

EVALUATION OF THE QUALIFICATION PROCESS IN PRIMARY CARE FOCUSING ON THE VALORIZATION OF THE WORKER

EVALUACIÓN DEL PROCESO DE CUALIFICACIÓN EN ATENCIÓN PRIMARIA SE CENTRA EN LA VALORACIÓN DEL TRABAJADOR

AVALIAÇÃO DO PROCESSO DE QUALIFICAÇÃO NA ATENÇÃO BÁSICA COM FOCO NA VALORIZAÇÃO DO TRABALHADOR

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ABSTRACT

Objective: to evaluate the process of qualification in Primary Care focused on valuing the worker. **Method:** this is a descriptive, cross-sectional, exploratory study, with a quantitative approach, conducted in the Primary Care teams. The sample was made up of 43 nurses, representing 50% of the teams in the municipality that could be contracted in the first evaluation cycle. A semi-structured questionnaire was used for data collection. Data analysis was done using descriptive statistics with simple frequency of the selected variables. **Results:** there was a prevalence of professionals who had at least one year and at most two years (34.8%). As for the further education of these professionals, the same number of professionals in the sample was observed for two categories (34.8%). In the city, the prevalence of nurses' performance regarding the time of performance and professional qualification are above average (55.8%). When observing the stratum (48.1%), the state (48.1%) and Brazil (47.9%), the situation is inverted, and the performance prevalence is still average or a little below average. The permanent education activities presented a very satisfactory performance. However, the work relationship is precarious, generating instability and turnover of professionals, revealing a median performance. **Conclusion:** besides the need to program career plans that contemplate social protection, progression by performance evaluation and/or development is essential. **Keywords:** Primary Health Care; Workers; Health Management; Health Services Administration; Quality Management.

RESUMEN

Objetivo: evaluar el proceso de cualificación en la Atención Básica con foco en la valorización del trabajador. **Método:** estudio descriptivo, transversal, exploratorio, con abordaje cuantitativo, realizado en los equipos de Atención Primaria. La encuesta estaba compuesta por 43 enfermeros, lo que representa el 50% de los equipos implantados en el municipio que pueden ser contratados en el primer ciclo de evaluación. Como instrumento de recogida de datos se utilizó un cuestionario semiestructurado. El análisis de los datos se realizó mediante estadística descriptiva con frecuencias simples de las variables seleccionadas. **Resultados:** hubo una prevalencia de profesionales que presentaron un mínimo de un año y un máximo de dos años (34,8%). En lo que respecta a la formación complementaria de estos profesionales, se observa el mismo número de profesionales de la ostra para dos categorías (34,8%). En el municipio, la prevalencia de la actuación de los enfermeros en relación con el tiempo de actuación y la cualificación profesional son superiores a la media (55,8%). Al observar el Estrato (48,1%), el Estado (48,1%) y Brasil (47,9%), la situación se invierte y la prevalencia de desempeño sigue siendo mediana o un poco inferior a la media. Las actividades de educación permanente presentaron unos resultados muy satisfactorios. Sin embargo, el vínculo laboral es precario generando inestabilidad y rotación de profesionales revelando un rendimiento medio. **Conclusión:** más allá de la necesidad de programar planos de carrera que contemple a protección social, es imprescindible la progresión por evaluación de desempeño y/o desenvolvimiento. **Palabras clave:** Atención Primaria de Salud; Trabajadores; Gestión en Salud; Administración de los Servicios de Salud; Gestión de la Calidad.

