

Nevada HIV Needs Assessment in Minority Communities

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Introduction

The State Office of HIV/AIDS, Nevada Division of Public and Behavioral Health contracted with the Center for Program Evaluation, School of Community Health Sciences, University of Nevada, Reno to conduct a needs assessment focusing on HIV prevention and care in minority communities in Nevada. This needs assessment was conducted between April 2015 and June 2016 in conjunction with the statewide HIV/AIDS needs assessment, both of which were used to inform the development of Nevada’s Integrated HIV Prevention and Care Plan 2017-2021, including the Statewide Coordinated Statement of Need, which was completed in September 2016. The additional funding for the minority needs assessment allowed for additional focus groups to increase representation of minority groups. This report is designed to highlight the needs assessment results with respect to four minority ethnic/racial groups in Nevada—Latino, African American, Asian Pacific Islander, and Native American. The integrated plan can be accessed online at the state Office of HIV/AIDS webpage¹.

HIV/AIDS Epidemiologic Overview²

Nevada Demographic Characteristics

Nevada is the seventh largest state (geographically) in the nation. It is comprised of 17 counties spread across 110,540 square miles. Nevada is a frontier state with a 2013 population estimate of almost 2.8 million (Nevada State Demographer) and is traditionally divided into three regions: Clark County (72.3% of the population), Washoe County (15.2% of the population), and all other counties (12.5% of the population). It is the fifth fastest growing state in the nation. Approximately 81.1% of Nevada’s land area is owned by the federal government, with 67% administered by the Bureau of Land Management. The remaining 18.9% is under private ownership or state/local jurisdiction.

In 2013, the race/ethnicity composition of Nevada was 58.3% White, 26.5% Hispanic, 7.2% Black, 6.7% Asian/Pacific Islander, and 1.3% Native American or Alaska Native. Nevada is one of nine states to potentially become a minority-majority state as Nevada has a minority population of 41.7%. Over one-half of the population in Nevada was between the ages of 25 and 64 (52.8%); another one-third was between the ages of 0 and 24 (35.5); while the remaining 12.7% of

¹ http://dpbh.nv.gov/Programs/HIV/HIV_and_AIDS_Prevention_-_Home/

² This section contains excerpts from the Epidemiologic Overview of Nevada’s Integrated HIV Prevention and Care Plan 2017-2021, which was written and compiled by the Office of Public Health Informatics and Epidemiology (OPHIE), DPBH.

population was age 65 and older. Just over half of the population (50.5%) is male with the remaining 49.5% female.ⁱ

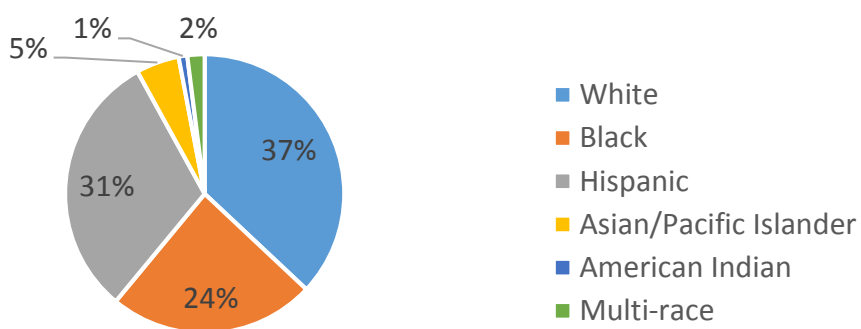
Nevada Health Status

In 2013, Nevada had a higher rate of uninsured residents than the national average, at 23.0% compared to 15.6%. The percentage of government funded insurance is lower in Nevada than the national average. By race/ethnicity, Hispanics had the highest uninsured rate at 35%, according to the Kaiser State Health Facts report. According to the United States Census 2012 Statistical Abstract, Nevada ranked 47th in the nation for doctors per 100,000 resident population in 2009 (most recent data).ⁱⁱ Twelve of Nevada's counties have areas or population groups within county lines that are considered to be Primary Medical Care Health Professional Shortage areas.ⁱⁱⁱ

Socio-Demographic Characteristics of Populations at Risk for HIV, Newly Diagnosed, or Living with HIV

In 2014, 87% of persons newly diagnosed with HIV were male; and 74% of newly diagnosed males reported a transmission category of male-to-male sexual contact. Among newly diagnosed females, 52% reported no identified risk/no reported risk (NIR/NRR), while 36% reported a transmission category of heterosexual contact. In 2014, 88% of newly diagnosed persons resided in Clark County. White, non-Hispanics represented 37% of newly diagnosed persons; Hispanics comprised 31%; and black, non-Hispanics represented 24% (Figure 1). In 2014, 34% of newly diagnosed persons were 25-34 years old; and 23% were 13-24 years old.

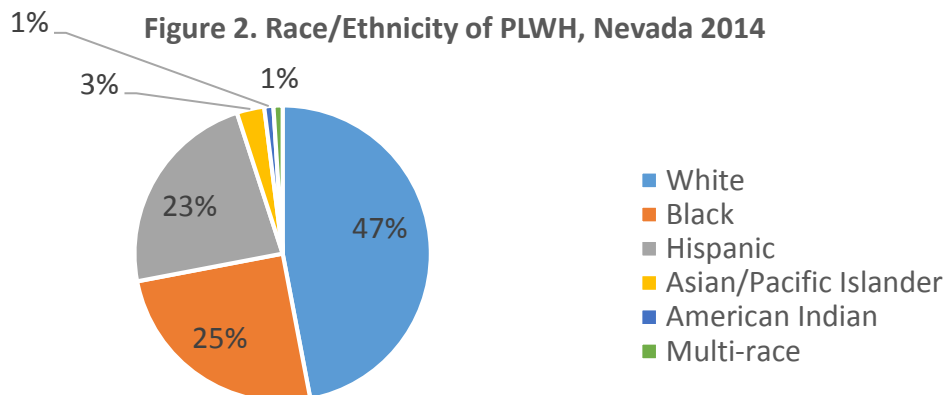
Figure 1. Race/Ethnicity Of Newly Diagnosed with HIV, Nevada 2014



Source: Nevada State Health Division HIV/AIDS Reporting System (eHARS), (March 2016)

In 2014, there were 4,689 persons living with HIV (not HIV stage 3 (AIDS)) and 5,044 persons living with HIV stage 3 for a total of 9,733 persons living with HIV (PLWH). Of these 9,733 persons, 35% were diagnosed with HIV infection before coming to Nevada; and 84% were male. The highest proportion of PLWH (86%) resided in Clark County. Nearly half of PLWH were white (47%), while

24% were black, non-Hispanics, and 23% were Hispanics (Figure 2). For males living with HIV, 76% reported male-to-male sexual contact as the transmissions category. Among females living with HIV, 60% reported heterosexual contact as the transmission category. Persons between the ages of 45 and 54 years represented 24% of PLWH, while 22% were 35 to 44 years old.



Source: Nevada State Health Division HIV/AIDS Reporting System (eHARS), (March 2016)

Of Nevadans responding to the BRFSS 2014 survey, 41% had ever been tested for HIV. The percentage of respondents who had been tested for HIV was highest among Black, non-Hispanic respondents at 64% and lowest for other races, non-Hispanic (27%), white, non-Hispanic (39%) and Hispanic (41%; Table 1). With respect to age, the lowest percentage who had been tested was 31% of respondents ages 18-24. Additional epidemiological data is available both in the integrated plan³ and on Nevada’s HIV/AIDS Surveillance Program website⁴.

Table 1. Percent of Individuals Who Answered the Question, “Have you ever been tested for HIV?” on the Behavioral Risk Factors Surveillance Survey (BRFSS) by Race/Ethnicity, Nevada 2014^{iv}

	Yes	CI*	No	CI*
Race/Ethnicity				
White, non-Hispanic	39.4	(36.4-42.4)	60.6	(57.6-63.6)
Black, non-Hispanic	63.7	(54.3-73.2)	36.3	(26.8-45.7)
Hispanic	40.6	(34.2-46.9)	59.4	(53.1-65.8)
Other, non-Hispanic	27.0	(17.7-36.3)	73.0	(63.7-82.3)
Multiracial, non-Hispanic	49.5	(33.4-65.6)	50.5	(34.4-66.6)
Total	40.7	(38.0-43.3)	59.4	(56.7-62.0)

*95% confidence intervals are calculated based on the rate.

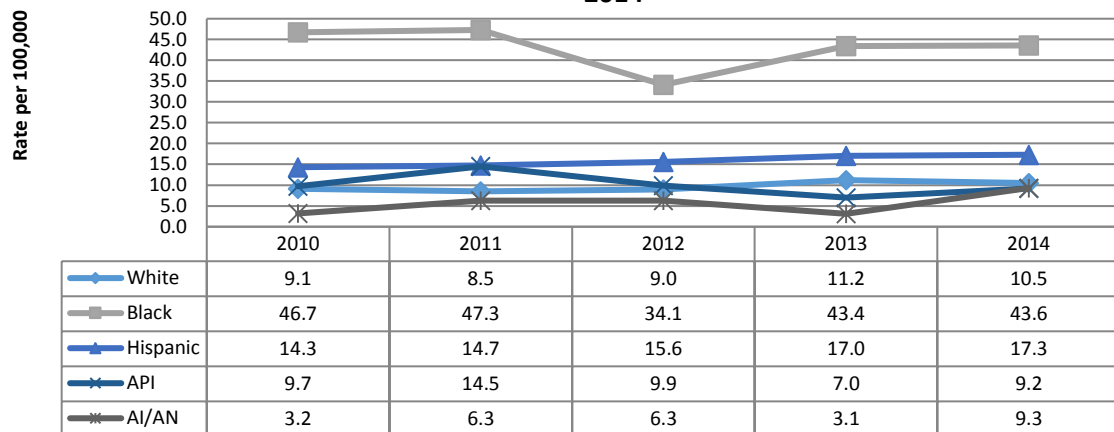
³ http://dpbh.nv.gov/Programs/HIV/HIV_and_AIDS_Prevention_-_Home/

⁴ [http://dpbh.nv.gov/Programs/HIV-OPHIE/dta/Publications/HIV/AIDS_Surveillance_Program_\(HIV-OPHIE\)_-Publications/](http://dpbh.nv.gov/Programs/HIV-OPHIE/dta/Publications/HIV/AIDS_Surveillance_Program_(HIV-OPHIE)_-Publications/)

The Burden of HIV in Nevada by Race/Ethnicity

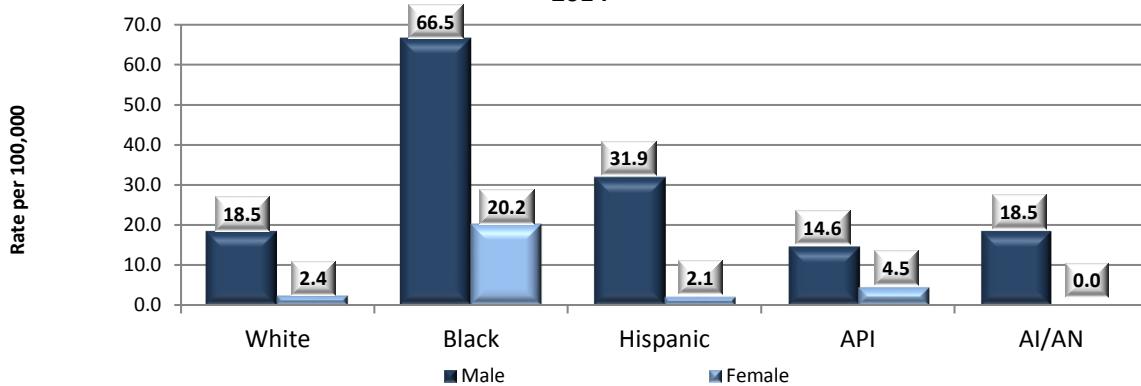
Large racial/ethnic disparities exist within Nevada, especially among Blacks/African Americans. In 2014, the rate of new HIV diagnoses among Blacks was over 4 times that of Whites (43.6 vs. 10.5 per 100,000 population; Figure 3). Rates of new HIV diagnoses were highest among Black males (66.5 per 100,000 population) and 3.6 times higher than that of White males (18.5 per 100,000 population). This disparity is even greater for Black females, whose rate of new HIV diagnoses was 8.4 times higher than that of White females (20.2 vs. 2.4 per 100,000 population; Figure 4).

Figure 3. Annual Rate of New HIV Diagnoses in Nevada by Race/Ethnicity, 2010–2014*



*The number of persons who identified as multi-racial was 7 in 2010; 5 in 2011; 9 in 2012; 14 in 2013; and 10 in 2014. Data for these persons were not included in this figure.

Figure 4. Annual Rate of New HIV Diagnoses in Nevada by Sex and Race/Ethnicity, 2014

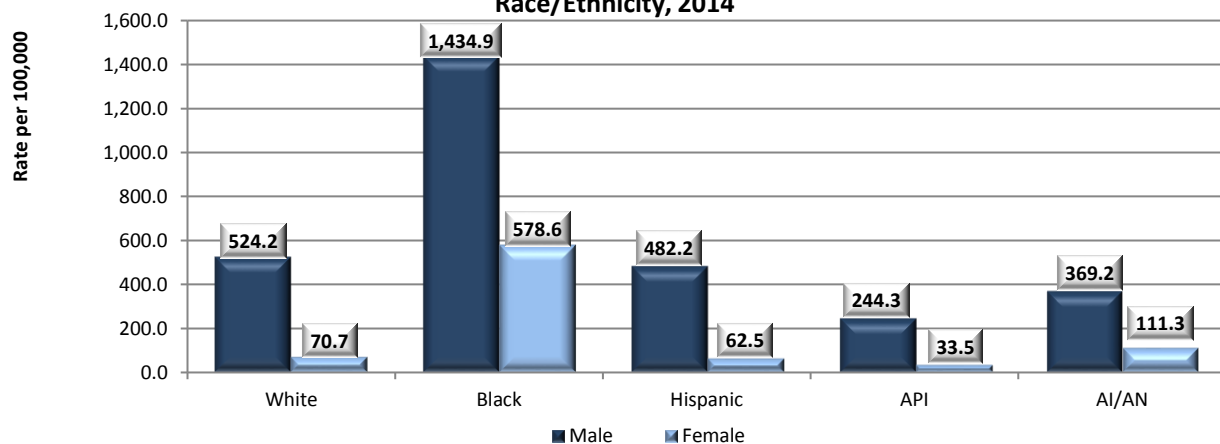


In addition, the rate of new HIV diagnoses among Black youths (13-24 years) was over 9 times higher than that of White youths (90.7 vs. 9.9 per 100,000 population). From 2010 to 2014, the rate of new HIV diagnoses increased among APIs, while the rate among Blacks and Whites decreased. However, the rate among Blacks dropped suddenly in 2012, which may have been caused by the unexpected disruption in SNHD’s testing services in 2012. Due to the small number

of new diagnoses, the rate among American Indians/ Alaska Natives (AI/AN) has been unstable over the past five years.

In 2014, Hispanic and Asian/Hawaiian/Pacific Islander (API) males also experienced disparately high rates of new HIV diagnoses (31.9 and 14.6 per 100,000 population, respectively). AI/AN have very small counts causing their rates to vary greatly. For both males and females, the highest rate of PLWH was among Blacks (Figure 5). The rate among Black males was 2.7 times that of White males (1,434.9 vs. 524.2 per 100,000 population), and the rate among Black females was nearly 8.2 times that of White females (578.6 vs. 70.7 per 100,000 population). The rate of PLWH was lowest among API. API males had a rate of 244.3 per 100,000 population, and API females had a rate of 33.5 per 100,000 population.

