June 2025

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FY26 Governmental Public Health Appropriations Book

June 17th, 2025

Dear Members of Congress,

The Association of State and Territorial Health Officials (ASTHO) is the *only* national professional society representing public health agencies across states, territories, and freely associated states. ASTHO's members—the chief public health officials of these jurisdictions—have been committed to developing, influencing, and implementing sound, evidence-based public health policies while ensuring excellence in state-based public health practice. Supporting their efforts is a robust network of affiliate organizations, united in their mission to safeguard the public's health and prevent illness and injury.

Federal investment is the cornerstone of public health infrastructure and initiatives. It is essential that Congress provide increased, long-term, sustained, and flexible discretionary funding to strengthen public health preparedness, build up the workforce, modernize data systems, enhance laboratory capacity, and address other critical priorities. Federal funding accounts for nearly half of all state and territorial health department budgets. Therefore, we urge Congress to prioritize and fully fund public health programs in FY26 to ensure the continuation of this vital work.

To support your deliberations, ASTHO has compiled this comprehensive resource outlining the top federal funding priorities and recommendations for public health in FY26. This resource highlights ASTHO's identified appropriations requests and those of organizations listed in the Table of Contents.

We stand ready to collaborate with Congress to address the pressing public health challenges and seize opportunities to improve the health of our nation. Thank you for your leadership and dedication to protecting and promoting the health of all Americans.

If you have any questions or requests, please do not hesitate to contact ASTHO's Senior Director of Government Affairs, Jeffrey Ekoma (jekoma@astho.org).

Sincerely,

Joseph M. Kanter, MD, MPH
Chief Executive Officer
Association of State and Territorial Health Officials

Contents

ASTHO Requests

Affiliate Requests

Organization: Association of State and Territorial Health Officials
Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies
Agency and Office: Centers for Disease Control and Prevention, CDC-Wide Activities and Program Support
Program: Public Health Infrastructure and Capacity

*ASTHO requests that Congress appropriate **$1 billion for the Public Health Infrastructure and Capacity, also known as the Public Health Infrastructure Grant (PHIG),** for FY26, a $650 million increase over the FY25 level.*

PHIG funding enables essential and sustainable upgrades to local and state health departments' infrastructure, workforce, and data systems. This historic investment provides sustainability to public health departments to enable a more responsive and flexible workforce to meet emerging needs and priorities.

Program	FY24 Enacted	FY25 Enacted	FY26 President's Request	FY26 Recommendation
Public Health Infrastructure and Capacity	$350,000,000	$350,000,000	$260,000,000	$1,000,000,000

Justification: A sustained $1 billion investment in the Public Health Infrastructure Grant (PHIG) for FY26 is crucial to ensuring health departments are equipped to address emerging needs, environmental crises, and chronic health disease issues. The "boom-and-bust" cycle of public health funding, in which funds spike during emergencies but drop afterward, has left many departments struggling with outdated technology, hiring challenges, and insufficient workforces and resources. This cycle significantly limits their ability to build long-term resilience and respond to emerging threats. The PHIG program is groundbreaking due to its flexibility that enables jurisdictions to address their communities' most pressing needs.

PHIG's emphasis on workforce development is helping to establish a local talent pipeline. For example, training and retaining professionals, such as epidemiologists, lab scientists, community health workers, and data analysts, has improved the ability to meet public health needs. Many jurisdictions use PHIG to recruit staff to better support the communities they serve, including rural, economically disadvantaged, medically underserved, and minority populations. Investing in scalable, flexible, and interoperable data technologies is essential for daily operations and crisis response. PHIG's commitment to modernizing data infrastructure supports efforts in outbreak detection, chronic disease management, food and water safety, and environmental response.

Program Summary: Administered by CDC, the PHIG program strengthens public health systems by modernizing infrastructure, addressing workforce shortages, and enhancing data capabilities. Launched in 2022, PHIG provides flexible funding to state, local, and territorial health departments, allowing jurisdictions to address their unique needs by braiding supplemental funding with discretionary funding. Unlike traditional grants focused on specific health issues, PHIG offers flexibility for a wide range of public health improvements. This disease-agnostic, adaptable, and sustainable funding approach ensures that states are best equipped to rapidly respond to public health threats and emergencies.

Public Health Impact: After decades of underfunding, public health departments are on the cusp of being able to rebuild and modernize. By 2024, 107 public health departments across states, territories, tribal nations, and major metropolitan areas received PHIG funding, significantly enhancing their capacity and effectiveness. PHIG funding supports efforts to:

- Predict, prevent, and respond to disasters, including those caused by extreme weather and human activity.
- Strengthen foundational public health capabilities, including communication systems, community engagement, and internal operations.
- Address chronic workforce shortages by supporting recruitment, equitable compensation, and training for a skilled workforce.
- Modernize technology, improve interoperability across health departments, hospitals, and federal agencies and enhance staff training.
- Upgrade outdated data systems to improve health threat tracking, reporting, and response.
- Promote health equity by providing resources to address disparities in underserved, rural, and high-risk communities.

For more information visit CDC's website.

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S**ee updates to this paper** on ASTHO's website. Last revised June 2025.

Organization: Association of State and Territorial Health Officials
Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies
Agency and Office: Centers for Disease Control and Prevention (CDC), Office of Readiness and Response
Program: Public Health Emergency Preparedness

*ASTHO requests that Congress appropriate **$1 billion for Public Health Emergency Preparedness (PHEP)** for FY26, a $265 million increase over FY25 funding. PHEP funding reached a peak of $939 million in FY23.*

Funding for PHEP is vital to ensure public health departments can respond effectively to emergencies, minimize the economic and human costs of disasters, support recovery efforts, and establish a resilient infrastructure capable of handling future threats.

Program	FY24 Enacted	FY25 Enacted	FY26 President's Request	FY26 Recommendation
Public Health Emergency Preparedness	$735,000,000	$735,000,000	$350,000,000	$1,000,000,000

Justification: Investing $1 billion in PHEP for FY26 is a strategic measure to protect public health nationwide. Public health systems play a critical role in meeting the needs of at-risk populations, tribal communities, and people with disabilities or limited mobility during crises. State and territorial health agencies ensure the public health of their jurisdictions through their inherent and often legal authority to protect and promote the health, safety, and general welfare of their populations. Health emergencies are costly in terms of both human lives and economic impact. Proactively investing in PHEP helps reduce the long-term costs of emergencies by alleviating hospital pressures, preventing health care system overload, and mitigating economic disruptions.

Program Summary: Since 2002, PHEP funds have helped develop emergency-ready public health departments that can respond to diverse public health threats, including infectious diseases, natural disasters, and biological, chemical, nuclear, and radiological events.

Public Health Impact
Launched in 2025, CDC's Next Generation of PHEP (Next Gen PHEP) initiative aims to strengthen public health preparedness nationwide. Through PHEP, CDC provides annual guidance, technical assistance, and resources to support health departments' strategic planning. Resources include field staff, the monthly PHEP Connects webinar series, and the Online Technical Resource and Assistance Center (On-TRAC). CDC's Response Readiness Framework emphasizes ten priority areas:

- Risk-based all-hazards planning that adapts to evolving threats and supports medical countermeasures.
- Partnership building with federal and nongovernmental organizations to bolster community preparedness.
- Enhancing local public health support for improved jurisdictional readiness.
- Streamlining administrative and budgeting systems for rapid resource access.
- Expanding public health workforce capacity for surge events and staff recruitment.

- Modernizing data systems for situational awareness and improved agency interoperability.
- Strengthening public outreach and communications to share information accurately and counter misinformation.
- Working to reduce health inequities by supporting underserved and rural areas.
- Advancing capacity for laboratory testing and surveillance.
- Focusing on community recovery with lessons learned from past events.
- Funding for climate-related health emergency preparedness, including emergency shelters, surge capacity, and disease prevention systems.

Report Language: The committee provides increased investments to continue enhancing public health departments' ability to develop and maintain capable, flexible, and adaptable public health systems to respond to public health emergencies. America's public health preparedness systems need increased and stable base-funding to rebuild, improve, and continue preparing for future public health emergencies.

For more information visit ASTHO's Preparedness web page and CDC's Emergency Preparedness Program and Guidance web page.

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Organization: Association of State and Territorial Health Officials
Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies
Agency and Office: Administration for Strategic Preparedness and Response (ASPR)
Program: Health Care Readiness and Recovery

*ASTHO requests that Congress appropriate **$500 million for the Health Care Readiness and Recovery** for FY26 — a $260 million increase over the FY25 level. At its peak in FY03, funding was $515 million.*

A $500 million investment in FY26 for Health Care Readiness and Recovery, under which the Hospital Preparedness Program (HPP) falls, is crucial to safeguard public health during disasters. After adjusting for inflation, funding has been reduced by half over the past decade while the demand for emergency preparedness has increased due to prolonged and frequent crises. During a disaster, hospitals and health care facilities must collaborate to overcome unique challenges with coordinated plans and partnerships to save lives.

Program	FY24 Enacted	FY25 Enacted	FY26 President's Request	FY26 Recommendation
Health Care Readiness and Recovery	$240,000,000	$240,000,000	$29,774,000	$500,000,000

Justification: Investing in the Hospital Preparedness Program (HPP), which is part of Health Care Readiness and Recovery, strengthens hospitals' capacity across states, territories, and tribal nations to prepare for and respond effectively to major emergencies and disasters. This program is the only source of funding for health care system readiness and response and is essential to protecting health and saving lives.

Program Summary: Launched in 2003, the HPP provides leadership and funding through cooperative agreements to support hospitals in planning for and managing large-scale emergencies. As the only federal program dedicated to health care system readiness, HPP enhances patient outcomes, reduces dependence on federal and state resources, and enables rapid recovery.

In partnership with state and local health departments, HPP empowers health care delivery systems to respond effectively through Health Care Coalitions (HCCs). These coalitions unite health care and emergency response organizations within a region—such as hospitals, emergency medical service (EMS) providers, and public health agencies—ensuring each member has essential resources, real-time information, effective communication systems, and trained personnel, especially in rural or underserved areas. These HHCs play a critical role in responding to emergency situations and ensuring smooth recoveries in the aftermath.

Public Health Impact: This funding is critical to our nation's public health surge capacity, and supports efforts to:

- Enhance data tracking and emergency communications.
- Develop and maintain emergency plans, conduct training and drills, and strengthen communication among health care and emergency response teams.
- Build medical surge and mass casualty capabilities.
- Procure critical equipment (personal protective equipment (PPE), ventilators, mobile units) and specialized training tools.
- Assist with post-disaster recovery by helping health care facilities restore services and address community health impacts.

