Review article

Critical analysis of mental health policies, laws, and challenges in Central America

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Análisis crítico de las políticas, leyes y desafíos en la salud mental en Centroamérica

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Abstract
Mental health has been a relevant topic since 1940, however, its explicit visibility as a right began in the year 2000, when states were invited to recognize it as part of the right to health. Following this awareness-raising process, the Central American countries have developed public policies, based on their legislatures, for the creation of laws, regulations, plans and mental health policies. Currently, there is no analysis that describes the main historical events, legal framework and public policy on mental health as a right in Central America. The objective of the review is to identify main historical milestones, the current status and the challenges that persist in the region to strengthen the approach to mental health as a fundamental right of the populations. Search strategy, websites of Ministries of Health, Central American justice bodies, and Google Scholar and Google database, from 1949 to 2023. The construction of public policies on mental health in Central American countries presents advances, setbacks or stagnation according to their national context. There is still a poor political disposition in various Central American countries to promote a Mental Health Law or update existing mental health laws and documents.

Keywords
Right to Health, Legislation, Mental Health, Human Rights, Health Policy.

Resumen
La salud mental es un tema relevante desde 1940, sin embargo, su visibilidad como derecho se presenta hasta el año 2000, invitándose a los estados a reconocerla como parte de los derechos a la salud. A partir de esta concientización, los países centroamericanos han elaborado políticas públicas, tomando como base marco normativo. Actualmente, no se cuenta con un análisis que aborde los principales acontecimientos históricos, marco legal y políticas públicas en relación a la salud mental como un derecho en Centroamérica. La finalidad de la revisión narrativa es identificar los principales hitos históricos, el estado actual de la salud mental y los desafíos de la misma en la región, para fortalecer el enfoque de la salud mental como un derecho fundamental de las poblaciones. Se realizó la búsqueda de información en sitios web de los ministerios de salud centroamericanos, órganos de justicia centroamericanos, y base de datos de Google y Google Académico, desde 1949 al 2023. La construcción de políticas públicas y leyes en salud mental, en los países centroamericanos presenta avances, retrocesos o estancamientos, de acuerdo a su contexto nacional. Persiste una baja disposición política en diversos países centroamericanos, para promover una ley de salud mental o actualizar leyes y documentos de salud mental ya existentes.

Palabras clave
Derecho a la Salud, Legislación Sanitaria, Salud Mental, Derechos Humanos, Política de Salud.

Introduction

The desire to halt the spread and minimize the effects of COVID-19 led to contingency strategies worldwide, including social distancing measures, social isolation, suspension of educational activities, border closures, and the creation of quarantine and containment centers for suspected or confirmed COVID-19 cases.[i] Although these measures contained the disease and helped prepare for it, they also caused uncertainty, increased human losses due to problems related to chronic diseases, collapsed health systems, spread false information, and allowed misinformation,[i,ii] which had negative effects on the mental health of the population.[iii]

In this new context, the World Report on Mental Health (2022) recognizes that COVID-19 has generated a global mental health crisis and that responses are insufficient and inadequate; therefore, policies and laws in favor of mental health are needed. To make this possible, governments need to formulate national laws, policies, and mental health plans with a human rights approach in order to strengthen "mental health as a universal right".[iv,v]

The implementation of policies and regulatory frameworks seeks to facilitate mental health actions that respond to the needs of the population, promote well-being, prevent discrimination and abuse, and reinforce the active participation of all sectors of society in this commitment. To prepare this article, a search was conducted for national laws, regulations, guidelines, and policies of Central American countries on the websites of ministries of health and libraries of judicial bodies in Central America, as well as in Google Scholar and Google database, from 1949 to 2023. The keywords "mental health laws," "health policies," "mental health regulations," and "mental health history" were used to identify historical milestones in mental health in the Central American Isthmus.

Discussion

Mental health became more widely recognized in the first half of the 20th century, so its prominence is recent, between 1940 and 1970,[vi] the same period in which several institutions emerged in both Europe and North America, including the World Health Organization (WHO) and the United Nations Educational, Scientific and Cultural Organization (UNESCO) in 1945.[vi] This concept has been shaped by a variety of social, cultural, ideological, political, and economic factors.[vii] The WHO defines mental health as "a state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and can make a contribution to his or her community".[viii] Since 1946, the WHO has recognized mental health as a fundamental human right, an integral part of general health, and an essential component of universal health coverage.

