

Research Article

Influence of demographic variables on mentally-ill patients' satisfaction at two different treatment centres in akwa ibom state, nigeria

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ABSTRACT

Given the level of mental health resources in many developing countries, improvement in socioeconomic indices may help as strategies in targeting quality and affordable mental care and services. This study compared the influence of demographic profiles on mentally-ill patients' satisfaction at two centres (State and Federal) in Akwa Ibom State, Nigeria, to determine the contextual variables. A total of 368 patients comprising 201 (54.6%) from State and 167 (44.4%) Federal were randomly recruited and assessed for satisfaction of care and services, using a short-form of Patient Satisfaction Questionnaire (PSQ-18). The mean age of patients from State and Federal treatment centre was 34.3 ± 11.05 and 31.5 ± 5.12 years, respectively. Subjects from Federal treatment centre were less satisfied. Gender significantly influenced the difference in

Interpersonal Manner between the two centres ($t=-2.27$; $p<0.02$); age on Interpersonal Manner ($t=-2.27$; $p<0.03$); Communication ($t=-2.90$; $p<0.04$); Financial Aspects ($t=-4.07$; $p<0.01$) and Accessibility/Convenience ($t=-2.90$; $p<0.01$); educational level on Technical Quality ($t=-3.16$; $p<0.03$) and Communication ($t=-1.98$; $p<0.05$); occupation on Communication ($t=3.16$; $p<0.01$) and Time spent with the Doctor ($t=2.31$; $p<0.04$); while marital Status influenced Communication ($t=3.81$; $p<0.01$); Financial Aspects ($t=2.38$; $p<0.02$) and Accessibility/Convenience ($t=1.95$; $p<0.05$). Demographic profiles are the bedrocks for assessing the overall patients' satisfaction can serve as important strategy for measuring outcome of care and services in our environment.

Key words: Mentally-ill, Treatment centre, Satisfaction

Introduction

Patients' satisfaction of care and services are increasingly being recognized as an important concept [1-4]. This is critical in planning and formulating guidelines for treatment and care in many countries [5,6]. In developed countries, perceived satisfaction of patients' assessment is a major index used in measuring and bridging the, gaps in healthcare delivery [3,7-9]. It is an indicator of the structure, process, and outcome of care [10]. Reports have shown that it is a major predictor of consumer behavior [11,12]. The situation in developing countries is pathetic, issues of healthcare delivery is poorly conceptualized and planned [13-16]. There are limited researches and data on patients' satisfaction to allow proper evaluating of patients'

needs, with ultimate strategies for bridging the possible gaps in healthcare delivery [17-20]. It is evident that these cultures lack strategies for sustainable healthcare planning and development [21,22].

Improvement in patients' experience has several medical and economic benefits [1,23]. Better clinical outcome and compliance to treatment, fewer readmission rates and better patients' perception and less risk of malpractice litigations are some of the medical and economic advantages [23]. Several reports have reported that it influences patronage and compliance with medications and procedures [10,24]. The assessment of patients' satisfaction is important because of its close relationship with the quality of life [3,14,17,25,26].

It enhances confidence in caregivers' abilities and increased utilization of healthcare facilities [7,19]. One major factor that has been identified as important factor in patients' satisfaction is the attitudes of personnel. Many researchers have shown that it is crucial in confidence building [10,12,27]. Studies have shown that medical aspects of care would only excel in facilities, where staffs are courteous, hardworking, diligent, kind and honest [2,11,16].

In Nigeria, mental health services and facilities are not given priority at both State and Federal levels [28]. In many secondary and tertiary levels of care, there are no provisions for the treatment of people with mental illness. The absence of social services imposes burden of care on individuals and families, with the resultant lack of desirable and affordable care. In view of the myriad of challenges impeding provision of quality mental healthcare delivery in our environment, it is therefore imperative to look at the impact of demographic profiles of people with mental illness on their experiences at different treatment facilities.

Methods

Method

This study was a cross-sectional study conducted among 368 randomly recruited subjects aged 15 years and above. It comprises 167 (44.4%) from the Federal and 201 (54.6%) from State treatment centres, all in Akwa Ibom State, Nigeria. The Federal treatment centre is a unit in the University of Uyo Teaching Hospital, a 500-bed hospital situated at the outskirts of Uyo, capital of Akwa Ibom State, while the State treatment centre is the State Psychiatric Hospital, situated at Eket, a Local Government Area headquarter, 50 kilometres from Uyo.

