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Research Article

Behind the Gates of Safety:
Trauma and Behaviour at an SOS Children's Village in South Africa

Ratidzai Shoko*

Department of Educational Foundations, University of South Africa, Pretoria, 0003, South Africa.

***Corresponding author's e-mail:** kratidzai@gmail.com

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ABSTRACT

Background: Children entering alternative care systems such as SOS Children's Village typically carry histories of neglect, abandonment, abuse, or family breakdown. Little research examines how frontline staff recognise and respond to trauma within SOS Children's Village settings, a gap relevant to child mental health policy and health system strengthening in South Africa and other low- and middle-income countries (LMICs).

Aims: This study describes how childhood trauma manifests behaviourally and developmentally among children in residential alternative care and identifies systemic gaps limiting a trauma-informed response.

Methods: A secondary qualitative analysis used Braun and Clarke's six-phase thematic analysis of semi-structured interviews with six purposively sampled staff respondents at a single SOS Children's Village in South Africa, spanning frontline and management-level roles. The UNISA College of Education Ethics Review Committee granted ethical clearance.

Results: Six themes were identified: nature and sources of trauma, behavioural manifestation, mental health and developmental impact, secondary trauma of caregivers, systemic barriers, and protective factors and resilience; most consistently, secondary trauma of caregivers and systemic barriers. Trauma manifested through externalising behaviour (aggression, bullying, sexualised conduct, including re-enacted sexual victimisation in one case), developmental delay, and attachment difficulty. Compounding these were limited psychological services, no formal mental health framework, and caregiver-reported secondary traumatic stress. Residentially raised children appeared more dependent post-care than those in community-based family strengthening; given the single-site design, this is illustrative rather than generalisable.

Conclusion: Childhood trauma at this SOS Children's Village follows a consistent behavioural and developmental profile that extends psychologically to caregivers. Addressing this requires a formal, organisation-wide trauma-informed framework, caregiver supervision, and interdisciplinary case coordination. These offer concrete ways to strengthen trauma-informed practice in comparable residential care settings, with implications for child mental health policy and health system strengthening in South Africa and other LMICs.

Keywords: *Childhood trauma; Residential care; SOS Children's Village; Trauma-informed care; Secondary traumatic stress.*
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1. Introduction

Children who enter alternative care systems such as SOS Children's Village typically arrive with histories of neglect, abandonment, abuse, or family breakdown. The SOS Children's Village model is a particularly important setting in which to study this question because, unlike residential models that rely on rotating shift staff, it retains a family-style structure built around a consistent, non-rotating caregiver and small sibling groups, so that trauma unfolds under conditions of relative relational stability rather than staff turnover. Bowlby's (1969/1982) attachment theory established that a child's early relationship with a consistent caregiver organises subsequent emotional regulation and social behaviour; disruption to that bond has consequences extending well beyond the period of disruption itself. Although the behavioural and developmental consequences of early adversity are well documented across the foster and institutional care literatures broadly (Barboza et al., 2017; Font & Maguire-Jack, 2016), comparatively little research examines how trauma is recognised, interpreted, and responded to by frontline staff within a specific SOS Children's Village setting, where staff observation is frequently the only available window into a child's trauma history.

This staff-mediated perspective cannot substitute for children's own accounts. Interviewing children directly about their trauma carries a meaningful risk of re-traumatisation and raises considerable ethical and developmental complexity within an already vulnerable care population, so staff accounts represent the most feasible and protective available source of insight into how trauma is expressed and managed day-to-day. Still, caregivers' interpretations shape the everyday responses children receive, so gaps in how staff understand trauma translate directly into gaps in the support children are offered. Within South Africa specifically, published evidence on how trauma is recognised and responded to inside SOS Children's Village settings is virtually absent, despite the country's high burden of childhood adversity and its heavy reliance on residential alternative care, a burden that underpins the statutory framework for child protection and alternative care set out in the Children's Act 38 of 2005.

