



*Eunice Kennedy Shriver* National Institute  
of Child Health and Human Development

## **National Advisory Child Health and Human Development (NACHHD) Council**

### **Meeting Summary**

6710B Rockledge Drive, Rooms 1425 & 1427,

Bethesda, MD

July 8, 2026

U.S. Department of Health and Human Services (HHS)

National Institutes of Health (NIH)

*Eunice Kennedy Shriver* National Institute of Child Health and  
Human Development (NICHD)

The [NACHHD Council](#) convened its 191st meeting at 9:00 a.m. ET on Wednesday, July 8, 2026, at 6710B Rockledge Drive, Rooms 1425 and 1427, in Bethesda, Maryland. It was a hybrid meeting that was open to the public from 9:00 a.m. to 2:00 p.m. ET. The Council then met from 2:15 p.m. to 5:00 p.m. ET in a session that was closed to the public. As provided in Sections 552b(c)(4) and 552b(c)(6), Title 5, U.S.C., and Section 10(d) of Public Law 92-463, sessions for the review, discussion, and evaluation of grant applications and related information are closed to the public. NICHD Acting Director Rohan Hazra, M.D., presided.

### **Council Members Present<sup>1</sup>**

Rohan Hazra, M.D. (Chair)  
Anna Aizer, Ph.D., M.S.  
Susan L. Brooks, J.D., M.A.  
Marcelle Ivonne Cedars, M.D.  
Cynthia Gyamfi-Bannerman, M.D., M.S.,  
FACOG

Ethylin Wang Jabs, M.D.  
Yvonne A. Maldonado, M.D.  
Ignatia Barbara Van den Veyver, M.D.

### **Council Members Absent**

None

### ***Ex Officio* Members**

Timothy Brindle, Ph.D., M.S., PT  
Reem Ghandour, Dr.P.H., M.P.A.

### **National Advisory Board on Medical Rehabilitation Research Council Liaison**

Linda Ehrlich-Jones, Ph.D., RN, FAAN

### **Subject Matter Experts**

Derek McLean, Ph.D.  
Diana Torgersen, D.Phil.

### **U.S. Department of War**

Gayle Vaday, Ph.D.

### **Executive Secretary**

Rebekah Rasooly, Ph.D.

In each section of this meeting summary, the number in parentheses that follows each heading refers to the time stamp on the [NIH VideoCast](#). Please go to that point in the recording to listen to the full presentation.

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<sup>1</sup> Council members absent themselves from the meeting when the Council discusses applications from their own institutions or when a conflict of interest might occur. The procedure applies only to individual applications discussed, not to *en bloc* actions.

## **I. Call to Order and Introductory Remarks (00:00:03)**

Dr. Hazra opened the meeting and welcomed the members of the NACHHD Council and all in-person and online attendees. Dr. Hazra also welcomed Derek McLean, Ph.D., and Diana Torgersen, D.Phil, who served as subject matter experts (SMEs) and *ad hoc* members of the Council. Timothy Brindle, Ph.D., M.S., PT, also introduced himself as the new *ex officio* member from the U.S. Department of Veterans Affairs (VA).

## **Review of Confidentiality and Conflicts of Interest (00:02:17)**

Rebekah Rasooly, Ph.D., the Council's executive secretary, reminded NACHHD Council members that they are required to read, agree to, and sign the confidentiality and nondisclosure rules for special government employees on the Council member website before they evaluate any NIH grant applications. Before the meeting, Council members received and signed the required conflict of interest certification forms. Dr. Rasooly also reminded Council members that they are required to recuse themselves and leave the meeting before any discussion that involves organizations or universities for which they are in conflict, in addition to those listed in the Council action document. Council members are not allowed to serve on any NIH peer review panel while serving on the Council, because NIH policy indicates that individuals may not serve on both the first and second levels of peer review. Furthermore, during closed sessions, Council members must turn off cloud-based voice services (e.g., Alexa) that are capable of capturing confidential information.

## **Council Minutes (00:03:00)**

The 190th NACHHD Council was held on both January 26 and March 20, 2026. Ethylin Wang Jabs, M.D., made a motion to approve these meeting minutes as written. Cynthia Gyamfi-Bannerman, M.D., M.S., FACOG, seconded the motion. Council members voted to approve the minutes.

## **Future Meeting Dates (00:03:37)**

Dr. Rasooly announced that the future Council meetings are scheduled for October 14, 2026 (NIH Bethesda Campus, Building 45); January 25–26, 2027 (virtual); June 7–8, 2027 (NIH Bethesda Campus, Building 31); September 7–8, 2027 (NIH Bethesda Campus, Building 31); January 25–26, 2028 (virtual); June 12–13, 2028 (NIH Bethesda Campus, Building 31); and September 12–13, 2028 (NIH Bethesda Campus, Building 31).

## **II. Acting NICHD Director's Report (00:08:30)**

In his report, Dr. Hazra provided an update on fiscal year (FY) 2027 appropriations, described recent NIH and NICHD policy and program updates, reviewed current application and award trends, and shared staff updates across NICHD and NIH.

## **FY 2027 Appropriations Update (00:08:58)**

In FY 2026, the president proposed a 40% cut to NIH's budget. Congress did not adopt this proposal, and NIH instead received a flat budget.

For FY 2027, which begins October 1, 2026, the president has proposed an approximately 12% cut to NIH. This cut would bring the total NIH budget to \$41.5 billion. The House of Representatives has passed an appropriations bill that would instead provide a slight increase of \$100 million to the overall NIH budget, bringing the total for NIH to \$48.8 billion. The House bill does not include funding for the *All of Us* Research Program, but it would increase funding for the INvestigation of Co-occurring conditions across the Lifespan to Understand Down syndrome (INCLUDE) Project to \$120 million. The House bill calls for a flat budget for NICHD at \$1.77 billion, including flat funding for the Implementing a Maternal health and PRegnancy Outcomes Vision for Everyone (IMPROVE) initiative. The Senate has not yet released their appropriations bill. Once available, the House and Senate bills will need to be conferenced and signed by the president before the FY 2027 budget is finalized.

## **NIH and NICHD Policy Updates (00:10:34)**

### **Status of Peer Review Meetings (00:10:35)**

Because of the lapse in government funding at the beginning of FY 2026, NIH peer review has been delayed by approximately one Council round. To address these delays, the Center for Scientific Review (CSR) created a “competitive, not discussed” category. Under this approach, the top third of applications were discussed, and applications in the middle third were placed in the “competitive, not discussed” category. Summary statements have used a bulleted format for the resumption of discussion. CSR intends to meet its usual summary statement deadlines.

