3 GOOD HEALTH AND WELL-BEING

GOAL 3
Ensure healthy lives and promote well-being for all at all ages[39]

Context

In 2019, the Ministry of Health was renamed the Ministry of Health and Wellness (MOHW), to reflect more closely the World Health Organization's holistic definition of health, expanding the scope of the ministry's policy and programmatic focus to include all dimensions of wellness.

Jamaica's human development index places the country in the high human development category. The health sector in Jamaica has succeeded in areas such as the prevention, management and control of diseases. Improvements have been observed in life expectancy and a steady decline in infant and under-5 mortality. Nonetheless, challenges have been identified as the country is experiencing both a demographic and epidemiological transition and high rates on non-communicable diseases. Violence and injuries also place an additional burden on the health system. Further issues identified are *inter alia,* the need to improve efficiencies in health worker distribution, coordination of care, hospital and bed capacity, and administrative inefficiency. Challenges have also been experienced with keeping health facilities well-resourced and responsive to emerging situations, owing in part to the decreasing fiscal space due to low economic growth and high debt burden.

Public health expenditure is generally pro-poor however out-of-pocket expenses remain high, whilst health insurance coverage is low. Human Resources for Health need to be reviewed to better manage the epidemiologic and demographic transition of Jamaica. The Vision for Health 2030- Ten Year Strategic Plan (2019-2030), emanated from a comprehensive assessment of the health system and aims to address gaps through four defined components, which include a standard comprehensive essential benefits package, the health service delivery network, finance and governance, as two supportive elements, namely human resources and infrastructure. The Vision for Health 2030 is the Strategic Agenda to address the gaps and promote transformation in key areas toward reversing downward trends and accelerating progress toward universal access to health and universal health coverage in Jamaica.

The review for the period 2018-2022 summarizes key achievements, issues and challenges concerning health and wellbeing.

39 This section was written by the Ministry of Health and Wellness and is the only report developed by a Ministry for the VNR process. It demonstrates ownership of the process and the level of alignment with the SDGs.

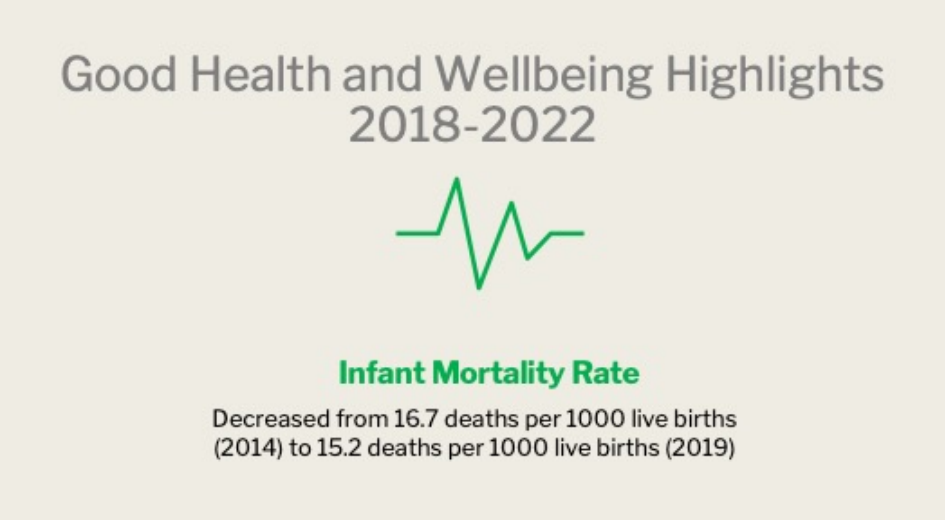


FIGURE 13: **HIGHLIGHTS, GOOD HEALTH AND WELLBEING 2018 –2021**

Discussion

Target 3.1 By 2030, Reduce the Global Maternal Mortality Ratio to Less than 70 per 100 000 Live Births

The maternal health programme of the Ministry of Health and Wellness is geared at ensuring that all pregnant women have access to quality healthcare throughout their pregnancy. If mortality occurs during childbirth, the classification of maternal deaths are Class 1 notifiable events, so healthcare providers must report these health events on suspicion to the respective Parish Health Departments within 24 hours of contact or the National Surveillance Unit (NSU)[40]. Notified deaths are reviewed at the institutional, regional, and national levels by inter-disciplinary teams who classify them and identify any delays, which can be addressed to prevent future deaths. The team of experts consists of obstetricians, epidemiologists, medical officers of health, midwives and public health nurses. The data on maternal deaths are collated, entered into a database, and analyzed by the NSU. Three hundred and two (302) suspected pregnancy-related deaths were reported to the NSU between 2016 and 2020. Two-thirds of these cases (66.8 per cent, n = 202) met the WHO case definition and were further classified as maternal deaths (Figure 14).

40 (Ministry of Health, 2009)

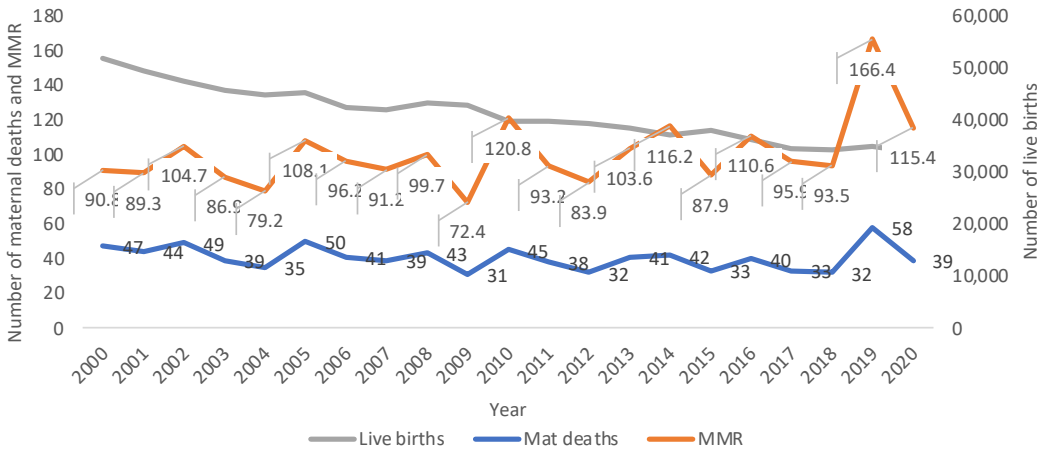


FIGURE 14: **MATERNAL MORTALITY RATIO, MATERNAL DEATHS AND LIVE BIRTHS BY YEAR: JAMAICA, 2000–2020**
Source: Ministry of Health and Wellness

Temporal Trends in the Maternal Mortality Ratio

The annual number of live births in Jamaica has steadily decreased over the last two decades from over 50 000 to approximately 35 000 live births each year. In addition, a general increase was noted in the last five years from 2016 to 2020. However, the number of maternal deaths and consequently the Maternal Mortality Ratio (MMR) has fluctuated. The MMR ranged from 72.4 (31 maternal deaths) in 2009 to 166/100 000 live births (58 maternal deaths) in 2019 (Figure 14).

Classification of Maternal Deaths

Nationally there was a general increase in the number of live births at older maternal age from 1980 to 2020. The general trend for the period between 2008 and 2020 was a decline in direct maternal deaths and a general increase in indirect maternal deaths. Direct maternal deaths are obstetric complications of the pregnant state from interventions, omissions, incorrect treatment, or a combination of any of the above. Indirect maternal deaths are pre-existing diseases or disease that develops during pregnancy and which was not due to obstetric causes but was aggravated by the physiological effects of the pregnancy. The number of direct (n=34) and indirect (n=24) deaths was highest in 2019 (Figure 15).

