



SOUTH DAKOTA DEPARTMENT OF HEALTH

Integrated HIV Prevention and Care Plan

Statewide Coordinated Statement of Need 2027–2031

Developed under the auspices of the
South Dakota Department of Health
HIV Prevention and Surveillance Program
and Ryan White Part B Program

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I. Introduction

The South Dakota CY 2027–2031 Integrated HIV Prevention and Care Plan, inclusive of the Statewide Coordinated Statement of Need (SCSN), serves as the State’s comprehensive, coordinated blueprint for delivering HIV prevention, care, and treatment services. This Integrated Plan ensures that resources and activities are focused, aligned, and responsive to the goals of the National HIV/AIDS Strategy (NHAS) and the federal Ending the HIV Epidemic (EHE) initiative. The operational goals of South Dakota’s five-year Integrated Plan are to coordinate activities, maximize state and federal resources, and ensure that all organizations involved in HIV prevention and care across South Dakota collaborate under a unified, data-driven framework to achieve national HIV goals.

For the CY 2027–2031 planning cycle, the South Dakota Department of Health (SDDOH) chose to revise and strengthen its existing Integrated HIV Prevention and Care Plan rather than develop a new plan. The State determined that the current plan continues to accurately describe South Dakota’s epidemiologic landscape, service system infrastructure, emerging trends, and persistent service gaps. The existing SCSN framework remains relevant and reflective of statewide prevention and care needs. Through updated data analysis and stakeholder engagement, South Dakota has refined its goals, objectives, and strategies to better address current epidemiological trends, health disparities, and system challenges within existing resources. This updated plan builds on prior planning cycles while also incorporating new strategies to strengthen integration, coordination, and impact.

The CY 2027–2031 Integrated Plan incorporates updated HIV surveillance data, evaluation findings from the 2022–2026 planning period, and new qualitative and quantitative stakeholder input to inform priorities for the next five years. Planning activities included a SOAR (Strengths, Opportunities, Aspirations, Results) analysis conducted with the South Dakota Prevention Planning Group (PPG) in the fall of 2025, a Ryan White Part B consumer satisfaction survey conducted at the end of 2025, and a statewide provider survey conducted in early 2026. These activities provided insight into system strengths, service gaps, emerging needs, and opportunities to improve coordination between HIV prevention and care systems. South Dakota will conduct an additional statewide consumer survey during this planning period to further inform continuous quality improvement efforts, and the Integrated Plan will be updated accordingly as part of its annual review process.

This Integrated Plan incorporates a comparison of prior demographic and epidemiologic data with current trends to identify shifts in populations disproportionately affected by HIV and to address both emerging and persistent disparities. Evaluation of previous goals and objectives, in coordination with ongoing stakeholder engagement through PPG meetings and partner consultations, informed the refinement of updated, measurable goals and objectives for this cycle. Existing program materials, including the Ryan White Part B Manual and statewide resource guides, will continue to be updated to support implementation of this five-year plan. Telehealth and telemedicine strategies remain a critical component of prevention and care delivery, particularly for rural and underserved communities across South Dakota. Capacity-building efforts also remain a priority to ensure rural providers have the resources, training, and technical assistance needed to effectively deliver HIV prevention and care services. Consistent with federal guidance, this Integrated Plan includes the required SCSN components. Section III outlines the epidemiological overview, HIV prevention and care continuum, resource inventory (including financial and human resources), and data sources and systems that inform statewide planning. Section IV provides a comprehensive assessment of current needs, service gaps, barriers, and structural challenges across the HIV prevention and care continuum. Together, these sections fulfill legislative and programmatic SCSN requirements and ensure that prevention and care resources are allocated based on demonstrated need.

Alignment with the current National HIV/AIDS Strategy and the federal EHE framework is central to the success of this plan. The South Dakota CY 2027–2031 Integrated HIV Prevention and Care Plan mirrors the four pillars of the EHE initiative:

- **Diagnose** all people with HIV as early as possible
- **Treat** people with HIV rapidly and effectively to reach sustained viral suppression
- **Prevent** new HIV transmissions using proven interventions, including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and syringe services programs (SSPs)
- **Respond** quickly to potential HIV outbreaks to ensure timely prevention and treatment services

Each of South Dakota’s goals aligns with these pillars and supports the broader objectives of the National HIV/AIDS Strategy by emphasizing health equity, reduction of disparities, meaningful community engagement, and fully integrated prevention and care systems. The CY 2027–2031 Integrated Plan is designed as a living document that will guide coordinated action, data-informed decision-making, and ongoing system improvement throughout the five-year planning period.

A. The Approach

In summer 2025, the South Dakota HIV Program and Ryan White HIV/AIDS Program (RWHAP) Part B Program, in conjunction with the South Dakota Department of Health Disease Prevention Program, initiated steps to inform the development of the 2027-2031 Integrated HIV Prevention and Care Plan. This comprehensive approach assessed access to care, existing data, service capacity, and progress since implementation of the 2022-2026 Integrated HIV Prevention and Care Plan. Integral to the approach included engagement of program partners and the PPG to ensure that the 2027-2031 Integrated Plan was shaped by individuals working directly with PLWH and PLWH, including the PPG. The PPG was engaged throughout the assessment and development process through in-person and virtual meetings. In addition, RWHAP and the Prevention Program contracted with SLM Consulting LLC to assist in the development of the 2027-2031 Integrated Plan, leveraging their experience with facilitation, strategic planning, and engaging with government programs.

Preliminary steps included an assessment of the 2022-2026 Integrated HIV Prevention and Care Plan by RWHAP and Prevention program staff and SLM Consulting to explore alignment of the goals, objectives, and strategies with NHAS and EHE goals. The assessment included a review of available data collected relevant to the 2022-2026 Integrated Plan objectives and proposed outcomes. A SOAR (Strengths, Opportunities, Aspirations, Results) analysis was also conducted by the PPG in collaboration with RWHAP and Prevention program staff during an on-site PPG strategic meeting. The process was designed to answer the question, What is the health and well-being of South Dakotans currently living with HIV/AIDS and/or at risk for developing the disease? This process led the PPG through an assessment of the strength of current efforts, including the 2022-2026 Integrated Plan, as well as opportunities to advance HIV prevention and care in the 2027-2031 Integrated Plan. These preliminary steps were necessary to determine the extent to which the previous plan goals and objectives/strategies would inform the 2027-2031 Integrated Plan.

Additional efforts included engagement of providers who are not RWHAP Part B/C subrecipients or HIV Prevention contractors to understand opportunities and challenges to access to care for PLWH. The intent of including non-funded providers was to gain insight into what type of collaboration for client needs are present so that the new plan is more effective in meeting NHAS/EHE goals. The RWHAP and Prevention program contracted with the Community Healthcare Association of the Dakotas to develop and disseminate an updated provider survey to collect data from healthcare providers to inform the strategies proposed in this plan and promote access to care. Where applicable, the updated survey modeled the 2022-2026 provider survey to allow for trend and comparison data. Updated

needs assessment data is not included in this plan due to time and capacity restraints, however an updated needs assessment will be conducted during the 2026-2027 project year. The needs assessment will elicit timely consumer input to inform program goals, objectives, and strategies since the 2014 needs assessment.

The State of South Dakota utilized the current Cluster Detection and Response (CDR) Inventory as the primary tool to identify partners, services, and resource gaps, building upon this existing framework to strengthen coordination and responsiveness. This effort was further supplemented by the 211 Helpline Resource Guide, which provided a comprehensive view of available community-based services across the state. Together, these resources supported both the evaluation of existing capacity and the identification of opportunities for expanded outreach and service integration.

As SDDOH receives only RWHAP Part B funding, maintaining strong knowledge of external resources across South Dakota remains essential to ensure appropriate resource utilization and adherence to the payer of last resort requirement as outlined in HRSA HIV/AIDS Bureau (HAB) Policy Clarification Notice (PCN) 21-02. Leveraging the CDR Inventory and 211 Helpline enhances coordination among organizations with shared goals and improves alignment of prevention and care activities within the Integrated Plan.

The inclusion of the Healthy AF Campaign in the new Plan supports statewide promotion of HIV-related resources and access points. This campaign highlights available HIV testing sites, the self-testing program, Ryan White HIV/AIDS Program services, and Community Health Centers that provide access to affordable healthcare. By increasing awareness of these services, the campaign aims to improve early diagnosis, linkage to care, and ongoing engagement in services across South Dakota.

B. Documents Submitted

Documents used to meet submission requirements:

1. South Dakota 2027-2031 Integrated Plan
2. 2026 HIV Work Plan
3. SOAR analysis results
4. Cluster, Detection, and Response Manual
5. 2026 Annual HIV Surveillance Report
6. HIV Epi Profile
7. Provider survey results
8. Ryan White Part B Satisfaction Survey

II. Community Engagement and Planning Process

A. Jurisdiction Planning Process

The development of the Integrated HIV Prevention and Care Plan followed a collaborative, data-driven planning process. The SDDOH began by engaging the Prevention Planning Group (PPG) and key stakeholders in a SOAR (Strengths, Opportunities, Aspirations, and Results) activity, a facilitated strategic planning exercise used to identify current assets, envision future goals, and align priorities across partners. Participants included Ryan White Part B partners, community-based organizations, HIV care and prevention providers, Tribal entities, and community members representing priority populations and people living with HIV. Quantitative data from the HIV Annual Surveillance Report and the State HIV Epidemiologic Profile were used to assess trends, disparities, and areas of greatest need. To supplement this data, a provider survey was conducted to identify emerging issues related to HIV testing, PrEP awareness and prescribing, and linkage to HIV care. Additionally, individuals enrolled in the State's Ryan White Part B Program were invited to participate in a consumer satisfaction survey to

help identify service gaps and barriers to accessing care. Together, these inputs informed the identification of priorities and the overall direction of the Integrated Plan.

B. Entities Involved

The 2027–2031 SDDOH Integrated HIV Prevention and Care Plan is the result of extensive participation, input, and collaboration from the PPG, funded and non-funded providers for HIV prevention and care services, consumers, and community members across South Dakota. Stakeholders contributed through structured planning meetings, data review sessions, and participation in the SOAR analysis to evaluate progress under the previous plan and identify priorities moving forward.

The Ryan White Part B Program supported engagement with PLWH by developing a consumer satisfaction survey and inviting Part B participants to complete it to gather feedback. In addition, a provider survey was conducted to gather feedback from prevention and care providers regarding service delivery capacity, emerging needs, system gaps, and barriers to care. These combined efforts provided valuable insight into current service needs, emerging gaps, and ongoing barriers to viral suppression, specifically related to access in rural areas, transportation challenges, stigma, and workforce capacity.

The PPG contributed by reviewing and discussing the surveillance data and prevention program insights to identify testing trends, key points of entry into care, and populations disproportionately impacted by HIV in South Dakota. The PPG also participated in the SOAR analysis to assess the strength of current efforts and identify opportunities to advance HIV prevention and care. Medical providers and clinical partners offered updates regarding service capacity, including substance use disorder services, behavioral health integration, and telehealth/telemedicine advancements. Discussions also highlighted innovative strategies implemented by agencies to improve retention in care, including technology-based appointment reminders and expanded access supports for clients.

Together, engagement of these entities informed the development of goals, objectives, and strategies for the 2027–2031 Integrated Plan to strengthen prevention efforts, improve linkage and retention in care, and support sustained viral suppression statewide.

C. Role of the RWHAP Part A Planning Council/Planning Body

South Dakota does not receive RWHAP Part A funding.

D. Role of Planning Bodies and Other Entities

South Dakota is a RWHAP Part B and CDC Prevention Program recipient. SDDOH HIV Prevention/Surveillance and Ryan White Part B program staff work in collaboration with key stakeholders and the PPG to plan and execute Prevention Planning, HIV Care Continuum Planning, and the 5-year Integrated Plan. South Dakota does not receive funding for EHE or other nationwide initiatives such as Fast Track Cities. Despite not having these additional funded programs, South Dakota continues to stay apprised of such initiatives to gain knowledge in best practices, expand partnerships with successful programs, and integrate successful initiatives as applicable.

The South Dakota Ryan White Part B program includes SDDOH staff, a statewide community-based provider, a contracted specialty pharmacy, and Ryan White Part B clients. The program also works in collaboration with Ryan White Part C. The Ryan White Care Council is comprised of the same group of individuals as the South Dakota Ryan White Part B program.

Under the previous Integrated Plan, the Care Council convened formally once a year. As the members of the council overlap with the program itself, stakeholder participation and engagement in the formal

meeting were sparse, and the information presented was largely redundant. In the past few years, Ryan White Part B planning has occurred informally with vested stakeholders and staff prioritizing funded activities in accordance with available funding. Under the next five year Integrated Plan, the Ryan White Part B program intends to rebuild its Ryan White Care Council defining a clear purpose and goals, establishing ground rules including meeting time, frequency, and format (virtual, in-person, hybrid), establishing membership, leadership, responsibilities, and auditing the overall programmatic needs including Clinical Quality Management, Part B, and ADAP to ensure needs and requirements are met without a duplication of effort.

The following list provides details on each agency and its role in the community:

- **Great Plains Tribal Leaders Health Board:** Agency provides Native Americans support services and clinical services at the Oyate Health Center for mental health, primary care, dental care, physical therapy, and vision care; located in Rapid City, SD -- not a contracted provider. Receives Substance Abuse and Mental Health Services Administration (SAMHSA) funding for prevention of substance use, mental health services, and substance use disorder treatment.
- **Complete Health:** A community-focused federally qualified health center (FQHC) offering a broad range of primary care and supportive health services to individuals and families in the Black Hills region, regardless of insurance status or ability to pay. Services include medical care (preventative, chronic disease, and family health services), sexual and reproductive health services (HIV, STI, and viral Hepatitis testing), dental care, mental and behavioral health counseling, immunizations, LGBTQ+ IRIS clinic services, and on-site pharmacy support.
- **Falls Community Health:** A FQHC that provides primary care, dental care, mental health services, family planning services, HIV prevention (PrEP), care, and case management; Located in Sioux Falls, SD. This agency is funded by RWHAP Part C and is a SDDOH Prevention Program subrecipient receiving CDC funds.
- **Dakota Area Education and Training Center:** A partner agency of the Mountain West AIDS Education Training Center (MWAETC); Receives RWHAP Part F
- **Heartland Health Resource Center:** HIV prevention and RWHAP Part B subrecipient; provides HIV testing, support groups, transportation, health insurance premium assistance, and assists with ADAP applications; offices located in Sioux Falls, SD and Rapid City, SD, the two most populated cities in South Dakota and the areas where the greatest HIV-related disparities are concentrated.
- **Episcopal Migration Ministries:** Non-profit faith-based organization that works with the Office of Refugee Resettlement (ORR). Migration services provided include intensive case management aimed at assisting clients to achieve self-sufficiency; services are provided to minor individuals (under 18 years old), single-parent households, the elderly, LGBT clients, and HIV-positive clients; Receives federal funds from the ORR.
- **Avera Infectious Disease Specialist:** Avera Medical Group Infectious Disease Specialists in Sioux Falls provides specialized HIV care and clinical management for people living with HIV, supporting both initial diagnosis and long-term treatment.
- **Sanford Infectious Disease Specialist:** Sanford Infectious Disease Specialists in Sioux Falls provides specialized HIV care and clinical management for people living with HIV, supporting both initial diagnosis and long-term treatment.

E. Collaboration with RWHAP Parts

The PPG is a collaborative body convened through the SDDOH (HIV Prevention, STI, and Ryan White HIV/AIDS Program). The PPG works with community members from across South Dakota to ensure coordinated statewide efforts to end the HIV epidemic. Membership includes representatives from healthcare organizations, social service agencies, community-based organizations, and people with lived experience, including persons living with HIV. The PPG meets quarterly (either in person or virtually) at various locations throughout the state.

The work of the PPG includes ongoing review and revision of the Integrated Plan to ensure that strategies address populations of focus (including Native Americans, African Americans, and MSM), stigma, substance use disorder, housing instability, transportation barriers, and access to care. Key stakeholders include Ryan White Part B and Part C providers, as well as CDC-funded Prevention contractors, ensuring alignment and coordination between HRSA- and CDC-funded programs.

Currently, PPG members are organized into focus groups aligned with the EHE pillars: Diagnose, Treat, Prevent, and Respond. These focus groups are responsible for identifying gaps, recommending strategies, implementing activities, and coordinating projects to advance South Dakota's progress toward meeting the National HIV/AIDS Strategy (NHAS) and EHE goals.

RWHAP Part A: South Dakota does not receive Part A funding.

RWHAP Part B: The PPG includes a member representative of Heartland Health, the sole statewide provider funded through RWHAP Part B, to deliver medical and non-medical case management, health insurance assistance, early intervention services, and other allowable client services based on local needs assessments. This member participates in the PPG focus group aligned with the EHE Treat pillar, with a primary emphasis on linking people diagnosed with HIV to care and treatment.

RWHAP Part C: Falls Community Health Clinic is located in the City of Sioux Falls Health Department clinic and is an HIV care provider funded by Ryan White Part C. A representative of the Falls Community Health Clinic participates in an HIV Care Continuum workgroup focusing on people diagnosed with HIV.

RWHAP Part D: South Dakota does not receive Part D funding.

RWHAP Part F: The Mountain West AIDS Education and Training Center (MWAETC) serves a 10-state region, including South Dakota, with local support from the Community HealthCare Association of the Dakotas (CHAD) through the Dakotas AETC (DAETC), which participates in the PPG and workgroups to align training with regional HIV care priorities. MWAETC and partners provide education, clinical consultation, and technical assistance to support evidence-based HIV prevention, care, and comorbidity management, delivered through case-based learning, consultations, conferences, presentations, capacity building, The Extension for Community Healthcare Outcomes- Project ECHO, and individualized preceptorships. Providers also have access to national resources such as the National HIV and PrEP Curricula, offering free modules and clinical tools. Additionally, a South Dakota FQHC participates in a regional practice transformation program using coaching, education, and consultation to strengthen clinical capacity and improve retention in care and viral suppression outcomes. Engagement of People with HIV. The representative from Part F participates in the prevention work group focusing on PrEP awareness and other prevention interventions to prevent new infections.

F. Engagement of People with HIV

The South Dakota HIV/AIDS Prevention Program and the Ryan White Part B Office continually elicit feedback from PLWH and providers of services to PLWH to inform the planning of services, strategies, and activities needed to decrease service gaps, barriers, and needs, and to achieve optimal success in viral

load suppression and capacity building. The following describes the ways that PLWH were engaged in the design of the 2027-2031 HIV Integrated Prevention and Care Plan.

SDDOH Consumer and Provider Needs Assessment Surveys

The SDDOH, in collaboration with its partners, conducted a Ryan White Part B Consumer and Provider Needs Assessment in January 2026 to evaluate service gaps, barriers to care, and emerging needs across the HIV care continuum. While this Integrated HIV Prevention and Care Plan is being updated, SDDOH is planning an additional consumer survey to further assess current needs among priority populations, including South Dakotans living with HIV. Findings from the 2022 assessment, as well as subsequent planning discussions and program data, indicate that many of the identified needs and barriers remain consistent and continue to inform statewide HIV prevention and care efforts.

2022 Consumer Needs Assessment

A comprehensive consumer needs assessment specifically targeting vulnerable populations and individuals living with HIV was not completed during the current planning cycle. However, the SDDOH plans to conduct a focused assessment by the end of 2027 to better capture the experiences and needs of people living with HIV and populations disproportionately impacted by HIV. In the absence of updated data, findings from the 2022 Consumer Needs Assessment were reviewed and determined to remain relevant to the current service landscape. The 2022 assessment highlighted ongoing challenges related to transportation, access to services in rural and frontier areas, confidentiality concerns, and disparities impacting Native American populations. These persistent barriers continue to inform program planning and underscore the need for sustained efforts to improve access, expand culturally responsive care, and address social determinants of health. SDDOH will incorporate findings from the planned 2027 assessment, along with ongoing stakeholder engagement and data collection, to ensure that future updates to the Integrated Plan remain responsive to evolving community needs.

2026 SDDOH Ryan White Part B Client Satisfaction Survey

The SDDOH deployed a Ryan White Part B Client Satisfaction Survey to better understand client experiences with HIV care and support services. The survey was initially administered through SurveyMonkey; however, response collection was limited to 25 participants due to platform constraints. Additional efforts to expand responses through Google Forms resulted in a small number of additional responses. Findings for this survey can be found on page 59 of this document. While the overall sample size was limited, the feedback collected provides valuable insight into client satisfaction and ongoing service needs. Survey responses indicate that clients who participated are generally satisfied with the services they receive through the Ryan White Part B program, including access to medical care, support services, and case management. Clients reported positive experiences with providers and expressed that services help support their engagement in care and overall well-being. However, consistent with other assessment findings, responses also suggest ongoing barriers to care, including substance use, lack of support services, and mistrust in the medical system or healthcare providers.

Although limited in scope, the survey results align with findings from the 2022 Consumer Needs Assessment and other planning activities, reinforcing the need to continue strengthening client-centered services, improving access to care, and addressing structural barriers. SDDOH will continue to incorporate client feedback into program planning and will seek to enhance future data collection efforts to ensure broader participation and more comprehensive representation of client experiences across the state.

2026 SDDOH Provider Needs Assessment Survey

The SDDOH collaborated with CHAD to deploy a provider survey to collect data from healthcare providers to inform the strategies proposed in this plan and promote access to care. Specifically, providers who are

not RWHAP Part B/C subrecipients or HIV Prevention contractors were targeted to understand opportunities and challenges to access to care for PLWH. The survey was designed to understand provider experiences, practices, and needs related to HIV testing, prevention, and care across South Dakota. The survey modeled the previous provider survey where applicable to allow for trend and comparison data, as well as included additional questions to explore training gaps and opportunities and referral networks related to HIV testing, prevention, and care.

The survey was developed and managed through SurveyMonkey and deployed to SDDOH and CHAD partner organizations whose reach includes healthcare providers across South Dakota. We had 68 respondents.

Data from the survey will inform training and resource development to support the healthcare workforce. The SDDOH remains committed to continuously gathering input, analyzing data, and revising the Integrated Plan as needed to respond to emerging trends to better serve its populations.

Priority Setting and Resource Allocations

Historically, the Ryan White Part B program only solicited client input for priority setting and resource allocation by inviting clients to attend and participate in the South Dakota Ryan White Part B/ADAP Advisory Care Council meeting. As discussed, this meeting was held once a year with light client attendance. As such, the program considered other ways to solicit this vital input under the proposed plan and settled on feedback solicited through an anonymous survey. Data collected from that survey is included in this five-year plan and has proved to be a much more successful way to elicit lived experience input from Part B clients.

Under this Integrated Plan, the program intends to rebuild its Care Council and will continue to elicit participation from its clients, but will also continue to survey clients with the frequency and purpose to be defined under the rebuild. The information collected will continue to inform this plan as well as the Part B program and clinical quality management activities, priorities, etc.

Development of goals and objectives

The task of developing the goals and objectives is the responsibility of members from the PPG, Advisory Council, and the SDDOH. Members of the community, including PLWH, either serve on these committees or act in a capacity to advise them. PLWH are involved by providing their expert opinion and experience, which informs the development or revision of Integrated Plan strategies to ensure relevance and effectiveness. When monitoring and evaluating the strategies, their feedback guides proposed changes for the greatest impact on achieving desired outcomes.

G. Priorities

Priorities for the CY 2027–2031 Integrated HIV Prevention and Care Plan were established through a comprehensive review of multiple data sources and stakeholder engagement activities. These methodologies ensured that priorities are data-driven, reflective of current system needs, and aligned with the experiences of providers and communities across South Dakota.

Primary data sources included statewide surveillance data, specifically the South Dakota Annual HIV Surveillance Report and the HIV Epidemiologic Profile. This data was used to identify trends in HIV incidence and prevalence, populations disproportionately impacted by HIV, geographic distribution of cases, and outcomes across the HIV care continuum. Consistent with prior analyses, populations most impacted by HIV continue to include males, Black/African American and American Indian/Alaska Native populations, foreign-born individuals, and adults between the ages of 25–44. Geographic clustering remains concentrated in the southeastern and western regions of the state, with ongoing disparities in viral suppression observed in these areas.

In addition to surveillance data, priorities were informed by qualitative and stakeholder-driven assessment activities. The Prevention Planning Group (PPG) participated in a SOAR (Strengths, Opportunities, Aspirations, and Results) analysis focused on HIV prevention and care, which provided a structured, strengths-based approach to identifying key themes, gaps, and opportunities across the Diagnose, Treat, Prevent, and Respond framework. This process allowed for meaningful engagement of partners, including individuals with lived experience, and ensured that priorities reflect both system strengths and areas for improvement.

Further input was gathered through a statewide provider survey conducted in partnership with the Community Healthcare Association of the Dakotas (CHAD). The provider survey identified critical barriers impacting service delivery, including limited time and competing priorities in clinical settings, gaps in provider knowledge and comfort with HIV prevention strategies such as PrEP, and challenges related to referral pathways and care coordination. These findings reinforced the need to strengthen provider capacity, expand training opportunities, and improve integration of HIV services into routine care.

Findings from the 2022 Consumer Needs Assessment in the current plan were also reviewed and remain highly relevant to the current planning process. Persistent challenges identified in 2022—including transportation barriers, limited access to services in rural and frontier areas, confidentiality concerns, and disparities impacting Native American populations—continue to reflect the realities experienced across the state. These ongoing needs, the provider survey, combined with current data and stakeholder input, confirm the importance of sustained and targeted strategies to address structural and systemic barriers.

Together, these data sources and engagement activities provide a comprehensive and consistent picture of HIV prevention and care needs in South Dakota. The alignment of findings across surveillance data, stakeholder input, and prior assessments supports the prioritization of efforts to expand access to testing and prevention services, improve linkage to and retention in care, address disparities among disproportionately impacted populations, and strengthen coordination across the HIV service delivery system.

H. Updates to Other Strategic Plans Used

Integration with the HIV Prevention Plan

The SDDOH HIV Prevention Program and the Ryan White Program continue to collaborate closely to ensure alignment between prevention and care efforts, as reflected in the current Integrated HIV Prevention and Care Plan. Building on previous planning efforts, both programs coordinate strategies to reduce duplication and support a comprehensive, status-neutral approach to HIV prevention and care. Priority populations remain consistent with prior analyses, including males, Black/African American, American Indian, and individuals with identified exposure risks such as IDU and MSM.

Guided by the current HIV Prevention work plan and aligned with the EHE initiative, SDDOH has strengthened its approach across key pillars: Diagnose, Treat, Prevent, Respond, Surveillance, and Community Engagement. To support earlier diagnosis, efforts have focused on expanding routine, opt-out, and at-home HIV testing in both healthcare and non-healthcare settings. These efforts are reinforced through targeted digital marketing campaigns and provider training. Together, these strategies aim to increase awareness, normalize testing, reduce late diagnoses, and improve access to testing statewide.