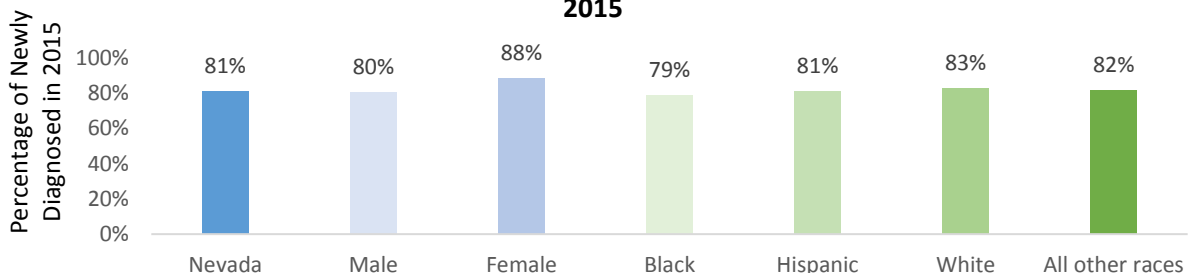
Figure 5. Annual Rate of Persons Living with HIV in Nevada by Sex and Race/Ethnicity, 2014



HIV Care Continuum

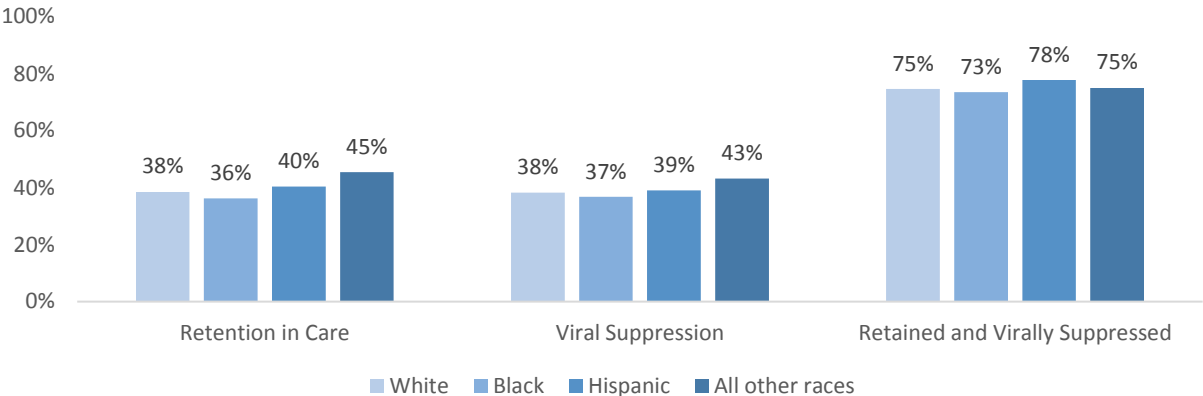
Some disparities exist in Nevada’s HIV Care Continuum by sex, race/ethnicity, and age. Figure 6 compares the percentages of individuals newly diagnosed with HIV who were linked to care within 90 days of diagnosis. A lower percentage of males compared to females were linked to care within 90 days. Comparing individuals of different races/ethnicities, linkage to care was similar across groups but was slightly lower for newly diagnosed black clients (79%).

Figure 6. Linkage to Care within 90 Days of Diagnosis, by Sex and Race, Nevada, 2015



Of PLWH in Nevada, Black clients had the lowest rates of retention of care and viral suppression. Hispanics and all other races had the highest rates of retention and viral suppression, although overall numbers are low. Among those who were retained in care during 2015, the highest percentage of virally suppressed clients was Hispanic and the lowest was Black (Figure 7).

Figure 7. Retention in Care and Viral Suppression-Persons Living with HIV/AIDS by Race/Ethnicity, Nevada, 2015



Needs Assessment Methods and Demographic Data

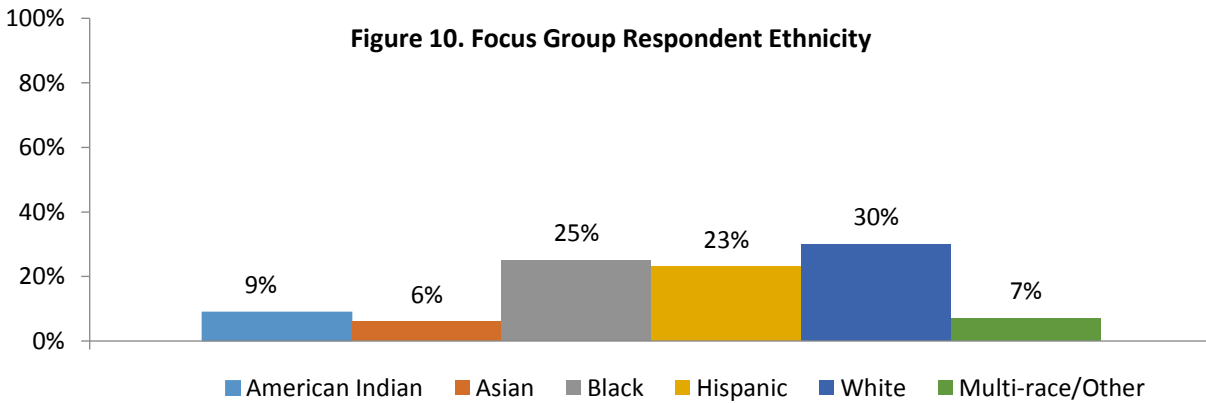
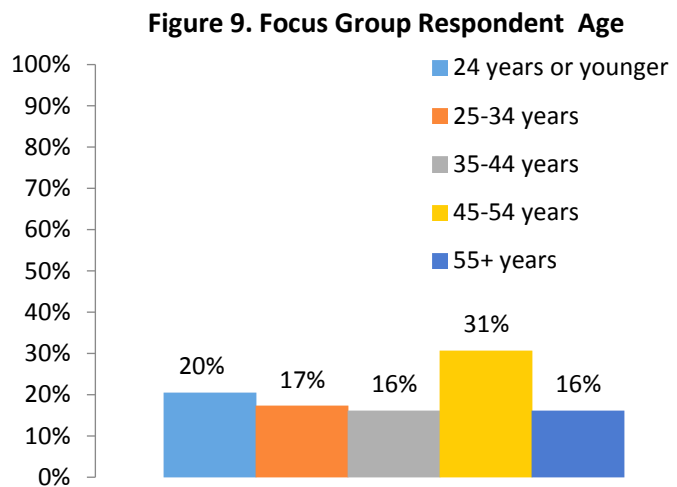
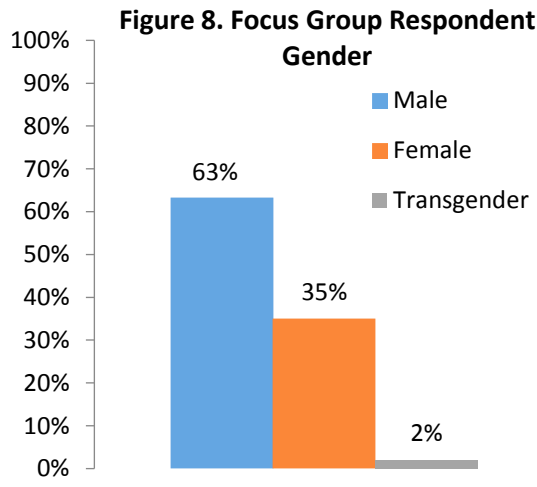
Focus Groups

Twenty HIV client and prevention focus groups were held in Northern and Southern Nevada between August 2015 and May 2016, with 191 people participating. Six groups were specifically for HIV positive individuals, while 14 groups had a prevention focus, but sometimes included PLWH. Four focus groups were conducted with Hispanic individuals, three with African Americans, two with Native Americans, and one with Asian/Pacific Islanders (Table 2). The other 10 focus groups included individuals of a variety of ethnic groups.

Focus group participants completed a brief demographic survey before the groups started. HIV positive individuals represented nearly half of the participants (43%). The majority of participants was male (63%) and resided in Southern Nevada (69%). Participants ranged in age from 11 to 83 years, with a mean age of 40 years. Participants were well distributed among various ethnic groups. Thirty percent of participants was white; 25% black; 23% Hispanic; 9% Native American; 6% Asian, and 7% multi-race or other. Half the participants (52%) indicated they were heterosexual; 35% homosexual; and, 7% bisexual.

Table 2. Description of Focus Groups with Specific Ethnic/Racial Groups

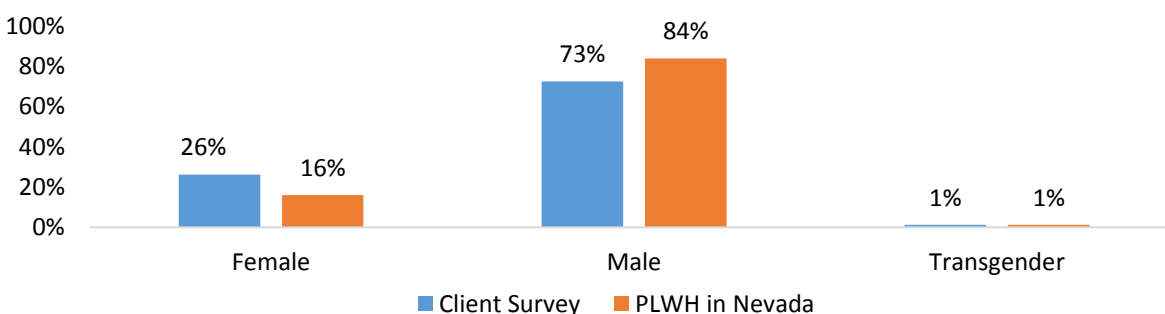
Focus	Population	# participants	Location
HIV Care	HIV positive (mostly women; majority African American)	10	Las Vegas
HIV Care	HIV positive; Hispanic men (includes some MSM)	10	Reno
HIV Prevention	African American men; (Includes some MSM; some HIV+)	7	Las Vegas
HIV Prevention	African American women (Includes some HIV+)	20	Las Vegas
HIV Prevention	Hispanic women	9	Las Vegas
HIV Prevention	Hispanic men	8	Las Vegas
HIV Prevention	Hispanic men	7	Las Vegas
HIV Prevention	Native American	10	Reno
HIV Prevention	Native American	5	Las Vegas
HIV Prevention	Asian/Pacific Islander	7	Las Vegas



HIV Client Survey

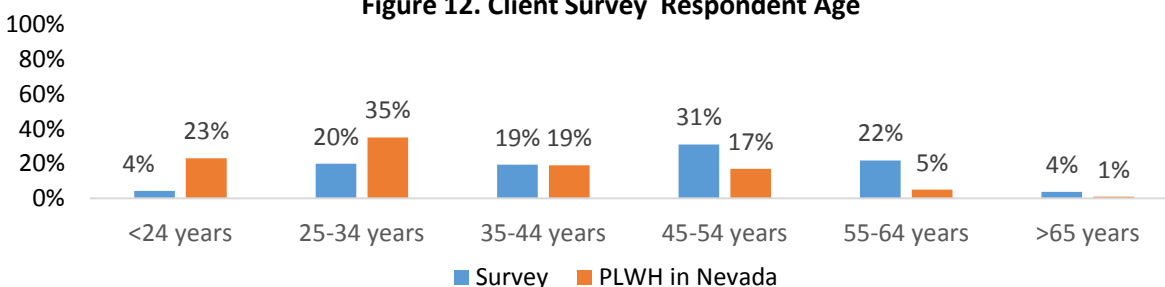
The HIV Client Survey was completed by 177 PLWH between January and March 2016. While the survey was available online, most respondents completed the survey on paper at a service provider site. The survey was available in both English and Spanish. Demographic characteristics of the client survey are compared to the 2014 Nevada HIV/AIDS Surveillance data for PLWH. The majority of client survey respondents were male, as is the case in Nevada PLWH. However, the survey had slightly higher representation of females than found in Nevada. The percentage of transgender survey respondents was similar to that of Nevada transgender PLWH.

Figure 11. Client Survey Respondent Gender

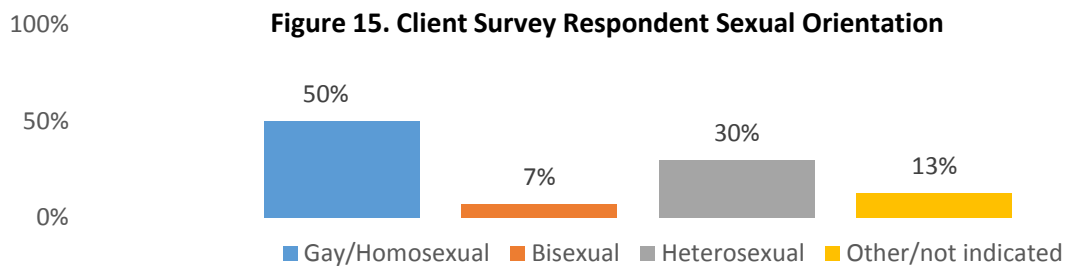
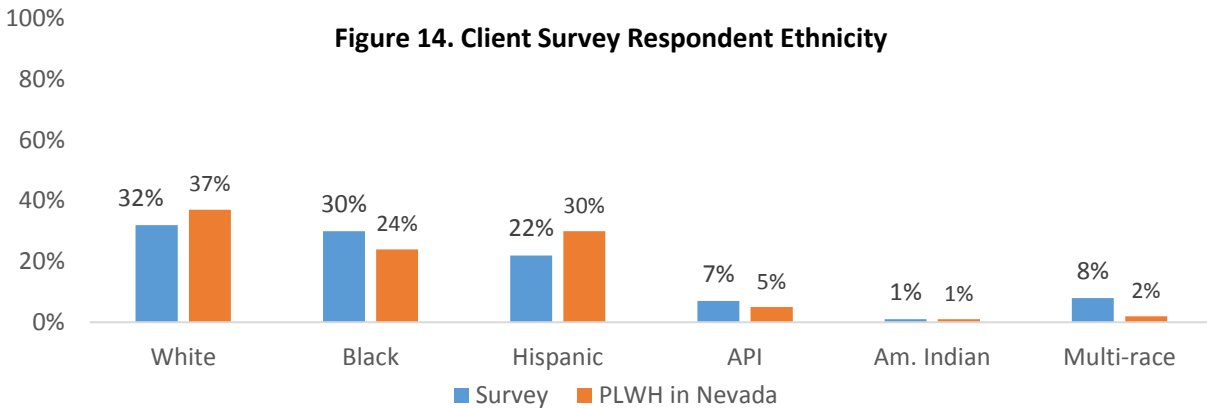
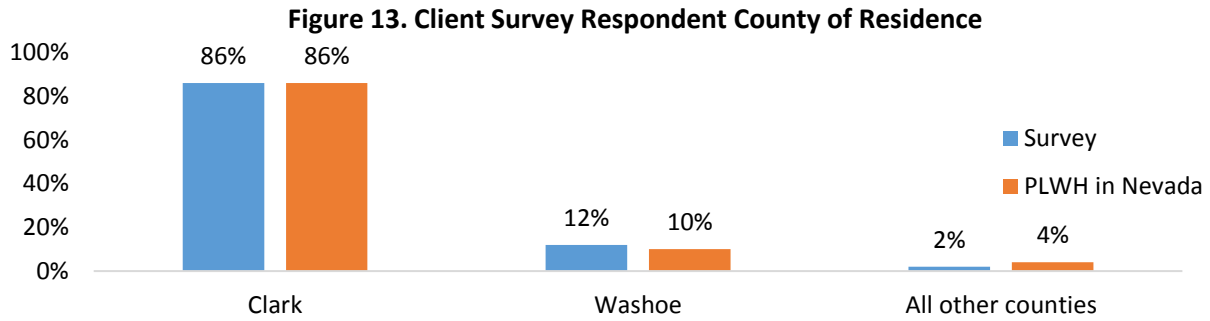


The mean age of survey respondents was 45 years. The survey sample was somewhat older than PLWH in Nevada. Higher percentages of survey respondents were 45 years and older and fewer were under 35 years, compared to Nevada statistics.