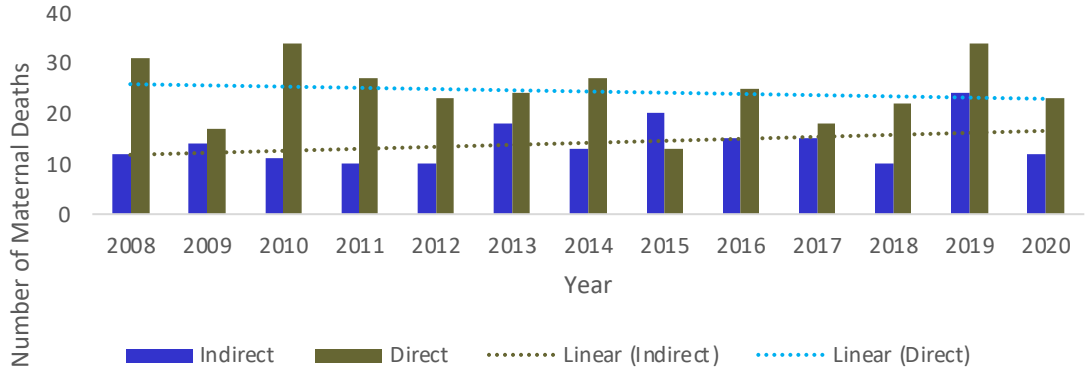


FIGURE 15: **NUMBER OF DIRECT AND INDIRECT MATERNAL DEATHS OCCURRING IN JAMAICA BY YEAR, 2008–2020**
Source: Ministry of Health and Wellness

Cause of Death

The leading direct causes of maternal deaths by triennium from 1998 to 2018 were gestational hypertension, obstetric haemorrhage, and obstetric embolism (Figure 15). Diseases of the circulatory system, sickle cell disease, and HIV/AIDS were the main contributors to indirect maternal deaths between 1998 and 2018. However, a decrease in maternal deaths due to HIV/AIDS was noted (Figure 16).

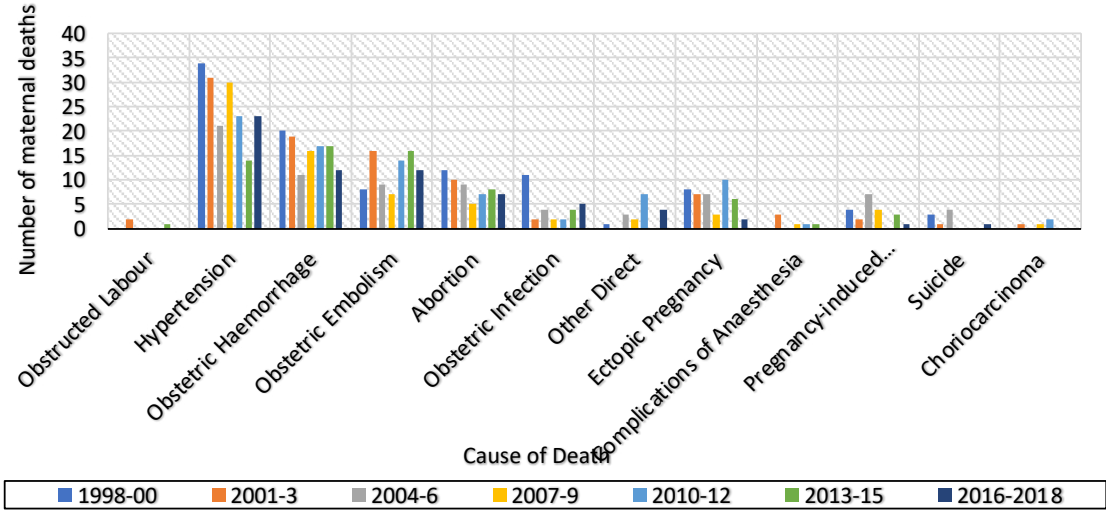


FIGURE 16: **DIRECT CAUSES OF MATERNAL DEATHS BY TRIENNIUM FROM 1998–2018**
Source: Ministry of Health and Wellness

The leading causes of maternal deaths in Jamaica in 2018-2020, were direct causes, including hypertensive syndromes, obstetric haemorrhage and obstetric embolism while indirect causes included circulatory disorders, sickle cell disease and respiratory diseases.

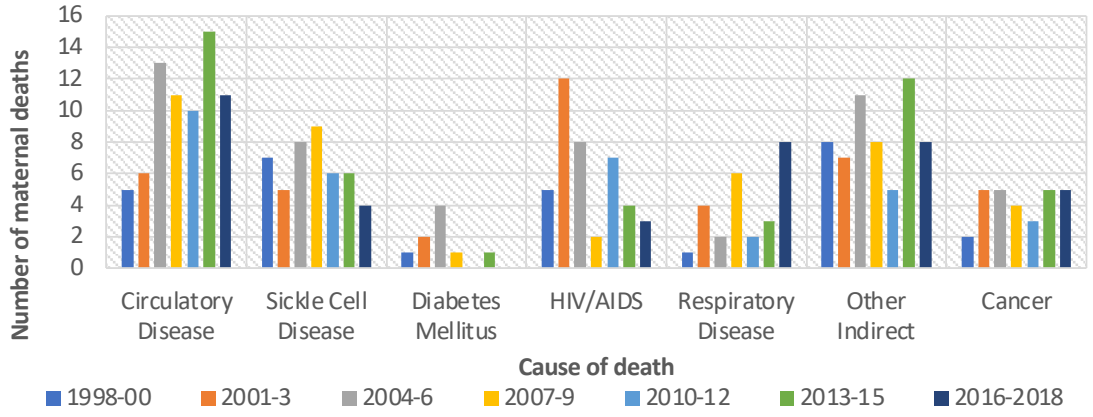


FIGURE 17: **INDIRECT CAUSES OF MATERNAL DEATHS BY TRIENNIUM FROM 1998–2018**
Source: Ministry of Health and Wellness

The government, through the Family Health Unit instituted the following mitigating strategies to address maternal mortality:

- Established a teenage clinic at the largest maternity hospital – the Victoria Jubilee Hospital to reduce teenage pregnancy.
- Jamaica has complemented facility-based records with home-based records with the implementation of the Maternal Record book for each pregnant mother
- National Annual Maternal Health conferences and workshops were conducted to share national maternal health status and the plan of action to achieve the Sustainable Development Goals (SDG)

Target 3.2. By 2030, End Preventable Deaths of Newborns and Children Under 5 Years of Age, With All Countries Aiming to Reduce Neonatal Mortality To At Least As Low As 12 Per 1,000 Live Births and Under-5 Mortality To At Least As Low As 25 Per 1000 Live Births.

In 2019, the infant mortality rate for Jamaica decreased to 15.2 deaths per 1 000 live births from 16.7 deaths per 1 000 live births. Based on the data identified in table 9, there has downward trend followed by three years of increases, with the lowest child mortality rate of 17.4 deaths per 1000 live births in 2016.

TABLE 9: **NEONATAL AND UNDER-FIVE MORTALITY RATE 2014–19**

Rates	2014	2015	2016	2017	2018	2019
Neonatal mortality rate/ 1,000 live births	16.7	16.0	12.7	14.1	13.8	15.2
Under 5 mortality rate/ 1,000 live births	20.5	19.6	17.4	18.4	19.4	20.5

Source: Ministry of Health and Wellness

The ministry has prioritized this SDG target by conducting ongoing in-service education for doctors and nurses on safe motherhood, with a special focus on Neonatal Resuscitation and Reproductive Health. The Programme for the Reduction of Maternal and Child Mortality (PROMAC) 2013 -2021 was implemented in collaboration with the European Union to reduce the incidence of neonatal and maternal deaths due to inadequate access to High Dependency Units. Under the PROMAC, four (4) maternal and neonatal HDUs were established in the following hospitals: Bustamante Hospital for Children, St Ann's Bay, Victoria Jubilee, and Spanish Town Hospitals. The PROMAC facilitated the training of thirty-six (36) Doctors in Obstetrics and Gynaecology, Anaesthetics, and Intensive Care Paediatrics. Seven doctors were trained in Maternal-Foetal Medicine and Emergency Obstetrics, and forty-six (46) nurses received post-basic midwifery training. Hence, over one thousand and eight hundred health professionals were trained in Neonatal and Maternal skills.

