



**FIRST NATIONS
EYE HEALTH ALLIANCE**

Funding Submission

Project: A Vision for a Bright Future: National Program for Free Glasses for Aboriginal and Torres Strait Islander Children

First Nations Eye Health Alliance Limited

January 2026

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Hon Mark Butler MP
Minister for Disability and the National Disability Insurance
Scheme, Minister for Health and Ageing, Australian Labor Party
21 Commercial Road, Port Adelaide, SA, 5015

Date: 30th of January 2026

Dear Hon Mark Butler MP,

On behalf of the First Nations Eye Health Alliance (FNEHA), I am pleased to present this submission seeking Commonwealth funding for a national program to provide free prescription glasses for Aboriginal and Torres Strait Islander children.

The proposal, "A Vision for a Bright Future," builds upon state-led initiatives for universal pre-school vision screening and aligns directly with the National Agreement on Closing the Gap (Priority Reforms 1–4), the National Aboriginal and Torres Strait Islander Health Plan, the National Aboriginal and Torres Strait Islander workforce plan and the National Preventive Health Strategy. This proposal has been developed in partnership between the FNEHA, Optometry Australia, Minum Barreng: Indigenous Eye Health Unit, and The Fred Hollows Foundation, and has strong sector support.

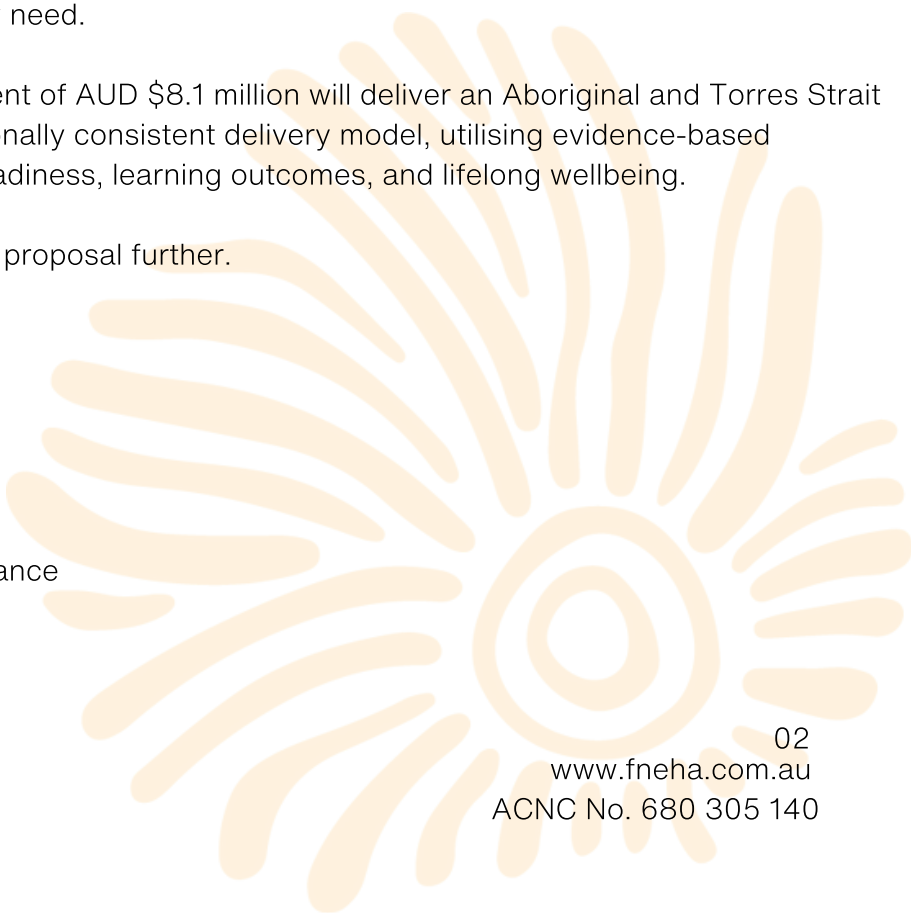
It builds on a compelling evidence base of inequity in vision outcomes between Aboriginal and Torres Strait Islander children and their non-Indigenous counterparts. It proposes a program which, if implemented, would ensure that every identified Aboriginal and Torres Strait Islander child receives the corrective lenses they need.

