

Introduction

On 23 March 2021, the Australian Health Protection Principal Committee (AHPPC) endorsed the *National strategic approach for responding to rising rates of syphilis in Australia 2021* (Strategic Approach) developed to guide the national response to the continued rise in syphilis notifications in Australia. The Strategic Approach outlines three national targets which provide a specific focus for efforts towards addressing the rising rates of syphilis and adverse outcomes in Australia:

1. Reduce incidence of syphilis overall, with a focus on women of reproductive age.
2. Eliminateⁱ congenital syphilis.
3. Control outbreaksⁱⁱ among Aboriginal and Torres Strait Islander peoples in Queensland, the Northern Territory, Western Australia, and South Australia.

Supporting the Strategic Approach is the *National syphilis surveillance and monitoring plan* (Surveillance Plan) which outlines indicators that will be used to monitor progress towards achieving the three specific targets.

This report provides a quarterly account of progress against the targets and indicators in the Strategic Approach and Surveillance Plan.

Analysis

The Department of Health and Aged Care acknowledges the providers of the many sources of data used in this report and greatly appreciates their contribution.

Summary

- Syphilis notifications are being monitored across four population groups: non-Indigenous males, non-Indigenous females, Aboriginal and Torres Strait Islander males and Aboriginal and Torres Strait Islander females.
- Aboriginal and Torres Strait Islander people continue to be disproportionately represented in the syphilis notification data, with notification rates overall 8 times that of non-Indigenous people in the previous 12 months (1 January – 31 December 2022).
- The greatest proportion of syphilis cases were reported in non-Indigenous men, who largely resided in major cities, with notification rates declining over the previous 12 months.
- Notification rates in Aboriginal and Torres Strait Islander men and women aged 15-24 years residing in major cities of Australia reported the greatest increase compared to the preceding 12 months (1 January 2021 – 31 December 2022).
- Notification rates in Aboriginal and Torres Strait Islander people in remote and very remote areas of Australia continue to be the highest, reflecting sustained transmission associated with the outbreak in Queensland, the Northern Territory, Western Australia and South Australia.
- Notification rates among Aboriginal and Torres Strait Islander women of reproductive age (15-44 years) residing in major cities increased over the previous 12 months, whereas non-Indigenous women of reproductive age observed increases in inner/outer regional areas.
- Increases among women of reproductive age in recent years have coincided with the highest number of congenital syphilis cases diagnosed in 2020 (n=17) since 2001.
- Eighty per cent (80%) of women giving birth to an infant with congenital syphilis were diagnosed late in pregnancy.ⁱⁱⁱ

Data presented are to 31 December 2022 unless otherwise specified.

ⁱ The 2018-22 National STI Strategy and Aboriginal and Torres Strait Islander BBV and STI Strategy, define elimination of congenital syphilis as 'no new cases of congenital syphilis nationally notified for two consecutive years'.

ⁱⁱ At the time of writing Queensland, the Northern Territory, Western Australia and South Australia were the only jurisdictions with officially declared outbreak regions. New outbreak regions in other jurisdictions may be declared with endorsement from the CDNA, after which this target will be amended.

ⁱⁱⁱ 'Late diagnosis' is defined as a syphilis diagnosis less than 30 days prior to delivery, at birth (day of delivery) or post birth.



Considerations

This report aims to increase awareness of syphilis in Australia by providing an analysis of available notification and testing data. Delays in the reporting of data may cause data to change retrospectively. When considering the below analysis, it is important to note that the impact of the COVID-19 pandemic on health seeking behaviours, testing and sexual behaviour in relation to syphilis is not yet known. However, it is expected that syphilis testing will have declined overall due to the diversion of resources to COVID-19 testing and changes in people's behaviours during the pandemic.

Target 1: Reduce incidence of syphilis overall, with a focus on women of reproductive age

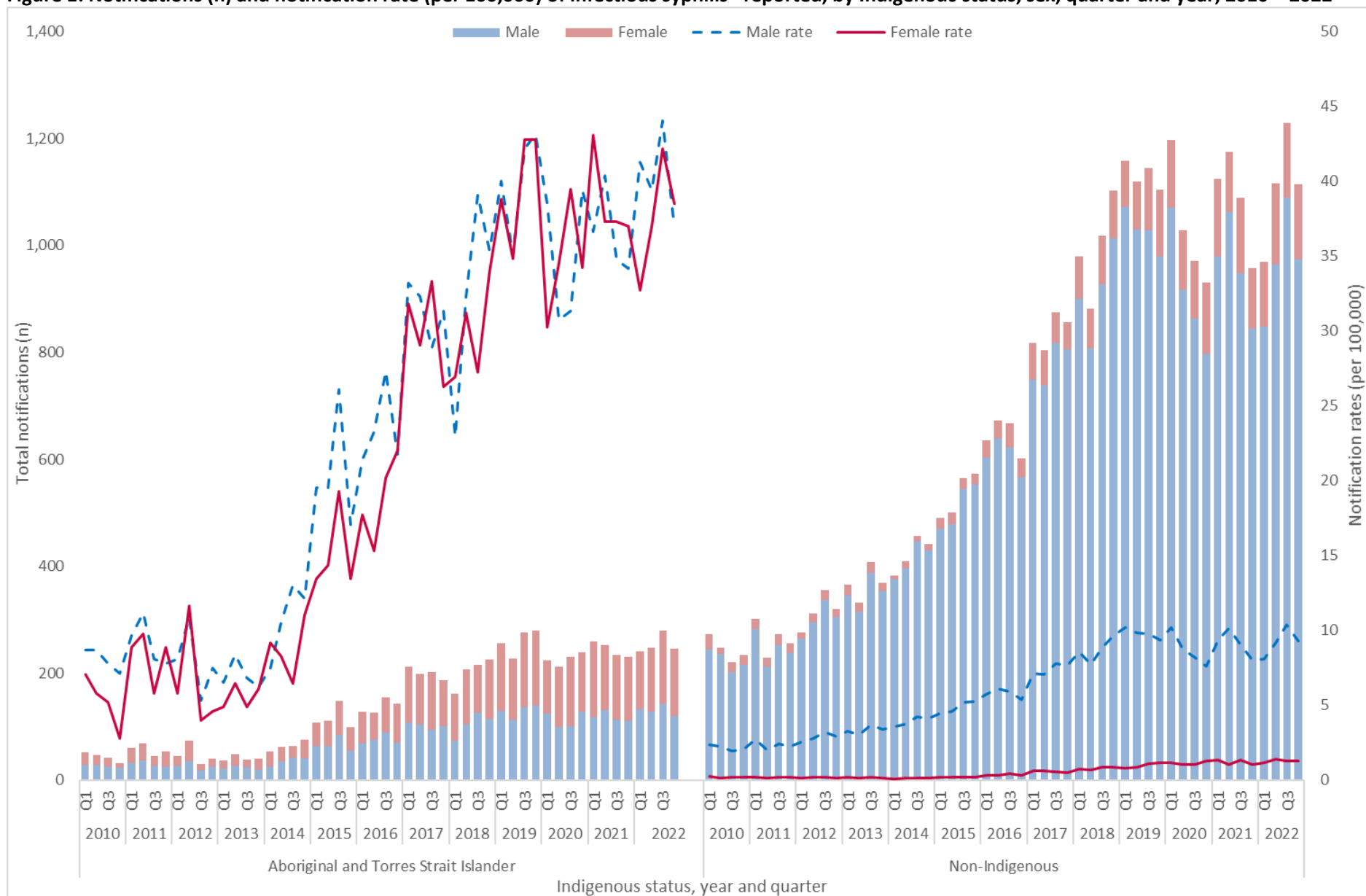
Indicator 1.1 - Rate of infectious syphilis

In the previous 12 months (1 January – 31 December 2022), there were 6,251 cases of infectious syphilis reported to the National Notifiable Diseases Surveillance System (NNDSS), with 5,443 cases (87%) reporting Indigenous status and sex:

- The greatest proportion of cases were among non-Indigenous males (71%, n=3,878/5,443), followed by non-Indigenous females (10%, 552/5,443), Aboriginal and Torres Strait Islander males (10%, 521/5,443) and Aboriginal and Torres Strait Islander females (9%, 492/5,443).
- Aboriginal and Torres Strait Islander males and females are disproportionately represented in the notification data, with notification rates reported for the previous 12 months as 162 and 150 per 100,000 respectively. Non-Indigenous males, despite representing the greatest proportion of total notifications, reported a notification rate substantially lower (37 per 100,000) followed by non-Indigenous females (5 per 100,000) (Figure 1).
- In the previous 12 months, Aboriginal and Torres Strait Islander males and non-Indigenous females observed an increase in notification rates compared to the preceding 12 months (1 January – 31 December 2021), with rates increasing by 10% and 7% respectively. Aboriginal and Torres Strait Islander females observed a small decline (3%) over the same period while non-Indigenous males remained the same.
- Compared to the 5-year mean, notification rates increased in non-Indigenous females (17%), Aboriginal and Torres Strait Islander males (9%) and Aboriginal and Torres Strait Islander females (4%). Notification rates remained the same in non-Indigenous males.



Figure 1: Notifications (n) and notification rate (per 100,000) of infectious syphilis* reported, by Indigenous status, sex, quarter and year, 2010 – 2022



*Excludes cases for whom sex and/or Indigenous status was not reported.



Remoteness area

Across all remoteness areas of Australia, Aboriginal and Torres Strait Islander men and women have substantially higher notification rates compared to non-Indigenous men and women (Figures 2 a-c and 3 a-c).

In the previous 12 months (1 January – 31 December 2022) the highest notification rates were reported among Aboriginal and Torres Strait Islander men and women aged 15-34 years old residing in remote and very remote areas of Australia, reflecting sustained transmission associated with the infectious syphilis outbreak in Queensland, the Northern Territory, Western Australia and South Australia (see Target 3 below for further information on the outbreak).

- Major cities

Non-Indigenous men represented the greatest proportion (83%) of syphilis notifications in major cities across Australia. Notification rates in this population group observed either small declines or remained stable across all age groups, with the exception of the 15-24 year age group which increased slightly (6%), in the previous 12 months as compared to the preceding 12 months (1 January – 31 December). Aboriginal and Torres Strait Islander men and women aged 15-24 years observed the greatest increases overall compared to the preceding 12 months, 71% and 67% respectively. Increases were also reported in the Aboriginal and Torres Strait Islander men aged 45+ years (16%) and women aged 35-44 and 25-34 years over the reporting period, 43% and 26% respectively. Non-Indigenous women reported declines across all age groups in the previous 12 months, with the exception of 45+ year old women (noting it was from a lower base) (Figures 2a and 3a).

- Inner and outer regional areas

Non-Indigenous men represented the greatest proportion of cases reported in the past 12 months in inner and outer regional areas (48%) followed by non-Indigenous women (18%) and Aboriginal and Torres Strait Islander women and men (18% and 17% respectively)^{iv}. When comparing the previous 12 months to the preceding 12 months, increases were reported for Aboriginal and Torres Strait Islander men in all age groups, with the two greatest overall increases reported in the 35-44 year age group (113%) and 25-34 year age group (76%). Aboriginal and Torres Strait Islander women also reported increases across all age groups, with the third greatest rate increase overall in 35-44-year age group (69%). Non-Indigenous women reported increases across all age groups, noting that changes were from a lower base. Non-Indigenous males reported decreases in the 15-34 year age groups and increases in 35-44 and 45+ age groups (Figures 2b and 3b).

