



A monthly update covering people, events, research, and key developments

Editor's Note:

Labor Day is over and we're all back to work. With that comes a jam packed issue of the EpiMonitor. You'll find a listing of free online calculators in Resources this month. If you're interested in a flexible schedule, in the Job Hunt this month we have a piece on how to start winning contract work. This month's AI piece discusses AI adoption outpacing training in field epidemiology programs.

Our reader opinion of the month addresses how evidence based medicine opposed vaccines and undermined public health. You'll note we've followed that up with a popular article from our archives about how you can effectively discuss vaccines across the partisan divide.

From our regular contributors you will find a piece on wildfire smoke written by the father of a firefighter. You will also find a piece about NHANES, it's work over 70 years and the questions it raises as a natural outgrowth of its work.

At this time of year the EpiMonitor begins the annual project of building our worldwide event calendar for the upcoming year. We normally publish that in the issue that comes out on New Year's Eve. If your institution has an event that runs at least 8 hours we'd like to include it in this issue. We normally list short courses, conferences, summer/winter programs, meetings, and unique events such as hackathons. We need the name of the event, sponsor(s), date(s), location, and website for the event in order to list it. We also have advertising opportunities to help you spread the word about your event. Please feel free to [reach out](#) to us with any questions you may have.

In jobs this month you'll find almost 100 open positions including, for the first time ever in the EpiMonitor, a full page of fellowship opportunities. Fall is prime job posting season and the next 60-90 days should be chock full of openings for you to review. Have an open job? [Reach out](#) and we'll send you information about our advertising program for jobs.

As always, we continue to provide you with our popular monthly word game feature, an overview of what we are reading from the public media, and a listing of near term upcoming events. This month's Notes on People includes 14 of your peers - many of whom are being honored for their work. Ask us about the sponsorship opportunities for these standard monthly features - it offers you great exposure for your event, institution, book or other item of interest to our readers!

Until next month - stay safe and busy!

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Did you miss last month's issue? Read it here: <https://tinyurl.com/436ur2jz> or here: <https://tinyurl.com/bdzezwh>

The Invisible Made Visible

How a quiet government survey revealed the reality of everyday life - and the power of prevention

Author: Bruce Lanphear, MD, MPH

NOTE: This article was originally published on May 5, 2026 by [Plagues, Pollution & Poverty](#) on Substack.



Measuring a Nation, One Person at a Time

It doesn't look like a laboratory.

The trailer is parked in a school lot, its steps worn from years of use. Inside, the air is cool and clinical. A nurse draws blood while another technician calibrates a machine that will measure something most people have never heard of—and never asked about. Outside, a line forms: a truck driver, a grandmother, a teenager who was told to skip breakfast.

They are not patients. They are participants.

Each will leave with little more than a thank you. But together, they are building something far more valuable: a portrait of a nation's health, drawn not from clinics or hospitals, but from everyday life.

For more than half a century, the National Health and Nutrition Examination Survey—NHANES—has done something no clinic, hospital, or randomized trial could do. It has measured us as a population: what we eat, what we carry in our blood, what is changing—and what is not.

It has, in a very real sense, made the invisible visible. And yet, for all its influence, NHANES

remains largely unknown outside public health.

The Decision to See Clearly

The effort to measure the health of Americans began with a quiet but consequential piece of legislation. The National Health Survey [Act](#) of 1956 authorized a continuing, nationwide survey to measure the amount, distribution, and effects of illness and disability. It marked a shift in how government approached health—not simply treating disease but measuring it across the population.

That shift was driven, in part, by a changing pattern of disease. Infectious diseases were receding, while chronic conditions—heart disease, cancer, and stroke—were emerging as the leading causes of death and disability. These were not diseases that appeared suddenly or spread through outbreaks. They developed slowly, often invisibly, and were shaped by the conditions of everyday life.

The mandate [led](#) to the National Health Interview Survey in 1957 and, soon after, to the National Health Examination Survey, which added direct physical exams. Instead of relying on hospital records or physician reports, federal officials chose to collect data directly from households and communities. Blood pressure was measured. Vision and hearing were tested. Children were examined for growth and development.

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This was not glamorous work. It was logistical, methodical, and expensive. But it reflected a new idea: understanding health required seeing it where people lived.

Still, these early surveys could describe illness better than they could explain it. They could tell you who was sick, but not why.

Connecting Behavior, Biology, and Disease

That gap led to a second decision. In 1971, federal health officials [expanded](#) the survey to include nutrition, launching NHANES. This was more than a change in name. It was a change in purpose.

Now, the survey could connect behavior, biology, and disease. It could link what people ate to what appeared in their blood and how their bodies functioned. It could begin to trace the pathways between exposure and outcome.

Subsequent [phases](#) built on that foundation, including NHANES II, which began in February 1976 and continued through 1980, and NHANES III, which expanded the scale and scope of measurement even further. By the time NHANES III was completed, the survey had matured into a national instrument—capable not just of describing health, but of helping to explain it.

With each iteration, the survey moved closer to its central aim: not just to document disease, but to understand how it arises—and how it might be prevented.

When Exposure Became Visible

One of the most consequential decisions within NHANES was to include a blood test for [lead](#). At the time, lead poisoning was still framed as a problem of extremes—industrial exposure, peeling paint, severe cases. If exposure was not

obvious, it was assumed not to matter.

That assumption began to shift in the mid-1970s. As NHANES II (1976–1980) was being planned, concern about low-level exposure was growing.

The push to measure blood lead came through an interagency effort, but one figure was pivotal. Kathryn Mahaffey, then at the FDA, recognized the need for nationally representative data and helped ensure that blood lead testing was included.

NHANES operates on a simple principle: agencies that want specific measures added must help fund them. With support from FDA and others, the resources were secured. Once in place, the proposal fit squarely within NHANES' mission, and there appears to have been little resistance at NCHS.

What followed was a revelation.

When blood lead levels were measured across the population, it became clear that [exposure](#) was not rare. It was widespread. Children across the United States—regardless of geography—had measurable levels of lead in their blood. What had been considered a niche problem was, in fact, a population-wide exposure.

Then something even more important happened. As policies were implemented to remove lead from gasoline, NHANES tracked the results. Blood lead levels [fell](#)—dramatically and consistently—across the entire population.

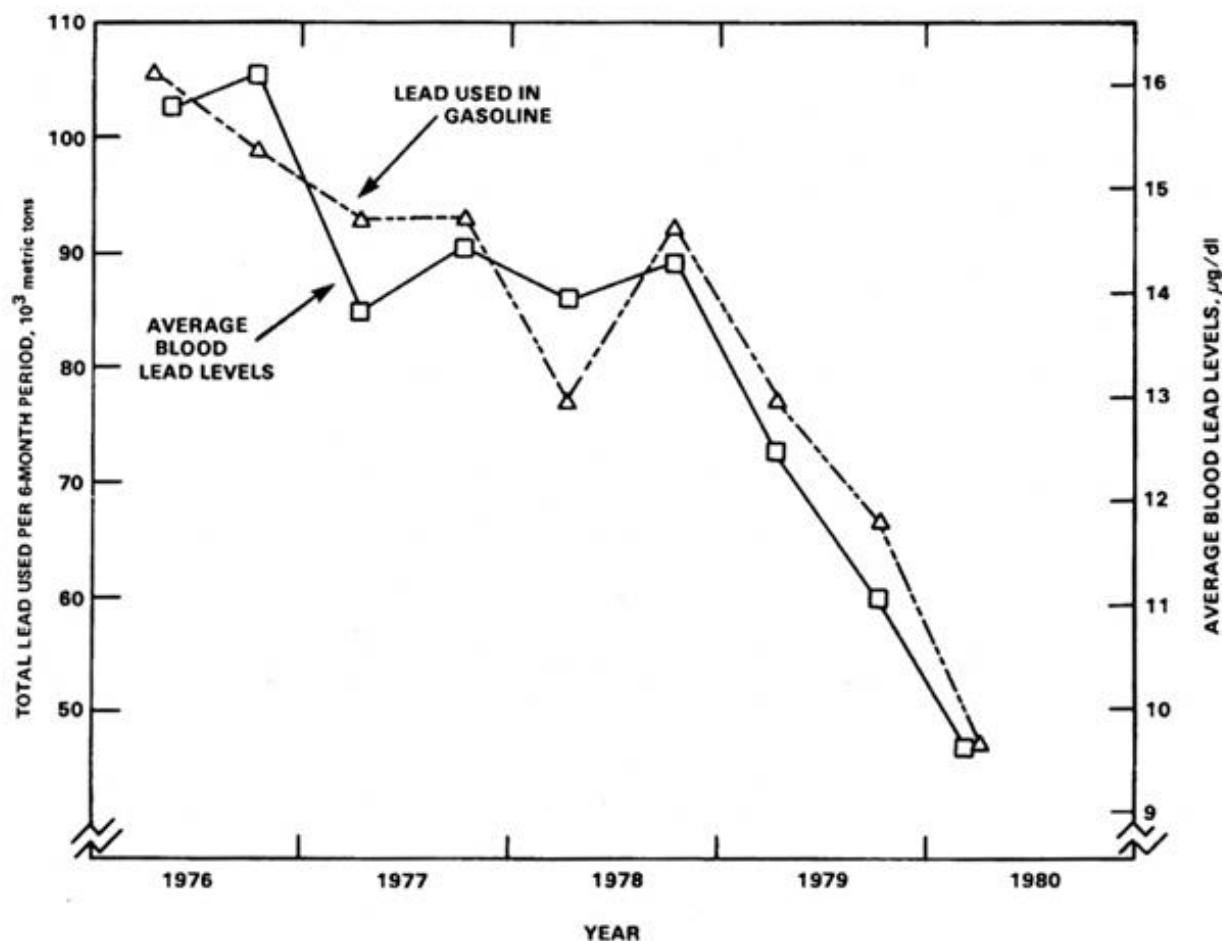


Figure 1-16. Parallel decreases in blood lead values observed in the NHANES II Study and amounts of lead used in gasoline during 1976-1980.

This was one of the clearest demonstrations in modern public health that reducing exposure can shift the health of a nation. It did not depend on treatment. It depended on prevention.

NHANES did not create that policy. But it made its impact undeniable.

From Snapshots to Surveillance

For decades, NHANES operated in cycles. Data were collected, analyzed, and then the survey paused before the next phase began. That model produced important insights, but it limited the ability to track change over time.

In 1999, federal officials made another pivotal decision: NHANES would become continuous.

Each year, mobile examination caravans would visit communities across the United States, collecting data from a nationally representative sample. This transformed NHANES from a series of snapshots into a moving picture. Trends could now be observed as they unfolded, rather than reconstructed after the fact.

This was surveillance in the best sense of the word—not monitoring individuals, but understanding patterns across a population.

Linking Exposure to Outcome

Another innovation extended the reach of NHANES beyond measurement: mortality follow-up. By linking participants to national

death records, government scientists created a bridge between exposure and outcome. Measurements taken at one point in time could now be connected to events years or decades later.

This transformed NHANES into something more than descriptive. It became explanatory.

Researchers could examine how blood pressure [predicts](#) mortality, how diabetes [shortens](#) life, and how physical activity [influences](#) long-term risk. It also made it possible to examine environmental exposures in a new way.

NHANES, with its nationally representative biomonitoring and mortality follow-up, provided some of the first rigorous [evidence](#) that low-to-moderate levels of metals like lead and cadmium—well below existing thresholds—were linked to cardiovascular disease and death. It helped move these exposures from the margins into mainstream cardiovascular risk assessment, on par with traditional risk factors. In my own research, we linked blood lead levels to mortality and found that lead exposure was the [leading](#) risk factor for coronary heart disease deaths—surpassing even smoking.

What had once been considered a narrow toxicological concern emerged as a major population-level risk factor. NHANES made that connection possible—not through a single experiment, but through sustained measurement over time.

From a Few Chemical to Hundreds

Over time, the [scope](#) of NHANES expanded beyond a few key biomarkers to include hundreds of chemicals. This evolution reflected another shift in thinking within government: that exposure should not be inferred indirectly when it could be measured directly.

When NHANES began in the 1970s, it [measured](#) only a few environmental chemicals—most notably blood lead and organochlorine pesticides, like DDT. It was a narrow but important window into exposure at a time when leaded gasoline and legacy pesticides dominated concern.