The estimated three-year investment of AUD \$8.1 million will deliver an Aboriginal and Torres Strait Islander-led, sustainable, and nationally consistent delivery model, utilising evidence-based interventions to improve school readiness, learning outcomes, and lifelong wellbeing.

We look forward to discussing this proposal further.

Yours sincerely,

Lose Fonua
CEO, First Nations Eye Health Alliance





Ministerial Brief and Executive Summary

Funding Submission:

A Vision for a Bright Future: National Program for Free Glasses for Aboriginal and Torres Strait Islander Children

Prepared by:

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Date:

30th January 2026

Purpose:

To seek Commonwealth funding for a national program providing free prescription glasses for Aboriginal and Torres Strait Islander children, delivered in partnerships with Aboriginal Community Controlled Health Organisations (ACCHOs) under the leadership of the First Nations Eye Health Alliance Limited (FNEHA), the principal voice and peak body for Aboriginal and Torres Strait Islander eye care.

Alignment:

This proposal operationalises key elements of The Roadmap to Close the Gap for Vision (Taylor et al., 2015), particularly Recommendations 2.3 (low-cost spectacles), 3.1–3.6 (local coordination and case management), 4.1–4.6 (eye health workforce distribution), and 6.1–6.7 (monitoring and evaluation). It provides a nationally consistent spectacle scheme and community-led coordination. It also aligns directly with the National Agreement on Closing the Gap (Priority Reforms 1–4), the National Aboriginal and Torres Strait Islander Health Plan, the National Aboriginal and Torres Strait Islander workforce plan and the National Preventive Health Strategy.

Key Rationale:

Ask:

That the Australian Government commit to providing **\$8.1 million over three years** to fund a national, Aboriginal and Torres Strait Islander-led program to provide free prescription glasses for Aboriginal and Torres Strait Islander children

Expected Outcomes:

- Reduction in preventable vision impairment in First Nations children.
- Enhanced child wellbeing and community participation.
- Improved educational performance and school attendance.
- Strengthened data systems and accountability aligned with Closing the Gap targets.



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1.0 Background

Uncorrected refractive error remains one of the most common and treatable causes of visual impairment in Aboriginal and Torres Strait Islander children. This proposal seeks to establish a national, community-controlled program providing free prescription glasses to Aboriginal and Torres Strait Islander children under <15 years old who require them across a three-year period. The initiative directly complements state-based universal preschool screening proposals currently underway in Victoria and South Australia, ensuring the national system delivers both detection and correction.

The program will be led by FNEHA as the principal voice and national peak body for Aboriginal and Torres Strait Islander eye care, implemented through ACCHOs and regional partners, and evaluated independently to demonstrate the current true rate of vision loss for Aboriginal and Torres Strait Islander children in this age group.

2.0 Context and Rationale

2.1 The Unmet Need

This project builds on a body of work that has evaluated vision screening and vision disorders in Australian children. (Hopkins et al., 2017; Pai et al., 2011) which has established the unmet need for paediatric eye care services, especially among Aboriginal and Torres Strait Islander children (Cox et al., 2021; Read et al., 2023).

Inequities exist within the current delivery of paediatric eye-care services, which are delivered privately by community optometrists. Therefore, Aboriginal and Torres Strait Islander children and those living in areas of greater socioeconomic deprivation are less likely to access eye-care services.

The early school years are crucial for developing basic literacy, numeracy, and science skills; clear, comfortable vision is essential for all academic tasks. In addition, good vision is vital for developing social skills and engaging in activities such as art, music, and sport. The diagnosis and treatment of vision problems require children to be appropriately assessed and able to access and afford eye health care.

