MINISTRY OF HEALTH & WELLNESS

CARE

THE COMMUNITY ARRANGED RESPONSE EFFORTS

C.A.R.E. AGENDA

An Excerpt of the Sectoral Presentation 2026
by Dr. the Hon. Chris Tufton, CD, MP, Minister of Health & Wellness

Madam Speaker, a critical measurement of the quality of life is the happiness and wellness of individuals and families in communities. Decisions around life are normally driven by what we see, feel and experience either through those we interact with at home, work, community or social and on other media.
Our health centres are at the epicentre of family and community. Public health has always built its critical outreach programmes around the nexus of these social groups.
From maternal health to aging, the prevention of communicable and non-communicable diseases. Madam Speaker, we have had many successes, from the elimination of polio from immunization, to expansion of life expectancy.

The Social Determinants of Health

Madam Speaker, poverty and inequality, environmental and lifestyle choices, cultures and subcultures impact health outcomes. Health interventions must begin early and incorporate seemingly unrelated clinical interventions. To do this we must look at the enabling institutions that make these interventions possible and effective.

Madam Speaker, the two most critical institutions are Family and Community.

1. The family that nurtures and forms healthy individuals who are able to contribute to the society, and

2. The community that creates and sustains the normative structures that not only fashion identity but re-enforces positive health decisions and practices.

Madam Speaker, Professor Elsa Leo-Rhynie, OJ, professor emerita of the University of West Indies (UWI), in her thesis on the Jamaican Family — Continuity and Change, points to the many varied challenges of the Jamaican family post emancipation, post-colonialism, and into the post-modern constructs of the Jamaican identity.

Many of the issues pointed out by Professor Leo-Rhynie persists as more and more families move away from extended family units where elders played a crucial role in the development and formation of children, to more nuclear families and the increasing presence of matrifocal family units. Added to the pressures facing the Jamaican family is the increasing number of women (who are the main caregivers within our society) in the workforce. Leaving a massive void in the mechanisms that make families work in any society.

Madam Speaker, some may ask: “What does this have to do with health?”.

The fact is that the reduction in the effectiveness of the nurturing role of the family has a direct relationship to the preventative strategies of the health system. From prenatal and postnatal care, vaccine coverage, childhood nutrition, sexual and reproductive health, menopause and elder care; the family is integral to the successful staging of any intervention aimed at mitigating the health risks along the life course.

I contend that it would be very possible, Madam Speaker, to draw causations between the existing constructs of the Jamaican family and many of the issues that impact the health outcome of the Jamaican Population. Some of these issues include lower than expected vaccine coverage, childhood obesity, early initiation into sex, poor sexual practices, poor work-life balance, mental illness as well as poor elder care practices. These challenges exacerbate the economic realities of the Jamaican people and undermine the country's ability to meet our shared vision for the future.

The Community

Madam Speaker, the community is another facet of the Jamaican society that has seen significant change over the years.

In this regard Adam Kapur's (prominent South African-born British anthropologist) work in defining the issues affecting the Jamaica Society serves as a good reference for the changes that are impacting post modern Jamaica.

The advent of technology and the ever-increasing impact of Artificial Intelligence (AI) on the way we live represent both challenges and opportunities within our new dispensation. The concomitant values of the postmodern world marked by its lack of connectedness and collegiality, our movement towards social isolationism and inwardness; undermines our ability to be our "brother's keeper".

This impacts health directly as we experience daily the many instances of trauma, whether through domestic violence, interfamily violence or inter community violence.

We see this in the increases in the number of hospital-related social cases, the lack of care for the elderly and children who are abused by trusted adults and caregivers as symptomatic of a reduction in the levels of social capital that were a hallmark of our "Jamaicaness". Community and community-based values are today threatened and require a new approach.

A New Informed Approach

We must begin with the enabling environment that supports positive re-enforcement of outcomes of our prevention strategies. This approach must be evidence based and participatory.

Today I will present a series of initiatives that will engage families and communities through consultation, research and policy formation aimed at supporting a more family and community integrated approach to holistic healthcare. These initiatives are not exhaustive but represent social determinants of holistic healthcare. Some cut across Ministries and agencies and will include civil society groups for better understanding and participation.

Madam Speaker, to begin, we will be collaborating with the University of the West Indies to develop and execute research to answer the following policy issues:

1. Primary Health Services in Jamaica: A look at Health Centres and how the community responds to the services provided through the first point of contact in health.

2. A study on misinformation and disinformation; the impact of social media on health choices the Jamaican population, especially on children under 16 years.