Today, NHANES [measures](#) more than 400 hundred chemicals in blood and urine, including metals, pesticides, plasticizers, flame retardants, and per- and polyfluoroalkyl substances. We have moved from tracking a few well-known toxicants to surveying a far more complex chemical landscape—one that includes mixtures, short-lived compounds, and emerging contaminants, many of which remain poorly understood.

This approach—biomonitoring—asked a simple question: what is actually inside the human body?

The answer was remarkably consistent. People were not exposed to one chemical at a time. They were exposed to many, often simultaneously, at levels low enough to escape clinical detection but high enough to raise questions about long-term effects.

This was not the model that risk assessment had been built on. Traditional approaches assumed discrete exposures and clear thresholds. NHANES revealed a more complex reality: continuous, cumulative exposure across the population.

Living in a Chemical World

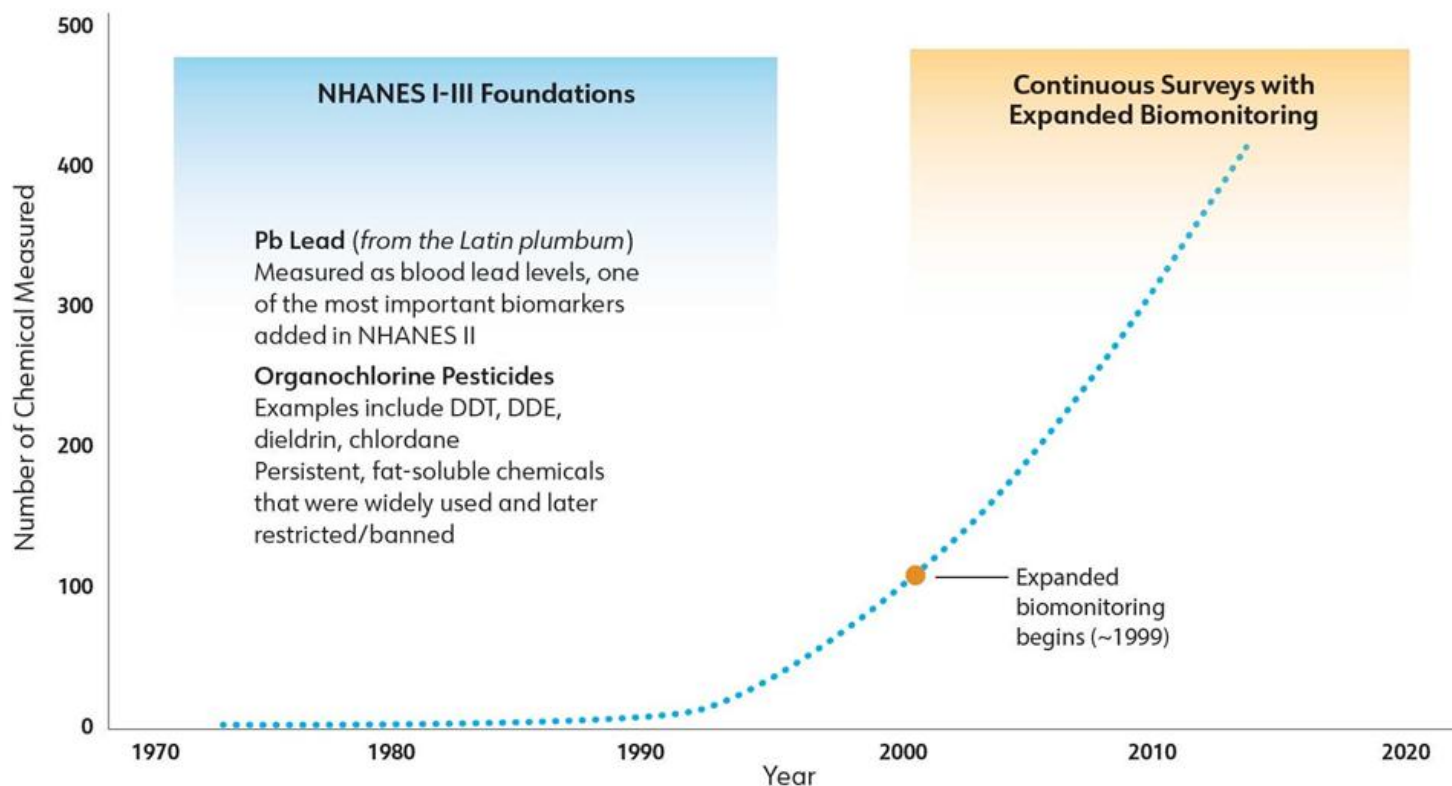
NHANES helped normalize a new understanding of risk. The older model assumed identifiable hazards and clear lines between exposed and

unexposed groups. The new model was less comfortable.

Exposure was widespread. It was ongoing. And it was layered. We were not living in a world of isolated risks. We were living in a chemical world.

This did not mean that every chemical caused harm. But it did mean that the burden of exposure was shared, and that understanding its effects required new ways of thinking—about mixtures, timing, and cumulative impact.

From a Few Chemicals to More than Four Hundred: Expansion of NHANES Biomonitoring



From National Tool to Global Standard—With a Critical Blind Spot

The success of NHANES did not go unnoticed. A few countries built similar systems, adapting the model to their own populations. Canada established the Canadian Health Measures Survey, or CHMS. South Korea launched KNHANES.

Each reflected the same insight: that understanding health requires direct, population-based measurement—not just of disease, but of the conditions that produce it.

learned. Most countries still do not measure industrial chemicals in their populations in any systematic way. That absence is not a technical limitation—it is a failure of public health surveillance.

In the 21st century, where toxic metals and synthetic chemicals permeate air, water, food, and our bodies, biomonitoring is not optional. It is foundational. Without it, we are left to track disease while ignoring its upstream drivers—measuring the consequences while remaining blind to the causes.

- Visible cont'd on page 8

But the deeper lesson has been only partially

A Quiet Engine of Evidence

NHANES has been used in more than 30 thousand publications. Its data underpin clinical guidelines, environmental regulations, and public health recommendations. It informs how we define normal, how we detect risk, and how we measure change.

And yet, NHANES itself rarely appears in headlines. It does not produce a single discovery. It produces a steady accumulation of evidence.

It is infrastructure for knowledge—quiet, persistent, and essential.

The Next Questions

For all its strengths, NHANES has limits. It measures individuals at a point in time, which makes it difficult to capture trajectories. It measures chemicals individually, even though real-world exposure occurs in mixtures. It provides biomarkers, but not always the biological pathways that connect them to disease.

These limitations matter because the questions we now face are more complex. What is the combined effect of multiple endocrine disruptors? How do environmental exposures interact with genetic susceptibility? Why are some chronic conditions rising so rapidly that we struggle even to track them?

These are not peripheral questions. They are central to understanding modern disease.

Toward a More Complete Picture

The solution is not to abandon NHANES, but to build on it. A larger and more integrated system could begin to address these gaps. Expanding the sample size would improve the ability to

study less common outcomes and vulnerable subgroups. More systematic integration of genomic and emerging epigenetic data—building on existing NHANES biospecimens—would strengthen the study of gene-environment interactions. And improving the assessment of cumulative and repeated exposures would better reflect real-world conditions.

Following individuals over time would transform the survey from a series of measurements into a narrative of health across the life course.

Such a system would require investment. It would also require a shift in priorities—from reacting to disease to anticipating it.

The Pattern Beneath Disease

NHANES did something deceptively simple. It measured the population. But in doing so, it changed how we think about disease.

It showed that disease is not random. It is shaped by environment. And, in many cases, it is preventable.

Because NHANES is representative of the population, it allows us to go a step further—to calculate how much disease, and how many deaths, can be attributed to specific exposures. These calculations translate risk into consequence. They move us from association to accountability.

And once you can attribute disease to an exposure, the question is no longer whether it matters. It is whether we are willing to act.

Seeing Clearly Is Only the Beginning

We have built a system that can see what was once invisible. We have measured exposures, tracked their decline, and linked them to health outcomes. We have shown that prevention is not only possible, but powerful.

And yet, we hesitate. We debate, we delay, and we ask for more certainty—even when the pattern is already clear.

NHANES is still operating, but not as securely as it once did. After being suspended during the pandemic, it was relaunched in 2025. The trailers keep moving, the blood keeps being drawn, and the data continue to accumulate—quietly, patiently—waiting for us to catch up. Yet the system that once measured a nation with steady precision now shows signs of strain:

fewer participants, disrupted cycles, and the growing challenge of maintaining a truly representative sample.

That tension—between what we can see and what we are willing to do about it—points to something deeper. Once you measure a nation, you inherit a responsibility: not just to observe, but to act; not just to describe what is happening, but to ask why and to change it. We built a system to see ourselves clearly. What we do with that vision is no longer a scientific question—it is a moral one.

What we measure is not just a technical decision—it determines what becomes visible. And what remains unseen can shape our understanding of health for years, even decades.

■



Take a deep dive into the hidden environmental drivers of **CHRONIC DISEASE** and the toxic truths mainstream media won't touch.

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If you care about **HEALTH** and **PREVENTION**, check out:

Plagues, Pollution & Poverty
blanphear.substack.com

Let's rethink what's really making us sick.

When Wildfire Smoke Hits Home

With a son on the fire line,
what I've learned about protecting the air we breathe.

Author: Matt Willis, MD, MPH

NOTE: This article was originally published on August 19, 2026 by [Your Local Epidemiologist](#) on Substack.

Wildfires have been all over the news, not just in the U.S. but in Europe as well, where I (Katelyn) have been. For Matt Willis, the author of [YLE California edition](#), it just became very personal. I'll let him explain.

The text came on July 27: *Made it to Bend. Heading to the fire line tomorrow.*

My son just finished his wildland firefighting certification. He's spent the summer working as an EMT and was sent to the fires burning in Oregon. He's 22, and this was his first fire.



Picture my son texted me. Brewery Fire, Oregon, July 27, 2026

I went deep into air filtration. My son's exposure may be more extreme, but the lessons are increasingly relevant for all of us. This is what I learned.

Yes, wildfires are increasing.

When I'm not writing with Katelyn for YLE, I work with climate scientists to model the health impacts of climate change. Our report will be out in December (stay tuned), but here's a teaser—the increased burden of wildfires we're feeling isn't a one-summer fluke. Even the best-case scenarios show an upward trend in wildfire size, frequency, and intensity until we can slow global warming.

This doesn't just matter for those of us with houses in dry areas. Wildfire smoke risk isn't limited to "fire county." Our most fire-prone states are in the West, and prevailing winds blow east. In late July, smoke from the fire my son was fighting in Oregon reached Florida.



