Director's Letter

On behalf of the National Institutes of Health (NIH), I am transmitting NIH's Congressional Justification for the fiscal year (FY) 2026 budget. This request for $27.9 billion, including discretionary and mandatory resources, will support the NIH mission to turn biomedical research discoveries into better health for all.

As I begin my tenure as the 18th NIH Director, I am honored to lead this agency in service of the American people. I want to first express my appreciation for NIH staff and NIH-funded scientists across the country whose work has contributed to lifesaving breakthroughs in biology and medicine. I look forward to playing an instrumental role in shaping the agency's activities and outlook and ensuring they align with the goals of the President's Make America Healthy Again Commission.

NIH's mission to advance science to improve health remains vital as millions of children and adults in this country face poor outcomes due to chronic conditions like obesity, heart disease, and cancer. We must Make America Healthy Again by building on the agency's track record of tackling complex challenges and recommit to our mission to address the chronic disease crisis. While basic research will continue to lay the groundwork for future discoveries, we will invest in innovative, cutting-edge research that has the power to transform health. Most importantly, we will invest our resources where they are needed most, maximizing the impact of NIH research. Additionally, we need to restore our reputation among the American people – our discoveries will only make an impact if the public has confidence in our findings and trusts that we are working in their best interests.

NIH Priorities

To help achieve these goals, I have established the following five top priorities:

1. **Focus on Improving Population Health**: The work of NIH, whether basic or applied, must address the health needs of the American people, including the chronic disease crisis that has hampered the well-being of countless Americans.

2. **Reproducibility and Rigor:** The research NIH conducts and supports must be rigorous, reproducible, and unbiased. NIH must address and solve the reproducibility crisis in the biomedical sciences.

3. **Innovation and Collaboration**: NIH must be at the forefront of biomedical innovation. This will involve embracing new technologies, new ideas, and new approaches to old and emerging problems.

4. **Research Safety and Transparency**: NIH must ensure that all the experiments we support pose no risk of harm to human health and meet the highest ethical standards. We must maintain the highest standards of transparency in all our endeavors.

5. **Academic Freedom**: Advances in science require the freedom to think differently from the scientific consensus. I will foster an environment where varied perspectives are valued and encouraged at NIH and the broader scientific community.

Innovative Research

NIH will continue its vital research in support of these priorities. Chronic disease is a major contributor to disability, morbidity, and mortality for millions of Americans. NIH funds many programs across multiple Institutes to address this issue. The Nutrition for Precision Health (NPH) study, powered by the *All of Us* Research Program, is examining how genes, lifestyle, health history, the gut microbiome, and other factors influence how a person's body responds to different foods, thus potentially leading to new discoveries about the role of nutrition in preventing many chronic conditions and diseases. The National Collaborative on Childhood Obesity Research (NCCOR) is a public-private partnership to improve the efficiency, effectiveness, and application of childhood obesity research, and to halt—and reverse—childhood obesity through enhanced coordination and collaboration.

Combatting neurodegenerative diseases is among the greatest public health challenges of the 21st century. These conditions, including Alzheimer's disease (AD) and AD-related dementias (ADRD), amyotrophic lateral sclerosis (ALS), and Parkinson's disease (PD), have devastating consequences for people and their families, and the associated economic costs are staggering. An estimated 6.9 million Americans currently live with AD, and it is predicted that more than 13 million will be living with the disease by 2060. PD affects another 1 million Americans. NIH leads federal research efforts on dementia, the sixth leading cause of death for adults 65 and older and a major contributor to loss of independence, as well as emotional and financial burdens borne by affected families. NIH-funded research on disease mechanisms has identified biomarkers to aid early detection and treatment along with a growing number of potential targets for new therapies to prevent or modify the progressive course of these conditions.

Rural communities in the United States are often significantly impacted by chronic diseases and other health conditions. This is due to many factors, including poverty and limited access to care that are often found in these communities. Due in part to these same factors, people from rural communities often do not have the same ability to participate in clinical research studies, which hampers the ability to effectively apply medical research findings to them. Increasing rural representation in clinical trials and other studies creates opportunities for research findings that address the unique challenges of delivering care to people living in rural areas as well as the burden of diseases and conditions faced by these communities. The new NIH CARE for Health™ initiative aims to address these issues by building a network of research networks to expand research opportunities to the frontlines of clinical care in primary care settings, with its pilot focused on testing feasibility in rural areas.

NIH also continues its ongoing programs to address rural health. The Institutional Development Award (IDeA) program funds capacity-building programs that broaden the participation of institutions in 23 states and Puerto Rico that have historically received lower levels of NIH support. The IDeA Clinical and Translational Research (CTR) program funds statewide networks to build capacity for clinical and translational research in IDeA states, many of which have

substantial rural populations. Also central to our efforts is bringing care to Americans where they live – across America's heartland and beyond. The Risk Underlying Rural Areas Longitudinal (RURAL) cohort study is addressing the high burden of chronic diseases in rural areas through its state-of-the-art mobile exam unit, bringing high-tech health care, health technologies, and health research directly to communities and neighborhoods.

To solve these health issues and many more, NIH uses every avenue of research available, including supporting High Risk High Reward (HRHR) research. The NIH's Common Fund, which supports bold scientific programs that catalyze discovery across all biomedical and behavioral research, funds the HRHR program to support creative scientists proposing innovative and transformative research in any scientific area within the NIH's mission. These awards are intended to address questions that are inherently difficult and scientifically risky, but necessary to accelerate the pace of scientific discovery and advance human health. The HRHR program has resulted in many exciting breakthroughs, including a potential molecular treatment that could reverse changes associated with aging at the cellular level, safer ways to treat gut inflammation using therapeutic bacteria, and a potential new type 2 diabetes treatment that targets brain circuits that control glucose metabolism.

New Initiatives

I would like to highlight two new NIH initiatives within the Office of the Director that will be essential to restoring trust in NIH and advancing the health of all Americans. First, NIH will continue its work to better understand the cause of autism spectrum disorders (ASD) and associated conditions, and to translate that causal research into better treatment strategies that improve quality of life and address ASD community priorities. The goal of this Understanding ASD Initiative is to integrate diverse data to examine complex factors influencing the rapid rise in ASD. Earlier this year, the Centers for Disease Control and Prevention (CDC) released data estimating that 1 in 31 children were affected by ASD in 2022, a sharp increase from previous years. ASD has many potential causes, and understanding its etiology is crucial to treating and preventing the range of conditions this disorder presents. Working with patient organizations and the autism community, NIH is committed to finding causes, risk factors, and treatments through investments in research programs and coordination of interagency activity. NIH will fund researchers across the United States to use methods ranging from basic science to epidemiological approaches to help millions of families manage the difficulties that arise with having a child with ASD.

Second, NIH is making a strategic shift toward ensuring human-based research technologies are incorporated throughout NIH-funded science. This new initiative aims to expand the development and use of cutting-edge, non-animal models—such as organoids, tissue chips, computational models, and real-world data—to address long-standing translational challenges in biomedical research.

NIH will establish the Office of Research Innovation, Validation, and Application (ORIVA). ORIVA will coordinate NIH-wide efforts to develop, validate, and expand the use of non-animal research methods, while serving as a central hub for interagency collaboration and regulatory alignment to support public health. This initiative reflects NIH's commitment to advancing

innovative, translationally effective research while aligning with broader federal efforts to reduce reliance on animal models where an alternative approach may provide more value.

The U.S. biomedical enterprise is primed to Make America Healthy Again, and NIH Institutes are dedicated to working together to address the range of diseases and scientific problems we face. Each Institute provides a specific research focus, recruiting experts from across the United States. However, we also tackle the toughest problems together as one agency, with cross-cutting platform initiatives that engage multidisciplinary teams to address issues like chronic conditions, data science, drug development, neurodegenerative diseases, and mental health. NIH is ready to continue to support vital research to enhance the health of the American people and rebuild the trust in the agency for many years to come.

Jay Bhattacharya, M.D., Ph.D.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

OVERALL APPROPRIATIONS

SUPPLEMENTARY TABLES

LEGISLATIVE PROPOSALS

COMMON FUND

OFFICE OF AIDS RESEARCH

General Notes

1. FY 2025 Enacted levels cited in this document reflect the FY 2025 full-year continuing resolution (Public Law 119-4) and include the effects of the FY 2025 HIV/AIDS transfer.
2. FY 2026 FTE levels reflect estimates and are subject to change.
3. Detail in this document may not sum to the subtotals and totals due to rounding.

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 to apply that knowledge to optimize health and prevent or reduce illness for all people. 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.

NIH fuels the biomedical research enterprise—cultivating world-class scientists and catalyzing new scientific fields, tools, and resources that have changed science. 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, NIH-supported research leads to improvements in health that can bolster the economy, improve productivity, and reduce the costly burden of illness in the United States and worldwide. 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 health for all.

OVERVIEW OF BUDGET REQUEST

Summary

For Fiscal Year (FY) 2026, the National Institutes of Health (NIH) requests a total program level of $27.9 billion, a $18.1 billion reduction from the $46.0 billion program level in the FY 2025 full-year continuing resolution (CR).[1] This request seeks to maximize the impact of NIH research by streamlining processes and more efficiently providing funding to NIH-supported institutions. NIH's budget level will continue to support critical research conducted in service of the agency's mission and administration priorities as well as support new and ambitious priority investments necessary for Making America Healthy Again.

NIH strategically leverages its budget by supporting researchers in every state to ensure that all communities benefit from research. Through these investments, NIH pursues innovative research proposals and cutting-edge scientific techniques to address our most difficult healthcare challenges. Current priority issues such as finding treatments and interventions for devastating diseases such as cancer, diabetes, and HIV/AIDS; reducing maternal mortality rates; supporting the scientific workforce; fully understanding the causes of autism spectrum disorders (ASD); and combatting the ongoing opioid crisis remain critical areas of concern. Moving forward, NIH will also prioritize improving population health, solving the reproducibility crisis, embracing innovation and collaboration, maintaining research safety and transparency, and ensuring academic freedom.

NIH-funded researchers and staff are expected to uphold the highest ethical standards to support the best science. NIH promotes the principles of scientific integrity and rigor within the biomedical research community and ensures that results of research are effectively reported and disseminated. NIH is also pursuing the best methods for incorporating the voices of people and communities most directly impacted by healthcare challenges into the research lifecycle, which will in turn lead to improved healthcare outcomes. Finally, NIH announced a new initiative in FY 2025 to expand innovative, human-based science using new and emerging technologies to help biomedical researchers answer previously difficult or unanswerable questions.[2] Developing and using cutting-edge alternative non-animal research models aligns with the U.S. Food and Drug Administration's (FDA) recent initiative to replace animal models that have low translational confidence.

With these goals in mind, NIH will continue to build on its foundational legacy of groundbreaking biomedical research to address current and future healthcare challenges and support the highest quality basic, translational, and clinical research to improve health for all.

NIH – A History of Scientific Discovery and Biomedical Research Advancement

NIH has always maximized investments to support basic, translational, and clinical research to develop health research advances that benefit all people. The discoveries made possible by NIH-

[1] The FY 2026 President's Budget proposes to relocate the National Institute for Environmental Health Sciences (NIEHS) outside of NIH, in the Administration for a Healthy America. The FY 2025 funding level is adjusted to remove NIEHS funding for comparability.

[2] nih.gov/news-events/news-releases/nih-prioritize-human-based-research-technologies

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. To get the most out of this investment, NIH promotes science that emphasizes rigor and reproducibility through every stage of the scientific process, from conception of ideas to the conduct of the research to the dissemination of results and beyond. NIH research is conducted with the utmost integrity. When presenting the findings from NIH-funded research, NIH promotes a culture of transparency to ensure that the results of research advances reach the people that will benefit the most – the public. This includes 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, and promotes transparency.

The culmination of this foundation is research that has a tremendous impact on lives. However, the treatments and interventions that have been developed as the result of NIH clinical research could not have been achieved without years 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. Since its inception in 1953, the NIH Clinical Center has been involved in 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 developed in part by NIH research have saved, and continue to save, lives every day.

No greater testament of NIH's past and continued success in scientific endeavors can be found than the fact that NIH has supported 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.[3]

While NIH has a strong history of conducting and supporting groundbreaking research and medical advances, it must reestablish trust 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.

Maximizing The Impact of NIH Research

American taxpayers invest precious resources into NIH and expect a positive return on that investment. To maximize that return, NIH must deeply reflect on its structure, policies, and research. This budget request proposes significant changes to the organization to streamline activities and produce the most robust scientific findings possible.

First, the Budget proposes to eliminate the National Institute of Nursing Research (NINR), the National Center for Complementary and Integrative Health (NCCIH), the Fogarty International Center (FIC), and the National Institute on Minority Health and Health Disparities (NIMHD). Further, to minimize redundancies and maximize collaboration, the Budget proposes to reorganize the remaining Institutes and Centers with direct appropriations into an eight-Institute

[3] nobelprize.org/prizes/chemistry/2024/press-release/

structure, while maintaining the Office of the Director and the Buildings and Facilities accounts. Table 1 illustrates the new plan.

Table 1 – Proposed Institute Structure

New Institute Structure	Current Institutes and Centers
National Cancer Institute (NCI)	NCI
National Institute of Allergy and Infectious Diseases (NIAID)	NIAID
National Institute on Aging (NIA)	NIA
National Institute on Body Systems (NIBS)	National Heart, Lung, and Blood Institute (NHLBI), National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS), National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)
National Institute on Neuroscience and Brain Research (NINBR)	National Institute of Dental and Craniofacial Research (NIDCR), National Institute of Neurological Disorders and Stroke (NINDS), National Eye Institute (NEI)
National Institute of General Medical Sciences (NIGMS)	NIGMS, National Human Genome Research Institute (NHGRI), National Library of Medicine (NLM), National Institute of Biomedical Imaging and Bioengineering (NIBIB), National Center for Advancing Translational Sciences (NCATS)
National Institute for Child and Women's Health, Sensory Disorders, and Communication (NICWHSDC)	*Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD), National Institute on Deafness and Other Communication Disorders (NIDCD)
National Institute of Behavioral Health (NIBH)	National Institute on Alcohol Abuse and Alcoholism (NIAAA), National Institute on Drug Abuse (NIDA), National Institute of Mental Health (NIMH)

In addition to the proposed reorganization within NIH, one institute will be relocated within the Department of Health and Human Services. The National Institute of Environmental Health Sciences (NIEHS) will reside within the Administration for a Healthy America.

Another way in which the Budget will maximize the impact of NIH research investments is to increase the share of each dollar awarded for research grants that goes directly toward research. In addition to direct costs for particular research or projects, NIH awards funds for Facilities and Administration (F&A) costs of grantee institutions, also known as “indirect costs.” The amount awarded to each institution varies based on negotiated rates, and 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, this budget proposes to continue the policy of capping 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.

In FY 2026, the Budget will continue the FY 2025 policy of reserving half of the NIH budget allocation for competing research project grants (RPGs) for awards that fully fund their outyear commitments as part of the initial grant obligation, to facilitate efficient management of resources across multiple years. Traditionally, most NIH research grants have been awarded for more than one year and funded incrementally; each year's commitment is obligated from that year's appropriation. Under this 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. Providing the grantee with funding for every year of the RPG from the start 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.

The Budget also proposes to increase the efficiency of NIH intramural research by capping the base pay of staff paid under Title 42 at the maximum rate payable for senior-level positions under 5 USC 5376 ($225,700 in 2025). The current salary range for these employees goes up to $350,000, due to their leadership roles and the much higher compensation earned by their counterparts at academic institutions and hospitals.

Major Health Impacts Now – NIH Funds Biomedical Research That Saves Lives

While it is important to acknowledge the decades of previous biomedical advancements made possible by NIH investments, many public health challenges remain that affect health across populations and the lifespan. NIH supports biomedical and behavioral research to meet the full spectrum of public health needs and continues to invest in research that benefits all people across their lifespans.

Investments for Public Health across Populations

Tackling the Chronic Disease Crisis

Despite significant investment in U.S. health care, our country's health is declining. America has the highest rates of chronic disease compared to other wealthy countries.[4] The United States ranks last in terms of health among developed nations, and life expectancy is declining for many groups of Americans. By establishing the new National Institute on Body Systems (NIBS), which combines the National Heart, Lung, and Blood Institute (NHLBI); the National Institute on Diabetes and Digestive and Kidney Diseases (NIDDK); and the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS), NIH is poised to address the needs of Americans with chronic diseases in a coordinated and streamlined manner.

A poor diet is the leading cause of U.S. mortality and is directly related to malnutrition and chronic diseases including obesity, type 2 diabetes, cardiovascular disease, and many cancers. Approximately one million people die annually in this country from diet-related chronic diseases, and this number continues to rise. Diet-related chronic diseases also disproportionally affect underserved communities and exacerbate health conditions.[5,6] Moreover, nutrition has not

[4] commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019
[5] frontiersin.org/journals/public-health/articles/10.3389/fpubh.2024.1339859/full
[6] pubmed.ncbi.nlm.nih.gov/28267855/

been prioritized in either medical education or routine primary care medicine.[7,8] The Food is Medicine Centers of Excellence Program[9] 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 current barriers that exist both in communities and within health care systems that severely limit the ability to reduce obesity and other diet-related diseases (e.g., type 2 diabetes, cardiovascular disease, and cancer). Significantly, this innovative Program will also support implementation science and intervention and health quality research on culturally sensitive Food is Medicine initiatives and other strategies to improve public health and address barriers to care. Additionally, the Nutrition for Precision Health (NPH)[10] initiative powered by the *All of Us* Research Program seeks to develop algorithms that predict individual responses to food and dietary patterns. The NPH program will build on recent advances in biomedical science including AI, microbiome research, as well as the infrastructure and large participant group of the *All of Us* Research Program.[11] These advances provide unprecedented opportunities to generate new data to provide insight into personalized nutrition, also referred to as precision nutrition.

Under the new NIH-FDA Nutrition Regulatory Science Program (NRSP), announced in May 2025, the agencies will implement and accelerate a comprehensive nutrition research agenda that will provide critical information to inform effective food and nutrition policy actions to help make Americans' food and diets healthier.[12] The initiative, led and coordinated by the NIH Office of Nutrition Research (ONR), an office within the Office of the Director (OD), will aim to answer questions such as: how and why can ultra-processed foods harm people's health; how might certain food additives affect metabolic health and possibly contribute to chronic disease; and what is the role of maternal and infant dietary exposures on health outcomes across the lifespan, including autoimmune diseases? Answering these questions and many others will enable effective policy development and help inform Americans about the foods they are eating and how those foods can impact their health. The FDA will provide its critical expertise in regulatory science and NIH will provide the infrastructure for the solicitation, review, conduct, and management of scientific research. This initiative will bring together experts in many disciplines—including chronic disease, nutrition, toxicology, risk analysis, behavioral science, and chemistry—all with the goal to advance the gold standard of nutrition and food science. NIH and FDA will work together to develop a research agenda for the NRSP and are committed to ensuring all research conducted under the Program is fair, independent, and free of conflicts of interest. The new Program will also enable effective policy development and ensure that Americans understand the health impacts of the foods they eat.

[7] pubmed.ncbi.nlm.nih.gov/8424377/
[8] pubmed.ncbi.nlm.nih.gov/38705195/
[9] dpcpsi.nih.gov/sites/default/files/Day-1-155PM-ONR-Concept-Food-is-Medicine-Lynch-background-508.pdf
[10] commonfund.nih.gov/nutritionforprecisionhealth
[11] allofus.nih.gov/
[12] nih.gov/news-events/news-releases/fda-nih-announce-innovative-joint-nutrition-regulatory-science-program

Understanding the Cause of Autism

The incidence of ASD in the United States has increased from 1 in 36 in 2020 children to 1 in 31 children in 2022.[13] Identifying the root causes of the childhood chronic disease crisis, including ASD, is a priority for HHS and NIH.

Currently, NIH supports research to better understand the full range of symptoms that people with ASD may experience. This includes research to identify biological and behavioral characteristics to understand symptoms, how symptoms and needs may change over time, and the best treatments, services, and support.

NIH also supports research to find better ways to meet the individual needs of people with ASD. This includes research to improve early screening so that children with ASD can be connected with appropriate services and support as early as possible. This also includes research on supporting people with ASD as they age, from childhood to adolescence and throughout adulthood.

The Autism Centers of Excellence Program[14] is an NIH-wide initiative that supports large-scale multidisciplinary studies on ASD, with the goal of determining the disorder's causes and potential treatments. The program, established in 2007, includes research centers that foster collaboration between teams of specialists who share the same facility to address a particular research problem in depth, and research networks that consist of researchers at many facilities throughout the country, all of whom work together on a single research question.

NIH and the Centers for Medicare and Medicaid Services announced an initiative in 2025 to integrate diverse data that will enable researchers to examine complex factors influencing ASD rates.[15]

Research to Understand and Improve the Health of Older Adults

Thanks to advances in health and technology, the United States and global populations are living longer. NIH has long supported a portfolio focused on the health of aging populations and on conditions that primarily or disproportionately affect older adults. Since its establishment over 50 years ago, the National Institute on Aging (NIA) has been at the forefront of the nation's research activities dedicated to understanding the nature of aging; supporting the health and wellbeing of older adults; and extending the healthy, active years of life. NIA is the designated NIH Institute for research into the health of older adults and collaborates across the agency to ensure that this important work is integrated across disciplines and scientific fields. For example, NIA collaborates with other NIH partners to fund research and develop research priorities specific to Alzheimer's disease and Alzheimer's disease related dementias (AD/ADRD), which include Lewy body dementias, frontotemporal dementias, and vascular contributions to cognitive impairment and dementia. This coordination includes implementation of the National Alzheimer's Project Act's national plan to accelerate research on AD/ADRD, and to provide

[13] cdc.gov/mmwr/volumes/74/ss/ss7402a1.htm?s_cid=ss7402a1_w
[14] nichd.nih.gov/research/supported/ace
[15] nih.gov/news-events/news-releases/nih-cms-partner-advance-understanding-autism-through-secure-access-select-medicare-medicaid-data

better clinical care and services for people living with dementia and their families.

With increased investment in AD/ADRD, NIH has led incredible progress over the last decade. Through innovative collaborations across NIH and with other federal agencies and industry and the broader community – including 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 combination therapy development; discovered tools to detect, diagnose, and monitor dementia; identified lifestyle and behavioral interventions to reduce risk; deepened understanding of how social and physical environmental factors affect dementia risk and disparities; and expanded research on dementia care and care partner support.[16]

Based on these important advancements, NIH is now enabling precision medicine advances by funding a range of clinical trials in AD/ADRD. NIH researchers are testing a variety of novel and diverse therapeutic targets, such as those implicated in inflammation, synaptic plasticity, resilience, and neuroprotective mechanisms. In addition to drug trials, NIH-funded investigators are studying promising behavioral and lifestyle interventions to reduce dementia risk and improve cognition and memory. For example, recent NIH-funded clinical trials identified interventions such as controlling blood pressure, correcting hearing loss, and personalizing health coaching that can reduce cognitive decline and dementia risk. These examples add to the growing body of evidence for modifiable behaviors that can reduce dementia risk, highlighting that this area is a vibrant field for ongoing and future research.

NIH is also deeply committed to funding basic research to better understand how we can live longer and healthier lives. In recent years, researchers have turned to the growing field of geroscience, which seeks to translate knowledge gained from biology of aging research into methods and interventions to prevent, minimize, or reverse detrimental age-related changes and functional decline in older individuals. By studying what happens during the aging process at the cellular and molecular level, NIH investigators hope to identify interventions to extend the portion of life spent in good health, also known as "healthspan" in older adults. A particularly promising avenue of research involves studying cellular senescence, a cellular state during which damaged cells resist cell death, linger, and harm neighboring normal cells. To identify and characterize how different types of senescent cells affect multiple tissues to impact human health, disease, and lifespan, the NIH Common Fund launched the Cellular Senescence Network (SenNet). A deeper understanding of cellular senescence will help researchers to develop new therapies that encourage beneficial effects of senescent cells while suppressing their tissue-damaging effects. Additionally, NIH-funded researchers have found that treatment with drugs that remove senescent cells, called 'senolytics,' delayed the onset of several age-related ailments in mice compared to untreated peers. Senolytics are currently being tested in clinical trials of various conditions to determine their potential to ultimately help treat age-related conditions. More research must be conducted to test the translation of these and other geroscience findings more broadly into the clinic.

Collectively, NIH is committed to advancing discovery on age-related diseases and conditions and general aging processes to help ensure that Americans are living longer and healthier lives.

[16] nia.nih.gov/about/professional-judgment-budget-proposal

Landmark Progress in Type 1 Diabetes

The Special Statutory Funding Program for Type 1 Diabetes Research, or Special Diabetes Program, is a special funding program supporting research on the prevention, treatment, and cure of type 1 diabetes and its complications. The Special Diabetes Program has led to landmark progress that is improving the health and quality of life of people with and at risk for type 1 diabetes. For example, Special Diabetes Program-supported research has culminated in recent FDA approvals of the first drug (teplizumab) that can delay onset of type 1 diabetes diagnosis in people at high risk for developing the disease; the first cellular therapy (islet transplantation) to treat adults with type 1 diabetes who have recurrent episodes of dangerously low blood glucose levels; and hybrid artificial pancreas devices that have greatly eased the burden of type 1 diabetes management.[17] Ongoing research is addressing urgent areas, such as investigating the neurocognitive impact of type 1 diabetes in children; identifying mechanisms that promote the development of heart disease in people with type 1 diabetes; identifying factors that restore awareness of hypoglycemia in adults with type 1 diabetes and impaired awareness of hypoglycemia; and developing next-generation hybrid artificial pancreas systems. This research is critical for improving health outcomes in people with type 1 diabetes. The budget request includes $159.0 million to extend the Special Diabetes Program through FY 2026.

Pioneering Personalized Medicine through the Undiagnosed Disease Network

Approximately 30 million Americans are living with a rare disorder. The Undiagnosed Disease Network (UDN), which builds on the success of the Undiagnosed Diseases Program at the NIH Clinical Center, is a nationwide network of clinicians and researchers who use both basic and clinical research to uncover the underlying disease mechanisms associated with rare and undiagnosed conditions. The UDN pioneered a new personalized medicine model for helping patients who have historically been the most difficult for the medical community to diagnose, taking advantage of cutting-edge technologies such as genomic sequencing, metabolomics, and assessing patient variants in model organisms to give clinicians and researchers new, powerful information to help understand and treat rare diseases. Since its launch in 2013, the UDN has made over 800 diagnoses, including 77 newly described conditions, and has identified more than 100 disease-linked genes and genomic variants. The network includes 22 new and continuing Diagnostic Centers of Excellence that are poised to expand geographic coverage and access for groups that experience health disparities. Moving forward, the UDN is exploring the use of AI to further enhance diagnostic capabilities, as well as additional, non-genomic diagnostic strategies that consider environmental, metabolic, immunologic, or other contributors to disease.