The first study is to provide information on primary healthcare, as our main tool for prevention, is perceived by the communities they serve. This will enable the Ministry to complete a comprehensive Strength, Weakness, Opportunities and Threats (SWOT) analysis on Primary care system to better equip us to respond to the new challenges in this new dispensation.

The second study will provide us with information on how social media is influencing the health choices of the population and how exposure to social media is impacting the health outcome of our children in particular.

Madam Speaker, our aim is to build the proverbial "big tent" to tackle the issues of community and its contribution to effective prevention strategies.

Community Arranged Response Efforts (C.A.R.E Fund)

In this regard the Ministry will be launching the J$500M C.A.R.E Fund to support community projects linked to our strategies for NCD prevention. This will be over two years.

Madam Speaker, this fund will be managed by the Ministry's Enabling Environment in Health & Client Services Division and will seek to work with Community Based Organisations, Faith Based Organisations and other Civil Society Groups to: increase health seeking behaviour, improve and strengthen families to support vulnerable persons like the disabled and elderly, and promote prevention strategies for NCDs along the life course.

The Ministry will publish a call for proposals on Monday, June 15, 2026, inviting organisations from across the island to participate in this collaboration to manage the many societal risks. The Ministry will also approach strategic entities to support the engagement of our communities and families ensuring that we have the broadest and most engaged collaborative structure to meet the objectives that have been established. At the end of the interventions, it is our intention to:

1. Refocus on the family as the main form of social engineering for healthy living and better health practices.

2. Revive the value of community and community-based involvement in social structures that support the care and treatment of the most vulnerable within the society.

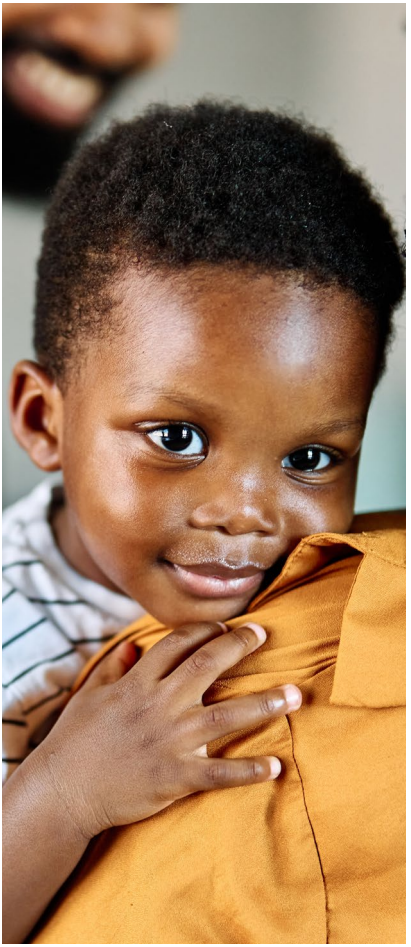
3. Reinvigorate positive social norms and values around holistic living at all stages of the life cycle.

The Community Arranged Response Efforts

C.A.R.E. AGENDA

Madam Speaker, in this context, over the next two years we will assess a range of issues impacting Jamaicans in the context of family and community health. We will examine the threats and opportunities for new and emerging policies to support holistic health, to protect the vulnerable and enhance quality and longevity of life. We will seek partnerships, research and advocate for new ideas around these goals which will strengthen our life-stage approach to community or primary healthcare.

Madam Speaker, we will start with our C.A.R.E Agenda to highlight and influence critical determinants of better family and community health.



01
Social Media and Children

Madam Speaker, Jamaica's digital landscape reflects rapid and widespread adoption, with approximately 2.54 million internet users in 2025 and 3.18 million active cellular connections - we have a strong mobile-first culture.

Social media penetration is equally significant, with over 1 million Jamaicans using Instagram and about 1.6 million on Facebook by late 2025, driven largely by users aged 25-34. While these platforms have transformed communication, networking, and entrepreneurship, they have also introduced measurable social and psychological strain.

Among children aged 0-14, 64% report that social media negatively affects their mental health, while 47% of adolescents aged 15-19 report similar impacts. Usage intensity is a critical factor, as children spending more than three hours daily online are twice as likely to experience mental health problems. Regionally, the Caribbean has also seen rising levels of cyberbullying, sexting, emotional distress, and suicidal ideation, reinforcing concerns that social media has evolved into a public health issue rather than just a communication tool.

These trends align with global shifts toward stronger government intervention. Countries such as Australia (16+), Denmark (15+), France (15+), and Indonesia (16+) have already implemented age-based restrictions, while Spain, Greece, Norway, and Austria are actively considering similar policies. Broader regulatory frameworks, including the UK's Online Safety Act, now require platforms to monitor harmful content, enforce age verification, and remove addictive features such as autoplay and infinite scrolling, with substantial penalties for non-compliance.

