Division of Chronic Disease and Prevention

NONCOMMUNICABLE DISEASE STRATEGIC PLAN



2026-2030

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Commissioner's Message

I am pleased to present the 2026 – 2030 Noncommunicable Disease Strategic Plan for the Virgin Islands Department of Health, Division of Chronic Disease and Prevention. This plan reflects our commitment to the health and strength of the people of the Virgin Islands and serves as a guiding framework for reducing the burden of chronic disease across our territory over the next five years.

Chronic diseases such as heart disease, diabetes, cancer, asthma, and hypertension continue to affect far too many of our families and friends. These conditions impact daily life, limit opportunities, and contribute to health inequities across our islands. Addressing them requires more than clinical care. It requires strong communities, supportive environments, and meaningful partnerships.

This strategic plan was developed with input from community members, healthcare providers, public health professionals, and partner organizations who share a common goal of improving health outcomes for all Virgin Islanders. It prioritizes prevention, early detection, effective disease management, and policies that support healthy living where people live, work, learn, and play. Central to this plan is a focus on ensuring that our strategies reach populations most affected by chronic disease.

The Virgin Islands Department of Health recognizes that lasting progress depends on collaboration. Community organizations, schools, faith-based institutions, businesses, and residents all play a vital role in creating a healthier Virgin Islands. This plan is not only a Department of Health initiative. It is a shared call to action for our entire community. As we move forward from 2026 through 2030, we remain committed to using data driven strategies, honoring community voices, and strengthening partnerships to build sustainable systems that support long term health.

I thank the Division of Chronic Disease and all partners who contributed to the development of this plan and to the ongoing work of protecting and promoting the health of our community. Together, through sustained collaboration and collective action, we can reduce the burden of noncommunicable diseases and build a healthier future for the United States Virgin Islands.

Sincerely,

Justa "Tita" Encarnacion, RN, BSN/MBA/HCM
Commissioner Virgin Islands Department of Health

INTRODUCTION

The Virgin Islands Department of Health (VIDOH), Division of Chronic Disease and Prevention within the Division of Health Promotion and Disease Prevention, plays a vital role in addressing the rising rates of diabetes, hypertension, cardiovascular disease, cancer, asthma, and other preventable conditions that disproportionately impact residents across the United States Virgin Islands (USVI) and the healthcare system in the USVI. The program is also responsible for conducting ongoing population health surveillance to monitor trends, identify disparities, and inform evidence-based decision-making. With limited healthcare resources, geographic fragmentation, and diverse cultural and linguistic populations, the burden of chronic disease presents significant challenges for individuals, families, and the healthcare system. Developing a strategic plan ensures a coordinated, data-driven approach to prevention, early detection, treatment, and health promotion. This Plan provides a shared vision, clearly defined goals, baseline and target measures, and measurable objectives that align partners across public health, healthcare, education, and community sectors. The framework incorporates the core public health functions to efficiently measure progress along the way. By prioritizing collaboration, equity, and sustainability, the Strategic Plan establishes a roadmap to reduce disparities, improve health outcomes, and strengthen the capacity of the department of health to prevent and manage chronic diseases now and in the future.

VISION

The USVI will be a place where all Virgin Islanders can achieve their fullest health potential and thrive in safe, supportive, and healthy communities.

MISSION

To improve population health and promote healthy behaviors that aid in the prevention and management of noncommunicable diseases (NCDs).

GOALS

- Create a culture of health and wellness throughout the United States Virgin Islands
- Create a more coordinated system of care and strengthen inter-agency collaboration
- Engage policymakers in noncommunicable disease policy
- Improve population health for all Virgin Islanders

OUR SHARED PURPOSE

The Noncommunicable Disease (NCD) Strategic Plan reflects a unified commitment to improving the health and quality of life of all people in the USVI. It provides a clear roadmap for reducing the burden of chronic diseases through prevention, early detection, coordinated care, and policy action. The Strategic Plan will be used to coordinate strategic activities that address common risk factors and improve epidemiology, environmental, health system, and clinical-community approaches.



Within the Division of Health Promotion and Disease Prevention, the Division of Chronic Disease and Prevention serves as the central hub for this work. Its programs work collaboratively rather than in isolation to share data, align goals, and co-develop initiatives. They also coordinate community outreach and clinical services to ensure programs are delivered in an integrated, efficient, and culturally responsive manner across the Territory.

This Plan strengthens coordination among partners, minimizes duplication of efforts, and leverages resources to address shared risk factors through evidence-based policy, systems, and environmental change. These core functions are instrumental in the implementation of public health programs and services. It also aligns and complements ongoing activities across key chronic disease prevention and management areas, including:

- Tobacco Prevention and Control
- Nutrition and Physical Activity
- Diabetes
- Cancer
- Heart Disease and Stroke
- Sickle Cell Disease

PLAN DEVELOPMENT

The development of the NCD Strategic Plan was supported through funding and technical assistance from the Centers for Disease Control and Prevention (CDC). In March 2023, the Division of Chronic Disease and Prevention formally requested technical assistance from CDC to support a coordinated, territory-wide approach to chronic disease prevention and control.

Through this request, CDC connected the Division with the Association of State and Territorial Health Officials (ASTHO), one of its national technical assistance partners. Beginning in June 2023, the Division engaged in a series of virtual planning meetings with ASTHO to assess needs, identify priorities, and determine how technical assistance could best support strategic planning efforts. These discussions also informed the planning of an in-person convening to engage a broader group of stakeholders.

In December 2023, ASTHO facilitated the U.S. Virgin Islands Noncommunicable Disease Strategic Planning In-Person Meeting. The purpose of this meeting was to bring together stakeholders from across the Territory to collaboratively develop a strategic framework that strengthens coordination and collaboration around shared NCD priorities. Participants included Department of Health leadership; staff from the Division of Chronic Disease and Prevention, Community Health Clinics, the Epidemiology Division, and the Health Disparities Program; and representatives from multiple sectors, including the Governor's Health Policy Advisor, Federally Qualified Health Centers (FQHCs), and community-based organizations.

During this convening, participants developed a strategic map centered on a shared NCD challenge, strategic priorities, and strategic objectives. Following the meeting, the Division continued to engage the Chronic Disease Advisory Group through virtual sessions to further refine and finalize the strategic map and align it with existing programs, data, and community needs.

In September 2025, the National Governors Association (NGA) provided additional technical assistance to convene leaders involved in NCD prevention and management. This engagement further refined the Plan's goals and objectives and strengthened alignment with policy, systems, and environmental approaches.

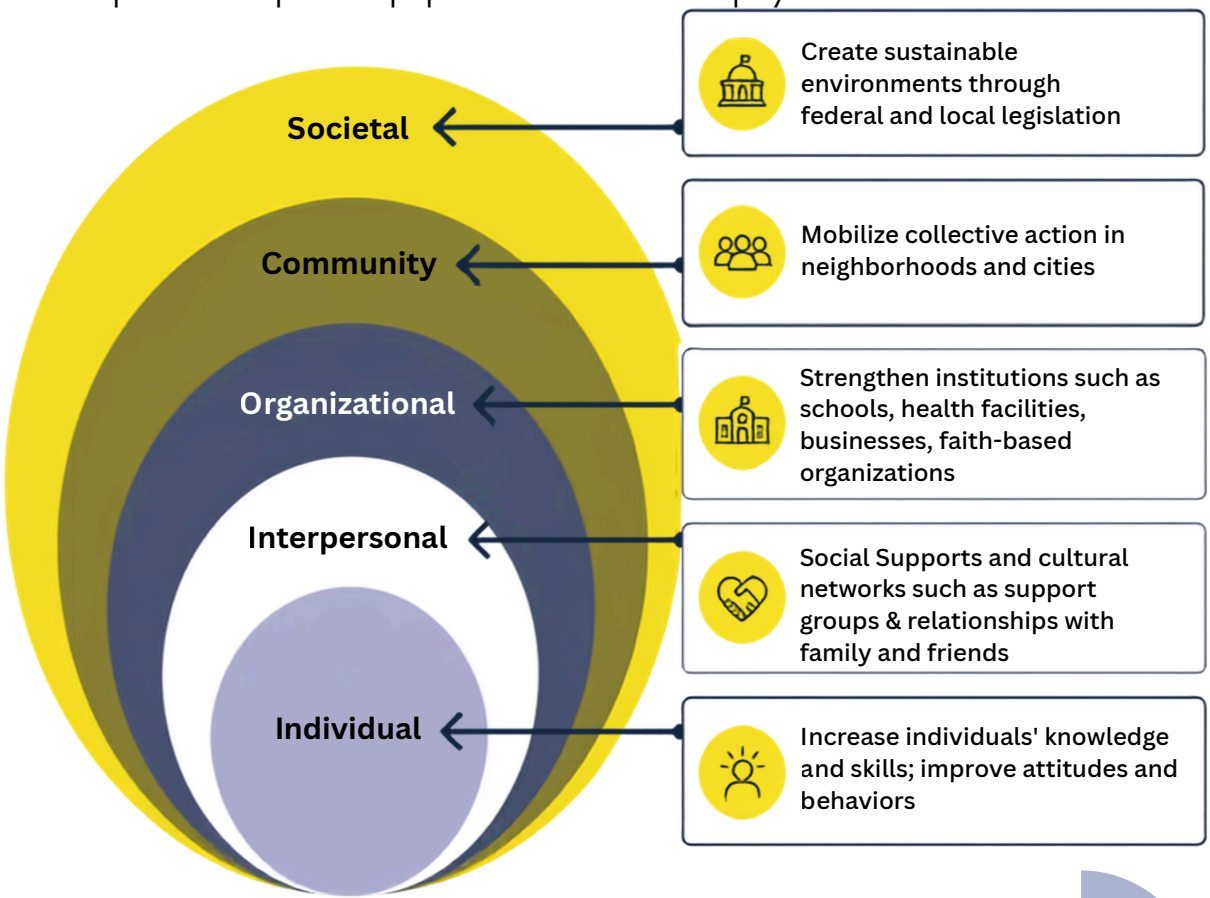
The development of the final NCD Strategic Plan was a collaborative effort. Many sections were drafted by staff within the Division, with input and review from Department of Health leadership and key partners. This inclusive, multi-sector approach ensures the Plan reflects local priorities, builds on existing strengths, and provides a coordinated framework to guide NCD prevention and control efforts across the U.S. Virgin Islands.

OUR COMMON PLAN FRAMEWORK

The NCD Strategic Plan is guided by two primary frameworks–the Social Ecological Model (SEM) and the Policy, Systems, and Environmental (PSE) Change Model–and is supported by a set of Core Cross-Cutting Elements that underpin all goals and strategies. Together, these frameworks provide a comprehensive approach to addressing chronic diseases by targeting individual behaviors, strengthening community environments, and creating supportive systems and policies. Each framework complements the others, ensuring that the Plan is both population-focused and equity-centered, while remaining adaptable to local needs and external challenges.

SOCIAL ECOLOGICAL MODEL

This model illustrates that health outcomes are shaped by the interaction between individual, interpersonal, organizational, community, and societal factors. It emphasizes that no single intervention can effectively address chronic diseases and that lasting change requires coordinated action across multiple levels of influence. By working on all levels simultaneously, the Plan amplifies its impact on population health and equity.



PSE CHANGE MODEL

The PSE Model, developed by the CDC, provides a framework for creating sustainable, long-term change by modifying the environments, systems, and policies that influence health behaviors. This approach moves beyond one-time interventions to reduce barriers and create conditions where healthy choices are practical, affordable, and accessible to all Virgin Islanders (ACS, 2025).

Policy Change: Enacting laws, regulations, and rules that promote health
Systems Change: Changing organizational rules, workflows, or procedures to create sustainable improvements in health outcomes
Environmental Change: Modifying physical or social environments to make healthy choices easier

The following table shows examples of various PSE change strategies, provided by American Cancer Society and the Centers for Disease Control and Prevention through their PSE Change Guide. Each column shows a different type of policy, systems, or environmental change strategy.

SETTING	POLICY CHANGE	SYSTEMS CHANGE	ENVIRONMENTAL CHANGE
School	Prohibiting the sale of soda on school grounds	Incorporating local produce into the lunch menu and integrating lessons on nutrition into classrooms	Increasing shade in high use areas of schools, such as lunch areas, walkways, playgrounds, and bus stops
Workplace	Implementing a comprehensive tobacco-free worksite policy that addresses all burned tobacco products, e-cigarettes (vaping), hookahs, and smokeless tobacco	Providing employees access to breast cancer, cervical cancer, and colorectal cancer screenings with no out-of-pocket costs	Providing employees an on-site workout room with a variety of equipment and offering classes such as basic yoga or cardio routines
Community	Educating decision makers about the benefits of providing palliative care for patients with cancer from the time of diagnosis	Providing cancer screening and treatment navigation for groups experiencing disadvantages	Launching a complete streets initiative to ensure neighborhood streets are accessible for walking and biking

CROSS-CUTTING ELEMENTS

The NCD Strategic Plan is rooted in several cross-cutting elements that connect all goals, objectives, and strategies. These elements ensure that efforts are coordinated, data-driven, and resilient in the face of evolving challenges.

Element	Purpose and Integration
Health Equity & Social Determinants of Health	Embed equity into all interventions to eliminate disparities by language, socioeconomic status, and ethnicity. Ensure underserved populations—including Spanish and Haitian Creole speakers—have equitable access to prevention and care.
Coordination & Partnerships	Strengthen collaboration among government agencies, healthcare, schools, providers, nonprofits, and community organizations to align goals and share resources.
Linkages to Care	Use Community Health Workers (CHWs), referral networks, and clinical partnerships to connect individuals to screening, treatment, and follow-up services.
Epidemiology & Surveillance	Leverage data from Behavioral Risk Factor Surveillance System (BRFSS), the USVI Central Cancer Registry, and other surveillance systems to guide action, measure progress, and inform continuous improvement.
Resilience & External Threats	Prepare for disruptions from hurricanes, pandemics, and other emergencies by strengthening system resilience, ensuring continuity of care, and protecting vulnerable populations.

POPULATION HEALTH

Achieving population health in the USVI requires a coordinated, systems-level approach that addresses the conditions in which people live, work, learn, and age. The VIDOH advances population health by focusing on prevention, early detection, effective management of NCDs, and the reduction of health inequities across all islands.

This NCD Strategic Plan reflects a population health framework that moves beyond individual behavior change to strengthen community environments, access to preventive services, and cross-sector collaboration. Reducing the burden of chronic disease is one of six priorities in Healthy Virgin Islands 2030. The strategic priorities focus on reducing the burden of chronic diseases such as diabetes, heart disease, cancer, stroke, and sickle cell disease while improving quality of life for all Virgin Islanders.

PREVENTION AND RISK REDUCTION

VIDOH promotes evidence-based strategies that reduce modifiable risk factors, including tobacco use, poor nutrition, and physical inactivity. Public education campaigns, community-based programs, and policy-informed interventions support healthier choices and foster a culture of health and wellness throughout the Territory.

EARLY DETECTION AND DISEASE MANAGEMENT

Improving population health depends on timely screening, early diagnosis, and coordinated chronic disease care. VIDOH works with healthcare and community partners to expand access to preventive services, strengthen referral and follow-up systems, and promote self-management education and support—particularly for populations disproportionately affected by NCDs.

