Research Article
Perceptions of Community Resources and Insights for Program Development from Southern, Rural Hypertensive Women

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Background. Hypertension affects millions of Americans each year and is a significant contributor to the development of cardiovascular disease. African Americans, especially those living in rural locations, experience greater disparities in the incidence and prevalence rates of hypertension and cardiovascular disease. Methods. This study utilizes qualitative descriptive methodology. Focus groups involving African American women reporting hypertension were conducted in a rural community in Alabama. Results. The mean age was 60.3 years of age (SD = 10.3). Most were married and half were college educated. The majority reported an overweight or obese status. Most were aware that they had hypertension for more than five years, all were nonsmokers, and the majority had a family history of heart disease, hypertension, and/or heart attack or stroke. Key themes emerging from the focus groups included strengths of the community, support for the community, support for a healthy lifestyle, and intervention development. Conclusion. Hypertension is a treatable and preventable disease that not only causes disability, but also significantly decreases the quality of life in affected individuals. Findings from this study provide insight into the unique needs and perceptions of African American women residing in rural Alabama as they relate to community resources.

1. Background
Hypertension (HTN) affects millions of Americans each year and is a significant contributing factor in the development of cardiovascular disease (CVD) [1, 2]. Disparities related to HTN and CVD persist by gender, as well as race; however, while disparities in diagnosis, treatment, and outcomes have decreased significantly in respect to gender, disparities related to race have not improved [3]. Greater disparities related to the incidence and prevalence rates of HTN and CVD are especially noted among African Americans [3, 4], and African Americans are more likely to experience poor outcomes directly related to complications stemming from CVD and associated conditions [1]. Health disparities related to HTN and CVD are magnified even further among African Americans residing in rural locations [5]. High rates of HTN and CVD combined with the likely development of multiple comorbid conditions, and the long-term disabling effects of chronic disease are a source of deep concern.

Local, state, and national initiatives related to ongoing health disparities address risk factors contributing to the incidence of HTN and CVD among African Americans [1, 6–9]. Other interventions for persons with established HTN focus on healthy lifestyle choices, such as physical activity and/or diet, in disease management [4, 8, 10]. However, although physical activity and dietary interventions are effective, long-term change in personal health behavior is difficult to maintain [7]. In addition to identifying interventions that stimulate long-term change, these strategies must address the unique needs of rural populations.

Recent studies have focused on rural populations [11–13], yet few studies focused solely on African Americans residing in rural locations [14–16], and even fewer focused on African Americans in rural areas of the Southern United States [10, 14, 17, 18]. Given the higher rate of HTN and CVD, additional efforts are needed to address the incidence and prevalence of these diseases among African Americans in rural locations, especially in the south.
One approach to discover effective ways to decrease health disparities related to HTN and CVD is to employ community-based participatory research (CBPR) [4, 6, 19]. This involves the community directly, focusing on the strengths of that community [20, 21], and has been utilized to address issues of disease prevention as well as health promotion [22, 23]. Specifically, in rural communities, CBPR has been successful in addressing emerging issues related to the effective management of HTN and CVD [24].

A foundational principle of CBPR is the involvement of community members throughout the research process [20, 25]. Community members must be involved in all aspects of the project: beginning with conception, including evaluation of the program, and finally disseminating findings. Once the community has been engaged, an assets-oriented approach employs the strengths of that community, and the team identifies additional resources and other undiscovered or underused assets available [26]. The assets-oriented approach uncovers resources currently available in the community which may be used as the foundation for program development, as well as serve as foundational support for the sustainability of that program.

Yadrick and colleagues [27] emphasized the fact that “for a community-based intervention to be effective and sustainable, perceptions of community members must be determined and then used to plan and tailor interventions’ (page 267). Conducting focus groups within a community provides insight into community resources that can be incorporated and serve as a starting point for developing a CBPR program to address disparities related to HTN in the community. Therefore, the purpose of this study was to ascertain and describe the perceptions of community dwelling African American women with HTN, specifically related to (1) community resources and assets and (2) explicit needs for development of a CBPR program for African American women with HTN who reside in rural Alabama.

2. Methods

This study was conducted by utilizing a qualitative descriptive methodology which allows the researcher to stay close to the data by maintaining the results in the participants’ own words [28]. This also provides the opportunity to begin to engage stakeholders and for community members to identify and maintain their role throughout the process of program development. When the results are provided, they are presented in a way that is clear and easy to understand.

