International Journal of Science Academic Research
Vol. 06, Issue 04, pp.9769-9776, April, 2025
Available online at http://www.scienceijsar.com

ISSN: 2582-6425

Research Article

WOMEN, CHOICES, AND FAMILY PLANNING IN SOUTH ASIAN NATIONS: A COMPARATIVE LOOK

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Received 14th February 2025; **Accepted** 12th March 2025; **Published online** 25th April 2025

Abstract

Delving into the National Family Planning Programs of select South-Asian countries, this paper will analyze using extensive literature and review the trajectories, impact, and challenges of each program. The countries studied are - India, Sri Lanka, Bangladesh, and Nepal - owing to their similar lower-middle income status and shared socio-cultural history. The analysis will look into contraceptive use-trends, variation across the countries, change in rationale of policy focus and the prevalence of these methods - all within the ambit of the national policy. Historical data will also be employed to compare and contrast the impact of each program. The shared past of the region features relentless efforts to control population growth, high dependence on temporary methods, and high maternal and infant mortality. Therefore, considering that these programs have depended heavily on women's initiatives and bodies, this analysis will throw light on the gender dependence of these programs. While offering conceptual data-based policy recommendations.

Keywords: Family Planning, Contraceptive, Fertility, Women's Health, Policy.

INTRODUCTION

As the global population surpasses 8 billion and is projected to exceed 9.9 billion by 2050, the urgency of addressing population growth is self-evident, particularly in low-middle-income countries such as India, Bangladesh, Nepal and Sri Lanka [1]. These countries face similar barriers associated with growing populations owed to challenges such as poverty, literacy, cultural and religious sensitivities. Additionally, with a relatively high density of youth, they face high fertility rates which, along with declining mortality rates among reproductive age groups, further amplifies pre-existing issues. In addressing these challenges, family planning programs (FPP) have shown promising results both at the individual and societal level. South Asian Nations are currently far from reaching the third Sustainable Development Goal that highlights "ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs"[2]. In a generation where Sustainable Developmental Goals are also speaking about bringing equality among all genders, the gap remains where family planning practices have been women oriented while the male participation has remained negligible for a very long time in spite of having equal contribution. Family planning programs have emerged as a critical interference in answering to control population growth and improve health outcomes. The effectiveness and implementation of these programs vary significantly across the South Asian nations. Poverty, literacy, religion, unmet needs and limited access to family planning services profoundly influence reproductive behaviors and childbearing patterns, creating a web of challenges that block national development [3]. The trends of family planning program have drastically improved through increased uptake of modern contraceptives, but the challenges remain pertaining to unmet needs for contraceptives. The change in contraceptive usage has shown a significant impact on maternal and child mortality [4]. According to WHO, there are 1.9 billion reproductive aged women in between the age group of 15- 49 within which 1.1 billion people for whom the family planning is required. In these, unmet need for contraception includes over 164 million [5]. Almost 17% of South Asian women still face unmet needs and around 9% use traditional methods which are less effective and associated with complications like unsafe abortions, and increased child and maternal mortality [6]. The global demand for family planning has undergone many changes over the past few decades. This paper does a comparative analysis of family planning programs across four nations namely India, Bangladesh, Nepal, and Sri Lanka taking a multidimensional approach that analyses the interlinkages between gender, socio-economic and fertility rates in order to better understand the yields of their family planning programs, identifying their impacts and shortcomings.

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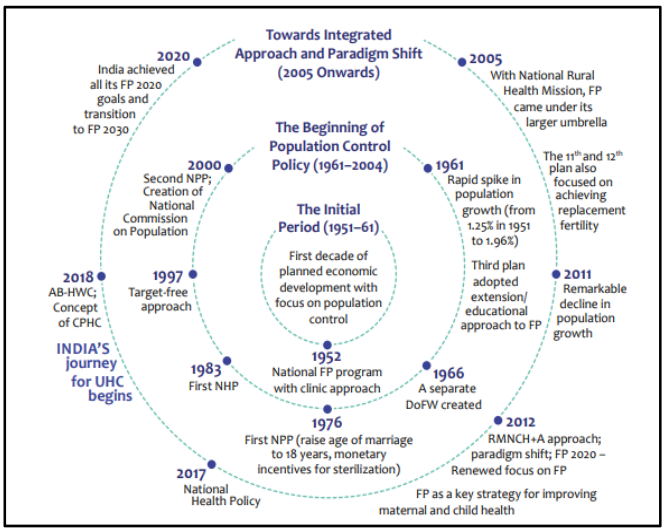
Family Planning Programs/Milestones

India: India introduced and implemented the world's first National Family Planning Programs in 1952. Said program has evolved dramatically over the decades to meet shifting health requirements and demographic challenges. To address high fertility and mortality rates, a more strategic and interdisciplinary approach to child and reproductive health, focusing on population growth, maternal and child mortality rates, was taken, starting in 2000, where these factors were initially targeted through clinical approach.