Additionally, a National Maternal and Perinatal Health Committee was formed in 2017, consisting of the following stakeholders: Obstetricians and Paediatricians from each Region, the Regional Epidemiologists, Medical Epidemiologists from National Surveillance Unit, and Programme Development Officer, Family Health Unit. The primary function of the committee is to develop, revise and implement maternal and perinatal health tools to end preventable morbidity

and mortality in Jamaica. This team continues to function as the governing body to produce and revise guidelines to standardize Obstetric and Neonatal Care in Jamaica. Moreover, a National Strategic Plan for Maternal and Perinatal Mortality Surveillance and Response was developed in collaboration with the Pan American Health Organization (PAHO) for Jamaica for 2018-2022 to improve the effectiveness of the maternal mortality surveillance process by integrating routine monitoring and evaluation of the response component at the facility, regional and national levels.

Target 3.3 By 2030, End the Epidemics of Aids, Tuberculosis, Malaria and Neglected Tropical Diseases and Combat Hepatitis, Water-Borne Diseases and Other Communicable Diseases.

HIV/AIDS is a priority communicable disease for the MOHW as Jamaica has both a general and concentrated HIV epidemic. The prevalence among adults (15-49 years) has decreased from 1.8 per cent (2013) to 1.4 per cent in 2020 with an estimated 32 000 people living with HIV (PLHIV).

Jamaica engaged several new strategies to address HIV prevention as part of a comprehensive national response to meet global targets and commitments to end AIDS as a public health threat by 2030. The National HIV Programme (NHP) located within the MOHW is mandated by the Government of Jamaica (GOJ) to coordinate and lead the implementation of the national HIV/AIDS response. The NHP is executed using a multi-sectoral approach, which focuses on prevention, treatment and care, enabling environment and human rights, empowerment and governance. Critical to this effort has been the commitment and support of the GOJ, donors and international partners such as the United States Agency for International Development (USAID), Global Fund, the World Bank, and civil society.

Advances in prevention strategies included piloting HIV Self-Testing kits in 21 pharmacies from April to June 2021, by the National Family Planning Board (NFPB) which received overall favourable numbers with 67.0 per cent of pharmacies continuing with the programme. An increase in promotional material and capacity-building trainings of stakeholders was also used to increase the knowledge of HIV/STI in the population as well as increased media exposure both traditional and digital.

UNAIDS introduced their 95-95-95 global strategy for ending the HIV/AIDS epidemic by 2030 where 95.0 per cent of persons living with HIV (PLHIV) are diagnosed and aware of their status, 95.0 per cent of PLHIV diagnosed are on antiretroviral (ARV) and 95per cent of PLHIV on ARVs are virally suppressed. Jamaica set an intermediate goal of 90-90-90 by 2020. The intermediate goal was not attained however; progress has been made in slowing the spread of the virus in Jamaica, which is outlined in the table 10 by the increase in percentage of persons on ARVs and virally suppressed.

TABLE 10: **AWARENESS AND TREATMENT STATUS OF PERSONS LIVING WITH HIV**

Year	Percentage of PLHIV aware of their status	Percentage of PLHIV aware of their status and on antiretroviral	Percentage of PLHIV on ARVs and virally suppressed
2018	76	49	62
2019	82	54	65
2020	85	47	72

Challenges remain with keeping adolescents living with HIV on treatment and in care. A UNICEF-supported 2020 Situational Analysis on Jamaican Adolescents Living with HIV (ALHIV) found that many adolescents were challenged with staying in care and on treatment. Reports of "treatment fatigue" and a sharp reduction in adherence during adolescence, pointed to the need for peer-to-peer, family-based and professional support as part of the package of care for ALHIV. Based on these findings, the NHP has initiated plans to build a peer support network for ALHIV with the first set of eight youth PLHIV facilitators trained in 2021.

Continued education of service providers and empowerment of PHLIV mitigate risks of stigma or discrimination. The COVID-19 pandemic caused additional strain on the health sector especially related to disruptions in supply chain management, access to healthcare services and task shifting of healthcare workers. To combat these issues, telemedicine was implemented, clinic hours were extended, programme delivery was realigned and staff numbers were increased. The challenges with linkage to care are evident in the overall cascade. The availability of additional places to access care as well as social and psychological support are necessary to increase the percentage of PLHIV aware of their status and on antiretroviral.

Civil Society Organisations (CSOs) and other government entities focused on social services, building legislative frameworks and education were engaged to ensure polices, plans and programmes reach the marginalized in society. Enhanced Package of Care for Key and Vulnerable Populations was also used to reach, namely – men who have sex with men (MSM), transgender women, women, and adolescents, out of school youths, persons living with disabilities, homeless, and drug users.

Target 3.4 By 2030, Reduce by One-Third Premature Mortality from Non-Communicable Diseases through Prevention and Treatment and Promote Mental Health and Well-Being.

Non-Communicable Diseases (NCDs)

NCDs have been the leading cause of global morbidity in developing nations; they account for 54.0 per cent of deaths in developing nations and 87.0 per cent in developed nations (MOHW, 2013). Data from the Caribbean Public Health Agency (CARPHA) names heart disease as the leading cause of death within the region. Within 15 years, spanning 1985-to 2000, the agency reports that heart disease accounted for 15.3-17.5 per cent of deaths within the region (Ministry of Health and Wellness, 2013). For Jamaica, 70.0 per cent of deaths in 2010 were attributed to four (4) major NCDs: cancer, diabetes, disease of the circulatory system and chronic lower respiratory disease. Of these deaths, 27.0 per cent were individuals who were under 70 years (The Statistical Institute of Jamaica, 2010). With Jamaica's average life expectancy at 73.43 years, these deaths would be classified as premature. When the data are disaggregated, there seems to be a gender disparity. For women, diabetes was the leading cause of morbidity while for men, the leading cause of death was from external forces (accidents and homicides), followed by cardiovascular disease, diabetes and prostate cancer. The most recent Jamaica Health and Lifestyle Survey (2016-2017) has shown an increase in NCDs such as diabetes, hypertension and obesity among adults. Notably one in two adults in Jamaica is overweight or obese.[41]

These diseases share four common behavioural risk factors: tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol. The most recent Jamaica Health and Lifestyle Survey highlighted dietary behaviours with almost 8/10

41 Ministry of Health. (2018) Jamaica Health and Lifestyle Survey III (2016-2017) Preliminary Key findings. Retrieved from https://www.moh.gov.jm/jamaica-health-and-lifestyle-survey-iii-2016-2017/

Jamaicans aged 15-74 consuming fast foods more than once daily and 1 in 10 consuming excess salt at the table or frequently had salty sauces or high salt processed foods. In tandem with this, eighty-two per cent of Jamaican 15-74 are engaged in low physical activity and low rates of food label reading and fruit and vegetable consumption were also identified. Alcohol use was reported in 41.0 per cent of the population; highest in the 24-35 age group and current use of tobacco was reported in 15.0 per cent of the population.[2] Poor feeding practices in Jamaica begin very early in life with low rates of exclusive breastfeeding and inappropriate complementary feeding practices. The exclusive breastfeeding rate in Jamaica is below the 40.0 per cent target for exclusive breastfeeding for infants under six months of age. The principal concern is the inappropriate timing of early feeds, the increase in the incidence of nutrition-related childhood diseases and the increased risk of chronic NCDs in adulthood that may result from these practices. Childhood obesity and overweight, and the early onset of non-communicable diseases (NCDs) are issues of growing concern in Jamaica from infancy through the adolescent years. Approximately 6 per cent of children under 5 are overweight.[42] Meanwhile, rates of obesity have doubled among adolescent boys over the past decade and have increased by almost 50.0 per cent in adolescent girls aged 13-17. Among adolescents aged 13-15, approximately 7 out of 10 boys and girls drink one or more soda per day, on average and only 23.2 per cent of adolescents are physically active for at least 60 minutes per day.[43]