Wildfire smoke plume, July 29, 2026. Source: NOAA

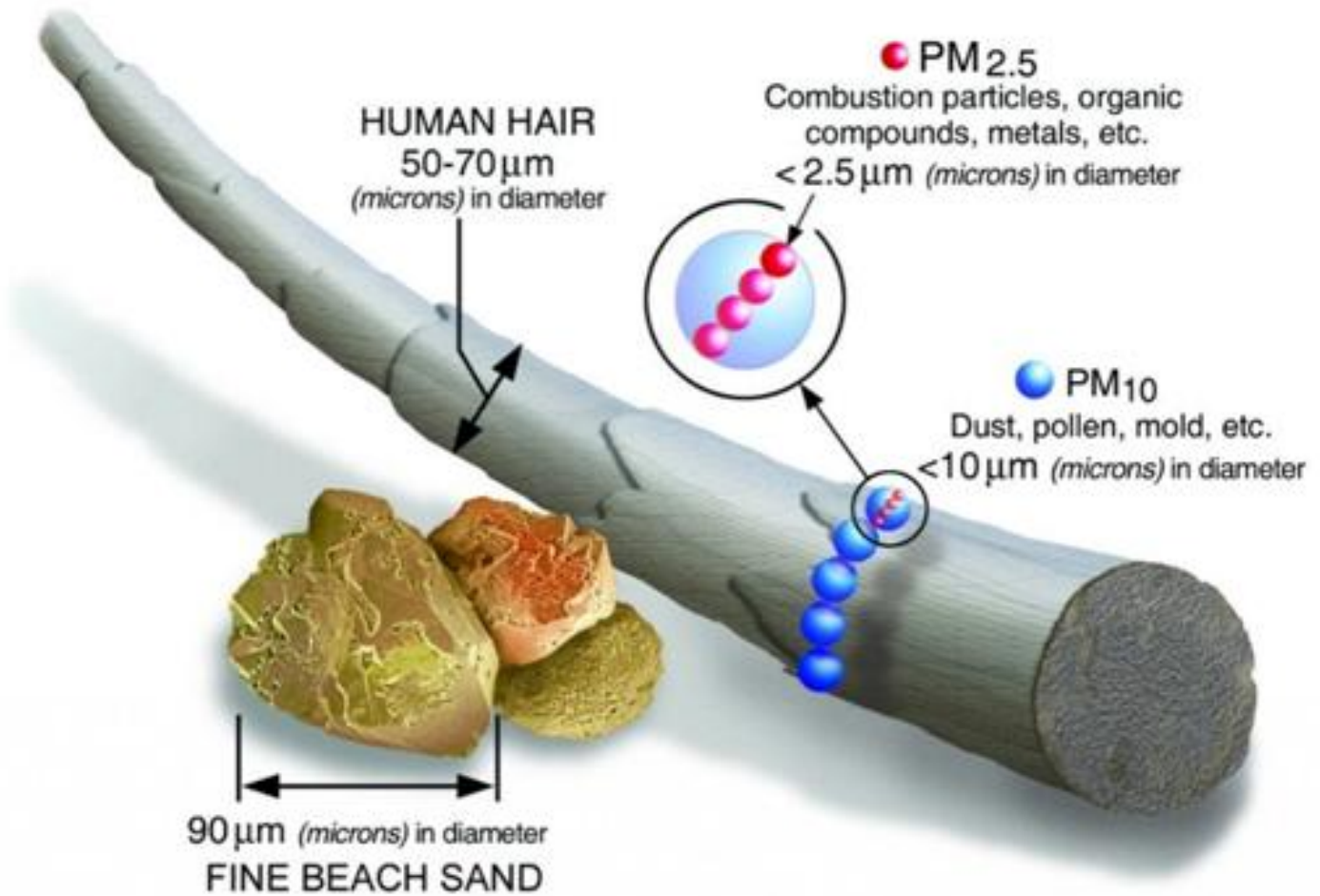
- Wildfire cont'd on page 11

Long-term climate models indicate that we can expect increased smoke exposure in the coming years.

We need to adapt quickly. That starts with filtering air.

We breathe in about [2,000 gallons](#) of air a day

at rest—almost enough to fill a swimming pool. On smoky days, every gallon we take in carries potentially harmful compounds. The most damaging bits are smaller than 2.5 microns (a centimeter has 10,000 microns), called “PM 2.5”, which is much smaller than a human hair.



Size comparisons for PM particles

Source: EPA

So, any air filtration for wildfire smoke needs to have a very fine weave. On smoky days, scrubbing the particles out of that air before we breathe it can be surprisingly simple. Outside, it's a mask. Inside, it's your home's air filtration system.

A well-fitted N95 mask is highly effective against wildfire smoke. A 2025 [review](#) of 33 studies found that N95 face masks removed up to 94% of PM_{2.5}. The authors also concluded that “masks were relatively underutilized” in wildfire response.

Outside masks are a neglected tool.

- Wildfire cont'd on page 12

Until recently, masks have not been prioritized in wildfire response. In fact, **until last year, wildland firefighters weren't allowed to wear anything beyond a bandana** on the fire line. Somehow, despite mountains of evidence of the benefit, the U.S. Forest Service only [authorized](#) voluntary N95 use for firefighters in 2025. This is a massive occupational health failure that harmed generations of firefighters. It's finally being corrected, just as my son joins the ranks.

That history also helps us understand the impact of repeated, unprotected— and preventable exposures. Career wildland firefighters have an [estimated](#) 8–43% increased risk for lung cancer and a 16–30% increased risk of cardiovascular death, depending on years of service and season intensity. A more recent [study](#) of almost 13,000 firefighters, looking back over 25 years, found that emphysema, pneumonia, asthma, and cardiovascular disease all increased with more fire line hours.

The wide range of effects isn't surprising—the smallest inhaled particles damage lung tissue directly and enter the bloodstream, causing inflammation in sensitive blood vessels, including those in the heart and brain. These health impacts aren't just during an event, but accumulate, fire after fire. This “dose-response” curve means higher exposure levels lead to worse health outcomes—and any measure that reduces exposure helps.

What this means for you: Wear a well-fitting N95 mask when you're outside anytime it's smoky. An air quality index (AQI) of 150 is a good trigger point for masking up. People in [sensitive groups](#) should consider masking at an AQI of 100 or higher. (Check [AirNow's Fire and Smoke Map](#) for AQI in near real time during a fire.) I'm relieved that my son and his crew

have access to the protection we've been promoting to the public for years.

“Go indoors” is only a start.

Here's something I wish I'd been clearer about in twelve years of writing smoke advisories as a health officer: “move indoors” treats your house like it's a sealed box, and it isn't. AQI is generally measured outdoors, but being inside doesn't automatically protect you.

Air moves through gaps, doors, windows, even walls. Researchers [tracking](#) indoor and outdoor air side by side during smoke events (the “infiltration ratio”) have found that, without indoor filtration, 60% of outdoor pollution can enter indoors within hours. If the AQI is 300 outside, it can approach 200 inside without filtration.

With proper filtration, the indoor/outdoor ratio can drop below 20%. Your indoor AQI can be below 50 on the same day the outdoor AQI is 300.

What this means for you: Clean indoor air.

Every home can have good air filtration through a few simple steps:

- 1. Know what kind of system you have.** If your home has vents blowing heated or cooled air and a thermostat, you've got a central air system—it already has a filter, and that's your main asset. If your house uses radiators, baseboard heat, or window units, you'll probably need portable filters.

2. Use the right filter. For central air, look for the MERV rating, a 1 to 16+ scale for how fine a particle it catches. MERV 13 is recommended for PM 2.5 in smoke. Most systems come with MERV 8 as default, so you may need to upgrade. For portable purifiers, look at two factors—the filtration type, and how large an area it can purify. Look for HEPA-rated filters, which effectively capture 99% of wildfire smoke particles. For room size, CADR (clean air delivery rate) is the number of square feet of air it can filter per minute. As a rule of thumb, CADR should be close to your room's square footage. (A 10 ft by 10 ft room is 100 square feet and would need a filter with a CADR of 80-100.)

3. During a smoke event, run it continuously, not just on "auto." Filtration only works while it's running. A central

system on "auto" may only cycle for a few minutes an hour. During a smoke event, switch the setting to "on" so air keeps moving through the filter. Portable purifiers should run around the clock, too; shutting one off lets a room's air quality slide back within an hour or two.

4. Pick one room and make it your clean-air refuge. If you're using portable filters, you don't need to filter the whole house. One well-sealed room, usually the bedroom, gives your household somewhere reliable to breathe easy and sleep.

5. Close the gaps before smoke season, not during it. Weatherstripping around doors and windows makes the house less leaky and improves the inside/outside ratio. For renters, removable weatherstripping, draft snakes, or even a towel under a leaky door can help.

6. A box fan can get you most of the way there. A box fan paired with a MERV-13 filter taped to the intake side costs a fraction of a purifier and effectively captures fine particles. It's also fully portable, which helps if you're renting or moving between rooms.



Source: Yale School of Public Health

- Wildfire cont'd on page 14

While we can take personal measures, we're also seeing promising policies that will help bake some of these protections into more resilient communities. These include [building codes](#) that mandate MERV-13 filters, [rebates](#) for portable HEPA filters, and free mass [mask distribution](#) policies for smoky days.

Bottom line

My son is home now, safe and sound. He slept in a trailer near the fire, where AQI readings reached the 600s. I texted him daily, probably annoyingly, reminding him to wear his N95 mask outside and run the HEPA filter in his trailer. I knew what stood between him and hazardous air was technology that's available to

all of us. These are simple measures, but getting the basics right is more than half the battle in public health.

Most of us won't ever fight a fire at its source. But we can decide, before the next smoky day arrives, how ready we'll be to respond to it. ■

Dr. Matt Willis is the author of Your Local Epidemiologist in California. He's served as a primary care physician, a CDC epidemiologist, a public health officer for Marin County, and a climate researcher. He lives in Marin with his family and their dogs, Teddy and Ramona.



YLE can be found here: <https://yourlocalepidemiologist.substack.com/>

[Your Local Epidemiologist](#) (YLE) is founded and operated by Dr. Katelyn Jetelina, MPH PhD—an epidemiologist, wife, and mom of two little girls. YLE reaches more than 305,000 people in over 132 countries with one goal: “Translate” the ever-evolving public health science so that people will be well-equipped to make evidence-based decisions. This newsletter is free to everyone, thanks to the generous support of fellow YLE community members.

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How Did Evidence-Based Medicine Come to Oppose Vaccines and Undermine Public Health?

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Note: This article originally appeared on [SSRN](#) on September 16, 2026.



Intended to restore [trust](#), President Trump's August 2026 [executive order](#) on "gold standard" child vaccine policy relies on a [report](#) that contains [no evidence](#) regarding vaccine efficacy or safety and is full of [errors](#). Although it remains to be seen whether the order has any [legal power](#), it will succeed in [sowing confusion](#) and contribute to waning measles vaccination rates while cases are [soaring](#).

This is the latest attempt by Trump and Health and Human Services Secretary Robert F. Kennedy Jr. to use "gold standard," "scientific," and "evidence-based medicine (EBM)" to justify their policies. EBM is an approach to grounding clinical and public health decisions in the best available research. Yet some of EBM's most visible champions have invoked a narrow, interpretation that elevates one study design – randomized clinical trials (RCTs) – to cast doubt on vaccines, delegitimize long-standing regulatory and advisory processes, and justify sweeping policy changes. Together, these actions reveal a striking inversion: the rhetoric of evidence-based medicine is being used selectively to question vaccine benefits while accepting weak or nonexistent evidence for

vaccine harms.

Beyond the [dubious rationale](#) and vast [consequences](#) of these changes for vaccine access and child health, these actions delegitimize the contributions of science and undermine trust in public health. Ironically, restoring confidence in vaccines – and public health generally – will require preserving the well-developed vaccine regulatory and advisory system Kennedy [seems determined to dismantle](#), which is actually a crown jewel of evidence-informed public health.

Evidence-Based Medicine during the pandemic: from nuanced framework to RCT absolutism

As described by Guyatt and others in 1992, [Evidence-Based Medicine](#) advocated the "conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients." RCTs are regarded as the top of the "evidence pyramid" because they help establish a causal relationship. Case studies cannot establish cause and effect, so are at the bottom of the pyramid. There are many observational and quasi-experimental designs between these two poles that can provide useful evidence. Whatever the design, theoretical support and careful planning and execution are critical. This is especially true when RCTs are infeasible, as in many public-health interventions.

- Evidence cont'd on page 16

Some EBM adherents see RCTs as not just the best but the only acceptable type of evidence. During the pandemic, for instance, some argued that mask requirements and social distancing measures were not supported by [RCTs](#). However, observational studies [showed](#) that wearing masks, supported by mask mandates, generally reduced the transmission of SARS-CoV-2 infection.

Based on observational evidence alone, Ioannidis [wrote](#) in March 2020 that the virus might take only 10,000 lives in the US. In April, he and others [reported](#) on a sample of Santa Clara County residents tested for antibodies to the virus. Serious [biases](#) in this and related analyses seriously underestimated the infection fatality rate, making the virus seem less harmful, including to children. These analyses [falsely shaped public understanding](#) of pandemic risks and the benefits of interventions, including vaccination.

In 2025, Ioannidis and others published a [study](#) that underestimated the benefits of COVID-19 vaccines and exaggerated their harms, contributing to the false narrative that vaccines are dangerous and not effective. This [was the result of assumptions](#) – all biased in the same direction – about the infection fatality rate and other model parameters, simplifications in model structure such as ignoring the impact of vaccines on transmission and ignoring the impact on hospitalizations and non-health benefits to vaccinated individuals and the community.