Figure 12. Client Survey Respondent Age

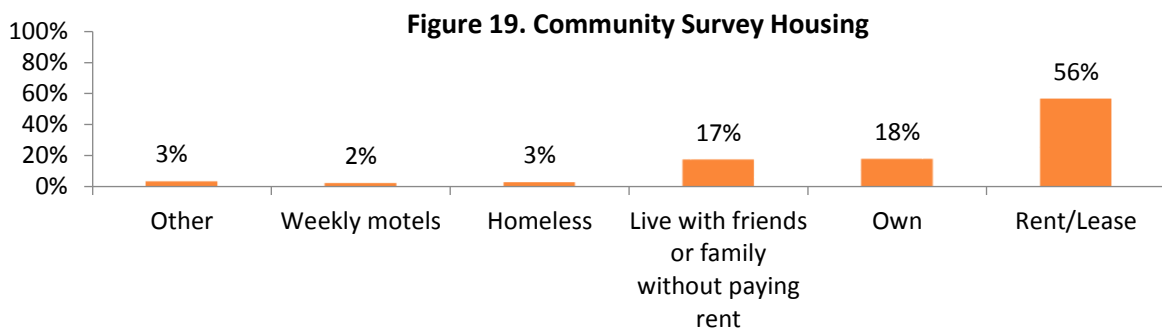
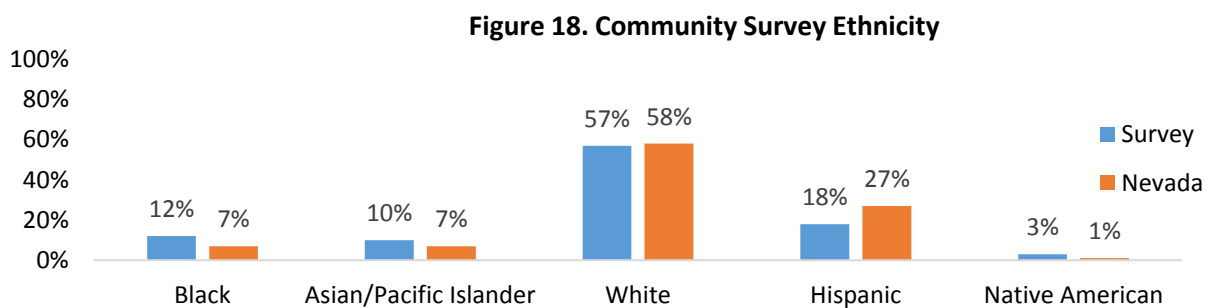
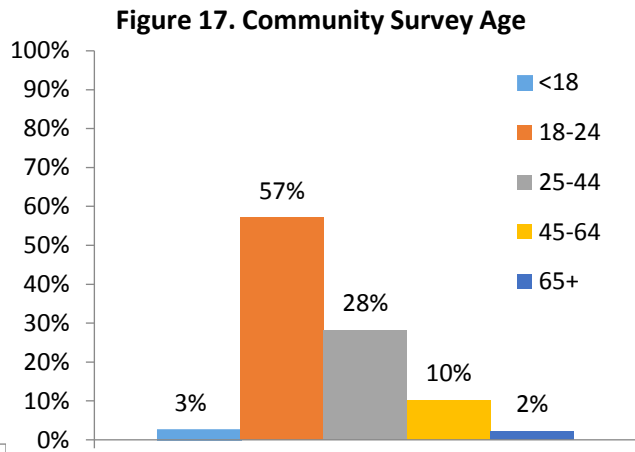
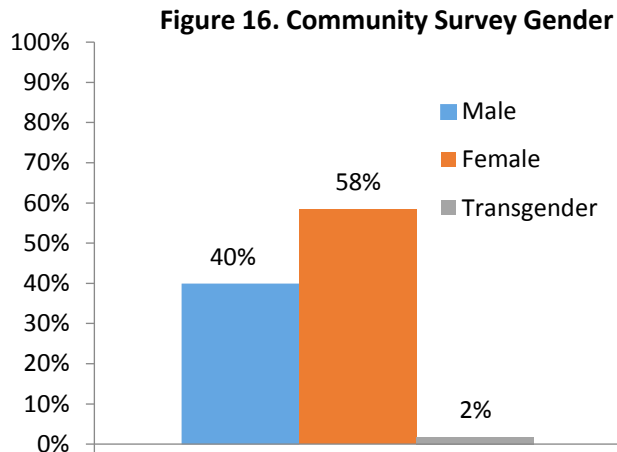


Respondents were asked to provide their zip code of residence which was then coded into Clark County, Washoe County and all other Nevada counties. The distribution of the survey respondents closely matches the Nevada statistics for PLWH, with most respondents residing in Clark County (86%). Half the sample identified as gay/homosexual; 30% heterosexual; 7% bisexual and the remaining 13% as other or they did not indicate sexual orientation. Client survey respondents were generally representative of PLWH in Nevada with respect to race/ethnicity; however, Hispanics were underrepresented in the sample (sample = 22%; Nevada = 30%), while multi-race and blacks were slightly overrepresented.



HIV Community (Prevention) Survey

The HIV Community Survey was collected from 1687 respondents around the state from April 2015 to March 2016. Prevention community survey respondents were recruited through flyers, social media and in person at a variety of community locations, including places that people at higher risk of HIV infection may frequent. The survey collected information regarding HIV risks, barriers to prevention and community needs. More than half the community survey respondents were female (58%), aged 24 or younger (60%), and white (57%). Compared to Nevada’s general population, Black, Asian/Pacific Islander, and Native American populations were slightly overrepresented in the community survey sample. Latino/Hispanic respondents were underrepresented in the survey sample compared to Nevada’s general population. The sample was well educated, with 81% attending some college or some higher degree. More than half the sample rented or leased (56%). Nearly half the sample was single (49%).



African American/Black Needs Assessment Findings

African American Focus Group Summary

Three focus groups with African Americans were conducted in Las Vegas. Overall, the focus group participants expressed positive opinions about current services being offered for people living with HIV. AFAN, Golden Rainbow, and Ryan White services were all named as beneficial. However, participants still felt resources were limited and there was a need for more housing, case managers, and a crisis hotline. A desire to have more providers of the same race was also mentioned. Participants also stated needs for help paying for medical costs, dental care, and housing.

The focus group participants revealed that most HIV education within the African American community was happening through word of mouth and peer advocates. The groups all agreed that more education was needed. It was indicated that TV, radio, newspapers, Internet, and social media would be good methods of raising awareness for HIV prevention and services. God and religion were brought up more with the African American population than any of the other subgroups interviewed. This supports participants' suggestions that social gatherings, such as church, would be another successful way of reaching this target population with HIV education.

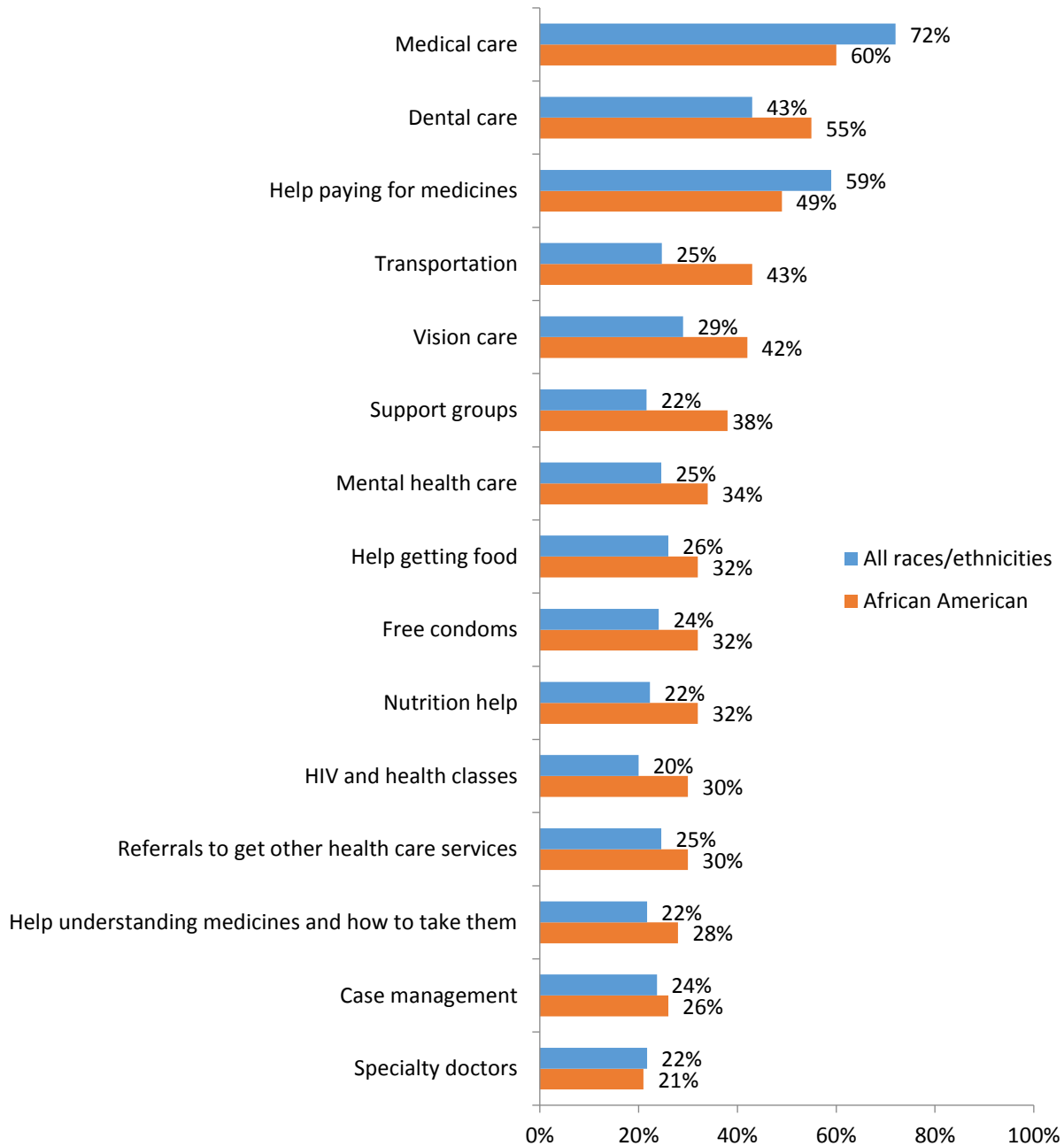
Other barriers to services included transportation issues, stigma associated with HIV, and fear/denial of potential HIV status. Red tape with insurance and having limited office hours (i.e. 9am-5pm) hinders current resources being accessed. Focus group participants identified risky behaviors, such as drug/alcohol use and looking for danger as other factors contributing to HIV. Unprotected sex was mentioned, as well as concerns with use of condoms as a form of birth control, but not for HIV prevention.

The African American focus group demographic survey had 47 total respondents. There were 25 males and 22 females that ranged from 13 to 83 years of age. Three participants reported being veterans. Over 50% had some college or higher education. In regards to sexual orientation, most participants (27) were straight; 16 identified as gay, one "closet gay", and one bisexual. Twenty-six participants were single, nine married, three separated/divorced, five in a committed relationship, and two were in open relationships. Over 90% of respondents had been tested for HIV, with 18 participants testing negative and 25 testing positive. Four had not been tested or did not know HIV status. In addition, 11 individuals reporting using social media to find partners. Used apps included Christiandating.com, COMCC, Facebook, google, and Plenty of Fish (POF).

[African American HIV Client Survey Summary](#)

There were 53 African American respondents in the client survey. A majority of respondents (79%) didn't have any problems seeing a doctor after their diagnosis. For those that had problems, not knowing where to go and not wanting to think about having HIV were the most frequently chosen responses. Of the services currently being used, African Americans identified medical care, dental care, help paying for medication, transportation, and vision care as most used (Figure 20). While they identified medical care and help paying for medicines as top used services, fewer black clients were using medical care and help paying for medicines than the total sample. Higher percentages of African American clients reporting using many of the other services including dental care, vision care, support groups, mental health care, help getting food, free condoms, nutrition help, and HIV and health classes.

Figure 20. Most Highly Used Client Services, African American



Dental and vision care were listed as top services needed (Figure 21). A higher percentage of African American respondents compared to the total sample reported needing transportation. Not knowing where to go was the top reason respondents (25%) gave for not receiving needed services (Figure 22).

Figure 21. Clients' Most Needed Services, African American

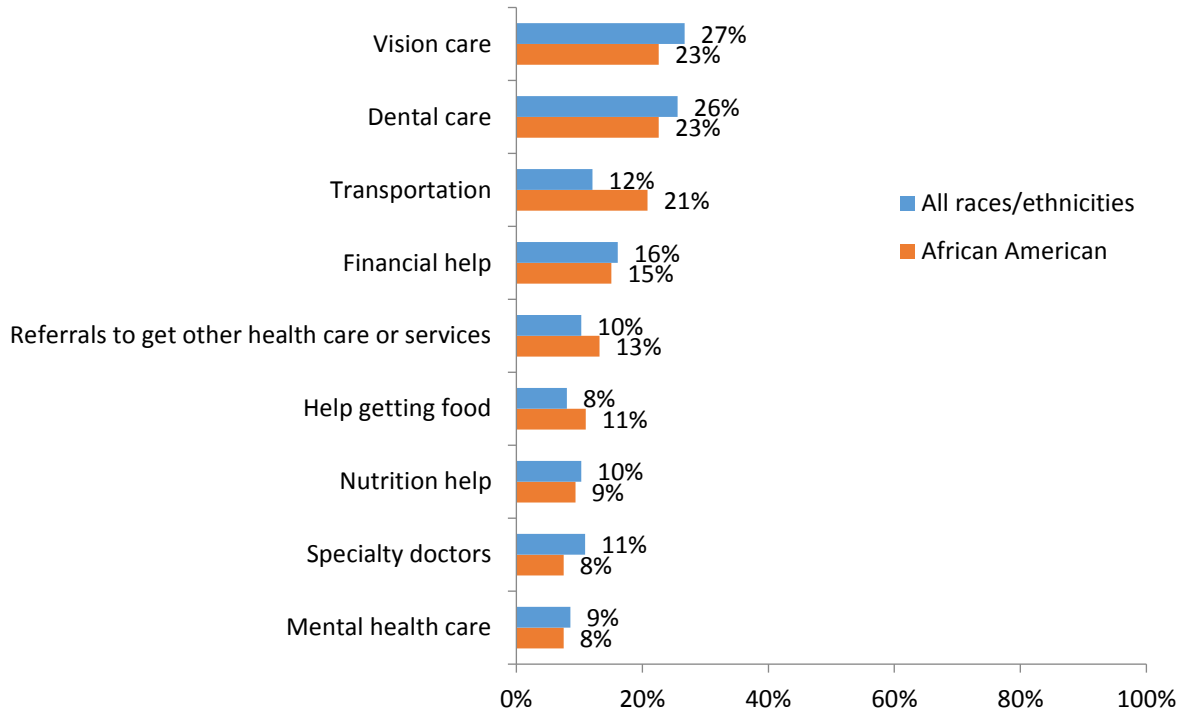
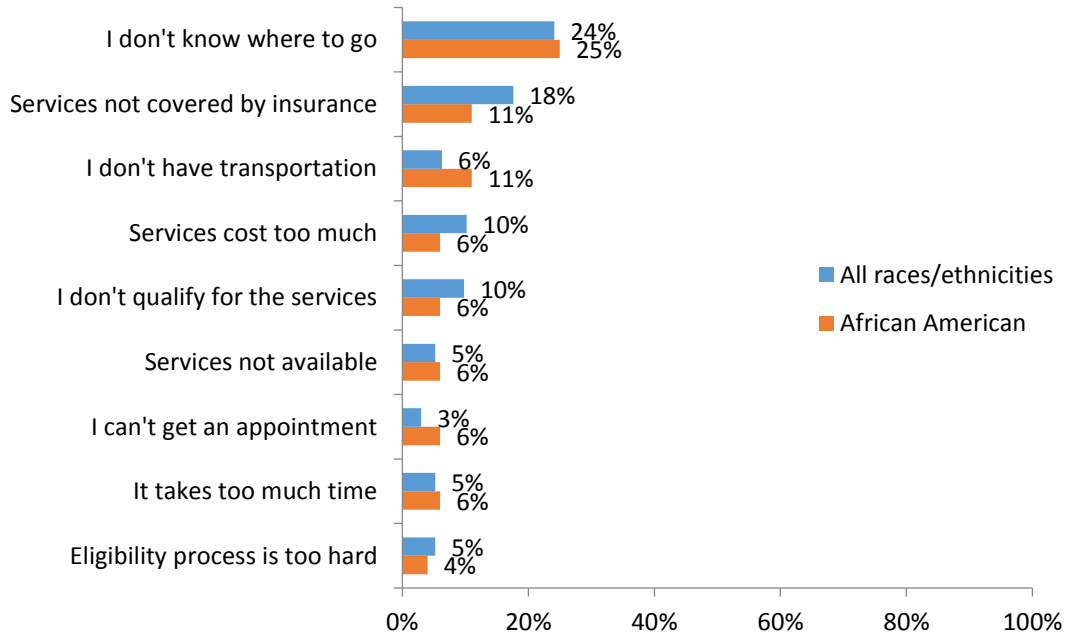