Report Language: This funding is critical and provides grants to states to build health care coalitions that enhance regional and local hospital preparedness and improve overall surge capacity in public health emergencies. HPP must continue to fund existing awardees—all states, territories, freely associated states, and four directly funded large cities—as this program is essential to the foundational capabilities of health care preparedness.

For more information visit ASTHO's Preparedness web page.

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Organization: Association of State and Territorial Health Officials and National Association of Chronic Disease Directors
Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies
Agency and Office: Centers for Disease Control and Prevention
Program: Preventive Health and Health Services Block Grant

ASTHO and the National Association of Chronic Disease Directors request that Congress appropriate ***$175 million for the Preventative Health and Health Services (PHHS) Block Grant****, a $15 million increase over FY25.*

PHHS Block Grant aims to enhance public health and promote better health outcomes particularly in areas with significant health disparities.

Program	FY24 Enacted	FY25 Enacted	FY26 President's Request	FY26 Recommendation
Preventive Health and Health Services Block Grant	$160,000,000	$160,000,000	$0	$175,000,000

Justification: A sustained $175 million investment in the PHHS Block Grant is critical to ensuring health departments can meet all jurisdictional public health needs. Grant recipients fill gaps in health departments' critical, evidence-based programs, services, and resources when existing infrastructures are unavailable or inadequate to address chronic disease among other priorities. Chronic disease conditions contribute to poor quality of life and premature death, increased disability, higher health care costs, increased risk of poverty, reduced military readiness, and reduction in economic output.

- Preventable and treatable chronic diseases either cause or are associated with five of the top ten leading causes of death in the U.S.[1]
- More than half of the U.S. population has at least one chronic disease and more than 27% of adults have two or more chronic conditions.[2]

Program Summary: For more than 40 years, CDC's PHHS Block Grant has provided flexible funding for health departments in states, territories, and tribal nations to build, improve, and sustain local public health objectives set by Healthy People 2030. Targeted funds address emerging health issues and gaps, decrease premature death and disability, reduce health disparities, support local departments to improve health metrics, and establish data and surveillance systems. Grant recipients fill gaps in health departments' critical evidence-based programs, services, and resources when existing infrastructure is unavailable or inadequate.

1. Hacker K. The Burden of Chronic Disease. Mayo Clin Proc Innov Qual Outcomes. 2024 Jan 20;8(1):112-119. doi: 10.1016/j.mayocpiqo.2023.08.005. Erratum in: Mayo Clin Proc Innov Qual Outcomes. 2024 Dec 13;9(1):100588. doi: 10.1016/j.mayocpiqo.2024.11.005. PMID: 38304166; PMCID: PMC10830426.
2. Boersma P, Black LI, Ward BW. Prevalence of Multiple Chronic Conditions Among US Adults, 2018. Prev Chronic Dis 2020;17:200130. DOI: http://dx.doi.org/10.5888/pcd17.200130

PHHS Block grant funding complements the Public Health Infrastructure Grant (PHIG). While both provide flexible funding to jurisdictions, the PHHS Block Grant provides work at the program, service, and intervention level. Meanwhile, PHIG funding works at the system level to strengthen health departments, with a focus on meeting workforce, foundational capability, and data modernization needs not met by categorical or disease-specific funding.

Public Health Impact: For decades, the PHHS Block Grant has been instrumental in supporting existing public health programs, implementing new programs, and responding to unexpected emergencies. In 2022, 632 public health agencies improved the capacity of their information systems, 707 agencies improved the efficiency and effectiveness of their operations, programs, and services, 118 emerging public health needs were addressed, and 776 evidence-based public health interventions were implemented.

PHHS Block Grants continue to support health departments by:

- Using evidence-based methods and interventions.
- Reducing risks to population health due to poor nutrition, smoking, and physical inactivity.
- Establishing policy, social, and environmental changes.
- Monitoring and evaluating funded programs.

Partnering Organizations: ASTHO and the National Association of Chronic Disease Directors work closely with many national partners to assure high-quality and consistent approaches to addressing these public health challenges.

For more information visit CDC's website on the Preventive Health and Health Services (PHHS) Block Grant.

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Organization: Association of State and Territorial Health Officials
Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies
Agency and Office: Centers for Disease Control and Prevention, Chronic Disease Prevention and Health Promotion
Program: Social Determinants of Health

*ASTHO requests that Congress appropriate **$153 million for Social Determinants of Health (SDOH)** funding at CDC, a $147 million increase over FY25 levels.*

An individual's health is influenced by a continuous and complex intersection of non-medical factors. Living environments, socioeconomic factors, and education, all play a role in access to medical care, mental health services, substance use disorder services, and health outcomes. Creating healthy environments will reduce rates of chronic disease morbidity and mortality and lower health care costs.

Program	FY24 Enacted	FY25 Enacted	FY26 President's Request	FY26 Recommendation
Social Determinants of Health	$6,000,000	$6,000,000	$0	$153,000,000

Justification: A $153 million investment in SDOH in FY25 is a means to reduce rates of chronic disease, improve health outcomes, reduce health care spending, and ensure opportunities to live healthier.

- According to NIH, people who live in rural areas are more likely to die prematurely from the leading causes of death in the U.S., including heart disease, cancer, lung disease, and stroke.[1]
- People of racial/ethnic minorities are 1.5 to 2.0 times more likely than their white counterparts to have many of the major chronic diseases.[2]
- Chronic diseases are leading causes of death and illness in the U.S. and are leading drivers of the nation's annual $4.1 trillion health care costs.[3]

Program Summary: Launched in 2021, CDC's National Center for Chronic Disease Prevention and Health Promotion has funded 71 recipients in state, county, city, and territorial health departments and organizations to date. These grants enable jurisdictions to improve chronic disease outcomes among people experiencing health disparities. Grantees form implementation-ready Accelerator Plans for programs covering clinical care linkages, built environment, social connectedness, tobacco-free policy, and food and nutrition security.

1. NIH - News in Health
2. NIH: Racial/Ethnic Disparities in Chronic Diseases of Youths and Access to Health Care in the United States
3. Chronic Disease Prevalence in the US: Sociodemographic and Geographic Variations by Zip Code Tabulation Area

Public Health Impact: Clinical care is only one of many factors that impact a person's overall health. Studies estimate that social, economic, and environmental drivers of health can account for 80% of health outcomes, whether positive or negative.[4] Public health programs that reduce health disparities among society's most vulnerable sub-populations are critical in addressing our nation's unrelenting and costly issues associated with chronic disease, access to care, social isolation, adequate nutrition, and tobacco cessation.

This funding targets community resources and encourages public and private sector collaboration to tackle specific issues unique to the communities they serve. For example, the program grants in FY23 (each in the amount of $125,000) went to services related to clinical care linkages and social connectedness in Pennsylvania, Maine, and the Commonwealth of the Northern Mariana Islands, and tobacco-free policy and food and nutrition security programs in North Carolina, New Jersey, and Rhode Island.

For more information visit CDC's website Supporting Communities to Address Social Determinants of Health.

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4. Let's Get It Right: Consistent Measurement of the Drivers of Health

Organization: Association of Immunization Managers (AIM)
Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies
Agency and Office: CDC National Center for Immunization and Respiratory Diseases (NCIRD)
Program: Section 317 Immunization Program

*AIM requests that Congress appropriate **$1.1 billion for the Section 317 Immunization Program** for FY26, a $418 million increase over the FY25 level.*

The Section 317 Program provides funding to 64 state, local, and territorial health agencies to track vaccination rates and vaccine inventory; conduct outbreak response; enroll, educate, and provide vaccines to over 37,000 private physicians in the Vaccines for Children Program (vaccinating millions of children annually); purchase vaccines for uninsured adults; and identify disease incidence and stop transmission of deadly, preventable disease.

Program	FY24 Enacted	FY25 Enacted	FY26 President's Request	FY26 Recommendation
Section 317 Immunization Program	$682,000,000	$682,000,000	$731,933,000	$1,100,000,000

Justification: We are here to ring the alarm bell. America is at a crossroads. Routine childhood vaccine coverage rates are dropping. Adult vaccine rates for diseases like flu, RSV, and shingles are less than optimal. Trust in the institutions manufacturing, approving, recommending, and administering vaccines has eroded. States are facing an onslaught of anti-vaccine legislation often fueled by misinformation. Both public health officials and vaccine providers report being overwhelmed and burned out.

We need this committee's help and leadership to turn this situation around. As of March 27, 2025, a total of 483 confirmed measles cases were reported by 20 jurisdictions Tragically, two people have died. This past flu season was one of the worst in recent memory. There have been at least 41 million illnesses, 540,000 hospitalizations, and 23,000 deaths from flu[1]. This represents both unnecessary suffering and a drag on our economy. And although it doesn't make headlines, there were 20 influenza-associated pediatric deaths reported for a single week in mid-March, bringing the 2024-2025 seasonal total to 159 pediatric deaths.[2]

1. Preliminary Estimated Flu Disease Burden 2024-2025 Flu Season | Flu Burden | CDC
2. Weekly US Influenza Surveillance Report: Key Updates for Week 10, ending March 8, 2025 | FluView | CDC

Program Summary: Currently about half of 317 funding goes to states via:

- **Immunization infrastructure grants** (currently $246 million): funds awarded to 64 immunization programs (all 50 states, the District of Columbia, five large cities, five U.S. territories, and three Pacific freely associated states) to support immunization workforce and systems at the state and local levels to recruit and educate networks of immunization providers, provide continual quality assurance, promote public awareness of new and expanded vaccine recommendations, manage vaccine shortages, and prepare for and respond to vaccine--preventable outbreaks.

- **Vaccine purchase** (currently about $75 million): federally purchased vaccines allocated to the 64 immunization programs to protect non-Vaccines for Children (VFC) Program-eligible populations with routinely recommended vaccines, and to meet urgent needs such as responding to VPD outbreaks. Unlike VFC Program vaccines, for which there are very specific eligibility criteria, Section 317 vaccines can be used to rapidly protect all members of a community when VPD outbreaks occur.
  The remaining $357 million supports:

- **Extramural program operations**: contributes to the systems and workforce that conduct disease surveillance, assess vaccination coverage, perform post-marketing evaluation of vaccine effectiveness and safety, develop and implement immunization information technologies, support centralized vaccine ordering and distribution systems, and create and implement public awareness campaigns and resources, as well as provider education and tools.

