

COVID-19 related community lockdowns in two low-income communities in Jamaica

Cameal Chin-Bailey¹, Camelia Thompson², Desmalee Holder-Nevins³, Dawn Walters¹, Kayon Donaldson-Davis⁴, Kenneth James³

¹ Assistant Lecturer, Department of Community Health and Psychiatry, The University of the West Indies, Mona. Tel: 876-927-1660

² Lecturer, Department of Community Health and Psychiatry, The University of the West Indies, Mona. Tel: 876-927-1660

³ Senior Lecturer, Department of Community Health and Psychiatry, The University of the West Indies, Mona. Tel: 876-927-1660

⁴ Lecturer, Mona Ageing and Wellness Center, The University of the West Indies, Mona. Tel: 876-927-1660

Corresponding Author:

Cameal Chin-Bailey

Email: cameal.chinbailey@uwimona.edu.jm

DOAJ: [eddf14d809d8116a11fb426d4](https://doaj.org/eddf14d809d8116a11fb426d4)

DOI: <https://doi.org/10.48107/CMJ.2025.03.001>

Copyright: This is an open-access article under the terms of the [Creative Commons Attribution License](https://creativecommons.org/licenses/by/4.0/) which permits use, distribution, and reproduction in any medium, provided the original work is properly cited.

©2025 The Authors. Caribbean Medical Journal published by Trinidad & Tobago Medical Association

ABSTRACT

Objective: Community quarantine has been one of the public health management strategies used to control the spread of COVID-19 in Jamaica. This paper sought to understand COVID-19 related community lockdown experiences reported by residents in two communities in Jamaica.

Methods: Forty-three in-depth interviews were completed in two communities that experienced COVID-related 'community lock-down'. Using qualitative content analysis, themes and subthemes were identified and further categorized as pros and cons. Excerpts from the voices of participants were then utilized to further illuminate their feelings and experiences.

Results: Females constituted the majority (53%) of participants and the mean age of participants was 44.1 years (SD =20). 'Pros' and 'Cons' as broad categories embodied nuances held by participants about their lockdown experiences. 'Time to Bond', Attention to Social Needs' and 'Staying Informed' emerged as 'Pro' themes, while 'Communication Pains', 'Nuff Discrimination [a lot of discrimination]' and 'Unmet Needs' were the 'Con' themes emerging from participants' experiences.

Conclusion: The study highlights important issues related to communities and their lockdown experiences and the relevance of these to health promotion efforts. Heightened interest in health related information and education are opportunities for increased health promotion. Implementation of community lockdowns should not be an ad hoc process, but one with forethought, taking into account communication, social realities, political dynamics and health promotion.

KEYWORDS: COVID-19; community quarantine, lockdown; social reality; Jamaica

INTRODUCTION

The COVID-19 pandemic has posed one of the biggest challenges to public health globally and continues to cause disruptions in the lives of families and many aspects of community life.¹ Several disease prevention and health promotion approaches have been employed to meet the challenges of COVID-19 and these will need to be adapted in the future as the pandemic evolves.⁽²⁻⁴⁾ An outcome of the first International Conference on Health Promotion was the Ottawa Charter of Health Promotion in which health is defined as a resource for living and is created where people live, work and play. (WHO, 1983). Health promotion advances healthy living through collaborative relationships and the creation of healthy settings where individuals can live productive lives close to home, work and play venues.^(5,6) Identifying and responding to social determinants of health have been highlighted as priority areas for the promotion of health and this is critical to the achievement of sustainable development goals.⁽⁷⁻⁹⁾ Health promotion at the individual and community levels, requires innovative and competency based responses if health systems are to effectively respond to the COVID-19 pandemic.¹⁰

The COVID-19 pandemic directly impacts social determinants of health, jeopardizing economic stability, community and family relationships, health care and employment, food security and educational pursuits.^(9,11,12) Community partnerships and cohesiveness and social factors that are key to building healthy communities can be negatively or positively affected in this pandemic. As such, community interventions that impact wellbeing should be informed by the social realities of the communities. Social reality refers to *'reality or fact of life peculiar to a particular society'*.¹³ Social realities include social class, income and employment, communication options, social capital and social support systems, cultural practices and political representation. Ecological models point to the relevance of intrapersonal or individual factors, interpersonal or group factors, organizational or institutional factors, environmental factors and policy influences including governance and social support systems^(14,15) in the construct of social realities.

