

Notifications of syphilis in Queensland

2025 report

Copyright statement

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Acknowledgements

Queensland Health respectfully acknowledges the Traditional and Cultural Custodians of the lands, waters and seas across Queensland and pays our respects to Elders past and present. We value the culture, traditions and contributions First Nations people have made to our communities and recognise our collective responsibility as government, communities and individuals to ensure equitable recognition and advancement of First Nations people in Queensland.

Contributions

This report was prepared by the Communicable Disease Epidemiology Unit, Public Health Intelligence Branch in collaboration with the Blood Borne Viruses and Sexually Transmissible Infections Unit, Communicable Diseases Branch, Population Health Division. Contributions from the Queensland Syphilis Surveillance Service and members of the Blood Borne Viruses and Sexually Transmissible Infections Advisory Committee are gratefully acknowledged. These perspectives, from frontline operations and across government and non-government sectors, strengthen interpretation of surveillance data and reporting of epidemiological insights.

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Summary

This report describes temporal trends in syphilis notifications among Queensland residents during the period 2001–2025, and demographic and geographic distributions of syphilis notifications in the period 2011–2025.

What the epidemiology tells us:

Syphilis notifications continue to rise

Since 2001, notifications of infectious syphilis have substantially increased in Queensland, from 112 (3.1 per 100,000 population) in 2001 to 1,479 (26.5 per 100,000) in 2025. Similarly, notifications of late latent syphilis or syphilis of unknown duration have increased from 154 (4.2 per 100,000 population) in 2001 to 387 (6.9 per 100,000 population) in 2025.

Regional trends differ

North Queensland continues to report the highest infectious syphilis notification rate; however, annual rates have steadily increased in South East Queensland. In 2025, infectious syphilis notification rates in North and South East Queensland (30.2 and 28.4 per 100,000 population, respectively) were higher than the state-wide rate (26.5 per 100,000 population).

Priority populations are disproportionately impacted

[First Nations peoples](#) are substantially over-represented in infectious syphilis notifications. In 2025, 20 per cent (n=303) of infectious syphilis notifications were among First Nations peoples. The infectious syphilis notification rate among First Nations peoples was 4.8 times higher than non-First Nations peoples (103.5 and 21.5 notifications per 100,000 population, respectively).

[Gay, bisexual, and other men who have sex with men \(GBMSM\)](#) accounted for 51 per cent (n=704) of notifications with sexual partner type recorded in 2025. Overall, males accounted for 76% of infectious syphilis notifications.

There were 399 syphilis (infectious and late latent) notifications among [women of reproductive age](#) and 72 notifications among [pregnant women in 2025](#).

Syphilis should be considered across a broad age spectrum

In 2025, while most infectious syphilis notifications occurred among people aged 20–39 years (61 per cent, n=891), one in five notifications was among those aged 40–49 years (21 per cent, n=304). The notification rate was highest among those aged 30–39 years (69.0 per 100,000 population), representing a 5.9-fold increase since 2011.

Primary care providers play an important role in the syphilis response

For infectious syphilis notifications received in 2025, the most common test requestor provider type was general practitioner (51 per cent, n=750) followed by sexual health services (24 per cent, n=351). Similarly, syphilis notifications made in pregnancy during 2025 were mostly diagnosed through general practitioners (61 per cent, n=44).

Flexible models of care remain essential

In 2025, the proportions of notifications made through public hospitals, correctional services, and Aboriginal Medical Services were higher among First Nations peoples than the state-wide patterns, highlighting the importance of system-wide and flexible models to provide a culturally safe syphilis response.

Eliminating congenital syphilis remains an urgent priority

The changing epidemiology of syphilis in Queensland has resulted in continued notifications of congenital syphilis. In 2025, there were six notifications of congenital syphilis and three were associated with intrauterine foetal deaths. First Nations communities and families are disproportionately impacted by congenital syphilis outcomes. Every outcome of congenital syphilis represents a lack of timely testing, diagnosis, and/or treatment of syphilis during pregnancy.

What this means for policy and practice

Sustained and coordinated action* is required across Queensland:

- Support service providers to design and deliver population-focused syphilis awareness initiatives, across a variety of platforms and resources throughout Queensland.
- Maintain investment in the Queensland Health workforce to enable continued prevention, testing, and treatment across Queensland.
- Strengthen contact tracing activities, particularly among opposite-sex sexual partners, to reduce transmission risk to women of reproductive age and other priority populations.
- Support primary health care providers, Aboriginal Medical Services, and other non-government health service providers to offer syphilis testing and treatment to priority populations; First Nations peoples, women of reproductive age, gay and bisexual men who have sex with men, and opposite-sex sexual partner networks.
- Support sustained investment in First Nations-led and community-controlled approaches, alongside culturally safe models of care that support timely access to testing, treatment, partner management, and antenatal care.
- Build flexible models of care to support women experiencing barriers to accessing care. Strategies may include assertive outreach testing models and partnerships with non-health services accessed during pregnancy to support timely linkage into care, asymptomatic and universal opportunistic and guideline-based testing.
- Strengthen a 'no wrong door approach' for pregnant women who interact with health services to be offered testing, including Emergency Departments, Urgent Care Clinics, Alcohol and other Drug Services, and Mental Health Services.
- Monitor testing patterns in regions, by provider, and within populations at risk to enhance and/or sustain testing initiatives.
- Ensure congenital syphilis cases are investigated, and local analysis reporting is completed, to inform opportunities for earlier engagement with antenatal care, timely syphilis testing, and appropriate treatment throughout pregnancy to prevent congenital syphilis and adverse pregnancy outcomes.

**The [Queensland Syphilis Action Plan 2023–2028](#) highlights the importance of collaboration among government, non-government, and community-based organisations in responding to syphilis. Within this broader multi-agency effort, this report provides a focused epidemiological perspective to inform and support ongoing response activities.*

Introduction

Syphilis is a multistage disease caused by bacteria *Treponema pallidum*, subspecies *pallidum*. It is frequently sexually transmitted but may also be acquired by vertical transmission from mother to child.¹ It is preventable and curable with treatment.

If left untreated, syphilis can progress to late-stage disease and may result in severe clinical outcomes, including permanent neurological impairment, visual or hearing loss, and cardiovascular complications.¹ In pregnancy, untreated syphilis can lead to miscarriage or stillbirth, or congenital syphilis; when the infection is transmitted to the unborn child. The risk of vertical transmission from mother to child is high for untreated infectious syphilis, with the risk diminishing with latent infection but never disappearing. Syphilis may increase the risk of HIV infection, as syphilitic genital ulcers provide a portal of entry for HIV acquisition, and a focus for HIV transmission.²

In 2022, an estimated 8 million new syphilis cases occurred globally among individuals aged 15–49 years (range: 5.6–10.4 million).³ For the same period, the World Health Organization estimated 700,000 congenital syphilis cases with 390,000 resulting in adverse birth outcomes, including 220,000 foetal and neonatal deaths.⁴

In Australia, infectious syphilis notifications have increased from 612 notifications in 2004 (when national reporting commenced) to 6,066 notifications in 2025. The corresponding notification rate increased from 3 to 23 per 100,000 population.⁵ In August 2025, Australia's Chief Medical Officer declared syphilis a Communicable Disease Incident of National Significance which enables improved coordination of national efforts to stop the spread and detrimental outcomes of syphilis.⁶

The [Queensland Syphilis Action Plan 2023–2028](#) and [Queensland STI Plan 2030](#) outline Queensland's approach to reducing the impact of syphilis. Aligned with the [National Syphilis Response Plan 2023–2030](#), Queensland aims to decrease the incidence of syphilis, ensure all cases of syphilis in pregnancy are treated and resolved prior to birth, and to have no new cases of congenital syphilis reported by 2028.

The epidemiology of syphilis in Queensland presented in this report is based on notifications received by Queensland Health, with important insights made possible through the work of the Queensland Syphilis Surveillance Service. See [data notes](#) for more information.

¹D. Mabey, M. Marks "Syphilis", Control of Communicable Diseases Manual. DOI: 10.2105/CCDM.2745.137

² World Health Organization [Internet]. Report on global sexually transmitted infection surveillance 2018. World Health Organization. 2018. Available from: <https://apps.who.int/iris/handle/10665/277258>

³ Global HIV, Hepatitis and STIs Programmes Team [Internet]. Implementing the global health sector strategies on HIV, viral hepatitis and sexually transmitted infections, 2022–2030: Report on progress and gaps 2024, second edition. World Health Organization. 2024. Available from: <https://www.who.int/publications/i/item/9789240097872>

⁴ Global sexually transmitted infections programme [Internet]. Mother-to-child transmission of syphilis. World Health Organization. 2025. Available from: <https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/stis/prevention/mother-to-child-transmission-of-syphilis#>

⁵ Australian Centre for Disease Control. National Communicable Disease Surveillance Dashboard. <https://nindss.health.gov.au/pbi-dashboard/>. Data extracted 03/07/2026.

⁶ Australian Centre for Disease Control. Syphilis declared a Communicable Disease Incident of National Significance. Media release. August 07 2025. Available from: <https://www.cdc.gov.au/newsroom/news-and-articles/syphilis-declared-cdins>

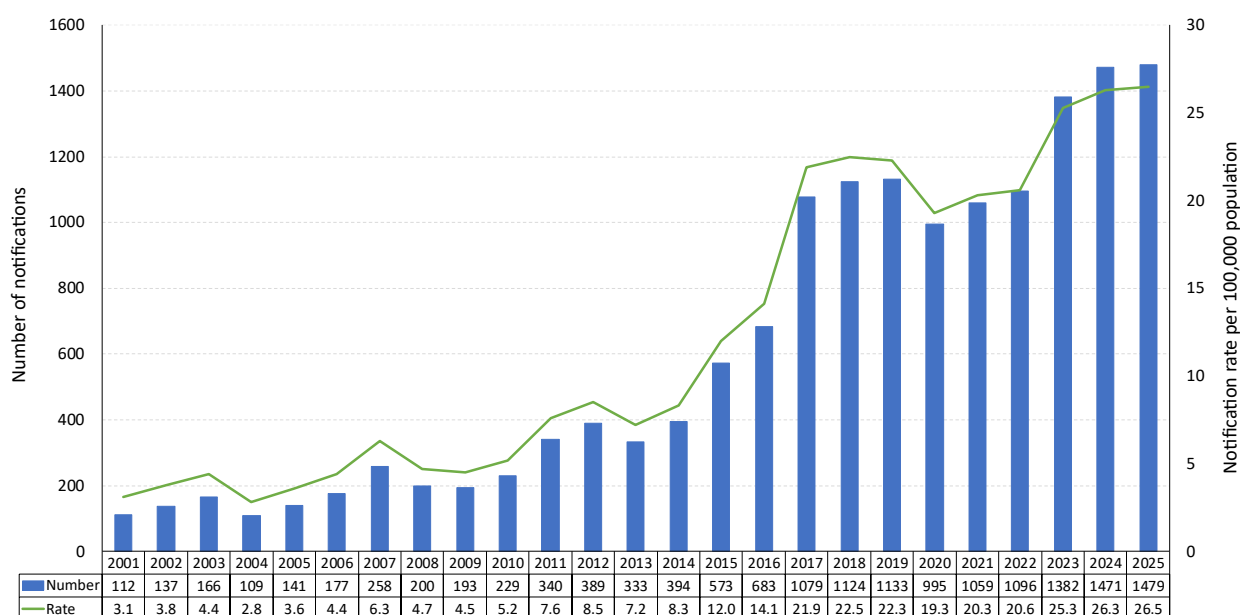
Temporal trends

Infectious syphilis

Infectious syphilis notifications in Queensland have increased substantially over the past two decades, rising from 112 (3.1 per 100,000 population) in 2001 to 1,479 (26.5 per 100,000) in 2025 (Figure 1). A similar trend was observed nationally, with notification rates increasing from 3 to 23 per 100,000 population between 2004 and 2025.⁷

In the early 2000s in Queensland, increases in infectious syphilis notifications were observed among gay, bisexual, and other men who have sex with men. In 2011, an outbreak affecting young First Nations peoples was declared (see [report section](#)). Since 2017, a rapid increase in notifications was observed across population groups and regions of Queensland. While trends during 2020 to 2022 should be interpreted in the context of the COVID-19 pandemic, trends before 2019 and after 2022 indicate a sustained increase. These increases likely reflect increased transmission as well as a combination of other factors such as expanded testing coverage, greater public and clinical awareness, and changes in surveillance practices.

Figure 1: Annual infectious syphilis notifications, Queensland, 2001–2025

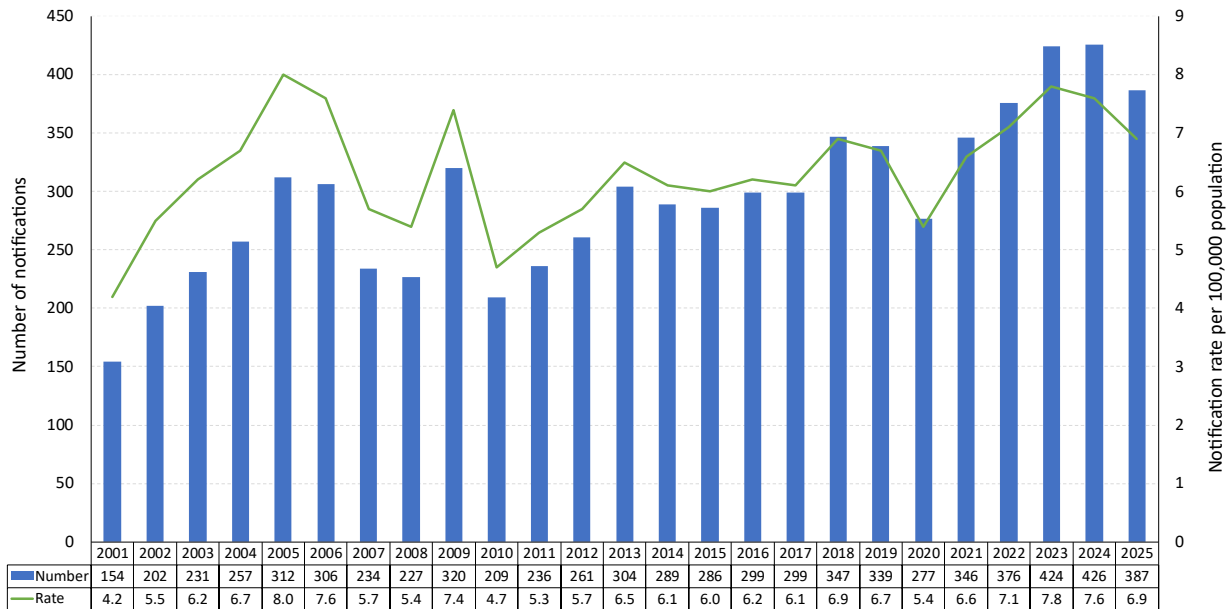


⁷ Australian Centre for Disease Control. National Communicable Disease Surveillance Dashboard. <https://nindss.health.gov.au/pbi-dashboard/>. Data extracted 03/07/2026.

