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Prevalence and factors associated with intimate partner violence against adult women in Brazil: National Survey of Health, 2019

Prevalência e fatores associados a violência por parceiro íntimo contra mulheres adultas no Brasil: Pesquisa Nacional de Saúde, 2019

Nádia Machado de Vasconcelos[I], Fabiana Martins Dias de Andrade[I], Crizian Saar Gomes[I], Isabella Vitral Pinto[I], Deborah Carvalho Malta[II]

ABSTRACT: ***Objective:*** To estimate the prevalence and factors associated with intimate partner violence against adult women in Brazil. ***Methods:*** Quantitative cross-sectional epidemiological study using the database of the National Survey of Health 2019. The prevalence in the last 12 months and crude and adjusted prevalence ratios of intimate partner violence were calculated, stratified by sociodemographic characteristics. ***Results:*** Intimate partner violence was reported by 7.60% of Brazilian women aged from 18 to 59 years, with higher prevalence among younger women (8.96%), black women (9.05%), those with lower education level (8.55%) and low income (8.68%). After adjusted analysis, the age groups of 18–24 years old (PRadj: 1.41) and 25–39 years old (PRadj: 1.42) and income lower than one minimum wage (PRadj: 1.55) remained associated with intimate partner violence. ***Conclusions:*** Intimate partner violence was associated with younger and poorest women. This result points to the need to develop intersectoral policies, especially those aimed at reducing social inequalities and at the coping with intimate partner violence among adult women.

Keywords: Intimate partner violence. Gender-based violence. Epidemiology. Cross-sectional studies. Health surveys.

[I]Graduate Program in Public Health, School of Medicine, Universidade Federal de Minas Gerais – Belo Horizonte (MG), Brazil.
[II]Department of Maternal and Child Nursing and Public Health, School of Nursing, Universidade Federal de Minas Gerais – Belo Horizonte (MG), Brazil.

Corresponding author: Nádia Machado de Vasconcelos. Avenida Alfredo Balena, 190, Santa Efigênia, CEP: 30130-100, Belo Horizonte (MG), Brazil. E-mail: nadiamv87@yahoo.com.br

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RESUMO: ***Objetivo:*** Estimar a prevalência da violência por parceiro íntimo sofrida por mulheres adultas no país e os fatores associados a ela. ***Métodos:*** Estudo epidemiológico transversal quantitativo utilizando base de dados da Pesquisa Nacional de Saúde 2019. Foram calculadas as prevalências e razões de prevalência bruta e ajustada da violência por parceiro íntimo nos últimos 12 meses segundo características sociodemográficas. ***Resultados:*** A violência por parceiro íntimo foi relatada por 7,60% das mulheres brasileiras de 18–59 anos, com maior prevalência entre as mais jovens (8,96%), aquelas que se autodeclararam pretas (9,05%), com menor escolaridade (8,55%) e baixa renda (8,68%). Após análise ajustada, permaneceram associadas à violência por parceiro íntimo as faixas etárias 18–24 anos (RPa: 1,41) e 25–39 anos (RPa: 1,42) e renda menor que um salário mínimo (RPa: 1,55). ***Conclusões:*** A violência por parceiro íntimo se associou às mulheres mais jovens e com pior renda. Esses resultados apontam a necessidade de desenvolvimento de políticas intersetoriais, especialmente as relacionadas à redução das desigualdades sociais e para o enfrentamento da violência por parceiro íntimo entre mulheres adultas.

Palavras-chave: violência por parceiro íntimo. violência de gênero. epidemiologia. estudos transversais. inquéritos epidemiológicos.

INTRODUCTION

Intimate partner violence (IPV), understood as "any behavior within an intimate relationship that causes physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviors" displayed by current or previous partners[1], constitutes a global public health issue and an evident attack on Human Rights[2].

