

Perceived Susceptibility to Hiv/Aids: Influence of Traditional Gender Role on Risky Behaviour among Youth

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Abstract

120 Undergraduate (60 males and 60 females) participated in the study, with a mean age of 23.25 years. The Hypergender Ideology Scale, Likelihood to take Risk Scale, HIV Risk taking Behaviour Scale and Perceived Susceptibility to HIV/AIDS scale were used. Findings revealed that participants who had hypergender ideologies were more likely to take risks $F(1,119) = 3,296$ $P < 0.05$ and perceived themselves as susceptible to HIV/AIDS $F(1,119) = 4.043$ $P < .047$. In addition the view that younger hypergender youth would engage in more risk behaviour and perceived themselves as less susceptible to HIV/AIDS was not supported, $F(1,56) = 1.576$ $P > .215$ and $f(1,56) = .074$ $P < .786$. The comparison between hypergender males and non-hypergender females was significant on likelihood to take risk $F(1,82) = 10.822$ $P < .001$ but not significant for HIV risk taking behaviour and perceived susceptibility to HIV/AIDS $F(1,82) = .749$ $P > 1.040$, $P > .311$ respectively. The implications of these findings were discussed in the light of current literature.

Keywords: Risky Behaviour, Youth, Gender, HIV/AIDS, Susceptibility

Introduction

STIs are the most pervasive infectious diseases confronting adolescents. Strong evidence supports several biological mechanisms through which STIs facilitate HIV transmission by increasing both HIV infectiousness and HIV susceptibility. Fleming DT, Wasserheit JN (1999). It has been known for at least a decade that gender is a significant factor in the transmission of HIV/AIDS. Gender influences vulnerability to infection, stigma, preventive behaviour, treatment, care and support (Geeta Rao Guota 2000).

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Gender here refers to the widely shared expectations and norms within society about appropriate male and female behaviour characteristics and roles. Gender is the psychological experiences of one's sex (Gentile 1993). Individuals who have extremely strict adherence to traditional gender ideals have been labelled as hypergender. They possess extremely stereotypic views about sex-related variables and gender beliefs (Hamburger, Hogben, McGowan and Dawson 1996)

Throughout the world almost 6,000 youths are infected with HIV infection each day accounting for more than half of all new HIV infections around the world. As a result almost 12 million youths are with HIV or AIDS. 62% of those infected youth are females. In sub-saharan Africa nearly 9 million youths are infected with HIV and 67% of them are females. Prevalence rates exceed 20% in Southern Africa and experts fear that the rates will rise in West Africa (Advocates for Youths 2003). Behavioural, psychological and socio-cultural factors make young people more vulnerable than adult's to HIV infections. Youth within this age group naturally explore and take risk in relationships. Those who have sex may change partners frequently, have more than one partner at the same time period, engage in unprotected sex, exchange sex for favours due to economic reasons and fail to see themselves at risk of infection.

All these factors contribute to the spread of HIV/AIDS, and increase young people's risk of contracting HIV. Because of their sexual behaviours Nigeria youths between the ages of 15 and 24 years like their counterparts in West Africa are the most affected age group. To further complicate matters young Nigerians are poorly informed about reproductive health and HIV/AIDS in particular. Harding, Anadu, Gray and Champeau (1999) surveyed 380 Nigerian students on one campus. They found that while the majority were sexually active and knowledgeable about HIV transmission, it did not prevent them from engaging in risky behaviour, 60% females and 71% of males reported vaginal sex without condoms.

Gender norms and expectations in turn fuel these behaviours making both young men and women vulnerable to HIV/AIDS.

Today's young people are the AIDS generation. They have never known a world without HIV. Millions already have died. Yet the HIV/AIDS epidemic among the youth remains largely invisible to adults and to the young people themselves. Stopping HIV/AIDS requires comprehensive strategies that focus on youth. (Population report 2001).

Youth in this study refers to individuals' who fall within the age of 15-30. Age intersects with gender to determine the distribution of power in society. Younger member of society typically have less power than older individuals and younger women or girls have less power than younger men or boys. In many societies young people are no longer fully under the protection and guidance adult parents, yet they are also not endowed with the rights and responsibilities of adult men and women.