The “competitive, not discussed” category will no longer be used beginning with the January 2027 Council round, for which review meetings will occur in October and November 2026. For that Council round, the discussion rate will return to approximately 50% of applications. CSR plans to continue using the bulleted summary statement format, but Dr. Hazra noted that CSR is working to improve the substance and quality of these reviews. CSR anticipates meeting its usual summary statement deadlines. Dr. Hazra emphasized that this year’s delays were not specific to NIH but were rather caused by the lapse in funding in FY 2026.

### **NIH Requests for Information (00:12:34)**

Dr. Hazra notified attendees of two NIH-wide requests for information (RFIs). The RFI [NOT-OD-26-086](#) seeks input on a proposal to cap the number of simultaneous research project grants held by a principal investigator (PI), with the goal of supporting a greater number of investigators. Comments on that RFI are due August 3, 2026.

The RFI [NOT-OD-26-087](#) seeks input on effective approaches for measuring and rewarding scientific impact beyond common measures such as citation counts and number of manuscripts. Comments on this RFI are due August 19, 2026.

### **NIH Grants and Funding Page (00:13:28)**

Dr. Hazra reminded attendees that NIH funding opportunities are no longer published in the NIH Guide. Investigators must visit [Grants.nih.gov](https://grants.nih.gov) for this information. The NIH Guide will continue to communicate NIH policy and procedural information.

Dr. Hazra also described NIH’s ongoing effort to reduce the number of funding opportunity announcements and replace many of them with Highlighted Topics. Highlighted Topics

allow institutes and centers (ICs) to advertise areas of high scientific priority. Institute priorities are also being consolidated through centralized NIH communications. Dr. Hazra said that over time the research community should expect fewer institute-specific websites and more centrally available information.

### **Strategic and Research Plans (00:14:53)**

The [NIH Strategic Plan for Disability Health Research](#) was released in March 2026. Dr. Hazra acknowledged the role of NICHD's National Center for Medical Rehabilitation Research (NCMRR) staff and Director Theresa Cruz, Ph.D., in developing the plan. NIH is also developing its 2027-2031 Strategic Plan, expected to be released early in FY 2027. The NIH Research Plan on Rehabilitation, which NCMRR has also played a leading role in developing, is also forthcoming.

### **Surgeon General's Warning on the Harms of Screen Use (00:15:40)**

Dr. Hazra highlighted the [Surgeon General's Warning on the Harms of Screen Use](#) among children and adolescents. He acknowledged NICHD staff, especially in the Child Development and Behavior Branch (CDBB), who provided technical assistance for the report. The report describes known negative effects of excessive screen use on cognitive and emotional development, physical and metabolic health, mental health, and educational outcomes. It also includes a toolkit organized around setting expectations for healthy screen use, modeling healthy screen behavior, delaying screen time from the earliest age, providing alternatives to screen use, and scheduling screen-free time in everyone's day. Dr. Hazra noted that the evidence base for some of these recommendations is limited, but both NICHD and NIH's broader research agenda on technology and digital media will be instrumental in further elucidating the effect of screens on health and development.

### **MAHA Implementation Strategy and Governance at NIH (00:16:43)**

Dr. Hazra described an NIH-wide effort to coordinate research activities related to the Make America Healthy Again (MAHA) Initiative. Rick Woychik, Ph.D., former Director of the National Institute of Environmental Health Sciences (NIEHS), is serving as a special advisor to NIH and is leading the coordination effort. Preliminary discussions are focused on assessing how the NIH research portfolio already addresses most, if not all, MAHA goals and priorities. Additional initiatives are expected to emerge from this effort.

### **FY 2025 Versus FY 2026 Award Rate Comparison (00:17:48)**

NICHD is ahead of its FY 2025 award pace. For FY 2026, NICHD has currently issued 285 more awards than it had at the same time in FY 2025, reflecting a 26.7% increase. Awards for most major mechanisms are ahead of the FY 2025 pace. Dr. Hazra acknowledged the grants management and program staff for their work under challenging circumstances, including understaffing and adjusting to new requirements.

Application numbers have remained relatively steady, with 6,938 applications received in FY 2026 compared with 6,892 in FY 2025. The most common application mechanisms remain the R01 and F31.

## Current Funding Opportunities and Highlighted Topics (00:19:14)

Although NIH is substantially reducing the number of funding opportunities it publishes, NICHD has released four funding opportunities in recent months. These include a reorientation of the learning disabilities hub group to examine artificial intelligence (AI) and learning disabilities ([RFA-HD-27-006](#)), a limited competition for the Intellectual and Developmental Disabilities Research Centers (IDDRCs; [RFA-HD-27-012](#)), an opportunity to use archived data and specimen collections for human immunodeficiency virus (HIV) research ([RFA-HD-27-007](#)), and a biological testing facility opportunity ([PAR-27-111](#)). NICHD is also participating in several [Highlighted Topics](#), both as a primary and secondary institute.

## Staff Updates (00:20:40)

Dr. Hazra began these updates with an *in memoriam* to Caroline C. Signore, M.D., M.P.H., who passed away in April 2026. Dr. Signore was the inaugural and only deputy director of the Division of Extramural Research (DER). Dr. Hazra described Dr. Signore as a remarkable colleague. Her death is a tremendous loss to NICHD and the research community. He shared words from the May celebration of Dr. Signore's life: "Be kinder than necessary. Show up for people. Do meaningful work but laugh when you can. Do not assume there will always be more time. And above all, do not let suffering close your heart." Dr. Hazra then observed a moment of silence in Dr. Signore's honor.

Dr. Hazra has served as Acting NICHD Director since Alison Cernich, Ph.D., left the institute at the end of February 2026. David Clark, Dr.P.H., M.P.H., has stepped into the role of acting director of DER, and Dr. Cruz is serving as acting deputy director of DER. Dr. Hazra announced that NICHD will soon recruit a new deputy director of DER through a Title 42 position. Council members will be asked to help circulate the announcement once it is available.

Dr. Hazra also provided updates on NIH leadership. Jonathan Green, M.D., M.B.A., has been named chief executive officer (CEO) of the NIH Clinical Center (CC). Dr. Green joined NIH in 2018 as director of the NIH Office of Human Subjects Research Protections (OHSRP) and previously served as associate dean for human studies at Washington University in St. Louis. NICHD is working closely with Dr. Green and Clinical Director Catherine Gordon, M.D., M.S., to expand pediatric research at the Clinical Center. A major priority in this space will be allowing patients 6 months of age to be admitted to the CC.