A UNICEF/CAPRI Study on the socioeconomic impact of the COVID-19 pandemic in 2020, found that most households reported increases in children's level of overeating (57.0 per cent) and that under 40 per cent of children older than six do not get any exercise at all daily.[44] UNICEF's Situational Analysis of Children 2021 noted that the combination of household income loss and the suspension of the school feeding programme due to COVID-19 may lead to an increased risk of malnutrition and consumption of cheaper processed foods with higher fat and sugar content.[3]

To combat the harmful effects of NCDs, Jamaica has implemented several programmes under defined areas, some of which include:

Policy and Advocacy

- **National Health Fund**, offers pharmaceutical services for the elderly through **Jamaica Drug for the Elderly Programme (JADEP)** - launched in 1996, JADEP improves access to essential drugs through payment subsidies.
- Abolition of User Fees at government health facilities-2008
- National Infant and Young Child Feeding Policy, 2014
- Interim Guidelines for Beverages in Schools, 2019
- National Strategic Action Plan for the Prevention and Control of NCDs
- National Operational Action Plan for the Prevention and Control of Obesity in Children and Adolescents in Jamaica

42 UNICEF and CAPRI. Situational Analysis of Jamaican Children 2021

43 NCDA, WHO, CDC. Global School Based Student Health Survey 2017

44 UNICEF, CAPRI (2021). Lasting impact: Educational, social and psychological effects of the COVID-19 pandemic on children https://www.unicef.org/jamaica/reports/lasting-impact

- National Food and Nutrition Security Policy, 2006
- National Policy and Strategic Plan for the Promotion of Healthy Lifestyle

Physical Activity

- **Jamaica Moves** is the Ministry's primary physical activity initiative that embraces the Ottawa Charter for Promotion. It creates a vibrant and sustainable behaviour change model to tackle the risk factors of NCDs. The programme targets all members of the society at the individual, interpersonal, organizational and community levels.

Chronic Disease Surveillance and Management

- Formation of the Sickle Cell Clinical Management Subcommittee to provide technical support for improving Jamaica's Sickle Cell Disease Programme.
- Development of National Screening Guidelines for Priority Non-communicable Diseases in Primary Health Care.

Through a policy and investment loan from the Inter-American Development Bank (IDB), the ministry launched its Health Systems Strengthening Programme for Prevention and Control of Non-Communicable Disease in late 2019. This project will be implemented over 5 years. The policy component of the Programme seeks to consolidate regulatory measures to address the preventable causes of NCDs and to reorient the health system to address the prevention and control of NCDs through a people-centred primary health chronic care model. During the 2019/2020 financial year, some of the policy and legislative measures were advanced. This includes the drafting of a Concept Paper for the Screening Guidelines of Priority NCDs and the development of the Chronic Care Model. From these programmes, National Screening Guidelines for Priority non-communicable diseases were developed for the Primary Health Care system and there was the launch of the National Committee on NCDs, additionally, the government launched the Public-Private Partnership of non-communicable (PPP4NCDs), which engaged private general practitioners in the shared management of primary care clients with hypertension or diabetes.

The unit also focused on the commencement of Phase 1 of the Glycosylated A1C (HbA1c) programme to enhance point-of-care testing for glucose control for primary care clients with diabetes. For better management of disease, the Sickle Cell Clinical Management Subcommittee was formed to provide technical support or improve Jamaica's Sickle Cell Disease program. The Cabinet approved the proposal for exemption of fee at Public Pharmacies for all persons with Sickle Cell Disease. From the programme, National Screening Guidelines for Priority non-communicable diseases were developed for the Primary Health Care system.

In 2021, the Ministry of Health and Wellness (MOHW) launched the National NCD Committee charged with buttressing the ministry's work to effectively combat NCDs in Jamaica. Moving forward, the Ministry plans to implement additional programmes to increase the management and care of NCDs. This includes: a National Cervical Cancer Elimination Plan, implement the Chronic Care Model and the approval of free access to chemotherapeutic drugs for children with cancers at the UHWI, to name a few.

In 2019, the Ministry of Education, Youth and Information and the MOHW signalled steps to develop and implement a National School Nutrition Policy (formerly the National School Feeding Policy) and supporting standards for meals; non-meal items, such as snacks available in the school food environment. Progress has been made in 2022, towards the

approval of the policy which will ensure that meals and snacks offered in Jamaica's School Feeding Programme meet the necessary nutritional standards. Discussions commenced in 2019 between the Ministry of Agriculture, MOHW and MOEY for the establishment of a Home-Grown School Feeding Programme in Jamaica to encourage children to eat more locally produced food.

There is a further need to strengthen Jamaica's policy, legal and programming environment to address several gaps including a lack of awareness and knowledge on good nutrition, school environments that enable easy access to unhealthy foods and few healthy options for children and adolescents, marketing of unhealthy foods to children and front of package labelling to improve food choices.

Mental Health

The goal of Mental Health Services (MHS) is to promote peaceful interaction among the Jamaican people, improve parenting and promote mental well-being for all. At present, the National Community Mental Health service has an estimated caseload of 23 500 individuals managed by 334 mental health workers. The Government of Jamaica has identified methods to bolster the work of Mental Health clinicians and strengthen their response to Mental Health. The National Mental Health Policy was drafted after discussion with relevant stakeholders and the senior ministry directorate has been reviewed and is awaiting cabinet submission. Under the Mental Health Action Plan (MHAP), a major objective is the provision of effective leadership and governance of mental health services. This will be achieved through the cabinet approval of a National Mental Health Strategic Plan (2020-2025) which provides a framework to identify the determinants of good mental health and implement strategies that acknowledge the need for a partnership approach to addressing mental illness including at the level communities.

The Mental Health Act (1996) is being amended to reflect the predominant non-custodial approach to MHS delivery and to provide a legal framework for delivery of these services per the UN Convention on the Rights of Persons with Disabilities. Under the MHAP, there is a thrust towards shifting mental health service delivery from hospital-based to community-based services and providing a service integrated into primary and secondary care. As it stands, psychiatric patients are treated in most regions on medical wards of general hospitals instead of localized community-based institutions, inevitably reducing public access to these services. In response to these inequities, the government is promoting the re-organization of Bellevue Hospital (the only mental hospital in Jamaica). This will involve reducing the size of the hospital while expanding the community mental health services. The realignment of service in the manner described above provides increased access and acceptability of service and potentially better outcomes.

Mental health promotion and prevention are ongoing activities executed by Mental Health teams in all health regions with targeted monthly sessions. In addition, there is an ongoing National Mass Mental Health Media campaign from 2019, which, through a variety of platforms, seeks to promote mental health and prevent mental illness. The ultimate goal of this campaign is to reduce Mental Health stigma and promote {Mental} health-seeking behaviours among the population.

At present, the ministry records attempted suicides per region (Table 11), however, there is a gap in the reporting method. At present, death by suicide is not recorded as such; instead, it is recorded based on the medical cause of death, that is, the death is reported as asphyxiation rather than death by suicide. The data presented in Table 11 represent only the number of attempts made, and there is no distinction based on repeat attempts versus first-time ones.

Over the last five years, there has been a great fluctuation in suicide attempts within each region, with South East

Regional Health Authority recording the largest numbers. The refinement of MH data collection techniques would significantly impact the psychosocial determinants of mental illness and may strengthen the government's response to reducing suicidal attempts

TABLE 11: **ATTEMPTED SUICIDE RATES BY REGION AND YEAR**

Year	Region									
	NERHA		WERHA		SERHA		SRHA		BVH	
2016	21	44	15	37	31	62	49	65	0	2
2017	13	40	22	28	23	60	22	49	1	0
2018	13	35	20	38	25	75	12	22	0	0
2019	4	39	19	44	16	38	11	37	0	0
2020	7	12	18	31	18	26	13	30	0	0

Source: Table obtained for Hospital Monthly Summary Report (HMSR) illustrating the suicide attempts disaggregated by gender

In response to the increasing number of attempted suicides, the government has implemented the following interventions:

- Establishing a free 24-hour mental health and suicide Prevention Helpline operated by the MOHW (Table 12).
- Improving access to clinic services remotely through free tele-mental health services.
- Collaborating with UNICEF to establish a U-Matter Chat line providing emotional support for youth who may prefer to text rather than make voice calls.

