Director's Letter

On behalf of the National Institutes of Health (NIH), I am transmitting NIH's Congressional Justification for the fiscal year (FY) 2027 budget. This request for $41.5 billion will support NIH's mission to advance biomedical and behavioral research and translate scientific discoveries into better health for all.

Since beginning my tenure as the 18th NIH Director, it has been clear that NIH's impact is driven by the extraordinary dedication and expertise of its staff and the investigators it supports. Across the agency, staff bring deep scientific knowledge, a strong commitment to public service, and operational excellence to every aspect of the research enterprise—from setting priorities and stewarding public resources to ensuring rigor, safety, and transparency. This depth of talent, combined with sustained federal investment, enables NIH to support world-class research, respond to emerging health needs, and deliver discoveries that improve lives across the Nation.

Building on the priorities established in my first year as NIH Director, FY 2027 represents a shift from setting direction to executing with focus and accountability. Over the past year, NIH has worked to strengthen the rigor, transparency, and stewardship that underpin public trust in biomedical research, while sharpening our focus on improving population health and addressing the Nation's chronic disease burden. We will build on this foundation by accelerating translation, broadening research portfolios to drive innovation, and ensuring that NIH's investments deliver measurable benefits for patients, families, and communities across the country.

NIH Priorities

My top priorities for FY 2027 are to:

1. **Improve Population Health:** Further align NIH-supported research across basic, translational, and clinical domains to reduce the burden of chronic and infectious disease, improve prevention and early intervention, and deliver effective treatments across the lifespan.
2. **Build Reliable and Actionable Science:** Strengthen rigor, reproducibility, transparency, and access to research so that all high-quality research, regardless of outcome, contributes to cumulative knowledge, informs decision-making, and accelerates translation.
3. **Broaden Research Portfolios to Drive Innovation:** Steward balanced research portfolios that support foundational discovery, early-stage and high-risk ideas, and translational research, creating space for new approaches while sustaining areas of proven impact.
4. **Accelerate Discovery with Next-Generation Tools:** Leverage data, artificial intelligence, and human-based research models to speed discovery and improve relevance to human health.
5. **Ensure Safety, Transparency, and Accountability:** Protect research participants and data, strengthen oversight and compliance, and ensure responsible stewardship of public resources to maintain the confidence and trust of the American people.

Advancing Population Health Through Integrated Science

Improving population health requires coordinated investment across the research continuum. NIH supports research that spans prevention, diagnosis, treatment, and long-term management of disease, while ensuring that discoveries are applicable to real-world settings and accessible to all populations.

Chronic diseases remain the leading causes of death and disability in the United States, underscoring the importance of prevention-focused and translational research. NIH continues to advance precision prevention strategies through efforts such as the Nutrition for Precision Health study, powered by the *All of Us* Research Program. This research examines how genetics, lifestyle, the gut microbiome, and other factors influence individual responses to diet, with the goal of informing more effective strategies to prevent chronic disease.

Autoimmune diseases affect an estimated 24 million Americans, often requiring lifelong care and significantly limiting quality of life. NIH-supported research is advancing understanding of immune dysregulation and accelerating development of more effective treatments for conditions such as multiple sclerosis and lupus, which disproportionately affect women and individuals in their prime working years.

Neurodegenerative diseases represent another major public health challenge. NIH leads federal research on Alzheimer's disease and Alzheimer's disease-related dementias, Parkinson's disease, and amyotrophic lateral sclerosis (ALS). These conditions affect millions of Americans and place significant emotional and financial strain on families and caregivers. NIH-supported research has advanced biomarker discovery, improved early detection, and identified new therapeutic targets to slow or prevent disease progression.

NIH continues to support research to better understand autism spectrum disorders and associated conditions. Through integrated basic, clinical, and epidemiological approaches, NIH is working to identify risk factors, improve diagnosis, and inform interventions that can improve outcomes for children and families.

Building Reliable Science and Translating Discovery

To ensure that research leads to meaningful health impact, NIH is advancing the "science of science" by emphasizing rigor, reproducibility, and transparency. NIH values well-designed studies and accessible results regardless of outcome, recognizing that learning from positive, negative, and null findings accelerates progress and reduces research waste.

Recent NIH-supported advances—from gene-editing approaches for rare pediatric diseases to innovative brain-computer interfaces restoring communication and sensation—demonstrate how rigorous science can rapidly improve lives. NIH is also expanding access to real-world data networks, enabling researchers to study treatment effectiveness across populations, monitor safety after approval, understand disease progression, and inform prevention and care strategies that reflect real-world health needs.

Fostering Innovation and Expanding Access to Research

NIH fosters innovation by supporting a diverse and balanced research portfolio. Through a unified funding strategy, NIH is strengthening its ability to curate portfolios that encompass the full spectrum of scientific approaches within each research area with the goal of supporting foundational discovery, translational research, and early-stage innovative ideas.

Programs such as the High-Risk, High-Reward (HRHR) Research Program, supported through the NIH Common Fund, enable investigators to pursue bold ideas that may be too novel for traditional funding mechanisms.

The Institutional Development Award (IDeA) Program strengthens research capacity in states and territories that have historically received lower levels of NIH funding, many of which include rural and underserved communities. Specifically, IDeA supports infrastructure, workforce development, and clinical research networks in these communities.

Additionally, through initiatives such as NIH CARE for Health™, NIH is working to integrate research into primary care settings and expand participation in clinical studies, particularly in areas with limited research infrastructure and access to care. These efforts improve the relevance of research findings and help expand access to care and research opportunities.

Looking Ahead

As we look ahead to FY 2027, NIH is focused on advancing research that is rigorous, cutting-edge, and directly responsive to the most pressing health challenges facing the American people. Millions of children and adults continue to experience poor outcomes from chronic conditions such as obesity, heart disease, cancer, and related disorders. To Make America Healthy Again, we must build on NIH's strong track record of addressing complex scientific challenges and recommit to confronting the chronic disease crisis affecting families and communities nationwide. While NIH will continue to lead in basic research, we will also emphasize research with the potential to translate more directly and rapidly to the patients who need it.

Equally important, NIH must maintain the confidence and trust of the American people. Scientific discoveries can only improve health if the public has confidence in the rigor, transparency, and integrity of the research that underpins them. Strengthening that trust is essential to ensuring NIH continues to serve the public interest effectively.

NIH will continue to sustain the Nation's investment in biomedical research and to advance science that improves health, reduces disease burden, and delivers real benefits for the American people.

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INTRODUCTION AND MISSION

The mission of the National Institutes of Health (NIH) is to seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability. As the largest public funder of biomedical and behavioral research in the world, NIH is the driving force behind decades of advances that improve health, revolutionize science, and serve society more broadly.

NIH fuels the biomedical research enterprise—cultivating world-class scientists and catalyzing new scientific fields, tools, and resources that have changed how science is done. Discoveries emerging from NIH-supported research have led to new ways to prevent, diagnose, and treat illness, ultimately improving the health of the nation and the world. Additionally, these improvements in health bolster the U.S. economy by improving productivity and reducing the costly burden of illness. NIH funding also spurs economic growth, both by supporting jobs in research and by generating biomedical innovations that lead to growth in the biotechnology sector. Through careful stewardship of public resources in pursuit of its mission, NIH enhances the lives of all Americans.

OVERVIEW OF BUDGET REQUEST

Summary

For Fiscal Year (FY) 2027, the National Institutes of Health (NIH) requests a total program level of $41.5 billion, a $5.0 billion reduction from the $46.5 billion program level in the FY 2026 Enacted budget.[1] This request seeks to maximize the impact of NIH research by streamlining processes and more efficiently providing funding. The NIH budget level will continue to support critical research conducted in service to the agency's mission and administration priorities as well as support new and ambitious priority investments necessary for Making America Healthy Again.

The Nation's investment in NIH is born from the recognition that a healthy population is a productive and thriving population. The benefits of NIH research can be felt in the near term through development of novel health interventions and continue well into the future as transformations in the diagnosis, prevention, and treatment of disease today become standard practice tomorrow.

NIH strategically invests its budget in the highest quality research, which is conducted by intramural researchers working at NIH labs and extramural researchers at universities, medical schools, and research institutions in every state. Through these investments, NIH pursues innovative research proposals and cutting-edge scientific techniques to address our most pressing health challenges. Combatting chronic diseases, finding new treatments for devastating diseases and conditions, harnessing the power of artificial intelligence and real-world data (RWD), ensuring research results produce reliable and translatable outcomes, and bolstering the scientific workforce remain critical matters. NIH approaches these challenges not only by investing in science, but also by investing in the people and infrastructure upon which these advances are built and sustained.

Strengthening and sustaining the biomedical research ecosystem itself remains critical to ensuring NIH advances its mission of enhancing health and reducing illness in the decades to come. NIH researchers and staff are held to the highest ethical standards to support the best science, and NIH continues to embed principles of scientific integrity and rigor throughout the research lifecycle. NIH is also prioritizing transparency in all activities, with new efforts directed towards ensuring that results of research are effectively reported and disseminated to the people who will directly benefit. Importantly, all efforts are underpinned by a commitment to academic freedom in the pursuit of new knowledge.

In FY 2027, NIH will continue to support groundbreaking biomedical research to address current and future health challenges and support the highest quality basic, translational, and clinical research to improve health for all. The discoveries made possible by NIH-supported research have led to a vast number of treatments, interventions, prevention strategies, and more that have helped ease the burden of disease, promote wellbeing, and extend life. This includes

[1] The FY 2027 President's Budget proposes to relocate the National Institute for Environmental Health Sciences (NIEHS) to the Centers for Disease Control and Prevention. The FY 2026 funding level is adjusted to remove NIEHS funding for comparability.

incorporating public voices early and often throughout the course of the biomedical research lifecycle, ensuring that NIH-funded science meets the needs of patient communities.

NIH clinical research has a tremendous impact on many lives. However, the treatments and interventions that have been developed as the result of NIH clinical research could not have been achieved without years' worth of basic, foundational research. This underscores the need to bridge laboratories, clinics, and communities to work synergistically to achieve common goals. NIH is actively building upon this legacy of basic and clinical research excellence. For example, since its inception in 1953, the NIH Clinical Center has trailblazed numerous medical milestones, from pioneering cancer treatments, to developing interventions to treat HIV and AIDS, to the development of diagnostic and imaging technologies. The advances supported by NIH research have saved, and continue to save, lives every day.

Maximizing The Impact of NIH Research

NIH has a strong history of conducting and supporting groundbreaking research and medical advances. No greater testament of NIH's past and continued success in scientific endeavors can be found than the fact that NIH has supported a total of 174 researchers who have received or shared 104 Nobel Prizes. An NIH-funded researcher received the Nobel Prize in 2024 for the development of groundbreaking artificial intelligence (AI) tools to predict the complex structure of proteins – tools that have already been used by millions of researchers across the globe.[2]

NIH investments in research stimulate increased private investment – a $1.00 increase in public basic research stimulates an estimated additional $8.38 of industry R&D investment in a particular research area after eight years. In rural states, each $1.00 of NIH spending generated an average of $2.30 of total economic impact. Discoveries arising from NIH-funded research provide a foundation for the U.S. biomedical industry, which contributes over $69 billion to the U.S. Gross Domestic Product (GDP) each year and supports over 7 million jobs.[3] Each permanent one percent reduction in cancer deaths alone has been approximated to have a value of nearly $500 billion to current and future generations of Americans. A full cure could be worth more than three times today's GDP.[4]

However, for NIH to maintain its leadership and deliver on its promise to Americans, it must reestablish trust in NIH as an agency and realign priorities to focus on conditions plaguing the Nation. As NIH enters its next era, it will continue to bridge basic, translational, and clinical research in novel and innovative ways to continue developing new advances and maintain its status as the world leader in health science research. American taxpayers invest precious resources into the NIH and to maximize that investment NIH is highlighting a range of new policies and research programs.

The budget proposes to consolidate the National Institute of Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism into the new National Institute of Substance Use and Addiction Research. In addition, the budget proposes the elimination of the National Center for Complementary and Integrative Health, Fogarty International Center, and National Institute on

[2] nobelprize.org/prizes/chemistry/2024/press-release/
[3] nih.gov/about-nih/impact-nih-research/serving-society/spurring-economic-growth
[4] ucema.edu.ar/u/je49/capital_humano/Murphy_Topel_JPE.pdf

Minority Health and Health Disparities and to relocate the National Institute of Environmental Health Sciences from NIH to the Centers for Disease Control and Prevention (CDC).

Enhancing Transparency and Research Integrity

NIH has a longstanding commitment to making the results of NIH-funded research available, as illustrated by scientific data sharing policies, including: the Data Management and Sharing Policy, the Genomic Data Sharing Policy, and the Public Access Policy.[5] Responsible data management and sharing have many benefits, including accelerating biomedical research, enabling validation of research results, and providing accessibility to high-value datasets. To train and support researchers in their data sharing efforts, and to advance FAIR (findability, accessibility, interoperability, and reusability) data principles, NIH maintains a robust modern data resource ecosystem made up of biomedical data repositories and knowledgebases.

Accelerating Access to Research Results: Since the release of NIH's 2008 Public Access Policy, more than 1.5 million articles reporting on NIH-supported research have been made freely available to the public through PubMed Central. While the 2008 Policy allowed for up to a 12-month delay before such articles were required to be made publicly available, in 2024, NIH revised the Public Access Policy to remove the embargo period so that researchers, students, and members of the public have rapid access to these findings. To provide unrestricted access to scientific results and publications produced by NIH-funded investigators, the NIH Public Access Policy effective date was accelerated and the policy is now in effect as of July 2025.[6]

Maximizing Funds for Research: NIH aims to maximize the value of each research grant, and as such, NIH grantees should utilize as much of their grant funds as possible for research activities. While NIH recognizes the value of disseminating and publishing findings, journals with large publishing fees can lead awardees to pay unreasonably high fees from their NIH awards that lessen the funds available for conducting research and which burden American taxpayers. On July 8, 2025, NIH announced a proposal to develop and implement a new policy to maximize the value of each research grant by limiting allowable publication costs (APCs). To balance feasibility of providing research results with maximizing the use of taxpayer funds to support research, NIH sought public input on the proposed policy options and related topics to help keep journal publication costs, including APCs and other publication fees paid by NIH, reasonable. NIH has received public input on five policy options ranging from completely disallowing publication costs to implementing various caps on per-publication expenses and total award spending limits and plans to release a policy in 2026. NIH maintains its strong commitment to public access and ensuring that research findings remain freely available to the public without placing unreasonable financial burdens on researchers or taxpayers.

Another way in which the FY 2027 Budget will maximize funds for research is to limit the share of each dollar awarded for research grants that goes toward indirect costs rather than the direct costs for research. The amount awarded for indirect costs -- also known as Facilities and Administration (F&A) costs -- varies based on rates negotiated with each grantee institution, and

[5] grants.nih.gov/policy-and-compliance/policy-topics/sharing-policies

[6] grants.nih.gov/policy-and-compliance/policy-topics/public-access/nih-public-access-policy-overview; nih.gov/about-nih/nih-director/statements/accelerating-access-research-results-new-implementation-date-2024-nih-public-access-policy

the way the money is used is unclear and often ambiguous. To increase transparency in NIH funding and maximize the research supported by the taxpayers' investments, the Budget proposes to cap F&A costs at 15 percent of the applicable direct cost base for each award, and to eliminate the appropriations general provision regarding changes to NIH F&A cost policies.

Streamlining and Strengthening Funding Processes: Establishing and maintaining transparent and efficient processes for awarding NIH funds remains essential. To enhance transparency regarding the scientific experts NIH relies on to drive scientific review, NIH makes public the standing review panels, the rosters of individuals who participate in review panels, and information on each funded grant. Beginning January 2025, scoring factors and the review process were streamlined into the Simplified Peer Review Framework to address the complexity of the review process and potential for reputational bias. The reframing of the criteria serves to focus reviewers on three central questions reviewers should be evaluating: How important is the proposed research, how rigorous and feasible are the methods, and whether the investigators and institution have the expertise/resources necessary to carry out the project. In March 2025, NIH announced a new plan to centralize the initial peer review process for all applications for grants, cooperative agreements, and research and development (R&D) contracts solely within the Center for Scientific Review (CSR). By centralizing peer review, NIH can make review more efficient and consistent across the agency. Additionally, the proposed approach is expected to save more than $65 million annually by eliminating duplicative efforts across the agency. NIH also launched a unified funding strategy[7] to bring greater clarity, consistency, and focus across its funding ecosystem.

Fostering Open Discourse and Dissent: Open debate is the cornerstone of scientific progress as interrogating evidence and challenging the status quo are essential for ensuring scientific rigor and meaningful results. In August 2025, NIH implemented a new Intramural Academic Freedom policy focused on protecting scientific discourse, streamlining and harmonizing research communication procedures, reducing barriers to publication, and facilitating media engagement about science research while maintaining necessary institutional oversight.[8]

Safeguarding NIH-Funded Research

NIH must continue to lead gold standard research conducted under gold standard safety and security conditions. As life sciences research technologies, capabilities, and risks evolve, it remains critical that the United States oversight keeps pace. In FY 2027, NIH will prioritize modernizing biosafety and biosecurity oversight, strengthening responsibilities shared across the federal government, research institutions, local institutional oversight bodies, and researchers themselves. First, NIH will devote substantial efforts to promoting a culture of biosafety, biocontainment, and biosecurity vigilance in support of the President's Executive Order (EO) on Improving the Safety and Security of Biological Research in May 2025.[9] Second, NIH is undertaking a comprehensive effort to modernize and strengthen biosafety policies, practices,

[7] grants.nih.gov/sites/default/files/Leveraging-Funding-Policies-Framework.pdf
[8] oir.nih.gov/sourcebook/submitting-research-publications/intramural-academic-freedom-guidance
[9] whitehouse.gov/presidential-actions/2025/05/improving-the-safety-and-security-of-biological-research/

and oversight to keep pace with the evolving risks posed by today's rapidly advancing science and technology.[10,11]

As a domestic organization, NIH investments in international research must deliver both scientific and taxpayer value. In support of the Administration's national security efforts, NIH implemented measures to protect participant data[12] and clarify expectations for safeguarding sensitive data[13] and biospecimens[14] from foreign adversaries, providing greater certainty and consistency for the research community. Additionally, in May 2025, NIH announced that it will implement a new grant structure that supports productive collaborations between U.S. institutions and foreign collaborators that enhance the agency's capabilities to provide effective oversight and management of financial obligations in support of rigorous scientific research.[15,16] The new grant structure was implemented in 2025.[17] By creating a more unified view of where NIH dollars are going, NIH is strengthening public trust and improving accountability for recipients of federal dollars.

Emphasizing Human-Centered Research and New Approach Methodologies

NIH is making major efforts to prioritize new and emerging technologies that can offer unique strengths to expand the toolbox for researchers to answer previously difficult or unanswerable biomedical research questions. These innovative technologies that model human biology provide a complementary approach to traditional models when utilized correctly or in combination. While alternative approaches cannot completely replace the use of animals at this time, NIH is committed to transparently assessing where animal use can be reduced or eliminated by transitioning to alternatives. Areas where research using animals is currently necessary represent high-priority opportunities for investment in alternatives.

NIH will explore supporting and expanding human-centered science to complement, reduce, and replace animal research in the future. As part of this commitment, NIH will further its efforts to coordinate agency-wide efforts to develop, validate, and scale the use of alternatives across the agency's biomedical research portfolio and facilitate interagency coordination and regulatory translation for public health protection. In July 2025, NIH announced it will no longer develop new funding opportunities focused exclusively on animal models of human disease.[18] Rather, going forward, new funding opportunities will be designed more broadly to allow for the use of animal models while also including language that encourages various innovative, human-based approaches to be considered and supported. This new emphasis on human-centered research will accelerate medical advances; advance the replacement, refinement, and reduction of animals in research; and help NIH achieve its crucial mission of improving human health.

[10] nih.gov/about-nih/nih-director/statements/nih-launches-initiative-modernize-strengthen-biosafety-oversight
[11] osp.od.nih.gov/policies/biosafety-and-biosecurity-policy#tab2/
[12] grants.nih.gov/grants/guide/notice-files/NOT-OD-25-159.html
[13] grants.nih.gov/grants/guide/notice-files/NOT-OD-25-083.html
[14] grants.nih.gov/grants/guide/notice-files/NOT-OD-25-160.html
[15] grants.nih.gov/grants/guide/notice-files/NOT-OD-25-104.html
[16] grants.nih.gov/grants/guide/notice-files/NOT-OD-25-127.html
[17] grants.nih.gov/grants/guide/notice-files/NOT-OD-25-155.html
[18] grants.nih.gov/news-events/nih-extramural-nexus-news/2025/07/nih-funding-announcements-to-align-with-nih-initiative-to-prioritize-human-based-research

For more than a decade, researchers have been working to create tiny 3D structures called organoids that can mimic the structure and function of various organs, which may be a viable alternative to using animal models. These little organoids generally form spheres smaller than a grain of rice. They have been used to test drugs, assess potential therapies, and reveal the underpinnings of many disorders. A key challenge has been to create organoids that have blood vessels that simulate the vasculature of specific organs, such as lungs, heart, or liver. NIH-supported researchers were able to grow organs and blood vessels together at the earliest stages of development.[19] These new organoids closely paralleled how the equivalent organs develop and behave in the human body. Organoids with organ-specific vasculature will help scientists better understand how blood vessels form and function in different parts of the body and what goes wrong in various diseases. They also offer a human-based system that may be more accurate for testing new drugs.[41]

NIH is taking these steps in alignment with efforts by the Food and Drug Administration's (FDA's) recent initiative, Roadmap to Reducing Animal Testing in Preclinical Safety Studies, to reduce animal testing in the development of monoclonal antibody therapies and other drugs.[20] NIH anticipates that advances from NIH-supported efforts will accelerate the development and adoption of these technologies.

The FY 2027 Budget proposes $25.0 million to support new approach methodologies that provide alternatives to animal models across the NIH biomedical research portfolio.

Promoting Research Focused on Scientifically Valid, Measurable Outcomes

Replicable, reproducible, and generalizable research must serve as the basis for truth in biomedical science. The "publish or perish" culture favors the promotion of only favorable results, and replication work is little valued or rewarded. NIH is prioritizing research that produces robust, reproducible results and exploring various mechanisms to support scientists focused on replication work, to publish negative findings, and to elevate replication research.

Since FY 2024, NIH has launched several new research programs and committees focused on enhancing the reproducibility of biomedical research and novel technologies, such as the NIH Common Fund's Replication to Enhance Research Impact Initiative (Replication Initiative).[21] The new Replication Initiative will support replication efforts for preclinical, translational, and technology development research studies from NIH Common Fund programs and NIH-supported research across different scientific research areas. Genomics research is an area that is ripe for reproducibility efforts, thanks to the vast amounts of multimodal data available, such as machine learning (ML) and AI. ML/AI Tools to Advance Genomic Translational Research (MAGen)[22] will enable researchers to collaboratively explore the feasibility of ML/AI tools in predicting how individuals with pathogenic genetic variants manifest disease, enabling the development of better ML/AI-enabled medical devices. MAGen researchers will leverage existing multimodal genomic and non-genomic data, and the ML/AI tools will be cross validated in genomic

[19] nih.gov/news-events/nih-research-matters/scientists-create-organoids-specialized-blood-vessels
[20] fda.gov/news-events/press-announcements/fda-announces-plan-phase-out-animal-testing-requirement-monoclonal-antibodies-and-other-drug
[21] commonfund.nih.gov/replication-initiative
[22] genome.gov/research-funding/Funded-Programs-Projects/ML-AI-tools-to-advance-genomic-translational- -MAGe

translational research settings to ensure the robustness and generalizability of the tools for translational purposes.

NIH is also developing Reproducibility and Integrity Guidance to Optimize Research (RIGOR) for Dietary Supplements[23] to strengthen the experimental design and methodological rigor applied in NIH-funded dietary supplement and related nutrition research. These activities may include creating best practice guidance and training resources, prioritizing research funding opportunities, or enhancing the review of NIH grant applications.

Finally, NIH is exploring ways to support individual replication of significant areas of research in support of the wider NIH efforts to enhance research rigor and reproducibility. This work may build on the Common Fund's Replication Initiative,[24] a pilot effort to provide support to independently replicate significant areas of research and validate novel technologies.

The FY 2027 Budget proposes $100.0 million to support these efforts to advance a coordinated, cross-Institute approach that elevates replication and reproducibility as a transformative scientific priority. This broad initiative will involve a multi-tiered strategy that integrates targeted funding mechanisms, technological innovation, and institutional culture change.

Combating the Chronic Disease Crisis

The chronic disease crisis is responsible for the majority of health care costs and premature mortality, and is increasing in intensity and severity, particularly in children. To address the chronic disease crisis, NIH will intensify investment in integrative research that uncovers underlying causes, risk factors, and effective prevention strategies. This includes leveraging longitudinal cohorts, biosensor data, and implementation science to bring precision prevention and early intervention into everyday clinical and community settings. Chronic diseases are influenced by complex interactions among genetic, behavioral, and environmental factors; NIH will harness AI to integrate RWD from electronic health records (EHRs), wearable sensors, and environmental exposures to develop predictive models for chronic disease onset and progression. Investments will support large-scale, longitudinal research initiatives that uncover the biological mechanisms, behavioral factors, and social drivers of chronic diseases, enabling widespread solutions across the American public. NIH will also prioritize R&D that enables scalable, personalized approaches to understand causes and disrupt disease onset and progression.

Focusing on rural communities: Rural communities are disproportionately affected by chronic disease, and it is imperative that individuals from rural areas have access to the benefits of NIH-funded research. One approach for addressing the chronic disease crisis in the United States is the CARE for Health Program. Through this program, primary care providers embedded in rural communities provide access to NIH-supported clinical trials through a national research network. This network will address barriers to clinical research participation by integrating innovative research with routine clinical care in real world settings.

Understanding the role of nutrition in chronic diseases: NIH will champion initiatives rigorously exploring the role of poor diets in causing common chronic conditions and the

[23] ods.od.nih.gov/Funding/ProductIntegrityGuidance.aspx
[24] commonfund.nih.gov/replication-initiative

identification of healthy diets that can prevent and better manage these conditions. NIH will prioritize projects focusing on the role of maternal and infant dietary exposures on health outcomes across the lifespan. NIH will also work to initiate long-term studies to understand the impacts of certain foods and diets on obesity and insulin resistance in children.

The Food is Medicine Centers of Excellence Program[25] is an NIH-wide, nutrition-focused initiative. It will specifically address the existing gap between nutrition support and clinical care by supporting programs that respond to the critical link between diet and health with the provision of healthy food, as well as having health care organizations as their nexus. The program will also address the difficulties that both communities and health care systems have with their ability to reduce obesity and other diet-related diseases (e.g., type 2 diabetes, cardiovascular disease, and cancer).

There has been growing interest from both the public and the scientific community for understanding the health impact of ultra-processed food (UPF), which constitutes around 60 percent of the daily caloric intake in the United States and comprises around 70 percent of the U.S. food supply. Despite epidemiological research suggesting an association between an UPF-rich diet and increased risks for adverse health outcomes, significant research gaps remain in understanding the mechanisms of these relationships. There is also a need for research to explore interventions to reduce unhealthy UPF intake in the United States to improve population health. NIH is exploring plans to support robust multidisciplinary research across the lifespan on the mechanisms by which UPF affects chronic disease and provides the evidence base needed to inform dietary guidance, policies, and programs that improve health and promote disease prevention.

The FDA and NIH have launched a joint Nutrition Regulatory Science Program[26] to address the rising diet-related chronic disease crisis in America through comprehensive nutrition research. Modeled after the successful FDA-NIH Tobacco Regulatory Science Program, this initiative will investigate critical questions about how ultra-processed foods, food additives, and dietary exposures affect health outcomes, including their potential links to metabolic disorders, chronic diseases, and autoimmune conditions. The FDA will contribute regulatory science expertise while NIH will manage research infrastructure, bringing together multidisciplinary experts to conduct independent, conflict-free studies that will inform evidence-based food and nutrition policies. The program aims to provide Americans with transparent information based on science to help inform their food choices and better understand how food impacts their health, ultimately supporting the goal of making America healthier by tackling the root causes of diet-related chronic diseases.

Supporting progress against cardiovascular disease: The Framingham Heart Study[27] is one of the most influential and long-running epidemiological studies in medical history. The Framingham Heart Study began in 1948 in the town of Framingham, Massachusetts. Over the decades, the study has contributed significantly to the understanding of cardiovascular health and

[25] dpcpsi.nih.gov/sites/default/files/Day-1-155PM-ONR-Concept-Food-is-Medicine-Lynch-background-508.pdf
[26] fda.gov/news-events/press-announcements/fda-and-nih-announce-innovative-joint-nutrition-regulatory-science-program
[27] framinghamheartstudy.org/

disease, including key findings on the risk factors for heart disease; predictors such as blood pressure, cholesterol and triglycerides; the protective effects of high-density lipoprotein (HDL) cholesterol; and the risk factors for atrial fibrillation and stroke. More recent findings include the genetic underpinnings of heart disease, the significant impact of lifestyle factors, new blood biomarkers that can predict the risk of heart disease, the role of inflammation in the development of cardiovascular disease, and the link between mental health and increased cardiovascular risk. The Framingham Heart Study is a landmark research project that has vastly expanded our understanding of cardiovascular disease, leading to better prevention, diagnosis, and treatment strategies, ultimately improving public health outcomes globally.

Addressing multiple chronic diseases: The Congressionally mandated Multiple Chronic Disease Research Centers initiative[28] will support existing and new regional comprehensive research centers to optimize prevention, diagnosis, treatment and management of multiple chronic diseases (MCDs) and to improve health outcomes among pediatric and adult populations. The centers will advance the Make America Healthy Again Commission goals,[29] focusing on innovative research that: (1) develops, tests, and evaluates novel models or strategies, and/or (2) implements effective interventions in various settings such as community or health care settings/systems. In addition, research design and methodologies that are replicable, reproducible and generalizable are priorities.

The FY 2027 Budget proposes $60.0 million to intensify investment in integrative research that uncovers underlying causes, risk factors, and effective prevention strategies for chronic disease. The funding will support prioritizing research and development that enables scalable, personalized approaches to understand causes and disrupt disease onset and progression.

Reflecting on Progress from the 21st Century Cures Act

FY 2026 marks the final year of funding authorized under the 21st Century Cures Act, which was signed into law on December 13, 2016. Over a 10-year period, the Cures Act authorized $4.8 billion for NIH to advance biomedical research across the spectrum, from foundational basic research studies to advanced clinical trials of promising new therapies. The Cures Act notably provided multi-year funding for four Innovation Projects: *All of Us*,[30] Brain Research through Advancing Innovative Neurotechnologies (BRAIN®) Initiative,[31] Cancer Moonshot℠,[32] and the Regenerative Medicine Innovation Project.[33]

All of Us: The *All of Us* Research Program is a transformative national resource to advance precision medicine and biomedical research. With over 872,000 participants enrolled as of December 2025, the Program has built the world's largest and most comprehensive biomedical dataset. This resource includes genomic sequencing data, electronic health records, survey responses, physical measurements, clinical notes, and the world's largest collection of longitudinal Fitbit data available to researchers. In 2026, the next data release will include whole

[28] grants.gov/search-results-detail/358870
[29] whitehouse.gov/presidential-actions/2025/02/establishing-the-presidents-make-america-healthy-again-commission/
[30] allofus.nih.gov
[31] braininitiative.nih.gov/
[32] cancer.gov/research/key-initiatives/moonshot-cancer-initiative
[33] nih.gov/regenerative-medicine-innovation-project-rmip

genome sequencing from more than 535,000 participants, making it the largest dataset of its kind made securely available to qualified researchers. These data are allowing researchers to better understand the many factors that influence health and accelerate research on how chronic conditions are defined, diagnosed, and treated. Already more than 21,000 registered researchers from more than 1,280 institutions across every state and the world are using *All of Us* data to advance their scientific research.

Strategic partnerships among more than 20 ICs further expand the depth and utility of the *All of Us* dataset to NIH's research priorities – with substantial cost efficiency and time savings. In partnership with the Office of Nutrition Research and the Common Fund,[34] *All of Us* is conducting the world's largest precision nutrition study to develop algorithms that predict individual responses to food and dietary patterns. The study will build on recent advances in AI and microbiome research to generate new data that will enable personalized nutrition. Additional collaborations include Exploring the Mind with the National Institute of Mental Health (NIMH),[35] which collects behavioral task data through exercises measuring attention, decision-making, and emotional recognition; the Environmental Health and Exposomics study with the National Institute of Environmental Health Sciences (NIEHS),[36] which is analyzing over 5,500 blood samples to examine environmental exposures in participants with type 2 diabetes; and Eyes on Health with the National Eye Institute, which is collecting eye images from 5,000 *All of Us* participants to explore how the eye connects to conditions like cardiovascular disease, diabetes, and neurological disorders. With *All of Us*, NIH may leverage existing infrastructure to lower costs and enhance NIH-wide research capabilities.

All of Us aims to accelerate health research and medical breakthroughs, enabling individualized prevention, treatment, and care for all of us, including children. Expanding enrollment to include infants, children, and adolescents in the *All of Us* cohort enables researchers to address critical issues in children's health and better understand the developmental origins of adult disease. The program began limited enrollment of birth to 5 years of age in 2024 through 6 health care provider organizations, including 2 federally qualified health centers, operating across Arizona, California, Colorado, Connecticut, Kansas, Michigan, Missouri, and Pennsylvania.