- **National program operations**: provides national public health expertise in vaccine-preventable diseases that supports national, state, and local vaccination program efforts, including expertise in epidemiology and surveillance, laboratory methods and science, immunology, immunization policy, health communications science, vaccine management, and program implementation.

Public Health Impact: For each dollar invested in the U.S. childhood immunization program, there are over ten dollars of societal savings and three dollars in direct medical savings. Moreover, CDC estimates that vaccination of children born between 1994 and 2021 prevented 472 million illnesses, 29.8 million hospitalizations, and help avoid 1,052,000 deaths, saving $2.2 trillion in total societal costs. Inadequate vaccination will result in preventable illness, suffering, and death.

For more information visit Vaccines & Immunizations | CDC.

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See updates to this paper on ASTHO's website. Last revised June 2025.

Organization: Association of Maternal & Child Health Programs (AMCHP)
Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies
Agency and Office: Centers for Disease Control and Prevention, Division of Reproductive Health
Program: Safe Motherhood and Infant Health

*AMCHP requests that Congress appropriate **$164 million for the Safe Motherhood and Infant Health Program** for FY26, a $53.5 million increase over the FY25 level.*

The CDC's Safe Motherhood and Infant Health Program supports activities to improve the health of moms and babies before, during, and after pregnancy. This continued investment supports reducing pregnancy-related complications and deaths through data-driven interventions, provider education, and public health partnerships.

Program	FY24 Enacted	FY25 Enacted	FY26 President's Request	FY26 Recommendation
Safe Motherhood and Infant Health	$110,500,000	$110,500,000	$0	$164,000,000

Justification: The United States leads the developed world in rates of maternal mortality. According to the Centers for Disease Control and Prevention (CDC), data show a nearly twofold increase in pregnancy-related deaths from 2019 to 2021. More than 80% of these pregnancy-related deaths in the United States are preventable. Further, CDC released data indicating that the total infant mortality rate in the U.S. increased by 3% from 2021-2022.

$164M for the Safe Motherhood and Infant Health line in FY26 would enable CDC's Division of Reproductive Health (CDC/DRH) to build the national infrastructure for maternal mortality prevention, including Maternal Mortality Review Committees (MMRCs), Perinatal Quality Collaboratives (PQCs), CDC Levels of Care Assessment Tool (LOCATe), and the Hear Her Campaign. Funding will support implementation of multi-level maternal mortality prevention activities in communities with a focus on individuals' first postpartum year. Funding will also support states in leveraging public health infrastructure to ensure pregnant and postpartum women get the right care, in the right place and at the right time.

Program Summary: This portfolio of programs at CDC supports a broad range of activities that seek to improve the health of moms and babies before, during, and after pregnancy. This includes support for the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program, Perinatal Quality Collaboratives (PQCs), CDC's HEAR HER Campaign, and other programs, including Sudden Unexplained Infant Death (SUID) and the Sudden Death in the Young (SDY) Case Registry.

- ERASE MM provides funding, technical assistance, and guidance to state maternal mortality review committees (MMRCs) to most accurately identify the causes of maternal mortality and work across communities to implement solutions. CDC has made 52 awards, supporting 46 states and six US territories for the ERASE MM Program.
- PQCs are state or multi-state networks of teams working to improve the quality of care for mothers and babies. Currently, there are 36 states with CDC-funded PQCs out of 50 total programs.
- CDC's HEAR HER Campaign is a communication campaign to increase awareness of warnings signs that could lead to pregnancy-related death or delivery complications and strengthen patient and provider communication.

Public Health Impact: CDC has made 46 awards, supporting 44 states and two US territories for the ERASE MM Program. This work will:

- Facilitate an understanding of the drivers of maternal mortality and complications of pregnancy and better understand the associated disparities.
- Determine what interventions at patient, provider, facility, system, and community levels will have the most effect.
- Inform the implementation of initiatives in the right places for families and communities who need them most.

Currently, there are 36 states with CDC-funded PQCs out of 50 total programs. PQCs have contributed to the following changes:

- Reduced preterm births.
- Reduced severe pregnancy complications associated with high blood pressure and hemorrhage.
- Reduced cesarean births among low-risk pregnant women.
- Improved screening and treatment for mothers with substance use disorder (including opioids), and affected newborns.
- Improved outcomes by implementing initiatives to address birth equity and improve respectful care.
- Improved connections between clinical and community settings to address nonmedical factors that influence health outcomes.

For more information visit AMCHP's website.

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Organization: Association of Maternal & Child Health Programs (AMCHP)
Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies
Agency and Office: Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities
Program: Surveillance for Emerging Threats to Mothers and Babies

*AMCHP requests that Congress appropriate **$100 million for Surveillance for Emerging Threats to Mothers and Babies (SET-NET)** for FY26, a $77 million increase over the FY25 level.*

SET-NET leverages existing data to enable CDC and state and local health departments to detect emerging health threats to mothers and babies. Findings from SET-NET help families, health care providers, public health professionals, and policymakers take action to save lives, reduce risk, and improve the health of mothers and infants.

Program	FY24 Enacted	FY25 Enacted	FY26 President's Request	FY26 Recommendation
Surveillance for Emerging Threats to Mothers and Babies	$23,000,000	$23,000,000	$23,000,000	$100,000,000

Justification: With $100 million in FY26, Surveillance for Emerging Threats to Mothers and Babies program (SET-NET) could expand to support up to 64 state, local, and territorial health departments as they collect, analyze, and report data on additional existing and emerging infectious disease threats to pregnant women and their babies and broaden the scope of the program. A national SET-NET that collects data in every state and territory would increase the robustness of data available on the impacts of exposures during pregnancy on women, infants, and children. With additional resources, SET-NET could also support academic institutions and clinical networks to conduct mother-baby longitudinal cohort studies to examine the risks, benefits, and adoption of prevention and treatment strategies for specific health threats. Investing in this sustainable framework for rapid, evidence-based data collection will ensure that the United States is prepared to monitor and address the unique health impacts on pregnant individuals and infants during public health emergencies.

Program Summary: SET-NET is an innovative data collection system that leverages existing data sources to enable CDC and health departments to detect the impact of new and emerging health threats on mothers and their babies. Currently, CDC funds 25 state, local, and territorial health departments to monitor the health outcomes of mothers and babies exposed to threats such as syphilis, hepatitis C, congenital cytomegalovirus (CMV), and dengue. Findings from SET-NET help families, health care providers, public health professionals, and policymakers take action to save lives, reduce risk, and improve the health of mothers and infants.

SET-NET collects health information of people exposed to a health threat during pregnancy and their infants over time to understand the effects of emerging and reemerging threats on mother-baby. These data are then used to inform clinical decision-making and public health action.

Public Health Impact: SET-NET data is used to:

- Monitor and improve the health of pregnant people and infants.
- Link families to medical and social services to get recommended care.
- Strengthen laboratory and clinical testing to find emerging health threats quickly.
- Ensure public health is ready and prepared to meet the needs of pregnant people and infants during emergencies.

For more information visit AMCHP's website.

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Organization: Association of Maternal & Child Health Programs (AMCHP)
Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies
Agency and Office: Health Resources and Services Administration, Maternal and Child Health Bureau
Program: Title V Maternal and Child Health Block Grant

*AMCHP requests that Congress appropriate **$1 billion for the Title V Maternal & Child Health Block Grant** for FY26, a $186.3 million increase over the FY25 level.*

The Title V Maternal & Child Health Services Block Grant is the only federal program of its kind devoted solely to improving the health of all mothers, children, and their families. This historic investment into maternal and child health programs works to improve the health of all women, children, and families in their specific communities.

Program	FY24 Enacted	FY25 Enacted	FY26 President's Request	FY26 Recommendation
Title V Maternal & Child Health Block Grant	$813,700,000	$813,700,000	$767,250,000	$1,000,000,000

Justification: According to the Centers for Disease Control and Prevention (CDC), data show a nearly twofold increase in pregnancy-related deaths from 2019 to 2021. More than 80% of these pregnancy-related deaths in the United States are preventable. Further, CDC released data indicating that the total infant mortality rate in the U.S. increased by 3% from 2021-2022. The Title V Maternal & Child Health Services Block Grant is the only federal program of its kind devoted solely to improving the health of mothers, children, and their families. Maternal and child health programs and the maternal and child health workforce need sustained, increased investment to best serve the nation's maternal and child health populations now and into the future.

Title V funds are distributed to state and territorial maternal and child health agencies in 59 states and jurisdictions by formula, which considers the proportion of low-income children in each state. States and jurisdictions must match every $4 of federal Title V money that they receive with at least $3 of state and/or local money.

Public Summary: The Title V Maternal & Child Health Services Block Grant (Title V) is the only federal program of its kind devoted solely to improving the health of all mothers, children, and their families. Statutorily flexible, states and jurisdictions use Title V funds to design and implement a wide range of maternal and child health programs to fit the needs of their specific populations. Although initiatives may vary among the states and jurisdictions, all Title V programs function as chief strategists for maternal and child health initiatives in their respective states, working with local, state, and national partners to ensure people receive an array of most-needed preventive services to avoid more costly chronic conditions later in life, thereby saving federal and state governments money. Title V key priorities include, but are not limited to: significantly reducing maternal morbidity and mortality; reducing infant morbidity and mortality; improving overall maternal health; meeting the nutritional and developmental needs of mothers, children, and families; responding to maternal and child health needs in the context of public health emergencies; increasing breastfeeding rates; ensuring children with special health care needs have a medical home; and increasing the number of adolescents who are getting an annual well-visit.

Public Health Impact: In FY 2023, approximately 95 percent of pregnant women, 99 percent of infants, and 59 percent of children nationally benefitted from a Title V-supported service, translating to improvements in areas such as reducing infant mortality, reducing smoking during pregnancy, and increasing rates of preventive dental visits for children.

Through this program, states are working to reduce infant mortality and maternal mortality; promote preventive services; help individuals access appropriate health care; improve state systems of care; provide wrap-around supports, medical homes, and family-centered, community-based systems of care for children and youth with special health care needs; and more. It is a cost-effective, accountable, and flexible funding source used to address the most critical, pressing, and unique needs of maternal and child health populations in each state, territory, and jurisdiction. In recent years, the Block Grant has also proven to be an effective means of responding to maternal and child health needs during public health crises, including natural disasters such as the recent LA wildfires and 2023 Maui wildfire, the COVID-19 pandemic, and the opioid epidemic.

For more information visit AMCHP's website.

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See updates to this paper on ASTHO's website. Last revised June 2025.