21st Century Cures Act

FY 2026 marks the final authorizing year for 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*, Brain Research through Advancing Innovative Neurotechnologies (BRAIN®) Initiative, Cancer Moonshot℠,[18] and the Regenerative Medicine

[17] niddk.nih.gov/about-niddk/budget-legislative-information/how-special-diabetes-program-creating-hope-living-with-type-1-diabetes

[18] cancer.gov/research/key-initiatives/moonshot-cancer-initiative

Innovation Project. Authorized funding for *All of Us* and BRAIN in FY 2026 totals $226.0 million. There is no authorized funding for Cancer Moonshot in FY 2026, as Cures Act authorized funding for Cancer Moonshot ended in FY 2023. The Budget will provide these two programs with a solid base of funding to continue program activities following the complete expiration of Cures Act funding after FY 2026.

Preparing for and Preventing Emerging and Continued Public Health Threats

Advancing Universal Vaccines

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 Centers for Disease Control and Prevention (CDC) estimates that the disease burden of influenza has resulted in between 9.3 million and 41 million illnesses, between 120,000 and 710,000 hospitalizations, and between 6,300 and 52,000 deaths annually between 2010 and 2024,[19] all of which results in an estimated $87.1 billion in total annual economic burden.[20] 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. Several universal influenza vaccine candidates developed by the National Institute of Allergy and Infectious Diseases (NIAID) are currently being tested in clinical trials, including those using protein nanoparticle and inactivated virus platform technologies. Some of the candidate vaccines are capable of inducing antibody responses against several influenza strains. Additionally, NIH-supported researchers are actively identifying and developing novel adjuvants for influenza vaccines to increase their effectiveness and durability. Continued investment in this research will enable the development of universal influenza vaccines to protect millions of people from infection.

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.[21] This initiative represents a decisive shift toward transparency, effectiveness, and comprehensive preparedness, funding the development of universal influenza and coronavirus vaccines, including candidates BPL-1357 and BPL-24910. These vaccines aim to provide broad-spectrum protection against multiple strains of pandemic-prone viruses such as H5N1 avian influenza and coronaviruses including SARS-CoV-2, SARS-CoV-1, and MERS-CoV.

Generation Gold Standard:

- Recalibrates America's pandemic preparedness. Unlike traditional vaccines that target specific strains, BPL-inactivated whole-virus vaccines preserve the virus's structural

[19] cdc.gov/flu-burden/php/about/index.html
[20] pubmed.ncbi.nlm.nih.gov/17544181/
[21] nih.gov/news-events/news-releases/hhs-nih-launch-next-generation-universal-vaccine-platform-pandemic-prone-viruses

integrity while eliminating infectivity. This approach induces robust B and T cell immune responses and offers long-lasting protection across diverse viral families. Moreover, the intranasal formulation (i.e., taken through the nose) of BPL-1357 is currently in Phase Ib and II/III trials and is designed to block virus transmission—an innovation absent from current flu and COVID-19 vaccines.

- Embodies efficient, transparent, and government-led research.
- Marks the future of vaccine development. In addition to influenza and coronavirus, the BPL platform is adaptable for future use against respiratory syncytial virus (RSV), metapneumovirus, and parainfluenza. It also offers the unprecedented capability to protect against avian influenza without causing mutations in the virus that allow it to evade immune response—a major step forward in proactive pandemic prevention.

The Future is Bright: NIH's Innovative Approaches for Scientific Discovery

NIH uses scientific advances and innovative, cutting-edge research methodologies today to create the basic and clinical research discoveries of tomorrow. NIH also fosters and develops the next generation of biomedical researchers, whose innovative ideas will be the backbone of future of biomedical research.

NIH Clinical Research Engagement Efforts

Individuals, communities, and members of the public are essential and equal partners in the success of clinical research. During a series of in-person conversations held in six communities across the country by NIH in support of efforts of the Novel and Exceptional Technology and Research Advisory Committee (NExTRAC),[22] members of the public emphasized the importance of engagement early and often during the clinical research process to build trust and transparency between NIH-funded researchers and the broader public. More information is needed on how to incorporate meaningful public engagement across the full clinical research lifecycle. To address this issue, NIH asked the NExTRAC to form the Engaging the Public as Partners in Clinical Research (ENGAGE) Working Group, a group of patients, advocates, researchers, clinicians, and non-profit representatives tasked with developing a vision and framework for incorporating public voices in all phases and types of clinical research.

In its first year, the ENGAGE Working Group has drafted a definition of clinical research engagement, developed a vision and goal, and is creating a framework for incorporating public voices in clinical research. Its progress was presented during a public meeting of the NExTRAC in June 2024.[23] NIH has launched a website[24] focused on clinical research engagement that includes case studies[25] describing successful tools and methods for engaging the public in NIH-funded clinical research. In July 2024, NIH, in support of the ENGAGE Working Group, hosted a virtual listening session[26] to understand public perspectives on clinical research engagement and has since hosted six in-person conversations[27] around the country to speak directly to

[22] osp.od.nih.gov/wp-content/uploads/2023/02/Tab3_NIH_UCSD_Workshop_Community_Conversation_Summary_230227_508.pdf
[23] partnersinresearch.nih.gov/events/novel-and-exceptional-technology-and-research-advisory-committee-meeting/
[24] partnersinresearch.nih.gov/
[25] partnersinresearch.nih.gov/case-studies/
[26] partnersinresearch.nih.gov/events/nih-engage-virtual-webinar-and-listening-session/
[27] partnersinresearch.nih.gov/community-conversations/

communities on their needs, perspectives, and goals for clinical research engagement. The information gathered during these conversations will inform NExTRAC's report on how to meaningfully engage the public during all phases of clinical research.

Cutting-Edge Technologies to Progress Biomedical Research Forward

Increasing use of new and improved biomedical technologies, such as gene editing, AI, and induced pluripotent stem cells, is fundamentally changing the way science is done. Harnessing the power of emerging technologies to advance novel scientific approaches holds tremendous promise for helping us better understand fundamental biology to advance human health.

Integrating Artificial Intelligence Across the Biomedical Research Enterprise

AI has spurred tremendous advances in medical research to enhance human health and longevity. For example, using AI, researchers can enable real-time mental health interventions through digital health devices, better forecast which seasonal flu viruses may circulate to manage public health, and integrate across large volumes of multi-modal data to guide personalized medicine. NIH advances the safe and responsible use of AI in biomedical research by 1) supporting development of algorithms and models for research; 2) contributing to AI-ready data and infrastructure, including computing and datasets that accelerate discovery; and 3) encouraging multi-disciplinary partnerships that drive transparency, privacy, and equitable health. At the same time, without proper safeguards, AI models and algorithms may exacerbate ongoing challenges associated with large datasets such as protecting privacy. Fortunately, NIH has a robust suite of relevant research policies to protect research participants and the privacy of their data while prioritizing public health and safety. Finally, NIH is actively piloting mechanisms to ease administrative processes through AI and train members of the workforce on when and how to employ AI responsibly. Detailed illustrations of NIH AI efforts include:

Scoping the use of AI across biomedical research through focused research funding

For example, the Bridge to AI (B2AI) program sets the stage for widespread adoption of AI in medicine by defining best practices for AI analyses, establishing training curricula, and generating new, ethically sourced "flagship" data sets for broad community use. This program and work by other NIH-funded investigators have already contributed to studies demonstrating that AI can speed identification of genetic variations underlying Alzheimer's and rare diseases, "read" X-rays to provide earlier detection and more accurate prognosis for certain cancers, and assess heart disease and risk of stroke through non-invasive imaging of the eye.

Resources to cultivate a culture of safe and responsible use of AI in biomedical research

To guide investigators and mitigate risks, NIH has a robust system of policies relevant for research with AI.[28] For example, the "Common Rule" ensures institutional oversight for research with human participants through Institutional Review Boards,[29] the NIH Certificates of Confidentiality policy protects research data from unauthorized disclosure,[30] and the NIH Policy on Data Management and Sharing ensures NIH review of investigators' plans for responsible data sharing and management.[31] NIH also supports investigator costs for data sharing,

[28] osp.od.nih.gov/policies/artificial-intelligence/
[29] grants.nih.gov/grants/guide/notice-files/NOT-OD-19-050.html
[30] grants.nih.gov/policy-and-compliance/policy-topics/human-subjects/coc
[31] sharing.nih.gov/data-management-and-sharing-policy

management and storage to maximize reuse of data, and provides processes and infrastructure for controlled access to sensitive data. Importantly, recognizing that AI may raise new challenges, NIH's Advancing Health Research through Ethical, Multimodal AI Initiative aims to improve our understanding of the complexities of human disease by finding ethically appropriate ways to leverage powerful multimodal AI approaches.[32] Administered from the NIH Office of Data Science Strategy (ODSS), the program will establish a portfolio of innovative projects that address systems level biomedical challenges using collaborative and participatory approaches for multimodal AI that will elucidate unique opportunities, risks, and challenges.

Commitment to integration of AI appropriate for a more effective workforce

NIH has supported development and application of AI in research for decades. Internally, NIH employees are testing AI analysis of research portfolios to identify emerging research priorities and ease the administrative burden associated with grant applications and referrals. Additionally, the NIH Science and Technology Research Infrastructure for Discovery, Experimentation, and Sustainability (STRIDES) Initiative aims to provide researchers with equal access to powerful cloud computing systems. Through the STRIDES Cloud Lab, NIH and NIH-funded institutions use cloud-based computational architecture as a testbed to learn how to share and analyze data, including through AI applications. Finally, NIH has several incipient efforts to integrate AI into day-to-day work, including a generative AI community of practice where hundreds of staff share AI tools, training, and lessons learned and generative AI chatbots in beta testing within a secure environment. NIH expects these activities to yield productivity-enhancing tools that are used responsibly and expand on NIH's existing use of AI in grants management processes.

Charting the Course for the Development and Use of New Approach Methods

From its founding to the present day, NIH has funded research into the development and application of new approach methods/methodologies (NAMs) as valuable tools in supporting its mission. These experiments *in chemico* (cell-free models), *in vitro* (cultured cells), and *in silico* (computational modeling and simulation) can complement and refine the use of animals in research. NIH investment in NAMs has increased dramatically over the past 15 years alongside the agency's ever-expanding technological capabilities. By continuing to increase its portfolio investment in NAMs, NIH aims to provide researchers with complementary tools to existing animal models that hold great promise in establishing more accurate and reliable research into human health and disease in distinct settings. In January 2023, the Acting NIH Director charged an Advisory Committee to the Director's Working Group on *Catalyzing the Use and Development of Novel Alternative Methods* to consider how NAMs are being used and to make recommendations on where NAMs may be most applicable or beneficial, especially to advance our understanding of human health.[33] This Working Group included members with expertise in a wide range of technologies, scientific fields, and backgrounds including members from academia, industry, and federal partners with *ex officio* members. The final report, published in December 2023, identified bold, ambitious, and equitable high priority areas for future investment and highlighted opportunities to integrate the work of different disciplines, sectors, technologies, and data.[34,35] Consistent with the report, NIH announced a new NIH-wide

[32] datascience.nih.gov/artificial-intelligence/MultimodalAI
[33] acd.od.nih.gov/working-groups/novel-alternatives.html
[34] acd.od.nih.gov/documents/presentations/12142023_NAMs_Working_Group_Report.pdf
[35] acd.od.nih.gov/documents/presentations/12142023_NAMs_Working_Group_Report.pdf

Common Fund program called Complement Animal Research in Experimentation (Complement-ARIE), to catalyze the development, standardization, validation, and use of human-based NAMs.[36] Complement-ARIE has already awarded $1 million in a crowdsourcing prize competition and plans to publish funding opportunities to create Technology Development Centers, a NAMs Data Hub and Coordinating Center, and a Validation and Qualification Network.[37] The program is expected to launch in full in winter of 2025.

In April 2025, NIH announced a new initiative to expand innovative, human-based science while reducing animal use in research.[38] Developing and using cutting-edge alternative non-animal research models aligns with the FDA's recent initiative[39] to reduce testing in animals. While traditional animal models continue to be vital to advancing scientific knowledge, using new and emerging technologies can offer unique strengths that, when utilized correctly or in combination, can expand the toolbox for researchers to answer previously difficult or unanswerable biomedical research questions.

To integrate innovative human-based science, NIH intends to establish the Office of Research Innovation, Validation, and Application (ORIVA) within NIH's Office of the Director. The new office will coordinate NIH-wide efforts to develop, validate, and scale the use of non-animal approaches across the agency's biomedical research portfolio and serve as a hub for interagency coordination and regulatory translation for public health protection.

ORIVA will expand funding and training in non-animal approaches and awareness of their value in translational success. New funding opportunities will include evaluation criteria that assess methods based on their suitability for the research question, context of use, translatability, and human relevance. Infrastructure for non-animal approaches will also be expanded to make these methods more accessible to researchers.

Investing In Tomorrow's Discoveries by Supporting Robust Research Resources, Policies, and Infrastructure

As NIH continues to address the ongoing challenges that threaten the health of the Nation while anticipating the potential threats of the future, it is imperative to continue supporting the infrastructure that underpins NIH's biomedical enterprise. This includes both the physical and digital infrastructure, as well as NIH-promoting policies.

Bolstering Infrastructure Needed to Tackle New Challenges

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 state-of-the-art imaging, discover tumors at the earliest stage possible, develop safe and effective novel

[36] commonfund.nih.gov/complementarie/strategicplanning
[37] commonfund.nih.gov/complementarie/
[38] nih.gov/news-events/news-releases/nih-prioritize-human-based-research-technologies
[39] fda.gov/news-events/press-announcements/fda-announces-plan-phase-out-animal-testing-requirement-monoclonal-antibodies-and-other-drugs

treatments such as cellular therapy, and more. Support for NIH's physical and digital infrastructure ensures that it can continue to produce the best biomedical products.

Buildings and Facilities for a Changing Biomedical Research Landscape

Facilities must co-evolve with science for NIH to achieve its full potential. In the FY 2026 President's Budget, the NIH request for Buildings and Facilities (B&F) is $210.0 million, a $140.0 million decrease from the FY 2025 Full-Year CR. These amounts 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 $4.1 billion at the end of FY 2024. The B&F request would enable NIH to improve the condition of its facilities and continue to 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.

Modernizing Data Ecosystems

The lifeblood of a research-driven agency is its data, and for NIH, this includes data generated in fundamental research (basic science), clinical research settings, and collected in health care systems or individual communities. NIH seeks to reach the full potential of data from biomedical, behavioral, and social sciences research and clinical care to develop new treatments, prevention approaches, and health-care delivery methods that improve the lives of all people. NIH will continue to work with funding awardees and across other HHS agencies to develop a modern infrastructure that optimally supports data sharing and use.

Impactful Policy to Shape Biomedical Research

Ensuring the highest level of scientific integrity, public accountability, and social responsibility in the conduct of science is paramount to cultivating trust. NIH has for many years been a leader in promoting practices, policies, and procedures that help ensure that the research it funds and conducts is done in accordance with the highest possible standards.

Establishing an NIH Academic Freedom Policy

NIH seeks to foster a culture in which scientists are incentivized to engage in open academic discourse in pursuit of NIH's mission to seek fundamental knowledge and improve the health of all Americans. 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.

NIH will undertake a comprehensive review of all policies and practices within its Intramural Research Program (IRP) to establish academic freedom as the rule and not the exception.[40] With principles of academic freedom in place, NIH scientists can be certain they are afforded the ability to engage in open academic discourse as part of their official duties and in their personal capacities without risk of official interference, professional disadvantage or workplace retaliation.

[40] nih.gov/about-nih/who-we-are/nih-director/statements/nih-reviews-policies-promote-academic-freedom

NIH policies have always supported the public dissemination of research. However, academic freedom matters most in the edge cases where scientists are pursuing evidence that others find inconvenient or objectionable. By prioritizing academic freedom across the agency, NIH can work to restore public trust in NIH's ability to carry out its mission.

Maximizing Access to Publications and Data that Result from NIH-Supported Research

Building public trust in science is an important aspect of public health. The responsible stewardship and sharing of scientific research data with the public is an important part of building trust, as is ensuring the results of NIH-funded research are publicly available in a timely manner. NIH has a long-standing commitment to supporting data access and to ensuring public access to publications resulting from NIH funding.

In January 2023, after several years of communications with the research community, NIH implemented the Data Management and Sharing Policy (issued in October 2020) to promote the sharing of scientific data.[41] Under this policy, NIH expects investigators and institutions to: 1) plan and budget for the managing and sharing of data; 2) submit a data management and sharing plan for review when applying for funding; and 3) comply with the approved data management and sharing plan. This policy expects researchers to maximize appropriate sharing of scientific data underlying peer-reviewed journal articles while protecting privacy, the rights of research participants, and compliance with laws, regulations, and policies. Planning for how scientific data will be managed and ultimately shared is a crucial step in enhancing the impact of NIH-supported research and will aid in accelerating biomedical research discovery by enabling validation of research results, providing access to high-value datasets, and promoting data reuse for future research studies.

NIH's longstanding commitment to making publications resulting from NIH funding available is reflected in its 2008 Public Access Policy, which requires the submission of such publications to NIH's PubMed Central with a maximum embargo period of 12 months before they must be publicly available. In June 2024 NIH released its Draft Public Access Policy, which outlines the proposal to require that NIH-funded publications be freely available and publicly accessible upon publication without embargo, for public comment.[42] To accelerate access to research results, NIH recently moved up the implementation date of the Public Access Policy from December 31, 2025; it will now be effective July 1, 2025.[43] The revised Public Access Policy will replace the 2008 Policy. To develop the Draft Public Access Policy, NIH sought the input of partners and the public. NIH considered ideas gathered through a public listening session, an NIH-sponsored workshop held by the National Academies of Science, Engineering and Medicine, and comments submitted in response to the request for information (RFI) on the NIH Plan to Enhance Public Access to the Results of NIH-Supported Research.[44] Implementing timely access to publications resulting from NIH funding offers many benefits to the scientific community and the public who funded the underlying work. The ability for patients, families, and members of the public to rapidly access published findings resulting from NIH funding enables them to better understand

[41] grants.nih.gov/grants/guide/notice-files/NOT-OD-21-013.html
[42] federalregister.gov/documents/2024/06/18/2024-13373/request-for-information-on-the-national-institutes-of-health-draft-public-access-policy
[43] sharing.nih.gov/public-access-policy/public-access-policy-overview
[44] grants.nih.gov/grants/guide/notice-files/NOT-OD-23-091.html

and address the most critical public health concerns facing their communities. It also allows researchers, students, and health care providers in all communities to have access to such content. This access can accelerate future research, lead to collaboration, and allow interested readers and patients to keep up more closely with critical advances.

Additionally, as indicated in NIH's Plan to Enhance Public Access to the Results of NIH-Supported Research, NIH is working to ensure the appropriate uses of metadata and persistent identifiers related to authors, scholarly publications, and scientific data. Specifically, NIH is considering how NIH-supported authors, manuscripts, and data will be identified with metadata that are conveyed in public access repositories to ensure proper attribution and versioning. An updated plan to achieve these goals was published in December 2024,[45] with a final policy to be implemented by 2027. These efforts strive to promote the highest level of scientific integrity and public accountability while also promoting recognition of researchers' contributions.

NIH's Commitment to Promoting Safe and Secure Research

Research focused on understanding how pathogens evolve and spread is critical for protecting public health and safeguarding national security. To ensure this research is conducted safely and securely, the United States must implement a comprehensive biosafety, biocontainment, and biosecurity oversight system. This system must be built on a robust foundation of regulations, guidelines, and policies that create an interlocking set of responsibilities shared across federal and local governments, research funders, research institutions, and researchers themselves.

In May 2025, the President issued an Executive Order (EO) on *Improving the Safety and Security of Biological Research*. The EO addresses risks associated with dangerous gain-of-function research and the procurement of synthetic nucleic acids. NIH is working with the Office of Science and Technology Policy and the National Security Council to implement the provisions of the EO and ensure effective and consistent implementation. In FY 2026, NIH will continue to prioritize its stewardship over biosafety and biosecurity oversight at NIH-supported institutions, including by furthering work toward implementing these policies and continuing to strengthen education and outreach to ensure effective implementation of these and all other relevant United States policies.

Patient Access Planning

NIH funding is critical to stimulating new knowledge and discoveries driving innovation across sectors, and the agency seeks to drive effective partnerships that foster a shared commitment to transforming knowledge into improved health for all. NIH recognizes that all too often, however, patients across the country and across the globe may be unable to access medical products they need: a treatment for their disease may not yet exist or it might exist but be out of reach because it is too expensive or difficult to take. NIH has proposed a new patient access planning policy within the NIH IRP, which would involve incorporating patient access consideration into the commercialization process for NIH-owned inventions.[46] NIH has proposed a flexible approach to allow licensees to pursue tailored, commercially reasonable strategies that promote patient access across a range of medical technologies. Such early access planning can be a crucial step in

[45] grants.nih.gov/grants/guide/notice-files/NOT-OD-25-047.html
[46] osp.od.nih.gov/policies/innovation-and-translation#tab1/

advancing equitable patient access to emerging biomedical technologies, and NIH is committed to helping licensees achieve access goals.

Conclusion

The Nation's investment in NIH is born from the recognition that a healthy population is a productive and thriving population. NIH fosters a culture of scientific minds with diverse backgrounds and ideas; a culture that endeavors to conduct science with the highest standards of rigor and integrity to achieve NIH's mission of improving the health and wellbeing for all. Each year, NIH awards thousands of competitive grants that directly support researchers at research institutions across the country.

A healthier nation is a more productive and economically sound nation. 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.[47] 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.

[47] ucema.edu.ar/u/je49/capital_humano/Murphy_Topel_JPE.pdf

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 2026 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 shows 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*,[48] 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 Administration's goal of protecting and improving the health and well-being of the American people.

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

[48] nih.gov/about-nih/nih-wide-strategic-plan

Institutes and OD offices carry out priority setting, performance monitoring, and progress reviews, and also make adjustments 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 and consistently applied 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.[49] 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

[49] As of February 2025, the standing working groups are: Board of Scientific and Clinical Directors; Clinical Center Governing Board; Data Science Policy Council; 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, the reviews may lead to the development of new award 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 of the 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 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY 2026 +/- FY 2025 Enacted
Total, NIH Program Level	**$46,357.946**	**$46,001.287**	**$27,915.100**	**-$18,086.187**
Less mandatory and funds allocated from different sources:				
PHS Program Evaluation	$1,412.482	$1,412.482	$250.000	-$1,162.482
Mandatory Type 1 Diabetes Research - Baseline	$195.753	$119.094	$0.000	-$119.094
Mandatory Type 1 Diabetes Research - Proposed	$0.000	$0.000	$159.000	$159.000
Mandatory Type 1 Diabetes Research - Subtotal	$195.753	$119.094	$159.000	$39.906
Total, NIH Discretionary Budget Authority[5]	**$44,749.711**	**$44,469.711**	**$27,506.100**	**-$16,963.611**
Number of Competing RPGs	*10,086*	*6,095*	*4,312*	*-1,783*
Total Number of RPGs	*42,143*	*38,069*	*27,478*	*-10,591*
FTE[6,7]	*19,089*	*19,031*	*16,297*	*-2,734*

1 Numbers may not add due to rounding.

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

3 The FY 2026 Budget proposes to relocate NIEHS and NIEHS Superfund from NIH to the Administration for a Healthy America. Funding levels in this table are displayed comparably and as a result do not include $993.521 million in each of FY 2024 and FY 2025 for these programs. For information on these programs, please see the AHA Congressional Justification.

4 The FY 2024 and FY 2025 columns reflect a reduction by transfer of $5.0 million from OD to the HHS Office of Inspector General.

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

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

7 FY 2026 FTE levels reflect estimates and are subject to change.

IMPACT OF BUDGET LEVEL ON PERFORMANCE

Programs and Measures[1] (Dollars in Millions, except where noted)	**FY 2024 Final**	**FY 2025 Full-Year CR**	**FY 2026 President's Budget**	**FY 2026 +/- FY 2025**
Research Project Grants	$26,221.126	$26,683.583	$15,112.853	-43.4%
Competing Average Cost (in thousands)	$598	$969	$863	-10.9%
Number of Competing Awards (whole number)	10,086	6,095	4,312	-29.3%
Estimated Competing RPG Success Rate	18.5%	10.3%	7.3%	-29.1%
Research Centers	$2,706.087	$2,612.069	$1,484.319	-43.2%
Other Research	$3,135.587	$3,109.077	$1,860.681	-40.2%
Training	$978.924	$1,013.730	$654.470	-35.4%
Research & Development Contracts	$3,742.850	$3,128.497	$2,027.602	-35.2%
Intramural Research	$4,924.989	$4,942.933	$3,625.439	-26.7%
Research Management and Support	$2,429.454	$2,492.469	$1,757.570	-29.5%
Common Fund (non-add)	*$685.001*	*$685.001*	*$347.401*	*-49.3%*
Buildings & Facilities Appropriation	$350.000	$350.000	$210.000	-40.0%
Other Mechanisms[2,3]	$1,868.929	$1,668.929	$1,182.166	-29.2%
Total, Program Level[4]	**$46,357.946**	**$46,001.287**	**$27,915.100**	**-39.3%**

[1] The FY 2026 Budget proposes to relocate NIEHS and NIEHS Superfund from NIH to the Administration for a Healthy America. Funding levels in this table are displayed comparably and as a result exclude NIEHS and NIEHS Superfund in FY 2024 and FY 2025. For NIEHS and Superfund amounts excluded are $993.5 million (FY 2024 and FY 2025).

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

[3] Amounts in FY 2024 and FY 2025 reflect directive transfer of $5.0 million to the HHS Office of Inspector General.

