Australian Government
Department of Health, Disability and Ageing

Interim Australian Centre for Disease Control

National Syphilis Surveillance Report

Quarter 2 2025

Introduction

On 21 November 2023, the Australian Health Protection Committee (AHPC) endorsed the National Syphilis Response Plan 2025 – 2030 (Response Plan). Four overarching national goals have been adopted to be pursued throughout the life cycle of the Response Plan (2023-2030):

1. Strengthen prevention and testing strategies for syphilis in priority populations and settings, targeting high-burden areas.
2. Reduce ongoing transmission and incidence of syphilis across priority populations.
3. Reduce morbidity and mortality associated with syphilis.
4. Eliminate congenital syphilis (defined as sustained zero congenital syphilis cases).

The Response Plan builds on the efforts of the National strategic approach for responding to rising rates of syphilis 2021.

The National Syphilis Surveillance and Monitoring Plan (the Surveillance Plan) outlines indicators that will be used to monitor progress towards achieving the above goals. Each goal covers a set of related indicators that can be disaggregated to allow finer-grained interpretation.

Reporting

This report provides a quarterly account of progress against the goals and selected indicators in the Surveillance Plan, using data available at the time of writing. A complete list of indicators and the reporting schedule are provided at Appendix A.

Completeness of NNDSS data used in this report have been calculated and are summarised at Appendix B. Where completeness is less than 50% data have been excluded from reporting.

A quarterly summary of data reported against selected indicators is provided in Table 1 and Table 2.

Guidance

When considering this report we recommend you refer to the Surveillance Plan for detailed notes on the indicators and data sources.

Table 1: Quarterly summary of indicator data for the reporting period

Legend: ↑increase ↓decrease → stable

Indicators		Comparisons		
Ref.	**Summarised indicator description**	**Current quarter (Q2 2025)***	**Previous quarter (Q1 2025)**	**Previous 12 months (quarterly average) (Q3 2024 – Q2 2025)**
GOAL 1 - Strengthen prevention and testing strategies for syphilis in priority populations and settings, targeting high-burden areas				
Indicators 1.1 and 1.4 – 1.10 reported annually				
1.2	Number of syphilis tests	7,631 ↓↑ (cumulative 168,804)	7,907	7,475
1.3	Syphilis testing coverage – target population	16% →↑	16%	15%
	Syphilis testing coverage – total population	26% →↑	26%	25%
	Type of syphilis test – total population	87% ↓↓	92%	91%
	Serology only	3% ↑↑	1%	2%
	PoCT only			
	Both (PoCT & serology)	10% ↑↑	7%	7%
GOAL 2 - Reduce ongoing transmission and incidence of syphilis across priority populations				
2.1	Infectious syphilis rates – Aboriginal and Torres Strait Islander males	34 (per 100,000) ↓↓	43 (per 100,000)	36 (per 100,000)
	Infectious syphilis rates – Aboriginal and Torres Strait Islander females	33 (per 100,000) ↓↓	36 (per 100,000)	31 (per 100,000)
	Infectious syphilis rates – Non-Indigenous males	8 (per 100,000) ↓→	9 (per 100,000)	8 (per 100,000)
	Infectious syphilis rates – Non-Indigenous females	2 (per 100,000) →→	2 (per 100,000)	2 (per 100,000)
Mapped indicators 2.2 and 2.3				
2.4		44 (per 100,000) ↓↓	52 (per 100,000)	46 (per 100,000)

Indicators		Comparisons		
Ref.	**Summarised indicator description**	**Current quarter (Q2 2025)***	**Previous quarter (Q1 2025)**	**Previous 12 months (quarterly average) (Q3 2024 – Q2 2025)**
	Remoteness area and women of reproductive age: Infectious syphilis rates – Aboriginal and Torres Strait Islander women	36 (per 100,000) ↓↑	44 (per 100,000)	35 (per 100,000)
	Major cities Inner/outer regional Remote/very remote	201 (per 100,000) ↓↑	208 (per 100,000)	183 (per 100,000)
	Remoteness area and women of reproductive age: Infectious syphilis rates – non-Indigenous women	3 (per 100,000) ↓→	4 (per 100,000)	3 (per 100,000)
	Major cities	3 (per 100,000) ↑→	2 (per 100,000)	3 (per 100,000)
	Inner/outer regional Remote/very remote	2 (per 100,000) ↓→	4 (per 100,000)	2 (per 100,000)
2.5	Men, notified with infectious syphilis, reporting sexual exposure with men only (%)	51% →↑	51%	49%
2.6	Men, notified with infectious syphilis, reporting sexual exposure with men and women (%)	6% ↓→	7%	6%
Indicators 2.7 – 2.10 reported annually				
GOAL 3 - Reduce morbidity and mortality associated with syphilis				
Data reported annually (indicators 3.1 – 3.3)				
GOAL 4 - Eliminate congenital syphilis (defined as sustained zero congenital syphilis cases)				
4.4	Women of reproductive age pregnant at infectious syphilis diagnosis – Aboriginal and Torres Strait Islander women	11% ↓↓	16%	14%

Indicators		Comparisons		
Ref.	**Summarised indicator description**	**Current quarter (Q2 2025)***	**Previous quarter (Q1 2025)**	**Previous 12 months (quarterly average) (Q3 2024 – Q2 2025)**
	Women of reproductive age pregnant at infectious syphilis diagnosis – non-Indigenous women	14% ↓→	16%	14%
Summary for indicators 4.1 – 4.3 and 4.5 - 4.8 in table 2				

*Arrows indicate increase/decrease compared to subsequent columns.

Table 2: Summary of indicator data for the reporting period

Indicators		Comparisons		
Ref.	**Summarised indicator description**	**Current year to date (Q1 - Q2 2025)**	**Last complete year (2024)**	**Previous complete year (2023)**
GOAL 4 - Eliminate congenital syphilis (defined as sustained zero congenital syphilis cases)				
4.1 & 4.2	Congenital syphilis cases (deaths) Aboriginal and Torres Strait Islander infants	4 (3)	3 (0)	13 (7)
	Congenital syphilis cases (deaths) – non-Indigenous infants	5 (1)	6 (3)	7 (3)
	Congenital syphilis cases (deaths) – unknown Indigenous status	-	1 (1)	-
4.3	Congenital syphilis notification rate (per 100,000 live births) - Aboriginal and Torres Strait Islander infants	16 (per 100,000 live births)1	12 (per 100,000 live births)	53 (per 100,000 live births)
	Congenital syphilis notification rate (per 100,000 live births) – non-Indigenous infants	2 (per 100,000 live births)1	2 (per 100,000 live births)	3 (per 100,000 live births)
4.5	Women giving birth to an infant with congenital syphilis diagnosed late in pregnancy – Aboriginal and Torres Strait Islander women (% all cases)	3 (75%)	2 (67%)	11 (85%)

[1] The denominator (live births) is for the complete year, whereas the numerator (congenital syphilis notifications) represents cases for the reporting period. The rate calculated may be lower than rates reported for a complete (12 months) year.

Indicators		Comparisons		
Ref.	**Summarised indicator description**	**Current year to date (Q1 - Q2 2025)**	**Last complete year (2024)**	**Previous complete year (2023)**
	Women giving birth to an infant with congenital syphilis diagnosed late in pregnancy – non-Indigenous women (% all cases)	4 (80%)	6 (100%)	4 (57%)
4.6	Women giving birth to an infant with congenital syphilis who did not receive adequate treatment prior to delivery (% all cases)	8 (89%)	7 (70%)	19 (95%)
Total numbers reported for indicators 4.7 – 4.8 (2020 – Q2 2025)				
4.7	Number of women giving birth to an infant with congenital syphilis that did not have a syphilis test/s prior to diagnosis during their pregnancy (% of all cases)	52 (63%)		
4.8	Number of women giving birth to an infant with congenital syphilis reinfected during the current pregnancy (% of all cases)	2 (3%)		

Goal 1: Strengthen prevention and testing strategies for syphilis in priority populations and settings, targeting high-burden area

Key facts

- More than **168,000 syphilis tests** were administered through participating Aboriginal Community Controlled Health Services (ACCHS).
- Quarter 2 (Q2) 2025 maintained the **highest reported testing coverage** for all age groups (16%) including the target age group of 15- 34 years (26%) at participating ACCHS.
- **Serology** was the **most common** method of syphilis diagnosis (87%) in participating ACCHS.

Strengthening Australia's prevention and testing strategies for syphilis requires ongoing evaluation of current approaches, and reflection on required improvements and missed opportunities among vulnerable people and communities at a greater risk of infection. This includes people who are pregnant and have a syphilis infection, and regions and populations with disproportionately high rates of syphilis, for example Aboriginal and Torres Strait Islander peoples.

An important consideration when interpreting these data is that syphilis testing coverage reflects only a proportion of Aboriginal and Torres Strait Islander peoples attending selected ACCHS, funded by the Australian Centre for Disease Control to deliver point of care testing. These data do not include individuals accessing care outside of participating ACCHS or data from other health services and therefore may not be representative of the health service participation or testing coverage among the Aboriginal and Torres Strait Islander population more broadly. Routine collection of other suitable data sources, including data from mainstream services and ACCHS not currently funded through the national syphilis response are currently being explored and will be indicated, as appropriate, in future iterations of the Surveillance Plan.

1.2 Cumulative number of syphilis tests delivered through participating ACCHS, by target and total population

1.3 Proportion of people attending participating ACCHS receiving a syphilis test within the previous 12 months, by target and total population (syphilis testing coverage)

In August 2018 as part of the Enhanced Syphilis Response, the test and treat model commenced at selected ACCHS in Queensland, the Northern Territory and Western Australia. (1, 2) Since then the program has expanded, with a view for further expansion in the future to target high burden areas and communities impacted by syphilis.

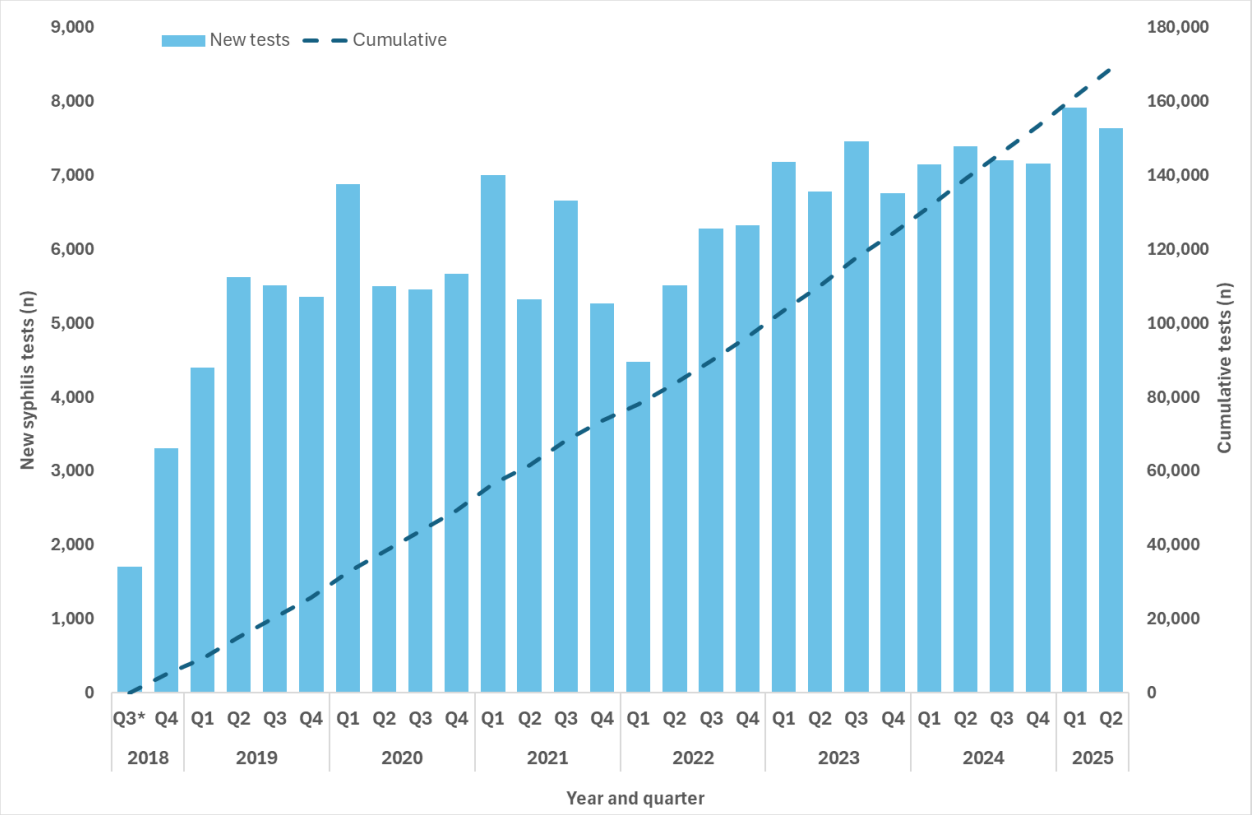
Between August 2018 to the end of (Q2) 2025, through participating ACCHS (Figure 1) 168,804 syphilis tests, point-of-care tests (PoCT) and serological tests were delivered at over 20 services. Over this period on average 6,029 new tests were performed each quarter.