DATA-INFORMED PLANNING

Available surveillance and program data are used to monitor trends, identify disparities, and guide planning and resource allocation. While data challenges exist, VIDOH leverages existing systems to inform decision-making and strengthen population-level interventions, with plans to enhance surveillance capacity over time.

PARTNERSHIPS AND HEALTH EQUITY

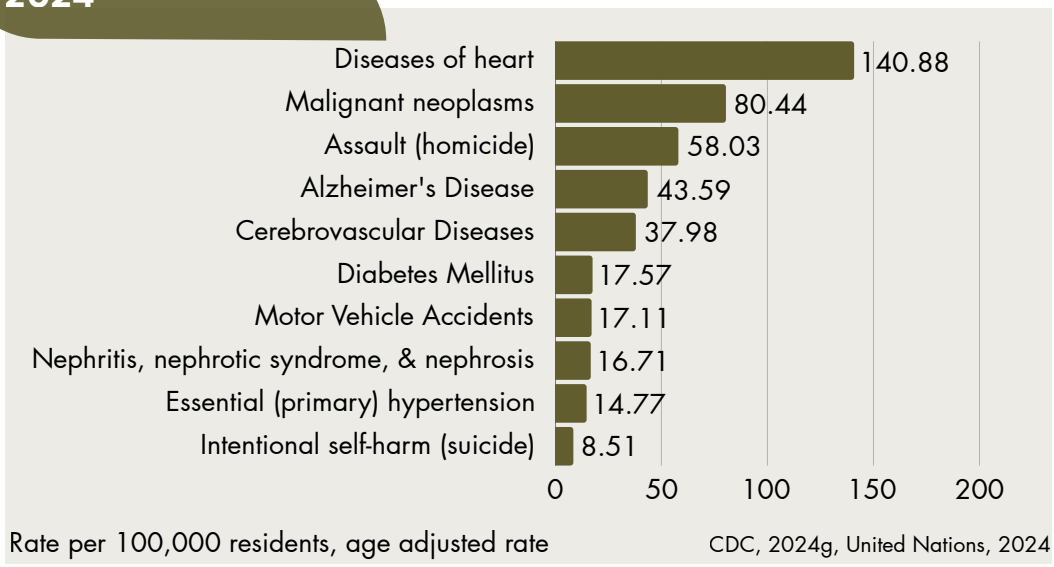
Strong partnerships across government, healthcare, community organizations, and other sectors are essential to improving population health. VIDOH serves as a convener and coordinator to align efforts, integrate services, and support shared NCD priorities. Health equity is foundational to this work, with intentional collaboration to ensure that strategies are responsive to community needs and promote fair access to prevention and care.

POPULATION HEALTH SNAPSHOT: USVI

To contextualize the population health priorities outlined above, the graphs below present key demographic characteristics of the USVI and leading causes of death that inform the focus and direction of this NCD Strategic Plan.

LEADING CAUSES OF DEATH IN THE USVI

2024

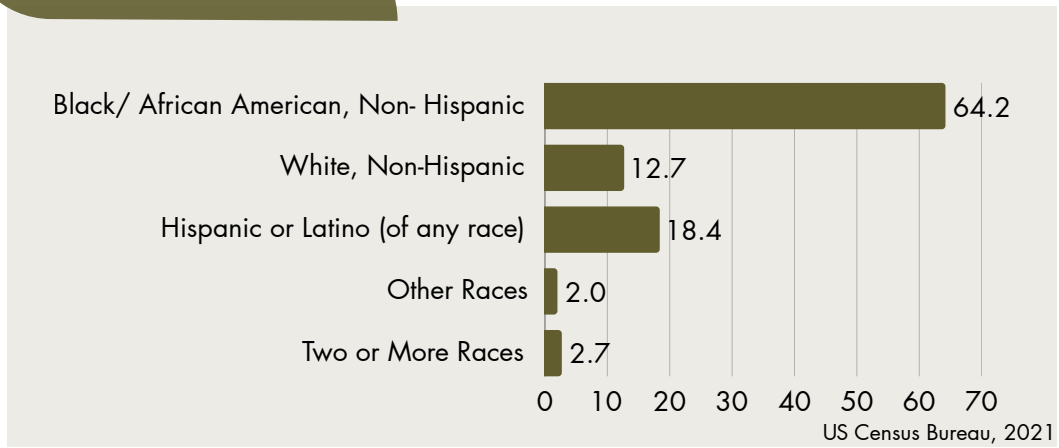


Rate per 100,000 residents, age adjusted rate

CDC, 2024g, United Nations, 2024

DEMOGRAPHICS IN THE USVI

2020 Census



US Census Bureau, 2021

*Throughout the NCD Plan, some groups may not be represented in racial/ethnic breakdowns due to small sample sizes.

PRIORITY POPULATIONS

THE UNINSURED

Many people in the USVI do not have access to health insurance. Unlike in the mainland United States, there is no state health insurance marketplace, and few insurance companies offer individual health insurance plans. Uninsured populations are less likely to seek preventive care or screenings, which may allow for chronic conditions to go undiagnosed for longer. Later diagnosis of conditions such as cancer, hypertension, heart disease or diabetes can lead to further complications and worse outcomes.

BLACK OR AFRICAN AMERICAN ADULTS

71.4% of Virgin Islanders identify their race as Black or African American, including 7.2% who are Black and Hispanic and 64.2% who are Black and non-Hispanic. Despite being the majority in the Virgin Islands population, Black Virgin Islanders still face many health disparities and challenges that are amplified by the limited medical resources in the territory (US Census Bureau, 2021). Black and African American adults are more likely to be diagnosed with diabetes than adults in the total population. This trend extends to the territory, where Black Virgin Islanders face higher diabetes rates than other racial groups, and the diabetes rate is substantially higher than the national average (CDC, 2024d).

Similarly, Black men have higher incidence of prostate cancer than other racial categories (Lillard, 2022). Prostate cancer is the most common type of cancer diagnosed in the USVI and is diagnosed at a much higher rate than in the United States overall or among Black men nationwide (CDC, 2024d).

Many health conditions also disproportionately impact Black women. Black women have higher breast and cervical cancer fatality rates than white women, while also facing some of the highest rates of high blood pressure, obesity, and cardiovascular disease among any other demographic (CDC, 2024d).

MEN

Men in the USVI are less likely to be diagnosed with diabetes, pre-diabetes, high blood pressure, high cholesterol and heart disease than women (BRFSS, 2024d). However, diabetes, heart disease and stroke remain among the leading causes of death in the territory, signifying that the decreased rate of diagnosis likely does not signify decreased disease prevalence among men, but rather points to a larger trend of underdiagnosis of chronic conditions in men.

Men in the USVI are less likely than women to seek preventative care or medical attention. 30.1% of men do not have one or more primary care providers, compared to only 13.4% of women. Only 77.4% of men in the territory have health insurance, compared to 88.3% of women (BRFSS, 2024d).

PRIORITY POPULATIONS

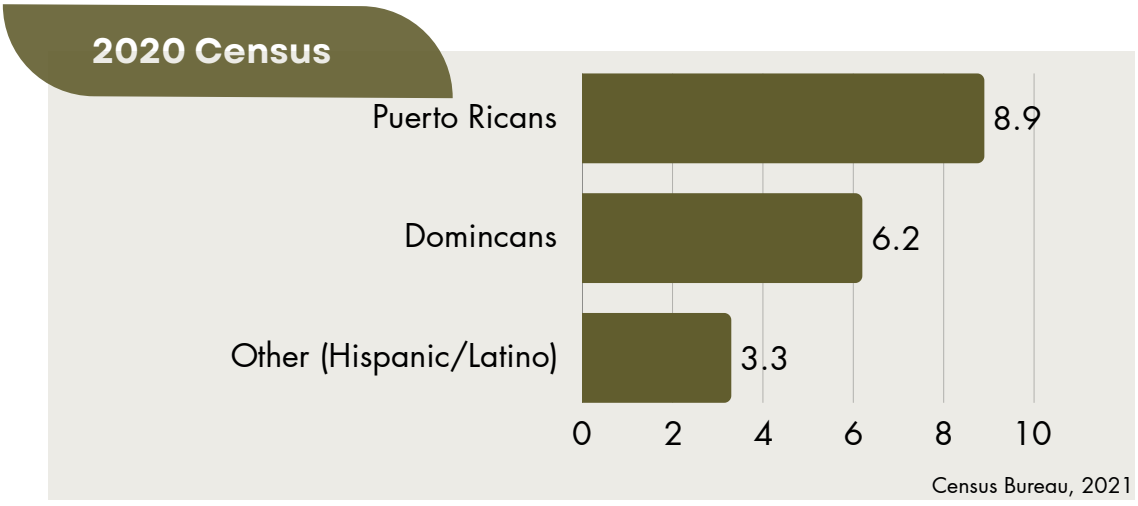
Social and cultural factors also contribute to men being less likely to seek medical care. Some men may dismiss or ignore minor medical concerns and not voice symptoms of discomfort or pain due to social stigmas. Men may also avoid discussing sensitive topics such as their physical and mental health with friends, coworkers and family. Additionally, certain medical procedures, such as digital rectal exams for prostate cancer screening, may be considered embarrassing or invasive. Unfortunately, this stigma can have severe, and even lethal health consequences, given the high rates of prostate cancer in the USVI.

HISPANICS

The Virgin Islands population is 18.4% Hispanic/ Latino, predominantly of Puerto Rican and Dominican descent (U.S. Census Bureau, 2021). Out of any racial or ethnic group, Hispanics are the least likely to report having health insurance, at only 65%. Additionally, 20% of Hispanics in the USVI reported not being able to go to a doctor for a present medical issue in the past year because of cost (CDC, 2024d).

Other health behaviors put Hispanic Virgin Islanders at further risk. While smoking rates remain low in the USVI, Hispanics are almost twice as likely to smoke cigarettes than Black Virgin Islanders and have the highest obesity rates in the territory (BRFSS, 2024d). Additionally, Hispanics are also the least likely to meet the recommendations for colorectal and cervical cancer screening criteria and are the least likely to get a PSA test to test for prostate cancer.

% HISPANIC/LATINO USVI POPULATION



PRIORITY POPULATIONS

NON-ENGLISH SPEAKERS

While English is the official language of the USVI, over 30% of Virgin Islanders speak a language other than English at home, most commonly Spanish and Haitian Creole/ French. About 9% of Virgin Islanders know English less than "very well," which can create barriers in access to health services and preventive care (U.S. Census Bureau, 2021). While many providers and health programs have Spanish speaking providers, translated health resources and/or translators, those speaking predominantly French or Haitian Creole may have fewer access to health services they can easily understand.

YOUNGER ADULTS (AGE 25-34)

BRFSS data consistently reveals a drastic increase in obesity rates among young adults. In BRFSS years 2021-2024, there has been a sharp increase in obesity rates from the age 18-24 group to the 25–34-year-old age group, and the increase continues until the age 45–54-year-old age group. The pronounced rise of overweight and obesity in these age categories reveals a critical need for nutrition and physical activity education among young adults.

LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUEER+ (LGBTQ+)

As a small community, little information is available on the health impacts of being LGBTQ+ in the USVI. While small, there is a significant subset of people (4.5%) who identify as something other than straight, as well as a few Virgin Islanders who identify as transgender or non-binary (BRFSS, 2024d). There is an established link between LGBTQ+ identity and certain chronic health indicators, such as disability, poor mental health, heart attack and stroke, and certain types of cancer (Fredrikson-Golden et al., 2017).



ASTHMA & ARTHRITIS: USVI

Conditions such as asthma and arthritis, while not supported by dedicated programs, contribute significantly to morbidity in the Territory and are influenced by environmental, behavioral, and social factors addressed through existing NCD strategies. These data highlight the broader chronic disease burden in the Territory and inform cross-cutting prevention strategies, partnerships, and future program planning.



US Virgin Islanders with Asthma, 2023



Male US Virgin Islanders



Female US Virgin Islanders

CDC, 2024d

US Virgin Islanders with Arthritis, 2023



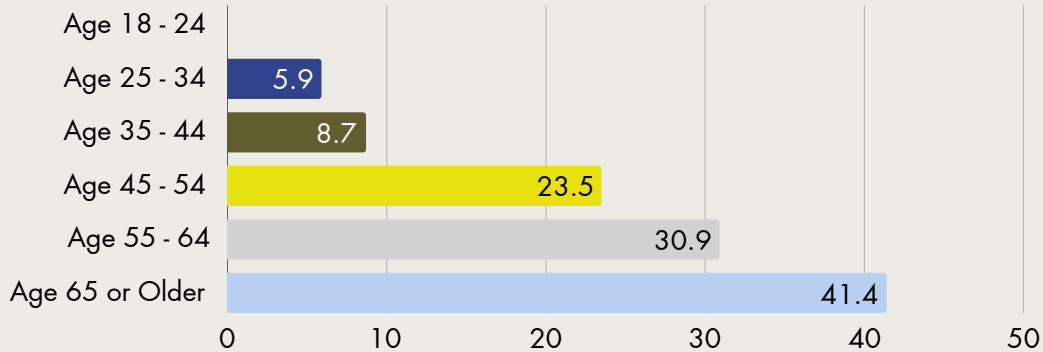
Male US Virgin Islanders



Female US Virgin Islanders

CDC, 2024d

% of Virgin Islanders with Arthritis by Age, 2023



CDC, 2024d

CHRONIC DISEASE RISK FACTORS IN THE USVI

Chronic Disease development is influenced by a combination of behavioral, environmental, and genetic risk factors. While family history, age, sex, and race/ethnicity are unmodifiable, chronic disease risk can be mitigated through behavioral modification and supportive social environments. Well-established behavioral risk factors contributing to chronic disease risk include nutrition, physical activity, tobacco use, and alcohol consumption. Hypertension, obesity, cholesterol, and pre-diabetes are also considered intermediate risk factors and can be controlled or reversed through behavioral modifications.

Equally important, behavioral and mental health are critical to chronic disease prevention and management. Stress, depression, and other mental health challenges affect lifestyle behaviors, treatment adherence, and overall health outcomes.

Chronic Diseases develop over time, largely as a result of behavioral risk factors. Even small modifications to lifestyle habits can largely alter one's overall risk of chronic disease development. Some examples include:

- Across four studies involving over 50,000 people, participants with high genetic risk for coronary artery disease who did not smoke, maintained a healthy weight, ate a nutritious diet and engaged in regular physical activity had an almost 50% lower relative risk than those who did not maintain a healthy lifestyle (Khera, 2016).
- A 5-7% maintained weight loss can reduce the risk of type 2 diabetes for those with pre-diabetes or at high risk for diabetes (CDC, 2024h).
- Post smoking cessation, heart disease risk drops sharply within 1-2 years, and decreases by an additional half in the following 3-6 years. Risk of lung, bladder, esophageal and kidney cancers decrease significantly in 10-15 years (CDC, 2024c).
- Early detection of cancers can significantly increase survivorship. Early detection of colorectal cancer has a 90% 5-year survival rate (American Cancer Society [ACS], n.d.-b).
- Localized breast cancer has a 99% 5-year survival rate (ACS, n.d.-a).
- A 2022 meta-analysis found that for each 5-mmHg reduction in systolic blood pressure, the risk of developing cardiovascular events fell by 10% (Canoy et al., 2022).