[4] 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 2024 Final[8]		FY 2025 Full-Year CR[8]		FY 2026 President's Budget		FY 2026 +/- FY 2025 Full-Year CR	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Research Projects:								
Noncompeting	30,336	$18,500,707	30,331	$19,277,742	22,183	$10,652,175	-8,148	-$8,625,567
Administrative Supplements[3]	*(3,409)*	457,458	*(1,836)*	279,001	*(109)*	12,624	*(-1,727)*	-266,377
Competing	10,086	$6,030,356	6,095	$5,907,445	4,312	$3,719,278	-1,783	-$2,188,167
Subtotal, RPGs	40,422	$24,988,521	36,426	$25,464,188	26,495	$14,384,077	-9,931	-$11,080,111
SBIR/STTR	1,721	1,232,605	1,643	1,219,395	983	728,775	-660	-490,620
Research Project Grants	42,143	$26,221,126	38,069	$26,683,583	27,478	$15,112,853	-10,591	-$11,570,731
Research Centers:								
Specialized/Comprehensive	997	$2,179,873	1,001	$2,161,532	755	$1,301,978	-246	-$859,554
Clinical Research	36	252,427	22	198,722	13	72,913	-9	-125,809
Biotechnology	38	65,279	31	40,387	17	20,584	-14	-19,803
Comparative Medicine	46	129,188	49	131,213	32	88,844	-17	-42,368
Research Centers in Minority Institutions	21	79,321	22	80,215	0	0	-22	-80,215
Research Centers	1,138	$2,706,087	1,125	$2,612,069	817	$1,484,319	-308	-$1,127,750
Other Research:								
Research Careers	5,024	$930,380	4,780	$900,532	3,035	$569,108	-1745	-$331,424
Cancer Education	83	23,601	75	21,391	43	12,180	-32	-9,211
Cooperative Clinical Research	248	439,328	261	466,617	198	381,448	-63	-85,169
Biomedical Research Support	154	112,827	134	103,999	27	15,111	-107	-88,888
Other Biomedical Research Support	83	33,890	30	17,530	24	8,666	-6	-8,864
Other	2,637	1,595,561	2,587	1,599,007	1,571	874,167	-1,016	-724,840
Other Research	8,229	$3,135,587	7,867	$3,109,077	4,898	$1,860,681	-2,969	-$1,248,396
Total Research Grants	51,510	$32,062,801	47,061	$32,404,729	33,193	$18,457,853	-13,868	-$13,946,876
Ruth L Kirchstein Training Awards:	FTTPs		FTTPs		FTTPs		FTTPs	
Individual Awards	3,936	$198,312	3,962	$200,864	2,415	$123,177	-1,547	-$77,687
Institutional Awards	13,034	780,612	13,385	812,867	8,263	531,293	-5,122	-281,574
Total Research Training	16,970	$978,924	17,347	$1,013,730	10,678	$654,470	-6,669	-$359,261
Research & Development Contracts	2,857	$3,742,850	2,532	$3,128,497	1,677	$2,027,602	-855	-$1,100,895
(SBIR/STTR) (non-add)[3]	*(109)*	*(81,851)*	*(85)*	*(72,250)*	*(44)*	*(35,197)*	*(-41)*	*(-37,054)*
Intramural Research		$4,924,989		$4,942,933		$3,625,439		-$1,317,494
Research Management & Support		2,429,454		2,492,469		1,757,570		-734,898
SBIR Admin (non-add)[3]		*(13,635)*		*(13,226)*		*(8,471)*		*(-4,755)*
Office of the Director - Appropriation[3,5]		*(2,832,425)*		*(2,633,425)*		*(1,681,062)*		*(-952,363)*
Office of the Director - Other		1,838,929		1,638,929		1,164,166		-474,763
ORIP (non-add)[3,5]		*(308,495)*		*(309,495)*		*(169,495)*		*(-140,000)*
Common Fund (non-add)[3,5]		*(685,001)*		*(685,001)*		*(347,401)*		*(-337,600)*
Buildings and Facilities[6]		380,000		380,000		228,000		-152,000
Appropriation[3]		*(350,000)*		*(350,000)*		*(210,000)*		*(-140,000)*
Type 1 Diabetes[7]		-195,753		-119,094		-159,000		-39,906
Program Evaluation Financing[7]		-1,412,482		-1,412,482		-250,000		1,162,482
Subtotal, Labor/HHS Budget Authority		**$44,749,711**		**$44,469,711**		**$27,506,100**		**-$16,963,611**
Interior Appropriation for Superfund Research		0		0		0		0
Total, NIH Discretionary Budget Authority		**$44,749,711**		**$44,469,711**		**$27,506,100**		**-$16,963,611**
Type 1 Diabetes		195,753		119,094		159,000		39,906
Total, NIH Budget Authority		**$44,945,464**		**$44,588,805**		**$27,665,100**		**-$16,923,705**
Program Evaluation Financing		1,412,482		1,412,482		250,000		-1,162,482
Total, Program Level		**$46,357,946**		**$46,001,287**		**$27,915,100**		**-$18,086,187**

See footnotes on 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 and excludes supplemental-related financing.

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

4 The FY 2026 Budget proposes to relocate NIEHS and NIEHS Superfund from NIH to the Administration for a Healthy America (AHA). Funding levels in this table are displayed comparably and as a result do not include $993.521 million in each of FY 2024 and FY 2025 for these programs. For information on these programs, please see the AHA 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 such 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 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 Reduced by a transfer of $5.0 million from OD to the HHS Office of Inspector General.

NARRATIVE BY ACTIVITY TABLE/HEADER TABLE

(Dollars in Millions)	**FY 2024 Final[5]**	**FY 2025 Full-Year CR[5]**	**FY 2026 President's Budget**	**FY 2026 +/- FY 2025**
Program Level[1,2,3]	$46,357.9	$46,001.3	$27,915.1	-$18,086.2
FTE[4]	19,089	19,031	16,297	-2,734

[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 of (in thousands) $1,412,482 in FY 2024, $1,412,482 in FY 2025, and $250,000 in FY 2026.

[3] The FY 2026 Budget proposes to relocate NIEHS and NIEHS Superfund from NIH to the Administration for a Healthy America (AHA). Funding levels in this table are displayed comparably and as a result do not include $993.5 million and 642 FTE in FY 2024, and $993.5 million and 613 FTE in FY 2025, for these programs. For information on these programs, please see the AHA Congressional Justification.

[4] FY 2026 FTE levels reflect estimates and are subject to change.

[5] 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 the causes, prevention, and treatments of human diseases and disorders; processes in healthy development and aging; and methods for collecting and disseminating data and health information.

In FY 2024, NIH-funded scientists continued to make paradigm-shifting contributions across the full spectrum of biomedical, behavioral, and social sciences research from groundbreaking basic science through pivotal clinical trials and implementation research. NIH has continued to adopt new approaches to enhance mission-critical scientific research and funding. The lessons learned continue to both inform other research areas and ensure preparedness for future public health emergencies. Examples of these critical efforts and scientific research areas are described below.

Supporting Cancer Research

Cancer research is a priority for NIH, which is committed to accelerating scientific discovery in cancer, fostering greater collaboration, and improving the sharing of cancer research data. Since 2016, NIH has made significant progress, launched over 70 research programs and consortia, and supported more than 250 research projects, leading to more than 3,400 research publications and 89 clinical trials.[50] Research advances have led to more precise cancer diagnostic tools, novel cancer treatment options, and new data sharing networks, including the Cancer Research Data Commons.[51] To reach the goal of reducing cancer deaths by half in the next 25 years, NIH is substantially increasing the number of people who participate in clinical trials, improving access to current and new standards of cancer care, enhancing the cancer research workforce, and increasing the pipeline of new cancer drugs.[52]

Researchers in the National Cancer Institute's (NCI) intramural research program have developed a non-chemotherapy treatment regimen that is achieving full remissions for some people with aggressive B-cell lymphoma, a cancer of the white blood cells, that has come back or is no longer responding to standard treatments. The five-drug combination targets multiple molecular pathways that diffuse large B-cell lymphoma (DLBCL) tumors use to survive. In a clinical trial at NIH's Clinical Center, the researchers tested a new combination of therapeutic medications called ViPOR in 50 patients with DLBCL, the most common type of lymphoma. The treatment shrank tumors substantially in 54 percent of the patients, with 38 percent of those patients' tumors disappearing entirely, known as a complete response.[53] The researchers designed the five-drug regimen to test in human trials, based on laboratory studies that analyzed which targeted drugs could best be combined to kill DLBCL cells in a synergistic manner. A larger, multi-center trial is now in development.

[50] cancer.gov/research/key-initiatives/moonshot-cancer-initiative/progress
[51] datacommons.cancer.gov/
[52] cancer.gov/research/key-initiatives/moonshot-cancer-initiative/progress
[53] cancer.gov/news-events/press-releases/2024/vipor-combination-therapy-b-cell-lymphoma

In 2024, NIH launched the Cancer Screening Research Network (CSRN)[54] to evaluate emerging technologies for cancer screening. The CSRN will conduct rigorous, multi-center cancer screening trials with large and varied populations in a variety of health care settings. These studies will systematically evaluate emerging technologies – such as multi-cancer detection tests (MCDs) – with the goal of reducing cancer-related illnesses and deaths. The CSRN is investigating how to identify cancer earlier, when it may be easier to treat.

Pediatric cancers are also a focus of efforts at NIH. For example, one initiative studied the biology of novel fusion oncoproteins, abnormal molecules made of the fused parts of two proteins, that are drivers of several pediatric cancers. Ewing sarcoma is an aggressive childhood cancer that is particularly difficult to treat, and little progress has been made in developing effective therapies for patients with this disease that has spread or come back after treatment. Using genetic screening techniques, researchers discovered that a protein called ETV6 promotes tumor growth by modulating the activity of the fusion protein that leads to Ewing sarcoma.[55] They also determined that ETV6 is important for tumor cell survival, but not for normal cells. New mechanistic insights from this work may inform the development of a targeted drug that interferes with ETV6 to treat Ewing sarcoma. These results may also be translatable to treatment options for other cancers where ETV6 is important, such as the most common form of childhood leukemias.

NIH is building on exceptional research and focusing on areas of cancer research and prevention that are most likely to benefit the American people.

Promoting Artificial Intelligence and Machine Learning Research

NIH promotes the safe and responsible use of Artificial Intelligence and Machine Learning (AI/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.

The Bridge to 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.[56] Bridge2AI generates flagship data sets that include voice and other data to identify abnormal changes in the body, data to make connections between genetic pathways and changes in cell shape and function, data to improve decision-making in critical care settings, and data to uncover biological processes underlying recovery from illness. This program also produces tools, software, and standards to accelerate the creation of AI/ML-ready data sets; designing training materials and activities for skills and workforce development; and fostering cultural change based on best practices for ethical sourcing of AI/ML-ready data. A key component of Bridge2AI is bringing together technological and biomedical experts with social scientists to broaden the perspectives in AI/ML research and enable collection and use of data according to the robust ethical principles.

[54] prevention.cancer.gov/major-programs/cancer-screening-research-network-csrn
[55] cancer.gov/news-events/cancer-currents-blog/2023/ewing-sarcroma-etv6-treatment-target
[56] bridge2ai.org/

Research Across the Lifespan

NIH supports research across the human lifespan – from screening newborns for fatal disease to better understanding the fundamental reasons why humans age and how healthy lifespan can be improved and even extended. For humans to live a long and healthy life, it is critical to identify disease early and to identify and understand any possible mitigating factors for disease onset and progression.

A study led by NIH-funded researchers has demonstrated just how important early disease detection can be. The NIH-funded Primary Immune Deficiency Treatment Consortium (PIDTC) led a study to measure how effective population-wide newborn screening for a disease called severe combined immunodeficiency (SCID) is at preventing health complications and death. Infants with SCID appear healthy at birth but are highly susceptible to severe infections and death unless they receive immune-restoring treatment. Analyzing data from the PIDTC, researchers found that early detection using newborn screening and subsequent intervention of SCID led to a 5-year survival rate of 92.5 percent among children with no family history of the disease.[57]

Early intervention and prevention of harmful exposures is also essential for brain development. Despite gains through remediation and screening, more than half a million children in the United States under the age of five have elevated levels of blood lead, with children in low-income households most at risk.[58] There is no safe threshold level of lead and exposure can result in permanent neurological, cognitive, and behavioral effects. NIH supported a study that developed a screen-printed electrode sensor that can measure the presence of lead in just a few drops of a child's blood with 77 percent accuracy and 94 percent precision.[59] The sensor holds promise as an alternative to expensive and often impractical lab tests to allow more frequent monitoring for lead in children in at increased risk communities.

Researchers are working to better understand the fundamental biological processes for why humans age, what factors contribute to aging, and how we might be able to slow down or mitigate risks that contribute to aging and age-related disease. In a recent collaborative study, researchers contributed to our fundamental understanding of the biological process of senescence, a hallmark of human aging, where cells are in an arrested state, no longer growing or dividing. While studying tissue regeneration in *Hydractinia symbiolongicarpus*, a small, tube-like shaped animal that is related to both jellyfish and coral, researchers found senescent cells. This discovery that senescent cells are involved in regeneration in *Hydractinia* changes how researchers think of senescence, its role in aging, and how the function of senescence may have evolved over time.[60] In another surprising discovery, researchers who have long studied a role for hunger and fasting in aging and longevity found that genetically altering fruit flies to activate their brain's hunger response could increase lifespan, suggesting that activating the biological processes involved in hunger is sufficient to increase lifespan, even when animals are not actually fasting.[61]

[57] nih.gov/news-events/news-releases/screening-newborns-deadly-immune-disease-saves-lives
[58] ptfcehs.niehs.nih.gov/subcommittees/pbex
[59] ncbi.nlm.nih.gov/pmc/articles/PMC10862559/
[60] nih.gov/news-events/news-releases/scientists-discover-clues-aging-healing-squishy-sea-creature
[61] nia.nih.gov/news/study-fruit-flies-finds-hunger-causes-brain-changes-slow-aging

NIH supports basic science and health research that promises to benefit all ages, from testing that saves the lives of newborns to research that provides insights on how to live longer, healthier lives.

Down Syndrome Research and the INCLUDE Project

The INvestigation of Co-occurring conditions across the Lifespan to Understand Down syndrome (INCLUDE) Project is an NIH-wide initiative, engaging Institutes across NIH, that aims to better understand critical health and well-being needs for individuals with Down syndrome (DS). Since its launch in FY 2018, the INCLUDE Project has funded more than 362 research awards spanning all 3 components of the initiative: basic science studies on chromosome 21, large cohort development for individuals with DS, and the inclusion of individuals with DS in clinical trials. Now entering its seventh year, the INCLUDE Project continues to grow its impact by supporting innovative research and expanding the field of investigators by enhancing career pathways for trainees, early-stage investigators, and established investigators with expertise related to conditions commonly experienced by individuals with DS.

The goal of this NIH-wide program is to support basic, translational, and clinical research that has the potential to make a positive impact on the health and well-being of people with DS. The studies supported by the INCLUDE Project establish and build on basic scientific discoveries to develop an understanding of both the biological and genetic underpinnings of DS as well as the conditions commonly experienced by individuals with DS. To support collaboration, rigor, and transparency in DS-related research, the INCLUDE Project has driven advances in data sharing and storage infrastructure. The INCLUDE Data Coordinating Center[62] offers free, accessible tools, like the INCLUDE Data Hub,[63] that provide shared access to DS research study data and a suite of data tools that further enhance the potential for INCLUDE-funded DS research to improve the health and well-being of individuals with DS.

The INCLUDE Project also aims to establish needed knowledge and infrastructure for advancing treatments and other clinical therapies that are safe and effective for people with DS. In FY 2025, the INCLUDE Project continues to support 15 clinical studies investigating potential treatments for critical and co-occurring conditions associated with DS, such as sleep apnea, Attention-Deficit/Hyperactivity Disorder (ADHD), and inflammatory skin and scalp conditions. NIH anticipates increasing its support for clinical trials in the coming years, including support for trials to examine the effect of anti-amyloid drugs and weight loss for prevention of Alzheimer's disease in individuals with DS. As the INCLUDE Project continues to support the highest-quality targeted research designed to address critical health needs and well-being for individuals with DS and their families, the applications of such research will lead to even greater improvements to care.

To ensure that DS research participants include broad representation of those affected by DS, INCLUDE launched an initiative in FY 2024 to develop and build an INCLUDE Down Syndrome Cohort Development Program. The goal of this program is to make it easier for

[62] includedcc.org/
[63] portal.includedcc.org/

individuals with DS from diverse communities to participate in research studies across the country. The Cohort Development Program granted several awards to establish new Cohort Research Sites that will recruit participants with DS across the lifespan. In addition, INCLUDE supported the development of a Down Syndrome Clinical Cohort Coordinating Center that provides organizational support for collaboration across Cohort Research Sites and a Federated Biobanking resource that will store and distribute biospecimens collected by the Cohort Research Sites. The Federated Biobanking resource will serve as a DS-Biorepository that develops a centralized system linking existing biorepositories to facilitate the search of all publicly available biospecimen data relevant to the study of DS. All data coordinated and generated by this program is submitted to the INCLUDE Data Hub in coordination with the INCLUDE Data Coordinating Center to fully leverage all existing data resources to inform DS research.

In April 2024, NIH hosted an INCLUDE Investigators Meeting, bringing together more than 250 DS researchers to share their work and inform future and emerging areas of DS science. More than 80 early-career investigators, students, and post-doctoral fellows attended the INCLUDE Investigators Meeting where the program provided information about early career support and training opportunities for Down syndrome researchers. In addition, INCLUDE is implementing a communications strategy to better inform, engage, and improve awareness of and participation in INCLUDE Project-funded activities across the researcher and the broader DS community, as well as to continue to communicate INCLUDE-funded research findings with the scientific, medical, and DS community.

***All of Us* Research Program**

Nationally launched in 2018, the *All of Us* Research Program is an ambitious effort to gather health data from one million or more people living in the United States to accelerate health and medical breakthroughs to enable individualized prevention, treatment, and care for all. *All of Us* is committed to recruiting a diverse participant pool that includes members of groups that have been left out of research in the past.

With more than 859,000 participants enrolled, *All of Us* is one of the largest health databases of its kind, capable of informing thousands of studies on a variety of health conditions. The *All of Us* platform enables more rapid and efficient scientific discovery than stand-alone, disease-specific studies. For example, research on the genetic basis of primary hypothyroidism—a common condition in which the thyroid does not create and release enough hormones into the bloodstream, thereby slowing metabolism—can now be done in weeks rather than years. In the early 2010s, a network analysis of this disease required more than 40 people, 2.5 years, and hundreds of thousands of dollars. However, in 2020, this research was replicated and expanded using *All of Us* data within 6 weeks and cost approximately $40 to calculate.[64] This research also identified more than 10 unique genes associated with the condition that were previously unreported. Thousands of such projects are underway now, with new discoveries in genes that cause heart disease, identifying approaches to prevent kidney disease in African Americans, creating a more personalized, risk-based approach to breast cancer screening, and comparing the risks of side effects in medications.

[64] pubmed.ncbi.nlm.nih.gov/21981779/

With more than 4 petabytes of data, the program's platform brings substantial cost benefits to the more than 840 organizations registered to use it.[65] Each registered institution saves an estimated $16.5 million per year in technology costs that would otherwise be needed to store and process the data locally. The *All of Us* access model also allows researchers to complete registration, verify their identity, receive training, and begin research in an average of 29 hours, compared to the months to a year that similar datasets take. In these ways, the Program is transforming how medical research is conducted.

Institutes across NIH are leveraging the *All of Us* infrastructure to advance their scientific goals through ancillary studies. Built on top of the Program's core protocol, these studies deliver additional value to participants and add more data for use by researchers.[66] The Common Fund is working with *All of Us* to power Nutrition for Precision Health (NPH), one of the most ambitious nutrition studies that NIH has undertaken. This NIH-wide effort aims to discover how people's genes, culture, and environment affect how they respond to food. Researchers will use participant data to develop algorithms that predict individual responses to food and dietary patterns. *All of Us* was also able to collect almost 10 times as much data in approximately 10 months from an NIH-funded program Exploring the Mind[67] (which helps researchers make connections between health factors and behavior) than the program alone was able to collect in approximately 10 years.

Further, since 2018, NIH Institutes have supported more than $28 million in NIH research project grants, $4 million in training awards, and $9 million in infrastructure-related awards using *All of Us* data. Each of these studies represents huge cost savings for NIH and investigators by minimizing the need to recruit individual cohorts and collect and maintain disparate datasets.

Studies using *All of Us* data are yielding meaningful insights that stand to advance health care. So far, the program has discovered 275 million previously unreported DNA variants identified from data shared by nearly 250,000 participants. Health-related DNA results have also identified 32,500 DNA variants in a subset of genes that are associated with certain serious health conditions, such as hereditary cancers and heart disease, more than 7,000 of which had never been observed previously.[68] *All of Us* submitted this de-identified information to the public database, ClinVar, for use by health care providers to help diagnose and manage health conditions. Through another project, researchers uncovered instances when a certain DNA test clinicians use to verify the dosage for two commonly used chemotherapies does not work as expected. The finding, published in 2024, has already led to an update to a clinical guideline for *DPYD* gene testing for chemotherapy use, to make it more reliable.[69,70]

Investigators with the eMERGE Program applied *All of Us* data to adjust polygenic risk scores for 10 common conditions so that the scores are more accurate for individuals from many ancestries.[71] These scores calculate an individual's risk of disease by considering genetic and

[65] researchallofus.org/institutional-agreements/
[66] allofus.nih.gov/about/all-us-research-program-protocol
[67] nimh.nih.gov/news/science-news/2024/using-games-to-explore-the-mind
[68] joinallofus.org/what-participants-receive/hereditary-disease-risk
[69] ncbi.nlm.nih.gov/pmc/articles/PMC10777430/
[70] files.cpicpgx.org/data/guideline/publication/fluoropyrimidines/2017/29152729.pdf
[71] genome.gov/Funded-Programs-Projects/Electronic-Medical-Records-and-Genomics-Network-eMERGE

family history factors. While these scores are not yet used in doctors' offices, this work helps move health care closer to using accurate personalized risk scores in the future.[72]

To drive more discoveries across the lifespan, in FY 2024 *All of Us* began limited pediatric enrollment, resulting in the enrollment of over 100 children by the end of the fiscal year. With support from their parents or guardians, pediatric participants shared physical measurements, biosamples, and data from electronic health records.[73]

Maternal Health and Growth of the IMPROVE Initiative

The United States has a higher maternal mortality rate than any other developed nation. In 2021, the U.S. maternal mortality rate was estimated at 22.3 deaths per 100,000 live births. NIH generates ground-breaking research that seeks to better understand the dynamics of maternal health in the United States.

In 2019, NIH launched the Implementing a Maternal health and PRegnancy Outcomes Vision for Everyone (IMPROVE) initiative to support research to reduce preventable causes of maternal deaths and to improve health for women before, during, and after delivery.[74] IMPROVE places a special emphasis on health disparities and populations that are disproportionately affected by severe pregnancy complications and maternal death. In FY 2024, as part of this initiative, NIH distributed $8 million in awards to the winners of the Rapid Acceleration of Diagnostics Technology (RADx® Tech) for Maternal Health Challenge, a prize competition aimed to accelerate the development of technologies to improve maternal health outcomes in "maternity care deserts."[75] IMPROVE also sponsored the Connecting the Community for Maternal Health Challenge[76] to encourage and reward non-profit community-based or advocacy organizations to develop research capabilities and infrastructure to pursue research projects in the area of maternal health, inclusive of maternal morbidity and mortality.

Additionally, NIH funded two new Maternal Health Research Centers of Excellence in FY 2024, each receiving $2 million in first-year funding. In total, the twelve Maternal Health Research Centers received over $28 million in NIH funding over FYs 2023 and 2024. These centers are designed to develop and implement research projects to address the biological, behavioral, environmental, sociocultural, and structural factors that affect pregnancy-related complications and deaths. Research centers will partner with community collaborators, such as state and local public health agencies, community health centers and faith-based organizations. Additionally, the research centers will support training and professional development for maternal health researchers.[77]

NIH-supported maternal health research has provided much-needed insight into causes of death or morbidity during pregnancy and postpartum. NIH's continued efforts to better understand social, structural, and genetic risk factors that increase maternal mortality rates will lead to more

[72] allofus.nih.gov/news-events/research-highlights/exploring-polygenic-risk-scores-using-all-us
[73] allofus.nih.gov/news-events/announcements/nihs-all-us-research-program-begins-limited-enrollment-children
[74] nichd.nih.gov/research/supported/IMPROVE
[75] nichd.nih.gov/newsroom/news/040323-RadxTech-Deep-Dive
[76] challenge.gov/?challenge=community-maternal-health
[77] nichd.nih.gov/newsroom/news/062624-maternal-health-research-centers-of-excellence

innovative technologies, earlier intervention, and better disease detection that will improve maternal health outcomes in the United States.

Innovations in Mental Health Research and Treatment

Research shows that mental illnesses are common in the United States, affecting tens of millions of people each year, but estimates suggest that only half of people with mental illnesses receive treatment.[78] 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. Recent basic science advances include the development of multidimensional maps of gene regulation networks in the brain,[79] which improve the understanding of genetic risk for mental disorders including schizophrenia, post-traumatic stress disorder, and depression.

Building on findings from the Recovery After an Initial Schizophrenia Episode (RAISE) initiative,[80] the Early Psychosis Intervention Network (EPINET)[81] is a broad clinical research initiative that aims to determine the best way to treat people experiencing symptoms of early psychosis. Psychosis refers to a collection of symptoms that affect the mind, where there has been some loss of contact with reality. During an episode of psychosis, a person's thoughts and perceptions are disrupted, and they may have difficulty recognizing what is real and what is not. Left untreated, psychotic symptoms can disrupt school and work activities, strain family relationships, lead to separation from friends, and make a person's mental health problems worse. Research from RAISE demonstrated that coordinated specialty care (CSC) was more effective for treating psychosis than typical care. CSC is a recovery-oriented, team approach to treating early psychosis that promotes easy access to care and shared decision-making among specialists, the person experiencing psychosis, and family members.[82] It involves individual or group psychotherapy, family support and education programs, medication management, supported employment and education services, and case management. EPINET funded awards to establish regional scientific hubs connected to multiple CSC programs that provide early psychosis treatment and a national data coordinating center. The initiative has expanded to 8 regional hubs in 17 states with more than 100 clinics that provide CSC.[83]

Mental disorders are highly prevalent among youth and the rates of youth with moderate and severe depression have increased over the last 20 years. The increased prevalence of severe mental health disorders in youth has led to a devastating increase in suicide rates across all youth age groups (10-14 years; 15-19 years; 20-24 years) since 2001.[84] NIH launched the Advanced Laboratories for Accelerating the Reach and Impact of Treatments for Youth and Adults with Mental Illness (ALACRITY) Research Center program which supports 14 mental health research centers across the country whose goals are to rapidly transform treatments for youth mental illness by providing a space to develop and test new mental health research and interventions in a

[78] nimh.nih.gov/health/statistics
[79] nimh.nih.gov/news/science-updates/2024/scientists-map-networks-regulating-gene-function-in-the-human-brain
[80] nimh.nih.gov/research/research-funded-by-nimh/research-initiatives/recovery-after-an-initial-schizophrenia-episode-raise
[81] nimh.nih.gov/research/research-funded-by-nimh/research-initiatives/early-psychosis-intervention-network-epinet
[82] nimh.nih.gov/research/research-funded-by-nimh/research-initiatives/recovery-after-an-initial-schizophrenia-episode-raise
[83] nimh.nih.gov/research/research-funded-by-nimh/research-initiatives/early-psychosis-intervention-network-epinet
[84] samhsa.gov/data/release/2021-national-survey-drug-use-and-health-nsduh-releases

clinical setting.[85] NIH continues to support funding for ALACRITY and to renew resources for research in mental health disorders, test new mental health interventions, and support clinical trials at ALACRITY Research Centers. Building on the success of the ALACRITY model, NIH began supporting seven Practice-Based Suicide Prevention Research Centers, which are focused on developing, refining, and testing effective and scalable approaches for reducing suicide rates in the United States.[86]

Additionally, NIH is investing in understanding the impacts of social media on the mental health of children and youth. The Adolescent Brain Cognitive Development (ABCD) Study is the largest long-term study of brain development and child health in the United States.[87] Approximately 12,000 children ages 9-10 years have joined the study and will be surveyed into young adulthood about digital media and technology use. Data can be correlated with other assessments, such as measures of mental health, cognition, and sleep. Current research explores the relation between technology and digital media use and children's executive functioning, language development, attention, and other health outcomes, as well as ways to promote healthy screentime usage. NIH recently began funding 11 new studies focused on understanding bidirectional influences between adolescent social media use and mental health, responding to the U.S. Surgeon General's Advisory on Youth Mental Health.