Estimates from the World Health Organization (WHO) indicate that approximately 30% of women over 15 years of age have been victims of physical and sexual IPV at least once in their lives[3]. For Brazil, a meta-analysis carried out by the Pan American Health Organization (PAHO) in 2019 concluded that 16.7% of women aged between 15 and 49 years suffered physical and/or sexual IPV in their lifetime and 3.1% in the last year[4]. More than an isolated event in a woman's life, IPV can be part of a continuous pattern of abuse[5] and, in Brazil, approximately 33% of women victims of IPV report recurrence of violence[6].

IPV is an important cause of morbidity and disability, being recognized as a determinant of health and well-being, in addition to increasing the risk of premature death, not only directly, but also due to the development of health problems[7]. It is estimated that, in the last 20 years, approximately 175 thousand disability-adjusted life years (DALY) were lost per year in Brazil as a result of IPV, and more than 80 thousand potential years of life lost (YLL) among women aged 15–49 years in 2019[8].

IPV is associated with social inequities, and studies show higher prevalence of IPV among black women and those whit lower education levels[9]. The fact that IPV is associated with regions with a higher rate of male homicides[10] and that both injuries are related to socioeconomic inequalities shows that Public Health has an important role in understanding the

complex interaction between economic disadvantages and health-disease processes[11], in such a way that monitoring the factors associated with IPV becomes essential.

In this context, the National Survey of Health (*Pesquisa Nacional de Saúde* – PNS), considered the most important study among Brazilian health surveys, being the largest, most complete and comprehensive health research ever conducted in the country[12], provides information on the health determinants, conditions, and needs of the population, allowing for the implementation of consistent measures capable of assisting in the development of public policies and achieving greater effectiveness in health interventions[13].

It is noteworthy that in Brazil, no previous nationwide study estimated IPV and its subtypes in a representative sample of the population. Broadening the knowledge of IPV among women is essential for the production of coping strategies, thus guaranteeing women's right to life and equity.

Considering the importance of studying IPV and the magnitude of PNS for public policies, this study aimed to estimate the prevalence and factors associated with IPV suffered by adult women in the country.

METHODS

STUDY DESIGN AND DATA SOURCE

Cross-sectional epidemiological study, with an analytical character and a quantitative approach, using data from the PNS 2019. The research evaluated individuals aged 15 years or older residing in permanent private households in Brazil.

The PNS sample originated from a previously established master sample and consisted of a three-stage cluster sampling plan of selection: census tracts or set of sectors (primary units), households (secondary units), and adult residents (tertiary units). The minimum size defined for the sample was 108,525 and the final sample was 94,114 households with one interview conducted, with a response rate of 93.6% (n=90,846). For the present study, women aged 18–59 years who responded to the violence module were selected (n=34,334). More details about the PNS methodology can be seen in a specific publication[14].

VARIABLES

The outcome variable, IPV, was constructed using the questions from the violence module (V). In 2019, this questionnaire module was reformulated, allowing for better characterization of the types of suffered violence, in addition to identifying the perpetrators of each type and their link with the victim.

The presence of violence was considered when the woman answered "yes" to any of the alternatives of the following questions in the questionnaire, related to psychological, physical, and sexual violence, respectively:

- V2: In the last 12 months, did someone:
  a) offend, humiliate, or ridicule you in front of other people?;
  b) yell at you or call you names?;
  c) use social media or cell phone to threaten, offend, curse, or expose your images without your consent?;
  d) verbally threaten to hurt you or someone important to you?;
  e) destroy something of yours on purpose?;
- V14: In the last 12 months, did someone:
  a) slap you?;
  b) push you, hold you tightly, or throw something at you with the intention of hurting you?;
  c) punch, kick, or drag you through your hair?;
  d) try or actually strangle, choke, or burn you on purpose?
  e) threaten or wound you with a knife, firearm, or some other weapon or object?;
- V27: In the last 12 months, did someone:
  a) touch, manipulate, kiss, or expose parts of your body against your will?;
  b) threaten or force you to have sex or any other sexual acts against your will?

