



Government of **Western Australia**
Department of **Health**

Public Health Review of Congenital Syphilis Cases in WA Jan 2019 – Dec 2025: Summary Report

Contents

1. Executive Summary	2
2. Introduction	4
2.1 Overview of syphilis epidemiology and antenatal syphilis testing in WA	4
3. Case Review Findings	7
4. Statewide Public Health Actions to Date	13
4.1 WA Syphilis Outbreak Response Group	13
4.2 Strategy and investment	13
4.3 Prevention, education and community engagement	14
4.4 Workforce development	17
4.5 Testing, treatment and contact tracing	17
4.6 Surveillance and reporting	18
4.7 Other key achievements	20
5. Conclusions	20
Appendix 1. Antenatal syphilis testing in WA, Q3 2021 – Q4 2025.	22
Appendix 2. WA Department of Health syphilis campaign examples, 2020 – 2024.	25
Appendix 3. WA Department of Health's Syphilis Point-of-Care Testing program.	29

1. Executive Summary

Infectious syphilis is a notifiable sexually transmissible infection (STI) which, predominantly due to risk of congenital syphilis, is a significant public health concern. In Western Australia (WA), the occurrence of a congenital syphilis case is a sentinel event and public health reviews for each case of congenital syphilis are conducted for the purpose of health system improvement and preventing future cases.

Twenty-five public health reviews were conducted for 20 (13 live, 7 stillbirths) cases of congenital syphilis and five “near miss”¹ cases notified between Jan 2019 and Dec 2025. The cases occurred in both regional (12 cases) and metropolitan (13 cases) public health regions, and 16 of the infants were Aboriginal.

People exposed to one or more of the following situations were over-represented in those who had a baby with congenital syphilis or a near miss: living in a remote area, experiencing homelessness, alcohol use, drug use and/or other complex social issues. Inability to access culturally safe and comprehensive primary health care was a frequent factor contributing to inadequate/absent reproductive health and antenatal care, resulting in delayed syphilis diagnosis and treatment, and congenital syphilis. Staff lack of syphilis outbreak knowledge and the importance of syphilis testing in pregnancy contributed to only a few cases, mostly before 2022.

Recommendations from congenital syphilis reviews are implemented under the governance of the WA Syphilis Outbreak Response Group (WA SORG). WA SORG uses a partnership approach to STI control and sexual health promotion. Key interventions include:

- all pregnant people are offered syphilis testing at first antenatal visit, 28 and 36 weeks (or at time of any preterm birth),
- establishment of surveillance systems for infectious syphilis case and contact management and for antenatal syphilis testing,
- public health units coordinating multi-disciplinary case management of pregnant people with infectious syphilis,
- development and timely updating of WA guidelines for managing syphilis, syphilis in pregnancy and congenital syphilis,
- availability of point-of-care testing in many primary health care and Aboriginal community controlled health services, and some hospitals in WA, and
- statewide and local community and patient syphilis education campaigns.

The first case of congenital syphilis associated with the current outbreak occurred in 2018, four years after the outbreak started in WA. Infectious syphilis notifications in WA peaked in 2021 then declined until 2024 before rising in 2025 to just below 2022’s level. Congenital syphilis notifications plateaued at four per year from 2020 to 2023, followed by zero and three congenital syphilis notifications in 2024 and 2025, respectively. This indicates that WA’s syphilis outbreak response, initiated in 2018 and informed by the findings and recommendations of congenital syphilis case reviews, is beginning to control congenital syphilis. Given the potentially long lag time between a female of reproductive age acquiring syphilis and vertical transmission during pregnancy to an infant, it is hoped that congenital syphilis notifications will reduce as adherence with testing for syphilis three times during pregnancy continues to improve.

Meanwhile, alternative and co-designed models of care need to be explored with Aboriginal women, other affected communities and key stakeholders to ensure that people of reproductive age can access comprehensive and culturally safe primary health care services that include

¹ Defined as a diagnosis of infectious syphilis in a pregnant person, who did not receive adequate treatment, and baby was not diagnosed with congenital syphilis in the neonatal period.

provision of holistic, culturally safe and competent reproductive health care including contraception and antenatal care. While background syphilis rates remain high, health care improvement/reorientation alone are unlikely to be sufficient to prevent all cases of CS unless social determinants of health are also addressed.

2. Introduction

Infectious syphilis is a notifiable sexually transmissible infection (STI) which, predominantly due to risk of congenital syphilis, is a significant public health concern in Western Australia (WA). WA has experienced a marked increase in syphilis notifications over recent years which has included cases of congenital syphilis. This has resulted in a targeted and comprehensive response at both statewide and local levels. One component of this response has included public health reviews of the congenital syphilis cases (reviews).

The information included in the report relates to the reviews of 21 cases of congenital syphilis and five near misses (diagnosis of infectious syphilis in a pregnant person who did not receive adequate treatment, and baby was not diagnosed with congenital syphilis in the neonatal period), notified between 1st January 2019 and 31 December 2025.

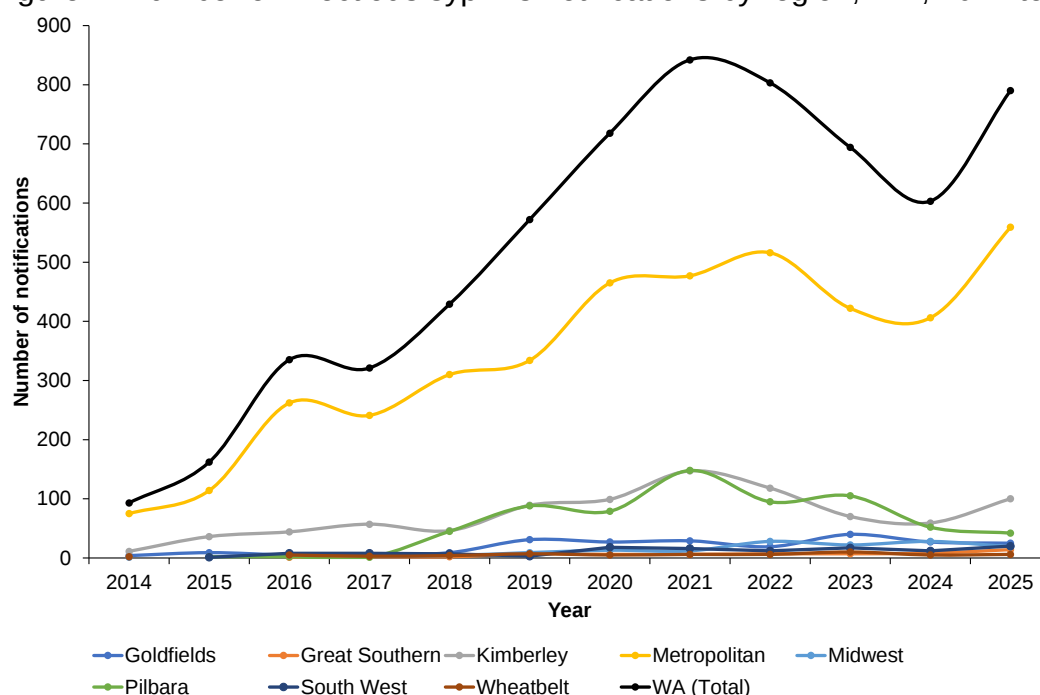
2.1 Overview of syphilis epidemiology and antenatal syphilis testing in WA

There has been an ongoing infectious syphilis outbreak affecting Aboriginal people in regional and remote Northern and Central Australia primarily in people aged 15 to 34 years. The outbreak began in northern Queensland in 2011 and reached the Northern Territory in 2013. The outbreak moved into the Kimberley region in mid-2014 with related clusters identified in mid-2018 in the Pilbara region and the Goldfields in early-2019.

In mid-2020 the Chief Health Officer authorised a statewide public health response to infectious syphilis in identified at-risk populations after increasing syphilis notifications in the Perth metropolitan area and South West region, the majority of which were not epidemiologically linked to the Kimberley, Pilbara or Goldfields.

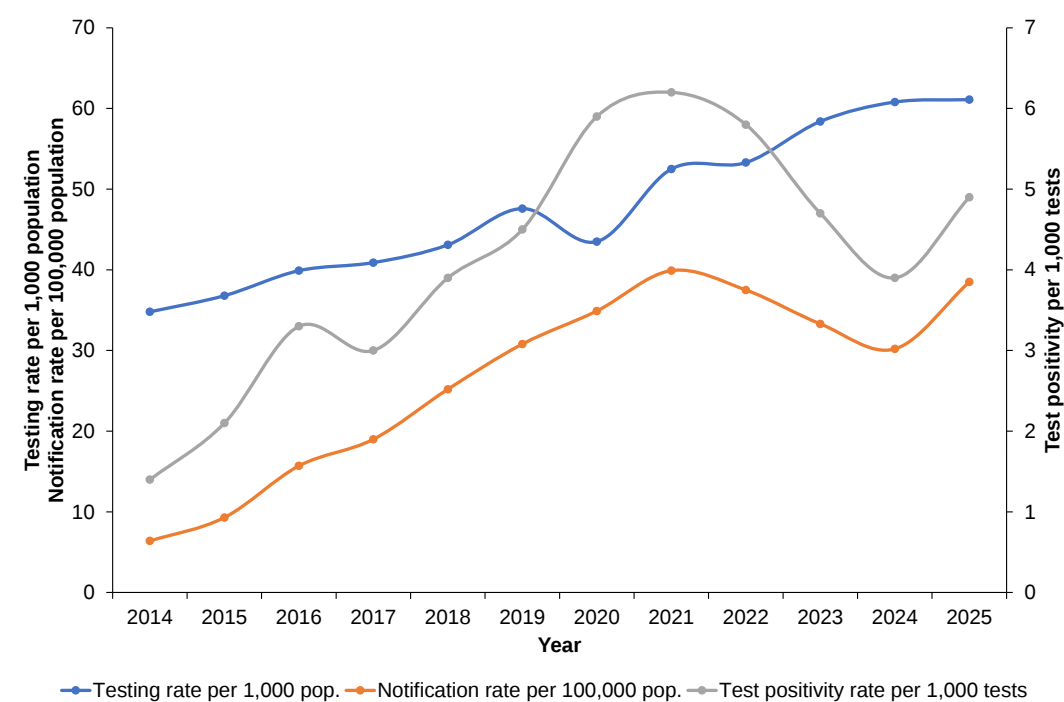
The number of infectious syphilis notifications in WA increased from 93 in 2014 to 842 in 2021, decreased to 603 in 2024 and increased to 790 in 2025 (Figure 1). From 2024 to 2025, the number of infectious syphilis notifications among females increased from 189 to 220 and 88% of were of reproductive age (15 to 44 years) (Figure 3).

