MSU CLUBS

McMaster University

World Health Organization

MACMUN 2017 | WHO Background Guide

MACMUN

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> *"There is nothing we can say to the world's children that can convince them the world needs to be the way it is. That means we must do everything we can to close the gap between the world as it is, and the world as it should be."*
> *– UN Secretary General Ban Ki-moon*

Committee Overview

Mandate and Function of the Committee

The goal of the World Health Organization (WHO) of the United Nations is to build a better, healthier future for people on a global scale. Headquartered in Geneva, Switzerland, with 194 member states, the organization was founded on April 7th 1948, a date celebrated globally as "World Health Day". In 1945, diplomats met in San Francisco and agreed that there has been insufficient collaboration between countries to control the spread of dangerous diseases across the world. Together, they decided on the need for a global organization overseeing global health, culminating in the creation of the WHO. Currently, the organization has 6 regional offices and a secretariat that works synergistically with governments and other partners, ensuring the highest attainable health for all people. WHO strives to combat diseases – infectious diseases like Zika, influenza and HIV, and noncommunicable ones like cancer and heart disease. The WHO ensures adequate air, food and water quality and emphasizes the medicines and vaccines they need. By looking at health trends and new threats, the WHO always seeks new opportunities to improve public health. The WHO hires top experts to examine critical health issues and define the best solutions by delivering and implementing the strongest recommendations. The organization helps to prepare countries for health emergencies, including the Ebola epidemic in West Africa, by determining necessary actions when these emergencies strike. The ultimate goal of the WHO reflects its slogan that "no country or person should miss out on the opportunity to live a healthy life in all aspects." The current objectives of the WHO are laid out in a Six-Point-Agenda.

The WHO has six leadership priorities in where progress on these priorities will accelerate the new Sustainable Development Goal (SDG) for health:

I. Advancing universal health coverage
II. Achieving health-related development goals
III. Addressing the challenge of noncommunicable diseases (NCDs) and mental health, violence, injuries, and disabilities
IV. Ensuring that all countries can detect and respond to acute public health threats under the International Health Regulations
V. Increasing access to quality, safe, efficacious and affordable medical products (medicines, vaccines, diagnostics and other health technologies)
VI. Addressing the social, economic and environmental determinants of health as means to reduce health inequalities between countries

Timeline History of the WHO

These dates are major historic accomplishments of the WHO and also help illustrate the function and significance of the WHO.

- **1948**: WHO constitution is passed and the organization starts its work by focusing on mass campaigns against tuberculosis (TB), malaria, yaws, syphilis, smallpox and many other communicable diseases transmitted from person to another, or by animal to person.
- **1950**: The discovery of present-day antibiotics begins and the WHO starts advising countries on their controlled usage.
- **Mid 1950's:** Jonas Salk and Albert Sabin discovered the poliovirus vaccine, paving the way for mass global campaigns facilitated by WHO, which have lead to the near eradication of polio.
- **1969**: The World Health Assembly establishes the first International Health Regulations, representing an agreement between the WHO member states allowing them to work together to prevent and respond to acute public health risks that have the potential to cross borders and threaten worldwide health.
- **1972**: Training in Human Reproduction (HRP) program is created within the WHO, the sole body within the UN system that possesses a global mandate to carry out research into sexual and reproductive health and rights.
- **1975**: WHO founds the programme for Research and Training in Tropical Diseases (TDR). This helps facilitate, support and influence efforts to combat diseases of poverty. As of 2016, five of eight diseases the programme was created to tackle are close to eradication.
- **1978**: The International Conference on Primary Health Care (ICPHC) in Kazakhstan sets the aspirational goal of the WHO: "Health for All." This lays down the groundwork for WHO's first leadership priority (advancing health coverage).
- **1979-1983**: A 12-year global vaccination campaign held by the WHO against smallpox is hailed successful as the disease is eradicated. Moreover, human immunodeficiency virus (HIV), which causes AIDS, is discovered.
- **1987**: WHO shifted its priorities as AIDS spreads globally and the first antiretroviral medication to control HIV infection and prevent its progression to AIDS is licensed.
- **1999**: Major players in global immunization, including the WHO, government representatives, leaders of the vaccine industry and many more, form a new partnership; the Global Alliance for Vaccines and Immunization (GAVI), whose role would be to overcome barriers and allowing millions of children worldwide to receive vaccines.
- **2000**: The largest gathering of world leaders adopts the Millennium Development Goals (MDGs). These goals had set a deadline for 2015 and included specific goals for health such as eradicating poverty and gender disparities in governments. Moreover, the WHO Global Outbreak Alert and Response Network (GOAR) is established to detect and combat international spread of outbreaks. This year was arguably the most important in WHO evolution and progression.
- **2003**: The World Health Assembly unanimously adopts WHO's first global public health treaty, WHO Framework Convention on Tobacco Control (FCTC), aimed towards reducing tobacco related deaths worldwide. A major "3 by 5" progression was also instituted to bring treatment to 3 million people living with HIV by 2005, and reaches 13 million in 2013.