Two studies speak directly to the SOS model. Dumaret (1988) found that children raised within SOS Children's Villages continued to display elevated behavioural and emotional difficulty relative to non-institutionalised peers despite the model's family-style stability. Lassi et al. (2010) found that SOS-raised children showed fewer behavioural problems than children in a conventional orphanage, though meaningful difficulty persisted, suggesting even a comparatively protective care model cannot substitute for targeted, trauma-specific clinical intervention. The broader evidence is similarly nuanced: the Bucharest Early Intervention Project found that early institutional deprivation produced measurable cognitive impairment relative to family-based care (Nelson et al., 2007), while a large multi-country comparison found institutional living was not, in itself, associated with worse wellbeing once caregiving quality was accounted for (Whetten et al., 2009), suggesting caregiver stability and quality, rather than the institutional or family-based label, is decisive. Caregivers themselves are also affected: adults who care for traumatised children frequently develop secondary traumatic stress (Figley, 1995; Helder et al., 2026). This paper examines, through staff interviews at an SOS Children's Village in South Africa, how childhood trauma manifests behaviourally and developmentally among children in care and identifies the systemic gaps that limit a trauma-informed response, to inform recommendations for practice and policy, with relevance to child mental health policy and health system strengthening beyond this setting. Specifically, this study aims to: (1) describe how childhood trauma manifests behaviourally and developmentally among children in residential alternative care, as reported by frontline and management-level staff; and (2) identify the systemic gaps that limit a trauma-informed response at this SOS Children's Village.

2. Methods

This is a secondary qualitative analysis of data originally collected at an SOS Children's Village in South Africa in 2024, using Braun and Clarke's (2006) six-phase thematic analysis. A secondary, staff-focused design was chosen because the existing dataset already captured detailed staff accounts across several distinct caregiving and management roles, offering an efficient route to describing trauma manifestation and systemic gaps without further data collection from an already vulnerable child population.

Rationale for a Multiple-Case Design

A multiple-case study approach was considered appropriate because it allowed the manifestation of trauma and the organisational response to it to be examined from multiple, functionally distinct vantage points within the same institution, rather than treating staff as a single, homogeneous source. Each case was defined as a respondent's organisational role, spanning caregiving, social work, programme coordination, and management, with its own scope of contact with children and responsibilities within the organisation. Analysing these roles as separate cases, and then comparing across them, made it possible to identify which patterns of trauma manifestation and which systemic gaps were consistent across the organisation and which were specific to a particular vantage point.

Study Design / Research Procedures

Data consist of semi-structured interviews with six purposively recruited respondents occupying different roles. Inclusion required a caregiving, social work, coordination, or management role with direct exposure to children's case histories and behaviour. Participants held between five and fifteen years in their current role (mean = 8 years); five respondents identified as female and one as male. The programme director acted as gatekeeper for initial access but was not themselves a participant in the primary interviews, a separation intended to limit the influence of positional authority on respondents' willingness to speak candidly; recruitment and interviewing were nonetheless conducted with awareness that some respondents reported to the gatekeeper directly, and this possible source of social-desirability bias is noted as a limitation. The original primary data collection and interviewing were conducted by the original research team; the present authors conducted the secondary thematic analysis reported here and participated in the original interviews. These six cases spanned frontline caregiving, social work, programme coordination, and management, ensuring the analysis captured how trauma is recognised and responded to at different levels of the organisation, and allowing frontline, case-level accounts to be compared against management-level, organisational accounts within the same analysis.

Data Collection

An interview guide elicited staff accounts of children's trauma histories, behavioural and developmental patterns, the organisation's approach to psychological support, and staff members' own experiences of the emotional demands of the role, with follow-up probes tailored to each respondent's role. Interviews were audio-recorded with consent and transcribed verbatim.

Data Analysis

Transcripts were read repeatedly for familiarization, and then coded inductively, capturing both semantic and latent content. Codes were grouped into candidate themes, reviewed against the coded extracts and full dataset, then refined and named, producing the six themes reported below. Particular attention was paid to whether a pattern held across frontline and management-level respondents or reflected only one role. Credibility was supported through prolonged engagement and triangulation across roles; dependability through a documented audit trail from transcript to code to theme; and confirmability through researcher reflexivity, given that the researchers' role was one of secondary interpretation rather than original data collection, which precluded member-checking of emerging themes. Emerging themes were validated through systematic comparison of codes and extracts against the full dataset, discussion of candidate themes within the research team to reach consensus, and a peer debrief in which an independent colleague reviewed the coding framework and theme definitions for fit with the data. Information sufficiency was judged to have been reached once successive transcripts ceased to generate new codes relevant to the study objective and each theme was supported by data from more than one respondent role, rather than resting on a single account.