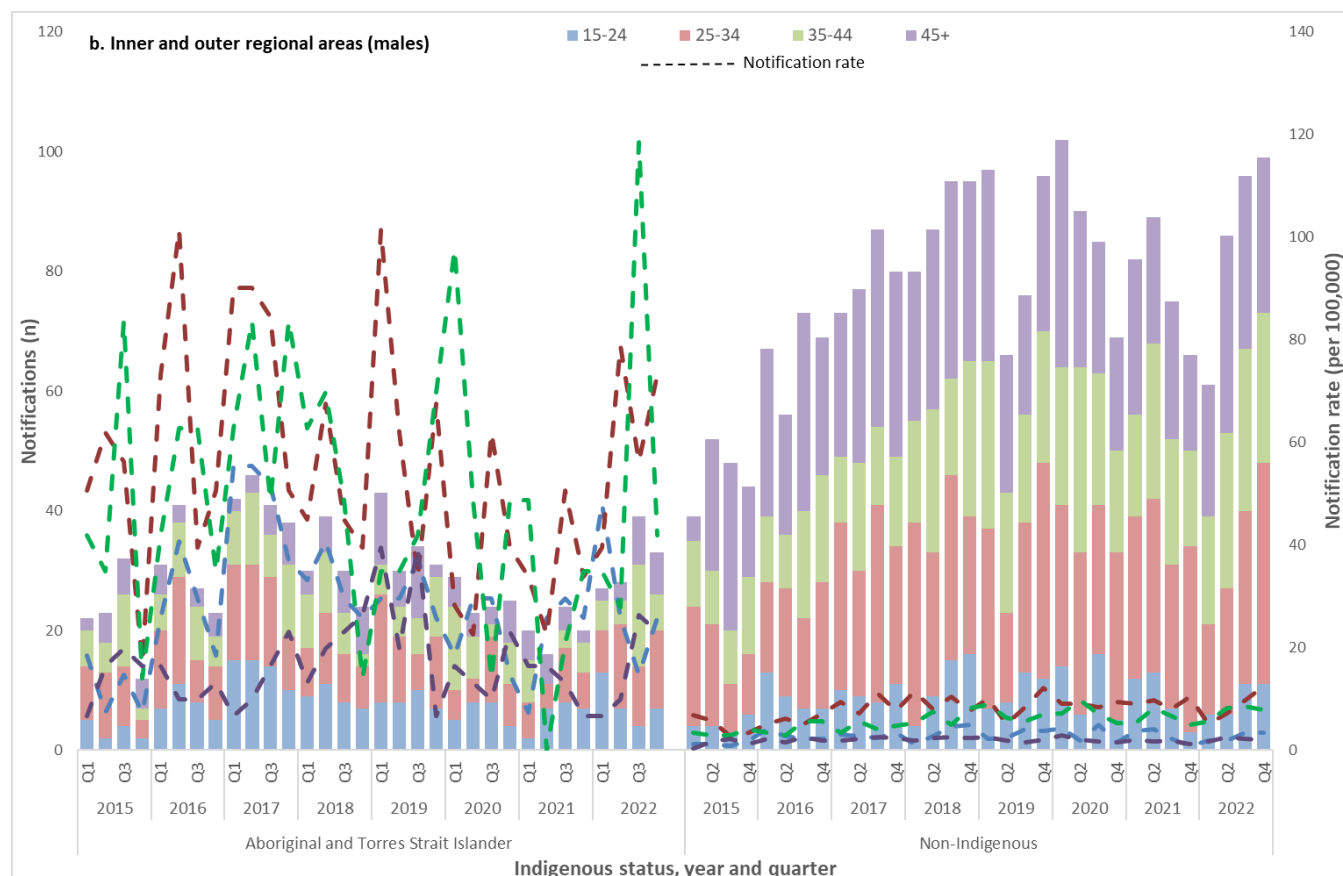
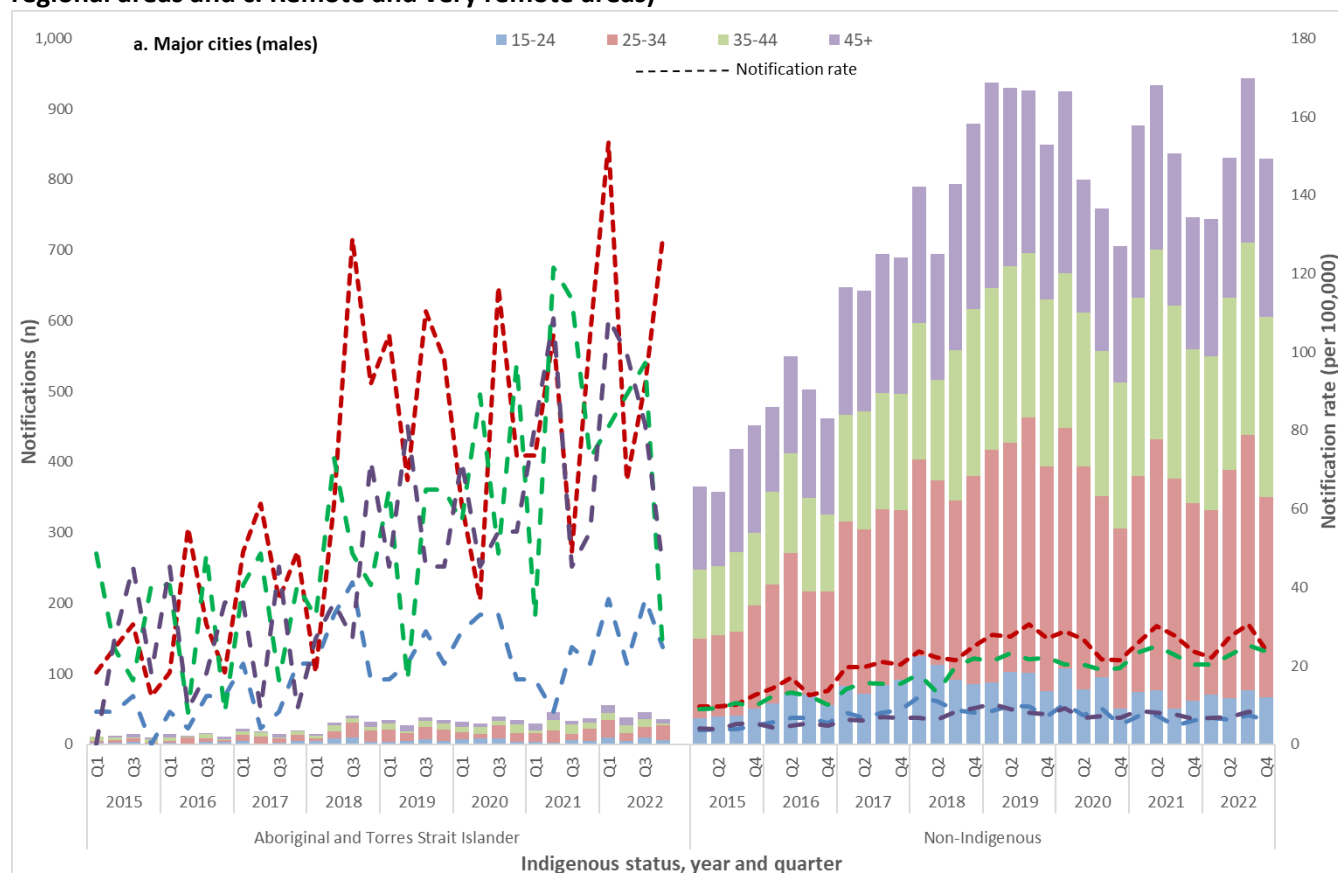
- Remote and very remote areas

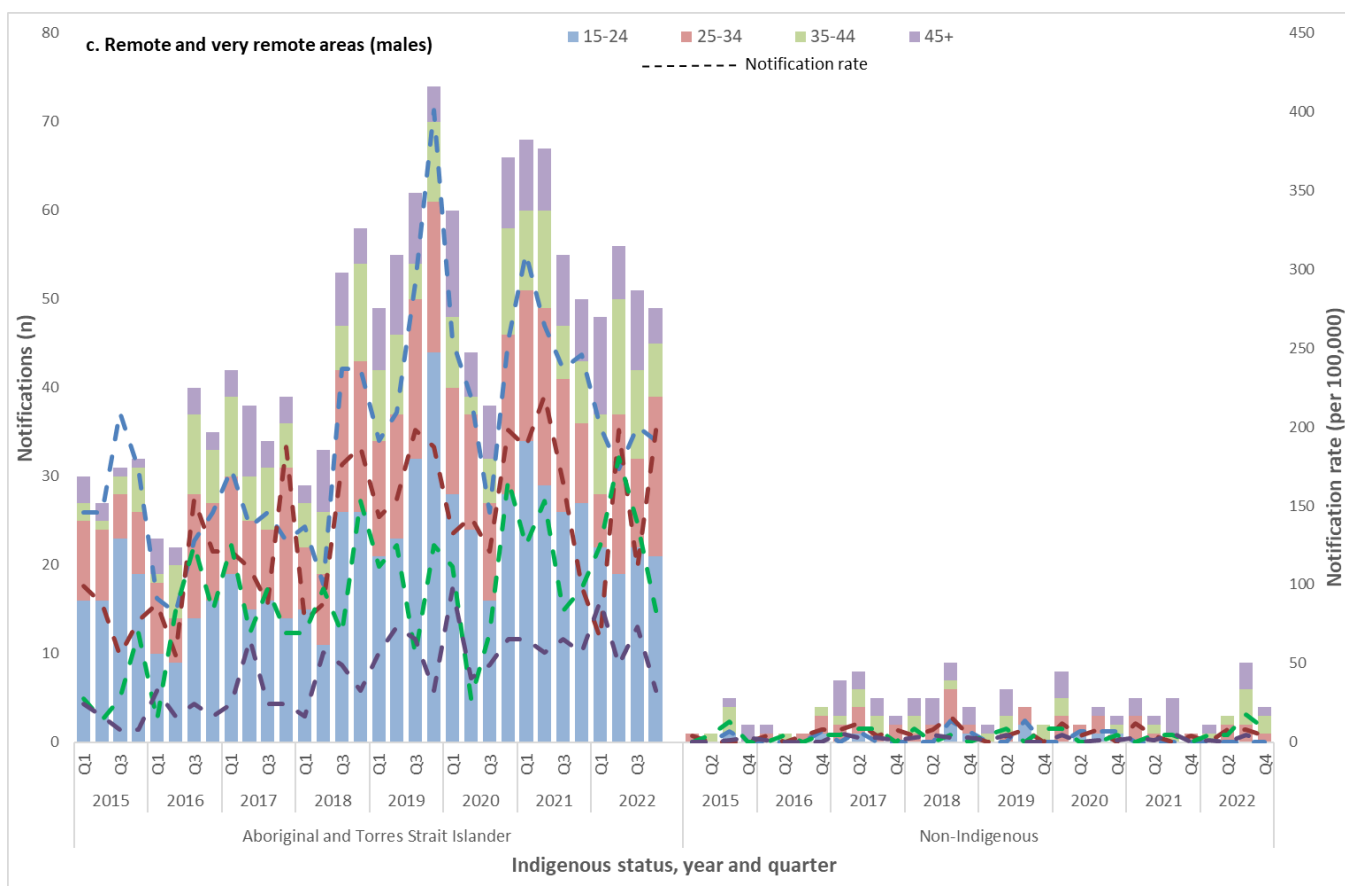
Aboriginal and Torres Strait Islander women and men represented 95% of cases reported over the previous 12 months in remote and very remote areas of Australia. Across all remoteness areas, notification rates were highest in Aboriginal and Torres Strait Islander men and women, particularly in the 15-24 year age group (Figures 2c and 3c).

^{iv} Totals may not equal 100% due to rounding.



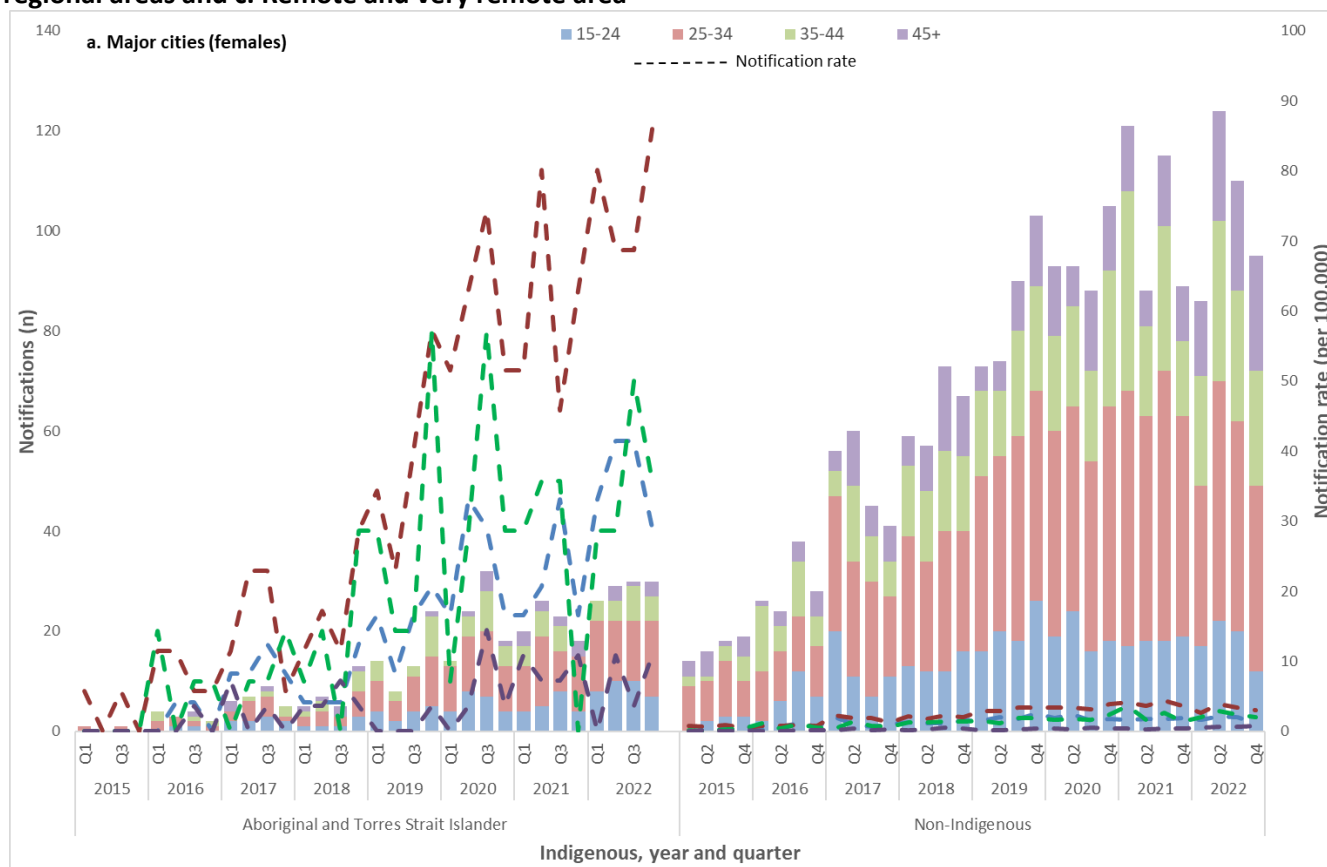
Figure 2 a-c: Notifications (n) and notification rate (per 100,000) of infectious syphilis reported in males, by Indigenous status, remoteness area, age, quarter and year, 2015 – 2022 (a. Major cities, b. Inner and outer regional areas and c. Remote and very remote areas)*