Brain Research Through Advancing Innovative Neurotechnologies® (BRAIN) Initiative: The BRAIN Initiative[37] is an ambitious program to develop and apply new technologies to answer fundamental questions about the brain and ultimately to inspire new treatments for brain diseases.[38] A cross-NIH initiative spanning 10 of the 27 NIH ICs, BRAIN is uniquely situated for cross-cutting and accelerated discovery in neuroscience that goes beyond the mission of any single IC by tapping into synergies across multiple fields to understand how the 86 billion neurons in the human brain, and their trillions of connections, function normally and go awry in injury or disease. With NIH-wide coordination overseen by the NIH Office of the BRAIN Director, BRAIN is a critical resource for ICs to advance their own mission-driven research on

[34] commonfund.nih.gov/nutritionforprecisionhealth
[35] support.researchallofus.org/hc/en-us/articles/33451505815316-Overview-of-Exploring-the-Mind-Data-in-the-Researcher-Workbench
[36] reporter.nih.gov/project-details/11193137#description
[37] braininitiative.nih.gov/
[38] officeofbudget.od.nih.gov/pdfs/FY23/br/Overview of FY 2023 Cross-cutting Initiatives.pdf

dementia, communication loss from paralysis or stroke, behavioral disorders, addiction, vision disorders, and many other conditions affecting the nervous system.

In recent years, BRAIN Initiative investments have created highly precise brain maps that offer a new perspective on brain architecture at stunning levels of detail. These new, extremely detailed brain atlases[39] reveal the exceptionally complex human cells as well as nonhuman primate and mouse brains.[40] BRAIN Initiative research has also yielded multiple ground-breaking clinical successes in early-stage trials.[41] These limited proof-of-principle studies lay the foundation for further optimization and development that could in the future benefit thousands, if not millions, of people. The BRAIN Initiative is exemplary of cross-NIH research: its mission and activities are transforming neuroscience by fostering an ecosystem of open, inclusive, and ethical science that is favorable to innovation and is accelerating discoveries toward cures.

Cancer Moonshot: The Cancer Moonshot℠ supported the ambitious but attainable goal of reducing age-adjusted cancer death rates by 50 percent by 2047 and improving the quality of life of cancer patients and survivors. Since the Cancer Moonshot was launched in 2016, remarkable progress and notable scientific accomplishments have been made. For example, to help expand our knowledge of tumor growth at the molecular and cellular level NIH launched the Human Tumor Atlas Network (HTAN) in 2018, as part of the Cancer Moonshot initiative.[25] HTAN funded research teams across the country to develop new imaging, genetic analysis, and computational tools to map out the workings of single cells within a tumor. Overall, the network gathered tissue samples from 21 different organ types taken from almost 2,000 people. These included samples from tumors and pre-cancerous growths, and cells from blood cancers like leukemia. NIH-funded researchers were able to identify distinct substructures, which they called microregions, within many tumors. The study showed that cells in different microregions within the tumors often behaved differently. Such tumor cell diversity can pose a challenge for treatment using therapies to target specific mutations. A second phase of HTAN now aims to further build on these results.

With support from the Cancer Moonshot, the National Cancer Institute (NCI) has supported over 70 programs and consortia and almost 300 research projects. The Cancer Moonshot is also responsible for the generation of over 3,400 publications, 89 clinical trials, and 78 patent applications—20 of which have been granted.

Improving Maternal and Women's Health

Women's health is a wide-ranging category that includes health issues that are unique to women, as well as conditions that affect both men and women, but that may affect women differently, such as heart disease and diabetes. While NIH has long supported research into these areas, NIH launched the Women's Health Research Initiative to advance a cutting-edge, interdisciplinary research agenda and to establish a new nationwide network of research centers of excellence and innovation in women's health—which would serve as a national gold standard for women's health research across the lifespan. To support this agenda, the Office of Research on Women's Health (ORWH) ensures that research conducted and supported by NIH addresses issues

[39] pubmed.ncbi.nlm.nih.gov/37824675/
[40] pubmed.ncbi.nlm.nih.gov/38092916/
[41] congress.gov/crs-product/IF12504

regarding women's health. ORWH developed the NIH-Wide Strategic Plan for Research on the Health of Women to outline collective, strategic goals for supporting research through 2028.[42] The plan aims to advance research that examines the multiple biological and behavioral factors that influence the health of women; improve data science and data management practices to prevent and treat conditions affecting women; promote scientific workforce training and education that advances the health of women; support the basic and translational study of the biology underlying sex influences and its intersection with disease and health preservation in women at all ages; and advance community-engaged science across the research and practice continuum and enhance the dissemination and implementation of evidence-based solutions to improve the health of women.

Despite living in one of the world's wealthiest nations, U.S. populations experience the highest rates of maternal deaths and severe maternal morbidity relative to people in other high-income nations. In 2023, the U.S. maternal mortality rate decreased to 18.6 deaths per 100,000 live births from a rate of 32.9 in 2021 and 22.3 in 2022.[43] NIH is tackling these issues head on by implementing multifaceted, innovative research approaches focused on reducing preventable maternal deaths and improving maternal health before, during, and after delivery. Through the NIH-wide Implementing a Maternal health and PRegnancy Outcomes Vision for Everyone (IMPROVE) initiative,[44] NIH drives research to mitigate preventable maternal mortality, decrease severe maternal morbidity, and promote health for all in the United States.

Bolstering maternal health will require collaboration across communities. The NIH Maternal Health Research Centers of Excellence, which was launched in 2023 as part of IMPROVE, works with community partners to design and implement research projects addressing the biological, behavioral, environmental, sociocultural, and structural factors that affect pregnancy-related complications and deaths. Through these partnerships, IMPROVE develops and evaluates innovative approaches to reduce pregnancy-related complications and deaths and promote maternal health. NIH has 12 research centers, a data innovation and coordinating hub, and an implementation science hub.

Understanding and Improving the Health of Older Adults

As Americans live longer, more research is needed on typical and atypical aging processes. NIH has long supported a portfolio focused on the health of aging populations and on conditions that primarily affect older adults. One area of major emphasis is research on Alzheimer's Disease and related dementias (AD/ADRD). The National Institute on Aging (NIA) is the primary federal agency supporting and conducting AD/ADRD research. NIA plays a lead role in implementation of the National Alzheimer's Project Act's national plan to accelerate research on AD/ADRD, and to provide better clinical care and services for people living with dementia and their families. With increased investment in AD/ADRD research, NIH has made incredible progress over the last decade. Through enhanced collaboration and innovative partnerships with industry, other agencies, and people living with dementia and their families, NIH has: advanced understanding of the risk factors, genetics, and mechanisms of disease in dementia; diversified and de-risked the therapeutic pipeline for disease modifying drugs; advanced drug repurposing and

[42] orwh.od.nih.gov/sites/orwh/files/docs/ORWH_NIH-Wide%20Strategic%20Plan_FY2024-2028-508C.pdf
[43] cdc.gov/nchs/data/hestat/maternal-mortality/2023/maternal-mortality-rates-2023.htm
[44] nichd.nih.gov/research/supported/IMPROVE

combination therapy development; discovered tools to detect, diagnose, and monitor dementia; advanced clinical research on lifestyle interventions; increased understanding of how social and physical environmental factors affect dementia risk; and expanded research on dementia care and care partner supports.

Another research area critical to the health of older adults is the field of geroscience, which seeks to understand the genetic, molecular, and cellular mechanisms that make aging a major risk factor and driver of numerous chronic conditions and diseases, including Alzheimer's disease, cancer, cardiovascular diseases, and many others. This growing field is focused on the discovery and translation of methods and interventions to prevent, minimize, or reverse age-related changes in the body that diminish health and quality of life for older people. Research on the biology of aging has shown that the course of aging can be altered in mammals. Geroscience interventions encompass ways to interrupt the molecular and cellular drivers of aging, such as through diet, physical activities, and pharmacology.

The FY 2027 Budget includes $25.0 million for geroscience research at the National Institute on Aging that advances understanding of the causal biomarkers of aging and disease and elevates interventions that interrupt the drivers of aging through diet, physical activities, and pharmacology.

Ending the HIV Epidemic

Ending the HIV epidemic in the United States remains a key priority. For more than 40 years, NIH support has enabled significant advances in antiretroviral therapies, transforming the landscape of care and prevention approaches. Recent breakthroughs in simpler-to-take treatments and long-acting prophylactics, and many other recent breakthroughs, provide us with the technological tools needed to finally win this long battle. To take advantage of this opportunity, the NIH will support implementation science and other research directions to improve the uptake of and access to existing medical and behavioral interventions that can significantly limit and eventually eradicate HIV infection from the United States. Research on HIV/AIDS prevention, treatment, and cure will continue as needed to support this goal.

The NIH Office of AIDS Research (OAR) will coordinate a landscape analysis to understand the current and potential future opportunities for research on HIV and implementation science across NIH Institutes and will work with ICO directors to conduct an analysis of the NIH HIV/AIDS funding portfolio to determine current dollar allocations dedicated to implementation science. OAR will convene a Task Force to inform and expedite the research on the implementation of lenacapavir for HIV treatment and prevention, as well as convene an HIV and implementation science working group comprised of subject matter experts to grow the research program in HIV and implementation science.

NIH will support the continuum of research including discovery, development, and rigorous evaluation of novel interventions and therapeutic agents seeking to prevent, diagnose, treat, and cure HIV. The upcoming FY 2026-2030 NIH Strategic Plan for HIV and HIV-Related Research will outline priorities across the research-to-practice continuum (e.g., aging, co-occurring conditions) to ensure that NIH-funded research remains dynamic and attuned to HIV's changing landscape.

Advancing a Universal Flu Vaccine

The influenza virus remains a deadly and costly pathogen, placing a substantial health and economic burden on the United States and across the world each year. In the United States, the CDC estimates that the disease burden of influenza from 2010 to 2025 has resulted in between 9.4 million and 51 million illnesses, between 120,000 and 710,000 hospitalizations, and between 6,300 and 52,000 deaths annually, all of which results in an estimated $27 billion in health costs.[45]

Current influenza vaccination strategies rely on the development of an annual vaccine targeting the circulating strains that are anticipated to spread in the United States. NIH supports a research portfolio with the goal of developing a universal influenza vaccine to generate robust, long-lasting protection against multiple subtypes of influenza, eliminating the need to update the vaccine each year and protect against newly emerging strains with pandemic potential. NIH-funded researchers are making progress toward this goal by utilizing several novel approaches to develop vaccine candidates for clinical testing. Additionally, NIH-supported researchers are actively identifying and developing novel adjuvants for influenza vaccines to increase their immunogenicity and effectiveness.

In May 2025, HHS and NIH announced the development of the next-generation, universal vaccine platform, Generation Gold Standard, using a beta-propiolactone (BPL)-inactivated, whole virus platform.[46] This initiative represents a decisive shift toward transparency, effectiveness, and comprehensive preparedness, funding NIH's in-house development of universal influenza and coronavirus vaccines, including candidates BPL-1357 and BPL-24910.

Addressing Long COVID

Millions of Americans have recovered from COVID-19 infections, but unfortunately many people are still dealing with the long-term effects, known as post-acute sequelae of SARS-CoV-2 (PASC, or commonly known as Long COVID). Those who suffer from Long COVID experience debilitating fatigue, shortness of breath, pain, difficulty sleeping, racing heart rate, exercise intolerance, gastrointestinal, and other symptoms, as well as cognitive problems that make it difficult to perform at work or school. These symptoms persist long after the initial acute phase of COVID-19 infection has ended. To address this growing public health concern, NIH launched the Researching COVID to Enhance Recovery (RECOVER) initiative,[47] a national research program to understand PASC. The NIH RECOVER initiative funds research that aims to understand how people recover from COVID-19 infection, and why some people do not fully recover and develop Long COVID. The RECOVER initiative brings together patients, caregivers, clinicians, community leaders, and scientists from across the Nation to understand, prevent, and treat Long COVID.

In 2023, the NIH RECOVER initiative launched an open enrollment for phase II clinical trials to evaluate potential treatments for Long COVID. Since establishment, RECOVER has established

[45] cdc.gov/flu-burden/php/about/index.html, February 25, 2026
[46] nih.gov/news-events/news-releases/hhs-nih-launch-next-generation-universal-vaccine-platform-pandemic-prone-viruses
[47] recovercovid.org/

200 observational study sites across 41 states, and funds 8 clinical trials testing 13 potential treatments as well as conducting over 60 pathobiology studies and analyzing over 60 million EHRs.[48] Treatments include drugs, biologics, medical devices, and other therapies. The clinical trials are designed to evaluate multiple treatments simultaneously to identify more swiftly those that are effective. In 2025, RECOVER researchers published 15 research papers in scientific journals to report findings from observational studies and EHR studies. Some key discoveries from the RECOVER observational studies include:

- Females were more likely to have Long COVID symptoms than males.
- Adults who had COVID-19 were more likely to develop a chronic condition called myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) compared to those who did not have COVID-19.
- The most common Long COVID symptoms experienced by children 0 to 5 years old can be different from those experienced by older children and adults.

Based on key collaborator input and lessons learned during its establishment, the RECOVER clinical trials program will be re-envisioned as the RECOVER-Treating Long COVID (RECOVER-TLC) to move beyond symptom-based therapies. Biological insights stemming from the RECOVER program will inform approaches proposed in the RECOVER-TLC clinical trial agenda.

Supporting Innovations in Mental Health Research and Treatment

Progress in basic science has led to new tools and resources which enable investigators to gain significant insight into the complex interactions between the brain, environment, and disease. Intervention research continues to enhance the understanding and effectiveness of evidence-based care in a broad range of settings. NIH supports innovative research to transform the understanding and treatment of mental illness to pave the way for prevention, recovery, and cure. Research has yielded effective, evidence-based preventive interventions for people at high risk of mental and behavioral disorders, as well as interventions that, when delivered early in the course of illness, can significantly improve mental and behavioral health. For example, preventive and early interventions can be effective for alleviating depression, anxiety, schizophrenia, suicide risk, and substance use disorders, and for improving educational attainment. However, there is still a pressing need for research to validate which interventions work best. To address this need, NIH supports targeted initiatives fostering:

- Research focused on streamlining and optimizing evidence-based preventive and early interventions and services for mental and behavioral disorders, and evaluating their effectiveness when implemented in accessible settings (e.g., community clinics, schools, primary care); and
- Implementation research focused on developing and testing strategies to promote the adoption and sustained use of research-informed, high-quality interventions and services, including strategies for training and supporting providers to ensure provider competency and sustained fidelity in the wide-scale delivery of effective preventive and early interventions.

[48] recovercovid.org/news/recovers-mid-year-milestones-look-2025-progress

The Helping to End Addiction Long-term® (HEAL) Initiative

The public health crisis of opioid misuse, addiction, and overdose in America continues to cause suffering and loss, complicated by an increasing overlap with other public health challenges, including those of untreated chronic pain and the national mental health crisis. It is estimated that more than 2 million Americans have opioid use disorder (OUD), and 10 million Americans misuse opioids.[49] Additionally, more than 25 million Americans experience daily pain, putting them at increased risks for opioid use and misuse.[50] Additionally, since early in the COVID-19 pandemic, studies have found increases in the use of many kinds of drugs, including fentanyl, cocaine, heroin, methamphetamine, cannabis, and alcohol.[51] The need for new and effective treatments is real and urgent. NIH continues to identify novel treatment options, including the recent identification of a novel, highly potent synthetic opioid that shows potential as a therapy for both pain and opioid use disorder.[52] This compound demonstrates high pain-relieving effects without causing respiratory depression, tolerance or other indicators of potential for addiction in humans.

NIH launched the HEAL Initiative in 2018 to provide scientific solutions to the opioid crisis and offer new hope for individuals, families, and communities affected by this devastating crisis.[53] The HEAL Initiative continues to be an urgent priority in the face of an evolving opioid crisis. This cross-cutting NIH effort integrates basic, translational, clinical, and implementation science on opioid misuse, addiction, and pain to deliver real outcomes from those affected. To date, the HEAL Initiative has funded over $3.9 billion in research, representing more than 2,200 research projects in all 50 states and the District of Columbia, focused on identifying new therapeutic targets for both pain and OUD, reducing the risk of opioids through nonpharmacological strategies for pain management, and improving opioid addiction treatment in a variety of settings.

Exploring Contributors to the Cause of Autism Spectrum Disorder

NIH is supporting initiatives to understand the etiology and the treatment and care needs of people with autism spectrum disorder (ASD). The Autism Data Science Initiative (ADSI)[54] will continue to support investigators in identifying and addressing data gaps in scientific understanding of the etiology of autism and commonly co-occurring conditions. The program aims to develop knowledge to improve health outcomes for people on the autism spectrum. ADSI will bring together diverse data resources to explore possible contributors to the causes of autism. ADSI will also work to identify how existing treatments/interventions are used and better understand their outcomes to inform the design of future clinical studies. This initiative will achieve these goals through four strategic aims:

1. Support the integration of existing data resources with rigorous privacy protections for analysis by autism researchers.

[49] samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduh-annual-national-report.pdf
[50] cdc.gov/mmwr/volumes/67/wr/mm6736a2.htm?s_cid=mm6736a2_w
[51] pubmed.ncbi.nlm.nih.gov/33965972/
[52] nih.gov/news-events/news-releases/nih-researchers-discover-pain-relieving-drug-minimal-addictive-properties
[53] heal.nih.gov/
[54] dpcpsi.nih.gov/autism-data-science-initiative/funding-opportunities

2. Identify gaps in available data and conduct data generation specifically to fill those gaps.
3. Support analysis of the new data resources to explore the contribution of a variety of health and other factors to the causes of autism.
4. Support independent replication and validation of the initiative's findings.

Accelerating Progress for Individuals with Rare Diseases

NIH remains committed to accelerating progress for individuals with rare and undiagnosed conditions, many of whom still lack basic diagnostic clarity or effective treatments. Of the over 10,000 different rare diseases, less than 5 percent have FDA-approved treatments. NIH remains committed to conducting research to find treatments and cures for rare diseases, with top priorities covering all aspects of the "many diseases at a time" research strategy, with components in awareness, information, diagnosis, and treatment. The agency will expand support for the use of multi-omic profiling, platform trials, and decentralized clinical trial designs, via the Rare Diseases Clinical Research Network (RDCRN)[55] and related programs. The RDCRN program is a highly collaborative, patient-centric program of 20 clinical research consortia studying over 200 rare diseases. Since 2010, the FDA has approved 12 treatments for 11 rare diseases, which would not be possible without the expertise and infrastructure built by the RDCRN.

To treat diseases at the root cause, NIH is improving genome-editing technologies through the Common Fund Somatic Cell Genome Editing program which develops therapeutic platform treatments to impact many diseases. Additionally, both the Bespoke Gene Therapy Consortium and Platform Vector Gene Therapy programs are developing multiple gene therapy products towards first in human clinical trials, while exploring how to navigate the regulatory path more efficiently and disseminating this knowledge.

NIH is able to rapidly screen existing pharmaceutical collections for potential targets through the Therapeutics for Rare and Neglected Diseases Program which supports preclinical development and testing of therapeutic candidates intended to treat rare and neglected disorders. The Clinical Trial Readiness for Rare Diseases, Disorders, and Syndromes Program supports projects focused on collecting the data needed to move promising rare disease therapies and diagnostics into clinical trials.

NIH will also leverage AI and RWD to identify previously unrecognized subpopulations, exogenous contributors such as environmental chemical exposures or lifestyle factors, and novel therapeutic targets. Technological advances in Alternative Testing Models, such as patient-derived organoids and computational digital twins, will be applied to better understand individual phenotypes and gene-environment interactions contributing to disease manifestations and inform treatment strategies.

Shifting to Solution-Oriented Approaches

The Risk Underlying Rural Areas Longitudinal (RURAL) cohort study,[56] founded in 2019, helps address the high burden of chronic disease in America's heartland. RURAL addresses the high burden of chronic heart and lung disease in 10 rural counties in Alabama, Kentucky, Louisiana,

[55] ncats.nih.gov/research/research-activities/rdcrn/consortia
[56] reporter.nih.gov/project-details/9710174#description

and Mississippi by using community-engaged partners and high-tech mobile research units to collect data, including medical histories, as well as familial, lifestyle, and behavioral factors. The study will follow more than 4,600 participants over the course of 6 years. RURAL's state-of-the-art mobile exam unit (MEU) brings badly needed health technologies that make it possible for researchers to get the information they need to the region. The MEU has the functionality of an urban primary care office, housing a high-tech medical imaging room, examination room, laboratory, and waiting room

Integrating AI Across Biomedical Research

NIH promotes the use of AI and ML in biomedical research through programs that support the development and use of algorithms and models for research, contribute to AI-ready datasets that accelerate discovery, and encourage multi-disciplinary partnerships that drive innovation.

NIH Data Science Strategy: The NIH Strategic Plan for Data Science was released in June 2025, charting the course for how biomedical data will transform health research over the next five years. The plan has five goals: 1) Improve data management and sharing capabilities, 2) Enhance human-derived data for research, 3) Advance software, computational methods, and AI, 4) Support a federated biomedical research data infrastructure, and 5) Strengthen the data science community. The updated NIH Strategic Plan for Data Science sets a bold vision for the future, in which data generated in individual care and from biomedical and basic research become powerful inputs that enhance our understanding of fundamental biology and enable the development of new clinical treatments and diagnostic technologies.[57]

TrialGPT: A team of researchers from NIH's National Library of Medicine (NLM) and NCI harnessed the power of large language models to develop an innovative tool called TrialGPT to streamline the clinical trial matching process. TrialGPT first processes a patient summary, which contains relevant medical and demographic information. The algorithm then identifies relevant clinical trials from ClinicalTrials.gov for which a patient is eligible and excludes trials for which they are ineligible. TrialGPT then explains how the person meets the study enrollment criteria. The final output is an annotated list of clinical trials—ranked by relevance and eligibility—that clinicians can use to discuss clinical trial opportunities with their patient.[58] Given promising benchmarking results, the research team was recently selected for The Director's Challenge Innovation Award to further assess the model's performance and fairness in real-world clinical settings. The researchers anticipate that this work could make clinical trial recruitment more effective and help reduce barriers to participation for populations underrepresented in clinical research.

Investing in the Next Generation of Biomedical Researchers

A critical aspect of NIH supporting the discovery of novel diagnostics, therapeutics, and cures to disease is training the next generation of biomedical researchers and enabling the use of top tier facilities, infrastructure, and ecosystems that can support the state-of-the-art science advances that NIH makes every day.

[57] datascience.nih.gov/nih-strategic-plan-data-science
[58] ncbi.nlm.nih.gov/research/trialgpt/

The health of the Nation stands on the shoulders of the creative, proficient, and dedicated biomedical research workforce committed to pursuing scientific inquiry and tackling public health challenges. As such, NIH has prioritized investing in the brightest minds in biomedical research and supporting programs preparing the next cohort of biomedical researchers necessary for driving the health care advances of the 21st century. NIH training programs will continue to focus on training future physicians and scientists to lead American preeminence in biomedical research. Programs will allow trainees to design and conduct the highest quality scientific studies. Importantly, these programs will be based on merit, follow civil rights law, and not discriminate against anyone. NIH and NIH-funded institutions must also uphold safe, equal, and healthy working and learning conditions conducive to high-quality research and free inquiry.

Additionally, NIH is committed to addressing longstanding challenges faced by Early-Stage Investigators (ESIs) trying to embark upon and sustain independent research careers. NIH has launched a variety of innovative initiatives aimed at fostering the next generation of the biomedical workforce. NIH implemented the Next Generation Researchers Initiative (NGRI)[59] in 2017 to promote earlier research independence through policies that increase opportunities for new researchers to receive funding and enhance training and mentorship programs. Among other things, NGRI prioritizes R01-equivalent ESI applications for funding. By providing priority for ESI applications, NIH aims to increase awards that support researchers earlier in their career.

As a result of NGRI initiatives and other ESI policy efforts, the number of NIH-funded ESIs has increased from 978 in FY 2016 (before NGRI was started) to 1,144 in FY 2025.[60,61] The policies prioritizing ESIs have also led to a lower age at first R01-equivalent award supporting ESIs (median age of 39 years) compared to others supported by their first award (median age of 47 years) in FY 2023. These data suggest the focus on ESIs may be lowering the age at which these new investigators are supported by their first NIH award compared to their peers.

The NIH Director's New Innovator Award, also known as the DP2, a component of the High-Risk, High-Reward Program of the Common Fund, is coordinated with multiple NIH Institutes. The award supports exceptionally creative ESIs who propose innovative, high-impact projects in the biomedical, behavioral, or social sciences within the NIH mission. This award is different from traditional NIH grants as it specifically supports exceptionally creative investigators with highly innovative research ideas at an early stage of their career when they may lack the preliminary data required for a conventional R01-equivalent grant application. The NIH Director's New Innovator Award supported 29 investigators in FY 2025.[62]

The NIH Director's Early Independence Award, also known as the DP5, is a Common Fund initiative coordinated with multiple NIH Institutes. This award supports outstanding junior scientists with the intellect, scientific creativity, drive, and maturity to bypass the traditional

[59] grants.nih.gov/ngri.htm
[60] report.nih.gov/nihdatabook/category/15
[61] report.nih.gov/nihdatabook/report/304
[62] commonfund.nih.gov/highrisk/news/nih-award-over-179-million-support-highly-innovative-biomedical-and-behavioral

postdoctoral training period to accelerate the launch of their independent research careers. The Early Independence Award supported 13 investigators in FY 2025.[63]

Easing Administrative and Regulatory Burdens in Research and Grantmaking

Administrative burden represents the cost, in terms of time and resources, spent applying for, receiving, or participating in federal programs, including federal research funding. While these requirements are essential in ensuring the proper oversight, stewardship, and transparency of NIH-supported biomedical and behavioral research, reducing administrative burden where possible increases the amount of time that investigators can spend on research and that administrators can spend supporting the research enterprise.

NIH is committed to reducing potential administrative burden throughout its extramural research activities, when feasible, through a variety of initiatives. NIH has formed a board, in collaboration with the Federal Demonstration Partnership, tasked with making recommendations meant to reduce administrative burden on researchers. To ease administrative burden in the grant application process, NIH has implemented a Common Disclosure Form, allowed just-in-time reporting for appropriate application sections, redesigned the NIH Grants and Funding site, adopted electronic signatures on National Research Service Award Payback Agreements, initiated the use of the open researchers and contributor identification (ORCID) system, and expanded the use of National Institute of General Medical Sciences (NIGMS) Maximizing Investigators' Research Awards to reduce the time spent by researchers writing and reviewing grant applications. NIH also reduced administrative burden in the peer review of grant applications by implementing the simplified review framework, applying updates to institutional training grant applications, and adopting changes to the NIH fellowship application and review process. NIH has also improved grants management by strengthening foreign subaward reporting, eliminating the quarterly federal cash transaction report, and making administrative flexibilities available.

The FY 2027 Budget proposes to fully fund the outyear commitments of all competing research project grant (RPG) awards as part of the initial grant obligation, to facilitate efficient management of resources across multiple years. This policy continues the transition to increase full funding for RPGs that began in FY 2025. Traditionally, most NIH research grants were awarded for more than one year and funded incrementally; each year’s commitment was obligated from that year’s appropriation. Under the incremental funding approach, grants are classified as competing in the first year of award or renewal, and noncompeting in the remaining years of each award. As an alternative to incremental funding, full funding was provided up front for a limited number of grants and cooperative agreements as appropriate in special circumstances. Completing the transition to upfront funding for competing RPGs will increase NIH budget flexibility by no longer encumbering large portions of each year’s appropriation for the continuation of research projects that were initiated in previous years. As “legacy” noncompeting research projects phase out over the next few years, this shift in grants policy will make a greater portion of RPG funding available for new research projects each year.

[63] commonfund.nih.gov/highrisk/news/nih-award-over-179-million-support-highly-innovative-biomedical-and-behavioral

Supporting Research Resources and Infrastructure

A critical aspect of NIH supporting the discovery of novel diagnostics, therapeutics, and cures to disease is having facilities, infrastructure, and ecosystems that can support the state-of-the-art science advances that NIH makes every day.

Real-World Data Platform (RWD) and Clinical Center (CC) Electronic Health Records (EHR) Modernization: NIH's RWD platform will serve as a national foundation for 21st-century health research by integrating a variety of large-scale data streams, such as EHRs, claims data, wearable and sensor outputs, genomics data, and environmental exposure data, into an AI-ready, interoperable research infrastructure that maintains the highest standards of security and privacy. The FY 2027 Budget includes $60.0 million to further expand and operationalize this platform to support scalable, privacy-preserving data sharing across NIH Institutes and partners such as the Centers for Medicare & Medicaid Services (CMS), FDA, the Department of Veteran's Affairs (VA), and others, while advancing methodological innovation in causal inference, data harmonization, and quality assurance. As a single, integrated solution, it will eliminate redundancies from data collection, linkage, and analysis infrastructures, and dramatically reduce administrative overhead by relying on a unified set of data use and governance agreements. It will also provide direct access to advanced computational resources such as ML/AI modeling, petabyte-scale storage/compute, and high-throughput analytics. The platform will be central to enabling research that is reflective of real-world populations, delivers actionable insights, and is relevant to dynamic, evolving health challenges.

This initiative will also support a new EHR system at the NIH CC. The goal of the EHR modernization project is to improve the NIH CC's current EHR, decrease complexity and fragility, and improve user acceptance in the provision of safe and high-quality care to patients at the CC. This would replace the existing Clinical Research Information System (CRIS) that was first installed in 2004 and is reaching the end of its useful life. Funds for the CC EHR upgrade will be executed through the CC's existing mechanism.

Buildings and Facilities (B&F)*:* Facilities must co-evolve with science for NIH to achieve its full potential. In FY 2027, the Budget proposes $350.0 million for B&F, sustaining the FY 2026 Enacted funding level. This amount will assist in addressing the pressing campus-wide infrastructure needs identified in the independent review of the facility needs of NIH's main campus in 2019 by the National Academies of Sciences, Engineering, and Medicine. NIH's Backlog of Maintenance and Repair (BMAR) was approximately $4.6 billion at the end of FY 2025. The B&F request would enable NIH to improve the condition of its facilities and curtail the growth of the BMAR. Research facilities will play an important role in NIH's ability to respond to national and global health threats. This budget aims to adapt NIH buildings and infrastructure to a changing biomedical research landscape, while maintaining the safety and reliability of its buildings and infrastructure.

Research Resource Infrastructure: NIH opened a new fabrication facility, the Biomedical Engineering and Technology Acceleration (BETA) Center Makerspace,[64] on the Bethesda campus. It offers the NIH research community access to various fabrication tools and equipment to help meet their needs. Through project consultation, workshops, and hands-on training, the

[64] nibib.nih.gov/labs-at-nibib/center-for-biomedical-engineering-technology-acceleration-beta/makerspace

Makerspace aims to help users build their confidence in operating available fabrication equipment to innovate and advance their research. The Makerspace offers NIH scientists access to various tools, such as fused disposition modeling, resin, and metal 3D printers and laser cutters. Officially launched in May 2025, the Makerspace has welcomed NIH scientists who have already used the facility to fabricate specialized tools, including a positioning device designed to accurately center biological samples in Petri dishes for imaging.

Cybersecurity: NIH continues to prioritize and invest in cybersecurity infrastructure to protect sensitive research data and maintain the integrity of its research enterprise systems.

Conclusion

The FY 2027 President's Budget request for NIH supports its focus on advancing research that is rigorous, cutting-edge, and directly responsive to the most pressing health challenges facing the American people. Millions of children and adults continue to experience poor outcomes from chronic conditions such as obesity, heart disease, cancer, and related disorders. To Make America Healthy Again, NIH must build on its strong track record of addressing complex scientific challenges and recommit to confronting the chronic disease crisis affecting families and communities nationwide. While NIH will continue to lead in basic research, it will also emphasize research with the potential to translate more directly and rapidly to the patients who need it.

Equally importantly, NIH must maintain the confidence and trust of the American people. Scientific discoveries can only improve health if the public has confidence in the rigor, transparency, and integrity of the research that underpins them. Strengthening that trust is essential to ensuring NIH continues to serve the public interest effectively.

NIH will continue to sustain the Nation's investment in biomedical research and to advance science that improves health, reduces disease burden, and delivers real benefits for the American people.

OVERVIEW OF PERFORMANCE

The NIH mission is to seek fundamental knowledge about the nature and behavior of living systems and to apply that knowledge to enhance health, lengthen life, and reduce illness and disability. Investments in basic biomedical and behavioral research make it possible to understand the causes of disease onset and progression, design preventive interventions, develop better diagnostics, and discover new treatments and cures. Realizing the benefits of fundamental biomedical discoveries depends on supporting research to translate and effectively disseminate that knowledge to advance the development and adoption of new diagnostics, therapeutics, and preventive measures to improve health.

The FY 2027 budget request reflects the Agency's longstanding commitment to invest strategically using performance-based analysis, as emphasized in the Government Performance and Results Act (GPRA) (P.L. 103-62), as amended by the GPRA Modernization Act of 2010 (P.L. 111-352). Through the continuous evaluation and strategic management of its research portfolio, NIH focuses on funding research that offers the greatest promise for improving the overall health and well-being of the American people. In addition, NIH continually seeks to identify and address high-priority scientific opportunities and emerging public health needs. By managing its research portfolio to support key research priorities, NIH ensures the most effective use of funds to achieve the greatest impact on the health and welfare of the Nation. In particular, NIH's strong peer-review process, site visits, performance monitoring, program evaluation, and performance-based contracting enable the Agency to ensure that its investments generate results for the American people.

NIH strives to achieve transparency and accountability by regularly reporting results, achievements, and the impact of its activities. As outlined in the *NIH-Wide Strategic Plan for FY 2021-2025,*[65] NIH supports a wide spectrum of biomedical and behavioral research and engages in a full range of activities that enable research. Because of this variability and complexity, NIH uses a set of representative performance measures that reflects the priorities enumerated in the *Plan* and allows for tracking progress on the *Plan*. Collectively, NIH's measures reflect the Agency's objectives to 1) advance biomedical and behavioral sciences; 2) develop, maintain, and renew scientific research capacity; and 3) exemplify and promote the highest level of scientific integrity, public accountability, and social responsibility in the conduct of science. Furthermore, the measures support the Department of Health and Human Services mission to enhance the health and well-being of all Americans.