In Q2 2025 testing coverage for clients attending participating services for all age groups and the target age group (15- 34 years) was 16% and 26% respectively. This was the same as Q1 2025 and is the highest recorded percentage coverage since the program commenced (Figures 2 a-b).

In Q2 2025 diagnosis by serology only was the most common method of detecting syphilis (87%) consistent with historical trends (average 89%). A combination of serology and PoCT represented the second highest proportion (10%; historical average 8%) followed by PoCT only (3%; historical average 3%) (Figure 3).

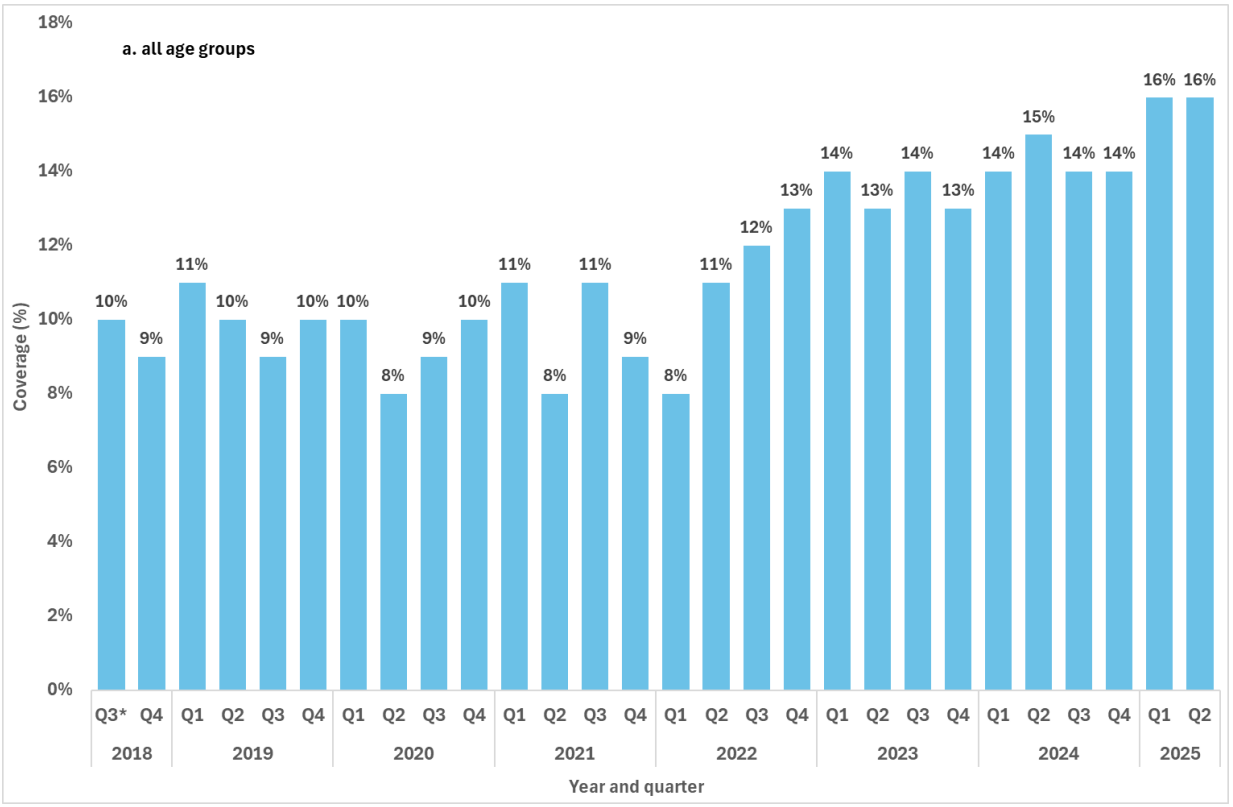
Please note that at the time of writing data were missing for some services and therefore testing numbers reported are likely to be an underestimate of all tests delivered.

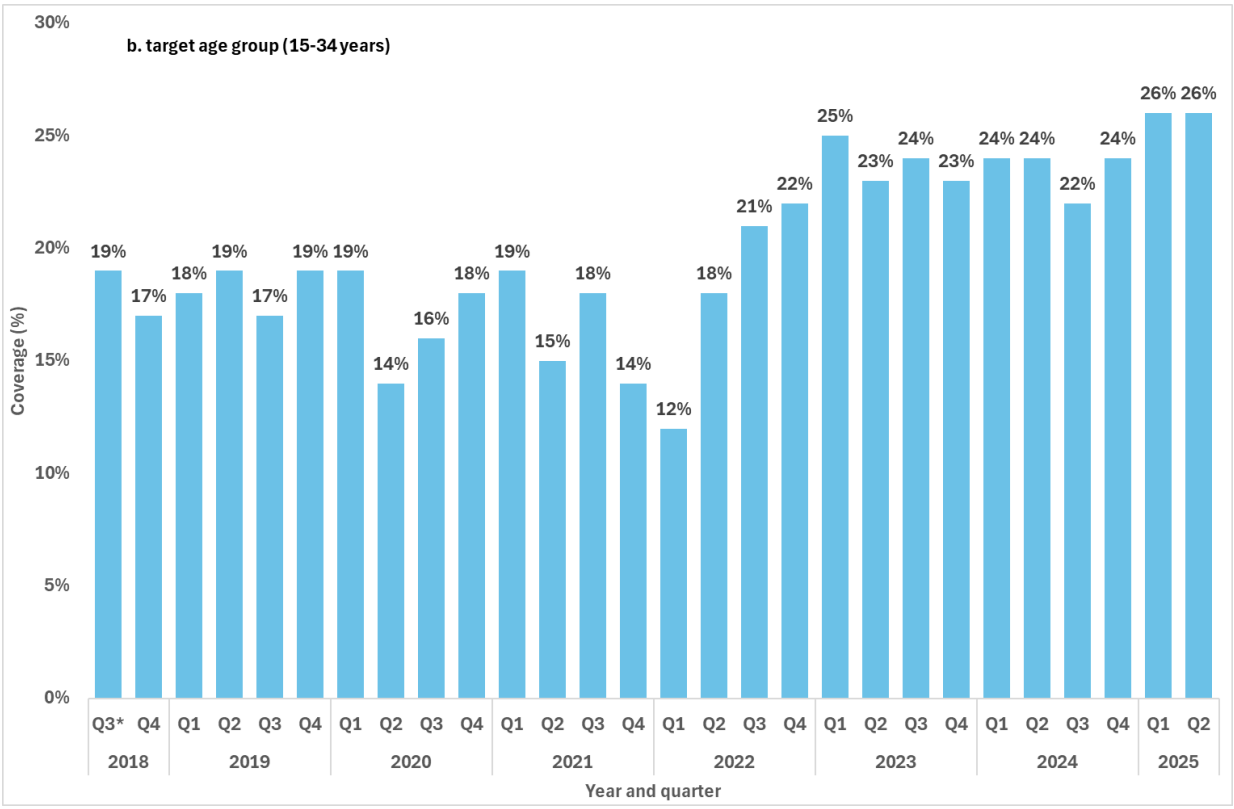
Figure 1: Cumulative number of syphilis tests (PoCT and/or serology) delivered through participating ACCHS to Aboriginal and Torres Strait Islander peoples, by quarter and year, Q3 2018[2] – Q2 2025



[2] Q3 2018 includes data for August and September only.

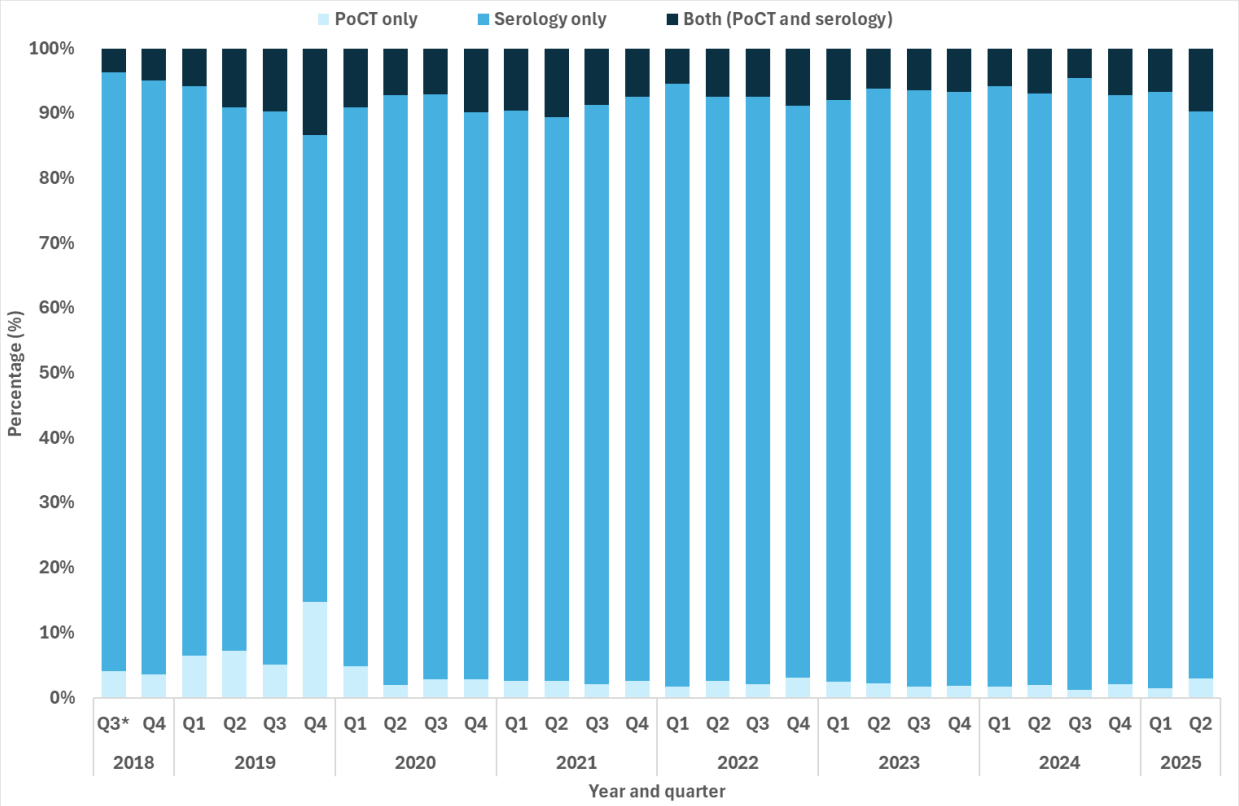
Figure 2: Proportion of Aboriginal and Torres Strait Islander clients attending participating ACCHS who received a syphilis test (PoCT and/or serology), quarter and year, Q3 2018 – Q2 2025[3] (a. all age groups b. target age group 15-34 years)





[3] Excludes testing data for individuals for whom age was not reported.

Figure 3: Proportion of syphilis tests delivered through participating ACCHS, by test type (PoCT only, serology only and both serology and PoCT), by quarter and year, Q3[2] 2018 – Q2 2025



Goal 2: Reduce ongoing transmission and incidence of syphilis across priority populations

Key facts

- **In the first 6 months of 2025, 3,153 infectious syphilis** cases were notified.

In **Q2 2025**:

- **1,550 infectious syphilis** cases were notified, a **2% and 3% increase** compared to the 12 month quarterly mean and the 5 year quarterly mean.
- **Highest** notification rates were reported in 15-24 year old **Aboriginal and Torres Strait Islander peoples in remote/very remote** areas.
- Compared to the 12-month quarterly average, notification rates in:
  - Aboriginal and Torres Strait Islander males declined in 15-24 year olds across all remoteness areas.
  - Aboriginal and Torres Strait Islander females increased in inner/outer and remote/very remote areas in people 15-24 and 25-34 year olds.
  - Non-Indigenous males decreased across most age groups and remoteness areas.
  - Non-Indigenous females declined slightly or remained the same.

In the first half of 2025, 3,153 cases of infectious syphilis were notified, slightly higher than the same reporting period in 2024 (n=3,020) and 5-year average (n=3,121). In Q2 2025, 1,550 infectious syphilis cases were notified, a 3% decrease compared to Q1 2025 (n=1,603) but a small increase compared to the quarterly mean over the past 12 months (1,526, Q3 2024 – Q2 2025) and 5 years (1,508, Q3 2020 – Q2 2025) (Figure 4).

Consistent with historical trends, in Q2 2025 notifications were predominately reported in males (78%) and were aged 25-34 years (35%) (Table 3). While notifications were largely reported among residents of major cities (73%), proportions in inner/outer regional areas are continuing to increase due in part to rises in notifications in urban areas in the Northern Territory (Darwin classified as an outer regional area), and areas in north Queensland (Map 2). Proportional increases in remote/very remote areas reflects consistent reporting of cases in these areas, and rises in remote/very remote areas in the Northern Territory, including previously unaffected communities (Groote Eylandt and Maningrida in East Arnhem) (Map 1 and 2) (3).

