Elder Abuse and its Association with Residential Care in Obio/Akpor Local Government Area, Rivers State, Nigeria

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Abstract
Elder abuse is a public-health and human-rights concern, especially where older adults depend on relatives or other caregivers for daily support. Local evidence is important because patterns of dependency, household support and access to services vary across settings. This paper re-examines reported data from 411 adults aged 65 years and above in Obio/Akpor Local Government Area, Rivers State, Nigeria, with particular attention to nutrition, functional assistance, accommodation and their reported association with elder abuse. The source study used a multistage sampling approach and a semi-structured questionnaire. The available manuscript reports descriptive frequencies and percentages and bivariate chi-square tests and odds ratios for selected health, nutrition, personal-care and accommodation variables. The present recast retains the reported results while reorganising them into a clearer analytical structure. Charts are visual summaries of the figures in the source tables, not additional observations. The manuscript reports that emotional abuse was the most common form of abuse, followed by financial, physical and sexual abuse. In the detailed association tables, 56 of 411 respondents (13.6%) were classified as having experienced abuse. Assistance needs were associated with notably higher reported abuse prevalence: 60.3% among respondents needing help with home cleaning, 44.7% among those needing laundry assistance, 43.0% among those needing bathing assistance, 42.7% among those needing meal-preparation assistance and 42.1% among those needing mobility assistance. The source also reports statistically significant associations for selected health and nutrition indicators and for rent-payment arrangements, although some cells, denominators, percentages, p-values and confidence intervals are internally inconsistent. The available findings suggest that functional dependency and the arrangements through which older people obtain everyday support deserve attention in elder-protection strategies. However, the data as presented do not establish causation and do not directly compare formal residential-care facilities with community living. Before submission to an international journal, the original dataset and statistical output should be checked, particularly where tables conflict with the narrative.

Keywords*: elder abuse; older adults; functional dependency; residential care; nutrition; accommodation; Nigeria; Rivers State.*

1. Introduction

Population ageing creates important public-health, social-care and human-rights questions. Older people differ widely in health, functional capacity, income, social relationships and the degree of assistance they require. Some remain independent in daily activities, while others need support with bathing, mobility, preparing meals, household maintenance or managing medication. Where assistance is provided within relationships marked by dependency and unequal power, the quality and reliability of care become central to older people's safety and dignity. (World Health Organization [WHO], 2024; Mbam et al., 2022)

The World Health Organization defines abuse of older people as a single or repeated act, or failure to take appropriate action, within a relationship of expected trust that causes harm or distress. Recognised forms include physical, psychological or emotional, sexual and financial abuse, neglect, abandonment and loss of dignity. A WHO synthesis published in 2024 reports that approximately one in six people aged 60 years and older experienced some form of abuse in community settings during the preceding year; it also highlights the seriousness of abuse in institutional settings. These global estimates provide context but should not be treated as directly comparable with the prevalence reported in this local study because the age thresholds, settings, definitions and measurement procedures may differ. (WHO, 2024; Yon et al., 2017)

In Nigeria, family networks remain a major source of practical and financial support for older adults, while formal long-term care and social protection may be unevenly accessible. Family care can provide continuity, familiarity and belonging, but dependence on relatives may also expose older people to neglect, verbal humiliation, coercion or financial exploitation when support systems are strained or safeguards are weak. The National Policy on Ageing provides a policy framework intended to promote security, participation, comprehensive care and dignity for older people. Policy implementation requires locally grounded evidence on the circumstances associated with abuse and the practical support older adults need. (Mbam et al., 2022; Ojifinni et al., 2023) The study from Obio/Akpor is useful because it brings together information on nutrition, personal-care assistance, accommodation and selected health indicators. These variables can help identify areas for screening and prevention. Nevertheless, a careful distinction is required between residential care as a formal service or institution and accommodation history as measured in a household survey. The tables available in the source primarily describe respondents' housing and assistance needs; they do not provide a direct comparison of residents in formal care facilities against older people living in the community. The revised analysis therefore avoids claiming that the study establishes the effect of residential-care placement.

2. Problem Statement

Elder abuse may remain hidden when it occurs within family relationships or where older adults depend on the people responsible for their care. Limited reporting, stigma, economic dependency, fear of retaliation and uncertainty about where to seek assistance can prevent disclosure. At the same time, functional limitations and chronic health problems can increase the amount of support required, making the quality of that support a key issue for prevention. (WHO, 2024; Ojifinni et al., 2023)

The source manuscript cites Nigerian studies documenting physical, emotional, financial and other forms of elder abuse, but it offers limited local evidence on how abuse is distributed across indicators of nutrition, daily assistance and accommodation in Obio/Akpor. This study seeks to contribute to that local evidence base. Its interpretive value, however, depends on the internal

consistency of the reported tables and on a clear definition of what was measured as elder abuse. (Akpan & Umobong, 2013; Ojifinni et al., 2023)

3. Aim and Objectives

The overall aim is to examine reported patterns of elder abuse and their association with selected health, nutrition, personal-care and accommodation characteristics among adults aged 65 years and above in Obio/Akpor Local Government Area, Rivers State.

To describe the reported forms of elder abuse among the respondents.

To summarise respondents' nutritional status, daily assistance needs and accommodation characteristics.

To examine reported associations between elder abuse and selected health and nutrition indicators.