Late latent syphilis or syphilis of unknown duration

Notifications of late latent syphilis or syphilis of unknown duration in Queensland have increased from 154 (4.2 per 100,000 population) in 2001 to 387 (6.9 per 100,000 population) in 2025 (Figure 2). Notifications of late latent syphilis reflect undiagnosed historical infections rather than active transmission chains. Notification trends for late latent syphilis or syphilis of unknown duration can represent health complications associated with untreated infections, delayed access to testing, or asymptomatic testing and screening practices. The factors contributing to the decline in notifications between 2024 and 2025 are not yet clear.

Figure 2: Annual notifications of late latent syphilis or syphilis of unknown duration, Queensland, 2001–2025



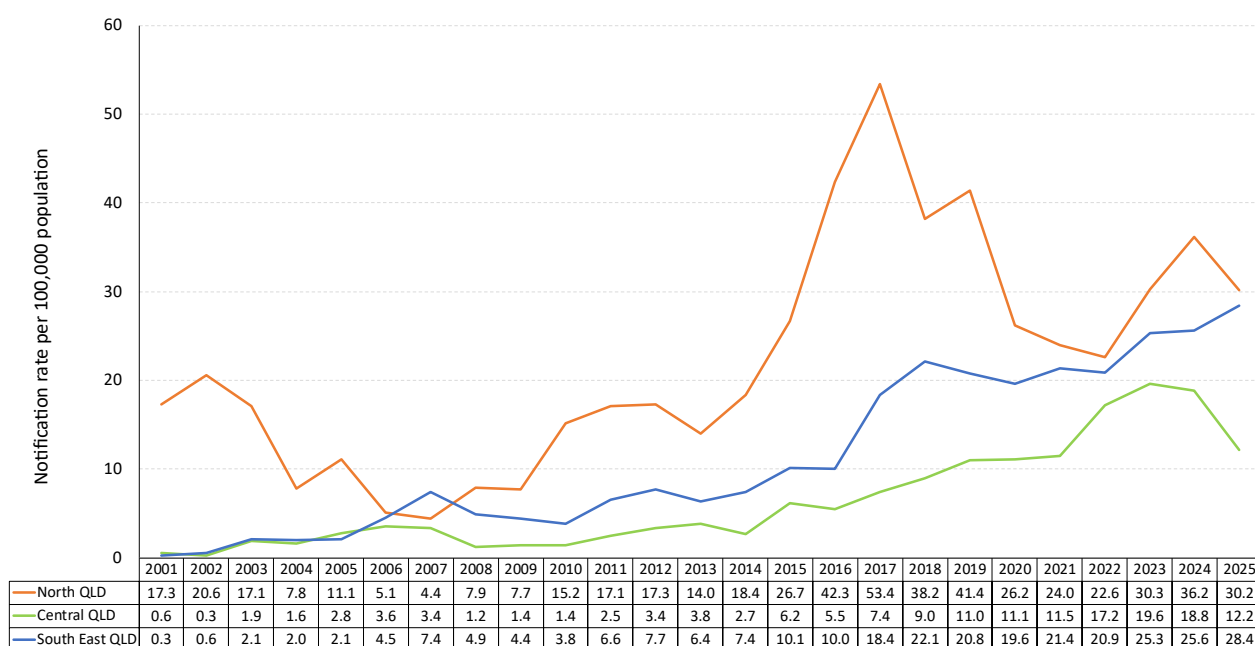
Geographic distribution

Infectious syphilis

Of the 1,479 infectious syphilis notifications reported in 2025, 77 per cent (n=1,135) were from South East Queensland, 16 per cent (n=234) were from North Queensland, 7 per cent (n=100) were from Central Queensland, and 1 per cent (n=10) were overseas residents.

Infectious syphilis notification trends vary by Queensland region. Annual notification rates in North Queensland peaked at 53.4 per 100,000 population in 2017 and have fluctuated since to 30.2 per 100,000 population in 2025 (Figure 3). Notification rates in South East Queensland have steadily increased reaching 28.4 per 100,000 population in 2025. After a gradually increasing trend, the notification rate in Central Queensland declined to 12.2 per 100,000 population in 2025. These differing patterns across regions reflect the changing epidemiology of syphilis since an initial outbreak declaration in North Queensland in 2011 and transmission patterns across priority population groups.

Figure 3: Infectious syphilis notification rates by region, Queensland, 2001–2025



Increasing infectious syphilis notification rates were observed across most Hospital and Health Service (HHS) areas between 2011 and 2025 (Figures 4a and 4b).

[Appendix 1](#) includes the infectious syphilis notification rate for each HHS between 2011 and 2025. In 2025, Torres and Cape HHS reported the highest infectious syphilis notification rate in North Queensland (56.9 per 100,000 population), Central West HHS reported the highest rate in Central Queensland (18.5 per 100,000 population), and West Moreton HHS reported the highest rate in South East Queensland (34.4 per 100,000 population).

Figure 4a: Infectious syphilis notification rates by HHS, Queensland, 2011

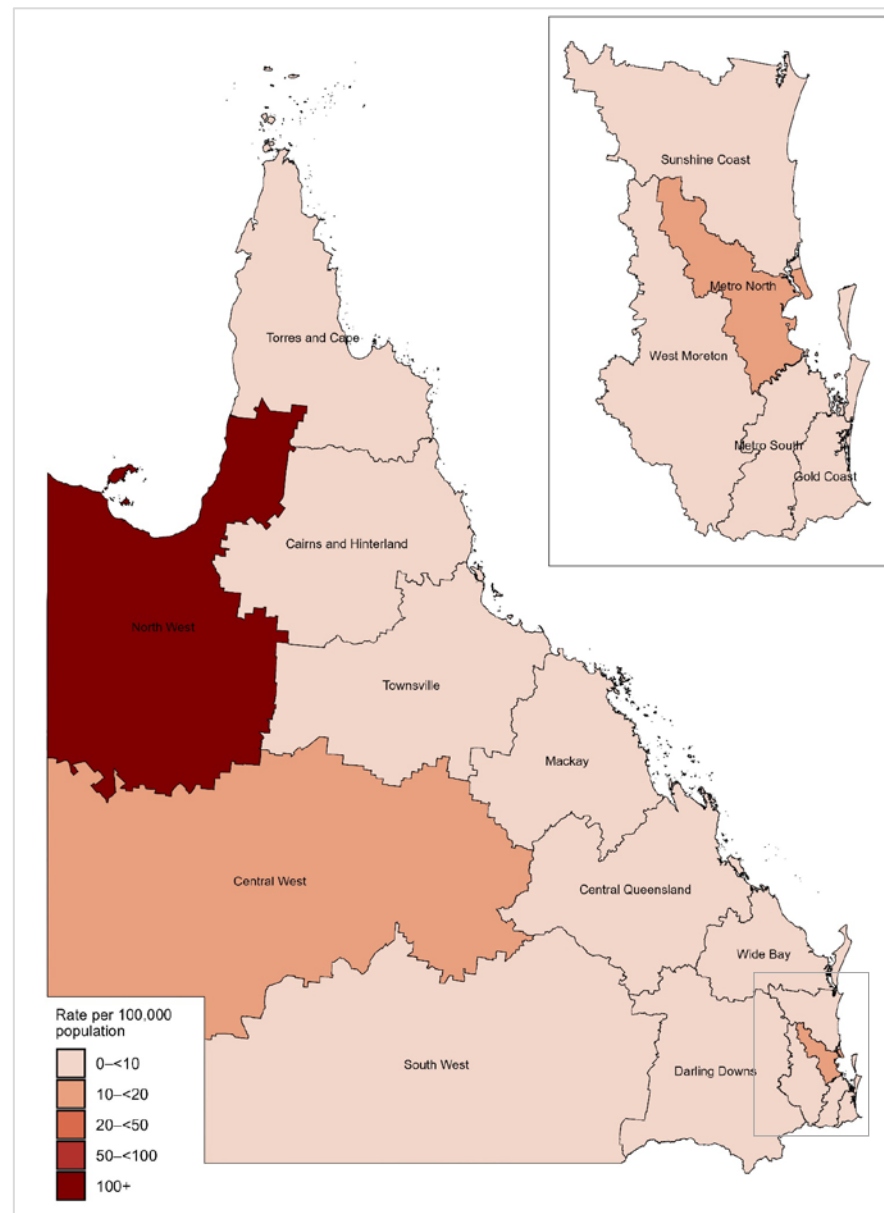
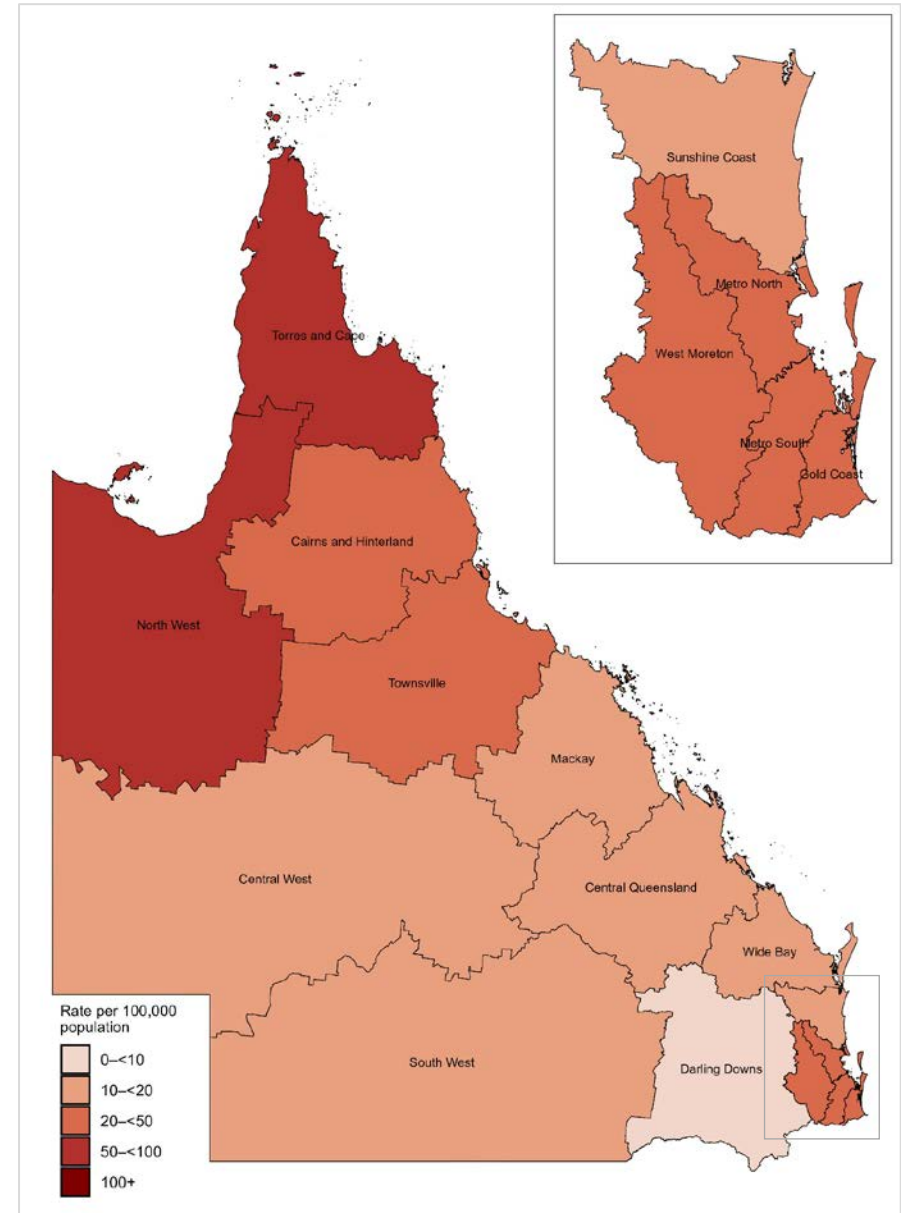


Figure 4b: Infectious syphilis notification rates by HHS, Queensland, 2025

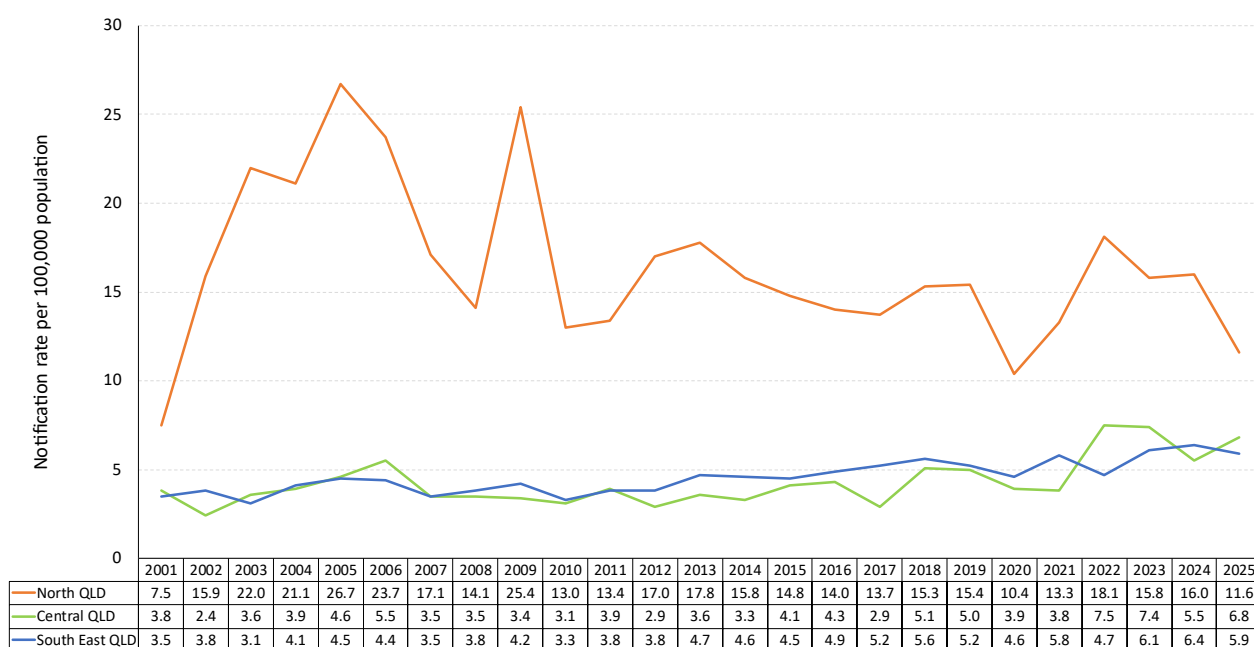


Late latent syphilis or syphilis of unknown duration

Of the 387 notifications of late latent syphilis or syphilis of unknown duration reported in 2025, 61 per cent (n=236) were from South East Queensland, 23 per cent (n=90) were from North Queensland, 14 per cent (n=56) were from Central Queensland, and 5 notifications were among overseas residents.