Social determinants and social realities mediate gains that can be achieved through health promotion. For example, communities with high population density, overcrowding and restricted geographic layouts are ideal settings that can facilitate the rapid spread of the virus. Community lockdown/quarantine, which is *'the compulsory physical*

*separation, including restriction of movement, of populations or groups of healthy people who have been exposed to a contagious disease'*¹⁶, is a common strategy to curtail the spread of the virus in such settings. However, community lockdowns, by isolating persons within their communities, may diminish intra-community social interaction, hinder effective functioning of community institutions and interfere with the normal execution of socially important ritualistic events. On the other hand, the spread of the coronavirus in some communities may result in residents becoming more close-knit¹⁷ and developing coping strategies to reduce stigma and discrimination.¹⁸ Community quarantine therefore has short and long-term consequences. From a multi-level perspective, individual attitudes and actions, family and community social group responses, as well as institutional support and policies, shape the lived experiences during lockdowns.

Residents in 'lockdown communities' are strategically placed to describe their experiences. How were families and communities impacted by these measures and what lessons can be learnt about community lockdown and health promotion? This qualitative study sought to understand COVID-19-related community lockdown experiences as reported by residents in two communities in Jamaica. It further aims to unearth consequences of the lockdown and implications for the promotion of health and wellbeing in communities.

Jamaica, located in the Caribbean has a population of 2.9 million people.¹⁹ The country has been classified by the World Bank as 'middle income' and 'developing'. In the present COVID-19 pandemic, Jamaica managed to contain the spread of COVID-19 cases across the entire island to 1031 cases²⁰ in the first five months. Community quarantine locally referred to as 'community lockdown', was utilised by the authorities as a measure to limit spread beyond close contacts and beyond geographically defined communities. Under quarantine, community ingress and egress were severely restricted, and residents were advised to stay at home while multidisciplinary public health teams conducted relevant testing and provided support services. Exceptions to confinement within the community were made to accommodate essential workers and medical emergencies.²⁰

METHODS

For this qualitative study, a constructivist worldview²¹ was adopted with the assumption that people apply individual meanings to different situations and life experiences in their natural world. As a consequence 'an interpretive

naturalistic approach' was applied to illuminate the lifeworld as shared by participants in their natural community settings and using their words.²¹

The setting

Two communities placed under lockdown were chosen. These two communities were of particular interest because they were among the earliest to experience 'lockdown' and faced more challenges from prevailing social vulnerability due to low-income status and poor physical infrastructure. They were COVID-19 naïve communities and because of their nascent exposure regarding COVID-19 and lockdowns, they were ideally suited for sharing their novel experience. One community (Community A) was peri-urban, with some residents employed in industrial/manufacturing jobs and others earning a living through elementary occupations and 'hustling' ('hustling' refers to informal opportunities/activities for earning much needed funds on a daily basis and can range from serendipitous trading in small items to the ad hoc provision of services in return for immediate rewards). The other community (Community B) was more rural with a farming-based economy.

Selection of Participants

For phenomenological studies, Creswell & Poth (2018) have recommended that at least 10 to 15 interviews be conducted.²¹ Bearing in mind this recommendation and the need to capture a range of experiences among participants, persons from each community who were residents and present in the communities during the quarantine period were purposively selected. Purposive selection focused on recruiting a mix of males and females, spanning young, middle-age and older persons; all study participants being 18 years and older. Forty three persons were interviewed. Data saturation was achieved after 27 interviews in Community A, and after 16 in Community B.

Data Collection

The data collection period ran from July 1, 2020 to July 31, 2020. This was approximately three months post community quarantine for both communities. One community was quarantined from March 13, 2020 to March 26, 2020 while the other was quarantined from March 19, 2020 to April 1, 2020. Three members of the research team visited each community and interviewed participants face to face, each interview lasting approximately 15 minutes. The interview guide broached and probed the following areas: experiences during lockdown; relationships; communication; how time was

utilized; and feelings related to security forces, health teams and affiliated personnel, and the community itself during lockdown. These areas were chosen for exploration based on literature review, authors' knowledge of lockdowns and research interests. The interviews were audio-recorded with permission and were manually transformed into scripts for analysis. The research team was competent in quantitative and qualitative research.

Data Analysis

Qualitative content analysis (CA) as described by Vaismoradi and colleagues²² was used for data analysis. Qualitative content analysis and thematic analysis, according to these authors, focus on describing the research participants' subjective meanings and social realities. First, two members of our team independently read a sample of scripts that were developed from the interviews. Codes were then applied to the sample of scripts and both researchers compared these codes to establish reviewer convergence on the issues shared by participants. Through an iterative process, agreement was reached on the use of these and other emerging codes and categories in the remaining scripts, and the software QDA Miner was utilized to complete the coding process. For this paper, the analysis focused on identifying two data categories, the advantages (pros) and disadvantages (cons) of community quarantine through the eyes of community residents. For each category, chunks of data were selected and grouped across three emerging themes for pros and cons respectively, with a total of 19 subthemes across these themes. The themes and subthemes were then described in the findings with selected quotes.