Focus groups are effective in gaining insight into participant perspectives regarding issues related to health and healthcare [29, 30]. The dynamics provided by focus group interaction lends itself to support for group participants and provides a safe and supportive environment to share thoughts and ideas [31]. Although responses may be shaped by the atmosphere of the group, if participants are familiar with one another, they express statements supporting one another’s ideas, yet still express their own opinions.

A purposive sampling technique recruited participants for the focus groups. Participants were enrolled from local churches of a community located in a rural county in the Black Belt of Alabama, an area of rich culture, rich soil, and primarily agricultural industry [32]. The total population of the county was 43,820. The total available population of African American females in this community was 16,883 (of those women: 6,734 were aged 15–44; 4,338 aged 45–64; and 1,756 aged 65–84) [33]. Pastors of local churches were contacted regarding the study, and information about the study was provided. The principal investigator made an announcement during church service or during a ministry meeting, and flyers were given to women who expressed interest. If interested, after hearing the announcement and/or receiving a flyer, potential participants invited other women who were interested in participating in the study. Sample selection criteria included women aged 36–75 years of age who self-reported as hypertensive, African American, a rural dweller for a minimum of five years [34], and English speaking. Once eligibility was determined, participants were invited to a focus group meeting at a local church. The research assistant made a reminder phone call to participants regarding the time and date of the focus group. A healthy lunch was provided for participants during the focus group along with $25 remuneration in appreciation for their time.

2.1. Instruments. Participants were asked a series of open-ended questions using a prescribed focus group interview guide. Questions were based in part upon work by Sharpe et al. [26] and Peters et al. [30]. The purpose of the focus group was to gain insight into the resources and assets currently available in the community as well as gain general information regarding support for developing a culturally appropriate program focused on the management and treatment of HTN. Participants completed a demographic and health history information form developed by the researcher and adapted from a previous study [35]. The demographic and health history information form captured information regarding age; self-reported height and weight; family health history of CVD and HTN as well as personal health history; health information; health behaviors.

2.2. Data Analysis. Descriptive statistics explicated sociodemographic variables, biologic factors, and the HTN-related health status of participants. Responses of participants, elicited during focus groups, were analyzed using qualitative content analysis and Krueger and Casey’s [31] methodology for analyzing focus groups. The audio-taped data were transcribed verbatim and analyzed by utilizing an iterative process. The coded data was then analyzed for themes and content [36, 37]. The study protocol was approved by the University’s Institutional Review Board.

3. Results

The mean age of the women was 60.3 years of age (SD = 10.3). Most women were married, not currently employed, and about half were college educated (33.3%, 70.8%, and 50.1%, resp.). Yearly incomes for the majority of women were less than $20,000; however, most had health insurance and...
Table 1: Demographic characteristics (N = 24).

| Characteristics          | n  | %   |
|--------------------------|----|-----|
| Age (years)              |    |     |
| 40–49                    | 4  | 16.7|
| 50–59                    | 7  | 29.2|
| 60–69                    | 9  | 37.4|
| 70–79                    | 4  | 16.7|
| Education                |    |     |
| High school              | 10 | 41.7|
| Trade school             | 2  | 8.3 |
| Junior college           | 4  | 16.7|
| Undergraduate degree     | 7  | 29.2|
| Graduate degree          | 1  | 4.2 |
| Marital status           |    |     |
| Single                   | 6  | 25.0|
| Married                  | 8  | 33.3|
| Widowed                  | 5  | 20.8|
| Divorced                 | 5  | 20.8|
| Income                   |    |     |
| Less than $10,000        | 5  | 22.7|
| $10,000–$19,999          | 9  | 40.9|
| $20,000–$30,999          | 0  | 0.0 |
| $31,000–$40,999          | 4  | 18.2|
| $41,000–$50,999          | 1  | 4.5 |
| Greater than $51,000     | 3  | 13.6|
| Health insurance         |    |     |
| Yes                      | 20 | 87  |
| No                       | 3  | 13  |
| Internet access          |    |     |
| Yes                      | 19 | 82.6|
| No                       | 4  | 17.4|

Note: the total percentages for each item may range from less than to greater than 100% due to rounding and/or missing participant responses.

