

**Blood borne viral and
sexually transmissible
infections in Aboriginal and
Torres Strait Islander peoples:
Annual surveillance report**

2025



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Cover Artwork

The cover artwork was created by Jasmine Sarin. Jasmine is a proud Kamilaroi and Jerrinja woman from NSW. Born and raised in Dharawal Country (Wollongong) as well as Jerrinja and Yuin Country (Nowra) and has family connections in Kamilaroi Country (Coonabarabran). Jasmine is also a Rescue Qualified Firefighter with Fire and Rescue NSW, a lover of good coffee, rugby league and a self-taught Aboriginal artist and graphic designer.

The narrative for this artwork can be found on the inside back cover of this report.

“My artwork predominantly features bright and bold colours. The narratives behind my artworks are often linked to the way we connect, the way we come together, and how we grow as community. These concepts are illustrated in my work as concentric circles, connection lines, floral emblems, and textured patterns symbolic of landscape. All of which reflect the cultural connection of country. We stand in footsteps millennia old, may we acknowledge all traditional owners of this great land... past, present and emerging.”

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Blood borne viral and sexually transmissible infections in Aboriginal and Torres Strait Islander peoples:

Annual surveillance report 2025

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Preface

This report provides information on the occurrence of blood borne viruses (BBV) and sexually transmissible infections (STI) among Aboriginal and Torres Strait Islander peoples in Australia. The report is published by the Kirby Institute, UNSW Sydney for the purposes of stimulating and supporting discussion on ways to minimise the risk of transmission of these infections as well as the personal and social impacts within Aboriginal and Torres Strait Islander communities.

This report is published annually as an accompanying document to the [HIV, viral hepatitis and sexually transmissible infections in Australia: annual surveillance report](#) ¹ and is overseen by the National Blood Borne Virus and Sexually Transmissible infections Surveillance Sub-Committee (NBBVSTI SSC) and the Annual Surveillance Report Advisory Committee with input provided by the National Aboriginal Community Controlled Health Organisation (NACCHO).

The report is produced for use by a wide range of health service providers and consumers, and particularly Aboriginal and Torres Strait Islander health services and communities. Tables and graphs also available online at the [Kirby Institute website](#).

Unless specifically stated otherwise, all data provided in this report are to the end of 2024. Data in this report are provisional and subject to future revision.

The Kirby Institute acknowledges Traditional Custodians of Country throughout Australia and recognises the continuing connection to lands, waters and communities. We pay our respect to Aboriginal and Torres Strait Islander Elders past and present. We acknowledge the unique position of Aboriginal and Torres Strait Islander peoples' culture, history and as the original inhabitants of the land. We extend our gratitude to the Kirby Institute Aboriginal and Torres Strait Islander Surveillance Reference Group, for providing expert insight, advice, and Aboriginal and Torres Strait Islander perspectives for previous reports, without whose input this report would not be possible. We also acknowledge Jasmine Sarin, a proud Kamilaroi and Jerrinja women who created the beautiful artwork for this report.

Abbreviations

ABS	Australian Bureau of Statistics
ACCESS	Australian Collaboration for Coordinated Enhanced Sentinel Surveillance
ANSPS	Australian Needle Syringe Program Survey
BBV	blood borne virus
HPV	human papillomavirus
PBS	Pharmaceutical Benefits Scheme
PrEP	Pre-Exposure Prophylaxis
STI	sexually transmissible infection

Summary

We recognise the devastating impacts colonisation and the social systems that continue to uphold social inequalities have on the health and wellbeing of Aboriginal and Torres Strait Islander peoples. This report provides high-quality and important data about persistent and emerging public health threats and inequities to inform public health responses and to address these issues. This report also identifies success in genital warts and donovanosis elimination, HPV vaccination program, and decline in HIV notifications. We also acknowledge the importance of the cultural determinants for Aboriginal and Torres Strait Islander health, and support principles of empowerment, community ownership, co-design, and partnership.

The years for comparison in this report are from 2020 to 2024 and 2015 to 2024, depending on data availability. Many indicators in the report were affected by the COVID-19 pandemic, where the changes between 2019 to 2022, are highlighted.

The 2021–2024 rates are impacted by a larger than expected increase in counts of people who identified as being of Aboriginal and Torres Strait Islander origin in the 2021 Census, hence comparison with prior years should be interpreted in this context.

Sexually transmissible infections

Infectious Syphilis

- There were 5866 infectious syphilis notifications in Australia in 2024, of which 989 (17%) were among Aboriginal and Torres Strait Islander peoples, 4549 (77.5%) were in non-Indigenous people, and 328 (5.5%) were among people for whom Aboriginal and Torres Strait Islander status was not reported.
- In 2024, among infectious syphilis notifications for Aboriginal and Torres Strait Islander peoples, 536 (54%) were males, 276 (28%) were aged 30-39 years, 381 (38.5%) were living in regional areas, and 319 (32%) were living in urban areas.
- Infectious syphilis notification rates among Aboriginal and Torres Strait Islander peoples are based on data from all jurisdictions, where Aboriginal and Torres Strait Islander status was at least ≥80% complete in each year from 2015 to 2024.
- The age-standardised infectious syphilis notification rate among Aboriginal and Torres Strait Islander peoples increased by 76% in the 10-year period, from 57.3 per 100 000 in 2015 to 100.7 per 100 000 population in 2024. Infectious syphilis notification rates among both Aboriginal and Torres Strait Islander males and females were nearly 3.5 times and 15 times as high as their non-Indigenous sex equivalent, respectively.
- There were 10 cases of congenital syphilis recorded in 2024, of which 3 (30%) were among Aboriginal and Torres Strait Islander infants, six (60%) were among non-Indigenous infants with one case (10%) missing Aboriginal and Torres Strait Islander status.

Chlamydia

- Chlamydia was the most frequently diagnosed sexually transmissible infection in Australia. In 2024, there were 101 742 chlamydia notifications in Australia, of which 9885 (9%) were among Aboriginal and Torres Strait Islander peoples, 48 751 (48%) were in non-Indigenous people, and Aboriginal and Torres Strait Islander status was not reported for 43 106 (42%) notifications.
- In 2024, of the chlamydia notifications among Aboriginal and Torres Strait Islander peoples, 6334 (64%) were among Aboriginal and Torres Strait Islander females, 3430 (35%) were among people aged 15-19 years, and 2845 (45%) were living in remote areas.
- Chlamydia notification rates among Aboriginal and Torres Strait Islander peoples were based on data from five jurisdictions (New South Wales, the Northern Territory, South Australia, Queensland and Western Australia), where Aboriginal and Torres Strait Islander status was ≥50% complete for all chlamydia notifications in each year from 2020 to 2024.
- In 2024, the age standardised chlamydia notification rate for Aboriginal and Torres Strait Islander peoples (950.6 per 100 000 population) was more than twice as high as that among non-Indigenous people (369.4 per 100 000 population).
- Between 2020 and 2024, the chlamydia age-standardised notification rate among Aboriginal and Torres Strait Islander peoples and non-Indigenous people fluctuated, with declines between 2020 and 2022 likely related to impacts of the COVID-19 pandemic.

Gonorrhoea

- There were 44 210 gonorrhoea notifications in Australia in 2024. Of these, 5934 (13%) were among Aboriginal and Torres Strait Islander peoples, 29 622 (67%) were among non-Indigenous people, and 8654 (19.5%) were among people for whom Aboriginal and Torres Strait Islander status was not reported.
- In 2024, of the gonorrhoea notifications among Aboriginal and Torres Strait Islander peoples, 3187 (54%) were among Aboriginal and Torres Strait Islander females, 1468 (28%) were among people aged 15-19 years, and 2845 (89%) were living in remote areas.
- Gonorrhoea notification rates among Aboriginal and Torres Strait Islander peoples are based on data from all jurisdictions, except Victoria, where Aboriginal and Torres Strait Islander status was ≥50% complete for gonorrhoea notifications in each of the years from 2020 to 2024.
- In 2024, the age standardised gonorrhoea notification rate among Aboriginal and Torres Strait Islander peoples was almost four times that of non-Indigenous people (576.6 per 100 000 vs. 145.8 per 100 000 population).

Donovanosis

- Australia is on track to eliminate donovanosis, which was once a frequently diagnosed sexually transmissible infection among remote Aboriginal populations. No cases have been reported since 2015.

Human papillomavirus

- In Australia, the national vaccination program for human papillomavirus (HPV) was introduced for girls aged 12 to 13 years in 2007 and was extended to include boys of the same age in 2013. Since 2007 there have been considerable reductions in the proportions diagnosed with genital warts among Aboriginal and Torres Strait Islander males and females aged 21 years or younger attending sexual health clinics included in the Genital Warts Surveillance Network for their first visit.

HIV

- In 2024, there were 23 HIV notifications among Aboriginal and Torres Strait Islander peoples, representing 3% of all HIV notifications in Australia (757 notifications overall). Of these, 19 (83%) were among males.
- In 2024, the age-standardised HIV notification rate was 2.8 per 100 000 population among both Aboriginal and Torres Strait Islander peoples and all non-Indigenous people.
- In 2024, among Aboriginal and Torres Strait Islander peoples, the HIV notification rate was 4.5 per 100 000 population for those aged 35 or older and was 1.0 per 100 000 population for those under 35 years. In non-Indigenous people, the HIV notification rate was 2.8 per 100 000 population for both those aged 35 and older and those aged under 35 years.
- In the five-year period from 2020 to 2024, the proportion of HIV notifications attributed to male-to-male sex was 33% among Aboriginal and Torres Strait Islander peoples, compared with 51% in non-Indigenous people. The proportion of HIV notifications attributed to injecting drug use was 13% among Aboriginal and Torres Strait Islander peoples compared with 4% in non-Indigenous people.
- Based on mathematical modelling, an estimated 610 Aboriginal and Torres Strait Islander peoples were living with HIV in Australia in 2024 (range: 520-670). This corresponds to an estimated HIV prevalence of 0.09% (range: 0.07%-0.10%), compared with 0.14% (range: 0.12%-0.16%) for both the overall non-Indigenous population and the total Australian population, and 0.12% (range: 0.10%-0.12%) for Australian-born non-Indigenous people.
- Based on the test for immune function (CD4+ cell count), 22% of HIV notifications among Aboriginal and Torres Strait Islander peoples in 2024 were classified as late diagnoses (CD4+ cell count of less than 350 cells/ μ L). These notifications are likely to have been in people who had acquired HIV at least four years prior to diagnosis. In 2024, for HIV notifications among Aboriginal and Torres Strait Islander peoples, the proportion of HIV diagnoses resulting from asymptomatic screening was 43% and 39% in non-Indigenous people.

Hepatitis C

- In 2024, there were 1527 hepatitis C notifications among Aboriginal and Torres Strait Islander peoples, accounting for 21% of all hepatitis C notifications (7281 notifications overall). There were a further 1811 (25%) notifications among people for whom Aboriginal and Torres Strait Islander status was not reported.
- In 2024, of the hepatitis C virus (HCV) notifications among Aboriginal and Torres Strait Islander peoples, 1180 (77%) were among Aboriginal and Torres Strait Islander males, 426 (28%) were among people aged 30-39 years, and 733 (62%) were living in regional areas.
- Hepatitis C notification rates among Aboriginal and Torres Strait Islander peoples were based on data from five jurisdictions (the Northern Territory, Queensland, South Australia, Tasmania and Western Australia), where Aboriginal and Torres Strait Islander status was $\geq 50\%$ complete for all hepatitis C notifications for each year from 2020 to 2024.
- In 2024, the age-standardised hepatitis C notification rate for Aboriginal and Torres Strait Islander peoples was seven times as high as compared to non-Indigenous people (165.4 vs 22.7 per 100 000 populations).

Hepatitis B

- In 2024, there were 5594 notifications of hepatitis B virus (HBV) infection in Australia, of which 144 (3%) were among Aboriginal and Torres Strait Islander peoples and 3443 (62%) were in non-Indigenous people. Aboriginal and Torres Strait Islander status was not reported for 2007 (36%) notifications.
- In 2024, of the HBV notifications among Aboriginal and Torres Strait Islander peoples, 95 (66%) were among Aboriginal and Torres Strait Islander males, 63 (43%) were among people who were 30-49 years old, and 50 were living in regional area.
- HBV notification rates among Aboriginal and Torres Strait Islander peoples were based on data from five jurisdictions (the Australian Capital Territory, the Northern Territory, Queensland, South Australia and Western Australia), where Aboriginal and Torres Strait Islander status was $\geq 50\%$ complete for all HBV notifications for each year from 2020–2024.
- The age standardised hepatitis B notification rate among Aboriginal and Torres Strait Islander peoples decreased by 32% between 2020 and 2024 (from 34.6 to 23.6 per 100 000 population). In 2024, the age-standardised notification rate of HBV for Aboriginal and Torres Strait Islander peoples was higher compared to non-Indigenous people (23.6 vs. 17.1 per 100 000 population).
- From 2020 to 2024, HBV vaccination coverage rates for Aboriginal and Torres Strait Islander children aged 12 and 24 months were consistently at or above 89% however coverage has declined since 2020. In 2024, the coverage rate declined to 89% for children aged 12 months, not meeting the 95% vaccination target outlined in the Third National Hepatitis B Strategy (2018–2022), for children aged 12 and 24 months.

1 Interpretation

The increases in infectious syphilis among Aboriginal and Torres Strait Islander peoples emphasise the need to enhance culturally safe and community led health promotion, testing and treatment strategies in partnership with Aboriginal and Torres Strait Islander stakeholders and communities. In particular, antenatal care needs to be more accessible with enhanced syphilis screening for pregnant women, regardless of the healthcare setting.

There has been some success in controlling a limited number of STIs among Aboriginal and Torres Strait Islander peoples. Donovanosis, once frequently diagnosed among remote Aboriginal populations, is now virtually eliminated. Significant declines in the number of genital warts diagnoses have been observed after previously being recorded as the most common STI managed at sexual health clinics among Aboriginal and Torres Strait Islander peoples. These declines reflect the success of the National Immunisation Program (NIP) for HPV, introduced in 2007 for girls and in 2013 for boys. Also, declines in the number of hepatitis B notifications among younger Aboriginal and Torres Strait Islander people reflect the success of the NIP which provides free hepatitis B vaccinations for Australian infants, along with better antenatal care. Maintaining high vaccine coverage for both HPV and hepatitis B are crucial to maintain and extend these gains.

In 2024, age-standardised STI notification rates remained higher among Aboriginal and Torres Strait Islander peoples than in non-Indigenous people: infectious syphilis was more than 5 times as high, chlamydia was more than twice as high, and gonorrhoea was almost four times as high. The age standardised HIV notification rate in Aboriginal and Torres Strait Islander peoples fluctuated between 2015 and 2024 and remained higher as compared to all non-Indigenous people. Trends in HIV notification rates among Aboriginal and Torres Strait Islander peoples are based on small numbers (23 notifications in 2024) and may reflect localised occurrences rather than national patterns.

At the end of 2024, there were an estimated 610 (range: 520-670), Aboriginal and Torres Strait Islander people living with HIV in Australia. Australia is yet to meet the first UNAIDS 2025 target of 95% of Aboriginal and Torres Strait Islander people living with HIV being diagnosed (98% (600) had been diagnosed). Of those diagnosed at the end of 2024, an estimated 97% of Aboriginal and Torres Strait Islander people (580) were retained in care, meeting the UNAIDS target, which shows strong engagement with healthcare services, which is crucial for managing HIV. 95% (570) of those diagnosed were receiving antiretroviral therapy, and 100% (570) of those on antiretroviral therapy had a suppressed viral load, meeting the 95% target and highlights the success of treatment programs. A significant proportion of HIV diagnosis resulted from the screening process, highlighting the effectiveness of HIV testing programs. This success also contributes to the lower estimates of undiagnosed HIV (1.6%) within the Aboriginal and Torres Strait Islander population.

In 2024, Hepatitis C notification rates remain more than seven times higher among Aboriginal and Torres Strait Islander peoples compared with non-Indigenous people, suggesting an increase in the at-risk population and/or barriers to accessible harm reduction. Aboriginal and Torres Strait Islander people are over-represented among clients accessing needle/syringe programs (NSP), comprising 26% of the sample of people who inject drugs accessing NSPs recruited in the Australian NSP Survey (ANSPS) in 2024. Data disaggregated by Indigenous status was not available from the ANSPS (for which ethics committee approval is pending), but among the entire sample HCV antibody prevalence was 39% and 8% were HCV RNA positive. Further, there is hyper-incarceration of Aboriginal and Torres Strait Islander peoples in these settings where access to evidence-based harm-reduction strategies are substantially limited. Given the high proportion of hepatitis C notifications without a reported Aboriginal and Torres Strait Islander status, the actual hepatitis C-related burden of disease among Aboriginal and Torres Strait Islander peoples may be even higher. Improved completeness of Aboriginal and Torres Strait Islander status among notifications data is required to better measure the true impact of hepatitis C on Aboriginal and Torres Strait Islander communities.

The declining trend in hepatitis B notifications in Aboriginal and Torres Strait Islander peoples younger than 40 years suggests that immunisation programs for hepatitis B have had a clear benefit and have reduced the gap in hepatitis B notification rates between Aboriginal and Torres Strait Islander peoples and non-Indigenous people. However, hepatitis B notification rates in Aboriginal and Torres Strait Islander peoples in older age groups remained high compared to non-Indigenous people, highlighting the need for a continued focus on hepatitis B testing, immunisation, and engagement in care among Aboriginal and Torres Strait Islander peoples.

Wider determinants of health, such as access to health care, education, unemployment, poverty, discrimination and racism, also influence risk factors for blood borne viruses (BBV) and sexually transmissible infections (STI).² These social determinants must be acknowledged in the development of strategies to address the concerning trends in BBV and STI rates and the associated burden of disease.

2 Overview

Aboriginal and Torres Strait Islander status completeness

Incomplete information on Aboriginal and Torres Strait Islander identification has the potential to misrepresent the true extent of BBVs and STIs in Aboriginal and Torres Strait Islander peoples. The National Notifiable Diseases Surveillance System uses 'Indigenous status' to indicate Aboriginal and Torres Strait Islander identity. For the purposes of reporting, when discussing data sourced from the National Notifiable Diseases Surveillance System, 'Aboriginal and Torres Strait Islander status' will be used in place of 'Indigenous status'.

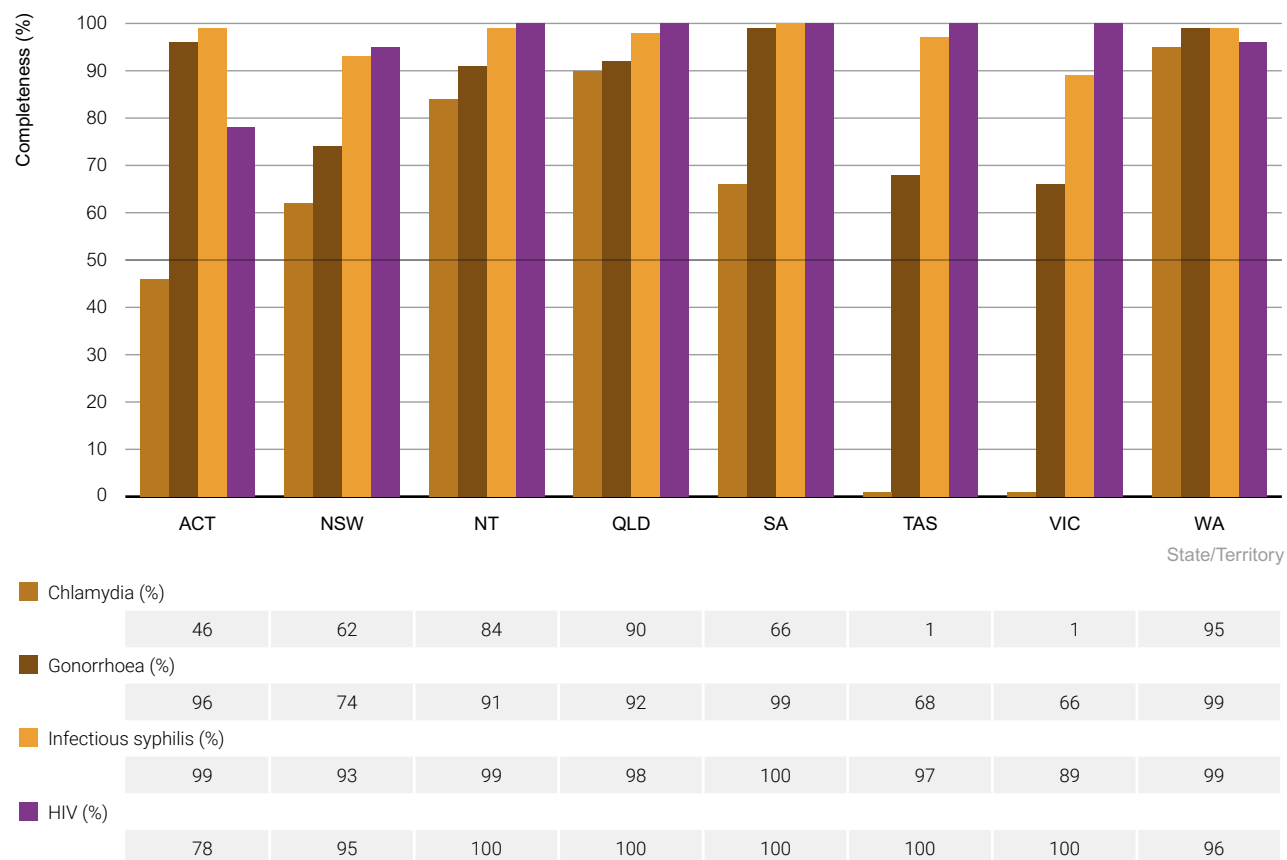
In 2024, all jurisdictions reported Aboriginal and Torres Strait Islander status for at least 50% of HIV and infectious syphilis notifications. However, for the following BBV/STIs, Aboriginal and Torres Strait Islander status was reported for less than 50% of notifications in these jurisdictions (Figure 1, Figure 2):

- Chlamydia: The Australian Capital Territory, Tasmania and Victoria
- Gonorrhoea: Victoria
- Hepatitis C: The Australian Capital Territory, New South Wales and Victoria.
- Hepatitis B: New South Wales, Tasmania and Victoria

Jurisdictions were included in notification rate calculations over time for specific BBV/STIs if Aboriginal and Torres Strait Islander status was reported for at least 50% of notifications for that infection in each year from 2020 to 2024. Jurisdictions which met the 50% threshold in 2024 (Figure 1 and Figure 2) but not in other years were not included in the presentation of notification rates, unless otherwise mentioned. Caution is advised when interpreting these data as fully representative of national epidemiology among Aboriginal and Torres Strait Islander peoples, given that the 50% reporting threshold is low.

Multiple enhanced surveillance and health workforce education activities are being undertaken at the jurisdictional and national level to improve the completeness of Aboriginal and Torres Strait Islander status. This includes consideration of the addition of Aboriginal and Torres Strait Islander status to pathology forms, continuing education of health care providers, and enhanced data review processes. Continued focus on this area is essential to improve completeness of data relating to Aboriginal and Torres Strait Islander peoples, to report against national strategy equity thresholds, as stated in national strategies³. It is important to recognize that an individual's willingness to identify as Aboriginal and Torres Strait Islander can be influenced by the perceived safety of the health system. Eliminating discrimination and racism within healthcare is therefore a critical component in creating an environment where people feel safe and respected to disclose their identity.

Figure 1 Reporting of Aboriginal and Torres Strait Islander status at notification of chlamydia, gonorrhoea, infectious syphilis and HIV by State/Territory, 2024



Source: National Notifiable Diseases Surveillance System; see [Methodology](#) for details.

Figure 2 Reporting of Aboriginal and Torres Strait Islander status at notification of viral hepatitis by State/Territory, 2024

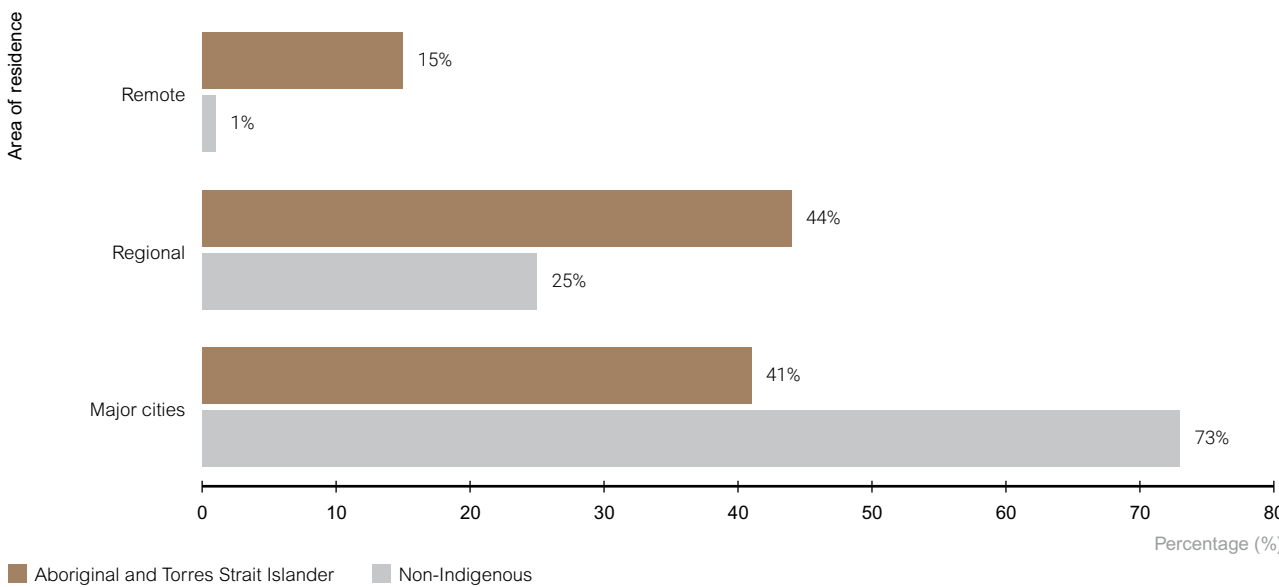


Source: National Notifiable Diseases Surveillance System; see [Methodology](#) for details.

Area of residence

Based on ABS population projections, it is estimated that in 2024, 15% of Aboriginal and Torres Strait Islander peoples lived in remote areas, 44% in regional areas and 41% in major cities, compared with 1%, 25%, and 73% of non-Indigenous people, respectively (Figure 3). See [Methodology](#) for further information.

Figure 3 Area of residence by Aboriginal and Torres Strait Islander status, 2024



Source: Australian Bureau of Statistics, July, 2025 see [Methodology](#) for details.

Aboriginal and Torres Strait Islander peoples in Australia

Aboriginal and Torres Strait Islander peoples make up 3.8% of the Australian population, with the greatest proportions living in New South Wales (34%) and Queensland (28%) (Table 1).

Table 1 Number and proportion of Aboriginal and Torres Strait Islander peoples living in each state and territory, 2024

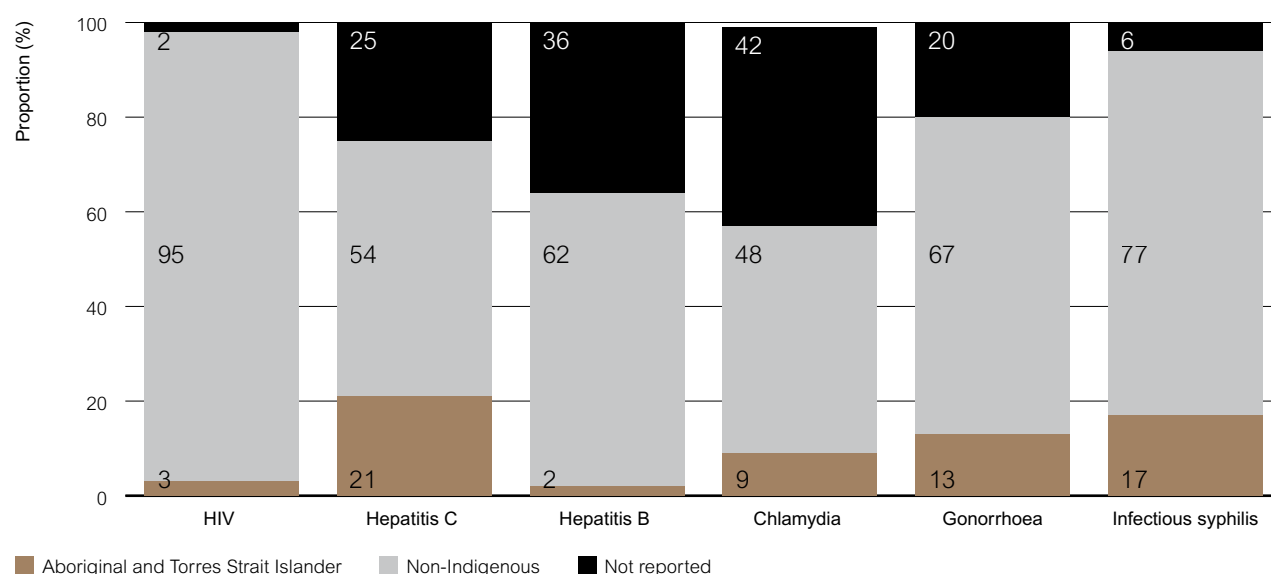
	Estimated resident Aboriginal and Torres Strait Islander population	Proportion of total Australian Aboriginal and Torres Strait Islander population
State/Territory		
Australian Capital Territory	10 197	1%
New South Wales	358 114	34%
Northern Territory	78 237	8%
Queensland	292 735	28%
South Australia	54 626	5%
Tasmania	35 246	3%
Victoria	83 752	8%
Western Australia	126 807	12%
Total	1 039 959	100%

Source: [Estimates of Aboriginal and Torres Strait Islander Australians 2011-2031, on October, 2025](#), Australian Bureau of Statistics.

Number of notifications and notification rates in Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander peoples make up 3.8% of the Australian population but accounted for a disproportionate level of most BBV and STI notifications in 2024 (Figure 4). For many notifications, this proportion may not be truly representative due to the incomplete reporting of Aboriginal and Torres Strait Islander status.

Figure 4 Proportion of all notifications by Aboriginal and Torres Strait Islander status, 2024



Source: National Notifiable Diseases Surveillance System and NHR; see [Methodology](#) for details.

To enable a more appropriate comparison between Aboriginal and Torres Strait Islander peoples and non-Indigenous people, age-standardised notification rates per 100 000 population were calculated, accounting for differences in the distribution of age within these populations. In 2024, age standardised notification rates of BBVs and STIs in Aboriginal and Torres Strait Islander peoples were higher than those for non-Indigenous people, except for HIV, where notifications rates were comparable between the two populations. (Table 2).

Table 2 Number and notification rate of sexually transmissible infections and blood borne viruses in Australia by Aboriginal and Torres Strait Islander status, 2024

Notifications of sexually transmissible infections, HIV and viral hepatitis	Aboriginal and Torres Strait Islander		Non-Indigenous		Fold difference	Excluded jurisdictions ^c
	Number ^a	Rate ^b	Number ^a	Rate ^b		
Chlamydia	9 885	950.6	48 751	369.4	2.6	Australian Capital Territory, Tasmania, Victoria
Gonorrhoea	5 934	576.6	29 622	145.8	4.0	Victoria
Infectious syphilis	989	100.7	4 549	18.9	5.3	None
HIV	23	2.8	716	2.8	1.0	None
Hepatitis B	144	23.6	3 443	17.1	1.4	Tasmania, Victoria, New South Wales
Hepatitis C	1 527	165.4	3 943	22.7	7.3	Australian Capital Territory, Victoria, New South Wales

a All jurisdictions.

