

Young Aboriginal people's sexual health risk reduction strategies: a qualitative study in remote Australia

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Abstract. *Background:* Surveillance data indicate that Aboriginal and Torres Strait Islander young people are more likely than their non-Indigenous counterparts to experience sexually transmissible infections (STIs) and teenage pregnancy. Despite increasing emphasis on the need for strengths-based approaches to Aboriginal sexual health, limited published data document how young Aboriginal people reduce sexual health risks encountered in their everyday lives. *Methods:* In-depth interviews with 35 young Aboriginal women and men aged 16–21 years in two remote Australian settings were conducted; inductive thematic analysis examining sexual health risk reduction practices was also conducted. *Results:* Participants reported individual and collective STI and pregnancy risk reduction strategies. Individual practices included accessing and carrying condoms; having a regular casual sexual partner; being in a long-term trusting relationship; using long-acting reversible contraception; having fewer sexual partners; abstaining from sex; accessing STI testing. More collective strategies included: refusing sex without a condom; accompanied health clinic visits with a trusted individual; encouraging friends to use condoms and go for STI testing; providing friends with condoms. *Conclusion:* Findings broaden understanding of young Aboriginal people's sexual health risk reduction strategies in remote Aboriginal communities. Findings signal the need for multisectoral STI prevention and sexual health programs driven by young people's existing harm minimisation strategies and cultural models of collective support. Specific strategies to enhance young people's sexual health include: peer condom distribution; accompanied health service visits; peer-led health promotion; continued community-based condom distribution; enhanced access to a fuller range of available contraception in primary care settings; engaging health service-experienced young people as 'youth health workers'.

Additional keywords: Indigenous, pregnancy, STIs, strengths-based, youth.

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Introduction

In Australia, surveillance data show persistent disparities in the sexual health of Aboriginal and Torres Strait Islander (referred to as 'Aboriginal' hereafter) young people, with the former

experiencing higher rates of sexually transmissible infections (STIs), teenage pregnancy and teenage births than their non-Aboriginal counterparts.^{1–3} STI notification rates are also up to 5-, 30- and 50-fold higher respectively for chlamydia,

gonorrhoea and infectious syphilis in remote and very remote areas.¹ Qualitative research can enhance our understanding of these issues by examining the reasons why young Aboriginal people are at increased risk of unintended or unwanted sexual health outcomes⁴ and their strategies for reducing sexual health risks, to inform the design and delivery of culturally appropriate youth-centred sexual health services and programs.⁵

Published qualitative data from the Northern Territory, Western Australia, Far North Queensland and South Australia suggest that young Aboriginal people in some settings have a limited awareness of how to prevent STIs^{6–8} and pregnancy,^{7,9,10} and low rates of condom use and other forms of contraception.^{6–8,10–12} However, only one study undertaken in Townsville, a large urban setting in Queensland, has explicitly examined young Aboriginal people's sexual health risk reduction strategies.^{13–15} Limited to a focus on STIs in a large metropolitan setting, this study sought to understand how young people build on individual and community strengths to protect themselves against adverse sexual health outcomes and enhance their health and wellbeing.¹³

There is a lack of strengths-based sexual health studies that focus on STIs and unintended pregnancy in young Aboriginal people, particularly in remote settings of Australia. Drawing on recent qualitative research with young Aboriginal people in remote Australian settings, this study sought to understand young Aboriginal people's individual and more collective sexual health risk reduction practices.

Methods

The qualitative study adopted a strengths-based approach to focus on how people and communities act individually and with assistance from others with the goal of improving their health.^{14,16,17} Strengths-based approaches to health involve a focus on actions taken by community members to improve their health outcomes, rather than focussing only on the problems and difficulties highlighted by deficit models in health promotion and research.^{14,16,17} Guided by the concept of 'sexual agency'^{5,18}, it focussed on how young Aboriginal people try to maintain control over their sexual health, while navigating broader social expectations, often, but not always, in ways that are satisfying and relatively free of risk.

