SA Health

Surveillance of sexually transmitted infections and blood-borne viruses in South Australia, 2024

Communicable Disease Control Branch
Public Health Division

Government of South Australia
SA Health

Acknowledgements

SA Health acknowledges and respects the traditional custodians of country throughout South Australia, and recognises their continuing connection to land, waters and community. We pay our respects to them, their cultures, contributions, and to Elders past and present.

The term Aboriginal is used at times in this document as an all-encompassing term for South Australian Aboriginal and Torres Strait Islander people and culture.

The authors would also like to acknowledge the following organisations for their contributions to this report: Adelaide Sexual Health Centre, SA Pathology and private laboratories, and healthcare professionals working in metropolitan, rural and remote healthcare facilities.

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Acronyms

Aboriginal	Used respectfully as an all-encompassing term for South Australian Aboriginal and Torres Strait Islander peoples and cultures.
ABS	Australian Bureau of Statistics
ASHC	Adelaide Sexual Health Centre, Central Adelaide Local Health Network
BBV	blood borne viruses
CDNA	Communicable Diseases Network Australia. Provides national public health co-ordination and leadership and supports best practice for the prevention and control of communicable diseases. CDNA is a sub-committee of the Australian Health Protection Committee.
Chlamydia	*Chlamydia trachomatis*
Gonorrhoea	*Neisseria gonorrhoeae*
GP	general practitioner
HBV	hepatitis B
HCV	hepatitis C
HDV	hepatitis D
HIV	human immunodeficiency virus
IDU	injecting drug use
MSM	men who have sex with men (includes homosexual and bisexual men and men who have sex with men but do not identify as either homosexual or bisexual)
STI	sexually transmissible infections

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Introduction

The Communicable Disease Control Branch, SA Health conducts surveillance for sexually transmissible infections (STI) and blood borne viruses (BBV) in South Australia under the legislative framework of the *South Australian Public Health Act 2011*.

The surveillance system in South Australia utilises a dual notification strategy for most diseases where the laboratory ('laboratory notification') and the diagnosing medical practitioner ('medical notification') provide information on each episode of infection. As of November 2022, notification of chlamydia by medical practitioners is no longer required unless a person is aged less than 17 years or dies from chlamydia (which would be exceedingly rare). A person could be notified more than once during the reporting period and with the same or more than one type of infection. Information collected as part of the notifiable diseases surveillance system is entered into a database at the time of notification and analysed.

The case definitions used for classifying STI and BBV notifications in this report is consistent with criteria agreed upon nationally by the Communicable Diseases Network Australia (CDNA). These definitions are available online at https://www.health.gov.au/resources/collections/cdna-surveillance-case-definitions.

Data for all diseases were extracted from the SA Health Notifiable Infectious Disease Surveillance (NIDS) system and, unless otherwise indicated, correct as of 8 September 2025. Data for all diseases except HIV are presented by date of first notification. HIV data are presented by date of first positive specimen collection in line with national practice. Please note that surveillance data are subject to continual revisions.

Notification rates were calculated using the June 2024 estimated resident population counts from the Australian Bureau of Statistics (ABS). Notification rates among Aboriginal and Torres Strait Islander people were calculated using ABS catalogue 3238.0- Estimates of Aboriginal and Torres Strait Islander Australians, 2006 to 2031. Notification rates by Indigenous status include notifications with missing Indigenous status in the non-Indigenous category. For conditions such as chlamydia where the overall completeness of Indigenous status is low, this may lead to an underestimate of rates among the Aboriginal and Torres Strait Islander population.

Please also note that some rates are based on a very small numbers of notifications, which leads to considerable variation between years. Trends therefore need to be interpreted with caution. To avoid rate fluctuations that are not due to meaningful changes in epidemiological trends, no forward projections of rates are presented for diseases with fewer than 20 notifications for the current year and rates are not disaggregated by Indigenous status for diseases with fewer than five notifications per year in each sub-group included in the analysis.

Summary

Impact of the COVID-19 pandemic in South Australia

South Australian surveillance data indicates a decrease in the number of STI and BBV notified diagnoses per 100,000 population between 2020 and 2022, and an increase from 2023 onwards.

It is likely that this relates to both underreporting of cases during this period due to restrictions on health service access and reduced STI and BBV testing, as well as a true reduction in incidence due to factors such as reduced migration, the suspension of international travel and behavioural changes during periods of heightened COVID-19 restrictions.

As such, data for this period should be used with caution and with these factors in mind.

STI and BBV notifications 2019 to 2024

In 2024, there were 9,172 notifications of STI and BBV in South Australia. This figure represents an 5% decrease in the number of notifications compared to notifications received in 2023 (n=9,652) and a 4% decrease since 2019 (n=9,538).

Table 1 Notifications of all STI and BBV in South Australia, by year of diagnosis and five year average, 2019 to 2024

Infection	2019	2020	2021	2022	2023	*Five year average 2019-2023*	2024
Chlamydia trachomatis (chlamydia)	6,437	5,665	5,521	5,620	6,417	*5,932*	5,815
Lymphogranuloma venereum (LGV)*	0	0	4	1	5	*2*	7
Gonorrhoea	2,086	1,677	1,433	1,789	2,262	*1,849*	2,462
Syphilis: Congenital	0	2	0	0	0	*0*	2
Syphilis: Infectious	165	131	247	295	323	*232*	229
Syphilis: Unspecified	146	86	70	68	81	*90*	103
Hepatitis B (HBV): Newly acquired	5	2	2	0	2	*2*	2
HBV: Unspecified	305	265	198	192	237	*240*	261
Hepatitis D	5	6	8	4	8	*6*	10
Hepatitis C (HCV): Newly acquired	30	19	14	19	31	*23*	13
HCV: Unspecified	329	275	225	200	253	*256*	228
Human immunodeficiency virus (HIV)^	30	29	21	22	33	*27*	31
Mpox**	N/A	N/A	N/A	2	0	*NA+*	9
TOTAL	**9,538**	**8,157**	**7,743**	**8,212**	**9,652**	***NA+***	**9,172**

* LGV is a subset of chlamydia and so these numbers are also included in the line above.
** Mpox is not an STI, but it is transmitted via close contact including sexual contact.
^ HIV cases diagnosed for the first time in South Australia.
N/A = Not available.
NA+ = No calculation as surveillance was not carried out for the whole period.

The remainder of this report will focus on the following infections:

- Chlamydia
- Lymphogranuloma venereum
- Gonorrhoea
- Infectious syphilis
- Congenital syphilis
- Human immunodeficiency virus
- Hepatitis B
- Hepatitis D
- Hepatitis C
- Mpox.

Chlamydia

In 2024, there were 5,815 notifications of *Chlamydia trachomatis* (chlamydia), which is a 9% decrease compared to 2023 when 6,417 notifications were received.

The notification rate among Aboriginal and Torres Islander people remains elevated compared to non-Indigenous people, with the disparity in rates consistently less pronounced than for gonorrhoea.

In 2024, 50% of notifications were among females, which is lower than the average from 2019 to 2023 (54% of notifications).

The active follow-up of outstanding medical notifications for chlamydia ceased in 2019. In addition, chlamydia is no longer medically notifiable as of November 2022 unless a person is aged less than 17 years (or the person dies due to chlamydia, which is rare). Therefore, epidemiological information previously supplied by clinicians on a range of factors including Aboriginal status, clinical presentation and risk exposures will differ in completeness from datasets presented in previous years.

Figure 1 Number of chlamydia cases notified by year of notification and sex at birth, South Australia, 1 January 2019 to 31 December 2024

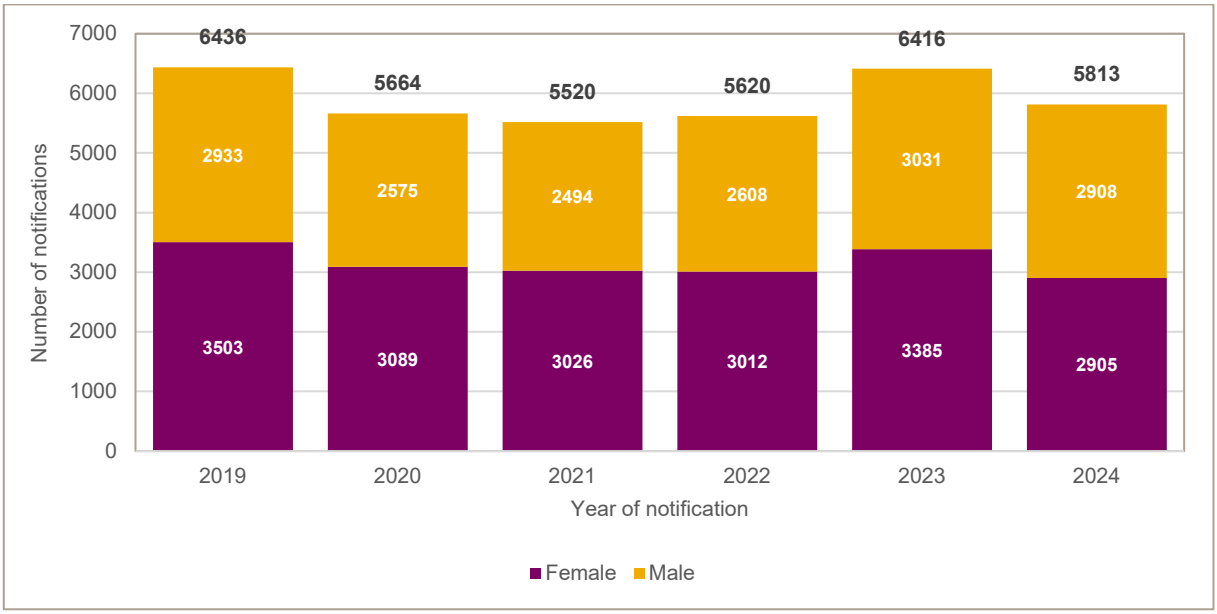


Figure 2 Number of chlamydia cases notified by year of notification and age group (years), South Australia, 1 January 2019 to 31 December 2024

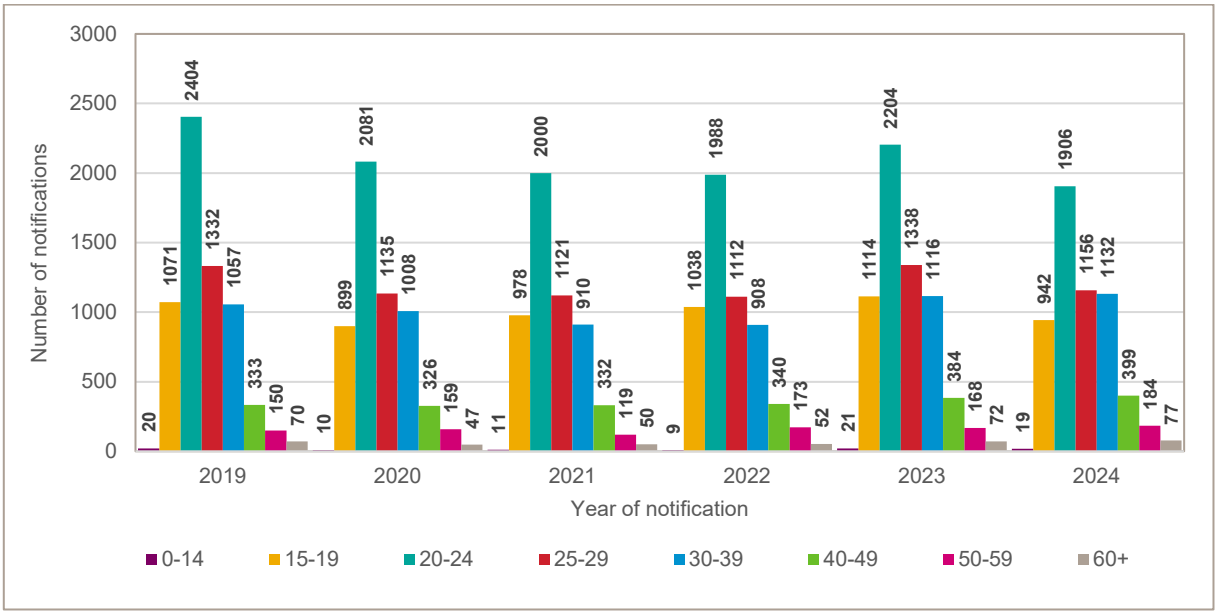


Figure 3 Number of chlamydia cases notified by year of notification and Indigenous status, South Australia, 1 January 2019 to 31 December 2024

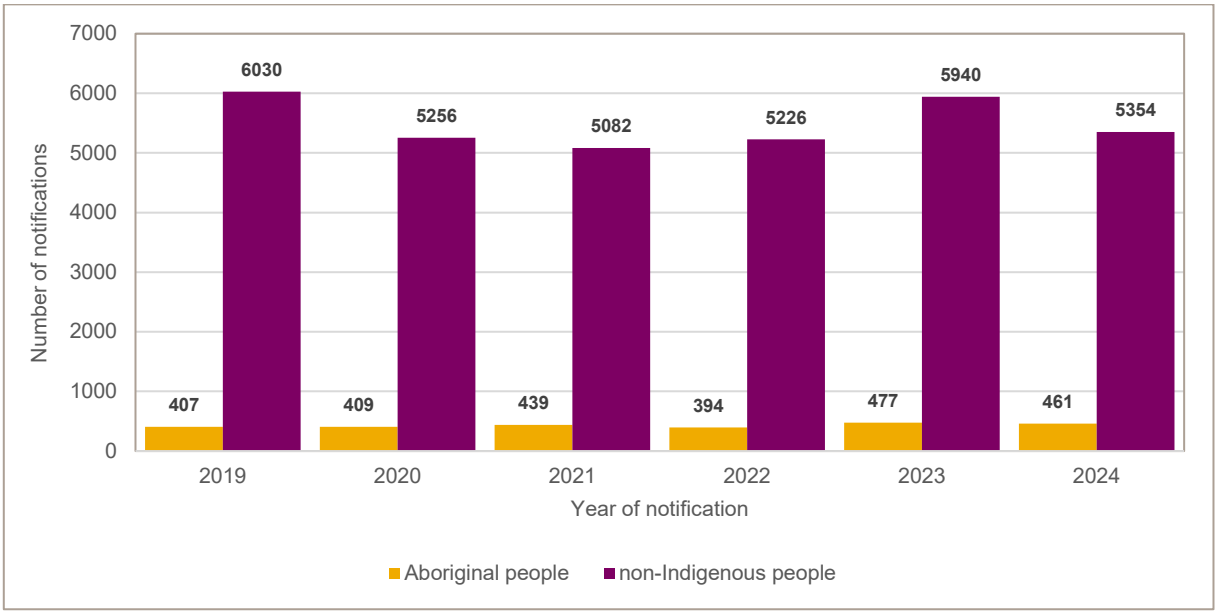


Figure 4 Chlamydia notification rate per 100,000 population by year of notification and Indigenous status, South Australia, 1 January 2014 to 31 December 2024