RISK FACTOR: PHYSICAL ACTIVITY



Overwhelming evidence supports the importance of physical activity in chronic disease prevention and management. Regular physical activity can reduce an individual's susceptibility to developing chronic health conditions by aiding in weight loss and maintenance, reducing the risk of cardiovascular disease, improving insulin sensitivity and reducing risk of type two diabetes. Physical activity is also linked to lower incidence of several cancers, including a 13% reduction in bladder cancer, 12-21% reduction in breast cancer, a 19% reduction in colon cancer, as well as significant reductions in endometrial, renal, esophageal, and gastric cancers (CDC, 2025b).

Consistent physical activity can also reduce frequency and severity of asthma attacks, reduce joint pain and stiffness associated with arthritis, and reduce the likelihood of falls or developing injuries from falls. Physical activity also has cognitive benefits, such as improvements in mood and a reduction in the risk of Alzheimer's disease (CDC, 2025b).

Adults are recommended to get at least 150 minutes of moderate intensity physical activity per week, as well as two days per week of muscle strengthening exercises for all major muscle groups. A lack of muscle strengthening exercise increases the risk of falls and injuries from falls, as well as osteoporosis in older women (U.S. Department of Health and Human Services, 2018).

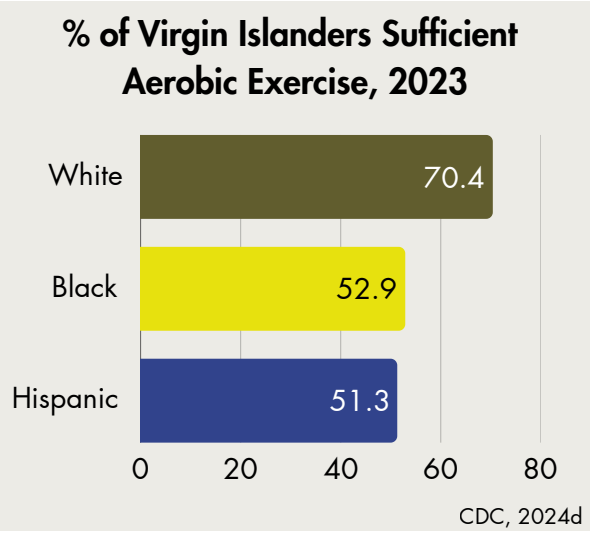
55.4%

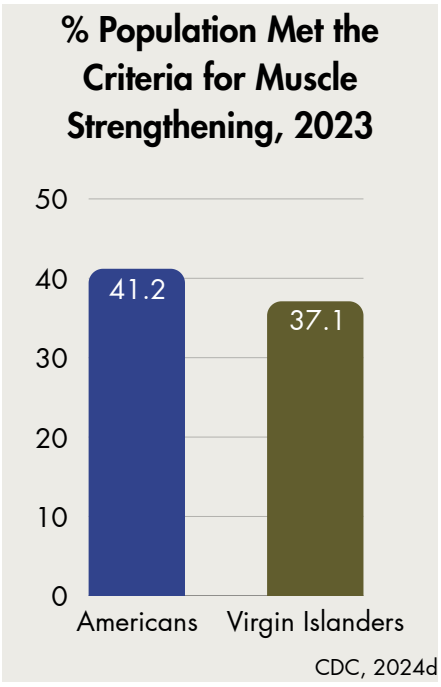
Virgin Islanders met the criteria for aerobic activity in 2023 compared to 59.9% of Americans (CDC, 2024d).

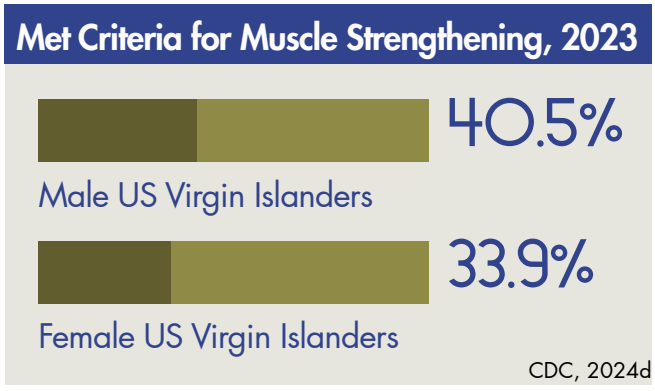
As of 2023, USVI adults ages 35 & older were also more likely to meet the criteria for sufficient exercise than adults ages 18-34 (CDC, 2024d).

RISK FACTOR: PHYSICAL ACTIVITY









RISK FACTOR: NUTRITION

The USVI faces significant food security issues as challenging terrain, frequent hurricanes, and infrastructure limitations which results in imports accounting for approximately 97% of food consumed (The Borgen Project, 2025). Recent innovations in USVI agriculture include solar energy use, rainwater harvesting, drip irrigation, and cover crops to improve efficiency. The USVI food systems dashboard highlights challenges in diet quality, food availability, and nutritional outcomes, flagging high levels of obesity, diabetes, and food insecurity (Islands Staff, 2025).



37.2%

high school students in the USVI were overweight or obese, including 21.2% classified as obese (Valmond et. al., 2019).

Poor diet and low physical activity were prevalent, underscoring the need for early intervention and family-wide behavior change (Valmond et. al., 2019).

In December 2022, SNAP benefit reductions impacted nearly 11,000 households and cut $2.1 million in assistance—highlighting the fragility of food support systems (The Borgen Project, 2025). The U.S. Department of Agriculture's (USDA) Food and Nutrition Service increased school meal reimbursement rates in the USVI by 17% to 30% above the contiguous U.S. rates, enhancing equitable access to healthy food in schools and strengthening the local food system. In October 2024, USDA allocated over $1.5 million through the Resilient Food Systems Infrastructure Program to bolster supply chain resilience—funds aimed at improving food processing, safety, and access for underserved producers (St. Thomas Source, 2023).

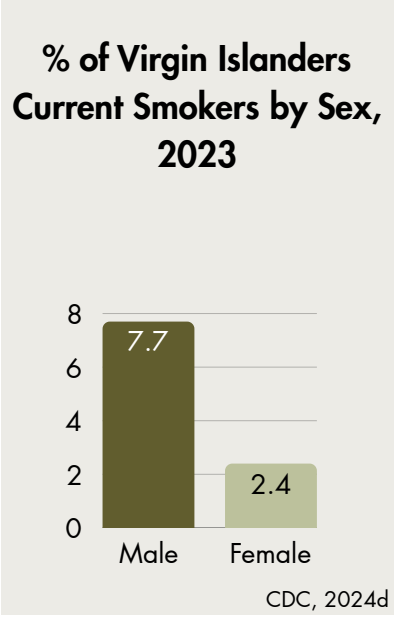
RISK FACTOR: TOBACCO & SMOKING

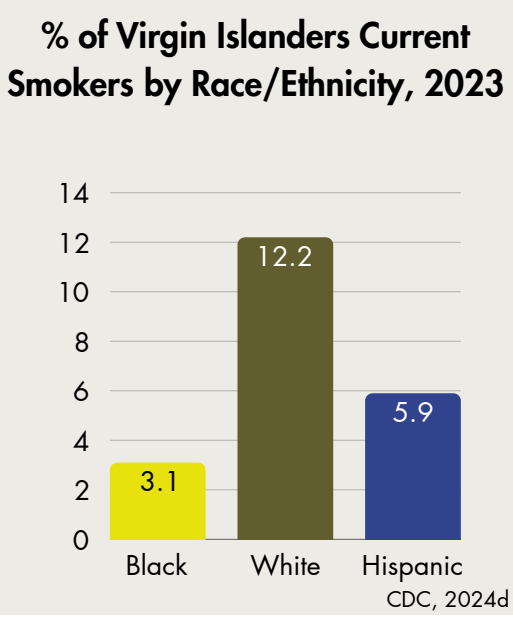
Tobacco use remains one of the most preventable causes of disease, disability, and death in the USVI and globally. It is a major risk factor for cancer, heart disease, stroke, lung diseases, and diabetes, and contributes to premature mortality and economic costs through healthcare expenditures and productivity loss. According to the CDC, cigarette smoking causes more than 480,000 deaths annually in the U.S., including deaths from second-hand smoke exposure (CDC, 2025c).

Tobacco use contributes to:

- High rates of lung and oral cancers
- Cardiovascular diseases, including heart attack and stroke
- Chronic Obstructive Pulmonary Disease (COPD)
- Low birth weight and pregnancy complications when used during pregnancy

Although the USVI has implemented important tobacco control measures, including public smoking bans and youth access restrictions, challenges persist in both traditional cigarette smoking and emerging tobacco product use, such as e-cigarettes, vapes, and fonta, particularly among youth.





RISK FACTOR: TOBACCO & SMOKING

The USVI reports relatively low rates of traditional cigarette smoking, but the use of 'Fonta'—a tobacco leaf often mixed with marijuana—remains a prevalent practice particularly among the younger populations. According to recent data, approximately 71% of Black individuals who use marijuana in the territory also report using fonta, raising significant public health concerns (CDC, 2024d). This method of consumption increases exposure to harmful tobacco toxins and may contribute to long term respiratory and cardiovascular issues.

Emerging data show an increase in vaping among adolescents in the Caribbean, reflecting national and global trends. Without decisive action, these patterns may reverse decades of progress in tobacco control (Healthy Caribbean Coalition, 2023).



Reducing tobacco use is critical to achieving broader health objectives, including those related to chronic disease prevention, health equity, and youth wellness. This strategy aligns with global frameworks such as the World Health Organization's (WHO) Framework Convention on Tobacco Control and CDC's Best Practices for Comprehensive Tobacco Control Programs (WHO, 2003).



RISK FACTOR: ALCOHOL

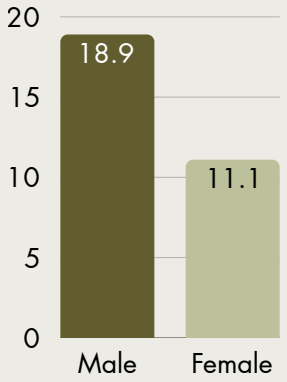
Alcohol, even in moderation, can contribute to poor health outcomes. Alcohol use increases the risk of several types of cancer, such as mouth, throat, voice box, esophagus, colorectal, liver, breast, and possibly prostate cancer. Excessive alcohol use can also cause liver damage and cirrhosis, motor vehicle accidents and hospitalizations from alcohol overdose and poisoning. Alcohol also negatively impacts brain and heart health (CDC, 2024b).

Moderate alcohol use, defined as no more than two drinks per day for men and one drink per day for women, is associated with fewer negative health impacts than excessive alcohol use, and abstaining from alcohol use is associated with fewer health risks than moderate use (CDC, 2024f).

Seven percent of Virgin Islanders met the criteria for heavy drinking (14 or more drinks per week for adult men and 7 or more drinks per week for adult women) in comparison with 6.1% of Americans. Shockingly, 5.8% of Virgin Islanders reported drinking and driving in the past year, compared to 3% nationally (CDC, 2024d).

Tourism and liquor—rum in particular—are some of the largest industries in the Caribbean, including the USVI. Additionally, unlike in the United States, the drinking age in the USVI is 18, and there are no open container laws, which may contribute to the normalization of problematic alcohol usage.

% of Virgin Islanders Binge Drinking, 2023



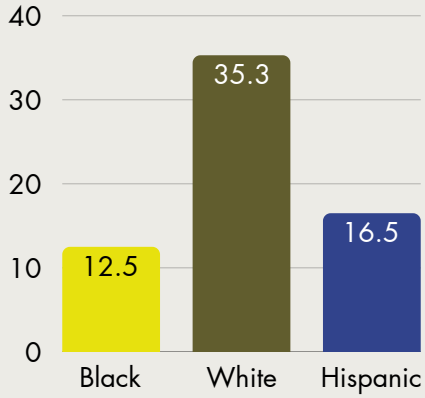
CDC, 2024d

47.5%

of Virgin Islanders reported drinking alcohol in the last 30 days, in comparison with 52.2% of Americans (CDC, 2024d).



% of Virgin Islanders Binge Drinking Race/Ethnicity, 2023



CDC, 2024d

RISK FACTOR: WALKABILITY

There is overwhelming evidence pointing to a strong association between a sedentary lifestyle and chronic disease. Walkable communities, which allow for easy accessibility of amenities within a reasonable walking distance, are known to reduce chronic disease risk factors such as obesity and physical inactivity (Sallis, 2004).

However, many communities, such as the majority of those within the US Virgin Islands, are not designed with the pedestrian in mind. As of a 2016 study, only 11.3% of streets in the US Virgin Islands had sidewalks. Street lighting, sidewalks, transit stops, and destinations (such as stores and restaurants) were less prevalent on residential streets. Only 27.4% of streets had traffic calming features such as speed bumps, and 53.2% had some lighting (Omura et al., 2018).

While walkability remains a challenge in the territory, there has been significant progress towards more walkable communities in recent years. In St. Croix, the long-awaited opening of the Aloy "Wenty" Nielson Bypass has improved traffic and walkability in Christiansted since 2013 (St. Croix Source, 2013). In 2022, the Virgin Islands Legislature passed a law to implement Complete Streets, a transportation policy and design approach that aims to improve usability of streets and sidewalks to all users (Act No. 8548, 2022). The Comprehensive Land and Water Use Plan was adopted by the USVI Legislature in 2024, creating a roadmap for further infrastructural changes across the territory (Department of Planning and Natural Resources, 2024).

In Charlotte Amalie, St. Thomas, an ongoing, multi-phase process to improve traffic flow on Veterans Drive while expanding and beautifying the popular Waterfront Promenade is underway. The second phase of the Veterans Drive Modernization Project is projected to break ground in 2026 (Government of the USVI, 2025).



RISK FACTOR: OVERWEIGHT/OBESITY



Obesity and overweight are common but serious chronic health concerns. More than 2 out of 5 Americans have obesity, and Black and Hispanic populations are at highest risk. Obesity is costly to the medical system, accounting for nearly $173 billion in medical expenditures yearly (CDC, 2024a).

Obesity is strongly associated with many chronic health conditions, including hypertension, type 2 diabetes, and certain cancers. Additionally, associations between obesity and fertility issues, sleep apnea, arthritis, poor mental and sexual health are well documented, suggesting that those with obesity may encounter more obstacles to their quality of life. Those with obesity are also more likely to have severe illness and even death in response to COVID-19 (CDC, 2024a).

Obesity is multifactorial. Diets high in excess calories and a sedentary lifestyle are the primary causes of weight gain. However, other factors that may influence an individual's weight include genetics, health conditions, medications, cultural and familiar influence, and social determinants of health (CDC, 2024a).

US Virgin Islanders Overweight or Obese, 2023



63.7%

Male US Virgin Islanders



76.5%

Female US Virgin Islanders

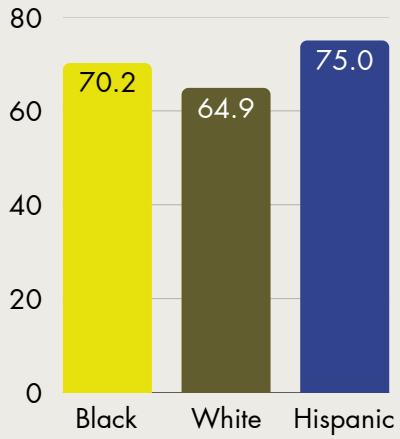
CDC, 2024d

RISK FACTOR: OVERWEIGHT/OBESITY

As of 2023, 70.3% of Virgin Islanders have obesity or overweight, compared with 69% of Americans. In both the United States and USVI, non-Hispanic Black adults have the highest incidence of obesity, followed by Hispanic adults (CDC, 2024d).



