

The Disproportionate Impact of COVID-19 in Minority Communities

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Abstract

COVID-19 has profoundly and disproportionately impacted minority populations in Nevada as evidenced by disparities in hospitalizations and deaths. Unless public health professionally actively work to account for risk factors and adjust to meet the needs of minority populations, then COVID-19 health disparities will continue to grow. Minority communities face numerous risk factors that lead to poorer COVID-19 health outcomes such as pre-existing conditions, essential work occupations, inadequate access to PPE, higher household density, lower access to medical care, and insufficient health communications. Many of the factors are directly impacted by existing social inequities. These factors have worked in tandem with the COVID-19 virus to amplify social and health inequities. Critical strategies to reduce social and health inequities include improving surveillance, building trusting in the healthcare system through equitable care, increasing community engagement and outreach, reducing social stigma, and taking account of exceptionally vulnerable members early on.

Keywords: Minority, health equity, COVID-19, disparities, disability, Latinx, Black, Asian, Indigenous, LGBTQI

COVID-19 Health Impacts in Minority Communities

Minority, immigrant, and low socioeconomic status communities experience a disproportionate number of infections, hospitalizations, and deaths from COVID-19 (Centers for Disease Control and Prevention, 2021a;

Poulson et al., 2021). As seen in Table 1, Black, American Indian, and Latinx populations are about 3 times more likely to be hospitalized and approximately 2 times more likely to die from COVID compared to non-Hispanic Whites in the U.S. (Centers for Disease Control and Prevention, 2021a). Furthermore, examining health disparities within racial/ethnic categories reveals deeper disparities. For instance, while Asians fare better than other racial/ethnic groups nationwide, 31% of nurses who have died from COVID-19 are Filipino, despite only making up 4% of nurses nationally (National Nurses United, 2020).

Table 1. COVID-19 U.S. Hospitalizations and Deaths by Demographic Characteristics

Rate ratios compared to non-Hispanic White	Hospitalizations	Death
American Indian/ Alaska Native	3.5x higher	2.4x higher
Asian	1.0x higher	1.0x higher
Black/African American	2.8x higher	1.9x higher
Latinx/Hispanic	3.0x higher	2.3x higher
LGBTQI+	No Data	No Data
Undocumented	No Data	No Data

Data: CDC Hospitalization and Death by Race/Ethnicity, Updated April 23, 2021

COVID-19 has also had profound and unique health impacts in other minority communities who have difficulties accessing health services, such as those who are undocumented (Page et al., 2020), have a disability (Goggin & Ellis, 2020), and/or are sexual and gender minorities (Cahill, 2020). However, because these demographic characteristics are not customarily captured in COVID-19 case, hospitalization and death records, it is difficult to know how deeply COVID-19 has impacted these communities.

Risk Factors for Poor COVID-19 Health Outcomes in Minority Communities

Social determinants of health are the non-medical factors that influence health outcomes (World Health Organization, 2020). They include the conditions in which people are born, work, live, and age; as well as a wider set of systems that shape these conditions (World Health Organization, 2020). Social

inequities by race/ethnicity, social class, sexual orientation and gender identity, and disability have been long-standing and lead to unnecessary, avoidable, and unfair health inequities (Whitehead, 1991). Several key factors related to these inequities are linked to poor COVID-19 health outcomes in minority communities including pre-existing conditions, essential work occupations, inadequate access to personal protective equipment (PPE), higher household density, lower access to medical care, and health communications. These factors, as well as others, will be discussed below.

Pre-Existing Health Conditions and Race/Ethnicity

Pre-existing health conditions and race/ethnicity are strongly associated with poor COVID-19 health outcomes. In particular, pre-existing health conditions such as diabetes, hypertension, cardiovascular disease and chronic obstructive pulmonary disease tend to lead to poorer COVID-19 outcomes that result in hospitalization and death (Sanyaolu et al., 2020). In Nevada, American Indians, Blacks, and Latinxs have higher rates of these chronic conditions compared to Whites (Office of Analytics, Department of Health and Human Services, 2019)

Essential Workers

Essential workers conduct work that is vital to maintain critical infrastructure and continue critical services and functions (CDC, 2021b). These types of occupations must be performed on-site and typically involve being in close proximity to the public or to coworkers (CDC, 2021b). Notably, more than half (56%) of people in the U.S. have had to work in-person during the pandemic (Dey et al., 2020). These numbers are especially high for Latinxs (71%) and Blacks (61%) (Dey et al., 2020). Additionally, Latinxs and Blacks are overrepresented in food preparation and serving (Williams et al., 2020), while Pacific Islanders are overrepresented in health-care support, child care, and warehousing (Kaholokula et al., 2020).