Before the Universal Declaration of Human Rights, certain rights had already been recognized since Ancient Greece, such as the Law of Retaliation, in which their pursuit was associated with human dignity.[ix]

Later, this recognition was linked to the struggles for emancipation, beginning the development of civil rights legislation, examples of which include the Magna Carta (1215) and the Bill of Rights (1689) in England, the Declaration of the Rights of Man and of the Citizen in France, and the Bill of Rights of 1791 in the United States. However, each of these documents had gaps, depending on their political and economic context, such as the continued existence of slavery, whom had no rights.[ix]

The path to the Universal Declaration of Human Rights, like previous declarations, has been linked to situations of social injustice and cruelty experienced during world wars, especially World War II.[x] To prevent the repetition of such inhuman acts, the Universal Declaration of Human Rights was proclaimed in Paris, France (1948) by the United Nations General Assembly, which, in Article 25, includes the right to health, family, and well-being, as well as to medical care and necessary social services. Although mental health is not explicitly mentioned, it is implicit in the word "health".[xi]

The right to mental health was explicitly stated in the pronouncement of the Committee on Economic, Social, and Cultural Rights in General Comment No. 14, in Article 12, where States Parties recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".[xii] The right to health in this new context imposes three types of duties and obligations on States: to respect, to protect, and to fulfill, which includes facilitating, providing, and promoting physical and mental health. This implies that, to achieve the highest level of health, States must promote equal access to mental health services, prevent third parties from interfering with this right, and adopt appropriate legislative, administrative, economic, and judicial measures to make it effective.[xii]

Development of psychiatric care in Central America

Guatemala

Within this framework, psychiatric care in hospitals in Central America began in Guatemala in 1857 with the founding of the "Casa de la Misericordia". In 1890, the "Asilo de Dementes" (Insane Asylum) was opened, and later, in 1901, another facility with the same name was established in the city of Quetzaltenango, although it did not operate. In 1948, the name was changed to "Hospital Neuropsiquiátrico", and in 1983, it was renamed as "Hospital Dr. Miguel F. Molina". In 1946, the Guatemalan Social Security Institute (IGSS) established a psychiatric service for its members. In 1984, the first Psychiatric Care Unit was founded at the Roosevelt

University Hospital in Guatemala, and in 2002, the Comprehensive Mental Health Care Center was created at the IGSS (Figure 1).[xiii]

Costa Rica

In Costa Rica, in 1890, the "Hospital San Juan de Dios" was created, also known as the "Hospital de Locos" (Hospital for the Insane) or "Asilo Nacional de Locos" (National Asylum for the Insane); between 1950 and 1952, two other hospitals were founded. In 1946, the Costa Rican Social Security Fund (CCSS) provided its first services in this field. In 1961, a psychiatric service was established in a general hospital, and with the 1973 law transferring hospitals to Social Security, the CCSS became officially responsible for the care of people with mental disorders. In 1974, the new Psychiatric Hospital was inaugurated, and in the 1980s, the prevention and detection of mental health problems was promoted at the primary care level (Figure 1).[xiv-xvi]

El Salvador

In 1894, "La Casa de las Locas" (The House of Madwomen) was created to care for women, while men were taken to municipal jails. That same year, the "Hospital de Dementes o Manicomio Central" was founded, which was damaged in 1917 and relocated in 1927, becoming known as the "Asilo Salvador" (Salvador Asylum). In 1975, it was relocated again and renamed the "Hospital Psiquiátrico Nacional ". In 1971, the Psychiatric Hospital of the Salvadoran Social Security Institute was founded (Figure 1).[xvi]

State care was provided at the Psychiatric Hospital, at a clinic in the Rosales National Hospital, and at another in the Benjamin Bloom National Children's Hospital. In 1972, the Mental Health Unit was created within the Ministry of Health (MINSAL) with the aim of developing a community-based approach to mental health. However, it was suspended in 1974 due to the armed conflict that was brewing.