- **2004**: Following the Indian Ocean Tsunami disaster, the Strategic Health Operations Centre (SHOC) is built to serve as the nucleus of the networks of emergency operations.
- **2005-2008**: The WHO sees its first successful campaign from its initiation, with the number of children who die before their 5th birthday declining below 10 million for the first time in recent history. By 2008, noncommunicable diseases (heart disease and stroke) emerged as the number one killers, globally. The WHO notes this global shift and strengthen its focus on non-communicable diseases. In 2012, global leaders signed off, for the first time in history, global standards to control and prevent heart disease, diabetes, cancer, lung disease and others.
- **2009**: The emergence of the new H1N1 influenza virus sees the world brace itself for the first influenza pandemic since 1968. WHO worked with collaborating centres on controlling the virus and developing vaccines in record time.
- **2014**: The biggest outbreak of Ebola virus disease strikes West Africa. The WHO Secretariat mounts an unprecedented response to the outbreak, deploying thousands of experts, support staff and medical equipment to the ground.
- **2015**: Delegates from around the world meet at the UN Summit to sign off on the 2030 Sustainable Development Goals (SDG's) which apply to all countries worldwide and move beyond the failed MDG's. The SDG's add economic, social and environmental objectives on top of the millennium goals in the promise of a more peaceful and inclusive global community.
- **2016**: WHO announces zero cases of Ebola in West Africa, but warns that the disease might flare up anytime and countries in the region need to remain vigilant and prepared. WHO convenes the Emergency committee, concluding that the neurological birth defects that appear to be related to the Zika virus among pregnant women, represents a Public Health Emergency of International Concern.

Who Pays for the WHO?

WHO is financed in part by dues paid by Member States. The amount that each Member State pays is calculated relative to the country's wealth and population. Additional financing comes from voluntary contributions which in recent years have accounted for more than 3/4 of the Organization's financing.

Simulation Style/Composition of the Committee

The World Health Organization will be composed of two chairs responsible for maintaining the course of debate in accordance to the National Model UN rules and procedures. The chairs will take on the role of the PGA including opening and closing each meeting, setting the agenda, managing the list of speakers, and facilitating the discussion. In addition, the chairs are given the final rule on any disputed points, and declare when motions are to be voted on by the body. It is also the decision of the chairs to pass any draft resolution to be introduced for debate.

The WHO will consist of 35 delegates representing their assigned Member States. Delegates are expected to search the following topics, submit a position paper and be prepared to debate based on their countries global stance and foreign policy.

One page will be present during the meetings to pass notes between delegates. Pages will be screening notes to ensure appropriate content and to maintain a professional environment.

Each Member State of the World Health Organization will have one vote. Matters are decided by simple majority. Decisions on important issues such as international health coverage, admitting new members and the UN budget are decided by a two-thirds majority.

Case Study: Vanuatu – Moving Towards an End to Yaws

Yaws is a contagious infection transmitted by skin contact that leads to disfigurement and disability, especially in children. The disease was once widespread in tropical countries. Campaigns in the 1950s and 1960s, in which yaws was treated with one shot of penicillin, led to a 95% decline worldwide. Half a century, later yaws made a comeback, specifically in Vanuatu. A 2011 WHO-supported survey revealed an urgent need for renewed action and that the Tafea province was especially hard hit. In 2013, Vanuatu's Ministry of Health, assisted by WHO, reached 96% of Tafea's population with needed treatment. As one can see, the WHO is vital in integrating health coverage globally.