Performance Management

Performance management at NIH is an integrated and collaborative process to ensure that the Agency is achieving its mission to conduct and support research to improve public health. At the Agency level, the NIH Director sets priorities, monitors performance, and reviews results across its component Institutes and the Office of the Director (OD). OD is the central office responsible for setting policy for NIH, and for planning, managing, and coordinating the programs and activities of all NIH components. The NIH Director provides leadership to the Institutes and helps identify needs and opportunities, especially for efforts that involve multiple institutes. The

[65] nih.gov/about-nih/nih-wide-strategic-plan (NIH's FY 2026-2030 *Plan* is forthcoming)

Institutes and OD offices carry out priority setting, performance monitoring and progress reviews, and adjust based on progress achieved in their respective areas of science. In addition to the performance management processes that occur for the NIH research program, there are equivalent processes for research capacity-building programs and administrative management functions.

The NIH performance framework includes: 1) priority setting with input from key communities; 2) implementation and management of activities that support priorities; 3) monitoring and assessment of progress, and identification of successes, challenges, and new opportunities; 4) oversight by institute leadership and OD office directors in assessing overall progress toward priorities and identification of best practices, appropriate next steps, and corrective actions (as needed); 5) incorporation of regular feedback from institute and OD office leadership to enhance activities; 6) regular reviews of priorities, progress, and outcomes by the NIH Director and Institute Directors; and 7) regular review of performance and priorities by external expert review groups including grant peer-review groups, Advisory Councils, and ad-hoc working groups.

Qualitative and quantitative information is used to monitor progress and help to identify successes, as well as obstacles in achieving short- and long-term goals. Supporting high-quality research is a process of adapting to new developments and newly identified barriers, and frequently involves shifting resources to pursue promising unanticipated results that may provide critical new information. Moreover, the impact of research may not be immediately known and may depend on additional development or on advances in other fields. Despite these challenges, NIH leadership is able to manage performance effectively by using the best available information to assess progress toward achieving priorities and making appropriate adjustments.

All scientific research carried out through NIH support is subjected to a rigorous review process. For example, the Extramural Research Program, which accounts for the majority of NIH-funded research, utilizes two levels of peer review. The first level, in which scientific excellence is assessed, consists of chartered scientific review groups composed of outside experts in particular scientific disciplines. The second level, in which public health relevance is assessed, is conducted by National Advisory Councils of the Institutes. For the Intramural Research Program, the progress of individual scientists and their laboratories is evaluated once every four years by Boards of Scientific Counselors composed of external experts. These reviews enable ongoing assessments of all intramural labs and the accomplishments of the scientists who contribute to them. It is through this well-honed system of peer review that NIH maintains its focus on supporting research of the highest possible quality with the greatest potential of furthering NIH's mission.

The NIH approach to performance management is undergirded by the NIH Governance Structure. That structure includes the NIH Steering Committee and standing Working Groups.[66] Ad-hoc working groups are established, as needed, to address emerging issues. The premise of the structure is that shared governance, which depends on the active participation of the Institute

[66] As of January 2026, the standing working groups are: Board of Scientific and Clinical Directors, Clinical Center Governing Board, Extramural Activities Working Group, Enterprise Information Technology Council, Facilities Working Group, Management and Budget Working Group, Research Services Working Group, and the Scientific Data Council.

Directors with the NIH Director, will foster the collaborative identification of corporate issues and a transparent decision-making process. With active participation by the Institute Directors in NIH-wide governance, NIH can maximize its perspective and expertise in the development and oversight of policies common to NIH and its components. Through the governance process, corporate decisions are made; these may be long-term and strategic (e.g., facilities planning, budget strategy, and research policy direction) or short-term and tactical (e.g., stipend levels, resource allocations, and compliance oversight). This process does not include issues related to the setting of scientific priorities, which is reserved for meetings of all Institute Directors. The NIH Director meets with the Institute Directors on a bi-weekly basis, and scientific initiatives are discussed, as well as major management issues that affect the Agency. In addition, scientists – from within and outside the Agency – are invited to present on new or emerging research opportunities. The NIH Director stays informed of priorities through regular meetings with Institute and OD Office Directors. Similarly, the Institute Directors monitor performance through regular meetings with the Division Directors and Scientific/Clinical Directors in their respective Institutes.

Based on these reviews, leadership and their staff take appropriate actions to support research activities. For example, reviews may lead to the development of new policies or programs for early-career researchers, the development of new funding announcements for promising research areas, or new collaborations across NIH and/or with other Federal and non-Federal partners. The NIH Director and senior leadership receive regular updates on the progress on priorities, provide feedback, and incorporate the latest information into the NIH's overall planning and management efforts. This constant feedback loop enables NIH to make critical adjustments periodically to align activities and target resources in support of its research priorities.

ALL PURPOSE TABLE

(Dollars in Millions)[1,2,3,4]	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Total, NIH Program Level	**$46,001.287**	**$46,497.193**	**$41,471.405**	**-$5,025.788**
Less mandatory and funds allocated from different sources:				
PHS Program Evaluation	$1,412.482	$1,427.482	$260.000	-$1,167.482
Mandatory Type 1 Diabetes Research[5]	$119.094	$200.000	$47.538	-$152.462
Total, NIH Discretionary Budget Authority[6]	**$44,469.711**	**$44,869.711**	**$41,163.867**	**-$3,705.844**
Number of Competing RPGs	*8,016*	*9,712*	*5,145*	*-4,567*
Total Number of RPGs	*39,885*	*38,611*	*31,162*	*-7,449*
FTE[7]	*18,733*	*17,208*	*17,557*	*349*

1 Numbers may not add due to rounding.

2 Includes 21st Century Cures Act funding; excludes supplemental and emergency funding.

3 The FY 2027 Budget proposes to relocate NIEHS and NIEHS Superfund from NIH to the Centers for Disease Control and Prevention (CDC). Funding and other levels in this table are displayed comparably and as a result exclude $993.521 million in FY 2025 and $990.907 million in FY 2026 for these relocated programs. For information on NIEHS and NIEHS Superfund, please see the CDC Congressional Justification.

4 The FY 2025, 2026, and 2027 columns reflect a reduction by transfer of $5.0 million from OD to the HHS Office of Inspector General.

5 FY 2027 amount reflects funding of $50.411 million provided by the Consolidated Appropriations Act, 2026 and is reduced by $2.873 million for Budget Control Act sequestration.

6 All discretionary budget authority is within the Labor/HHS appropriations subcommittee.

7 Includes 4 NIH FTEs funded by PHS trust funds in all years.

IMPACT OF BUDGET LEVEL ON PERFORMANCE

Programs and Measures[1,2,3] (Dollars in Millions, except where noted)	**FY 2025 Final**	**FY 2026 Enacted**	**FY 2027 President's Budget**	**FY 2027 +/- FY 2026**
Research Project Grants	$26,997.951	$27,207.696	$24,424.756	-10.2%
Competing Average Cost (in thousands)	$759	$720	$1,771	146.0%
Number of Competing Awards (whole number)	8,016	9,712	5,145	-47.0%
Estimated Competing RPG Success Rate	13.0%	14.9%	7.8%	-47.7%
Research Centers	$2,594.578	$2,579.935	$2,044.692	-20.7%
Other Research	$3,161.514	$3,119.376	$2,619.214	-16.0%
Training	$948.625	$1,008.982	$932.827	-7.5%
Research & Development Contracts	$3,080.476	$3,286.257	$2,805.380	-14.6%
Intramural Research	$4,811.858	$4,916.778	$4,635.986	-5.7%
Research Management and Support	$2,387.355	$2,379.525	$2,139.159	-10.1%
Common Fund (non-add)	*$685.001*	*$572.401*	*$515.401*	*-10.0%*
Buildings & Facilities Appropriation	$350.000	$350.000	$350.000	0.0%
Other Mechanisms[4,5]	$1,668.929	$1,648.644	$1,519.392	-7.8%
Total, Program Level[6]	**$46,001.287**	**$46,497.193**	**$41,471.405**	**-10.8%**

[1] Numbers may not add due to rounding.

[2] The FY 2027 Budget proposes to relocate NIEHS and NIEHS Superfund from NIH to the Centers for Disease Control and Prevention. Funding levels in this table are displayed comparably and as a result exclude NIEHS and NIEHS Superfund in FY 2025 and FY 2026. For NIEHS and Superfund amounts excluded are $993.5 million in FY 2025 and $990.9 million in FY 2026.

[3] Excludes the Advanced Research Projects Agency for Health.

[4] Includes Office of the Director-Other, and Buildings and Facilities funding in the National Cancer Institute.

[5] Amounts reflect directive transfer of $5.0 million to the HHS Office of Inspector General.

[6] Includes discretionary budget authority received from Labor/HHS appropriations bill. Also includes program evaluation financing and mandatory budget authority for Type 1 Diabetes.

BUDGET MECHANISM TABLE

(Dollars in Thousands)[1,2,3,4]	FY 2025		FY 2026		FY 2027			
	Final[9]		Enacted[9]		President's Budget[9]		+/- FY 2026	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Research Projects:								
Noncompeting	30,217	$19,287,977	27,186	$18,551,167	24,462	$13,910,125	-2,724	-$4,641,042
Administrative Supplements[3]	*(2,204)*	387,057	*(1,933)*	386,309	*(1,506)*	265,086	*(-427)*	-121,223
Competing	8,016	$6,084,538	9,712	$6,990,875	5,145	$9,113,485	-4,567	$2,122,609
Subtotal, RPGs	38,233	$25,759,571	36,898	$25,928,351	29,607	$23,288,696	-7,291	-$2,639,656
SBIR/STTR	1,652	1,238,380	1,713	1,279,344	1,555	1,136,060	-158	-143,284
Research Project Grants	39,885	$26,997,951	38,611	$27,207,696	31,162	$24,424,756	-7,449	-$2,782,940
Research Centers:								
Specialized/Comprehensive	1,025	$2,145,422	1,041	$2,204,743	1,010	$1,875,085	-31	-$329,658
Clinical Research	24	196,809	13	114,231	0	0	-13	-114,231
Biotechnology	30	39,295	29	41,285	29	38,266	0	-3,019
Comparative Medicine	46	128,158	48	132,458	48	131,341	0	-1,117
Research Centers in Minority Institutions	21	84,895	22	87,219	0	0	-22	-87,219
Research Centers	1,146	$2,594,578	1,153	$2,579,935	1,087	$2,044,692	-66	-$535,244
Other Research:								
Research Careers	4,745	$904,813	4,907	$936,186	4,439	$846,577	-468	-$89,609
Cancer Education	92	25,863	92	25,863	92	25,863	0	0
Cooperative Clinical Research	184	470,459	284	495,898	277	438,487	-7	-57,412
Biomedical Research Support	127	107,705	120	102,185	32	87,044	-88	-15,141
Other Biomedical Research Support	38	14,439	8	9,495	8	8,712	0	-783
Other	2,291	1,638,235	2,181	1,549,750	1,821	1,212,531	-360	-337,218
Other Research	7,477	$3,161,514	7,592	$3,119,376	6,669	$2,619,214	-923	-$500,162
Total Research Grants	48,508	$32,754,043	47,356	$32,907,007	38,918	$29,088,661	-8,438	-$3,818,346
Ruth L Kirchstein Training Awards:	FTTPs		FTTPs		FTTPs		FTTPs	
Individual Awards	3,595	$183,604	4,101	$212,591	3,641	$187,416	-460	-$25,175
Institutional Awards	12,246	765,021	12,505	796,391	11,754	745,411	-751	-50,980
Total Research Training	15,841	$948,625	16,606	$1,008,982	15,395	$932,827	-1,211	-$76,155
Research & Development Contracts	2,268	$3,080,476	2,284	$3,286,257	1,888	$2,805,380	-396	-$480,878
(SBIR/STTR) (non-add)[3]	*(79)*	*(62,988)*	*(49)*	*(43,066)*	*(35)*	*(32,028)*	*(-14)*	*(-11,038)*
Intramural Research		$4,811,858		$4,916,778		$4,635,986		-$280,792
Research Management & Support		2,387,355		2,379,525		2,139,159		-240,365
(SBIR Admin) (non-add)[3]		*(12,842)*		*(16,336)*		*(14,660)*		*(-1,676)*
Office of the Director - Appropriation[3,5]		*(2,633,425)*		*(2,498,971)*		*(2,290,514)*		*(-208,457)*
Office of the Director - Other		1,638,929		1,618,644		1,489,392		-129,252
ORIP (non-add)[3,5]		*(309,495)*		*(307,926)*		*(285,721)*		*(-22,205)*
Common Fund (non-add)[3,5]		*(685,001)*		*(572,401)*		*(515,401)*		*(-57,000)*
Buildings and Facilities[6]		380,000		380,000		380,000		0
Appropriation[3]		*(350,000)*		*(350,000)*		*(350,000)*		*(0)*
Type 1 Diabetes[7,8]		-119,094		-200,000		-47,538		152,462
Program Evaluation Financing[7]		-1,412,482		-1,427,482		-260,000		1,167,482
Subtotal, Labor/HHS Budget Authority		**$44,469,711**		**$44,869,711**		**$41,163,867**		**-$3,705,844**
Total, NIH Discretionary Budget Authority		**$44,469,711**		**$44,869,711**		**$41,163,867**		**-$3,705,844**
Type 1 Diabetes[8]		119,094		200,000		47,538		-152,462
Total, NIH Budget Authority		**$44,588,805**		**$45,069,711**		**$41,211,405**		**-$3,858,306**
Program Evaluation Financing		1,412,482		1,427,482		260,000		-1,167,482
Total, Program Level		**$46,001,287**		**$46,497,193**		**$41,471,405**		**-$5,025,788**

See footnotes on the following page.

Budget Mechanism Table footnotes.

[1] All Subtotal and Total numbers may not add due to rounding.

[2] Includes 21st Century Cures Act funding; excludes supplemental-related funding.

[3] All numbers in italics and brackets are non-add.

[4] The FY 2027 Budget proposes to relocate NIEHS and NIEHS Superfund from NIH to the Centers for Disease Control and Prevention (CDC). Funding and other levels in this table are displayed comparably and as a result do not include $993.521 million in FY 2025 and $990.907 million in FY 2026 for these relocated programs. For information on NIEHS and NIEHS Superfund, please see the CDC Congressional Justification.

[5] Number of grants and dollars for the Common Fund and ORIP components of OD are distributed by mechanism and are noted here as non-adds. Office of the Director - Appropriation is the non-add total of these amounts and the funds accounted for under OD - Other.

[6] Includes B&F appropriation and monies allocated pursuant to appropriations acts provisions that funding may be used for facilities repairs and improvements at the NCI Federally Funded Research and Development Center in Frederick, Maryland.

[7] Number of grants and dollars for mandatory Type 1 Diabetes (T1D) and NIGMS Program Evaluation financing are distributed by mechanism above; therefore, T1D and Program Evaluation financing amounts are deducted to provide subtotals for Labor/HHS Budget Authority.

[8] FY 2027 amount reflects funding of $50.411 million provided by the Consolidated Appropriations Act, 2026 and is reduced by $2.873 million for Budget Control Act sequestration.

[9] Reflects a reduction by transfer of $5.0 million from OD to the HHS Office of Inspector General.

AUTHORIZING LEGISLATION

(Dollars in Thousands)	FY 2026 Amount Authorized	FY 2026 Amount Appropriated	FY 2027 Amount Authorized	FY 2027 President's Budget
National Institutes of Health Activity:				
1. Biomedical Research under Section 301 and Title IV of the PHS Act:				
General Authorization: Section 402A(a)(1) of the PHS Act[1,2]	TBD	46,977,400	TBD	41,416,267
Advanced Research Projects Agency-Health: Section 499A(s) of the PHS Act	500,000	1,500,000	500,000	945,000
Pediatric Research Initiative: Section 402A(a)(2) of the PHS Act	12,600	12,600	12,600	12,600
2. Superfund Research Program: Section 311(a) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, and Section 126(g) of the Superfund Amendments and Reauthorization Act of 1986[2]	Indefinite	77,100	Indefinite	0
3. 21st Century Cures Act:				
Precision Medicine: Section 1001(b)(4)(A)	31,000	31,000	0	0
BRAIN Initiative: Section 1001(b)(4)(B)	195,000	195,000	0	0
Cancer Moonshot: Section 1001(b)(4)(C)	0	0	0	0
4. Special Diabetes Programs: Section 330B(b) of the PHS Act[3]	200,000	200,000	50,411	47,538

[1]The authorization of appropriations expired as of September 30, 2020.

[2]The FY 2026 Amount Appropriated column includes NIEHS and NIEHS Superfund. The FY 2027 Budget proposes to relocate NIEHS and NIEHS Superfund from NIH to the Centers for Disease Control and Prevention.

[3]The amount for the Special Diabetes Programs in the FY 2027 Amount Authorized column reflects the funding level enacted on February 3, 2026 in Public Law 119-75 for the period beginning on October 1, 2026, and ending on December 31, 2026. The amount for the Special Diabetes Programs in the FY 2027 President's Budget column reflects a reduction of $2.873 million due to Budget Control Act sequestration.

NARRATIVE BY ACTIVITY TABLE/HEADER TABLE

(Dollars in Millions)	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Program Level[1,2,3,4]	$46,001.3	$46,497.2	$41,471.4	-$5,025.8
FTE	18,733	17,208	17,557	349

[1] All columns exclude supplemental funds.

[2] Includes 21st Century Cures Act funding and mandatory funding for Type 1 Diabetes; includes NIGMS Program Evaluation funding (in thousands) of $1,412,482 in FY 2025, $1,427,482 in FY 2026, and $260,000 in FY 2027.

[3] The FY 2027 Budget proposes to relocate NIEHS and NIEHS Superfund from NIH to the Centers for Disease Control and Prevention (CDC). Funding levels in this table are displayed comparably and as a result exclude $993.521 million and 615 FTE in FY 2025, and $990.907 million and 561 FTE in FY 2026 for these programs. For information on these programs, please see the CDC Congressional Justification.

[4] All years reduced by transfer to the HHS Office of Inspector General ($5.0 million).

Allocation Methods: Competitive Grants; Contract; Intramural; Other

PROGRAM DESCRIPTIONS AND ACCOMPLISHMENTS

The National Institutes of Health (NIH) seeks fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to improve the health of the Nation. To achieve these goals, NIH supports research on healthy development and aging and the causes, prevention, and treatments of human diseases and disorders. NIH also advances methods for collecting and disseminating data and health information.

In FY 2025, NIH-funded scientists continued to make paradigm-shifting contributions across the full spectrum of biomedical, behavioral, and social sciences. NIH has continued to adopt new approaches to enhance mission-critical scientific research. The lessons learned continue to both inform other research areas and ensure preparedness for future public health challenges. Examples of these accomplishments include:

- NIH-funded researchers developed a **brain-computer interface** that quickly translates brain activity into audible words. The researchers implanted a device over the brain area where speech is encoded in a 47-year-old woman with paralysis. She had not been able to speak or make any vocal sounds for 18 years following a stroke. The team used a deep learning system they designed to translate the woman's thoughts into spoken words. The researchers found that the system was not limited to trained words or sentences—it could make out novel words and decode new sentences to produce fluent speech. The device could also produce speech indefinitely without interruption. These findings show that such devices can allow those unable to speak to join in more natural conversation again, but more research is needed to test the device.[67]

- A research team supported by NIH has developed and safely delivered a **personalized gene editing therapy** to treat an infant with a life-threatening, incurable rare genetic disease. Researchers set out to develop a way to create a personalized gene therapy for patients with rare metabolic disorders, specifically one manifested in infancy, where ammonia builds up and causes damage to the brain and liver, making liver transplant necessary. After years of development and testing, the Food and Drug Administration approved their experimental gene therapy customized to correct an infant's specific mutation. Within weeks after the infusions, the infant showed signs of response to treatment with no negative side effects. The researchers will continue long-term follow-up to fully analyze the safety and effectiveness of this therapy, but with further study, this type of personalized gene therapy holds promise for treating a variety of disorders.[68]

- NIH-funded researchers designed a blood test to measure levels of three compounds that could **predict women's risk for cardiovascular disease** decades later. The study measured blood cholesterol and inflammation for up to 30 years to see if those measures had predictive capability for cardiovascular disease later in life. The findings may lead to ways to detect and treat cardiovascular disease earlier.[69]

[67] nih.gov/news-events/nih-research-matters/brain-computer-interface-restores-natural-speech-after-paralysis
[68] nih.gov/news-events/nih-research-matters/infant-rare-disease-receives-customized-gene-therapy
[69] nih.gov/news-events/nih-research-matters/blood-test-predicts-30-year-cardiovascular-disease-risks-women

- Research teams funded by NIH have created a versatile set of gene delivery systems that can reach different neural cell types in the human brain and spinal cord with exceptional accuracy. These delivery systems are a significant **step toward future precise gene therapy to the brain** that could safely control errant brain activity with high precision. Currently, therapies for brain disorders mostly treat only symptoms, so a breakthrough delivery system could enable targeted therapies for many neurological disorders like Alzheimer's disease.[70]

NIH Innovation Fund and the 21st Century Cures Act

The 21st Century Cures Act,[71] passed in 2016, reached its 10th and final funding year in FY 2026. The Cures Act supports NIH's mission to improve the health of Americans by providing NIH with critical tools and resources to promote biomedical research across the spectrum, from foundational basic research studies to advanced clinical trials and promising new therapies. In line with this mission, the Cures Act, via the Innovation Fund, has provided funding for four highly innovative initiatives at NIH: (1) the Precision Medicine Initiative and *All of Us* Research Program, (2) *Brain Research through Advancing Innovative Neurotechnologies (BRAIN)* Initiative, (3) Cancer Moonshot℠,[72] and (4) Regenerative Medicine (RM) Innovation Project.

***All of Us* Research Program:** This is a key element of the Precision Medicine Initiative, building one of the largest, most diverse biomedical data repositories to gain better insights into the biological, environmental, and behavioral influences on diseases that lack proven means of prevention or treatment. Some examples of discoveries by *All of Us*-supported researchers have included optimized genetic tests for 10 conditions and identification of environmental exposures linked to type 2 diabetes. Additionally, researchers are using the data within the repository to advance treatments for Alzheimer's disease and to build knowledge for personalized nutrition. *All of Us* plans to continue to expand, with programs beginning in pediatric data collection and rural communities.

The BRAIN Initiative®: This initiative is identifying how neural circuits carry out complex, higher functions of the brain and what goes wrong in mental health and neurological disorders. Over the past few years, BRAIN Initiative® investments have yielded multiple clinical successes in early-stage trials. These small proof-of-principle studies lay the foundation for further development. Looking forward, the Initiative is developing a *BRAIN Research Roadmap* to guide neuroscience research over the next 10 years. This roadmap encompasses the development of a comprehensive BRAIN Knowledgebase to integrate BRAIN data to better unlock neuroscience and health discoveries. It also includes a program to target neural circuits with molecular precision for transformative therapeutics, as well as another program that will bridge fundamental knowledge, technologies, and brain-inspired artificial intelligence (NeuroAI).

The Cancer Moonshot℠ has accelerated our understanding of cancer and promoted progress in cancer prevention, diagnosis, treatment, and care. The program has aided in the development of cancer vaccines, more sensitive diagnostic tests for cancer, immunotherapy and combination

[70] nih.gov/news-events/news-releases/scientists-design-gene-delivery-systems-cells-brain-spinal-cord
[71] govinfo.gov/content/pkg/PLAW-114publ255/pdf/PLAW-114publ255.pdf
[72] cancer.gov/research/key-initiatives/moonshot-cancer-initiative/progress

therapies, and other research that has the potential to transform the field. Cancer Moonshot-funded research has led to 49 clinical trials and over 30 patent filings.[73]

Projects that continue to be supported by Cancer Moonshot carryover funds include the Pediatric Immunotherapy Network, Participant Engagement and Cancer Genome Sequencing network, the Cancer Research Data Commons,[74] the Human Tumor Atlas Network, and collaborations with the Department of Energy.

The RM Innovation Project (RMIP): Offers an opportunity to galvanize the field of regenerative medicine and stimulate a comprehensive and coordinated effort to foster major scientific advances and ensure that clinical studies are standardized, reproducible, and generalizable. RMIP funding has been used for preclinical and Investigational New Drug/Investigational Device Exemption-enabling studies as well as carefully selected clinical trials that exemplify rigorous science, optimal regulatory compliance, and enhanced data sharing.

Cancer Research

NIH is committed to accelerating scientific discovery in cancer, fostering greater collaboration, and improving the sharing of cancer research data. Long-term U.S. investment in cancer research has led to a steady decline over 20 years[75] in overall death rates among both women and men, and cancer death rates decreased an average of 1.5 percent per year among children (ages 0-14 years) from 2001 through 2022. Research accomplishments include the following:

Advancing cancer prevention: NIH-funded scientists are studying environmental risk factors that may lead to lung cancer in never-smokers.[76] As part of the Sherlock-Lung study, researchers assembled the largest-ever whole-genome analysis of lung cancer in individuals who have never smoked. The study showed that air pollution exposure increased cancer-driving and cancer-promoting genetic mutations. Lung tumors from never-smokers found associations between air pollution exposure and specific genetic changes previously associated with tobacco smoking. These results may lead to more prevention strategies for never-smokers.

Improving early detection: Early detection of cancer can improve a patient's response to treatment and overall outcomes. Cervical cancer, commonly caused by infection with the human papilloma virus (HPV), is usually slow-growing.[77] It seldom has symptoms, but screening tests can detect HPV infections even in precancerous stages. A NIH-funded research team aimed to assess whether at-home collection of samples using mailed self-collection kits could increase participation in cervical cancer screening among at-risk groups. They launched a clinical trial that enrolled nearly 2,500 participants aged 30 to 65 who were all overdue for cervical cancer screening. The study showed that women who used at-home test kits were more than twice as likely to complete screening for cervical cancer as women who received only telephone

[73] congress.gov/crs-product/IF12504
[74] datacommons.cancer.gov/
[75] seer.cancer.gov/report_to_nation/
[76] nih.gov/news-events/news-releases/nih-study-links-particulate-air-pollution-increased-mutations-lung-cancers-among-nonsmokers
[77] nih.gov/news-events/nih-research-matters/home-test-kits-boost-screening-cervical-cancer

reminders to receive clinic-based screening. The findings suggest that access to self-testing kits might help reduce obstacles to regular screening for this often-preventable cancer.

Promoting Artificial Intelligence and Machine Learning Research

NIH promotes the safe and responsible use of machine learning (ML) and artificial intelligence (AI) in biomedical research through programs that support the development and use of algorithms and models for research, contribute to AI-ready datasets and encourage multi-disciplinary partnerships.

Harnessing AI: The Bridge to Artificial Intelligence (Bridge2AI) program aims to set the stage for widespread adoption of AI to tackle complex biomedical and behavioral research problems that are beyond human intuition.[78] Bridge2AI generates data sets to identify abnormal changes in the body, make connections between genetic pathways, identify changes in cell shape and function, improve decision-making in critical care settings, and uncover biological processes underlying recovery from illness. This program also produces tools, software, and standards to accelerate the creation of ML/AI-ready data sets and designs training materials and activities for workforce development. A key component of Bridge2AI is bringing together technological and biomedical experts with social scientists to broaden the perspectives in ML/AI research and enable collection and use of data according to robust ethical principles. In 2025, Bridge2AI-funded researchers combined advanced imaging with AI tools to create detailed cell maps to study how proteins interact and function. Using these maps, the research team pinpointed multiple protein assemblies that are often mutated in pediatric cancers and uncovered over 100 new proteins linked to cancer development. These newly identified links provide researchers with valuable new targets to explore in their efforts to slow pediatric cancer progression.[79]

Improving access to clinical trials: A team of NIH researchers harnessed the power of large language models to develop an innovative tool called TrialGPT that streamlines the clinical trial matching process. TrialGPT first processes a patient summary that contains relevant medical and demographic information. It then identifies relevant clinical trials from ClinicalTrials.gov for which a patient is eligible, excluding trials for which they are ineligible. TrialGPT then explains how the person meets the study enrollment criteria. The final output is an annotated list of trials—ranked by relevance and eligibility—that clinicians can use to discuss clinical trial opportunities with their patient.[80] Given promising results, the research team was recently selected for The Director's Challenge Innovation Award to further assess the model's performance and fairness in real-world clinical settings. The researchers anticipate that this work could make clinical trial recruitment more effective and help reduce barriers to participation for diverse populations in clinical research.

Nutrition Research and Human Health

NIH supports research focused on understanding the biological effects of nutrients and food components on various aspects of health. It also supports research to better understand the effects of behavior, socioeconomic factors, and environmental exposures on an individual's nutritional status. Highlights of research in this area include:

[78] bridge2ai.org/
[79] commonfund.nih.gov/bridge2ai/highlights/music-maps-composing-cell-maps-explore-disease
[80] nih.gov/news-events/news-releases/nih-developed-ai-algorithm-matches-potential-volunteers-clinical-trials

Measuring ultra-processed foods (UPFs) in the diet: Self-reported eating patterns in clinical studies are prone to bias and error. Researchers set out to assess if metabolite levels in a participant's blood and urine could indicate the UPFs in a participant's diet. The researchers used a ML algorithm to select metabolites for each specimen type to combine into "poly-metabolite scores." After testing over two weeks of varying diet, the team found that the scores differed significantly between ultra-processed or minimally processed diets, even for the same participant.[81]

Advancing nutrition science through the Food is Medicine Centers of Excellence: NIH is also leading programs to help put nutrition and better health practices into action. The Food is Medicine Centers of Excellence Program is a NIH-wide, nutrition-focused initiative to address the existing gap between nutrition support and clinical care by supporting programs that respond to the critical link between diet and health with the provision of healthy food, as well as having health care organizations as their nexus.

Tackling the Chronic Disease Crisis

Despite significant investment in U.S. health care, our country's health is declining. NIH is continuing its critical work needed to treat chronic diseases, such as cardiovascular disease and diabetes. Examples include:

Identifying the role of sleep in recovery from heart injury: A NIH-funded study found that after heart injury, immune cells called monocytes travel to the brain and trigger a deep sleep that promotes recovery in both mice and humans. By studying mouse brainwaves, they found that immediately after a heart attack, mice spent much more time asleep and had a significant increase in deep sleep, lasting for at least a week. Deep sleep, or slow-wave sleep, is thought to be restorative, helping to strengthen tissues and immune function. The researchers saw similar outcomes in humans. They examined data from about 80 patients with a cardiac condition that reduces blood flow to the heart. People who slept poorly in the following month had twice as many health problems during two years of follow-up as those who had healthy sleep patterns.[82] The results highlight the importance of quality sleep after a heart attack, although more research is needed to understand the underlying processes in humans.

Reducing the risk of diabetes: Current U.S. dietary guidelines recommend no consumption of added sugar from in utero up until age 2. Yet most U.S. children are exposed to added sugar from a very early age. This can include before birth and during breastfeeding through the mother's diet. An NIH-funded research team studied how exposure to sugar in utero and during infancy affects later risk of diabetes and hypertension using a natural experiment: sugar rationing in the United Kingdom during and after World War II. Using data from the UK Biobank, the team looked at health outcomes for more than 60,000 people born between October 1951 and March 1956. Participants were aged 51–66 when last surveyed. Those born in July 1954 or later were conceived after the end of rationing, and thus never experienced sugar rationing, even in utero. The rest experienced rationing to varying extents, ranging from only in utero up to 2 years of age. The researchers found that early life exposure to rationing reduced the risk of diabetes and

[81] nih.gov/news-events/nih-research-matters/measuring-ultra-processed-foods-diet
[82] nih.gov/news-events/nih-research-matters/how-sleep-leads-healing-after-heart-attack

hypertension decades later. Risk declined with longer exposure to rationing, particularly for exposures longer than six months postnatally. People with the longest exposure to rationing had about 35 percent lower diabetes risk and 20 percent lower hypertension risk than people who were never exposed to rationing.[83] The findings suggest that restricting sugar intake during this critical period could have lifelong health benefits.

Research Across the Lifespan

NIH supports research across the human lifespan. This includes research in early life, such as screening newborns for fatal disease; midlife, like women's and maternal health; and late life, to better understand the fundamental reasons why humans age and how a healthy lifespan can be improved and extended.

Improving child and adolescent health: Research on child and adolescent health encompasses biological and behavioral processes that control development, including development of social-emotional health, cognitive development, learning, and physical growth. NIH research programs help support the evidence base for pediatric medicine, through clinical studies in pharmacology, endocrinology, trauma and critical illness, and other aspects of health throughout infancy, childhood, and adolescence. In a recent Adolescent Brain and Cognitive Development (ABCD) Study project, researchers discovered a connection between diet and sleep in children and adolescents. They found that whole grains, green vegetables, and berries were shown to be linked to lower difficulties initiating and maintaining sleep, while sweet pastries, fast food, and butter cream were linked to higher difficulties initiating and maintaining sleep.[84] This research is an another example of how the ABCD study will increase our understanding of environmental, social, genetic, and other biological factors that affect brain and cognitive development and that can enhance or disrupt a young person's mental health and life trajectory.