RESUMO

Objetivo: avaliar o processo de qualificação na Atenção Básica com foco na valorização do trabalhador. **Método:** trata-se de um estudo descritivo, transversal, exploratório, com abordagem quantitativa, realizada nas equipes de Atenção Básica. A amostra foi composta por 43 enfermeiros os quais representaram 50% das equipes implantadas no município que poderiam fazer a contratualização no primeiro ciclo de avaliação. Utilizou-se um questionário semiestructurado como instrumento de coleta de dados. A análise dos dados foi feita por meio da estatística descritiva com frequência simples das variáveis selecionadas. **Resultados:** houve prevalência de profissionais que apresentavam no mínimo um ano e no máximo dois anos (34,8%). Quanto à formação complementar destes profissionais, observa-se o mesmo número de profissionais da amostra para duas categorias (34,8%). No município, a prevalência do desempenho dos enfermeiros quanto ao tempo de atuação e qualificação profissional se encontram acima da média (55,8%). Ao observar o Estrato (48,1%), o Estado (48,1%) e o Brasil (47,9%), a situação se inverte e a prevalência de desempenho ainda é mediana ou um pouco abaixo da média. As atividades de educação permanente apresentaram desempenho muito satisfatório. Entretanto, o vínculo de trabalho é precário gerando instabilidade e rotatividade dos profissionais revelando um desempenho mediano. **Conclusão:** além da necessidade de programar planos de carreira que contemple a proteção social, é imprescindível a progressão por avaliação de desempenho e/ou desenvolvimento. **Palavras-chave:** Atenção Primária à Saúde; Trabalhadores; Gestão em Saúde; Administração de Serviços de Saúde; Gestão da Qualidade.

INTRODUCTION

Health work is a collective process, essential for all human beings, and is part of the sphere of non-material production, since the final product is inseparable from the process that produces it. Thus, the very realization of the activity has as its purpose the therapeutic health action in which its object is the individual in its singularity or the collectivity. Presents the knowledge in health and the technical level of knowledge as a working tool; and the final product is the provision of health care^(1,2). The work process (WP) in healthcare is compartmentalized, that is, each professional group is organized and provides part of the assistance separately from the others, causing duplication of actions and even generating contradictory attitudes due to the division of WP and the fragmentation of tasks^(1,2). The Family Health Strategy (FHS) is considered the way to break the division of the WP in search of accountability for the community and humanization of health practices in overcoming the team as a grouping of professionals^(3,4).

This team must base its actions on the principle of integrality, which contemplates the concept of care seen as an integral and integrated action in an area of communion of various knowledges and doings of different actors in search of the production of health actions with the overcoming of the Cartesian, fragmented vision, of the juxtaposition of different professionals and fragmentation of care present in the daily life of health services⁽⁵⁾. However, to achieve this goal, the indispensable condition is

the team as integration of work and articulation in a new dimension, which is interdisciplinarity in search of transdisciplinarity in order to provide a reciprocal relationship of communication and interaction⁽³⁾. This new way of doing admits the diversity of action, seeking the interrelation of professional tasks with the passage from a work that is only individual to a collective action⁽⁴⁾.

The way the team should work is defined as the way in which professionals rearrange themselves to assist a person, family or group in a holistic way, becoming a tissue of relationships between different knowledges, powers, social classes, enabling a permanent movement of construction, deconstruction and reconstruction through moments of greater interaction of work and life, (dis)articulation, (dis)encouragement, creation and invention, (non) knowledge, trust, strangeness, cooperation, aiming at the common purpose: care⁽⁶⁾. The collective responsibility results in collective management with cooperation and trust, enabling the construction of a bond of union, where the absence of trust and the rotation of professionals result in fragmentation of the work, interfering with the quality of care, since working in a team requires the management of a common knowledge that is guided by ethical values that underpin the collective choices⁽⁵⁾.

The precarious work, characterized by the absence of social protection, with the loss of labor and social security rights, along with the lack of stability, low wages, inadequate working conditions, and long working hours, causes

psychic suffering that generates emotional instability, decreased quality of life (QL) at work, and difficulty in the effectiveness of care, WP is no longer something pleasurable, but rather martyrdom and sacrifice, because it produces physical and mental wear, increasing the risk of getting sick and dying of workers, characterized mainly by occupational and psychosomatic diseases and, consequently, influences the quality of care and the regularity of the professionals' work^(7,8).

In this sense, the QL at work is articulated to issues related to work management in which well-being at work is directly linked to the salary level, the way of entering the labor market, the degree of control over the conditions and organization of the WP allied to the effective existence of a Career, Positions and Salaries Plan (CPSP) which advocates training and qualification from the perspective of permanent education (PE), the Performance Evaluation Program (PEP), criteria for progression and promotion, the Personal Development Plan (PDP), shared management of the career between managers and workers⁽⁷⁾. The valorization of health workers and the lack of job security is one of the greatest challenges in the process of strengthening the Unified Health System (UHS), given the significant number of professionals hired in unconventional ways (service contracts, outsourcing, cooperatives) generating unstable relations and precarious bonds that do not guarantee the labor and social security rights enshrined in law, causing losses

not only for the workers but also for the users⁽⁹⁻¹¹⁾.