Since 2001, the annual notification rate of late latent syphilis or syphilis of unknown duration in North Queensland has remained consistently higher than those observed in Central and South East Queensland (Figure 5). The annual notification rate in North Queensland has periodically fluctuated and was 11.6 per 100,000 population in 2025. The corresponding rates in South East and Central Queensland have demonstrated a modest, incremental increase, to 5.9 and 6.8 per 100,000 population in 2025, respectively.

Figure 5: Late latent syphilis or syphilis of unknown duration notification rates by region, Queensland, 2001–2025



Infectious syphilis distribution

By sex

Across 2011–2025, 78 per cent of all infectious syphilis notifications were among males (annual range: 72–84 per cent, Figure 6). In 2025, 76 per cent (n=1,127) of infectious syphilis notifications were among males. The higher proportion of notifications among males may reflect the disproportionate burden of infectious syphilis among gay, bisexual, and other men who have sex with men.

Between 2011 and 2025, there was a 3.4-fold increase in the infectious syphilis notification rate among males, from 12.0 to 40.8 per 100,000 population (Figure 7). There was a 3.9-fold increase among females, from 3.2 to 12.4 per 100,000 population.

Figure 6: Infectious syphilis notification counts by sex, Queensland, 2011–2025

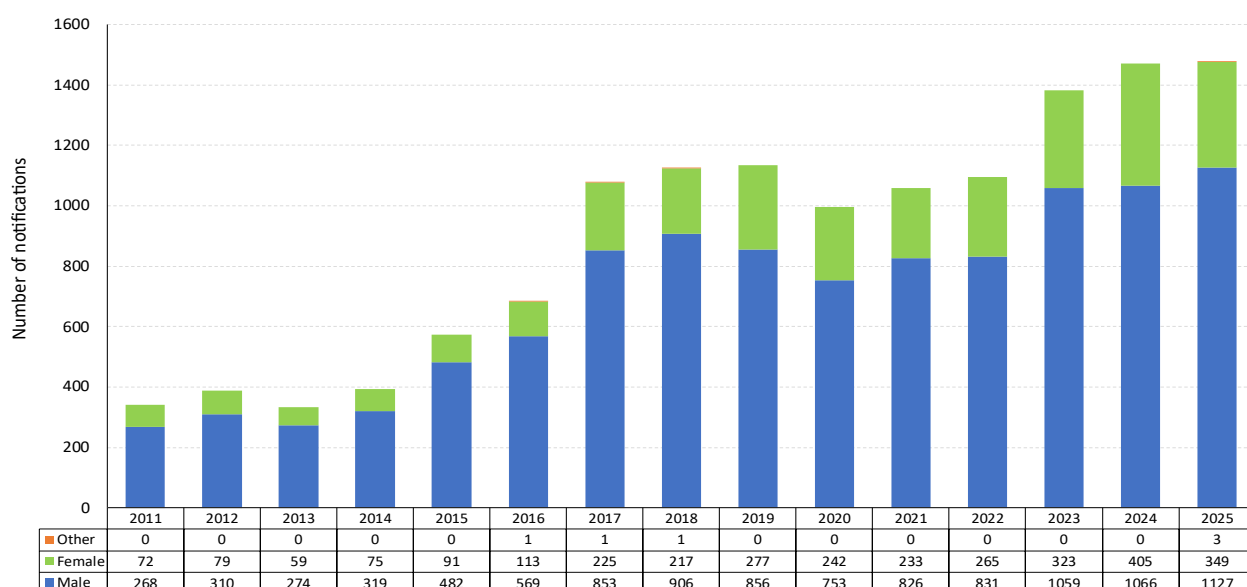
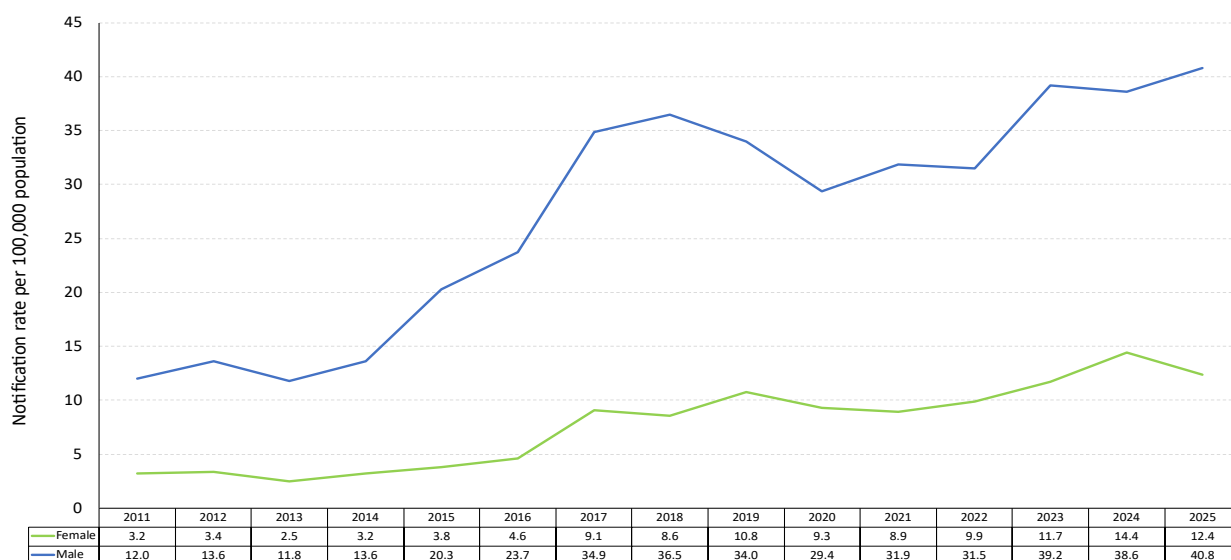


Figure 7: Infectious syphilis notification rates by sex, Queensland, 2011–2025



By age group

From 2011 to 2025, infectious syphilis notifications were most commonly reported among people aged 20–29 years and 30–39 years, with each age group accounting for 31 per cent of notifications. People aged 40–49 years accounted for the next highest proportion, at 18 per cent (Figure 8).

The age distribution of notifications in 2025 was broadly consistent with the overall pattern observed from 2011 to 2025, with a larger proportion among people aged 30–39 years. In 2025, 37 per cent of notifications occurred among people aged 30–39 years, 24 per cent among those aged 20–29 years, and 21 per cent among those aged 40–49 years. The notification rate was highest among those aged 30–39 years (69.0 per 100,000 population), representing a 5.9-fold increase since 2011 (Figure 9).

Infectious syphilis notifications show a broader age distribution than other sexually transmissible infections, which are generally more concentrated among young adults.⁸ These differences have important implications for clinical practice. Clinicians should consider the possibility of syphilis in differential diagnoses and offer appropriate testing across a broad age spectrum.

Figure 8: Infectious syphilis notification counts by age group, Queensland, 2011–2025

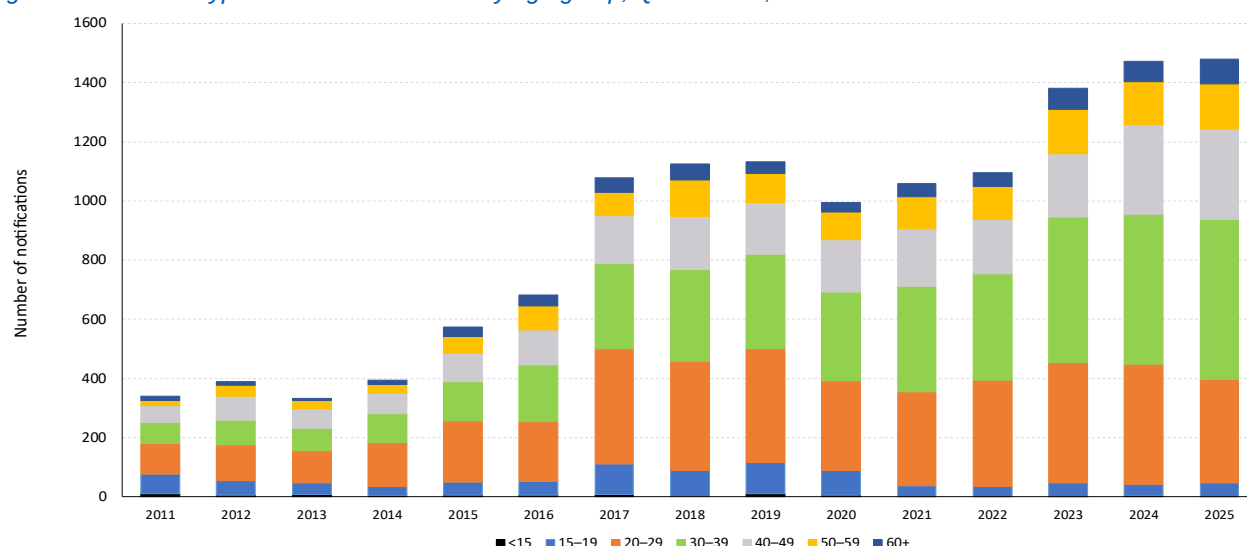
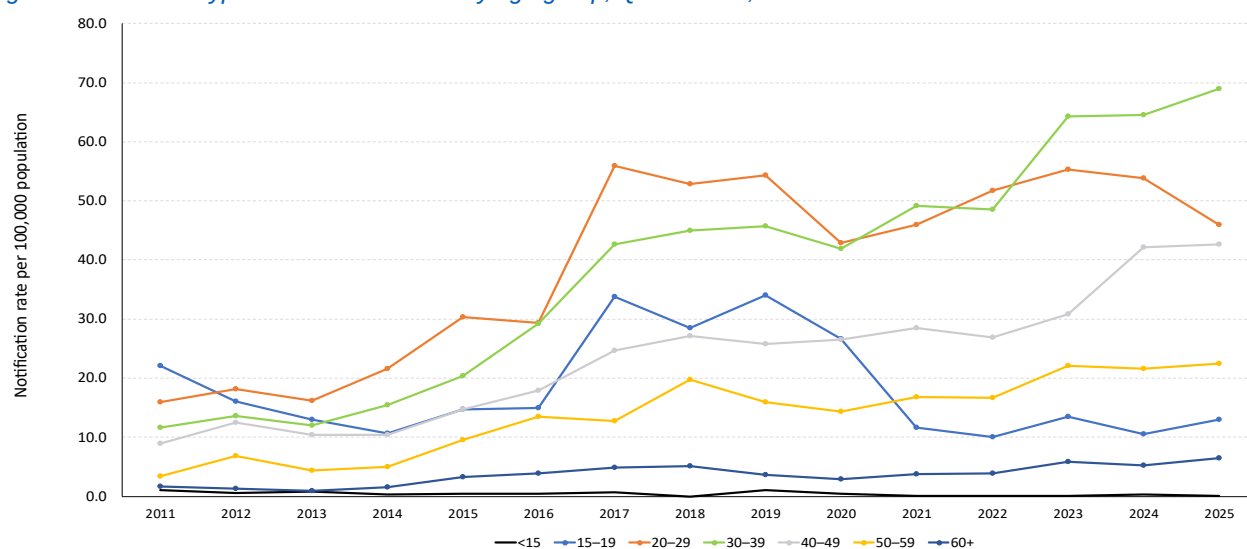


Figure 9: Infectious syphilis notification rates by age group, Queensland, 2011–2025

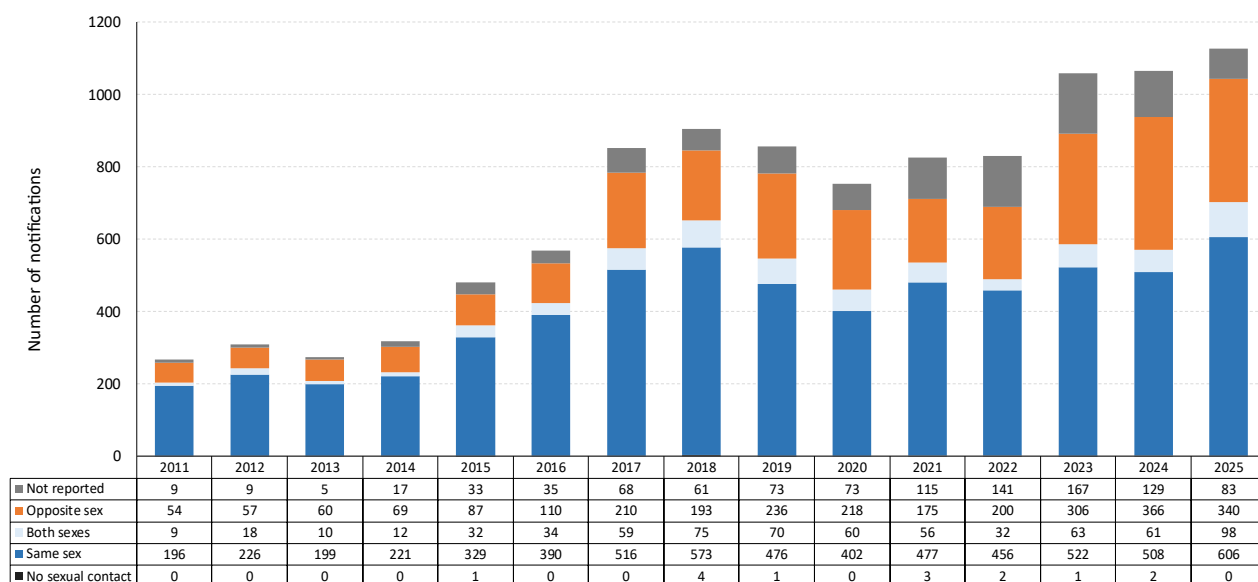


⁸ Queensland Health. Notifications of bloodborne viruses and sexually transmissible infections (BBVSTIs) in Queensland: 1 January–31 December 2025. Available from: https://www.health.qld.gov.au/__data/assets/pdf_file/0029/1468226/bbv-sti-quarterly-surveillance-2025.pdf