Study settings and study participants

Between October 2015 and November 2016, 35 young Aboriginal people (14 young women; 21 young men), aged 16–21 years and resident in two remote settings in the Northern Territory, were interviewed. Young people were sampled purposively¹⁹ to reflect diversity by age and gender in each setting. Recruitment occurred via introductions by representatives of health services and youth development organisations, and subsequent snowball recruitment techniques via youth participant networks. Due to the sensitivity of the study, strategies were taken to protect the identities of individuals, health services and communities involved; neither location is named (instead referred to as

'setting 1' and 'setting 2' when differentiating between them) and limited social, cultural and demographic description of each setting is provided.

Data collection

Semi-structured interviews were conducted in person on an individual basis. In setting 1, interviews were conducted by two adult researchers – SB (a non-Indigenous male researcher with no prior connection to either research setting) and WM (an Aboriginal female research officer with previous work experience in this location). In setting 2, interviews were conducted by two adult researchers – SB and AL (an Aboriginal male research officer with previous work experience in this location) – and six Aboriginal youth researchers who were recruited for this specific project to undertake research with other young people in their local social networks. They participated in a 4-day research training workshop covering semi-structured, in-depth interviewing; applied research ethics, with a particular emphasis on confidentiality, anonymity, informed voluntary consent and the use of participant information sheets and consent forms; the use of a digital recorder; data management; and interviewee recruitment. They also received a further 14 days of intensive research support from SB and AL to enhance interviewing skills as data collection progressed.

The topic guide, piloted with youth researchers, covered three themes: (1) sexual experiences and relationships; (2) STIs and risk practices; and (3) prevention, risk reduction and STI testing and treatment. The third theme started with the question, '*How do young people prevent sexual health problems?*' This paper analyses young people's open-ended responses to this question. Interviews took place in audio-private settings (e.g. private rooms in youth and sports organisations; at home on verandas and in gardens; and under trees in public spaces). Interviews lasted between 25 and 90 minutes and were conducted in English.

Data analysis

Interviews were audio-recorded, transcribed verbatim, anonymised, checked for accuracy and imported into NVIVO V.12 qualitative data analysis software (QSR International, Melbourne, Vic., Australia). Prior to analysis, interview audio files were reviewed by Aboriginal youth researchers involved in data collection for initial interpretation of data. Thereafter, thematic inductive analysis was undertaken by the first author using a system of open and axial coding²⁰ to examine young people's strategies of risk reduction, with a focus on STIs and pregnancy.

Ethical considerations

Ethical approval was granted by the Central Australian Human Remote Ethics Committee (HREC 15–314) and noted by the UNSW Sydney Human Research Ethics Committee. Interviewees were remunerated with a A\$30 store voucher (setting 1) or A\$30 mobile phone credit (setting 2).

Results

Condom use

Condom use was the most widely cited form of risk reduction, primarily to prevent STIs, but sometimes for pregnancy prevention. Participants reported that condoms were widely accessible from Aboriginal community-controlled and government clinics and hospitals and community-based condom dispensers in both settings, as well as from pharmacies and 24-h shops in setting 2.

Are condoms easy to find here?

'Yeah from the clinic. And in the oval. Sometimes [clinicians] take and put them in that white thing [plastic dispenser]. Sometimes [young men] go and ask for the condom, saying 'can you go and put condom in the oval?' There's another one at the clinic. Just outside.' (man, 20 years old, Interviewee 24)

Participants reported preferring access to condoms without adult interaction.

'All clinics got condoms, the hospital has them. There's plenty around. And they're in good spots where you can go grab them without adults around.' (woman, 19 years old, Interviewee 20)

One woman (21 years old, Interviewee 30) described how boys aged 16 years and under discreetly access condom dispensers: *'They use some condom, from the clinic, sometimes they use [the condom dispenser] at dark at night time'*. One man (17 years old, Interviewee 21) said, *'I got condom at home, only one. Still got it, never use it. Use it when I'm ready'* and another man (19 years old, Interviewee 4) said *'I actually take them off my mates, 'cos often they get big packs, and I'm just taking two'*. Two men in setting 2 explained that they brought condoms to parties to be prepared for sex. One said, *'You've gotta bring it yourself. You've gotta be prepared before you go to the party'* (18 years old, Interviewee 10).