In Jamaica, emerging research from 2025–2026 confirms a strong link between social media use and increased anxiety, depression, and digital addiction, particularly among youth and content creators. Youth under 24 spend an average of 6±5 hours daily on social media, compared to 4±5 hours for adults and 3±4 hours for seniors. Among content creators, 42% report anxiety and 38% report depressive symptoms such as low mood and irritability, while 47% experience burnout driven by the pressure to maintain an online persona and secure income opportunities.

At the same time, 36% of Jamaican content creators produce content involving physical altercations, and 29% engage in aggressive online behaviour, contributing to a broader cultural shift marked by increased vulgarity and normalization of harmful content.

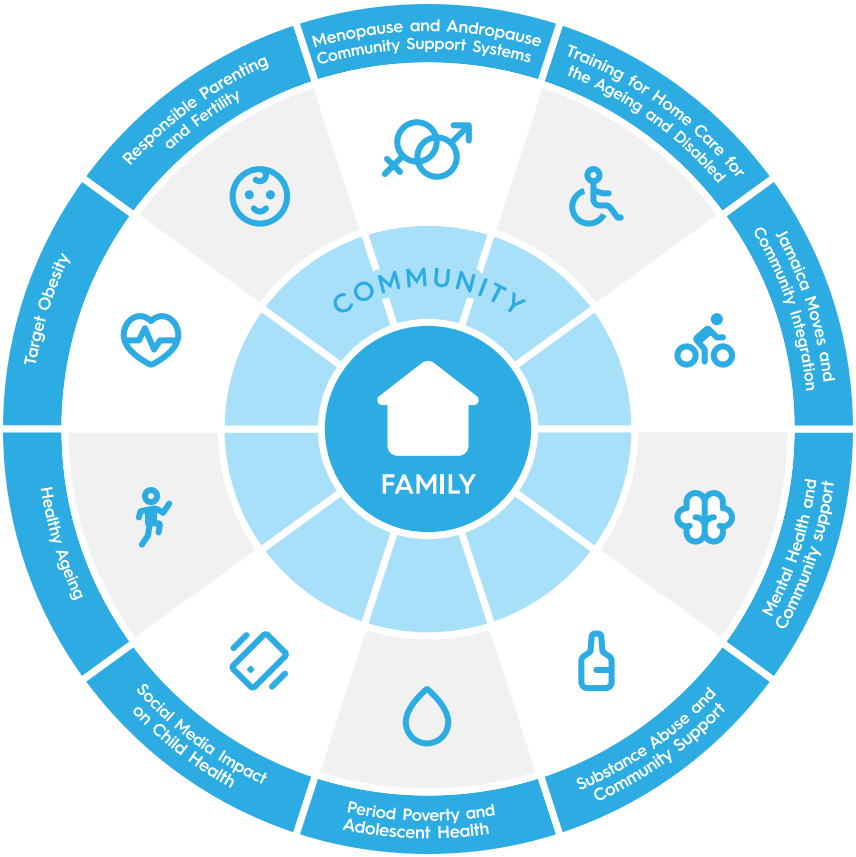
Madam Speaker, Jamaica lacks a coordinated national response to this public health threat. The time has come to use research-based policy formulation to determine age-based regulation, platform accountability, national digital health guidelines, school-based digital wellness education, expanded youth mental health services, public awareness campaigns for caregivers, and a national surveillance system to track usage patterns and mental health outcomes. Earlier I announced research which will inform further advocacy around relevant policy.

With the completion of this national study on public perceptions of social media regulation for minors, the Government will now move decisively into the next phase of action. We will translate these evidence-based findings into a clear policy framework by developing and assessing regulatory options, and engaging key stakeholders, including parents, educators, youth representatives, and digital platform providers, to ensure that any measures introduced are balanced, practical, and in the best interest of our children. This consultative and structured approach will guide the preparation of a comprehensive policy for the regulation of social media.

02
Healthy Ageing

Madame Speaker Healthy ageing must involve family and community. The Jamaican population is aging, and the fastest-growing age group is the 60-plus, now totalling 375,000 persons or 14% of the population. Furthermore, this age group is growing at 1.9% annually compared to 0.2% for the total population. So, it is expected that by 2030, the number will be approximately 400,000. It is well known that there is more chronic disease among older persons. The Mona Ageing & Wellness Centre (MAWC) 2011 study reported 72% having at least one chronic disease. That survey also identified loneliness and other social issues as debilitating to their health. This demographic shift is creating additional demand for healthcare services, including long-term care.