Because people of color are overrepresented in frontline jobs they experience substantially higher workplace exposures to COVID-19 (Dey et al., 2020). Recent research suggests that excess COVID-19 mortality among Latinxs may largely have been the result of frontline workplace exposures (Do & Frank, 2021).

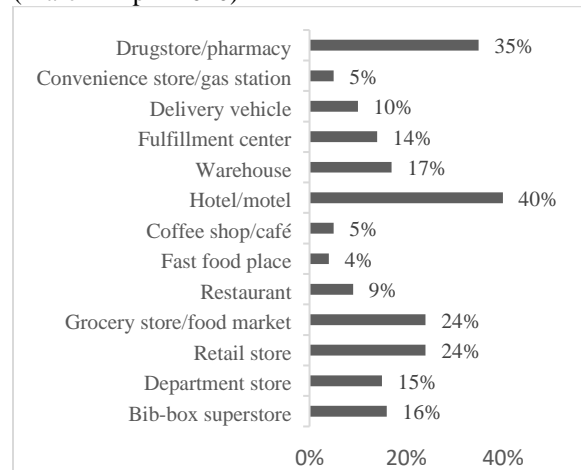
Personal Protective Equipment

Essential workers not only face greater exposure to COVID due to higher face-to-face interactions, but also because they are constrained in their ability to social distance on the job. For example, the majority of essential workers indicated that they are unable to practice social distancing at work (71%), most do not feel safe at work (60%), and the majority have experienced increased stress related to these conditions (86%; Hammonds et al., 2020).

Another concern for employees during the early part of the pandemic was that many employers did not provide personal protective equipment (PPE) or did not provide a sufficient amount of PPE. Disparities in access to PPE and the lack of mask mandates early in the pandemic resulted in substantially higher workplace exposures for essential frontline workers. Furthermore, low wage workers are the most likely to report inadequate access to COVID safety training, face masks, hand sanitizer, and access to hand washing (Hammonds et al., 2020).

As seen in Figure 1, essential workers in fast-food, convenience stores, restaurants, and coffee shops reported the lowest access to employer-provided face masks followed by those working in fulfillment centers, warehouses, delivery vehicles, and big-box stores (Schneider & Harknett, 2020). Similarly, relative to White frontline healthcare workers, Latinx, Black, & Asian frontline healthcare workers are less likely to be provided with adequate PPE for the job by their employer and consequently were more likely to have to reuse PPE (Nguyen et al., 2020).

Figure 1. U.S. Mask Availability by Industry (March - April 2020)



Source: Adapted from Schneider and Harknett 2020; The Shift Project Dataset, n = 29,722

High Density Households

High density households, in which two or more people live in a room, have been found to facilitate the spread of COVID-19 (Emeruwa et al., 2020). If one person gets sick, the limited space and higher number of people in the home increases the likelihood that others will also get sick. In addition, structural barriers by race/ethnicity and social class contribute to high household density (Blake et al., 2007; IDSA & HIVMA [Infectious Disease Society of American and HIV Medicine Association], 2020; Kaholokula et al., 2020; Keene & Batson, 2010).

Structural barriers such as legacy of racial residential segregation and mortgage lending discrimination (Massey & Denton, 1993), in addition to contemporary disparities in home appraisals (Howell & Korver-Glenn, 2018) continue to systematically devalue minority owned-homes, reduce home equity, and drive the racial wealth gap (Howell & Korver-Glenn, 2018; Massey & Denton, 1993). Cumulatively, these factors constrain access to quality and affordable housing options (Howell & Korver-Glenn, 2018), which may contribute to the need for higher density and multigenerational households.

Additionally, structural barriers in occupation also impact housing. Minority communities are overrepresented in occupations that do not provide livable wages and this financial strain makes it harder to secure quality, single family housing; which consequently leads to families doubling up in a home (Keene & Batson, 2010).

Household density plays a critical role in the spread of COVID infections— even more than urban density (Emeruwa et al., 2020). People of color in general, and undocumented persons in particular, experience high levels of household density or crowding. For example, 14 times as many Latinxs and 3 times as many Blacks live in crowded housing compared to Whites (Blake et al., 2007). Meanwhile, undocumented persons experience the overall greatest burden of crowded housing (McConnell, 2015).