Ethical approval for this study was obtained from the Mona Campus Research Ethics Committee, (ECP 211, 19/20) (blinded for review). All participants provided informed consent. During interviews, there was strict adherence to COVID-19 safety precaution measures. In this paper, studied communities are pseudonymized.

Statement of Positionality

The research team comprised trained, experienced public health academics who had no ties to the communities surveyed and had not previously experienced community quarantine nor had family members who experienced same. To ensure that the insider perspectives of those interviewed were captured, each interviewer faced the task with an open mind to what participants shared, engaged in probing while avoiding leading questions and refrained from comments on the information shared. A

debriefing session at the end of each of the three days of data collection, allowed for interviewers to share experiences regarding the data gathering process and plan for moving forward.

Trustworthiness

All participants experienced lockdown in the communities studied. They were of varying age groups and the perspectives of both genders were sought and included. Enough time was spent in each community on each day of data collection, allowing for unhurried interviews of the 43 persons involved. Triangulation in the data analysis phase of the study involved an iterative process of moving from an agreed emergent coding scheme and continuing with repeated visits to scripts to match themes with data chunks.

RESULTS

Socio-demographic Profile of Interviewees

The socio-demographic characteristics of those interviewed are presented in Table 1. Community 'A' had a larger proportion of study participants (62.8%). The mean age of participants was 44.1± 20 years and females constituted the majority (53.5%) of participants.

The two broad categories under which the data was organized 'Pros' and 'Cons' are summarized in Figure 1 with the relevant themes and subthemes emerging from the analysis.

The Pros of Community Lockdown

The themes classified as advantages of community lockdown were 'Time to bond', 'Attention to social needs' and 'Stay informed'.

Time to bond: There were three subthemes around 'time to bond'; these were 'family time', 'community jelling' and 'partnerships developed'. Increased time with family and friends was a recurrent theme across communities: Younger residents from both communities perceived lockdown as an opportunity to bond with family members and friends since there were increased opportunities for time spent together. Specific mention was made of watching television together, discussing COVID-19 related current affairs and playing games to pass the time. One college student said [I spent] 'a lot of time with my family [be]cause everybody was home, everybody in one place so it was very nice'. It was also time for sharing family history as one young person quipped to, 'I got to know more about my family'. Two males mentioned the increased opportunity to spend

quality time with children/family. Respondents asserted that families had to face the crisis together even though it was not their fault.

Table 1: Socio-demographic characteristics of interviewees by location

Characteristics	Community A n (%)	Community B n (%)	Total Sample n (%)
Sex (n=43)			
Male	15 (55.6)	5 (68.7)	20 (46.5)
Female	12 (44.4)	11 (31.3)	23 (53.5)
Total	27 (100)	16 (100)	43 (100)
Occupation			
Professional	5 (18.5)	0 (0.0)	5 (11.6)
Skilled & agricultural	2 (7.4)	1 (6.3)	3 (7.0)
Sales	9 (33.3)	3 (18.7)	12 (27.9)
Clerks	0 (0.0)	1 (6.3)	1 (2.3)
Elementary occupations	3 (11.1)	5 (31.2)	8 (18.6)
Other or not specified	8 (29.6)	6 (37.5)	14 (32.6)
Total	27 (100)	16 (100)	43 (100)

'Community jelling and partnerships': This captures the feeling that for both communities, there seemed to have been varying levels of bonding among residents including sharing with and helping each other. As one young resident described it 'for the community, we were kind of separated before; no one wanted to play anymore and so on, but during the lockdown we were playing together, dandy shandy' (a kind of ball game). The nuance that we are 'in this together' and 'it's us against them' seemed to have been pervasive and the lockdown accentuated this kind of response. The security forces who were sent to effect the lockdown were perceived as playing a very active role to bridge the divide between 'us' and 'them'. The perceived authoritative regimented stance by the security forces in the first week of lockdown, changed to a more humanistic and collaborative approach in subsequent weeks as relationships were built. Respect became mutual and consideration was given to individual needs. A shop keeper in Community A reported how soldiers were known to accompany her to the boundary of the quarantine cordon to purchase goods from delivery trucks for her business. She said the soldiers ensured that COVID-19 protocols were not breached and physical distance was maintained in the transaction process.