The Ministry of Health (MH), through Ordinance No. 1.654 GM/MH, of July 19, 2011, created the National Program for Improvement of Access and Quality of Basic Attention (PMAQ-AB) as the main strategy to induce changes in the operation of Basic Health Units (BHU) aiming at the progressive and permanent expansion of access and quality of care practices, management, and participation in Basic Attention (BA) with the guarantee of comparable quality standards nationally, regionally, and locally, resulting in greater effectiveness in health services with greater transparency of governmental actions. PMAQ-AB is organized in four complementary phases that make up a cycle of access and quality improvement in which the primary care teams must voluntarily adhere: (1) adhesion and contractualization; (2) development; (3) external evaluation (EE); and (4) re-contractualization. This program includes three evaluation axes: structure, process, and user satisfaction⁽¹²⁻¹³⁾.

Based on these premises, this study aimed to evaluate the process of qualification in the BA with a focus on valuing the worker.

METHOD

This is a section of a larger study entitled "Evaluation of Primary Health Care from the perspective of the National Program for Improving Access and Quality of Primary Health Care (PMAQ)" presented to the Department of

Graduate Studies in Health Sciences of the State University of Montes Claros (GSHS/UNIMONTES). Montes Claros – Minas Gerais, Brazil. 2012.

This is a descriptive, cross-sectional, exploratory study with a quantitative approach, conducted in the primary care teams of the municipality of Montes Claros during the PMAQ evaluation in 2012. The study was based on secondary data pertaining to the EE component available in the consolidated performance of the municipality based on PMAQ-AB data provided by the Department of BA/MH. The sample consisted of 43 primary care professionals from the municipality of Montes Claros, Minas Gerais, Brazil. These represented 50% of the teams deployed in the municipality that could be contracted in the first evaluation cycle.

An introductory letter and an Institutional Consent Form (ICF) were sent to the Coordination of BA of the Municipal Health Secretariat (MHS) for study authorization. The institution was duly informed about the research guidelines and signed the ICF to authorize the research. Data collection was performed in the second half of 2012, during the EE held in October, by the responsible researcher.

We included in this study the primary care nurses who had been working in the institution for more than six months, who agreed to participate in the research and who showed up on the day and time scheduled for the interview. Professionals from other categories were excluded, as well as on-duty and outsourced

staff, and those who have been with the institution for less than six months.

A semi-structured questionnaire was used as a data collection instrument, based on the instrument of EE of the PMAQ-AB. For this study, the data from the questions of "Module II - Interview with health professional of the BA team and verification of documents in the BHU" were considered. For the construction of the analysis, the "Dimension III - Team concept: dimension and appreciation of the worker" was chosen, containing four sub-dimensions related to qualification, PE, work management, and career plan and variable remuneration.

Through the four subdimensions of Dimension III, the following categories were stipulated for the data analysis of this study: (1) length of service and qualification of the professionals of the BA team (Subdimension 1); (2) PE in the process of qualification of the actions developed by BA teams (Subdimension 2); (3) labor management: guarantee of labor and social security rights and the prospect of continuity of employment (Subdimension 3); and (4) career plan and variable remuneration (Subdimension 4).

Data were stored in the Statistical Package for the Social Sciences (SPSS®) database, version 20.0. They were tabulated and presented in tables through absolute and percentage frequencies, in which the Microsoft Excel® program, version 2010, was used for their construction. Data analysis was performed using descriptive statistics with simple frequency

of the selected variables, grouped according to teams, stratum, region and Brazil.

The study followed the ethical precepts established by Resolution No. 466, December 12, 2012, of the National Health Council (NHC), which regulates the conduct of research involving human beings. The research project was reviewed and approved by the Research Ethics Committee of the State University of Montes Claros (REC UNIMONTES), under consubstantiated opinion No. 126.227/2012. Certificate of Submission for Ethical Appreciation (CAAE) no. 04740012.2.0000.5146.

The participants were duly oriented as to the study guidelines, and signed the Informed Consent Form in order to authorize the research.

