Nevada Syndemic Plan Needs Assessment: Community Focus Groups Summary Report

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Nevada Office of Statewide Epidemiology
Larson Institute for Health Impact and Equity

Table of Contents

Purpose

Focus groups and one-on-one interviews were conducted to inform the 2027-2031 Nevada Syndemic Plan. Questions were designed to understand community experiences, perspectives, and needs related to sexually transmitted infections (STIs), substance use, and access to prevention and supportive services across Nevada. Discussions explored topics such as community knowledge, stigma, barriers to care, service gaps, and recommendations for improving outreach, education, and resources. A series of 12 focus groups and 6 individual interviews were conducted between December 7, 2025, and April 14, 2026, with a total of 88 participants. All 12 focus groups and one individual interview were conducted in person, while the remaining five interviews were conducted virtually through Zoom/Teams. Audio from all focus groups and interviews was recorded and transcribed by members of the Office of State Epidemiology team, and the Larson Institute and University of Nevada, Reno School of Public Health teams analyzed the data using a condensed inductive thematic analysis approach.

Recruitment Methods

Focus group and interview participants were recruited through outreach conducted by syndemic planning partners, local organizations, and statewide networks connected to sexual health, substance use, and related public health services. Recruitment efforts included direct outreach, email invitations, flyers with QR codes, and word-of-mouth or snowball sampling methods. Some individuals who had participated in related community assessments or interviews for other assessments being conducted across the state were also invited to participate in the syndemic assessment.

Table 1. Sociodemographic characteristics of focus group participants, 2027-2031 Nevada Syndemic Plan community assessment.

Demographic Characteristics (N = 88)	N	%
County of Residence		
Clark County	46	52.3
Washoe County	14	15.9
Quad Counties (Carson, Douglas, Storey, Lyon)	22	25.0
Other Rural Counties	6	6.8
Total	88	100.0
Age		
18-24	6	6.8
25-34	13	14.8
35-44	15	17.0
45-54	14	15.9
55-64	18	20.5
65 and older	21	23.9
Missing	1	1.1
Total	88	100.0
Primary Race or Ethnicity		
American Indian or Alaska Native	3	3.4
Asian/ Native Hawaiian or Pacific Islander	2	2.3
Black or African American	18	20.5
Hispanic/ Latinx/o/a	15	17.0
White, non-Hispanic	41	46.6
Multi-race/ethnicity	6	6.8
Other and missing	3	3.4
Total	88	100.0
Primary Gender Identity		
Male	49	55.7
Female	38	43.2
Transgender or gender non-conforming	1	1.1
Total	88	100.0
Educational Attainment		
Some high school (no diploma)	12	13.6
High school graduate (or equivalent, such as GED)	23	26.1
Some college, no degree	27	30.7
Technical school degree (such as cosmetology or computer technician)/Associate's degree (AA, AS, etc.)	12	13.7
Bachelor's degree (BA, BS, etc.)	13	14.8

Master's degree (MA, MS, MSW, etc.)/ Doctorate or professional degree (PhD, MD, JD, etc.)	1	1.1
Total	88	100.0
Identification Groups		
Sexually active individuals	52	59.1
People living with HIV	34	38.6
Individuals with a history of incarceration	26	29.5
Men who have sex with men	25	28.4
Former use of opioids or stimulants*	24	27.3
Currently using opioids or stimulants*	9	10.2
Current diagnosis or history of hepatitis C	5	5.7
Currently or previously engaged in sex work	4	4.5
Individuals who did not identify with any listed groups	8	9.1

* Non-medical use or used in a manner not prescribed

Source: 2027-2031 Syndemic Plan community focus groups demographic survey

Focus group participants were asked to select one or more populations they identify with from a list of groups disproportionately impacted by syndemic conditions (Table 1). Among the 88 focus group respondents, 50.0% identified as non-White, 6.8% were between the ages of 18–24 years, and 1.1% identified as transgender or gender non-conforming. The most frequently selected identification group was sexually active individuals (59.1%), followed by people living with HIV (38.6%), individuals with a history of incarceration (29.5%), men who have sex with men (28.4%), and individuals in recovery from non-medical opioid or stimulant use (27.3%). Smaller proportions of respondents identified as currently using opioids or stimulants in a manner not prescribed (10.2%), having a current diagnosis or history of hepatitis C (5.7%), or currently or previously engaging in sex work (4.5%). Additionally, 9.1% of respondents did not identify with any listed priority population.