TABLE 12: **COMPARISON OF HELPLINE CALLS IN THE FIRST QUARTER BETWEEN 2020 AND 2021**

Months	Calls	Months	Calls
April 2020	89	April 2021	198
May 2020	81	May 2021	133
June 2020	61	June 2021	202

Source: Ministry of Health and Wellness

In the first quarter of 2021, some 533 calls were made to the Mental Health and Suicide Prevention Helpline which was double the number of calls made in the same period in 2020 (231). The U-Matter Chat line was launched in March 2022 and within the first week of operation received more than 100 contacts from adolescents and youth in need of

support. The MHU has also launched Reach-Out-Rangers, a contingent comprised of volunteers who are trained in the use of Psychological First Aid for community intervention. These Reach out Rangers were deployed to communities where persons may be experiencing emotional distress but are not prioritizing mental health-seeking. This initiative has seen a tripling in engagement (33) in November than that of the previous month (11). Those persons who are assessed as requiring more than the emotional support expected with the above training will be referred to the local mental health team for further management. There is also the inclusion of mental health in the Non-Communicable Disease Commission whose mandate includes the prevention and control of NCDs including mental illness. The subcommittee on mental health will pay particular attention to strategies to improve the promotion of mental wellness and early diagnosis and treatment of mental illness. Finally, there is a current review of human resources for the national mental health program, which should increase the number of mental health service providers available to respond to the MH crisis.

Target 3.5. Strengthen the Prevention and Treatment of Substance Abuse, Including Narcotic Drug Abuse and Harmful Use of Alcohol

The Cabinet sanctioned the drafting of the Harmful Alcohol Policy in June 2021, which is a major achievement towards addressing harmful alcohol use among the population. Coupled with ongoing meetings of the Cabinet's Joint Select Committee to report on the draft Tobacco Control Act of 2020, this will foster the climate to control the supply, marketing, interference, and monitoring of substances within these industries. The policy is expected to increase public awareness of the harms of use; increase the availability and access to prevention and treatment interventions; protect the vulnerable population, especially children; improve public health and reduce the burden on the health system. The average age of first use of harmful substances was 12.3 years old[45]; the government through the National Council on Drug Abuse (NCDA) aims to increase the age of first use by 1.7 years by 2025. Additionally, there has been an increase in the capacity of primary health care workers and school personnel trained to conduct Screening, Brief Intervention and Referral to Treatment (SBIRT) in health care centres and hospitals across the island, expanding the capacity and publics' access to drug counselling intervention in communities island-wide.

The implementation of policies is informed by the collection and analysis of field data. The main method of data collection for the NCDA is surveys, which has been greatly impacted by the Novel Corona Virus and severe funding constraints resulting in the most recent population survey being conducted in 2017. Adopting other methods of data collection, the NCDA in collaboration with Inter-American Drug Abuse Control Commission (OAS/CICAD), carried out an Online COVID and Drug Use survey. The survey indicated an increase in substance use, within the past year. The use of alcohol increased by (32.0 per cent), cannabis (37.0 per cent) and tobacco (25.0 per cent) among adults who used these substances. This represents a strong relationship between increased drug use and pandemic conditions. The population consisted of rural and urban participants whose ages ranged from 18-39 years old, majority of the participants (75.0 per cent) were female which highlights gender patterns in substance abuse. The study further highlighted that mental health problems such as depression, anxiety, loneliness and financial problems associated with the pandemic were factors associated with increased drug use. The agency has also noted an increasing trend toward vaping and risk perception of cannabis use among adolescents. Some 60.0 per cent of youth thought cannabis use was very harmful, 10.0 per cent deemed it moderately harmful while 7.0 per cent thought it slightly harmful[46]. Perceived risk of harmful substance(s) is highly subjective; with 17.0 per cent of youth deeming cannabis use slightly to be moderately harmful.

45 National Secondary School Survey

46 National Secondary School Survey

Strengthening public education campaigns targeting youth would serve as the best mitigating strategy.

The findings from the 2016 NCDA National Household Survey revealed that over 30 000 individuals reported that they felt the need for drug treatment to address their dependence and another 317 000 persons were classified as harmful alcohol consumers. Within this context, there is a need to scale up treatment facilities to increase access and availability island-wide to include treatment for adolescents and women with families.

The government, through the Ministry of Health and Wellness (MOHW) and the National Council on Drug Abuse, have acknowledged the gaps, which exist within the legislative system, and is proactively working to increase public knowledge about substance use and abuse. A strengthened public education programme on substance abuse is to be implemented to dispel myths and provide the population, especially youth, with accurate and current information concerning the negative effects of substance misuse. The ongoing discussion concerning Ganja/Cannabis has been vibrant and NCDA has introduced its Good Ganja Sense Public Education Campaign. An initiative labelled a Ganja Literacy project designed to explain what decriminalization means, and how Jamaicans should operate in a decriminalized environment. The programme engages all members of society on the changes to the 2015 Dangerous Drug Act that dispel the myths that are popular about ganja, highlighting the negative consequences, opportunities for medical use, and the rights of Rastafarians to religious and sacramental use. Additionally, there has been an increase in the capacity of primary healthcare workers to conduct Screening, Brief Intervention and Referral to Treatment (SBIRT) in healthcare centres across the island. The approved screening tool used for intake for new patients now includes screening questions on drug use. The MOHW has also committed to secure funding for a larger public education programme for alcohol misuse and tobacco use.

The National Drug Control Master Plan is a Strategic five-year plan which identifies the priority areas for national drug control, has expired and is to be revised for the next 5 years. The NCDA is working with the Inter-American Drug Abuse Control Commission (OAS/CICAD), as well as the Pan American Health Organization to develop the next Master Plan and needs significant support to formally table and adopt this plan so the Drug Demand and Supply reduction strategies can be more structured, planned and have a basis for sound evaluation.

The NCDA is committed to ensuring equity among the population. As such, their programmes are categorized as:

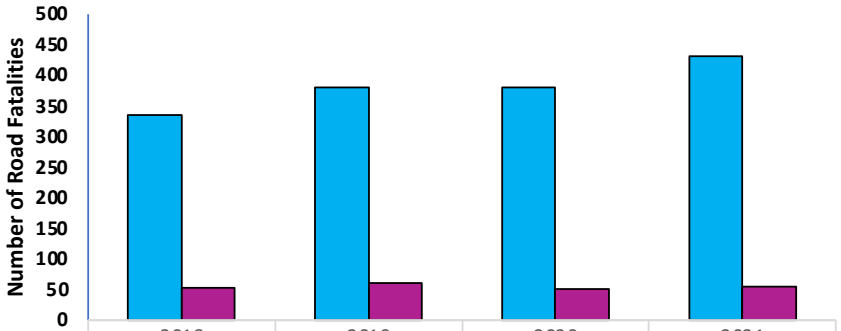
- Universal these programmes target the entire population with drug prevention education whether or not you are a user,
- Selective: target members of the population that are at high risk for use because of certain risk factors affecting the individual or that are present in their environment
- Indicated: target those individuals who have started drug use and have deemed it problematic but are not yet addicted. Clients who need indicated programmes are deemed most at risk.

The school and community network, along with the evaluation from the field staff regarding an individual's level of drug use and their risk profile enables the NCDA to target the most at-risk individuals. After identification, the appropriate prevention/treatment initiative is identified that will assist them in reducing and eventually ceasing their substance misuse. The school-based programmes offered nationally are evidence-based and informed by relevant research.

Target 3.6. By 2020, Halve the Number of Global Deaths and Injuries from Road Traffic Accidents

In 2021, the number of road fatalities was 432, the highest number of fatalities recorded in Jamaica since 2002. As shown

in Figure 18, 88 per cent of the road fatalities recorded in 2021 were males, while 12.0 per cent were females.