Steven Schiff, M.D., Ph.D., has been named Director of the Fogarty International Center and NIH associate director for international research. Dr. Schiff is a pediatric neurosurgeon with nearly 40 years of experience in global health, epidemiology of microbial diseases, and pediatric neurological disorders. He is also a former grantee of NICHD's Maternal and Pediatric Infectious Disease Branch (MPIDB). Dr. Hazra said that Dr. Schiff's appointment signals that global health research remains an NIH priority. Notably, Dr. Schiff's first day began with NIH Director Jay Bhattacharya, M.D., Ph.D., asking him to lead NIH's response to the Ebola outbreak. Dr. Schiff's contacts in the Democratic Republic of the Congo and Uganda have been invaluable in this effort.

Raymond Jacobson, Ph.D., has been named Director of CSR. Dr. Jacobson has been at CSR since 2009 and previously served as acting deputy director of the NIH Office of Extramural

Research in 2025 and acting CSR director in 2026.

Matthew Gillman, M.D., S.M., retired as director of the Environmental influences on Child Health Outcomes (ECHO) Program on May 31, 2026. Joshua Denny, M.D., M.S., CEO of the *All of Us* Research Program, is now acting director of ECHO. Dr. Hazra said Dr. Denny has already reached out to discuss expanding collaborations with both ECHO and *All of Us*.

At the time of this meeting, there are 13 acting directors among NIH's ICs. Dr. Hazra noted that John Powers III, M.D., has recently been named Deputy Director and Acting Director of the National Institute of Allergy and Infectious Diseases (NIAID).

With the centralization of NIH's webpages, NICHD staff have brainstormed how to continue sharing institute-focused news with the extramural community. Dr. Hazra closed his report describing NICHD ConnEXion, a monthly extramural-based report. ConnEXion will provide a monthly roundup of funding opportunities, grant policy updates, upcoming events, and other news. Dr. Hazra encouraged attendees to [join the report's listserv](#) and share this resource. He also welcomed feedback and suggestions for ways NICHD can continue to improve its communications.

## **Discussion (00:29:16)**

Dr. Jabs asked whether the Gabriella Miller Kids First Pediatric Research Program will continue to receive funding. Dr. Hazra said that he understood that the House bill keeps Kids First funding flat at \$12.6 million, but NICHD is waiting to see what the Senate proposes.

Dr. Jabs also asked whether the number of R01 applications has increased because there are fewer funding opportunities for program projects and other collaborative projects. Dr. Hazra and Dr. Rasooly said that the R01 remains the most popular mechanism, but that does not reflect a substantial increase in these applications. NIH is moving toward parent announcements for more complex mechanisms, as opposed to releasing separate RFAs. Dr. Hazra added that although NIH leadership is emphasizing more investigator-initiated science, NICHD remains able to support many of the programs it has historically supported.

Ignatia Van den Veyver, M.D., asked for clarification on Highlighted Topics and Notices of Intent released on Grants.gov before a funding opportunity is issued. Dr. Hazra said that Notices of Intent, also referred to as Forecasts, have long been used across the federal government but were not commonly used by NIH. NIH now issues a Forecast before publishing certain funding announcements. Dr. Hazra said that a Notice of Intent does not guarantee that a funding opportunity will ultimately be published, because publication can be affected by available funds or additional review. However, such notices undergo significant scrutiny before they are released even as a Forecast. Highlighted Topics do not require a forecast.

Dr. Maldonado asked for NICHD's targets for new investigator T32 and K awards. Dr. Hazra said that NICHD remains committed to supporting early-stage investigators by allocating additional funds to branches for early-stage investigator applications. Dr. Hazra said he did not have exact target numbers, but NICHD has not had difficulty meeting these goals. Dr. Bhattacharya is also eager to support early-stage investigators across all of NIH. Dr. Hazra said that NICHD has committed approximately 6% of its extramural research

budget to training programs. How those funds should be distributed across F, K, and T mechanisms would be discussed later in the meeting.

Dr. Hazra also highlighted the Loan Repayment Program (LRP) as an area of increased support that is not counted as a training program. LRP is managed by a team that includes Tracy King, M.D., M.P.H.; Parisa Parsafar, Ph.D.; and Doris Chen, M.P.H. NICHD is on track for an approximately 30% increase in loan repayment awards this year. Dr. Hazra acknowledged the increased staff work required to manage the program, especially given the need to align awards with new priorities and constraints on contract funding.

Dr. Gyamfi-Bannerman asked about future changes to peer review after the “competitive, not discussed” category goes away. Dr. Hazra said that NIH leadership is emphasizing that scores should be one of many factors considered in funding decisions. NICHD has not used paylines for several years and instead uses a pay-zone and discretionary-zone approach. However, Dr. Hazra acknowledged that most funded applications still fall broadly in score order. NICHD is being encouraged to deemphasize scores as much as possible, which will require additional work from program staff, branches, and NICHD leadership.

During the break, Council members had the opportunity to attend a poster session for 30 NICHD-supported extramural junior investigators taking part in the NICHD Junior Investigator Workshop. Dr. Hazra thanked Dr. Gyamfi-Bannerman for arriving early to provide mentorship and guidance to workshop participants.

### **III. NIH Strategic Plan for Disability Health Research (00:40:32)**

Adam Politis, M.S., senior advisor for disability health research, provided an overview of the NIH Strategic Plan for Disability Health Research.

More than 1 in 4 people in the United States have a disability. Disabilities may be present at birth, be acquired at any point across the lifespan, or be a natural part of the human experience. Disabilities may be physical, sensory, cognitive, intellectual, developmental, psychological, or related to chronic illness. Disabilities may be visible or invisible, and they may be temporary or persist for a lifetime. People may also have more than one disability, and the nature of their disability or disabilities may change. Finally, individuals in some communities may not consider themselves disabled, but they still experience the stigma and perception of disability. In sum, disability is a complex, multidimensional construct that may be conceptualized and defined in various ways.

Historically, the predominant model of disability has been the medical model. This model views disability as an impairment or impairments that must be fixed or cured in order to make an individual “normal.” In contrast, the social model views disability as the result of environmental, social, and attitudinal barriers that may prevent people from fully participating in society. Disability is increasingly understood through interactional models, which suggest that disability results from a dynamic interplay between individual medical conditions and biological, behavioral, sociocultural, and environmental factors.