Sample Timeline

9:30-9:40 – Roll Call
9:40-9:55 – Setting the Agenda
9:55-12:30 – Debate on the Agenda Topic and Motions
12:30-1:30 – Lunch
1:30-4:00 – Debate on the Agenda Topic, Motions, and Draft Resolutions
4:00-4:30 – Voting on the Draft Resolutions
4:30 – Closure/Adjournment of Debate

Forming Resolutions

Resolutions represent the opinions of the United Nations body as a comprehensive solution to the issue at hand. It is a final result of the discussions and negotiations regarding a topic that details a recommended course of action. A resolution is first considered a draft resolution prior to being voted on by the body. During the course of debate delegates can decide to work alone or collaborate with others to write a draft resolution. The delegates writing the resolution are considered "sponsors" and must recruit a certain number delegates as "signatories" in order for their resolution to be introduced by the Chairs to the committee. Signatories are members who wish to bring the resolution to debate but do not have to support the document. Once brought to debate, amendments can be made until the final resolution is voted on by the body.

Position Papers

The Position Paper is a detailed essay of your country's policies and position on the topics that are going to be discussed in your committee. The creation of your position paper is an important task because it will help you, the delegate, to organize your thoughts and ideas about MACMUN topics so that you can successfully engage with the rest of the committee. Additionally, the position papers will be judged by the conference hosts, and the writer of the top position paper in each committee will be recognized at the conference award ceremony. Please note that to be considered for any award at MACMUN 2017, you must submit a position paper.

Your goals are to research your assigned country in depth, to examine the stance they take on the given topics, and to summarize this information in one position paper. The length should not exceed one page per topic, single spaced.

A strong MACMUN position paper should include the following:

1. How your country is affected by the issues
2. Your country's policies with respect to the issues
3. Quotes from your country's leaders about the topics
4. Actions that your country has taken with regard to the issues
5. What your country believes should be done to address the issues
6. What your country would like to accomplish in the committee's resolution
7. Description of your relations with other countries' as it relates to the issues at hand

Important Notes:

- Include your name, assigned country, and committee
- Please do not include illustrations, diagrams, decorations, national symbols, watermarks, or page borders
- Include citations and a reference page, making sure to use a standardized citation style of your choice consistently, giving due credit to the sources used in research (the reference page is not included in the page limit)

The deadline to submit your position paper is ***February 5, 2017 at 11:59PM***; submissions should be emailed to macmunconference@gmail.com.

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Topic #1: Climate Change and Human Health

> *"Climate change is not of the making of the small island developing States, but we bear the full brunt of it, which is why we will never cease to raise the issue in every forum, including this one, because we are the conscience of the world."*
> *– Former Seychelles President James a. Michel*

Introduction

Anthropogenic (man-made) climate change poses a great risk to our world. The United Nations Environmental Programme (UNEP) and United Nations Framework Convention on Climate Change (UNFCCC) both aim to slow the production of greenhouse gases and reduce the impact of climate change. Despite the international community's best attempts to combat it, climate change is undeniably changing the Earth's environment and will continue to do so. With changing climate patterns, the habitats for certain organisms are changing. Unfortunately, the habitat of the deadliest organism to ever live on earth, the mosquito, is currently spreading globally. Particular species of mosquitoes carry with them deadly viruses and diseases which may lead to the start of an epidemic in certain regions (e.g. Chikungunya in the Caribbean).