Ethical Clearance

Because data were collected from staff rather than children directly, all statements about children's trauma are mediated through caregiver observation rather than direct child self-report. Ethical clearance was granted by the

UNISA College of Education Ethics Review Committee (2024/06/12/000000031/01/RB), and consent to publish was obtained from participants. Identifying details of participants and children were removed or generalised throughout, and all transcripts and derived data were stored on password-protected, university-managed servers accessible only to the research team, consistent with UNISA data storage and security requirements. Figure 1 summarises the overall study process, from secondary dataset identification through to final theme reporting.

Step 1 — Secondary dataset identified: transcripts of six semi-structured staff interviews already collected at the SOS Children's Village.

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Step 2 — Multiple-case framing applied: each respondent's organisational role (caregiving, social work, programme coordination, management) treated as a distinct case.

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Step 3 — Familiarisation: transcripts read repeatedly to develop overall familiarity with the dataset.

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Step 4 — Inductive coding: semantic and latent content coded case by case.

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Step 5 — Candidate theme generation: codes grouped into candidate themes and compared across cases.

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Step 6 — Theme review and validation: candidate themes checked against coded extracts and the full dataset, discussed to consensus within the research team, and peer-reviewed; information sufficiency confirmed once no new relevant codes emerged.

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Step 7 — Final themes reported: six themes finalised, distinguishing patterns consistent across frontline and management perspectives from those specific to a single role.

Figure 1. Study process flow chart

3. Results

Six themes were identified. Frontline respondents supplied most case-level detail, consistent with closer daily contact with children, while management-level respondents corroborated patterns and contributed organisational context. The themes identified were: Nature and sources of trauma, Behavioural manifestation, Mental health and developmental impact, Secondary trauma of caregivers, Systemic barriers, and Protective factors and resilience. Of these, Secondary trauma of caregivers and Systemic barriers were the most consistently reported across cases, corroborated independently by both frontline and management-level respondents, whereas the examples reported below that are attributed to a single participant are identified as such and should be read as illustrative rather than corroborated across cases. Details of sensitive incidents involving children have been generalised throughout this section to protect child identity.

These six themes answer the study's objective by tracing a single arc: children's trauma originates in identifiable adverse histories, manifests through a consistent cluster of behavioural and developmental presentations, extends psychologically to the caregivers who support them, and is met by an organisational response that remains largely informal and under-resourced, moderated by protective factors that are real but insufficient on their own. Examined together, the themes show not only how trauma presents at this SOS Children's Village but where the systemic response to it breaks down (as shown in Figure 2).

Nature and Sources of Trauma

Presenting histories converged on a small set of adverse origins: abandonment, neglect, exposure to household sexual activity, sexual abuse, and family disruption linked to poverty, illness, or death. One respondent described five boys who, having themselves been molested before placement, later re-enacted this trauma on an animal, framed by staff as "unhealed trauma" rather than deviance, consistent with Finkelhor and Browne's (1985) traumagenic dynamics model. Most children entered care before age eleven, with neglect and abuse the leading grounds for removal, consistent with the cumulative-trauma pattern described by Felitti et al. (1998) and Barboza

et al. (2017). Admission data reflect similarly disadvantaged socioeconomic circumstances, with most children arriving from households already affected by unemployment, overcrowding, or inadequate housing before placement. These adverse origins rarely occurred in isolation. Poverty, family instability, and exposure to violence have frequently co-occurred within the same child's history rather than presenting as a single, discrete traumatic event. This pattern of compounding adversity mirrors Font and Maguire-Jack's (2016) finding that childhood abuse rarely occurs as an isolated event among children who enter foster care, but instead clusters with other risk factors that shape health and behavioural trajectories well into adulthood.