Sri Lanka: In 1968, in response to a population explosion, Sri Lanka established family planning as a national policy under the Ministry of Health.



Source: India's Vision FP 2030 [7]

The programs strategy primarily included preventive health measures with a secondary focus on curative interventions. The key indicators used to assess the impact of the program are New Acceptor Rates and Contraceptive prevalence Rate (CPR). CPR measures the percentage of people using any method of contraception at given point of time while New Acceptor measures individuals who used modern contraception (excluding condoms) for the first time. The programsemphasized women's health, gender concerns, perimenopausal care, and maternal health was into antenatal, intrapartum, postpartum, and maternal morbidity and mortality surveillance.

1965: Government took a policy decision to include family planning as part of the maternal and child health program
1966: Minister of Health appointed an advisory committee to advice on the implementation of the national family planning program
1968: The Family Health Bureau (FHB) was established
1971: The importance of family planning was stressed in the FiveYear Plan of the government
1973: Project Agreement was signed by the Government with the United Nations Population Fund for assistance in making family planning facilities available to all sections of the population
1977: Population policy formulation and coordination was assigned to the Ministry of Plan Implementation
1979: Government decided to give financial incentives to medical teams who perform voluntary sterilizations
1980: Family planning program received high visibility with a vigorous information, education and communication campaign
1980's: Population policy formulation and coordination was re-assigned to the Ministry of Health
1994: Sri Lanka became a signatory to the global consensus of a broad based concept of reproductive health detailed in the Program of Action at the International Conference on Population and Development
1998: Formulation of the Population and Reproductive Health Policy
2016: The Ministry of Health Nutrition and Indigenous Medicine has reaffirmed the importance of family planning in the National Health Strategic Master Plan

Source: Multi-Year Costed Action Plan for the National Family Planning Programs in Sri Lanka, 2019 [8]Bangladesh has made a significant improvement since 2012 in family planning by aiming to achieve targets set in FP2020 at London Summit. The Cost Implementation Plan for Family Planning Action (2016 - 2020) was initiated after Bangladesh was addressed as having one of the most densely populated youth populations.

1953-59: Voluntary and semi-government efforts
1960-64: Government sponsored clinic-based Family Planning Program
1965-70: Field-based Government Family Planning Program
1972-74: Integrated Health & Family Planning Program
1975-80: Maternal and Child Health (MCH)-based Multi-sectoral Program
1980-85: Functionally Integrated Program
1985-90: Intensive Family Planning Program
1990-95: Reduction of rapid growth of population through intensive service delivery and community participation
1998-2003: Health and Population Sector Program (HPSP)
2003-2011: Health, Nutrition and Population Sector Program (HNPSP)
2011-2016: Health, Nutrition and Population Sector Development Program (HNPSDP)
2016-2020: The Cost Implementation Plan for Family Planning Action

Source: Directorate General of Family Planning, Government of Bangladesh [9]

Nepal: The family planning program in Nepal was initiated by family planning association in 1959 and later established under Ministry of Health. Significant improvements in availability and accessibility to contraceptives were achieved in Nepal from 1976 to 1986, as well as increased knowledge and practice of family planning.

1959: FP Program initiated-Family Planning association of Nepal
1963: Establishment of MCM under Ministry of Health
1965: Government adopted policy to bring equilibrium between population growth and economic growth by policy on family planning
1968: Government supported Family Planning Service
1965-70: Third Five year development plan –Family Planning considered a crucial instrument in addressing high fertility
1978: Established contraceptive retail sale- company to distribute condom, pills
1995: Ministry of Population and Environment (MoPE) was established following principles of ICPD 1994
1998: National Reproductive Health Strategy is formed
1998: Safe Motherhood Policy –need of family planning services as key component of maternal care
2000: National adolescent health and development strategy endorsed
2003: National safe abortion policy
2005: MoPE merged with Ministry of Health and renamed Ministry of Health and Population
2011-12: National Strategy for Family Planning Services 2068/69
2015: National Family Planning Costed Implementation Plan 2015-2020

