Experiences of COVID-19-Related Stigma: A Qualitative Study on Nurses Caring for Patients With COVID-19

Makoto TSUKUDA1* • Tomonori KAYANO2 • Yoshiyasu ITO3

ABSTRACT

Background: Healthcare workers caring for patients with Coronavirus Disease 2019 (COVID-19) have been a primary target of stigmatization and discrimination during the COVID-19 outbreak. Thus, there is an urgent need to develop a support system for Asian healthcare workers who care for patients with COVID-19.

Purpose: This study was designed to understand the characteristics of COVID-19-related stigma experienced by nurses caring for patients with COVID-19.

Methods: A qualitative content analysis methodology was used. This study was conducted between April 2020 and March 2021. The participants were 10 female registered nurses working at three medical facilities that accepted patients with COVID-19. The data included specific narratives on the instances of stigma experienced when caring for patients with COVID-19, including connected situations and ideas. The data were collected using focus group interviews with three or four participants in each group. Data analysis was conducted based on the inductive qualitative analysis approach of Krippendorff.

Results: The content analysis identified two categories and seven subcategories of stigma experienced by clinical nurses. The category “directly experienced prejudice and discrimination” included the subcategories “being avoided,” “being treated as dirty,” “discrimination toward family members,” and “others praying.” The category “self-imposed coping behavior” included the subcategories “keeping oneself apart,” “feeling guilty,” and “nondisclosure.”

Conclusions/Implications for Practice: The participants internalized their experiences of stigma, as Japanese culture emphasizes keeping such things to oneself. Therefore, there is an urgent need to strengthen the support system for nurses who care for patients with COVID-19. This study addressed the problem of the stigmatization of these nurses and their families by others as well as their colleagues. The main findings were that stigma was directly experienced as discrimination and prejudice and often resulted in self-imposed coping behavior. The major implication of these findings is the need to establish systematic, active, and ongoing organizational support programs for nurses who are discriminated against because of COVID-19-related stigma.

KEY WORDS: stigma, COVID-19, focus groups, nurses, qualitative content analysis.
showed that patients with schizophrenia perceived themselves as socially rejected and oppressed by others. The basis of this was the fact that other people generally displayed their disinclination toward communicating with them, stayed at a distance from them out of fear, behaved aggressively toward them and their families, and humiliated and ridiculed them with incorrect judgments (Rezayat et al., 2019). This type of stigmatization is associated with depression and is known to adversely affect the mental health of patients (Dickerson et al., 2002; Pellet et al., 2019; Rossi et al., 2017).

Apropos of COVID-19-related stigma, healthcare workers caring for those affected by COVID-19, in particular, have been at the receiving end of the stigmatization (Chopra & Arora, 2020). Similar to the effects of stigma experienced by the patients with schizophrenia in the study mentioned above, social avoidance by family and friends of healthcare workers, because of the nature of their healthcare workers, has been associated with depression, anxiety, and stress (Zhu et al., 2020). Thus, akin to the stigma associated with patients with schizophrenia, COVID-19-related stigma affects the mental and physical well-being of healthcare workers (Do Duy et al., 2020). For example, doctors and nurses in Mexico were forced to use bicycles because they were reportedly denied access to public transport and were subjected to physical assaults. In Malawi, healthcare workers were reportedly barred from using public transport, insulted on the street, and evicted from rented apartments. Moreover, in India, media reports revealed that doctors and medical staff dealing with patients with COVID-19 faced substantial social ostracism—they were ordered to vacate rented homes and were even attacked while carrying out their duties (Bagcchi, 2020).

However, despite such reports, not enough is known about the COVID-19-related stigma experienced by healthcare workers, and few studies have focused on this topic, although nurses are the most predominant among all the healthcare workers involved in caring for patients with COVID-19. There are reports that Asians around the world are being discriminated against because COVID-19 originated in China. Besides, Asian healthcare professionals around the world may also be experiencing stigmatization (Cheah et al., 2020; Piotr & Michal, 2020). To provide support for healthcare workers experiencing stigma, it is necessary to analyze the characteristics of stigma experienced by Asian medical professionals and build support systems. It is a well-known cultural characteristic of Japan that expressing impatience and negative thoughts is frowned upon (Purnell, 2013). However, nurses in particular tend to prioritize patient care over self-care. It has been suggested that the stigmatizing attitudes of people in Japan are stronger than those in other countries because of institutionalism, lack of national campaigns to tackle stigma, and the value society places on conformity (Ando et al., 2013). By exploring the characteristics of stigma in Japan, we believe that we can build a support system for Asian medical professionals around the world who are stigmatized because of COVID-19. Therefore, this study was developed to explore the characteristics of COVID-19-related stigma as experienced by nurses in Japan, with a specific focus on nurses working at medical facilities that accept patients infected with COVID-19.