Trauma exposure:
Abandonment, neglect, abuse, family breakdown.
↓
Behavioural and developmental manifestations:
Aggression, sexualised behaviour, developmental delay, attachment difficulty, secondary trauma in caregivers.
↓
Organisational response gaps:
No formal mental health framework, limited specialist training, resource-dependent training, high caregiver-to-child ratios
↓
Net effect:
An informal, individually-dependent trauma response requiring systemic, organisation-wide reform.

Figure 2. Conceptual summary of findings.

Behavioural Manifestation

Respondents described a consistent cluster of externalising behaviours: anger, aggression, bullying, stealing, lying, and manipulation, particularly among adolescents, who often experienced the supervised environment as confining: *"The children regard SOS as a prison because the mothers... ensure the children are safe as they are monitored on a daily basis. The aggression starts where the freedom of the children is limited"*.

One case, recounted by one participant, involved a child who took a table knife to a caregiver after being told, "I do not want you, you are not my child," and was subsequently referred for psychological support and medication. Sexualised behaviour was reported as a distinct, trauma-driven category, with older children directing newly admitted peers toward secluded areas during unsupervised play; supervision has since been intensified in response. These accounts mirror Lassi et al. (2010), who found aggression and conduct problems the most persistent difficulties even within the comparatively protective SOS model. Manipulation was described as extending beyond individual interactions to an awareness of institutional process, with staff noting that some children had learned how to provoke a reaction or use the referral and admission system to their own advantage. In one instance, a child who did not respond to therapeutic intervention expressed this frustration physically, breaking a classroom desk in two during a confrontation with staff, illustrating the intensity these behaviours can reach when underlying trauma goes unaddressed.

Mental Health and Developmental Impact

Respondents described marked cognitive and developmental effects, including a sixteen-year-old functioning at a three-to-four-year reasoning level, and children exhibiting extreme distress, including climbing structures, when anticipated family visits fell through. Staffs have since stopped pre-announcing visits. Access to formal psychiatric assessment is a recurring constraint: no resident clinical psychologist serves the area, and diagnostic reports from external referrals are often withheld from social workers, consistent with Hambrick et al.'s (2016) finding that trauma-specific intervention remains inconsistent across care settings. No formal mental health framework exists for children or caregivers. These developmental gaps were described as affecting schooling directly, with several children requiring remedial or special-needs placement despite chronological ages that would ordinarily place them in mainstream classrooms. The absence of accessible, resident psychiatric expertise also meant that some children were prescribed psychotropic medication by external clinicians without a clear diagnostic picture being shared back with the caregivers responsible for their day-to-day care.

Secondary Trauma of Caregivers

Participants described carrying children's distress home, consistent with Figley's (1995) concept of secondary traumatic stress. One participant corroborated emotional breakdowns and hypertension among social workers and noted that his own professional boundary with the team leaves him with few internal outlets, relying on friends and family "to get that space, debrief and vent." A formerly structured debriefing service has been discontinued. One participant described receiving only one debriefing session after a child died in care. This mirrors Helder et al.'s (2026) finding that carers' secondary traumatic stress is shaped as much by organisational support as by trauma severity. This burden was compounded by an informal support role that many participants described taking on for one another, with more experienced staff reporting that they often absorbed colleagues' distress in addition to their own. Structured self-care initiatives, such as peer support groups organised by staff themselves, existed but functioned as a substitute for, rather than a complement to, professional debriefing. Salloum et al. (2015) found that self-care practices can buffer burnout and secondary trauma among child welfare workers, but only when paired with organisational support, a combination participants described as largely absent at SOS. Without this combination, participants suggested that the psychological costs of the role were increasingly being carried individually rather than shared systematically across the organisation.