To improve treatment outcomes, SDDOH is enhancing linkage to care by promoting rapid connection to services within 30 days of diagnosis through strong collaboration with Ryan White providers and case managers. The SDDOH is also prioritizing training for DIS on referrals to essential support services, including housing, transportation, behavioral health, and substance use treatment to support

sustained engagement in care. Ongoing monitoring of linkage-to-care data allows for identification of barriers and continuous quality improvement.

Prevention-focused strategies emphasize increasing awareness and utilization of PrEP and PEP through digital prevention campaigns, provider education, and DIS training on PrEP referral processes. Additional efforts include expanding condom distribution and strengthening partnerships with community-based organizations to broaden reach. At the same time, SDDOH continues to enhance its ability to identify and respond to HIV clusters and outbreaks through regular multidisciplinary collaboration, timely data analysis, and rapid response activities.

The SDDOH also maintains a strong focus on surveillance and data systems by improving data collection, monitoring progress toward EHE goals, and ensuring strict adherence to data security and confidentiality standards. Community engagement remains central to all efforts, with ongoing collaboration through the PPG, quarterly meetings, tribal jurisdiction calls, and engagement with individuals with lived experience to inform program direction and ensure culturally responsive approaches.

Together, these coordinated, data-driven strategies strengthen the integration of HIV prevention and care services, expand access to both clinical and essential support services, and improve health outcomes for individuals at risk for or living with HIV across South Dakota.

How South Dakota will use annual needs assessment data and feedback from PLWH to adjust priorities

South Dakota uses annual needs assessment data to inform and adjust the priorities of its Integrated HIV Prevention and Care Plan. The South Dakota Department of Health (SD DOH) plans to regularly conduct needs assessments through multiple avenues, including input from providers, community members who access services, people living with HIV (PLWH), and other key stakeholders. Findings from these assessments will be used to identify emerging gaps, monitor changing needs, and guide data-driven updates to statewide priorities, ensuring the plan remains responsive, equitable, and aligned with current epidemiological trends and community needs. How SD incorporates ongoing feedback from PLWH and stakeholders

In addition to formal assessment activities, SDDOH incorporates continuous qualitative feedback from community members and service providers. This input is gathered through regional office interactions, including testing and partner services, as well as through community-based organizations and healthcare entities delivering prevention and care services. These partners often identify real-time systemic barriers, such as challenges related to access, service availability, and care engagement. While some of this feedback is informal and not always captured through standardized tools, it remains especially valuable in a rural state like South Dakota, where collaboration is critical to maximize limited resources. Together, these data sources inform ongoing adjustments to plan priorities, ensuring a responsive, data-driven approach that reflects the evolving needs of the populations served.

Changes to the plan because of updates, assessments, and community input

The 2022–2026 Integrated HIV Prevention and Care Plan was not formally updated during its implementation period. Moving forward, the SDDOH will establish an annual review and update process for the 2027–2031 Integrated Plan to ensure priorities remain responsive to emerging data and community needs. This process will be incorporated into the PPG agenda, with EHE Pillar Workgroups tasked with reviewing and updating their respective goals and objectives on an annual basis. To support this effort, updated epidemiologic data and performance measures will be provided to the PPG each year to inform discussion, guide decision-making, and ensure that plan modifications are data-driven and reflective of current trends and identified needs.

Changes were made to the planning process as a result of evaluating the planning process

No formal updates were made to the Integrated Plan during the current implementation period; however, the SDDOH, in collaboration with the PPG, has evaluated the planning process and implemented improvements to strengthen ongoing plan review and updates. The planning process has now been formally incorporated into the PPG meeting agenda, with dedicated time during in-person meetings to review progress, assess goals and objectives, and incorporate current data and community input. In addition, EHE Pillar Workgroups have been established to support the review and refinement of goals and objectives moving forward, ensuring a more structured and continuous quality improvement approach to plan implementation

III. Contributing Data Sets and Assessments

A. Data Sharing and Use

The SDDOH collects statewide HIV surveillance data using Maven and eHARS. HIV Surveillance collects, analyzes, interprets, and disseminates data for prevalence and incidence for the most recent completed calendar year (e.g., data dissemination of 2025 is provided in 2026).

The SDDOH Epidemiologic Profile of HIV, 1985 to 2024, published in Spring 2026, was used as a baseline for data for the Integrated Plan. Demographic data were used to be able to identify PLWH retention and viral suppression in the HIV Care Continuum. Stratifying data based on specific demographics such as race/ethnicity, risk factors (MSM, IDU), and age helps narrow the emphasis for populations of focus with continued health disparities that this Plan needs to address. Maps that use surveillance data to illustrate HIV incidence by county and viral suppression rates as a proportion provide a snapshot of areas where HIV transmission rate and disease burden are highest. Geographic data heat maps with overlay maps locating current medical care locations, as well as Native American reservation boundaries, also helped to understand where HIV care “deserts” may exist. Additionally, data collected from the HIV Prevention Plan was also used to strategize collaborative efforts between HIV Prevention and Care that would make the biggest impact.

B. Epidemiologic Snapshot

Before addressing the epidemiologic data of PLWH who reside in South Dakota, it is important to understand the geographic characteristics of the state. South Dakota is considered a frontier area. Frontier areas are extremely remote and sparsely populated parts of the rural–urban continuum, where residents often live far from healthcare, schools, grocery stores, and other essential services.

The state’s entire geographic boundary is 77,116 square miles, with over 12 percent of that being Native American reservation or trust land. The majority of South Dakota’s population resides in Sioux Falls and Rapid City, which are located at opposite ends of the southern part of the state. Due to this geographic makeup, South Dakota is also considered a rural state.

Information in this plan is based on the SDDOH’s Epidemiologic Profile of HIV and the 2026 Surveillance Report. As of December 31, 2025, 908 individuals diagnosed with HIV were known to be living in South Dakota. “Late testers” are defined as individuals who receive an AIDS diagnosis within 12 months of their initial HIV diagnosis; among those diagnosed between 2015 and 2024 in South Dakota, 16.1% met this definition. Since 2015, the state has reported an average of 37.8 cases annually, corresponding to an incidence rate of 4.1 per 100,000 population and a prevalence of 93 per 100,000 population. These rates place South Dakota among the states with the lowest HIV incidence in the nation. Demographic characteristics of South Dakotans living with HIV/AIDS as of December 31, 2025, are presented in Figures 1–10. Demographic characteristics of South Dakotans living with HIV/AIDS

Race and Ethnicity

Racial and ethnic disparities remain a prominent feature of the HIV epidemic in South Dakota. Although the state’s overall number of HIV cases is relatively low, the impact is disproportionately borne by certain populations. This is illustrated in Figures 1-4. Black/African American individuals make up about 2.0% of the state’s population but account for approximately 22% of HIV/AIDS cases. American Indian/Alaska Native populations represent roughly 9% of the population yet comprise about 20% of cases. Hispanic/Latino individuals, who constitute approximately 4–4.4% of the population, account for an estimated 12% of HIV/AIDS cases statewide.

These disparities reflect the uneven burden of HIV across racial and ethnic groups and emphasize the need for targeted, culturally responsive prevention and care efforts. Structural factors, including limited access to healthcare, stigma, socioeconomic conditions, and geographic barriers, contribute to these inequities. Many individuals within these populations are also more likely to live in rural or underserved areas, where access to HIV prevention, testing, and treatment services can be limited.

Reducing these disparities remains a priority for the SDDOH. Ongoing efforts will focus on expanding access to testing, prevention services such as PrEP, and timely linkage to care, while also strengthening partnerships with tribal communities, community-based organizations, and providers serving populations that are disproportionately impacted. These approaches are intended to decrease inequities and improve health outcomes for all South Dakotans affected by or at risk for HIV

Figure 1. Race

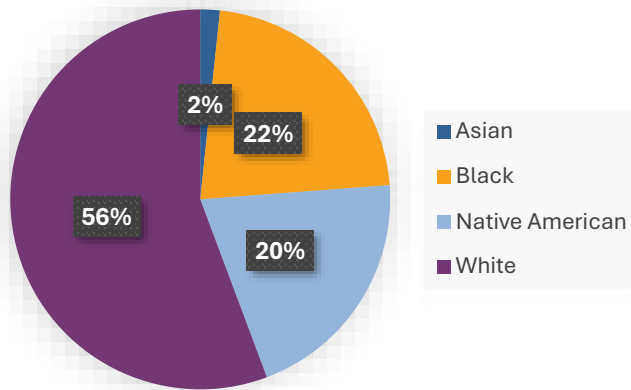


Figure 1. White individuals represented the largest proportion of prevalent HIV cases (54%), followed by Black (22%) and American Indian/Alaska Native individuals (21%). Asian and Other racial groups each accounted for approximately 1% of prevalent cases.

Figure 2 Ethnicity

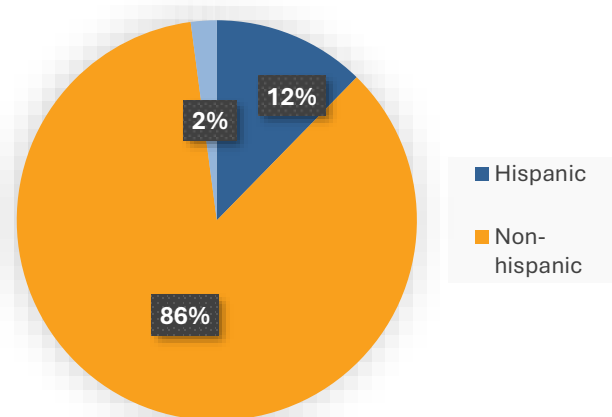


Figure 2. The majority of prevalent HIV cases in South Dakota were among individuals identified as non-Hispanic (86%), while Hispanic individuals accounted for 12% of cases. Ethnicity was unknown for 2% of persons living with diagnosed HIV.

Figure 3 Racial and Ethnic Disparities, SD, 2022-2024

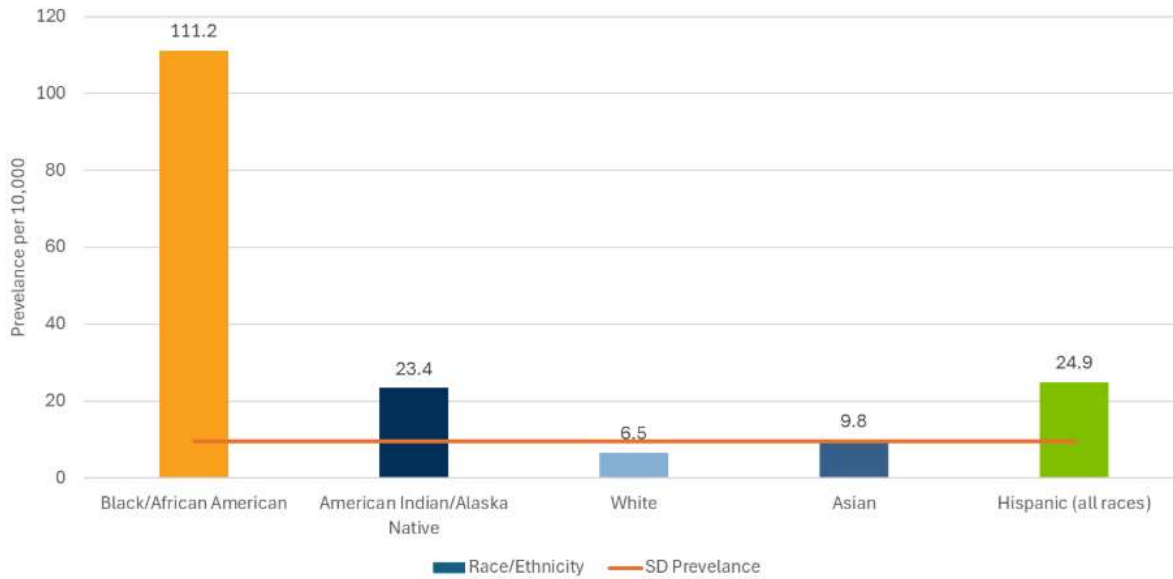


Figure 3. This figure illustrates disparities in HIV prevalence across racial and ethnic groups in South Dakota, with Black/African American, Hispanic, and American Indian/Alaska Native populations experiencing substantially higher prevalence rates than the statewide average and White population.

Figure 4. HIV/AIDS prevalence by Race, SD, 2022-2024

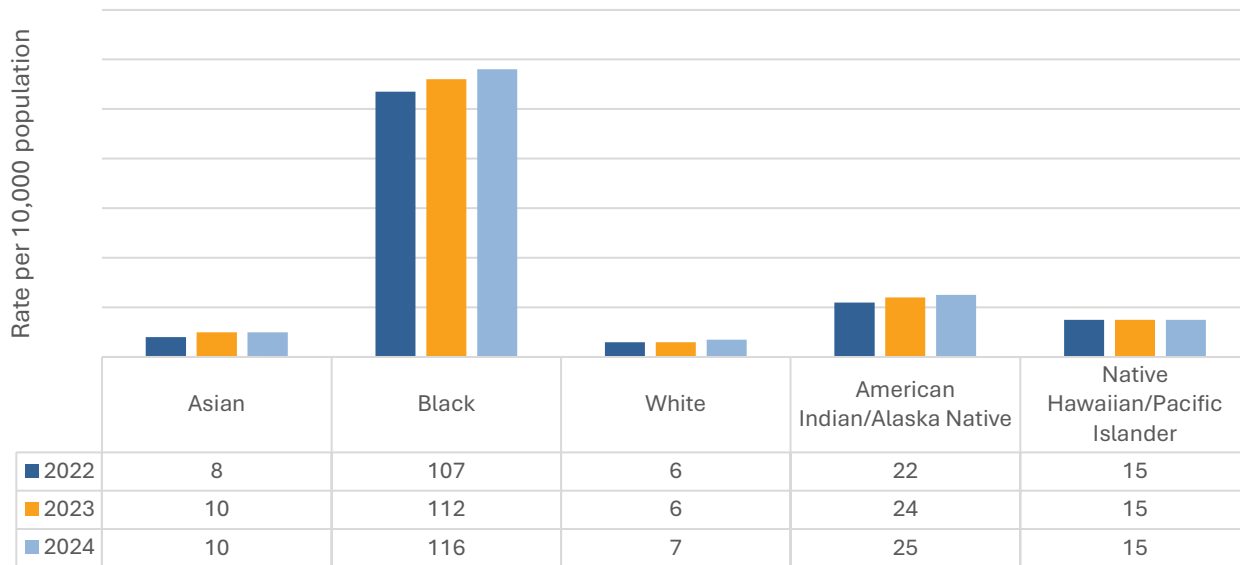


Figure 4. HIV prevalence rates increased slightly among most racial groups from 2022 to 2024. Black individuals consistently had the highest prevalence rates, while White individuals had the lowest, demonstrating ongoing racial disparities in HIV prevalence.

Gender

Gender differences continue to influence the HIV epidemic in South Dakota, with males accounting for the majority of diagnoses over time. Data from the gender distribution graphs show that men represent a substantially higher proportion of cases than women, consistent with national patterns and the ongoing impact of transmission among men who have sex with men and other higher-risk groups.

Although females account for a smaller share of overall cases, they remain an important focus for prevention and care efforts, particularly in relation to heterosexual transmission and overlapping risk factors.

The distribution of cases by gender (Figures 5 & 6) has remained relatively stable over time, with males continuing to experience the highest burden of disease. At the same time, the presence of cases among females underscores the need for sustained, targeted prevention strategies, including routine testing, timely linkage to care, and access to prevention services such as PrEP when appropriate. These findings highlight the importance of maintaining gender responsive approaches within HIV prevention and care programming.

The SDDOH will continue to use these data to guide strategies that address the specific needs of populations most affected by HIV while ensuring that services remain accessible and responsive to all individuals at risk for or living with HIV.

Figure 5. Gender

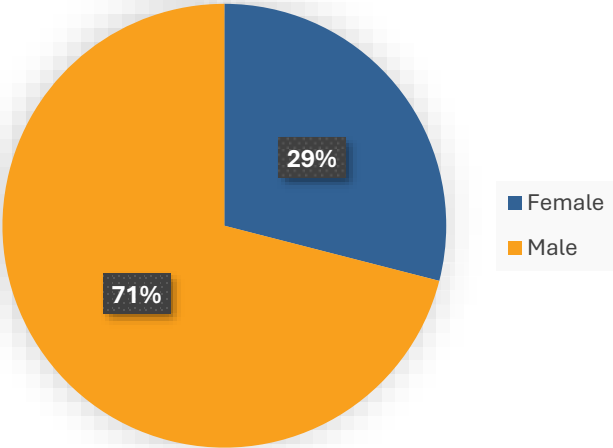


Figure 5. The majority of persons living with diagnosed HIV in South Dakota were male (71%), while females accounted for 29% of prevalent cases.

Figure 6. HIV/AIDS prevalence by gender, SD, 2022-2024

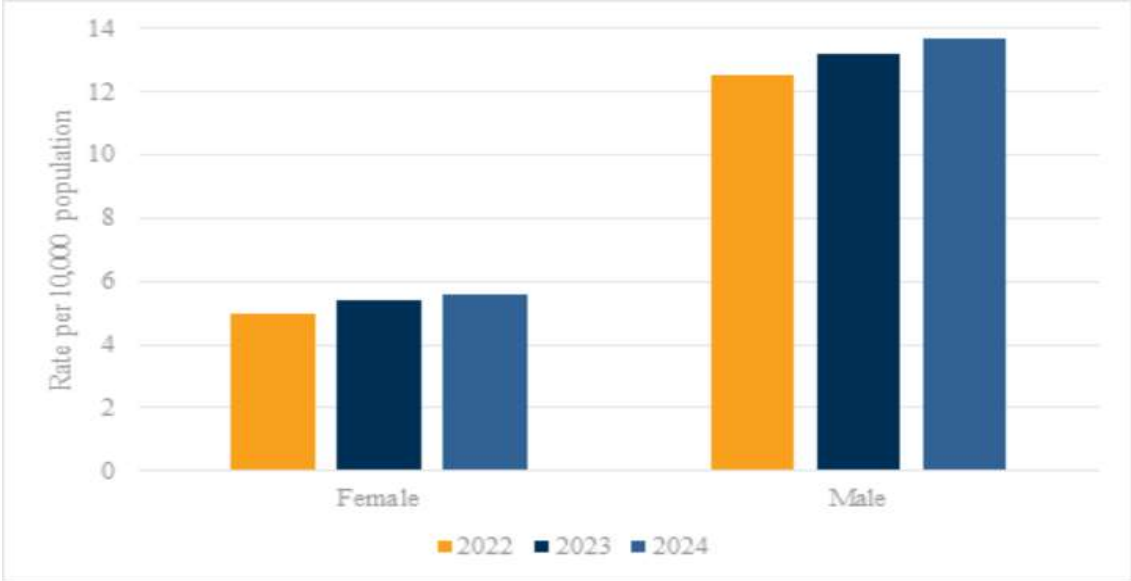


Figure 6. HIV prevalence rates increased slightly among both males and females from 2022 to 2024. Males consistently had higher prevalence rates than females throughout the period.

Age

Age-related trends in South Dakota’s HIV epidemic show that diagnoses are concentrated within specific adult age groups, with the greatest burden occurring among individuals in middle adulthood. Figures 7 and 8 identify that individuals aged 40 to 64 account for a substantial proportion of HIV cases, underscoring the continued impact of HIV among older adults. At the same time, cases are also identified among younger adults, highlighting the importance of prevention efforts across all stages of adulthood.

These patterns suggest that, although HIV prevention efforts have often emphasized younger populations, there is a continued need to engage older adults in testing, prevention, and ongoing care services. The higher prevalence observed in older age groups is also influenced by increased longevity among people living with HIV, reflecting the success of effective treatment and improved care. As individuals with HIV live longer, they make up a growing share of the overall population living with HIV. Additional contributing factors may include delayed diagnosis, lower perceived risk, and missed opportunities for routine screening. Younger populations also remain a key focus for targeted prevention strategies aimed at reducing new infections and supporting early diagnosis.

The SDDOH will continue to use age-specific data to inform prevention and care strategies, ensuring that services are appropriately tailored to meet the needs of both younger and older populations. These efforts support a comprehensive, lifespan approach to HIV prevention and care across the state.

Figure 7. Age Groups

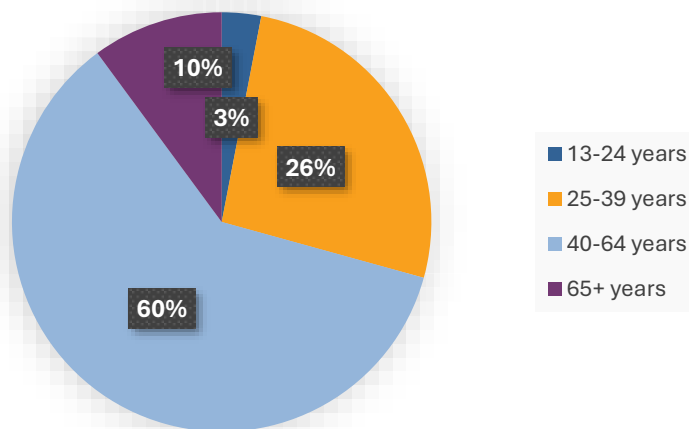


Figure 7. Most persons living with diagnosed HIV in South Dakota were aged 40–64 years (60%), followed by those aged 25–39 years (26%). Individuals aged 65 years and older accounted for 10% of cases, while those aged 13–24 years represented 3%.

Figure 8. HIV prevalence by age, SD, 2022-2024

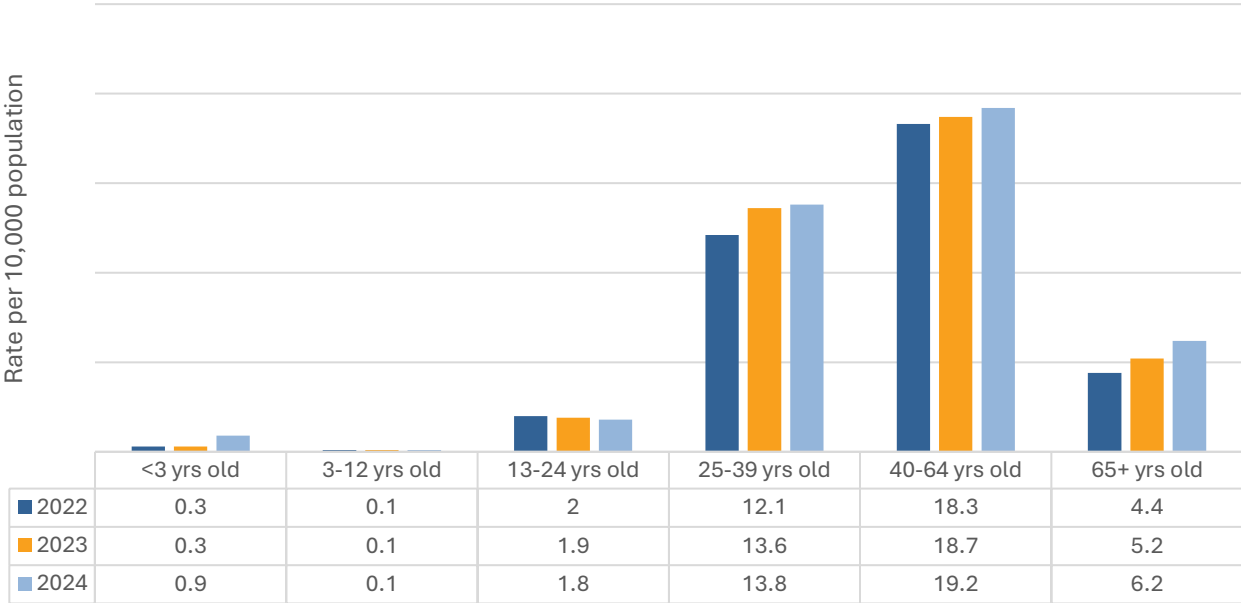


Figure 8. HIV prevalence rates were highest among individuals aged 40–64 years, followed by those aged 25–39 years. Prevalence increased slightly among most age groups from 2022 to 2024, while rates among younger age groups remained low.

Men who have sex with men

Men who have sex with men (MSM) continue to be a primary transmission category for HIV in South Dakota, as seen in Figure 9, consistent with national trends and highlighting the need for focused prevention efforts. Analysis of transmission categories shows that male-to-male sexual contact accounts for a substantial proportion of HIV cases, particularly among White individuals, where it represents the predominant route of transmission. As shown in Figure 10, approximately 78.7% of HIV cases among White individuals are attributed to male-to-male sexual contact, underscoring the significant impact of this transmission category within this population.

Although MSM remains a leading transmission category overall, patterns differ by race and ethnicity. Among Black/African American and American Indian/Alaska Native populations, heterosexual contact accounts for a larger share of transmission compared to male-to-male sexual contact. Even so, MSM transmission is present across all racial and ethnic groups, reinforcing the need for inclusive and culturally responsive prevention strategies. In addition, a notable proportion of cases are classified as having no identified risk factor, which may reflect gaps in data collection or reporting and indicates a need for continued investigation and strengthened surveillance practices.

These findings highlight the importance of prioritizing MSM in HIV prevention efforts, including expanding access to routine testing, increasing PrEP awareness and uptake, and addressing stigma and barriers to care. The South Dakota Department of Health will continue to use these data to inform targeted interventions and ensure prevention strategies effectively reach populations at highest risk for HIV transmission.

Figure 9. HIV/AIDS cases by transmission category, SD, 1985-2024

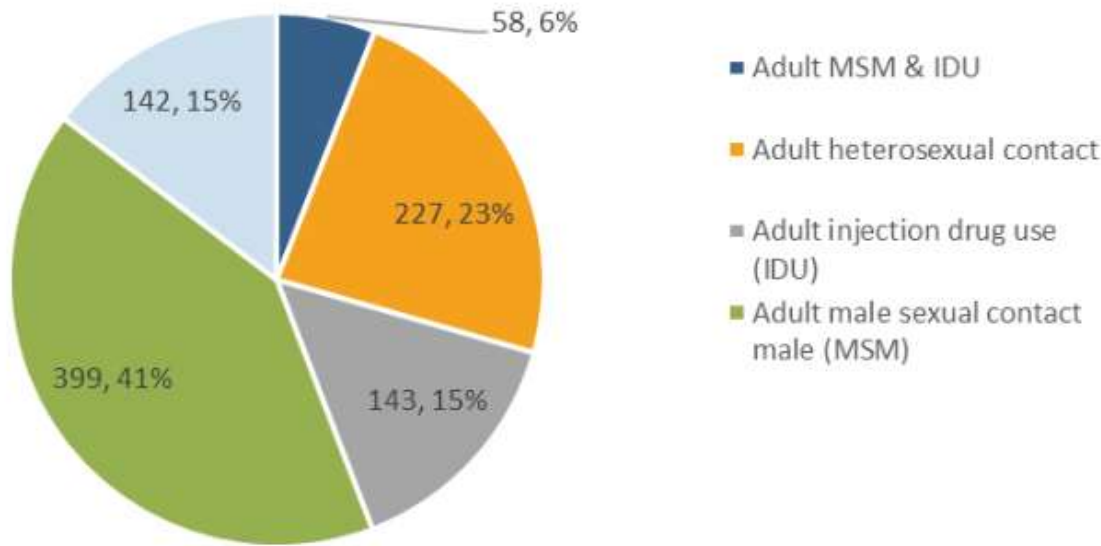


Figure 9. Male-to-male sexual contact (MSM) was the most common HIV transmission category, accounting for 41% of cases. Heterosexual contact represented 22% of cases, while injection drug use (IDU) and unknown transmission category each accounted for 15%. Cases attributed to both MSM and IDU comprised 7% of reported HIV/AIDS cases.