By sexual partner type

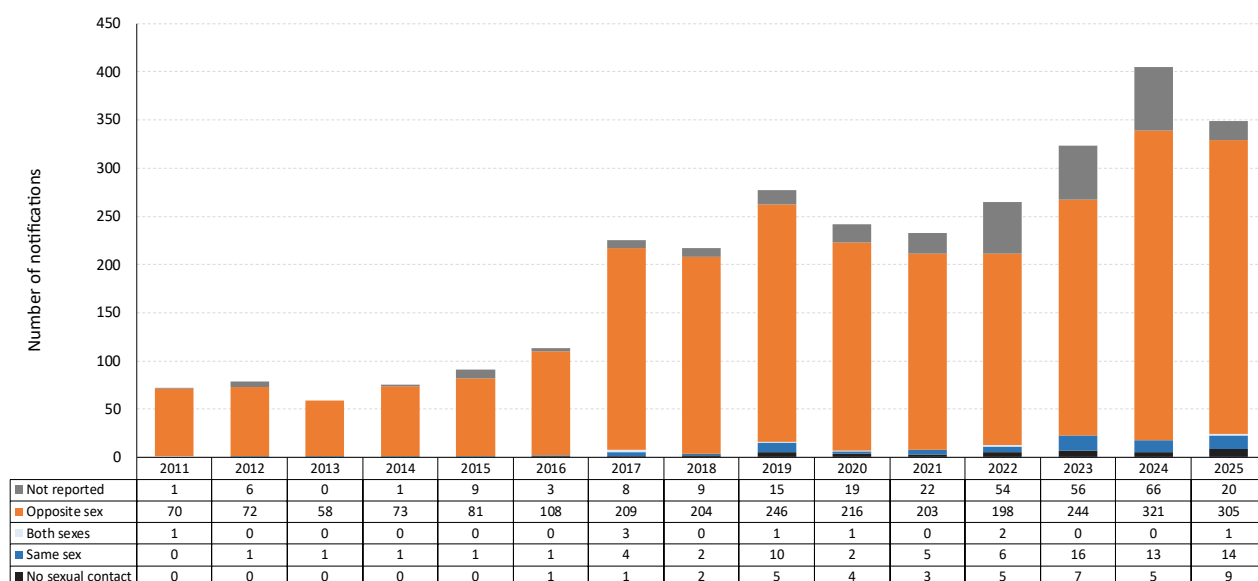
Of 10,499 infectious syphilis notifications recorded among males between 2011 and 2025, 58 per cent (n=6,097) reported having sex with a partner of the same sex, 26 per cent (n=2,681) reported having sex with a partner of the opposite sex, 7 per cent (n=689) reported having sex with both men and women, and 10 per cent (n=1,018) did not have data reported (Figure 10a).

Figure 10a: Infectious syphilis notification counts by type of sexual partner, males, Queensland, 2011–2025



Of 3,025 infectious syphilis notifications recorded among females between 2011 and 2025, 86 per cent (n=2,608) reported having sex with a partner of the opposite sex, 3 per cent (n=77) reported having sex with a partner of the same sex, and 10 per cent (n=289) did not have data reported (Figure 10b).

Figure 10b: Infectious syphilis notification counts by type of sexual partner, females, Queensland, 2011–2025



In 2025, data on type of sexual partner were recorded for 1,376 infectious syphilis notifications (Table 1). Of these, 51 per cent (n=704) were notifications among gay, bisexual, and other men who have sex with men (GBMSM). GBMSM represented the highest proportion of notifications across North, Central, and South East Queensland regions (37, 38, 55 per cent, respectively). These data rely on self-reported sexual partner type which could be influenced by a person's comfort disclosing sexual behaviour.

Table 1: Infectious syphilis notification counts by type of sexual partner and region, Queensland, 2025

Region	GBMSM*		Opposite sex male		Opposite sex female		Other†		Total	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
North Queensland	75	37	62	31	61	30	4	2	202	100
Central Queensland	33	38	23	26	32	36	0	0	88	100
South East Queensland	594	55	217	20	243	23	23	2	1,077	100
Overseas residents	2	22	3	33	4	44	0	0	9	100
Queensland	704	51	305	22	340	25	27	2	1,376	100

* GBMSM = Gay, bisexual, and other men who have sex with men.

† Other = same sex female, no sexual contact, or data not reported.

By reason for testing and test provider type

In 2025, the most common primary reason for syphilis testing was due to symptoms (45 per cent, n=659), followed by asymptomatic screening (32 per cent, n=476), highlighting the important role of asymptomatic screening in detecting and managing syphilis. The most common test requestor provider type was general practitioner (51 per cent, n=750) followed by sexual health services (24 per cent, n=351), highlighting the important role of primary health care providers in the syphilis response. In North and Central Queensland, public hospitals and Aboriginal Medical Services represented a higher relative proportion of notifications than in South East Queensland, highlighting the differing healthcare contexts across the state.

Table 2: Infectious syphilis notification counts by primary reason for testing and test requestor provider type, regions of Queensland, 2025

	North Queensland (n=234)		Central Queensland (n=100)		South East Queensland (n=1,135)		Overseas residents (n=10)		Total (n=1,479)	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
Primary reason for testing*										
Symptomatic (syphilis or other STI)	88	38	33	33	528	47	10	100	659	45
Asymptomatic STI screen (incl. PrEP)	57	24	34	34	385	34	0	0	476	32
Contact of Syphilis case	30	13	9	9	100	9	0	0	139	9
Unknown	37	16	10	10	63	6	0	0	110	7
Correctional services screening	11	5	9	9	15	1	0	0	35	2
Antenatal screening	6	3	4	4	20	2	0	0	30	2
Sexual contact of a person(s) with an STI	1	0	0	0	14	1	0	0	15	1
Confirm reactive point-of-care test	3	1	1	1	8	1	0	0	12	1
Other	1	0	0	0	2	0	0	0	3	0
Test requestor provider type										
General Practitioner	83	35	31	31	635	56	1	10	750	51
Sexual Health Service	69	29	20	20	260	23	2	20	351	24
Hospital Public	39	17	20	20	88	8	6	60	153	10
Correctional service/Justice health	17	7	14	14	75	7	0	0	106	7
Unknown	2	1	4	4	54	5	1	10	61	4
Aboriginal Medical Service	23	10	9	9	16	1	0	0	48	3
Other	1	0	2	2	7	1	0	0	10	1

*A person may have multiple reasons for undergoing syphilis testing and in these instances, these are distinguished as primary reason for testing and other reason(s) for testing.

Priority populations

First Nations peoples

First Nations peoples are substantially over-represented in infectious syphilis notifications statewide and across regions. In 2025, while accounting for approximately 5 per cent of the total Queensland population, 20 per cent (n=303) of infectious syphilis notifications were among First Nations peoples (Table 3). First Nations peoples accounted for 14 per cent (n=154) of notifications in South East Queensland, 40 per cent (n=40) in Central Queensland, and 47 per cent (n=109) in North Queensland, despite representing 3 per cent, 7 per cent, and 13 per cent of the respective regional populations. Statewide, the infectious syphilis notification rate among First Nations peoples was 4.8 times higher than non-First Nations peoples (103.5 and 21.5 notifications per 100,000 population, respectively).

The reasons for these disproportionate impacts of infectious syphilis on First Nations communities are complex and multifactorial, including the ongoing results of colonisation and discrimination. These data highlight an urgent need to improve the cultural safety of health care. An evaluation of the Enhanced Syphilis Response (ESR)⁹, coordinated by the National Aboriginal Community Controlled Health Organisation (NACCHO) demonstrates the effectiveness of First Nations-led, community-controlled approaches to deliver culturally safe public health action. Working with key partners, including jurisdictional and national government health departments, and strengthened by a workforce of Aboriginal and Torres Strait Islander Health Workers and Practitioners, the ESR increased testing and treatment for syphilis and other sexually transmissible infections while reducing stigma.

The amplification of First Nations voices is essential in the response to syphilis, and to sexual health and wellbeing more broadly. The [Queensland Syphilis Action Plan 2023–2028](#), has committed to ensuring First Nations peoples and organisations that represent them are actively engaged in the syphilis response. This aligns with the broader Queensland Health commitment to partner with First Nations peoples to eliminate racism, reshape the system, transform care, and strengthen the First Nations workforce.¹⁰

Table 3: Infectious syphilis notification counts by First Nations status and region, Queensland, 2025

	North Queensland		Central Queensland		South East Queensland		Overseas residents		Total	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
First Nations peoples	109	47	40	40	154	14	0	0	303	20
Non-First Nations peoples	123	53	59	59	949	84	9	90	1,140	77
First Nations status unknown	2	1	1	1	32	3	1	10	36	2
Total population	234	100	100	100	1,135	100	10	100	1,479	100

⁹ Equity Economics. Blueprint for the future. Evaluation of NACCHO's role under the Enhanced Syphilis Response. 2021. Available from: <https://www.equityeconomics.com.au/report-archive/evaluation-of-nacchos-role-under-the-enhanced-syphilis-response>

¹⁰ Queensland Health. First Nations health programs and initiatives. Available from: <https://www.health.qld.gov.au/public-health/groups/first-nations-health/first-nations-health-programs-and-initiatives>

Regional distribution among First Nations peoples

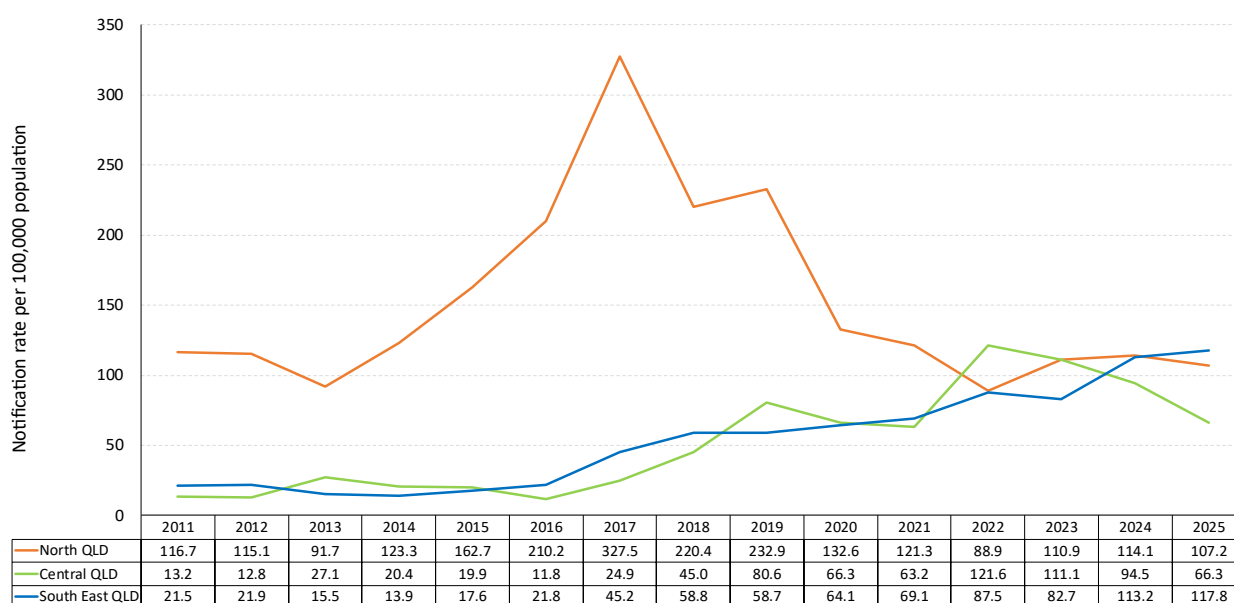
Of the 303 infectious syphilis notifications among First Nations peoples in 2025, 36 per cent (n=109) were from North Queensland, 13 per cent (n=40) from Central Queensland, and 51 per cent (n=154) from South East Queensland.

Across the reporting period 2011–2025, the infectious syphilis notification rate among First Nations peoples increased from 58.7 to 103.5 per 100,000 population (Appendix 1, Table 10).

Regionally, the trends were as follows (Figure 11):

- In North Queensland, the notification rate peaked in 2017 at 327.5 per 100,000 population, declined until 2022 and increased again to 107.2 per 100,000 population in 2025.
- In Central Queensland, there was a 9.0-fold increase from 13.2 per 100,000 population in 2011 to 121.6 per 100,000 population in 2022. Since 2022, the notification rate has gradually declined to 66.3 per 100,000 population in 2025.
- In South East Queensland, there was a 5.5-fold increase from 21.5 per 100,000 population in 2011 to 117.8 per 100,000 population in 2025.

Figure 11: Infectious syphilis notification rates by region, First Nations peoples, Queensland, 2011–2025



Increasing infectious syphilis notification rates among First Nations peoples were observed across most HHS areas between 2011 and 2025 (Figures 12a and 12b). [Appendix 1](#) includes the infectious syphilis notification rate for First Nations peoples by HHS between 2011 and 2025. In 2025, North West HHS reported the highest infectious syphilis notification rate among First Nations peoples in North Queensland (149.3 per 100,000 population), Central Queensland HHS reported the highest rate in Central Queensland (99.9 per 100,000 population) and West Moreton HHS reported the highest rate in South East Queensland as well as state-wide (163.7 per 100,000 population).

