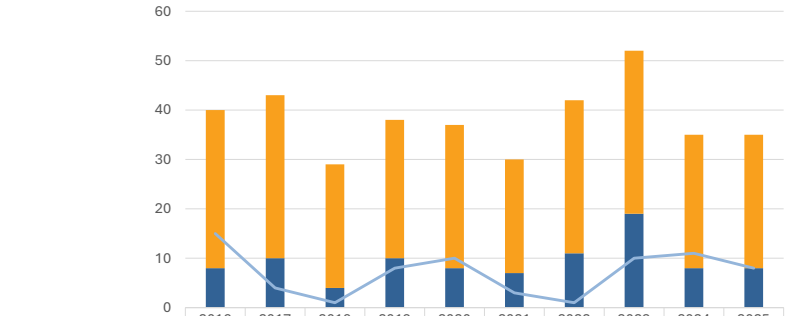
2026 HIV/AIDS Surveillance Report

Persons newly diagnosed with HIV or AIDS in South Dakota, cases by gender, 2016-2025

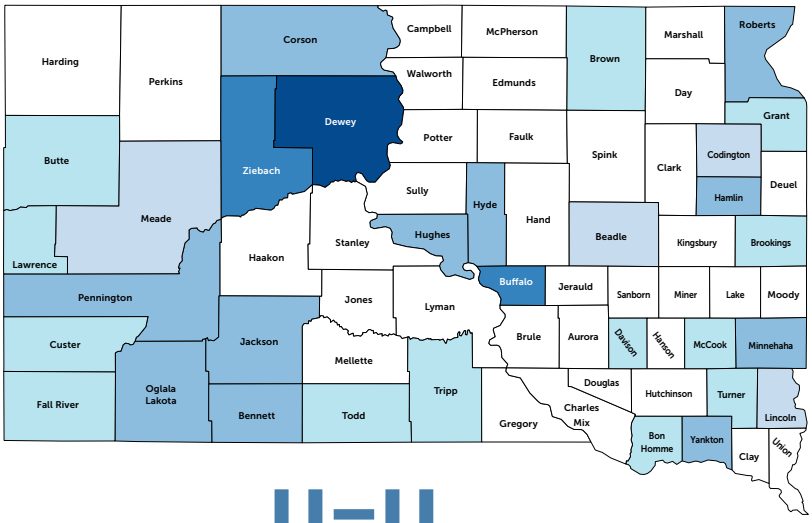
**Gender is shown in this report as that which was assigned at birth.*

**8 (23%) of incident cases diagnosed in 2025 were among foreign-born cases.*



	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Male	32	33	25	28	29	23	31	33	27	27
Female	8	10	4	10	8	7	11	19	8	8
Foreign-born US cases	15	4	1	8	10	3	1	10	11	8

Persons diagnosed with HIV in South Dakota, Cumulative Incidence rate, by county of residence at diagnosis, 2021-2025.



Rate per 10,000

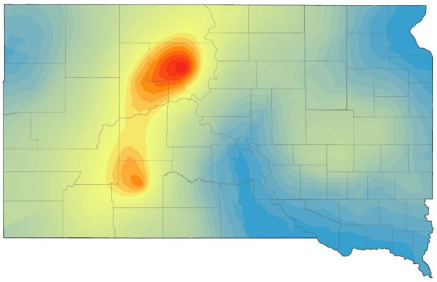
- 0
- 0.1 - 0.7
- 0.71 - 1.8
- 1.81 - 8.1
- 8.11 - 21.0
- 21.01 - 40.0

Rates have been calculated based on number of diagnoses, per county, since 2021 in South Dakota. To portray an accurate disease rate per county, rates were calculated per 10,000, based on 2023 SD county population estimates from the United States National Cancer Institute.[1]

U=U

Undetectable = Untransmittable

Research shows that people living with HIV who maintain an undetectable (virally suppressed) viral load do not transmit HIV to sexual partners.[2] Viral suppression occurs when HIV treatment reduces the amount of virus in the blood to fewer than 200 copies/mL.



Maintaining viral suppression requires consistent access to HIV medical care, antiretroviral therapy, and supportive services. When individuals experience disruptions in care — such as gaps in insurance coverage, transportation barriers, housing instability, stigma, mental health concerns, or substance use challenges — maintaining viral suppression can become more difficult.