Priorities content

Eight major themes synthesized across all transcripts:

1. Stigma and Shame as a Pervasive Barrier
2. Gaps in Knowledge and Awareness — Uneven Across Populations
3. Intersection of Substance Use and Sexual Health
4. Fragmented, Inequitable Care
5. Structural Barriers and Social Determinants of Health
6. Rural-Specific Gaps
7. What Works — Facilitators and Bright Spots
8. What Participants Want — Recommendations

1. Stigma and Shame as a Pervasive Barrier Stigma emerged as the most consistent barrier, cutting across HIV, STIs, and substance use.

- Fear of testing positive, shame around disclosing status or risky behaviors, and reluctance to discuss sexual health with providers were nearly universal
- Stigma is compounded for BIPOC, Latino, and LGBTQ+ communities, and is greater in rural and tribal settings where these topics are less openly discussed
- Internalized stigma around SUD — including shame when seeking basic care like detox or treatment for an abscess — deters help-seeking
- The emotional toll of living with HIV and not being able to talk openly about it was described as significant; building community was identified as essential
- Concern that naloxone and PrEP enable risky behavior reflects lingering stigma and misconceptions that complicate prevention messaging

2. Gaps in Knowledge and Awareness — Uneven Across Populations Awareness of prevention tools, transmission routes, and available services varied widely by population, geography, and age.

- Naloxone awareness was relatively strong; PrEP awareness was moderate but uneven; PEP and Doxy PEP were largely unknown across most groups
- Persistent misconceptions remain — that HIV is a "gay disease," that it is curable, and that modern medications eliminate the need for prevention behaviors
- Prevention advertising was seen as too narrowly targeted, reinforcing stereotypes and excluding heterosexual men, Black cis women, elderly populations, and rural communities
- Seniors, tribal communities, and youth were consistently identified as under-reached populations with distinct awareness gaps
- Outdated views on HIV transmission persist broadly, including misinformation about mother-to-child transmission and casual contact

3. Intersection of Substance Use and Sexual Health Participants consistently described substance use and sexual risk as deeply intertwined.

- Drug use and sexual behavior frequently co-occur, with substances influencing decision-making, medication adherence, and engagement in higher-risk behaviors
- Sex work intersects with both substance use and HIV/STI risk across multiple communities
- Substance use was described as a coping mechanism for trauma, pain, isolation, and stress — with addiction often intergenerational
- Withdrawal symptoms were identified as a direct barrier to safer use practices

4. Fragmented, Inequitable Care Participants described a healthcare system that is inconsistent, fragmented, and frequently failing those who need it most.

- Care is siloed — patients navigate multiple providers and locations for HIV, SUD, mental health, and primary care, creating gaps and burden
- Provider quality varies widely; some providers listen and screen comprehensively while others turn patients away, don't read charts, or perpetuate stereotypes
- Providers outside specialty settings are less educated on transmission, at-risk populations, and how to communicate a positive diagnosis
- High provider turnover disrupts continuity of care, particularly damaging for PLWH managing long-term treatment
- Insurance barriers — excessive documentation requirements, forced provider changes, and Ryan White bureaucracy — were described as exhausting and a driver of disengagement
- The cumulative burden of simultaneously attending multiple required programs while maintaining employment was identified as unsustainable (e.g., IOP, NA, etc.)
- Fear of funding cuts and losing access to life-saving medication was prominent among PLWH

5. Structural Barriers and Social Determinants of Health Structural conditions consistently compound health risks and limit access to care.

- Homelessness creates cascading barriers — no address for results, no phone for callbacks, medication loss or theft, and unsafe living conditions
- Transportation is a major barrier across settings — long bus routes, inability to reach services, and difficulty getting to pharmacies
- Cost of medications, insurance, food, and rent creates compounding financial strain that deprioritizes health
- Immigration status prevents some individuals from seeking care due to fear of legal repercussions
- Lack of cultural and familial connection was named as a driver of substance use, suggesting social belonging is a protective factor current services don't adequately address

6. Rural and Frontier-Specific Gaps Rural, frontier, and tribal communities represent a distinct and acute level of need.

- HIV, STIs, and substance use are not openly discussed in rural and tribal communities, and awareness of available resources is extremely low
- Specialty HIV care, SUD treatment, mental health providers, and stocked pharmacies are largely absent outside urban centers
- Frontier areas were described as having essentially no resources
- LGBTQ+ individuals in rural settings face compounded stigma with fewer support structures
- Telehealth and medication mail delivery were identified as needed solutions but are not yet widely accessible

7. What Works — Facilitators and Bright Spots Despite significant barriers, participants identified conditions and approaches that support engagement.