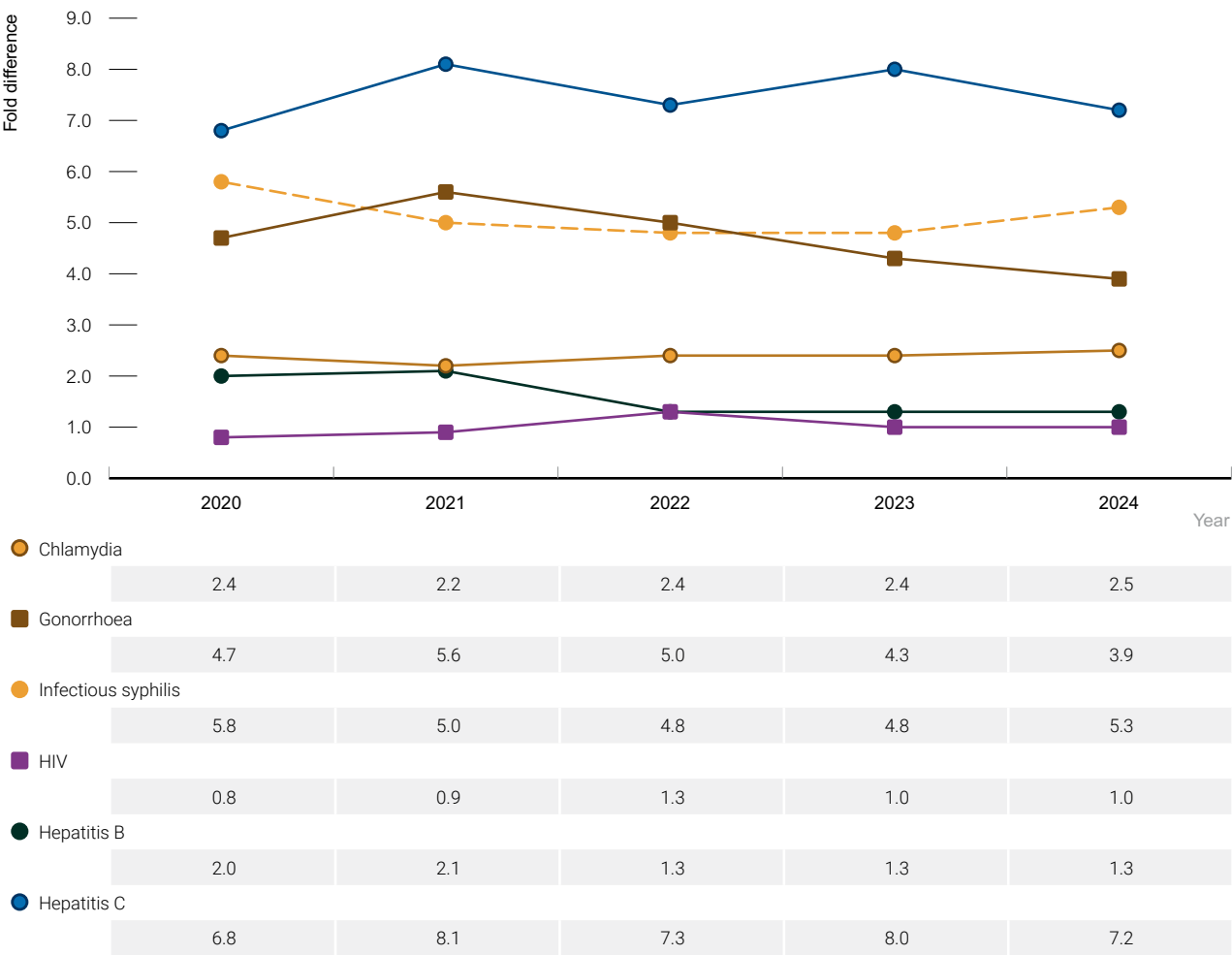
b Age-standardised rate per 100 000 population.

c Jurisdictions in which Aboriginal and Torres Strait Islander status was reported for less than 50% of notifications.

Source: National Notifiable Diseases Surveillance System; National HIV Registry; see [Methodology](#) for details.

Between 2020 and 2024 the difference between the age-standardised notification rates of Aboriginal and Torres Strait Islander peoples and non-Indigenous people, expressed as a ratio, fluctuated for infectious syphilis, declined for hepatitis B, slightly increased for chlamydia, Hepatitis C and HIV and slightly declined for gonorrhoea following an initial increase (Figure 5).

Figure 5 Notification rates ratio by Aboriginal and Torres Strait Islander status and infection, 2020–2024



Source: National Notifiable Diseases Surveillance System; see [Methodology](#) for details.

3 Sexually transmissible infections

Please see p. 6 for summary.

Syphilis

Infectious syphilis

Infectious syphilis is a sexually transmissible infection caused by the bacterium *Treponema pallidum*. A more comprehensive infectious syphilis national case definition was implemented in July 2015 in all jurisdictions except for New South Wales, where it was implemented in July 2016. The expanded case definition includes a subcategory of 'probable' infectious syphilis to capture infectious syphilis cases in people without a prior testing history, particularly young people aged 15-19 years. The probable infectious syphilis cases are included in the total number of infectious syphilis notifications from 2015 onwards.

At least 80% of all infectious syphilis notifications in all jurisdictions had Aboriginal and Torres Strait Islander status complete for each year from 2015 to 2024. For this reason, infectious syphilis data are presented for the 10-year period 2015 to 2024.

There were 5866 infectious syphilis notifications in Australia in 2024. Of these, 989 (17%) notifications were among Aboriginal and Torres Strait Islander peoples, 4549 (77.5%) were in non-Indigenous people, and 328 (5.5%) were in people for whom Aboriginal and Torres Strait Islander status was not reported (Table 3). Between 2015 and 2024, more than half (53%) of the 103 congenital syphilis notifications were among Aboriginal and Torres Strait Islander infants, with three Aboriginal and Torres Strait Islander congenital syphilis notifications reported in 2024 (Table 3).

The male to female ratio of infectious syphilis notifications in Aboriginal and Torres Strait Islander peoples in 2024 was almost 1:1 compared with 5:1 in non-Indigenous people (data not shown). This may indicate greater transmission occurring through heterosexual contact among Aboriginal and Torres Strait Islander peoples, while male-to-male transmission may be more common in non-Indigenous people.

Table 3 Infectious syphilis notifications in Aboriginal and Torres Strait peoples, by characteristic, 2015–2024

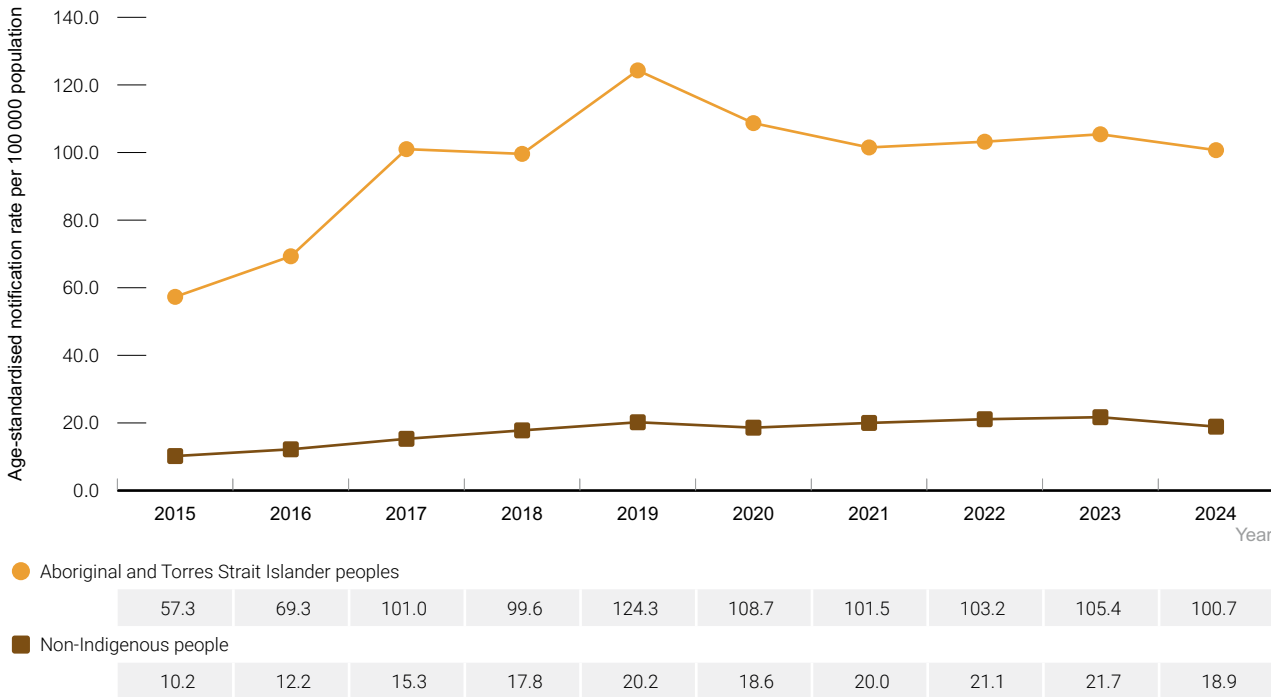
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Characteristic										
Total cases	468	556	811	820	1056	931	1000	1015	1060	989
Gender^a										
Female	199	247	394	394	525	458	510	494	564	452
Male	269	309	417	426	513	473	490	521	496	536
Median age in years	28	22	23	23	23	26	27	27	26	27
Age group										
0-14	16	17	23	7	30	17	12	8	11	20
15-19	142	140	173	170	271	239	241	201	208	155
20-24	108	93	159	175	171	150	208	204	211	169
25-29	69	104	129	140	175	133	162	185	184	157
30-39	78	118	181	183	225	217	215	251	269	276
≥40	55	84	146	144	183	175	162	166	177	212
Remoteness										
Major cities	53	74	111	158	205	234	245	316	332	319
Regional	156	207	349	249	287	217	181	242	285	269
Remote	250	269	340	410	557	468	555	440	423	381
Not reported	9	6	11	3	12	12	19	17	20	20
State/Territory										
Australian Capital Territory	1	0	1	3	4	5	0	0	2	2
New South Wales	26	34	54	55	90	109	114	143	154	131
Northern Territory	184	206	270	289	307	241	203	204	195	249
Queensland	177	221	357	293	326	226	222	255	275	311
South Australia	17	12	28	38	34	34	27	22	43	33
Tasmania	0	0	0	0	0	0	1	0	6	2
Victoria	17	31	31	40	50	23	49	45	69	53
Western Australia	46	52	70	102	245	293	384	346	316	208
Congenital syphilis	2	1	5	4	1	8	9	9	13	3

a Excludes 'Not reported'.

Source: National Notifiable Diseases Surveillance System.

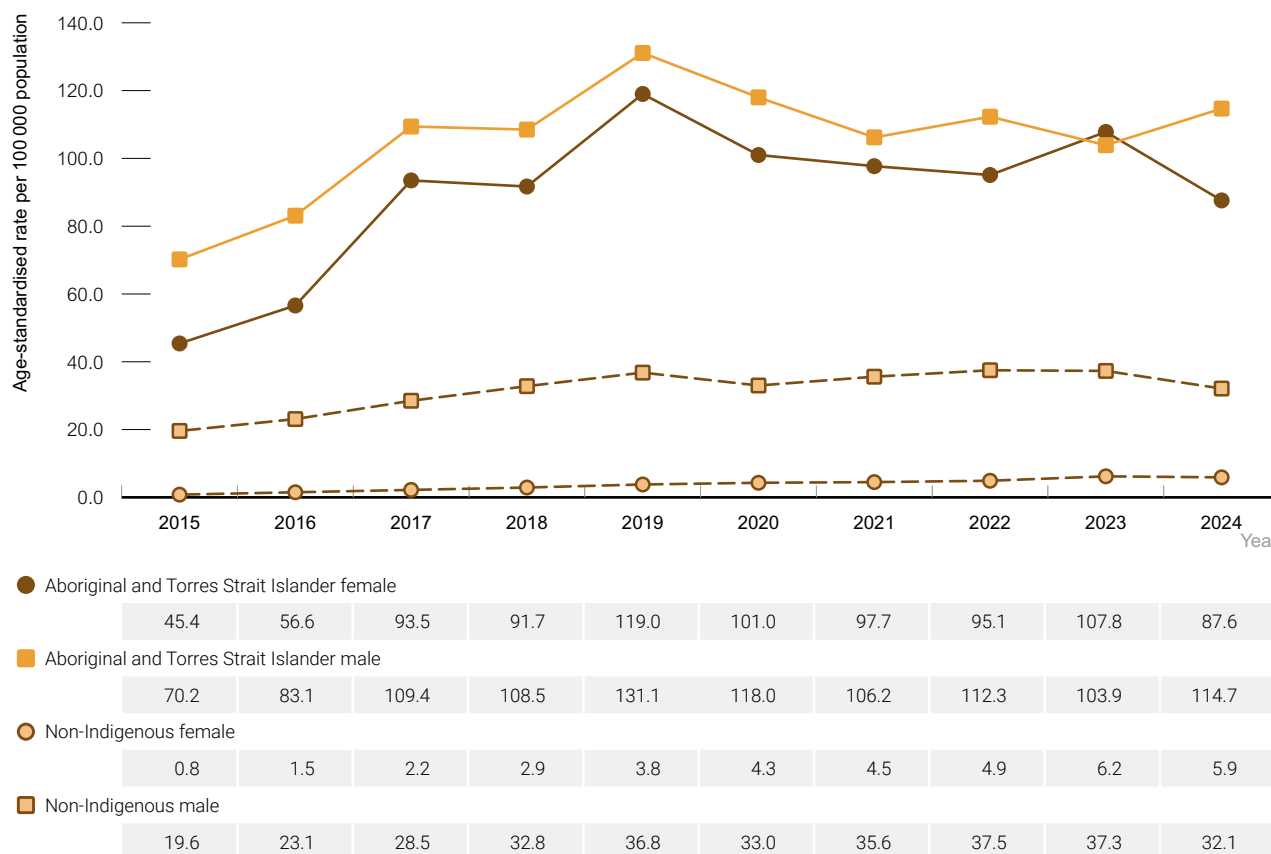
In 2024, the age-standardised infectious syphilis notification rate in Aboriginal and Torres Strait Islander peoples was more than five times as high as among non-Indigenous people (100.7 vs. 18.9 per 100 000) (Figure 6). Among Aboriginal and Torres Strait Islander peoples, the infectious syphilis notification rate more than doubled between 2015 and 2019 from 57.3 to 124.3 per 100 000. Between 2019 and 2024, the age standardised infectious syphilis notification rate declined from 124.3 to 100.7 per 100 000 (Figure 6). A similar trend over time was seen among Aboriginal and Torres Strait Islander males and females (Figure 7). Infectious syphilis notification rates among Aboriginal and Torres Strait Islander males and females were 3.5 times and over 15 times as high as their non-Indigenous gender equivalent, respectively (Figure 7).

Figure 6 Age standardised Infectious syphilis notification rate per 100 000 population by Aboriginal and Torres Islander status, 2015–2024



Source: Australian National Notifiable Diseases Surveillance System.

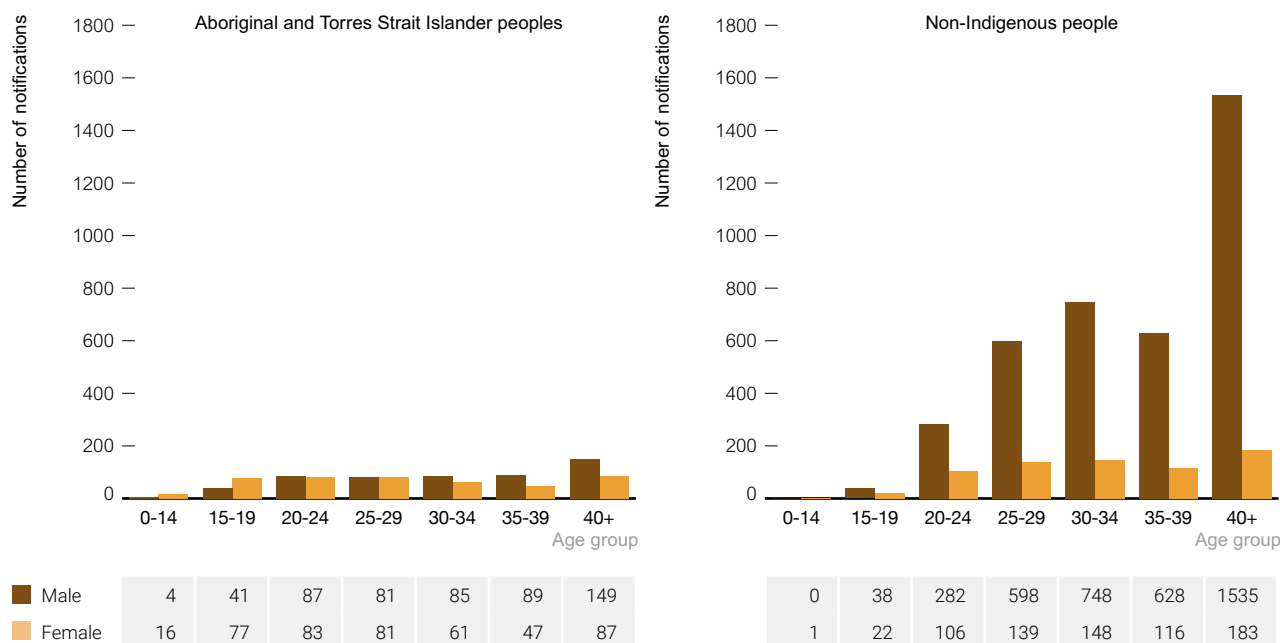
Figure 7 Age standardised infectious syphilis notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and gender, 2015–2024



Source: Australian National Notifiable Diseases Surveillance System.

Differences in age at diagnosis of infectious syphilis exist between Aboriginal and Torres Strait Islander peoples and non-Indigenous people. The age group with the second highest proportion of infectious syphilis notifications among Aboriginal and Torres Strait Islander peoples was 20–24 years, which is notably younger than the corresponding non-Indigenous group of 30–34 years. In 2024, the greatest proportion of infectious syphilis notifications in Aboriginal and Torres Strait Islander peoples occurred among those aged 40 and over followed by 20 to 24 years. By comparison, in 2024 the highest proportion of notifications in non-Indigenous people occurred in those aged over 40 years (1535 among males and 183 among females) (Figure 8).

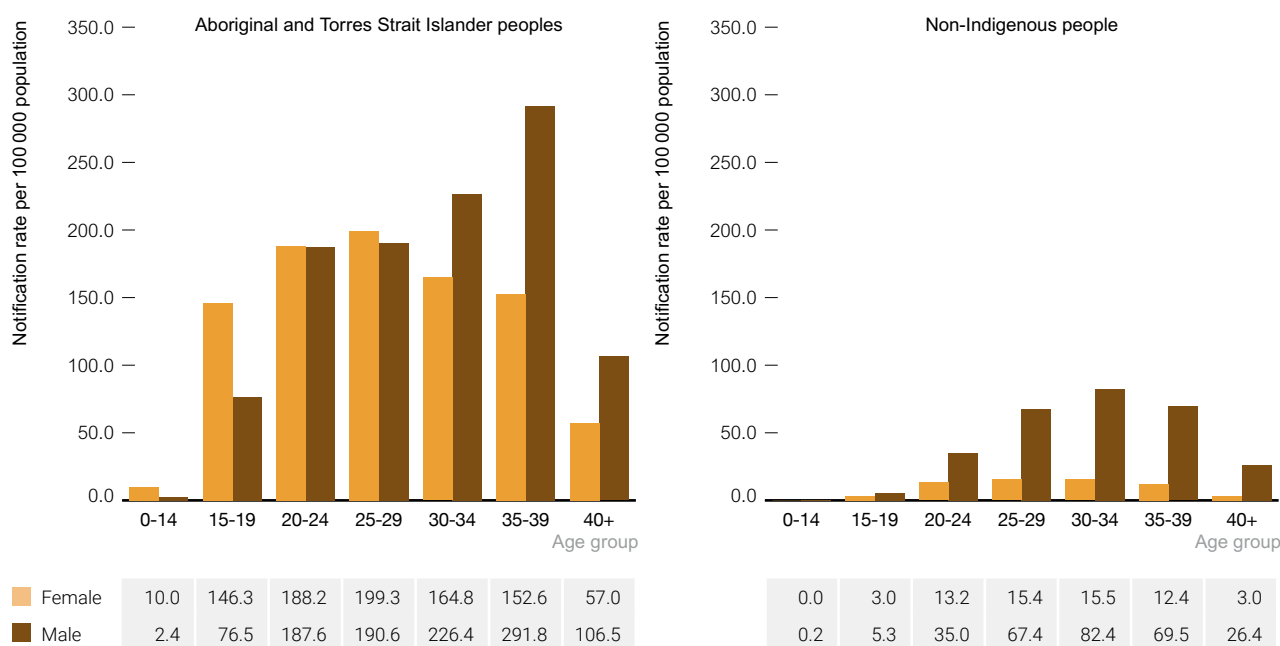
Figure 8 Number of infectious syphilis notifications by Aboriginal and Torres Strait Islander status, gender, and age group, 2024



Source: Australian National Notifiable Diseases Surveillance System.

In 2024, the infectious syphilis notification rate in was highest in those aged 30 to 34 years for Aboriginal and Torres Strait Islander males and non-Indigenous males (226.4 per 100 000 and 82.4 per 100 000 respectively). For non-Indigenous females the notification rate was highest and similar for those aged 30 to 34 years (15.5 per 100 000) and 25-29 years (15.4 per 100 000). However, for Aboriginal and Torres Strait Islander females, the infectious syphilis notification rate was highest for those aged 25 to 29 years (199.3 per 100 000) followed by those aged 20-24 years (188.2 per 100 000) (Figure 9).

Figure 9 Infectious syphilis notification rate per 100 000 population by Aboriginal and Torres Strait Islander status, age group and gender, 2024



Source: Australian National Notifiable Diseases Surveillance System.

Between 2015 and 2019, infectious syphilis notification rates increased sharply among Aboriginal and Torres Strait Islander peoples aged 15 to 19 years and 20 to 29 years, increasing from 140.0 to a peak of 255.0 per 100 000 and 145.3 to a peak of 246.8 per 100 000, respectively (Figure 10). Infectious syphilis notification rates declined between 2019 and 2022, with notification rates likely impacted by COVID-19 public health measures. In 2024 notification rates among Aboriginal and Torres Strait Islander peoples aged 15 to 19 years were at their lowest over the ten year period (110.6 per 100 000), a similar trend was also observed among those aged 20 to 29 years (191.2 per 100 000). Across all years and age groups, the infectious syphilis notification rate was higher in Aboriginal and Torres Strait Islander peoples than non-Indigenous people.

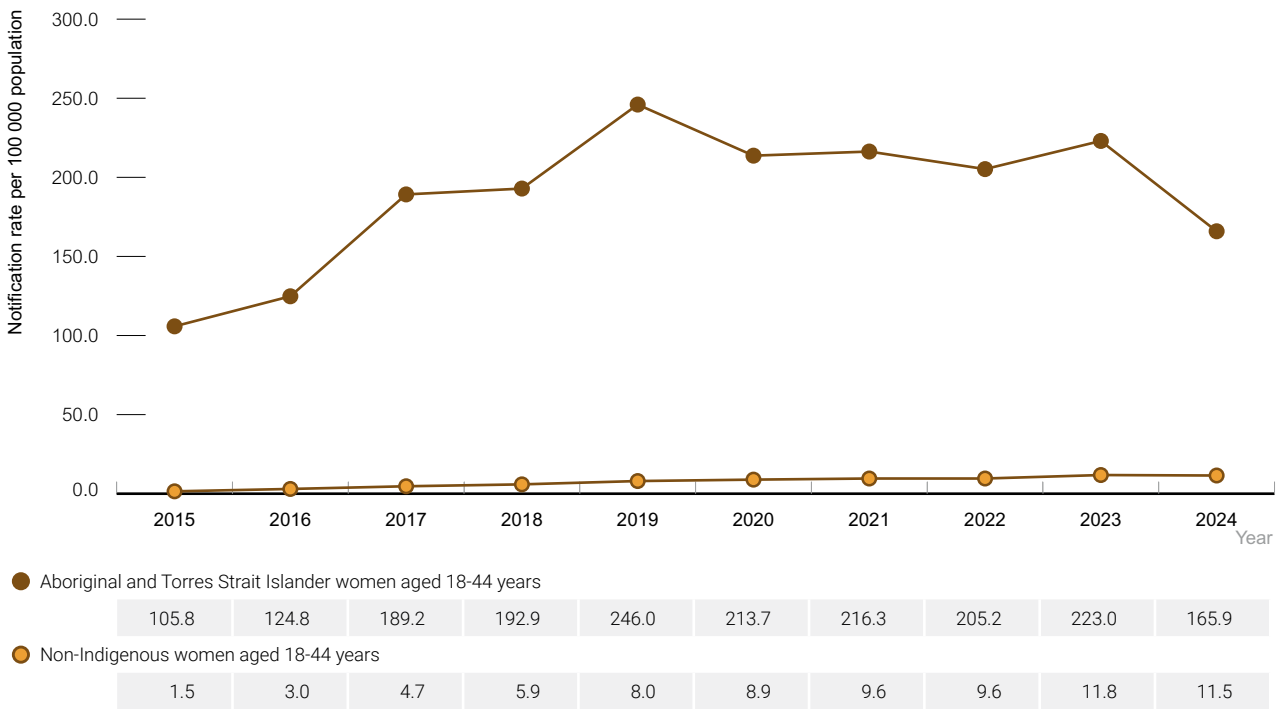
Figure 10 Infectious syphilis notification rate per 100 000 population in Aboriginal and Torres Strait Islander peoples by age group, 2015–2024



Source: Australian National Notifiable Diseases Surveillance System.

Between 2015 and 2024, the infectious syphilis notification rates among Aboriginal and Torres Strait Islander women of reproductive age (18-44 years old) was disproportionately high in 2015 at 105.8 per 100 000, rising to a peak of 246.0 per 100 000 in 2019. Despite the notification rate decreasing to 165.9 per 100 000 in 2024, it continues to remain markedly high. In comparison, notification rates in non-Indigenous women aged 18-44 years are considerably lower across all years, with a gradual increase over time to an observed peak in 2023 (11.8 per 100 000). In 2024, the notification rate was 14 times as high among Aboriginal and Torres Strait Islander women as compared to non-Indigenous women (165.9 per 100 000 and a 11.5 per 100 000, respectively) (Figure 11).

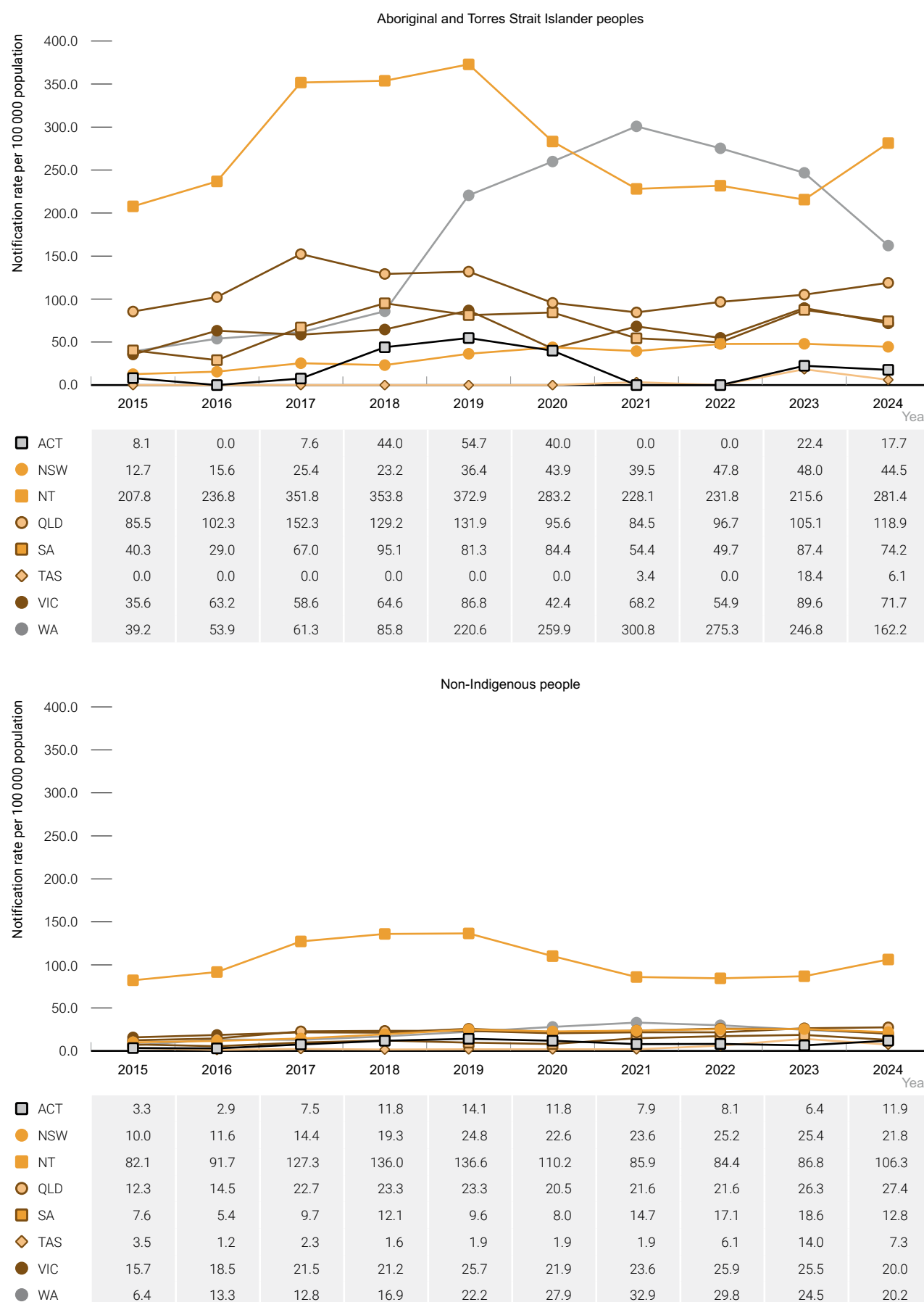
Figure 11 Infectious syphilis notification rate per 100 000 population in women aged 18-44 years, by Aboriginal and Torres Strait Islander status, 2015–2024



Source: Australian National Notifiable Diseases Surveillance System.

In 2024, infectious syphilis notification rates among Aboriginal and Torres Strait Islander peoples were highest in the Northern Territory (281.4 per 100 000), followed by Western Australia (162.2 per 100 000), and Queensland (118.9 per 100 000). Between 2015 and 2021, infectious syphilis notification rates among Aboriginal and Torres Strait Islander peoples increased in every state and territory apart from the Australian Capital Territory and Queensland. In 2024, notification rates were eight times higher in Western Australia, six times higher in South Australia and four times higher in Queensland and Victoria among Aboriginal and Torres Strait Islander peoples compared with non-Indigenous people in the respective states. Aboriginal and Torres Strait Islander peoples residing in the Northern Territory had the highest notification rates during 2015 to 2020, but Western Australia had the highest rates from 2021–2023, and in 2024 the Northern Territory reported the highest notification rates again (Figure 12).