In 1979, the Mental Health Program was created as part of the Epidemiology Program, and later became part of the Health Education Program. In the 1980s, a Mental Health Department was created with the support of an Italian non-governmental organization. It was closed in 1994, only to be re-established in 1998 as the Mental Health Unit. The Mental Health Program was made official by ministerial decree in 2000.[xvii]

Currently, the Mental Health Unit is part of the Directorate of Comprehensive Health, Quality of Life, and Inclusion[xviii] (Figure 1).

Honduras

In Honduras, the "Hospital General" was created in 1926, now known as "San Felipe," giving rise in 1929 to the "Asilo de indigentes y alienados"; in 1960, the Neuropsychiatric Hospital was created, which disappeared 16 years later; then, in 1973, the "Dr. Mario Mendoza" Acute Psychiatric Hospital was established; in 1975, the Mental Health Division was created within the Ministry of Health, and in 1976, the "Santa Rosita" National Psychiatric Hospital was established (Figure 1).[xvi, xix]

Panama

In the early decades of the 20th century, Panama separated from Colombia and became a republic. Mental health care was provided by the Canal Zone authorities at the Ancón Hospital, which was administered by the United States (US) Army, in a ward separate from those with leprosy. However, in 1905, after the construction of the Psychiatric Hospital in Corozal, the patients were transferred.

Because the Panamanian government had to pay a high cost to the US for this care, in 1924 the first law was passed ordering the construction of a psychiatric hospital, which became a reality on June 26, 1933, thus inaugurating the first psychiatric care center called "Retiro Matías Hernández".[xx] Between 1940 and 1950, it was renamed National Psychiatric Hospital. In 1955, the Social Security Fund (CSS) began providing psychiatric care with a single office, which in 1959 became the Neuropsychiatry Unit, facilitating the creation of the Psychiatry Service at the General Social Security Hospital. In 1962, outpatient psychiatric consultations were provided both at the Ministry of Health (MINSA) and at CSS polyclinics. In 1970, "two psychiatric wards were created at Santo Tomás Hospital and the Children's Hospital." In 2004, the psychiatric hospital changed its name to the National Institute of Mental Health (Figure 1).[xxi,xxii]

Nicaragua

Care began in 1935 with the opening of the "Asilo de Alienados" (Asylum for the Insane), which in 1956 took the name "Hospital Psiquiátrico Nacional" (National Psychiatric Hospital). In 1979, the Centers for Psychosocial Care (CAPS) were created, opening seven-day hospitals and also providing care in general hospitals, carrying out community interventions (these decreased over

time). In 1986, the National Center for Child Mental Health (CENASMI) was created.[xvi] Between 1990 and 2005, the Mental Health Care Network underwent a regressive process, with the CAPS losing importance and the National Center for Child Mental Health (CENASMI) closing. In 2007, mental health care was reorganized under the National Health Policy.

Evolution of mental health policies towards a human rights approach

The development of public health policies is a necessity that arose in order to respond to poor health conditions. However, the process has been slow, especially in the field of mental health.[iv] Although the first mental health initiatives in Central America and the Caribbean began during the colonial era, they were developed in the context of removing "the mad" or "the insane" from society, as they were considered a threat or were the object of ridicule. To this end, shelters were created, initially run by religious communities or by creating spaces in state or cities prisons for their internment.

Therefore, these people lost all their rights and were segregated from society in order to be isolated. Subsequently, their institutionalization to "asylums" or psychiatric hospitals was solidified until our current context, where the prevailing paradigm of humanizing care recognizes them as subjects of rights, also acknowledging the existence of social determinants in mental health and highlighting the political and social nature of mental health.[xvi]

From the recognition and conceptualization of mental health (1950) by the WHO,[vi] to its more explicit link to human rights and the need to decentralize care, as set out in the Caracas Declaration (1990),[xxiv] a process that encouraged the creation of mental health bills and the development of national policies on this issue, with a human rights approach in various countries. This situation was reaffirmed in 2000, when the member states of the United Nations recognized that every person has the right to the highest level of not only physical health but also mental health.

Among the legal and regulatory documents on mental health found in Central America, mental health laws, regulations, decrees, institutional policies, and strategic plans stand out, as shown in Table 1.

There are also state documents in each country that serve as the basis for the creation of the Mental Health Law or other regulatory documents that support mental health policies and actions, as shown in Table 2.