Addressing maternal health: NIH runs the Incidental Detection of Maternal Neoplasia Through Non-invasive Cell-Free DNA Analysis (IDENTIFY) study,[85] a clinical study that explores how prenatal blood test results for the baby might also detect cancer in the mother. Prenatal blood tests, known as non-invasive prenatal testing, detect freely floating DNA in the bloodstream originating from both the mother and the placenta, which is genetically similar to fetal DNA. Since the tests are highly accurate and only involve a blood draw, they have quickly become routine in pregnancy screening. In some cases, atypical results may arise, though the specific cause for abnormal results may range from a tumor, to autoimmune disease, to blood abnormalities in the pregnant person. Researchers at NIH, via analysis of IDENTIFY participants, have standardized a process wherein abnormal tests may be clarified. Using whole body magnetic resonance imaging (MRI), researchers identified some type of cancer in 48.9 percent of participants with abnormal test results, enabling treatment and improving maternal health. Researchers hope that these results can change medical management of patients who receive abnormal or inconclusive prenatal blood test results that may indicate cancer, ultimately helping clinicians make decisions about their care.[86]

[83] nih.gov/news-events/nih-research-matters/early-life-sugar-intake-affects-chronic-disease-risk
[84] sciencedirect.com/science/article/pii/S2352721825000877?via%3Dihub#bib23
[85] genome.gov/Clinical-Research/Current-NHGRI-Clinical-Studies/IDENTIFY-Study
[86] nih.gov/news-events/news-releases/abnormal-prenatal-blood-test-results-could-indicate-hidden-maternal-cancers

Identifying factors associated with healthy aging:
For humans to live long and healthy lives, it is critical to identify disease early and to understand possible mitigating factors for disease onset and progression. The Baltimore Longitudinal Study of Aging (BLSA) is America's longest-running scientific study of human aging, consisting of volunteers who have made the lifelong commitment to be part of the research. Recently, researchers examined the neurocognitive and plasma proteomic profiles of participants in the BLSA and found that individuals with a more robust immune response to several common viruses exhibited better neurocognitive outcomes, such as lower odds of dementia, improved cognitive performance, and even a preservation of regional brain volumes.[87]

Understanding the Brain
The BRAIN Initiative® is an ambitious program to develop and apply new technologies to answer fundamental questions about the brain and ultimately to inspire new treatments for brain diseases. Accomplishments from this initiative include:

Understanding memory formation: Researchers revealed the structural underpinnings of memory formation across a broad network of neurons in the mouse brain. Using a combination of advanced tools, researchers reconstructed a wiring diagram of neurons involved in learning. This work sheds light on the flexible nature of how memories are made.[88] Understanding this flexibility may help explain why memory and learning processes sometimes go awry, also aiding in better understanding diseases like Alzheimer's and related dementias.

Making a map of the brain: In another BRAIN study, a scientific team unveiled the first complete map of the neural connections of the common fruit fly brain. The map provides a wiring diagram, known as a connectome, and is the largest and most complete connectome of an adult animal ever created, detailing over 50 million connections between more than 130,000 neurons.[89] This work offers critical information about how brains are wired and the signals that underlie healthy brain functions.

Mental Health, Pain, and Addiction Research
Mental illnesses affect tens of millions of people in America each year, but estimates suggest that only half of people with mental illnesses receive treatment. NIH supports innovative research to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure. Research highlights include:

Developing new treatments for mental health disorders: NIH-funded researchers created a new version of lysergic acid diethylamide (LSD) to aid in the treatment of psychiatric disease. Psychedelic drugs, like LSD, have shown promise relieving some symptoms of psychiatric diseases, particularly by enabling the growth of new neuronal connections. Researchers have developed a modified form of LSD, termed JRT, that encourages neuronal growth with less hallucinogenic side effects. JRT also showed potential antidepressant effects in an animal model,

[87] pmc.ncbi.nlm.nih.gov/articles/PMC12124368/
[88] nih.gov/news-events/news-releases/study-illuminates-structural-features-memory-formation-cellular-subcellularlevels
[89] nih.gov/news-events/news-releases/researchers-fully-map-neural-connections-fruit-fly-brain

doing so at doses 100-fold lower than ketamine, a drug used for treatment-resistant depression.[90] These results suggest JRT could be a safer alternative to psychedelics for treating neuropsychiatric diseases like schizophrenia.

Developing new pain medications: There also exists a lack of safe and effective treatments for pain, which has been a driver of the national opioid and overdose crisis. The Helping to End Addiction Long-term (HEAL) Initiative, launched by NIH in 2018, supports research to accelerate scientific solutions to the overdose crisis and interventions for opioid use disorder, addiction, and pain management. In one study supported by the HEAL Initiative, researchers have developed a medication that shows promise in treating acute and chronic pain. The drug, known as VIP36, targets the body's cannabinoid receptor type 1 (CB1). It was found to be effective in three different animal models for pain and does not appear to cause the harmful side effects that have frustrated other efforts to target CB1. These results enhance understanding of how to design safer and more effective drugs targeting cannabinoid receptors and are an important step towards developing novel, non-addictive treatments for pain.[91]

These and other discoveries by NIH-funded investigators deliver new treatments, cures, and innovative prevention strategies to communities and patients around the world. In FY 2027, NIH will continue to make bold investments in novel ideas and enable the scientific workforce with cutting-edge resources and opportunities.

[90] nih.gov/news-events/nih-research-matters/lsd-analogue-treating-psychiatric-diseases
[91] nih.gov/news-events/news-releases/nih-funded-research-team-engineers-new-drug-targeting-pain-sensation-pathway

FUNDING HISTORY (FIVE-YEAR FUNDING TABLE)

Fiscal Year	Amount[1, 2, 3]
2023[4]	$48,186,471,000
2024	$47,862,774,424
2025	$47,506,114,960
2026 Enacted	$48,002,021,000
2027 Budget Request[5]	$42,421,404,534

[1] Appropriated amounts include discretionary budget authority received from Labor/HHS appropriations. Also includes mandatory budget authority derived from the Special Type 1 Diabetes account in the amount of $141,450,000 in FY 2023, $195,753,424 in FY 2024, $119,093,960 in FY 2025, $200,000,000 in FY 2026, and $47,537,534 in the FY 2027 request. Includes NIGMS Program Evaluation financing of $1,412,482,000 in FY 2023 through FY 2025, $1,427,482,000 in FY 2026, and $260,000,000 in the FY 2027 request. Includes CURES Act amounts of $1,085,000,000 in FY 2023, $407,000,000 in FY 2024, $127,000,000 in FY 2025, and $226,000,000 in FY 2026. Includes Advanced Research Projects Agency for Health (ARPA-H) amounts of $1,500,000,000 in FY 2023 through FY 2026, and $945,000,000 in the FY 2027 request.

[2] Excludes supplemental appropriations and the effects of permissive and directive transfers unless otherwise noted.

[3] The FY 2027 Budget proposes to relocate NIEHS and NIEHS Superfund from NIH to the Centers for Disease Control and Prevention. Funding levels in this table are displayed comparably and as a result exclude NIEHS and NIEHS Superfund in FY 2023 to FY 2026. For NIEHS and Superfund amounts excluded are $997,014,000 (FY 2023), $993,693,000 (FY 2024 and FY 2025) and $991,079,000 (FY 2026).

[4] Reflects mandatory sequestration of $8,550,000 for the Special Type 1 Diabetes Research account.

[5] The Consolidated Appropriations Act, 2026 provides FY 2027 funding of $50,410,959 for mandatory Special Type 1 Diabetes from October 1, 2026 to December 31, 2026, and is reduced by $2,873,425 for Budget Control Act sequestration.

SUMMARY OF REQUEST NARRATIVE

The FY 2027 President's Budget (PB) request provides a program level of $41.5 billion for the National Institutes of Health (NIH), which is $5.0 billion, or 10.8 percent, below the FY 2026 Enacted comparable[92] level of $46.5 billion.

The PB proposes to relocate the National Institute of Environmental Health Sciences (NIEHS) and the related Superfund program to the Centers for Disease Control and Prevention and proposes to eliminate three Institutes and Centers: the National Institute on Minority Health and Health Disparities (NIMHD), the National Center for Complementary and Integrative Health (NCCIH), and the Fogarty International Center (FIC). The PB also proposes to consolidate the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) into a new National Institute of Substance Use and Addiction Research (NISUAR).

The following summary references program level funding, which is the sum of discretionary budget authority in the Department of Labor, Health and Human Services, and Education, and Related Agencies appropriations bill ($41.2 billion in FY 2027); mandatory budget authority provided for type 1 diabetes research ($47.5 million in FY 2027); and Program Evaluation Financing for the National Institute of General Medical Sciences (NIGMS) under Section 241 of the Public Health Service Act ($260.0 million in FY 2027).

The primary budget mechanisms discussed below include allocations by mechanism of Program Evaluation Financing and Type 1 Diabetes.

In FY 2027, the Budget proposes to cap the indirect costs of all research grant awards at no more than 15 percent of total modified direct costs. It also proposes to provide upfront funding for all competing research project grant (RPG) awards to facilitate efficient management of resources across multiple years. This policy continues the transition to increase full funding for RPGs that began in FY 2025. Traditionally, most NIH research grants were awarded for more than one year and funded incrementally; each year's commitment was obligated from that year's appropriation. Under the incremental funding approach, grants are classified as competing in the first year of award or renewal, and noncompeting in the remaining years of each award. As an alternative to incremental funding, full funding was provided up front for a limited number of grants and cooperative agreements as appropriate in special circumstances. Completing the transition to upfront funding for all competing RPGs will increase NIH budget flexibility by no longer encumbering large portions of each year's appropriation for the continuation of research projects that were initiated in previous years. As "legacy" noncompeting research projects phase out over the next few years, this shift in grants policy will make a greater portion of RPG funding available for new research projects each year. In addition, the Budget reflects the impact of the compensation cap for Title 42 employees of $235,100 annually.

Research Project Grants (RPGs)
The FY 2027 President's Budget provides $24.4 billion for RPGs, which is $2.8 billion less than the FY 2026 Enacted level. This amount would fund 5,145 competing RPGs, or 4,567 fewer than

[92] The comparable level excludes the National Institute of Environmental Health Sciences (NIEHS).

projected in FY 2026. It would also support 24,462 noncompeting RPGs, or 2,724 fewer than projected in FY 2026. Due to the policy to fund all competing RPGs up front, the projected average cost for competing RPG awards in FY 2027 would rise to approximately $1.8 million, an increase of 146 percent from the FY 2026 projected average cost of $720,000.

- **Small Business Innovation Research/Small Business Technology Transfer (SBIR/STTR) RPGs.** The FY 2027 President's Budget provides $1,136.1 million for SBIR/STTR program grants, which is $143.3 million below the FY 2026 Enacted level. The statutory minimum set-aside requirement of 3.65 percent for NIH-wide SBIR/STTR support is achieved in FY 2027.[93]

Research Centers
The FY 2027 President's Budget provides $2,044.7 million for Research Centers, which is $535.2 million less than the FY 2026 Enacted level. This amount would fund 1,087 grants, 66 fewer than projected in FY 2026. The FY 2027 request for Research Centers includes zero funding for the Clinical Research submechanism line, because of the expected completion of the transition of support for Clinical and Translational Science Awards in the National Center for Advancing Translational Sciences from this submechanism into RPGs. Funding for Research Centers for Minority Institutions is also discontinued as part of the proposed elimination of NIMHD.

Other Research
The FY 2027 President's Budget provides $2,619.2 million for this mechanism, which is $500.2 million less than the FY 2026 Enacted level. This amount would fund 6,669 awards, which is 923 fewer than the number of awards projected in FY 2026.

Training
The FY 2027 President's Budget provides $932.8 million for research training, which is $76.2 million less than the FY 2026 Enacted level. This amount would fund 15,395 Full-Time Trainee Positions (FTTPs), which is 1,211 fewer than projected in FY 2026, and would reflect a freeze in trainee stipends and benefits in FY 2027.

Research & Development (R&D) Contracts
The FY 2027 President's Budget provides $2,805.4 million for R&D contracts, which is $480.9 million less than the FY 2026 Enacted level. The requested amount would fund an estimated 1,888 contracts, or 396 fewer than in FY 2026.

- **SBIR/STTR R&D Contracts.** The FY 2027 President's Budget includes a $32.0 million set-aside within the R&D Contracts mechanism for support of qualified SBIR/STTR contracts.

Intramural Research (IR)
The FY 2027 President's Budget provides $4,636.0 million for IR, which is $280.8 million less than the FY 2026 Enacted level. The request includes an allowance for the annualization of the

[93] The President's Budget assumes reauthorization of the SBIR and STTR program, the authorization for which expired as of September 30, 2025.

January 2026 civilian and military pay raises, the proposed January 2027 military pay raise, and the estimated cost increase in the agency share for health insurance premiums. The IR level also reflects the impact of the compensation cap for Title 42 employees of $235,100 annually.

Research Management and Support (RMS)
The FY 2027 President's Budget provides $2,139.2 million for RMS, which is $240.4 million less than the FY 2026 Enacted level. As with intramural research, the amount covers actual and anticipated pay increases as well as growth in health insurance premiums.

Office of the Director (OD)
The FY 2027 President's Budget provides $2,290.5 million for OD, which is $208.5 million less than the FY 2026 Enacted level.

- **Common Fund (CF)**
  Funding of $515.4 million is allocated for CF-supported programs, which is $57.0 million less than the FY 2026 Enacted level.

- **Office of Research Infrastructure Programs (ORIP)**
  Funding of $285.7 million is allocated for ORIP, which is $22.2 million less than the FY 2026 Enacted level.

- **Other**
  The $1,489.4 million allocated for OD components other than the Common Fund or ORIP is a decrease of $129.3 million from the FY 2026 Enacted level. The request for OD Other includes the termination of extramural construction grants for biomedical research facilities.

Buildings & Facilities (B&F)
The FY 2027 President's Budget provides $380.0 million for infrastructure sustainment projects associated with the B&F program, the same as the FY 2026 Enacted level. This amount includes $350.0 million for NIH's Buildings and Facilities appropriation, and $30.0 million within the appropriation for the National Cancer Institute (NCI) for facility repair and improvement activities at NCI's Frederick, Maryland, facility.

Program Evaluation Financing
The FY 2027 President's Budget provides $260.0 million for Program Evaluation Financing purposes in NIGMS, which is a decrease of $1,167.5 million from the FY 2026 Enacted level. The request adjusts discretionary budget authority for NIGMS so that the overall reduction in NIGMS in FY 2027 is similar to the reductions for other Institutes.

OUTPUTS AND OUTCOMES

NIH-Wide Strategic Plan Objective: Advancing Biomedical and Behavioral Sciences

Measure[94]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
SR-NCATS-001 By 2027, increase efficiencies in the gene therapy development pathway and disseminate findings and best practices to advance gene therapies for people with rare diseases. (Output)	FY 2025: Investigators supported by the Somatic Cell Genome Editing program, co-led by the National Center for Advancing Translational Sciences (NCATS), submitted a single patient emergency Investigational New Drug (IND) to treat a baby with a rare metabolic disease using genome editing. In addition, a program within the NCATS-led Bespoke Gene Therapy Consortium received IND clearance from FDA for a gene therapy trial of CMT4J, a rare neurologic disease. Target: Provide the scientific and technical resources needed for the development and submission of at least one IND application for a gene therapy product through activities supported by NCATS-enabled gene therapy clinical platform. (Target Met)	Support the development and submission of at least two IND applications for different gene therapy products.	Receive IND clearance for one first-in-human trial of a gene therapy product resulting from gene therapy programs, and provide public disseminations of findings and best practices in navigating challenges in gene therapy research and development.	N/A
SR-NCI-001 By 2027, increase the number of tumors sequenced from tumor types that currently lack sufficient molecular and clinical data to address critical knowledge gaps in the types of molecular alterations in tumors and potential contributors to these alterations by enrolling 2,400 participants in the Participant Engagement	FY 2025: The PE-CGS Network enrolled 993 participants and sequenced 519 tumors. Target: Enroll an additional 800 participants and sequence an additional 400 tumors lacking sufficient clinical and molecular data. (Target Exceeded)	Enroll an additional 600 participants and sequence an additional 400 tumors lacking sufficient clinical and molecular data.	Sequence an additional 350 tumors lacking sufficient clinical and molecular data.[95]	N/A

[94] The measures' unique identifiers are aligned with the current NIH organizational structure and will be revised following the reorganization proposed in the FY 2027 President's Budget, including the three Institutes and Centers proposed for elimination in the Budget.

[95] The FY 2027 target takes into account cumulative progress made through September 2025 (enrolled 2,519 participants and sequenced 977 tumors). Enrollment targets were achieved by FY 2026 and only the sequencing target remains for FY 2027. The measure is on track to be achieved in FY 2027 and the decrease in tumors sequenced reflects a planned winding down of this activity.

Measure[94]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
and Cancer Genome Sequencing (PE-CGS) Network and sequencing 1,400 tumors from the enrolled patients. (Output)				
SR-NIAAA-001 Advance treatment of alcohol misuse in underage populations by conducting research to inform, develop, refine, or evaluate intervention strategies. (Output)	FY 2025: An ongoing trial is testing implementation of virtually delivered Screening, Brief Intervention, and Referral to Treatment at pediatric primary care clinics to improve early identification and treatment for adolescent alcohol and other drug use and comorbid mental health problems among adolescents. Target: Conduct research to develop and evaluate the effectiveness of mobile and telehealth interventions to address alcohol misuse in underage populations. (Target Met)	Develop and/or evaluate an alcohol treatment intervention to reduce underage alcohol use and associated consequences among populations in greatest need.	Evaluate the effectiveness of an intervention for reducing alcohol misuse among underage populations with comorbid conditions.	N/A
SR-NIAAA-002 By 2025, identify neurobehavioral precursors or consequences of adolescent substance use or other childhood experiences. (Outcome)	FY 2025: NIH-supported researchers are identifying neurobiological mechanisms linking sleep disruption to adolescent alcohol misuse through clinical studies in adolescents, and providing knowledge about the interactions between the circadian sleep system and the stress axis in adolescent alcohol abuse through laboratory studies in animal models. Target: Conduct research to identify or characterize neurobiological mechanisms underlying the relationship between sleep and adolescent alcohol misuse. (Target Met)	Discontinued	Discontinued	N/A
SR-NIAAA-003 By 2025, advance one to two new or repurposed compounds that act on neurobiological targets that may have the potential for treating alcohol or other	FY 2025: NIH completed a Phase 2 clinical trial evaluating oxytocin (a brain hormone associated with positive social behaviors and human interactions) as a treatment for alcohol use disorder, and supported several clinical trials demonstrating that a glucagon-like peptide-1 (hormone that regulates blood sugar	Discontinued	Discontinued	N/A

Measure[94]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
substance use disorders. (Outcome)	and food intake) mimicking drug reduces alcohol craving. Target: Evaluate a repurposed candidate compound that acts on a neurobiological target for the treatment of alcohol use disorder in a preclinical and/or clinical study. (Target Met)			
SR-NIAAA-004 Advance prevention of alcohol misuse and related consequences in underage populations by conducting research to inform, develop, refine, or evaluate intervention strategies and promote their use. (Outcome)	FY 2025: Researchers continued evaluating a preventive intervention to reduce alcohol and cannabis use in underage populations, and the use and effectiveness of CollegeAIM in the selection of evidence-based alcohol reduction strategies to inform the implementation of these strategies to reduce risky drinking. Target: Develop and/or evaluate an intervention to address alcohol misuse among college age individuals and disseminate these or other evidence-based intervention strategies for preventing substance abuse and its consequences in underage populations. (Target Met)	Develop and/or evaluate an intervention to prevent or reduce alcohol misuse during major developmental transitions in underage individuals.	Evaluate the effectiveness of a technology-based intervention to prevent or reduce alcohol use among underage populations.	N/A
SR-NIAID-001 By 2026, advance research toward the development of 10 antiviral drug candidates. (Outcome)	FY 2025: NIH-funded researchers advanced the preclinical and clinical development of seven antiviral therapeutic candidates. Target: Advance preclinical or clinical development of one antiviral therapeutic. (Target Exceeded)	Advance preclinical or clinical development of one antiviral therapeutic.	Discontinued	N/A
SR-NIAID-002 Advance research on the prevention and treatment of sexually transmitted infections, including HIV, by developing model systems to understand host-pathogen interactions (how pathogens infect hosts,	FY 2025: NIH-supported researchers refined two models that mimic aspects of disease found in humans. Target: Refine two of the models that best mimic aspects of disease found in humans. (Target Met)	Use the two models to understand aspects of the host-pathogen interaction and the underlying disease.	Identify two new approach methodologies that can be utilized in laboratory environments to better understand interactions between	N/A

Measure[94]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
evade immune responses, replicate, and cause disease). (Outcome)			pathogens and human systems.	
SR-NIAID-003 Advance the development of a universal influenza vaccine with the potential to provide long-lasting protection against numerous flu strains rather than a select few, by discovering and testing new vaccine candidates. Such vaccines could reduce the risk of an influenza pandemic as well as eliminate the need for annual flu vaccines. (Outcome)	FY 2025: Nine broadly protective influenza vaccine candidates were evaluated in late preclinical and early clinical studies. The candidate pool was expanded beyond the six candidates reported in FY 2024. Target: Evaluate the four new influenza vaccine candidates or delivery approaches in either preclinical or clinical models. (Target Exceeded)	Discover three additional influenza vaccine candidates or delivery approaches that show protection against multiple influenza viruses.	Evaluate two additional next-generation, universal vaccine platforms in clinical studies.	N/A
SR-NIBIB-001 By 2026, establish a formalized funding pathway for the development, validation, and regulatory review of diagnostic technologies. (Outcome)	FY 2025: NIH supported the development of eight multiplexed tests that include combinations of COVID-19 and flu that received FDA market authorization. NIH also worked with research teams to include respiratory syncytial virus in combination with COVID-19 and flu, three of which are in clinical studies. Target: Submit for FDA authorization or approval two home, point-of-care, or lab-based diagnostics, at least one of which detects multiple pathogens. (Target Exceeded)	Receive FDA authorization or approval for one home, point-of-care, or lab-based diagnostics which detects multiple pathogens.	Discontinued	N/A

Measure[94]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
SR-NICHD-001 By 2026, identify two promising approaches to improve diagnosis, prevention, and/or treatment of endometriosis, a disease that results in chronic pain, infertility, and a higher risk of some cancers and affects an estimated 10 percent of women in the U.S. (Output and Outcome)	FY 2025: Researchers, with the help of genome-wide association data and a 3D cell culture model, identified a signaling pathway in a type of immune cell called M2 macrophages as a promising treatment target for endometriosis. Target: Identify in animal, tissue, or other model systems a new approach to the diagnosis or prevention of endometriosis. (Target Met)	Identify an additional new approach to improve the diagnosis, prevention, and/or treatment of endometriosis.	Discontinued	N/A
SR-NICHD-002 By 2026, develop at least one targeted strategy to improve the prevention of and/or response to labor and delivery complications that lead to maternal morbidity and mortality. (Output and Outcome)	FY 2025: The Implementing a Maternal Health and Pregnancy Outcomes Vision for Everyone Maternal Health Research Centers of Excellence initiative supported at least three research projects that addressed clinical, social, or behavioral factors associated with maternal morbidity and mortality. Target: In consultation with community partners, select at least three clinical, social, or behavioral factors associated with maternal morbidity and mortality and develop research projects focused on these factors. (Target Met)	Develop at least one targeted strategy to improve the prevention of and/or response to labor and delivery complications that lead to maternal morbidity and mortality.	Discontinued	N/A
SR-NIDA-001 By 2026, evaluate the efficacy of new or refined interventions to treat opioid use disorders (OUD).[96] (Output)	FY 2025: Researchers successfully conducted a human validation study of a novel formulation of naloxone; however, it is undergoing further development to comply with FDA requirements. Target: File one New Drug Application with the FDA for a new treatment for OUD. (Target Not Met but Improved)	Conduct a multisite clinical trial of a medication to treat OUD.	To Be Determined	N/A

[96] NIH is planning to extend SR-NIDA-001 beyond FY 2026.

Measure[94]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
SR-NIDA-002 By 2027, advance research on prevention interventions for substance use disorders (SUD). (Output)	FY 2025: Researchers continued preliminary epidemiological studies to inform strategies to prevent substance use among youth and young adults. Target: Continue preliminary epidemiological research to inform a pilot study that will develop novel strategies to prevent substance use among youth and young adults. (Target Met)	Launch a pilot study, informed by epidemiological research, to develop and test an intervention to prevent substance use among youth and young adults.	Continue the pilot study to develop and test an intervention to prevent substance use among youth and young adults.	N/A
SR-NIDA-003 By 2027, develop evidence on the effectiveness and implementation of new and existing services to minimize adverse outcomes of drug use and identify strategies to address barriers to implementing these services, through research studies and community engagement. (Outcome)	FY 2025: Investigators began analyzing clinical studies data and engaged in discussions with the Helping to End Addiction Long-term (HEAL) Initiative® Data Stewardship Group about future data sharing through the HEAL Data Ecosystem. Target: Begin data analysis for clinical research studies and begin sharing data collected as part of these studies via the HEAL Data Ecosystem, a cloud-based platform for sharing and analyzing data collected through the HEAL Initiative. (Target Not Met but Improved)	Continue data analysis and data sharing activities, and begin dissemination activities to share research findings with the research community and other interest groups.	Continue data analysis and dissemination activities to ensure findings are shared with the research community and other interest groups.	N/A
SR-NIDA-004 By 2027, strengthen community-informed research on the effectiveness of recovery support services for persons taking medications for opioid use disorder (MOUD). (Outcome)	FY 2025: The pilot trial linking MOUD treatment to recovery community centers began recruiting. Investigators published an observational study that informed this trial, and have presented preliminary findings at scientific conferences; however, data sharing via the Helping to End Addiction Long-term (HEAL) Initiative® Data Ecosystem is delayed. Target: Publicly report early results of the pilot studies and disseminate recovery research tools to other researchers via the HEAL Data Ecosystem.	Publicly report final, peer-reviewed results of the pilot studies.	Broadly disseminate key study findings to help strengthen recovery support services for people taking MOUD.	N/A

Measure[94]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
	(Target Not Met but Improved)			
SR-NIDCD-001 By 2025, increase the number of potential treatment options for communication disorders that are being tested in clinical trials by adding one new treatment option per year. (Outcome)	FY 2025: NIH initiated a clinical trial testing the ability of paralyzed individuals to control a speech communication device with their thoughts. Target: Initiate testing one new treatment for a disorder affecting speech. (Target Met)	Discontinued	Discontinued	N/A
SR-NIDCD-002 Support research to improve accessible and affordable hearing health care. (Output)	FY 2025: NIH initiated a new project to identify ways to improve and measure hearing health care outcomes in a variety of settings. Target: Initiate one new project that seeks ways to predict, improve, and/or measure hearing health care outcomes. (Target Met)	Initiate one new project to investigate how to improve delivery of care for people with hearing loss.	Initiate or provide continued support for one project focused on addressing evidence gaps in adult hearing screening.	N/A
SR-NIDCR-001 By 2027, discover and validate biomarkers for early detection of head and neck cancer by establishing multi-disciplinary research collaborations and leveraging existing NIH resources. (Output and Outcome)	FY 2025: 235 samples of head and neck cancer have been identified in high-risk populations and subsequently analyzed or sequenced. Target: Identify samples of head and neck cancer in high-risk populations. (Target Met)	Demonstrate progress on the development of novel tools to identify and validate molecular biomarkers for early detection.	Disseminate findings of newly discovered and validated biomarkers for early detection of head and neck cancer.	N/A
SR-NIDCR-002 By 2027, revitalize the dentist-scientist workforce by increasing the percentage of dental school faculty, students, and residents who receive practice-based research training and experience. (Output and Outcome)	FY 2025: 13 practice-based pilot or small-scale studies were implemented through 10 NIH-supported programs that included dental school faculty and students as investigators. Target: Implement 10 practice-based pilot or small-scale studies through NIH-supported programs that include both dental school faculty and students as investigators. (Target Exceeded)	Complete data analysis of 10 practice-based pilot or small-scale studies.	Increase the percentage of faculty, students, and residents who received practice-based research training.	N/A

Measure[94]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
SR-NIDDK-001 By 2030, identify four factors that are associated with risk of developing inflammatory bowel disease (IBD) or associated with treatment outcomes in IBD. (Outcome)	FY 2025: The Clinical, Imaging, and Endoscopic Outcomes of Children Newly Diagnosed with Crohn's Disease (CAMEO) study enrolled a cumulative total of 400 participants, and the IBD Genetics Consortium enrolled over 4,300 people with IBD. Target: Enroll a cumulative total of 250 children with newly diagnosed Crohn's disease who start using anti-TNF therapy (drugs that suppress inflammation) into the CAMEO study; and enroll 4,000 participants into the IBD Genetics Consortium. (Target Exceeded)	Enroll a cumulative total of 500 children with newly diagnosed Crohn's disease who start anti-TNF therapy into the CAMEO study, and identify one new factor (such as a genetic, microbiome, or other biomarker/ predictor) associated with IBD or IBD treatment outcomes from the IBD Genetics Consortium.	Identify two new factors (such as genetic, microbiome, or other biomarker/ predictor) associated with IBD or with IBD treatment outcomes from the CAMEO study or the IBD Genetics Consortium.	N/A
SR-NIGMS-001 By 2025, expand the use of program-focused versus target-focused award mechanisms by National Institute of General Medical Sciences (NIGMS) investigators. (Output)	FY 2025: Out of 4,338 investigators supported by R01 or the Maximizing Investigator's Research Award (MIRA) /R35 grants, 3,132 were MIRA/R35 investigators (72 percent). This is an increase of 9 percentage points from 63 percent in FY 2024. Target: Expand NIGMS investigator participation in the MIRA program by two percentage points. (Target Exceeded)	Discontinued	Discontinued	N/A
SR-NIMH-002 Increase the number of implementation science research initiatives with a focus on more effective interventions and strategies for improving HIV prevention, treatment, and care outcomes among populations most in need. (Output)	FY 2025: NIH developed an initiative to expand implementation of prevention and treatment opportunities through pharmacies. Of the 70 applications submitted, 11 were approved for funding. Target: Add one new initiative to study effective interventions and strategies for improving HIV outcomes and HIV implementation outcomes for those in greatest need. (Target Met)	Add one new initiative to leverage cutting-edge advances in multimodal artificial intelligence to accelerate HIV diagnosis, prevention, and treatment.	Add one new initiative to support implementation science efforts that scale up and implement effective interventions and strategies for reducing HIV incidence and improving health outcomes for	N/A

Measure[94]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
			people living with HIV.	
SR-NIMHD-001 By 2026, enhance understanding of how five health information technologies can be applied effectively to improve health. (Output)	FY 2025: NIH-funded investigators identified the key barriers and facilitators influencing the adoption of health information technologies for chronic disease self-management. Target: Identify barriers and enhancers to adoption of health information technologies for chronic disease self-management. (Target Met)	Analyze studies to determine the impact of health information technologies on improving health.	Discontinued. NIMHD is proposed for elimination in the President's Budget.	N/A
SR-NINDS-001 By 2029, complete 15 clinical trials testing the effectiveness of novel pain-management interventions that can be implemented in a variety of health care settings. (Output and Outcome)	FY 2025: The Helping to End Addiction Long-term (HEAL) Initiative® completed five clinical trials evaluating the effectiveness of pain interventions that can be implemented in primary and specialty care settings. Target: Complete four clinical trials evaluating the effectiveness of pain interventions that can be implemented in primary and specialty care settings. (Target Exceeded)	Complete three additional clinical trials evaluating the effectiveness of pain interventions that can be implemented in primary and specialty care settings.	Complete five clinical trials evaluating the effectiveness of pain interventions that can be implemented in community-based health care and clinical rehabilitation settings.	N/A
SR-NINR-001 By 2028, enhance support for the health of rural populations and communities by supporting rural health research, building research capacity, and enhancing rural community engagement in research. (Outcome)	FY 2025: The National Institute of Nursing Research (NINR) initiated six projects utilizing community-based research to strengthen community engagement in rural health. Target: Initiate one to two projects that investigate the use of community-based research methodologies to enhance community engagement in rural health research. (Target Exceeded)	Support one to two studies focused on mitigating chronic disease by addressing conditions of daily life, such as community-engaged nutrition interventions.	Support one to two studies focused on childhood chronic disease prevention by addressing conditions of daily life, such as community-based school health interventions that target obesity.	N/A
SR-OSC-001 By 2027, develop a catalogue of genetic variants across multiple human tissues from a broad donor population to better	FY 2025: NIH collected 22 tissues from 53 human donors (73 total collected). 22 tissues from 33 human donors were sequenced. Target: Collect 10-15 tissues from 40	Collect 10 to 15 tissues from 40 additional human donors (100 total collected); from the pool of donors	Collect 10-15 tissues from 40 additional human donors (140 total collected); from the pool of donor	N/A

Measure[94]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
understand how much genetic variation (somatic mosaicism) exists within an individual and how this variation influences human health, development, and disease. (Output)	additional human donors (60 total collected); from the pool of donors collected, sequence biospecimens from at least 10 tissues from 25 additional human donors (30 total sequenced). (Target Exceeded)	collected, sequence biospecimens from at least 10 tissues from 40 additional human donors (70 total sequenced).	tissues collected, sequence biospecimens from at least 10 tissues from 40 additional human donors (110 total sequenced). Release an expanded, publicly accessible catalogue of somatic genetic variants based on the first 100 donors.	