Systemic Barriers

Barriers spanned training, resourcing, and admissions practice. A participant described how referring statutory social workers may under-report a child's trauma history to secure placement. Another participant independently confirmed that policy formally excludes children with primarily behavioural presentations, but difficult to enforce once a court order is in place, suggesting the incentive to conceal is structural. Staff lacked training in sexual trauma and disability care, significantly given that children with disabilities face two-to-three-times greater odds of victimisation (Jones et al., 2012). Funding has narrowed since COVID-19, with donor loss shared across the organisation's eleven facilities. The caregiver-to-child ratio is approximately one to eight, sitting uneasily against UN guidelines for individualised attention (United Nations General Assembly, 2010). One participant explained that requests for training were rarely declined outright but were dependent on the availability of external donors willing to fund a specific workshop, meaning the timing and scope of professional development were driven by funding cycles rather than assessed need. This resource dependency was described as particularly constraining for disability-related training, an area participants identified as chronically under-resourced despite the elevated vulnerability of the children it would serve. Figure 2 summarises how these systemic barriers complete the full arc from trauma exposure to an informal, individually dependent organizational response.

Protective Factors and Resilience

Findings were not uniformly negative. Respondents described vocational commitment, stakeholder partnerships, and alumni who completed tertiary education or returned to serve as motivational speakers, consistent with Lassi et al. (2010) and Dumaret (1988) on the protective value of SOS's family-style structure. However, one participant observed that children raised within the Village showed less resilience after leaving care than those supported through community-based family strengthening, describing the former as "more dependent on the SOS care and the caregivers." This complicates a straightforward reading of the model as protective, suggesting relational stability and material provision may also foster dependency that becomes a liability at the point of exit.

Frontline and Management Perspectives Compared

Frontline and management-level respondents converged closely on the nature of trauma presentations and on the absence of a formal mental health framework, reflecting shared exposure to the same case histories and resourcing constraints. They diverged, however, in emphasis and interpretation. Frontline respondents, closer to daily caregiving, emphasised the intensity and immediacy of behavioural crises and their own emotional toll, describing secondary traumatic stress in personal, embodied terms. Management-level respondents were more likely to frame the same presentations in organisational terms, discussing funding cycles, donor dependency, and policy constraints on admissions and training. Assessments of protective factors also diverged: management-level

accounts pointed to institutional achievements such as alumni outcomes and stakeholder partnerships, while a frontline account raised a more critical, dependency-related qualification about resilience after leaving care. This divergence suggests that a fuller trauma-informed response requires deliberately connecting frontline, case-level observation with management-level decisions about resourcing and policy, rather than assuming the two automatically align.

4. Discussion

These findings describe complex childhood trauma operating within a relationally stable but clinically under-resourced care environment, with implications that extend beyond this single site to child mental health policy and health system strengthening in South Africa and other low- and middle-income countries. The behavioural presentations documented are consistent with what attachment theory (Bowlby, 1969/1982) and trajectory evidence (Barboza et al., 2017) would predict following chronic early exposure to neglect and instability: dysregulated affect and behaviour that functions as survival adaptation rather than simple misconduct. For psychosocial care specifically, this reframing matters because it shifts the operative question away from managing individual behaviour and toward building a care environment, staffing, supervision, and referral pathways, capable of holding and responding to trauma as a routine feature of the population served, rather than as an occasional crisis. That staff themselves framed trauma re-enactment in these terms, rather than as delinquency, suggests a degree of trauma awareness already present in practice. This is consistent with a recent systematic review finding that institutional caregivers' own competence mediates children's attachment outcomes (Martínez-Usarralde et al., 2025), reinforcing that caregiver consistency and skill, not merely a family-style structure, are the operative mechanism.

The absence of a documented mental health framework and the shortage of specialist training indicate that this awareness has not translated into the standardised, organisation-wide protocol envisaged by trauma-informed care frameworks (Substance Abuse and Mental Health Services Administration, 2014), built around concrete elements such as routine trauma screening, structured clinical supervision, and cross-disciplinary case meetings, leaving a system that depends heavily on individual judgement and improvisation, a dependency that is itself unsustainable given the secondary traumatic stress documented among staff (Helder et al., 2026); this is the basis for this paper's recommendation, below, for routine clinical supervision and funded staff debriefing rather than informal debriefing alone. Should SOS move toward a formal model, implementation evidence suggests the choice of framework matters less than the quality of its implementation: leadership commitment, staff support, and use of outcome data determine success (Bryson et al., 2017), while the evidence base for any single model's comparative effectiveness remains limited (Bailey et al., 2019).