Intimate partner violence was considered when the woman stated that it was perpetrated by:

1. Spouse or partner;
2. Ex-spouse or ex-partner;
3. Partner, boyfriend/girlfriend, ex-partner; ex-boyfriend/girlfriend.

The selected sociodemographic variables were: age group (18–24 years; 25–39 years; and 40–59 years); education level (no formal education and some elementary school; elementary school and some high school; high school and some college; college degree); race/skin color (white, black and mixed-race); region (North, Northeast, Southeast, South, and Midwest); income (up to one minimum wage [MW]; more than one to three MW; more than three to five MW; more than five MW). The Asian and Indigenous races/skin colors are included in the total, but the Brazilian Institute of Geography and Statistics does not disclose these data in a discriminated way due to the small number of observations and high coefficient of variation.

DATA ANALYSIS

In the descriptive analysis, the prevalence rates and their respective 95% confidence intervals (95%CI) of total IPV were calculated according to sociodemographic characteristics.

In order to assess factors associated with IPV, the prevalence ratios (PR) and their respective 95%CI were estimated using the Poisson regression model with robust variance. First, bivariate analyses were carried out between the IPV (outcome) and each sociodemographic variable (explanatory), and the crude PRs (PRc) were estimated. Subsequently, the

multivariate model was performed, in which the explanatory variables with at least one category presenting a p-value ≤0.20 were gradually included in the model. The final model was considered at a significance level of 5%.

Due to the complex sampling design and the different selection probabilities, the PNS analysis requires prior definition of sample weights for selected households and residents. The final weigh considered results from the inverse of the expressions of selection probability of each stage of the sample and comprises the correction of nonresponses and adjustments to the population totals[14].

The Software for Statistics and Data Science (Stata), version 14.0, was used for data analysis through the survey module, which considers the effects of the sampling plan.

ETHICAL ASPECTS

All participants informed consent at the time of the interview. The PNS project was submitted to the National Commission of Ethics in Research/National Council of Health (Brazilian Ministry of Health) and approved under Opinion No. 3.529,376, issued on August 23, 2019. This study used secondary data from PNS and therefore did not need to be considered by the research ethics committee, in accordance with Resolution No. 466/2012.

RESULTS

A total of 34,334 women were evaluated. Most aged between 40–59 years (46.16%), had education level from high school to some college (41.20%), self-reported to be mixed-race (45.25%), resided in the southeast region (42.65%), and earned up to one MW per month (56.21%) (Table 1).

The total prevalence of IPV was 7.60%, with psychological violence accounting for the highest prevalence (7.07%), followed by physical (2.75%) and sexual (0.68%) violence (Figure 1).

A higher prevalence of IPV was observed in women aged 18–24 years (8.96%), followed by women aged 25–39 years (8.88%). Younger women had 47% higher prevalence ($p<0.01$) than women aged 40–59 years (6.08%), and those with intermediate age, 46% higher than older women ($p<0.01$). The prevalence in women with lower education level (8.55%) was 26% ($p=0.040$) higher than the prevalence in women with a college degree (6.79%); in those who self-reported to be black (9.05%), it was 25% ($p=0.049$) higher than among women who self-reported to be white (7.22%); of women with income lower than one MW (8.68%), it was 65% ($p=0.007$) higher than that of women who earned more than five MW (5.26%). Among the Brazilian regions, the Northeast had the highest prevalence (8.17%) and the South, the lowest prevalence (6.77%) (Table 2).

In the multivariate model, it was observed that women aged 18–24 years (PRadj: 1.41) and 25–39 years (PRadj: 1.42) had higher prevalence rates of IPV, in addition to those with income lower than one MW (PRadj: 1.55). The other variables did not show a statistically significant difference (Table 3).

Table 1. Sociodemographic characteristics of the study sample (n=34,334). National Survey of Health, 2019.