Figure 4: Notifications (n) and notification rate (per 100,000) of infectious syphilis, by Indigenous status, sex, year and quarter, 2020 – Q2 2025

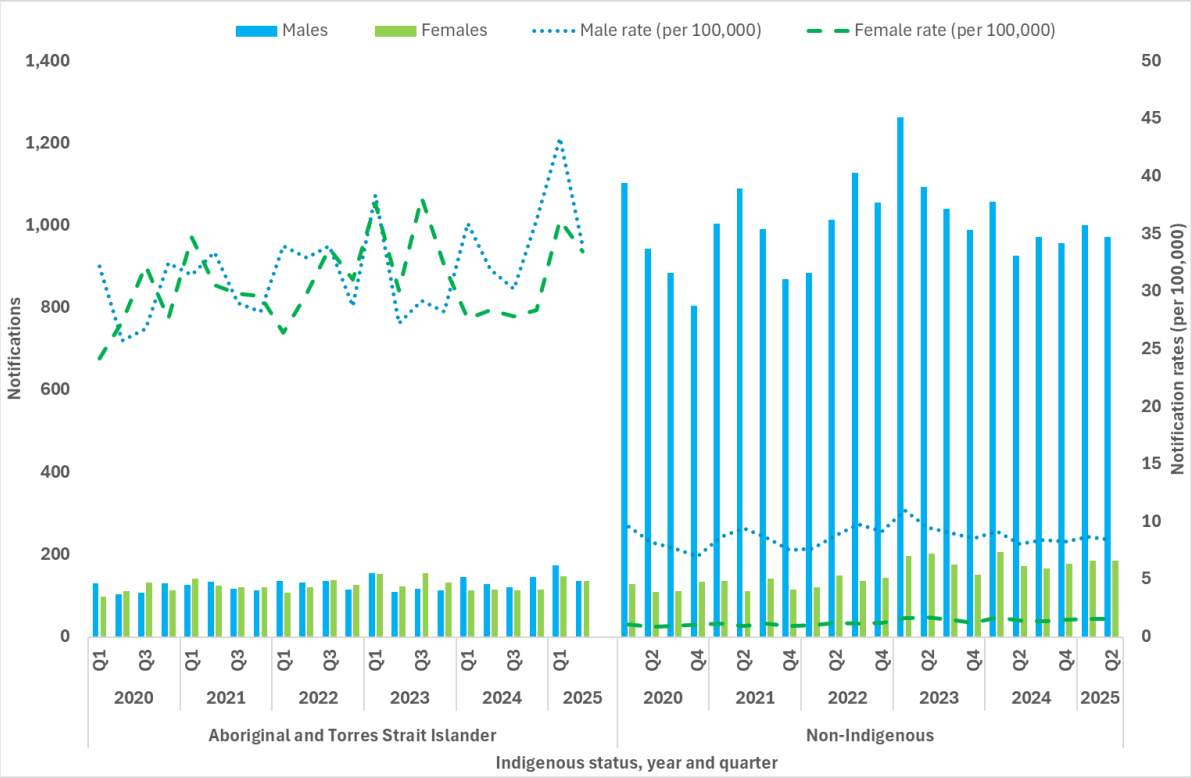


Table 3: Demographic summary of infectious syphilis notifications, 2020 – Q2 2025

Characteristics		2020	2021	2022	2023	2024	2025	
							Q1	Q2
Total		**5,363**	**5,764**	**6,187**	**6,565**	**5,971**	**1,603**	**1,550**
Sex	Female	958	1,038	1,084	1,334	1,216	346	345
	Male	4,388	4,707	5,075	5,221	4,745	1,253	1,202
	X*	4	6	8	5	1		
	Not reported	13	13	20	5	9	4	3
Age group	15-24	880	842	841	926	766	189	165
	25-34	1,911	2,143	2,280	2,361	2,101	559	545
	35-44	1,334	1,500	1,648	1,715	1,642	479	451
	45+	1,222	1,264	1,406	1,547	1,437	369	383
Mean age at diagnosis	Female	30	30	31	32	33	33	34
	Male	37	37	38	38	38	38	39
	Overall	36	36	36	37	37	37	38
Indigenous status	Aboriginal and Torres Strait Islander	929	1,004	1,019	1,062	1,002	323	274
	Non-Indigenous	4,239	4,481	4,659	5,123	4,646	1,187	1,159
	Not reported	195	279	509	380	323	93	117
Remoteness	Major cities	4,085	4,414	4,771	4,989	4,480	1,172	1,134
	Inner/outer regional	661	608	755	912	918	240	253
	Remote/very remote	486	573	463	470	409	136	121
	Not reported/Overseas resident	131	169	198	194	164	55	42

*Persons who reported their sex assigned at birth as another term, other than male or female.

2.1 Notification rate of infectious syphilis by Indigenous status, sex, age and remoteness area classification

Aboriginal and Torres Strait Islander males

In Q2 2025, notification rates among Aboriginal and Torres Strait Islander males decreased across most age groups in major cities, among 15-24 year olds in remote/very remote areas and inner/outer regional areas and among those aged 45+ year in inner/outer regional areas compared to the 12-month quarterly mean. The greatest notification rate increase compared to the 12-month quarterly mean was reported in 45+ year olds in remote/very remote areas (39%) and in 25-34 year olds in inner/outer regional areas (36%) (Figure 5 a-c).

Non-Indigenous males

On average non-Indigenous males represent around 81% of all infectious syphilis notifications, with most of these cases reported in major cities of Australia (Figure 5a). In Q2 2025, notification rates in most age groups across all remoteness areas reported a decrease compared to the 12 month and 5 year quarterly mean (Figure 5a-c).

Aboriginal and Torres Strait Islander females

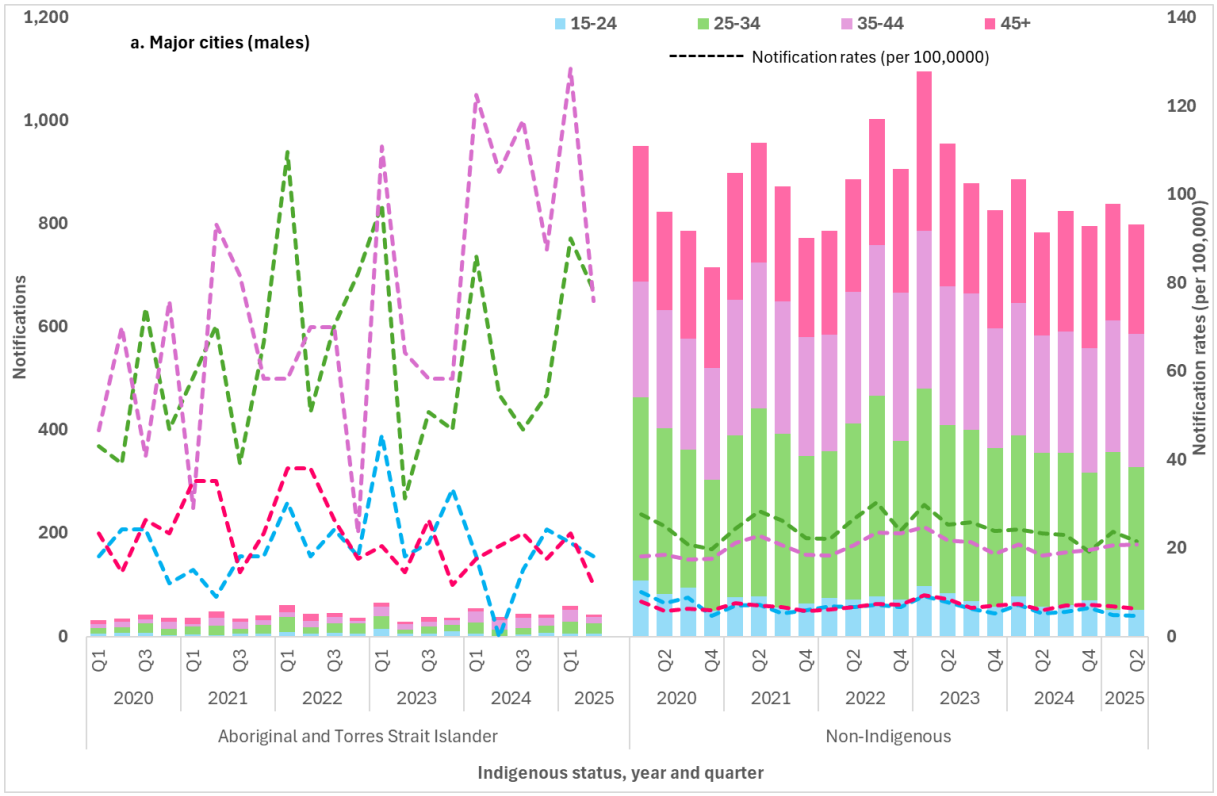
In Q2 2025, Aboriginal and Torres Strait Islander females aged 15-24 years in remote/very remote areas recorded the highest notification rate among all population and geographical groups, with a rate of 290 per 100,000 (Figure 6c). Other age groups in these geographical areas reported increases in notification rates compared to the 12 month quarterly mean with the greatest increase reported in 45+ year olds (41%) and 25-34 year olds (33%) (Figure 6a-c).

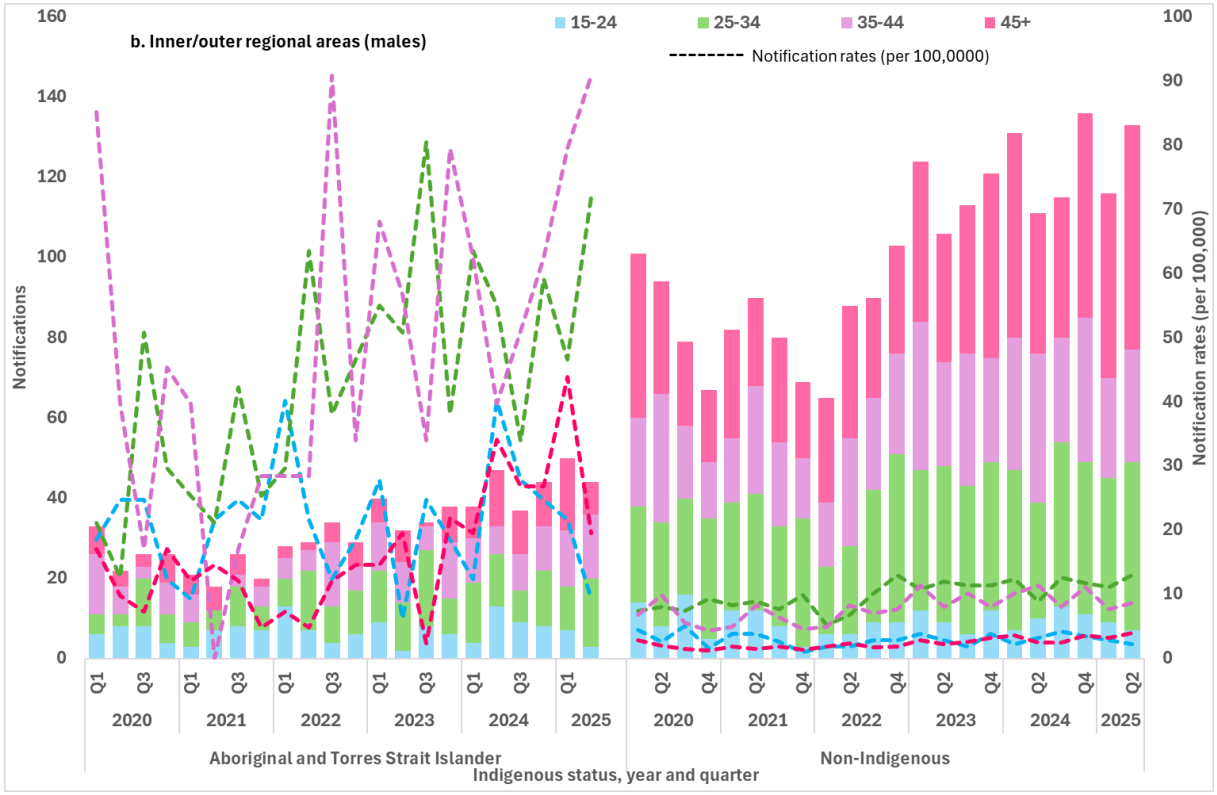
Non-Indigenous females

In Q2 2025, compared to the 12 month quarterly mean, notification rates in non-Indigenous females showed small declines or remained similar across most age and geographical groups, except for females aged 35-44 and 45+ years in major cities of Australia where an increasing trend was observed (Figure 6a-c). Compared to the 5 year quarterly mean however considerable increases were reported in all age groups in major cities of Australia (Figure 6a).