The data also illustrate a tension between structure and autonomy. Adolescents experience protective supervision as restrictive, a loss of freedom that itself triggers oppositional behaviour, and staff routinely overestimate how safe children feel relative to children's own reports, in which relationship quality with staff, not supervisory control, is the strongest predictor of felt safety (Sellers et al., 2020). Comparative evidence from other SOS and institutional settings reinforces this same point (Dumaret, 1988; Lassi et al., 2010; Whetten et al., 2009), and unresolved trauma continues to shape adjustment well beyond the period of care (Font & Maguire-Jack, 2016). These findings extend Dumaret (1988) and Lassi et al. (2010) by identifying the specific behavioural and developmental presentations, sexualised conduct, extreme reactions to family-visit disruption, and institutional manipulation of referral processes that sit beneath the general elevated-difficulty finding those studies report. They also challenge any assumption that the SOS model's family-style stability is, by itself, protective: the dependency pattern described here suggests the model's central mechanism can also become a liability without a parallel, deliberate focus on children's eventual independence.

Given the small, single-site sample, this study lies less in generalisable prevalence claims than in the depth of the staff-mediated account it offers, complementing comparative literature that relies on standardised measures across many sites. Whether the specific presentations documented here, trauma re-enactment, severe developmental delay, and staff secondary traumatic stress, are characteristic of the SOS model more broadly or specific to this site's pre-placement histories and resourcing is a question this design cannot resolve. Two further limitations warrant note. First, findings come entirely from staff interviews rather than children themselves, so

they capture caregiver observation and interpretation of trauma rather than children's own experience. Second, with only six respondents from one site, findings cannot be generalised to other centres or contexts; the secondary nature of the analysis also precluded member-checking of emerging themes with participants.

Despite this single-site design, several features of the findings are likely to transfer to other child-care institutions operating under similar conditions in South Africa and other low- and middle-income countries: high caseloads relative to caregiver numbers, limited access to specialist mental health services, and donor-dependent funding for training. Where these structural conditions hold, similar gaps between committed frontline practice and the absence of a formal trauma-informed framework should be expected, making the organisational, rather than individual, response the more useful unit of comparison across settings.

5. Conclusion

This study set out to describe how childhood trauma manifests behaviourally and developmentally among children at an SOS Children's Village, and to identify the systemic gaps limiting a trauma-informed response. This objective was achieved. The study identified a consistent behavioural and developmental profile through which trauma manifests, and it identified concrete systemic gaps: an absent mental health framework, restricted specialist access, resource-dependent training, and unsupported secondary traumatic stress that limit trauma-informed practice at this site. Drawing on staff interviews across frontline and management roles, it has shown that trauma manifests through aggression, bullying, sexualised conduct, and developmental delay, with psychological weight extending to the social workers and caregivers who support these children. The organisation demonstrates genuine strengths, a committed workforce, stakeholder partnerships, and documented long-term positive outcomes that compare favourably with the broader evidence on family-style residential care, but these strengths currently operate without the formal trauma-informed infrastructure the scale of children's histories would warrant. Ultimately, closing these gaps depends on systemic organisational change, formal frameworks, interdisciplinary case coordination, dedicated clinical resourcing, and monitored protocols, rather than on the commitment of individual caregivers alone, which, as the findings show, is already considerable but cannot substitute for structural reform. These recommendations are likely relevant to other residential care settings in low- and middle-income countries operating with similar resource constraints.

6. Recommendations

For practice, frontline staffs need targeted training in sexual trauma response and disability care, together with routine clinical supervision rather than informal debriefing alone. For organisational policy, SOS should formally adopt an organisation-wide trauma-informed framework backed by a resident or regularly available clinical psychologist, routine trauma screening and standardised trauma assessment at intake and at defined intervals thereafter, structured monitoring of intervention outcomes over time, funded staff debriefing, and caregiver ratios and training aligned with UN international care standards (United Nations General Assembly, 2010). For future research, priorities include interviewing children directly to capture what staff-mediated data cannot, and evaluating the effectiveness of trauma-informed interventions longitudinally, including direct comparison of different trauma-informed models within SOS-model settings, since the current evidence base remains limited (Bailey et al., 2019).

Conflict of Interest

The authors declare no conflict of interest. Nothing to disclose.

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