The role of RCTs in vaccine approval

The EBM community showed no concern about the efficacy of the original COVID-19 vaccines, but some questioned the need for, and safety

of, vaccines for new strains of the virus. In 2025, Prasad and Makary published a [commentary](#) calling for placebo-controlled randomized trials for new COVID-19 vaccines for all but the most high-risk individuals. This policy demonstrates a profound misunderstanding of ethics, epidemiology, and biostatistics.

Ethics: Efficacy was established in 2020 in RCTs with [43,500](#) and [30,000](#) participants. Once proven effective, it is [unethical](#) to withhold the vaccine from the control group.

Biostatistics: RCTs must be [exceptionally large](#) to identify rare adverse events. Post-marketing surveillance systems covering millions of patients provide better information on safety.

Epidemiology: Once shown to be effective, surveillance on circulating strains and [immunobridging](#) studies are needed to see whether the viral strains incorporated in the vaccine match those circulating in the population. Requiring RCTs would delay the availability of the vaccine, perhaps until it no longer matches the circulating strain.

Assessing vaccine risks

Assessing vaccine risks requires the same evidentiary discipline that EBM claims to defend. Yet Kennedy and his colleagues have long [argued](#) that vaccines are dangerous, perhaps causing more deaths than COVID-19 cases they prevented, and even [stated](#) there are no vaccines that are safe and effective. Once in office, his associate Tracy Høeg was given access to the Vaccine Adverse Event Reporting System (VAERS), which contains unverified reports of side effects or bad experiences with

vaccines submitted by doctors, patients, or even someone who sees a report on social media. In September 2025, officials [announced](#) that they planned to link vaccines to the deaths of 25 children.

Two months later, Prasad asserted in an internal [email](#) that “at least 10 children have died after and because of receiving COVID-19 vaccination. These deaths are related to vaccination (likely/probable/possible attribution made by staff).” No details were included, but Prasad called for stricter regulation of all vaccines, not just COVID-19, based on case reports rather than RCTs. Shortly afterwards, [MedPage Today](#) reported that Prasad’s assertion was false. FDA scientists analyzed 7, not 10, cases, and all had an alternative explanation for the cause of death.

Revisions to the childhood vaccine schedule

In January 2026 the CDC sharply reduced the number of vaccines that are routinely recommended for children. [Described](#) as a “scientific, evidence-based, data-driven response,” the [report](#) contains [no evidence](#) at all regarding vaccine efficacy or safety. Echoing Prasad and Makary’s call for more RCTs, the report ignores [many vaccine studies](#) – [randomized](#) and observational – that have been [done](#) over the years.

CDC’s latest decisions were never [considered](#) by CDC scientists or the Advisory Committee on Immunization Practices (ACIP). Rather than evidence about vaccine efficacy and safety, [Caplan](#) suggests that the changes are driven by a moral argument that prioritizes personal freedom to choose, regardless of the health consequences.

Suppression of non-RCTs

In April 2026, Jay Bhattacharya, who was temporarily overseeing the CDC, [suppressed](#) the publication of a report finding that the 2025-26 COVID-19 vaccine helps protect against serious illness by reducing the risk of hospitalization and emergency department/urgent care visits, adding protection for a population with significant existing immunity from previous infections and vaccinations. The [study](#) was eventually published in the peer-reviewed *JAMA Network Open*.

As [explained](#) by statistician Natalie Dean, the study’s “test-negative” design estimates vaccine effectiveness by comparing vaccination status in individuals seeking care for COVID-19-like illness (and test positive) are compared to controls in the same care sites who test negative. Because the U.S. has no large cohorts of vaccinated and unvaccinated populations, this design has been used for decades for influenza vaccine monitoring. Bhattacharya’s [justification](#) does not acknowledge the long history and established merits of the study’s design. Its statistical arguments are inconsistent with those offered by statistician Martin Kulldorff (another EBM advocate), neither of which hold up to [scrutiny](#). Given the established record of efficacy and safety of mRNA vaccines, it is hard to see the suppression as anything other than an undue preference for RCTs.

Restoring confidence in vaccines and public health requires preserving the U.S. vaccine process

EBM has [three foundational principles](#):

(1) not all evidence is created equal and medical practice should be based on the best available evidence; (2) it is better to be led by the totality of evidence rather than by cherry-picking individual studies that support a particular claim; and (3) decisions can only be reached by considering the values and preferences of the person being treated.

Bhattacharya and his colleagues effectively treat the first principle as an absolute preference for RCTs, even when observational designs are better suited, e.g. for detecting rare adverse effects. In contrast to the second principle, they seem to frequently dismiss studies that demonstrate vaccine benefits and safety.

The U.S. vaccine regulatory and advisory [system](#), developed and refined over more than half a century, begins with FDA's review of laboratory and clinical data as well as RCTs to assess a vaccine's efficacy and safety. Post-marketing surveillance systems, including VAERS and the [Vaccine Safety Datalink](#), identify potential risks and investigate them in large clinical datasets to assess safety.

Consistent with EBM's second principle, the FDA approval process incorporates many different types of evidence: virology, immunology, and molecular biology to characterize pathogens; epidemiology and biostatistics to identify who is at risk, routes of transmission, and the impact of prevention and treatment strategies; and social, behavioral, and managerial sciences to develop effective public strategies. Greenhalgh and colleagues' [call](#) for the EBM community to embrace mechanistic evidence on a par with RCTs is a welcome step.

Once approved, CDC in conjunction with the Advisory Committee on Immunization Practices

(ACIP) [makes recommendations about the vaccine's use](#). CDC's recommendations consider efficacy and safety in different groups plus epidemiologic information about the risk of infection, as well as practical issues such as the standard schedule for well-baby care, thus aligning with the second and third EBM principles. ACIP's "[Evidence to Recommendation](#)" framework systematically evaluates factors like the evidence quality, balance of benefits vs. harms (including safety data), and cost-effectiveness, to create comprehensive public health guidelines. And consistent with the third EBM principle, it considers affected populations' values.

Impact on policy, health outcomes, and trust in public health

The August 2026 [Executive Order](#) attempts to reinstate Kennedy's vaccine recommendations that were [blocked](#) by the court on procedural grounds, resurrect long disproved claims that vaccines cause [autism](#), split the MMR vaccine into three components (despite its infeasibility), and urge states to loosen school vaccine [requirements](#) (which are not a federal issue). Rather than "gold standard" science, the order is shot through with [errors](#), rests on a selective view of evidence, and risks deepening public confusion at precisely the moment measles vaccination rates are waning and cases are [soaring](#).

Three weeks later, medical professional organizations [issued](#) their own guidelines for influenza, COVID-19, and respiratory syncytial virus vaccines. These were based on an evidence review conducted by the [Vaccine Integrity Project](#) at the University of Minnesota and a process like the one CDC abandoned, and

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many states are using these to set their own policies.

While reasonable people can differ about the benefits, harms, and costs of some public health policies, the benefits of childhood vaccines to individuals and the community clearly outweigh the harms. But rather than argue the value questions, Kennedy and some prominent EBM advocates have argued the science. Beyond the consequences for vaccine access and child health, each side having its own “facts” can only delegitimize science and thus undermine trust in public health in general.

Although the motivation for the EBM experts is unclear, their actions align with Kennedy's [efforts](#) to undermine U.S. vaccine policy. The implications are already being felt in waning measles vaccination rates while cases are [soaring](#). More broadly, they sow doubt on the scientific basis for vaccine policy, [undermining](#) trust in public health in general.

Conclusion

Evidence-based medicine was never meant to privilege a single study design above all others, nor to provide rhetorical cover for policy changes made without credible evidence. Yet in recent years, a distorted version of EBM—one that treats randomized trials as the only admissible evidence and disregards decades of mechanistic, observational, and implementation research—has been marshaled to oppose vaccines and to weaken core public-health institutions. The CDC's 2026 revisions to the childhood vaccine schedule, the suppression of non-RCT evidence on COVID-19 vaccines, and the close alignment of certain EBM advocates with Robert F. Kennedy Jr.'s agenda all reflect this troubling trend. Restoring public

confidence in both vaccines and EBM requires moving in the opposite direction.

During the pandemic, the emphasis on “following the science” without explicit consideration of harms [arguably](#) contributed to conservatives' declining trust in public health. Although Kennedy's moves are intended to increase trust, Naomi Oreskes [argues](#) that we are warranted in placing “informed trust” in the “critically achieved consensus of the scientific community.” This consensus is informed by careful consideration of empirical evidence, which come in many forms, so a focus on one method (such as RCTs) above all others is a kind of “fetish.” Oreskes also reminds us of the critical role of the social character of science. Objectivity depends on scientists' participation in the give-and-take of critical discussion, because the practices and procedures of scientific communities increase the odds that scientific consensus is reliable.

Rebuilding trust [requires](#) that public health officials lead with honesty about uncertainty, explain their reasoning, and give people a genuine voice in decisions. The vaccine regulatory and advisory system that Kennedy wants to change is actually a model for evidence-informed policy that does precisely this by integrating diverse forms of evidence and incorporating stakeholder values.

Public-health leaders should reaffirm EBM's three core principles: that not all evidence is created equal but many forms of evidence matter; that policy should be guided by the totality of high-quality evidence, not isolated studies that support a preferred position; and

that decisions must incorporate the values and preferences of affected individuals and communities. Protecting the independence and integrity of the FDA and ACIP, transparently communicating how evidence is weighed, and resisting efforts to sideline robust observational and mechanistic data are necessary steps. The U.S. vaccine regulatory and advisory system, far

from being an obstacle to reform, remains a model of evidence-informed policymaking. Preserving and strengthening that system is our best hope for aligning EBM with its original purpose: improving health by making decisions that are both scientifically sound and socially responsive.

■

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Does your institution have an event scheduled for 2027 that lasts longer than 8 hours? If so, the EpiMonitor would like to add it to our annual event calendar which reaches 35,000+ epidemiologists, biostatisticians, and public health professionals.

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- ▶ Event Type
(Short Course / Conference / Meeting / Summer or Winter Programs / Miscellaneous Events)
- ▶ Event Sponsor(s)
- ▶ Event Location (including virtual / hybrid)
- ▶ Event Date(s)
- ▶ Event Contact Information (URL or Email address)

For more information please contact:

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How to Discuss Vaccines Across the Partisan Divide

Interviewer: Sarah Talpos

NOTE: *This interview was originally printed by [Undark Magazine](#) on January 9, 2025 and we thank them for their permission to reprint.*



Biostatistician Jeffrey Morris says effective dialogue requires an awareness of how politics shape a person's beliefs.

What's the best way to discuss vaccines with a politically polarized public? Jeffrey Morris has been considering this question since the Covid-19 pandemic, when he created a dedicated [blog](#) and ramped up his use of [X](#) (formerly Twitter) in an effort to pass along trustworthy information about the new virus. He eventually came to focus on Covid-19 vaccines, in part because so many false claims were circulating about them online.

As a biostatistician, Morris was well-positioned to explain statistical concepts and techniques employed in vaccine studies. But good communication requires more than data, he said. Social media and artificial-intelligence algorithms have helped create opposing echo chambers, in which individuals aligned with one group may view members of another group with distrust or even hostility. Particularly under these conditions, Morris says, effective dialogue requires respect, transparency, a willingness to acknowledge uncertainty, and an awareness of how politics and partisanship can shape a person's beliefs.

Morris' views seem particularly timely given the



Jeffrey S. Morris, PhD
University of Pennsylvania - Director, Biostatistics

contentious atmosphere surrounding Robert F. Kennedy Jr.'s nomination to become the next head of the Department of Health and Human Services. "My primary concern is that the HHS director, whoever it is, follows the principles of evidence-based science," Morris said. "To me that means using all of the best available evidence from the existing studies and data to guide practice and recommendations."

Morris recently published a [commentary](#) in the American Journal of Epidemiology that summarizes the evidence about the effectiveness of Covid-19 mRNA vaccines over time and that discusses some of the fallacies that have proliferated online. He is currently the director of the Division of Biostatistics at the University of Pennsylvania's Perelman School of Medicine.

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Our interview was conducted over Zoom and has been edited for length and clarity.