Figure 5 a-c: Notifications (n) and notification rate (per 100,000) of infectious syphilis reported in males, by Indigenous status, remoteness area, age, quarter, and year, 2020

– Q2 2025 (a. Major cities, b. Inner and outer regional areas and c. Remote and very remote areas)[4]





[4] Excludes cases for whom sex, age, Indigenous status and/or residential postcode were not reported.

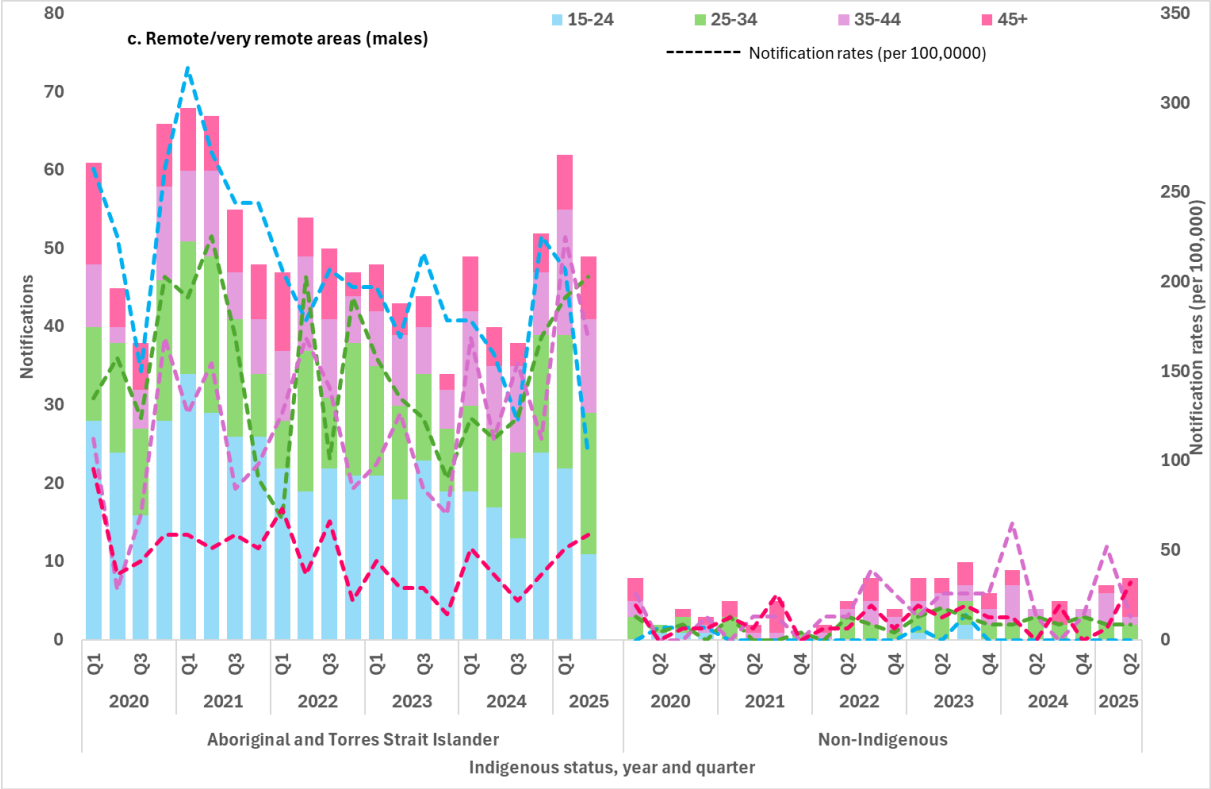
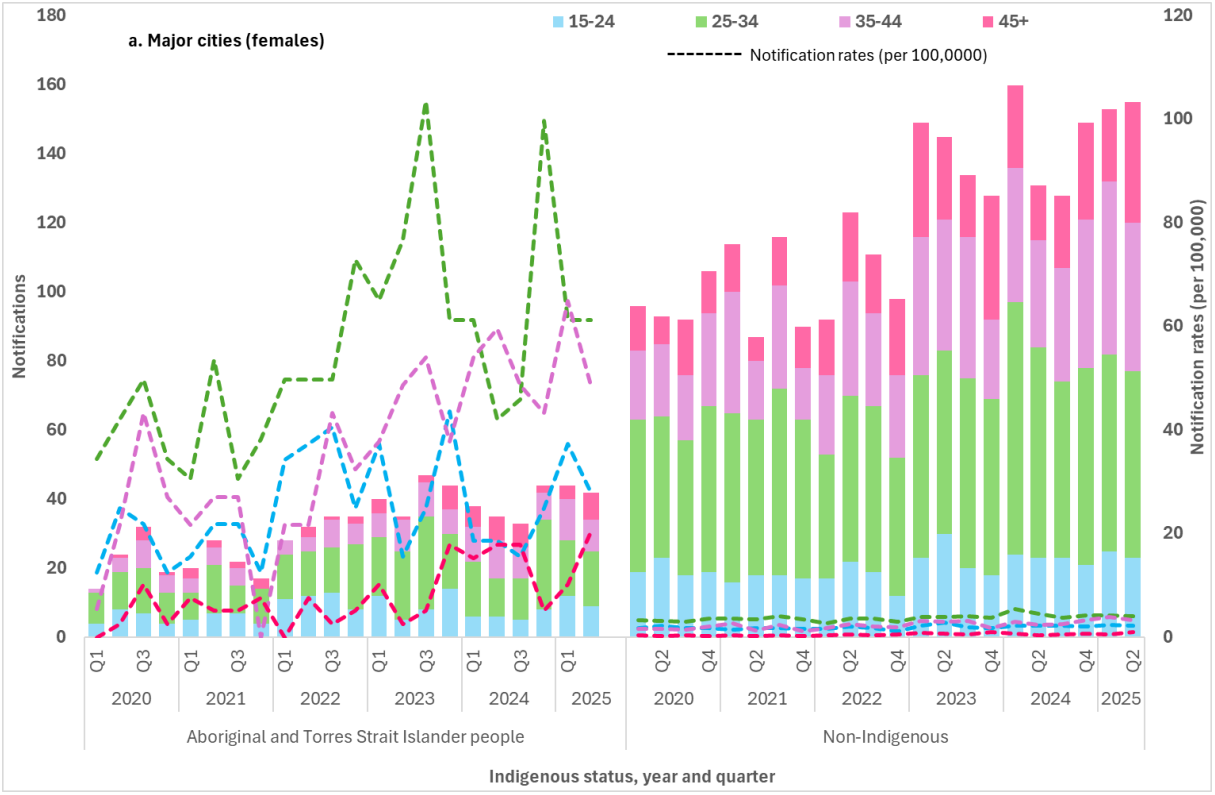
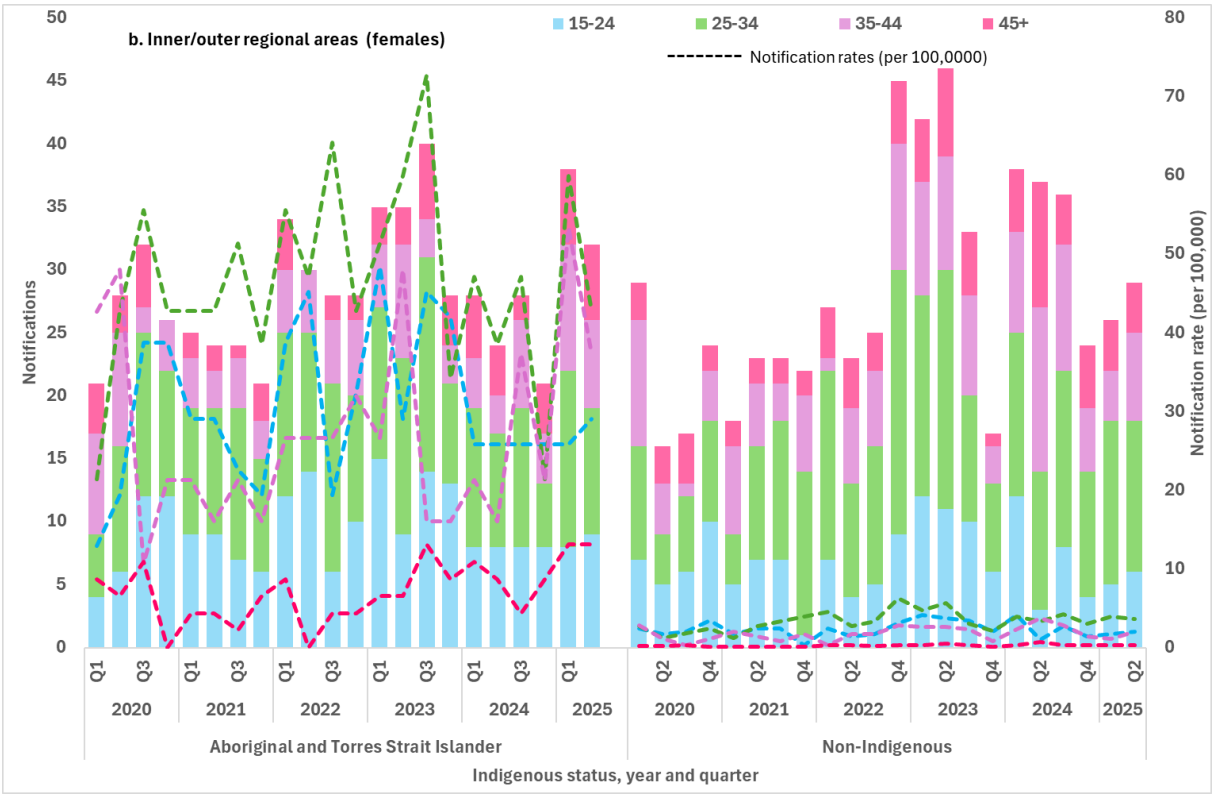
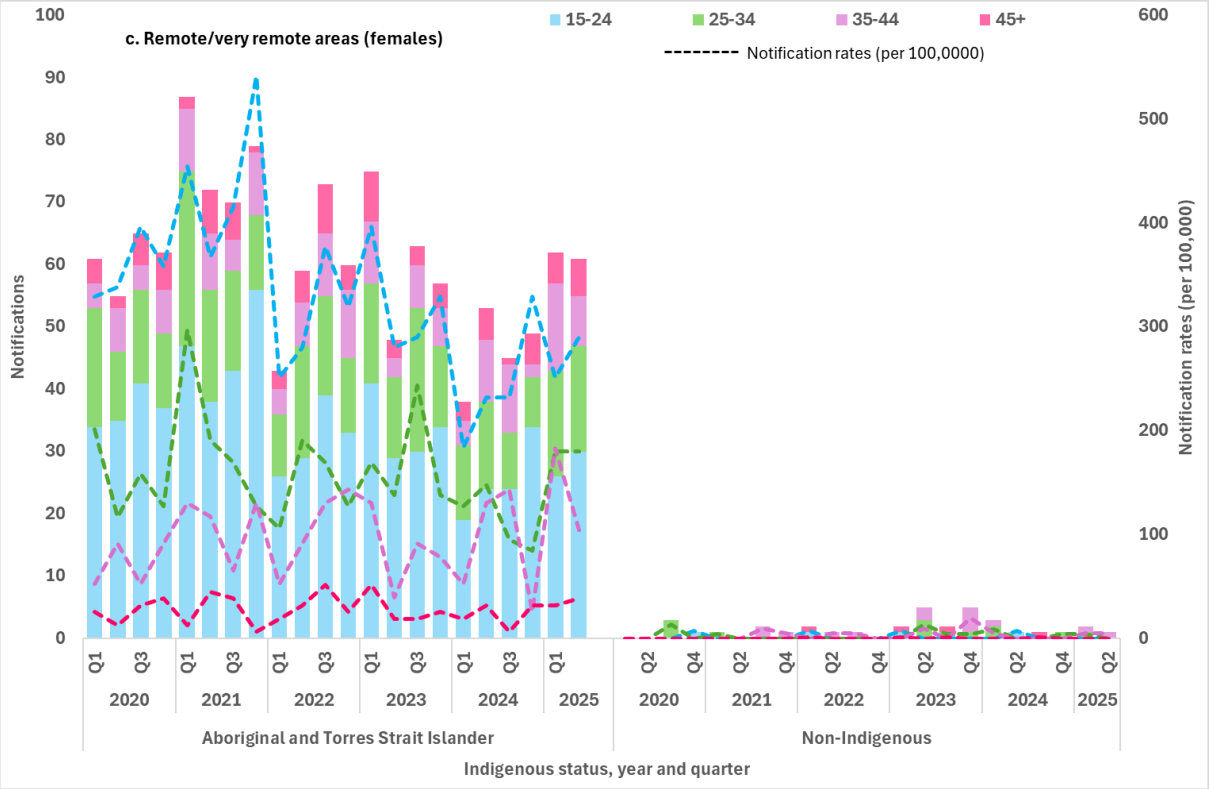

c. Remote/very remote areas (males)
15-24
25-34
35-44
45+
Notification rates (per 100,0000)
Notifications
Notification rates (per 100,000)
80
70
60
50
40
30
20
10
0
350
300
250
200
150
100
50
0
Q1 Q3 Q1 Q3 Q1 Q3 Q1 Q3 Q1 Q3 Q1
2020 2021 2022 2023 2024 2025
Aboriginal and Torres Strait Islander
Q2 Q4 Q2 Q4 Q2 Q4 Q2 Q4 Q2 Q4 Q2
2020 2021 2022 2023 2024 2025
Non-Indigenous
Indigenous status, year and quarter

Figure 6 a-c: Notifications (n) and notification rate (per 100,000) of infectious syphilis reported in females, by Indigenous status, remoteness area, age, quarter, and year, 2020 – Q2 2025 (a. Major cities, b. Inner and outer regional areas and c. Remote and very remote area)[4]







2.2 Notification rate of infectious syphilis in Aboriginal and Torres Strait Islander peoples by Indigenous Areas (IAREs)

2.3 Notification rate of infectious syphilis by Statistical Area 3 (SA3), by Indigenous status

An important consideration when interpreting mapped notification data is that the postcodes used to allocate cases to a geographical area is done so based on the residential postcode of the notified case. This may not necessarily reflect where the infection was acquired and in some instances the postcode reported may reflect the location where the case was diagnosed rather than residence and locality of acquisition. If the postcode reflects the location where an individual sought health care, the mapped notifications may reflect areas of high volume or centralised services where people are being diagnosed rather than areas with a high burden of infection or acquisition. Availability and accessibility of safe and culturally appropriate health services, particularly in remote/very remote areas and Aboriginal and Torres Strait Islander communities, along with other social factors may influence where people are tested and diagnosed, noting that this may occur outside of an individual's place of residence (4).