Elevated viral loads may reflect barriers to care rather than lack of effort. Addressing structural and social determinants of health is essential to improving viral suppression rates and preventing new HIV infections in South Dakota.

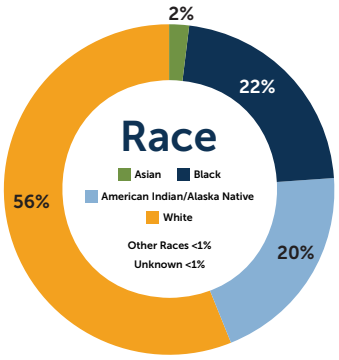
The map illustrates the geographic distribution of viral suppression among people living with HIV in South Dakota. Areas shown in red represent a higher proportion of individuals with unsuppressed viral loads, while areas in blue represent a higher proportion of individuals who are virally suppressed.

Characteristics of persons living with HIV in South Dakota (SD)

According to data available in February, 2026

As of December 31, 2025, there were 908 people with HIV and/or AIDS known to be living in South Dakota.

Of the 135 additional prevalent cases reported during 2024-2025, 79 (59%) cases were diagnosed out of state and reported residence in SD in 2025.



Prevalence Rate by Race and Ethnicity

*Based on 2023 SD population estimates from the National Cancer Institute [1]

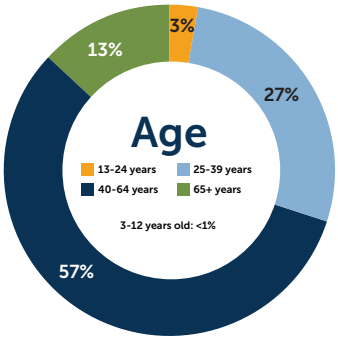
BLACK/AFRICAN AMERICAN: **67.1** per 10,000

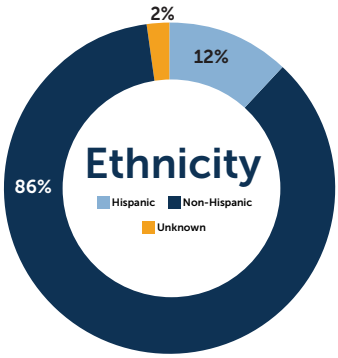
AMERICAN INDIAN/ALASKA NATIVE: **22.0** per 10,000

WHITE: **6.4** per 10,000

ASIAN: **7.9** per 10,000

HISPANIC: **23.9** per 10,000



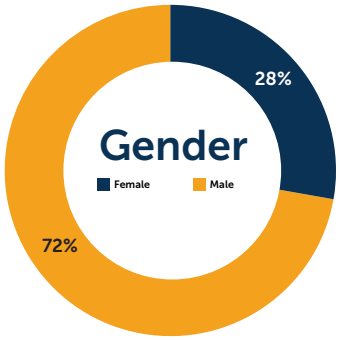


Racial & Ethnic Disparities in South Dakota

BLACK/AFRICAN AMERICAN:
Black/African Americans make up only **3.2%** of South Dakota's population, but account for **22%** of SD HIV/AIDS cases.[1]

AMERICAN INDIAN/ALASKA NATIVE:
American Indian/Alaska Natives make up only **9%** of South Dakota's population, but account for **20%** of SD HIV/AIDS cases.[1]

HISPANIC ETHNICITY:
Individuals of Hispanic ethnicity make up only **5%** of South Dakota's population, but account for **12%** of SD HIV/AIDS cases.[1]



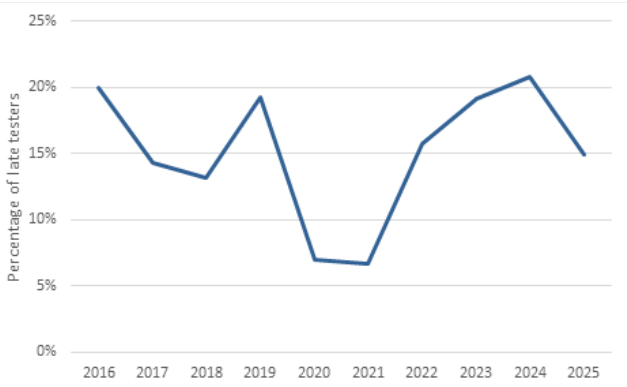
HIV and AIDS (Stage 3 HIV)