Organization: Association of Public Health Laboratories (APHL) and Council of State and Territorial Epidemiologists (CSTE)
Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies
Agency and Office: Centers for Disease Control and Prevention
Program: Epidemiology and Laboratory Capacity

*APHL and CSTE request that Congress appropriate **$120 million for the Epidemiology and Laboratory Capacity Program (ELC)** base funding line for FY26, an $80 million increase over the FY25 level.*

The ELC program enables a skilled workforce to rapidly detect and respond to health threats across the country. Increasing ELC's base funding line will help address workforce gaps and enhance preparedness for emerging disease threats.

Program	FY24 Enacted	FY25 Enacted	FY26 President's Request	FY26 Recommendation
Epidemiology and Laboratory Capacity Program	$40,000,000	$40,000,000	$40,000,000	$120,000,000

Justification: On average, more than 80 percent of health department epidemiology funds are provided by the federal government, specifically CDC. An important component of that, the ELC program, currently has a base funding line of $40 million from the Prevention and Public Health Fund (PPHF) and is the only source of core infectious disease epidemiology and laboratory capacity in state and local health departments across the U.S. These funds are awarded to 65 state, local, and territorial health departments to efficiently address urgent infectious disease threats, with the flexibility to meet community-specific needs. **The ELC program awards 94 percent of the PPHF funding received directly to state and local health departments**. These investments support approximately **500 highly skilled public health professionals**, protecting our communities on the front lines and allowing them to rapidly detect and respond to infectious disease threats.

In addition to the ELC base funding line, which provides foundational funding to the ELC program to support jurisdictions to hire and retain flexible response ready epidemiologists, more resources are needed for the National Center for Emerging and Zoonotic Infectious Diseases (NCEZID) to fund up to $500 million of existing requests from health departments to the ELC program to support disease detection and response. Disease specific NCEZID funding supports capacity within specific disease program areas (e.g., vector-borne disease, foodborne illness, antibiotic resistance, and health care-acquired infections), and is distributed by the ELC program to jurisdictions. However, this funding is tied to specific diseases, and when a new threat emerges funding is not immediately available for response.

Unfortunately, pandemic-era resources that were allocated to states from CDC and were still being used to support public health efforts, were terminated unexpectedly, putting critical epidemiology work in danger. More than $11 billion in funding was pulled back from states—much of it already allocated to critical services. This immediate loss of existing funding and the fact that the ELC funding line has not grown since 2011—means state and local epidemiology and laboratory efforts across the country are tremendously underfunded.

Recently announced restructuring and reductions in force across the Department of Health and Human Services, including a 2,400 person staff reduction at CDC, will also severely impact public health, including epidemiology and laboratory capacity in states.This includes the ability to respond to current and future infectious disease outbreaks, where often the sole expertise for a particular disease or pathogen belongs to CDC staff.

Public Summary: The ELC base funding line supports a core applied epidemiology, informatics, and laboratory workforce that can work across disease and condition disciplines, which is critical to ensure optimal capacity, coordination, and outbreak needs. An increase for the ELC base funding line in FY 2026 will help mitigate known gaps in our nation's applied epidemiology and laboratory workforce. The national **Epidemiology Capacity Assessment (ECA)** represents the most complete and comprehensive national data on the applied epidemiology workforce. The 2024 ECA, finds that an additional 2,537 epidemiologists (44% increase in staffing) are needed to deliver basic public health services in state health departments alone. More than 8,000 epidemiologists are needed to achieve true public health transformation at (STLT) health departments. These applied epidemiology workforce gaps leave public health unprepared when new threats emerge.

Public Health Impact: As recent years have demonstrated via concurrent outbreaks of novel influenza A(H5N1), measles, tuberculosis, pediatric hepatitis, mpox, Ebola Sudan virus, Marburg, RSV, and other threats, the US remains at high risk for new and emerging diseases. Health departments in every state and territory require epidemiology and laboratory staff to address a wide and increasing range of disease threats.

The ELC program's investments are critical for maintaining a robust public health infrastructure, supporting 65 state, local, and territorial health departments with only $40 million in funding to protect communities from infectious disease threats. Increasing ELC base funding line to $120 million will help to close gaps in the applied epidemiology and laboratory workforce, enhancing the nation's capacity to manage and mitigate public health emergencies.

For more information visit CDC's page on Epidemiology and Laboratory Capacity (ELC) Program.

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Organization: Association of State and Territorial Dental Directors
Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies
Agency and Office: National Center for Chronic Disease Prevention and Health Promotion
Program: Division of Oral Health

Association of State and Territorial Dental Directors requests that Congress appropriate ***$36,250,000 for the Division of Oral Health (DOH)*** *for FY26, a $16,000,000 increase over the FY25 level.*

Funding for the CDC Division of Oral Health supports evidence-based programs in 15 states, data collection at state and national levels, and will allow CDC to identify areas with the greatest need, improve access to effective interventions, and improve care coordination for chronic diseases associated with oral health.

Program	FY24 Enacted	FY25 Enacted	FY26 President's Request	FY26 Recommendation
Division of Oral Health	$20,250,000	$20,250,000	$0	$36,250,000

Justification: Oral health has a direct effect on one's body, mind, emotional, social, and career wellness. Oral diseases, including cavities, gum diseases, and oral cancers, progress and become more complex over time, affecting people at every stage of life. This creates a significant personal and financial burden on individuals, public health systems and dental care systems. Oral diseases are chronic, just like diabetes and high blood pressure. They cause people to lose time from work, affect school performance, and impact some people's ability to get a job or enlist in the military. While CDC provides funding to every State Health Department for cancer; diabetes; cardiovascular diseases; and to support tobacco control programs, it funds less than half of states for oral disease prevention programs. These proposed efforts will allow CDC and states to identify areas with the greatest need, improve access to effective interventions, and improve care coordination for chronic diseases associated with oral health.

Program Summary: The Division of Oral Health (DOH), located in CDC's National Center for Chronic Disease Prevention and Health Promotion, currently receives $20.25 million from Congress to support states and territories to reduce cavities and oral disease rates among different populations. ASTDD strongly recommends an appropriation of $36.25M for the DOH, a $16M increase over the FY24 appropriation. With this increase, $10M would be directed to evaluating and enhancing the nation's surveillance data collection efforts to better identify oral health burden at national, state, and local levels and make data available more quickly. The main tool for tracking state-level oral disease burden is the Basic Screening Survey which focuses on children. Some states have completed screenings in Head Start programs and elder care settings, but this school-administered instrument primarily provides a snapshot of third graders, and occasionally of younger schoolchildren. The DOH is exploring more cost-effective and valid methods to collect data. Current assessments conducted at the state level need enhancement through demonstration projects. This is due to the difficulty in getting permission to conduct surveillance in schools; therefore, exploration of other approaches is warranted to facilitate state level data collection.

Data collection at the state and national levels is critical for strengthening the ability to monitor state oral health conditions and promising preventive dental interventions as well as monitoring the burden of disease across the lifespan in the US and tracking Healthy People 2030 objectives. An additional $2M will enable exploration and evaluation of methods to track adherence to infection prevention and control guidelines for dental settings. $4M of the increase would support educational efforts focusing on medical-dental integration (MDI), a deliberate effort to increase coordination of care that is patient-centered and takes into account a person's oral health as part of their whole-body system.

Public Health Impact:

- Cavities are the most common chronic disease in the United States.
- Over half (52%) of children aged 6 to 8 years have had a cavity in their primary (baby) teeth.
- Almost 1 in 5 (17%) adolescents aged 12 to 19 years have at least one untreated cavity.
- Children aged 5 to 19 years from low-income families are twice as likely (25%) to have cavities, compared with children from higher-income households (11%).
- More than 1 in 4 (27%) adults in the United States have untreated cavities.
- Nearly half (46%) of all adults aged 30 years or older show signs of gum disease; severe gum disease affects about 9% of adults.
- On average, over 34 million school hours and 92 million work hours are lost yearly because of unplanned (emergency) dental care.
- Over $45 billion is lost in productivity in the US each year because of untreated oral disease.
- The US health care system could save up to $100 million a year if dental offices screened patients for diabetes, high blood pressure, and high cholesterol and referred them for treatment.
- Nearly 18% of working-age adults report that the appearance of their mouth and teeth affects their ability to interview for a job. For those with low incomes, the percentage increases to 29%.
- Oral health has been linked with other chronic diseases, like diabetes and heart disease. Oral disease is also associated with risk behaviors like using tobacco and consuming sugary foods and beverages.

For more information visit ASTDD.org.

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Organization: National Association of Chronic Disease Directors

Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies

Agency and Office: Centers for Disease Control and Prevention

Program: National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity

National Association of Chronic Disease Directors requests that Congress appropriate ***$125 million for the Division of Nutrition, Physical Activity, and Obesity (DNPAO)*** *for FY26, a $66.58 million increase over the FY25 level.*

A sustained and sufficient level of investment in nutrition and physical activity interventions through state-based public health programs can improve health outcomes, quality of life, and help individuals maintain optimal health at every age.

Program	FY24 Enacted	FY25 Enacted	FY26 President's Request	FY26 Recommendation
Division of Nutrition, Physical Activity, and Obesity	$58,420,000	$58,420,000	$0	$125,000,000

Justification: An increase in funding in FY 2025 for the Division of Nutrition, Physical Activity, and Obesity (DNPAO) will continue efforts to improve nutrition and increase physical activity across the lifespan, with a special focus on young children ages 0-5 years. Currently, only 17 states receive funding to support physical activity and healthy eating through state-based public health programs. Public health programming per capita expenditure is approximately $0.25, far below the estimated $1,429 per capita cost of obesity-related medical care.

A sustained and sufficient level of investment in nutrition and physical activity interventions through state-based public health programs can improve health outcomes, quality of life, and help individuals maintain optimal health at every age. The CDC directs funding to evidence-based interventions that promote nutrition and physical activity and obesity prevention, including increasing access to healthy food and beverages, increasing physical activity access and outreach, designing communities that support safe and easy places for people to walk, improving nutrition and increasing physical activity in Early Care and Education (ECE) settings, and improving support for mothers who choose to breastfeed.

Program Summary: Despite the proven health benefits of physical activity, only half of American adults and about a quarter of adolescents get enough aerobic physical activity to maintain good health and avoid disease. Physical activity saves lives, saves money, and protects health. If Americans met the recommended physical activity levels, one in ten premature deaths could be prevented. In addition, meeting physical activity recommendations could prevent:

- $117 billion in annual healthcare expenditures.
- 1 in 8 cases of breast and colorectal cancers.
- 1 in 15 cases of heart disease.