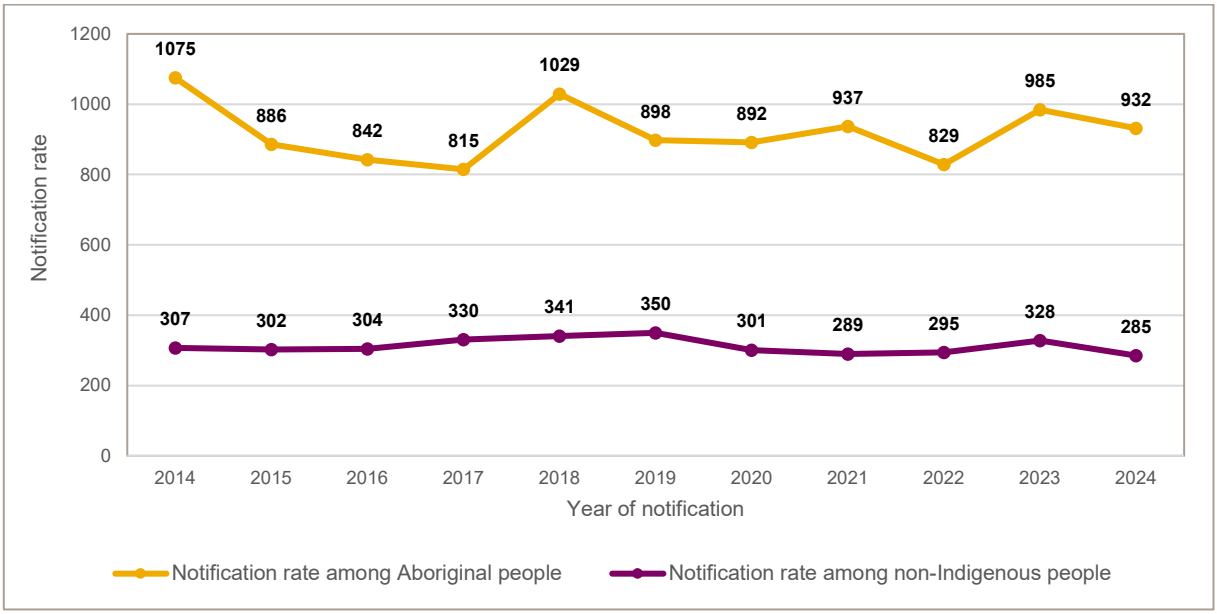
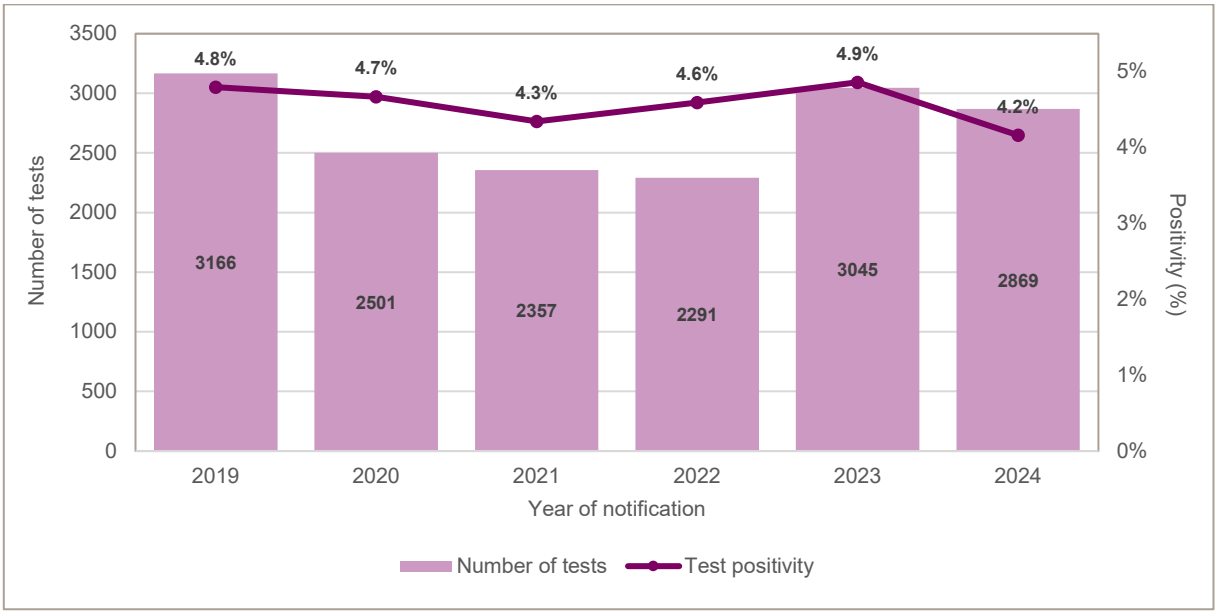


Table 2 Proportion of notifications received by SA Health with completed Indigenous status by year, South Australia, 1 January 2019 to 31 December 2024

	2019	2020	2021	2022	2023	2024
Completeness of Indigenous status	82%	82%	84%	84%	72%	70%

Figure 5 Chlamydia testing and positivity by year of diagnosis, South Australia, 1 January 2019 to 31 December 2024



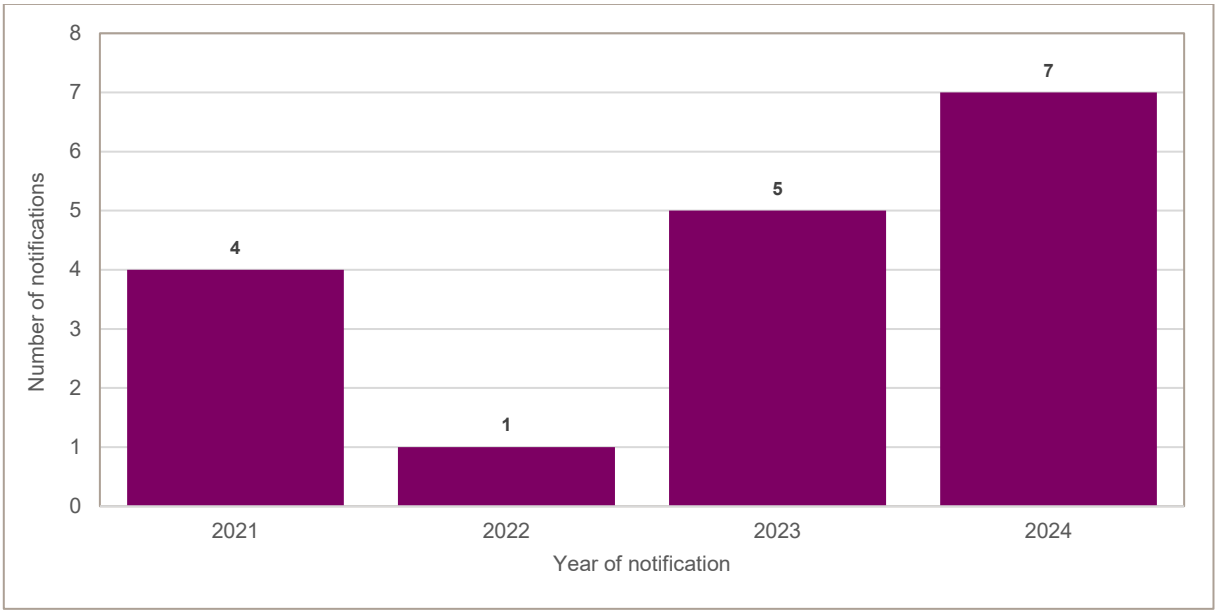
Note: This data comes from SA Pathology only.

Lymphogranuloma venereum (LGV)

LGV is a condition caused by invasive strains of *Chlamydia trachomatis* (serovars L1-3) and has the potential to cause severe disease if left untreated. For more information about LGV, visit the SA Health website.

No cases of LGV were notified in 2019 and 2020. There were 17 cases of LGV notified from 2021 to 2024.

Figure 6 Number of LGV cases notified by year of notification, South Australia, 1 January 2021 to 31 December 2024



Gonorrhoea

There was a significant increase in gonorrhoea notifications in South Australia during the 2010s. Notifications declined from 2020 to 2022, and then increased again from 2022 to 2024. This trend likely reflects COVID-19 related impacts on access to health services including STI testing leading to underreporting of cases, as well as a true reduction in incidence due to reduced migration, suspension of international travel and behavioural changes during periods of heightened COVID-19 restrictions.

In 2024:

- there were 2,462 notifications of gonorrhoea, which is the highest number of cases ever reported in a single year in South Australia.
- 67% of notifications were among males. This proportion was higher than 2021 to 2023 (62% of notifications), but consistent with 2019 to 2020 (66% of notifications).
- 433 cases were reported among Aboriginal and Torres Strait Islander people, which is high relative to long term trends but lower than the 499 cases reported in 2023. The notification rate among Aboriginal and Torres Islander people remains over eight times higher than the notification rate among non-Indigenous people.

Figure 7 Number of gonorrhoea cases notified by year of notification and sex at birth, South Australia, 1 January 2019 to 31 December 2024

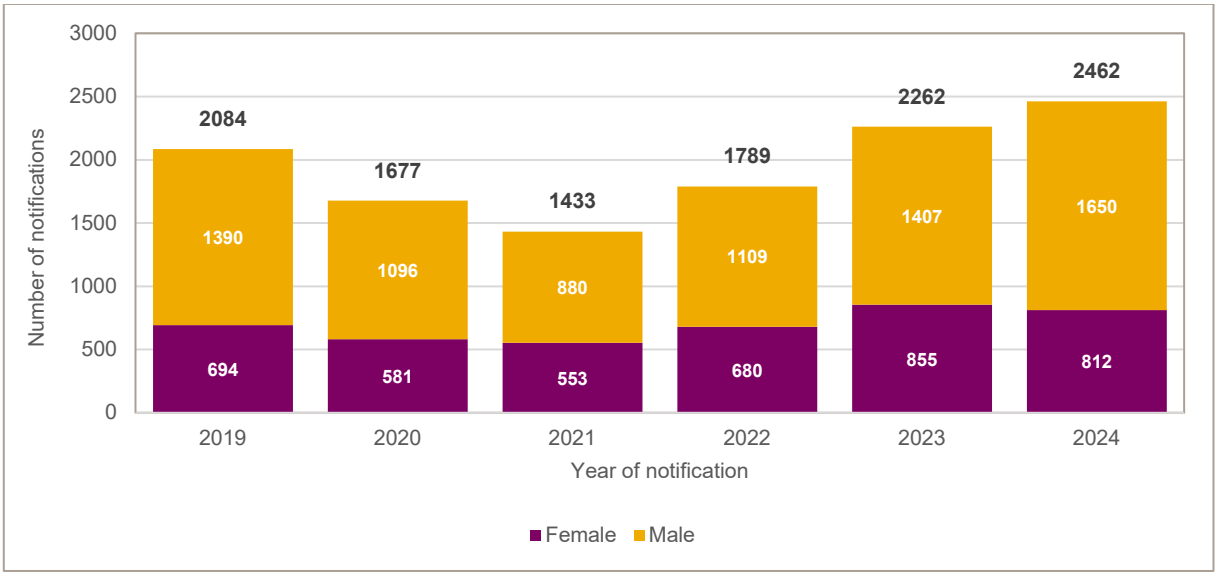


Figure 8 Number of gonorrhoea cases notified by year of notification and age group (years), South Australia, 1 January 2019 to 31 December 2024

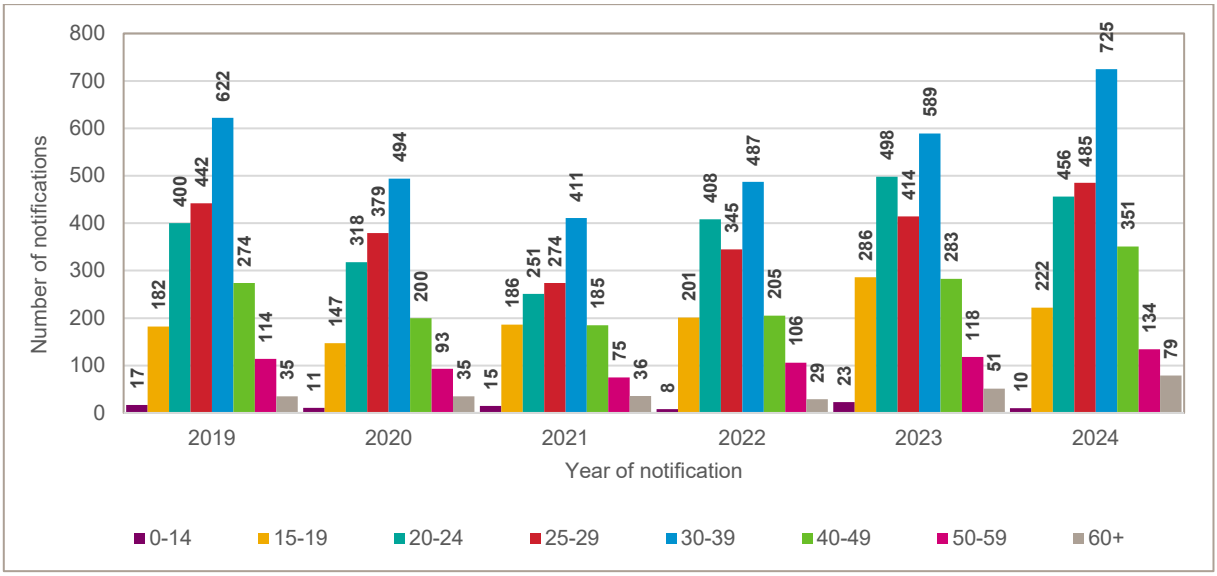


Figure 9 Number of gonorrhoea cases notified by year of notification and Indigenous status, South Australia, 1 January 2019 to 31 December 2024

