ECONOMICS
& Sociology

Kim, A., Shrestha, S., Jaglowski, I., & Dunnings, A. (2022). Collective resilience to meet the challenge of the global pandemic of Covid-19. *Economics and Sociology. Economics and Sociology, 15*(2), 11-23. doi:10.14254/2071-789X.2022/15-2/1

COLLECTIVE RESILIENCE TO MEET THE CHALLENGE OF THE GLOBAL PANDEMIC OF COVID-19

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Received: July, 2021
1st Revision: March, 2022
Accepted: June, 2022

DOI: 10.14254/2071-789X.2022/15-2/1

JEL Classification: I14

ABSTRACT. Utilizing a Community-Based Participatory Research model, faculty members of a local university school of social work completed a qualitative study of an emerging Bhutanese minority group's subjective view of their living experiences related to Covid-19 while living in Northeast, Pennsylvania, U.S.A. Utilizing purposive sampling methodology, fifty samples, such as bilingual (English & Nepali) community leaders and Bhutanese residents participated in individual telephone interviews due to the high surge of Covid-19, from October 2020 to January 2021. The purpose of the study is to understand the subjective views of Bhutanese residents' lived experience during the peak of the global pandemic, COVID-19. The interview incorporated two components: 1. Demographic information and 2) Questionnaires developed by the researchers which were reviewed by two independent researchers in the university before their use. The study found that the Bhutanese community residents identified challenging needs in the areas of language barriers, unemployment, multigenerational living, and strategies to overcome hardship of Covid-19. The study findings point to the benefits of an interprofessional collaborative action with community organizations (faith-based organizations, social institutions, and cultural centers) to close the gap of social and health care disparities among minority populations. Community health care and social service institutions and organizations need to build relationships with leaders of local minority organizations in order to provide culturally and linguistically appropriate information about treatment, care and prevention of Covid-19 in the future.

Keywords: health disparities, economic inequalities, Covid-19, interprofessional collaboration, Bhutanese minorities

Introduction

The global pandemic of COVID-19 has caused millions of people either to fall ill or be hospitalized or die. Particularly, the healthcare disparities, economic insecurity and the gap of social services at the peak of Covid-19 evidently led minority groups into a higher number of infections, hospitalization and deaths.

The quality of hospital facilities can be identified by the characteristics and location of the population they serve. In a report, findings show increased rates of chronic conditions compounded with socioeconomic factors led to higher rates of COVID-19 deaths among minorities (Georgetown University school of Nursing & Health Sciences, 2020). According to Hooper, Napoles, & Perez-Stable's study (2020), minority populations such as, Black and Hispanic groups in America disproportionately represent a high number of infection and deaths from the Covid-19 virus compared to the White population. Wang's study (2020) also found that the Black population's hospitalizations remain 2.7 times higher than their non-Hispanic, White counterparts, and Blacks come in with more severe symptoms (Azar, Romanelli, Lockhart, Smits, Robinson, Brown, & Pressman., 2020). The Center for Disease Control, 2020 and the U.S. Census Bureau also substantiated that Blacks and Hispanic groups have shown significantly increased rates of hospitalization across the United States. Interestingly, even Blacks who possess health insurance often choose to wait until their COVID-19 symptoms become acute before they seek professional care. Similarly, with other minorities, America has a long history of discrimination against Asian Americans because of their race and ethnicity (Chow, 2020). In the global pandemic of Covid-19, the Asian American population has experienced bullying, discrimination, blame, and has been attacked by non-Asian individuals and groups. They blamed, bullied and attacked Asians and Asian-American groups because they believed that Asians are responsible for bringing Covid-19 into their midst.