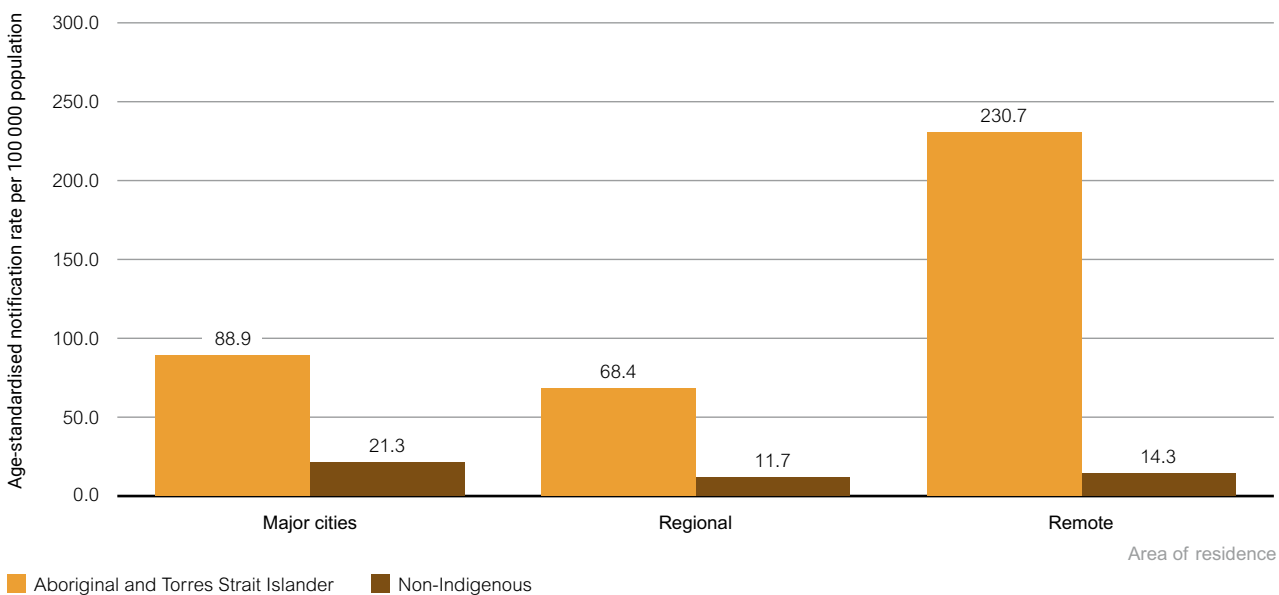
Figure 12 Infectious syphilis notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and jurisdiction, 2015–2024



Source: Australian National Notifiable Diseases Surveillance System.

In 2024, the infectious syphilis notification rate among Aboriginal and Torres Strait Islander peoples in major cities was nearly four times as high as among non-Indigenous people (88.9 vs. 21.3 per 100 000), increasing to six times in regional areas (68.4 vs. 11.7 per 100 000), and 16 times in remote areas (230.7 vs. 14.3 per 100 000) (Figure 13).

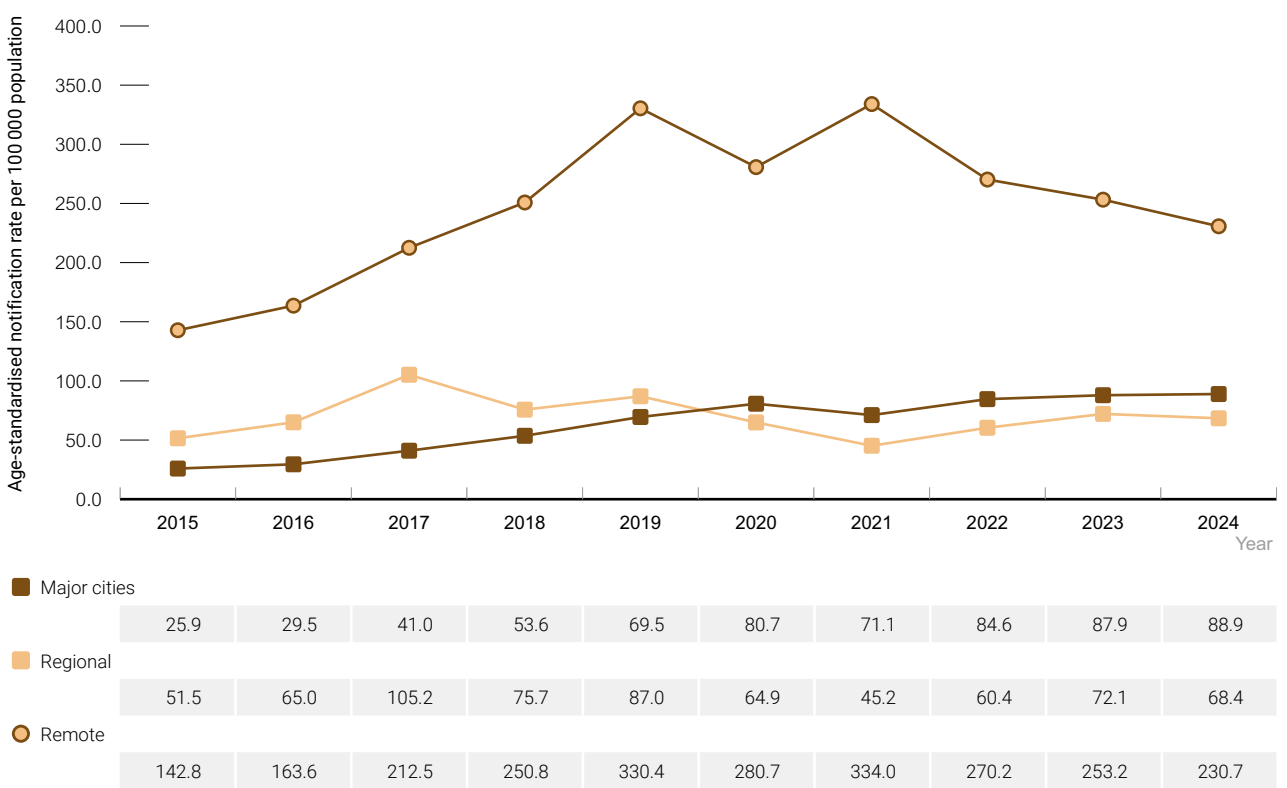
Figure 13 Infectious syphilis notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and area of residence, 2024



Source: Australian National Notifiable Diseases Surveillance System.

Between 2015 and 2024, age standardised infectious syphilis notification rates among Aboriginal and Torres Strait Islander peoples living in major cities, remote areas and regional area increased 3.4 times, 1.5 times and 1.6 times respectively in 2024 (Figure 14).

Figure 14 Infectious syphilis notification rate per 100 000 population by area of residence, 2015–2024

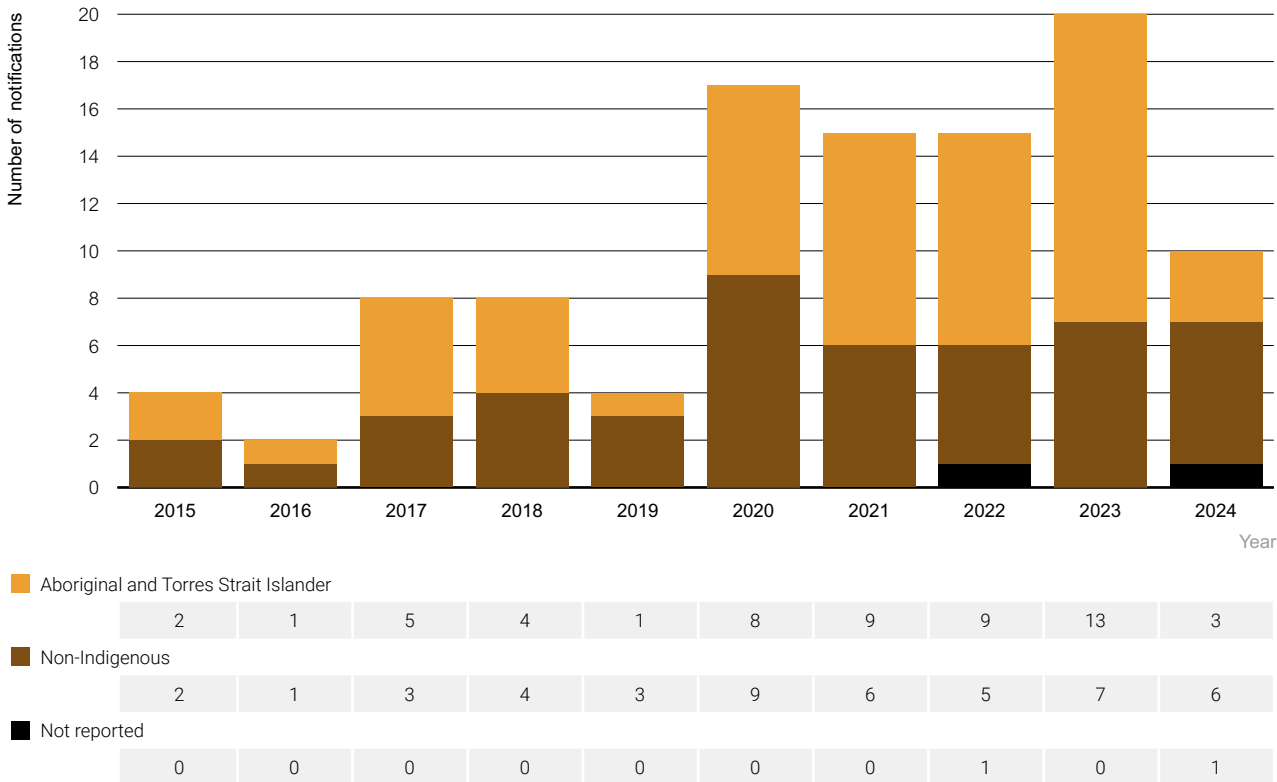


Source: Australian National Notifiable Diseases Surveillance System.

Congenital syphilis

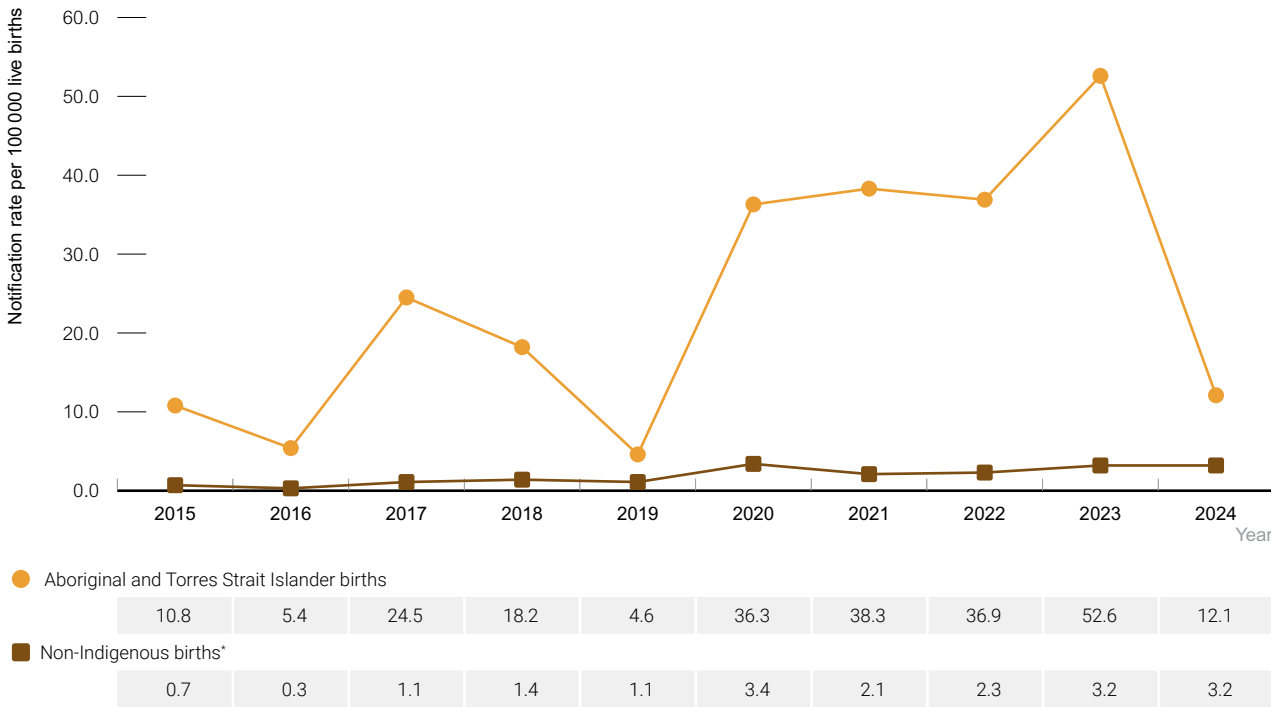
Congenital syphilis occurs when syphilis is passed from a pregnant person to an infant during foetal development or at birth. If untreated, this can result in intrauterine foetal death, stillbirth, neonatal death, or a premature baby. Between 2015 and 2024, more than half (53%) of the 103 congenital syphilis notifications were among Aboriginal and Torres Strait Islander infants, with three notifications reported in 2024 (Figure 15). The congenital syphilis notification rate among Aboriginal and Torres Strait Islander infants was 3.7 times as higher than among non-Indigenous infants (12.1 per 100 000 live births in 2024 in comparison with 3.2 per 100 000 live births in non-Indigenous) (Figure 16).

Figure 15 Number of congenital syphilis cases by Aboriginal and Torres Strait Islander status, 2015–2024



Source: Australian National Notifiable Diseases Surveillance System.

Figure 16 Congenital syphilis rate per 100 000 live births by Aboriginal and Torres Strait Islander status, 2015–2024

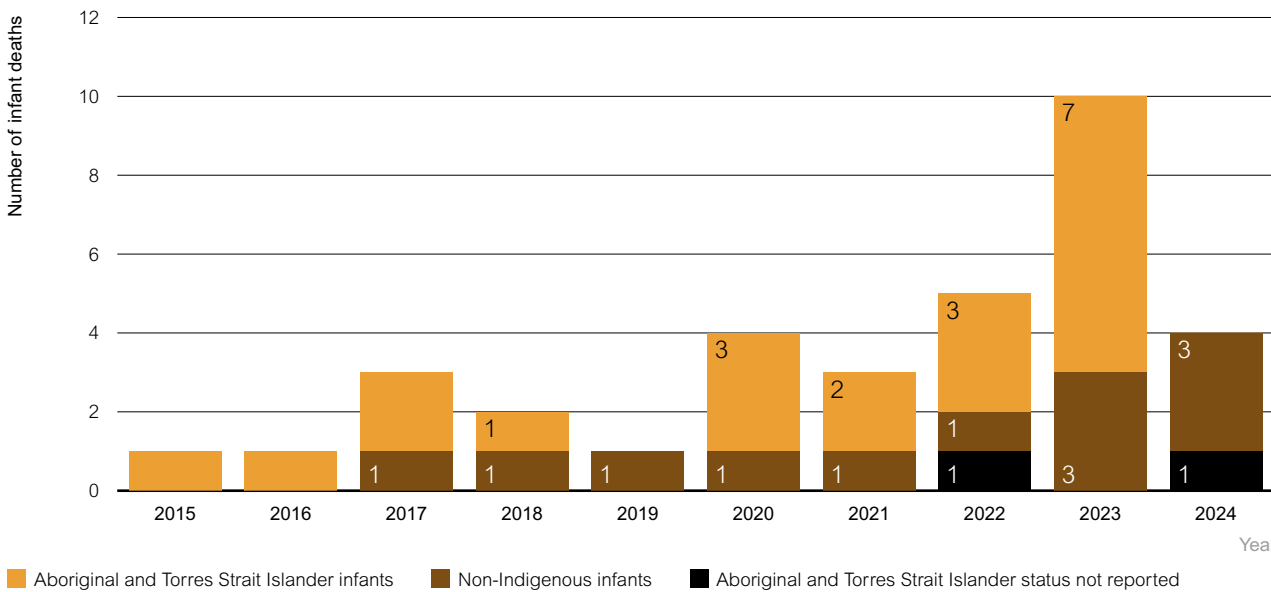


* Includes notifications where Aboriginal and Torres Strait Islander status was not reported.

Source: Australian National Notifiable Diseases Surveillance System.

Of the 103 congenital syphilis cases notified between 2015 and 2024, 34 cases resulted in the death of the infant (including stillbirth). Of these, 20 (59%) were Aboriginal and Torres Strait Islander infants, 12 (35%) were non-Indigenous infants and two deaths (6%) were in infants without a reported Aboriginal and Torres Strait Islander status (Figure 17).

Figure 17 Number of deaths attributed to congenital syphilis by Aboriginal and Torres Strait Islander status, 2015–2024



Source: Australian National Notifiable Diseases Surveillance System.

Chlamydia

Chlamydia is a sexually transmissible infection caused by a specific strain of bacteria known as *Chlamydia trachomatis*. Chlamydia was the most frequently notified STI in Australia in 2024, with a total of 101 742 notifications, of which 9885 (9%) were among Aboriginal and Torres Strait Islander peoples, 48 751 (48%) were in non-Indigenous people, and 43 106 (42%) were people for whom Aboriginal and Torres Strait Islander status was not reported ¹. Details of Aboriginal and Torres Strait Islander chlamydia notifications for the 2020–2024 reporting period are provided in Table 4.

Table 4 Chlamydia notifications in Aboriginal and Torres Strait peoples, by characteristic, 2020–2024

	2020	2021	2022	2023	2024
Characteristic					
Total cases	8253	8481	8960	10 364	9885
Gender^a					
Female	5329	5447	5756	6633	6334
Male	2923	3029	3199	3701	3544
Median age in years	22	24	23	24	24
Age groups					
0-14	211	185	177	210	164
15-19	3104	3217	3429	3713	3430
20-24	2263	2395	2401	2925	2693
25-29	1252	1291	1341	1553	1496
30-39	1001	1053	1174	1417	1516
≥40	422	340	438	546	586
Remoteness					
Major cities	2357	2515	2583	2943	2821
Regional	2866	3012	3161	3502	3273
Remote	2931	2847	3090	3728	3596
Not reported	99	107	126	191	195
State/Territory^{b,c}					
Australian Capital Territory	61	49	49	63	33
New South Wales	1396	1469	1560	1872	1728
Northern Territory	1720	1557	1591	1872	1946
Queensland	3193	3510	3710	4141	3807
South Australia	395	425	378	457	442
Western Australia	1484	1467	1657	1957	1922
Tasmania	2	4	12	0	0

a Excludes 'Not reported'; The National Notifiable Diseases Surveillance System includes the variable 'Sex' to indicate Sex/Gender. For reporting purposes, 'Gender' is used in place of 'Sex'.

b Numbers of notifications in some jurisdictions may be strongly influenced by completeness of Aboriginal and Torres Strait Islander status.

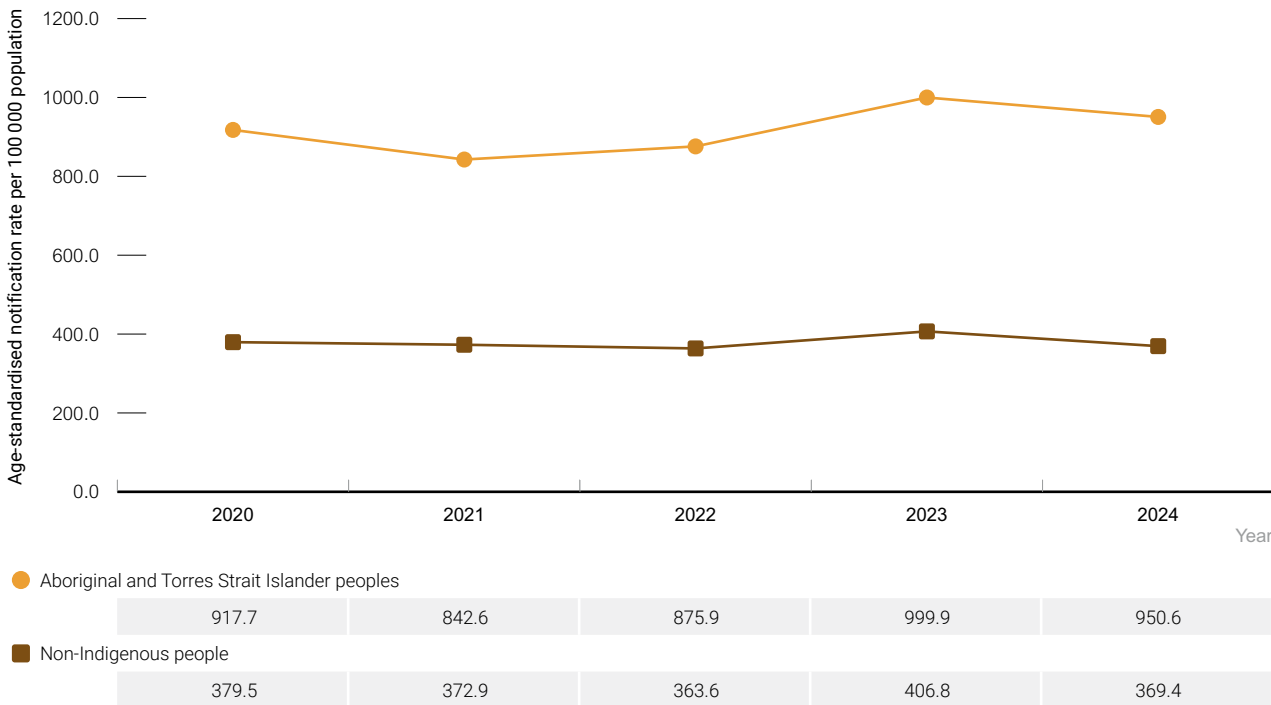
c Victoria data not included as chlamydia is a laboratory notified condition in Victoria and indigenous status is not reported by laboratory.

Source: National Notifiable Diseases Surveillance System.

Notification rates are based on data from five jurisdictions (the Northern Territory, South Australia, Queensland, Western Australia, New South Wales), where Aboriginal and Torres Strait Islander status was at least 50% complete for chlamydia notifications for year from 2020 to 2024.

In 2024, the age standardised chlamydia notification rate for Aboriginal and Torres Strait Islander peoples (950.6 per 100 000) was more than two and a half times that of non-Indigenous people, at 369.4 per 100 000 population (Figure 18).

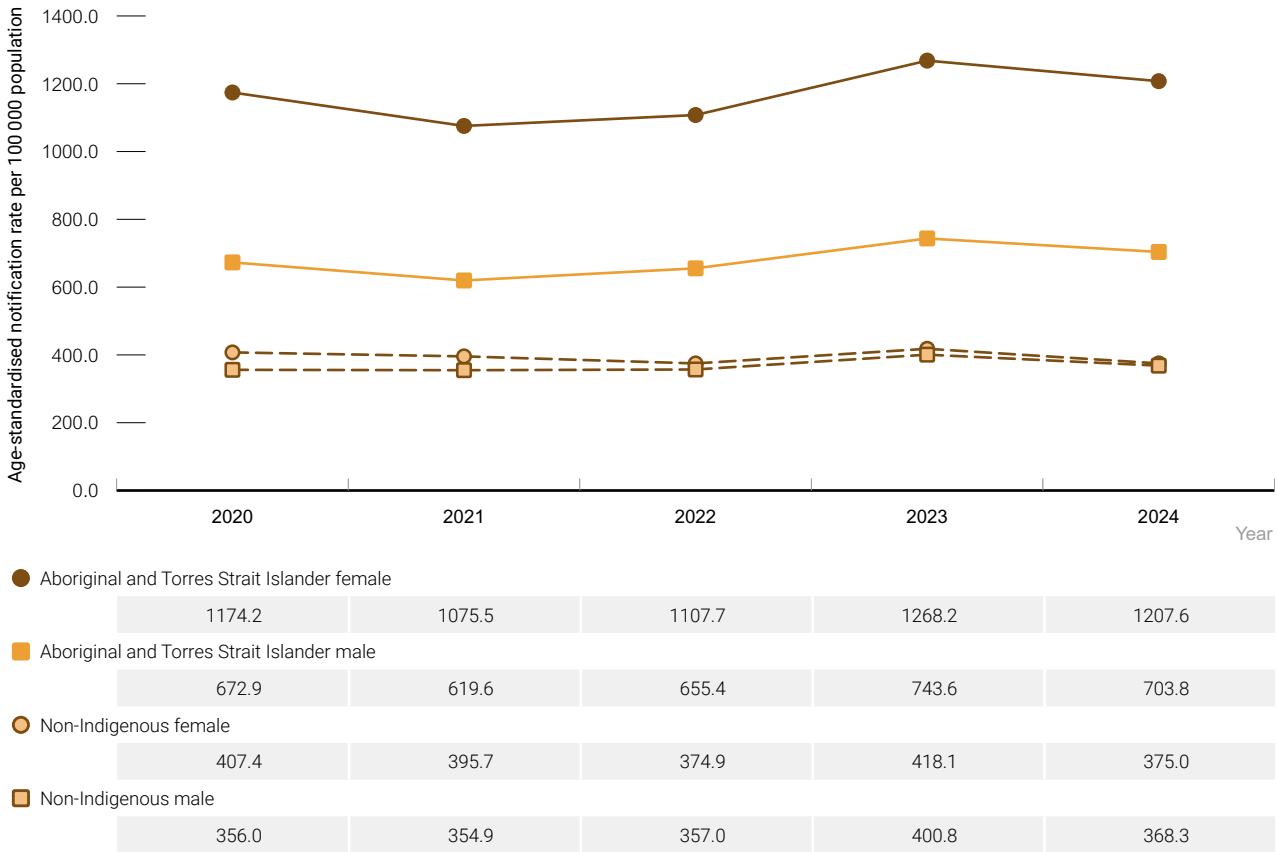
Figure 18 Chlamydia notification rate per 100 000 population by Aboriginal and Torres Strait Islander status, 2020–2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for $\geq 50\%$ of notifications for each year (Northern Territory, South Australia, Western Australia, New South Wales, Queensland).

Between 2020 and 2024, chlamydia notification rates among Aboriginal and Torres Strait Islander males and females remained relatively stable - 672.9 to 703.8 per 100 000 and 1174.2 to 1207.6 per 100 000 respectively. In 2024, the age standardised chlamydia notification rate among Aboriginal and Torres Strait Islander females was over three times as high as compared to non-Indigenous females (1207.6 per 100 000 vs 375.0 per 100 000), and more than one and a half times as high in Aboriginal and Torres Strait Islander males as in non-Indigenous males (703.8 per 100 000 vs 368.3 per 100 000) (Figure 19).

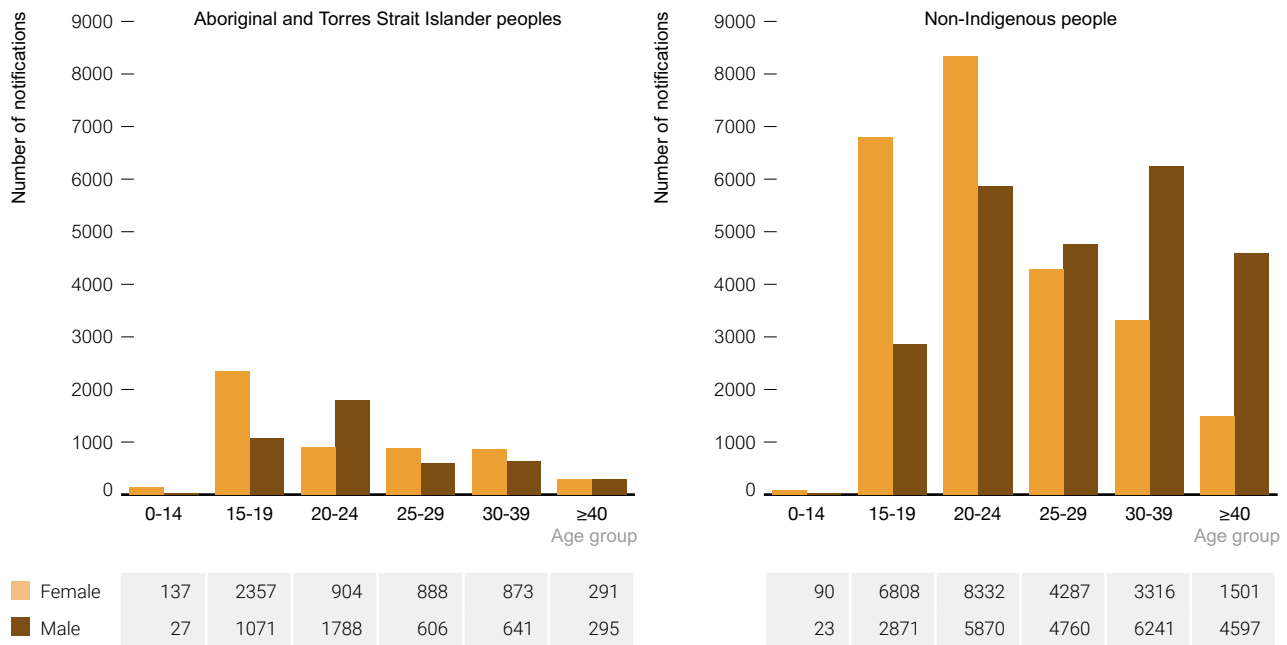
Figure 19 Chlamydia notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and sex, 2020–2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Northern Territory, South Australia, Western Australia, New South Wales, Queensland).

In 2024, 77% of chlamydia notifications among Aboriginal and Torres Strait Islander peoples were aged 15-29 years, with non-Indigenous people accounting for 68% of this age group in. In 2024, of the chlamydia notifications among Aboriginal and Torres Strait Islander peoples, 3544 (35.8%) were among males and 6334 (64%) among females, a male-to-female ratio of 1:1.79 compared to 1:1 in non-Indigenous people (Figure 20). This may reflect differences in health-seeking behaviour and suggests an under-identification of cases of chlamydia among men compared to women.

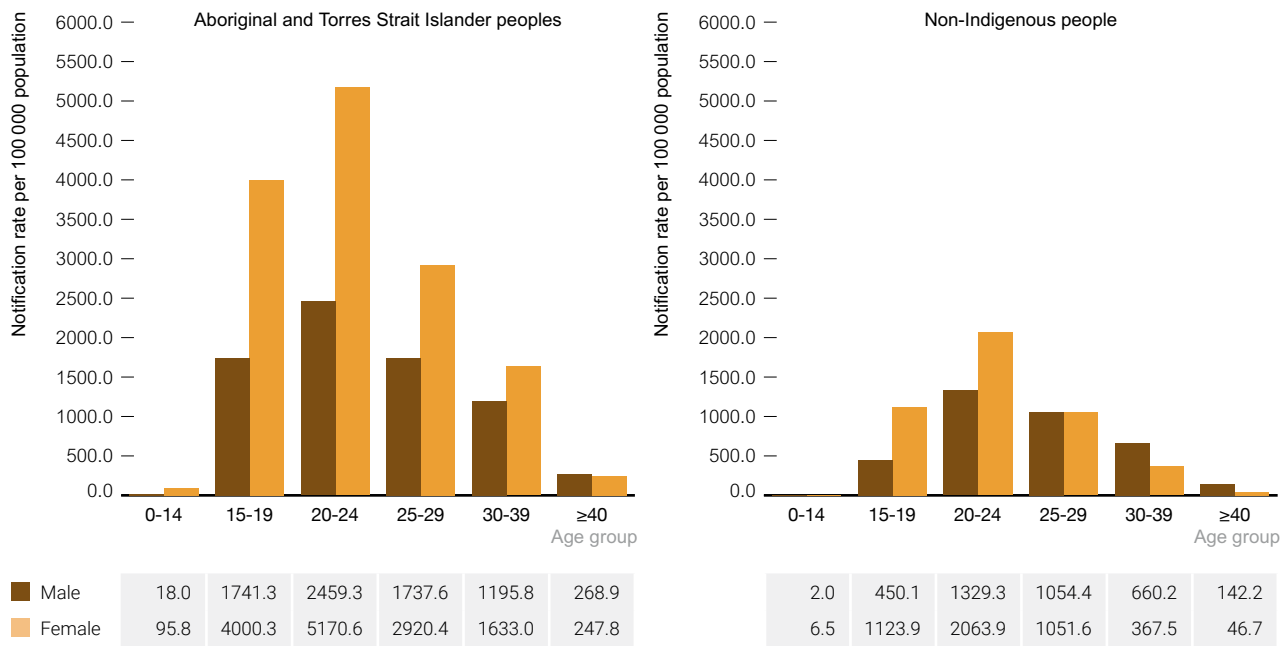
Figure 20 Number of chlamydia notifications by Aboriginal and Torres Strait Islander status, gender, and age group, 2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Northern Territory, South Australia, Western Australia, New South Wales, Queensland).

