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Economy Experiences with the Revision Process of the Zanzibar Essential Health Care Package

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ABSTRACT

Zanzibar, a semiautonomous region of Tanzanaia, undertook a revision of its essential health care package in 2019–22 with the aim of providing a comprehensive, inclusive, evidence-based, and fair package of health services. The revision gained high-level political support and engaged many key stakeholders through a participatory deliberative process. Several consensus-building workshops were held from the community to the national level. Zanzibar's final health care package has a total of 302 interventions across 22 health program areas. Focusing on primary care, the package will be scaled up over 10 years and is expected to cost US$198 per disability-adjusted life year averted. With effective implementation, it is expected to save about 120,000 lives and increase life expectancy from 65 years to 71 years by 2032.

INTRODUCTION

Awareness and understanding of universal health coverage (UHC) have increased both globally and in many specific settings such as Zanzibar (Hashimoto, Adrien, and Rajkumar 2020; WHO 2020b). Key principles of UHC are to provide the health services people need without exposing them to financial risk. In Zanzibar and elsewhere, especially in low- and middle-income countries, resources are scarce, and many competing priorities exist (Hanson et al. 2022; Kapiriri 2013). An explicit national essential health care package (EHCP), or a list of high-priority health services that the government promises to provide, is an important policy tool

for setting health priorities in achieving UHC fairly and efficiently (Verguet et al. 2021). Thus, transparent and fair priority setting is key in the development process of EHCPs (Barroy, Sparkes, and Dale 2016). It can replace conventional implicit priority-setting mechanisms like denial of services, dilution of quality of care, delay in providing services that patients have a right to, suboptimal standards of health facilities, and deterrence behavior of health workers due to an overwhelming number of tasks and responsibilities (Kapiriri and Martin 2007). An EHCP explicitly defines essential services that should be prioritized within a limited budget using specified criteria, describes how those services should be financed, and identifies who should receive them. Concretely, such an explicit list of high-priority services can serve as overarching policy guidance over a longer period to assure feasible health financing systems, like public health insurance, and investments in the most important services within a country. Further, it can guide future plans and policies on health personnel and essential medicines (Glassman, Giedion, and Smith 2017; Watkins et al. 2018).

Even though many countries have gone through an EHCP revision, implementation success will depend on the quality of the development process. Zanzibar has had two previous revisions of the EHCP, the latest one in 2018. Neither was comprehensive and both failed to be implemented with a consequence of low coverage of essential health services (Ministry of Health and Social Welfare 2017). Those revisions needed more comprehensive development processes rather than rapid expert-driven listing of essential health interventions. Selection of essential services and eligible populations into an EHCP requires a combination of robust methods and high-quality data as well as fair processes that include adequate institutionalization and legal frameworks (Baltussen et al. 2023). It also involves hard political choices, balancing the claims of various stakeholder groups engaged in the process (Gustavsson and Tinghög 2020; Mitton and Donaldson 2004).

Currently, many countries are developing and revising EHCPs (El-Jardali et al. 2019; Youngkong, Kapiriri, and Baltussen 2009). Ethiopia and Pakistan have recently conducted comprehensive revisions of their national EHCPs, and both countries are now in the implementation phase. Recent revisions of EHCPs have also taken place in countries like Somalia and Sudan, settings with fragile health systems. Further, many international expert guidance reports have been published in the last five years and they all emphasize the importance of having a fair and democratic process when making an EHCP (Jansen, Baltussen, and Bærøe 2018; Norheim 2018; WHO 2020a). A recent review of EHCP revisions in six countries presents a framework for decision-making processes, including both practical organizational and normative considerations in the revision of EHCPs (Baltussen et al. 2023). Countries that took part in that review appeared to follow the elements of that framework, although with organizational differences based on the specific context of each country.