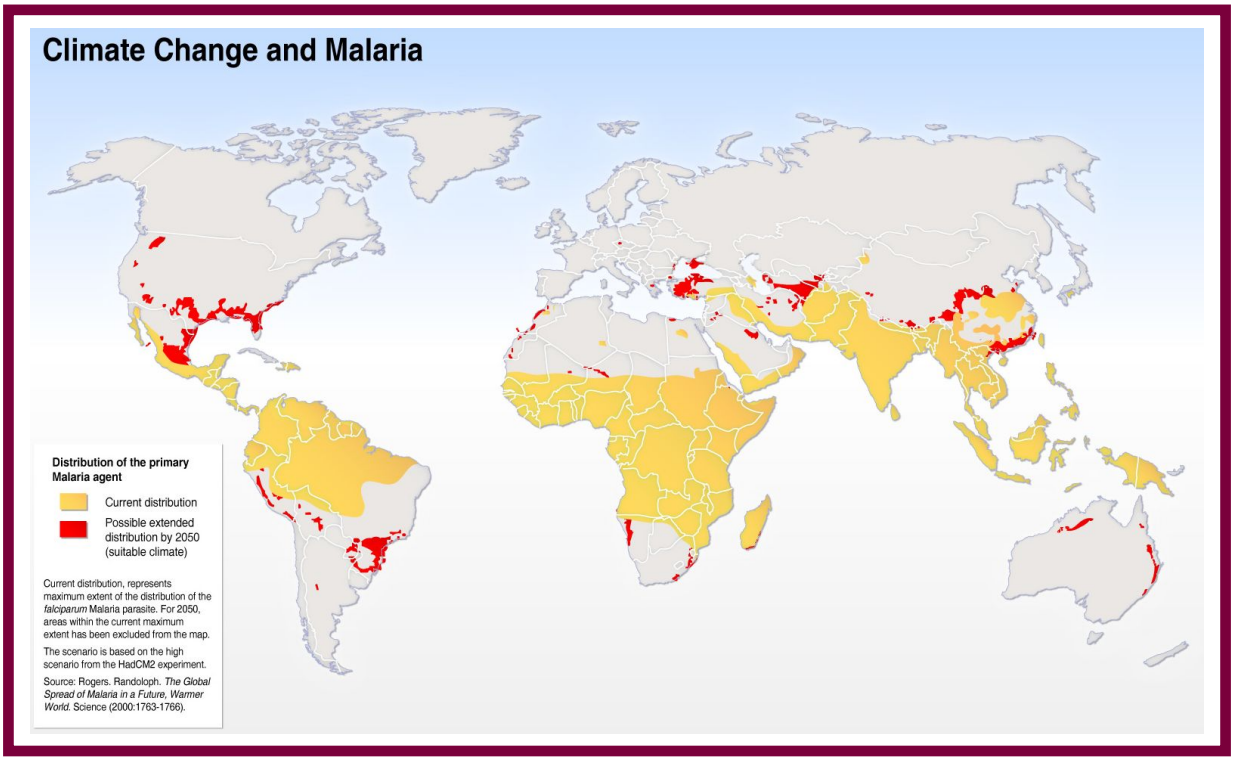

Figure 1: A map depicting the current maximum distribution of the *falciparum* Malaria parasite and the possible maximum distribution of the parasite in 2050. This prediction is based on the high scenario from the HadCM2 Experiment.