Figure 1. Number of infectious syphilis notifications by region, WA, 2014 to 2025.



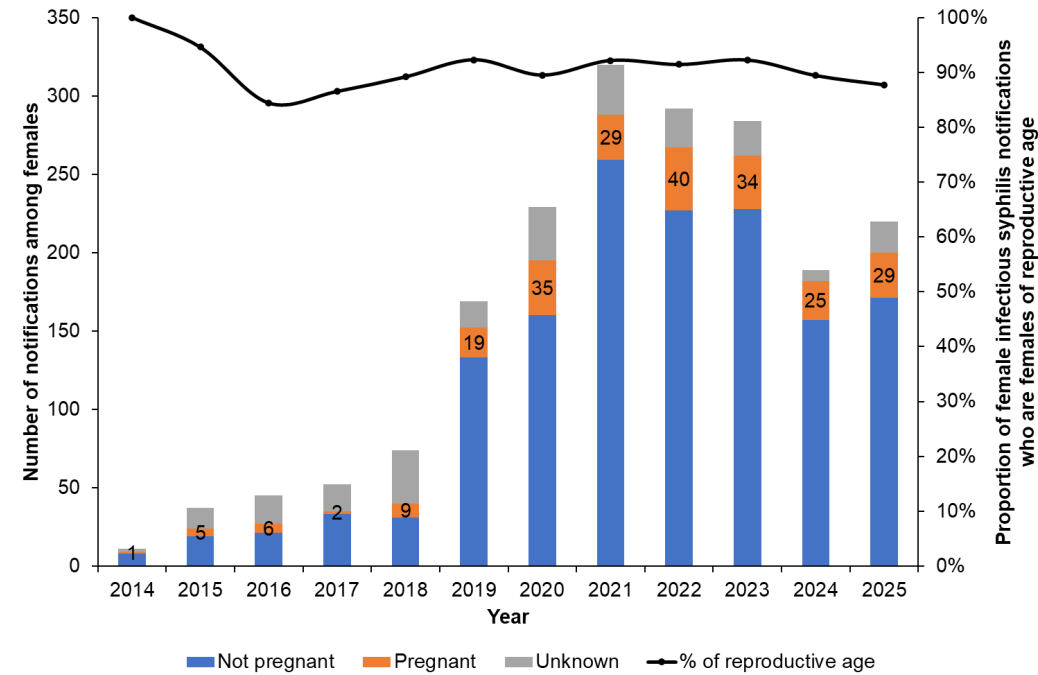
The increase in syphilis notifications from 2024 to 2025 was primarily driven by increased disease transmission while the testing rate remained stable (Figure 2).

Figure 2. Syphilis testing rate, notification rate and test positivity rate in WA by year, 2014 to 2025.



The number of pregnant people notified with infectious syphilis each year increased from one in 2014 to 40 in 2022 and decreased to 29 in 2025 (Figure 3).

Figure 3. Number of infectious syphilis notifications among females by pregnancy status and proportion of female infectious syphilis notifications who are females of reproductive age (15 to 44 years), WA, 2014 to 2025.



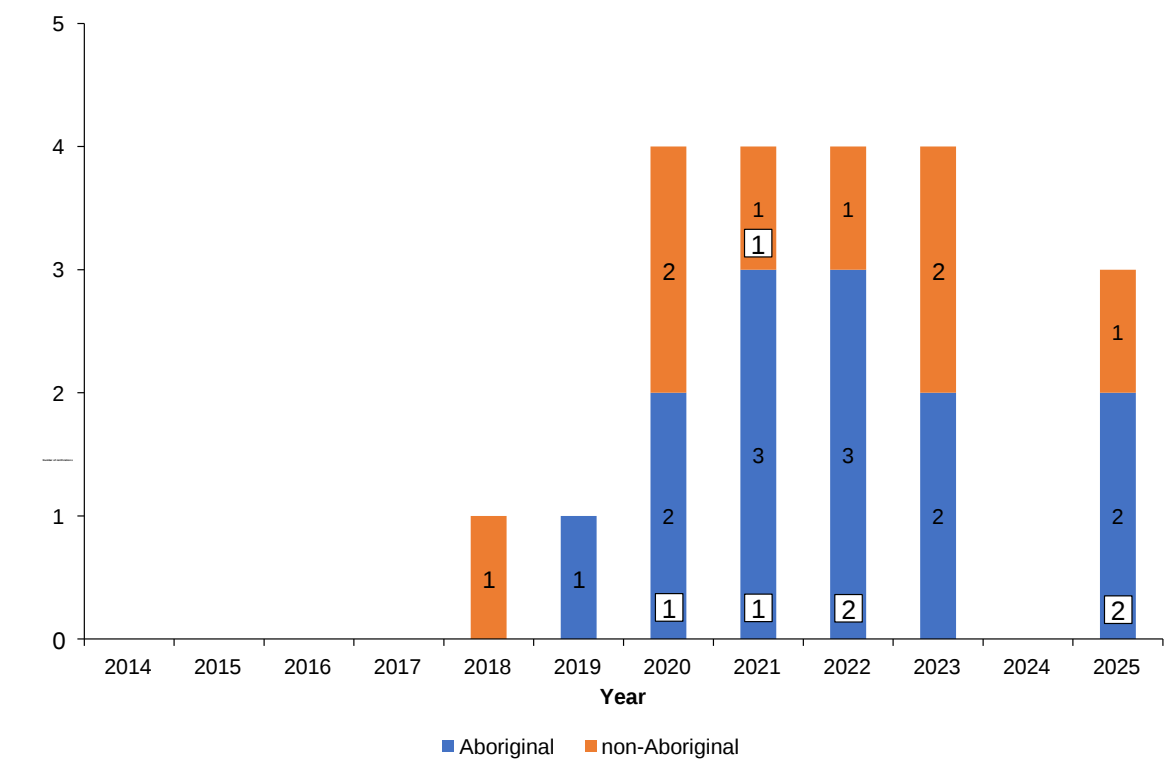
Of the 234 pregnant people notified with infectious syphilis from 2014 to 2025, 91% were born in Australia, more than two-thirds (68%) were Aboriginal, the majority (56%) lived outside metropolitan Perth and the median gestation at diagnosis was 12 weeks (Table 1). Between 2014-2019 and 2020-2025, there was an increase in the proportions who were non-Aboriginal (21% vs 34%) and lived in metropolitan Perth (26% vs 27%) (Table 1).

Table 1. Characteristics of pregnant people diagnosed with infectious syphilis, WA, 2014-19 and 2020-2025.

	2014-2019		2020-2025		2014-2025	
Characteristics	Number	Percent	Number	Percent	Number	Percent
Aboriginality						
Aboriginal	34	79%	127	66%	161	69%
non-Aboriginal	9	21%	65	34%	74	31%
Country of birth						
Australia	40	93%	174	91%	214	91%
Overseas	3	7%	17	9%	20	9%
Area of residence						
Metro	11	26%	91	47%	102	43%
Non-metro	32	74%	101	53%	133	57%
Gestation at diagnosis						
Median (weeks)	13		12		12	
Range (weeks)	4 to 37		4 to 38		4 to 38	

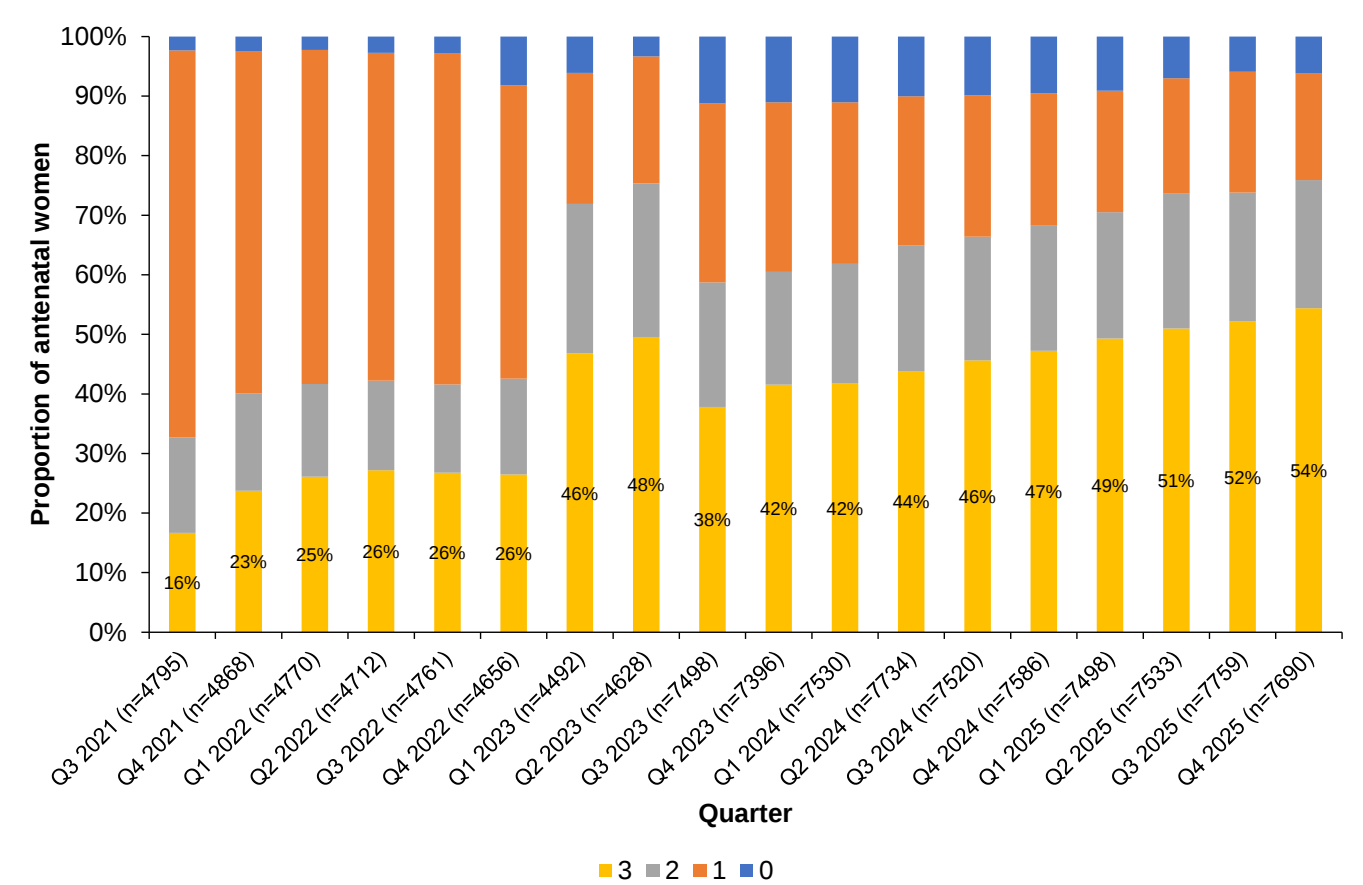
From 2014 to 2025, there were a total of 21 congenital syphilis notifications: 13 among Aboriginal infants and 8 among non-Aboriginal infants. Of these 21 congenital syphilis cases, 7 (6 Aboriginal and 1 non-Aboriginal) were stillborn infant (Figure 4).