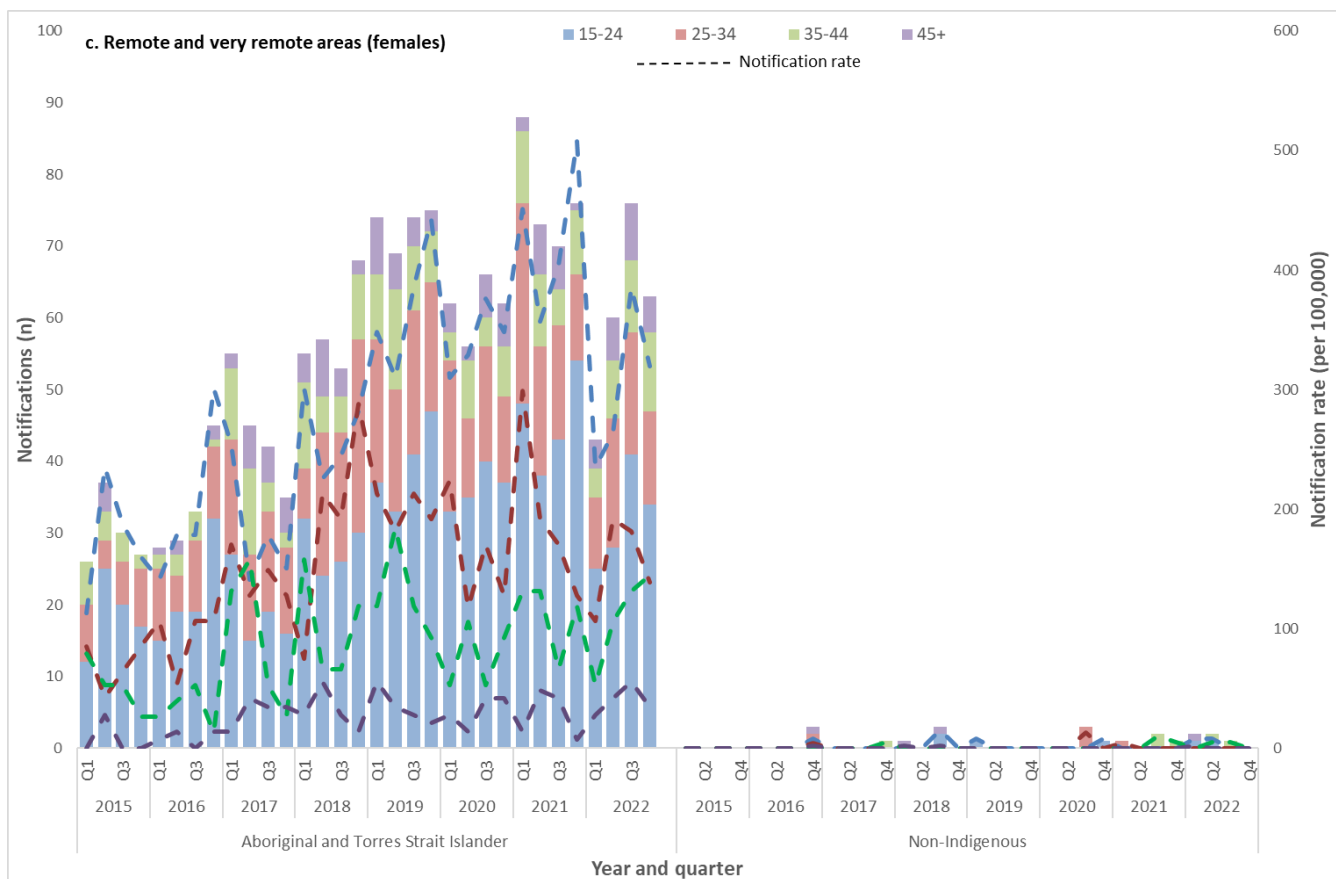
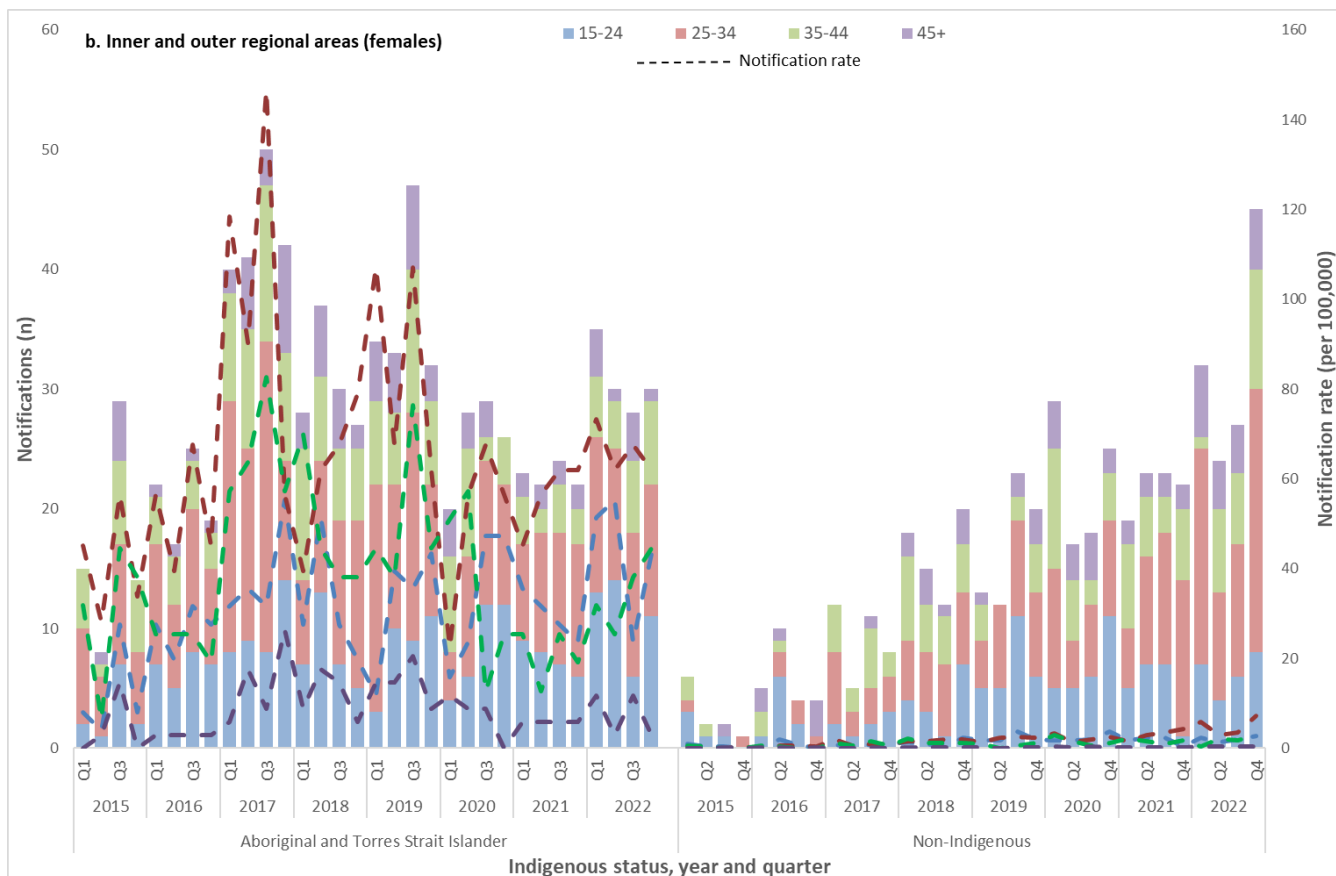




*Excludes cases for whom sex, age, Indigenous status and/or residential postcode were not reported

Figure 3 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, 2015 – 2022 (a. Major cities, b. Inner and outer regional areas and c. Remote and very remote area*