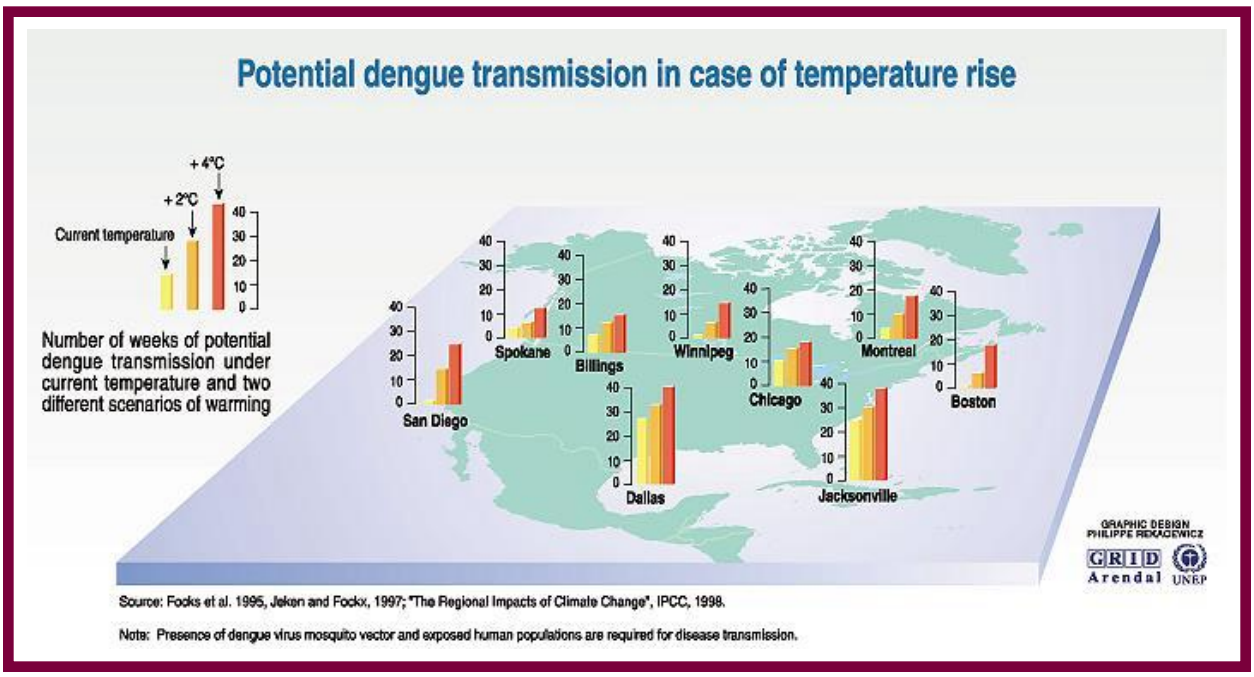

Figure 2: A map depicting the number of weeks in the year that have the potential for Dengue transmission in North American cities with current temperature, +2˚C in warming, and +4˚C in warming.

History and Background

Humans have known that climate conditions affect epidemic diseases long before we had science and technology to prove and verify this speculation. Way before infectious agents were even discovered, Roman aristocrats retreated to hill resorts each summer to avoid mosquitoes transmitting malaria. Moreover, South Asians (India, Bangladesh, and Laos) learnt early that, in strong summers, strongly piquant foods were less likely to cause diarrhoea. Diarrhoea is caused by severe dehydration and a bacterial infection. As of 2013, it is the second leading cause of death in children under five years old, killing 800 000 children annually. Infectious agents vary greatly in the size, type and mode of transmission. Microorganisms, such as viruses, bacteria, protozoa and multicellular parasites, cause "anthroponoses" and have adapted via evolution to the human species as their primary exclusive host. Anthroponoses is the direct transmission from one human to another. There are two types for this mode of transmission, direct and indirect. An example of a direct mode of transmission would be TB or HIV/AIDS. Animal communities and habitats are also affected by infectious agents. Non-human species are the natural reservoir for those infectious agents and cause "zoonoses". Zoonoses is the indirect transmission of infectious agents to humans, usually through animals that transmit these agents through their own community and then to the human population. There is a direct and indirect transmission for zoonoses, as well (e.g. rabies). Our main focus of attention in this topic would be the indirect transmission of both types (anthroponoses and zoonoses) which occurs by vector-borne transporters that cause a wide array of diseases such as dengue fever, malaria and others. Indirect transmission by zoonoses cause diseases such as the bubonic plague and Lyme disease.

Current Situation

These three determinants are the most important for vector-borne disease transmission:

1. Vector survival and reproduction
2. Vector's birthing rate
3. Pathogen's incubation rate within the vector organism

Vectors, pathogens and hosts all survive within a range of optimal climatic conditions. Temperature and precipitation are the most important, whilst sea level elevation, wind, and daylight duration following passively. Unfortunately, due to human activity, all these climatic conditions are rapidly changing. Global temperatures are increasing with a predicted increase of 3°C by the end of 2020. Precipitation is fluctuating globally with increased rainfall and snowfall in certain areas and droughts in others. All of these climatic conditions are causing the spread of vectors, instigating epidemics, affecting the physiology of life, and impacting human health. It is up to the WHO and its collaboration with governments to reduce the impacts of climate change on climatic patterns and eradicate the widespread of infectious agents.

Temperature Sensitivity

Extreme temperatures often are lethal to the survival of disease-causing pathogens, but incremental changes in temperatures will cause varying effects. When a vector lives in an environment where the mean temperature approaches the limit of physiological tolerance of the pathogen, then a small increase in temperature will exert lethality upon the pathogen. Alternatively, when a vector habituates in an environment with a low mean temperature then a small increase may result in increased development, incubation and replication of the pathogen.

Temperature modifies the growth of disease carrying vectors by altering their biting rates and alters the rate at which they come into contact with humans. Most importantly, the length of the transmission season is extended by a great range with a shift of uprising temperatures.