Figure 12a: Infectious syphilis notification rates by HHS, First Nations peoples, 2011

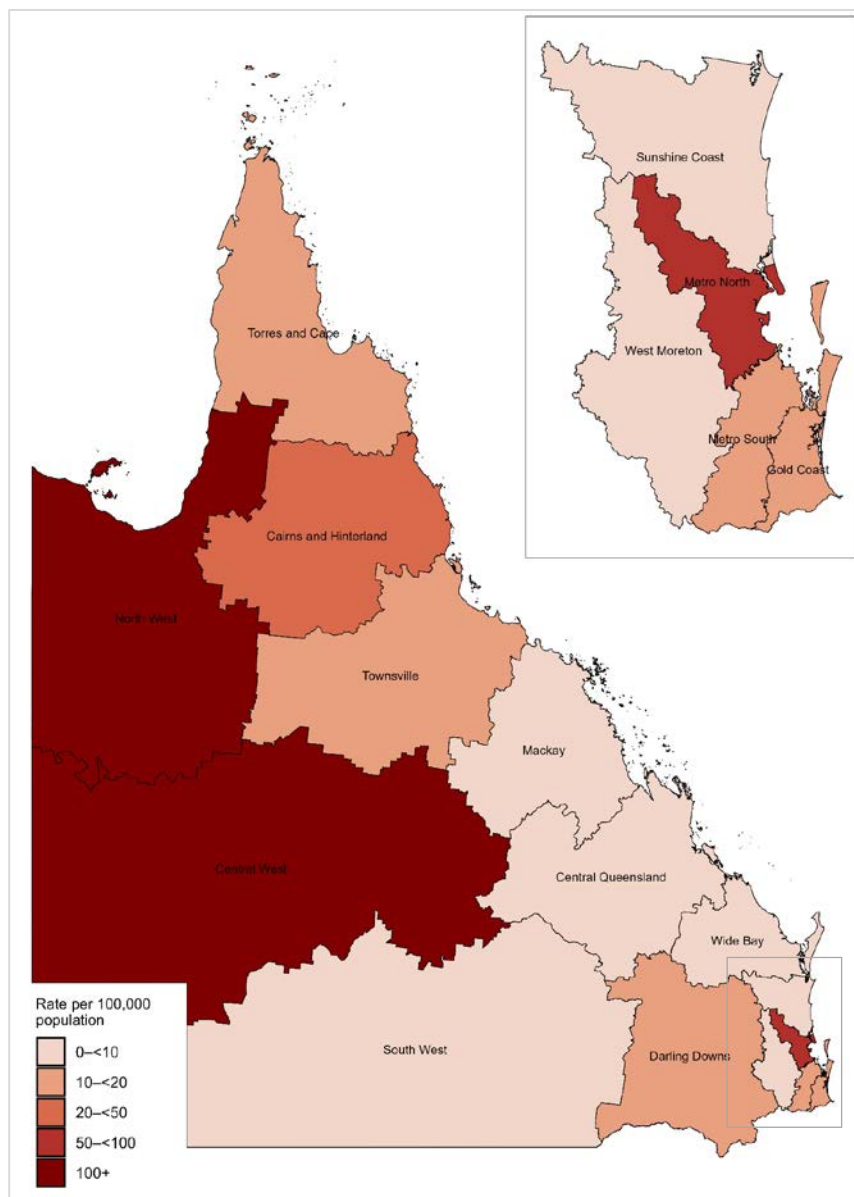
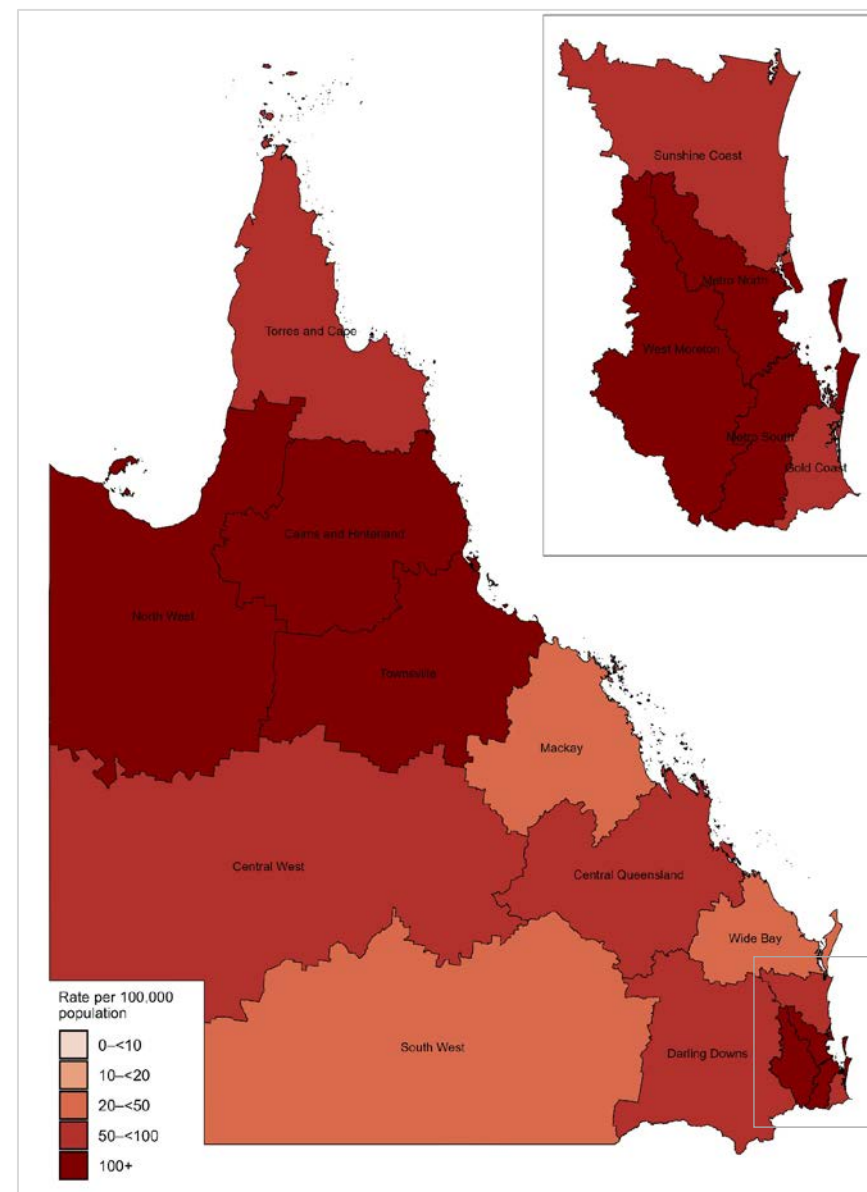


Figure 12b: Infectious syphilis notification rates by HHS, First Nations peoples, 2025



Distribution by age and sex among First Nations peoples

In 2025, the highest notification rates among males were observed in the 30–39-year age group; 366.3 notifications per 100,000 First Nations males and 95.3 per 100,000 non-First Nations males (Table 4). Among females, the highest rates were reported in the 20–29-year age group among First Nations females; 226.7 per 100,000 population and 30–39-year age group among non-First Nations females; 19.5 per 100,000 population.

The age-specific trends among males influence the overall state-wide distribution, as males account for most infectious syphilis notifications. The differing age distribution between males and females may reflect variations in transmission dynamics, particularly between sexual networks in which opposite-sex sexual contact does and does not occur. They could also reflect differing interaction with the healthcare system and subsequent testing patterns.

Table 4: Infectious syphilis notification count and rate by age group, sex, and First Nations status, Queensland, 2025

Demographic	Age group (years)						
	<15	15–19	20–29	30–39	40–49	50–59	60+
Number of notifications							
First Nations male	1	5	37	67	36	19	4
First Nations female	0	14	54	40	22	4	0
Non-First Nations male	0	15	182	352	202	103	74
Non-First Nations female	0	13	62	74	37	20	3
Notification rate per 100,000 population							
First Nations male	2.0	31.6	152.6	366.3	267	153.5	31.8
First Nations female	0.0	91.7	226.7	215.4	152.9	29.8	0.0
Non-First Nations male	0.0	8.8	50.8	95.3	60.2	32.0	12.4
Non-First Nations female	0.0	8.1	17.7	19.5	10.6	6.0	0.5

Distribution by sexual partner type among First Nations peoples

In 2025, data on type of sexual partner were recorded for 269 infectious syphilis notifications among First Nations peoples (Table 5). Of these, 77 per cent (n=208) reported opposite-sex sexual partners and 21 per cent (n=56) were among gay, bisexual, and other men who have sex with men (GBMSM). These trends differ from those reported among non-First Nations peoples whereby GBMSM represented 59 per cent of notifications across Queensland. Among First Nations peoples, the proportion of notifications among GBMSM was highest in the South East Queensland region (28 per cent, n=41).

These data rely on self-reported sexual partner type which could be influenced by a person's comfort disclosing sexual behaviour.

Table 5: Infectious syphilis notification counts by type of sexual partner, First Nations status, and region, Queensland, 2025

Region	GBMSM*		Opposite sex male		Opposite sex female		Other†		Total	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
First Nations peoples										
North Queensland	12	13	44	49	32	36	1	1	89	100
Central Queensland	3	9	15	44	16	47	0	0	34	100
South East Queensland	41	28	55	38	46	32	4	3	146	100
Queensland [^]	56	21	114	42	94	35	5	2	269	100
Non-First Nations peoples										
North Queensland	62	56	18	16	28	25	3	3	111	100
Central Queensland	29	55	8	15	16	30	0	0	53	100
South East Queensland	541	60	156	17	189	21	19	2	905	100
Queensland [^]	632	59	182	17	233	22	22	2	1,069	100

* GBMSM = Gay, bisexual, and other men who have sex with men.

† Other = same sex female, no sexual contact, or data not reported.

[^] Queensland totals may differ to those presented elsewhere in this report. This is due to the exclusion of data that do not meet the inclusion of region and First Nations status.

Distribution by test provider type and reason for testing among First Nations peoples

In 2025, the most common primary reason for syphilis testing among First Nations peoples was due to symptoms (32 per cent, n=98), followed by asymptomatic screening (29 per cent, n=88), highlighting the important role of asymptomatic screening in detecting and managing syphilis. The important role of contact tracing is also highlighted; with 11 per cent (n=34) of notifications tested for this reason. The most common test requestor provider type was general practitioner (32 per cent, n=98) followed by public hospitals (20 per cent, n=61). The proportions of notifications made through public hospitals, correctional services, and Aboriginal Medical Services are higher among First Nations peoples than the state-wide trends reported in Table 2, highlighting the importance of system-wide and flexible models to provide a culturally safe syphilis response.

Table 6: Infectious syphilis notification counts by primary reason for testing and test requestor provider type and reason for testing, First Nations peoples, regions of Queensland, 2025

	North Queensland (n=109)		Central Queensland (n=40)		South East Queensland (n=154)		Total (n=303)	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
Primary reason for testing*								
Symptomatic (syphilis or other STI)	27	25	9	22	62	40	98	32
Asymptomatic STI screen (incl. PrEP)	25	23	13	32	50	32	88	29
Contact of Syphilis case	25	23	6	15	3	2	34	11
Unknown	14	13	3	8	16	10	33	11
Correctional services screening	10	9	7	18	10	6	27	9
Antenatal screening	4	4	2	5	7	5	13	4
Sexual contact of a person(s) with an STI	0	0	0	0	4	3	4	1
Confirm reactive point-of-care test	3	3	0	0	0	0	3	1
Other	1	1	0	0	2	1	3	1
Test requestor provider type								
General Practitioner	35	32	7	18	56	36	98	32
Hospital Public	24	22	12	30	25	16	61	20
Correctional services/Justice health	15	14	9	22	31	20	55	18
Aboriginal Medical Service	23	21	9	22	15	10	47	16
Sexual Health Services	11	10	2	5	24	16	37	12
Unknown	1	1	0	0	3	2	4	1
Other	0	0	1	2	0	0	1	0

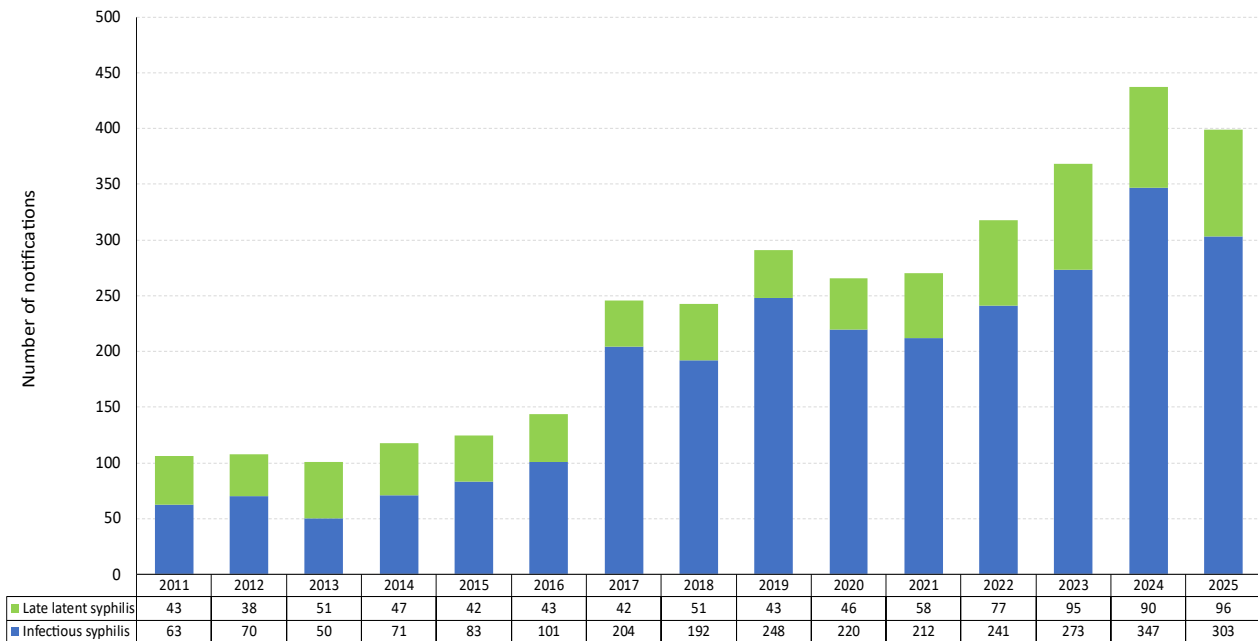
* A person may have multiple reasons for undergoing syphilis testing and in these instances, these are distinguished as primary reason for testing and other reason(s) for testing.

Women of reproductive age (15–44 years)

Clinical classification

In 2025, there were 399 syphilis notifications among women of reproductive age (Figure 13). Of these, 303 were infectious syphilis; 15 per cent higher than the previous five-year average 2020–2024 (n=259) but lower than the 2024 count (n=347). There were 96 notifications of late latent syphilis or syphilis of unknown duration; 24 per cent higher than the previous five-year average (n=73).

