DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2027

Centers for Disease Control and Prevention

Justification of Estimates for Appropriation Committees

MESSAGE FROM THE DIRECTOR

The mission of the Centers for Disease Control and Prevention (CDC) is to protect health, save lives, and strengthen the nation's resilience against health threats. Every day, CDC is strengthening our focus on domestic and global health security to prevent, detect, and respond to health threats worldwide to keep Americans safe. This includes detecting threats early, coordinating efforts across sectors, and ensuring we are ready to respond to public health emergencies both domestically and globally.

CDC is committed to maximizing the impact of every dollar entrusted to the agency. The FY 2027 budget request enables CDC to sharpen the focus on the core mission to keep Americans safe from health threats, including sustained investment in the foundational capabilities that make this mission possible: advanced data systems, robust laboratory capacity, scientific expertise, and a prepared public health workforce ready to respond on the front lines.

The FY 2027 President's Budget request supports targeted increases to enhance early warning and detection of diseases that can rapidly strain health care systems; address urgent antimicrobial-resistant threats spreading in the United States, including *Candida auris* and carbapenem-resistant *Enterobacterales*; and strengthen food and water safety by identifying high-risk practices and expanding research on emerging contaminants such as micro- and nanoplastics in human biological samples. The request also supports the development and deployment of Biothreat Radar capabilities, including metagenomic surveillance at ports of entry, to improve monitoring of emerging threats and help prevent dangerous pathogens from entering the United States. We are investing in gold-standard science to ensure rapid, evidence-based responses to crises, foster innovation, and accelerate the development of new and innovative tools to address emerging challenges.

Protecting the nation's health is essential for the future. The FY 2027 President's Budget positions CDC to focus squarely on core responsibilities, including infectious disease surveillance, outbreak investigation, preparedness and response, and maintenance of the nation's public health infrastructure. These efforts are grounded in gold-standard science and a commitment to transparency and accountability that fosters public trust.

The FY 2027 President's Budget request reflects a strong commitment to the health and well-being of every American. With this support, CDC will continue to strengthen public health infrastructure and empower communities to prevent disease, detect threats, and respond quickly and precisely. These investments ensure the nation remains resilient in the face of current and future health challenges, securing a healthier and stronger future for all.

All the best,

Jay Bhattacharya, MD, PhD
Acting Director, CDC
Acting Administrator, Agency for Toxic Substances and Disease Registry

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INTRODUCTION AND MISSION

The Centers for Disease Control and Prevention (CDC), an agency within the U.S. Department of Health and Human Services, is the nation's public health protection agency and a critical component of America's health security infrastructure.

CDC's mission is to protect the United States from health, safety, and security threats that originate both domestically and internationally. To fulfill this mission, CDC conducts rigorous scientific research and provides timely, evidence-based health information to prevent disease, respond to public health emergencies, and reduce the impact of emerging threats. CDC also investigates the relationship between environmental factors and health, develops guidance, and builds partnerships to support healthy decision-making.

Through this work, CDC strengthens the nation's health security and resilience. Operating at the forefront of public health and health security, CDC detects and confronts global disease threats through advanced surveillance, epidemiology, and laboratory science. By analyzing large volumes of data and biological specimens, CDC rapidly identifies risks and develops solutions to protect public health. The agency also invests in national preparedness by strengthening data systems, modernizing communications, and developing a highly skilled public health workforce that supports strong, well-resourced capabilities at the federal, state, and local levels.

As the nation's health protection agency, CDC is committed to building a sustainable and resilient public health system that can respond effectively to both emerging threats and ongoing public health challenges, ensuring Americans remain safe and healthy.

EXECUTIVE SUMMARY

OVERVIEW OF BUDGET REQUEST

The Fiscal Year (FY) 2027 budget request for the Centers for Disease Control and Prevention (CDC) is $5.485 billion in discretionary funding, which includes $5.280 billion in budget authority and $205 million in Public Health Service Evaluation funds. This request supports CDC's ability to protect the health of the American people through a modern, agile, and accountable public health system.

CDC's FY 2027 budget prioritizes core public health capabilities, including data modernization, surveillance, laboratory science, and global preparedness. These foundational investments strengthen CDC's ability to prevent, detect, and respond to health threats across all programs. By working in partnership with federal, state, local, tribal, territorial, and international partners, CDC helps safeguard the nation's health security.

The request emphasizes continued investment in public health infrastructure, particularly interoperable data systems that provide timely, high-quality information to support rapid, evidence-based decision-making. Laboratory capacity remains essential to quickly identify and characterize health threats, while continued investment in gold-standard science accelerates innovation and improves response to emerging challenges.

The FY 2027 budget strengthens domestic and global health security by supporting early threat detection, coordination across sectors, and readiness to respond to public health emergencies. Targeted increases focus on healthy and safe food, clean water, and infection prevention and control, including detection of emerging and antimicrobial-resistant pathogens such as *Candida auris* and carbapenem-resistant *Enterobacterales*.

To improve efficiency, CDC proposes structural realignments that consolidate related programs and strengthen coordination. The proposed National Center for Chemicals and Toxins will consolidate HHS environmental, toxicological, and chemical programs within a single organizational framework, improving operational efficiency, strengthening scientific rigor, and enhancing the protection of the American people.

Overall, the FY 2027 request strengthens CDC's scientific capacity, public health infrastructure, and partnerships with state, local, tribal, and territorial health departments. Highlights of the request are provided below.

Antimicrobial Resistance Initiative (+$22.278 million)

CDC will expand efforts to prevent and detect urgent antimicrobial-resistant threats such as *Candida auris* and carbapenem-resistant *Enterobacterales*. These pathogens spread easily in healthcare settings, are resistant to multiple treatment options, and cause severe infections with high mortality rates. Early detection through specialized testing is critical to preventing silent spread within healthcare facilities and into surrounding communities.

Food Safety (+$33.0 million)

This increase supports the Healthy and Safe Food Initiative, strengthening prevention and surveillance of foodborne and waterborne diseases through systems such as FoodNet and PulseNet. Investments modernize laboratory and informatics infrastructure, incorporate next-generation metagenomics, and enhance collaboration with state, tribal, local, and territorial partners. Funding also addresses critical gaps in understanding exposure to micro- and nanoplastics by developing standardized testing methods, generating baseline exposure data, and launching pilot health-effects studies.

Biothreat Radar (+$45 million) (Travel and Port Health Protection; Advanced Molecular Detection)

The FY 2027 request continues the Biothreat Radar Initiative to strengthen early detection and response to emerging and high-consequence infectious disease threats. Coordinated investments in

traveler-based genomic surveillance and domestic metagenomic capacity enhance U.S. biosecurity and improve national public health preparedness through a layered, early-warning approach implemented in coordination with federal, state, local, and territorial partners.

Biothreat Radar integrates pathogen-agnostic testing with innovative surveillance and laboratory systems. The initiative will harness revolutionary advances in pathogen genomics, laboratory diagnostics, data integration and AI-driven analytics to transform the nation's ability to detect and track novel pathogens and early signals of emerging threats, generate actionable intelligence, and respond effectively to biological threats whether naturally occurring, accidental, or intentional.

These activities provide timely, actionable information for healthcare providers and public health officials and strengthen situational awareness of global health threats. CDC will also support secure, standardized metagenomic surveillance for multiple pathogens, maintain sequencing and analytic capacity, and continue workforce training. These investments strengthen pathogen genomics capabilities in state and local health departments, advance data analytics, and ensure sequencing quality and consistency to support rapid, effective public health action.

OVERVIEW OF PERFORMANCE

As the nation's health protection agency, the Centers for Disease Control and Prevention (CDC) works 24/7 to protect America from health, safety, and security threats, both foreign and in the United States. To achieve maximum public health impact, CDC conducts research; implements strategic, evidence-based programs; and monitors results through ongoing data collection. Performance in each of these areas and in all of CDC's work is strengthened through the use of rigorous and ongoing performance metrics and program evaluation data to monitor program effectiveness and compare performance to established targets. The accomplishments described below highlight the importance of investing in high quality public health programs, preventing disease, and protecting health.

Rapidly Respond to Emerging Threats

- CDC played a crucial role in the Southwest measles outbreak, including making 7,000 additional MMR vaccine doses available to the Texas Department of State Health Services, 2,900 doses for the New Mexico Department of Health, and 2,000 doses for the Oklahoma State Department of Health and provided ongoing technical assistance. Additionally:
  - CDC sent three separate teams to Texas as needs were identified during the Southwest measles response. An Epi-Aid was also conducted in New Mexico.
  - The CDC Measles Response published two advisories to notify clinicians, public health, and travelers; coordinated biweekly measles readiness calls for partners; held two clinician calls for providers; added new resources to the Be Ready for Measles Toolkit available on CDC's website and released an MMWR on U.S. measles cases.
- CDC provided technical assistance to the Kansas Department of Health and Environment (KDHE) for one of the largest TB outbreaks in recent history. From January 2024 to November 2025, over 68 active TB and 110 latent TB cases were identified and treated, 2 individuals died. CDC assisted KDHE with conducting contact investigations, testing and screening activities, and collaborations with community leaders on health education initiatives through approximately 40 separate deployments to Kansas over the course of the outbreak.
- CDC responded to an increase in invasive Group A *streptococcus* (iGAS), which can cause acute rheumatic fever (ARF)/rheumatic heart disease (RHD), in Alaska, predominately affecting children and Native Alaskans. CDC remains active in supporting clinicians at tribal health facilities serving these populations to develop guidelines for the diagnosis and management of ARF and RHD.
- Since March 2024, CDC has worked with state and local health departments to monitor people exposed to infected animals and provide testing and treatment if someone contracts bird flu (influenza A (H5)). Between March 2024-December 2025, more than 21,000 people have been monitored, with more than 990 people tested for influenza A (H5). A total of 71 human cases have been identified as of December 30, 2025. Additionally, since February 2024, public health laboratories using CDC's diagnostic tools tested over 223,000 specimens capable of detecting A(H5) and other novel influenza viruses, with six of the 71 human cases detected through this national influenza surveillance.
- In April 2024, CDC responded to a request for technical assistance from the Great Plains Tribal Leaders' Health Board (GPTLHB) to address syphilis and congenital syphilis outbreaks among American Indian/Alaskan Native persons in the Great Plains Area of South Dakota. CDC experts located 25 individuals who needed syphilis treatment, including six of seven pregnant women who were prioritized for treatment. Additionally, CDC led trainings to tribal staff on partner services, disease investigation, and clinical best practices for syphilis control.
- In 2024, CDC supported 220 healthcare-associated outbreak responses and, to date in 2025, 54 healthcare-associated outbreak responses. These efforts prevent future infections and save U.S. healthcare systems, payers, and patients millions of dollars in prevented hospitalization and treatment costs. For example, in 2025, CDC, in partnership with the Florida Department of Health, investigated a series of Hepatitis C Virus (HCV) infections among patients exposed to unsafe

infection control practices in an outpatient pain management clinic. There were 19 confirmed and 6 probable cases. CDC's intervention prevented an additional 56 infections and yielded an estimated $9.4 million in cost savings over the next 5 years.

- In FY 2025, over 60 CDC staff responded to Hurricanes Helene and Milton, providing expertise that prevented illness in temporary shelters, helped people safely return to their homes and reopen schools, evaluated private wells and septic systems to prevent waterborne illness, prevented disease due to mold and vector-borne exposures, and created tools showing health facility functionality, capability, and needs that responders used to inform and prioritize emergency response actions.
- CDC partnered with Gas Station TV to play a short video on the safe use of portable generators at 3,000 gas stations in the affected areas, reaching 2 million people in two weeks in order to prevent carbon monoxide poisoning cases. During the recovery, provided proactive 24/7 morbidity and mortality surveillance of data from the National Poison Data System, National Syndromic Surveillance Program, American Red Cross, and media sources to rapidly identify emerging issues.
- CDC developed and implemented a survey to assess local health department's functionality, capabilities, and needs, with an accompanying data dashboard that allowed emergency managers to rapidly see changes in capacity and need in order to effectively allocate resources. CDC also developed a mobile-based well and septic inspection survey and associated dashboard that let responders collect and analyze real-time data to address water and sanitary system needs.
- In 2024, CDC responded to the contamination of Diamond Shruumz mushroom products with a toxin that sickened 180 individuals, led to 73 hospitalizations, and resulted in three deaths. CDC experts coordinated with America's Poison Centers to monitor for cases of illness, provided information for healthcare clinicians on how to identify and manage patients, and supported 34 states with their responses to cases in their jurisdiction.
- In 2025, CDC staff deployed to more than 20 countries experiencing polio outbreaks, contributing over 1,200 combined days of field response, and worked with funded partners to deliver services in hard-to-reach, polio-affected areas. This strengthened outbreak preparedness and response and ensured accountability for U.S.-funded activities. CDC also provided critical expertise in laboratory specimen testing and genetic sequencing, surveillance, and data analytics to directly support field operations. Together, these efforts helped stop outbreaks at their source, prevent international spread of poliovirus, and sustain global eradication momentum—contributing to a 99.9% reduction in polio cases worldwide since 1988.
- On September 27, 2024, Rwanda declared its first outbreak of Marburg, a highly infectious and often fatal illness closely related to Ebola that was quickly deemed one of the largest Marburg outbreaks ever recorded. CDC's Rwanda Country Office, provided 182 trained outbreak response staff, all of whom were alumni of the Field Epidemiology and Laboratory Training Program. Additionally, 73% of CDC-supported sites, including laboratories, provided the essential infrastructure and systems for outbreak response. Rwanda had the tools to detect and respond to the Marburg outbreak, which was declared over in a matter of months, in large part due to CDC's support for building infrastructure for surveillance, strengthening laboratory systems, and supporting a robust local public health workforce.
- In 2024-2025, CDC detected foodborne outbreaks faster and more efficiently after transitioning to PulseNet 2.0, a modern, cloud-based platform that speeds outbreak detection with whole genome sequencing (WGS) and strengthens data sharing with partners across the country. Implementing WGS helped CDC detect *Salmonella* outbreaks more than 2 weeks faster, with almost 40% fewer cases needed to detect an outbreak. *Salmonella* outbreaks in 2024 were almost a week shorter and more than 10% smaller than the pre-WGS era, because of the implementation of this innovative new technology in combination with a continuous improvement approach to outbreak investigation processes.

Expert Public Health Workforce and Cutting-Edge Laboratories

- In June 2025, CDC responded to an urgent call from a Texas hospital about a patient who recently returned from Central Africa and was critically ill with a rare disease that could rapidly become fatal without treatment. Within hours, CDC recognizing the disease to be Human African Trypanosomiasis (HAT), mobilized a response to save this patient's life. CDC laboratory experts provided remote laboratory diagnostics services to confirm diagnosis. HAT was confirmed within one hour, enabling targeted treatment and ruling out similar parasitic diseases like malaria. CDC medical experts provided clinical guidance to the healthcare provider on the type of treatment needed, care of the patient, and initiated the CDC Drug Services process to obtain the necessary drug treatment for shipment from CDC. The necessary drug, suramin, is not commercially available in the U.S. and CDC is the only U.S. source for this drug. Thanks to CDC's rapid and coordinated response, the drug was delivered to the patient within 24 hours.
- In FY 2025, CDC laboratory safety officers inspected more than 2,000 laboratories across all biosafety levels, surveyed over 127,000 inventory samples, reviewed over 1,400 laboratory risk assessments, and safely removed over 535 pounds of radioactive waste.
- In FY 2025, CDC developed the first ever qualitative diagnostic test for confirming exposures to Novichoks, a class of highly toxic nerve agents that are extremely stable and evade current treatments. This innovative method uses a technique that can lead to the development of additional assays to confirm exposures to other chemical threats, including organophosphate pesticides and emerging nerve agents.
- In FY 2025, CDC developed a method for measuring anthrax lethal factor in dried blood spots. This method will improve CDC's response to anthrax threats in remote locations where refrigerated shipping is difficult and in large-scale events where quicker and easier sample collection is needed.
- In FY 2025, CDC provided dried blood spot quality assurance materials to 681 newborn screening laboratories in 87 countries worldwide to ensure the early and accurate identification of babies born with life-threatening or disabling conditions. Additionally, CDC developed a method that dramatically accelerates the sample preparation steps for lysosomal disorders screening. The new approach shortens a required analytical step from 18 hours down to only 3 hours, allowing for the first time same-day analysis and reporting of time-critical newborn screening results.
- In FY 2025, CDC substantially improved its laboratory method for determining human exposure to aflatoxins – harmful compounds produced by various *Aspergillus* mold species that contaminate crops and feeds such as corn, peanuts, cottonseed, and tree nuts. This innovation significantly enhances the speed and reliability of CDC's response to emergency investigations of suspected aflatoxin exposure and the analysis of samples in large-scale surveillance studies.
- In FY 2025, CDC efforts significantly improved the accuracy of tests for chronic disease biomarkers that are critical for patient care. CDC identified and addressed discrepancies in lipid and free thyroxine measurements made by U.S. clinical labs, preventing misinterpretations that could lead to unnecessary prescriptions and misclassification of patients, ultimately benefiting over 270 million Americans. These efforts not only improve patient care and health outcomes but also generate substantial cost savings for individuals and the healthcare system.
- In FY 2025, CDC completed laboratory measurements of trans fatty acid levels in the National Health and Nutrition Examination Survey that demonstrate how Americans' levels of trans fatty acids have decreased over approximately the past two decades, showing that public health actions aimed at reducing Americans' intake of trans fatty acids through partially hydrogenated vegetable oils are highly effective.
- The Strengthening Laboratory Management Toward Accreditation (SMLTA) program advances U.S government priorities by delivering measurable improvements in global HIV diagnostics while strengthening preparedness for emerging infectious diseases. In FY 2025, the Democratic Republic of the Congo achieved its first-ever international accreditation of two laboratories, the result of sustained CDC technical assistance. This top-tier accreditation enhances the accuracy of

HIV testing and patient care essential for controlling the HIV epidemic and establishes robust infrastructure and quality systems that enable rapid response to the emergence of dangerous diseases, such as Ebola, commonly recurring in the country. This milestone demonstrates how U.S. investments, can protect Americans from dangerous infectious diseases while maximizing the impact of U.S. taxpayer dollars.

- In 2024, CDC used a newly developed laboratory method to identify the strain of anthrax affecting a patient in Louisiana in a matter of hours, instead of the days required for other methods. This informed the selection of the correct antibody treatment. CDC monitoring of the patient's anthrax toxin blood levels during treatment also revealed that the patient would require multiple antibody doses, instead of the standard one dose, to ensure survival. CDC is currently the only laboratory in the United States able to make these rapid, critical measurements for this toxin in human blood samples.
- In FY 2024, CDC supported 282 full-time fellows assigned to positions in state, Tribal, local, and territorial (STLT) health agencies across 5 fellowship programs. Additionally, 235 fellows supported short-term emergency responses and public health priorities through epi-aids, lab-aids, info-aids, deployments, needs assessments, evaluation projects, and rotations.

World Class Data and Analytics

- CDC supported the stand-up of the Mpox Clade I response in 1CDP in mere hours, requiring ~65% fewer data analytic and visualization personnel than the prior Mpox Clade II response. This reduction in staff to stand up a response was due to the reuse of existing data pipelines, dashboards, and reports that were used and updated from prior Mpox responses and which were maintained by the program. This helped to preserve precious manpower and resources to focus on other new data to action work specific to the Mpox Clade I response.
- In 2024, CDC responded to nearly 1,200 community, state, and federal requests for assistance, including requests to respond to the BioLab fire in Conyers, GA. CDC integrated real-time air quality data and toxicological modeling to assess the gaps in chlorine health guidance, provide timely information on the fate and transport of chlorine gas, and enable effective public health interventions to prevent respiratory health effects. CDC also evaluated EPA air sampling data to monitor for health risks to the community, worked with the Georgia Poison Center to monitor for illness related to exposures, and supported state agencies as they provided health messaging and support to affected residents. CDC partnered with the Association of Occupational and Environmental Clinics and Grady Hospital staff in Atlanta to share information on keeping children in the affected communities safe.
- In FY 2025, published 154 MMWRs and reached an audience of 12.7 million the *MMWR* Surveillance Summaries ranked #1 and the *MMWR* Weekly Reports ranked #2 in journal impact factor in the category of "Public, Environmental, & Occupational Health." 30% of MMWR reports rank in the top one percent of research.
- CDC launched an effort to include new data into the National Syndromic Surveillance Program growing commercial laboratory data from 1 to 5 laboratory companies and expanding existing Emergency Department data feeds to incorporate inpatient visits with active engagements in 18 states.
- CDC established national pediatric COVID-19 mortality reporting in coordination with the Council of State and Territorial Epidemiologists.
- CDC improved immunization data quality and availability through increased data modernization to facilitate data exchange, including reporting of the past 10 years of Veterans Affairs (VA) vaccination records (~24 million historical immunization records)

Other CDC Accomplishments

- In 2025, CDC continued to send life-saving drugs for rare diseases to patients around the country. Through an extensive network of partners, CDC Port Health Staff released antitoxins for emergency treatment of botulism or diphtheria within 8 hours on multiple occasions. For example, the Chicago Port Health Station staff learned a recent drug release was successful in saving the life of someone with botulism.
- As of FY 2025, CDC has enrolled over 20,000 ALS patients into the National ALS Registry, connected thousands of patients with more than 80 clinical trials and epidemiological studies, collected specimens from more than 1,700 patients for the National ALS Biorepository, and funded 30 research grants. In 2024, the National ALS Registry released the first state-level analysis of ALS prevalence data, advancing the understanding of ALS distribution across the United States, including among veterans. In 2025, the registry also released the first analysis of state-level incidence data, furthering the understanding of both ALS case distribution and potential risk factors.
- CDC began decommissioning leased office space in Atlanta, so that cost savings of approximately $8 million in FY 2024 could be redirected to public health program needs. By the end of FY 2025, CDC reduced its leased portfolio for office space to only four locations. This reduction in leasing cost for office space has resulted in an overall $18 million in annual savings.

Agency Performance Planning and Management

CDC conducts continuous program improvement through program strategic planning, performance monitoring and accountability, and program evaluation. CDC collects information on program priorities, measurable outcomes, strategies, and progress through annual updates. Additionally, CDC has developed a Performance Improvement Framework to advance a culture of performance improvement and build performance improvement capacity at all levels of the agency. CDC awards the majority of its budget through grants, cooperative agreements, and contracts to help accomplish its mission. CDC cooperative agreement funding announcements require applicants to specify how they are measuring, monitoring, and evaluating the activities they are implementing and progress toward achieving the intended outcomes.

Agency Use of Evaluation and Evidence

CDC is a data-driven agency and incorporates use of data for decision-making and to continuously improve our programs. CDC continues to focus on the development and use of evidence to enhance all aspects of the Agency's mission. CDC is leveraging the Foundations for Evidence-Based Policymaking Act to strengthen program evaluation activities and data use for decision-making across the agency. CDC uses a prospective evidence-building approach to innovate, test, evaluate, and model strategies to identify those that are most impactful, cost-effective, and feasible for achieving our public health goals. As additional evidence is generated, some of these questions and approaches may shift. By continuously building and assessing the evidence, CDC is better positioned to optimize our impact and strategically drive informed decisions. This prospective generation of key evidence and ongoing data evaluation is critical for data-driven policymaking.

Alignment to Administration Priorities and Initiatives

CDC is committed to supporting the national priorities and initiatives set by the Administration. CDC leads key activities, such as strengthening public health surveillance, epidemiology, and laboratory capacity and mitigating and preventing infectious diseases, that support the Administration's priorities and initiatives.

LEGISLATIVE PROPOSALS

Discretionary Proposals

Federal Public Health Data Reporting Authority

CDC seeks authority to secure access to deidentified public health data in a timely and coordinated way that gives CDC, its state and local partners, providers, decision makers, and the public a clearer picture of the nation's health. The current framework for collecting and sharing public health data has resulted in fragmented and inconsistent reporting to CDC, and to state and local public health partners. Giving CDC the authority to set reporting requirements about which data elements should be reported to public health authorities, including CDC, from healthcare providers, facilities, and suppliers, pharmacies; laboratories and service organizations; and state, local, Tribal, and territorial agencies will improve the agency's capacity to detect and respond to public health threats, monitor and evaluate the distribution of medical countermeasures and critical supplies, and connect communities with resources and services.

CDC Non-Competitive Fellowship Conversion

CDC seeks authority to convert CDC fellows in fellowship and training program appointments to term or permanent positions in the competitive service within 120 days of program completion, without having to use the competitive examination and hiring process. The proposal enables CDC to retain talented fellows and develop a highly skilled workforce equipped to combat the critical health challenges facing Americans today and in the future.

ALL PURPOSE TABLE

(dollars in thousands)	FY 2025 Final[1]	FY 2026 Enacted[1]	FY 2027 President's Budget[2,3]	FY 2027 +/- FY 2026
Immunization and Respiratory Diseases	**$919,291**	**$913,291**	**$963,291**	**$50,000**
Budget Authority	$237,358	$316,901	$963,291	$646,390
ACA/PPHF	*$681,933*	*$596,390*	*$0*	*-$596,390*
Viral Hepatitis, STI and TB Prevention	**$377,344**	**$370,344**	**$300,000**	**-$70,344**
Emerging and Zoonotic Infectious Diseases[4]	**$812,272**	**$833,272**	**$927,764**	**$94,492**
Budget Authority	$760,272	$781,272	$927,764	$146,492
ACA/PPHF	*$52,000*	*$52,000*	*$0*	-$52,000
National Center for Chemicals and Toxins[5]	**$1,758,702**	**$1,752,287**	**$1,034,757**	**-$717,530**
Budget Authority	$1,707,702	$1,701,287	$1,034,757	-$666,530
ACA/PPHF	*$51,000*	*$51,000*	*$0*	-$51,000
Public Health Scientific Services[6]	**$622,100**	**$610,100**	**$704,600**	**$94,500**
Budget Authority	$622,100	$610,100	$499,600	-$110,500
PHS Eval	*$0*	*$0*	*$205,000*	*$205,000*
Global Health[4]	**$663,843**	**$663,843**	**$663,843**	**$0**
Public Health Preparedness and Response[6]	**$883,200**	**$883,200**	**$489,000**	**-$394,200**
CDC-Wide Activities and Program Support	**$663,570**	**$646,570**	**$361,570**	**-$285,000**
Budget Authority	$503,570	$396,570	$361,570	-$35,000
ACA/PPHF	$160,000	$250,000	$0	-$250,000
Buildings and Facilities	**$40,000**	**$40,000**	**$40,000**	**$0**
Total CDC - Budget Authority	**$5,795,389**	**$5,763,517**	**$5,279,825**	**-$483,692**
PHS Evaluation Transfer	$0	$0	$205,000	$205,000
Total CDC - BA & PHS Evaluation Transfer	**$5,795,389**	**$5,763,517**	**$5,484,825**	**-$278,692**
Prevention and Public Health Fund (PPHF) Transfer[3]	$944,933	$949,390	$0	-$949,390
CDC Program Level - BA, PPHF, & PHS Eval[1]	**$6,740,322**	**$6,712,907**	**$5,484,825**	**-$1,228,082**
Energy Employees Occupational Illness Compensation Program Act (EEOICPA)[7]	$50,763	$50,763	$50,763	$0
World Trade Center Health Program (Current Law)[8]	$847,697	$913,025	$954,820	$41,795
Vaccines for Children (Current Law)	$6,575,625	$6,072,286	$6,783,662	$711,376
Other User Fees	$2,226	$2,226	$2,226	$0
Total CDC Funding	**$14,216,633**	**$13,751,207**	**$13,276,296**	**-$474,911**

[1] FY 2025 and FY 2026 Levels are comparably adjusted to align with the proposed HHS reorganization for the FY 2027 Budget.

[2] In alignment with the proposed HHS reorganization, the FY 2027 Budget reorganizes all or some of the funding to the Administration for a Healthy America (AHA) from the following CDC Accounts: 1) HIV/AIDS activities; 2) Chronic Disease Prevention and Health Promotion; 3) Birth Defects, Developmental Disabilities, Disability and Health; and 4) Injury Prevention and Control. In addition, the Budget realigns Health Statistics to the HHS Office of the Secretary Office of Strategy (OS). The FY 2027 Budget is displayed comparably.

[3] The FY 2027 Budget eliminates the Prevention and Public Health Fund (PPHF).

[4] FY 2025 and FY 2026 Levels are comparably adjusted to reflect the proposed realignment of the following lines into *Emerging Infectious Diseases*: *Surveillance for Emerging Threats to Mothers and Babies* and *Parasitic Diseases and Malaria*.

[5] The FY 2027 Budget establishes a new Center within CDC, National Center for Chemicals and Toxins, and realigns PPAs from NCEH, NIOSH, ATSDR; National Institute of Environmental Health Sciences (formerly of NIH); and National Center for Toxicological Research (formerly of FDA).

[6] FY 2025 and FY 2026 totals are comparably adjusted to reflect the proposed realignment of the funding line*, Ready Response Enterprise Data Integration Platform and Forecasting and Outbreak Analytics* into the *Public Health Data Modernization (DMI)* line within the PHSS account.

[7] EEOICPA levels reflect post-sequester amounts.

[8] World Trade Center Health Program reflects Federal share estimated obligations only; NYC share estimated obligations are not included.

BUDGET EXHIBITS

SUMMARY OF CHANGES

	Dollars	FTEs[1]
FY 2026 Enacted (Discretionary Program Level, includes PPHF)[2]	$6,712,907	10,169
FY 2027 President's Budget (Discretionary Program Level)[3,4]	$5,484,825	8,887
Net Change	**($1,228,082)**	**(1,282)**

(dollars in thousands)	FY 2026 Enacted		FY 2027 President's Budget		FY 2027 +/- FY 2026	
	BA	FTE	BA	FTE	BA	FTE
Increases:						
Immunization and Respiratory Diseases		1,075		1,075		0
Immunization and Other Respiratory Diseases[5]	$681,933	---	$731,933	---	$50,000	---
Emerging and Zoonotic Infectious Diseases		1,608		1,728		121
Antimicrobial Resistance Initiative	$197,000	---	$219,278	---	$22,278	---
Emerging Infectious Diseases[6]	$275,997	---	$303,897	---	$27,900	---
Food Safety	$74,000	---	$107,000	---	$33,000	---
Travel and Port Health Protection	$57,772	---	$79,772	---	$22,000	---
Advanced Molecular Detection (AMD)	$43,000	---	$66,000	---	$23,000	---
Public Health Scientific Services		1,432		1,138		-294
Surveillance, Epidemiology, and Informatics	$298,100	---	$327,600	---	$29,500	---
Public Health Data Modernization[7]	$215,000	---	$280,000	---	$65,000	---
Total Increases	**$1,842,802**	**--**	**$2,115,480**	**--**	**$272,678**	**--**
Decreases:						
Viral Hepatitis, STI and TB Prevention		926		508		-418
Account Level	$370,344	---	$300,000	---	($70,344)	---
Emerging and Zoonotic Infectious Diseases		1,608		1,728		121
Vector-borne Diseases	$91,603	---	$87,817	---	($3,786)	---
Prion Disease	$9,000	---	$0	---	($9,000)	---
Chronic Fatigue Syndrome	$5,400	---	$0	---	($5,400)	---
Harmful Algal Blooms	$3,500	---	$0	---	($3,500)	---
Healthcare-Associated Infections (PPHF)	$12,000	---	$0	---	($12,000)	---
National Center for Chemicals and Toxins[8]		1,124		1,591		467
Climate and Health	$10,000	---	$0	---	($10,000)	---
Trevor's Law	$3,000	---	$0	---	($3,000)	---
Environmental and Health Outcome Tracking Network	$34,000	---	$0	---	($34,000)	---
Asthma	$33,500	---	$0	---	($33,500)	---
National Occupational Research Agenda (NORA)	$120,500	---	$0	---	($120,500)	---
Education and Research Centers	$32,000	---	$0	---	($32,000)	---
Personal Protective Technology	$23,000	---	$16,000	---	($7,000)	---
Other Occupational Safety and Health Research	$115,100	---	$0	---	($115,100)	---
National Institute for Environmental Health Sciences	$913,979	---	$594,086	---	($319,893)	---
National Institute for Environmental Health Sciences Interior-Superfund	$77,100	---	$51,814	---	($25,286)	---
National Center for Toxicological Research	$71,758	---	$56,307	---	($15,451)	---
Agency for Toxic Substances and Disease Registry	$79,800	---	$78,000	---	($1,800)	---

Public Health Preparedness[7]		464		396		-69
Public Health Emergency Preparedness Cooperative Agreement	$735,000	---	$350,000	---	($385,000)	---
Academic Centers for Public Health Preparedness	$9,200	---	$0	---	($9,200)	---
CDC-Wide Activities and Program Support		1,574		1,568		-6
Preventive Health and Health Services Block Grant (PPHF)	$160,000	---	$0	---	($160,000)	---
Infectious Diseases Rapid Response Reserve Fund[9]	$25,000	---	$0	---	($25,000)	---
Public Health Infrastructure and Capacity	$360,000	---	$260,000	---	($100,000)	---
Total Decreases	**$3,294,784**	**---**	**$1,794,024**	**---**	**($1,500,760)**	**---**
Transfers						
	$0	---	$0	---	$0	---
Built-In:						
1. Annualization of 2026 Pay Raise	$0	---	$0	---	$0	---
2. FY 2027 Pay Increases	$0	---	$0	---	$0	---
3. Infrastructure	$0	---	$0	---	$0	---
Total Built-In	**$0**	**---**	**$0**	**---**	**$0**	**---**
Total Increases (Program Level)	**$1,842,802**	**--**	**$2,115,480**	**--**	**$272,678**	**--**
Total Decreases (Program Level)	**$3,294,784**	**--**	**$1,794,024**	**--**	**($1,500,760)**	**--**
NET CHANGE - Program Level	**$6,712,907**	**10,169**	**$5,484,825**	**8,887**	**($1,228,082)**	**-1,282**
Other Program Level Changes						
1. Vaccines for Children (Current Law)	$6,072,286	---	$6,783,662	---	$711,376	---
2. World Trade Center (WTC)[10]	$913,025	---	$954,820	---	$41,795	---
Total - Other Program Level Net Increase	**$6,985,311**	**---**	**$7,738,482**	**---**	**$753,171**	**---**
NET CHANGE: CDC BUDGET AUTHORITY & MANDATORY PROGRAM LEVEL	**$13,698,218**	**10,169**	**$13,223,307**	**8,887**	**($474,911)**	**-1,282**

[1] FTE displayed reflect current estimates, which may differ from the system of record. FY 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. These estimates are subject to change.

[2] In alignment with the proposed HHS reorganization, FY 2026 Level is comparably adjusted.

[3] In alignment with the proposed HHS reorganization, the FY 2027 Budget reorganizes all or some of the funding to the Administration for a Healthy America (AHA) from the following CDC Accounts: 1) HIV/AIDS activities; 2) Chronic Disease Prevention and Health Promotion; 3) Birth Defects, Developmental Disabilities, Disability and Health; and 4) Injury Prevention and Control. The FY 2027 Budget is displayed comparably.

[4] The FY 2027 Budget eliminates the Prevention and Public Health Fund (PPHF).

[5] FY 2026 Level for Immunization and Other Respiratory Diseases reflects funding from PPHF.

[6] FY 2026 Level is comparably adjusted to reflect the proposed realignment of the following lines into *Emerging Infectious Diseases: Surveillance for Emerging Threats to Mothers and Babies* and *Parasitic Diseases and Malaria*.

[7] FY 2026 Level is comparably adjusted to reflect the proposed realignment of the funding line, *Ready Response Enterprise Data Integration Platform and Forecasting and Outbreak Analytics* into the *Public Health Data Modernization (DMI)* line within the PHSS account.

[8] The FY 2027 Budget establishes a new Center within CDC, National Center for Chemicals and Toxins, and realigns PPAs from NCEH, NIOSH, ATSDR; National Institute of Environmental Health Sciences (formerly of NIH); and National Center for Toxicological Research (formerly of FDA).

[9] The Budget Request does not propose budget authority for the Infectious Disease Rapid Response Reserve Fund in 2027; however this program is proposed to continue. Existing funds remain available until expended for future public health threats.

[10] WTC reflects Federal share estimated obligations only; NYC share estimated obligations are not included.

AUTHORIZING LEGISLATION

(dollars in thousands) Enabling Legislation Citation[1]	Enabling Legislation Status	Allocation Methods	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Immunization and Respiratory Diseases					
PHSA § 222; PHSA § 301; PHSA § 304; PHSA § 306; PHSA § 307; PHSA § 310; PHSA § 311; PHSA § 313; PHSA § 317 (including PHSA § 317P - Johanna's Law); PHSA § 319; PHSA § 327; PHSA § 340C; PHSA § 352; PHSA § 2102; PHSA § 2125; PHSA § 2126; PHSA § 2127; PHSA § 2713(a)(2); PHSA § 2821; PHSA § 319C-1	Permanent Indefinite	Direct Federal/ Intramural; Competitive Cooperative Agreements/ Grants, including Formula Grants; Contracts; and Other	$919,291	$913,291	$963,291
Viral Hepatitis, STD, and TB Prevention					
Viral Hepatitis: PHSA § 317N; PHSA § 301; PHSA § 317; PHSA § 306; PHSA § 310 (b); PHSA § 318; PHSA § 319; PHSA § 352; Sec. 1928 of Social Security Act [Program for Distribution of Pediatric Vaccines] (42 U.S.C. 1396s) STIs: PHSA § 301; PHSA § 306; PHSA § 310(b); PHSA § 318; PHSA § 318A; PHSA § 317; PHSA § 317P; PHSA § 352 TB: PHSA § 317E; PHSA § 352; PHSA § 306; PHSA § 310(b); PHSA § 311; PHSA § 322 Other: PHSA § 318; PHSA § 319; PHSA § 301; PHSA § 317; PHSA § 317N; Sec. 1928 of Social Security Act [Program for Distribution of Pediatric Vaccines] (42 U.S.C. 1396s)	Permanent Indefinite	Direct Federal/ Intramural, Competitive Grants/ Cooperative Agreements, Formula Grants/ Cooperative Agreements, Contracts, and Other	$377,344	$370,344	$300,000
Emerging and Zoonotic Infectious Diseases					
PHSA § 301; PHSA § 304; PHSA § 307; PHSA § 308(d); PHSA § 310; PHSA § 317; PHSA § 319; PHSA § 352; PHSA § 353; PHSA § 2821 PHSA § 319E PHSA § 317U; PHSA § 2822; PHSA § 317S PHSA § 317P PHSA § 319B; PHSA § 319D; PHSA § 319F; PHSA § 319C-3; 22 USC § 7634; PHSA § 317C; PHSA § 317L; PHSA § 317K PHSA § 317R; PHSA § 399V-5; FSMA § 205; FSMA § 210 PHSA § 399II; PHSA § 399JJ PHSA § 311; PHSA § 322; PHSA § 325; PHSA §s 361-369; INA § 212; INA § 232; INA § 412 PHSA § 2824 33 USC § 4001 seq.	Permanent Indefinite	Direct Federal/ Intramural, Contracts, and Competitive Grants/ Cooperative Agreements	$812,272	$833,272	$927,764

(dollars in thousands) Enabling Legislation Citation[1]	Enabling Legislation Status	Allocation Methods	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
PHSA § 2821; PHSA § 2822					
National Center for Chemicals and Toxins					
PHSA § 301; PHSA § 307; PHSA § 311; PHSA § 310; PHSA § 317; PHSA § 327; PHSA § 1706; PHSA § 302; PHSA § 368 Frank R. Lautenberg Chemical Safety for the 21st Century Act, Public Law No. 114-182, section 21; Children's Health Act of 2000 Food Safety Modernization Act, Pub. Law 111–353, title II, § 205; PHSA § 319; 42 USC § 300hh; Water Infrastructure Improvements for the Nations Act § 2203(b); Lead Control Contamination Act of 1988, PHSA § 317B, PHSA § 317A; PHSA § 317O; PPACA § 4002; OSH Act §§ 20–22, Pub. L. 91-596 as amended; Federal Mine Safety and Health Act of 1977 (FMSH Act) §§103, 501, Pub. L. 91-173; The Coast Guard Authorization Act of 2010 (P.L. 111-281), as amended; Toxic Substances Control Act, Pub. L. 94-469 as amended by Pub. L. 102-550; Public Law 117 - 105 - Dr. Lorna Breen Health Care Provider Protection Act; PHSA § 399MM -399MM-3 Federal Coal Mine Health and Safety Act of 1969, 30 U.S.C. § 843; Black Lung Benefits Reform Act of 1977 § 19 (Pub. L. 95-239); Bureau of Mines Act, 30 USC § 1; Research Concerning Refuge Alternatives; Mine Improvement and New Emergency Response (MINER) Act, § 13; Firefighter Cancer Registry Act of 2018, (Pub. L. 115-194); Firefighter Cancer Registry Reauthorization Act of 2023 (reauthorizes registry until 2028) PHSA Section 401(a); Superfund Research Program: Section 311(a) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, and Section 126(g) of the Superfund Amendments and Reauthorization Act of 1986 Federal Food, Drug, and Cosmetic Act (21 U.S.C. 393(b) (1)); Food and Drug Administration Modernization Act; Food and Drug Administration Amendments Act of 2007; FDA Food Safety	Permanent Indefinite	Direct Federal/ Intramural, Contracts, Competitive Grants/ Cooperative Agreements	$1,758,702	$1,752,287	$1,034,757

(dollars in thousands) Enabling Legislation Citation[1]	Enabling Legislation Status	Allocation Methods	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Modernization Act (P.L. 111-353); Modernization of Cosmetics Regulation Act of 2022 42 USC § 9604(i); 10 USC § 2704; National Defense Authorization Act of 2018 (P.L. 115-91 § 316); 42 U.S.C. § 1397h; 42 U.S.C. § 9611(c)(4) Water Infrastructure Improvements for the Nation Act, Pub. L. 114-322, § 2203					
Public Health Scientific Services					
PHSA § 319D; PHSA § 317G; PHSA § 317; PHSA § 352; PHSA § 319B PHSA § 319D; PHSA § 353; PHSA § 301 PHSA § 2823; PHSA § 319; PHSA § 310B; PHSA § 2825; PHSA § 2341; PHSA § 778; PHSA § 768; Intelligence Reform and Terrorism Prevention Act of 2004, § 7211	Permanent Indefinite	Direct Federal/ Intramural, Competitive Grants/ Cooperative Agreements, Contracts	$ 622,100	$ 610,100	$ 704,600
Global Health					
Foreign Assistance Act § 104; PEPFAR Stewardship and Oversight Act; PHSA § 2341; PHSA §317T; PHSA § 2320 PHSA § 317E; PHSA § 404B PHSA § 319F; Global Health Security and International Pandemic Prevention, Preparedness and Response Act of 2022 (FY 2023 NDAA); United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, § 403	Permanent Indefinite	Direct Federal/ Intramural, Competitive Grants/ Cooperative Agreements, Direct Contracts, Interagency Agreements	$ 663,843	$ 663,843	$ 663,843
Public Health Preparedness and Response					
PHSA § 319C-1; PHSA § 317(k)(2); PHSA § 2814; PHSA § 319A; PHSA § 301; PHSA § 317; PHSA § 2821; PHSA § 2824; PHSA § 2802; PHSA § 319J; PHSA § 214 PHSA § 319F FD&C Act § 564A; FD&C Act § 564B; PHSA § 307; PHSA § 319B; PHSA § 2801; PHSA § 2811-1; PHSA § 2814; PHSA § 2825; PHSA § 307; PHSA § 310; PHSA § 311; PHSA § 319; PHSA § 319D; PHSA § 319D-1; PHSA § 319F-2; PHSA § 319G; PHSA § 351A; PHSA § 361	Permanent Indefinite	Direct, Federal Intramural, Cooperative Agreements, including Formula Grants/ Cooperative Agreements; and Contracts	$ 883,200	$ 883,200	$ 489,000
CDC-Wide Activities and Program Support					
PHSA Title XIX, Part A; 42 USC § 300w-320w-10 PHSA § 353; Consolidated Appropriations Act, 2023 Explanatory Statement; PHSA § 317G	Permanent Indefinite	Direct Federal/ Intramural, Contracts, Competitive Grants/	$ 663,570	$ 646,570	$ 361,570

(dollars in thousands) Enabling Legislation Citation[1]	Enabling Legislation Status	Allocation Methods	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019, Continuing Appropriations Act, 2019 PHSA § 317b; American Rescue Plan Act , § 2501;' PHSA §2825.		Cooperative Agreements			
Building and Facilities					
PHSA § 319D(a)	Permanent Indefinite	N/A	$40,000	$40,000	$40,000

[1] Expired/Expiring noted with *

APPROPRIATIONS HISTORY TABLE[1,2]

Fiscal Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2017 Budget Authority [3]	5,967,376,000	6,875,144,000	6,153,448,000	6,293,503,000
2017 Public Health Prevention Fund	944,470,000	908,300,000	891,300,000	891,300,000
2017 ATSDR	74,691,000	74,691,000	74,691,000	74,691,000
2018 Budget Authority	4,991,675,000	6,010,153,000	6,318,953,000	7,204,908,000
2018 Public Health Prevention Fund	840,600,000	840,600,000	800,900,000	800,900,000
2018 Disaster Relief Supplement (PL 115-123)	--	--	--	200,000,000
2018 ATSDR	62,000,000	72,780,000	74,691,000	74,691,000
2019 Budget Authority	5,524,935,000	6,781,908,000	7,004,483,000	6,477,883,000
2019 Public Health Prevention Fund	0	848,000,000	808,300,000	804,500,000
2019 Disaster Relief Supplement (PL 116-20)	--	--	--	20,000,000
2019 ATSDR	62,000,000	74,691,000	74,691,000	74,691,000
2020 Budget Authority	5,214,882,000	7,177,725,000	6,608,665,000	6,839,946,000
2020 Public Health Prevention Fund	893,950,000	854,250,000	854,250,000	854,250,000
2020 ATSDR	62,000,000	79,691,000	74,691,000	76,691,000
2021 Budget Authority	5,565,318,000	7,100,396,000	6,908,446,000	6,963,296,000
2021 Public Health Prevention Fund	893,950,000	856,150,000	856,150,000	856,150,000
2021 ATSDR	62,000,000	79,000,000	76,691,000	78,000,000
2022 Budget Authority	8,454,861,000	9,625,761,000	8,636,611,000	7,498,546,000
2022 Public Health Prevention Fund	903,300,000	903,300,000	903,300,000	903,300,000
2022 ATSDR	81,750,000	81,750,000	81,750,000	80,500,000
2023 Budget Authority	9,620,961,000	9,540,696,000	9,542,171,000	8,258,932,000
2023 Public Health Prevention Fund	903,300,000	903,300,000	903,300,000	903,300,000
2023 Disaster Relief Supplement (PL 117-328)	--	--	--	86,000,000
2023 ATSDR	85,020,000	85,020,000	85,020,000	85,020,000
2024 Budget Authority[4]	10,217,311,000	6,350,008,000	7,711,702,000	7,980,532,000
2024 Public Health Prevention Fund	1,186,200,000	1,186,200,000	1,186,200,000	1,186,200,000
2024 ATSDR	86,020,000	76,000,000	85,020,000	81,619,000
2025 Budget Authority[4]	8,397,132,000	6,204,500,000	8,043,499,000	7,980,532,000
2025 Public Health Prevention Fund	1,186,200,000	1,186,200,000	1,186,200,000	1,186,200,000
2025 ATSDR	85,020,000	85,020,000	85,020,000	81,619,000
2026 Budget Authority	4,037,575,000	5,995,647,000	7,696,363,000	7,706,314,000
2026 Public Health Prevention Fund[5]	0	1,398,375,000	1,398,375,000	1,398,375,000
2026 ATSDR	78,000,000	81,619,000	81,619,000	79,800,000
2027 Budget Authority[2,4]	5,201,825,000	--	--	--
2027 Public Health Prevention Fund[5]	0	--	--	--
2027 ATSDR[2]	78,000,000	--	--	--

[1] Reflects totals as enacted and estimates as submitted to Congress; does not include comparability adjustments to reflect the HHS reorganization proposed in the FY 2027 Budget.

[2] For historical tracking purposes, ATSDR amounts are displayed separately and not included within CDC's budget authority. The FY 2027 Budget realigns ATSDR to the proposed National Center for Chemicals and Toxins within CDC.

[3] FY 2017 Appropriation includes funding for Flint, Michigan response, which includes $15 million for Lead Poisoning Prevention and $20 million for a Lead Exposure Registry and Advisory Council.

[4] FY 2024 through FY 2026 Appropriation includes $43 million in funding from PHS Evaluation Transfer. FY 2027 Budget request includes $205 million in funding from the PHS Evaluation Fund.

[5] The 2027 Budget Request eliminates funding from the Prevention and Public Health Fund (PPHF).

NARRATIVE BY ACTIVITY

IMMUNIZATION AND RESPIRATORY DISEASES

(dollars in millions)	FY 2025 Final[1]	FY 2026 Enacted[1]	FY 2027 President's Budget[2]	FY 2027 +/- FY 2026
Budget Authority	$237.358	$316.901	$963.291	$646.390
Prevention and Public Health Fund (PPHF) Transfer[2]	$681.933	$596.390	$0.000	-$596.390
Total Request	**$919.291**	**$913.291**	**$963.291**	**+$50.000**
FTEs[3]	1,125	1,075	1,075	0
-- Immunization and Other Respiratory Diseases	$681.933	$681.933	$731.933	+$50.000
-- Immunization Program	$0.000	$85.543	$731.933	+$646.390
-- Immunization Program (PPHF)	*$681.933*	*$596.390*	*$0.000*	*-$596.390*
-- Influenza Planning and Response	$231.358	$231.358	$231.358	$0.000
Current Law Mandatory Programs Total	**$6,575.625**	**$6,072.286**	**$6,783.662**	**+$711.376**
-- Vaccines for Children (Current Law)[4,5]	$6,575.625	$6,072.286	$6,783.662	+$711.376

[1] FY 2025 Final reflects full year Continuing Resolution level.
[2] The FY 2027 Budget eliminates funding for the Prevention and Public Health Fund (PPHF).
[3] FTE displayed reflect current estimates, which may differ from the system of record. FTE estimates may not represent expected FTE levels across FY 2027. These estimates are subject to change.
[4] Reflects current law mandatory estimates as of baseline update for the FY 2027 President's Budget. Updated VFC levels are primarily driven by changes in COVID vaccine purchase demand.
[5] FY 2027 mandatory amounts reflect funding provided by the Consolidated Appropriations Act, 2026

Enabling Legislation Citation: PHSA § 222; PHSA § 301; PHSA § 304; PHSA § 306; PHSA § 307; PHSA § 310; PHSA § 311; PHSA § 313; PHSA § 317 (including PHSA § 317P - Johanna's Law); PHSA § 319; PHSA § 327; PHSA § 340C; PHSA § 352; PHSA § 2102; PHSA § 2125; PHSA § 2126; PHSA § 2127; PHSA § 2713(a)(2); PHSA § 2821; PHSA § 319C-1

Enabling Legislation Status: Permanent Indefinite

Authorization of Appropriations for FY 2026: Indefinite; Expired/Expiring noted with *

Allocation Methods: Direct Federal/Intramural; Competitive Cooperative Agreements/Grants, including Formula Grants; Contracts; and Other

CDC's FY 2027 budget request of **$963,291,000** for Immunization and Respiratory Diseases is **$50,000,000** above the FY 2026 enacted level. This increase will support enhanced respiratory threat surveillance, supporting cross-CDC investments coordinated with the proposed Biothreat Radar Detection System.