Understanding the BRAIN

The NIH *Brain Research Through Advancing Innovative Neurotechnologies*® (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.[88] Over the past few years, BRAIN Initiative investments have yielded multiple ground-breaking clinical successes in early-stage trials. These small 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 highly collaborative within NIH, across Federal agencies, and with private organizations and the international scientific community.

As an NIH-wide initiative, BRAIN is a critical resource for Institutes to advance their own mission-driven research on dementia, communication loss from paralysis or stroke, addiction, vision disorders, and many other conditions affecting the nervous system. For example, BRAIN-enabled advances in deep brain stimulation (DBS) and artificial intelligence were applied to individuals with obsessive compulsive disorder (OCD) to record and interpret mood states from brain electrical activity, enabling researchers to predict whether an individual will respond to DBS therapy.[89] These findings may lead to more effective personalized therapies for individuals living with treatment-resistant OCD. In another breakthrough, BRAIN Initiative researchers used "brain-to-speech" neuroprosthetic devices to convert a person's brain electrical activity (their thoughts) into the ability to speak a few words. In one study, a participant had lost the ability to

[85] nimh.nih.gov/research/research-funded-by-nimh/research-initiatives/advanced-laboratories-for-accelerating-the-reach-and-impact-of-treatments-for-youth-and-adults-with-mental-illness-alacrity
[86] nimh.nih.gov/research/research-funded-by-nimh/research-initiatives/practice-based-suicide-prevention-research-centers-0
[87] nimh.nih.gov/research/research-funded-by-nimh/research-initiatives/adolescent-brain-cognitive-developmentsm-study-abcd-studyr
[88] braininitiative.nih.gov/
[89] pubmed.ncbi.nlm.nih.gov/38997607/

speak due to paralysis,[90] and in another study, the participant was affected by amyotrophic lateral sclerosis (ALS).[91] Even a limited ability to communicate can make a dramatic difference for individuals who are unable to speak with family and friends due to a disease.

Neurosurgeons record brain activity in the operating room to guide treatment of seizures, cancer, and other brain disorders. These recordings allow for precise identification of diseased tissue, which can then be removed while preserving the integrity of surrounding tissue. In an exciting preclinical study, BRAIN Initiative-funded researchers created a new, ultrathin sensing film that is 100 times more precise than currently available options.[92] This new film sits directly on the brain's surface and allows for much more detailed recordings of neural activity – potentially making these intricate procedures safer for patients undergoing surgery to remove diseased brain tissue. The new film will also enable future brain-mapping research to better understand movement, speech, sensation, and thought.

BRAIN Initiative advances also created highly precise brain maps that offer a new perspective on brain architecture at stunning levels of detail.[93] These new, extremely detailed brain atlases reveal the exceptionally complex diversity of cells in human, nonhuman primate, and mouse brains.[94] These maps reveal key similarities and differences about how genes and cells contribute to brain function, bringing us closer to precision treatments for brain disorders. In other work, BRAIN-funded scientists created a three-dimensional, cell-by-cell reconstruction of a tiny piece of human brain tissue (about the size of a grain of rice), discovering 57,000 cells and 150 million neural connections and setting the stage for a reconstruction of whole mammalian brains.[95] Together, these foundational brain mapping resources will provide researchers with a blueprint of the brain's organization, thereby enabling a deeper understanding of how this remarkable organ makes us human. BRAIN Initiative-derived resources have also been applied to specific neurodegenerative disorders such as Alzheimer's disease, deepening our understanding of its progression from early-stage to severe disease.[96]

Opioid Use Disorder and Pain Research

The Helping to End Addiction Long-term Initiative, or NIH HEAL Initiative, was launched by NIH in 2018 and is an NIH-wide effort that supports research to accelerate scientific solutions to the overdose crisis, including improved interventions for opioid use disorder, overdose reversal and pain management. The lack of safe and effective treatments for pain has been a driver of the national opioid and overdose crisis. HEAL has two main goals: improving the understanding, management, and treatment of pain, and improving the prevention and treatment of opioid misuse and addiction. HEAL research in pain and opioid misuse and addiction addresses urgent unmet needs across the lifespan – from infants exposed to opioids during pregnancy to older adults living with chronic pain. HEAL research covers many areas of scientific promise and concrete strategies capable of providing rapid and lasting solutions to the opioid crisis.

[90] pubmed.ncbi.nlm.nih.gov/36347863/
[91] pubmed.ncbi.nlm.nih.gov/37612500/
[92] pubmed.ncbi.nlm.nih.gov/38233418/
[93] pubmed.ncbi.nlm.nih.gov/37824675/
[94] pubmed.ncbi.nlm.nih.gov/38092916/
[95] pubmed.ncbi.nlm.nih.gov/38723085/
[96] biorxiv.org/content/10.1101/2023.05.08.539485v3

Chronic pain and its companion crisis of opioid misuse have taken a terrible toll on Americans. The impact has been even greater on U.S. service members and veterans, who often deal with the compounded factors of service-related injuries and traumatic stress.[97] This disproportionate burden of chronic pain among veterans and service members led NIH to forge a collaboration in 2017 across the agency, the U.S. Department of Defense (DoD), and the U.S. Department of Veteran's Affairs (VA) to establish the Pain Management Collaboratory (PMC).[98,99] The PMC's research focusing on the implementation and evaluation of non-drug approaches for the management of pain is urgently needed in the military and across our entire country. Non-drug approaches require a shift in thinking: rather than focusing solely on blocking pain temporarily using analgesics, non-drug approaches work with the mind and body to promote the resolution of chronic pain and the long-term restoration of health. This resolution comes through techniques and practices such as manual therapy, yoga, and mindfulness-based interventions. Addressing chronic pain in ways that do not only rely on drugs means addressing underlying issues such as joints and connective tissue that lack adequate movement or training our brains to "turn down the volume" on pain signals. Using mind and body practices to reduce pain can help promote health in other ways. Possible additional benefits include better sleep, more energy for physical activity, a better mindset for making good nutritional choices, and/or improved mood. The PMC supports a shared resource center and 13 large-scale pragmatic clinical trials. Within this real-world health care setting, the clinical trials have enrolled more than 8,200 participants across 42 veteran and military health systems. These studies offer both significant numbers of participants and insights into what happens when information from controlled clinical trials collides with the realities of health care delivery and the complexities of daily life.

NIH research through HEAL seeks to bring tangible solutions to people with addiction and at risk for overdose. Recent studies aimed to improve access to and retention of the medication buprenorphine, a lifesaving tool for the treatment of opioid use disorder. Although medications can prevent overdose and death and aid individuals on their path to long-term recovery, most individuals with an opioid use disorder are not prescribed medication. Recent NIH-supported findings have demonstrated that providing patients with buprenorphine in the emergency room following an overdose was safe and effective for individuals using fentanyl, a powerful synthetic opioid responsible for nearly 70 percent of overdose deaths.[100] Additional studies found that higher doses of buprenorphine were associated with improved long-term retention in treatment for opioid use disorder.[101] Together this research gives hospitals and clinicians vital tools to help people with addiction and prevent opioid overdose death.

In a continued commitment to elevating health in every community and in direct response to priorities identified in Tribal Consultations in 2018 and 2022, HEAL developed and launched the Native Collective Research Effort to Enhance Wellness (N CREW) Program, a highly collaborative partnership between NIH, Tribes and Native American Serving Organizations

[97] directorsblog.nih.gov/2023/03/28/a-whole-person-approach-to-lifting-the-burden-of-chronic-pain-among-service-members-and-veterans/
[98] nccih.nih.gov/news/press-releases/federal-agencies-partner-for-military-and-veteran-pain-management-research
[99] painmanagementcollaboratory.org/
[100] nida.nih.gov/news-events/news-releases/2023/03/Buprenorphine-initiation-in-ER-found-safe-and-effective-for-individuals-with-OUD-using-fentanyl
[101] nida.nih.gov/news-events/news-releases/2023/09/higher-buprenorphine-doses-associated-with-improved-retention-in-treatment-for-opioid-use-disorder

(T/NASOs), and ally organizations established to directly respond to the opioid public health emergency. The N CREW Program will continue to support T/NASOs to conduct locally prioritized research to address substance use, overdose, and pain, including related factors such as mental health and wellness.[102] These and other efforts across NIH work together to steward NIH's investments in the best science to improve health and life in every community.

Further, HEAL is committed to improving pain management across the lifespan. The HEAL Knowledge, Innovation, and Discovery Studies (KIDS) Pain Program supports multi-site, large-scale clinical trials that aim to improve pediatric acute pain care. Foci include advancing the understanding, assessment, measurement, treatment, and prevention of acute pain for infants, children, and adolescents.

Recognizing the importance of creating a sustainable workforce, HEAL has also made significant investments in training the next generation of opioid use disorder and pain researchers. The HEAL Partnerships to Advance INterdisciplinary (PAIN) Training in Clinical Pain Research Cohort Program is a group of institutional training awards that was recently launched to support postdoctoral fellows interested in clinical pain research. This unique program centers on partnerships between departments typically involved in pain research (e.g., anesthesiology) and those not typically involved in pain research (e.g., sociology) to bring new mentorship perspectives into the pain field. At the next career stage, the National K12 Pain Scholars program supports trainees with an interest in clinical pain research careers who come from institutional environments that cannot adequately support this goal. The program coordinates mentorship at the national level for these scholars. Among the mentoring team are people with a lived experience of pain. Their mentorship helps promote the likelihood that trainees' research projects will be impactful to people living with pain. There have been two cohorts with seven total trainees in the program to date. The Positively Uniting Researchers of Pain to Opine, Synthesize, and Engage (PURPOSE) Network is a digital networking platform that helps coordinate trainings and cohort experiences across these programs. It also provides an avenue for pain researchers to connect across all career stages. The PURPOSE Network has over 3,300 users across the United States. These combined workforce efforts will contribute to the long-term sustainability of the HEAL Initiative.

Scientific Breakthroughs Ushered by NIH

NIH Institutes support basic, translational, and clinical research in specific areas of health, the human body, and disease to fulfill both their own unique missions and the broader NIH mission of enhancing public health and advancing scientific breakthroughs. The distinctive approaches to research taken by each Institute have led to critical scientific discoveries and work together to accomplish the NIH's mission. Among the many examples of recent accomplishments supported by the Institutes include:

- NIH-funded research which resulted in some fascinating new findings that could one day give healthcare providers the tools to better understand and perhaps even predict

[102] heal.nih.gov/research/research-to-practice/native-collective-research-effort-enhance-wellness-overdose-substance-mental-health-pain

labor. The research team produced an atlas showing the patterns of gene activity that take place in various cell types during labor. This remarkable study is the first to analyze gene activity at the single-cell level to better understand the communication that occurs between cells and tissues during labor.[103]

- The PsychENCODE Consortium accelerates discovery of non-coding functional genomic elements in the human brain and elucidates their role in the molecular pathophysiology of psychiatric disorders. Recently, researchers created massive, advanced maps of the complex networks that regulate gene function in the brains of people with and without mental disorders. The findings offer new insights into how gene activities affect the brain, which could lead to improved treatments for mental health conditions for all.[104]

- NIH-funded researchers developed an AI-driven tool, dubbed PERCEPTION (PERsonalized single-Cell Expression-based Planning for Treatments In ONcology), which allows researchers to better understand underlying genetic changes in tumors, but also illuminates how those changes impact gene activity.[105] This proof-of-concept study shows that it is possible to fine-tune predictions of a patient's treatment responses from bulk RNA data by zeroing in on what is happening inside single cells. This tool represents a significant advancement in precision oncology, the field in which doctors choose cancer treatment options based on the underlying molecular or genetic signature of individual tumors.

- HDPulse is a new online resource designed to provide easy access to interventions. This portal helps researchers, health care providers, and community groups make informed, actionable decisions about appropriate interventions for specific populations in their communities.[106]

- NIH researchers have published findings related to the potential use of semaglutide, a modified peptide that mimics the glucagon-like peptide-1 (GLP-1) and is an active ingredient in Ozempic, in the treatment of alcohol use disorder. Evidence supports that the GLP-1 system is involved in the neurobiology of addictive behaviors, and current research using rodent models indicate that GLP-1 analogues could be used effectively for the treatment of alcohol use disorder.[107]

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 2026, NIH will continue to make bold investments in novel ideas and enable the scientific workforce with cutting-edge resources and opportunities.

[103] science.org/doi/10.1126/scitranslmed.adh8335
[104] nih.gov/news-events/nih-research-matters/scientists-map-gene-regulating-networks-human-brain
[105] pubmed.ncbi.nlm.nih.gov/38637658/
[106] nimhd.nih.gov/news-events/news-releases/2024/nih-launches-health-disparities-interventions-portal.html
[107] ncbi.nlm.nih.gov/pmc/articles/PMC10371247/

FUNDING HISTORY (FIVE-YEAR FUNDING TABLE)

Fiscal Year	Amount[1, 2, 3]
2022[4]	$44,258,281,000
2023[4]	$46,686,471,000
2024	$46,362,774,424
2025	$46,006,114,960
2026 Budget Request	$27,915,100,000

[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. Includes NIGMS Program Evaluation financing of $1,309,313,000 in FY 2022, $1,412,482,000 in FY 2023 through FY 2025, and $250,000,000 in the FY 2026 request. Includes CURES Act amounts of $496,000,000 in FY 2022, $1,085,000,000 in FY 2023, $407,000,000 in FY 2024, $127,000,000 in FY 2025, and $226,000,000 in the FY 2026 request.

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

[3] The FY 2026 Budget proposes to relocate NIEHS and NIEHS Superfund from NIH to the Administration for a Healthy America and proposes to relocate ARPA-H from NIH to the Assistant Secretary for a Healthy Future. Funding levels in this table are displayed comparably and as a result exclude NIEHS, NIEHS Superfund, and ARPA-H in FY 2022 to FY 2025. For NIEHS and Superfund amounts excluded are $924,709,000 (FY 2022), $997,014,000 (FY 2023), and $993,693,000 (FY 2024 and FY 2025). For ARPA-H amounts excluded are $1,000,000,000 (FY 2022) and $1,500,000,000 (FY 2023, FY 2024, and FY 2025).

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

SUMMARY OF REQUEST NARRATIVE

The FY 2026 President's Budget (PB) request provides a program level of $27.9 billion for the National Institutes of Health (NIH), which is $18.1 billion, or 39.3 percent, below the FY 2025 Enacted comparable[108] level of $46.0 billion. The PB proposes restructuring NIH into eight Institutes with direct appropriations while maintaining the Office of the Director (OD) and the Building and Facilities account. The NIH Clinical Center, Center for Information Technology, and Center for Scientific Review would continue to be supported internally through the Management Fund and the Service and Supply Fund. The proposed eight-institute structure includes the National Cancer Institute (NCI), the National Institute of Allergy and Infectious Diseases (NIAID), the National Institute on Aging (NIA), and five new consolidated Institutes. The proposed consolidated Institutes are:

- the National Institute on Body Systems (NIBS), which will consolidate the National Heart, Lung, and Blood Institute (NHLBI), the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS), and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK);
- the National Institute on Neuroscience and Brain Research (NINBR), which will consolidate the National Institute of Dental and Craniofacial Research (NIDCR), the National Institute of Neurological Disorders and Stroke (NINDS), and the National Eye Institute (NEI);
- the National Institute of General Medical Sciences (NIGMS), which will consolidate the current NIGMS, the National Human Genome Research Institute (NHGRI), the National Library of Medicine (NLM), the National Institute of Biomedical Imaging and Bioengineering (NIBIB), and the National Center for Advancing Translational Sciences (NCATS);
- the National Institute for Child and Women's Health, Sensory Disorders, and Communication (NICWHSDC), which will consolidate the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD) and the National Institute on Deafness and Other Communication Disorders (NIDCD); and
- the National Institute of Behavioral Health (NIBH), which will consolidate the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse (NIDA), and the National Institute of Mental Health (NIMH).

In addition, the PB proposes to transfer the National Institute of Environmental Health Sciences (NIEHS) and the related Superfund program to the new Administration for a Healthy America (AHA) and proposes to eliminate four Institutes and Centers: the National Institute of Nursing Research (NINR), 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 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 ($27.5 billion in FY 2026); mandatory budget authority provided for type 1 diabetes research ($159.0 million in FY 2026); and Program Evaluation

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

Financing for NIGMS under Section 241 of the Public Health Service Act ($250.0 million in FY 2026).

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

In FY 2026, the Budget proposes to implement the 15 percent indirect cost cap policy and to continue the FY 2025 policy of reserving half of NIH funding allocated toward competing research project grant (RPG) awards for awards that fully fund their outyear commitments as part of the initial grant obligation, to facilitate efficient management of resources across multiple years. Traditionally, NIH research grants have been awarded for more than one year and funded incrementally; each year's commitment is obligated from that year's appropriation. Under this 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. Additionally, full funding has been provided up front for a limited number of grants and cooperative agreements as appropriate in special circumstances. Shifting to upfront funding for half of each year's allocation 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.

Research Project Grants (RPGs)
The FY 2026 President's Budget provides $15.1 billion for RPGs, which is $11.6 billion less than the FY 2025 Enacted level. This amount would fund 4,312 competing RPGs, or 1,783 fewer than projected in FY 2025. It would also support 22,183 noncompeting RPGs, or 8,148 fewer than projected in FY 2025. Due to the implementation of the policy to cap indirect costs on research grants at no more than 15 percent of direct costs, the projected average cost for competing RPG awards in FY 2026 is approximately $863,000, a decrease of 11 percent from the FY 2025 projected average cost of $969,000.

- **Small Business Innovation Research/Small Business Technology Transfer (SBIR/STTR) RPGs.** The FY 2026 President's Budget provides $728.8 million for SBIR/STTR program grants, which is $490.6 million below the FY 2025 Enacted level. The statutory minimum set-aside requirement of 3.65 percent for NIH-wide SBIR/STTR support is achieved in FY 2026.

Research Centers
The FY 2026 President's Budget provides $1,484.3 million for Research Centers, which is $1,127.8 million less than the FY 2025 Enacted level. This amount would fund 817 grants, 308 fewer than projected in FY 2025 Enacted.

Other Research
The FY 2026 President's Budget provides $1,860.7 million for this mechanism, which is $1,248.4 million less than the FY 2025 Enacted level. This amount would fund 4,898 awards, which is 2,969 fewer than the number of awards projected in FY 2025 Enacted.

Training
The FY 2026 President's Budget provides $654.5 million for research training, which is $359.3 million less than the FY 2025 Enacted level. This amount would fund 10,678 Full-Time Trainee Positions (FTTPs), which is 6,669 fewer than projected in FY 2025, and would reflect a freeze in trainee stipends and benefits in FY 2026.

Research & Development (R&D) Contracts
The FY 2026 President's Budget provides $2,027.6 million for R&D contracts, which is $1,100.9 million less than the FY 2025 Enacted level. The requested amount would fund an estimated 1,677 contracts, or 855 fewer than in FY 2025.

- **SBIR/STTR R&D Contracts.** The FY 2026 President's Budget includes a $35.2 million set-aside within the R&D Contracts mechanism for support of qualified SBIR/STTR contracts.

Intramural Research (IR)
The FY 2026 President's Budget provides $3,625.4 million for IR, which is $1,317.5 million less than the FY 2025 Enacted level. The request includes an allowance for the annualization of the January 2025 civilian and military pay raises, the proposed January 2026 military pay raise, and the estimated cost increase in the agency share for health insurance premiums. The IR level also reflects the impact of capping the base pay of Title 42 staff.

Research Management and Support (RMS)
The FY 2026 President's Budget provides $1,757.6 million for RMS, which is $734.9 million less than the FY 2025 Enacted level. As with intramural research, the amount covers actual and anticipated pay cost increases as well as growth in health insurance premiums.

Office of the Director (OD)
The FY 2026 President's Budget provides $1,681.1 million for OD, which is $952.4 million less than the FY 2025 Enacted level.

- **Common Fund (CF)**
  Funding of $347.4 million is allocated for CF-supported programs, which is $337.6 million less than the FY 2025 Enacted level. A portion of the reduction is due to the shift of the Gabriella Miller Kids First Pediatric Research Program out of the Common Fund and into OD Other.

- **Office of Research Infrastructure Programs (ORIP)**
  Funding of $169.5 million is allocated for ORIP, which is $140.0 million less than the FY 2025 Enacted level.

- **Other**
  The $1,164.2 million allocated for OD components other than the Common Fund or ORIP is a net decrease of $474.8 million from the FY 2025 Enacted level. The request for OD Other includes a shift of the Gabriella Miller Kids First Pediatric Research Program

into OD Other initiatives, as mentioned above, and the termination of extramural construction grants for biomedical research facilities.

Buildings & Facilities (B&F)
The FY 2026 President's Budget provides $228.0 million for infrastructure sustainment projects associated with the B&F program, which is $152.0 million below the FY 2025 Enacted level. This amount includes $210.0 million for NIH's Buildings and Facilities appropriation, and $18.0 million within the appropriation for the National Cancer Institute (NCI) for facility repair and improvement activities at NCI's Frederick, Maryland, facility, a decrease of $12.0 million from FY 2025.

Program Evaluation Financing
The FY 2026 President's Budget provides $250.0 million for Program Evaluation Financing purposes in NIGMS, which is a $1,162.5 million decrease from the FY 2025 Enacted level. The request adjusts discretionary funding for NIGMS so that the overall reduction in NIGMS in FY 2026 is similar to the reductions for other Institutes.

OUTPUTS AND OUTCOMES

NIH plans to meet the proposed FY 2026 targets, budget permitting. If needed, adjustments will be made in accordance with HHS guidance.

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

Measure[109]	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2025 Target**	**FY 2026 Target**	**FY 2026 Target +/-FY 2025 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 2024: NCATS-led initiatives disseminated findings and best practices in navigating challenges in gene therapy through multiple public channels, including public-facing websites, publications, posters, and events at professional conferences. Target: Provide public disseminations of findings and best practices in navigating challenges in gene therapy through two public channels, such as through white papers and toolkits on regulatory approaches and novel clinical designs advanced within the National Center for Advancing Translational Sciences (NCATS)-led gene therapy programs. (Target Exceeded)	Provide the scientific and technical resources needed for the development and submission of at least one Investigational New Drug application for a gene therapy product through activities supported by NCATS-enabled gene therapy clinical platform.	Support the development and submission of at least two Investigational New Drug applications for different gene therapy products through activities supported by NCATS-enabled clinical platforms.	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	FY 2024: The PE-CGS Network enrolled 636 participants and sequenced 358 tumors. Target: Enroll an additional 500 participants and sequence an additional 200 tumors lacking sufficient clinical and molecular data.	Enroll an additional 800 participants and sequence an additional 400 tumors lacking sufficient clinical and molecular data.	Enroll an additional 600 participants and sequence an additional 400 tumors lacking sufficient clinical and molecular data.	N/A

[109] The measures' unique identifiers are aligned with the current NIH organizational structure and will be revised following the reorganization proposed in the FY 2026 President's Budget, including the four Institutes and Centers proposed for elimination in the Budget.