- Staff and outreach workers with lived experience were the most consistently cited facilitator — building trust and rapport quickly
- Established provider relationships were identified as a key driver of retention in care
- Walk-in, low-barrier service models and one-stop-shop care settings were praised where available
- Peer support groups and a sense of community were identified as protective factors, particularly for PLWH
- Incentives such as gift cards and bus passes for attending appointments or getting tested were identified as effective engagement tools
- Non-fear-based, normalizing social media messaging and community event outreach were seen as the most effective communication approaches

8. What Participants Want — Recommendations Participants offered concrete, actionable recommendations across all pillars.

- A one-stop-shop care model integrating HIV, SUD, mental health, and primary care was the most frequently cited recommendation
- Care navigators or CHWs embedded in clinical appointments, particularly for people with infectious disease
- Mental health support and peer community spaces specifically for PLWH to address the emotional burden of living with HIV
- Expanded funding for Certified Peer Recovery Support Specialists, particularly in rural and frontier areas
- Mobile medical services, telehealth, and medication mail delivery for rural populations
- 24/7 SSP access and community-based distribution of naloxone, condoms, and fentanyl test strips
- Diversified, inclusive prevention messaging across all media channels representing the full range of affected populations

- Transportation support and appointment incentives as standard components of care engagement

Pillar Alignment

The four pillars originate from the federal Ending the HIV Epidemic (EHE) Initiative. They are: Diagnosis and Detect, Treat, Prevent, and Respond.

Pillar One: Diagnose

In focus groups, stigma and uneven awareness of testing resources were the most prominent barriers to diagnosis, alongside provider-level gaps in routine screening.

Strengths

- Sexual and gender minority participants were generally knowledgeable about testing locations and resources
- Community events and trusted spaces such as LGBTQ+ centers and SSPs were identified as effective venues for testing outreach

Challenges

- Stigma was a consistent barrier — participants described fear of being outed, shame around a positive result, and reluctance to discuss sexual health with providers
- Providers outside specialty clinics rarely conduct sexual health histories or offer routine HIV screening
- Rural, frontier, and tribal participants had little awareness of available testing and limited local access to services
- Fear of legal repercussions due to immigration status prevents some individuals from seeking testing
- Jail represents a missed opportunity — some screening occurs but with no linkage to care upon release

Needs

- Normalize testing by integrating it into routine care and bringing it to trusted community spaces and events
- Peers and trusted community members as messengers for normalizing testing, particularly in communities where stigma is highest
- Diversify prevention messaging to reach heterosexual men, Black cis women, elderly populations, and rural communities
- Provider training on sexual health screening and communicating a positive diagnosis, ideally delivered by people with lived experience

Pillar Two: Treat

Participants highlighted fragmented care, provider inconsistency, and the emotional burden of living with HIV as central treatment challenges, with strong consensus around integrated, navigated care models.

Strengths

- Participants who found a trusted HIV specialist and primary care provider described significantly better care experiences
- Staff and outreach workers with lived experience were identified as key to building trust and supporting retention in care
- Peer support groups and community spaces for PLWH were identified as meaningful facilitators of treatment engagement and emotional wellbeing

Challenges

- Care is fragmented — PLWH navigate multiple providers and locations for HIV, SUD, mental health, and primary care
- Provider quality varies widely; high turnover disrupts continuity of care
- Insurance barriers — excessive documentation, forced provider changes, and Ryan White bureaucracy — were described as exhausting and a driver of disengagement
- Rural and frontier participants face acute shortages of HIV specialty care, SUD treatment, and mental health providers
- Fear of funding cuts and losing access to life-saving medication was prominent among PLWH

Needs

- Integrated one-stop-shop care model covering HIV, SUD, mental health, and primary care
- Care navigators or CHWs embedded in clinical appointments for people with infectious disease
- Telehealth and medication mail delivery for rural and frontier populations
- Culturally and linguistically appropriate treatment options, including Spanish-speaking SUD programs
- The emotional toll of living with HIV was described as significant and underaddressed — dedicated mental health support and support groups specifically for PLWH are needed

Pillar Three: Prevent

Participants identified uneven awareness of prevention tools, persistent misconceptions about who prevention medications are for, and strong support for community-based outreach and social media engagement.