Attention to social needs: 'Help from outside', 'Government's food-and-more measures', and 'Isolation is protection' were the subthemes identified in meeting social needs. In Community 'A', an informal leader made the news as she highlighted the plight of residents. This action not only got national attention but also garnered support and 'Help from outside'. Community 'B' reported that they also benefitted from external support by various entities.

Since lockdown prevented free movement of individuals in and out of the targeted areas, interviewees in both communities expressed appreciation for the provision of basic supplies to families; supplies originating from various neighbouring but external allies, including churches, families, independent individuals and private organisations. The timeliness of their response (often the first) to fill residents' needs was said to be commendable, filling the void before 'government's food-and-more measures' were implemented. Supplies by government-affiliated and sponsored social services included food and other items 'beyond just food' (medications, educational supplies, transportation to health facilities in emergencies). The provision of assistance from all these sources reportedly led residents to adjust their thoughts as they faced their circumstances; not feeling forgotten or under punishment.

The idea that 'Isolation is Protection' helped to foster a feeling of tolerance and undoubtedly a reasoned appreciation of the rationale for community lockdown. Being limited to one's home and immediate family was viewed as personal protection. 'This is for our good' and 'at least we were protected from getting the virus', were typical responses expressed by interviewees in support of community lockdown.

Stay informed: 'Listen to the news', 'Follow social media' and 'Use the grapevine' were actions taken to stay informed. Residents reported that while restricted in movement, they became interested in any new developments surrounding the COVID-19 pandemic. Staying informed facilitated learning what other threats were eminent for their communities and trends in the disease at the local and international levels. For some younger residents, social media provided timely and credible information which kept them abreast of updates locally and abroad and satisfied their curiosity. For older persons, WhatsApp messages and telephone calls were used for dissemination of the latest 'COVID news' even if it was already known. The traditional 'grapevine' was augmented by the pervasive use of cell phones. Some

persons reported that they were regularly updated on the movements and plans of the health team and other authority figures.

The Cons of Community Lockdown

Three themes were identified as Cons of Lockdown; these were 'Communication pains', 'Nuff Discrimination' and 'Unmet needs'.

Communication Pains: The issue of communication was on the lips of most persons interviewed. Concerns held about this were: lockdown takes you 'off guard and unprepared'; the lockdown is accompanied by 'signs of scorn' from externally appointed officials sent to work in the communities; and the lockdown brings 'undesirable media reports' and stirs up 'political vibes'.

All persons asserted that they were taken 'off guard and unprepared' for lockdown; they woke up to see soldiers on patrol in their communities and restrictions placed on their movements even if they had to go to work or procure much needed resources. A typical remark was that 'nobody warned us' and as one female framed it, "I expected some mature communication from the bigger heads [authorities]. I don't see where the people were consulted" (female tertiary student Community A).

There were reports of negative actions from social service team members whom they said exhibited 'signs of scorn' through their non-verbal behaviours. Specific mention was made of workers 'throw[ing] down the bag with food on the ground' instead of putting these in their hands (male, age 22 years, Community B). This they said was a gesture that left some feeling scorned and rejected and this was cause for hurt. Besides, media reports related to lockdown were perceived by some as negative as this placed the communities under the spotlight drawing public attention to their plight. In Community A, many felt this led to 'political vibes' as there were claims and counterclaims from political representatives about who did or did not take actions on behalf of the community. For others, media reports drew attention to their communities, with the potential to be held blamable and with other social repercussions such as being viewed as pariah communities with attendant stigmatization.

'Nuff discrimination': Negative responses referred to as 'nuff discrimination' (a lot of discrimination) was reportedly directed at residents from these communities as they ventured beyond their community borders post-lockdown of their community. 'Discrimination' alludes to negative differential treatment because of fears that community residents might be infected with COVID-19

and were thus to be shunned, kept at a distance or avoided. This was a recurrent theme in both communities and some examples were cited: 'Taxis naah carry wi' (Taxis not transporting us), 'people step back from wi' (people distance themselves from us) and 'workplace ban wi' (we were banned from the workplace). In response, some persons resorted to alighting from taxis in adjacent communities, then trekking home, or traveling by government buses (Community A) which take longer, and using only the few taxis based in their communities. The few persons who were banned from their workplaces were not acrimonious but rationalized such action as 'protection policy' and indicated that they were allowed back at work after a while.

'Unmet needs' during the lockdown were also reported.