Procedure

The subjects were given a short-form of Patient Satisfaction Questionnaire, PSQ-18 to complete. A section for eliciting information on sociodemographic characteristics was designed and included into PSQ-18. The subjects were selected on each clinic day, using the table of random numbers at the end of every consultation. They responded by circling or ticking the number in each line of the statements in PSQ-18 instrument rated 1 to 5, to reflect how strongly they agree, agree, uncertain, disagree or strongly disagree. Those with little or no education were assisted to complete the questionnaire. This study lasted for three months from January to March 2018. Permission to carry out the study was obtained from the local Hospital Medical Advisory Panel on Research. The PSQ-18 items are about the feelings, good and bad, how the patients are feeling about the medical care they received. Some PSQ-18 items are worded so that agreement reflects satisfaction with medical care, whereas other items are worded so that agreement reflects dissatisfaction with medical care. All items in the PSQ-18 are rated 1 to 5 and scored so that the highest scores reflect satisfaction. The original Patient Satisfaction Questionnaire, containing 80 items (PSQ-80) was developed in 1976 [29]. A version, containing 50 items that taps global satisfaction with medical care as well as satisfaction with six aspects of care-

technical quality, interpersonal manner, communication, finance aspect of care, time spent with doctor, and accessibility of care was later designed to facilitate easy usage [30]. The short form, (PSQ-18) was used in this study because it is brief and easy to complete within 3-4 minutes. And also, because there is a similarity of both the magnitude of the correlation coefficients and the overall pattern of correlation among PSQ-18 subscales. This short form contains 18 items tapping each of the seven dimensions of satisfaction with medical care measured by the PSQ-50: general satisfaction, technical quality, interpersonal manner, communication, financial aspects, time spent with doctor, and accessibility/convenience. PSQ-18 subscale scores are substantially correlated with their full-scale counterparts and possess general adequate internal consistency reliability.

Data analysis

After item scoring, items within the same subscale are averaged together to create the seven subscale scores. The PSQ-18 yields separate scores for each of seven different subscales. This was analyzed using Statistical Package for Social Sciences (SPSS 17.0). Sample means, and percentages were generated from which simple frequency tables were created. Statistical derivation from the means was calculated and comparisons of means were done using students' t-test. The p-value of less than or equal to 0.05 was used to determine the level of statistical significance.

Results

A total of 368 comprising 167 and 201 patients attending both the Federal and State treatment centres respectively, were included in the study. One hundred and sixty-seven, consisting of 66 (39.5%) males and 101 (60.5%) females were from Federal Treatment, while 201 consisting of 93 (46.3%) males and 108 (53.7%) females were from the State treatment centre. The mean age of the subjects from Federal Treatment centre was 31.5 ± 5.12 while that from the State was 34.3 ± 8.05 . Table 1 shows the sociodemographic characteristics of the participants.

Table 2 shows the mean scores of the two groups of participants on PSQ-18 in each centre. The mean score for Federal patients in general satisfaction was 2.81 ± 0.11 compared to 3.00 ± 0.05 ($t=1.72$; $p=0.09$) for State patients; Technical Quality 3.74 ± 0.73 and 3.60 ± 0.63 ($t=-0.95$; $p=0.35$); for Interpersonal Manner, the mean score for Federal patients was 4.26 ± 0.78 compared to 3.90 ± 0.77 for State patients ($t=-2.27$; $p=0.03$). The mean score was statistically significant. For communication mean was 3.93 ± 0.84 against 4.40 ± 0.58 ($t=-2.90$; $p=0.04$). This was statistically significant. In Financial Aspects, mean was 3.86 ± 0.83 for Federal patients against 3.15 ± 0.88 state patients ($t=-4.07$; $p=0.01$); mean for time spent with the doctor was 3.68 ± 0.97 against 3.63 ± 0.73 ($t=-0.47$; $p=0.62$). Similarly, in Accessibility and Convenience, mean was 3.96 ± 0.78 for Federal patients against 3.55 ± 0.72 ($t=-2.90$; $p=0.01$). This was statistically significant [28-30].