	Prevalence	95%CI	
	%	Upper limit	Inferior limit
Age group			
18–24	16.88	16.03	17.77
25–39	36.96	36.02	37.90
40–59	46.16	45.19	47.13
Education level			
No formal education and some elementary school	25.08	24.20	25.98
Elementary school and some high school	14.53	13.86	15.22
High school and some college	41.20	40.24	42.16
College degree	19.20	18.35	20.08
Race/skin color			
White	41.91	40.88	42.94
Black	11.59	10.98	12.22
Mixed-race	45.25	44.28	46.22
Region of residence			
North	8.20	7.83	8.58
Northeast	27.03	26.24	27.85
Southeast	42.65	41.49	43.81
South	14.25	13.62	14.90
Midwest	7.80	7.46	8.30
Income			
Up to one MW	56.21	55.08	57.34
More than one to three MW	34.12	33.15	35.11
More than three to five MW	5.54	5.09	6.04
More than five MW	4.12	3.72	4.57

MW: minimum wage. Source: Brazilian Institute of Geography and Statistics; CI: confidence interval.

DISCUSSION

IPV was reported by approximately 8% of Brazilian women, with a higher prevalence of psychological violence. Stratified by sociodemographic characteristics, the highest prevalence rates were verified among the youngest women, with lower education level, who self-reported black skin color, residents of the northeast region, and with lower income. In the adjusted model, age (women aged 18–24 years and 25–39 years) and low income remained associated.

Changing the violence module in the PNS 2019 questionnaire broadened the possibility of studying IPV in a population-based health survey, analyzing its subtypes. The prevalence of IPV found in this study was 7.60%. A study carried out with the PNS 2013 found a prevalence of 3.10% of violence against women committed by people they knew, which also included family, friends, and neighbors[15]. Another study with the same survey found a 1.58% prevalence of IPV among women[16]. However, the focus of PNS 2013 was only on physical violence and aggression[17], which may have led to an underestimation of IPV. In 2012, a population-based survey conducted by the National Institute of Public Policies on Alcohol and Other Drugs (*Instituto Nacional de Políticas Públicas do Álcool e Outras Drogas* – INPAD) found a prevalence of 6.3% of IPV among adult women[18], a percentage close to that found in the present study. It is noteworthy that the aforementioned study was restricted to women who lived with their partners.

IPV against women is one of the forms that gender-based violence can take. This violence can be understood as a power relationship established from the social roles imposed on

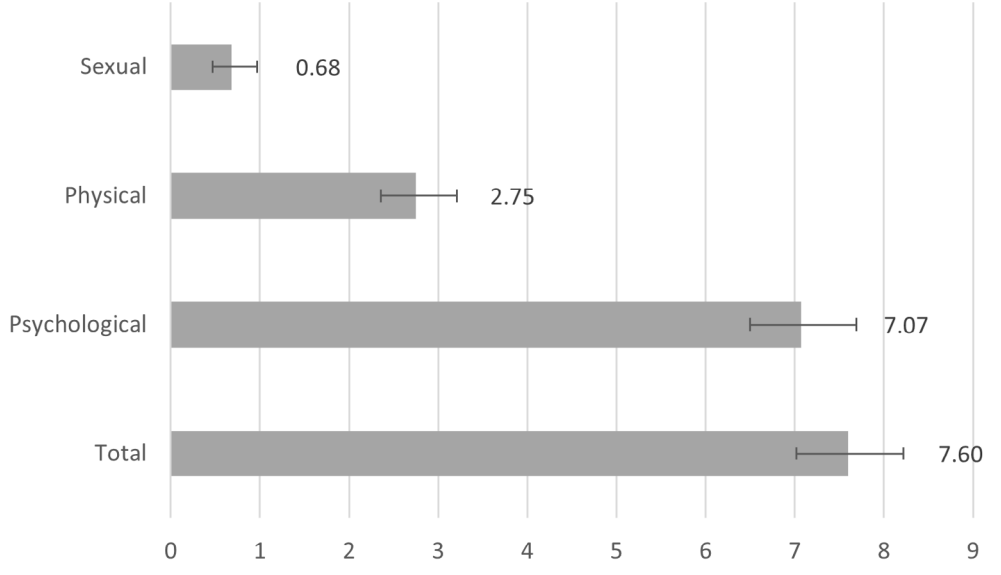

Figure 1. Prevalence of intimate partner violence against adult women by violence subtype. National Survey of Health, 2019.