In contrast to those who felt food packages distributed were adequate, others in both communities felt 'food [was] not enough' for large families and that the variety of contents was limited and lacking in preferred items. This was further compounded by the fact that people 'cyaan hustle', meaning they were restricted from daily going to irregular or odd jobs to earn something to meet family needs. Restricted movements also meant that utility and other bills, that became due in the period, were not paid; there was no way to get to collection agencies and/or decreased income for two to three weeks of lockdown meant reduced funds to pay bills. Furthermore, mothers of newborns reported that they were not provided with supplies for babies such as formula and diapers.

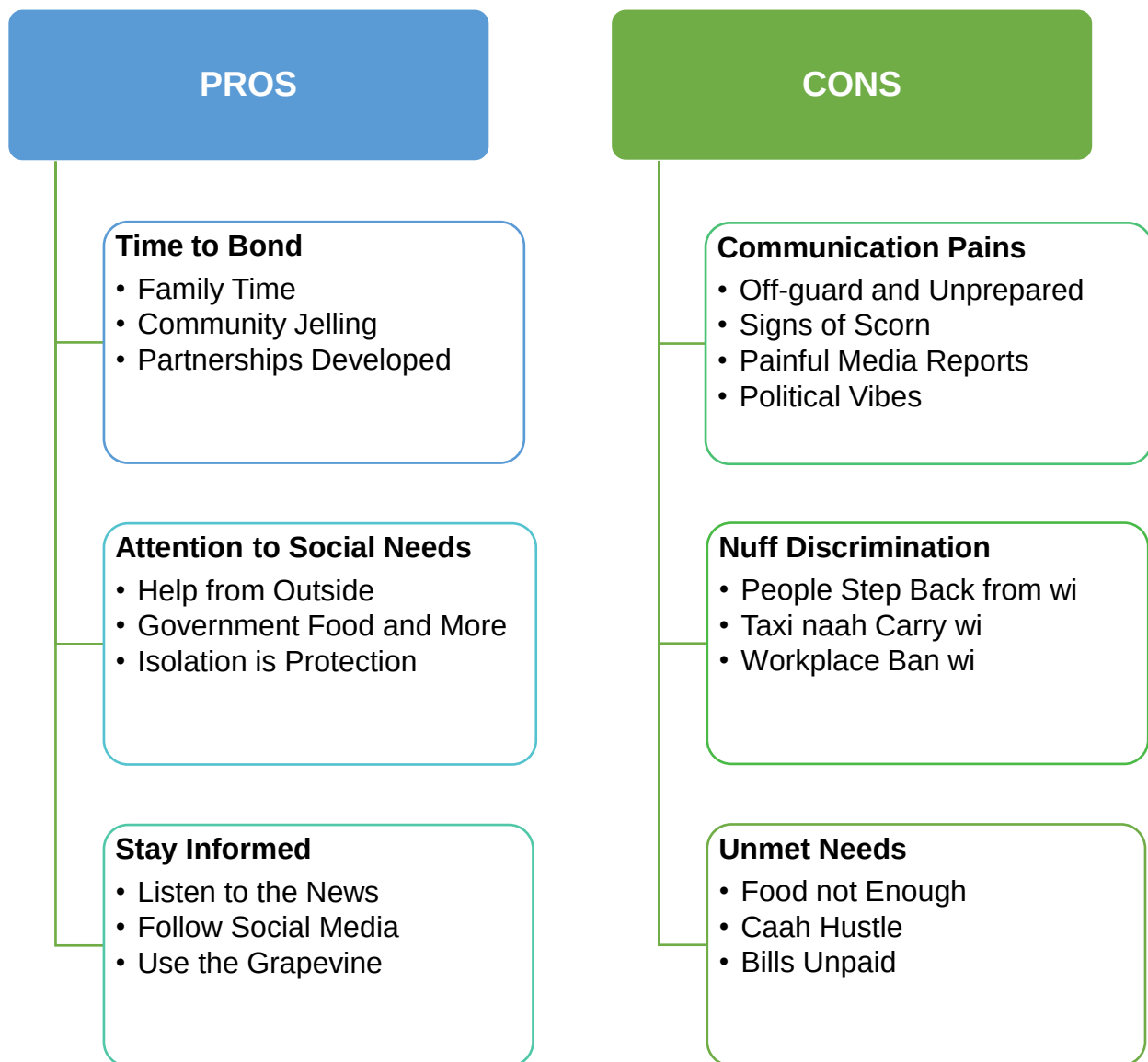


Figure 1: Pros and cons of community lockdown: themes and sub-themes

DISCUSSION

Health programmes and interventions in communities can have intended and unintended impacts, which may be positive or negative.^(23,24) Specifically related to COVID-19, rapid implementation of mitigation measures can have multiple unintended outcomes.²⁵ Unintended consequences can influence the compliance/adherence with recommended actions and behaviours. Community lockdown represents/exemplifies an intervention where the intent is noble and designed to address an important problem, but which potentially can create other issues, which directly or indirectly affect social determinants of health. Effects of community lockdowns are particularly poignant as they are linked with the social identity of individuals and their relationships with others.²⁶