Despite the importance of a democratic and transparent priority-setting process (Bhaumik et al. 2015), limited evidence exists from country experiences in conducting and applying democratic deliberative methods in priority setting of national EHCPs. Although the literature shows widespread application of sound technical and systematic processes in revising/developing EHCPs

(Bhaumik et al. 2015; Jansen, Baltussen, and Bærøe 2018; Nagpal et al. 2023; WHO 2020a), it offers limited clarity on whether priority decisions were made through democratic processes and how stakeholders were actually involved in the revision. We still need more evidence from actual decision-making on how substantial and complicated health economic analyses and equity impact assessments can be combined with input and participation of the people who will be affected by these decisions. Such evidence is needed in aiming for fairness, legitimacy, and impartiality in health priorities (Jansen, Baltussen, and Bærøe 2018; Razavi et al. 2019). Decision-making processes need to go beyond inclusion of only individuals in strategic positions who are trained in expressing their preferences and opinions (Allotey et al. 2019; Odugleh-Kolev and Parrish-Sprowl 2018; Warren et al. 2021). In the revision of its EHCP, Zanzibar has demonstrated a good practice of engaging community, and this chapter aims to describe the overall experience there.

Country Context

Zanzibar is a semiautonomous region of Tanzania. It consists of two islands (Pemba and Unguja) surrounded by smaller satellite islets in the Indian Ocean. Although part of Tanzania, Zanzibar addresses its health priorities independently because health remains among non-Union matters. It has a total per capita health expenditure of US$34 per year (Ministry of Health Zanzibar 2014), with 30 percent of that expenditure coming from donor funds and 16 percent from out of pocket.

The first EHCP in Zanzibar (ZEHCP), from 2007, was considered important as part of the strategy for improving population health, economic growth, and poverty reduction (Revolutionary Government of Zanzibar 2017). Evaluating the success of the first ZEHCP, and later revisions, presents difficulties because many of the specific priorities and health intervention targets were too broad to be evaluated (for example, "Conduct blood glucose screening"). The policies said little about the cost-effectiveness and actual resources needed for each intervention, or about finance mechanisms and which target coverage levels to aim for at various delivery platforms. Nevertheless, the fact that the Ministry of Health chose a national ZEHCP as one of the milestones for its overall health policy, the 2006–07 Plan of Action, reveals the importance that the national health authorities attached to the first edition of the EHCP.

Health Care System

The health care system in Zanzibar has for many years comprised four levels: (1) the primary level that includes Primary Health Care Units, Primary Health Care Units+, and Primary Health Care Centers; (2) the district level; (3) the regional level; and (4) the tertiary level. Because of the complicated categorization at the primary level, the Ministry of Health proposed in the 2019–22 ZEHCP revision to simplify the structure of health care delivery platforms and to map priorities to those platforms. Table 5.1 presents the revised delivery platforms, reflecting a current total of 167 public health care facilities through which the ZEHCP will be implemented (Ministry of Health Zanzibar 2018).

Table 5.1 Number of Health Facilities in Zanzibar, by District and Delivery Platform, 2022 and 2024

	Primary level		Secondary level		Tertiary level	
	Dispensary	Health center	District hospital	Regional hospital	Referral and specialty hospitals	Total
Pemba						
2022	52	15	2	1	0	70
2024	33	21	4	1	0	59
Unguja						
2022	73	19	2	0	3	97
2024	50	26	7	1	3	87
Total Zanzibar (2024)	83	47	11	2	3	146

Source: Ministry of Health Zanzibar 2024.

Note: The upper row for each district shows numbers of platforms in 2022, immediately after the revision of Zanzibar's essential health care package; the lower row shows numbers in January 2024, about one year after the revision.

Scope and Mandate

In 2019, Zanzibar's Minister of Health requested that the World Health Organization (WHO) and the Bergen Center for Ethics and Priority Setting (BCEPS) provide technical support in the revision of the EHCP. The revision process of the ZEHCP was locally driven; the first author of this chapter, who at the time was the head of the Noncommunicable Diseases Unit in Zanzibar's Ministry of Health and is currently a PhD candidate at BCEPS, led the core group in the entire process. That core group had a mandate to provide an explicit list of essential health services that address the most important health needs of Zanzibar's population across their life course, with special emphasis on services at the primary, secondary, and tertiary health care levels. The final ZEHCP report was intended to provide relevant guidance for future health policies and actual priority setting at all levels of Zanzibar's health system in the next 10 years, with subsequent regular reviews and updates. The revised ZEHCP forms part of the operationalization of the Zanzibar Health Sector Strategic Plan IV and Zanzibar's commitment to pursue the Sustainable Development Goals.