Analysis of the development of mental health care from the perspective of public policy

Returning to Table 1 and Table 2, it can be seen that approximately 50 years have passed since the Central American constitutional documents of the latter half of the 20th century and the first Mental Health Policy, drawn up in Central America in 1991, therefore, the political and social vision of providing a response to the growing need for mental health care has been progressively slow and, in some countries, has stagnated.[xxx, xliv,xlviii,lviii,lxii,lxxiii]

Guatemala[xiii]	Costa Rica[xiv-xvi]	El Salvador[xvi-xviii]	Panama[xx-xxii]	Honduras[xvi,xix]	Nicaragua[xxiii]
1857 – Foundation of the "Casa de la Misericordia" (House of Mercy). **1890** – Opening of the "Asilo de Dementes". **1901** – Attempt to open another asylum in Quetzaltenango (did not work). **1946** – IGSS develops the psychiatry service. **1948** – Name changed to Neuropsychiatric Hospital. **1983** – Renamed Dr. Miguel F. Molina Hospital. **1984** – The first psychiatric unit is founded at Hospital Roosevelt. **2002** – Creation of the Comprehensive Mental Health Care Center at IGSS.	**1890** – Creation of the San Juan de Dios Hospital ("Hospital de Locos"). **1946** – CCSS initiates psychiatric care. **1950-1952** – Two hospitals are founded for psychiatric care. **1961** – Psychiatry service established in general hospital. **1973** – Law of transfer of hospitals to CCSS. **1974** – Inauguration of the new Psychiatric Hospital. **1980s** – Prevention and detection in primary care is promoted.	**1894** – Creation of the Casa de las Locas and Hospital de Dementes or Central Insane Asylum. **1917** – Damage to the original hospital. **1927** – Relocation and new name Asilo Salvador. **1971** – Foundation of the ISSS Psychiatric Hospital. **1972** – Creation of mental health unit in MINSAL. **1974** – Suspension of the unit due to armed conflict. **1975** – Relocation and renaming of the National Psychiatric Hospital. **1979** – Mental Health Program attached to epidemiology. **1980s** – Creation of the Mental Health Department with Italian NGO support. **1994** – Closure of the department. **1998** – Reopening as Mental Health Unit. **2000** – Mental Health Program made official by ministerial decree.	**1905** – Creation of the Psychiatric Hospital in Corozal. **1924** – Law to build its own psychiatric hospital. **1933** – Inauguration of the Matías Hernández Retreat. **1940-1950** – Change of name to National Psychiatric Hospital. **1955** – CSS begins psychiatric care. **1959** – Creation of Neuropsychiatry Unit. **1962** – Outpatient clinics in MINSAL and CSS. **1970** – Psychiatric wards in Hospital Santo Tomás and Hospital del Niño. **2004** – Psychiatric Hospital changes its name to National Institute of Mental Health.	**1926** – Creation of the San Felipe General Hospital. **1929** – Opening of the Asilo de Indigentes y Alienados. **1960** – Creation of the Neuropsychiatric Hospital (closes 1976). **1973** – Inauguration of the Dr. Mario Mendoza Acute Psychiatric Hospital. **1975** – Creation of the Mental Health Division in the Ministry. **1976** – Creation of the Santa Rosita National Psychiatric Hospital.	**1935** – Opening of the Asilo de Alienados. **1956** – Change of name to National Psychiatric Hospital. **1979** – Creation of Psychosocial Care Centers (CAPS). **1986** – Creation of CENASMI (National Center for Children's Mental Health). **1990-2005** – Regressive process, closure of CAPS and CENASMI. **2007** – National Health Policy reorganizes mental health care.

Figure 1. Development of psychiatric care in Central America

Table 1. Laws, policies, and strategic plans of Central American countries.

Type of Document	Guatemala	El Salvador	Honduras	Costa Rica	Nicaragua	Panama
National Mental Health Law	-	2017[xxv]	-	2023[xxvi]	-	2023[xxviii]
Law on the Protection of Human Rights of Patients with Mental Health Problems	-	-	-	-	2008[xxviii]	-
Regulations of the Mental Health Act	-	2019[xxix]	-	-	-	-
Executive Decree No. 20665-S Restructuring of Psychiatry and Mental Health	-	-	-	1991[xxx]	-	-
National Mental Health Policy	2007-2015[xxxi]	2008[***xxxii] 2011[***xxxiii] 2018[***xxxiv]	2008[*xxxv]	2012-2021[xxxvi] 2024-2034[xxxvii]	-	-
Mental health policy implementation plan	-	2011-2014[axxxviii] 2019[xxxix]	-	-	-	-
National Mental Health Plan	-	-	-	2004-2010[xl]	-	2003[xli]
Institutional Mental Health Policy	2023-2028[xlii]	-	-	-	-	-
National Strategic Plan for the Promotion of Mental Health	2007-2020[xliii]	-	2021[**xxxv]	-	-	-

* No digital document found, its content is mentioned in the 2021 National Health Policy, p. 48.