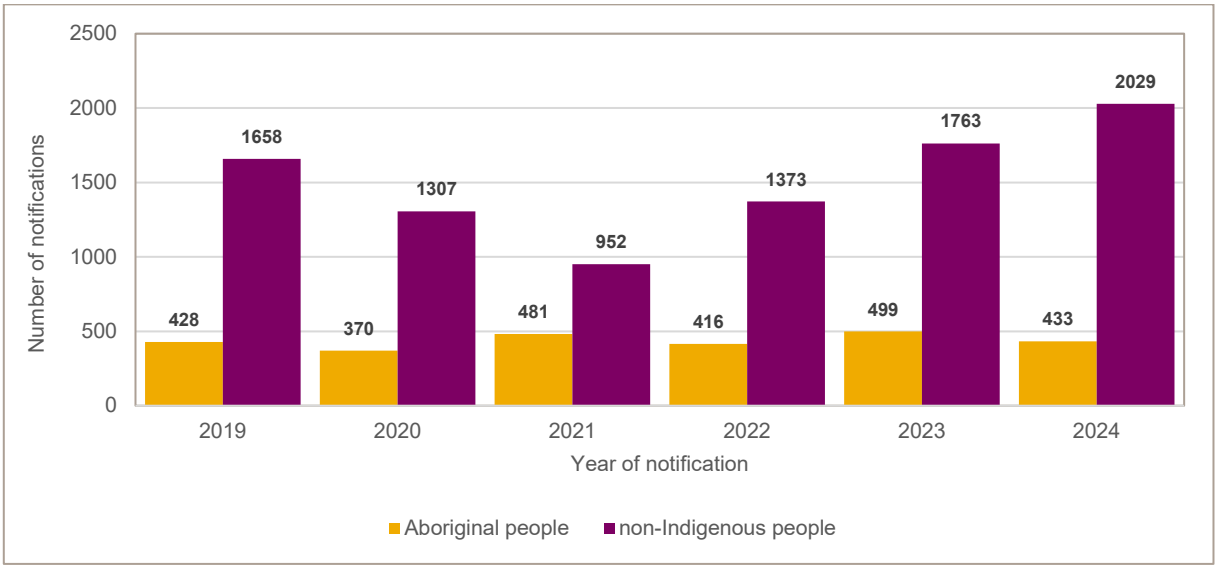


Figure 10 Gonorrhoea notification rate per 100,000 population by year of notification and Indigenous status, South Australia, 1 January 2014 to 31 December 2024

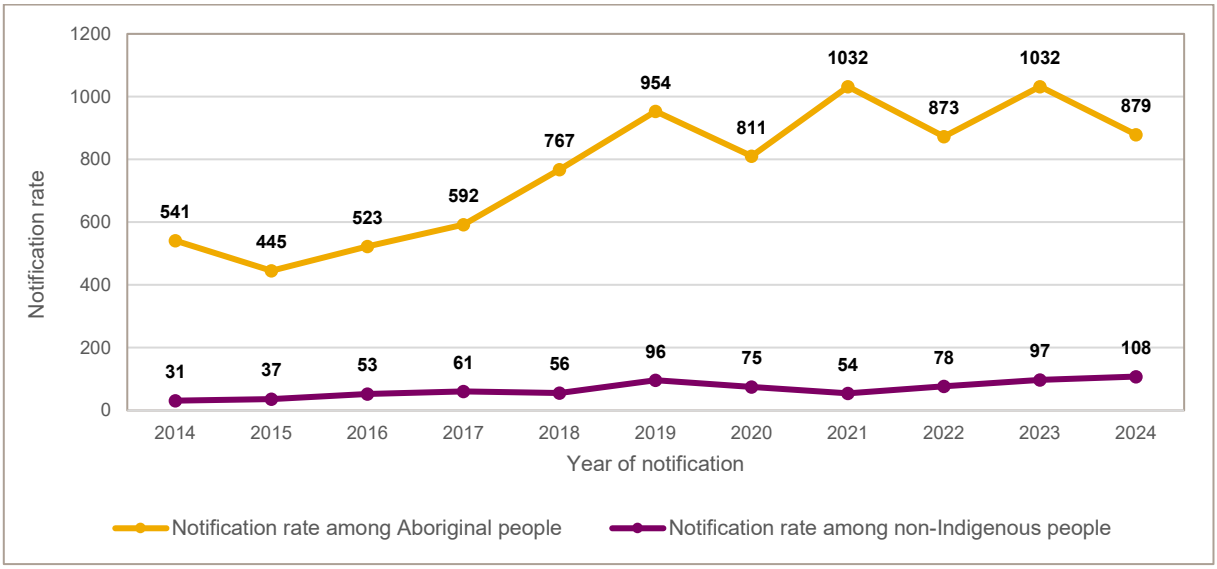
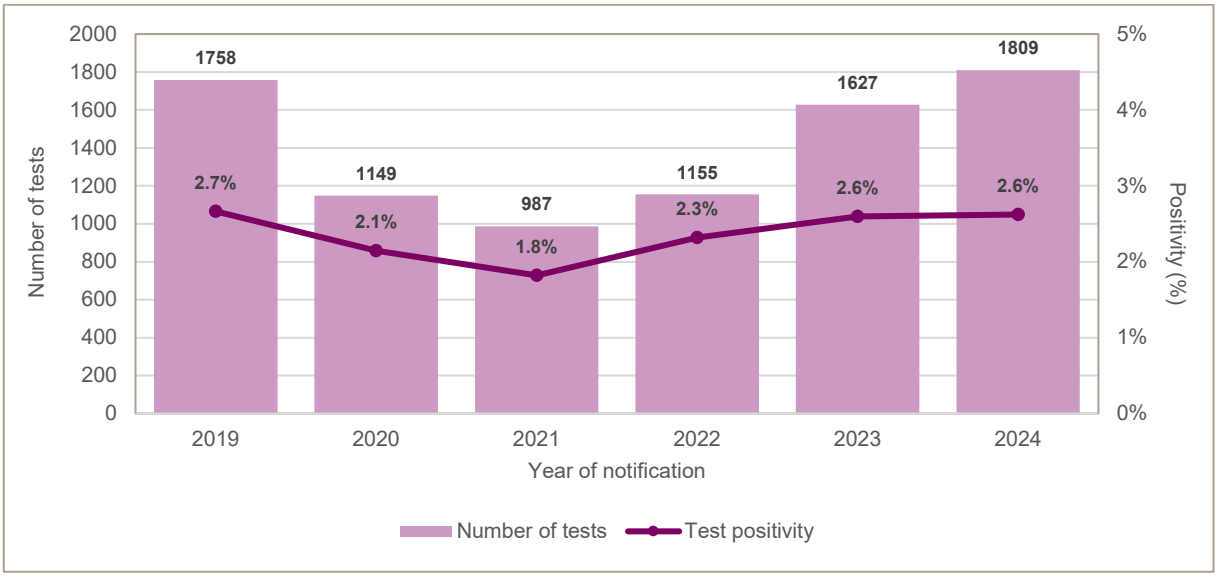


Figure 11 Gonorrhoea testing and positivity by year of diagnosis, South Australia, 1 January 2019 to 31 December 2024



Note: This data comes from SA Pathology only.

Infectious syphilis

There was a significant increase in infectious syphilis notifications in South Australia from 2011 to 2023.

In 2024, 229 notifications of infectious syphilis were reported in South Australia, a 29% decrease compared to 2023 when 323 notifications were received (the highest number of cases ever reported in a single year in South Australia).

The recent decline in cases is predominantly due to a large reduction in notifications among males reporting male sexual partners, and among Aboriginal people living in regional and remote areas, associated with enhanced control efforts. Infectious syphilis notifications in these groups declined by 53% and 59% from their respective peaks in 2022 and 2018 to the end of 2024.

In 2024, 34 cases were notified among Aboriginal and Torres Strait Islander people, lower than the 42 cases notified in 2023. In 2024, 68% (n=23) of Aboriginal and Torres Strait Islander cases were among people residing in metropolitan Adelaide at the time of diagnosis, compared to 35% (n=14) of cases in 2018, reflecting geographical shifting of the South Australian syphilis epidemic from regional and remote areas into metropolitan Adelaide.

Among both Indigenous and non-Indigenous people there has been a significant increase in the number of cases occurring among females and among males reporting female sexual partners, particularly in urban areas.

In 2024:

- 51 cases of infectious syphilis were reported among females (22% of all cases), an 82% increase compared to the 28 cases reported in 2019 (17% of all cases).
- Similarly, 79 cases were reported among males reporting female sexual partners (34% of all cases), a 65% increase compared to the 48 cases reported in 2019 (29% of all cases).

These changes are of concern as they increase the risk of syphilis in pregnancy and congenital syphilis.

Figure 12 Number of infectious syphilis cases notified by year of notification and sex at birth, South Australia, 1 January 2019 to 31 December 2024

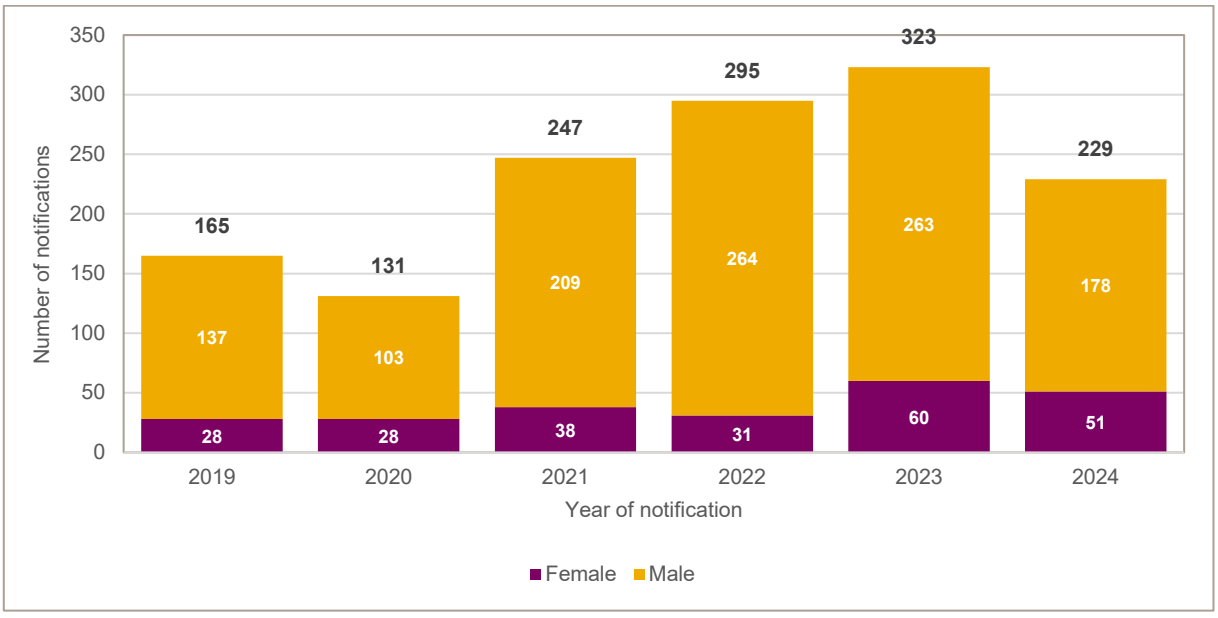


Figure 13 Number of infectious syphilis cases notified by year of notification and age group (years), South Australia, 1 January 2019 to 31 December 2024

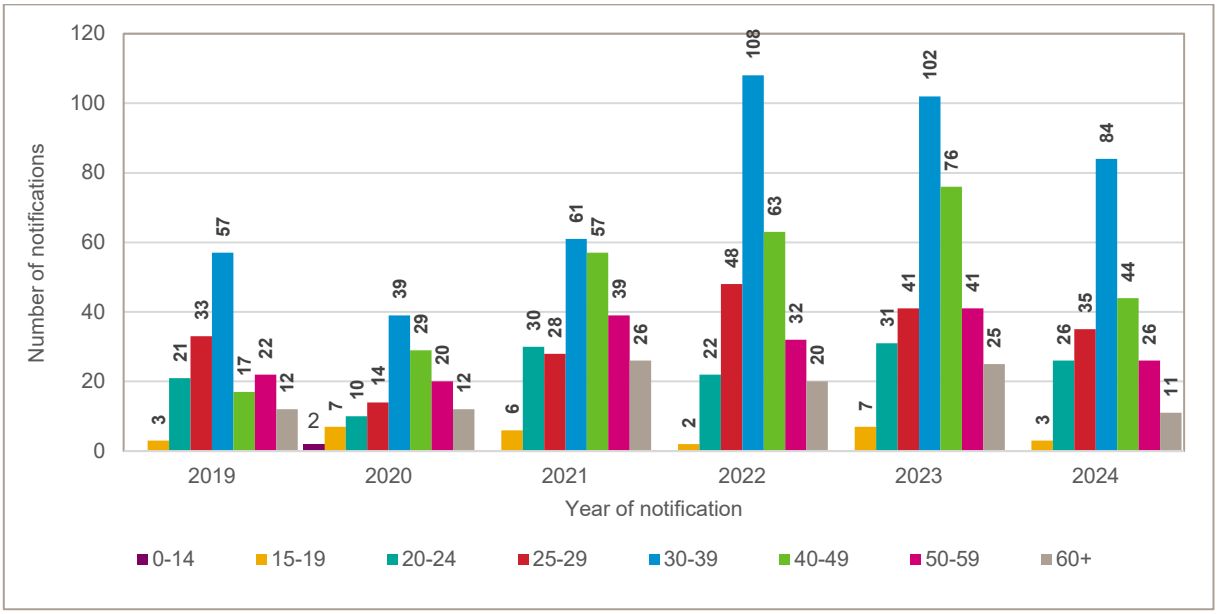


Figure 14 Number of infectious syphilis cases notified by year of notification and Indigenous status, South Australia, 1 January 2019 to 31 December 2024