% of Virgin Islanders Overweight or Obese by Race/Ethnicity, 2023

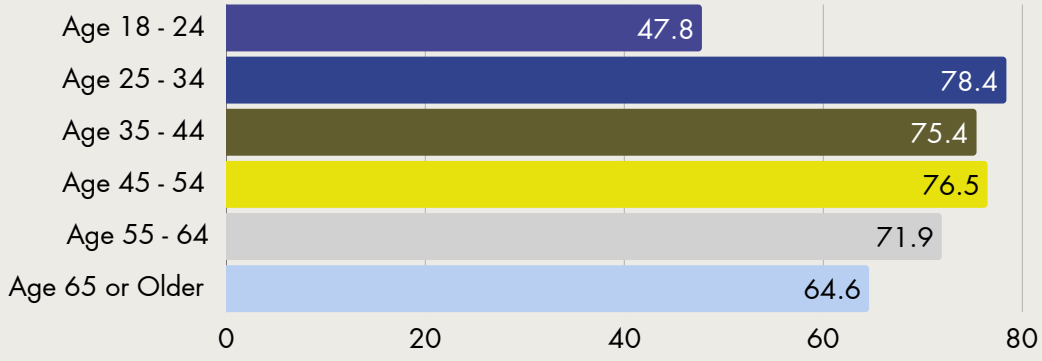


CDC, 2024d

1 in 3 Vigin Islanders has obesity.

2 in 3 Virgin Islanders have overweight or obesity.

% of Virgin Islanders Overweight or Obese by Age, 2023



CDC, 2024d

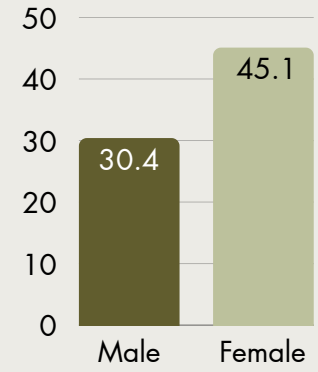


RISK FACTOR: HYPERTENSION

Hypertension, or high blood pressure, is defined by blood pressure that is consistently above 130/80 mmHg. Hypertension is an intermediate risk factor for cardiovascular disease and stroke. It can contribute to damage to vision, cognitive decline, kidney dysfunction, and peripheral arteries. Therefore, blood pressure control is essential on a population level (CDC, 2025a).

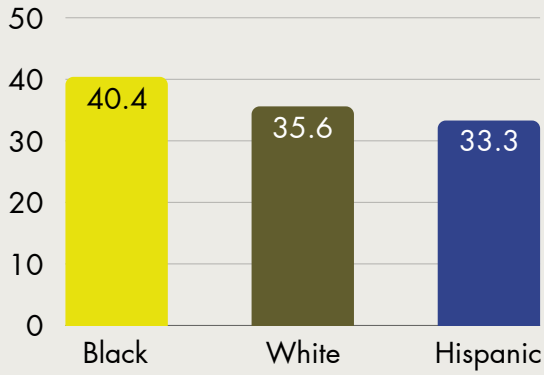
The prevalence of adults self-reporting that they have high blood pressure in the USVI was 38.3%, a 7% increase from the previous year (CDC, 2024d). For comparison, the median across U.S. states that year was 48.1%, an indication that almost half of all Americans are affected by this condition, which is a significant public health concern (CDC, 2025a).

% of Virgin Islanders with Hypertension by Sex, 2023



CDC, 2024d

% of Virgin Islanders Hypertension by Race/Ethnicity, 2023



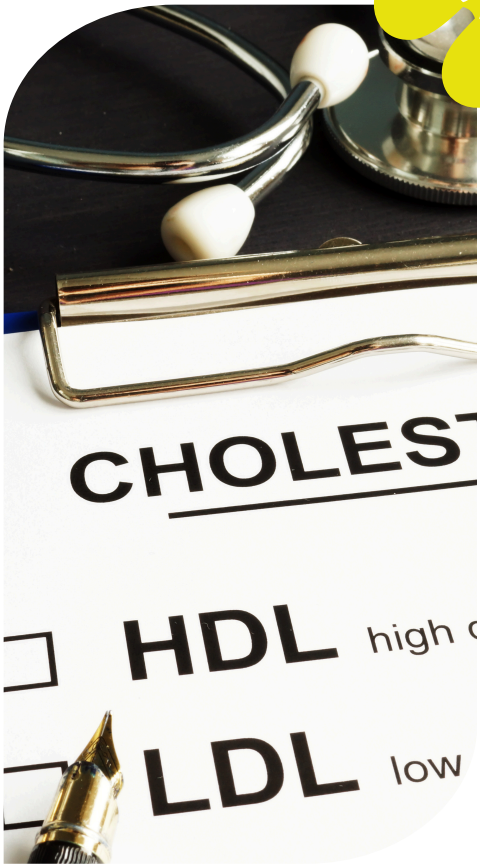
CDC, 2024d

In the United States, racial minorities, and Black Americans in particular are more likely to experience hypertension and experience higher rates or morbidity and mortality related to hypertension (Ogunniyi, 2021). This trend extends to the USVI as well, where hypertension prevalence among Black adults was estimated at 40.3%, while 45.1% reported were women.

RISK FACTOR: HIGH CHOLESTEROL

Cholesterol is a waxy substance found in the blood that is used to build healthy cells. Blood cholesterol tests detect both low-density lipoprotein, or LDL ("bad" cholesterol) as well as high-density lipoprotein, or HDL ("good" cholesterol). High levels of LDL cholesterol raise one's risk for heart disease and stroke, while high levels of HDL can reduce this risk (CDC, 2024d).

Lifestyle habits such as a diet low in saturated fats and high in fiber, regular physical activity, stress management, sufficient sleep and avoiding smoking and tobacco products can reduce LDL cholesterol and the overall risk of heart disease and stroke (CDC, 2024e).

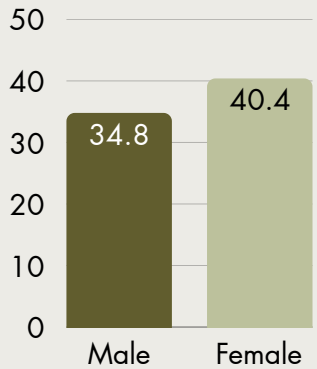


37.8%

Virgin Islanders reported having high cholesterol, compared to 37.2% of Americans (CDC, 2024d).

With heart disease being the number one cause of death of adults both in the United States as well as the USVI, promoting habits that decrease one's cholesterol is crucial to reducing likelihood of premature death.

% of Virgin Islanders with High Cholesterol by Sex, 2023

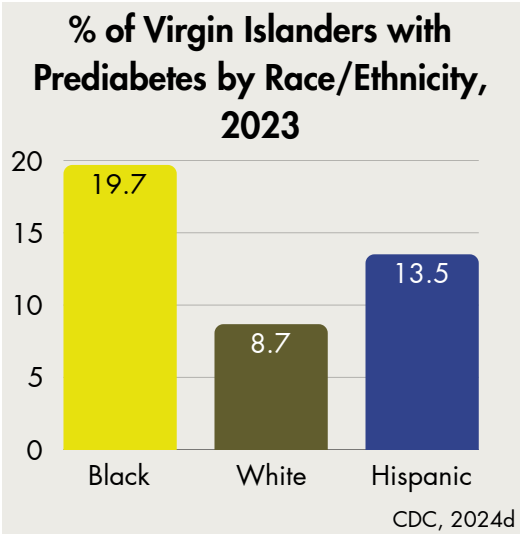


CDC, 2024d

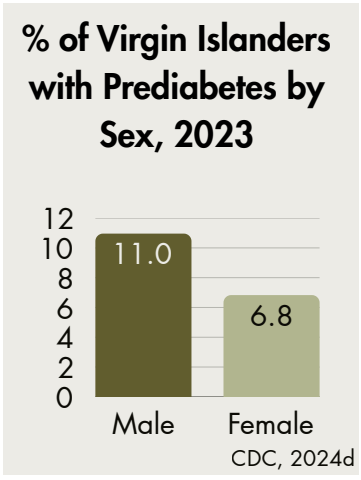
RISK FACTOR: PREDIABETES

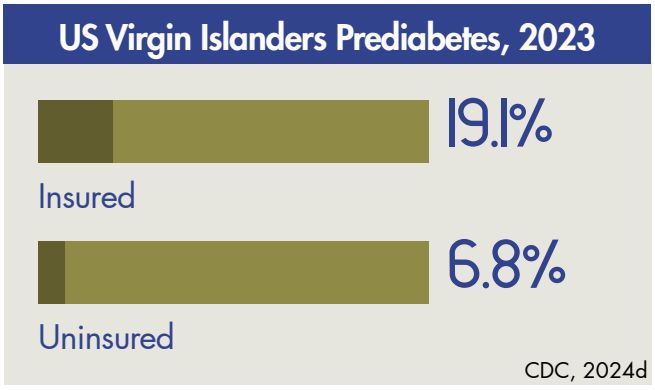
Prediabetes represents a significant early warning stage of type 2 diabetes, where blood glucose levels are higher than normal but not yet at the diabetes threshold. Diabetes and Prediabetes are both major health concerns in the USVI. 16.8% of adults in the territory have been diagnosed with pre-diabetes, putting them at higher risk of developing other chronic conditions (CDC, 2024h). As prediabetes often does not cause any symptoms, many may be living with elevated blood sugars without knowing, furthering their risk of developing a chronic condition.

Risk factors for developing prediabetes, such as overweight, obesity, physical inactivity, unhealthy diet patterns, and family history of diabetes, all increase the likelihood of insulin resistance and elevated glucose levels (CDC, 2024h). Early screening and lifestyle modification remain the central strategies to reduce risk factors and prevent the development of Type 2 diabetes in the territory.



1 in 6 people in the US Virgin Islands has prediabetes.





RISK FACTOR: BEHAVIORAL HEALTH

Behavioral health—including mental health, substance use, and the enduring impact of trauma—is deeply interconnected with chronic disease prevention and management. Individuals with serious mental illness (SMI), such as schizophrenia, bipolar disorder, or major depression, are significantly more susceptible to developing chronic health conditions such as diabetes, cardiovascular disease, and respiratory illnesses. Life expectancy for those with SMI is reduced by an estimated 10–25 years, largely due to preventable physical diseases and associated health behaviors (Firth et. al, 2019; Pizzol et.al, 2023).

Additionally, people living with chronic physical conditions—diabetes, heart disease, or cancer—have nearly double the prevalence of depression and anxiety compared to the general population, complicating treatment adherence and reducing quality of life (DeLong et al., 2025). These societal dynamics are mirrored in the USVI. For example, a 2025 study on health-related quality of life in U.S. territories found that 11.7% of USVI adults reported frequent mental distress—on par with other territories. Community survey data also reveals that more than half (52%) of respondents identified chronic health conditions such as diabetes and hypertension as leading health challenges (McSorley et al., 2025). Given the well-documented chronic disease burden in the USVI, the integration of behavioral health into chronic disease prevention strategies is critical.

Trauma—including adverse childhood experiences (ACEs), sexual assault, and domestic violence—further magnifies this burden. Survivors of trauma are more likely to develop depression, anxiety, and PTSD, and often turn to coping behaviors such as smoking, substance use, and disordered eating—all of which increase chronic disease risks. ACE studies demonstrate long-term health consequences, including obesity, diabetes, and heart disease.

18.4%

of adults expressed their parents physically hurt them during childhood on multiple occasions (CDC, 2024d).

4.8%

of adults and nearly 1 in 13 adult women (7.7%) reported experiencing unwanted sexual touching during childhood (CDC, 2024d).

RISK FACTOR: BEHAVIORAL HEALTH

4.9%

USVI adults reported never feeling protected by an adult during childhood (CDC, 2024d).

3.2%

USVI adults reported never having their basic needs met by an adult during childhood (CDC, 2024d).

While territory-specific ACE data are limited, youth mental health surveys in the USVI are compelling. According to the 2017 Youth Risk Behavior Survey (YRBS), 22.5% of middle-school students reported seriously considering suicide, and 35.5% of high school students reported persistent sadness or hopelessness that interfered with daily activities. These indicators reflect deep emotional distress, which may be worsened by events such as hurricanes, pandemic disruptions, and ongoing inequities (Valmond et. al., 2019).

Recognizing these intertwined risks, public health strategies must be integrative and trauma-informed. This requires routine screening for depression, anxiety, substance use, and trauma in primary care and chronic disease programs, establishing seamless referral pathways to behavioral health services, and expanding community-based supports.

Collaboration across providers, victim services organizations, schools, and social systems is essential. Policies should prioritize trauma-informed practices, reduce stigma, and address systemic barriers that limit access to care, especially for vulnerable and marginalized populations.

By acknowledging behavioral health as both a driver and a consequence of chronic disease—and grounding strategies in local USVI data such as prevalence of mental distress, diabetes, and youth behavioral health indicators—the territory can more effectively align noncommunicable disease and behavioral health initiatives. This integrated approach will reduce disparities, improve outcomes, and promote whole-person well-being across the Virgin Islands.



EXTERNAL THREATS & CHALLENGES

The NCD Strategic Plan aims to improve population health and encourage healthy behaviors to reduce the burden of chronic diseases. However, several external factors have created significant obstacles to achieving these goals. These challenges affect program sustainability, service delivery, workforce capacity, and community resilience across the Territory.

FUNDING INSTABILITY

Fluctuations in federal funding and changing national priorities have created uncertainty for local program implementation and staffing. Essential prevention and health promotion activities face potential disruptions. This instability may limit the Department of Health's ability to sustain long-term community initiatives, strengthen local capacity, and maintain adequate workforce levels. Continued investment and diversification of funding sources are needed to ensure the sustainability of NCD prevention and control efforts.

PANDEMIC IMPACTS ON THE HEALTH SYSTEM

The COVID-19 pandemic placed an unprecedented strain on the USVI's healthcare system. The demand for services, coupled with workforce and infrastructure limitations, disrupted access to routine care and chronic disease management. The pandemic also underscored the importance of mental health services and social support systems, highlighting the need for a resilient health system that can maintain essential services during emergencies.

STAFFING LIMITATIONS

Ongoing workforce shortages across healthcare and public health sectors present a major barrier to delivering consistent, high-quality services. Recruiting and retaining staff, especially in specialized areas and community-based roles, remains a challenge to program reach and effectiveness. Limited staffing capacity also restricts outreach, program expansion, and data collection efforts. Addressing these gaps is critical to sustaining NCD prevention and management programs across the Territory.

EXTERNAL THREATS & CHALLENGES

IMPACTS OF NATURAL DISASTERS

The long-term effects of past hurricanes and other natural disasters continue to influence the health and well-being of Virgin Islanders. Damaged infrastructure, housing instability, and the economic repercussions of these events have created barriers to care and hindered health recovery efforts. For individuals living with chronic diseases, disaster preparedness and post-disaster management are critical. Disruptions in access to medications, medical supplies, and routine care can lead to serious complications or disease progression. Ensuring that persons with chronic conditions have emergency plans, access to continuity of care, and support systems during and after disasters is essential to safeguarding their health. Strengthening preparedness, continuity of operations, and community resilience are key priorities to minimize future disruptions and protect the most vulnerable populations (Artiga et al., 2018).

