

Living in the Everydayness of HIV Infection: Experiences of Young African-American Women

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Human immunodeficiency virus (HIV) infection is a life-threatening chronic disease that increases concerns about imminent mortality and managing a complex disease (Simoni et al., 2011). Although African Americans represent 13% of the female population in the United States, 64% of U.S. females who are HIV-positive are African American. Despite successes in the development and implementation of antiretroviral therapy to halt the disease trajectory, HIV/AIDS was the 7th leading cause of death in 2010 for African-American women ages 25-44 (Kaiser Family Foundation, 2014).

Despite advances in the diagnosis and medical management of HIV infection, living with a chronic, incurable, and eventually fatal disease presents multiple challenges and has significant physiological, psychological, social, and spiritual implications (Peltzer & Leenerts, 2007). Challenges are heightened when individuals have other stressors (e.g., poverty) that compete with their ability to engage fully in treatment regimens to manage their disease (National Alliance of State & Territorial AIDS Directors, 2008).

Literature Review

A comprehensive understanding of the health of young African-American women infected with HIV has remained elusive because how they live with HIV infection has not been explored extensively. A comprehensive review of the literature 2000-2012 was conducted through Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, and Google

The purpose of this Heideggerian phenomenological study was to explore the lived experiences, including spiritual and self-care practices, of young African-American women infected with the human immunodeficiency virus. One theme, "Living in the Everydayness of HIV," and implications for nurses will be discussed.

Scholar, using CINAHL Headings, Medical Subject Headings terms, and generic terms that included *HIV, African American, women, females, spirituality, and self-care*.

Health-promoting self-care activities and spirituality may assist individuals in managing their disease and may mediate the relationship between multiple stressors and disease outcomes. Few researchers have examined self-care behaviors among African-American women infected with HIV. Hurst, Montgomery, Davis, Killion, and Baker (2005) evaluated the influence of certain basic conditioning factors (age, socio-cultural orientation, family system, health state) on self-care agency and self-care practices among 62 African-American women infected with HIV. Although significant correlations did not exist between most of the basic conditioning factors and self-care agency and self-care practices, authors found significant positive correlations between health state and self-

care practices, suggesting women who had increased reports of their health state had increased levels of self-care agency and greater levels of engagement in self-care practices. Significant positive correlations were found between functional and social support and self-care agency and self-care behaviors, suggesting social support systems increase women's self-care agency and ability to engage in self-care practices.

Shambley-Ebron and Boyle (2006) conducted a critical ethnographic study of 10 African-American mothers infected with HIV to explore their experiences, beliefs, values, traditions, self-care practices, and mothering experiences of children infected with HIV. The overarching theme was *Creating a Life of Meaning*, with subthemes of *Disabling Relationships*, *Strong Mothering*, and *Redefining Self-Care*. Rather than follow the self-care practices prescribed by health care practitioners, which participants believed to be impractical in the setting of poverty and scarce

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resources, they redefined and incorporated creative, culturally consistent self-care practices, such as spirituality and religion, the act of being a mother, and family support.

Tufts, Wessell, and Kearney (2010) explored self-care behaviors, and facilitators and barriers to self-care activities in a sample of 21 African-American women infected with HIV. Two overarching themes about the meaning of self-care behaviors emerged: *Me First* and *Mind, Body, and Spirit*. Within these themes, women described taking care of themselves as doing what the doctor says and living healthy. Participants described spirituality, social support, and acceptance of the disease as facilitators to engaging in self-care behaviors. Barriers to self-care behaviors included caregiver responsibilities, stigma, nondisclosure, and negative attitudes (held by the participants or others).