NIH-Wide Strategic Plan Objective: Developing, Maintaining, and Renewing Scientific Research Capacity

Measure[94]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
RC-NCATS-001 By 2026, demonstrate the usefulness of the newly expanded research resource, the National Clinical Cohort Collaborative (N3C), which builds on an existing electronic health records research platform, in making real-world clinical data securely and widely available to biomedical researchers who study a wide variety of diseases. (Output and Outcome)	FY 2025: The National Center for Advancing Translational Sciences (NCATS) pivoted from disease-specific tenants to a more cost-effective "Dynamic Workspace" model to better align with the administration's priorities. While disease-specific tenant research was not launched, development of the new flexible architecture is underway to support a broader array of diseases in FY 2026. Target: Demonstrate the ability of the N3C tenant model to support at least one research project in a disease priority area. (Target Not Met but Improved)	Disseminate N3C methodology to the biomedical research community to enable broader adoption of similar approaches for a broad array of diseases, including chronic diseases.	Discontinued	N/A

Measure[94]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
RC-NEI-001 Launch and expand a participant registry for cerebral/cortical visual impairment (CVI), a disorder caused by damage to the parts of the brain that process vision, to serve as a resource for researchers, clinicians, and participants to advance clinical research. (Output)	FY 2025: A clinical protocol was established, but not yet submitted to the Institutional Review Board for approval. Target: Establish a clinical protocol to enroll participants and submit it to the Institutional Review Board for approval. (Target Not Met but Improved)	Recruit individuals with CVI to participate in the CVI participant registry by partnering with at least three clinical sites.	Enroll 30 participants into the CVI research registry.	N/A
RC-NIDDK-001 Foster a robust workforce in kidney, urologic, hematologic, diabetes, obesity, and/or nutrition research by administering career development programs that provide mentorship, networking, and collaboration opportunities to researchers at different career stages. (Output)	FY 2025: The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) administered three career development programs that provide mentorship to researchers as various career stages. Target: Administer three career development programs. (Target Met)	Administer three career development programs.	Administer three career development programs.	N/A
RC-NIGMS-001 Maintain the yearly number of undergraduate students with mentored research experiences through the IDeA (Institutional Development Award) Networks of Biomedical Research Excellence (INBRE) program in order to sustain a pipeline of undergraduate students who will pursue health research careers. (Output)	FY 2025: More than 1,450 undergraduate students participated in mentored research experiences. Target: Sustain the yearly number of undergraduate mentored research experiences between 1,450 and 1,500. (Target Met)	Sustain the yearly number of undergraduate mentored research experiences between 900 and 940.	Sustain the yearly number of undergraduate mentored research experiences between 900 and 940.	N/A
RC-NIMH-001 To advance research on brain and behavior, collect and distribute human tissue samples and associated molecular and genomic	FY 2025: Brain tissue from 55 new donors was obtained. Samples were distributed to 37 investigators. Target: Collect brain tissue from an additional 30 new donors and distribute tissue samples or data	Collect brain tissue from an additional 20 new donors and distribute tissue samples or data derived from	Collect brain tissue from an additional 20 new donors and distribute tissue samples or data derived from	N/A

Measure[94]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
data to the scientific community. (Output)	derived from tissue to 20 researchers studying mental or neurological disorders. (Target Exceeded)	tissue to 20 researchers studying mental or neurological disorders.	tissue to 20 researchers studying mental or neurological disorders.	
RC-NINDS-001 By 2027, increase the capacity of the Undiagnosed Diseases Network (UDN) to evaluate people with undiagnosed diseases and expand access to individuals who do not typically participate in NIH clinical research. (Output and Outcome)	FY 2025: The UDN developed, tested, and implemented at least five complementary tools and strategies that streamline workflows, reduce burden and cost, and enhance the diagnostic yield across the Network. Target: Develop and test two new tools or strategies that increase the efficiency and cost-effectiveness of the Network's clinical evaluation. (Target Exceeded)	Establish partnerships with local organizations across 50 percent of UDN clinical sites to increase awareness in rare/undiagnosed diseases.	Develop and implement at least one new strategy or method, in partnership with local organizations, to increase the capacity of the UDN.	N/A
RC-ODSS-001 Enhance researchers' ability to detect and treat human diseases by advancing innovative multimodal artificial intelligence (AI) technologies that combine and analyze complex data from multiple sources, such as electronic health records, medical images, wearable devices, and genetic information. (Outcome)	FY 2025: The Multimodal AI Initiative has developed five innovative multimodal AI models to advance biomedical research discoveries. Target: Develop three multimodal AI technologies for advancing biomedical research discoveries. (Target Exceeded)	Demonstrate the feasibility of two multimodal AI technologies to generate patient-specific treatment options to advance biomedical research discoveries in a research setting.	Disseminate two multimodal AI models and associated documentation and code to the research community.	N/A
RC-ODSS-002 Improve the health of Americans facing chronic diseases by supporting multidisciplinary research projects that harness artificial intelligence (AI), training AI researchers and clinicians, and enhancing the AI capabilities and infrastructure of communities and hospitals across the U.S. (Outcome)	FY 2025: NIH supported over 40 research projects that address chronic disease or improve health care and outcomes by harnessing responsible development and application of AI and through partnerships with academic institutions, healthcare providers and non-profits. Target: Support multidisciplinary research projects that harness AI to improve the health of Americans facing chronic diseases by facilitating collaborations with healthcare providers, the private sector, and public organizations.	Enhance AI capabilities and infrastructure of communities and institutions across the U.S. to broaden participation and accelerate uptake and innovation of AI for advancing biomedical research.	Launch two demonstration projects to advance the innovative use of AI in health research or healthcare settings.	N/A

Measure[94]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
	(Target Met)			
RC-OER-001 Provide research training, mentoring, and skills development for predoctoral trainees and fellows that promotes the potential for a productive, independent research career in a health-related field. (Output)	FY 2025: NIH-funded predoctoral trainees and fellows in biomedical and behavioral sciences were 15.7 percentage points more likely to remain active in biomedical science research than those individuals in non-NRSA related training and fellowship programs. Target: Former predoctoral trainees and fellows who received a National Research Service Award (NRSA) are 10 percentage points more likely to receive subsequent NIH research funding than non-NRSA trainees and fellows. (Target Exceeded)	Former predoctoral trainees and fellows who received a NRSA are 10 percentage points more likely to receive subsequent NIH research funding than non-NRSA trainees and fellows.	Former predoctoral trainees and fellows who received a NRSA are 10 percentage points more likely to receive subsequent NIH research funding than non-NRSA trainees and fellows.	N/A
RC-OER-002 Provide research training, mentoring, and skills development for postdoctoral fellows that promotes the potential for a productive independent research career in a health-related field. (Output)	FY 2025: NIH-funded postdoctoral fellows were 18.3 percentage points more likely to remain active in biomedical and behavioral science research than non-NIH fellows. Target: Former postdoctoral fellows who received a National Research Service Award (NRSA) are 10 percentage points more likely to receive subsequent NIH research funding than non-NRSA postdoctoral fellows. (Target Exceeded)	Former postdoctoral fellows who received a NRSA are 10 percentage points more likely to receive subsequent NIH research funding than non-NRSA postdoctoral fellows.	Former postdoctoral fellows who received a NRSA are 10 percentage points more likely to receive subsequent NIH research funding than non-NRSA postdoctoral fellows.	N/A
RC-ORIP-001 Verify that state-of-the-art research instruments are installed at NIH-supported research institutions across the nation within two years after the award is made. (Output)	FY 2025: The NIH's Shared Instrumentation Grant (S10) Program awarded 121 grants in FY 2023. Of the 121 grant awards, 105 instruments (87 percent) were installed within 24 months of the Notice of Award date. Target: Verify 75 percent of awarded state-of-the-art instruments are installed at NIH-supported research	Verify 75 percent of awarded state-of-the-art instruments are installed at NIH-supported research institutions across the nation 24 months after award is made.	Verify 70 percent of awarded state-of-the-art instruments are installed at NIH-supported research institutions across the nation 24 months after award is made.[97]	N/A

[97] The FY 2027 target reflects anticipated delays due to sustained supply chain issues that affect installation of research instruments.

Measure[94]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
	institutions across the nation 24 months after award is made. (Target Exceeded)			

NIH-Wide Strategic Plan Objective: Exemplifying and Promoting the Highest Level of Scientific Integrity, Public Accountability, and Social Responsibility in the Conduct of Science

Measure[94]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
OS-NBS-001 Provide an integrated enterprise business solution for NIH that meets the unique needs of the world's largest funder of biomedical research. (Output)	FY 2025: The Office of NIH Business Systems successfully transitioned from the outdated TIBCO Integration Platform to Oracle's Service-Oriented Architecture microservices platform. Target: Implement Microservices Architecture to standardize, secure, and support real time integration within the NIH Business System Cloud IT portfolio. (Target Met)	Transition NIH to the new HHS travel system (ETSNext), without interrupting staff's ability to schedule official travel supporting the NIH mission.	Transition the internal NIH Buy/Sell interagency agreement to G-Invoicing to meet a Department of Treasury mandate.	N/A
OS-NIBIB-001 By 2028, build partnerships with other federal agencies, the private sector, and the public, that enhance coordination, expertise, resources, and networks to accelerate technology development for unmet critical healthcare needs. (Output and Outcome)	FY 2025: NIH established multiple intra-agency partnerships and expanded the scope of a strategic partnership with the CDC and FDA, creating seven new funding initiatives to accelerate the development of technology-based biomedical innovations. Target: Establish new partnerships that release one new funding mechanism (challenge, solicitation, grant, etc.) to accelerate the development of technology-based biomedical innovations. (Target Exceeded)	Support up to five grants, contracts, or awards for biomedical technology innovations through partnerships.	Submit for FDA authorization or approval two technologies resulting from partnerships.	N/A

Measure[94]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
OS-NIDDK-001 By 2028, sustain a national center that provides investigators with research resources (community engagement sessions and research consultation services) to partner with communities (patients, health care systems, etc.) in conducting type 2 diabetes research that aligns with the priorities of people most affected by the disease and likely to benefit from the research. (Output)	FY 2025: The National Center for Engagement in Diabetes Research offered 46 services, including 5 community engagement sessions and 82 research consultations, to advance type 2 diabetes research. Target: Complete two community engagement sessions and seven scientific research consultations on partnership development and engagement methods with community members to advance type 2 diabetes research. (Target Exceeded)	Complete four community engagement sessions and eight scientific research consultations on partnership development and engagement methods with community members to advance type 2 diabetes research.	Complete four community engagement sessions and eight scientific research consultations on partnership development and engagement methods with community members to advance type 2 diabetes research.	N/A
OS-NINDS-001 By 2028, strengthen engagement throughout the research process by increasing the number of interactions with people with lived experience (PWLE) of neurological disorders to 55 per year and incorporating their perspectives into research priorities, planning, implementation, and/or the dissemination of results. (Output and Outcome)	FY 2025: The National Institute of Neurological Disorders and Stroke (NINDS) engaged in at least 332 interactions with PWLE through a variety of avenues. This includes the NINDS Non-Profit Forum, involvement of PWLEs in the Helping to End Addiction Long-term Initiative®, and programmatic amyotrophic lateral sclerosis meetings and focus groups. Target: Engage in at least 45 interactions with PWLE, including participation in relevant committees and working groups, public meetings, or individual conversations, to incorporate their perspectives into research priorities, planning, implementation, and/or dissemination of results. (Target Exceeded)	Engage in at least 50 interactions with PWLE, including participation in relevant committees and working groups, public meetings, or individual conversations, to incorporate their perspectives into research priorities, planning, implementation, and/or dissemination of results.	Engage in at least 55 interactions with PWLE, including participation in relevant committees and working groups, public meetings, or individual conversations, to incorporate their perspectives into research priorities, planning, implementation, and/or dissemination of results.	N/A
OS-OAR-001 By 2026, increase use of the NIH Office of AIDS Research (OAR) Data Hub, a new resource to promote greater understanding of HIV research at the NIH and to enable researchers and the public to identify	FY 2025: OAR improved the usability of the NIH OAR Data Hub based on customer input. The landing page was restructured for easier navigation, the guidance material was displayed more prominently for user convenience, and the data notes were clarified to support better user interpretation of data resources.	Increase the number of total annual visitors to the NIH OAR Data Hub by 10 percent compared to FY 2024 baseline.	Discontinued	N/A

Measure[94]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
awards relevant to their specific interests. (Output)	Target: Improve the NIH OAR Data Hub in three ways (e.g., updates or new features) informed by feedback from the HIV community. (Target Met)			
OS-OEPR-001 By 2028, strengthen NIH's capacity for evidence-based decision making and efficient external reporting by making available to NIH staff the Strategic Tracking and Reporting Tool (START), a knowledge management system that can centralize the collection, management, and aggregation of data used for strategic plan tracking, performance monitoring, risk management, and program evaluation. (Output)	FY 2025: NIH successfully launched an evaluation module from START, providing a new resource to all NIH staff. Target: Launch a new module from START to assist NIH staff with evaluation planning and conduct. (Target Met)	Launch a new module from START to assist NIH staff with performance monitoring or risk management.	Integrate artificial intelligence capabilities within select START modules.	N/A
OS-OHR-001 Develop and implement annual strategies to recruit and/or retain highly qualified staff to support NIH's mission to enhance health, lengthen life, and reduce illness and disability. (Output)	FY 2025: The impact of changes to the qualification requirements for the Scientist Administrator positions could not be evaluated due to the hiring freeze. However, NIH finalized the qualification requirements after obtaining input from over 100 subject matter experts and adding eligible occupational series to better accommodate the diverse functions performed by Scientist Administrators. Target: Examine the impact of the change in qualification requirements for the Scientist Administrator positions (e.g., Health Scientist Administrator, Social and Behavioral Scientist Administrator) at NIH to guide future approaches to filling vacancies. (Target Not Met but Improved)	Examine the use of a recruitment calendar for administrative positions in three job series used NIH-wide to remove inefficiencies and determine if selection rates increase.	Assess the results of the implementation of the Merit Hiring Plan/Chance to Compete efforts to date.	N/A

Measure[94]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
OS-OIR-001 Use the results of external reviews conducted by Boards of Scientific Counselors (BSC) to allocate resources in support of impactful medical and behavioral research. (Output)	FY 2025: Twenty-five percent of Principal Investigators were reviewed, resulting in $7,151,754 of resources recommended to be reallocated. Target: Conduct BSC reviews annually of 25 percent of Principal Investigators to assess quality of science and prioritize resources. (Target Met)	Conduct BSC reviews annually of 25 percent of Principal Investigators to assess quality of science and prioritize resources.	Conduct BSC reviews annually of 25 percent of Principal Investigators to assess quality of science and prioritize resources.	N/A
OS-ORF-001 Manage all Buildings and Facilities (B&F) line-item projects, which support the completion of capital facility projects, so that all line-item projects are completed within 100 percent of the final approved project cost. (Output)	FY 2025: The NIH B&F portfolio expanded to 55 active projects. Four projects were completed during the fiscal year at the final approved cost, while the remaining projects remain ongoing. Target: 27 Active Projects (Target Not Met but Improved)	30 Active Projects	30 Active Projects	N/A
OS-ORF-002 Manage all Buildings and Facilities (B&F) capital facility projects so that no more than 10 percent of the projects may have their approved scope adjusted by more than 10 percent. (Output)	FY 2025: The NIH B&F project portfolio expanded to 55 active projects due to the availability of funds. Four projects were completed at the final approved cost, while design and construction of the remaining projects continued. NIH effectively managed the portfolio, with fewer than 10 percent of projects experiencing approved scope adjustments exceeding 10 percent. Target: 27 Active Projects (Target Met)	30 Active Projects	30 Active Projects	N/A
OS-ORF-003 Reduce the footprint of office and warehouse space in NIH's owned and leased facilities portfolio by one percent annually to comply with guidelines in the Office of Management and Budget (OMB) Memorandum M-	FY 2025: The usable square footage of rentable office and warehouse space was reduced by one percent. Target: Reduce the usable square feet identified in FY 2024 by one percent. (Target Met)	Reduce the usable square feet identified in FY 2025 by one percent.	Reduce the usable square feet identified in FY 2026 by one percent.	N/A

Measure[94]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2026 Target	FY 2027 Target	FY 2027 Target +/-FY 2026 Target
12-12, Promoting Efficient Spending to Support Agency Operations. (Output and Efficiency)				

GRANT AWARDS TABLE

	FY 2025 Final[3,a,b,A]	FY 2026 Enacted[3,a,b,A]	FY 2027 President's Budget[a,b,A]
Number of Awards	48,508	47,356	38,918
Average Award (in Whole $s)	$675,230	$694,886	$747,435
Range of Awards (in Whole $s)[1,2]	$1,000 to $52,660,898	$1,000 to $54,193,861	$1,000 to $137,474,840

[1] Award range excludes minimum values of zero to under $1,000 related primarily to no-cost extensions and co-funded actions.

[2] Award maximum estimates are based on an extrapolation from the most recent historical actual while accounting for expected budget policies applicable to each future fiscal year. The actual year-to-year fluctuations are roughly eight million dollars, plus or minus.

[3] Includes 21st Century Cures Act funding.

[a] Figures do not include any awards or funding related to ARPA-H.

[b] For FY 2026, the maximum award cost is projected to grow at the same rate as the average cost of the "Total Research Projects" awards. In FY 2027, it is expected to increase substantially due to the requirement that all competing awards be fully obligated in their first year. The projected year-over-year changes for FY 2025, FY 2026, and FY 2027 are -3.9%, 2.9%, and 153.7%, respectively.

[A] Figures do not include NIEHS, for comparability with the proposed reorganization of NIEHS from NIH to the Centers for Disease Control and Prevention.

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BUDGET REQUEST BY IC (SUMMARY TABLE)

(Dollars in Thousands)[1]	FY 2025 Final[4]	FY 2026 Enacted[4]	FY 2027 President's Budget[5]
NCI	$7,221,241	$7,344,106	$7,353,000
NHLBI	$3,985,158	$3,996,876	$3,699,975
NIDCR	$520,138	$525,138	$490,163
NIDDK[2]	$2,432,192	$2,528,324	$2,207,167
NINDS	$2,644,918	$2,897,094	$2,601,557
NIAID	$6,561,652	$6,546,425	$4,751,000
NIGMS[3]	$3,244,679	$3,269,679	$3,248,381
NICHD	$1,757,784	$1,780,014	$1,650,676
NEI	$896,136	$896,136	$833,000
NIA	$4,512,090	$4,528,939	$4,216,770
NIAMS	$687,639	$687,639	$637,819
NIDCD	$534,330	$534,330	$499,502
NIMH	$2,237,153	$2,309,116	$2,040,397
NISUAR[5]	$2,260,481	$2,262,267	$2,097,238
NINR	$197,671	$198,540	$138,385
NHGRI	$659,686	$659,686	$619,514
NIBIB	$440,625	$440,625	$408,391
NIMHD	$535,138	$540,137	---
NCCIH	$170,384	$170,384	---
NCATS	$928,323	$942,323	$873,320
FIC	$95,130	$95,130	---
NLM	$495,314	$495,314	$464,636
OD[6]	$2,633,425	$2,498,971	$2,290,514
B&F	$350,000	$350,000	$350,000
Total, NIH Program Level	**$46,001,287**	**$46,497,193**	**$41,471,405**
Special Type 1 Diabetes Research (mandatory)	-$119,094	-$200,000	-$47,538
PHS Program Evaluation	-$1,412,482	-$1,427,482	-$260,000
Total, NIH Labor/HHS Budget Authority	**$44,469,711**	**$44,869,711**	**$41,163,867**

[1] Includes funding derived by transfer from the NIH Innovation Account under the 21st Century Cures Act.

[2] Includes Type 1 Diabetes mandatory funding with proposal as shown later in the table.

[3] Includes Program Evaluation financing as shown later in the table.

[4] Amounts reflect HIV/AIDS transfers across ICs under the authority of the Office of AIDS Research.

[5] The FY 2027 Budget proposes to restructure the NIH Institutes and Centers by consolidating NIDA and NIAAA, eliminating three Institutes and Centers, and relocating NIEHS and the related Superfund program from NIH to the Centers for Disease Control and Prevention. The FY 2025 and FY 2026 figures in the table are displayed comparably and as a result show NIDA and NIAAA in their consolidated structure and do not include $993.521 million and $990.907 million for NIEHS in FY 2025 and FY 2026 respectively.

[6] Amounts in all years reflect directive transfer of $5.0 million to the HHS Office of Inspector General.

APPROPRIATIONS ADJUSTMENT TABLES (FY 2025)

(Dollars in Thousands)	FY 2025 Enacted	Permissive Transfer (NIH Innovation Account)[3]	OIG Transfer[4]	HIV/AIDS Transfer[5]	Comparability Adjustment[6]	FY 2025 Final
NCI	$7,224,159			-$2,918		$7,221,241
NHLBI	$3,982,345			$2,813		$3,985,158
NIDCR	$520,163			-$25		$520,138
NIDDK[1]	$2,429,815			$2,377		$2,432,192
NINDS	$2,603,925	$45,500		-$4,507		$2,644,918
NIAID	$6,562,279			-$627		$6,561,652
NIGMS	$3,244,679					$3,244,679
NICHD	$1,759,078			-$1,294		$1,757,784
NEI	$896,549			-$413		$896,136
NIEHS[2]	$993,693			-$172	-$993,521	$0
NIA	$4,507,623			$4,467		$4,512,090
NIAMS	$685,465			$2,174		$687,639
NIDCD	$534,333			-$3		$534,330
NIMH	$2,187,843	$45,500		$3,810		$2,237,153
NIDA	$1,662,695			$670	-$1,663,365	$0
NIAAA	$595,318			$1,798	-$597,116	$0
NINR	$197,693			-$22		$197,671
NHGRI	$663,200			-$3,514		$659,686
NIBIB	$440,627			-$2		$440,625
NIMHD	$534,395			$743		$535,138
NCCIH	$170,384					$170,384
NCATS	$928,323					$928,323
FIC	$95,162			-$32		$95,130
NLM	$497,548			-$2,234		$495,314
NISUAR					$2,260,481	$2,260,481
OD	$2,732,514	-$91,000	-$5,000	-$3,089		$2,633,425
B&F	$350,000					$350,000
ARPA-H	$1,500,000					$1,500,000
Total, NIH Program Level	**$48,499,808**	**$0**	**-$5,000**	**$0**	**-$993,521**	**$47,501,287**
Less funds allocated from different sources:						
Mandatory Type 1 Diabetes Research	-$119,094					-$119,094
PHS Program Evaluation	-$1,412,482					-$1,412,482
Total, NIH Discretionary Budget Authority	**$46,968,232**	**$0**	**-$5,000**	**$0**	**-$993,521**	**$45,969,711**
Interior Budget Authority	-$79,714				$79,714	$0
Total, NIH Labor/HHS Budget Authority	**$46,888,518**	**$0**	**-$5,000**	**$0**	**-$913,807**	**$45,969,711**

[1]Includes Type 1 Diabetes.

[2]Includes Interior Budget Authority (for Superfund Research activities).

[3]Reflects redistribution of NIH Innovation Account for the 21st Century Cures Act.

[4]Reflects directive transfer of $5.0 million from OD to the HHS Office of Inspector General.

[5]Reflects HIV/AIDS transfers across ICs under the authority of the Office of AIDS Research.

[6]The FY 2027 Budget proposes to consolidate NIDA and NIAAA into NISUAR and relocate NIEHS and NIEHS Superfund from NIH to the CDC.

APPROPRIATIONS ADJUSTMENT TABLES (FY 2026)

(Dollars in Thousands)	FY 2026 Enacted	Permissive Transfer (NIH Innovation Account)[3]	OIG Transfer[4]	HIV/AIDS Transfer[5]	Comparability Adjustment[6]	FY 2026 Final
NCI	$7,352,159			-$8,053		$7,344,106
NHLBI	$3,990,345			$6,531		$3,996,876
NIDCR	$525,163			-$25		$525,138
NIDDK[1]	$2,526,721			$1,603		$2,528,324
NINDS	$2,804,925	$97,500		-$5,331		$2,897,094
NIAID	$6,585,279			-$38,854		$6,546,425
NIGMS	$3,269,679					$3,269,679
NICHD	$1,769,078			$10,936		$1,780,014
NEI	$896,549			-$413		$896,136
NIEHS[2]	$991,079			-$172	-$990,907	$0
NIA	$4,517,623			$11,316		$4,528,939
NIAMS	$685,465			$2,174		$687,639
NIDCD	$534,333			-$3		$534,330
NIMH	$2,189,843	$97,500		$21,773		$2,309,116
NIDA	$1,662,695			$670	-$1,663,365	$0
NIAAA	$595,318			$3,584	-$598,902	$0
NINR	$197,693			$847		$198,540
NHGRI	$663,200			-$3,514		$659,686
NIBIB	$440,627			-$2		$440,625
NIMHD	$538,395			$1,742		$540,137
NCCIH	$170,384					$170,384
NCATS	$942,323					$942,323
FIC	$95,162			-$32		$95,130
NLM	$497,548			-$2,234		$495,314
NISUAR					$2,262,267	$2,262,267
OD	$2,701,514	-$195,000	-$5,000	-$2,543		$2,498,971
B&F	$350,000					$350,000
ARPA-H	$1,500,000					$1,500,000
Total, NIH Program Level	**$48,993,100**	**$0**	**-$5,000**	**$0**	**-$990,907**	**$47,997,193**
Less funds allocated from different sources:						
Mandatory Type 1 Diabetes Research	-$200,000					-$200,000
PHS Program Evaluation	-$1,427,482					-$1,427,482
Total, NIH Discretionary Budget Authority	**$47,365,618**	**$0**	**-$5,000**	**$0**	**-$990,907**	**$46,369,711**
Interior Budget Authority	-$77,100				$77,100	$0
Total, NIH Labor/HHS Budget Authority	**$47,288,518**	**$0**	**-$5,000**	**$0**	**-$913,807**	**$46,369,711**

[1]Includes Type 1 Diabetes.

[2]Includes Interior Budget Authority (for Superfund Research activities).

[3]Reflects redistribution of NIH Innovation Account for the 21st Century Cures Act.

[4]Reflects directive transfer of $5.0 million from OD to the HHS Office of Inspector General.

[5]Reflects HIV/AIDS transfers across ICs under the authority of the Office of AIDS Research.

[6]The FY 2027 Budget proposes to consolidate NIDA and NIAAA into NISUAR and relocate NIEHS and NIEHS Superfund from NIH to the CDC.

BUDGET MECHANISM TABLE

(Dollars in Thousands)[1,2,3,4]	FY 2025 Final[9]		FY 2026 Enacted[9]		FY 2027 President's Budget[9]		+/- FY 2026	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Research Projects:								
Noncompeting	30,217	$19,287,977	27,186	$18,551,167	24,462	$13,910,125	-2,724	-$4,641,042
Administrative Supplements[3]	*(2,204)*	387,057	*(1,933)*	386,309	*(1,506)*	265,086	*(-427)*	-121,223
Competing	8,016	$6,084,538	9,712	$6,990,875	5,145	$9,113,485	-4,567	$2,122,609
Subtotal, RPGs	38,233	$25,759,571	36,898	$25,928,351	29,607	$23,288,696	-7,291	-$2,639,656
SBIR/STTR	1,652	1,238,380	1,713	1,279,344	1,555	1,136,060	-158	-143,284
Research Project Grants	39,885	$26,997,951	38,611	$27,207,696	31,162	$24,424,756	-7,449	-$2,782,940
Research Centers:								
Specialized/Comprehensive	1,025	$2,145,422	1,041	$2,204,743	1,010	$1,875,085	-31	-$329,658
Clinical Research	24	196,809	13	114,231	0	0	-13	-114,231
Biotechnology	30	39,295	29	41,285	29	38,266	0	-3,019
Comparative Medicine	46	128,158	48	132,458	48	131,341	0	-1,117
Research Centers in Minority Institutions	21	84,895	22	87,219	0	0	-22	-87,219
Research Centers	1,146	$2,594,578	1,153	$2,579,935	1,087	$2,044,692	-66	-$535,244
Other Research:								
Research Careers	4,745	$904,813	4,907	$936,186	4,439	$846,577	-468	-$89,609
Cancer Education	92	25,863	92	25,863	92	25,863	0	0
Cooperative Clinical Research	184	470,459	284	495,898	277	438,487	-7	-57,412
Biomedical Research Support	127	107,705	120	102,185	32	87,044	-88	-15,141
Other Biomedical Research Support	38	14,439	8	9,495	8	8,712	0	-783
Other	2,291	1,638,235	2,181	1,549,750	1,821	1,212,531	-360	-337,218
Other Research	7,477	$3,161,514	7,592	$3,119,376	6,669	$2,619,214	-923	-$500,162
Total Research Grants	48,508	$32,754,043	47,356	$32,907,007	38,918	$29,088,661	-8,438	-$3,818,346
Ruth L Kirchstein Training Awards:	FTTPs		FTTPs		FTTPs		FTTPs	
Individual Awards	3,595	$183,604	4,101	$212,591	3,641	$187,416	-460	-$25,175
Institutional Awards	12,246	765,021	12,505	796,391	11,754	745,411	-751	-50,980
Total Research Training	15,841	$948,625	16,606	$1,008,982	15,395	$932,827	-1,211	-$76,155
Research & Development Contracts	2,268	$3,080,476	2,284	$3,286,257	1,888	$2,805,380	-396	-$480,878
(SBIR/STTR) (non-add)[3]	*(79)*	*(62,988)*	*(49)*	*(43,066)*	*(35)*	*(32,028)*	*(-14)*	*(-11,038)*
Intramural Research		$4,811,858		$4,916,778		$4,635,986		-$280,792
Research Management & Support		2,387,355		2,379,525		2,139,159		-240,365
(SBIR Admin) (non-add)[3]		*(12,842)*		*(16,336)*		*(14,660)*		*(-1,676)*
Office of the Director - Appropriation[3,5]		*(2,633,425)*		*(2,498,971)*		*(2,290,514)*		*(-208,457)*
Office of the Director - Other		1,638,929		1,618,644		1,489,392		-129,252
ORIP (non-add)[3,5]		*(309,495)*		*(307,926)*		*(285,721)*		*(-22,205)*
Common Fund (non-add)[3,5]		*(685,001)*		*(572,401)*		*(515,401)*		*(-57,000)*
Buildings and Facilities[6]		380,000		380,000		380,000		0
Appropriation[3]		*(350,000)*		*(350,000)*		*(350,000)*		*(0)*
Type 1 Diabetes[7,8]		-119,094		-200,000		-47,538		152,462
Program Evaluation Financing[7]		-1,412,482		-1,427,482		-260,000		1,167,482
Subtotal, Labor/HHS Budget Authority		**$44,469,711**		**$44,869,711**		**$41,163,867**		**-$3,705,844**
Total, NIH Discretionary Budget Authority		**$44,469,711**		**$44,869,711**		**$41,163,867**		**-$3,705,844**
Type 1 Diabetes[8]		119,094		200,000		47,538		-152,462
Total, NIH Budget Authority		**$44,588,805**		**$45,069,711**		**$41,211,405**		**-$3,858,306**
Program Evaluation Financing		1,412,482		1,427,482		260,000		-1,167,482
Total, Program Level		**$46,001,287**		**$46,497,193**		**$41,471,405**		**-$5,025,788**

See footnotes on the following page.

Budget Mechanism Table footnotes.

[1] All Subtotal and Total numbers may not add due to rounding.

[2] Includes 21st Century Cures Act funding; excludes supplemental-related funding.

[3] All numbers in italics and brackets are non-add.

[4] The FY 2027 Budget proposes to relocate NIEHS and NIEHS Superfund from NIH to the Centers for Disease Control and Prevention (CDC). Funding and other levels in this table are displayed comparably and as a result do not include $993.521 million in FY 2025 and $990.907 million in FY 2026 for these relocated programs. For information on NIEHS and NIEHS Superfund, please see the CDC Congressional Justification.

[5] Number of grants and dollars for the Common Fund and ORIP components of OD are distributed by mechanism and are noted here as non-adds. Office of the Director - Appropriation is the non-add total of these amounts and the funds accounted for under OD - Other.

[6] Includes B&F appropriation and monies allocated pursuant to appropriations acts provisions that funding may be used for facilities repairs and improvements at the NCI Federally Funded Research and Development Center in Frederick, Maryland.

[7] Number of grants and dollars for mandatory Type 1 Diabetes (T1D) and NIGMS Program Evaluation financing are distributed by mechanism above; therefore, T1D and Program Evaluation financing amounts are deducted to provide subtotals for Labor/HHS Budget Authority.

[8] FY 2027 amount reflects funding of $50.411 million provided by the Consolidated Appropriations Act, 2026 and is reduced by $2.873 million for Budget Control Act sequestration.

[9] Reflects a reduction by transfer of $5.0 million from OD to the HHS Office of Inspector General.

BUDGET AUTHORITY BY OBJECT CLASS INCLUDING TYPE 1 DIABETES

NIH-Wide Budget Authority by Object Class Including Type 1 Diabetes Funds[1,2]

(Dollars in Thousands)

Object Classes	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Personnel Compensation			
Full-Time Permanent (11.1)	$1,299,790	$1,281,335	-$18,455
Other Than Full-Time Permanent (11.3)	$681,261	$676,319	-$4,942
Other Personnel Compensation (11.5)	$84,995	$82,678	-$2,317
Military Personnel (11.7)	$17,644	$16,835	-$808
Special Personnel Services Payments (11.8)	$239,596	$234,254	-$5,342
Subtotal, Personnel Compensation (11.9)	**$2,323,286**	**$2,291,421**	**-$31,865**
Civilian Personnel Benefits (12.1)	$787,153	$785,487	-$1,666
Military Personnel Benefits (12.2)	$3,568	$3,558	-$10
Benefits to Former Personnel (13.0)	$27,279	$8,621	-$18,658
Total Pay Costs	**$3,141,286**	**$3,089,088**	**-$52,198**
Travel & Transportation of Persons (21.0)	$35,918	$32,900	-$3,018
Transportation of Things (22.0)	$6,158	$5,520	-$639
Rental Payments to GSA (23.1)	$32,356	$34,089	$1,733
Rental Payments to Others (23.2)	$228	$219	-$9
Communications, Utilities & Misc. Charges (23.3)	$22,162	$21,956	-$205
Printing & Reproduction (24.0)	$243	$231	-$12
Consultant Services (25.1)	$1,376,333	$1,202,237	-$174,096
Other Services (25.2)	$1,071,858	$926,365	-$145,493
Purchase of Goods and Services from Government Accounts (25.3)	$3,426,956	$3,094,683	-$332,273
Operation & Maintenance of Facilities (25.4)	$45,376	$42,429	-$2,947
R&D Contracts (25.5)	$1,731,691	$1,469,022	-$262,669
Medical Care (25.6)	$22,248	$21,890	-$358
Operation & Maintenance of Equipment (25.7)	$305,891	$274,053	-$31,838
Subsistence & Support of Persons (25.8)	$0	$0	$0
Subtotal Other Contractual Services	**$7,980,354**	**$7,030,679**	**-$949,675**
Supplies & Materials (26.0)	$228,141	$211,798	-$16,343
Equipment (31.0)	$120,813	$116,821	-$3,992
Land and Structures (32.0)	$305,628	$305,790	$162
Investments & Loans (33.0)	$0	$0	$0
Grants, Subsidies & Contributions (41.0)	$33,151,260	$30,317,488	-$2,833,772
Insurance Claims & Indemnities (42.0)	$0	$0	$0
Interest & Dividends (43.0)	$946	$897	-$49
Refunds (44.0)	$52	$52	$0
Financial Transfers (94.0)	$44,166	$43,877	-$289
Subtotal Non-Pay Costs	**$41,928,425**	**$38,122,317**	**-$3,806,108**
Total Budget Authority	**$45,069,711**	**$41,211,405**	**-$3,858,306**

[1] Excludes supplemental appropriations and program evaluation financing.