Multigenerational Housing

Compared to Whites and U.S.-born individuals, people of color and immigrants are more likely to live in multigenerational housing— homes with two or more generations of adults living in a single dwelling (Easthope et al., 2015; Keene & Batson, 2010). The tendency for families to live in multigenerational housing is shaped by cultural and structural factors (Keene & Batson, 2010). Among people of color and immigrants, cultural values and

norms place high importance on the maintenance of close familial social ties, especially with grandparents (Blake et al., 2007; Kaholokula et al., 2020; Keene & Batson, 2010). Unfortunately, the close ties to elders, which is a source of strength in minority communities, places older adults in multigenerational homes at a higher risk for contracting COVID-19. Older adults may contract COVID-19 from other household members, especially those who may work in essential frontline jobs. This highlights a significant concern as older adults of color are especially susceptible to hospitalization and death from COVID-19 (Shahid et al., 2020).

Access to Paid Sick Leave

People of color and sexual and gender minorities tend to have lower access to paid sick leave, paid medical leave, and lower rates of health care benefits compared to dominant groups (Goldberg, 2020; Loo & Chang, 2020; Piper et al., 2017). The lack of employer provided paid sick leave forces socially and economically marginalized populations to have to choose between going to work sick or losing earnings for essentials like housing and food. To avoid facing hunger or eviction, workers end up going to work sick, which may contribute to the spread of COVID-19.

Health Insurance

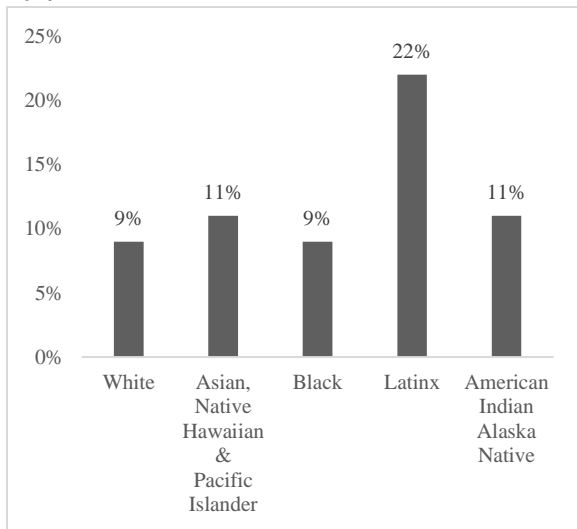
Compared to Whites, people of color were overall more likely to be uninsured prior to, and as a result of, the pandemic (Hayes, 2020; Kaholokula et al., 2020; Kaiser Family Foundation, 2020; Parker et al., 2020). Similarly, sexual and gender minorities are also more likely to be uninsured compared to others—this is especially the case for transgender persons (Phillips et al., 2020; Ranji et al., 2014).

Prior to the pandemic, 22% of Latinxs were uninsured in Nevada as seen in Figure 2 (Kaiser Family Foundation, 2020). Next, Figure 3 shows that Black and Latinx communities were most likely to lose health insurance as a result of the pandemic, 9% and 8%, respectively (Parker et al., 2020). Consequently, both groups were more likely to forgo medical care due to cost barriers, with Latinxs being more likely than any other racial/ethnic group to do so (Buchmueller & Levy, 2020).

Individuals from federally recognized American Indian or Alaska Natives tribes are eligible for care through the Indian Health Services (IHS). However, IHS is regularly underfunded, understaffed, and operating beyond capacity (Bernard et al., 2017; IDSA & HIVMA, 2020; Indian Health Services, 2020; Van Dorn et al., 2020). Additionally, IHS is

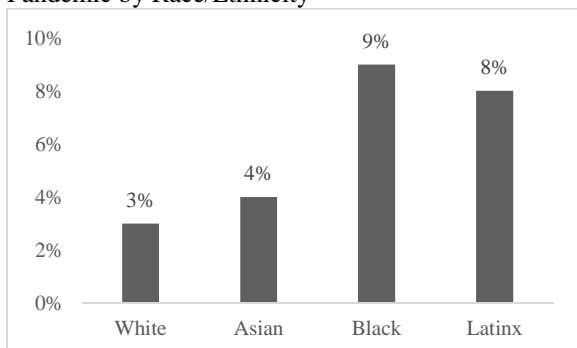
not an insurance program and American Indians experience the second-highest rate of being medically uninsured (Indian Health Services, 2020; Kaiser Family Foundation, 2020). In some cases, direct health care services can be provided through Purchased/Referred Care (PRC) at non-IHS facilities, but IHS cannot always guarantee funds are available and prioritization goes to those with life-threatening illnesses or injuries (Indian Health Services, 2020). IHS is not a replacement for medical insurance, but in a majority of cases, it is the extent of medical care available.