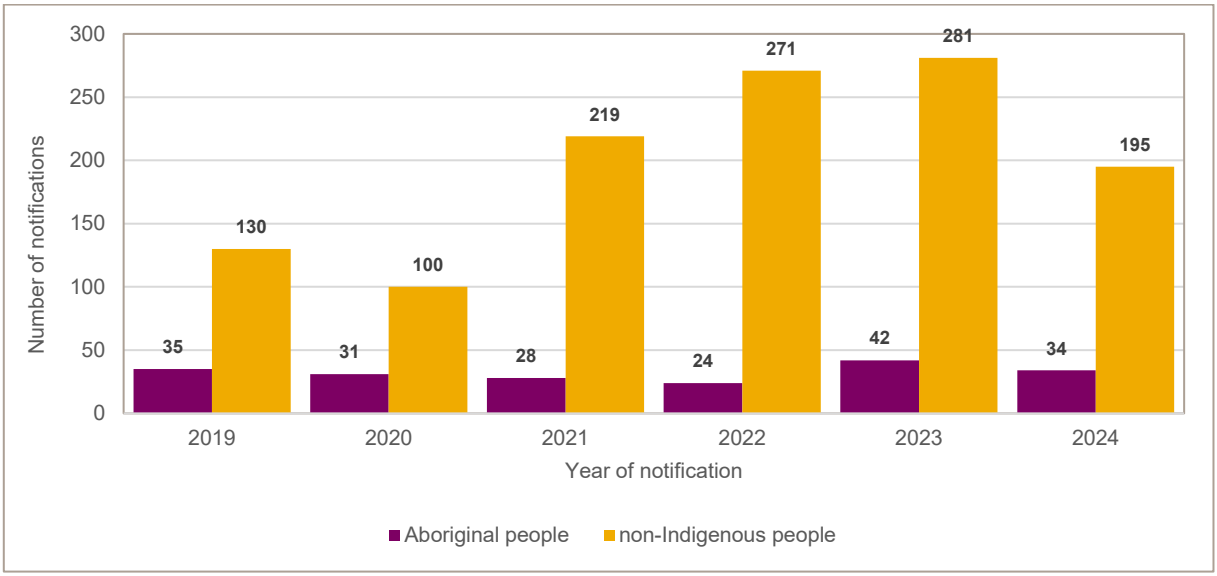


Figure 15 Infectious syphilis notification rate per 100,000 population by year of notification and Indigenous status, South Australia, 1 January 2014 to 31 December 2024

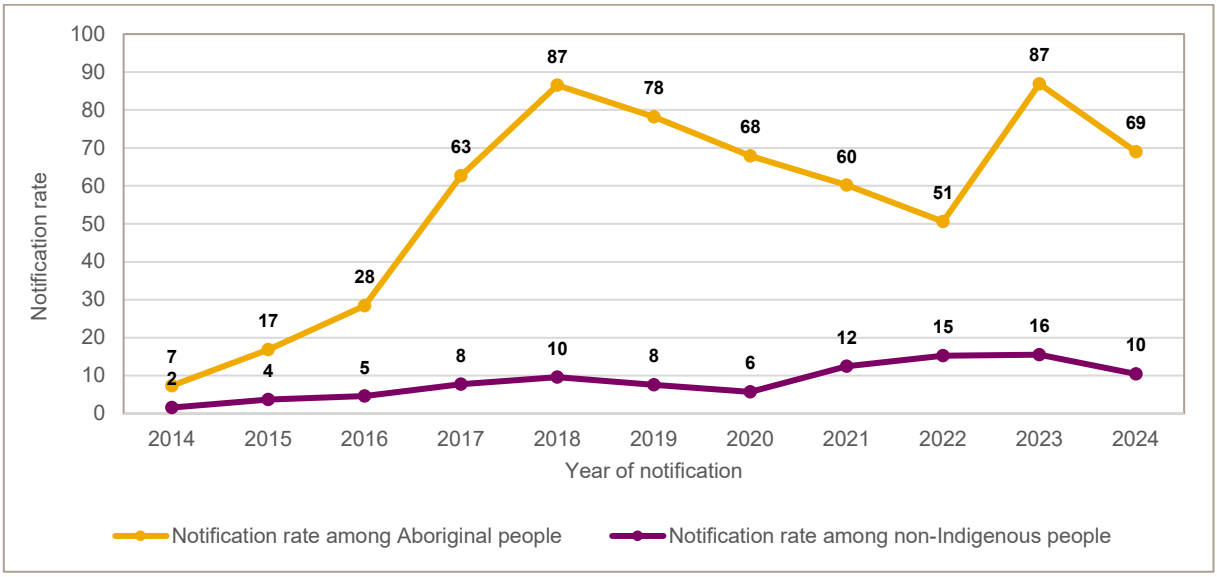
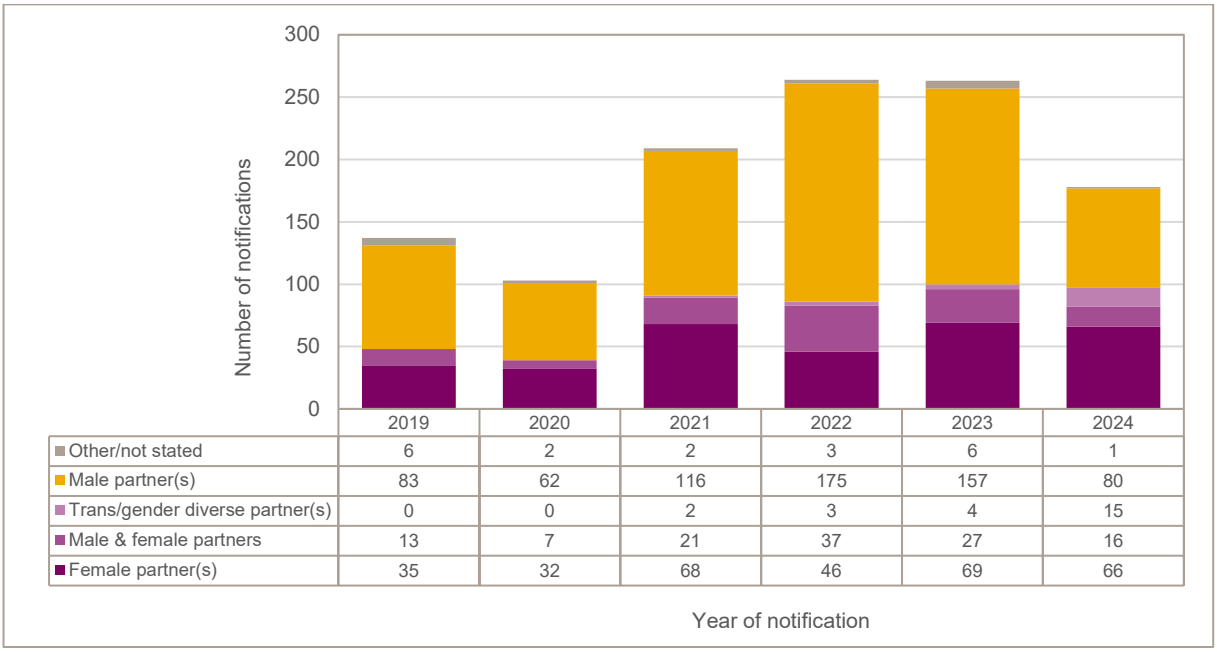
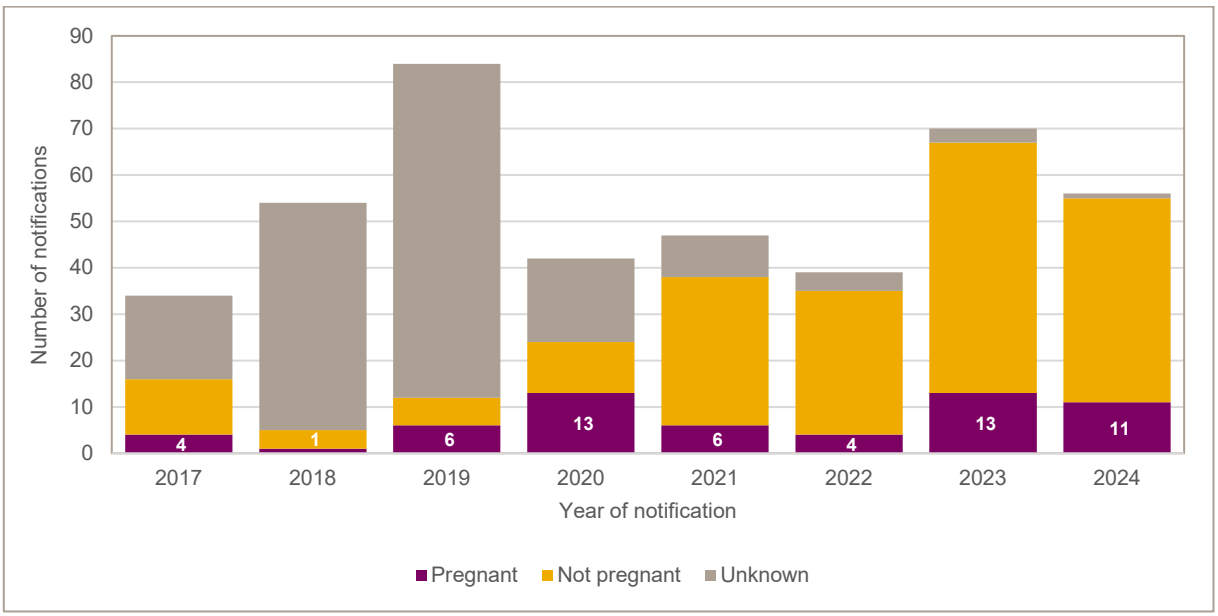


Figure 16 Reported sexual exposures among males with infectious syphilis by year of notification, South Australia, 1 January 2019 to 31 December 2024



	2019	2020	2021	2022	2023	2024
Other/not stated	6	2	2	3	6	1
Male partner(s)	83	62	116	175	157	80
Trans/gender diverse partner(s)	0	0	2	3	4	15
Male & female partners	13	7	21	37	27	16
Female partner(s)	35	32	68	46	69	66

Figure 17 Notifications of syphilis (infectious and non-infectious) among females by year of notification and pregnancy status at time of diagnosis, South Australia, 1 January 2017 to 31 December 2024



Note: Pregnancy data has been requested systematically on the notification form since 2020, prior to this information was obtained opportunistically.

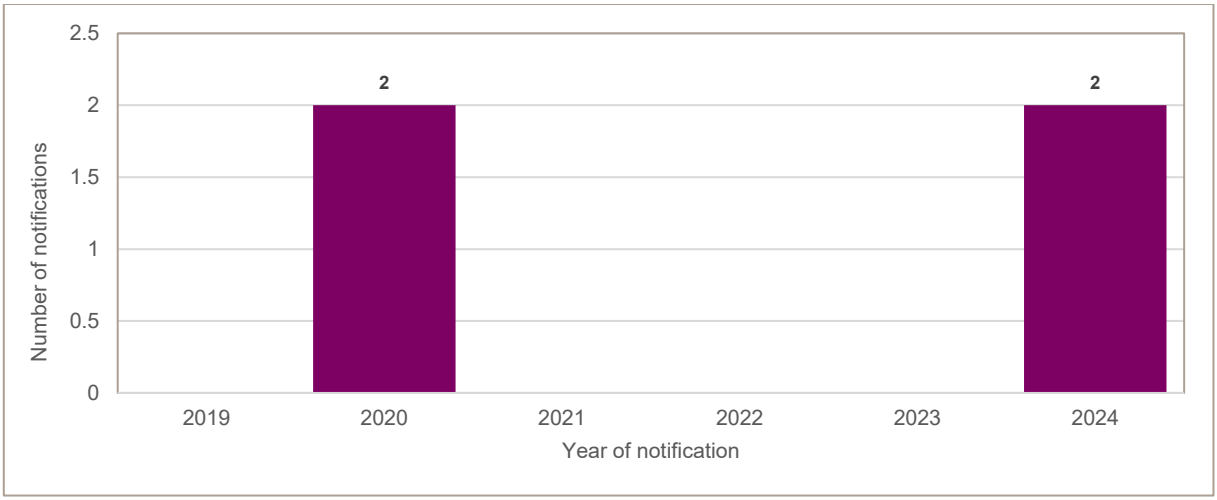
Congenital syphilis

Syphilis can also be passed on to babies during pregnancy, either while the baby is in the uterus or during vaginal delivery (this is called congenital syphilis).

Two cases of congenital syphilis were reported in 2024. The first case was in a non-Indigenous infant and the second case in an Aboriginal infant, both were notified in the first two quarters of 2024.

These cases are the first cases of congenital syphilis reported in South Australia since 2020 when two cases (both Aboriginal infants) were notified.

Figure 18 Number of congenital syphilis cases by year of notification, South Australia, 1 January 2019 to 31 December 2024



Neurosyphilis

Neurosyphilis refers to infection of the central nervous system by the bacterium that causes syphilis.