DATA COLLECTION & SURVEILLANCE CHALLENGES

Reliable and timely data are essential for monitoring chronic disease trends, evaluating programs, and guiding decision-making. While faced with challenges such as limited staffing and administrative delays, the programs continue to maintain core surveillance systems and effectively use available data to inform the NCD Strategic Plan. These challenges may slow productivity, efficiency, and reporting, but they have not halted progress. Continued investment in data systems, workforce capacity, and partnerships will strengthen surveillance and support more timely evidence-based decision-making.

HEALTHCARE ACCESS & POPULATION DIVERSITY

The USVI faces unique healthcare access challenges shaped by its geography, workforce limitations, and population diversity. Many residents must travel off island for specialty care, which can delay treatment and increase financial strain. Language and cultural differences further affect communication and health literacy, particularly among Spanish and Haitian Creole-speaking populations.

Efforts to improve access include expanding community-based services, strengthening partnerships with faith and community organizations, and increasing the number of bilingual healthcare providers. Addressing these factors is critical to achieving equitable health outcomes and ensuring that all residents benefit from prevention, early detection, and chronic disease management programs (National Association of Community Health Centers, 2023).

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM

PROGRAM OVERVIEW & GOALS

The Behavioral Risk Factor Surveillance System (BRFSS) is a national telephone-administered survey that collects data directly from adult US residents regarding their health-related risk factors, chronic health conditions, and use of preventive services.

The Virgin Islands BRFSS Program, housed within the Division of Chronic Disease and Prevention, administers the survey on a territorial level, collecting chronic disease data that is used across all program areas and by other community partners and government agencies.

The program focuses on the following goals:

- **Conduct the Virgin Islands BRFSS Survey on an annual basis**, collecting data that is used locally and contributing to the US National BRFSS Database.
- **Collect data about health concerns specific to the USVI** by selecting optional modules and state-added questions on relevant health topics, as well as working within the community to determine additional areas of focus.
- **Maintain community involvement and access to data** through media outreach, an advisory board, and promotion of the survey.

PROGRAM SUCCESSES

- **BRFSS Data Collection:** The BRFSS Program has been active in the territory since 2005. Despite internal challenges and delays related to the 2017 Hurricanes, the data collected in the survey is used to inform strategic plans, policy and other public health measures in the territory.
- **Chronic Disease Risk Factor Session:** The BRFSS Program has also been expanded to include community outreach, including an informational session which shared data and information about the survey to the general population. This session was the first step in the process of a BRFSS Advisory Board to continue guiding the direction of the survey.

TOBACCO PREVENTION & CONTROL

PROGRAM OVERVIEW & GOALS

The Tobacco Prevention and Control Program, housed within the Division of Chronic Disease and Prevention, works to reduce tobacco-related illness and death through evidence-based prevention and cessation strategies. The program focuses on the following four goals:

- **Prevent initiation**: Reduce the number of youth and young adults who begin using tobacco or nicotine products.
- **Promote quitting:** Support individuals of all ages in their efforts to quit.
- **Eliminate exposure to secondhand smoke:** Protect the public from harmful tobacco smoke in workplaces and public spaces.
- **Advance health equity:** Reduce tobacco-related disparities among vulnerable and disproportionately affected populations.

Key strategies include implementing tobacco-free policies, conducting culturally tailored media and education campaigns, building partnerships with schools and community organizations, and using surveillance data to guide program planning.

PROGRAM SUCCESSES

The Tobacco Prevention and Control Program has made significant progress toward creating a tobacco-free USVI:

- **Locally Developed Media Campaigns:** An annual, culturally relevant media campaign raises awareness about the dangers of tobacco and vaping among youth, using messages developed by and for Virgin Islanders.
- **Tobacco 21 Policy:** Passage of the Tobacco 21 law raised the minimum legal purchase age for tobacco products from 18 to 21, helping to prevent youth initiation.
- **Smoke-Free Public Spaces:** The VIDOH continues to enforce the USVI Smoke-Free Policy, which prohibits smoking in workplaces, schools, and public spaces.
- **Tobacco Surveillance:** Tobacco use data are collected through the BRFSS to monitor trends and inform decision-making.
- **Provider Trainings:** Healthcare providers receive annual training on implementing Brief Tobacco Interventions (BTIs) to help patients quit tobacco use.
- **Community and School Outreach:** Ongoing education and outreach activities in schools and community settings raise awareness of the dangers of smoking, vaping, and secondhand smoke.

NUTRITION & PHYSICAL ACTIVITY

PROGRAM OVERVIEW & GOALS

The Nutrition and Physical Activity Program, within the Division of Chronic Disease and Prevention, promotes healthy eating and active living to reduce the risk of obesity and other chronic diseases such as diabetes, hypertension, and heart disease. The program focuses on:

- **Encouraging healthy eating habits** through community education, nutrition, skill-building, and promotion of locally grown foods.
- **Increasing physical activity opportunities in** workplaces, schools, and community settings.
- **Building community capacity** by training local leaders to promote nutrition and physical activity within their networks.
- **Advancing health equity** by addressing environmental and social factors that limit access to healthy food and safe spaces for activity.

Through partnerships with public agencies, community organizations, and local farmers, the program fosters a culture of wellness that supports healthier choices for all Virgin Islanders.

PROGRAM SUCCESSES

- **Eat Healthy, Be Active Intervention:** The program successfully implemented the *Eat Healthy, Be Active* Community Workshops, an evidence-based intervention promoting healthy lifestyle behaviors. CHWs and Chronic Disease staff were trained as facilitators, empowering them to deliver sessions that reached residents across the Territory.
- **Employee Physical Activity Initiative:** In partnership with colleagues across the VIDOH, the program launched a *Physical Activity Employee Resource Group.* This initiative promotes active lifestyles among VIDOH staff through group activities and educational sessions, improving morale, teamwork, and overall wellness.
- **Local Media and Public Education Campaigns:** A locally developed media campaign and public service announcement promoted healthy eating for all ages and encouraged residents to "buy local" and support Virgin Islands' farmers. These culturally tailored messages reinforced the benefits of fresh, locally sourced produce and balanced nutrition.

DIABETES

PROGRAM OVERVIEW & GOALS

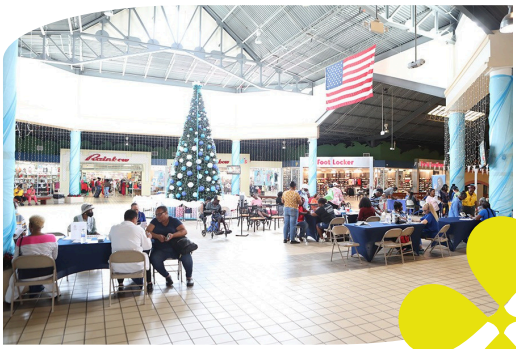
The VIDOH Diabetes Program uses a coordinated, evidence-based approach to prevent Type 2 diabetes, improve disease management, and reduce disparities across the USVI. The program emphasizes early intervention, self-management support, and equitable access to services to reduce complications and improve quality of life for individuals and communities. The program's priorities include:

- **Primary Prevention**
  - Reduce the risk of Type 2 diabetes among individuals with prediabetes through lifestyle change interventions.
  - Promote healthy behaviors such as increased physical activity and sustainable weight management.
  - Expand access to the National Diabetes Prevention Program (NDPP) through in-person, virtual, and distance learning models.
  - Ensure program quality through participation in the CDC Diabetes Prevention Recognition Program.
- **Secondary Prevention**
  - Improve diabetes management and quality of life for individuals living with diabetes.
  - Increase access to Diabetes Self-Management Education and Support services to reduce preventable complications.
- **Health Equity**
  - Focus efforts on populations with the highest burden of diabetes.
  - Address social and environmental factors that contribute to diabetes risk across the lifespan.



DIABETES

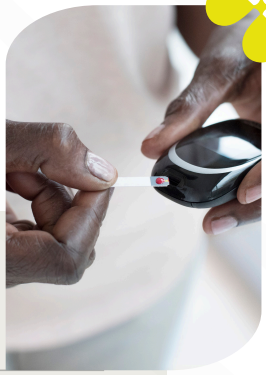
PROGRAM SUCCESSES

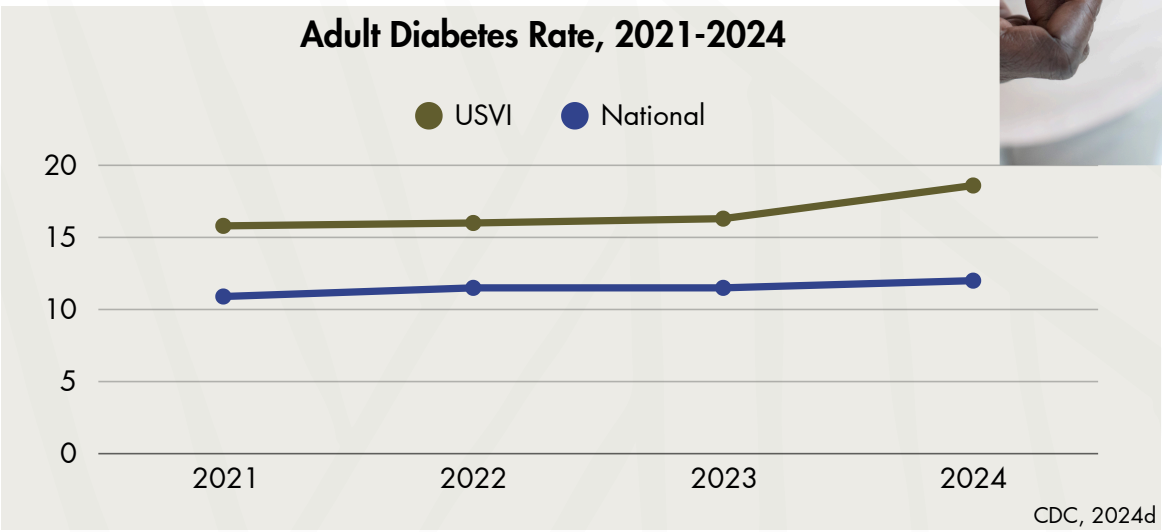


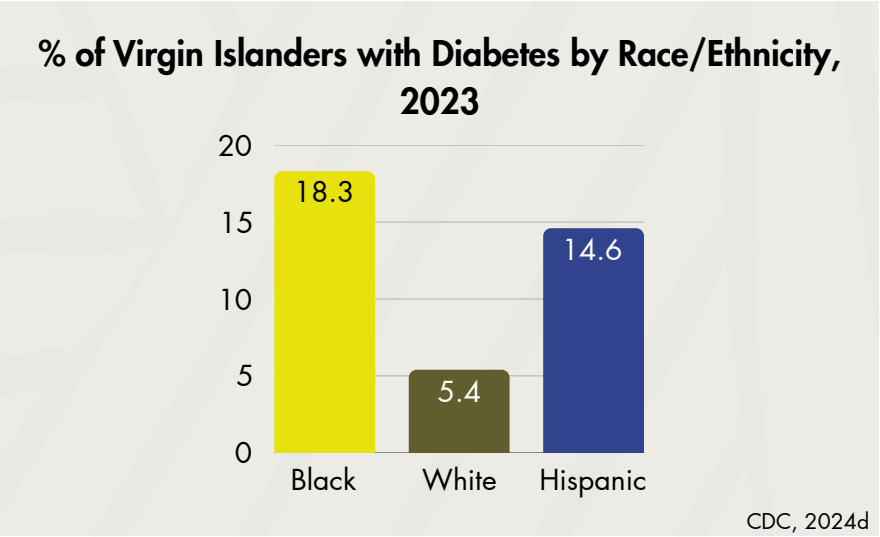


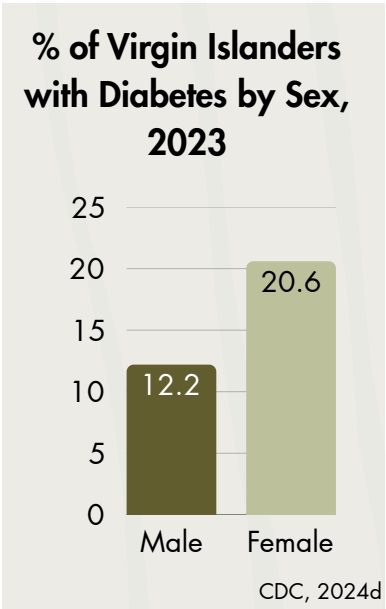
- **Lifestyle Prevention and Risk Reduction:** In 2025, VIDOH re-launched the NDPP, an evidence-based lifestyle intervention designed to help adults at risk for Type 2 diabetes make sustainable behavior changes related to diet, physical activity, and stress management. The program is offered in community settings and led by trained facilitators, improving accessibility across the islands.
- **Self-Management:** Since 2018, the Chronic Disease Self-Management Program (CDSMP) and Diabetes Self-Management Program (DSMP) have empowered residents with diabetes to take control of their condition, reduce complications, and improve quality of life. Participants receive tools, group support, and culturally tailored education to promote healthy daily routines. The program is offered in community settings and led by trained facilitators, improving accessibility across the islands.
- **Clinical Collaboration and Quality Improvement:** Through the NCD Collaborative, the Diabetes Program works with Federally Qualified Health Centers (FQHCs) and Community Health Clinics to strengthen clinical systems. Efforts include identifying patients with uncontrolled A1C levels, providing personalized education, and improving care coordination using the Chronic Care Model.
- **Data and Surveillance:** VIDOH tracks diabetes and prediabetes prevalence through the BRFSS to monitor trends and guide public health action. In addition, the Chronic Kidney Disease, Stroke, and Diabetes Registry, which was established through Act. No. 8814, will serve as a future tool to enhance surveillance, data integration, and care coordination across chronic disease programs once fully implemented.
- **Community Partnerships:** The program conducts school and community outreach events to raise awareness about diabetes prevention and healthy living. Locally produced media campaigns and public service announcements promote healthy eating, physical activity, and regular screening.

DIABETES









Approximately 1 in 6 people in the US Virgin Islands has Diabetes

CANCER PREVENTION & CONTROL

The VIDOH Cancer Prevention and Control Program works to reduce the burden of cancer through prevention, early detection, data surveillance, and improved access to care. The program integrates three key components:

- Virgin Islands Breast and Cervical Health Program
- Virgin Islands Comprehensive Cancer Control Program
- Virgin Islands Central Cancer Registry

Together, these initiatives strengthen the Territory's capacity to prevent cancer and expand access to screening, diagnosis and treatment services.

VIRGIN ISLANDS BREAST & CERVICAL HEALTH PROGRAM (VIBCHP) OVERVIEW & GOALS

The VIBCHP increases access to breast and cervical cancer screening and diagnostic services for eligible women across the Territory, with a focus on those who are uninsured and underinsured. The program reflects the VIDOH's commitment to providing equitable, high-quality screening and timely follow-up care.