Source: Family Planning Programs in Nepal, 2021 [10]

Overview of Family Planning in South-Asian Countries

Between 2000 and 2020, the number of women using a modern contraceptive method increased from 663 million to 851 million. An additional 70 million women are projected to be added by 2030. Between 2000 and 2020, the contraceptive prevalence rate (percentage of women aged 15–49 who use any contraceptive method) increased from 47.7 to 49.0% [11]. The proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods (SDG indicator 3.7.1) is 77.5% globally in 2022, a 10% increase since 1990 (67%) [12]. Family planning (FP) interventions have improved the use of modern contraceptives, yet a high unmet need for contraception still exists in South Asia. South Asia, in particular, has the second-highest burden of maternal mortality after Africa, indicating poor reproductive health. Even though the worldwide usage of modern contraceptives has increased over the last few decades, it remains low in the South Asian region at 42% compared to the global average of 49% [13]. Approximately 17% of women in South Asia still have an unmet need for FP services and 9% are not using any modern methods, relying on less effective traditional methods that can lead to unintended pregnancies, unsafe abortions, and higher maternal and neonatal mortalities [14]. Country disaggregated data from South Asia highlight

significant disparities in modern contraceptive use and fertility rates both across and within countries [15].The frequently reported barriers to modern contraceptive use among Asian women include cultural norms, lack of method knowledge, fear of side effects, and religious restrictions[16][17].Nonetheless, noteworthy accomplishments have been observed in certain countries with regard to the decline in fertility rates by eliminating barriers to modern contraception and improving access to FP services. In Bangladesh, the effective implementation of FP interventions has resulted in a steady decline in fertility rates [18].Other studies have evidenced that India, Indonesia and Iran have experienced accelerated contraceptive use owing to FP interventions and by educating females [19][20][21]. A systematic review of 63 studies (conducted between 1994 and 2008 in LMICs) concluded that both demand-generation and supply-side interventions successfully increase knowledge, improve attitudes and beliefs, and facilitate effective communication around FP. The meta-analysis reveals that FP interventions had a significant impact on improving modern contraceptive use. It demonstrated the effectiveness of different approaches, extending beyond the demand generation. Strategies integrating FP into health system and franchised FP clinic models were particularly successful in the South Asian context [22]. Provider restrictions present another set of supply-side barriers to FP access in urban settings. Restrictions based on age, marital status, parity, and spousal consent have been identified in urban settings of South Asia [23].Urban women in South Asia may face restrictions on accessing popular contraceptive methods, such as the pill, condoms, and injectable, based on age, marital status, parity, and spousal consent. Some countries in South Asia, such as Nepal and Bangladesh, have pro-rich inequalities in access to modern methods. Efforts to reduce adolescent fertility rates may include educating girls so they can become healthy mothers and contribute to South Asia's growth [24].

The use of mobile health (mHealth) and digital platforms for family planning education and service delivery is growing across the region [25]. These tools help address geographic and social barriers to access. There is a trend towards integrating family planning with other health services, such as maternal and child health, HIV prevention, and nutrition programs. This holistic approach enhances service delivery and utilization. Increasing male involvement in family planning is recognized as crucial [26].Programs are being designed to target men and address cultural norms that hinder their participation. Recognizing the high rates of adolescent pregnancies, countries are prioritizing youth-friendly services and comprehensive sexuality education [27].

Recent studies from India, indicate a slight increase in the use of modern contraceptives, but there is still a significant unmet need [28].The National Family Health Survey (NFHS-5, 2019-21) reports that the total unmet need for contraception is around 9.4%. Initiatives like Mission Parivar Vikas, focusing on high fertility districts, have shown promise in increasing contraceptive prevalence [29].These programs emphasize spacing methods and postpartum family planning. Despite progress, regional disparities persist. Rural areas and states like Bihar and Uttar Pradesh show lower contraceptive use compared to urban regions and southern states. India digital health tool ‘Project Ujjwal’, sought to increase demand, access and quality of family planning services available in the Indian states of Bihar and Odisha [30].The two-year program was designed to support the Indian Ministry of Health and Family Welfare’s commitment to improve maternal health and child survival.