The most common cause of vision impairment in children is uncorrected or under corrected refractive errors (long-sightedness, short-sightedness, and astigmatism), which can cause blurred vision at distance and/or near, headaches, eyestrain, and poor eye coordination (Hopkins et al., 2020). Astigmatism (rotational asymmetry of the eye's refractive power) is the most common childhood refractive error affecting one in four Australian six-year-olds (Huynh et al., 2006) and, when uncorrected, significantly reduces oral reading fluency (Harvey et al., -

-2016), reading performance, visual processing and reading-related eye movements (Narayanasamy et al., 2015b). Likewise, hyperopia (long-sightedness) can result in fatigue and disengagement with learning activities due to the additional demand required to maintain clear vision for near tasks (Mavi et al., 2022)

2.2 Rising Myopia And Global Context

Without appropriate intervention, myopia is anticipated to affect 50% of the world's population and 20 million Australians by 2050 (Holden et al., 2016). There is no level of myopia which is considered safe, and even low to moderate amounts of myopia increase the risk of eye disease two to ten-fold (Bullimore & Brennan, 2019; Flitcroft, 2012). Therefore, efforts to reduce the incidence, progression, and severity of myopia could have a significant impact on public health. In 2021, the World Council of Optometry (WCO) passed a resolution that supports myopia management as the standard of care by optometrists in their practice. (Hendicott & Block, 2022). This resolution identifies three main components of myopia management:

- Mitigation – counselling children and their families, during early and regular eye examinations, about lifestyle and other factors to prevent or delay the onset of myopia.
- Measurement – regular and comprehensive eye health and vision examinations to evaluate ocular status through measurement of refractive error and ocular biometry, where available.
- Management – addressing patients' needs through correcting myopic refractive error while also providing evidence-based interventions to slow myopia progression.

There is now substantial evidence that myopia management therapies reduce the rate of refractive error progression and axial elongation of the eye, while simultaneously providing appropriate optical correction, which fully corrects distance (and near) vision. A recent Cochrane review (Lawrenson et al., 2023) found that all myopia interventions (except for under-correction with single vision spectacle lenses, standard single vision rigid gas permeable lenses and the use of adenosine antagonist 7-methylxanthine) were effective at slowing myopia progression in terms of both refractive error and axial length of the eye at 12 and 24 months.

2.3 A National Need

Vision disorders can have debilitating consequences not only on the general well-being and mental health of young children but also on their academic performance, particularly in high hyperopia. (Smith, 2009).

In South Australia, twenty-five per cent of 7-9-year-old children do not have the spectacles they need for clear and comfortable vision (Figure 1, unpublished data), increasing their risk of reduced academic outcomes and exclusion from many broader educational and social activities.



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Uncorrected refractive error reduces school performance, and results in lost economic gain and hampers employability and general quality of life in adulthood (Resnikoff, 2008) and optical correction with spectacles is one of the most cost-efficient health interventions for improving quality of life and productivity (Resnikoff, 2008; Smith, 2009).

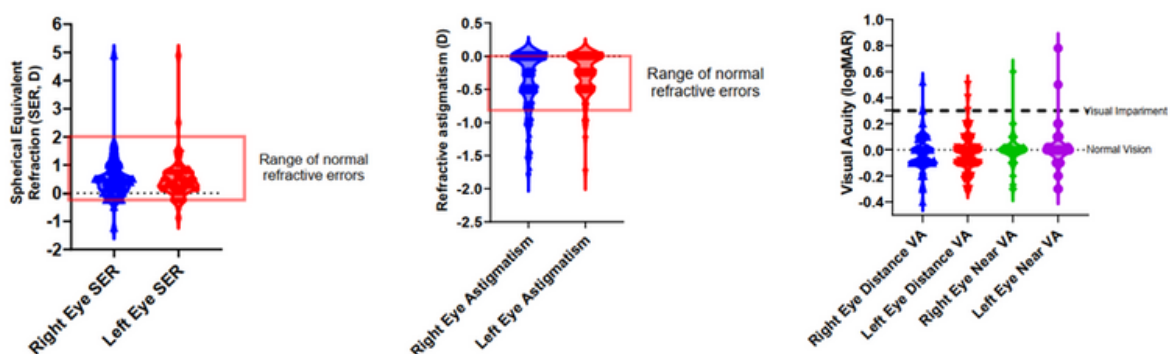


Figure 1: Distribution of uncorrected spherical equivalent refraction (SER, left), astigmatism (middle) and reduced visual acuity (VA, right) in 7-9-year-old children in South Australia (CESSA project)