Table 2: Range, mean, and standard deviation of height, weight, and body mass index (N = 24).

| Characteristics | Range          | Mean (SD)    |
|-----------------|----------------|--------------|
| Height          | 60–68          | 63.708 (2.0319) |
| Weight          | 135–302        | 196.26 (40.432) |
| BMI             | 29.3–54.4      | 34.052 (7.9912) |

Note: height and weight are self-reported values.

Table 3: Personal health history (N = 24).

| Characteristics                      | n  | %   |
|--------------------------------------|----|-----|
| Known to have hypertension*          |    |     |
| Less than one month                  | 2  | 9.1 |
| 1–6 months                           | 0  | 0   |
| 7–11 months                          | 1  | 4.5 |
| 2–5 years                            | 5  | 22.7|
| Greater than 5 years                 | 14 | 63.6|
| Last blood pressure check by professional |    |     |
| In the past two weeks                | 7  | 29.2|
| 1 month ago                          | 6  | 25.0|
| 2–4 months ago                       | 6  | 25.0|
| 5–6 months ago                       | 1  | 4.2 |
| 6–12 months ago                      | 4  | 16.7|
| Told about high cholesterol**        |    |     |
| Yes                                  | 18 | 78.3|
| No                                   | 5  | 21.7|
| Last time cholesterol checked*       |    |     |
| Less than a month                    | 5  | 22.7|
| 1–6 months                           | 8  | 36.4|
| 7–11 months                          | 3  | 13.6|
| 1 year                               | 5  | 22.7|
| Never                                | 1  | 4.5 |

Note: the total percentages for each item may range from less than to greater than 100% due to rounding and/or missing participant responses.

The qualitative results analyzed from the focus group transcripts revealed several key themes. The themes that emerged included: strengths of the community, support for the community, support for a healthy lifestyle, and intervention development. These themes are discussed in detail throughout the next section of the paper.

3.1. Strengths of the Community. Participants identified a number of community strengths. These included the large number of churches, geography, history, and caring for others. One participant noted “History. We have a lot of history here.” Other sentiments included “Concern with others,” “sharing with others,” and “checking on the elderly.” Another participant noted that members of the community provide transportation for the elderly who do not have access “...carrying back and forth to the doctor, assisting those elders who do not have assistance.” Strengths of the community were identified, and talents of community members were discussed.

Community members were considered to have a wide variety of talents, with participants providing a number of examples. “We have a lot of talents. There are singers, musicians, actors, speakers.” “I would say we have just about everything you could think of, somebody that can do it. It’s a very talented area. There’s a lot of talent in this area.” “We actually have a good bit of variety, variety in all fields.” Participants also mentioned having artists in the area, along
Table 4: Family health history (N = 22).

| Characteristics                        | n   | %   |
|----------------------------------------|-----|-----|
| Family history of heart disease        |     |     |
| Yes                                    | 19  | 86.4|
| No                                     | 3   | 13.6|
| Primary relative with heart disease    |     |     |
| At least one                           | 5   | 26.3|
| At least two                           | 6   | 31.6|
| At least three                         | 2   | 10.5|
| Nonprimary                             | 6   | 31.6|
| Family history of hypertension         |     |     |
| Yes                                    | 21  | 88  |
| No                                     | 1   | 12  |
| Primary relative with hypertension     |     |     |
| At least one                           | 5   | 23.8|
| At least two                           | 10  | 47.6|
| At least three                         | 6   | 28.6|
| Nonprimary                             | 0   | 0   |
| Family history of heart attack or stroke|  | |
| Yes                                    | 17  | 80  |
| No                                     | 5   | 20  |
| Primary relative heart attack or stroke|      |     |
| At least one                           | 9   | 52.9|
| At least two                           | 6   | 35.1|
| At least three                         | 0   | 0   |
| Nonprimary                             | 2   | 11.8|

Note: the total percentages for each item may range from less than to greater than 100% due to rounding and/or missing participant responses.

with educators, and persons skilled at trades of all types. One participant noted “We have great students academically-in our church, of course. We have students who excel in math, science; who have vocal…they sing.”