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

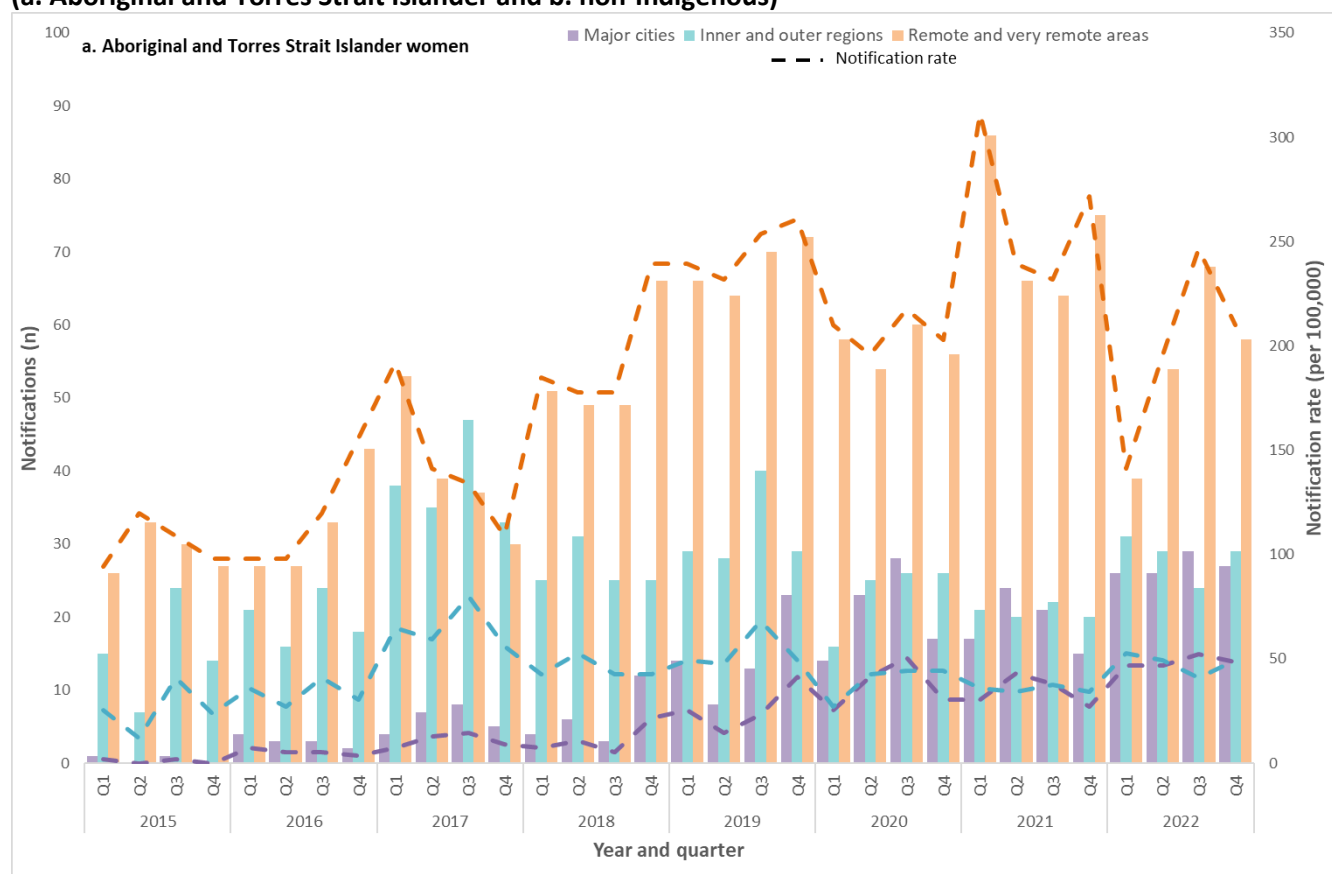


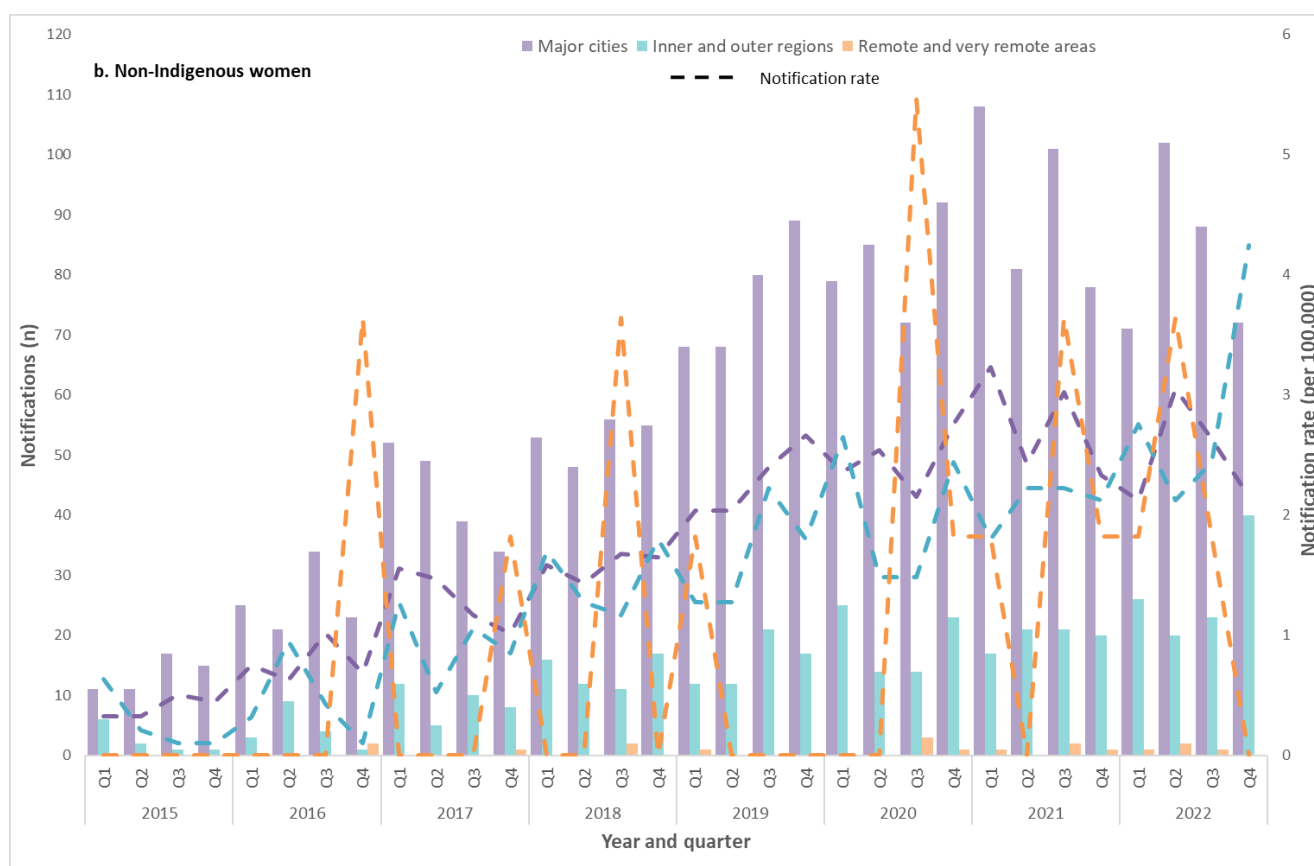
Indicator 1.2 - Rate of infectious syphilis among women of reproductive age (15-44 years)

Over the previous 12 months (1 January – 31 December 2022) notifications of syphilis among Aboriginal and Torres Strait Islander women aged 15-44 years were predominately in residents of remote and very remote areas of Australia, consistent with historical trends (Figure 4a). The highest notification rates, as expected, were in remote and very remote areas with rates declining by 25% in the previous 12 months compared to the preceding 12 months (1 January – 31 December 2021) and 11% compared 5-year mean. Inner/outer regional areas recorded the second highest rates in the previous 12 months, increasing from the preceding 12 months by 36 and, 8% compared to the 5-year average. Notification rates in Aboriginal and Torres Strait Islander women residing in major cities of Australia, increased by 40% compared to the preceding 12 months and 54% compared to the 5-year average.

Non-Indigenous women of reproductive age diagnosed with syphilis over the previous 12 months were predominately residents of major cities of Australia, consistent with historical trends (Figure 4b). Notification rates decreased for this group by 10% between the previous 12 months and the 12 months prior and increased by 8% compared to the 5-year average. Notification rates in inner/outer regional areas increased between the previous 12 months and the 12 months prior (38%) and compared to the 5-year average increased by 43%. Notification rates in remote and very remote Australia have fluctuated, noting that overall notifications in these areas are low for non-Indigenous women.

Figure 4a-b: Notifications (n) and notification rate (per 100,000) of infectious syphilis reported in females aged 15-44 years, by Indigenous status, remoteness area, quarter and year, 2015 – 2022
(a. Aboriginal and Torres Strait Islander and b. non-Indigenous)*





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

Indicator 1.3 - Proportion of infectious syphilis notifications in men reporting sexual exposure with men only

Indicator 1.4 - Proportion of infectious syphilis notifications in men reporting sexual exposure with both men and women

Enhanced data (sexual exposure: same sex, opposite sex and both sexes) are used to report against indicators 1.3 and 1.4.

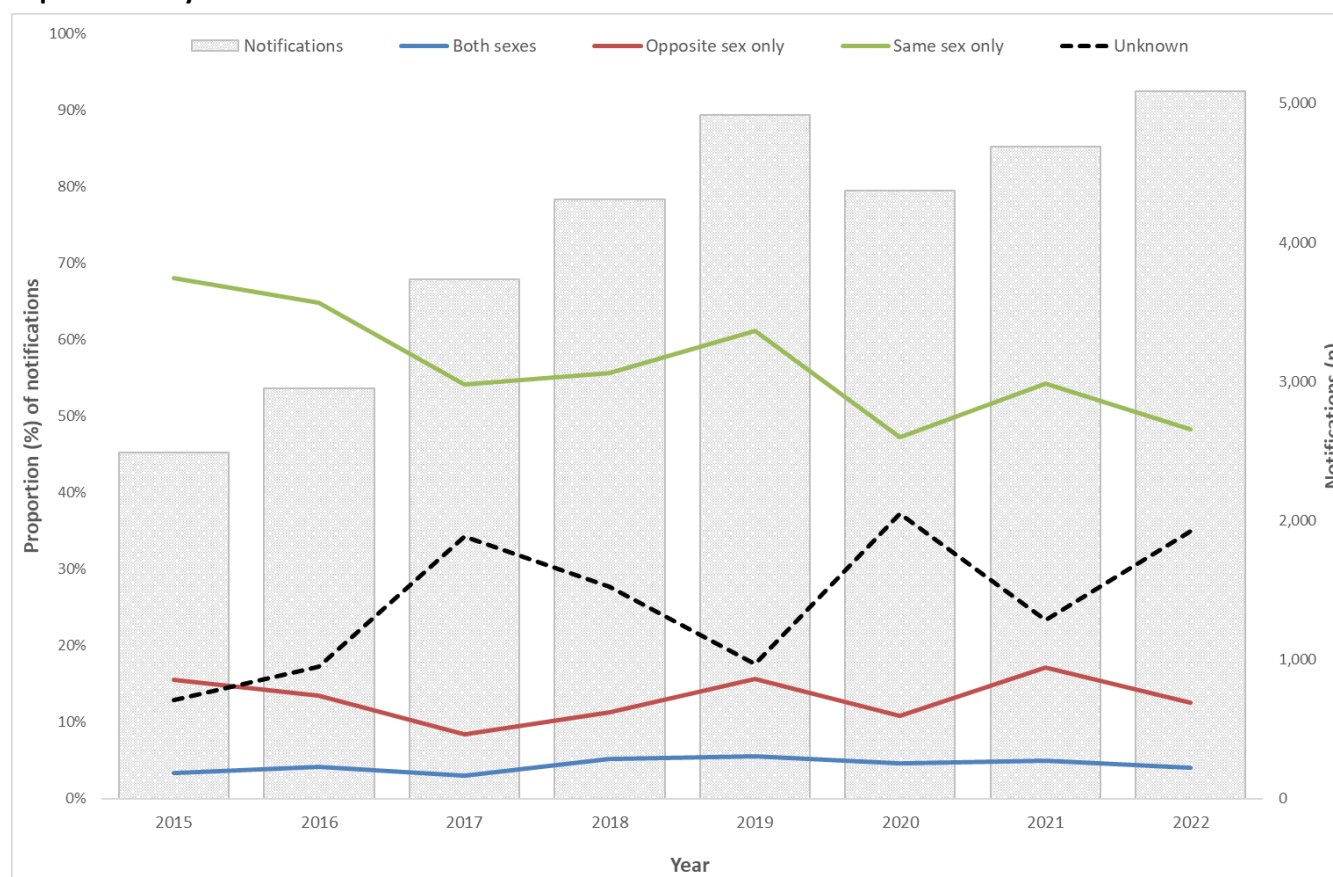
Completeness of enhanced sexual exposure data

Completeness of sexual exposure in males notified with infectious syphilis fluctuated between 2015 and 2022, ranged from 63% and 87% (average 74%).

Same sex only was the most frequently reported sexual exposure across all, representing on average 56% of notifications overall, followed by opposite sex only (13%) and both sexes (4%). The proportion of cases reporting same sex only exposure fluctuate across the reporting period with the highest in 2015 (68%) and lowest in 2020 (47%), noting higher proportions of unknown cases in more recent years (Figure 5).

Although men reporting sexual exposure with both men and women represented the lowest proportion of all cases during the reporting period (range 3 -6%), notifications reported for this category of sexual exposure increased by 19% between 2015 and 2021.

Figure 5: Number of infectious syphilis notifications among men and proportion (%) of cases by sexual exposure and year 2015 – 2022



Target 2: Eliminate congenital syphilis

Indicator 2.1 - Number of congenital syphilis notifications

Indicator 2.2 - Notification rate of congenital syphilis per 100,000 live births

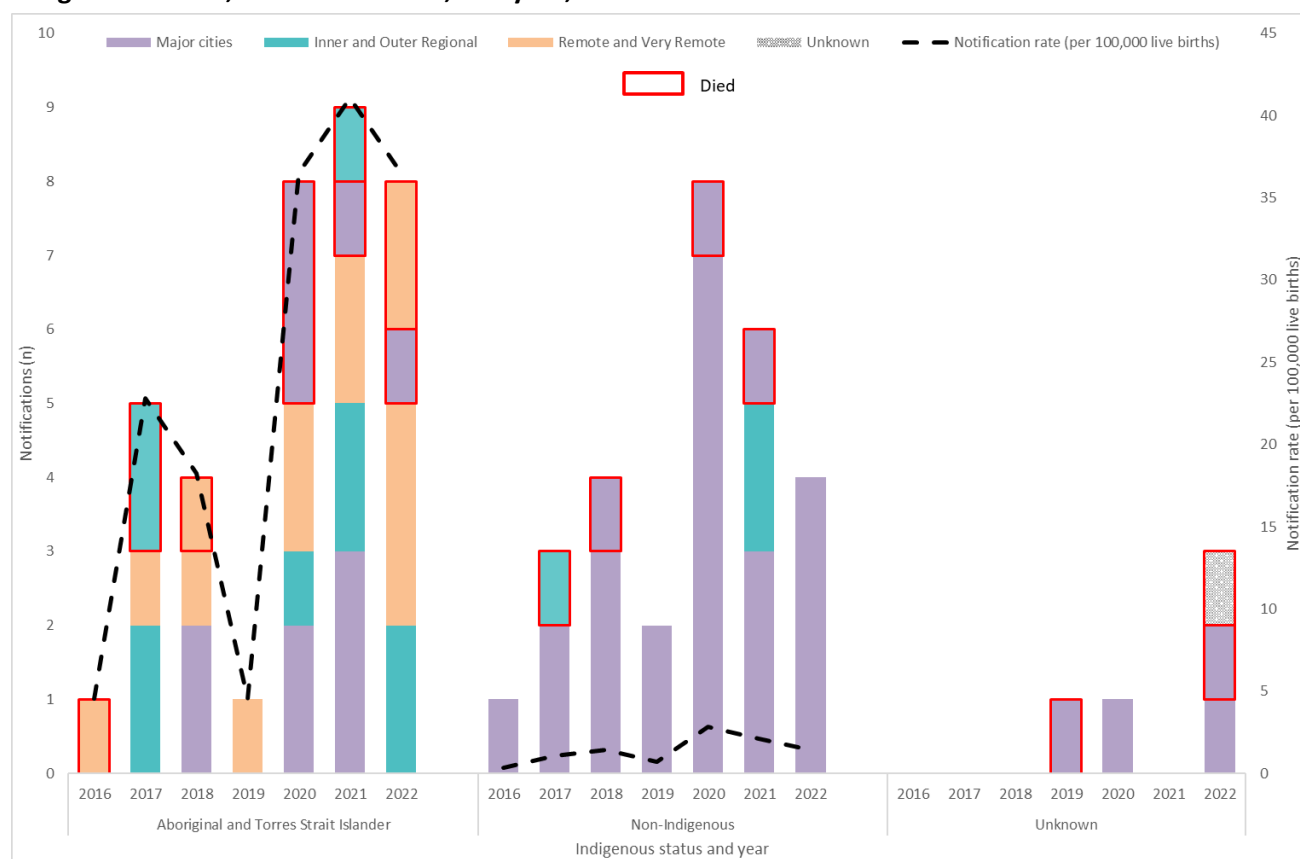
Indicator 2.3 - Number of congenital syphilis cases that were reported to have died from the condition

Sixty-nine (69) cases of congenital syphilis were reported between 2016 and 2022, 36 were reported in Aboriginal and Torres Strait Islander infants, 28 were non-Indigenous and 5 had an unknown Indigenous status (Figure 6). Among the 36 Aboriginal and Torres Strait Islander cases, 33% (12/36) were residents of major cities, 28% (10/36) from inner/outer regional areas and 39% (14/36) from remote/very remote areas. Eighty-nine per cent (89%, 25/28) of non-Indigenous cases were residents of major cities and 11% (3/28) from inner/outer regional areas. Four (4) of the cases with an unknown Indigenous status were reported from major cities (80%, 4/5), and the remaining case did not have a residential location reported (20%, 1/5).