Description of methods and results is influenced by the authors' applied involvement in the process. The 2019 revision of the ZEHCP followed a participatory deliberative process involving many relevant stakeholders from the community level to the national level. Through various organized consensus-building workshops, the core team led the revision with support from Technical Working Groups. During the first six months, participants made decisions on which criteria to use for priority setting and which interventions to consider as candidates in the revised ZEHCP. The next 18 months focused on analytics and collection of evidence to use in the assessment of consequences of various priority decisions and information needed to set priorities. A budget space analysis was conducted and decision on the feasible size of the health budget increase up to 2032 was made, and final approval of the ZEHCP was made at the highest political level in Zanzibar. The final comprehensive

ZEHCP report, published in November 2022, included details about criteria for priority setting, interventions in the package, and financing scenarios (Ministry of Health Zanzibar 2022). The report also proposed implementation arrangements as well as a monitoring framework.

Priority-Setting Process

The revision of the ZEHCP began with a meticulous planning phase, with the core team following a 10-step revision process presented in detail elsewhere (Mwalim et al., forthcoming, a). The core team developed an initial comprehensive road map that underwent rigorous scrutiny and approval through workshops and consensus-building meetings, involving experts from various organizations, including WHO, as well as senior officials from the Ministry of Health and other stakeholders. Following input from diverse stakeholders, the Ministry of Health sanctioned the road map for operationalization.

Stakeholder engagement played a pivotal role in the process, involving participants from community to national levels, each representing distinct interests. The stakeholders actively contributed to defining criteria for intervention selection, acknowledging the crucial role of the ZEHCP in achieving UHC. Consultative meetings with civil society organizations, medical experts, and other key stakeholders resulted in agreement on six criteria—budget impact, disease burden, cost-effectiveness, financial risk protection, equity, and political/public acceptability—which formed the basis for intervention selection.

Subsequently, 11 extensive consultation meetings were conducted to review and accept 302 interventions spanning preventive, curative, rehabilitative, and intersectoral domains for inclusion in the EHCP. Controversial interventions, such as induced abortion, were excluded, considering feasibility, affordability, and positive gains during the selection process. Baseline and target coverages were assigned to each intervention.

Regarding financing, stakeholders recommended a budget increase for effective EHCP implementation, noting the inadequacy of the per capita expenditure, set at US$34 according to the National Health Accounts. They recommended doubling the health budget, prompting the government to introduce a health financing reform that included two enduring financing mechanisms—a new Universal Health Insurance scheme and a pro-poor Zanzibar Health Equity Fund—to support implementation of the ZEHCP.

Implementation considerations highlighted the crucial role of District Health Management Teams, especially in primary health care, where most interventions were concentrated. To ensure effective implementation, stakeholders agreed to assure proper resource allocation to facilities and to establish an efficient referral system, as well as robust links between health facilities and communities. Monitoring and evaluation was also considered, with responsibilities assigned to the Health Management Information System to ensure ongoing assessment of

implementation progress. That collective effort aims to guide Zanzibar's health sector toward overarching goals, ultimately resulting in improved health outcomes for the population.

Analytics

The revision process of the ZEHCP included a comprehensive analysis using two analytical tools—the BCEPS FairChoices: DCP Analytics Tool and the WHO OneHealth Tool (OHT). The integration of FairChoices and OHT in the analytics of the ZEHCP revision facilitated a comprehensive assessment of costs, benefits, cost-effectiveness, and equity impact for various health interventions. Mwalim et al. (forthcoming, b) explains the details of the FairChoices methods in the Zanzibar revision. During the revision, a technical team prepared local parameters for both FairChoices and OHT, undertaking a thorough cost analysis that considered various scale-up scenarios for interventions within Zanzibar's health system over a 10-year period.

These tools employed distinct cost analysis approaches: OHT used an ingredient-based costing methodology, involving the summation of quantities and prices for all necessary components, whereas FairChoices employed a broader unit cost approach combined with population in need and baseline target coverage assumptions for each intervention. The unit cost approach encompassed aggregate cost to deliver health interventions per patient, including factors such as human resources, drugs, equipment, and other relevant elements. Local sources—including the Central Medical Store, Health Management Information System, published reports, and surveys—provided local data, which were further supplemented by information from published cost-effectiveness papers.