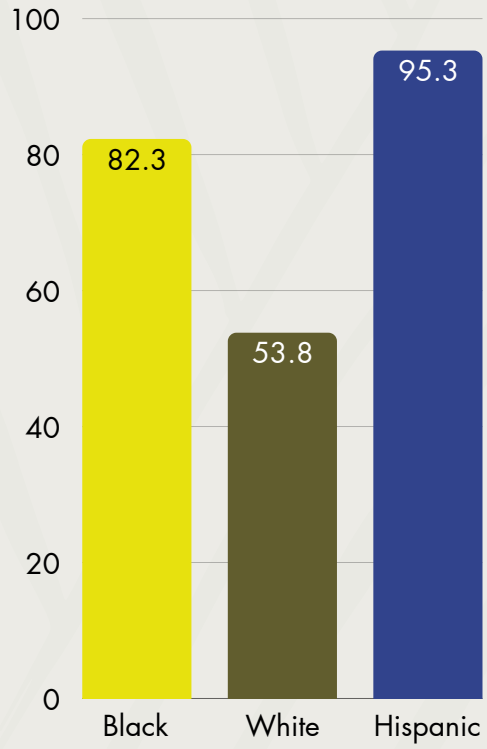
VIBCHP PROGRAM SUCCESSES

- Since its launch in January 2025, the program has provided breast and cervical cancer screening services to more than 200 eligible clients at the Family Planning Clinics.
- The program offers diagnostic follow-up and patient navigation to ensure clients receive appropriate and timely care.
- The VIBCHP collaborates with the USVI Cancer Coalition and other chronic disease programs to recruit clients and conduct outreach and education through faith-based organizations, health fairs, sporting events, and housing communities.

Through these efforts, the VIBCHP continues to reduce barriers to care, improve early detection, and promote preventive health behaviors among women throughout the USVI.

BREAST CANCER

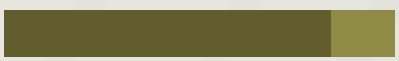
% of Virgin Islanders Who Received a Mammogram in the Past Two Years, 2023



CDC,2024d



US Virgin Islanders Up to Date with Mammogram by Insurance Status, 2023



83.4%

Insured

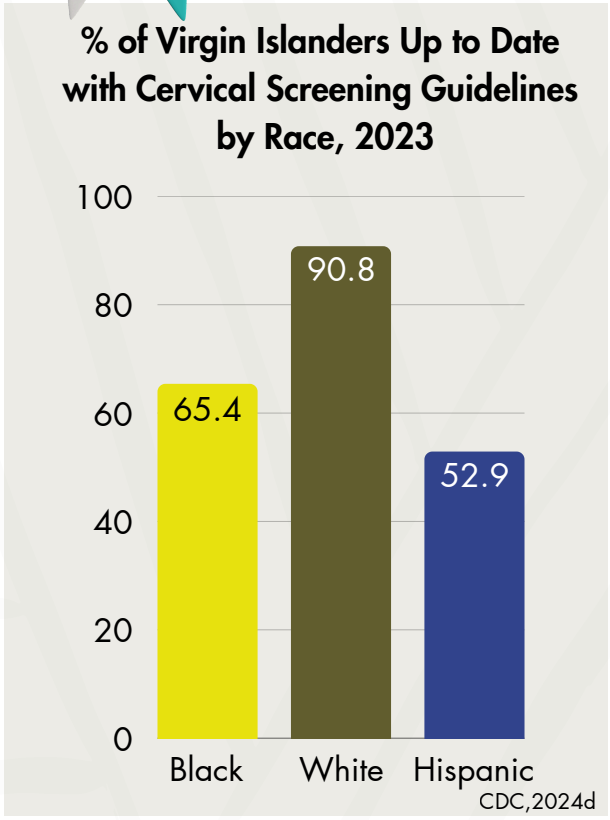


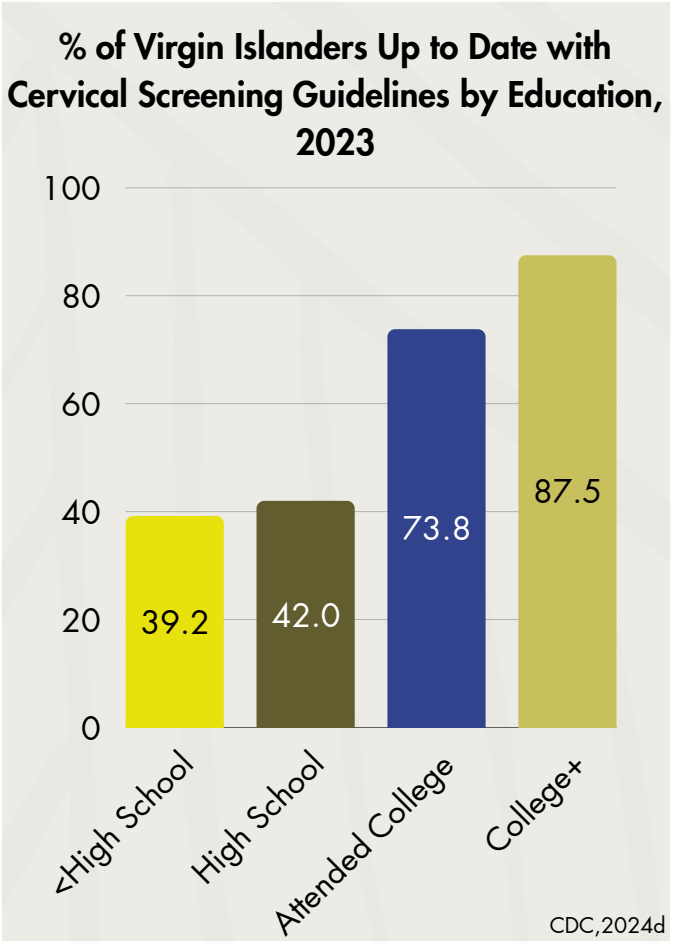
66.3%

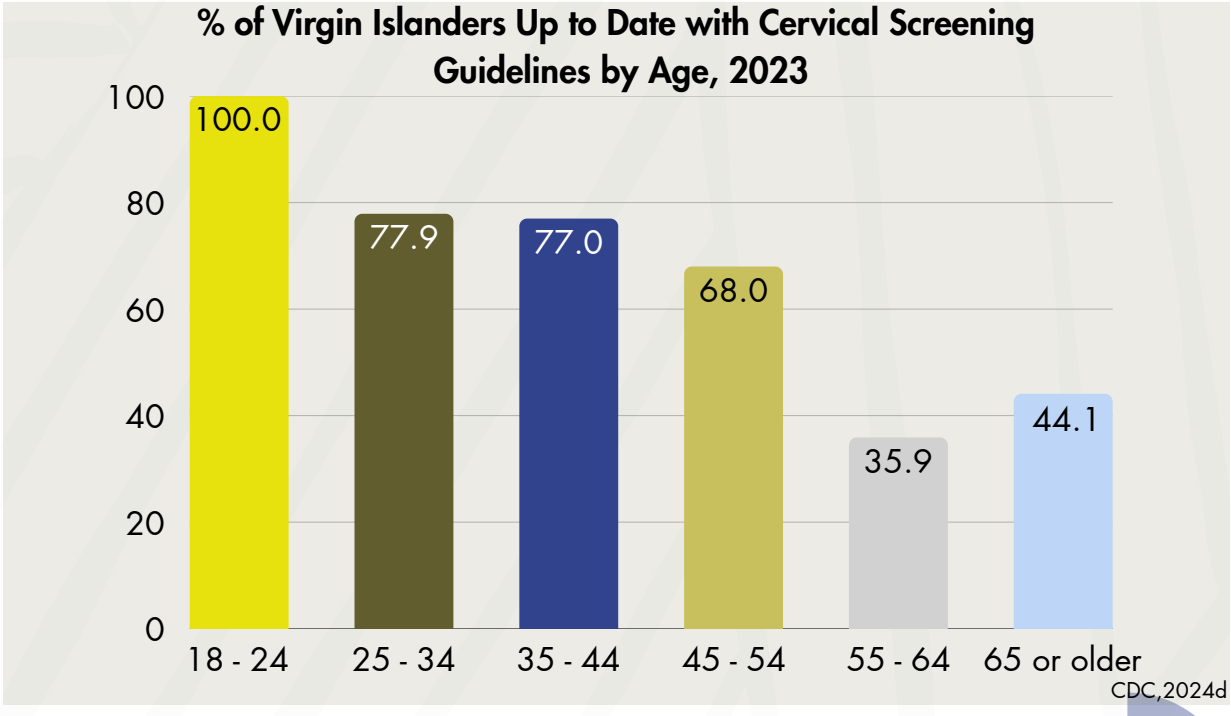
Uninsured

CDC,2024d

CERVICAL CANCER







CANCER PREVENTION & CONTROL

VIRGIN ISLANDS COMPREHENSIVE CANCER CONTROL PROGRAM (VICCCP) OVERVIEW & GOALS

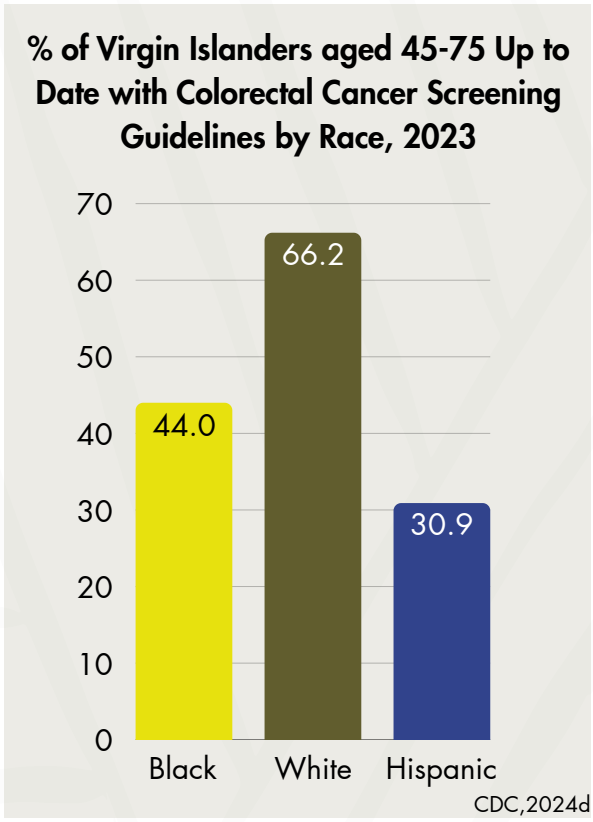
The VICCCP coordinates a territory-wide approach to cancer prevention, early detection, treatment, and survivorship. By fostering collaboration among healthcare providers, community organizations, public health professionals, and advocates, the program works to reduce cancer risk factors and improve outcomes for all Virgin Islanders.

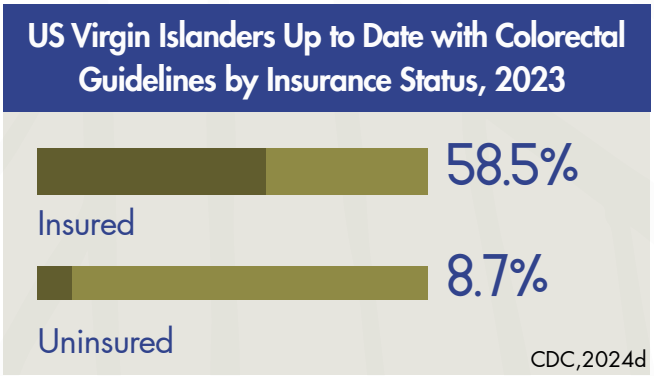


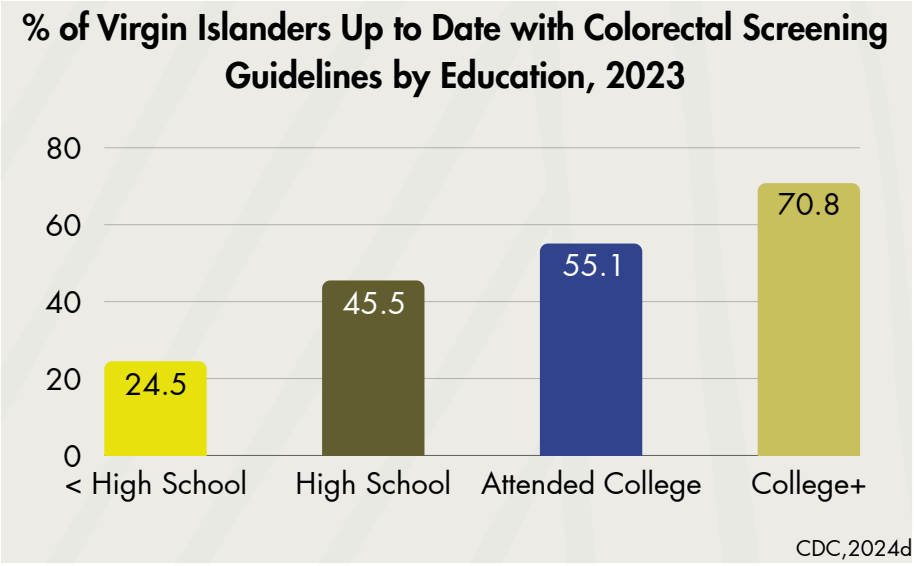
VICCCP PROGRAM SUCCESSES

- Leads the implementation of the USVI Cancer Plan, which serves as a strategic roadmap for guiding prevention, early detection, treatment, and management efforts across the Territory.
- Supports and convenes the USVI Cancer Coalition, a diverse network of partners committed to addressing cancer through coordinated policy, education, and community engagement.
- Hosts the annual USVI Cancer Summit, a key forum that brings together coalition members, healthcare professionals, and community stakeholders to review progress, share data, and set priorities for the upcoming year.
- Promotes evidence-based interventions that address modifiable risk factors such as tobacco use, poor nutrition, and physical inactivity.
- Partners with the VIBCHP and other VIDOH Programs to conduct joint outreach and education campaigns that emphasize early detection, screening, and healthy lifestyles.
- Implements health promotion initiatives, including Human Papilloma Virus and Hepatitis B vaccination campaigns, to reduce the incidence of infection-related cancers and improve vaccination uptake across islands.

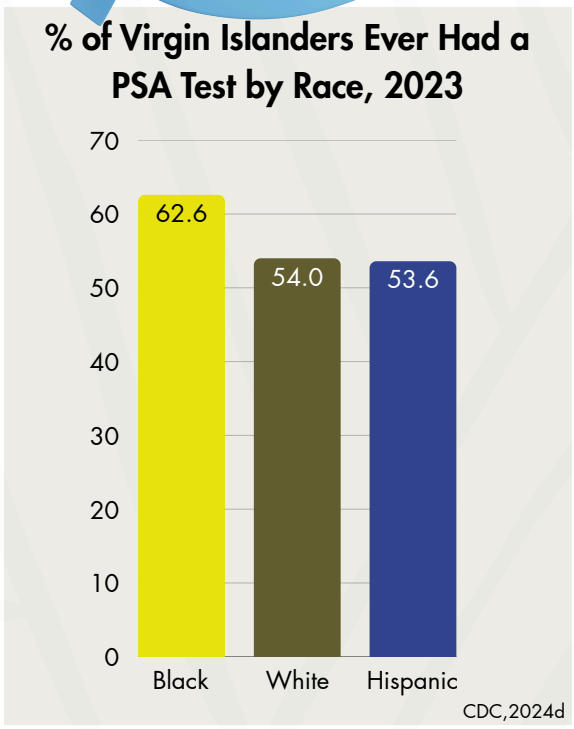
COLORECTAL CANCER



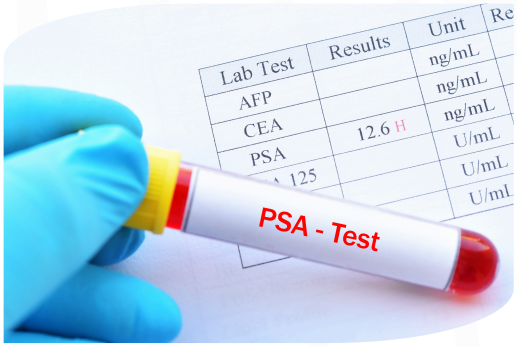




PROSTATE CANCER



A Prostate Specific Antigen Test, or PSA Test, is a blood test that can be used to screen for prostate cancer.