	2018	2019	2020	2021
Male	336	380	381	432
Female	53	60	52	55

FIGURE 18: **ROAD FATALITIES DISAGGREGATED BY SEX**
Source: Ministry of Health and Wellness

In an attempt to reduce the number of road fatalities in Jamaica, the Road Safety Unit collaborated with various Ministries, Departments, and Agencies of the Government (MDAs), Non-Government Organizations, Private Organizations, and the National Road Safety Council (NRSC) to develop several interventions and road safety campaigns. The Prime Minister of Jamaica signed the United Nations Second Decade of Action for Road Safety 2021-2030, which aims to prevent at least 50.0 per cent of road traffic deaths and injuries by 2030. The Prime Minister, being the chair of the National Road Safety Council, has prioritized this SDG target by stipulating that all rehabilitative road works currently on schedule must undergo a road safety inspection and be audited by the Road Safety Audit team. This is to ensure that the safety needs of all road users are satisfied and to reduce the instance of crash fatalities and injuries in Jamaica.

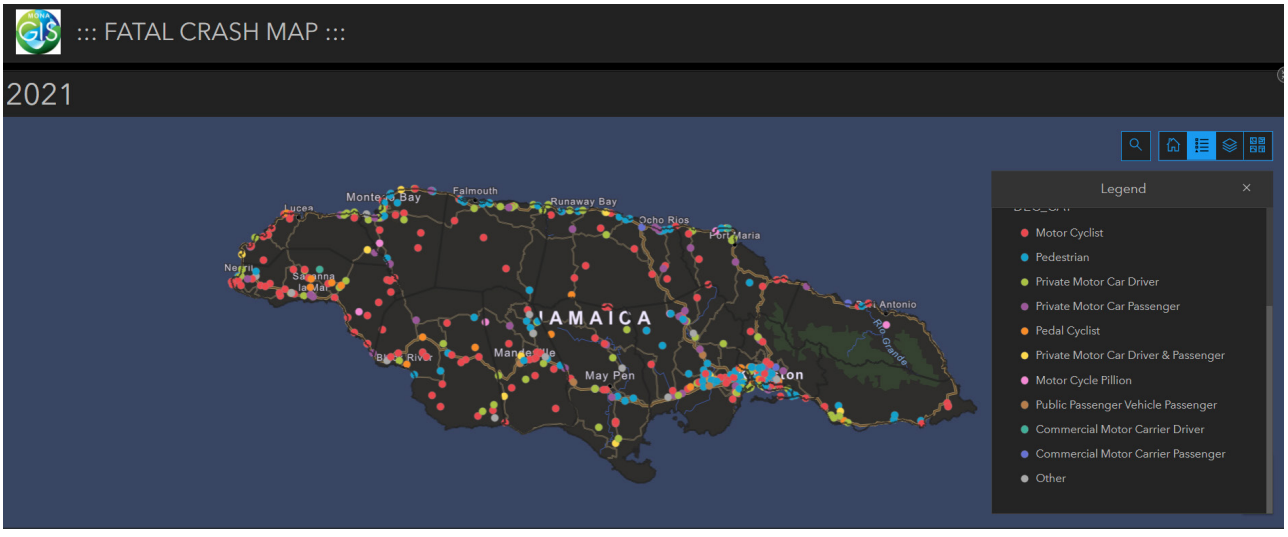


FIGURE 19: **ROAD FATALITIES MAP BY CATEGORY**
Source: Mona GeoInformatics

Moreover, various government entities are working together to achieve this SDG target, such as the National Road Safety Council (NRSC), Ministry of National Security, Jamaica Public Service, Ministry of Transport and Mining, National Works Agency, Ministry of Justice, Island Traffic Authority, Jamaica Constabulary Force (Public Safety Enforcement Branch), and MOHW. Additionally, the United Nations Children's Fund and Pan American Health Organization, along

with other Non-Government Agencies and Private Organizations, are working collectively with the Government of Jamaica to achieve this SDG target. The stakeholders meet quarterly to discuss goals and targets as relates to reducing road fatalities, however, a Transport Policy Guideline for vulnerable road users (pedestrians, pedal cyclists, and disabled persons) is needed. In partial response to this shortcoming, a Pedestrian Safety Committee (PSC) has been formed to address the road safety issues faced by pedestrians to reduce the number of pedestrian fatalities and injuries across the island. The PSC was developed based on the National Road Safety Council's 2019 Recommendations and the UN Second Decade of Action 2021-2030 Safe Systems Principles: Safe Road Infrastructure and Safe Road Users.

Target 3.7 By 2030, Ensure Universal Access to Sexual and Reproductive Health-Care Services, Including Family Planning, Information and Education, and the Integration of Reproductive Health into National Strategies and Programmes

The National Family Planning Board (NFPB) executes the commitment to ensuring universal access to sexual and reproductive healthcare services in Jamaica. Strengthening Jamaica's Sexual Reproductive Health (SRH) Programme is an important part of achieving this target. To bolster the SRH Programme, the NFPB also carries out the following: strategic planning of various programme activities, enabling a Reproductive Health Survey (approximately 90.0 per cent complete) for sound evidence-based decisions on SRH matters, as well as, contributing to the Population and Sustainable Development Policy as well as conducting research and investigation.

SDG target 3.7 can be further broken down into indicators 3.7.1 and 3.7.2. Indicator 3.7.1 refers to the percentage of women of reproductive age (15-49 years) who have demand for family planning satisfied by modern methods. The components of this indicator are contraceptive prevalence and unmet need for family planning. The NFPB, having recognized the interconnectivity of family planning with the 17 SDGs, enabled the strengthening of the Contraceptive Logistics Management Information System across the Regional Health Authorities (RHAs). The Logistic Indicators Assessment Tool (LIAT) which was developed by USAID was tailored and used to monitor/audit the contraceptive logistics systems throughout the health facilities at the clinic level. With such stringent and consistent monitoring over the years, coupled with capacity building of key health care providers in Contraceptive Forecasting Methodologies, as well as the evaluation of the CLMIS (using the Organization for Economic Co-operation and Development - Development Assistance Committee Model), the following improvements have been noted and published:

- Contraceptive stock-out on the day of visit significantly declined to five (5.0) per cent (2019) from seventeen (17) per cent (2015).
- The prevalence of stock-out over six months declined significantly to twenty (20.0) per cent (2019) from eight-five (85.0) per cent (2015).
- Improvement in standardized recording of information using the Family Planning Register and Logbook.
- Improvement in the storage of contraceptive methods.

Indicator 3.7.2 measures the annual number of births to females aged 15-19 years per 1 000 females in the respective age group. The NFPB relies on the Reproductive Health Survey for adolescent fertility rate information. Data are still being collected for the 2021 survey. As such, information from the last survey (2008) is being used which reflected 72 births per 1 000 girls. Given the lull (14 years: 2008 to 2022) in the period of the RHS, other pertinent documents aided in the process of SRH decision-making; for example, the World Bank Group (2021) data reveal that:

- The current fertility rate for Jamaica in 2022 is 1.930 births per woman – being a 0.77per cent decline from 2021.
- In 2021, there were 1.945 births per woman, a 0.82 per cent decline from 2020.
- In 2020, there were 1.961 births per woman, a 0.76 per cent decline from 2019.
- In 2019, there were 1.976 births per woman, a 0.75 per cent decline from 2018.
- The adolescent fertility rate was 49.88/1 000 in 2019.

In terms of a National Policy on Reproductive Health, the MOHW initiated the development of such a policy in 2018 and drafted a concept note in 2020. To date, the policy has not been submitted to Cabinet.

In advancing universal access to sexual and reproductive health services, the NFPB has made efforts to ensure that relevant policies, plans and programmes reach the most marginalized without prejudice. In doing so, the following may be noted:

- The use of traditional media to reach the most marginalized, for example, with the mass media campaigns on Human Rights ('Know Your Rights') and delaying adolescent pregnancy (with the tag line 'Live Life Before You Give Life') placed on television and radio stations with wide viewership and listenership.
- Radio and television placements of parenting advice.
- Social media was utilized to communicate with audiences via Instagram Live Chat sessions (meeting them on the most popular platform), regular posts answering questions and concerns on FP/HIV/STIs
- Use of face-to-face interventions across the island via the "Rispek Tour" to bring social protection partners with their services to a wide cross-section of rural and urban dwellers.
- Reporting stock-outs of commodities at clinics.