3.0 The Case for Investment:

3.1 Child And Youth Vision

Eye disease and vision disorders are the third-highest contributor towards health inequities for Aboriginal and Torres Strait Islander Peoples, and 90% of the associated vision impairment is preventable. (Mitchell et al., 2020). Published data from the 2015-2016 National Eye Health Survey found vision loss was 2.8 times more prevalent in Indigenous Australians than in non-Indigenous Australians, and that the leading causes of vision loss were uncorrected refractive error (60.8%), cataract (20.1%), and diabetic retinopathy (5.2%) (Foreman et al., 2017).

Updated data from the Australian Eye and Ear Health Survey (Kha et al., 2024) suggests that rates of bilateral vision impairment from uncorrected refractive error have fallen to ~40%; however, remoteness and socio-economic factors remain key risks for both eye and ear health. Although both of these studies recruited adult participants, most refractive errors (other than presbyopia) develop in childhood due to a failure of the emmetropisation process (Logan, 2009).



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Good vision is linked with learning outcomes (Ma et al., 2014). Although learning is a complicated and multifactorial process, for many children, poor vision represents one barrier that is readily treatable with spectacles, which provide a safe, easy and cost-effective therapeutic option.

3.2 The Leaky Pathway

As illustrated in The Roadmap's Patient Journey model (p. 6), the current referral pathway for eye care functions as a "leaky pipe with a blockage at its end" where detection is common, but correction fails due to coordination breakdowns, cost barriers, and service fragmentation. The proposed program directly seals that gap by embedding ACCHO-led tracking and glasses provision within the same care pathway.

The Australian Eye and Ear Health Survey (2024) (AEEHS) and Roadmap both highlight persistent service gaps across the vision-care continuum:

Step in Care Pathway	Challenge	Proposed Solution
Screening	Inconsistent access across jurisdictions	Align with the National Framework for Vision Screening for 3.5-5-year-olds
Referral	Low follow-up (48%) after failed screenings	Automatic referral via ACCHO-led tracking
Correction	Cost and access barriers to spectacles	Free glasses program under FNEHA coordination
Review	No data linkage between screening and outcomes	National data system aligned to Closing the Gap indicators

3.3 Cost-Effectiveness and Prevention

The Roadmap's economic modelling demonstrated that every \$1 invested yields \$5 in community benefit and that the total cost to close the vision gap nationally was \$19.5 million per annum in 2011.

This proposal's three-year funding envelope aligns proportionately with inflation and includes program management, workforce, and evaluation infrastructure.

3.4 Existing Spectacle Supply Schemes across Australia

Uncorrected refractive error is the most common cause of visual impairment for both Indigenous and non-Indigenous Australians. While the proportion of Aboriginal and Torres Strait Islander Peoples who possessed appropriate spectacles increased, from 20% in 2008 to 82% in 2016 (Foreman et al., 2017). There is a need for improved access to spectacle subsidy schemes for Aboriginal and Torres Strait Islander Peoples.

Schemes are available in all Australian jurisdictions for subsidised or free spectacles for low-income earners, with varying eligibility criteria, payment and product choices in different states and territories. Eligibility of and access to these schemes vary across the country, and knowledge of and access to these schemes is reported as being problematic for Aboriginal and Torres Strait Islander patients. Studies suggest that in some states, the schemes are not well-advertised or understood, and that communities and service providers may not be aware of their availability (Razavi et al., 2018).

In a 2012 survey of Australian optometrists, the majority of participants confirmed their support for a nationally consistent scheme to provide high-quality glasses to Aboriginal and Torres Strait Islander people at low cost or a set price (Morse et al., 2013).

Principles and Recommended Implementation Standards for nationally consistent subsidised spectacle schemes were developed by Optometry Australia and endorsed by NACCHO and Vision 2020 Australia in 2015. Advocacy has been ongoing over the last decade to pursue amendments to ensure that state-run schemes meet these Principles and Recommended Implementation Standards, thereby ensuring equitable eligibility and access to appropriate low-cost spectacles for Aboriginal and Torres Strait Islander Peoples. This advocacy has experienced mixed results.