Americans with disabilities, like everyone living in the United States, may experience a range of medical conditions that affect their health and well-being. They may also

experience nonmedical issues in accessing health care and resources. Disability health research seeks to understand and address the effects of medical conditions, nonmedical factors, and their interaction with the health and well-being of those with disabilities. Disability health research is centered on the person rather than the disability and emphasizes that disabled people have health needs and goals that are both related and unrelated to disability.

NIH supports a broad range of disability health research, ranging from basic science to clinical and translational research. In FY 2024, NIH funded \$619 million in disability health research to investigate topics that included biological mechanisms, medical rehabilitation interventions to improve function and quality of life, and disparities in health and health care outcomes experienced by people with disabilities. These efforts have typically been focused on specific conditions or impairments, rather than on addressing people with disabilities as a population with unique health care needs. A notable exception to this trend is NCMRR. As the understanding of disability has evolved, there has also been growing recognition that NIH needs a more harmonized, coordinated, and person-centered approach to disability health research.

This recognition has led to two developments. First, in August 2021, NIH established the Advisory Committee to the Director Working Group on Diversity Subgroup on Individuals with Disabilities. The subgroup issued a report in 2022, emphasizing the need for an agency-wide approach to disability. Second, in September 2023, the Director of the National Institute on Minority Health and Health Disparities (NIMHD), in consultation with the Director of the Agency for Healthcare Research and Quality (AHRQ), formally designated people with disabilities as a population with health disparities. These developments, along with increasing scientific evidence and advocacy for disability health research, led the NIH Director to charge the Division of Program Coordination, Planning, and Strategic Initiatives (DPCPSI) with forming the Disability Health Research Program (DHRP) in spring 2024. In September 2024, DHRP launched a strategic plan to advance innovative and responsible research to improve the health and well-being of people with disabilities.

DHRP has led the development process of the NIH Strategic Plan for Disability Health Research FY 2026–2030 with the Disability Health Research Coordinating Committee (DHRCC), which has more than 16 members from across 24 ICs and 18 offices and programs. Throughout the process of developing the plan, DHRP and DHRCC prioritized input from individuals and organizations with experience in disability. The two groups also used information and data from scientific literature, relevant reports, and feedback from SMEs. DHRP and DHRCC also conducted an analysis of the existing disability research portfolio, held engagement events, gathered responses to an RFI, and collaborated with the NIH Council of Councils' (CoC's) Disability Health Research Working Group. Data were synthesized and used to develop the final plan, released in March of this year.

The strategic plan's framework features a comprehensive approach organized around four strategic goals, each supported by three to four objectives. The plan also has four crosscutting themes. These goals, objectives, and themes will guide research and are meant to guide cross-agency research and supplement individual ICs' strategic plans. The plan's crosscutting themes specifically include Whole Person Health, Inclusion of People with Disabilities in Research, Interdisciplinary Collaboration, and Technology. Mr. Politis emphasized that disabled people should be included not only as research participants but

also as partners in planning, designing, conducting, and communicating research. He also noted that emerging technologies, including AI and machine learning (ML), can improve diagnosis, personalized care, and independent living, but they raise ethical issues related to accessibility, privacy, security, bias, affordability, and misuse.

Mr. Politis then reviewed the four goals of the strategic plan. Broadly, the four goals of the plan are centered around the following: (1) research, (2) the workforce, (3) resources and infrastructure, and (4) stewardship. Goal 1 aims to advance the science of disability health by supporting innovative, rigorous, person-centered research that can generate evidence to inform policies, practices, and interventions that improve health outcomes for people with disabilities.

Goal 2 is to foster a highly skilled, multidisciplinary, sustainable disability health research workforce. Activities around this goal will be focused on expanding research capacity by developing accessible entry points into the biomedical, behavioral, and scientific ecosystem for trainees and early-career researchers, followed by consistent funding opportunities to sustain those careers. Goal 2 is also aimed at providing educational opportunities for the broader scientific workforce so that disabled people have meaningful inclusion and can benefit from all disability research.

Under Goal 3, the strategic plan is supporting the development of accessible, state-of-the-art disability health research resources and infrastructure that enable the full involvement of disabled people as both researchers and participants. Strategic investments in these resources will foster a more robust and representative disability health research ecosystem. Goal 3 also supports ethical and standardized data collection and sharing of disability data to produce policies and practices to improve the health of people with disabilities.

Lastly, Goal 4 promotes collaborative, responsible, and ethical management of disability health research activities. This goal includes actively engaging disabled people throughout the research process to ensure that research reflects communities' priorities, evaluating NIH structures and processes, and maintaining high standards of scientific integrity to build trust and advance high-quality research.

In sum, the Strategic Plan for Disability Health Research provides a comprehensive framework that advances innovative and responsible research that promotes the health and well-being of people with disabilities. By adopting a harmonized, coordinated, person-centered approach, NIH can use the strengths of its ICs to drive progress on disability health research priorities. NIH is also committed to building and sustaining strong partnerships with disabled people and their communities. DHRP and DHRCC are partnering to develop an implementation and evaluation plan for the next 5-year period. They will also engage with the CoC and the CoC's working group for input and recommendations on priorities, collaborations, strategies, and approaches to optimize outreach to disability communities.

DHRP and DHRCC will prioritize next steps and activities that promote awareness of the strategic plan, especially through meaningful engagement with disability communities. Additional next steps will include providing training and resources to both internal and external stakeholders, fostering innovative and impactful disability health research projects through Highlighted Topics and challenges, and partnering with NIH ICs to coordinate across mission areas. New activities will be shared on the DHRP website.

Mr. Politis closed the presentation by thanking the contributors to the strategic plan.

## **Discussion (00:58:00)**

Marcelle Cedars, M.D., asked how NIH will implement the plan across ICs and whether implementation will include program projects or other cross-institute mechanisms. Mr. Politis said implementation will include short-, medium-, and long-term strategies. Early efforts will focus on sharing concepts across NIH and the extramural community so that institutes, centers, and offices (ICOs) can incorporate them into strategic plans, Notices of Funding Opportunities (NOFOs), and Highlighted Topics. Evaluation will include funding trends but will also consider whether the plan produces cultural change in how NIH defines and supports disability health research across its portfolio.

Dr. Cedars asked whether funding has been set aside for this effort. Mr. Politis said DHRP has a modest coordinating budget and is working with ICs that have budgets for this effort within their mission areas. Discussions of a more robust budget are still preliminary, making it especially important for DHRP to demonstrate its value during this time.