Youths are confronted by traditional social values that prescribe strict gender roles for male and female by condoning male sexual promiscuity while placing high value on female fidelity. Cindy, Shelley, Meghan and Eva (2005) conducted a study that sought to describe college students' gender role attitudes and to examine the association between these attitudes and risky sexual behaviours and condom related beliefs. Results showed that participants reported moderately risky sexual behaviour. 82% of sexually active participants had sex without a condom in their life time, 50% had not used a condom during their most recent sexual intercourse and finally 23% had sex with a casual partner during their last sexual intercourse. In general women were more comfortable with the idea of a condom than men. With regards to gender role attitudes significant gender differences emerged for all gender role measures. In every case women reported less traditional attitudes than men.

According to available data, misinformation and misconceptions put young people at increased risk of HIV/AIDS, therefore making them a high risk group. Amirkhanian, Yiunov and Kelly (2001) conducted a study on risk factors for HIV and other sexually transmitted diseases among adolescents in St. Petersburg, Russia. These researchers used a 1995 survey of 533 student's aged 15-17 attending eight St. Petersburg high schools and assessed their sexual risk practices, AIDS-specific attitudes and beliefs, sexual relationship patterns, and preference and social characteristics.

Students were sexually experienced and these young people had, had an average of 3.4 sexual partners. Only 29% of sexually experienced students said they consistently used condoms and 29% said they never did.

Personal factors include lack of HIV knowledge and widespread misconceptions; limited knowledge of preventive methods, and greater biological susceptibility for girls to STIs/HIV infections and its consequences Gubhaju B (2012), UNESCAP (2005).

Sexual risk behaviours include initiation of sexual intercourse at an early age, multiple sex partners within a short period, and practice of unsafe sex such as no condom use Magnani RJ, Karim AM, Weiss LA, Bond KC, Lemba M, Morgan GT (2002), Dixon-Mueller (1996), and presence of STI symptoms Bryan AD, Aiken LS, West SG (1997). Sexual behaviour is dependent upon the social and cultural environment in which one lives, and is influenced by societal sexual norms and practices, and not just self-perceived susceptibility to HIV infection Akwara PA, Madise NJ, Hinde A (2003).

Unprotected intercourse was the predominant and preferred sexual practice. It also was the practice that most often occurred with student's last sexual partners. In all 28% of students defined "safer sex" as condom use. Many young people believe that AIDS is a threat only to members of particular "risk group" relatively few believe they could get AIDS (17%) or said that AIDS information had influenced their sexual behaviour (29% of those who were sexually experienced). Females were more likely than males to prefer having an exclusive partner, and males were more likely to prefer having casual partners. The conclusion therefore was that educational and behavioural interventions are urgently needed to help young people in Russia avoid HIV and STDs.

In a more recent studies Harrison A, Xaba N, Kunene P, Ntuli N (2001), Sales JM, DiClemente RJ (2010), Sychareun V, Faxelid E, Thomsen S, Somphet V, Popenoe R (2011). Found that Adolescents aged 13 to 19 have been identified as a vulnerable group for acquiring STIs and HIV/AIDS, especially adolescents from ethnic minorities. Auerbach J (2011), Tomlinson RH, Rohleder P, Swartz L, Drimie S, Kagee A (2011) The vulnerability of adolescents to the HIV infection is due to personal and socio-cultural factors Sychareun V, Faxelid E, Thomsen S, Somphet V, Popenoe R (2011), 13Gage AJ (1998).

Moore, Gullone, and McArthur (2004) conducted a study on risk taking and HIV/AIDS among young people in Cameroon. The aim of the study was to assess the reliability and validity of the Adolescents Risk taking Questionnaire (ARQ) (Gullone, Moore, Moss & Boyd, 2000) with Cameroon adolescents and to evaluate the measure as a screening device for those at risk of HIV/AIDS. Result showed that 15% of 53 girls (12 to 20 years in the Catholic girls school and 10% of 181 youths (79 boys and 102 girls, 11 to 19 years) in the Islamic co education school were HIV positive. For boys risk behaviour differences between HIV status groups were statistically significant, with HIV positive young men admitting to more risky behaviour than did HIV negative young men.

It was also found that admitting to unprotected sex was related to HIV negative young men. It was also found that fimiris prediction power was weak.