Target 3.8 Achieve Universal Health Coverage, Including Financial Risk Protection, Access to Quality Essential Health-Care Services and Access to Safe, Effective, Quality and Affordable Essential Medicines and Vaccines for All

Jamaica lacks sustainable and adequate funding for the health sector. The challenge of health care financing in Jamaica has been twofold: limited financial resources as a result of weak economic growth, and insufficient prioritization for allocation of resources to the health sector. However, the MOHW has been active in identifying the gaps in the health systems and outlining the directions for the health sector. The Vision for Health 2030 Plan addresses health financing in Goal 3, emphasizing increased and improved health financing for equity and efficiency through:

- The gradual increase in direct government funding toward the PAHO benchmark of 6 per cent of GDP as public investment in health.
- The establishment of a health care reserve (The Health Care Reform Fund) under the MOHW for discretionary investments related to the Vision for Health 2030 Plan implementation.
- The establishment of a National Health Insurance (NHI) scheme.

- The implementation of a series of policy measures to promote efficiency gains and spending rationalization in the health care sector.

The MOHW jointly with PAHO is currently proposing a fiscal space study to access the fiscal space for health. It is also being proposed that the National Health Accounts be strengthened and further used to identify possible financial revenues to fund health care. Further proposed solutions to address the gaps include:

- An assessment of Jamaica's health financial needs
- The best financial and policy tools for meeting these financial needs
- Pooling of existing resources to mitigate individual-level health risk and increase universal health coverage
- Preventing a further increase in poverty because of ill-health and catastrophic out-of-pocket payments
- Improvements in efficiency and effectiveness of resource use across the health system
- Cost-effective health programmes
- Providing resources to improve primary health care and effective coverage, especially for the most vulnerable and those in the lowest quintiles.

Human Resource for Health

There is limited information on the human resources for health regarding geographical distribution and the type of resource. However, the MOHW acknowledges the need for the strengthening of HRH, as currently, the health professional to population ratio stands at less than three (3) health professionals per 1000 patients. Owing to the many challenges outlined, there are to be considerable and immediate actions to address this issue. To this effect, PAHO proposed a plan of action with three strategic lines of action for HRH, namely:

1. Strengthen and consolidate governance and leadership in human resources for health.
2. Develop conditions and capacities in human resources for health to expand access to health and health coverage, with equity and quality.
3. Partner with the education sector to respond to the needs of health systems in the transformation toward universal access to health and universal health coverage.[47]

Key to the implementation of the human resource for health reforms is the establishment of an HRH planning mechanism, functioning within and being led by the MOHW, and involving a core group of staff. This mechanism would also involve participation from the Ministry of Finance, the Cabinet, the Ministry of Education, the Public Service Commission, and other key stakeholders, to ensure full communication across the health sector (including the private sector). This HRH mechanism will contain an ongoing dynamic and iterative monitoring and evaluation approach.

47 Plan of Action on Human Resource for Universal Access to Health and Universal Health Coverage

Target 3.9. By 2030, Substantially Reduce the Number of Deaths and Illnesses from Hazardous Chemicals and Air, Water, and Soil Pollution and Contamination

The MOHW, guided by the standards and regulations stipulated by the National Environmental and Planning Agency (NEPA), sets standards for wastewater systems and indoor air quality. The Environmental Health Unit prioritizes this SDG target by conducting technical assessments on applications for the development of sub-divisions, which includes water systems, plants, etc. at the parish-level and national level. Given the grave impact on the natural environment, the frequency in which these assessments are conducted ranges from weekly to quarterly, and as often as necessary. In 2020, the ministry received 749 applications, of which 94.0 per cent were processed and approved. In 2018, the ministry received 720 applications, of which 95.0 per cent were processed and approved. An inter-sectoral mechanism was established to ensure compliance and maintenance of standards as stipulated by the Ministry. A Technical Review Committee was formed with the mandate to oversee and monitor all operations to achieve this target; the committee is comprised of representatives from NEPA, Natural Resource Conservation Authority (NRCA), MOHW, Kingston, and St Andrew Municipal Corporation (KSMC), and Water Resource Authority (WRA). However, there are compliance issues as it relates to monitoring and evaluation; the Public Health Act (Nuisance Act) guides remedial actions. In addition, the turnaround time to process applications is affected by the low bandwidth experienced when using the e-system (AMANDA). Notable, all policies and programmes implemented by the MOHW are guided by the Public Health Act.

Based on the mortality table produced by the Registrar General's Department (Table 13), there was a decrease in the number of deaths attributed to accidental poisoning by and exposure to noxious substances in 2019 when compared with 2018.

TABLE 13: **MORTALITY**

External causes of morbidity and mortality	ICD-10 Mortality Summary Codes	2018	2019
Exposure to smoke, fire, and flames	X00-X09	12	10
Accidental poisoning by and exposure to noxious substances	X40-X49	5	11
All other external causes	W20-W64, W75-W99, X10-X39, X50-X59, Y10-Y89	595	585
Total		**612**	**606**

Source: The Registrar General's Department (RGD) (Data for the year 2020-21 are not available as they are awaiting validation)

Target 3.D. Strengthen the Capacity of All Countries, in Particular Developing Countries, for Early Warning, Risk Reduction and Management of National and Global Health Risks

Jamaica has a well-established and maintained national surveillance system for health involving epidemiological and laboratory monitoring at the borders, through the port health programmes, during national crises/ disaster situations and at health services interfaces in public and private clinics and hospitals. It is effective in the surveillance of known

and novel diseases and the identification of possible sources, including COVID-19 now known to be caused by the novel coronavirus SARS-CoV2, and the endemic mosquito-borne illness, dengue, that manifests as seasonal outbreaks. It is the mechanism that provides an early warning signal for disease outbreaks and informs risk management strategies. This allows for evidence-based plans of action for preparedness and response, and the management of national and global health risks.

Additionally, institutionalized multi-stakeholder systems, such as the Emergency Health Planning Committee of the National Disaster Risk Management Council and the programme of activities for Jamaica's obligation under the International Health Regulations (2005), allow for a responsive system with health partners to better manage national and global health risks. The International Health Regulations (IHR) is the main instrument providing a legal basis for responding to Public Health Emergencies of International Concern (PHEOC) including the pandemics. Under the IHR (2005), State Parties, including Jamaica, are obliged to develop and maintain minimum core capacities for surveillance and response, including at points of entry, to detect, assess, notify and respond to any potential public health events of international concern. Core capacity C11 refers to Points of Entry (POE) and Border Health. It has core capacity requirements at all times and public health response at POE and a risk-based approach to international travel-related measures.

Over the last few years, there have been more intense weather events impacting population health and the health system and an unusually protracted Dengue Outbreak in 2019, followed by the introduction of COVID-19 in 2020. These situations presented unprecedented demands requiring strengthening capacities across the full spectrum of health and medical services. To address the challenges, major investments were made in various areas for improved early warning systems for public health issues; reducing health risks posed by communicable diseases and overburdened public health and medical operational capacity for the general population and vulnerable sub-groups, thereby mitigating severe adverse outcomes and high-volume caseload. There have been strategic Information and Communication Technology (ICT) Upgrades, and enhanced coordination capacity, workforce modifications for improved efficiency and resilience, expanded diagnostic capacity and critical care capacity, and innovation in service delivery methodologies that enabled more responsive epidemiologic projections and forecasts and expanded access to care, allowing for a more resilient health system. The strengthened capacity is illustrated in the response to the COVID-19 pandemic.