**The 2021 National Health Policy is not exclusively about mental health, but it does address mental health issues.

***Documents: National mental health policies and plans repealed.

The management of mental health in most Central American countries dates back to 1857[xiii], when care for people began in isolated spaces managed by religious or altruistic individuals from the upper social classes. These care facilities have been given pejorative names with a strong discriminatory connotation. In addition, the people confined to these institutions lost their rights, with most being abandoned by their families, increasing the maintenance costs of these facilities. As a result, their upkeep was transferred to the state through the creation of psychiatric hospitals, applying various therapies, according to the possibilities of the states.[xvi]

The WHO's assessment of mental health reveals an increase in health problems and a lack of access to care, leading to guidelines for the decentralization of services in 1990, [xxiv] offering a path to improving access to care and treatment. However, the process in the various countries of the Central American region has been very slow and met with considerable resistance to change, as can be seen in:

The creation and elimination of mental health offices within ministries of health and state health agencies. Legal regulatory documents and public mental health policies in the Central American region have been created to enable member countries to respond to WHO provisions and address increases in mental health problems (suicide, depression, anxiety) among the population.

Low budgets for mental health care; hospital care always has a larger budget, despite efforts to decentralize care in various countries.

There is little legal documentation related to mental health. The only Central American countries with a Mental Health Law are Panama, El Salvador, and Costa Rica. Nicaragua only has a specific law that protects the human rights of patients with mental health problems. In terms of national mental health policy, the two countries without this resource are Nicaragua and Panamal[xxvii].

Table 2. Legal Documents from Central American Countries.

Guatemala	El Salvador	Honduras	Nicaragua	Costa Rica	Panamá
Constitution[xliv]	Constitution[xlviii]	Constitution[lviii]	Constitution[lxii]	Constitution[lxvi]	Constitution[lxxiii]
Health Code[xliv]	Health Code[xlix]	Childhood and Adolescence Code[lix]	Pluriannual Health Plan 2015–2021[lxiii]	Sanitary Code[lxvii]	Sanitary Code[lxxiv]
Law on the Care of Persons with Disabilities[xlvi]	Family Code[l]	Health Code[lx]	General Health Law No. 423[lxiv]	General Health Law No. 5395[lxviii]	Health Policy and Strategy 2005–2009 Policy 2. Guideline 2.5[lxxv]
Comprehensive Protection Law for Children and Adolescents[xlvii]	Law on Benefits for the Protection of the War Wounded and Disabled as a Result of the Armed Conflict (amended in 2022, Decree No. 631) *[li]	Civil Procedural Code[lxi]	Regulations of the General Health Law[lxv]	Code of Childhood and Adolescence[lxx]	
	Special law of inclusion of the people with disability[lii]			National Health Policy 2015[lxxi]	
	Special Comprehensive Law for a Life Free of Violence (LEIV)[liii]			National Health Plan 2010–2021[lxxii]	
	"Born with Love" Law[liv]				
	General Youth Law				
	General Law on Occupational Risk Prevention[lvi]				
	Law on the Duties and Rights of Patients and Health Service Providers[lvii]				

* Amendments to the Special Law to Regulate the Benefits and Social Provisions for Military Veterans of the Armed Forces and Former Combatants of the Farabundo Martí National Liberation Front, who participated in El Salvador's internal armed conflict from January 1, 1980, to January 16, 1992.