To align the policies of the ZEHCP and Health Sector Strategic Plan IV, the team undertook an intermediate cost analysis for the Health Sector Strategic Plan IV using OHT. Simultaneously, it employed FairChoices to estimate the health benefits and equity associated with the candidate interventions.

Cost-effectiveness played a pivotal role in ranking interventions by their potential to maximize population health. Whenever possible, the analysis used incremental cost-effectiveness ratio, representing the incremental cost and incremental effect of transitioning from the current baseline coverage of each intervention to a defined target coverage level. In that context, achieving coverage levels exceeding 90 percent was designated as the UHC endpoint. To ensure the robustness and validity of the incremental cost-effectiveness ratio values derived from FairChoices, the revision team conducted a thorough validation process. That process involved referencing peer-reviewed publications and the gray literature spanning the years 2010 to 2019.

RESULTS

The ZEHCP reflects the diverse health needs of Zanzibar's population. The package was carefully designed to address specific health challenges with the distribution

of interventions hihghlighting strategic prioritization of resources. Primary health care facilities are central to the ZEHCP because they account for most interventions, costs, and health outcomes. The detailed and expansive nature of the ZEHCP underscores the commitment of the Ministry of Health to improving overall health outcomes and ensuring equitable access to essential health services across Zanzibar.

STRUCTURE OF THE ZEHCP

The ZEHCP encompasses a total of 302 interventions distributed across 22 health program areas (table 5.2). Each program area represents a distinct health domain, and the number of interventions allocated to each area highlights the comprehensive nature of the health care package. That comprehensive package strategically prioritizes a diverse array of health interventions, addressing a wide spectrum of health needs within Zanzibar's health care system.

Table 5.2 Overall Summary of Cost, Effect, and Health Outcomes of the ZEHCP, by Program Area, 2022–32

Program area	Cost-effectiveness (US$/HLY)	Cost (10 years, US$)	Healthy life years (10 years)	Life years (10 years)	Lives saved (10 years)
Surgery	2,348	15,402,854	6,560	4,303	35
Emergency care	25,956	11,498,754	443	493	4
Maternal and newborn health	52	18,583,478	359,765	411,720	6,171
Child and adolescent health	182	44,605,652	245,699	283,327	1,707
Reproductive health	—	—	—	—	—
HIV and sexually transmitted infections	86	6,413,687	74,443	89,743	1,202
Malaria	1,083	1,704,379	1,574	1,811	16
Tuberculosis	213	4,804,053	22,554	26,009	209
Neglected tropical diseases	904	321,263	355	119	1
Infections in general	720	11,596,866	16,104	17,912	173
Cancer	9	3,982,554	448,295	587,838	575
CVD and diabetes	4,748	58,976,782	12,422	14,899	347
Musculoskeletal disorders	21,612	651,210	30	18	1
Respiratory disorders	51,029	32,450,618	636	736	6
Mental and SUDs	5,864	21,833,853	3,723	3,461	35
Neurological disorders	117	629,111	5,386	2,493	20
Rehabilitation	—	—	—	—	—
Nutrition	414	3,841,319	9,271	7,604	72
Hearing and vision improvement	5,080	1,375,382	271	—	—
Interpersonal violence	—	—	—	—	—
Epidemic infections (including COVID-19)	—	—	—	—	—
Intersectoral interventions	—	—	—	—	—
Total	**198**	**238,671,814**	**1,207,531**	**1,452,485**	**10,572**

Source: Ministry of Health Zanzibar 2022.

Note: CVD = cardiovascular disease; HLY = healthy life year; SUD = substance use disorder; ZEHCP = Zanzibar essential health care package; — = not available.

The ZEHCP spreads interventions, expected costs, and health benefits (healthy life years) across various delivery platforms of the health care system. Primary health care facilities play a predominant role, constituting 68 percent of ZEHCP interventions, representing 65 percent of the associated costs, and contributing to 82 percent of the overall effects in terms of healthy life years. Secondary-level health care facilities follow, representing 22 percent of interventions and 31 percent of costs, and contributing to 16 percent of healthy life year impact. Referral hospitals, despite representing 10 percent of interventions, make up 3 percent of the overall cost and yield 1 percent of the total healthy life year impact.