Obesity rates are still too high. Nationally, 42% of adults and 19% of all children and adolescents (ages 2 to 19 years) have obesity. Over the last two decades, obesity rates for adults over 60 have been steadily increasing from 24% in 1988-1994 to almost 43% in 2017-2018.

Obesity costs the U.S. healthcare system $147 billion a year. Obesity and related chronic diseases cost employers up to $93 billion per year in health insurance claims. Persons with obesity are at higher risk for hypertension, high cholesterol, type 2 diabetes, heart disease, certain cancers, and early death. Obesity also negatively impacts our nation's businesses, economy, and military readiness. Nearly 1 in 4 young adults are too heavy to serve in our military.

Public Health Impact: At $125 million, DNPAO and states will:

- Reduce the age-adjusted proportion of adults who are obese.
- Reduce the proportion of children and adolescents (ages 2 through 19) who are obese.
- Increase the contribution of vegetables to the diets of the population ages 2 years and older (cup equivalents per 1,000 calories).
- Increase the proportion of adults who engage in physical activity.
- Increase in the number of states with nutrition standards for foods and beverages provided in early care and education centers.
- Increase the number of states with physical education standards that require children in early care and education centers to engage in vigorous- or moderate-intensity physical activity.
- Increase the proportion of infants who are breastfed at 6 months.

Supporting Organizations: NACDD works closely with many national partners to ensure high-quality and consistent approaches to address public health challenges. These include the American Diabetes Association, American Heart Association, YMCA of the USA, and many others.

For more information visit chronicdisease.org.

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See updates to this paper on ASTHO's website. Last revised June 2025.

Organization: Association of Public Health Laboratories (APHL), Association of State and Territorial Health Officials (ASTHO), Council of State and Territorial Epidemiologists (CSTE), and National Association for Public Health Statistics and Information Systems (NAPHSIS)

Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies

Agency and Office: Centers for Disease Control and Prevention

Program: Public Health Data Modernization

*ASTHO, APHL, CSTE and NAPHSIS request that Congress appropriate **$340 million for Public Health Data Modernization** for FY26, a $165 million increase over the FY25 level.*

Public Health Data Modernization upgrades critical data systems nationwide that provide the ability to detect, track, and respond to health threats in real time. This investment strengthens public health resilience and equips health departments to protect communities against routine and emerging crises.

Program	FY24 Enacted	FY25 Enacted	FY26 President's Request	FY26 Recommendation
Public Health Data Modernization	$175,000,000	$175,000,000	$175,000,000	$340,000,000

Justification: CDC's Public Health Data Modernization is a commitment to building a world-class data workforce and systems to meet the nation's ongoing responsibility to safeguard health. Public Health Data Modernization is not just an emergency response need for jurisdictions and CDC; it is necessary for rapidly identifying, tracking, and responding to daily public health threats of all types—acute, chronic and emerging. As technology evolves, our public health data systems—like all technology—must continuously adapt, requiring ongoing updates and training for staff.

Providing adequate yearly funding to state, territorial, local, and Tribal (STLT) health departments through CDC's Data Modernization is a key investment for the continuous improvement of our public health data infrastructure. In fact, the Data: Elemental to Health Campaign estimates it will cost at least $7.8 billion over five years at the STLT levels **alone** to truly modernize our public health data infrastructure.

By supporting the CDC, Congress directly impacts every state and local public health jurisdiction's ability to keep their communities safe. So far, Congress has provided more than $1 billion for Data Modernization. Lack of consistent future funding will halt progress, and cause health departments to move backwards or even lose capability to understand when and where diseases are occurring.

CDC is streamlining its existing data platforms into the One CDC Data Platform (1CDP), a scalable and secure system that strengthens real-time data integration across jurisdictions. The Response Ready Enterprise Data Integration (RREDI) platform enhances pandemic preparedness by managing diverse data sources, while the Center for Forecasting and Outbreak Analytics (CFA) leverages predictive analytics to improve outbreak response. Without sustained, separate investment in each of these components, public health agencies risk stagnation, leaving communities vulnerable to emerging threats.

Recently, pandemic-era resources that were allocated to states from CDC and were being used to support data modernization efforts, were terminated unexpectedly, putting critical upgrades in danger. More than $11 billion in funding was pulled back from states. While the impact varies by state some states many have lost more than $100 million and have already laid off staff or cancelled contracts. This includes federally funded projects that may now remain incomplete, squandering the initial investment. Restructuring and reductions in force across HHS, including a 2,400 person staff reduction at CDC, will also severely endanger public health data modernization in states as a skilled workforce is required to operate and maintain these systems.

Program Summary: CDC's Public Health Data Modernization focuses on building a standards-based, interoperable infrastructure to facilitate seamless communication and data sharing across systems. This modernization enhances information storage and sharing, enabling timely detection, reporting, and targeted responses to protect communities most impacted by public health threats.

The initiative is built on five core pillars:

1. **Electronic Case Reporting (eCR)** – Automates disease reporting from electronic health records, streamlining early intervention efforts to limit the spread of infectious agents.
2. **Electronic Vital Records System** – Spanning 57 jurisdictions, it enables secure electronic collection of birth and death data, ensuring timely, accurate vital statistics crucial for tracking health crises and reducing preventable deaths.
3. **Laboratory Information Systems** – Includes the Laboratory Response Network (LRN) and Electronic Laboratory Reporting (ELR), which enhance the collection, management, and sharing of lab data, empowering rapid responses to biological, chemical, and other emergencies.
4. **National Notifiable Disease Surveillance System (NNDSS)** – Collects critical case investigation data nationwide to create a comprehensive view of disease burden, essential for effective outbreak response.
5. **Syndromic Surveillance** – Provides near real-time emergency department data to quickly detect and monitor community health incidents, including pandemics, natural disasters, and opioid overdoses.

Public Health Impacts: Continuous investment in these crucial activities is essential to ensure the strength and resilience of the nationwide public health system. Public health action by STLT public health authorities and CDC facilitates interventions to prevent the spread of infections, reduce morbidity and mortality, and improve health across the entire population. **Modernizing public health data systems is a strategic investment to facilitate automated reporting between health care organizations and public health entities—making health care providers jobs easier!** Recent health threats have revealed significant gaps in public health data systems, prompting Congress to provide crucial supplemental funding for essential upgrades. Sustained, long-term funding will equip public health officials to respond to future threats.

For more information visit CSTE.org.

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See updates to this paper on ASTHO's website. Last revised June 2025.

Organization: National Association for Public Health Statistics and Information Systems (NAPHSIS)
Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies
Agency and Office: Centers for Disease Control and Prevention
Program: National Center for Health Statistics

*NAPHSIS requests that Congress appropriate **$220 million for the National Center for Health Statistics (NCHS)** for FY26, a $32.6 million increase over the FY25 level.*

The National Center for Health Statistics collects and analyzes vital records to monitor public health trends and improve health programs. Modernizing these systems will enhance data accuracy and timeliness, benefiting public health monitoring and reducing waste, fraud, and abuse in federal programs.

Program	FY24 Enacted	FY25 Enacted	FY26 President's Request	FY26 Recommendation
National Center for Health Statistics	$187,397,000	$187,397,000	$175,000,000	$220,000,000

Justification: NCHS data have long been the gold standard for measuring health status and changes in health outcomes for Americans and identifying emerging health issues for the United States. Vital records—birth, death, marriage, and divorce data—are a critical pillar of public health data and are in urgent need of modernization. NCHS faces the challenge of continuing to provide essential data while also making necessary upgrades to bring vital records into the 21st century. An increased investment in NCHS of $220 million will improve vital records collection and improve the timeliness of data through systems modernization and staff training and capacity.

Program Summary: NCHS is the nation's principal health statistics agency, whose mission is to provide information that will guide actions and policies to improve the health of the American people. Consistent with the constitutional framework set forth by our founding fathers in 1785, states were assigned certain powers—one of which is the collection of vital records data. NCHS then collects vital records information from the 57 vital records jurisdictions across the country. These records are permanent legal documents of life events and are crucial for monitoring public health trends, developing health programs, and evaluating their effectiveness.

The 57 vital records jurisdictions, not the federal government, have legal authority for the registration of these records, which are thus governed under state laws. The laws governing what information may be shared, with whom, and under what circumstances vary by jurisdiction. In an example of effective federalism, the vital records jurisdictions provide the federal government with data collected through birth and death records to compile national health statistics, facilitate secure Social Security number (SSN) issuance to newborns through the Enumeration at Birth (EAB) Program, and report individual deaths.

Public Health Impact: Vital records are essential for public health, civil registration, and administration. These data are used to monitor disease prevalence and trends and our nation's overall health status, develop programs to improve public health, and evaluate the effectiveness of those interventions. However, the process needs technology and systems upgrades. For example, the mechanisms to report deaths—whether by a state medical examiner, coroner, hospital, physician, or other provider—are not interconnected with a patient's medical record or electronic health record (EHR) and require reporters to enter data twice into two different systems or worse, still rely on fax machines. The National Vital Statistics System (NVSS) has been modernized thanks to the enduring support and leadership of Congress, but ongoing improvements are required. NCHS has funded states and territories to speed the release of birth and death statistics, including infant mortality and prescription drug overdose deaths. In fact, the percentage of mortality records reported within 10 days has increased from less than 10 percent in 2010 to 68 percent in 2022.

More granular and timely data products are needed to understand the broader influences on health, especially chronic conditions. With additional resources, NCHS could increase sample sizes in the agency's signature surveys and build NCHS's new Model-Based Early Estimates (MBEE) program to help with both timeliness and region- or population- specific statistics. Funding is also needed to support the new NCHS Rapid Surveys System (RSS), which addresses decision makers' need for time-sensitive data about emerging and priority health concerns.

NCHS funding will also help us better understand America's chronic disease epidemic. The National Health and Nutrition Examination Survey (NHANES) is the only national survey that includes health exams and lab tests combined with dietary interviews. NHANES monitors the health and nutritional status of both adults and children, providing essential health statistics. It can also detect undiagnosed chronic diseases, such as diabetes, allowing for interventions that could improve chronic disease outcomes. With increased investment NCHS can reach a greater population of individuals through NHANES Mobile Exam Centers increasing our knowledge of nutrition and chronic conditions.

For more information visit National Center for Health Statistics and Friends of NCHS: Resources.