Figure 22. Top Reasons for Not Receiving Needed Services



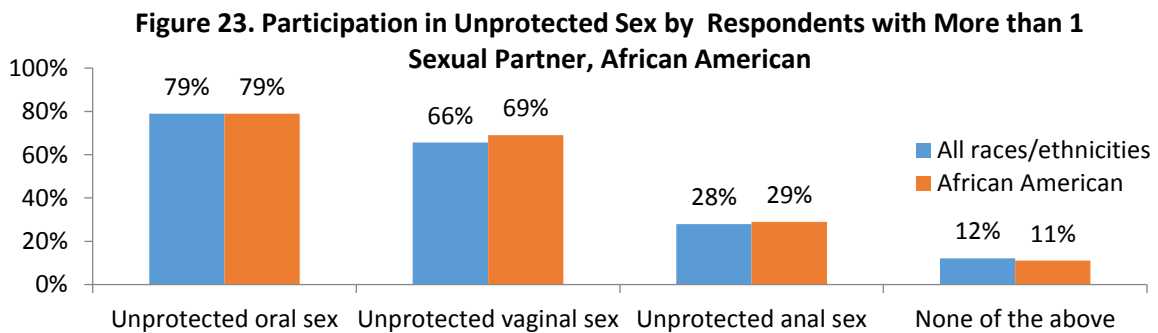
When asked how HIV/AIDS services could be improved in Nevada, some suggestions included having more PLWH work with people, job training and job referrals, transitional housing, and more public service announcements to increase awareness. Table 3 lists a sample of suggestions from African American respondents.

Table 3. PLWH Ideas for Improving HIV/AIDS Services in Nevada, African American

- *By helping those who need help immediately without red tape*
- *Get job referrals and create jobs*
- *Gift cards, provide lunch at classes because some of us have to eat to take meds*
- *Have more people with HIV/AIDS work with people*
- *Have training classes for work services or schooling*
- *Help people get off the streets, help with finding housing location, and tell all services that are available*
- *I feel more help with knowing where to go to get assistance would greatly help*
- *If they had some kind of transitional housing for people with HIV/AIDS "not free housing." They pay rent.*
- *More doctors*
- *More people in community or family members take HIV classes*
- *More public service announcement on radio and TV media as to where to get help and service*
- *Opening an office in Henderson and West Nevada*
- *Reaching out more to those who are afraid*

African American HIV Community Survey Summary

Within the community survey, 189 respondents identified as African American/Black (12% of the sample). Over half (56%) of the respondents were between the ages of 18 and 24 years. Seventy-five percent of the respondents had at least some college experience. More than half of the African American respondents (56%) reported having had more than one sexual partner in the past 12 months. Figure 23 shows the percentages of respondents with more than one sexual partner who engaged in unprotected sex in the past 12 months. Of those with more than one sexual partner, 31% reported seldom or never using a condom when they had sex in the past 12 months. Top reasons African American respondents with more than one sexual partner gave for not using condoms were not liking the feeling, it ruins the moment/is inconvenient, and can't afford condoms.



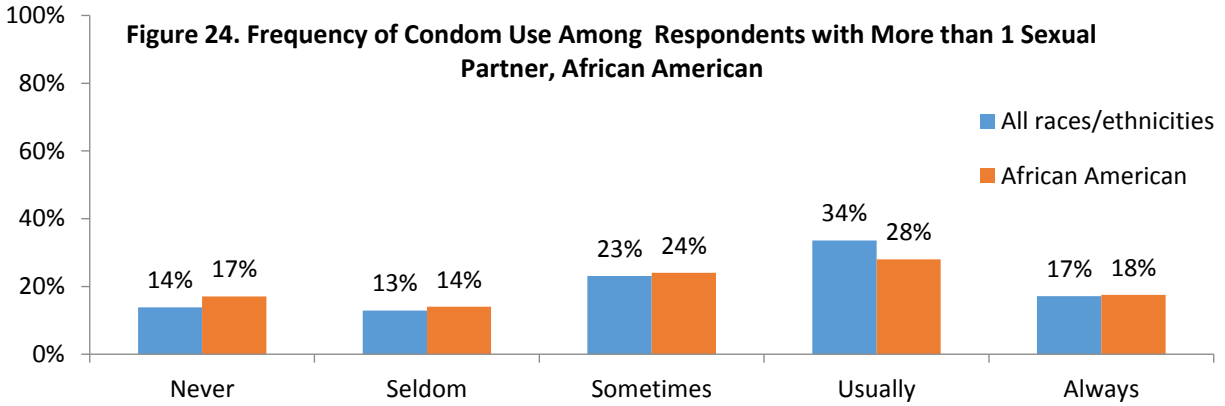
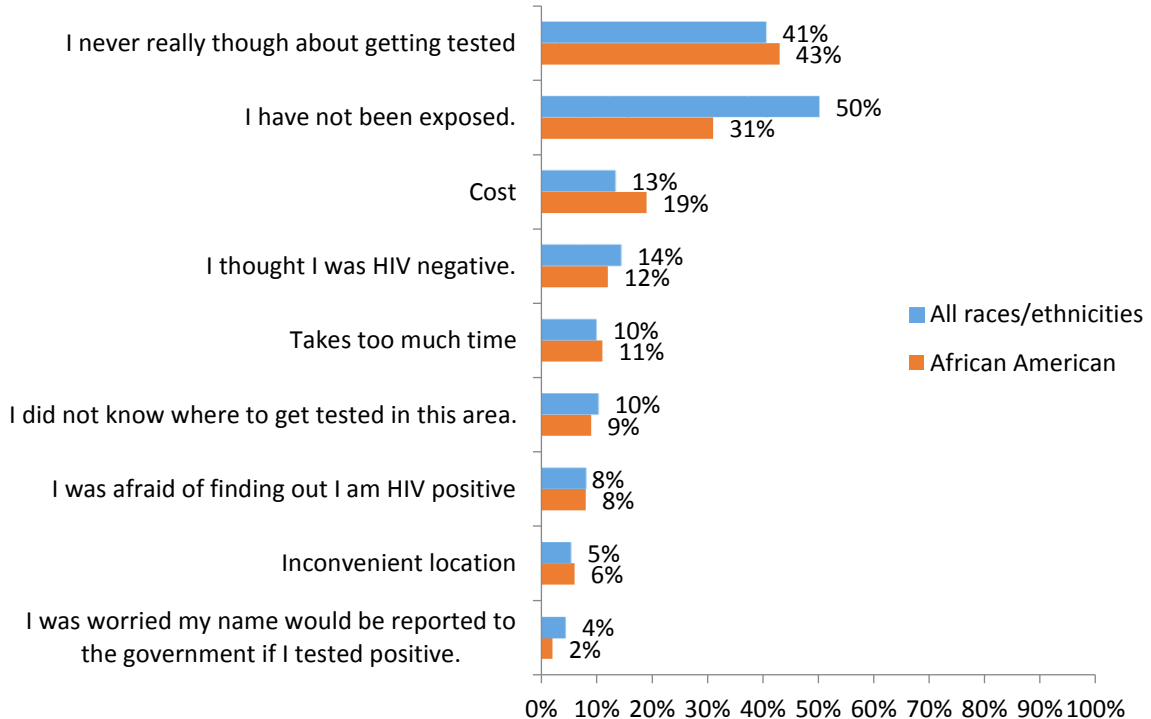


Table 4. What Prevents Respondents with More than One Sexual Partner from Using Condoms

	All Races/Ethnicities	African American
Don't like feeling	39%	36%
Ruin moment/inconvenient	38%	35%
Can't afford	8%	16%
Person refuses to use	13%	13%
Uncomfortable to talk about	12%	11%

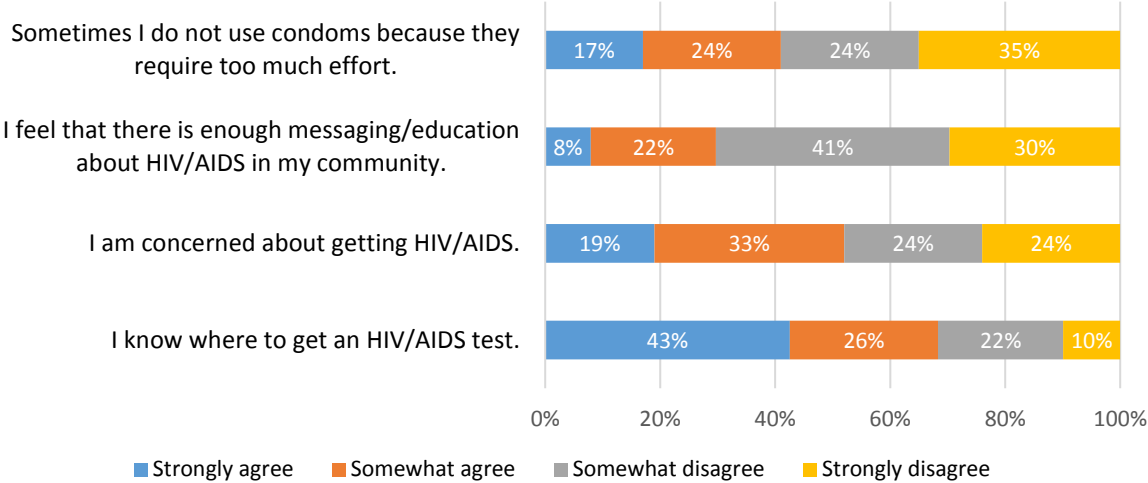
About half of the African American respondents (51%) had never been tested for HIV. Of those who had not been tested, not thinking about getting tested and not being exposed to HIV were the highest reported reasons. Test cost was a reason for 19%.

Figure 25. African American Respondents' Reasons for Not Getting an HIV Test



Less than one-third of African American respondents (30%) agreed or strongly agreed that there was enough messaging/education about HIV/AIDS in their community (Figure 26). The majority (69%) agreed or strongly agreed they knew where to get an HIV/AIDS test.

Figure 26. African American Respondent Beliefs about HIV/AIDS



African American respondents most preferred to receive HIV/AIDS information from the internet or from a health care provider (Figure 27). Brochures and community agency were methods preferred by 26% of African American respondents.

Figure 27. African American Community Survey Respondents' Preferred Ways to Receive HIV/AIDS information

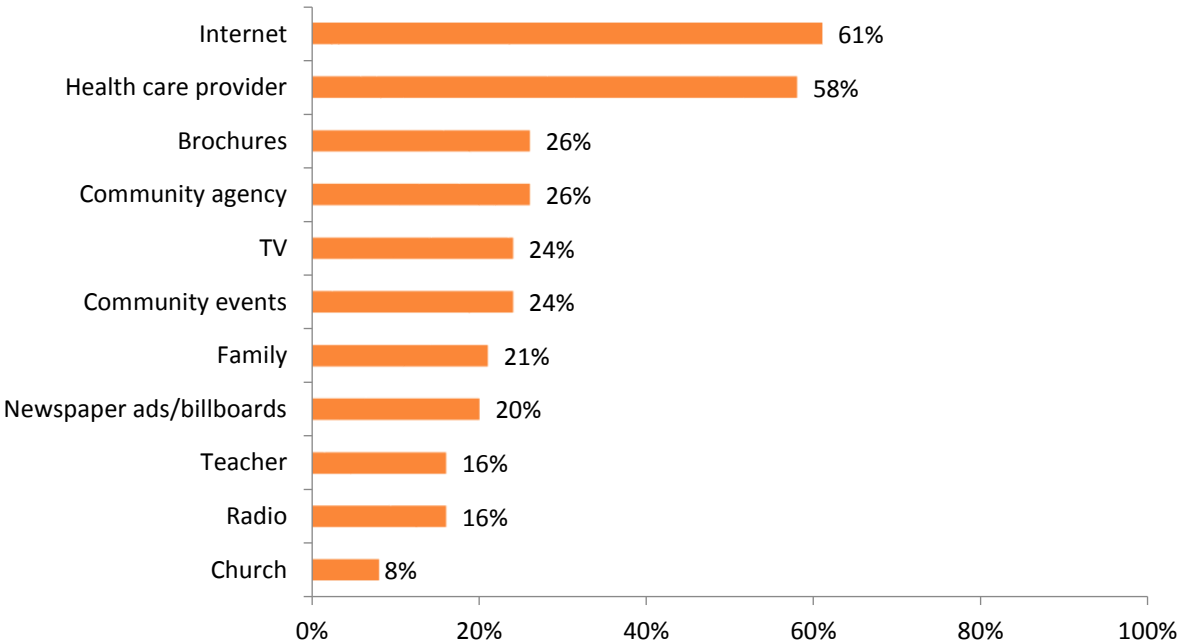


Table 5. Needs in the African American Community to Address HIV/AIDS

- *Access to free or low cost tests*
- *Access to reduced price condoms and protection methods*
- *Advertisements on where to get tested*
- *Awareness and outreach to keep the community educated and aware that HIV/AIDS are real and can be dangerous*
- *Clean needle drives or supplies to the public to promote clean needle injections*
- *Educate on how behaviors affect the risk of getting HIV*
- *Free testing*
- *Funding for dental, vision and gerontology. Safe, affordable housing.*
- *Generalized awareness because of stigmas and unawareness*
- *More required information on it in middle/high school*
- *Leaders both young and old pushing the movement*
- *More clinics that address HIV/AIDS and talk about it*
- *More community information and statistics for certain populations.*
- *More information geared toward youth.*
- *More mobile presence*
- *More walk in clinics*
- *Test everyone*

Top African American Needs and Gaps

HIV Prevention

- Increased education and awareness in the community
- Education in the schools, with youth
- Ad campaigns-TV, radio, internet, social media
- Messaging and education through churches, social gatherings, leaders in the community, health care providers
- Education about condom use
- Education about risky behaviors
- Education about testing
- Free and low cost testing
- Syringe services programs

HIV Care

- More African American providers
- More people with HIV to work with PLWH
- Housing, transitional housing
- Transportation
- Awareness of where to get HIV care and resources
- Dental care
- Vision care
- Job training and job referrals
- Reduction of stigma
- Increased office hours for services

Asian Pacific Islander Needs Assessment Findings

Asian Pacific Islander Focus Group Summary

Asian and Pacific Islanders are among the smallest populations in Nevada. Culturally known for being quiet and private, participants discussed concerns with family/friends knowing details about their sex lives. During the focus group, Asian participants described the fear of being ostracized for purchasing condoms or getting tested for HIV. While participants felt that sex and HIV discussions should be normalized, they also felt its taboo nature would create resistance.