Measure[109]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
enrolling 2,400 participants in the Participant Engagement and Cancer Genome Sequencing (PE-CGS) Network and sequencing 1,400 tumors from the enrolled patients. (Output)	(Target Exceeded)			
SR-NIAAA-001 Advance treatment of alcohol misuse in underage populations by conducting research to inform, develop, refine, or evaluate intervention strategies. (Output)	FY 2024: A clinical trial is ongoing to evaluate the effectiveness of a computer-facilitated alcohol screening and brief intervention to reduce binge drinking among at-risk adolescents, delivered by pediatric primary care clinicians during well-visits. Target: Continue a clinical trial to evaluate the effectiveness of screening and brief intervention in primary care for reducing alcohol misuse among underage populations. (Target Met)	Conduct research to develop and evaluate the effectiveness of mobile and telehealth interventions to address alcohol misuse in underage populations.	Develop and/or evaluate an alcohol treatment intervention to reduce underage alcohol use and associated consequences among populations in greatest need.	N/A
SR-NIAAA-002 By 2025, identify neurobehavioral precursors or consequences of adolescent substance use or other childhood experiences. (Outcome)	FY 2024: NIH-supported researchers are validating a neurobiological model for the identification of risk for alcohol misuse in trauma-exposed youth. Target: Examine the neurobiological mechanisms that underlie the relationship between childhood trauma and increased risk of alcohol misuse during adolescence and adulthood. (Target Met)	Conduct research to identify or characterize neurobiological mechanisms underlying the relationship between sleep and adolescent alcohol misuse.	N/A	N/A
SR-NIAAA-003 By 2025, advance one to two new or repurposed compounds that act on neurobiological targets	FY 2024: NIH is supporting a phase two clinical trial to evaluate administration of oxytocin (a brain hormone associated with	Evaluate a repurposed candidate compound that acts on a neurobiological	N/A	N/A

Measure[109]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
that may have the potential for treating alcohol or other substance use disorders. (Outcome)	positive social behaviors and human interactions) in combination with an integrated psychotherapy intervention for the treatment of co-occurring alcohol use disorder and posttraumatic stress disorder in U.S. military veterans. Target: Conduct a clinical study to evaluate a candidate compound for the treatment of alcohol use disorder in individuals with a co-occurring mental health condition. (Target Met)	target for the treatment of alcohol use disorder in a preclinical and/or clinical study.		
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 2024: Researchers evaluated the feasibility, acceptability, and efficacy of a social media intervention to reduce alcohol use among young adults. Target: Develop and/or evaluate a preventive intervention to address alcohol use in underage populations. (Target Met)	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 misuse and its consequences in underage populations.	Develop and/or evaluate an intervention to prevent or reduce alcohol misuse during major developmental transitions in underage individuals.	N/A
SR-NIAID-001 By 2026, advance research toward the development of 10 antiviral drug candidates. (Outcome)	FY 2024: NIH-funded researchers advanced the clinical development of three antiviral therapeutic candidates. Target: Advance preclinical or clinical development of two antiviral therapeutics. (Target Exceeded)	Advance preclinical or clinical development of one antiviral therapeutic.	Advance preclinical or clinical development of one antiviral therapeutic.	N/A
SR-NIAID-002 Advance research on the	FY 2024:	Refine two of the models that best	Use the two models to understand	N/A

Measure[109]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
prevention and treatment of sexually transmitted infections, including HIV, by developing model systems to understand host-pathogen interactions (how pathogens infect hosts, evade immune responses, replicate, and cause disease). (Outcome)	NIH-supported researchers identified and used three experimental models to better understand host-pathogen interactions for further development and/or evaluation. Target: Identify three experimental models to understand host-pathogen interactions for further development and/or evaluation. (Target Met)	mimic aspects of disease found in humans.	aspects of the host-pathogen interaction and the underlying disease.	
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 2024: Six broadly protective candidate vaccine products that show protection against multiple influenza viruses were discovered. Target: Discover four new influenza vaccine candidates or delivery approaches that show protection against multiple influenza viruses. (Target Exceeded)	Evaluate the four new influenza vaccine candidates or delivery approaches in either preclinical or clinical models.	Discover three additional influenza vaccine candidates or delivery approaches that show protection against multiple influenza viruses.	N/A
SR-NIBIB-001 By 2026, establish a formalized funding pathway for the development, validation, and regulatory review of diagnostic technologies. (Outcome)	FY 2024: NIH supported the development of six at-home multiplex tests for COVID-19 and flu, one lab-based diagnostic for mpox disease that received FDA emergency use authorization, and one point-of-care test for hepatitis C that received traditional FDA authorization. NIH engagement with test manufacturers resulted in new features added to existing tests to be more accessible to people with disabilities. Target: Receive FDA authorization or approval	Submit for FDA authorization or approval two home, point-of-care, or lab-based diagnostics, at least one of which detects multiple pathogens.	Receive FDA authorization or approval for one home, point-of-care, or lab-based diagnostics which detects multiple pathogens.	N/A

Measure[109]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
	(including updated authorization or approval) for at least two home, point-of-care, or lab-based diagnostics, at least one of which is more accessible to people with disabilities. (Target Exceeded)			
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 United States. (Output and Outcome)	FY 2024: NIH launched a research program that supports the development of new platforms and organoid culture systems to provide scientists a better way to study the female reproductive tract in the laboratory. Target: Launch a research program to develop techniques or technologies to model the female reproductive tract (healthy and disease states) and gonadal function. (Target Met)	Identify in animal, tissue, or other model systems a new approach to the diagnosis or prevention of endometriosis.	Identify an additional new approach to improve the diagnosis, prevention, and/or treatment of endometriosis.	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 2024: NIH established the IMPROVE Maternal Health Research Centers of Excellence to support collaborative partnerships between scientists and the community to conduct research to reduce preventable causes of maternal deaths and improve health for women before, during, and after pregnancy. Two additional centers of excellence were created, beyond what was initially planned, in communities with high burdens of severe pregnancy-related problems and deaths. Target: Establish the Implementing a Maternal Health and Pregnancy Outcomes Vision for Everyone (IMPROVE) Centers of Excellence to design	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.	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.	N/A

Measure[109]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
	and implement research projects to address a wide range of factors that affect pregnancy-related complications and deaths. (Target Exceeded)			
SR-NIDA-001 By 2026, evaluate the efficacy of new or refined interventions to treat opioid use disorders (OUD). (Output)	FY 2024: Researchers conducted a phase one clinical trial of an anti-oxycodone vaccine and early results are promising. In a second study, researchers obtained an Investigational New Drug application and are expected to launch a phase one clinical trial in FY 2025 of an anti-heroin vaccine for the treatment of heroin use disorder. Target: Conduct phase one clinical trials of at least two anti-opioid vaccines. (Target Not Met but Improved)	File one New Drug Application with the FDA for a new treatment for OUD.	Conduct a multisite clinical trial of a medication to treat OUD.	N/A
SR-NIDA-002 By 2027, advance research on prevention interventions for substance use disorders (SUD). (Output)	FY 2024: Researchers conducted preliminary epidemiological research in a population with high rates of substance use and in need of tailored prevention interventions. Target: Launch preliminary epidemiological research studies to inform pilot studies that will develop novel strategies to prevent substance use among youth and young adults. (Target Not Met but Improved)	Continue preliminary epidemiological research to inform a pilot study that will develop novel strategies to prevent substance use among youth and young adults.	Launch a pilot research study, informed by epidemiological research, to develop and test prevention interventions for 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	FY 2024: Dissemination activities, including creation of an online portal, collaboration on a special issue publication, and the first Dissemination Advisory Group	Begin data analysis for clinical research studies and begin sharing data collected as part of these studies via the	Continue data analysis and data sharing activities, and begin dissemination activities to share	N/A

Measure[109]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
outcomes of drug use and identify strategies to address barriers to implementing these services, through research studies and community engagement. (Outcome)	meeting, are in progress and will continue into FY 2025. Target: Initiate steps of the dissemination and publication plan to ensure that findings from the clinical research studies will reach a broad audience. (Target Met)	Helping to End Addiction Long-term (HEAL) Initiative® Data Ecosystem, a cloud-based platform for sharing and analyzing data collected through the HEAL Initiative®.	research findings with the research community and other interest groups.	
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 2024: The research team engaged in several pilot trial preparatory activities that informed the design of the study; however, the trial is delayed and now expected to launch in FY 2025. Target: Launch a third pilot trial to test the feasibility, acceptability, and preliminary effectiveness of an intervention to link individuals taking MOUDs to recovery community centers. (Target Not Met)	Publicly report early results of the pilot studies and disseminate recovery research tools to other researchers via the Helping to End Addiction Long-term (HEAL) Initiative® data ecosystem.	Publicly report final, peer-reviewed results of the pilot studies.	N/A
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 2024: NIH initiated a clinical trial testing one new treatment for a disorder affecting balance. Target: Initiate testing one new treatment for a disorder affecting balance. (Target Met)	Initiate testing one new treatment for a disorder affecting speech.	N/A	N/A
SR-NIDCD-002 Support research to improve accessible and affordable hearing health care. (Output)	FY 2024: NIH initiated a new project that explores barriers and incentives for adults seeking hearing health care. Target: Initiate one new project that explores and/or addresses barriers and incentives for adults	Initiate one new project that seeks ways to predict, improve, and/or measure hearing health care outcomes.	Initiate one new project to investigate how to improve delivery of care for people with hearing loss.	N/A

Measure[109]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
	seeking hearing health care. (Target Met)			
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 2024: NIH established interdisciplinary research collaborations within NIH to leverage the resources of its Early Detection Research Network. Target: Begin establishing interdisciplinary research collaborations with the National Cancer Institute's Early Detection Research Network. (Target Met)	Identify samples of head and neck cancer in high-risk populations.	Demonstrate progress on the development of novel tools to identify and validate molecular biomarkers for early detection.	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 2024: NIH supported the development of clinical and practice-based research curricula and patient-oriented research opportunities through inter-institutional and intra-institutional collaborations in 10 dental schools. Target: Support the development of clinical and practice-based research curricula, as well as patient-oriented research opportunities through inter-institutional and intra-institutional collaborations, in 10 dental schools. (Target Met)	Implement 10 practice-based pilot or small-scale studies through NIH-supported programs that include both dental school faculty and students as investigators.	Complete data analysis of 10 practice-based pilot or small-scale studies.	N/A
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 2024: Twenty-six CAMEO study sites have initiated enrollment, and the IBD Genetics Consortium has enrolled about 3,000 people with IBD. Target: Initiate enrollment at 20 pediatric sites for the Clinical, Imaging, and Endoscopic Outcomes of Children Newly	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	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	N/A

Measure[109]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
	Diagnosed with Crohn's Disease (CAMEO) study; and enroll 1,600 participants who have IBD into the IBD Genetics Consortium. (Target Exceeded)	participants into the IBD Genetics Consortium.	other biomarker/predictor) associated with IBD or IBD treatment outcomes from the IBD Genetics Consortium.	
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 2024: Out of 4,342 investigators supported by R01 or MIRA/R35 grants, 2,742 were MIRA/R35 investigators (63 percent). This is an increase of eight percentage points from 55 percent in FY 2023. Target: Expand NIGMS investigator participation in the Maximizing Investigators' Research Award (MIRA) program by two percentage points. (Target Exceeded)	Expand NIGMS investigator participation in the Maximizing Investigators' Research Award (MIRA) program by two percentage points.	N/A	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 2024: NIH created a baseline report of implementation science initiatives focusing on AIDS research that was supported by the National Institute of Mental Health (NIMH) from FY 2021 to FY 2024. Target: Create a baseline report of implementation science initiatives focusing on AIDS research supported by NIMH from FY 2021 to FY 2024. (Target Met)	Add one new initiative to study effective interventions and strategies for improving HIV outcomes and HIV implementation outcomes for those in greatest need.	Add one new initiative to study effective interventions and strategies for improving HIV outcomes and HIV implementation outcomes for those in greatest need.	N/A
SR-NIMHD-001 By 2026, enhance understanding of how five health information technologies can be applied effectively to improve health and	FY 2024: NIH-funded investigators identified potential barriers to and enhancers for adopting new health information technology tools for use among populations	Identify barriers and enhancers to adoption of health information technologies for	Analyze studies to determine the impact of health information technologies on improving health	N/A

Measure[109]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
reduce health disparities. (Output)	who experience health disparities. Target: Identify barriers and enhancers to adoption of health information technologies, such as clinical decision aids. (Target Met)	chronic disease self-management.	and reducing health disparities.	
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)	N/A (Measure will begin reporting in FY 2025)	Complete four clinical trials evaluating the effectiveness of pain interventions that can be implemented in primary and specialty care settings.	Complete three additional clinical trials evaluating the effectiveness of pain interventions that can be implemented in primary and specialty care 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)	N/A (Measure will begin reporting in FY 2025)	Initiate one to two projects that investigate the use of community-based research methodologies to enhance community engagement in rural health research.	Initiate one to two research projects that build on existing research in clinical areas that particularly impact rural populations, such as maternal health.	N/A
SR-OSC-001 By 2027, develop a catalogue of genetic variants across multiple human tissues from a broad donor population to better understand how much genetic variation (somatic mosaicism) exists within an individual and how this variation influences human health, development, and disease. (Output)	FY 2024: NIH collected 13-18 tissues from 20 human donors. From these donors, at least 10 tissues from five human donors were sequenced. Target: Collect 10-15 tissues from 20 human donors; from these donors, sequence biospecimens from at least five tissues from five human donors. (Target Exceeded)	Collect 10-15 tissues from 40 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).	Collect 10 to 15 tissues from 40 additional human donors (100 total collected); from the pool of donors collected, sequence biospecimens from at least 10 tissues from 40 additional human donors (70 total sequenced).	N/A

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

Measure[109]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 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 earlier 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 2024: A collaborative team established the first application of the expanded N3C model to rapidly access the N3C Education Tenant and synthetic (artificial data that mimics real-world data) datasets for training; and to launch, conduct, and complete interprofessional team projects. All the teams plan to continue using N3C to advance their projects. Target: Establish the "Education Tenant" pilot as the first application of the expanded N3C model. Assess the ability of the model to support 5-10 users/groups in accessing data, conducting analyses, and exporting results; and gather feedback on end user experience. (Target Exceeded)	Demonstrate the ability of the N3C tenant model to support at least one research project in a disease priority area.	Disseminate N3C methodology to the biomedical research community to enable broader adoption of similar approaches for a broad array of diseases, including chronic diseases.	N/A
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)	N/A (Measure will begin reporting in FY 2025)	Establish a clinical protocol to enroll participants and submit it to the Institutional Review Board for approval.	Recruit individuals with CVI to participate in the CVI participant registry by partnering with at least three clinical sites and by presenting registry information at three or more conferences.	N/A
RC-NIDDK-001 Foster a robust workforce in kidney, urologic, hematologic, diabetes, obesity, and/or nutrition research by administering career development	FY 2024: The National Institute of Diabetes and Digestive and Kidney Diseases administered three career development programs that provide	Administer three career development programs.	Administer three career development programs.	N/A

Measure[109]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
programs that provide mentorship, networking, and collaboration opportunities to researchers at different career stages. (Output)	mentorship to researchers at various career stages. Target: Administer three career development programs. (Target Met)			
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 2024: 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 1,450 and 1,500.	Sustain the yearly number of undergraduate mentored research experiences between 1,450 and 1,500.	N/A
RC-NIMH-001 To advance research on brain and behavior, collect and distribute human tissue samples and associated molecular and genomic data to the scientific community. (Output)	FY 2024: Brain tissue from 47 new donors was obtained. Samples were distributed to 48 researchers. Target: Collect brain tissue from an additional 30 new donors and distribute tissue samples or data derived from tissue to 20 researchers studying mental or neurological disorders. (Target Exceeded)	Collect brain tissue from an additional 30 new donors and distribute tissue samples or data derived from tissue to 20 researchers studying mental or neurological disorders.	Collect brain tissue from an additional 35 new donors and distribute tissue samples or data derived from tissue to 25 researchers studying mental or neurological disorders.	N/A
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	N/A (Measure will begin reporting in FY 2025)	Develop and test two new tools or strategies that increase the efficiency and cost-effectiveness of the Network's clinical evaluation.	Develop metrics to monitor the Network's progress toward increasing engagement and the participation of individuals who do not typically	N/A

Measure[109]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
NIH clinical research. (Output and Outcome)			participate in NIH clinical research.	
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 2024: A program to develop innovative multimodal AI models that advance biomedical research discoveries was launched, and seven candidate projects were identified. Target: Establish a program to develop innovative multimodal AI models as a proof-of-concept for significant advances in biomedical and behavioral research and clinical care. (Target Met)	Develop three multimodal AI technologies for advancing biomedical research discoveries.	Demonstrate the feasibility of two multimodal AI technologies to generate patient-specific treatment options to advance biomedical research discoveries in a research setting.	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 2024: The NIH AIM-AHEAD Program trained 105 AI researchers and clinicians from across the nation in the use and development of AI models to advance health research. Target: Build a talent pool of researchers and clinicians to harness AI in biomedical research and medicine through training, mentorships, and professional development. (Target Met)	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.	N/A
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 2024: NIH-funded predoctoral trainees and fellows in the biomedical and behavioral sciences were 14.5 percentage points more likely to remain active in biomedical research than non-NIH trainees and fellows. Target: N ≥ 10 percent	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-	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

Measure[109]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
	(Target Exceeded)	NRSA trainees and fellows.		
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 2024: NIH-funded postdoctoral fellows were 17.8 percentage points more likely to remain active in biomedical and behavioral research than non-NIH fellows. Target: N ≥ 10 percent (Target Exceeded)	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.	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 2024: The NIH's Shared Instrumentation Grant (S10) Program awarded 156 grants in FY 2022. Of the 156 grant awards, 138 instruments (88 percent) were installed within 24 months of the Notice of Award date. Target: 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. (Target Exceeded)	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 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.	N/A

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[109]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
OS-NBS-001 Provide an integrated enterprise business solution for NIH	FY 2024: The NIH Business System (NBS) successfully transitioned	Implement Microservices Architecture to	Transition NIH to the new HHS travel system (ETSNext),	N/A

Measure[109]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
that meets the unique needs of the world's largest funder of biomedical research. (Output)	to the FedRAMP-certified Oracle Cloud Infrastructure and is in alignment with the OMB M-11-29 Federal Cloud First policy. Target: Transition the NBS portfolio to a FedRAMP-certified cloud service provider. (Target Met)	standardize, secure, and support real time integration within the NIH Business System Cloud IT portfolio.	without interrupting staff's ability to schedule official travel supporting the NIH mission.	
OS-NHGRI-001 By 2027, reach 750,000 total visits to the National Human Genome Research Institute's (NHGRI) recently revamped Talking Glossary of Genomic and Genetic Terms, a remote-learning resource to help make genomics and genetics more accessible and understandable to a wide array of audiences. (Output)	FY 2024: There were 167,301 pageviews in FY 2024, bringing the number of total visits to approximately 471,706 since the release of the revamped Talking Glossary. Target: Increase visits to NHGRI's Talking Glossary of Genomic and Genetic Terms by 100,000 to reach 250,000 total visits. (Target Exceeded)	Increase visits to NHGRI's Talking Glossary of Genomic and Genetic Terms by approximately 100,000 to reach 550,000 total visits.	Increase visits to NHGRI's Talking Glossary of Genomic and Genetic Terms by approximately 100,000 to reach 650,000 total visits.	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)	N/A (Measure will begin reporting in FY 2025)	Establish new partnerships that release one new funding mechanism (challenge, solicitation, grant, etc.) to accelerate the development of technology-based biomedical innovations.	Support up to five grants, contracts, or awards for biomedical technology innovations through partnerships.	N/A
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	FY 2024: The center was launched and a planning meeting was held to discuss and layout the future and goals, including the vision of collaborative research for long-term partnerships. Target: Fund the national center	Complete two community engagement sessions and seven scientific research consultations on partnership development and engagement	Complete four community engagement sessions and eight scientific research consultations on partnership development and engagement	N/A

Measure[109]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
(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)	and hold a planning meeting that includes the grantees (project leaders), center investigators, program staff from the National Institute of Diabetes and Digestive and Kidney Diseases, and organizational partners, to prepare for future community engagement sessions and scientific research consultations. (Target Met)	methods with community members to advance type 2 diabetes research.	methods with community members to advance type 2 diabetes research.	
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 2024: The National Institute of Neurological Disorders and Stroke (NINDS) designed and completed a quantitative and qualitative analysis of engagement with PWLE and nonprofit organizations to assess the number and types of current interactions and to identify opportunities for incorporating the perspectives of PWLE throughout the research process. Target: Design and complete a quantitative and qualitative analysis of engagement with PWLE and nonprofit organizations by NINDS to assess the number and types of current interactions and to identify opportunities for incorporating the perspectives of PWLE throughout the research process. (Target Met)	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.	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.	N/A
OS-OAR-001 By 2026, increase use of the NIH Office of AIDS Research (OAR) Data Hub, a new resource to promote	FY 2024: OAR increased features of the NIH OAR Data Hub by adding three new topical dashboards. The new dashboards include	Improve the NIH OAR Data Hub in three ways (e.g., updates or new features) informed	Increase the number of total annual visitors to the NIH OAR Data Hub by 15 percent	N/A

Measure[109]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
greater understanding of HIV research at the NIH and to enable researchers and the public to identify awards relevant to their specific interests. (Output)	HIV and Coinfections, HIV and Aging, and Longitudinal Trends. Target: Enhance features of the NIH OAR Data Hub by adding two new topical data dashboards. (Target Exceeded)	by feedback from the HIV community.	compared to FY 2024 baseline.	
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)	N/A (Measure will begin reporting in FY 2025)	Launch a new module from START to assist NIH staff with evaluation planning and conduct.	Launch a new module from START to assist NIH staff with performance monitoring or risk management.	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 2024: Use of available resources to assist Human Resources (HR) Specialists expanded posting efforts and broadened the awareness of NIH positions among veteran's groups. NIH is gathering data to determine the impact of these efforts on applicant pools. Target: Examine use of available resources to assist HR Specialists with the promotion of vacancies to veterans in an effort to increase awareness of NIH opportunities and determine the impact on the	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.	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.	N/A

Measure[109]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2025 Target	FY 2026 Target	FY 2026 Target +/-FY 2025 Target
	NIH's applicant pools. (Target Not Met but Improved)			
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 2024: Twenty five percent of Principal Investigators were reviewed, resulting in $1,586,458 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 2024: NIH's portfolio was expanded to include 33 projects. Three projects (nine percent) were completed in FY 2024 at or below the final approved project cost. The remaining 30 projects (91 percent) were not completed in FY 2024. Target: 27 Active Projects (Target Not Met but Improved)	27 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 2024: The NIH B&F project portfolio was expanded early in the fiscal year to include 33 projects due to the availability of funds. NIH managed the design and construction of 32 of the 33 funded projects within a plus or minus 10 percent adjustment to the scope. One project was placed on hold due to unavailability of funds late in the fiscal year. Target: 27 Active Projects	27 Active Projects	30 Active Projects	N/A

Measure[109]	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2025 Target**	**FY 2026 Target**	**FY 2026 Target +/-FY 2025 Target**
	(Target Met)			
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-12-12, Promoting Efficient Spending to Support Agency Operations. (Output and Efficiency)	FY 2024: The usable square footage of rentable office and warehouse space was reduced by one percent. Target: Reduce one percent of FY 2023 usable square feet. (Target Met)	Reduce the usable square feet identified in FY 2024 by one percent.	Reduce the usable square feet identified in FY 2025 by one percent.	N/A

GRANT AWARDS TABLE

	FY 2024 Final[3,a]	FY 2025 Full-Year CR[3,a,b]	FY 2026 President's Budget[3,a,b]
Number of Awards	51,510	47,061	33,193
Average Award (in Whole $s)	$622,458	$688,569	$556,077
Range of Awards (in Whole $s)[1,2]	$1,000 to $54,770,177	$1,000 to $190,000,000	$1,000 to $190,000,000

[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] Due to the usage of substantial multi-year funding in FY 2025 and FY 2026, the maximum award cost is estimated to be roughly $190 million.

BUDGET REQUEST BY IC (SUMMARY TABLE)

(Dollars in Thousands)[1]	FY 2024 Final[4]	FY 2025 Full-Year CR[4]	FY 2026 President's Budget[5]
NCI	$7,221,241	$7,221,241	$4,530,833
NIBS[2, 5]	$7,181,648	$7,104,989	$4,311,062
NINBR[5]	$4,101,692	$4,061,192	$2,444,972
NIAID	$6,561,652	$6,561,652	$4,174,965
NIGMS[3, 5]	$5,768,627	$5,768,627	$3,677,297
NIA	$4,512,090	$4,512,090	$2,686,541
NICHD[5]	$2,292,114	$2,292,114	$1,413,630
NIBIB[5]	$4,538,134	$4,497,634	$2,784,738
NINR	$197,671	$197,671	---
NIMHD	$535,138	$535,138	---
NCCIH	$170,384	$170,384	---
FIC	$95,130	$95,130	---
OD[6]	$2,832,425	$2,633,425	$1,681,062
B&F	$350,000	$350,000	$210,000
Total, NIH Program Level	**$46,357,946**	**$46,001,287**	**$27,915,100**
Special Type 1 Diabetes Research (mandatory)	-$195,753	-$119,094	-$159,000
PHS Program Evaluation	-$1,412,482	-$1,412,482	-$250,000
Total, NIH Labor/HHS Budget Authority	**$44,749,711**	**$44,469,711**	**$27,506,100**

[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 2026 Budget proposes to restructure the NIH Institutes and Centers into eight consolidated Institutes, and proposes to relocate NIEHS and NIEHS Superfund from NIH to the Administration for a Healthy America. The FY 2024 and FY 2025 figures in the table are displayed comparably and as a result show the Institutes in their reorganized structure and do not include $993.521 million for NIEHS in each of FY 2024 and FY 2025.

[6] Amounts in FY 2024 and FY 2025 reflect directive transfer of $5.0 million to the HHS Office of Inspector General.

APPROPRIATIONS ADJUSTMENT TABLES (FY 2024)

(Dollars in Thousands)	FY 2024 Enacted	Permissive Transfer (NIH Innovation Account)[3]	OIG Transfer[4]	HIV/AIDS Transfer[5]	Comparability Adjustment[6]	FY 2024 Final
NCI	$7,224,159			-$2,918		$7,221,241
NHLBI	$3,982,345			$2,813	-$3,985,158	$0
NIDCR	$520,163			-$25	-$520,138	$0
NIDDK[1]	$2,506,474			$2,377	-$2,508,851	$0
NINDS	$2,603,925	$86,000		-$4,507	-$2,685,418	$0
NIAID	$6,562,279			-$627		$6,561,652
NIGMS	$3,244,679				$2,523,948	$5,768,627
NICHD	$1,759,078			-$1,294	-$1,757,784	$0
NEI	$896,549			-$413	-$896,136	$0
NIEHS[2]	$993,693			-$172	-$993,521	$0
NIA	$4,507,623			$4,467		$4,512,090
NIAMS	$685,465			$2,174	-$687,639	$0
NIDCD	$534,333			-$3	-$534,330	$0
NIMH	$2,187,843	$86,000		$3,810	-$2,277,653	$0
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	$0
NIBIB	$440,627			-$2	-$440,625	$0
NIMHD	$534,395			$743		$535,138
NCCIH	$170,384					$170,384
NCATS	$928,323				-$928,323	$0
FIC	$95,162			-$32		$95,130
NLM	$497,548			-$2,234	-$495,314	$0
NIBS					$7,181,648	$7,181,648
NIBH					$4,538,134	$4,538,134
NINBR					$4,101,692	$4,101,692
NICWHSDC					$2,292,114	$2,292,114
OD	$3,012,514	-$172,000	-$5,000	-$3,089		$2,832,425
B&F	$350,000					$350,000
ARPA-H	$1,500,000				-$1,500,000	$0
Total, NIH Program Level	**$48,856,467**	**$0**	**-$5,000**	**$0**	**-$2,493,521**	**$46,357,946**
Less funds allocated from different sources:						
Mandatory Type 1 Diabetes Research	-$195,753					-$195,753
PHS Program Evaluation	-$1,412,482					-$1,412,482
Total, NIH Discretionary Budget Authority	**$47,248,232**	**$0**	**-$5,000**	**$0**	**-$2,493,521**	**$44,749,711**
Interior Budget Authority	-$79,714				$79,714	$0
Total, NIH Labor/HHS Budget Authority	**$47,168,518**	**$0**	**-$5,000**	**$0**	**-$2,413,807**	**$44,749,711**

[1]Includes Type 1 Diabetes.

[2]Includes Interior appropriation for Superfund Research activities as shown later in the table.

[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 2026 Budget proposes to restructure NIH into eight directly appropriated institutes, proposes to relocate NIEHS and NIEHS Superfund from NIH to the Administration for a Healthy America, and proposes to relocate ARPA-H from NIH to the Assistant Secretary for a Healthy Future.