To assess the relationship between assistance with activities of daily living, accommodation-related factors and reported elder abuse.

To identify implications for community health practice, caregiver support and older-person protection.

4. Conceptual Background and Literature

4.1 Understanding elder abuse

Elder abuse is not limited to visible injury. Physical abuse may involve hitting, pushing or other force; emotional abuse may involve threats, insults, humiliation, intimidation or persistent rejection; financial abuse may include unauthorised use of money or property; and sexual abuse involves sexual contact or acts without valid consent. Neglect can arise when a person responsible for care fails to provide essential food, hygiene, medical attention, supervision or other necessary support. Different forms may coexist, and an older person may not label an experience as abuse even when it meets a formal definition. (WHO, 2024; Ojifinni et al., 2023)

4.2 Functional dependency and caregiving

A need for assistance is not itself evidence of abuse. Rather, dependency may create more frequent contact with caregivers and greater exposure to the consequences of poor-quality care. The WHO identifies functional dependency, disability, poor physical or mental health and low income among individual-level factors associated with vulnerability; relationship dependency and social norms can also matter. These relationships are not deterministic: reliable caregiving, respite support, accessible health services and mechanisms for reporting concerns can reduce risks.

4.3 Housing, household support and formal residential care

Housing conditions can influence privacy, safety, access to sanitation and the availability of nearby assistance. However, housing type or ownership alone cannot be used as a proxy for the quality of care. An older person living in a spacious family home may still experience coercion or neglect, while an older tenant may have strong autonomy and supportive relationships. Formal residential care likewise should not automatically be presumed protective or harmful; quality depends on staffing, accountability, safeguarding procedures, residents' autonomy and access to independent complaints mechanisms. (WHO, 2024; Mbam et al., 2022)

4.4 Nigerian policy context

Nigeria's National Policy on Ageing and the National Senior Citizens Centre provide a policy foundation for improving older people's wellbeing and coordinating programmes for senior citizens. Policy commitments need to be translated into practical systems: community screening, caregiver education, accessible social support, financial safeguards, referral pathways and reliable reporting data. A local study such as this one can help direct attention to the circumstances that merit further investigation, but its findings should be used cautiously where the underlying tables contain inconsistencies. (Federal Ministry of Information and National Orientation, 2021; Mbam et al., 2022)

5. Methodology

5.1 Study design and setting

The source manuscript describes a questionnaire-based study of older adults living in Obio/Akpor Local Government Area, Rivers State, Nigeria. It reports a multistage sampling technique and a sample of 411 eligible respondents aged 65 years and above. The available text does not provide enough detail to reconstruct all sampling stages, the fieldwork dates, the response rate, the operational definition of abuse, or the full ethics and consent procedures. These details should be inserted from the original protocol and field records before journal submission.

5.2 Data collection and analysis

A semi-structured questionnaire was reportedly used. The source tables present frequencies, percentages, chi-square statistics, p-values, odds ratios and confidence intervals for selected associations. The recast manuscript retains the reported descriptive data and highlights the direction and practical meaning of observed patterns. No respondent-level dataset was supplied; therefore, the analyses could not be independently recalculated, and no new inferential statistics have been generated.

5.3 Data integrity and reporting note

Several inconsistencies appear in the source manuscript. For example, the overall detailed association tables classify 56/411 respondents (13.6%) as abused, while the abstract reports 226 (76.4%) and separately gives a distribution of abuse types with a denominator of 226. Some row totals and percentages do not match the stated sample size; Table 6 contains varying denominators for the same assistance categories; and some p-values and confidence intervals appear inconsistent with the accompanying interpretation. The source also uses different denominators in the medication and adequate-care rows. These issues are not silently corrected in this recast. The authors should verify each table against the raw dataset and statistical output before submission.

6. Results

The results below are reorganised into seven evidence tables. Each chart visualises selected values reported in the source manuscript. The charts are intended to make patterns easier to interpret; they do not resolve inconsistencies in the underlying data.

6.1 Nutritional profile

Indicator	Category	Frequency	Percentage
Self-rated feeding status	Very well	241	58.6
	Well	103	25.1
	Average	46	11.2
	Poor	21	5.1
Self-rated appetite	Very good	92	22.4
	Good	222	54.0
	Fair	73	17.8
	Poor	19	4.6
	Very poor	5	1.2
Adequacy of food	Yes	354	86.1
	No	57	13.9
Meals per day	Once	11	2.7
	Twice	36	8.8
	Thrice	262	63.7
	Four or more	102	24.8