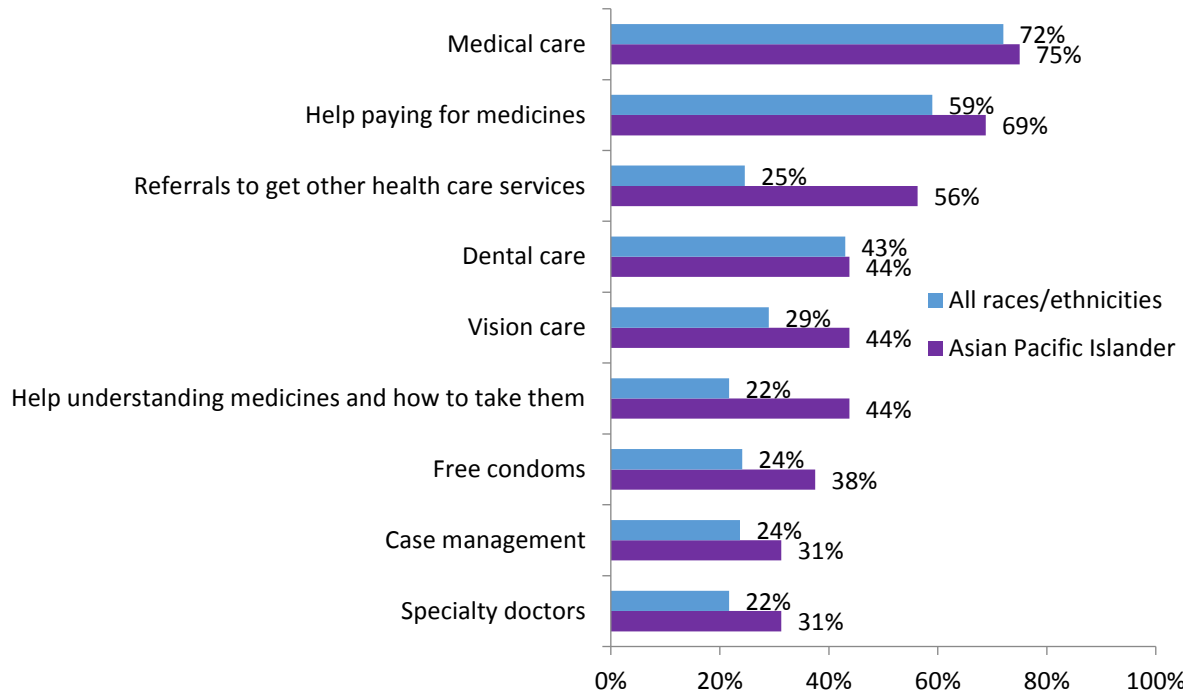
Like other groups, the Asian and Pacific Islanders felt that education was an important key to success in both HIV prevention and general healthy behaviors. Current education is coming from peers and the internet. To be successful, participants felt comprehensive education by schools and parents was needed. It was established that education needs to be about, not only, HIV, but also sex, pregnancy, all STDs, drug use, and other related topics. While monogamy and consistent partners are cultural norms that were brought up during the focus group, participants also established a concern about risky sexual behaviors within the Asian population. This included individuals having sex with tourist women and prostitutes.

The focus group demographic survey had 12 Asian respondents between the ages of 19 and 52. There were five males, five females, and two transgender individuals (both MTF). Of the 12 participants, 11 reported their sexual orientation—eight identified as straight, one gay, one bisexual, and one other. At the time of the survey, seven reported being single, two married, and three in a committed relationship. Seven participants had been tested for HIV (five tested negative and two tested positive); and, five had not been tested or didn't know their HIV status. Eight participants had attended some college or received a bachelor's degree and four had a high school diploma or lower.

Asian Pacific Islander HIV Client Survey Summary

The HIV client survey had 16 Asian Pacific Islander participants. Over half of the participants (63%) reported no problems with seeing a doctor after diagnosis. For those that had problems, not wanting anyone to know they had HIV and not knowing where to go were top issues. Of the services currently being used, Asian Pacific Islander clients identified medical care, help paying for medication, referrals to get other health services, dental care, and vision care as most used (Figure 28). Compared to the total sample, Asian Pacific Islander clients indicated higher usage of help paying for medicines, referrals, vision care, help understanding medicines and how to use them, and free condoms.

Figure 28. Most Highly Used Client Services, Asian/Pacific Islander



Dental care, transportation, vision care, and financial help were listed as top services needed (Figure 29). A higher percentage of Asian Pacific Islander respondents compared to the total sample reported needing transportation. Services not covered by insurance was the top reason respondents (25%) gave for not receiving needed services, followed by not knowing where to go (19%; Figure 30).

Figure 29. Clients' Most Needed Services, Asian Pacific Islander

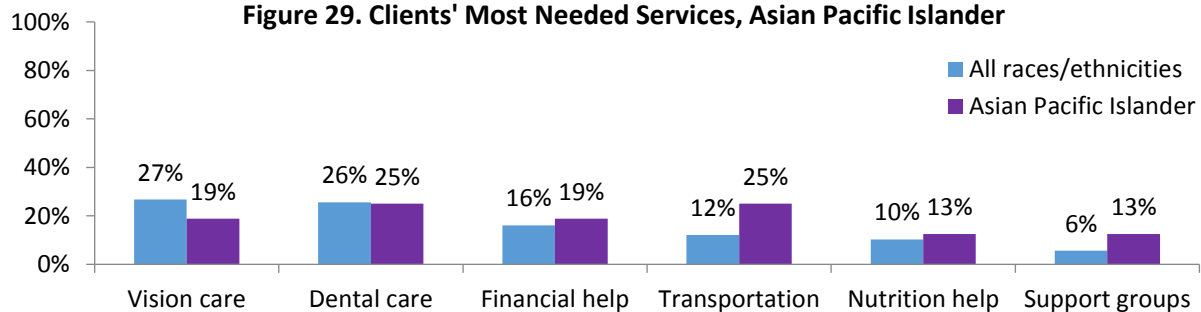
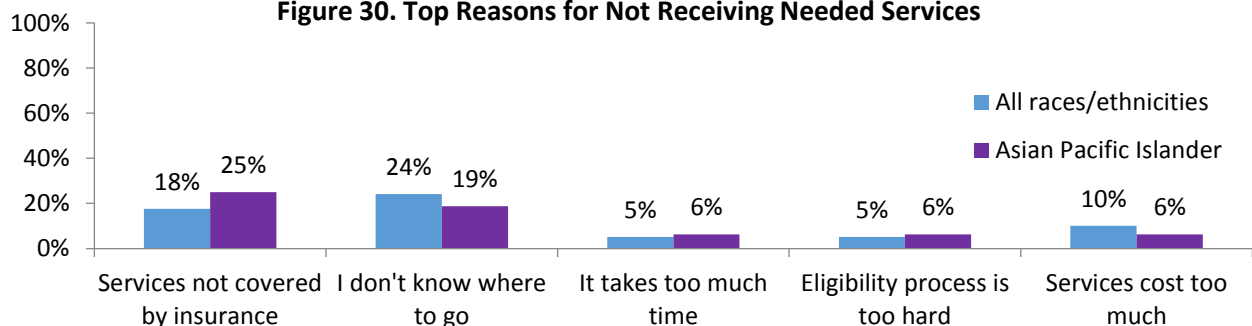


Figure 30. Top Reasons for Not Receiving Needed Services



When asked how HIV/AIDS services could be improved in Nevada, some suggestions included creating a one-stop shop for all services, giving food and gas cards, and more education.

Asian Pacific Islander HIV Community Survey Summary

Within the community survey, 157 respondents identified as Asian Pacific Islander (10% of the sample). Over half (61%) of the respondents were between the ages of 18 and 24 years. Ninety-one percent of the respondents had at least some college experience. Thirty-eight percent of the API respondents reported having had more than one sexual partner in the past 12 months. Figure 31 shows the percentages of respondents with more than one sexual partner who engaged in unprotected sex in the past 12 months. Of those with more than one sexual partner, 24% reported seldom or never using a condom when they had sex in the past 12 months (Figure 32). Top reasons API respondents with more than one sexual partner gave for not using condoms were it ruins the moment/is inconvenient, not liking the feeling, and partner refuses to use them (Table 6).

Figure 31. Participation in Unprotected Sex by Respondents with More than 1 Sexual Partner, Asian Pacific Islander

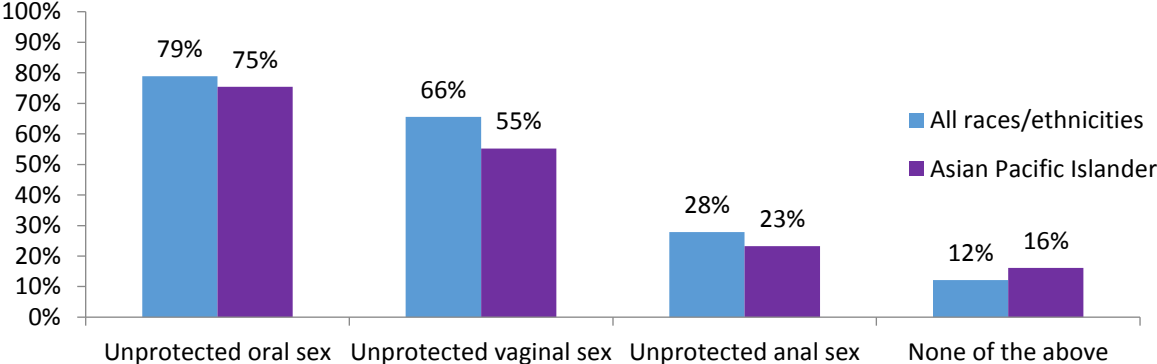


Figure 32. Frequency of Condom Use Among Respondents with More than 1 Sexual Partner, Asian Pacific Islander

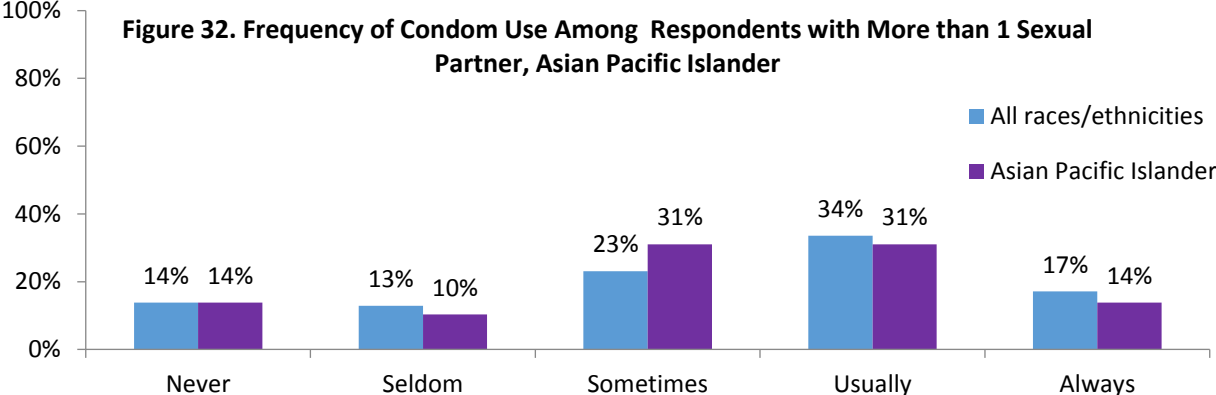
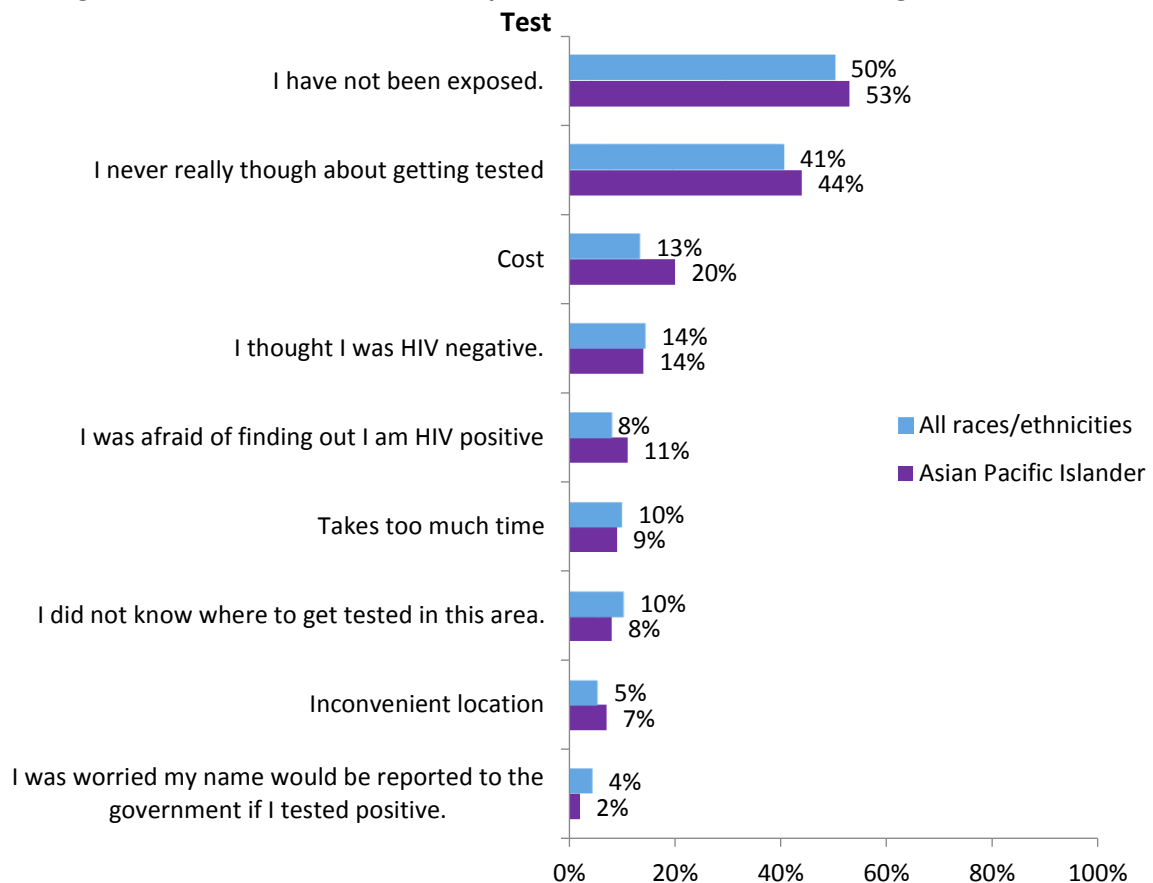


Table 6. What Prevents Respondents with More than One Sexual Partner from Using Condoms

	All Races/Ethnicities	Asian Pacific Islander
Ruin moment/inconvenient	38%	46%
Don't like feeling	39%	45%
Person refuses to use	13%	24%
Uncomfortable to talk about	12%	9%
Can't afford	8%	2%

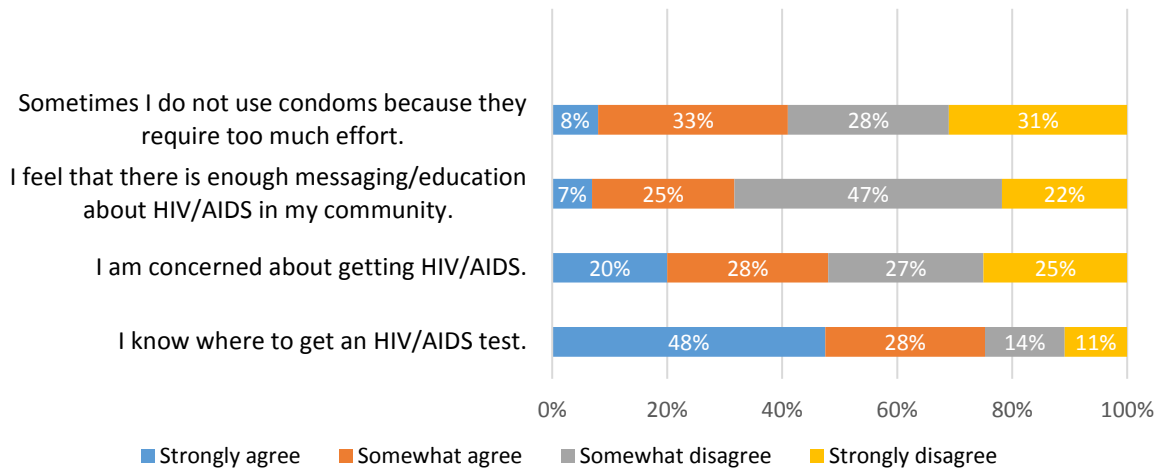
Less than 40% of the API respondents (39%) had never been tested for HIV. Of those who had not been tested, not being exposed to HIV and not thinking about getting tested and were the highest reported reasons. Test cost was a reason for 20%.