### Methods

#### Theoretical Framework

Stigma is defined as “a mark of shame or frustration that causes an individual to be rejected, discriminated against, or unable to participate in various areas of society.” The reality of stigma is described as consisting of three interrelated aspects: perceptions of responsibility and danger, feelings of anger and fear, and avoidance and repression behaviors (Corrigan & Shapiro, 2010). These formative factors include “demographic characteristics” such as age, gender, and education; “biomedical and psychosocial knowledge” about the affected person’s illness and experiences; “knowledge about the harmful effects of stigma” regarding the impact of discrimination and prejudice on society; “perception about risk of morbidity” regarding the affected person’s own risk; “perception about risk of economic and social disruption” regarding the risk of economic and social disruption by the affected person; and “experience of contact with affected individuals” regarding opportunities for contact with the affected person and the presence of the affected person in family and friends. The social problems caused by the presence of stigma included “discrimination/prejudice,” “rumors/bullying,” and “avoidance of receiving behavior” (Griffiths et al., 2008; Stangl et al., 2013; Turan et al., 2017). In particular, this study targets nurses who not only are involved in COVID-19 but also carry out their roles to ensure that people in society are not affected by COVID-19. Therefore, this study covered all the elements that are experienced or felt as described above (Figure 1).

#### Design

A qualitative content analysis methodology was used in this study. When conducting exploratory work in an area about which little is known, content analysis is suitable for the basic description of common issues mentioned in the data (Vaismoradi et al., 2013). When a phenomenon has not been well researched or existing knowledge is not integrated, an inductive approach to content analysis is recommended (Elo & Kyngäs, 2008). This study aimed to explore the characteristics of COVID-19-related stigma experienced by nurses. Considering that COVID-19-related stigma experienced by nurses in the aforementioned context has not been well researched and that such knowledge remains fragmented, the inductive content analysis method was used.

#### Participants

Ten female registered nurses who were ward chief nurses working at three medical facilities accepting patients with
COVID-19 in the Hyogo area in Japan comprised the study’s participants. The inclusion criteria were as follows: (a) involved in caring for patients with COVID-19, (b) having experienced negative attitudes from others because of their role in providing care to patients with COVID-19, and (c) working in the position of chief ward nurse. The justification for the latter is that chief nurses may possess aggregated information about nurses’ experiences of COVID-19-related stigma through their support and management of other staff nurses.

The chief nurses at each of the three targeted hospitals used purposive sampling to recruit qualified participants. In this purposive sampling, intensity sampling was employed, and participants with richer information about their experiences of COVID-19-related stigma were selected.

Data Collection

Focus group interviews

Three focus group interviews were conducted between December 2020 and January 2021. Focus group interviews were conducted because they have the advantages of elucidating both individual and shared views on a topic and of providing rich information (Krueger & Casey, 2015). Each focus group consisted of three or four participants from the same workplace to ensure the smoothest possible communication. An example of a key question was, “Have you ever experienced prejudice or discriminatory attitudes from people around you because you are a nurse working with patients with COVID-19?” To collect data, a semistructured interview was conducted, and an interview guide was used that included opening and introductory questions, transition questions, and key questions. The interview guide focused on any prejudice or discriminatory content received from others because the nurse worked with patients with COVID-19.