Enhanced respiratory threat surveillance will strengthen the nation's early warning detection and response capabilities for routine respiratory and other vaccine-preventable diseases, including influenza, Respiratory Syncytial Virus (RSV), and novel respiratory diseases. These efforts will leverage expertise across multiple CDC Centers, Institutes, and Offices. This investment will strengthen core public health infrastructure by expanding workforce capacity, modernizing disease surveillance, data, and laboratory networks, and increasing the use of advanced technologies to detect, characterize, and monitor emerging biothreats, such as Avian Influenza (H5N1), polio, and Middle East respiratory syndrome (MERS). Funding will enable CDC to enhance laboratory networks and genomic capabilities, apply advanced data analytics to monitor changes in circulating pathogens, and inform the development and implementation of comprehensive disease control approaches. These approaches include vaccines, therapeutics, non-pharmaceutical interventions, and behavioral mitigation strategies that reduce transmission and disease severity. Activities will be carried out in coordination with state, tribal, territorial, local, and non-governmental partners to ensure efficient use of federal resources and improved preparedness and measurable public health outcomes.

IMMUNIZATION AND RESPIRATORY DISEASES

By the Numbers

- **>223,000—**Influenza specimens tested nationwide by U.S. public health laboratories in one year as part of the domestic avian influenza A (H5N1) outbreak response.
- **258,000—**Total continuing education hours earned by health care professionals nationwide in support of CDC immunization initiatives.
- **2,900—**Clinician and public inquiries regarding vaccines received; nearly all were addressed within 24 hours.
- **23—**Inquiries from state, local, and territorial health departments concerning potential cluster/outbreaks of several different viruses.
- **80%—**Estimated effectiveness of the long-acting monoclonal antibody Nirsevimab in reducing intensive care unit admissions for RSV among infants.
- **27%—**Increase in enrollment of U.S. birthing hospitals in the Vaccines for Children (VFC) Program from 2023 to 2025, expanding access to RSV protection for infants; during the same period, Nirsevimab orders more than doubled, rising from approximately 47,000 to 102,000 doses.
- **70-79%—**Estimated effectiveness of maternal RSV vaccination in preventing infant RSV-related hospitalizations.
- **58%—**Reduction in RSV-related hospitalization risk over two RSV seasons among adults aged 60 and older who received the RSV vaccine.
- **79%—**Reduction in cervical precancer rates occurred among women aged 20-24 years following HPV vaccination.
- **8 seconds—**Time required for CDC machine learning tools to identify cooling towers within a 0.25-mile radius during Legionnaires' disease outbreak investigations.
- **$11,600,000,000—**Estimated net societal savings over 10 years from use of a higher-valent pediatric pneumococcal conjugate vaccine, compared with a similar vaccine covering fewer *Streptococcus pneumoniae* serotypes.

NOTE: Unless otherwise noted, all information and calculations are from CDC program data.

Immunization and Respiratory Diseases Funding History	
Fiscal Year	Dollars (in Millions)
FY 2023 Final (BA)	$499.941
FY 2023 Final (PPHF)	$419.350
FY 2024 Final (BA)	$237.358
FY 2024 Final (PPHF)	$681.933
FY 2025 Final (BA)	$237.358
FY 2025 Final (PPHF)	$681.933
FY 2026 Enacted (BA)	$316.901
FY 2026 Enacted (PPHF)	$596.390
FY 2027 President's Budget (BA)	$963.291
FY 2027 President's Budget (PPHF)[1]	$0.000

[1] The Budget Request eliminates the Prevention and Public Health Fund (PPHF).

Immunization Program Ten Year Funding History	
Fiscal Year	**Dollars (in millions)**
FY 2018 Final (BA)	$285.529
FY 2018 Final (PPHF)	$324.350
FY 2019 Final (BA)	$287.106
FY 2019 Final (PPHF)	$320.550
FY 2020 Final (BA)	$419.705
FY 2020 Final (PPHF)	$370.300
FY 2021 Final (BA)	$240.706
FY 2021 Final (PPHF)	$372.200
FY 2022 Final (BA)	$231.447
FY 2022 Final (PPHF)	$419.350
FY 2023 Final (BA)	$262.583
FY 2023 Final (PPHF)	$419.350
FY 2024 Final (BA)	$0.000
FY 2024 Final (PPHF)	$681.933
FY 2025 Final (BA)	$0.000
FY 2025 Final (PPHF)	$681.933
FY 2026 Enacted (BA)	$85.543
FY 2026 Enacted (PPHF)	$596.390
FY 2027 President's Budget (BA)	$731.933
FY 2027 President's Budget (PPHF)[1]	$0.000

[1]The Budget Request eliminates funding from the Prevention and Public Health Fund (PPHF).

Immunization and Other Respiratory Diseases

The Immunization and Respiratory Diseases Program supports CDC's Section 317 Discretionary Immunization Program, which provides the foundational infrastructure for U.S. immunization activities, including state immunization programs. For more than 60 years, the Section 317 Program has supported access to vaccines that prevent infectious diseases. CDC provides support to 66 U.S. immunization programs to strengthen prevention and response efforts for measles, pertussis, perinatal hepatitis B, and other respiratory and vaccine-preventable disease threats, including avian influenza.

On July 1, 2025, CDC awarded a new five-year cycle of the Immunization Cooperative Agreement (CDC-RFA-IP25-0007, *Strengthening Vaccine-Preventable Disease Prevention and Response*) to 66 jurisdictional recipients, including two new cities, Los Angeles and Phoenix.

The cooperative agreement emphasizes outbreak prevention and response, including enhanced mechanisms for jurisdictions to rapidly access funding to respond to small-scale outbreaks of vaccine-preventable diseases. It also establishes time-specific reporting requirements for jurisdictions to notify CDC of selected reportable diseases, including measles, polio, rubella, novel influenza A, pediatric influenza-associated deaths, mumps, and pertussis.

This funding supports state and local immunization managers and program staff in conducting vaccine preparedness exercises, strengthening Vaccines for Children (VFC) provider networks, and collecting and using public health data to support emergency response and target immunization program activities.

CDC supports staff in U.S. localities and the Indian Health Service who assist with daily operations and outbreak responses. In FY 2025, 18 jurisdictions requested additional funds to purchase vaccines to respond to active outbreaks, including hepatitis A, varicella, and measles. Vaccine response preparedness for American veterans was strengthened through the connection of 54 Immunization Information Systems to Veterans Health Administration clinics, enhancing data quality, interoperability, and outbreak response coordination.

Additionally, CDC provides national leadership by partnering with healthcare systems, health departments, public and private laboratories, and other domestic and global partners to collect and analyze pathogen data. Investments in state and local health departments support timely disease surveillance, pathogen strain characterization, and outbreak investigations, generating measurable returns through earlier detection, more targeted interventions, and avoided health care and response costs.

Budget Request

CDC's FY 2027 budget request of **$731,933,000** for Immunization and Other Respiratory Diseases program is **$50,000,000** above the FY 2026 enacted level. This funding is critical to sustaining essential public health activities that ensure the nation is prepared to rapidly detect, monitor, and respond to respiratory viral and bacterial threats. Investments will strengthen national surveillance capacity and enable CDC to respond nimbly to emerging pandemic risks, helping to protect the American public from severe illness and health system strain.

Collectively, the surveillance systems supported through this funding will provide a coordinated, government-wide approach to monitoring respiratory viruses and bacteria. These systems generate foundational data used by federal partners, state and local public health agencies, and health care providers to guide timely, evidence-based action. Specifically, CDC will strengthen capacity across the following key areas:

- **Disease surveillance and pandemic preparedness**. CDC will support early identification of respiratory threats by monitoring how viruses and bacteria evolve and spread across the country.

Through a national network of sentinel sites and platforms such as RESP-Net, the only public-facing system that tracks severe respiratory illness outcomes, CDC analyzes trends in infectivity, severity, and transmission to detect emerging threats and inform rapid response.

- **Pathogen characterization and genomic analysis.** CDC's leadership in pathogen genomics enables detailed understanding of how respiratory viruses and bacteria change at local, state, and national levels. Tools such as Nowcast provide timely information on emerging variants and novel pathogens, allow public health officials and health care providers to anticipate impacts and implement mitigation strategies with speed and precision.
- **Evaluation of vaccines and prevention strategies**. CDC will continue to support core vaccine effectiveness and surveillance platforms, including the Virtual SARS-CoV-2, Influenza, and Other respiratory viruses Network (VISION) and the New Vaccine Surveillance Network (NVSN). These systems are critical for evaluating vaccine performance, particularly for pediatric populations, and for monitoring the epidemiology of common childhood respiratory illnesses. CDC maintains VaxView to improve access to vaccination coverage data, supporting evidence-based decisions that prevent severe outcomes and protect American families.

Program Accomplishments

CDC's Immunization and Respiratory Disease program provides the resources and technical support for state, tribal, local, and territorial public health programs to protect children, their families, and their communities against respiratory and vaccine-preventable diseases. Investments supported the following:

RSV Prevention Reduced Infant Hospitalizations: New RSV prevention tools, including vaccines and Nirsevimab, became available in 2023, followed by the ACIP recommendation of clesrovimab in June 2025. CDC partnered with states to enroll more than 1,000 birthing hospitals in the Vaccines for Children Program to protect infants at birth. Preliminary CDC analyses show RSV hospitalizations among infants under eight months declined by 28–43 percent, with hospitalizations among infants under three months reduced by approximately 50 percent compared to pre-product seasons. At 50 percent coverage, RSV immunization could prevent an estimated 107,000 outpatient visits, 15,000 hospitalizations, and 10 infant deaths annually.

Before these products became available, RSV caused approximately 2 million medical encounters, between 58,000-80,000 hospitalizations, and 100-300 deaths among children under 5 years of age annually.

CDC Response Supported Measles Outbreak Control: As of December 30, 2025, 2,065 confirmed measles cases were reported across 44 jurisdictions. CDC supported state and local outbreak response through epidemiology and laboratory technical assistance, genomic sequencing; vaccine deployment and deployment of four Epi-Aid teams. Funding for additional MMR vaccines doses has been made available to states. CDC also issued a Health Alert Network Advisory, notifying target audiences about the risks and signs of measles infections, released the *Be Ready for Measles* toolkit, published guidance in *MMWR*, and convened biweekly national readiness calls.

New Guidance Addressed Antibiotic-Resistant Meningococcal: CDC worked with partners to develop new recommendations for antibiotic-resistant *Neisseria meningitidis*. More than 11 jurisdictions have implemented these recommendations, strengthening protection against this rapidly fatal disease. These bacteria cause meningococcal disease which can be deadly in a matter of hours.

Machine Learning Improved Legionnaires' Disease Response: CDC provided leadership to create TowerScout, a machine learning tool, that rapidly identifies water cooling towers from aerial imagery, enabling timely field investigations and remediation during Legionnaires' disease outbreaks. Because outbreaks are often caused by improperly maintained cooling towers that can generate infectious

aerosols traveling for miles, rapid identification is critical. Since 2021, TowerScout has been used in more than 35 outbreak investigations, improving the speed and effectiveness of outbreak response. *Maternal Screening Prevented Perinatal Hepatitis B Transmission:* In alignment with CDC Strategic Initiative to increase hepatitis B screening of pregnant women, CDC-supported programs identified more than 6,300 pregnant women with hepatitis B and provided case management for over 7,000 infants to prevent mother-to-child transmission.

CDC will continue to build and sustain a robust, effective immunization program that supports national readiness to detect and respond to respiratory diseases with public health emergency potential, while protecting health across the lifespan by maintaining access to routine immunizations and generating measurable returns through avoided illness, hospitalizations, and response costs.

Immunization Cooperative Agreements[1]

(dollars in millions)	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Number of Awards	66	66	66
- New Awards	2	0	0
- Continuing Awards	64	66	66
Average Award	$4.908	$4.908	$4.908
Range of Awards	$0.581–$30.783	$0.581–$30.783	$0.581–$30.783
Total Awards	$323.957	$323.957	$323.957

[1] These funds are awarded by formula.

Influenza Planning and Response Budget Request

CDC's influenza program supports the detection, control, and prevention of both seasonal influenza, which causes annual epidemics, and novel influenza viruses that emerge from animal reservoirs and have pandemic potential. Because influenza viruses continually evolve, CDC supports robust national surveillance systems that enable CDC and state, tribal, local, and territorial health departments to identify when and where influenza is circulating and to inform prevention and treatment decisions.

CDC laboratories characterize and sequence influenza viruses to monitor changes that may affect disease severity or the effectiveness of vaccines, diagnostics, and antiviral medications. To reduce the burden of seasonal influenza, CDC recommends annual influenza vaccination for everyone six months of age and older. Vaccines are produced and administered annually to account for viral evolution and to optimize protection against circulating strains.

Budget Request

CDC's FY 2027 budget request of **$231,358,000** for Influenza Planning and Response is level with the FY 2026 enacted level. This funding will support the following activities:

- **Influenza surveillance**: Maintain and strengthen U.S. influenza surveillance systems to monitor circulating viruses and ensure timely data reporting from public health laboratories, emergency department syndromic surveillance, electronic health record–based hospital surveillance, long-term care facilities, commercial testing laboratories, and other clinical providers. Funding will also support more than 50 surveillance coordinators in state health departments who work with CDC to sustain national influenza and respiratory disease surveillance. These systems provide critical situational awareness to guide prevention and treatment decisions.
- **Laboratory analysis**: Characterize and sequence influenza viruses to identify emerging threats and detect changes that may reduce the effectiveness of vaccines, antiviral medications, or diagnostic tests. These activities are essential to ensuring the availability and effectiveness of medical countermeasures for both seasonal and pandemic influenza.
- **Vaccine effectiveness:** Conduct annual influenza vaccine effectiveness studies through a national network of U.S. hospitals to assess performance each flu season. These data support evidence-based vaccination policy and directly advance the U.S. Government's National Influenza Vaccine Modernization Strategy.
- **Avian Influenza:** Support state, tribal, local, and territorial health departments in preparing for and responding to human cases of Highly Pathogenic Avian Influenza A (H5), which continues to circulate in animals and has resulted in sporadic human infections. Funding will sustain CDC's influenza surveillance systems to detect avian influenza cases and abnormal transmission patterns, and support three National Influenza Reference Centers in state public health laboratories to provide surge sequencing capacity for pandemic threats**.**

Program Accomplishments

Prior-year funding enabled CDC to strengthen influenza preparedness, rapidly detect emerging threats, and protect public health through timely laboratory analysis, surveillance, and coordinated response. Key accomplishments include:

Virus Characterization Strengthened Pandemic Preparedness: CDC's seasonal influenza activities form the foundation of the agency's pandemic preparedness efforts by assessing the effectiveness of medical countermeasures and identifying emerging threats. In FY 2025, CDC influenza laboratories sequenced more than 7,700 virus specimens and developed six new candidate vaccine viruses against emerging and novel influenza threats with epidemic and pandemic potential.

In August 2025, CDC laboratories were the first to identify a new influenza A (H3N2) subclade (later designated H3N2 subclade K) that showed antigenic drift from the 2025–26 seasonal vaccine strain.

Early detection informed national situational awareness during a season historically associated with increased hospitalizations and deaths among older adults and young children. CDC continued to monitor influenza activity throughout the season and reported findings publicly on a weekly basis.

Rapid Investigation of Pediatric Influenza-Associated Neurologic Complications: CDC worked with health departments and clinicians to investigate reports of pediatric influenza-associated encephalopathy and encephalitis (IAE), including acute necrotizing encephalopathy (ANE). During the 2024–2025 influenza season, CDC received reports of pediatric influenza cases presenting with ANE, including two deaths, and rapidly assessed disease scope while providing guidance to public health and clinical partners. CDC continued IAE surveillance into the 2025–2026 influenza season to strengthen early detection and response to severe pediatric outcomes.

Preparedness Investments Supported the H5N1 Dairy Cattle Response: When avian influenza A (H5N1) was identified in U.S. dairy cattle herds in March 2024, CDC, working with ASPR, USDA, NIH, and FDA, rapidly established a coordinated response structure. CDC's long-standing preparedness and surveillance investments enabled immediate action to protect human health.

Between March 2024 and December 2025, more than 21,300 people were monitored for infection, and over 990 symptomatic individuals were tested for influenza A (H5). CDC surveillance systems were critical for detecting potential community transmission, with more than 223,000 specimens tested nationally since February 2024. In July 2025, CDC formally deactivated the outbreak response following sustained declines in human and animal cases and an overall low public health risk. CDC continues to monitor exposed individuals, conduct influenza A (H5) surveillance, and maintain routine One Health coordination with USDA and other federal partners.

These accomplishments reflect the value of continued investment in CDC's influenza program in maintaining national readiness to identify, assess, and respond to seasonal and pandemic influenza threats.

VIRAL HEPATITIS, SEXUALLY TRANSMITTED INFECTIONS, AND TUBERCULOSIS

(dollars in millions)	FY 2025 Final[1]	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Budget Authority	$377.344	$370.344	$300.000	-$70.344
Total Request[2]	**$377.344**	**$370.344**	**$300.000**	**-$70.344**
FTEs[3]	988	926	508	-418
-- Consolidated Hepatitis, Sexually Transmitted Infections, and Tuberculosis Prevention Grant[4]	N/A	N/A	$300.000	N/A

[1] FY 2025 Final reflects full year Continuing Resolution level.
[2] FY 2025 and FY 2026 Levels do not reflect funding for Domestic HIV/AIDS Prevention and Research. CDC's Domestic HIV programs will be realigned to the Administration for a Healthy America (AHA) under the planned HHS reorganization; Domestic HIV funding is reflected in the AHA CJ.
[3] FTE displayed reflect current estimates, which may differ from the system of record. FTE estimates may not represent expected FTE levels across FY 2027. These estimates are subject to change.
[4] The FY 2027 Budget proposes to realign the following PPAs into the proposed line Consolidated Hepatitis, Sexually Transmitted Infections, and Tuberculosis Prevention Grant: Viral Hepatitis, Sexually Transmitted Infections (STIs), Domestic TB, and Infectious Diseases and the Opioid Epidemic.

Enabling Legislation Citation: Viral Hepatitis: PHSA § 317N; PHSA § 301; PHSA § 317; PHSA § 306; PHSA § 310 (b); PHSA § 318; PHSA § 319; PHSA § 352; Sec. 1928 of Social Security Act [Program for Distribution of Pediatric Vaccines] (42 U.S.C. 1396s)
STIs: PHSA § 301; PHSA § 306; PHSA § 310(b); PHSA § 318; PHSA § 318A; PHSA § 317; PHSA § 317P; PHSA § 352
TB: PHSA § 317E; PHSA § 352; PHSA § 306; PHSA § 310(b); PHSA § 311; PHSA § 322
Other: PHSA § 318; PHSA § 319; PHSA § 301; PHSA § 317; PHSA § 317N; Sec. 1928 of Social Security Act [Program for Distribution of Pediatric Vaccines] (42 U.S.C. 1396s)

Enabling Legislation Status: Permanent Indefinite

Authorization of Appropriations for FY 2023: Indefinite; Expired/Expiring noted with *

Allocation Methods: Direct Federal/Intramural, Competitive Grants/Cooperative Agreements, Formula Grants/Cooperative Agreements, Contracts, and Other

CDC envisions a future free of viral hepatitis, sexually transmitted infections (STIs), and tuberculosis (TB). In working toward that future, CDC prioritizes cost-effective, scalable programs, policies, and research to achieve the greatest reduction in the incidence and disparities of these conditions, all of which have substantial individual and economic costs for all Americans. From 2017 to 2020, up to 4 million people had hepatitis C virus infection in the United States and an estimated 660,000 were living with hepatitis B. Approximately one in three people with hepatitis C and about one in two people with hepatitis B are unaware of their infection. Viral hepatitis is a serious public health threat and a leading cause of liver cancer.

STIs continue as a national public health problem, spanning various communities and groups and all regions of the United States. In 2023, more than 2.4 million cases of chlamydia, gonorrhea, and syphilis were reported. Beyond individual and community health impacts, STIs are costly. An estimated 26 million new STI cases occur annually, resulting in approximately $18 billion in lifetime direct medical costs to the healthcare system. Collectively, over the past 15 years, CDC-funded state and local STI programs prevented 6.4 million cases of syphilis, gonorrhea, and chlamydia, saving $2.7 billion in lifetime direct medical costs.

CDC is the lead agency for eliminating TB in the United States and a global expert in programmatically relevant TB research, laboratory science, TB surveillance, education, and training. CDC data show that TB incidence increased for a fourth year in a row in the United States. While the United States maintains one of the lowest TB incidence rates in the world and most U.S. residents are at minimal risk, in 2024, U.S. TB cases increased to 10,388 cases compared to 9,626 in 2023. Overall, the U.S. TB rate increased by seven percent from 2.9 per 100,000 persons in 2023 to 3.1 per 100,000 persons in 2024. In 2024, six states reported large TB outbreaks which ranged in size from 10 to 64 TB cases. This highlights the importance of continuing to engage communities with higher TB rates and their medical providers in TB elimination efforts and strengthening the capacity of public health programs to carry out critical disease control and prevention strategies.

VIRAL HEPATITIS, SEXUALLY TRANSMITTED INFECTIONS, AND TUBERCULOSIS

By the Numbers

- ***Preventing STIs****:* Over the past 15 years, state and local STI programs funded by CDC have prevented 6.4 million cases of syphilis, gonorrhea, and chlamydia saving the U.S. healthcare system $2.7 billion in lifetime medical costs.
- ***Preventing TB Cases and Cutting Costs****:* Between 1995 and 2024, U.S. TB control efforts helped prevent up to 549,000 TB cases, saving the country up to $26 billion in medical and societal costs.
- ***Preventing Viral Hepatitis****:* 59 state and local health departments received CDC support since 2021 to improve viral hepatitis response, prevention and service integration; by 2024, 83% of recipients improved data quality and completeness, and more than 4,000 providers were trained to diagnose and treat viral hepatitis.

*References: Unless otherwise noted, all information and calculations are from CDC program data.

Viral Hepatitis, STI and TB Prevention Funding History[1,2]	
Fiscal Year	Dollars (in Millions)
FY 2023 Final	$377.344
FY 2024 Final	$377.344
FY 2025 Final	$377.344
FY 2026 Enacted	$370.344
FY 2027 President's Budget	$300.000

[1] FY 2023 through FY 2025 Final amounts for the Viral Hepatitis, STI and TB Prevention account do not reflect funding for Domestic HIV/AIDS Prevention and Research. CDC's Domestic HIV programs will be realigned to AHA under the planned HHS reorganization and are reflected in the AHA CJ.

[2] The budget request carries forward the proposal to realign the Viral Hepatitis, Sexually Transmitted Infections (STIs), Domestic TB, and Infectious Diseases and the Opioid Epidemic funding lines into the proposed Consolidated Viral Hepatitis, STI, and Tuberculosis Prevention Grant program.

Viral hepatitis, STIs, and TB are serious public health threats which have substantial individual and economic costs. Through the consolidated grant, CDC will offer recipients strategic direction, technical support, and laboratory and programmatic expertise. The grant program provides an opportunity to integrate delivery services to the public to address related infections, develop capacities across programs, improve efficiency and cost effectiveness, and achieve optimal health outcomes.

Budget Request

CDC's FY 2027 budget request of **$300,000,000** for the Consolidated Hepatitis, STI, and Tuberculosis Prevention Grant program is **$70,344,000** below the FY 2026 enacted level**.** The budget request realigns the funding lines, Viral Hepatitis, Sexually Transmitted Infections (STIs), Domestic TB, and Infectious Diseases and Opioid Epidemic into the new proposed Consolidated Viral Hepatitis, STI and Tuberculosis Prevention Grant program. The FY 2027 budget gives states flexibility to address local needs and state specific challenges by consolidating funding for Infectious Disease and Opioids, Viral Hepatitis, STIs, and TB programs into one newly established grant program.

CDC prioritizes cost-effective, burden based, and scalable programs to efficiently and effectively reduce incidence of these infectious diseases. In FY 2027, CDC will support state, local, and territorial health departments to implement proven public health interventions, conduct infectious disease surveillance to track and respond to outbreaks, and address the dynamic consequences these diseases present. CDC will provide resources allocated through a burden-based formula to ensure funds are distributed efficiently and achieve maximum impact.

Viral Hepatitis, STI and TB Prevention

(dollars in thousands)

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget[1]
Number of Awards	62	62	TBD
Average Award	$3,309.376	$3,309.376	TBD
Range of Awards	$315.376 - $17,544.392	$315.376- $17,544.392	TBD

[1] Grant award estimates are under development.

EMERGING AND ZOONOTIC INFECTIOUS DISEASES

(dollars in millions)	FY 2025 Final[1]	FY 2026 Enacted[1]	FY 2027 President's Budget[2]	FY 2027 +/- FY 2026
Budget Authority	$760.272	$781.272	$927.764	+$146.492
Prevention and Public Health Fund (PPHF) Transfer[2]	$52.000	$52.000	$0.000	-$52.000
Total Request	**$812.272**	**$833.272**	**$927.764**	**+94.492**
FTEs[3]	1,660	1,608	1,728	+121
-- Antimicrobial Resistance Initiative	$197.000	$197.000	$219.278	+$22.278
-- Vector-borne Diseases[4]	$90.603	$91.603	$87.817	-$3.786
-- Prion Disease	$8.000	$9.000	$0.000	-$9.000
-- Chronic Fatigue Syndrome	$5.400	$5.400	$0.000	-$5.400
-- Emerging Infectious Diseases[5]	$265.997	$275.997	$303.897	+$27.900
-- Food Safety	$72.000	$74.000	$107.000	+$33.000
-- National Health Care Safety Network	$24.000	$24.000	$24.000	$0.000
-- Travel and Port Health Protection[6]	$53.772	$57.772	$79.772	+$22.000
-- Advanced Molecular Detection (AMD)	$40.000	$43.000	$66.000	+$23.000
-- Harmful Algal Blooms	$3.500	$3.500	$0.000	-$3.500
-- Epi and Lab Capacity Program	$40.000	$40.000	$40.000	$0.000
-- Epi and Lab Capacity program (BA)	$0.000	$0.000	$40.000	+$40.000
-- Epi and Lab Capacity program (PPHF)	*$40.000*	*$40.000*	*$0.000*	*-$40.000*
-- Healthcare-Associated Infections (PPHF)	*$12.000*	*$12.000*	*$0.000*	*-$12.000*

[1] FY 2025 Final reflects full year Continuing Resolution level.
[2] The FY 2027 Budget eliminates funding for the Prevention and Public Health Fund (PPHF).
[3] FTE displayed reflect current estimates, which may differ from the system of record. FTE estimates may not represent expected FTE levels across FY 2027. These estimates are subject to change.
[4] Includes funding for Lyme Disease and Other Tick-Borne Diseases.
[5] FY 2025 and FY 2026 totals are comparably adjusted to reflect the proposed realignment of the following activities into Emerging Infectious Diseases: Surveillance for Emerging Threats to Mothers and Babies and Parasitic Diseases and Malaria.
[6] Formerly reflected as “Quarantine” PPA name.

Enabling Legislation Citation: PHSA § 301; PHSA § 304; PHSA § 307; PHSA § 308(d); PHSA § 310; PHSA § 317; PHSA § 319; PHSA § 352; PHSA § 353; PHSA § 2821; PHSA § 319E PHSA § 317U; PHSA § 2822; PHSA § 317S; PHSA § 317P; PHSA § 319B; PHSA § 319D; PHSA § 319F; PHSA § 319C-3; 22 USC § 7634; PHSA § 317C; PHSA § 317L; PHSA § 317K PHSA § 317R; PHSA § 399V-5; FSMA § 205; FSMA § 210; PHSA § 399II; PHSA § 399JJ PHSA § 311; PHSA § 322; PHSA § 325; PHSA §s 361-369; INA § 212; INA § 232; INA § 412

Enabling Legislation Status: Permanent Indefinite

Authorization of Appropriations for FY 2026: Indefinite; Expired/Expiring noted with *

Allocation Methods: Direct Federal/Intramural, Contracts, and Competitive Grants/Cooperative Agreements

CDC defends the country against public health threats by preventing and controlling a wide range of infectious diseases, including outbreaks caused by bacteria, viruses, fungi, parasites, Select Agents, high-consequence pathogens, and other zoonotic pathogens that threaten national security. CDC's world-class scientists, researchers, laboratory scientists, and outbreak responders reduce illness and deaths associated with infectious diseases through several core functions, including:

- **Public health surveillance**: CDC's disease surveillance systems, which serve as early warning systems, are critical to enabling CDC experts to quickly identify and rapidly respond to emerging threats, control outbreaks, and save lives.
- **Outbreak preparedness and response**: CDC has unique scientific expertise on over 880 pathogens and works closely with partners to rapidly detect and contain outbreaks at the source, protecting Americans.
- **Laboratory expertise**: CDC laboratories advance disease detection, identification, and prevention and serve as world-renowned reference laboratories for the United States and abroad. These laboratories develop state-of-the-art diagnostic tools, support essential confirmatory testing activities to identify pathogens, and research new targets for drug and vaccine development, capabilities that do not exist elsewhere in the United States. CDC's virtual and specialized reference laboratories (e.g., MicrobeNet, DPDx, and CDC's National Rabies, Smallpox, and Viral Hemorrhagic Fever Reference Laboratories) provide tools to identify rare and complex pathogens quickly and accurately, leading to early diagnosis, tailored approaches to treatment, and prevention of new infections.
- **Improving healthcare quality, health systems resilience, and patient safety:** CDC uses science, data, and expertise to protect patients, keep healthcare workers safe, and strengthen healthcare delivery systems both domestically and internationally through surveillance and tracking, medical product safety, infection prevention and control training and capacity building, and health system strengthening.
- **Support to state and local health departments**: The Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) program works to detect, track, and stop a wide range of infectious threats. It provides direct financial support to 65 jurisdictions, including all 50 states, seven localities, and U.S. territories and affiliates for monitoring, detection, outbreak response, and prevention of infectious diseases while providing recipients world-class expertise and strategic direction.
- **Protecting public health through CDC Port Health Protection System:** CDC plays a vital role limiting the introduction and spread of contagious diseases with epidemic potential. CDC Port Health Protection staff, including doctors and veterinarians, respond to reports of ill travelers at ports of entry, alert travelers to health threats, and restrict the importation of animals and products that may carry disease. Together, these measures proactively identify and mitigate health risks at U.S. borders and points of entry, protecting public health nationwide.

CDC's FY 2027 budget request of **$927,764,000** for Emerging and Zoonotic Infectious Diseases is **$94,492,000** above the FY 2026 enacted level. This request includes support for two new secretarial initiatives and funding to prioritize emerging and re-emerging infectious disease threats and to expand innovative outbreak detection through CDC's Biothreat Radar program.

In coordination with the White House and the Department of War, CDC will support a Biothreat Radar detection system that leverages advances in pathogen genomics and data integration to strengthen the nation's ability to rapidly detect and respond to infectious disease threats before they escalate, building on CDC's Advanced Molecular Detection (AMD) and Traveler-based Genomic Surveillance (TGS) programs.

CDC will work with federal partners and state, local and territorial partners to implement Biothreat Radar as a layered early warning system that expands innovative metagenomic detection approaches and

strengthens outbreak signal detection. By integrating multiple data streams, the system will help distinguish meaningful signals from background noise, enabling timely and effective public health action. With resources to implement the Biothreat Radar system, CDC will:

- **Deploy innovative metagenomic tools** to efficiently detect and analyze multiple pathogens from a single clinical or community sample;
- **Expand traveler-based genomic surveillance** to improve detection of pathogens with international origins and assess patterns of global spread;
- **Integrate complex data into a unified analytic platform** to accelerate automated outbreak and signal detection and translate data into actionable intelligence; and,
- **Enhance data sharing and partnerships** with federal and jurisdictional partners to support modernized infectious disease investigation and coordinated preparedness and response.

CDC launched the integration of the Biothreat Radar program in 2025 with additional resources dedicated to metagenomic testing, data analytics, and the AMD and TGS programs. This request sustains the ongoing program implementation to ensure an early warning system that will protect Americans for years to come.

EMERGING AND ZOONOTIC INFECTIOUS DISEASES

By the Numbers[1]

- **>235,000 tests conducted** from January to December 2025 by the Antimicrobial Resistance Laboratory Network to rapidly detect and respond to AR threats across healthcare, the community, food supply, and environment.
- **~200 healthcare-related outbreaks** across U.S. jurisdictions were contained in 2025 using CDC experts.
- **>394 expert consultations** on cases involving bacterial biothreat agents that cause anthrax and melioidosis and other rare but deadly pathogens in 2025.
- **>11,000 port health protection activities** (e.g., ill traveler or death, animal/animal products importation) requiring CDC Port Health Station staff response at U.S. land, air, and seaports of entry in 2025.
- **~270,000 illnesses prevented** and at least **$500 million saved** in medical costs and lost productivity through CDC's PulseNet laboratory network, which uses whole genome sequencing to stop foodborne outbreaks, delivering a $70 return for every $1 invested.
- **>1,700** rabies inquiries into CDC's Rabies Hotline from 48 states and 36 countries in 2025.
- **>2,700 parasitic disease diagnosis and healthcare consultation services** were provided in 2025 at the request of U.S. healthcare providers and public health officials from across **49** states.
- **>900 arboviral disease calls** fielded in 2025 from 47 states, Washington DC, Puerto Rico, and other countries, providing support for diagnosis and clinical management of mosquito-borne diseases.

[1] All statistics are from CDC program data unless otherwise stated.

Emerging and Zoonotic Infectious Diseases Funding History	
Fiscal Year	Dollars (in Millions)
FY 2023 Final (BA)	$698.772
FY 2023 Final (PPHF)	$52.000
FY 2024 Final (BA)	$760.272
FY 2024 Final (PPHF)	$52.000
FY 2025 Final (BA)[1]	$760.272
FY 2025 Final (PPHF)[1]	$52.000
FY 2026 Enacted (BA)[1]	$781.272
FY 2026 Enacted (PPHF)[1]	$52.000
FY 2027 President's Budget (BA)	$927.764
FY 2027 President's Budget (PPHF)[2]	$0.000

[1] FY 2025 and 2026 Levels reflect the proposed realignment of the following activities into Emerging Infectious Diseases: Surveillance for Emerging Threats to Mothers and Babies and Parasitic Diseases and Malaria.
[2] The Budget Request eliminates funding for the Prevention and Public Health Fund (PPHF).

Antimicrobial Resistance Initiative Budget Request

Antimicrobial resistance (AR) occurs when bacteria or fungi no longer respond to medications designed to treat infections and poses a serious and growing threat to public health, modern medicine and the U.S. veterinary and agricultural sectors. Antimicrobial-resistant infections are difficult or impossible to treat, resulting in increased illness, death, and healthcare costs. Each year, AR threats such as *Candida auris* (*C. auris)* and carbapenem-resistant Enterobacterales (CRE), are estimated to cause nearly 3 million infections and approximately 50,000 deaths in the United States.

CDC works to rapidly prevent, detect, contain, and respond to AR threats and outbreaks. Through Antimicrobial Resistance Initiative (*AR Initiative)*, CDC leads the national public health response to combat AR by strengthening surveillance, laboratory capacity, outbreak response, and prevention activities. The *AR Initiative* supports a comprehensive and coordinated approach to ensure resilient public health infrastructure is in place to address AR wherever it emerges, helping to protect patients and preserve the effectiveness of lifesaving treatments.

Budget Request

CDC's FY 2027 budget request of **$219,278,000** for the Antimicrobial Resistance Initiative is **$22,278,000** above the FY 2026 enacted level. The proposed increase strengthens CDC's ability to protect patients and communities from urgent AR threats by expanding early detection, genomic characterization, infection prevention and control, and rapid containment of highly dangerous pathogens, including *Candida auris* (C. auris) and carbapenem-resistant *Enterobacterales* (CRE). In every state, as well as some large cities and territories, public health laboratories provide specialized testing capacity for these urgent AR threats through the CDC Antimicrobial Resistance Laboratory Network (AR Lab Network) and health department Healthcare-associated Infection & AR (HAI/AR) Programs to respond rapidly to detect, control, and prevent AR outbreaks.

C. auris and CRE are urgent AR threats because they are resistant to multiple, and in some cases all, available antifungal or antibiotic treatment options, spread efficiently in healthcare settings, and are associated with severe illness and high mortality. These pathogens disproportionately affect hospitals and long-term care facilities serving patients, where lapses or gaps in infection prevention and control can accelerate transmission. Individuals may be colonized with *C. auris* or CRE on skin or in the gastrointestinal tract without symptoms, allowing silent transmission through contaminated surfaces, shared medical equipment, or person-to-person contact. Effective infection prevention and control rely on specialized laboratory testing, including colonization screening and whole genome sequencing, to detect these pathogens, characterize resistance mechanisms, and link cases during outbreaks. Without early detection and rapid infection control response, *C. auris*, CRE, and other AR threats can spread within healthcare facilities and into surrounding communities, significantly increasing the risk of untreatable infections.

The FY 2027 increase will enable CDC to:

- Expand rapid laboratory detection, colonization screening, whole genome sequencing, and outbreak investigation to identify transmission pathways and inform infection prevention and control strategies for *C. auris*, CRE, and other urgent AR threats through the AR Lab Network.
- Strengthen federal, state, territorial, and local capacity to detect, contain, and sustain infection prevention control measures to detect, contain, and prevent AR outbreaks across acute care hospitals, long-term care facilities, and other healthcare settings through health department programs.
- Collaborate with other HHS operating divisions to advance development and evaluation of microbiome interventions and research such as pathogen-reduction products and approaches, including decolonization strategies and environmental controls, that support prevention and control and reduce infection and transmission among individuals colonized with *C. auris* or CRE.

CDC's FY 2027 request supports core public health capacities critical to protecting against emerging and existing health threats. Funding will strengthen infection prevention and control, antibiotic stewardship, and healthcare quality improvement activities nationwide. By reducing infections caused by urgent AR threats, these investments help preserve the effectiveness of existing antibiotics and antifungals, limit the spread of resistance, and reduce preventable illness and death, particularly among individuals with chronic conditions.

FY 2027 request supports:

- Sustained AR testing and genomic surveillance capacity through the AR Lab Network for rapid detection of resistance mechanisms and transmission patterns in healthcare, food, and community settings.
- Partnerships with public health and healthcare stakeholders to improve patient safety and promote appropriate antibiotic use across inpatient and outpatient settings.
- Critical scientific infrastructure to support the development of new antibiotics, antifungals, prevention products, and diagnostics.
- Global laboratory and response capacity through the Global Antimicrobial Resistance Laboratory and Response Network to detect emerging AR threats and slow their spread before they reach the United States.

Program Accomplishments

State, Local, and Territorial Investments: In FY 2025, CDC invested more than $86 million to sustain core AR laboratory and epidemiological capacity in all states, as well as several large cities and territories. These investments enabled health departments to rapidly detect, respond to, and contain AR threats in healthcare and community settings.

Since 2019, health departments' HAI/AR Programs have responded to more than 150,000 confirmed and potential outbreaks and conducted more than 29,000 prevention-based infection control assessments.

As of June 2025, CDC's AR Lab Network has performed more than 1.5 million tests to support rapid detection and outbreak control, including nearly 457,000 isolate characterizations; more than 453,000 colonization screenings; and more than 609,000 whole genome sequences to identify resistance mechanisms and transmission patterns.

Supporting treatment and prevention options to combat AR: In FY 2025, CDC invested approximately $32 million in innovative approaches to prevent infections and combat AR. CDC advanced the identification and evaluation of pathways for novel pharmaceutical and non-pharmaceutical interventions, including pathogen-reduction products, to better prevent the spread of resistant infections and protect patients.

Through CDC's Prevention Epicenters Program, FY 2025 research demonstrated that pathogen reduction approaches, such as fecal microbiota transplantation, reduced infection frequency among long-term acute care hospital patients colonized with multidrug-resistant organisms, supporting new prevention strategies for high-risk healthcare settings.

In FY 2025, CDC's Antibiotic Resistance in Communities and Hospitals (ARCH) program identified alarmingly high rates of AR in community and hospital settings across six low- and middle-income countries, underscoring the continued risk of global AR spread and the importance of sustained international surveillance and response to protect U.S. health security.

As of December 2025, the CDC–FDA AR Isolate Bank had distributed more than 500,000 AR isolates to approved diagnostic device and drug manufacturers, researchers, and clinical laboratories. These

materials support the development of new diagnostics, therapeutics, and prevention products, strengthening laboratory capacity, and enable rapid detection of emerging AR threats requiring swift public health action.

Travel and Port Health Protection (formerly Quarantine) Budget Request

CDC's travel and port health protection activities create a multi-layered system of public health defenses that mitigate the risk of communicable diseases spreading into and within the United States and protect U.S. travelers going abroad. This comprehensive system ensures that there are medical and veterinary experts at U.S. ports of entry available 24/7 to respond to travelers, animals, or animal products at risk of transmitting dangerous pathogens so the flow of travel is not interrupted. Despite the increasing number and complexity of public health emergencies and higher volumes of international travelers over the past decade, resources dedicated to national border health security activities have not kept pace with expanding risk.

The budget request includes renaming the Quarantine appropriations line to Travel and Port Health Protection to better align with programmatic work, including the Port Health Stations and the Traveler-Based Genomic Surveillance program. The new name will better reflect the breadth of work that CDC does beyond the use of quarantine to protect the United States from communicable disease threats. CDC is using innovative surveillance technology to detect pathogens entering the United States and relies on multiple tools and systems to prevent the introduction of communicable disease into and within the United States.

Budget Request

CDC’s FY 2027 budget request of **$79,772,000** for the Travel and Port Health Protection program is **$22,000,000** above the FY 2026 enacted level. The request includes an increase for the Traveler-based Genomic Surveillance program (TGS) as part of the Biothreat Radar Initiative. These resources support CDC’s ability to protect national public health security at key ports of entry and mitigate the risk of international outbreaks and epidemics reaching U.S. communities.

Funding supports CDC’s core travel and port health protection activities, including surveillance, response, and coordination with domestic and global partners. CDC will continue to leverage its expertise, surveillance systems, and global partnerships to develop timely public health alerts, recommendations, and education for American travelers and healthcare providers, helping Americans travel safely while reducing risk of disease importation. Activities supported through the Travel and Port Health Protection line strengthen U.S. preparedness and contribute to a safer, more resilient nation.

CDC’s travel health surveillance activities are essential to assessing the risk of a high-consequence diseases entering the United States through ports of entry and enabling rapid public health response to incoming threats. Funding for TGS will allow CDC to build on existing travel and port health protection surveillance that supports early warning systems for emerging and re-emerging pathogens. These resources will enable TGS to scale rapidly, expand testing for additional pathogens, and provide timely genomic insights to address gaps in global surveillance. Funding will also allow the use of metagenomic sequencing approaches, expanding pathogen-agnostic testing capabilities. Together, these activities strengthen U.S. biosecurity and help protect communities from imported disease threats.

Program Accomplishments

Preparedness and Response: In 2025, CDC Port Health Station staff conducted more than 11,000 port health protection activities, including responding to nearly 1,600 reports of ill travelers or deaths at U.S. land, air, and seaports of entry. These activities also included distributing life-saving medications on 125 occasions to prevent further illness and protect public health.

For example, in February 2025, the Washington DC Port Health Station responded to report involving a Virginia resident who traveled from Marseille, France via Paris to Washington, DC while infectious with *Neisseria meningitidis*, a highly contagious and potentially fatal pathogen. CDC conducted a contact investigation, coordinating with U.S. state health departments, and issued Foreign Public Health Notifications to enable rapid notification, follow-up, and prevention of additional cases.

Travelers' Health: In June 2025, CDC's Traveler-based Genomic Surveillance (TGS) program detected the first known global case of influenza A (H3N2) clade K, demonstrating the program's value as an early warning system for emerging respiratory threats. TGS surpassed 1 million voluntary air travel participants in the program as of January 2026

In 2025, CDC's Travelers' Health website received more than 19 million views, making it one of the most frequently accessed areas of CDC's website. The site includes the digital CDC *Yellow Book*, the authoritative reference for travel medicine authored by more than 200 leading experts. CDC fully revised and updated the *Yellow Book* in 2025, releasing the 2026 print edition in June 2025. The 2026 edition compiles the U.S. government's most current travel health guidance, including pre-travel vaccine recommendations, destination-specific health guidance, and user-friendly maps and graphics. CDC also regularly updates Travel Health Notices and destination pages on provide American travelers with timely information on outbreaks and other health risks, helping keep travelers safe before, during, and after international travel.

Emerging Infectious Diseases Budget Request

Emerging Infectious Diseases (EI) funding supports CDC's core capacity to protect the United States from viruses, bacteria, and other pathogens that emerge as new or evolving public health threats. EI provides flexible, pathogen-agnostic resources that sustain foundational capabilities across CDC's laboratories, applied research, surveillance, and outbreak response activities. These cross-cutting resources are essential to maintain readiness for emerging threats that may not align with disease-specific funding but require immediate CDC engagement.

The number of newly emerging pathogens and the complexity of outbreaks in the United States and globally have increased substantially in recent years. EI funding enables CDC to rapidly detect, characterize, and assess new infectious threats and to initiate response activities to contain outbreaks at their source. Supported activities include identification and tracking of novel pathogens, investigation of transmission pathways and exposure risks, and development and evaluation of medical countermeasures and prevention strategies.

EI funding ensures CDC can respond quickly and flexibly to emerging public health threats by providing surge-ready, infectious disease response resources during outbreaks. These funds allow CDC to initiate and lead response activities early in an emergency, before disease-specific funding is available, and sustain response efforts until outbreaks are contained or transitioned to a larger federal response. EI also supports CDC's role in providing critical laboratory and epidemiologic assistance to state, territorial, and local public health partners, including identifying unusual or unknown pathogens, diagnosing unexplained illnesses, and coordinating rapid, multi-jurisdictional investigations to protect public health.

Budget Request

CDC's FY 2027 budget request of **$303,897,000** for Emerging Infectious Diseases (EI) is **$27,900,000** above the FY 2026 enacted level. The request includes the realignment of Surveillance for Emerging Threats to Mothers and Babies and Parasitic Diseases and Malaria into the EI funding line.

This funding enables CDC to sustain foundational infectious disease capabilities while building the capacity needed to respond to an increasing number of high-consequence outbreaks in the U.S. and

globally. Preventing and containing emerging infectious diseases is essential to protecting lives, reducing healthcare costs, strengthening preparedness for future public health emergencies, and safeguarding national security. The FY 2027 request supports:

- **Infectious disease outbreak investigations** across healthcare and clinical settings, including hospitals, nursing homes, ambulatory surgical centers, outpatient facilities (such as dental clinics), and blood, organ, and tissue donation systems. CDC also provides outbreak consultation and response support to federal partners, including the Indian Health Service, Department of War, and Veterans Health Administration.
- **Foodborne and waterborne disease investigations** nationwide, using advanced detection tools to identify sources of contamination, assess risk factors, and rapidly respond to outbreaks linked to contaminated food and water.
- **Fungal disease detection and response,** including outbreak investigations, laboratory services, national surveillance, and technical assistance to state and local health departments to monitor emerging fungal threats and antifungal resistance.
- **Threat detection and prevention for mothers and babies,** including reducing the impact of infectious diseases such as dengue during pregnancy and examining potential links between emerging threats and adverse pregnancy outcomes, including stillbirth.
- **24/7 parasitic disease diagnostic and clinical support,** providing expert consultation and reference testing for more than 80 parasitic disease pathogens though CDC's national parasitic disease reference laboratories to prevent serious illness and death.
- **Implementation of CDC's Hospital Sepsis Program Core Elements,** including expanded data collection and collaboration with CMS and other partners to develop three healthcare quality measures that improve sepsis detection and outcomes nationwide.
- **Advanced diagnostic, vaccine, and therapeutic development** in CDC's high-containment BSL3 and BSL4 laboratories, where specialized scientists develop countermeasures against some of the world's most dangerous pathogens, including Ebola and anthrax.
- **Poxvirus preparedness and response,** including validated diagnostic testing for known and emerging poxviruses, technical support to more than 100 U.S. laboratories, and development of safer vaccines, therapeutics, and enhanced diagnostics to strengthen readiness for threats such as monkeypox, and novel poxviruses (e.g., borealpox).
- **Rabies diagnostics and response,** through CDC's National Rabies Reference Laboratory–the only reference center for rabies diagnosis in the United States–which provides technical support to more than 130 laboratories and is one of only three U.S. laboratories capable of testing human organ or tissues samples.
- **Identification of unexplained infectious disease illness and death** through CDC's pathology laboratories, providing critical diagnostic expertise that informs patient care and guides rapid public health action.

Strengthening Readiness for High-Consequence Pathogens

This request strengthens CDC's readiness for high-consequence pathogens with pandemic potential, including viral hemorrhagic fevers (such as Ebola and Marburg viruses), poxviruses, and other emerging threats that often lack effective treatments or vaccines. As novel pathogens emerge with increasing frequency and geographic spread, amplified by global travel and trade, these threats pose growing risks to public health and national security.

Resources also support CDC's nationally recognized infectious disease pathology program and ensure medical countermeasures in the Strategic National Stockpile are safe, ready, and supported by clear guidance for rapid deployment during public health emergencies.

Community-Level Detection and Early Warning
EI funding also supports the use of community-level surveillance tools that complement clinical surveillance to detect emerging infectious diseases earlier. These approaches strengthen nationwide early warning capabilities, improve understanding of transmission patterns, and inform faster, more targeted response actions in coordination with expanded capabilities under the Biothreat Radar Initiative.

Program Components Realigned in EI
Surveillance for Emerging Threats to Mothers and Babies (SET-NET)
SET-NET is a multi-faceted surveillance program that detects, understands, and reduces threats to pregnant women and infants. CDC funds a nationwide network of geographically distributed health departments and clinics to collect and link high-quality, population-based mother-infant data. SET-NET findings directly inform clinical and public health guidance; for example, evidence generated through SET-NET led the American College of Obstetricians and Gynecologists to recommend syphilis screening three times during pregnancy.

Parasitic Diseases and Malaria
Parasitic diseases cause severe illness and death in the United States and globally and can be transmitted through vectors, contaminated food or water, blood or tissue donation, congenital exposure, or person-to-person contact. CDC provides unique diagnostic expertise, surveillance, and rapid-response capacity for rare, emerging, and severe parasitic infections, including malaria and neglected tropical diseases.

CDC maintains life-saving treatments not commercially available in the United States through its Drug Service and conducts 129 CLIA-approved parasitic disease tests, seven of which are available only at CDC. In 2025, Washington and New Jersey reported malaria cases among individuals without recent international travel, representing the first probable local transmission in decades in those areas and underscoring the need for enhanced clinician awareness and vector surveillance.

CDC is also monitoring malaria trends and strengthening response capacity related to the invasive mosquito *Anopheles stephensi*, while working with federal, tribal, and state partners to address the northward spread of New World Screwworm, a serious re-emerging parasitic threat.

Program Accomplishments

Strategic CDC investments are delivering public health and national security returns through rapid detection and response to high-consequence infectious disease threats, as reflected in the accomplishments below.