Table 2. Prevalence and crude prevalence ratio of violence perpetrated by an intimate partner in adult women according to sociodemographic characteristics. National Survey of Health, 2019.

	Intimate partner violence			
	Prevalence (95%CI)	PRc	95%CI	p-value
Age group (years)				
18–24	8.96 (7.26–11.01)	1.47	1.15–1.88	0.002
25–39	8.88 (8.03–9.82)	1.46	1.26–1.69	0.000
40–59	6.08 (5.38–6.86)	1.00		
Education level				
No formal education and some elementary school	8.55 (7.40–9.86)	1.26	1.01–1.57	0.040
Elementary school and some high school	8.29 (7.11–9.65)	1.22	0.94–1.58	0.132
High school and some college	7.16 (6.30–8.12)	1.05	0.82–1.35	0.681
College degree	6.79 (5.55–8.34)	1.00		
Race/skin color				
Black	9.05 (7.56–10.79)	1.25	1.00–1.57	0.049
Mixed-race	7.58 (6.91–8.30)	1.05	0.90–1.23	0.555
White	7.22 (6.27–8.31)	1.00		
Region of residence				
Northeast	8.17 (7.45–8.96)	1.21	1.01–1.44	0.039
Southeast	7.63 (6.48–8.97)	1.13	0.90–1.41	0.293
Midwest	7.35 (6.33–8.52)	1.09	0.88–1.34	0.448
North	7.23 (6.34–8.24)	1.07	0.87–1.31	0.521
South	6.77 (5.81–7.88)	1.00		
Income				
Up to one MW	8.68 (8.01–9.40)	1.65	1.15–2.37	0.007
More than one to three MW	6.40 (5.16–7.91)	1.22	0.81–1.83	0.348
More than three to five MW	5.84 (4.29–7.90)	1.11	0.75–1.65	0.609
More than five MW	5.26 (3.70–7.44)	1.00		

PRc: crude prevalence ratio; MW: minimum wage; CI: confidence interval. Source: Brazilian Institute of Geography and Statistics

Table 3. Prevalence and adjusted prevalence ratio of violence perpetrated by an intimate partner in adult women according to sociodemographic characteristics. National Survey of Health, 2019.

	Intimate partner violence		
	PRadj	95%CI	p-value
Age group (years)			
18–24	1.41	1.10–1.82	0.007
25–39	1.42	1.23–1.65	0.000
40–59	1.00		
Education level			
No formal education and some elementary school	1.17	0.92–1.49	0.209
Elementary school and some high school	1.01	0.77–1.32	0.950
High school and some college	0.88	0.68–1.12	0.295
College degree	1.00		
Race/skin color			
Black	1.12	0.89–1.40	0.338
Mixed-race	0.93	0.78–1.11	0.440
White	1.00		
Region of residence			
Northeast	1.08	0.88–1.34	0.463
Southeast	1.13	0.89–1.43	0.330
Midwest	1.07	0.85–1.35	0.557
North	0.97	0.77–1.22	0.775
South	1.00		
Income			
Up to one MW	1.55	1.08–2.23	0.018
More than one to three MW	1.22	0.79–1.86	0.369
More than three to five MW	1.09	0.73–1.62	0.666
More than five MW	1.00		