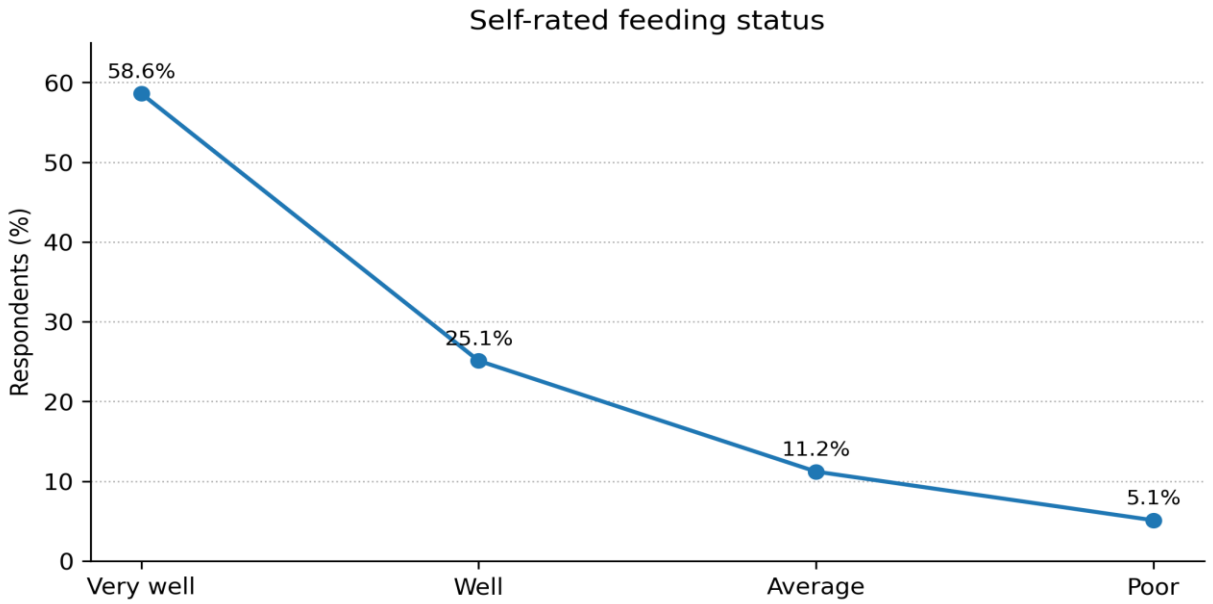

Figure 1. Line plot of self-rated feeding status percentages (ordered categories).

Most respondents rated their feeding as very good or good (83.7% combined), while 16.3% reported average or poor feeding. Most respondents also reported that food was available (86.1%) and that they ate three times daily (63.7%). These self-reported indicators suggest that many respondents perceived their basic nutritional circumstances positively, but a meaningful minority reported food insufficiency or less favourable feeding. Food availability alone does not establish nutritional adequacy, dietary diversity or food security over time. (WHO, 2024)

6.2 Personal-care assistance

Daily activity	Needs assistance n (%)	Does not need assistance n (%)
Moving around	76 (18.5)	335 (81.5)
Bathing	79 (19.2)	332 (80.8)
Cleaning the home	63 (15.3)	348 (84.7)
Washing clothes	94 (22.9)	317 (77.1)
Preparing meals/washing utensils	75 (18.2)	336 (81.8)

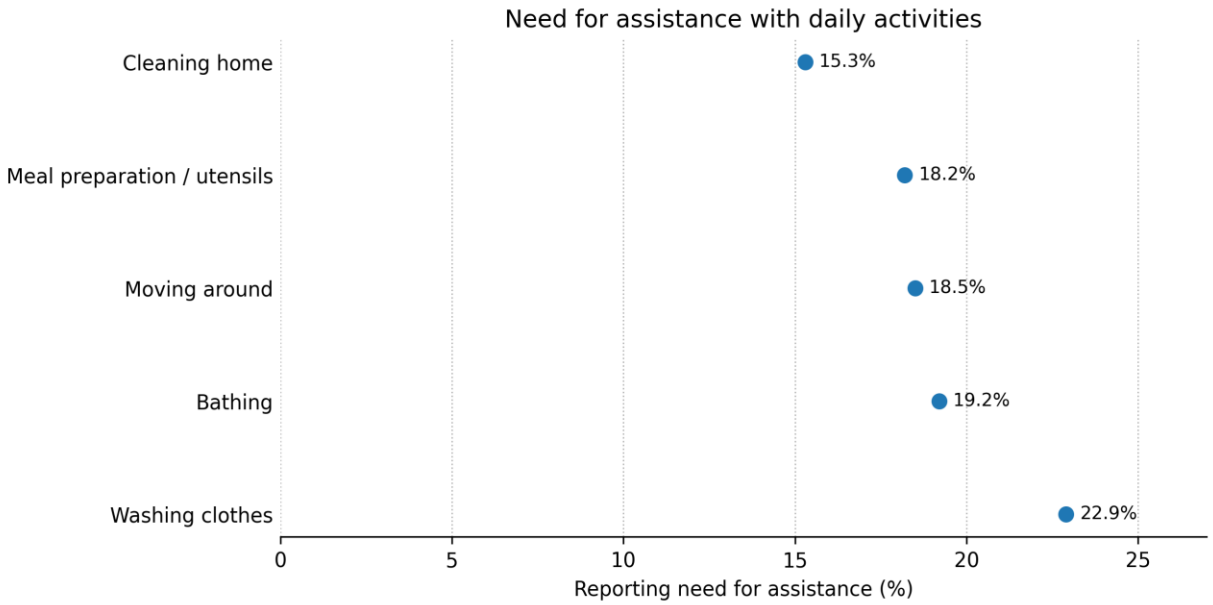

Figure 2. Cleveland dot plot of respondents reporting a need for assistance with selected daily activities.