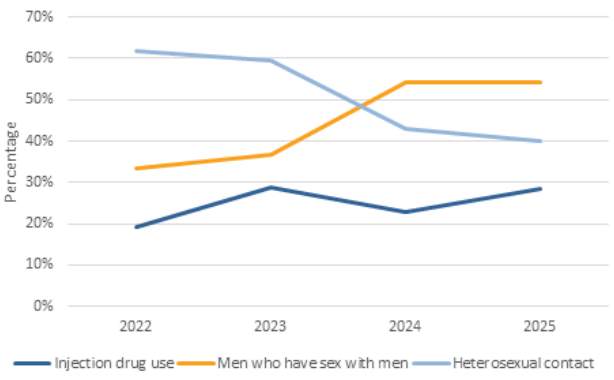
A person is diagnosed with AIDS (also called Stage 3 HIV) when HIV has significantly damaged the immune system. This is determined by specific laboratory criteria or the presence of certain opportunistic infections.

Without treatment, HIV can progress to AIDS over time. However, with early diagnosis and consistent treatment, most people with HIV can live long, healthy lives and may never develop AIDS.[2] In South Dakota, 33.2% of people living with HIV have received an AIDS (Stage 3) diagnosis.

"Late Testers"

Individuals diagnosed at a later stage miss the opportunity for early treatment and viral suppression, which may contribute to ongoing transmission. Reducing late diagnoses is therefore essential for both improving health outcomes and preventing new infections.[2]





Risk factors reported for persons newly diagnosed with HIV in South Dakota, 2022-2025

Intravenous drug use continues to be a common means of HIV transmission in the United States. Most recently published by the Centers for Disease Control and Prevention (CDC), by the end of 2022, people who inject drugs accounted for 7% of the total HIV diagnoses in the United States[3]. In comparison, 29% of South Dakotans diagnosed with HIV in 2025 reported injection-drug use.

HIV Care Continuum

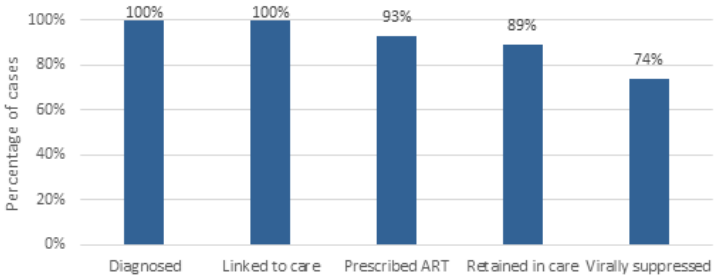
The HIV Care Continuum illustrates the number of clients in South Dakota who are:

Diagnosed: Clients who have a positive confirmatory HIV test.

Received Care: Clients who have been referred to a care provider and have received at least one visit.

Retained in Care: Clients who are seeing their provider on a routine basis.

Prescribed ART: Clients who have been prescribed anti-retroviral therapy.



Virally Suppressed: Clients who have an undetectable viral load. Scientific advances have shown that antiretroviral therapy (ART) preserves the health of people living with HIV. People with HIV who take HIV medicine as prescribed and get and keep an undetectable viral load (or stay virally suppressed) have effectively no risk of transmitting HIV to their HIV-negative sexual partners.[2] Viral suppression is defined as HIV RNA less than 200 copies/mL.[2]

Table on the right shows the number of individuals newly diagnosed with HIV that had a documented history of a prior STI, including hepatitis C. These findings demonstrate the importance of incorporating routine HIV testing into all STI screening to ensure earlier diagnosis and linkage to care.