Bangladesh continues to be a model for family planning in the region, with a contraceptive prevalence rate (CPR) of 62% [31]. The Family Welfare Assistants program, which provides door-to-door services, remains effective [32]. Recent efforts have targeted adolescent reproductive health, addressing early marriage and pregnancy. The introduction of adolescent-friendly health services has contributed to a decline in teenage pregnancies. Challenges include geographic disparities and the need for more male involvement in family planning decisions. Additionally, supply chain issues occasionally disrupt the availability of contraceptives.

Nepal has seen progress in family planning over the past decade, but there is still work to be done. The CPR remains around 43%, and the unmet need is approximately 24% [33]. The government has launched the “National Family Planning Costed Implementation Plan 2015-2020” to enable women and couples to attain the desired family size and have healthy spacing of childbirths by improving access to rights-based FP services and reducing unmet need for contraceptives [34].The Costed Implementation Plan (CIP) of MoHP focuses on five strategic areas: enabling environment, demand generation, service delivery, capacity building, and research and innovation, to address the existing challenges and opportunities for scaling up rights-based FP in the country. The expected outcomes from these approaches are to increase demand satisfied for modern contraceptives, increase the contraceptive prevalence rate (CPR) for modern methods, reduce unmet need, and diminish the adolescent fertility rate, as well as total fertility rate, as targeted by the plan [35].

Sri Lanka has maintained high contraceptive use, with a CPR of 65%, with 54% using modern methods [36].The country’s robust public health infrastructure supports widespread access to family planning services. Efforts include the use of digital tools for family planning education like ‘Ask me Hotline’ phone consultation. As part of the South-South Learning Exchange program, sharing of best practices across Nepal and Sri Lanka has contributed positively in improving the knowledge and capacity of national and subnational FP program managers on technical and programmatic issues and contributed to strengthening the health systems of both countries to better elaborate, implement and deliver quality FP programs [37].

Family planning is a key part of primary health care and can be a cost-effective investment in global health [38].It can help people make informed choices about their sexual and reproductive health through education, information, and contraceptive methods. Family planning can also help reduce birth rates to levels that are compatible with socioeconomic development and environmental protection. Achieving universal access and the realization of sexual and reproductive health services will be essential to fulfil the pledge of the 2030 Agenda for Sustainable Development that “no one will be left behind”. It will require intensified support for contraceptive services, including through the implementation of effective government policies and programs [39]. Fertility rate is more or less similar for all the 4 nations. Fertility rate is defined as the average number of children born to women during their reproductive years [40].High fertility rates in developing

nations poses a challenge in developing nations leading to resource constraints, hinders economic development, and also healthcare services. Lower fertility rates often conversely results in maternal mortality and child mortality rates, and also positively impacts economic stability. Figure 1 below indicates the decline in fertility rate since the 1950's.

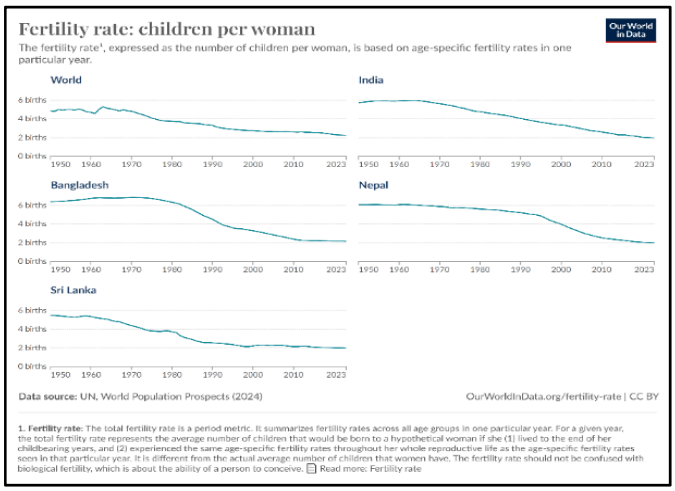
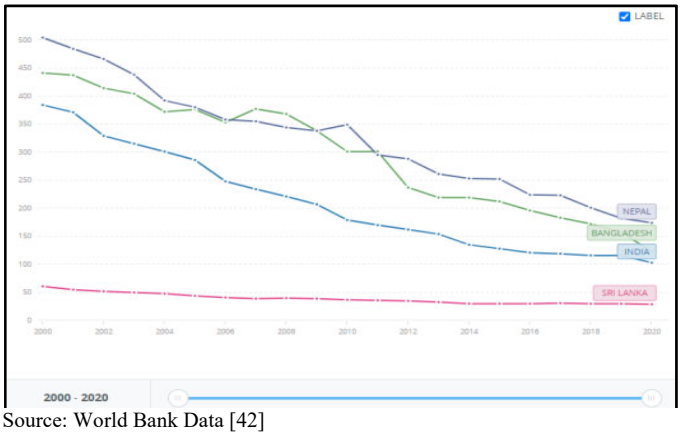