The role of spirituality has been described as an important predictor of physical and mental well-being for individuals with HIV and AIDS (Coleman et al., 2006). Morse and colleagues (2000) examined the use of religion as a component of a longitudinal study of HIV-infected African-American women and their uninfected children. Using a matched sample of 104 women infected with HIV and 149 HIV-negative women, they compared religiosity, perceived physical health status, mental health status, high-risk behaviors, and health status between the two groups. They found a statistically significant difference in religious practices, with women with HIV infection more often using private methods such as prayer, and less likely to participate in public religiosity such as attending church services. Women with HIV infection who participated in public religious practices were more likely to seek mental health care and had increased perceptions of physical health status, enhanced healthy lifestyle behaviors, increased perception of control over their health, and higher educational attainment.

Woodard (2002) conducted a grounded theory study to examine how 13 African-American women

with HIV infection living in North Carolina defined spirituality and used spirituality to manage their disease. The theory of *Engaging Spirituality to Manage HIV* emerged from the analysis. Two conditions, *Learning about Spirituality* and the *Catalytic Event* (being diagnosed with HIV infection), existed prior to the participants being able to engage in spirituality to manage HIV. After a period of time, they went through two stages of engaging in spirituality. *Falling Back on Faith* and then *Living the Engaged Life*, in which they were able to diminish feelings of isolation, became empowered, and transcended the present.

As part of a study grounded in social construction theory, Wright (2003) examined spirituality as a coping mechanism among nine African-American women infected with HIV. The participants progressed in "moving from seeing themselves as dying to recognizing how they could, in fact, live with AIDS" (p. 142). Four common themes emerged from their narratives: separating oneself from the victim role, a new reason to live, gaining the strength to go on, and spirituality – individualized definitions. For these women, viewing themselves as women with AIDS and not AIDS victims was important. Spirituality was central in reframing their lives as being meaningful.

Prado and colleagues (2004) conducted a study of 252 urban, low-income HIV-positive African-American mothers to examine religion within a stress process framework and evaluate the relationship among religion, social support, coping mechanisms, and psychological distress. Social support and coping mediated the relationship between religious involvement and psychological distress; however, religious involvement did not mediate the relationship between stress and psychological distress. Religious involvement was related directly to higher levels of active coping and high levels of social support. Active coping was related negatively to psychological distress.

Polzer Casarez and Shandor Miles (2008) conducted a qualitative descriptive secondary analysis to explore how spirituality affected 38 African-American HIV-seropositive mothers of seropositive infants. Three overarching themes were explicated from the data analysis: God in control, God requires participation, and the consequences of their relationship with God, specifically for themselves and their infants. Participants believed God controlled all aspects of their lives and provided strength to manage their lives. They also believed they had to be active participants in their relationship with God through prayer, Bible reading, and other spiritual practices. Because they believed God was in control, through active participation with God, they were able to decrease their distress about living with HIV and, in particular, their concern about dying. As a result of strong spiritual beliefs, the participants experienced less stress and fear related to their children's health and their diagnosis.

Lacking in the literature is an understanding of how young African-American women with HIV infection portray the everydayness of their lives while living with HIV, and how the everydayness of their lives may be affected by spirituality and the integration of self-care practices to support health. Previous studies have examined spirituality and self-care behaviors within the context of coping, quality of life, or being a mother. This research provides an understanding of the constructs of quality of life, coping, and being a mother within the context of living with HIV infection. However, little research has focused on the totality of the experience of living with HIV infection. This research should explore additional factors in the everydayness of being an African-American woman with HIV infection that hinder or facilitate spirituality and self-care behaviors to support their health in the context of living with a chronic, incurable, eventually life-threatening disease.