The Bhutanese minority group in Northeast, PA initially entered the U.S. as refugees. They were forced to flee their homes in Bhutan to escape discrimination, imprisonment, and torture perpetrated by their own government and the political system. Many Bhutanese have lived in refugee camps in Nepal for years and these Bhutanese refugees were relocated to the U.S. to seek a better life. The United States of America has accepted 78,473 Bhutanese refugees out of the 92,639 who have been resettled from 2007 to January 2013 (UNHCR, 2014). Bhutanese refugees faced many difficulties to rebuild their lives in a new country, in the U.S., while oftentimes, recovering from traumatic life experiences in Bhutan and in the refugee camps of Nepal. Refugee-status Bhutanese families relied on designated resettlement agencies "to provide a welcome reception and integration services." (United Nations High Commissioner for Refugees (2002). However, the original intention or purpose of the refugee resettlement policy limits the provision of reception and integration services to only ninety days post arrival, thus, a huge economic, social and cultural stress and strain are on refugees and residents of suburban communities and small cities in Northeast, PA. Traditionally, the homogenous residents in Northeast, PA have not considered themselves responsible to invest human capital development with the Bhutanese refugees in their communities. Relatively the young minority group of the South-Asian Bhutanese population in Northeast, PA's struggles were no different than the rest of the minority groups in the U.S.: language barriers, lack of connection with the community at large, lack of a transportation system, economic insecurity and unfamiliarity with the U.S medical system. The Bhutanese minority group struggled to stay safe and well during Covid-19. This study was intended to gather the collective voices of the Bhutanese minority group's lived experience at the peak of the Global pandemic of Covid-19, from October 2020 to January 2021. The vaccine was not available at that time. This study is important because the literature on the Bhutanese minority group's challenging experiences

during the Covid-19 is limited and has not been studied to any great extent since this population is a relatively new group in the United States.

1. Literature review

Lack of sufficient numbers of Bhutanese specific studies, a deficit that the authors of this study desire to remedy, the vast majority of articles utilized in the literature review focused on other minority populations.

With the influx of immigrants and refugee groups' settlement in small suburban towns and cities, these groups have commonly challenging issues:1) the English language barrier, 2) disparities of the health care service, 3) inadequate public transportation systems and 4) the lack of community integration services. These minority group's language barriers, economic insecurity and lack of a connection with the larger community hugely disadvantaged and discriminated them from receiving the medical and social welfare resources they needed during the Global pandemic of Covid-19.

Health care service disparities based on race and ethnicity:

Minority groups, including Blacks, have higher rates of Covid related infections, hospitalizations and deaths compared with the White population. The history of health care disparities within the U.S. perhaps leads minority groups to be more susceptible to have severe cases of COVID-19. Artiga, Corallo, & Pham (2020) study found that disparities of Covid-19 cases among diverse race and ethnic groups were due to environmental factors such as, where people live, work, play, and go to school. In addition, health care disparities and social inequalities were the risk factors for exposure to the virus among ethnic and racial minority groups regardless of age. Coronavirus Disease 2019-Associated Hospitalization Surveillance Network (COVID-NET) reported that Blacks, Hispanics, and American Indians and Alaskan Native people are at an increased risk of hospitalization due to COVID-19 than their White counterparts (CMS.gov, 2020). Even in nursing homes, where most residents who identify as people of color showed higher rates of COVID-19. Also, the CDC Morbidity and Mortality Weekly Report (2020) stated that Black and Hispanic pregnant women and children are most at risk of increased hospitalizations with COVID-19.

Economic insecurity issues:

Minority populations are disproportionately represented in essential frontline jobs which have increased chances of exposure to Covid-19 and leads to higher rate of infection, hospitalization and death with Covid-19 (Jin Rho, Brown & Fremstad 2020). Statistically, Blacks and Hispanics/Latinos are overrepresented in essential jobs and they receive low working wages. Essential workers and workers without sick time cannot afford the cost of missing work and many of them may live with untreated chronic health conditions. They are forced to have long hours of work in order to provide the basic needs of the family. Consequently, their exposure to the virus has increased (COVID-19 Tracker). Essential workers such as mail delivery, the food industry, retail, warehouses, and transportation, these workers increase their risk of developing COVID-19 due to institutional and systemic maltreatment. Without adequate pay and secure jobs and suitable housing, the public health situation will continue to fall with risks compounded by issues of socio-economic-medial injustices (Hammonds & Reverby, 2019).

Housing issues:

Multigenerational lower-income homes and houses were proven to be difficult circumstances to maintain required social distancing. Unless the government provides temporary housing for family members who are infected with Covid-19, the infected family member has no means to be separated from the rest of the family members. Also, economically

struggling groups of people also live in environmentally hazardous locations and have few resources available, such as, lack of medical services, grocery stores and reliable public transportation that jeopardize their recovery from Covid.