Figure 1. Fertility Rate 1950 to 2023 in India, Bangladesh, Nepal and Sri Lanka

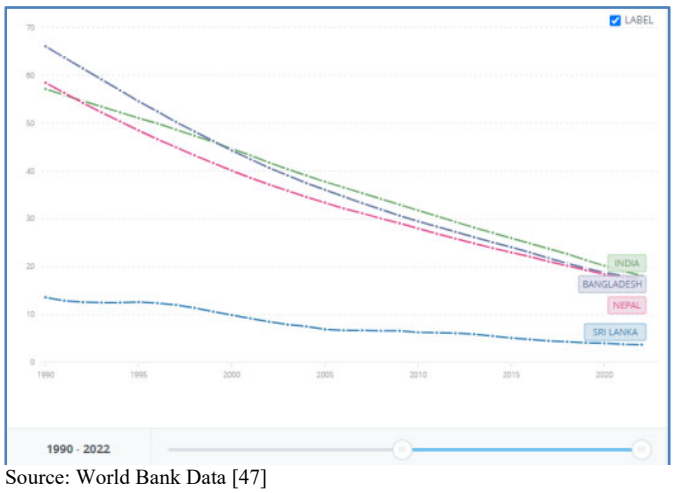
A wide range of factors – women's empowerment, the increasing well-being and status of children, technological and economic changes, changing norms, and opportunities for family planning – have led to the reduction in the total fertility rate. The level of education in a society of women in particular is one of the most important predictors for the number of children families have. Better education also improves knowledge, the use of contraceptives, and the ability of better-educated women to reduce the gap between their desired number of children and the actual number of children they have. Maternal mortality refers to death occurring as the result of pregnancy complications or complications arising from childbirth. According to inter-agency estimates from the United Nations, global maternal mortality ratio has decreased by 34% since the year 2000 and 2020 from 339 to 223 per 1, 00,000 of live births. An annual average decrease rate in this ratio has been estimated at 2.1%. This only equates to 1/3 of the 6.4% annual rate required to meet the Sustainable Development Goal (SDG) target of 70 maternal deaths for every 100,000 live births by 2030 [41].This is far reaching for India, Bangladesh and Nepal despite the decline in past decades (Fig 2).



Source: World Bank Data [42]

Figure 2. Maternal Mortality Ratio (2000-2020)

Despite the progress in reducing under-five mortality, millions of young lives still hang in the balance. Under current trends, 59 countries will miss the SDG under-five mortality target and even more – 64 countries – will miss the neonatal mortality target [43]. According to UNICEF data, three quarters of still births in the world occurs in South Asia and Sub- Saharan Africa indicating the highest stillbirths [44]. The figure 3 below indicates the decline in neonatal mortality rate from 1990 to 2022; India 57 to 18, Bangladesh 66 to 17, Nepal 59 to 17, Sri Lanka 14 to 4. Despite the progress, the leading causes of death for newborns have remained the same, accounting for 4 in 10 deaths in children under 5 years old. Family planning services can help reduce newborn deaths by increasing contraceptive use [45-46].



Source: World Bank Data [47]

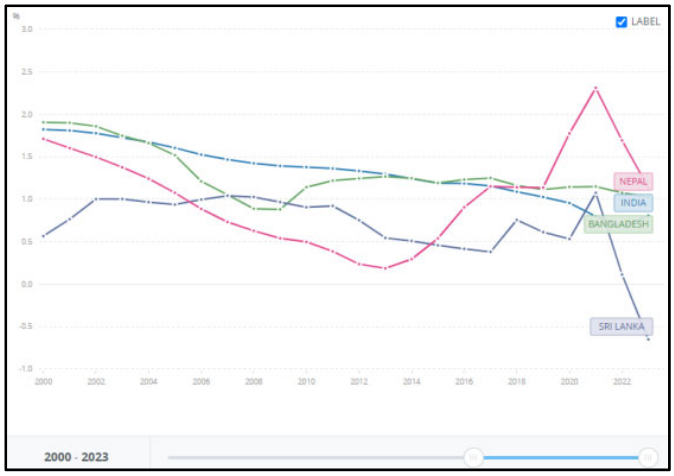
Figure 3. Neonatal Mortality Rate (1990-2022)