Strengths

- Naloxone awareness was relatively strong, attributed to distribution through SSPs and community-based settings
- Community events and social media identified as trusted, effective channels for prevention outreach and supply distribution
- Healthy peer networks and a sense of community connection were identified as protective factors against substance use initiation and risky sexual behavior

Challenges

- Persistent misconception that PrEP, PEP, and DoxyPEP are exclusively for LGBTQ+ populations; PEP and DoxyPEP awareness was low across nearly all groups
- Prevention advertising seen as too narrowly targeted, reinforcing stereotypes and excluding heterosexual men, Black cis women, and elderly populations
- PrEP has created a false sense of security among some groups, reducing condom use and perceived risk
- Retail cost of naloxone is a barrier for those without another source; 24/7 SSP access is unavailable in many areas
- Withdrawal symptoms and SSP access gaps lead to needle reuse

Needs

- Diversified, inclusive prevention messaging representing the full range of affected populations across all media channels
- Community event distribution of naloxone, condoms, and fentanyl test strips
- Expanded SSP hours and access points, particularly in rural and frontier areas
- Non-fear-based, normalizing social media campaigns as a primary outreach channel

Pillar Four: Respond

Participants identified structural barriers, systemic distrust, and rural service gaps as the most significant obstacles to an effective community response, with peer-based and integrated service models identified as key solutions.

Strengths

- Staff and outreach workers with lived experience were consistently identified as the most trusted model for community engagement
- Walk-in, low-barrier service models and one-stop-shop settings were praised where available
- Appointment incentives such as gift cards and bus passes were identified as effective tools for supporting engagement

Challenges

- Structural barriers — transportation, housing instability, lack of phone or address — prevent engagement even when services exist
- Distrust of systems among BIPOC, rural, and unhoused populations, driven by programs being started and then cut
- Frontier areas were described as having essentially no resources
- Low Medicaid reimbursement, funding cuts, and eliminated positions threaten continuity and quality of services
- Criminalization of homelessness and immigration-related fears create additional barriers to engagement

Needs

- CHWs and Certified Peer Recovery Support Specialists embedded in clinical settings and deployed for community outreach, with expanded funding particularly in underserved areas
- Sustained, consistent investment in programs to rebuild community trust
- Transportation support as a standard component of care, including ride services to appointments
- Mobile medical services and medication mail delivery for rural and frontier populations
- Support groups and community spaces — particularly for PLWH and PWUD — to address mental health, reduce isolation, and build connection were among the most frequently cited recommendations

Appendix: Syndemic Plan Focus Group Questions

Before each discussion, moderators explained that participation was completely voluntary and that participants could skip any question or leave at any time without affecting any services they receive. To help protect privacy, participants were asked to use an alias instead of their real name. Discussions were audio recorded so the research team could best capture participant discussion. Recordings were kept confidential and not shared outside the research team. Participants were also encouraged to respect each other's privacy and keep what was shared during the discussion confidential. Below are the questions that were asked during the discussions.

What is Known

1. Describe what you and your peers know about HIV/AIDS or other STIs (chlamydia, gonorrhea, syphilis, and hepatitis B/C)?
    a. Probe: What do you and your peers know about how those infections are spread?
    b. Probe: Do you and your peers feel at risk for those types of infections? Why or why not? What do you feel is the most dangerous or high-risk activity for those types of infections?
    c. Probe: Do you know where to get tested, how testing is conducted/done, when to get tested?
    d. Probe: How about getting treated for those types of infections, where to go, how treatment works or what is involved?

2. Describe what you and your peers know about substance use, misuse or abuse, including how people begin to use substances or why they start to use substances and why some people become addicted to certain substances? (as a reminder, especially opioids such as prescription pills, heroin, fentanyl, and stimulants like cocaine and meth).
    a. Probe: What do you all know about substance use when it comes to opioids and stimulants? How to identify addiction or misuse?
    b. Probe: Why might someone start using a substance like opioids or stimulants? Why might someone become addicted to these substances?
    c. Probe: If you knew someone who was using substances like opioids or stimulants do you know of any programs or agencies that would be able to provide assistance?

Behaviors and Patterns

3. What behaviors or patterns do you or your peers engage in that might put them at risk for HIV/AIDS, STIs, or substance use?
    a. Probe: Describe the behaviors or patterns you see occurring in your community related to an increase or decrease in risk related to HIV/STI and substance use
    b. Probe: Where do these behaviors or patterns happen?

c. Probe: What are the differences between those behaviors or patterns between HIV/STIs and substance use?