Laundry was the most commonly reported activity requiring assistance (22.9%), followed by bathing (19.2%), mobility (18.5%), meal preparation and utensil washing (18.2%), and home cleaning (15.3%). These findings support the need to assess functional ability rather than relying on chronological age alone when planning community support. The results do not identify who provided the assistance, its quality or whether the assistance was adequate. (WHO, 2024; Mbam et al., 2022)

6.3 Accommodation profile

Accommodation indicator	Category	Frequency	Percentage
Type of accommodation	Single room	7	1.7
	2–3 rooms in tenant building	6	1.5
	Self-contained apartment	58	14.1
	1–2 bedroom apartment	214	52.1
	3–4 bedroom duplex	126	30.7
Comfort with accommodation	Yes	343	83.5
	No	68	16.5
Residence status	Landlord/family	310	75.4
	Tenant	101	24.6
Rent payer among tenants (n=101)	Self	34	33.6
	Spouse	5	4.9
	Children	60	59.4
	Other family members	2	1.9

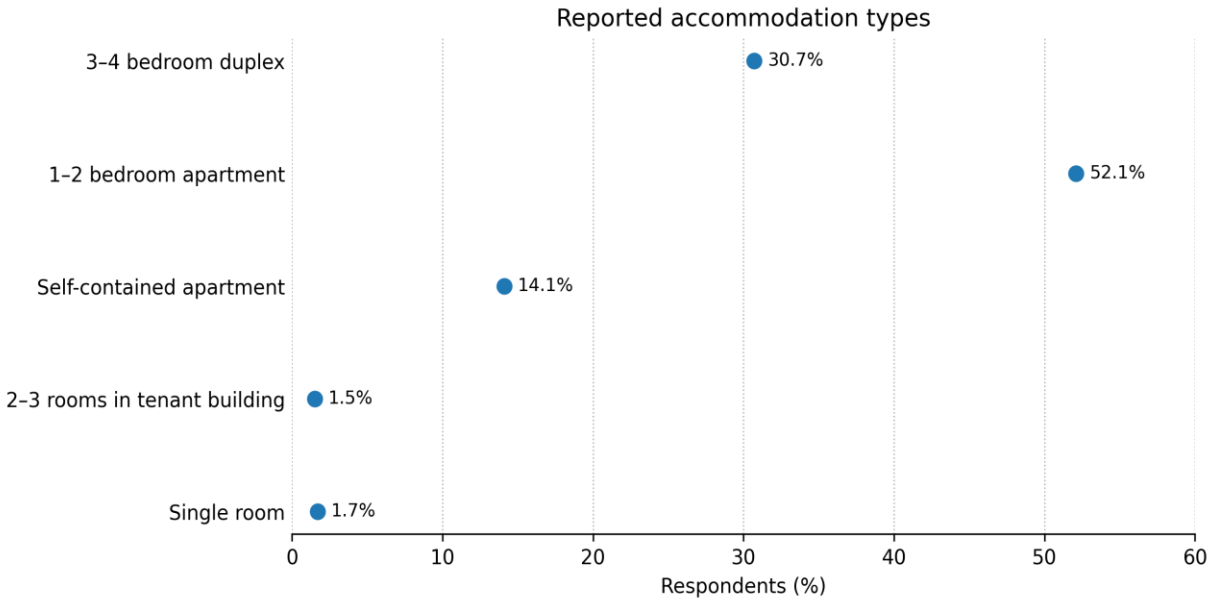

Figure 3. Dot plot of the reported distribution of accommodation types.

More than half of respondents were reported to live in a one- or two-bedroom apartment (52.1%), while 30.7% lived in a three- or four-bedroom duplex. Most reported being comfortable with their accommodation (83.5%), and 75.4% were categorised as landlords/family household residents. Among tenants, children were reported as the rent payer most often (59.4%). Because the accommodation categories and labels are not fully consistent across the descriptive and

association tables, the raw data should be checked before making housing-level comparisons. (Mbam et al., 2022)

6.4 Health indicators and elder abuse

Health indicator	Category	Abuse n/N (%) as reported	Reported χ^2 (p-value)	Reported OR (95% CI)
Current health status	Very well/well	46/382 (12.1)	8.24 (p reported <.001)	4.92 (0.020–0.12)
	Sick/very sick	10/29 (34.5)		
Health-problem grouping	Respiratory/cardiovascular/metabolic	58/237 (24.5)	17.48 (p reported <.001)	4.02 (2.02–8.03)
	Musculoskeletal/sensory/other	29/205 (14.1)		
Duration of health problem	≤24 months	56/310 (18.1)	21.12 (p reported <.001)	0.82 (0.78–0.86)
	≥25 months	0/101 (0.0)		
Hospital treatment	Yes	45/300 (15.0)	1.78 (p=.199)	1.60 (0.80–3.23)
	No	11/111 (9.9)		
Medication	Yes	45 (source row percentages inconsistent)	0.24 (p=.73)	1.19 (0.59–2.41)
	No	11 (source row percentages inconsistent)		
Adequate care	Yes	46 (source row percentages inconsistent)	3.44 (p=.078)	1.96 (0.95–4.03)
	No	10 (source row percentages inconsistent)		