Dr. Maldonado described work at Stanford University with a disability-focused affinity group. The group released survey results showing a mismatch between people who report a condition or limitation that qualifies as a disability and people who formally identify as disabled. She encouraged NIH to consider how disability is measured and how aware investigators are of disabilities within the populations they aim to study. Mr. Politis agreed that such measurement is complex; functional limitations, diagnostic codes, and self-identification capture specific populations but do not provide a holistic view of disability. One strategic plan objective focuses on disability data and measurement with the goal of producing better participant-level data. Such insights should aid investigators in considering accessibility and inclusion in research.

Anna Aizer, Ph.D., M.S., asked how the plan defines “well-being.” Mr. Politis said the term is intended broadly and includes community integration, positive social experiences, and social and economic dimensions of health.

Dr. Aizer also encouraged NIH to include children with disabilities and consider large federal programs that serve them, such as the Individuals with Disabilities Education Act (IDEA) program. Mr. Politis agreed with this sentiment and said that both children with disabilities and disability across the lifespan are important focuses of the strategic plan.

## **IV. Voice of the Trainee (01:08:42)**

### **Nathan Campbell, Ph.D. (01:08:58)**

Dr. Campbell is an instructor in the Department of Pharmacology and Toxicology at the University of Mississippi Medical Center (UMMC), where he studies the role of the immune system in preeclampsia and the risk of cardiovascular disease among offspring. His postdoctoral studies are supported by an NICHD F32 fellowship.

Dr. Campbell began his research training as a sophomore at Murrah High School in Jackson, Mississippi, through Base Pair, a program that pairs students with mentors at UMMC. Through Base Pair, Dr. Campbell spent part of each school day in a laboratory and worked full time in the lab during the summer. After high school, Dr. Campbell earned a bachelor’s degree in

biomedical engineering from The George Washington University and continued fueling his passion for research by returning to UMMC each summer. He then completed his doctoral research in experimental therapeutics and pharmacology at UMMC, studying inflammation in preeclampsia and offspring cardiovascular outcomes. This training was supported by an NICHD F31 award.

Dr. Campbell remains committed to studying preeclampsia because of the disease's effects on virtually all of the body's systems. He also described the importance of conducting this work in Mississippi, a state with poor pregnancy outcomes that include a 15.0% preterm birth rate. Mississippi is also a maternal care desert. With UMMC as the only tertiary care center in the state, the institution is a central site for care and research related to preeclampsia.

Preeclampsia currently has no cure other than delivery of the fetal-placental unit. Dr. Campbell's research program aims to develop therapeutics that improve maternal health without compromising fetal health. His work focuses on chronic inflammation in preeclampsia and the agonistic autoantibody to the angiotensin II type 1 receptor (AT1-AA). His lab has found that memory cells generated during preeclamptic pregnancies can contribute to long-term production of this autoantibody in postpartum women up to 8 years after their pregnancy. Recent studies also suggest the autoantibody's presence in offspring, which may contribute to developmental programming of cardiovascular disease in adulthood. Dr. Campbell's F32-funded work tests a novel therapeutic peptide designed to inhibit AT1-AA activity and examines whether such inhibition can benefit postpartum mothers and their children.

Dr. Campbell said NICHD funding validated his science and mentorship, gave him freedom to pursue new experimental approaches, supported travel to conferences and workshops, and helped him build a strong scientific network. NICHD support also helped him develop a bioassay to measure AT1-AA. His lab is currently the only lab in the country using this technique to measure this autoantibody. In the future, Dr. Campbell hopes this assay can help identify medications that will be most effective for treating hypertension after a preeclamptic pregnancy.

Dr. Campbell is now working to publish data from his current grants and generate preliminary data for a K99/R00 application. His long-term goal is to lead a lab that investigates the long-term immune-mediated consequences of preeclampsia among children in order to identify therapeutics that reduce adult risk of cardiovascular disease.

### **Discussion (01:18:04)**

Dr. Hazra thanked Dr. Campbell and said that the junior investigators' presentations and poster session has been inspiring for NICHD staff and Council members.

Dr. Cedars noted that she has access to a longitudinal cohort with maternal health data and adult offspring data. She offered Dr. Campbell an opportunity to test his assay in this cohort.

Dr. Gyamfi-Bannerman praised Dr. Campbell for intentionally remaining in Jackson, Mississippi, to do work that addresses a high-prevalence disease in his home state.

Dr. Van den Veyver asked what advice Dr. Campbell would give to those developing early engagement and mentorship programs. Dr. Campbell encouraged NIH to support avenues that give high school and college students opportunities to participate in medical research and to

meet researchers who love their work.

### **Sarah Coggins, M.D., M.S.C.E. (01:21:13)**

Dr. Coggins is an assistant professor of pediatrics and neonatology at Children's Hospital of Philadelphia and the University of Pennsylvania. Her research focuses on antimicrobial pharmacology and antibiotic exposure among newborns, and her work is supported by an NICHD K23 Career Development Award.

Dr. Coggins grew up in central Arkansas and completed her undergraduate education at Vanderbilt University, where she began her career in research through an undergraduate thesis on comparative innate immunity in mosquitoes. During medical school at Vanderbilt University, she became interested in fetal and neonatal physiology and found her clinical home in the neonatal intensive care unit (NICU). She later completed a pediatrics residency and neonatology fellowship at Children's Hospital of Philadelphia. Her fellowship research focused on neonatal infection epidemiology, risk assessment, and sepsis recognition and diagnosis. Although this fellowship was disrupted by the coronavirus disease 2019 (COVID-19) pandemic, the experience further drove Dr. Coggins' interest in clinical research. She then earned her master's degree in clinical epidemiology from the University of Pennsylvania with support from a T32 award from the National Heart, Lung, and Blood Institute (NHLBI).

While applying for her K23 award, Dr. Coggins recognized her expertise in neonatal infection epidemiology and clinical management but realized that many antibiotic prescribing practices in newborns are not supported by sufficient pharmacokinetic (PK) data. Newborns have distinct physiology that limits direct extrapolation from adult and small children's populations. Limited PK data then hamper the ability to optimize the effectiveness and safety of antimicrobials in very small newborns with developing organ systems and to implement proper antimicrobial stewardship. Her K23 award is therefore meant to address this gap by helping her become an independent clinical scientist focused on neonatal antimicrobial pharmacology.