Influence of sociodemographic variables on the perceived respondents' satisfaction was variable. Table 3 showed the variable sociodemographic variables and their impact on

Table 1. Showing the Sociodemographic Characteristics of the Respondents

Variables	Subjects					
	FTC (N=167)			STC (N=201)		
	Male n (%)	Female n (%)	Total n (%)	Male n (%)	Female n (%)	Total n (%)
Sex	66 (39.5)	101 (60.5)	167 (100)	93 (46.3)	108 (53.7)	201 (100)
Age in years						
15-24	18 (27.3)	21 (20.8)	39 (23.4)	27 (29.0)	29 (26.9)	56 (27.9)
25-34	25 (37.9)	33 (32.7)	58 (34.7)	33 (35.5)	33 (30.5)	66 (32.8)
35-44	13 (19.7)	24 (23.8)	37 (22.1)	21 (22.6)	23 (21.3)	44 (21.9)
45-54	8 (12.1)	15 (14.8)	23 (13.8)	8 (8.6)	16 (14.8)	24 (11.9)
>55	2 (3.0)	8 (7.9)	10 (6.0)	4 (4.3)	7 (6.5)	11 (5.5)
Education						
No formal education	9 (13.6)	12 (11.9)	21 (12.6)	17 (18.3)	23 (21.3)	40 (19.9)
Primary Education	10 (15.1)	33 (32.6)	43 (25.7)	25 (26.9)	31 (28.7)	56 (27.9)
Secondary Education	34 (51.5)	41 (40.6)	75 (44.9)	30 (32.2)	39 (36.1)	69 (34.3)
Higher Education	13 (19.7)	15 (14.9)	28 (16.8)	21 (22.6)	15 (13.9)	36 (17.9)
Occupation						
Unemployed	31 (47.0)	57 (56.4)	88 (52.7)	61 (65.6)	74 (68.5)	135 (67.2)
Employed	24 (36.4)	31 (30.7)	55 (32.9)	23 (24.7)	29 (26.9)	52 (25.9)
Business	11 (16.6)	13 (12.9)	24 (14.4)	9 (9.7)	5 (4.6)	14 (6.9)
Marital Status						
Single	43 (65.2)	54 (53.5)	97 (58.1)	42 (45.2)	53 (49.1)	95 (47.3)
Married	13 (19.7)	31 (30.7)	44 (26.3)	35 (37.6)	31 (28.7)	66 (32.8)
Living together without married	1 (1.5)	3 (3.00)	4 (2.4)	5 (5.4)	3 (2.8)	8 (4.0)
Separated, divorced or widowed	9 (13.6)	13 (12.8)	22 (13.2)	11 (11.8)	21 (19.4)	32 (15.9)

FTC: Federal Treatment Centre Patients; STC: State Treatment Centre Patients.

Table 2. comparing the mean scores of the Respondents' Satisfaction in two Centres

Variables	Subjects			
	FTC Mean Score (SD)	STC Mean Score (SD)	t-test	P-value
General Satisfaction	2.81 ± 0.11	3.00 ± 0.05	1.72	0.09
Technical Quality	3.74 ± 0.73	3.60 ± 0.63	-0.95	0.35
Interpersonal Manner	4.26 ± 0.78	3.90 ± 0.77	-2.27	0.03*
Communication	3.93 ± 0.84	4.40 ± 0.58	-2.90	0.04*
Financial Aspects	3.86 ± 0.83	3.15 ± 0.88	-4.07	0.01*
Time spent with doctor	3.68 ± 0.97	3.63 ± 0.73	-0.47	0.62
Accessibility/Convenience	3.55 ± 0.72	3.96 ± 0.78	-2.90	0.01*

*Statistically significant

FTC: Federal Treatment Centre patients; STC: State Treatment Centre patients

satisfaction. There were significant differences in various subscales of satisfaction and sociodemographic variables. In all the subscales of satisfaction, gender only significantly influenced the difference in Interpersonal manner with a mean of score of 3.84 ± 0.78 for Federal patients and 4.11 ± 0.78 ($t=-2.27$; $p=0.02$). Age statistically influenced differences in Interpersonal Manner in the two groups of patients, mean score 4.26 ± 0.78 against 3.90 ± 0.77 ($t=-2.27$; $p=0.03$); also, in Communication 3.93 ± 0.84 against 4.40 ± 0.58 ($t=-2.90$; $p=0.04$); Financial Aspects 3.86 ± 0.83 versus 3.15 ± 0.88 ($t=-4.07$; $p=0.01$); Accessibility/Convenience 3.96 ± 0.78 against 3.55 ± 0.72