Rosenstock IM (2008), argued that the Health Belief Model (HBM) identifies the perceived susceptibility or perceived risk, perceived severity, perceived benefits, and perceived barriers as predictor of safer sexual activity. While Akwara PA, Madise NJ, Hinde A (2003), Maticka-Tyndale T (2008), Anderson B, Maughan B (2007, and Tenkorang E, Rajulton F, Maticka-Tyndale E (2009), indicates that previous researchers have suggested that there is an association between higher level of sexual risk taking and high level perceived risks of contracting HIV; however, some researchers have not found any association Toroitich-Ruto C (1997). Other studies have found that low level of sexual risk-taking results from high levels of perceived risks of contracting HIV Anderson KG, Beutel AM, Maughan-Brown B (2007).

Cybil (2005) in a review of available research concerning the sexual behaviour of adolescents in South Africa found that although awareness and knowledge about HIV/AIDS are high among adolescents in South Africa, this has not translated into substantial behaviour change (Galloway, 1999). A survey by Harvey (1997) showed that although adolescents are sexually active and have basic knowledge about AIDS, they do not know how the virus is transmitted nor do they know how to protect themselves from the diseases. Thus adolescents in South Africa must be regarded as a high risk group for HIV infection.

UNICEF in (1995) studied adolescents' knowledge and experience of sexually through focus group in five province in South Africa, it was revealed that adolescents receive conflicting messages about sex and sexuality and that they lack the knowledge, confidence and skills to discuss sexual issues, including contraception and prevention. Students' feedback indicated that their need for accurate information could be satisfied through AIDS education in schools. The following key findings of this research emerge as reasons for the high HIV infections among adolescents in South Africa. More than a third of adolescents in South Africa are sexually active and they commence sexual activity at an early age (average of 15 years) reasons for this include peer pressure and coercion (particularly for young girls) and material gains. The conclusion of the study therefore is that despite efforts of researchers there has been no significant change in the rate of infection among adolescents in South Africa.

This study therefore recommends a new generation of behavioural intervention, which will provide both factual knowledge and life skills, which promote behavioural risk reduction.

This study therefore sought to fill the void on perceived susceptibility to HIV/AIDS and the influence of traditional gender role on risky behaviour among youth in Nigeria. There are no studies that have examined the role of traditional gender stereotypes on HIV/AIDS in Nigeria. The following research questions are therefore put out to be answered.

- Will there be a significant difference between hyper-gender and non-hyper-gender participants on risk taking and perceived susceptibility?
- Is there any significant main effect of age among hyper-gender participants on risk taking and perceived susceptibility?
- Do hyper-gender males differ significantly from non- hyper-gender females on risk taking and perceived susceptibility?

Method

Participants

The study utilized a sample of 120 participants, made up of 60 males and 60 females. The age range for males was 16-24 years with a mean of 21.66 and the range for females was 25-30 years with a mean age of 26.43 the participants were students of a tertiary institution in Damaturu.

Instrument

A collection of four instruments were merged in to a questionnaire and used in this study. The questionnaire consisted of 4 sections labelled 1, 2, 3, 4,. Section 3 had a sub scale labelled section 3 ii.

Section 1 Contained the Hypergender Ideology Scale (HGIS) developed by Hamburger M. E. Hogben E, McGowan S and Dawson (1996). The scale measures the degree to which individual's adhere to traditional gender roles. It is a new measure designed to replace the Hyper-Family Scale (HFS) by Mumen & Berne (1991) and the Hyper-Masculinity Scale (HMI), by Mosher & Sirkin (1984). The HGIS is suitable for both men and women and this alleviates the need for two separate scales.

The scale also assessed stereotypical gender roles. The HGIS is a 57-items instrument that uses a 6-point Likert type scale. The alpha coefficient is .93. The validity of the HGIS was supported by the finding that the HGIS is significantly and positively correlated with HMI in independent sample of men. $r(148) = .76$ and $r(106) = .60$. Additional independent samples of women indicated a correlation between the HGIS and the HFGS with $r(145)$ and $r(125) = .60$.