The women were asked to provide the greatest sources of community pride. These included “its history” and “culture.” More specifically, a participant pointed out “We offer a lot as far as culture.” The community’s role in the civil rights movement was identified by a number of participants. Other responses about community pride included families, a good place to retire, productivity, and “good cooking.” Although having “good cooking” was discussed as a source of pride, participants also noted that sometimes “it’s not healthy.” Building upon the strengths, talents, and pride within the community is a good foundation for program development; however, when areas of concern arise, they must be addressed as well.

Several issues arose during the discussion about community strengths. Even though the women expressed a number of community strengths, areas of concern and/or need were also discussed. Content of that interaction included worries related to the adequacy of and access to quality medical care. For example, one participant stated “We have a lot of healthcare providers. I do not know how effectively we use them or how well what is available is advertised. We do not have a continuum of care because we do not have the directory we need.” Another participant responded that “It’s being worked on” in reference to the directory. Another commented “…we only have one hospital.” A participant (addressing the availability of healthcare providers) commented “Everybody leaves here.” There were mixed responses regarding whether specialists were accessible in the area. Several participants noted that specialists were available, but one woman commented “There are a lot of doctors trained, but I’m talking about specialists that specialize in each different thing.” The information the participants shared varied but demonstrated the importance of the women’s perceptions of the type and quality of health care resources available, and the need to be certain about this information is disseminated throughout the community.

During the focus group interactions, issues related to transportation were explored. The community does not have a system of “mass transportation” or taxis; however, if individuals met certain requirements, they could use a local public transportation service. A bus route from a national bus company previously had a station in the community, but that was no longer the case. A participant indicated “People need to go places, but there’s just not enough people getting on that bus. I mean that gas is expensive. It was expensive.” One participant remarked that one could catch the local bus station to a neighboring larger city and travel from there. This participant also noted “…someone you know, a neighbor or a family member, will take you where you have to go. We just do not have [taxis] like we used to have them, so you have to really know somebody to take you where you have to go.” Participants did describe a transportation service available for transporting children, but as previously noted, certain requirements had to be met. Limited transportation affects not only health care access, but can also affect accessibility to community resources and resources to support a healthy lifestyle.

3.2. Support for the Community. A number of local churches, community, and civic organizations were discussed as contributing to the overall well-being of the community and to taking care of community members. A participant noted “The YMCA, I think, because it offers a place where you can exercise. That’s one of the things that, you know, [you do] to try and be healthier: you try and do some exercise. For me personally, it has the pool, and that’s what I use, the pool, because I have arthritis very bad, and I can’t do a lot of on-land exercise, but I can exercise in the pool. So for me, that’s very important.” In relation to organizations working to improve the community, one participant commented “There are a lot of sororities and fraternities and civic clubs and national organizations that do a lot of work, a lot of community work, especially with kids…”

Overall, participants noted that the extent to which people knew their neighbors depended upon the particular area of the community they lived in. There were a number of varied responses to this question such as “According to the community you live in, according to the neighborhood,” “I only know the ones that live on each side of me,” and “Some folks know a lot of them.” Another participant commented “I am a neighbor in my neighborhood. I am a neighbor.” In
relation to individuals who take care of others outside of this work being a required part of their job, some participants discussed that they serve in that capacity (i.e., helping others or taking care of other people in the community); churches in the community were a key resource, and a local community center provided assistance.

3.3. Support for a Healthy Lifestyle. Resources identified as needed in order to become or stay healthy included fresh vegetables (participants noted a community market open on weekends), money, motivation, and a healthy environment. One participant commented “You need fresh vegetables, and we do have the markets on weekends…. We have walking trails so we can get exercise. You need to see your doctor. You need to take your medications and follow your doctor’s advice.” Other participants echoed similar sentiments, sharing additional thoughts when asked about what was needed to encourage and support exercising and eating right, such as “You need money” and “motivation” and “a healthy environment.” More specifically, “…sometimes a healthy environment can include your home, you know, how you live, because that’s the main thing.” A participant noted that although type of food was important, so was how the food was prepared. Although participants acknowledged the presence of walking trails, one participant noted that a walking trail was not in the immediate area where the focus group was held, yet one was near her place of residence. A few participants were unaware that one of the parks in the area was still open but noted that the park contained only open space without trees or shade. Participants did perceive the (indoor) shopping mall as an area to walk.