Against this background, we have commenced developing a healthcare programme for older persons within primary care. The family and the community will be critical to this. Jamaica's Primary Healthcare (PHC) Reform, the Healthy Ageing agenda, and the worldwide emphasis on an integrated approach to health of older persons will provide an opportunity to strengthen older persons' health across the life course, with an emphasis on specific services for older persons through our community health centres.



This year we will be launching Geriatric clinics in St. Ann and St. Catherine, at a Community or District Health Centre as a pilot to inform the launch of an islandwide programme. The clinics will offer complete geriatric assessments including for function, the geriatric giants – falls, incontinence, immobility, mental function and social factors, and recommend appropriate interventions. The community-based personnel will be involved to do home assessments.

We will do this through collaboration with the Ministry of Labour & Social Security, National Council for Senior Citizens and local government and Community Organizations. We will be accepting referrals where appropriate, including for loneliness and social isolation. This will be in keeping with long term care will and improving and maintaining functional independence as persons age.

03
Menopause and Andropause Community support systems

Menopause typically occurs among women in their late 40s to 50s. There are approximately 240,000 in this age cohort. These women report a wide spectrum of symptoms, including hot flashes, fatigue, mood instability, and vaginal dryness. Severe cases, such as heavy menstrual bleeding (menorrhagia) and haemorrhages, are more pronounced in underserved rural communities.

Andropause, or age-related testosterone decline, affects men gradually, typically becoming more evident between ages 51 and 60. There are approximately 145,000 men in this age cohort. Symptoms include reduced libido, erectile dysfunction, fatigue, depression, and loss of muscle mass. Despite its impact, it is often mischaracterized as a lifestyle issue or "midlife crisis," contributing to underdiagnosis and limited care-seeking behaviour.

Research shows that countries with formal menopause strategies achieve more consistent care and better access to services. When women receive trusted information and clinical support, symptoms are more likely to be recognised and effectively managed.

For Jamaica, this evidence supports an integrated, family and community-based approach rather than isolated clinic care.

Madam Speaker, we are in the final stages of creating a dedicated menopause and andropause policy which will guide governance of men and women with adverse conditions at the level of the family, community and workplace.

Local research done over the past 3 months by the Ageing Committee named earlier this year and led by Professor Denise Eldemire-Shearer has identified the main areas for action locally and has informed the Ministry of Health and Wellness plan for the next 12 - 24 months, including:

01 Drafting a menopause/ andropause policy which will go to cabinet this month, and once approved will go to the Chief Parliamentarian Council (CPC) for drafting instructions.

02 A national education/ health promotion programme.

03 A training programme to ensure that menopause and andropause are covered in health professional curricula.

04 Engaging a consultant to work with the professional associations to develop clinical guidelines and standard operating procedures for use locally in both public and private practices.

The Standards and Regulations Division in the Ministry will review the current system of applications for importation of menopause related treatments so as to facilitate rapid review of such applications.

04
Training for Home Care for the Older Persons and disabled

Jamaica already relies on a significant but largely invisible care system for older persons and people living with disabilities at the family and community levels. These are Unpaid Caregivers; The children, aunts, cousins, neighbors, church brother or sister. We must recognize them and salute them.

Madam Speaker, this is not unique to Jamaica. International and Caribbean evidence suggests that between one-quarter and one-third of persons aged 60 years and older require regular assistance with activities of daily living, with care provided predominantly within households and largely unpaid (PAHO, 2026; IDB, 2018; ECLAC, 2023). The implication is clear: long-term care systems are already built on household labour, whether recognised or not. It is time we recognize this and support where we can.

And Madam Speaker, Its scale is not marginal. In Jamaica, unpaid care and domestic work is estimated at between 15% and 45% of GDP, reaching up to J$991 billion annually. Yet it remains largely unsupported, unstructured, and disconnected from formal services, even though it underpins day-to-day care for frail older adults and persons with functional limitations.

Madam Speaker, our Community Health Aides (CHAs) number some 2,500 and represent the Ministry's community outreach, under the supervision of the public health nurse and midwife. We must promote through partnerships, training and integrating a stronger link between our CHAs and unpaid family and community care givers - a redesign that links them into a single, functioning system.

This year we will commence a phased pilot of home-based long-term care that explicitly includes unpaid caregivers as part of the care team for older persons and people with disabilities.

In this model, CHAs will provide structured home visits embedded within primary care, supported by nurse supervision. This includes practical training to improve care quality and safety, inclusion in care planning and decision-making, access to psychosocial support. These measures reduce caregiver strain while improving outcomes for those receiving care.