Funding the ZEHCP

The revised ZEHCP anticipates an increase of US$39 per capita in annual health expenditure by 2032, necessitating a doubling of total health spending to US$73 per capita annually within the next decade. The team conducted a comprehensive 10-year fiscal space analysis in collaboration with the Ministries of Health and Finance and later presented and discussed it with policy makers, development partners, Ministry of Health program managers, and other stakeholders. That expert-driven analysis considered various factors such as economic growth expectations, population growth, government investment, donor funding, and the introduction of a social health insurance scheme.

The analysis projects an increase in the government's health care expenditure as a percentage of gross domestic product from the current 1.7 percent to 2.5 percent by 2032. Further, it proposed increasing government spending from 53 percent to 60 percent, reducing donor contributions from 29 percent to 15 percent, and decreasing out-of-pocket expenditure from 16 percent to 10 percent.

To fulfill commitments outlined in the updated 2022 ZEHCP, the government undertook significant financial reforms, including the introduction of Universal Health Insurance and the Zanzibar Health Equity Fund. Universal Health Insurance, initially targeting formal sector individuals, will later be extended to the informal sector, with the aim of improving health care accessibility and affordability. Meanwhile, the Equity Fund focuses on supporting vulnerable groups, particularly those below the poverty line. The reforms aim to ensure sustainable funding for ZEHCP implementation, highlighting the government's commitment to securing accessible and quality health care in Zanzibar.

However, when comparing the ambitious target of increasing per capita spending to US$73 with the reality on the ground, the team also considered and documented scenarios of increasing per capita spending by US$1 or US$2 per year.

Implementation Monitoring and Evaluation

The ZEHCP implementation plan is guided by strategic priorities aligned with Ministry of Health strategies. It focuses on enhancing the health care financing

system, providing comprehensive health services, ensuring equitable distribution of the health workforce, improving the availability of drugs and equipment, strengthening health information systems and patient management, fostering community and stakeholder involvement, and reinforcing governance, leadership, and accountability within the health system.

In the realm of health care financing, the plan aims to progressively increase government health expenditure, provide health insurance to the entire population, introduce earmarked taxes on specific products, and establish trust funds to enhance mobilization of domestic resources. The provision of health services involves developing a clear referral system, updating treatment guidelines, and strengthening disease-specific registries. Additionally, the plan involves efforts to recruit qualified health workers, enhance training programs for equitable deployment, and improve the availability of drugs, supplies, and diagnostic equipment. The focus on health information systems and patient management includes strengthening national monitoring teams, enhancing digital medical record systems, increasing service access through partnerships, and aligning outcome metrics with ZEHCP objectives.

Responsibility for the continuous evaluation of the ZEHCP will lie with the planning unit through the Health Management and Information System and the Monitoring and Evaluation Division at the Ministry of Health, in collaboration with the Health Sector Reform Secretariat. In addition, heads of the departments and sections, and health care providers, shall ensure the smooth implementation of the health care package. The evaluation process will also engage the grassroots level, emphasizing the bottom-up approach to implementing the ZEHCP.

Lessons Learned

The design of benefit packages should reflect the priorities of respective countries. With that lesson in mind, it is highly recommended that countries manage the entire process themselves and ensure full participation of stakeholders at different levels. Additionally, the process requires the availability of sufficient and reliable evidence so that it can project costs and effects for the defined period. In its process, Zanzibar learned several lessons, discussed in the following paragraphs, that other countries could consider while doing similar work.

Ownership of the process. To carry out a benefit package development process efficiently, a country must lead the exercise. This aspect is crucial because local counterparts know who to involve and where to obtain the necessary information. Further, by leading the process, the country can build trust in what it has produced and can advocate for the resources needed.

Local capacity building. It has been common practice in many countries to employ foreign experts to undertake some assignments that local staff could do. Such was not the case in Zanzibar when it revised its benefit package. It recruited a core team, which was given basic health economic and priority-setting training organized

by the Addis Center for Ethics and Priority Setting and BCEPS. The trainings, conducted in Ethiopia and Zanzibar, enabled the team to manage the entire exercise. The knowledge gained greatly helped in clarifying different issues that emerged during deliberative meetings.