An additional content area of support for a healthy lifestyle included thoughts on how health information was obtained. Information was generally obtained from multiple resources including physicians, the health department, church health ministries, social clubs, the local extension office, as well as family, friends, and coworkers. One participant commented “We get a lot of things circulated through our church. We have a senior adult ministry that meets here on a Wednesday, and when someone has materials, they will usually get it to the facilitator or someone, and they will bring it to this group.” Another added “Matter of fact, that’s how we got the information about this group; it came to the senior adult ministry.” Other comments included “…you get information from church members and friends or organizations that you participate in.” Only one participant noted that she lived in the county area (outside of the town limits) and resources were somewhat limited there.

Further support for a healthy lifestyle included issues related to medication access and taking medications correctly. The expressed concerns included costs, difficulty with insurance, and issues related to communication with healthcare providers. One participant stated it “cost too much.” Another commented “And the insurance, most of them do not want to let you get the real stuff.” A number of participants commented that they had problems with generic medications, indicating they believed nonbranded medications did not work as well. One participant described what she saw in practice, “Being a case manager, I saw a lot of people who couldn’t afford—they had to buy food or the medicine.” One participant commented further “You cannot buy when your income is limited, because that medicine will take every dime of it.” Another participant provided a specific example, “I had a situation last year where there were two medications… when you get into something called the donut hole.” Access to quality health care is a key factor in leading a healthy lifestyle, as it is good communication with healthcare providers.

When discussing communication with health care providers, comments varied. A participant noted “But the thing is, the doctors sometimes—if you do not ask them such as, ‘I need you to give me something that my insurance will supplement well,’ you just—I do not know what you do. I just do not know what people do.” One participant discussed the importance of going back to the office if the prescription was too expensive to fill “…you go back to the doctor and say, ‘Look this is too expensive. I need something that will do the same thing.’” A number of participants emphasized the importance of communication and, more importantly, effective communication. Pharmaceutical assistance programs were discussed as a possible option for assistance, as utilizing medications that were part of a discount prescription plan at chain stores. The interplay of all of these elements can affect disease management, effective control, and health promotion.

3.4. Intervention Development. Participants indicated positive support for an intervention addressing HTN management and treatment, identified key community members who should be involved in intervention development, and other persons who may be willing and able to participate in the intervention. Community members identified for participation in program development included, “people with high blood pressure,” healthcare professionals (e.g., doctors, nurses, case managers, and pharmacists), social workers, ministers, and “just lay people.” School counselors, the school system, and church outreach programs were also discussed as possible important contributors. Specifically targeting schools’ use of interventions, the women discussed the importance of sharing information related to prevention. One participant stated “Make kids aware of this because they have to be aware of this.” Another echoed the sentiment stating “The counselors at the schools can come to make the kids aware.” Participants actively discussed the importance of involving the whole community by commenting “And I feel you need maybe some people that do not have it. A cross section ought to be involved, I think.” Another participant noted “In other words, the community as a whole. I guess that sums it up.”

Participants shared similar feelings regarding who they thought would participate in the program. One participant shared “Persons who have high blood pressure are the most important. I mean, the others, of course, we need those assisting. But first you must find the ones who are affected.” Other comments included “the elderly” and “people that are concerned about their health.” Participants also noted a
“trickle” effect. Further support included “Well, I think with the high blood pressure being such a serious matter, I think more would participate.”

Upon conclusion of the focus group, participants were given the opportunity to provide additional feedback or comments. One participant noted “I remember at one point in time the health department had an office just dealing with people with high blood pressure, and when people that had it could not afford their medication, they went to the health department and got prescriptions. And, you know, any type [if] they felt bad or whatever and they didn’t have the money to go to the doctor, they went to the health department, and I really would like to know what happened to that program.” Another participant emphasized the importance of education “…education is the main key that we need to develop.”

4. Discussion

This study identified perceptions regarding resources and assets currently available in a rural community in the Black Belt of Alabama. Perceptions of need for an intervention addressing effective management of HTN were also explored. Women who participated in the study discussed a number of resources available in the community and how those resources were utilized. The community considered itself rich in talents, culture, and history, with a vast array of resources, available through a variety of sources. However, there were areas of concern, such as healthcare access and medication access. Although participants discussed access to healthcare providers and resources to maintain a healthy lifestyle in a positive light, they also discussed challenges. Individuals living in rural communities often face unique issues related to healthcare access including economic difficulties, fewer numbers of health care providers in the area, and lack of adequate transportation [38–40].