The progress of a nation is attributed by the population. Rapid population growth in low- income and low middle income nations makes is invariably difficult with respect to public expenditures on eradication of malnutrition, hunger, poverty, health care and education which are entwined with the country's development. Ensuring that people, especially women, have the autonomy to choose how many children they want and when to have them can significantly enhance wellbeing and break the cycle of poverty that persists throughout generations. Improving access to high-quality reproductive health care services, such as family planning that is both safe and effective, may assist lower fertility and hasten social and economic advancement. Fig 4 shows the population growth rate for India, Bangladesh and Nepal in range of 0.8 to 1.1%, however a decline by -0.7% based on the balance of birth and death rates, as well as migration. Family planning is a key element in managing population growth and promoting health and well-being among families. At its core, it involves making informed decisions about when to have children, how many children to have, and the use of contraception to prevent unwanted pregnancies [48].

Family planning through gender lens

Gender norms and gender-based discrimination are critical drivers of family planning (FP) outcomes in India and globally. With more than 70% of contraceptive-users worldwide being women, global contraceptive-use is gender imbalanced (UNDESA, 2019). A growing emphasis has been placed on the use of inclusive language in family planning. Terms like "enabling access to quality contraceptives" are being advocated to ensure service quality for all demographics. The

focus should also be on male adolescents whose increased participation could be a game changer. Building capacity among health workers, addressing intersectionality, and implementing innovative solutions through effective public and private partnerships and advocacy initiatives can significantly improve access to family planning services and the overall health of our younger population.



Source: World Bank Data [49]

Figure 4. Population Growth Rate (% annual)

While the countries of South Asia have made progress in increasing access to modern family planning, and reducing total fertility rates, the region still accounts for the second highest burden of maternal deaths. Poor, marginalized and uneducated households do not have access to the reproductive health services they need, including family planning. Adverse socioeconomic and cultural factors like low levels of education, no exposure to mass media, lack of or limited knowledge about family planning, poor household wealth status, religion, and ethnicity remain impediments to the use of modern contraceptives [50]. There are cross-country as well as within-country disparities, with lower levels of contraceptive use among poorer, illiterate, rural, and younger women. Further these disparities are most pronounced in southern region of Asia, including India.

Studies show that in the Indian society many factors like urban vs rural residence, socioeconomic factors like household wealth and media exposure are likely to influence contraceptive use. Multiple pieces of research in India have extensively focused on the trend of contraceptive use, differentials, and its predictors. However, the level of economic inequality in the use of modern contraceptives and its relationship remains unknown. A cross-country study including India, Bangladesh, Nepal, and Pakistan on contraceptive use and inherent socioeconomic inequality showed illiteracy, poor economic status, and rural contributed negatively to inequalities in contraceptive use. Likewise, another study including 11 low- and middle-income countries shows inequalities in the prevalence of contraceptive use were higher among poorer, older, and non-educated women. In addition, previous researches also revealed that modern contraception use is linked to education, exposure to mass media, knowledge about family planning, household wealth status, surviving son, religion, and ethnicity. This study further reveals that modern contraceptive use is concentrated among women from poor socioeconomic strata both in young and non-young categories. The non-use was more common among women in the highest wealth quintile, the probable reason might be the fear of side effect or health concern among wealthy women. An example of Jharkhand state in India, only 13% of women from the poorest economic stratum use modern contraceptives compared to 52% of women from the richest stratum.15% of tribal women without any education use modern contraceptives compared to 35% of women with 10 or more years of education. Employed married tribal women are more likely to use modern contraceptives than unemployed women.

Education is a strong protective factor against child marriage, and policies that promote girls' completion of secondary schooling can help to reduce child marriage. In this context, interventions that support girls' school attendance and retention through cash or in-kind transfers – notably the provision of conditional cash transfers or subsidies, such as school uniforms and supplies – have been identified as strong deterrents [51].Also observed in some settings of South Asia and sub-Saharan Africa are positive effects of technical and vocational education and training programs that empower young people economically and can enable the exercise of voice in marriage and childbearing decision-making.