Figure 10. HIV/AIDS cases by transmission category- SD, 1985-2024

	American Indian/Alaska Native	Asian	Black	White
Adult MSM & IDU	31.03%	0.00%	1.72%	67.24%
Adult heterosexual contact	28.38%	1.35%	39.64%	30.18%
Adult Injection Drug Use (IDU)	39.72%	0.71%	7.09%	52.48%
Adult Male Sexual Contact Male (MSM)	14.47%	0.51%	6.35%	78.68%
Unknown	20.00%	2.86%	35.00%	42.14%

Figure 10. Illustrates that American Indians and Blacks have a higher chance of acquiring HIV by heterosexual contact, while MSM is the major route of acquisition for Whites. By looking at row percentages, we may conclude that the highest percentage of acquisitions by MSM route occurs among Whites (78.7%), while the highest acquisition by heterosexual route occurs among Blacks (50.87%). IDU as a route of transmission demonstrates that this route is the highest among Whites, followed by American Indians (52.48% and 39.72%, respectively).

Substance Use

Substance use continues to be an important factor influencing HIV risk and outcomes in South Dakota. Between 2021 and 2023, the United States experienced historically high levels of drug overdose deaths, with annual deaths exceeding 100,000 at their peak. Beginning in 2024, provisional national data indicate a substantial decline in overdose deaths, with decreases of approximately 24 to 27 percent and continued improvement suggested in early 2025. In contrast, South Dakota has experienced a slight increase during the same period, with state data indicating an increase in overdose deaths from 2023 to 2024, including 73

deaths reported in 2024. This divergence from national patterns highlights ongoing and emerging challenges related to substance use within the state and underscores the continued need to address substance use as a key component of HIV prevention and care efforts.

Drug overdose deaths disproportionately impact adults in early and middle adulthood. National data from the CDC indicate that in 2023, overdose death rates were highest among individuals ages 35 to 44, followed by those ages 45 to 54 and 55 to 64. Younger populations, including those ages 15 to 24, experienced the lowest rates of overdose death.

From 2023 to 2024, provisional data show declines in overdose death rates across all age groups, with the largest decreases observed among younger individuals ages 15 to 24. However, adults in the 35 to 64 age range continue to experience the highest burden of overdose mortality, highlighting the ongoing impact of substance use among working-age populations.

Substance use is associated with increased risk of HIV transmission through behaviors such as injection drug use and impaired decision making, which may lead to higher-risk sexual behaviors. In addition, individuals experiencing substance use disorders may face barriers to accessing healthcare, maintaining engagement in care, and achieving viral suppression. These challenges are often compounded in rural and frontier areas of South Dakota, where access to substance use treatment and harm reduction services may be limited.

The SDDOH recognizes the critical intersection between substance use and HIV and continues to prioritize coordination with substance use treatment providers, behavioral health services, and community-based organizations. Efforts include strengthening referral systems, improving provider awareness of available resources, and expanding partnerships to better support individuals at risk for or living with HIV who are also affected by substance use. Addressing substance use as part of a comprehensive, status-neutral approach remains essential to reducing new HIV transmissions and improving health outcomes across the state.

Alcohol use, including binge drinking, is an additional factor influencing HIV risk and care outcomes in South Dakota. Excessive alcohol use is associated with impaired judgment and increased likelihood of engaging in higher-risk sexual behaviors, which can elevate the risk of HIV transmission. Binge drinking, typically defined by the Centers for Disease Control and Prevention as consuming four or more drinks for women or five or more drinks for men on a single occasion, remains prevalent in the Midwest and in rural communities, see Figure 11. Individuals who engage in binge drinking may also experience challenges with medication adherence, retention in care, and sustained viral suppression.

Alcohol misuse can further compound existing barriers to care, particularly in rural and frontier areas where access to behavioral health services may be limited. In addition, alcohol use frequently co-occurs with other substance use, increasing overall risk and complexity of care needs. Addressing alcohol use as part of a comprehensive, integrated approach to HIV prevention and care is essential. This includes screening and brief intervention in clinical settings, strengthening referral pathways to treatment, and expanding partnerships with behavioral health and community-based organizations to support individuals at risk for or living with HIV.

Figure 11. Binge drinking prevalence among adults. South Dakota versus the United States, 2020-2023

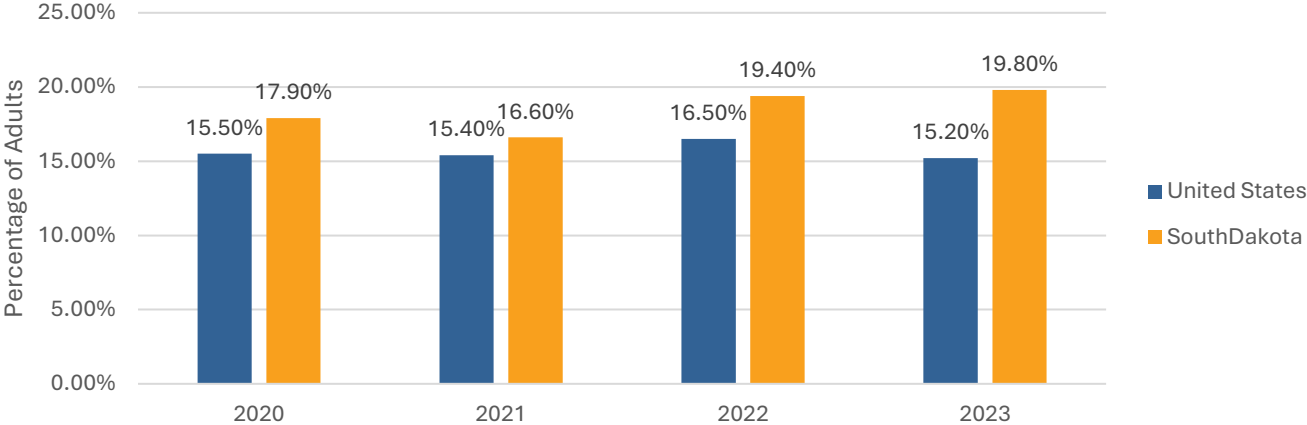


Figure 11. The prevalence of binge drinking among adults in South Dakota was consistently higher than the national average from 2020 to 2023. South Dakota rates increased over the period, reaching 19.8% in 2023 compared with 15.2% nationally.

Injection drug use, an important contributor to HIV transmission. According to the CDC, people who inject drugs accounted for approximately 7 percent of HIV diagnoses in the United States in the most recently published national data. In comparison, 17 percent of individuals diagnosed with HIV in South Dakota in 2025 reported injection drug use (Figure 12). This difference highlights the disproportionate impact of injection-related risk within the state and reinforces the need for integrated prevention, harm reduction, and treatment strategies.

Figure 12. Transmission risk reported by persons newly diagnosed with HIV, SD, 2022-2024

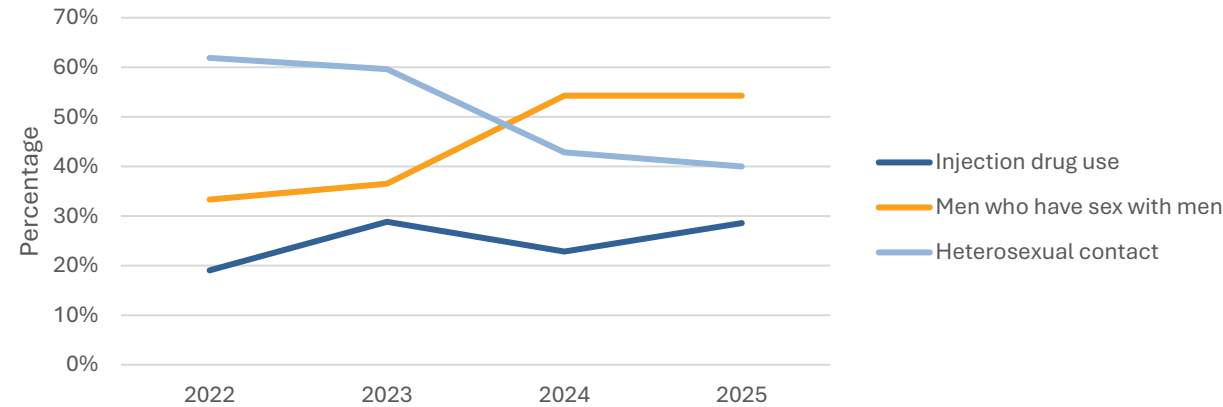


Figure 12. Heterosexual contact and men who have sex with men (MSM) were the most commonly reported transmission risks among newly diagnosed HIV cases. The proportion attributed to MSM increased over the period, while heterosexual contact declined. Injection drug use remained a less common but persistent transmission risk.

Refugee Population

As illustrated in Figure 13, the distribution of HIV diagnoses in South Dakota from 1985 to 2024 reflects both longstanding disparities and changing demographic patterns over time. Among newly diagnosed cases, 58% occurred among White individuals, followed by American Indian/Alaska Native populations at 22%, Black/African American individuals at 18%, Hispanic/Latino individuals accounted for 8%, and Asian populations at 2% of incident cases.

Although White individuals represent the largest share of cases in absolute numbers, Figure 14 shows that the rate of HIV diagnosis is disproportionately higher among Black/African American populations. The cumulative diagnosis rate is 647.6 per 100,000 for Black/African American individuals compared to 79.3 per 100,000 among White individuals.

Figure 13. Distribution of incident cases by race, SD, 1985-2024

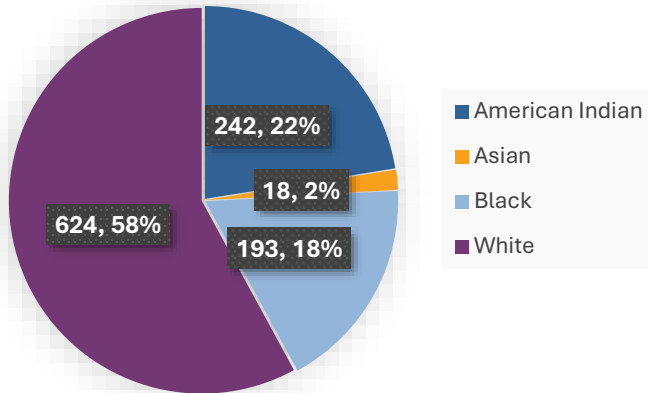


Figure 13. Individuals identifying as white accounted for the majority of incident HIV cases (58%), followed by American Indian individuals (22%) and Black individuals (18%). Asian individuals represented 2% of incident cases reported during this period.

Both Black males and females experience significantly higher rates of HIV compared to other racial and ethnic groups, highlighting persistent inequities in disease burden. Hispanic males represent the third-highest rate group, further emphasizing emerging disparities. In contrast, rates among White and Asian populations remain below the statewide average. These patterns demonstrate that while HIV impacts all populations in South Dakota, certain communities continue to experience a disproportionate burden.

Figure 14. HIV/AIDS Diagnosis and cumulative rates per 100,000 populations by race/ethnicity and sex, SD, 1985-2024

Race		Female	Rate for females	Male	Rate for males	Total	Rate for total
American Indian	Frequency	92	218.2	149	356.2	241	286.9
	Row Pct	38.17		61.83		22.5	
	Col Pct	33.21		18.63			
Asian	Frequency	8	78.9	10	113.2	18	94.9
	Row Pct	44.44		55.56		1.7	
	Col Pct	2.89		1.25			
Black	Frequency	83	651.5	110	644.7	193	647.6
	Row Pct	43.01		56.99		17.9	
	Col Pct	29.96		13.75			
White	Frequency	94	24.3	530	132.6	624	79.3
	Row Pct	15.06		84.94		57.9	
	Col Pct	33.94		66.25			
Total for all races	Frequency	277	61.3	800	171.2	1077	117.1

Ethnicity		Female	Rate for females	Male	Rate for males	Total	Rate for total
Hispanic	Frequency	20	90.9	64	258.4	84	179.6
	Row Pct	23.81		76.19		7.8	
	Col Pct	7.25		7.95			

Figure 14. HIV/AIDS diagnosis rates varied by race/ethnicity and sex, with the highest cumulative rates observed among Black and American Indian populations. Across most racial and ethnic groups, males experienced higher rates than females. These findings highlight persistent disparities in the burden of HIV/AIDS in South Dakota.

Recent data also suggest a demographic shift in the epidemic, particularly among Hispanic populations, which aligns with broader population changes in the state, including a 63% increase in the Hispanic population since 2013 (see Figure 15). In addition, the recent rise in reported HIV cases is largely driven by an increase in cases among Black/African American individuals. Although Black individuals represent only 3.2% of the state’s population, they account for 18% of HIV cases, highlighting persistent disparities.

A substantial proportion of these cases occur among non-U.S.-born individuals, with only 35% of cases among Black individuals occurring in U.S.-born residents. When non-U.S.-born individuals are excluded, the proportion of cases among Black populations decreases notably, underscoring the impact of migration and immigration patterns on the state’s HIV epidemiology.

Figure 15. Race of cases by date of HIV/AIDS diagnosis, SD, 1985-2024

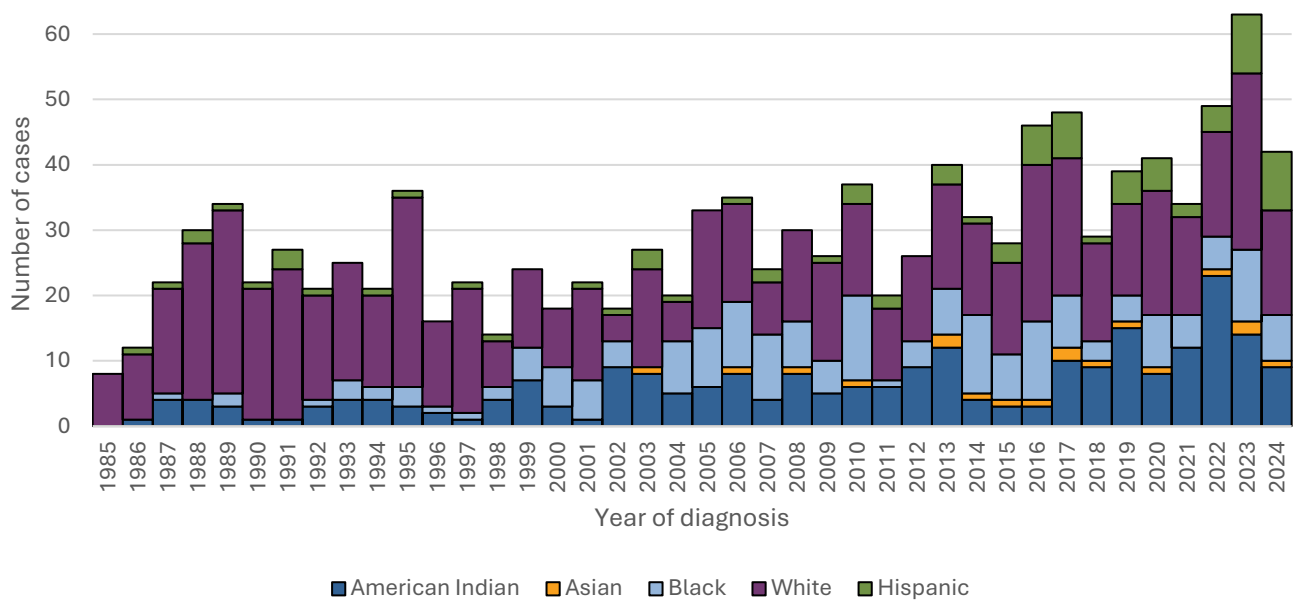


Figure 15. The annual number of HIV/AIDS diagnoses varied over time, with White individuals accounting for the largest proportion of cases in most years. Diagnoses among American Indian, Black, Hispanic, and Asian populations also occurred throughout the period, illustrating the ongoing impact of HIV across multiple racial and ethnic groups in South Dakota.

Overall, while the number of HIV cases among South Dakota residents has remained relatively stable over time, recent increases are primarily attributed to non-U.S.-born populations, which accounted for 18% of all reported cases from 1985 to 2024 and 23% of cases in the past decade (see Figure 16). These findings

reinforce the importance of culturally responsive, population-specific prevention and care strategies that address the unique needs of both long-term residents and newly arrived populations.

Figure 16. Number of cases by year of diagnosis and by place of birth, SD, 1985-2024

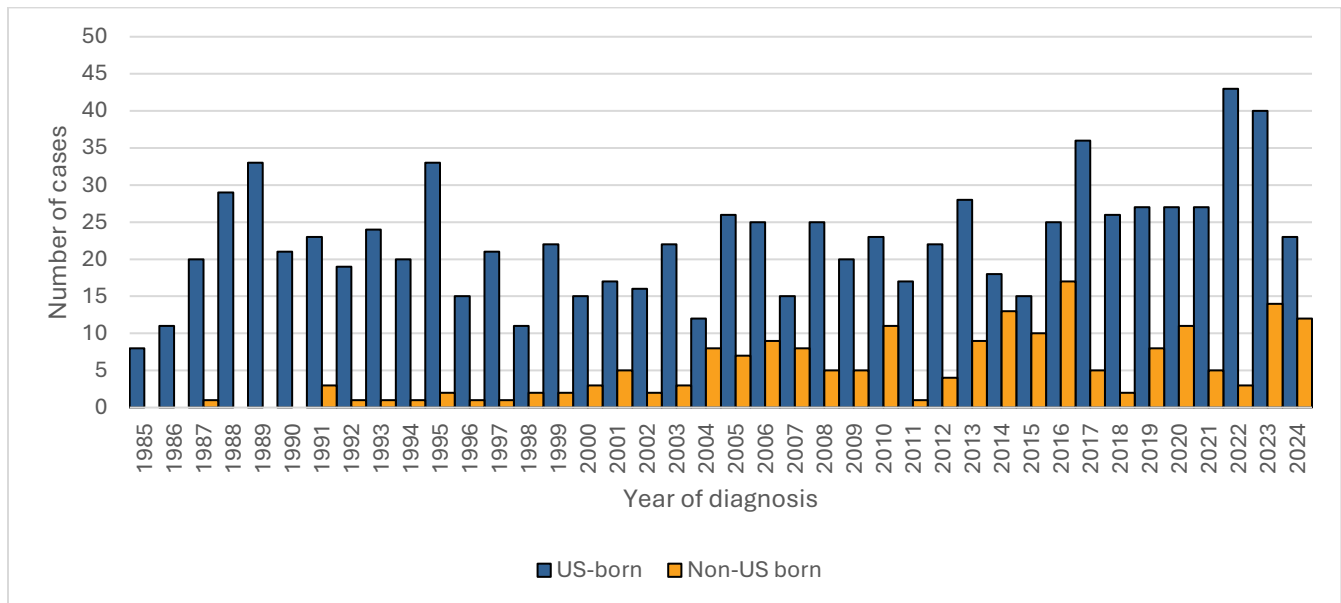


Figure 16. Most HIV/AIDS diagnoses in South Dakota occurred among U.S.-born individuals throughout the study period. However, the number of diagnoses among non-U.S.-born individuals increased over time, reflecting the growing diversity of populations affected by HIV in the state.

“Late Testers”

Late diagnosis of HIV continues to be a significant concern in South Dakota, as demonstrated by trends in simultaneous HIV and AIDS diagnoses. Simultaneous detection is a key indicator of late testing and is associated with more advanced disease at diagnosis and increased morbidity. As shown in Figure 17, the number of cases diagnosed with both HIV and AIDS at the same time has increased over the course of the epidemic, particularly after the early years (1984 to 1990). While the trend appears to stabilize somewhat between 2015 and 2019, the overall pattern indicates that late diagnosis remains an ongoing issue.

Figure 17. Number of reported cases by their diagnosis status, SD, 1985-2024

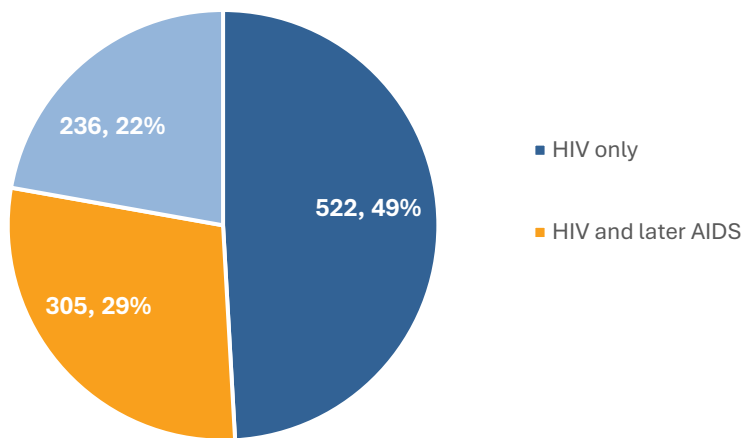


Figure 19. This pattern is further supported by Figure 18 (Late Testers), which illustrates the proportion of cases identified at a late stage. Figure 18 shows a gradual increase in the percentage of simultaneous HIV and AIDS diagnoses over time, with an average annual increase of approximately 0.22%. Although the rate of increase is modest, the persistent upward trend highlights continued gaps in early HIV detection and suggests that a portion of the population is not being reached through current testing strategies.

Late HIV Testing Among Newly Diagnosed Cases in South Dakota, 1985-2024.

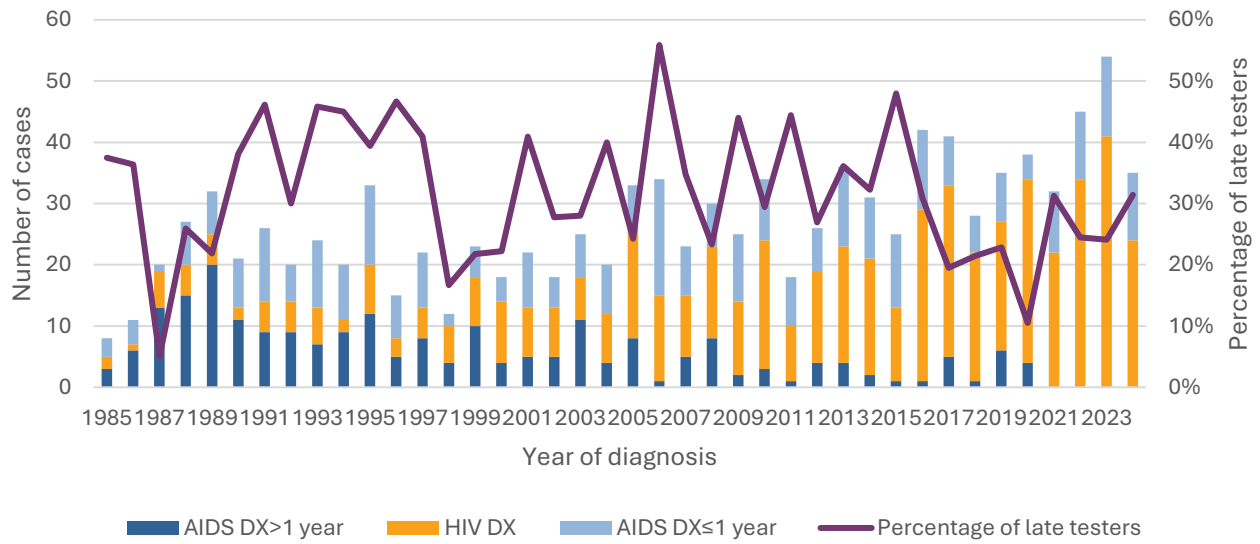


Figure 18. The proportion of individuals diagnosed with AIDS within one year of their HIV diagnosis varied over time, indicating fluctuations in late HIV testing. Despite annual variation, a substantial proportion of newly diagnosed individuals continued to be identified at a later stage of infection, highlighting the ongoing need for earlier HIV testing and diagnosis.

Figure 19. Percentage of simultaneous diagnosis with HIV and AIDS among all cases by year of reporting, SD, 1985-2024

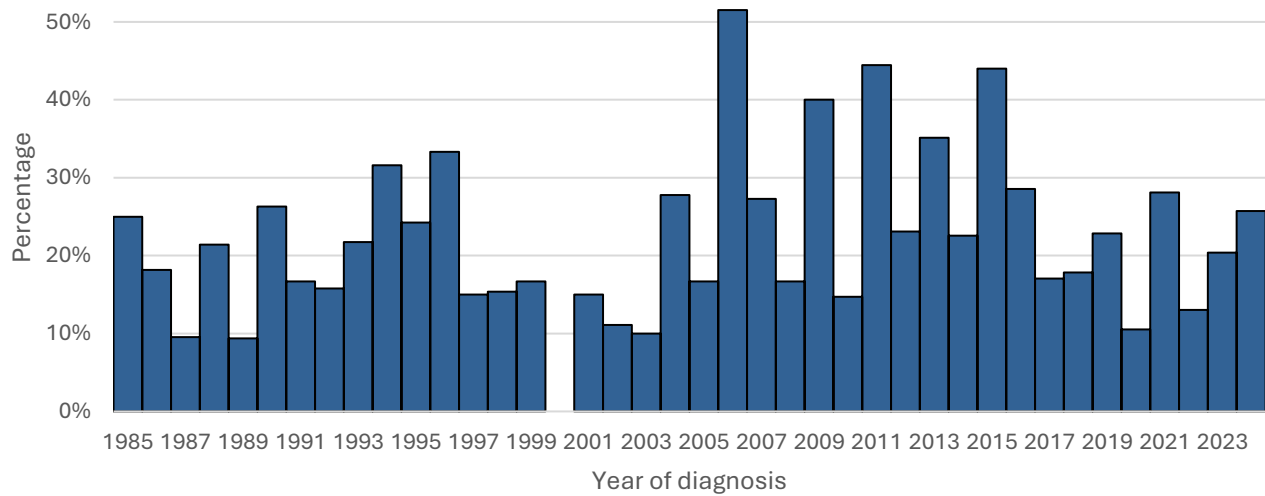


Figure 19. The percentage of cases diagnosed with HIV and AIDS simultaneously varied considerably over time, indicating fluctuations in the proportion of individuals diagnosed at a late stage of infection. These findings underscore the continued importance of timely HIV testing and early diagnosis.