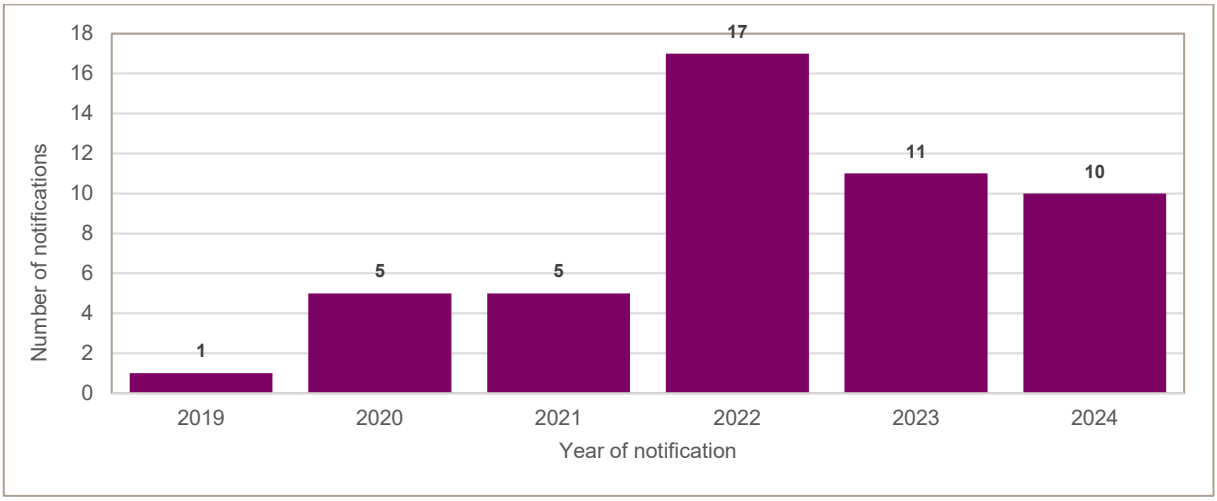
Neurosyphilis can result in loss of vision, loss of hearing, meningitis, palsies, dementia and other severe neurological complications which can lead to severe, permanent disability and extensive costs to the health system.

Neurosyphilis can occur at any stage of syphilis infection, and typically requires specialist inpatient review and management, post-discharge rehabilitation, and disability support services.

There has been an increasing trend for cases of neurosyphilis in South Australia and nationally.

Between 1 January 2019 and 31 December 2024, 49 cases of early neurosyphilis were notified to SA Health. Many of these cases experienced significant delays to diagnosis, and poor outcomes including loss of vision and hearing, ataxia, and frontotemporal dementia.

Figure 19 Number of early neurosyphilis cases notified by year of notification, South Australia, 1 January 2019 to 31 December 2024



Human immunodeficiency virus

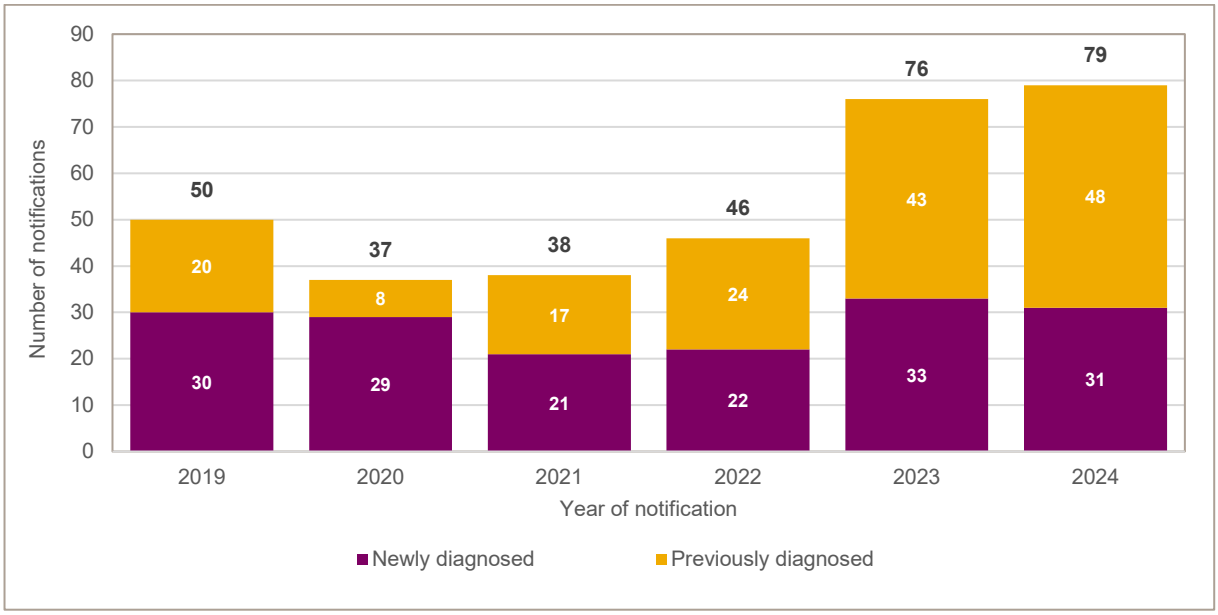
In 2024, there were 79 notifications of human immunodeficiency virus (HIV) in South Australia. Of these:

- 48 (61%) notifications were in cases that had been previously diagnosed overseas*, compared to 20 (40%) cases in 2019.
- 31 (39%) notifications were in cases with a first ever diagnosis in South Australia (newly diagnosed)†, compared to 30 (60%) cases in 2019.

These data reflect the long term increasing trend in South Australia for HIV notifications among overseas travellers and people born overseas.

Cases who were first diagnosed overseas and subsequently underwent confirmatory testing as part of their transfer of care are not counted as new cases in South Australia but are included in the figure below to provide an overview of the number of cases newly engaged in care in South Australia, these cases are reported on nationally.

Figure 20 Number of HIV cases notified by year of notification and diagnosis type, South Australia, 1 January 2019 to 31 December 2024



HIV newly diagnosed

This section is limited to cases of HIV with a first ever diagnosis in South Australia (newly diagnosed).

In contrast to the long-term declining trend from 2013 to 2021, there was an increase in newly diagnosed HIV notifications in South Australia from 2022 to 2024. This trend likely reflects COVID-19 related impacts on access to health services including HIV testing leading to underreporting of cases, as well as true changes in incidence due to the suspension and reintroduction of migration and international travel, and behavioural changes during periods of heightened COVID-19 restrictions.

* Previously diagnosed overseas: Cases notified to SA Health and supported to transition their care arrangements upon arrival. These cases are counted in South Australia for the purposes of national reporting.

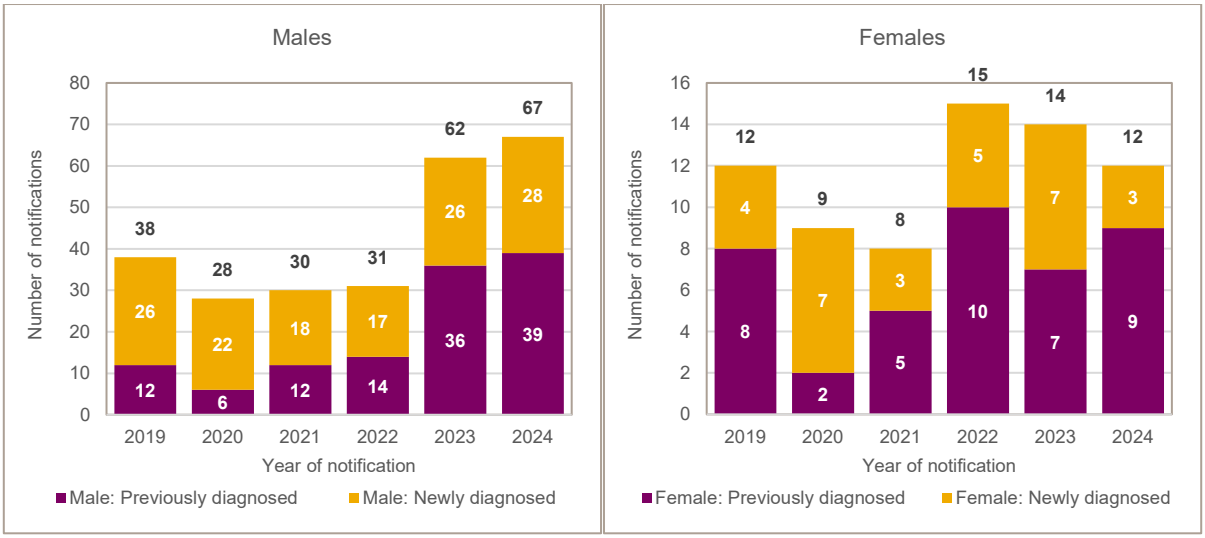
† First ever diagnosis in South Australia (newly diagnosed): Includes cases acquired overseas and diagnosed upon arrival, and cases acquired in South Australia that are potentially preventable through the local programmatic response.

In 2024, there were 31 newly diagnosed HIV notifications in South Australia compared with 33 notifications in 2023.

Of the 166 newly diagnosed HIV notifications reported from 2019 to 2024:

- 45% (n=75) were diagnosed late (CD4 count <350 cells/mm^3, infection likely acquired more than four years prior to diagnosis). Addressing barriers to timely HIV diagnosis and linkage to care is key to improving health outcomes for people living with HIV and preventing HIV transmission. The proportion of newly diagnosed HIV notifications who are diagnosed late is increasing over time.
- 53% (n=88) were among people born overseas.
- 83% (n=137) of cases were in males. Of these, 53% (n=73) acquired their infection in South Australia, and 30% (n=41) overseas. Sexual contact is the main risk factor for transmission, with 62% (n=85) of cases reporting only having male sexual partners, 20% (n=27) of cases reporting only having female sexual partners, and 15% of cases reporting both male and female sexual partners (n=21).
- 17% (n=29) of cases were in females. Of these, 66% (n=19) of cases acquired their infection overseas, and 24% (n=7) of cases acquired their infection in South Australia. All cases had heterosexual contact as a risk factor for acquisition, with the majority being with males born overseas.
- 3% (n=5) were among Aboriginal and Torres Strait Islander people (0 cases in 2024).

Figure 21 Number of HIV cases notified by year of notification, sex at birth and type of diagnosis, South Australia, 1 January 2019 to 31 December 2024



Note: The scale in these two graphs is different

Figure 22 Number of newly diagnosed HIV cases notified by year of diagnosis and age group (years), South Australia, 1 January 2019 to 31 December 2024

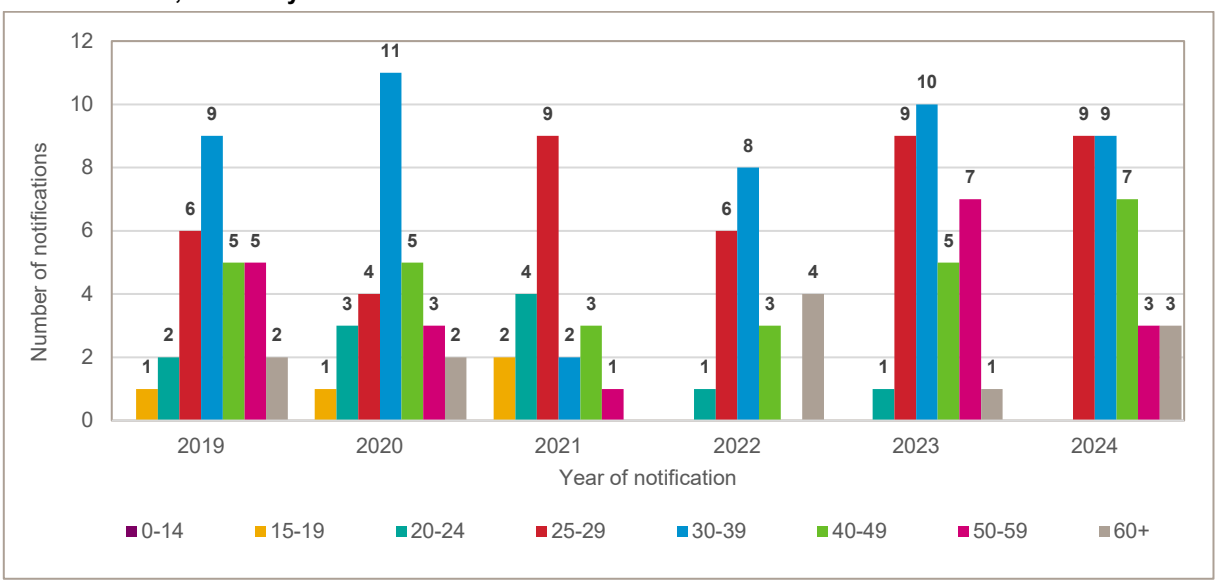


Figure 23 Number of newly diagnosed HIV cases notified by year of notification and Indigenous status, South Australia, 1 January 2019 to 31 December 2024

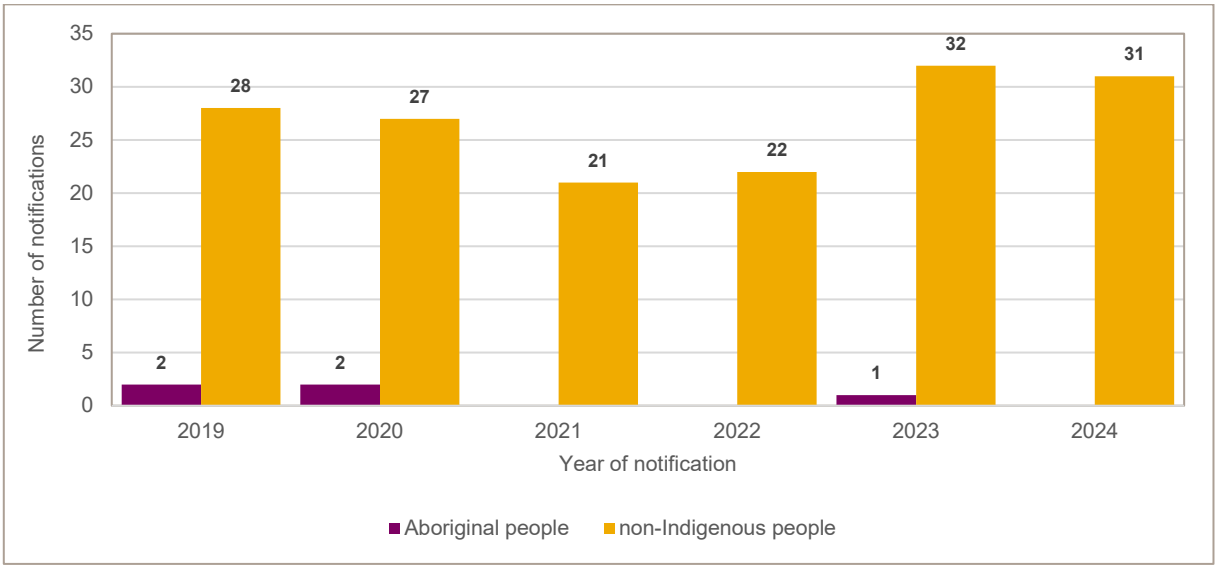


Figure 24 Newly diagnosed HIV notification rate per 100,000 population by year of notification, South Australia, 1 January 2014 to 31 December 2024