[2] The FY 2027 Budget proposes to relocate NIEHS and the NIEHS Superfund program from NIH to the Centers for Disease Control and Prevention. Funding levels in this table are displayed comparably and as a result do not include $990,907 thousand for NIEHS and Superfund in FY 2026.

BUDGET AUTHORITY BY OBJECT CLASS INCLUDING SSF AND MF

NIH-Wide Budget Authority by Object Class Including Service and Supply Fund and Management Fund [1,2,3]

(Dollars in Thousands)

Object Classes	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Personnel Compensation			
Full-Time Permanent (11.1)	$1,919,815	$2,038,109	$118,293
Other Than Full-Time Permanent (11.3)	$739,658	$739,568	-$91
Other Personnel Compensation (11.5)	$138,952	$141,584	$2,632
Military Personnel (11.7)	$27,427	$26,976	-$451
Special Personnel Services Payments (11.8)	$248,655	$243,490	-$5,166
Subtotal, Personnel Compensation (11.9)	**$3,074,508**	**$3,189,726**	**$115,218**
Civilian Personnel Benefits (12.1)	$1,043,076	$1,093,197	$50,122
Military Personnel Benefits (12.2)	$4,893	$4,932	$39
Benefits to Former Personnel (13.0)	$32,227	$11,643	-$20,584
Total Pay Costs	**$4,154,704**	**$4,299,498**	**$144,794**
Travel & Transportation of Persons (21.0)	$39,693	$35,921	-$3,773
Transportation of Things (22.0)	$13,403	$11,315	-$2,087
Rental Payments to GSA (23.1)	$118,877	$103,343	-$15,535
Rental Payments to Others (23.2)	$5,256	$4,242	-$1,014
Communications, Utilities & Misc. Charges (23.3)	$160,818	$113,526	-$47,291
Printing & Reproduction (24.0)	$249	$237	-$12
Consultant Services (25.1)	$525,209	$379,906	-$145,304
Other Services (25.2)	$1,957,135	$1,622,581	-$334,554
Purchase of Goods and Services from Government Accounts (25.3)	$1,315,331	$1,177,815	-$137,517
Operation & Maintenance of Facilities (25.4)	$160,193	$134,481	-$25,712
R&D Contracts (25.5)	$1,754,870	$1,487,647	-$267,223
Medical Care (25.6)	$47,802	$44,773	-$3,029
Operation & Maintenance of Equipment (25.7)	$625,656	$512,887	-$112,768
Subsistence & Support of Persons (25.8)	$0	$0	$0
Subtotal Other Contractual Services	**$6,386,195**	**$5,360,089**	**-$1,026,106**
Supplies & Materials (26.0)	$420,415	$379,237	-$41,179
Equipment (31.0)	$154,785	$145,094	-$9,691
Land and Structures (32.0)	$416,766	$394,886	-$21,881
Investments & Loans (33.0)	$0	$0	$0
Grants, Subsidies & Contributions (41.0)	$33,153,286	$30,319,109	-$2,834,177
Insurance Claims & Indemnities (42.0)	$0	$0	$0
Interest & Dividends (43.0)	$1,045	$979	-$66
Refunds (44.0)	$52	$52	$0
Financial Transfers (94.0)	$44,166	$43,877	-$289
Subtotal Non-Pay Costs	**$40,915,007**	**$36,911,907**	**-$4,003,100**
Total Budget Authority	**$45,069,711**	**$41,211,405**	**-$3,858,306**

[1] Excludes supplemental appropriations and program evaluation financing.

[2] This table redistributes NIH institute and center payments for SSF and MF services from object classes 25.1 and 25.3 to the pay and nonpay object classes where SSF and MF obligate those collections.

[3] The FY 2027 Budget proposes to relocate NIEHS and the NIEHS Superfund program from NIH to the Centers for Disease Control and Prevention. Funding levels in this table are displayed comparably and as a result do not include $990,907 thousand for NIEHS and Superfund in FY 2026.

DETAIL OF FULL-TIME EQUIVALENT EMPLOYMENT (FTE)

Institutes and Centers	FY 2025 Actual [4]	FY 2026 Estimate [4]	FY 2027 Estimate [4]
NCI	3,119	2,702	2,678
NHLBI	950	813	862
NIDCR	230	194	203
NIDDK	683	648	647
NINDS	689	611	631
NIAID	2,026	1,921	1,921
NIGMS	195	195	195
NICHD	585	492	483
NEI	280	246	245
NIA	679	520	519
NIAMS	261	233	235
NIDCD	146	132	132
NIMH	614	570	565
NISUAR	629	507	496
NINR	72	47	54
NHGRI	351	318	318
NIBIB	142	139	139
FIC	54	54	---
NIMHD	107	105	---
NCCIH	95	59	---
NCATS	312	291	314
NLM	627	627	625
OD	1,193	1,006	1,094
Central Services:			
OD - CS	928	869	1,107
CC	1,848	1,815	1,851
CSR	492	735	735
CIT	190	164	173
ORS	480	542	542
ORF	756	653	793
Subtotal Central Services[1]	**4,694**	**4,778**	**5,201**
PHS Trust Fund (non-add) [2]	*4*	*4*	*4*
CRADA (non-add) [3]	*	*	*
Total	**18,733**	**17,208**	**17,557**

* Less than 0.5 FTE.

[1] Reflects FTE associated with Central Services positions whose payroll costs are financed from the NIH Management Fund and the NIH Service and Supply Fund.

[2] PHS Trust Fund positions are incorporated within the IC's Direct-funded civilian FTE category and are treated as non-add values.

[3] CRADA positions are distributed across multiple ICs and are treated as non-add values.

[4] The FY 2027 Budget proposes to consolidate NIDA and NIAAA into a new National Institute of Substance Use and Addiction Research and to relocate NIEHS from NIH to the Centers for Disease Control and Prevention. The FY 2025 and FY 2026 figures in the table are displayed comparably and as a result show NIDA and NIAAA consolidated into NISUAR and exclude 615 FTE in FY 2025 and 561 FTE in FY 2026 for NIEHS.

PROGRAMS PROPOSED FOR ELIMINATION

Programs Proposed for Elimination in the FY 2027 Budget
(dollars in millions)

Program[98]	Description	FY 2026 Enacted	Rationale
National Institute on Minority Health and Health Disparities (NIMHD)	Supports minority health and health disparities research under section 301 and title IV of the PHS Act.	$538.395	The President's Budget proposes to reform NIH and focus NIH research activities, in line with the Administration's commitment to "Make America Healthy Again."
National Center for Complementary and Integrative Health (NCCIH)	Supports research on integrative health interventions with respect to complementary and integrative health under section 301 and title IV of the PHS Act.	$170.384	The President's Budget proposes to reform NIH and focus NIH research activities, in line with the Administration's commitment to "Make America Healthy Again."
Fogarty International Center (FIC)	Provides funding aimed at reducing gaps in global health under subpart 2 of part E of title IV of the PHS Act.	$95.162	The President's Budget proposes to reform NIH and focus NIH research activities, in line with the Administration's commitment to "Make America Healthy Again."
Office of the Director, Extramural Construction Grants for Biomedical Research Facilities	Provides grant support to research institutions for renovation, alteration, or construction of biomedical research facilities.	$80.000	The Budget prioritizes support for direct research activities and provides a reduced indirect cost rate to support facilities and administrative expenses of grantee institutions.

[98] Programs were proposed for elimination in the 2026 President's Budget.

PHYSICIAN'S COMPARABILITY ALLOWANCE WORKSHEET

		FY 2024 Actual	FY 2025 Actual	FY 2026 Estimate[1]	FY 2027 Estimate
1) Number of Physicians Receiving PCAs		89	80	63	63
2) Number of Physicians with One-Year PCA		3	3	2	2
3) Number of Physicians with Multi-Year PCA		86	77	61	61
4) Average Annual Physician Pay (without PCA payment)		$188,042	$192,214	$188,914	$188,914
5) Average Annual PCA Payment		$22,659	$22,442	$25,025	$25,088
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position				
	Category II Research Position	89	80	63	63
	Category III Occupational Health				
	Category IV-A Disability Evaluation				
	Category IV-B Health and Medical Admin.				

7) If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than I through IV-B). Provide the number of PCA agreements per additional category for the PY, CY and BY.

N/A

8) Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.

Maximum annual PCA amounts for category II and IV-B vary based on grade level, amount of federal service and length of the PCA agreement. The monetary range is between $4,000 and $30,000. These flexible amounts are necessary to recruit and retain the caliber of physician needed to carry out the NIH mission which directly impacts the health of the

9) Explain the recruitment and retention problem(s) for each category of physician in your agency (this should demonstrate that a current need continues to persist).(Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)

NIH strives to make progress recruiting and retaining qualified physicians to the Federal service. However, due to competition and more lucrative compensation in the private sector it continues to be challenging. NIH consistently has had a high turnover rate for physicians. NIH physicians require unique and specialized qualifications that make it difficult to fill vacancies.

10) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year. (Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)

In FY 2025, there were a total of 80 PCA recipients across NIH. In FY 2026 and beyond, as indicated by the decrease in recipients to-date relative to the prior year, the critical need continues to exist for highly qualified, specialized physicians to support the NIH mission. NIH still requires compensation flexibilities such as PCA to attract and retain qualified physicians.

11) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

N/A

[1] FY 2026 data will be approved during the FY 2027 Budget cycle.

STATISTICAL DATA: DIRECT AND INDIRECT COSTS AWARDED

(Dollars in Thousands)	Direct Cost Awarded[A]	Indirect Cost Awarded	Percent of Total		Percent Change	
			Direct Cost Awarded	Indirect Cost Awarded	Direct Cost Awarded	Indirect Cost Awarded
FY 2015	$15,645,282	$6,020,843	72.2%	27.8%	0.5%	1.9%
FY 2016	$16,791,158	$6,445,133	72.3%	27.7%	7.3%	7.1%
FY 2017[1]	$17,799,515	$6,838,801	72.2%	27.8%	6.0%	6.1%
FY 2018[1]	$19,599,758	$7,481,452	72.4%	27.6%	10.1%	9.4%
FY 2019[1]	$20,544,931	$7,953,747	72.1%	27.9%	4.8%	6.3%
FY 2020[1]	$21,765,222	$8,406,459	72.2%	27.8%	5.9%	5.7%
FY 2021[1]	$22,363,606	$8,620,853	72.2%	27.8%	2.8%	2.6%
FY 2022[1,a]	$23,352,941	$8,993,865	72.2%	27.8%	4.4%	4.3%
FY 2023[1,a]	$24,173,424	$9,609,670	71.6%	28.5%	3.5%	6.9%
FY 2024[1,a]	$24,107,798	$9,386,009	72.0%	28.0%	-0.3%	-2.3%
FY 2025 Final[1,a,B]	$24,249,071	$9,453,597	72.0%	28.1%	0.6%	0.7%
FY 2026 Enacted[1,a,B]	$24,395,512	$9,520,477	71.9%	28.1%	0.6%	0.7%
FY 2027 President's Budget[a,b,B]	$26,178,368	$3,843,120	87.2%	12.8%	7.3%	-59.6%

Notes: 1) Data for FY 2026 and later represent estimates and will change as actual data are received; 2) Awards made through the OD-Other mechanism are excluded from the tabulation of Direct and Indirect Costs; 3) Percentages are calculated using the costs in whole dollars.

[A] Not all Direct Costs contribute to the "Modified Total Direct Cost," over which the Indirect Cost Rate is computed.

[B] Figures for the years before FY 2025 include NIEHS. The figures for 2025 through 2027 do not include NIEHS, for comparability with the proposed reorganization of NIEHS from NIH to the Centers for Disease Control and Prevention. The 2025 -- 2027 figures are not directly comparable to previous years.

[1] Includes 21st Century Cures Act funding.

[a] Figures do not include any funding related to ARPA-H.

[b] The FY 2027 Budget reflects the policy to limit indirect costs of grant awards to 15 percent of modified total direct costs. Under the policy, the NIH-wide indirect cost rate is estimated to average 13.4 percent, including awards such as training and some SBIR/STTR grants for which indirect costs are already below the 15 percent cap.

RPGS – TOTAL NUMBER OF AWARDS AND FUNDING

(Dollars in Thousands)	FY 2017 Actual[1]	FY 2018 Actual[1]	FY 2019 Actual[1]	FY 2020 Actual[1]	FY 2021 Actual[1]	FY 2022 Actual[1,a]	FY 2023 Actual[1,a]	FY 2024 Actual[1,a]	FY 2025 Final[1,a,A]	FY 2026 Enacted[1,a,A]	FY 2027 President's Budget[a,A]
No. of Awards:											
Competing	10,123	11,116	11,020	11,373	11,258	11,333	11,106	10,251	8,016	9,712	5,145
Noncompeting	24,638	25,780	27,624	28,366	28,492	29,423	30,177	30,739	30,217	27,186	24,462
Subtotal	34,761	36,896	38,644	39,739	39,750	40,756	41,283	40,990	38,233	36,898	29,607
SBIR/STTR	1,807	2,034	2,023	1,832	1,863	1,840	1,893	1,761	1,652	1,713	1,555
Total	**36,568**	**38,930**	**40,667**	**41,571**	**41,613**	**42,596**	**43,176**	**42,751**	**39,885**	**38,611**	**31,162**
Average Annual Cost:											
Competing RPGs	$522	$527	$573	$559	$599	$588	$611	$596	$759	$720	$1,771
Total RPGs[X]	523	546	552	571	583	594	613	617	674	703	787
Percent Change in Average Cost from Prior Year[Y]											
Competing RPGs	7.8%	1.0%	8.7%	-2.4%	7.2%	-1.8%	3.8%	-2.5%	27.5%	-5.2%	146.1%
Total RPGs[X]	4.0%	4.4%	1.1%	3.5%	2.1%	2.0%	3.1%	0.7%	9.3%	4.3%	11.9%
Average Length of Award in Years[Z]	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.7**	**3.4**	**3.4**	**1.0**

NOTE: Includes awards supported by the Common Fund program (for all years) and the Type 1 Diabetes mandatory account.

[X] Includes Noncompeting RPGs and Administrative Supplements. Excludes SBIR/STTR awards.

[Y] Based on average costs in whole dollars.

[Z] Based on Competing RPGs and Administrative Supplements, including awards for T1D and OD. Under the policy of 100 percent upfront funding in FY 2027, each award has a single year of obligation which covers all years of research performance.

[1] Includes 21st Century Cures Act funding.

[a] Figures do not include any awards or funding related to ARPA-H.

[A] Figures for the years before FY 2025 include NIEHS. The figures for 2025 through 2027 do not include NIEHS, for comparability with the proposed reorganization of NIEHS from NIH to the Centers for Disease Control and Prevention. The 2025 -- 2027 figures are not directly comparable to previous years.

RPGS – SUCCESS RATES

INSTITUTES & CENTERS[+,1,2]	FY 2018 Final[3]	FY 2019 Final[3]	FY 2020 Final[3]	FY 2021 Final[3]	FY 2022 Final[3,a]	FY 2023 Final[3,a]	FY 2024 Final[3,a]	FY 2025 Final[3,a,b,A]	FY 2026 Enacted[3,a,b,A]	FY 2027 President's Budget[a,b,A]
NCI	11.3%	11.9%	12.9%	13.8%	15.4%	16.1%	13.4%	9.5%	11.1%	9.2%
NHLBI	25.1%	22.3%	22.2%	20.5%	21.3%	21.1%	19.7%	16.6%	17.5%	6.7%
NIDCR	22.2%	23.8%	21.7%	21.8%	21.0%	22.0%	19.1%	18.2%	20.0%	17.9%
NIDDK	21.6%	20.3%	24.4%	22.7%	22.1%	22.9%	21.5%	12.7%	18.4%	7.8%
NINDS	22.4%	20.4%	23.7%	20.2%	22.1%	21.6%	16.3%	11.5%	10.5%	7.8%
NIAID	22.9%	22.1%	23.9%	17.5%	17.3%	20.8%	18.3%	15.4%	16.6%	1.5%
NIGMS	29.2%	32.6%	32.3%	33.4%	35.8%	36.3%	31.5%	25.9%	30.6%	12.0%
NICHD	18.4%	19.5%	18.0%	18.4%	17.3%	18.8%	18.9%	14.0%	16.1%	6.7%
NEI	26.7%	28.4%	29.6%	24.8%	25.6%	26.2%	26.7%	17.6%	19.3%	22.2%
NIEHS[A]	17.1%	14.8%	14.2%	14.4%	16.7%	15.1%	16.4%			
NIA	28.9%	29.2%	25.8%	24.2%	25.3%	24.0%	18.0%	8.0%	7.4%	6.3%
NIAMS	16.7%	17.1%	18.0%	17.6%	18.4%	17.8%	18.0%	12.5%	13.3%	10.0%
NIDCD	27.1%	25.2%	24.2%	24.0%	25.0%	26.9%	25.0%	17.5%	18.8%	8.7%
NIMH	22.2%	24.8%	22.5%	22.1%	24.3%	22.4%	20.7%	10.6%	13.8%	6.6%
NIDA	19.4%	17.5%	16.9%	14.7%	19.4%	22.1%	19.3%	13.6%	12.5%	
NIAAA	26.7%	20.9%	21.4%	17.1%	27.1%	30.5%	22.6%	12.4%	19.4%	
NINR	10.3%	9.3%	10.8%	12.6%	15.4%	16.9%	15.7%	9.9%	27.4%	6.6%
NHGRI	28.0%	19.2%	21.8%	24.7%	25.1%	22.0%	19.6%	7.3%	9.2%	8.8%
NIBIB	16.8%	18.3%	19.8%	17.2%	21.5%	17.7%	16.1%	12.8%	15.7%	10.5%
NIMHD	10.7%	7.5%	7.9%	11.2%	17.2%	18.8%	13.5%	3.7%	8.5%	
NCCIH	20.3%	12.5%	11.6%	11.1%	14.8%	14.4%	16.0%	7.1%	25.2%	
NCATS	36.4%	20.7%	25.2%	14.7%	20.4%	26.8%	14.2%	15.0%	15.7%	18.5%
FIC	19.5%	20.6%	19.7%	13.8%	20.9%	22.3%	19.8%	16.8%	37.9%	
NLM	17.7%	18.4%	13.4%	11.9%	15.3%	14.8%	13.1%	8.4%	7.4%	9.7%
ORIP	17.8%	34.2%	29.6%	25.9%	27.1%	34.0%	34.0%	27.5%	25.0%	8.5%
Common Fund	10.9%	11.0%	9.5%	8.8%	11.8%	14.6%	7.2%	6.1%	7.0%	10.1%
NIH[A]	20.3%	20.1%	20.7%	19.1%	20.8%	21.4%	18.5%	13.0%	14.9%	**N/A**
NISUAR[4]								13.3%	14.3%	7.5%
NIH[A]	20.3%	20.1%	20.7%	19.1%	20.8%	21.4%	18.5%	13.0%	14.9%	7.8%

[+] Success Rates identified in FY 2026 and beyond are estimates, and will change as applications are received and selected for funding.

[1] Application success rates represent the percentage of applications that are awarded during the fiscal year.

[2] Includes Special Type 1 Diabetes Research program administered by NIDDK. Excludes NIEHS Superfund Research and OD Other awards.

[3] Includes 21st Century Cures Act funding.

[4] Proposed consolidated IC in FY 2027.

[a] Figures do not include any awards related to ARPA-H.

[b] Success Rates are lower compared to FY 2024 due to a decline in Program Level and/or a shift to upfront funding for Competing RPGs.

[A] Figures for the years before FY 2025 include NIEHS. The figures for 2025 through 2027 do not include NIEHS, for comparability with the proposed reorganization of NIEHS from NIH to the Centers for Disease Control and Prevention. The 2025 -- 2027 NIH total figures are not directly comparable to previous years.

TOTAL R01 EQUIVALENT DATA FOR FIRST-TIME AND ESTABLISHED INVESTIGATORS

R01 Equivalent Grants[1,2,3,4]	FY 2022 Actual[5,a]	FY 2023 Actual[5,a]	FY 2024 Actual[5,a]	FY 2025 Final[5,a,A]	FY 2026 Enacted[5,a,A]	FY 2027 President's Budget[a,A]
Applications						
Received	36,198	35,072	37,478	41,336	44,694	45,565
Funded	**7,832**	**7,629**	**6,991**	**5,374**	**6,549**	**3,450**
Total Investigators						
Received	33,177	32,547	34,302	36,524	40,230	40,932
Funded	**9,828**	**9,702**	**9,001**	**6,898**	**8,575**	**4,586**
Established Investigators						
Received	20,492	20,454	21,686	22,996	25,651	26,264
Funded	**6,948**	**6,888**	**6,422**	**5,008**	**6,231**	**3,363**
First-time Investigators						
Received	12,685	12,093	12,616	13,528	14,579	14,668
Funded	**2,880**	**2,814**	**2,579**	**1,890**	**2,344**	**1,223**

[1] R01 Equivalent Grants form a subset of all RPG awards. In FY 2025 they comprised roughly 67% of Funded Applications, 70% of Funded Total Investigators, 79% of Funded Established Investigators, and 58% of Funded First-time Applicants. The year-to-year variation of these figures is about 2%, plus or minus.

[2] The ratio of total and funded applicants to applications and the proportion of total and funded first-time applicants are based on linear extrapolation of five years of the latest actual data.

[3] Excludes applications and awards associated with reimbursable agreements and Superfund Research account.

[4] Estimates for received applications reflect consolidations of Institute/Center validated refinements to linear extrapolation of five years of latest actual data. Funded application figures are estimates based on total new/competing RPG awards identified in the mechanism budget table.

[5] Includes 21st Century Cures Act funding.

[a] Figures do not include any awards related to ARPA-H.

[A] Figures for the years before FY 2025 include NIEHS. The figures for 2025 through 2027 do not include NIEHS, for comparability with the proposed reorganization of NIEHS from NIH to the Centers for Disease Control and Prevention. The 2025 -- 2027 figures are not directly comparable to previous years.

MF GENERAL STATEMENT

Management Fund

General Statement

The NIH Management Fund (MF) was established on June 29, 1957, by Public Law 85-67. The MF was created to finance a variety of centralized support services and administrative activities that are required for the efficient and effective operation of all NIH programs and facilities. The services provided by the MF include a research hospital and outpatient clinic; receipt, review and referral of research and training grant applications; and general administrative support services. These services are financed through offsetting collections received by the MF from the NIH Institutes and Centers representing charges for services provided. Pursuant to a provision of the appropriation language for the NIH Office of the Director, these collections remain available for one fiscal year after the fiscal year in which they are deposited.

MF BUDGET AUTHORITY BY ACTIVITY

Budget Authority by Activity [1,*]

(Dollars in Thousands)

	FY 2025 Final		FY 2026 Enacted		FY 2027 President's Budget		FY 2027 +/- FY 2026 Enacted	
Extramural Research	**FTE**	**Amount**	**FTE**	**Amount**	**FTE**	**Amount**	**FTE**	**Amount**
Detail								
Clinical Center	1,848	$735,971	1,815	$779,752	1,851	$740,764	36	-$38,988
Center for Scientific Review, SREA[2]	492	$151,543	735	$161,848	735	$153,756	0	-$8,092
Office of Research Services, and Administrative services, support		$105		$0		$0		$0
TOTAL	**2,340**	**$887,620**	**2,550**	**$941,600**	**2,586**	**$894,520**	**36**	**-$47,080**

[1] Royalties excluded for all years.

[2] FTE levels for FY 2026 and FY 2027 reflect the centralization into CSR of the initial NIH peer review process for grants, co-operative agreements, and R&D contracts.

[*] Includes FTEs whose payroll obligations are supported by the NIH Common Fund.

MF BUDGET AUTHORITY BY OBJECT CLASS

		FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Total compensable workyears:				
	Full-time equivalent	2,550	2,586	36
	Full-time equivalent of overtime and holiday hours	41	41	0
	Average ES salary	$226	$226	$0
	Average GM/GS grade	11.9	11.9	0.0
	Average GM/GS salary	$130	$130	$0
	Average salary, Commissioned Corps (42 U.S.C. 207)	$176	$182	$6
	Average salary of ungraded positions	$161	$161	$0
	OBJECT CLASSES	**FY 2026 Enacted**	**FY 2027 President's Budget**	**FY 2027 +/- FY 2026**
	Personnel Compensation			
11.1	Full-Time Permanent	$285,245	$285,958	$713
11.3	Other Than Full-Time Permanent	$46,745	$46,862	$117
11.5	Other Personnel Compensation	$34,036	$34,121	$85
11.7	Military Personnel	$6,611	$6,852	$241
11.8	Special Personnel Services Payments	$8,422	$8,444	$21
11.9	**Subtotal Personnel Compensation**	**$381,059**	**$382,237**	**$1,177**
12.1	Civilian Personnel Benefits	$130,789	$131,116	$327
12.2	Military Personnel Benefits	$909	$942	$33
13.0	Benefits to Former Personnel	$98	$0	-$98
	Subtotal Pay Costs	**$512,855**	**$514,295**	**$1,440**
21.0	Travel & Transportation of Persons	$2,839	$2,271	-$568
22.0	Transportation of Things	$760	$608	-$152
23.1	Rental Payments to GSA	$244	$232	-$12
23.2	Rental Payments to Others	$2	$2	$0
23.3	Communications, Utilities & Misc. Charges	$2,486	$1,989	-$497
24.0	Printing & Reproduction	$6	$6	$0
25.1	Consulting Services	$19,219	$15,183	-$4,036
25.2	Other Services	$99,728	$89,265	-$10,463
25.3	Purchase of Goods and Services from Government Accounts	$81,808	$71,181	-$10,627
25.4	Operation & Maintenance of Facilities	$1,989	$1,790	-$199
25.5	R&D Contracts	$820	$738	-$82
25.6	Medical Care	$24,403	$21,962	-$2,440
25.7	Operation & Maintenance of Equipment	$45,428	$40,886	-$4,543
25.8	Subsistence & Support of Persons	$0	$0	$0
25.0	**Subtotal Other Contractual Services**	**$273,395**	**$241,004**	**-$32,391**
26.0	Supplies & Materials	$136,189	$122,570	-$13,619
31.0	Equipment	$10,954	$9,859	-$1,095
32.0	Land and Structures	$1,852	$1,667	-$185
33.0	Investments & Loans	$0	$0	$0
41.0	Grants, Subsidies & Contributions	$0	$0	$0
42.0	Insurance Claims & Indemnities	$0	$0	$0
43.0	Interest & Dividends	$17	$17	$0
44.0	Refunds	$0	$0	$0
94.0	Financial Transfers	$0	$0	$0
	Subtotal Non-Pay Costs	**$428,745**	**$380,225**	**-$48,520**
	Total Budget Authority by Object Class	**$941,600**	**$894,520**	**-$47,080**

[1] Includes FTEs whose payroll obligations are supported by the NIH Common Fund.

MF DETAIL OF POSITIONS

GRADE	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Total, ES Positions	2	2	2
Total, ES Salary	$447,579	$452,055	$452,055
General Schedule			
GM/GS-15	125	181	182
GM/GS-14	368	478	481
GM/GS-13	380	404	411
GS-12	507	506	517
GS-11	351	351	358
GS-10	35	34	35
GS-9	84	98	100
GS-8	64	63	64
GS-7	164	172	175
GS-6	24	24	24
GS-5	6	5	5
GS-4	3	3	3
GS-3	6	6	6
GS-2	2	2	2
GS-1	0	0	0
Subtotal	2,119	2,327	2,363
Commissioned Corps (42 U.S.C. 207)			
Assistant Surgeon General	0	0	0
Director Grade	6	6	6
Senior Grade	8	10	10
Full Grade	10	10	10
Senior Assistant Grade	9	9	9
Assistant Grade	0	0	0
Junior Assistant	0	0	0
Subtotal	33	35	35
Ungraded	181	186	186
Total permanent positions	2,173	2,404	2,440
Total positions, end of year	2,335	2,550	2,586
Total full-time equivalent (FTE) employment, end of year	2,340	2,550	2,586
Average ES salary	$223,790	$226,028	$226,028
Average GM/GS grade	11.7	11.9	11.9
Average GM/GS salary	$123,044	$130,202	$130,202

SSF GENERAL STATEMENT

Service and Supply Fund

General Statement

The NIH Service and Supply Fund (SSF) was established on July 3, 1945, under 42 U.S.C. 231. The SSF was created to finance a variety of centralized research support services and administrative activities that are required for the efficient and effective operation of all NIH programs and facilities. The SSF provides a single means for consolidating the financing and accounting of business-type operations, including the sales of services and commodities to customers. The services provided through the SSF include: mainframe computing, enterprise information technology (IT) software planning and development, facilities engineering, planning and design, facility use and maintenance including leased buildings, telecommunications, procurement, shipping and receiving, motor pool, research animals, utilities and plant maintenance, finance and accounting operations, government-wide contracting for IT, biomedical engineering, security, human resources, collaborative computer science research, and other administrative support services. The SSF is financed through offsetting collections from the NIH Institutes and Centers representing charges for goods and services provided.

SSF BUDGET AUTHORITY BY ACTIVITY

Budget Authority by Activity*

(Dollars in Thousands)

	FY 2025 Final		FY 2026 Enacted		FY 2027 President's Budget		FY 2027 +/- FY 2026 Enacted	
Extramural Research	FTE	Amount	FTE	Amount	FTE	Amount	FTE	Amount
Detail								
Research Support and Administrative, OD, CC-CIF[1]	1,408	$1,378,664	1,411	$1,547,563	1,649	$1,364,092	238	-$183,471
Office of Research Facilities, Development & Operations	756	$644,063	653	$580,418	793	$515,474	140	-$64,944
Center for Information Technology	190	$494,387	164	$487,300	173	$429,727	9	-$57,573
TOTAL	**2,354**	**$2,517,114**	**2,228**	**$2,615,281**	**2,615**	**$2,309,293**	**387**	**-$305,988**

[1] FTE estimates reflect the effects of the centralization of contracting and other functions from the Institutes and Centers to the Office of the Director.

* Includes FTEs whose payroll obligations are supported by the NIH Common Fund.

SSF BUDGET AUTHORITY BY OBJECT

		FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Total compensable workyears:				
	Full-time equivalent	2,228	2,615	387
	Full-time equivalent of overtime and holiday hours	65	65	0
	Average ES salary	$265	$265	$0
	Average GM/GS grade	12.3	12.4	0.1
	Average GM/GS salary	$149	$149	$0
	Average salary, Commissioned Corps (42 U.S.C. 207)	$146	$152	$5
	Average salary of ungraded positions	$105	$105	$0
	OBJECT CLASSES	**FY 2026 Enacted**	**FY 2027 President's Budget**	**FY 2027 +/- FY 2026**
	Personnel Compensation			
11.1	Full-Time Permanent	$334,781	$470,816	$136,035
11.3	Other Than Full-Time Permanent	$11,652	$16,387	$4,735
11.5	Other Personnel Compensation	$19,921	$24,785	$4,864
11.7	Military Personnel	$3,173	$3,288	$116
11.8	Special Personnel Services Payments	$636	$792	$155
11.9	**Subtotal Personnel Compensation**	**$370,163**	**$516,067**	**$145,905**
12.1	Civilian Personnel Benefits	$125,134	$176,595	$51,461
12.2	Military Personnel Benefits	$416	$432	$15
13.0	Benefits to Former Personnel	$4,850	$3,021	-$1,828
	Subtotal Pay Costs	**$500,562**	**$696,115**	**$195,553**
21.0	Travel & Transportation of Persons	$937	$749	-$187
22.0	Transportation of Things	$6,484	$5,188	-$1,297
23.1	Rental Payments to GSA	$86,277	$69,022	-$17,255
23.2	Rental Payments to Others	$5,026	$4,021	-$1,005
23.3	Communications, Utilities & Misc. Charges	$136,170	$89,581	-$46,588
24.0	Printing & Reproduction	$0	$0	$0
25.1	Consulting Services	$71,258	$57,006	-$14,252
25.2	Other Services	$785,549	$606,952	-$178,597
25.3	Purchase of Goods and Services from Government Accounts	$421,848	$321,244	-$100,604
25.4	Operation & Maintenance of Facilities	$112,828	$90,262	-$22,566
25.5	R&D Contracts	$22,359	$17,887	-$4,472
25.6	Medical Care	$1,151	$921	-$230
25.7	Operation & Maintenance of Equipment	$274,336	$197,948	-$76,388
25.8	Subsistence & Support of Persons	$0	$0	$0
25.0	**Subtotal Other Contractual Services**	**$1,689,328**	**$1,292,220**	**-$397,108**
26.0	Supplies & Materials	$56,085	$44,868	-$11,217
31.0	Equipment	$23,017	$18,414	-$4,603
32.0	Land and Structures	$109,287	$87,429	-$21,857
33.0	Investments & Loans	$0	$0	$0
41.0	Grants, Subsidies & Contributions	$2,026	$1,621	-$405
42.0	Insurance Claims & Indemnities	$0	$0	$0
43.0	Interest & Dividends	$81	$65	-$16
44.0	Refunds	$0	$0	$0
94.0	Financial Transfers	$0	$0	$0
	Subtotal Non-Pay Costs	**$2,114,719**	**$1,613,178**	**-$501,541**
	Total Budget Authority by Object Class	**$2,615,281**	**$2,309,293**	**-$305,988**

[1] Includes FTEs whose payroll obligations are supported by the NIH Common Fund.