At the same time, data indicate that early diagnosis leads to improved outcomes. As of December 31, 2024, approximately 51% of individuals diagnosed with HIV have progressed to AIDS, while a subset of individuals diagnosed in earlier years have not progressed even after 20 or more years, reflecting the

effectiveness of timely diagnosis and treatment. However, the continued presence of late testers underscores the need for expanded and targeted efforts.

Together, the data presented in Figures 17, 18, and 19 demonstrate that late diagnosis remains an ongoing challenge in South Dakota. These findings reinforce the importance of strengthening routine as well as opt-out HIV testing, increasing provider education, and expanding access to testing, particularly for populations at higher risk, to ensure earlier diagnosis and improved health outcomes.

Viral Suppression

The heat map illustrated in Figure 20 demonstrates the geographic distribution of viral suppression among people living with HIV in South Dakota. Areas shown in red represent a higher proportion of individuals with unsuppressed viral loads, while areas in blue represent a higher proportion of individuals who are virally suppressed.

Figure 20. South Dakota Heat Map of Viral Suppression

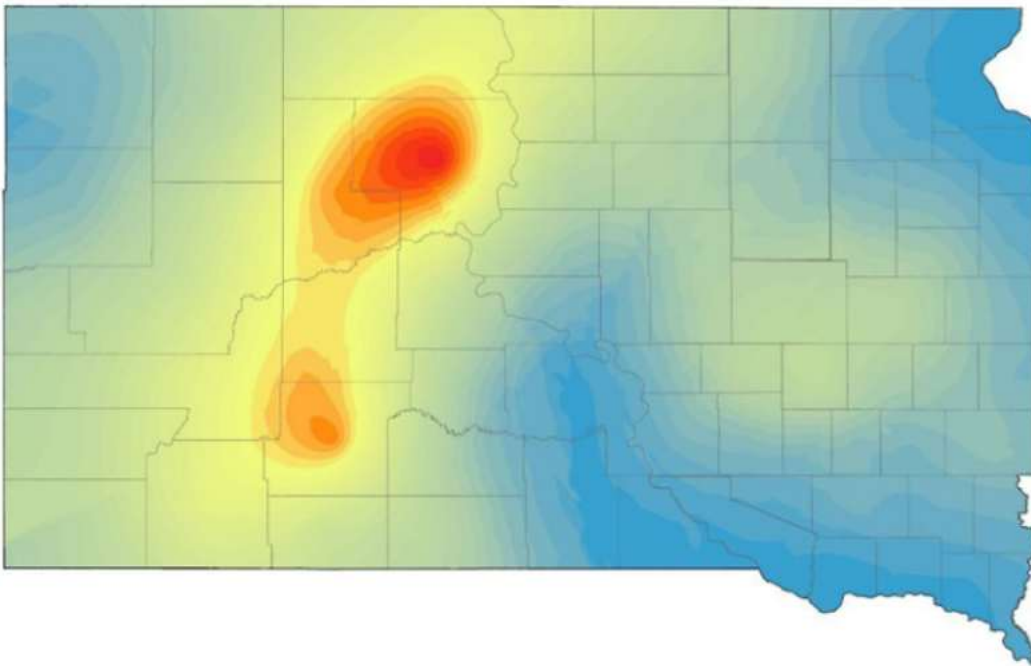


Figure 20. The incidence map in illustrates the rate of new HIV diagnoses across South Dakota counties, standardized per 10,000 population to allow for accurate comparisons regardless of county size. In this map, darker blue areas represent counties with higher rates of new HIV diagnoses, indicating where transmission is occurring more frequently relative to the population, while lighter blue areas reflect lower rates of new diagnoses. These rates are based on diagnoses from 2021 and 2023 county population estimates, providing a recent snapshot of HIV transmission patterns across the state.

Figure 21. New Diagnosis per 10,000, SD, 2021-2023

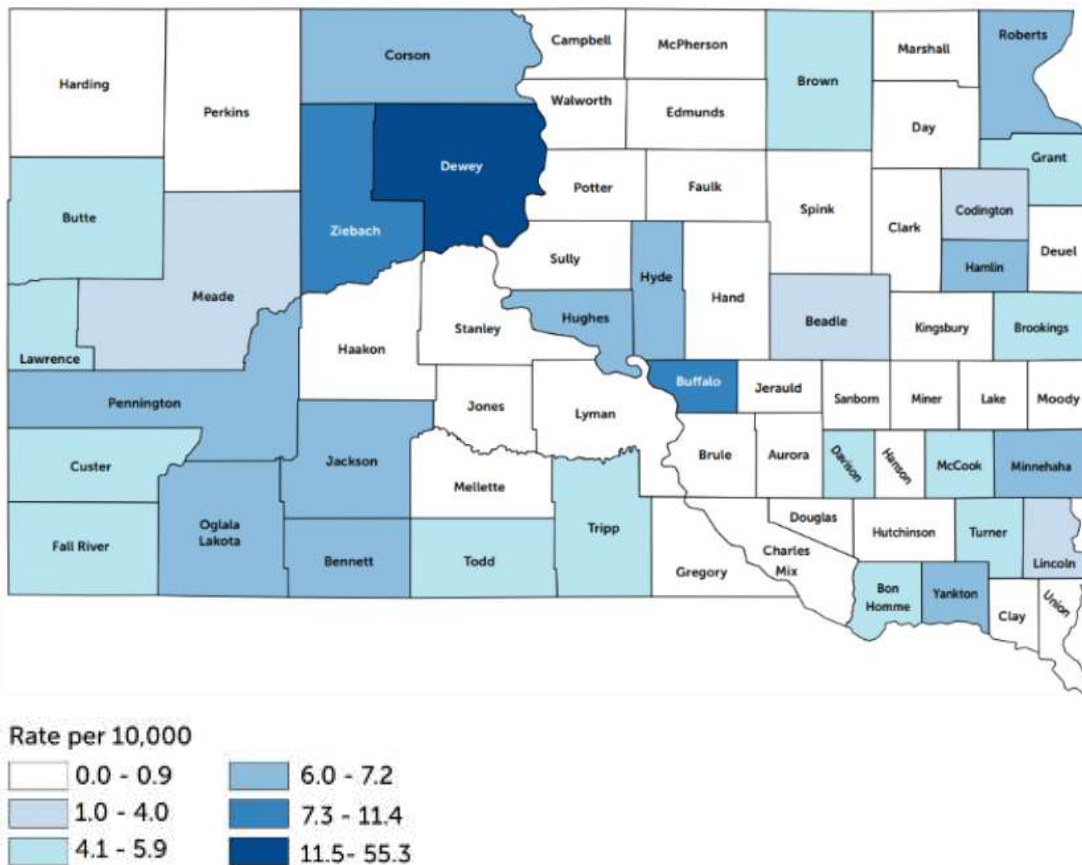


Figure 21. New HIV diagnosis rates varied across South Dakota counties during 2021–2023. Higher rates were concentrated in a limited number of counties, while many counties reported few or no new diagnoses. This geographic variation highlights the importance of targeted prevention, testing, and care efforts in areas with the greatest burden of new HIV infections.

From a public health perspective, counties with higher incidence rates may indicate more active transmission and potential gaps in prevention efforts, such as limited access to HIV testing, pre-exposure prophylaxis (PrEP), or other prevention services. When considered alongside viral suppression data, these higher-incidence areas often align with regions where fewer individuals are virally suppressed, reinforcing the connection between unsuppressed viral load and increased risk of transmission. Overall, the incidence map helps identify where new infections are occurring most frequently and supports targeted strategies to reduce HIV transmission in South Dakota.

The data presented in the maps demonstrates a relationship between areas with lower rates of viral suppression and higher rates of new HIV diagnoses across South Dakota. Counties shown in red, indicating a higher proportion of individuals with unsuppressed viral loads, tend to align with areas experiencing more recent HIV diagnoses, suggesting a strong correlation between lack of viral suppression and ongoing transmission.

This pattern is consistent with established public health evidence: individuals who achieve and maintain viral suppression (fewer than 200 copies/mL) do not transmit HIV sexually. Conversely, when viral loads remain elevated, the likelihood of transmission increases, contributing to new infections within the community.

The geographic overlap between unsuppressed viral load and higher diagnosis rates reflects underlying barriers to consistent HIV care. Viral suppression depends on sustained engagement in care, including access to antiretroviral therapy, regular medical visits, and supportive services. In areas where individuals face challenges such as limited healthcare access, transportation issues, housing instability, stigma, mental health concerns, or substance use, maintaining viral suppression becomes more difficult. These disruptions can lead to higher community viral load, which in turn fuels ongoing transmission.

Importantly, the data suggest that elevated viral loads are not simply the result of individual behavior, but rather indicators of broader structural and social determinants of health. Counties with lower suppression rates may lack adequate healthcare infrastructure or resources, creating conditions where people living with HIV are less able to remain engaged in care. This reinforces the need for targeted interventions that address both medical and social barriers.

Overall, the heat map and incident rates above demonstrate that improving viral suppression is not only critical for individual health outcomes but is also one of the most effective strategies for preventing new HIV infections. By focusing efforts on counties with lower suppression rates through expanded access to care, supportive services, and addressing social determinants, South Dakota can reduce new HIV diagnoses and move toward ending the HIV epidemic.

HIV Care Continuum

Figure 22. HIV Care Continuum



Figure 22. HIV care continuum outcomes in South Dakota remained stable from 2022 to 2024, with consistently high linkage to care (98%) and viral suppression (85%). Antiretroviral therapy (ART) showed a slight increase (93% to 94%), while retention in care remained relatively steady with a small decline from 93% to 92% in 2024.

Figure 23. HIV Care Continuum of all PLWH, SD, 2022-2024

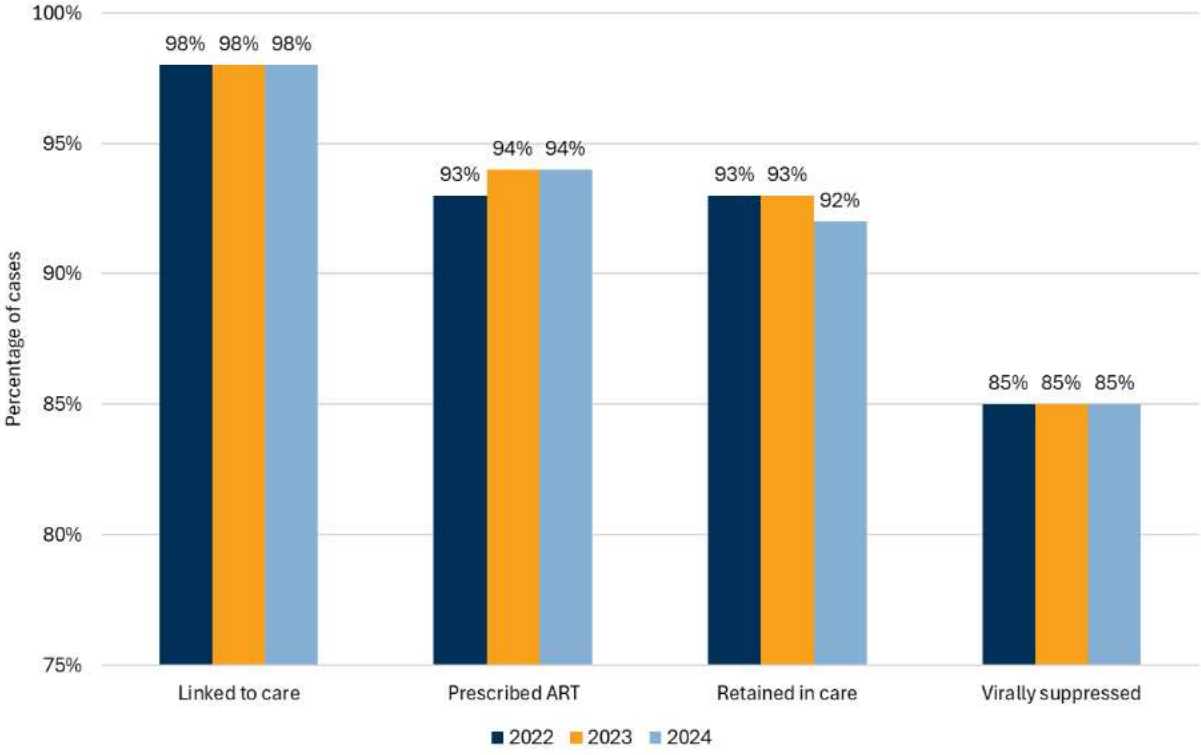


Figure 23. South Dakota maintained high levels of engagement across the HIV care continuum from 2022 to 2024. Linkage to care remained at 98%, while more than 90% of persons living with HIV were prescribed antiretroviral therapy and retained in care. Viral suppression remained stable at 85% throughout the period.

The HIV Continuum of Care, also referred to as the HIV care cascade, is a framework used to monitor the progression of individuals living with HIV from initial diagnosis through successful treatment and viral suppression. Each stage represents a critical point in the delivery of services and highlights opportunities to improve outcomes and reduce HIV transmission.

Diagnosis of HIV Infection

Diagnosis is the first step in the HIV care continuum and involves identifying individuals living with HIV through routine, targeted, or risk-based testing. Early diagnosis is essential for improving individual health outcomes and reducing onward transmission. Strategies to support timely diagnosis include routine opt-out screening in healthcare settings, community-based testing, mobile testing initiatives, and at-home self-testing options. Delays in diagnosis can occur due to limited access to testing, stigma, low perceived risk, and lack of routine screening in clinical practice.

Linkage to HIV Medical Care

Linkage to care refers to the process of connecting individuals newly diagnosed with HIV to a healthcare provider for HIV-related medical services, ideally within 30 days of diagnosis. Rapid linkage is critical to initiating antiretroviral therapy (ART) as soon as possible and improving long-term health outcomes. Effective linkage involves coordination between testing entities, Disease Intervention Specialists (DIS), case managers, and medical providers. Barriers to timely linkage may include geographic distance, limited provider availability, transportation challenges, and lack of awareness of available services.

Receipt of HIV Medical Care

Receipt of care indicates that an individual has accessed HIV medical services, typically measured by at least one documented HIV-related medical visit or laboratory test (such as CD4 or viral load testing) within a specified time period. This stage reflects initial engagement in the healthcare system following linkage. Ensuring access to care requires a sufficient network of providers, integration of services within healthcare systems, and support for navigating insurance and service eligibility.

Retention in Medical Care

Retention in care refers to the ongoing engagement of individuals in HIV medical services over time. It is commonly measured by having continued medical visits or laboratory tests each year. Sustained retention is essential for effective treatment, monitoring of health status, and prevention of disease progression. Barriers to retention may include transportation issues, housing instability, mental health and substance use challenges, stigma, and limited access to culturally responsive services. Supportive services such as case management, peer support, and access to essential resources play a critical role in maintaining engagement in care.

Achievement and Maintenance of Viral Suppression

Viral suppression is achieved when an individual's HIV viral load is reduced to fewer than 200 copies/mL through consistent use of antiretroviral therapy. Maintaining viral suppression is the ultimate goal of HIV treatment, as it leads to improved health outcomes, reduces morbidity and mortality, and eliminates the risk of sexual transmission (Undetectable = Untransmittable, or U=U). Achieving and sustaining viral suppression requires consistent access to medications, adherence to treatment, regular monitoring, and support services to address barriers such as cost, stigma, and social determinants of health.

Summary

Progression through each stage of the HIV Continuum of Care is essential for improving individual health outcomes and reducing HIV transmission at the population level. Gaps at any stage—whether in diagnosis, linkage, retention, or treatment—represent opportunities for targeted interventions and system improvements. Strengthening the continuum requires coordinated efforts across prevention, care, and support services, with particular attention to populations disproportionately impacted by HIV and those facing structural barriers to care.

C. HIV Prevention, Care, and Treatment Resource Inventory

Inventory Narrative

The SDDOH maintains a comprehensive and collaborative approach to identifying and coordinating HIV prevention, care, and treatment resources across the state. This resource inventory reflects a combination of federally funded programs, state-supported services, tribal partnerships, and community-based resources that together form the foundation of HIV service delivery in South Dakota. Recognizing the complexity and geographic challenges of the state, SDDOH has developed this inventory as a practical and evolving tool to support providers, partners, and individuals in accessing both HIV-specific services and essential support services such as transportation, housing, food, and behavioral health. The inventory is not intended to be exhaustive but serves as a strong starting point, informed by regional input and existing systems, and will continue to expand as new partners and opportunities are identified.

A key strength of the resource inventory is the integration of the 211 Helpline, a comprehensive and continually updated statewide platform that organizes services by category and geographic location. By leveraging 211, SDDOH avoids duplication of effort while enhancing accessibility to a wide range of

services beyond HIV care, including essential support services critical to successful health outcomes. This approach ensures that providers and clients can more easily navigate available resources and connect to needed services promptly.

SDDOH receives funding to provide HIV primary medical care and ART for PLWH through HRSA HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP), including Part B and ADAP funds. The SDDOH also receives HIV Prevention funding from the CDC, supporting statewide testing, prevention, and surveillance activities. Additional RWHAP Part C funding is available through a local community health center, further expanding access to clinical care services. South Dakota also benefits from RWHAP Part F funding through partnerships with the Community Healthcare Association of the Dakotas (CHAD) and the Mountain West AIDS Education and Training Center (MWAETC). These programs provide critical support through provider education, continuing education credits (CEUs), participation in ECHO® forums, HIV prevention medical provider coaching, and clinical technical assistance. SDDOH does not directly receive Housing Opportunities for Persons with AIDS (HOPWA) funding, highlighting the importance of leveraging partnerships and existing community resources to address housing and other essential needs.

Additional key partners include the Great Plains Area Indian Health Service (IHS) Office in Aberdeen, South Dakota, which works in conjunction with its 19 IHS and tribally managed service units to provide care to approximately 130,000 Native Americans across the region. SDDOH routinely collaborates with IHS on strategic planning, data sharing, and technical assistance. Disease Intervention Specialists (DIS) also provide support to these service units as needed, strengthening coordination and service delivery. The Great Plains Tribal Leaders Health Board further contributes through its Behavioral Health Department, which serves multiple tribes in South Dakota by providing mental health services, substance use treatment, and addiction counseling across several locations. In addition, the South Dakota Department of Social Services Division of Behavioral Health supports prevention efforts through regional prevention resource centers that provide materials, training, and technical assistance.

Together, these resources and partnerships illustrate a coordinated, multi-system approach to HIV prevention and care in South Dakota. By leveraging federal funding, strengthening Tribal and community partnerships, and utilizing tools such as the 211 Helpline, SDDOH continues to enhance access to both clinical and supportive services, particularly in rural and underserved areas of the state.

Strategy for Coordinating the Provision of Substance Use Prevention and Treatment Services

The SDDOH has previously identified coordination with substance use treatment and behavioral health services as a critical component of comprehensive HIV prevention and care. During the update of the State's Cluster Detection and Response (CDR) Manual, gaps in service awareness and coordination were recognized as ongoing barriers to effective prevention, linkage to care, and sustained engagement in treatment. In response, SDDOH prioritized the development of a comprehensive resource inventory to support field staff, including DIS and partner agencies, in identifying and connecting clients to appropriate services across the continuum of care (see Table 2).

Recognizing the geographic diversity of South Dakota, SDDOH developed region-specific resource inventories aligned with the Office of Disease Prevention (ODP) field office regions. This approach acknowledges that resource availability varies significantly across the state. While more populated areas may offer a broader range of medical, behavioral health, and substance use treatment services, many rural and frontier counties have limited or no access to these resources. The regional inventory process allowed SDDOH to systematically identify available services, including medical providers, Ryan White programs, tribal health organizations, correctional facilities, substance use treatment centers, and community-based organizations, and, importantly, to highlight gaps in care and service availability.

Through this effort, the SDDOH has developed a clearer understanding of disparities in access to substance use treatment and supportive services, particularly in underserved areas. The inventory has become an important tool for improving coordination between HIV prevention, care, and behavioral health systems by increasing provider awareness of available resources and supporting more effective referral processes.

These findings continue to guide strategic planning efforts, with an emphasis on strengthening partnerships, expanding service availability where feasible, and improving linkage to care across all regions of the state. These activities directly support the goals of the Integrated HIV Prevention and Care Plan by enhancing system coordination, improving access to comprehensive services, and addressing structural barriers that affect health outcomes for individuals at risk for or living with HIV.

Table 2. South Dakota Community Organizations and Facilities by ODPS Regions

<i>West Region ODPS Field Office</i>		
Organization	Facility	Funding
Medical Organizations	Oyate Health Center, Complete Health, Pine Ridge IHS Service Unit, Monument Health Family Medicine Residency Clinic	IHS, federal programs, grants, and private donations.
Ryan White Organizations	Heartland Health Resource Center – Rapid City Ryan White Part B Services	Ryan White HIV/AIDS Program Related Funding
Tribal Organizations	Great Plains Tribal Leaders’ Health Board, Oglala Sioux Tribe Health Administration	IHS, grants, third-party revenue
Correctional Facilities	Pennington County Jail, Oglala Sioux Tribe Department of Corrections	Grants, federal funds, state funds, and local taxes
Substance Abuse Treatment Facilities	Care Campus	State of South Dakota-DSS
Community Organizations	West River HIV Health Network, Cornerstone Rescue Mission	Contributions and grants
<i>Pierre ODPS Field Office (Main Regional Office) Mobridge ODPS Field Office</i>		
Organization	Facility	Funding
Ryan White Organizations	Heartland Health Resource Center – Rapid City & Sioux Falls Ryan White Part B Services, Sioux Falls Department of Health/Falls Community Health Ryan White Part C Services	Ryan White HIV/AIDS Program Related Funding
Tribal Organizations	Great Plains Tribal Leaders’ Health Board, Cheyenne River Sioux Tribal Health Dept., Standing Rock Sioux Tribal Health Administration	IHS, grants, third-party revenue

Correctional Facilities	Lower Brule Detention Center, Rosebud Sioux Tribe Adult Corrections, Winner City/Tripp County Jail, Cheyenne River Detention Center, Standing Rock Corrections, Hughes County Jail, South Dakota Women’s Prison	State and federal funds, local taxes
Substance Abuse Treatment Facilities	Capital Area Counseling Services, South Dakota Urban Indian Health-Pierre, Northeastern Mental Health Center	IHS, state and federal funds, and insurance
Community Organizations	House of Hope (Domestic Violence Shelter), Midwest Street Medicine	State and federal funds

***Aberdeen ODPS Field Office (Main Regional Office)
Watertown ODPS Field Office***

Organization	Facility	Funding
Ryan White Organizations	Heartland Health Resource Center – Sioux Falls Ryan White Part B Services, Sioux Falls Department of health/Falls Community Health Ryan White Part C Services	Ryan White HIV/AIDS Program Related Funding
Tribal Organizations	Great Plains Tribal Leaders’ Health Board	IHS, grants, third-party revenue
Correctional Facilities	Aberdeen Brown County Jail, Brookings County Detention Center, Faulk County Jail, Beadle County Correction Center, Roberts County Detention Center, Coddington County Detention Center	State and federal funds, local taxes
Substance Abuse Treatment Facilities	NADRIC Addiction Services, Dakotah Pride Center, Great Plains Youth Regional Treatment Center	IHS, state and federal funds, and insurance
Community Organizations	Human Services Agency	HRSA, SAMHSA, HHS grants

***Sioux Falls ODPS Field Office (Main Regional Office)
Mitchell ODPS Field Office***

Organization	Facility	Funding
Ryan White Organizations	Heartland Health Resource Center – Sioux Falls Ryan White Part B Services, Sioux Falls Department of Health/Falls Community Health Ryan White Part C Services	Ryan White HIV/AIDS Program Related Funding
Tribal Organizations	Great Plains Tribal Leaders’ Health Board	IHS, grants, third-party revenue

Correctional Facilities	South Dakota State Penitentiary, Minnehaha County Jail	State funds
Substance Abuse Treatment Facilities	Keystone Treatment Center, Lewis and Clark Behavioral Health, Sioux River Mental Health Services	State funds, private insurance, SAMHSA, grants, South Dakota Community Foundation
Community Organizations	Midwest Street Medicine, Bishop Dudley Hospitality House, Union Gospel Mission, St. Francis House	Helmsley Charitable Trust, grants, federal community development funds

How Services Will Maximize the Quality of Health and Support Services Available to Persons at Risk for or with HIV

South Dakota maximizes the quality of health and support services for persons at risk for or living with HIV through a coordinated approach that integrates high-impact HIV prevention strategies, a comprehensive resource inventory, and targeted training for DIS and sub-recipient partners. The updated resource inventory serves as a central tool to support linkage to care, enabling DIS and partners to quickly identify and refer clients to appropriate services, including HIV medical care, antiretroviral therapy, and HIV prevention services such as PrEP. The inventory is designed to be user-friendly and searchable by service type, allowing providers to efficiently connect clients to behavioral health and substance use disorder services, as well as essential social supports such as housing, food assistance, transportation, and financial assistance, all of which are critical to reducing barriers to care and improving health outcomes.

DIS and partner agencies utilize the resource inventory as part of routine client engagement, ensuring that individuals are not only linked to HIV testing and treatment services but also connected to comprehensive support systems that promote retention in care and viral suppression. This approach reflects high-impact HIV prevention by prioritizing evidence-based interventions, targeting resources to populations and geographic areas with the greatest need, and addressing social determinants of health that contribute to HIV risk and poor outcomes. Ongoing training and technical assistance are provided to ensure DIS and partners remain knowledgeable about available resources and emerging service gaps, strengthening their ability to deliver timely and effective referrals.

In addition to the state resource inventory, providers and clients are encouraged to utilize the 211 Helpline Center, a statewide, centralized resource that connects individuals to a wide range of health and human services. Available 24/7 via phone, text, or online search, 211 offers a comprehensive, regularly updated database of local services, including housing assistance, food resources, behavioral health services, financial support, and healthcare access. DIS and partner agencies incorporate 211 into referral practices to ensure clients have multiple pathways to access services, particularly in rural or underserved areas where local resources may be limited. The Helpline Center also provides personalized assistance, helping individuals navigate complex service systems, including benefits navigation, and identify resources that best meet their needs.

Although many of these services are available, geographic disparities persist, particularly in more rural regions where some resources are limited. The SDDOH, in collaboration with partners, routinely assesses these gaps and works to identify strategies to expand services, strengthen referral networks, and improve access across underserved areas.

Together, these efforts ensure a more responsive, data-informed, and equitable system of care that supports both prevention and treatment, ultimately improving access, engagement, and health outcomes for individuals at risk for or living with HIV in South Dakota.

Assessment of Strengths and Gaps

Evaluation of resource inventory identified gaps and strengths, opportunities for capacity building, as well as general underutilization of services.