Indigenous Areas

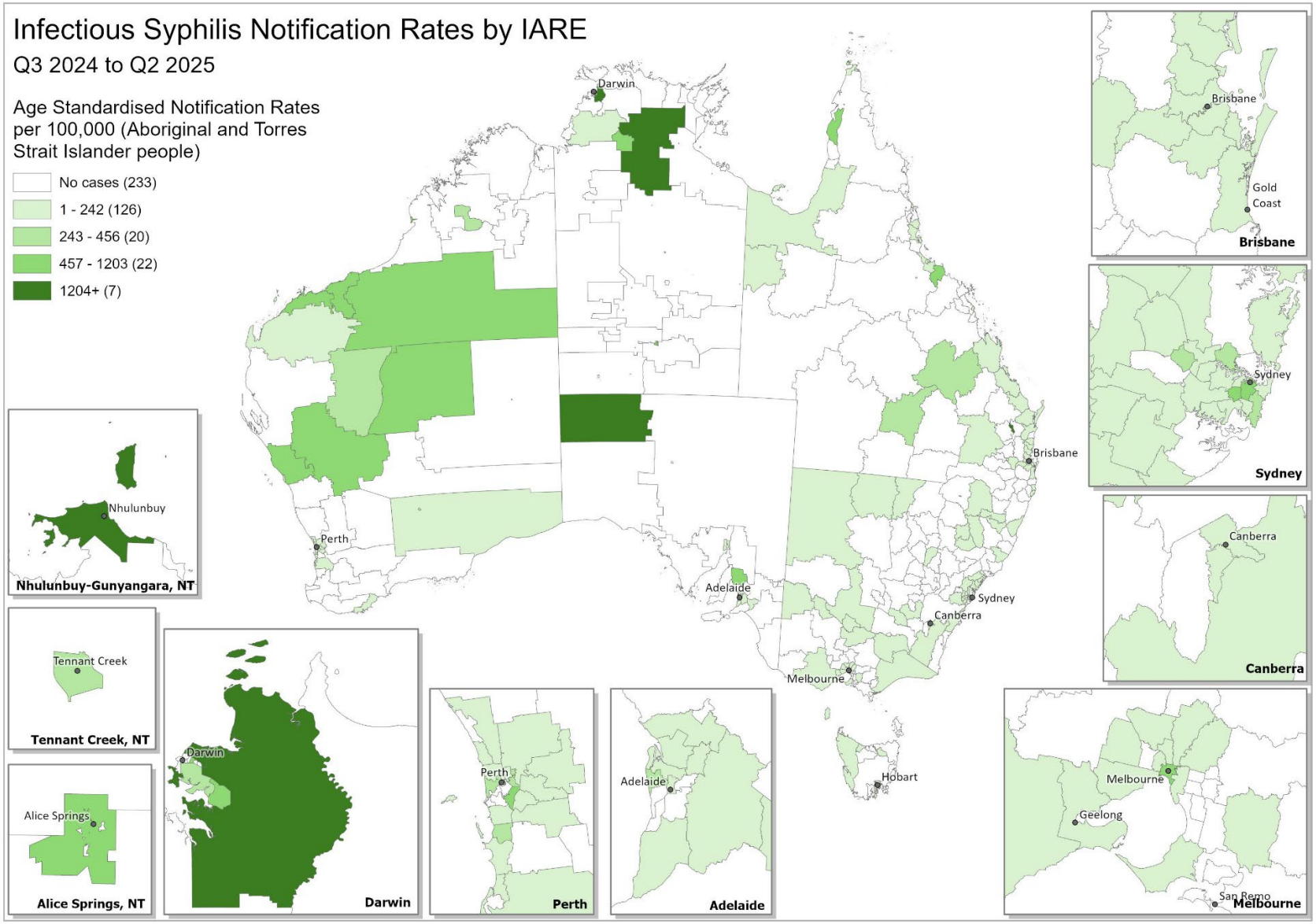
Indigenous Areas (IAREs) are geographic areas built from Indigenous Locations, which are designed to represent Aboriginal and Torres Strait Islander communities (urban and rural) that are near each other or that share language, traditional borders or Native Title (5). Age standardised infectious syphilis notification rates by IAREs for Aboriginal and Torres Strait Islander peoples are presented in Map 1 for the previous 12 months (Q3 2024 – Q2 2025). The highest notification rates were reported largely in very remote areas of Western Australia, South Australia and the Northern Territory, noting that in some IAREs the population was small. High notification rates in outer regional areas (Darwin and surrounds) reflect the increase in reported cases in urban areas in the Northern Territory.

Statistical Area 3 (SA3)

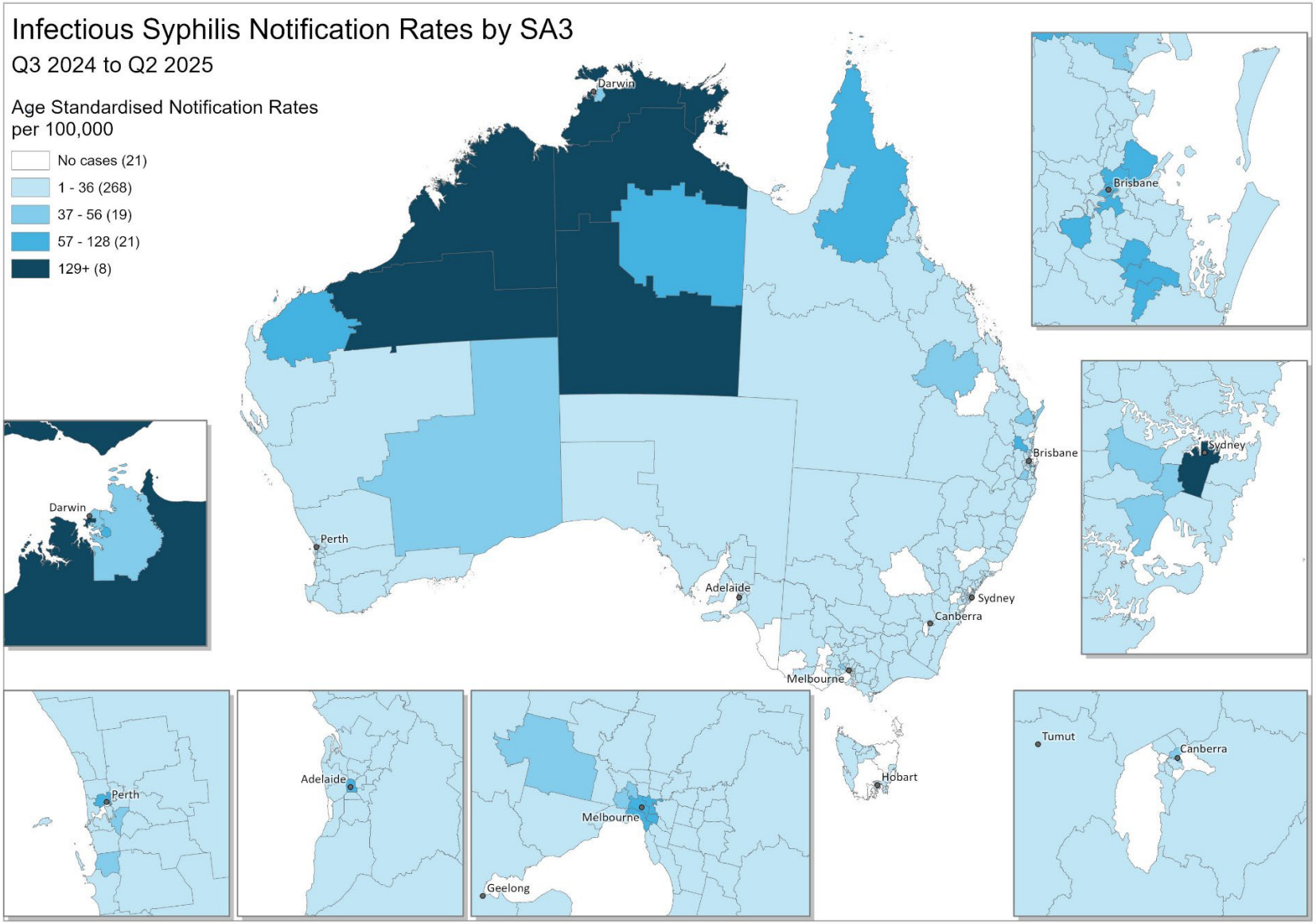
In the previous 12 months age-standardised notification rates of infectious syphilis by statistical area 3 (SA3) were widely distributed across Australia (Map 2). The highest rates were reported across very remote areas in the north-west of Australia and SA3's in some major cities, including Sydney. This geographical distribution reflects the concurrent infectious syphilis outbreaks and sub-epidemics occurring across populations groups in Australia, including Aboriginal and Torres Strait Islander peoples in regional and remote areas, gay and bisexual men in major cities of Australia, and non-Indigenous women in major cities.

Please refer to the methodological notes for further information on the development of the maps.

Map 1: Notification rate (per 100,000) of infectious syphilis in Aboriginal and Torres Strait Islander peoples by Indigenous Areas (IAREs) in the previous 12 months (Q3 2024 – Q2 2025)[4]



Map 2: Age-standardised notification rate (per 100,000) of infectious syphilis by Statistical Area 3 (SA3) in the previous 12 months (Q3 2024 – Q2 2025)[4]



2.4 Notification rate of infectious syphilis in women[5] of reproductive age (15-44 years) by Indigenous status and remoteness area

Between 2020 and Q2 2025, of infectious syphilis cases reported among women, most (86%) were in women aged between 15-44 years of age, with the average proportion among Aboriginal and Torres Strait Islander women higher (89%) and non-Indigenous women lower (84%) (Figure 7a-b).

Aboriginal and Torres Strait Islander women

The highest proportion and notification rates among Aboriginal and Torres Strait Islander women of reproductive age have consistently been reported in remote/very remote areas of Australia, representing half of the cases (50%) reported between 2020 and Q2 2025 (Figure 7a). Although lower notifications and rates have been reported in major cities of Australia, the proportion of cases overall has been increasing since 2022 (average total 27% over the reporting period), while in inner and outer regional areas the proportion has remained relatively constant (average total 23%) (Figure 7a).

Non-Indigenous women

Most notifications among non-Indigenous women of reproductive age were reported in major cities of Australia, on average representing 80% of cases reported between 2020 and Q2 2025. A smaller proportion (average 19%) were reported in inner/outer regional areas, and very small proportion (average 1%) in remote and very remote Australia (Figure 7b).

Figure 7 a-b: Notifications (n) and notification rate (per 100,000) of infectious syphilis reported in women5 aged 15-44 years, by Indigenous status, remoteness area, quarter, and year, 2020 – Q2 2025 (a. Aboriginal and Torres Strait Islander and b. non-Indigenous)[4]

[5] The term women is used, but it is acknowledged that this may also include people with a uterus who are non-female identifying.

2.5 Proportion of infectious syphilis notifications in men reporting sexual exposure with men only

2.6 Proportion of infectious syphilis notifications in men reporting sexual exposure with men and women[5]

Enhanced data (sexual exposure: same sex, opposite sex and both sexes) are used to report against indicators 2.5 and 2.6.