Stakeholder engagement. The participatory process of designing a benefit package needs broad inclusion of different stakeholder groups (Heath 1997). During its revision process, Zanzibar held a total of 11 sessions that involved community-level stakeholders, development partners, health professionals, and various government leaders. The consultative meetings served as awareness-creation platforms for addressing several concerns. The biggest challenge for stakeholders was to understand the concepts of priority setting. Following detailed sessions, the stakeholders gave their opinions about the criteria to be used for selecting interventions, the list of interventions to include in the package, and the proposed increase in the health budget from the central government. The final package was approved by Zanzibar's highest decision-making bodies, including the Multisectoral Technical Committee—comprising all government principal secretaries—and the Minister's Cabinet, chaired by His Excellency the President of Zanzibar and the Chairman of the Revolutionary Council.

Advocacy for the package. During the evaluation of the previous package, it became apparent that most stakeholders were not aware of the benefit package, which had resulted from a more top-down expert-driven process. That lack of awareness was due to limited involvement during the earlier package's development and partly to the lack of its implementation. With proper advocacy, the package can be used as a tool to mobilize resources, which, if secured, will make its implementation successful. Zanzibar used the revision process as an opportunity to advocate for the package and explain the importance of setting priorities.

Aligning the package with existing financing mechanism(s). For efficient implementation of the package, the process must identify several sources of funding from which funds can be allocated to the prioritized interventions. Zanzibar has implemented a free health care policy for decades but recently decided to introduce public health insurance. The challenge that has emerged involves the lack of harmony between the insurance benefit package and the EHCP. Because neither was officially endorsed, the teams of experts are trying to align the two. Zanzibar's experience highlights the importance of ensuring proper intragovernment communication when developing policy documents to avoid inconvenience.

Prospects for future review. Other key lessons learned while revising the ZHECP relate to progress on achieving Sustainable Development Goal targets, efforts to address noncommunicable diseases, and the development of national strategies to combat emerging health conditions. Additionally, there is significant optimism regarding the potential availability of funds to support package implementation because of major financial reforms under way. These insights suggest that implementation of the package may evolve over time, indicating the possibility of reviewing this case study as its implementation progresses.

Legislation. Meanwhile, because the ZEHCP is not bound by law, its implementation may not be as effective as expected, which could hamper resource allocation. Following a conversation between the Ministry of Health, BCEPS, and Zanzibar's Attorney General, the Attorney General advised putting the ZEHCP's existence into law. Having a law in place will clearly identify a list of services that all Zanzibaris have the right to access and will necessitate resource allocation for ZEHCP implementation; however, it will also prevent introduction of health interventions that may have huge budget impact. Enacting such a law will require a process of gathering opinions at all levels, preparing a bill, and sending it to parliament for discussion and approval.

Limitations

The ZEHCP review team had major difficulties in collecting all the quantitative and qualitative data necessary to review the current service package; in some cases, it did not have reliable data readily available in the required format. For instance, inadequate data about service outputs (in terms of numbers of clients served) at the level of health institutions, about human resources, and about logistics had to be substantiated by data from the Health Management Information System, which lacked sufficient data at the time. Thus, the team used evidence from the Tanzania Demographic Health Survey 2010 and 2015/16 and OHT along with data from the Institute for Health Metrics and Evaluation's Global Burden of Disease study.

CONCLUSION

A national EHCP serves as an explicit mechanism for operationalizing entitlements to health. Ranking of services by priority should follow WHO recommendations, be evidence based, and align well with other social goals (WHO 2014). Competing priorities within the health sector and across other sectors need to be handled carefully using a fair process and rigorous and pragmatic methods. Successfully implementing UHC at the national level requires compromises on the parts of various stakeholders, including policy makers, providers, payers, insurance companies, product manufacturers, and patients. Local engagement is important when defining an EHCP at the country level. In Zanzibar, as elsewhere, multiple interests are involved, institutions are short of capacity, resources are extremely scarce, and the political setting is complex. The ZEHCP outlines key interventions that Zanzibar will make available to its population as it works to ensure high coverage with public financing, so it can assure population health and well-being.

ACKNOWLEDGMENTS

We extend our deepest gratitude to the Ministry of Health Zanzibar, along with all stakeholders and funders, for their invaluable support in making this study possible. Special thanks go to NORAD, the Trond Mohn Foundation, the Bill & Melinda Gates Foundation, and the World Health Organization for their generous funding.

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