Aboriginal and Torres Strait Islander infants are disproportionately represented in the notification data, with rates per 100,000 live births on average almost 20 times that of non-Indigenous infants, noting that rates have fluctuated in both groups over time.

Nineteen (19) congenital syphilis associated deaths were reported between 2016 and 2022, 12 (63%, 12/19) were Aboriginal and Torres Strait Islander infants, 4 (21%, 4/19) were non-Indigenous and 3 (16%, 3/19) had an unknown Indigenous status. Of the Aboriginal and Torres Strait Islander infants that died, 5 (42%, 5/12) were reported in major cities, 3 (25%, 3/12) from inner/outer regional areas and 4 (33%, 4/12) from remote/very remote areas. Of the non-Indigenous infants, 3 (75%, 3/4) were reported in major cities and 1 (25%, 1/4) a resident of an inner/outer regional area. Of the remaining 3 cases (unknown Indigenous status) 2 (66%, 2/3) were from major cities and 1 (33%, 1/3) did not have a residential location reported.

Figure 6: Notifications (n) and notification rate (per 100,000 live births) of congenital syphilis reported in, by Indigenous status, remoteness area, and year, 2016 – 2022



Indicator 2.4 - Proportion of syphilis notifications among women who were pregnant at time of diagnosis

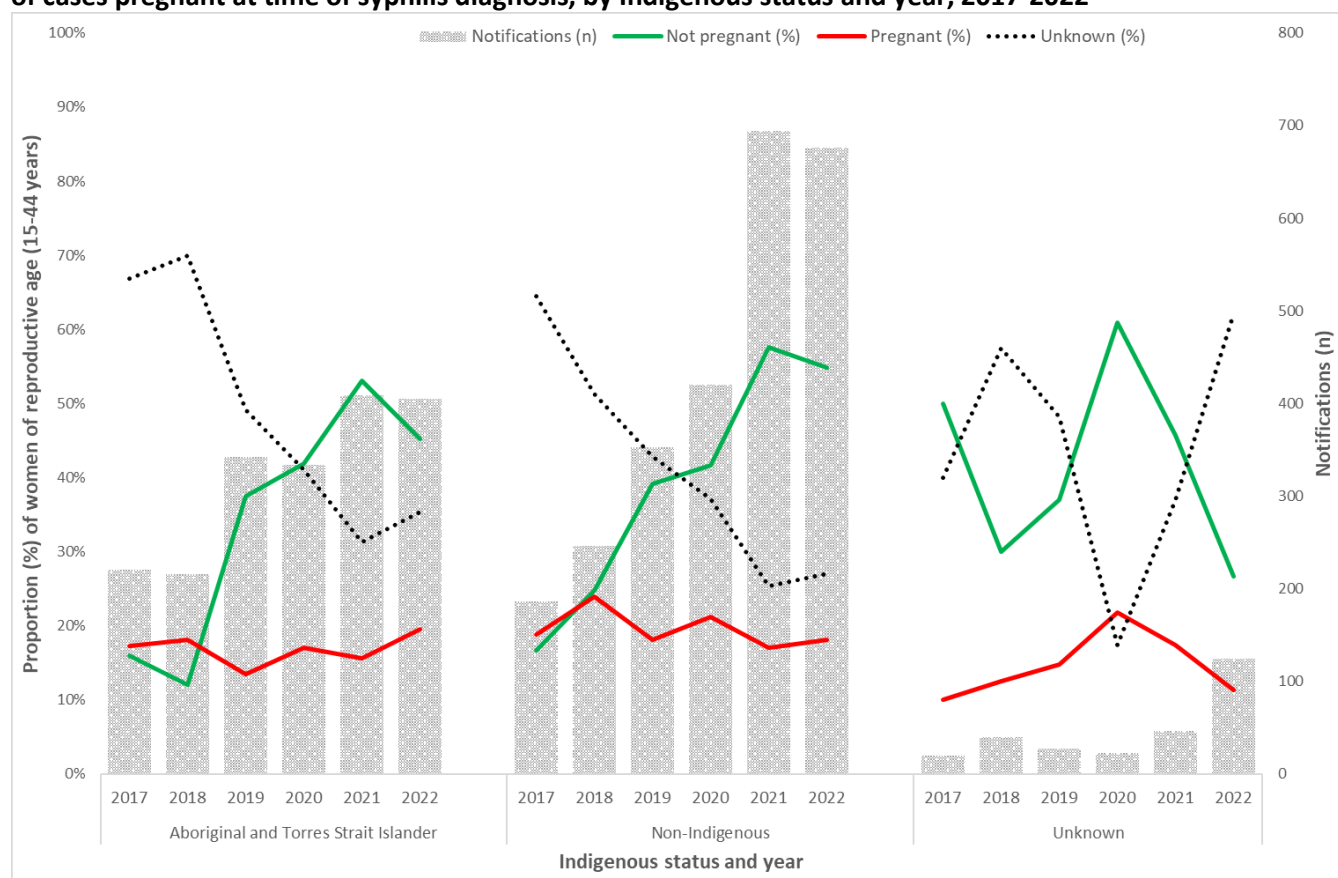
Pregnancy status was available from 7 jurisdictions in 2021 and 2022, 6 in 2020 and 4 between 2017 and 2019. Given the high proportion of cases with an unknown pregnancy status and retrospective changes to the data, trends overtime should be interpreted with caution.

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 addition, previous reports have included data from the NT; however these data have been excluded due to known data issues.

In 2022, of the syphilis notifications among Aboriginal and Torres Strait Islander women of reproductive age (15-44 years), 20% were pregnant at the time of diagnosis, 45% were not pregnant and 35% had an unknown pregnancy status (Figure 7). In previous years, the proportion of Aboriginal and Torres Strait Islander women pregnant at time of syphilis diagnosis was lower than 2022, ranging between 13% and 18%, noting that the number of jurisdictions reporting data each year varied.

Among non-Indigenous women of reproductive age in 2022, 18% were pregnant at the time of diagnosis, 55% were not pregnant and 27% had an unknown pregnancy status (Figure 7). In previous years, the proportion of non-Indigenous women pregnant at time of syphilis diagnosis ranged between 17% and 24%, noting that the number of jurisdictions reporting data each year varied.

Figure 7: Number of syphilis notifications among women of reproductive age (15-44 years) and proportion (%) of cases pregnant at time of syphilis diagnosis, by Indigenous status and year, 2017-2022



Indicator 2.5 - Number of women giving birth to an infant with congenital syphilis who were diagnosed with syphilis in pregnancy by gestation period

Indicator 2.6 - Number of women giving birth to an infant with congenital syphilis who were diagnosed with syphilis late^v in pregnancy

Enhanced data are used to report against indicators 2.5 and 2.6.

Completeness of enhanced congenital syphilis data

Between 2016 and 2022, 96% (66/69) of congenital syphilis cases had enhanced data available at the time of writing, including information about the mother of the infant diagnosed with congenital syphilis.

Of the 66 congenital syphilis cases reported between 2016 and 2022, (6%, 4/66) mothers giving birth to an infant with congenital syphilis were diagnosed in the 2nd trimester, 14 (21%, 14/66) in the 3rd trimester, 18 (27%, 18/66) on the day of delivery, 25 (38%, 25/66) post-birth and 5 (8%, 5/66) had an unknown stage of pregnancy at the time of syphilis diagnosis (Table 1).

Eighty per cent (80%, 53/66) of mothers giving birth to an infant with congenital syphilis were diagnosed late in pregnancy, including 10 mothers diagnosed in the 3rd trimester less than 30 days prior to delivery.

^v 'Late diagnosis' is defined as a syphilis diagnosis less than 30 days prior to delivery, at birth (day of delivery) or post birth.



Table 1: Number of women giving birth to an infant with congenital syphilis, by gestation period mother was diagnosed with syphilis and year, 2016 – 2022

Mothers gestation period at syphilis diagnosis	2016	2017	2018	2019	2020	2021	2022
1 st Trimester	0	0	0	0	0	0	0
2 nd Trimester	1	0	0	0	1	0	2
3 rd Trimester	1	2	3	2	2	3	1
At birth (Day of delivery)	0	2	2	0	6	5	3
Post-birth	0	3	2	2	8	7	3
Unknown	0	1	1	0	0	0	3
Total	2	8	8	4	17	15	12
Late diagnosis	0	6	7	3	15	15	7

Target 3: Control outbreaks among Aboriginal and Torres Strait Islander peoples in Queensland, the Northern Territory, Western Australia and South Australia

An outbreak of infectious syphilis began in northern Queensland in January 2011, extending to the Northern Territory in July 2013, the Kimberley in Western Australia in June 2014, and South Australia in November 2016.

The AHPPC, in consultation with affected jurisdictions, Aboriginal Community Controlled Health Services (ACCHS) and key stakeholders, developed a National Strategic Approach and Action Plan to address the disproportionately high rates of syphilis and other BBV and STI in regional and remote Aboriginal and Torres Strait Islander communities. The Strategic Approach and Action Plan were endorsed by the Australian Health Ministers Advisory Council in December 2017.

Further information on the outbreak and response activities are available on the Department of Health and Aged Care [website](#).

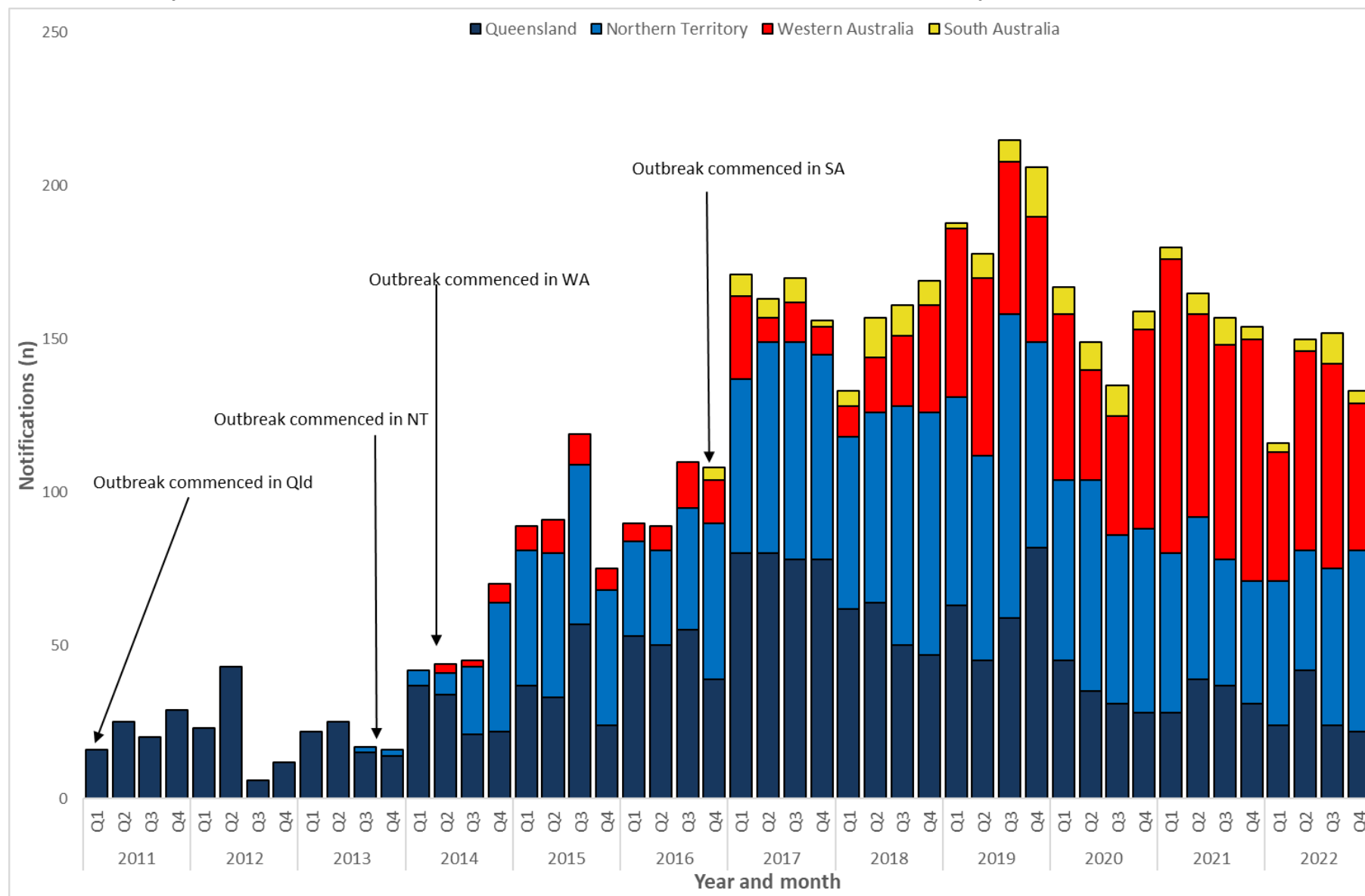
Indicator 3.1 - Number of outbreak associated infectious syphilis notifications