($t=-2.90$; $p=0.01$). Similarly, educational level of patients significantly influenced Technical Quality 3.78 ± 0.61 against 2.82 ± 0.94 ($t=-3.16$; $p=0.03$) and Communication 4.13 ± 0.79 versus 3.30 ± 1.64 ($t=-1.98$; $p=0.05$); while occupation also has impact significantly on Communication 4.30 ± 0.57 against 3.88 ± 0.89 ($t=3.16$; $p=0.01$); Time spent with the Doctor 3.81 ± 0.89 against 3.52 ± 0.71 ($t=2.31$; $p=0.04$). Also, marital Status has significant impact on Communication 4.37 ± 0.66 versus 3.89 ± 0.83 ($t=3.81$; $p=0.01$); Financial Aspects 3.17 ± 0.87 against 3.57 ± 0.97 ($t=2.38$; $p=0.02$); Accessibility/Convenience 3.56 ± 0.74 versus 3.80 ± 0.68 ($t=1.95$; $p=0.05$).

Table 3. showing the Comparison of influence of Sociodemographic variables on Respondents' satisfaction

Variable	Subjects			
	FTCP Mean (SD)	STCP Mean (SD)	t-test	p-value
Gender				
General Satisfaction	2.89 ± 0.73	3.03 ± 0.59	1.73	0.17
Technical Quality	3.71 ± 0.63	3.54 ± 0.73	1.62	0.11
Interpersonal Manner	3.84 ± 0.78	4.11 ± 0.78	-2.27	0.02*
Communication	4.04 ± 0.92	4.00 ± 0.70	0.34	0.73
Financial Aspect	3.22 ± 0.84	3.34 ± 0.98	-0.81	0.42
Time spent with Doctor	3.66 ± 0.83	3.58 ± 0.75	-0.61	0.54
Accessibility/convenience	3.61 ± 0.72	3.64 ± 0.75	-0.35	0.73
Age				
General Satisfaction	2.80 ± 0.11	3.00 ± 0.05	1.72	0.09
Technical Quality	3.74 ± 0.73	3.60 ± 0.63	-0.95	0.35
Interpersonal Manner	4.26 ± 0.78	3.90 ± 0.77	-2.27	0.03*
Communication	3.93 ± 0.84	4.40 ± 0.58	-2.90	0.04*
Financial Aspect	3.86 ± 0.83	3.15 ± 0.88	-4.07	0.01*
Time spent with Doctor	3.68 ± 0.97	3.60 ± 0.73	-0.47	0.62
Accessibility/Convenience	3.96 ± 0.78	3.55 ± 0.72	-2.90	0.01*
Educational Level				
General Satisfaction	3.01 ± 0.47	2.70 ± 0.45	-1.46	0.20
Technical Quality	3.78 ± 0.61	2.82 ± 0.94	-3.16	0.03*
Interpersonal Manner	3.96 ± 0.75	3.20 ± 1.92	-1.32	0.25
Communication	4.13 ± 0.79	3.30 ± 1.64	-1.98	0.05*
Financial Aspect	3.60 ± 1.29	3.27 ± 1.02	0.55	0.60
Time spent with Doctor	3.00 ± 0.05	3.48 ± 0.75	-1.23	0.22
Accessibility/Convenience	3.83 ± 0.74	3.22 ± 0.82	-1.75	0.08
Occupation				
General Satisfaction	3.01 ± 0.47	2.85 ± 0.62	-1.56	0.12
Technical Quality	3.76 ± 0.67	3.57 ± 0.63	1.76	0.08
Interpersonal Manner	3.90 ± 0.81	4.11 ± 0.72	1.67	0.09
Communication	4.30 ± 0.57	3.88 ± 0.89	3.16	0.01*
Financial Aspect	3.34 ± 0.91	3.25 ± 0.92	0.62	0.53
Time spent with Doctor	3.81 ± 0.89	3.52 ± 0.71	2.31	0.04*
Accessibility/Convenience	3.60 ± 0.73	3.70 ± 0.73	0.92	0.36
Marital Status				
General Satisfaction	2.94 ± 0.62	3.00 ± 0.79	0.44	0.66
Technical Quality	3.61 ± 0.60	3.67 ± 0.75	0.46	0.65
Interpersonal Manner	3.90 ± 0.79	4.15 ± 0.77	1.88	0.06
Communication	4.37 ± 0.66	3.89 ± 0.83	3.81	0.01*
Financial Aspect	3.17 ± 0.87	3.57 ± 0.97	2.38	0.02*
Time spent with Doctor	3.66 ± 0.05	3.60 ± 0.73	0.38	0.74
Accessibility/Convenience	3.56 ± 0.74	3.80 ± 0.68	1.95	0.05*