Sample questions included “What have you heard from colleagues about negative experiences they have had from others related to COVID-19?”, “Please share your negative experiences and thoughts received from others related to COVID-19.”, “Do you worry about whether you will be discriminated or prejudiced regarding COVID-19?”, and “When you feel at ease, how you deal with your worries?” The focus group interviews began with opening questions to make the participant feel comfortable conversing. Introductory questions were then asked to identify the focus topics and encourage conversation between participants. Thereafter, transitional questions were asked to bring the conversation closer to the key questions. All of the focus group interviews were conducted by one interviewer and one recorder/observer to encourage the participants to speak. The interviews took between 1 and 1.5 hours to complete. Together with our coresearchers, we determined and confirmed that no further interviews would provide additional data, and we ended data collection based on theoretical saturation. The focus group interviews were held in a quiet, private room in the participants’ workplace. The conversations were digitally recorded and converted to text data for analysis.

Ethical Considerations

The institutional review board of the College of Nursing and Research Institute of Nursing Care for People and Community, University of Hyogo, approved the scientific and ethical validity of this study (Approval Number 2020F12). All of the
participants received both written and oral explanations regarding the significance, purpose, and methods of the study; the voluntary nature of participation; how personal information would be protected; and how the study results would be published. It was also explained that the participants would not be disadvantaged if they did not participate in the study or withdrew. Signed consent was obtained from all of the participants. None of the participants withdrew from the study.

Data Analysis
Analysis was done using inductive content analysis. Data analysis was based on the qualitative analysis approach of Krippendorff (2004). Inductive content analysis was conducted in three phases, including the “preparation phase,” “organizing phase,” and “reporting the analyzing process and the results” (Elo & Kyngäs, 2008). The preparation phase consisted of selecting the unit of analysis and making sense of the data as a whole. The entire interview was selected as the unit of analysis in this study, and the interview data were read repeatedly to understand their meaning and obtain an overall understanding. The organizing phase consisted of open coding, coding sheets, grouping, categorization, and abstraction. In the open coding phase, the interview data were read while writing notes and headings, and codes were created to explain all aspects of the content while rereading the written memos and headings. The codes created were collected in a coding sheet. Then, all of the collected codes were grouped based on similarity of semantic content. At this point, subcategories were created and the subcategories were classified into categories of higher abstraction levels. In this process, open coding was conducted independently by each of the three researchers to collect codes without omission from the interview data, and the interpretation and grouping of similar semantic content and the creation and abstraction of categories were conducted through repeated discussions among the researchers.

Rigor

Credibility
Credibility may be defined as the level of confidence assigned to the truth of specific research findings (Korstjens & Moser, 2018). All of the research team members involved in this study shared a common coding list that was created from precoding work and referenced during the coding process. When adding a code that was not on the list, we checked the content and code names among the members each time and added the code to the code list. Up to this point in this study, the analysis was carried out in the local language (Japanese), which enhanced the trustworthiness of the phenomenon.

Confirmability
Confirmability is largely an issue of presentation and refers to the objectivity or neutrality of the data (Polit & Beck, 2006). We confirmed the transcripts among the members of each area and confirmed that there was no bias in the coding process. We recorded the topics that were unique and interesting during data collection and shared them within small group meetings. Several small group meetings were held to continue the discussion related to data analysis.

Dependability
Dependability refers to stability, that is, the extent to which data change over time and the resulting alterations made to researcher decisions during analysis (Lincoln & Guba, 1985). During the entire research process, discussions about dependability were conducted among the research team members, and efforts were made to accurately describe the background of the study, data collection methods, and the entire process from data analysis to the derivation of results.

Transferability
Transferability refers to the degree to which the results may apply to other settings or groups and the number of informants or study objects (Lincoln & Guba, 1985). Transferability was ensured by the researchers providing a thick description of the participants, research setting, data collection techniques, and time frame for data collection.

Authenticity
A rich, vigorous, and fair presentation of the findings with appropriate quotes and examples of the abstraction and interpretation processes was outlined to ensure authenticity (Graneheim & Lundman, 2004; Graneheim et al., 2017). To establish credibility and trustworthiness, peer debriefing and member checking were conducted (Holloway, 1997; Thomas & Magilvy, 2011). In member checking, the primary researcher received a peer debriefing from an experienced researcher. The primary researcher was supervised by an experienced researcher throughout this study on the issues of reflexivity and depth description (Holloway, 1997).