The majority of women had a family history of heart disease, hypertension, and/or heart attack and stroke. It was interesting to note that none of the women reported being smokers. Cigarette smoking for all adults in Alabama is estimated to be between 19 and 21.9%, which is slightly higher than the United States (US) rate of 19.3%. The overall rate of cigarette smoking for women in the USA is 17.3% [41]. This 17.3% rate should yield an expected response of about four self-reporting cigarette smoking women. Other studies involving similar groups demonstrate a smoking rate of approximately 15.9–21.9% or 18.9–25.6% [42, 43]. The reason behind this high rate of nonsmokers was not explored during the study; however, the fact that the study participants were recruited from local churches may have been a factor. Church members are often discouraged from participating in negative health behaviors such as smoking [44, 45].

The results suggest that a combination of factors must be addressed to best support effective management of HTN in community members. Participants were aware of the severity and potential for grave prognoses of CVD and HTN, ways to manage HTN, and that the community should be directly involved to fully address the disparity in incidence, prevalence, and poorer outcomes. However, it was noted that although individuals with HTN may be aware of their diagnosis and the necessary measures for disease management and prevention of developing comorbid conditions, they may not participate in those behaviors [35, 46]. A number of factors affect lack of participation in positive health behaviors, such as difficulty of participating in the treatment plan due to difficulty of obtaining medications as the women discussed. Programs previously developed to address the health issues of CVD and HTN were no longer in existence, yet significant issues with prevalence and management of HTN continue to exist.

4.1. Limitations. The limitations to this study include a small purposive sample which limits the ability to generalize findings beyond the population of focus, African American women residing in a US Southern rural area. Further studies in other populations and with larger sample sizes may provide further illumination. The resources and assets identified may be unique to this community, although similar communities may have similar resources or have similar challenges. As with any self-reported research, consideration must be made regarding socially desirable answers.

5. Conclusion

Hypertension is a treatable and preventable disease that causes not only disability, but also significantly decreases the quality of life in affected individuals. To address continued disparities related to race and a rural location of residence, continued efforts to develop and implement programs supporting sustainable change are needed [7]. Findings from this study provide insight into the unique needs and perceptions of African American women residing in rural Alabama as they relate to community resources. Before beginning to develop a program addressing the unique needs of African American women residing in rural Alabama, this study was conducted to identify the perceptions of those residents related to community resources.

Identification of perceptions is important because even though a resource may be available, if community members are unaware of that resource (or do not perceive it as being accessible), they may not use it. In turn, this provides a challenge for incorporating old and new resources. For example, a participant stated that there was a walking trail nearby. However, upon further discussion, it was determined that a walking trail was located in the community or in a nearby area. Continuing to discuss this type of topic may assist community members in recognizing resources. They may then state “yes” they have one, but due to distance and/or lack of transportation, they do not perceive the trail as being located in their community, or close enough to their residence to be readily accessible. The trail may be within the mapped area but not perceived as nearby. Understanding and addressing issues of perception assist the researcher, community, and planning team in determining measures to address during program development, and how to best implement better use of resources currently in place.

One of the best ways to maintain a program is to develop that program by building on resources currently available and by adding more resources that are relatively easy to
maintain whether or not external funding continues to be available. The key is sustainability. Downey and colleagues [47] note that “rural communities, particularly those experiencing health disparities, present a unique challenge for sustainability of health promotion processes and outcomes, in part because of resource limitations inherent in small communities” (page 183). Those authors and others specifically point out the need to build capacity as a mechanism for sustainability in the community as well as, during development of health promotion programs [47–49].

Ongoing effective programming requires a great deal of resources; however, when funding is no longer available, the program may dissolve. Continuous formative evaluation of the program’s strengths and weaknesses throughout the process can assist with sustainability. Initiatives and approaches that are demonstrated to be effective can be continued, and methods that do not work or are ineffective can be discontinued. Effective core elements of the program can be continued beyond the focus of the research program to provide continuity and to continue to support healthy lifestyle behaviors that may significantly address issues known to affect health disparities in the population discussed in this report.

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