Since the commencement of the outbreak on 1 January 2011 to 30 September 2022, a total of 5,226 infectious syphilis outbreak cases (category 1 and 2^{vi}) were reported from 4 jurisdictions (Figure 8, Table 2):

- 1,947 from Queensland;
- 1,922 from the Northern Territory;
- 1,170 from Western Australia;
- 187 from South Australia.

^{vi} Outbreak cases are reported as either category 1 or category 2: category 1 cases include Aboriginal and Torres Strait Islander people residing in an outbreak declared region at the time of diagnosis, and; category 2 cases include people who are a sexual contact of a confirmed outbreak case which includes Aboriginal and Torres Strait Islander people who do not reside in an outbreak area at the time of diagnosis and non-Indigenous people regardless of where they reside. **All data are provisional and subject to change due to ongoing case investigation.**

Figure 8: Notifications of category 1 infectious syphilis outbreak cases notified in Aboriginal and Torres Strait Islander people residing in affected regions of Queensland, the Northern Territory, Western Australia, and South Australia from commencement of the outbreak in each jurisdiction to 31 December 2022





Across the 4 outbreak jurisdictions, 54% (2,766/5,110) of all category 1 cases were female and 46% (2,343/5,110) were male, with a male to female ratio of 0.8:1 suggesting predominately heterosexual transmission overall, noting the variability across specific outbreak regions and jurisdictions (Figure 9 a-d, Table 2).

On 19 November 2020, the Multi-Jurisdictional Syphilis Working Group endorsed the expansion of the 'target age group' from 15-29 years to 15-34 years^{vii}. This change came into effect from February 2021. Overall, 72% (3,681/5,110) of all outbreak cases were reported in 15-34-year-olds, with the proportion of cases in this age group across the outbreak period (1 January 2011 – 31 December 2022) ranging between 68% and 82% (Figure 9a-d).

Table 2: Characteristics of infectious syphilis outbreak cases notified in Aboriginal and Torres Strait Islander people residing in affected regions^{viii} of Queensland, the Northern Territory, Western Australia, and South Australia to 31 December 2022

	Queensland (five HHSs)	Northern Territory (seven regions)	Western Australia (three regions)	South Australia (three regions)
Category 1				
Outbreak commencement month/year	January 2011	July 2013	June 2014	November 2016
Total number of cases	1,886	1,885	1,164	175
% Male / % Female	46% / 54%	46% / 54%	44% / 56%	53% / 47%
% 15-34 year age group	70%	73%	74%	64%
Category 2				
Aboriginal and Torres Strait Islander people ^{ix}	15	14	6	-
Non-Indigenous people ^x	46	23	-	12

^{vii} [Multijurisdictional Syphilis Outbreak Surveillance Report: February 2021](#)

^{viii} Qld - North West Hospital and Health Service (HHS) area (from 1 January 2011); Torres and Cape Hospital and Health Service area (from 1 December 2012); Cairns and Hinterland Hospital and Health Service area (from 1 August 2013); Townsville Hospital and Health Service area (from 1 January 2014); Central Queensland Hospital and Health Service area (from 1 June 2017) NT - Alice Springs Rural and Urban or Barkly district (from 1 July 2013); Katherine district (from 1 May 2014); East Arnhem district (from 1 November 2015); Darwin Rural and Urban (from 1 January 2017); WA - Kimberley region (from 1 June 2014); Pilbara region (from 1 February 2018); Goldfields region (from 1 January 2019); SA - Far North and Western and Eyre regions (from 15 November 2016); Adelaide (from 1 February 2018).

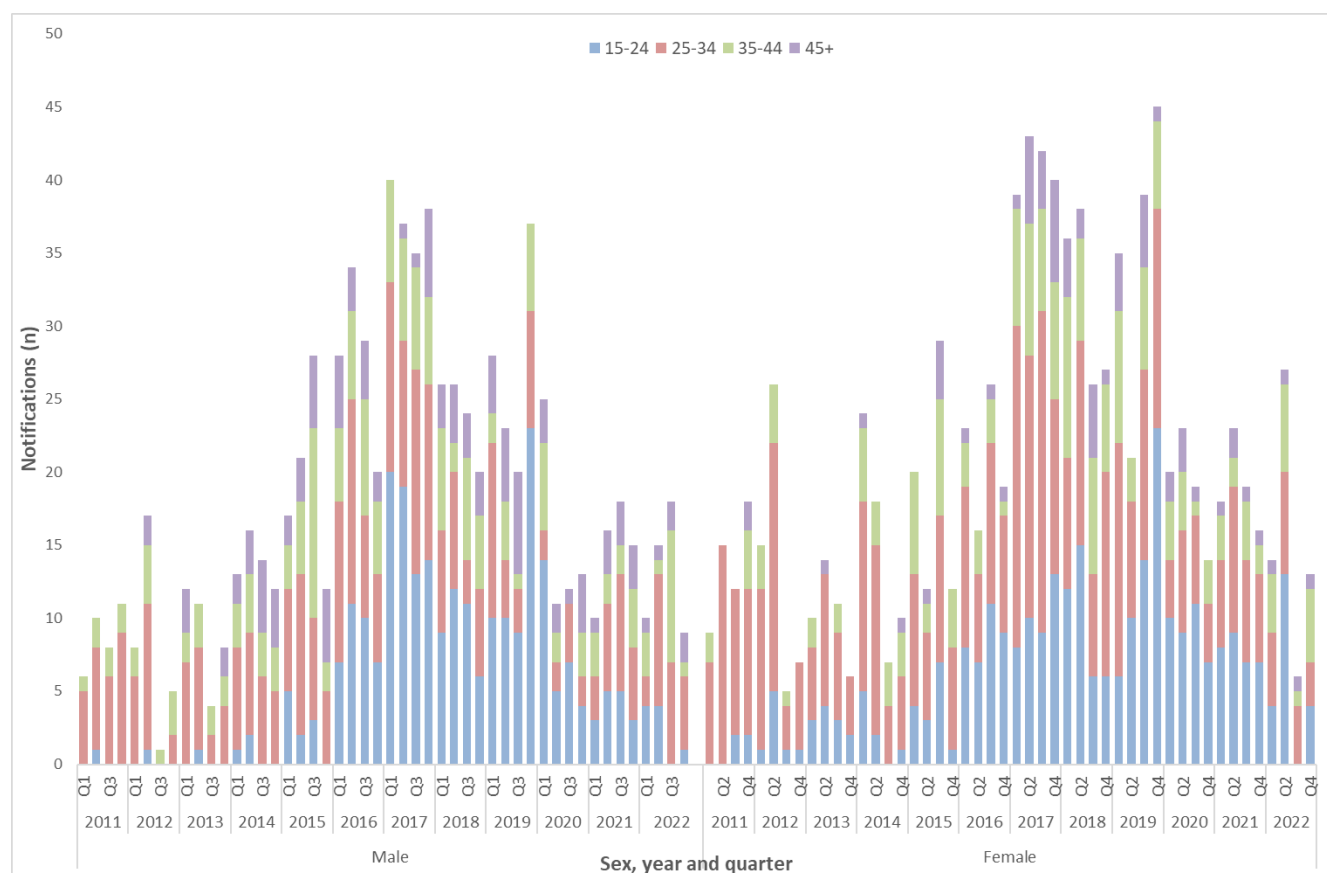
^{ix} Aboriginal and Torres Strait Islander people who are sexual contacts of a confirmed outbreak case and reside outside an outbreak declared region at the time of diagnosis.

^x Non-Indigenous people who are sexual contacts of a confirmed outbreak case and reside in or out of an outbreak declared region at the time of diagnosis.



Figure 9 a-d: Notifications (n) of category 1 outbreak associated syphilis cases, by age*, sex, jurisdiction, year, and quarter from commencement in each jurisdiction to 31 December 2022 (a. Queensland, b. the Northern Territory, c. Western Australia and d. South Australia)^{xi}

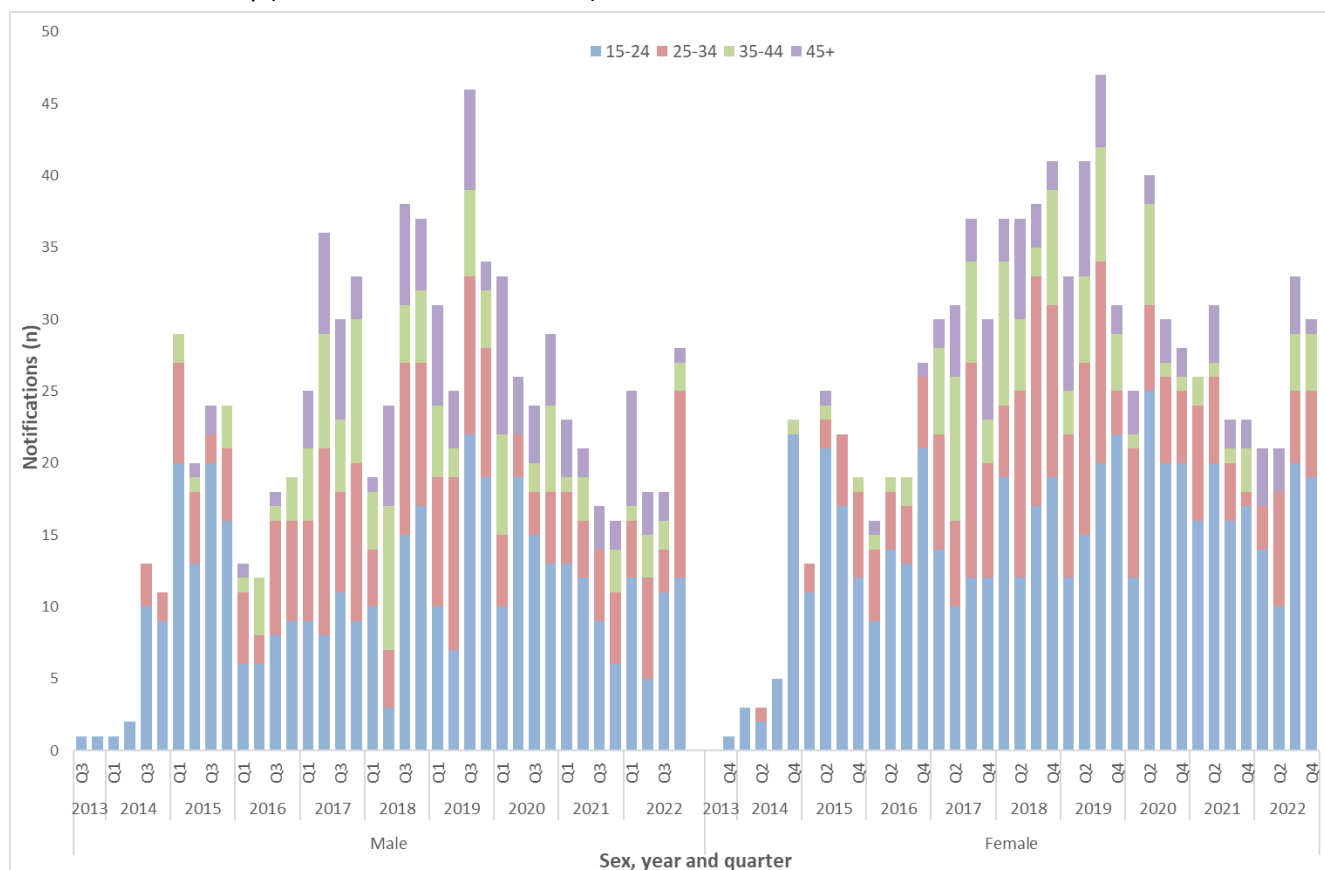
a. Queensland (2011 – 31 December 2022)