In 2024, notification rates were highest in Aboriginal and Torres Strait Islander females, aged 20 to 24 years (5170.6 per 100 000 population) followed by those aged 15 to 19 years (4000.3 per 100 000). By age group and gender, the chlamydia notification rate for males aged 15 to 19 years was three times as high among Aboriginal and Torres Strait Islander males as compared to non-Indigenous males (1741.3 per 100 000 vs 450.1 per 100 000) (Figure 21). The chlamydia notification rate for Aboriginal and Torres Strait Islander females aged 15 to 19 was three and a half times as high as the rate in non-Indigenous females in the same age group (4000.3 per 100 000 vs 1123.9 per 100 000). Among Aboriginal and Torres Strait Islander females aged 20 to 24 years old, the rate was nearly two and a half times as high as the rate in non-Indigenous females of the same age group (5170.6 per 100 000 vs. 2063.9 per 100 000) (Figure 21). In the absence of testing data, it is uncertain if the high rates in this age group are attributed solely to higher rates of transmission or due to increased testing.

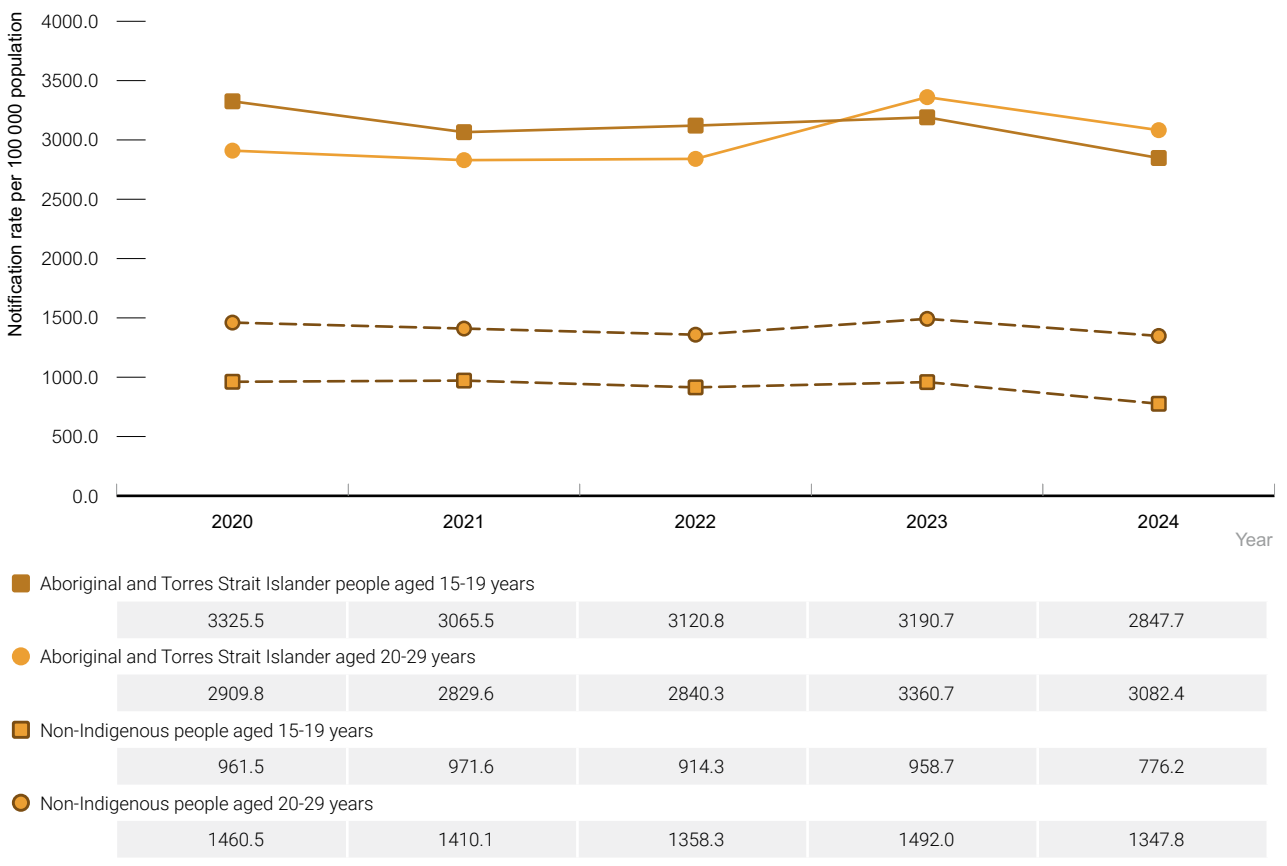
Figure 21 Chlamydia notification rate per 100 000 population by Aboriginal and Torres Strait Islander status, gender and age group, 2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Northern Territory, South Australia, Western Australia, New South Wales, Queensland).

Between 2020 and 2024, the chlamydia notification rate among Aboriginal and Torres Strait Islander peoples aged 15 to 19 years declined by 14.3%, from 3325.5 per 100 000 in 2020 to 2847.7 per 100 000 in 2024. Among Aboriginal and Torres Strait Islander peoples aged 20 to 29 years, notification rates increased by 5.9% from 2909.8 per 100 000 in 2020 to 3082.4 per 100 000 in 2024 (Figure 22). Rates also declined by 19.2% in non-Indigenous people aged 15 to 19 years, from 961.5 per 100 000 in 2020 to 776.2 per 100 000 in 2024. The chlamydia notification rate in non-Indigenous people aged 20 to 29 years remained steady and was 1347.8 per 100 000 in 2024.

Figure 22 Chlamydia notification rate per 100 000 population by Aboriginal and Torres Strait Islander status, by age group, 2020–2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Northern Territory, South Australia, Western Australia, New South Wales, Queensland).

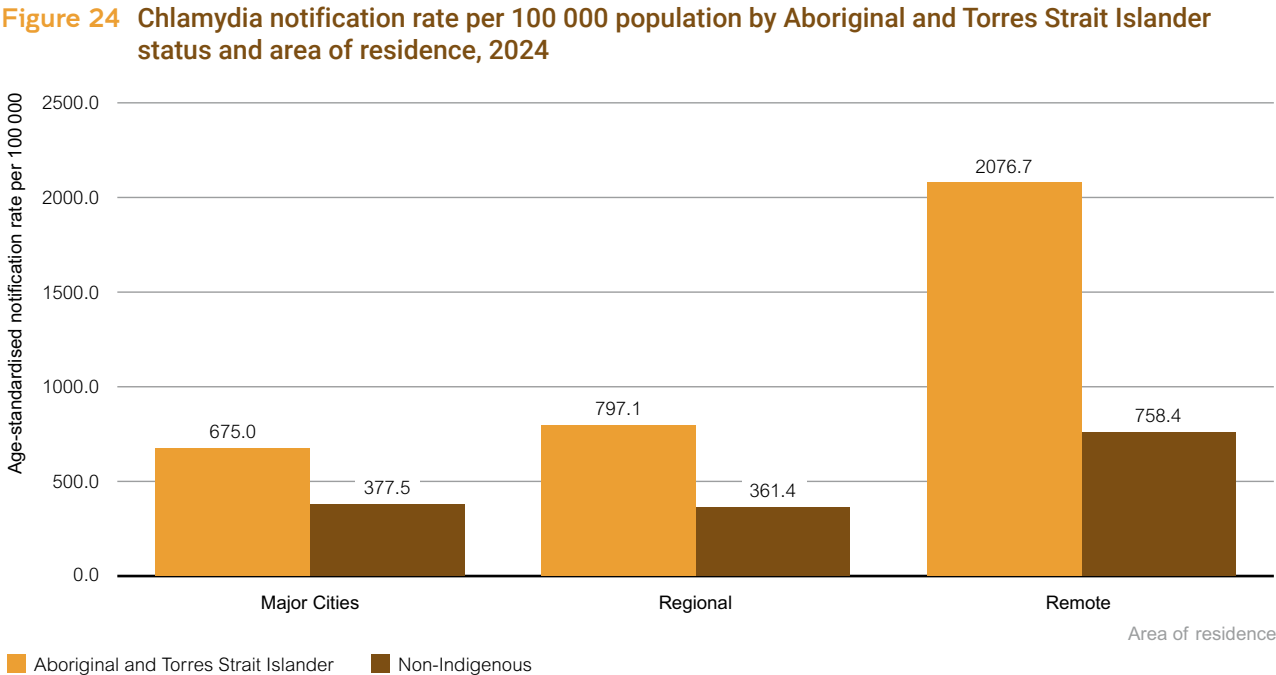
In 2024, chlamydia notification rates among Aboriginal and Torres Strait Islander peoples were highest in the Northern Territory (2095.1 per 100 000), followed by Western Australia (1312.9 per 100 000), and Queensland (1138.1 per 100 000). Chlamydia notification rates among Aboriginal and Torres Strait Islander peoples declined between 2020 and 2022 which is likely related to the impact of COVID-19 public health measures, rates increased again in 2024 in all states and territories except in Queensland. In 2024, notification rates were higher among Aboriginal and Torres Strait Islander peoples compared with non-Indigenous people in every reported state and territory (Figure 23).

Figure 23 Chlamydia notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and State/Territory 2020–2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Northern Territory, South Australia, Western Australia, New South Wales, Queensland).

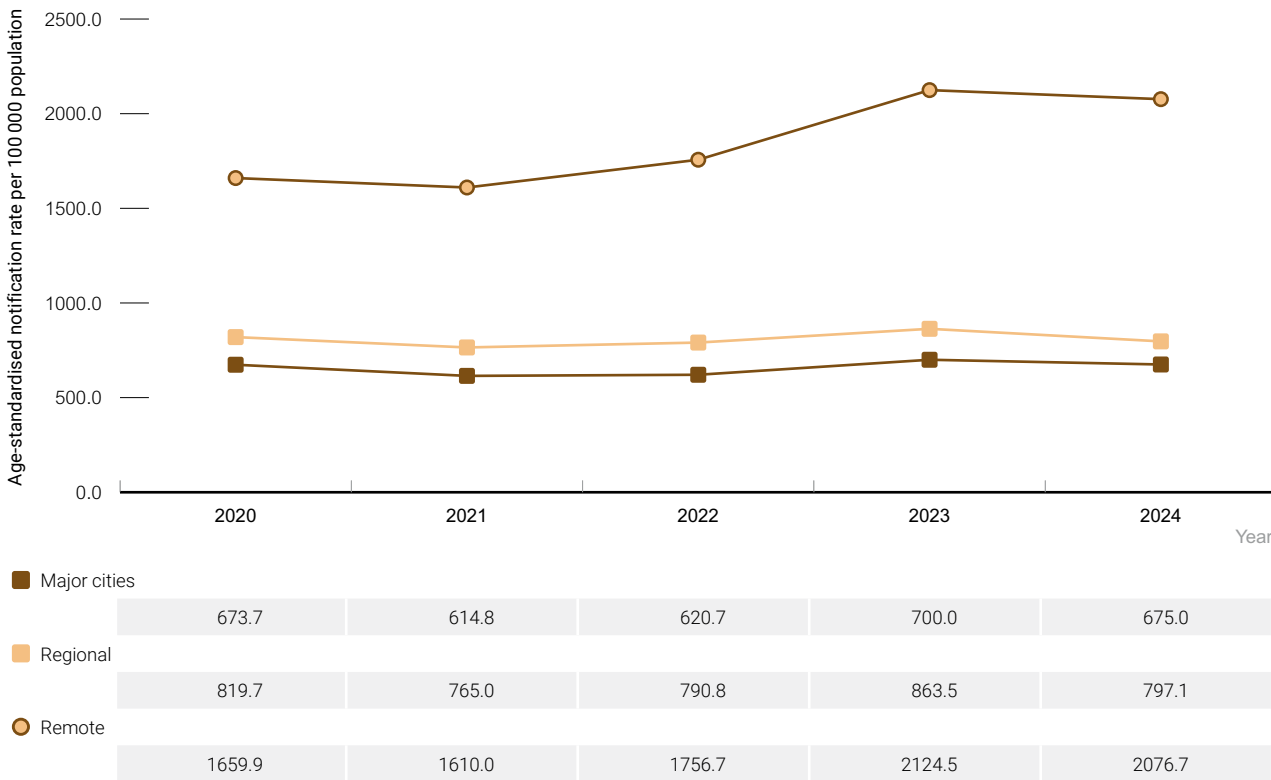
In 2024, the chlamydia notification rate among Aboriginal and Torres Strait Islander peoples compared to non-Indigenous people was higher in all areas of residence. In regional areas the chlamydia notification rates were nearly 2.2 times as high increasing to 2.7 times as high in remote areas (Figure 24).



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Northern Territory, South Australia, Western Australia, New South Wales, Queensland).

Between 2020 and 2024, age standardised chlamydia notification rates among Aboriginal and Torres Strait Islander peoples living in major cities decreased from 673.7 per 100 000 to 675 per 100 000. Similarly, notification rates among Aboriginal and Torres Strait Islander peoples living in regional areas decreased by nearly 2.7% from 819.7 per 100 000 in 2020 to 797.1 per 100 000 in 2024. Among Aboriginal and Torres Strait Islander peoples living in remote areas notification rates fluctuated in last 5 years and increased in 2020 from 1659.9 per 100 000 to 2076.7 per 100 000, with fluctuations throughout this period (Figure 25).

Figure 25 Chlamydia notification rate in Aboriginal and Torres Strait Islander peoples per 100 000 population by area of residence, 2020–2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Northern Territory, South Australia, Western Australia, New South Wales, Queensland).

Gonorrhoea

Gonorrhoea is a sexually transmissible infection caused by the bacterium *Neisseria gonorrhoeae*. There were 44 210 gonorrhoea notifications in Australia in 2024. Of these, 5934 (13%) were among Aboriginal and Torres Strait Islander peoples, 29 622 (67%) were in non-Indigenous people, and 8654 (19.5%) were in people for whom Aboriginal and Torres Strait Islander status was not reported (Table 5).

In 2024, the ratio of male to female gonorrhoea notifications among Aboriginal and Torres Strait Islander peoples was 0.9:1 compared with 3.2:1 in non-Indigenous people (data not shown). This suggests that transmission among Aboriginal and Torres Strait Islander peoples may be more likely to occur through heterosexual transmission whereas in non-Indigenous people, transmission is more likely to occur among men who have sex with men.

Table 5 Gonorrhoea notifications among Aboriginal and Torres Strait Islander people, by characteristic, 2020–2024

	2020	2021	2022	2023	2024
Characteristic					
Total cases	4610	4811	5285	6093	5934
Gender^a					
Female	2445	2532	2817	3414	3187
Male	2165	2278	2464	2670	2746
Median age in years	22	24	23	24	24
Age group					
0-14	127	137	95	156	92
15-19	1322	1331	1466	1661	1468
20-24	1027	1125	1197	1424	1372
25-29	858	845	935	1092	1022
30-39	933	1023	1145	1245	1389
≥40	343	350	447	515	591
Remoteness					
Major cities	1228	1056	1117	1416	1728
Regional	1007	1100	1175	1355	1268
Remote	2316	2585	2920	3209	2845
Not reported	59	70	73	113	93
State/Territory^b					
Australian Capital Territory	12	21	27	36	25
New South Wales	443	409	492	606	604
Northern Territory	1189	1495	1819	2036	1934
Queensland	1144	1198	1246	1458	1366
South Australia	370	485	410	501	428
Tasmania	21	18	17	32	26
Victoria	78	74	81	167	154
Western Australia	1353	1111	1193	1257	1397

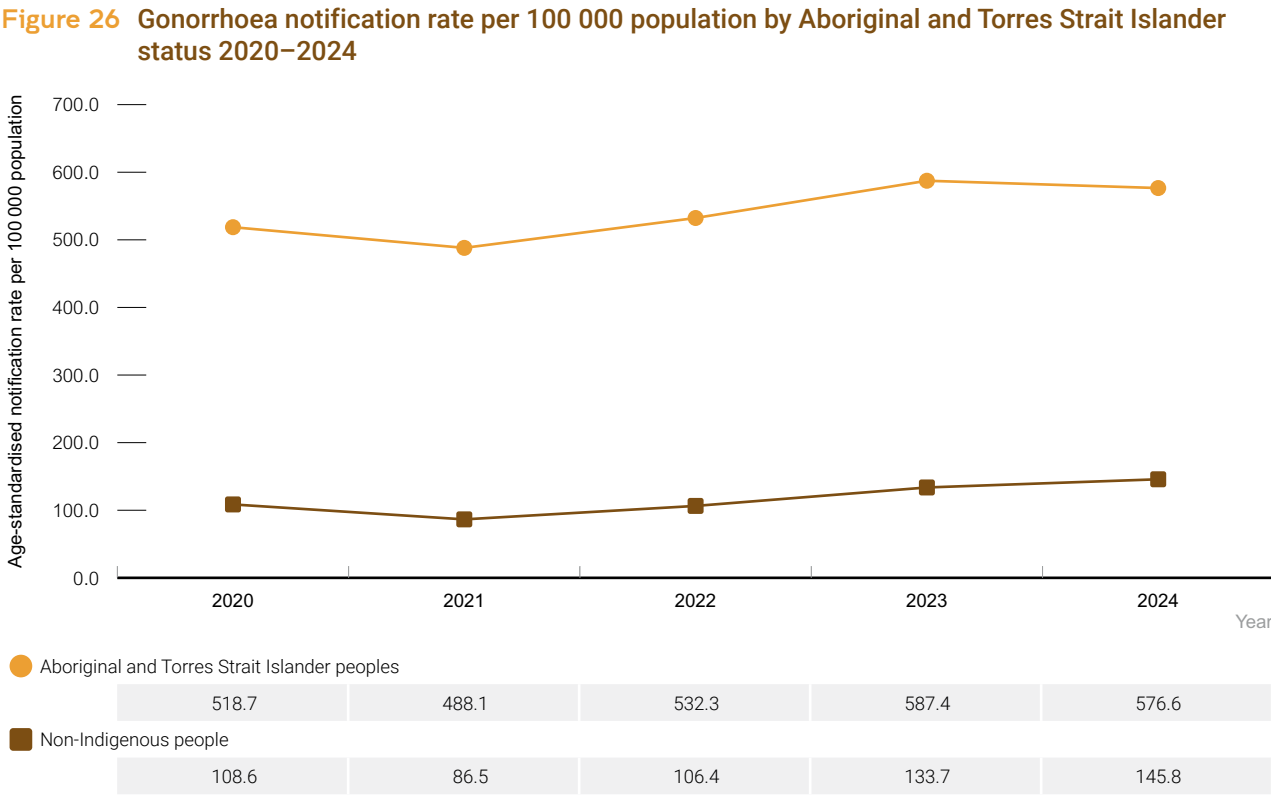
a Excludes 'Not reported'.

b Numbers of notifications in some jurisdictions may be strongly influenced by completeness of Aboriginal and Torres Strait Islander status.

Source: National Notifiable Diseases Surveillance System.

In the period 2020–2024, Aboriginal and Torres Strait Islander status was at least 50% complete in each year in all states and territories, except Victoria. Hence, Victoria is excluded for the data presented in the figures below.

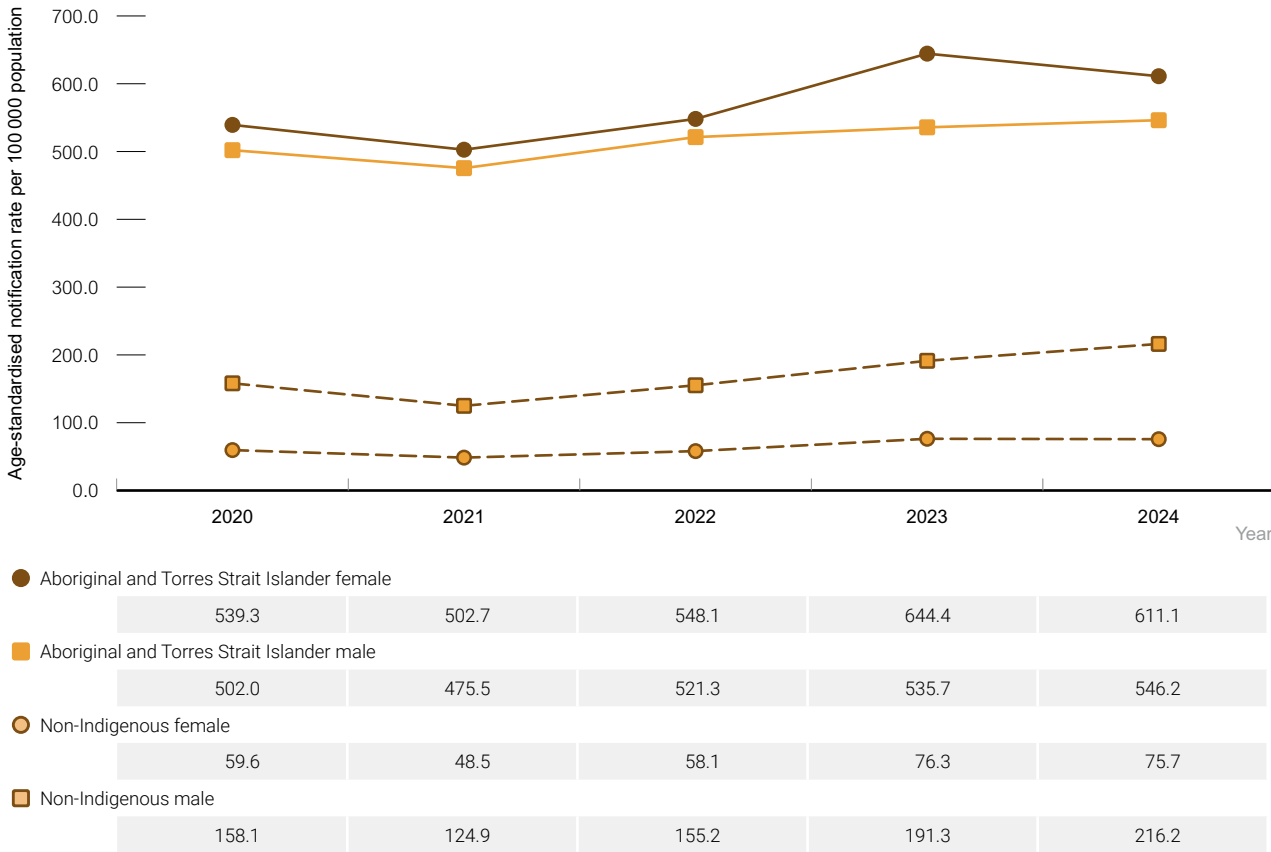
The age-standardised gonorrhoea notification rate for Aboriginal and Torres Strait Islander peoples in 2024 was almost four times that of non-Indigenous people (576.6 and 145.8 per 100 000 population, respectively). Between 2020 and 2024 the gonorrhoea notification rate among Aboriginal and Torres Strait Islander peoples increased by 11% (518.7 per 100 000 vs 576.6 per 100 000) (Figure 26). The increase in gonorrhoea rates each year from 2021 are in the context of overall declines in other BBVs and STIs during the COVID-19 pandemic.



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Indigenous status was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, South Australia, Western Australia, Queensland, Tasmania and New South Wales).

In 2024, the age standardised gonorrhoea notification rate for Aboriginal and Torres Strait Islander females was almost eight times that of non-Indigenous females (611.1 and 75.7 per 100 000, respectively) (Figure 27). The gonorrhoea notification rate for Aboriginal and Torres Strait Islander males in 2024 was more than two and a half times that of non-Indigenous males (546.2 and 216.2 per 100 000, respectively). Gonorrhoea notification rates among Aboriginal and Torres Strait Islander males and females increased between 2020 and 2024 by 9% and 13%, respectively (Figure 27).

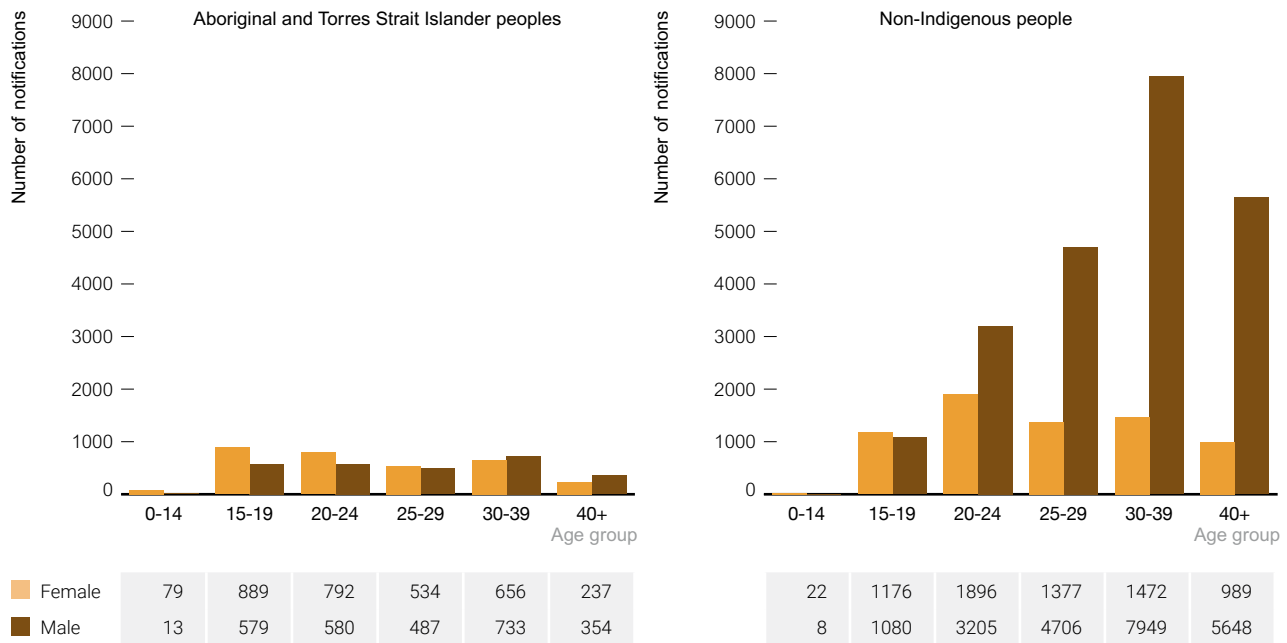
Figure 27 Gonorrhoea notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and sex, 2020–2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Indigenous status was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, South Australia, Western Australia, Queensland, Tasmania and New South Wales).

Differences in age at notification exist between Aboriginal and Torres Strait Islander peoples and non-Indigenous people. In 2024, the greatest proportion of gonorrhoea notifications among Aboriginal and Torres Strait Islander peoples occurred among those aged 15 to 19 years (25%). By comparison the highest proportion of notifications in non-Indigenous people in 2024 occurred among those aged 30 to 39 years (32%) (Figure 28).

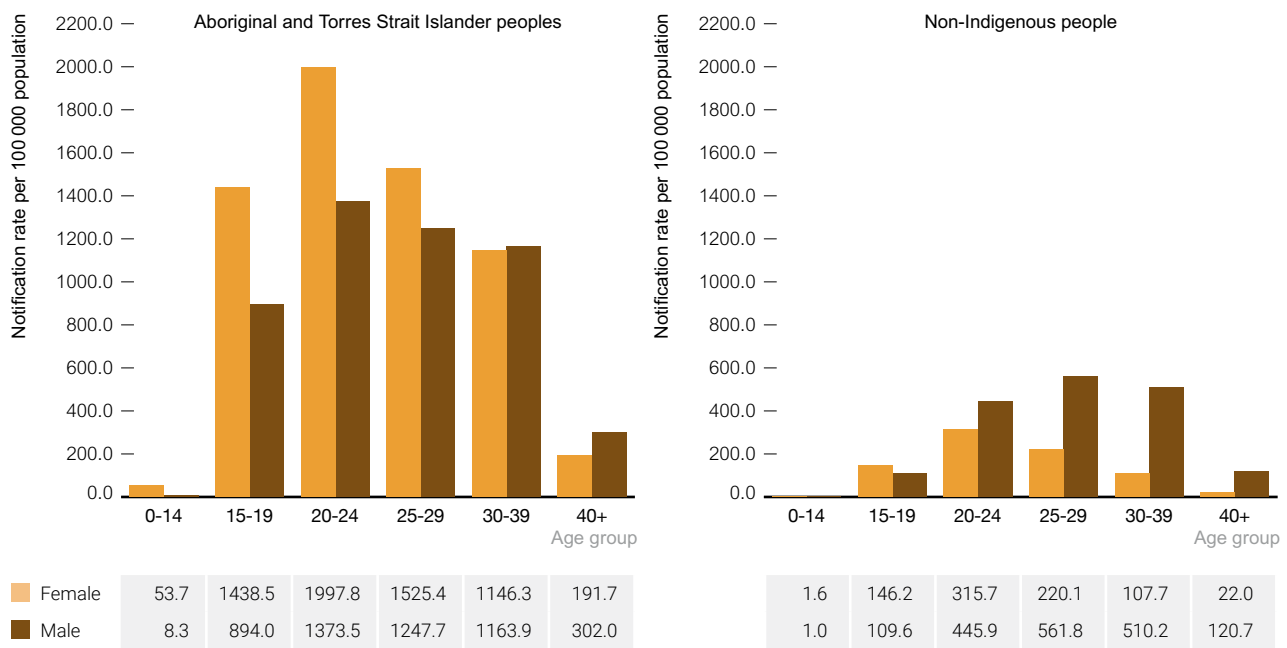
Figure 28 Number of gonorrhoea notifications by Aboriginal and Torres Strait Islander status, gender, and age group, 2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Non-Indigenous people was reported for $\geq 50\%$ of notifications for each year (Australian Capital Territory, Northern Territory, South Australia, Western Australia, Queensland, Tasmania and New South Wales).

Gonorrhoea notification rates among Aboriginal and Torres Strait Islander peoples were significantly higher than in non-Indigenous people across all age groups for both males and females (Figure 29). Notification rates were more than nine times as high among Aboriginal and Torres Strait Islander females aged 15 to 19 years than among non-Indigenous females of the same age group (1438.5 and 146.2 per 100 000, respectively). In the 15-19 year age group, the gonorrhoea notification rate was eight times as high among Aboriginal and Torres Strait Islander males as compared to non-Indigenous males (894.0 and 109.6 per 100 000, respectively).