In this paper, the experiences of residents in two low-income communities in Jamaica, pertaining to COVID-19 related community lockdown were highlighted. Understanding and addressing social determinants of health are keys to promoting wellbeing in any community. Lockdown is an intervention to control the spread of COVID-19, but the realities of loss of income and employment as described in the findings are ripple effects faced by individuals and families. Another concern is food security. In low income communities, where cash flow is tight and uncertain, some families shop for food weekly while others do so on a daily basis as they earn. There are families that shop only when dire need arises due to competing demands on their income and meagre savings. Some families rely on quick unpredictable daily earnings, referred to as 'hustle', and the 'hustle' dictates the frequency and quantity of foods purchased. Moreover, restrictions and lockdowns can restrain food procurement behaviour and food supply. In the literature, one review of the impact of the pandemic on the food supply chain has alluded to changes in patterns of consumer behaviour during COVID-19 related restrictions.²⁷ That review outlined patterns of harvesting and distribution of food, and how restrictions in movements can hinder timely supplies of food to consumers, and disrupt buying patterns of consumers themselves. In our study, the convergent effect of the lack of hustle and inadequacy of food and food supply was a cause of concern as well as a source of discontent. This was no surprise as suppliers of food and other commodities, often referred to as corner shops, are stocked and restocked on a daily basis (depending on sales). Traditionally, these small businesses have little or no capacity to have capital tied up in stores and reserves. Furthermore, lockdowns give limited opportunities to replenish supplies. Health

promotion efforts are likely to be stymied when lockdowns create dissatisfaction and are viewed as repressive. Consequently, attention must be paid to such issues. The United Nations has reinforced the calls for solidarity among nations to adopt policies to protect food security due to threats of increased hunger and malnutrition worldwide.²⁸ In our research we garnered information about what happens at the consumer end and argue that families' access to food can be impacted for various lockdown-related reasons. Community lockdowns threaten food security and concurrent plans to assure food security should be in place as lockdowns are implemented.

Social connectedness with family and friends, political affiliations and relationships with authority figures emerged as important issues in the locked-down communities. In both communities, many persons belonged to large kinship groups within and outside the communities. In Community B, COVID-19 infected families reportedly were socially shunned by other residents, while in Community A, there was greater solidarity (evident in the 'us' and 'we' versus 'them') among residents in facing perceived discrimination and lockdown challenges. Residents were supported by the wider and extended community in respect of much needed supplies.

Politics and political affiliation became topical in the case of Community 'A' and can be advantageous or disadvantageous in public discourse related to COVID-19. Political representatives, being aware of the realities of their constituents, can lobby for immediate help and assistance. During the interviews, persons mentioned political vibes but did not proceed to elaborate further on this. There is an emic understanding that people know what this means. It is a way of subtly commenting on local politics which dictates who gets what, where, when and in what amounts without risking violent confrontation, backlash, reprisals or jeopardizing one's future prospects and opportunities. Politics in Jamaican communities can be divisive²⁹, eroding community cohesion and collaboration. Health promotion emphasizes strengthening of social networks and social support and moves beyond individual health care into the social arena and community life. Politics therefore can enhance or hinder health promotion efforts in the management and control of COVID-19 in communities. With regard to relations with authorities, both communities, over time, developed partnerships between themselves and the monitoring security forces. This led to supportive actions by the security forces beyond the call of duty and perhaps

reflects the negotiation skills of residents and empathy from the security forces. New and re-emergent diseases are on the rise³⁰, and community quarantine measures will be required from time to time. When such measures are imposed, there is need to recognize the social and political dynamics at play to avoid exacerbation of social division and health disparities in already vulnerable communities.

Allegedly, there were 'signs of scorn' from members of the multidisciplinary team managing the intervention on the ground. Those who spearhead community interventions should avoid stigmatization of communities as this can lead to mistrust of teams and their advice, and render interventions ineffective. COVID-19 stresses not only those infected with the disease, but also those who provide health and allied services. The literature points to mental health challenges faced by health workers due to uncertainties associated with managing coronavirus-related disease.³¹ Where such challenges exist, professional delivery of health services (including non-stigmatization of those affected by COVID-19) can be compromised. Specific and periodic training of staff is warranted in preparation for community lockdowns.