Figure 2. Uninsured in Nevada by Race/Ethnicity-2019



Notes: Analysis of the Census Bureau’s American Community Survey (ACS) by Kaiser Family Foundation
 Uninsured: includes those without health insurance and those who have coverage under the Indian Health Service only.
 Latinx refers to Hispanic ethnicity

Figure 3. Loss of Health Insurance Due to the Pandemic by Race/Ethnicity



Data: PEW Research Center Survey of U.S. adults conducted Aug. 3-16, 2020.

Notes: Latinx refers to Hispanic ethnicity

Access to Healthcare

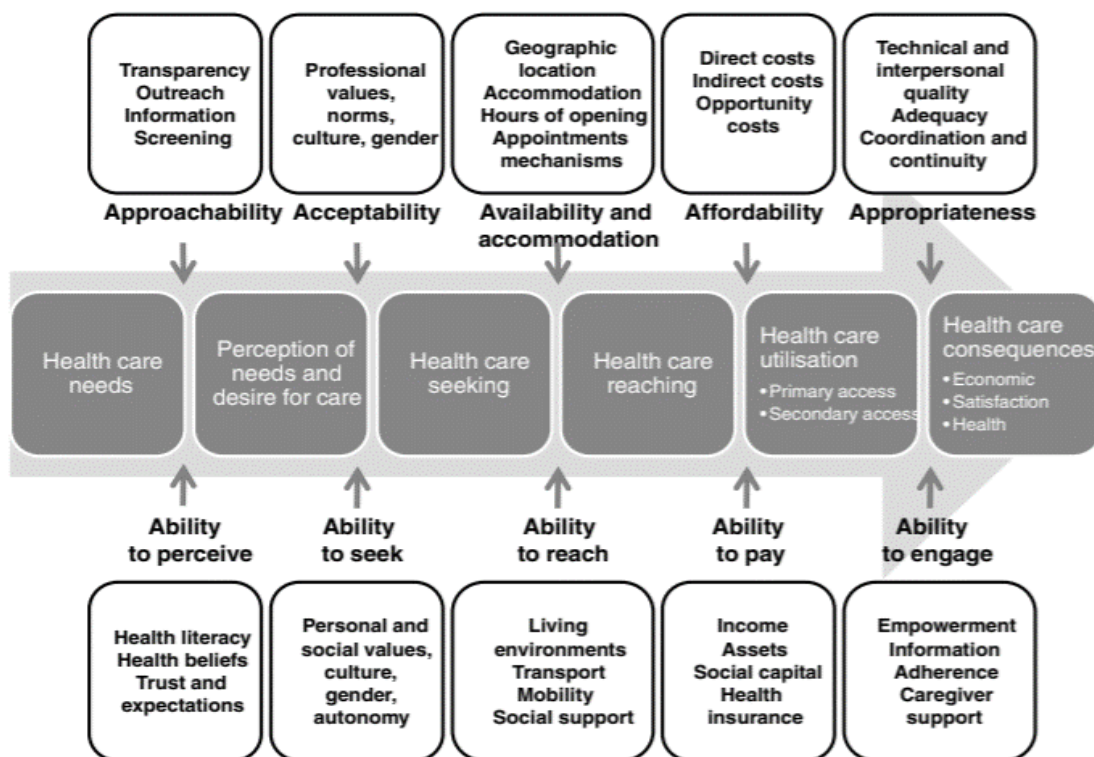
Even among those with health insurance, people of color and populations with low socioeconomic status were more likely to forgo medical care because of cost barriers (e.g., copays, deductibles), compared to Whites (Allen et al., 2017; Morisako et al., 2017). American Indians in Nevada face numerous challenges to accessing health care such as the underfunding of the Indian Health Services, a lack of board-certified staff, a limited number of and distance to Indian Health Service facilities, and an absence of telemedicine (IDSA & HIVMA, 2020; Van Dorn et al., 2020). Furthermore, Nevada has no tribal health emergency services, there are only clinics that provide outpatient services (Indian Health Services, 2020; *Las Vegas Paiute Tribe Health & Human Services*, n.d.). Additionally, these clinics do not cover medical services for individuals who are not a part of the local tribe. Nevada is home to many American Indians who were born out-of-state or in a different part of the state than where they currently reside—consequently, these individuals are not able to receive covered medical services locally.