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Organization: National Alliance for State and Territorial AIDS Directors (NASTAD)
Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies
Agency and Office: Centers for Disease Control and Prevention
Program: Division of HIV Prevention

*NASTAD requests that Congress appropriate **$1,217,000,000 for the Division of HIV Prevention (DHP)** for FY26, a $242.1 million increase over the FY25 level.*

Reducing new HIV diagnoses is critical to improving health outcomes. While prevention strategies have driven progress, persistent disparities remain. Sustained, focused investments in HIV prevention are essential to build on current progress and close these persistent gaps.

Program	FY24 Enacted	FY25 Enacted	FY26 President's Request*	FY26 Recommendation
Division of HIV Prevention	$975,600,000	$975,600,000	--	$1,217,000,000

Justification: NASTAD requests that Congress appropriate $1.217 billion for CDC's Division of HIV Prevention (DHP) in FY26 to strengthen the nation's HIV prevention infrastructure and sustain progress toward ending the HIV epidemic. With recent advances in science and health policy, the United States has an unprecedented opportunity to achieve large-scale, measurable progress in a short timeframe. Increased investment in the DHP program—particularly for the 60 state, territorial, and local health departments it funds—is essential to reaching national HIV prevention goals and improving health outcomes in communities most impacted by HIV.

DHP is the federal government's primary investment in HIV prevention infrastructure, supporting testing, surveillance, pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) access, and community-based prevention. In many jurisdictions, DHP funds are the only sustained source for these services. Health departments also serve as key coordinators of broader infectious disease response. During outbreaks of mpox, meningitis, and hepatitis, HIV prevention programs were often repurposed to support emergency response—demonstrating their adaptability but also highlighting how thinly stretched this infrastructure can become. Despite limited resources, many departments launched innovative approaches such as at-home HIV testing and telePrEP to maintain care access. To scale and sustain these innovations, federal investment in HIV prevention capacity must grow.

DHP funds also enhance and sustain efforts launched through Ending the HIV Epidemic: A Plan for America (EHE), which supports 57 priority jurisdictions with the goal of reducing new transmissions by 90% by 2030. Between 2019 and 2023, new HIV diagnoses declined by 21% in EHE jurisdictions, compared to 6% in non-EHE areas. These results show that targeted, resourced strategies work—but only when supported by ongoing investment. DHP plays a critical role in scaling EHE-aligned activities nationwide, particularly in advancing testing, care linkage, and access to PrEP and PEP.

*The President's FY26 budget request proposes moving $220 million for the Ending the HIV Epidemic to the Administration for a Healthy America and eliminating all HIV Prevention and Research Funding.

CDC's DHP program underpins our national HIV prevention system. It enables state and local health departments to serve as central hubs of innovation, equity, and rapid response. Additional investment will preserve the progress made, ensure resilience in the face of future public health emergencies, and bring us closer to ending the HIV epidemic.

Program Summary: CDC's *High-Impact HIV Prevention and Surveillance Programs for Health Departments* (PS24-0047) announced in 2024, reaffirms the agency's commitment to high-impact, science-based HIV prevention and surveillance. CDC provided first-year awards of $485 million, and the new five-year funding cycle began on August 1, 2024. Funding is allocated by formula to eligible state and local health departments, which may issue subawards to local health agencies and community-based organizations. Program focus areas include HIV testing, partner services, surveillance, increasing PrEP and PEP uptake, support linkage to care and viral suppression efforts, and addressing outbreaks. Health departments are central to coordinating federal, state, and local HIV prevention efforts and serve as essential partners in achieving national goals.

A standout success of the EHE initiative is the Together TakeMeHome program, which provides free, mailed HIV self-test kits nationwide and distributed over 444,000 kits in its first year—more than double its initial goal. The program effectively reached first-time testers and communities disproportionately impacted by HIV. Nearly 50% of orders came from EHE-prioritized areas, demonstrating the power of innovative, community-driven strategies to expand access to HIV testing.

Public Health Impact: More than 1.2 million people are living with HIV in the U.S. While prevention strategies have driven progress, persistent disparities remain. From 2017 to 2021, HIV diagnoses declined by 12% overall, including a 10% decline among women. However, annual diagnoses have plateaued at approximately 36,000 per year since 2013. During the same period, the percentage of people aware of their HIV status increased only slightly—from 86% to 87%—and only 66% of people diagnosed with HIV achieved viral suppression. These gaps are even more pronounced in the South and among Black, Latino, and transgender communities.

Sustained, focused investments in HIV prevention are essential to build on current progress and close these persistent gaps. CDC's Domestic HIV Prevention and Surveillance program is the agency's largest HIV investment, and one of the most critical levers to reduce new transmissions, advance health equity, and ultimately end the epidemic.

Reduction in Force (RIF) Impact: The recent RIF at CDC has significantly affected DHP, leading to the loss of critical staff, expertise, and institutional capacity. These reductions jeopardize the ability of DHP to provide technical assistance, monitor national surveillance systems, and support innovation in HIV prevention. Health departments rely on DHP staff not only for guidance on data and program implementation, but also to coordinate urgent responses to emerging public health needs. Without adequate staffing and sustained funding, DHP's ability to fulfill its core mission—and to support jurisdictions working to end the HIV epidemic—is at serious risk.

For more information visit NASTAD.org

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Organization: National Alliance for State and Territorial AIDS Directors (NASTAD)
Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies
Agency and Office: Health Resources and Services Administration
Program: Ryan White Part B and AIDS Drug Assistance Program

*NASTAD requests that Congress appropriate **$1,488,300,000 for the Ryan White Part B and AIDS Drug Assistance Program (ADAP)** for FY26, a $123.4 million increase over the FY25 level.*

The Ryan White Program Part B and ADAP funds jurisdictions to provide care, treatment, and support services for low-income uninsured and underinsured people living with HIV. With these funds, states and territories provide access to HIV clinicians, life-saving and life-extending therapies, and a full range of vital coverage completion services.

Program	FY24 Enacted	FY25 Enacted	FY26 President's Request	FY26 Recommendation
Ryan White Part B (Care & ADAP)	$1,364,900,000	$1,364,900,000	$1,364,878,000	$1,488,300,000

Justification: The Ryan White HIV/AIDS Program (RWHAP) Part B is a cornerstone of the nation's HIV care and treatment infrastructure. It provides grants to all 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and five U.S. Pacific Territories/ Associated Jurisdictions to deliver critical HIV care, medications, and support services to low-income people living with HIV (PLWH) who are uninsured or underinsured. Through the AIDS Drug Assistance Program (ADAP), states ensure access to life-saving antiretroviral therapy (ART) medications and treatment adherence support for individuals with no or limited health coverage.

The cost of care continues to rise and caseloads are growing. RWHAP Part B programs are also increasingly affected by changes in the broader health coverage landscape. While Medicaid expansion under the Affordable Care Act helped increase coverage for many PLWH in some states, others—especially in non-expansion states—continue to rely heavily on Ryan White for access to care and medications. Moreover, RWHAP has stepped in to support insurance purchasing, care coordination, and services not typically covered by other payers, including medical transportation and case management.

Any future reductions, restrictions, or instability in Medicaid or other safety net programs—whether due to eligibility rollbacks or administrative barriers—could dramatically increase the number of PLWH who depend on RWHAP for essential services. Without reliable coverage, more individuals will turn to Ryan White Part B and ADAP to access HIV treatment, medications, and wraparound supports. Sustained and increased federal funding is critical to ensure the program can absorb this increased demand and continue to close gaps in care and coverage for vulnerable populations.

Program Summary: RWHAP Part B awards include base grants, ADAP Base and Supplemental funds, and a Part B Supplemental award for states with demonstrated need. HRSA requires that at least 75% of funds be used for core medical services, including outpatient HIV care, ADAP, oral health, health insurance assistance, and case management. Support services—such as medical transportation and non-medical case management—must be tied to improved health outcomes.

The Ryan White Program served more than 576,000 people in 2023—over half of the PLWH in the U.S. Among clients receiving HIV medical care, 90.6% achieved viral suppression, a critical metric for both individual and community health. This represents a dramatic improvement from 69.5% in 2010 and underscores the effectiveness of the RWHAP in improving health outcomes, particularly among communities facing continued barriers to care.

RWHAP Part B also plays a central role in advancing the goals of the Ending the HIV Epidemic in the U.S. (EHE) initiative. Funded jurisdictions have implemented innovative service delivery models, expanded telehealth, improved linkage to care, and supported rapid access to ART. These efforts directly support EHE's aim to reduce new HIV transmissions by 90% by 2030. The high rates of viral suppression achieved through Ryan White Part B demonstrate the program's essential role in achieving these national goals.

Public Health Impact: The Ryan White Program remains one of the most effective tools for reducing HIV-related morbidity, mortality, and transmission. Scientific evidence confirms that individuals who are durably virally suppressed do not sexually transmit HIV. By providing access to ART, care coordination, and adherence support, RWHAP Part B and ADAP are key to reaching and maintaining viral suppression at scale.

Despite major progress, structural inequities persist. Many communities continue to face intersecting barriers—including poverty, lack of insurance, unstable housing, and stigma—that prevent timely access to care and treatment. Without increased federal funding, states and territories will be unable to meet growing demand or address gaps in access to health care. Sustained investment in Ryan White Part B is essential to protect the gains made, reduce disparities, and continue progress toward ending the HIV epidemic in the United States.

Reduction in Force (RIF) Impact: The HIV/AIDS Bureau (HAB) at HRSA has not been immune to recent federal staffing reductions, with RIF-related losses further straining their capacity to manage grants, provide technical assistance, and support the delivery of care through the RWHAP. These staffing cuts come at a time when the demand for services continues to grow and program needs are increasingly complex. Concurrently, the proposed transition of HAB into the newly envisioned Administration for Healthcare Accessibility (AHA) raises concerns about preserving the integrity and community-centered focus of the Ryan White Program. Any administrative restructuring must ensure that HAB's mission, workforce expertise, and connection to the HIV community are protected. Increased and sustained funding is essential to stabilize the program, support remaining staff, and safeguard access to comprehensive HIV care.

For more information visit NASTAD.org.

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See updates to this paper on ASTHO's website. Last revised June 2025.

Organization: National Alliance for State and Territorial AIDS Directors (NASTAD)
Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies
Agency and Office: Centers for Disease Control and Prevention
Program: Division of Viral Hepatitis Prevention

*NASTAD requests that Congress appropriate **$150 million for the Division of Viral Hepatitis Prevention (DVHP)** for FY26, a $107 million increase over the FY25 level.*

CDC's Division of Viral Hepatitis Prevention has been underfunded for decades, and recent increases in the number of new hepatitis B and C cases place a new urgency for increasing funding to these programs. Increasing funding would allow CDC's hepatitis program to enhance existing programs, build up clinical capacity, and create new programs.