Laws, mental health policies and strategic plans in different countries have been modified according to the periods of the new heads of health portfolios in each country and their respective national contexts: within the Mental Health Law of El Salvador, the mental health of the population is visualized, from prevention to rehabilitation, with a human rights approach, also taking into account the responsibility and duty of the patients and their families, detailing care modalities that include family and community care, according to available resources; although decentralization of services is not mentioned, it seems implicit in the distribution of care, the Law does not contemplate the allocation of budgetary resources for mental health.[xxv]

The Costa Rican Mental Health Act includes human rights and promotes the community mental health care model, emphasizes the principle of non-discrimination, includes the rights of health workers, and stipulates that hospitalizations are evaluated by psychiatric staff, respecting the human rights of the patient. It does not explicitly mention budgetary resources.[xxvi]

The Panamanian Mental Health Law, like the previous one, protects the mental health and well-being of its citizens, incorporating a human rights perspective into care. But it is more direct in reducing suicide and discrimination by insurers and service providers. It is the only law that emphasizes the prohibition of the opening and operation of public or private mental hospitals, and it mentions that the state will allocate the necessary budgetary resources to guarantee mental health care services in order to comply with the law.[xxvii]

National mental health policies have been the most developed public policy tool in various countries in the absence of mental health laws. In several countries, these policies remain in force since their enactment, except in El Salvador, where two national policies from 2008 and 2011 have already been repealed (Table 1).

All policies share a focus on rights, social and community participation, and include elements such as research, a life cycle approach, and human resource development for a comprehensive approach to mental health.

National plans, institutional policies, and strategic plans for promoting mental health in Central American countries are also seen as a response to the absence of specific mental health legislation. They are important for organizing mental health care and covering each state's morbidity and mortality reduction goals, according to their context, and they include approaches based on rights, intersectorality, culture, and migration. The latter especially in documents from Guatemala and Honduras.[xxxi,xxxv,xlii,xliii]

The documents from Guatemala and Honduras recognize that mental health care is a weak area, with limited funding. Little progress has been made in decentralizing and modernizing mental health care, which is centralized in the capital of each country, with a limited focus on the management of treatment of the disease.[xxxv,xlii]

Mental health challenges in Central America

The main advance in the region is the formal recognition of mental health as a human right in laws, policies, and strategies; however, its implementation faces multiple challenges. One of the main obstacles is a lack of willingness to promote new specific mental health laws or update existing ones (Table 1). This limitation translates into insufficient public policies and a gap in the economic resources dedicated specifically to this area of health, which restricts the capacity of systems to provide adequate care.

Stigmatization and discrimination against people with mental health problems also persist as a significant barrier. The history of psychiatric care in the region is marked by negative attitudes, with people confined to institutions with pejorative names such as "asylums" or "insane houses".[xvi] Although progress has been made toward more humane and rights-respecting care, these stigmas still influence the perception and treatment of patients.[lxxviii]

In addition, care remains highly centralized in capital cities, limiting access to services for those living in rural areas. Despite efforts to decentralize care, most resources and services are concentrated in major cities, exacerbating inequalities in access to mental health care.[xxxv,xlii]

The limitations of the review were: scarce and fragmented information on the history of mental health in different countries, and the fact that some Central American government health websites do not have digital archives of historical documents mentioning mental health plans and public policies, including older policies that do not appear, requiring the use of Google Scholar for research.

Given the above, it is suggested that documentary studies be carried out on the history of psychiatry and mental health in Central America, or at the level of each country, and that a more in-depth study be conducted on the impact of public policies on mental health in the countries where the most progress has been made in this area. Likewise, it is suggested that states return to mental health as a right in the drafting and updating of laws and public policies that strengthen mental health care in each country.

Conclusion

Central American countries share similar historical contexts in terms of mental health. However, it is common in all countries to see advances, setbacks, or stagnation in the development of public mental health policies. In the Central American isthmus, mental health laws and public policies are an indispensable tool for developing actions through health programs and interventions that help improve people's quality of life, recognize their rights, and promote the individual and collective development of the population to identify, treat, and rehabilitate mental health problems and promote mental health. There continues to be a lack of political will in several Central American countries to promote specific mental health laws or update existing ones, and to ensure that these laws include adequate budgetary allocations for the recognition, addressing, and implementation of public policies that respond to national mental health demands.

Updates to existing national mental health documents in some of the countries studied are outdated with the current context (except for Panamanian and Costa Rican law), which shows that mental health is a little-discussed topic in

state health policies, despite the increase in mental health problems evidenced by the scientific community following the COVID-19 pandemic.

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