Gaps

Qualitative data and ongoing engagement with partners across South Dakota indicate significant gaps in the availability and accessibility of both HIV prevention and care services, as well as essential support services such as transportation, food assistance, and housing—particularly in rural and frontier counties. Stakeholders consistently report that resources in these areas are limited and, in some cases, not available at all, requiring individuals to travel long distances to access not only HIV-related services but also the basic supports necessary to remain engaged in care. These geographic and structural barriers contribute to challenges in maintaining consistent treatment adherence, which is reflected in lower rates of viral suppression in more rural parts of the state. The overall provider network is also limited, with few contracted providers offering HIV-specific services, and FQHCs in these areas are not currently integrated as key partners in the HIV prevention and care system. Together, these gaps highlight the need for expanded infrastructure, stronger partnerships, and targeted strategies to ensure equitable access to both clinical and supportive services statewide.

Strengths

A key strength of the current resource inventory is the inclusion of 211 Helpline as a comprehensive and continually updated platform that supports both providers and individuals in identifying available services across South Dakota. The 211 system serves as a centralized, user-friendly resource that organizes services by category, such as healthcare, transportation, food, and housing, and by geographic location, making it easier to navigate and access needed supports. Its ongoing maintenance and regular updates ensure that information remains current and relevant, which is especially critical in a landscape where services may change frequently. This level of organization and accessibility enhances coordination across systems of care and helps connect people to both HIV-related services and essential support services, strengthening the overall service delivery network statewide.

Geographic Landscape

South Dakota's resource inventory demonstrates key strengths, including strong statewide coordination, established public health partnerships, and the ability to align prevention and care efforts across systems. However, the state's predominantly rural and frontier landscape presents persistent challenges. Large geographic distances, limited transportation infrastructure, and sparse provider availability create barriers to consistent access to HIV testing, PrEP, and ongoing care—particularly in tribal communities and remote areas. These factors contribute to gaps in service coverage and can delay linkage to care or prevention services, underscoring the need for expanded mobile services, telehealth, and locally accessible resources.

Capacity Building

The SDDOH continues to build capacity for HIV prevention, care, and essential support services through a multifaceted approach focused on workforce development, partnership expansion, and system coordination. Efforts include training DIS to not only support HIV-related services but also to effectively identify and refer clients to essential support services such as transportation, food, and housing, ensuring a more holistic approach to care. Additional training is provided with benefits navigators

to strengthen linkage to insurance and supportive resources, as well as ongoing education on PrEP to expand prevention knowledge and access across the provider network. Capacity building also includes strengthening partnerships with tribal communities through monthly calls with all nine federally recognized tribes in the state, as well as quarterly engagement with the Great Plains Tribal Leaders Health Board to support collaboration and culturally responsive service delivery. Furthermore, the SDDOH is working with CHAD to expand HIV prevention and care services within FQHCs, particularly in areas experiencing increases in new diagnoses and lower viral suppression rates. Together, these efforts enhance the ability of the system to respond effectively to HIV while improving access to both clinical and supportive services statewide.

Cluster and Outbreak Response

The state has strengths in its use of surveillance data, partner services, and coordinated response efforts to identify and respond to HIV clusters and potential outbreaks. Established communication channels and collaboration with Regional Offices and DIS and Tribal partners support targeted interventions when clusters are detected. However, gaps remain particularly in rural areas where resources and workforces are limited. These limitations can delay detection and response to emerging clusters, increasing the risk of continued transmission. Strengthening real-time data systems, enhancing local response capacity, and expanding culturally responsive outreach will be critical to improving South Dakota's ability to quickly identify, investigate, and contain HIV clusters and outbreak occurrences.

Underutilization

Assessment of service utilization indicates that PrEP remains underutilized across South Dakota. Qualitative findings from partner engagement and program review identified consistently low referral rates for PrEP services. Several key barriers contribute to this gap, including a limited number of providers willing or able to prescribe PrEP, low perceived risk among clients who may benefit from its use, and gaps in knowledge among DIS regarding appropriate referral pathways. To address these challenges, the SDDOH is taking steps to expand access by incorporating national telehealth PrEP providers as a strategy to reach underserved areas and populations. Additionally, the SDDOH is exploring opportunities to formalize partnerships with these telehealth agencies to improve access to services and enhance the collection and integration of PrEP utilization data. These efforts aim to reduce barriers, increase awareness, and improve uptake of PrEP as a critical HIV prevention strategy.

Approaches and Partnerships

The SDDOH utilized a collaborative and iterative approach to complete the HIV prevention, care, and treatment resource inventory, ensuring representation from partners with direct knowledge of local service landscapes. A key component of this process was the engagement of the SDDOH regional office staff across the state, with firsthand experience and established relationships with local providers and community-based organizations that were instrumental in identifying existing services and assessing capacity. By leveraging the expertise of these regional teams, the SDDOH was able to capture a more accurate and geographically relevant picture of available resources, including both HIV-specific services and essential support services.

In addition to internal collaboration, the inventory development process incorporated input from a range of partners, including healthcare providers, community-based organizations, tribal partners, and emerging stakeholders identified through ongoing outreach and engagement efforts. This included both longstanding partners and new collaborators, particularly in areas where service gaps or increased need have been identified. The SDDOH recognizes that service capacity is dynamic, and as such, the inventory is not intended to be an exhaustive list, but rather a strong foundational tool that reflects current known resources while allowing for continued expansion.

Importantly, the SDDOH intentionally leveraged existing infrastructure, including the 211 Helpline. The ability to utilize 211 avoided duplications of effort and enhanced the inventory by aligning it with a trusted, user-friendly resource already widely used by providers and communities. The SDDOH acknowledges that as outbreaks, clusters, and emerging needs arise, additional partners and service opportunities may be identified, and the inventory will continue to evolve accordingly. This flexible and collaborative approach ensures the inventory remains a relevant and practical tool for supporting HIV prevention, care, and treatment efforts across South Dakota.

D. Needs Assessment

The South Dakota Department of Health utilized multiple needs assessment activities to inform the development of goals and objectives for the CY 2027–2031 Integrated HIV Prevention and Care Plan. These efforts included engagement with key stakeholders, individuals with lived experience, and healthcare providers to ensure a comprehensive understanding of system strengths, gaps, and emerging needs. The Prevention Planning Group (PPG) participated in a SOAR (Strengths, Opportunities, Aspirations, and Results) analysis focused on HIV prevention and care, which provided a structured, strengths-based approach to identifying priorities, opportunities for growth, and desired outcomes across the continuum. In addition, the Ryan White Part B Program conducted a consumer satisfaction survey to assess the experiences, needs, and barriers faced by people living with HIV who are currently receiving services, with particular attention to access, quality of care, and essential support services.

To further assess system capacity, the HIV Program partnered with the Community Healthcare Association of the Dakotas (CHAD) to administer a provider survey, which gathered critical input from healthcare providers on their ability to deliver HIV prevention and care services. This survey identified key barriers such as limited time, training needs, and challenges related to PrEP prescribing and referral pathways. While a targeted consumer survey focused on vulnerable populations was not completed during this assessment period, the SDDOH recognizes this as a critical gap. Plans are in place to conduct this assessment by the end of 2027, with findings to be incorporated into future updates of the Integrated Plan.

Together, these complementary assessment activities provide a robust, multi-perspective understanding of needs across prevention, care, and service delivery systems, ensuring that the goals and objectives outlined in this plan are data-driven and responsive to both client and provider experiences.

SOAR Analysis Narrative Summary

The SOAR analysis conducted by the PPG explored key questions to identify strengths, opportunities, aspirations, and results to answer the guiding question: What is the health and well-being of South Dakotans currently living with HIV/AIDS and/or at risk of developing the disease? These findings provided key perspectives on understanding what is working well and opportunities for the future.

Strengths: What is working well to advance the health and well-being of South Dakotans currently living with HIV/AIDS and/or at risk for developing the disease?

The program is strengthened by passionate staff, including an HIV Program Leader, Ryan White coordinators, dedicated DIS, providers, a program manager, and a collaborative care team. Strong relationships and collaborations—among the SD DOH, IHS, FQHCs, Falls Community Health, Ryan White partners, and newly diagnosed people living with HIV (PLWH)—support seamless referrals and coordinated care. There is growing mental health awareness and resources, with increased dialogue, reduced stigma, and improved access for PLWH. Robust community support is evident through rapid testing in local communities and effective CBO engagement. Increased access to care has been achieved through faster linkage to services and improved medication availability, with organizations like Heartland Health and Falls Community Health filling early gaps. Additionally, support for social drivers of health

This structured, strengths-based planning activity also focused on identifying key themes across the four pillars (diagnose, treat, prevent, and respond) for actionable, intersection strategies of HIV prevention and care continuum.

Diagnose

SOAR findings in the Diagnose category emphasized the need to expand targeted HIV testing strategies, particularly among rural and American Indian populations. Opportunities identified included increasing culturally responsive outreach, improving access to testing in remote areas, and enhancing data-driven approaches to identify priority populations.

Treat

In the Treat category, the SOAR analysis highlighted the importance of reducing disparities in viral suppression and improving access to mental health and substance use services. Participants identified opportunities to strengthen care coordination, improve documentation of co-occurring conditions, and expand support services to ensure sustained engagement in care including peer support groups.

Prevent

Prevention-focused findings emphasized the need for targeted PrEP campaigns and increased awareness among communities with higher incidence rates. Barriers identified included limited awareness, stigma, and lack of access to providers. Opportunities include expanding culturally tailored messaging and increasing provider training.

Respond

In the Respond category, the SOAR analysis identified opportunities to strengthen data systems, improve rapid response to clusters and outbreaks, and enhance collaboration with community and tribal partners. Participants emphasized the importance of reducing disparities and improving coordination across systems.

Provider Survey Findings Narrative

2026 Survey Overview:

The majority of respondents (n = 68) serve patients in Minnehaha, Lincoln, and Pennington Counties and their surrounding areas. A smaller proportion indicated that they serve patients in more rural areas of South Dakota's central and northeastern regions. Over half of respondents (65%) serve patients in community health centers or primary care clinics. At over 60%, physicians are the largest provider group represented (see Table 1). Respondents who selected 'other' as their primary role included certified medical assistants, mental health counselors, and quality directors. Overall, more than 50% of respondents reported having 10 or more years of experience in their roles.

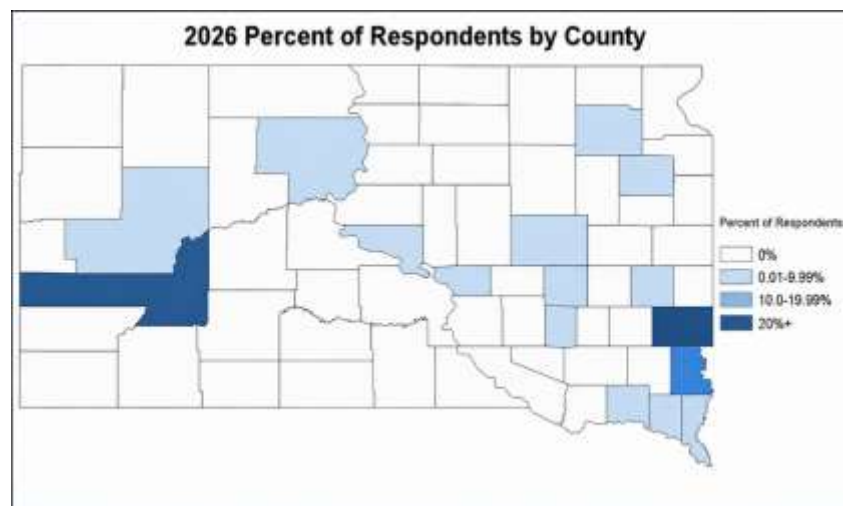
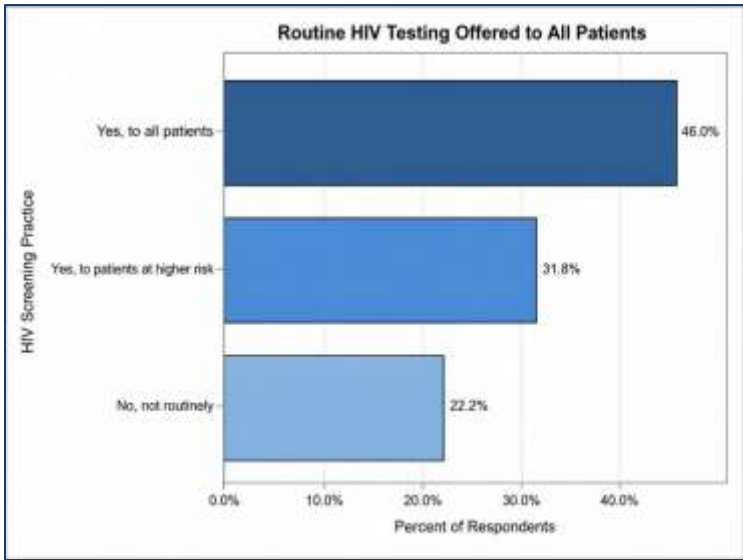


Table 1: Overview of 2026 Survey Respondents (Total N=68)

Metric	Level	Total	Rural	Urban	Minnehaha	Pennington
Primary Employment Setting	Primary Care Clinic	30.9% (21)	55.6% (5)	25.0% (14)	11.8% (2)	20.0% (4)
	Community Health Center	33.8% (23)	33.3% (3)	35.7% (20)	11.8% (2)	75.0% (15)
	Hospital / ED	11.8% (8)	--	14.3% (8)	29.4% (5)	--
	Infectious Disease Clinic	14.7% (10)	11.1% (1)	14.3% (8)	29.4% (5)	--
	Public Health Department	--	--	--	--	--
	Specialty Clinics	8.8% (6)	--	10.7% (6)	17.7% (3)	5.0% (1)
Years of Experience	Less than 1 year	1.5% (1)	--	--	--	--
	1-3 years	11.6% (8)	--	14.0% (8)	17.7% (3)	9.5% (2)
	4-6 years	16.0% (11)	11.1% (1)	15.8% (9)	17.7% (3)	19.1% (4)
	7-10 years	14.5% (10)	11.1% (1)	15.8% (9)	17.7% (3)	14.3% (3)
	10+ years	56.5% (39)	77.8% (7)	54.4% (31)	47.1% (8)	57.1% (12)
Primary Role	Physician	61.2% (41)	44.4% (4)	66.1% (37)	100% (17)	20.0% (4)
	Nurse Practitioner	10.5% (7)	33.3% (3)	7.1% (4)	--	15.0% (3)
	Physician Assistant	6.0% (4)	22.2% (2)	3.6% (2)	--	--
	Nurse	16.4% (11)	--	16.1% (9)	--	45.0% (9)
	Case Manager	--	--	--	--	--
	Social Worker	--	--	--	--	--
	Other	6.0% (7)	--	7.1% (4)	--	20.0% (4)

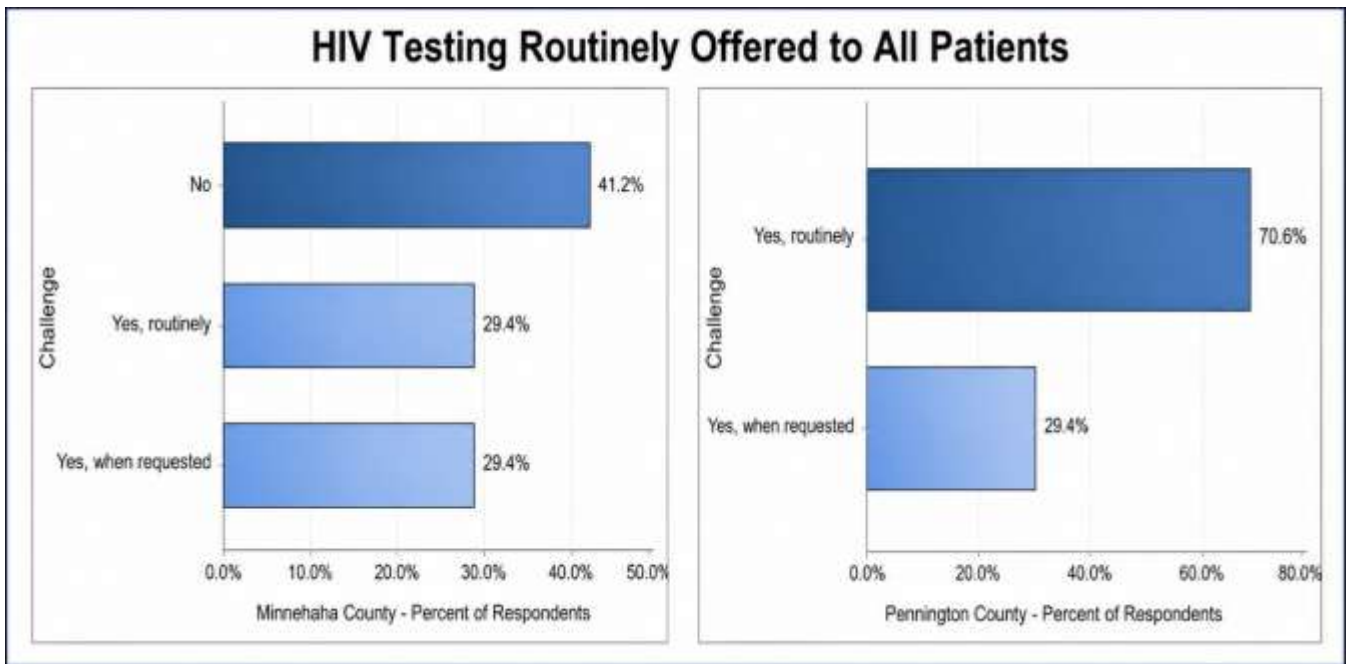
Note: Values in all are presented as column percentages with counts (n), then further broken down by locations designated as more urban than those designated as more rural, as defined by USDA Far and Remote Area codes. Those designated as more urban are areas or towns near cities with greater access to healthcare resources. Those designated as rural are areas or towns that are further from cities, in places where access to healthcare resources may be more limited. Additionally, as Pennington and Minnehaha Counties serve the largest number of HIV patients,

the responses for these counties are highlighted as well. Denominators vary due to item-level missingness. Percentages may not come to 100 due to rounding and multiselect items.

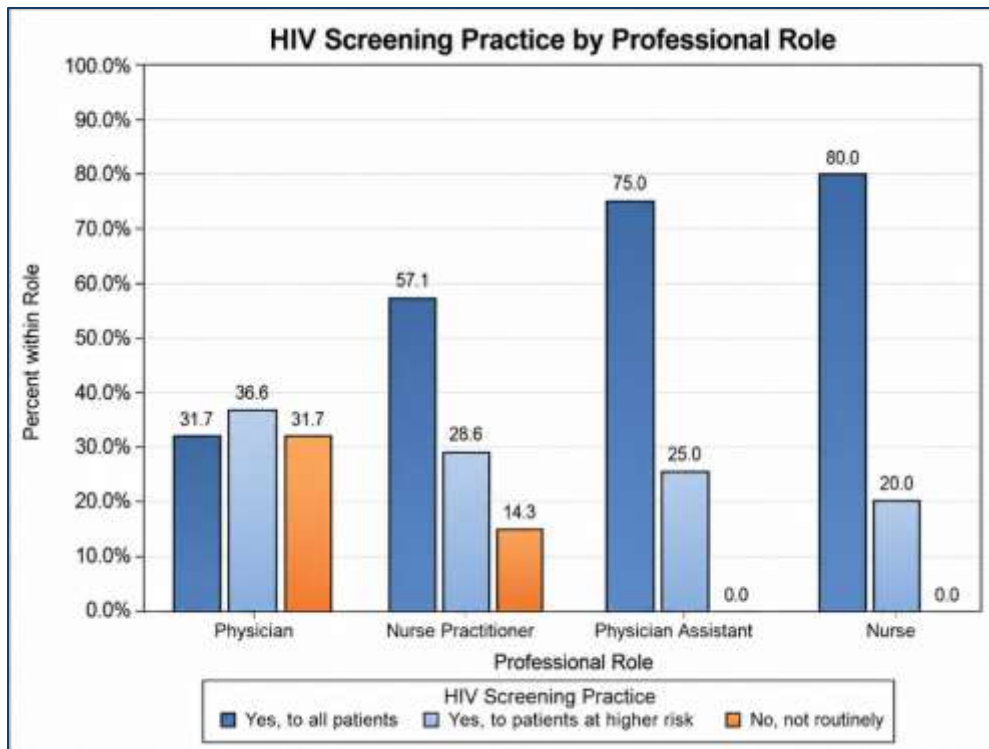


HIV Testing Services:

More than 75% of respondents (n=63) routinely offer HIV testing to patients. Overall, approximately 46% of respondents routinely offer HIV testing to all patients. Of note, approximately 70% of respondents in Pennington County routinely offer HIV testing to all patients (see Table 2).



Routine discussion of HIV prevention strategies, including pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP), represents an area for improvement. Over 40% of all respondents reported that they do not routinely discuss these strategies with patients, with this proportion increasing to more than 65% among providers practicing in rural settings.



Among the respondents to the survey, physicians' assistants (PAs) and registered nurses (RNs) most consistently routinely offer HIV testing to all patients.

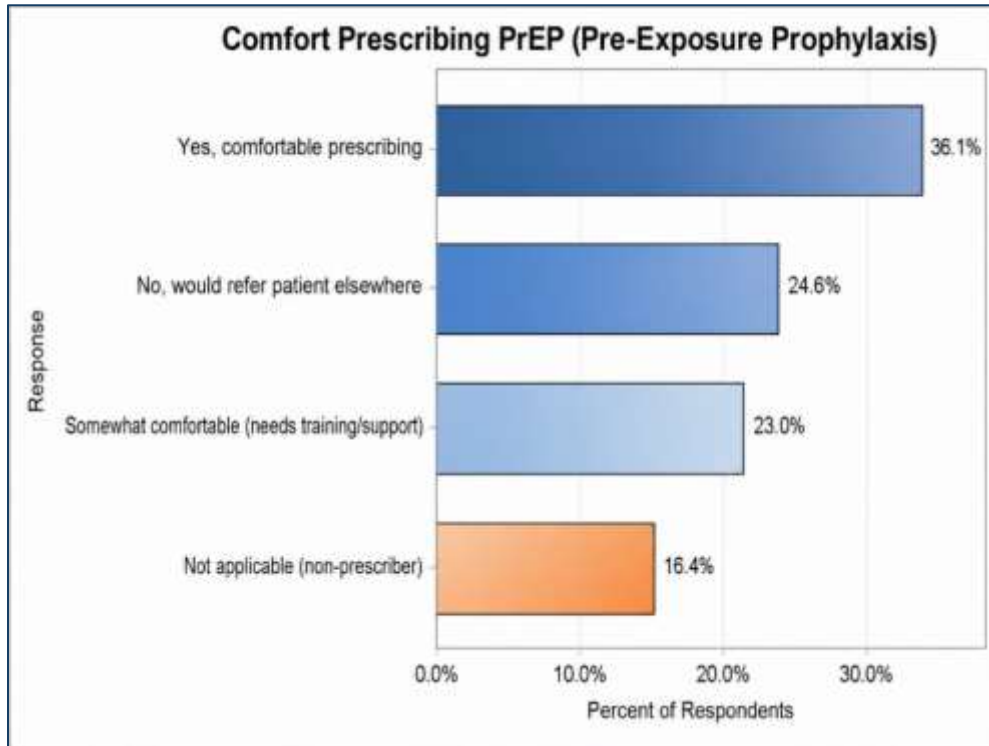


Table 2: HIV Testing Services - General

Metric	Level	Total	Rural	Urban	Minnehaha	Pennington
Offer routine HIV testing to all patients	Yes, to all patients	46.0% (29)	44.4% (4)	45.3% (24)	29.4% (5)	70.6% (12)
	Yes, to patients at higher risk	31.8% (20)	33.3% (3)	32.1% (17)	29.4% (5)	29.4% (5)
	No, not routinely	22.2% (14)	22.2% (2)	22.6% (12)	41.2% (7)	--
Routinely discuss HIV prevention strategies (PrEP or PEP)	Yes, routinely	22.9% (14)	11.1% (1)	25.5% (13)	23.5% (4)	33.3% (5)
	Yes, when requested	36.1% (22)	22.2% (2)	37.2% (19)	29.4% (5)	53.3% (8)
	No	41.0% (25)	66.7% (6)	37.2% (19)	47.1% (8)	13.3% (2)
Comfort prescribing PrEP	Comfortable prescribing	36.1% (22)	33.3% (3)	37.2% (19)	43.8% (7)	29.4% (5)
	Somewhat comfortable, but would like additional support	22.9% (14)	44.4% (4)	19.6% (10)	12.5% (2)	11.8% (2)
	Not comfortable, would refer the patient elsewhere	24.6% (15)	22.2% (2)	25.5% (13)	43.8% (7)	5.9% (1)
	Not applicable	16.4% (10)	--	17.6% (9)	--	52.9% (9)
Number of people living with HIV seen annually	None	20.7% (12)	33.3% (3)	18.8% (9)	7.1% (1)	--
	1 to 5	41.4% (24)	55.6% (5)	37.5% (18)	35.7% (5)	35.3% (6)
	6 to 10	8.6% (5)	11.1% (1)	8.3% (4)	7.1% (1)	17.6% (3)
	11 to 25	10.3% (6)	--	12.5% (6)	21.4% (3)	11.8% (2)
	26 to 50	6.9% (4)	--	8.3% (4)	21.4% (3)	--
	More than 50	12.1% (7)	--	14.6% (7)	7.1% (1)	35.3% (6)
Resources for newly diagnosed patients referred for follow-up	Infectious Disease	38.4% (38)	77.8% (7)	63.8% (30)	78.6% (11)	46.7% (7)
	Ryan White Program	29.3% (29)	11.1% (1)	25.5% (12)	21.4% (3)	40.0% (6)
	Department of Health	24.2% (24)	11.1% (1)	4.3% (2)	--	--
	Other	8.1% (8)	--	6.4% (3)	--	13.3% (2)

HIV Testing Services for Pregnant People:

Among providers who deliver obstetric (OB) care to pregnant patients, more than 80% reported routinely offering HIV testing at the first prenatal visit. However, this proportion was notably lower among rural providers, with only approximately 60% indicating routine testing at the initial prenatal appointment. Across all respondents providing OB care, only about 50% reported offering repeat HIV testing in the third trimester for patients at high risk. Respondents identified several resources that could better support HIV testing discussions during prenatal care, including clearer referral pathways, quick-reference tools for screening and referral guidelines, and improved access to current screening and treatment recommendations (see Table 3).