Lack of transportation and lack of testing site issues:

In the beginning to mid-2020, few data existed on the racial disparities of COVID-19. In May of 2020, the New Orleans drive-through testing site learned that the lack of local transportation was the reason African Americans living in primarily racially segregated communities were unable to access testing sites (Rader, Astley, Sy, Sewalk, Hswen, Brownstein, Kraemer, & Phil, 2020). Also reported that contrary to Whites, predominantly Black, Hispanic and other minority neighborhoods' lack of access to the testing sites is associated with the lack of local transportation issues. Minority neighborhoods had a higher demand for testing but longer wait times (Kimm, Vann, Bronner & Manthey, 2020). A study looking at testing in New York City (Lieberman-Cribbin, Tuminello, Flores, & Taioli, 2020), predominantly White neighborhoods had more testing sites than minority neighborhoods, even though, higher rates of positive COVID-19 cases came from minority and low socioeconomic status neighborhoods (McMinn, Carlsen, Jaspers, 2020). Minorities who get infected often die with Covid-19 due to a lack of access to testing and treatment (Koma, Artiga, Neuman, ClaxtonRae, Kates, & Michaud, 2020).

In conclusion: According to the National Center for Health Statistics (2021), the ethnic and racial disparities of Covid-19 cases, hospitalizations and deaths between Whites, Blacks, and Hispanics/Latinos was due to existing social inequalities among these groups. Also, a racially segregated living environment and inequality of working conditions (Gould & Wilson, 2020), pre-existing health conditions and comorbidities among minority groups (Yancy, 2020), and a lack of access to health care and other services (Taylor, 2020) are contributing factors for minority groups to have higher rates of Covid-19 cases, hospitalizations and deaths than white groups.

2. Methodological approach

Research study preparation

Using Saleeby's (2006) strengths perspective, research team members took leadership roles for various project tasks over six months. The pre-research study field work consisted of community networking, such as communicating with the bilingual (English & Bhutanese) community leaders and Bhutanese residents via telephone and zoom technology.

Bhutanese residents initially entered the United States with a refugee status. Over the years, their legal status changed from refugee to residents of the U.S.

Conduct of the study

This study, guided by a community-based participatory research (CBPR) approach, utilizes a partnership which emphasizes a number of principles: 1) viewing the community as the unity of identity that is involved in a co-learning process; 2) focusing on systems development while, at the same time, fostering community capacity building; 3) balancing research with action; and 4) promoting activities that are participatory, cooperative, empowering, and evidence-based (Israel et.al (2011). According to deHames and Kilty (2007) and Kennedy et.al (2011), a CBPR model promotes community-driven problem-solving strategies between agencies, organizations and the community at large.

Design

Utilizing the qualitative methodology of an empowerment action model included individual interviews with community-based Bhutanese community leaders and Bhutanese residents.

The purpose of research study

The purpose of this research study was discovering the Bhutanese minority group's subjective view of their living experiences related to Covid-19 while living in Northeast, PA, U.S. This research study with the Bhutanese minority group took place in Northeast, PA starting from October 2020 to January 2021 when the global pandemic of Covid 19 was in a peak period and a vaccine was not available.

3. Conducting research and results

The samples

Utilizing purposive sampling methodology, a process that encouraged the participation of individuals who have experiential knowledge related to the research questions, fifty samples, such as bilingual (English & Nepali) community leaders, Bhutanese residents who participated in individual telephone interviews due to the high surge of Covid-19. All the participants were self-identified as Bhutanese and were 18 years of age or older.

Demographic information (see table 1)

The Bhutanese participants' average length of living in the U.S. was almost 10 years and the average family size was 6. The majority 52 %, was between 20-30 and 31-40 years old; 30%, was 61-older; 82% were married and 68% were bilingual (English & Nepali).

