.gov/Programs/Pages/infectious-disease.aspx
Emerging Global Leader Award (K43 Independent Clinical Trial Required) (PAR-24-295)	December 3, 2026	https://grants.nih.gov/grants/guide/pa-files/PAR-24-295.html
Emerging Global Leader Award (K43 Independent Clinical Trial Not Allowed) (PAR-24-296)	December 3, 2026	https://grants.nih.gov/grants/guide/pa-files/PAR-24-296.html

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