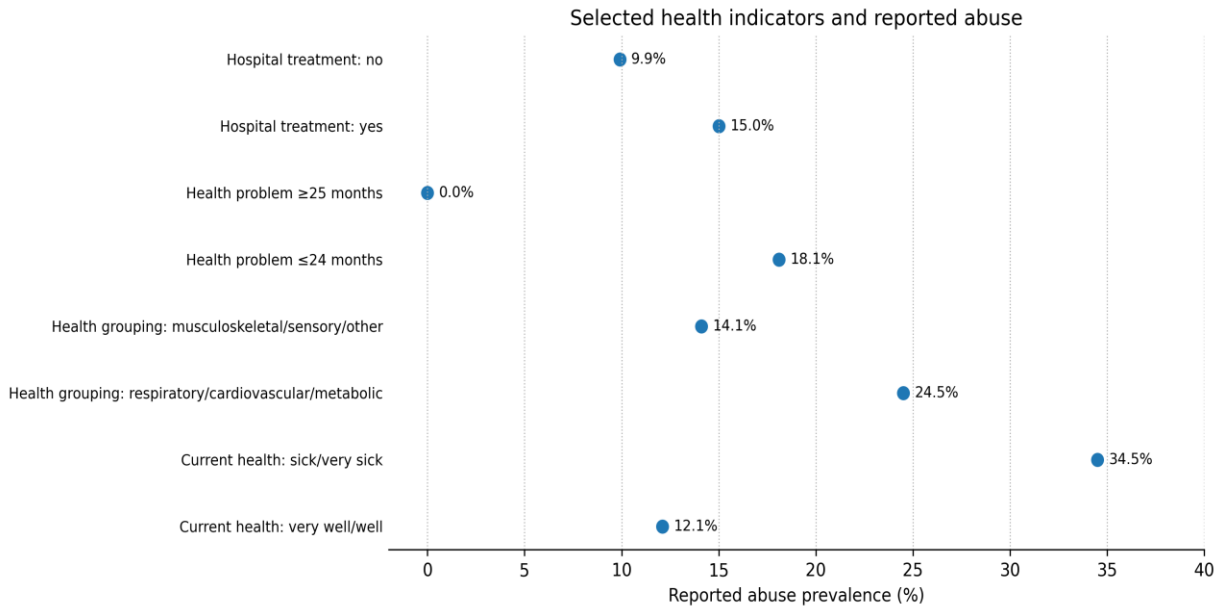

Figure 4. Point plot of selected health indicators and reported abuse percentages as printed in the source table.

The source reports statistically significant chi-square associations for current health status, health-problem grouping and duration of health problems. It reports no statistically significant association for hospital treatment, medication or adequate care at the stated 5% threshold. However, the current-health-status odds ratio and confidence interval appear mathematically incompatible, and the health-problem table has a total of 442 in one row despite the study sample being 411. The figures should therefore be treated as provisional until the original analysis is checked. The association between illness and abuse cannot be interpreted as causal from these cross-sectional results.

6.5 Nutrition indicators and elder abuse

Nutrition indicator	Category	Abuse n/N (%) as reported	Reported χ^2 (p-value)	Reported OR (95% CI)
Level of feeding	Very well/well	35 (source percentage inconsistent)	8.74 (p=.001)	0.837 (0.799–0.88)
	Average/poor	21 (source percentage inconsistent)		
Appetite	Very good/good	45/314 (14.3)	0.56 (p=.503)	1.31 (0.65–2.64)
	Fair/poor/very poor	11/97 (11.3)		
Food availability	Yes	53/354 (15.0)	3.9 (p=.047)	3.17 (0.96–10.51)
	No	3/57 (5.3)		
Meals per day	Once/twice	11/47 (23.4)	4.312 (p reported .67 in table; .067 in narrative)	2.179 (1.03–4.56)
	Thrice or more	45 (source denominator inconsistent)		