High consequence viral pathogen outbreaks: Over the past two years, CDC has responded to 22 outbreaks or cases involving viral hemorrhagic fevers (VHFs) and other high-consequence viruses, including Ebola virus disease in the Democratic Republic of Congo, Marburg virus disease in Ethiopia, Sudan virus disease in Uganda, Chapare virus infection in Bolivia, Lassa fever in Iowa, and imported cases of novel hantavirus in the United States linked to travel from Paraguay. CDC rapidly deployed epidemiologic and laboratory teams to affected locations or provided technical assistance to support containment and limit spread.

In 2025, CDC subject matter experts provided 111 clinical consultations related to VHFs and other high-consequence pathogens in response to outbreaks and suspected domestic importations. CDC also supported epidemiologic investigations and partnerships to expand diagnostic testing capacity, helping reduce transmission, prevent further spread, and protect national security.

In the past 13 months, CDC worked with state partners to rapidly detect, contain, and prevent onward transmission of 10 cases of clade I monkeypox in the United States. Historically, clade I monkeypox has

been associated with higher severity and mortality than clade II monkeypox, which caused a U.S. outbreak of more than 30,000 cases in 2022. CDC leveraged capabilities strengthened during the 2022 response, including enhanced genomic surveillance, expanded clade-specific diagnostic testing, improved specimen handling and waste management, and updated prevention, clinical, and vaccination guidance, to prevent a clade I monkeypox outbreak in the United States.

Identification of emerging bacterial infections: In 2025, CDC subject matter experts responded to more than 394 clinical inquiries involving high-risk bacterial pathogens, including agents that cause anthrax, melioidosis, brucellosis, and other rare but deadly infections. Through these consultations, CDC provided guidance to clinicians and health departments on patient management, exposure assessment, and outbreak investigation.

CDC also supported epidemiologic investigations, provided specialized laboratory testing, refined and developed new diagnostic tools to detect these pathogens and associated antimicrobial resistance, and ensured access to available therapeutics. These efforts strengthened rapid response to emerging bacterial threats and helped protect the American public.

Investigating Rabies in Organ Donation Recipient: In February 2025, CDC's National Rabies Reference Laboratory confirmed rabies virus infection as the cause of death in a kidney transplant recipient with no known animal exposure. CDC rapidly coordinated a multi-state investigation to identify the source of infection and determine others at risk, as rabies is nearly always fatal without prompt post-exposure prophylaxis (PEP).

The investigation determined the organ donor had been scratched by a skunk six weeks prior to death, and CDC detected rabies virus in the donor's kidney, confirming transplant-associated transmission. CDC rapidly traced tissue distribution, intercepted one cornea before implantation, and ensured identification and PEP administration for high-risk contacts, including three cornea recipients. As a result of CDC's swift action, no additional rabies cases occurred. Findings from this investigation prompted CDC, the Health Resources and Services Administration, and partners to modify organ donor screening protocols to prevent future transplant-associated rabies and save lives.

Confronting Parasitic Threats and Protecting Public Health: CDC continues to serve as the nation's last line of defense against parasitic disease threats. In 2025, more than 9 million users accessed CDC's parasitic diseases website for prevention and treatment guidance on malaria and other parasitic infections, protecting Americans in the United States and those traveling, living, or stationed overseas.

As a national reference laboratory for parasitic diseases, CDC processed more than 900 diagnostic tests in 2025, many with same-day results, for conditions such as New World Screwworm, testing that is largely unavailable elsewhere in the United States. CDC experts also provided more than 2,700 clinical consultations for diagnosis and treatment of at least 48 parasitic diseases, including malaria, across 49 states, Washington, DC, Puerto Rico, and the U.S. Virgin Islands. These critical services directly contributed to lives saved and strengthened national preparedness against emerging and re-emerging parasitic threats.

Vector-Borne Diseases Budget Request

The United States faces increasing risk from vector-borne diseases as ticks, mosquitoes, fleas, and other vectors expand into new geographic areas, placing more Americans at risk of infection. CDC leverages state-of-the-art scientific techniques and unique expertise to prevent, detect, and respond to cases and outbreaks of vector-borne diseases, including Oropouche, dengue, chikungunya, and yellow fever. CDC also leads national efforts to protect Americans from Lyme disease, the most common vector-borne disease in the United States.

Budget Request

CDC's FY 2027 budget request of **$87,817,000** for Vector-Borne Diseases is **$3,786,000** below the FY 2026 enacted level. This request continues the consolidation of Lyme Disease and Related Tick-borne Illnesses and Vector-Borne Diseases into a single Vector-Borne Diseases line maintaining core surveillance, prevention, and outbreak response capacity.

In FY 2027, CDC will continue to protect Americans from expanding and emerging vector-borne disease threats by:

- **Respond to emerging and re-emerging infectious disease threats**, including dengue, chikungunya, and Oropouche viruses, as well as expanding threat of Lyme disease, including fielding clinical inquiries to support the diagnosis and clinical management of vector-borne diseases.
- **Increase national and jurisdictional preparedness and response capacity** for vector-borne diseases through the vector-borne disease Centers of Excellence (COEs); Training, and Evaluation Centers (TECs); and the ELC cooperative agreements.
- **Improve and develop diagnostic tests**, for new and emerging diseases, as well as existing diseases such as Lyme disease, for which reliable diagnosis at early and late stages of illness remains challenging.
- **Develop, expand, and refine vector surveillance** to better understand the risk factors for vector-borne diseases, including factors driving the expansion and emergence of diseases transmitted by mosquitoes, ticks, and biting midges.
- **Prioritize prevention** by developing improved vector control tools, vaccines, and other public health prevention strategies; working with partners to evaluate and implement these approaches through public health programs; and educating healthcare providers and the public on best practices for prevention and management of acute and persistent symptoms following infection.

Program Accomplishments

Responding to emerging and re-emerging vector-borne disease threats: In June 2025, CDC deactivated the emergency response structure established to support the United States and U.S. territories during the dengue outbreak in Puerto Rico and the U.S. Virgin Islands. This response occurred amid a record global surge in dengue, with more than 13 million reported in the Americas in 2024, including a record 3,483 dengue cases identified among U.S. travelers. Throughout the response, CDC supported dengue surveillance, vector control, and laboratory testing to promote prevention strategies and best practices and to reduce transmission.

During the same period, large outbreaks of Oropouche virus (OROV) occurred in South America and expanded into new geographic areas, including Cuba and Panama. CDC identified 109 returning travelers with OROV during this outbreak, with deaths reported among otherwise healthy individuals. Infections during pregnancy were also associated with fetal death and possible birth defects. CDC is continuing to assess the risk of severe disease, adverse birth outcomes, and potential spread in the United States. To strengthen detection capacity, CDC facilitated the development of two commercial molecular assays for OROV, expanding access to testing for this emerging threat.

CDC also responded to emerging mosquito-borne disease threats, including monitoring a large chikungunya outbreak in Cuba, which resulted in 276 travel-associated cases across 15 states and U.S. territories and one locally transmitted case in New York as of December 2025. To support clinical recognition and management of emerging and re-emerging vector-borne diseases, CDC conducted 918 clinical consultations in 2025. CDC also launched new vector-borne disease training and education modules for clinicians, including a module on alpha-gal syndrome, a tickborne disease–associated meat allergy.

National Healthcare Safety Network (NHSN) Budget Request

NHSN is the nation's most comprehensive and widely used system to identify emerging and enduring threats across healthcare, including those caused by AR pathogens, emerging infectious diseases, and infections leading to sepsis.

Almost 39,000 U.S. healthcare facilities, including nearly every hospital, ambulatory surgery center, dialysis facility, and CMS-certified nursing home participate in NHSN. The number of healthcare facilities participating has doubled since 2015 and there are now more than 160,000 users from healthcare providers to health departments sending data to inform action. NHSN data and analytics help drive real-time patient safety and healthcare quality improvement by enabling healthcare facilities to track, report, assess gaps, and take actions related to a range of urgent health threats.

Budget Request

CDC's FY 2027 budget request of **$24,000,000** for NHSN is level with the FY 2026 enacted level. With this funding, CDC will continue collecting and sharing data and analytical tools with healthcare facilities, states, and other federal partners to help them better identify, prepare for, and respond to a wide range of infectious disease threats. NHSN will also continue working to automate and further integrate the data systems necessary to track hospital admissions for respiratory diseases and monitor hospital bed capacity to provide situational awareness for health departments, state and federal agencies, and healthcare facilities to better assess hospital capacity during emergencies. NHSN will continue working closely with healthcare facilities and state, local, and federal government agencies to meet Centers for Medicare and Medicaid Services (CMS) and other regulatory requirements.

Program Accomplishments

Real-time hospital capacity data: In 2024, CDC launched NHSN's Bed Connectivity Initiative, to provide real-time hospital capacity to health departments, other state and federal partners. These data support emergency and surge planning and improve patient safety. In 2025, NHSN continued its efforts to automate data reporting from facilities to increase the timeliness of actionable data and reduce healthcare worker burden. Participation has increased to 35 jurisdictions, up from three in 2023, with more than 360 facilities reporting automated hospital bed capacity data. Timely, accurate data strengthen national, state, and local efforts to optimize and mitigate resources constraints, particularly during emergencies.

Advanced Molecular Detection (AMD) Budget Request

The AMD program is a cross-cutting, collaborative program that has transformed public health surveillance and response at CDC and across the U.S. public health system using genomic sequencing. The AMD program is a key component of our national biosecurity, providing a flexible, cross-cutting, and multi-pathogen set of tools for sequencing and bioinformatics that allow us to rapidly detect and respond to emerging infectious disease threats.

Budget Request

CDC's FY 2027 budget request of **$66,000,000** for AMD is **$23,000,000** above the FY 2026 enacted level to support CDC's Biothreat Radar Initiative. This initiative will build capacity to conduct metagenomic surveillance for multiple pathogens in the United States and inform clinical and public health action. CDC's AMD program will work across interagency partners, and with public and private sector partners, to establish a secure, next generation surveillance approach that ensures privacy and consistency across laboratories and supports efficient, timely data sharing for action.

In FY 2027, CDC will maintain critical support for federal, state, and local sequencing capacity, sequencing analytics, cloud-based computing, and workforce training in state and local public health agencies. The program will continue to support Pathogen Genomic Centers of Excellence to drive innovation, advance the use of cutting-edge technology, and strengthen response readiness and pathogen genomics capabilities. The AMD program will continue to focus investments in four key areas:

- **Fostering innovation in advanced genomic technologies** to improve detection, tracking, and response to infectious diseases;
- **Advancing data tools and next-generation analytics** to generate actionable insights from complex pathogen sequencing data;
- **Strengthening pathogen genomic capacity in state and local health departments** to translate data into action and protect communities; and
- **Enhancing quality and standardization of pathogen sequencing tests** to ensure accuracy, reliability, and readiness public health use.

Program Accomplishments

Pathogen Genomics Centers of Excellence (PGCoE): The *PGCoE* network fosters innovation and builds technical capacity in pathogen genomics at state health departments, academic institutions, and private partners, leveraging advances in genomic and bioinformatic technologies to support public health response needs. For example, Massachusetts dairy farmers participated in a Highly Pathogenic Avian Influenza (HPAI) virus monitoring program through the New England PGCoE, achieving 100 percent participation and confirming farms were virus-free at no cost to farmers.

AMD Platform for federal, state, and local data analysis: AMD has developed and is deploying a comprehensive, cloud-based AMD Platform to support high-volume biological data exchange, management, transformation, and analysis for CDC and state and local jurisdictions. The platform enables more secure, standardized sharing of pathogen genomic data on a common infrastructure and provides data visualization tools to help public health partners interpret complex datasets, strengthening outbreak detection and pathogen surveillance and control. For example, AMD Platform reduced the average time for tuberculosis sample analysis by 94 percent - from 18 hours to 57 minutes–allowing public health partners to access sequencing results within one day of data submission rather than days or weeks. These improvements have supported earlier identification of a multi-state case cluster and enabled a faster, more tailored public health response.

Food Safety Budget Request

CDC has a unique role in detecting and investigating foodborne illnesses and outbreaks, including attributing illnesses to specific foods and exposure settings. CDC works in collaboration with Food and Drug Administration (FDA), the U.S. Department of Agriculture (USDA), state and local health departments, and food industries to protect Americans from food contaminated with dangerous pathogens.

CDC's food safety surveillance network is the only source of human enteric disease illness data across the U.S. government, providing nationwide visibility into foodborne illness trends and outbreaks. Through this network, CDC works to reduce the size, scope, and severity of foodborne outbreaks by rapidly detecting outbreaks caused by priority pathogens, strengthening molecular surveillance systems to quickly identify and characterize foodborne threats, and supporting coordinated prevention and response efforts with federal, state, local, and industry partners.

Budget Request

CDC's FY 2027 budget request of **$107,000,000** for Food Safety is **$33,000,000** above the FY 2026 enacted level and reflects a targeted investment to modernize food and water safety systems, close critical surveillance gaps, and strengthen prevention of foodborne and waterborne illness. The proposed increase supports the Healthy and Safe Food Initiative, a cross-cutting effort that enhances CDC's capacity to prevent, detect, and respond to foodborne and waterborne illness in coordination with federal, state, tribal, local, and territorial partners.

Funding for the Healthy and Safe Food Initiative will support activities including:

- Expanding prevention efforts through proven programs such as FoodNet, in collaboration with state, tribal, local, and territorial (STLT) partners, to identify emerging threats, target high-risk practices, and inform upstream interventions to keep food and water safer for all Americans.
- Assessing human exposure to micro- and nanoplastics (MNPs) by developing standardized methods to detect MNPs in biological samples, such as blood and urine, and conducting pilot studies to evaluate potential health effects – addressing a critical gap in understanding how plastics enter and affect the human body.
- Developing public-private partnerships to explore new, low-cost methods for detecting plastics in food.

Clean water and safe food are essential to a healthy America. Each year, 48 million people – one in six Americans – experience foodborne illness, resulting in approximately 128,000 hospitalizations and 3,000 deaths. An additional 7 million people become ill from waterborne pathogens annually, leading to 7,000 fatalities and $3.3 billion in direct healthcare costs. These illnesses underscore the importance of sustained investments in prevention, early detection, and response.

CDC's food and water programs conduct essential science and build prevention strategies to protect the public from foodborne, waterborne, and One Health threats. Waterborne disease prevention remains particularly under-resourced at the state and local level. CDC provides critical expertise and tools to detect, investigate, and mitigate outbreaks, including those caused by emerging threats such as parasites and brain-eating amoebas. Faster detection, stronger infrastructure, and coordinated response can contain outbreaks early and prevent further spread.

With this investment, CDC's Healthy and Safe Food Initiative will:

- **Modernize surveillance systems such as PulseNet,** a national laboratory network that links foodborne and waterborne illness cases using whole genome sequencing (WGS) to identify pathogen DNA 'fingerprints'. To keep pace with evolving clinical practices, public health laboratories must adopt next-generation metagenomics methods that extract molecular data directly from patient samples without reliance on culture, requiring advanced laboratory and

informatics infrastructure at CDC and in state and local health departments. This ensures surveillance systems remain strong and responsive despite evolving clinical technologies.

- **Develop and apply reliable testing methods**, to generate baseline exposure data for the U.S. population and launch pilot studies to explore the health effects of human exposure to micro- and nanoplastics.
- **Establish public-private partnerships** to explore innovative, low-cost methods for detecting plastics in food.
- **Streamline and modernize data collection and transmission**, to support a unified vision for efficient, interoperable systems. These surveillance tools empower state, tribal, local, and territorial partners to identify and contain outbreaks swiftly, and ultimately guide smarter prevention strategies to reduce future risk.

In FY 2027 CDC will continue to:

- Use WGS in the PulseNet USA network to rapidly identify outbreaks and better define the sources of foodborne pathogens that make foods unsafe. CDC will also support expanded adoption of WGS methods through PulseNet International to improve global detection and reduce the risk of pathogens reaching the United States.
- Access foodborne illness trends and disparities, identify high-risk foods, and evaluate the effectiveness of prevention strategies.
- Coordinate with FDA, USDA, and NIH to apply advanced laboratory technologies—including genomics, metagenomics, and bioinformatics, for outbreak detection and characterization of foodborne pathogens.

Program Accomplishments

Rapid outbreak detection: Each year, PulseNet prevents an estimated 270,000 illnesses and saves at least $500 million in medical costs and lost productivity–representing an estimated $70 in savings for every $1 invested. The use of WGS has significantly improved CDC's ability to detect and investigate widespread problems in the food supply. In 2025, CDC worked with state, local, territorial, and federal regulatory partners to investigate Listeria illnesses linked to frozen nutritional shakes. Rapid coordination with states and the FDA supported timely traceback, environmental testing, and public communication. Through enhanced surveillance, data analysis, and targeted risk messaging, CDC provided timely guidance to consumers, retailers, and policymakers, helping prevent additional severe illnesses among high-risk populations, including individuals in institutional settings such as nursing homes.

Training to improve capacity for laboratory partners: In FY 2025, CDC trained more than 1,009 domestic and global public health laboratory personnel in best practices for foodborne disease detection, surveillance, laboratory methods–including WGS–pathogen identification, and outbreak investigation and control through trainings, webinars, and knowledge-sharing sessions. Following a pilot of next generation metagenomic sequencing methods in nine domestic PulseNet member laboratories, more than 2,500 specimens have been tested using these techniques. CDC continues to support these laboratories as they implement and refine metagenomic sequencing methods, which are critical to sustaining and modernizing PulseNet surveillance. Investments in laboratory capacity building have strengthened preparedness, enabling CDC and partners to respond to outbreaks more rapidly and effectively, improving public health outcomes and reducing foodborne illnesses.

Epidemiological and Laboratory Capacity (ELC) Program Budget Request

The Epidemiology and Laboratory Capacity Program and cooperative agreement (ELC) provide support to all 50 states, seven large localities, and eight U.S. territories to address growing infectious diseases threats. The program provides recipients with flexibility to meet program goals and milestones while allowing jurisdictions to tailor approaches to their unique community needs.

The ELC program awards more than $200 million annually across multiple CDC programs and serves as the primary mechanism for supporting state, local, territorial, and tribal epidemiology and laboratory capacity for emerging infectious diseases. These funds support more than 3,000 infectious disease staff nationwide, providing jurisdictions with a critical public health workforce and leadership capacity.

Budget Request

CDC's FY 2027 budget request of **$40,000,000** for the ELC Program is level with the FY 2026 enacted level.

This funding will strengthen emerging infectious disease epidemiology, laboratory, and information system capacity in communities across the United States, including support for a skilled public health workforce and flexible systems capable of responding to address emergent infectious disease threats and outbreaks. These investments support approximately 500 highly skilled, cross-trained public health professionals at the state and local level. This funding helps ensure that state and local health departments, the front lines of the nation's health security, maintain the capacity to detect and respond to new or unexpected pathogens and address urgent public health needs.

Program Accomplishments

Hepatitis A in New York City: In February 2025, the New York City Health Department and Mental Hygiene responded rapidly to a case of hepatitis A involving a food worker at a local restaurant. Supported by CDC ELC funding, investigators and epidemiologists quickly identified the source of exposure and individuals at risk. The department established an on-site clinic to provide post-exposure prophylaxis to nearly 100 staff members, preventing further transmission and averting a wider outbreak. This rapid response demonstrates how ELC-supported public health capacity protects public health and supports the continuity of local businesses.

Rapid Response to Infectious Diseases in Chicago: The Chicago Department of Public Health strengthened its infectious disease response capacity by using CDC ELC funds to partner with academic medical centers and establish a Rapid Response Team (RRT). The RRT deploys mobile teams to conduct testing and specimen collection in shelters, clinics and healthcare facilities. Over the past two years, this capacity has enabled faster, more flexible responses to monkeypox and measles outbreaks. On-site testing has reduced strain on hospitals, protected healthcare workers, and limited disease spread, demonstrating how ELC investments support timely, effective outbreak response and protect community health.

Epidemiology and Laboratory Capacity Program

	FY 2025 Final	FY 2026 Enacted[1]	FY 2027 President's Budget[1]
Number of Awards	65	TBD	TBD
Average Award	$4,566,430	TBD	TBD
Range of Awards	$409,917-$18,769,109	TBD	TBD

[1] Grant award estimates are TBD/under development.

NATIONAL CENTER FOR CHEMICALS AND TOXINS

(dollars in millions)	FY 2025 Final[1]	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Budget Authority	$1,700.888	$1,701.287	$1,034.757	-$666.530
Prevention and Public Health Fund (PPHF) Transfer[2]	$51.000	$51.000	$0.000	-$51.000
Total Request[3]	**$1,751.888**	**$1,752.287**	**$1,034.757**	**-$717.530**
FTEs[4]	1,244	1,124	1,591	+467
-- Environmental Health Laboratory	$70.750	$70.750	$70.750	$0.000
-- Environmental Health Activities	$48.600	$48.600	$35.600	-$13.000
-- Environmental Health Threats Prevention	$17.000	$17.000	$17.000	$0.000
-- Safe Water	$8.600	$8.600	$8.600	$0.000
-- Amyotrophic Lateral Sclerosis Registry (ALS)	$10.000	$10.000	$10.000	$0.000
-- Climate and Health	$10.000	$10.000	$0.000	-$10.000
-- Trevor's Law	$3.000	$3.000	$0.000	-$3.000
-- Environmental and Health Outcome Tracking Network	$34.000	$34.000	$0.000	-$34.000
-- Asthma	$33.500	$33.500	$0.000	-$33.500
-- Lead Exposure Registry	$5.000	$5.000	$5.000	$0.000
-- Childhood Lead Poisoning Prevention	$51.000	$51.000	$51.000	$0.000
-- Childhood Lead Poisoning Prevention	$0.000	$0.000	$51.000	+$51.000
-- Childhood Lead Poisoning Prevention (PPHF)	*$51.000*	*$51.000*	*$0.000*	*-$51.000*
-- National Occupational Research Agenda (NORA)	$119.500	$120.500	$0.000	-$120.500
-- Education and Research Centers	$32.000	$32.000	$0.000	-$32.000
-- Occupational Safety and Health Research and Services	$115.100	$115.100	$0.000	-$115.100
-- Personal Protective Technology	$23.000	$23.000	$16.000	-$7.000
-- Mining Research	$66.500	$68.500	$68.500	$0.000
-- National Mesothelioma Registry and Tissue Bank	$1.200	$1.200	$1.200	$0.000
-- Firefighter Cancer Registry	$5.500	$6.500	$6.500	$0.000
-- National Institute for Environmental Health Sciences	$913.979	$913.979	$594.086	-$319.893
-- National Institute for Environmental Health Sciences Interior-Superfund	$79.714	$77.100	$51.814	-$25.286
-- National Center for Toxicological Research	$77.740	$71.758	$56.307	-$15.451
-- Agency for Toxic Substances and Disease Registry	$81.619	$79.800	$78.000	-$1.800

[1] FY 2025 Final reflects full year Continuing Resolution level.
[2] The FY 2027 Budget eliminates the Prevention and Public Health Fund (PPHF).
[3] The FY 2027 Budget establishes a new Center within CDC, National Center for Chemicals and Toxins, and realigns PPAs from NCEH, NIOSH, ATSDR; National Institute of Environmental Health Sciences (formerly of NIH); and National Center for Toxicological Research (formerly of FDA).
[4] FTE displayed reflect current estimates, which may differ from the system of record. FTE estimates may not represent expected FTE levels across FY 2027. These estimates are subject to change.

Enabling Legislation Citation: PHSA § 301; PHSA § 307; PHSA § 311; PHSA § 310; PHSA § 317; PHSA § 327; PHSA § 1706; PHSA § 302; PHSA § 368 Frank R. Lautenberg Chemical Safety for the 21st Century Act, Public Law No. 114-182, section 21; Children's Health Act of 2000
Food Safety Modernization Act, Pub. Law 111–353, title II, § 205; PHSA § 319; 42 USC § 300hh; Water Infrastructure Improvements for the Nations Act § 2203(b); Lead Control Contamination Act of 1988, PHSA § 317B, PHSA § 317A; PHSA § 317O; PPACA § 4002; OSH Act §§ 20–22, Pub. L. 91-596 as amended; Federal Mine Safety and Health Act of 1977 (FMSH Act) §§103, 501, Pub. L. 91-173; The Coast Guard Authorization Act of 2010 (P.L. 111-281), as amended; Toxic Substances Control Act, Pub. L. 94-469 as amended by Pub. L. 102-550; Public Law 117 - 105 - Dr. Lorna Breen Health Care Provider Protection Act; PHSA § 399MM -399MM-3 Federal Coal Mine Health and Safety Act of 1969, 30 U.S.C. § 843; Black Lung Benefits Reform Act of 1977 § 19 (Pub. L. 95-239); Bureau of Mines Act, 30 USC § 1; Research Concerning Refuge Alternatives; Mine Improvement and New Emergency Response (MINER) Act, § 13; Firefighter Cancer Registry Act of 2018, (Pub. L. 115-194); Firefighter Cancer Registry

Reauthorization Act of 2023 (reauthorizes registry until 2028) PHSA Section 401(a); Superfund Research Program: Section 311(a) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, and Section 126(g) of the Superfund Amendments and Reauthorization Act of 1986 Federal Food, Drug, and Cosmetic Act (21 U.S.C. 393(b) (1)); Food and Drug Administration Modernization Act; Food and Drug Administration Amendments Act of 2007; FDA Food Safety Modernization Act (P.L. 111-353); Modernization of Cosmetics Regulation Act of 2022 42 USC § 9604(i); 10 USC § 2704; National Defense Authorization Act of 2018 (P.L. 115-91 § 316); 42 U.S.C. § 1397h; 42 U.S.C. § 9611(c)(4) Water Infrastructure Improvements for the Nation Act, Pub. L. 114-322, § 2203

Enabling Legislation Status: Permanent Indefinite

Authorization of Appropriations for FY 2026: Indefinite; Expired/Expiring noted with *

Allocation Methods: Direct Federal/ Intramural, Contracts, Competitive Grants/ Cooperative Agreements

CDC's FY 2027 budget request of **$1,034,757,000** for National Center for Chemicals and Toxins is **$717,530,000** below the FY 2026 enacted level. This request establishes a new Center within CDC named National Center for Chemicals and Toxins, including PPAs from National Center for Environmental Health, National Institute for Occupational Safety and Health, Agency for Toxic Substances and Disease Registry; National Institute of Environmental Health Sciences (formerly of NIH); and National Center for Toxicological Research (formerly of FDA). Bringing these programs together will allow HHS to streamline Environmental Health and Chemical/Toxic programming into a single entity to increase operational efficiency, improve effectiveness and coordination, and strengthen gold-standard scientific research to ensure the safety of the American people.

National Center for Chemicals and Toxins Funding History[1,2]	
Fiscal Year	Dollars (in Millions)
FY 2023 Final (BA)	$1,751.431
FY 2023 Final (PPHF)	$17.000
FY 2024 Final (BA)	$1,707.295
FY 2024 Final (PPHF)	$51.000
FY 2025 Final (BA)	$1,700.888
FY 2025 Final (PPHF)	$51.000
FY 2026 Enacted (BA)	$1,701.287
FY 2026 Enacted (PPHF)	$51.000
FY 2027 President's Budget (BA)	$1,034.757
FY 2027 President's Budget (PPHF)	$0.000

[1] FY 2024 and FY 2025 totals reflect the proposed realignment to National Center for Chemicals and Toxins.
[2] The 2027 Budget eliminates funding for the Prevention and Public Health Fund (PPHF).

National Institute for Environmental Health Sciences Funding History[1]	
Fiscal Year	Dollars (in Millions)
FY 2023 Final	$913.983
FY 2024 Final	$993.693
FY 2025 Final	$993.693
FY 2026 Enacted	$993.693
FY 2027 President's Budget	$645.900

[1]Amounts do not include the HIV/AIDS permissive transfer under the authority of NIH's Office of AIDS Research.

Environmental Health Laboratory

CDC facilitates disease detection and treatment by developing laboratory tests to identify harmful environmental exposures like per- and polyfluoroalkyl substances (PFAS), nutritional deficiencies, and disease markers. CDC also funds state laboratories to develop their own capacity for detecting environmental exposures. CDC ensures the accuracy of clinical tests for over 45 disease markers, including the millions of tests for cholesterol and thyroid disease each year that doctors rely on to diagnose and treat their patients, and provides reference intervals to help healthcare providers identify patients with abnormal test results, ensuring accurate diagnoses and reducing medical costs. CDC's Newborn Screening Program is the only one in the world that assures the quality of laboratories' newborn screening test results, leading to the early detection and treatment of newborn disorders and preventing the severe disability or death of over 6,000 American infants annually.

CDC protects national security by maintaining laboratory readiness for identifying and mitigating health risks during natural and man-made disasters, including chemical agent, radiological, and nuclear events. CDC develops and performs unique laboratory tests, such as the Rapid Toxic Screen, a series of tests that can detect up to 150 chemical agents in 40 samples within 36 hours of receipt at CDC. After identifying the chemicals, CDC can measure up to 1,000 patient samples per day during an emergency. Results of the Rapid Toxic Screen help identify which chemicals were used, who was exposed, and how much of a particular chemical their bodies absorbed. This information is critical to medical and public health personnel managing a chemical public health emergency.

CDC maintains 24/7 laboratory response capability and can deploy the Chemical Emergency Response Team within two hours of a request to assist with specimen collection, packaging, storage, and shipment. CDC scientists work with state and local officials to collect samples and transport them to CDC where testing can be done to assess people's exposure to chemical agents.

CDC is currently the only laboratory in the United States capable of rapidly measuring anthrax toxin in human blood samples. During a radiological or nuclear emergency, CDC is also the only laboratory that can provide results on over 100 samples within eight hours of sample receipt. In addition, CDC works with public health laboratories in states, territories, cities, and counties through the Laboratory Response Network – Chemical (LRN-C) to assist in expanding local laboratory capacity and preparedness for response to chemical threats.

Budget Request

CDC's FY 2027 budget request of **$70,750,000** for Environmental Health Laboratory is level with the FY 2026 enacted level. CDC will continue to provide diagnostic methods and exposure information for over 400 chemicals; respond to environmental health emergencies; support state capacity through the State Biomonitoring Cooperative Agreement and the Laboratory Response Network; and maintain the Newborn Screening Center of Excellence, which assists states in implementing newborn screening programs.

Program Accomplishments

CDC develops unique, mass spectrometry-based methods to rapidly and accurately detect and diagnose diseases from dangerous toxins and living things that make toxins. CDC has developed specific and sensitive methods for toxins from bacteria, fungi, and algae. For example:

- In 2024, CDC used its newly developed laboratory test to identify the strain of anthrax affecting a Louisiana patient, providing results within hours instead of the days required for other methods. As a result, doctors were able to select the correct antibody treatment right away and monitor the patient's blood levels of anthrax toxin while they were on treatment. CDC monitoring also revealed that doctors would need to administer multiple doses of antibody treatment instead of the standard single antibody dose to assure the patient would survive. In 2025, CDC developed a method for measuring anthrax lethal factor in dried blood spots, improving CDC's response to anthrax threats in remote

locations where refrigerated shipping is difficult and in large-scale events where quicker and easier sample collection is needed.
- In 2025, CDC developed the first ever qualitative diagnostic test for confirming exposures to Novichoks, a class of highly toxic nerve agents that are extremely stable and evade current treatments. This innovative method uses a technique that can lead to the development of additional assays to confirm exposures to other chemical threats, including organophosphate pesticides and emerging nerve agents.

CDC's Environmental Health Laboratory also improves methods used across the United States for improving laboratory detection of synthetic opioids and maintains quality assurance materials that help clinical laboratories identify more than 250 synthetic opioid-related compounds. Additionally, in 2025, CDC identified and addressed discrepancies in lipid and free thyroxine measurements made by U.S. clinical labs, preventing misinterpretations that could lead to unnecessary prescriptions and misclassification of patients. This work ultimately benefitted over 270 million Americans, improving patient care and health outcomes and generating substantial cost savings for individuals and the healthcare system.

State Biomonitoring Cooperative Agreements

(dollars in millions)	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Number of Awards	6	6	6
Average Award	$0.833	$0.833	$0.833
Range of Awards	$0.750-0.900	$0.750-0.900	$0.750-0.900
Total Awards	$5.000	$5.000	$5.000

Newborn Screening Cooperative Agreements

(dollars in millions)	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Number of Awards	1	1	1
Average Award	$1.000	$1.000	$1.000
Range of Awards	No range: one award	No range: one award	No range: one award
Total Awards	$1.000	$1.000	$1.000

Environmental Health Activities

Funding to Environmental Health Activities enables CDC to detect and respond to emerging environmental health threats, including preventing disease related to natural and man-made disasters. CDC serves as a crucial resource with expertise that health departments depend on to identify and implement measures to protect people from disease related to environmental exposures. CDC also deploys staff to assist with investigating illnesses with unknown environmental origins and provides surge capacity for health departments during environmental health emergencies.

Budget Request

CDC's FY 2027 budget request of **$35,000,000** for Environmental Health Activities is level with the FY 2026 enacted level. Funds will support health departments as they identify and address exposures to chemicals and toxins; develop tools, guidance, and training to prevent environmental-related disease; and support responses to environmental health emergencies including natural disasters and chemical exposures. CDC will also protect national security by maintaining readiness to respond to chemical agent, radiological, and nuclear events.

Environmental Health Threats Prevention

CDC maintains 24/7 capability that state and local health departments rely on to quickly find and help people at risk for emerging environmental health threats, such as exposures to harmful chemicals, radiation, and toxins. Whether exposures are unintentional, as in the case of an industrial accident, or intentional, as in the case of a terrorist attack, CDC's assistance allows health departments to rapidly identify the causative agent, effectively treat affected individuals, and minimize future exposures. CDC experts also remain available to provide surge capacity support during environmental health emergencies.

Budget Request

CDC's FY 2027 budget request of **$17,000,000** for Environmental Health Threats Prevention is level with the FY 2026 enacted level. Funding will support health departments as they identify and address environmental exposures; develop tools, guidance, and training to prevent environmental-related disease; and support responses to environmental health emergencies including natural disasters and chemical exposures. CDC will also protect national security by maintaining readiness to respond to chemical agent, radiological, and nuclear events.

Program Accomplishments

In 2025, the City of Milwaukee Health Department identified hazardous levels of lead contamination in nearly 100 Milwaukee public schools. CDC responded by helping the Milwaukee Health Department's laboratory set up a new laboratory instrument to expand their blood lead testing capacity for this issue; reviewing blood lead screening data and providing guidance on testing prioritization; assisting with communicating risks to parents, caregivers, school staff, and the public; and providing information to local healthcare providers to help them identify and treat children with lead exposure. CDC also awarded $394,000 in emergency funding to support blood lead testing of 8,000 students in schools that have not yet been renovated.

In 2025, CDC responded to the southern California wildfires that displaced over 200,000 people, providing resources and expertise that allowed state and local health departments to anticipate and minimize health effects due to poor air quality, prevent illness in shelters, protect the health of first responders, and evaluate childcare centers for contamination prior to reopening. CDC consulted to design sampling plans to identify air, soil, and water contamination that could affect residents' and first responders' health and reviewed ocean water sample data to determine if there were any human health impacts or concerns.

Safe Water

For over two decades, the Safe Water Program has helped protect Americans from environmental contamination and waterborne illness stemming from the water they rely on for drinking, recreation, sanitation, and hygiene. The Safe Water Program provides critical subject matter expertise to state, local, tribal, and territorial health departments to address and eliminate water-related environmental exposures from natural and industrial processes, including flooding, harmful algal blooms, industrial accidents, and water system failures. In FY 2025, the program provided funding through cooperative agreements for 29 health departments to strengthen state and local programs and services for drinking and recreational water. CDC funding also helps state and local health departments improve the prevention and control of *Legionella* and has led to systems that prevent the growth of and exposure to the bacteria in 70,000 buildings.

Budget Request

CDC's FY 2027 budget request of **$8,600,000** for Safe Water Program is level with the FY 2026 enacted level. This request strengthens and supports services in health departments for drinking and recreational water within their jurisdiction. The safe water programs in health departments will provide support to address the cause of water-related environmental exposures; including preventing exposure to legionellosis and other contaminants found in building plumbing systems, and prioritizing efforts to keep small drinking water systems and private wells free from contamination.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Environmental Health Capacity (Includes Safe Water)

(dollars in millions)	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Number of Awards	46	44	44
Average Award	$0.107	$0.112	$0.112
Range of Awards	$0.040-0.249	$0.040-0.249	$0.040-0.249
Total Awards	$4.910	$4.910	$4.910

Program Accomplishments

- The cooperative agreement enabled funded states to develop well-water initiatives, including identifying at-risk wells and other private water systems with elevated levels of chemical, radiological, and biological contaminants such as arsenic, uranium, nitrates, and E. coli. Funded states collected and tested over 26,000 well water samples, finding that one out of six (over 4,300) had high levels of contaminants. This well testing allowed the states to take action to protect the health of the approximately 11,000 people served by those wells.
- With support from the Safe Water Program, the Madison County Department of Health in New York sampled over 400 private wells, finding 39% contaminated with coliform bacteria. The sampling results and subsequent outreach by the county led to 40% of households disinfecting their well and 61% replacing well caps to prevent future contamination.
- The Safe Water Program provided expertise that allowed one state to analyze the risks of harmful algal blooms at 41 locations and supported actions to post needed signage and notices in areas depending on risks.
- A local health department in Wisconsin used the Safe Water cooperative agreement to support the certification of laboratory staff to test for arsenic, reducing well water testing prices for western Wisconsin.

National Amyotrophic Lateral Sclerosis (ALS) Registry

An estimated 34,000 people in the United States live with ALS, with cases projected to rise to over 36,000 by 2030. Launched in 2010, the National Amyotrophic Lateral Sclerosis Registry—a joint effort between CDC and the Agency for Toxic Substances and Disease Registry (ATSDR)—is an important resource for scientists to understand, prevent, and potentially cure the disease. Also known as Lou Gehrig's disease, ALS is a progressive, fatal, neurodegenerative disorder that has no cure and the cause of which is not fully understood. The main goals of the Registry are to determine the epidemiology of ALS in the United States, characterize the demographics of those living with ALS, and identify potential risk factors.

Because ALS is not a notifiable disease, CDC/ATSDR has developed novel approaches to identify ALS cases. The first approach identifies prevalence cases from existing national administrative databases—Medicare, Medicaid, Veterans Health Administration, and Veterans Benefits Administration. The second method uses a secure web portal to identify cases not included in the national administrative databases and offers persons with ALS the opportunity to take brief, online surveys to help researchers learn more about potential risk factors for the disease. Registry participants have the option to donate blood, urine, tissue, and other samples to a biorepository that researchers can use to help better understand the cause(s) of ALS. To date, patients in all 50 states have enrolled in the registry. Another critical function of the ALS program is advancing science through studies with over 30 research grants funded to date.

In the last few years, the National ALS Registry has also conducted listening sessions to hear stakeholder and partner ideas to enhance the Registry, created a public dashboard to display current national ALS data, and published a 12-year analysis on the National ALS Registry's findings to-date.

Budget Request

CDC's FY 2027 Budget Request of **$10,000,000** for the National ALS Registry is level with the FY 2026 enacted level. The ALS program will continue efforts to explore the epidemiology, demographics and risk factors of the disease and will continue to connect patients with researchers to further the understanding of ALS.

Program Accomplishments

As of 2025, ATSDR has enrolled over 20,000 ALS patients into the National ALS Registry, connected thousands of patients with more than 80 clinical trials and epidemiological studies, collected specimens from more than 1,700 patients for the National ALS Biorepository, and funded 30 research grants. In 2024, the National ALS Registry released the first state-level analysis of ALS prevalence data, advancing the understanding of ALS distribution across the United States, including among veterans. In 2025, the registry also released the first analysis of state-level incidence data, furthering the understanding of both ALS case distribution and potential risk factors.

ALS Research Grants[1]

(dollars in millions)	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Number of Awards	8	8	8
- New Awards	3	0	0
- Continuing Awards	5	8	8
Average Award	$0.400	$0.400	$0.400
Range of Awards	$0.300-0.500	$0.300-0.500	$0.300-0.500
Total Awards	$3.200	$3.200	$3.200

[1] These funds are not awarded by formula.

Lead Exposure Registry

This program supports the Flint Lead Exposure Registry, a model for the nation's first lead-free city and supports the Flint, Michigan community. In FY 2024, Michigan State University continued its work under the five-year grant awarded in 2022 to continue community, tribal, and stakeholder outreach and training; registrant enrollment via targeted outreach; data collection; referral of registrants to services to reduce or control lead exposure effects; measurement of registrants' exposure, health, and developmental milestones with their interventions, services, and enrichment activities; cohort maintenance of enrolled participants; and evaluation and dissemination of findings to share best practices.

Budget Request

CDC's FY 2027 Budget request of **$5,000,000** for Lead Exposure Registry is level with the FY 2026 enacted level.

Program Accomplishments

As of August 2025, over 22,200 people have been fully enrolled in the Flint Registry and over 35,100 referrals to services have taken place.

Flint Registry

(dollars in millions)	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Number of Awards	1	1	1
Average Award	$4.800	$4.800	$4.800
Range of Awards	No range: one award	No range: one award	No range: one award
Total Awards	$4.800	$4.800	$4.800

Childhood Lead Poisoning Prevention

Lead exposure can cause adverse effects in nearly every system in the body and seriously harm a child's health or cause death. Even at low levels, lead exposure has the potential to affect growth and development, hearing and speech, IQ, academic achievement, and behavior. Nearly 29 million U.S. homes contain at least one lead hazard, and over 10 million U.S. homes rely on lead-containing service lines to carry water from municipal sources into family dwellings, putting large numbers of children at risk for lead exposure. An analysis from the Health Impact Project estimates that eliminating lead hazards from the places where children live, learn, and play could generate approximately $84 billion in long-term benefits per birth cohort, including $18.5 billion in savings for the federal government and $9.6 billion for states from increased revenue and savings to the health care, education, and criminal justice systems.[1] Permanently removing lead hazards from the environment would also benefit future birth cohorts, compounding savings over time.

The Childhood Lead Poisoning Prevention Program (CLPPP) reduces the number of children exposed to lead by funding state and local health departments to improve blood lead testing and reporting systems, analyze and track trends to identify risk hot spots, link lead-exposed children to services, and implement community-specific interventions to prevent lead exposure. Currently, this program funds 62 states and localities to address critical gaps in services.

CLPPP also conducts research to identify and evaluate best practices in lead poisoning prevention; develops case management guidelines to assist health departments and healthcare providers; assists states with the development, implementation, and evaluation local lead poisoning prevention activities; provides training and education materials for public health professionals, healthcare providers, and others; and maintains the Childhood Blood Lead Surveillance System voluntarily used by state and local health departments to efficiently manage blood lead surveillance, case management, and reporting activities. These activities are essential for a coordinated approach for eliminating childhood lead poisoning within the United States and have led to increased lead testing in pediatric healthcare practice.

This program also supports communities across the United States as they eliminate lead exposures and its associated negative health effects. Communities have access to a national network of resources and subject matter experts that can help them engage the multiple areas of the public and private sector that can provide education on the risks of lead exposure and steps to prevent exposure. In FY 2025, this program funded 11 community-based organizations to help families avoid the dangers of lead in their homes through community engagement, prevention education, and family support.

Budget Request

CDC's FY 2027 budget request of **$51,000,000** for Childhood Lead Poisoning Prevention Program is level with the FY 2026 enacted level.

Program Accomplishments

- In 2024, the CLPPP-funded North Carolina Childhood Lead Poisoning Surveillance Program discovered the cause of a nationwide lead poisoning outbreak linked to cinnamon applesauce pouches. Their work began the chain of events that has led to the removal of the product from retailers around the world and the identification of more than 550 cases from 44 states.
- The Indiana state health department used CLPPP support to launch universal blood lead testing for children under age 7, prioritizing testing during 1 to 2 years of age. Nearly 94,000 children received blood lead testing in 2023, an increase of more than 57 percent compared to 2022.
- To increase the number of children tested for lead poisoning, the Salt Lake County Health Department used CLPPP funding to provide participating clinics with a point of care analyzer, education, and help with creating and implementing policies and workflows to test blood lead levels.

[1] https://cheac.org/health-impact-project-publishes-report-on-childhood-lead-exposure/

As a result, three participating clinics had a 260 percent increase in capillary blood tests and a 405 percent increase in venous testing.

Childhood Lead Poisoning Prevention and Surveillance of Blood Lead Levels in Children

(dollars in millions)	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Number of Awards	62	62	62
Average Award	$0.475	$0.483	$0.483
Range of Awards	$0.273-0.608	$0.250-0.437	$0.250-0.437
Total Awards	$29.942	$29.942	$29.942

Supporting Communities to Reduce Lead Poisoning

(dollars in millions)	FY 2025 Final	FY 2026 Enacted	2027 President's Budget
Number of Awards	11	20	20
Average Award	$0.180	$0.099	$0.099
Range of Awards	$0.125-0.200	$0.075-0.150	$0.075-$0.150
Total Awards	$1.977	$1.977	$1.977

Agency for Toxic Substances and Disease Registry

By Congressional mandate, ATSDR protects people's health from harmful exposures to hazardous substances by evaluating hazardous exposures in communities, conducting studies to address emerging environmental health concerns, providing scientific information on hazardous substances to public health professionals and healthcare providers, and responding to environmental health emergencies. Based in Atlanta, ATSDR also has staff located in regional offices who are prepared to respond 24/7 to hazardous substances exposures from natural disasters, chemical spills, and other environmental health emergencies. ATSDR staff represent a variety of disciplines and have extensive experience addressing some of the most significant and difficult environmental health hazards in the United States.

In the last 10 years, ATSDR's mission has become increasingly complex with communities around the United States concerned about possible exposure to hazardous substances, including per- and polyfluoroalkyl substances (PFAS) and lead. Over the last five years, ATSDR has averaged approximately 770 annual requests for assistance from communities, states, and federal agencies, an increase of 27% compared to the average for the preceding five-year period.

ATSDR fulfills the congressional mandate to investigate community exposures to hazardous substances through two types of evaluations: Public Health Assessments and Health Consultations. Public Health Assessments are comprehensive evaluations that examine exposures to multiple contaminants through multiple pathways, while Health Consultations provide a more rapid response that focuses on a specific question or concern about specific hazardous exposures. In the last year, ATSDR conducted over 80 evaluations analyzing the health risks of over 200,000 people with potential exposures that could cause cancer, disabilities, neurologic and cardiovascular complications, or other severe health problems. In 2025, ATSDR also provided funding to 30 state health departments through ATSDR's Partnership to Promote Local Efforts to Reduce Environmental Exposure (APPLETREE) cooperative agreement to help them develop the capacity to quickly and efficiently respond to hazardous exposures in their jurisdictions.

ATSDR is mandated by law to maintain toxicological databases, disseminate scientific information on hazardous exposures, and conduct medical education. ATSDR currently maintains scientific data and health information in 184 toxicological profiles and has developed 481 Minimal Risk Levels (MRLs), which are screening values used during exposure evaluations to determine if additional information is needed to protect people from potential health effects. Healthcare and environmental professionals use ATSDR's toxicological resource materials to make health-protective decisions when addressing hazardous exposures and responding to emergencies. ATSDR also manages a national network of 10 Pediatric Environmental Health Specialty Units (PEHSUs), located in each federal region across the United States, to advise pediatric healthcare providers, parents, and caregivers on protecting and caring for children potentially exposed to harmful chemicals.

During both natural and man-made environmental health disasters, ATSDR provides state, territorial, local, tribal, and federal partners expertise and resources to prevent and reduce the health risks of hazardous exposures during the response and recovery process. Over the last year, ATSDR has responded to over 14 environmental health disasters, with activities including reviewing and analyzing environmental data for health risks, providing risk communication materials to health departments to effectively reach people affected by the disaster, and providing information on potential health impacts of hazardous exposures to public health professionals and healthcare providers.

Budget Request

CDC's FY 2027 budget request of **$78,000,000** for ATSDR is **$1,800,000** below the FY 2026 enacted level. In FY 2027, ATSDR will continue to investigate and monitor hazardous exposures, develop science-based tools and resources, and maintain a state of readiness to respond to environmental health emergencies.

Program Accomplishments

- Nearly everyone in the U.S. has been exposed to PFAS. Many communities have been concerned about possible health effects from PFAS exposure and have been looking to healthcare providers for counseling and support. In January 2024, ATSDR released PFAS Information for Clinicians. This document provides updated information for clinicians to consider when seeing patients who have concerns about per- and polyfluoroalkyl substances (PFAS) exposure or possible health effects.
- ATSDR published two health studies evaluating cancer incidence and mortality among Marines, Navy personnel, and civilian workers exposed to contaminated drinking water at Camp Lejeune, providing information that can be used to protect the health of more than 100,000 veterans.
- In FY 2025, ATSDR responded to the BioLab fire in Conyers, Georgia, that released chlorine gas into neighboring communities. ATSDR integrated real-time air quality data and toxicological modeling to assess the gaps in chlorine health guidance, provide timely information on the fate and transport of chlorine gas, and enable effective public health interventions to prevent respiratory health effects. ATSDR also evaluated EPA air sampling data to monitor for health risks to the community, worked with the Georgia Poison Center to monitor for illness related to exposures, and supported state agencies as they provided health messaging and support to affected residents. ATSDR's Pediatric Environmental Health Specialty Unit partnered with the Association of Occupational and Environmental Clinics and Grady Hospital staff in Atlanta to share information on keeping children in the affected communities safe.

ATSDR Partnership to Promote Local Efforts to Reduce Environmental Exposure (APPLETREE)

(dollars in millions)	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Number of Awards	30	30	30
Average Award	$0.465	$0.465	$0.465
Range of Awards	$0.295-0.688	$0.295-0.688	$0.295-0.688
Total Awards	$13.951	$13.951	$13.951

Personal Protective Technology

NIOSH's Respirator Approval Program (RAP)[1] evaluates and approves all respirators used in American workplaces and serves as a critical component of the nation's public health and occupational safety infrastructure. Achieving NIOSH approval ensures that respirators meet rigorous performance standards and quality assurance requirements to protect workers across all sectors. In 2025, the RAP completed 425 respirator approval decisions and conducted 262 quality assurance audits, sustaining timely access to compliant respiratory protection. NIOSH also strengthened protections against fraudulent and substandard products by partnering with U.S. Custom and Border Protection and the National Institutes of Health to enforce U.S. Patent and Trademark Office-registered certification marks (12 distinct marks, 2020-2024), and by coordinating internationally through certification mark registrations in 15 countries.

Budget Request

CDC's FY 2027 Budget request of **$16,000,000** for Personal Protective Technology is **$7,000,000** below the FY 2026 enacted level. This funding will continue the NIOSH RAP conformity assessment activities and its supporting research to improve the program, including topics like respirator design, breathability, fit, comfort, and usability. This will also support the development and implementation of artificial intelligence and advanced robotic technologies to inform personal protective equipment (PPE) standards and provide innovative Respirator Approval Program advancements. The RAP will also develop and validate standardized tools and methods to improve cleaning, decontamination, and contamination risk assessment of fireground-exposed PPE.