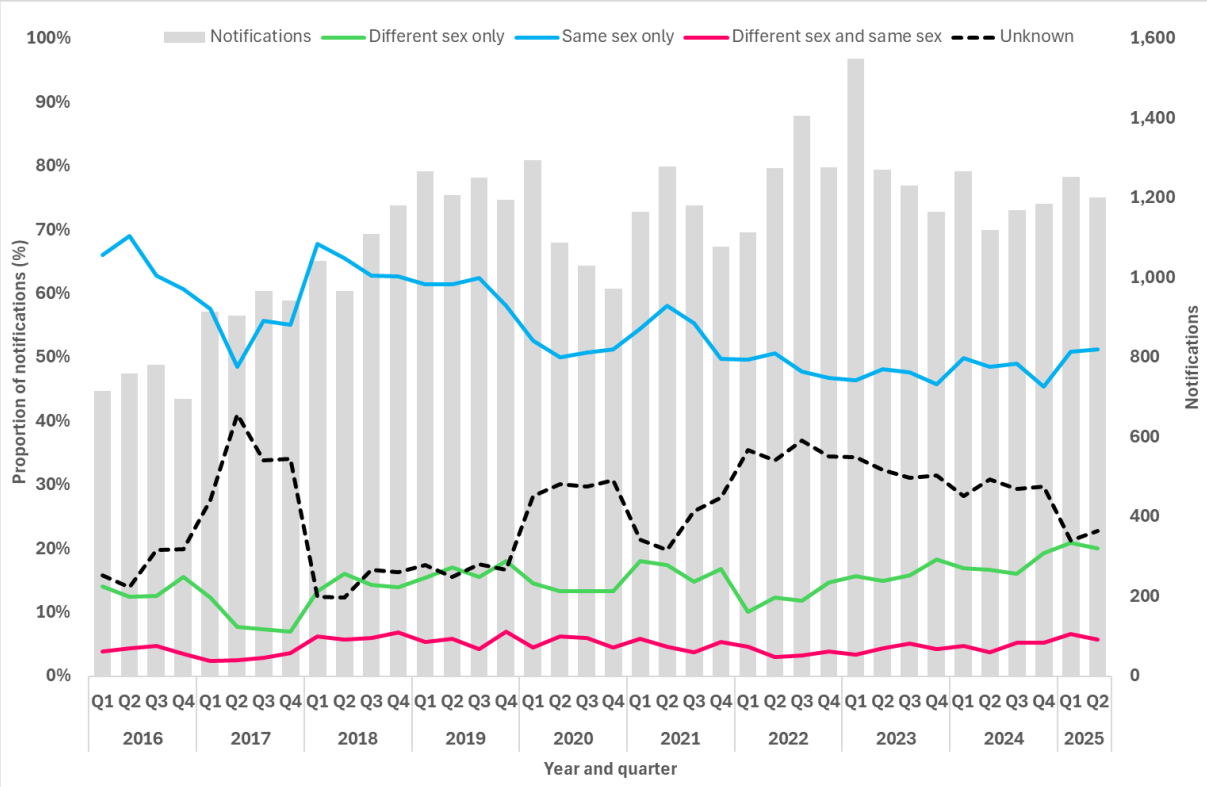
Completeness of sexual exposure[6] in males notified with infectious syphilis fluctuated between 2020 and Q2 2025, ranging from 63% to 80% (average 71%).

Males reporting sexual exposure with the same sex only, represented the highest proportion of sexual exposure events (51%) in Q2 2025 consistent with historical trends. The proportion of males reporting sexual exposure with people of a different sex only, was 20% in Q2 2025, with proportional increases compared with the 12 month and 5 year quarterly means, 19 and 16% respectively. Proportionally males reporting sexual exposure with people of different and same sex was 6% in Q2 2025. (Figure 8).

Changes in sexual exposure over time suggests potential overlapping in sexual networks influencing the epidemiology of syphilis transmission across Australia, including increasing exposure risk for females. This concept has also been observed in genomic analysis of Treponema pallidum (syphilis) in Australia and other sexually transmissible infections (6, 7).

[6] 'Sexual exposure' refers to the sex of the sexual contact of the notified case and can be reported as either: person (s) of different sex only; person (s) of same sex only; person (s) of different sex AND person(s) of same sex; and sexual exposure unknown.

Figure 8: Number of infectious syphilis notifications among males and proportion (%) of cases by sexual exposure and year 2020 – Q2 2025



Goal 3: Reduce morbidity and mortality associated with syphilis

Death and hospitalisations data reported to the NNDSS are not used in reporting against this goal due to poor completeness and inconsistencies in reporting. More comprehensive data are available through The Australian Bureau of Statistics (ABS) and The Australian Institute of Health and Welfare (AIHW) data collections, however these data are less timely with at least a minimum one to two year delay from the reporting year.

The latest available data from the ABS and AIHW will be incorporated into annual reporting for this goal.

Goal 4: Eliminate congenital syphilis (defined as sustained zero congenital syphilis cases)

Key facts

- **9 cases** of **congenital syphilis** were reported in the first six months of 2025:
  – 5 non-Indigenous infants, including 1 who sadly died.
  – 4 Aboriginal and Torres Strait Islander infants, including 3 who sadly died.
- **Seven women**[4] who gave birth to these infants were diagnosed with syphilis **late in pregnancy** and did not receive adequate treatment prior to delivery.
- In the first six months of 2025, **15%** of women of reproductive age were **pregnant** at syphilis diagnosis.

Long term trends

- **86** of congenital syphilis have been reported between **2020 – Q2 2025**, including **30 deaths**:
  – 46 Aboriginal and Torres Strait Islander infants, including 18 deaths.
  – 38 non-Indigenous infants, including 10 deaths.
  – 2 infants with unknown Indigenous status who died of the infection.
- Of the women giving birth to an infant with congenital syphilis between **2020 – Q2 2025**:
  – 81% were diagnosed late5 in pregnancy.
  – 96% did not receive adequate6 treatment prior to delivery.
  – 63% did not have a previous syphilis test in pregnancy.

4.1 Number of congenital syphilis cases by remoteness area and Indigenous status

4.2 Number of congenital syphilis related deaths by Indigenous status

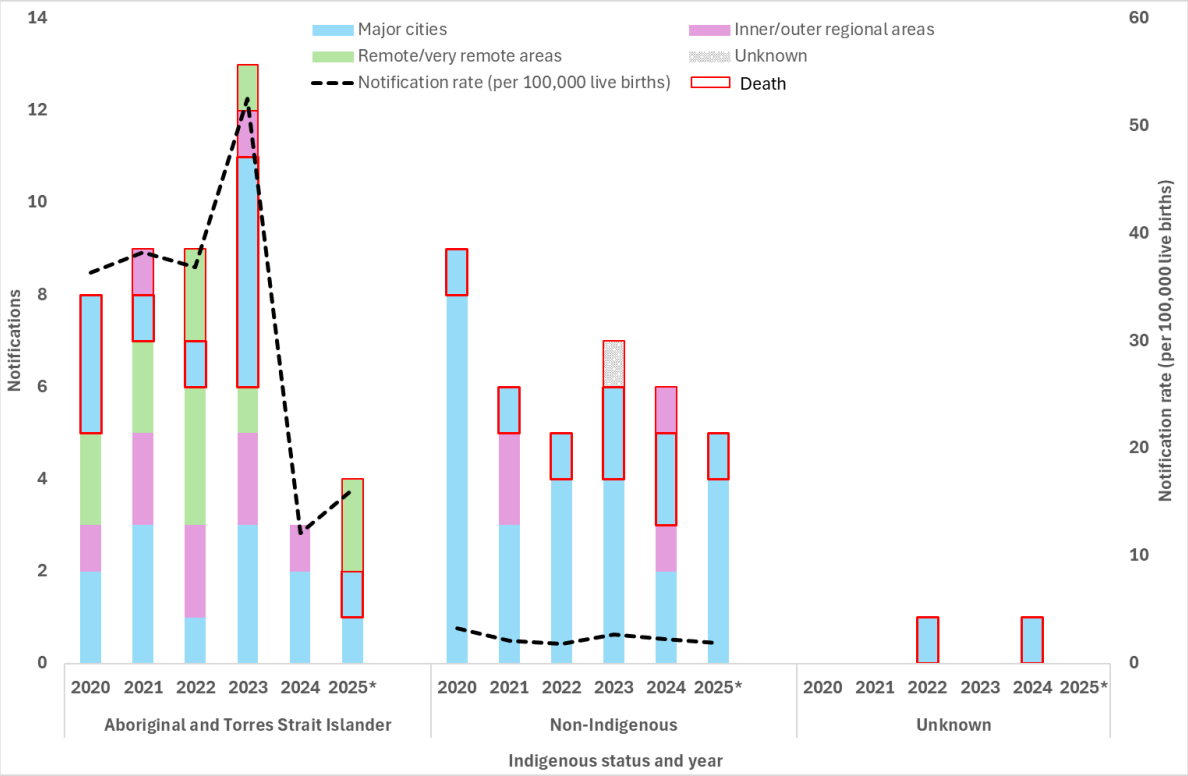
4.3 Notification rate of congenital syphilis per 100,000 live births by remoteness area and Indigenous status

In the first six months of 2025, nine cases of congenital syphilis were reported:

- five in non-Indigenous infants from major cities of Australia, including one infant who sadly died.
- four Aboriginal and Torres Strait Islander infants, two from major cities including one who died and two from remote/very remote Australia, both who sadly died of the infection.

Between 2020 and Q2 2025, 86 cases of congenital syphilis cases have been notified. More than half (46/86, 53%) were reported in Aboriginal and Torres Strait Islander infants, 35 in non-Indigenous infants (38/86, 44%) and two cases with an unknown Indigenous status reported (2/86, 2%). Of the 86 cases reported, 30 infants tragically died, 18 Aboriginal and Torres Strait Islander infants, 10 non-Indigenous infants, and two infants with an unknown Indigenous status (Figure 9).

Figure 9: Notifications (n) and notification rate (per 100,000 live births) of congenital syphilis, by Indigenous status, remoteness area, and year, 2020 – Q2 2025[1]*



4.4 Proportion of syphilis notifications among women[5] of reproductive age (15- 44 years) who were pregnant at time of diagnosis, by remoteness area and Indigenous status

Pregnancy data were available for six jurisdictions in 2020 (excluding Victoria and the Northern Territory), seven jurisdictions in 2021 to 2023 (excluding the Northern Territory), eight jurisdictions in 2024, and seven jurisdictions in Q1 and Q2 2025 (excluding Victoria as data were not available at the time of writing).

Given the high proportion of cases with an unknown pregnancy status and retrospective changes to the data, trends over time should be interpreted with caution. Please note there may be differences with previous reports due to pregnancy status being reclassified in some women and the inclusion of new historical data from jurisdictions.

In the first six months of 2025, 15% of all women of reproductive age, including those with an unknown Indigenous status, were reported to be pregnant at the time of their syphilis diagnosis, higher than the 12-month quarterly mean (14%) and lower than the 5 year quarterly mean (17%) (Figure 10). Over the same period, 13% and 15% respectively of Aboriginal and Torres Strait Islander and non-Indigenous women of reproductive age reported were pregnant at the time of syphilis diagnosis (Figure 10 and 11a-b).

Figure 10: Number of syphilis notifications among women[5] of reproductive age (15-44 years) and proportion (%) of cases pregnant at time of syphilis diagnosis, by year, 2020 – Q2 2025