Despite narratives of access, readiness and use, participants confirmed that condoms were not always used. Reasons included being *'annoying to put on'* (man, 18 years old, Interviewee 10) and *'not so pleasurable'* (man, 16 years old, Interviewee 1). Others referred to decreased concerns about risk reduction when *'under the influence [alcohol] and thinking they can just root without a condom and not worry about the consequences later on down the track'* (woman, 16 years old, Interviewee 17). Others said, *'But if there's no condom then they just do it'* (woman, 16 years old, Interviewee 32). Talking about a friend, one man said:

'He likes partying. He likes getting with chicks.

Does he have a girlfriend? A permanent girlfriend?

No. He keeps himself free...

What's the likelihood that he'll carry a condom?

If he had one at home, like before we started drinking, he'd chuck it in his pocket. But if he didn't have one, he'd probably be like 'oh', and if a girl comes up to him, he'd be like yeah, that's alright then.

As in, if he was at a party, didn't have a condom, and a girl came up he'd still go and have sex with her?

Yeah.' (man, 19 years old, Interviewee 4)

Two women reported collective efforts to promote condom use in friendship groups.

'Some couple of girls talking together, like how to use condom, like if we meet boys always use condom because you don't know if that boy has sickness or not.' (woman, 17 years old, Interviewee 34)

Another woman described a strategy focusing on negotiating the use of condoms due to her prior pregnancy experience and looking after her son without support from the father:

'[Young women] know [sex without a condom is] a risk, and they still do it. I think it's just them trusting the boys too much. Fuck, don't trust nobody. I have to be in a stable relationship to do stuff like that. If it's just for fun, it's gotta be all wrapped [using a condom]... Most [young men] are like, 'Oh no, you can't feel anything', blah, blah. And girls are stupid enough to say 'oh well, you know, take it off then'. Whatever. I just say, 'I don't give a fuck. Stop if it's not good enough, I'm taking off'. Nah, there's no way. I've already learnt the hard way, on getting pregnant. I don't unwrap it. I gotta use protection.' (woman, 19 years old, Interviewee 16)

Other female respondents highlighted the difficult interpersonal nature of negotiating condom use. One woman (19 years old, Interviewee 20) said, *'It's a shame thing for them, for a girl telling a boy to put a condom on'*. When asked if young women ask young men to use condoms in setting 1, another woman (17 years old, Interviewee 35) responded, *'Sometimes it's not easy'*.

Two men in setting 2 said they had never been asked to use a condom by the young women they had had sex with at parties. Both said that they would use a condom if requested. One said, *'If a girl just said, 'use protection', they probably just would, you know'* (19 years old, Interviewee 4) and the other said, *'They don't ask. But I would chuck it on.'* (18 years old, Interviewee 10)

Pregnancy prevention

For women in both settings, the key priority in relation to sex was to reduce the risk of unplanned or unwanted pregnancy, particularly where condom use did not occur and could not easily be negotiated. The most commonly cited pregnancy prevention method in both settings was 'Implanon', also referred to as 'the bar'. Apart from condoms, this was the most common strategy accessed by young women in setting 2.

Did you ever hear of any other contraception?

'Yeah, Implanon. I do have one. Two years now.

Must be nearly time to get it checked ay?

(Laughs) Tomorrow.

Do you know any other kind of contraception people might use?

Nah.' (woman, 17 years old, Interviewee 34)

While Implanon was also the preferred contraceptive in setting 2, women in this setting described other strategies. Although discussed rarely, these included, 'taking the pill' (woman, 16 years old, Interviewee 18), using 'the morning after pill [emergency contraception]' (woman, 16 years old, Interviewee 17) and 'the Depo needle [hormone injection]... and the Mar, what is it? Marine? Marina? [intrauterine device]?' (woman, 19 years old, Interviewee 20).

Three women explained their contraceptive decision making, with their preferences influenced by effects on the menstrual cycle, as well as a perception that long-term contraception was more reliable because it was not dependent on remembering to take a tablet each day. Only one female participant noted the importance of also using condoms to prevent STIs.

'If you just forget to take [the pill] you'll be pregnant! Bar in your arm, at least it's inside and it's there for three years. You don't have to worry about swallowing any tablets or getting needles every three months. I'd just rather have it in for three years. Like I got mine. No way am I getting pregnant. I like this, this is cool, 'cos my body reacts good to it too. Different ones for different girls. People say 'no, I can't last long on the bar', 'feel sick', they get their period too much. Mine's just normal.