PRadj: adjusted prevalence ratio; MW: minimum wage; CI: confidence interval. Source: Brazilian Institute of Geography and Statistics

women and men that transcends the biological characteristics of each one[19]. The description of masculinity is based on notions of dominance, insensitivity and honor, which lead to the interpretation of violence as an inherent characteristic of men[20]. At the same time, there is the construction of the ideal of a woman, who must be obedient, take care of the house and children, and remain faithful to her partner[21]. Hence, there is an idea of the man's possession of the woman, justifying obsessive jealousy and controlling behavior, with psychological abuse being a means of domination[5]. Several cultures naturalize IPV and consider that, to repress women and reaffirm the hierarchy of the relationship, men have the right to inflict physical punishment on their partners and to have sexual relations against their will[22].

In this perspective, the several types of violence are often superimposed: psychological violence is the one that most often occurs in isolation, though it is also accompanied by the other two types (sexual and physical violence)[23]; and physical violence is accompanied by psychological coercion and sexual abuse[24]. Overall, sexual violence committed by an intimate partner is not recognized by women due to the patriarchal culture that associates sexual practice with the wife's duty, even if in a non-consensual way[23]. Schraiber *et al.*[23] analyzed the prevalence rates found in a cross-sectional study carried out by the WHO between 2000 and 2003 and concluded that psychological violence had a prevalence of 37.6% in the city of São Paulo [SP] (state of São Paulo, Brazil) and 32% in the Zona da Mata Pernambucana region [ZMP] (state of Pernambuco, Brazil). Physical (8.5% in SP and 4.1% in ZMP) and sexual (0.5% in SP and 1.9% in ZMP) violence had similar prevalence to the present study.

In the present study, higher prevalence rates of IPV were observed in younger women, an association that remained significant after adjustment for other variables. Similar results were found in other studies. The WHO study, for example, showed that in Brazil IPV was concentrated in the aged group of 20–39 years[23]. Another study with notification data from the Notifiable Diseases Information System, between 2011 and 2017, also showed higher proportions of IPV in this same age group[25]. A possible explanation for this finding is due to the fact that younger women may find themselves more dependent on their partner to take care of their children and provide for the house[26]. Conversely, older women may have greater financial and social autonomy, which gives them an advantage to disentangle themselves from abusive relationships[27].

This study showed a decrease in the prevalence of IPV among more educated women. It is known that women with higher level of education have greater access to the social, cultural, and financial resources required to interrupt the cycle of violence[25]. A descriptive study with data from urgent and emergency care services surveyed by the Violence and Accident Surveillance System (VIVA Survey) 2014 showed that, among victims of IPV, more than half had low education level[28]. This fact is corroborated by a systematic review with meta-analysis published in 2018, in which the results showed that women without high school education were 40% more likely to experience IPV in adulthood[9]. Although education has not remained in the multivariate model, income did, and it is known that education is a prerequisite for entering the labor market, being a proxy for income[29].

IPV was higher in women who self-reported to be black, which is corroborated by the literature. A study showed that women who self-reported to be white are 28% less likely

to be victims of IPV[9], whereas an ecological study that used the standardized mean coefficient of female mortality from aggression as a marker of femicide in the 2007–2009 and 2011–2013 trienniums concluded that black women are twice as likely to die from this cause compared to white women[10]. Race cannot be understood only based on genetic variations[30]; it is rather considered a social variable that carries the weight of historical and cultural constructions and represents an important determinant of the lack of equity in health among racial groups[31]. In Brazil, the black race is deemed as a marker of social disadvantage, acting as a proxy for unfavorable socioeconomic situations[32]. In the current study, race/skin color did not remain in the final model; nevertheless, there may be a relationship between race, education, and income. Therefore, mixed-race and black women do not necessarily suffer more IPV, but they accumulate vulnerabilities, which can lead to difficulty in disentangling from the aggressor and chronic situations of violence.