In 2015, the Victorian Aboriginal Spectacle Subsidy Scheme (VASSS) published their 5-year program delivery findings (Fricke et al., 2021). Established in 2010, the VASS aims to improve access to affordable spectacles for Aboriginal and Torres Strait Islander Victorians, as an additional subsidy to the Victorian Eyecare Service, and is based on principles that include:



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certain patient co-payments of \$10; an expanded spectacle frame range; and community participation in service governance and implementation. Between 2009 and 2014, patient services provided by the VASS increased from 400 to 1,800 per year, with an average of 1,400 pairs of glasses provided between 2010 and 2014, and a projected delivery of 1,650 spectacles for 2016/17.

The scheme in NSW has extended eligibility for Aboriginal and Torres Strait Islander Peoples across NSW and the ACT, and minor changes to the South Australian scheme have ensured streamlined pathways for eligible Aboriginal and Torres Strait Islander patients. A temporary Indigenous Spectacle Supply Scheme was established under limited Federal Government funding in 2022, and experienced positive evaluation outcomes, but has since concluded. (Vision 2020 Australia (2023))

It is widely understood that within these schemes, access by eligible Aboriginal and Torres Strait Islander children is limited and that Indigenous people overall have lower spectacle access. (Read et al., 2023; Nejatian et al., 2025))

3.5 Opportunity for Action

The 2026 Federal Budget provides a critical opportunity to build a nationally coordinated, community-led model that guarantees free spectacles for every child who needs them, a small investment delivering large and measurable benefits.

This alignment ensures the program functions not as a stand-alone initiative but as the childhood component of the broader Close the Gap for Vision ecosystem.

4.0 Program Alignment with the National Frameworks

Framework / Recommendation (Rec)	How This Program Delivers
Roadmap to Close the Gap for Vision Rec 2.3	Establishes a national subsidised (free) spectacles scheme for children.
Roadmap to Close the Gap for Vision Rec 7.1–7.4 – Governance & oversight	National oversight by FNEHA as the lead body, reporting to the Commonwealth and sector partners
National Agreement to Closing the Gap Priority Reform 4 and Roadmap to Close the Gap for Vision Rec Monitoring & evaluation	Data collection to ascertain the true extent of vision loss in children aged under 15 years. Indigenous data sovereignty integrated, centring Aboriginal ownership and local evaluation, and an integrated impact framework with annual government reporting and QALY measurement.



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Framework / Recommendation (Rec)	How This Program Delivers
Roadmap Recs 3.1–3.6	Implements local coordination via ACCHOs, ensuring every screened child receives follow-up and glasses.
Vision 2020 National Framework for Vision Screening (2021)	Extends screening coverage to correction and adherence under one governance model.
Closing the Gap Priority Reforms 1–4	Delivers community-led governance, data sovereignty, and shared accountability.
Strong Eyes, Strong Communities	Extends community-controlled delivery to children's vision. Operationalises the next stage of the plan, focusing on youth equity.
National Preventive Health Strategy 2021–2030	Targets childhood prevention and equity
The Vision 2020 National Framework for Vision Screening (2021)	Explicitly recognises ACCHO's as core delivery sites and calls for culturally safe, community-led screening and follow-up. This proposal directly operationalises these principles through FNEHA's leadership.
The National Aboriginal and Torres Strait Islander Health Plan 2021–2031	Cultural Safety as a Cross-Cutting Input: The Framework mandates formal cultural-safety and competency training for all screeners and inclusion of ACCHO in governance. All to ensure First Nations people are able to access the health system free of racism and culturally unsafe practices.

5.0 Evidence Base

In Australian classrooms, children typically engage with sustained near tasks for 23 ± 5 minutes at a time (Narayanasamy et al., 2016) and even relatively low hyperopia impairs performance 9–21% across a range of academic tasks, the effects of which are exacerbated after 20 minutes of sustained near work (Narayanasamy et al., 2015a). A recent meta-analysis found a moderate adverse effect of uncorrected hyperopia on reading skills and general educational achievement (Mavi et al., 2022).