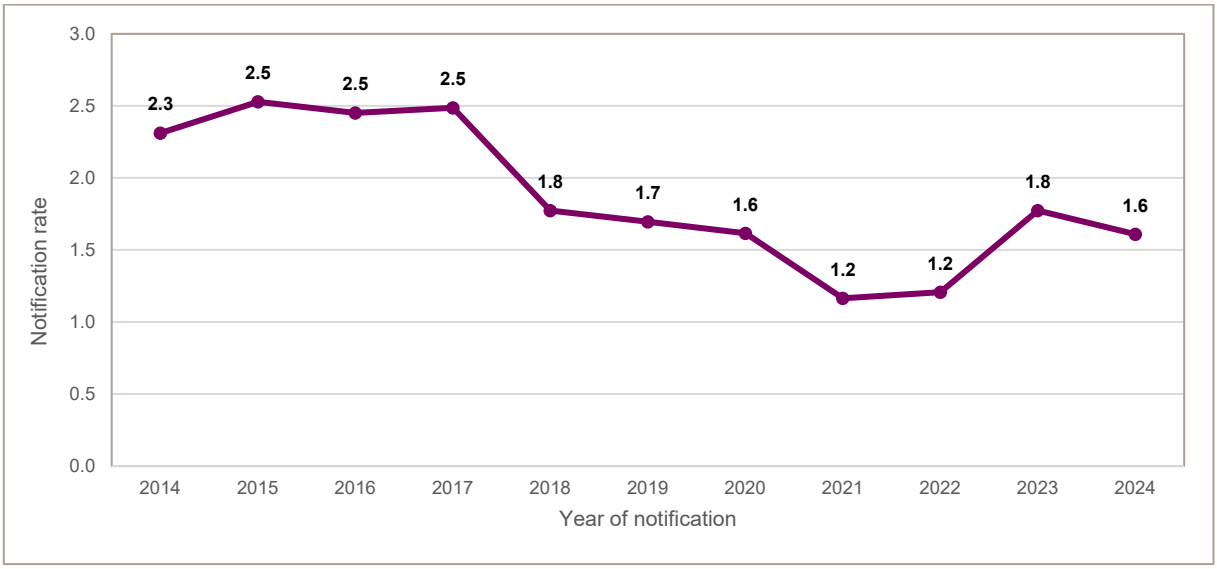
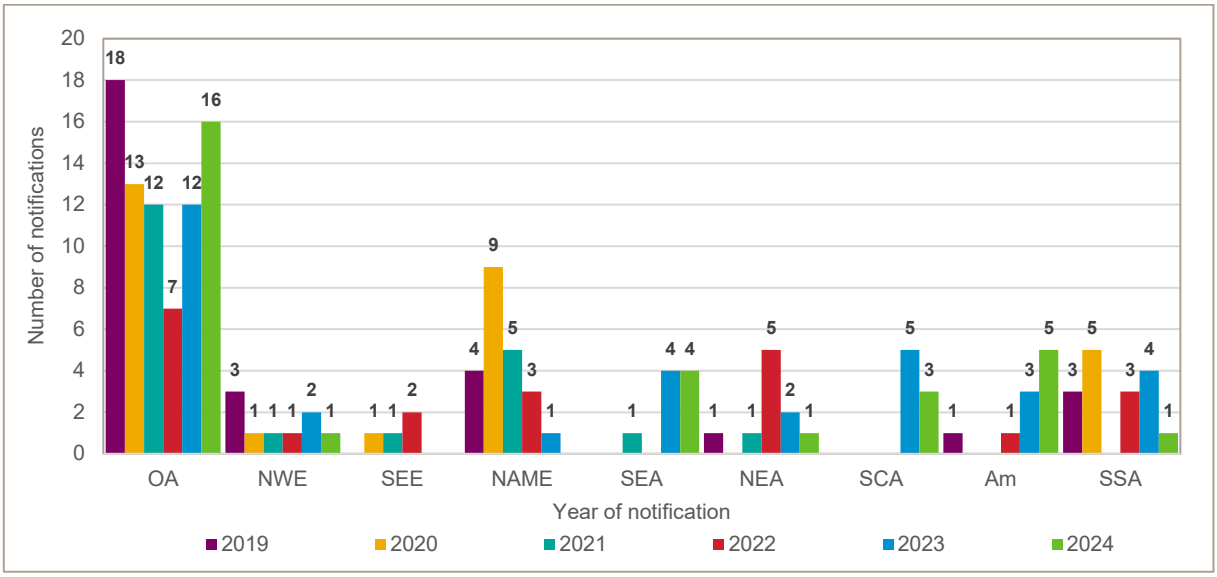
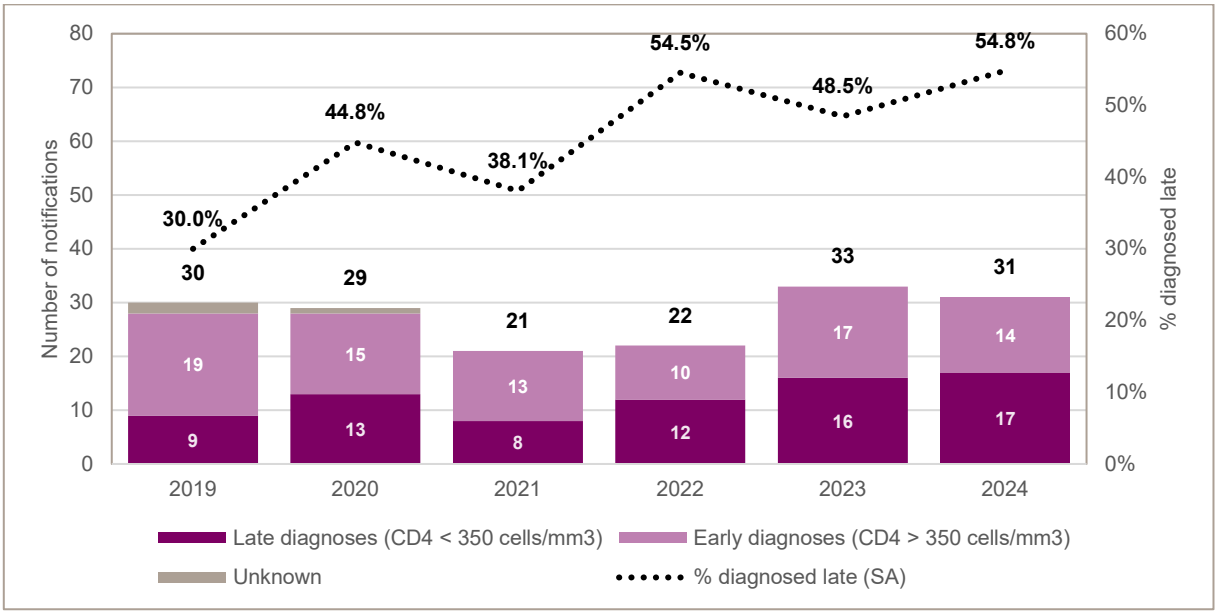


Figure 25 Number of newly diagnosed HIV cases notified by country of birth (major region) and year of diagnosis, South Australia, 1 January 2019 to 31 December 2024



OA: Oceania & Antarctica; **NWE**: North-West Europe; **SEE**: Southern & Eastern Europe; **NAME**: North Africa & Middle East; **SAE**: South-East Asia; **NEA**: North-East Asia; **SCA**: Southern & Central Asia; **Am**: Americas; **SSA**: Sub-Saharan Africa

Figure 26 Number of newly diagnosed HIV cases notified by time of diagnosis and year of diagnosis, South Australia, 1 January 2019 to 31 December 2024



Hepatitis B

Hepatitis B notifications are classified into two categories:

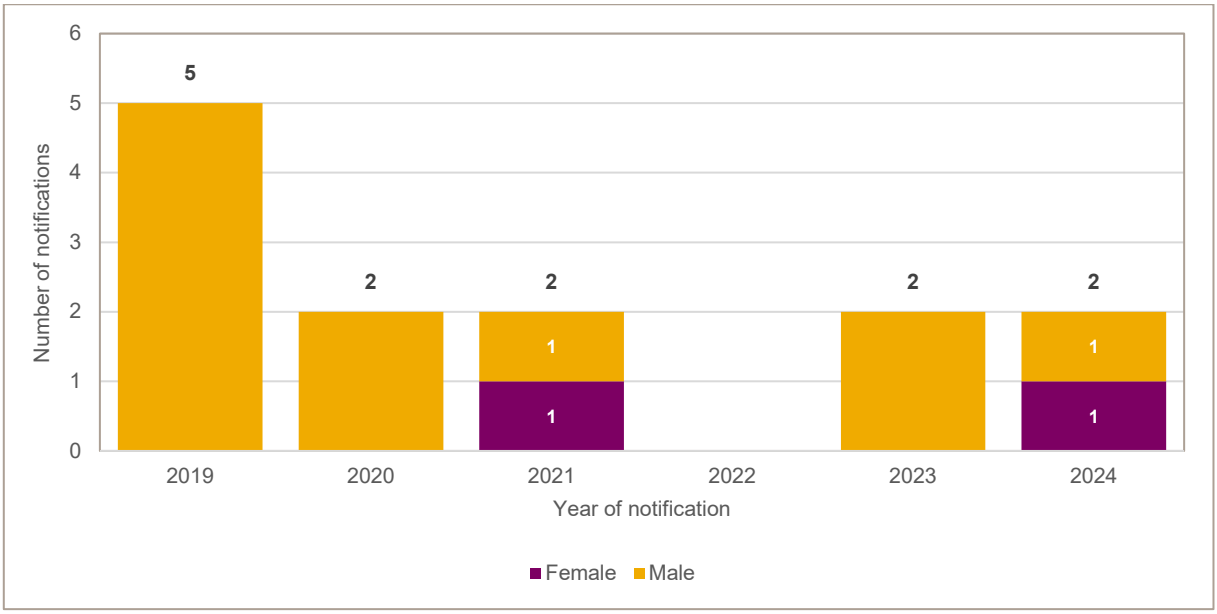
- newly acquired (evidence of hepatitis B acquisition within two years before diagnosis), and
- unspecified (cases that do not meet any of the criteria for a newly acquired case, and likely acquired hepatitis B more than 24 months before diagnosis or for cases of unknown duration).

Hepatitis B (newly acquired)

In 2024, two cases of newly acquired hepatitis B virus (HBV) were reported.

Low numbers of newly acquired hepatitis B cases are reflective of the ongoing success of hepatitis B vaccination programs and increasing levels of immunity at a population level. In Australia, these vaccination programs were implemented for populations at high risk of infection from the late 1980s before universal childhood vaccination commenced in the year 2000.

Figure 27 Number of HBV (newly acquired) cases notified by year of notification, South Australia, 1 January 2019 to 31 December 2024



Hepatitis B (unspecified)

Hepatitis B disproportionally impacts people born overseas in high prevalence countries.

In 2024, there were 261 notifications of unspecified hepatitis B, which is slightly higher than the 237 notifications received in 2023. The number of notifications in 2021-2022 (n=390) was considerably lower than in 2018-2020 (n=845), likely due to a combination of a reduction in international migration and a decrease in screening as a result of the COVID-19 pandemic.

The number of notifications among Aboriginal and Torres Strait Islander people has varied considerably over time due to small numbers and trends need to be interpreted with caution. In addition to service disruptions related to the COVID-19 pandemic, the low and decreasing number of cases among Aboriginal and Torres Strait Islander people likely also reflects a true decrease in hepatitis B incidence and prevalence, associated with high uptake of hepatitis B vaccination and increasing immunity at a population level.

Figure 28 Number of HBV (unspecified) cases notified by year of diagnosis and sex at birth, South Australia, 1 January 2019 to 31 December 2024

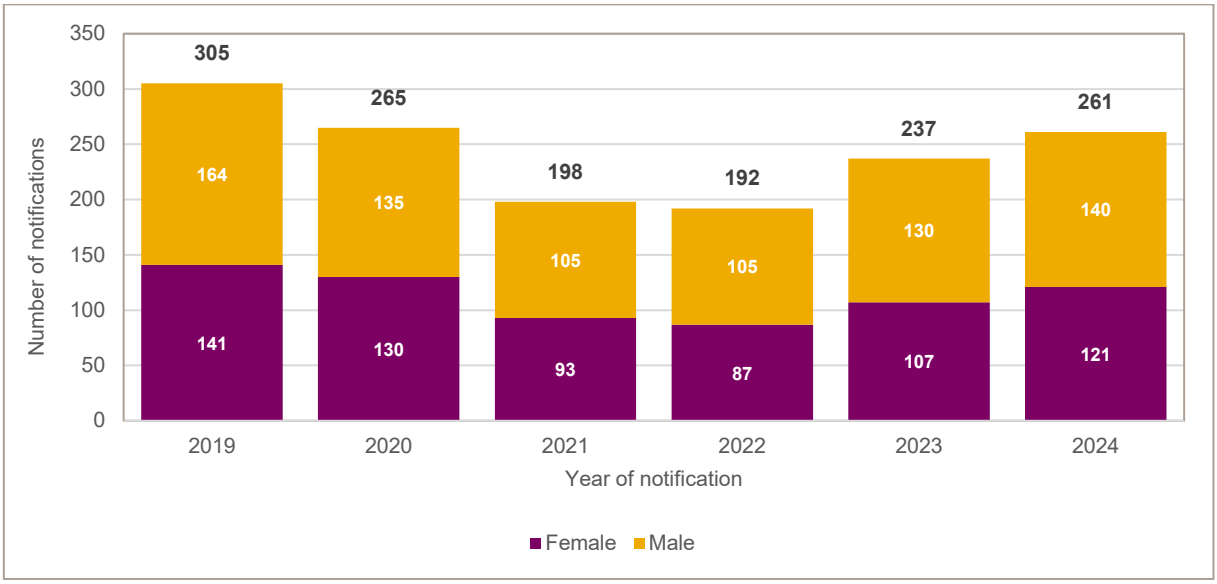


Figure 29 Number of HBV (unspecified) cases notified by year of notification and age group (years), South Australia, 1 January 2019 to 31 December 2024