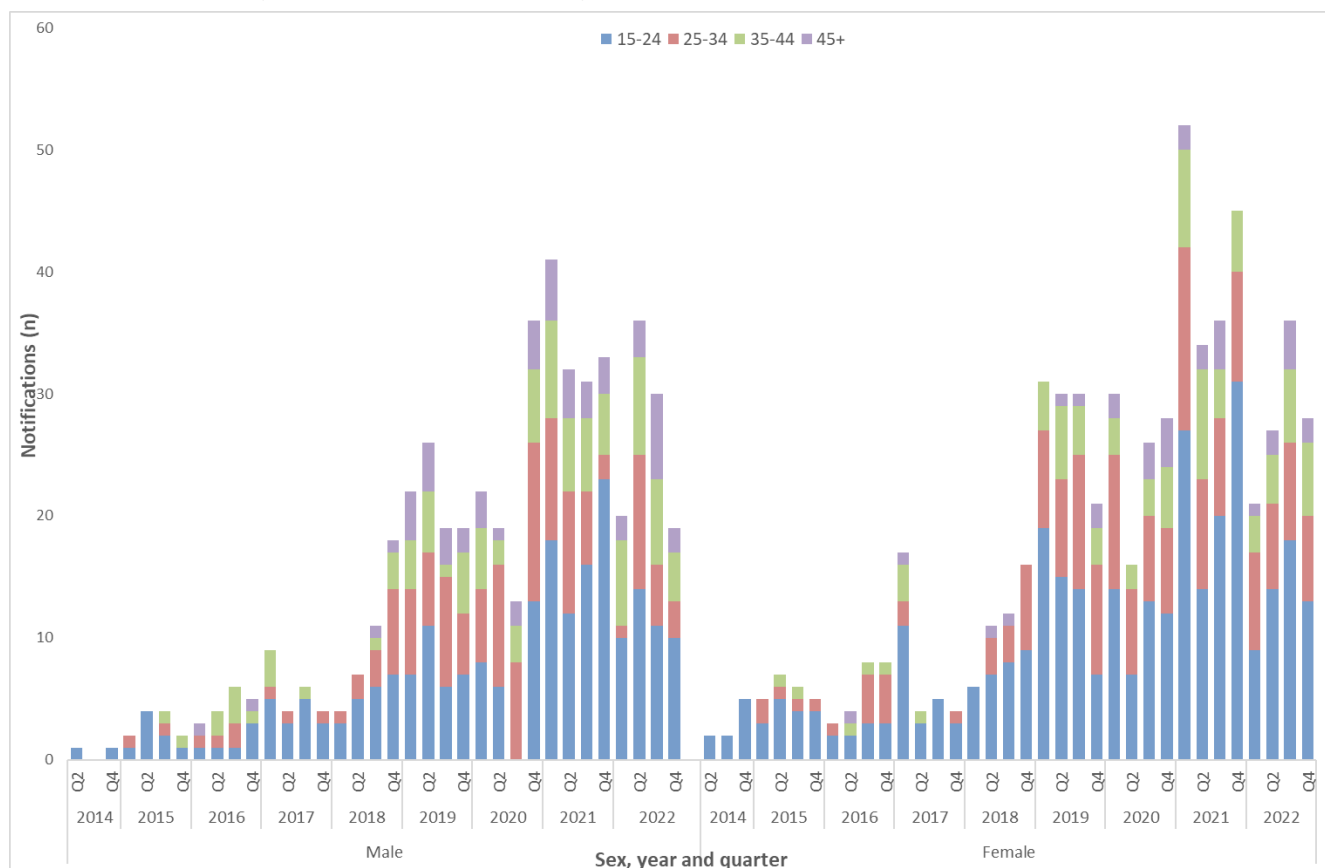
^{xi} Qld - North West Hospital and Health Service (HHS) area (from 1 January 2011); Torres and Cape Hospital and Health Service area (from 1 December 2012); Cairns and Hinterland Hospital and Health Service area (from 1 August 2013); Townsville Hospital and Health Service area (from 1 January 2014); Central Queensland Hospital and Health Service area (from 1 June 2017) NT - Alice Springs Rural and Urban or Barkly district (from 1 July 2013); Katherine district (from 1 May 2014); East Arnhem district (from 1 November 2015); Darwin Rural and Urban (from 1 January 2017); WA - Kimberley region (from 1 June 2014); Pilbara region (from 1 February 2018); Goldfields region (from 1 January 2019); SA - Far North and Western and Eyre regions (from 15 November 2016); Adelaide (from 1 February 2018).



b. Northern Territory (2013 – 31 December 2022)

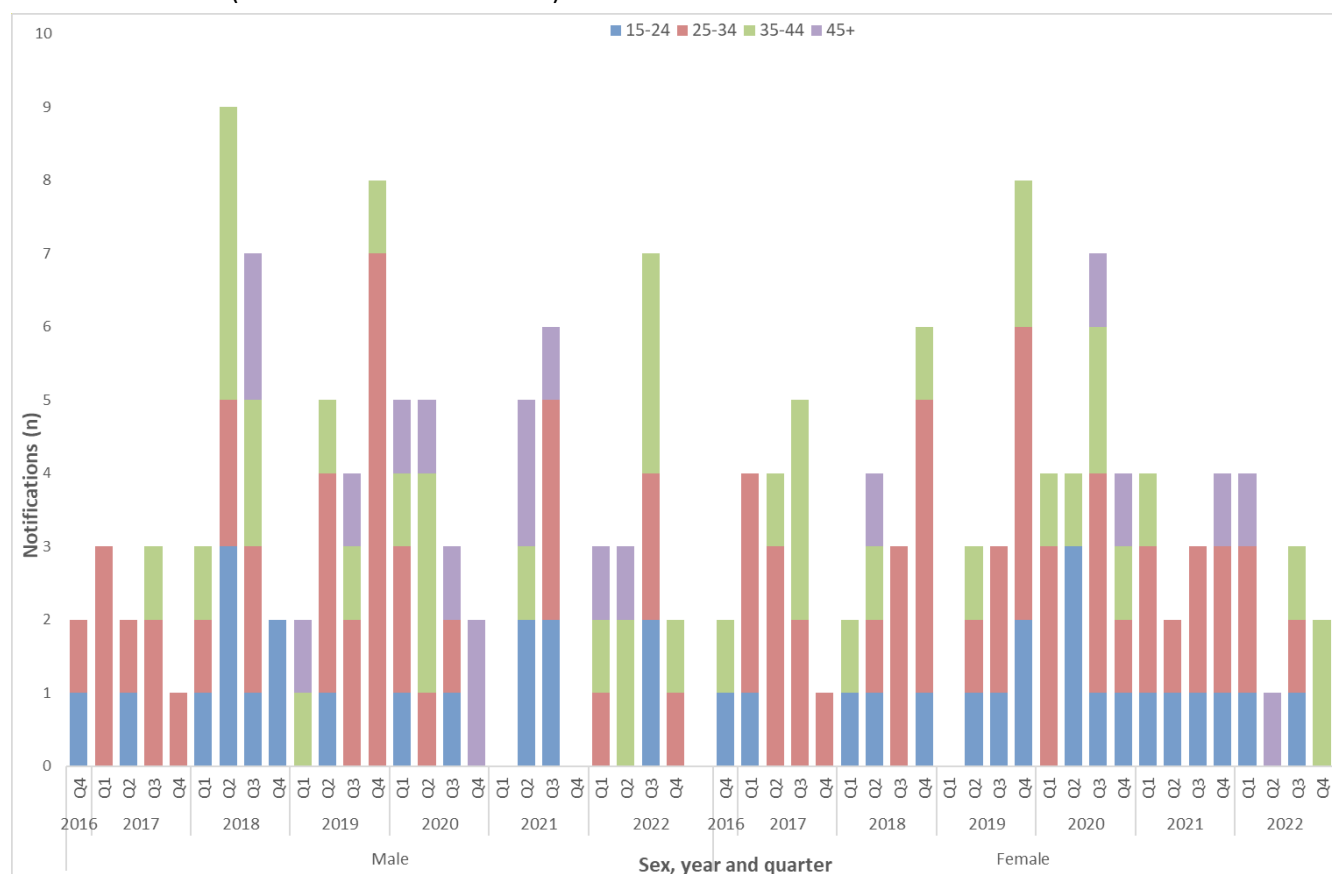


c. Western Australia (2014 – 31 December 2022)





d. South Australia (2016 – 31 December 2022)



*Excludes cases aged <15 years of age.

Indicator 3.2 - Number of outbreak associated congenital syphilis notifications

Indicator 3.3 - Number of outbreak associated congenital syphilis cases that were reported to have died from the condition

Since the commencement of the outbreak in January 2011 to 2022, there were 30 outbreak associated cases of congenital syphilis reported, 11 from Queensland, 9 from the Northern Territory, 7 from Western Australia and 3 from South Australia. Ten (10) of these cases were reported to have died from the condition, 7 from Queensland and 3 from Western Australia (Figure 10).

Please note that an outbreak case of congenital syphilis previously reported for the NT in 2013 has since been re-classified to a congenital syphilis case with highly suggestive links to the outbreak. This case no longer meets outbreak case definition for congenital syphilis and therefore has been excluded in the analysis for these indicators and figure 10 below.

Figure 10: Notifications (n) of outbreak associated congenital syphilis cases and reported deaths, by jurisdiction, and year, 2011 – 2022



Indicator 3.4 - Proportion of outbreak associated infectious syphilis notifications among women who were pregnant at time of diagnosis

Pregnancy status was available for all 3 outbreak jurisdictions from 2020 onwards (Queensland, Western Australia, and South Australia). Between 2017 and 2019, pregnancy status was available for 2 out of 4 jurisdictions (Queensland and Western Australia). 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 addition, previous reports have included data from the NT; however these data have been excluded due to known data issues.

In 2022, of the outbreak associated notifications of infectious syphilis among women of reproductive age (15-44 years) reported in Queensland, Western Australia, and South Australia, 15% were pregnant, 51% were not pregnant and 34% had an unknown pregnancy status (Figure 11). This is consistent with historical trends (2017-2021 range: 12%-17%).

Figure 11: Proportion (%) of outbreak associated syphilis notifications among women of reproductive age (15-44 years), by pregnancy status at time of syphilis diagnosis and year, 2017 – 2022



Indicator 3.5 - Cumulative number of syphilis tests delivered through participating ACCHS in outbreak affected jurisdictions

Indicator 3.6 - Proportion of people attending participating ACCHS who received a syphilis test

On 1 August 2018, the test and treat model to curb the syphilis outbreak commenced at ACCHS in Townsville (Queensland), Cairns (Queensland) and Darwin (Northern Territory). These sites were chosen in consultation with the jurisdictions and the National Aboriginal Community Controlled Health Organisation (NACCHO). On 1 September 2018, the second phase commenced in ACCHS in Katherine (Northern Territory), East Arnhem (Northern Territory) and the Kimberley east (Western Australia). On 1 May 2019, the third phase commenced with additional services in the West Arnhem (Northern Territory), Pilbara (Western Australia) and Kimberley west (Western Australia). The first ACCHS in South Australia were funded as part of the third phase (Western and Eyre, Far North and Adelaide). The fourth phase commenced from May 2020 at ACCHS in Mt Isa (Queensland), and Tennant Creek (Northern Territory). The below data summarises syphilis testing data and coverage for participating ACCHS, noting that data are missing for some services.

Please note there may be differences with previous reports due to changes in reporting periods from monthly to quarterly; retrospective revision of data and; completeness of historical data.