Disease carrying vectors will adapt to changes in temperatures by changing their geographical distribution. For example, an emergence of malaria in the cooler climates of the African highlands may be a result of the mosquito vector shifting habitats to cope with increased ambient air temperatures. Another possibility that is quite controversial is the evolutionary perspective. Vectors can undergo an evolutionary response to adapt with increasing temperatures. There is recent evidence that suggests that the pitcher-plant mosquito (Wyeomia smithii) can adapt genetically to survive the longer growing seasons associated with climate change. Bradshaw and Holzapfel demonstrated this by documenting a change in the photoperiodic response between two different time periods in two populations of pitcher-plant mosquitoes. The change in response was correlated to a marked genetic shift within the mosquito species. Micro-evolutionary response was found at a greater degree and associated with mosquito populations living in higher latitudes. The theory states that because these populations have greater selection pressure, they have also a greater ability to evolve genetically. Although this study was only limited to one type of mosquito, this can possibly be translated to other mosquitoes; disease

carrying vectors may undergo analogous microevolution which would allow adaptation to altered seasonal patterns associated with global climate change.

Precipitation Sensitivity
Variability in precipitation may have direct consequences on infectious disease outbreaks. Increased precipitation may increase the presence of disease vectors by expanding the size of existent larval habitat and creating new breeding grounds. Increased precipitation may support a growth in food supplies, which in turn support a greater population of vertebrate reservoirs. Alternatively, flooding may force insect or rodent vectors to seek refuge in houses and increase the likelihood of vector-human contact. An example is epidemics of leptospirosis, a rodent-borne disease, which have been documented following severe flooding in Brazil. In the wet tropics, unseasonable drought can cause rivers to slow and create stagnant pools which are the most ideal vector breeding habitats.

Humidity Sensitivity
Although less researches, this climate change variable can influence vector borne diseases greatly, particularly for insect vectors. Mosquitoes and ticks can desiccate (dehydrate) easily and survival decreases under dry conditions. Dengue fever and Lyme disease are the most affected by relative humidity (saturation deficit).

Sea-Level Sensitivity
The projected rise in sea level associated with climate change is likely to decrease or eliminate breeding habitats for salt-marsh mosquitoes. Inland intrusion of salt water may turn former freshwater habitats into salt-marsh areas which could support vector and host species displaced from former salt-marsh habitats

Case Study: The Highland Malaria Project

WHO estimates that approximately 300-500 million cases of malaria occur worldwide each year. High altitude regions have been protected from malaria because parasite sporogony (form of reproduction) and vector development are inefficient in low temperatures. However, there appears, currently, to be an emergence of malaria in the African highlands. This may be attributable to a true change in disease pattern caused by increasing temperatures associated with climate change. As global temperatures continue to rise, it is important to have a system that allows public health practitioners to forecast where and when malaria epidemics may occur. The Highland Malaria Project (HIMAL) is part of the umbrella international collaboration “Mapping Malaria Risk in Africa” (MARA). This project consists of two phases. The main objective of phase one was to create a model of malaria risk for several select regions in the African highlands using “Geographic Information System” (GIS) modelling and to compare these special models to known historical distribution of malaria epidemics. This phase prepares for a future phase two with the goal of predicting where and when malaria epidemics may occur. This project was used on several African countries including: Kenya, Uganda and Rwanda.