Distrust of Healthcare

Minority communities have a long history of experiencing discrimination in health care setting based on race/ethnicity, immigration status, disability, income, sexual orientation, gender identity. Historical abuses of minority communities, such as the Tuskegee Syphilis Experiment on African Americans and forced sterilizations of Mexican Americans and American Indians, have resulted in deep levels of suspicion, mistrust, fear of discrimination, and consequently lower likelihood of seeking medical care (Goldberg, 2020; Human Rights Campaign Foundation & Sage Advocacy & Services for LGBT Service Elders, 2020; Jahromi & Hamidianjahromi, 2020; Kaholokula et al., 2020; Phillips et al., 2020).

Today, implicit bias and explicit discrimination in health care continue to result in drastically different health outcomes by race/ethnicity, sexual orientation, gender identity, and disability. As such, an urgent need exists for healthcare providers to understand and account for the fact that poor health outcomes in minority communities are not purely due to insufficient individual effort, but that they are intimately tied to larger social determinants of health (Scott et al., 2019; Whitehead, 1991; World Health Organization, 2020). Healthcare providers can play a key role in reducing these health inequities by providing ethical care that centers on the experiences

Figure 4: A Conceptual Framework of Access to Healthcare Source: Levesque et al. (2013)



of marginalized groups, by listening to the concerns of minority communities, acknowledging historical traumas, and recognizing that access to care does not necessarily result in receiving *equitable* quality care (Scott et al., 2019).

Reconceptualizing Patient-Centered Access to Healthcare

Patient-centered access to healthcare is a complex and dynamic process that involves both the healthcare provider and patient. As depicted in Figure 4, Levesque (2013) provides a framework composed of five domains of accessible healthcare delivery and receipt. From the provider-side, these components include: 1) *approachability* which refers to the ways in which healthcare systems disseminate information, including transparency of the organization, how information is distributed in regards to treatment/services, and how outreach activities are implemented. 2) *acceptability* which entails how social and cultural factors may affect services obtained from the healthcare system and the ability to accept such services. 3) *availability and accommodation* denote whether health services, including the physical space and healthcare providers, can be reached physically and in a timely manner. 4) *affordability* accounts for the cost of care

delivered by the health provider and the ability of the individual to pay and have time to undergo services. 5) *appropriateness of care* refers to the fit between services and clients' need, its timeliness, the care spent in assessing health problems and determining proper treatment, and the technical and interpersonal quality of services provided.

From the patient-side, accessible healthcare includes the following five abilities. 1) *Ability to perceive* the need for health care, which entails health literacy, health beliefs, trust, and expectations. 2) *Ability to seek* health care, which must account for personal and social values, culture, gender, and autonomy. 3) *Ability to reach* healthcare, which considers living environments, transportation, mobility, and social support. 4) *Ability to pay* for health care, which must account for income, assets, social capital, and health insurance. Lastly, 5) *Ability to engage* with healthcare providers in decision-making and treatment decisions, entails empowerment, information, adherence, and caregiver support (Levesque et al., 2013). In sum, accessible healthcare entails the patient being fully engaged in care and healthcare providers actually offering and providing appropriate services — across these five domains. Furthermore, this patient-centered framework highlights that a holistic approach is vital

to ensure equitable access to care across the continuum of healthcare touch points.

Health Communications

Health communications entail a two-way process between public health entities and the audiences that the materials are intended for. When public health professionals generate health communication materials, or have personal interactions that do not account for cultural differences, non-English language speakers, and variations in literacy and comprehension, then underrepresented groups such as those with disabilities, racial/ethnic minorities, immigrants, and low-income communities are less likely to find the information accessible and useful (Jacobson et al., 2016; Kuenburg et al., 2016; U.S. Department of Health and Human Services, 2020). Consequently, these target audiences are less likely to act on that information. For example, some individuals that are deaf or hard of hearing rely on the ability to lip read to enhance their ability to communicate, however the requirement to wear a mask severely limited communication for these individuals during the pandemic especially because there was no wide-spread messaging to inform health care professionals or the general public that individuals were permitted to request others to temporarily pull down their face masks to facilitate lip reading (Marquez et al., 2020). Given the deep impact that COVID-19 has had on underrepresented communities, it is paramount for public health entities to create linguistically and culturally tailored COVID-19 resources for minority communities (Kuenburg et al., 2016; Phillips et al., 2020).