HIV Co-infection with Chlamydia, Gonorrhea, Hepatitis C, Syphilis & Tuberculosis (TB) by Sex and Age, South Dakota, 2025

		Sex		Age Groups			
	Total*	Female	Male	13-24 Years	25-44 Years	45-65 Years	66+ Years
Chlamydia	6	2	4	4	1	1	0
Gonorrhea	4	0	4	0	2	2	0
Hepatitis C	5	2	3	2	2	1	0
Syphilis	10	1	9	2	5	3	0
TB	0	0	0	0	0	0	0
Total	25	5	20	8	10	7	0

PrEP: Pre-Exposure Prophylaxis

HIV can be prevented. Pre-exposure prophylaxis (PrEP) is medication taken by people at risk of HIV to prevent infection. [4]

Daily oral PrEP (Truvada® or Descovy®) reduces the risk of getting HIV from sex by up to 99% when taken as prescribed. Among people who inject drugs, PrEP reduces the risk of HIV by at least 74%.

Long-acting injectable PrEP options are also available:

- Apretude® (cabotegravir) is FDA-approved for adults and adolescents weighing at least 77 pounds and is administered once every two months.
- A six-month injectable PrEP option (lenacapavir) has been approved, expanding prevention choices for individuals who prefer less frequent dosing.

Injectable PrEP may be a good option for individuals who:

- Prefer not to take a daily pill
- Have difficulty taking daily medication
- Are not candidates for oral PrEP

PrEP does not replace other prevention strategies, such as condom use or treatment for people living with HIV, but it is a highly effective tool to prevent new infections.

Provider Resources

Clinicians interested in prescribing PrEP can access consultation and clinical support through the National Clinician Consultation Center (1-855-448-7737, Monday–Friday, 10 a.m.–7 p.m. CT).

South Dakota providers can also access state-specific prevention resources and patient education materials at:

Healthy AF – South Dakota's HIV Prevention Resource Page: https://communityhealthcare.net/healthy-af/

Healthy AF connects community members and providers to information about HIV testing, prevention, and PrEP services across the state.

Perinatal Exposure

During 2016–2025, 36 infants in South Dakota were exposed to HIV during pregnancy which resulted in one (2.7%) confirmed case of transmission. This highlights the critical role of routine perinatal HIV screening, maintaining maternal viral suppression during pregnancy, and ensuring timely post-exposure prophylaxis for infants born to mothers with HIV to prevent perinatal transmission

Ryan White Program

Background

The populations hit hardest by the HIV epidemic are those at elevated risk for poverty, those who lack health insurance, and those who are disenfranchised from the health care system. In August 1990, Congress enacted the Ryan White Care Act.[5] The Care Act established different parts (A, B, C, D, and F) to fund HIV care. Ryan White Part B funding is awarded directly to states and territories to improve availability of care for low-income, uninsured or underinsured individuals affected by HIV. Funding is allocated with an emphasis on service quality and fiscal accountability. The Office of Disease Prevention Services in the Division of Disease Prevention and Control manages this award. The award partially funds Part B Services in South Dakota.

Benefits

The South Dakota Department of Health administers benefits in accordance with federal guidelines and available funding. The Department subcontracts with a community-based organization (CBO) to help HIV+ individuals access Part B Services.

- AIDS Drug Reimbursement Program (ADAP) – financial assistance for specific prescription drugs
- Medical Case management – a range of client centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatment is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, throughout, ongoing assessments of the clients and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV treatments. The main goal results in the client reaching optimum level health and being able to manage his or her own care.
- Assistance with specific healthcare needs.

For information on how to apply, visit https://doh.sd.gov/topics/disease-prevention-services/hivaids/ryan-white-part-b-program/. For more information on program specifics, contact the Ryan White Program Coordinator at 605-367-4795 or via email at Virginia.Albertson@state.sd.us.

Confidential Disease Reporting

The South Dakota Department of Health is authorized by SDCL 34-22-12 and ARSD 44:20 to collect and process mandatory reports of communicable diseases.

HOW TO REPORT:

SECURE WEBSITE: http://sd.gov/diseasereport

TELEPHONE: 1-800-592-1861 or 605-773-3737

MAIL OR COURIER:
Infectious Disease Surveillance, Department of Health, 615 East 4th Street, Pierre, SD 57501

Positive Connections

The Disease Intervention Specialists (DIS) assist to provide linkage to care services for HIV/AIDS patients who have fallen out of care. If you have a patient for whom you would like to discuss reengagement in care, please contact the Positive Connections Coordinator via email at Ana.Nemec@state.sd.us.

Surveillance Questions?