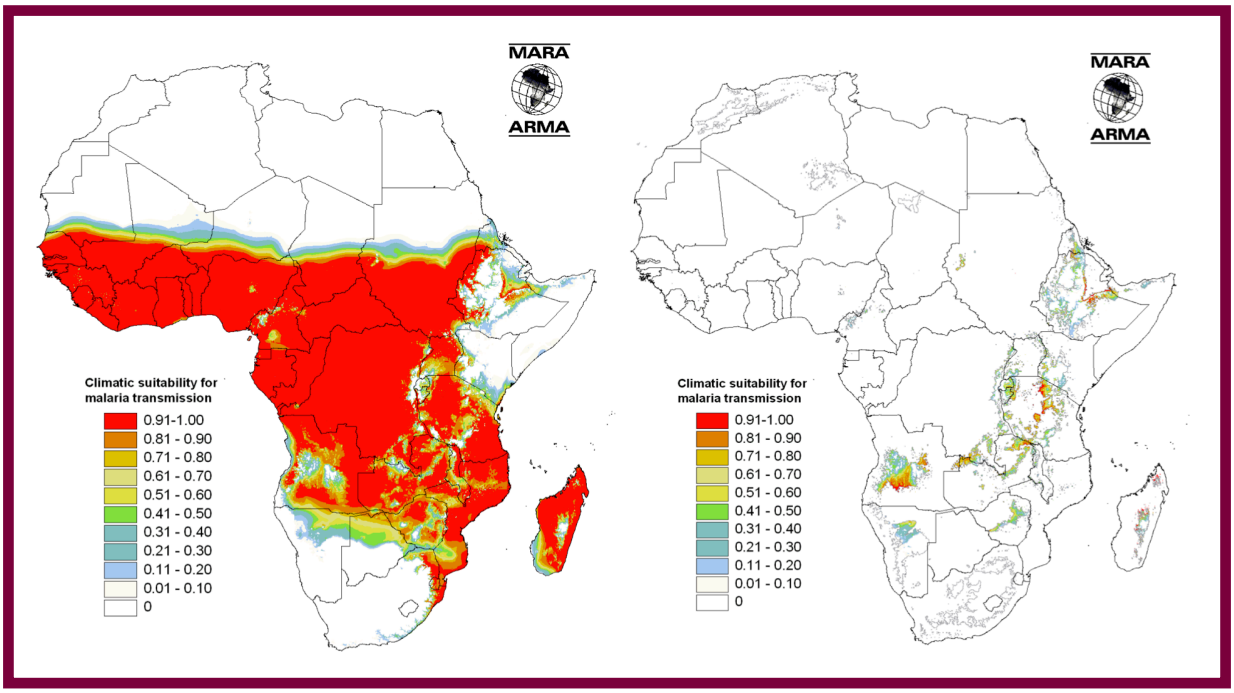

Figure 3: Maps depicting the climatic malaria distribution model, where 0 = unsuitable (malaria transmission is most unlikely) and 1 = suitable (stable malaria transmission is highly likely). The map on the left shows a general overview of climatic suitability for Africa, while the map on the right shows this for regions above 1300m in elevation (indicated by the grey contour lines).

According to the MARA climate suitability model, areas of climate unsuitability include both deserts (low rainfall) and highland areas (cold temperatures), as is the region bound between the borders of Uganda and Rwanda. This project aims to start mapping out possible epidemics that the WHO can tackle before they occur and is very important to understanding how resolutions could be developed during the conference.

Committee Mission

The spread of infectious diseases due to climate change has long been a global issue left to the discretion of each state to solve. Progress has been made with some initiatives and member states taking action. However, it is imperative to note that mosquitoes are still expanding their range of habitat and the world is still observing emergence of infectious diseases in new regions that were unaccounted for. It is the WHO's mission, in collaboration with member, states to make sure that our world sees a sustainable future in terms of climate change such that infectious diseases can be predicted and dealt with accordingly.

Research Questions

1. How is your country affected by altering climatic variables (temperature, precipitation, etc.)? How involved is your country in managing these variables and maintain a sustainable future.
2. Has your country seen an emergence of infectious diseases recently? If so, due to what? How did your country solve this?
3. Does your country have financial, technological, or other expertise that they could contribute to recovery efforts?
4. Is there any danger on your country's border for an infectious disease emergence? What is the extent of the disease and its vector range?
5. How will your country use the WHO and its assets to combat infectious diseases and its effect on human health?

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Topic #2: Approaching Mental Health

> *"At the root of this dilemma is the way we view mental health in this country. When it comes to mental health conditions, we often treat them differently from other diseases like cancer, diabetes or asthma. And that makes no sense. Whether an illness affects your heart, your leg or your brain, it's still an illness, and there should be no distinction."*
> *– First Lady to the President of the United States of America, Michelle Obama*

Introduction

The WHO constitution states: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." This definition affirms that mental health is an integral component of health that should not be overlooked. Good mental health enables people to realize their potential, cope with the normal stresses of life, work productively, and contribute to their communities. Around 450 million people suffer mental disorders, placing mental disorders among the leading causes of ill-health and disability worldwide. There are treatments available, but nearly two-thirds of people with a known mental disorder never seek help from a health professional. With stigma, discrimination and neglect surrounding mental disorders, there are challenges in mental health care that needs to be addressed in order to execute a comprehensive care program.