Program Accomplishments

- Strengthened RAP's continuity and efficiency by expanding technical assistance to applicants and cross-training of staff across critical personal protection functions, increasing the acceptability of new applications and surge capacity, reducing operational risk, and ensuring timely respirator approvals during public health emergencies.
- Mitigated public health risks and prevented more than $20 million in losses by leading the RAP's removal of 188 fraudulent respirator listings from online marketplaces, demonstrating the return on investment from sustained oversight activities.
- Ensured the availability of high-performing respiratory protection for the fire service by enhancing preparedness for chemical, biological, radiological, and nuclear (CBRN) incidents by issuing new NIOSH RAP approvals for critical emergency responder protection for CBRN self-contained breathing apparatus (SCBA) that complies with the latest NFPA 1970 performance standards.
- Identified and advanced near- and mid-term NIOSH respiratory protection solutions that address the unique inhalation hazards and improve the safety of wildland firefighters by leveraging interagency collaboration with federal and state partners.
- Advanced RAP rulemaking essential for combination unit respirators by publishing a Federal Register Notice of Proposed Rulemaking on Combined Unit Respirators[2] and initiating public comment review to support the development of a final rule. This rulemaking expands NIOSH approval pathways, improves worker protection across multiple hazard types, reduces employer procurement costs, and promotes innovation and competition in the respirator market.
- Developed and published actionable protection decisions for individuals who manage respirators within their inventory of stockpiled medical countermeasures from analysis of post market testing and evaluation findings.
- Completed the Alpha Version of a Mobile Face Measuring Application showing the ability to calculate facial dimensions and assign users to the CDC/NIOSH anthropometric facial panels, which will help initial respirator size selection and save time with current fit-testing procedures.

2 [1] https://www.cdc.gov/niosh/npptl/respmanuf.html [2] https://www.federalregister.gov/documents/2024/03/15/2024-03849/approval-tests-and-standards-for-combination-unit-respirators

- Partnered with the California Department of Public Health to establish a community-based respirator fit testing framework that empowers trusted organizations (e.g., fire departments and schools) to provide critical on-demand fit testing to workers without Respiratory Protection Programs and the public, strengthening emergency response capacity.
- Invested in advanced testing infrastructure through development of the Advanced Humanlike Articulated Respirator Test Simulator (AHARTS), evaluated its ability to replace human subject testing which will improve testing efficiency, reduce costs, and support long-term innovation within the RAP.

Mining Research

The Federal Mine Safety and Health Act of 1977 mandates the National Center for Occupational Safety and Health (NIOSH) to conduct mining safety and health research. The NIOSH Mining Health and Safety Program directly enhances miner safety and health practices associated with the extraction and processing of critical minerals essential to U.S. economic and national security. Its work reduces operational risks in critical mineral supply chains, helping ensure a reliable and safe domestic mining workforce and infrastructure. Addressing these issues is essential to achieving the program's goal of preventing mining-related illness, injury, and death and supports the America First priorities.

This program funds several high-impact initiatives: (1) emergency disaster response and rescue training, (2) automation and autonomous operations, (3) exposure assessment and interventions of hazards related to the mining and processing of critical minerals, (4) mine ventilation and explosion prevention, (5) battery safety for underground mines, (6) behavioral science and mental health among miners and (7) medical surveillance and interventions to mitigate black lung in coal miners. These priorities are informed by NIOSH statutory responsibilities; industry and partner input; recent mining accidents, fatalities, and health and safety surveillance data; and shifts in mining operations, including the increased use of battery-powered equipment and growing demand for critical minerals.

Budget Request

CDC's FY 2027 budget request of **$68,500,000** for Mining Health and Safety Program is level with the FY 2026 enacted level. This funding will continue to support high-impact initiatives to ensure miner safety and health practices.

Program Accomplishments

- The Spokane and Pittsburgh Mining Research Divisions conducted research and service across the country and partnered in special projects with industry and other government partners. Active research and work activities include over 100 site partners in 32 US States and 4 international groups.
- Enabled rapid on-site measurement of respirable crystalline silica exposure with the Field Analysis of Silica Tool (FAST), allowing immediate action to protect miners from lung disease. Updated FAST software in December 2024.
- Enhanced emergency response capabilities for over 950 mine workers using advanced Virtual-Reality Mine Rescue Training (VR-MRT), directly improving workplace safety and emergency preparedness.
- Addressed a wide range of health risks in mining, including heat stress, fatigue, mental health challenges, and unique risks for women mine workers through the National Miner Health Program.
- Collaborated with MSHA to develop and publish a resource guide for the mining program focused on opioids titled *Implementing Effective Workplace Solutions to Prevent Opioid Use Disorder: A Resource Guide for the Mining Industry* in October 2024.

- Reduced the risk of uncontrollable fires in mines by developing improved battery enclosures, directly enhancing safety for underground workers.
- Improved operational safety and efficiency in mining with real-time data access through wireless integration and advanced automation.
- Strengthened the workforce in critical safety and technical areas by supporting over 70 faculty members and training more than 280 MS and PhD candidates in mining safety and related fields.
- Effectively engaged with coal mines and provided medical examinations to coal miners across fiscal year 2025, including 4,015 chest radiographs and 1,934 spirometry (lung function) tests.

National Mesothelioma Registry and Tissue Bank

This program supports National Mesothelioma Registry and Tissue Bank (NMBV). Mesothelioma is a rare and aggressive cancer affecting the lining of the chest or abdomen and is primarily linked to previous asbestos exposure up to 50 years in the past. Progress in translational and clinical research depends on the ability of researchers to access high-quality tissue samples and robust clinical and demographic data. Low-incidence rates have limited the number of mesothelioma cases available for banking or tissue collection and storage. Funded in 2006 in response to this need, the NMVB provides biospecimens (blood, plasma, white blood cells, and normal and mesothelioma tissues) together with demographic and clinical data to the research community. These resources assist in the development of early markers of disease, biomarkers of stage and prognosis, as well as improved clinical treatments.

Budget Request

CDC's FY 2027 Budget request of **$1,200,000** for National Mesothelioma Virtual Bank (NMVB) is level with the FY 2026 enacted level. This funding will enable the NMBF to continue to expand its collection of high quality biospecimens, accelerating research on diagnostics and treatments for this deadly cancer.

Program Accomplishments

Investments contributed to advances in diagnosing and treating mesothelioma by expanding biomaterial collections and providing valuable research data for malignant mesothelioma studies.

National Firefighter Cancer Registry

The National Firefighter Cancer Registry is a congressionally mandated, national program led by the National Institute for Occupational Safety and Health (NIOSH) to advance firefighter health research and improve first responder safety. Firefighters are exposed to toxic substances on the job and are at increased risk for certain cancers. The U.S. has lacked a national system to comprehensively study cancer incidence in this population. To address this gap, NIOSH established and manages the Registry, which collects data from active and retired U.S. firefighters to support high-quality epidemiologic research. The funding supports continued development of formal partnerships to conduct further outreach with fire services, enhanced and more in-depth data analysis, identification of new data sources, essential data linkages (e.g., with state cancer registries), and new follow-up questionnaires and resources for firefighters and fire service leaders.

Budget Request

CDC's FY 2027 budget request of **$6,500,000** for Firefighter Cancer Registry is level with the FY 2026 enacted level. This funding will continue support for enhancements to data collection, adding new data sources and partnerships to improve our understanding of cancer risks among U.S. firefighters.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Program Accomplishments

- Enrolled more than 38,000 firefighters nationwide in the Registry initiative, addressing cancer risks among firefighters across all 50 states and demonstrating significant national reach and impact.
- Reduced occupational cancer risks for firefighters through collaboration with the Fire Fighter Cancer Cohort Study and targeted initiatives for exposure reduction.
- Recognized more than 80 fire departments in 27 states as Gold Helmet Departments for achieving high participation in the NFR for Cancer.
- Established the NFR Champions program with more than 20 fire service organizations being recognized, including several state and local organizations.
- Published an interactive data dashboard to publicly share the latest trends in the Registry enrollments by state, fire service specialty, and more.
- Responded to information inquiries from firefighters, fire leadership, and fire service organizations, including questions related to emergency response hazards.

National Institute of Environmental Health Sciences (NIEHS)

Since 1966, the National Institute of Environmental Health Sciences (NIEHS) has supported research on how the environment affects biological systems across the lifespan, and translation of this knowledge to reduce disease and promote human health.

NIEHS funds research through its extramural programs, supporting research projects, centers, and training at universities and other research organizations via grants and cooperative agreements. NIEHS also supports research through its intramural programs, where NIEHS scientists conduct biomedical health-related laboratory and clinical research such as studies to explore genetic and mechanistic causes of disease influenced by environmental factors, predictive and applied toxicology research, as well as research in support for the National Toxicology Program (NTP).

Budget Request

CDC's FY 2027 budget request of **$594,086,000** for National Institute of Environmental Health Sciences (NIEHS) is **$319,893,000** below the FY 2026 enacted level.

This request will support focused research investments across scientific divisions and research areas, aligned with administration priorities, to continue essential research into how the environment impacts human biology and human health, the prevention and treatment of illnesses and chronic diseases, and living a healthy life.

Program Accomplishments

Fundamental Research aims at discovering, identifying, and understanding basic shared mechanisms, such as epigenetic changes and gene expression - or common biological pathways, such as inflammation that underlie diseases and disorders, enabling development of prevention and treatments. NIEHS supported research projects and findings include:

- Research on how RNA mediates cellular responses to physiological and environmental stresses, regulating gene expression in health and disease. A molecule (an RNA enhancer) called AANCR is pivotal to regulating the expression of a gene implicated in Alzheimer's disease called APOE. Researchers showed that APOE expression decreased when AANCR transcript levels declined. They also revealed AANCR located near the APOE gene. The team also identified a pathway promoting AANCR transcription that was linked to inflammatory responses in nervous system cells. These findings suggest AANCR is a key regulator of APOE expression and neuroinflammation and could inform development of therapeutic targets for neurodegenerative diseases.
- A machine-learning system trained to better predict potentially safe exposure levels of approximately 34,000 environmental chemicals. The study found several thousand chemicals of moderate concern and several hundred chemicals of high concern for adverse health effects at estimated median population exposure levels, greatly expanding the ability to characterize chemical risks and impacts.

Exposure Research identifies environmental exposures that impact human health, including quantification of the exposome—an individual's environmental exposures over their life course in combination with genetics, diet, and environmental stressors to determine impacts on biological systems that contribute to both health and disease. NIEHS supported research projects and findings related to exposure research include:

- Development of a new approach to pinpoint chemicals that are likely to disrupt metabolism, or metabolism-disrupting agents, builds on previous work identifying characteristics of carcinogenic chemicals and helps organize data to systematically detect metabolism-disrupting substances. The method successfully identified known disruptors like tributyltin, which exhibited all 12 characteristics, demonstrating its effectiveness. Chemicals showing multiple

key characteristics can be prioritized for further analysis since they are likely to affect several important biological processes. This approach could aid in hazard identification, risk assessment, and chemical classification for metabolism-disrupting chemicals. Additionally, the key characteristics may help guide the development of assays to further study these chemicals.

- Microplastics (defined as particles smaller than 5 mm) and nanoplastics (particles smaller than 1000 nanometers) concentrations in human bodies increased significantly between 2016 and 2024. NIEHS-supported-researchers analyzed liver, kidney, and brain tissue samples from postmortem donors, measuring levels of polyethylene, polypropylene, polyvinyl chloride, and styrene-butadiene rubber. Brain tissue accumulated the highest levels of plastics, particularly polyethylene, compared to other organs examined. Individuals diagnosed with dementia at death had higher plastic concentrations in their brains than those without dementia, but more research is needed to determine if plastics play a direct role. Given rising micro- and nanoplastic exposure levels, more research is essential to determine if these materials contribute to neurological disorders and other health issues.
- Patients with atherosclerosis who had detectable amounts of microplastics and nanoplastics (MNPs) had a higher risk of myocardial infarction, stroke, or death than people whose MNPs were not detected.
- Polyexposure scores—in this case, a sum of 13 environmental exposure variables derived from health questionnaire data—were more predictive for type 2 diabetes than scores based solely on genetics. NIEHS has developed ways to evaluate multi-ancestry data from the Personalized Environment and Genes Study (PEGS), a long-term project to collect health, exposure, medical, and genetic data from individuals in North Carolina.

Translational Research moves basic research findings to knowledge that promotes health, prevents disease, and develops evidence-based interventions. NIEHS-supported research projects and findings related to exposure research include:

- NIEHS' Sister Study focuses on a large cohort of women with breast cancer and their sisters. Scientists found links between exposure to pesticides in childhood and adolescence from residential and farm spraying and application and incidence of inflammatory bowel disease. Preventing early pesticide exposures may help to prevent development of this disease.
- Preterm birth and early term birth are the leading causes of infant death in the United States. NIEHS scientists have found that mothers with indicators of higher exposure to per- and polyfluorinated alkyl substances (PFAS) were more likely to give birth early. Investigators compared molecular signatures of prenatal exposure and identified eight pathways and 52 metabolites through which PFAS acts to disrupt pregnancies.
- Researchers recently studied blood samples from 200 women collected 6 years apart to examine both old and new types of PFAS. While they found levels of older PFAS declining over time (as these have been phased out), they detected nearly 2,000 newer replacement PFAS that are increasing in people's blood. The older PFAS stayed relatively stable in people's bodies over the 6-year period, but the newer PFAS varied much more, likely because they break down faster or come from inconsistent exposure sources. Both old and new PFAS mixtures were linked to changes in how the body processes fats, proteins, and other essential nutrients, but the newer PFAS affected an even wider range of metabolic processes including hormone function and vitamin metabolism. These findings highlight the urgent need to study these newer replacement chemicals.
- Wildfire smoke travels well beyond the acres burned and may cause far- reaching health impacts. One NIEHS study examined exposure to wildland fire smoke and more than 5 million pregnancies in California and found that higher exposure to small particulate matter (PM2.5) during wildfire events was associated with increased risk of preterm birth, with highest risks related to exposure in weeks of the second and third trimesters. Wildfire smoke also appears to increase the risk of dementia more than other types of PM2.5.

NIEHS is a key member of the federal response to the 2023 train derailment and hazardous materials release in East Palestine, Ohio. In FY 2024, NIEHS initially funded six researcher groups to collect health data, characterize exposures, and report back to the affected communities in the region. In FY 2025, NIEHS announced the East Palestine, Ohio Train Derailment Study. This study will create a program that is co-developed by the community, academic researchers, and other stakeholders to address the immediate and longer-term health concerns from exposures to chemicals released during the train derailment.

Predictive toxicology assesses hazards of real-world chemical mixtures and determines how to evaluate broad classes of chemicals efficiently, identifying early biomarkers of health effects, and modeling non-chemical stressors that contribute to disparities in health outcomes. One example includes:

- NIEHS scientists developed The GeoTox Package, which is a free, open-source software tool to assess environmental health risks. It addresses the challenge of understanding how multiple environmental exposures—including chemicals, physical conditions, and lifestyle factors—affect human health at both individual and population levels. Using a modular, step-by-step approach, GeoTox allows researchers and practitioners to build computational workflows that account for the diversity of real-world exposure combinations and individual susceptibilities. This tool represents a significant advancement in environmental risk assessment by providing a practical way to analyze the complex relationships between where people live, what they are exposed to, and their potential resulting health risks.

Training and education programs prepare the next generation of scientists to solve complex environmental health problems to improve the lives of every American. NIEHS-supported trainees at academic institutions are often at the leading edge of technology development and adoption. NIEHS-funded research projects conducted by trainees included a participatory intervention that educated farmworkers on heat health, a survey of pediatric providers of asthma care that assessed knowledge gaps on wildfire smoke, and the development of a machine learning model to measure the actual amount of lead in cells.

National Institute of Environmental Health Sciences Awards[1]

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Number of Awards	822	806	525
Average Award	$574,394	$581,514	$541,371
Range	$5,000-$3,303,869	$5,000-$3,303,869	$5,000-$5,903,096

[1] NIEHS estimates assume the policy to fully fund project awards at an equal level to FY 25 with the initial grant obligation in FY 2026 and to fully fund 100% of all project awards with the initial grant obligation in FY 2027.

NIEHS Superfund-Related Activities

The National Institute of Environmental Health Sciences Superfund-Related Activities has been seeking scientific solutions and training advancements to health and environmental problems associated with hazardous waste and disaster response since 1987. This program consists of two interdependent components: the Superfund Research Program and the Worker Training Program. The Superfund Research Program supports scientists who research, develop, test, and implement unique, solution-oriented approaches that positively impact public health and address complex environmental health problems. The Worker Training Program provides health and safety training to hazardous waste cleanup workers and emergency responders to protect communities from hazardous exposures and disasters.

Budget Request

The FY 2027 budget request of **$51,814,000** for the NIEHS Superfund-Related Activities program is **$25,286,000** below the FY 2026 enacted level.

At this level, NIEHS will align investments with administration priorities to continue to fund critical, high-impact research and training support through existing grants under NIEHS Superfund-Related Activities. (comprised of the NIEHS Superfund Research Program and the NIEHS Worker Training Program). Additionally, the Superfund Research Program will continue to collaborate with partners to inform research opportunities and translate research findings into applications, and to pursue new partnerships to translate research efforts into advancements in water safety.

Program Accomplishments

Since its inception the Superfund Research Program has awarded grants to more than 2,100 researchers at over 140 institutions and small businesses; grantees have patented more than 205 inventions and published over 15,700 research articles; and researchers have conducted research in over 380 contaminated sites. Superfund Research Program-funded technology has resulted in millions of dollars in estimated savings at Superfund cleanup sites. Examples include:

Children's Health

- Researchers found that some PFAS and metals may alter how an infant's immune system responds to environmental contaminants, meaning that exposure to certain chemicals may increase the risk of a baby developing asthma, food allergies, or other immune-related issues later in life.

Environmental toxicant remediation-related research

- As hazardous substances spread through the ground, water, and air, human exposure to them raises the risk of numerous diseases and serious ailments. SRP-funded researchers recently designed a special polymer material by combining the power of sunlight and lignin, a component of plants, which effectively degrades potentially harmful compounds.

Nutrition/Food Safety

- Grantees discovered that omega-3 fatty acids found in fish oil may help prevent lung cancer caused by polycyclic aromatic hydrocarbons (PAHs). These findings suggest omega-3s may serve as effective preventive agents for individuals exposed to environmental carcinogens.

Strengthening Tribal Health through Research

- To prevent harm from exposure to arsenic, a naturally occurring element found in soil and water which is toxic to humans, NIEHS funded a program in Tribal communities across the Northern Great Plains that provided faucet filters and periodic health check-ins. These efforts resulted in a 50% reduction in urinary arsenic among participants.

Program Accomplishments: Worker Training Program

Since 1987, the Worker Training Program has funded training more than 5 million workers in the United States and territories, empowering them to safely handle or remove hazardous materials. The program has built a national workforce that can protect themselves, co-workers, and communities from environmental hazards as well as respond to natural and man-made disasters. In addition, the Environmental Careers Worker Training Program (ECWTP) adds a cumulative average of $99.3 million annually to the U.S. economy, providing opportunities for unemployed and underemployed individuals to obtain careers in environmental cleanup, construction, hazardous waste removal, and emergency response. The ECWTP has trained more than 15,000 people and has a 70% average job placement rate.

Accomplishments include:

- Developing innovative and collaborative resources to address significant exposures to firefighters and emergency responses from PFAS and wildfires, and infectious diseases, including in rural and volunteer settings. The program encourages innovation for training difficult-to-reach populations and addresses issues such as literacy, appropriate adult education techniques, and training quality improvement.
- Training people from 46 Native American tribes from 23 states to become wildlife conservation officers, environmental scientists, firefighters, law enforcement officers, casino security personnel, social workers, public health personnel, public works and utility personnel, and other Tribal jobs.
- Incorporating mental health resiliency training to address psychological health effects of exposure to traumatic events.

Under the National Response Framework's Worker Safety and Health Support Annex, the WTP has historically been tasked to support the safety and health training of workers involved in disaster response and cleanup using subject matter expertise. Tasks have included creating a site-specific safety and health training curriculum, conducting training needs assessments, and providing training to responders and volunteers. In coordination with the Administration for Strategic Preparedness and Response (ASPR), WTP staff have aided in identifying homes in Georgia communities experiencing mold contamination following hurricane damages, especially Hurricane Helene. Additionally, staff have conducted training for building inspectors and building code enforcement officers to recognize and identify mold contamination and removal actions in the described areas.

The Superfund Research Program and the Worker Training Program Awards[1]

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Number of Awards	58	41	33
Average Award	$1,312,138	$,1836,490	$1,537,513
Range	$78,552-$4,336,164	$108,900-$2,606,421	$99,000-$2,292,599

[1] NIEHS estimates assume the policy to fully fund project awards at an equal level to FY 25 with the initial grant obligation in FY 2026 and to fully fund 100% of all project awards with the initial grant obligation in FY 2027.

National Center for Toxicological Research

The National Center for Toxicological Research (NCTR) was established in 1971 as a national scientific resource. NCTR conducts peer-reviewed research to advance regulatory science and engage globally to encourage the implementation of science-based standards. NCTR enhances science-based regulatory decision-making by conducting collaborative research to:

- Support the translation of laboratory findings to clinical and regulatory applications.
- Assess novel toxicological testing strategies to assist in the regulatory decision-making process, minimizing the need for animal studies.
- Conduct timely and authoritative toxicity assessments on FDA-regulated products, in close collaboration with Agency partners.

Budget Request

CDC's FY 2027 budget request of **$56,307,000** for National Center for Toxicological Research (NCTR) is **$15,451,000** below the FY 2026 enacted level**.** NCTR works with agency partners to ensure that research activities answer regulatory science questions. The results of this collaborative research inform regulatory activities that ensure the safety, efficacy, and quality of FDA-regulated products. Specifically, NCTR will continue to:

- Accelerate the agency's capability to manage and analyze research and regulatory data using bioinformatics and artificial intelligence (AI).
- Minimize the need for animal studies by validating and advancing the use of new alternative methods (NAMs) by assessing emerging toxicological testing strategies.
- Support FDA's Predictive Toxicology Roadmap and Advancing Alternative Methods work.
- Supports the investigation of emerging drug compounding concerns to ensure safe and effective compounded drug products.

NCTR manages the Perinatal Health Center of Excellence (PHCE). The PHCE aims to fill knowledge gaps in safety, efficacy, or potential toxicity that currently exist for the understudied perinatal period. This knowledge will strengthen the scientific basis of decision-making for FDA-regulated products used during the perinatal period.

Program Accomplishments

NCTR conducts cutting-edge, gold-standard scientific research to ensure the safety of FDA-regulated products. NCTR's work supports and informs science-based decision-making across the agency, helping to identify, understand, and mitigate health risks associated with food, drugs, medical devices, and other regulated products. The following are NCTR's FY 2025 accomplishments:

- Leveraged artificial intelligence driven platforms to increase data access and reduce FDA review times, including use of SafetAI to assess drug-induced liver injury risks in safety evaluations.
- Evaluated new alternative methods to reduce animal testing in preclinical safety studies, including in vitro skin permeation models to predict the dermal absorption of chemicals.
- Led FDA's Perinatal Health Center of Excellence to fill knowledge gaps about the safety, efficacy, and toxicity of FDA-regulated products used during the vastly understudied perinatal period.
- Protected food, drug, and consumer products by investigating the skin permeation of cosmetic ingredients, nitrosamine drug substance-related impurities, and antibiotic resistance.
- Initiated preliminary studies to develop methods for the isolation, detection, identification and quantification of microplastics and nanoplastics in water and human and animal food.

PUBLIC HEALTH SCIENTIFIC SERVICES

(dollars in millions)	FY 2025 Final[1]	FY 2026 Enacted[1]	FY 2027 President's Budget	FY 2027 +/- FY 2026
Budget Authority	$622.100	$610.100	$499.600	-$110.500
PHS Evaluation Transfer	$0.000	$0.000	$205.000	+$205.000
Total Request[2]	**$622.100**	**$610.100**	**$704.600**	**+$94.500**
FTEs[3]	1,594	1,432	1,138	-294
-- Surveillance, Epidemiology, and Informatics[4]	$298.100	$298.100	$327.600	+$29.500
-- Advancing Laboratory Science	$23.000	$26.000	$26.000	$0.000
-- Public Health Data Modernization	$230.000	$215.000	$280.000	+$65.000
-- Public Health Data Modernization	$230.000	$215.000	$75.000	-$140.000
-- Public Health Data Modernization (PHS Eval) [5]	*N/A*	*N/A*	*$205.000*	*+$205.000*
-- Public Health Workforce	$71.000	$71.000	$71.000	$0.000

[1] FY 2025 Final reflects full year Continuing Resolution level.
[2] In alignment with the proposed HHS reorganization, FY 2025 and FY 2026 Levels do not reflect funding for Health Statistics. The FY 2027 Budget proposes the realignment of the program to the HHS Office of the Secretary Office of Strategy (OS).
[3] FTE displayed reflect current estimates, which may differ from the system of record. FTE estimates may not represent expected FTE levels across FY 2027. These estimates are subject to change.
[4] FY 2025 and 2026 funding for Disease Risk Factor Surveillance is reflected with the Administration for Healthy America. The FY 2027 President's Budget proposes to maintain these activities in CDC.
[5] The FY 2027 request proposes realignment and consolidation of the Ready Response Enterprise Data Integration and the Center for Forecasting and Outbreak Analytics activities, previously under the Public Health Preparedness and Response account, within the Public Health Data Modernization activity.

Enabling Legislation Citation: PHSA § 319D; PHSA § 317G; PHSA § 317; PHSA § 352; PHSA § 319B PHSA § 319D; PHSA § 353; PHSA § 301; PHSA § 2823; PHSA § 319; PHSA § 310B; PHSA § 2825; PHSA § 2341; PHSA § 778; PHSA § 768; Intelligence Reform and Terrorism Prevention Act of 2004 § 7211

Enabling Legislation Status: Permanent Indefinite

Authorization of Appropriations for FY 2026: Indefinite; Expired/Expiring noted with *

Allocation Methods: Direct Federal/Intramural, Competitive Grants/Cooperative Agreements, Contracts

CDC collects, analyzes, and reports scientific data to inform policies and practices to protect the health of all Americans through Public Health Scientific Services (PHSS) activities. CDC has made substantial progress modernizing the data ecosystem used for gathering, analyzing, and sharing data across public and private health care systems. Making data available for more rapid decision-making is a monumental effort requiring upgrades to hundreds of individual systems that previously operated independently. CDC's leadership in laboratory response and safety results in millions of laboratory tests being completed accurately and safely, providing data for decision-makers regarding patient care and public health response. U.S. investment is aligning systems to seamlessly share data across public and private sector health systems, while also maintaining individual privacy and confidentiality.

Key activities include:

- Modernizing CDC and state, territorial, local, and tribal data, surveillance, and analytics capabilities
- Expanding data linkages between CDC health data and datasets from other federal agencies
- Increasing laboratory data exchange
- Ensuring the safety of laboratory personnel and compliance with laboratory protocols and regulatory requirements
- Collaborating with clinical and public health laboratories and federal partners to ensure timely and actionable data are available to protect public health; and
- Strengthening and supporting the public health workforce.

Budget Request

CDC's FY 2027 budget request of **$704,600,000** for Public Health Scientific Services is **$94,500,000** above the FY 2026 enacted level.

PUBLIC HEALTH SCIENTIFIC SERVICES

By the Numbers

- **7,200—**Healthcare facilities across the 50 states, Washington, D.C., and Guam contributed data to the National Syndromic Surveillance Program.
- **60,500—**Healthcare facilities, including hospitals, clinics, urgent care centers, nursing homes, schools, and occupational health clinics, used electronic case reporting to share case data with 72 state, tribal, local, and territorial public health jurisdictions.
- **6 million—**Case notifications were received by the National Notifiable Diseases Surveillance System for response, surveillance, analysis, and research purposes.
- **6—**New reusable products were developed, yielding faster delivery through RREDI response efficiencies in platform setup time and enabling more timely, informed decision-making during critical incidents.
- **2,202—**CDC laboratory spaces received onsite, in-person safety inspections from CDC laboratory safety officials each year.
- **285,000—**Laboratory systems trainings were accessed by CDC and non-CDC learners in FY 2025.
- **1.83 million—**CDC publication downloads occurred from CDC Stacks, which houses over 200,000 CDC document releases.
- **4 million—**Accesses to CDC Stacks occurred, supporting dissemination of over 200,000 CDC document releases.
- **500—**Technology transfer agreements were executed to advance scientific research and discovery, including 12 Influenza A(H5) assay technology agreements.
- **289—**CDC-supported fellows participated across 11 full-time fellowship programs in FY 2025.
- **156—**Fellows from five fellowship programs* were assigned to positions in state, tribal, local, and territorial health agencies.
- **136,000—**Unique health professionals earned free continuing education through CDC TRAIN, saving an estimated $8 million in FY 2025.

*These 5 fellowships include CDC's Epidemic Intelligence Service (EIS), Laboratory Leadership Service (LLS), Public Health Associates Program (PHAP), as well as 2 joint fellowships with partners, the CDC/CSTE Applied Epidemiology Fellowship (AEF), CDC/CSTE Applied Public Health Informatics Fellowship (APHIF).

Public Health Scientific Services Funding History[1,2,3]	
Fiscal Year	Dollars (in Millions)
FY 2023 Final (BA)	$597.100
FY 2024 Final (BA)	$597.100
FY 2025 Final (BA)	$622.100
FY 2026 Enacted (BA)	$610.100
FY 2027 President's Budget (BA)	$499.600
FY 2027 President's Budget (PHS Eval)	$205.000

[1] FY 2023 through FY 2026 Levels do not reflect funding for Health Statistics, which the FY 2027 Budget continues the proposed realignment of the program to the HHS Office of the Secretary Office of Strategy (OS).

[2] The FY 2027 realigns and consolidates Ready Response Enterprise Data Integration and the Center for Forecasting and Outbreak Analytics activities, previously under the Public Health Preparedness and Response account, within the Public Health Data Modernization activity.

[3] FY 2027 Level includes funding for Disease Risk Factor Surveillance. This funding is reflected within the Administration for Healthy America for FY 2025 and 2026.

Surveillance, Epidemiology, and Informatics Budget Request

Surveillance, Epidemiology, and Informatics are foundational to the nation's ability to identify and respond to health threats. CDC supports state and local capacities that alert people to health threats, how they are affecting their communities, and what can be done to keep people healthy and safe.

CDC supports public health surveillance systems, laboratory exchange between public health and clinical laboratories, and high-quality scientific publications that give vital information about the nation's health – from case reporting to emergency department visits to laboratory result data. Continued investment is needed to support and maintain platforms for syndromic data and case reporting while modernizing systems at the federal, state, and local level to ensure that data can move faster than the spread of disease.

Budget Request

CDC's FY 2027 budget request of **$327,600,000** for Surveillance, Epidemiology, and Informatics is **$29,500,000** above the FY 2026 enacted level. CDC will support public health surveillance systems and improving public health data for CDC emergency responses. In FY 2027, the Budget will continue to support the agency's scientific integrity and quality infrastructure; clinical and public health laboratory activities; long-standing surveillance systems such as the National Syndromic Surveillance Program (NSSP) and National Notifiable Diseases Surveillance System (NNDSS) for specific diseases and conditions; and the Disease Risk Factor Surveillance System to collect data on health-related conditions that threaten communities' resilience to infectious diseases.

National Syndromic Surveillance Program (NSSP)

CDC's NSSP provides local, state, and federal health officials with near-real time situational awareness for detecting and monitoring health events. NSSP tracks symptoms and diagnoses of patients across secure electronic health data sources to detect unusual levels or changing patterns of infectious diseases. More than 2,000 users across local, state, and federal government search data to inform decision-making and action.

Electronic Case Reporting Program (eCR)

eCR enables the secure transfer of data to public health authorities for use with disease tracking, case management, and contact tracing. Derived data, with patient identifiers removed, that meet nationally notifiable disease criteria are shared by public health departments with the CDC through the National Notifiable Diseases Surveillance System (NNDSS). Public health departments rely on eCR to receive patient case data in less than one minute from healthcare providers in their jurisdictions. Increasing eCR coverage provides health departments with expanded access to healthcare facility data from hospitals,

clinics, urgent care centers, nursing homes, schools, and occupational health clinics while reducing the clinical and administrative burden.

National Notifiable Diseases Surveillance System (NNDSS)

Across the United States, more than 3,000 state, tribal, local, and territorial health departments collect data on 120 diseases and conditions that threaten health. CDC supports health departments in receiving and analyzing data to identify outbreaks and prevent disease spread. CDC continues to make progress on modernizing NNDSS functionality, especially by improving data validation, processing, and provisioning pipelines. These improvements include utilizing additional cloud functionality, providing alternative methods for receiving data, and implementing tools to assist jurisdictions with data reconciliation. The NNDSS program leads efforts to implement a CDC-wide system for receiving Minimal Data Necessary, a subset of data needed to inform decisions in the early stages of a public health emergency, for case data.

Disease Risk Factor Surveillance

CDC will support broad, state-based surveys used across health conditions and risk factors for both ongoing programs and CDC emergency responses. State-based surveillance systems for risk factors for disease are critical for proactively addressing public health challenges. These systems continuously monitor a wide range of risk factors, providing health authorities with real-time data to identify emerging threats and track trends over time. Early detection of these risk factors enables timely interventions, which can prevent diseases from spreading or becoming more severe. By capturing these data, surveillance systems allow public health officials to make informed decisions and implement strategies that reduce the impact of these risks on the population, helping to prevent widespread illness and improve overall health outcomes. In addition to early detection, these surveillance systems enhance the efficient allocation of resources. With a clear understanding of where risk factors are most prevalent, public health efforts can be directed to areas that need them most.

Scientific Integrity and Quality

CDC ensures the highest standards of scientific integrity, relevance, credibility, and transparency for data, publications, research, and communication materials in alignment with the core tenets of gold standard science, which emphasizes rigorous methodologies, reproducibility, and the ethical conduct of research. CDC scientific services include training, guidance, consultations, library resources, science dissemination, extramural research coordination, and technology transfer facilitation for scientists across the agency and funded partners.

CDC’s investments ensure the timely dissemination of scientific information by promoting data sharing, public access, and alignment with federal data initiatives and privacy, ethics, and confidentiality principles. CDC executes technology transfer agreements, in which CDC partners with industry, academia, non-profits, and other government agencies to transfer CDC’s research portfolio, including diagnostics assays, early therapeutics, vaccine candidates, and software, into products and services to improve public health. These agreements foster dissemination and application of CDC science and technology innovations, enabling rapid prevention, detection, and treatment of public health threats.

Morbidity and Mortality Weekly Report (MMWR)

CDC’s mission is to detect and respond to health threats that require rapid dissemination of relevant and credible scientific information for public health action. CDC's *MMWR*, is the agency’s primary vehicle for releasing timely, reliable, and objective scientific findings. High priority releases are disseminated within 48-72 hours to more than 130,000 public health professionals and the public. MMWR also includes public health recommendations for prevention and treatment, surveillance findings, and supplemental information.

Program Accomplishments

Examples of Surveillance, Epidemiology, and Informatics accomplishments include the following:

- CDC used NSSP data to provide more in-depth insight into infectious diseases and to coordinate surveillance efforts across public health jurisdictions and federal agencies, such as the H5N1 avian influenza response.
- The number of reportable conditions within the eCR infrastructure and the engagement and coordination with electronic health record industry partners has increased from 6 in 2020 to over 200 in 2024.
- CDC developed a detailed NNDSS Technical Roadmap for transformational improvements and further modernization of its case notification systems. The roadmap aims at improving adoption of automation, better response readiness capabilities for case data, and reduced burden for jurisdictions.

National Syndromic Surveillance Program (NSSP) Awards[1,2]

(Dollars in millions)	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Number of Awards	51	51	51
- New Awards	0	0	0
- Continuing Awards	51	51	51
Total Awards	$6.000	$6.000	$6.000

[1] Table includes core funding from the Surveillance, Epidemiology, and Public Health Informatics budget activity and other CDC programs.
[2] These funds are not awarded by formula.

National Notifiable Diseases Surveillance System (NNDSS) Awards[1]

(Dollars in millions)	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Number of Awards	64	64	64
- New Awards	0	0	0
- Continuing Awards	64	64	64
Average Award	$0.172	$0.172	$0.172
Range of Awards	$0.003 - $0.342	$0.003 - $0.342	$0.003 - $0.342
Total Awards	$11.035	$11.035	$11.035

[1] These funds are not awarded by formula.

Advancing Laboratory Science Budget Request

Laboratories are core to the U.S. public health infrastructure. Americans receive more than 15.6 billion diagnostic laboratory tests from more than 300,000 clinical and public health laboratories each year. These critical test results detect and prevent disease and harmful exposures and inform the nation's response to public health emergencies. CDC provides scientific expertise and technical services to public health and clinical laboratories nationwide to advance:

- High-quality and safe laboratory science
- Reliable testing for diseases and harmful exposures
- Strong laboratory partnerships for readiness and response

Budget Request

CDC's FY 2027 budget request of **$26,000,000** for Advancing Laboratory Science is level with the FY 2026 enacted level. The program will continue to improve CDC's diagnostic testing capacity through a partnership with commercial laboratories for test development and surge testing. CDC will maintain the consistency, quality, and response readiness of laboratory testing within CDC and across laboratories in the public and private sectors by:

- Providing tools, services, and resources to CDC laboratories for quality and safety, risk management and mitigation, and regulatory compliance.
- Developing comprehensive educational resources to enhance diagnostic testing quality and laboratory safety.
- Developing, improving, and distributing diagnostic tests for CDC and public health laboratories through internal activities and partnerships with commercial laboratories for test development and surge testing.
- Improving technical services to CDC laboratories and increasing operational efficiency for diagnostic testing at CDC.
- Improving coordination and communication across diagnostic testing partners nation-wide for a public health response to emergencies that is timely, scalable, and resilient.
- Implementing efficient, coordinated strategies for laboratory readiness and response, including strengthening the Laboratory Response Network.

Program Accomplishments

In FY 2025, CDC's consolidated laboratory systems expertise and services bolstered internal laboratories and public health and clinical laboratories across the nation. For example,

- CDC reached more than 100,000 laboratory professionals via the Laboratory Outreach Communication System (LOCS) providing technical support and assistance for urgent problems, such as shortages of laboratory resources during a public health emergency.
- CDC developed and hosted trainings through CDC OneLab™, a training community of practice of over 58,000 members that gives U.S. laboratory staff and testers open access to innovative tools and courses.
- CDC supported the development and distribution of four new diagnostic laboratory tests through its partnership with commercial laboratories.

Public Health Data Modernization Budget Request

Modernizing public health data is critical to national security and a fundamental component of response readiness. Most critically, the detection, prevention, and response to disease threats depends on core data and surveillance systems, which provide essential information to detect threats, track disease spread and severity and provide actionable information that can be used to save lives. CDC's investment in data infrastructure and data modernization at both the national and state health department levels enable core data to flow faster for earlier threat detection and informed public health response decision-making.

Budget Request

CDC's FY 2027 budget request of **$280,000,000** for Public Health Data Modernization is **$65,000,000** above the FY 2026 enacted level. This request includes **$75,000,000** in budget authority and **$205,000,000** in PHS Evaluation funds. The request also consolidates the Center for Forecasting and Outbreak Analytics (CFA) and the Response Ready Enterprise Data Integration (RREDI) PPAs into the Data Modernization line.

In FY 2027, CDC will support the enhancement and expansion of core data sources for surveillance of disease threats by investing in critical infrastructure necessary to exchange data securely and in real time, across and with jurisdictional public health authorities, healthcare, and other federal agencies.

Funding for State, Local, Tribal, and Territorial Jurisdictions

CDC will continue to provide direct funding and technical assistance to state, tribal, local, and territorial health departments to improve timeliness and quality of core data, to support automated integrated surveillance and analytic capabilities, and improve interoperability with healthcare and CDC.

Building U.S. Data Capabilities to Protect Health

CDC will also continue improving access to open data, increasing data linkage, automating analytic and data processes, enhancing data visualization, and improving interagency information sharing. CDC will leverage data intermediaries, including Health Data Utilities and Health Information Exchanges, to efficiently route data between healthcare providers, health departments, and CDC. CDC will investigate the use of Artificial Intelligence to efficiently process large, complex datasets and rapidly generate actionable insights. This approach aims to enhance the detection of signals and accelerate the identification of disease spikes and increases across various data sources, supporting timely public health actions and interventions during potential threats.

Program Accomplishments

Data modernization investments have improved every aspect of public health data gathering and reporting so that all levels of government have faster, actionable insights for decision-making. CDC provided essential funding and support for collection and analyses, system modernization (e.g., cloud services), and capacity building at public health departments to implement new technological innovations. Because of modernization efforts, CDC has more data for decision-making, particularly across the core surveillance systems used by many CDC programs and public health partners, including the following examples:

- In as little as 8 seconds, eCR sends patient case reports to public health departments for more than 200 conditions, including biothreat agents, respiratory diseases, and infectious diseases.
- CDC built a new electronic pathway for COVID-19 laboratory-based diagnostic tests that has handled over one billion diagnostic test reports, reaching over 1.5 million per day, and is supporting reporting for mpox, allowing CDC to evaluate testing practices, assess percent positivity, and inform response.
- Advancements in interoperability of immunization information systems have improved national situational awareness. Data pipelines have allowed for aggregate reporting of over one million mpox vaccine doses.

Response Ready Enterprise Data Integration (RREDI)

Response Ready Enterprise Data Integration (RREDI) is the emergency response operations component of the One CDC Data Platform (1CDP) and provides critical capabilities for data analysis and data management necessary for CDC and USG-wide public health emergency responses. RREDI provides a secure, centralized platform for real-time access and sharing of integrated data. RREDI enables rapid information sharing with decisionmakers across the USG and with state and local health departments during public health responses. CDC and its partners use RREDI during public health events and emergencies to integrate data from hundreds of sources across federal, state, and local public health, to provide essential tools and capabilities for responses, and for rapid information sharing.

CDC will continue development and use of tools for preparedness and response functions. CDC will expand deployment of enterprise response capabilities in 1CDP/RREDI, including solutions for streamlined ingestion, standardized data management, automated alerting, and coordination with STLTs and USG partners. CDC will maintain RREDI operations, including training, security, and user onboarding. CDC will also integrate both new and existing data assets and expand the provisioning of data to federal and non-federal partners for increased data usability. CDC will continue to support public health response operations at all levels of public health, as well as those of federal and non-federal partners.

Program Accomplishments

CDC developed tools for preparedness and response functions and deployed enterprise response capabilities. CDC will continue to maintain operations and integrate new and existing data assets and expand data usability to support public health response operations. In FY 2025, RREDI supported 7 responses (Mpox, Dengue-Oropouche, H5N1, Polio, Measles, viral hemorrhagic fevers (x2), and 2 exercises (Cobalt Magnet and COVID/Flu). Additionally, in FY 2025 RREDI released the Interagency Readiness and Response Hub, which is designed to facilitate collaboration and coordinate information sharing among USG partners during public health interagency responses. The Interagency Readiness and Response Hub serve as a common operating picture, providing interagency-specific dashboards, situation reports, and other resources to enhance situational awareness, communication, and decision-making across a USG response.

Center for Forecasting and Outbreak Analytics

The U.S. lacks sufficient capacity—and no market yet exists—for modeling, forecasting, and simulating infectious disease outbreaks nor communicating those projections with state and local jurisdictions. Therefore, as the nation's lead for health security, CDC is leading the work needed to advance U.S. capacity. CDC's Center for Forecasting and Outbreak Analytics (CFA) is the only U.S. government entity with the primary mission of providing infectious disease forecasts, models, and simulations to support outbreak response. CFA continues to make measurable progress towards its three programmatic goals:

1) PREDICT – Deliver actionable analysis and response-ready modeling tools.
2) INFORM – Generate practical decision support products.
3) INNOVATE – Drive technological and analytic innovation.

Advancing capacity and developing tools for use at state and local outbreak response remains a priority for the Center. Innovation is a key component and requires meaningful partnerships with academic institutions, the private sector, and state and local health departments.

CDC will continue to:

- Apply the best methods and latest technologies to continue advancing the country's capacity to forecast and model infectious disease outbreaks.
- Produce interactive outbreak simulators to explore the potential impacts of infectious disease outbreaks on U.S. communities.

- Strengthen state and local outbreak response efforts by providing more granular models and forecasts at the county level.
- Support Insight Net, a network of public health experts dedicated to creating, testing, and implementing next generation forecasting and modeling tools.

Program Accomplishments

CDC is improving response capabilities by developing real-time forecasting and modeling tools for infectious diseases. These models and forecasts guide public health action, quickly delivering insights into epidemic trends, hospital admissions, and future outbreak scenarios. CFA's data scientists have developed 40 tools, with 11 more in development, to support infectious disease outbreak response. Since its establishment in 2021, CFA has provided modeling, forecasting, and other analytic support to 19 outbreak responses, including responses in FY 2025 for disease outbreaks related to measles, Ebola, and respiratory syncytial virus.

CFA equips U.S. leaders with precise, localized insights to protect communities. For example, CFA developed an interactive measles simulator, a tool for public health decision-makers to explore the potential impact of three key public health interventions — isolation, quarantine, and vaccination — on measles outbreaks. The three interventions can be turned on and off and layered on top of one another. Timely modeling and simulation tools can support outbreak response efforts to help decision-makers pinpoint the most effective resource allocation for response.

Since 2023, CFA has been publishing disease growth estimate maps (Rt) showing predictions for seasonal respiratory viruses (COVID-19 and influenza) across all 50 states. In FY 2024, CFA quickly adapted to a shifting data landscape regarding hospitalization data. CFA developed new ways to layer surveillance and readily available emergency department data to make forecasts and disease growth models more resilient and reliable. CFA continued to innovate by providing more granular models and forecasts. Beginning in FY 2026, CFA will be releasing weekly Rt estimates for COVID, influenza, and RSV at the county level. Having access to these detailed forecasts helps communities respond more effectively to these seasonal viruses. This progression highlights the growing capabilities of CDC's data scientists in developing innovative and adaptable modeling tools.

Public Health Workforce Budget Request

CDC's workforce programs build capacity and strengthen public health department core capabilities. These CDC programs deliver measurable results for communities by boosting frontline services, enhancing emergency response, and driving continuous improvement. These essential components of the nation's public health defense require tools, resources, and a well-trained workforce to work better, faster, and smarter.

- CDC strengthens the U.S. public health workforce through world-class public health fellowships. CDC fellows provide boots-on-the-ground expertise wherever they are needed most – supporting outbreak response, disease investigation, and data systems improvement in jurisdictions across the nation.
- A highly skilled public health workforce depends on access to high-quality, affordable training. CDC leads national efforts to provide free continuing education and accredited learning opportunities to public health professionals. These trainings promote quality improvement, prepare the workforce to prevent and respond to health threats, and strengthen public health leadership nationwide.

Budget Request

CDC's FY 2027 budget request of **$71,000,000** for Public Health Workforce is level with the FY 2026 enacted level. In FY 2027, CDC will support state, tribal, local, and territorial health departments through CDC fellowships and training programs to identify and address public health workforce gaps and build capacity to respond to current and future public health threats.

Program Accomplishments

- Placed public health experts in the field to protect communities through CDC fellowship programs that train and deploy professionals to support jurisdictions in their response to health threats nationwide.
- Curated courses reaching over 6.4 million learners through the TRAIN platform (a free shared learning management system) ensuring the public health workforce can access standardized training to stay at the forefront of emerging health threats, best practices, and innovations.

GLOBAL HEALTH

(dollars in millions)		FY 2025 Final[1]	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
	Budget Authority	$663.843	$663.843	$663.843	$0.000
	Total Request[2]	**$663.843**	**$663.843**	**$663.843**	**$0.000**
	FTEs[3]	1,045	1,005	882	-123
-- Global HIV/AIDS Program		$128.921	$128.921	$128.921	$0.000
-- Global Tuberculosis		$11.722	$11.722	$11.722	$0.000
-- Global Immunization Program		$230.000	$230.000	$230.000	$0.000
-- Polio Eradication		$180.000	$180.000	$180.000	$0.000
-- Measles and Other Vaccine Preventable Diseases		$50.000	$50.000	$50.000	$0.000
-- Global Public Health Protection		$293.200	$293.200	$293.200	$0.000

[1] FY 2025 Final reflects full year Continuing Resolution level.
[2] FY 2025 and FY 2026 Levels are comparably adjusted to reflect the proposed realignment of Parasitic Diseases and Malaria into Emerging Infectious Diseases in the Emerging and Zoonotic Infectious Diseases Account.
[3] FTE displayed reflect current estimates, which may differ from the system of record. FTE estimates may not represent expected FTE levels across FY 2027. These estimates are subject to change.

Enabling Legislation Citation:

PHSA § 214, PHSA § 301, PHSA § 304, PHSA § 307, PHSA § 310, PHSA § 317T,* PHSA § 319, PHSA § 322, PHSA § 327, PHSA § 340C, PHSA § 361-369, PHSA § 2315, PHSA § 2341, Foreign Assistance Act of 1961 §§ 104A, 104C, 627, and 629, Federal Employees International Organization Service Act § 3, Foreign Employees Compensation Program, Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria (P.L. 110-293, as amended by P.L. 115-305), PEPFAR Stewardship & Oversight Act of 2013 (Pub. L. 113-56)

Enabling Legislation Status: Permanent Indefinite

Authorization of Appropriations for FY 2026: Indefinite; Expired/Expiring noted with *

Allocation Methods: Direct Federal/Intramural, Competitive Grants/Cooperative Agreements, Direct Contracts, Interagency Agreements

CDC's global presence provides the United States with early warning and real-time intelligence on emerging infectious disease threats before they reach U.S. borders. Through more than 60 overseas offices, CDC experts work alongside trusted bilateral, regional, and global partners to strengthen prevention, detection, and response capacities. These partnerships are the most effective and cost-efficient way to protect Americans from health threats that originate overseas.

Decades of sustained engagement have built trusted peer-to-peer relationships and global public health networks that enable rapid information sharing and early outbreak detection. CDC staff are often among the first to identify emerging threats, enabling earlier response efforts, reducing the risk of international spread, and supporting timely preparedness actions in the United States. This early detection and response help prevent the need for more costly emergency interventions.

Through this global workforce, CDC serves as the nation's first line of defense against emerging infectious diseases, protecting American communities, U.S. businesses, and the broader economy. CDC will play a key role in implementing an America First approach to global health to replace the functions of the World Health Organization, pursuant to the President's Executive Order 14155.

Budget Request

CDC's FY 2027 budget request of **$663,843,000** for Global Health is level with the FY 2026 enacted level. CDC will continue to protect Americans by preventing, detecting, and responding to public health threats

around the globe, improving health outcomes by reducing morbidity and mortality, and building public health systems that partner with the United States. In FY 2027, CDC will continue working to strengthen global health protection, improve global immunization, and advance the control of HIV and TB to prevent, detect, and rapidly respond to emerging health threats before they reach the United States.