TABLE 1.
Description of Sample

	N	Mean	Range
Age in Years	11	25	21-35
Educational Level in Years	11	12	8-14
Number of Children	11	1.8	1-5
Number of Children at Home	11	1.2	1-5
Years Living with HIV	11	7.45	1-22
CD4 Count	4	608	300-760
Viral Load	2	5,630	1,260-10,000

Note: CD4 lymphocytes cells are white blood cells that protect the body from infections. CD4 count is the number of cells per microliter of plasma and is used to stage HIV (U.S. Department of Health and Human Services [DHHS], 2011). Normal range is 500 cells/mm³ to 1,200 cells/mm³. The HIV viral load (RNA level) is the amount of HIV virus as measured by number of copies of HIV RNA per milliliter of plasma (DHHS, 2011). It also is used as a staging marker of disease progression. Levels range from undetectable to 750,000 copies/mL. The *N* is much smaller for CD4 counts and viral loads, as many of the women did not know their CD4 counts or viral load. Two women did not know the specific viral load, but reported it was nondetectable.

Purpose

The purpose of this study was to understand the lived experience of being a young African-American woman with HIV infection, how the affected woman defines spirituality and how spirituality may be incorporated into her everyday life while living with HIV infection, and how she defines and practices self-care in the context of living with HIV infection. Understanding the lived experiences is important for development of holistic, culturally appropriate nursing interventions that will optimize the overall health of young African-American women with HIV infection.

Methodology

Heideggerian hermeneutical phenomenology was used as the research method. Heidegger's methodology focuses on the understanding of what it is to be in the world and understanding a phenomenon in the everydayness of an individual in the context of larger human existence (Heidegger, 1962). Through phenomenological research, nurses can gain the understanding of what an individual's experience was like as it was lived (Connelly, 2010).

Sample and Setting

A purposive sample of 11 HIV-infected African-American women living near a Midwestern metropolitan city participated in the study (see Table 1). Participants were recruited through case managers employed through the Ryan White Comprehensive AIDS Resources Emergency Act at a safety net clinic and at a metropolitan infectious disease clinic that serves a large number of persons with HIV infection. Researchers continued to recruit and interview participants until no new findings emerged in data analysis. A sample size of 11 persons is congruent with the average sample size of 10-15 participants in phenomenological nursing research (Crist & Tanner, 2003). Inclusion criteria identified women ages 18-35 who were African American, seropositive for HIV, U.S.-born, and able to speak and read English. Exclusion criteria included a neurological disorder that affects cognition, such as dementia due to HIV/AIDS. Interviews were conducted in the environment deemed by the participant as most comfortable and safe. Of the 11 participants, 8 were interviewed in their homes, 2 preferred a

private room at a library, and 1 chose a private office in a school of nursing.

Data Collection

Approval from the institutional review board at an academic medical center in the community where the study was conducted was gained prior to commencement of the study. Informed consent was obtained from all participants prior to data collection at the initial meeting. The researcher collected basic demographic information used to describe the study population during the first meeting, and an unstructured audiotaped interview was completed. Interviews began with the prompt, "Please tell me a story that describes your experience of living with HIV infection." Example questions to elicit further information included, "How has HIV influenced your life?" A second follow-up interview was conducted to provide clarification of information from the first interview and garner additional information that further described and interpreted the experience of living with HIV infection. During the second interview, salient points from the initial interview were introduced with the prompt, "In our first interview, you told me your story about living with HIV infection. Could you discuss (topic) further?" Three women could not be reached for second interviews due to disconnected telephone numbers; thus only their initial interviews were used in the data analysis.

Data Analysis

The recorded interviews were transcribed verbatim in the conversational language to ensure linguistic and cultural nuances were revealed. Any information that could identify the participant was removed from the transcripts. A pseudonym was given to each participant to ensure confidentiality in the written discussion of the findings. The transcribed texts were read in their entirety while listening to the audiotapes for accuracy. The pri-

mary researcher developed narratives for each participant that described and interpreted the experiences of the woman. The narratives were written using the transcripts, notations made during the interviews, researcher journal entries, and multiple analytic discussion sessions with one of the research team members. Through this iterative process, one pattern with four inter-related themes emerged from the data.