Table 3: HIV Testing Services – Pregnant People

Metric	Level	Total	Rural	Urban	Minnehaha	Pennington
Provide care for pregnant people	Yes	49.1% (28)	55.6% (5)	46.8% (22)	42.9% (6)	40.0% (6)
	No	50.9% (29)	44.4% (4)	53.2% (25)	57.1% (8)	60.0% (9)
Familiarity with ACOG HIV screening recommendations	Very familiar	46.5% (27)	33.3% (3)	50.0% (24)	66.7% (10)	33.3% (5)
	Somewhat familiar	29.3% (17)	55.6% (5)	25.0% (12)	13.3% (2)	33.3% (5)
	Not familiar	24.1% (14)	11.1% (1)	25.0% (12)	20.0% (3)	33.3% (5)
Routinely offer HIV screening to all at the 1st prenatal visit	Yes, routinely	87.5% (21)	60.0% (3)	94.7% (18)	100.0% (4)	83.3% (5)
	Sometimes	4.2% (1)	--	5.3% (1)	--	16.7% (1)
	Rarely	--	--	--	--	--
	Never	8.3% (2)	40.0% (2)	--	--	--
Routinely offer repeat HIV testing in the 3rd trimester	Yes, routinely	42.9% (9)	20.0% (1)	50.0% (8)	50.0% (1)	50.0% (3)
	Sometimes	23.8% (5)	20.0% (1)	25.0% (4)	50.0% (1)	33.3% (2)
	Rarely	33.3% (7)	60.0% (3)	25.0% (4)	--	16.7% (1)
Comfort discussing HIV testing during pregnancy	Comfortable	91.3% (21)	100% (5)	88.9% (16)	100% (4)	100% (5)
	Neutral	8.7% (2)	--	11.1% (2)	--	--
	Uncomfortable	--	--	--	--	--
Resources most helpful to improve HIV screening for	Access to up-to-date screening & treatment guidelines	17.5% (7)	25.0% (1)	46.1% (6)	--	60.0% (3)

Table 3: HIV Testing Services – Pregnant People

Metric	Level	Total	Rural	Urban	Minnehaha	Pennington
pregnant people	Clinical decision support in the EHR	15.0% (6)	--	15.4% (2)	--	20.0% (1)
	Staff training on opt-out HIV screening & perinatal HIV prevention	7.5% (3)	--	7.7% (1)	--	--
	Patient education materials	15.0% (6)	25.0% (1)	--	--	--
	Quick reference tools to streamline prenatal HIV testing	17.5% (7)	25.0% (1)	15.4% (2)	--	20.0% (1)
	Referral pathways to perinatal HIV programs	20.0% (8)	--	7.7% (1)	100% (1)	--
	Other	7.5% (3)	25.0% (1)	7.7% (1)	--	--

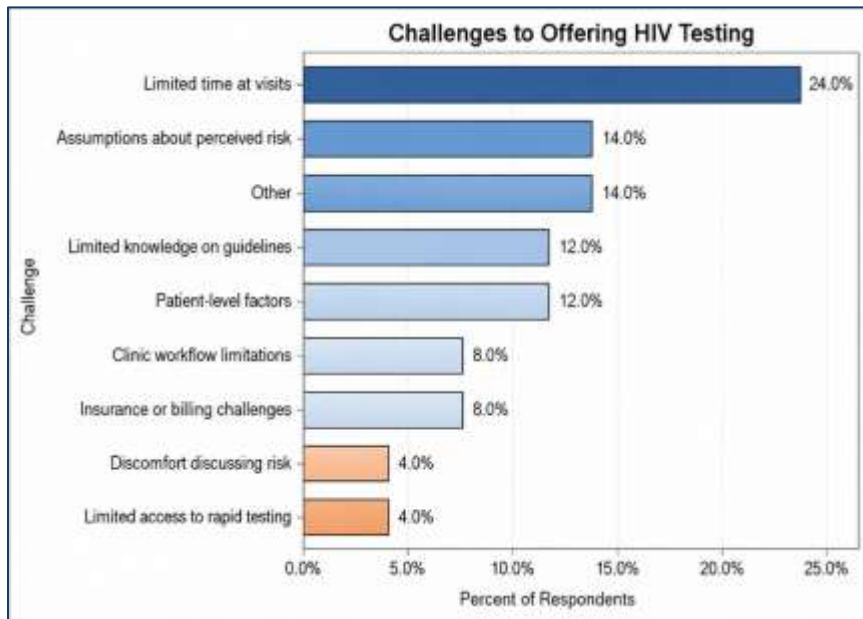
HIV Care & Treatment:

Overall, nearly 85% of respondents reported either initiating antiretroviral therapy (ART) or referring newly diagnosed patients to appropriate care within seven days of diagnosis. Despite this, more than half of respondents indicated that they were not fully comfortable prescribing or managing ART and expressed a need for additional training and support; these providers are more likely to refer patients to another provider or specialist for HIV care management. Approximately 84% of all respondents and over 90% of respondents in Minnehaha and Pennington Counties initiate antiretroviral therapy (ART) or refer newly diagnosed HIV patients to other providers for care within seven days of diagnosis. The primary HIV care management resource that patients were referred to was infectious disease specialists, followed by referral to the Ryan White HIV/AIDS Program (RWHAP). Approximately 40% of respondents were familiar with the RWHAP, and 29% reported that their organization receives funding from the RWHAP (see Table 4).

Table 4: HIV Care & Treatment

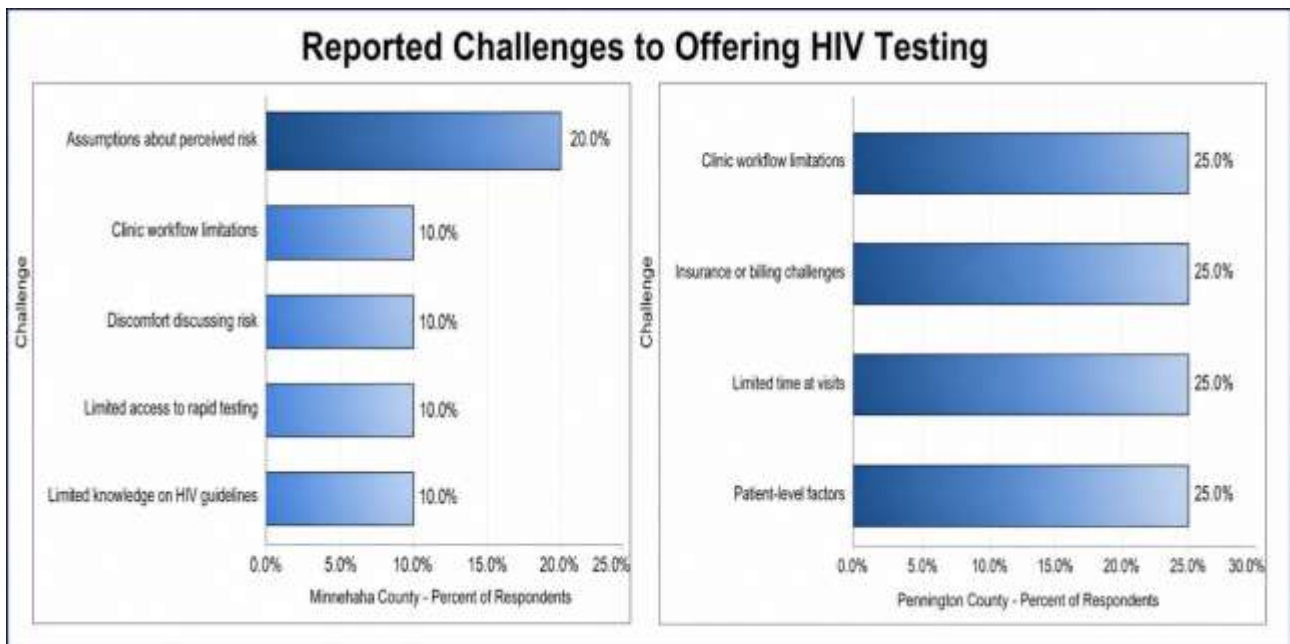
Metric	Level	Total	Rural	Urban	Minnehaha	Pennington
Initiate antiretroviral therapy (ART) treatment or rapidly refer newly diagnosed patients to care (Within 7 days of diagnosis)	Yes, Routinely	84.2% (48)	77.8% (7)	85.1% (40)	93.3% (14)	92.9% (13)
	No	15.8% (9)	22.2% (2)	14.9% (7)	6.7% (1)	7.1% (1)
Comfort with prescribing & managing ART	Very comfortable	24.5% (13)	22.2% (2)	25.0% (11)	33.3% (5)	18.2% (2)
	Somewhat comfortable	18.9% (10)	22.2% (2)	18.2% (8)	13.3% (2)	27.3% (3)
	Not comfortable, refer to another provider	56.6% (30)	55.6% (5)	56.8% (25)	53.3% (8)	54.5% (6)
Familiarity with the Ryan White HIV/AIDS Program (RWHAP) services to support patients living with HIV, including pregnant people	Yes	39.0% (23)	33.3% (3)	40.8% (20)	46.1% (6)	47.4% (9)
	No	25.4% (15)	33.3% (3)	24.5% (12)	23.1% (3)	5.3% (1)
	Heard of the program but unfamiliar with available services	35.6% (21)	33.3% (3)	34.7% (17)	30.8% (4)	47.4% (9)
Organization receives RWHAP funding	Yes	29.2% (7)	--	33.3% (7)	28.6% (2)	33.3% (3)
	No	20.8% (5)	33.3% (1)	19.1% (4)	--	33.3% (3)
	Not sure	50.0% (12)	66.7% (2)	47.6% (10)	71.4% (5)	33.3% (3)

Barriers to Access:



Overall, the most prominent barriers to HIV testing emerged as limited time at patient visits and assumptions about perceived risk. Of those who selected the “other” category, most indicated testing only when patients presented as high risk or for a suspected exposure. For example, one respondent remarked, “I have a surgical practice, so I only test if there is an OR exposure.” Another respondent noted, “I am a pediatrician. I offer [HIV testing] to them around 19 to 20.” However, one respondent did indicate a procedural barrier to offering HIV testing, stating that “the need for

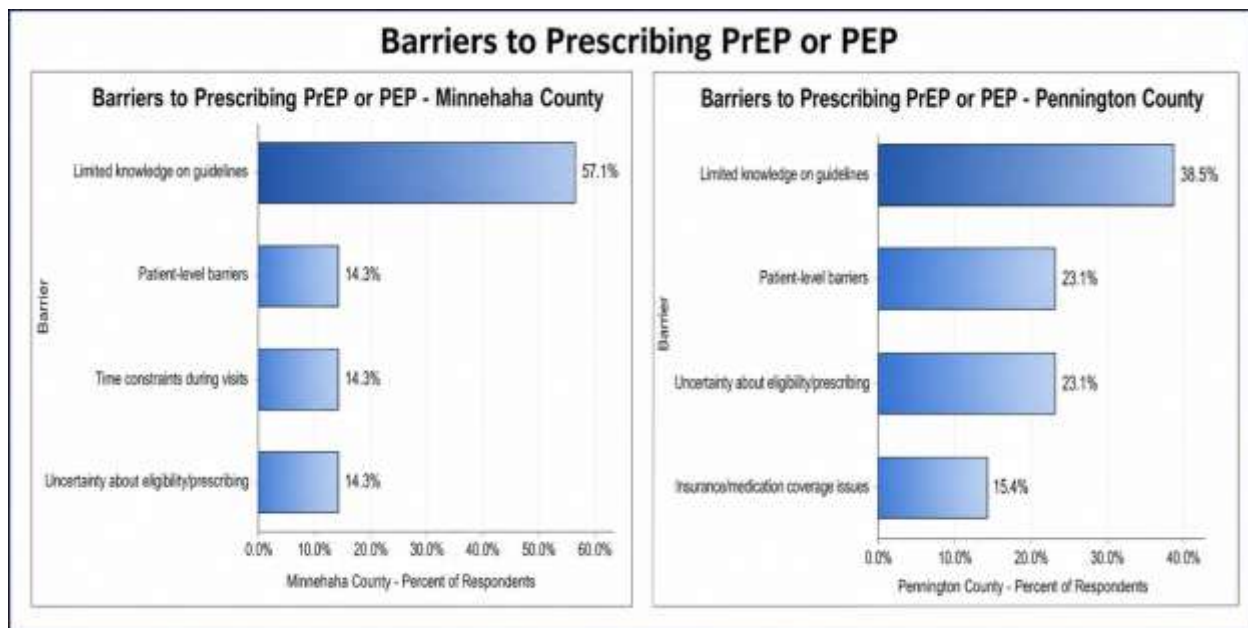
PCP [primary care physician] or health department follow-up” presents a challenge (see Table 5).



A comparison of the two counties in which the majority of patients receive testing and treatment, Minnehaha and Pennington counties, revealed notable differences in perceived barriers to HIV testing. In Minnehaha County, the primary barrier was identified as provider assumptions regarding patients’ perceived risk. In contrast, respondents in Pennington County reported a broader range of barriers to offering routine HIV testing to all patients, including patient-level factors, limited time during clinical visits, clinic workflow constraints, and insurance or billing challenges, all of which were cited with similar frequency.

Table 5: Barriers to Access, Care, & Treatment – HIV Screening

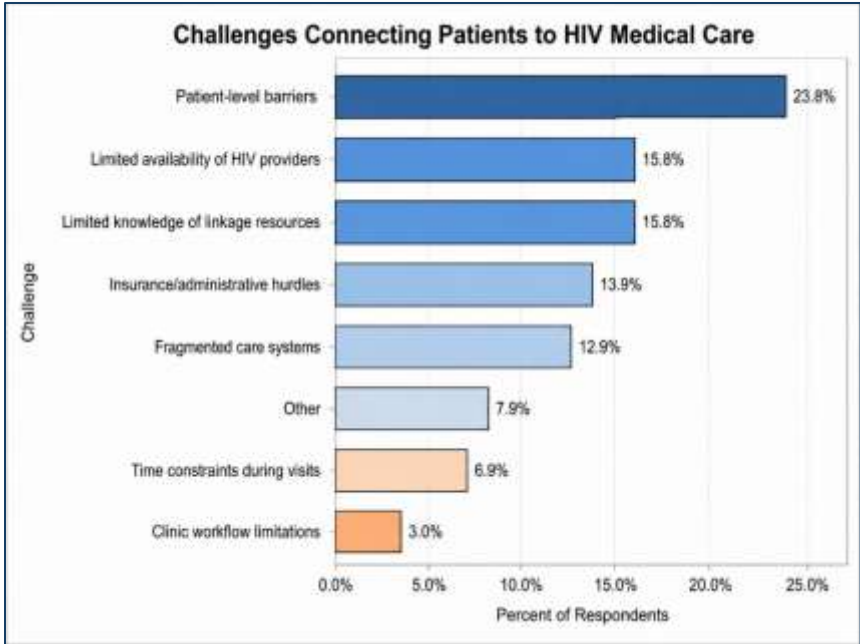
Metric	Level	Total	Rural	Urban	Minnehaha	Pennington
Challenges faced in offering HIV testing	Limited knowledge of current guidelines	12.0% (6)	25.0% (1)	20.0% (5)	10.0% (1)	--
	Limited time during visits	24.0% (12)	50.0% (2)	20.0% (5)	--	25.0% (1)
	Clinic workflow limitations	8.0% (4)	--	8.0% (2)	10.0% (1)	25.0% (1)
	Limited access to rapid testing	4.0% (2)	--	4.0% (1)	10.0% (1)	--
	Insurance or billing challenges	8.0% (4)	--	4.0% (1)	--	25.0% (1)
	Discomfort discussing risk	4.0% (2)	--	4.0% (1)	10.0% (1)	--
	Assumptions about perceived risk	14.0% (7)	--	8.0% (2)	20.0% (2)	--
	Patient-level factors	12.0% (6)	--	8.0% (2)	--	25.0% (1)
	Other	14.0% (7)	25.0% (1)	24.0% (6)	40.0% (4)	--



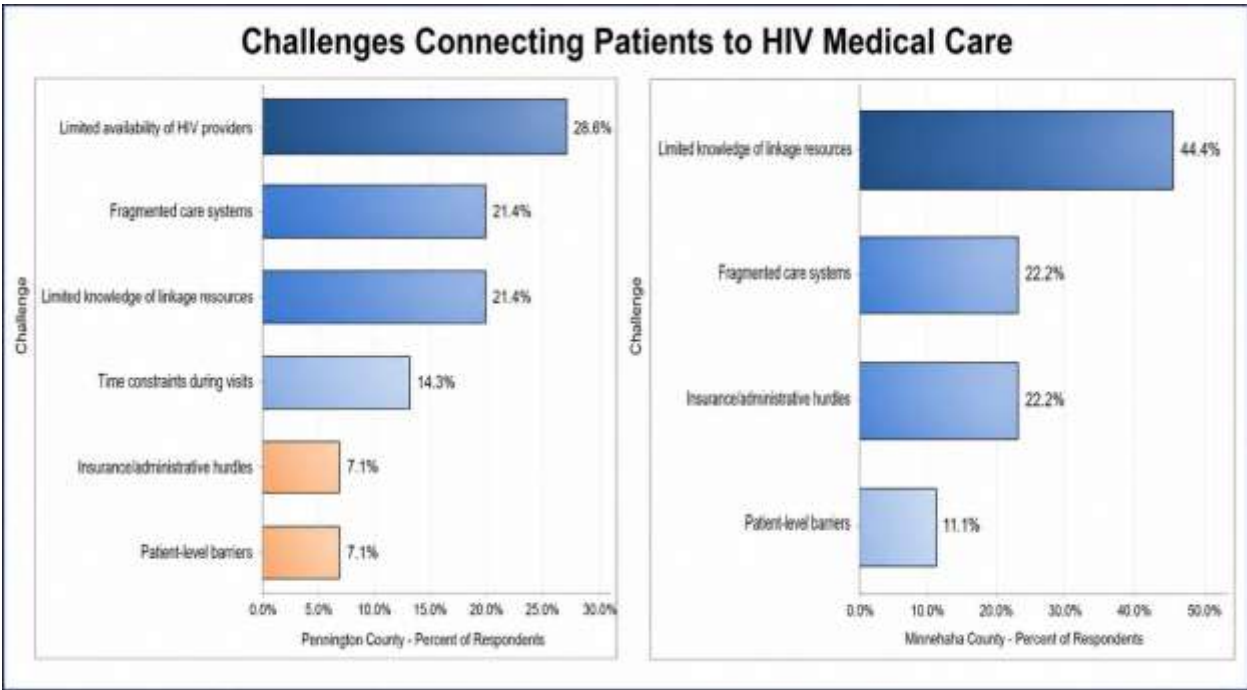
Patient-level barriers and limited knowledge about guidelines for prescribing PrEP and PEP emerged as a primary barrier overall. In this regard, Minnehaha and Pennington Counties share similar barriers, with limited knowledge of guidelines ranking as the most salient. These findings suggest that additional training and support resources would be beneficial in addressing this knowledge gap (see Table 6).

Table 6: Barriers to Access, Care, & Treatment – Prescribing PrEP/PEP

Metric	Level	Total	Rural	Urban	Minnehaha	Pennington
Barriers to providing PrEP or PEP, if not routinely done	Limited knowledge on PrEP/PEP guidelines	22.3% (21)	44.4% (4)	43.6% (17)	40.0% (4)	33.3% (5)
	Discomfort discussing risk	4.3% (4)	11.1% (1)	2.6% (1)	--	--
	Time constraints during visits	6.4% (6)	11.1% (1)	2.6% (1)	10.0% (1)	--
	Uncertainty about eligibility or prescribing	14.9% (14)	11.1% (1)	12.8% (5)	10.0% (1)	20.0% (3)
	Limited support for follow-up labs	6% (5)	11.1% (1)	--	--	--
	Clinic workflow limitations	4.3% (4)	--	2.6% (1)	--	--
	Insurance or medication coverage issues	13.8% (13)	--	5.1% (2)	--	13.3% (2)
	Patient-level barriers	20.2% (19)	11.1% (1)	15.4% (6)	10.0% (1)	20.0% (3)
	Other	8.5% (8)	--	15.4% (6)	30.0% (3)	13.3% (2)



The largest overall barrier identified in connecting patients to HIV medical care was patient-level factors, followed by limited availability of HIV care providers and limited knowledge of linkage resources. In rural and urban areas alike, the largest barrier identified was limited knowledge of linkage resources (see Table 7).



When comparing Minnehaha and Pennington Counties, the primary challenge in connecting patients to HIV medical care in Minnehaha County was identified as a limited availability of HIV care providers, while the primary challenge in Pennington County emerges as a limited knowledge of linkage resources. Both counties noted fragmented care systems as a significant challenge in connecting patients to HIV medical care.

Table 7: Barriers to Access, Care, & Treatment – Connecting Patients to HIV Medical Care

Metric	Level	Total	Rural	Urban	Minnehaha	Pennington
Challenges experienced in connecting clients to HIV medical care	Limited knowledge of linkage protocols or resources	15.8% (16)	37.5% (3)	28.9% (13)	33.3% (4)	20.0% (3)
	Time constraints during visits, limited care coordination	6.9% (7)	--	6.7% (3)	--	13.3% (2)
	Fragmented care systems	12.9% (13)	12.5% (1)	11.1% (5)	16.7% (2)	20.0% (3)
	Clinic workflow limitations	3.0% (3)	12.5% (1)	--	--	--
	Limited availability of HIV care providers	15.8% (16)	12.5% (1)	11.1% (5)	--	26.7% (4)
	Insurance or administrative hurdles	13.9% (14)	12.5% (1)	8.9% (4)	16.7% (2)	6.7% (1)
	Patient-level factors	23.8% (24)	12.5% (1)	17.8% (8)	8.3% (1)	6.7% (1)
	Other	7.9% (8)	--	15.6% (7)	25.0% (3)	6.7% (1)

Overall, the biggest challenge in prescribing or managing ART for HIV care was limited knowledge of linkage protocols and resources. Patient-level factors were the next largest challenge when considering prescribing or managing ART, with one respondent stating. Another sentiment emphasized was the problematic nature of insurance coverage. One respondent expressed the already overburdened healthcare system as a significant challenge, stating, “[It’s] too much for family medicine to manage all of this” (see Table 8).

Table 8: Barriers to Access, Care, & Treatment – Prescribing or Managing ART

Metric	Level	Total	Rural	Urban	Minnehaha	Pennington
Challenge to prescribing or managing ART	Limited knowledge in prescribing ART or HIV management	32.4% (35)	87.5% (7)	65.1% (28)	50.0% (6)	64.3% (9)
	Concerns about drug resistance or interactions	12.0% (13)	--	4.7% (2)	16.7% (2)	--

Table 8: Barriers to Access, Care, & Treatment – Prescribing or Managing ART

Metric	Level	Total	Rural	Urban	Minnehaha	Pennington
	Time constraints during patient visits	8.33% (9)	--	4.7% (2)	--	--
	Clinic workflow limitations	5.6% (6)	--	--	--	--
	Limited access to HIV specialists for consultation	6.5% (7)	--	--	--	--
	Insurance coverage concerns	13.0% (14)	12.5% (1)	7.0% (3)	8.3% (1)	--
	Patient-level factors	14.8% (16)	--	7.0% (3)	--	21.4% (3)
	Other	7.4% (8)	--	11.6% (5)	25.0% (3)	14.3% (2)

Barriers to Access – Pregnant People:

When considering offering routine testing to pregnant people at their first visit, limited time during prenatal visits and limited guidance on testing and referrals were identified as the main barriers to discussing HIV testing during pregnancy. A delay in seeking OB care can contribute to delayed screening, with over 65% of respondents noting a delay in pregnant patients’ first visits. On this topic, one respondent noted that a main reason for the delay was, “[There are] no providers available for Medicaid patients” (see Table 9).

Table 9: Barriers to Access, Care, & Treatment – Pregnant People

Metric	Level	Total	Rural	Urban	Minnehaha	Pennington
Delays noted in patients’ 1st prenatal visits	Yes, routinely	26.3% (5)	--	33.3% (5)	--	60.0% (3)
	Sometimes	42.1% (8)	66.7% (2)	40.0% (6)	50.0% (1)	40.0% (2)
	Rarely	31.6% (6)	33.3% (1)	26.7% (4)	50.0% (1)	--
Challenges to offering HIV screening to pregnant people	Limited training on guidelines	21.4% (3)	--	27.3% (3)	100% (1)	--
	Discomfort discussing HIV testing	--	--	--	--	--
	Limited time during prenatal visits	21.4% (3)	--	27.3% (3)	--	25.0% (1)

Table 9: Barriers to Access, Care, & Treatment – Pregnant People

Metric	Level	Total	Rural	Urban	Minnehaha	Pennington
	Competing clinical priorities	14.3% (2)	--	18.2% (2)	--	25.0% (1)
	Limited access to HIV testing	--	--	--	--	--
	Perception that patients are at low risk for HIV	7.1% (1)	--	--	--	--
	Other	35.7% (5)	100% (2)	27.3% (3)	--	50.0% (2)

Barriers to Access – Resource, Policy, & Community Factors

South Dakota requires reporting positive HIV cases to be reported immediately to the Department of Health; overall, almost 80% of respondents were confident in their ability to meet this requirement. When considering their facilities’ ability to respond to an increase in HIV cases, approximately 65% of urban respondents were confident their facility could effectively handle the increase, while only 33% of rural respondents felt that confidence. In this respect, over 70% of providers in both Minnehaha and Pennington Counties were confident in their facilities’ ability to effectively handle an increase in cases. Overall, resources identified as potentially enhancing facility response capacity included public health contact information and communication channels with the health department. However, when responses were stratified by rural and urban settings, clear reporting protocols emerged as the most urgently needed resource for both groups (see Table 10).

Table 10: Barriers to Access, Care, & Treatment – Reporting & Facility Capacity

Metric	Level	Total	Rural	Urban	Minnehaha	Pennington
Confidence meeting South Dakota's HIV reporting requirements to the Dept of Health	Yes	79.7% (47)	100% (9)	76.0% (38)	71.4% (10)	73.7% (14)
	No	1.7% (1)	--	2.0% (1)	--	--
	Not sure	18.6% (11)	--	22.0% (11)	28.6% (4)	26.3% (5)
Confidence in the facility's capacity to respond effectively to an	Confident	59.3% (35)	33.3% (3)	65.3% (32)	71.4% (10)	77.8% (14)
	Neutral	30.5% (18)	66.7% (6)	22.4% (11)	21.4% (3)	16.7% (3)
	Not confident	10.2% (6)	--	12.2% (6)	7.1% (1)	5.6% (1)

Table 10: Barriers to Access, Care, & Treatment – Reporting & Facility Capacity

Metric	Level	Total	Rural	Urban	Minnehaha	Pennington
increase in HIV cases						
Resources needed to respond more effectively to an increase in HIV cases (select all that apply)	Clear reporting protocols	18.8% (21)	37.5% (3)	41.9% (18)	45.5% (5)	40.0% (6)
	Public health contact information	23.2% (26)	37.5% (3)	20.9% (9)	9.1% (1)	33.3% (5)
	Communication channels with the health department	23.2% (26)	--	11.6% (5)	18.2% (2)	6.7% (1)
	Access to local surveillance data	17.9% (20)	12.5% (1)	9.3% (4)	9.1% (1)	6.7% (1)
	Training on cluster detection & response	14.3% (16)	12.5% (1)	11.6% (5)	9.1% (1)	13.3% (2)
	Other	2.7% (3)	--	4.7% (2)	9.1% (1)	--

Considering barriers to providing effective HIV care within their communities, respondents indicated patient financial or insurance barriers as the largest hurdle, followed closely by transportation and geographic barriers. In rural communities, patient financial or insurance barriers was the largest barrier, followed by a lack of trained providers or specialists. Conversely, in urban areas, the largest barriers were limited access to healthcare services and stigma related to HIV. Surprisingly, a lack of trained providers was ranked third among urban respondents. This apparent discrepancy, limited access despite a relatively sufficient provider workforce, may indicate an issue with provider workloads, insurance coverage barriers, or inefficiencies in referral pathways. The prominence of HIV-related stigma in urban communities, particularly in Minnehaha County, highlights a need for enhanced public health messaging surrounding what HIV is, is not, screening, treatment, and current prognosis (see Table 11).