Figure 33. Asian Pacific Islander Respondents' Reasons for Not Getting an HIV Test



One-third of API respondents (32%) agreed or strongly agreed that there was enough messaging/education about HIV/AIDS in their community (Figure 34). The majority (76%) agreed or strongly agreed they knew where to get an HIV/AIDS test.

Figure 34. Asian Pacific Islander Respondent Beliefs about HIV/AIDS



Asian Pacific Islander respondents most preferred to receive HIV/AIDS information on the internet or from a health care provider (Figure 35). Brochures and community agency were methods preferred by 30% and 25% of Asian Pacific Islander respondents, respectively.

Figure 35. Asian Pacific Islander Community Survey Respondents' Preferred Ways to Receive HIV/AIDS information

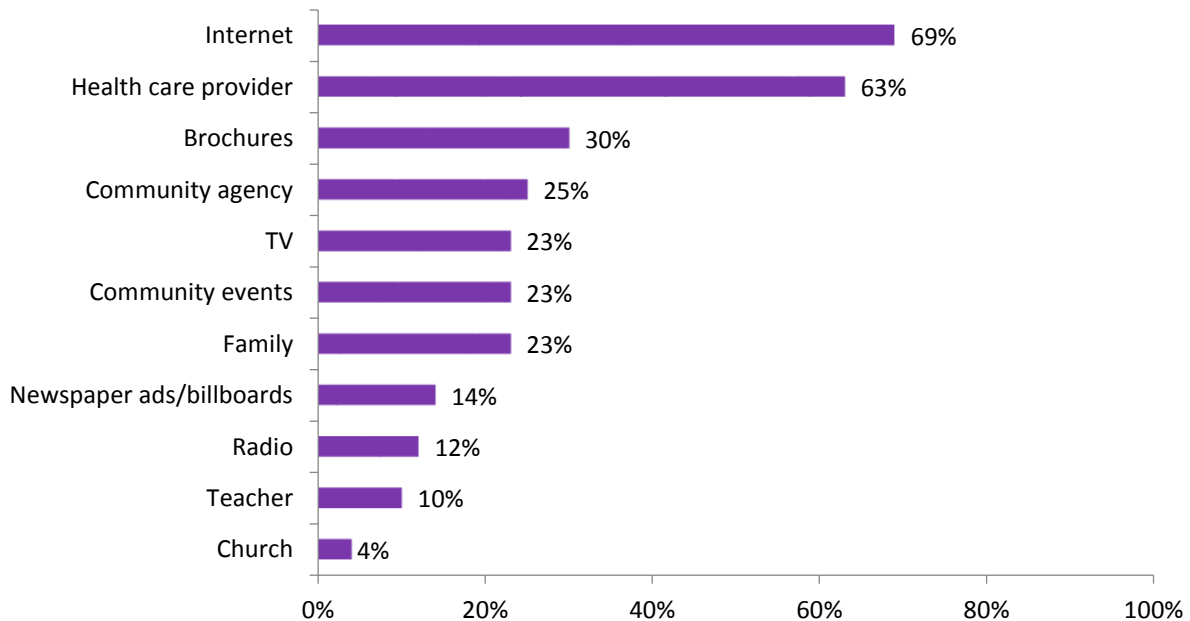


Table 7. Needs in the Asian Pacific Islander Community to Address HIV/AIDS

- Accessible information for students
- Advocacy for the normalization of people who are HIV positive or have AIDS. Our community gravely needs to stop dehumanizing people for having HIV/AIDS.
- Awareness
- Better access to testing
- Comprehensive sex education in public school
- Convenient testing facility
- Education and outreach
- Education on sharing needles, and more sexual protection measures distributed
- Generally, more awareness of both the importance of getting tested and the resources someone might have in order to get tested.
- Maybe make classes like informational classes or community health care events that will help with outreach.
- More ads and public speakers. I think that there should be more classes open to the public (especially for those who are afraid to attend one). Private classes should also be available, and protection (birth control, condoms, etc.) Should also be more available to the public.
- More PSA ads targeted for teens.
- Social media

Top Asian Pacific Islander Needs and Gaps

HIV Prevention

- Reduction of stigma within API community
- Education in schools
- Education about risky behaviors
- Education about condom use
- Education about importance of testing
- Free and low cost testing
- Convenient testing
- Increased awareness and education in the API community
- Ads, public speakers, classes, social media campaigns
- Syringe services programs and education

HIV Care

- Reduction of stigma within API community
- Awareness of where to go for HIV services
- Dental care
- Transportation
- Financial help
- One-stop shops for all services
- More education about HIV

Latino Needs Assessment Findings

Latino Focus Group Summary

The Latino focus group participants identified several areas of improvement for HIV prevention and care. Education was a key factor discussed in every group. Focus group participants discussed the need for more education in schools, education for parents, and education in social settings, such as churches. In addition, this population specifically identified using peer-to-peer trainings as a potential method of successful education. It was established that people were currently using the Internet and YouTube videos to become educated about HIV. While the groups all supported using social media as a method of reaching target populations, there was a clear demand for more formal education.

Service locations that were identified included hospitals, community counseling centers, gay and lesbian centers, local health departments, planned parenthoods, and clinics. Health fairs were also identified as a location to educate the local Latino community about HIV prevention and services. Easy access to free condoms was another service this population recognized as a need. Currently, condoms are expensive and not easily accessible. It was mentioned that in many sale locations, condoms are behind counters or inside locked glass cabinets that require a customer to ask for assistance before purchasing. The focus group participants recognized that their Latino peers were having unprotected or risky sex, as well as the connection between condom use and HIV prevention.

When HIV testing was discussed, locations and lack of information on testing centers were identified as major barriers. Participants suggested having testing centers in more convenient locations, such as near shopping malls, schools, or supermarkets. Regardless of location, cost and confusion was still preventing Latinos from getting tested. Latino participants felt it was important to provide the public with additional information on the cost and different methods of HIV tests. Home testing kits were brought up as possible solution to counteract stigma and fear of asking for a test. Having mandatory testing to reduce stigma also was suggested in one focus group.

Additional risk factors acknowledged by the Latino population included drug and alcohol use, having multiple sexual partners, and a general lack of concern for contracting the virus. It was stated that peers feel invincible, so they continue to engage in risky behaviors. There was a much greater fear for other unintended consequences of risky sex, such as pregnancy, than the fear of contracting HIV. In addition, there was a perception in the Latino community that HIV only affects the gay community or “bad people.” With the stigma associated with HIV, there was very little

discussion about the virus within the community; however, focus group participants acknowledged the need for a culture shift regarding HIV.

The focus group demographic survey included 44 Hispanic/Latino respondents. There were 30 males, 13 females, and one did not report gender. The age of participants ranged from 8 to 62. Nine of the participants were under the age of 18. Twenty-eight identified as straight, 12 as gay, and three bisexual. Twenty-eight also reported being single, four married, two separated/divorced, and eight in a committed relationship. Thirty-two respondents reported being tested for HIV (16 negative, 16 positive); and, 12 had not been tested or did not know HIV status. Thirty percent of respondents used social media apps to find partners. These apps included Facebook, Omegle, Grinder, Adam-4-Adam, Scruff, OK Cupid, Pandora, Whatsapp, Baoo and Ourtime. Of the 44 total respondents, 21 completed the survey in English and 23 completed in Spanish.

Latino HIV Client Survey Summary

Thirty-seven total Latino PLWH completed the client survey. The survey was offered in both English (65% respondents) and Spanish (35% respondents). Nearly half (47%) of PLWH were able to see a doctor immediately after receiving their diagnosis. While 73% of PLWH didn't have any problems getting into the doctors after diagnosis, some of the top problems others had were not knowing where to go; not feeling sick; not wanting to think about HIV status; and being nervous. The most popular services that Latino respondents reported currently using were medical care, help paying for medicines, and dental care (Figure 36). Compared to the total sample, higher percentages of Latino respondents reported usage of help paying for medicines, help getting health insurance, and help filling out forms. Compared to the total sample, fewer Latino respondents reported using mental health care, HIV and health classes, specialty doctors, and case management.

Clients reported that the top services they needed but didn't get are dental and vision care, as well as general financial help (Figure 37). A higher percentage of Latino respondents compared to the total sample reported needing financial help. Top reasons for not getting those services were not knowing where to go, services not being covered by insurance, the cost of services, and issues with qualifying for the said service (Figure 38).

Figure 36. Most Highly Used Client Services, Latino

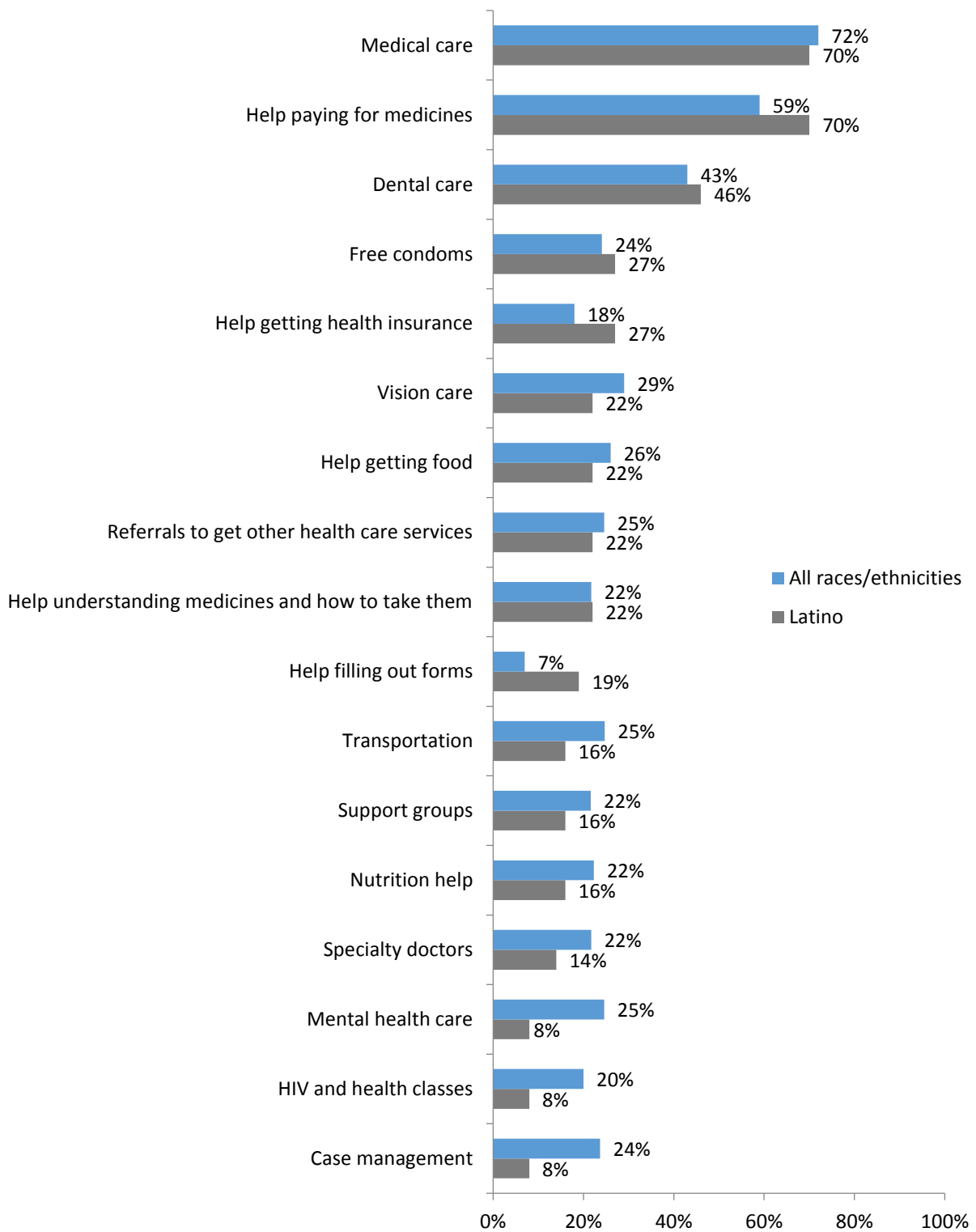


Figure 37. Clients' Most Needed Services, Latino

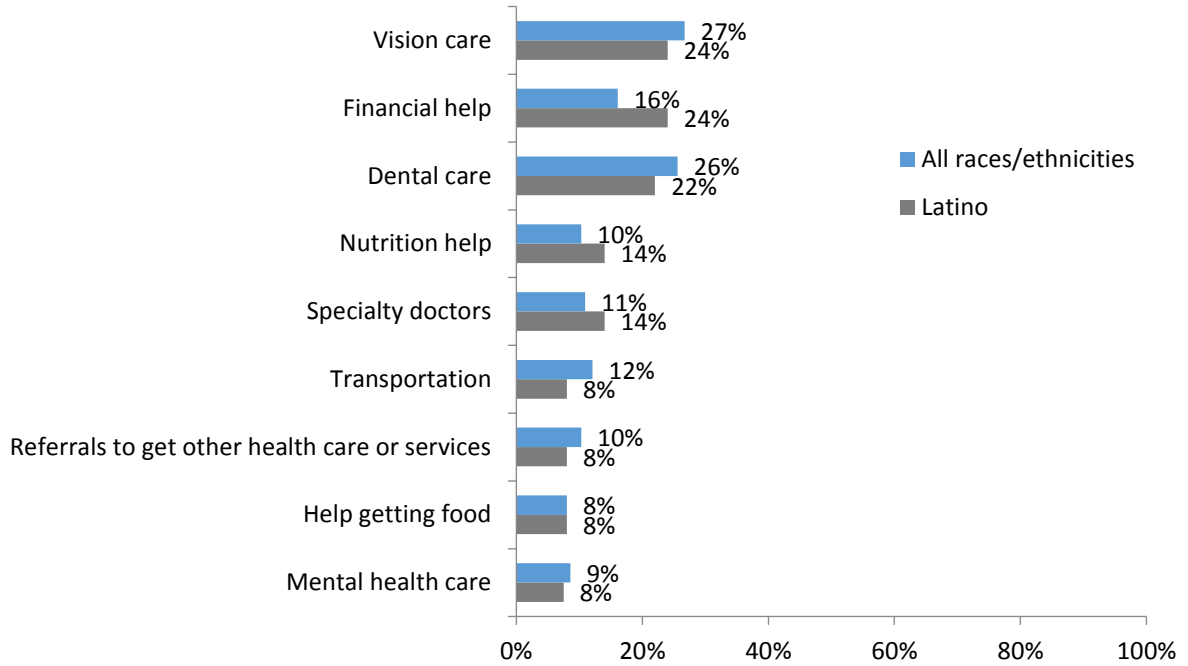
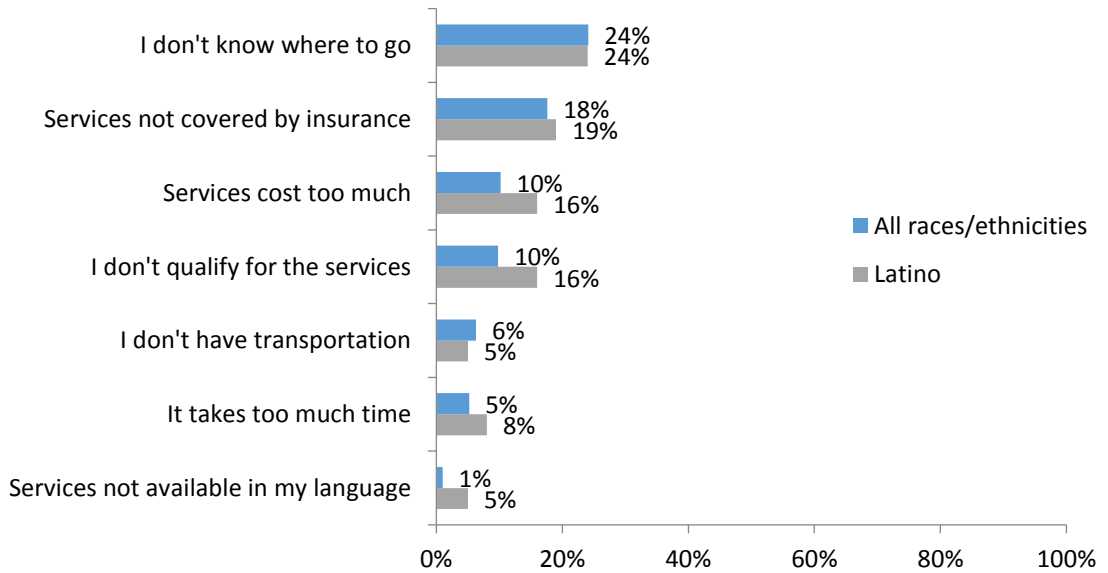


Figure 38. Top Reasons for Not Receiving Needed Services



When asked how HIV/AIDS services could be improved in Nevada, some suggestions included having more people with HIV/AIDS work with people, job training and job referrals, transitional housing, and more public service announcements to increase awareness. Table 8 lists a sample of suggestions from Latino respondents.