Figure 13: Syphilis notifications among women aged 15–44 years by clinical classification group, Queensland 2011–2025

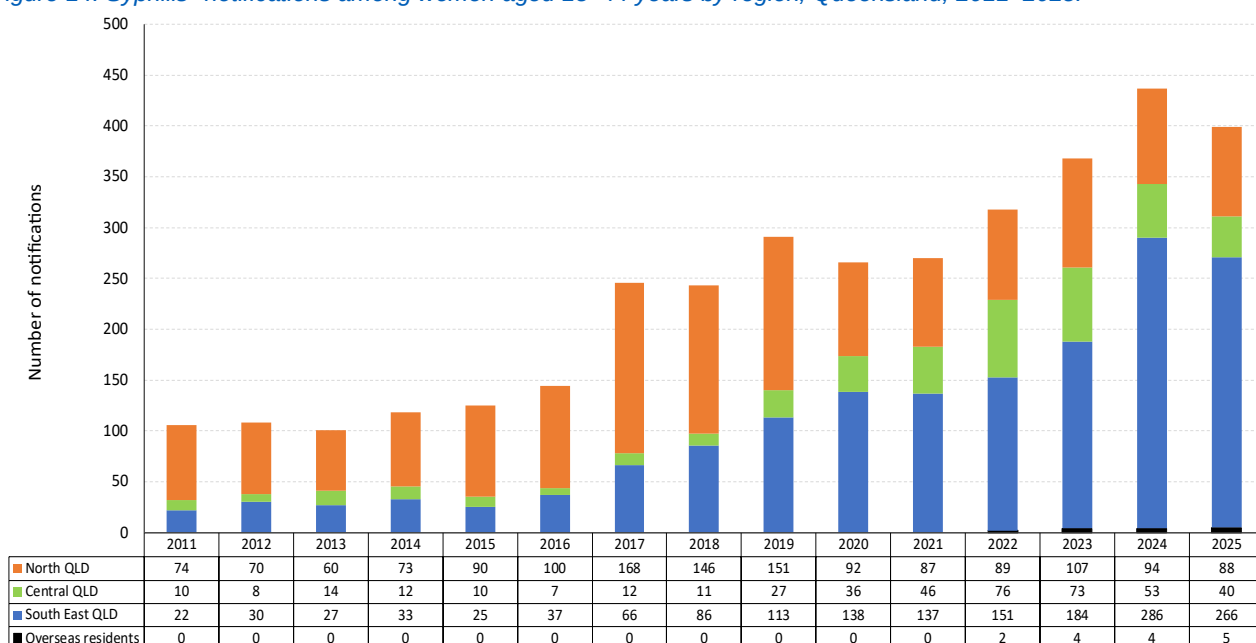


Regional distribution

Of the 399 syphilis notifications reported among women of reproductive age in 2025, 67 per cent (n=266) were from South East Queensland, 22 per cent (n=88) from North Queensland, and 10 per cent (n=40) from Central Queensland (Figure 14). Notifications in North and Central Queensland were lower than the previous five-year average (7 and 42 per cent reduction, respectively), whereas notifications in South East Queensland were 33 per cent higher than the previous five-year average.

The notification trends among women of reproductive age reflect a shifting epidemiological landscape. The increases observed in South East Queensland may be influenced by increased opposite-sex sexual transmission, underlying testing patterns, or other local factors.

Figure 14: Syphilis* notifications among women aged 15–44 years by region, Queensland, 2011–2025.



*Includes infectious and late latent/unknown duration

First Nations women of reproductive age

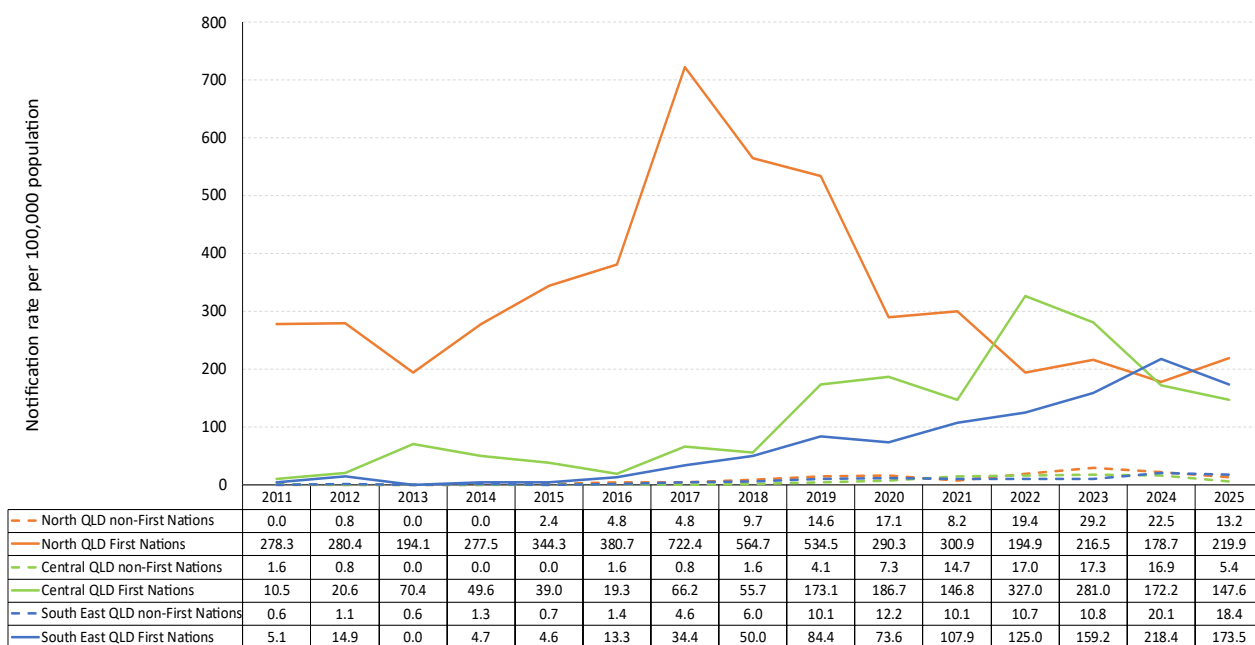
From 2011 to 2021, the infectious syphilis notification rate among First Nations women of reproductive age in North Queensland was consistently much higher than the rate for First Nations women of reproductive age in other regions or non-First Nations women of reproductive age (Figure 15). The rate peaked in 2017 at 722.4 per 100,000 population, then sharply declined; reflecting the achievements of the [North Queensland Aboriginal and Torres Strait Islander Sexually Transmissible Infections Action Plan 2016–2021](#). In contrast, the notification rates among First Nations women of reproductive age in Central Queensland and South East Queensland increased across the reporting period (14.1- and 34.0-fold, respectively).

In 2025, First Nations women of reproductive age in North Queensland had the highest infectious syphilis notification rate (219.9 per 100,000 population) when compared with First Nations women of reproductive age from other regions or non-First Nations women of reproductive age.

Non-First Nations women of reproductive age

From 2011 to 2025, the infectious syphilis notification rate among non-First Nations women of reproductive age increased across all regions (Figure 15). The highest magnitude of increase was observed in South East Queensland, where there was a 30.7-fold rise from 0.6 to 18.4 per 100,000 population.

Figure 15: Infectious syphilis notification rates in women aged 15–44 years by region and First Nations status, 2011–2025



Pregnant women

In December 2024, Queensland Health updated the [‘Syphilis and pregnancy’ clinical guidelines](#) to support clinicians in best practice approaches to syphilis screening and management during pregnancy. Notably, the guidelines now recommend universal testing for syphilis for all pregnant women at least three times during pregnancy.

In 2025, there were 72 syphilis notifications among pregnant women (44 infectious and 28 late latent/unknown duration). Of these notifications (Table 7):

- First Nations women were over-represented (36 per cent, n=26), demonstrating the disproportionate impacts of syphilis on First Nations communities.
- Most were tested due to antenatal screening (75 per cent, n=54), highlighting the important role of universal screening in detecting syphilis during pregnancy.
- Most diagnoses were made during the first (57 per cent, n=41) and second (24 per cent, n=17) trimesters; providing a beneficial opportunity for adequate syphilis treatment at least 30 days prior to birth.
- General practitioners were the most common test provider type (61 per cent, n=44), followed by public hospitals (26 per cent, n=19), emphasising the important role of the primary health care sector in detecting and managing syphilis during pregnancy.

Table 7: Descriptive epidemiology of syphilis* in pregnancy in Queensland, 2025 (n=72)

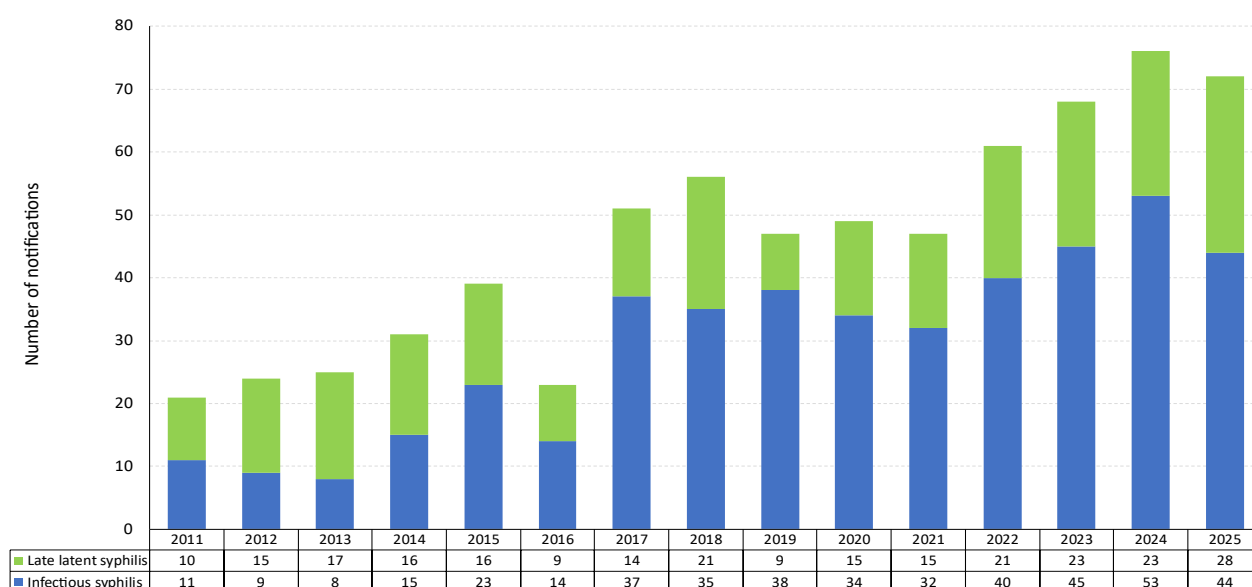
	Notifications	
	(n)	(%)
<i>First Nations status</i>		
First Nations	26	36
Non-First Nations	44	61
Unknown	2	3
<i>Primary reason for testing</i>		
Antenatal screening	54	75
Asymptomatic STI Screening	4	6
Contact of syphilis case	1	1
Symptomatic - syphilis	6	8
Unknown	7	10
<i>Maternal stage of pregnancy at diagnosis</i>		
First trimester	41	57
Second trimester	17	24
Third trimester	5	7
Post birth	3	4
Unknown	6	8
<i>Test provider type</i>		
General Practitioner	44	61
Public Hospital	19	26
Aboriginal Medical Service	4	6
Correctional services/Justice health	2	3
Other	2	3
Sexual Health Services	1	1

*Includes infectious and late latent/unknown duration

Clinical classification

Of the 72 syphilis notifications among pregnant women in 2025, 44 were infectious syphilis (Figure 16) which was 7 per cent higher than the previous five-year average 2020–2024 (n=41). The remaining 28 notifications were late latent syphilis or syphilis of unknown duration which was 31 per cent higher than the previous five-year average (n=19). The larger relative increase of notifications of late latent syphilis or syphilis of unknown duration could reflect increased testing practices for syphilis in pregnancy following the changed clinical guidelines in December 2024.

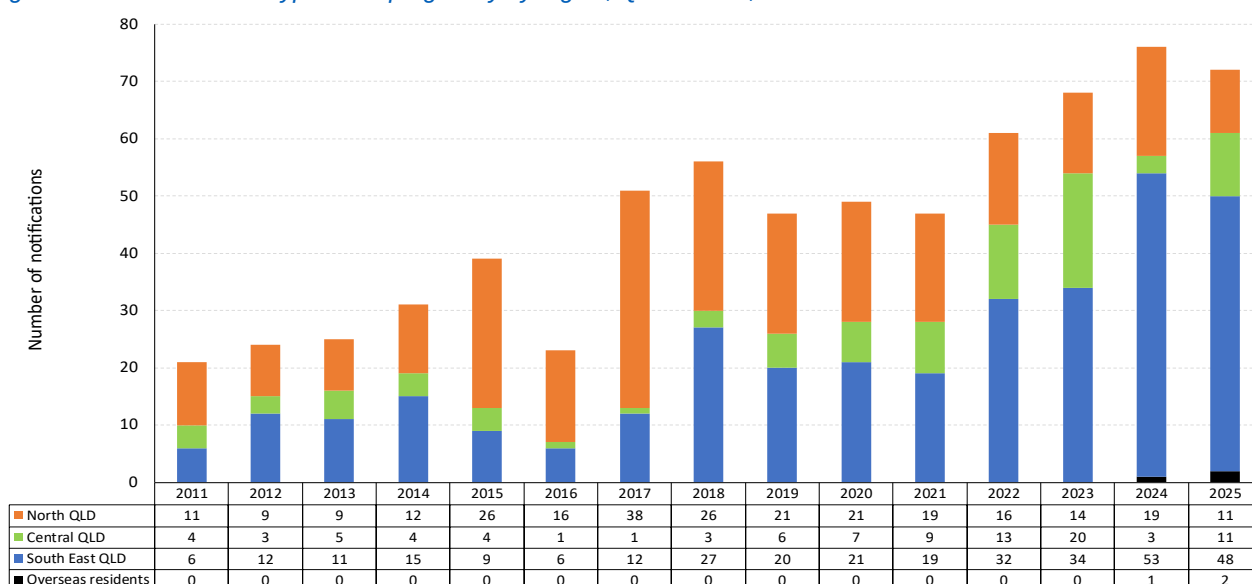
Figure 16: Notifications of syphilis in pregnancy by clinical classification group, Queensland 2011–2025



Regional distribution

Of the 72 syphilis notifications reported among pregnant women in 2025, 67 per cent (n=48) were from South East Queensland and both Central and North Queensland reported 15 per cent (n=11) (Figure 17). Notifications in North Queensland were 62 per cent lower than the previous five-year average (n=18), whereas notifications in South East Queensland were 34 per cent higher than the previous five-year average (n=32).