Undark: You're a biostatistician, which is not a job one usually associates with politics. Yet you've suggested it's important for people who work in public health to be thoughtful about politics and political polarization when communicating about vaccines. Can you elaborate?

Jeffrey Morris: People's political views have a major impact on what information is presented to them and how they frame that information. Because of this, when it comes to scientific communication of public health messages, politics must be taken into account. There's a few principles that I think we need to keep in mind.

First, we should all self-scout and be mindful of our own political beliefs and views that could bias how we view and interpret the emerging data, and for scientists to be disciplined to try to remove that bias and to see the data as objectively as possible.

Second, I think scientists, especially those involved in scientific communication, should be very careful not to overtly identify themselves with one political side or the other. In my opinion, it would be best if those individuals keep their political views private, but it's critical to at least avoid blatant partisan comments, and especially to not attack individuals they perceive to be on the other political side. Especially in matters of public health, it's crucial to effectively engage the entire society, as we can't afford to alienate half the population by being perceived as partisan.

Third, I think we need to understand and account for the political diversity of our society

in our scientific communication and our public health messaging. During the pandemic, I frequently witnessed people being silenced for asking legitimate questions about matters such as varying Covid risks across different [groups](#), the potential collateral effects of mitigation policies, the immunity from previous infections, and vaccine [safety](#) — often because their inquiries were linked to specific political or policy perspectives.

I think we would be in a stronger position regarding public trust if policy makers, the media, and the scientific community had done a better job of listening to those questions, responding objectively with evidence-based answers, openly acknowledging the uncertainties in our knowledge, and the potential limitations of the policies, and most importantly, showing respect for those asking the questions.

The impatient and aggressive responses to these questions only deepened polarization and division, driving people into the arms of those spreading false information, thereby legitimizing and empowering them.

UD: A clear majority of Americans, [69 percent](#), say that it's extremely or very important for children to be vaccinated. But this number has fallen by 25 percentage points since 2001. What do you think is driving the decline?

JM: It's difficult to know for certain, but there's a number of likely factors that I think are important here. First of all, the past 25 years have been characterized by the emergence and organization of anti-vaccine activism, partially fueled by the later [retracted](#) Wakefield paper.

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[That paper, which claimed to show a link between vaccines and autism, was found to be [incorrect and fraudulent](#). Subsequent [studies](#) have found [no such link](#).]

Looking at the report you cited, it's interesting that 15 of the 25-point decline has occurred just since the beginning of the pandemic. It's clear that pandemic-associated factors have accelerated this decline. So if we think about the factors: the rapid development, approval, and deployment of Covid vaccines raised significant concerns to many, as did the fact that some of these vaccines utilize cutting-edge technologies that had not previously been publicly disseminated. I think that's one factor.

But I also believe that the widespread [mandates](#) for these vaccines strongly contributed to this backlash. Had they been voluntary, individuals with serious concerns could have simply chosen to decline them. However, the sense of being coerced into taking the vaccines heightened fear and anxiety, fostering an environment that allowed vaccine skepticism to grow. These factors also heightened the visibility and influence of vaccine skeptics, including not only those who raise legitimate questions and concerns, but also those spreading false claims and exaggerating the vaccines' harms.

I also believe the false claims about Covid vaccines, which continue to circulate and thrive on social media, have contributed to a decline of trust in vaccines. This opposition now seems to have expanded more broadly to include all vaccines.

It's also worth noting that the survey you cited also highlights an escalating political divide on this issue, further reinforcing the concerns I raised earlier about political influence and selective information.

UD: Can you tell me about the work that you're doing with the Annenberg Public Policy Center?

JM: I'm working with them to help prepare materials to educate the public about the vaccine safety monitoring systems used in the USA, including passive reporting systems like [VAERS](#) to identify potential safety signals, as well as active reporting systems looking at medical records and claims data to test and validate them. There's been a great deal of misunderstanding of these systems and their nuances, much of it related to statistical aspects of how to properly interpret the data from the various systems.

We're also working to study the effectiveness of these messages using randomized designs within the [Annenberg Science and Public Health Knowledge survey](#), or ASAPH. This study uses a diverse cohort of individuals from across the political spectrum to assess beliefs and understanding and then utilizes randomization to assess the effectiveness of particular scientific communication strategies.

Just trying to rigorously evaluate scientific communication itself — using randomized studies and careful cohort designs — is, to me, very interesting and promising.

UD: I think you had spoken to me once before about how there's a tendency, sometimes, to simplify messaging around vaccines so that it's understood by everyone, but that there may be a desire for more sophisticated levels of information.

JM: Yes, actually, I think part of what has contributed to some of the confusion and maybe even loss of trust among the public has

been oversimplification of messaging, either by media or by scientific communicators. Sometimes that's done to try to promote practices and recommendations that they determine to be good for the public health.

They want to keep the message simple because they think that has the best chance of being understood. But I think that this can kind of backfire.

Much of the public in the U.S. is quite sophisticated and educated. If they feel like they're being talked down to, or talked to like children — and especially if nuances that are easily found online are ignored and withheld from the public, the way parents might withhold more difficult-to-explain information from a child — this contributes to the erosion of trust.

In controversial issues, in newly emerging issues, where there's considerable uncertainty — where there's real risks, where there's real concerns — transparency is critical to show the public that nothing is being hidden. Everything is being looked at.

I understand the concern that once you acknowledge a risk, it's akin to leaving a door cracked, and some people will come and try and kick that door open. For example, if there's a new vaccine that has a rare but serious risk in some subgroup. This becomes known to scientists and published but some people are hesitant to talk too much about it because some will exaggerate that risk and try and use that to disproportionately criticize the vaccines. But coming back to that main point, I think it's critical for scientific communication to be done as transparently and as completely as possible.

UD: Prominent public health officials have expressed concern about Robert F. Kennedy

Jr.'s nomination for head of Health and Human Services, particularly with regard to his views on vaccines. Do you share these concerns?

JM: I would be concerned if there was any move to discontinue any of the current childhood vaccines, or to discourage parents from vaccinating their children, either directly or indirectly, since this could invite dangerous childhood diseases that have been previously eradicated and controlled to return.

I support any efforts to promote rigorous studies to answer important unanswered questions. But it's also important that all existing scientific knowledge be taken into account, and in particular, that all the available literature needs to be considered when identifying the research gaps that need to be addressed and prioritized, or any policies and recommendations that they think need to be revisited.

UD: Is there anything else that you'd like to add?

JM: I think if you have people that are both well-intentioned making good faith arguments about what they really believe, and they respect each other, and they're curious to understand the other perspective, I think it's possible for any two people to talk about any issue, no matter how controversial.

I think people can even talk about politics and religion in this manner, if they're disciplined to have respect for the other person, to be curious about what they believe, and to not just try and attack them and tell them they're wrong, but

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them. Then it's fair enough for you to say, "I agree with this part, but this is the part I disagree with."

If we talk that way to each other — if we dealt that way with the uncertainty of accruing scientific knowledge — I think we would all discover the truth together, and we would be

unified in it. But that process and discourse, especially in modern society, is more and more rare to see. ■



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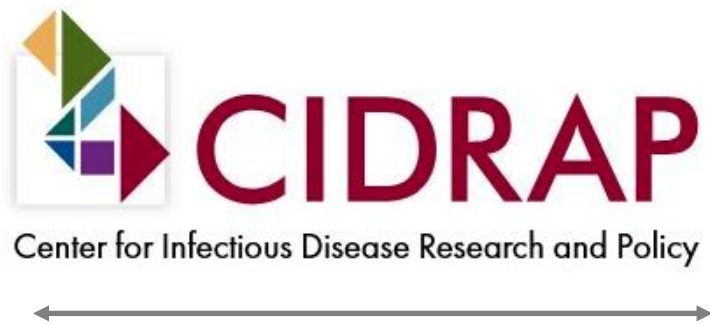
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Adoption of AI Outpaces Training in Field Epidemiology Programs

Author: [Laine Bergeson](#)

Note: This piece was originally published by the [University of Minnesota's CIDRAP \(Center for Infectious Disease Research and Policy\)](#) on July 27, 2026 and is printed here with their full permission.



A new study found that two-thirds of epidemiologists in specialized training programs used artificial intelligence (AI) in their work, despite only one in five having received AI training and one-quarter expressing ethical concerns about accuracy and bias.

For [the study](#), published in *Eurosurveillance*, researchers led by a team at the Public Health Agency of Canada surveyed 105 participants in Field Epidemiology Training Programs (FETPs), referred to as field epidemiologists, about their use of AI. The survey consisted of 20 open- and closed-ended questions written in a neutral tone to reduce response bias. The respondents hailed from Canada, Europe, and the United States.

FETPs are specialized programs that train participants to develop technical capabilities in applied epidemiology and improve their professional judgment and ability to communicate information.

While AI has the potential to improve efficiency for field epidemiologists, the researchers write, it also raises concerns about the development of critical-thinking skills and professional discernment in a field that “places a premium on judgment and interpretation, and the ability to communicate uncertainty.”

Troubleshooting coding errors

Among the 105 respondents, 66% said they use AI in their field epidemiology work. AI adoption was highest among fellows in the European program (32 of 36 [89%]), compared with 30 of 56 (54%) in the US program and seven of 13 (54%) in the Canadian program. Use difference was not statistically significant between first- and second-year fellows.

Among AI users, 42% said they use the technology weekly, 30% said they use it daily, and 26% reported using it occasionally. Most reported feeling either somewhat comfortable (49%) or comfortable (35%) using AI, while 12% reported feeling very comfortable, and 4% reported feeling uncomfortable.

ChatGPT was by far the most commonly used platform (87%), followed by institution-specific AI tools (25%).

The most common applications of AI were troubleshooting coding errors (91%), writing code (75%), and improving work efficiencies (42%). Qualitative responses suggested that AI generally improved coding efficiency.

- Adoption cont'd on page 27

“AI reduced the time spent troubleshooting coding errors, aided in learning new coding techniques, simplified existing code, facilitated code transfer across different coding software programmes, and was helpful for generating ideas for data analysis,” the researchers note.

Respondents also said AI helped improve writing quality and efficiency, as well as streamline routine administrative tasks, such as writing meeting minutes and organizing project timelines. Some said AI helped them better understand new topics, conduct background research, and summarize information.

Training lags behind adoption

At the same time, 41% of AI users reported barriers to adopting the new technology. Common concerns included technical limitations, limited access to AI tools, uncertainty about institutional rules governing AI use, and questions about the accuracy and reproducibility of AI-generated content. One-quarter of AI users also reported ethical concerns, including data privacy, potential bias, environmental impacts, and the possibility of overreliance on AI.

Respondents said they wanted practical instruction on using AI for coding, data analysis, scientific writing, data visualization, and outbreak detection.

The survey also found substantial gaps in institutional guidance and training. Only one in five fellows reported receiving any formal or informal AI training.

Respondents said they wanted practical instruction on using AI for coding, data analysis, scientific writing, data visualization, and outbreak detection, as well as training on ethical considerations and effective prompting strategies. Respondents also expressed interest in learning about the limitations of AI, such as increased awareness of common mistakes.

Curricula should promote AI literacy

The authors say FETP curricula should promote AI literacy and include education on the technology's limitations, biases, and ethical implications, especially now that it has become a routine part of field epidemiology practice for many training program participants.

“Possible recommendations for training might include hands-on workshops, real-world case studies, and access to AI tools and platforms,” they write. “The FETPs need to ensure learners gain experience using AI in foundational epidemiological tasks like coding, study design, data analysis, scientific writing, and topics such as surveillance and outbreak detection.” ■

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FREE Resources

Online Epidemiologic & Statistical Calculators

Note: This month's free resource list comes to us from our friends at [Epi Centre](#)

Here is a list of free online epidemiologic and statistical calculators. These are free programs that are available online through use of a browser and therefore do not require installation of software. These programs can be useful for a number of purposes:

1. In teaching epidemiology and biostatistics, students can use these simple calculators and focus on the interpretation of the results. Sometimes when students need to write programs to get the answers, such as R or SAS, the focus is on the programming and less on interpretation.
2. For analyzing data, sometimes the raw data is not available and these calculators provide a simple way to perform the analysis. Note that most statistical programs can deal with reading summary data but frequently this takes more time than just plugging the summary data in a calculator.
3. Some calculators provide statistical analysis output that might not be available in some statistical programs.