Table 8. PLWH Ideas for Improving HIV/AIDS Services in Nevada, Latino

- *Helping more people out with pills/food/etc.*
- *Centralized services*
- *Mental health and medicines*
- *More doctors*
- *More publicity, commercials, announcements*

Latino HIV Community Survey Summary

In the community survey, 286 reported being Latino (18% of the sample). Over sixty percent (64%) of the respondents were between the ages of 18 and 24 years. Seventy-eight percent of the respondents had at least some college experience. Half of the Latino respondents reported having had more than one sexual partner in the past 12 months. Figure 39 shows the percentages of respondents with more than one sexual partner who engaged in unprotected sex in the past 12 months. Of those with more than one sexual partner, 23% reported seldom or never using a condom when they had sex in the past 12 months. Top reasons Latino respondents with more than one sexual partner gave for not using condoms were not liking the feeling, it ruins the moment/is inconvenient, and can't afford condoms (Table 9).

Figure 39. Participation in Unprotected Sex by Respondents with More than 1 Sexual Partner, Latino

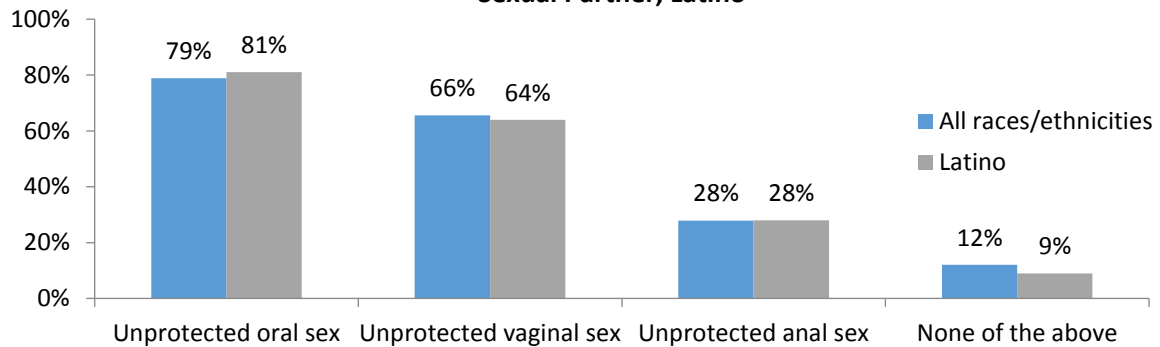


Figure 40. Frequency of Condom Use Among Respondents with More than 1 Sexual Partner, Latino

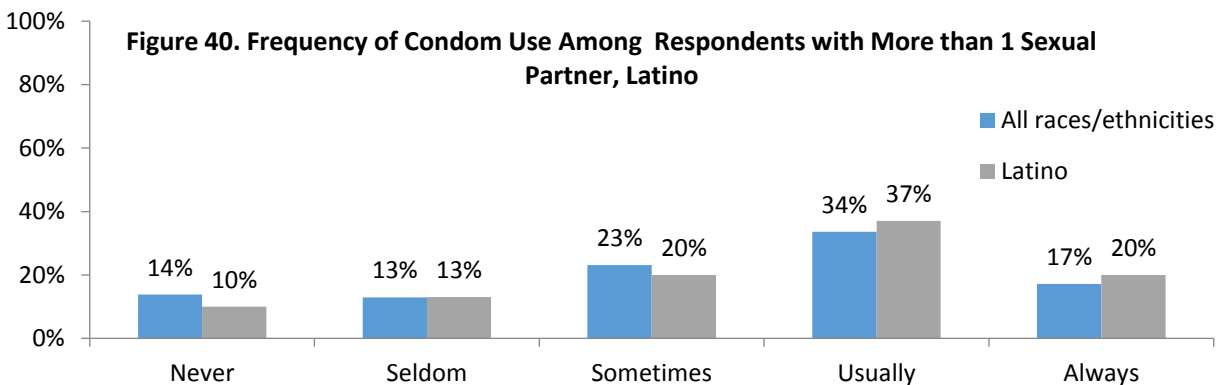
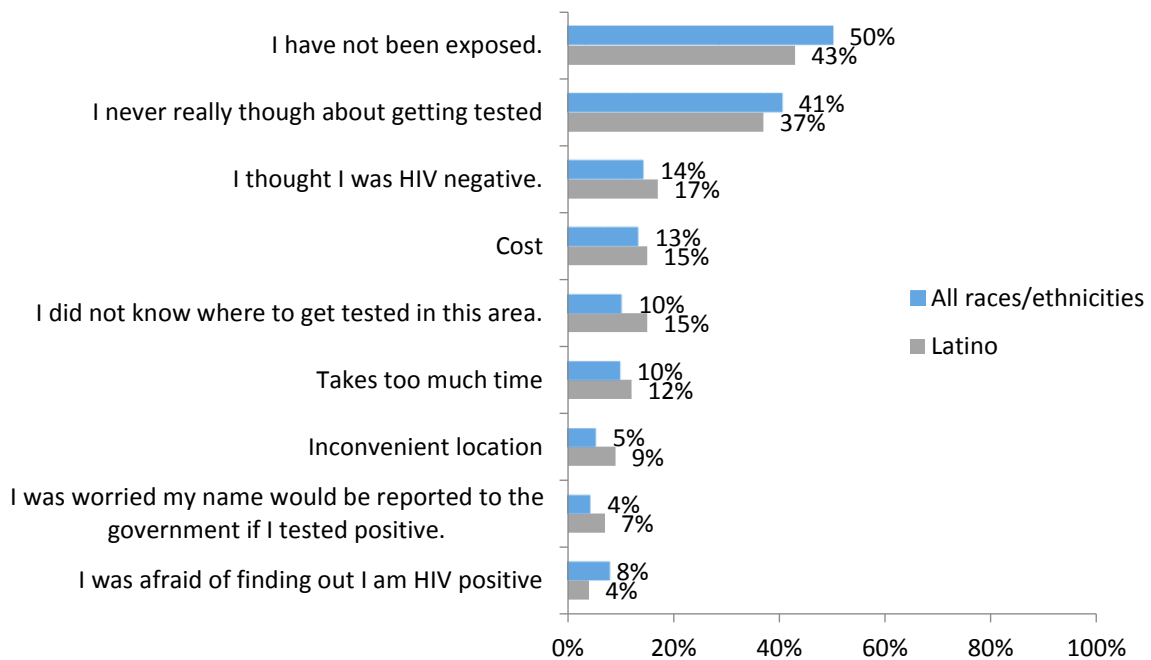


Table 9. What Prevents Respondents with More than One Sexual Partner from Using Condoms

	All Races/Ethnicities	Latino
Don't like feeling	39%	42%
Ruin moment/inconvenient	38%	41%
Can't afford	8%	8%
Person refuses to use	13%	11%
Uncomfortable to talk about	12%	12%

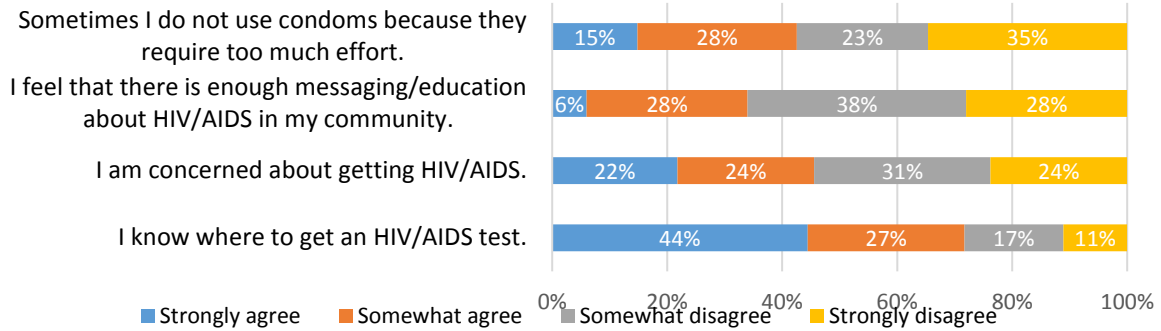
Nearly half of Latino respondents (47%) had not been tested for HIV, compared to 53% of the total sample. Of those who had not been tested, the most frequently reported reasons were not being exposed to HIV and not thinking about getting tested (Figure 41). Compared to the total sample, higher percentages of Latino respondents gave the following reasons for not getting tested: not knowing where to get tested, inconvenient location, and worried their name would be reported to the government.

Figure 41. Latino Respondents' Reasons for Not Getting an HIV Test



One-third of Latino respondents (34%) agreed or strongly agreed that there was enough messaging and education about HIV/AIDS in their community (Figure 42). The majority (71%) agreed or strongly agreed they knew where to get an HIV/AIDS test.

Figure 42. Latino Respondent Beliefs about HIV/AIDS



Receiving HIV/AIDS information from the internet was Latino respondents' most preferred source (Figure 43). Other preferred sources included health care provider and brochures.

Figure 43. Latino Community Survey Respondents' Preferred Ways to Receive HIV/AIDS information

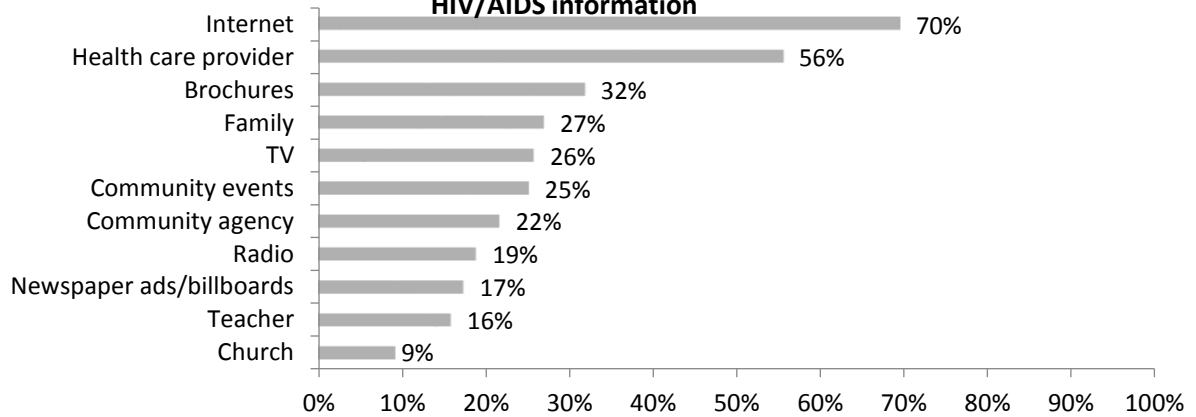


Table 10. Needs in the Latino Community to Address HIV/AIDS

- *Access to condoms. Schools should have some available. Sex education in schools desperately needs to be improved.*
- *Accessible, bilingual, and culturally appropriate preventive materials.*
- *Admitting that it is still a relevant issue that needs to be addressed and that it affects all groups*
- *Better access to testing, free testing*
- *Events in the streets where information is provided or free check ups*
- *Find ways to eliminate needle sharing*
- *Free condoms*
- *If you had a person who has HIV/AIDS talk to the community, I think anyone would respond better.*
- *Las Vegas would greatly benefit from more public service announcements related to HIV/AIDS and services.*
- *Less of a stigma when it comes to sex and sexual acts. Need more of an open dialogue*

- *More availability to women.*
- *More awareness & people willing to talk about it in a public forum/meeting*
- *More doctors to talk with people.*
- *More Latino outreach for HIV/AIDS stigma.*
- *More needle exchanges*
- *More publication of HIV testing. Awareness of symptoms of HIV*
- *More testing sites.*
- *More websites*
- *Not enough agencies promote their services to mainstream community it is still considered a stigma*
- *Rising poverty and drug use needs to be addressed.*
- *Start education young, in middle school, high school education on STI and HIV/AIDS will help younger population help not spread it around*

Top Latino Needs and Gaps

HIV Prevention

- Education in schools
- Education for parents
- Education in social settings, churches, health fairs, on the internet
- Bilingual, culturally appropriate educational materials
- Peer-to-peer trainings
- Free and low cost condoms
- Easily accessible condoms
- Education about risky behaviors, including drugs and alcohol, and multiple sex partners
- Education about condom use
- Convenient testing locations
- Awareness of testing locations
- Education about testing
- Universal testing
- Increased discussion of HIV in the Latino community
- Reduction of stigma in Latino community
- Syringe services programs
- Addressing poverty, drug and alcohol abuse

HIV Care

- Awareness of where to go for HIV services
- Help paying for medicines
- Help getting health insurance
- Help filling out forms
- Accessing mental health care
- Accessing HIV and health classes
- Accessing specialty doctors
- Accessing case management
- Dental and vision care
- Financial help
- Job training, job referrals
- Transitional housing
- More PLWH to help PLWH
- Public service to increase awareness
- Centralized services
- More doctors and other health care professionals

Native American Needs Assessment Findings

Native American Focus Group Summary

Two Native American focus groups were conducted, one in Reno and one in Las Vegas. During the discussions, participants brought up the need to normalize conversations about HIV in the Native American community. It was revealed that Native Americans were very embarrassed to talk about HIV. To counteract this, it was suggested that elders and tribal leaders be used as role models. Increased formal education and community outreach also were suggested as methods to increase HIV discussions with these local communities.

With limited access to information, community members were relying on the Internet and outdated brochures to answer their HIV questions. While Northern Nevada HOPES, Planned Parenthood, and other clinics were all mentioned as current resources, participants described a need for additional services. At the top of the list was HIV testing centers. Within the smaller communities there was a major concern with the lack of privacy that hinders individuals from getting tested. Adding to the stigma associated with HIV testing, the fear of potential HIV positive results was a major barrier in Native Americans in Nevada getting tested for HIV.