I heard some fellas going round to check to see whether people have got a bar or not?

Yeah, they'll say 'the bar's here', and they'll be like oh, yeah! But it's still, you know, wrap it' (woman, 19 years old, Interviewee 16)

There was awareness of pregnancy prevention strategies among men in both settings, with participants also listing condoms, Implanon, the oral contraceptive pill and the emergency contraceptive pill. Men reported learning about these options through conversations and experiences with sexual partners. Implanon was preferred by men due to the ability to have sex without the potential consequence of unplanned pregnancy:

'I don't know, I'm not a girl. They can put, what's them pills in their arm, take pills and shit like morning after pill. I know few girls that got them bars in their arm. Yeah, so they don't get pregnant.' (man, 19 years old, Interviewee 12)

Partner-related risk reduction strategies

Participants also reported several sexual partner-related risk reduction strategies. Some men adopted strategies such as having fewer sexual partners. One said, 'don't go getting with heaps of girls all in one weekend' (man, 19 years old, Interviewee 4). Four men stated that STI risk could be reduced by just having sex with the same person:

'Say, like, you know you're both clean, youse both don't have fuckin' STIs, youse just banging each other, no sleeping around with other people that might have something.' (man, 19 years old, Interviewee 12)

Others talked about having sex within a trusted long-term relationship:

'Just do it one time, just have one kid and later on just have a family life, grow up your kids. Maybe later on, if you feel like to have sex you might have another kid. Being parents you know, families. Just having sex with the wife.' (man, 17 years old, Interviewee 21)

Women described a range of partner-related risk reduction strategies. One participant described women's deliberate decision to abstain from sex, 'they don't get in sexual relationships, and like, don't have sex, they just worry about other things, put other things first' (woman, 16 years old, Interviewee 18). Another said, 'staying at home or just going out with friends at night, but no sex.' (woman, 17 years old, Interviewee 34).

Other strategies were more collective in nature. One woman said that she chose a boyfriend who would respect her decisions about sex, while another described how her friends (including close sisters and cousins) looked out for each other in social situations and advised each other to avoid men that are believed to pose health risks.

'In our little group, if someone says 'oh, they want to go with someone but he's not good', we'll be like 'don't be stupid, he cause problems'. We'll all say 'you're not going, and that's that. We don't care if it's your own choice, but you're not going'. And then they say thank you the next day when they sober themselves up.' (woman, 19 years old, Interviewee 16)

Accessing services for STI testing and treatment

Most participants were able to list STI testing locations in their respective communities. Eleven participants (three woman and eight men) indicated personal experience of STI testing and/or treatment and others talked about friends with these experiences.

The main reason for STI testing was because of suspected STI symptoms or to resolve anxiety after having had sex without a condom.

'You got that [government clinic] which is your STI tester. ...I've been there once, just like precaution ...If you're worried that you might have STI, you can just go there and if you do have one you can get treated as soon as possible. ...After having sex a couple of times, I got worried 'cos some of those rumours going round that one of the girls I slept with had an STI. I went to the clinic and got the all clear, so that was all good.' (man, 17 years old, Interviewee 2)

Participants described strategies that enabled access to STI testing, despite the risk of gossip if seen visiting a clinic. Two men noted the importance of secret visits to clinics, saying, 'Keeping it secret you know? I go own way to clinic' (21 years old, Interviewee 23) and, 'Just go their own, secret, and talk to a doctor without telling anybody' (16 years old, Interviewee 8). Another described making up 'cover' stories about clinic attendance:

'People feel shame as they might see someone there [at clinic]. They might ask him 'hey what's wrong you come to clinic?' He might get shame. Yeah. But he can say 'I got, I got sick'. And pretend that it's just other, something else. 'I got sore ears'. [laughs]. Make it up.' (man, 18 years old, Interviewee 25)

Young women in one setting described actions that were more of a collective nature, including supported clinic visits that involved asking someone they trusted – most usually a female friend, sibling or grandmother – to attend the clinic with them.

'I always let my big sister know and she always takes me to the clinic. She talks to me. She just says I love you. She just tells me good, good ways. Mm. . . I only got my sister.

So you'd do that for another friend would ya?