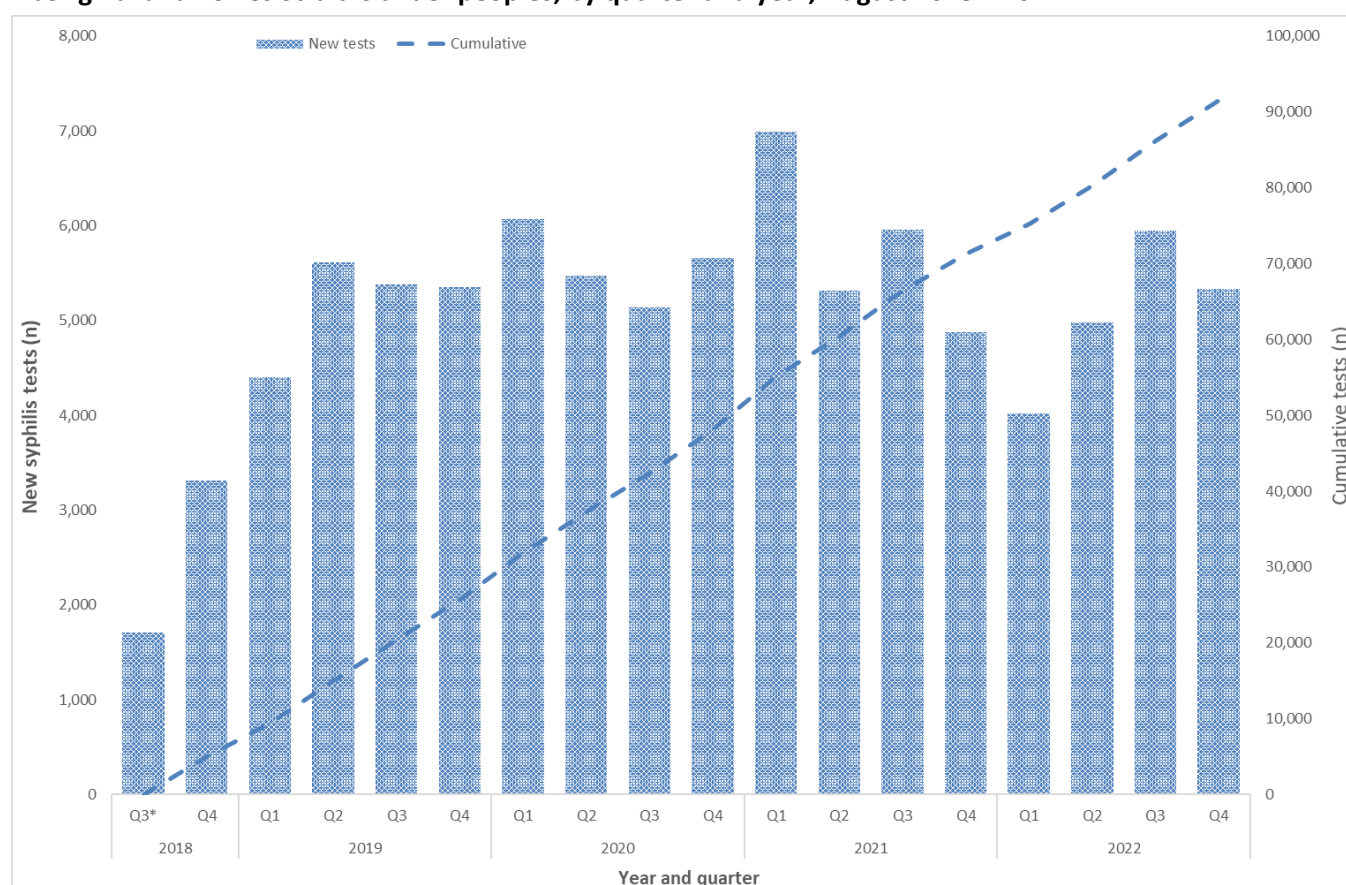


As at 31 December 2022, through participating ACCHS (Figures 12 and 13 a-b):

- 91,542 syphilis tests, point-of-care tests (PoCT) and serological tests, were delivered from the commencement of phase 1 of the test and treat model rollout on 1 August 2018. On average 5,385 new tests are performed each quarter (Figure 12).
- the quarterly testing coverage for all individuals was 13%, higher than the quarterly average for the preceding 12 months (11%, 1 January – 31 December 2022) (Figure 13a).
- the quarterly testing coverage for the target age group (15-34 years) was 23%, higher than the quarterly average for the preceding 12 months (19%) (Figure 13b).

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 12: Cumulative number of syphilis tests (PoCT and serology) delivered through participating ACCHS to Aboriginal and Torres Strait Islander peoples, by quarter and year, August 2018 – 2022

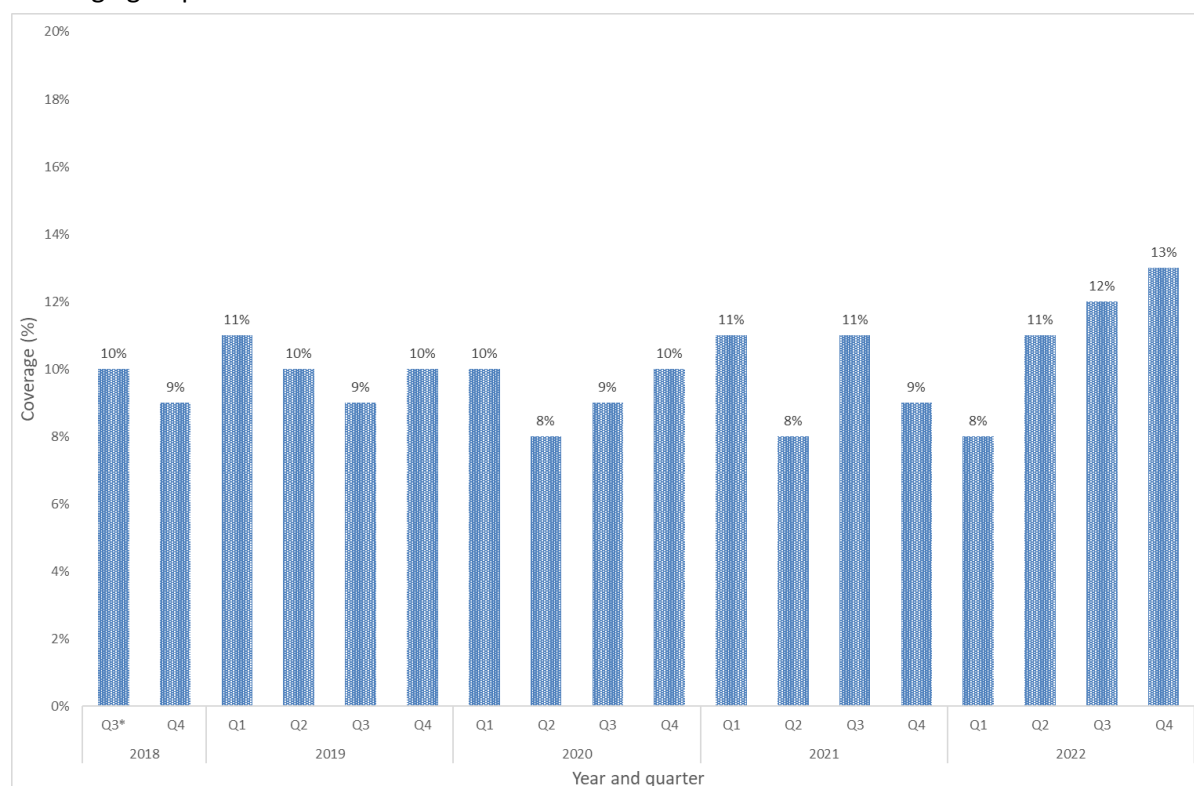


*Q3 2018 includes data for August and September only.

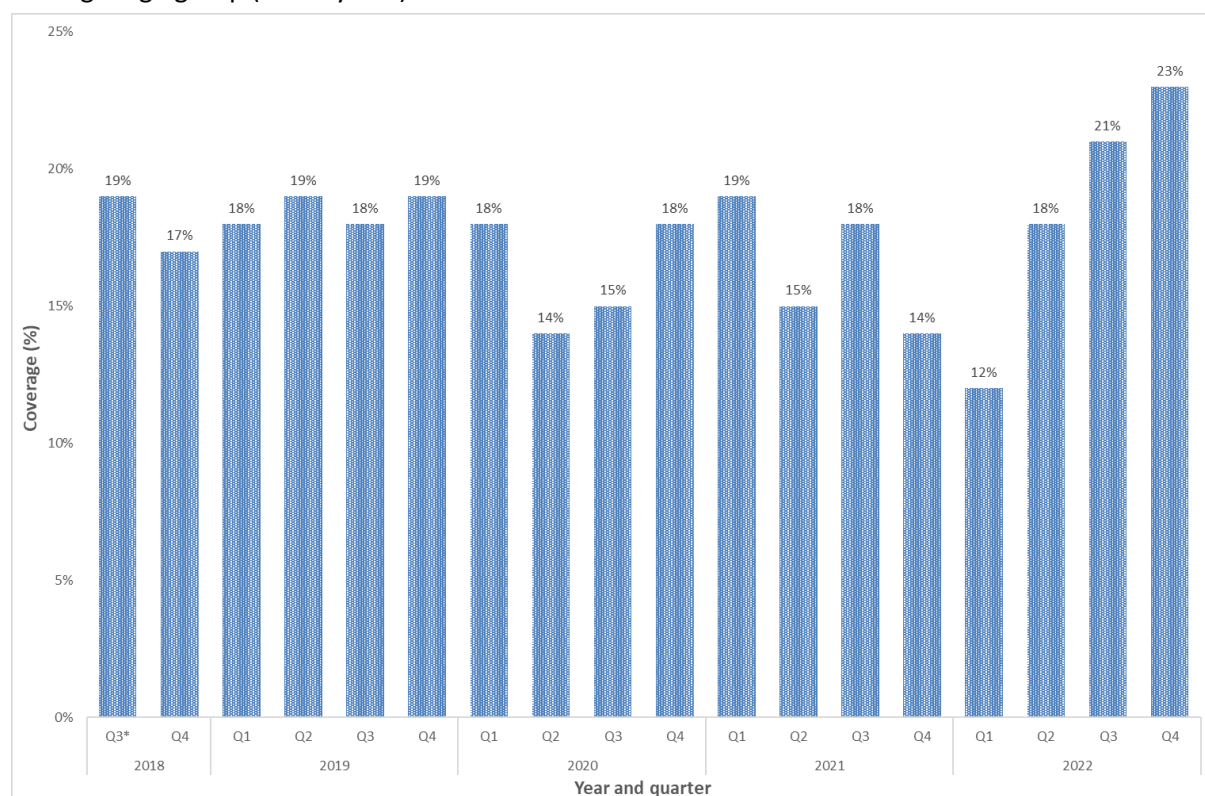


Figure 13 a-b: Proportion of Aboriginal and Torres Strait Islander peoples attending participating ACCHS who received a syphilis test (PoCT and/or serology), quarter and year, August 2018 – 2022^{xii}
(a. all age groups b. target age group 15-34 years)

a. All age groups



b. Target age group (15-34 years)



*Q3 2018 includes data for August and September only.

^{xii} Excludes testing data for individuals for whom age was not reported.



Methodological notes

Data were extracted from the NNDSS on 23 March 2023, 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 31 December 2022 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' reported to the NNDSS was used to allocate notifications of infectious and congenital syphilis to *remoteness areas* (as defined by the Australian Bureau of Statistics). Where a postcode was not reported the notification was excluded from remoteness area analysis.
 - o Tasmania and Northern Territory do not have major cities as defined by the Australian Bureau of Statistics. Tasmanian "major cities" refers to inner regional areas and in the Northern Territory refers to outer regional areas.
- '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.
- The 'population denominator' used to calculate remoteness area rates and rates by sex and age (per 100,000 population) was extracted from the Australian Bureau of Statistics Census Table Builder (based on 2016 Census data) on 23 March 2023.
- 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 and Aged Care to deliver point of care testing in syphilis outbreak regions. Services extract data from local clinical information management systems reporting to the Australian Government Department of Health and Aged Care. 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>.

The outbreak case definition classifying cases reported under 'Target 3: Control outbreaks among Aboriginal and Torres Strait Islander peoples in Queensland, the Northern Territory, Western Australia and South Australia' is defined:

Nationally, an infectious syphilis outbreak case is defined as: any person who is newly diagnosed with confirmed or probable infectious syphilis according to the CDNA national surveillance case definition for infectious syphilis, **AND**, is an Aboriginal or Torres Strait Islander person who resides in any of the following outbreak declared regions as defined and documented by that jurisdiction, at or after the dates indicated: Qld - North West Hospital and Health Service area (from 1 January



2011); Torres and Cape Hospital and Health Service area (from 1 December 2012); Cairns and Hinterland Hospital and Health Service area (from 1 August 2013); Townsville Hospital and Health Service area (from 1 January 2014); Central Queensland Hospital and Health Service area (from 1 June 2017) NT - Alice Springs Rural and Urban or Barkly district (from 1 July 2013); Katherine district (from 1 May 2014); East Arnhem district (from 1 November 2015); Darwin Rural and Urban (from 1 January 2017); WA - Kimberley region (from 1 June 2014); Pilbara region (from 1 February 2018); Goldfields region (from 1 January 2019); SA - Far North and Western and Eyre regions (from 15 November 2016); Adelaide (from 1 February 2018) (category 1 outbreak cases) OR, is a sexual contact of a confirmed outbreak case (category 2 outbreak cases).

Acknowledgements

We, the Department of Health and Aged Care, 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 Department of Health and Aged Care 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; participating Aboriginal Community Controlled Health Services, and; all public and private laboratories that support laboratory surveillance in Australia.

Contact

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