Program	FY24 Enacted	FY25 Enacted	FY26 President's Request*	FY26 Recommendation
Division of Viral Hepatitis Prevention	$43,000,000	$43,000,000	$0	$150,000,000

Justification: NASTAD requests that Congress appropriate $150 million for CDC's Division of Viral Hepatitis Prevention in FY26—a $107 million increase over the FY25 enacted level. This investment is critical to support the public health infrastructure that prevents, detects, and responds to viral hepatitis across the country.

For decades, DVH has been chronically underfunded, despite viral hepatitis being one of the most deadly and preventable infectious diseases in the U.S. In many jurisdictions, federal funding through DVH is the only dedicated source of support for hepatitis surveillance, outbreak response, prevention, and linkage to care. Health departments rely on this funding to build and maintain capacity to monitor hepatitis trends, investigate outbreaks, prevent perinatal hepatitis B transmission, and engage populations disproportionately impacted.

Critically, we have the tools to eliminate viral hepatitis: hepatitis A and B are vaccine-preventable, and hepatitis C virus (HCV) is curable with well-tolerated, short-course antiviral treatment. But without adequate funding, health departments cannot scale up testing, vaccination, and treatment programs to reach communities most impacted.

CDC's Integrated Viral Hepatitis Surveillance and Prevention Program (IVHSP) funds 59 jurisdictions to build core infrastructure and deliver community-informed, equitable prevention strategies. It also supports collaboration with community-based partners—particularly critical in responding to the ongoing intersection of viral hepatitis and the opioid crisis. As we continue to see hepatitis B and C transmission through shared injection equipment, federal investment in DVH remains essential to reduce transmission, expand testing and vaccination, and reach people with limited access to care.

*The Administration is proposing $300 million to support a new consolidated grant program that will allow states to have more flexibility when addressing sexually transmitted infections, viral hepatitis, and tuberculosis.

Sustained and increased DVH funding would allow CDC to expand hepatitis screening and vaccination initiatives, improve data systems and workforce capacity, support community partnerships, and advance national goals to eliminate viral hepatitis as a public health threat by 2030.

Program Summary: Fifty-nine jurisdictions currently receive DVH funding through the IVHSP cooperative agreement. This program provides critical infrastructure to support hepatitis surveillance, outbreak detection and response, perinatal hepatitis B prevention, and access to testing, treatment, and vaccination services. State and local health departments use this funding to implement tailored prevention strategies, strengthen provider and community engagement, and coordinate across health and clinical systems.

In most states, the health department is the only government-funded entity dedicated to hepatitis prevention and control. Additional federal investment is necessary to fully implement CDC's universal screening and vaccination recommendations, expand access to care, and address longstanding poor health outcomes that impact people living with or impacted by hepatitis B and C.

Public Health Impact: Viral hepatitis remains one of the most deadly and underdiagnosed infectious diseases in the U.S. According to CDC's 2024 National Viral Hepatitis Progress Report, an estimated 67,600 new HCV infections occurred in 2022—nearly twice the national reduction target. While progress has been made in reducing hepatitis B virus (HBV) incidence among some populations, the HBV-related mortality rate remained elevated, at 0.44 deaths per 100,000, exceeding the national goal of 0.39. Hepatitis B-related deaths were 8.5 times higher among non-Hispanic Asian and Pacific Islander persons than among non-Hispanic White persons. Additionally, CDC reported 93,805 newly identified chronic HCV cases in 2022.

Disparities in new infections and outcomes remain stark. Acute HBV rates among non-Hispanic Black persons increased by 11.1% between 2021 and 2022, and HCV transmissions continue to increase among people who inject drugs, particularly younger adults. In many jurisdictions, people aged 15 to 29 now account for more new hepatitis C cases than any other age group. These outcomes are especially troubling given that safe, effective vaccines are available for hepatitis A and B, and HCV is fully curable. With adequate investment, the public health system has the tools to prevent every case of hepatitis A and B and cure nearly every person living with HCV.

Increasing funding for DVH would ensure that state and local health departments have the tools they need to prevent infections, reduce disparities, and make measurable progress toward national viral hepatitis elimination goals.

Reduction in Force (RIF) Impact: As part of the recent CDC RIF, the DVH laboratory was closed—eliminating a key federal resource used to support outbreak response, genotyping, and surveillance. The DVH lab played a vital role in detecting transmission patterns, investigating clusters, and validating diagnostic tools used by health departments and partner labs across the country. Its closure significantly reduces national capacity to track HBV and HCV infections and undermines efforts to rapidly respond to emerging threats. This loss further underscores the urgent need for increased DVH funding to rebuild essential infrastructure and maintain core public health functions.

For more information visit NASTAD.org.

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Organization: National Coalition of STD Directors

Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies

Agency and Office: Centers for Disease Control and Prevention

Program: Sexually Transmitted Infections

*National Coalition of STD Directors requests that Congress appropriate **$322,500,000 for CDC's Division of STD Prevention (DSTDP)** for FY26, a $148,190,000 increase from the FY25 level.*

The CDC's Division of STD Prevention (DSTDP) works to prevent and reduce Sexually Transmitted Infections (STIs) and associated health burdens. DSTDP achieves this goal by advancing science-based public health interventions that focus on surveillance, prevention, diagnosis, and treatment.

Program	FY24 Enacted	FY25 Enacted	FY26 President's Request*	FY26 Recommendation
Sexually Transmitted Infections	$174,310,000	$174,310,000	--	$322,500,000

Justification: The $322,500,000 funding request is crucial to enable awardees to build upon existing programs and not lose ground in the fight against STIs as well as address the high incidence and the chronic aspects of many of these diseases. In 2023, after more than 20 years of funding declines, federal funding, while still below the level of need, returned to the 2003 level. Adjusted for inflation, programs have lost more than 40 percent of their purchasing power over that timeframe. This funding increase would enable State and local health departments to help offset some of the disease intervention specialist (DIS) positions lost by the rescission of COVID-19 funds in the Fiscal Responsibility Act. Building on a congressional directive instructing DSTDP to hold harmless health departments' STI prevention and control funding levels, the request includes $98,000,000 for Strengthening Sexually Transmitted Disease Prevention and Control for Health Departments (STD PCHD), providing State and local health departments with a larger percentage of funding to address rising STI rates, plan for future outbreaks, and provide grantee training and technical assistance. The requests would also support coordination with other agencies; find innovative approaches to respond to the spread of STIs, including telehealth, point of care and over-the-counter testing; and increased screening and treatment, especially in areas with higher risks of poor healthcare access and outcomes.

Program Summary: DSTDP partners with all 50 State health departments and seven large urban areas to support STI prevention and surveillance. Funds are awarded to State and city health agencies through an STI morbidity-based formula. Because of the hold-harmless language contained in previous appropriations bills, no jurisdiction receives less than it did in the prior year. This funding is used by health agencies to support STI monitoring, outbreak response, assurance of appropriate screening and treatment by healthcare providers, contact tracing (DIS), linkage to care, and providing STI prevention information to the general public. In most jurisdictions, the State health agency is the sole entity doing this essential work.

*The Administration is proposing $300 million to support a new consolidated grant program that will allow states to have more flexibility when addressing sexually transmitted infections, viral hepatitis, and tuberculosis.

Public Health Impact: STIs pose a significant public health threat, with rising cases in the US and across the globe. Alarming increases, especially among young adults and certain underserved populations, the rise on congenital syphilis cases, and the increase in infertility rates, highlight the need for additional funding, routine testing, and comprehensive sexual health services. Without intervention, the continued surge in STI cases will lead to serious health complications and place further strain on healthcare systems. In 2023, the US reported: Kansas Attorney General used KS-VDRS to form a Youth Suicide Prevention Task Force. The task force used KS-VDRS data and CDC suicide prevention resources to develop eight recommendations for the state. Because of these recommendations, the attorney general's office appointed a legislatively mandated Youth Suicide Prevention Coordinator and is developing a suicide prevention mobile application to provide youth with mental health resources.

- 2.4 million cases of syphilis, gonorrhea, and chlamydia.
- 209,000 syphilis cases, a one percent rise compared to 2022.
- 3,882 congenital syphilis cases, up 3 percent from 2022, (a 32 percent increase from 2021-2022).
- 600,000 gonorrhea cases.
- 1.6 million chlamydia cases.

Report Language: *Sexually Transmitted Infections (STIs)* - The Committee has included $322,500,000 to address the high incidence of STIs and the chronic aspects of many of these diseases. The Committee recommends that CDC provide State and local entities with a larger percentage of STI funding to address the increasing rates of STIs as well as plan for future outbreaks. Within the fund provided, no less than $98,000,000, of the fund provided, shall be for Strengthening Sexually Transmitted Disease Prevention and Control for Health Departments (STD PCHD) and training and technical assistance grantees.

The Committee also encourages CDC to work with other agencies, as appropriate, to develop innovative approaches to respond to the spread of STIs, including telehealth, point of care and over-the-counter testing, to increase screening and treatment, to curb the spread of STIs, especially in areas with higher risks of poor healthcare access and outcomes.

For more information visit NCSDDC.org.

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Organization: Safe States Alliance
Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies
Agency and Office: Centers for Disease Control and Prevention
Program: Core State Injury Prevention Program

*Safe States Alliance requests that Congress appropriate **$12.7 million for the Core State Injury Prevention Program (Core SIPP)** for FY26, a $5 million increase over the FY24 level.*

The Core State Injury Prevention Program supports health department infrastructure, data, and partnerships to identify and respond to existing and emerging injury threats with data-driven public health actions. This support is intended to increase protective factors and reduce risk factors using the best available evidence to prevent injuries and death. The Core SIPP program includes utilizing robust data and surveillance, strengthening strategic collaborations and partnerships, and conducting assessment and evaluation.

Program	FY24 Enacted	FY25 Enacted	FY26 President's Request	FY26 Recommendation
Core State Injury Prevention Program	$7,700,000	$7,700,000	$0	$12,700,000

Justification: Administered by the CDC's National Center for Injury Prevention and Control (NCIPC), the Core SIPP is a unique program that helps states implement, evaluate, and disseminate strategies that address the most pressing injury and violence prevention issues. The program provides funds to support states' "core" or baseline capacity.