MANAGEMENT OF NATIONAL AND GLOBAL HEALTH RISK

Following the WHO alert of the 2019 novel coronavirus, the SARS CoV2, the Government of Jamaica (GOJ), acting through the Ministry of Health and Wellness (MOHW) initiated a response and commenced sensitization of internal stakeholders and the population, as well as, activated the Ministry of Health Emergency Operations Centre (MOHW EOC), for coordination. Pre-existing Plans and other tools, instruments and mechanisms were used to develop guidance to respond to the threat of a COVID-19 pandemic. This built on existing activities through various combinations of expansion, acceleration in the implementation and innovation in initiatives.

EARLY WARNING

Pre-existing Capacity: Among the thirteen Prevention and Control Sub-Plans of the MOHW Disaster Management Manual, is the pre-existing Pandemic Influenza Plan which has a well-elaborated surveillance plan for acute respiratory illnesses as one prioritized condition for public health early warning systems. It, therefore, provided a sound basis for the development of the COVID-19 Prevention and Control Plan that guides Jamaica's overall COVID-19 response in a comprehensive and organized manner. The COVID-19 Prevention and Control Plan provides details for Alert and Pandemic Phases.

Pre-event Initiatives and Innovation: Development of a permanently established Health Emergency Operations Centre, Health System Strengthening for Universal Access to Care, reform of mental health services and Digital Transformation of the Health Sector were among programmes identified as a priority that will enhance the performance of the public health system. By accelerating the Digital Transformation programme activities, innovation in business processes was realized in the approach to data and interoperability that enabled artificial intelligence, geospatial technologies, data science and other emerging technologies to enhance various aspects of the health system. This included Health Emergency Operations Centre functionalities at national and subnational levels, including enhanced capacity for real-time tracking of COVID-19 cases across the country, while continually monitoring for other health risks including those related to international travel. Early identification of the localized occurrence of, for example, COVID-19 or mosquito breeding sites, and expansion of laboratory capabilities at the National Public Health Laboratory with strengthened partnerships with Regional Laboratories and private laboratories, allowed for the early mobilization of resources for prevention and containment to mitigate the adverse impacts and reduce national and global risks. In addition, improved access to mental health services allowed for earlier detection of mental health effects of various events allowing for early interventions.

RISK REDUCTION

Per the overarching strategy of GOJ's response to the COVID-19 pandemic, the approach throughout the outbreak has been risk management using variable degrees of risk avoidance, risk reduction and risk retention to balance the protection of lives and livelihoods, through a whole government approach. The stated strategic goals of the Government were to delay, detect, contain, manage and communicate for COVID-19.

Pre-existing Capacity: The MOHW has made investments to elaborate an Enterprise Risk Management Program that will address various identified and prioritized risks. Among these are the issues of adequacy of Access to Health Care across the life course, the scope of public health surveillance system and public health laboratory capacity.

Pre-event Initiatives and Innovation: The COVID-19 outbreak presented an opportunity to leverage developmental activities using the Information Systems for Health (IS4H) Framework and improved access to specialist care with the Extension for Community Healthcare Outcomes, (ECHO) model. It continues throughout the pandemic response with increasing access to health care through a mobile app, used as part of the implementation of Jamaica's chronic care model.

With the enhanced Surveillance Capacity with improved data and information management capabilities, COVID-19 trends in Jamaica are continuously monitored, establish epidemiological characteristics of COVID-19 infection in Jamaica, and inform risk assessment and decision-making that reflect the updated situation. This augmented the Early Warning Capabilities of the public health system.

A robust and responsive testing infrastructure is essential to containing the spread of communicable diseases, including that caused by the SARS-CoV-2, with notification of a COVID-19 case based on the results of COVID-19 testing, triggering a series of activities. Jamaica, in collaboration with the Pan American Health Organization (PAHO), established local testing capacity in February 2020 at the long-established National Influenza Centre, which is housed at the University of the West Indies. This was subsequently supplemented with an open and a closed system established at the National Public Health Laboratory (NPHL) with the assistance of the Government of the Republic of Korea, the International Atomic Energy Agency (IAEA) and PAHO/WHO. This resulted in the increased sample throughput that was required to process the increased number of samples arising from increased SARS-CoV-2 infection in the country. These interventions will be sustained and now allow for improved Diagnostic Capacity of endemic, new and emerging threats.

Significant investment was also made to retrofit strategically located hospitals for the provision of critical care and high dependency care, and cope with surge demands. This included infrastructure upgrades for reliable piped oxygen delivery, procurement and installation of critical care equipment and enhanced human resource training for the management of patients with critical care needs. Crises were created by the recurrent high demand for oxygenation resulting from hospitalization for persons of interest in relation to COVID-19.

Following formal evaluation of the systems at hospitals by the sole provider of medical-grade oxygen in Jamaica, the capacity for oxygen supply was increased and recommendations to improve delivery at the point of care were provided. Through additional support from our international partners, more interventions are to be undertaken within the USAID/JA Global Health American Rescue Plan. UNICEF has procured an oxygen plant to serve the needs of hospitals within the Northeast Health Region. The plant will be placed at the St Ann's Bay Hospital in the region and will be fitted to deliver medical oxygen to surrounding public health facilities.

Recognizing the normally high bed occupancy levels with annual variability, surge protocols were created to manage a rise in COVID-19 cases, to maintain order, quality of service and provision of adequate medical care for citizens during the ongoing global pandemic. In addition to identifying COVID-19 dedicated beds and updating existing surge plans for in-patient care tailored to the capacities, two Fixed Surge facilities for COVID-19 cases that require hospitalizations were secured for a capacity of 70 patients. The MOHW also acquired three Rapid Assembly Surge Systems for In-patient Care that has been installed at the Spanish Town Hospital, the May Pen Hospital and the University Hospital of the West Indies.

The MOHW commenced programmes to leverage partnerships to enhance access to care. The COVID-19 pandemic catalysed networking initiatives and advanced the Strategy of Health in all policies. The COVID-19 Pandemic has underscored the importance of health considerations in various aspects of society. The input of the MOHW has been keenly sought in a variety of areas including Safe Resumption of International Travel for Business and Recreational Purposes by both air and sea travel, including enhanced Border Sector Processes and Safe Resumption of Organised Sporting Activities. There have been several guidelines developed to support health and medical services in the context of the COVID-19 Outbreak as well as other areas outside of health service delivery. The MOHW has developed and issued several policies, protocols and guidelines.

A critical part of risk reduction measures for COVID-19 has been strong and consistent communication with the public. Early in 2020, shortly after the first case was reported, UNICEF supported communication efforts to raise awareness among the public. Working closely with the MOHW and PAHO, UNICEF produced public service announcements geared toward engaging children and their families to promote proper handwashing.

Jamaica became the first country in Latin America and the Caribbean to develop and roll out a digital vaccine registration platform. As vaccines were introduced in 2021, the MOHW with support from UNICEF and the Private Sector Vaccine developed and deployed a digital vaccine information management platform to manage the vaccination process as well as monitor and provide real-time reports on the status of COVID-19 vaccine delivery across the island. Further, UNICEF supported the development of digital COVID-19 vaccination certification for members of the public.

Additionally, UNICEF has supported the MOHW to improve its cold chain and vaccination supply chain systems with the procurement and installation of critical cold chain equipment in 70 health care facilities across the island. The installation was guided by a Cold Chain Inventory Assessment which has quantified the need for the health system and has filled approximately 60per cent of the gap (UNICEF, 2021).

Resource Requirements

The Vision for Health 2030 outlines the financing requirements for the public health sector in keeping with international benchmarks. The plan identifies, that in the short to medium term, there is "consolidation of existing finance base to ensure implementation of a health benefits package/ National Insurance Scheme through a gradual increase in direct government funding toward the PAHO benchmark of 6.0 per cent of GDP as public investment in health and the establishment of a health care reserve (The Health Fund) under the MOHW for particular discretionary investments related to the Vision for Health 2030 Plan implementation." In additional, the Plan recommends that in the long-term, there "is the development of the basis for establishing two strategic finance sources to complement the existing government finance sources: establishment of a National Health Insurance (NHI) scheme; [and] implementation of a series of policy measures to promote efficiency gains and spending rationalization in the health care sector" (MOHW 2019: 5).