The Amplification of Existing Inequalities due to COVID-19

Social inequities built into our institutions and policies result in lower wages, greater unemployment, greater housing and food insecurity, and greater social stigma for disadvantaged populations. Inequities existed prior to COVID-19, but have been amplified by the pandemic. People of color and sexual and gender minorities are overrepresented in the hardest hit sectors (Cahill, 2020; Parker et al., 2020). Compared to Whites, people of color were more likely to (Parker et al., 2020): have taken a pay cut since the start of the pandemic, have been laid off since the start of the pandemic, had trouble paying rent/mortgage and bills since the start of the pandemic, and have gotten food from a foodbank since the start of the pandemic.

Additionally, compared to dominant groups (i.e., cisgender and heterosexuals), gender and sexual

minorities are more likely to work in food service, restaurants, and entertainment sectors which have closed due to the pandemic, leading to reduced earnings or unemployment (Badgett et al., 2019; Cahill, 2020). Closely tied to reduced earning and unemployment is the looming eviction crisis. Even though Nevada's eviction moratorium has been extended to May 2021 (State of Nevada, 2021), the ending of this moratorium will result in greater homelessness, especially among minority communities, the most impacted by existing social inequities. This issue needs to be addressed structurally through policy that provides relief to both parties to avoid an eviction crisis that will have a deep and widely-felt ripple effect throughout society.

COVID-19 has also exacerbated interpersonal racism. Since the start of the pandemic, people of color have reported increases in prejudice and discrimination, especially Asians and Pacific Islanders (Liu et al., 2020; University of Southern California Dornsife Center for Economic and Social Research, 2020). Unfortunately, minority groups are often singled out and scapegoated for infectious disease outbreaks (Keil & Ali, 2006; O'Shea et al., 2020). This stems from a lack of knowledge of how COVID-19 actually spreads, a need to blame someone, fear of getting COVID-19, and anger from how COVID-19 has impacted individuals' lives. As a result, race-based social stigma has dramatically increased since the start of the pandemic.

Asian Americans and Pacific Islanders experienced the greatest surge in racial discrimination due to COVID-19 and the current sociopolitical climate (Litam, 2020). STOP AAPI HATE (2020) documented 2,583 reports of anti-Asian discrimination nationally since the start of the pandemic (Stop AAPI Hate, 2020). Asians Americans and Pacific Islanders have been cursed at, blamed for the pandemic, spit upon, barred from establishments, and physically attacked—simply for being Asian (Liu et al., 2020; Stop AAPI Hate, 2020; University of Southern California Dornsife Center for Economic and Social Research, 2020). Latinxs and Blacks have also experienced an increase in racial discrimination in the form of verbal harassment since the start of the pandemic. This may be the result of race - and class - based prejudices directed toward those who work in frontline jobs (Liu et al., 2020; University of Southern California Dornsife Center for Economic and Social Research, 2020).

Recommendations for a Health Equity Response to Public Health Emergencies

The COVID-19 pandemic is not the first, nor the last, public health emergency to test our nation and

state's capacity to respond to a widescale crisis. Although, the social, economic, and health impacts of this pandemic will not be completely realized for years to come, we have learned valuable lessons that can help reduce human suffering and health inequities as we continue to battle COVID-19 and prepare for future public health emergencies.

Key Ways to Bolster Our Response to Future Public Health Emergencies

Improve Surveillance

Data limitations such as the lack of standardized and consistently captured demographic data and the absence of data sharing agreements, will slow our ability to identify and respond to burgeoning health inequities. To better understand disparate health outcomes in minority communities, we must strengthen surveillance. The first steps toward this goal is to ensure that surveillance efforts capture key demographic data from the beginning of future public health emergencies. Delays in racial/ethnic demographic data collection hampered timely responses during the early periods of the COVID-19 pandemic. Additionally, it is crucial to collect racial/ethnic data by ethnic subgroup as lumping heterogeneous populations together conceals profound disparities experienced by some ethnic subgroups. In addition to racial/ethnic data, it will be important to collect other demographic measures that are known to shape exposure to risk and access to resources such as sexual orientation and gender identity, disability, and undocumented status. The absence of these data made it difficult to identify and allocate appropriate resources to protect the health of those who need it most.