Methodological rigor was established through several methods. The researcher assured credibility through member-checking of the pattern and themes by three participants. A detailed audit trail of the research process, including field notes and a researcher journal, assured openness to the decision-making process. Concreteness, in which the findings are useful for nursing practice, was achieved through the development of recommendations for nursing practice and further research (DeWitt & Ploeg, 2006).

Findings

The lived experiences of 11 young African-American women with HIV infection were characterized as *Infected Lives*, as HIV had invaded every aspect of their being. *Infected Lives*, the overarching pattern, was supported by four themes: *Living Alone with HIV*, *Living with Unresolved Conflicts*, *Living with Multiple Layers of Betrayal*, and *Living in the Everydayness of HIV*. The pattern and themes were grounded in Heidegger's philosophy (Heidegger, 1962) and VanManen's four life-worlds: lived body, lived space, lived time, and lived relationships (van Manen, 1990). For example, the theme, *Living in the Everydayness of HIV*, was developed from Heidegger's idea that individuals experience phenomena in their everyday lives (Heidegger, 1962). It also describes how HIV has influenced the women's relationships, their perception of time, and their relation to others. *Living in the Everydayness of HIV* will be discussed because of its relevance to and important implications for

medical-surgical nurses. The other findings have been reported elsewhere (Peltzer, Domian, & Teel, 2014).

Living in the Everydayness of HIV

Living in the everydayness of HIV describes and interprets the daily experiences of the women and their families. All the women described a life that was different since receiving the diagnosis of HIV infection. Many women stated they no longer felt normal; living with HIV was not normal. Katelyn said the following:

When I look up in the morning and I look in the mirror, I try not to look at myself like, you know, you have HIV. I don't try at all, cause if I did, I probably wouldn't be mentally okay.

While the women understood HIV as a chronic illness, they also felt very diseased emotionally. Thus their feelings of self-worth were altered. Contributing to their diminished feelings of self-worth were many episodes of discrimination, particularly in the health care setting. Dutchess recalled an episode in which the stigma of HIV left her feeling humiliated.

Well, on my chart it says I'm a Ryan White patient. Any of the nurses down there, they know that Ryan White sponsors HIV treatment. I'm sitting in the room on the gurney and they didn't close the little glass door. There's a group of about six or seven nurses and I can see their feet. But one of the nurses goes, "Oh, these people with HIV and AIDS kill me. They really need to just ship them all off to an island so they can keep breathing and infecting each other." And I'm, like, this is coming out of a nurse's mouth.

Dutchess was not only humiliated but also felt dehumanized. Instead of health care providers and the public seeing HIV-positive individuals as people who have an illness that is affecting their bodies, she said, they are made to feel like lepers.

Already filling multiple roles of mother, partner, sister, and daughter, the women also were coping with depression, caring for themselves in new ways, relinquishing control to God, and leaning on their families for support. All participants expressed feeling depressed upon learning their diagnosis. When she received the diagnosis, Katelyn said:

I went into an intense, intense depression. I just didn't know what to do with myself. I didn't even go outside ever, like I felt like everybody could see, I guess, what was wrong with me, and I just remember that day and it was rough.

For all participants, the depression has remained pervasive. The women were resistant to taking medications, particularly if they were receiving antiretroviral therapy, as antidepressants would be yet another medication to add to their regimens. Women feared working with a counselor because they were concerned the counselor would force them to talk about being HIV-positive, which worsened their depression.

The women realized taking care of themselves was important to their overall health. Maintaining physical health was confounded by co-morbid disorders resulting from HIV or its treatment. As Alisa shared, "People don't realize, when you have HIV, you have all kinds of mental issues that come along with it. You have all these health conditions that come along with it." Disease management became more complicated with multiple medication regimens, appointments, and the need for education about their co-morbidities. Maintaining a close relationship with their health care providers and understanding the disease process were important for maximizing physical health. Dutchess stated:

If I feel like there's something seriously wrong, I'm immediately at the doctor; I'm on the phone, you know, with my prevention counselors, or I'm on the phone with the specialist...

just trying to figure out what it is that I'm feeling, if there's something that I need to be on the lookout for or alarmed about.