Table 1. Demographics of individual Bhutanese participants: (N=50: Male=24, Female=26)

Average years of living in the U.S.		9.94 years	
Average Family Size		6.06	
Primary Language	Nepali only	16	32 %
	English only	-	
	Bilingual (English & Nepali)	34	68 %
Age	20-30	7	14 %
	31-40	16	32 %
	41-50	10	20 %
	51-60	2	4%
	61-older	15	30 %
Marital Status	Single	7	14 %
	Married	41	82 %
	Separated	1	2%
	Divorced	-	
	Widowed	1	2%
Housing	Rent home	8	16 %
	Rent apartment	1	2 %
	Own home	40	80 %

Source: *own calculation*

Research questions

The questions were developed by the researchers and it was reviewed by two independent researchers in the university before their use. The individual participant completed a demographic profile, followed by a phone interview focusing on the following: 1) when you have confronted the global pandemic of Covid 19, a) what are your solution strategies? b) what resources have you looked for? c) what hindered you from finding the means? d) what coping abilities do you have? 2) Are you hopeful about your financial, health and emotional security in your adopted new country, the United States of America?

Data collection

A Collaborative Institutional Training Initiative (CITI)-certified bilingual (English & Nepali) moderator facilitated each individual interview, lasting between 40 and 50 minutes each. The consent form explained in Nepali, the nature of the study, indicated the voluntary nature of their participation, and cautioned participants not to use identifying information during the interview. The recording of each interview was fully transcribed by a bilingual transcriptionist and then translated into English for the current analysis. The content was analyzed independently by a coder in conducting and analyzing the interview discussions. These data serve to highlight the participants' lived experiences and to illustrate the context for priority issues that were identified in this study.

Data analysis

General stressors among immigrant/migrant/refugee populations are the language barrier, loneliness, social isolation, lack of resources, changes in family relationships, social discrimination, lack of transportation, and poor health. The Bhutanese community residents who participated in the interviews identified the following topics: 1) language barriers, 2) unemployment issues, 3) multigenerational living issue, and 4) the Bhutanese community's network strategies during Covid-19.

Theme 1: Language barrier related to health care access

English language proficiency is often a barrier for immigrants and refugees which limits acculturation and access to support, social and health services and employment opportunities Kim & Burke (2014). Mui and Kang (2006) found that depression was correlated with poor health, stressful life events, distance from the rest of the family, and the amount of time in the United States. Immigrants who resettle in small towns often face additional obstacles. Immigrants are often geographically dispersed and are not living in a community that shares their culture and language. In addition, Mossaad, Ferwerda, Lawrence, Weinstein & Hainmueller (2020), explain that different contexts of reception influence the integration (or lack thereof) of immigrants into the small communities. Immigrants in small communities were geographically dispersed and this affected the immigrant's participation in acculturation activities, such as English lessons which directly impact job opportunities and economic self-sufficiency. Smaller communities often struggle with obtaining funding to provide services because they do not have a larger number of immigrants for whom to provide services.

The participants expressed frustration and confusion about accessing health care services. Bhutanese residents with limited English speaking and understanding and knowledge about how to navigate the health care system hindered their utilization efforts.

"Testing places for Covid-19, I went to Wright Center. Between my wife and I, we got different bills although we have the same insurance. We were confused and I ended up paying the bills."

"We were worried because some people in our community got infected and it was difficult to hear that those in the hospitals did not understand why families could not visit."

Theme 2: Unemployment issue

The unexpected outbreak of COVID-19 has affected the entire global nations. To control the fast spread of the Covid-19, governments enforced social distance restrictions which created a negative impact on entire industries and crippled systems. Businesses were shut down indefinitely and they laid off non-essential workers from their jobs. The outcomes of the lockdown caused 114 million people to lose jobs in 2020. The crisis of either losing jobs or reduced working hours certainly disrupted labor markets on an unprecedented scale (Statista, 2021). Minority groups were especially vulnerable to navigate their economic needs due to their limited savings and lack of economic mobility. The Bhutanese minority group is a vulnerable population which is more likely to live in poverty because they are under-educated and unskilled laborers who work at lower pay in high-risk job areas. Many of these positions are part of the defined essential work including, food preparation, food serving, home care, in factories and sales. These services and production industries were the first group of businesses to shut down and let go of their employees. Many minority groups who lost their jobs were ineligible for unemployment assistance or the stimulus checks, thus they faced tremendous challenges such as food insecurity and inability to pay their rent. Baran, Valcea, Porter and Gallagher's study (2018) with refugees and refugee assistance organizations, refugees experienced higher levels of underemployment when compared to non-refugees and that underemployment predicts yet lower job and life satisfaction.

It was very difficult because our family lost jobs. We had a very difficult time affording rent. We learned about government assistance such as food stamps so we were able to get some help. We did not have masks to go out but then the Bhutanese community did distribute masks so it helped" We went to the food distribution place, but the lines were so long and waiting was very long.