Results

Characteristics of the Participants
All of the participants were female, and their ages ranged between 37 and 61 years (mean: 48.0 ± 7.2 years). Their average number of years of experience as registered nurses was 25.7 ± 6.4 (range: 15–36), and their average number of years of experience as ward chief nurses was 3.7 ± 1.6 (range: 2–6). All of the participants had family members living with them.

Content Analysis Findings
Content analysis extracted two categories consisting of seven subcategories of stigma experienced by clinical nurses. These
categories were “directly experienced prejudice and discrimination” and “self-imposed coping behavior.” The categories, subcategories, and examples of participants’ narratives are summarized in Table 1.

**Category 1: directly experienced prejudice and discrimination**

The category “directly experienced prejudice and discrimination” consisted of four subcategories: “being avoided,” “being treated as dirty,” “discrimination toward family members,” and “others prying.”

**Being avoided**

The participants discussed their experiences of being avoided by others. In particular, the participants experienced being avoided not only by the direct words and actions of others but also through sensing their own avoidance from the attitudes and atmosphere expressed by others. This was expressed in the narratives of “appearance of being avoided” and “feelings of being avoided.” Furthermore, these forms of stigma were experienced as coming not only from other people in general but also from nurses, other medical staff, and their families working at the facility. Examples of participants’ narratives follow below:

I’m not exactly sure that people are actually avoiding me, but I wonder if that’s the case.

They don’t say, “Don’t come here” or “Don’t come close,” but I can feel it in the air.

**Being treated as dirty**

The participants experienced being treated as “dirty” by others. This experience of being treated as dirty by other healthcare professionals or family members stemmed from being involved with a patient with COVID-19 or actually being told by others that they are dirty. Similar to the experience of being avoided by others, the participants were treated as dirty by others, resulting in their feeling dirty after interacting with patients with COVID-19. This phenomenon was emphasized by the healthcare professionals engaged in the medical and nursing care of patients with COVID-19. Examples of actual narratives follow:

They wear gloves when they handle anything that I have touched with my bare hands.

I’m asked: “Why are you here?”

My laundry is done separately.

**Discrimination toward family members**

Families of nurses involved in caring for patients with COVID-19 were considered sources of stigmatization because of anxiety about their being mistreated by others. Participants discussed being treated as if their family members were infected or that their family members might be treated as if they were infected. Examples of actual narratives follow:

I had to keep my children home.

Because people know my job, I think they’re avoiding my family.

**Others prying**

Nurses working at a COVID-19 receiving facility treating patients with COVID-19 and the families of these nurses experienced a form of discrimination that encouraged some nurses to take measures not to be noticed or addressed by others. In addition to the work done by the participants, their family members also experienced individuals prying into the participant’s work. This resulted in the participants spending

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**Table 1**

**Categories and Subcategories Identified by Content Analysis**

| Category                                      | Subcategory                      | Example of Participants’ Narratives                                                                                                                                 |
|-----------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Directly experienced prejudice and discrimination | Being avoided                   | I’m not exactly sure if people are actually avoiding me, but I wonder if that’s the case.                                                                            |
|                                               | Being treated as dirty           | They wear gloves when they handle anything that I have touched with my bare hands.                                                                                |
|                                               | Discrimination toward family members | I had to keep my children home. Because people know my job, I think they’re avoiding my family.                                                                   |
|                                               | Others prying                    | My family is frequently asked whether I deal with patients with COVID-19.                                                                                         |
| Self-imposed coping behavior                  | Keeping oneself apart           | I can’t just purposely or casually go out.                                                                                                                        |
|                                               | Feeling guilty                   | I feel like I’m doing something bad and can’t tell anyone about it.                                                                                                |
|                                               | Nondisclosure                    | I tell my family things about the hospital but asked them not to tell anyone.                                                                                      |
time worrying that they and their families would be asked about by others. Examples of actual narratives follow:

When I meet people, they try to find out about my work.

I walk without being noticed by others so that our eyes don’t meet.

My family is frequently asked whether I deal with patients with COVID-19.

**Category 2: self-imposed coping behavior**

The category “self-imposed coping behavior” consisted of three subcategories: “keeping oneself apart,” “feeling guilty,” and “nondisclosure.”