Figure 4. Number of congenital syphilis notifications by Aboriginality and year, WA, 2014 to 2025 (stillbirths indicated in boxes).



Since March 2021 the [WA STI and BBV management guidelines](#) have recommended that all pregnant people in WA should be offered serologic testing for syphilis at the first antenatal visit, and 28 weeks and 36 weeks gestation (or at time of any preterm birth). The proportion of people who had undergone 3 syphilis tests in pregnancy increased from 16% in the third quarter (Q3) of 2021 to 54% in the final quarter (Q4) of 2025 (Figure 5). Improvement in the proportion of pregnant people tested for syphilis 3 times in pregnancy was greater in non-Aboriginal people (15% in Q3 2021, 55% in Q4 2025) than Aboriginal people (27% in Q3 2021, 51% in Q4 2025) (Appendix 1). In Q4 2025, the Pilbara region recorded the highest proportion of Aboriginal people with 3 antenatal syphilis tests (61%), and the Kimberley region recorded the highest proportion among non-Aboriginal people (85%). The Metropolitan region recorded the lowest proportion of Aboriginal people with 3 antenatal syphilis tests (46%), and the Great Southern region recorded the lowest proportion among non-Aboriginal people, although the latter has not been engaged in the outbreak response for as long as some other regions (Appendix 1).

Figure 5. Proportion of pregnant people in WA tested for syphilis by number of tests, Q3 2021 to Q4 2025.



Note: Data from Q3 2021 to Q2 2023 collected through STORK and includes only data from public hospitals and homebirths. Mandatory reporting of antenatal syphilis testing commenced in July 2023. Data from Q3 2023 to Q4 2023 collected through STORK and MNS and includes data from public hospitals and home births, and private hospitals and homebirths.

3. Case Review Findings

Between 2019 and 2025, 26 reviews were conducted in accordance with the [WA Guidelines for review of congenital syphilis cases](#).

As shown in Table 2, nearly all mothers who delivered a baby with congenital syphilis or near miss from 2019 to 2025 were aged 20 to 37 years (92%) and had acquired their infection in

Australia (88%). Just over one half (54%) resided in the Perth metropolitan area. Of the seven mothers who delivered a stillborn baby with congenital syphilis, five (71%) were from the Goldfields or Pilbara WA Country Health Service (WACHS) regions and six (86%) were Aboriginal. All but one of the stillborn babies were Aboriginal. Although the Kimberley has WA's highest syphilis notification rate, this region contributed only one congenital syphilis notification; this occurred and at the beginning of the outbreak.

The proportion of mothers who delivered a baby with congenital syphilis or near miss who had presented for health care (excluding delivery) in the first or second trimester, dropped from 90% in 2019-2024 to 20% in 2025. A common feature of the three congenital syphilis cases and one near miss from 2025 was social/personal circumstances that inhibited the mother's access to comprehensive primary health care in general and specifically, to reproductive health care including contraception and antenatal care. In two of the three cases in 2025, the first presentation to a health service during the pregnancy was at the time of delivery.

Many mothers were affected by homelessness, unstable accommodation, alcohol and/or drug use and other complex social issues, e.g. foetal alcohol spectrum disorder (FASD), family and domestic violence, family substance use issues, sexual assault, children under the care of the Department of Communities Child Protection. These complex issues, in combination with widespread shortages of bulk-billed general practice appointments, often result in inequity of access to comprehensive, patient-centred primary health care, including culturally safe and competent antenatal care. Furthermore, these traumas can affect the mother's capacity to trust and be receptive to care offered by government, health care, social and other support services.

Table 2. Demographic and disease characteristics of mothers who delivered a baby with congenital syphilis or near miss, 2019 to 2025.

Maternal characteristics	Congenital syphilis live birth, n=13	Congenital syphilis stillbirth, n=7	Near miss, n=5	Total, n=25
Age (years)				
<20	0 (0%)	2 (29%)	1 (20%)	3 (12%)
20 to 29	10 (77%)	3 (43%)	1 (20%)	14 (56%)
30 to 39	3 (23%)	2 (29%)	3 (60%)	8 (32%)
Median, range	27, 20-36	23, 16-31	34, 19-38	27, 16-38
Residential location				
Metropolitan Perth	8 (62%)	2 (29%)	3 (60%)	13 (52%)
Goldfields, Kimberley or Pilbara WA Country Health Service (WACHS) regions	4 (31%)	5 (71%)	1 (20%)	10 (40%)
Great Southern, Midwest, South West or Wheatbelt WACHS regions	1 (8%)	0 (0%)	1 (20%)	2 (8%)
Aboriginality				
Aboriginal	7 (54%)	6 (86%)	3 (60%)	16 (64%)
Non-Aboriginal	6 (46%)	1 (14%) (baby Aboriginal)	2 (40%)	9 (36%)
Country of birth				
Australia	11 (85%)	7 (100%)	3 (60%)	21 (84%)
Other	2 (15%)	0 (0%)	2 (40%)	4 (16%)
Place of syphilis acquisition				
Australia	12 (92%)	7 (100%)	3 (60%)	22 (88%)
Other	1 (8%)	0 (0%)	2 (40%)	3 (12%)
Homeless/unstable accommodation				
Yes	5 (38%)	1 (13%)	2 (40%)	8 (32%)
No	8 (62%)	6 (86%)	3 (60%)	13 (52%)
Cont'd on next page				

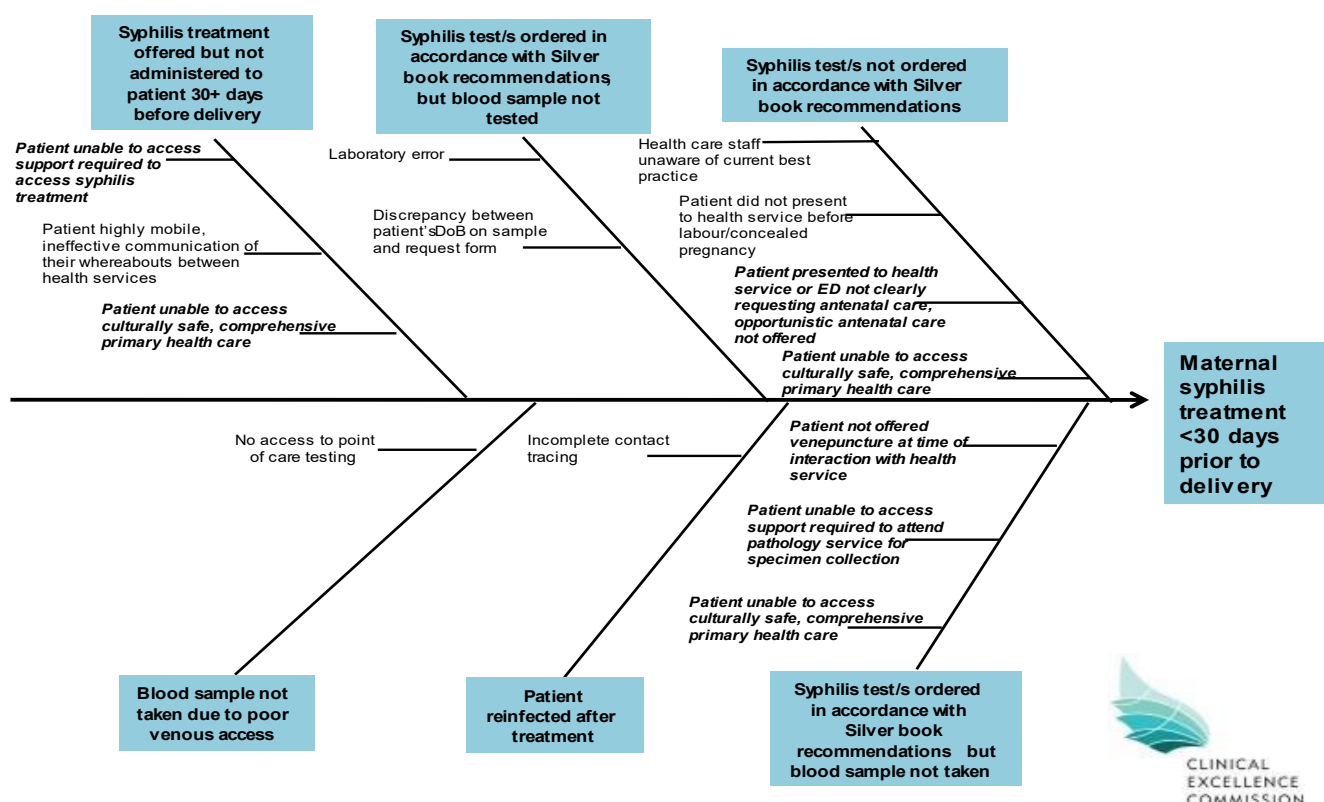
Maternal characteristics	Congenital syphilis live birth, n=13	Congenital syphilis stillbirth, n=7	Near miss, n=5	Total, n=25
Alcohol/other drug use during pregnancy				
Yes	7 (54%)	2 (29%)	2 (40%)	11 (46%)
No	6 (46%)	5 (71%)	3 (60%)	14 (56%)
Other complex social issues, e.g. pregnant mother has FASD, family and domestic violence, family substance use issues, sexual assault, DCPFS involvement				
Yes	9 (69%)	2 (29%)	3 (60%)	14 (56%)
No	4 (31%)	5 (71%)	2 (40%)	11 (46%)
Trimester in which mother first presented for health care				
1	9 (69%)	2 (29%)	3 (60%)	14 (56%)
2	2 (15%)	3 (3%)	1 (20%)	6 (24%)
3	1 (8%)	0 (0%)	0 (0%)	1 (4%)
At delivery	1 (8%)	2 (29%)	1 (20%)	4 (16%)
Tested for syphilis in pregnancy during trimester				
1	5 (38%)	0 (0%)	2 (40%)	7 (28%)
2	3 (23%)	1 (20%)	3 (60%)	7 (28%)
3	4 (31%)	0 (0%)	3 (60%)	7 (28%)
Trimester/time of syphilis diagnosis				
1	0 (0%)	0 (0%)	1 (20%)	1 (4%)
2	1 (8%)	0 (0%)	1 (20%)	2 (10%)
3	4 (31%)	0 (0%)	2 (40%)	6 (24%)
At delivery	7 (54%)	7 (100%)	1 (20%)	15 (60%)
>6 weeks post-partum	1 (8%)	0 (0%)	0 (0%)	1 (4%)
Syphilis treatment within 14 days of diagnosis				
Yes	11 (85%)	5 (71%)	4 (80%)	20 (80%)
No	2 (15%)	2 (29%)	1 (20%)	5 (20%)
Syphilis treatment 30+days prior to delivery				
Yes	0 (0%)	0 (0%)	1 (reinfected after treatment)	1 (4%)
No	13 (100%)	7 (100%)	4 (80%)	24 (96%)

Of the 20 mothers who delivered a live or stillborn baby with congenital syphilis from 2019 to 2025, all but one (95%) were diagnosed with syphilis in the third trimester or later. None had received syphilis treatment more than 30 days prior to delivery (Table 2).