I'd try and ask. I always try help my youngest cousin, but she always gets shame from me.' (woman, 17 years old, Interviewee 34)

Discussion

For the first time in remote Australian communities, our findings provide substantial evidence of sexual health risk reduction practices among young Aboriginal people. Complementing evidence from literature focusing on a metropolitan setting,^{13–15} but with a broader focus on STI prevention and pregnancy, our study identified how young Aboriginal people use existing strengths – on their own and with support from others – to reduce sexual health risks. These strategies were gendered; young men tended to use individual ways to reduce risk, whereas young women adopted more collective strategies.

At an individual level, young men reported accessing condoms from a range of sources, keeping an available condom supply at home and carrying condoms to parties in case they were needed. Some chose to have sex with only a regular sexual partner, or within a long-term trusting relationship, whereas others reduced the number of casual sexual partners. Some accessed STI testing – sometimes secretly – to check symptoms and resolve worries.

Young women's major concern was pregnancy prevention. Some used long-acting reversible contraception, including contraceptive implants, injections and hormonal intrauterine devices. Although much less common, they also reported the use of short-term contraception, including the oral contraceptive pill and the emergency contraception pill. Others avoided interactions or social situations in which unplanned sex might occur, or else abstained from sex.

Beyond these individual-level actions, participants – particularly young women – relied on more collective strategies to reduce sexual health risks. Young women described encouraging friends to use condoms during sexual encounters and accompanied health clinic visits with support from a friend or family member. Some described 'looking out' for friends in social circumstances where unwanted or unplanned sex might occur (e.g. at parties or in the local community at night) and advising friends against having sex

with someone who had a bad reputation. Some young women also described refusing to have sex without a condom, standing up for themselves and stating their preferences during negotiations with potential male sexual partners. Young men described making up 'cover' stories to protect their reputation when being seen in the clinic for STI testing, sharing condoms with friends and establishing longer-term relationships to reduce STI risk. Both young men and young women encouraged friends to attend STI testing.

Rather than focussing on sexual health problems, a strengths-based approach enables an exploration of the actions that young Aboriginal people and other community members take to improve their sexual health outcomes.^{14,16,17} However, it is important to recognise how young people's agency in sexual health risk reduction is constrained by broader social and cultural factors. As with non-Indigenous young Australians,^{11,21} our data point to gendered sexual health roles and responsibilities,^{6–8,10,14,15} whereby young men are largely responsible for accessing and carrying condoms and young women assume control of other pregnancy prevention strategies. Although condom use was reported by some participants, others noted how the difficult interpersonal nature of negotiating condom use constrained this practice. Furthermore, the need for privacy or support from others when accessing STI testing services or condoms, cover stories to explain clinic attendance, and shame associated with gossip stemming from rumours about sexual activity all allude to the social and cultural constraints that limit what young people can do to reduce STI risks.

Limitations

The sample of young people in this study was relatively small and encompassed two different settings in the Northern Territory. While the sample was large enough to document a range of risk reduction strategies, this was a qualitative study and care must be taken not to assume that all young people were engaged in safe or risk-free sexual encounters. Data collection by several different peer and adult interviewers may have increased variation among individual responses, although 'internal reliability'²² was enhanced by interviewers working together, supported by the first author to ensure rigour and consistency in data collection and interpretation.

Implications for policy, programs and services

Despite these limitations, our findings provide insights into potential actions to reduce sexual health risks among young Aboriginal people in remote settings. To be effective, sexual health risk reduction and health promotion responses must be part of continued multi-sectoral efforts – involving health, education and community sector organisations – that elicit change at individual, interpersonal, community, institutional and policy levels. As such, our recommendations reinforce those made in previous studies^{13–15} and guidelines.^{23,24}

At a policy level, distinguishing between individual and collective risk reduction strategies may help ensure that public

health responses to STIs and unwanted pregnancy in these communities move beyond narrowly framed individual behaviour change to recognise the social opportunities for sexual health risk reduction associated with peer, family and community networks.^{14,18,25} Our findings illustrate the value of drawing on same age and intergenerational networks for sexual and reproductive health support^{5-7,12-15} and support previous research documenting the value of 'community strengths'¹⁶ in Aboriginal youth sexual health practice.