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	$0
NIDCR	$520,163			-$25	-$520,138	$0
NIDDK[1]	$2,429,815			$2,377	-$2,432,192	$0
NINDS	$2,603,925	$45,500		-$4,507	-$2,644,918	$0
NIAID	$6,562,279			-$627		$6,561,652
NIGMS	$3,244,679				$2,523,948	$5,768,627
NICHD	$1,759,078			-$1,294	-$1,757,784	$0
NEI	$896,549			-$413	-$896,136	$0
NIEHS[2]	$993,693			-$172	-$993,521	$0
NIA	$4,507,623			$4,467		$4,512,090
NIAMS	$685,465			$2,174	-$687,639	$0
NIDCD	$534,333			-$3	-$534,330	$0
NIMH	$2,187,843	$45,500		$3,810	-$2,237,153	$0
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	$0
NIBIB	$440,627			-$2	-$440,625	$0
NIMHD	$534,395			$743		$535,138
NCCIH	$170,384					$170,384
NCATS	$928,323				-$928,323	$0
FIC	$95,162			-$32		$95,130
NLM	$497,548			-$2,234	-$495,314	$0
NIBS					$7,104,989	$7,104,989
NIBH					$4,497,634	$4,497,634
NINBR					$4,061,192	$4,061,192
NICWHSDC					$2,292,114	$2,292,114
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	$0
Total, NIH Program Level	**$48,499,808**	**$0**	**-$5,000**	**$0**	**-$2,493,521**	**$46,001,287**
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**	**-$2,493,521**	**$44,469,711**
Interior Budget Authority	-$79,714				$79,714	$0
Total, NIH Labor/HHS Budget Authority	**$46,888,518**	**$0**	**-$5,000**	**$0**	**-$2,413,807**	**$44,469,711**

[1]Includes Type 1 Diabetes.

[2]Includes Interior appropriation for Superfund Research activities as shown later in the table.

[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 2026 Budget proposes to restructure NIH into eight directly appropriated institutes, proposes to relocate NIEHS and NIEHS Superfund from NIH to the Administration for a Healthy America, and proposes to relocate ARPA-H from NIH to the Assistant Secretary for a Healthy Future.

BUDGET MECHANISM TABLE

(Dollars in Thousands)[1,2,3,4]	FY 2024 Final[8]		FY 2025 Full-Year CR[8]		FY 2026 President's Budget		FY 2026 +/- FY 2025 Full-Year CR	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Research Projects:								
Noncompeting	30,336	$18,500,707	30,331	$19,277,742	22,183	$10,652,175	-8,148	-$8,625,567
Administrative Supplements[3]	*(3,409)*	457,458	*(1,836)*	279,001	*(109)*	12,624	*(-1,727)*	-266,377
Competing	10,086	$6,030,356	6,095	$5,907,445	4,312	$3,719,278	-1,783	-$2,188,167
Subtotal, RPGs	40,422	$24,988,521	36,426	$25,464,188	26,495	$14,384,077	-9,931	-$11,080,111
SBIR/STTR	1,721	1,232,605	1,643	1,219,395	983	728,775	-660	-490,620
Research Project Grants	42,143	$26,221,126	38,069	$26,683,583	27,478	$15,112,853	-10,591	-$11,570,731
Research Centers:								
Specialized/Comprehensive	997	$2,179,873	1,001	$2,161,532	755	$1,301,978	-246	-$859,554
Clinical Research	36	252,427	22	198,722	13	72,913	-9	-125,809
Biotechnology	38	65,279	31	40,387	17	20,584	-14	-19,803
Comparative Medicine	46	129,188	49	131,213	32	88,844	-17	-42,368
Research Centers in Minority Institutions	21	79,321	22	80,215	0	0	-22	-80,215
Research Centers	1,138	$2,706,087	1,125	$2,612,069	817	$1,484,319	-308	-$1,127,750
Other Research:								
Research Careers	5,024	$930,380	4,780	$900,532	3,035	$569,108	-1745	-$331,424
Cancer Education	83	23,601	75	21,391	43	12,180	-32	-9,211
Cooperative Clinical Research	248	439,328	261	466,617	198	381,448	-63	-85,169
Biomedical Research Support	154	112,827	134	103,999	27	15,111	-107	-88,888
Other Biomedical Research Support	83	33,890	30	17,530	24	8,666	-6	-8,864
Other	2,637	1,595,561	2,587	1,599,007	1,571	874,167	-1,016	-724,840
Other Research	8,229	$3,135,587	7,867	$3,109,077	4,898	$1,860,681	-2,969	-$1,248,396
Total Research Grants	51,510	$32,062,801	47,061	$32,404,729	33,193	$18,457,853	-13,868	-$13,946,876
Ruth L Kirchstein Training Awards:	FTTPs		FTTPs		FTTPs		FTTPs	
Individual Awards	3,936	$198,312	3,962	$200,864	2,415	$123,177	-1,547	-$77,687
Institutional Awards	13,034	780,612	13,385	812,867	8,263	531,293	-5,122	-281,574
Total Research Training	16,970	$978,924	17,347	$1,013,730	10,678	$654,470	-6,669	-$359,261
Research & Development Contracts	2,857	$3,742,850	2,532	$3,128,497	1,677	$2,027,602	-855	-$1,100,895
(SBIR/STTR) (non-add)[3]	*(109)*	*(81,851)*	*(85)*	*(72,250)*	*(44)*	*(35,197)*	*(-41)*	*(-37,054)*
Intramural Research		$4,924,989		$4,942,933		$3,625,439		-$1,317,494
Research Management & Support		2,429,454		2,492,469		1,757,570		-734,898
SBIR Admin (non-add)[3]		*(13,635)*		*(13,226)*		*(8,471)*		*(-4,755)*
Office of the Director - Appropriation[3,5]		*(2,832,425)*		*(2,633,425)*		*(1,681,062)*		*(-952,363)*
Office of the Director - Other		1,838,929		1,638,929		1,164,166		-474,763
ORIP (non-add)[3,5]		*(308,495)*		*(309,495)*		*(169,495)*		*(-140,000)*
Common Fund (non-add)[3,5]		*(685,001)*		*(685,001)*		*(347,401)*		*(-337,600)*
Buildings and Facilities[6]		380,000		380,000		228,000		-152,000
Appropriation[3]		*(350,000)*		*(350,000)*		*(210,000)*		*(-140,000)*
Type 1 Diabetes[7]		-195,753		-119,094		-159,000		-39,906
Program Evaluation Financing[7]		-1,412,482		-1,412,482		-250,000		1,162,482
Subtotal, Labor/HHS Budget Authority		**$44,749,711**		**$44,469,711**		**$27,506,100**		**-$16,963,611**
Interior Appropriation for Superfund Research		0		0		0		0
Total, NIH Discretionary Budget Authority		**$44,749,711**		**$44,469,711**		**$27,506,100**		**-$16,963,611**
Type 1 Diabetes		195,753		119,094		159,000		39,906
Total, NIH Budget Authority		**$44,945,464**		**$44,588,805**		**$27,665,100**		**-$16,923,705**
Program Evaluation Financing		1,412,482		1,412,482		250,000		-1,162,482
Total, Program Level		**$46,357,946**		**$46,001,287**		**$27,915,100**		**-$18,086,187**

See footnotes on 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 and excludes supplemental-related financing.

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

4 The FY 2026 Budget proposes to relocate NIEHS and NIEHS Superfund from NIH to the Administration for a Healthy America (AHA). Funding levels in this table are displayed comparably and as a result do not include $993.521 million in each of FY 2024 and FY 2025 for these programs. For information on these programs, please see the AHA 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 such 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 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 Reduced by a transfer of $5.0 million from OD to the HHS Office of Inspector General.

BUDGET AUTHORITY BY OBJECT CLASS INCLUDING TYPE 1 DIABETES

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

(Dollars in Thousands)

Object Classes	FY 2025 CR	FY 2026 President's Budget	FY 2026 +/- FY 2025
Personnel Compensation			
Full-Time Permanent (11.1)	$1,432,673	$1,122,120	-$310,553
Other Than Full-Time Permanent (11.3)	$680,455	$587,655	-$92,800
Other Personnel Compensation (11.5)	$87,974	$74,619	-$13,355
Military Personnel (11.7)	$18,142	$15,988	-$2,154
Special Personnel Services Payments (11.8)	$255,441	$220,243	-$35,198
Subtotal, Personnel Compensation (11.9)	**$2,474,685**	**$2,020,626**	**-$454,059**
Civilian Personnel Benefits (12.1)	$822,368	$708,695	-$113,673
Military Personnel Benefits (12.2)	$3,842	$3,189	-$653
Benefits to Former Personnel (13.0)	$41,895	$34,646	-$7,248
Total Pay Costs	**$3,342,790**	**$2,767,156**	**-$575,634**
Travel & Transportation of Persons (21.0)	$49,770	$31,297	-$18,473
Transportation of Things (22.0)	$7,064	$4,389	-$2,676
Rental Payments to GSA (23.1)	$30,350	$9,848	-$20,502
Rental Payments to Others (23.2)	$623	$498	-$126
Communications, Utilities & Misc. Charges (23.3)	$11,146	$5,836	-$5,310
Printing & Reproduction (24.0)	$192	$157	-$35
Consultant Services (25.1)	$1,425,583	$997,025	-$428,558
Other Services (25.2)	$1,283,987	$827,353	-$456,633
Purchase of Goods and Services from Government Accounts (25.3)	$3,365,213	$2,244,793	-$1,120,420
Operation & Maintenance of Facilities (25.4)	$53,557	$37,904	-$15,653
R&D Contracts (25.5)	$1,519,688	$963,055	-$556,633
Medical Care (25.6)	$37,178	$27,382	-$9,796
Operation & Maintenance of Equipment (25.7)	$283,751	$170,904	-$112,847
Subsistence & Support of Persons (25.8)	$0	$0	$0
Subtotal Other Contractual Services (25.0)	**$7,968,957**	**$5,268,416**	**-$2,700,541**
Supplies & Materials (26.0)	$222,060	$148,882	-$73,178
Equipment (31.0)	$166,990	$114,727	-$52,263
Land and Structures (32.0)	$270,812	$128,696	-$142,116
Investments & Loans (33.0)	$0	$0	$0
Grants, Subsidies & Contributions (41.0)	$32,473,412	$19,141,018	-$13,332,394
Insurance Claims & Indemnities (42.0)	$420	$0	-$420
Interest & Dividends (43.0)	$629	$591	-$38
Refunds (44.0)	$0	$0	$0
Financial Transfers (94.0)	$43,590	$43,590	$0
Subtotal Non-Pay Costs	**$41,246,015**	**$24,897,944**	**-$16,348,071**
Total Budget Authority	**$44,588,805**	**$27,665,100**	**-$16,923,705**

[1] Excludes supplemental appropriations and program evaluation financing.

[2] The FY 2026 Budget proposes to relocate NIEHS and the NIEHS Superfund program from NIH to the Administration for a Healthy America and proposes to relocate ARPA-H from NIH to the Assistant Secretary for a Healthy Future. Funding levels in this table are displayed comparably and as a result exclude NIEHS and ARPA-H.

BUDGET AUTHORITY BY OBJECT CLASS INCLUDING SSF AND MF

Budget Authority by Object Class NIH Wide Including Service and Supply Fund and Management Fund[1, 2, 3]
(Dollars in Thousands)

Object Classes	FY 2025 CR	FY 2026 President's Budget	FY 2026 +/- FY 2025
Personnel Compensation			
Full-Time Permanent (11.1)	$1,917,852	$1,606,601	-$311,252
Other Than Full-Time Permanent (11.3)	$732,327	$636,543	-$95,784
Other Personnel Compensation (11.5)	$138,813	$119,942	-$18,871
Military Personnel (11.7)	$28,515	$25,097	-$3,418
Special Personnel Services Payments (11.8)	$265,091	$226,363	-$38,728
Subtotal, Personnel Compensation (11.9)	**$3,082,598**	**$2,614,545**	**-$468,053**
Civilian Personnel Benefits (12.1)	$1,052,308	$934,623	-$117,685
Military Personnel Benefits (12.2)	$5,297	$3,945	-$1,352
Benefits to Former Personnel (13.0)	$43,199	$36,001	-$7,197
Total Pay Costs	**$4,183,403**	**$3,589,115**	**-$594,287**
Travel & Transportation of Persons (21.0)	$54,011	$34,215	-$19,796
Transportation of Things (22.0)	$12,840	$8,027	-$4,813
Rental Payments to GSA (23.1)	$117,666	$75,510	-$42,156
Rental Payments to Others (23.2)	$11,130	$8,399	-$2,731
Communications, Utilities & Misc. Charges (23.3)	$153,528	$133,367	-$20,162
Printing & Reproduction (24.0)	$204	$167	-$37
Consultant Services (25.1)	$630,986	$210,066	-$420,920
Other Services (25.2)	$2,505,742	$1,733,480	-$772,262
Purchase of Goods and Services from Government Accounts (25.3)	$1,067,891	$495,722	-$572,169
Operation & Maintenance of Facilities (25.4)	$189,948	$148,391	-$41,557
R&D Contracts (25.5)	$1,522,488	$964,474	-$558,015
Medical Care (25.6)	$64,161	$52,795	-$11,366
Operation & Maintenance of Equipment (25.7)	$575,184	$384,439	-$190,745
Subsistence & Support of Persons (25.8)	$0	$0	$0
Subtotal Other Contractual Services (25.0)	**$6,556,400**	**$3,989,367**	**-$2,567,034**
Supplies & Materials (26.0)	$411,610	$298,471	-$113,139
Equipment (31.0)	$213,513	$143,717	-$69,796
Land and Structures (32.0)	$346,249	$191,872	-$154,377
Investments & Loans (33.0)	$0	$0	$0
Grants, Subsidies & Contributions (41.0)	$32,483,522	$19,148,621	-$13,334,901
Insurance Claims & Indemnities (42.0)	$420	$0	-$420
Interest & Dividends (43.0)	$718	$662	-$57
Refunds (44.0)	$0	$0	$0
Financial Transfers (94.0)	$43,590	$43,590	$0
Subtotal Non-Pay Costs	**$40,405,402**	**$24,075,985**	**-$16,329,418**
Total Budget Authority	**$44,588,805**	**$27,665,100**	**-$16,923,705**

[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 2026 Budget proposes to relocate NIEHS and the NIEHS Superfund program from NIH to the Administration for a Healthy America and proposes to relocate ARPA-H from NIH to the Assistant Secretary for a Healthy Future. Funding levels in this table are displayed comparably and as a result exclude NIEHS and ARPA-H.

DETAIL OF FULL-TIME EQUIVALENT EMPLOYMENT (FTE)

Institutes and Centers	FY 2024 Actual[4]	FY 2025 Estimate[4]	FY 2026 Estimate[4, 5]
NCI	3,298	3,167	2,660
NIBS[4]	1,947	1,911	1,604
NINBR[4]	1,216	1,211	988
NIAID	2,134	2,069	1,731
NIGMS[4]	1,625	1,681	1,403
NIA	656	675	513
NICWHSDC[4]	737	731	629
NIBH[4]	1,274	1,279	1,022
NINR	87	69	---
NIMHD	103	107	---
NCCIH	102	98	---
FIC	55	52	---
OD	1,202	1,202	1,006
Central Services:			
OD - CS	934	936	666
CC	1,805	1,890	1,955
CSR	473	498	760
CIT	200	200	190
ORS	482	472	431
ORF	759	783	739
Subtotal Central Services[1]	**4,653**	**4,779**	**4,741**
PHS Trust Fund (non-add)[2]	*4*	*4*	*4*
CRADA (non-add)[3]	*1*	*1*	*1*
Total	**19,089**	**19,031**	**16,297**

[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 2026 Budget proposes to restructure the NIH Institutes and Centers into eight consolidated Institutes, and proposes to relocate NIEHS from NIH to the Administration for a Healthy America. The FY 2024 and FY 2025 figures in the table are displayed comparably and as a result show the Institutes in their reorganized structure and do not include 642 FTE in FY 2024 and 613 FTE in FY 2025 for NIEHS.

[5] FY 2026 FTE levels reflect estimates and are subject to change.

PROGRAMS PROPOSED FOR ELIMINATION

Programs Proposed for Elimination in the FY 2026 Budget

(dollars in millions)

Program	Description	FY 2025 Enacted	Rationale
National Institute of Nursing Research (NINR)	Supports nursing research, training, and other programs in patient care research under section 301 and title IV of the Public Health Service (PHS) Act.	$197.693	The Budget proposes to reform NIH and focus NIH research activities, in line with the President's commitment to Making America Healthy Again.
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.	$534.395	The Budget proposes to reform NIH and focus NIH research activities, in line with the President's commitment to Making 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 Budget proposes to reform NIH and focus NIH research activities, in line with the President's commitment to Making 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 Budget proposes to reform NIH and focus NIH research activities, in line with the President's commitment to Making America Healthy Again.
Office of the Director, Extramural Construction Grants for Biomedical Research Facilities	Provide 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.

PHYSICIAN'S COMPARABILITY ALLOWANCE WORKSHEET

		FY 2023 Actual	FY 2024 Actual	FY 2025 Estimate[1]	FY 2026 Estimate
1) Number of Physicians Receiving PCAs		91	89	83	83
2) Number of Physicians with One-Year PCA		3	3	3	3
3) Number of Physicians with Multi-Year PCA		88	86	80	80
4) Average Annual Physician Pay (without PCA payment)		$179,325	$188,042	$187,415	$187,415
5) Average Annual PCA Payment		$22,918	$22,659	$25,515	$25,643
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position				
	Category II Research Position	91	89	87	87
	Category III Occupational Health				
	Category IV-A Disability Evaluation				
	Category IV-B Health and Medical Admin.	0	0	0	0

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 nation.

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 2024, there were a total of 89 PCA recipients across NIH. In FY 2025 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 2025 data will be approved during the FY 2026 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 2014	$15,568,553	$5,908,275	72.5%	27.5%	4.4%	2.7%
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 Final[1,a,B]	$23,780,360	$9,261,365	72.0%	28.0%	-1.6%	-3.6%
FY 2025 Enacted[1,a,B]	$24,052,104	$9,366,355	72.0%	28.0%	1.1%	1.1%
FY 2026 President's Budget[1,a,b,B]	$17,123,419	$1,988,903	89.6%	10.4%	-28.8%	-78.8%

Notes: 1) Data for FY 2025 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 2024 include NIEHS. The figures for 2024 through 2026 do not include NIEHS, for comparability with the proposed reorganization of NIEHS from NIH to the Administration for a Healthy America. The 2024 -- 2026 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 2026 Budget reflects the policy to limit indirect costs of grant awards to 15 percent. 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 2016	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 Final[1,a,A]	FY 2025 Enacted[1,a,A]	FY 2026 President's Budget[1,a,A]
No. of Awards:											
Competing	10,364	10,123	11,116	11,020	11,373	11,258	11,333	11,106	10,086	6,095	4,312
Noncompeting	23,528	24,638	25,780	27,624	28,366	28,492	29,423	30,177	30,336	30,331	22,183
Subtotal	33,892	34,761	36,896	38,644	39,739	39,750	40,756	41,283	40,422	36,426	26,494
SBIR/STTR	1,689	1,807	2,034	2,023	1,832	1,863	1,840	1,893	1,721	1,643	983
Total	**35,581**	**36,568**	**38,930**	**40,667**	**41,571**	**41,613**	**42,596**	**43,176**	**42,143**	**38,069**	**27,477**
Average Annual Cost:											
Competing RPGs	$484	$522	$527	$573	$559	$599	$588	$611	$598	$969	$863
Total RPGs[X]	502	523	546	552	571	583	594	613	618	699	543
Percent Change in Average Cost from Prior Year[Y]											
Competing RPGs	7.2%	7.8%	1.0%	8.7%	-2.4%	7.2%	-1.8%	3.8%	-2.1%	62.1%	-11.0%
Total RPGs[X]	4.8%	4.0%	4.4%	1.1%	3.5%	2.1%	2.0%	3.1%	0.9%	13.1%	-22.3%
Average Length of Award in Years[Z]	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.7**	**3.4**	**3.4**

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, Administrative Supplements, T1D, and OD awards.

[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 2024 include NIEHS. The figures for 2024 through 2026 do not include NIEHS, for comparability with the proposed reorganization of NIEHS from NIH to the Administration for a Healthy America. The 2024 -- 2026 figures are not directly comparable to previous years.

RPGs – SUCCESS RATES

INSTITUTES & CENTERS[+,1,2]	FY 2017 Final[5]	FY 2018 Final[5]	FY 2019 Final[5]	FY 2020 Final[5]	FY 2021 Final[5]	FY 2022 Final[5,a]	FY 2023 Final[5,a]	FY 2024 Final[5,a,A]	FY 2025 Enacted[5,a,b,A]	FY 2026 President's Budget[5,a,b,A]
NCI	11.7%	11.3%	11.9%	12.9%	13.8%	15.4%	16.1%	13.4%	6.8%	8.3%
NHLBI	23.5%	25.1%	22.3%	22.2%	20.5%	21.3%	21.1%	19.7%	11.9%	
NIDCR	17.8%	22.2%	23.8%	21.7%	21.8%	21.0%	22.0%	19.1%	10.1%	
NIDDK	17.8%	21.6%	20.3%	24.4%	22.7%	22.1%	22.9%	21.5%	10.5%	
NINDS	17.7%	22.4%	20.4%	23.7%	20.2%	22.1%	21.6%	16.3%	7.1%	
NIAID	19.1%	22.9%	22.1%	23.9%	17.5%	17.3%	20.8%	18.3%	13.4%	7.1%
NIGMS	30.6%	29.2%	32.6%	32.3%	33.4%	35.8%	36.3%	31.5%	16.7%	
NICHD	16.1%	18.4%	19.5%	18.0%	18.4%	17.3%	18.8%	18.9%	11.3%	
NEI	24.9%	26.7%	28.4%	29.6%	24.8%	25.6%	26.2%	26.7%	12.3%	
NIEHS[A]	15.0%	17.1%	14.8%	14.2%	14.4%	16.7%	15.1%			
NIA	26.6%	28.9%	29.2%	25.8%	24.2%	25.3%	24.0%	18.0%	6.0%	3.7%
NIAMS	17.0%	16.7%	17.1%	18.0%	17.6%	18.4%	17.8%	18.0%	9.5%	
NIDCD	24.4%	27.1%	25.2%	24.2%	24.0%	25.0%	26.9%	25.0%	13.3%	
NIMH	20.9%	22.2%	24.8%	22.5%	22.1%	24.3%	22.4%	20.7%	13.7%	
NIDA	19.7%	19.4%	17.5%	16.9%	14.7%	19.4%	22.1%	19.3%	11.0%	
NIAAA	22.0%	26.7%	20.9%	21.4%	17.1%	27.1%	30.5%	22.6%	13.5%	
NINR	8.9%	10.3%	9.3%	10.8%	12.6%	15.4%	16.9%	15.7%	16.7%	
NHGRI	23.9%	28.0%	19.2%	21.8%	24.7%	25.1%	22.0%	19.6%	7.6%	
NIBIB	13.0%	16.8%	18.3%	19.8%	17.2%	21.5%	17.7%	16.1%	14.9%	
NIMHD	21.5%	10.7%	7.5%	7.9%	11.2%	17.2%	18.8%	13.5%	8.2%	
NCCIH	16.7%	20.3%	12.5%	11.6%	11.1%	14.8%	14.4%	16.0%	6.5%	
NCATS	21.8%	36.4%	20.7%	25.2%	14.7%	20.4%	26.8%	14.2%	10.0%	
FIC	10.8%	19.5%	20.6%	19.7%	13.8%	20.9%	22.3%	19.8%	10.4%	
NLM	14.9%	17.7%	18.4%	13.4%	11.9%	15.3%	14.8%	13.1%	8.1%	
ORIP	16.5%	17.8%	34.2%	29.6%	25.9%	27.1%	34.0%	34.0%	21.3%	6.4%
Common Fund	11.8%	10.9%	11.0%	9.5%	8.8%	11.8%	14.6%	7.2%	6.8%	15.7%
NIH[A]	**18.7%**	**20.3%**	**20.1%**	**20.7%**	**19.1%**	**20.8%**	**21.4%**	**18.5%**	**10.3%**	**N/A**
NIBS[4]								20.1%	11.0%	7.2%
NINBR[4]								18.6%	8.2%	4.8%
NIGMS, New[4]								25.6%	14.8%	7.3%
NICWHSDC[4]								20.2%	11.8%	11.1%
NIBH[4]								20.4%	12.7%	9.5%
NIH[A]	**18.7%**	**20.3%**	**20.1%**	**20.7%**	**19.1%**	**20.8%**	**21.4%**	**18.5%**	**10.3%**	**7.3%**

[+] Success Rates identified in FY 2025 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 2026.

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

[b] Success Rates are lower due to the shift to upfront funding for Competing RPGs as of FY 2025 and a decline in program level in FY 2026.

[A] Figures for the years before FY 2024 include NIEHS. The figures for 2024 through 2026 do not include NIEHS, for comparability with the proposed reorganization of NIEHS from NIH to the Administration for a Healthy America. The 2024 -- 2026 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,B]	FY 2021 Actual[5]	FY 2022 Actual[5,a]	FY 2023 Actual[5,a]	FY 2024 Final[5,a,B]	FY 2025 Enacted[5,a,A,B]	FY 2026 President's Budget[5,a,A,B]
Applications						
Received	37,987	36,198	35,072	36,985	40,801	41,160
Funded	**7,647**	**7,832**	**7,629**	**7,013**	**4,265**	**3,036**
Total Investigators						
Received	33,856	33,177	32,547	34,550	38,554	39,338
Funded	**9,503**	**9,828**	**9,702**	**9,046**	**5,574**	**4,018**
Established Investigators						
Received	20,777	20,492	20,454	21,638	24,252	24,851
Funded	**6,715**	**6,948**	**6,888**	**6,420**	**3,959**	**2,856**
First-time Investigators						
Received	13,079	12,685	12,093	12,912	14,302	14,487
Funded	**2,788**	**2,880**	**2,814**	**2,626**	**1,615**	**1,162**

[1] R01 Equivalent Grants form a subset of all RPG awards. In FY 2024 they comprised roughly 70% of Funded Applications, 73% of Funded Total Investigators, 78% of Funded Established Investigators and 62% 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 reflect the annual estimate identified in the New/Competing RPG line of mechanism budget table.

[5] Includes 21st Century Cures Act funding.

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

[A] Figures are not adjusted for any possible change in paylines for First-time vs Established Investigators. For the purpose of this exhibit, it is assumed that the number of Applicants and Applications are not affected by the changes in the Success Rate in fiscal years 2025 and 2026.