Of the men who reported ever having a PSA test done in 2023:

65%

had their last PSA within the past year, while 5% said their last PSA test was 5 or more years ago (CDC, 2024d).

74%

of men had it as part of a routine exam, while almost 15% reported having it because of a problem (CDC, 2024d).

71%

had it after a suggestion from a nurse, doctor or other medical provider, while almost 20% initiated it themselves (CDC, 2024d).

CANCER PREVENTION & CONTROL

VIRGIN ISLANDS CENTRAL CANCER REGISTRY (VICCR) OVERVIEW & GOALS

The VICCR plays a vital role in strengthening cancer surveillance and providing the data needed to guide prevention and control strategies. The registry is guided by local legislation, which mandates that healthcare providers, laboratories, and hospitals report cancer data to the VICCR. The VICCR collects, analyzes, and reports high-quality data on cancer incidence, including patient demographics, cancer type, stage at diagnosis, first course of treatment received, and survival outcomes across the Territory.

VICCR PROGRAM SUCCESSES

- Strengthens data quality through ongoing provider training and technical assistance to ensure complete and timely reporting.
- Collaborates with regional and national partners to maintain compliance with the National Program of Cancer Registries (NPCR) standards.
- Publishes cancer incidence reports that provide valuable insights into cancer trends and burden across the Territory, supporting evidence-based planning and resource allocation.

HEART DISEASE & STROKE

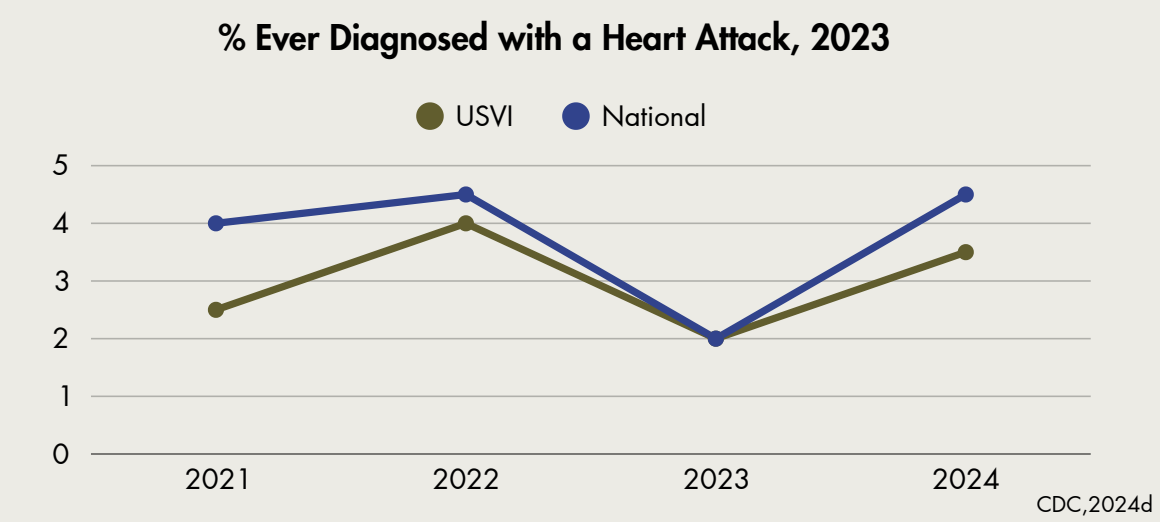
PROGRAM OVERVIEW & GOALS

Heart disease remains the leading cause of death in the USVI, reflecting a major public health concern for the Territory. Contributing factors such as hypertension, diabetes, obesity, and physical inactivity continue to drive high rates of cardiovascular disease and stroke. The Heart Disease and Stroke Prevention Program works to reduce these risks through prevention, early detection, and improved management of chronic conditions. The program emphasizes culturally relevant education, community engagement, and system-level collaborations that promote long-term heart health and support healthier lifestyles across the islands.

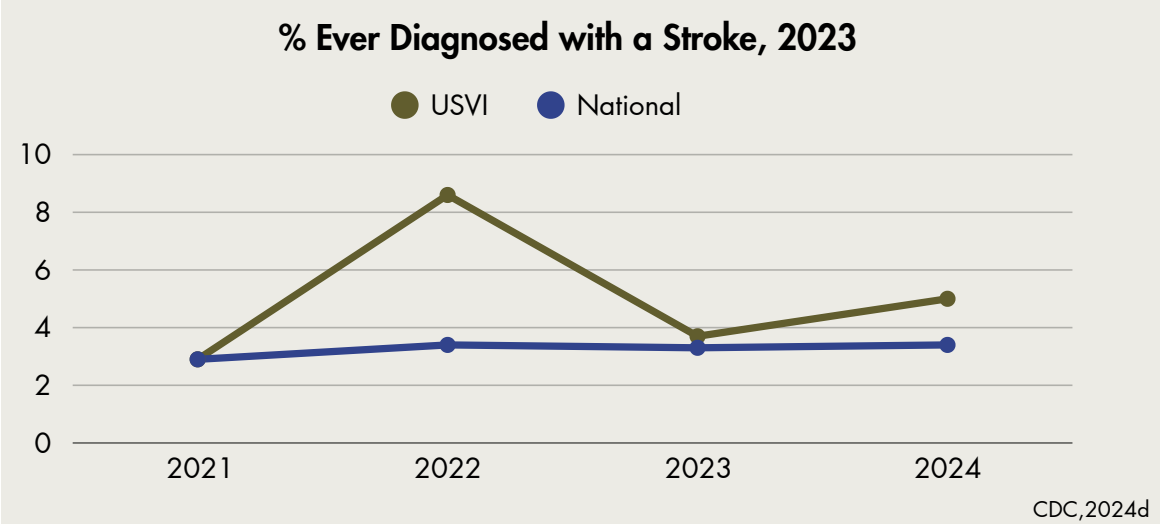
PROGRAM SUCCESSES

- Promotes heart-healthy lifestyles through a culturally relevant multimedia campaign that highlights popular local dishes and encourages eating traditional foods in moderation. This campaign connects culture and health, helping residents make informed dietary choices while maintaining cultural traditions.
- Annual engagement of the University of the Virgin Islands (UVI) to implement Health Empowerment, a self-management program focused on cardiovascular disease and stroke prevention and management. This initiative supports individuals at risk or living with heart disease and stroke, empowering them with tools for lifestyle change, medication adherence, and stress management.
- Provides support and resources to local community organizations to educate seniors on cardiovascular disease and stroke prevention and management.
- Hosts the annual Heart-2-Heart Walk, a community event designed to promote physical activity and raise awareness about heart disease and stroke prevention while fostering unity and community engagement.
- Participates in community outreach activities across schools, community organizations, workplaces, and health fairs to provide heart health education and raise awareness about risk factors and prevention strategies.

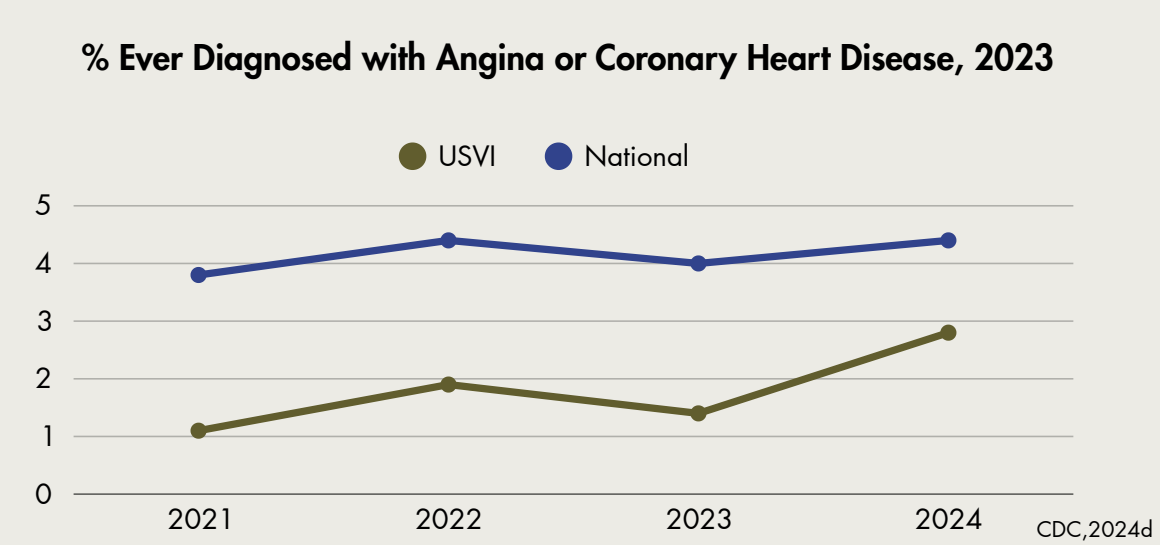
USVI COMPARED TO USA



CDC,2024d



CDC,2024d



CDC,2024d

SICKLE CELL DISEASE

PROGRAM OVERVIEW & GOALS

Sickle Cell Disease (SCD) is one of the most common inherited blood disorders in the U.S. Virgin Islands, affecting the quality of life of both children and adults. Individuals with SCD experience a range of complications, including pain episodes, anemia, organ damage, and increased infection risk. Recognizing these challenges, the VIDOH Sickle Cell Disease Program works to increase public awareness, improve access to care, and strengthen support systems for affected families. The program's approach combines education, advocacy, and collaboration with healthcare providers and local partners to reduce stigma, promote early diagnosis, and improve disease management and quality of life for individuals living with SCD.

PROGRAM SUCCESSES

- **Community Awareness Campaigns:** Develops and airs annual media ads for World Sickle Cell Day and Sickle Cell Awareness Month to raise awareness of the disease, promote early testing, and encourage community support for individuals and families affected by SCD.
- **Annual "Shine the Light on Sickle Cell Walk":** Hosts an annual walk to commemorate World Sickle Cell Day, bringing together patients, families, healthcare providers, and the community to raise awareness and promote solidarity.
- **Partnership with the Virgin Islands Sickle Cell Parent Support Group:** Collaborates closely with the support group to host outreach events, educational sessions, and family support initiatives, ensuring that those affected by SCD receive both practical and emotional assistance.
- **Sickle Cell Care Packages**: Distributes care packages to Sickle Cell patients during Sickle Cell Awareness Month as a gesture of support and to raise awareness of the ongoing needs of individuals living with SCD.
- **Registry Development:** Engages with UVI to develop and implement a Voluntary Sickle Cell Disease Patient Registry, designed to collect data on individuals living with SCD in the Territory. Once established, the registry will enhance understanding of disease patterns, inform program planning, and improve patient care coordination.

GOAL 1

Create a culture of health and wellness throughout the U.S. Virgin Islands.

1.1 Objective 1.1: Implement five self-management programs to educate the community on the prevention & management of chronic diseases.

Strategies 1.1

- Partner with CDC-recognized and evidence-based programs (e.g., NDPP and the Self-Management Resource Center).
- Train and certify local facilitators, including CHWs and nurses, to deliver these programs.
- Offer programs in community centers, churches, workplaces, and virtually.
- Track participant enrollment, completion rates, and satisfaction.

Baseline: 3 programs **2027 Target: 5 programs**

1.2 Objective 1.2: Collaborate with the Virgin Islands Department of Education (VIDE) to update two nutrition & physical activity policies.

Strategies 1.2

- Establish a joint task force between VIDOH and VIDE.
- Review existing policies.
- Conduct stakeholder focus groups that include students, parents and teachers.
- Implement policy changes and monitor compliance.

Baseline: 0 policies updated **2029 Target: 2 policies implemented**

1.3 Objective 1.3: Utilize Community Health Workers (CHWs) to provide preventive health education in six community settings where people live, work, learn, and play.

Strategies 1.3

- Train and assign CHWs to settings such as schools, churches, senior centers, housing communities, and workplaces.
- Develop standard curricula on diabetes, hypertension, nutrition, and mental wellness.
- Track number of sessions, participants, and referrals to care.
- Secure funding through federal and national grants and community partnerships.

Baseline: 0 settings using CHW-led programs **2028 Target: 6 settings**

GOAL 1

1.4 Objective 1.4: Host four annual community wellness activities that promote physical health for all ages.

Strategies 1.4

- Identify partners such as NGOs, faith-based institutions, local gyms, and private sector businesses.
- Organize events such as fitness days, walks, and health fairs.
- Offer free health screenings, fitness demonstrations, and nutrition workshops at each event.
- Track attendance, number of screenings completed, and participant feedback.

Baseline: 2 coordinated wellness activities | **Target: 4 activities annually by 2026**

1.5 Objective 1.5: Support and encourage the Department of Sports, Parks, & Recreation (DSPR) in the implementation of two sustainable physical activity programs.

Strategies 1.5

- Collaborate with DSPR to identify facilities and communities with highest need.
- Develop structured physical activity programs (e.g., after-school youth sports, senior walking clubs).
- Integrate sustainability plans including training local instructors and secure funding.
- Monitor participation rates and program continuity.

Baseline: Pending | **2028 Target: 2 programs implemented & operating**

1.6 Objective 1.6: Facilitate conversations and initiatives to promote emotional and behavioral health across the Territory.

Strategies 1.6

- Partner with the Behavioral Health Division MCH and CSHCN Program, faith leaders, and NGOs to host safe, stigma-free community dialogues.
- Launch a mental wellness campaign (radio, social media, town halls) focused on stress management, depression, trauma, and resilience.
- Provide Mental Health First Aid training for CHWs, teachers, and community leaders.
- Track attendance, training completion rates, and referrals to mental health services.

Baseline: Pending | **Target: 3 community health forums or campaigns annually**

GOAL 2

Create a more coordinated system of care and strengthen inter-agency collaboration.

2.1 Objective 2.1: Train four community and faith-based organizations on chronic disease self-management programs.

Strategies 2.1

- Identify a training curriculum using evidence-based models
- Partner with faith-based organizations, NGOs, and other government agencies.
- Train trainers within organizations to ensure sustainability.
- Collect pre/post knowledge assessments and track the number of workshops hosted by trained organizations.

Baseline: 0 Organizations trained **2027 Target: 4 Organizations**

2.2 Objective 2.2: Increase the integration of health and wellness practices among Maternal and Child Health (MCH) programs, pediatricians, USVI Department of Human Services (DHS), schools, and other youth-serving organizations.

Strategies 2.2

- Establish an Interagency Child & Adolescent Health Task Force comprised of VIDOH, VIDE, DHS, and pediatric health providers.
- Identify and distribute standardized resources for obesity, nutrition counseling, behavioral health, and physical activity.
- Provide training on screening tools (BMI percentiles, ACEs, adolescent depression screening).
- Integrate health promotion into existing programs like WIC, MCH & CSHCN, Head Start, and after-school programs.
- Track number of agencies adopting integrated practices and number of referrals made.