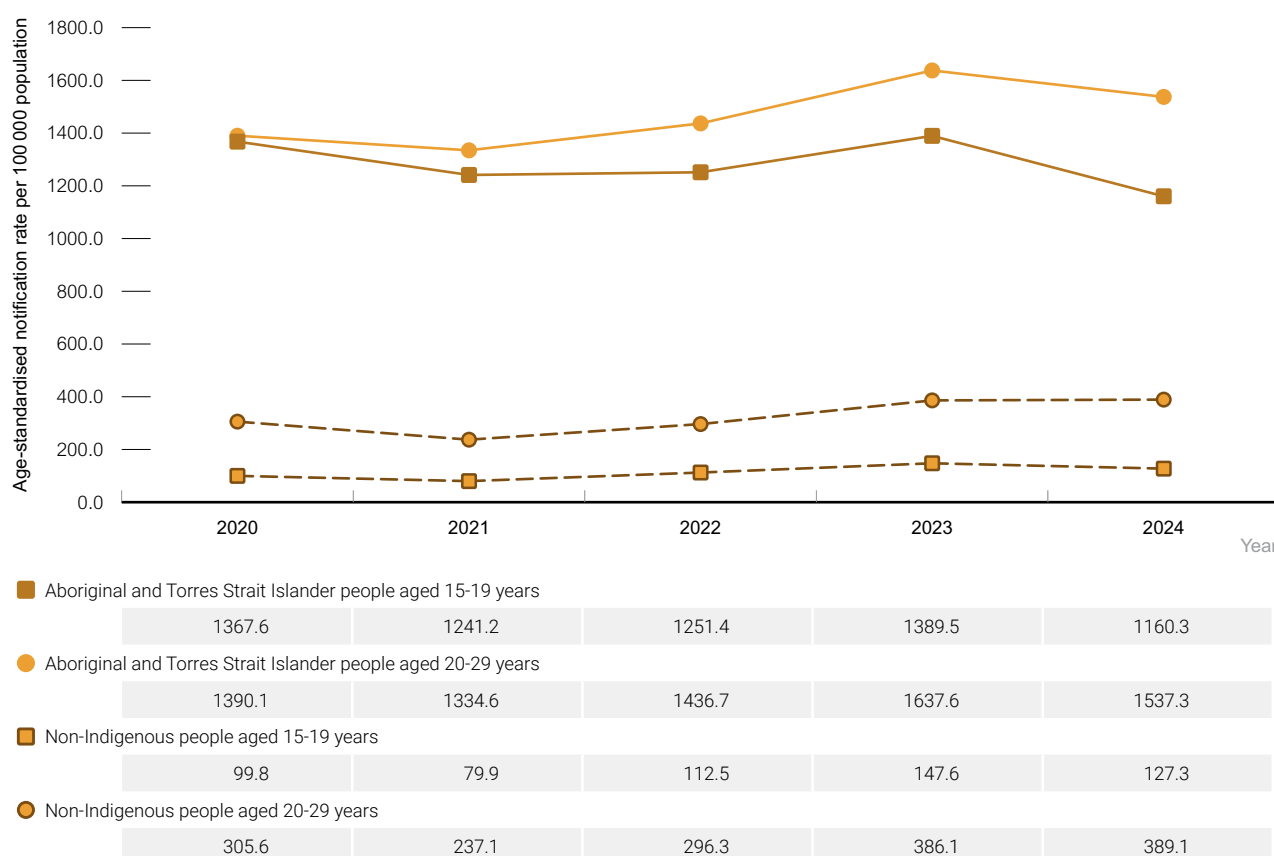
Figure 29 Gonorrhoea notification rate per 100 000 population by Aboriginal and Torres Strait Islander status, gender and age group 2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Non-Indigenous people was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, South Australia, Western Australia, Queensland, Tasmania and New South Wales).

The gonorrhoea notification rate among Aboriginal and Torres Strait Islander peoples aged 15 to 19 years was relatively unchanged between 2020 and 2024 and was 1160.3 per 100 000 in 2024 (Figure 30). Among Aboriginal and Torres Strait Islander peoples aged 20 to 29 years, the gonorrhoea notification rate increased by 17% from 1390.1 per 100 000 in 2020 to 1537.3 per 100 000 in 2024 (Figure 30). In 2024, the gonorrhoea notification rate in those aged 15-19 years among Aboriginal and Torres Strait Islander peoples was nine times as high as compared to non-Indigenous people. Also in 2024, the gonorrhoea notification rate in those aged 20 to 29 years, among Aboriginal and Torres Strait Islander peoples was nearly four times as high as compared to non-Indigenous people (Figure 30).

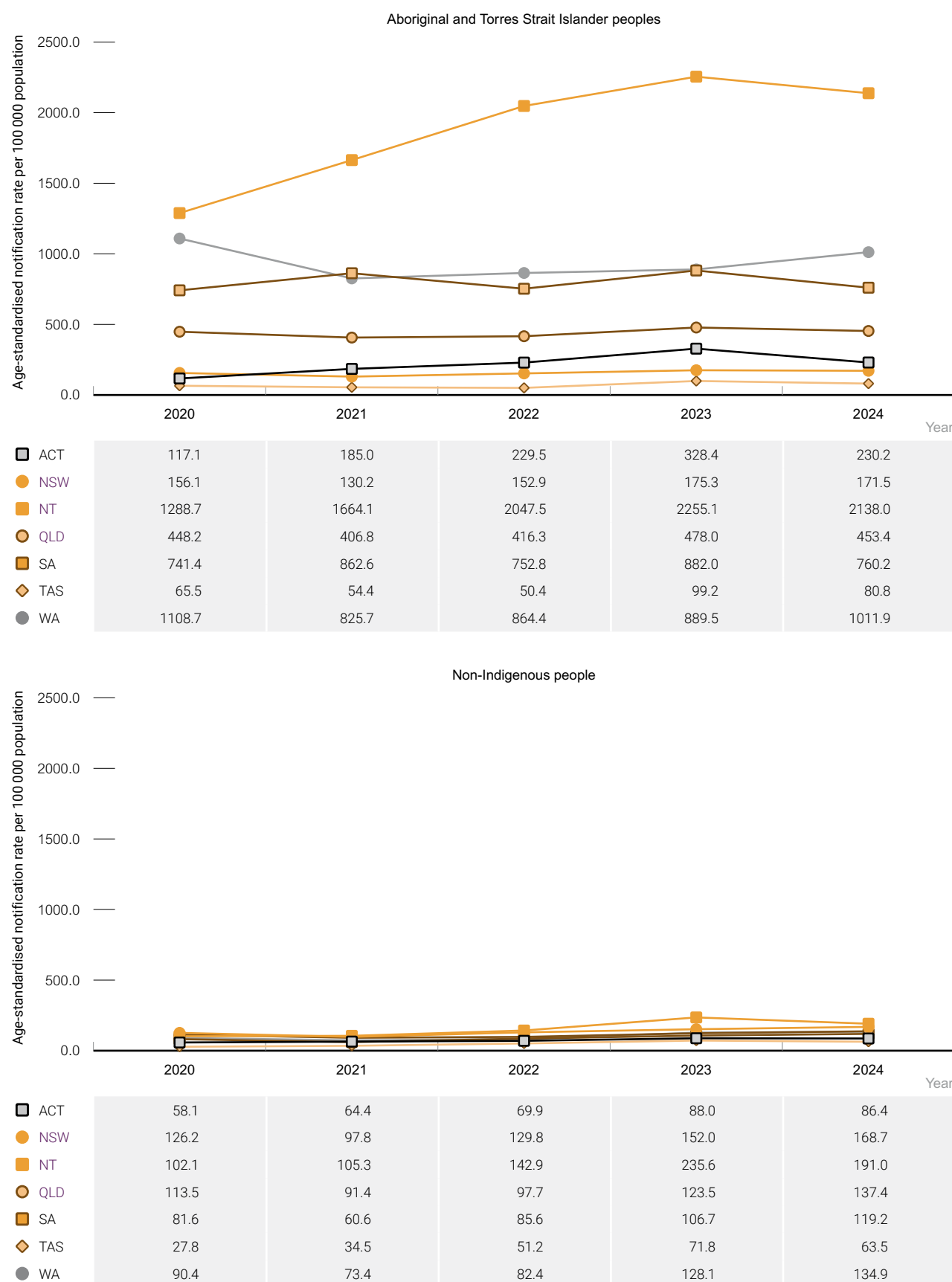
Figure 30 Gonorrhoea notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and age group, 2020–2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Non-Indigenous people was reported for $\geq 50\%$ of notifications for each year (Australian Capital Territory, Northern Territory, South Australia, Western Australia, Queensland, Tasmania and New South Wales).

In 2024, age standardised gonorrhoea notification rates among Aboriginal and Torres Strait Islander peoples were highest in the Northern Territory (2138.0 per 100 000), followed by Western Australia (1011.9 per 100 000), and South Australia (760.2 per 100 000). Despite declines in testing due to the COVID-19 pandemic, gonorrhoea notification rates among Aboriginal and Torres Strait Islander peoples increased in the Australian Capital Territory, Northern Territory and Tasmania between 2020 and 2022. In comparison, notification rates in New South Wales, Queensland, South Australia and Western Australia fluctuated. In 2024, notification rates in Queensland were more than three times as high among Aboriginal and Torres Strait Islander peoples compared with non-Indigenous people, 11 times as high in the Northern Territory, seven times higher in Western Australia and three times higher in Queensland (Figure 31).

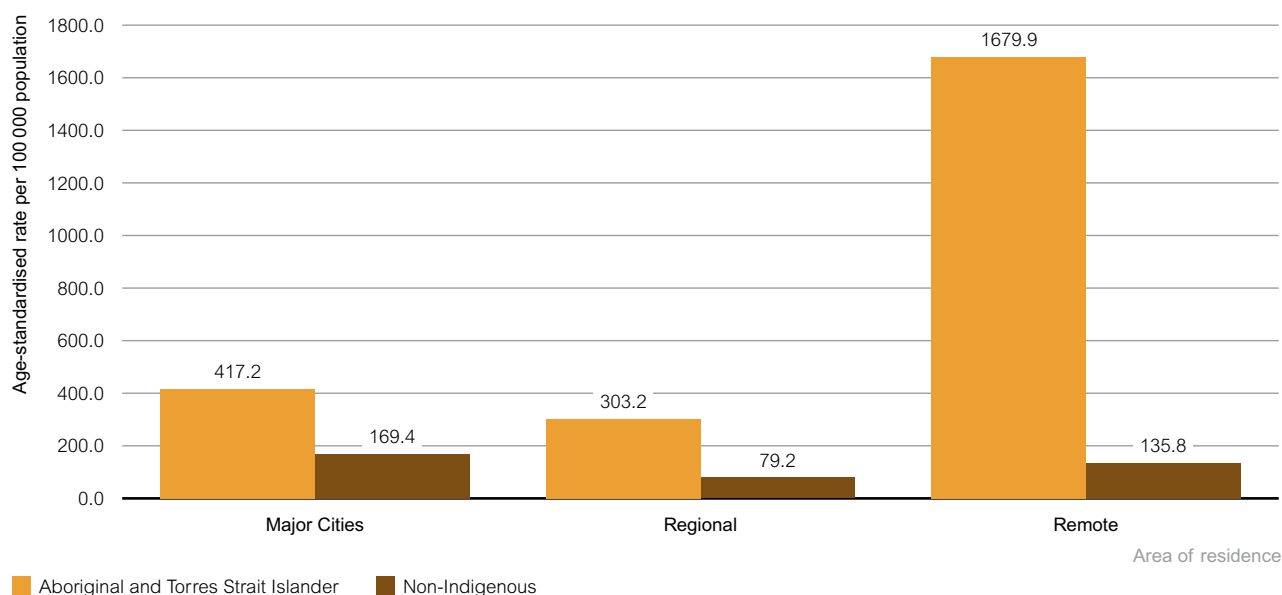
Figure 31 Gonorrhoea notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and state/ territory, 2020–2024



Source: Australian National Notifiable Diseases Surveillance System. Includes all jurisdictions except Victoria, as Aboriginal and Torres Strait Islander status was reported for $\geq 50\%$ of notifications for each year.

In 2024, the age standardised gonorrhoea notification rate among Aboriginal and Torres Strait Islander peoples living in major cities, was 2.4 times as high compared to non-Indigenous people (417.2 vs 169.4 per 100 000), 3.8 times as high in regional areas (303.2 vs. 79.2 per 100 000), and almost 12 times as high in remote areas (1679.9 vs. 135.8 per 100 000) (Figure 32).

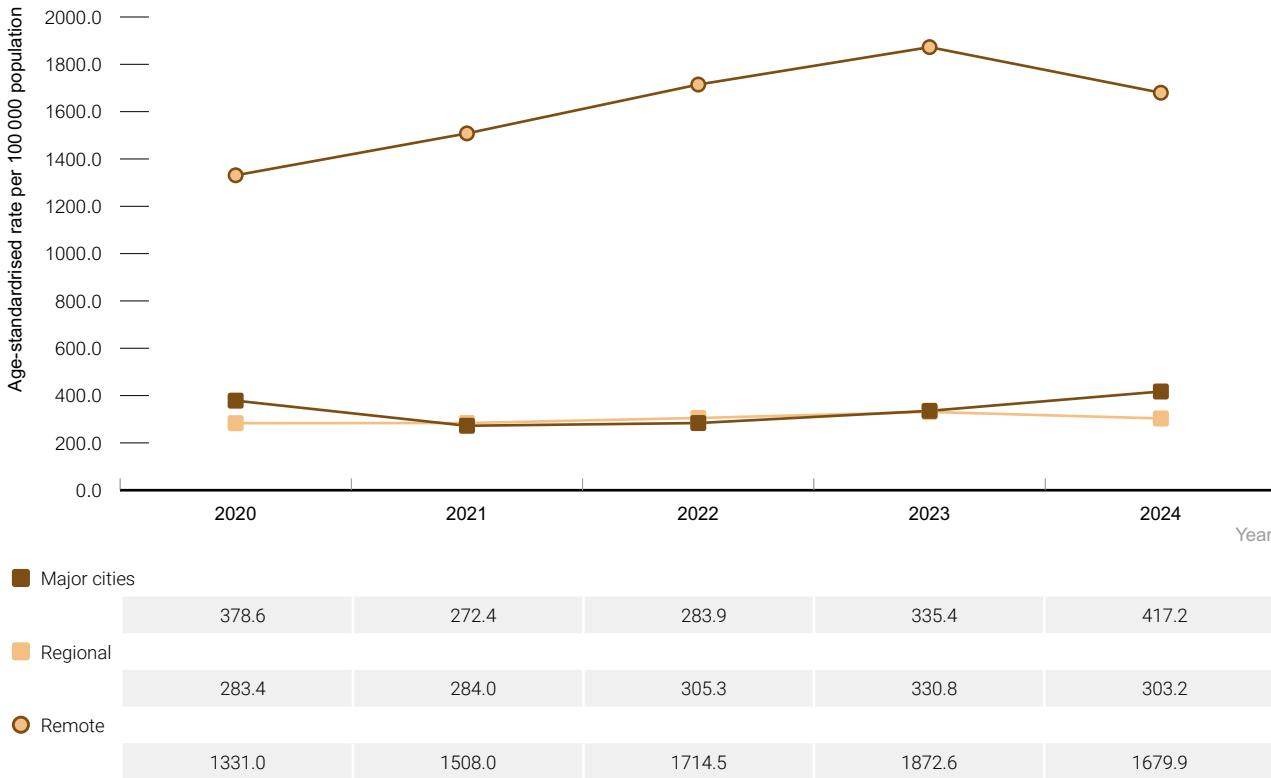
Figure 32 Gonorrhoea notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and area of residence, 2024



Source: Australian National Notifiable Diseases Surveillance System. Includes all jurisdictions except Victoria, as Aboriginal and Torres Strait Islander status was reported for $\geq 50\%$ of notifications for each year.

Between 2020 and 2024, notification rates among Aboriginal and Torres Strait Islander peoples fluctuated for people living in major cities and regional areas. Amongst Aboriginal and Torres Strait Islander peoples living in remote areas, rates increased year on year between 2020 and 2023 then declined to 417.2 per 100 000 in 2024 (Figure 33).

Figure 33 Gonorrhoea notification rate in Aboriginal and Torres Strait Islander peoples per 100 000 population by area of residence, 2020–2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Non-Indigenous people was reported for $\geq 50\%$ of notifications for each year (Australian Capital Territory, Northern Territory, South Australia, Western Australia, Queensland, Tasmania and New South Wales).

Donovanosis

The National Donovanosis Eradication (Elimination) Project was implemented in 2001–2004, following the introduction of improved methods of diagnosis and treatment of donovanosis. The project employed strategies such as targeted surveillance, high-quality education, and support of primary healthcare workers in their management of genital ulcerative disease, intermittent or short-course oral medication and new laboratory techniques.

Donovanosis is now extremely rare in Australia. Donovanosis, which was once a frequently diagnosed STI among remote Aboriginal and Torres Strait Islander populations appears to have been eliminated. There have been no cases since 2015.

Human papillomavirus

Human papillomavirus (HPV) types 16 and 18 cause 70% to 80% of cervical cancer and about half of high-grade cervical intraepithelial neoplasia (CIN grade 2 or 3) lesions, and genotypes 6 and 11 cause most cases of genital warts. In Australia, the nonavalent HPV vaccine (types 6, 11, 16, 18, 31, 33, 45, 52 and 58) is provided free in school to all students aged 12-13 years under the National HPV Vaccination Program, in a single dose schedule. The vaccine type and schedule has changed over time, however the program began in 2007 for females aged 12-13 years and was extended in 2013 to include males the same age.

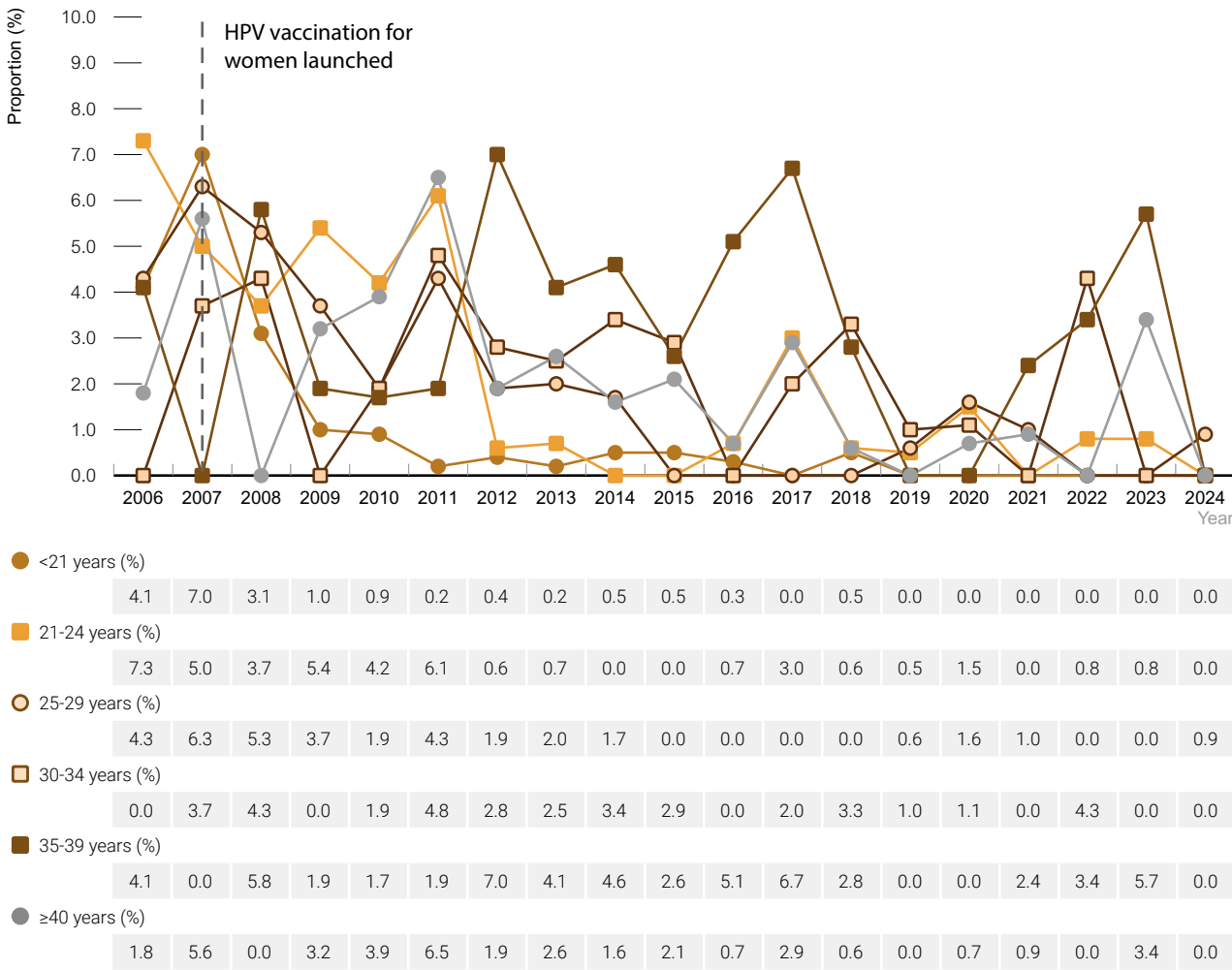
Catch-up programs through schools, general practices and community immunisation services were run from 2007 to 2009 for females aged 14-26 years, and from 2013 to 2015 for males aged 14-15 years ⁶. Data on HPV vaccination coverage is currently not available by Aboriginal and Torres Strait Islander status but will be available in the future. The Genital Warts Surveillance Network is a sentinel surveillance system that includes over 50 sexual health clinics across Australia and provides evaluation of the population-level effects of the National HPV Vaccination Program. The network monitors epidemiological trends of genital wart diagnoses by collecting routinely collected de-identified electronic medical record data on demographics, sexual behaviours, and genital wart clinical diagnoses from the clinics.

Following the introduction of vaccination against HPV in 2007, a decline has been seen in the number of diagnoses of genital warts at first visit at sexual health clinics (see the [HIV, viral hepatitis and sexually transmissible infections in Australia: annual surveillance report 2025](#) for further detail). Information available from sexual health clinics participating in the Genital Warts Surveillance Network within the Australian Collaboration for Coordinated Enhanced Sentinel Surveillance (ACCESS) system indicates a considerable reduction in the proportion of both Aboriginal and Torres Strait Islander males and females under 30 notified with genital warts at their first visit since 2007.

Among Aboriginal and Torres Strait Islander females aged less than 21 years, the proportion diagnosed with genital warts at first visit declined from 4.1% in 2006 to 0.0% in 2024. Among women aged 21 to 24 years and 25-29 years, the proportion diagnosed with genital warts reduced from 7.3% in 2006 to 0.0% and from 4.3% to 0.0%, respectively, in 2024. The proportion of Aboriginal and Torres Strait Islander women aged 35-39 years diagnosed with genital warts diagnoses increased from 4.1% in 2006 to 5.7% in 2023 then declined to 0.0% in 2024 (Figure 34).

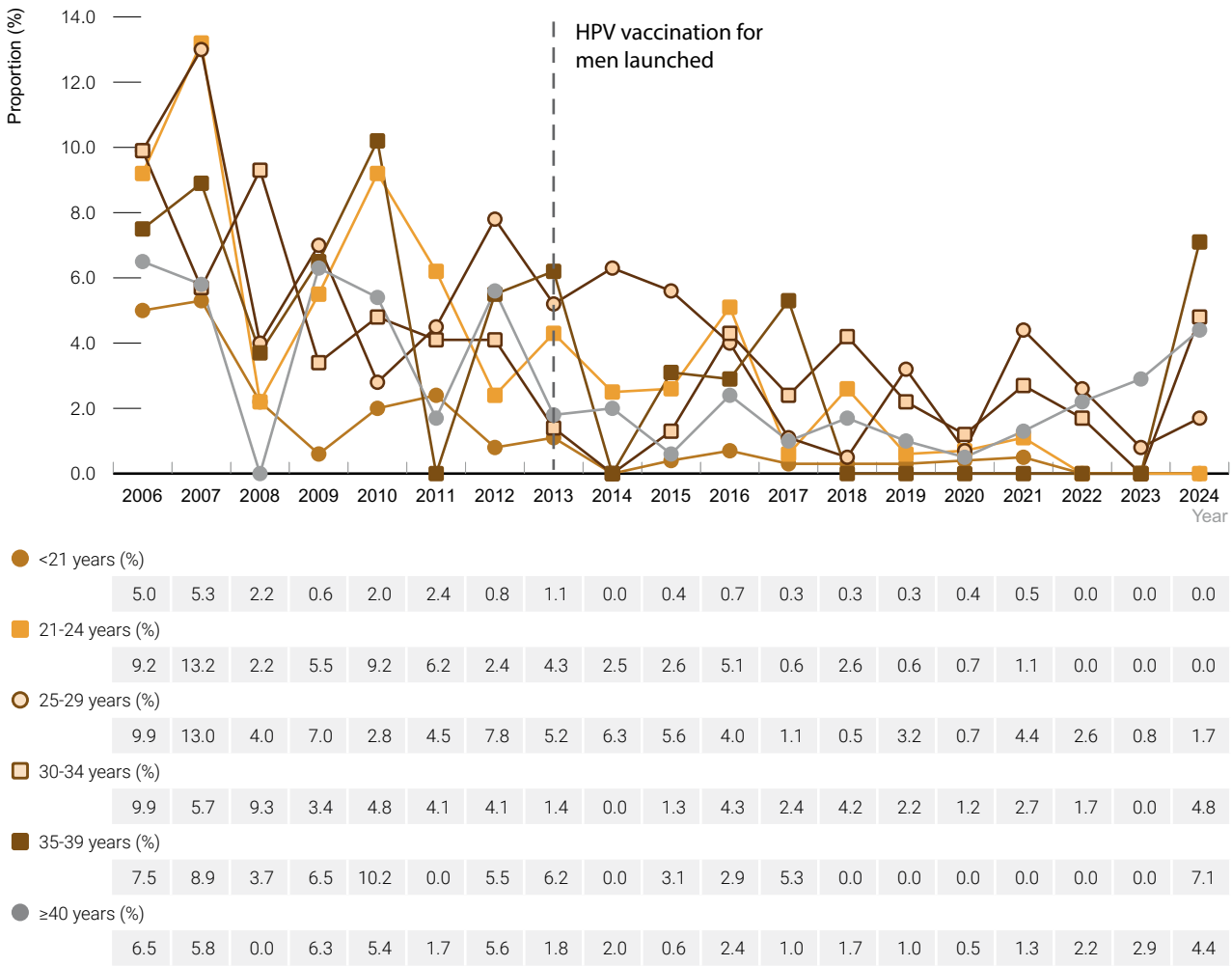
Among Aboriginal and Torres Strait Islander males aged less than 21 years, the proportion diagnosed with genital warts at first visit declined from 5.0% in 2006 to 0.0% in 2024. Among men aged 21 to 29 years the proportion diagnosed with genital warts reduced from 13.5% in 2007 to 0.0% in 2024. The proportion of Aboriginal and Torres Strait Islander men aged 30-34 years or older diagnosed with genital warts diagnoses declined from 9.9% in 2006 to 4.8% in 2024. The proportion of Aboriginal and Torres Strait Islander men aged 35-39 years or older diagnosed with genital warts diagnoses remained stable from 7.5% in 2006 to 7.1% in 2024, after declining between 2013 and 2023 (Figure 35).

Figure 34 Proportion of Aboriginal and Torres Strait Islander women notified with genital warts at first visit at sexual health clinics by age group, 2006–2024



Source: ACCESS (Australian Collaboration for Coordinated Enhanced Sentinel Surveillance); Genital Wart Surveillance Network.

Figure 35 Proportion of Aboriginal and Torres Strait Islander men notified with genital warts at first visit at sexual health clinics, by age group 2006–2024



Source: ACCESS (Australian Collaboration for Coordinated Enhanced Sentinel Surveillance); Genital Wart Surveillance Network.

4 HIV

Please see p. 8 for summary.

HIV notifications

All jurisdictions have high completeness rates (>95%) for the reporting of Aboriginal and Torres Strait Islander status for HIV notifications over the ten years of reporting (2015–2024) and thus data from all jurisdictions are included. There were 757 new HIV notifications in Australia in 2024, of which 23 (3%) were among Aboriginal and Torres Strait Islander peoples. Of these 23 notifications, 19 were among males and four among females. The median age at diagnosis was 36 years (Table 6).

In the 10 year period, the highest number of HIV notifications was reported in 2016 (47) and has been lower in all subsequent years. There were 23 HIV notifications among Aboriginal and Torres Strait Islander peoples in 2024, which represents stable numbers of notifications in the last three years, after a decline in 2020 and 2021, likely influenced by COVID-19 public health measures. A similar trend was seen among males and females with more notifications among males than females for every year from 2015 to 2024.

Table 6 Characteristics of HIV notifications among Aboriginal and Torres Strait peoples, by characteristic, 2015–2024

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Characteristic										
Total cases^a	40	47	31	33	25	16	17	25	24	23
Gender^b										
Male	36	41	23	30	20	14	17	22	15	19
Female	4	5	7	3	5	1	0	3	9	4
Newly acquired HIV infections^c	33%	30%	32%	27%	40%	44%	18%	36%	33%	30%
Median age	32.5	29.7	33.0	28.0	31.0	34.5	38.0	36.0	33.3	36.0
Late and advanced HIV infection status at HIV diagnosis (%)^d										
Late diagnosis	30%	25%	25%	25%	23%	6%	41%	21%	30%	22%
Advanced diagnosis	16%	14%	7%	21%	9%	0%	20%	14%	17%	9%
State/Territory										
Australian Capital Territory	0	0	0	1	0	0	0	0	0	0
New South Wales	7	10	8	11	7	4	1	6	11	5
Northern Territory	1	5	1	1	0	0	1	0	0	1
Queensland	13	20	11	13	9	7	6	5	8	8
South Australia	2	2	5	1	2	2	0	0	1	0
Tasmania	2	0	1	0	1	0	1	0	0	0
Victoria	8	8	2	4	4	1	3	5	1	6
Western Australia	7	7	3	2	2	2	5	9	3	3
Exposure category										
Male-to-male sex ^e	55%	57%	39%	55%	48%	50%	53%	40%	25%	30%
Male-to-male sex and injecting drug use	10%	13%	6%	12%	20%	31%	12%	16%	17%	26%
Heterosexual contact	18%	21%	26%	24%	16%	13%	18%	20%	50%	30%
Injection drug use	15%	4%	23%	3%	16%	0%	18%	20%	8%	8%
MTCT	0%	0%	0%	0%	0%	0%	0%	4%	0%	0%
Other	3%	4%	6%	6%	0%	6%	0%	0%	0%	4%

a Total includes Transgender. Not adjusted for multiple reporting.

b Excludes 'Other/Not reported'.

c Newly acquired HIV was defined as a new HIV diagnosis with a negative or indeterminate HIV antibody test result or a diagnosis of primary HIV within one year before HIV diagnosis.