RESULTS

Regarding the time of nursing practice in the BA, there was a prevalence of professionals who had at least one year and at most two years (n=15; 34.8%), followed by those professionals with less than one year in the BA (n=10; 23.2%). Regarding the complementary training of these professionals, we observed the same number of professionals in the sample for two categories, being Residency in Family Health (n=15; 34.8%) and Specialization in Family Health (n=15; 34.8%) (Table 1).

Table 1 - Time of work and complementary education of the nursing professionals participating in the current PMAQ-AB. Montes Claros (MG), Brazil (n=43)

Variables	n	%
Time of performance		
Less than 01 year	10	23,2
From 01 to 02 years	15	34,8
From 03 to 05 years	09	21,0
More than 06 years	09	21,0
Complementary training		
Family Health Residency	15	34,8
Specialization in Family Health	15	34,8
No specialization	10	23,2
Master in Health Sciences	02	4,9
PhD in Health Sciences	01	2,3

Source: PMAQ-AB Database, 2012.

In Montes Claros, a medium-sized municipality, the prevalence of nurses' performance in the EE of PMAQ-AB regarding the time of performance and professional qualification is above average (55.8%). When observing the stratum (48.1%), the state (48.1%), and Brazil (47.9%), the situation is reversed, and the prevalence of performance is still median or

slightly below average (Table 2). It is noteworthy that the consolidated performance considered the time of work in the team associated with the professional's qualification performing a weighted average, comparing the value to the result of the municipality, stratum, state and Brazil.

Table 2 – Consolidated performance regarding the time of performance and qualification of the professionals of the BA team (Subdimension 1).

CONSOLIDATED PERFORMANCE								
Performance	Municipality		Stratum		State		Brazil	
	n	%	n	%	n	%	n	%
Way above average	09	21,0	396	15,9	395	15,2	2.790	18,1
Above average	24	55,8	900	36,0	961	36,7	5.283	34,0
Average or somewhat	10	23,2	1.204	48,1	1.261	48,1	7.442	47,9
Below average								
Total	43	100	2500	100	2617	100	15515	100

Source: PMAQ-AB Database, 2012.

In this sub-dimension, the existence of qualification actions for the professionals of the BA was verified through institutional support in health, such as: face-to-face and distance learning courses; activities related to the Telehealth Program; tutoring/preceptorship activities according to the demands and needs of the teams. Considering the PE in the process of

qualification of the actions developed by the BA teams, it can be observed that in Montes Claros the prevalence of nurses' performance in the EE of PMAQ-AB is well above the average (55.8%). This increase could be observed in the Stratum (55.4%). The state (35.4%) and Brazil (42.8%) still have average or slightly below average performances (Table 3).

Table 3 - Consolidated performance regarding the PE in the process of qualifying the actions developed by the BA teams (Subdimension 2).

CONSOLIDATED PERFORMANCE								
Performance	Municipality		Stratum		State		Brazil	
	n	%	n	%	n	%	n	%

Way above average	24	55,8	346	13,9	881	33,7	2.582	16,7
Above average	18	41,8	1386	55,4	809	30,9	6.286	40,5
Average or somewhat	01	2,4	768	30,7	927	35,4	6.647	42,8
Below average								
Total	43	100	2.500	100	2.617	100	15.515	100

Source: PMAQ-AB Database, 2012.

DISCUSSION

Length of experience and qualification of the professionals in the BA team (Subdimension 1)

The professional EE respondents in this study were 100% nurses; this result corroborates the result found in other studies^(8,14), in which the participation of nurses as informants and coordinator of the BA team corresponded to 92.3%. It is worth noting that in these studies^(8,14) there were no significant differences when analyzed by population size in which nurses predominated as coordinators and EE respondents in 2012. Since the recommendation of the MH within the PMAQ-AB is that the professional who responds to the interview should be the one who adds the most knowledge about the team's PW⁽¹³⁾.

The explanation for this result is based on the training of nurses, in which the national curricular guidelines for the undergraduate course contemplate in the general competencies that nurses should be able to assume leadership positions involving commitment, responsibility, empathy, decision-making, communication and management skills in an effective and efficient

manner with the community's well-being in mind, in addition to the management and administration of both the workforce, physical and material resources and information, in the same way that they should be able to be managers, employers or leaders in the health team⁽¹⁵⁾.