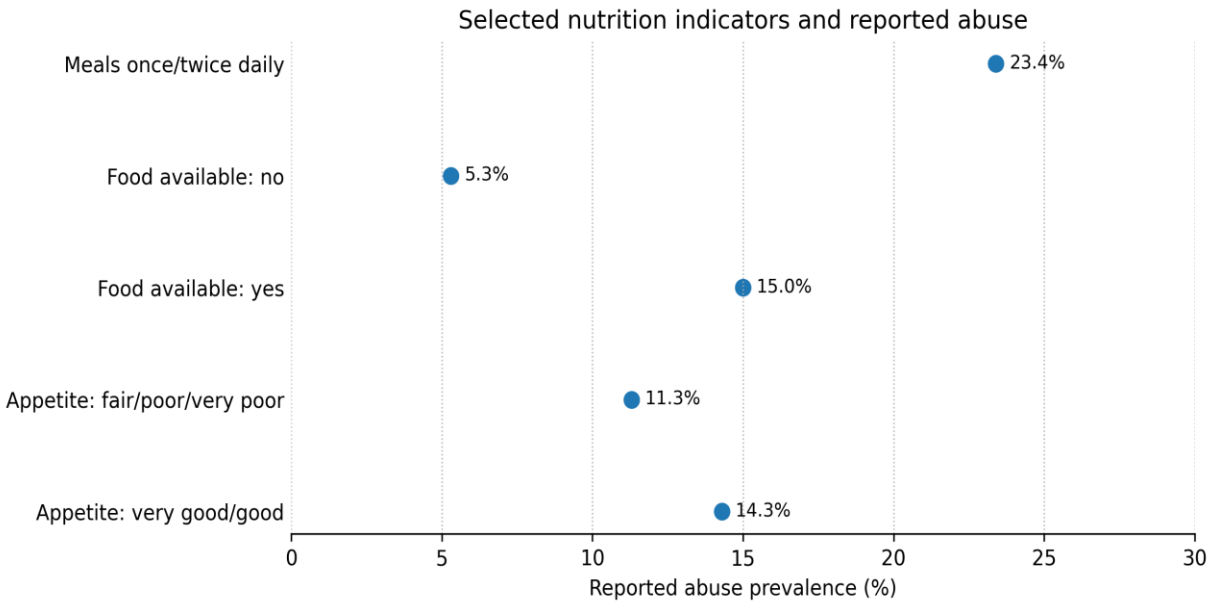

Figure 5. Point plot of selected nutrition indicators and reported abuse percentages as printed in the source table.

The source table reports an association between feeding level and abuse (p=.001) and a borderline association between food availability and abuse (p=.047). Appetite was not statistically significant (p=.503). For meal frequency, the table and narrative report different p-values (.67 and .067), so no firm conclusion should be drawn until the output is verified. The reported odds ratio for food availability has a confidence interval that includes 1 despite the reported p-value of .047, another inconsistency requiring review. Nutritional status may be relevant to safeguarding, but these data do not establish whether nutritional difficulty preceded abuse or resulted from it.

6.6 Assistance needs and elder abuse

Activity	Needs assistance: abuse n/N (%)	No assistance: abuse n/N (%)	Reported χ^2	Reported OR (95% CI)
Moving around	32/76 (42.1)	24/335 (7.2)	64.262	9.42 (4.85–18.28)
Bathing	34/79 (43.0)	27/332 (8.1)	61.517	8.53 (4.50–16.13)
Cleaning home	38/63 (60.3)	18/348 (5.1)	137.835	27.87 (13.20–59.18)
Washing clothes	42/94 (44.7)	14/317 (4.0)	99.875	17.48 (8.56–36.85)
Preparing meals	32/75 (42.7)	24/336 (7.1)	65.745	9.67 (4.97–18.80)

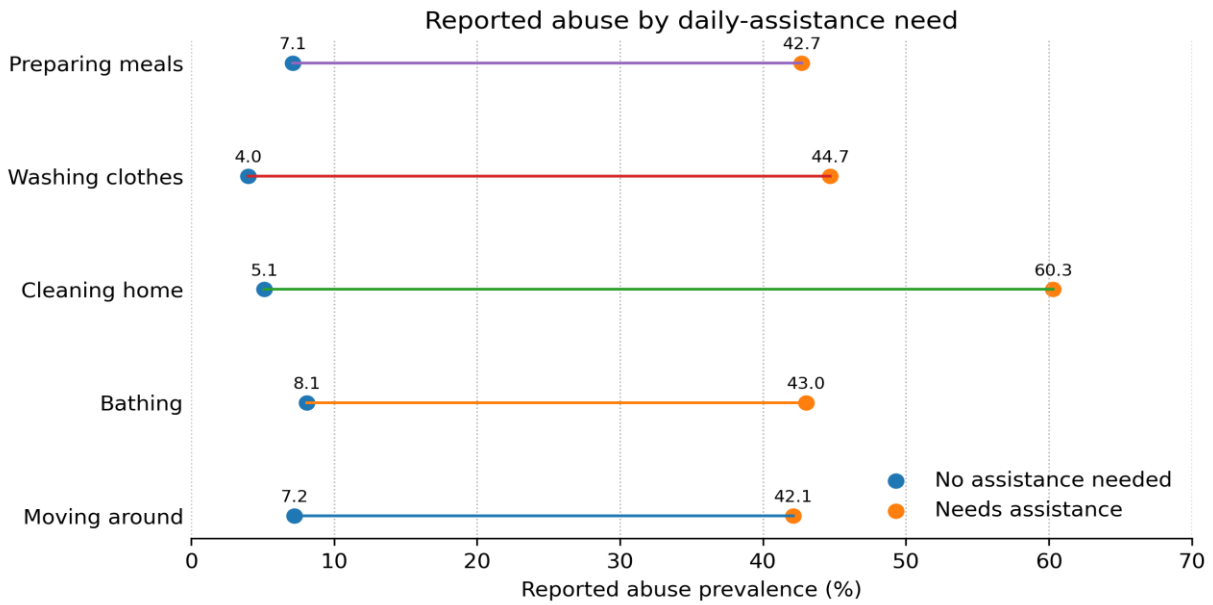

Figure 6. Paired dot-and-slope plot comparing reported abuse prevalence by daily-assistance need.

This is the clearest pattern in the source results: respondents who reported needing assistance had higher reported abuse percentages across all five daily activities. The largest contrast appears for home cleaning, where the source reports abuse among 60.3% of those needing assistance compared with 5.1% of those not needing assistance. The reported odds ratios are also elevated across activities. Yet the bathing, laundry and other rows contain denominator inconsistencies between the table and narrative, so the estimates should be confirmed from the raw data. Even if confirmed, assistance needs should be understood as markers for targeted screening and support, not as proof that dependency itself causes abuse.