Qualitative analysis of review documents, including meeting minutes and case summaries, identified factors contributing to syphilis treatment not being completed 30 or more days before delivery. These factors are summarised in Figure 6. A common issue was the mother's inability to access antenatal care within the context of a culturally safe, comprehensive primary health care service. This is due to the siloed nature of many health services and their requirement for the patient to "fit into" the health service's requirements, rather than having the flexibility to provide patient-centred care that meets the patient's individual requirements. Presentation to an emergency department (ED) was a frequent "symptom" of this issue. There was significant variability in EDs interest in, and capacity to, provide opportunistic antenatal care and/or referral to antenatal care for pregnant people who presented to ED with non-urgent pregnancy-related conditions. This was despite the fact that the person was obviously pregnant, had received little/no antenatal care and was using the ED as a primary health care service because of limited access to a GP/primary health care.

Lack of staff knowledge about the syphilis outbreak and the importance of syphilis testing in pregnancy contributed to only a few cases, mostly before 2022.

Figure 6. Factors contributing to syphilis treatment not being completed 30 or more days before delivery (factors in *italic font* were identified in many cases).



Clinical management, including infection control, of all babies with congenital syphilis was implemented in accordance with the Child and Adolescent Health Service's guideline [Syphilis: Investigation and management of the neonate born to a mother with syphilis](#).

The following vignettes are based on features common to many of the cases.

Vignette 1

Mariam, aged 29 years, and her partner are in Australia on overseas student visas and do not have access to Medicare. Her syphilis, hepatitis B and HIV tests at the first trimester antenatal visit were negative, she was not offered testing for chlamydia or gonorrhoea. She presented to ED at 20 weeks with vaginal discharge and was treated empirically with azithromycin for chlamydia which was detected in the high vaginal swab, no other STI tests were offered in ED and contact tracing was not mentioned. She did not mention the chlamydia infection at her 28 week check-up. Syphilis testing was requested along with the oral glucose tolerance test at 28 weeks but she did not present for the blood test due to a respiratory infection and financial barriers to accessing care. At her next presentation for antenatal care at 37 weeks, syphilis testing showed RPR 128 and positive treponemal antibody test. Syphilis treatment was commenced promptly but she delivered a baby with clinical features of congenital syphilis at 38 weeks. She reported her partner as being her only sexual contact during pregnancy. Questioning and testing of her partner indicated that he had probably acquired syphilis a few weeks before she presented with chlamydia, contact tracing was not possible because he reported that this person was no longer living in Australia.

Vignette 2

Abigail, aged 28 years, is from a remote region A. Her medical history includes FASD, methamphetamine, alcohol use and several hospital admissions for psychotic symptoms. She has 3 other children, all of whom are under the care of the DCPFS. She presented to a health service for homeless people in Perth at 10 weeks gestation to discuss options for this unplanned pregnancy. The health service did not take her blood but gave her a laboratory request form for routine first visit antenatal blood tests including syphilis. Due to the transient nature of their patients, the health service does not proactively follow up patients and was unaware that she had not presented to the laboratory specimen collection centre. Her next presentation at a health service was at a hospital ED in region B at 20 weeks gestation with soft-tissue injuries inflicted by her partner. Her pregnancy was noticed; blood was taken for a full set of first visit antenatal blood tests (point of care syphilis testing was not available at this hospital's ED), and she was given an appointment for the antenatal clinic. Three days later, when the syphilis test result (RPR 128 and positive treponemal antibody test) became available the regional public health unit (PHU) attempted to find her and were informed she was had left region B to escape her partner. An alert in the public hospital system notified the regional PHU that she was back in Perth 4 weeks later when she presented to a metropolitan ED at night with a sprained ankle, but she had left hospital before ED staff realised she needed syphilis treatment. Two weeks later she presented with symptoms of sepsis at a different metropolitan hospital and delivered a stillborn baby found to have congenital syphilis at post-mortem.

Vignette 3

Lucy, aged 17 years, lives far away from a financially accessible primary health care service. She presented to hospital in labour at 28 weeks and delivered a stillborn baby found to have congenital syphilis. Testing at the time of delivery showed a high RPR and positive treponemal antibody test; she had never been tested for syphilis previously. Syphilis treatment was commenced in hospital and completed after discharge. She had not received any antenatal care and it was difficult to determine whether she was truly unaware she was pregnancy or had concealed her pregnancy. She had not been attending school for several years. She had no engagement with primary health care or any medical conditions that would have required her to do so. She named one contact, her boyfriend, who was tested and found not to have syphilis. Her family were generally supportive but were keen for her to be discharged soon after delivery and appeared not to encourage her to engage with the Perinatal Loss Service.

4. Statewide Public Health Actions to Date

Recommendations from congenital syphilis public health reviews are developed by attendees at the end of each meeting to address the gaps in healthcare for the discussed case/s. Recommendations are then reviewed by Communicable Disease Control Directorate (CDCD) to implement statewide recommendations. CDCD engages with relevant stakeholders regarding the feasibility and process of activating relevant recommendations. Key recommendations which were activated are noted below.

It may be determined through stakeholder engagement a recommendation is not actionable as a policy change for a range of reasons such as the recommendation has already been activated or the recommendation's desired impact could be better achieved using other strategies.

Some recommendations are for entities outside of CDCD, such as GPs or Department of Justice, in which case CDCD communicates with the relevant entity so they may consider the recommendation and implement as appropriate.

4.1 WA Syphilis Outbreak Response Group

The WA Syphilis Outbreak Response Group was formed in August 2018 and is responsible for coordinating a statewide response to the increasing notifications of infectious syphilis that are being experienced in WA. The group is chaired by the Director of the CDCD and a nominated representative from the Aboriginal Health Council of WA (AHCWA).

The aim of the WA SORG is to control the outbreak of syphilis among communities and eliminate congenital syphilis in WA using partnership strategies that, wherever possible, are applicable to the sustainable control measures for STIs and promotion of sexual health in WA communities.

The WA SORG developed the original *Western Australian Syphilis Outbreak Response Action Plan* (the *Action Plan*) following a statewide consultation with key stakeholders in November 2018. This *Action Plan* was launched by the Minister for Health in Broome, July 2019. The five priority areas of the *Action Plan* are:

- prevention, education and community engagement
- workforce development
- testing, treatment and contact tracing
- surveillance and reporting
- antenatal and postnatal care.

Review findings and recommendations are tabled at WA SORG and were considered in the development of WA's [updated Action Plan](#) and accompanying monitoring framework which were published in 2023. At the time of writing, the 2026-2028 Action Plan is being developed.

Review findings and recommendations also informed local action implemented by Syphilis Outbreak Response Teams (SORTs) located in each Western Australian region. Each SORT has a tailored action plan that closely aligns to the statewide action plan and guides the local response to syphilis outbreaks.

4.2 Strategy and investment

Antenatal and postnatal care remains one of the key priorities of the WA SORG and is integral in the prevention of congenital syphilis. A significant amount of work has been done in the area at both the statewide and local level with several initiatives still underway.

WA SORG has provided funding to the outbreak regions for localised syphilis outbreak response activities since 2019-20. One of the initiatives from this funding was the development of a *Baby*

Baskets Program in the Pilbara, which was later adapted in the Goldfields. This program provides information and incentives for pregnant people to attend regular antenatal care in-line with syphilis testing guidelines. A [case study](#) and video presentation of the program is available on the WA Syphilis Outbreak Response [site](#).

4.3 Prevention, education and community engagement

Statewide syphilis campaigns

The CDCD funds regular statewide campaigns with a focus on infectious and congenital syphilis.

Across 2024 and 2025, three health promotion campaigns were in market and raising awareness of syphilis; two of the campaigns were targeted at people aged 18 to 34 years in WA and ran between December 2023-June 2024 and October-December 2025. These campaigns used a range of mediums including cinema advertising, YouTube advertising, Meta advertising, Snapchat radio advertisement, digital audio, and out-of-home advertising (bus-back posters, public transport station posters and electronic displays) (Figure 7). Key outcomes of the campaign are shown in Table 3 and 4. The large discrepancy between the out-of-home media for the two campaigns is likely due to the second campaign displaying advertisements across 19 train stations and three bus stations, which are high-traffic areas.

Table 3. Outcomes from the non-social media assets for the two CDCD-funded syphilis campaigns.

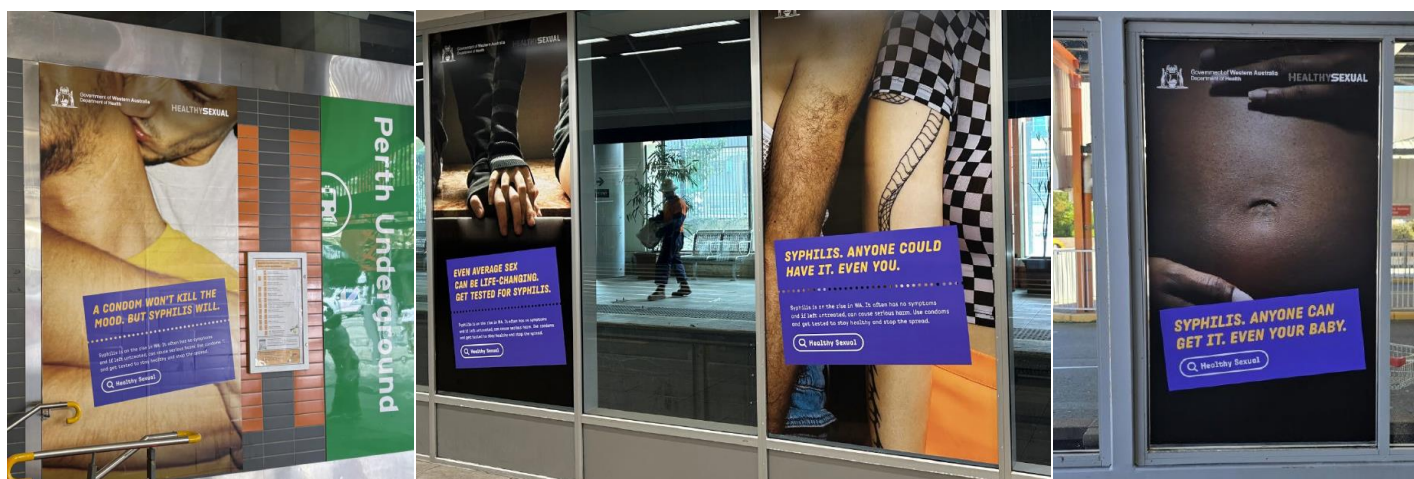
	December 2023-June 2024	October-December 2025
Campaign Channel	Number of Views/Listens	Number of Views/Listens
Out of home*	1,092,374	14,865,780
Digital audio	694,820	703,301
YouTube	2,434,515	NA
Cinema	112,578	NA

**estimated*

Table 4. Outcomes from the social media assets for the two CDCD-funded syphilis campaigns.