Women, literacy, poverty and Family planning

These countries have relied heavily on temporary contraceptive methods and have faced issues with sensitive health indicators, such as maternal mortality and infant mortality rates. The gendered nature of these programs, which often places the burden on women particularly. This study highlights the gendered dependence of family planning programs and proposes conceptual policy recommendations based on data. These insights are important for developing strategies that can effectively address the region's population growth challenges and promote sustainable development. An increased focus on women's sexual and reproductive health (SRH), rights, and quality access to contraception and FP services have become a part of the government's women empowerment package, especially after the ICPD. Recognizing dynamic connections between sustainable development, demographic dynamics, human rights, and empowerment of women, the 2019 ICPD demonstrates a commitment towards enabling women as equal partners in development, stating that "gender equity and empowerment have been guiding principles in the development policies of the Government of India."

However, even this discourse of women empowerment within family planning policy fails to engage with gender-imbalances in contraceptive practices, hence flourishing without being cognizant of the unfair share of the contraceptive burden that women carry and the social, emotional and bodily drawbacks that accompany this burden [52]. Instead, an increase in the use of contraceptives amongst women is only celebrated as their empowerment [53].

Literacy and Family planning - Case Study from Nepal and India

This study from Nepal on the nexus between women's literacy rate and family size utilizing data spanning three decades from the National Population Census (1991 to 2021). The findings reveal a considerable rise in women's literacy rates over the three decade period, marking a noteworthy shift from the substantially low rates observed in 1991. Crucially, an intriguing relationship emerged between women's literacy rates

and family size. Historically, when female literacy rates were considerably lower, the national average family size tended to be higher. However, with the progressive increase in female literacy rates in recent y ears, a marked shift toward smaller, nuclear family sizes, averaging around four members, was observed. This shift implies that literate women exhibit heightened self- awareness regarding family planning, influencing the move toward maintaining smaller nuclear families [54]. These findings underscore the critical role of women's education in influencing family planning and size, marking a pivotal factor in shaping societal structures and developmental paradigms.

The impact of female literacy and family planning was evaluated through a research done among married women in rural South India. The study was conducted on 100 married women in their reproductive age i.e., 15-45 years from three PHC's in rural Tamil Nadu. The study proved the positive effect of women's literacy on family planning concepts, which also suggested that increased literacy levels among women lead to a satisfactory family planning practice. This makes it evident that female literacy serves as a tool to promote the right utilization of contraception to address the population growth in India as well as other South Asian countries as well. This study also highlights the need for strategic intervention emphasizing on female literacy for a better outcome of family planning practices and reduce the negative impacts on women's reproductive health [55].

Conclusion

The comparative analysis of national family planning programs in South Asian nations reveals a diverse landscape of contraception practices, policies, and outcomes. While significant progress has been made in expanding access to contraceptive services, challenges persist in ensuring equitable access, addressing cultural barriers, and improving the quality of family planning services. Countries have demonstrated effective strategies by integrating family planning with broader health initiatives, but still face gaps in coverage and quality. The gendered nature of these programs, which often places the burden of family planning on women, further complicates the landscape. The contraceptive measures are mainly focused on women starting from educating women in order to reduce fertility rates to family planning programs with give prominence to women contraceptive methods while male participation has been considerably low. In the world where sustainable goals are focusing on women, child and equality, the Family planning programs are women- centric further exacerbating inequality among people causing an adverse effect in developing nations like India, Sri Lanka, Bangladesh, Nepal which are low and middle income countries influenced by cultural, social and economic factors. Only half of the problem can be solved through the current programs but to address the battle of population growth, maternal mortality, infant mortality and fertility rates it crucial to involve men at every step. Enabling men and women equally by educating and involving them in family planning practices could create a responsible society and reduce the burden on women and children and improve reproductive health overall. This can be the potential way ahead to tackle this issue. The analysis underscores the importance of context-specific approaches that account for the unique cultural, socio-economic, and demographic factors of each nation. The role of government policies, international partnerships, and civil society in advancing family planning cannot be overstated. However, to sustain and accelerate progress, there is a need for continuous innovation, stronger political will, and investment in education and community engagement.

Acknowledgements

I gratefully acknowledge the support of Dr.Muktha Subramanya for her valuable assistance in literature review that contributed to the development of this paper.

Statement of Competing Interest: No competing interests

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