6.7 Accommodation factors and elder abuse

Accommodation factor	Category	Abuse n/N (%) as reported	Reported χ^2 (p-value)	Reported OR (95% CI)
Accommodation type	Single room	11/71 (15.5)	0.25 (p=.57)	1.20 (0.56–2.46)
	2–3 bedroom	45/340 (13.2)		
Comfort	Comfortable	45/343 (13.1)	0.45 (p=.591)	0.78 (0.38–1.60)
	Not comfortable	11/68 (16.1)		
Residence status	Landlord/family	45/310 (14.5)	0.85 (p=.407)	1.39 (0.69–2.80)
	Tenant	11/101 (10.9)		
Rent payment among tenants	Self	14/34 (41.2)	15.42 (p reported <.001)	0.13 (0.04–0.42)
	Family	42/67 (62.7)		

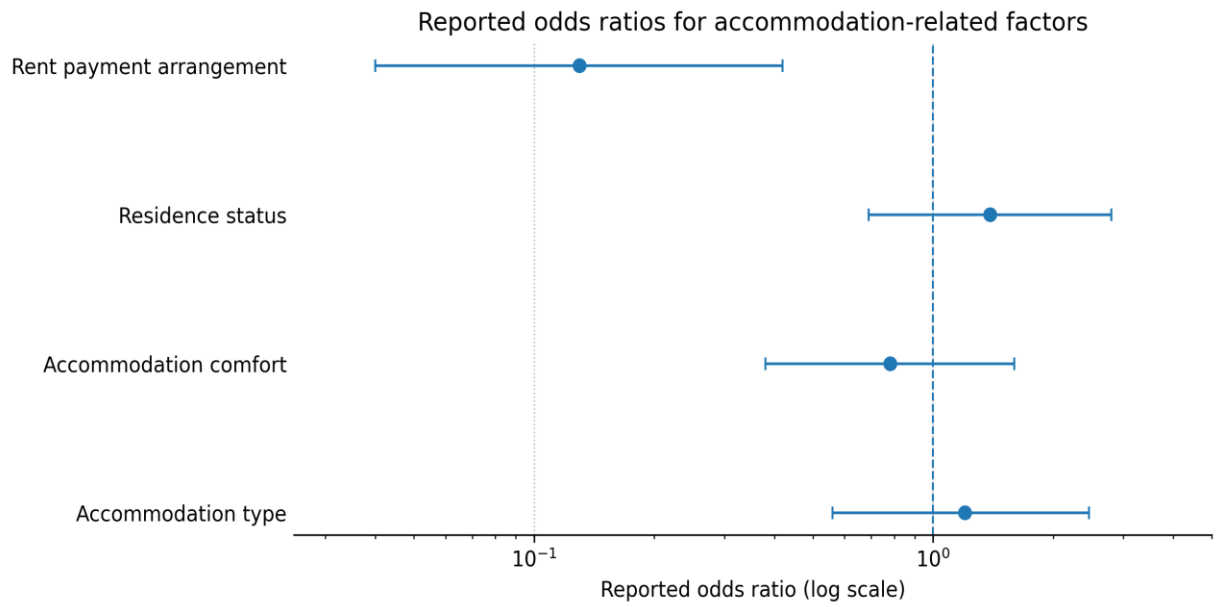

Figure 7. Forest plot of reported odds ratios and 95% confidence intervals for accommodation-related factors; interpret cautiously because source estimates require verification.

The source reports no statistically significant association for accommodation type, comfort or residence status. Rent-payment arrangements are reported as significantly associated with abuse, with higher reported abuse among tenants whose rent was paid by family members than among those who paid themselves. This should not be interpreted to mean that family assistance causes abuse: the table may reflect economic dependency, household circumstances or other unmeasured factors, and the source contains inconsistencies in the rent-payment row. The findings require verification and more detailed analysis before policy conclusions are drawn.

7. Discussion

Three broad observations emerge from the reported results. First, the source manuscript identifies emotional abuse as the most common form in its abstract, followed by financial, physical and sexual abuse. This pattern is consistent with the wider recognition that psychological or emotional mistreatment can be common and may be less visible than physical injury. However, the abstract's figure of 226 respondents (76.4%) who considered their treatment abusive conflicts with the detailed tables' overall classification of 56 respondents (13.6%). The prevalence and distribution of abuse types cannot be stated definitively until the authors establish which denominator and measure are correct. (WHO, 2024; Yon et al., 2017; Gedfew et al., 2024) Second, functional assistance needs show large descriptive differences in reported abuse. Respondents needing help with domestic tasks, personal hygiene, meal preparation or mobility had higher reported abuse percentages than respondents not reporting such needs. This pattern is substantively plausible because dependence increases contact with caregivers and may limit an older person's ability to avoid or report harmful treatment. It also points to a practical response: routine, confidential safeguarding questions can be integrated into community health visits and assessments of functional ability. However, the cross-sectional data cannot determine temporal order or exclude confounding by illness, income, household structure or caregiver burden. (WHO, 2024; Ojifinni et al., 2023)

Third, accommodation characteristics alone show weaker reported associations than assistance needs. Housing type, comfort and ownership status were not statistically significant in the source analysis, whereas rent-payment arrangements were reported as significant. This contrast cautions against treating housing size or ownership as a simple indicator of safety. Social relations, autonomy over money, quality of care and the ability to seek outside help may be more relevant than the physical form of the dwelling. (WHO, 2024; Mbam et al., 2022)