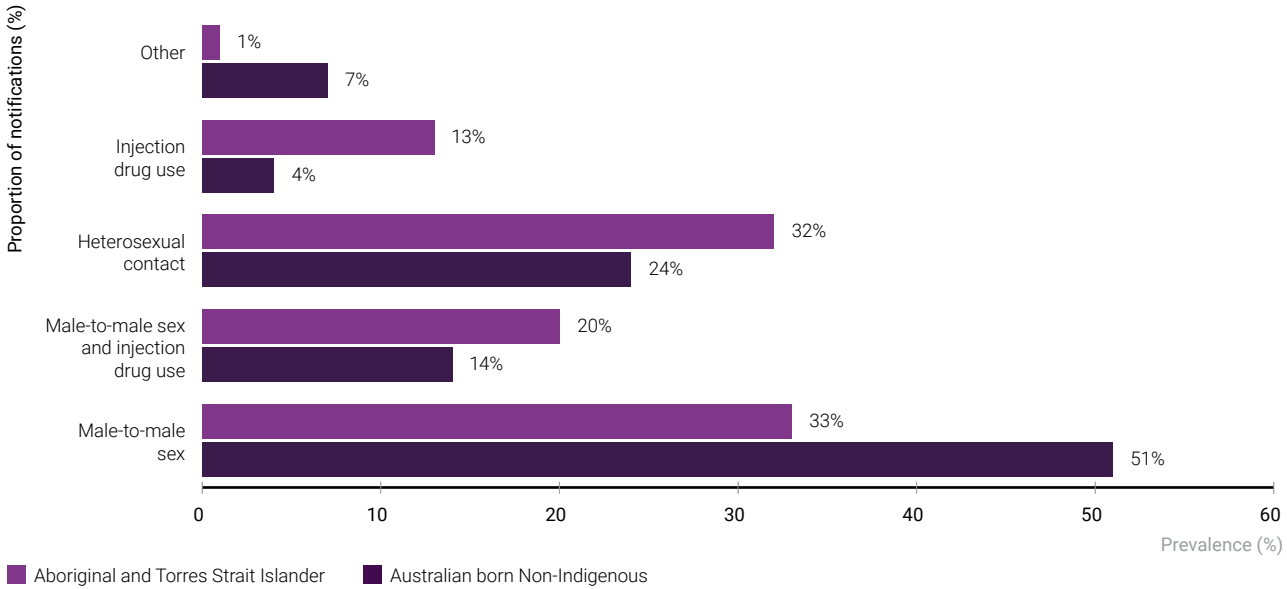
d Late HIV diagnosis was defined as newly notified HIV with a CD4+ cell count of less than 350 cells/μL, and advanced HIV as newly notified infection with a CD4+ cell count of less than 200 cells/μL. Newly acquired HIV was not categorised as a late or advanced diagnosis irrespective of CD4+ cell count.

e Includes males who had sex with both males and females.

Source: State and Territory health authorities; includes all jurisdiction.

Between 2020 and 2024, by exposure classification, the proportion of notifications attributed to heterosexual sex was 32% among Aboriginal and Torres Strait Islander peoples, compared with 24% among Australian born non-Indigenous people. The proportion of notifications attributed to injection drug use was 13% among Aboriginal and Torres Strait Islander peoples compared with 4% in non-Indigenous people. The proportion of HIV notifications attributed to male-to-male sex was 33% among Aboriginal and Torres Strait Islander peoples, compared with 51% in non-Indigenous people. The proportion of HIV notifications attributed to male-to-male sex and injection drug use was 20% among Aboriginal and Torres Strait Islander peoples and 14% in non-Indigenous people (Figure 36).

Figure 36 HIV notification exposure category by Aboriginal and Torres Strait Islander status, 2020–2024



Source: State and territory health authorities; see [Methodology](#) for detail.

Notification rates

Between 2015 and 2016, the age standardised HIV notification rate among Aboriginal and Torres Strait Islander peoples increased from 6.0 to 6.5 per 100 000 and then declined to 3.3 per 100 000 population in 2019. Notification rates declined further during 2020 and 2021 (2.1 per 100 000 both years). In 2022 and 2023, the HIV notification rate increased to 2.9 per 100 000 among Aboriginal and Torres Strait Islander peoples, remaining stable in 2024, at 2.8 per 100 000 population. In non-Indigenous people, the HIV notification rate in 2024 was also 2.8 per 100 000 in 2024. The notification rate among Australian-born non-Indigenous people was slightly lower (2.0 per 100 000) in 2024. Trends in HIV notification rates in the Aboriginal and Torres Strait Islander population are based on small numbers and may reflect localised occurrences rather than national patterns (Figure 37).

Figure 37 HIV notification rate by Aboriginal and Torres Strait Islander status per 100 000 population, 2015–2024

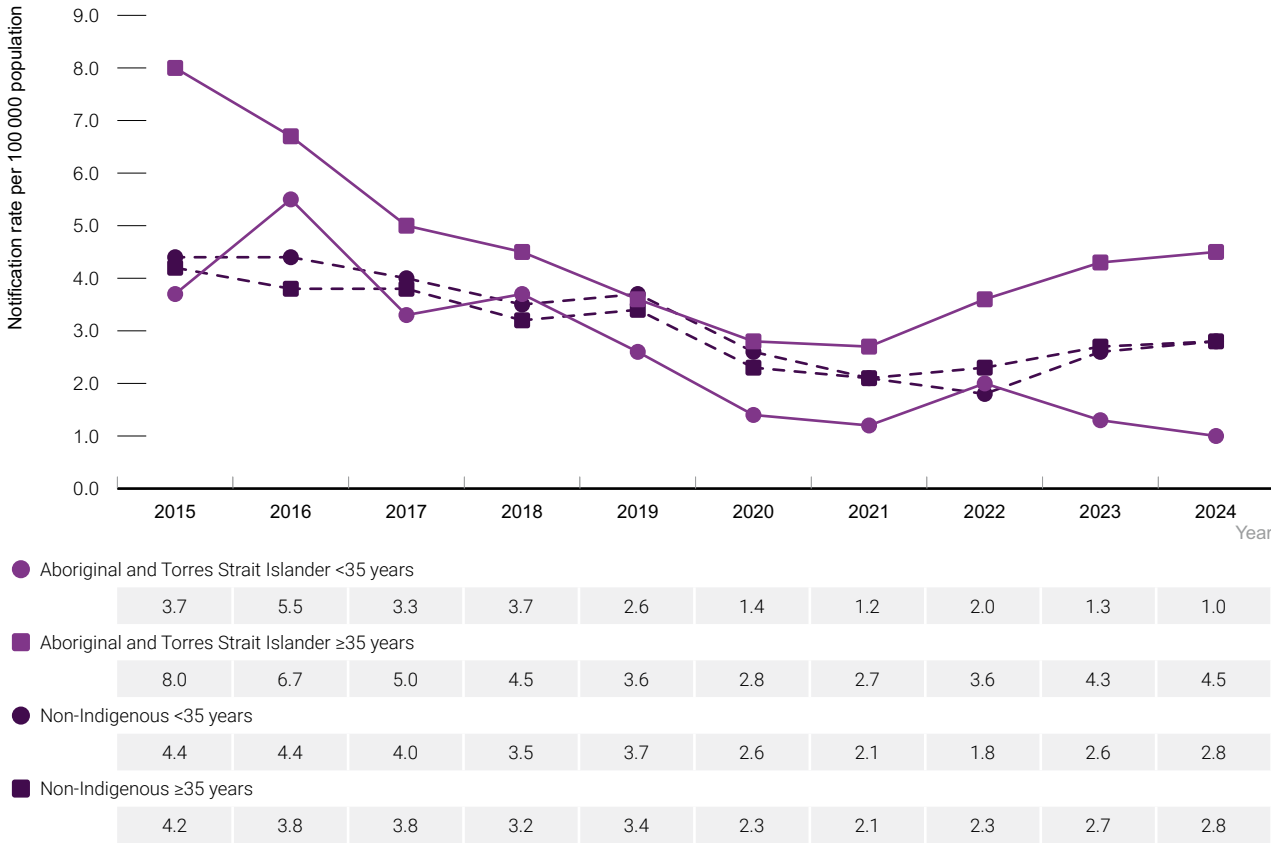


Source: State and territory health authorities; see [Methodology](#) for detail.

Between 2015 and 2024, by age group, HIV notification rates decreased among Aboriginal and Torres Strait Islander peoples aged 34 years and younger and were 3.7 per 100 000 and 1.0 per 100 000, respectively. Among Aboriginal and Torres Strait Islander peoples aged 35 years or older, HIV notification rates declined from 8.0 per 100 000 in 2015 to 4.5 per 100 000 in 2024 (Figure 38).

Between 2015 and 2024, notification rates declined among non-Indigenous people aged both 34 years and younger and 35 years or older. In 2024, HIV notification rates were 2.8 per 100 000 among both those aged 34 years and younger, and among those aged 35 years or older. Due to small numbers of notifications by age group among Aboriginal and Torres Strait Islander peoples, trends over time should be interpreted with caution (Figure 38).

Figure 38 HIV notification rate per 100 000 population by Aboriginal and Torres Strait Islander status, and age group, 2015–2024



Source: State and territory health authorities; see [Methodology](#) for detail.

In 2024, age standardised HIV notification rates among Aboriginal and Torres Strait Islander males steadily decreased from 11.0 per 100 000 in 2015 to 4.7 per 100 000. Over this period HIV notification rates among non-Indigenous males decreased from 7.8 per 100 000 to 4.9 per 100 000 (Figure 39).

Between 2015 and 2024, age standardised notification rates among Aboriginal and Torres Strait Islander females and non-Indigenous females remained below that of the rates of males in both populations across all years. In 2024, the HIV notification rate among Aboriginal and Torres Strait Islander females remained low (0.8 per 100 000) (Figure 39).

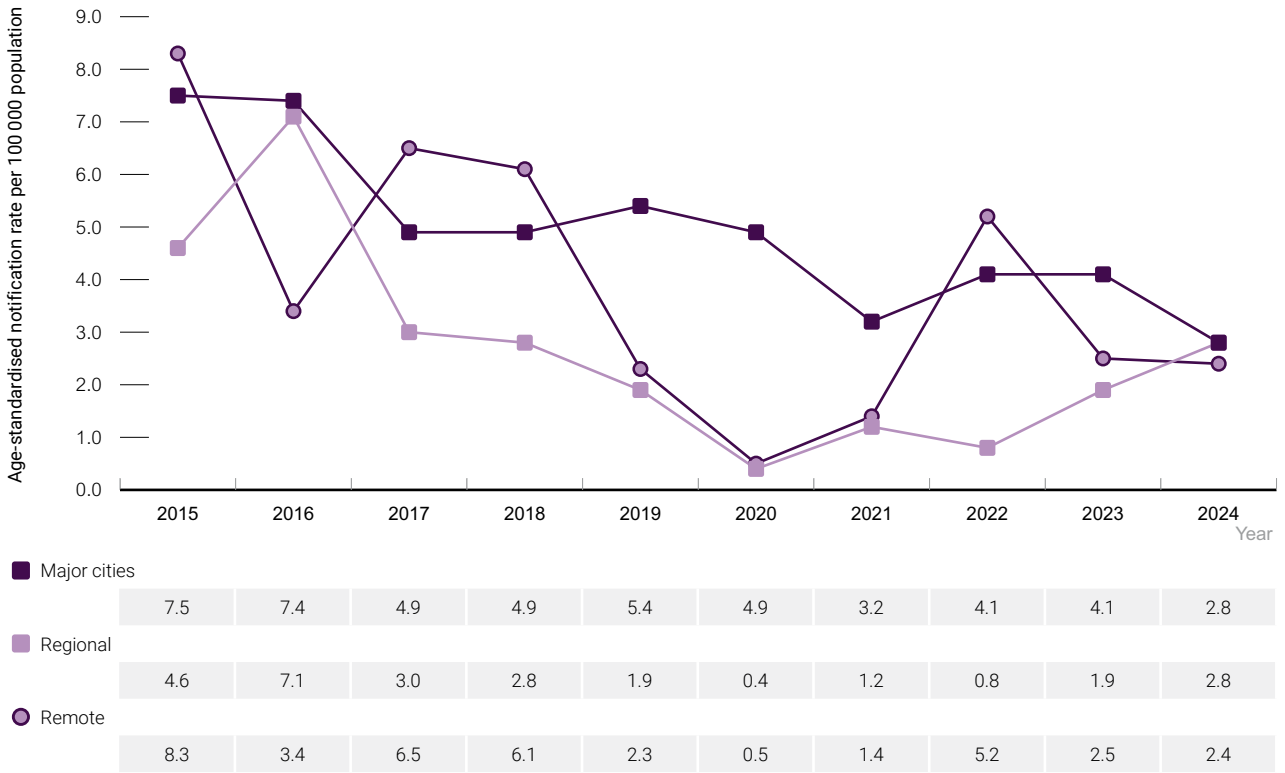
Figure 39 HIV notification rate per population by Aboriginal and Torres Strait Islander status and gender, 2015–2024



Source: State and territory health authorities; see [Methodology](#) for detail.

HIV notification rates among Aboriginal and Torres Strait Islander peoples residing in regional areas declined by 1.6 times between 2015 and 2024 from 4.6 to 2.8 per 100 000. In major cities the HIV notification rate declined from 7.5 per 100 000 in 2015 to 2.8 per 100 000 in 2024 with fluctuations in the interim. Due to the small number of HIV notifications, the HIV notification rate in remote areas fluctuated between 2015 and 2024 and was 2.4 per 100 000 in 2024 (Figure 41). Caution should be taken in interpretation of these trends, due to small numbers of notifications.

Figure 40 HIV notification rate among Aboriginal and Torres Strait Islander peoples per 100 000 population by area of residence



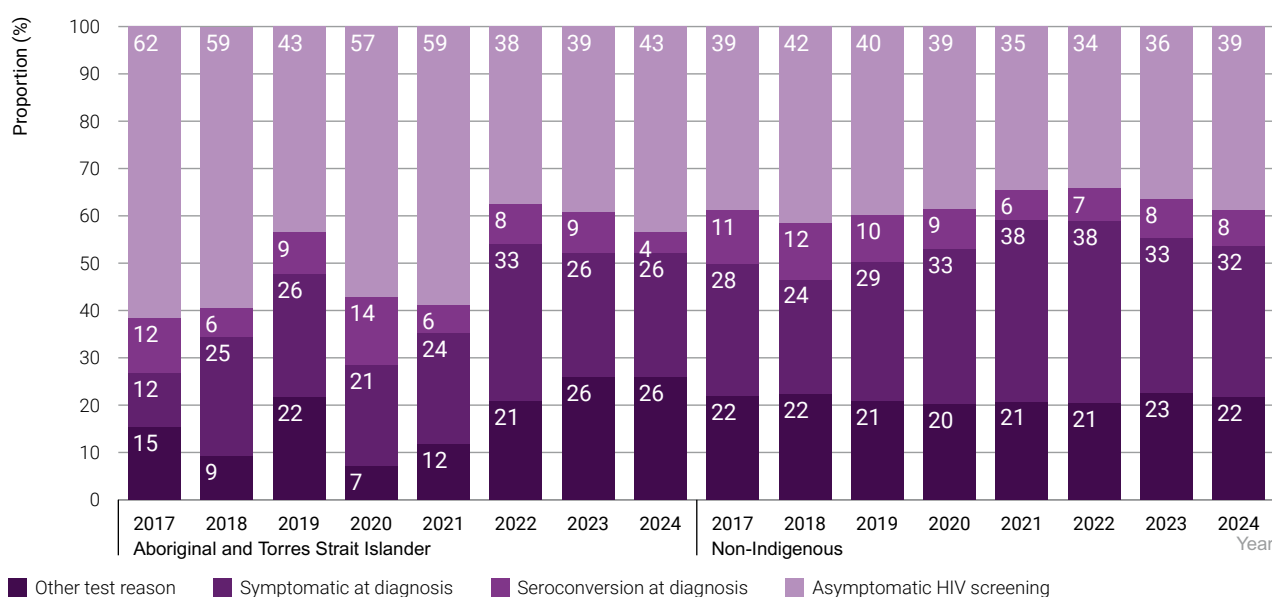
Source: State and territory health authorities; see [Methodology](#) for detail.

Reasons for HIV testing

Reasons for HIV test is routinely reported by the diagnosing clinician as part of an HIV notification and is subsequently recorded in the National HIV Registry. Reasons for testing recorded in the National HIV Registry include contact tracing, reported risk behaviour, bloodborne virus screening, STI screening, testing due to clinical symptoms indicative of HIV, pregnancy/fertility screening, immigration screening, reactive self-test, reactive point-of-care test, and HIV pre-exposure prophylaxis (PrEP) screening. Multiple reasons for testing may be recorded in a single HIV notification. Using these test reasons as well as clinical status at diagnosis, four HIV test reason categories were derived: asymptomatic HIV screening, symptomatic at diagnosis, seroconverting at diagnosis, and other test reason. ⁴

In 2024, for HIV notifications among Aboriginal and Torres Strait Islander peoples, the proportion of HIV diagnoses resulting from asymptomatic screening was 43% and 39% in non-Indigenous people (Figure 42). Conversely, for each year in the reporting period, for HIV notifications among Aboriginal and Torres Strait Islander peoples, the proportion of HIV diagnoses resulting from testing while symptomatic was lower than HIV notifications among the non-Indigenous population.

Figure 41 Reasons for HIV testing, by Aboriginal and Torres Strait Islander status, 2017–2024



Source: State and territory health authorities; see [Methodology](#) for detail.

HIV Cascade of care

This report includes the ‘HIV diagnosis and care cascade’, which estimates the number of Aboriginal and Torres Strait Islander people living with HIV in Australia, tracks their progression through key stages of care looking at the number and proportion of people, who are diagnosed, receiving antiretroviral treatment, retained in care (defined as having had a viral load or CD4+ cell count in the past year) and who have a suppressed viral load (defined as <200 HIV-1 RNA copies/mL). These estimates are used to support the improvement of the delivery of services to people with HIV across the entire continuum of care. Using available data and accounting for uncertainties, the number of people in each stage of the cascade in Australia was estimated.

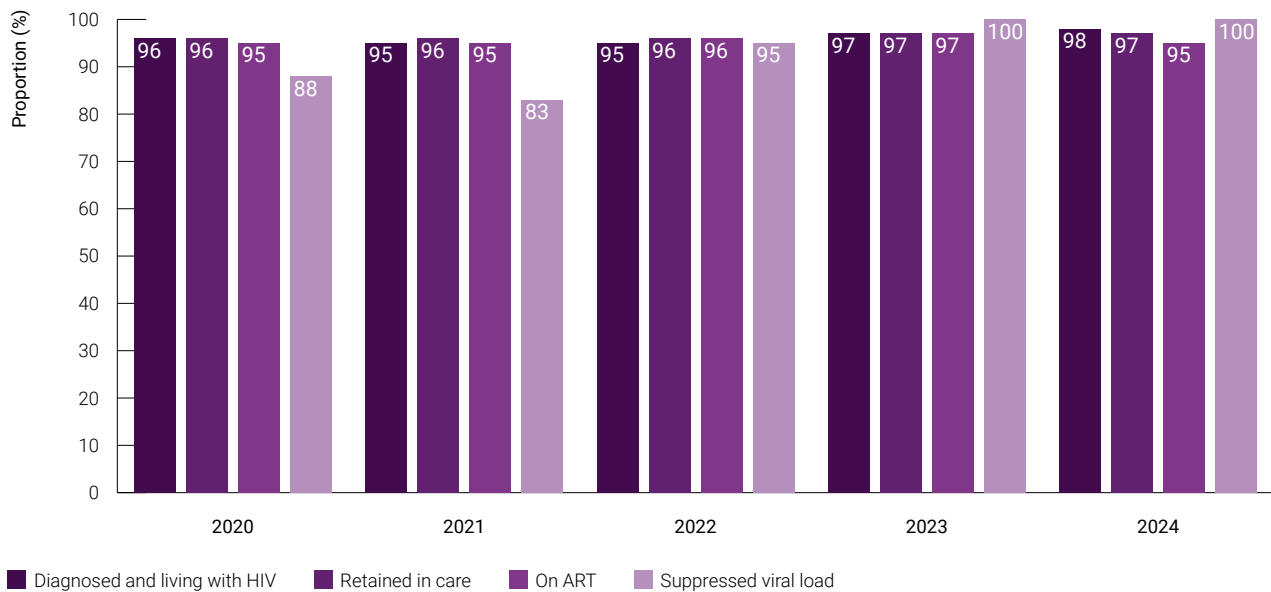
UNAIDS has set targets for HIV diagnosis and treatment by the year 2025:

- 95% of all people living with HIV to be diagnosed,
- 95% of all people with diagnosed HIV to be on antiretroviral therapy,
- and 95% of all people receiving antiretroviral therapy to have a suppressed viral load.

This corresponds to a target of 86% of all people living with HIV having a suppressed viral load.

At the end of 2024, there were an estimated 610 Aboriginal and Torres Strait Islander peoples living with HIV in Australia (with a range of 520-670 Aboriginal and Torres Strait Islander peoples). Of these an estimated 98% (600) had been diagnosed, increasing from 96% in 2020 (540). Of those diagnosed at the end of 2024, an estimated 97% (580) were retained in care, similar to 96% (530) in 2020. Of those diagnosed, 98% (570) were receiving antiretroviral therapy, an increase from 98% (520) in 2020. All people (100%, 570) on antiretroviral therapy had a suppressed viral load, a significant increase from earlier years (2021: 83%, 440) (Figure 43). These findings indicate that Australia has successfully achieved the three UNAIDS 2025 95% targets, for HIV diagnosis and treatment and viral suppression for Aboriginal and Torres Strait Islander peoples.

Figure 42 HIV cascade of care, 2020–2024



Source: See [Methodology](#) for details for mathematical modelling used to generate estimates.

Undiagnosed HIV

At the end of 2024, an estimated 10 Aboriginal and Torres Strait Islander peoples (1.6% of Aboriginal people living with HIV) (Table 7) were living with HIV who were unaware of their HIV status (undiagnosed). In comparison, at the end of 2024, an estimated 1930 all non-Indigenous people (6.4% of all people living with HIV) were living with HIV and were unaware of their HIV status.

Table 7 Undiagnosed proportion by Aboriginal and Torres Strait Islander status, 2024

	People living with HIV (range)	Number diagnosed (range)	Number undiagnosed (range)	Proportion undiagnosed	HIV prevalence (range)	Population size (>15 years of age)
Demographics						
Total¹	30 890 (27 480 to 35 990)	28 940 (27 480 to 33 620)	1 950 (0 to 2 370)	6.30%	0.14% (0.12% to 0.16%)	22 602 181
Aboriginal and Torres Strait Islander peoples	610 (520 to 670)	600 (510 to 660)	10 (10 to 10)	1.60%	0.09% (0.07% to 0.07%)	709 482
Australian born non-Indigenous	16 680 (13 980 to 19 450)	16 190 (13 670 to 18 630)	490 (310 to 820)	2.90%	0.12% (0.10% to 0.12%)	13 531 838
Overall non-Indigenous	30 270 (25 440 to 35 270)	28 340 (23 910 to 32 940)	1 930 (1 530 to 2 330)	6.40%	0.14% (0.12% to 0.16%)	21 892 699

1 Sum of sub populations will not add to the total estimated people living with HIV due to people potentially associated with multiple categories.

5 Hepatitis C

Please see p. 8 for summary.

Hepatitis C notifications

This section focuses on notified cases of hepatitis C infection, referring to individuals who were previously undiagnosed and have since tested positive for hepatitis C, or those who were previously cured, but have been identified as reinfected through subsequent testing.

A total of 7281 hepatitis C notifications were reported in 2024 in Australia; 1527 (21%) occurred among Aboriginal and Torres Strait Islander peoples, 3943 (54%) were in non-Indigenous people, and there were a further 1811 (25%) notifications among people for whom Aboriginal and Torres Strait Islander status was not reported. Details of Aboriginal and Torres Strait Islander notifications for the 2020 to 2024 reporting period are provided in Table 8.

Table 8 Hepatitis C notifications among Aboriginal and Torres Strait Islander peoples, by characteristic, 2020–2024

	2020	2021	2022	2023	2024
Characteristic					
Total cases	1308	1456	1235	1747	1527
Sex^a					
Female	422	422	346	390	338
Male	924	1033	889	1352	1180
Age group					
0-14	14	8	5	7	5
15-19	120	110	105	157	123
20-24	276	247	224	328	266
25-29	249	269	208	347	291
30-39	350	431	332	494	426
>40	337	391	361	414	416
Remoteness					
Major cities	538	596	512	660	578
Regional	630	682	559	826	733
Remote	74	95	78	91	65
Not reported	104	83	86	170	151
State/Territory^b					
Australian Capital Territory	22	14	8	13	11
New South Wales	403	329	368	572	536
Northern Territory	25	27	22	37	25
Queensland	559	669	461	672	514
South Australia	42	41	33	35	32
Tasmania	7	9	6	4	11
Victoria	18	49	57	91	67
Western Australia	270	318	280	323	331

a Excludes 'Not reported'; The National Notifiable Diseases Surveillance System includes the variable 'Sex' to indicate Sex/Gender. For reporting purposes, 'Sex' is used as 'Gender' was not reported historically.

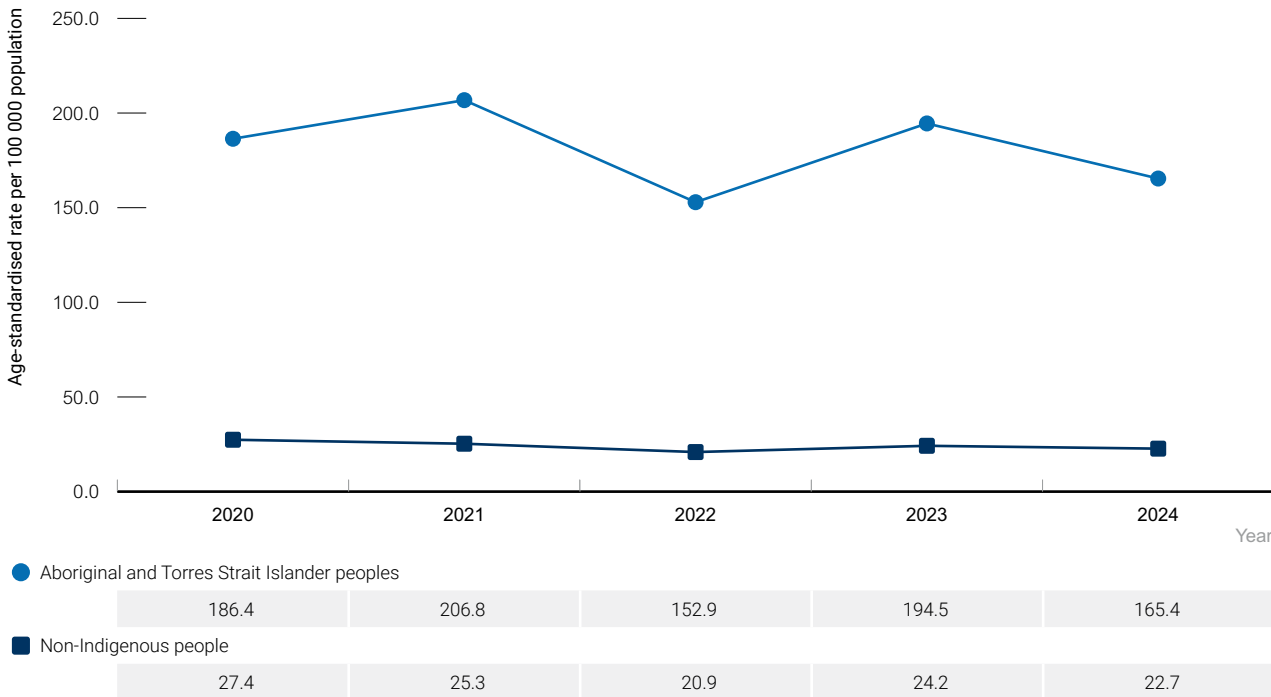
b Numbers of notifications in some jurisdictions may be strongly influenced by completeness of Aboriginal and Torres Strait Islander status.

Source: National Notifiable Diseases Surveillance System.

Notification rates of hepatitis C among Aboriginal and Torres Strait Islander peoples are based on data from five jurisdictions (the Northern Territory, Queensland, South Australia, Tasmania and Western Australia), where Aboriginal and Torres Strait Islander status was $\geq 50\%$ complete for all hepatitis C notifications for each years from 2020 to 2024. Incomplete reporting of Aboriginal and Torres Strait Islander status can result in a misrepresentation of the true extent of the notifications among Aboriginal and Torres Strait Islander peoples and may not reflect national trends.

In 2024, the age-standardised notification rate of hepatitis C among Aboriginal and Torres Strait Islander peoples decreased by 11% from 186.4 per 100 000 in 2020 to 165.4 per 100 000, with fluctuations during this period. By comparison, in non-Indigenous people, the hepatitis C notification rate steadily decreased by 17% from 27.4 per 100 000 in 2020 to 22.7 per 100 000 in 2024 (Figure 44). In 2024, the age-standardised hepatitis C notification rate for Aboriginal and Torres Strait Islander peoples was more than seven times as high as compared to non-Indigenous people (165.4 per 100 000 vs 22.7 per 100 000).

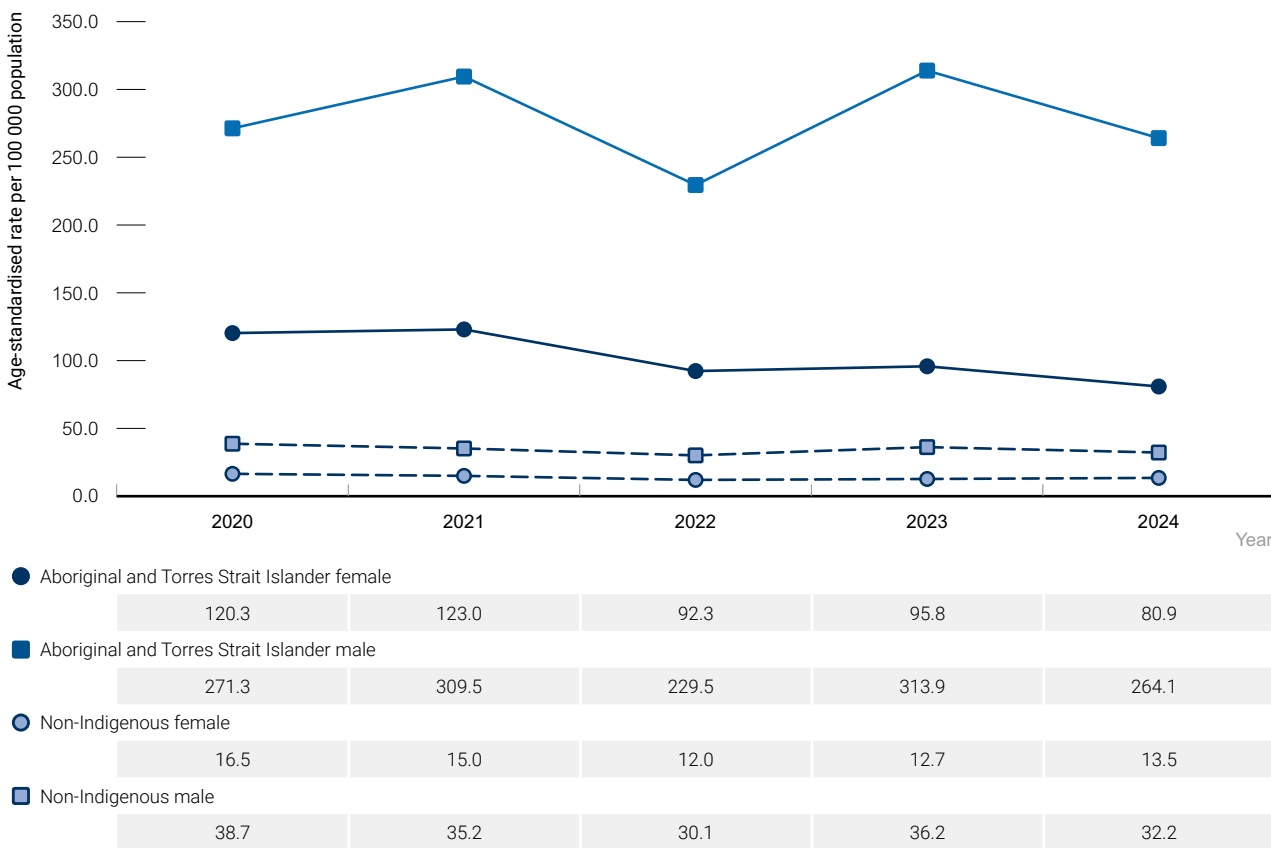
Figure 43 Age standardised hepatitis C notification rate per 100 000 population by Aboriginal and Torres Strait Islander status, 2020–2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for $\geq 50\%$ of notifications for each year (Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

Across all years from 2020 to 2024, among Aboriginal and Torres Strait Islander peoples, the age standardised hepatitis C notification rate was higher in males and females than in gender equivalent non-Indigenous people (Figure 45). Rates among Aboriginal and Torres Strait Islander males were 3.2 times higher than their female counterparts. Among Aboriginal and Torres Strait Islander males, the hepatitis C notification rate decreased slightly by 3% from 271.3 per 100 000 in 2020 to 264.1 per 100 000 in 2024, with fluctuations during this period. There was a much larger decrease among Aboriginal and Torres Strait Islander females, with the hepatitis C notification rate decreasing by 32.7% from 120.3 per 100 000 in 2020 to 80.9 per 100 000 in 2024 (Figure 45).