GLOBAL HEALTH

By the Numbers[1]

- **>250**—Infectious disease outbreak investigations conducted by CDC country offices globally in 2024 alone, including Ebola, cholera, polio, hepatitis, measles, monkeypox, and novel respiratory clusters.
- **>22,500**—Graduates of CDC's Field Epidemiology Training Program (FETP), creating a global workforce of disease detectives and public health leaders in nearly 90 countries worldwide. This program builds national, regional, and local capabilities to rapidly detect and contain outbreaks before they reach the U.S.
- **14,500,000**—Men, women, and children living with HIV received life-saving antiretroviral treatment (ART) from CDC in FY 2025, preventing new infections, and protecting Americans from acquiring dangerous drug-resistant strains of HIV.
- **10,400,000**—CDC-supported TB screenings, enabling early detection and treatment to reduce deaths, prevent catastrophic costs, limit drug resistance, and reduce the risk of TB spread into the United States.
- **99%**—Decline in Polio cases since 1988, with wild poliovirus remaining in only Afghanistan and Pakistan; global eradication is the most effective way to protect Americans.

[1]All statistics are from CDC program data unless otherwise stated.

Global Health Funding History[1]	
Fiscal Year	Dollars (in millions)
FY 2023	$692.843
FY 2024	$692.843
FY 2025 Final	$663.843
FY 2026 Enacted	$663.843
FY 2027 President’s Budget	$663.843

[1] FY 2025 and FY 2026 levels are comparably adjusted to reflect the proposed realignment of Parasitic Diseases and Malaria into Emerging Infectious Diseases.

Global HIV/AIDS Budget Request

The CDC Division of Global HIV and TB serves as the comprehensive public health partner and implementing agency for the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), working across 46 countries in Central and South America, Asia, Eastern Europe, and Africa. CDC brings unmatched scientific and technical expertise to the global response for HIV and TB and supports country governments and local experts to develop sustainable public health programs that build country self-reliance.

CDC's global HIV and TB programs strengthen core public health systems that prevent, detect and respond to dangerous infectious disease threats before they reach the United States. These activities form the backbone of overseas surveillance, laboratory and workforce capacity that protects Americans by stopping outbreaks at their source. For example, CDC supports nearly 1,700 HIV and TB molecular laboratory facilities globally, creating critical infrastructure that is used not only for HIV and TB, but also to identify, monitor and respond to other high-consequence infectious disease threats. The laboratory, data, surveillance, and workforce systems supported and strengthened by CDC's Division of Global HIV and TB represent America's first defense against dangerous diseases, including Ebola and Marburg, before they can cross borders and endanger American lives.

Budget Request

CDC's FY 2027 budget request of **$128,921,000** for Global HIV/AIDS is level with the FY 2026 enacted level. In FY 2027, CDC will lead global HIV/AIDS program innovation and implementation, utilizing CDC's scientific and technical experts worldwide. CDC will use evidence-based approaches to concentrate efforts on the countries, populations, and programs where resources maximize public health impact. CDC will also optimize staffing and technical resources to address the highest-priority global HIV needs, while ensuring that ongoing and new activities are consistent with U.S. government priorities. In addition, CDC's global HIV work, including data, surveillance, and laboratory systems strengthening, will continue to provide the infrastructure for an integrated disease framework, underpinning countries' responses to emerging diseases and supporting the U.S. government's global health security efforts.

Program Accomplishments

In FY 2025, CDC's global public health contributions to HIV and TB activities provided lifesaving HIV treatment for over 14.5 million people, prevented HIV infections in over 400,000 newborns by providing treatment to expectant mothers with HIV, and screened more than 10 million people living with HIV for TB, a leading cause of death among people with HIV.

Strengthening HIV Diagnostics While Preparing for Emerging Threats: CDC's Strengthening Laboratory Management Toward Accreditation (SMLTA) program advances U.S. government priorities by delivering measurable improvements in global HIV diagnostics while strengthening preparedness for emerging infectious diseases. Since 2013, SMLTA has supported more than 400 laboratories in low- and middle-income countries to achieve internationally recognized accreditation, improving the accuracy of HIV testing and treatment outcomes through sustainable, country-led systems.

Long-Term Investments that Protect Americans: Accredited laboratories also provide the quality systems and workforce capacity needed to rapidly detect and respond to high-consequence threats such as Ebola. In FY 2025, the Democratic Republic of the Congo (DRC) achieved its first-ever international accreditation of two laboratories, the result of sustained CDC technical assistance. This milestone demonstrates the return on long-term U.S. investments. By strengthening laboratory systems at outbreak sources, SMLTA reduces the risk of global spread and costly emergency responses, protecting Americans while maximizing the impact of U.S. taxpayer dollars.

Preserving the Effectiveness of Lifesaving HIV Treatment: The global scale-up of antiretroviral treatment (ART) is one of the most significant public health achievements in recent times; however,

long-term success depends on its continued effectiveness. Through Cyclical Acquired HIV Drug Resistance Surveillance (CADRE), CDC leads global efforts to monitor HIV drug resistance, focusing on dolutegravir-based regimens, which account for 92 percent of U.S. government-provided ART. Through CADRE, CDC strengthens surveillance to better understand the factors contributing to HIV drug resistance. This provides crucial data to guide treatment choices for people living with HIV on dolutegravir-based regimens, preventing severe disease, death, and transmission of drug-resistant HIV. Ultimately, this work safeguards Americans' health by preventing drug resistant strains of HIV from reaching the U.S.

Global Tuberculosis Budget Request

Tuberculosis (TB) remains the world's leading infectious disease killer, and drug-resistant TB poses a direct, growing threat to U.S. health security because it is airborne, difficult to treat, and increasingly imported through global travel and migration. Approximately 10.6 million people, including 1.3 million children, become sick with TB disease each year. Drug-resistant TB is a further threat to public health worldwide, with 410,000 people developing multidrug-resistant or rifampicin-resistant TB (MDR/RR-TB). A single case of multidrug-resistant TB in the United States can cost up to $500,000 to treat. Most TB cases in the United States occur among people born outside the country, underscoring that global TB control is essential to protecting U.S. public health. CDC is working on the frontlines with partner governments in more than 42 countries to prevent, diagnose, and treat TB. CDC focuses on strengthening national TB control programs and strategies in priority countries with high rates of TB, drug-resistant TB, and TB/HIV co-infection. CDC's global TB efforts strengthen critical disease surveillance and laboratory systems that are essential to reduce the burden of TB.

Budget Request

CDC's FY 2027 budget request of **$11,722,000** for Global Tuberculosis is level with the FY 2026 enacted level. In FY 2027, CDC will leverage its expertise and global network to address key drivers of the TB epidemic, including missed cases, TB/HIV co-infection, and drug-resistant TB, reducing the public health and economic toll on the U.S.

Program Accomplishments

CDC's Division of Global HIV & TB remains a global leader in addressing the urgent threat of drug-resistant TB (DR TB), the emergence of which is now found in every country and poses a significant threat to eliminating TB in the U.S. and worldwide.

Strengthening Global Detection and Monitoring of Drug-Resistant TB: In FY 2025, DGHT's laboratorians developed and produced low-cost quality assurance materials to ensure accuracy and reliability of DR TB diagnostic testing globally. For example, in India, home to the world's largest burden of multidrug-resistant TB, CDC has supported national health authorities to deploy next-generation genomic sequencing to rapidly identify drug resistance and transmission patterns missed by conventional diagnostics. CDC assistance enabled the establishment of India's first national drug-resistant TB sequencing database and a country-specific resistance mutation catalogue, directly improving treatment decisions and accelerating adoption of effective diagnostics and regimens. CDC investments improve early detection and control of drug-resistant TB in the highest-burden setting, reducing international spread, protecting U.S. communities, and avoiding costly domestic treatment and response costs of imported cases.

Global Immunization Budget Request

CDC's global immunization program protects Americans by stopping vaccine-preventable diseases before they reach the United States. By stopping outbreaks at their source, CDC saves lives, reduces emergency response costs, and limits disruption to U.S. communities and the economy. Over the past 50 years, global immunization efforts have saved 154 million lives, eradicated smallpox, and reduced polio cases by more than 99 percent. CDC's global immunization program reduces risks to the United States by focusing on three strategic priority areas: global polio eradication; reducing measles and other vaccine preventable diseases; and strengthening vaccination in public health emergencies. Across these priorities, CDC builds the infrastructure and rapid response capacity needed to prevent and contain outbreaks abroad before they escalate into emergencies that threaten American lives. Targeted investments in high-risk geographies strengthen disease surveillance and improve readiness for emergency immunization delivery. Through focused technical and financial support, CDC helps countries close critical readiness gaps and stop outbreaks at their source.

Polio Eradication

Vaccination eliminated polio from the United States in 1979, ending a disease that once paralyzed or killed thousands of Americans each year. However, polio remains a global threat and continues to pose a direct risk to the United States through international travel. Recent events illustrate this risk: in 2022, a paralytic polio case in New York was genetically linked to virus circulating in the United Kingdom and Israel, and in 2024, a poliovirus variant originating in Nigeria was detected across multiple European countries with high travel volumes to and from the United States. These events underscore that polio anywhere remains a risk everywhere.

Gaps in immunity increase the likelihood that imported poliovirus could spread domestically. While national childhood vaccination coverage remains high, some U.S. communities have coverage below 40 percent, and an estimated 46 million Americans lack protective antibodies against polio. A single paralytic case in the U.S. resulted in approximately $1.6 million in medical costs and productivity losses. Re-established transmission in the U.S. could lead up to 13,000 paralytic cases, approximately 800 deaths and more than $10 billion in lost productivity, highlighting the economic cost of this preventable infectious disease. Global eradication remains the most cost-effective way to permanently eliminate this risk.

Measles and Other Vaccine Preventable Diseases

Widespread, large, and disruptive global outbreaks pose a direct and ongoing risk to U.S. communities through international travel. Every measles outbreak in the United States begins with an imported case, often a U.S. traveler exposed overseas, and spreads when it reaches under-vaccinated populations. From 2000 through 2024, the U.S. recorded 4,485 measles cases linked to international importations. In 2025, over 2,000 measles cases were reported across 44 state and local jurisdictions, accounting for almost half of all U.S. measles cases reported over the past 25 years and reflecting increased global transmission. This threat was further underscored by the loss of measles elimination status in Canada and regionally in the Americas in late 2025.

This resurgence demonstrates how quickly measles can re-establish transmission when global measles activity increases and immunity gaps widen domestically. Infectious disease threats can spread from remote locations overseas to the United States in less than 36 hours, making early containment essential to protecting U.S. health, security, and economic stability. Preventing outbreaks overseas is far more cost-effective than responding once diseases reach the United States: preparing U.S. hospitals to manage a single imported Ebola case costs approximately 20 times more than vaccinating populations abroad, and across diseases, every dollar invested in immunization yields more than $50 in savings from avoided healthcare costs, lost wages, and reduced productivity.

Strengthening Vaccination in Public Health Emergencies
CDC supports vaccination during public health emergencies by enabling rapid vaccine deployment, supporting outbreak response vaccination campaigns, and providing technical assistance to countries to contain outbreaks at their source. These capabilities have been critical during recent emergency responses, including Ebola outbreaks, where vaccination played a central role in interrupting transmission.

Budget Request

CDC's FY 2027 budget request of **$230,000,000** for Global Immunization is level with the FY 2026 enacted level. In FY 2027, CDC will protect Americans by advancing global polio eradication, reducing measles and other vaccine preventable diseases, and strengthening vaccination in public health emergencies. CDC will sustain critical global polio eradication efforts to permanently stop the virus and protect Americans from reintroduction and costly outbreaks. CDC will prioritize stopping wild poliovirus transmission in Afghanistan and Pakistan, ending outbreaks across Africa and Asia, and strengthening global disease intelligence through its global polio laboratory network. CDC laboratories maintain the world's leading polio reference network for quality assurance, laboratory confirmation, genomic sequencing and rapid virus detection.

CDC will prioritize stopping measles outbreaks at their source by strengthening global immunization coverage, enhancing surveillance and laboratory capacity, and supporting rapid outbreak detection and response in high-risk countries.

CDC will also strengthen vaccine readiness and rapid deployment during public health emergencies by improving delivery systems, deploying technical experts, and enabling countries to use vaccines quickly during outbreaks. These investments shorten response time, reduce uncertainty during crises, and directly enhance U.S. preparedness.

Program Accomplishments

Progress in Polio Eradication: As a founding member and co-lead of the Global Polio Eradication Initiative, the United States has supported a 99.9 percent reduction in paralytic polio cases worldwide, from an estimated 350,000 cases annually in 1988 to fewer than 400 cases globally in 2024.

Ebola Outbreak Response: CDC supported the response to the Democratic Republic of Congo Ebola outbreak through key vaccination activities. 44,453 Ebola vaccine doses were administered, which reduced projected case counts by half, and successfully stopped the outbreak where it started. CDC is supporting intermediate, medium, and long-term activities to evaluate the effectiveness of vaccination as a tool in response to Ebola outbreaks to help inform future responses.

Global Public Health Protection Budget Request

CDC is the U.S. government's lead agency for infectious disease outbreak response and global health security implementation, work that keeps Americans safe at home and abroad. Epidemics and public health crises can weaken economies and destabilize societies, making early detection and containment critical. CDC's global presence provides a frontline defense by enabling early detection and rapid containment of threats before they reach U.S. borders. CDC's technical expertise and trusted in-country partnerships are critical to stopping infectious disease outbreaks at their source.

Through its global health protection programs, CDC advances U.S. government priorities on health security and biodefense by leading public health emergency responses, training and deploying disease detectives, and strengthening country capacity to detect and respond to health threats. For example, CDC's multi-year investments in genomic surveillance in Southeast Asia have improved biothreat detection and response. Strengthened sequencing capacity in Vietnam enabled the country's first detection of a swine-origin influenza A (H1N1v) variant in 2025, allowing rapid threat assessment and information sharing.

CDC will continue to amplify global health security efforts by working with partner countries to build capabilities necessary for identifying and containing local outbreaks before they become epidemics or pandemics. With world-leading expertise in disease detection, outbreak investigation, emergency response, and public health capacity strengthening, CDC's global health protection programs protect American lives and livelihoods from infectious disease threats.

Budget Request

CDC's FY 2027 budget request of **$293,200,000** for Global Public Health Protection is level with the FY 2026 enacted level. This funding will enable CDC to continue its mission to prevent, detect, and respond to global health threats before they reach U.S. borders.

Program Accomplishments

Global Outbreak Response: Since January 2024, CDC has responded to over 250 outbreaks worldwide, including Crimean Congo Hemorrhagic Fever, Rift Valley Fever, Lassa Fever, yellow fever, dengue, cholera, malaria, and respiratory illnesses. This has included leading rapid responses to extinguish multiple high-consequence viral disease outbreaks, including Sudan ebolavirus in Uganda, Nipah virus in Bangladesh, and Marburg virus in Equatorial Guinea and Tanzania, where it was a CDC-trained expert who identified the outbreak.

Monkeypox Detection in West Africa: In early 2024, CDC supported Ghana's response to a surge in suspected monkeypox virus cases by coordinating expertise across CDC headquarters, CDC staff in Ghana, Ghana's National Public Health and Reference laboratory, and the Association of Public Health Laboratories. This collaboration tripled the number of laboratories capable of monkeypox genomic sequencing in Ghana and neighboring Sierra Leone, improving regional detection capacity and strengthening U.S. access to early biothreat intelligence.

Surveillance and Workforce: Over the past two years, CDC has strengthened more than 50 disease surveillance systems and trained over 2,000 disease detectives and 400 laboratory staff across more than 40 countries. These investments enhance global detection, investigation, and containment of emerging threats while advancing U.S. early warning systems.

Laboratory Capacity: CDC established a regional molecular diagnostics laboratory in Tambacounda, Senegal, to improve detection of bacterial meningitis in a high-risk region of the Africa meningitis belt. By decentralizing testing, the laboratory reduced turnaround times and has since been used to detect multiple epidemic-prone diseases including Rift Valley fever and dengue, demonstrating the flexibility and durability of the investment.

Outbreak Testing: Through CDC's International Reagent Resource (IRR) program, CDC strengthens global surveillance and outbreak response for high-consequence viral diseases such as measles and polio by providing laboratory kits and reagents. These investments enable accurate testing, faster reporting, and earlier detection of emerging threats—helping protect the U.S. by improving timely access to actionable data.

CDC Implementation of Foreign Assistance Transparency and Accountability Act (FATAA)

CDC's activities funded by the President's Emergency Plan for AIDS Relief (PEPFAR) comply with the Foreign Assistance Transparency and Accountability Act (FATAA) of 2016. CDC will implement-monitoring and evaluation in alignment with the America First Global Health Strategy and the bilateral agreements (or MOUs) and agency requirements.

CDC's routine program data and evaluation are key in generating the evidence needed to know what works and how to implement efficient and cost-effective interventions. CDC's PEPFAR program works with the Department of State's Bureau of Global Health Security and Diplomacy (GHSD) to implement monitoring frameworks and provide guidance for activities implemented by CDC. FATAA's requirements for monitoring and evaluation are operationalized at CDC as part of the annual program planning and reporting processes and business cycles, which solicit and monitor CDC-funded programs through cooperative agreements with extramural implementing partners. Evaluation and Performance Monitoring Plans are required on every cooperative agreement to ensure alignment and compliance with GHSD requirements and FATAA.

PUBLIC HEALTH PREPAREDNESS AND RESPONSE

(dollars in millions)	FY 2025 Final[1]	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Budget Authority	$883.200	$883.200	$489.000	-$394.200
Total Request[2]	**$883.200**	**$883.200**	**$489.000**	**-$394.200**
FTEs[3]	478	464	396	-69
-- Public Health Emergency Preparedness Cooperative Agreement	$735.000	$735.000	$350.000	-$385.000
-- Academic Centers for Public Health Preparedness	$9.200	$9.200	$0.000	-$9.200
-- CDC Preparedness and Response	$139.000	$139.000	$139.000	$0.000

[1] FY 2025 Final reflects full year Continuing Resolution level.
[2] FY 2025 and FY 2026 totals are comparably adjusted to reflect the proposed realignment and consolidation of Ready Response Enterprise Data Integration Platform and the Center for Forecasting and Outbreak Analytics into the Public Health Data Modernization (DMI) line within the Public Health Scientific Services (PHSS) account.
[3] FTE displayed reflect current estimates, which may differ from the system of record. FTE estimates may not represent expected FTE levels across FY 2027. These estimates are subject to change.

Enabling Legislation Citation: PHSA § 301, PHSA § 307, PHSA § 310, PHSA § 311, PHSA § 319, PHSA § 319C-1, PHSA § 319D, PHSA § 319F, PHSA § 319F-2*, PHSA § 319G*, PHSA § 351A*, PHSA § 361, PHSA § 2801, PHSA § 2812

Enabling Legislation Status: Permanent Indefinite

Authorization of Appropriations for FY 2026: Indefinite; Expired/Expiring noted with*

Allocation Methods: Direct, Federal Intramural, Cooperative Agreements, including Formula Grants/Cooperative Agreements; and Contracts

The United States must be prepared to face emerging health threats in today's highly connected world; the COVID-19 pandemic underscored this fact and highlighted the essential need for sustained investment in our domestic public health preparedness and response infrastructure. Local disease outbreaks can quickly escalate into regional, national, and global emergencies. Over the last two decades, we have seen outbreaks of influenza, (H1N1, H7N9, H5N1), Ebola, Zika, SARS-CoV-1 (SARS), SARS-CoV-2 (COVID-19), monkeypox and measles. These emerging infectious diseases and localized disease outbreaks spread rapidly and affect populations around the world. CDC empowers communities to respond to any public health emergency that may strike, including natural disasters, chemical incidents, and terrorist attacks. CDC's preparedness efforts rely on the integration of expertise in laboratory science, public health surveillance, epidemiology, and public health emergency response, in addition to its longstanding coordination and relationships with federal, state, tribal, local, territorial, and global partners.

Budget Request

CDC's FY 2027 budget request of **$489,000,000** for Public Health Preparedness and Response is **$394,200,000** below the FY 2026 enacted level. CDC will continue to support state, tribal, local, and territorial health departments to ensure their capability, flexibility, and adaptability in the face of naturally occurring or intentional events that cause public health emergencies.

PUBLIC HEALTH PREPAREDNESS AND RESPONSE

By the Numbers

- **>4,500**—State and local positions in health departments across 50 states, 4 localities, and 8 U.S. territories and freely associated states of the Pacific supported by PHEP. State recipients support approximately 3,000 local public health jurisdictions, including 72 metropolitan statistical areas as part of the Cities Readiness Initiative (CRI) program. These staff include nurses, doctors, epidemiologists, laboratorians, logistics and operations staff, and other public health preparedness and response employees working on the front lines to provide critical public health expertise where emergencies begin—at the local level—enabling faster and more effective responses.

- **>600**—Responses to requests for information and technical assistance from U.S. state, tribal, local, and territorial (STLT) health departments related to current public health emergencies and preparation for impending threats.
- **0**—Releases of select agents or toxins resulting in illness, death, or transmission among workers or to the outside of a laboratory into the surrounding environment or community; more than 270 incident reports involving occupational exposures in 2024.
- **~3700**—CDC staff from across the agency pre-identified to respond to public health emergencies of any scope and scale, and who possess a wide range of essential skills and knowledge critical to public health response.
- **24** — Disparate, outdated, single-function systems that were replaced by one system, CDCReady, to streamline and right-size emergency response operations and support any and all concurrent responses at a lower overall operating cost. CDCReady can be accessed by all agency staff before, during, and after an event, for a total of around $800 a month—less than 4 cents per user per month for the nearly 22,000 network users.
- **197** – Final Federal Select Agent Program (FSAP) inspection reports issued in 2024, with 100% of those reports being issued on time for the third consecutive year.
- **90** – Improvement actions that have been completely addressed as the result of response evaluations since 2022. Those improvements ensure that CDC's response capabilities, operations, and procedures are more robust ahead of the next public health emergency.
- **5** – Biological agents removed from the FSAP-regulated select agents and toxin list in 2024, significantly reducing the regulatory burden on some entities and facilitating greater focus on those agents posing the highest risk to the public. This underscores FSAP's commitment to calibrating and adjusting regulatory oversight based on biorisk.

Public Health Preparedness and Response Funding History[1]	
Fiscal Year	Dollars (in Millions)
FY 2023 Final	$905.100
FY 2024 Final	$938.200
FY 2025 Final	$883.200
FY 2026 Enacted	$883.200
FY 2027 President's Budget	$489.000

[1]FY 2025 and FY 2026 totals are comparably adjusted to reflect the proposed realignment and consolidation of Ready Response Enterprise Data Integration Platform and the Center for Forecasting and Outbreak Analytics into the Public Health Data Modernization (DMI) line within the PHSS account.

Public Health Emergency Preparedness Cooperative Agreement

The Public Health Emergency Preparedness (PHEP) Cooperative Agreement is an indispensable national security asset that provides direct funding to 62 state, local, and territorial jurisdictions. PHEP supports thousands of front-line workers (nurses, doctors, epidemiologists, laboratorians, logistics, operations, and other preparedness and response employees) in health departments across the United States that do critical work to prevent, detect and respond to life-threatening events.

Budget Request

CDC's FY 2027 budget request **$350,000,000** for Public Health Emergency Preparedness (PHEP) Cooperative Agreement is **$385,000,000** below the FY 2026 enacted level**.** Funding will support federal preparedness staff positioned in state, tribal, local, and territorial (STLT) jurisdictions that provide expertise in emergency preparedness and response, to ensure multi-hazards readiness for health threats requiring rapid distribution, dispensing, and administration of critical medical countermeasures. Also, investments will support STL and tribal capability to respond faster and more effectively to infectious diseases, natural disasters, and other health emergencies.

Program Accomplishments

During FY 2025, CDC provided critical support for STLT preparedness in several areas, advancing CDC's capabilities in workforce development, laboratory preparedness, outbreak response, and overall domestic preparedness. CDC supported local health department activities through additional funding for more than 400 local planning jurisdictions that are part of the PHEP program's Cities Readiness Initiative. CDC funded Career Epidemiology Field Officers (CEFO) and Preparedness Field Assignees (PFA) staff also made major contributions to emergency responses in jurisdictions across the country, often in leadership positions.

In FY 2025, CDC continued to execute on the public health mission of enhancing STLT preparedness and response capabilities. Examples include:

- Consistent with Administration priorities, CDC is prioritizing a risk-based approach to all-hazards planning to improve readiness, response, and recovery capacity for existing and emerging public health threats, which CDC is implementing with STLT partners in responding to H5N1 and planning for the 2026 World Cup.
- CDC's CEFO and PFA in Texas played critical leadership roles in responding to outbreaks of measles and coordinating the operations in response to historic flooding. CEFOs in Kansas, Arizona, and South Carolina also played critical leadership roles responding to measles outbreaks. Hawaii-based CEFOs and PFAs also worked closely with Kaua'i District Health Office officials to conduct and publish a needs assessment that rapidly obtained population-based estimates about the health and resource needs of their community pre- and post-disaster.
- No-notice Critical Contact Drills with the 62 PHEP funded recipients ensure the lines of communication are reliable, quick, and open between designated preparedness personnel when a public health emergency necessitates rapid contact across every state and territory. Required completion time is 60 minutes, and 100% of jurisdictions passed drill #1 (on-call Epidemiologist to on-call Laboratorian to CDC watch desk); 92% passed drill #2 (on-call Epidemiologist to PHEP Director to CDC watch desk).
- The PHEP program funds 10 level one chemical laboratories capable of testing for toxic metals, nerve agents, and toxic industrial chemicals. In 2025, the PHEP-funded Wisconsin laboratory reached the milestone of over 900 trained firefighters, National Guard members, bomb technicians, and other law enforcement personnel on evaluating unknown substances, using complex field instrumentation, and sample collection during threat events. The laboratory works closely with State Asset HazMat teams and provides 24/7 reach-back support during responses, ensuring immediate access to expert consultation.

PHEP Awards

	FY 2025 Final[1]	FY 2026 Enacted	FY 2027 President's Budget[2]
Number of Awards	62	62	TBD
- New Awards	0	0	TBD
Average Award	$10,666,000	$10,666,000	TBD
Range of Awards	$370,000 - $44,882,000	$370,000 - $44,882,000	TBD
Total Awards	$653,738,609	$653,738,609	TBD

[1] CDC awards PHEP funding using the formula established under section 319C-1 of the Public Health Service Act. The formula includes a base funding amount; population funding based on risk; and dedicated funding for Cities Readiness Initiative jurisdictions and Level 1 Chemical Laboratories.
[2] Grant award estimates are under development.

CDC Preparedness and Response

CDC has a unique role in integrating programs, science, data, communications, and partners across the U.S. Government and the public health system to ensure constant readiness and a coordinated response to public health threats in the United States and around the world.

Budget Request

CDC's FY 2027 budget request of **$139,000,000** for CDC Preparedness and Response is level with the FY 2026 enacted level. In FY 2027, CDC will continue to support and maintain the end-to-end programming and evaluation of preparedness and response at the agency, including the Emergency Operations Center (EOC), the 24/7 response management hub that mobilizes CDC experts and resources to protect Americans from health threats. These investments also support CDC's recent consolidation of 24 outdated systems and functions into one system, CDCReady, which serves as the enterprise platform for the agency's emergency response systems.

Preparedness funding also facilitates biosafety and biosecurity oversight through the Federal Select Agent Program, Import Permit Program, and U.S. National Authority for Containment of Poliovirus, which ensure the safe and secure handling of deadly biological agents and toxins across the nation by conducting nearly 200 select agent lab inspections, processing more than 2,500 permits for import of infectious biological agents, and working with facilities to prevent the accidental release of poliovirus.

Program Accomplishments

CDC uses the agency's response framework to guide the management of public health emergency responses, ensuring effective and efficient operations regardless of the event's size and scope. In FY 2025, CDC:

- Responded to multiple concurrent threats including 2024 Influenza A/H5N1 and three viral hemorrhagic fever responses across multiple countries, meeting the unique needs of each event while limiting impact on other CDC activities and resources, and stopping spread of outbreaks and other hazards and protecting lives in the U.S.
- Inspected nearly 200 registered laboratory facilities to ensure compliance with the select agent regulations. These inspections allow CDC to confirm appropriate biosafety and security measures are in place.

CDC-WIDE ACTIVITIES AND PROGRAM SUPPORT

(dollars in millions)	FY 2025 Final[1]	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Budget Authority	$503.570	$396.570	$361.570	-$35.000
Prevention and Public Health Fund[2]	$160.000	$250.000	$0.000	-$250.000
Total Request	**$663.570**	**$646.570**	**$361.570**	**-$285.000**
FTEs[3]	2,006	1,574	1,568	-6
-- Preventive Health and Health Services Block Grant (PPHF)	*$160.000*	*$160.000*	*$0.000*	*-$160.000*
-- Public Health Leadership and Support	$128.570	$101.570	$101.570	$0.000
-- Infectious Disease Rapid Response Reserve Fund[4]	$25.000	$25.000	$0.000	-$25.000
-- Public Health Infrastructure and Capacity	$350.000	$360.000	$260.000	-$100.000
-- Public Health Infrastructure and Capacity	$350.000	$270.000	$260.000	-$10.000
-- Public Health Infrastructure and Capacity (PPHF)	*$0.000*	*$90.000*	*$0.000*	*-$90,000*

[1] FY 2025 Final reflects full year Continuing Resolution level.
[2] The FY 2027 Budget eliminates the Prevention and Public Health Fund (PPHF).
[3] FTE displayed reflect current estimates, which may differ from the system of record. FTE estimates may not represent expected FTE levels across FY 2027. These estimates are subject to change.
[4] The Budget Request does not propose budget authority for the Infectious Disease Rapid Response Reserve Fund in 2027; however, this program is proposed to continue. Existing funds remain available until expended for future public health threats.

Enabling Legislation Citation: PHSA Title XIX, Part A; 42 USC § 300w-320w-10
PHSA § 353; Consolidated Appropriations Act, 2023 Explanatory Statement; PHSA § 317G
Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019, Continuing Appropriations Act, 2019
PHSA § 317b; American Rescue Plan Act, § 2501; PHSA §2825.

Enabling Legislation Status: Permanent Indefinite

Authorization of Appropriations for FY 2026: Indefinite; Expired/Expiring noted with*****

Allocation Methods: Direct Federal/Intramural, Contracts, Competitive Grants/Cooperative Agreements

The CDC-Wide Activities and Program Support account supports cross-cutting agency functions that drive coordination, enhance foundational capacities, and support CDC's ability to deliver rapid, decisive responses to emerging public health threats.

Budget Request

CDC's FY 2027 budget request of **$361,570,000** for CDC-Wide Activities and Program Support is **$285,000,000** below the FY 2026 enacted level.

CDC-WIDE ACTIVITIES AND PROGRAM SUPPORT

By the Numbers

- **>100**—State, local, and territorial health departments directly funded to strengthen public health infrastructure including emergency response and disease surveillance.
- **250**—Number of overseas outbreaks that CDC responded to and helped resolve in 2024 before they reached the United States, including hemorrhagic fevers, cholera, hepatitis, mpox, respiratory illnesses, measles, and polio.
- **$82.5 million—**Awarded to 34 American Indian and Alaska Native Tribal nations and regional tribally designated organizations from across CDC since 2023 to strengthen the people, services, and systems needed to prevent disease, promote health, and protect communities from emerging health threats and longstanding health challenges.

*References: Unless otherwise noted, all information and calculations are from CDC program data.

CDC-Wide Activities and Program Support Funding History[1]	
Fiscal Year	Dollars (in Millions)
FY 2023 Final (PPHF)	$160.000
FY 2023 Final (BA)	$503.570
FY 2024 Final (PPHF)	$160.000
FY 2024 Final (BA)	$503.570
FY 2025 Final (PPHF)	$160.000
FY 2025 Final (BA)	$503.570
FY 2026 Enacted (PPHF)	$250.000
FY 2026 Enacted (BA)	$396.570
FY 2027 President's Budget (PPHF)[1]	$0.000
FY 2027 President's Budget (BA)	$361.570

[1] The FY 2027 Budget eliminates funding for the Prevention and Public Health Fund (PPHF).

Public Health Leadership and Support Budget Request

This budget line supports cross-cutting activities including communications, policy, and science that enable CDC to manage with efficiency, transparency, and accountability. CDC will continue to provide public health leadership to the nation and fulfill its responsibilities for responsive and timely communication to the public, key partners, and Congress. Staff offices will continue to work across the agency to maintain responsive communications, legislative, and policy functions. With support from this line, CDC carries out the following activities:

- Ensures CDC's science, programs, and recommendations are accessible, understandable, and actionable and maximize public trust and credibility.
- Identifies high-value prevention and public health policies and interventions; increases the understanding and use of credible evidence of preventions' impacts by policymakers, health care, and public health professionals; and catalyzes collaboration among public health, health care, and other sectors.
- Guides CDC's policy development and coordinates review of policies and other documents across the agency and with other federal agencies to ensure consistent federal policies.
- Receives and responds to requests for information and assistance from Congress, Government Accountability Office (GAO), and the Office of the Inspector General (OIG) to facilitate audits and engagements.

Budget Request

CDC's FY 2027 budget request of **$101,570,000** for Public Health Leadership and Support is level with the FY 2026 enacted level. These funds will continue to support national public health coordination, communication, and partnerships.

Program Accomplishments

CDC responded to more than 4,000 unique correspondences on more than 1,000 topic areas from stakeholders, including Congress, academia, the business sector, employers, and other federal, state, and local partners.

Supported rural populations through the Office of Rural Health by developing and disseminating resources tailored to rural public health needs, providing technical assistance to support rural workforce development and training, and working with partners and communities to expand rural outreach and engagement.

Infectious Disease Rapid Response Reserve Fund Budget Request

The Infectious Disease Rapid Response Reserve Fund (IDRRRF) is a critical source of funding for immediate action to address emerging outbreaks that threaten the health of Americans and national security. The IDRRRF was created by Congress in 2019 following the epidemics of Ebola in West Africa and Zika in the Americas – two public health emergencies in which CDC lacked sufficient funding for early response. The IDRRRF is designed as a flexible and immediate source of funds for CDC to use to respond quickly to an urgent problem to mitigate the impacts of an outbreak.

The IDRRRF supported CDC's response to Ebola Virus Disease in Africa in 2019, with subsequent responses in 2021 and 2022; early and aggressive response to the global outbreak of COVID-19 in 2020; and the monkeypox outbreak in the United States in 2022. In 2023, the IDRRRF supported CDC's monkeypox response activities and provided capacity to detect and respond to Ebola outbreaks in Africa, including possible reintroduction of Ebola related to prior outbreaks. In 2024, the IDRRRF supported responses to Clade I Monkeypox in Africa and Marburg virus in Rwanda. In 2025, IDRRRF supported CDC's response to Ebola in the Democratic Republic of Congo. CDC worked to provide laboratory capacity including testing materials, strengthen workforce capacity, and conduct case investigation, case management, infection prevention and control, border health, and risk communication and community engagement. The rapid efforts funded by IDRRRF helped stop these outbreaks before they became full-blown emergencies or reached the United States.

Budget Request

CDC's FY 2027 budget request does not include new budget authority for FY 2027. Existing funds are available until expended for future public health threats.

Public Health Infrastructure and Capacity Budget Request

States and local communities continue to face life-threatening infectious disease outbreaks. Meeting these challenges requires people, services, and systems to protect health in every community. After decades of underinvestment, the need for sustained public health infrastructure investment is deep and largely unmet, with an estimated $4.5 billion annual gap in foundational public health capabilities in the United States.[3] With a stronger infrastructure, public health departments will be able to help maintain every American's health by tracking diseases, stopping outbreaks, and monitoring data.

Jurisdictions have expressed the need to build capacity to respond to emergencies and provide essential services like tracking the spread of an emerging disease. Jurisdictions also emphasized a need for sustainability to support and maintain a more robust public health system.

Budget Request

CDC's FY 2027 budget request of **$260,000,000** for Public Health Infrastructure and Capacity is **$100,000,000** below the FY 2026 enacted level. In FY 2027, CDC will continue to directly fund state, local, tribal, and territorial health departments to support jurisdictions' public health infrastructure by enhancing workforce capacity, cultivating robust community partnerships, and strengthening public health outcomes. With this investment, health departments will strengthen their abilities to effectively respond to a range of public health threats, while maintaining programs and services in other areas of longstanding public health need.

Program Accomplishments

In FY 2026, CDC awarded $245,000,000 in Public Health Infrastructure and Capacity base funds to 106 jurisdictions including all 50 states, 22 cities, 26 counties, and eight territories and freely associated

[3] DeSalvo K, Parekh A, Hoagland GW, et al. Developing a financing system to support public health infrastructure. *Am J Public Health*. 2019;109(10):1358-1361. doi:10.2105/AJPH.2019.305214PubMedGoogle ScholarCrossref

states for foundational capabilities. Over the five-year grant period, these funds will be used to create a stronger, more resilient public health system that is ready to face future health threats.

Public Health Infrastructure Grant: Foundational Capabilities[1]

	FY 2025 Final[2]	FY 2026 Enacted[3]	FY 2027 President's Budget[4]
Number of Awards	106	106	TBD
- New Awards	0	0	0
- Continuing Awards	106	106	TBD
Average Award	$2,311,000	$2,311,000	TBD
Range of Awards	$493,000-$10,514,000	$493,000-$10,514,000	TBD
Total Awards	$245,000,000	$245,000,000	TBD

[1] Awards noted for Strengthening U.S. Public Health Infrastructure, Workforce, and Data Systems Grant Activity 2: -Foundational Capabilities, awarded December 2024.
[2] Awarded using FY 2024 appropriations. FY 2024 appropriations (2-year funds) for public health infrastructure and capacity shall remain available through September 30, 2025.
[3] Awarded using FY 2025 appropriations. FY 2025 appropriations for public health infrastructure and capacity shall remain available through September 30, 2026.
[4] Grant award estimates are under development.

In addition to jurisdiction awards, CDC also provides Infrastructure and Capacity funding to Tribes and other public health partner organizations to support infrastructure across the country. For example, in FY 2026, CDC awarded $5,408,000 in Public Health Infrastructure and Capacity funds to 26 federally recognized AI/AN Tribes and regional AI/AN Tribally designated organizations. This investment provides the support AI/AN communities need to overcome unique public health infrastructure challenges such as data access barriers, public health workforce shortages, and remote locations.

Strengthening Public Health Systems and Services in Indian Country Cooperative Agreement

	FY 2025 Final[1]	FY 2026 Enacted[2]	FY 2027 President's Budget[3]
Number of Awards	34	26	TBD
- New Awards[4]	8	0	0
- Continuing Awards	26	26	TBD
Average Award[5]	$355,000	$208,000	TBD
Range of Awards	$208,000-$832,000	$208,000	TBD
Total Awards	$12,064,000	$5,408,000	TBD

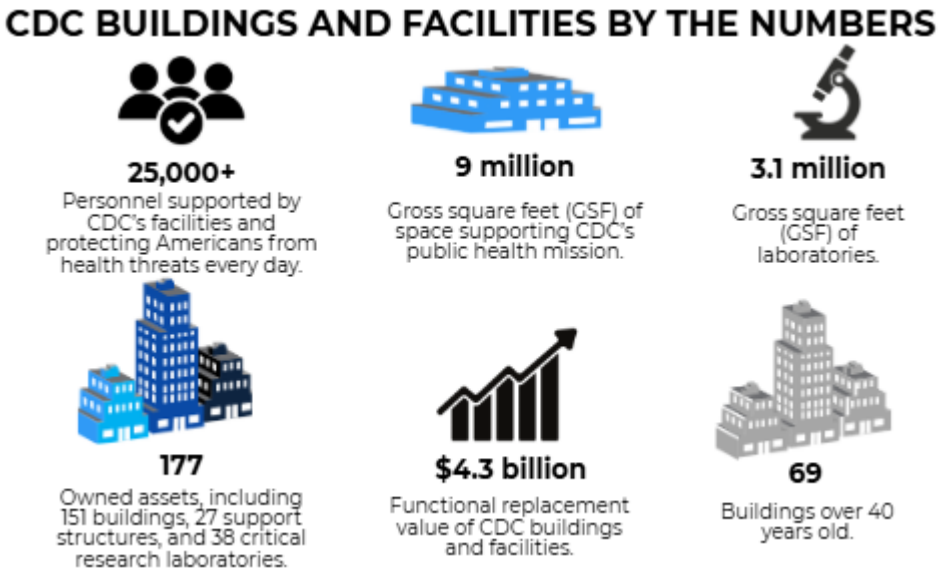
[1] Awarded using FY 2024 appropriations. FY 2024 appropriations for public health infrastructure and capacity shall remain available through September 30, 2025.
[2] Awarded using FY 2025 appropriations. FY 2025 appropriations for public health infrastructure and capacity shall remain available through September 30, 2026.
[3] Grant award estimates are under development.
[4] In FY 2025, eight new recipients were awarded $832,000 each with FY 2024 appropriations (performance period spanning June 1, 2025 – August 30, 2028).
[5] In FY 2025, 26 recipients received $208,000 in continuing awards.

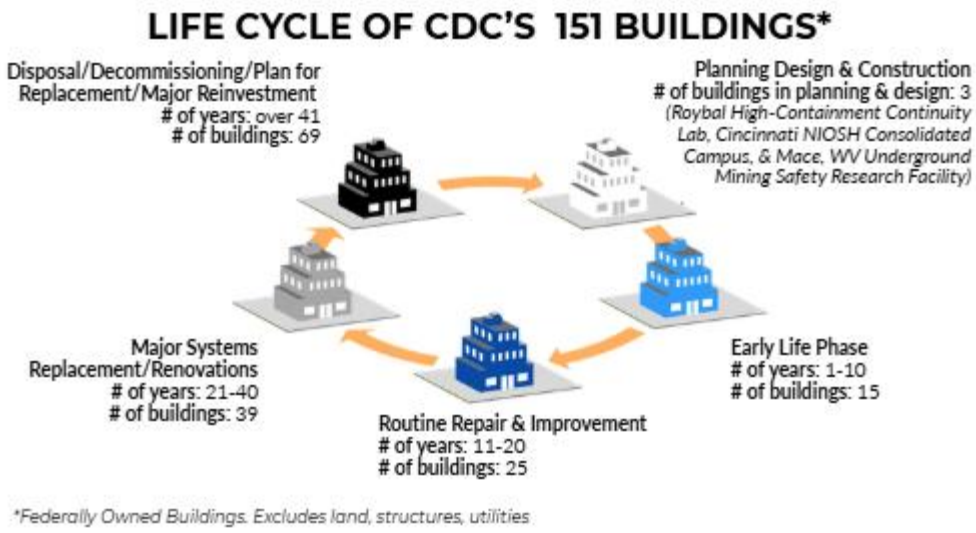
BUILDINGS AND FACILITIES

(dollars in millions)	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Budget Authority	$40.000	$40.000	$40.000	$0.000
Total Request	**$40.000**	**$40.000**	**$40.000**	**$0.000**
-- Buildings and Facilities	$40.000	$40.000	$40.000	$0.000

Safe, secure, and fully operational laboratories and facilities equip CDC with the infrastructure needed to protect Americans through infectious disease surveillance and rapid responses to outbreaks and other public health emergencies. CDC's laboratories and facilities must be in excellent condition for CDC staff to respond to health threats such as measles, viral hemorrhagic fevers, and polio.

Buildings and Facilities (B&F) funds allow CDC to delay the physical decline of its buildings, supporting structures and property, and ensuring the safety of people on campus and in the surrounding neighborhoods. Research and laboratory buildings require consistent maintenance and upgrades to prevent equipment and system failures that can threaten safety and interrupt essential laboratory functions. CDC strategically invests in repairs and improvements (R&I) to outdated or inefficiently operating laboratories to ensure that all U.S. locations are safe and remain capable of supporting the nation's public health mission.





Budget Request

CDC's FY 2027 budget request of **$40,000,000** for Buildings and Facilities is level with the FY 2026 enacted level. This funding exclusively supports renovations to existing buildings and repairs and improvements (e.g., laboratory ventilation upgrades, structural repairs, roof replacements, and electrical and mechanical repairs) needed to restore, maintain, and improve CDC's assets. This investment will allow CDC to continue to address the backlog of maintenance and repairs of about $238,510,000 across all CDC campuses.

CDC prioritizes R&I projects by need and available funding within the following categories:

- Execution of fire and life safety required improvements
- Mission-critical support projects
- Replacement of technologically antiquated mechanical and electrical infrastructure
- Improvement of operational efficiency, and increased resiliency in alignment with federal requirements
- Reduction of the current backlog of maintenance and repair

Critical program support initiatives and facilities maintenance planned for FY 2027 will address these urgent needs, ensuring CDC facilities remain operational, safe, and capable of supporting the agency's mission. The following items highlight the key projects and improvements scheduled:

- Upgrade the walk-in refrigerators and freezers at CDC's Lawrenceville facility to better support select agent and other laboratory activities. This enhancement will significantly improve reliability and operational stability. These units are at or past their useful service life, with some over 15 years old. They are unable to maintain the required temperature levels consistently and continue to disrupt research with un-scheduled shutdowns.
- Replace heating, ventilation and air conditioning (HVAC) units in laboratory cold rooms on the Roybal Campus. This project will replace the HVAC units in these cold rooms that are unreliable and consistently breaking down. Replacing the HVAC units will increase the storage integrity of laboratory reagents and specimens, supporting the quality of the lab testing.
- Repair fire suppression leaks on the Roybal Campus. CDC has discovered pinhole leaks in the fire suppression system that serves all of the laboratory buildings. CDC has been repairing the piping as needed but due to the age of the piping it will require replacement in order to prevent impact to all lab buildings.

- Upgrade the CDC San Juan Campus plumbing and sewer systems. This will include the campus' domestic cold and hot water systems and address findings to correct or improve the booster pumps sizing and functionality, thereby sustaining CDC's critical mission and reducing operational risk.
- Replace waterlines across CDC's Pittsburgh Campus domestic potable water and fire water distribution systems creating a loop configuration. This multi-phase project will create a combined fire and potable water supply serving the entire campus by delivering a safer, more reliable, and higher-quality system that enhances fire safety and supports uninterrupted mission operations.

Program Accomplishments

The B&F Program played a pivotal role in leading the response and recovery efforts at the Roybal Campus following the August 8 active shooter incident. Team members promptly assessed the damage and initiated cleanup efforts in Buildings 16, 18, 21, 24, and at the two guard stations. CDC developed a comprehensive plan to ensure a safe and swift return to normal operations for CDC staff – including contract awards for window glass permanent repairs and door replacements by the end of FY 2025.

Buildings and Facilities Funding History	
Fiscal Year	Dollars (in millions)
FY 2023 Final	$40.000
FY 2024 Final	$40.000
FY 2025 Final	$40.000
FY 2026 Enacted	$40.000
FY 2027 President's Budget	$40.000

WORKING CAPITAL FUND
CDC FY 2027 WORKING CAPITAL FUND TABLE

(dollars in thousands)

CDC Programs	FY 2026 Estimate	FY 2027 Estimate[1]
Immunization and Respiratory Diseases	$78,558	TBD
Viral Hepatitis, STI and TB Prevention	$57,534	TBD
Emerging and Zoonotic Infectious Diseases	$96,110	TBD
Chronic Disease Prevention and Health Promotion[2]	$48,223	TBD
Birth Defects, Developmental Disabilities, Disability and Health[2]	$11,009	TBD
Environmental Health[3]	$30,422	TBD
Injury Prevention and Control[2]	$25,189	TBD
Public Health Scientific Services	$96,866	TBD
Occupational Safety and Health[3]	$44,253	TBD
Global Health	$59,646	TBD
Public Health Preparedness and Response	$44,170	TBD
CDC Wide Activities	$24,620	TBD
CDC Program Total	**$616,600**	**TBD**
Other CDC Funding Sources		
Agency for Toxic Substances and Disease Registry[3]	$7,455	TBD
Energy Employees Occupational Illness Compensation Program Act (EEOICPA)	$2,058	TBD
Vaccines for Children	$48,799	TBD
World Trade Center Health Program	$8,524	TBD
PEPFAR	$44,316	TBD
Other Reimbursable Income	$19,790	TBD
Other CDC Programs Contributions Total	**$130,942**	**TBD**
Total CDC Programs Contributions	**$747,542**	**TBD**

[1] To date, the FY 2027 WCF Operating budget is not yet approved.
[2] In alignment with the proposed HHS reorganization, the 2027 Budget moves these programs from CDC to the Administration for Healthy America.
[3] The FY 2027 Budget establishes a new Center within CDC, National Center for Chemicals and Toxins, and realigns CDC funding lines from NCEH, NIOSH and ATSDR.

The Working Capital Fund (WCF) is a revolving fund with extended availability and serves as the funding mechanism for centralized business services support across CDC. Business service offices provide services to CDC programs and the WCF bills programs for the services consumed based on pre-established rates. Services include office and other space management, information technology, financial transactions, human resources support and security services. The WCF supports CDC's core operations to achieve the agency's public health mission.

WCF promotes efficiency through more effective cost control in two primary ways. First, it provides business service offices with better information on the amount of customer demand for their services. With this information, business service offices can target inefficient processes and performance issues and enhance overall resource planning. Second, by providing customers with visibility into service costs, it incentivizes programs to understand the factors that drive the costs of services they consume and to exercise greater control over the incurred costs.

REIMBURSEMENTS AND TRUST FUNDS

(dollars in millions)	FY 2025 Actual	FY 2026 Estimate	FY 2027 Estimate
Reimbursements and Trust Funds[1]	$145.212	$187.000	$186.000

[1] Reimbursement and Trust Fund estimates reflect anticipated collections based on actuals collected.

Authorizing Legislation: PHSA §§ 214, 301, 306(b)(4), 311, 353; Consolidated Appropriations Act, 2016 (P.L. 114-113)

CDC's reimbursable activities provide scientific and programmatic expertise to other agencies and organizations. CDC has a long history of partnering with other federal agencies in the shared interest of improving public health and prevention programs. Examples of these activities include:

- CDC will continue its longstanding agreements with other agencies of the Public Health Service and HHS to provide scientific and programmatic expertise in areas such as genetic diseases, laboratory tests, investigations, and training and model screening programs. In addition to reimbursable agreements and user fees, CDC receives funds from Cooperative Research and Development Agreements (CRADAs) to enhance and facilitate collaboration between the agency's laboratories and various partners.
- CDC will continue to work with the Administration for Strategic Preparedness and Response and FEMA providing support for the Department's public health and medical response and recovery missions including, but not limited to, Stafford Act declarations, Public Health Emergencies (PHEs), and National Special Security Events (NSSEs) on direct mission agreements.
- CDC will continue to process Intra-Departmental Delegation of Authority (IDDAs) providing an alternative to allocations and transfers (where non-expenditure transfers are permissible) which enables HHS OpDivs to assist each other in areas such as grant issuance. Use of an IDDA must not result in an unauthorized augmentation of an appropriation.