SSF DETAIL OF POSITIONS

GRADE	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Total, ES Positions	6	6	6
Total, ES Salary	$1,571,574	$1,587,290	$1,587,290
General Schedule			
GM/GS-15	112	134	147
GM/GS-14	340	394	406
GM/GS-13	709	789	832
GS-12	303	366	386
GS-11	121	134	136
GS-10	11	13	14
GS-9	66	76	83
GS-8	42	59	55
GS-7	85	100	92
GS-6	4	7	7
GS-5	9	10	7
GS-4	5	5	7
GS-3	4	5	4
GS-2	4	3	3
GS-1	1	0	1
Subtotal	1,816	2,095	2,180
Commissioned Corps (42 U.S.C. 207)			
Assistant Surgeon General	0	0	0
Director Grade	2	2	2
Senior Grade	7	7	7
Full Grade	6	6	6
Senior Assistant Grade	2	2	2
Assistant Grade	0	0	0
Junior Assistant	0	0	0
Subtotal	17	17	17
Ungraded	284	313	386
Total permanent positions	2,065	2,114	2,492
Total positions, end of year	2,123	2,431	2,589
Total full-time equivalent (FTE) employment, end of year	2,354	2,228	2,615
Average ES salary	$261,929	$264,548	$264,548
Average GM/GS grade	12.3	12.3	12.4
Average GM/GS salary	$143,929	$148,921	$148,921

NIH Common Fund

CONGRESSIONAL JUSTIFICATION
FY 2027

Department of Health and Human Services
National Institutes of Health

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL INSTITUTES OF HEALTH

NIH Common Fund (CF)

FY 2027 Budget Table of Contents

General Notes

1. Estimates assume reauthorization of the SBIR/STTR program in FY 2026 and FY 2027.
2. Detail in this document may not sum to the subtotals and totals due to rounding.

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ICO OVERVIEW

NIH Common Fund Overview

The Common Fund (CF) supports research to address scientific challenges and opportunities that are high priorities for NIH as a whole.[99] CF supports bold, goal-driven research programs that catalyze discovery across biomedical and behavioral research and span the NIH mission. These programs support research that leads to new understanding of the basic biological and behavioral processes that influence human health and disease and establish innovative approaches to translate new therapeutics into the clinic. CF also evaluates novel models to support the biomedical research workforce. CF programs are intended to be timely, capitalizing on new knowledge and technological advances to catalyze an area of science. The innovative research supported by CF benefits from strategic coordination across the NIH and is designed to achieve specific, high-impact goals and milestones within 10 years.

Many CF programs produce specific deliverables, such as data sets, tools, or technologies, that fill a significant need across multiple fields of research. Although support for CF programs is time-limited, the catalytic nature of these programs frequently allows them to spur subsequent discoveries with far-reaching impacts that last beyond their lifespan. For example, the Stimulating Peripheral Activity to Relieve Conditions (SPARC) program has advanced the field of bioelectronic medicine by developing new technologies that modulate electrical activity in nerves to ultimately improve organ function in conditions such as bladder and bowel dysfunction, atrial fibrillation, and gastroparesis.[100] The Extracellular RNA Communication program has identified potential biomarkers for nearly 30 diseases and conditions, including cardiovascular disease, pregnancy complications, glaucoma, diabetes, and multiple types of cancer.[101] These RNA molecules can allow us to learn valuable information about healthy functioning and disease development throughout the body. Future research may lead to these RNAs being harnessed to deliver information to parts of the body to treat diseases.

CF is well-poised and experienced to address emerging and pressing scientific opportunities and challenges of the future. As programs end, funds are available to address new areas of research. Through a robust strategic planning process involving broad input and prioritization across the NIH, new program concepts are identified that are high priority across NIH, such as the new Precision Medicine with AI: Integrating Imaging with Multimodal Data (PRIMED-AI) program, which will drive integration of clinical imaging data with other multi-modal data types, enabling artificial intelligence (AI)-powered, cost-effective, and accessible precision medicine for a variety of diseases and conditions.[102]

[99] commonfund.nih.gov/
[100] commonfund.nih.gov/sparc
[101] commonfund.nih.gov/Exrna
[102] commonfund.nih.gov/primed-ai

MAJOR CHANGES

Major Changes in the Budget Request

Major changes by budget mechanism and/or budget activity detail are briefly described below. Note there may be some overlap between budget mechanisms and activity detail, and these highlights will not sum to the total for the FY 2027 President's Budget request for the Common Fund, which is $515.4 million, a decrease of $57.0 million or 10 percent compared with the FY 2026 Enacted level. Overall, this budget allows the Common Fund to continue supporting some high priority activities while scaling back support across the program as a whole. The decrease includes effects of implementing the new NIH-wide indirect cost limit in FY 2027 under which indirect costs on all research projects are limited to no more than 15 percent of the modified total direct costs. In addition, the modified total direct costs will be adjusted specifically for Common Fund awards to include both a 10 percent reduction to the full commitment level on noncompeting awards and the direct cost requested level on competing awards.

Research Project Grants (RPGs) (-$31.4 million; total $329.1 million):
The Common Fund will support a total of 268 RPG awards in FY 2027. FY 2026 grant funding policies contribute to the decrease in noncompeting RPGs, 14 fewer awards. With savings from the indirect cost limit and the 10 percent reduction to direct costs for competing and noncompeting awards, the Common Fund will fund 112 competing RPGs. The FY 2027 request reflects the FY 2027 NIH policy of fully funding the outyear commitments of all competing RPGs as part of the initial grant award.

Research Centers (-$0.1 million; total $50.5 million):
The Common Fund will support a total of 23 Research Centers awards in FY 2027, 7 fewer than in FY 2026. The funding level also reflects the 15 percent indirect cost limit and 10 percent direct cost reduction on new and continuing Research Centers in FY 2027.

Other Research (-$27.1 million; total $77.2 million):
The Common Fund will support a total of 71 Other Research awards in FY 2027, 21 awards more than in FY 2026. Other Research grants within the Nutrition for Precision Health, and Venture programs that are focused on development and application of imaging technologies for the emerging field of oculomics receive a final funding increment in FY 2026. The decrease in funding is also due to the 15 percent indirect cost limit and 10 percent direct cost reduction on new and continuing Other Research awards in FY 2027.

BUDGET MECHANISM TABLE

Mechanism (Dollars in Thousands)	FY 2025 Final		FY 2026 Enacted		FY 2027 President's Budget		FY 2027 +/- FY 2026	
	Number	Amount	Number	Amount	Number	Amount	Number	Amount
Research Projects:								
Noncompeting	239	$244,112	170	$279,452	156	$117,191	-14	-$162,261
Administrative Supplements	*(26)*	$9,570	*(22)*	$7,573	*(9)*	$2,213	*-(13)*	-$5,360
Competing:								
Renewal	0	$0	0	$0	0	$0	0	$0
New	81	$78,216	80	$73,524	112	$209,745	32	$136,221
Supplements	0	$0	0	$0	0	$0	0	$0
Subtotal, Competing	**81**	**$78,216**	**80**	**$73,524**	**112**	**$209,745**	**32**	**$136,221**
Subtotal, RPGs	320	$331,899	250	$360,550	268	$329,150	18	-$31,400
SBIR/STTR	0	$0	0	$0	0	$0	0	$0
Research Project Grants	320	$331,899	250	$360,550	268	$329,150	18	-$31,400
Research Centers								
Specialized/Comprehensive	43	$76,415	30	$50,614	23	$50,485	-7	-$129
Clinical Research	0	$0	0	$0	0	$0	0	$0
Biotechnology	0	$0	0	$0	0	$0	0	$0
Comparative Medicine	0	$0	0	$0	0	$0	0	$0
Research Centers in Minority Institutions	0	$0	0	$0	0	$0	0	$0
Research Centers	**43**	**$76,415**	**30**	**$50,614**	**23**	**$50,485**	**-7**	**-$129**
Other Research:								
Research Careers	0	$0	0	$0	0	$0	0	$0
Cancer Education	0	$0	0	$0	0	$0	0	$0
Cooperative Clinical Research	6	$16,859	6	$14,872	0	$0	-6	-$14,872
Biomedical Research Support	0	$0	0	$0	0	$0	0	$0
Minority Biomedical Research Support	0	$0	0	$0	0	$0	0	$0
Other	87	$216,210	44	$89,485	71	$77,241	27	-$12,244
Other Research	**93**	**$233,068**	**50**	**$104,357**	**71**	**$77,241**	**21**	**-$27,116**
Total Research Grants	456	$641,382	330	$515,521	362	$456,876	32	-$58,644
Ruth L Kirschstein Training Awards:	FTTPs		FTTPs		FTTPs		FTTPs	
Individual Awards	0	$0	0	$0	0	$0	0	$0
Institutional Awards	0	$0	0	$0	0	$0	0	$0
Total Research Training	**0**	**$0**	**0**	**$0**	**0**	**$0**	**0**	**$0**
Research & Develop. Contracts	4	$8,876	2	$4,531	4	$12,415	2	$7,883
SBIR/STTR (non-add)	*(0)*	*($0)*	*(0)*	*($0)*	*(0)*	*($0)*	*(0)*	*($0)*
Intramural Research	0	$341	0	$2,000	0	$1,800	0	-$200
Res. Management & Support	0	$34,402	0	$50,349	0	$44,310	0	-$6,039
SBIR Admin. (non-add)		*($0)*		*($0)*		*($0)*		*($0)*
Construction		$0		$0		$0		$0
Buildings and Facilities		$0		$0		$0		$0
Total, Common Fund	**0**	**$685,001**	**0**	**$572,401**	**0**	**$515,401**	**0**	**-$57,000**

* All items in italics and brackets are non-add entries.

BUDGET BY INITIATIVE

Common Fund Program (Dollars in Thousands)	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
4D Nucleome	$208	$0	$0
Acute to Chronic Pain Signatures	$3,823	$878	$340
Bridge to Artificial Intelligence (Bridge2AI)	$54,975	$1,328	$13,776
CARE for Health™	$16,674	$35,000	$29,557
Cellular Senescence Network (SenNET)	$38,812	$7,868	$66,644
Common Fund Data Ecosystem	$32,633	$13,214	$14,750
Community Partnerships to Advance Science for Society (ComPASS) Program	$13,584	$22,974	$21,298
Complement-Animal Research in Experimentation (Complement-ARIE)	$0	$29,997	$21,869
Faculty Institutional Recruitment for Sustainable Transformation (FIRST)	$744	$20,913	$4,279
Gabriella Miller Kids First Pediatric Research[1]	$12,884	$400	$0
Harnessing Data Science for Health Discovery and Innovation in Africa (DSI-Africa)	$16,259	$381	$0
High-Risk Research High-Reward Research (HRHR)	$212,007	$168,932	$210,260
Human BioMolecular Atlas Project (HuBMAP)	$19,562	$350	$0
Human Virome Program (HVP)	$32,197	$38,964	$26,251
Molecular Transducers of Physical Activity	$15,234	$1,480	$304
Nutrition for Precision Health	$46,646	$42,015	$220
Precision Medicine with AI: Integrating Imaging with Multimodal Data (PRIMED-AI)	$0	$0	$20,172
Somatic Cell Genome Editing	$49,422	$83,849	$5,609
Somatic Mosaicism across Human Tissues (SMaHT)	$30,604	$68,712	$365
S.P.A.R.C. - Stimulating Peripheral Activity to Relieve Conditions	$311	$350	$0
Transformative High Resolution Cryo-Electron Microscopy (CryoEM)	$4,055	$105	$0
Transformative Research to Address Health Disparities	$13,587	$5,121	$0
Venture Program	$41,537	$7,272	$8,416
Strategic Planning, Evaluation, and Infrastructure	$29,244	$22,300	$20,067
Subtotal Common Fund	$685,001	$572,401	$464,177
New Initiatives in Common Fund	$0	$0	$51,224
Total Common Fund	$685,001	$572,401	$515,401

[1]The Gabriella Miller Kids First Pediatric Research Program is relocating out of the Common Fund in FY 2026 pursuant to the Gabriella Miller Kids First Research Act 2.0.

JUSTIFICATION OF BUDGET REQUEST

NIH Common Fund

Budget Authority (BA):

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
BA	$685,001,000	$572,401,000	$515,401,000	-$57,000,000
FTE	0	0	0	0

Program funds are allocated as follows: Competitive Grants/Cooperative Agreements; Contracts; Direct Federal/Intramural and Other.

Overall Budget Policy: The FY 2027 President's Budget request for the Common Fund (CF) is $515.4 million, a decrease of $57.0.0 million or 10.0 percent compared with the FY 2026 Enacted level. This funding level will continue to support some high priority activities within programs, as described below. CF is prepared to support additional programs to deliver important cutting edge biomedical and behavioral science and innovative approaches to translating science into new therapeutics for the clinic in the future.

Program Descriptions and Accomplishments

The CF supports over 20 programs, most of which consist of a series of integrated initiatives that collectively address a set of goals that can be achieved within 10 years. Planned activities and budgets for CF programs are strategically developed, with clear milestones defined throughout the lifetime of the program to enable measurement of progress towards pre-defined goals. CF programs are responsive to the needs and activities for each program and often undergo planned budget shifts. Highlighted below are programs that exemplify the high priority science to be supported in FY 2027, and/or which are undergoing significant programmatic changes in FY 2027.

Complement Animal Research in Experimentation (Complement-ARIE)

Complement-ARIE aims to increase the speed of development, standardization, validation, and use of human-based New Approach Methodologies (NAMs).[103] NAMs are lab or computer-based research approaches intended to more accurately model human biology and complement, or in some cases replace, traditional research models. Recently developed NAMs have been able to model human biology in new ways, such as a "digital twin" that virtually represents human biological systems. "Organ-on-chip" technology replicates human organ systems within a

[103] commonfund.nih.gov/complementarie

microchip to test the effect of different medications or substances. Advances in NAMs technologies may result in better methods of modeling human disease available to multiple sectors of scientific research, leading to better clinical trial outcomes and new potential treatments.

Budget Policy: The FY 2027 President's Budget request is $21.9 million, a decrease of $8.1 million or 27.1 percent compared with the FY 2026 Enacted level, as the program launched in FY 2026. Funds requested in FY 2027 will support technology development to stimulate NAMs in biomedical research areas of greatest need (e.g. chronic disease, neurodevelopment), data and resource coordination and sharing, and validation and qualification of NAMs to support regulatory, industrial, and research use.

High-Risk, High-Reward (HRHR) Program

The HRHR program supports creative scientists proposing innovative research in any scientific area within the NIH's mission through four complementary initiatives: the Pioneer Award, New Innovator Award, Transformative Research Award, and Early Independence Award.[104] These awards support research that is inherently difficult and scientifically risky, but necessary to accelerate the pace of scientific discovery and advance human health. Recently, a HRHR New Innovator awardee developed a wearable, non-invasive brain-computer interface that integrates electrical brain data with a camera-enabled AI "co-pilot" to interpret user intent in real time and complete tasks such as moving a robotic arm or a computer cursor.[105] This advance could support the development of a wide range of technologies to help people with limited physical capabilities, such as those with paralysis or neurological conditions.

Budget Policy: The FY 2027 President's Budget request is $210.3 million, an increase of $41.3 million or 24.5 percent compared with the FY 2026 Enacted level. Funds requested in FY 2027 will be used to support additional innovative projects with the potential for exceptional impact in biomedical research.

Nutrition for Precision Health (NPH), powered by the *All of Us* Research Program

NPH, powered by the *All of Us* Research Program, aims to develop algorithms that predict individual responses to food and dietary patterns based on factors such as lifestyle, genomics, environment, and the microbiome – the collection of microbes that reside in and on our bodies.[106] In the future, these predictive algorithms may enable individuals to make better informed decisions about healthy food choices and to improve their overall health. NPH is enrolling at least 8,000 participants from various backgrounds, making it the largest nutrition study of its kind.

Budget Policy: The FY 2027 President's Budget request is $0.2 million, a decrease of $41.8 million or 99.5 percent compared with the FY 2026 Enacted level. The FY 2027 spending

[104] commonfund.nih.gov/highrisk
[105] Lee, J.Y., Lee, S., Mishra, A. *et al.* Brain–computer interface control with artificial intelligence copilots. *Nat Mach Intell* **7**, 1510–1523 (2025). doi.org/10.1038/s42256-025-01090-y
[106] commonfund.nih.gov/nutritionforprecisionhealth

commitments are significantly reduced for the Nutrition for Precision Health (NPH) program, as those commitments will be funded in FY 2026.

Acute to Chronic Pain Signatures (A2CPS)

Chronic pain affects over 100 million people in the United States alone, but available treatments are ineffective for many of these individuals, in large part because the underlying causes that lead to chronic pain are not well understood. Prevention of the transition from acute to chronic pain is a major challenge in pain management. A2CPS aims to develop an objective set of biomarkers that provides "signatures" to predict whether someone is likely to develop chronic pain after acute pain.[107] A2CPS researchers are looking for differences in the brains of people who transition from acute to chronic pain versus those who do not, which could reveal biomarkers associated with this change. Findings could help accelerate therapy development, guide pain prevention strategies, and lead to better, more individualized treatments for patients.

Budget Policy: The FY 2027 President's Budget request is $0.3 million, a decrease of $0.5 million or 61.3 percent compared with the FY 2026 Enacted level. The A2CPS Consortium will continue to analyze data through FY 2027 and will make de-identified data publicly available in FY 2027 for further study.

Bridge to Artificial Intelligence (B2AI)

B2AI is setting the stage for widespread adoption of AI to tackle complex biomedical challenges beyond human intuition.[108] This program is generating new AI and machine learning (ML)-ready data and developing and disseminating software, standards, tools, and other resources. The program is also focused on advancing ethical principles and best practices for biomedical AI and creating AI and ML training materials and activities.

Budget Policy: The FY 2027 President's Budget request is $13.8 million, an increase of $12.4 million or 937.7 percent compared with the FY 2026 Enacted level. Funds requested in FY 2027 will launch the second stage of this program, which will support integration, evaluation, and dissemination of best practices for ethics, standards, tools, data, teamwork, and training, as well as support data generation projects.

Cellular Senescence Network (SenNet)

During aging, tissues throughout the body accumulate small numbers of specialized cells (senescent cells) that no longer divide but remain active and develop specialized characteristics that are different from other non-dividing cells. There are many unanswered questions about how, when, why, and where senescent cells form and what impact they have on human health and disease. The goal of SenNet is to comprehensively identify and characterize the differences in senescent cells across the body, across various states of human health, and across the lifespan.[109] A deeper understanding of cellular senescence will help researchers to develop

[107] commonfund.nih.gov/pain
[108] commonfund.nih.gov/bridge2ai
[109] commonfund.nih.gov/senescence

therapies that encourage beneficial effects of senescent cells while suppressing their tissue-damaging effects.

Budget Policy: The FY 2027 President's Budget request is $66.6 million, an increase of $58.8 million or 747.0 percent compared with the FY 2026 Enacted level. Funds requested in FY 2027 will support the launch of the second stage of this program and will support senescence technology projects, and discovery, validation, and data coordination centers. The funding request also reflects the NIH policy of fully funding outyear commitments for FY 2027 competing RPG awards as part of the initial grant award.

Somatic Mosaicism across Human Tissues (SMaHT)

The SMaHT program aims to transform our understanding of how somatic mosaicism, or genetic variation within an individual, influences biology and disease.[110] Although we know that certain kinds of somatic mosaicism can lead to cancer, we don't know how much somatic mosaicism there is in our personal genomes or how much it impacts human biology or other disease processes. There is mounting evidence that somatic mosaicism plays important roles in human development, aging, and disease. However, technical challenges in detecting rare somatic variations mean this phenomenon is understudied. SMaHT will catalog somatic variants in select tissues from many human donors, develop innovative sequencing tools and analysis methods, and create a workbench to integrate analysis of somatic variation with the human genome.

Budget Policy: The FY 2027 President's Budget request is $0.4 million, a decrease of $68.3 million or 99.5 percent compared with the FY 2026 Enacted level. Funds requested in FY 2027 will support closing out the first stage of the program. After reviewing the accomplishments of the first stage and considering additional gaps and opportunities, NIH leadership will determine if a second stage should be pursued for this program in FY 2028.

Molecular Transducers of Physical Activity in Humans (MoTrPAC)

Physical activity promotes health in a wide variety of ways, and lack of physical activity is a contributing factor to many common chronic health problems. However, we have a limited understanding of the molecular mechanisms that underlie how physical activity provides health benefits. A better understanding of the molecules that underlie the benefits of physical activity could lead to the development of improved, personalized exercise recommendations, as well as therapies for individuals who are unable to exercise due to illness or disability. MoTrPAC is cataloging the biological molecules affected by physical activity in humans, identifying some of the key molecules that underlie the systemic effects of physical activity and characterizing their function.[111] Initial results from MoTrPAC's complementary animal studies are revealing exciting new insights into the effects of physical activity on biological pathways related to metabolism and sex-specific differences in these pathways.[112] Human studies and subsequent analyses are currently ongoing.

[110] commonfund.nih.gov/smaht
[111] commonfund.nih.gov/MolecularTransducers
[112] Many, G.M., Sanford, J.A., et al. Sexual dimorphism and the multi-omic response to exercise training in rat subcutaneous white adipose tissue. Nat Metab (2024). doi: 10.1038/s42255-023-00959-9

Budget Policy: The FY 2027 President's Budget request is $0.3 million, a decrease of $1.2 million or 79.4 percent compared with the FY 2026 Enacted level. Funds requested in FY 2027 represent the closeout of this program.

Somatic Cell Genome Editing (SCGE) Program

The SCGE program is accelerating the translation of genome editing therapies into the clinic. By developing targeted delivery technologies and advancing clinical development these therapies may one day be able to treat currently untreatable conditions and diseases in humans, such as hearing loss and fatal prion diseases.[113] This program is removing barriers that slow the adoption of genome editing and laying the groundwork for clinical trials that assess the safety and efficacy of promising genome editing therapies, including disseminating successful strategies for starting clinical trials through a publicly accessible platform. Research and funding from the SCGE program contributed to a recent first-in-human study where a research team developed and safely delivered a personalized gene editing therapy to treat an infant with a life-threatening, incurable genetic disease.[114]

Budget Policy: The FY 2027 President's Budget request is $5.6 million, a decrease of $78.2 million or 93.3 percent compared with the FY 2026 Enacted level. Funds requested in FY 2027 reflect the planned ramping down of the program, including continued support for quality control of metadata protocols.

Venture Program

The Venture Program is a new approach at the Common Fund to support bold, short-term initiatives with the potential for significant impact.[115] Venture initiatives are intended to be nimble, modest, focused investments that can be implemented quickly and deliver specific outcomes, such as new knowledge, methods, or technologies, in three years or less. Current Venture initiatives are supporting development of non-invasive eye imaging technologies to identify disease biomarkers, integration of data sets for cross-disease research, pilot testing a new model for newborn screening using whole genome sequencing, advancing non-invasive optical imaging approaches for a variety of tissues, and developing new therapeutics that act on RNA.

Budget Policy: The FY 2027 President's Budget request is $8.4 million, an increase of $1.1 million or 15.7 percent compared with the FY 2026 Enacted level. Funds requested in FY 2027 will support these ongoing efforts but will not be used to launch new initiatives.

Strategic Planning, Evaluation, and Infrastructure

Strategic planning is undertaken every year to identify new scientific challenges and opportunities ready for dedicated investment via a CF program or Venture initiative. Planning

[113] commonfund.nih.gov/editing
[114] Musunuru K, Grandinette SA, et al. Patient-Specific In Vivo Gene Editing to Treat a Rare Genetic Disease. N Engl J Med. (2025). doi: 10.1056/NEJMoa2504747
[115] commonfund.nih.gov/venture

activities first identify broad scientific areas that are priorities for NIH as a whole and then establish a focused strategy for investments that will catalyze research progress in those areas. The initial idea-gathering phase of strategic planning leverages the wide-ranging expertise of NIH's senior leadership and scientific staff, combined with public input. The strategy development phase involves specific consultations with external experts, analysis of NIH and other research portfolios, and literature reviews to articulate specific gaps and areas of biomedical research where opportunities for transformative progress are possible.

Since CF programs are goal-driven, evaluation is critical for monitoring progress and developing strategies to adapt the program. Evaluation includes both formal and informal evaluative activities. Informal evaluation involves convening grantees and NIH-wide teams to review progress, discuss new challenges, and develop strategies to adopt as part of routine program management. It also involves gathering input from external consultants and using their input, together with internal analysis, to help guide the implementation of the program. Formal evaluations involve the development of baseline data for new programs and the development of multiple metrics of outcomes. The utility of data, resources, technologies, and other program outputs is assessed through surveys, expert opinion, and the analysis of bibliometric data such as citation analyses.

Funds Available for New Initiatives in the Common Fund

Planning for CF programs and initiatives leverages the wide-ranging expertise of NIH leadership, scientific staff, and the public. As CF is intended to address scientific opportunities and gaps that are high priority NIH-wide, selection of potential new ideas for CF activities is driven by a collaborative decision-making process involving leadership from across NIH. As shown in the "Budget by Initiative" table, the Common Fund proposes $51.2 million for new programs in FY 2027. The CF planning process led to the identification of the below programs, which are anticipated to be launched in FY 2027.

- **Research Rigor and Replication to Promote Excellence, Accuracy, and Translation in Science (R3PEATS)**: Pending approval, this program will support replication of significant areas of research in support of the wider NIH efforts to enhance research rigor and reproducibility. R3PEATS builds in part, on the Common Fund's Replication to Enhance Research Impact Initiative (Replication Initiative), a pilot effort to provide support to independently replicate significant areas of research and validate novel technologies across preclinical and translational research studies across different scientific research areas.[116] R3PEATS seeks to create a synergy of research, partnership, engagement, and coordination to drive culture change to better promote rigorous, transparent, and replicable practices that broadly benefit NIH-funded research, the wider scientific community, and the general public.

- **RNomics Program:** The RNomics program aims to build the tools and technologies needed to study the human RNome—the entire catalogue of RNA molecules in the body—including how various structural forms and chemical modifications impact human health. Current tools cannot adequately sequence full-length RNA and study these modifications in detail, so the RNomics program will support the development of these

[116] commonfund.nih.gov/replication-initiative

tools. This program would develop RNA sequencing technologies, molecular and computational tools, and standard reference RNA molecules to ensure reproducibility.

- **Ultra-Processed Food: Investigating Mechanisms, Prevention, and Action for Chronic Disease and Transformation (UPF-IMPACT)**: Pending approval, this program will support multidisciplinary research across the lifespan to understand the health impacts of ultra-processed foods. This research will provide the evidence base needed to inform dietary guidance, policies, and programs that improve health and promote disease prevention. This new program would include research to understand the metabolic, biological, and behavioral mechanisms by which components and combinations of UPF exposure impact health across the lifespan.

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Office of AIDS Research

CONGRESSIONAL JUSTIFICATION
FY 2027

Department of Health and Human Services
National Institutes of Health

National Institutes of Health
Office of AIDS Research

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL INSTITUTES OF HEALTH

Office of AIDS Research (OAR)

FY 2027 Budget Table of Contents

General Notes

1. Estimates assume reauthorization of the SBIR/STTR program in FY 2026 and FY 2027.
2. Detail in this document may not sum to the subtotals and totals due to rounding.

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ICO OVERVIEW

Office of AIDS Research Overview

The Office of AIDS Research (OAR) supports fundamental, pre-clinical, clinical, and implementation research on human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) research across the National Institutes of Health (NIH). Building on this knowledge base, OAR funds research projects testing biomedical and psychosocial interventions to identify the most effective and cost-effective approaches to prevent, diagnose, and treat HIV. The mission of OAR is to ensure that HIV research funding is directed at the highest priority research areas and to facilitate maximal return on investment. To achieve this mission, OAR convenes, catalyzes, coordinates, and communicates HIV-related research across NIH, the Department of Health and Human Services (HHS), other government agencies, academia, and community organizations through collaborations and partnerships.

In the 1980s, an HIV infection was a fatal diagnosis. Sustained investment in HIV research enabled significant advances in antiretroviral therapies (ART), transforming the landscape of care and prevention approaches. With access to treatment and care, people with HIV have a normal life expectancy. Treatment for HIV is also a powerful prevention tool; an overwhelming body of clinical evidence has firmly established that people with HIV who achieve and maintain an undetectable viral load cannot sexually transmit HIV to others (Undetectable = Untransmittable). Recent breakthroughs include simpler-to-take treatments and long-acting prophylactics.

NIH will focus on supporting implementation science and other research directions to improve the uptake of and access to existing medical and behavioral interventions that can significantly limit and eventually end the HIV epidemic in the United States. Implementation science shows us how, where, and when to implement interventions and who should conduct implementation strategies to effectively reach people most in need and optimize adoption by broader systems. This research includes adapting effective interventions for people living in the United States most impacted by new infections and high viral load.

NIH will also support research on co-occurring conditions associated with HIV. People with HIV experience accelerated aging, altered metabolism, and chronic immune activation that converge and contribute to the development of several comorbidities. Comorbid conditions that disproportionately affect people with HIV include cardiovascular disease, chronic kidney disease, liver disease, frailty and reduced bone density, and cancers. Neuropsychiatric conditions, such as depression and neurocognitive disorders, also are significantly more prevalent among people with HIV than those without HIV.

HIV crosses nearly every area of medicine and scientific investigation. NIH will maintain a multidisciplinary portfolio to maximize the reach and uptake of existing evidence-based prevention and treatment, meet the needs of people aging with HIV, address comorbidities associated with HIV, develop novel formulations to support choice and widespread access in HIV prevention and treatment, and continue to pursue a cure for HIV.

BUDGET AUTHORITY BY INSTITUTE, CENTER, AND OFFICE

NATIONAL INSTITUTES OF HEALTH
Office of AIDS Research
Budget Authority by Institute, Center, and Office
(Dollars in Thousands)

Institute, Center, and Office	FY 2025 Final[1, 2]	FY 2026 Enacted [1, 2]	FY 2027 President's Budget	FY 2027 +/- FY 2026
NCI	$256,734	$251,599	$251,599	-
NHLBI	92,953	96,671	82,104	-14,567
NIDCR	20,174	20,174	18,157	-2,017
NIDDK	38,699	37,925	34,891	-3,034
NINDS	41,206	40,382	37,253	-3,129
NIAID	1,911,364	1,873,137	1,383,828	-489,309
NICHD	152,881	165,111	170,029	4,918
NIA	28,538	35,387	36,580	1,193
NIAMS	4,875	4,875	4,547	-328
NIDCD	2,262	2,262	2,104	-158
NIMH	199,584	217,547	213,123	-4,424
NISUAR	314,252	316,038	283,920	-32,118
NINR	17,375	18,244	15,872	-2,372
NIBIB	1,954	1,954	1,954	-
NIMHD	24,982	25,981	-	-25,981
NCCIH	796	796	-	-796
FIC	25,919	25,919	-	-25,919
NLM	7,685	7,685	7,685	-
OD	146,255	146,801	146,801	-
OAR	67,806	69,921	69,921	-
ORIP	78,449	76,880	76,880	-
Subtotal, OD	146,255	146,801	146,801	-
TOTAL, NIH	**$3,288,488**	**$3,288,488**	**$2,690,447**	**-$598,041**

[1] Reflects HIV/AIDS transfers under the authority of Section 213 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2025 and 2026.

[2]For comparability, FY 2025 and FY 2026 columns reflect Institute and Center restructuring proposed in the FY 2027 President's Budget, including relocation of the National Institute for Environmental Health Sciences (NIEHS) outside of NIH.