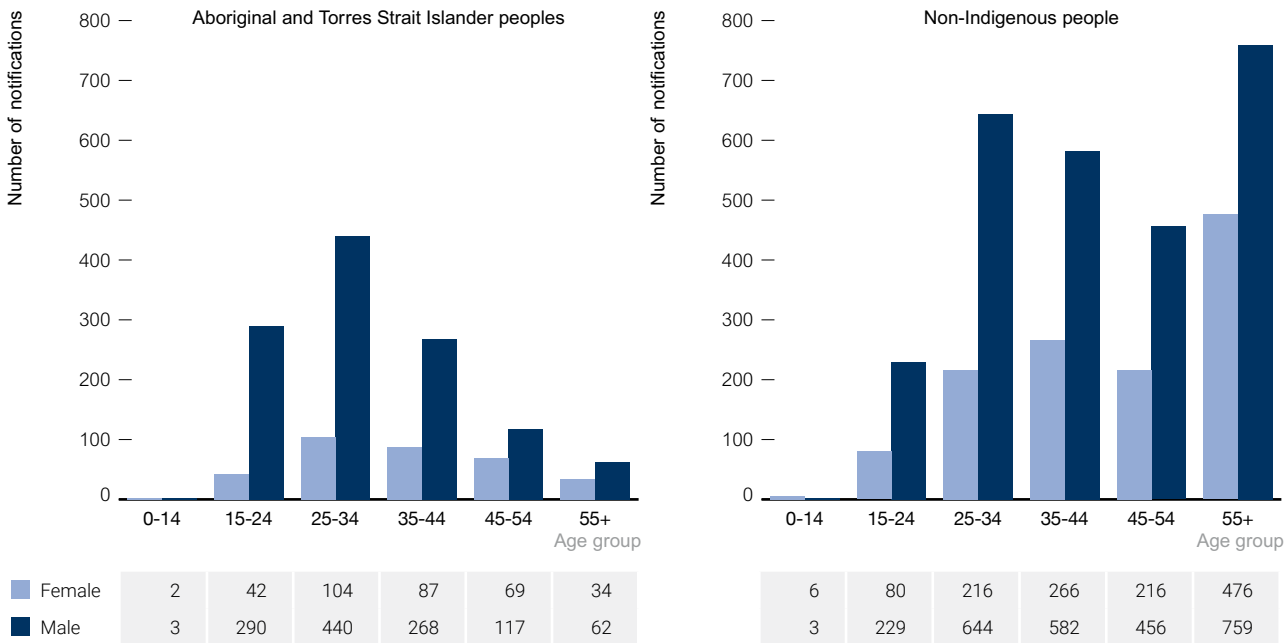
Figure 44 Hepatitis C notification rates per 100 000 population by Aboriginal and Torres Strait Islander status and gender, 2020–2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for $\geq 50\%$ of notifications for each year (Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

In 2024, 37% of hepatitis C notifications among Aboriginal and Torres Strait Islander males and 31% among Aboriginal and Torres Strait Islander females occurred in people aged 25-34 years (Figure 46).

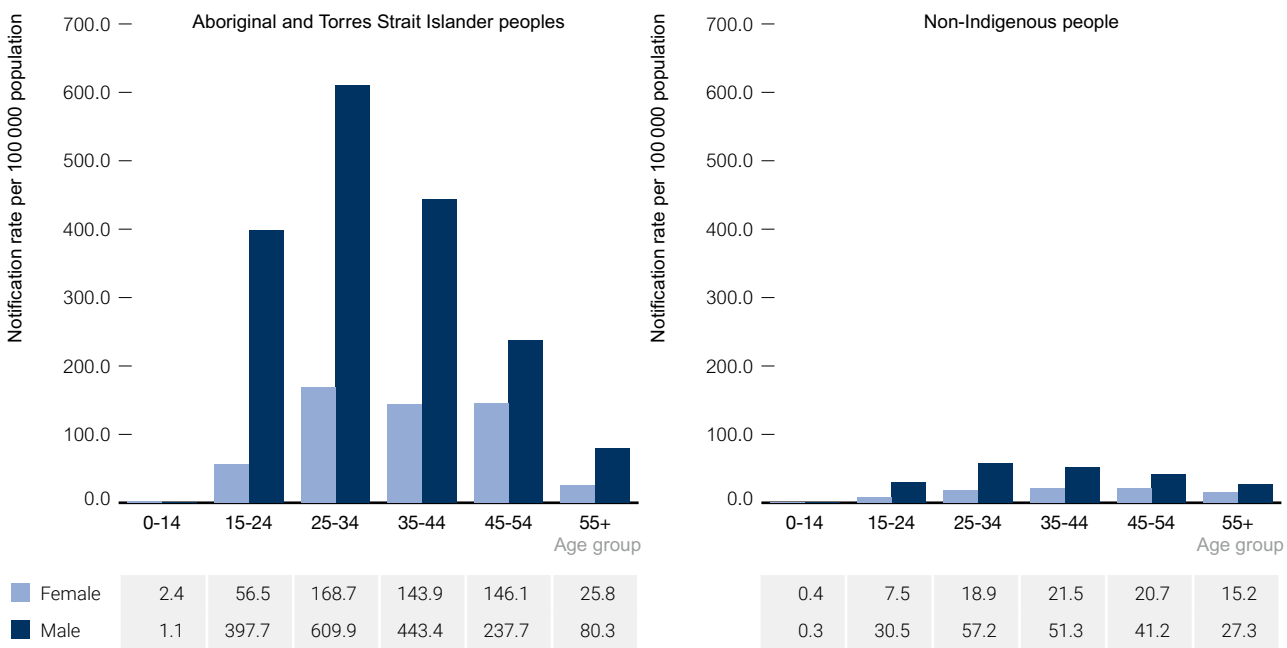
Figure 45 Number of hepatitis C notifications by Aboriginal and Torres Strait Islander status, age group, and gender, 2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for $\geq 50\%$ of notifications for each year (Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

In 2024, the highest notification rates among both Aboriginal and Torres Strait Islander females were among those aged 25 to 34 years (168.7 per 100 000). In contrast in non-Indigenous females the highest rate was among those aged 35 to 44 years (21.5 per 100 000). For both Aboriginal and Torres Strait Islander males and non-Indigenous males, the highest rates were among those aged 25 to 34 years (609.9 per 100 000 and 57.2 per 100 000). By gender, hepatitis C notification rates for Aboriginal and Torres Strait Islander males and females were higher than notification rates for non-Indigenous males and females for every age group in 2024 (Figure 47).

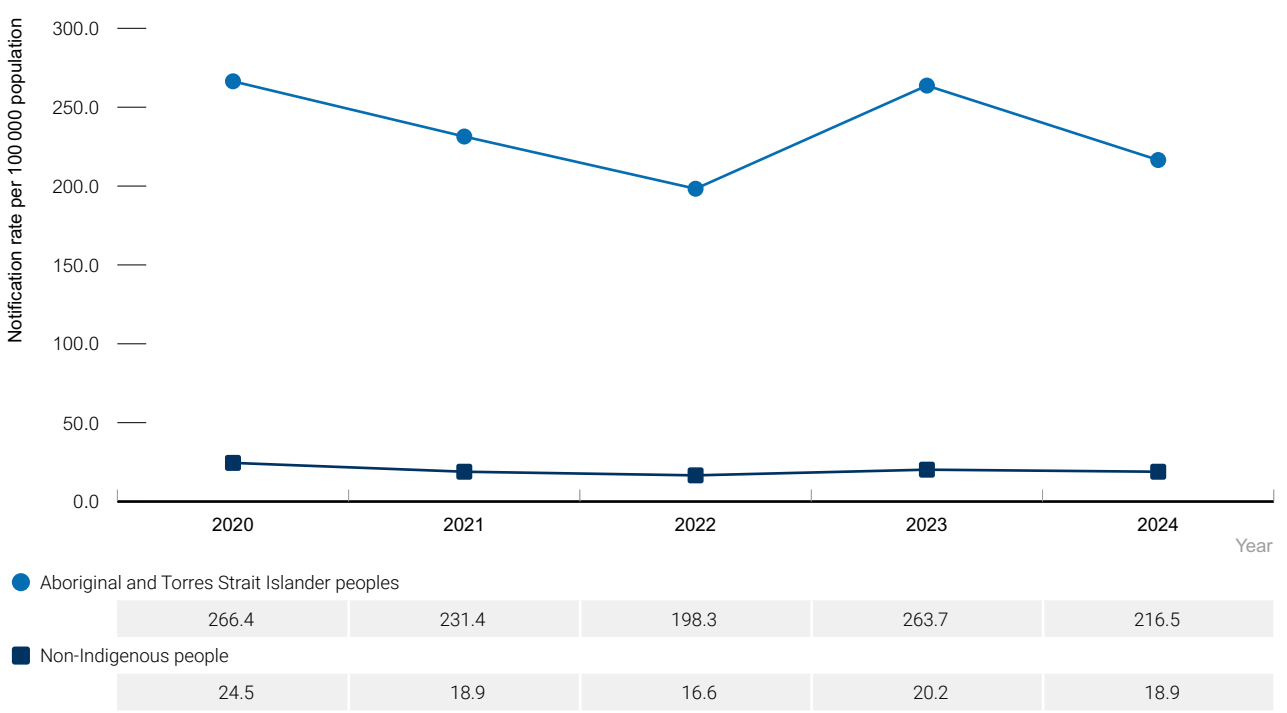
Figure 46 Hepatitis C notification rate per 100 000 population by Aboriginal and Torres Strait Islander status, gender and age group, 2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for $\geq 50\%$ of notifications for each year (Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

Compared with older age-groups, most primary hepatitis C infections among those aged 15 to 24 years are recently acquired⁵. Therefore, trends in notification rates among those aged 15 to 24 years are used here as a proxy for the incidence of hepatitis C infection. The hepatitis C notification rate among Aboriginal and Torres Strait Islander peoples aged 15 to 24 years declined by 18.7% from 266.4 per 100 000 in 2020 to 216.5 per 100 000 in 2024. Similarly, the hepatitis C notification rate in non-Indigenous people aged 15 to 24 years declined by 22.8% from 24.5 per 100 000 in 2020 to 18.9 per 100 000 in 2024 (Figure 48). A breakdown of hepatitis C notification rates by age-group and Aboriginal and Torres Strait Islander status can be found on the Kirby Institute data site.

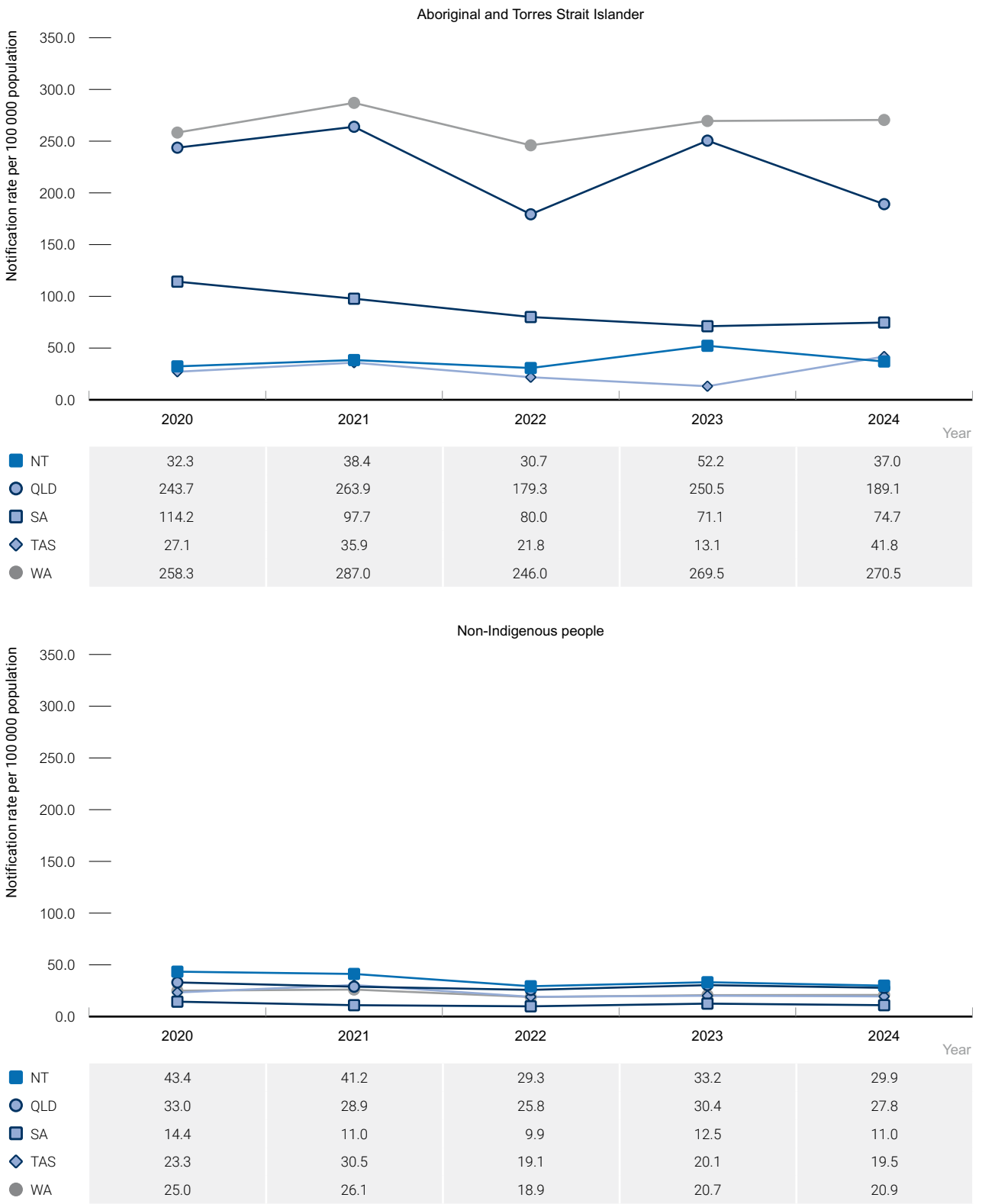
Figure 47 Hepatitis C notification rate per 100 000 in people aged 15-24 years and younger by Aboriginal and Torres Strait Islander status, 2020–2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

In 2024, hepatitis C notification rates among Aboriginal and Torres Strait Islander peoples were highest in Western Australia (270.5 per 100 000), followed by Queensland (189.1 per 100 000), and South Australia (74.7 per 100 000). In the Northern Territory and Western Australia hepatitis C notification rates fluctuated between 2020 and 2024. In all other states and territories rates declined (Figure 49).

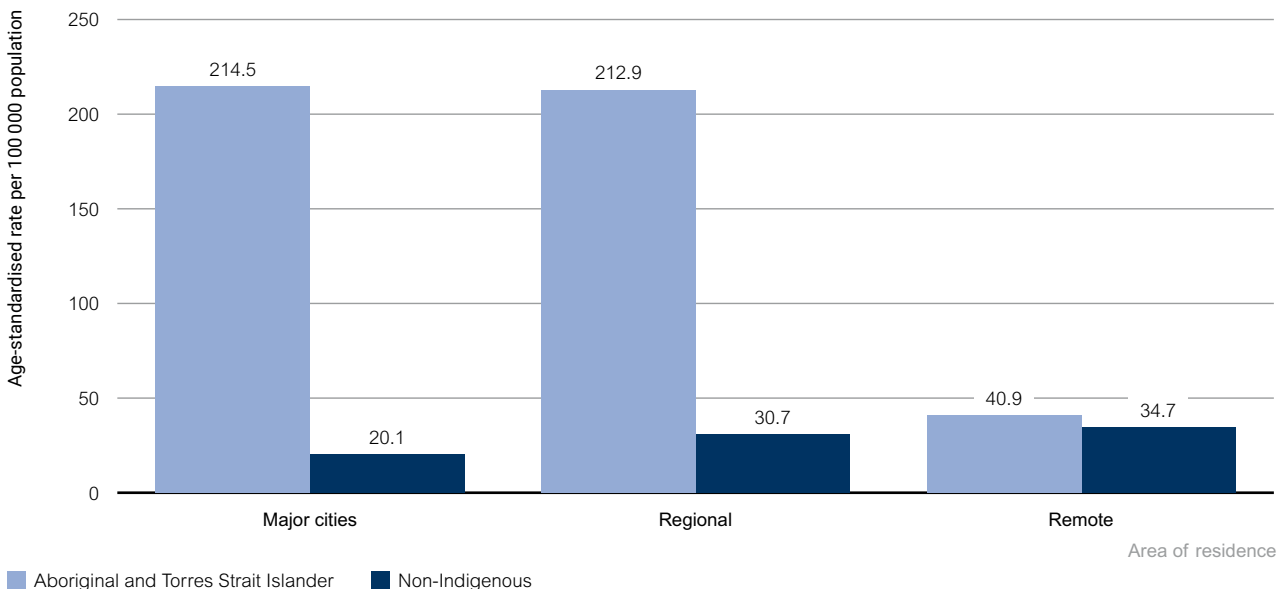
Figure 48 Hepatitis C notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and state/territory, 2020–2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

In 2024, the hepatitis C notification rate in major cities was ten times as high in Aboriginal and Torres Strait Islander peoples compared to non-Indigenous people (214.5 and 20.1 per 100 000, respectively). In regional areas, the rate among Aboriginal and Torres Strait Islander peoples was almost seven times as high as in non-Indigenous people (212.9 and 30.7 per 100 000, respectively). In remote areas, hepatitis C notification rates among the Aboriginal and Torres Strait Islander population were slightly more as compared to non-Indigenous people (40.9 and 34.7 per 100 000, respectively) (Figure 49).

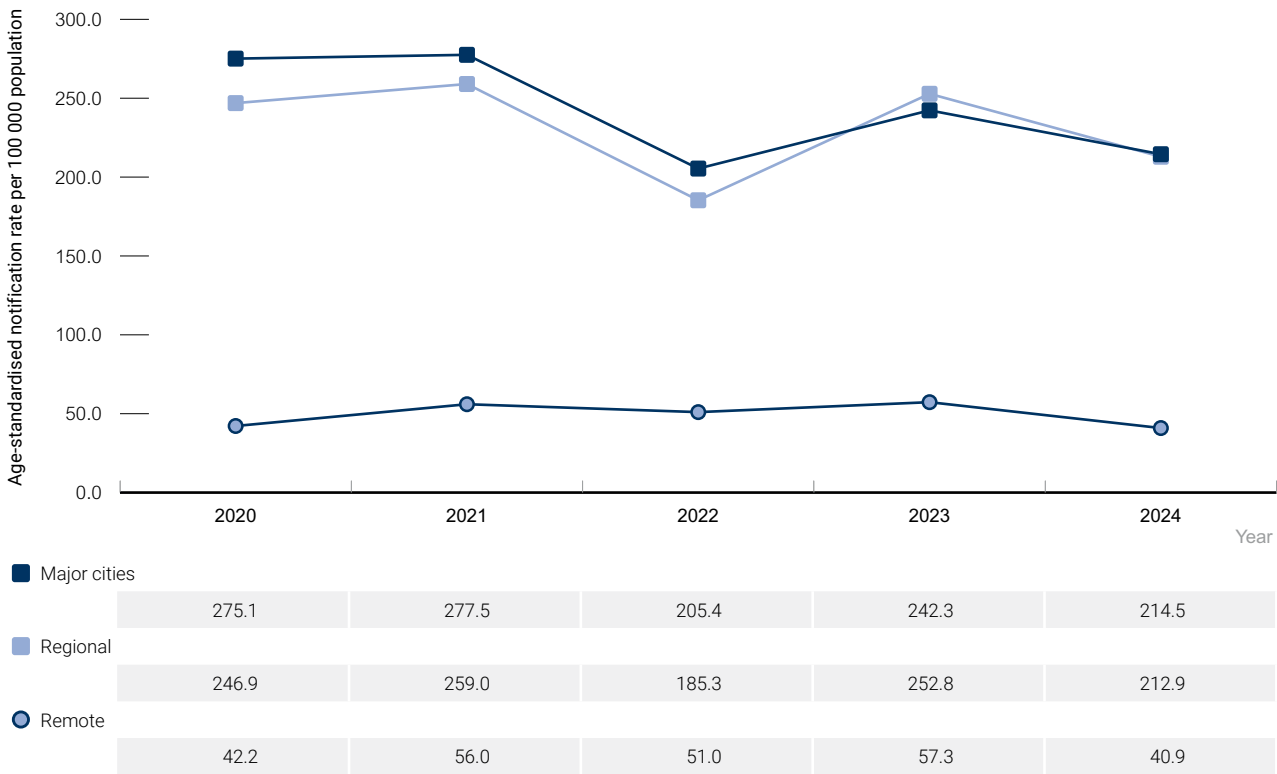
Figure 49 Hepatitis C notification rate per 100 000 population by Aboriginal and Torres Strait Islander area of residence, 2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for $\geq 50\%$ of notifications for each year (Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

Hepatitis C notification rates declined by 22% among Aboriginal and Torres Strait Islander peoples living in major cities from 2020 to 2024 (275.1 per 100 000 and 214.5 per 100 000 respectively) and by 14% among Aboriginal and Torres Strait Islander people living in regional areas (246.9 per 100 000 to 212.9 per 100 000). In remote areas rates fluctuated and were 40.9 per 100 000 in 2024 (Figure 51).

Figure 50 Hepatitis C notification rate per 100 000 population among Aboriginal and Torres Strait Islander peoples by area of residence, 2020–2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for $\geq 50\%$ of notifications for each year (Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

6 Hepatitis B

Please see p. 9 for summary.

Hepatitis B notifications

This section focuses on notified cases of hepatitis B infection, which means that a person previously not known to have the infection has since been tested and now found to have hepatitis B.

There was a total of 5594 hepatitis B notifications in Australia in 2024. Of these 144 (3%) were among Aboriginal and Torres Strait Islander peoples (Table 9), 3443 (62%) were in non-Indigenous people, and 2007 (36%) were among people for whom Aboriginal and Torres Strait Islander status was not reported. Details of Aboriginal and Torres Strait Islander notifications for the 2020–2024 reporting period are provided in Table 9.

Table 9 Hepatitis B notifications among Aboriginal and Torres Strait peoples, by characteristic, 2020–2024

	2020	2021	2022	2023	2024
Characteristic					
Total cases	177	163	112	138	144
Sex^a					
Female	70	60	40	43	49
Male	107	103	72	95	95
Age group					
<20	12	10	6	7	11
20-29	24	13	14	20	28
30-39	45	29	24	29	31
40-49	43	51	19	33	31
50-59	35	35	29	21	19
60-69	13	17	14	23	20
70+	5	8	6	5	4
Remoteness					
Major cities	51	43	35	34	42
Regional	56	51	42	50	50
Remote	60	67	35	48	47
Not reported	10	2	0	6	5
State/Territory^b					
Australian Capital Territory	0	0	2	1	0
New South Wales	46	39	35	32	30
Northern Territory	21	6	11	30	20
Queensland	59	58	30	44	54
South Australia	10	1	2	1	2
Tasmania	0	0	0	0	0
Victoria	2	4	2	5	4
Western Australia	39	55	30	25	34

a Excludes 'Not reported'; The National Notifiable Diseases Surveillance System includes the variable 'Sex' to indicate Sex/Gender.

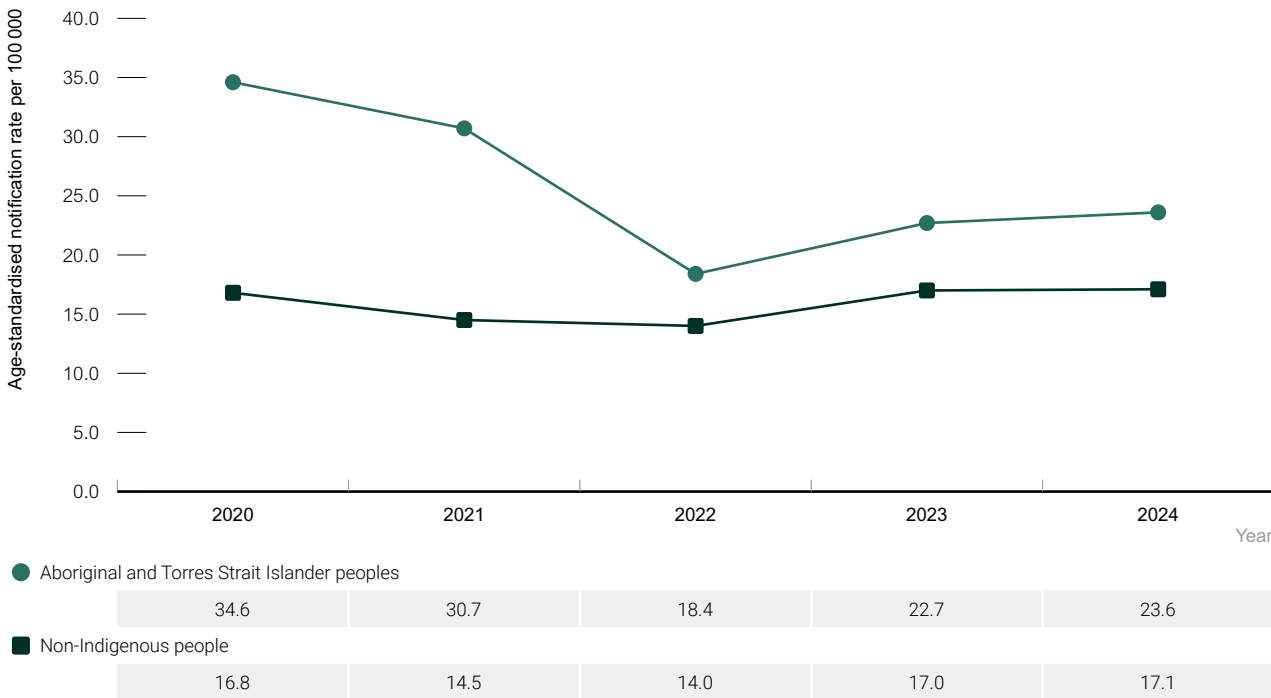
b Numbers of notifications in some jurisdictions may be strongly influenced by completeness of Aboriginal and Torres Strait Islander status.

Source: National Notifiable Diseases Surveillance System.

In the five-year period 2020–2024, Aboriginal and Torres Strait Islander status was recorded for at least 50% of notifications per year in the Australian Capital Territory, the Northern Territory, Queensland, South Australia and Western Australia. These five jurisdictions are therefore included in reporting below.

Incomplete reporting of Aboriginal and Torres Strait Islander status can result in a misrepresentation of the true extent of the notifications among Aboriginal and Torres Strait Islander peoples and may not reflect national trends. The hepatitis B age standardised notification rate among Aboriginal and Torres Strait Islander peoples decreased by 31.7% between 2020 and 2024 from 34.6 per 100 000 to 23.6 per 100 000. The hepatitis B notification rate in non-Indigenous people remained stable between 2020 and 2024 at 16.8 and 17.1 per 100 000 (Figure 52).

Figure 51 Hepatitis B notification rate per 100 000 population by, Aboriginal and Torres Strait Islander status, 2020–2024

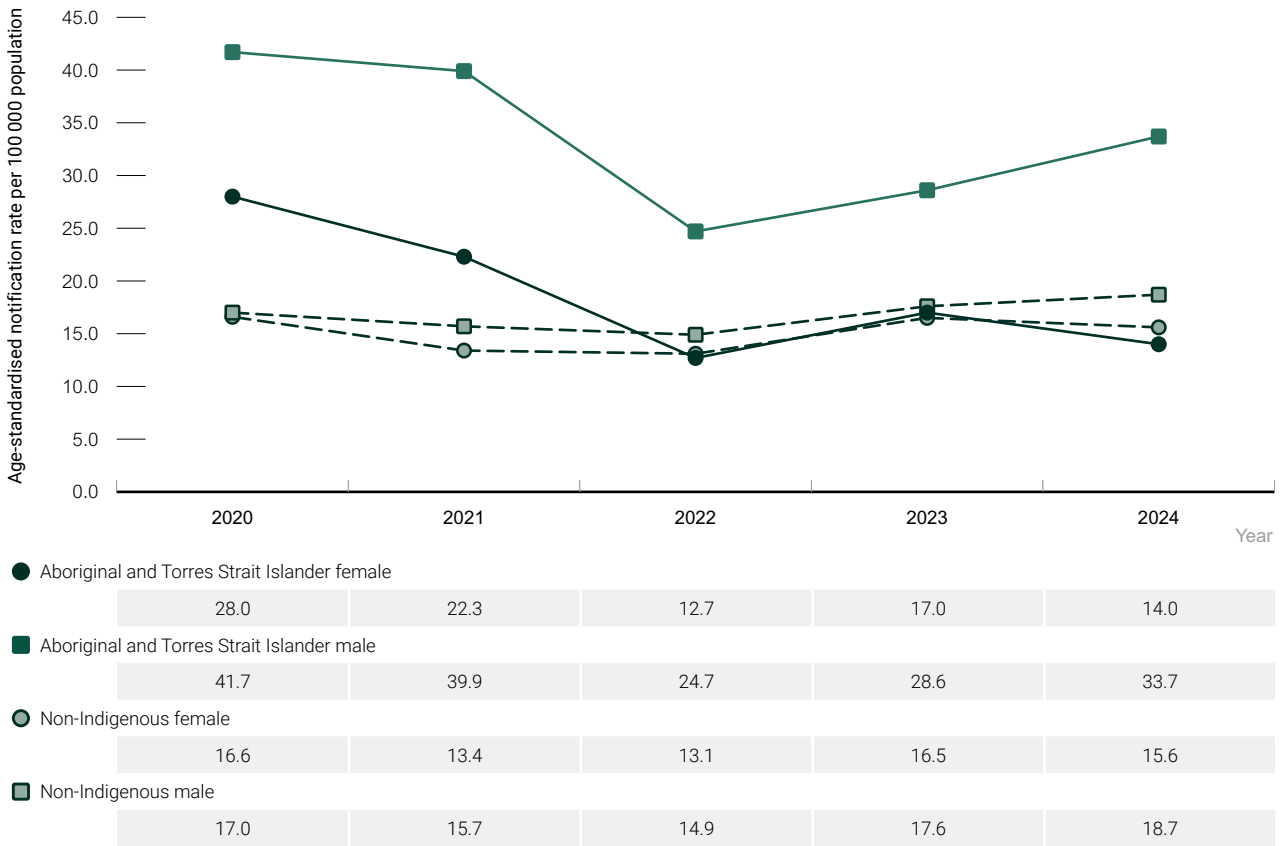


Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Non-Indigenous people was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, Queensland, South Australia and Western Australia).