To improve the care by families, community persons and paid caregivers to older people and persons with disabilities at home to reduce dependency, caregiver burnout and the need for institutional care.

During 2025 - 2026 a pilot programme of training of 148 Community Health Aides (CHAs) was done.

Professor Denise Eldemire-Shearer will oversee a national training programme for community caregivers on how to care for older persons and persons with disabilities. A task force will be established including the Ministries of Labour and Social Security, Education, Youth, Skills & Information and Local Government & Community Development – all three Ministers have agreed, churches, community organizations and age care organizations and their main function will be to identify persons for training ensuring wide community participation. All CHAs will be trained.

We are in dialogue with the Heart/NTA Trust and our public schools to partner with the training programme, using a mixture of online and face-to-face teaching. Public Health Nurses will be recruited to oversee practices at each training site in all 14 parishes. The curriculum will include the basics of health ageing, geriatric assessment including home assessment and intervention, chronic diseases management, social aspects of ageing, caregivers support and avoiding caregiver's burnout. The format will be lectures, demonstration and practicum. A budget of J$50M will be given and 5,000 caregivers trained in the first year.

05
LifeStyle Clinics

Madam Speaker, obesity is one of the most pressing public health challenges facing Jamaica today. Over the past two decades, we have witnessed a rapid rise in the prevalence of overweight and obesity across all age groups, contributing significantly to the burden of non-communicable diseases (NCDs), including diabetes, hypertension, cardiovascular disease and some cancers.

More than half of the Jamaican population 15 years and older, approximately 53.8%, are overweight or obese. The disparity is particularly pronounced among women, where prevalence rates reach 67.6%, compared to 38.8% among men. Even more alarming is the trend among our youth, with obesity rates among adolescents aged 10 to 19 years having doubled between 2000 and 2017.

Madam Speaker, the implications extend beyond health outcomes. The economic burden associated with overweight and obesity in Jamaica is high. In 2019, it was estimated at approximately US$425.3 million, and projections indicate that this figure could increase by 3-fold to US$1.53 billion by 2030, or US$544 per capita, and 5.9% of GDP, representing a significant proportion of national expenditure and economic productivity. These trends underscore the urgent need for a coordinated, sustained approach to managing the already large population that requires comprehensive obesity management.

In this regard, the Ministry of Health and Wellness will establish Lifestyle Clinics, one per Region (SERHA – Kingston and St. Andrew at a Comprehensive health centre, SRHA – a District health centre, and NERHA - St. Mary - in a District health centre) within the primary healthcare system, using a life-course approach, supported by an integrated network of care. This initiative is designed to provide comprehensive, multidisciplinary, patient-centred clinical management of obesity.

The clinics will deliver a full spectrum of services, including medical assessment, nutrition therapy, behavioural counselling, exercise prescription and pharmacological interventions where clinically indicated. Importantly, these services will be supported by a robust referral system to ensure continuity and quality of care.

The clinics will be implemented in a phased approach and will form a part of a network of centres of excellence for research and training.

In the first year, priority actions will include:

· Setting the standards of care by developing national guidelines for the clinical management of obesity by December 2026

· Targeted capacity-building and training of the health care workforce in obesity management and preparing suitable sites. Service delivery will commence in the last quarter of the fiscal year.

The service model will be expanded over health regions over a three-year period. This initiative represents a critical step toward strengthening people-centred primary health care, improving equitable access to essential obesity services and reducing the prevalence, long-term health and economic impacts of obesity in Jamaica. Ultimately, this is not only a health intervention, but it is also an investment in the well-being, productivity, and sustainable development of Jamaica.

The intention is to engage families and communities as a collective to better understand and support to target obesity. We will encourage outreach to civic groups to develop special programmes to tackle obesity.

Madam Speaker, this is not just a health intervention, but an investment in the well-being, productivity, and sustainable development of Jamaicans.

06
Fertility and Responsible Parenting

Jamaica's total fertility rate has fallen to approximately 1.3 children per woman — well below the replacement level of 2.1. This decline threatens the country's long-term economic stability, social support systems, and national workforce. The consequences include an ageing population, rising dependency ratios, reduced domestic economic activity, and a shrinking human capital base. The Government's position is clear: this is not a future problem but a present crisis requiring immediate, structured action.

What the Evidence Says

Global research confirms that no single intervention reverses declining fertility. What works is a comprehensive, sustained policy environment that reduces the real costs — financial, physical, and psychological — of having and raising children. Generous parental leave with high wage-replacement has been linked to 5–23% increases in birth rates in Canada and Norway. Subsidised childcare and universal pre-kindergarten have raised births in Germany and other nations. One-off cash payments, by contrast, produce only brief spikes before fertility returns to trend, as documented in Spain and Australia.