The nutrition findings also merit careful interpretation. Most respondents reported adequate food availability and relatively favourable feeding, but the association tables suggest that feeding level, food availability and meal frequency may be linked with abuse. The inconsistent p-values and confidence intervals mean these results should be considered exploratory. Nutrition screening can nevertheless be useful because unexplained weight loss, recurrent hunger, dehydration or inability to access food may signal unmet care needs and warrant respectful assessment. (WHO, 2024) In comparison with global evidence, the local results should be treated as a context-specific signal rather than a prevalence estimate directly comparable with the WHO's global estimate. Differences in age threshold, recall period, definition, setting and sampling can substantially change estimates. The study also appears to concern older people in the community and their accommodation, rather than a defined sample of residents in formal care institutions. Future research should explicitly distinguish home-based family care, supported housing and institutional long-term care, and should use validated measures of abuse. (WHO, 2024; Yon et al., 2017; Gedfew et al., 2024)

8. Implications for Public Health and Policy

First, primary healthcare providers and community health workers should receive practical training to recognise indicators of emotional, physical, sexual and financial abuse, as well as neglect. Screening should be confidential, survivor-centred and sensitive to the risk that disclosure may lead to retaliation. A referral pathway should connect older people to clinical services, social welfare, legal assistance and emergency protection where needed. (WHO, 2024)

Second, caregiver support should be strengthened. Community education can cover respectful communication, safe mobility support, personal hygiene, nutrition, medication assistance and the management of caregiver stress. Respite services and links to community organisations may help reduce the pressure on households, while safeguarding procedures should make clear that caregiver stress never justifies abuse. (Ojifinni et al., 2023; Mbam et al., 2022)

Third, functional assessment should be incorporated into older-person services. The high reported abuse percentages among respondents needing help with daily activities justify further investigation and may support targeted assessment, provided the underlying data are confirmed. Health workers should ask older people privately about their preferences, whether assistance is provided respectfully and whether they feel safe with those who help them. (WHO, 2024)

Fourth, financial autonomy requires protection. Older people should be supported to understand and control their pensions, savings, property and household spending wherever they wish and are able to do so. Practical safeguards may include clear consent procedures for financial assistance, trusted independent contacts and accessible routes for reporting suspected exploitation. (WHO, 2024) Finally, implementation of Nigeria's National Policy on Ageing and the National Senior Citizens Centre's mandate should be accompanied by reliable local data. Local governments, health facilities, civil society and older-person organisations can collaborate on community awareness, referral directories, caregiver education and monitoring. National policy

commitments provide a framework, but services need adequate funding, clear accountability and evaluation.

9. Strengths and Limitations

A strength of the source study is its attention to several practical dimensions of older people's lives, including health, nutrition, personal care and housing. The sample of 411 respondents provides a useful local starting point for understanding possible safeguarding concerns. The inclusion of association statistics, where reliable, could also help identify variables for future analytical work. (Mbam et al., 2022) Important limitations restrict the conclusions. The manuscript does not clearly report the operational definition or recall period for elder abuse, the questionnaire's validation, fieldwork dates, response rate, missing-data handling or ethics approval. The design appears cross-sectional, so causality and temporal direction cannot be established. The available document contains conflicting sample counts, percentages, denominators, p-values and confidence intervals. It also does not directly measure placement in a formal residential-care facility, despite the title's emphasis on residential care. Finally, no raw dataset was provided for independent reanalysis. These limitations should be addressed transparently rather than resolved through assumptions.

10. Recommendations

Audit the original dataset and statistical output before publication; reconcile the 226 (76.4%) figure in the abstract with the 56/411 (13.6%) figure in the association tables.

Recalculate every cross-tabulation, chi-square statistic, p-value, odds ratio and 95% confidence interval from the respondent-level data, using consistent denominators and clearly defined reference categories. Report the instrument used to measure abuse, the recall period, sampling stages, recruitment dates, response rate, missing data, ethical approval and informed-consent procedures. Distinguish community-dwelling older adults from residents of formal residential-care facilities in both the title and analysis. If no institutional sample was recruited, revise the title to reflect the measured population and variables. Develop community-based screening and referral arrangements for older adults who require assistance with mobility, bathing, laundry, domestic work and meal preparation. Provide caregiver education and practical support, including respite options, safe-care training and guidance on respectful communication and the protection of older people's autonomy. Strengthen access to food, healthcare, social support and financial-protection mechanisms for older adults who are economically or functionally dependent. Conduct a larger follow-up study using a validated elder-abuse measure and multivariable analysis to examine whether associations persist after adjustment for age, sex, marital status, income, living arrangement, health and functional status.

11. Conclusion

The source study provides a valuable local prompt for examining elder abuse in Obio/Akpor, particularly in relation to daily assistance, health, nutrition and accommodation. The reported tables suggest that respondents who need help with routine activities experience higher reported abuse percentages, while selected accommodation characteristics show weaker associations. These patterns highlight the importance of respectful caregiving, confidential safeguarding, caregiver support and accessible social services. However, contradictions within the source tables prevent the prevalence and several inferential results from being treated as definitive. A transparent data audit and, where necessary, reanalysis are essential before the manuscript is

submitted to an international journal. The study should also avoid presenting accommodation history as evidence about formal residential-care facilities unless that exposure was directly measured.

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