Questions regarding the surveillance report may be directed to Justin Reinfeld, HIV Prevention and Surveillance Coordinator, at 605-367-7202 or Justin.Reinfeld@state.sd.us.

Department of Health Confidential HIV Testing Centers - *Call Toll Free 1-800-592-1861*

RAPID CITY
221 Mall Dr., Suite 102, Rapid City, SD 57701
605-394-2289 & 1-866-474-8221

SIOUX FALLS
1501 S. Highline Ave., Suite 1F, Sioux Falls, SD 57106
605-367-5363 & 1-866-315-9214

ABERDEEN
402 S. Main St.
Aberdeen, SD 57401
605-626-2373
1-866-805-1007

PIERRE
740 E. Sioux Ave., Suite 107
Pierre, SD 57501
605-773-5348
1-866-229-4927

WATERTOWN
2001 SW 9th Ave., Suite 500
Watertown, SD 57201
605-882-5096
1-866-817-4090

MITCHELL
1420 North Main St
Mitchell SD 57301
605-995-8051

MOBRIDGE
210 E Grand Crossing, Ste A
Mobridge, SD 57601
605-951-9165
1-833-618-2740

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1. National Cancer Institute. Surveillance, epidemiology and end results program. Retrieved from https://seer.cancer.gov/popdata/download.html#single. Accessed 02/08/2026.
2. Centers for Disease Control. (October, 2024) HIV Treatment as Prevention. Retrieved from https://www.cdc.gov/hivpartners/php/hiv-treatment/index.html#:~:text=Purpose,sometimes%20called%20treatment%20as%20prevention. Accessed on 03/04/2025
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SOUTH DAKOTA DEPARTMENT OF HEALTH

2026 HIV/AIDS Surveillance Report
TECHNICAL NOTES

Page 1.

New diagnosis of HIV reflected in the figure "Persons newly diagnosed with HIV or AIDS in South Dakota, cases by gender, 2016-2025". New diagnosis of HIV is based on incident (newly reported) cases of HIV/AIDS diagnosed in South Dakota during 2016-2025 by diagnosis year. People moving to South Dakota already diagnosed with HIV/AIDS are excluded if they were previously reported in another state. The figure describes confirmed cases of HIV/AIDS that have been completed and pending completion. The figure captures distribution of cases by gender assigned at birth.

Distribution of incident cases by county. "Persons diagnosed with HIV in South Dakota, Incidence rate, by county of residence at diagnosis, 2020-2025". The figure describes incident HIV cases diagnosed in South Dakota in 2020-2025 by county of residence at time of diagnosis. The rates are calculated per 10,000 population using 2023 National Cancer Institute estimates for South Dakota counties.

Prevalence: The prevalent cases include confirmed HIV cases, with investigation status of completed, pending or out of state, who have been known to SDDOH as being alive as of December 31, 2025, and known to reside in South Dakota. Prevalent case count excludes cases that have been reported as dead as of December 31, 2025, by either state's vital records or national death index (NDI). Likewise, a person's county or city of residence is assumed to be the most recently reported value unless the SDDOH is otherwise notified. Resident information is updated through standard case reporting, routine lab reporting, and/or correspondence with other state health departments. People diagnosed with HIV infection while imprisoned in a state correctional facility are included in the data presented unless otherwise noted (people who are federally and privately incarcerated are excluded).

The heatmap titled "U=U: Undetectable=Untransmittable" is based on prevalent HIV/AIDS cases who are alive and live in South Dakota, regardless of state/country of diagnosis. The heatmap indicates counties with the highest prevalence of non-virally suppressed cases (in red color). Calculations are based on three-step procedure: First, we calculate percentage of virally unsuppressed cases among all prevalent HIV cases by county. Second, we calculate prevalence of all HIV cases by county (regardless of viral suppression status). In a final step we multiply percentage of virally suppressed cases for each county to the overall prevalence of HIV by county. This way we generate non-virally suppressed rate weight by HIV prevalence rate which is presented on the heatmap.

Page 2.

Data displayed on race, ethnicity, age, and gender, reflect the prevalent HIV case counts. Race categories presented are self-reported and are further classified based on a hierarchy prioritizing racial minorities (e.g. Native American/American Indian and Black/African American) when individuals are multi-racial. Age groups are based on age as of December 31, 2025, and are calculated using date of birth of each case.