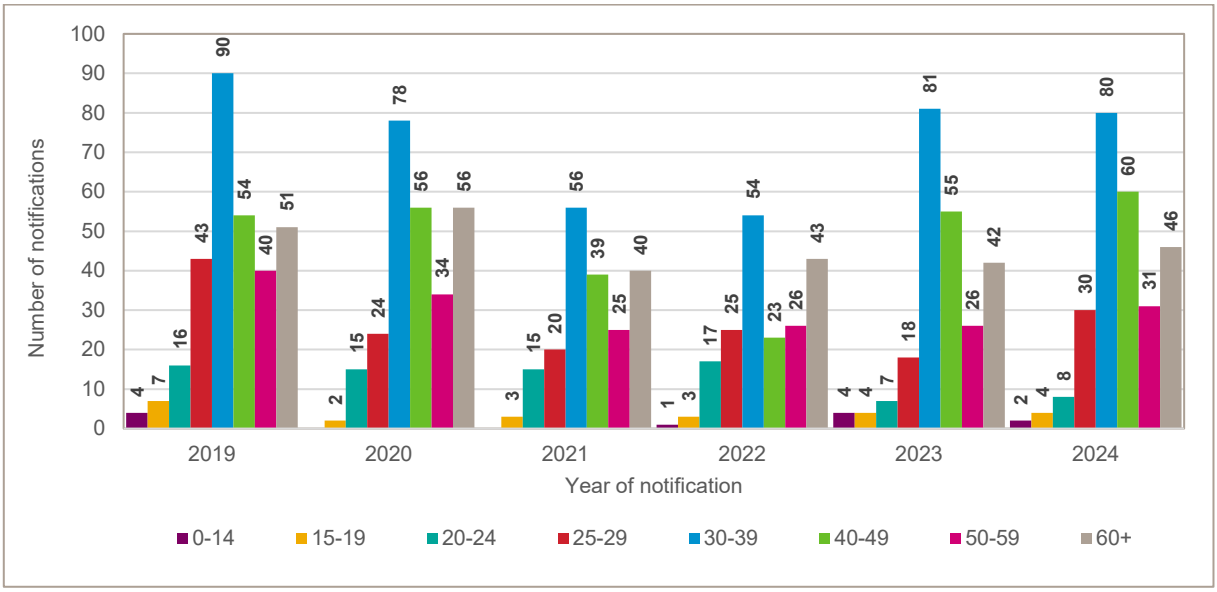
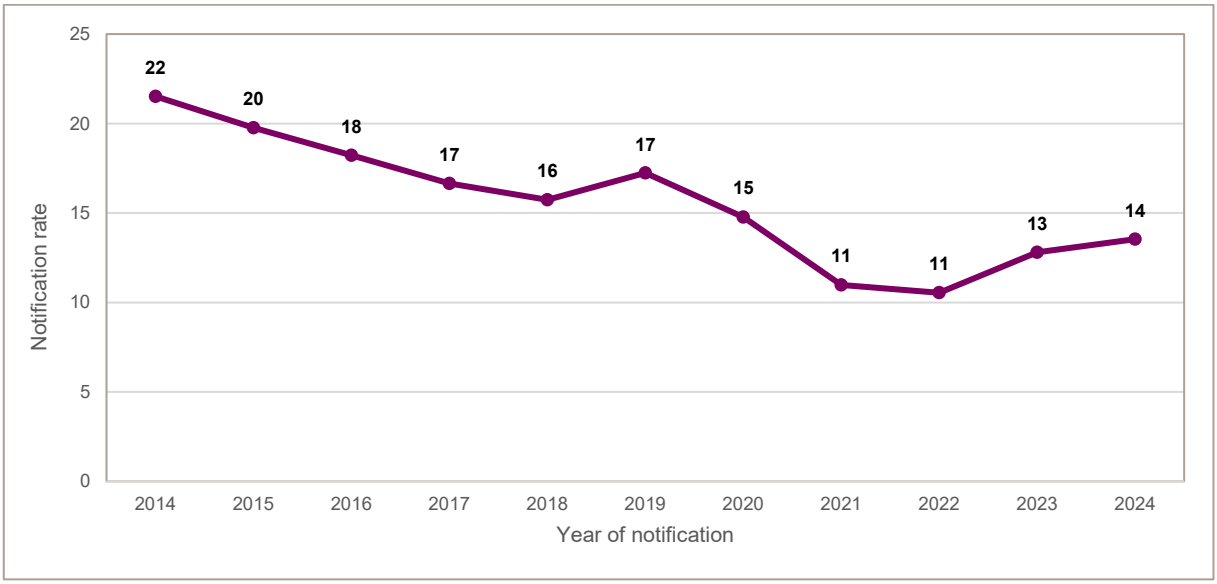


Figure 30 HBV (unspecified) notification rate per 100,000 population by year at notification, South Australia, 1 January 2014 to 31 December 2024

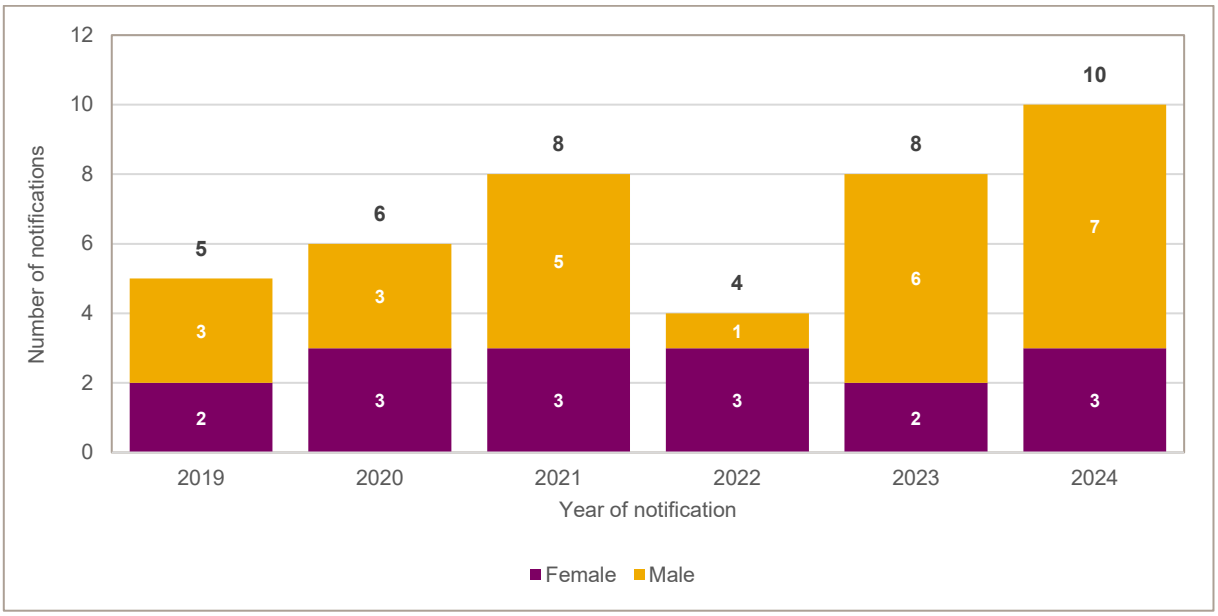


Hepatitis D virus

Hepatitis D virus (HDV) is uncommon in Australia and only occurs in people who have an HBV infection, as HDV requires HBV to survive and multiply. For more information about HDV visit the SA Health website.

In 2024, there were 10 cases of HDV notified, three cases in females and seven cases in males. All cases were in non-Indigenous people.

Figure 31 Number of HDV cases notified by year of notification and sex at birth, South Australia, 1 January 2019 to 31 December 2024



Hepatitis C

Hepatitis C notifications are classified into two categories:

- newly acquired (evidence of hepatitis C acquisition within two years before diagnosis), and
- unspecified (cases that do not meet any of the criteria for a newly acquired case, and likely acquired hepatitis C more than 24 months before diagnosis or for cases of unknown duration).

Hepatitis C (newly acquired)

In 2024, there were 13 notifications of newly acquired hepatitis C virus (HCV), including seven notifications among Aboriginal and Torres Strait Islander persons. This is a 58% decrease compared to 2023 when 31 notifications were received.

The number of notifications in 2020-2022 (n=52) was considerably lower than in 2018-2019 (n=72), likely due to a combination of a real reduction in transmission as well as a reduction in opportunistic screening as a result of the COVID-19 pandemic.

Note that notification rates have varied considerably over time due to small numbers and need to be interpreted with caution, particularly among Aboriginal and Torres Strait Islander people due to the smaller population base.

In recent years, the hepatitis C (newly acquired) notification rate among Aboriginal and Torres Strait Islander people has been consistently at least 10 times higher than among non-Indigenous people. This likely reflects ongoing disparities in disease burden as well as likely differences in the frequency of screening for bloodborne viruses in some settings, which makes it more likely that Aboriginal and Torres Strait Islander people diagnosed with hepatitis C can be recognised as newly acquired cases (as opposed to unspecified HCV).

Figure 32 Number of HCV (newly acquired) cases notified by year of notification and sex at birth, South Australia, 1 January 2019 to 31 December 2024

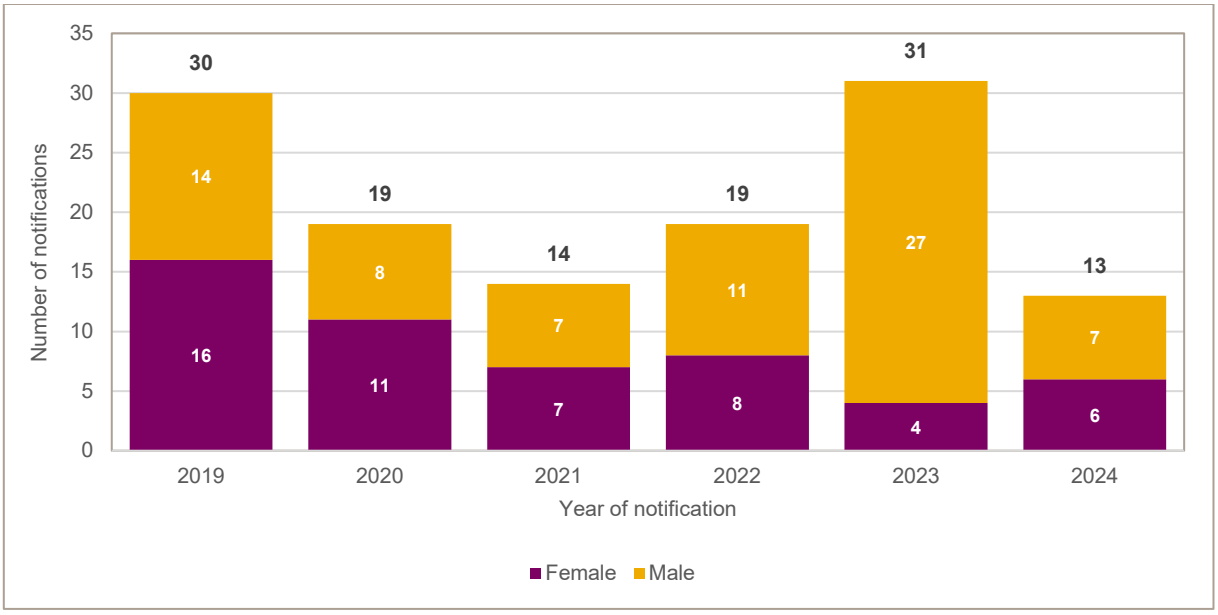


Figure 33 HCV (newly acquired) notification rate per 100,000 population by year of notification and Indigenous status, South Australia, 1 January 2014 to 31 December 2024