"Our families, friends and our community helped with groceries and PPE. All we had to do was contact the Bhutanese grocery stores and they gave us things on credit and even delivered groceries."

Theme 3: Social distance living situation issue

Cultural factors come into play when considering the effects of COVID-19, such as in minority communities where family first values outweigh all others. Zhang, Gurung, Angelwicz & Yun (2020) study with 188 Bhutanese and 30 Burmese refugee populations found that essential workers are at a higher risk of infection with Covid-19 than non-essential workers among the refugee populations. These groups of people may struggle to have social distance at home if they are infected or have tested positive with Covid-19. Als Yi's (2020) interview with 218 immigrant warehouse workers learned that these workers are more often traveling to work in crowded shared transportation since many of them do not own personal vehicles. They are also more likely to live in multi-generational households. Federgruen and Naha 's study (2021)

explored whether population density, along with the household size, the poverty, and age were attributing factors in the increased number of Covid-19 cases in New York City. The results indicated that household size, poverty and age were positively correlated with the confirmed number of Covid-19 cases in NYC.

"I wish, there were designated places to quarantine away from personal homes. A lot of families have limited space in their home. If a family member were to contract the virus, there isn't extra room/bathroom to quarantine."

"I did not have severe symptoms but some fever. Still, I had to quarantine. However, due to the lack of enough space in my family home, my friend and I found a remodeled home for quarantine. If there is a government facilitated place for quarantining, that would be good."

Theme 4: Facing hardship of covid through collective resilience and hope

In the wake of COVID-19, the government used public health policies and social media to educate the public about the global pandemic of Covid-19 and the data about the spread of the virus in the country. Social media platforms certainly reached out to a majority of people but this publication channel made critical mistakes. For example, at the time of the outbreak, the news of coronavirus, its meaning, and how to prevent it and exercising a contact tracing process were presented in the English language, thus the public health information had its own limited audience. Bhutanese minority individuals and communities at large were not aware of the access to hotlines, medical care, and educational welfare resources. Ethnic language-based communication would help individuals and minority groups to decrease the risks of contracting the virus and receiving needed resources. Bilingual (English-Nepali) translation facts into other languages, such as Nepali quickly allowed for faster and broader circulation of information, decreased exposure to the virus. Also, translating information while keeping cultural concepts in mind remains vital for saving lives from COVID-19. The strength of the Bhutanese local minority group's strong sense of community, collective resilience and bilingual (English & Nepali) Bhutanese community leaders were the key to handle the challenging time. Despite the disconnection between the larger community and the Bhutanese minority group led them to overcome the threat of Covid-19. They were optimistic and satisfied with their lives and expressed a positive outlook for their children's future in the United States. The Bhutanese minority group's collective culture and their cultivating hope are the sustaining tools to face the hardship during Covid 19 in their new country, the United States.

"The Bhutanese people shopped for us for what we needed because our family was in quarantine. Bhutanese leaders talked to community members about needed and helpful information."

"Our Bhutanese families have been a great help during the time our family experienced Covid. Yes, we live close by with other Bhutanese community so we feel connected. We were giving each other safety information, so it all worked out"

"Very satisfied here. Our family did not have much back in the refugee camp. We did not have much food or appropriate clothing. Going to school was not easy. Here we find jobs, food assistance is available. Compared to life in camp, life in U.S. is better. I am hopeful about my future here."

4. Limitation of the study

Even though the Bhutanese minority community population had increased over the years in the Northeast Pennsylvania, the study findings may not be generalized to other suburban Bhutanese populations in the United States. Every city or town has their own unique composition, needs and qualities based on their own population. Furthermore, the small sample's size, along with the non-random nature of the sample itself, does not present to be representative of the larger population. However, the study's outcomes are generated from the qualitative data and provides an in-depth view of each Bhutanese minority individual's lived experiences and their effects on Bhutanese group's attempt to overcome the harsh reality as a community during the peak of Covid-19. For future, it will be valuable to study focusing on the Bhutanese leaders' experience working with their own community members during COVID-19 in the US.