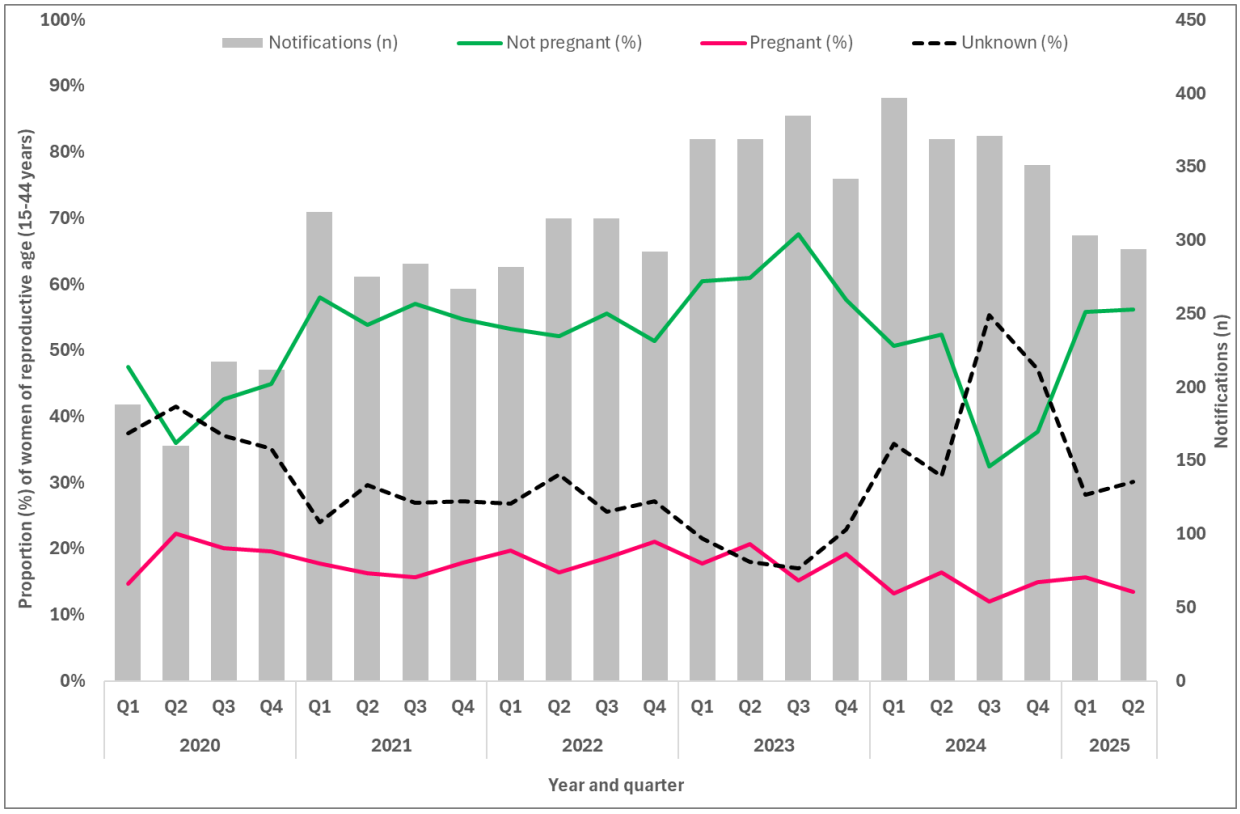
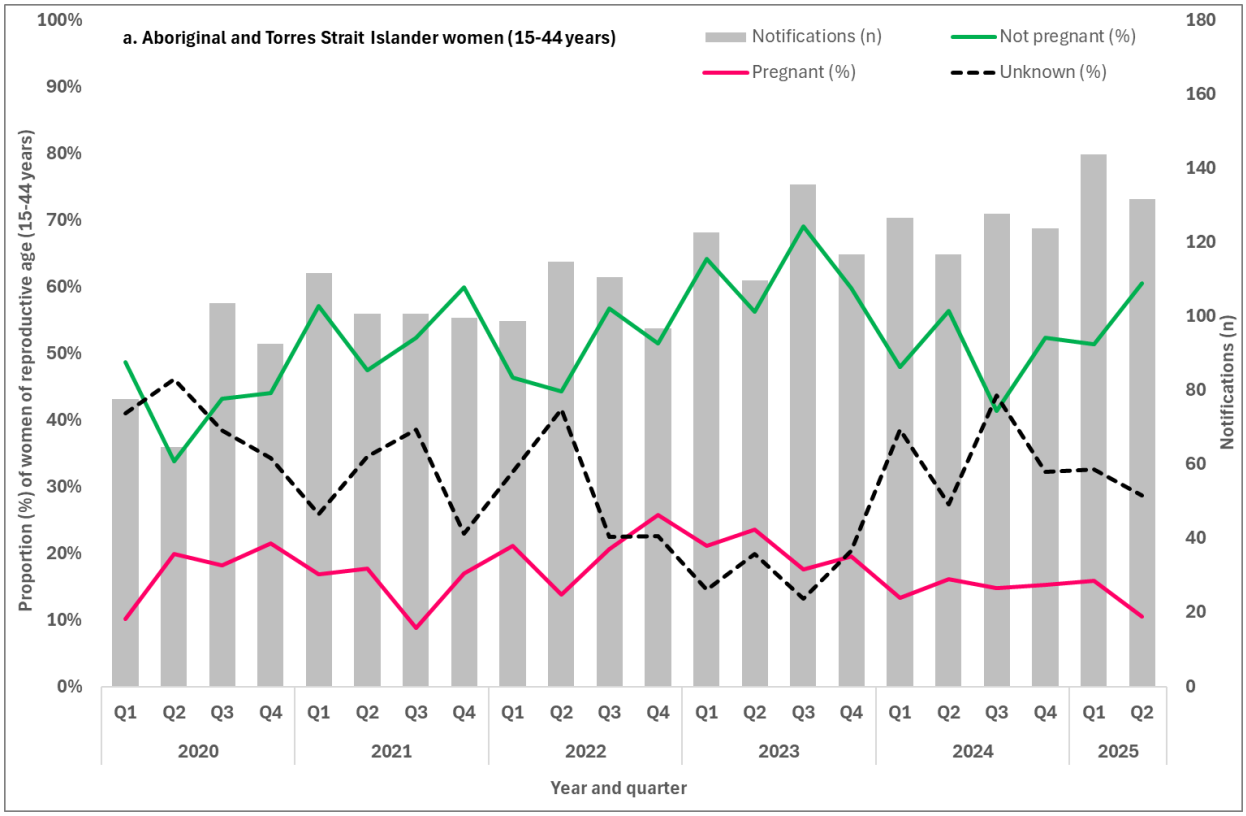
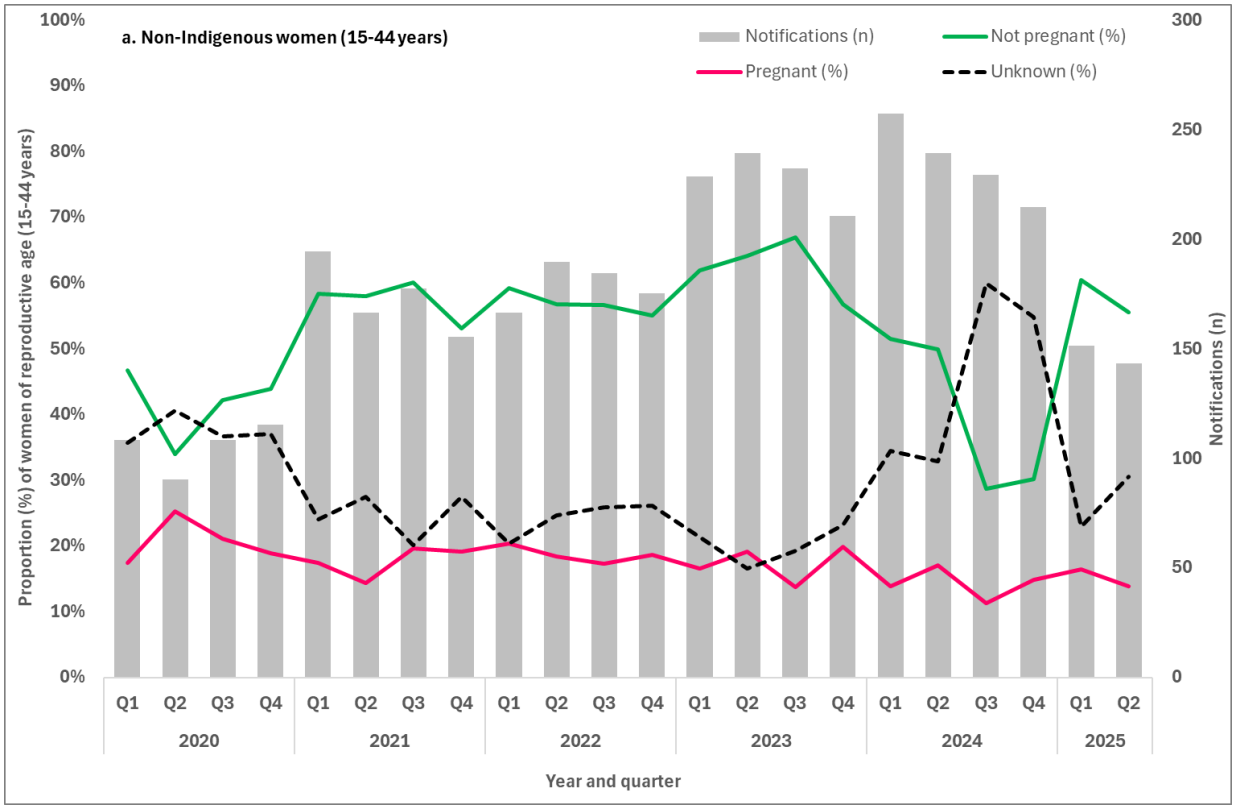


Figure 11 a-b: Number of syphilis notifications among women[5] of reproductive age (15-44 years) and proportion (%) of cases pregnant at time of syphilis diagnosis, by Indigenous status and year, 2020 – Q2 2025 (a. Aboriginal and Torres Strait Islander and b. non-Indigenous)[4]





4.5 Number of women[5] giving birth to an infant with congenital syphilis who were diagnosed with syphilis late[7] in pregnancy by Indigenous status

Late diagnosis with syphilis in pregnancy refers women who did not receive treatment more than 30 days prior to delivery. Late diagnosis also includes women who were diagnosed with syphilis at-birth (day of delivery) or post-birth and therefore could not receive adequate treatment for their syphilis infection.

Most women (81%, 70/86) giving birth to an infant with congenital syphilis between 2020 and Q2 2025, were diagnosed late in pregnancy. Among non-Indigenous women, this proportion was 84% (32/38), and 78% for Aboriginal and Torres Strait Islander women (36/46) (Table 4).

[7] Late diagnosis is defined as a diagnosis of infection within 30 days prior to delivery, at birth (day of delivery), or post birth.

Table 4: Number of women[5] giving birth to an infant with congenital syphilis, by trimester mother was diagnosed with syphilis and year, 2020 – Q2 2025

Trimester	2020	2021	2022	2023	2024	2025	
						Q1	Q2
Aboriginal and Torres Strait Islander women							
1st	-	-	-	-	1	-	-
2nd	1	-	2	2	-	-	1
3rd	-	2	1	4	-	1	-
At birth	4	4	3	4	1	-	-
Post birth	3	3	-	3	1	-	2
Unknown^	-	-	3	-	-	-	-
Late diagnosis	7	9	4	11	2	1	-
Total	**8**	**9**	**9**	**13**	**3**	**1**	**3**
Non-Indigenous women							
1st	-	-	-	-	-	-	
2nd	-	-	1	3	-	-	1
3rd	2	1	1	-	1	-	
At birth	2	1	1	1	1	2	1
Post birth	5	4	2	3	4	-	1
Unknown^	-	-	-	-	-	-	
Late diagnosis	8	6	4	4	6	2	2
Total	**9**	**6**	**5**	**7**	**6**	**2**	**3**
Total women^							
1st	-	-	-	-	1	-	-
2nd	1	-	3	5	-	-	2
3rd	2	3	2	4	1	1	-
At birth	6	5	4	5	2	2	1
Post birth	8	7	3	6	6	-	3
Unknown^	-	-	3	-	-	-	-
Late diagnosis	15	15	9	15	9	3	4
Total	**17**	**15**	**15**	**20**	**10**	**3**	**6**

^Includes cases with an unknown stage of pregnancy at syphilis diagnosis.

4.6 Proportion of women[5] giving birth to an infant with congenital syphilis receiving adequate treatment prior to delivery

Maternal treatment of syphilis was reported for 93% (80/86) of women giving birth to an infant with congenital syphilis between 2020 and Q2 2025. Of these women 96% (77/80) did not receive adequate treatment[8] prior to delivery (Figure 12) this includes 53 women who were diagnosed at-birth (day of delivery) or post-birth and 12 women who were diagnosed in the third trimester (<30 days prior to delivery). Of the remaining cases, nine were diagnosed in the 2nd trimester and three had an unknown trimester of diagnosis.

Of the 77 women who did not receive adequate treatment prior to delivery, over one-third (35%, 27/77) of these pregnancies resulted in a congenital syphilis fetal death (still-birth or following birth). Thirty-four percent of these women (34%, 26/77) gave birth to a live-born infant with a range of clinical symptoms associated with congenital syphilis including bone abnormalities, damage to spleen and/or liver, anaemia, hearing loss, jaundice and sepsis. Eight women gave birth to infants (10%, 8/77) with congenital syphilis that were diagnosed in the weeks and months following their birth. Where additional information was available, the reason for the later diagnosis were reported as the infant not being investigated at birth as they were clinically well, the mother was diagnosed with syphilis post-birth and the infant presented with symptoms post-birth. The remaining 16 women gave birth to infants (21%, 16/77) with congenital syphilis that were live-born with no congenital syphilis symptoms.