PERFORMANCE BY ACTIVITY

IMMUNIZATION AND RESPIRATORY DISEASES

Immunization Program and Program Implementation and Accountability

Performance Measure for Long-term Objective: Ensure that children and adolescents are appropriately vaccinated

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/- FY 2026
1.2.1c Achieve and sustain immunization coverage of at least 90% in children 19 to 35 months of age for one dose of MMR vaccine (Intermediate Outcome)	FY 2024: 92.3% Target: 90% (Target Exceeded)	90%	90%	0
1.2.1h Achieve and sustain immunization coverage of at least 90% in children 19 to 35 months of age for at least 4 doses of pneumococcal conjugate vaccine (Intermediate Outcome)	FY 2024: 81.8% Target: 90% (Target Not Met but Improved)	90%	90%	0
1.2.1i Achieve and sustain immunization coverage of at least 80% in children 19 to 35 months of age for 2-3 doses of rotavirus (Intermediate Outcome)	FY 2024: 75.1% Target: 80% (Target Not Met)	80%	80%	0
1.2.2a Achieve and sustain immunization coverage of at least 80% in adolescents 13 to 15 years of age for 1 dose of Tdap (tetanus and diphtheria toxoids and acellular pertussis) (Intermediate Outcome)	FY 2024: 90.9% Target: 90% (Target Exceeded)	90%	90%	0
1.2.2b Achieve and sustain immunization coverage of at least 80% in adolescents 13 to 15 years of age for 1 dose of meningococcal conjugate vaccine (MenACWY) (Intermediate Outcome)	FY 2024: 89.1% Target: 87% (Target Exceeded)	87%	87%	0
1.L.1: Achieve and sustain vaccination coverage of at least 80% for receiving recommended doses of human papillomavirus (HPV) vaccine (among adolescents 13 to 15 years of age)	FY 2024: 58.7% Target: 60% (Target Not Met)	65%	65%	0

[1] Please note that these measures reflect the childhood and adolescent immunization schedule as of 2025. They have not yet been updated to reflect the updated immunization recommendations recently made by CDC.

Performance Measures for Long-term Objective: Increase the proportion of adults who are vaccinated annually against influenza and ever vaccinated against pneumococcal disease

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/- FY 2026
1.3.1b Increase the percentage of adults aged 65 and older who are vaccinated with at least one dose of pneumococcal vaccine (Intermediate Outcome)	FY 2024: 64.7% Target: 85% (Target Not Met but Improved)	85%	85%	0
1.3.2c Increase the percentage of non- institutionalized adults ages 18 to 64 at increased risk of pneumococcal disease who are vaccinated with at least one dose of pneumococcal vaccine (Intermediate Outcome)	FY 2024: 24.0% Target: 29% (Target Not Met but Improved)	29%	29%	0
1.3.3a Increase the percentage of adults aged 18 years and older who are vaccinated annually against seasonal influenza (Intermediate Outcome)	FY 2024: 45.1% Target: 70% (Target Not Met)	70%	70%	0

Performance Trends: Vaccination is one of the most important public health tools to prevent serious illness and death across the lifespan. CDC estimates that vaccination of children born during 1994–2023 helped prevent approximately 508 million illnesses and 1,129,000 deaths, saving nearly $2.7 trillion in societal costs. CDC prioritizes achieving high vaccination coverage rates as it leads to population immunity, ultimately reducing disease incidence and preventing outbreaks of vaccine-preventable diseases. Over the past decade, CDC has demonstrated improvements in vaccination coverage rates across the lifespan, yet challenges remain.

Childhood Vaccination Coverage: Rotavirus vaccine coverage among children increased by 20 percentage points from 59% in FY 2010 to 79% in FY 2021; despite this progress, CDC noted that coverage rates fell to 75.1% in FY 2023 and FY 2024, further missing the 80% target (Measure 1.2.1i). Since FY 2010, measles, mumps, and rubella (MMR) vaccinations have exceeded the 90% target for coverage rates (Measure 1.2.1c). However, during the 2024-2025 school year, vaccination coverage with state-required numbers of doses for kindergarteners decreased to about 92% for select routine vaccines like MMR (92.5%) and DTaP (92.1%), declining slightly from the 2023-2024 school year (92.3% DTaP and 92.7% MMR) and continuing to decline from pre-pandemic years (2019-2020: 94.9% DTaP and 95.2% MMR). The vaccination exemption rate increased to 3.6% during the 2024-2025 school year compared to 3.3% (2023-2024 school year). Four dose coverage of pneumococcal conjugate vaccine was 82.0% in FY 2024, which is lower than rates in recent fiscal years (Measure 1.2.1h). Effective strategies to improve the fourth dose of PCV coverage are in place and CDC expects more children will become fully vaccinated in the future.

Adolescent Vaccination Coverage: Vaccine coverage for Tetanus, diphtheria, and acellular pertussis (Tdap) among adolescents aged 13-15 years increased from 74% in FY 2010 to 90.9% in FY 2024 (Measure 1.2.2a), exceeding the target of 90%. Meningococcal conjugate vaccine (MCV4) coverage increased from 65% in FY 2010 to 89.1% in FY 2024, which exceeded the target of 87% (Measure 1.2.2b). In FY 2023, CDC revised the Measure 1.L.1 to align with the Healthy People 2030 HPV measure, Increase the proportion of adolescents who get recommended doses of the HPV vaccine — IID08. This change allows CDC to demonstrate the short term (e.g., one-year) impact of immunization program processes for the HPV vaccine. Vaccination coverage among adolescents 13-15 years of age receiving the recommended doses of HPV vaccine was 58.6% in FY 2022, 57.3% in FY 2023, and 58.7% in FY 2024, falling short of the 60% target.

Adult Vaccination Coverage: CDC did not meet the FY 2024 target for pneumococcal vaccination coverage among noninstitutionalized adults aged 18-64 years at increased risk for pneumococcal disease; coverage has remained below 25% for the past five years (Measure 1.3.2c). CDC did not meet the FY 2024 target for pneumococcal vaccination coverage among adults 65 and older; coverage has remained below 70% for the past five years (Measure 1.3.1b). Seasonal influenza vaccination rates for adults ages 18 years old and over increased from 42% in FY 2015 to 51% in FY 2023 (Measure 1.3.3a) but fell to 45.1% in FY 2024 and short of the 70% target. Despite not meeting targets and a decline in adult influenza vaccination coverage, CDC has demonstrated gradual improvements towards these goals and is implementing strategies to improve adult vaccination coverage, such as informing health care professionals about the Standards for Adult Immunization Practice.

CDC Programs Improving Vaccination Coverage Across the Lifespan: CDC supports 66 state, tribal, local, and territorial immunization programs to implement the Vaccines for Children (VFC) and CDC's Discretionary Immunization Program. These two long-standing programs provide the foundation of our nation's immunization infrastructure. CDC works with immunization programs to support informed decision-making about vaccines and ultimately increase vaccine coverage in communities across the nation.

Influenza Planning and Response

Performance Measures for Long-term Objective: Protect Americans from infectious diseases – Influenza

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/- FY 2026
1.M Number of virus specimens received and fully characterized using deep sequencing from global National Influenza Centers for use in determining vaccine strain selection annually (Output)	FY 2025: 7,756 Target: 4,500 (Target Exceeded)	4,500	4,500	0
1.P Percentage of select influenza partners reporting data routinely into CDC monitored global surveillance reporting systems (Output)	FY 2025: 97% Target: 92% (Target Exceeded)	95%	95%	0
1.Q The number of state/territorial/local health departments with full and partial laboratorians and/or influenza coordinators trained and funded through Epidemiology and Laboratory Capacity (ELC) grant (Output)	FY 2025: 59 Target: 57 (Target Exceeded)	57	57	0
1.R.1: Percentage of influenza partners with a respiratory disease surveillance system that meets two quality indicators (Output)	FY 2025: 84% Target: 70% (Target Exceeded)	70%	73%	+3

Domestic Influenza Surveillance Performance Trends: CDC continues to increase testing and surveillance capacity for influenza. This includes integrating surveillance systems to monitor and test for multiple respiratory pathogens and improving laboratory capacity by conducting trainings on sequencing and the use of new diagnostics that can detect both influenza and other respiratory pathogens.

CDC enhanced U.S. influenza surveillance capacity in FY 2025 by funding 59 laboratorians or influenza surveillance coordinators in State, Tribal, Local and Territorial (STLT) health departments (Measure 1.Q). This investment enabled rapid response to the avian influenza (H5N1) outbreak across 16 states, and detection of 71 human cases between April 2024 and December 2025. With CDC support and using CDC's diagnostic tools, STLT public health laboratories tested over 217,000 specimens for influenza A(H5), with seven of the 71 human cases detected through national influenza surveillance. CDC’s training and support for influenza surveillance coordinators ensures a skilled workforce ready to respond immediately to outbreaks of novel influenza.

In FY 2025, CDC influenza laboratories received and characterized over 7,756 virus specimens using genomic sequencing to inform seasonal influenza vaccine strain selection (Measure 1.M). The number of specimens sequenced reflected both prolonged seasonal influenza activity in the United States, and increased sequencing by State public health laboratories in response to the U.S. avian influenza outbreak. Enhanced summer surveillance ensured ongoing testing during months when influenza activity is typically low, providing critical data for both seasonal and novel influenza preparedness. CDC has worked extensively with its state and local partners to determine an appropriate representative sample of virus specimens to fully characterize, a process called “right-sizing” and is a significant program performance enhancement, aimed at sequencing specimens across a range of populations to achieve more targeted results efficiently while streamlining resources. While a targeted range of 4,000-7,000 viruses fully characterized using genomic sequencing is appropriate for seasonal influenza epidemics in order to understand patterns of different influenza types and subtypes and to provide the data needed to make recommendations for the composition of seasonal influenza vaccines, systems need to be scalable to quickly sequence many more viruses for novel or pandemic viruses. CDC built the sequencing infrastructure to have flexibility to respond when public health concerns arise. Sequencing has been a critical component of the ongoing influenza A (H5) response to be able to detect cases occurring in the community.

Global Influenza Surveillance Performance Trends: CDC continues to strengthen the health of Americans by equipping partner nations with the capacity to detect and respond to global health threats, maintain national influenza surveillance systems, and submit influenza testing data to global influenza surveillance systems. CDC's efforts to strengthen international influenza epidemiological and virological surveillance and pandemic preparedness have increased as measured by the number of CDC-funded partners routinely reporting influenza data to CDC monitored global surveillance networks. CDC's investments have strengthened global reporting, with the percentage of CDC-funded partners submitting regular influenza data rising from 40% in FY 2005 to 97% in FY 2025 (Measure 1.P).

Building on these gains in reporting, CDC's influenza program also supports partner countries in sustaining high quality surveillance systems that strengthen global health security and expand monitoring to other respiratory pathogens, such as RSV. Strong, year-round tracking of Influenza Like Illness (ILI) and Severe Acute Respiratory Infection (SARI) enables earlier detection of emerging threats before they cross borders, directly informing Unites States preparedness. The quality of partner countries' surveillance systems continues to improve: 84% of partners met the new quality measure in FY 2025 (Measure 1.R.1), which is a notable increase from 71% in FY 2024.

During FY 2025 CDC has also supported responses to global cases of influenza A(H5N1), or bird flu, providing technical assistance and field support to local health authorities for outbreak investigations and contract tracing, to help ensure potential pandemic threats are mitigated at the source. CDC has also worked with local health officials to increase clinician outreach and awareness to quickly detect and report human bird flu cases in affected countries. During FY 2025, CDC identified alternative strategies to effectively monitor influenza global threats in preparation for the U.S. withdrawal from WHO and pursued strategic bilateral agreements in priority geographic locations to ensure coverage in all influenza epidemic zones and areas at high risk for animal-to-human spillover of influenza viruses.

VIRAL HEPATITIS, SEXUALLY TRANSMITTED INFECTIONS, AND TUBERCULOSIS

Viral Hepatitis

Performance Measures for Long-term Objective: Reduce the rates of viral hepatitis in the United States

Measure	Most Recent Result and Target	FY 2026 Target[1]	FY 2027 Target	FY 2027 +/-FY 2026
2.6.4 Increase the number of health departments (states and District of Columbia) reporting acute and chronic viral hepatitis data of sufficient quality to be included in national surveillance reports (Output)	FY 2023: 42 Target: 45 (Target Not Met but Improved)	45	45	0
2.6.7 Reduce estimated new hepatitis A virus infections (Outcome)	FY 2023: 3,300 Target: 4,000 (Target Exceeded)	3,100	2,800	-300
2.6.8 Reduce estimated new hepatitis B virus infections (Outcome)	FY 2023: 14,400 Target: 18,000 (Target Exceeded)	8,520	5,360	-3,160
2.6.9 Reduce estimated new hepatitis C virus infections (Outcome)	FY 2023: 69,000 Target: 35,000 (Target Not Met)	16,640	10,520	-6,120
2.6.10 Reduce reported rate of hepatitis C-related deaths per 100,000 population (Outcome)	FY 2023: 2.52/100,000 Target: 3.00/100,000 (Target Exceeded)	2.06/100,000	1.75/100,000	-0.31/100,000
2.6.11 Reduce reported rate of hepatitis B-related deaths per 100,000 population (Outcome)	FY 2023: 0.44/100,000 Target: 0.37/100,000 (Target Not Met)	0.24/100,000	0.20/100,000	-0.04/100.000

[1] CDC has set its viral hepatitis targets based on the HHS National Viral Hepatitis Strategic Plan (NVHSP) elimination targets. The NVHSP goals are based on calendar year and apply to surveillance data reported that year (i.e., the 2026 targets in the strategic plan apply to 2024 surveillance data).

Performance Trends: In the U.S., hepatitis A virus (HAV), hepatitis B virus (HBV), and hepatitis C virus (HCV) are the main causes of viral-induced hepatitis. Hepatitis C is the most common bloodborne infection in the United States. After a decade of continuous increases from 2011–2021, the rate of reported acute hepatitis C cases remained relatively stable from 2021–2023. The highest rates were observed among adults 30-39 years of age, and injection drug use was the most commonly reported risk factor. From 2014 to 2021, the U.S. experienced an almost 130% increase in the number of estimated cases of acute hepatitis C, from 30,500 in 2014 to 69,800 in 2021. In 2023, there were an estimated 69,000 acute hepatitis C infections, which was above the annual target of 35,000 (Measure 2.6.9); this highlights the need for continued efforts to reduce new infections. CDC data revealed that from 2013-2022, only 34% of persons *diagnosed* with hepatitis C were cured (i.e., had evidence of viral clearance) during this time, indicating that far too few people diagnosed with hepatitis C are accessing curative treatment. The rate of reported hepatitis C-related deaths during 2023 was 2.52 deaths per 100,000 population, which was below the target of 3.00 deaths per 100,000 (Measure 2.6.10).

In 2023 there were an estimated 14,400 new hepatitis B virus infections in the U.S., 20% below the 2023 goal of 18,000 estimated infections (Measure 2.6.8). Among the 2,214 acute hepatitis B cases reported in 2023, 52% had some risk behavior or exposure information available; the most commonly

reported risks included injection drug use (19% of the 963 cases with information available), having multiple sexual partners (20% of the 528 cases with information available), and male-to-male sexual contact (21% of the 256 male cases with information available). In 2023, the rate of reported hepatitis B-related deaths was 0.44 deaths per 100,000 population, which was slightly higher than the target of 0.37 deaths per 100,000 (Measure 2.6.11).

Hepatitis A cases increased over 800% from 2016-2019 due to large outbreaks involving dozens of states associated with person-to-person transmission among people who use drugs and people experiencing homelessness. During 2023, there were an estimated 3,300 hepatitis A virus infections, which was below the annual target of 4,000 estimated infections (Measure 2.6.7). The most commonly reported risk was international travel to a hepatitis A-endemic region (21% of 748 cases with international travel history information available identified this risk). This marks a change from 2022 when the most commonly reported risk was injection drug use. Increased hepatitis A vaccination coverage, particularly among adults at increased risk for infection with hepatitis A virus or for severe disease from infection, is critical to preventing future hepatitis A deaths.

Accurate and complete case identification is especially needed to rapidly detect and prevent new viral hepatitis infections and ensure that persons receive appropriate care or curative treatment (hepatitis C) to prevent transmission and avoid premature death. To ensure that more states and local jurisdictions have the capacity for high-quality, comprehensive viral hepatitis surveillance, CDC works with states to ensure providers navigate patients through the entire cascade. These efforts increase the number of states submitting quality data to CDC. In FY 2025 (corresponding to data for the year 2023), 42 jurisdictions (including 41 states and the District of Columbia) reported acute and chronic viral hepatitis data, an increase from 40 jurisdictions in 2022 (Measure 2.6.4).

Sexually Transmitted Infections

National Level Performance Measures and CDC Contextual Indicators for Long-term Objective: Reduce pelvic inflammatory disease in the United States

Contextual Indicators	Most Recent Result
2.7.6e Increase the proportion of sexually active women aged 16-24 enrolled in commercial health plans who are screened for chlamydia infections	FY 2023: 49.7%
2.7.6f Increase the proportion of sexually active females enrolled in Medicaid plans who are screened for chlamydia infections: Females aged 16-24 years	FY 2023: 59.9%
2.7.7 Reduce the rate of symptomatic gonorrhea cases in men	FY 2023: 175.1/100,000

Performance Measures for Long-term Objective: Reduce syphilis rates (all stages and congenital syphilis) in the United States

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/-FY 2026
2.9.1 Reduce the rate of primary & secondary syphilis in women aged 15-44 (per 100,000 population) (Outcome)	FY 2023: 17.7/100,000 Target: 8.5/100,000 (Target Not Met but Improved)	16.3/100,000	14.4/100,000	-1.9/100,000
2.9.2 Reduce the rate of congenital syphilis (per 100,000 live births) (Outcome)	FY 2023: 105.8/100,000 Target: 62.3/100,000 (Target Not Met)	54.2/100,000	50.1/100,000	-4.1/100,000

2.9.4 Increase the proportion of potential congenital syphilis cases averted (Outcome)	FY 2023: 61.6% Target: 75% (Target Not Met but Improved)	75%	75%	0
2.9.5 Reduce the rate of primary and secondary syphilis (Outcome)	FY 2023: 15.8/ 100,000 Target: 13.3/100,000 (Target Not Met but Improved)	13.0/100,000	12.8/100,000	-0.2/100,000

Performance Trends: More than 26 million sexually transmitted infections (STIs) occur in the U.S. each year, costing the healthcare system nearly $18 billion in lifetime direct medical care costs, when including sexually transmitted HIV. CDC's long-term STI objectives are to eliminate congenital syphilis, prevent syphilis, prevent antimicrobial resistant gonorrhea, and prevent STI-related infertility and pregnancy complications, including serious illness, miscarriage, stillbirth, and even infant death. Private and public health plans have improved screening rates for chlamydia, increasing from 2021 to 2023 (commercially insured, 48.4% to 49.7% [Measure 2.7.6e]; Medicaid, 58.3% to 59.9% [Measure 2.7.6f]).

In 2023, a total of 601,319 cases of gonorrhea were reported, making it the second most common nationally notifiable STI in the U.S. for that year. After reaching a historic low in 2009, rates of reported gonorrhea increased through 2021; however, the overall rate of gonorrhea decreased 9.2% from 2021 to 2022 and then decreased 7.7% from 2022 to 2023. From 2022 to 2023, rates decreased among men and women, most age groups, and most race/Hispanic ethnicities, and decreases were observed in 40 states. During 2022-2023, the rate of reported gonorrhea among men decreased from 3.4% (236.3 to 228.3 per 100,000) and the rate among women decreased 14.1% (152.1 to 130.7 per 100,000). The rate of symptomatic gonorrhea cases in men decreased from 214 cases per 100,000 in 2022 to 175.1 cases per 100,000 in 2023 (Measure 2.7.7).

In 2023, 209,253 cases of syphilis (all stages including congenital syphilis) were reported, which is the greatest number of cases reported since 1950 and an increase of 1% since 2022. Although the number of reported cases of syphilis (all stages) increased 1% when comparing 2023 to 2022, the rate of reported cases of syphilis per 100,000 persons was relatively stable (<1% change, 61.1 to 61.3 per 100,000); however, trends varied by stage of syphilis. Rates of unknown duration or late syphilis increased 12.2% (from 26.3 to 29.5 per 100,000). Cases of syphilis staged for surveillance as unknown duration or late syphilis reflect diagnoses that likely occurred after the infectious period (i.e., more than a year earlier) and are often identified through routine screening. Recent increases in cases staged as unknown duration or late syphilis may, in part, reflect delayed diagnosis of infections occurring during disruptions of STI prevention and care services.

CDC identified a new baseline (10.8/100,000) for reducing the rate of primary and secondary (P&S) syphilis among women aged 15-44 in 2020, which better reflects the current state of syphilis rates and efforts to reduce them. The rate of P&S syphilis among women aged 15-44 decreased from 19.1 cases per 100,000 in 2022 to 17.7 cases per 100,000 in 2023 (Measure 2.9.1). In 2023, the total rate of P&S syphilis across sexes decreased to 10.7% to 15.8 cases per 100,000 from 17.7 cases per 100,000 in 2022, missing the target (Measure 2.9.5).

Congenital Syphilis (CS) is a preventable disease, which could be eliminated through consistent screening before and during pregnancy and timely treatment of infected women. In 2023, 3,882 cases of congenital syphilis were reported, including 279 congenital syphilis-related stillbirths and neonatal/infant deaths. This is the largest number of cases of congenital syphilis since 1992. The national congenital syphilis rate of 105.8 cases per 100,000 live births in 2023 represents a 3% increase relative to 2022 (Measure 2.9.2). Although the majority of congenital syphilis cases were reported from a few states, in 2023, almost all jurisdictions (48 states and the District of Columbia) reported at least one case of congenital syphilis.

Elimination of CS would contribute to reductions in lost pregnancies, stillbirths, infant deaths, and preterm/low birth weight infants. The proportion of potential congenital syphilis cases averted in 2023 was 61.6%, remaining level with 2022 (Measure 2.9.4). Nearly 9 in 10 CS cases might have been prevented with timely testing and adequate treatment during pregnancy.

Tuberculosis

Performance Measures for Long-term Objective: Decrease the rate of cases of tuberculosis (TB) among U.S. born persons in the United States

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/-FY 2026
2.8.1 Decrease the rate of cases of tuberculosis among U.S.-born persons (per 100,000population) (Outcome)	FY 2024: 0.80/100,000 Target: 0.5/100,000 (Target Not Met)	0.5/100,000	0.5/100,000	0
2.8.2 Increase the percentage of newly diagnosed TB patients who complete treatment within 12 months (where ≤12 months of treatment is indicated) (Outcome)	FY 2022: 86.7% Target: 93% (Target Not Met)	93%	93%	0
2.8.3 Increase the percentage of culture- positive TB cases with initial drug susceptibility results reported (Outcome)	FY 2024: 92.7% Target: 98.5% (Target Not Met)	98.5%	98.5%	0
2.8.4 For contacts to sputum acid-fast bacillus smear-positive TB cases who have started treatment for newly diagnosed latent TB infection, increase the proportion of TB patients who complete treatment (Outcome)	FY 2022: 79.7% Target: 75% (Target Exceeded)	82%	82%	0

Performance Trends: The U.S. reported a total of 10,388 tuberculosis (TB) cases (3.1/100,000 population) for 2024, representing an increase of 762 cases (7.9%) as compared with 2023. Reported TB incidence increased from 2.9 per 100,000 persons in 2023 to 3.1 per 100,000 persons in 2024. U.S. TB case rates are 31 times higher than the national TB elimination goal of one case per million population, disproportionately affecting certain racial and ethnic populations and those spending time in close contact with one another, for example, in homeless shelters, correctional facilities, and long-term care facilities. Among persons born in the U.S., the incidence rate in 2024 was 0.8 per 100,000 (Measure 2.8.1), which was unchanged from 2023 and does not meet the annual target.

Treating TB disease until cured is credited with keeping multidrug-resistant (MDR) TB disease in the U.S. steady at approximately one percent of the total number of new TB cases per year. In 2025, CDC funded 60 state, local, and territorial health departments to prevent and control tuberculosis. CDC supports public health laboratory testing for drug resistance and use of Advanced Molecular Detection (AMD) tools to genetically map TB specimens to develop a database to better understand and halt the spread of the disease. For example, AMD methods, such as whole genome sequencing, have enabled CDC to identify extensive ongoing TB transmission within the U.S., particularly among high-risk populations. Detecting recent transmission more accurately allows state and local TB programs to focus limited resources and prevent ongoing transmission. In 2024, 92.7% of culture-positive TB cases underwent initial drug susceptibility testing, which is lower than the target of 98.5% (Measure 2.8.3). In an effort to ensure high quality test results, CDC operates the Model Performance Evaluation Program, which analyzes the performance and practices of clinical, commercial and public health laboratories in the U.S. that perform drug susceptibility testing. Accurate and timely reporting of test results is essential for the success of TB surveillance, prevention, and treatment programs.

In addition to preventing drug resistance, completion of treatment for TB disease immediately reduces the spread of TB. In 2022, 86.7% of patients with TB disease completed a curative course of treatment

for TB within 12 months (Measure 2.8.2). Completion of therapy may be more difficult for people with health problems such as HIV infection, diabetes, substance use disorders, and persons experiencing homelessness or who have been incarcerated. CDC allocates federal funding to provide resources to programs that serve larger proportions of populations for which therapy may be difficult.

CDC-funded recipients conduct contact investigations for every case of infectious TB disease, evaluating more than 38,000 people every year. CDC measures each step of the care cascade for people who were exposed to someone with infectious TB disease beginning with the identification of contacts, medical evaluation for TB disease or latent TB infection, and initiation of treatment as needed. CDC reported that in 2022, 79.7% of persons at highest risk for TB disease completed treatment for latent TB infection, exceeding the target of 75% (Measure 2.8.4).

Untreated TB disease can be fatal. If people who are sick are not promptly diagnosed and treated, people in close contact with them can get sick as well. During FY 2025, TB programs continued to report lack of access to TB first-line drugs. The unstable supply is largely driven by the small number of manufacturers. When one company has an issue with production lines or decides to discontinue a product, there are few, if any, other producers ready to compensate with increased production. Since 2016, through the HHS Program Support Center, CDC has maintained a small stockpile of critical drugs used in treating TB disease and latent TB infection during an FDA- defined shortage.

EMERGING AND ZOONOTIC INFECTIOUS DISEASES

Emerging Infectious Diseases

Performance measure for Long-term Objective: Build and Strengthen health information systems capacity in state and local health departments

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/- FY 2026
3.G Proportion of test orders and results processed through Electronic Test Orders and Result Reporting (ETOR) at the PHL (Output)	FY 2024: 49% Target: 75% (Target Not Met)	80%	80%	0

Performance measures for Long-term Objective: Protect Americans from death and serious harm caused by medical errors and preventable complications of healthcare

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/- FY 2026
3.3.3a Reduce the central line-associated bloodstream infection (CLABSI) standardized infection ratio (SIR) in acute care hospitals (Outcome)	FY 2023: 1.0 (Baseline)	0.76	Discontinued	N/A
3.3.2b Reduce invasive healthcare- associated Methicillin-resistant Staphylococcus aureus (MRSA) infections[1] (Outcome)	FY 2024: 0.79 Target: 0.88 (Target Not Met)	0.76	0.68	-0.08
3.3.5: Infections prevented for three high-impact healthcare-associated infections (CLABSI, CAUTI, C.Difficile)	FY 2024: 16,380 (Historical Actual)	11,000	20,000	+1,000

[1] Rebaselined and targets updated to reflect refined methodology.

Performance Trends: Electronic Test Order Reporting (ETOR) replaces paper-based orders and results, which accelerates workflows at the public health laboratories; streamlines ordering from and sending results back to clinicians, hospitals, and commercial laboratories; and decreases errors and duplicate reporting. ETOR adoption and infrastructure modernization were largely driven and enabled by COVID supplemental funding.

CDC anticipates continued progress but at a slower rate due to multiple factors. Since 2022-2023, the proportion of COVID-specific laboratory reporting has decreased and impacted overall test reporting results (Measure 3.G) for FY 2024 progress. CDC anticipates that future progress will also occur incrementally as jurisdictions continue to improve systems (e.g., LIMS, ETOR web portals) with fewer resources, while maintaining existing systems. This has impacted their ability to add reportable tests and onboard new submitters.

HAI-AR Prevention: CDC provides national leadership in healthcare-associated infection (HAI) and antimicrobial resistance (AR) prevention and provides the scientific foundation for preserving quality care, improving patient safety, and advancing U.S. healthcare practices. Reducing HAIs across all healthcare settings supports HHS' mission to prevent infections, improve patient safety, combat AR and its complications, as well as reduce excess U.S. healthcare costs. In FY 2027, CDC will retire Measure 3.3.3a and replace it with an all-encompassing measure of overall reductions for three high-impact HAIs by increasing the number of infections prevented annually (Measure 3.3.5). These are three of the most common HAIs in hospitals and this new measure will provide information necessary to promote targeted patient and healthcare worker safety. In FY 2024, 16,380 of these infections were prevented in U.S. hospitals, saving hundreds of lives and millions of dollars in healthcare costs.

The number of healthcare-associated MRSA cases in FY 2022 (Measure 3.3.2b), increased from the 2020 baseline to 53,700. While hospital onset MRSA infections decreased significantly from 2021 to 2022, there was an increased burden of healthcare-associated community-onset (HACO) infections driving this increase in healthcare-associated MRSA cases. Due to significant delays in the data collection for this measure, CDC will revise Measure 3.3.2b to focus on measuring the burden of hospital-onset MRSA through NHSN data. This measure will be timelier and more accurately reflect current burden of MRSA infections in these healthcare settings. Using the revised measure, the invasive hospital onset MRSA SIR decreased to 0.79, a 21% decrease from the 2022 baseline and exceeding the 2024 target.

Vector-Borne Diseases

Performance measure for Long-term Objective: Protect Americans from Infectious Diseases – Vector-borne

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/- FY 2026
3.H Number of states that report tick surveillance data to CDC's vector surveillance system (ArboNET) (Output)	FY 2025: 43 Target: 44 (Target Not Met)	46	46	0

Performance Trends: CDC serves as a national and international leader in the prevention of vector-borne viral, bacterial, and rickettsial diseases. Vector-borne diseases are now some of the most common nationally reported diseases in the U.S., with cases rising with the expansion of mosquito and tick vectors and more vector- borne pathogens discovered or introduced in the U.S.

Approximately three-quarters of reported vector-borne disease cases are tickborne disease cases. This measure reflects state capacity to conduct tick surveillance, which is a vital component to preventing and controlling tickborne disease and one of the core competencies for prevention and control. Vector surveillance allows public health departments to know which vectors are present in their area, which informs the selection and implementation of vector-borne disease prevention programs.

In FY 2025, CDC fell short of meeting the target of having 44 states report tick surveillance data to CDC's vector surveillance system (Measure 3.H). A total of 43 states reported tick surveillance data to CDC in FY 2025, falling just one state short of our previous adjustment for a more aggressive (increase)to the FY 2025 and FY 2026 targets. One more state is currently conducting tick surveillance, but had not yet transmitted tick surveillance data through ArboNET to CDC as of December 2025. The more rapid success that the program achieved can be attributed to continued increases in FY 2021-2024 CDC funding that was used to support vector surveillance within states and CDC's increase in the provision of technical assistance to support this activity within these states. In FY 2026 and FY 2027, CDC hopes to achieve and maintain the target that 46 states and the District of Columbia will have reported tick surveillance data to CDC. A new measure will be proposed for FY 2028 that reflects county participation in this critical surveillance activity.

Antimicrobial Resistance

Performance measure for Long-term Objective: Reduce the spread of antimicrobial resistance

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/- FY 2026
3.2.3b Maintain the proportion of hospitals with carbapenem-resistant Klebsiella spp. Or Escherichia coli (E. coli) healthcare-associated infections (Outcome)	FY 2024: 4.8% Target: 7.0% (Target Exceeded)	7.0%	Discontinued	N/A
3.2.4b Reduction in hospital-onset Clostridioides difficile infections standardized infection ratio (SIR) (Outcome)	FY 2023: 1.0 (Baseline)	0.88	Discontinued	N/A
3.2.6a: Increase the percentage of CDC Antimicrobial Resistance (AR) Laboratory Network (AR Lab Network) member laboratories that meet or exceed the target laboratory result turnaround times for isolate testing of the urgent antimicrobial-resistant threat carbapenem-resistant Enterobacterales (CRE)	FY 2024: 68% (Baseline)	90%	95%	+5
3.2.6b: Increase the percentage of CDC Antimicrobial Resistance (AR) Laboratory Network (AR Lab Network) member laboratories that meet or exceed the target laboratory result turnaround times for isolate testing of the urgent antimicrobial-resistant threat Candida auris	FY 2024: 50% (Baseline)	90%	95%	+5
3.2.7: Improve appropriate antibiotic use for respiratory conditions among individuals under the age of 65 in outpatient human healthcare settings by decreasing unnecessary prescribing	FY 2023: 34% (Historical Actual)	32.5%	32%	-.5

Performance Trends: CDC is a leader in the fight to combat antimicrobial resistance (AR). CDC is committed to protecting America's health, safety, and interests through science, surveillance, and services. AR is a growing threat internationally, and some antimicrobial-resistant infections are already untreatable. Carbapenem-resistant Enterobacterales (CRE) are a group of bacteria resistant to almost all antibiotics. Because of limited treatment options, CRE bloodstream infections can be fatal in nearly half of all cases. Clostridioides difficile infection (CDI) is a preventable, life-threatening bacterial infection that can occur in both inpatient and outpatient healthcare settings. Infections occur most often in people who have taken antibiotics for other health conditions. As previously mentioned, CDC will introduce a new comprehensive measure of overall reductions for three high impact HAIs and will retire Measures 3.2.3b and 3.2.4b.

CDC has been reporting national antibiotic use in outpatient settings in the U.S. for many years, and overall antibiotic use and rates of inappropriate use have declined. Defining conditions and settings where antibiotics are prescribed most commonly or inappropriately helps CDC inform communication and education on improving antibiotic prescribing. In FY 2027, CDC will introduce a new measure that focuses on improving inappropriate antibiotic use for respiratory conditions by decreasing unnecessary prescribing (Measure 3.2.7).

The AR Lab Network is the first network in the nation providing comprehensive antimicrobial resistance testing of HAIs and community-associated infections, fungal diseases, sexually transmitted infections, and drug-resistant *Mycobacterium tuberculosis*. AR Lab Network data are used by health departments, public health laboratories, healthcare facilities, and CDC to inform patient care, track AR, and inform rapid outbreak response. To date, the AR Lab Network has conducted more than 1.5 million AR laboratory tests to accurately detect AR threats. CDC will introduce two new measures that aim to increase the percentage of CDC AR Laboratory Network member laboratories that meet or exceed the target laboratory result turnaround times for isolate testing of CRE and Candida auris (Measures 3.2.6a-b). In FY 2024 (baseline), 68% of AR Lab Network laboratories met or exceeded the target

turnaround time for CRE isolate testing; 50% met or exceeded the target for *C. auris*. Timely reporting of laboratory results by the AR Lab Network is a strong indicator of U.S. AR laboratory capacity and indicates that appropriated funds are being used as effectively as possible to combat the urgent public health threat of antimicrobial resistance.

Food Safety

Performance measures for Long-term Objective: Protect Americans from infectious diseases – foodborne illnesses

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/- FY 2026
3.C Increase the epidemiologic capacity of ELC Program G recipients for Salmonella, Listeria, and Shiga Toxin-producing E. coli (STEC), surveillance and outbreak investigations (Output)	FY 2024: 47% Target: 85% (Target Not Met)	85%	85%	0
3.D Percentage of isolates of priority PulseNet pathogens (Salmonella, Shiga toxin-producing E. coli, and Listeria monocytogenes) sequenced and uploaded to the PulseNet National Database (Output)	FY 2024: 91% Target: 85% (Target Exceeded)	90%	90%	0
3.E Increase the percentage of cases with positive culture-independent diagnostic tests (CIDTs) for Shiga toxin-producing E. coli (STEC) and culture isolation attempted or specimen metagenomics obtained (Output)	FY 2024: 78.1% Target: 90% (Target Not Met but Improved)	90%	90%	0

Performance Trends: In 2024, CDC transitioned to PulseNet 2.0, a cloud-based open-source analytic platform to enhance data analysis, management, and visualization capabilities of whole genome sequencing (WGS) data for outbreak detection and surveillance which will improve and streamline how CDC stores, processes, accesses, and shares data to detect outbreaks earlier and faster. Data indicates in FY 2023, 83% of isolates of priority PulseNet pathogens (Salmonella, Shiga toxin-producing E. coli (STEC), and Listeria monocytogenes) were sequenced and uploaded to the PulseNet National Database (Measure 3.D). These data exceeded the FY 2024 target and show an 8% increase over FY 2023.

Every year, over 175 multistate clusters of foodborne disease are identified, which, in turn, will need to be investigated to determine if they are outbreaks. Tracking state epidemiologic interview capacity is important to help identify and address challenges in the availability of epidemiologic data critical for multistate foodborne outbreak investigations. The FY 2024 result of 47% of cases interviewed with an outbreak-specific questionnaire in multistate outbreaks of Salmonella, Listeria, and STEC (Measure 3.C) is below the FY 2024 target (85%). This may indicate a lack of staffing capacity to conduct all interviews due to turnover and difficulty hiring as well as insufficient training once positions have been filled. Additionally, there has been a continued increase in patients that are unreachable or refusing to be interviewed. All jurisdictions continued to investigate and respond to infectious disease threats, including H5N1 Avian influenza and measles. This included staff being reassigned and decreased capacity to conduct enteric disease interviews and investigations.

Recent changes in diagnostic practices at clinical laboratories across the U.S. to more culture-independent methods is challenging CDC's ability to find outbreaks and monitor disease trends. CIDTs are commonly used by physicians to rapidly diagnose their patients' diseases. These tests do not provide the data needed by CDC to link cases to outbreaks unless laboratories perform additional testing to grow the bacteria, a process called reflex culture. Tracking the increased use of CIDTs and the proportion of specimens for which reflex culture is performed is important to better understand

surveillance data on enteric bacteria, identify foodborne disease outbreaks, and inform program decisions. FY 2024 data show that culture isolation was attempted, or specimen metagenomics were obtained for 78.1% of positive CIDTs for STEC (Measure 3.E). While this is below the FY 2024 target, it represents a slight increase in the proportion of specimens for which reflex culture was performed in FY 2023; this might be because of efforts by CDC and state partners to relay to clinical laboratories the importance of performing reflex culture for CIDTs that are positive for STEC. It might also be due to heightened awareness of STEC by clinicians due to high-profile outbreaks within the last year. Ongoing collaboration between federal, state and clinical laboratory partners is essential.

National Healthcare Safety Network

Performance measure for National Healthcare Safety Network

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/- FY 2026
3.3.4 Increase the number of hospitals and other selected health care settings that report into the National Healthcare Safety Network (NHSN) (Output)[1]	FY 2024: 39,130 Target: 37,000 (Target Exceeded)	38,700	Discontinued	N/A
3.3.4b: Increase the number of hospitals that report to NHSN using automated electronic data feeds. (Connected to NHSN for Fast Healthcare Interoperability Resources (FHIR) data exchange)	FY 2024: 12 Target: 6 (Target Exceeded)	25	100	+75

[1] Measure discontinued because CDC is reaching upper limit of available facilities to enroll and will replace this measure with Measure 3.3.4b focused on increasing the number of facilities reporting through automated electronic systems.

Performance Trends: CDC's National Healthcare Safety Network (NHSN) is the nation's most comprehensive and widely used surveillance and quality improvement system to identify emerging and enduring threats across healthcare, such as healthcare-associated infections (HAIs) and antimicrobial-resistant infections. NHSN data drive HAI prevention and improves quality of care at local, state, and national levels.

CDC continues to enroll and provide support for healthcare facilities in NHSN to report HAIs, including those caused by antimicrobial-resistant bacteria. Due to the success of CDC to enroll healthcare facilities to NHSN and report into this system CDC, CDC is reaching the upper limit of available facilities to enroll and will retire Measure 3.3.4. CDC will replace this measure with one focused on **i**ncreasing the number of facilities reporting through automated electronic systems (Measure 3.3.4b). This will help public health take the next step toward increasing patient and healthcare worker safety while also reducing the reporting burden for healthcare staff, facilities, and systems. Access to faster public health data also allows decisionmakers to identify and respond to concerning trends faster. Twelve facilities have already adopted the use of Fast Healthcare Interoperability Resources (FHIR) data exchange for automated reporting in NHSN, exceeding the FY 2024 target.

Travel and Port Health Protection

Performance measures for Long-term Objective: Prevent the importation of infectious diseases to the U.S. in mobile human, animal, and cargo populations

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/- FY 2026
3.4.9 Maintain the number of U.S. ports of entry that have demonstrated a validated capability to respond to a communicable disease event involving mobile populations in the previous 3 years (Output)	FY 2024: 51 Target: 49 (Target Exceeded)	51	51	0

Performance Trends: CDC enhances the public health security of U.S. communities and addresses infectious disease risks associated with international travel and globally mobile populations by preventing the importation and spread of disease into and within the U.S. CDC Port Health Stations are strategically located at 20 ports of entry and land-border crossings that cover approximately 80% of international travelers arriving in the U.S. Port health protection officers are available 24/7 and rapidly respond to health threats to prevent further spread of communicable diseases. Having a validated capability to respond to communicable disease events involving travelers at U.S. ports of entry is integral to CDC's preparedness for the next outbreak. Performing this task is made more effective, efficient, and resilient over time if all ports of entry can routinely demonstrate validated public health response capabilities. In FY 2025, 58 U.S. ports of entry (POEs) that demonstrated a validated capability to respond to a communicable disease event involving mobile populations (Measure 3.4.9). CDC exceeded the FY 2025 target despite the challenges and resources required to respond to measles and viral hemorrhagic fever outbreaks. CDC has continued its use of a “priority sub port” strategy based on travel volume and the status of preparedness plans to target POEs nearing a validated capability and to identify and recruit advocates at each CDC Port Health Station to serve as the lead for validating capabilities within their respective jurisdictions.

Parasitic Diseases and Malaria

Budget Output Measure for Long-term Objective: Decrease the burden of malaria through evidence-based guidelines, policies, programs, and practices

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/- FY 2026
10.C.A The number of CDC authored publications that inform the evidence for malaria control and prevention programs (Output)	FY 2024: 71 Target: 155 (Target Not Met)	75	75	0

CDC Performance Measure for Long-term Objective: To deliver timely and accurate reference diagnostic laboratory services for the detection of parasites in specimens submitted by domestic and international public health partners to CDC

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/- FY 2026
10.C.4 The percentage of laboratory test results reported within the expected turn-around time upon receipt by CDC labs (Outcome)	FY 2024: 94% Target: 90% (Target Exceeded)	90%	90%	0

Performance Trends: Malaria prevention and treatment tools are among the most cost-effective interventions available to control and eliminate malaria. CDC’s research informs the development of

new tools to manage and mitigate threats from drug and insecticide resistance, guides future program and policy decisions, and builds public health capacity through strategic partnerships to ensure U.S. health departments and other governments can quickly detect and stop potential malaria outbreaks from spreading further.

CDC continues to lead the development of evidence-based policy guidelines and peer-reviewed scientific publications to strengthen malaria prevention and control practices. Recent CDC co-authored research has identified a more effective dosing strategy for primaquine to prevent relapse of *Plasmodium vivax* malaria, a strain often seen in U.S. travelers. The agency is also closely monitoring the spread of *Anopheles stephensi*, an invasive mosquito species, and has co-authored findings that emphasize the urgent need for expanded vector control in regions like Ethiopia to prevent widespread transmission. These efforts not only reduce the burden of malaria in other countries, but they also help protect Americans traveling to malaria-endemic regions.

Overall, the number of CDC authored peer-reviewed publications decreased from 77 in FY 2023 to 71 in FY 2024, which did not meet the current target (Measure 10.C.A). All publications contribute to growing the evidence base to support policy and program needs. CDC anticipates some variation in the number of publications from year to year based on the publication process and the timelines for study initiation, completion, and data analysis, as well as competing demands such as supporting and leading emergency response.

CDC's parasitic disease labs serve as global and national resources for ensuring efficient and high-quality analyses, essential to timely and accurate diagnosis and treatment. In FY 2024, CDC analyzed and reported results for 94% of submitted specimens in a timely manner (within the expected turnaround times posted in the CDC test directory for each test), exceeding the target of 90% (Measure 10.C.4). Since FY 2023, CDC has been focused on test modernization efforts to introduce technical improvements and conduct validations for nearly all of the parasitic disease tests. Maintaining momentum in test modernization will ensure CDC's parasitic diseases labs can continue to fill the technical gap and laboratory capacity which is not readily available at the state and local levels. These improvements include adapting new methods using newer laboratory instrumentation typically available in state and local public health laboratories. CDC is utilizing new test methods incorporating recombinant antigens for serology tests to ensure reagent sustainability. Recently, CDC improved a malaria PCR assay which was made available to all US public health and clinical labs in January 2025. CDC continues to develop external laboratory testing protocols for other parasitic diseases that state and local public health laboratories can reference. CDC plans to complete these improvements by the end of FY 2026.

NATIONAL CENTER FOR CHEMICALS AND TOXINS

Environmental Health Laboratory

Performance Measures for Program: Environmental Health Laboratory

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/-FY 2026
6.1.1 Number of environmental chemicals and nutritional indicators that are measured in surveys and studies of the U.S. population (Output)	FY 2025: 406 Target: 450 (Target Not Met)	455	455	0
6.1.3 Number of laboratories participating in DLS Quality Assurance and Standardization Programs to improve the quality of their laboratory measurements (Output)	FY 2025: 1,683 Target: 2,055 (Target Not Met)	2,060	1,700	-360
6.1.4 Number of chronic disease biomarkers included in standardization programs that improve the quality of laboratory measurements (Output)	FY 2025: 50 Target: 47 (Target Exceeded)	48	50	+2
6.D: Number of biomarkers of newborn disease covered by CDC newborn screening quality assurance materials (Output)	FY 2025: 76 Target: 77 (Target Not Met)	90	84	-6
6.B Number of laboratory studies conducted to measure levels of environmental chemicals in exposed populations (Output)	FY 2025: 41 Target: 90 (Target Not Met)	92	50	-42

Performance Trends: CDC develops and uses laboratory tests for chemical exposures, nutrition status, and disease biomarkers to identify environmental exposures and provide information about Americans' health status. In FY 2025, CDC measured and published data on 406 environmental chemicals and nutrition indicators (Measure 6.1.1), a decrease from the FY 2024 result and below the FY 2025 target due to the cycling out of measurements for infrequently detected chemicals. In the next couple years, CDC will continue to add new measurements for several chemicals while transitioning out measurements for infrequently detected chemicals, with the FY 2027 target adjusted to reflect expected changes. CDC collaborated on 41 studies of environmental chemicals in FY 2025 (Measure 6.B), fewer than expected. Results for this measure depend on the number of opportunities with collaborators, the size and complexity of required laboratory measurements, and proposed work's alignment with CDC mission and budget. CDC has adjusted the FY 2027 target to align with expected future performance based on these factors, as well as expected resources.

CDC provides voluntary quality assurance and standardization programs for clinical health laboratories that help ensure the accuracy and comparability of clinical laboratory measurements for disease biomarkers that are essential for patient care. In FY 2025, 1,683 laboratories used CDC quality assurance and standardization programs (Measure 6.1.3), falling below the target. CDC added priority biomarkers of thyroid and cardiovascular health to the standardization program in FY 2025, exceeding the target for Measure 6.1.4. CDC set FY 2027 targets for Measures 6.1.3 and 6.1.4 to reflect expected resources and clinical laboratory participation. CDC also provides newborn screening quality assurance materials to state newborn screening programs to help them identify and get treatment to newborns that would have died or experienced severe disability without early intervention. In 2025, CDC newborn screening quality assurance materials covered 76 disease biomarkers (Measure 6.D). CDC expects to add 4 new biomarkers in FY 2026 and FY 2027 as resources and priorities allow.

Agency for Toxic Substances and Disease Registry Performance

Performance Measures for Long-term Objective: Protect Americans from harmful exposures by recommending and taking responsive public health actions

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/-FY 2026
14.2.1 Number of toxicological profiles for substances hazardous to human health published (Output)	FY 2025: 18 Target: 10 (Target Exceeded)	10	10	0
14.B Number of requests ATSDR and cooperative agreement partners have responded to from environmental agencies, health agencies, policy makers and community members (Output)	FY 2025: 1,259 Target: 720 (Target Exceeded)	750	800	+50
14.C.1: Percent of individuals registered for Continuing Education credits who completed a training module of the Public Health Assessment Guidance Manual online training	FY 2025: 65% Target: 73% (Target Not Met)	73%	73%	0
14.L Number of health professionals trained on environmental health topics (Output)	FY 2025: 35,791 Target: 36,000 (Target Not Met)	36,000	36,000	0

Performance Trends: By Congressional mandate, CDC's Agency for Toxic Substances and Disease Registry (ATSDR) protects Americans from exposures to hazardous substances by investigating exposures in communities, publishing the best available science on hazardous exposures, and training health department staff and healthcare clinicians to recognize and address disease related to hazardous exposures. Annual targets align with fulfilling the mandate and providing the best service possible to protect people from hazardous exposures.

On average, CDC receives over 1,000 annual requests for assistance from federal partners, state and local governments, and the public. In FY 2025, CDC exceeded the target and responded to 1,259 requests for assistance (Measure 14.B), a 7% increase from FY 2024. CDC will increase the FY 2027 target to 800 responses to requests, with CDC's ability to meet the target depending on the number of requests received and the available resources to respond.

CDC currently maintains 184 toxicological profiles that provide scientific and health information about hazardous exposures that health department staff and healthcare providers use to protect people's health. CDC exceeded the target by publishing 18 profiles in FY 2025 (Measure 14.2.1) and, anticipating similar resources and performance, will maintain the target in FY 2027.

CDC's trainings build state and local capacity to investigate and address hazardous exposures in their jurisdictions, with the Public Health Assessment Guidance Manual online training serving as a foundational resource. In FY 2025, 722 individuals registered for Continuing Education credits for a module in the Public Health Assessment Training online training, with 462 completing the module (Measure 14.C.1).

In FY 2025, CDC and funded partners educated 35,791 health professionals on ways to diagnose and treat conditions related to hazardous exposures (Measure 14.L), a slight decrease from the previous year. In FY 2027, CDC will focus on pediatric environmental health and will maintain the target due to this focus.

Occupational Safety and Health

Performance Measures for Long-term Objective: Reduce workplace illness, injury, and mortality in targeted sectors

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/-FY 2026
9.2.2e: Achieve and sustain percentage of active underground and surface coal mines in the U.S. that possess NIOSH-approved plans to perform surveillance for respiratory disease (Outcome)	FY 2025: 97% Target: 93% (Target Exceeded)	93%	93%	0
9.2.3c Increase the number of product and manufacturing site audits completed to ensure the quality of NIOSH certified respirators (Outcome)	FY 2025: 188 Target: 260 (Target Not Met)	260	260	0
9.B Number of certification decisions issued for personal protective equipment (Output)	FY 2025: 436 Target: 425 (Target Exceeded)	425	425	0

Performance Trends: Exposure to coal mine dust causes various pulmonary diseases, including coal workers' pneumoconiosis and Chronic Obstructive Pulmonary Disease (COPD). CDC works with coal mines in the United States to develop plans to perform surveillance for pneumoconiosis and COPD. In FY 2025, 97% of active underground and surface coal mines in the United States had NIOSH-approved plans to perform surveillance for respiratory disease (Measure 9.2.2e). The targets remain at 93% percent as CDC works with mines to incorporate spirometry into their plans, the newest medical test added to coal workers' surveillance. An estimated 20 million workers use personal protective equipment (PPE) to protect themselves from death, disability, and illnesses. CDC's National Personal Protective Technology Laboratory program provides expertise from many scientific disciplines to advance federal research on respirators and other personal protective technologies for workers. In FY 2025, CDC completed 436 certified respirator decisions (Measure 9.B), exceeding both the previous performance baseline of 400 and the revised target of 425, which was increased in FY 2024 to reflect projected growth in program demand.