Table 11: Barriers to Access, Care, & Treatment – Community Barriers

Metric	Level	Total	Rural	Urban	Minnehaha	Pennington
Significant barriers to providing effective HIV care in the community	Limited access to healthcare services	10.4% (21)	11.1% (1)	43.5% (20)	33.3% (4)	38.9% (7)
	Lack of trained providers	13.4% (27)	33.3% (3)	15.2% (7)	--	22.2% (4)
	Stigma related to HIV	12.4% (25)	11.1% (1)	21.7% (10)	16.7% (2)	33.3% (6)
	Patient financial or insurance barriers	18.3% (37)	44.4% (4)	10.9% (5)	33.3% (4)	--
	Transportation or geographic barriers	15.3% (31)	--	2.2% (1)	--	5.6% (1)
	Limited access to medications or treatment programs	7.9% (16)	--	--	--	--
	Cultural or language barriers	9.4% (19)	--	--	--	--
	Limited patient awareness or health literacy	8.9% (18)	--	--	--	--
	Systemic or administrative challenges	4.0% (8)	--	--	--	--

Ryan White Part B Consumer Satisfaction Survey Narrative Summary

The Ryan White Part B Consumer Satisfaction Survey was conducted to assess the experiences of people living with HIV receiving services in South Dakota. Due to platform limitations and low response rates, the survey yielded a small sample size (25 respondents). Among respondents, feedback was largely positive, with individuals expressing satisfaction with services and strong relationships with program staff. One respondent specifically highlighted the quality of support provided by Ryan White staff. The limited number of responses did not identify consistent or recurring barriers to care or support services. While the survey provides some insight into positive client experiences, it does not provide enough data to conclude broader system challenges or unmet needs. Additional efforts to collect more comprehensive consumer feedback, particularly among vulnerable populations, are planned to better inform future program improvements.

Needs Assessment Summary

1. HIV Testing Services

Services needed for HIV testing access

Assessment findings indicate a need to expand routine and accessible HIV testing across South Dakota, particularly in rural and frontier areas. Provider survey data show variability in testing practices, with some providers not routinely offering HIV testing due to time constraints, competing priorities, and limited integration into standard workflows. Additional needs include expanding non-traditional testing strategies such as mobile testing and at-home testing options to address geographic barriers and confidentiality concerns identified through prior assessments and stakeholder engagement.

One of the key objectives in the previous Integrated HIV Prevention and Care Plan was expanding alternative HIV testing strategies, including the development of an at-home self-testing program. This priority emerged from the 2022 Townhall, SWOT analysis, and community survey findings, which identified limited mobile testing options, confidentiality concerns, and strong interest in more accessible and private testing methods. In response, the SDDOH prioritized the development of an at-home testing approach to address these gaps and expand statewide access to HIV testing.

In January 2026, the DOH launched a statewide HIV self-testing program that allows residents to request up to two test kits through the agency's website. Kits are mailed directly to individuals' homes in discreet packaging, reducing barriers related to transportation, stigma, and privacy while increasing access for those less likely to use traditional testing settings.

To further expand reach, the Department has partnered with community organizations to distribute test kits directly within local communities, with emphasis on populations disproportionately affected by HIV and those facing barriers to care. This combined model of direct mail access and community distribution helps ensure coverage across both rural and urban areas of the state.

Overall, the program directly addresses gaps identified in the 2022 assessment, particularly around confidentiality and geographic access. By offering multiple pathways to testing, the SDDOH is working to increase early diagnosis, normalize routine HIV screening, and improve access for underserved populations statewide.

Services for staying HIV negative (e.g., PrEP, SSPs)

There is a clear need to expand HIV prevention services, particularly access to and awareness of PrEP. Provider survey results identified low levels of routine discussion of HIV prevention strategies and gaps in provider knowledge and comfort with prescribing PrEP. Barriers include limited training, uncertainty about eligibility, and patient-level factors such as low perceived risk and stigma.

The SOAR analysis further emphasized the need for targeted, culturally responsive prevention efforts, particularly among populations disproportionately impacted by HIV. Additionally, no syringe-exchange programs (SSPs) exist in South Dakota due to laws prohibiting them, highlighting a need for expanded prevention infrastructure and partnerships.

According to AIDSVu.org continues to be underutilized across South Dakota despite its proven effectiveness as an HIV prevention strategy. During the 2022 Townhall session, it was noted that some providers delivering services to clients on PrEP have questioned why individuals are taking HIV medication when they are not diagnosed with HIV, indicating ongoing gaps in provider knowledge and understanding. It was also discussed that PrEP is more readily accepted and offered in settings where it is normalized, such as during STD/STI testing encounters.

Additionally, findings from the 2022 SWOT analysis revealed that, due to religious preferences or organizational policies, some providers choose not to prescribe or are not permitted to prescribe PrEP. As a result, even with available education and training opportunities, uptake may remain limited due to these administrative and belief-based barriers.

The SDDOH continues to address these challenges by providing ongoing training, technical assistance, and educational resources to healthcare providers to increase knowledge, reduce stigma, and support the integration of PrEP into routine clinical practice. In addition, SDDOH is leveraging national telePrEP resources as an alternative strategy, particularly for individuals in rural areas where confidentiality concerns or limited local access may present barriers. These combined efforts aim to expand equitable access to PrEP services and improve uptake across the state.

Rapid linkage to HIV care after positive diagnosis

Findings indicate that South Dakota has strong linkage-to-care practices, with most providers reporting timely referral or initiation of care following diagnosis. However, system-level challenges remain, including reliance on a limited number of HIV specialty providers and geographic barriers to accessing care.

The assessment identified opportunities to strengthen referral pathways, improve coordination between providers and public health systems, and ensure consistent linkage practices across all regions of the state.

2. HIV Care and Treatment

Services for maintaining HIV care and reaching and sustaining viral suppression

While overall outcomes along the HIV care continuum are strong, maintaining engagement in care remains a challenge for some populations. Provider survey findings indicate limited provider capacity to manage HIV treatment, with many providers referring patients to specialists due to lack of experience or training.

The SOAR analysis and stakeholder input highlighted the need to expand access to mental health, substance use, and other essential support services, which are critical to sustained viral suppression. Tribal and frontier communities face additional challenges due to limited availability of services, transportation barriers, and reduced access to culturally responsive care.

3. Barriers to Access

HIV testing barriers

Key barriers to HIV testing identified through the provider survey include:

- Limited time during patient visits
- Assumptions about patient risk
- Lack of provider training or comfort
- Stigma and confidentiality concerns

These barriers are compounded in rural areas where access to testing sites may be limited.

Challenges with state laws and regulations

While no specific regulatory barriers were directly identified through the consumer survey, broader stakeholder engagement and system-level discussions indicate that policy and regulatory considerations impact the implementation and expansion of certain prevention strategies. In South Dakota, state law currently prohibits syringe service programs, limiting the ability to implement evidence-

based harm reduction approaches such as syringe exchange. This restriction presents a structural barrier to reducing HIV transmission among people who inject drugs. Continued evaluation of the policy environment, along with exploration of alternative harm reduction strategies within existing legal frameworks, is needed to support comprehensive HIV prevention efforts.

HIV prevention, care, and treatment service access issues

Across all assessment activities, the following access issues were consistently identified:

- Limited provider capacity, particularly in rural areas
- Geographic and transportation barriers
- Limited availability of essential support services (housing, transportation, food, behavioral health)
- Gaps in awareness of available services among both providers and clients
- Fragmentation between prevention, care, and support service systems

These issues disproportionately impact rural populations and communities of color, particularly American Indian/Alaska Native populations.

4. Priorities

Key priorities identified through the needs assessment include:

- Expanding access to HIV testing, including routine, mobile, and at-home testing
- Increasing provider capacity and training for HIV prevention and treatment, particularly PrEP
- Improving referral systems and coordination across prevention, care, and support services
- Expanding access to essential support services, especially in rural and frontier areas
- Increasing awareness and utilization of HIV prevention tools and Ryan White services
- Strengthening culturally responsive approaches for disproportionately impacted populations

5. Action Taken

In response to identified needs and barriers, the South Dakota Department of Health has undertaken several key activities, including:

- Implementation of a statewide at-home HIV testing program
- Expansion of mobile and community-based testing partnerships
- Training for Disease Intervention Specialists (DIS) on referrals to essential support services
- Provider education and training on HIV testing, PrEP, and care practices
- Engagement with Tribal partners through regular meetings and collaboration
- Partnership with the Community Healthcare Association of the Dakotas (CHAD) to expand provider capacity and conduct provider assessments
- Exploration and incorporation of telehealth PrEP providers to improve access
- Use of the 211 Helpline to improve access to and coordination of support services

6. Approach

The South Dakota Department of Health utilized a multi-method collaborative approach to complete the needs assessment, incorporating both qualitative and quantitative data sources. The Prevention Planning Group (PPG), which includes representation from public health, healthcare providers, community-based organizations, Tribal partners, and individuals with lived experience, played a central role in the process.

A SOAR (Strengths, Opportunities, Aspirations, and Results) analysis was conducted with the PPG to identify system strengths, gaps, and priorities across the HIV prevention and care continuum. The Ryan

White Part B Program conducted a consumer satisfaction survey to gather feedback from people living with HIV currently receiving services, providing insight into client experiences and satisfaction.

To assess provider capacity and system-level barriers, the HIV Program partnered with the Community Healthcare Association of the Dakotas (CHAD) to administer a provider survey, which captured perspectives on HIV testing, prevention, treatment, and referral practices.

Although a targeted consumer survey for vulnerable populations was not completed during this assessment period, this has been identified as a priority, and plans are in place to conduct this assessment by the end of 2027.

Together, these activities ensured that the needs assessment incorporated input from people with HIV, healthcare providers, and community stakeholders, including populations disproportionately impacted by HIV, and aligned with federal guidance for inclusive and comprehensive planning.

IV. Situational Analysis

A. Strengths, Challenges, and Identified Needs

The South Dakota CY 2027–2031 Integrated HIV Prevention and Care Plan situational analysis synthesizes findings from community engagement activities—including a statewide SOAR (Strengths, Opportunities, Aspirations, and Results) strategic planning process—alongside epidemiologic data, resource inventory, and provider survey results. The SOAR activity engaged members of the Prevention Planning Group (PPG), Ryan White Part B partners, community-based organizations, Tribal entities, HIV providers, and individuals representing priority populations and people living with HIV to identify system strengths, gaps, and a shared vision for the future. Together, these qualitative and quantitative data sources provide a comprehensive overview of strengths, challenges, and systemic barriers impacting HIV prevention and care across the state.

South Dakota demonstrates strong outcomes across portions of the HIV care continuum; however, persistent structural and systemic challenges—particularly related to rurality, provider capacity, stigma, and access to essential support services—continue to impact equitable access to care. These challenges disproportionately affect American Indian/Alaska Native populations, Black/African American and foreign-born individuals, men who have sex with men (MSM), and individuals who inject drugs or experience substance use, as well as those residing in rural and frontier areas. SOAR findings reinforced these disparities while also highlighting key system strengths, including strong partnerships across SD DOH, IHS, FQHCs, Ryan White providers, and community-based organizations, as well as dedicated program staff and increasing access to mental health resources and supportive services such as transportation assistance.

B. Diagnose: Early Identification of HIV

South Dakota has made progress in expanding HIV testing through routine, opt-out testing, mobile testing strategies, and the implementation of a statewide at-home HIV testing program. However, provider survey data indicate variability in testing practices across clinical settings.

While 46.03% of providers reported offering routine opt-out HIV testing, 22.22% indicated they do not routinely offer testing, suggesting missed opportunities for early diagnosis.

Providers identified several systemic barriers to routine testing, including limited time during patient visits (41.38%), assumptions about patient risk (24.14%), and limited knowledge or training on HIV screening guidelines (20.69%).

SOAR findings further emphasized the need to expand targeted and culturally responsive HIV testing strategies, particularly among rural communities and American Indian populations.

Participants identified opportunities to increase outreach in remote areas, improve access to testing services, and strengthen data-driven approaches to better identify and reach priority populations.

These challenges are particularly relevant for populations disproportionately impacted by HIV, including American Indian/Alaska Native communities, Black/African American and foreign-born individuals, and MSM, where stigma, limited access to culturally responsive care, and inconsistent provider practices contribute to delayed diagnosis.

These findings highlight ongoing structural challenges, including workflow limitations, inconsistent integration of HIV testing into routine care, and provider-level knowledge gaps. In rural and frontier areas, these barriers are compounded by limited access to healthcare services, transportation challenges, and concerns around confidentiality and stigma.

C. Treat: Rapid Linkage and Sustained Viral Suppression

South Dakota continues to demonstrate strong linkage to care outcomes, with providers reporting that they routinely initiate treatment or connect patients to care within 7 days of diagnosis.

Despite this strength, provider survey findings reveal ongoing challenges in sustaining treatment and expanding treatment capacity. Over half of providers reported they are not comfortable prescribing or managing antiretroviral therapy (ART) and would refer patients to another provider.

Barriers to treatment and retention in care include limited provider knowledge or experience, patient-level challenges such as adherence, mental health, and substance use, and uncertainty regarding insurance coverage and medication access.

Additionally, providers identified broader structural barriers to linkage and retention in care, including transportation challenges, geographic isolation, and limited availability of HIV specialty providers.

SOAR findings reinforced these challenges while also highlighting strengths in coordinated care and partnerships that support rapid linkage to services. Participants emphasized the importance of improving access to mental health and substance use services, strengthening care coordination, and expanding peer support programs to improve retention in care and achieve sustained viral suppression.

Disparities in sustained viral suppression—particularly among some Tribal jurisdictions and individuals experiencing substance use or co-occurring mental health conditions—highlight the need for improved care coordination, expanded support services, and increased provider capacity to manage HIV treatment.

These findings underscore the need to expand provider capacity, strengthen integration of HIV care into primary care settings, and address social determinants of health that impact sustained viral suppression.

D. Prevent: Reducing New HIV Infections

Prevention efforts in South Dakota are significantly impacted by gaps in provider engagement and access to prevention services, particularly related to PrEP. Provider survey results indicate that only a portion of providers routinely discuss HIV prevention strategies, while many do not discuss them unless prompted.

Although some providers report feeling comfortable prescribing PrEP, a substantial proportion indicated the need for additional training or reported referring patients elsewhere.

Key barriers to PrEP implementation include limited knowledge or training, patient-level barriers such as low awareness or stigma, uncertainty about eligibility, and insurance or medication access challenges.

SOAR findings aligned with these results, emphasizing the need for targeted PrEP campaigns, increased community awareness, and expanded provider training. Participants highlighted opportunities to normalize HIV prevention through broader sexual health education, increase access to PrEP and PEP through primary care providers, and reduce stigma through culturally responsive messaging and community engagement.

These prevention gaps disproportionately affect MSM, Black/African American and foreign-born populations, and individuals at risk through substance use, where barriers such as stigma, low awareness, and limited access to PrEP providers contribute to underutilization of prevention services.

These findings reinforce broader system-level challenges identified through qualitative data, including limited provider networks, low perceived risk among clients, and gaps in referral pathways. Together, these factors contribute to the underutilization of PrEP and other prevention strategies.

Geographic disparities further exacerbate these challenges, particularly in rural and frontier areas where access to prevention services, including harm reduction programs, is limited or not available.

E. Respond: Cluster Detection and Outbreak Response

South Dakota maintains established surveillance systems and reporting requirements; however, provider survey data indicate variability in confidence and capacity to respond to increases in HIV cases.

While a majority of providers reported confidence in meeting HIV reporting requirements, fewer indicated confidence in their facility's ability to respond effectively to an increase in HIV cases.

Providers identified several needs to improve response capacity, including stronger communication with public health agencies, increased access to public health information, and clearer reporting protocols.

SOAR findings further identified opportunities to strengthen data systems, improve rapid response to clusters and outbreaks, and enhance collaboration with community and Tribal partners. Participants emphasized the importance of improving coordination across systems and ensuring timely, data-informed responses to emerging trends.

Strengthening response capacity is particularly important for populations at increased risk of rapid transmission, including individuals who inject drugs and communities with limited access to prevention and care services, where timely, coordinated responses are critical.

These findings highlight opportunities to strengthen coordination between healthcare providers and public health systems, particularly in rural areas where infrastructure and workforce capacity may be limited.

F. People and Communities Disproportionately Impacted by HIV

Based on epidemiologic data, provider survey results, and findings from the SOAR community engagement process, several populations in South Dakota experience disproportionate impacts across the HIV prevention and care continuum. These include American Indian/Alaska Native communities, Black/African American and foreign-born individuals, men who have sex with men (MSM), and individuals who inject drugs or experience substance use. Across these populations, disparities are driven by a combination of

structural and systemic factors, including limited access to culturally responsive care, stigma, geographic isolation, transportation barriers, and gaps in provider capacity and prevention service availability.

Specific disparities identified include lower rates of viral suppression in some tribal jurisdictions, gaps in awareness and utilization of prevention strategies such as PrEP among MSM and Black/African American and foreign-born populations, and increased vulnerability to rapid transmission among individuals who inject drugs. While strengths such as strong community partnerships, testing infrastructure, and coordinated care systems exist, these disparities highlight the need for targeted, culturally appropriate, and data-driven approaches to improve outcomes. The goals and objectives outlined in this plan are designed to address these disparities by building on existing strengths while focusing resources and strategies on populations most impacted by HIV.

G. Cross-Cutting Systemic Barriers and Disparities

Across all pillars, providers identified consistent structural and systemic barriers impacting HIV prevention and care. The most frequently cited barriers included financial and insurance-related challenges, transportation and geographic barriers, stigma related to HIV, and limited access to trained providers or specialists.

These barriers disproportionately impact priority populations, including American Indian/Alaska Native communities, Black/African American and foreign-born individuals, MSM, and people who inject drugs, further contributing to disparities across the HIV care continuum.

These findings are consistent with themes identified through the SOAR process, where participants emphasized stigma, workforce limitations, and access challenges—particularly in rural and tribal communities—as key barriers. At the same time, SOAR findings highlighted important system strengths, including strong partnerships, dedicated providers and staff, effective community-based organizations, and innovative supports such as transportation assistance and rapid testing services.

Opportunities identified through SOAR included expanding provider education and training, telemedicine for PrEP such as MISTR, increasing access to peer support groups, strengthening partnerships with Tribal and community organizations, and enhancing culturally responsive care. Aspirations emphasized reducing stigma through normalized sexual health education, expanding access to testing and prevention services, and increasing representation of people with HIV in planning and decision-making processes.

Additionally, awareness and utilization of key programs such as the Ryan White HIV/AIDS Program remain inconsistent, with many providers reporting limited familiarity with available services.

H. Summary

Overall, the situational analysis demonstrates a strong foundation for HIV prevention and care in South Dakota, supported by coordinated programs, surveillance systems, and community partnerships. SOAR findings further underscore the state's strengths in collaboration, dedicated workforce, and community engagement, while highlighting a shared commitment to improving access, reducing stigma, and addressing disparities across the HIV care continuum.

However, significant gaps remain in provider capacity, prevention service utilization, and access to care—particularly among populations disproportionately impacted by HIV, including American Indian/Alaska Native communities, Black/African American and foreign-born individuals, MSM, and people who inject drugs, as well as individuals living in rural and underserved areas.

Provider survey findings and community input reinforce the need to expand provider training and workforce capacity, improve integration of HIV services into routine care, increase awareness and utilization of PrEP,

strengthen referral systems and coordination, and address social determinants of health. These priorities reflect both data-driven needs and community-identified opportunities, including improving viral suppression in Tribal communities, expanding prevention access, and strengthening system-wide coordination.

These findings directly inform the goals, objectives, and strategies outlined in the remainder of the Integrated HIV Prevention and Care Plan and support a targeted, equitable approach to improving HIV outcomes statewide.

V. 2027–2031 Goals and Objectives

The goals and objectives outlined in this Integrated HIV Prevention and Care Plan were developed directly from the findings of the situational analysis, which incorporated epidemiologic data, provider survey results, resource inventory, and stakeholder input through the SOAR (Strengths, Opportunities, Aspirations, and Results) process.

Quantitative data identified key gaps in routine HIV testing, provider capacity to deliver HIV treatment and prevention services, limited PrEP awareness and prescribing, and ongoing barriers to care such as stigma, transportation, and workforce shortages—particularly in rural and tribal communities.

These findings were reinforced by SOAR results, which highlighted both system strengths—such as strong partnerships, dedicated providers, and coordinated care systems—and critical opportunities for improvement. SOAR participants emphasized the need to expand culturally responsive testing strategies, strengthen provider training and confidence, increase access to mental health and peer support services, improve community awareness of HIV prevention tools, and enhance data systems and cross-sector collaboration.

In addition, SOAR aspirations underscored the importance of normalizing HIV and sexual health discussions, expanding access to PrEP and PEP through primary care, increasing representation of people with HIV in programs and planning efforts, and reducing stigma across communities. Desired results focused on measurable improvements in early diagnosis, increased PrEP access, stronger peer engagement, improved retention in care, and higher rates of viral suppression.

Together, these findings directly informed the four overarching goals of this plan—Diagnose, Treat, Prevent, and Respond—and guided the development of specific, measurable objectives and strategies designed to address identified gaps while building on existing strengths.

A. Description of Goals and Objectives

Goal 1: Diagnose all People with HIV as Early as Possible			
<p>Objective 1: By December 31, 2031, reduce the number of HIV diagnoses in South Dakota that are "late testers" (i.e., diagnosed with AIDS with ≤ 1 year of initial HIV diagnosis) from approximately 25% to 10% as measured annually by the SDDOH HIV/AIDS surveillance report. (Report to be run annually with HIV surveillance report)</p>			
Key Strategies	Activities	Responsible Parties	Key Partners
<p>1. Expand routine and opt-out HIV screening in healthcare settings to increase early diagnosis and linkage to care</p> <p>2. Strengthen provider capacity and access to resources to deliver HIV prevention, testing, and care services</p> <p>3. Integrate HIV Prevention best practices within healthcare systems by providing medical providers and staff with training, resources, and decision-making tools</p>	<p>1. Develop provider toolkits, promote testing in primary and urgent care, and normalize HIV screening as part of routine care</p> <p>2. Implement training programs, distribute educational resources, and integrate HIV testing protocols</p> <p>3. Create and implement provider toolkits, incorporate and support HIV testing and PrEP discussions</p>	<p>DOH, HIV Prevention sub-recipients, Ryan White Part B sub-recipients</p>	<p>DOH, community-based organizations, correctional facilities, FQHCs, tribal health clinics, GPTEC, IHS facilities, clinics, urgent cares, emergency rooms, university residency programs, family planning clinics</p>
<p>Performance Measures:</p> <p>Total number of provider toolkits distributed and/or requested</p> <p>Total number of education trainings conducted annually</p> <p>Total number of education/trainings/toolkit resources created</p>			
<p>Progress toward National HIV Goals: Increase the number of people who know their HIV status to ensure early diagnosis and treatment to prevent new infections and reduce HIV related health disparities</p>			

Objective 2: By December 31, 2027, increase statewide access distribution of free at-home HIV testing kits from a baseline of 0 in 2025 to at least 500 kits per year by implementing a statewide distribution system tracked through DOH field offices and sub-recipients

Key Strategies	Activities	Responsible Parties	Key Partners
1. Expand access to HIV testing through community-based and at-home testing resources	1. Identify community partners to distribute at-home kits, promote pickup locations, and ensure availability in high-need areas	DOH, HIV Prevention sub-recipients, Ryan White Part B sub-recipients	Community-based organizations, people disproportionately impacted by HIV, and the DOH
2. Increase awareness and utilization of HIV self-testing through targeted outreach and digital promotion	2. Promote self-testing via social media, digital campaigns, and partnerships with local organizations		
3. Leverage technology to streamline access to HIV self-testing resources statewide	3. Develop and promote an online ordering system for free test kits through the DOH		

Performance Measures:
 Increase the number of at-home tests distributed.
 Number/type of community partners reached or engaged

Progress toward National HIV goals: Increase the number of people who know their HIV status to ensure early diagnosis and treatment to prevent new infections and reduce HIV related health disparities

Objective 3: By December 31, 2027, increase HIV prevention awareness among rural, tribal, and foreign-born communities in South Dakota from 0 targeted campaigns in 2025 to at least three geo- and demographically targeted social media campaigns.