Background Information

The WHO defines mental health as:

> *"…a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his her community."*

In this positive sense, mental health is the foundation for well-being and effective functioning for an individual and for a community. Neither mental nor physical health can exist alone. Mental, physical and social functioning are interdependent. Furthermore, health and illness may co-exist. They are mutually exclusive only if health is defined in a restrictive way as the absence of disease. Recognizing health as a state of balance including the self, others and the environment helps communities and individuals understand how to seek its improvement.

Multiple social, psychological and biological factors determine the level of mental health of a person at any point of time. For example, persistent socio-economic pressures are recognized risks to mental health for individuals and communities. Having a low income, being unemployed, living in poor housing, and low levels of education are associated with increased risk of experiencing a mental health problem. Poor mental health is also associated with rapid social

change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, risks of violence, physical ill-health and human rights violations.

There are also specific psychological and personality factors that make people vulnerable to mental disorders. Lastly, there are some biological causes of mental disorders including genetic factors, which contribute to imbalances in chemicals in the brain.

5 Key Barriers to Increasing Mental Health Services Availability

1. The absence of mental health from the public health agenda and the implications for funding
2. The current organization of mental health services
3. Lack of integration within primary care
4. Inadequate human resources for mental health
5. Lack of public mental health leadership

Current Initiatives & Efforts

Mental Health Action Plan 2013-2020
WHO's comprehensive mental health action plan 2013-2020 was adopted by the 66th World Health Assembly. The four major objectives of the action plan are to:

- Strengthen effective leadership and governance for mental health
- Provide comprehensive, integrated and responsive mental health and social care services in community-based settings
- Implement strategies for promotion and prevention in mental health
- Strengthen information systems, evidence and research for mental health

Each of the four objectives is accompanied by specific targets, which provide the basis for measurable action and achievement by Member States towards global goals. A set of core indicators relating to these targets, as well as other actions, have been developed and are being collected via the Mental Health Atlas project on a periodic basis.

In the 2014 edition of Mental Health Atlas, 171 out of WHO's 194 Member States were able to at least partially complete the Atlas questionnaire, representing a participation rate of nearly 90%. This has provided much of the baseline data against which progress towards the objectives and targets of the Mental Health Action Plan 2013-2020 will be measured.

Mental Health Gap Action Programme (mhGAP)
The WHO Mental Health Gap Action Programme (*mh*GAP) aims at scaling up services for mental, neurological and substance use disorders for countries especially with low and middle-income. The programme asserts that with proper care, psychosocial assistance and medication, tens of millions could be treated for depression, schizophrenia, and epilepsy, prevented from suicide and begin to lead normal lives– even where resources are scarce.

Case Study: Responding to Disaster-Affected Regions in the Philippines

Disasters and conflicts lead to increased rates of mental disorders. As a result, many people have difficulty functioning in their daily lives, which can have a severe impact on their communities and families, especially when those affected are the breadwinners or caregivers of children.

As part of the emergency response to Typhoon Hayan in the Philippines, the national department of health, WHO, the International Medical Corps, Save the Children and Médecins Sans Frontières collaborated to use the *mh*GAP curriculum to train health personnel, who were not mental health specialists, at the community level and in general health-care settings.

The training increased the capacity of national health staff and local communities to identify and manage priority mental health conditions using WHO *mh*GAP guidelines, and helped them to promote psychosocial well-being in affected communities. Four million people now have access to mental health care in the most affected disaster areas, giving new hope to millions of families. The mental health services offered in the Eastern Visayas are considered a model for other regions of this disaster-prone country.

Focus Questions

1. Your country's current approach to mental health (mental health programs and initiatives, mental health funding, accessibility etc.)
2. How is your country's health care system structured? What NGOs have strong histories of aiding countries with mental health care?
3. How has your country worked to reduce the stigma surrounding mental health issues?
4. How can the WHO assure that mental health care is made more comprehensive? How would it be implemented?
5. How can the allocation of resources become more effective?

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