Madam Speaker, different countries have applied different policies with different levels of success. It's time to have a conversation in the interests of preserving families, our communities and society.

Five Policy Pillars

Over the next two years, the MOHW will embark on exploratory conversations to advance community and society based interventions to support healthier families and communities through;

Financial Support

Expanding child tax credits, introducing tiered child allowances, and establishing a phased Responsible Parenting Incentive Grant delivered across a child's first three years, conditional on health visit attendance and early childhood enrolment. Mortgage support for young families

Leave and Work-Family Reform

Extending paid maternity leave, introducing statutory paternity leave, creating a shared parental leave mechanism, and partnering with the private sector on family-friendly workplace certification.

Affordable Childcare

Subsidising nursery and day-care fees, expanding community early childhood centres, introducing Universal Pre-K for all four-year-olds, and establishing after-school care at primary schools to support working parents.

Reproductive Health

Strengthening infertility treatment access within the public health system, launching a national male reproductive health initiative, scaling antenatal education, and improving postnatal mental health screening and support.

Parenting Education and Community

Scaling evidence-based parenting programmes through clinics and schools, integrating family life education into the secondary curriculum, partnering with faith and civil society organisations, and formally recognising kinship care networks.

The Proposed Taskforce

In consultation with the Minister of Labour and Social Security, we propose a Multi-Stakeholder National Taskforce on Fertility and Responsible Parenting. Drawing membership from health, labour, finance, education, the private sector, academia, and civil society, the Taskforce will produce a National Fertility and Family Support Strategy with clear targets for 2030 within 12 months.

Madam Speaker, let me be clear. The Government is not asking Jamaicans to have children for statistical reasons. It is committed to building conditions where family formation is genuinely affordable, structurally supported, and celebrated. The intention is to pursue this initiative to affirm that this Government continues to believe that family remains the foundation of the nation's future

Madam Speaker, there is another issue worth noting here.

Jamaica faces a striking demographic paradox: even as fertility has fallen well below replacement level, issues of paternity uncertainty remain widespread, with research suggesting roughly one in four cases may involve misattributed fatherhood. Together, these dynamics point not just to fewer births, but to deeper challenges around trust, family formation, and the social conditions that shape decisions about having and raising children.

For children, misattributed paternity can have lasting effects on identity formation, emotional security, and family belonging. From a child health perspective, inaccurate paternal information compromises the reliability of family medical histories, an increasingly important input into clinical decision-making, while disruptions in paternal bonding may reduce emotional and financial support, increasing the likelihood of unstable caregiving environments.

Madam Speaker, today we make no commitments on specific policies but we commit to engage, explore, educate and advocate in the interests of better families and communities.

07
Period Poverty and Adolescent Health

Period poverty is the inability to afford or access essential menstrual products, education, and sanitation facilities. It causes significant health risks, shame, and stigma, forcing many to use unsafe alternatives or miss school/work. Key causes include high costs, lack of infrastructure, and systemic inequality.

Globally, more than 500 million people lack access to menstrual facilities. Global studies show that over one-third of girls - approximately 35 per cent - treat menstruation as a private or taboo matter, limiting help-seeking behaviour and access to accurate reproductive health information. The challenge is not just Jamaica; in the US, nearly 1 in 4 students have struggled to afford period products and just under half had worn period products longer than recommended.

Madam Speaker, we all must be concerned about Period poverty among our young girls in schools. It's not just a hygiene issue, but a systemic barrier that keeps girls out of classrooms, undermines their academic potential, and reinforces cycles of inequality and poverty.

Here are some Key Statistics:

• 1 in 4 girls in low-income Jamaican communities miss school during their period due to lack of sanitary products.
• Only 30% of public schools provide free menstrual products.
• Period-related absenteeism is linked to lower academic performance and a widening gender gap.
• Across broader research, about 44% of girls in Jamaica experience period poverty.

With the average pack of sanitary napkins costing between approximately $250 and $600, many families on the PATH program (living on less than $1,300 JMD/day) must choose between food and menstrual hygiene.

This year we will establish the National Menstrual Health Equity Initiative to alleviate period poverty among school-aged girls in Jamaica through strategic partnerships, with the Ministry of Education, Youth, Skills and Information (MOESYI) and existing civic and multilateral groups such as HerFlow and UNICEF.