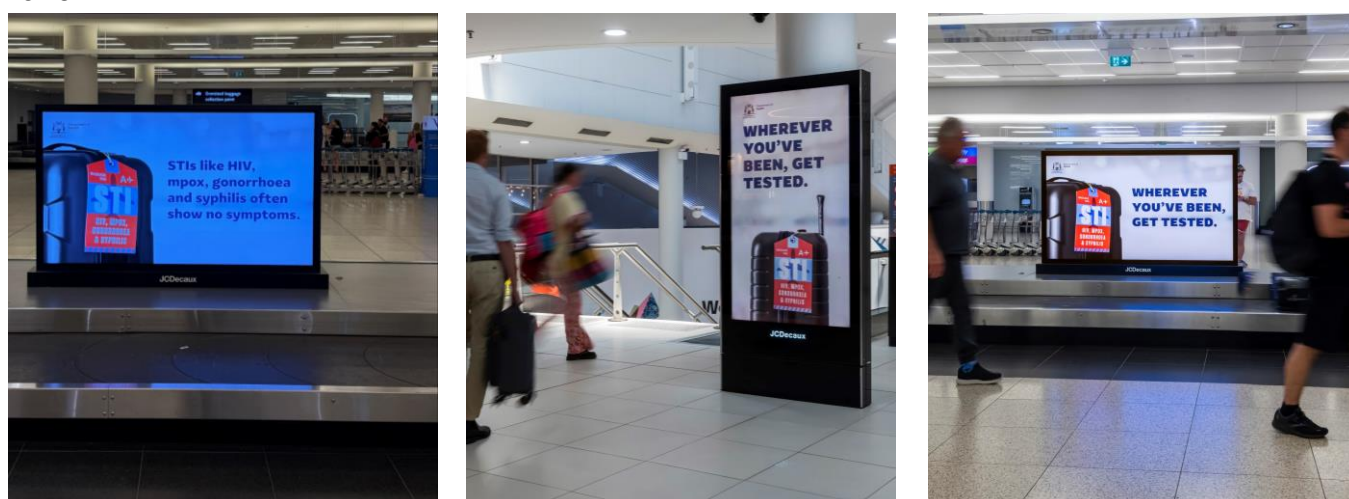
	December 2023-June 2024		October-December 2025	
Campaign Channel	Number of Views/Listens	Click-through rate	Number of Views/Listens	Click-through rate
Meta	6,556,178	1.13%	NA	NA
Snapchat	NA	NA	4,590,924	0.91%

Figure 7. WA Department of Health syphilis campaign materials October 2025-December 2025



The third campaign was a broader STI awareness campaign for travellers, which included syphilis, and comprised digital posters in and around Perth Airports from December 2025 to January 2026 (Figure 8). A total of 3,215,769 passengers went through Perth Airport between December 2025 to January 2026.

Figure 8. WA Department of Health STI Airport campaign materials December 2025-January 2026



Health promotion resources

Several education resources were created for consumers and health professionals to help raise awareness with regions adapting content to suit their target populations:

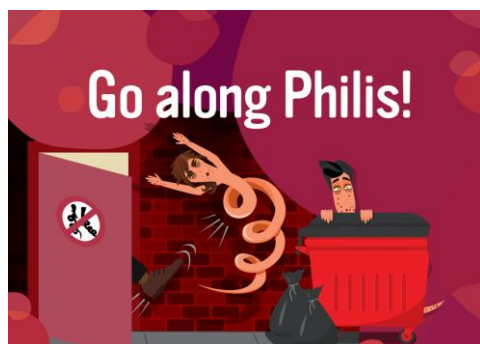
- WA Department of Health's posters and health promotion resources promoting antenatal syphilis testing and congenital syphilis prevention (Figure 9). Previous campaign posters are available in Appendix 2.

Figure 9. WA Department of Health syphilis-related posters, 2022/2023.



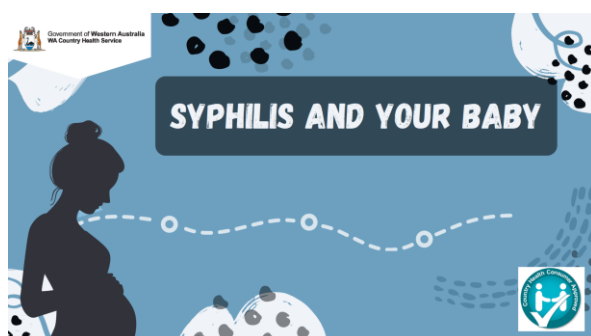
- AHCWA's *Go Along Philis* – a graphic flipchart for health practitioners, health promotion workers and other community-based workers (Figure 10).

Figure 10. AHCWA: *Go Along Philis* flipchart.



- *Syphilis and your baby* flipchart – The Pilbara, Goldfields, Great Southern and Metro PHUs created a graphic flipchart for health practitioners to have conversations with people in the metropolitan area who are pregnant or trying to get pregnant (Figure 11).

Figure 11. Great Southern Public Health Unit: *Syphilis and your baby* flipchart.



- [Syphilis testing in pregnancy: Patient information](#) booklet – Boorloo PHU created a booklet to inform pregnant people about why syphilis testing in pregnancy is important and what happens if a pregnant person has syphilis (Figure 12).

Figure 12. Boorloo Public Health Unit: [Syphilis testing in pregnancy: Patient information](#) booklet.



4.4 Workforce development

There has been increased investment into services to respond to the syphilis outbreak response. Funding has been provided for the recruitment of dedicated syphilis staff to implement a range of strategies aligned to the action plans. Several service providers are focussing on antenatal and postnatal care but there is also a large amount of crossover within other priority areas, especially prevention and testing activity.

Congenital syphilis and antenatal care have featured as part of the workforce development videoconference series. Related topics have included:

- Antenatal/postnatal testing, treatment, and management
- Congenital syphilis case reviews

The DoH has funded the development of an online learning module specifically for midwives, which was launched by the Australasian Society for HIV and Sexual Health Medicine (ASHM). In 2019, as a response to the initial syphilis outbreak, ASHM also developed an [online syphilis training website](#).

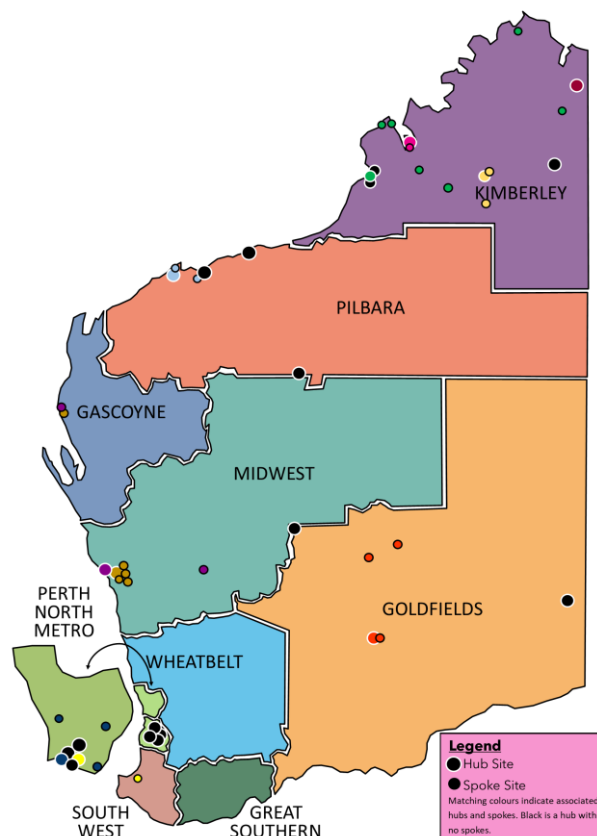
4.5 Testing, treatment and contact tracing

Testing guidelines have been updated to incorporate best practice syphilis testing in pregnancy protocols. These include the [WA STI and BBV Management Guidelines](#) and [Statewide Maternity Shared Care Guidelines](#). Direct correspondence has been sent to relevant stakeholders and clinicians to ensure healthcare workers are aware of updated guidelines.

Another important initiative to improve WA syphilis testing in pregnancy is the use of syphilis point-of-care testing (PoCT). The statewide WA Syphilis PoCT program was rolled out in 2020 and now operational in 27 hubsites across the state (Figure 13 and Appendix 3). Sites enrolled in the program include maternity services, EDs, local PHUs, Aboriginal community-controlled health

services (ACCHSs), prisons and non-government health services who provide healthcare support to marginalised communities. EDs, one hospital-based maternity department and primary health services providing antenatal care have been identified as important settings to provide syphilis PoCT to facilitate the early detection and treatment syphilis in the target populations and pregnant people. CDCD is exploring ways to encourage more health services, including maternity and antenatal care services, to enrol in the program. The National Aboriginal Community Controlled Health Organisation delivers a similar program for eligible ACCHSs. As of April 2024, there were 10 ACCHSs in WA offering syphilis PoCT.

Figure 13. Map of health services enrolled in the WA syphilis PoCT program.