Dr. Coggins provided background on antimicrobial exposure and gaps in the current knowledge base. Approximately 50% of U.S. newborns are exposed to at least one antibiotic before birth, during the intrapartum period. Common causes of exposure include prophylaxis for Group B streptococcus (GBS), treatment of suspected maternal intra-amniotic infection or chorioamnionitis, and perioperative prophylaxis before cesarean section. A commonly used antibiotic is penicillin, which has well-defined perinatal PK data, crosses the placenta effectively, and is the first-line prophylactic agent for GBS. However, some pregnant people cannot receive penicillin and are instead treated with vancomycin or clindamycin. Compared with the data on penicillin, much less is known about how these drugs cross the placenta and how much protection they provide against early-onset GBS disease.

Antibiotics are also the most prescribed medications for newborns and in the NICU. Each year approximately 200,000 U.S. newborns receive empiric antibiotics because of suspected early-onset neonatal sepsis. Ampicillin and gentamicin are most commonly used for these purposes, and many infants have also been exposed to these antibiotics during the intrapartum period. However, these exposures are not integrated into postnatal and neonatal dosing guidance. Dr. Coggins shared pilot data showing the potential significance of such exposures: In a pilot study of 26 mother-infant dyads, 85% of infants had circulating gentamicin concentrations in core blood above the clinical trough level used as a safe redosing threshold.

With her K23 award, Dr. Coggins is now enrolling 200 mother-infant dyads in a prospective PK study. The first aim is to create a population PK model integrating intrapartum and postnatal ampicillin and gentamicin exposures to inform the necessity, timing, and dosing of postnatal and neonatal antibiotics. The second aim is to quantify transplacental transfer of vancomycin and clindamycin to determine their adequacy as GBS prophylaxis. Data from this study could inform postnatal antibiotic dosing and improve antimicrobial stewardship.

Dr. Coggins said NICHD K23 support was essential to her promotion to assistant professor and has provided protected time for study management, manuscripts, conferences, and other research activities. She has also benefited from NICHD-supported resources, including the Maternal and Pediatric Precision in Therapeutics (MPRINT) Hub, the Principles of Pediatric Clinical Pharmacology and Therapeutics Lecture Series, and mentorship through the Pediatric Trials Network (PTN). Her long-term goal is to obtain R-level funding for prospective PK studies and randomized clinical trials that evaluate PK-guided, data-driven neonatal antimicrobial dosing regimens.

### **Discussion (01:33:23)**

Dr. Maldonado asked whether Dr. Coggins plans to examine longer-term effects of early antibiotic exposure on the gut microbiome. Dr. Coggins said one collaborator in her research group is focused on the microbiome and is collecting serum and stool samples. The literature suggests that early broad-spectrum antimicrobial exposure can disrupt microbiota and is associated with later outcomes like obesity and allergic or atopic disorders.

Dr. Maldonado also asked whether Dr. Coggins might examine other drugs, such as selective serotonin reuptake inhibitors (SSRIs). Dr. Coggins said she is not personally studying SSRIs, but the integrated PK platform could inform future studies of many medications used during pregnancy.

Dr. Gyamfi-Bannerman offered to connect Dr. Coggins to a pharmacology specialist in Philadelphia. Dr. Gyamfi-Bannerman also asked whether Dr. Coggins is studying maternal dosing. Dr. Coggins said her current study is not designed to interrogate maternal PK data in depth, but there is room to reevaluate maternal dosing based on how drugs cross the placenta. There has already been significant innovation in maternal dosing within the last 5 years with the move from flat- to weight-based dosing for gentamicin.

## **V. Presentations: Special Council Review & K12 Program (01:37:48)**

### **An Evaluation of NICHD's K12 Programs (01:38:06)**

Christopher Belter, M.L.I.S., a senior program analyst in DER, presented an evaluation of NICHD's K12 programs. NICHD examined these programs as follow-up to a 2015 Council working group that reviewed the training portfolio and found that individual K programs were more successful than K12 programs at producing researchers who obtained subsequent NIH funding. NICHD also wanted to revisit considerations from the 2023 Extramural Training Working Group on its training portfolio and address broader concerns about the future of the biomedical research workforce.

The K12 mechanism is an institutional career development program for clinicians interested in research careers. NICHD has a long history of supporting K12 programs, with some programs in existence for more than 40 years. NICHD K12 programs primarily fall into three research areas: pediatrics, reproductive medicine, and rehabilitation. NICHD supports approximately 200 to 250 individual K awards (\$30 million to \$35 million) and approximately 30 K12 awards each year (\$14 million to \$15 million).

To evaluate these K programs, NICHD first surveyed and interviewed program officers and reviewed related Requests for Applications (RFAs). Four goals emerged across K12 programs: (1) maintaining a pipeline of skilled investigators, (2) drawing clinicians into research careers, (3) building communities among trainees and established investigators, and (4) signaling NICHD's commitment to specific research fields. NICHD then compared K12 trainees with matched individual K awardees across these goals.

For the first goal, NICHD analyzed approximately 1,800 K trainees from 2012 to 2024, excluding K24 awardees. Trainees were assigned to scientific disciplines based on award text, grouped by the type of K training received, and assessed for subsequent NIH research project grant (RPG) awards and active publication rates. In pediatrics, individual K awardees outperformed K12 trainees on both subsequent RPG funding and active publication rates. In reproductive health and rehabilitation, however, K12 and individual K awardees showed little difference across both metrics.

NICHD also explored the possibility that K12 programs could serve as a bridge to individual K awards and later RPG funding. In reproductive health and rehabilitation, outcomes were similar regardless of whether trainees received only K12 training, only individual K support, or both. In pediatrics, trainees who received only K12 support and did not move on to an individual K award were the least successful group. Those who received both K12 and individual K support were more successful, but the most successful group consisted of those who went directly to an individual K award without K12 participation.

Mr. Belter then reviewed findings for Goals 2 through 4. There was no clear benefit of K12 programs in drawing clinicians into research careers beyond providing them a guaranteed training slot. K12 programs had a clear advantage over individual K programs regarding community building. Individual K awardees have reported feeling disconnected from the NICHD ecosystem, although NICHD is working to address that issue through activities such as the Junior Investigator Workshop. Lastly, K12 programs signal NICHD's commitment to a field largely because of guaranteed funding for career development in that area.

Mr. Belter also discussed concerns raised by the 2023 working group. K12 awards are concentrated at high-resource institutions that receive \$20 million or more in annual NIH funding, meaning that K12 opportunities are available to a narrower pool of potential trainees than individual K awards. K12 programs also have relatively little award turnover, raising questions about whether long-standing programs continue to innovate and provide up-to-date training.