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Speed of word recognition and vocabulary knowledge in early life predict cognitive and language outcomes in later childhood (Glewwe et al., 2018) and two published interventional studies (Glewwe et al., 2018; Ma et al., 2014) found that spectacle correction of hyperopia significantly improved reading speed and fluency.

Therefore, correction of refractive error may provide an efficient and cost-effective method for improving academic outcomes in children with undiagnosed vision disorders.

- Childhood is a critical period of visual development
- 15% of Aboriginal and Torres Strait Islander children (0-16 years of age) attending schools and daycare centres in QLD who consented to participation failed a vision screening and were referred to an optometrist for further assessment.(Elliott et al., 2010) Of the children referred, 39% (18/46) were seen in a single outreach optometry clinic.
- Mean SER of Aboriginal children is less hyperopic (closer to emmetropia) than that of non-Indigenous children in children aged 4-18 years in a rural town in SE QLD with low rates of myopia.(Cox et al., 2023)
- A study of children in a very remote region of FNQ, where 97% identified as Aboriginal and Torres Strait Islander, found 32% of primary school children examined had a vision disorder.(Read et al., 2023)
 - Most children had normal VA, with only 4% having VA worse than 6/12 in either eye
 - 18% had visually significant refractive errors, with 23 children having mild myopia, 4 moderate hyperopia, 2 high hyperopia, 3 moderate astigmatism, 5 high astigmatism (of these 5, only 18% had previously had an eye exam, and none had glasses)
 - 16% had BV or accom disorders, with 20 children lag of accom at least 1.50D
 - Only 10% of children tested had previously had an eye exam.
 - Three children had clinically significant unilateral eye health conditions all related to previous trauma
 - Community reported that due to limited access to eye health services, eye exams are often prioritised for older people with known eye conditions
- High rates of uncorrected vision problems in school children in rural QLD – overall prevalence 35%(Cox et al., 2021)
 - 40% of children in this study identified as Aboriginal and Torres Strait Islander
 - Only 23% of Indigenous children had previously had an eye examination, and 8% had been prescribed spectacles
 - 29% of Indigenous children had uncorrected vision conditions, including refractive error, strabismus, vergence, and accommodative dysfunction

6.0 Deficits in Current Vision Care Delivery

Existing state-subsidised spectacles schemes demonstrate goodwill but lack national consistency, Aboriginal and Torres Strait Islander governance, population-needs-based funding, and comprehensive follow-up.



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Deficit	Impact	FNEHA Response
Fragmented state eligibility rules	Unequal access across jurisdictions	Create a national floor of benefits under Commonwealth funding
No guaranteed follow-up post-screening	Children are lost between detection and correction	ACCHO-led tracking and recall systems
Limited procurement coordination	Higher cost and supply delays, and inconsistent pricing models nationally	Nationally consistent procurement with culturally appropriate frame options
Data silos	Lack of Closing the Gap reporting alignment	Shared data platform under FNEHA data sovereignty
Loss to follow up	The National Framework also highlights the ongoing challenge of children lost to follow-up after failed screening, recommending partnerships with community-controlled health organisations	ACCHO-led tracking and recall systems with FNEHA oversight

7.0 Program Design: “A Vision for a Bright Future”

7.1 Program objective

To eliminate uncorrected refractive error in Aboriginal and Torres Strait Islander children under 15 years old by ensuring free, timely, culturally appropriate access to prescription glasses nationwide.

7.2 Delivery model

- National leadership: FNEHA as the coordinating peak body.
- Local delivery: Aboriginal Community Controlled Health Organisations
- Clinical partners: Community Optometrists or Optometrists in the ACCHO sector
- Procurement: National supplier panel providing ready-made and custom spectacles with an Aboriginal and Torres Strait Islander optical provider.



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- Repair & replacement: 20% annual reserve for remakes, loss, and damage. Higher costs could be borne by more rural and remote regions, which need a flexible funding distribution system.
- Monitoring: Real-time data dashboard integrated with Closing the Gap reporting.