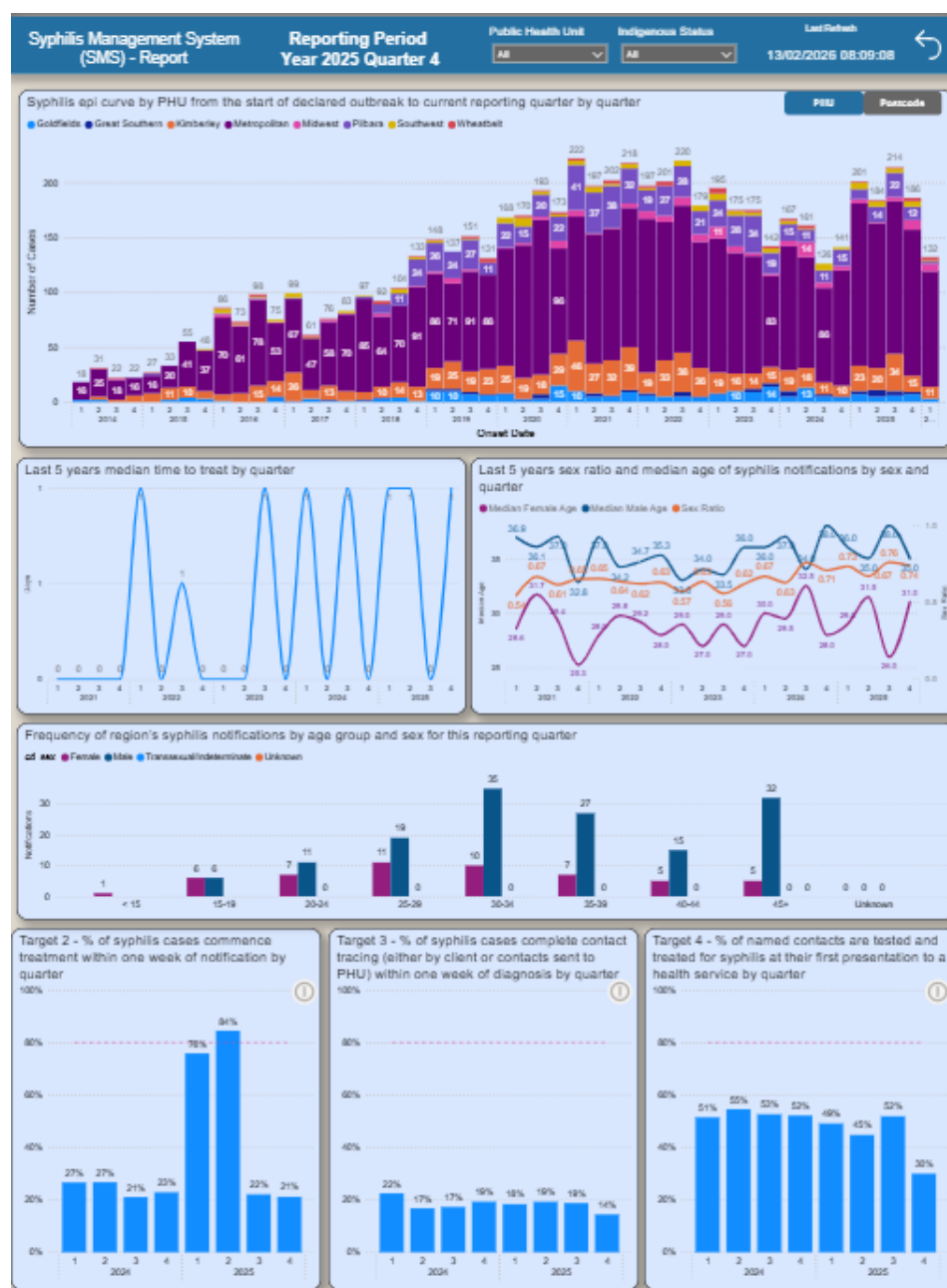


[Structured Administration Supply Arrangements](#) (SASAs) have been published to allow registered nurses (RNs), midwives and Aboriginal health practitioners (AHPs) to provide treatment for infectious syphilis. There has been ongoing work to advocate a reform to the *Health Insurance Act 1973* to allow RNs, Aboriginal health workers (AHWs) and AHPs to request STI testing that gains access to a Medicare rebate for pathology costs.

4.6 Surveillance and reporting

A high priority of CDCD is development and continued improvement of a centralised syphilis case management system to facilitate effective public health management of high-risk patients and their contacts. This is particularly important for cases and contacts who are highly mobile. Figure 14 shows a few of the indicators displayed on the syphilis case management system's dashboard.

Figure 14. A selection of some indicators displayed on the syphilis case management system's dashboard.



Surveillance of antenatal syphilis testing was enabled by inclusion of antenatal syphilis testing in the Midwives Notification System on 1 July 2023. This data is reported in the [Healthcare Quality Intelligence Unit's Maternity Dashboard](#) (accessible by WA Health employees). The dashboard reports the following indicators:

1. Syphilis test before 28 weeks: Proportion of women who had a syphilis test before 28 weeks
2. Syphilis test 28 to 35 weeks: Proportion of women who gave birth at 28+ weeks gestation who had a syphilis test between 28 and 35 weeks
3. Syphilis test 36+ weeks: Proportion of women who gave birth at 36+ weeks gestation who had a syphilis test at 36 weeks
4. Syphilis testing missing data: Proportion of women with "unknown" or "not stated" for one or more of the syphilis tests they were eligible to received given their gestation at time of delivery (indicator of completeness of data collection)

4.7 Other key achievements

Localised Syphilis Outbreak Response Team activities:

- Antenatal syphilis screening audits were conducted to assess compliance with guidelines and identify gaps in screening.
- PHUs engage regularly with local maternity services to provide education and advocate for increase syphilis screening.
- Review the local epidemiology and testing data to consider initiatives to improve testing and awareness of the syphilis outbreak.
- Implementation of syphilis PoCT in Midwest maternity services. The regions worked with relevant teams and staff, such as maternity Aboriginal liaison officers, to promote screening and follow up with at risk clients.
- Boorloo PHU established a *Syphilis in Pregnancy* program supported by a multidisciplinary and interagency committee to support people who are diagnosed with syphilis during pregnancy.²
- Creation of local resources for health and general public professionals and focused on increasing awareness of the syphilis outbreak and the importance of antenatal testing.
- Expansion of the [Integrated Case Management Program](#)'s scope to include providing a consultancy service to PHUs regarding people whose complex psychosocial needs are preventing them from engaging in timely clinical management of their syphilis infection.
- Development and publication of [Guidelines for the management of notifiable infectious disease transmission risk behaviours in Western Australia](#).

5. Conclusions

Review of 20 congenital syphilis (13 live, 7 stillbirths) and five near miss cases between 2019 and 2025, indicated that people with one or more of the following characteristics were over-represented: from a remote area, experiencing homelessness, alcohol use, drug use and/or other complex social issues.

Inability to access to culturally safe and comprehensive primary health care was a frequent factor contributing to inadequate/absent reproductive health and antenatal care, resulting in delayed syphilis diagnosis and treatment, and congenital syphilis.

Lack of staff knowledge about the syphilis outbreak and importance of syphilis testing in pregnancy contributed to only a few cases, mostly before 2022. These factors contrast with those reported in a qualitative study involving 34 Queensland health care workers that identified poor communication between health staff and between health staff and their patients, inadequate data systems that allow cases to “disappear”, a lack of knowledge about “key state guidelines” and how to treat syphilis as the main perceived barriers to optimal syphilis treatment in pregnancy.³

Many of the review recommendations have been implemented under the governance of the WA SORG, which uses a partnership approach in the control of STIs and sexual health promotion. Key interventions include:

- all pregnant people being offered syphilis testing at the first antenatal visit, 28 and 36 weeks,

² MacKenzie H, McEvoy SP, Ford TJ. Managing Risk for Congenital Syphilis, Perth, Western Australia, Australia. *Emerging Infectious Diseases*. 2023;29(10):2093-2101. doi:10.3201/eid2910.230432.

³ Fowler JA *et al.* Barriers to optimal management of syphilis in pregnancy and congenital syphilis in south-east Queensland: a qualitative investigation. *Sexual Health*. 2023;20(6): 506–513. doi:10.1071/SH23119

- establishment of surveillance systems for infectious syphilis cases, contact management, and antenatal syphilis testing,
- PHUs coordinating multi-disciplinary case management of pregnant people with infectious syphilis,
- development and timely updating of WA guidelines for managing syphilis, syphilis in pregnancy and congenital syphilis,
- availability of point of care testing in many hospitals, primary health care and ACCHSs across WA, and
- statewide and local syphilis education campaigns.

The first case of congenital syphilis associated with the current outbreak occurred in 2018, four years after the outbreak started in WA. Infectious syphilis notifications in WA peaked in 2021 then declined until 2024 before rising in 2025 to just below 2022's level. Congenital syphilis notifications plateaued at four per year from 2020 to 2023, followed by zero and three congenital syphilis notifications in 2024 and 2025, respectively. This indicates that WA's syphilis outbreak response, initiated in 2018 and informed by the findings and recommendations of congenital syphilis case reviews, is beginning to control congenital syphilis. Given the potentially long lag time between a female of reproductive age acquiring syphilis and vertical transmission during pregnancy to an infant, it is hoped that congenital syphilis notifications will reduce as adherence with testing for syphilis three times during pregnancy continues to improve.

Meanwhile, alternative and co-designed models of care need to be explored with Aboriginal women, other affected communities and key stakeholders to ensure that people of reproductive age can access comprehensive and culturally safe primary health care services that include provision of holistic, culturally safe and competent reproductive health care including contraception and antenatal care. While background syphilis rates remain high, health care improvement/reorientation alone are unlikely to be sufficient to prevent all cases of CS unless social determinants of health are also addressed.

Appendix 1. Antenatal syphilis testing in WA, Q3 2021 – Q4 2025.

Table A Number and proportion of antenatal women in WA tested for syphilis by Aboriginality and number of tests, Q3 2021 to Q4 2025.