[B] Figures for the years before FY 2024 include NIEHS. The figures for 2024 through 2026 do not include NIEHS, for comparability with the proposed reorganization of NIEHS from NIH to the Administration for a Healthy America. The 2024 -- 2026 figures are not directly comparable to previous years.

MF GENERAL STATEMENT

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. 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 [1,2]

(Dollars in Thousands)

	FY 2024 Final		FY 2025 Full-Year CR		FY 2026 President's Budget		FY 2026 +/- FY 2025 Full-Year CR	
Activity	FTE	Amount	FTE	Amount	FTE	Amount	FTE	Amount
Clinical Center	1,805	$721,578	1,890	$738,537	1,955	$701,610	65	-$36,927
Center for Scientific Review, SREA	473	$159,410	498	$163,155	760	$154,997	262	-$8,158
Office of Research Services, and Administrative services, support		$1,294		$0		$0		$0
TOTAL	**2,278**	**$882,282**	**2,388**	**$901,692**	**2,715**	**$856,608**	**327**	**-$45,085**

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

[2] Royalties are excluded for all years.

MF BUDGET AUTHORITY BY OBJECT CLASS

Budget Authority by Object Class [1]

(Dollars in Thousands)

		FY 2025 Full-Year CR	FY 2026 President's Budget	FY 2026 +/- FY 2025
Total compensable workyears:				
	Full-time equivalent	2,388	2,715	327
	Full-time equivalent of overtime and holiday hours	0	0	0
	Average ES salary	$223	$223	$0
	Average GM/GS grade	11.7	11.8	0.1
	Average GM/GS salary	$122	$122	$0
	Average salary, Commissioned Corps (42 U.S.C. 207)	$120	$124	4
	Average salary of ungraded positions	$153	$153	$0
	OBJECT CLASSES	**FY 2025 CR**	**FY 2026 President's Budget**	**FY 2026 +/- FY 2025**
	Personnel Compensation			
11.1	Full-Time Permanent	$241,230	$277,741	$36,511
11.3	Other Than Full-Time Permanent	$42,511	$40,954	-$1,557
11.5	Other Personnel Compensation	$31,051	$28,553	-$2,498
11.7	Military Personnel	$6,920	$6,183	-$737
11.8	Special Personnel Services Payments	$8,644	$5,267	-$3,377
11.9	**Subtotal Personnel Compensation**	**$330,356**	**$358,699**	**$28,343**
12.1	Civilian Personnel Benefits	$111,790	$125,800	$14,010
12.2	Military Personnel Benefits	$989	$361	-$628
13.0	Benefits to Former Personnel	$0	$250	$250
	Subtotal Pay Costs	**$443,135**	**$485,110**	**$41,975**
21.0	Travel & Transportation of Persons	$2,938	$1,938	-$1,000
22.0	Transportation of Things	$924	$874	-$50
23.1	Rental Payments to GSA	$0	$0	$0
23.2	Rental Payments to Others	$4	$4	$0
23.3	Communications, Utilities & Misc. Charges	$2,234	$2,138	-$96
24.0	Printing & Reproduction	$4	$4	$0
25.1	Consulting Services	$19,126	$25,496	$6,370
25.2	Other Services	$112,421	$71,907	-$40,513
25.3	Purchase of Goods and Services from Government Accounts	$82,817	$71,255	-$11,561
25.4	Operation & Maintenance of Facilities	$4,741	$4,486	-$254
25.5	R&D Contracts	$887	$780	-$107
25.6	Medical Care	$25,120	$24,012	-$1,108
25.7	Operation & Maintenance of Equipment	$52,176	$40,413	-$11,762
25.8	Subsistence & Support of Persons	$0	$0	$0
25.0	**Subtotal Other Contractual Services**	**$297,287**	**$238,351**	**-$58,936**
26.0	Supplies & Materials	$133,257	$107,257	-$26,000
31.0	Equipment	$19,673	$18,799	-$874
32.0	Land and Structures	$2,219	$2,116	-$103
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	$18	$17	-$1
44.0	Refunds	$0	$0	$0
94.0	Financial Transfers	$0	$0	$0
	Subtotal Non-Pay Costs	**$458,558**	**$371,498**	**-$87,060**
	Total Budget Authority by Object Class	**$901,692**	**$856,608**	**-$45,085**

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

MF DETAIL OF POSITIONS

Management Fund

Detail of Positions

GRADE	FY 2024 Final	FY 2025 CR	FY 2026 President's Budget
Total, ES Positions	2	2	2
Total, ES Salary	$437,138	$445,881	$445,881
GM/GS-15	127	132	184
GM/GS-14	363	376	508
GM/GS-13	364	400	438
GS-12	553	580	609
GS-11	370	390	414
GS-10	35	37	38
GS-9	86	90	107
GS-8	69	73	75
GS-7	153	159	174
GS-6	41	43	44
GS-5	8	8	9
GS-4	5	5	5
GS-3	7	7	8
GS-2	3	3	3
GS-1	0	0	0
Subtotal	2,184	2,303	2,616
Commissioned Corps (42 U.S.C. 207)			
Assistant Surgeon General	0	0	0
Director Grade	8	8	8
Senior Grade	8	8	10
Full Grade	12	12	12
Senior Assistant Grade	9	9	9
Assistant Grade	1	1	1
Junior Assistant Grade	0	0	0
Subtotal	38	38	40
Ungraded	212	216	216
Total permanent positions	2,196	2,315	2,628
Total positions, end of year	2,436	2,559	2,874
Total full-time equivalent (FTE) employment, end of year	2,278	2,388	2,715
Average ES salary	218,569	222,941	222,941
Average GM/GS grade	11.7	11.7	11.8
Average GM/GS salary	119,786	122,182	122,182

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 2024 Final		FY 2025 Full-Year CR		FY 2026 President's Budget		FY 2026 +/- FY 2025 Full-Year CR	
Activity	FTE	Amount	FTE	Amount	FTE	Amount	FTE	Amount
Research Support and Administrative, OD, CC-CIF	1,416	$1,626,348	1,408	$1,662,127	1,097	$1,163,489	-311	-$498,638
Office of Research Facilities, Development & Operations	759	$615,932	783	$629,482	739	$455,829	-44	-$173,653
Center for Information Technology	200	$513,474	200	$524,771	190	$498,532	-10	-$26,239
TOTAL	**2,375**	**$2,755,754**	**2,391**	**$2,816,380**	**2,026**	**$2,117,850**	**-365**	**-$698,530**

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

SSF BUDGET AUTHORITY BY OBJECT CLASS

Budget Authority by Object Class [1]

(Dollars in Thousands)

		FY 2025 Full-Year CR	FY 2026 President's Budget	FY 2026 +/- FY 2025
Total compensable workyears:				
	Full-time equivalent	2,391	2,026	-365
	Full-time equivalent of overtime and holiday hours	65	65	0
	Average ES salary	$226	$226	0
	Average GM/GS grade	12.2	12.2	0
	Average GM/GS salary	$132	$132	0
	Average salary, Commissioned Corps (42 U.S.C. 207)	$131	$136	4,986
	Average salary of ungraded positions	$92	$92	0
	OBJECT CLASSES	**FY 2025 CR**	**FY 2026 President's Budget**	**FY 2026 +/- FY 2025**
	Personnel Compensation			
11.1	Full-Time Permanent	$243,950	$206,739	-$37,210
11.3	Other Than Full-Time Permanent	$9,361	$7,933	-$1,428
11.5	Other Personnel Compensation	$19,788	$16,770	-$3,018
11.7	Military Personnel	$3,453	$2,926	-$527
11.8	Special Personnel Services Payments	$1,006	$853	-$153
11.9	**Subtotal Personnel Compensation**	**$277,557**	**$235,221**	**-$42,336**
12.1	Civilian Personnel Benefits	$118,150	$100,129	-$18,022
12.2	Military Personnel Benefits	$466	$395	-$71
13.0	Benefits to Former Personnel	$1,304	$1,105	-$199
	Subtotal Pay Costs	**$397,478**	**$336,850**	**-$60,628**
21.0	Travel & Transportation of Persons	$1,303	$980	-$323
22.0	Transportation of Things	$4,852	$2,765	-$2,088
23.1	Rental Payments to GSA	$87,316	$65,662	-$21,654
23.2	Rental Payments to Others	$10,502	$7,898	-$2,605
23.3	Communications, Utilities & Misc. Charges	$140,149	$125,392	-$14,757
24.0	Printing & Reproduction	$8	$6	-$2
25.1	Consulting Services	$87,970	$44,153	-$43,817
25.2	Other Services	$1,109,335	$834,220	-$275,115
25.3	Purchase of Goods and Services from Government Accounts	$436,242	$297,524	-$138,718
25.4	Operation & Maintenance of Facilities	$131,650	$106,001	-$25,649
25.5	R&D Contracts	$1,913	$639	-$1,274
25.6	Medical Care	$1,863	$1,401	-$462
25.7	Operation & Maintenance of Equipment	$239,257	$173,121	-$66,136
25.8	Subsistence & Support of Persons	$0	$0	$0
25.0	**Subtotal Other Contractual Services**	**$2,008,229**	**$1,457,058**	**-$551,170**
26.0	Supplies & Materials	$56,293	$42,333	-$13,961
31.0	Equipment	$26,850	$10,191	-$16,659
32.0	Land and Structures	$73,218	$61,060	-$12,158
33.0	Investments & Loans	$0	$0	$0
41.0	Grants, Subsidies & Contributions	$10,110	$7,603	-$2,507
42.0	Insurance Claims & Indemnities	$0	$0	$0
43.0	Interest & Dividends	$71	$54	-$18
44.0	Refunds	$0	$0	$0
94.0	Financial Transfers	$0	$0	$0
	Subtotal Non-Pay Costs	**$2,418,902**	**$1,781,001**	**-$637,902**
	Total Budget Authority by Object Class	**$2,816,380**	**$2,117,850**	**-$698,530**

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

SSF DETAIL OF POSITIONS

Service and Supply Fund

Detail of Positions

GRADE	FY 2024 Final	FY 2025 CR	FY 2026 President's Budget
Total, ES Positions	6	9	9
Total, ES Salary	$1,331,400	$2,037,042	$2,037,042
GM/GS-15	120	107	102
GM/GS-14	407	383	327
GM/GS-13	808	789	644
GS-12	384	357	304
GS-11	130	138	123
GS-10	9	11	11
GS-9	105	102	85
GS-8	48	48	42
GS-7	96	95	84
GS-6	6	6	5
GS-5	5	6	5
GS-4	11	8	7
GS-3	7	5	5
GS-2	11	7	5
GS-1	8	8	7
Subtotal	2,155	2,070	1,756
Commissioned Corps (42 U.S.C. 207)			
Assistant Surgeon General	0	0	0
Director Grade	4	4	4
Senior Grade	6	6	6
Full Grade	7	7	7
Senior Assistant Grade	0	0	0
Assistant Grade	0	0	0
Junior Assistant Grade	0	0	0
Subtotal	17	17	17
Ungraded	328	335	322
Total permanent positions	2,446	2,386	2,078
Total positions, end of year	2,506	2,431	2,104
Total full-time equivalent (FTE) employment, end of year	2,375	2,391	2,026
Average ES salary	221,900	226,338	226,338
Average GM/GS grade	12.2	12.2	12.2
Average GM/GS salary	129,035	131,616	131,616

LEGISLATIVE PROPOSALS

Mandatory Legislative Proposals

Reauthorization of the Special Statutory Funding Program for Type 1 Diabetes Research. Codified in Section 330B of the PHS Act, this Program began in FY 1998 with a funding level of $30.0 million per year over 5 years. In December 2000, the Program was renewed to increase the FY 2001 and 2002 levels to $100.0 million and to extend the FY 2003 level at $100.0 million of mandatory funds. In December 2002, the Program was extended and increased to $150.0 million per year for FY 2004-2008. The Program has subsequently been extended multiple times at this annual level of $150.0 million. For FY 2024 and FY 2025, the Program was extended in P.L. 118-15, P.L. 118-22, P.L. 118-35, P.L 118-42, P.L. 118-158, and P.L. 119-4 for a combined total funding of $314.8 million over those two years. No funding is provided after FY 2025 under current law.

The FY 2026 President's Budget proposal would reauthorize the NIH Special Diabetes Program for Type 1 Diabetes Research at an annual amount of $159.0 million for FY 2026. The reauthorization would help facilitate planning of research projects and enable the continuation of the program's unique, extraordinarily collaborative, and scientifically comprehensive research strategy to prevent, treat, and cure type 1 diabetes. The reauthorized funding level would restore some of the lost purchasing power of the program after remaining flat for 20 years prior to a 5 percent increase in FY 2024-2025.

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COMMON FUND

CONGRESSIONAL JUSTIFICATION
FY 2026

Department of Health and Human Services
National Institutes of Health

National Institutes of Health
Office of Strategic Coordination – The Common Fund

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL INSTITUTES OF HEALTH

NIH Common Fund (CF)

FY 2026 Budget Table of Contents

General Note

1. FY 2025 Enacted levels cited in this document reflect the FY 2025 full-year continuing resolution (Public Law 119-4).
2. Detail in this document may not sum to the subtotals and totals due to rounding.

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SUMMARY

The Common Fund (CF) is a funding entity within NIH managed by the Office of Strategic Coordination in the NIH Office of the Director, in partnership with NIH Institutes. It supports bold scientific programs that catalyze discovery across all biomedical and behavioral research. These programs create a space where investigators and multiple NIH Institutes collaborate on innovative research expected to address high-priority challenges for the NIH as a whole and make a broader impact in the scientific community.

In order to enhance the basic and applied research that has been a hallmark of the American innovation enterprise and the envy of the world, the CF supports research in areas of emerging scientific opportunities, public health challenges, and knowledge gaps that deserve special emphasis; that would benefit from strategic coordination and planning across NIH Institutes; and that are designed to achieve specific, high-impact goals and milestones within a 5- to 10-year timeframe. As a general framework, CF programs are grouped into three categories – transformational science and discovery; catalytic data resources; and re-engineering the research enterprise.

The FY 2026 budget request for NIH Common Fund is $347.4 million.

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 2026 President's Budget request for the Common Fund, which is $347.4 million, a decrease of $337.6 million or 49.3 percent compared with the FY 2025 Enacted level.

Research Project Grants (RPGs) (-$115.8 million; total $257.6 million):
The Common Fund expects to support a total of 245 RPG awards in FY 2026, 64 RPGs fewer than in FY 2025. Estimated awards for FY 2026 include 104 noncompeting RPGs and 141 competing RPGs. FY 2026 commitments were adjusted to reflect the policy which limits indirect costs for research grants to 15 percent of direct costs, and a general reduction was made to reflect plans for funding noncompeting awards at a level less than the fully committed level. Noncompeting commitments within the Somatic Cell Genome Editing (SCGE) program, the Human BioMolecular Atlas Program (HuBMAP), Harnessing Data Science for Health, Discovery, and Innovation in Africa (DS-I Africa), the Cellular Senescence Network (SenNet), and Transforming Research to Address Health Disparities (THD) received the final year of funding in FY 2025. The FY 2026 Common Fund request will continue the FY 2025 NIH policy of allocating half of the budget for competing RPGs for awards that fully fund their outyear commitments as part of the initial grant award.

Research Centers (-$60.7 million; total $16.1 million):
The Common Fund expects to support a total of 6 Research Centers in FY 2026, 24 awards fewer than in FY 2025. FY 2026 commitments were adjusted to reflect the proposed limit on indirect costs and a general reduction was made to reflect plans for funding noncompeting awards at a level less than the fully committed level. Centers within DS-I Africa, HuBMAP, SenNet, Bridge to Artificial Intelligence (B2AI), and Acute to Chronic Pain (A2CPS) received their final year of funding in FY 2025.

Other Research (-$148.7 million; total $50.1 million):
The Common Fund expects to support a total of 44 Other Research awards in FY 2026, 106 awards less than in FY 2025. The FY 2026 commitments do not include the Nutrition for Precision Health (NPH) program, where the plan is to fund those commitments in FY 2025. FY 2026 commitments were adjusted to reflect the continued limit on indirect costs and a general reduction to reflect plans for funding noncompeting awards at a level less than the fully committed level. Other Research Grants within the Kids First, HubMap, SenNet, DS-I Africa, the Molecular Transducers of Physical Activity Consortium (MoTrPAC), and the Transformative High-Resolution Cryoelectron Microscopy (CryoEM) Program received the final year of funding in FY 2025.

BUDGET MECHANISM TABLE

NATIONAL INSTITUTES OF HEALTH

Common Fund

(Dollars in Thousands)

Mechanism	FY 2024 Final		FY 2025 Full-Year CR		FY 2026 President's Budget		FY 2026 +/- FY 2025	
	Number	Amount	Number	Amount	Number	Amount	Number	Amount
Research Projects:								
Noncompeting	276	$256,595	235	$244,667	104	$80,879	-131	-$163,788
Administrative Supplements	*(14)*	$1,900	*(47)*	$6,365	*(0)*	$0	*-(47)*	-$6,365
Competing:								
Renewal	0	$0	0	$0	0	$0	0	$0
New	85	$89,763	74	$122,383	141	$176,766	67	$54,383
Supplements	0	$0	0	$0	0	$0	0	$0
Subtotal, Competing	85	$89,763	74	$122,383	141	$176,766	67	$54,383
Subtotal, RPGs	361	$348,258	309	$373,415	245	$257,646	-64	-$115,769
SBIR/STTR	0	$0	0	$0	0	$0	0	$0
Research Project Grants	361	$348,258	309	$373,415	245	$257,646	-64	-$115,769
Research Centers:								
Specialized/Comprehensive	56	$143,130	30	$76,919	6	$16,182	-24	-$60,737
Clinical Research	0	$0	0	$0	0	$0	0	$0
Biotechnology	2	$12,567	0	$0	0	$0	0	$0
Comparative Medicine	0	$0	0	$0	0	$0	0	$0
Res. Centers in Minority Instit.	0	$0	0	$0	0	$0	0	$0
Research Centers	58	$155,698	30	$76,919	6	$16,182	-24	-$60,737
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	$17,372	6	$17,059	0	$0	-6	-$17,059
Biomedical Research Support	0	$0	0	$0	0	$0	0	$0
Other Biomed. Res. Support	0	$0	0	$0	0	$0	0	$0
Other	93	$117,774	144	$181,752	44	$50,107	-100	-$131,645
Other Research:	99	$135,146	150	$198,811	44	$50,107	-106	-$148,704
Total Research Grants	518	$639,102	489	$649,145	295	$323,934	-194	-$325,211
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	5	$15,394	1	$1,026	1	$753	0	-$273
SBIR/STTR (non-add)	*(0)*	*($0)*	*(0)*	*($0)*	*(0)*	*($0)*	*(0)*	*($0)*
Intramural Research	0	$371	0	$383	0	$0	0	-$383
Res. Management & Support	0	$30,135	0	$34,447	0	$22,714	0	-$11,733
SBIR Admin. (non-add)		*($0)*		*($0)*		*($0)*		*($0)*
Office of the Director - Appropriation								
Office of the Director - Other		$0		$0		$0		$0
Common Fund (non-add)		*($0)*		*($0)*		*($0)*		*($0)*
ORIP (non-add)		*($0)*		*($0)*		*($0)*		*($0)*
Buildings and Facilities		$0		$0		$0		$0
Appropriation		*($0)*		*($0)*		*($0)*		*($0)*
Type 1 Diabetes		$0		$0		$0		$0
Program Evaluation Financing		$0		$0		$0		$0
Subtotal, Labor/HHS Budget Authority		**$685,001**		**$685,001**		**$347,401**		**-$337,600**
Interior Appropriation for Superfund Res.		$0		$0		$0		$0
Total, NIH Discretionary B.A.		**$685,001**		**$685,001**		**$347,401**		**-$337,600**
Type 1 Diabetes		$0		$0		$0		$0
Total, NIH Budget Authority		**$685,001**		**$685,001**		**$347,401**		**-$337,600**
Program Evaluation Financing		$0		$0		$0		$0
Total, Program Level		**$685,001**		**$685,001**		**$347,401**		**-$337,600**

BUDGET BY INITIATIVE

National Institutes of Health
Common Fund by Program
(Dollars in Thousands)

Common Fund Program	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget
4D Nucleome	$28,085	$245	$29
Acute to Chronic Pain Signatures	3,402	3,625	276
Bridge to Artificial Intelligence (Bridge2AI)	8,186	56,163	110
Cellular Senescence Network (SenNET)	42,501	38,850	256
Common Fund Data Ecosystem	18,325	27,526	9,433
CARE for Health™	0	17,000	18,250
Community Partnerships to Advance Science for Society (ComPASS) Program	17,681	10,354	6,816
Complement-Animal Research in Experimentation (Complement-ARIE)	0	0	39,928
Enhancing the Diversity of the NIH-Funded Workforce	120	0	0
Extracellular RNA Communication	113	0	0
Faculty Institutional Recruitment for Sustainable Transformation (FIRST)	70,860	841	0
Gabriella Miller Kids First Pediatric Research[1]	12,982	12,890	0
Harnessing Data Science for Health Discovery and Innovation in Africa (DSI-Africa)	16,354	16,748	0
High-Risk Research	200,884	228,456	155,403
NIH Director's Pioneer Award	*43,347*	*48,183*	*33,458*
NIH Director's New Innovator Award Program	*89,649*	*100,515*	*69,402*
Transformative Research Award	*42,822*	*48,350*	*31,166*
NIH Director's Early Independence Award Program	*25,066*	*31,407*	*21,377*
Human BioMolecular Atlas Project (HuBMAP)	34,563	18,275	256
Human Virome Program (HVP)	8,065	32,259	31,874
Illuminating the Druggable Genome	390	0	0
Molecular Transducers of Physical Activity	15,661	13,658	1,015
Nutrition for Precision Health	42,442	77,754	8,180
Somatic Cell Genome Editing	46,127	47,429	30,012
Somatic Mosaicism across Human Tissues (SMaHT)	25,911	30,927	22,227
S.P.A.R.C. - Stimulating Peripheral Activity to Relieve Conditions	39,340	463	256
Transformative High Resolution Cryo-Electron Microscopy (CryoEM)	3,938	4,055	73
Transformative Research to Address Health Disparities	15,974	10,190	2,250
Venture Program	9,865	14,996	4,011
Strategic Planning, Evaluation, and Infrastructure	23,234	22,300	16,746
Subtotal Common Fund	685,001	685,001	347,401
New Initiatives in Common Fund	0	0	0
Total Common Fund	$685,001	$685,001	$347,401

[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.

NIH Common Fund

Budget Authority (BA):

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY 2026 +/- FY 2025
BA	$685,001,000	$685,001,000	$347,401,000	-$337,600,000
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 2026 President's Budget request for the Common Fund is $347.4 million, a decrease of $337.6 million or 49.3 percent compared with the FY 2025 Enacted level. This funding level will support high priority activities within existing programs and support the launch of exciting new activities, as described below.

Program Descriptions and Accomplishments

The Common Fund (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.

Funding for several CF programs completed in FY 2025, including 4D Nucleome,[110] Human Biomolecular Atlas Program,[111] Stimulating Peripheral Activity to Relieve Conditions,[112] and Transformative High Resolution Cryo-Electron Microscopy.[113] The FY 2026 Common Fund request will focus on sustaining continuing programs and launching a new program, Complement Animal Research in Experimentation),[114] as described below.

Highlighted below are programs that exemplify the high priority science to be supported in FY 2026 and/or which are undergoing significant programmatic changes in FY 2026, such as a ramp down or change in scope.

[110] commonfund.nih.gov/4Dnucleome
[111] commonfund.nih.gov/HuBMAP
[112] commonfund.nih.gov/sparc
[113] commonfund.nih.gov/CryoEM
[114] Commonfund.nih.gov/complementarie

Acute to Chronic Pain Signatures (A2CPS)

Chronic pain affects over 100 million people in the United States alone. Acute pain from an injury, surgery, or disease can persist throughout life and become a chronic condition. Treatments remain ineffective for these devastating conditions, in large part because the underlying causes that lead to chronic pain are not well understood. Prevention of chronic pain is a major challenge in pain management.[115] 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. The A2CPS study reached over 2,500 MRIs as of April 2025, making it approximately the ninth largest human imaging study to date and likely the largest dataset of MRI imaging scans collected specifically to investigate pain. Using these data, the A2CPS team will look for differences observed between people who transition from acute to chronic pain and those who do not, which could reveal biomarkers associated with this change. The findings from this study could help accelerate therapy development, guide pain prevention strategies, and lead to better, more individualized treatments for patients. Additionally, A2CPS developed a new model for pain score variability that accurately classifies chronic pain. In FY 2026, A2CPS will end study recruitment and complete data generation efforts and decrease data integration and resource support. The A2CPS Consortium will continue to analyze data through FY 2026 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.[116] The program is generating flagship, AI-ready biomedical and behavioral data sets to support the development of AI/ML models to improve our health. The program includes voice and other data to identify abnormal changes in the body to help diagnose or screen for diseases, and multimodal data to uncover biological processes underlying recovery from illness. These flagship datasets also include data to improve decision-making in critical care settings and to improve our understanding of complex genetic pathways in cell functions. Taken as a whole, the program covers an array of health conditions, including respiratory disorders (e.g., sleep apnea), pediatric voice and speech disorders, mental health conditions, neurological disorders (e.g., Parkinson's Disease) and Type 2 Diabetes. Leveraging AI/ML models with these new data AI-ready sets will help researchers to learn more about these health conditions, develop better prevention methodologies, and advance treatment options with the aim to help people suffering from these conditions and improve their overall health. To support these new data, B2AI is developing and disseminating software, standards, tools, and other resources to the broader biomedical research community, as well as creating training materials and activities for skills and workforce development. Additionally, the program is advancing best practices for biomedical AI and machine learning analysis. In FY 2024, an initial set of AI-ready data was publicly released to the research community to encourage feedback and to facilitate future research. Another major achievement is a public portal to learn more about the program.[117] FY 2026 will represent the final year of funding for the first stage of the program. Funds requested in FY 2026 will support program closeout.

[115] commonfund.nih.gov/pain
[116] commonfund.nih.gov/bridge2ai
[117] bridge2ai.org

Cellular Senescence Network (SenNET)

As we age, tissues throughout the body accumulate small numbers of specialized cells, called senescent cells, that no longer divide but remain active and develop specialized characteristics that are different from other non-dividing cells. As they accumulate in the body, these cells can release molecules that can either damage or promote tissue growth. 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.[118] To date, SenNet has generated over 1000 datasets representing 15 human organs. SenNet researchers have published several tools for detecting senescent cells and have identified a collection of biomarkers that define subtypes of senescent cells. SenNet research has demonstrated that during aging, senescent cells accumulate in the skin, which may lead to senescence in other organs. This impairs muscle function and brain health. This discovery supports the concept that senescent cells in the skin could drive broader, systemic aging which could help explain the link between skin conditions and cognitive decline. Such discoveries may offer new pathways to maintain a healthy mind and body as we age. Funds requested in FY 2026 will support program closeout.