Performance for product and manufacturing site audits (Measure 9.2.3c) declined to 188 audits in FY 2025 following five consecutive years of exceeding targets. This reduction was driven by unforeseen, one-time disruptions outside program control, including contract cancellations, workforce reductions, travel restrictions, and disruptions to laboratory testing capacity. As a result, several audits and testing activities were deferred. These represent temporary conditions. Deferred audits and testing activities are scheduled for completion in FY 2026, as contracts are reestablished and travel and laboratory operations return to normal.

National Center for Toxicology Research

Long-term Objective: Research to advance the safety of FDA-regulated products to protect and improve the health of the American public

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/-FY 2026
262401: Develop biomarkers to assist in characterizing an individual's genetic profile in order to minimize adverse events and maximize therapeutic care. (Output)	FY 2025 Results: In collaboration with CDER, promoted the development of biomarkers and elucidate pathways that may support the development of more effective therapies for Alzheimer's Disease. Manuscript submitted to journal in FY 25: https://pubmed.ncbi.nlm.nih.gov/40809919/ FY 2025 Target: In collaboration with CDER, promote the development of biomarkers and elucidate pathways that may support the development of more effective therapies for Alzheimer's Disease. (Target Met)	Publication of a manuscript demonstrating CarcSeq's ability to assess/predict the carcinogenic impact of drug/chemical exposures using a known genotoxic lung carcinogen, thereby addressing a goal in the Predictive Toxicology Roadmap to find alternative and supplemental approaches that are more predictive and relevant to human cancer.	Initiate new biomarker studies in support of reducing adverse events and maximizing therapeutic care, focusing on high priority regulated compounds/products as defined by FDA leadership.	N/A
263102: Develop computer-based models and infrastructure to predict the health risk of biologically active products. (Output)	FY 2025 Results: Developed a preliminary database of extractable/leachable chemicals from medical devices. FY 2025 Target: In collaboration with CDRH, develop a preliminary database of extractable/leachable chemicals from medical devices. (Target Met)	Apply AI/ML to recognize safety and efficacy signals and predict the relevance of documents and their importance to pharmacovigilance.	Support regulatory decision-making by continuing to develop infrastructure to predict the health risk of FDA regulated products.	N/A

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/-FY 2026
263103: Conduct translational and regulatory research to advance the safety of products that FDA regulates. (Output)	FY 2025 Results: In collaboration with CDER, provided data to address scientific knowledge gaps regarding potential neuropsychiatric risks to patients chronically taking montelukast. Manuscript currently under journal consideration. FY 2025 Results: The project concluded in July 2025 with a final report submitted to OWH in September 2025, resulting in five published manuscripts and one manuscript currently in submission. Collectively, data suggest potential sex-specific risks and immune-related genetic factors that may contribute to herbal and dietary supplement-induced liver injury. FY 2025 Target: In collaboration with CDER, provide data to address scientific knowledge gaps regarding potential neuropsychiatric risks to patients chronically taking montelukast. FY 2025 Target: In collaboration with CDER and OWH, identify early signs of sex difference in adverse events during drug development using bioinformatics. (Targets Met)	Data from a full developmental neurotoxicity study will be published in a manuscript detailing neurodevelopmental consequences of perinatal exposure to medication-assisted treatment (buprenorphine and methadone) for opioid use disorder.	Develop New Approach Methodology (NAMs) as a follow-up to Ames test results.	N/A
263104: Use new omics technologies to develop approaches that assess risk and assure the safety of products that FDA regulates. (Output)	FY 2025 Results: Data from a full developmental neurotoxicity study was planned to be presented at the Society of Toxicology's annual meeting and published in a manuscript detailing neurodevelopmental consequences of perinatal exposure to medication-assisted treatment (buprenorphine and methadone) for opioid use disorder. Data was alternatively presented at the American College of Toxicology (ACT) conference. Publication will be achieved in FY 2026. FY 2025 Target: In collaboration with CDER, develop a preliminary human liver 3D cell model and use this model for assessing drug-induced liver toxicity. (Target Not Met)	Complete field trial validation of the efficacy and acceptability of metagenomic analysis detection method(s).	Support regulatory decision-making by continuing to utilize new omics technologies and NAMs to address risk and safety of FDA regulated products.	N/A
263201: Develop science base for supporting FDA regulatory review of new and emerging technologies. (Output)	FY 2025 Results: In collaboration with CDER, provided data to assist FDA in developing Guidance for Industry for the use of liver microphysiological system technology in drug safety evaluation. Draft Guidance for Industry on MPS submitted to CDER.	Complete the publication of two test method standards on nanomaterial drug products through ASTM International for nanomaterial	Continue to assess emerging NAMs for regulatory applicability.	N/A

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/-FY 2026
	FY 2025 Target: In collaboration with CDER, provide data to assist FDA in developing Guidance for Industry for the use of liver microphysiological system technology in drug safety evaluation. (Target Met)	measurement, in collaboration with other agency and industry stakeholders.		
264101: Develop risk assessment methods and build biological dose-response models in support of food protection. (Output)	FY 2025 Results: In collaboration with CVM, characterized potential targets for anti-virulence drugs in food-producing animals. FY 2025 Target: In collaboration with CVM, characterize potential targets for anti-virulence drugs in food-producing animals. (Target Met)	Develop a research program and initiative related to Microplastics/ Nanoplastics analysis in FDA regulated products.	In support of regulatory decision-making, continue to develop a Microplastics/ Nanoplastics program and expand capabilities.	N/A

PUBLIC HEALTH SCIENTIFIC SERVICES

Public Health Workforce and Career Development

Performance Measures for Long-term Objective: Develop and implement training to provide for competent, sustainable, and empowered public health workforce able to meet emerging and future health challenges.

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/-FY 2026
8.B.4.2 Increase the number of CDC trainees in state, tribal, local, and territorial public health agencies (Output)	FY 2025: 156 Target: 294 (Target Not Met)	294	199	-95
8.B.4.4 Increase the number of times health professionals earn free Continuing Education (CE) from CDC, demonstrating successful achievement of knowledge. (Output)	FY 2025: 376,187 Target: 613,000 (Target Not Met)	680,000	330,000	-350,000

Performance Trends: CDC fellowship programs promote on-the-job training and mentored learning through unique work experiences across public health disciplines allowing CDC fellows and trainees to fill critical workforce needs at CDC and in state, tribal, local, and territorial (STLT) public health agencies, while working in public health careers. Field placement of these fellows offers jurisdictions direct support from CDC and provides fellows and trainees an opportunity to work alongside professionals across a variety of public health settings. After completing CDC fellowships, graduates are qualified to apply for jobs with public health agencies, and data shows that most CDC fellowship graduates stay in public health positions. CDC placed 156 CDC trainees in STLT public health agencies in FY 2025 (Measure 8.B.4.2). This did not meet our FY 2025 target for CDC trainees in STLT public health agencies, in part because the number of trainees that can be placed in the field is dependent on the availability of qualified host-site supervisors, funding, and the ability to hire fellows. Due to changes in CDC's hiring policy, CDC was only able to onboard a 2025 class for three of the five fellowships included in this measure (Epidemic Intelligence Service, Laboratory Leadership Service, and CDC/CSTE Applied Epidemiology Fellowship).

An effectively trained public health workforce is our first line of defense against disease outbreaks, natural disasters, and other health threats domestically and globally. CDC designs, develops, and accredits quality learning opportunities and ensures these opportunities are available to the public health and health care workforce. The accredited learning opportunities CDC provides help ensure public health workers can maintain licensure and certification requirements, improve knowledge and skills, and ultimately enhance their overall competency. In FY 2025, over 136,000 unique health professionals earned free continuing education (CE) credit over 376,000 times, valued at an estimated $8 million (Measure 8.B.4.4). This did not meet our FY 2025 target for earned CE credit by unique users. Significant increases in FY 2020-FY 2021 were largely driven by health professionals seeking CE credit for COVID-19 related training content. FY 2025 CE attainment remains higher than pre-pandemic baselines but demonstrates more modest year-over-year trends as demand for immunization and COVID-19-related CE returns to pre-COVID levels.

State, Tribal, Local and Territorial Support

Performance Measures for Long-term Objective: Improve the capacity and performance of state, tribal, local, and territorial public health agencies to more efficiently and effectively manage and deliver high quality programs and services to protect the public's health

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/- FY 2026
8.C.1 (State) Increase the percentage of nationally PHAB accredited state public health agencies (Intermediate Outcome)	FY 2024: 82% Target: 84% (Target Not Met but Improved)	87%	87%	0
8.C.2 (Local) Increase the percentage of nationally PHAB accredited local public health agencies (Intermediate Outcome)	FY 2024: 17% Target: 18% (Target Not Met but Improved)	21%	21%	0

Performance Trends: CDC support and resources to state, tribal, local, and territorial (STLT) public health departments help improve the effectiveness, efficiency, and quality of public health programs. Additionally, CDC assists health departments in meeting nationally recognized, practice-focused, and evidence-based standards of the Public Health Accreditation Board (PHAB). Meeting these standards provides health departments with tools to improve the quality and performance of STLT public health programs and services and better positions them to rapidly respond to emerging threats and challenges. As of May 2025, there are 449 health departments — 40 states, 7 tribes, and 402 local health departments. These accredited health departments serve approximately 90% of the U.S. population. CDC partially met the FY 2024 target of 84% with 82% for state accreditation and partially met the target of 18% with 17% of local agencies accredited or reaccredited (Measures 8.C.1-2). State and local health departments not applying for or achieving reaccreditation can impact the proportion of accredited sites. Future accreditation or reaccreditation may be affected by programmatic funding availability and changing organizational priorities at the STLT level.

Science and Public Health Information

Performance Measures for Long-Term Objective: Improve access to and reach of scientific public health information among key audiences to maximize health impact

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/-FY 2026
16.A Increase the electronic media reach of the Morbidity and Mortality Weekly Report (MMWR) through use of mechanisms such as the MMWR website and social media outlets, as measured by page views, social media followers, and email subscribers (Output)	FY 2025: 13,855,301 Target: 31,500,000 (Target Not Met)	21,993,998	21,993,998	0

Performance Trends: CDC provides critical epidemiological data and recommendations for solving public health problems to approximately 136,000 clinicians and public health professionals through an extensive network of electronic communication channels for the *Morbidity and Mortality Weekly Report* (*MMWR*). During FY 2025, *MMWR* published approximately 170 reports. *MMWR* content is shared widely, with traditional and social media coverage averaging in the top three percent of all journal publications. Although MMWR did not meet its overall target for FY 2025, MMWR reached more than 13.8 million people and 35% of MMWR reports ranked in the top 1% of research (Measure 16.A). Targets for FY 2026 and FY 2027 have been revised to reflect 2020 pre-pandemic levels.

Laboratory Systems and Response

Performance Measures for Long-term Objective: Improve the efficiency and accuracy of public health and clinical laboratory testing

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/-FY 2026
17.A Increase registrations for CDC laboratory education and training courses and events as measured across all learning dissemination platforms (Output)	FY 2025: 110,889 Target: 88,574 (Target Exceeded)	115,146	149,690	+34,544

Performance Trends: A safe and prepared laboratory workforce is vital to protecting the health of people in our communities. It ensures that national and global public health systems can detect and respond quickly to public health threats of all kinds. CDC met the urgent need to expand laboratory training and public health emergency preparedness while also engaging laboratory testing communities through new initiatives that integrated microlearning videos into public YouTube playlists, improved access to training platforms, and successfully employed podcasts, interviews, print, and social media. In FY 2025 CDC again exceeded program registration goals by more than 22,000 registrants (Measure 17.A). CDC's learning management system, OneLab REACH (Rapid Education and Capacity-building Hub) provides a centralized online platform for free laboratory training. Since its launch in 2022, membership has grown to nearly 68,000 learners. In May 2023, CDC launched another new community of practice, OneLab TEST (Timely Education and Support of Testers), which supports testers in non-laboratory settings, such as drive-through testing sites and nursing homes. This first-of-its-kind community of practice effectively supports both disease detection and patient care. In FY 2025, OneLab TEST garnered over 13,000 members. OneLab Network, the complementary community of practice supporting clinical and public health laboratory professionals, has grown to more than 27,500 members.

Performance Measures for Long-term Objective: Enhance and sustain nationwide and international laboratory capacity to gather, ship, and screen and test samples for public health threats and to conduct research and development that lead to interventions for such threats

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/-FY 2026
17.1.A Sustain the percentage of Laboratory Response Network (LRN) laboratories that have demonstrated ability to rapidly detect select biological threat agents (Output)	FY 2025: 92% Target: 92% (Target Met)	92%	92%	0

Performance Trends: The Laboratory Response Network (LRN) challenge panel program demonstrates LRN laboratories' ability to rapidly identify biological threat agents and protect the health of the nation. These panels include exercises and evaluation tools that measure a laboratory's ability to successfully perform specific tests and utilize available electronic resources to submit results. Public health laboratories participating in CDC's LRN-B program are required to participate in all available challenge panels specific to their testing capacity. Between October 2024 and September 2025, 92% of LRN laboratories passed the challenge panels distributed by the CDC LRN program (Measure 17.1.A). Future targets will remain fixed at 92% because this level of proficiency provides CDC with confidence in the LRN network capabilities.

Data and Surveillance

Performance Measures for Long-term Objective: Lower barriers to data exchange across jurisdictions as part of an integrated strategy for public health surveillance and response

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/-FY 2026
18.B Increase the percentage of non-federal emergency department facilities that participate in the National Syndromic Surveillance Program to improve the coverage of syndromic surveillance data (Output)	FY 2025: 84% Target: 82% (Target Met)	85%	87%	+2
18.C: Decrease median Message Mapping Guide (MMG) adoption times to improve the quality and flexibility of the National Notifiable Diseases Surveillance System (NNDSS) (Output)	FY 2025: 141 business days Target: 163 business days (Target Exceeded)	158 business days	158 business days	0
18.D: Increase the percentage of rural critical access hospitals that use electronic case reporting (Output)	FY 2024: 56.5% Target: 50% (Target Exceeded)	60%	65%	+5

Surveillance Performance Trends: CDC continues its efforts to advance public health technology, data, and interoperability standards replacing some of CDC's older legacy infrastructure with more modern data strategies and standards. These investments have positioned CDC to receive data more efficiently during routine ongoing surveillance and response-related efforts. The National Notifiable Diseases Surveillance System (NNDSS) is a CDC collaboration with 60 state, local, and territorial public health jurisdictions to receive case surveillance data collected by 3,000 health departments for further analysis and use by CDC programs to better prevent and respond to disease outbreaks and inform public health interventions. More than 120 diseases and conditions are under nationwide surveillance.

The median adoption time of message mapping guides (MMGs) in the first six months of 2024, was 168 business days. Efforts began in 2024 to develop CaseBridge, a self-service web tool for jurisdictions, with the intention of eliminating some manual steps in the quality-assurance portions of the adoption process. The initial automation focus is on reducing the time it takes to complete one of the MMG validation steps that currently takes a median of 36 business days to complete. As of August 2025, work on CaseBridge is almost complete and ready for testing in CDC's One CDC Data Platform (1CDP). In addition to the efforts to speed up MMG onboarding, work to modernize NNDSS continues, including moving functionality to a cloud infrastructure and delivering analytic-ready datasets to CDC disease program partners, using new analytical tools such as 1CDP. These efforts improve CDC's ability to act more rapidly during response efforts, reduce burden for local and state jurisdictions, strengthen trust with case surveillance partners, and lower CDC's case surveillance costs. As of September 2025, median adoption time for MMGs was down to 141 days (Measure 18.C). These results show that NNDSS has exceeded its fiscal year 2025 target.

Electronic case reporting (eCR) automates the exchange of data between electronic health records and public health agencies. As of December 2025, eCR provides 73 state, tribal, local, and territorial public health jurisdictions with near real-time patient case reporting from >60,500 healthcare facilities. While eCR plays an important role in outbreak response nationwide, it is even more essential for underserved populations. Over 60 million people live in rural America with a 43% higher mortality rate than urban residents. Rural residents often live in poverty, are uninsured, and due to low numbers of rural primary

care providers, frequently seek care at a critical access hospital (CAH). Healthcare providers can use eCR send critical data to public health agencies in less than one minute, allowing public health agencies to respond quickly and quickly protect rural residents in their jurisdictions. eCR also allows for bidirectional communication from the public health department back to the healthcare provider, including treatment or fact sheets about the condition reported. To ensure these individuals' cases are being reported, this measure tracks the percentage of rural critical access hospitals that use eCR Measure 18.D). As of December 2025, CAHs in production with eCR is 56.5%, exceeding the target. These results show that eCR has exceeded its fiscal year 2025 target.

The National Syndromic Surveillance Program (NSSP) provides local, state, and federal health officials with a near real time system for detecting, understanding, and monitoring health events. By tracking symptoms and diagnoses of patients in emergency departments and other automated data sources, including commercial laboratory data, analysts can detect unusual levels or changing patterns of illness. In 2024-2025, across all levels of government, NSSP data were used to provide critical insights for responses addressing infectious diseases (e.g., H5 Influenza, Mpox, and Measles), injuries (e.g., overdose, poisonings, child abuse and elder abuse), and for monitoring mental health and mass gatherings, among others. Participation in NSSP is extensive, and NSSP continues its effort to expand participation. CDC uses a measure aimed at increasing the percentage of non-federal emergency department facilities that participate in NSSP to improve the coverage of syndromic surveillance data (Measure 18.B). As of December 2025, 84% of non-federal emergency department facilities report data to NSSP. These results show that NSSP has exceeded its fiscal year 2025 target.

GLOBAL HEALTH

Global HIV

Performance measures for Long-term Objective: Partner with ministries of health, international and local partners, and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) to reduce the worldwide rate of new HIV infections and save lives through focusing on highly effective, evidence- based HIV interventions and quality laboratory service, including: (1) antiretroviral treatment for prevention and health benefits, (2) voluntary medical male circumcision, and (3) laboratory and point of care testing site quality improvement programs

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/- FY 2026
10.A.1.5 Increase the number of adults and children with HIV infection receiving antiretroviral therapy (ART)[1] (Output)	FY 2025: 14,512,074 Target: 12,200,000 (Target Exceeded)	12,200,000	12,200,000	0
10.A.1.7 Increase the number of males age 15 and over circumcised as part of the minimum package of male circumcision for HIV prevention services (Output)[2]	FY 2025: 1,138,178 Target: 800,000 (Target Exceeded)	0	0	0
10.A.1.8 Increase the total number of laboratories and Point of Care Testing sites enrolled in a continuous quality improvement program (Output)	FY 2025: 11,246 Target: 10,050 (Target Exceeded)	10,050	10,050	0

[1] Targets and results reflect all people on ART, not just those with advanced HIV infection.
[2] Beginning in FY 26, CDC will not support implementing partners and country governments to implement VMMC programs. FY 2026 and FY 2027 targets updated to reflect decreased support.

Performance Trends: Global HIV funding supports CDC's essential role as the comprehensive public health partner and implementing agency for the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) in 46 countries. CDC's global HIV and TB programs form the backbone of overseas disease surveillance, laboratory systems, and workforce capacity that protects Americans by stopping the spread of HIV and other dangerous outbreaks at their source, before they reach the United States. CDC plays a leading role in U.S. Government efforts to reduce AIDS-related deaths, focusing on accountability, program quality, and the use of data to drive programmatic effectiveness and efficiency while building resilient and self-reliant health systems in host countries. CDC met and exceeded the FY 2025 treatment target by providing treatment to 14,512,074 men, women, and children living with HIV globally (Measure 10.A.1.5).

In FY 2027, CDC will maintain the target for Measure 10.A.1.5 at 12,200,000 and continue to work with host-country governments and implementing partners to ensure accountability, quality, and efficiency for treatment programs. CDC's lifesaving treatment program will continue to facilitate the transition to country ownership while prioritizing interventions that support the lives of millions of people with HIV, safeguard Americans from drug-resistant HIV strains, and advance national self-reliance.

In FY 2025, CDC-supported partners performed 1,138,178 voluntary medical male circumcisions (VMMCs) of males aged 15 and older by a qualified clinician, exceeding the FY 2025 target (Measure 10.A.1.7). Beginning in FY 2026, in accordance with U.S. government and Administration priorities, CDC will not support implementing partners and country governments to implement VMMC programs. Therefore, in FY 2026 and 2027, the target for Measure 10.A.1.7 will be decreased to 0.

Laboratory testing is the only way to diagnose and confirm existence of disease, gauge if medications are working, and measure overarching vital indicators. Point of Care Testing (POCT) sites allow traditional laboratory testing to be completed near the patient. CDC supports a Continuous Quality Improvement (CQI) process for laboratories and POCT sites to increase accuracy of results and maintain quality control. CDC-supported CQI processes improve quality through rigorous evaluation and development of evidence-based approaches to reduce waste, increase efficiency, and increase staff (internal) and patient (external) satisfaction. The more laboratory and POCT sites that participate in CDC-supported CQI processes and receive accreditation or become certified, the more trust is built into the system, which in turn allows newly diagnosed people living with HIV to be immediately placed on medications. By the end of 2025, CDC supported enrollment of 11,246 facilities with a laboratory or POCT site in CQI programs globally, exceeding the FY 2025 target (Measure 10.A.1.8). In 2027, as CDC supports a transition to host-government ownership and country self-reliance, CDC will maintain our performance Target for measure 10.A.1.8 at the current level of 10,050 laboratories and POCT sites enrolled in CQI. As countries allocate their own resources to the HIV response, more laboratories and POCT sites will be transitioned to Ministries of Health, and so the number of CDC supported facilities is expected to decrease.

CDC provides scientific expertise and peer-to-peer support working directly with Ministries of Health in 46 countries. In FY 2027, CDC will continue to support country-led programs to sustain HIV prevention, treatment, data and surveillance, and laboratory outcomes while accelerating the transition to host-country ownership of HIV programs.

Global Tuberculosis (TB)

Performance measures for Long-term Objective: Partner with ministries of health, TB and HIV programs, international and local partners, and other United States Government (USG) agencies to accelerate progress of ending TB in the U.S. and worldwide, by focusing on highly effective, evidence-based TB interventions for the most at risk and hardest-to-reach populations, including children and people living with HIV.

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/- FY 2026
10.G.1 Increase the number of adults and children with TB and HIV infection receiving antiretroviral therapy (ART) (Output)	FY 2025: 112,203 Target: 128,243 (Target Not Met)	110,000	110,000	0

Performance Trends: Tuberculosis (TB) TB remains the world's leading infectious disease killer, and drug-resistant TB poses a direct, growing threat to U.S. health security because it is airborne, difficult to treat, and increasingly imported through global travel and migration. CDC is integral to the U.S. Government's efforts to address TB and drug-resistant TB in the U.S. and globally. CDC's Global TB Program and partners are on the frontlines in 42 high-burden TB countries, working closely with governments to prevent, diagnose, and treat TB and build sustainable country responses. CDC's Global TB Program accelerates progress towards the global End TB Strategy – zero deaths, disease, and suffering due to TB by 2035. Strengthening End TB efforts in high TB burden countries is essential to eliminating TB in the U.S., where over 75 percent of TB diagnoses are among foreign born individuals. Since TB is airborne and contagious, advancing the End TB Strategy is critical for accomplishing U.S. national security and global health security goals and protecting U.S. citizens from this deadly disease.

TB is the leading cause of death among people living with HIV, who are 16 times more likely to develop TB disease. CDC is committed to increasing TB prevention, screening, and treatment

among this population. TB preventive treatment (TPT), when combined with HIV treatment, can prevent TB disease and reduce TB deaths among people living with HIV by 80 percent. In FY 2025, CDC's Global TB Program provided lifesaving ART medication for 112,203 people living with both TB and HIV (Measure 10.G.1). The decrease in the number of people supported by CDC's global TB program is explained by changes in partnerships for the United States and adjustments to programmatic reporting requirements; in FY 2024, 7,464 sites reported on this metric, while in FY 2025, 6,694 sites reported. In FY 2027, CDC will maintain the target for Measure 10.G.1 to 110,000. CDC's Global TB Program will continue providing essential TB prevention, screening, and lifesaving treatment for those living with HIV and TB, which is imperative for reducing TB disease and saving lives among people living with HIV.

Drug-resistant TB (DR TB) is the leading cause of illness and death from antimicrobial resistance. Approximately 10.6 million people, including 1.3 million children, become sick with TB disease each year. Drug-resistant TB is a further threat to public health worldwide, with 410,000 people developing multidrug-resistant or rifampicin-resistant TB (MDR/RR-TB). A single case of multidrug-resistant TB in the United States can cost up to $500,000 to treat. If left untreated, one person with TB or DR TB can infect 10 to 15 additional people per year, which means DR TB can easily and quickly spread across the globe. Most TB cases in the U.S. occur among people born outside the country, underscoring that global TB control is essential to protecting U.S. public health. With over 72 million international travelers arriving in the U.S. in 2024 alone, DR TB has the potential to kill millions and erase decades of progress on reducing TB and antimicrobial resistance. CDC's Global TB Program supports 30 countries with high TB and DR TB rates to introduce the latest technology and improve laboratory capabilities to increase detection, diagnosis, and treatment for DR TB.

Through on-the-ground implementation, cutting-edge research, long-standing relationships with ministries of health, and unmatched scientific and technical expertise, CDC's Global TB program is instrumental to the U.S. Government's response capabilities and TB efforts worldwide. CDC's Global TB Program saves lives and protects health by scaling up TB preventative treatment; improving access to TB screening, case finding, and enhanced diagnostics; optimizing treatment for TB and drug resistant TB; strengthening surveillance, laboratory systems, and infection prevention and control interventions; and, promoting evidence-based innovative strategies and guidelines to end the TB epidemic in the U.S. and abroad.

Global Immunization

Contextual Indicator	Most Recent Result
10.B.1.3 Reduce the number of countries in the world with endemic wild polio virus (Outcome)	FY 2024: 2

Performance measure for Long-term Objective: Help domestic and international partners achieve the goal of global polio eradication.

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/- FY 2026
10.B.1.2a Increase the number of children vaccinated with Polio Vaccine as a result of non-vaccine operational support funding to implement national or subnational supplemental immunization campaigns in Asia, Africa, and Europe (Output)	FY 2024: 18,035,380 Target: 6,000,000 (Target Exceeded)	12,000,000	12,000,000	0

Performance measure for Long-term Objective: Help domestic and international partners achieve the goal of global polio eradication

Contextual Indicator	Most Recent Result
10.B.2.1 Reduce the number of global measles-related deaths (Outcome)	FY 2024: 95,000

Performance measures for Long-term Objective: Work with global partners to reduce the cumulative global measles- related mortality by 95% compared with CY 2000 estimates (baseline 777,000 deaths) and to maintain elimination of endemic measles transmission in all 47 countries of the Americas

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/- FY 2026
10.B.2.2 Maintain number of non- import measles cases in all 47 countries of the Americas as a measure of maintaining elimination of endemic measles transmission (Outcome)	FY 2024: 0 Target: 0 (Target Met)	0	0	0
10.B.2.3 Increase the number of countries that achieve at least 90% immunization coverage in children under 1 year of age for DTP3 (three shot series of vaccines covering diphtheria, tetanus, and pertussis) (Outcome)	FY 2024: 111 Target: 143 (Target Not Met but Improved from FY 2023)	143	143	0

Performance Trends: Global immunization funding advances polio eradication and measles mortality reduction and elimination efforts. CDC is the lead technical monitoring agency for the Independent Monitoring Board of the Global Polio Eradication Initiative (GPEI).[4] The number of countries reporting endemic wild poliovirus (WPV) remained at two in FY 2024 (Measure 10.B.1.3).

[4] http://www.polioeradication.org/

Countries at highest risk for polio importation and circulating vaccine-derived poliovirus outbreaks have low routine immunization coverage levels (less than 80%), sub-optimal outbreak response, and weak health systems. CDC's expanded measure of polio vaccination (Measure 10.B.1.2a) improves accuracy by measuring children vaccinated by all types of polio vaccine. It reflects changes to the composition of the global supply of polio vaccine and CDC's enhanced financial support for operational costs of supplemental vaccination rounds, including social mobilization. In FY 2024, CDC vaccinated 18,035,380 children with polio vaccine in Asia, Africa, and Europe, exceeding the targets by 12 million children. While the number of ongoing outbreaks of vaccine-derived poliovirus across Africa and parts of Southeast Asia decreased in FY 2024, the overall number of outbreaks was still elevated post-pandemic, resulting in a continued increased need for special vaccination campaigns to compensate for inadequate coverage by routine immunization systems in high-risk countries. CDC anticipates an increased level of performance in subsequent years and has adjusted future targets accordingly. CDC's lead role as one of the five core partners in the Global Polio Eradication Initiative (GPEI) will be limited. CDC will continue to work with partners to reach its vaccination targets, focusing efforts on those areas that have been historically difficult to reach due to security issues and/or political instability.

In 2000, an estimated 800,000 people died from measles globally. The goal of reducing cumulative global measles-related mortality by 95% compared with CY 2000 estimates presents unique challenges. The Measles and Rubella Initiative updated the formula for calculating global measles mortality in 2018 with the following parameters: new measles vaccination coverage and annual country measles surveillance data. The updated formula uses and is responsive to annual trends in surveillance data, allowing the model to reflect measles outbreaks better. After the disruptions of the COVID-19 pandemic, measles vaccination rates fell to the lowest rate since 2008. In 2024, measles mortality fell to 95,000, representing a decrease of 88% since FY 2000 (Measure 10.B.2.1). The proportion of children receiving their first dose of measles vaccine increased from 83% in 2023 to 84% in 2024, well below the 2019 pre-pandemic level of 86%, leaving over 30 million children vulnerable to measles.

Measles surveillance continues to be suboptimal, and large and disruptive outbreaks were reported in 60 countries, an increase from 47 countries in 2023. Out of the 60 countries reporting large and disruptive measles outbreaks, 29 occurred in Africa. Measles outbreaks illustrate weaknesses in immunization programs more broadly. As a result, vigorous efforts are urgently needed to expand and strengthen immunization services and surveillance systems to prevent disease and death before large-scale outbreaks and preventable deaths occur. CDC is working closely with its partners to implement improvements to the quality of the supplemental immunization activities and target efforts to areas with high measles-related mortality.

The number of countries that achieve at least 90% immunization coverage in children under one year of age for DTP3 (third dose diphtheria, tetanus, pertussis vaccine) is the globally accepted performance indicator for national immunization programs. The number of countries meeting this coverage threshold for DTP3 increased in FY 2024 to 111 (Measure 10.B.2.3). Four countries report coverage of 87-89%, indicating how close some nations are to reaching the target. Globally, global DTP3 coverage stayed stagnant at 84% between 2023 and 2024. To assist both countries who struggle to maintain gains and those that struggle to reach the 90% target, CDC is conducting evaluations to study supply and demand factors that can impact and increase coverage.

Global Health Protection

Performance measures for Long-term Objective: To increase the number of public health staff skilled in epidemiology and surveillance in low and middle-income countries

Measure	Most Recent Result and Target	FY 2026 Target[1]	FY 2027 Target	FY 2027 +/- FY 2026
10.F.1c Number of cumulative Field Epidemiology Training Program (FETP) – Frontline graduates (Output)	FY 2024: 17,233 Target: 16,786 (Target Exceeded)	17,464	17,813	+349
10.F.1d Number of cumulative Field Epidemiology Training Program (FETP) – Intermediate and FETP – Advanced graduates (Output)	FY 2024: 7,777 Target: 7,631 (Target Exceeded)	7,940	8,099	+159

Performance Trends: CDC Field Epidemiology Training Programs (FETP) are recognized worldwide as an effective means to strengthen countries' capacity in surveillance, epidemiology, and outbreak response. FETP graduates strengthen public health detection and response performance, so individual countries are able to transition from U.S.-led global health investments to more long-term host country ownership. FETP Training has three tiers: frontline, intermediate, and advanced. Frontline is a three-month program that aims to increase the number of capable public health workers in a community setting. Intermediate is a nine-month program for mid-level health officials, and Advanced is a two-year, intensive program that aims to prepare leaders for work at the national level. All three tiers help countries improve country self-reliance for disease detection and containment. As of FY 2024, there have been a cumulative total of 17,233 Frontline program graduates and 7,777 Intermediate/Advanced program graduates an increase over FY 2023 and exceeding the FY 2024 target (Measures 10.F.1c-d). By tracking the number of people who graduate from FETP –Frontline and Intermediate/Advanced programs every year, CDC can better gauge its impact on developing other countries' abilities to detect and respond to disease outbreaks.

PUBLIC HEALTH PREPAREDNESS AND RESPONSE

State and Local Preparedness and Response Capability

Performance Measures for Long-term Objective: Integrate and enhance existing surveillance systems at the local, state, national, and international levels to detect, monitor, report, and evaluate public health threats

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/- FY 2026
13.1.5 Increase the number of CDC programs using the HHS Protect/Response Ready Enterprise Data Integration platform (RREDI) for day-to-day surveillance and response events (Output)[1]	FY 2025: 36 Target: 22 (Target Exceeded)	27	Discontinued	N/A
13.1.5b: Deploy reusable, response-specific tools within Response Ready Enterprise Data Integration platform (RREDI) that will improve operational efficiencies including response stand up, reporting, and workflow processes (Output)	FY 2025: 6 (Baseline)	5	7	+2
13.1.6 Increase the number of users that access RREDI for CDC partners in state, tribal, local, and territorial public health agencies and in other federal agencies (Output)	FY 2025: 3,241 Target: 1,577 (Target Exceeded)	2,366	4,000	+1,634
13.1.7 Increase the percentage of responses using RREDI to support use of a common operating picture for CDC and its partners (Output)	FY 2025: 88% Target: 65% (Target Exceeded)	70%	75%	+ 5
13.1.8: The percentage of jurisdictions that correctly convey a specified test message within a designated time allowance from the on-call Epidemiologist to the state's public health emergency preparedness director and then back to CDC (Output)	FY 2025: 85% (Baseline)	87%	89%	+2
13.1.9: The percentage of jurisdictions that correctly convey a specified test message within a designated time allowance from the on-call Epidemiologist to the state's on-call laboratorian and then back to CDC (Output)	FY 2025: 93% (Baseline)	94%	95%	+1

[1] Measure discontinued due to IT infrastructure and data modernization activities associated with 1CDP as well as retirement of HHS Protect.

Performance Trends: Response Ready Enterprise Data Integration (RREDI) is the emergency response arm of an enterprise-wide platform called One CDC Platform (1CDP) that consolidates and integrates the data that jurisdictions share with CDC, to generate information for decision-making related to protecting lives and improving health. Increasing the number of CDC programs using the 1CDP/RREDI platform will allow CDC to ensure the agency has a modernized infrastructure and a core data management platform to support a data ready public health ecosystem, and will allow for reduced implementation times/more real-time stand up for future public health responses. As of December 18, 2025, there were 36 CDC programs using 1CDP/RREDI for surveillance and response events (Measure 13.1.5).

Due to IT infrastructure and data modernization activities associated with 1CDP as well as the retirement of HHS Protect, this measure will be retired in FY 2027. With the advent of 1CDP as the agency's main data platform, and RREDI serving as the response arm of the platform, RREDI no longer onboards surveillance programs as this is now being managed through 1CDP. In addition, HHS Protect is no longer in use. It is being replaced with a measure that tracks the number of reusable, response-specific products developed within RREDI that demonstrably improve operational efficiency in response stand-up, reporting, and workflow processes.

Over the past several years, RREDI has demonstrated measurable improvements in the speed and efficiency of public health responses by centralizing access to core data sources and through the development and application of standardized, reusable products. Over the past year, the RREDI team has created 6 reusable products that provided response efficiencies in platform setup time and faster delivery of actionable insights, enabling responders to make more timely and informed decisions during critical incidents (Measure 13.1.5b). In addition, these same products, while designed for the purpose of responses, can be used for day-to-day surveillance needs allowing programs to be more response ready. Building on these results, RREDI will continue to evolve through automation, developing AI capabilities, designing new training, and developing analytical tools—further, shortening response times and improving reporting quality. This trajectory positions the program to sustain and expand its impact, even as public health threats grow more complex and resource demands increase.

The 1CDP/RREDI platform gives STLT and federal agency users a way to share data and collaborate with CDC programs and responses, review and analyze increase access to data, and provide increased situational awareness for decision-making. Collaboration with STLT and agency partners was vital for FY 2025 responses like HPAI, Measles, Mpox Clade I, and VHF —enabling real time data sharing, collaboration, and data dissemination. The 1CDP/RREDI platform continued to expand access to STLT and federal agency users thus ensuring transparent decision-making and data sharing. As of December 18, 2025, there are over 7,400 1CDP users with access to RREDI from state, tribal, local, and territorial public health agencies, and other federal agencies with 3,241 users accessing the 1CDP platform in FY 2025 (Measure 13.1.6). Using RREDI allows CDC to have a centralized data repository, real-time data sharing, and data-informed decision-making specific to public health emergency responses. Integrating data from across the response enables leaders to streamline operations, respond more quickly to public health emergencies, and improve decision-making. Within calendar year 2025, 7 out of 8 public health responses (88%) were supported by and actively used RREDI to support response data and operations (Measure 13.1.7).

Two of our proposed new measures are related to the Critical Contacts Drill (CCD) In FY, an annual, unannounced exercise made up of two similar drills. During this exercise, preparedness staff must proficiently capture technical information and accurately communicate that messaging to the necessary individuals within a set time. This ability helps ensure that preparedness programs can communicate information about public health emergencies of pandemic potential, and that they have the skilled staff that are necessary to coordinate a response. It is through essential preparedness exercises, like the CCD, that CDC can verify that PHEP programs are properly staffed to manage critical preparedness and response tasks and are able to send accurate notifications in a responsive manner. CDC resurrected the CCD as an annual drill requirement of CDC's 2024-2028 PHEP program. The baseline data represents the results of the first such drill during the 5-year funding period. In FY 2025, 85% of jurisdictions correctly conveyed a specified test message within a designated time allowance from the on-call Epidemiologist to the state's public health emergency preparedness director and then back to CDC and 93% of jurisdictions that correctly conveyed a specified test message within a designated time allowance from the on-call Epidemiologist to the state’s on-call laboratorian and then back to CDC (Measures 13.1.8 and 13.1.9)

BUILDINGS AND FACILITIES

Performance Measures for Long-term Objective: Improve efficiency and sustainability of CDC Facilities

Measure	Most Recent Result and Target	FY 2026 Target[2]	FY 2027 Target	FY 2027 +/- FY 2026
12.E.2 Increase the percent of CDC facilities (10,000 square feet and above) that meet the Guiding Principles for High Performance and Sustainable Federal Buildings (Efficiency)	FY 2025: 33.8% Target: 15% (Target Exceeded)	15%[1]	15%[1]	0[1]
12.E.1a Improve energy (E) consumption per square foot (Efficiency)	FY 2024: 23.5%* Target: 30% (Target Not Met)	30%[1]	30%[1]	0[1]
12.E.1b Improve water (W) consumption per square foot (Efficiency)	FY 2024: 42.9%* Target: 30% (Target Exceeded)	30%[1]	30%[1]	0[1]

[1] Metrics and targets are legacy targets based on the Energy and Policy Act of 2005 and Energy Independence and Security Act of 2007. CDC awaits guidance from HHS and CEQ for updated targets. Executive Order (EO) 14057: Catalyzing Clean Energy Industries and Jobs Through Federal Sustainability Efficient Federal Operations was revoked by Section 2 of EO 14148 signed by the President on January 20, 2025.
[2] Water and Energy data was unavailable at time of report. Data and narrative will be provided for next annual reporting period.

Performance Measures for Long-term Objective: Improve CDC's Buildings and Facilities processes and performance[1]

Measure	Most Recent Result and Target	FY 2026 Target[2]	FY 2027 Target	FY 2027 +/- FY 2026
12.2.1c Improve Condition Index (CI), as measured by the ratio of the functional replacement value (FRV) of an asset with its backlog of maintenance and repair (BMAR) needs (Output)	FY 2025: 82.27 Target[2]: 90 (Target Not Met)	90	90	0
12.2.1d Reduce non- mission dependency, as measured by the percentage of real property assets that are not deemed directly necessary to support the Agency's mission (Output)	FY 2025: 1.51% Target[2]: 2% (Target Exceeded)	2%	2%	0
12.2.1e Improve building utilization[3] (Output)	FY 2024: 3.51% Target[2]: 5% (Target Exceeded)	5%	5%	0
12.2.1f Improve buildings and facilities operating costs (Output)	FY 2025: $12.14/sq. ft. Target[2]: $10.29/sq. ft. (Target Not Met)	$10.29/sq.ft	$10.29/sq.ft	0

[1] Targets are set by HHS and align to EO 13327; the Federal Real Property Council (FPRC) defines the metrics.
[2] Targets beyond FY 2016 are projected and are not established from FRPC.
[3] Under-utilized (U); FRPC removed the metric Over-utilization (O) for FY 2013 and forward.

Performance Trends: CDC's mission is executed in a safe and dynamic workplace environment for CDC staff while ensuring efficiency and appropriate management of agency assets. In FY 2025, CDC had 33.7% of its owned and active buildings 10,000 gross square feet (GSF) and above meet the Guiding Principles for High Performance and Sustainable Federal Buildings (Measure 12.E.2), far exceeding the target of 15%. The completion of Building 108 on the Chamblee Campus has resulted in a major increase (over 14%) from 2024 results. Past targets and baselines set for improving energy consumption (Measure 12.E.1a) were based on the Energy Policy Act of 2005. For FY 2025, due to the government shutdown and other operational changes, data is not available at time of reporting. 23.5% was reported in FY 2024 target (Measure 12.E.1.a).

In FY 2024, CDC progressed on the water intensity goal, improving to a 42.91% reduction from the 2007 baseline. For FY 2025, due to the government shutdown and other operational changes, data is not available at time of reporting. (Measure 12.E.1.b). In FY 2023, CDC achieved a 34.65% reduction in water use intensity below the 2007 baseline. In FY 2023, CDC observed an 11% increase in water consumption compared to FY 2022. This is likely attributed to phased reentry of staff into facilities during 2022. In addition, record heat and warmer days in 2023 elevated demands for cooling and increased water consumption.

CDC did not meet its target for improving its condition index (CI) in FY 2025 (Measure 12.2.1c). There was a slight decrease in unweighted CI from FY 2024 (82.65 CI) to FY 2025 (82.27 CI). CDC's weighted CI increased from FY 2024 (94.05 CI) to FY 2025 (94.26 CI), which still exceeds the targeted goal of 90 CI. CDC moved to new software to manage the agency's Integrated Facility Management Systems (IFMS) data. With the software transition came several unexpected anomalies, including the software re-populating completed deficiencies, which inflated Backlog of Maintenance and Repair (BMAR). CDC is in the process of identifying the anomalies and cleaning them up in FY 2026, which will increase the CI. CDC also has large investments in both repair and improvement projects and new capital construction targeted specifically at improving or replacing some of CDC's assets with the poorest CI scores.

CDC exceeded its target for reducing non-mission dependency assets that are not deemed directly necessary to support CDC's mission (Measure 12.2.1d) in FY 2025 with a result of 1.51%. The under-utilization rate increased from 3.42% in FY 2024 to 3.51% in FY 2025 (Measure 12.2.1.e). CDC will continue disposing of under-utilized assets to meet or exceed this target.

CDC's operating costs decreased by approximately 5.75% from FY 2024 to FY 2025 (Measure 12.2.1f). Maintenance costs are largely affected by annual maintenance contract renewals. While energy costs have decreased by improved operating efficiencies, increases to utility rates have offset any additional potential savings. Most assets are not tabulated individually for maintenance costs or metered individually for energy costs. They are pro-rated according to square footage and asset type. It was found that some of this data needed adjustment beyond the yearly increases in utility and maintenance contracts. CDC also reiterates that the target for reduced operating costs does not consider high operating costs associated with laboratory assets. CDC's laboratories comprise approximately 44% of its square footage, resulting in disproportionately higher operating costs. Benchmarking studies have indicated CDC's asset portfolio is in the medium range of operating costs for similarly equipped institutional and private real asset portfolios with similar laboratory to non- laboratory asset.

WORKING CAPITAL FUND

Performance Measures for Working Capital Fund

Measure	Most Recent Result and Target	FY 2026 Target	FY 2027 Target	FY 2027 +/- FY 2026
15.2.2 Maintain the percent of invoices paid on time (Efficiency)	FY 2025: 99.8% Target: 98% (Target Exceeded)	98%	98%	0
15.5.1 Maintain the variance between annual revenues and annual costs (Efficiency)	FY 2025: 5.5% Target: 3% (Target Not Met)	3%	3%	0
15.5.2 Maintain the variance between estimated and actual cost (Efficiency)	FY 2025: 1.1% Target: 1% (Target Not Met)	1%	1%	0
15.5.3 Maintain the percent of bills that require correction (Efficiency)	FY 2025: 0.1% Target: 9% (Target Exceeded)	9%	9%	0

Performance Trends: CDC actively supports its goals and customers through fiscal stewardship and sound financial strategy. Annually, CDC has secured an unqualified audit opinion on the agency's financial statements since FY 1999. The Office of Management and Budget's Prompt Payment rule requires federal agencies to pay vendors in a timely manner and assesses late interest penalties against agencies that pay vendors after a payment due date. CDC has maintained a greater than 99% prompt payment level since FY 2013 (Measure 15.2.2). CDC will continue to exceed the 98% requirement of on time payments by ensuring program offices, the acquisition office, and the payment office communicate with each other and the agency's vendors.

CDC's Working Capital Fund (WCF) aims to achieve greater efficiency and transparency through the provision of Agency-wide business services. Currently, CDC estimates costs for business services 18 months prior to final fiscal year obligations being made. In FY 2025, CDC obligated less than revenue collected due to staffing reductions and contract award constraints and as a result did not meet its target (Measure 15.5.1). CDC will maintain its FY 2026 target in FY 2027. In measuring performance from a Center, Institute, Office (CIO) perspective in FY 2025, the original cost estimate varied 1.1% from the actual costs charged (Measure 15.5.2). Due to continued process improvements, CDC also exceeded its target of 9% for monthly bills requiring correction (Measure 15.5.3). CDC will keep FY 2027 targets for these measures level with the previous year.

SUPPLEMENTAL TABLES

OBJECT CLASS TABLE – DIRECT

(dollars in thousands)	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Personnel Compensation:				
Full-Time Permanent (11.1)	$768,714	$764,486	$680,423	-$84,063
Other than Full-Time Permanent (11.3)	$107,775	$107,182	$90,302	-$16,880
Other Personnel Comp. (11.5)	$44,995	$44,747	$37,700	-$7,047
Military Personnel (11.7)	$70,625	$70,237	$59,175	-$11,062
Special Personal Service Comp. (11.8)	$1,045	$1,040	$876	-$164
Total Personnel Compensation	**$993,153**	**$987,692**	**$868,475**	**-$119,216**
Civilian Personnel Benefits (12.1)	$333,408	$331,575	$331,263	-$312
Military Personnel Benefits (12.2)	$17,410	$17,314	$17,142	-$172
Benefits to Former Personnel (13.0)	$13,873	$13,797	$13,805	$8
Subtotal Pay Costs	**$1,357,844**	**$1,350,377**	**$1,230,684**	**-$119,692**
Travel (21.0)	$22,270	$22,147	$21,451	-$696
Transportation of Things (22.0)	$5,977	$5,944	$5,757	-$187
Rental Payments to GSA (23.1)	$194	$193	$188	-$4
Rental Payments to Others (23.2)	$5,293	$5,264	$5,099	-$166
Communications, Utilities, and Misc. Charges (23.3)	$3,726	$3,705	$3,589	-$117
NTWK Use Data TRANSM SVC (23.8)	$0	$0	$0	$0
Printing and Reproduction (24.0)	$886	$882	$854	-$28
Other Contractual Services (25):	$1,172,253	$1,165,806	$1,129,152	-$36,654
Advisory and Assistance Services (25.1)	$451,487	$449,004	$434,887	-$14,117
Other Services (25.2)	$38,163	$37,954	$36,760	-$1,193
Purchases from Government Accounts (25.3)	$578,525	$575,343	$557,254	-$18,090
Operation and Maintenance of Facilities (25.4)	$10,267	$10,211	$9,890	-$321
Research and Development Contracts (25.5)	$16,115	$16,026	$15,522	-$504
Medical Services (25.6)	$3,017	$3,001	$2,906	-$94
Operation and Maintenance of Equipment (25.7)	$74,679	$74,268	$71,933	-$2,335
Subsistence and Support of Persons (25.8)	$0	$0	$0	$0
Consultants, other and misc (25.9)	$0	$0	$0	$0
Supplies and Materials (26.0)	$18,235	$18,134	$18,086	-$48
Equipment (31.0)	$25,597	$25,456	$24,656	-$800
Land and Structures (32.0)	$14,488	$14,409	$13,809	-$600
Investments and Loans (33.0)	$0	$0	$0	$0
Grants, Subsidies, and Contrib (41.0)	$3,168,432	$3,151,007	$2,826,315	-$324,692
Insurance Claims and Indemnities (42.0)	$192	$191	$183	-$8
Interest and Dividends (43.0)	$2	$2	$2	$0
Refunds (44.0)	$0	$0	$0	$0
Subtotal Non-Pay Costs	**$4,437,545**	**$4,413,140**	**$4,049,141**	**-$364,000**
Total Budget Authority[1]	**$5,795,389**	**$5,763,517**	**$5,279,825**	**-$483,692**
Average Cost per FTE				
Civilian FTEs	**10,301**	**9,100**	**7,971**	**-1,129**
Civilian Average Salary and Benefits	$122	$137	$143	$6
Percent change	N/A	13%	4%	-8%
Military FTEs	**684**	**684**	**555**	**-129**
Military Average Salary and Benefits	$129	$128	$137	$10
Percent change	N/A	0%	7%	8%
Total FTE[2,3]	**10,985**	**9,784**	**8,526**	**-1,258**
Average Salary and Benefits	**$124**	**$138**	**$144**	**$6**
Percent change	**N/A**	**12%**	**5%**	**-7%**

[1] In alignment with the proposed HHS reorganization, FY 2025 and FY 2026 BA totals are comparably adjusted. [2] Total FTEs represent Direct and Working Capital Fund (WCF) FTE. Budget Authority excludes Reimbursable employees and includes ATSDR funding, which the FY 2027 Budget realigns to the proposed National Center for Chemicals and Toxins within CDC. [3] FTE displayed reflect current estimates, which may differ from the system of record. FY 2027 FTE levels reflect estimates and may not represent expected FTE levels across FY 2027. These estimates are subject to change.