Aboriginality	Number of tests	Q3 2021		Q4 2021		Q1 2022		Q2 2022		Q3 2022		Q4 2022		Q1 2023		Q2 2023		Q3 2023		Q4 2023		Q1 2024		Q2 2024		Q3 2024		Q4 2024		Q1 2025		Q2 2025		Q3 2025		Q4 2025	
		n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Aboriginal	0	16	4.9%	14	3.6%	15	3.6%	25	5.5%	24	5.0%	52	12.9%	20	4.9%	13	3.0%	39	7.6%	32	6.7%	17	3.8%	28	5.7%	23	4.9%	23	5.5%	23	5.3%	26	5.7%	29	5.7%	17	3.8%
	1	139	37.3%	134	34.4%	163	39.4%	159	35.2%	150	30.0%	151	37.6%	89	19.7%	105	23.9%	124	24.3%	110	23.0%	105	23.2%	103	20.8%	99	20.9%	78	18.7%	76	17.7%	73	14.8%	73	14.8%	88	19.6%
	2	84	22.5%	78	20.0%	91	22.0%	85	18.8%	96	22.4%	87	21.6%	124	30.5%	110	25.1%	147	28.8%	114	23.8%	122	26.9%	146	29.5%	127	26.8%	115	27.5%	127	29.5%	120	24.4%	120	24.4%	118	26.3%
	3	99	26.5%	131	33.6%	116	28.0%	148	32.7%	123	28.7%	97	24.1%	132	32.5%	162	36.9%	201	39.3%	223	46.6%	209	46.1%	218	44.0%	225	47.5%	202	48.3%	204	47.4%	271	55.1%	271	55.1%	226	50.3%
	Total	373	100.0%	390	100.0%	414	100.0%	452	100.0%	428	100.0%	402	100.0%	406	100.0%	439	100.0%	511	100.0%	479	100.0%	453	100.0%	495	100.0%	474	100.0%	418	100.0%	430	100.0%	492	100.0%	492	100.0%	449	100.0%
non-Aboriginal	0	90	2.2%	96	2.3%	85	2.1%	91	2.3%	98	2.4%	293	7.6%	220	5.9%	125	3.2%	803	11.5%	786	11.4%	786	11.1%	740	10.2%	697	9.9%	696	9.7%	659	9.3%	497	7.1%	497	7.1%	443	6.1%
	1	2708	65.6%	2448	58.5%	2284	56.2%	2198	55.7%	2301	57.3%	1944	50.1%	795	21.4%	785	20.4%	2130	30.5%	1994	28.8%	1961	27.7%	1858	25.7%	1687	23.9%	1603	22.4%	1454	20.6%	1391	19.0%	1391	19.8%	1487	20.3%
	2	615	14.9%	655	15.7%	397	14.4%	551	14.0%	541	13.5%	593	15.3%	890	24.0%	954	25.0%	1421	20.3%	1387	19.6%	1411	19.9%	1480	20.4%	1417	20.1%	1485	20.7%	1462	20.7%	1580	22.4%	1580	22.4%	1556	21.3%
	3	627	15.2%	919	22.0%	1023	25.2%	1021	25.9%	1027	25.6%	1005	26.4%	1749	47.1%	1916	49.8%	2633	37.7%	2850	41.2%	2919	41.2%	3161	43.7%	3245	46.1%	3384	47.2%	3493	49.4%	3573	50.7%	3573	50.7%	3824	52.3%
	Total	4125	100.0%	4183	100.0%	4066	100.0%	3948	100.0%	4019	100.0%	3878	100.0%	3714	100.0%	3851	100.0%	6987	100.0%	6917	100.0%	7077	100.0%	7239	100.0%	7046	100.0%	7168	100.0%	7068	100.0%	7041	100.0%	7041	100.0%	7310	100.0%

Figure A. Proportion of Aboriginal antenatal women in WA tested for syphilis by number of tests, Q3 2021 to Q4 2025.

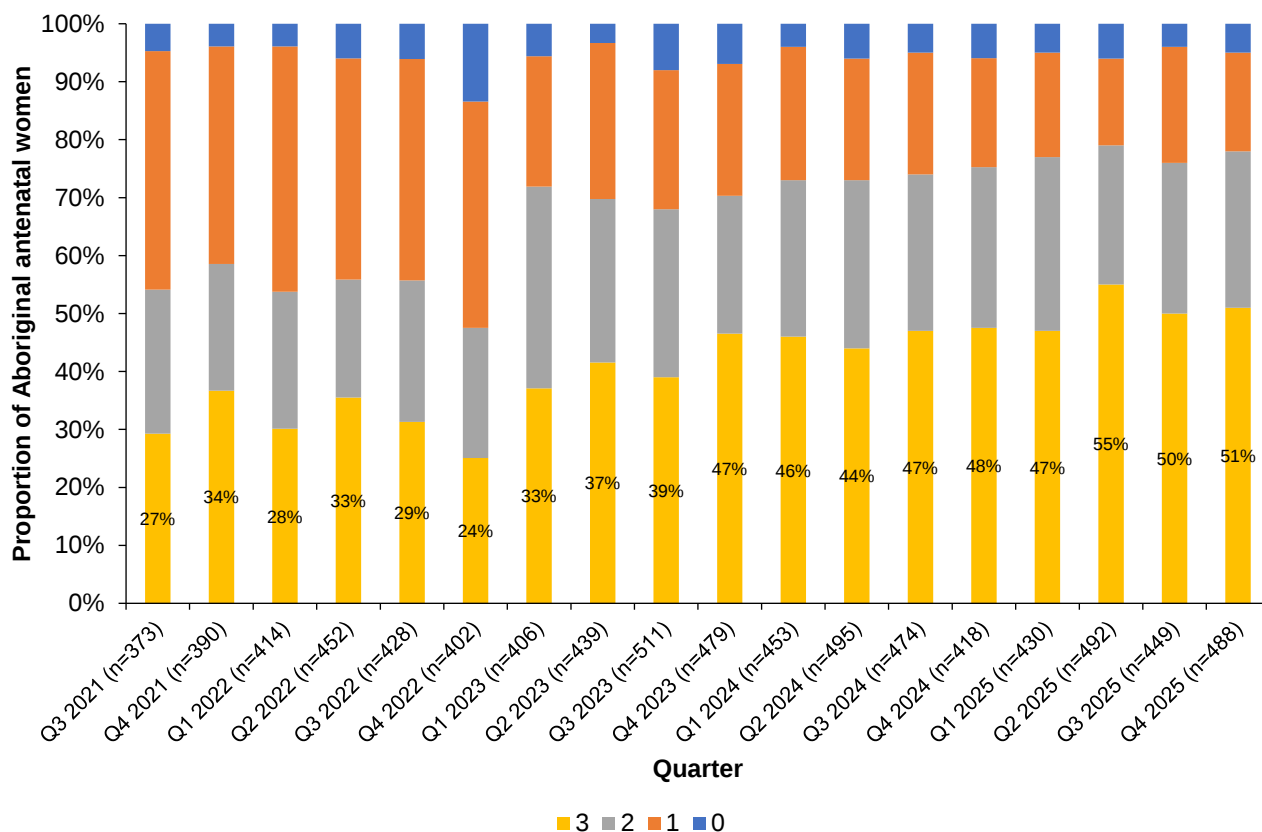


Figure B. Proportion of non-Aboriginal antenatal women in WA tested for syphilis by number of tests, Q3 2021 to Q4 2025.

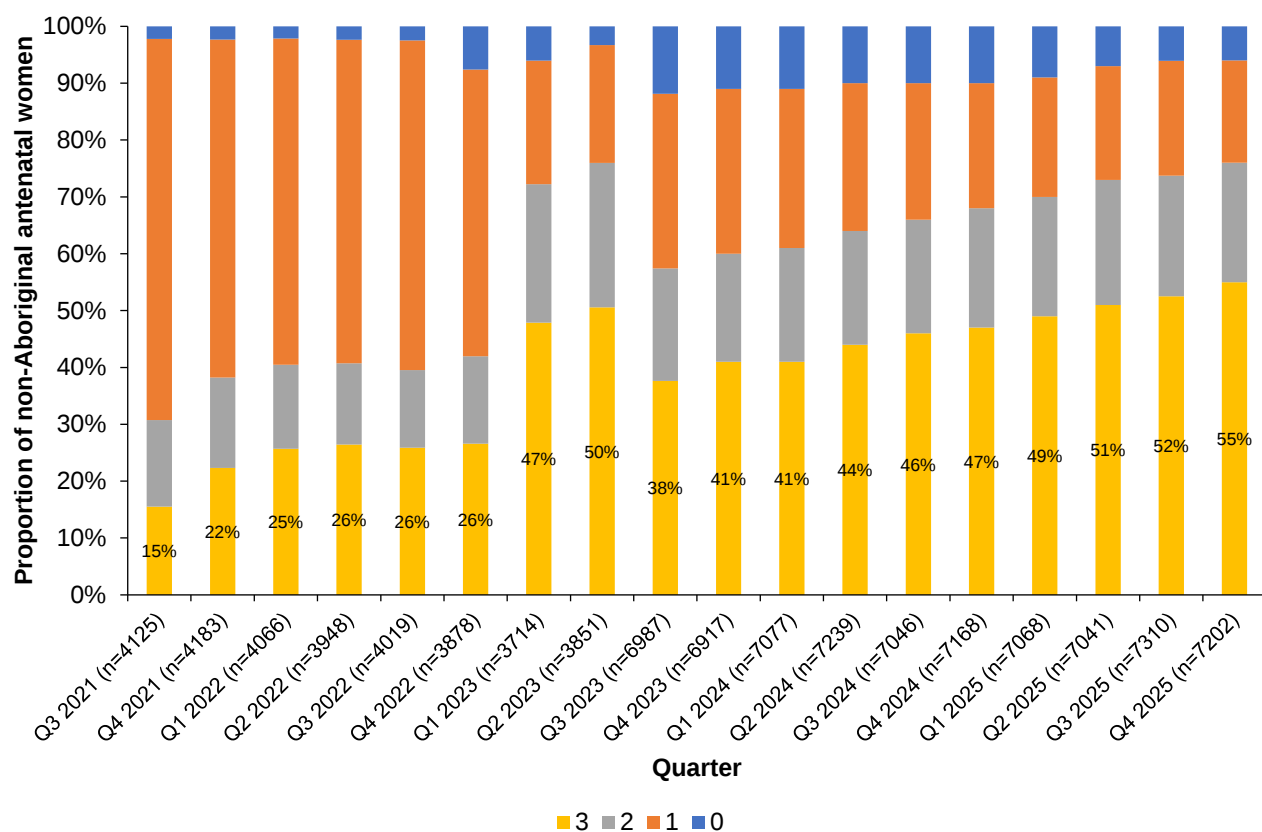


Figure C. Proportion of Aboriginal antenatal women in WA tested for syphilis by residential region and number of tests, Q4 2025.