Media, as a source of information and a channel for mobilization efforts, plays a key role in the promotion of community wellbeing. In our study, participants relied on various media sources to keep current on coronavirus disease updates while they were in lockdown. On the negative side, however, the media was also a source of publicity about the developments in the communities and appeared to fuel discrimination against residents of those communities. Consideration to the extent of information shared about community lockdown is warranted as we seek to find the elusive balance between factual details and stigmatization of communities. As details of distribution, prevalence and incidence of COVID-19 in communities are communicated, health promotion efforts to mobilize preventive actions can be undermined since communities may become more concerned about their image, with less focus on the prevailing health issues in the 'us' versus 'them' debacle.

In this study we were able to interview diverse individuals who were still in the process of coming to terms with community lockdown. This study provided context for interpreting and understanding the community lockdown experiences and identified associated pros and cons. This can inform strategies in community lockdown scenarios, as we seek to build partnership, and protect health in the COVID-19 pandemic and beyond.

Limitations

We studied communities early in the pandemic. Further studies on COVID-19 related community lockdowns could in future deepen understanding of their impact, since the experience of lockdowns may be different as communities and authorities adapt to the COVID-19 later on in the pandemic. We acknowledge that our findings may not apply to higher income communities where resources and community dynamics may be different.

Conclusions

Health promotion views populations as a whole in the context of everyday lives, rather than targeting people at risk for specific diseases. This study highlights important issues related to communities and their lockdown experiences. On one hand, there are concerns about stigma and discrimination, poor communication and social needs. On the other hand, there can be opportunities for enhancing social support and partnerships, greater cohesiveness in families and improved community relations. Heightened interest in health-related information and education are opportunities for increased health promotion. Health promotion can employ various but synergistic methods and approaches as it seeks to move beyond mere healthcare. Implementation of community lockdowns should not be an ad hoc process, but one with forethought, taking into account communication, social realities, political dynamics and health promotion principles

Acknowledgements: None.

Ethical approval statement: Obtained from The University of the West Indies, Mona Campus Research Ethics Committee, Mona, Kingston 7, Jamaica (ECP 211, 19/20)

Financial disclosure or funding: None.

Conflict of interest: The authors declare no conflict of interest.

Informed consent: All participants provided informed consent for participation in the study.

Author contributions: All authors contributed to the study conception and design. Material preparation, data collection and analysis were performed by all authors. All authors read and approved the final manuscript.