Section 2 Contained the Domain Specific Risk Attitude Scale (DOSPERT). The DOSPERT was developed by Elke U. Weber, Ann-Renee Blais, Nancy E. Betz (2002). This scale assesses risk taking in five content domains: Financial decisions (Investment versus gambling), health, safety, recreational, ethical and social decisions. Respondents rate the likelihood that they will engage in domain specific risk activities. This study adopted and use only 27 items out of the 40 items as contained in the DOSPERT, this adopted version is known as the Likelihood to Take Risk Scale. Higher overall mean therefore indicated greater risk behaviours. The scale's construct validity and consistency is evaluated for a sample of American undergraduate students (Weber et al 2002). The coefficient alpha across all items in the scale is reported at $\alpha = 0.88$.

Section 3 i contained the HIV Risk taking Behaviour Scale (HRBS) developed by Shane Darke, Wayne Hall, Nick Heather, Jeff Ward and Alex Wodak (1991). The HRBS consist of 11 items, each item having been chosen to address a specific HIV risk taking behaviour. The items cover both injecting and sexual behaviour.

This scale was validated on a sample of 175 adults (19-45) intravenous drugs users from Australia Cronbach with an $\alpha = 0.70$ and test re-test reliability $r = 0.86$.

Section 3 ii Health Belief Model – perceived susceptibility (HMBO) scale was used in section 3 ii and was developed by Kathelen M, Lux and Rick Petosa (1994). The HIV/AIDS perceived susceptibility scale is a sub-scale of Health Belief Model. Internal consistency (reliability) is Cronbach alpha (perceived susceptibility) = 0.72. (Lux and Peosa 1995). And finally the demographic information formed the last section-4.

Procedure

The study used the group method of administration. Permission was sought from the Authorities. The participants filled the instruments in their lecture halls, according to their levels. They were assured of confidentiality and participation was voluntary. They were also free to withdraw at any stage without incurring any penalty. The instruments took 45 minutes to complete.

Results

The data collected was analysed using ANOVA. The statistic was chosen in order to answer the research Questions.

Hyper-Gender Analysis

Table 1: ANOVA Values and mean Score for Gender Orientations on the Dependent Variable

Dependent Variable	Hyper-Gender Orientation		F values	P
	Hyper-gender mean	Non-Hyper-gender means		
Likely to take risk	67.70	63.37	3.926	0.05
HIV risk taking behaviour	4.19	4.17	.000	.986
Perceived Susceptibility	18.96	20.40	4.043	.047

Hyper-gender and Non-Hyper-gender individuals were compared on risk taking behaviour and perceived susceptibility. The results in table 1 shows that hyper-gender individuals' were likely to take more risks than non hyper-gender individual mean scores were 67.70 (SD, 12.963 and 63.37 (SD, 11.002) respectively. The differences were significant, ($F(1,119) 3.926 P < .051$).

On HIV risk taking behaviour, means were 4.19 (SD, 6.163) and 4.17 (SD, 6.044) for hyper-gender and non-hyper-gender individuals respectively. There was no significant difference, $F(1,119) = .000 P < .987$. And finally the comparison on their perceived susceptibility to HIV/AIDS, mean were 18.96 (SD., 4.424) and 20.40 (SD, 3.348) for hyper-gender and non-hyper-gender individuals respectively. The differences is statistically significant, $F(1,119) = 4.043 P < .047.S$

Hyper-gender by Age Analysis

Next was the comparison between age and Hyper-gender, risk taking behaviour and perceived susceptibility. The result (Table 2) revealed that hypergender younger youths take more risk than hyper-gender older youth, mean scores were 67.37 (SD, 12.921) and 68.37 (SD, 13.376), the difference was not statistically significant, $F(1, 56) = 0.74$ $P > .786$. And similar result was found on HIV risk taking behaviour, means 3.82 (SD, 6.388) and 4.95 (SD, 5.778), $F(1,56) = .423$ $P > .518$. Finally, comparison on perceived susceptibility to HIV/AIDS was also significant, means were 18.45 (SD, 4.757) and 20.00 (SD, 3.559), $F(1, 56) = 1.576$ $P > 0.215$.