Programmatically, continued access to contraception is vital. This includes condom distribution via a diverse range of means, including a strong commitment to the regular restocking of community-based condom dispensers to facilitate discreet access in community settings. It also requires access to the full range of available contraception in all primary care settings where young people access sexual health care. This includes ongoing support for young Aboriginal women's preferred use of including long-acting reversible contraception, as well as increasing access to the emergency contraception pill; both options are important for instances of unplanned unprotected sex. Such efforts are best supported by clear messages about the full range of strategies to prevent STIs and pregnancy, the role of condoms in STI and pregnancy prevention, as well as the risks of STI transmission when using long-acting reversible contraception without condoms or not knowing the sexual health of partners. Given the high incidence of STIs in this setting, there are existing interactions between health workers and young people – especially for young men who frequent health services less than young women – during STI testing, diagnosis and treatment consultations in primary healthcare settings. Such interactions could also be used to deliver culturally appropriate education and health promotion about contraception.

Our findings illustrate young Aboriginal people's collective actions to reduce risk, and point to the clear need for sexual health promotion services that extend beyond individual strategies and messages. Comprehensive relationships and sexuality education is needed in school and community settings to support the existing capabilities of young people, and focus on the interpersonal skills needed to navigate healthy and safe sexual relationships for STI and pregnancy prevention and access of sexual health services.^{23,26} Beyond the obvious focus on pregnancy and STIs, pertinent issues arising from this study to be covered as part of comprehensive relationships and sexuality education include: discussion on refiguring local social constructions of gender to enhance shared decision making, negotiation and responsibility for contraception; positive peer and partner influences on sexual practices; and individual and peer strategies relating to consent, decision making and opportunities for refusal when sex occurs alongside alcohol or drug use.²⁶ Such programs can draw on the existing harm minimisation strategies and cultural models of collective support that young people already use. Examples from this study include peer condom distribution networks; accompanied health service visits; peer-led conversations that promote condom use and reflection on choice of sexual partners; and group-based strategies

whereby young people 'look out' for friends who might be vulnerable to unwanted or unplanned sex.

In remote settings, there are persistently high STI prevalence and incidence rates.^{27,28} This is despite higher STI testing rates among Aboriginal young people – particularly young women, and young people aged 20–29 years – than older Aboriginal people and non-Indigenous peers,²⁹ and the existence of primary health care and sexual health services and programs and policy that includes STI control.³⁰ Given our findings that some Aboriginal young people are using STI risk reduction strategies, but that this population typically remains at greater risk of STI acquisition,¹ more concerted efforts to reduce community prevalence of STIs through innovative community-based testing and treatment programs are also needed.

Finally, public health programs targeting this group should emphasise existing capabilities and strategies for sexual health.¹⁶ At the community level, this involves tapping into the advice and networking that exists within peer, friendship and family networks, and the support offered as part of accompanied health clinic visits. Young people will continue to access sexual health care from primary healthcare clinicians in government and community-controlled health services. At the health service level, training and education programs for clinicians in primary care settings should be updated to reflect the diversity of strategies that young people already use to enhance their sexual health, and to help health professionals to support young people in building on these existing strengths. To enhance the delivery of culturally appropriate and age-specific health care, there may also be potential for engaging health service-experienced young people as 'youth health workers'. This would acknowledge young Aboriginal people's expertise and experience, the strengths of their social networks, and support their formal entry into sexual and reproductive health work in order to enhance the delivery of health education and promotion, clinic- and outreach-based sexual health services, and case management processes with young Aboriginal people.

Conclusion

Young Aboriginal people's experiences, perspectives and risk reduction practices remain largely absent from the qualitative sexual health literature in Australia.^{5,15} Our findings provide a positive portrayal of young Aboriginal people's efforts – on their own and with support from family and community members – to prevent and reduce harm from unwanted sexual health outcomes, albeit within the social and cultural constraints that limit their sexual health agency. We detail a range of strategies used by young Aboriginal people to enhance their sexual health that could be adopted as part of future service, program and policy enhancements to improve the persistently low levels of STI testing among young people attending primary healthcare centres, as well as engage young people who do not visit clinics frequently. Study findings support previous calls^{15,31} for the design and

delivery of culturally safe youth-centred sexual health promotion programs and services based on a strong understanding of what young people already do well in order to reduce sexual health risks.

Conflicts of interest

The authors declare no conflicts of interest.

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