BUDGET MECHANISM TABLE

NATIONAL INSTITUTES OF HEALTH
Office of AIDS Research
Budget Mechanism - AIDS [1]
(Dollars in Thousands)

Mechanism	FY 2025 Final[3]		FY 2026 Enacted[3]		FY 2027 President's Budget		FY 2027 +/- FY 2026	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Research Projects:								
Noncompeting	1,383	$1,434,203	1,226	$1,241,938	1,000	$1,024,172	-226	-$217,766
Administrative Supplements	*359*	$97,066	*336*	$99,755	*192*	$51,868	-144	-$47,887
Competing	338	$356,129	484	$524,034	219	$388,894	-265	-$135,140
Subtotal, RPGs	1,721	$1,887,398	1,710	$1,865,727	1,219	$1,464,934	-491	-$400,793
SBIR/STTR	13	$10,448	13	$10,461	9	$6,802	-4	-$3,659
Research Project Grants	1,734	$1,897,846	1,723	$1,876,188	1,228	$1,471,736	-495	-$404,452
Research Centers:								
Specialized/Comprehensive	62	$123,927	55	$123,258	68	$106,294	13	-$16,964
Clinical Research	0	$0	0	$0	0	$0	0	$0
Biotechnology	0	$0	0	$0	0	$0	0	$0
Comparative Medicine	19	$67,742	19	$67,767	20	$72,634	1	$4,867
Research Centers in Minority Institutions	0	$1,442	0	$1,442	0	$0	0	-$1,442
Research Centers	81	$193,111	74	$192,467	88	$178,928	14	-$13,539
Other Research:								
Research Careers	239	$41,785	230	$42,022	201	$39,084	-29	-$2,938
Cancer Education	0	$0	0	$0	0	$0	0	$0
Cooperative Clinical Research	20	$13,733	21	$13,031	19	$9,339	-2	-$3,692
Biomedical Research Support	15	$3,969	0	$3,161	0	$3,161	0	$0
Minority Biomedical Research Support	0	$0	0	$0	0	$0	0	$0
Other	126	$61,582	123	$52,602	58	$35,373	-65	-$17,229
Other Research	400	$121,069	374	$110,816	278	$86,957	-96	-$23,859
Total Research Grants	2,215	$2,212,026	2,171	$2,179,471	1,594	$1,737,621	-577	-$441,850
Ruth L. Kirschstein Training Awards:	FTTPs		FTTPs		FTTPs		FTTPs	
Individual Awards	61	$2,985	108	$6,668	69	$4,084	-39	-$2,584
Institutional Awards	210	$13,556	235	$15,392	246	$14,631	11	-$761
Total Research Training	271	$16,541	343	$22,060	315	$18,715	-28	-$3,345
Research & Develop. Contracts	101	$468,620	95	$459,502	54	$357,497	-41	-$102,005
(SBIR/STTR) (non-add)	*9*	*$6,321*	*6*	*$3,757*	*0*	*$101*	-6	-$3,656
Intramural Research		$336,553		$372,381		$335,762		-$36,619
Res. Management and Support		$186,942		$185,153		$170,931		-$14,222
Res. Management & Support (SBIR Admin) (non-add)		$0		$0		$0		$0
Office of the Director - Appropriation [2]		*$146,255*		*$146,801*		*$146,801*		$0
Office of the Director - Other		$67,806		$69,921		$69,921		$0
ORIP (non-add) [2]		*$78,449*		$76,880		$76,880		-$1,569
Total, NIH Discretionary B.A.		**$3,288,488**		**$3,288,488**		**$2,690,447**		**-$598,041**

[1] All items in italics and brackets are non-add entries.

[2] Number of grants and dollars for the ORIP component of OD are distributed by mechanism and are noted here as a non-add. Office of the Director - Appropriation is the non-add total of these amounts and the funds accounted for under OD - Other.

[3] Column is comparably adjusted to remove the National Institute for Environmental Health Sciences (NIEHS), since NIEHS is proposed to be transferred elsewhere in HHS in the FY 2027 President's Budget.

BUDGET AUTHORITY BY RESEARCH CAPACITY GOALS

NATIONAL INSTITUTES OF HEALTH
Office of AIDS Research
Budget Authority by Research Capacity Goal
(Dollars in Thousands)

Research Capacity Goal	FY 2025 Final[1]	FY 2026 Enacted [1]	FY 2027 President's Budget	FY 2027 +/- FY 2026
Optimize the Impact of HIV-related Research through Implementation Science and Dissemination of Research Fundings	$258,000	**	$460,000	**
Enhance Discovery and Advance HIV-related Science through Fundamental Research	1,154,255	**	930,026	**
Develop and Assess Interventions or Prevention, Treatment, Cure, and Co-occurring Conditions	1,423,735	**	884,331	**
Build HIV Research Capacity by Strengthening the Scientific Workforce and Infrastructure	452,498	**	416,090	**
Total	**$3,288,488**	**$3,288,488**	**$2,690,447**	**-$598,041**

[1] For comparability, FY 2025 and FY 2026 columns reflect Institute and Center restructuring proposed in the FY 2027 President's Budget, including relocation of the National Institute for Environmental Health Sciences (NIEHS) outside of NIH.

**For FY2026 Enacted, funding levels are displayed for statutory and report-directed PPAs. Amounts with an asterisk represent non-statutory PPAs, as levels have not yet been determined.

JUSTIFICATION OF BUDGET REQUEST

Office of AIDS Research

Budget Authority (BA):

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
BA[117]	$3,288,488,000	$3,288,488,000	$2,690,447,000	-$598,041,000

Program funds are allocated as follows: Competitive Grants/Cooperative Agreements; Contracts; Direct Federal/Intramural and Other.

Overall Budget Policy: The FY 2027 President's Budget request for OAR is $2,690.4 million, a decrease of $598.0 million or 18.2 percent compared with the FY 2026 Enacted level. This level of funding will support the research and capacity goals of the NIH HIV research agenda as described below, namely to enhance discovery and advance HIV science through fundamental research; develop and assess novel interventions for HIV prevention, treatment, cure, and co-occurring conditions; optimize the impact of HIV-related research through implementation science and dissemination of research findings; and build HIV research capacity by strengthening the research workforce and infrastructure.

Program Descriptions and Accomplishments

Optimize the Impact of HIV-related Research through Implementation Science and Dissemination of Research Findings

To optimize the public health impact of HIV research, scientific findings must be implemented in real-world settings with people affected by HIV. Understanding the factors that influence HIV prevention and treatment uptake is crucial to implementing interventions effectively in different communities. NIH encourages research on information dissemination and health communication strategies to promote public understanding, acceptance, and uptake of effective HIV-related interventions. Highlights of this research include:

Encouraging multiple HIV prevention strategies: A recent NIH-funded study demonstrated that a combination of text messages, online peer support, and coaching calls promotes HIV prevention methods, like PrEP, among young people with certain risk factors.[118] These supportive strategies, especially when combined, could be used more widely to strengthen prevention behavior among adolescents and young adults.

[117] Amounts in FY 2025 and FY 2026 are comparably adjusted to remove the National Institute for Environmental Health Sciences (NIEHS).
[118] pubmed.ncbi.nlm.nih.gov/38395539/

Ending the HIV Epidemic in the U.S: NIH-funded research demonstrated significant success with the HHS Ending the HIV Epidemic in the U.S. initiative. Beginning in 2019, NIH has supported implementation science projects through multiple networks of HIV research centers that partnered with state and local leaders and grassroots community groups to translate implementation research findings into improved delivery of HIV testing, prevention, treatment, and response services (which provide testing, prevention, and treatment in response to HIV outbreaks) for Americans most affected by HIV. For example, more than half of new HIV diagnoses occur in the southern United States. A recent study found that opt-out (routine and automatic) HIV testing in clinics and emergency rooms can prevent about a quarter of new HIV acquisitions in the southern United States over eight years.[119] Routine HIV testing can increase knowledge of one's status and facilitate faster linkage to care and treatment, reducing the spread of the virus.

Enhance Discovery and Advance HIV-related Science through Fundamental Research

Fundamental research drives the discovery and development of novel prevention and treatment strategies by expanding our understanding of the biological, physiological, epidemiologic, interpersonal, and social-structural mechanisms of HIV—i.e., how it operates as a virus at the basic level and as an infectious disease. Research highlights in this area include:

Finding and destroying "hidden" HIV: One of the main challenges in curing HIV is that the virus can hide in certain immune cells in a "silent" state—known as HIV reservoirs—making it hard to detect and eliminate. Progress toward an HIV cure will require the development of innovative methods to detect, target, and destroy these reservoirs. Although antiretroviral therapy (ART) prevents HIV from replicating, the silent state form of the virus can evade the immune system and presents challenges for the development of a safe, effective, and scalable cure for HIV. Researchers have developed a new mRNA-lipid nanoparticle (LNP) technology that can safely and efficiently deliver genetic instructions to these hidden cells, helping to "wake up" the virus so it can be targeted and destroyed.[120] This approach could open the door to new treatments that help remove hidden HIV from the body and may also be useful for other T cell-based therapies.

Addressing heart problems in people with HIV: The persistence of HIV affects the whole body, not only increasing the likelihood of infection by other pathogens but also causing many comorbidities and complications such as accelerated aging. People with HIV are more likely to develop heart problems, possibly because their immune systems age faster and cause changes in the heart. Researchers studied blood samples and heart scans to find protein patterns linked to these heart changes in people with HIV.[121] Many of the same protein changes are also found in older adults without HIV who later develop heart failure, suggesting shared causes of heart failure between HIV and aging.

[119] pubmed.ncbi.nlm.nih.gov/40372031/
[120] nature.com/articles/s41467-025-60001-2
[121] nature.com/articles/s41467-025-55911-0

Develop and Assess Interventions for Prevention, Treatment, Cure, and Co-occurring Conditions

Following basic discovery, the most promising strategies for prevention, treatment, and management of HIV and its complications move into clinical trials. Rigorous randomized control trials test biological outcomes (e.g., viral load) and/or behavioral outcomes (e.g., adherence) of novel interventions. Other studies may measure an intervention's acceptability and feasibility, including assessment of potential facilitators and barriers to its implementation and sustainability. Highlights of research include:

Improving adherence to HIV prevention and treatment: Long-acting forms of preexposure prophylaxis (PrEP) and ART are becoming available, providing more convenient formulations of HIV prevention and treatment for some populations. One study found that long-acting injectable cabotegravir is safe and well-tolerated for HIV prevention in adolescent girls.[122] Most participants completed all scheduled injections, and 62 percent said they would consider using it in the future. The few side effects observed were generally mild and not related to the drug, suggesting it is a promising prevention option for this age group.

Developing new immunotherapies: Another study showed that budigalimab, a monoclonal antibody, successfully targeted a protein molecule that prevents immune cells from functioning properly.[123] The study found that the regular, short-term low-dose injections of this treatment allowed immune cells to better recognize and attack cells infected with HIV. As an alternative to daily antiretroviral medication, this promising immunotherapy could control HIV by enhancing a person's own immune system response.

Enabling self-detection of viral load: Technologies currently under development could allow people to determine their HIV status in the privacy of their homes and enable people with HIV to monitor their viral loads over time, letting them take action if their viral load is no longer undetectable. These tools can support engagement in and adherence to HIV prevention and care, reduce stigma associated with testing outside the home, and empower individuals to take control of their health. Feedback from members of the HIV community and clinicians has expressed a preference for availability of point-of-care viral load monitoring technologies to assess responses to antiretroviral therapy and to prevent HIV transmission to others. To further encourage this progress, the Advanced Platforms for HIV Viral Load Testing at the Point-of-Care program[124] is a partnership of the National Institute of Biomedical Imaging and Bioengineering (NIBIB), OAR, the National Institute of Mental Health (NIMH), National Institute of Child Health and Human Development (NICHD), National Institute of Nursing Research (NINR), and the National Institute of Allergy and Infectious Diseases (NIAID) that aims to advance HIV viral load monitoring platforms for use at the point of care. Launched in spring 2024, the Advanced Platforms program harnesses the existing infrastructure of the NIH Rapid Acceleration of Diagnostics Technology, or RADx, program.[125] The RADx model combines best practices of

[122] thelancet.com/journals/lanhiv/article/PIIS2352-3018(24)00310-2/fulltext
[123] nature.com/articles/s41591-025-03993-0
[124] cimit.org/-/advanced-platforms-for-hiv-viral-load-monitoring
[125] nibib.nih.gov/programs/radx-tech-program

government, academia, and industry and leverages existing networks and expertise of the Point-of-Care Technology Network (POCTRN).[126]

Build HIV Research Capacity by Strengthening the Scientific Workforce and Infrastructure

Bringing research from the laboratory to the clinic and community requires continued support for a strong and innovative research workforce, reliable research infrastructure, and investment in development of new research tools and resources. NIH supports the development, recruitment, training, and retention of a multidisciplinary HIV research workforce.

OAR has collaborated with NIH Institutes, Centers, and Offices to provide resources and support for early-stage investigators and grantees within two years of their first award. OAR conducts annual workshops that foster mentorship, networking opportunities, and provide new information about HIV research funding opportunities and the NIH grant application process. The latest workshop in September of 2025 attracted more than 500 participants.

NIH will continue to spur progress in HIV science through support for research facilities, tools and instrumentation, resources, and data infrastructure, as well as making these resources available to the greater HIV research workforce. Sharing HIV-related data enables the widespread reuse of data, accelerating the pace of HIV research, enabling reproducibility and validation of research findings, and providing access to researchers, clinicians, health-related professionals, etc. to existing data sets. Modern data management and infrastructure, such as cloud-based storage, can improve long standing data sharing initiatives. Central to sharing scientific data is the recognized need to make data both secure and available, ensuring that the privacy and autonomy of research participants are protected, in alignment with NIH's data management and sharing policy.

[126] nibib.nih.gov/programs/point-care-technologies-research-network

RESOURCE SUMMARY

Drug Control Program
Department of Health and Human Services
National Institutes of Health (NIH)[1]

	Budget Authority (in millions)		
	FY 2025 Final	FY 2026 Enacted	FY 2027 Requested[2]
Drug Resources by Function			
Research and Development: Prevention	$636.112	$636.112	$562.208
Research and Development: Overdose Reduction	$113.837	$113.837	$100.122
Research and Development: Treatment	$948.395	$948.395	$834.518
Research and Development: Recovery	$32.208	$32.208	$28.327
Total, Drug Resources by Function	**$1,730.551**	**$1,730.551**	**$1,525.175**
Drug Resources by Decision Unit			
National Institute on Alcohol Abuse and Alcoholism (NIAAA)			
Research and Development: Prevention	$58.854	$58.854	--
Research and Development: Treatment	$8.332	$8.332	--
Total, National Institute on Alcohol Abuse and Alcoholism (NIAAA)	**$67.186**	**$67.186**	**--**
National Institute on Drug Abuse (NIDA)			
Research and Development: Prevention	$577.258	$577.258	--
Research and Development: Overdose Reduction	$113.837	$113.837	--
Research and Development: Treatment	$940.063	$940.063	--
Research and Development: Recovery	$32.208	$32.208	--
Total, National Institute on Drug Abuse (NIDA)	**$1,663.365**	**$1,663.365**	**--**
National Institute of Substance Use and Addiction Research (NISUAR)	**--**	**--**	**$1,525.175**
Total, Drug Resources by Decision Unit	**$1,730.551**	**$1,730.551**	**$1,525.175**
Drug Resources Personnel Summary			
Total FTEs (direct only)	434	316	*
Drug Resources as a Percent of Budget			
Total Agency Discretionary Budget (in Billions)[3]	$44.470	$44.870	$41.164
Drug Resources Percentage	3.89%	3.86%	3.71%

[1] Numbers may not total due to rounding.
[2] The FY 2027 drug control methodology is adjusted to align with the proposed reorganization of NIAAA and NIDA into NISUAR: the FY 2027 drug control budget excludes research management and support costs, including only direct research costs in NISUAR.
[3] The FY 2027 Budget proposes to relocate NIEHS and NIEHS Superfund outside the NIH. The funding levels are displayed comparably and as a result exclude funding for NIEHS.
* Drug control FTEs for NISUAR are to be determined.

PROGRAM SUMMARY

MISSION

Within the National Institutes of Health (NIH), the National Institute of Substance Use and Addiction Research (NISUAR) will support research in pursuit of the objectives of the National Drug Control Strategy.

The FY 2027 President's Budget proposes NISUAR as a newly streamlined Institute consisting of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA). The mission of these Institutes will be integrated into NISUAR. As relates to the National Drug Control Strategy, NISUAR's mission will be to generate and disseminate fundamental knowledge about the adverse effects of alcohol and other substances on health and well-being, and apply that knowledge to improve diagnosis, prevention, and treatment of substance use-related problems, across the lifespan. Through continued investments across a broad range of scientific approaches, goals, and objectives, NISUAR research will hold enormous promise to reduce the burden of addiction and mental illness and improve quality of life for all Americans.

Substance use disorders (SUDs) are a significant public health crisis. Over 48 million people in the United States had a SUD in 2024, and hundreds of thousands of people die each year from overdose and other drug- and alcohol-related causes. Until recently, drug overdose deaths in the United States had climbed for decades, driven in part by the rise of the potent synthetic opioid fentanyl and its analogues around 2013. In 2022, the crisis reached a peak with nearly 108,000 deaths, declining to about 79,000 in 2024.[127]

To continue turning the tide of the opioid crisis, NIH will continue funding a balanced research portfolio focused on SUD treatment, prevention, recovery, and overdose reduction. Such research has led to medications for treating opioid use disorder (OUD), as well as naloxone and other effective medications to reverse opioid overdoses. NIH-funded research also has addressed access barriers to these medications by developing strategies to extend them beyond addiction treatment settings to primary care, community centers, prisons and jails, and places of worship. However, challenges remain. For example, potent synthetic opioids remain pervasive in the illicit drug supply, and new addictive substances continue to emerge. Combined use of opioids with stimulants and other drugs plays an increasing role in both SUD and overdose, and there are no effective medications to address this polysubstance use. Moreover, SUD and overdose treatments remain difficult to access for some demographic groups, such as rural Americans. Finally, it remains unclear why some people are more vulnerable to transitioning from drug use to addiction and heightened overdose risk.

[127] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2024 on CDC WONDER Online Database, released in 2026. Data are from the Multiple Cause of Death Files, 2018-2024, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10-expanded.html on Apr 7, 2026.

Although the rate of underage drinking in the United States has declined over the past several decades, alcohol remains the most widely used substance among youth.[128] A major priority within NISUAR's mission will be research on the prevention and treatment of underage drinking and its harmful consequences. Binge drinking[129] and high intensity drinking[130] among young people remain significant concerns. These drinking patterns are particularly troubling as they increase risks for poor academic performance, alcohol-related blackouts, injuries, overdoses, sexual assault, unsafe sexual behavior, alcohol use disorder (AUD), and other detrimental consequences.

NISUAR will lead research advances to improve primary prevention of harmful substance use, extend the reach of evidence-based therapies for SUD, and develop new, more effective therapies. The Institute will also prioritize research in overdose prevention approaches such as community naloxone distribution and drug checking tools; and in recovery services such as residential and school-based programs.

METHODOLOGY

The FY 2027 drug control methodology is adjusted to align with the proposed reorganization of NIAAA and NIDA into NISUAR. The FY 2027 drug control budget excludes research management and support costs, including only direct research costs in NISUAR. All NISUAR research on drugs with addictive potential, other than alcohol, will be part of the National Drug Control Budget. Within alcohol research, the prevention and treatment components of NISUAR's underage drinking research program will be classified as a part of the National Drug Control Budget. Underage drinking research is defined as research that focuses on alcohol use by youth (individuals under the legal drinking age of 21), as well as the negative consequences of underage alcohol use (e.g., alcohol-related injuries, impact on adolescent development including on the developing brain, and risk for AUD). The proposed NISUAR National Drug Control Budget will include basic biological and behavioral research, epidemiological research, screening studies, the development and testing of preventive and treatment interventions, and efforts to disseminate evidence-based information.

[128] samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduh-annual-national/2024-nsduh-annual-national-html-071425-edited/2024-nsduh-annual-national.htm#taba.8b

[129] NIH defines binge drinking as a pattern of drinking that increases an individual's blood alcohol concentration to 0.08 percent or higher. This typically occurs after 4 drinks for women and 5 drinks for men – in about 2 hours. Research suggests that fewer drinks in the same timeframe result in the same blood alcohol concentration in youth.

[130] NIH defines high intensity drinking as two or more times the gender-specific binge drinking thresholds.

BUDGET SUMMARY

The FY 2027 budget request for drug control-related activities at NIH is $1,525.2 million.

As a component of the nation's drug control strategy, the proposed National Institute of Substance Use and Addiction Research (NISUAR) will continue to invest in substance use prevention, substance use disorder (SUD) treatment, overdose reduction, and recovery services related to substance use in alignment with the priorities of the Office of National Drug Control Policy (ONDCP).

Substance Use Prevention

NIH supports a broad portfolio of research to prevent substance use and addiction, including underage alcohol use. This includes epidemiologic research to understand patterns of drug and alcohol use, such as the Monitoring the Future (MTF) Survey and the Population Assessment of Tobacco and Health (PATH) Study. The MTF Survey collects data on substance use and related attitudes among U.S. 8th, 10th, and 12th graders each year. MTF data show that in 2024, overall substance use among adolescents hovered at record lows, with a record high proportion abstaining specifically from alcohol, tobacco, and other nicotine products.[131] The PATH Study is a collaboration between the Food and Drug Administration (FDA) and NIH that focuses on tobacco use and health. The study recently found that people who quit smoking had 30-40 percent better odds of recovering from other SUDs, suggesting the need to integrate smoking cessation interventions into addiction care.[132]

Adolescence is a period of heightened vulnerability to alcohol's effects and NIH supports several large multi-site interactive research collaborations that inform innovative prevention and treatment strategies for underage drinking. Established in 2012, the National Consortium on Alcohol and Neurodevelopment in Adolescence (NCANDA) is a multi-site longitudinal study to identify brain characteristics in humans that may predict alcohol misuse or occur because of adolescent alcohol exposure. NCANDA investigators are now following the initial adolescent cohort into young adulthood and examining the sex-specific relationships among brain maturation, alcohol misuse, mental health, and sleep. NCANDA recently reported altered connectivity among brain regions involved in executive function, which may help explain how early alcohol exposure disrupts decision making and increases risk-taking behavior.[133]

Complementary to NCANDA's studies, the Neurobiology of Adolescent Drinking in Adulthood (NADIA) consortium uses animal models to uncover the mechanisms by which adolescent drinking leads to changes in brain structure and function that persist into adulthood. One example of complementary human and animal studies comes from NIH-supported researchers who are identifying neurobiological mechanisms linking sleep disruption to adolescent alcohol misuse, which demonstrate that alcohol-related alterations in brain-body systems regulating sleep may contribute to risk for and persistence of problematic drinking in youth. An independent ongoing study in mice is providing knowledge about the interactions between the circadian sleep

[131] monitoringthefuture.org/data/bx-by/drug-prevalence
[132] pubmed.ncbi.nlm.nih.gov/40802176
[133] pubmed.ncbi.nlm.nih.gov/38137124

system and the stress axis in adolescent alcohol abuse, the long-term effects of these interactions, and the potential for melatonin to both reduce alcohol intake in adolescents and to reduce the risk of developing alcohol use disorders later in adulthood.[134]

Even with current advances, much remains to be learned about how a vast constellation of early-life experiences, combined with a person's genetic makeup, affects vulnerability to SUD and other psychiatric disorders. Building off NCANDA, the Adolescent Brain Cognitive Development (ABCD) Study is a large longitudinal study collecting brain imaging, environmental, and other data from more than 11,000 children aged 9-10 and following them through adulthood to help fill this knowledge gap. ABCD data have revealed specific brain connectivity patterns in early adolescence that predict substance use initiation and correlate with pollution exposure;[135] found that higher screen time is linked to poor sleep, obesity, hypertension, and increased mental health disorders;[136] and identified sociodemographic factors that influence adolescence diets.[137] More recently, with funding from other NIH Institutes and the NIH Helping to End Addiction Long-term (HEAL) Initiative®, the longitudinal HEALthy Brain and Child Development (HBCD) Study was launched to complement the ABCD study by following brain development in thousands of children from birth through their first decade of life.

NIH supports studies to understand and address the interactions between individuals and environments that contribute to drug use, addiction, and related health problems. NIH's portfolio in this area includes studies to develop, evaluate, and implement evidence-based prevention programs for youth. These programs include individual-, family-, school-, community-, and environmental-level interventions. For college settings, NIH provides the College Alcohol Intervention Matrix (CollegeAIM), an online resource that rates over 60 evidence-based alcohol interventions in terms of effectiveness, cost, and other factors, allowing school officials to select among the many potential interventions to address harmful and underage student drinking.

NIH also administers the HEAL Preventing Opioid Use Disorder (OUD) program,[138] which aims to identify risk factors for OUD among youth and test multi-level prevention interventions. Interventions under study include outreach and counseling for at-risk youth at community drop-in centers, school anti-drug programs that emphasize improving student engagement over disciplinary actions, and programs tailored to at-risk American Indian/Alaska Native (AI/AN) youth. One recent study found that AI/AN students who participated in a combined school and family drug use prevention program experienced large reductions in alcohol use, binge drinking, cannabis use, and prescription opioid misuse.[139] Despite the inherent strengths of Tribal communities and traditions, AI/AN communities face the highest overdose death rates. Launched in 2024, the Native Collective Research Effort to Enhance Wellness (N CREW) program supports Tribal community-led research on overdose, substance use, pain, and mental health.

[134] pubmed.ncbi.nlm.nih.gov/38137124
[135] pubmed.ncbi.nlm.nih.gov/39490580
[136] pubmed.ncbi.nlm.nih.gov/40172268
[137] pubmed.ncbi.nlm.nih.gov/39870773
[138] heal.nih.gov/research/new-strategies/preventing-opioid-use-disorder
[139] pubmed.ncbi.nlm.nih.gov/40768695

Increasing implementation of alcohol screening and brief intervention in primary care and developing evidence-based behavioral interventions to reduce underage drinking is another priority prevention area for NIH. For example, NIH's Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide was developed to assist pediatric and adolescent health practitioners in identifying patients at risk for underage drinking and associated problems. This screening resource has been validated among youth in pediatric emergency room settings, school settings, and primary care settings, as well as among youth with chronic health conditions.

Treatment

In 2024, among people who needed substance use treatment, only about one in five received it.[140] Moreover, while medications are available for alcohol, tobacco, and opioid use disorders, there are no FDA-approved treatments for other SUDs. Thus, NIH supports research to expand the reach of existing treatments, and to develop and evaluate novel medications, behavioral interventions, and medical devices to prevent and treat SUD and overdose. Since 2018, such research has led to more than 80 Investigational New Drug and 4 Investigational Device Exemption applications submitted to the FDA. Other products have received FDA fast-track designation, including a methamphetamine "sequestrant" designed to trap the drug and prevent it from entering the brain.

One exciting research area focuses on GLP-1 receptor agonists. These medications suppress food cravings and are used to treat diabetes and excess weight, and there is emerging evidence that they might suppress drug cravings. In NIH-funded studies, people taking the GLP-1 medication semaglutide for diabetes had lower incidence and recurrence of alcohol and cannabis use disorders, and lower OUD-related overdose risk.[141] Ongoing trials are testing whether GLP-1 medications can reduce drug and alcohol use among people struggling with SUD.

Another promising area focuses on non-invasive neuromodulation therapies for SUD. NIH-funded research helped inform a vagal nerve stimulation device that is used to treat opioid withdrawal during recovery from OUD. New research shows that among people receiving medications for OUD (MOUD), this device can adjust brain activity associated with impulsive behaviors, suggesting potential use as an adjunct treatment.[142]

NIH supports research on behavioral interventions for SUD. An ongoing study is testing the efficacy of two intervention approaches for non-college emerging adults who report heavy drinking.[143] One approach is a combined multi-session brief alcohol intervention with a Substance Free Activity Session (SFAS). The SFAS attempts to increase engagement in goal-directed activities that might provide alternatives to alcohol use and provides tools to reduce stress and develop mood-enhancing behavioral substitutes to drinking (or substance use). The researchers are also testing a second intervention, Relaxation Training, in combination with

[140] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2024. www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases/2024
[141] pubmed.ncbi.nlm.nih.gov/38486046; pubmed.ncbi.nlm.nih.gov/39320894
[142] pubmed.ncbi.nlm.nih.gov/40548916
[143] reporter.nih.gov/project-details/10157726

SFAS to determine if this intervention approach better addresses risk factors for alcohol misuse by enhancing wellness, managing stress, and increasing positive activities.

NIH also supports a Clinical Trials Network (CTN) that conducts research to evaluate new SUD treatments, as well as implementation studies to expand the reach of existing treatments, including MOUD. CTN-supported studies show that starting the MOUD buprenorphine (BUP) in emergency departments is safe and effective, even for patients using fentanyl. This work has established in-hospital emergency care as a critical touchpoint for OUD treatment. Other studies are evaluating BUP induction during prehospital emergency care, integration of pharmacists into BUP treatment plans, and the potential for physician's offices to provide methadone treatment for OUD (currently available only through federally regulated clinics.)

CTN has also prioritized research to determine how to optimally integrate SUD care in primary care settings. One study found that an electronic health record-integrated clinical decision support system improved OUD diagnosis, naloxone orders, and treatment rates in primary care.[144] Another found that adding a nurse care manager to primary care increased medication treatment rates, with improvements continuing into the third year of follow-up.[145]

HEAL-funded projects are working toward non-addictive treatments for chronic pain, including non-opioid medications and behavioral interventions. For example, a first-in-human study is examining the safety and pharmacology of Kindolor—a novel drug that may interrupt the nerve signals underlying pain.[146] The Integrative Management of chronic Pain and OUD for Whole Recovery (IMPOWR) program is testing interventions for patients with co-existing chronic pain and OUD, such as physical therapy, pain coping skills, and novel MOUD dosing regimens.

Recovery

Given that addiction is a chronic relapsing disorder, NIH is prioritizing research to identify best practices in recovery and relapse prevention. There are a variety of recovery service models—including peer-based mutual aid groups, recovery housing, and youth programs—but there is little evidence regarding which kinds of program work best for different people. Moreover, many such programs focus on short-term medical treatments and lack support for participants to receive long-term MOUD.[147] In 2020, NIH established the Recovery Research Networks program to develop tools, resources, and training to grow this area of research. With additional support from the HEAL Initiative®, this program has expanded and is testing new and existing recovery models through clinical trials.

The Recovery Research Networks are working to better integrate MOUD treatment into recovery settings. In the United States, recovery support has traditionally been the domain of treatment providers and peer support groups, with the latter sometimes viewing MOUD as inconsistent with recovery. Recovery community centers (RCCs) are a newer recovery model, offering peer support and other services, such as basic needs assistance. A recent Networks survey found that

[144] pubmed.ncbi.nlm.nih.gov/40658392
[145] pubmed.ncbi.nlm.nih.gov/39576637
[146] pubmed.ncbi.nlm.nih.gov/33117893
[147] pubmed.ncbi.nlm.nih.gov/34700201

most RCCs also link their clients to MOUD providers, thus combining the benefits of peer support with improved access to MOUD treatment.[148] Another study examined recovery outcomes among 600 people who received MOUD combined with smartphone-based contingency management, an approach in which small tangible incentives are provided for achieving recovery goals. Use of the smartphone app—which provided digital vouchers that could be redeemed for groceries, clothes, and other items—was associated with better MOUD treatment retention and more opioid-free days at the end of treatment.[149]

Sleep is also linked to drug use and to recovery, with research indicating that SUDs increase the risk of sleep disorders, which can in turn increase the risk of substance withdrawal, craving, and relapse. NIH-funded studies show that periods of withdrawal are associated with impaired sleep as well as increased levels of orexins, which are brain proteins that promote wakefulness.[150] Meanwhile, clinical trials are testing whether suvorexant, an orexin blocker used for insomnia, can improve sleep and withdrawal among people recovering from OUD.

Overdose Reduction

Amid the U.S. opioid overdose crisis, developing and implementing interventions to prevent drug overdose and other drug-related harms remains a national priority. With HEAL Initiative funding in FY 2022, NIH launched a research network that focuses on testing new overdose reduction strategies, evaluating new ways to deliver existing strategies, and reaching rural and underserved populations. Strategies under study include delivering these services via mobile vans and digital lock boxes, and use of digital health to provide overdose prevention resources.

Synthetic opioids and particularly illicitly manufactured fentanyl are the primary driver of overdose fatalities, making it critical to develop interventions to prevent and reverse opioid overdose. NIH is supporting research on several promising overdose reversal agents, including an anti-fentanyl antibody. In preclinical studies, the antibody reversed drug-induced respiratory depression within minutes and protected against later drug exposures over the next month.[151] Researchers have completed a phase 1 clinical study on the compound and are analyzing the data.

NIH also supports research to develop more robust overdose prevention and treatment tools, such as testing strips and other drug checking tools that people can use to test drugs for adulterants before taking them. Through NIH's Small Business Innovation Research (SBIR) programs, researchers have developed FDA-cleared test strips that can detect fentanyl in amounts 100 times lower than the limit of previously available test strips.[152] Researchers are also developing tests for more rapid, user-friendly, affordable deployment in emergency settings to help responders manage overdose more effectively.[153]

[148] pubmed.ncbi.nlm.nih.gov/38426533
[149] pubmed.ncbi.nlm.nih.gov/39621343
[150] pubmed.ncbi.nlm.nih.gov/36328706
[151] pubmed.ncbi.nlm.nih.gov/38052779
[152] pubmed.ncbi.nlm.nih.gov/38757262; pubmed.ncbi.nlm.nih.gov/38238757
[153] pubmed.ncbi.nlm.nih.gov/38757262; pubmed.ncbi.nlm.nih.gov/38584344

NIH also supports research to improve nationwide monitoring of substance use trends. For example, the National Drug Early Warning System (NDEWS) explores methods to enhance real-time data on emerging drug threats, such as by monitoring drug mentions in 911 calls and social media. NDEWS and other programs have found that counterfeit pills containing fentanyl have spread throughout illicit drug markets[154] and that the potent veterinary sedatives xylazine and medetomidine continue to spread as adulterants in illicit fentanyl.[155] Both substances can produce extreme sedation, and xylazine injection can cause painful skin wounds.

Through NDEWS and other programs, NIH continues efforts to develop, scale up, and improve wastewater-based epidemiology (WBE) to monitor emerging drug threats. NIH has funded WBE research for nearly 20 years, helping to establish that WBE can yield actionable data on drug threats in near real-time, overcoming the significant lag of clinical and survey data. In 2020, NIH awarded SBIR funds to a startup company, Biobot Analytics, to develop increasingly rapid, sensitive, and adaptable WBE technology and analytic approaches. Based on this work, in 2026, ONDCP contracted with Biobot to launch a nationwide wastewater intelligence program that will track more than 20 chemical targets.

[154] pubmed.ncbi.nlm.nih.gov/38744553; pubmed.ncbi.nlm.nih.gov/39079225
[155] pubmed.ncbi.nlm.nih.gov/38180756; pubmed.ncbi.nlm.nih.gov/39230918