This study found an association between IPV and low income. IPV is related to controlling attitudes of the partner, which often prevent women from leaving their homes and damage their social relationships[5]. This context can favor lesser financial autonomy for women and a decrease in their income[33]. Furthermore, women victims of IPV have higher rates of absenteeism, that is, absence from work, which leads to job instability and increases women's dependence on their aggressor, contributing to greater exposure to IPV[34]. In the adjusted model, the association between low income and IPV remained significant, a result that reinforces the importance of policies for combating violence against women to rethink strategies beyond the protection of women and punishment of aggressors, advancing in ensuring financial autonomy and right to housing, which will make it possible to break the cycle of IPV.

In the regional context, a population-based study conducted in 16 state capitals of Brazil showed that states in the South, Southeast and Midwest had 11.2% prevalence of severe physical violence, whereas in the North and Northeast this prevalence was 19%[35]. By classifying the types of violence according to severity, the comparison with the current study may not be reliable. In addition, in the current study, although the prevalence of IPV was higher in the Northeast compared with the South, this association no longer existed in the final model. Regional differences for IPV seem to be explained by the disparity in the rates of unemployment and urban violence in the communities in addition to macro-structural factors that refer to cultural norms about gender, access to public policies on welfare, education and employment[35]. Local studies are necessary to identify regions with the highest concentration of violence.

Gathering data on IPV generates pieces of evidence that serve as a valuable guide for the development of programs and public policies capable of leading to a reduction in violence[22]. Unfortunately, the political, economic, and social crises that began in 2015 and the austerity measures established by Constitutional Amendment 95 in 2016, which limited public spending for 20 years, brought dismantling and setbacks in social protection policies for the Brazilian population and unequally affected vulnerable groups[36]. With regard to IPV, the National Secretariat of Policies for Women has been drained and, in 2019, the *Casa da Mulher Brasileira* assistance program, which aims to integrate, in the same place, legal and

assistance services for women in situations of violence[37], did not receive any investment[38]. In the current government, the conservative discourse legitimizes male domination over women[39] and conceals structural machismo, palpable in the official stance against abortion in any circumstance[40], including an attempt to prevent care for victims of rape[41]. Furthermore, measures to facilitate access to weapons can increase the risk of women in situations of violence, a fact that has already been evidenced by the increase in femicide rates in the country[42].

Among the limitations of the study, the cross-sectional design is highlighted, which makes it impossible to determine causality. In addition, the sample excludes populations of homeless people, those living in asylums, *quilombos*, and villages. It is believed that the prevalence of IPV is underestimated, as women are more likely to hide the occurrence of a violent act due to the stigmatization of this condition[43]. The adopted measures seeking to minimize this limitation were ensuring privacy in the interview, keeping the woman away from a possible aggressor, and enabling the response to the module directly on the device, in such a way to minimize possible embarrassment. Moreover, to reduce the lack of understanding of the suffered violence, several situations were specified to better characterize the events. However, the questions were restricted to psychological, physical, and sexual violence, not addressing other types, such as patrimonial and moral violence, which are more difficult to define.

In conclusion, the PNS 2019 data show that IPV is related to macro-social (social class, race/skin color as a proxy for inequality and education) and generational factors. IPV can be avoided and its impact can be minimized. This depends on the intersectoral articulation of the areas of health, law, public safety, and education, aiming to act in an integrated manner in the development of policies for the protection of life, integrity, and the rights of women. The National Policy on Combating Violence Against Women must direct its attention to guaranteeing the right to education, income, employment, health, and housing.

It is noteworthy that, for the first time, the PNS deepened the investigation of IPV in a representative sample of the Brazilian population, specifying different situations to better characterize the event and discriminate the aggressor from each type of violence. In this sense, the findings of this study will support the surveillance of violence, monitor compliance with the goals of the 2030 Agenda for Sustainable Development[44], as well as help in the formulation of public policies aimed at reducing social inequalities and inequities. In addition, this study allows the development of a baseline of information from the PNS on IPV that will assist in monitoring the developments that have taken place in society due to the conservative position and the restriction of rights that the country is currently undergoing.

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