We will be embarking on a multi-sectoral National Menstrual Health Equity pilot initiative to distribute menstrual hygiene kits and conduct education sessions in 8 schools with high concentrations of PATH-registered girls, using an integrated school-health approach to adolescent wellness – incorporating menstrual wellness with WASH (water, sanitization, hygiene) improvements, HPV vaccinations, personal hygiene education, and HIV/STI prevention.

This 18-month pilot project, estimated at J$50 million, is expected to benefit 2000 girls while also reaching boys, teachers, parents, and school health personnel through education and community engagement activities. A multi-sectoral Technical Working Group, co-chaired by the MOHW and MOESYI, will be convened to coordinate the pilot and produce an evaluation report that will guide policy development and programmatic rollout.

08
Jamaica Moves and Community Integration

Jamaica is facing a growing health crisis driven by poor nutrition and increasingly inactive lifestyles, both of which are major risk factors for non-communicable diseases (NCDs). According to the Jamaica Health and Lifestyle Survey (2016–2017), one in three Jamaicans aged 15 years and older suffers from hypertension, while one in eight is living with diabetes. Alarmingly, four out of every 10 persons with either condition are unaware of their status. The situation is further compounded by the fact that more than half of the population is either pre-obese or obese, particularly among individuals aged 35 to 64, increasing their risk of cancer, heart disease, stroke, and diabetes by 20 to 30 percent. Physical inactivity alone accounts for 12 percent of deaths in Jamaica, with 82 percent of the population engaged in low levels of physical activity, 16 percent in moderate activity, and only 2 percent achieving high levels of activity.

This year we will review and relaunch Jamaica Moves 2.0 - a Family and Community event.

Jamaica Moves initiative will seek to strengthen community-based interventions to promote healthier lifestyles. Walking groups will be established across parishes to encourage regular physical activity and social engagement.

We will establish one highly accessible location in each parish centre designated and branded as a Jamaica Moves Healthy Zone by the end of 2026/2027, creating visible hubs for wellness activities.

Madam Speaker, a Jamaica Moves activity is coming to a community near you in 2026/27. We intend to partner and execute high energy events for the entire family while supporting health screenings and health education messaging.


JAMAICA MOVES
JAMAICA MOVES
JAMAICA MOVES

09
Mental Health and Community Support

The urgency of Jamaica's mental health response is evident in both national trends and patterns of service use. The 2024 Economic and Social Survey of Jamaica recorded a 1.5% increase in suicides to 67 cases, with males accounting for 91% of victims; although 2025 figures indicate an overall decline, a troubling surge between July and September signals continued risk based on Jamaica Constabulary Force (JCF) data. At the same time, more Jamaicans are seeking support, with 2,885 individuals counselled through the U-Matter text line and 4,781 calls received to the Ministry's Mental Health & Suicide Prevention Helpline, underscoring both the scale of need and growing awareness of available services.

These trends are reinforced by epidemiological data on depression with a national prevalence of 14.3% from the Jamaica healthy lifestyle survey - depression is defined as the presence of five or more symptoms and/or suicidal ideation. The burden falls disproportionately on women (18.5%) compared to men (9.9%), with the highest rates observed among urban women (19.2%) and the lowest among rural men (7.3%). Older adults are particularly affected, as Jamaicans aged 75 and older show the highest prevalence at 20.8%, highlighting the need for targeted, age- and gender-responsive interventions within the broader mental health response.

Against this backdrop, we will move to strengthen mental health services by expanding community-based care, recruiting more professionals, and deploying Psychiatric Emergency and Maintenance Teams to deliver rapid crisis support where it is needed most.

We are advancing the development of a National Mental Health Policy, with procurement for a consultant currently underway. We will expand the Mental Health & Psychosocial Support teams within affected communities. The teams would include Psychologists, Counselors and Problem Management Providers. The aim is to train some 200 lay persons as Problem Management Providers, with an approximate reach in the communities of more than 1,000 Jamaicans.

Regional Health Authorities are preparing to train approximately 145 more psychiatric nursing assistants in the first quarter of the 2026/27 period to address staffing gaps, while ongoing training for psychiatrists and mental health officers seeks to reduce long-standing shortages.

This year we will also train an additional 50 Guidance Counsellors under the School Mental Health Literacy Programme. Madam Speaker, we are hoping that community based organizations will engage us on this mission through training and partnerships to listen and support those in need.

10
Substance Abuse and Community Support

The National Drug Prevalence Survey shows that the substances most commonly used in Jamaica are alcohol, cannabis, and tobacco. Among these, alcohol remains by far the most dominant. Approximately 77% of Jamaicans—nearly eight in every ten people—report having consumed alcohol at least once in their lifetime.