Table 2: ANOVA values and mean Scores for age among Hyper-Gender Participants Groups on the Dependent Variables

Dependent Variable	Hyper-Gender Age			P
	Below 24	Above 24	F values	
Likelihood to take risk	67.37	68.37	.074	.786
HIV risk behaviour	3.82	4.95	.423	.518
Perceived Susceptibility	18.45	20.00	1.576	.215

Hyper-gender male's vs Non-hypergender Female's Analysis

Hyper-gender males and non-hyper-gender females were also compared on risk taking and perceived susceptibility (Table 3) and the assumption that hyper-gender male will take more risk, engage in HIV risk taking behaviour and perceive themselves susceptible to HIV/AIDS than non-hyper-gender was evaluated.

It was discovered that hyper-gender males were likely to take risk than non-hyper-gender females, means scores were 69.55 (SD, 11,538) and 61.65 (SD, 10.335) = 10,822 $P < .001$. Comparing hyper-gender males and non hyper-gender females on HIV risk taking behaviour showed that hyper-gender males were rated high, means 4.62 (SD, 6.701) than non-hyper-gender females 3.51 (SD, 4.944) though this rating was not significant, $F(1,82) = .749$ $P > .389$.

And on hyper-gender males and non-hyper-gender females rated high, means 19.79 (SD, 3.313) as against means 18.92 (5.0, 4.382) even though this was also not significant, $F(1,82) = 1.040$ $P > .311$.

Table 3: ANOVA Values and Means Scores for Hyper-Gender Males and Females on the Dependent Variable

Dependent Variable	Hyper-Gender Orientation		F values	P
	Hyper-Gender Males Mean	Non-Hyper-Gender Females Means		
Likely to take risk	69.55	61.65	10.822	0.001
HIV risk taking behaviour	4.62	3.51	.749	.389
Perceived Susceptibility	18.92	19.79	1.040	.311

Discussions

Youth and their future contribution to society is crucial to the survival and well-being of Nigeria. Therefore curbing the HIV epidemic by focusing on the specific issues that affects its spread amongst the Youth is an agent priority. Although Adolescents has been shown to be a vulnerable time, it is equally true that it provides window of opportunity to bring about changes in levels of knowledge, attitudes and behaviours including negative gender stereotypic behaviour before they are fully formed. There was a strong support for the prediction that hyper-gender individuals took more risks than non-hyper-gender individuals.

According to Cindy et al (2005) men who internalize social norms (hyper-gender males) feel pressured to embody the stereotypical masculine ideals of being adventurers and women who do likewise leave important decisions up to their partners and would go along with whatever their partner or society prescribes for them.

The result therefore show that regardless of an individual's gender (Males or Females) so long as the individual is hyper-gender (adheres to stereotypic ideals about how males and females should behave); he/she will be more prone to taking risks than males/females who are non-hyper-gender. The implication of this finding is that for this population can be regarded as risk takers since a large proportion of participants are hyper-gender.

The second part of the view that hyper-gender individuals will engage in more HIV risk taking behaviours than the non-hyper-gender, even though correct as shown by the mean differences between these two groups, runs contrary to earlier findings by Cindy et al (2005) that internalization of cultural values about traditional gender roles influences the sexual behaviour of young adults, resulting in riskier sexual practices. Also Courtenay (1998) in a study found that traditional notions of masculinity are strongly associated with a wide range of risk taking behaviours, De Bruyn and others (1995, Heise and Elias 1995), identify dominant ideologies of masculinity and femininity in many societies to be related to gender imbalance in power between men and women's gender relations which curtails women's sexual autonomy and expands men's sexual freedom thereby increasing women's and men's risk and vulnerability to HIV/AIDS.

There are a number of possible reasons why this finding is not in line with the above finding. Firstly the items in the HIV risk taking behaviour scale may have been too direct causing participants to under report their drug use and sexual behaviour. Secondly, it is also likely that the population size was not large enough and a large population size may have produced a significance in the results and provided support for the view that there was support for the prediction that hyper-gender individuals will perceive themselves as less susceptible to HIV/AIDS than non-hyper-gender individuals this is consistent with a study of men's perception of the risk of becoming infected with HIV/AIDS, by Guil (2004).

The men studied did not consider themselves at risk of acquiring HIV/AIDS, even when they had other female sexual partners besides their wives. They claimed two reasons for not being at risk, an association between HIV and homosexuality (which they stated was not their case) and that they knew their other partners well.