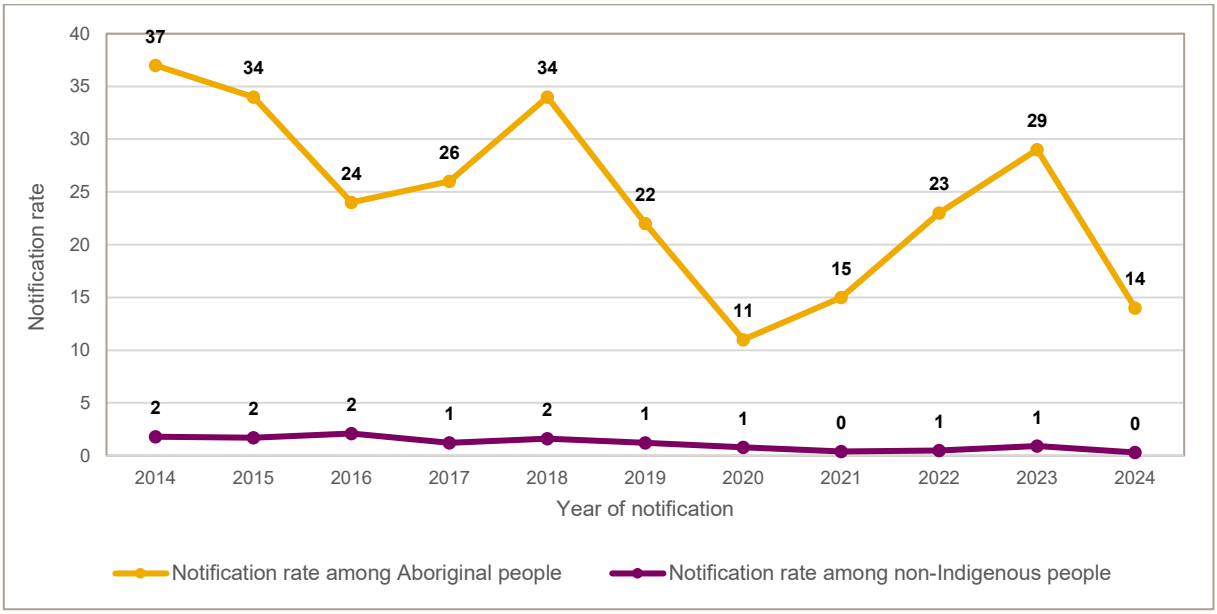
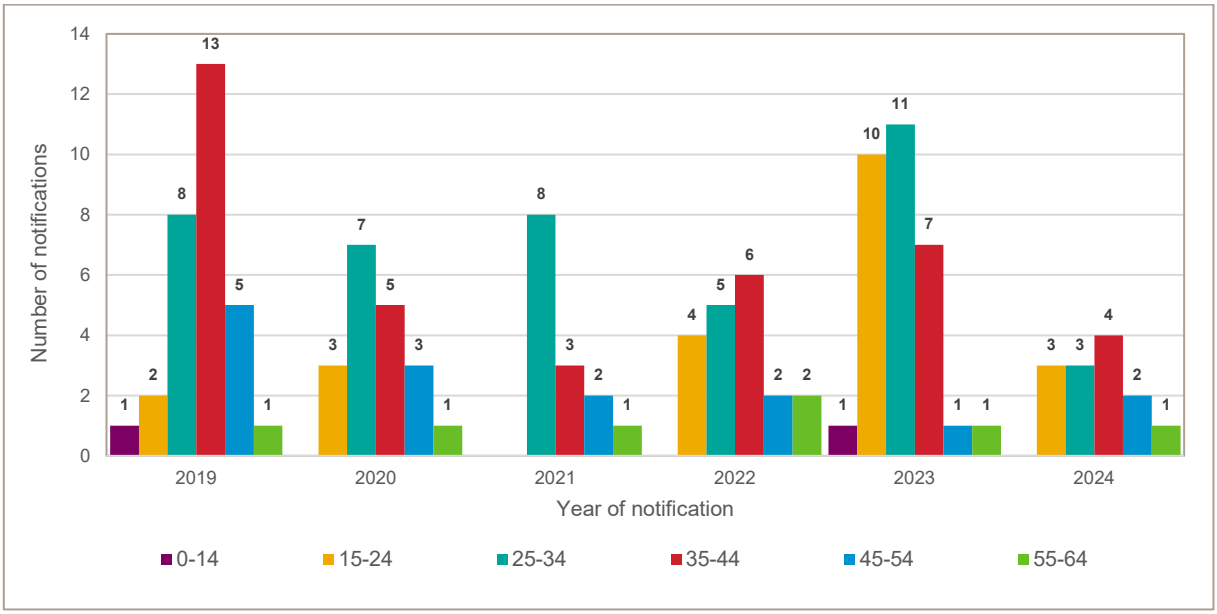


Figure 34 Number of HCV (newly acquired) cases notified by year of notification and age group (years), South Australia, 1 January 2019 to 31 December 2024



Hepatitis C (unspecified)

In 2024, there were 228 notifications of unspecified hepatitis C virus (HCV), which is lower than in 2023 where 253 notifications were received.

Notification rates for both non-Indigenous people and Aboriginal and Torres Strait Islander people have declined significantly and then plateaued following the listing of hepatitis C direct acting antiviral treatments on the Pharmaceutical Benefits Scheme (PBS) in 2016, and effective scale up of hepatitis C testing and treatment building on existing primary prevention strategies.

Similar to newly acquired cases, the difference in hepatitis C (unspecified) notification rates between Indigenous and non-Indigenous people likely reflects both considerable ongoing disparities in the disease burden as well as likely differences in screening for blood borne viruses.

Figure 35 Number of HCV (unspecified) cases notified by year of notification and sex at birth, 1 January 2019 to 31 December 2024

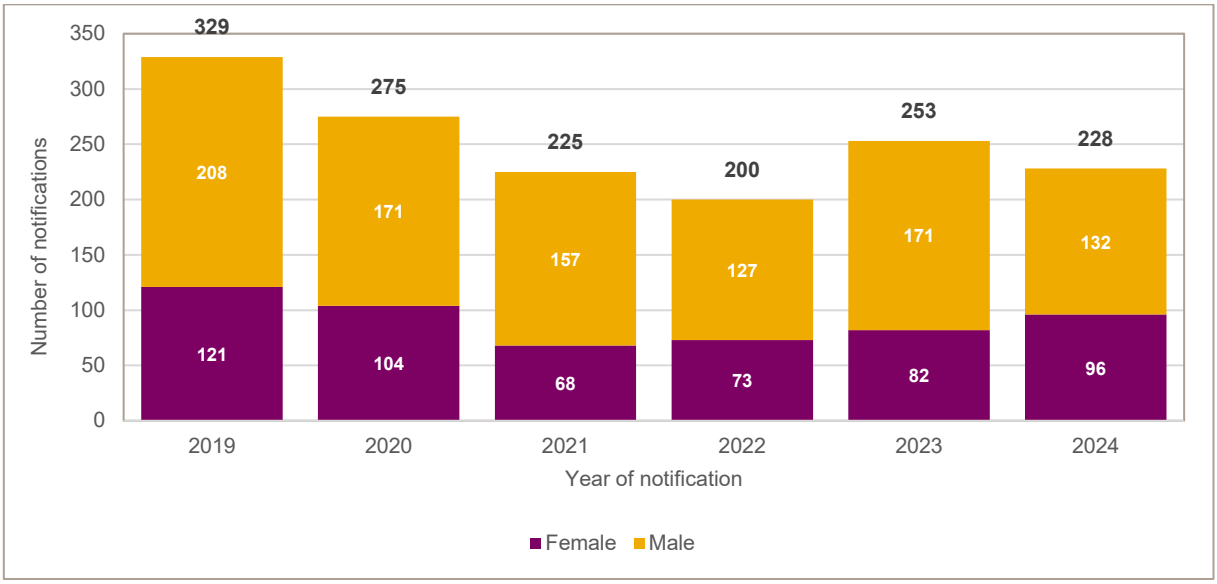


Figure 36 HCV (unspecified) notification rate per 100,000 population by year of notification and Indigenous status, South Australia, 1 January 2014 to 31 December 2024

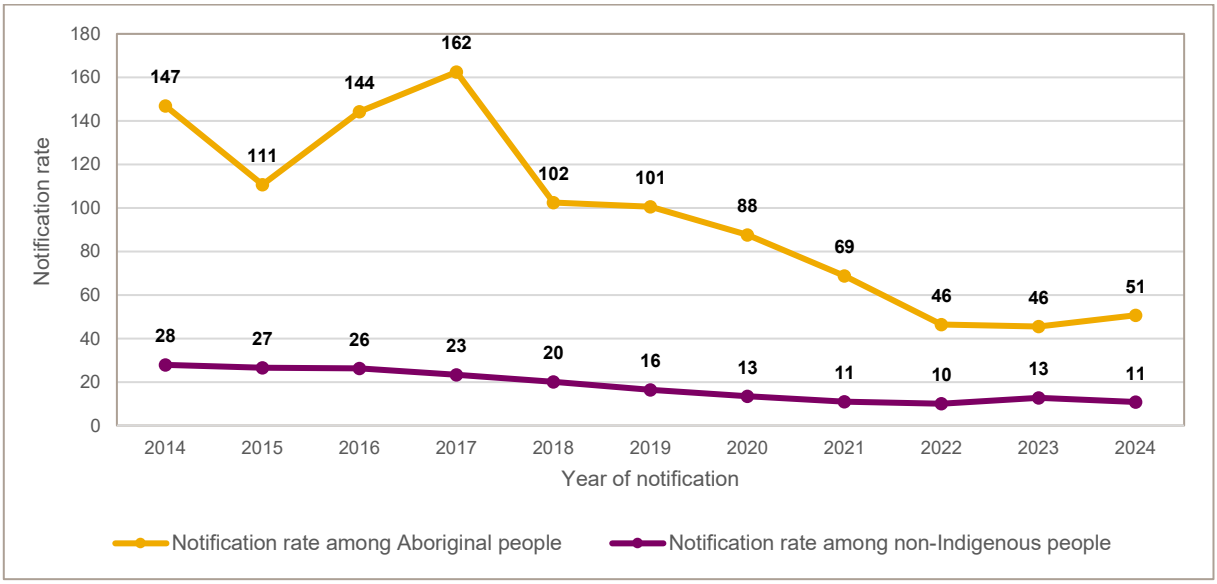
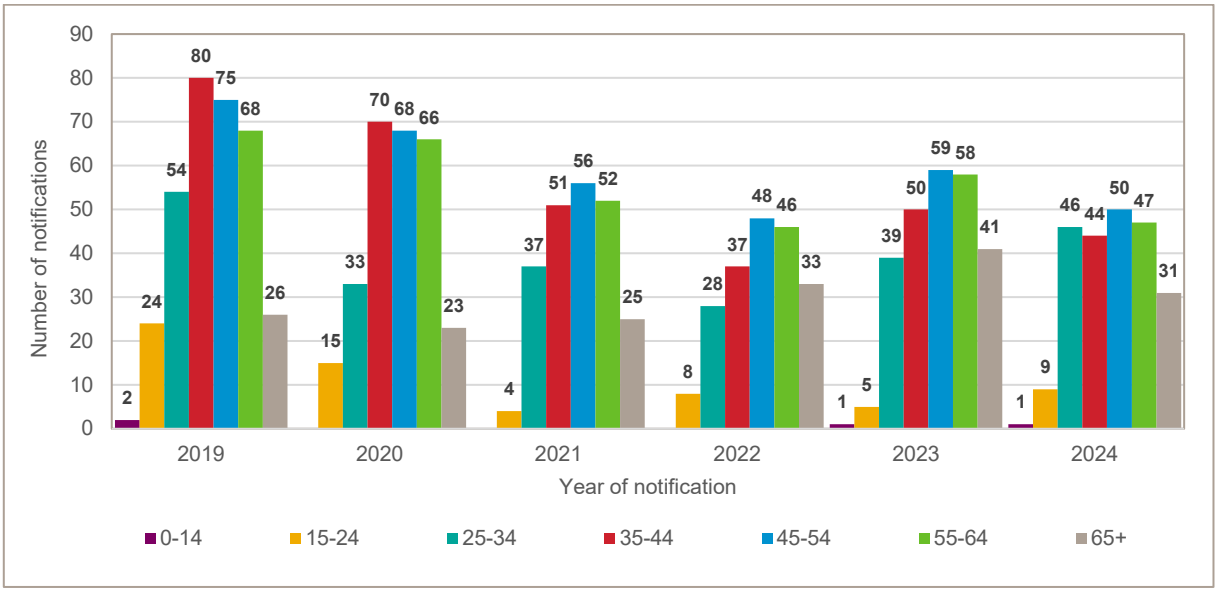


Figure 37 Number of HCV (unspecified) cases notified by year of notification and age group (years), South Australia, 1 January 2019 to 31 December 2024



Mpox

Mpox was previously known as monkeypox.

In May 2022, a global outbreak of mpox Clade II began, with cases identified in many countries where the disease is not usually present including Australia.

While mpox is not classified as a sexually transmissible infection, in South Australia it is mainly transmitted via close physical contact including sexual activity, and direct contact with infected body fluids, lesions or scabs on the skin.

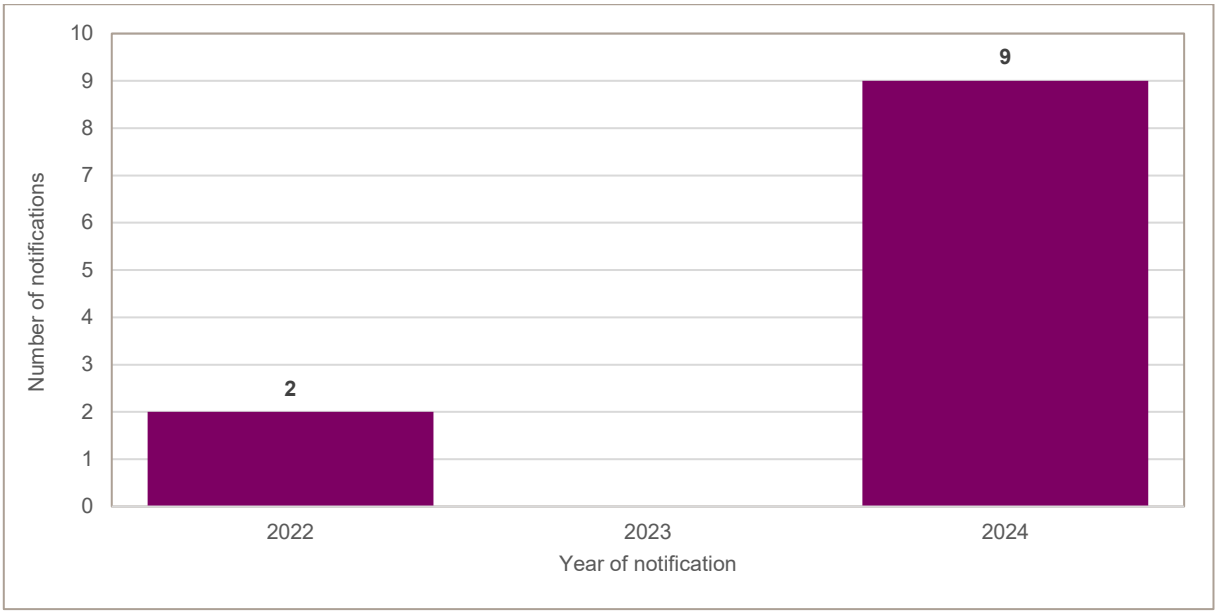
Mpox can also be transmitted through prolonged contact with respiratory droplets (from coughing, sneezing, breathing and speaking) and contact with contaminated materials or objects, such as contaminated clothing, towels or linen.

In 2024, there were 9 notifications of mpox, and were the first cases notified in South Australia since 2022. All cases are males reporting sex with other males (MSM).

Of the 11 cases of mpox diagnosed in South Australia since 2022:

- All cases were male with sexual contact with other males as the risk factor.
- 4 infections each were acquired overseas or interstate and 3 were acquired in South Australia.
- 7 cases had not been vaccinated (64%), 2 cases had been partially vaccinated (one dose of vaccine received) and 2 cases were fully vaccinated (two doses of vaccine received).

Figure 38 Number of mpox cases notified by year of diagnosis, South Australia, 1 January 2022 to 31 December 2024



For more information

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