Figure 17: Notifications of syphilis* in pregnancy by region, Queensland, 2011–2025



*Includes infectious and late latent/unknown duration

Congenital syphilis

In 2025, there were six notifications of congenital syphilis and three were associated with intrauterine foetal deaths. Every notification of congenital syphilis represents potential missed opportunities across the health system to provide timely testing, diagnosis, and treatment of syphilis during pregnancy. Prevention of congenital syphilis relies on detection and treatment of maternal syphilis at least 30 days prior to birth. Congenital syphilis serves as a sentinel indicator of broader syphilis epidemiology, reflecting both transmission within the population as well as the effectiveness of the public health response.

In October 2024, the [Protocol for reporting congenital syphilis](#) was added to the Queensland Health Patient Safety Health Service Directive. The protocol requires HHSs to conduct thorough, local analysis of all congenital syphilis cases and to submit a report to Patient Safety Queensland within 90 days. In 2025, all six congenital syphilis notifications were reported to Patient Safety Queensland for investigation. The findings of these internal investigations are not published.

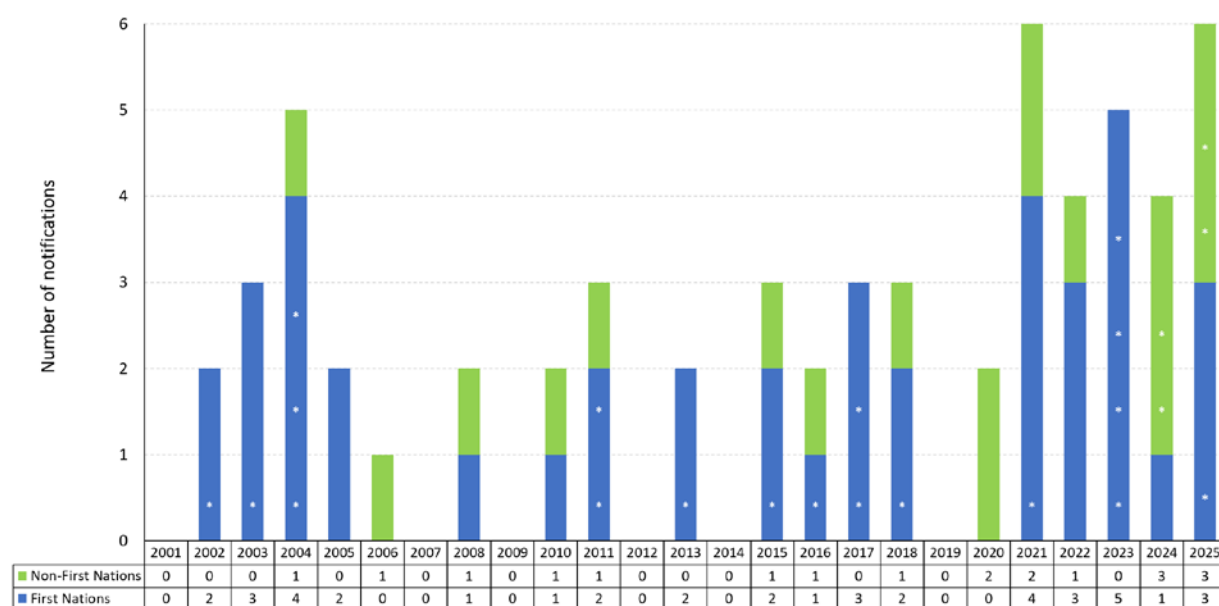
The Queensland Maternal and Perinatal Quality Council-led Congenital Syphilis Working Group also undertakes regular audits of all congenital syphilis cases in Queensland. This is aligned with the [Syphilis CDNA National Guidelines for Public Health Units](#) which recommends a root cause analysis for every case of congenital syphilis. Where the infant or their birthing parent identifies as Aboriginal and/or Torres Strait Islander, the root cause analysis process should include representation from First Nations health professionals or organisations. Congenital syphilis reviews have consistently identified complex layers of social determinants, gaps in healthcare, and individual behavioural risks. Where historical case reviews identified systemic failures in adherence to antenatal syphilis screening guidelines¹¹, the most common factor is limited or no antenatal care during pregnancy.

Of the six congenital syphilis notifications reported in 2025, two mothers first presented for antenatal care in the second trimester, two in the third trimester, and two did not present for antenatal care. Limited or no antenatal care contributes to late maternal diagnosis and incomplete or no maternal treatment prior to delivery. There is a need for models of antenatal and ongoing care that consider the needs of marginalised women, particularly when complex social factors are also present. Strategies could include assertive outreach testing models and partnerships with non-health services that women may be accessing during pregnancy to support linkage into care.

¹¹ [Congenital Anomaly Matters Edition 2 - Syphilis Screening in Pregnancy: Gaps in care affecting mothers and newborns](#)

Between 2001 and 2025, 60 congenital syphilis cases were notified in Queensland. Of these, 68 per cent (n=41) were First Nations infants and 32 per cent (n=19) were non-First Nations infants (Figure 18). In the same period, 23 congenital syphilis notifications were associated with intrauterine foetal deaths, stillbirths, or died after birth. Of these, 83 per cent (n=19) were First Nations infants; a tragic representation of the disproportionate impacts congenital syphilis has on First Nations families and communities.

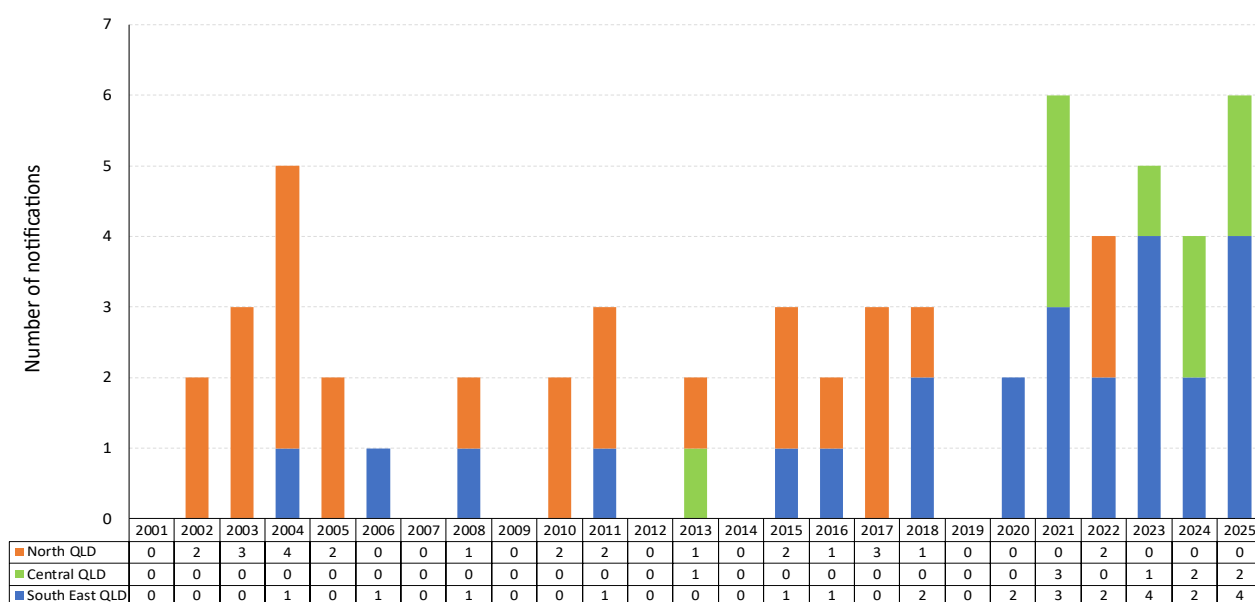
Figure 18: Notifications of congenital syphilis by First Nations status, Queensland 2001–2025



*Denotes death in a congenital syphilis case

Of the 60 congenital syphilis notifications reported between 2001 and 2025, 26 were from North Queensland, 9 were from Central Queensland, and 25 were from South East Queensland (Figure 19). The regional distribution of congenital syphilis cases reflects the changing epidemiology of syphilis and the increasing notifications among women of reproductive age in South East Queensland in recent years. [Appendix 2](#) includes the congenital syphilis notification count for each HHS between 2011 and 2025.

Figure 19: Notifications of congenital syphilis by region, Queensland, 2001–2025



Between 2011 and 2025, 3,540 syphilis notifications (2,678 infectious and 862 late latent or unknown duration) were reported among women of reproductive age in Queensland (Table 8). Of these, 19 per cent (n=684) were in pregnant women, including 436 infectious and 248 late latent or unknown duration notifications. A total of 43 cases of congenital syphilis were notified during the same period.

The highest number of syphilis notifications in pregnancy was reported among non-First Nations women from South East Queensland (n=242, 35 per cent of Queensland total). Of these notifications (114 infectious, 128 late latent or unknown duration), 11 congenital syphilis cases were notified.

The second highest number of syphilis notifications in pregnancy was reported among First Nations women from North Queensland (n=199, 29 per cent of Queensland total). Of these notifications (182 infectious, 17 late latent or unknown duration), 12 congenital syphilis cases were notified.

Table 8: Summary of notifications of syphilis* in women of reproductive age (aged 15–44 years), pregnant women, and congenital syphilis, by region and First Nations status, 2011–2025

Region/First Nations status	Syphilis notifications in women of reproductive age	Syphilis notifications in pregnant women ⁺	Congenital syphilis notifications
North - First Nations	1,165	199	12
North - non-First Nations	320	66	0
North - unknown	4	0	0
Central - First Nations	248	49	5
Central - non-First Nations	180	43	4
Central - unknown	7	2	0
South East - First Nations	358	75	11
South East - non-First Nations	1,215	242	11
South East - unknown	28	5	0
Overseas - non-First Nations	15	3	0
Queensland	3,540	684	43

*Syphilis notifications include infectious syphilis and late latent syphilis or syphilis of unknown duration.

⁺Excludes 6 notifications of syphilis in pregnancy among people who do not meet criteria for 'women of reproductive age'

Multijurisdictional syphilis outbreak

Since January 2011, there has been an ongoing infectious syphilis outbreak across northern Australia. The outbreak was first declared in North West Queensland, followed by the Northern Territory in July 2013, the Kimberley region in Western Australia in June 2014, and South Australia in November 2016. A Multijurisdictional Syphilis Outbreak (MJSO) Working Group was formed by the Communicable Diseases Network of Australia in 2015 to enable affected jurisdictions to coordinate the public health response. The MJSO has predominantly affected First Nations peoples residing in remote and rural areas. In recent years, syphilis notifications have increased across urban and major cities across Australia, including South East Queensland. Cases associated with the original MJSO continue to be classified and monitored with detailed information on declared MJSO regions reported in national syphilis monitoring reports.¹²

The five MJSO declared regions in Queensland are defined as follows:

- North West HHS area: from 1 January 2011
- Torres and Cape HHS area: from 1 December 2012 to 30 April 2024¹³
- Cairns and Hinterland HHS area: from 1 August 2013
- Townsville HHS area: from 1 January 2014
- Central Queensland HHS area: from 1 June 2017

MJSO cases are classified as either category 1 or category 2. Category 1 cases refer to infectious syphilis cases among First Nations peoples residing in MJSO declared regions at the time of diagnosis. Category 2 cases are infectious syphilis cases who are a sexual contact of a category 1 MJSO case, including First Nations peoples who reside outside MJSO declared regions at the time of diagnosis, and non-First Nations peoples regardless of where they reside.

Epidemiological trends

Between 2011 and 2025, 2,279 MJSO category 1 cases were notified. Of these, 52 per cent (n=1,183) were among females, 42 per cent (n=66) were among people aged 15–24 years, and 30 per cent (n=695) were among people aged 25–34 years. A total of 63 MJSO category 2 cases were notified, including 18 First Nations peoples and 48 non-First Nations peoples.

Of the 2,279 MJSO category 1 cases notified, 32 per cent (n=730) were from Cairns and Hinterland HHS, 26 per cent (n=599) from North West HHS, 21 per cent (n=474) from Townsville HHS, 11 per cent (n=242) from Torres and Cape HHS, and 10 per cent (n=234) from Central Queensland HHS (Figure 21).

In the same period, 13 congenital syphilis cases associated with the MJSO were notified (4 from Cairns and Hinterland HHS, 3 from Townsville HHS, 2 each from North West HHS, Torres and Cape HHS, and Central Queensland HHS). Of these, 8 were associated with intrauterine foetal deaths or deaths after birth.

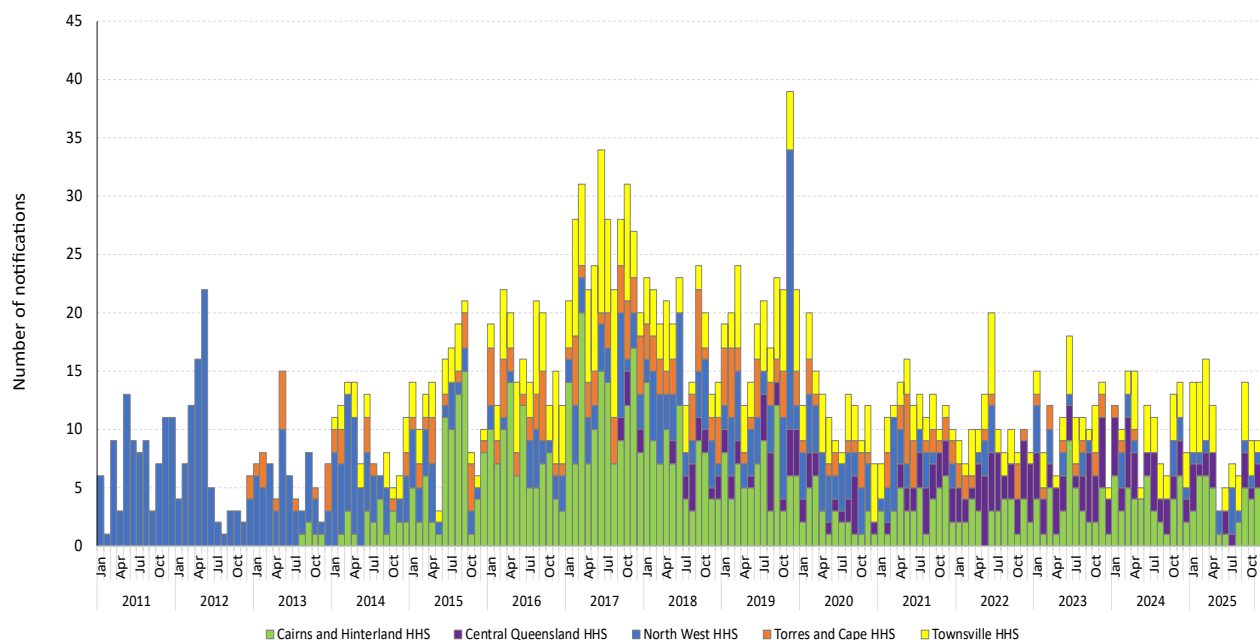
¹²[National syphilis monitoring reports | Australian Government Department of Health and Aged Care](#)

¹³From 1 May 2024, the Torres and Cape Hospital and Health Service was declassified as a multijurisdictional syphilis outbreak region.