REFERENCES

1. Lambert H, Gupte J, Fletcher H, et al. COVID-19 as a global challenge: towards an inclusive and sustainable future. Vol. 4, *The Lancet Planetary Health*. Elsevier B.V.; 2020. p. e312–4.
2. Kozlakidis Z, Kimball AM, Aisyah DN, et al. Status and Challenges of Public Health Emergency Management in China Related to COVID-19. *Front Public Heal* | www.frontiersin.org. 2020;1:250.
3. Sharma S, Bhatta J. Public health challenges during the COVID-19 outbreak in Nepal: a commentary. *J Heal Res*. 2020 Jun;34(4):373–6.
4. Ozili P. COVID-19 in Africa: socio-economic impact, policy response and opportunities. *Int J Sociol Soc Policy*. 2020;
5. Williamson DL, Carr J. Health as a resource for everyday life: Advancing the conceptualization. *Crit Public Health*. 2009;19(1):107–22.
6. Thompson SR, Watson MC, Tilford S. The Ottawa Charter 30 years on: still an important standard for health promotion. *Int J Heal Promot Educ*. 2018 Mar;56(2):73–84.
7. Kumar S, Preetha GS. Health promotion: An effective tool for global health. *Indian J Community Med*. 2012 Jan;37(1):5–12.
8. Fortune K, Becerra-Posada F, Buss P, et al. Health promotion and the agenda for sustainable development, who region of the Americas. *Bull World Health Organ*. 2018 Sep;96(9):621–6.
9. The Lancet Public Health. Will the COVID-19 pandemic threaten the SDGs? Vol. 5, *The Lancet Public Health*. Elsevier Ltd; 2020. p. e460.
10. Van den Broucke S. Why health promotion matters to the COVID-19 pandemic, and vice versa. Vol. 35, *Health promotion international*. NLM (Medline); 2020. p. 181–6.
11. Sharma S V., Chuang R-J, Rushing M, et al. Social Determinants of Health-Related Needs During COVID-19 Among Low-Income Households With Children. *Prev Chronic Dis*. 2020 Oct;17:200322.
12. Sahu P. Closure of Universities Due to Coronavirus Disease 2019 (COVID-19): Impact on Education and Mental Health of Students and Academic Staff. 2020;
13. Lexico. Social reality [Internet]. 2021. Available from: https://www.lexico.com/definition/social_reality
14. Golden SD, Earp JAL. Social Ecological Approaches to Individuals and Their Contexts: Twenty Years of Health Education & Behavior Health Promotion Interventions. *Heal Educ Behav* [Internet]. 2012 Jan 20;39(3):364–72. Available from: <https://doi.org/10.1177/1090198111418634>
15. Bronfenbrenner U. Toward an Experimental Ecology of Human Development. *Am Psychol*. 1977;32(7):513–31.
16. World Health Organization. Communicable disease alert and response for mass gatherings [Internet]. 2008. Available from: https://www.who.int/csr/Mass_gatherings2.pdf
17. Evans S, Mikocka-Walus A, Klas A, et al. From “It Has Stopped Our Lives” to “Spending More Time Together Has Strengthened Bonds”: The Varied Experiences of Australian Families During COVID-19 [Internet]. Vol. 11, *Frontiers in Psychology* . 2020. p. 2906. Available from: <https://www.frontiersin.org/article/10.3389/fpsyg.2020.588667>
18. Lohiniva A-L, Dub T, Hagberg L, et al. Learning about COVID-19-related stigma, quarantine and isolation experiences in Finland. *PLoS One* [Internet]. 2021 Apr 14;16(4):e0247962. Available from: <https://doi.org/10.1371/journal.pone.0247962>
19. Statistical Institute of Jamaica. Population Statistics [Internet]. 2017. Available from: https://statinja.gov.jm/Demo_SocialStats/Newpopulation.aspx
20. Ministry of Health and Wellness. COVID-19 Update: Eight New Cases Identified [Internet]. 2020. Available from: <https://www.moh.gov.jm/covid-19-update-eight-new-cases-identified/>
21. Creswell JW., Poth CN. Qualitative Inquiry & research Design Choosing Among Five Approaches. Fourth. Thousand Oaks: Sage Publications Ltd.; 2018. 1–459 p.
22. Vaismoradi M, Jones J, Turunen H, et al. Theme development in qualitative content analysis and thematic analysis. *J Nurs Educ Pract*. 2016;6(5):100–10.
23. Oliver K, Lorenc T, Tinkler J, et al. Understanding the unintended consequences of public health policies:

the views of policymakers and evaluators. BMC Public Health [Internet]. 2019;19(1):1057. Available from: <https://doi.org/10.1186/s12889-019-7389-6>

24. Unite for Sight. Unintended Consequences of Global Health Endeavors [Internet]. 2020 [cited 2021 Jun 1]. Available from: <https://www.uniteforsight.org/pitfalls-in-development/unintended-consequences>

25. Turcotte-Tremblay A-M, Gali Gali IA, Ridde V. The unintended consequences of COVID-19 mitigation measures matter: practical guidance for investigating them. BMC Med Res Methodol [Internet]. 2021;21(1):28. Available from: <https://doi.org/10.1186/s12874-020-01200-x>

26. Lorenc T, Oliver K. Adverse effects of public health interventions: a conceptual framework. J Epidemiol Community Health [Internet]. 2014 Mar 1;68(3):288 LP – 290. Available from: <http://jech.bmj.com/content/68/3/288.abstract>

27. Aday S, Aday MS. Impact of COVID-19 on the food supply chain. Vol. 4, Food Quality and Safety. Oxford University Press; 2020. p. 167–80.

28. United Nations. Food [Internet]. 2020. Available from: <https://www.un.org/en/global-issues/food#:~:text=Achieving%20food%20security%20for%20all,to%20lead%20active%2C%20healthy%20lives>.

29. BTI Transformation Index. BTI 2020 Jamaica Country Report [Internet]. 2020 [cited 2021 Jun 2]. Available from: <https://www.bti-project.org/en/reports/country-report-JAM-2020.html>

30. Morens DM, Fauci AS. Emerging Pandemic Diseases: How We Got to COVID-19. Cell [Internet]. 2020/08/15. 2020 Sep 3;182(5):1077–92. Available from: <https://pubmed.ncbi.nlm.nih.gov/32846157>

31. Khanal P, Devkota N, Dahal M, et al. Mental health impacts among health workers during COVID-19 in a low resource setting: A cross-sectional survey from Nepal. Global Health. 2020 Sep;16(1):89.