8.0 Implementation and Monitoring

8.1 Governance

- National coordination under FNEHA, as recommended in Roadmap Rec. 7.1–7.4.
- Regional oversight through ACCHOs and state-level coordination groups.
- Evaluation Framework
- Key indicators: rates of preventable vision impairment (measured by regular national First Nations-led eye health surveys), numbers of glasses dispensed (measured via data inclusion in annual AIHW Indigenous Eye Health Measures reporting).
- Data sovereignty: all data owned and governed by Aboriginal and Torres Strait Islander organisations.
- Annual reports: delivered to the Department of Health and Aged Care.

8.2 Project Staffing Costs

Role	Annual Cost	Description
Program Manager	\$182 000 *	Manages all aspects of project design, delivery and reporting.
Project Officer	\$117,000*	Supports implementation and community coordination.
Evaluation & Impact Officer (0.5 FTE)	\$48,750*	Measures health and educational impact.
Total	\$347,750 pa	
Total staffing budget for 3 years	\$1,096,281.875 for three positions over three years* (including 5% wage increase per year) *including on costs 30%.	



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8.3 Budget

- Average cost per corrected child for glasses provision is: \$150
- In 2021, the Aboriginal and Torres Strait Islander population was 983,700*
- 33.1%* of this population are under 15 years of age, meaning 325,605 Aboriginal and Torres Strait Islander children would be eligible for the scheme
- Vision screening programs estimate that on average 20% of children will be referred for follow-up, which = 65,120 Aboriginal and Torres Strait Islander children under 15 years old.
- Of these, approximately 17% are estimated to require vision correction = 11,070 children.
- This equates to 11,070 Aboriginal and Torres Strait Islander children requiring vision correction * \$150 average cost per corrected child = \$1,660,500 per annum
- The total costs to administer the program over 3 years is \$8,080,910 (Excl GST).

Note: Additional administrative costs may include product postage and ACCHO administration. Optometrists who provide prescriptions would also bill Medicare for the comprehensive eye exam.

Estimated Cost (AUD)					
Year	Staffing costs	Direct Costs Glasses	Other Costs	Project Admin 10%	Total Cost (Excl GST)
1	\$347,750	\$1,660,000	\$490,000	\$249,775	\$2,747,525
2	\$365,138	\$1,660,000	\$390,000	\$241,514	\$2,656,651
3	\$383,394	\$1,660,000	\$390,000	\$243,339	\$2,676,734
				Total over 3 years	\$8,080,910

The Budget key activities per include:

- Year 1: Website and systems setup & maintenance; Advertising and promotion, Travel & Accommodation, Program setup, recruitment, pilot roll-out, procurement, project administration
- Year 2: Glasses distribution. Expansion, communications, evaluation mid-term, website Maintenance, Advertising Budget, Travel and Accommodation Project admin 10%
- Year 3: Full delivery, impact evaluation, and reporting, website maintenance, Advertising Budget, Travel and accommodation, Project administration 10%

9.0 Implementation Timeline and Risk Management

9.1 Timeline

Phase	Period	Key Deliverables
Setup	Q3 2026 –Q1 2027	Governance, procurement, staff recruitment, pilot ACCHOs, and set up online technology.
Implementation	FY 2027–2028	National roll-out
Evaluation	Q4 2028–2029	Impact reporting, recommendations for renewal

9.2 Key Risks and Mitigations

Risk	Mitigation
Supply chain delays	Panel contracts and buffer stock
Low initial uptake	Community champions and co-designed promotion
Data non-compliance	Simplified reporting tools and training
Staff turnover	Local capacity building and ACCHO employment
Cost overruns	10 % contingency and staged funding

10. Conclusion and Call to Action

Vision correction is among the simplest, most cost-effective, and impactful interventions in child health. This program will enable every Aboriginal and Torres Strait Islander child aged under 15 years who needs vision correction to receive access to appropriate lenses for free, in a culturally appropriate way, locally, and with dignity.

FNEHA stands ready to partner with the Commonwealth to deliver A Vision for a Bright Future beginning in the 2026 Budget year.



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