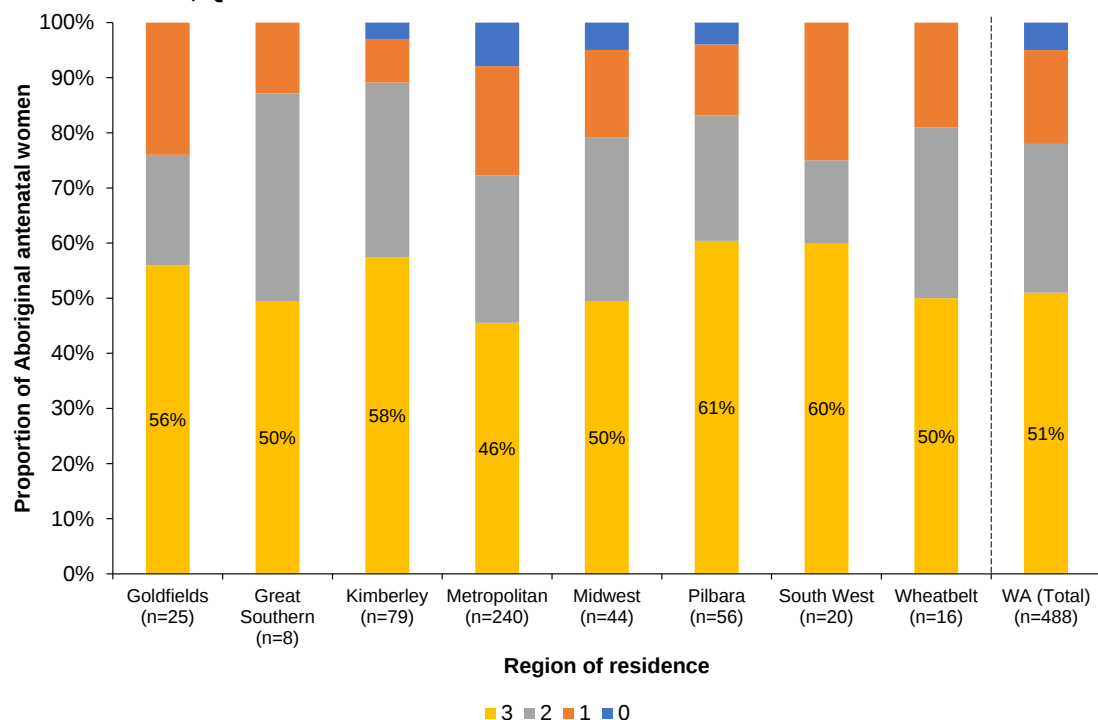
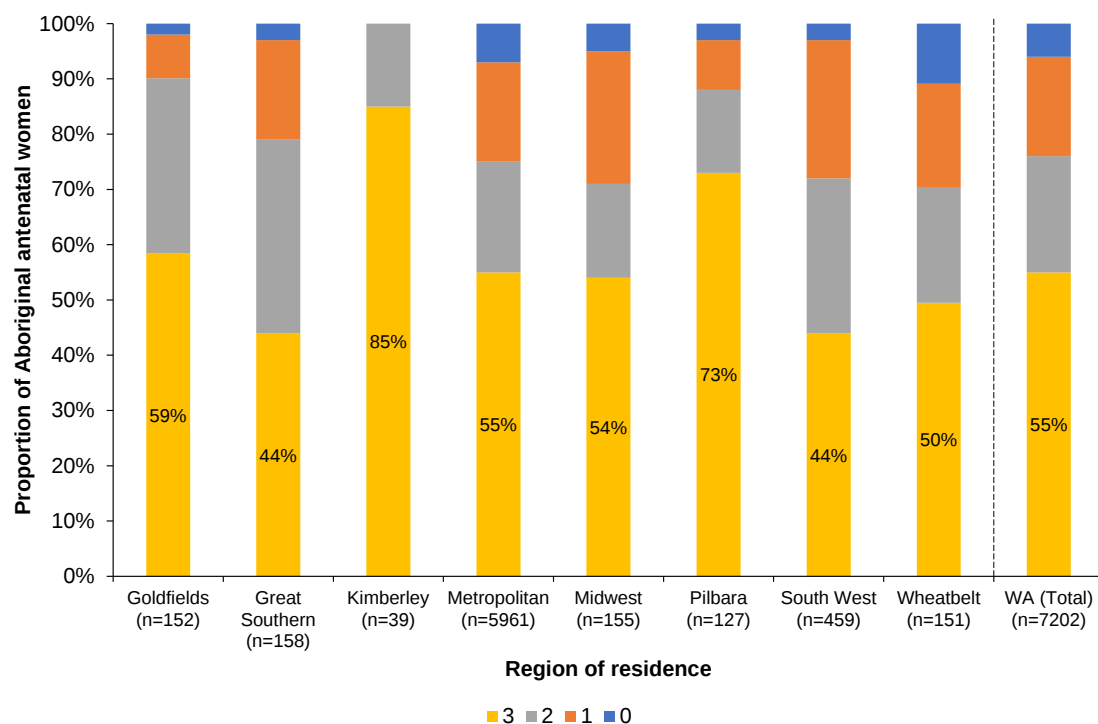


Figure D. Proportion of non-Aboriginal antenatal women in WA tested for syphilis by residential region and number of tests, Q4 2025.



Appendix 2. WA Department of Health syphilis campaign examples, 2020 – 2024.

Image 1. WA Department of Health pregnancy-specific syphilis campaign advertisement used on social media, December 2023-June 2024.

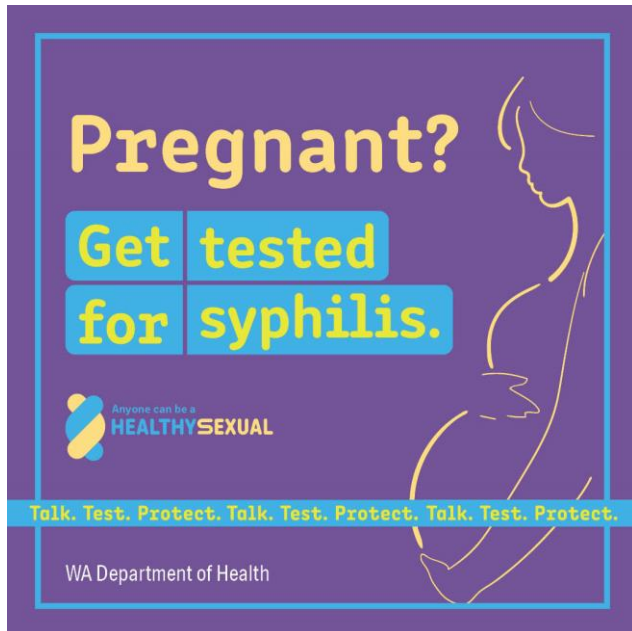


Image 2. WA Department of Health syphilis campaign advertisement used on social media December 2023-June 2024.



Image 3. WA Department of Health pregnancy-specific syphilis campaign advertisement on display in the Perth Underground Train Station, December 2023-June 2024.



Image 4. WA Department of Health pregnancy-specific syphilis campaign advertisement on display on the back of a Transperth bus, December 2023-June 2024.



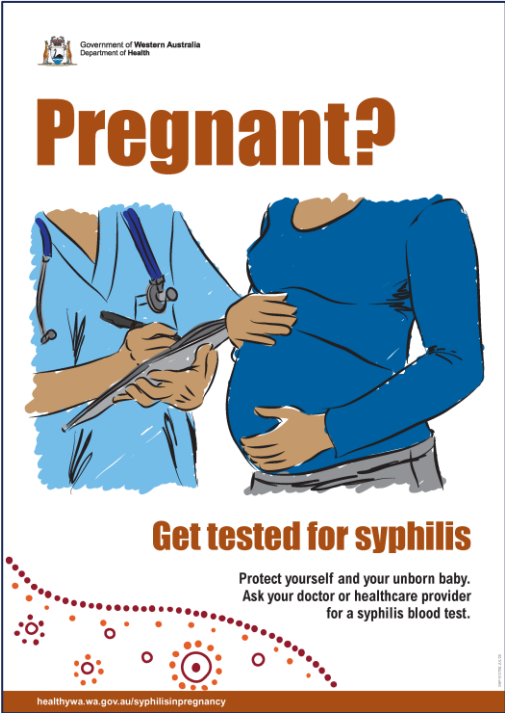
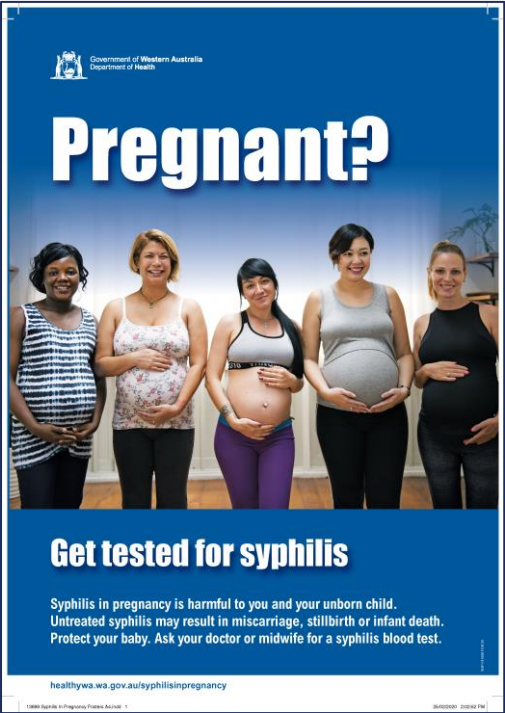
Image 5. WA Department of Health syphilis campaign advertisement in the December Medical Forum magazine, print and online versions



Image 6: WA Department of Health syphilis-related posters, 2021/2022.



Image 7: WA Department of Health syphilis-related posters, 2020/2021



Appendix 3. WA Department of Health's Syphilis Point-of-Care Testing program.

Services enrolled in the WA Department of Health's Syphilis Point-of-Care Testing program (not inclusive of WA Aboriginal Community Controlled Health Services [ACCHS] enrolled in the National Aboriginal Community Controlled Health Organisation's program), accurate as of 12/02/2026

Legend	WA Health	Department of Justice	ACCHS or non-government
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Primary Site	Satellite Sites		
Goldfields			
Goldfields Public Health Unit	Laverton Hospital	Leonora Hospital	
Ngangganawili Aboriginal Health Service			
Spinifex Health Service			
Kimberley			
Broome Community Health			
Broome Regional Prison			
Derby Community Health			
Fitzroy Crossing Community Health	Fitzroy Crossing Hospital	Wangkatjungka Clinic	
Halls Creek Community Health			
Kimberley Population Health Unit - Remote Services	Looma Clinic	Lombadina Clinic	One Arm Point Clinic
	Noonkunbah Clinic	Warmun Clinic	Kalumburu Clinic
Kununurra Community Health			
Metropolitan Perth / South West			
360 Health Street Doctor			
Boorloo Public Health Unit			
Derbarl Yerrigan Health Service (East Perth)	Derbarl Yerrigan Health Service (Maddington)	Derbarl Yerrigan Health Service (Midland)	Derbarl Yerrigan Health Service (Mirrabooka)
Homeless Healthcare			
Melaleuca Women's Prison			
Moorditj Koort Aboriginal Corporation			

Peer Based Harm Reduction WA (Perth)	Peer Based Harm Reduction WA (Bunbury)		
Pramana Medical Centre			
Midwest			
Geraldton Regional Aboriginal Medical Service			
Geraldton Regional Aboriginal Medical Service Murchison Outreach Service			
Geraldton Regional Aboriginal Medical Service Gascoyne Outreach Service			
Midwest Public Health Unit (Geraldton)	Midwest Public Health Unit (Carnarvon)	Geraldton Hospital Maternity Ward	Geraldton Hospital Emergency Department
	Midwest Public Health Unit – Mental Health and CADS		
Pilbara			
Hedland Health Campus			
Karratha Health Campus			
Roebourne Community Health			
Mawarnkarra Aboriginal Health Service			
Newman Hospital ED			

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