To leverage limited resources during public health emergencies and avoid duplication of effort, jurisdictions throughout Nevada must share critical population-level data. Additionally, jurisdictions must develop data sharing terms that include the highest level of data stewardship to protect sensitive individual-level data such as sexual orientation and undocumented status. It can take years to build trust with communities, but that trust can be broken in an instant.

Build Trust in the Healthcare System through Equitable Care

Healthcare settings that do not intentionally and explicitly work to address culturally and linguistically appropriate healthcare will likely alienate minority communities, resulting in lower trust in healthcare and lower utilization rates. In order

to promote more equitable care, we recommend four key strategies. First, healthcare centers should adopt and commit to the National Quality Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Healthcare. Second, healthcare centers should address the primary domains of healthcare services: a) approachability, b) acceptability, c) availability and accommodation, d) affordability, and e) appropriateness of care (Levesque et al., 2013).

Third, we recommend promoting self-assessment of patient health outcomes to identify and address unintentional or implicit bias in the delivery of quality care. By their very nature implicit biases are not readily apparent, thus we must rely on and value the input of patients when they share this information with us. Finally, the ultimate strategy is for healthcare centers to create a culture of accountability in which it is everyone's responsibility to ensure that quality care is being provided to all regardless of their actual or perceived sexual orientation, gender identity/presentation, ability, age, national origin, immigration status, or race/ethnicity.

Increase Community Engagement and Outreach

If minority communities do not have a seat at the table in planning and implementation of emergency public health efforts, there will be limited buy in and efficacy of such efforts resulting in limited impact. To increase efficacy, we must conduct community engagement and outreach so that members of minority communities are included in the decision-making process and have leadership roles in developing and executing public health responses. This will help account for the unique experiences, understanding of barriers, and knowledge of facilitators and gatekeepers in minority communities.

We must also ensure that public health campaigns are culturally and linguistically relevant to minority communities. Toward this objective, we must maintain ongoing engagement with minority communities to so that when an emergency arises, we can rapidly disseminate accurate information to the community. Lastly, we must acknowledge and act in accord with the credo, "Nothing about us, without us."

Reduce Social Stigma

Unless addressed preemptively and with cultural humility through widescale messaging campaigns and accurate information, social stigma in the form of harassment, vandalism, and physical attacks will surge and be directed toward the groups that are scapegoated as the cause of the pandemic (Liu et al.,

2020; Litam, 2020; Stop AAPI Hate, 2020). Therefore, to reduce social stigma, we must collectively ensure increase the quality of epidemiological information provided to the public, counter misinformation, build trust between healthcare systems and the general community, and engage marginalized voices.

Take Account of Exceptionally Vulnerable Members Early On

If limited resources are not allocated and made available to the most marginalized communities, this will drive exceptionally poor health outcomes for the entire community. To support those most at-risk, we must account for exceptionally vulnerable members of society early on in the pandemic such as those with multiple marginalized identities (e.g., ethnic/racial minorities, sexual minorities, low socioeconomic status, undocumented) who have high exposure to risk and limited resources to promote health.

We must equitably allocate and distribute resources to these populations in order to curb the exposure to risk and subsequent morbidity and mortality. For instance, one of the factors that drove COVID-19 transmission was the lack of employer provided PPE (i.e., masks) in Black and Latinx frontline workers during the early part of the pandemic prior to Nevada's mask mandate. This is why mask mandates at the city, county, and state level are essential to protect vulnerable frontline workers until widespread herd immunity is achieved through vaccination.

The Storm's Aftermath: Beyond COVID-19

It is important to recognize that once the COVID-19 pandemic is officially declared over, the social issues amplified through the pandemic will have a ripple effect that will reverberate for years to come. Unless we intentionally address the social issues that shape disparate outcomes, recovery for all members of society will be unequal and unnecessarily slowed. To successfully address recovery, we will have to contend with high rates of unemployment, lost wages, a housing crisis brought upon by widescale evictions, substance abuse, educational impacts, and mental health crises among other issues. Additionally, both medical and non-medical supports need to be put in place immediately and continued for the long-term. In sum, if we seek to ensure that everyone has an equal opportunity to achieve their full health potential, we, as key players in Nevada's public health infrastructure, must work

together to account for and respond to barriers that impede health equity.

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