Baseline: Limited or inconsistent health promotion across agencies **Target: At least 5 youth-serving agencies implementing coordinated health promotion practices by 2029**

GOAL 2

Create a more coordinated system of care and strengthen inter-agency collaboration.

2.3 Objective 2.3: Identify stakeholders that provide services to vulnerable populations and persons with special needs.

Strategies 2.3

- Identify stakeholders serving seniors, persons with disabilities, homeless individuals, uninsured, and undocumented populations.
- Conduct stakeholder surveys, listening sessions, and virtual meetings.
- Create a territorial resource directory in digital and print formats.
- Distribute the directory across government agencies, NGOs, hospitals, clinics, and CHWs.
- Maintain directory with annual updates.

Baseline: No centralized inventory of service providers	Target: Develop a comprehensive stakeholder directory by 2027

2.4 Objective 2.4: Use CHWs to engage organizations serving vulnerable populations and facilitate linkage to clinical care.

Strategies 2.4

- Deploy CHWs to partner agencies including elderly housing, public health clinics, and FQHCs.
- Train CHWs on motivational interviewing.
- Implement referral tracking system.
- Evaluate outcomes (number of individuals referred to primary care, specialist care, behavioral health, and social services).
- Research Medicaid/Medicare reimbursement pathways for CHW services where possible.

Baseline: No structured CHW linkage system in place	Target: CHWs actively collaborating with 6 agencies and making at least 50 referrals annually

GOAL 3

Engage policymakers in noncommunicable disease policy.

3.1 Objective 3.1: Engage with senators & the Department of Public Works (DPW) to implement the Complete Streets Policy.

Strategies 3.1

- Convene joint meetings with senators, DPW, and VIDOH to discuss policy rollout.
- Provide data on physical inactivity and community infrastructure needs.
- Advocate for inclusion of sidewalks, bike lanes, lighting, and accessibility in new infrastructure projects and repairs.
- Track meeting dates, attendance, and milestones.

Baseline: No formal engagement or implementation reports submitted

2027 Target: At least 2 meetings held and 1 implementation progress report or recommendations submitted

3.2 Objective 3.2: Support policies that increase access to a living wage and quality housing by providing data on social and economic determinants of health.

Strategies 3.2

- Partner with Department of Labor and DHS for shared data.
- Develop data reports on correlations between income, housing insecurity, and chronic disease outcomes in the USVI.
- Present findings to the Legislature, Economic Development Authority, and VI Housing Authority.
- Track number of reports, testimonies, and policy references to health data.

Baseline: No formal data provided to policymakers on wage/housing health impacts

Target: 1 policy brief and 2 legislative testimonies or presentations submitted by 2030

GOAL 3

3.3 Objective 3.3: Support policies that promote health education & wellness.

Strategies 3.3

- Advocate for policies such as mandatory health education in schools and workplace wellness incentives.
- Collaborate with VIDE, hospitals, NGOs, and other government agencies to draft language and provide public testimony.
- Track supported bills, public hearings, and testimonies.

Baseline: No coordinated policy advocacy efforts on health education and wellness policies	Target: At least 3 health-focused policy proposals or legislative amendments supported by 2030

3.4 Objective 3.4: Identify and highlight the importance of innovative Medicare and Medicaid models for chronic disease prevention and management.

Strategies 3.4

- Research models such as value-based care, CHW reimbursement, telehealth expansion, and Diabetes Prevention Program reimbursement.
- Engage Medicaid Office and insurers.
- Summarize feasibility and potential savings in a policy brief/report.
- Track dissemination and feedback.

Baseline: Limited exploration of alternative payment or service models in USVI	Target: Produce 1 policy report and present to CMS regional leadership and local policymakers by 2028

3.5 Objective 3.5: Partner with DPW or ride-share services to develop transportation solutions for patients with barriers to medical appointments.

Strategies 3.5

- Identify high-need patient groups (dialysis, elderly, disabled).
- Explore partnerships with DPW, local taxis, or rideshare providers.
- Secure funding through federal grants or local appropriations.
- Track number of rides provided, missed appointment reductions, and patient satisfaction.

Baseline: No formal patient transportation collaboration for NCD care	Target: Launch 1 pilot transportation program by 2029

GOAL 4

Improve population health for all Virgin Islanders.

4.1 Objective 4.1: Implement population-wide approaches and focused interventions for priority populations.

Strategies 4.1

- Launch island-wide campaigns on hypertension screening, diabetes prevention, nutrition, and physical activity.
- Implement targeted interventions for high-risk populations.
- Partner with FQHCs, public health clinics, faith-based organizations, and NGOs for delivery of targeted services.
- Track participation, screening outcomes, and behavior changes.

Baseline	Target
Baseline: No formal population-wide NCD intervention framework in place	**Target: 2 annual population-wide interventions and 1 annual targeted intervention such as the NCD Collaborative for high-risk groups**

4.2 Objective 4.2: Implement standardized approach to identify priority populations.

Strategies 4.2

- Develop criteria based on disease burden, income, geography, age, disability, and healthcare access.
- Use data from Behavioral Risk Factor Surveillance System (BRFSS), VI Central Cancer Registry, hospitals, insurers, and Medicaid.
- Develop a standardized tool and train epidemiologists and program managers on its use in planning and resource allocation.
- Review annually and update based on changing population needs.

Baseline	Target
Baseline: No standardized criteria for determining priority populations	**Target: A standardized priority population identification tool or framework adopted by DOH and at least 3 partner agencies by 2029**

GOAL 4

Improve population health for all Virgin Islanders.

4.3 Objective 4.3: Use data to identify areas of disparity as part of a comprehensive wellness care plan.

Strategies 4.3

- Analyze data by island, race/ethnicity, income level, insurance status, age, etc.
- Use data from BRFSS, hospital discharges, Medicaid, Vital Statistics, YRBS and the VI Central Cancer Registry.
- Present findings to VIDOH leadership, Legislature, FQHCs, and community partners.
- Use data to guide resource allocation, grants, and intervention targeting.

Baseline	Target
Limited or fragmented use of health data to assess disparities	**Develop a territory-wide NCD disparity report and integrate findings into wellness care planning by 2028**

4.4 Objective 4.4: Identify a health equity leader to serve as a liaison to the Health, Hospital, and Human Services Committee of the Legislature.

Strategies 4.4

- Develop selection criteria for the liaison role (experience, community trust, equity focus).
- Collaborate with VIDOH leadership and senators on the committee to approve and appoint the liaison.
- Define roles and responsibilities (provide data, advise on legislation, represent vulnerable populations).
- Establish regular reporting or meeting schedule between liaison, VIDOH, and the legislative committee.

Baseline	Target
No designated health equity liaison to the legislative committee	**1 health equity leader identified by 2026**

GOAL 4

Improve population health for all Virgin Islanders.

4.5 Objective 4.5: Increase the number of bilingual Community Health Workers (CHWs) and health staff to improve language access for Spanish- and Haitian Creole-speaking populations.

Strategies 4.5

- Partner with local churches, immigrant associations, NGOs, and schools to recruit bilingual community members.
- Provide CHW training.
- Identify translation needs and begin translating materials, forms, and health education tools into Spanish and Haitian Creole.
- Track number of bilingual staff, communities served, and encounters with non-English-speaking patients.

Baseline: Limited bilingual staff	Target: Recruit and train at least 10 bilingual CHWs by 2030



IMPLEMENTATION FRAMEWORK

The successful implementation of the NCD Strategic Plan requires coordinated action across divisions, clear communication, and practical tools that help staff and partners understand their roles in advancing the Plan. This section outlines how the Division of Chronic Disease and Prevention will operationalize the Plan across programs and the broader health system.

1 NCD Implementation Team

A cross-functional working group that meets monthly and is responsible for:

- Operationalizing the strategies and initiatives in the Plan
- Coordinating activities across islands
- Sharing updates, challenges, and resource needs
- Managing communication tools, dashboards, and data documents

2 Communication and Engagement

Internal Communication

Internal communication focuses on keeping VIDOH staff aligned with priority NCD work. Approaches include:

- Focused internal meetings held as needed where division directors and key program leads review data, troubleshoot challenges, and align priorities
- Internal Collaboration Platform: A shared workspace (e.g., Teams, SharePoint) where tools, templates, data documents, and updates are stored for consistent access

External Communication

External communication focuses on public awareness, community engagement, and policy visibility. Approaches include:

- Newsletters and public health bulletins
- Public-facing dashboards illustrating progress and health outcomes
- Infographics, fact sheets, and press briefings on high-priority NCD issues
- Community forums and stakeholder town halls
- Short explainer videos or visual materials describing the Plan's goals, strategies, and impact

IMPLEMENTATION FRAMEWORK

3 Integration Across VIDOH Programs

VIDOH will integrate prevention, screening, data-sharing, and communications across multiple programs to reduce fragmentation and move toward a coordinated system of care. Key integration actions include:

- Shared annual workplan aligning each program's activities with the Plan
- Unified public health messaging across tobacco, cancer, diabetes, nutrition, heart disease, and physical activity programs
- Integrated screening pathways used during community events and clinical encounters (hypertension + diabetes + tobacco use + cancer referrals + behavioral health screening)
- Cross training so staff across programs can deliver consistent health promotion messages

4 Partnership Engagement

External partners play a critical role in expanding reach, strengthening care coordination, and improving population health. Core partner activities include:

- Participation in quarterly NCD Coalition meetings
- Coordinated outreach activities and community screening events
- Joint campaigns on tobacco, immunization, hypertension, cancer screening, and nutrition
- Data-sharing agreements to support prevention and population health
- Engagement with schools, churches, and culturally-based organizations to strengthen community trust

IMPLEMENTATION FRAMEWORK

5 Roles and Responsibilities

- The Division of Chronic Disease & Prevention leads primary implementation of chronic disease strategies, community outreach, health promotion, and education.
- The Epidemiology Division provides surveillance, data analysis, trend reports, and program evaluation support.
- The Office of Health Advancement ensures that equity is embedded in all strategies, will lead workforce training, and support culturally grounded community engagement.
- FQHCs, public health clinics, and private providers provide screenings, education, referrals, and rapid linkages to care.
- The Behavioral Health division integrates mental health and substance use considerations into NCD activities and outreach.
- External Partners provide clinical services, community outreach, community engagement, policy input, and programmatic collaboration.

6 Partnership Engagement

VIDOH and partners will activate the Plan through a phased, structured approach that aligns directly with the timelines outlined in the Goals, Objective, and Strategies section of this Plan. These timelines will be used as the guiding framework for planning, coordination, and accountability.

Additional Year 1 Priorities:

- Establish structure of the NCD Coalition and Implementation Team
- Update annual workplans aligned to NCD goals and timelines
- Develop communication tools (dashboards, templates, newsletters)
- Launch coordinated community outreaches and integrated screening events

Additional Years 2 - 5 Priorities:

- Strengthen inter-agency collaboration and continuous quality improvement
- Sustain communication strategies and awareness campaigns
- Conduct annual implementation reviews and adjust strategies as needed

MONITORING & EVALUATION FRAMEWORK

1 Purpose of Evaluation

- Assess progress toward strategic goals (e.g., reducing incidence, improving quality of life).
- Identify strengths, gaps, and opportunities for improvement.
- Provide accountability to stakeholders and funders.

2 Key Evaluation Questions

- **Effectiveness:** Are interventions reducing disease prevalence or improving health outcomes?
- **Efficiency:** Are resources being used optimally?
- **Equity:** Are all target populations benefiting based on their needs?
- **Sustainability:** Can program impact be maintained long-term?

3 Indicators & Measures

- **Health Outcomes:**
  - % reduction in disease incidence (e.g., diabetes, hypertension, cancer)
  - Hospitalization rates for related complications
  - Patient-reported quality of life scores
- **Process Measures:**
  - Number of screenings conducted
  - Participation rates in prevention programs
  - Provider adherence to clinical guidelines
- **Equity Measures:**
  - Service utilization by demographic group
  - Geographic distribution of program reach

MONITORING & EVALUATION FRAMEWORK

4 Data Collection Methods

- Health registry and surveillance data
- Electronic health records (EHR)
- Surveys and focus groups with patients and providers
- Program activity logs and reports

5 Timeline & Reporting

- **Quarterly**: Process and participation metrics
- **Annually**: Outcome and equity analysis
- **Mid-term & End-term**: Comprehensive impact evaluation with recommendations

6 Feedback & Continuous Improvement

- Share findings with stakeholders in accessible formats
- Use results to refine interventions and resource allocation
- Incorporate community input for culturally relevant adjustments

ACRONYMS

- Adverse Childhood Experiences (ACEs)
- American Cancer Society (ACS)
- Association of State and Territorial Health Officials (ASTHO)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Body Mass Index (BMI)
- Brief Tobacco Intervention (BTI)
- Centers for Disease Control and Prevention (CDC)
- Children with Special Health Care Needs (CSHCN)
- Chronic Disease Self Management Program (CDSMP)
- Chronic Obstructive Pulmonary Disease (COPD)
- Community Health Workers (CHWs)
- Department of Public Works (DPW)
- Department of Sports, Parks, and Recreation (DSPR)
- Diabetes Self-Management Program (DSMP)
- Electronic Health Records (EHR)
- Federally Qualified Health Centers (FQHCs)
- Lesbian, Gay, Bisexual, Transgender, Queer+ (LGBTQ+)
- Maternal and Child Health (MCH)
- National Diabetes Prevention Program (NDPP)
- National Governors Association (NGA)
- Noncommunicable Diseases (NDCs)
- Non-governmental Organizations (NGOs)
- Policy, Systems, and Environmental (PSE)
- Serious Mental Illness (SMI)
- Social Ecological Model (SEM)
- University of the Virgin Islands (UVI)
- U.S. Department of Agriculture
- U.S. Virgin Islands (USVI)
- USVI Department of Human Services (DHS)
- Virgin Islands Breast and Cervical Health Program (VIBCHP)
- Virgin Islands Central Cancer Registry (VICCR)
- Virgin Islands Comprehensive Cancer Control Program (VICCCP)
- Virgin Islands Department of Education (VIDE)
- Virgin Islands Department of Health (VIDOH)
- Women, Infants, and Child (WIC)
- World Health Organization (WHO)
- Youth Risk Behavior Survey (YRBS)



PARTNERS

- American Cancer Society
- Association of State and Territorial Health Officials (ASTHO)
- Cancer Support VI
- Centers for Disease Control and Prevention (CDC)
- Department of Health Divisions (Community Health Clinics, Office of Health Equity, Maternal and Child Health Division, Epidemiology Division, Behavioral Health Division, Division of Environmental Health)
- Department of Human Services
- Department of Licensing and Consumer Affairs
- Department of Sports, Parks, and Recreation
- Dialysis Centers
- Division of Personnel
- Frederiksted Health Care
- Governor Juan F. Luis Hospital
- Family Resource Center
- Law Enforcement Planning Commission
- Private Health Care Providers
- National Association of Chronic Disease Directors (NACDD)
- National Governors Association (NGA)
- Schneider Regional Medical Center
- St. Thomas East End Medical Center Corporation
- University of the Virgin Islands
- USVI Cancer Coalition
- USVI Chronic Disease Advisory Group
- Virgin Islands Department of Education
- Virgin Islands Diabetes Center of Excellence
- Virgin Islands Housing Authority
- Virgin Islands Partners for Healthy Communities
- Virgin Islands Police Department
- Virgin Islands Sickle Cell Parent Support Group
- Women's Coalition of St. Croix
- YAG Foundation



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