*Statistically significant.

FTCP=Federal Treatment centre patients. STCP=State Treatment Centre patients.

Discussion

This study compared the influence of sociodemographic variables on psychiatric patients' satisfaction at two different treatment centres in Nigeria. It is important to note that although studies on patients' satisfaction in various disciplines have been growing in developing countries [13,16,18-20,24,25], not much has been focused on mentally-ill patients, especially in Nigeria. This is not surprising, in view of the seemingly neglect of people

with mental illness in many developing countries, including Nigeria. The implication is that individuals with mental illness in these countries are still being subjected to the stress of self-care [28,31,32]. The Nigerian citizens, unarguably have been the most victims of subservient and perverted economic policies. The lack of social services is a clear failure of government policy to provide adequate and affordable care. This lack of vision has deprived not only the people with mental illness, the inalienable rights to life, liberty and pursuit of happiness. It has

therefore become a moral burden on government at all levels to give serious attention to the plights of the people with mental illness in the society. This is possible if the government can guarantee those privileges, which are clothed within the yoke of fundamental human rights.

The basic sociodemographic characteristics of the respondents in this study has brought to fore the familiar and known socioeconomic profiles of people with mental illness [32,33,34]. Majority of the respondents in this study were young, single, unemployed with little or no education. These findings seem to corroborate the reports in previous studies [28,32,34]. In line with reports from several studies, these findings have wider implications on national growth and economic development [28,32]. Nothing has perhaps become as popular as claims that people with mental illness lack opportunities that could define quality life. The complexity of the decline in economic fortune of people with mental illness is difficult to understand. Often, curious researchers have pondered on the underlying reasons behind the poor economic fortune of the people with mental illness. One major explanation has been that the illness affects people in their prime age of productivity. Undoubtedly, the economic difficulties are often attributable to the social drift caused by the illness. Although this may seem like a dubious claim, several reports seem to give credence to this opinion. Individuals with mental illness suffer directly and indirectly from both the illness and their impacts [28,33]. With the swathe of poverty-stricken population often associated with mental illness, one may be tempted to join in the popular view that the unfavorable sociodemographic variables of the people with mental illness are the consequences rather than cause of the illness.

Surprisingly, the findings from this study have shown that patients from the Federal treatment centre were less satisfied compared to those from the State. This finding is a clear evidence that the location of the health facility is not important. What matters most is the quality of the services, which is often measured by patients' experience. One other crucial point from this finding is that it could reflect respondents' confidence in the ability of the healthcare providers, and this could also motivate the providers to do more. Reports from previous studies have shown that overall satisfaction provides overoptimistic evaluation of patients' experiences of health [4,6,8,9,26,35]. The State treatment centre has not undergone meaningful infrastructural development since its inception. Until recently, there were no trained specialists in any field except the nurses. The managements of patients were in the hands of general medical officers (GMO), who had no basic training and were often sent to the centre as punishment for wrong doings. Therefore, one may be tempted to conclude that the satisfactory experience reported by the respondents from this centre may be due to the recent change in policy by the government. Psychiatrists are being posted regularly to oversee the centre. The differences in the level of satisfaction may be attributable to the privileges enjoyed in the State treatment centre. For example, bed spaces are more in the State treatment centre and duration of admissions are not based on clinical judgments. The Federal treatment centre on the other hand, is a unit in the Federal Teaching Hospital with fewer bed spaces. Patients do not have the liberty to choose what they want.