Another study with men showed that they did not consider themselves vulnerable to HIV or STD'S in general because they did not belong to risk groups, they have decreased their number of female partners and they selected their female partners according to certain criteria. Similarly there are studies that have found that females are trusting and likely to be intimate with only one potential partner (Bjorkklund and Schackelford 1998, Bus 1995, Eagly and Wood 1999). For this reason they may regard themselves as not sexually promiscuous and therefore not susceptible to HIV/AIDS.

Due to such misconceptions these women may have unprotected sex with their partners and still believe that they are not susceptible to HIV/AIDS because their partners look and acts healthy, the same applies to men. The findings therefore indicates that there is an urgent need for HIV/AIDS education programmes on our campuses, that will correct all of the above misconceptions and address the gender pressure, that put these undergraduates at risk to help them better protect themselves to curb the spread of HIV/AIDS. The second notion that hyper-gender younger will take more risk, engage in more HIV risk taken behaviour and perceive themselves to be less susceptible to HIV/AIDS than hyper-gender older youth was not supported in this study.

From the previous discussions it has been established that being hyper-gender is associated with taking risk and perceiving one's self to be less susceptible to HIV/AIDS, the purpose for this question therefore was to find out whether age was a factor for hyper-gender individuals in these three categories, that is general risk taking, HIV risk taking and perceived susceptibility. Various studies (Craig and Richter Strydom 1983, Flisher et al 1993, Gollitiath 1995, Buga 1996 and Harvey, 1997) as cited in Cycil et al (2005), found that younger youth (less than 13) do not practice safe sex in general due to pressure to engage in early unprotected sexual intercourse, coercion, lack of access to user friendly productive health service, negative perception of condom, low perception about personal risk and low perceived self efficiency in preventing behaviour, also Harvey (1997) found that few young people perceive themselves to be at risk of AIDS decreased, all these findings did not support the finding of the present study.

In fact from the mean differences, the result revealed a higher mean for older hyper-gender youths than for the younger ones on the risk taking measures indicating that older hyper-gender youths were even more likely than younger hyper-gender youths to take risk and engage in more HIV risk taking behaviour, except for the perceived susceptibility to HIV/AIDS measure where they had a higher mean (older youths) indicating susceptibility to HIV/AIDS. This is consistent with a finding by Lkrtz et al (2005) which reported that older sexually active youth were likely than younger ones to express ongoing concern about becoming infected with HIV. The implication of the finding is that for this population, (hyper-gender individuals) perceived susceptibility to HIV/AIDS increases with age, however this does not result in any substantial behaviour change rather as age increases so does risk taking behaviour. It is therefore important that interventions start at an early age before negative stereotypic ideals about gender are fully formed.

Finally it was found that hyper-gender males were more likely to take risks than non-hyper-gender individuals regardless of their gender (male/female), the second view compared hyper-gender individuals based on their age. The comparison in this third statement was between hyper-gender and non-hyper-gender based on gender (Males and Females). As stated above hyper-gender males were found to be more likely to take risks than non-hyper-gender females. What this means is that males who were hyper-gender had higher scores on the general risk taking measure than females who were non-hyper-gender. The first part of this finding provided support for the present study, result of the study indicates that hyper-gender males will take more risk than non-hyper-gender females, however the second part of the finding does not support the current study, the result reveals that hyper-gender males will engage in more HIV risk taking behaviour and perceive themselves as less susceptible to HIV/AIDS. Despite the fact that this assumption is correct as indicated by the mean differences, it was not supported. Possible reason for this may be due to the socially desirable nature of under reporting sexual behaviour and drug use by participants and the small sample size.

The implication of the finding despite the above factors is that gender (Male/Female) and hyper-gender (adherences to traditional gender ideals) influence the risk taking behaviour if individuals and their perception of risk to HIV/AIDS. In this study males are more likely to engage in riskier behaviours or activities and perceive themselves as less susceptible to HIV/AIDS.

This study and others before it revealed that majority of participants in the sample population were hyper-gender and that this status was significantly related to risk taking behaviour and a lower perceived susceptibility to HIV/AIDS. Also for hyper-gender persons the level of risks increases with age and males were more likely than female to be hyper-gender, to take risks and to perceive themselves as less susceptible to HIV/AIDS. The conclusion therefore based on these findings is that there is need for substantial behaviour change for youths of all ages both males and females, increased HIV risk awareness, and there is also a need for more in depth and extensive research in this area.

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