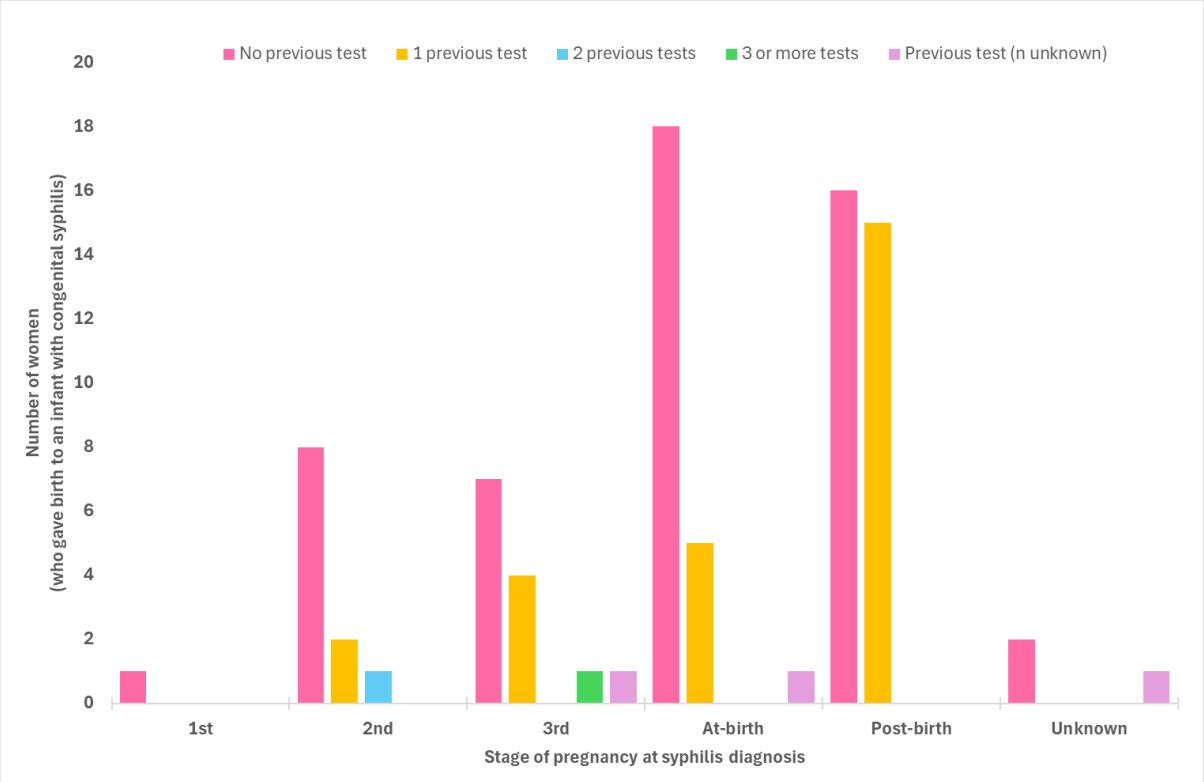
Figure 12: Adequate maternal treatment among women[5] giving birth to an infant with congenital syphilis, by year, 2020 – Q2 2025*

[8] Treatment is considered adequate if a stage-appropriate penicillin-containing regimen is administered 30 days or more prior to delivery and all antenatal and delivery pathology were performed and results verified with no evidence of reinfection.

4.7 Number of women[5] giving birth to an infant with congenital syphilis by number of syphilis tests received during their pregnancy

Maternal syphilis testing history was reported for 97% (83/86) of women giving birth to an infant between 2020 and Q2 2025 (Figure 13). Of those women 63% (52/83) did not report a previous syphilis test during their current pregnancy prior to being diagnosed with infectious syphilis. The remaining 27 cases (33%, 27/83) reported at least one previous syphilis test, however only one woman (1%) reported having three or more tests during their current pregnancy as recommended in national and jurisdictional guidelines (8-15) (Figure 13).

Figure 13: Maternal syphilis testing history^ during pregnancy among women[5] giving birth to an infant with congenital syphilis, by stage of pregnancy at syphilis diagnosis, 2020 – Q2 2025



^Excludes cases with unknown maternal screening history reported

4.8 Number of women[5] giving birth to an infant with congenital syphilis reinfected during their pregnancy

Maternal reinfection[9] data, either during the current pregnancy[10] or prior to the current pregnancy, were available for 97% (83/86) of women giving birth to an infant between 2020 and Q2 2025. Of the 83 women with data available, five (6%, 5/83) reported being diagnosed with a previous syphilis infection during the current or previous pregnancy and four (5%, 4/83) reported a previous infection but not while pregnant. The remaining 74 cases (89%, 74/83) did not report a previous syphilis infection prior to the current diagnosis.

[9] Reinfection is generally diagnosed on the basis of changes in RPR titre. A four-fold or two-titre rise in RPR, e.g. 1 in 2 to 1 in 8, following previous adequate treatment is considered a re-infection.
[10] Current pregnancy refers to the pregnancy when the maternal notification was made.

Methodological notes

Syphilis notification and enhanced data were extracted from the NNDSS on 31 October 2025, by diagnosis date. Due to the dynamic nature of the NNDSS, data in this extract are subject to retrospective revision and may vary from data reported in published NNDSS reports and reports of notification data by states and territories. Data are to 30 June 2025 unless otherwise specified.

In general, notification data represent only a proportion of the total cases occurring in the community, that is, only those cases for which health care was sought, a test conducted, and a diagnosis made, followed by a notification to health authorities. The degree of under-representation of all cases is unknown and is most likely variable by disease and jurisdiction.

In interpreting these data, it is important to note that changes in notifications over time may not solely reflect changes in disease prevalence or incidence. Changes in testing policies; screening programs including the preferential testing of high-risk populations; the use of less invasive and more sensitive diagnostic tests; and periodic awareness campaigns, may influence the number of notifications that occur annually.

Data elements

- 'Diagnosis year' was used to define the period of analysis. This date represents either the onset date or where the date of onset was not known, the earliest of the specimen collection date, the notification date, or the notification received date.
- 'Residential postcode' usually reflects the residential location of a case at the time of testing and does not necessarily represent the place where the disease was acquired.
- Residential postcode' reported to the NNDSS was used to allocate notifications of infectious and congenital syphilis to remoteness areas and mapped data by Statistical Area 3 (SA3) (as defined by the Australian Bureau of Statistics). Where a postcode was not reported the notification was excluded from remoteness area, SA3 and IARE analysis.
- The 'population denominator' used to calculate notification rates, including for remoteness areas, SA3 and IARE (per 100,000 population) was extracted from the Australian Bureau of Statistics Census Table Builder (based on 2021 Census data).
- The determination of the Indigenous status is by descent, self-identification, and community acceptance. While completeness of the Indigenous status field is generally high, it should be interpreted with caution as completeness of this field varies from year to year and jurisdiction to jurisdiction.
- 'Syphilis testing data' have been provided by participating ACCHS. A participating service refers to clinics currently funded by the Australian Government Department of Health, Disability and Ageing to deliver point of care testing in syphilis outbreak regions. Services extract data from local clinical information management systems. Data are provided for the reporting month, and cumulatively for the previous 12 months. 'Testing coverage' is calculated using as the denominator 'clients attending the service' (a participating ACCHS) during the reporting period.

Case definitions

The CDNA national surveillance case definitions for infectious and congenital syphilis, including any historical edits, are available at: https://www.health.gov.au/casedefinitions.

Acknowledgements

We, the Australian Centre for Disease Control, acknowledge the Traditional Owners and Custodians of Country throughout Australia. We recognise the strength and resilience of Aboriginal and Torres Strait Islander peoples and acknowledge and respect their continuing connections and relationships to country, rivers, land and sea. We acknowledge the ongoing contribution Aboriginal and Torres Strait Islander peoples make across the Health system and wider community. We also pay our respects to Elders past, present and future and extend that respect to all Traditional Custodians of this land.

The Australian Centre for Disease Control acknowledges the Communicable Diseases Network Australia; the work of public health officers involved in the collection of surveillance data; state and territory public health communicable disease surveillance managers and data managers; Aboriginal Community Controlled Health Services, and all public and private laboratories that support laboratory surveillance in Australia.

Contact

For any further details about information contained in this report please contact Ms Amy Bright by emailing syphilis.surveillance@health.gov.au

Appendix A – Reporting schedule

Table 5: National syphilis goals and indicators

No. Indicator	Indicator	Reporting
GOAL 1 - Strengthen prevention and testing strategies for syphilis in priority populations and settings, targeting high-burden areas		
1.1	Reported risk factors for people giving birth to an infant with congenital syphilis	Annually
1.2	Cumulative number of syphilis tests delivered through participating ACCHS, by target and total population	Quarterly
1.3	Proportion of people attending participating ACCHS receiving a syphilis test within the previous 12 months, by target and total population (syphilis testing coverage)	Quarterly
1.4	Proportion of people from priority populations tested for syphilis in the previous 12 months attending a site within the ACCESS network	Annually
1.5	Proportion of gay and bisexual men who have sex with men who have been tested for syphilis three or more times in the previous 12 months attending a site within the ACCESS network	Annually
1.6	Proportion of women who gave birth, by duration of pregnancy at first antenatal visit	Annually
1.7	Proportion of women who gave birth, by duration of pregnancy at first antenatal visit, by remoteness area	Annually
1.8	Proportion of women who gave birth, by number of antenatal visits	Annually
1.9	Proportion of women who gave birth, by number of antenatal visits, by remoteness area	Annually
1.10	Proportion of women who gave birth, by country of birth	Annually
GOAL 2 - Reduce ongoing transmission and incidence of syphilis across priority populations		
2.1	Notification rate of infectious syphilis by Indigenous status, sex, age and remoteness area classification	Quarterly
2.2	Notification rate of infectious syphilis in Aboriginal and Torres Strait Islander peoples by Indigenous Areas (IAREs)	Quarterly

No. Indicator	Indicator	Reporting
2.3	Notification rate of infectious syphilis by Statistical Area 3 (SA3), by Indigenous status	Quarterly
2.4	Notification rate of infectious syphilis in women of reproductive age (15-44 years) by Indigenous status and remoteness area	Quarterly
2.5	Proportion of infectious syphilis notifications in men reporting sexual exposure with men only	Quarterly
2.6	Proportion of infectious syphilis notifications in men reporting sexual exposure with men and women	Quarterly
2.7	Proportion of infectious syphilis notifications by primary reason for testing	Annually
2.8	Proportion of infectious syphilis notifications in gay and bisexual men who have sex with men reporting HIV PrEP use at time of syphilis diagnosis	Annually
2.9	Proportion of infectious syphilis notifications by clinical facility where the syphilis infection was diagnosed	Annually
2.10	Proportion of infectious syphilis notifications receiving treatment, by time to treatment	Annually
GOAL 3 - Reduce morbidity and mortality associated with syphilis		
3.1	Number of syphilis related deaths (ICD-10 coded), by stage of infection	Annually
3.2	Number of hospitalisations with a principal diagnosis of syphilis (ICD-10 coded)	Annually
3.3	Estimated number of Disability-adjusted life years (DALY) due to syphilis	Annually
GOAL 4 - Eliminate congenital syphilis (defined as sustained zero congenital syphilis cases)		
4.1	Number of congenital syphilis cases by remoteness area and Indigenous status	Quarterly
4.2	Number of congenital syphilis related deaths by Indigenous status	Quarterly
4.3	Notification rate of congenital syphilis per 100,000 live births by remoteness area and Indigenous status	Quarterly

No. Indicator	Indicator	Reporting
4.4	Proportion of syphilis notifications among women of reproductive age (15- 44 years) who were pregnant at time of diagnosis, by remoteness area classification and Indigenous status	Quarterly
4.5	Number of women giving birth to an infant with congenital syphilis who were diagnosed with syphilis 'late' in pregnancy by Indigenous status	Quarterly
4.6	Proportion of women giving birth to an infant with congenital syphilis receiving adequate treatment prior to delivery	Quarterly
4.7	Number of women giving birth to an infant with congenital syphilis by number of syphilis tests received during their pregnancy	Quarterly
4.8	Number of women giving birth to an infant with congenital syphilis reinfected during their pregnancy	Quarterly
4.9	Number of women of reproductive age (15-44 years) hospitalised with a principal diagnosis of syphilis (ICD-10 coded)	Annually
4.10	Number of women hospitalised with a principal diagnosis of syphilis in pregnancy, childbirth and puerperium (ICD-10 coded)	Annually

Appendix B – NNDSS syphilis notification and enhanced data completeness* by year, 2025

Variable	Completeness by year						
	2020	2021	2022	2023	2024	2025	
						Q1	Q2
Indigenous status							
Infectious syphilis	96%	95%	92%	94%	95%	94%	92%
Congenital syphilis	100%	100%	93%	100%	90%	100%	100%
Residential location (to map to reported geographies)							
Remoteness Area	98%	97%	97%	97%	98%	97%	98%
Statistical Area 3	[redacted]				98% (Q3 2024 – Q2 2025)		
Indigenous Areas					99% (Q3 2024 – Q2 2025; Aboriginal and Torres Strait Islander peoples only)		
Enhanced infectious syphilis							
Pregnancy status	62% (6 jurisdictions)	73% (7 jurisdictions)	72% (7 jurisdictions)	80% (7 jurisdictions)	58% (8 jurisdictions)	72% (7 jurisdictions)	70% (7 jurisdictions)
Sexual exposure (males)	70%	76%	65%	68%	70%	79%	77%
Enhanced congenital syphilis							
Stage of pregnancy	100%	100%	80%	100%	100%	100%	100%
Treatment prior to delivery	94%	100%	87%	95%	80%	100%	100%
Testing history	100%	100%	100%	95%	90%	67%	100%
Re-infection (current pregnancy)	88%	73%	100%	65%	80%	67%	83%

*Where completeness is less than 50% data have been excluded from reporting.

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