For the years 2020 to 2024, age standardised hepatitis B notification rates have been consistently higher among Aboriginal and Torres Strait Islander males than among Aboriginal and Torres Strait Islander females. Hepatitis B rates declined among Aboriginal and Torres Strait Islander females by 50.0% between 2020 and 2024 (28.0 per 100 000 to 14.0 per 100 000). Similarly, amongst Aboriginal and Torres Strait Islander males, rates decreased by 19.1% (declining from 41.7 to 33.7 per 100 000).

Hepatitis B notification rates remained stable among non-Indigenous females at 16.6 and 15.6 per 100 000 and declined among non-Indigenous males from 17.0 to 18.7 per 100 000 from 2020 to 2024 (Figure 53).

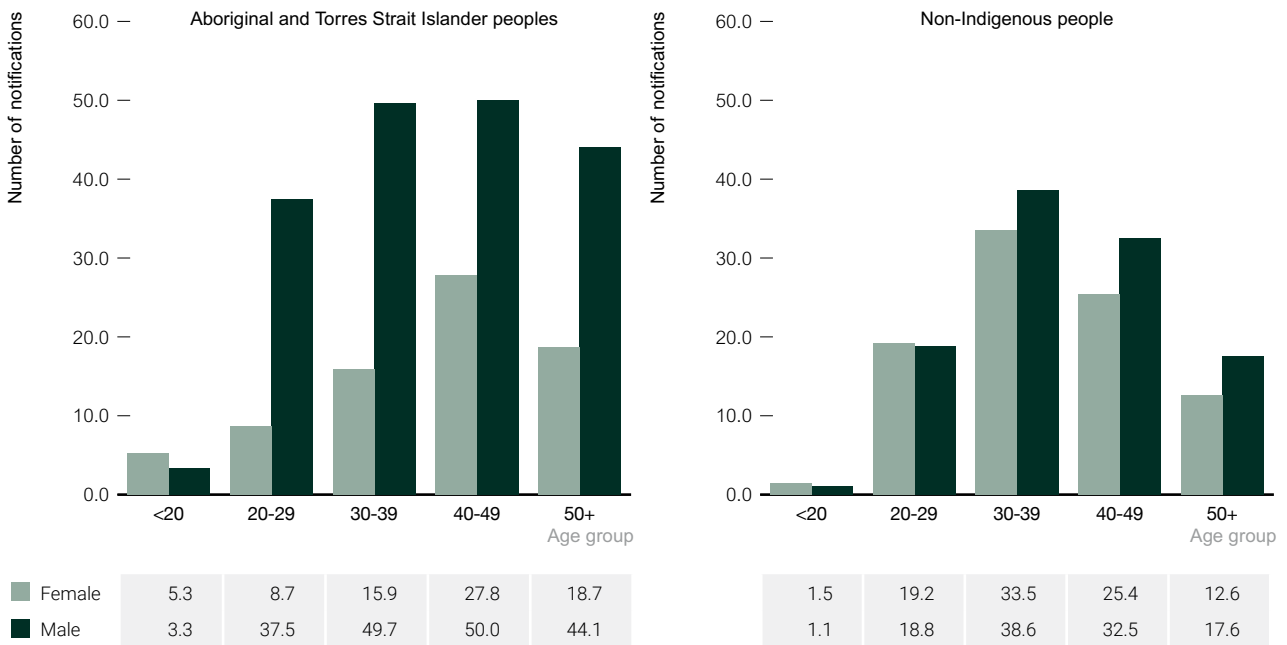
Figure 52 Hepatitis B notification rates per 100 000, by Aboriginal and Torres Strait Islander status and gender, 2020–2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Non-Indigenous people was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, Queensland, South Australia and Western Australia).

In 2024, hepatitis B notification rates among Aboriginal and Torres Strait Islander peoples were highest among men aged 40-49 years (50.0 per 100 000) and 30-39 years (49.7 per 100 000) and Aboriginal and Torres Strait Islander women aged 40 to 49 (27.8 per 100 000), (Figure 54). Among non-Indigenous men and women hepatitis B notification rates were highest among men and women aged 30 to 39. Small numbers of notifications among Aboriginal and Torres Strait Islander peoples mean that comparisons by age-group should be conducted with caution.

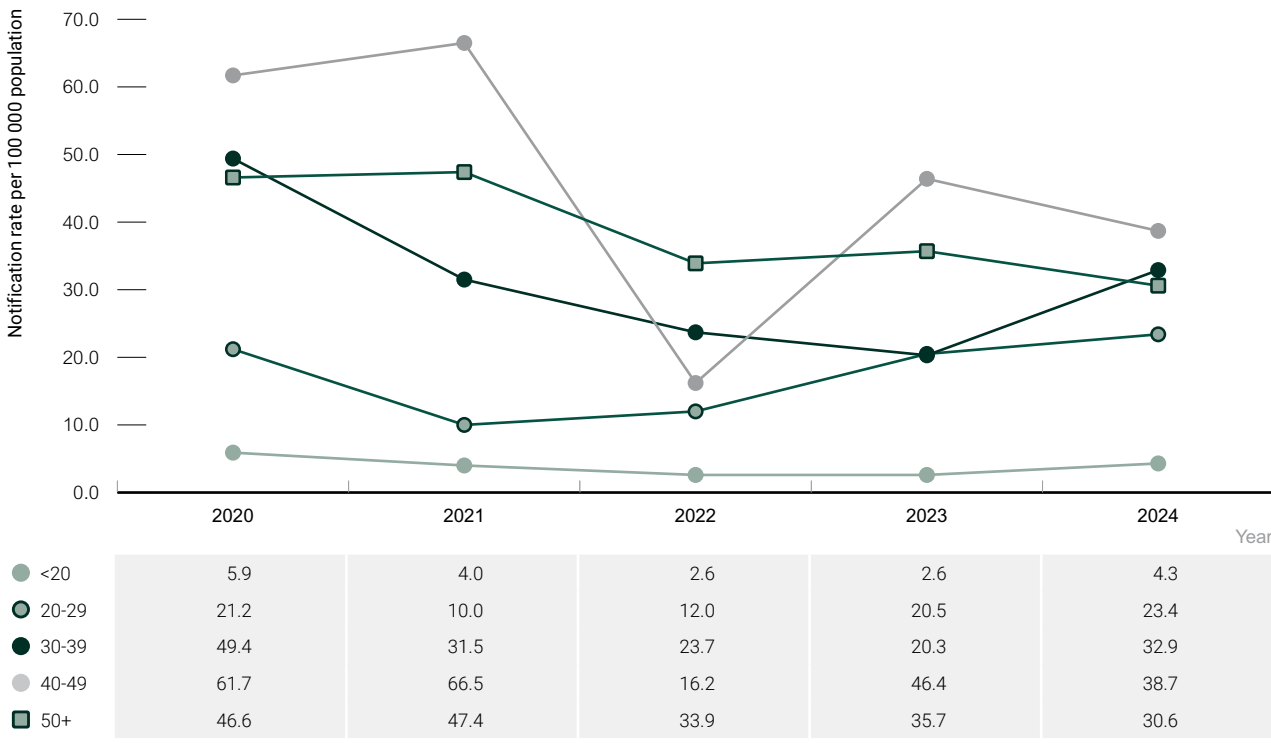
Figure 53 Hepatitis B notification rate per 100 000 population by Aboriginal and Torres Strait Islander status, age group and gender, 2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Non-Indigenous people was reported for $\geq 50\%$ of notifications for each year (Australian Capital Territory, Northern Territory, Queensland, South Australia and Western Australia).

By age-group, the highest hepatitis B rates in 2024 were among those aged 40 to 49 years (38.7 notifications per 100 000) followed by those aged over 50 years (30.6 per 100 000), likely reflecting the impact of childhood and adolescent vaccination programs in the younger age groups (Figure 55).

Figure 54 Hepatitis B notification rate per 100 000 population among Aboriginal and Torres Strait Islander peoples by age group, 2020–2024

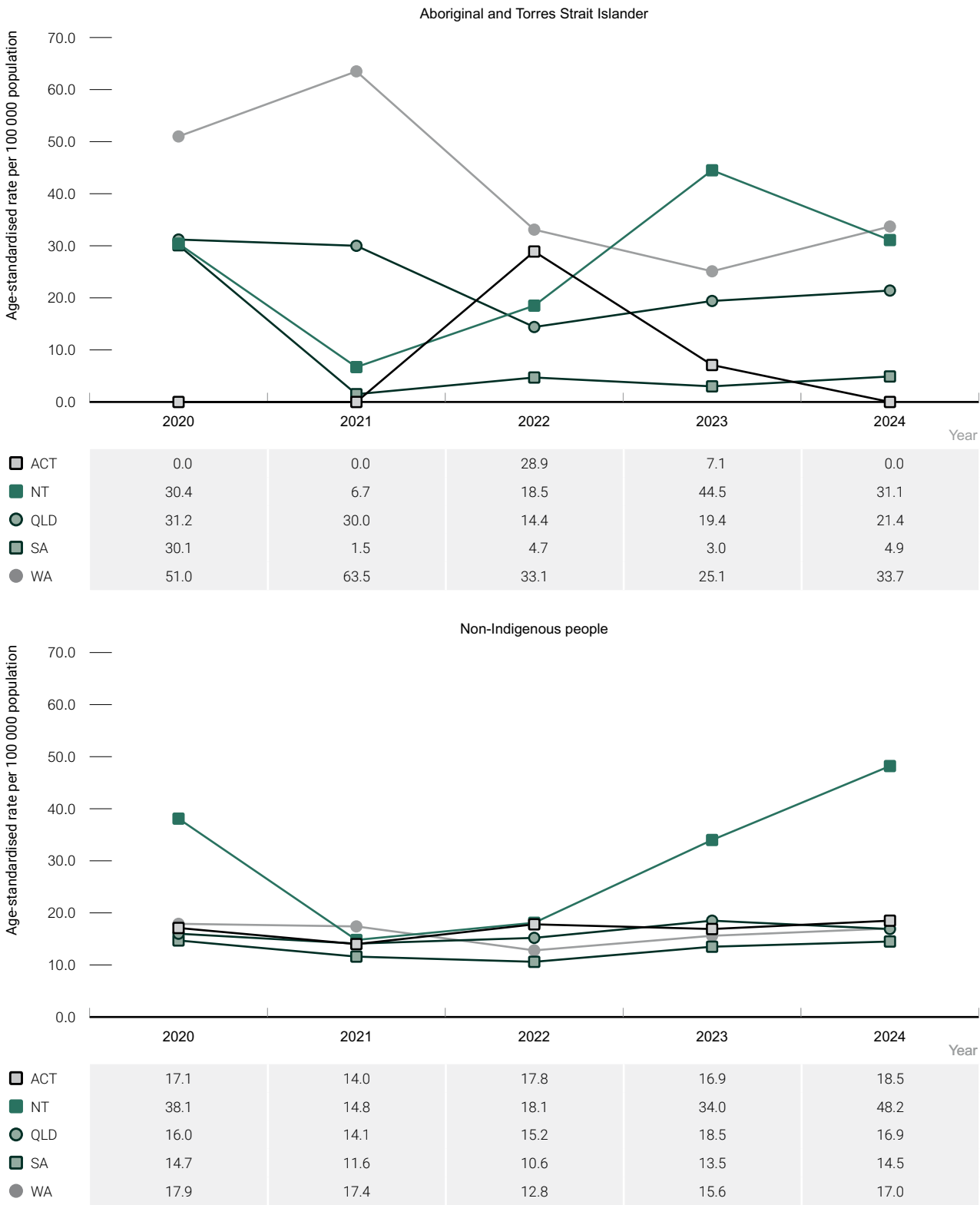


Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Non-Indigenous people was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, Queensland, South Australia and Western Australia).



In 2024, hepatitis B notification rates among Aboriginal and Torres Strait Islander peoples were highest in Western Australia (33.7 per 100 000), followed by the Northern Territory (31.1 per 100 000). Overall, notification rates were highest in non-Indigenous population for the Northern Territory (48.2 per 100 000). Interpretation of trends over time by state and territory are difficult due to the overall small number of notifications (Figure 56).

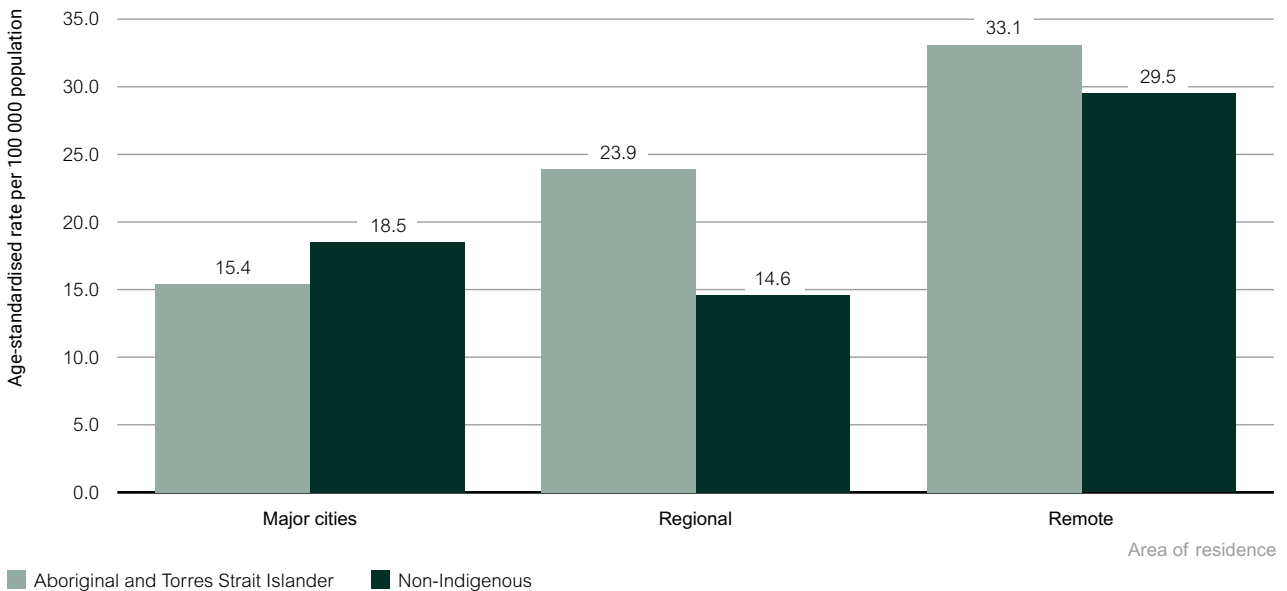
Figure 55 Hepatitis B notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and state/territory, 2020–2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Non-Indigenous people was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, Queensland, South Australia, South Australia and Western Australia).

In 2024, the hepatitis B notification rate among Aboriginal and Torres Strait Islander peoples was highest among people living in remote areas (33.1 per 100 000), followed by regional areas (23.9 per 100 000), then major cities (15.4 per 100 000). The hepatitis B notification rate among Aboriginal and Torres Strait Islander peoples was higher than in non-Indigenous people in all regional and remote areas. (Figure 57).

Figure 56 Hepatitis B notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and area of residence, 2024



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Non-Indigenous people was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, Queensland, South Australia, South Australia and Western Australia).

Over the five-year reporting period, hepatitis B notification rates among Aboriginal and Torres Strait Islander peoples decreased across all areas of residence. Rates decreased by 32% in regional areas (35.1 per 100 000 in 2020 and 23.9 in 2024), 37% in major cities (24.5 per 100 000 in 2020 and 15.4 in 2024) and 27% in remote areas. (Figure 57).

Figure 57 Hepatitis B notification rate per 100 000 population among Aboriginal and Torres Strait Islander peoples, by area of residence



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Non-Indigenous people were reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, Queensland, South Australia, South Australia and Western Australia).

Hepatitis B prevalence

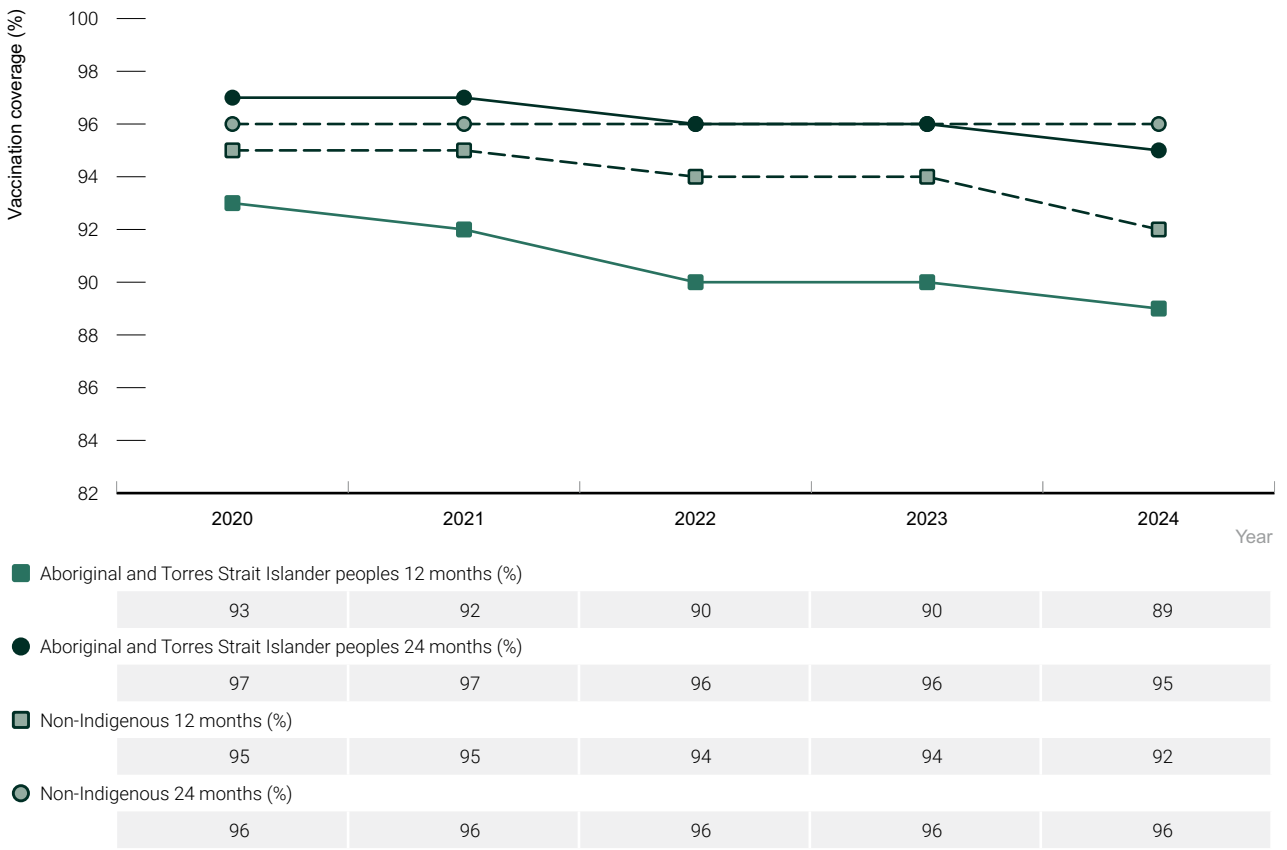
According to the 2024 estimates published in the [Viral Hepatitis Mapping Project: Hepatitis B](#), 14 785 Aboriginal and Torres Strait Islander people were living with chronic HBV (CHB), with a prevalence of 1.43%. Aboriginal and Torres Strait Islander people, the majority of whom likely acquired CHB via mother-to-child transmission in the era of vaccination, were estimated to represent 6.7% of people living with CHB in Australia.

Vaccination

In the Northern Territory in 1985, hepatitis B screening was introduced for all pregnant women as well as vaccination for infants born to people living with chronic hepatitis B infection. In 1990, universal infant vaccination was implemented in the Northern Territory and, in 1998, a catch-up program targeting children aged 6-16 years was introduced. Queensland delivered state-funded infant hepatitis B vaccination program for Aboriginal and Torres Strait Islander people and other at-risk groups from 1984 and was expanded in 1986 including babies born to HBsAg positive mothers (3 doses) ⁶. A universal school-based hepatitis B vaccination catch-up program for adolescents aged 12-15 years commenced in 1998 and in other jurisdictions of Australia, hepatitis B vaccination of all infants commenced in 2000 ⁷.

While the overall hepatitis b vaccination coverage for children between 2020 and 2024 was high, the vaccination coverage for Aboriginal and Torres Strait Islander children has been declining since 2021. For Aboriginal and Torres Strait Islander children, coverage was lower than for non-Indigenous children at 12 months of age (at 89% to 93%). At 24 months of age, vaccination coverage was similar between Aboriginal and Torres Strait Islander children and non-Indigenous children, at 95% and 96%, respectively. (Figure 58).

Figure 58 Hepatitis B vaccination coverage estimates at 12 and 24 months by Aboriginal and Torres Strait Islander status, 2020–2024



Source: National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases.

Acknowledgements

Groups and committees involved in the development of the Surveillance Report, as well as the individuals and organisations that provided data for inclusion in this report, are listed below. The Aboriginal and Torres Strait Islander report was initially developed by Professor James Ward.

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- Cairns Sexual Health Clinic, Cairns; Gold Coast Sexual Health Service, Miami;; Townsville Sexual Health Service, Townsville; Mackay Sexual Health Clinic, Mackay; Mount Isa Sexual Health Clinic, Mount Isa; Palm Island Sexual Health Clinic, Palm Island; Clinic 30, Brisbane; Medeco Inala, Inala; Stonewall Medical, Windsor; QulHN, Brisbane and multiple locations; QLD
- Clinic 275 Sexual Health, Adelaide; O'Brien Street General Practice, Adelaide; Shine SA clinics (including Rapido Testing Service) Adelaide; SA
- Hobart Sexual Health Service, Hobart; Launceston Sexual Health Service, Launceston; Devonport Sexual Health Service, Devonport; TAS
- Melbourne Sexual Health Centre, Melbourne; Barwon Reproductive and Sexual Health (BRASH) Clinic, Geelong; Barwon Health Drug and Alcohol Service, Geelong; Ballarat Community Health, Ballarat; Bendigo Community Health Clinic, Bendigo; Centre Clinic, St Kilda; South Wangaratta Medical Centre Docker St Medical Centre, Wangaratta; Frankston Health, Frankston; Cohealth, Melbourne; North Richmond Community Health, Richmond; EACH Social and Community Health, Melbourne; Dandenong Superclinic, Dandenong; Lygon Court Medical Centre, Carlton; Mediclinic, Clayton; Prahran Market Clinic, Prahran; Pronto!, Abbotsford; Northside Clinic, Fitzroy North; The Alfred Hospital HIV Clinic, Melbourne; Access Health (St Kilda), St Kilda; Yarram and District Health Services, Yarram; Kardinia Health, Belmont; Cranbourne West Medical Centre, Cranbourne West; Kings Park Medical Centre, Hillside; Modern Medical/Qualitas, Caroline Springs; Anglesea Medica, Anglesea; Andrew Place Clinic, Bundoora; Grandview Family Clinic, Cowes; WRAD Health, Warrnambool; Werribee Medical & Dental Centre (ForHealth), Werribee; Sexual Health Victoria Clinic, Box Hill; Sexual Health Victoria Clinic, Melbourne CBD; VIC
- South Terrace Sexual Health Clinic, Fremantle; Perth Sexual Health Clinic, Perth; Deen Clinic, Northbridge; GP on Beaufort, Mount Lawley; M Clinic, Perth; View St Medical, North Perth; Sexual Health Victoria, Northbridge; WA

Genital Warts Surveillance Network

- ACT - Canberra Sexual Health Centre, Canberra
- NSW - Liverpool Sexual Health Clinic, Liverpool; Coffs Harbour Sexual Health Clinic, Coffs Harbour; Grafton Sexual Health Clinic, Grafton; Albury Sexual Health Clinic, Albury; Bega Community Health Service, Bega; Goulburn Sexual Health Clinic, Goulburn; Griffith Sexual Health Clinic, Griffith; Narooma Sexual Health Clinic, Narooma; Queanbeyan Sexual Health Clinic, Queanbeyan; Wagga Sexual Health Clinic, Wagga Wagga; Holden Street Clinic, Gosford; Newcastle Sexual Health Clinic, Newcastle; Forster Sexual Health Clinic, Forster; Bligh Street Clinic, Tamworth; Taree Manning Clinic, Taree; Illawarra Sexual Health Clinic, Warrawong; Nowra Sexual Health Clinic, Nowra; Kirketon Road Centre, Darlinghurst; Clinic 180, Potts Point; Lismore Sexual Health Service, Lismore; Tweed Heads Sexual Health Service, Tweed Heads; Clinic 16, North Shore Sexual Health Service, Sydney; Manly Sexual Health Clinic, Sydney; RPA Sexual Health Clinic, Sydney; Short Street Centre Sexual Health Clinic, Kogarah; Western Sydney Sexual Health Centre, Parramatta; Mount Druitt Sexual Health Clinic (formerly Luxford Road Sexual Health Clinic), Mount Druitt; Blue Mountains Sexual Health Clinic, Katoomba; Nepean Sexual Health Clinic, Penrith; Sydney Sexual Health Centre, Sydney; WAYS Youth Health Clinic, Bondi Junction; Lightning Ridge Sexual Health Service, Lightning Ridge; Bourke Sexual Health Service, Bourke; Dubbo Sexual Health, Dubbo; Orange Sexual Health Clinic, Kite Street Community Health Centre, Orange; Broken Hill Sexual Health, Broken Hill; Balranald Sexual Health Service, Dareton; a[TEST], Darlinghurst; a[TEST], Newtown; a[TEST], Surry Hills
- NT - Alice Springs Clinic 34, Alice Springs; Darwin Clinic 34, Darwin
- QLD - Cairns Sexual Health Clinic, Cairns; Gold Coast Sexual Health Service, Miami; Princess Alexandra Sexual Health, Woolloongabba; Townsville Sexual Health Service, Townsville; Mackay Sexual Health Clinic, Mackay; Mount Isa Sexual Health Clinic, Mt Isa; Palm Island Sexual Health Clinic, Palm Island
- SA - Clinic 275 Sexual Health, Adelaide
- TAS - Hobart Sexual Health Service, Hobart; Launceston Sexual Health Service, Launceston; Devonport Sexual Health Service, Devonport
- VIC - Melbourne Sexual Health Centre, Melbourne; Barwon Reproductive and Sexual Health Clinic, Geelong
- WA - Fremantle Hospital Sexual Health Clinic, Fremantle

National Organisations

- Australasian Sexual Health Alliance, Sydney, NSW
- Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine, Sydney, NSW
- Australian Centre for Disease Control, Canberra, ACT
- Australian Injecting and Illicit Drug Users League, Canberra, ACT
- Australian Institute of Health and Welfare, Canberra, ACT
- Australian Paediatric Surveillance Unit, Westmead, NSW
- Australian Red Cross Lifeblood, Melbourne, VIC
- Centre for Social Research in Health, UNSW Sydney, Sydney, NSW
- Communicable Diseases Network Australia, Canberra, ACT
- Doherty Institute, Melbourne, VIC
- Health Equity Matters, Sydney, NSW
- Hepatitis Australia, Canberra, ACT
- Burnet Institute for Medical Research and Public Health, Prahran, VIC
- National Aboriginal Community Controlled Health Organisation, Canberra, ACT
- National Association of People with HIV Australia, Sydney, NSW
- National Serology Reference Laboratory, Australia, Fitzroy, VIC
- Scarlet Alliance, Australian Sex Workers Association, Sydney, NSW
- WHO Collaborating Centre for Viral Hepatitis, The Doherty Institute, VIC

State/Territory Health Departments

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- Steven Nigro, Monica Lahra, Liz Walker, Communicable Diseases Branch, Health Protection NSW, NSW Health, NSW Government, North Sydney, NSW
- Jerry Chen, Sexual Health and Blood Borne Virus Unit, Centre for Disease Control, NT Health, Northern Territory Government, Darwin, NT
- Damin Si, Emma Sanguinetti, Meg Dalmau, Communicable Diseases Branch, Queensland Department of Health, Queensland Government, Brisbane, QLD
- Trisha Rogers, Jamie Pearson, Communicable Disease Control Branch, SA Health, Government of South Australia, Adelaide SA
- Freya Hogarth, Department of Health, Tasmanian Government, Hobart, TAS
- Nasra Higgins, Communicable Disease Epidemiology and Surveillance, Health Protection Branch, Department of Health, Victoria State Government, Melbourne, VIC
- Carolien Giele, Byron Minas, Barry Combs, Kellie Mitchell, Nevada Pingault Communicable Disease Control Directorate, WA Department of Health, Government of Western Australia, Perth, WA

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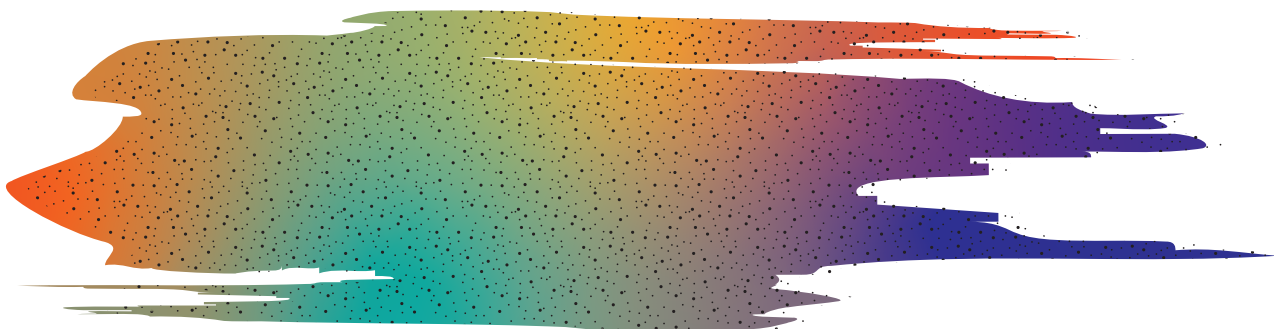
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Cover Artwork Narrative & Description

The circles represent the different communities and organisations we are part of. These circles are all made up of many other circles with different styles and patterns, this is symbolic of the different kinds of people that make up a community or an organisation. Each person has their own story, knowledge and experience.



The background is made up of the changing landscapes as we move across this land from country to country. There is blue for the coast, with yellow sands. We move further inland and get rainforest green and bushland before coming into the oranges and burnt umbers that make up the deserts and grasslands.



The lines that connect everything together have two meanings. They represent the way we engage with each other, with services, the way we move about across country. They also represent the way we can easily spread viruses and diseases if we are not careful about the way we engage with others. Everybody communicates differently and we engage services at different times and for different reasons. We are all on a journey and that will look different for each person.