Key Strategies	Activities	Responsible Parties	Key Partners
1. Increase awareness of testing and treatment among priority populations through culturally competent messaging	1. Develop and test messaging tailored to priority populations, ensure materials are culturally appropriate, and evaluate message reach and impact	DOH, HIV Prevention sub-recipients, PPG members	People disproportionately impacted by HIV, DOH, and community-based organizations

<p>2. Implement coordinated, targeted outreach campaigns using digital platforms to reach populations at greatest risk</p> <p>3. Utilize surveillance and epidemiological data to guide outreach and intervention efforts in areas with high or increasing HIV diagnoses</p>	<p>2. Launch geo-targeted and demographic-targeted social media campaigns, track engagement metrics, and adjust messaging based on performance</p> <p>3. Analyze current surveillance data, identify hotspots, and deploy targeted awareness and testing initiatives accordingly</p>		
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Performance Measures:

Number of targeted campaign ads developed and distributed
 Number of individuals reached on each social media platform

Progress toward National HIV goals: Decrease stigma to increase the number of people who know their HIV status to ensure early diagnosis and treatment to prevent new infections and reduce HIV related health disparities

Goal 2: Treat all People with HIV as Rapidly and Effectively as Possible to Reach Sustained Viral Suppression

Objective 1: By December 31, 2031, increase the 30-day linkage-to-care rate for newly diagnosed individuals in South Dakota from a baseline of 57% to 60%, as measured by Department of Health surveillance data

Key Strategies	Activities	Responsible Parties	Key Partners
<p>1. Increase the number of providers treating people with HIV</p> <p>2. Increase provider education on Rapid Linkage and ART</p>	<p>1. Implement task-shifting protocols to empower non-HIV specialists, establish HIV Clinical Mentorship Programs to guide non-specialist providers, and offer incentives to providers</p> <p>2. Focus training on rapid ART initiation, educate on U=U messaging and stigma</p>	<p>CDC recipient and subrecipients</p>	<p>Community-based providers, statewide healthcare providers, Federal and State recipients of HIV and Prevention funding, and others providing care and treatment to PLWH</p>

	reduction, standardize orientation that emphasizes the 30-day linkage-to-care objective		
<p>Performance Measures: Number of providers requesting or receiving education materials Number of providers treating people with HIV (<i>measure before and after education/activity implementation</i>) Number of referrals from providers after receiving education</p>			
<p>Progress toward National HIV Goals: By December 31, 2031, increase the 30-day ART start rate from 54% to 57% for newly diagnosed to prevent new HIV infections and improve HIV-related outcomes for People with HIV</p>			
<p>Objective 2: By December 31, 2031, the SDDOH will increase knowledge and understanding of HIV/AIDS among healthcare workers in mental health, addiction, and social work by offering at least 1 (one) free statewide training session per year</p>			
Key Strategies	Activities	Responsible Parties	Key Partners
<p>1. Create training for healthcare workers in mental health, addiction, and social work that focuses on reducing stigma and integrating HIV with co-occurring conditions (e.g., addiction, mental health)</p> <p>2. Offer training to healthcare workers in mental health, addiction, and social work through the SDDOH</p>	<p>1. Learn about the current knowledge gaps and biggest barriers healthcare workers in addiction, mental health, and social work face, secure free continuing education credit, partner with relevant organizations and develop curricula, and create simple printable cheat sheets for the workforce as a reference</p> <p>2. Offer hybrid and flexible formats, partner with other organizations to help market the training (if needed), and offer financial/logistical support to reduce barriers to participation</p>	SDDOH	SDDOH, Department of Corrections (DOC), DSS, Statewide Addiction, Mental Health, and Social Work Providers, University of South Dakota School of Medicine, Provider survey contractor
<p>Performance Measures: Number of annual trainings offered that focus on increasing knowledge and understanding of HIV</p>			

Number of providers who participate in annual trainings			
Progress toward National HIV goals: MH services are crucial for improving HIV-related outcomes by improving medication adherence and promoting higher rates of viral suppression and retention in care. Integrated services are also linked to improved quality of life/outcomes for PLWH.			
Objective 3: By December 31, 2031, increase viral suppression rates of PLWH from 85% to 95% by implementing social support services			
Key Strategies	Activities	Responsible Parties	Key Partners
1. Develop peer mentoring training and program for people living with HIV	1. Establish selection criteria and recruitment. Develop a standardized core curriculum focusing on understanding of ART adherence, viral suppression, U=U concept, confidentiality, and mandatory reporting. Implement a system for supervision	HRSA recipient and CDC and HRSA subrecipient	SDDOH, community-based providers and other providers and key stakeholders that serve PLWH
2. Offer peer mentoring services to people living with HIV	2. Prioritize newly diagnosed individuals, clients who have a detectable viral load, and clients identified as lost to follow-up		
Performance Measure: Number of peer mentors trained Number participating in mentoring program (mentors and mentees)			
Progress toward National HIV goals: Support for those living with HIV/AIDS has been shown to improve outcomes along the HIV care continuum. This includes enhanced linkage and retention in care, increased viral suppression, and better medication adherence. These improvements help in the prevention of new HIV infections and HIV-related outcomes for PLWH.			

Goal 3: Prevent New HIV Transmissions by Using Proven Interventions

Objective 1: By December 2028, increase the number of healthcare centers in rural South Dakota actively promoting and prescribing PrEP from two to five through targeted training, telehealth, and partnership development, to enhance local referral capacity and access to HIV prevention services

Key Strategies	Activities	Responsible Parties	Key Partners
1. Increase provider capacity to deliver PrEP services in rural and tribal areas through targeted education and resource distribution	1. Distribute a PrEP provider toolkit, implement virtual training sessions, and evaluate provider knowledge and confidence	SDDOH, HIV Prevention subrecipients, PPG members, people disproportionately impacted by HIV, community organizations, SD providers	SDDOH, HIV Prevention subrecipients, PPG members, people disproportionately impacted by HIV, community organizations, SD providers
2. Enhance referral networks and telehealth access to improve PrEP uptake among rural and tribal populations.	2. Integrate national PrEP telehealth programs such as Mistr and Sistr, develop a PrEP navigation and referral program, and track referral completion rates		
3. Develop and implement a statewide PrEP navigation system to support patients and providers	3. Create standardized referral workflows, provide navigation support, and monitor utilization and outcomes		

Performance Measures:

Number of providers prescribing PrEP
 Number of DIS/contracted referrals for PrEP

Progress toward National HIV goals: Increase PrEP access and usage to prevent new infections

Objective 2: By December 2027, increase the percentage of PrEP referrals provided from 56% to 80% to increase PrEP awareness and usage throughout South Dakota

Key Strategies	Activities	Responsible Parties	Key Partners
1. Increase accessibility of PrEP services by maintaining an up-to-date, available PrEP Provider directory	1. Develop and update a statewide PrEP provider list, promote it on the SDDOH website	SDDOH, HIV Prevention subrecipients, PPG members, people disproportionately impacted by HIV,	SDDOH, HIV Prevention subrecipients, PPG members, people disproportionately impacted by HIV,

<p>2. Enhance provider and DIS knowledge and capacity to deliver PrEP and PEP services</p> <p>3. Expand referral and navigation networks to improve PrEP uptake and continuity of care</p>	<p>and through subrecipients, and track the directory</p> <p>2. Provide targeted trainings for DIS and healthcare providers, assess knowledge gains, and monitor implementation of PrEP/PEP services</p> <p>3. Integrate national telehealth programs (e.g. Mistr, Sistr), develop a PrEP navigation referral program, and track referral completion and patient engagement</p>	<p>community organizations, SD providers</p>	<p>community organizations, SD providers</p>
<p>Performance Measures: Number of referrals given Number of trainings offered or provided to providers</p>			
<p>Progress toward National HIV goals: Increase PrEP access and usage to prevent new infections</p>			
<p>Objective 3: By December 2028, increase the number of identified PrEP access points in rural South Dakota from a 0 in 2025 to at least three by promoting national telehealth PrEP programs and supporting rural providers in offering PrEP services</p>			
Key Strategies	Activities	Responsible Parties	Key Partners
<p>1. Increase rural provider capacity to deliver PrEP services through targeted education and resources</p> <p>2. Enhance referral networks and telehealth access to improve PrEP uptake among rural populations</p>	<p>1. Distribute a PrEP provider toolkit, implement virtual training sessions, and evaluate provider knowledge and confidence</p> <p>2. Integrate national PrEP telehealth programs (e.g. Mistr, Sistr), develop a PrEP navigation referral program, and track</p>	<p>SDDOH, HIV Prevention subrecipients, PPG members, people disproportionately impacted by HIV, community organizations, SD providers, tribal partners</p>	<p>SDDOH, HIV Prevention subrecipients, PPG members, people disproportionately impacted by HIV, community organizations, SD providers, tribal partners</p>

3. Develop a statewide PrEP navigation system to support patients and providers	referral completion rates 3. Establish a statewide PrEP navigation referral program		
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Performance Measures:
Number of toolkits distributed to rural providers
Number of providers using the navigation system for patient referrals

Progress toward National HIV goals: Increase PrEP access and usage to prevent new infections

Goal 4: Respond Quickly to Potential Outbreaks to Get Appropriate Prevention and Treatment Services to People Who Need Them

Objective 1: By December 2031, develop a real-time data dashboard monitoring system to monitor current trends in new HIV infections to be able to detect and respond quickly to HIV clusters

Key Strategies	Activities	Responsible Parties	Key Partners
<p>1. Enhance HIV surveillance tools, partner services, and cluster detection systems to enable timely identification and response to HIV clusters</p> <p>2. Maintain a current, actionable State CDR Plan to guide roles, timelines, and communication processes</p> <p>3. Implement continuous evaluation of cluster detection and response efforts to improve effectiveness and outcomes</p>	<p>1. Develop and implement a cluster detection and response group to review surveillance data and monitor trends, and develop a HIV data dashboard</p> <p>2. Update the plan annually, communicate revisions to all stakeholders, and ensure alignment with CDC guidance</p> <p>3. Monitor cluster response metrics, conduct after action reviews, and adjust protocols based on evaluation findings</p>	<p>SDDOH, HIV Prevention subrecipients, PPG members, people disproportionately impacted by HIV, community organizations, SD providers, tribal partners</p>	<p>SDDOH, HIV Prevention subrecipients, PPG members, people disproportionately impacted by HIV, community organizations, SD providers, tribal partners</p>

Performance Measures:
The development of the HIV data dashboard

<p>Number of users accessing and utilizing the HIV dashboard monthly Annual review of the CDR Plan</p>			
<p>Progress toward National HIV goals: Continue to evaluate and improve our cluster detection and response plan and process to prevent new HIV infections, identify and reduce HIV related health disparities, and achieve an integrated coordinated effort to address the HIV epidemic</p>			
<p>Objective 2: By December 2028, DOH will have established and maintained partnerships with at least 5 tribal health agencies and 5 community-based organizations to support rapid response and delivery of HIV prevention and treatment services in priority areas (Baseline will be how many established MOUs we have currently)</p>			
Key Strategies	Activities	Responsible Parties	Key Partners
<p>1. Develop formal partnerships with tribal and community organizations to facilitate rapid communication and coordinated response to new HIV cases and clusters</p> <p>2. Strengthen ongoing engagement with tribal partners to support information sharing and coordinated HIV response</p> <p>3. Coordinate community-level HIV prevention and response efforts with tribal and community partners</p>	<p>1. Develop MOAs or data use agreements where possible, define roles and responsibilities, and track partnerships</p> <p>2. Host quarterly meetings, share cluster detection data, contact tracing updates, PrEP linkage information, and harm reduction strategies</p> <p>3. Implement targeted testing events, develop community-informed messaging campaigns, and evaluate reach</p>	<p>SDDOH, HIV Prevention subrecipients and contractors, PPG members, people disproportionately impacted by HIV, community organizations, SD providers, tribal partners</p>	<p>SDDOH, HIV Prevention subrecipients, PPG members, people disproportionately impacted by HIV, community organizations, SD providers, tribal partners</p>
<p>Performance Measures: Number of partnerships established Number of people reached through digital marketing campaigns</p>			
<p>Progress toward National HIV goals: Continue to increase and maintain tribal and community-based partnerships to achieve an integrated, coordinated effort that addresses the HIV epidemic among all partners and collaborators</p>			

Objective 3: By December 2027, implement at least two geo- targeted social media campaigns per year to reach populations identified in HIV hot spots, directing individuals to local testing and treatment services			
Key Strategies	Activities	Responsible Parties	Key Partners
<p>1. Use surveillance data and epidemiological data to target digital outreach in high-risk areas and networks</p> <p>2. Develop culturally appropriate digital content in partnership with community organizations to promote testing, PrEP, and treatment services</p> <p>3. Evaluate the effectiveness of digital outreach campaigns to improve engagement and HIV prevention efforts</p>	<p>1. Identify hotspot zip codes or networks with increased HIV diagnoses, prioritize outreach efforts, and monitor reach</p> <p>2. Create social media content, distribute social media channels, and track reach</p> <p>3. Measure clicks and website visits. Adjust campaign based on findings</p>	<p>SDDOH, HIV Prevention subrecipients, PPG members, people disproportionately impacted by HIV, community organizations, SD providers, tribal partners</p>	<p>SDDOH, HIV Prevention subrecipients, PPG members, people disproportionately impacted by HIV, community organizations, SD providers, tribal partners</p>
<p>Performance Measures: Number of hotspot and geo-targeted social media campaigns Number of people reached through social media campaigns (likes, shares, comments)</p>			
<p>Progress toward National HIV goals: Create and implement coordinated targeted social media campaigns with tribal and community-based partners to achieve an integrated, coordinated effort that addresses the HIV epidemic among all partners and collaborators</p>			

B. Updates to Other Strategic Plans Used

1. Integration with the HIV Prevention Plan

The SDDOH HIV Prevention Program and the Ryan White Program continue to collaborate closely to ensure alignment between prevention and care efforts, as reflected in the current Integrated HIV Prevention and Care Plan. Building on previous planning efforts, both programs coordinate strategies to reduce duplication and support a comprehensive, status-neutral approach to HIV prevention and care. Priority populations remain consistent with prior analyses, including males, Black/African American, American Indian, and individuals with identified exposure risks such as IDU and MSM.

Guided by the current HIV Prevention work plan and aligned with the EHE initiative, SDDOH has strengthened its approach across key pillars: Diagnose, Treat, Prevent, Respond, Surveillance, and Community Engagement. To support earlier diagnosis, efforts have focused on expanding routine, opt-out,

and at-home HIV testing in both healthcare and non-healthcare settings. These efforts are reinforced through targeted digital marketing campaigns and provider training. Together, these strategies aim to increase awareness, normalize testing, reduce late diagnoses, and improve access to testing statewide.

To improve treatment outcomes, SDDOH is enhancing linkage to care by promoting rapid connection to services within 30 days of diagnosis through strong collaboration with Ryan White providers and case managers. The SDDOH is also prioritizing training for DIS on referrals to essential support services including housing, transportation, behavioral health, and substance use treatment to support sustained engagement in care. Ongoing monitoring of linkage-to-care data allows for identification of barriers and continuous quality improvement.

Prevention-focused strategies emphasize increasing awareness and utilization of PrEP and PEP through digital prevention campaigns, provider education, and DIS training on PrEP referral processes. Additional efforts include expanding condom distribution and strengthening partnerships with community-based organizations to broaden reach. At the same time, SDDOH continues to enhance its ability to identify and respond to HIV clusters and outbreaks through regular multidisciplinary collaboration, timely data analysis, and rapid response activities.

The SDDOH also maintains a strong focus on surveillance and data systems by improving data collection, monitoring progress toward EHE goals, and ensuring strict adherence to data security and confidentiality standards. Community engagement remains central to all efforts, with ongoing collaboration through the PPG, quarterly meetings, tribal jurisdiction calls, and engagement with individuals with lived experience to inform program direction and ensure culturally responsive approaches.

Together, these coordinated, data-driven strategies strengthen the integration of HIV prevention and care services, expand access to both clinical and essential support services, and improve health outcomes for individuals at risk for or living with HIV across South Dakota.

VI. Implementation, Monitoring, and Follow-Up

A. Implementation

The South Dakota Department of Health (SDDOH) coordinates implementation of the Integrated HIV Prevention and Care Plan in collaboration with a network of partners, including Ryan White Part B and HIV prevention subrecipients, community-based organizations, tribal health partners, healthcare providers, and members of the Prevention Planning Group (PPG). These partners support implementation of activities across the HIV care continuum and ensure alignment with the plan's goals and objectives.

To achieve the goals and objectives of the Integrated Plan, SDDOH will strengthen coordination among existing partners while also engaging new partners, particularly those serving rural, tribal, and underserved communities. Efforts will focus on expanding partnerships with organizations that serve populations disproportionately impacted by HIV, including American Indian/Alaska Native communities, Black/African American and foreign-born individuals, men who have sex with men (MSM), and individuals who inject drugs or experience substance use.

People with HIV and representatives from disproportionately impacted communities will continue to be engaged through the PPG and other implementation activities. Their input will inform program design, service delivery, and ongoing improvements to ensure that strategies are responsive to community needs and reduce disparities across the HIV care continuum.

Providers and administrators across different funding streams, including CDC HIV Prevention and HRSA Ryan White HIV/AIDS Program (HAB) resources, will be coordinated through shared planning, communication, and aligned program activities. The Integrated Plan will guide how these funding streams are leveraged to support complementary prevention and care services, ensuring efficient use of resources while minimizing duplication and addressing service gaps.

The planning process identified a need to strengthen the use of the Integrated Plan as a guiding document for program activities. In response, SDDOH will align internal operations, partner activities, and funding decisions with the goals, objectives, and strategies outlined in the plan. Ongoing communication, targeted outreach, and partner engagement efforts will support collaboration across the state and ensure consistent implementation of plan activities.

B. Monitoring

The South Dakota Integrated HIV Prevention and Care Plan utilizes a structured, data-driven process to monitor progress toward achieving its goals and objectives. Monitoring is conducted collaboratively by the South Dakota Department of Health (SDDOH), Prevention Planning Group (PPG), and key stakeholders, including Ryan White Part B and HIV prevention subrecipients, community-based organizations, tribal partners, and healthcare providers.

Coordination across collaborators and funding streams is supported through shared reporting, regular communication, and alignment of activities across CDC HIV Prevention and HRSA Ryan White HIV/AIDS Program resources. This approach ensures integrated implementation of prevention and care services while minimizing duplication and identifying service gaps.

The PPG pillar groups, aligned with the Ending the HIV Epidemic (EHE) pillars—Diagnose, Treat, Prevent, and Respond—lead monitoring efforts for their respective goals. Each group receives biannual progress reports that include performance measures, surveillance data, and qualitative feedback. Progress is reviewed during biannual in-person meetings, where pillar groups assess whether objectives are being met, require continued effort, or need adjustments to strategies or goals.

The full PPG also convenes quarterly to review overall progress and ensure coordination with related plans, including Ryan White Part B planning and other statewide initiatives, helping to avoid duplication and address gaps in service delivery.

Monitoring activities follow established timelines, including quarterly and biannual reviews, to ensure timely assessment and continuous quality improvement. Together, these processes support a coordinated, efficient, and responsive approach to implementing the Integrated Plan.

C. Evaluation

Evaluation of the Integrated HIV Prevention and Care Plan will include both quantitative and qualitative methods to assess progress toward goals and objectives and support continuous quality improvement.

Quantitative evaluation will be based on performance measures for each objective, including indicators such as HIV testing, linkage to care, PrEP utilization, and viral suppression. Data will be collected from HIV surveillance, CDC HIV Prevention and HRSA Ryan White HIV/AIDS Program (HAB) reports, and partner-submitted data. Performance measures will be analyzed on an ongoing basis, with formal review conducted biannually to assess progress, identify trends, and address gaps.

Qualitative evaluation will be informed through ongoing engagement with partners and communities. Disease Intervention Specialists (DIS) and partners gather informal feedback through routine interactions with clients and priority populations, including people living with HIV. In addition, SDDOH will conduct

surveys to gather input from vulnerable populations, people with HIV, and providers to ensure broader representation.

Evaluation findings will be presented to the Prevention Planning Group (PPG) during biannual in-person meetings, where pillar groups review progress and determine whether strategies should be continued, modified, or replaced. The full PPG will also review data quarterly to ensure coordination across programs and funding streams.

These evaluation activities ensure the Integrated Plan remains data-informed, responsive, and aligned with statewide priorities.

D. Improvement

Continuous quality improvement (CQI) activities will be used to strengthen implementation of the Integrated HIV Prevention and Care Plan and ensure progress toward achieving established goals and objectives.

Data will be used on an ongoing basis to inform improvements, including analysis of performance measures, HIV surveillance data, and program reports. These data will be reviewed quarterly and biannually to identify trends, gaps, and areas where strategies may need to be adjusted.

Community input will also play a key role in the improvement process. Feedback gathered by Disease Intervention Specialists (DIS), community partners, providers, and people living with HIV—along with results from structured surveys—will be used to identify barriers, emerging needs, and opportunities to enhance services, particularly for populations disproportionately impacted by HIV.

Revision decisions will be made by the Prevention Planning Group (PPG) during biannual in-person meetings, with additional review occurring quarterly. Based on data and community input, the PPG will determine whether strategies should be continued, modified, or discontinued, and whether new approaches are needed to better achieve desired outcomes.

These processes ensure that the Integrated Plan remains responsive, data-informed, and aligned with community needs while supporting ongoing improvements in HIV prevention and care outcomes.

E. Reporting and Dissemination

The South Dakota Department of Health (SDDOH) will ensure that collaborators, including people living with HIV, providers, community partners, and other stakeholders, are regularly informed about progress on the Integrated HIV Prevention and Care Plan, including implementation, monitoring, evaluation, and improvement activities.

Progress updates will be shared with the Prevention Planning Group (PPG) on an annual basis, with comprehensive progress summaries developed and disseminated. Information will be presented through reports, presentations, and summary materials and distributed electronically to PPG members and stakeholders to support transparency and ongoing engagement.

Findings from monitoring and evaluation activities, along with updates on plan improvements, will be shared with collaborators to ensure alignment across partners and programs. Input gathered from people living with HIV, community partners, and providers through routine engagement and surveys will also be incorporated into reporting to ensure that dissemination reflects both data and community perspectives.

These processes ensure that collaborators remain informed of progress and have ongoing opportunities to contribute to the implementation and refinement of the Integrated Plan.

F. Achievements/challenges in implementing

1. Challenges in Reviewing and Updating the Integrated Plan

A key challenge during the previous performance period was the absence of a formalized process for routine review and updating of the Integrated HIV Prevention and Care Plan.

Without established expectations, timelines, or accountability mechanisms, the plan was not systematically revisited to assess progress, incorporate new data, or respond to emerging trends. This limited the state's ability to make timely, data-driven adjustments and ensure that strategies remain aligned with current epidemiological patterns and community needs.

Additionally, competing priorities, limited staff capacity, and the lack of a structured forum dedicated to planning review contributed to the difficulty in maintaining the plan as a living document. While data and stakeholder input were collected through various activities, there was no consistent mechanism to integrate this information into formal updates of the plan.

Recognizing these challenges, the South Dakota Department of Health (SDDOH) is prioritizing the development of a more structured and sustainable approach to ongoing plan review and revision under the new integrated plan.

2. Strategies to Resolve Challenges

To address challenges related to the lack of routine review and updating of the Integrated Plan, the South Dakota Department of Health (SDDOH) will implement a structured and sustainable review process. Review of the Integrated HIV Prevention and Care Plan will be established as a permanent agenda item during all in-person Prevention Planning Group (PPG) meetings, ensuring consistent oversight, discussion of progress, and identification of updates needed.

In addition, Pillar Work Groups will play an active role in reviewing relevant data, monitoring progress within their respective focus areas, and recommending updates as needed. This approach will support timely, data-driven modifications to the plan and reinforce its role as a living document that remains responsive to evolving needs, priorities, and epidemiological trends across the state.

VII. Letters of Concurrence

May 28, 2026

Andrew Schwenk
Project Officer
Centers for Disease Control and Prevention (CDC)
Division of HIV Prevention

Capt. Kathleen Edelman
Public Health Analyst
Health Resources and Services Administration (HRSA)
HIV/AIDS Bureau

Dear CDC and HRSA Project Officers:

Thank you for the opportunity to submit the State of South Dakota's CY 2027–2031 Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN), to the Centers for Disease Control and Prevention and the Health Resources and Services Administration.

I have reviewed the plan and find that the goals and objectives presented are aligned with South Dakota's statewide priorities as well as the National HIV/AIDS Strategic Plan and the Ending the HIV Epidemic initiative. The plan reflects a comprehensive, data-driven approach and incorporates meaningful input from consumer and provider stakeholders, members of the South Dakota Prevention Planning Group, Ryan White HIV/AIDS Program partners, and other community collaborators across the state.

The South Dakota Department of Health, Division of Disease Prevention and Control provides concurrence and fully supports the submission, implementation, monitoring, and ongoing evaluation of the State's 2027–2031 Integrated HIV Prevention and Care Plan.

We appreciate our continued partnership with CDC and HRSA in advancing HIV prevention, care, and treatment efforts throughout South Dakota.

Sincerely,



Joshua Clayton, PhD, MPH
State Epidemiologist/Director
Division of Disease Prevention and Control
South Dakota Department of Health

May 16, 2026

Andrew Schwenk
Project Officer
Centers for Disease Control and Prevention (CDC)
Division of HIV Prevention

Capt. Kathleen Edelman
Public Health Analyst
Health Resources and Services Administration (HRSA)
HIV/AIDS Bureau

RE: Letter of Concurrence – CY 2027–2031 Integrated HIV Prevention and Care Plan

Dear CDC and HRSA Project Officers,

On behalf of the South Dakota Prevention Planning Group (SD PPG), we affirm our concurrence with the State of South Dakota’s 2027–2031 Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN), submitted by the South Dakota Department of Health.

The SD PPG was actively engaged throughout the planning process, including reviewing surveillance, epidemiologic, and needs assessment data; identifying populations disproportionately impacted by HIV; participating in community engagement activities; and providing input on priorities, goals, and SMART objectives aligned with national HIV strategies.

Representing public health professionals, community-based organizations, HIV providers, Ryan White HIV/AIDS Program partners, people with HIV, and other key stakeholders, the SD PPG helped ensure a coordinated, data-driven approach to HIV prevention and care across South Dakota.

The SD PPG affirms that this Integrated Plan meets CDC Division of HIV Prevention planning requirements and reflects the needs of the populations and geographic areas most impacted by HIV in the state. We remain committed to partnering with the South Dakota Department of Health and stakeholders to implement, monitor, evaluate, and refine the plan throughout the 2027–2031 planning cycle.

Sincerely,



Justin Reinfeld
DOH Co-Chair, South Dakota Prevention Planning Group



Amber Corey
Community Co-Chair, South Dakota Prevention Planning Group

VIII. References

- AIDSvu. (2024). *PrEP use and HIV data visualization*. <https://aidsvu.org>
- Centers for Disease Control and Prevention. (2022). *HIV surveillance report, 2022* (Vol. 34). U.S. Department of Health and Human Services. <https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>
- Centers for Disease Control and Prevention. (2023). *Ending the HIV epidemic in the U.S. initiative*. <https://www.cdc.gov/endhiv>
- Centers for Disease Control and Prevention. (2024). *HIV care continuum*. <https://www.cdc.gov/hiv>
- Centers for Disease Control and Prevention. (2024). *Overdose prevention: Provisional drug overdose death counts*. <https://www.cdc.gov/overdose>
- Health Resources and Services Administration. (2022). *Ryan White HIV/AIDS Program Part B manual*. U.S. Department of Health and Human Services. <https://hab.hrsa.gov>
- Health Resources and Services Administration & Centers for Disease Control and Prevention. (2022). *Integrated HIV prevention and care plan guidance, including the statewide coordinated statement of need, 2022–2026*. U.S. Department of Health and Human Services.
- Helpline Center. (2026). *211 South Dakota resource database*. <https://www.helplinecenter.org>
- South Dakota Department of Health. (2025). *Cluster detection and response (CDR) manual*. Pierre, SD: South Dakota Department of Health.
- South Dakota Department of Health. (2026). *Epidemiologic profile of HIV in South Dakota, 1985–2024*. Pierre, SD: South Dakota Department of Health.
- South Dakota Department of Health. (2026). *HIV surveillance report, 2025*. Pierre, SD: South Dakota Department of Health.
- South Dakota Department of Health. (2026). *Provider needs assessment survey results*. Pierre, SD: South Dakota Department of Health.
- South Dakota Department of Health. (2026). *Ryan White Part B client satisfaction survey results*. Pierre, SD: South Dakota Department of Health.
- U.S. Department of Health and Human Services. (2022). *National HIV/AIDS strategy for the United States 2022–2025*. <https://www.hiv.gov/federal-response/national-hiv-aids-strategy>