The women talked about trying to maintain a healthy diet and taking vitamins to optimize overall health. However, limited financial resources influenced their ability to achieve a healthy diet. Most women did not exercise regularly for multiple reasons, such as depression-related lack of energy, family caregiving responsibilities, lack of money to go to a gym or exercise classes, or living in an area where walking was not safe (e.g., busy street without sidewalks). Several women had to rely on public transportation or family and friends. Despite the desire of many women to participate in support groups, they often were unable to do so because of lack of transportation. However, not all the women desired a network of HIV-positive women for support. Diana stated, "I can't talk to everybody. Somebody one-on-one I would talk to, like you."

Spirituality and religion were important to most women. Although several did not believe their spiritual views changed after their diagnosis, a few reported the diagnosis of HIV prompted development of a stronger relationship with God. As Alisa stated:

If you've never really thought about God and being on the spiritual level, when you become HIV-positive, it's almost like a person that's going to jail for the first time; you find spirituality and it becomes the biggest part of you. Sometimes people don't realize that [you] saying because I am so spiritual and I believe in God so much that nothing happens unless God allows it to. And therefore He wants us to lean on Him, to depend on Him, to need Him. And in that respect, when you become HIV-positive, you tend to turn to where you probably should have been in the beginning.

With the exception of one woman who believed God had turned against her, the women found strength in prayer and reading the Bible. All reported these strategies were particularly helpful for coping with depression.

Discussion

Being diagnosed with a chronic or life-threatening illness is life changing. Individuals with HIV infection are living with a life-threatening disease and are forced to contemplate a new life now physically measured by CD4 counts, viral loads, and adherence to a complex medication regimen. Mentally, psychologically, spiritually, and socially, these women are challenged to find the equilibrium between health and illness without allowing HIV infection to dominate their overall health.

All participants described chronic depression that commenced with the HIV diagnosis. Depression impacted their ability to conduct their daily lives, whether engaging in care for self or care for their children. Jones and Shorter-Gooden (2003) suggested depression is a complex issue for African-American women and they often remain silent about their depression. Depression is at odds with the cultural norms of being capable and strong. In addition, a common perspective among African Americans is that depression is a personal weakness, and professional treatment is not welcomed (Jones & Shorter-Gooden, 2003). Overall, participants were not treating the depression actively because they were reluctant to take medications or work with a therapist. In one study evaluating HIV disclosure, social support, and depression among African-American women living with HIV (Vyavaharkar et al., 2011), researchers found approximately 40% of participants had never been diagnosed with depression despite high scores on the Center for Epidemiologic Studies Depression Scale (CES-D). Of the participants who had been diagnosed with depression ($n=196$),

approximately 48% were not receiving treatment.

Concerns about depression in the present study are congruent with the ideas articulated by Jones and Shorter-Gooden (2003). Several women in this study were worried that discussions with health care providers about depression might have negative consequences. For example, they were concerned their health care providers might believe them to be unstable and require inpatient treatment; they then would be unable to care for their children. Rather than formally address depression with medications or counseling, women tried to find other strategies, such as prayer and other spiritual practices. Using spirituality as a coping mechanism also was discussed by Jones and Shorter-Gooden as a culturally appropriate method for African Americans to cope with depression.

Depression as a result of a diagnosis of HIV infection is not unique to the participants in this study. Examining the social context of rural women living with HIV, Phillips, Moneyham, Thomas, and Vyavaharker (2011) found participants experienced loss and depression; several women experienced depression severe enough to prompt them to contemplate suicide. Although several women in the present study discussed experiencing suicidal thoughts, they indicated this occurred immediately after receiving the diagnosis. One participant reported having suicidal thoughts between the first and second interviews, articulating she could not find meaning in her life. She denied suicidal thoughts at the time of the interview but promised she would contact her case manager to coordinate psychiatric services. At the time, she was experiencing significant losses, similar to participants in the study by Phillips and co-authors.