In regards to preventing HIV, access to condoms was brought up as a major obstacle. It is well known in the community that unprotected sex is a concern; however, high prices and limited access to condoms is decreasing use among sexually active Native Americans. One suggested solution included access to community condom bowls that would allow individuals to take condoms as they need without fear of stigma or financial obligation.

Unemployment, high number of one night stands, drug use, alcohol consumption, needle sharing, and meth use also were mentioned as concerns within the Native American communities. Not surprisingly, participants in Las Vegas brought up the issue that health concerns that are not associated with risky behavior, such as diabetes, are much higher on the priority list and more likely to get attention from community members.

Seventeen Native Americans completed the focus group demographic survey. Of those, eight were male and nine females. Respondents ranged in age from 21 to 55 years. Two respondents were veterans. Most (65%) participants had completed at least some college. Thirteen participants reported their sexual orientation as straight, three as gay, and one as bisexual. Five were single, five married, two separated/divorced, three in a committed relationship, and one was in an open relationship. Over 83% of respondents had been tested for HIV (13 individuals tested negative, 2 were positive).

Native American HIV Client Survey Summary

Seven Native Americans completed the client survey. While the majority (57%) did not have problems getting to see a doctor, some reported issues were transportation and being nervous to see the doctor.

Top Services Used by Native American Clients

- Medical care
- Help paying for medicine
- Dental care
- Vision care
- Help understanding medicines and how to take them
- Transportation

Top Service Needed by Native American Clients

- Dental care

The most frequently selected reason for not getting needed services was not knowing where to go. Suggestions for improving HIV/AIDS services included giving food and gas cards, housing assistance, and contracting with Access to Healthcare.

Native American HIV Community Survey Summary

Native Americans represented 3% of the community survey respondents (N=42). Forty-three percent of the Native American respondents reported having had more than one sexual partner in the past 12 months. Figure 44 shows the percentages of respondents with more than one sexual partner who engaged in unprotected sex in the past 12 months. Of those with more than one sexual partner, 42% reported seldom or never using a condom when they had sex in the past 12 months, higher than the 27% reporting that frequency among survey respondents of all races/ethnicities who had more than one sexual partner. Top reasons Native American respondents with more than one sexual partner gave for not using condoms were not liking the feeling, it ruins the moment/is inconvenient, and it is uncomfortable to talk about (Table 11).

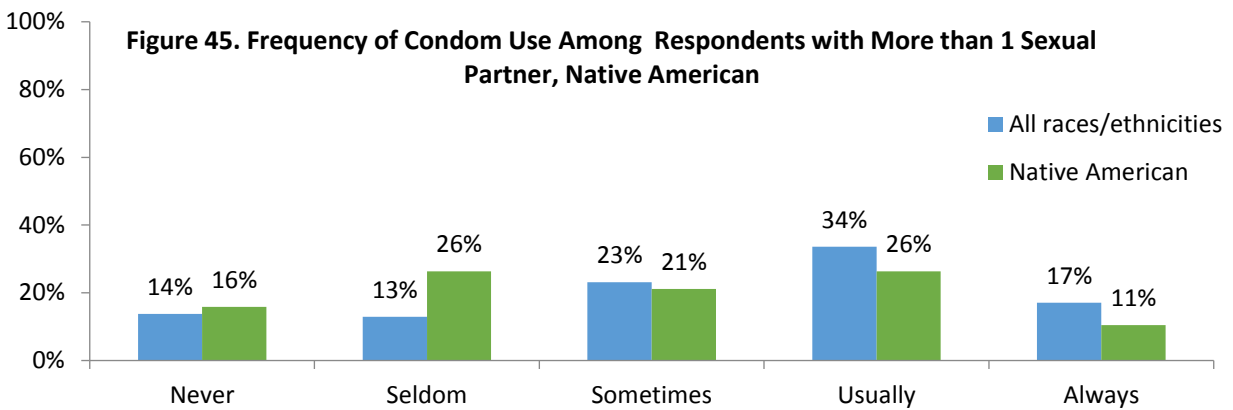
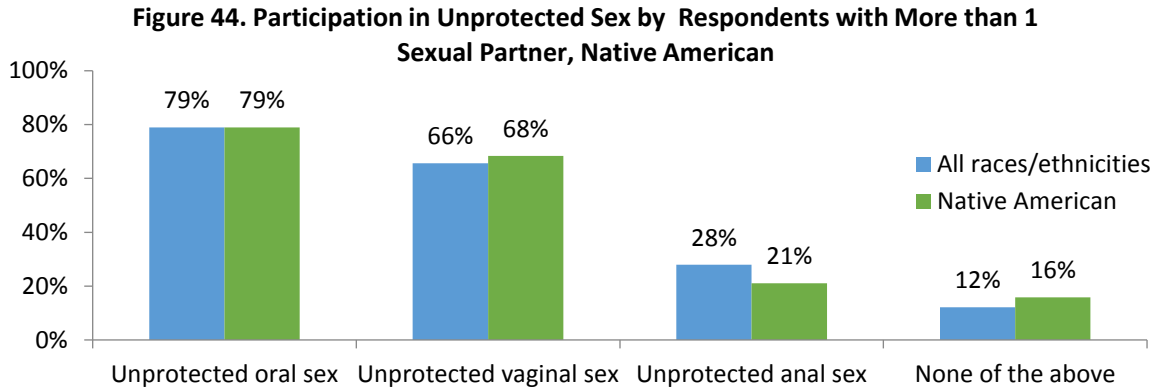
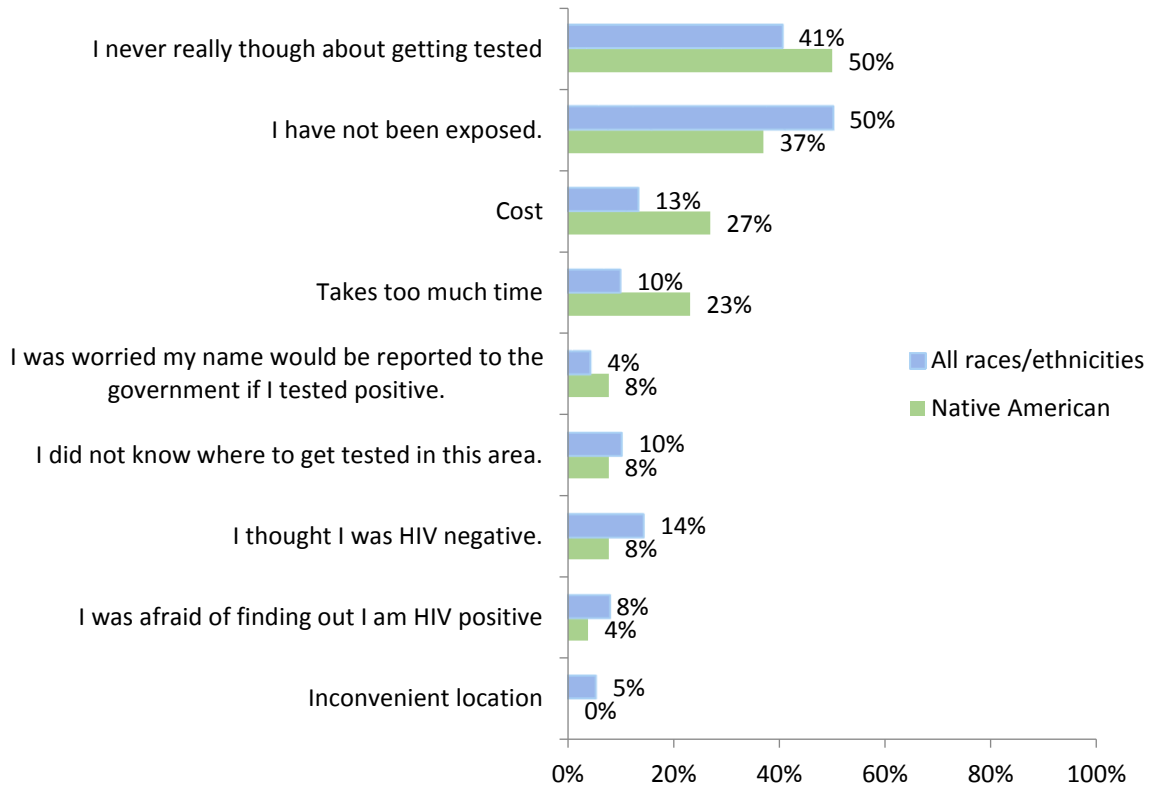


Table 11. What Prevents Respondents with More than One Sexual Partner from Using Condoms

	All Races/Ethnicities	Native American
Don't like feeling	39%	50%
Ruin moment/inconvenient	38%	42%
Uncomfortable to talk about	12%	30%
Person refuses to use	13%	15%
Can't afford	8%	15%

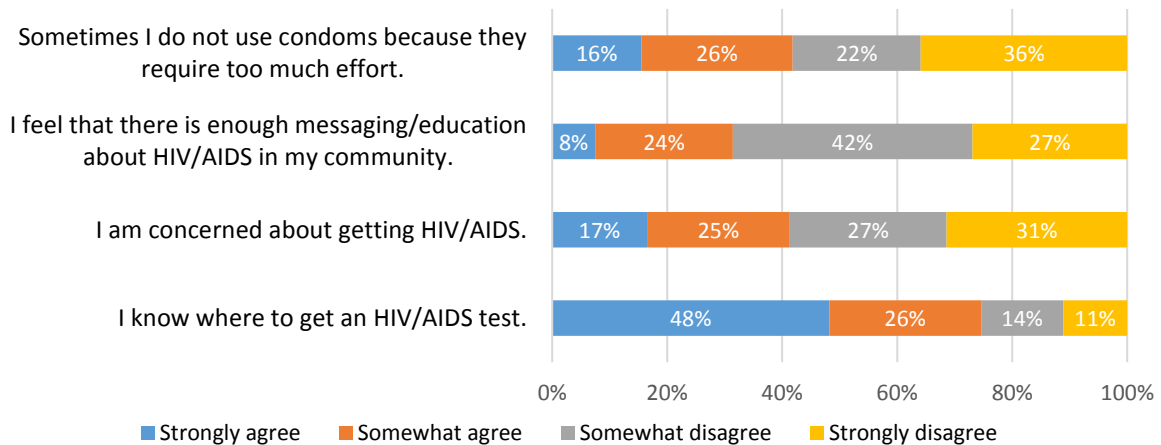
The majority of Native American community survey respondents (63%; N=27) had never been tested for HIV. Of those who had not been tested, not thinking about getting tested and not being exposed to HIV were the highest reported reasons. Test cost was a reason for 27%, while thinking the test takes too much time was a reason for 23%.

Figure 46. Native American Respondents' Reasons for Not Getting an HIV Test



Less than one-third of Native American respondents agreed or strongly agreed that there was enough messaging/education about HIV/AIDS in their community (Figure 47). Nearly half (48%) agreed or strongly agreed they knew where to get an HIV/AIDS test.

Figure 47. Native American Respondent Beliefs about HIV/AIDS



Native American respondents most preferred to receive HIV/AIDS information on the internet or from a health care provider (Figure 48). Brochures, family, TV, and community events were methods preferred by at least 30% of Native American respondents.

Figure 48. Native American Community Survey Respondents' Preferred Ways to Receive HIV/AIDS information

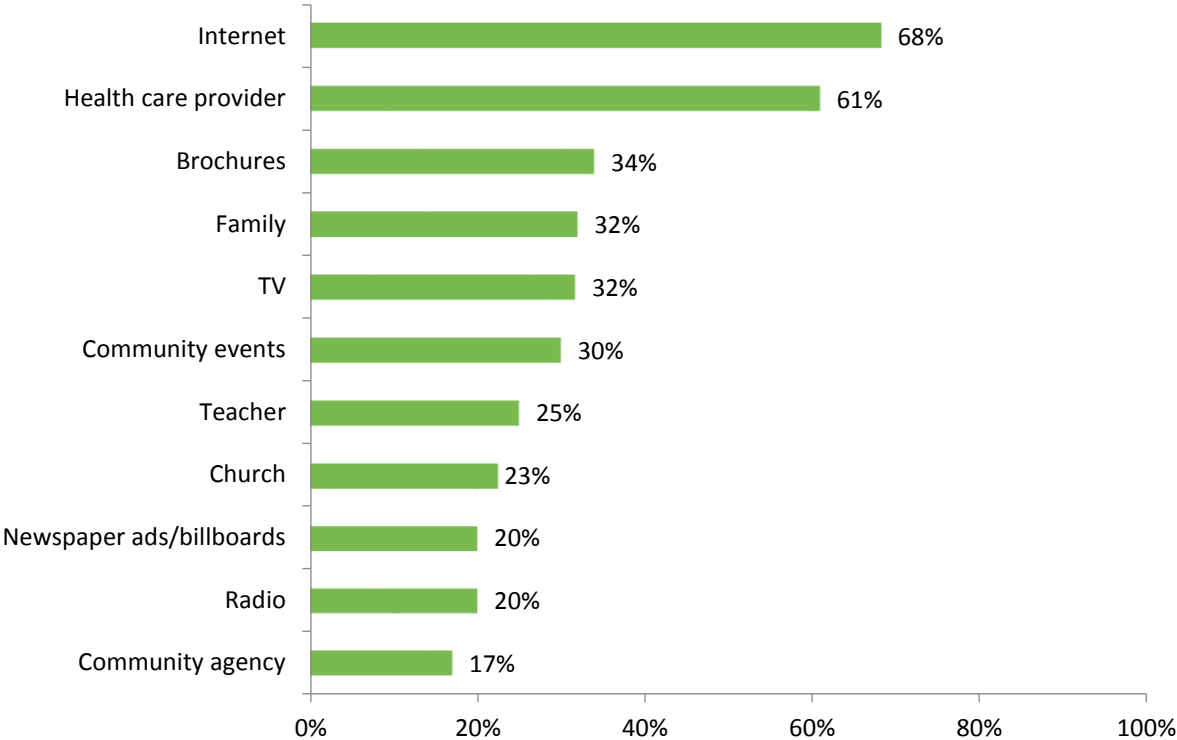


Table 12. Needs in the Native American Community to Address HIV/AIDS

- *AIDS information*
- *Awareness*
- *Having a place to get answers because not everyone knows a lot about HIV/AIDS*
- *More agencies that provide care*
- *More awareness about the continued presence of HIV/AIDS. No one talks about it anymore when it is very real and still here and most people don't even think about the risk of contracting the disease. Spread awareness however necessary.*
- *More convenient testing centers; keep teaching it in high school health*
- *Prevention, then treatment*
- *Radio station*
- *Safe sex habits need to be taught earlier; abstinence is not working*
- *Support groups*

Top Native American Needs and Gaps HIV Prevention

- Reduction of stigma in Native American community
- Involvement of elders and tribal leaders as role models for HIV issues
- Increased formal education and community outreach
- Increased discussion of HIV among Native Americans
- Updated brochures
- Education in schools
- Education about condom use
- Free and low cost, easily accessible condoms
- Education about risky behaviors including multiple sex partners, drug and alcohol abuse, needle sharing
- Education about importance of testing
- Awareness of testing locations
- More HIV testing centers, privacy for testing
- Free and low cost testing
- Universal testing

HIV Care

- Transportation
- Dental care
- Vision care
- Awareness of where to go for HIV services
- Housing assistance

Conclusion

This report examined the HIV prevention and care needs assessment results with respect to four minority racial/ethnic populations in Nevada—African American, Asian Pacific Islander, Latino, and Native American. While many of the needs and gaps in HIV prevention and care were similar across these communities, some unique aspects were found that should be considered when implementing and improving HIV prevention and care efforts going forward. Reduction of stigma related to HIV was important to each community, as was increased education in schools and in the community, and increased awareness of resources. The results highlighted in this report lay a foundation for further exploration of how best to prevent HIV and improve HIV care for people in a variety of ethnic communities using cultural appropriate strategies to do so. As Nevada works to achieve the goals and objectives outlined in the Integrated Plan, it is clear that involvement of these communities is key to successful efforts HIV prevention and care efforts.

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