Prohibits Prevention

4. What makes it harder for you and your peers to protect themselves from HIV/AIDS and STIs (barriers to protection)?
   a. Probe: What sorts of things do your peers do to minimize their risk of getting or transmitting HIV (e.g., condom use, avoiding sharing needles)?
   b. Probe: How commonly practiced are these strategies in your community?
   c. Probe: Describe some of the challenges that you and your peers experience with regular condom use, preventing any sharing of needles/sharps/works, or obtaining regular testing.

5. What do you think makes it harder for you and your peers to reduce substance use, or prevent misuse or abuse?
   a. Probe: What are the differences you have observed among those who may experiment with substances compared to those who develop a pattern of misuse, or addiction?
   b. Probe: What do you and your peers do to reduce substance use or prevent misuse or regular patterns of use?
   c. Probe: How commonly practiced are these strategies in your community?
   d. Probe: Describe some of the challenges that you and your peers experience when trying to reduce or prevent use and misuse of substances.

6. Describe your experiences in healthcare settings regarding sexual health.
   a. Probe: Do healthcare professionals usually screen you for risk factors related to sexually transmitted infections? Do healthcare professionals take a sexual health history and ask any questions about sexual practices or partners? Does it ever get brought up in your healthcare visits?
   b. Probe: Do they regularly offer testing for sexually transmitted infections?

7. For PLWH or those who work with PLWH: What challenges do people living with HIV face when it comes to accessing treatment and staying engaged in treatment?
      a. If you could change one thing about the HIV care system, what would that change be
      b. For PWLH: What care services do you need, but do not receive?
      c. For PWLH: If you could change one thing about the HIV care system, what would that change be?

8. Describe your experiences in healthcare settings regarding substance use?
   a. Probe: Has a healthcare provider ever asked questions related to habits or patterns or use for substances other than alcohol or tobacco?

b. Probe: What was that experience like?

Preventive Services

9. N/A for PLWH, except Doxy PEP: PRE-exposure prophylaxis, or PrEP, is an antiretroviral medicine, such as Truvada, that is taken daily by a person who is HIV-negative to reduce the risk of getting HIV. Post-exposure prophylaxis or PEP, can be provided within 72 hours following possible exposure to HIV to prevent infection. [STOP HERE and ask, then move to doxy]. Doxycycline for post-exposure prophylaxis or doxy PEP, can be prescribed after an exposure to chlamydia, gonorrhea, or syphilis to reduce the risk of bacterial infection after condomless sex or another exposure, such as oral sex. Before today, have you ever heard of PrEP, PEP or doxy PEP? If so, what do you know about it? (10 minutes)
   a. Probe: Do you know where to get PrEP, PEP or Doxy PEP?
   b. Probe: Would you feel comfortable using PrEP, PEP or Doxy PEP?
   c. Probe: What do you or your peers think about PrEP, PEP or Doxy PEP? Have either you or your peers experienced using it? What was their experience?
   d. Probe: What barriers would you or your community have in taking PrEP or accessing PEP or Doxy PEP?
   e. Probe: How can we encourage PrEP, PEP or Doxy PEP for you or your peers

10. Naloxone, sometimes referred to as Narcan, is an opioid-overdose prevention drug that can be administered by anyone in the event of a suspected opioid overdose.

    a. Probe: What have you heard about naloxone or Narcan?

    b. Probe: Do you know where to get naloxone or Narcan?

    c. Probe: How comfortable would you or your peers feel if you needed to administer naloxone or Narcan to someone if they suspected a person was experiencing an opioid overdose?

    d. Probe: What barriers are there to accessing naloxone or Narcan?

    e: Probe: What would encourage people to carry naloxone or Narcan?

11. What about any other services for people who use substances in your community, such as drug testing strips or sterile equipment, hygiene supplies, or even resources like clinicians who provide medication for opioid use disorder or medication assisted treatment (MAT)?
    a. Probe: Describe you or your peers experiences in accessing any of those types of services or supplies.

Education & Messaging

12. If you were to design a communications or educational campaign for your peers about sexual health, such as HIV and STI prevention, what would that look like? What would be the primary message? (10 minutes)
    a. Probe: What are the trusted forms of communications in your community? Where would your community trust the message from?
    b. Probe: Where would you reach the people in your community who would benefit from this type of information or messaging related to sexual health to prevent HIV/AIDS or other STIs?

13. If you were to design a communications or educational campaign for your peers about substance use, specifically opioids and stimulants, what would that look like? What would be the primary message?
    a. Probe: What are the trusted forms of communications in your community? Where would your community trust the message from?
    b. Probe: Where would you go to reach the people in your community who would benefit from this type of information or messaging related to preventing or reducing substance use and misuse?