In their study of African Americans living with HIV infection, Shandor Miles, Roman Isler, Banks, Sengupta, and Corbie-Smith (2010) found participants experienced socio-emotional suffering in trying to keep hidden the emotional dis-

tress of living with HIV. Women in the current study also alluded to having to keep their depression hidden. Hiding illness and depression may have fostered an even greater sense of aloneness.

Although study participants were asked about self-care activities, they usually shared information about living with HIV infection. When asked to describe self-care, a few women spoke of engaging in activities of daily living, such as attending to hygiene. A broader explanation of self-care was necessary to garner information about caring for self that supported physical, mental, and spiritual health. The researcher provided a definition of self-care as ways a person takes care of her health, such as eating a healthy diet, taking time for self, or praying. Providing this definition elicited additional information from the participants about methods they used to take care of themselves. Although several participants were limited by transportation and economics, participants in this study engaged in self-care by attending appointments, working with their case managers to ensure they had the necessary medical and social support to manage their illness, and maintaining a healthy diet.

These findings are supported by a previous study of self-care activities among African-American women living with HIV (Tufts et al., 2010). In that qualitative study, participants also articulated they maintained health care provider appointments and medication regimens, and tried to adhere to a healthy diet. Similar to the experiences of women in the present study, participants had to re-evaluate caring for self and caring for others; this transition took time from diagnosis to the present. The impracticalities of self-care voiced by several of the women in the present study also were articulated by participants in Shambley-Ebron and Boyle's (2006) study of mothers living with HIV (frustration with not fully engaging in self-care due to competing financial concerns, such as paying for utilities or buying fresh produce for healthy meals). For several women

in the present study, financial constraints created tension between supporting themselves/their children and optimizing their health.

Participants also described spiritual practices as self-care within the everydayness of living with HIV. This seemed to be the strongest form of self-care because it helped in coping with emotional and spiritual distress. Only two women in this study did not have strong spiritual or religious beliefs. The other nine regularly engaged in spiritual/religious practices, particularly when they were depressed or stressed. During these times, talking to God or reading the Bible encouraged them and provided strength. These findings are similar to those in other studies of African-American HIV-positive women. Polzer Casarez and Shandor Miles (2008) found a relationship with God increased hope and reduced distress in women with HIV infection.

Limitations

Monetary compensation of \$40.00 was provided for each interview, and motivation to participate in the study may have been related to this payment. Women were recruited from two clinics in an urban setting and were of a lower socioeconomic status. Although generalizability is not of concern in qualitative research, transferability of findings to like populations is a measure of trustworthiness (Lincoln & Guba, 1985). To ensure transferability of the findings to women living at a higher socioeconomic level or in rural communities, rich thick description was used in the discussion of the findings.

Nursing Implications

Because the majority of women in this study experienced multiple episodes of HIV-related stigma within the health care setting, a need exists for nurses to receive comprehensive HIV education that not only includes the pathology, medication therapy, and services, but also the everyday experiences of individuals living with HIV infection. Interactive simulation or interactive online modules created by

HIV specialists and patients could be offered as continuing education opportunities. Continuing education in equity, diversity, culture, and cultural competency should be considered as a way to decrease stigma within the health care setting and maximize culturally congruent patient-centered care.

Stories and themes explicated in this study clearly indicate HIV impacts every aspect of the affected individual's life. Although believing their disease was well managed, participants did not believe their mental health issues were addressed. Depression was a major concern of the women who participated in this study. The women continued to have untreated depressive episodes, which may be related to their silencing of their illness. Mental health should be addressed in culturally appropriate ways to obtain the most accurate understanding of the issues experienced by women with HIV infection. Education about the importance and validity of depression and other mental health concerns should be provided to affected women to help remove the stigma. Therapy/counseling as a treatment strategy needs to be approached in a way that makes them acceptable for the woman and the community.