**Keeping oneself apart**

“Keeping oneself apart” refers to participants voluntarily keeping away from others and their experiences of being avoided by others. These experiences encouraged the participants to distance themselves and to avoid others to avoid being stigmatized. Moreover, keeping oneself apart is not only a defensive action against stigmatization but also a deliberate attempt to prevent the spread of infection to others. An example of this narrative follows:

I can’t just purposely or casually go out.

**Feeling guilty**

The participants expressed feeling guilty about being involved with patients with COVID-19 and feeling that they could not be infected because they were medical professionals. Moreover, they were accused by others of being infected. Examples of actual narratives follow:

I’m not told directly, but people express unease when I do normal, everyday things.

I feel like I’m doing something bad and can’t tell anyone about it.

If I become the first one infected, I won’t be able to return to work.

**Nondisclosure**

This form of stigma encourages participants not to disclose to others that they are involved in caring for patients with COVID-19 or that they are a nurse. It is viewed as a defensive action taken by the individual or their family. In addition, the participants discussed what they did not want others to know and what neither their family nor they would disclose. Examples of actual narratives follow:

I don’t openly say that I deal with patients with COVID-19.

I hide the fact that I’m a nurse.

I tell my family things about the hospital but ask them not to tell anyone.

**Discussion**

In this study, the characteristics of COVID-19-related stigma experienced by professional nurses in Japan were identified. The initial hypothesis was that their identity as healthcare professionals was the main factor causing nurses to experience COVID-19-related stigmatization and that this factor was influenced by traits specific to Japanese culture. Two categories and seven subcategories were delineated to depict the nature of COVID-19-related stigma. On one hand, stigmatization experienced was described as “being avoided” and “being treated as dirty.” On the other hand, the participants' reactions and behaviors in the face of this stigma were classified as “keeping oneself apart” and “nondisclosure.” These measures may be motivated by their medical knowledge of COVID-19 infection prevention methods and by self-care measures used to protect their own mental health. Furthermore, the families of the participants were also identified in this study as targets of COVID-19-related stigma.

Nurses comprise the category of medical care workers that most frequently deals with patients with COVID-19. As healthcare professionals, nurses scrupulously exercise standard precautions, wear personal protective equipment, and enforce anti-infection measures when dealing with patients (Iqbal & Chaudhuri, 2020; Tabah et al., 2020; Unoki et al., 2020). Meanwhile, it has been reported that nurses fear contamination while in contact with infected patients (Galehdar et al., 2020). Consequently, intimidated by the threat of “feeling oneself as dirty” or “being made to feel guilty if infected,” nurses feel a natural inclination to distance themselves from others. This also leads to their being treated as unclean by people in their lives, including their own families. Consequently, nurses socially distance themselves from others. It is precisely because of their fear of becoming infected that they stringently impose anti-infection measures on others and restrictions on themselves.

Studies on stigma-related to HIV, mental disease, and SARS have reported risk awareness and fear of arousing avoidance, repressive attitudes, and related behaviors (Corrigan & Shapiro, 2010; Lee et al., 2005; Person et al., 2004). Current knowledge regarding COVID-19 remains unclear, and protocols related to preventive measures and treatment methods are still far from complete. In contrast to SARS and influenza, which are transmissible through personal contact and droplets, COVID-19 has been characterized as a disease contractable via asymptomatic transmission (as early as 2 days before onset).

This has led to suspicion and fear among the general public, which has been further fueled by the media. The rapid spread of COVID-19 caused a level of panic in Japan that significantly exceeded that experienced during the SARS outbreak. Increased fear and the perception of latent threats are factors that increase stigma. With the unprecedented spread of COVID-19, stigma against nurses and other healthcare workers has never been stronger. Hence, a vague fear of COVID-19 exists, with the ensuing avoidance/suppressive
behavior giving rise to feelings of “being avoided” and “being treated as dirty” as well as the counterreaction of “nondisclosure” adding to this perception of stigma (Midorikawa et al., 2021). Meanwhile, it is evident that COVID-19-related fear and avoidance behaviors promote anti-infection behaviors such as handwashing and hand disinfection (Wakashima et al., 2020). Accordingly, as a measure against stigma rooted in COVID-19, vague fear and avoidance behaviors should be eliminated, and the conquest of that fear based on accurate knowledge and anti-infection measures based on the true nature of COVID-19 is essential (Nguyen et al., 2020).