Base funding levels have been capped at $250,000 per state for more than a decade. Six of the 26 states receive additional funds of approximately $150,000 under an Enhanced Component. Core SIPP also includes a requirement that funded states address three topic areas that were prioritized by the NCIPC in 2021, which include traumatic brain injury, Adverse Childhood Experiences (ACEs), transportation-related injury.

Program Summary: The Core State Injury Prevention Program (Core SIPP) supports health department infrastructure, data, and partnerships to identify and respond to existing and emerging injury threats with data-driven public health actions. This support is intended to increase protective factors and reduce risk factors using the best available evidence to prevent injuries and death. The Core SIPP program includes utilizing robust data and surveillance, strengthening strategic collaborations and partnerships, and conducting assessment and evaluation.

Public Health Impact: Core SIPP states are making significant strides toward reducing injuries and violence in their communities, including:

- **North Carolina** State Injury Prevention Program (Core SIPP) developed a new program named Adverse Childhood Experiences (ACEs) and Suicide Prevention in a Remote Environment (ASPIRE, which included: 1) a six-month Collaborative Learning Institute (CLI) training program on using systems thinking approaches for ACEs and suicide prevention planning and 2) two toolkits designed to improve learning and demonstrate best practices for ACEs and suicide prevention.

- **New York** adopted new concussion management guidelines for children returning to physical education following a concussion. New York Core SIPP funded the Brain Injury Association of New York State (BIANYS) to develop a Return to Physical Education training program. The training explained the struggles a student may face after having a concussion. The program reached over 2,000 educators in New York State.

- **New Mexico** Core SIPP developed an introductory training for the New Mexico Injury Prevention Coalition (NMIPC) and partners on shared risk and protective factors (SRPFs), injury prevention, and the social ecological model (SEM). The University of New Mexico Prevention Research Center, NMIPC, and the New Mexico Department of Health staff helped develop the training, which raised awareness and improved knowledge of how the SRPF approach can apply to injury prevention.

- **Viriginia's** Core SIPP funding provided support for Every Ride, Safe Ride, an outreach project based on existing evidence in safe transportation of children (STC) principles. The initiative's goal is to equip pediatric and obstetric healthcare providers with the knowledge and resources to assess, screen, provide resources, and address safe transportation through pregnancy to a child's transition to the seat belt.

Impact Statement: Due to the recent Department of Health and Human Services (HHS) restructuring efforts, NCIPC has lost 200 staff. The Injury Center is one of the smallest centers at CDC, and this reduction in force will significantly impede its ability to support state and local health departments administer injury and violence prevention programs. The Injury Center is home to the most comprehensive data systems and surveillance programs used to inform public health policies, guide prevention efforts, and support evidence-based decision-making. The loss of internal staff at the Injury Center's Division of Injury Prevention (DIP) will cause a reduction in state and local health department capacity to support the Core SIPP program. State and local health departments will be left without technical support and program guidance, putting successful state programs at risk.

For more information visit CDC.gov.

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Organization: Safe States Alliance
Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies
Agency and Office: Centers for Disease Control and Prevention
Program: Firearm Injury and Mortality Prevention Research

*Safe States Alliance requests that Congress appropriate **$35 million for Firearm Injury and Mortality Research** for FY26, a $22.5 million increase over the FY25 level.*

The Centers for Disease Control and Prevention approach Firearm Injury and Mortality Prevention research through providing data to inform action, applying science to identify effective solutions, and promoting collaboration across multiple sectors to address firearm injury and mortality.

Program	FY24 Enacted	FY25 Enacted	FY26 President's Request	FY26 Recommendation
Firearm Injury and Mortality Prevention Research	$12,500,000	$12,500,000	$0	$35,000,000

Justification: Firearm violence is a serious public health problem in the United States that impacts the health and safety of Americans. Despite initial funding in FY 2021 to address firearm violence, significant gaps remain in our knowledge about the problem and ways to prevent it. Addressing these gaps is a crucial step toward keeping individuals, families, schools, and communities safe from firearm violence and its consequences.

Today there are calls for research to better understand the root causes of gun violence to inform evidence-based gun violence prevention programs. Additional funding is needed to inform policies that address topics such as, youth access to firearms, risk factors for firearm violence, and the risks and benefits of firearm ownership.

Program Summary: The Centers for Disease Control and Prevention (CDC) employ a public health approach to address firearm violence and to prevent firearm injury. This funding supports state health departments conduct research and disseminate their finding on firearm injury and its wider implications. From Hospital-based firearm violence and suicide prevention to firearm violence and injury impacting children and teams, states have made good use of this support, and increased funding will ensure that these efforts will continue to be supported.

Public Health Impact: The National Center for Injury Prevention and Control (NCIPC) funding opportunities are intended to support research that addresses:

- The characteristics of firearm violence.
- The risk factors and protective factors for interpersonal and self-directed firearm violence.
- The effectiveness of interventions to prevent firearm violence.

The goal of this research is to stem the continued rise of firearm violence in communities across the country and decrease the occurrence of mass shootings.

Research Grants to Prevent Firearm-Related Violence and Injuries

The National Center for Injury Prevention and Control, Division for Violence Prevention (DVP) is currently supporting over 30 research awards to improve understanding of firearm injury, inform the development of innovative and promising prevention strategies, and rigorously evaluate the effectiveness of strategies to keep individuals, families, schools, and communities safe from firearm-related injuries, deaths, and crime. DVP currently funds 12 recipients for the Advancing Violence Epidemiology in Real-Time (AVERT) program. These recipients work to improve the timeliness of surveillance data on emergency department (ED) visits for firearm injuries, other violence-related injuries, and mental health conditions. Recipients include:

- Arizona Department of Health Services
- District of Columbia Department of Health
- Georgia Department of Public Health
- Illinois Department of Public Health
- Kansas Department of Health and Environment
- University of Kentucky Research Foundation
- Michigan Department Health and Human Services

Impact Statement: Due to the recent Department of Health and Human Services (HHS) restructuring efforts, NCIPC has lost 200 staff. The Injury Center is one of the smallest centers at CDC, and this reduction in force will significantly impede its ability to support state and local health departments administer injury and violence prevention programs. The Injury Center is home to the most comprehensive data systems and surveillance programs used to inform public health policies, guide prevention efforts, and support evidence-based decision-making. The loss of internal staff at the Injury Center will cause a reduction in their ability to conduct this vital firearm injury and mortality prevention research. This will also diminish the Center's ability to support the 12 AVERT program recipients. Communities across the country will lose the expertise of subject matter experts that develop and evaluate effective strategies to keep individuals, youth, and families safe from firearm injury.

For more information visit CDC's page on Firearm Injury and Death Prevention.

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See updates to this paper on ASTHO's website. Last revised June 2025.

Organization: Safe States Alliance
Appropriations Bill: Labor, Health and Human Services, Education, and Related Agencies
Agency and Office: Centers for Disease Control and Prevention
Program: National Violent Death Reporting System

*Safe States Alliance requests that Congress appropriate **$34.5 million for the National Violent Death Reporting System (NVDRS)** for FY26, a $10 million increase over the FY25 level.*

The National Violent Death Reporting System collects information about violent deaths including homicides, suicides, and deaths caused by law enforcement acting in the line of duty.

Program	FY24 Enacted	FY25 Enacted	FY26 President's Request	FY26 Recommendation
National Violent Death Reporting System	$24,500,000	$24,500,000	$24,500,000	$34,500,000

Justification: To prevent violent deaths, Congress established the National Violent Death Reporting System (NVDRS), a surveillance system designed to collect information on the "who, when, where, and how" surrounding violent deaths. NVDRS is the only state-based surveillance system that pools more than 600 unique data elements from multiple sources into a usable, anonymous database. The system captures all types of violent deaths – including homicides and suicides – in all settings for all age groups.

The National Violent Death Reporting System (NVDRS) has seen many successes as increased funding and support have led to tremendous growth in the program; however, its ongoing evolution means that opportunities for improving program implementation and expanding utilization of the data in the field grow alongside the program.

As NVDRS continues to expand, the program's infrastructure must be improved to allow states to analyze violent deaths across their entire population, capture complete data sets, and meet the needs of a true nationwide program. Moreover, for NVDRS to solidify its standing as the premier data repository used to inform violent death research and practice, additional resources are needed to support greater data utilization, while testing innovative approaches that improve data collection, timeliness, and analysis.

Program Summary: The National Violent Death Reporting System (NVDRS) collects information about violent deaths including homicides, suicides, and deaths caused by law enforcement acting in the line of duty. NVDRS increases our knowledge about where violent deaths occur, who is most at risk, and the factors that contribute to violent deaths. These data provide the foundation for building successful strategies for preventing violence so that all communities are safe and free from violence and people can live to their full potential.

Public Health Impact: NVDRS data helps to build the evidence-based that informs the design and implementation of violent death prevention programs. Examples include:

- Kansas Attorney General used KS-VDRS to form a Youth Suicide Prevention Task Force. The task force used KS-VDRS data and CDC suicide prevention resources to develop eight recommendations for the state. Because of these recommendations, the attorney general's office appointed a legislatively mandated Youth Suicide Prevention Coordinator and is developing a suicide prevention mobile application to provide youth with mental health resources.
- The Wisconsin Department of Public Instruction used WI-VDRS data to inform which school districts and communities would benefit most from the Wisconsin School Mental Health Project, which includes a focus on youth suicide prevention. The project aims to reduce perceived stigma associated with mental illness and accessing mental health services.
- Oklahoma used NVDRS data on intimate partner violence homicides to evaluate the effectiveness of a pilot lethality assessment program. Police responding to domestic violence incidents connected victims at high risk for homicide with a local domestic violence service provider.
- The Utah Department of Health's Violence and Injury Prevention Program used NVDRS data to develop a suicide awareness toolkit to equip local media to more adequately report on suicide trends in the state.

Impact Statement: Due to the recent Department of Health and Human Services (HHS) restructuring efforts, NCIPC has lost 200 staff. The Injury Center is one of the smallest centers at CDC, and this reduction in force will significantly impede its ability to support state and local health departments administer injury and violence prevention programs. The Injury Center is home to the most comprehensive data systems and surveillance programs used to inform public health policies, guide prevention efforts, and support evidence-based decision-making. The loss of internal staff at the Injury Center's Division of Violence Prevention (DVP) will cause a reduction in state and local health department capacity to support their VDRS programs. Many state VDRS programs are entirely federally funded, meaning that they will lose the technical support of DVP staff to maintain their programs. These violent death reporting systems are critical to informing prevention work on the state and local level, and a lack of support from the Injury Center will put these programs at risk.

For more information visit National Violent Death Reporting System: Impact Examples.

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