Complement Animal Research in Experimentation (Complement-ARIE)

Complement-ARIE aims to increase the speed of the development, standardization, validation, and use of human-based New Approach Methodologies (NAMs).[119] 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 technologies have been able to model human biology in new ways, such as creating a “digital twin” which virtually represents human biological systems through data modeling to explore disease pathways, and “organ-on-chip" technology that replicates human organ systems within a microchip to test the effect of different medications or substances. Advances in NAMs technologies, validation, and qualification will 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. Funds requested in FY 2026 will support the launch of this new program, including 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 Research (HRHR)

The HRHR program supports creative scientists proposing innovative and transformative 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.[120] These awards intend to support transformative research that is inherently difficult and scientifically risky, but necessary to accelerate the pace of scientific discovery and advance human health. HRHR funded researchers have tested new ways to treat gut inflammation using therapeutic bacteria that is safer than currently used oral treatments. Gut

[118] commonfund.nih.gov/senescence
[119] commonfund.nih.gov/complementarie
[120] commonfund.nih.gov/highrisk

inflammation is linked to several human diseases including but not limited to chronic conditions like inflammatory bowel disease. Safely controlling inflammation could result in more symptom-free days for individuals with gastrointestinal disorders, and this technology may also lead to advancements to treat other diseases including cancer. HRHR research is also exploring a new way of treating Type 2 Diabetes by targeting brain circuits that control glucose metabolism. The study will test whether transplanting specific types of nerve cells can adjust brain signaling to achieve sustained diabetes remission. This new treatment could help millions of Americans to live healthier lives. Funds requested in FY 2026 will be used to support additional innovative projects with the potential for exceptional impact in biomedical research.

Human Virome Program

Viruses are the most abundant and diverse biological entities on earth. While most people are aware of the small number of viruses that are known to cause disease, there are also trillions of viruses that live in the human body without causing overt disease. Despite recent technological advances, significant challenges remain that have hindered exploration of these largely understudied viruses that make up the "healthy" human virome and may greatly influence human health, including impacting common chronic diseases. The Human Virome Program aims to identify and describe members of the "healthy" human virome.[121] The program will help us understand how we acquire our virome and its roles in human development, the immune system, and our overall health. One day, contributions from the program may also include new biomarkers for identifying emergent or chronic diseases and conditions, as well as development of potential therapies. Funds requested in FY 2026 will support characterization of the healthy human virome; development of novel tools, models, and methods; exploration of virome interactions with the human host; and data coordination and consortium organization.

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

Nutrition plays an integral role in human development and in the prevention and treatment of disease. However, there is no perfect, "one size fits all" diet. The 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, genetics, environment, and the microbiome – the collection of microbes that reside in and on our bodies. These predictive algorithms will enable tailored dietary recommendations to be provided by physicians, as well as the development of tools to allow individuals to make more informed decisions about healthy food choices and improve their overall health. NPH plans to enroll 8,000 participants from various backgrounds. Recruitment for NPH studies is underway and on track to meet study targets. Researchers funded by NPH demonstrated that large-scale human mobility data, based on smart phone geolocations, could be used as a surrogate measure of fast-food intake and diet-related illness. They found that mobility data that indicated visits to fast-food establishments could be used as a predictor of obesity and diabetes. These findings indicate that the use of mobility data can provide valuable insight into diet and its impact on health and chronic disease. Funds requested in FY 2026 will support final participant enrollment, data analysis for recruited participants, and algorithm development for the *All of Us* Workbench.

[121] commonfund.nih.gov/humanvirome

Somatic Cell Genome Editing (SCGE)

The SCGE program aims to remove barriers that slow the adoption of genome editing to treat a variety of disorders. SCGE is accelerating the translation of genome editing therapies into the clinic by developing targeted delivery technologies and advancing clinical development and evaluation of novel genome editing therapeutics. It is laying the groundwork for clinical trials that assess the safety and efficacy of promising genome editing therapies to treat multiple diseases. SCGE is disseminating successful strategies for starting clinical trials through a publicly accessible platform. SCGE research has recently demonstrated the viability of novel editing therapies and molecular tools with potential to treat patients with genetic hearing loss and fatal prion diseases, for which there are currently no cure. Funds requested in FY 2026 will support assay optimization, enhance therapeutic candidates to maximize efficacy and ensure safety, and support quality control of metadata protocols.

Venture Program

The Venture Program is a new approach within the Common Fund to support bold, short-term initiatives with the potential for significant impact.[122] Venture initiatives are intended to be modest, focused investments that can be implemented quickly and deliver specific outcomes, such as new knowledge, methods, or technologies, in three years or less. This new format of support allows the Common Fund to expand its scientific portfolio of action-oriented cross-cutting research programs by creating smaller, more focused research endeavors that will catalyze the development of new technologies or approaches within a short period of time. Venture initiatives are currently enhancing early diagnosis of treatable genetic conditions in newborns and supporting the development of a data science platform allowing researchers to seamlessly perform integrated analysis of mechanisms that can be shared across different disease types. Funds requested in FY 2026 will support the development of technologies to identify biomarkers for diseases through non-invasive imaging of the eye.

Strategic Planning, Evaluation, and Infrastructure

CF management requires that certain activities be undertaken for the benefit of the CF as a whole. These include activities related to strategic planning, evaluation, and infrastructure.

Strategic planning is undertaken every year to identify new scientific challenges and opportunities that may be ready for dedicated investment via a CF program or Venture initiative. Planning 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 of strategic planning involves specific consultations with external experts, analysis of NIH and beyond 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 program management. Evaluation includes both formal and informal evaluative activities. Informal evaluation involves convening grantees and NIH-wide teams to

[122] commonfund.nih.gov/venture

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

Planning for CF programs and initiatives leverages the wide-ranging expertise of NIH senior leadership, scientific staff, and members of the public. As the 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 NIH Institute Directors; the Directors of the Division of Program Coordination, Planning, and Strategic Initiatives and the Office of Strategic Coordination; and the NIH Director.

OFFICE OF AIDS RESEARCH

CONGRESSIONAL JUSTIFICATION
FY 2026

Department of Health and Human Services
National Institutes of Health

NIH 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

FY 2026 Budget Table of Contents

General Notes

1. FY 2025 Enacted levels cited in this document reflect the FY 2025 full-year continuing resolution (Public Law 119-4) and include the effects of the FY 2025 HIV/AIDS transfer.
2. Detail in this document may not sum to the subtotals and totals due to rounding.

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SUMMARY

The Office of AIDS Research (OAR) coordinates HIV/AIDS research across the National Institutes of Health (NIH). OAR supports both basic research on HIV/AIDS and research projects testing a variety of implementation strategies to identify the most successful and cost-effective strategies to prevent, diagnose, link to care, and treat HIV.

The vision of OAR is to advance research to end the HIV pandemic and improve health outcomes for people with HIV. In the 1980s, an HIV or AIDS diagnosis was a death sentence. At the peak of the epidemic in the 1990s and early 2000s, nearly two million people were dying annually in the United States. Today, the advances in treatment and prevention have led to a decrease in U.S. HIV-related deaths to fewer than 20,000 annually.

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. NIH maintains a comprehensive research portfolio to prevent HIV transmission, maximize the impact of existing interventions, and advance efforts toward a cure.

The FY 2026 budget request for OAR is $1,910.3 million.

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 2024 Final[1] [2]	FY 2025 Full-Year CR[2]	FY 2026 President's Budget	FY 2026 +/- FY 2025
NCI	$256,734	$256,734	$103,773	-$152,961
NIBS	136,527	136,527	80,205	-56,322
NINBR	61,380	61,380	35,771	-25,609
NIAID	1,911,364	1,911,364	1,215,628	-695,736
NICWHSDC	155,143	155,143	94,824	-60,319
NIA	28,538	28,538	16,980	-11,558
NIBH	513,836	513,836	283,425	-230,411
NINR	17,375	17,375	-	-17,375
NIGMS	9,639	9,639	8,857	-782
NIMHD	24,982	24,982	-	-24,982
NCCIH	796	796	-	-796
FIC	25,919	25,919	-	-25,919
OD	146,255	146,255	70,808	-75,447
OAR	67,806	67,806	27,860	-39,946
ORIP	78,449	78,449	42,948	-35,501
Subtotal, OD	146,255	146,255	70,808	-75,447
TOTAL, NIH	**$3,288,488**	**$3,288,488**	**$1,910,271**	**-$1,378,217**

[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, 2024.

[2] For comparability, FY 2024 and FY 2025 columns reflect Institute and Center restructuring proposed in the FY 2026 President's Budget, including relocation of the National Institute for Environmental Health Sciences elsewhere in HHS.

BUDGET AUTHORITY BY MECHANISM

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

Mechanism	FY 2024 Final[3]		FY 2025 Full Year C.R.[3]		FY 2026 President's Budget		FY 2026 +/- FY 2025	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Research Projects:								
Noncompeting	1,409	$1,491,912	1,354	$1,457,106	784	$768,071	-570	-$689,035
Administrative Supplements	*143*	61,774	*58*	40,158	*8*	1,760	*-50*	-38,398
Competing	469	286,127	396	441,640	323	293,022	-73	-148,618
Subtotal, RPGs	1,878	$1,839,813	1,750	$1,938,904	1,107	$1,062,853	-643	-$876,051
SBIR/STTR	15	11,663	13	10,502	12	10,442	-1	-60
Research Project Grants	1,893	$1,851,476	1,763	$1,949,406	1,119	$1,073,295	-644	-$876,111
Research Centers:								
Specialized/Comprehensive	60	$154,060	49	$129,409	35	$76,387	-14	-$53,022
Clinical Research	0	0	0	0	0	0	0	$0
Biotechnology	0	0	0	0	0	0	0	$0
Comparative Medicine	19	68,781	19	67,486	11	40,149	-8	-$27,337
Research Centers in Minority Institutions	0	0	0	981	0	0	0	-$981
Research Centers	79	$222,841	68	$197,876	46	$116,536	-22	-$81,340
Other Research:								
Research Careers	257	$44,039	247	$42,404	156	$28,089	-91	-$14,315
Cancer Education	0	0	0	0	0	0	0	$0
Cooperative Clinical Research	19	13,043	17	9,494	9	3,756	-8	-$5,738
Biomedical Research Support	0	2,510	0	4,232	12	500	12	-$3,732
Minority Biomedical Research Support	0	0	0	0	0	0	0	$0
Other	115	55,235	114	55,014	22	20,877	-92	-$34,137
Other Research	391	$114,827	378	$111,144	199	$53,222	-179	-$57,922
Total Research Grants	2,363	$2,189,144	2,209	$2,258,426	1,364	$1,243,053	-845	-$1,015,373
Ruth L. Kirschstein Training Awards:	FTTPs		FTTPs		FTTPs		FTTPs	
Individual Awards	79	$3,921	68	$3,395	47	$2,223	-21	-$1,172
Institutional Awards	230	$15,409	216	$16,043	189	$12,420	-27	-$3,623
Total Research Training	309	$19,330	284	$19,438	236	$14,643	-48	-$4,795
Research & Develop. Contracts	82	$467,078	108	$391,988	58	$231,242	-50	-$160,746
(SBIR/STTR) (non-add)	*14*	*9,251*	*7*	*8,594*	*7*	*7,594*	*0*	-$1,000
Intramural Research		$356,408		$358,440		$253,672		-$104,768
Res. Management and Support		188,722		192,390		139,801		-$52,589
Res. Management & Support (SBIR Admin) (non-add)		*0*		*0*		*0*		*$0*
Office of the Director - Appropriation [2]		*146,255*		*146,255*		*70,808*	0	-$75,447
Office of the Director - Other		67,806		67,806		27,860	0	-$39,946
ORIP (non-add) [2]		*78,449*		*78,449*		*42,948*		*-35,501*
Total, NIH Discretionary B.A.		**$3,288,488**		**$3,288,488**		**$1,910,271**		**-$1,378,217**

[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 2026 President's Budget.

BUDGET AUTHORITY BY RESEARCH CAPACITY GOAL

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

Research Capacity Goal	FY 2024 Final[1 2]	FY 2025 Full-Year CR[1 2]	FY 2026 President's Budget	FY 2026 +/- FY 2025
Enhance Discovery and Advance HIV Science Through Fundamental Research	$1,151,520	$1,153,823	$670,556	-$483,267
Advance the Development and Assessment of Novel Intervention for HIV Prevention, Treatment, and Cure	1,622,798	1,620,049	957,142	-662,907
Optimize Public Health Impact of HIV Discoveries Through Translation, Dissemination, and Implementation of Research Findings	50,853	50,094	29,118	-20,976
Build Research Workforce and Infrastructure Capacity to Enhance Sustainability of HIV Scientific Discovery	463,317	464,522	253,455	-211,067
Total	**$3,288,488**	**$3,288,488**	**$1,910,271**	**-$1,378,217**

[1] Reflects effects of Secretary's transfer

[2] 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 2026 President's Budget.

JUSTIFICATION OF BUDGET REQUEST

Office of AIDS Research

Budget Authority (BA):

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY 2026 +/- FY 2025
BA[123]	$3,288,488,000	$3,288,488,000	$1,910,271,000	-$1,378,217,000

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

Overall Budget Policy: The FY 2026 President's Budget request for OAR is $1,910.3 million. 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

Fundamental Research—Understanding the Biological and Behavioral Underpinnings of HIV

Fundamental research seeks to expand the 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.

Understanding the HIV Capsid

The new antiviral drug, lenacapavir, is the first in a new class of HIV antiretrovirals (ARV) medications, called capsid inhibitors. Lenacapavir can be used twice a year to treat or prevent acquisition of HIV. The convenience of twice-yearly injections addresses a key practical concern for many who cannot use daily antivirals due to logistics, finances, stigma, discrimination, side-effects, or other concerns. The efficacy of lenacapavir, even when HIV has mutated to resist other antivirals, reflects the fact that it interferes with multiple steps in the HIV life cycle.

The story of lenacapavir relies on decades of NIH investment aimed at understanding the 3D structure of viral proteins and their interactions within infected cells. Indeed, it was structure-

[123] Amounts in FY 2024 and FY 2025 are comparably adjusted to remove the National Institute for Environmental Health Sciences (NIEHS).

based design studies, by NIH funded-scientists in the 1980s and 1990s that led to the development of earlier ARV medications, including reverse transcriptase, protease, and integrase inhibitors. Continued support of structural studies at NIH, followed by support of the Centers for HIV Structural Biology in the early 2000s, enabled scientists to integrate techniques from structural biology, biochemistry, and cell biology to capture in unprecedented detail the three-dimensional structures of HIV proteins and nucleic acids and their interactions with cellular components. This information helped clarify how the different components interact and revealed new approaches for disrupting those interactions.

Extensive studies demonstrated that the CA proteins arrange themselves into regular shapes made of six (hexamers) or five (pentamers) CA proteins. Approximately 250 hexamers and exactly 12 pentamers assemble to create the capsid lattice. Understanding the shape and structure of the capsid was an essential step in creating capsid inhibitors. Lenacapavir binds two of these CA protein groups creating a structural change that prevent the virus's genetic material from entering the nucleus and producing new virus particles.

Studies in the basic sciences can take years to translate to effective prevention strategies or therapies, yet the development of lenacapavir exemplifies the latest example of how basic science leads to breakthroughs that have a profound impact on global public health.

Virology and Immunology Research

A deeper understanding of HIV biology and virology is crucial to continue developing better interventions to control the HIV pandemic. To replicate, retroviruses like HIV take over a cell's ability to express genetic material. This occurs within the cell nucleus, which can only be accessed through very selective nuclear pores. Recent studies have shown that the HIV capsid—which encapsulates the HIV genetic material and shields it from anti-viral sensors in cells—serves as a nuclear transporter, passing through the nuclear pore, despite its size. Further studies suggest that the elasticity of the cone-shaped capsid enables it to squeeze through the pore, underscoring the importance of the capsid as a therapeutic target.

At first, HIV vaccine candidates aimed to produce a better immune response by stimulating T cells. Studies of people who control HIV without ART revealed that their immune systems produce broadly neutralizing antibodies (bNAbs) that can prevent HIV infection. Vaccine research now focuses on creating these bNAbs. A recent study comparing the immune cells in past HIV vaccine recipients and in people whose immune system controlled HIV with bNAbs confirmed the current opinion that an effective vaccine will need to stimulate both T cell mediated protection and bNAbs.

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. Recent NIH-funded research shows that shifts in the sugars, called glycans, that attached to antibodies not only correlate with but also cause some of the changes associated with aging. Glycans could therefore serve as biomarkers of accelerated aging to enable earlier detection of aging-related complications. Furthermore, engineering antibodies to mimic the glycan signatures in younger people could be a new therapeutic approach. Building on research conducted predominantly in men, recent studies of women with HIV showed that accelerated aging could

be detected using measures of physical function such as walking speed or balance. This suggests approaches that could address functional deficits.

Epidemiologic Research

Epidemiologic research can identify who is affected by HIV and how, and thereby help understand how HIV affects the body. For example, people with HIV have a higher overall risk of chronic disease than people without HIV, including double the risk of major adverse cardiovascular events. People who acquired HIV at or around birth experience a lifetime exposure to HIV and ART, which can lead to additional complications. Indeed, a recent study of young adults with HIV acquired around the time of birth showed that by age 30, about 1 in 5 had diabetes, 1 in 2 had high triglycerides, 1 in 4 had hypertension, and 1 in 4 had chronic kidney disease. These rates are much higher than young adults in the general population or even than people with HIV. Differences by sex were prevalent, with men having a higher incidence of chronic kidney disease. These studies suggest that people with perinatally acquired HIV might need to be screened for these chronic conditions at a younger age to better prevent or treat these chronic conditions.

Basic Behavioral and Social Sciences Research

Fundamental research also examines the behavioral, interpersonal, and social (including structural) factors, processes, dynamics, and contexts that influence and are influenced by HIV. For example, pre-exposure prophylaxis (PrEP) remains disproportionally underutilized in many communities due to factors ranging from access to stigma. Understanding the factors that influence people along the whole continuum of care is crucial for effectively implementing PrEP interventions in differing communities. Furthermore, the complexity of access to a health provider or a pharmacy often limits adherence to an ongoing PrEP regimen. This barrier can be mitigated when clinics offer extra resources, such as facilitating travel or grouping healthcare services.

Applied Research—Developing and Evaluating Interventions for Prevention, Treatment, and Cure

NIH supports preclinical and clinical research to develop and evaluate interventions for HIV prevention, treatment, and cure. Current developments include injections of continuously released ART every two or six months and anti-HIV antibody infusions. These innovations aim to simplify treatment regimens, enhance adherence, and address drug resistance, which affects about 10 percent of people on ART. New treatments under study show promise in suppressing viral replication and potentially reversing immune system weakening. In addition to long-acting prevention strategies, NIH is also exploring multipurpose prevention technologies, interventions that can prevent both HIV and other sexually transmitted infections or pregnancy and may facilitate use of preventive interventions.

Preclinical Research

HIV mutates rapidly and evades the immune response, posing challenges for development of a preventive vaccine. To prevent or control HIV, a vaccine would need to elicit the production of broadly neutralizing antibodies (bNAbs), which bind to parts of the virus that remain constant even when it mutates. Several classes of HIV-specific bNAbs have been identified, each binding to a different section of proteins on the surface of the virus. This year, NIH scientists showed that

a human bNAb called VRC34.01, which targets the fusion peptide on HIV's surface, protected monkeys from acquiring simian immunodeficiency virus—the HIV primate equivalent—in a proof-of-concept study that is informing human vaccine design. This team and other NIH-supported researchers are using a technique called germline targeting to guide new B cells—a type of immune cells—to develop into mature B cells that can produce bNAbs. Using this approach, researchers are making progress toward eliciting several classes of bNAbs in human and animal studies.

Preclinical studies are also essential to improve therapeutic and cure approaches. While ART prevents HIV from replicating, the virus remains in protected reservoirs in the brain, liver, and lymph nodes. The brain is a particularly challenging organ due to the blood-brain barrier, which hinders entry to the brain of both pathogens and treatments such as ART. Extensive studies have shown that HIV infection in the brain targets specific macrophages. Recently, NIH-funded researchers explored a new therapeutic targeting these macrophages in a primate model. They found that using small molecules that pass the blood-brain barrier and inhibit macrophages could clear HIV from the brain without causing any major toxicity. These results suggest a new strategy to augment existing ART.

Recent Clinical Findings

NIH clinical trials explore the safety and efficacy of new interventions in multiple populations, including those historically underrepresented in research, such as pregnant women. People are more likely to acquire HIV through sexual intercourse during pregnancy, highlighting the need for comprehensive and highly effective PrEP options as part of sexual and reproductive health. Recent results from an NIH-funded trial showed that women could safely start using either the monthly dapivirine vaginal ring or daily oral PrEP starting in their second trimester of pregnancy to prevent HIV transmission. This year, results of another study showed that a more recent and long-acting form of PrEP, cabotegravir—which is injected every two months—was safe and well tolerated before and during pregnancy.

For babies with perinatally acquired HIV, recent studies have shown that ART initiation immediately after birth is safe and effective at suppressing HIV. An NIH-funded group launched a clinical trial to explore whether this treatment strategy could lead to an HIV cure. Six infants born with HIV were treated with ART within 48 hours of birth. The results were announced last year: When ART was interrupted at age 5, 4 of the 6 children remained without detectable HIV for over 48 weeks. These findings suggest that early ART initiation could be a viable option for treating newborns with HIV. Further studies will explore the differences underlying the varying effectiveness of early treatment.

NIH also collaborates with academic and industry scientists to develop and evaluate new interventions. For example, after discovering the capsid's role in the HIV life cycle, NIH and its grantees collaborated with Gilead Science, Inc., which developed lenacapavir. Gilead launched two multi-country trials, which showed that lenacapavir prevents HIV acquisition in men and women. Continuing the partnership, the NIH's HIV Prevention Trials Network is implementing two Gilead-sponsored trials of lenacapavir for PrEP in women and in people who inject drugs in the United States. Ongoing research will continue to inform future drug development and clinical research. NIH-funded scientists are conducting research to investigate lenacapavir activity in the

body, understand resistance to capsid inhibitors, and develop a method for analyzing lenacapavir drug levels.

NIH clinical research studies examine and address complications and comorbidities associated with HIV. HIV increases the risk of a type of liver disease that independently increases the risk of cardiovascular disease and death. An NIH-supported trial recently showed that semaglutide, a medication approved for treating type 2 diabetes, reduced the severity of liver disease in people with HIV. These promising early results suggest that semaglutide could improve quality of life and decrease mortality for people with liver disease and HIV.

NIH is implementing clinical research models that better address the needs of the community. For example, noninferiority trials—trials that assess whether a new intervention is as good as an existing one—and choice trials—where participants experience different interventions, then choose their favorite—are particularly useful for assessing interventions with varying access, usability, or convenience. These new clinical trial models facilitate the evaluation of interventions in practical, real-world contexts while preserving scientific and ethical standards. For instance, an NIH-supported noninferiority study recently showed that, compared to standard quarterly HIV testing and PrEP prescription, a six-month prescription for PrEP and home-based HIV self-testing prevented HIV acquisition and reduced clinic visits by half without affecting HIV testing, retention, or adherence. These findings indicate that less frequent contact, which may not be as burdensome to individuals, can be equally effective.

Dissemination and Implementation Research—Translating Research Findings into the Community

As NIH research has demonstrated the efficacy of HIV prevention, treatment, and cure interventions over the years, effective information sharing through community partnerships, research collaborations, and dissemination activities remains vital to amplify research impact and mitigate health disparities. Implementation research plays a pivotal role in translating research to practice by examining strategies to integrate evidence-based health interventions into clinical and community settings, increase adoption and improve population health. For example, a recent study evaluated various strategies to enhance the uptake of, and adherence to HIV prevention methods among adolescents aged 12-24 with certain risk factors. Automated text messaging combined with peer support and coaching significantly improved PrEP use, while the other interventions showed limited effects. The findings demonstrate the potential for technology and peer support to enhance HIV prevention among young people.

HIV Research Capacity—Strengthening Research Workforce, Infrastructure, and Novel Methodologies

Bringing research from the laboratory to the clinic and ultimately to the community requires continued support for a strong and innovative research workforce, reliable research infrastructure, and investment in development of new research tools and resources.

Research Workforce and Infrastructure

NIH has long supported training and career development awards to support the next generation of biomedical, behavioral, and social science professionals, including many opportunities specifically for those conducting HIV research. Pervasive HIV-related health disparities

underscore the need to cultivate a robust workforce representative of communities most affected by HIV. Accordingly, several NIH-funded Centers for AIDS Research include pathway or capacity programs that provide funding, mentorship, and networking opportunities for the HIV research community.

In 2024, NIH organized a third annual workshop for early career investigators in HIV research. The workshop offered valuable resources to early career investigators, including advice and presentations from other early career researchers, mentors, and NIH staff. The workshop exemplified NIH's commitment to supporting the next generation of researchers by equipping them with the knowledge, tools, and networking necessary for success in their path forward in their career.

Progress in HIV science relies on robust support for research facilities, tools and instrumentation, resources, and data infrastructure. NIH will continue to support development and improvement of research tools to support HIV research. Broadening access to such research resources will benefit the HIV research workforce.

Novel Methods and Technologies

Artificial intelligence and machine learning (AI/ML) techniques and applications are leading scientific breakthroughs in health and medicine by leveraging real-world data-driven insights for science, policy, and practice. Opportunities for AI/ML to address HIV prevention, care, and treatment needs have yet to be fully realized. Accordingly, NIH is encouraging research that generates cutting-edge synthetic datasets and applies privacy-conscious AI/ML approaches to expand capacity to address the evolving HIV pandemic. More widespread use of advanced data science approaches, including AI/ML and deep learning, can help identify the critical factors—including individual, interpersonal, community, social, structural, mental and other health challenges—that contribute to HIV outcomes, enabling focused prevention efforts and optimized treatment decisions.

HIV detection shortly after exposure enables the rapid initiation of treatment, limiting further transmission and improving health outcomes. NIH is encouraging the development of diagnostic technologies to enable rapid HIV self-testing or point-of-care testing and viral load monitoring using both Small Business Innovation Research contracts and the expanded Rapid Acceleration of Diagnostics (RADx) program. Technologies currently under development, such as user-friendly, smartphone-based devices for HIV self-testing and viral load monitoring, 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.