With regard to the length of professional experience described in Table 1, it is observed that most (58.0%) declared to have less than one year and up to two years of experience in the same team, revealing a low length of stay, a fact that can be attributed to the high turnover of professionals, which compromises the effectiveness of the BA; it is worth noting that the study⁽⁸⁾ revealed a national average of permanence in teams less than two years in 56.7% of respondents, resembling the result found in this research. The difficulty of fixing the professional in the workplace is often attributed to the dissatisfaction of the worker with working conditions, the absence or low conditions of professional advancement, the requirement of full workload are described as the cause and turnover as a consequence^(16,17).

Turnover can be understood as a consequence of both aspects external to the institution - the supply and demand situation of

human resources, the economic situation, and job opportunities - and factors internal to the organization linked to opportunities for professional and salary progression, the benefits policy, the physical and environmental working conditions, the policy for recruiting and selecting personnel⁽¹⁶⁾.

On the other hand, it is worth noting that 42.0% of the participants have been in the same team for at least three years, highlighting 21.0% who are inserted in the same BHU for more than six years, revealing the continuity of care and longitudinality, considered principles of BA, which allow a higher degree of bonding of professionals with families and communities, the establishment of ties between the various professionals who collectively provide assistance, besides favoring investment in training and improvement of the professional who remains for a long time in the same workplace^(16,17). Another aspect verified in this subdimension refers to the complementary training of higher education professionals participating in PMAQ-AB in family health, public health or collective health. This dimension refers to the flexible specialization component in which the defined quality standard concerns the qualified training both in terms of the workers' Lato Sensu and/or Strictu Sensu degrees and from the point of view of skills and competencies⁽¹⁸⁾.

The society requires quality assurance of health services provided by professionals, especially those of the BA, given the need for new professional profiles to work at the primary

level of care, in which professional qualification contributes to the acquisition of new skills and abilities specific to this level of care, resulting in greater resolvability of actions in the area of coverage through better technical and professional performance that reflects the improvement in work processes, planning and team interventions^(8,18,19). The reorganization of the BA requires a different professional profile with new skills and competencies to deal with the diversity of demands in addition to the need for a new daily work based on local reality and teamwork in an interdisciplinary way based on the sharing of knowledge, the ability to plan, organize, and develop actions directed to the community⁽²⁰⁾.

It is worth pointing out that the most outstanding difference between "Residency" and "Specialization" is the workload of each modality. While the specialization has a minimum duration of 360 hours, the Multiprofessional Residency programs must obligatorily fulfill the workload of 5.760 hours, distributed over two years and 60 hours per week. The value found in the study shows that the performance of the municipality is considered average, since the result presented by the MH⁽²⁰⁾ reveals that the percentage of teams participating in PMAQ-AB nationwide that had or were in complementary training was 83.4%, and in the state of Minas Gerais it was 80.8%. However, when evaluating the complementary training by degree and in the post-graduation modality of residency in family health, the result

is much higher than the national and state average.

Still on further education, contrasting with the results at the national level described in the study⁽⁸⁾ that found only 1.3% are residency completers and 3.2% have a master's degree and 0.7% a doctorate. The results of the first cycle of PMAQ-AB⁽²⁰⁾ revealed that in Brazil only 1.6% have residency in Family Health and only 2% at the state level. As for the Master's degree in Public/Collective Health, it represents 1.3% in Brazil and 1% in Minas Gerais. This standard of quality with higher qualification when compared to other studies is explained by the existence of Graduate Programs in the municipality, which is considered a university hub favoring access to greater professional qualification.

The existence of a flexible specialization appropriate to the specificities and singularities of the BA enables the team's professionals to use leadership skills and creativity, knowledge, skills, ability to produce innovations and deal with dissensions, conflict mediation, listening skills beyond the professional attributions in order to expand the team's ability to produce health in a shared and motivating way, resulting in better health indicators and consequently a satisfactory performance when compared to the stratum, state, and national references⁽¹⁹⁾ described in table 3.

PE in the process of qualifying the actions developed by the BA teams (Subdimension 2)

The PE as a component of autonomy granted provides a space for collective learning, resulting in training, production of subjectivity and work, which aims at facing and solving problems through increased diagnostic and planning capacity, in addition to autonomy in the implementation of transformative practices^(18,21,22). Communication within the health team should happen through a dialogical network, which promotes increased capacity for creation and transformation with more autonomy, always in a process of composition not only as a meeting of individuals, but as a collective policy, with a broader dimension of doing health⁽²³⁾.