Spirituality is important to African-American women living with HIV, a common theme found in several studies. Women also use spiritual practices as a way to cope with depression. Nurses should include spiritual beliefs and practices in their assessments and incorporate into plans of care. Early literature suggests women living with HIV infection enter into the health care system later in the disease trajectory than men (Trzynka & Erlen, 2004). Further complicating their disease trajectory are perceived barriers to treatment. Adherence to medication therapy is necessary if individuals are to achieve longevity and quality of life in the context of living with HIV infection and AIDS. In a study evaluating factors influencing medication adherence among 2,791 HIV-infected women in six U.S. cities, researchers found wo-

men reporting childcare burdens, living in households without other adults, and not receiving social services assistance were more likely to report low adherence to treatment therapies (Merenstein et al., 2009).

Clinical nurse specialists (CNSs), within their roles as direct patient care providers and educators, have multiple opportunities to optimize the health and well-being of this group of women in the acute care setting. CNSs' advanced knowledge in assessment, outcomes identification, and interventions (Lewis, 2002) lends particular expertise to the multiple challenges related to medication adherence. CNSs also can provide staff education and implementation of practice guidelines and disseminate research findings in their consultant roles (Lewis, 2002). Nurse case managers are key members of the inpatient interprofessional team caring for HIV-positive individuals. Case managers are educators, advocates, and navigators within the health care system, linking patients to necessary resources (Ross-Friend, Schuster, & Sherry, 2011). Nurse case managers always should be consulted when HIV-positive patients are admitted to an acute care setting to assist with a seamless transition to the community at discharge.

Future Research

Opportunities exist to evaluate nursing interventions that optimize spiritual self-care practices, particularly in addressing depression. The multiple episodes of HIV-related stigma that occurred within health care organizations warrant further examination of nurses' and other providers' beliefs, attitudes, and education about HIV/AIDS.

Conclusion

This study provided a brief view into the lives of 11 African-American women living with HIV. The overarching pattern portrays living with HIV, which has impacted every aspect of their lives. The themes provided support for the pattern and described the complex-

ities of the participants' lives. Physically, the women generally were able to participate in their daily routines. Emotionally and mentally, the women were experiencing significant distress. Family relationships were destroyed, friendships severed, and hostility and contempt experienced within the community. Shielding themselves was a form of protection, which unfortunately resulted in isolation. The themes from the study can be used to inform nursing practice, health care policy, and future research. **MSN**

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Minutes

EDSURG

AHRQ Stats: Out-Of-Pocket Health Spending

Nearly one in five people with health expenses paid more than \$1,000 out-of-pocket in 2011 while 8.2% paid more than \$2,000 out of pocket that same year. Overall, about 85% of the U.S. population had health care expenses in 2011, according to the Agency for Healthcare Research and Quality. In 2011, an average of \$703 was paid out of pocket for health care among people with some health care expenses. This average ranged from \$283 for children under age 18 to \$1,215 for the elderly age 65 and older. The overall average (\$703) was substantially larger than the overall median (\$237) because a small proportion of people had extremely large out-of-pocket expenses. Median out-of-pocket expenses were also substantially lower than averages across all age groups.

In 2011, 12.1% of people paid nothing out of pocket toward their health care expenses. However, this proportion decreased with age, ranging from 32.5% for children under 18 to 2.5% for people age 65 and older. Further, 14.4% of people age 65 and older had expenses greater than \$2,000 vs. only 8.5% for younger adults and 3.1% for children under 18.

For more info, see Machlin & Carper (2014). Out-of-pocket health care Expenses by age and insurance coverage, United States, 2011. *Statistical Brief #441*. Rockville, MD: Agency for Healthcare Research and Quality. **MSN**

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