One of the interesting findings from this study is in the different components of satisfaction, as indicated by the mean scores of various subscales. Understanding how participants performed in these various subscales is important, because this can influence the outcome of treatment, with respect to the decision of the family or patients on where to receive care [2,4,36,37]. In this study, the technical quality, interpersonal manner, financial aspects and time spent with the doctor were higher in patients from the Federal treatment centre; while communication and accessibility/convenience were higher in patients from the State treatment centre. Although studies have shown that the quality of infrastructure, training, competence of personnel and efficiency of operational system are major determinants of quality care, it is important to note that patients' satisfaction and willingness to recommend a medical facility does not imply that all aspects of care are successfully received [2,10,11,16,24,27]. Since patients are the end-users, their opinions are important and could be used to restructure and reposition any healthcare facility for a better quality of service.

The importance of these components of satisfaction needs to be highlighted and emphasized. Although, the findings from this study have shown different levels of satisfaction, each of them plays crucial role in the overall patients' experience. Several studies have rated communication very high, as reports have shown that patients are more relaxed and happier in treatment facilities where staffs are courteous, hardworking, diligent, kind and honest [10,24,27]. Communication and interpersonal manner are core attributes of providers' behaviour. In this study, communication and interpersonal manner were found to be higher in both centres. This has reinforced the importance of providers' behaviour, as it enhances confidence in patients and increased utilization of healthcare facilities [7,19,38]. It is useful to emphasize that diligent and good relationship with clients are important attributes that need to be stressed and inculcated in healthcare providers, if efforts aimed at better mental healthcare service is to be achieved. In addition to communication, accessibility/convenience score was found to be higher in respondents from the Federal treatment centre. This could mean that respondents had no difficulties accessing care and the convenience in doing this may have been boosted by the attitudes of the healthcare providers. Although reports from previous studies have shown that levels of satisfaction and associated factors varied across measures, sub-groups of patients, clinical stages, regions and health care systems, it may not be wrong to stress that communication and interpersonal manner are important attributes that are embedded in providers' behaviour [37,38]. Regardless of good infrastructure and equipment, communication and accessibility are among the primary components that form the matrix for patients' satisfaction. Interestingly, the financial aspects of the patients in this study were encouraging, especially from the State treatment centre. The lower mean score from this centre implies that respondents spent less to receive care. This finding has many advantages to the respondents. Mental illness is a lifetime condition and very expensive to treat. Many sufferers spend long years of follow-ups in hospitals and clinics, with heavy financial burden. The implication is that the respondents seemed

to be comfortable in the State treatment centre, unlike in Federal treatment centre, with specialized care and some services may be compulsory. The high score in accessibility/convenience may have been attributable to less financial expenditure in the treatment centre.

There were variable significant differences in the impact of basic demographic characteristics of the respondents on various components of satisfaction. This seems to imply that patient sociodemographic characteristics are major predictors of satisfaction [37,39,40]. This therefore has made the provision of basic mental health needs difficult. As in previous studies, communication is positively influenced in this study by almost all the demographic variables. This has re-emphasized the importance of this singular component in patients' satisfaction. Therefore, improvement in communication skills is very crucial and must be emphasized for a better healthcare service [10,24,27]. Regarding gender and age, the present study findings are consistent with most prior researches that found variable satisfaction scores among men and women [37,39,40], and older patients being more satisfied with received services than younger ones. Reports from previous studies have shown that these variables are important and need to be considered when evaluating patient satisfaction [13].

There are many limitations to this study

It is a cross-sectional study and using self-report to assess patients' satisfaction is bound to be biased. The restriction only to people with mental illness could influence the responses. The sample size is small and cannot be assumed as a true representation of people with mental illness. Therefore, the results cannot be generalized. There are lacks comparative outcome studies in Nigeria, with similar background to corroborate the findings.

Conclusion

This study has demonstrated that the overall mental healthcare service satisfaction is an aggregate of patients' experience and such experiences could be helpful in determining areas of needs and interventions. It is important never to neglect patients' demographic profiles when considering and looking for ways of improving service satisfaction. No matter how remote the health facility is located, better mental care and services could be achieved with the right attitude to work. In an environment such as ours with limited social services, there is need to engage a system that would embrace universal mental health coverage, because neither good living conditions nor dignified existence can be achieved through self-care.

Conflicts of Interest

The authors of this paper are responsible for the writing and its whole content. Therefore, there is no conflict of interest.

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