In this dimension, a very satisfactory performance was denoted, revealing that the participating teams carry out PE actions, therefore, a health practice resulting from the relationship between professionals who continually seek new knowledge through interdisciplinarity, understood as an act of exchange, of reciprocity between knowledge, since reality is complex, requiring various points of view, because no one is the bearer of absolute truth, only in a relative way, requiring the exchange of views constituting a factor of transformation and freedom of professionals who break the barriers between the fields of knowledge and people in search of an integral and integrated care⁽²⁴⁾. In a study⁽⁸⁾ it was found that the larger the size of the city, the higher the

percentage of PE actions, revealing greater access to spaces for the qualification of professional practices, this situation was also found in the studied city, which is characterized as large.

Labor management: guaranteeing labor and social security rights and the prospect of continued employment (Subdimension 3)

The participating workers report that the contracting agent is the Direct Administration with a contract through a temporary contract by the public administration governed by special legislation, municipal and the form of entry was not through public competition or public selection, fitting into another form (appointment) and resulting in a precarious bond, instability and turnover of professionals, causing the precariousness of the work through the rationalization of costs, in addition to the relaxation of the public competition for statutory, making it possible to fill public positions by other means, such as contract, commissioned position, among others, resulting in labor backwardness⁽⁷⁾.

The reality found in this study is similar to the results of other studies, the consolidation documents of the PMAQ-AB data⁽²⁰⁾ present the direct administration as the contracting agent in Brazil in 73.8% of the teams and in the state of Minas Gerais, 88.8%. In the article⁽⁸⁾, the hiring by the direct administration occurred in 77.9% of the Brazilian teams.

With regard to the guarantee of labor and social security rights, the municipal administration guarantees those provided by the Consolidation of Labor Laws (CLL), but the way they are hired reveals the precariousness of the labor relationship. In this aspect, all the teams participating in the study had their performance classified as average or slightly below average, revealing an unsatisfactory result. However, the reality of temporary contract by the public administration is present in Brazil⁽²⁰⁾ in 15.6% of the teams and in Minas Gerais in 30.2%, thus evidencing precarious contract without the guarantee of continuity of PW, besides labor and social security rights.

Career plan and variable remuneration (Subdimension 4)

Regarding the existence of CPSP, the teams replied that the plan only considers the progression by seniority and by title and that there is no progression according to performance evaluation and/or development (merit) and there is no incentive, bonus, or financial award for performance. All the teams participating in the study had their performance classified as Average or slightly below average, revealing an unsatisfactory result. That being said, this is a loss for health care since the career plan is a powerful management tool, especially when added to subsidies such as bonuses, performance and progression by qualification.

The fragility of the incorporation of CPSP predominates in Brazilian municipalities

as evidenced by the result of the 1st cycle of the PMAQ-AB evaluation in which 77.4% of Brazilian municipalities do not have a career plan and in Minas Gerais, 76.5%, revealing the major challenges to be faced in the context of the PW in the BA^(8,20). It is worth noting that the existence of management strategies that provide stability, retention and appreciation of the worker, directly influence the continuity of care, the formation of the link with the user and the satisfaction of the user-worker binomial.

CONCLUSION

When analyzing the performance of the BA management in the dimension "valuing workers to qualify the teams and the work bond", it was found that the nurse is the professional who performs the function of coordinator of the BA teams, therefore being the respondent of the EE instrument during the first PMAQ-AB cycle. With regard to the length of stay in the same team, there was a predominance of periods of less than two years, revealing a turnover of professionals, compromising the continuity, longitudinality, and effectiveness of the BA.

As for further education, there was a prevalence of nurses who declared to have completed or to be attending some post-graduation course (Residency or Specialization *lato sensu*) so as to reveal a result well above the average within the municipality when compared to the performance of the stratum, the state and the national. As far as PE is concerned, the result also reveals a very satisfactory performance.

However, regarding Labor Management with the assurance of labor and social security rights and the perspective of continuity of the bond, the municipality still has to improve the entry into public service through public competition resulting in the lack of job security for PW, besides valuing the work with the implementation of CPSP that contemplates social protection, progression by performance evaluation, and/or development.

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