I have used many of these programs over the years and used ChatGPT to identify other similar programs which are in the list below. Let me know if of your thoughts on these programs and if you know of the useful programs.

Calculator	Primary Focus	Selected Capabilities
1. OpenEpi	Epidemiology	2x2 tables, stratified analysis, rates, proportions, diagnostic tests, sample size/power, matched case-control, ANOVA, dose-response
2. OpenEpiSheets	Epidemiology	Epidemiologic/biostatistical calculators implemented in Google Sheets; sample size, analysis, and power (Beta version)
3. EpiTools – Ausvet	Epidemiology	2x2 and stratified analysis, prevalence, diagnostic tests, cohort/case-control sample size, surveillance, pooled testing
4. Statulator	Epidemiology Biostatistics	Sample size, CIs, hypothesis tests, stratified analysis, CSV dataset analysis, graphics
5. EpiCalc – PHT Lab	Epidemiology	Attack rates, OR/RR, DALYs, vaccine efficacy, screening test performance (Se/Sp/PPV/NPV), an SIR/SEIR epidemic simulator, and a general biostatistics suite (sample size, t-test, chi-square, ANOVA)

- Calculators cont'd on page 29

Calculator	Primary Focus	Selected Capabilities
6. EpiStat – PHT Lab	Epidemiology	Stratified analysis (Mantel-Haenszel), R x C tables, SMR, matched case-control, dose-response, WHO child-growth standards, and other statistics
7. EpiPlus – PHT Lab	Epidemiology Biostatistics	Design effect, cluster/stratified sample size, DALYs, PAF, standardization, VE, NNT/NNH, Poisson regression, meta-analysis
8. Wepisia	Epidemiology	OpenEpi-derived calculations plus epidemic simulation, mapping and in-browser R, in French
9. MedCalc Online Calculators	Medical statistics	Means, proportions, rates, RR, OR, NNT, diagnostic tests, ROC, sample size/power
10. GraphPad QuickCalcs	Biostatistics	Fisher exact, chi-square, McNemar, proportion CI, NNT, t tests, regression, distributions
11. Sample-Size.net – UCSF	Sample Size / Clinical research	Proportions, means, RR, diagnostic tests, clustered designs, logistic regression, survival, precision
12. ClinCalc	Clinical statistics	Sample size, power, NNT, OR-to-RR conversion, fragility index
13. SRUC Sample Size Calculator	Veterinary epidemiology	Prevalence estimation, disease detection and epidemiologic sample-size calculations
14. Social Science Statistics	General statistics	t tests, ANOVA, chi-square, Fisher exact, proportions, correlation, nonparametric tests, regression, power
15. VassarStats	General statistics	t tests, contingency tables, proportions, ANOVA, regression, correlation and other statistical procedures

For more information or to provide additional tools for this list, please contact Epi Centre as follows:

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RFP 101: Interested in Contract Work? - Here's Where to Start

Author: [Khurram Imam](#)

as published by Public Health Hiring Help

NOTE: This article was originally published on Substack by [Public Health Hiring Help](#) on September 14, 2026 and is reprinted here with their permission.



Imagine two public health professionals apply for the same contract role, just as they would a job, with similar experience, work quality, and qualifications. How does a client choose between them? While passion drives the professional, it is often the story a proposal tells that is the deciding factor.

Here's how to build one that holds up.

Understand the Request For Proposal (RFP) First

RFPs are lengthy, but worth examining. Do you meet the actual qualifications? Will the evaluation criteria favor you or is it a stretch? Before writing a word, carefully read the RFP guidelines—take note on *exactly* what the client is requesting.

RFPs usually outline the following:

- **Evaluation Criteria** — outlines how the sections will be scored and whether it will be based on a points or percentage system.
- **Required Forms and Attachments** — documents required by the client as part of the proposal. NOTE: review these as far

in advance as possible—some may take time to organize!

Fit, Not Flattery, is the Key

Reviewers look for the consultant or contractor who can address their specific problem. Focus your opening section on addressing this key question: *"Why am I the most suitable person for this RFP's work?"*

The opening is the place for honesty. Address any gaps, such as an unfamiliar field, population, or skill, by both naming it and discussing how you are actually and actively closing the gap, such as bringing in a qualified collaborator or by taking trainings.

Be Precise with the Budget

The types of items you can consider as line items in the budget include your rate or day fee, subscriptions to a tool specific to the project, equipment or materials, travel costs, and any services you may need to subcontract, such as a translator for an interview.

Many RFPs have a budget template you must follow. In that case, the work is simply to fill in the appropriate numbers.

For those that do not, identify the narrative structure of your proposal—such as deliverables, tasks, phases, or time frames—and break down the project costs in that outline.

- RFP cont'd on page 31

For example, if you organized your project through deliverables, use each section to identify all connected costs.

RFP Example

I recently responded to an RFP from a national disability rights organization looking to evaluate a core program's data collection tools. I built my proposal around four moving parts, in this order:

- **A research design to answer the evaluation question:** The RFP wanted to understand the tools and processes used to gather responses. I shared a concurrent mixed-methods design: a document with a tool inventory, stakeholder interviews and focus groups, then structured analysis against the field's own alignment standards. *Every method mapped directly back to the RFP's objectives.*
- **Dates connected to workplan phases:** Four phases, each with a named deliverable and a milestone check-in, so the client understood what each week would look like even prior to the contract beginning.
- **A detailed budget that connected to my narrative:** Every phase in the work

plan had its own budget line that explained the expected hours, rate, and total cost. The client could use this to connect every dollar back to a specific tool or deliverable per phase. My final budget came in under the client's stated maximum. I explained the difference in a short note and recommend that all do this explain their budget reasoning.

- **A necessary disclosure of any relevant information:** I had an international trip planned that overlapped with a small part of the project period. Instead of excluding it and having it be an issue in latter discussions, I addressed my availability and proposed how I would manage the work around it.

Finally, once you have gotten it all on paper, review it! The draft you submit should be your best effort for that time.

Network continuously. The best opportunities come from a place where you have an established relationship. Knowing the client may give you a leg-up in the review process. And, remember, practice makes perfect! Over time, you will improve as you become more comfortable writing proposals.

■



Khurram Imam is the Director of Zaki Impact Consulting, where he helps governments, nonprofits, and foundations design strategies and programs that are equitable, measurable, and built to last. His work sits at the intersection of public health, community systems, and workforce development. Connect with him on [LinkedIn](#) or explore his services at khurramimam.com/services.

Epi Word Search – September 2026

Statistically Speaking

This month's puzzle honors the calculators in our Resources section in this issue. That should make it easy for you to work the puzzle. Good luck - don't let the puzzle frustrate you!

For an interactive online version go to: <https://tinyurl.com/373vdkj>

D T D P P E R C E N T I L E N Q A S A C
O D E C N E D I C N I V Q P E E A E T I
P A R A M E T E R A A U S R O M L M E D
E P P S D Q I A E E A Y T R P U U M V T
Q R M V A S T T A R T T L L R E Y L I P
U E T E V I L T T I T R E E E R U L T A
A V V R D A C I V Q S P E P C E D G A A
L A E T M A L I P P E T G D N M I C T A
I L T E B E T N E N T E N P A E E E I T
T E T P T I L C R R V O A R S A A E T A
A N U D S T I R N E T A R A O N E I N D
T C R N I F I O D I V E L E L C E O A A
I E E E I S I M I N V S A U N R I E U E
V S M C A T C G N A I D E M E T L T Q C
E S I I A P E R T T D P V P A B A G R I
A T R I A V D A E U E V A L A A E T Q P
Y S V T D A A C E T P E U I O E N D I C
Y E C R E I L T U O E P R A P A I N T I
D U E L L E V F P C O A U R L I V I C L
I Y D I S I E E C P V L E I A L V E R B

Words to find:

1. Data
2. Deviation
3. Discrete
4. Incidence
5. Mean
6. Median
7. Outlier
8. P Value
9. Parameter
10. Percentile
11. Population
12. Prevalence
13. Qualitative
14. Quantitative
15. Quartile
16. Range
17. Sample
18. Sensitivity
19. Specificity
20. Value

Statistically Speaking by Michele Gibson
Powered by [PuzzleMe™](#)

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Contact: Michele Gibson / 770.309.7937
michele@epimonitor.net

What We're Reading This Month

Editor's Note: All of us are confronted with more material than we can possibly hope to digest each month. However, that doesn't mean that we should miss some of the articles that appear in the public media on topics of interest to the epi community. The EpiMonitor curates a monthly list of some of the best articles we've encountered in the past month. See something you think others would like to read? Please **send** us a link at info@epimonitor.net and we'll include it in the next month.

Public Health Topics

- ♦ Applying machine learning to identify unrecognized COVID-19 deaths recorded as other causes of death in the United States (Science)
<https://tinyurl.com/5n8s32mm>
- ♦ Why are so many Indigenous Panamanians contracting HIV — and dying of AIDS? (NPR)
<https://tinyurl.com/3k2kxc4b>
- ♦ Clinical research careers: £155mn funding for doctoral training programmes (Wellcome)
<https://tinyurl.com/rxwh2ju3>
- ♦ A mysterious kidney disease has arrived in Texas (Texas Monthly)
<https://tinyurl.com/239kbfk7>
- ♦ Leading medical groups are issuing their own vaccine guidance to fill a federal vacuum (NPR)
<https://tinyurl.com/2mbuembh>
- ♦ Congo's Ebola outbreak shows no signs of slowing as deaths top 3,000 (AP News)
<https://tinyurl.com/e396eztr>
- ♦ Scientists living on a remote sub-Antarctic research base are told to evacuate over a potential outbreak of a highly contagious bird flu (Daily Mail)
<https://tinyurl.com/2nbbr8cc>
- ♦ Study's Alarming Finding: At Least 1 in 4 N.F.L. Players Gets Brain Disease (NYT Gift Article)
<https://tinyurl.com/5aypwsx4>
- ♦ Mapping the unseen: advancements and innovations in spatial epidemiology for disease dynamics and public health interventions (Frontiers)
<https://tinyurl.com/mrah9s4v>

- Reading cont'd on page 34

Public Health Topics

- ♦ Kids in a wealthy California suburb are getting a rare cancer. Parents are desperate for answers. (LA Times via AppleNews)
<https://tinyurl.com/2zky2pzh>
- ♦ Seven ways to improve observational epidemiology and build trust (Nature)
<https://tinyurl.com/2dueajyd>
- ♦ How Ondo State is confronting Nigeria's changing Lassa fever threat (GAVI)
<https://tinyurl.com/5s32vtrb>
- ♦ Want to predict Lyme disease risk? Count the acorns, not the deer (CIDRAP)
<https://tinyurl.com/m25uez8c>
- ♦ Scientists Create Most Detailed Map Yet of Proteins Linked to Autism (NatGeo via AppleNews)
<https://tinyurl.com/ysv4mwks>
- ♦ Scientists are using AI to design new viruses. Should they be? (Scientific American)
<https://tinyurl.com/4yjndh5t>
- ♦ The family at the center of Pennsylvania's measles controversy tells their story (The Atlantic via AppleNews)
<https://tinyurl.com/4spfnkfe>
- ♦ DRC's Ebola Lessons: Learned and Unlearned (Part I) (Health Policy Watch)
<https://tinyurl.com/ma3wv6mp>
- ♦ Declining Flu Vaccination Rates Could Increase Severity of 2026 Influenza Season (Respiratory-Therapy)
<https://tinyurl.com/4wfkadtk>
- ♦ How the Death of a Newborn Has Inflamed a Debate Over Vaccination (WSJ via AppleNews)
<https://tinyurl.com/mswp3etm>

Notes on People

Do you have news about yourself, a colleague, or a student?

Please help The Epidemiology Monitor keep the community informed by sending relevant news to us at this address for inclusion in our next issue. michele@epimonitor.net



Honored: APHA has announced that **James Curran, MD, MPH**, dean emeritus and professor of epidemiology and global health at Emory University's Rollins School of Public Health, will receive the 2026 Sedgwick Memorial Medal for Distinguished Service in Public Health for his early and ongoing research promoting HIV/AIDS prevention and policy. His decades spent at the Centers for Disease Control and Prevention in the early years of the HIV/AIDS epidemic has been key to recognizing disease transmission and developing surveillance strategies that continues to save lives.