Compared with individual K awards, K12 programs are stronger at community building but have equivalent or lower trainee success rates, are available to fewer potential trainees, have less award turnover, and provide less direct funding to trainees because of overhead and program infrastructure costs. Mr. Belter said that possible next steps could include maintaining the current K12 structure with revisions to pediatric K12 programs, increasing

diversity and turnover among funded institutions, and shifting some K12 funding to individual K awards while maintaining field-specific funding pools to prevent pipeline disruptions. NICHD can also consider other approaches based on Council feedback. In addition, Mr. Belter is preparing an academic publication based on these analyses to gather additional feedback.

### **Discussion (02:04:36)**

Dr. Maldonado noted that many Council members mentor trainees and are concerned about the pipeline for these research areas. She asked whether NICHD could break down outcomes further for the Pediatric Scientist Development Program (PSDP). Dr. Maldonado also asked whether the evaluation could consider other career outcomes such as careers in industry or government. Mr. Belter agreed that small numbers could have affected the reported percentages. NICHD is also exploring broader metrics to capture other career outcomes. Mr. Belter recognized that the current metrics may need to be revisited for these alternative outcomes, because industry and government professionals may not be publishing despite having very successful careers.

Dr. Van den Veyver asked whether self-selection may predispose individual K awardees to better outcomes. Mr. Belter said that possibility has been discussed internally, but the differences in pediatrics appear across years and programs. He also pointed out that if individual K applicants were in fact predisposed to better outcomes, NICHD would still need to consider how funds are distributed across these K mechanisms.

Dr. Cedars noted that when NCMRR ended its K12 program after the 2015 working group, the total number of trainees in rehabilitation declined. She asked that NICHD consider this trend when making decisions on other K12 programs. Mr. Belter said that applications to individual NCMRR K programs increased modestly after the K12 program ended, but the number of awards did not. If NICHD were to shift toward individual K awards, it may need to establish separate funding pools or guarantee funding zones for different research areas to avoid crowding out fields with smaller applicant pools.

Dr. Gyamfi-Bannerman, a PI on a K12 award, emphasized that long-standing K12 programs provide infrastructure and attract trainees who want to work within that structure. She said that turnover in leadership can keep programs fresh and that institutional K programs differ from individual K awards because they provide an established training environment rather than requiring each trainee to quickly assemble a team. Mr. Belter thanked Council members for the feedback and said that NICHD wants to consider all these issues before making changes.

Dr. Hazra emphasized that NICHD is seeking input and has not made any decisions at this time. He proposed forming a Council working group to review the analysis, consider additional questions, and bring recommendations back to the full Council. The working group could be further augmented with additional experts. Dr. Gyamfi-Bannerman made a motion to approve the and Dr. Cedars seconded the motion. Members voted to approve formation of the group.

Dr. Maldonado noted that the transition from a K award to an R01 is less than 25%. The working group should therefore consider measures of success beyond K-to-R transition.

## **Year 1 of the NICHD Special Council Review Policy: A Preliminary Evaluation (02:19:50)**

Mr. Belter presented a preliminary evaluation of the first year of NICHD's Special Council Review (SCR) policy. SCR is an NIH policy that requires additional review for applications from investigators who already have significant NIH support. NIH established the policy to help manage resources and determine whether additional funds should be spread more equitably. Mr. Belter noted that the policy's goals are not explicitly stated, which made evaluation challenging.

NICHD first examined whether there is indeed a concentration of funding within the institute. Mr. Belter showed data indicating that the top 10% of investigators receive approximately 40% to 50% of the institute's grant dollars. Some of this concentration is likely built into the structure of grant mechanisms. Even within R01 awards, however, the top 10% of funded investigators receive approximately 20% of R01 funds. These data reflect a concentration of funds that has remained stable over time.

Mr. Belter noted several other factors that complicate how funding is allocated across awardees. Each year, NICHD has approximately 50 to 70 applications that score in the 15th percentile or better but do not receive awards because of funding limitations. NICHD also funds only about 20% of the investigators who apply in a given year, although the rate is higher for early-stage investigators because of the Next Generation Researchers Initiative. Finally, the median time from terminal degree to first RPG has risen by approximately 13 years, putting additional strain on investigators trying to establish their careers.

The SCR policy is meant to address these issues by (1) identifying who counts as a well-funded investigator and (2) deciding what to do with applications from well-funded investigators. Mr. Belter noted that with NICHD specifically, the institute's policy allows applications below the 7th percentile to be funded on merit without Council discussion. Applications at or above the 7th percentile may be brought to the Council if they represent a rare or unprecedented effort to address one or more NICHD priorities.

Mr. Belter evaluated whether previous NIH-wide and institute-specific SCR policies had in fact reduced PI funding concentrations. The analysis examined more than 192,000 R01 awards over 20 years across six ICs, including NICHD and institutes with similar funding levels. Award amounts were adjusted for inflation, and awards with multiple PIs were fractionally allocated. Mr. Belter examined funding concentrations using three measurements: funding received by the top 10% of PIs, the Gini coefficient, and the Theil index. Across these measures, SCR policies did not appear to reduce PI funding concentration. Mr. Belter noted that the policies affect a small percentage of investigators in any given year; applying a \$2 million threshold captures only approximately 6% to 8% of investigators.

Mr. Belter then showed data on NICHD's FY 2025 Special Council Review across approximately 3,200 RPG applications. Approximately 95% of applications were not subject to the policy. Of the applications subject to the policy, only five, representing approximately 1% of 425 competing RPGs, were not funded because of the policy. Thus, although NICHD funded 85% of the applications it could have funded under the policy, the policy itself did not meaningfully reduce funding concentration.

Mr. Belter concluded his presentation by asking Council members to consider whether NICHD is trying to address funding concentrations or provide more funding to targeted applications. If

the goal is to fund targeted applications, NICHD should consider whether SCR is the best mechanism for achieving this goal.

### **Discussion (02:41:07)**

Dr. Cedars said that one challenge with “competitive, not discussed” applications is that the Council reviews them in isolation rather than in comparison with other applications. Such missing context may make many applications seem fundable, even if NICHD cannot fund all similarly strong applications. Mr. Belter agreed that NICHD needs to find ways to give Council members the full context of applications under consideration.

Dr. Maldonado said that funding concentration and workforce development are multifactorial problems. She noted that the age at which investigators receive R01 awards, the time it takes to complete doctoral and postdoctoral training, and the role of institutions all affect the pipeline. She cautioned that redistributing funds away from successful senior investigators may not be sufficient in addressing this problem. Senior investigators may also wish to help early-stage investigators but have a hard time doing so without institutional direction. She suggested that NIH consider other ways to build flexibility into the funding pipeline to support younger investigators. Dr. Hazra encouraged Council members to respond to the [NOT-OD-26-086](#), the RFI on capping the number of grants held by investigators.