However, recent concerns are the increasing popularity of New Psychoactive Substances (NPS) and synthetic substances (like molly/ecstasy/MDMA) in youth and young adults. The public health risks include the combination of multiple substances unknown by the user, ease of access, difficulty in detection of the substance and high potential for addiction.

Additionally, the combined use of alcohol with other substances such as cannabis and energy drinks pose concerns.

Madam Speaker, we need a community based model to confront this risky behaviour. Public health evidence consistently demonstrates that enforcement-led approaches have limited impact on reducing use, while community-based responses—prevention, treatment, harm reduction, and social support—produce more sustainable outcomes.

Service Expansion

In August 2024, The National Council on Drug Abuse (NCDA) was integrated into the Ministry of Health and Wellness as a Department with a significantly expanded structure (60 to 309 staff) and mandate to include mental wellness promotion, specialized treatment services for dually diagnosed individuals and national crisis helpline and chat lines.

POSITION TYPE	OLD STRUC-TURE	NEW STRUC-TURE	FILLED AS AT MARCH 2026	ROLE RESPONSIBILITY	INTERVENTIONS
Psychiatrist	03		1	Medical management for mental health	Collaboration with RHA
Psychologist	01	27		Psychotherapy/Crisis Management	National Helpline (188), collaboration with RHA
Counsellor	02	71	7	Counselling	Collaboration with RHA
Psychosocial Officer	05	11	7	Mental Wellness promotion and interventions	Operation Lighthouse: Parenting Campaign
Substance Misuse Pre-vention Officer	14	54	17	Life skills initiatives focused on focused on building protective factors, and behaviour change	Anti Vaping Campaign Vendor Engagement
Harm Reduction Officer	02	31	3	Risk reduction interventions focused on lowering risk and promoting safe practices	Anti-Special Campaign: Mixing Alcohol with Energy Drink
Case Management Officer	01	31	1	Comprehensive case management	Collaboration with RHA
TOTAL	**14**	**183**	**83**		

In its expanded role the NCDA will embark over the next two years on a number of community based collaborative initiatives to target and reduce substance abuse.

Energy Drinks and Alcohol

Anecdotal evidence suggests that the use of alcohol and energy drinks, known as “special” is widespread across high-, middle-, and low-income groups, indicating its broad social reach. Known commonly in communities by this name, it has gained cultural visibility through popular music.

Energy drinks are non-alcoholic beverages containing high levels of stimulants, primarily caffeine. Caffeine is a stimulant and alcohol is a depressant, caffeine masks the feeling of being drunk and encourages binge drinking/ higher blood alcohol concentrations. Mixing alcohol with energy drink masks intoxication, encouraging heavier and more prolonged drinking while amplifying risky behaviours.

In the coming year the NCDA will conduct a National Rapid Situation Assessment to quickly understand how widespread the issue is, who is most affected, and the contexts in which it occurs. This will provide timely, evidence-based insights to guide targeted interventions and resource allocation. It will also help to identify risk factors and priority areas for prevention and control. This information could be used to strengthen policies like warning labels around the use of these products.

We will conduct a national public education campaign that will target the practice of combining energy drinks with alcohol and develop community-based partnerships to address the problem.

Parenting Initiative

We will roll out Operation Lighthouse, in 50 communities islandwide by our Substance Misuse Prevention and Psychosocial officers by March 2028. This is a universal substance misuse prevention programme that strengthens families by building essential life skills in parents and children.

It fosters strong family bonds, sets clear behavioural expectations, and helps parents better understand and manage their children's behaviour. Through skill-building for both parents and children, it promotes healthier family dynamics, reduces the risk of substance misuse and other at risk behaviours.

Anti-Vaping

Over the next 2 years an islandwide Anti-vaping multi-level programme will be rolled out in 150 schools and their surrounding communities. The aim is to build peer leaders capacity to engage in prevention, train teachers in Screening, Brief Intervention and Referral to Treatment (SBIRT), increase community and parental involvement and implement a public education campaign on the dangers of vaping to increase the perception of risk among youth.

Interventions with School Vendors

Madam Speaker, reports of vendors selling contraband to students throughout the school day require urgent attention. Without clear regulations, monitoring, and enforcement, some vendors may prioritize profit over safety, increasing the likelihood of harmful sales to minors. A focused approach will be implemented to strengthen vendor accountability, increase education on legal and health consequences, improve supervision around school zones, and involve parents and communities in safeguarding students.

Conclusion

Madam Speaker, with these announcements I hope, on behalf of this Government and all healthcare workers, that our mission is clear, working together for better families, better communities, better health.

God Bless Jamaica land we love!

Thank You.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