Honored: Jack Tsai, PhD, regional dean and professor of public health at UTHealth in San Antonio, will receive the 2026 APHA Award for Excellence for his innovative and evidence-based solutions to reduce and prevent homelessness. Tsai's work ranges from community-based interventions to national research projects that influence broader policy. His work as a research director for the National Center for Homelessness Among Veterans has helped halve veteran homelessness over a decade. His academic roles at both UTHealth and Yale University have resulted in research programs that emphasize holistic approaches to reducing homelessness, and health professionals who are trained to provide primary and preventive care services.



Honored: APHA has announced that **Theodore Tulchinsky, MD, MPH**, professor emeritus at Hebrew University of Jerusalem, will receive the 2026 Victor Sidel and Barry Levy Award for Peace for promoting health diplomacy among Israeli and Palestinian health authorities to prevent the spread of infectious diseases and strengthen the global public health workforce. Tulchinsky, a former public health director for Israel's Ministry of Health and supervisor of health in the West Bank and Gaza, built connections between researchers and healthcare professionals that resulted in improved maternal and child health outcomes and vaccination campaigns to eradicate polio and measles in Gaza.

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Honored: [Daniel Belsky](#), PhD, associate professor of Epidemiology at Columbia University Mailman School of Public in the Robert N. Butler Columbia Aging Center, has been named a 2026 Fierce 50 honoree by the editors of Fierce Pharma, Fierce Biotech and Fierce Healthcare. The Fierce 50 recognizes 50 individuals and organizations driving advancements in medicine, fostering innovation and shaping the future of biopharma and healthcare.



Honored: University of Michigan's **Donglin Zeng** was honored recently with the School of Public Health's 2026 Excellence in Research Award, which recognizes faculty whose research shows strong impact, innovation, productivity, creativity, leadership, interdisciplinarity and recognition by peers. His record reflects that broad reach: He has published more than 350 articles, been cited more than 17,000 times and holds an H-index of 65, a measure of sustained research impact. Zeng, who joined Michigan Public Health in 2023 after more than 20 years on the faculty at the University of North Carolina at Chapel Hill, has become a leading researcher at the intersection of statistics, machine learning and precision medicine.



Honored: **Alexander Sundermann**, DrPH, assistant professor of epidemiology at the University of Pittsburgh School of Public Health, has been named to Pittsburgh Magazine's 2026 40 Under 40 class. The annual recognition honors 40 professionals under the age of 40 who are making an impact in the Pittsburgh region through their professional accomplishments, leadership and community contributions.



Honored: **Dr. David Fardo**, Stephen W. Wyatt Endowed Professor of Public Health and Professor of Biostatistics at the University of Kentucky, will be the recipient of the 2026 Lagakos Distinguished Alumni Award. Dr. Fardo has built a broad research program at the intersection of biostatistics, genetics, and public health. His work uses statistical approaches to investigate complex questions in Alzheimer's disease, neurodegenerative disease, and aging, with additional expertise in genome-wide association studies and longitudinal data analysis.

Notes on People, con't from page 36

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Named: After serving as interim chair for the past two years, [Sudesh Srivastav](#) has been appointed chair of the Department of Biostatistics and Data Science at the Celia Scott Weatherhead School of Public Health and Tropical Medicine. Srivastav's background includes biostatistics, quantitative bioinformatics, experimental design, clinical trials, resampling methods and biological data analysis. The longtime professor has been part of the Tulane community since 1999.



Named: Shu (Joy) Jiang, the Eddie Goldenberg Research Chair of Canada in Translational Digital Health, is a biostatistician from Washington University School of Medicine in St. Louis who focuses on bringing artificial intelligence into clinical practice. She along with five other researchers at the forefront of advances in human health, technology, the natural world and the next frontier who have joined the University of Toronto through [a major federal initiative](#) to bring top international talent to Canada.



Named: SUNY Distinguished Professor **Pauline Mendola**, chair of the Department of Epidemiology and Environmental Health in the School of Public Health and Health Professions, has been named a Fellow of the International Society for Environmental Epidemiology (ISEE), one of the highest honors bestowed by the organization.



Appointed: [Michael Bloom](#), professor in George Mason University's Department of Global and Community Health, was appointed as a member of the Reproductive, Perinatal and Pediatric Health Study Section, Population Sciences and Epidemiology Integrated Review Group, which is part of the National Institutes of Health Center for Scientific Review.

Notes on People, con't from page 37

Do you have news about yourself, a colleague, or a student?

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Named: [Jon Donnelly, PhD](#) has joined Johns Hopkins Bloomberg School of Public Health as an assistant Professor. With a PhD in computer science from Duke University, Donnelly studies machine learning tools that integrate human medical expertise to solve problems in healthcare. His work spans a variety of tasks using unstructured data, from personalized risk scoring to scientific discovery, with applications in breast cancer, neurology, and virology. In each of these tasks, he aims to empower domain experts to understand, edit, and learn from complex models.



Guilty Plea: **Poul Thorsen**, a 65-year-old Danish researcher and former federal fugitive, pleaded guilty September 1st to wire fraud for operating a scheme that stole over \$1 million in federal grant money intended for overseas autism research. Thorsen previously served as a visiting scientist at the U.S. Centers for Disease Control and Prevention. Between 2000 and 2009, the CDC awarded more than \$11 million in grants to two Danish governmental agencies to study relationships between autism and vaccine exposure, cerebral palsy and infection during pregnancy and childhood development and fetal alcohol exposure.



Passed: Former Vermont Health Commissioner, **Dr. Anthony Robbins**, passed away at his home on July 5th. His death, which was not widely reported at the time, was caused by complications of long Covid, heart disease and Parkinson's disease. Over a career spanning roughly six decades, as a physician, professor, editor and health policy expert, Dr. Robbins was often willing to take controversial stands.

At the federal level, Dr. Robbins became the director of the National Institute for Occupational Safety and Health from 1978 to 1981, advising the White House on the government's response to the Three Mile Island nuclear accident in Pennsylvania in 1979. From 1981 to 1986, he worked on the senior health staff of the U.S. House Energy and Commerce Committee. He helped negotiate enhanced warning labels on cigarette packages. In 1993 and 1994, Dr. Robbins took leave from his own professorship, of public health at Boston University, to direct the first national vaccine plan for the Clinton administration.

<https://tinyurl.com/yk8zyt35>

Near Term Epidemiology Event Calendar

Every December The Epidemiology Monitor dedicates that issue to a calendar of events for the upcoming year. However that often means we don't have full information for events later in the upcoming year. Thus an online copy exists on our website that is updated regularly. To view the full year please go to: <http://www.epimonitor.net/Events> The events that we are aware of for the next month follow below.

October 2026

October 5-7 **Type:** Conference **Web:** <https://tinyurl.com/muyzzc9t>
Title: International Vaccines Conference
Sponsor: Magnus Group **Location:** Tokyo, Japan & Virtual

October 11-12 **Type:** Conference **Web:** <https://tinyurl.com/d24vwhnt>
Title: International Symposium on Public Health and Epidemiology
Sponsor: Scisynopsis Conferences **Location:** Singapore

October 18-21 **Type:** Conference **Web:** <https://tinyurl.com/2nerrtrp>
Title: ISPE Annual Conference
Sponsor: ISPE **Location:** Washington, DC

October 20-24 **Type:** Conference **Web:** <https://tinyurl.com/u2r3hncc>
Title: American Society for Human Genetics 2026 Annual Meeting
Sponsor: ASHG **Location:** Montreal, Canada

October 21-24 **Type:** Conference **Web:** <https://idweek.org/>
Title: IDWeek
Sponsor: Multiple **Location:** Washington, DC

October 22-23 **Type:** Conference **Web:** <https://tinyurl.com/mryn44sk>
Title: 9th Intl Conference on Public Health, Well-being and Healthcare Management
Sponsor: Conference Series **Location:** Paris, France

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or on Twitter at: @theEpimonitor or on Instagram at: @epimonitor

Near Term Epidemiology Event Calendar

November 2026

November 1-4 **Type:** Conference **Web:** <https://tinyurl.com/3hak6y99>
Title: APHA Annual Meeting & Expo
Sponsor: American Public Health Association **Location:** San Antonio, TX

November TBD **Type:** Conference **Web:** <https://bit.ly/3jcNVcY>
Title: 19th European Public Health Conference
Sponsor: EPH **Location:** TBD

November TBD **Type:** Conference **Web:** <https://tinyurl.com/ukxk929m>
Title: 18th International Conference on Molecular Epidemiology and Evolutionary Genetics of Infectious Diseases / MEEGID XVIII
Sponsor: Elsevier **Location:** TBD

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Open Public Health Positions

The list below has been compiled by [Public Health Hiring Help](#) the new Substack column that has been created to help individuals in the public health community find positions in the midst of the chaos that is now impacting governmental agencies and grant recipients. This list represents the most current positions PHHH has been able to identify. We thank PHHH for their permission to reprint these listings.

State of NM, [EH Assessment Epidemiologist](#) (Albuquerque, NM)

\$84-134k + benefits, Master's min

State of NM, [Toxicology Quality Assurance Coordinator](#) (Albuquerque, NM)

\$57-85k + benefits, Bachelor's min

Avalere Health, [Policy Research Scientist I](#) (Remote)

\$90-110k + benefits, Bachelor's min, Master's preferred

CDC Foundation, [HIV/AIDS Epidemiologist](#) (NYC)

\$70-75k + benefits, Bachelor's min, Master's preferred

RTI Health Solutions, [Implementation Science Research Associate](#) (Remote)

Not listed + benefits, Bachelor's min, Master's preferred

VA Health Care Foundation, [Program and Data Coordinator](#) (Richmond, VA)

\$70-85k + benefits, Bachelor's min, Master's preferred

IQVIA, [Clinical Research Associate](#) (Multiple locations)

\$72-140k + benefits, Bachelor's min

NYC Dept of Health, [Early Intervention Outreach Specialist](#) (NYC)

\$71k + benefits, Bachelor's min

NYC Dept of Health, [Disaster Epidemiology Research Scientist](#) (NYC)

\$98-113k + benefits, Master's min

Cook County Dept of Health, [Enhanced Surveillance Program Coordinator](#) (Chicago, IL)

\$99-115k + benefits, Master's min

WY Dept of Health, [Public Vaccine Program Manager](#) (Cheyenne, WY)

Not listed + benefits, Bachelor's min, Master's preferred

GA Dept of Health, [Emergency Preparedness Specialist](#) (Waycross, GA)

\$53-73k + benefits, Bachelor's min, Master's preferred

Open Public Health Positions

Health Research Inc, [Health Programs Administrator II](#) (Menands, NY)
\$100k + benefits, Bachelor's min, Master's preferred

Health Research Inc, [Grants Administrator I](#) (Menands, NY)
\$90k + benefits, Bachelor's min, Master's preferred

Task Force for Global Health, [Polio Eradication Support Specialist](#) (Atlanta, GA)
Not listed + benefits, Bachelor's min

Emory Univ, [Aging and Caregiving Research Associate](#) (Atlanta, GA)
Not listed + benefits, Master's min

Johns Hopkins Univ, [Mental Health Research Project Assistant](#) (Baltimore, MD)
\$50k + benefits, Bachelor's min

State of CT, [Toxic Hazards Epidemiologist](#) (Hartford, CT)
Not listed + benefits, Master's min

Allies in Caregiving, [Social Enterprise and Youth Development Manager](#) (Hammonton, NJ)
\$65-78k + benefits, Bachelor's min

Treatment Advocacy Center, [Education Program Specialist](#) (Remote)
\$68-72k + benefits, Bachelor's min

Boehringer Ingelheim, [Global PV and Epidemiology Specialist](#) (Johns Creek, GA)
Not listed + benefits, Bachelor's min

Univ of CA Davis, [Violence Prevention Research Analyst](#) (Davis, CA)
Not listed + benefits, Master's min

State of OH, [Public Health Consultant](#) (Columbus, OH)
\$70k + benefits, Bachelor's min

Southern NV Health District, [Public Health Informatics Scientist](#) (Las Vegas, NV)
\$95-140k + benefits, Bachelor's min