Dr. Aizer asked whether the scoring system may offer an advantage to investigators with a long track record of funding and whether NIH should incorporate that concern into scoring. Such an advantage may be inherent in the process, given that investigators with consistent funding will likely be able to draft stronger funding proposals. Dr. Hazra said that this question connects to the broader discussion of deemphasizing score.

Dr. Gyamfi-Bannerman noted that senior investigators also lost funding in FY 2025, suggesting that funding consistency has changed and may have affected these analyses. Still, she said she believed that NICHD was moving in the right direction by looking for ways to give more credit to innovation and potential. Mr. Belter said he recognized that FY 2025 may have affected these analyses. Dr. Rasooly added that success rates across NIH dropped substantially, but NICHD’s success rate dropped less than the overall NIH rate. Council members may be seeing the effects of multiyear funding constraints in these analyses.

Dr. Jabl suggested that NICHD could spend more time examining applications that are close to being funded to determine whether they should be pushed forward, rather than focusing primarily on whether already well-funded investigators should receive additional support. Dr. Cedars noted that doing so would still require reallocating funds from a fixed pool.

Mr. Belter recognized the discussion as converging on the need for NICHD to be more thoughtful about what it does and does not fund. Dr. Hazra thanked Mr. Belter and NICHD program analysts for generating evidence to guide these discussions.

## **VI. Concept Clearance (02:53:49)**

Dr. Rasooly led the Council through the review of three concepts. She explained that these concepts represent early stages of potential grant or contract solicitations. According to law, experts in the field must approve the concept before an initiative can be announced or developed into a funding opportunity. Council members are asked to review, comment on, and approve

concepts for their scientific merit and relative priority. Not all concepts are developed into formal initiatives. Those that are developed further may include details that are not in the original proposal. Concepts are presented in open session and specifically do not include details about future funding initiatives, which prevents Council members from having insider information that would exclude them from applying to any eventual funding initiative.

### **Elucidation and Validation of the Role of Transporters in Placenta, Lactating Mammary Gland, Developing Gut, and Blood-Brain Barrier (02:55:18)**

Aaron Pawlyk, Ph.D., presented a concept from the Obstetric and Pediatric Pharmacology and Therapeutics Branch (OPPTB). The concept would renew an initiative to study human perinatal transporters. The first cycle of this initiative established four cooperative centers. The renewal will build the next framework of shared standards, comparative datasets, validated human-based models, and early linked modeling approaches for a perinatal multibarrier transport network. The goal for renewal will be developing high-quality knowledge resources needed to predict exposure across the maternal-infant continuum. Dr. Maldonado asked why HIV and acquired immunodeficiency syndrome (AIDS) priorities were not applicable to this concept. Dr. Pawlyk explained that these priorities refer specifically to whether the concept seeks a particular amount of HIV/AIDS funding. The biology covered by the concept does not exclude HIV/AIDS studies, but the concept is not requesting specific HIV/AIDS funds. Dr. Gyamfi-Bannerman made a motion to approve the concept, and Dr. Cedars seconded the motion. **Decision: Approve.**

### **Chemical Screening and Optimization Facility (02:59:13)**

Chris Lindsey, Ph.D., presented a concept from the Fertility and Infertility Branch (FIB). This concept would provide investigators with access to a facility with a comprehensive suite of resources for reproductive research, supporting both early-stage investigators with their first funding opportunity and experienced researchers with their next funding opportunity. The concept meets public demand for safe contraceptives and reproductive therapies. It also aligns with the NICHD Strategic Plan's Themes 2 and 4, and FIB priorities to develop new and improved contraceptives. Dr. Van den Veyver made a motion to approve the concept. Dr. Gyamfi-Bannerman seconded the motion. **Decision: Approve.**

## **VII. Council Statement of Understanding (03:02:11)**

Dr. Rasooly asked Council members to approve the Council Statement of Understanding, which outlines the general procedures the Council uses for second-level review. The statement addresses Council membership, Council structure, procedures to review grant applications during closed session, administrative decisions, actions that do not require Council recommendation, voting options, expedited review of highly meritorious applications, interim review procedures, concept clearance procedures, and emergency procedures.

NICHD made minor updates to the statement for readability and accuracy. The revisions clarified that only requests to co-fund applications from an RFA would come to Council, rather than all co-funding requests. The revisions also clarified that Council discusses concerns about human subjects, animal welfare, or inclusion only when those concerns have not been resolved administratively. NICHD also removed language indicating that large applications involving more than \$500,000 in direct costs come to the Council. Dr. Van den Veyver made a motion to approve the statement, and the motion was seconded by

Dr. Gyamfi-Bannerman. **Decision: Approve.**

## **VIII. Closing Remarks (03:05:10)**

Dr. Hazra thanked the presenters, Council members, and members of the public for joining the Open Session. He adjourned the Open Session at 1:42 p.m. A total of 177 people viewed the live [NIH VideoCast](#).

## **IX. Closed Session**

The meeting was closed to the public in accordance with the provisions set forth in Section 55f2b(c)(4) and 552b(c)(6), title 5, U.S.C., and Section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2). NACHHD Council members provided second level review of NICHD extramural applications.

## **X. Review of Applications**

The session included a discussion of procedures and policies regarding voting and confidentiality of application materials, committee discussions, and recommendations. Members absented themselves from the meeting during discussion of and voting on applications from their own institutions or other applications in which there was a potential conflict of interest, real or apparent. Members were asked to sign a statement to this effect. The Council considered and approved 924 NICHD-primary applications requesting \$325,164,821 in direct costs and \$468,166,218 in total costs.

## **XI. Adjournment**

There being no further business, Dr. Hazra adjourned the meeting at 3:59 pm. The next Council meeting is scheduled for October 14, 2026, as an in-person meeting.

I hereby certify that, to the best of my knowledge, the foregoing minutes are accurate and complete.

**ROHAN HAZRA -S** Digitally signed by ROHAN HAZRA  
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Rohan Hazra, M.D.

NACHHD Chair

NICHD Acting Director

**JOSEPH G. GINDHART JR -S** Digitally signed by JOSEPH G.  
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Rebekah S. Rasooly, Ph.D.

NACHHD Executive Secretary

Director, NICHD Division of Extramural Activities