Prevalence per 10,000 population for each racial category is calculated using 2023 National Cancer Institute data for South Dakota with single race (not a combination of races) as a denominator.

Statement about racial and ethnic disparities describes racial and ethnic minorities (e.g. Native American/American Indian, Black/African American or Hispanic) and is based on percentage of cases classified as either racial category listed in surveillance data and is compared to percentage of population estimates provided by National Cancer Institute for 2023 as a single race.

Number of cases relocated to SD after being diagnosed with HIV in a different state was calculated based on a date reported as a case in SD.

Percentage of AIDS diagnoses among HIV-diagnosed individuals is based on prevalent case count (confirmed, completed, pending, out of state cases living in South Dakota) known to be alive as of December 31, 2025, and being diagnosed with HIV and/or AIDS on or before December 31, 2025.

Percentage of late testers (cases diagnosed with AIDS with ≤1 year) is based on incident HIV and AIDS cases (confirmed and completed cases with South Dakota as a state of diagnosis). Cases of AIDS have been diagnosed with AIDS-defining conditions during 2016-2025. Percentage of late testers have been calculated using AIDS cases that progressed into AIDS within ≤1 year of HIV diagnosis with HIV and AIDS combined as a denominator. The year of diagnosis is the year of HIV or AIDS diagnosis of cases.

Risk-factors of cases are based on incident cases of HIV diagnosed with HIV during 2016-2025 in South Dakota. Year of diagnosis is the year reported on the figure. Risk-factors do not follow hierarchy commonly used in risk-factor classification. If a case reports multiple risk-factors, overall percentage for each risk-factor is calculated separately for each risk-factor with total number of incident cases as a denominator. Number of individuals reporting injection drug use is calculated by summarizing number of cases who report only injection drug use and injection/non injection drug use.

Page 3.

HIV care continuum is based on prevalent HIV cases residing in South Dakota as of Dec 31, 2025, that have been diagnosed with HIV, linked to care, prescribed antiretroviral medications (ART), retained in care, or are virally suppressed as of Dec 31, 2025. Percentages are calculated using a common denominator of all prevalent cases.

According to CDC, STDs are associated with increased risk for HIV sexual acquisition and transmission[1]. **The table entitled "Coinfection with chlamydia, gonorrhea, hepatitis C, syphilis & Tuberculosis (TB)"** reflects prevalent HIV cases co-infected with chlamydia, gonorrhea, hepatitis C, syphilis & tuberculosis by year, age, and sex. Years of co-infection are based on event dates of chlamydia, gonorrhea, hepatitis C, syphilis, and tuberculosis (TB) rather than diagnosis of HIV. Coinfected cases with event dates prior to HIV diagnosis date are excluded from analysis. Only cases being diagnosed with chlamydia, gonorrhea, hepatitis C, syphilis & tuberculosis after being diagnosed with HIV are included. Coinfections are calculated using completed case counts of confirmed and probable cases of chlamydia, gonorrhea, hepatitis C (acute, chronic, perinatal), syphilis (all stages) and tuberculosis (active TB cases diagnosed in SD). Age and gender of cases presented in the table reflect age and gender at the time of chlamydia, gonorrhea, hepatitis C, syphilis, or tuberculosis event dates.

Perinatal exposure data are based on number of babies exposed in utero during 2016-2025 who subsequently developed HIV. Number of confirmed cases among the infants (children aged <1 years) is based on date of birth of a baby while number of perinatal exposures is based on event date (first labs, baby's birth date, or date SDDOH was notified of the birth).

Supplementary Information

Routine Interstate Duplicate Review (RIDR).
The South Dakota Department of Health continues to participate in RIDR. RIDR is a CDC project aimed at eliminating duplicate reports of HIV and AIDS cases among states. Each case of HIV and AIDS is assigned to the state (or states when the diagnosis of HIV and AIDS occurs in two different states) where a person was first diagnosed. RIDR is now an ongoing activity that all states are expected to undertake. CDC will release a RIDR report every six months which will affect the ownership of South Dakota cases. Ongoing participation in this initiative will allow for proper attribution of incident and prevalent cases in South Dakota.

References

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