Avalere Health, [Vaccine Policy Consultant](#) (DC)
\$90-110k + benefits, Bachelor's min, Master's preferred

State of VA, [Epidemiologist](#) (Richmond, VA)
\$73-78k + benefits, Master's min

Open Public Health *Intern* Positions

Congressional Black Caucus Foundation, [Communications Intern](#) (DC)

Public Health Alignment: HPM, BSHEs, GH, Undergrad, Grad

Center for Reproductive Rights, [Long Acting Contraceptives Advocacy Intern](#) (Bogota, Colombia)

Public Health Alignment: RMACH, BSHEs, GH, Undergrad, Grad

PATH, [Office of the President Intern](#) (London, UK)

Public Health Alignment: GH, HPM, Undergrad, Grad

Accenture, [Health Consulting Intern](#) (Chicago, IL)

Public Health Alignment: BSHEs, HPM, EPI, Grad

State of SD, [Maternal Child Health Intern](#) (Sioux Falls, SD)

Public Health Alignment: RMACH, BSHEs, HPM, Undergrad, Grad

State of AZ, [Program Coordinator Intern](#) (Phoenix, AZ)

Public Health Alignment: RMACH, BSHEs, EH, Undergrad, Grad

World Vision, [MEAL and Child Protection in Emergencies Intern](#) (Remote)

Public Health Alignment: GH, BSHEs, EPI, Undergrad, Grad

PING, [EHS Intern](#) (Phoenix, AZ)

Public Health Alignment: EH, Undergrad, Grad

AARP, [Outreach Intern](#) (St. Louis, MO)

Public Health Alignment: BSHEs, HPM, Undergrad, Grad

Duke Univ, [Research Intern](#) (Durham, NC)

Public Health Alignment: BSHEs, GH, EPI, Grad

General Dynamics, [Occupational Health Intern](#) (Bath, ME)

Public Health Alignment: EH, Undergrad, Grad

National Health Law Program, [Mission Advancement Intern](#) (Remote)

Public Health Alignment: HPM, GH, Undergrad

Marsh, [MercerWell Intern](#) (Multiple Locations)

Public Health Alignment: EPI, HPM, BSHEs, Grad

Humana, [Data Analytics Intern](#) (Multiple Locations)

Public Health Alignment: EPI, BIOS, HPM, Grad

Open Public Health *Fellowship* Positions

ORISE, [Data Science and AI Fellow](#) (Atlanta, GA)

Public Health Alignment: EPI, BIOS, Bachelor's, Master's

ORISE, [Biothreat Early Warning AI Fellow](#) (Atlanta, GA)

Public Health Alignment: EPI, BIOS, Undergrad, Grad, Bachelor's, Master's

David and Lucile Packard Foundation, [Philanthropy Fellow](#) (Berkeley, CA)

Public Health Alignment: RMACH, EH, HPM, Master's

Winston, [Winston Health Policy Fellow](#) (DC)

Public Health Alignment: HPM, GH, BSHEs, Grad, Master's

Congressional Black Caucus Foundation, [Research Fellow](#) (DC)

Public Health Alignment: HPM, BSHEs, GH, Master's, Bachelor's

Congressional Black Caucus Foundation, [Social Justice Fellow](#) (DC)

Public Health Alignment: HPM, BSHEs, GH, Master's, Bachelor's

Mayo Clinic, [Administrative Fellow](#) (Multiple Locations)

Public Health Alignment: HPM, Master's

Emory Healthcare, [Administrative Fellow](#) (Atlanta, GA)

Public Health Alignment: HPM, Master's

Vizient, [Healthcare Analytics Fellow](#) (Chicago, IL)

Public Health Alignment: EPI, BIOS, HPM, Master's

Vizient, [Data Science Fellow](#) (Chicago, IL)

Public Health Alignment: EPI, BIOS, Master's

Vizient, [Performance Improvement Fellow](#) (Chicago, IL)

Public Health Alignment: HPM, Master's

Partners for Public Good, [Research Fellow](#) (Remote)

Public Health Alignment: HPM, EH, Bachelor's, Grad, Master's

Case Method Institute for Education and Democracy, [Education and Program Coordination Fellow](#) (Cambridge, MA) Public Health Alignment: BSHEs, HPM, RMACH, Bachelor's, Master's

Congressional Black Caucus Foundation, [Congressional Fellow](#) (DC)

Public Health Alignment: HPM, BSHEs, GH, Master's, Bachelor's

Open Public Health *Flexible* Positions

CDC Foundation, [Project Implementation Manager \(CT\)](#) (Hartford, CT)

Public Health Alignment: HPM, GH, BSHES, Bachelor's, Master's

CDC Foundation, [Program Monitoring and Evaluation Specialist \(CT\)](#) (Hartford, CT)

Public Health Alignment: EPI, BSHES, GH, Master's

CDC Foundation, [Project Implementation Specialist \(CT\)](#) (Hartford, CT)

Public Health Alignment: GH, HPM, Bachelor's, Master's

CDC Foundation, [Health Communications Specialist \(CT\)](#) (Boston, MA)

Public Health Alignment: BSHES, GH, Master's

Junior Achievement of Eastern NC, [Program Coordinator \(PT\)](#) (Lenoir, NC)

Public Health Alignment: RMACH, BSHES, Bachelor's, Master's, Grad

IQVIA, [Clinical Research Coordinator I \(PT\)](#) (Ocala, FL)

Public Health Alignment: EPI, Bachelor's, Grad, Master's

The Funding Studio, [Nonprofit Operations Specialist \(PT\)](#) (Remote)

Public Health Alignment: HPM, Bachelor's, Grad, Master's

Community Servings Inc, [Volunteer Coordinator \(CT, PT\)](#) (Mansfield, MA)

Public Health Alignment: BSHES, Bachelor's, Grad, Master's

American Academy of Pediatrics, [Communications Manager \(CT\)](#) (Boston, MA)

Public Health Alignment: BSHES, HPM, RMACH, Bachelor's, Grad, Master's

Johns Hopkins, [EH Research Project Assistant \(PT\)](#) (Baltimore, MD)

Public Health Alignment: EH, GH, BSHES, Undergrad, Grad, Bachelor's, Master's

WA Conservation Action, [Communications Consultant \(PT, CT\)](#) (Remote)

Public Health Alignment: EH, BSHES, HPM, Bachelor's, Master's

GA Coalition Against Domestic Violence, [Sexual Assault Advocate \(PT\)](#) (Atlanta, GA)

Public Health Alignment: RMACH, BSHES, Bachelor's, Grad, Master's

CDC Foundation, [Health Communications Specialist \(CT\)](#) (Remote)

Public Health Alignment: BSHES, HPM, Master's

African Communities Together, [Project Coordinator \(PT, CT\)](#) (NYC)

Public Health Alignment: GH, HPM, Bachelor's, Grad, Master's

Open Public Health *Flexible* Positions

CDC Foundation, [Program Monitoring and Evaluation Specialist \(CT\)](#) (Hartford, CT)

Public Health Alignment: GH, EPI, HPM, Master's

CDC Foundation, [Project Implementation \(CT\)](#) (Hartford, CT)

Public Health Alignment: GH, HPM, BSHEs, Bachelor's, Master's

Health Research Inc, [Arbovirus Research Scientist I \(CT\)](#) (Albany, NY)

Public Health Alignment: EH, BIOS, EPI, Bachelor's, Master's

QA Commons, [Project Coordinator \(PT, CT\)](#) (Remote)

Public Health Alignment: BSHEs, HPM, RMACH, Bachelor's, Grad, Master's

LULAC National Educational Service Centers, [Program Coordinator \(PT\)](#) (Remote)

Public Health Alignment: BSHEs, HPM, RMACH, Bachelor's, Grad, Master's

Good Shepherd Volunteers, [Operations Assistant \(PT\)](#) (NYC)

Public Health Alignment: RMACH, BSHEs, HPM, Bachelor's, Grad, Master's

Public Equity Group, [Analyst I/II \(PT\)](#) (Remote)

Public Health Alignment: HPM, GH, EPI, Grad, Master's

CDC Foundation, [Rooted in Health Workforce Specialist \(CT\)](#) (Frankfort, KY)

Public Health Alignment: HPM, BSHEs, GH, Bachelor's, Master's

Golden LEAF Foundation, [Operations Coordinator \(PT\)](#) (Rocky Mount, NC)

Public Health Alignment: HPM, GH, Bachelor's, Master's, Grad

CA Dept of Health, [Epidemiologist \(CT\)](#) (Richmond, CA)

Public Health Alignment: EPI, Master's

Family Resource Centers of CA, [Project Assistant \(PT\)](#) (Alhambra, CA)

Public Health Alignment: RMACH, BSHEs, GH, Bachelor's, Grad, Master's

State of NC, [Motor Vehicle Traffic Injury Program Coordinator I \(CT\)](#) (Durham, NC)

Public Health Alignment: BSHEs, EPI, Bachelor's, Master's

Center for Violence Prevention Research, [Data Analyst \(PT\)](#) (Remote)

Public Health Alignment: EPI, BIOS, BSHEs, Master's

CDC Foundation, [National Healthcare Safety Epidemiologist \(CT\)](#) (Carson City, NV)

Public Health Alignment: EPI, BIOS, Bachelor's, Master's

Marketplace

For Full Information on jobs: <http://www.epimonitor.net/JobBank>

The EpiMonitor offers a variety of plans for you to advertise your job opening, event or other item of interest to our readers. The basic advertising options are:

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Lasker Clinical Research Scholars

The National Institutes of Health is Recruiting Lasker Clinical Research Scholars

The National Institutes of Health, in partnership with the Lasker Foundation, is pleased to announce the 2026-27 Lasker Clinical Research Scholars Program. This is an opportunity for up to 10 years of funding for clinical researchers.

The Lasker Scholars program supports a small number of exceptional clinical researchers to promote their development as early stage independent investigators. This unique program provides Scholars with five to seven years of support as an independent principal investigator in the NIH Intramural Research Program (IRP), followed by up to 3 years of funding at an extramural research institution. Scholars may also have the opportunity to remain in the IRP rather than leaving for an extramural position, by mutual agreement.

During the IRP (Si2) phase, Lasker Scholars become NIH employees and conduct research at the NIH as tenure-track investigators. Scholars will be offered competitive salaries, commensurate with experience and qualifications, and will be provided research space, supported personnel positions, and a research operating budget. In some cases, Lasker Scholars may be able to maintain an adjunct affiliation with their previous institution while working at the NIH. During the extramural (R00) phase, successful Scholars receive up to \$500,000 in direct costs per year for their research program.

Candidates must have a clinical doctoral degree (MD, MD/PhD, DO, DDS, DMD, RN/PhD or equivalent) from an accredited domestic or foreign institution and must have a professional license to practice in the United States. The program is intended for investigators at the early stages of their independent careers, and candidates cannot have already obtained tenure at a research institution. Applicants generally will have completed or will be completing a post-residency clinical fellowship and will have demonstrated significant patient-oriented research experience to qualify for a tenure-track level appointment.

The application will include a research proposal and submission of four letters of reference. The deadline for a full application is November 6, 2026. The positions will start in 2027, though the start date is flexible. The funding announcement and application instructions are in [PAR-27-076](#). Applications must be submitted as described in the funding announcement, NIH cannot accept applications submitted through this journal.

For questions, contact Dr. Charles Dearolf, Director of Program Development and Support, NIH Office of Intramural Research, at LaskerScholar@nih.gov.

More information and the list of research areas of interest are available at:
<https://www.nih.gov/research-training/lasker-clinical-research-scholars>.

The program honors the contributions of Mary and Albert Lasker to the National Institutes of Health and to the overall biomedical community. The Lasker Foundation will provide Scholars with the opportunity to participate in selected activities.



YLE can be found here: <https://yourlocalepidemiologist.substack.com/>

[Your Local Epidemiologist](#) (YLE) is founded and operated by Dr. Katelyn Jetelina, MPH PhD—an epidemiologist, wife, and mom of two little girls. YLE reaches more than 305,000 people in over 132 countries with one goal: “Translate” the ever-evolving public health science so that people will be well-equipped to make evidence-based decisions. This newsletter is free to everyone, thanks to the generous support of fellow YLE community members.

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