OBJECT CLASS TABLE – PREVENTION AND PUBLIC HEALTH FUND

(dollars in thousands)	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Personnel Compensation:				
Full-Time Permanent(11.1)	$67,776	$68,096	$0	-$68,096
Other than Full-Time Permanent (11.3)	$5,902	$5,930	$0	-$5,930
Other Personnel Comp. (11.5)	$3,247	$3,263	$0	-$3,263
Military Personnel (11.7)	$7,268	$7,302	$0	-$7,302
Special Personal Service Comp. (11.8)	$39	$40	$0	-$40
Total Personnel Compensation	**$84,232**	**$84,630**	**$0**	**-$84,630**
Civilian Personnel Benefits (12.1)	$28,055	$28,187	$0	-$28,187
Military Personnel Benefits (12.2)	$2,204	$2,215	$0	-$2,215
Benefits to Former Personnel (13.0)	$725	$728	$0	-$728
Subtotal Pay Costs	**$115,216**	**$115,760**	**$0**	**-$115,760**
Travel (21.0)	$696	$699	$0	-$699
Transportation of Things (22.0)	$113	$114	$0	-$114
Rental Payments to GSA (23.1)	$0	$0	$0	$0
Rental Payments to Others (23.2)	$0	$0	$0	$0
Communications, Utilities, and Misc. Charges (23.3)	$13	$13	$0	-$13
NTWK Use Data TRANSM SVC (23.8)	$0	$0	$0	$0
Printing and Reproduction (24.0)	$13	$13	$0	-$13
Other Contractual Services (25):	$177,562	$178,400	$0	-$178,400
Advisory and Assistance Services (25.1)	$93,908	$94,351	$0	-$94,351
Other Services (25.2)	$771	$774	$0	-$774
Purchases from Government Accounts (25.3)	$80,237	$80,615	$0	-$80,615
Operation and Maintenance of Facilities (25.4)	$24	$24	$0	-$24
Research and Development Contracts (25.5)	$0	$0	$0	$0
Medical Services (25.6)	$31	$31	$0	-$31
Operation and Maintenance of Equipment (25.7)	$2,592	$2,605	$0	-$2,605
Subsistence and Support of Persons (25.8)	$0	$0	$0	$0
Consultants, other and misc (25.9)	$0	$0	$0	$0
Supplies and Materials (26.0)	$65,501	$65,810	$0	-$65,810
Equipment (31.0)	$444	$446	$0	-$446
Land and Structures (32.0)	$0	$0	$0	$0
Investments and Loans (33.0)	$0	$0	$0	$0
Grants, Subsidies, and Contributions (41.0)	$585,370	$588,131	$0	-$588,131
Insurance Claims and Indemnities (42.0)	$6	$6	$0	-$6
Interest and Dividends (43.0)	$0	$0	$0	$0
Refunds (44.0)	$0	$0	$0	$0
Subtotal Non-Pay Costs	**$829,717**	**$833,630**	**$0**	**-$833,630**
Total Budget Authority	**$944,933**	**$949,390**	**$0**	**-$949,390**
Average Cost per FTE				
Civilian FTEs	**649**	**605**	**0**	**-605**
Civilian Average Salary and Benefits	$162	$174	-	-
Percent change	N/A	8%	-	-
Military FTEs	**54**	**51**	**0**	**-51**
Military Average Salary and Benefits	$177	$187	-	-
Percent change	N/A	6%	-	-
Total FTEs[1,2]	**702**	**656**	**0**	**-656**
Average Salary and Benefits	**$164**	**$177**	**-**	**-**
Percent change	**N/A**	**8%**	**-**	**-**

[1] PPHF FTEs based on direct hire estimates. The FY 2027 Budget eliminates the Prevention and Public Health Fund (PPHF). FY 2027 estimates assume zero due to proposed PPHF elimination.

[2] FTE displayed reflect current estimates, which may differ from the system of record. FY 2027 FTE levels reflect estimates and may not represent expected FTE levels across FY 2027. These estimates are subject to change.

OBJECT CLASS TABLE – REIMBURSABLE

(dollars in thousands)	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Personnel Compensation:				
Full-Time Permanent(11.1)	$19,581	$25,216	$25,082	-$135
Other than Full-Time Permanent (11.3)	$4,140	$5,332	$5,303	-$29
Other Personnel Comp. (11.5)	$1,222	$1,574	$1,566	-$8
Military Personnel (11.7)	$2,980	$3,837	$3,817	-$21
Special Personal Service Comp. (11.8)	$0	$0	$0	$0
Total Personnel Compensation	**$27,924**	**$35,960**	**$35,768**	**-$192**
Civilian Personnel Benefits (12.1)	$9,241	$11,900	$11,837	-$64
Military Personnel Benefits (12.2)	$578	$745	$741	-$4
Benefits to Former Personnel (13.0)	$128	$165	$164	-$1
Subtotal Pay Costs	**$37,872**	**$48,770**	**$48,509**	**-$261**
Travel (21.0)	$1,242	$1,599	$1,590	-$9
Transportation of Things (22.0)	$505	$651	$647	-$3
Rental Payments to GSA (23.1)	$235	$302	$300	-$2
Rental Payments to Others (23.2)	$238	$306	$305	-$2
Communications, Utilities, and Misc. Charges (23.3)	$164	$211	$210	-$1
NTWK Use, Data Transm Svc (23.8)	$0	$0	$0	$0
Printing and Reproduction (24.0)	$17	$22	$22	$0
Other Contractual Services (25):	$45,597	$58,718	$58,404	-$314
Advisory and Assistance Services (25.1)	$13,016	$16,762	$16,672	-$90
Other Services (25.2)	$2,253	$2,901	$2,886	-$16
Purchases from Government Accounts (25.3)	$17,843	$22,977	$22,854	-$123
Operation and Maintenance of Facilities (25.4)	$9	$12	$12	$0
Research and Development Contracts (25.5)	$0	$0	$0	$0
Medical Services (25.6)	$436	$561	$558	-$3
Operation and Maintenance of Equipment (25.7)	$12,040	$15,505	$15,422	-$83
Subsistence and Support of Persons (25.8)	$0	$0	$0	$0
Consultants, other and misc (25.9)	$0	$0	$0	$0
Supplies and Materials (26.0)	$1,555	$2,003	$1,992	-$11
Equipment (31.0)	$162	$208	$207	-$1
Land and Structures (32.0)	$0	$0	$0	$0
Investments and Loans (33.0)	$0	$0	$0	$0
Grants, Subsidies, and Contributions (41.0)	$36,544	$47,060	$46,809	-$252
Insurance Claims and Indemnities (42.0)	$20,928	$26,951	$26,806	-$144
Interest and Dividends (43.0)	$0	$0	$0	$0
Refunds (44.0)	$154	$199	$199	$0
Subtotal Non-Pay Costs	**$107,340**	**$138,230**	**$137,491**	**-$739**
Total Budget Authority	**$145,212**	**$187,000**	**$186,000**	**-$1,000**
Average Cost per FTE				
Civilian FTEs	**348**	**348**	**323**	**-25**
Civilian Average Salary and Benefits	$98	$127	$136	$9
Percent change	N/A	29%	7%	-22%
Military FTEs	**37**	**37**	**37**	**0**
Military Average Salary and Benefits	$96	$124	$123	-$1
Percent change	N/A	29%	-1%	-29%
Total FTEs[1,2]	**385**	**385**	**360**	**-25**
Average Salary and Benefits	**$98**	**$127**	**$135**	**$8**
Percent change	**N/A**	**29%**	**6%**	**-23%**

[1] FY 2026 and FY 2027 reflect estimates based on reported Prior-Year (PY) actual amounts for reimbursables.

[2] FTE displayed reflect current estimates, which may differ from the system of record. FTE estimates may not represent expected FTE levels across FY 2027. These estimates are subject to change.

DETAIL OF FULL-TIME EQUIVALENT EMPLOYMENT (FTE)

	FY 2025 Final			FY 2026 Enacted			FY 2027 President's Budget[1,2]		
	Civilian	CC	Total	Civilian	CC	Total	Civilian	CC	Total
Immunization and Respiratory Diseases	**1,048**	**77**	**1,125**	**998**	**77**	**1,075**	**998**	**77**	**1,075**
Direct	1,046	75	1,121	996	75	1,071	996	75	1,071
Reimbursable	2	2	4	2	2	4	2	2	4
Viral Hepatitis, STI and TB Prevention	**934**	**54**	**988**	**872**	**54**	**926**	**477**	**31**	**508**
Direct	933	53	986	871	53	924	476	30	507
Reimbursable	0.3	1	1	0.3	1	1	0.30	1.09	1
Emerging and Zoonotic Infectious Diseases	**1,515**	**144**	**1,660**	**1,463**	**144**	**1,608**	**1,571**	**157**	**1,728**
Direct	1,458	135	1,593	1,406	135	1,541	1,514	148	1,662
Reimbursable	57	10	67	57	10	67	57	10	67
National Center for Chemicals and Toxins[3]	**1,148**	**96**	**1,244**	**1,028**	**96**	**1,124**	**1,518**	**73**	**1,591**
Direct	1,093	84	1,177	973	84	1,057	1,464	60	1,524
Reimbursable	54	12	67	54	12	67	54	12	67
Public Health Scientific Services	**1,532**	**62**	**1,594**	**1,370**	**62**	**1,432**	**1,082**	**56**	**1,138**
Direct	1,328	53	1,381	1,166	53	1,219	878	47	925
Reimbursable	204	9	213	204	9	213	204	9	213
Global Health	**937**	**108**	**1,045**	**897**	**108**	**1,005**	**787**	**95**	**882**
Direct	931	106	1,038	891	106	998	781	94	875
Reimbursable	5	2	7	5	2	7	5	2	7
Public Health Preparedness and Response	**413**	**65**	**478**	**399**	**65**	**464**	**333**	**62**	**396**
Direct	413	64	477	399	64	463	333	61	394
Reimbursable	0.4	2	2	0.4	2	2	0.4	2	2
CDC-Wide Activities and Program Support	**1,965**	**41**	**2,006**	**1,533**	**41**	**1,574**	**1,528**	**41**	**1,568**
Direct	1,965	41	2,006	1,533	41	1,574	1,528	41	1,568
BA	278	15	293	596	15	611	590	15	605
WCF	1,687	26	1,713	937	26	963	937	26	963
CDC Total[4]	**10,649**	**721**	**11,370**	**9,448**	**721**	**10,169**	**8,295**	**592**	**8,887**
CDC Direct Total	10,301	684	10,985	9,100	684	9,784	7,971	555	8,526
CDC Reimbursable Total	348	37	385	348	37	385	323	37	360

[1] FY 2027 Level reflects FTE reductions due to proposed eliminations and realignments of PPAs/funding lines from CDC to AHA and is subject to change as reorganization efforts continue.

[2] In alignment with the proposed HHS reorganization, the FY 2027 Budget reorganizes all or some of the funding to the Administration for a Healthy America (AHA) from the following CDC Accounts: 1) HIV/AIDS activities; 2) Chronic Disease Prevention and Health Promotion; 3) Birth Defects, Developmental Disabilities, Disability and Health; and 4) Injury Prevention and Control. In addition, the Budget realigns Health Statistics to the HHS Office of the Secretary Office of Strategy (OS). The FY 2027 Budget is displayed comparably.

[3] The FY 2027 Budget establishes a new Center within CDC, National Center for Chemicals and Toxins, and realigns PPAs from NCEH, NIOSH, ATSDR; National Institute of Environmental Health Sciences (formerly of NIH); and National Center for Toxicological Research (formerly of FDA).

[4] FTE displayed reflect current estimates, which may differ from the system of record. FY 2027 FTE levels reflect estimates for October 1, 2026, and may not represent expected FTE levels across FY 2027. These estimates are subject to change.

DETAIL OF POSITIONS[1,2,3,4]

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget
Executive Level[4]			
Subtotal			
Total-Executive Level Salary			
ES-6			
ES-5			
ES-4			
ES-3			
ES-2			
ES-1			
Total - SES	**49**	**32**	**28**
Total - SES Salary	**$7,757,069**	**$6,070,752**	**$5,816,771**
GS-15	984	753	683
GS-14	2,938	2,400	2,228
GS-13	4,151	3,494	3,287
GS-12	1,934	1,548	1,494
GS-11	700	494	471
GS-10	22	16	15
GS-9	363	274	256
GS-8	36	29	28
GS-7	252	88	59
GS-6	10	6	5
GS-5	4	1	0
GS-4	4	2	1
GS-3	1	0	0
GS-2	0	0	0
GS-1	0	0	0
Subtotal	**11,399**	**9,105**	**8,527**
Total - GS Salary	**$1,397,937,123**	**$1,163,871,964**	**$1,161,159,548**
Average ES level			
Average ES salary			
Average GS grade	12.0	12.0	12.0
Average GS salary	$122,637	$127,828	$136,174
Average Special Pay Categories			
Average Comm. Corps Salary	$152,318	$165,498	$165,870
Average Wage Grade Salary	$66,507	$77,670	$77,692

[1] Includes special pays and allowances

[2] Totals include ATSDR; do not include reimbursable FTEs

[3] This table reflects "positions" not full-time equivalent(s) (FTEs). Does not include comparability adjustments to reflect the HHS reorganization proposed in the FY 2027 Budget.

[4] Executive level data not available

FULL TIME EQUIVALENTS FUNDED BY THE AFFORDABLE CARE ACT, P.L. 111-148

(dollars in millions) PPHF Program [1, 2]	ACA Sec.	2017 Total	2017 FTEs	2018 Total	2018 FTEs	2019 Total	2019 FTEs	2020 FTEs	2020 Total	2021 FTEs	2021 Total	2022 FTEs	2022 Total	2023 Total	2023 FTEs	2024 Total	2024 FTEs	2025 Total	2025 FTEs	2026 Total	2026 FTEs	2027 Total	2027 FTEs
Healthcare-associated Infections (HAI)	4002	$12.0	6.4	$12.0	6.4	$12.0	6.4	$12.0	6.4	$12.0	6.4	$12.0	6.4	$12.0	6.4	$12.0	6.4	$12.0	6.4	$12.0	6.4	$0.0	$0.0
Total[3,4]		**$12.0**	**6.4**	**$12.0**	**6.4**	**$12.0**	**6.4**	**$12.0**	**6.4**	**$12.0**	**6.4**	**$12.0**	**6.4**	**$12.0**	**6.4**	**$12.0**	**6.4**	**$12.0**	**6.4**	**$12.0**	**6.4**	**$0.0**	**$0.0**

[1] Excludes employees or contractors who: Are supported through appropriations enacted in laws other than PPACA and work on programs that existed prior to the passage of PPACA; Spend less than 50% of their time on activities funded by or newly authorized in ACA; or who work on contracts for which FTE reporting is not a requirement of their contract, such as fixed price contracts.
[2] CDC tracks total contract costs for ACA activities in the Affordable Care Act Object Class Table but does not track individual contract staff.
[3] The FY 2027 Budget eliminates the Prevention and Public Health Fund (PPHF).
[4] Total reflects estimates.

(dollars in millions) ACA Program [1, 2]	ACA Sec.	2017 Total	2017 FTEs	2018 Total	2018 FTEs	2019 Total	2019 FTEs	2020 FTEs	2020 Total	2021 FTEs	2021 Total	2022 FTEs	2022 Total	2023 Total	2023 FTEs	2024 Total	2024 FTEs	2025 Total	2025 FTEs	2026 Total	2026 FTEs	2027 Total	2027 FTEs
Medical Monitoring in Libby, MT	10323	$4.0	0.9	$4.0	0.9	$4.0	0.9	$4.0	0.9	$4.0	0.9	$4.0	0.9	$4.0	0.9	$4.0	0.9	$4.0	0.9	$4.0	0.9	$4.0	0.9
Total[3]		**$14.0**	**0.9**	**$4.0**	**0.9**	**$4.0**	**0.9**	**$4.0**	**0.9**	**$4.0**	**0.9**	**$4.0**	**0.9**	**$4.0**	**0.9**	**$4.0**	**0.9**	**$4.0**	**0.9**	**$4.0**	**0.9**	**$4.0**	**0.9**

[1] Excludes employees or contractors who: Are supported through appropriations enacted in laws other than PPACA and work on programs that existed prior to the passage of PPACA; Spend less than 50% of their time on activities funded by or newly authorized in ACA; or who work on contracts for which FTE reporting is not a requirement of their contract, such as fixed price contracts.
[2] CDC tracks total contract costs for ACA activities in the Affordable Care Act Object Class Table but does not track individual contract staff.
[3] Total reflects estimates.

PHYSICIANS' COMPARABILITY ALLOWANCE (PCA) WORKSHEET

1) Department and component:

Centers For Disease Control and Prevention

2) Explain the recruitment and retention problem(s) justifying the need for the PCA pay authority.

(*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.)*

CDC has found that SES salaries do not meet the threshold to attract top level senior officials for critical science-focused positions who are appointed under SES. The use of PCA is critical, as it allows CDC to recruit and retain top level senior officials who possess requisite scientific expertise, and whose national/international stature command salaries which exceed the SES salary level. In addition, Title V 602 Physicians who do not have a medical license should receive PCA.

3-4) Please complete the table below with details of the PCA agreement for the following years:

	PY 2025 (Actual)	CY 2026 (Estimates)	BY* 2027 (Estimates)
3a) Number of Physicians Receiving PCAs	2	1	1
3b) Number of Physicians with One-Year PCA Agreements	2	1	1
3c) Number of Physicians with Multi-Year PCA Agreements	0	0	0
4a) Average Annual PCA Physician Pay (without PCA payment)	358,376	146,325	146,325
4b) Average Annual PCA Payment	44,000	29,893	29,893

*BY data will be approved during the BY Budget cycle. Please ensure each column is completed.

5) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

The use of PCA has enabled successful recruitment and retention of physicians to key positions at CDC. It is anticipated that the failure to offer PCA to CDC physicians could have a negative impact on CDC's global mission.

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

The need will remain to pay PCA to any new physicians appointed under SES and Title 5 physicians with no medical license.

FY 2021-2027 CONSOLIDATED CDC GRANTS TABLE[1,2]

These funds are awarded by formula. Δ
These funds are not awarded by formula. ●
These funds are awarded partially by formula. ǂ

(dollars in millions)	FY 2021 Final	FY 2022 Final	FY 2023 Final	FY 2024 Final	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026	% Formula
Immunization Cooperative Agreements									Δ
- Number of Awards	64	64	64	64	66	66	66	0	
- Total Awards	$301.54	$369.77	$438.50	$276.72	$323.96	$323.96	$323.96	$0	
Viral Hepatitis, STI and TB Prevention									●
- Number of Awards	N/A	N/A	N/A	62	62	62	TBD	TBD	
- Total Awards			$205.18	$205.18	$205.18	$205.18	TBD	TBD	
Epidemiology and Laboratory Capacity									●
- Number of Awards	N/A	64	64	65	65	TBD	TBD	TBD	
- Total Awards		$197.04	$173.00	$364.44	$364.44	TBD	TBD	TBD	
State Biomonitoring Cooperative Agreements									●
- Number of Awards	N/A	N/A	6	6	6	6	6	0	
- Total Awards			$5.00	$5.00	$5.00	$5.00	$5.00	$0	
Newborn Screening Cooperative Agreements									●
- Number of Awards	N/A	N/A	5	5	1	1	1	0	
- Total Awards			$1.99	$1.99	$1.00	$1.00	1.00	$0	
National Syndromic Surveillance Program									●
- Number of Awards	51	51	51	51	51	51	51	0	
- Total Awards	$6.56	$6.56	$6.56	$6.00	$6.00	$6.00	6.00	$0	
National Notifiable Diseases Surveillance System									●
- Number of Awards	64	64	64	64	64	64	64	0	
- Total Awards	$11.03	$11.03	$11.03	$11.03	$11.03	$11.03	$11.03	$0	
PHEP Awards									Δ
- Number of Awards	62	62	62	62	62	62	TBD	TBD	
- Total Awards	$622.850	$651.788	$661.338	$653.74	$653.74	$653.74	TBD	TBD	

(dollars in millions)	FY 2021 Final	FY 2022 Final	FY 2023 Final	FY 2024 Final	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026	% Formula
Public Health Infrastructure Grant: Foundational Capabilities									Δ
- Number of Awards	N/A	N/A	106	106	106	106	TBD	TBD	
- Total Awards			$245.00	$245.00	$245.00	$245.00	TBD	TBD	
Environmental Health Capacity (includes Safe Water)									●
- Number of Awards	N/A	N/A	N/A	N/A	49	44	44	0	
- Total Awards					$4.91	$4.91	$4.91	$0	
ALS Research Grants									●
- Number of Awards	N/A	7	8	8	8	8	8	0	
- Total Awards		$3.10	$3.20	$3.20	$3.20	$3.20	$3.20	$0	
Flint Registry									●
- Number of Awards	N/A	N/A	N/A	N/A	1	1	1	0	
- Total Awards					$4.80	$4.80	$4.80	$0	
Childhood Lead Poisoning Prevention and Surveillance of Blood Lead Levels in Children									●
- Number of Awards	N/A	N/A	N/A	N/A	62	62	62	0	
- Total Awards					$29.94	$29.94	$29.94	$0	
Supporting Communities to Reduce Lead Poisoning									●
- Number of Awards	N/A	N/A	N/A	N/A	11	20	20	0	
- Total Awards					$1.98	$1.98	$1.98	$0	
ATSDR Partnership to Promote Local Efforts to Reduce Environmental Exposure (APPLETREE)									●
- Number of Awards	N/A	N/A	N/A	30	30	30	30	0	
- Total Awards				$13.95	$13.95	$13.95	$13.95	$0	
National Institute of Environmental Health Sciences Awards									●
- Number of Awards	N/A	N/A	N/A	N/A	822	806	525	-281	
- Total Awards					N/A	N/A	N/A	N/A	
The Superfund Research Program and the Worker Training Program Awards									●
- Number of Awards	N/A	N/A	N/A	N/A	58	41	33	-8	
- Total Awards					N/A	N/A	N/A	N/A	

[1] Grant award estimates with "TBD" are under development.
[2] N/A reflects information is not available for the fiscal year.

CONSOLIDATED STATE TABLES

State Table: Discretionary (Section 317)[1]

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Alabama	$5,124,563	$5,124,563	$5,124,563	$0
Alaska	$2,100,522	$2,100,522	$2,100,522	$0
Arizona [2]	$6,016,810	$6,016,810	$6,016,810	$0
Arkansas	$3,594,870	$3,594,870	$3,594,870	$0
California [2]	$30,783,479	$30,783,479	$30,783,479	$0
Colorado	$5,054,922	$5,054,922	$5,054,922	$0
Connecticut	$3,730,447	$3,730,447	$3,730,447	$0
Delaware	$2,132,633	$2,132,633	$2,132,633	$0
District of Columbia	$2,503,601	$2,503,601	$2,503,601	$0
Florida	$13,335,398	$13,335,398	$13,335,398	$0
Georgia	$9,623,287	$9,623,287	$9,623,287	$0
Hawaii	$3,025,750	$3,025,750	$3,025,750	$0
Idaho	$2,915,048	$2,915,048	$2,915,048	$0
Illinois	$7,756,631	$7,756,631	$7,756,631	$0
Indiana	$5,927,566	$5,927,566	$5,927,566	$0
Iowa	$3,708,512	$3,708,512	$3,708,512	$0
Kansas	$3,494,161	$3,494,161	$3,494,161	$0
Kentucky	$4,661,074	$4,661,074	$4,661,074	$0
Louisiana	$4,760,836	$4,760,836	$4,760,836	$0
Maine	$2,659,755	$2,659,755	$2,659,755	$0
Maryland	$4,750,684	$4,750,684	$4,750,684	$0
Massachusetts	$4,961,912	$4,961,912	$4,961,912	$0
Michigan	$7,209,660	$7,209,660	$7,209,660	$0
Minnesota	$5,100,159	$5,100,159	$5,100,159	$0
Mississippi	$4,107,073	$4,107,073	$4,107,073	$0
Missouri	$5,835,709	$5,835,709	$5,835,709	$0
Montana	$2,473,039	$2,473,039	$2,473,039	$0
Nebraska	$3,066,212	$3,066,212	$3,066,212	$0
Nevada	$3,440,856	$3,440,856	$3,440,856	$0
New Hampshire	$2,889,237	$2,889,237	$2,889,237	$0
New Jersey	$6,794,328	$6,794,328	$6,794,328	$0
New Mexico	$3,264,441	$3,264,441	$3,264,441	$0
New York	$8,387,260	$8,387,260	$8,387,260	$0
North Carolina	$9,583,195	$9,583,195	$9,583,195	$0
North Dakota	$2,113,021	$2,113,021	$2,113,021	$0
Ohio	$8,454,977	$8,454,977	$8,454,977	$0
Oklahoma	$4,820,712	$4,820,712	$4,820,712	$0
Oregon	$3,870,427	$3,870,427	$3,870,427	$0
Pennsylvania	$7,875,733	$7,875,733	$7,875,733	$0
Rhode Island	$1,958,114	$1,958,114	$1,958,114	$0
South Carolina	$4,650,375	$4,650,375	$4,650,375	$0
South Dakota	$2,231,868	$2,231,868	$2,231,868	$0
Tennessee	$6,444,084	$6,444,084	$6,444,084	$0
Texas [2]	$22,511,780	$22,511,780	$22,511,780	$0
Utah	$3,482,140	$3,482,140	$3,482,140	$0
Vermont	$2,262,937	$2,262,937	$2,262,937	$0
Virginia	$6,566,560	$6,566,560	$6,566,560	$0
Washington	$6,153,415	$6,153,415	$6,153,415	$0

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
West Virginia	$3,060,526	$3,060,526	$3,060,526	$0
Wisconsin	$5,155,068	$5,155,068	$5,155,068	$0
Wyoming	$2,033,058	$2,033,058	$2,033,058	$0
Subtotal States	**$288,418,426**	**$288,418,426**	**$288,418,426**	**$0**
Cities				
Chicago	$4,197,319	$4,197,319	$4,197,319	$0
Houston [2]	$2,066,049	$2,066,049	$2,066,049	$0
Los Angeles [2]	$2,299,992	$2,299,992	$2,299,992	$0
New York City	$7,589,765	$7,589,765	$7,589,765	$0
Philadelphia	$2,543,243	$2,543,243	$2,543,243	$0
Phoenix [2]	$1,576,768	$1,576,768	$1,576,768	$0
San Antonio [2]	$1,546,589	$1,546,589	$1,546,589	$0
Subtotal Cities	**$21,819,725**	**$21,819,725**	**$21,819,725**	**$0**
Territories				
American Samoa	$581,067	$581,067	$581,067	$0
Guam	$1,001,426	$1,001,426	$1,001,426	$0
Marshall Islands	$2,277,496	$2,277,496	$2,277,496	$0
Micronesia	$3,631,585	$3,631,585	$3,631,585	$0
Northern Mariana Islands	$853,471	$853,471	$853,471	$0
Puerto Rico	$3,554,532	$3,554,532	$3,554,532	$0
Republic of Palau	$686,054	$686,054	$686,054	$0
Virgin Islands	$1,132,737	$1,132,737	$1,132,737	$0
Subtotal Territories	**$13,718,368**	**$13,718,368**	**$13,718,368**	**$0**
Total States/Cities/Territories	**$323,956,518**	**$323,956,518**	**$323,956,518**	**$0**
Other Adjustments[3]	$93,043,482	$93,043,482	$93,043,482	$0
Total Resources	**$417,000,000**	**$417,000,000**	**$417,000,000**	**$0**

[1]This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees). Includes vaccine direct assistance and immunization infrastructure/operations grant funding. For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit http://www.cdc.gov/FundingProfiles/FundingProfilesRIA/

[2]Vaccine direct assistance for Houston, Los Angeles, Phoenix, and San Antonio is included with their respective states.

[3]Other adjustments include vaccine that is in inventory at the centralized distribution center but has not been ordered by immunization providers, funds for centralized vaccine distribution activities, a centralized vaccine ordering system, and program support services.

State Table: Viral Hepatitis, STI and TB Prevention Programs State Funding[1]

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget[2]	FY 2027 +/- FY 2026
Alabama	$2,888,917	$2,888,917	TBD	TBD
Alaska	$1,381,149	$1,381,149	TBD	TBD
Arizona	$3,790,146	$3,790,146	TBD	TBD
Arkansas	$2,106,801	$2,106,801	TBD	TBD
California	$17,544,392	$17,544,392	TBD	TBD
Colorado	$2,882,415	$2,882,415	TBD	TBD
Connecticut	$1,838,107	$1,838,107	TBD	TBD
Delaware	$985,613	$985,613	TBD	TBD
Florida	$11,282,647	$11,282,647	TBD	TBD
Georgia	$6,754,910	$6,754,910	TBD	TBD
Hawaii	$1,790,743	$1,790,743	TBD	TBD
Idaho	$1,170,635	$1,170,635	TBD	TBD
Illinois	$4,270,578	$4,270,578	TBD	TBD
Indiana	$3,191,036	$3,191,036	TBD	TBD
Iowa	$1,893,213	$1,893,213	TBD	TBD
Kansas	$1,670,403	$1,670,403	TBD	TBD
Kentucky	$2,519,333	$2,519,333	TBD	TBD
Louisiana	$3,218,274	$3,218,274	TBD	TBD
Maine	$1,160,841	$1,160,841	TBD	TBD
Maryland	$3,130,259	$3,130,259	TBD	TBD
Massachusetts	$3,989,943	$3,989,943	TBD	TBD
Michigan	$4,521,979	$4,521,979	TBD	TBD
Minnesota	$2,979,193	$2,979,193	TBD	TBD
Mississippi	$2,137,625	$2,137,625	TBD	TBD
Missouri	$3,114,855	$3,114,855	TBD	TBD
Montana	$830,392	$830,392	TBD	TBD
Nebraska	$1,160,505	$1,160,505	TBD	TBD
Nevada	$2,050,571	$2,050,571	TBD	TBD
New Hampshire	$837,555	$837,555	TBD	TBD
New Jersey	$5,259,640	$5,259,640	TBD	TBD
New Mexico	$1,665,745	$1,665,745	TBD	TBD
New York	$4,578,130	$4,578,130	TBD	TBD
North Carolina	$5,325,056	$5,325,056	TBD	TBD
North Dakota	$852,961	$852,961	TBD	TBD
Ohio	$4,963,388	$4,963,388	TBD	TBD
Oklahoma	$2,592,903	$2,592,903	TBD	TBD
Oregon	$2,463,464	$2,463,464	TBD	TBD
Pennsylvania	$3,872,943	$3,872,943	TBD	TBD
Rhode Island	$1,227,213	$1,227,213	TBD	TBD
South Carolina	$2,832,143	$2,832,143	TBD	TBD
South Dakota	$597,512	$597,512	TBD	TBD
Tennessee	$3,357,154	$3,357,154	TBD	TBD
Texas	$16,206,359	$16,206,359	TBD	TBD
Utah	$1,466,238	$1,466,238	TBD	TBD
Vermont	$820,083	$820,083	TBD	TBD
Virginia	$4,382,036	$4,382,036	TBD	TBD
Washington	$4,508,059	$4,508,059	TBD	TBD
West Virginia	$1,581,215	$1,581,215	TBD	TBD
Wisconsin	$2,479,847	$2,479,847	TBD	TBD
Wyoming	$814,498	$814,498	TBD	TBD
Cities				

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget[2]	FY 2027 +/- FY 2026
Baltimore	$1,845,312	$1,845,312	TBD	TBD
Chicago	$3,323,522	$3,323,522	TBD	TBD
Dallas	$315,000	$315,000	TBD	TBD
Houston	$1,786,408	$1,786,408	TBD	TBD
Los Angeles	$8,614,110	$8,614,110	TBD	TBD
New York City	$9,827,932	$9,827,932	TBD	TBD
Philadelphia	$2,963,487	$2,963,487	TBD	TBD
San Diego	$1,752,508	$1,752,508	TBD	TBD
San Francisco	$2,201,985	$2,201,985	TBD	TBD
Washington, D.C.	$1,457,133	$1,457,133	TBD	TBD
Territories				
Puerto Rico	$1,686,397	$1,686,397	TBD	TBD
Virgin Islands	$467,891	$467,891	TBD	TBD
Subtotal States	**$168,939,617**	**$168,939,617**	**TBD**	**TBD**
Subtotal Cities	**$34,087,397**	**$34,087,397**	**TBD**	**TBD**
Subtotal Territories	**$2,154,288**	**$2,154,288**	**TBD**	**TBD**
Total Resources	**$205,181,302**	**$205,181,302**	**TBD**	**TBD**

[1]This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial awardees).
[2] Grant award estimates are under development.

State Table: National Notifiable Diseases Surveillance System (NNDSS) Grants[1,2,3,4]

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Alabama	$6,000	$6,000	$6,000	$0
Alaska	$499,447	$499,447	$499,447	$0
Arizona	$325,723	$325,723	$325,723	$0
Arkansas	$162,710	$162,710	$162,710	$0
California	$175,375	$175,375	$175,375	$0
Colorado	$589,804	$589,804	$589,804	$0
Connecticut	$590,092	$590,092	$590,092	$0
Delaware	$25,000	$25,000	$25,000	$0
District of Columbia	$378,996	$378,996	$378,996	$0
Florida	$588,138	$588,138	$588,138	$0
Georgia	$292,923	$292,923	$292,923	$0
Hawaii	$244,237	$244,237	$244,237	$0
Idaho	$222,309	$222,309	$222,309	$0
Illinois	$221,019	$221,019	$221,019	$0
Indiana	$230,516	$230,516	$230,516	$0
Iowa	$55,187	$55,187	$55,187	$0
Kansas	$521,087	$521,087	$521,087	$0
Kentucky	-	-	-	$0
Louisiana	$206,711	$206,711	$206,711	$0
Maine	$388,615	$388,615	$388,615	$0
Maryland	$571,270	$571,270	$571,270	$0
Massachusetts	$313,523	$313,523	$313,523	$0
Michigan	$513,301	$513,301	$513,301	$0
Minnesota	$604,518	$604,518	$604,518	$0
Mississippi	$21,989	$21,989	$21,989	$0
Missouri	$101,844	$101,844	$101,844	$0
Montana	$47,241	$47,241	$47,241	$0
Nebraska	$272,251	$272,251	$272,251	$0
Nevada	$494,081	$494,081	$494,081	$0
New Hampshire	$294,999	$294,999	$294,999	$0
New Jersey	$589,450	$589,450	$589,450	$0
New Mexico	-	-	-	$0
New York	$636,783	$636,783	$636,783	$0
North Carolina	$263,454	$263,454	$263,454	$0
North Dakota	$351,141	$351,141	$351,141	$0
Ohio	$161,646	$161,646	$161,646	$0
Oklahoma	$16,147	$16,147	$16,147	$0
Oregon	$404,783	$404,783	$404,783	$0
Pennsylvania	$199,710	$199,710	$199,710	$0
Rhode Island	$136,014	$136,014	$136,014	$0
South Carolina	$64,573	$64,573	$64,573	$0
South Dakota	$228,477	$228,477	$228,477	$0
Tennessee	$376,318	$376,318	$376,318	$0
Texas	$180,495	$180,495	$180,495	$0
Utah	$1,052,903	$1,052,903	$1,052,903	$0
Vermont	$288,683	$288,683	$288,683	$0
Virginia	$41,914	$41,914	$41,914	$0
Washington	$351,963	$351,963	$351,963	$0
West Virginia	$427,676	$427,676	$427,676	$0
Wisconsin	$399,134	$399,134	$399,134	$0
Wyoming	$176,937	$176,937	$176,937	$0
Territories				

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget	FY 2027 +/- FY 2026
Guam	$267,745	$267,745	$267,745	$0
Marshall Islands	$70,495	$70,495	$70,495	$0
Micronesia	$3,733	$3,733	$3,733	$0
Northern Mariana Islands	-	-	-	$0
Palau	-	-	-	$0
Puerto Rico	$167,389	$167,389	$167,389	$0
Virgin Islands	$52,200	$52,200	$52,200	$0
American Samoa	-	-	-	$0
Cities				$0
Chicago	$267,495	$267,495	$267,495	$0
Houston	$483,192	$483,192	$483,192	$0
Los Angeles	$704,329	$704,329	$704,329	$0
New York City	$293,684	$293,684	$293,684	$0
Philadelphia	$382,631	$382,631	$382,631	$0
Number of Awards	**59**	**59**	**59**	**0**
Average Award	**$0.305**	**$0.305**	**$0.305**	**$0**
Range of Awards	**$0.003-$1.053**	**$0.003-$1.053**	**$0.003-$1.053**	**$0**
Subtotal States	**$15,307,107**	**$15,307,107**	**$15,307,107**	**$0**
Subtotal Territories	**$561,562**	**$561,562**	**$561,562**	**$0**
Subtotal Cities	**$2,131,331**	**$2,131,331**	**$2,131,331**	**$0**
Total Resources	**$18,000,000**	**$18,000,000**	**$18,000,000**	**$0**

[1] This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees); award totals will be revised after the end of the fiscal year. For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit https://www.cdc.gov/funding/funding-profiles/.
[2] CFDA Number:93.323 [Discretionary]
[3] These funds are not awarded by formula.
[4] Table includes core funding from the Surveillance, Epidemiology, and Public Health Informatics budget activity and other CDC programs.
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State Table: Public Health Emergency Preparedness Cooperative Agreement

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget[1]	FY 2027 +/- FY 2026
Alabama	$9,066,094	$9,066,094	TBD	TBD
Alaska	$5,210,000	$5,210,000	TBD	TBD
Arizona	$13,007,079	$13,007,079	TBD	TBD
Arkansas	$6,689,403	$6,689,403	TBD	TBD
California	$44,882,292	$44,882,292	TBD	TBD
Colorado	$10,612,843	$10,612,843	TBD	TBD
Connecticut	$7,823,961	$7,823,961	TBD	TBD
Delaware	$5,426,073	$5,426,073	TBD	TBD
Florida	$33,336,079	$33,336,079	TBD	TBD
Georgia	$17,431,023	$17,431,023	TBD	TBD
Hawaii	$5,386,337	$5,386,337	TBD	TBD
Idaho	$5,442,299	$5,442,299	TBD	TBD
Illinois	$16,759,039	$16,759,039	TBD	TBD
Indiana	$11,801,913	$11,801,913	TBD	TBD
Iowa	$6,873,572	$6,873,572	TBD	TBD
Kansas	$6,854,030	$6,854,030	TBD	TBD
Kentucky	$8,576,091	$8,576,091	TBD	TBD
Louisiana	$8,919,448	$8,919,448	TBD	TBD
Maine	$5,210,000	$5,210,000	TBD	TBD
Maryland	$11,942,223	$11,942,223	TBD	TBD
Massachusetts	$13,927,467	$13,927,467	TBD	TBD
Michigan	$17,051,164	$17,051,164	TBD	TBD
Minnesota	$11,981,559	$11,981,559	TBD	TBD
Mississippi	$6,593,485	$6,593,485	TBD	TBD
Missouri	$11,168,375	$11,168,375	TBD	TBD
Montana	$5,210,000	$5,210,000	TBD	TBD
Nebraska	$5,507,091	$5,507,091	TBD	TBD
Nevada	$7,383,461	$7,383,461	TBD	TBD
New Hampshire	$5,378,731	$5,378,731	TBD	TBD
New Jersey	$16,637,507	$16,637,507	TBD	TBD
New Mexico	$6,958,927	$6,958,927	TBD	TBD
New York	$19,892,548	$19,892,548	TBD	TBD
North Carolina	$15,763,551	$15,763,551	TBD	TBD
North Dakota	$5,210,000	$5,210,000	TBD	TBD
Ohio	$18,334,549	$18,334,549	TBD	TBD
Oklahoma	$8,008,571	$8,008,571	TBD	TBD
Oregon	$8,471,350	$8,471,350	TBD	TBD
Pennsylvania	$19,947,797	$19,947,797	TBD	TBD
Rhode Island	$5,415,557	$5,415,557	TBD	TBD
South Carolina	$10,505,907	$10,505,907	TBD	TBD
South Dakota	$5,210,000	$5,210,000	TBD	TBD
Tennessee	$11,981,492	$11,981,492	TBD	TBD
Texas	$42,915,264	$42,915,264	TBD	TBD
Utah	$7,233,853	$7,233,853	TBD	TBD
Vermont	$5,210,000	$5,210,000	TBD	TBD
Virginia	$16,085,770	$16,085,770	TBD	TBD
Washington	$13,364,241	$13,364,241	TBD	TBD
West Virginia	$5,231,898	$5,231,898	TBD	TBD
Wisconsin	$11,929,433	$11,929,433	TBD	TBD
Wyoming	$5,210,000	$5,210,000	TBD	TBD
Localities				

	FY 2025 Final	FY 2026 Enacted	FY 2027 President's Budget[1]	FY 2027 +/- FY 2026
Chicago	$10,471,504	$10,471,504	TBD	TBD
Washington, D.C.	$6,550,546	$6,550,546	TBD	TBD
Los Angeles County	$21,467,817	$21,467,817	TBD	TBD
New York City	$20,523,321	$20,523,321	TBD	TBD
Territories				
American Samoa	$413,850	$413,850	TBD	TBD
Guam	$544,542	$544,542	TBD	TBD
Marshall Islands	$419,776	$419,776	TBD	TBD
Micronesia	$478,510	$478,510	TBD	TBD
Northern Mariana Islands	$408,982	$408,982	TBD	TBD
Puerto Rico	$6,653,125	$6,653,125	TBD	TBD
Republic of Palau	$370,357	$370,357	TBD	TBD
Virgin Islands	$466,932	$466,932	TBD	TBD
Subtotal States	**$584,969,347**	**$584,969,347**	**TBD**	**TBD**
Subtotal Localities	**$59,013,188**	**$59,013,188**	**TBD**	**TBD**
Subtotal Territories	**$9,756,074**	**$9,756,074**	**TBD**	**TBD**
Total Resources	**$653,738,609**	**$653,738,609**	**TBD**	**TBD**

[1] Grant award estimates are under development.

State Table: Public Health Infrastructure Grant: Foundational Capabilities[1-4]

	FY 2025 Final[4]	FY 2026 Enacted[5]	FY 2027 President's Budget[6]	FY 2027 +/- FY 2026
Alabama	$3,663,591	$3,663,591	TBD	TBD
Alaska	$856,842	$856,842	TBD	TBD
Arizona	$5,424,624	5,424,624	TBD	TBD
Arkansas	$2,368,361	$2,368,361	TBD	TBD
California	$27,037,900	$27,037,900	TBD	TBD
Colorado	$4,298,521	$4,298,522	TBD	TBD
Connecticut	$2,452,692	$2,452,692	TBD	TBD
Delaware	$1,013,538	$1,013,538	TBD	TBD
District of Columbia	$849,048	$849,048	TBD	TBD
Florida	$15,069,593	$15,069,593	TBD	TBD
Georgia	$7,053,621	$7,053,621	TBD	TBD
Hawaii	$1,234,512	$1,234,512	TBD	TBD
Idaho	$1,440,020	$1,440,020	TBD	TBD
Illinois	$8,521,455	$8,521,455	TBD	TBD
Indiana	$4,797,188	$4,797,188	TBD	TBD
Iowa	$2,211,422	$2,211,422	TBD	TBD
Kansas	$2,075,781	$2,075,781	TBD	TBD
Kentucky	$3,668,501	$3,668,501	TBD	TBD
Louisiana	$3,430,130	$3,430,130	TBD	TBD
Maine	$1,211,521	$1,211,521	TBD	TBD
Maryland	$4,346,858	$4,346,858	TBD	TBD
Massachusetts	$4,782,115	$4,782,115	TBD	TBD
Michigan	$6,768,801	$6,768,801	TBD	TBD
Minnesota	$3,905,589	$3,905,589	TBD	TBD
Mississippi	$2,451,029	$2,451,029	TBD	TBD
Missouri	$4,444,195	$4,444,195	TBD	TBD
Montana	$1,054,522	$1,054,522	TBD	TBD
Nebraska	$1,947,901	$1,947,901	TBD	TBD
Nevada	$2,748,659	$2,748,659	TBD	TBD
New Hampshire	$1,145,359	$1,145,359	TBD	TBD
New Jersey	$5,788,843	$5,788,843	TBD	TBD
New Mexico	$1,821,692	$1,821,692	TBD	TBD
New York	$14,466,752	$14,466,752	TBD	TBD
North Carolina	$7,346,974	$7,346,974	TBD	TBD
North Dakota	$867,861	$867,861	TBD	TBD
Ohio	$7,619,438	$7,619,438	TBD	TBD
Oklahoma	$3,744,969	$3,744,969	TBD	TBD
Oregon	$3,218,338	$3,218,338	TBD	TBD
Pennsylvania	$8,670,267	$8,670,267	TBD	TBD
Rhode Island	$1,054,912	$1,054,912	TBD	TBD
South Carolina	$3,550,984	$3,550,984	TBD	TBD
South Dakota	$952,126	$952,126	TBD	TBD
Tennessee	$5,567,916	$5,567,916	TBD	TBD
Texas	$21,948,412	$21,948,412	TBD	TBD
Utah	$2,033,161	$2,033,161	TBD	TBD
Vermont	$789,002	$789,002	TBD	TBD
Virginia	$5,616,891	$5,616,891	TBD	TBD
Washington	$4,893,269	$4,893,269	TBD	TBD
West Virginia	$1,550,586	$1,550,586	TBD	TBD
Wisconsin	$4,189,972	$4,189,972	TBD	TBD
Wyoming	$747,753	$747,753	TBD	TBD

	FY 2025 Final[4]	FY 2026 Enacted[5]	FY 2027 President's Budget[6]	FY 2027 +/- FY 2026
Territories				
American Samoa	$471,974	$471,974	TBD	TBD
Guam	$565,772	$565,772	TBD	TBD
Micronesia	$514,127	$514,127	TBD	TBD
Puerto Rico	$2,788,026	$2,788,026	TBD	TBD
Virgin Islands	$517,468	$517,468	TBD	TBD
Northern Mariana Islands	$476,550	$476,550	TBD	TBD
Republic of Palau	$453,958	$453,958	TBD	TBD
Marshall Islands	$498,118	$498,118	TBD	TBD
Subtotal States	**$238,714,007**	**$238,714,007**	TBD	TBD
Subtotal Territories	**$6,285,993**	**$6,285,993**	TBD	TBD
Total Resources	**$245,000,000**	**$245,000,000**	**TBD**	**TBD**

[1] Table only reflects funds from CDC's annual appropriation.
[2] These funds are awarded by formula based on funding availability.
[3] Awards noted for Strengthening U.S. Public Health Infrastructure, Workforce, and Data Systems Grant Activity 2: -Foundational Capabilities.
[4] Awarded December 2024. FY 2024 appropriations for public health infrastructure and capacity shall remain available through September 30, 2025.
[5] Awarded December 2025. FY 2025 appropriations for public health infrastructure and capacity shall remain available through September 30,2026
[6] Grant award estimates are under development.

PROGRAMS PROPOSED FOR ELIMINATION IN THE FY 2027 BUDGET

(dollars in millions)

Program	FY 2026 Enacted
Prion Disease	$9.000
Chronic Fatigue Syndrome (Myalgic encephalomyelitis/ chronic fatigue syndrome (ME/CFS)	$5.400
Harmful Algal Blooms	$3.500
Healthcare-Associated Infections (HAI) (PPHF)	$12.000
Climate and Health	$10.000
Trevor's Law	$3.000
Environmental and Health Outcome Tracking Network	$34.000
Asthma	$33.500
National Occupational Research Agenda (NORA)	$120.500
Education and Research Centers	$32.000
Other Occupational Safety and Health Research	$115.100
Academic Centers for Public Health Preparedness	$9.200
Preventive Health and Health Services Block Grant (PPHF)	$160.000

CDC SPECIFIC ITEMS

CDC DRUG CONTROL PROGRAM AGENCY

Resource Summary

(Dollars in Millions)	FY 2025 Final[1]	FY 2026 Enacted	FY 2027 President's Budget[2,3]
Drug Resources by Function			
Prevention	$23.000	$23.000	$23.000
Total Drug Resources by Function	**$23.000**	**$23.000**	**$23.000**
Drug Resources by Decision Unit			
Consolidated Hepatitis, STI and Tuberculosis Prevention Grant[3]	$23.000	$23.000	$23.000
Total Drug Resources by Decision Unit	**$23.000**	**$23.000**	**$23.000**
Drug Resources Personnel Summary			
Total FTEs (Direct Only)	7	7	7
Consolidated Hepatitis, STD and Tuberculosis Prevention Grant	7	7	7
Drug Resources as a Percent of Budget			
Total Agency Budget[4]	$6,740.322	$6,712.907	$5,484.825
Drug Resources Percentage	0.34%	0.34%	0.42%

[1] FY 2025 Final reflects full year Continuing Resolution level.
[2] In alignment with the proposed HHS reorganization, the FY 2027 Budget realigns funding and activities for Opioid Abuse and Overdose Prevention and Surveillance to the proposed Administration for a Healthy America (AHA) within the Primary Care Pillar.
[3] In alignment with the proposed HHS reorganization, the FY 2027 Budget realigns Infectious Diseases and the Opioid Epidemic (IDO) into a new line, Consolidated Hepatitis, STI, and Tuberculosis Prevention. Estimates are subject to change.
[4] Includes funding from: Prevention and Public Health Fund; PHS Evaluation Transfers, and ATSDR, which the FY 2027 budget realigns to the proposed National Center for Chemicals and Toxins within CDC. Excludes other mandatory funding.

Program Summary

MISSION

CDC is the nation's leading science-based, data-driven, service organization that protects the public's health. Overdose is the leading cause of death for 18–44-year-olds in this country. However, these deaths are preventable using the same data-driven approaches that CDC has used to fight infectious diseases over the last century.

CDC continues to strengthen partnerships with public safety and scale up public health interventions like linking people with substance use disorders to care and increasing access to naloxone to support long-term recovery and reduce associated risks like rising rates of infectious diseases such as hepatitis C. Across the agency, CDC has dedicated efforts to reach those at greatest risk where public health action will have the greatest impact.

METHODOLOGY

CDC determined the drug control budget using the relevant amounts under the Consolidated Appropriations Act, 2026, P.L. 119-75. CDC is committed to an approach that protects the public's health, safety, and well-being, and prevents drug overdose and associated risk factors.

BUDGET SUMMARY

The FY 2027 budget request reflects the proposal to realign the Infectious Diseases and the Opioid Epidemic funding line into the Consolidated Viral Hepatitis, Sexually Transmitted Infections (STIs) and Domestic TB funding line and includes $23 million for drug prevention activities. As the nation continues to respond to the overdose epidemic, it must also stop the rising infectious diseases associated with drug use, such as hepatitis C and other drug-use-associated skin and soft tissue infections.

CDC will assess the impact of the change on CDC's ability to implement the programs, policies, and activities of the National Drug Control Program. CDC programs are implemented with other medical and social services that are vital to preventing disease transmission and improving the health of people who use drugs and their close contacts. With FY 2025 funds, CDC invested nearly $11.1 million in Infectious Diseases and Opioid Epidemic funding to strengthen programs to prevent infectious diseases among people who use drugs in 36 jurisdictions. These efforts were built on investments from prior fiscal years, which fortified the capacity of jurisdictions to prevent infectious disease and enhance community protection.

CDC is working to decrease barriers to prevention and care experienced by people who use drugs to increase access to services that save lives and improve health. These barriers prevent people from seeking help for substance use disorders (including previous negative experiences in healthcare settings). CDC reduces barriers to prevention and care by addressing misinformation, endorsing effective interventions, and promoting awareness of these barriers' impact including among populations disproportionately affected by substance use and overdose. In FY 2025, CDC invested approximately $4.2 million to support evidence-based services that reduce infectious disease morbidity and mortality associated with drug use in high-impact settings.