In 2025, there were 110 MJSO category 1 cases notified in Queensland, these included:

- 39 notifications from Townsville HHS; an increase from the previous five-year average (n=29.6)
- 38 notifications from Cairns and Hinterland HHS; consistent with the previous five-year average (n=38)
- 19 notifications from Central Queensland HHS; a decrease from the previous five-year average (n=33.2)
- 14 notifications from North West HHS; a decrease from the previous five-year average (n=20).

Figure 20: Multijurisdictional syphilis outbreak category 1 cases, Queensland, 1 January 2011–31 December 2025



Discussion

Queensland continues to observe increasing notifications of infectious syphilis with a peak 1,479 notifications recorded in 2025. This rise likely reflects increased transmission as well as a combination of other factors such as expanded testing coverage, greater public and clinical awareness, and changes in surveillance practices.

First Nations peoples are disproportionately impacted by syphilis. In 2025, 20 per cent of infectious syphilis notifications in Queensland were among First Nations peoples, and the notification rate was 4.8 times higher than for non-First Nations peoples. Syphilis also disproportionately impacts gay, bisexual, and other men who have sex with men; representing 51 per cent of infectious syphilis notifications with data on type of sexual partner in 2025.

The increase in infectious syphilis notifications has concerning ramifications on notifications among women of reproductive age (15–44 years) and continued notifications of syphilis in pregnancy. In 2025, there were 72 notifications of syphilis in pregnancy (44 infectious and 28 late latent or unknown duration) in Queensland and six notifications of congenital syphilis. Three of the congenital syphilis notifications were associated with intrauterine foetal deaths.

After symptomatic testing, asymptomatic screening was the next most recorded primary reason for testing, accounting for 32 per cent of notifications in 2025. A further nine per cent of notifications were tested due to being a sexual contact of another person with syphilis. This highlights the importance of comprehensive sexual health care, including asymptomatic screening and contact tracing, in detecting and managing syphilis. The important role of primary health care providers is also demonstrated with 51 per cent of notifications in 2025 having a general practitioner as the test requestor provider type, and a further 24 per cent being a sexual health service. In North and Central Queensland, public hospitals and Aboriginal Medical Services represented a higher relative proportion of notifications than in South East Queensland, highlighting the differing healthcare contexts across the state.

These epidemiological trends reinforce the importance of a targeted and comprehensive public health response. The [Queensland Syphilis Action Plan 2023–2028](#) prioritises a whole of system approach to promote health, prevent disease, and manage risk. Importantly, Queensland strives to eliminate congenital syphilis in line with the [National Syphilis Response Plan 2023–2030](#). Syphilis is everyone's business and addressing the detrimental impacts and persisting inequities requires a coordinated approach between government, non-government, and community organisations.

Data notes

Legislation and notification

Syphilis is a notifiable disease in Queensland under the *Public Health Act 2005* and *Public Health Regulation 2018*. All laboratory-diagnosed positive syphilis test results are notified and recorded in the Notifiable Conditions System (NoCS). The Queensland Syphilis Surveillance Service (north and south teams) reviews all syphilis notifications and provides the treating clinician with information about a patient's history of syphilis testing and treatment to support accurate staging of infection and clinical management. The service also plays a key role in enhanced surveillance data collection, enabling reporting on the changing epidemiology of syphilis in Queensland.

Data sources

Data were extracted from NoCS on 24 March 2026, covering notifications (confirmed or probable) with episode dates between 1 January 2001 and 31 December 2025. Notification rates were calculated with Estimated Resident Population (ERP) data supplied by Queensland Health. ERP data for 2001 were unavailable and are based on 2002 figures. ERP data for 2025 were unavailable and are based on 2024 figures.

Temporal trends

Different time periods are represented throughout this report. Data presented from 2001 represents when the Queensland Syphilis Surveillance Service was established, enhancing syphilis surveillance. Data presented from 2011 represent years following the outbreak declaration in North Queensland which subsequently became the multijurisdictional syphilis outbreak. Different time periods are used to demonstrate the changing epidemiology of syphilis.

Accuracy and limitations

Data are provisional and subject to change due to ongoing case investigations and data cleaning activities.

Data represent notifications received by the Queensland Department of Health and do not represent true incidence of the condition.

From January 2015, infectious syphilis notifications that meet the 'probable' case definition are included in addition to confirmed cases. This may have contributed to the overall increase in infectious syphilis notifications since this time. The impact is likely limited with only 13 per cent (n=1,624) of infectious syphilis notifications made between 2015 and 2025 in Queensland (n=12,074) classified as probable.

Data presented between 2020–2022 should be interpreted with caution due to the impact of the COVID-19 pandemic. The effects of the pandemic and its control measures are beyond the scope of this report, but likely include interruptions to testing and subsequent notifications, as well as potential impacts on disease transmission from interstate and international travel restrictions, restricted person movement, and potential changed sexual behaviour.

Terminology

The terminology used throughout this report reflects the sex categories recorded in the laboratory and surveillance reporting systems from which the data were sourced. We acknowledge that sex and gender are diverse and that these terms may not reflect the identities or experiences of all people represented in this report.

Regions

Throughout the report, North Queensland, Central Queensland, and South East Queensland are referred to as regions. These correspond with the following Hospital and Health Services.

North: Torres and Cape, North West, Cairns and Hinterland, Townsville, Mackay.

Central: Central West, Central Queensland, Wide Bay, South West, Darling Downs.

South East: Sunshine Coast, Metro North, Metro South, West Moreton, Gold Coast.

Definitions and classifications of syphilis

Infectious syphilis	Less than 2 years duration (includes primary, secondary and early latent stages of syphilis)		
	Stage of disease	Time post exposure	Major clinical features
	Primary syphilis	10–90 days	Chancre and ulcer at the site of infection (external/internal genitalia or a non-genital site)
	Secondary syphilis	4 weeks–6 months	Headache, fatigue, adenopathy, low grade fever, sore throat, rash, mucocutaneous lesions, and condylomata lata (large, raised, whitish or grey, flat-topped lesions found in warm moist areas).
	Early latent syphilis	Less than 2 years	No symptoms or signs of infection at the time of diagnosis.
Late latent syphilis	More than 2 years or unknown duration, with absence of clinical signs, and considered as non-infectious.		
Congenital syphilis	Infectious agent <i>Treponema pallidum</i> crosses the placenta and infects the foetus at any time in the pregnancy. If untreated, this can result in intrauterine foetal death, stillbirth or a premature baby. The infected baby can present with symptoms involving almost any organ including coryza, poor growth, eye lesions, long bone lesions, hepatitis, cerebral or pulmonary symptoms.		

For national surveillance case definitions, please refer to:

<https://www.health.gov.au/resources/collections/cdna-surveillance-case-definitions>

Appendix 1: Distribution of infectious syphilis by Hospital and Health Service (HHS)

Table 9: Infectious syphilis notification rate per 100,000 population by HHS, Queensland, 2011–2025

Region	Hospital and Health Service	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
North	Torres and Cape	8.1	20.0	63.2	47.1	69.4	117.3	147.9	129.7	118.8	57.9	89.3	42.5	49.8	87.3	56.9
	North West	282.5	255.6	174.9	195.3	97.1	76.8	147.2	168.4	220.8	149.5	86.7	27.8	45.1	45.2	52.1
	Cairns and Hinterland*	6.7	5.4	7.3	13.7	40.5	71.5	76.9	49.4	47.1	17.6	27.8	31.6	31.4	43.0	34.6
	Townsville*	3.1	8.6	3.0	9.3	16.4	28.5	41.3	22.9	31.6	27.0	15.3	14.7	21.7	29.8	33.7
	Mackay	2.3	1.7	2.3	2.3	2.9	1.7	5.7	8.0	6.2	13.3	10.9	16.6	34.8	26.5	12.5
Central	Central West	16.2	8.2	0.0	8.5	0.0	0.0	28.5	19.0	37.9	0.0	0.0	0.0	28.0	9.3	18.5
	Central Queensland*	1.9	3.3	6.4	5.9	7.3	7.3	8.7	12.3	15.0	15.8	25.5	38.5	38.3	27.9	17.6
	Wide Bay*	0.5	1.0	0.5	0.9	1.4	5.6	3.7	5.9	5.4	5.8	3.5	6.4	12.1	15.1	12.2
	South West	0.0	3.8	11.5	0.0	0.0	4.1	4.1	12.3	0.0	8.3	0.0	4.1	8.2	8.2	12.2
	Darling Downs	4.1	5.2	3.6	1.4	9.7	4.3	8.8	8.1	12.2	12.4	8.6	11.1	12.0	16.1	7.9
South East	Sunshine Coast	3.0	2.7	1.6	4.4	6.0	7.4	9.3	9.6	9.1	6.9	3.7	6.8	10.2	15.0	16.1
	Metro North*	12.1	14.2	9.9	9.5	15.0	17.7	28.6	35.9	30.0	30.8	29.4	28.5	32.4	30.8	31.0
	Metro South*	5.1	6.5	5.7	5.8	7.6	6.7	12.3	17.5	17.7	15.8	20.4	19.1	24.2	26.8	33.6
	West Moreton*	2.1	3.2	3.1	2.3	3.7	4.3	15.5	14.7	22.6	23.7	21.3	21.5	25.9	33.8	34.4
	Gold Coast*	4.9	4.8	6.9	11.7	12.7	8.0	20.9	20.1	18.6	15.1	22.6	21.3	26.1	18.5	20.3
Queensland		7.6	8.5	7.2	8.3	12.0	14.1	21.9	22.5	22.3	19.3	20.3	20.6	25.3	26.3	26.5

*Where [Hospital and Health Services provide healthcare in correctional settings](#), rates include notifications from these settings. Direct comparison with Hospital and Health Services that do not provide healthcare in these settings should be done with caution as differing disease incidence may be observed between these populations.

Table 10: Infectious syphilis notification rate per 100,000 population by HHS, First Nations peoples, Queensland, 2011–2025

Region	Hospital and Health Service	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
North	Torres and Cape	11.6	28.7	91.0	67.5	99.7	163.1	214.0	177.5	173.9	79.6	132.5	63.6	63.6	127.4	81.0
	North West	975.5	876.3	595.5	655.0	318.7	233.6	428.5	523.0	669.2	446.6	263.4	84.4	137.2	128.0	149.3
	Cairns and Hinterland*	28.7	12.6	21.8	68.4	242	282.7	428.8	275.5	225.5	89.4	121.8	94.5	120.4	135.3	111.8
	Townsville*	14.1	64.6	27.2	89.1	113.7	236.9	385.1	158.5	233.9	149.3	102.9	108.3	98.8	115.3	145.1
	Mackay	0.0	0.0	0.0	0.0	8.9	8.8	25.8	25.0	8.1	54.9	38.1	73.6	151.3	35.3	28.2
Central	Central West	155.3	81.0	0.0	90.7	0.0	np	np	np	np	0.0	0.0	0.0	97.7	95.7	95.7
	Central Queensland*	6.8	6.6	70.5	43.6	42.6	24.0	46.8	85.9	150.7	97.8	138.2	227.6	218	179.8	99.9
	Wide Bay*	0.0	0.0	0.0	8.9	0.0	8.4	0.0	24.1	31.5	23.1	15.1	29.3	35.9	42.0	42.0
	South West	0.0	0.0	0.0	0.0	0.0	0.0	0.0	54.0	0.0	25.7	0.0	0.0	23.9	23.4	23.4
	Darling Downs	19.6	25.1	12.1	5.9	17.2	5.6	10.8	21.3	47.0	77.0	40.3	113.2	77.9	62.8	58.0
South East	Sunshine Coast	0.0	0.0	0.0	0.0	9.3	9.0	26.0	25.2	24.5	23.9	23.2	30.2	29.5	71.5	71.5
	Metro North*	53	42.3	16.2	34.8	18.5	35.2	65.0	79.9	67.9	88.2	95.7	119.8	69.4	125.1	111.2
	Metro South*	10.5	23.8	19.9	9.7	22.1	18.4	35.8	69.6	53.4	57.3	71.4	86.8	100.1	123.2	139.5
	West Moreton*	8.0	15.3	14.6	0.0	6.7	19.4	49.7	35.9	69.0	66.6	75.0	97.5	134.0	139.6	163.7
	Gold Coast*	18.7	0.0	17.2	8.3	24.0	15.2	36.7	42.4	68.2	59.9	38.8	56.9	48.8	64.7	58.8
Queensland		58.7	57.6	48.3	58.3	74.4	91.9	147.9	116.4	127.7	89.6	86.8	95.1	98.6	109.7	103.5

^{np} Rates suppressed due to small population sizes and notification counts

*Where [Hospital and Health Services provide healthcare in correctional settings](#), rates include notifications from these settings. Direct comparison with Hospital and Health Services that do not provide healthcare in these settings should be done with caution as differing disease incidence may be observed between these populations.

Appendix 2: Distribution of congenital syphilis by Hospital and Health Service (HHS)

Table 11: Congenital syphilis notification counts by HHS, Queensland, 2011–2025

Region	Hospital and Health Service	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
North	Torres and Cape	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0
	North West	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Cairns and Hinterland	0	0	0	0	1	0	1	0	0	0	0	2	0	0	0
	Townsville	0	0	1	0	1	0	2	0	0	0	0	0	0	0	0
	Mackay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Central	Central West	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Central Queensland	0	0	1	0	0	0	0	0	0	0	3	0	0	1	1
	Wide Bay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	South West	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Darling Downs	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1
South East	Sunshine Coast	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Metro North	0	0	0	0	0	0	0	1	0	1	0	1	1	1	1
	Metro South	0	0	0	0	0	0	0	0	0	0	2	1	1	0	1
	West Moreton	0	0	0	0	1	0	0	0	0	1	1	0	1	0	2
	Gold Coast	0	0	0	0	0	1	0	1	0	0	0	0	1	1	0
Queensland		3	0	2	0	3	2	3	3	0	2	6	4	5	4	6

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