In Japan, stigma is distinctly characterized by the fact that, rather than being directly expressed, it is more often sensed in people's attitudes, the atmosphere during interactions, and eye signals (Ando et al., 2013). Furthermore, while going about their daily lives, individuals anticipate such attitudes, which causes additional anxiety and fear. Thus, nurses avoid disclosing the fact that they care for infected patients and even try to conceal their identity as a nurse. As Japanese culture discourages making negative disclosures, related interactions typically occur behind closed doors. Thus, although numerous medical facilities were approached to participate in this survey, most were reluctant to disclose stigma-related information and thus declined. Furthermore, the well-entrenched seniority system in Japanese society actively discourages newer nursing recruits and nurses in vulnerable positions from revealing negative stigma-related information. Moreover, it is feared that fatigue will set in. In particular, nurses are sometimes required to take responsibility for their own care, as they are expected to place the highest priority on patient care, even when this may be detrimental to their own health and well-being. The occurrence of stigma because of these factors may be a cultural feature unique to Japan. However, concerns about healthcare providers disclosing their involvement with patients with COVID-19 have also been reported in other Asian countries (Do Duy et al., 2020). Therefore, this may be a common feature of COVID-19-related stigma. Outbreaks of emerging infectious diseases have an inherent, developmental nature and are affected by scientific uncertainty. As such, they are often a source of great fear not only for the general public but also for certain communities such as healthcare professionals—especially when case numbers and deaths are high. The spread of misinformation on social media may have also exacerbated tensions and anxiety among healthcare workers (Perera et al., 2021). Alleviating the fear and discrimination directed at those infected or affected by infectious diseases is important in controlling transmission. With regard to the SARS outbreak in the United States in 2003, support systems such as “Employee Assistance Programs” were established. However, their low rates of utilization (only a few percent) indicate that much more still needs to be done. Firstly, there is a need for a policy framework to ensure that physical provisions such as personal protective equipment against infectious diseases are not exhausted. In addition, it is also necessary to provide psychological support to healthcare workers and their families and set up a third-party organization in the workplace to create an atmosphere in which negative content may be discussed. When medical staff are unable to express their psychological distress, including stigma, they tend to hold it inside. Thus, it is imperative for Employee Assistance Programs by external organizations to provide active and continuous psychological support to medical staff and their families. Policy-based systems are necessary to make substantive improvements in stigma amelioration (Cabarkapa et al., 2020; Khanal et al., 2020). Correct information about the spread of the virus and safety measures must be regularly communicated, as the nature of the spread of COVID-19 will change as the virus mutates and as vaccines are developed. Similarly, stigma may also change, making it a dynamic issue that should continue to be investigated.

Limitations
One limitation affecting this study is that this investigation was conducted during the COVID-19 emergency, when many healthcare professionals were prohibited by their organizations from contacting outsiders. Thus, the research team was limited in terms of access. In addition, unwillingness to expose negative information to outsiders is a cultural characteristic of Japan. Therefore, the numbers of facilities and subjects able to obtain permission to participate in this research study were small.

On the basis of the results of this survey, continued investigation to obtain more detailed factors and develop preventive measures is necessary.

Conclusions
The stigma experienced by nurses may be grouped into two categories: (a) directly experienced prejudice and discrimination and (b) self-imposed coping behavior. In addition to stigma directed at the nurses in this study, stigma was also directed at their families. The nurses internalized this stigma and avoided revealing their perceptions and feelings to others. This attitude is characteristic of Japanese culture, which emphasizes keeping negative perceptions and emotions to oneself. The results of this study should be disseminated to help promote an atmosphere in which negative information can be expressed; to create a support system for third parties, including nurses who care for patients with COVID-19 and their families; and to encourage national initiatives to provide accurate information.

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Data analysis and interpretation: All authors
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Critical revision of the article: MT

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*Address correspondence to: Makoto TSUKUDA, PhD, RN, College of Nursing Art and Science, University of Hyogo, 13-71, Kitaqjo-cho, Akashi, Hyogo 673-8588, Japan. Tel: +81-78-925-9419; E-mail: makoto_tsukuda@cnas.u-hyogo.ac.jp

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