5. Discussion and recommendations

According to the Center for Disease Control (CDC) Mental Health of 2021, the individuals and minority groups' living and working conditions, and their health circumstances and health inequalities were the causes for further consequences for contracting or exposure to the Covid-19 virus. Jay, Nsoesie, Lipson, Jones, Galea, & Raifman (2020) study stated that the primary strategy for limiting the spread of Covid-19 is physical distancing among people. However, minority people who live in a socially dense household/neighborhood are essential workers who can't afford to stay at home and they do not have enough space to distance themselves at home; if they are exposed or tested positive with Covid-19. Household income is a strong indicator of whether or not individuals can stay home to lessen the risk of Covid 19 exposure and that higher socioeconomic position leads to greater opportunity for good health.

What does the U.S. need to do to focus its efforts to avoid the health disparities among minorities and people of low socioeconomic status? Even before the outbreak of Covid-19, minority groups already live in disparity situations such as higher rates of chronic conditions and other health conditions, less access to health care, lower income, and being disconnected from the community at large (Alman & KFF, 2020). The CDC Mental Health of 2021 states that collaborative action with community organizations (faith-based organizations/institutions, schools, and cultural centers) would be an effective way to close the gap of social and health care disparities among minority populations. Bentley et al. (2020) study with Somali refugee communities in the U.S. reports that the Somali refugee population already has health vulnerabilities and has experienced health system gaps prior to Covid-19. The study suggests that the public health agency should utilize the Somali faith-based community to provide needed services. For the Somali community, faith is their way to develop resilience and build community bonds which typically have high rates of trauma and barriers to health care. Kluge, Jakab, Bartovic, D'Anna, & Severoni. (2020) reports that refugee and migrant populations are fearful to seek medical treatment or disclose symptoms due to stigma. These minority groups should receive Covid-19 information with culturally and linguistically appropriate information. Meanwhile, medical facilities need to identify individuals who need to treat underlying conditions to lessen their further risk to Covid-19 virus. The collaboration with faith-based organizations and other local ethnic minority community leaders would be an effective way to spread ethnic-language COVID-19 information and community resources to their own community members. Leaders of faith-based organizations and local ethnic minority communities are heavily involved in the community. These organizations and the leaders are positioned themselves to relay important information to their members. Rinker & Khadka

(2018) study with Bhutanese leaders and their members in the Greensboro, Highpoint and Winston-Salem area in North Carolina reports that co-creating community is the solution for creating positive connections, empowerment, and resiliency among Bhutanese members. Soller, Goodkind, Greene, Browning and Shantzek (2008) study with recently resettled refugees also found that perceived family support and a welcoming community from non-ethnic community members (Schultze, 2018) were positively associated with community attachment and having a better access to resources. Praetorius, Mitschke, Avila, Kelly & Henderson (2016) study with 65 Bhutanese women living in the Southwest, U.S. also reinforced how community-based empowerment models can help on refugee mental health and well-being. Grant's study (2020) shared examples of refugees and asylees' contribution to their communities during Covid-19. On the local level, refugees and asylees have had active roles in supporting the essential workers during the Covid-19. There have been refugees and asylees efforts to aid Covid responses such as recently resettled female refugees in New York to create personal protective equipment for hospital workers. Also, refugee women in Chicago made masks for frontline workers. Furthermore, Mera Kitchen Collective in Baltimore empowered refugees and immigrant women to distribute prepared meals to some of the laid off workers and people in need.

Conclusion

The future of refugee or immigrant resettlement in the U.S. is unclear. However, the United Nations High Commission for Refugees (UNHCR) addressed the key concepts of adaptation, mutual aid, and community building. This empowerment model encourages refugees to take a more active role in the reconstruction of their lives and communities. Numerous studies and government data revealed people of color suffer disproportionately from COVID-19 due to increased chronic conditions and health and socioeconomic disparities. Refugee groups' enhanced acquisition of knowledge, skills and a strong sense of community cohesion and positive cultural integration into the broader community would improve overall mental health and quality of life for refugees (Frounfelker, Assefa, Smith, Hussein & Betancourt (2017) & Benson, Sun, Hodge & Androff (2011). Community health care outreach, social welfare system and community institutions need to build relationships with leaders of local minority organizations in order to provide culturally and linguistically appropriate information about treatment, care and prevention of Covid-19 as well as closing the gap of health care and economic disparities in the future.

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