



Epidemiology of notifiable infectious diseases in metropolitan Perth

Annual report 2025



Epidemiology of notifiable infectious diseases in metropolitan Perth: Annual report 2025.

Boorloo (Perth) Public Health Unit
Public Health and Clinical Excellence
North Metropolitan Health Service

Note: For this report, the geographical boundaries of metropolitan Perth (henceforth referred to as Perth) are defined by the area within the East, North and South Metropolitan Health Services (EMHS, NMHS and SMHS). The use of the term 'Aboriginal' within this document refers to Australians of both Aboriginal and Torres Strait Islander descent. The term 'Aboriginal' is used in preference to 'Aboriginal and Torres Strait Islander' in recognition that Aboriginal people are the original inhabitants of Western Australia (WA). No disrespect is intended to our Torres Strait Islander colleagues and community.

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The NMHS acknowledges the traditional owners of the land, the Noongar people. We pay our respects to the elders past and present and recognise the continuing cultural and spiritual practices of the Noongar people.

Boorloo (Perth) Public Health Unit would like to acknowledge the assistance of medical, nursing and scientific staff working in general practices, hospitals and laboratories, for their assistance with public health follow-up of persons with notifiable diseases, and their essential contributions to prevention and control of communicable diseases in the Perth metropolitan area.

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Executive Summary

Boorloo (Perth) Public Health Unit (PHU) is responsible for the public health management of notifiable diseases in metropolitan Perth and contributes to communicable disease prevention through programs directed at immunisation and clinician support. This report aims to inform healthcare providers and stakeholders about local trends in notifiable disease epidemiology and to highlight relevant public health actions and issues.



81,157

Communicable disease notifications to Boorloo PHU in 2025.



On the rise

Influenza, measles, pertussis, syphilis, cryptosporidiosis



Immunisation

90.3% at 12 months (↓1.3%)
88.2% at 24 months (↓0.8%)
92.1% at 60 months (↓0.4%)



5x faster

Return of immunisation catch-up plans despite 21% increase in requests.

Increases in important vaccine-preventable diseases

- **Measles cases rose sharply**, reflecting global trends. Two major outbreaks (within prisons, then among mine site workers) required intense public health follow up.
- **Biggest flu season on record**: more influenza cases were reported in 2025 than any year on record, with a protracted season that caused enormous health system strain.
- **Invasive Pneumococcal Disease (IPD) notifications increased** to record levels (189 cases). A 20-valent immunisation was rolled out to increase serotype coverage.
- **Pertussis epidemic continued all year**, with case numbers per month still increasing at the end of 2025.

Sexually transmissible infections and bloodborne viruses remain key focus areas

- **Syphilis notifications reached record high levels**, driven by an increase in cases among men. There was one case of congenital syphilis in Perth in 2025.
- **Periodic community transmission of Mpox in Perth continued**: 26 cases were notified in 2025, with multiple introductions into WA resulting in onward local spread.
- **Boorloo PHU continued active follow-up of hepatitis C**, with 98.5% of notified cases completing ribonucleic acid (RNA) testing, and 75.1% of eligible community cases accessing treatment.

Successful immunisation programs amid overall waning coverage

- **Immunisation coverage in Perth continued to fall**, with rates of 90.3% at 12 months, 88.2% at 24 months, and 92.1% at 60 months (all lower than in 2024).
- **Immunisation coverage improved for Aboriginal children** at 12 and 24 months of age, with absolute gains of 0.7% and 2.1%, respectively. The Boorloo PHU Moorditj programs continue to support Aboriginal families to access immunisation services.
- **Catch-up plans were returned to clinicians 5x faster** in 2025 compared to previous years, after Boorloo PHU implemented multiple efficiency and automation measures.
- **Rabies post-exposure prophylaxis** was required for 373 Perth residents in 2025.

Background

Purpose

Boorloo PHU has responsibility for the public health management of notifiable diseases in metropolitan Perth. This report provides healthcare providers and other stakeholders with an overview of key notifiable diseases and immunisation trends in Perth in 2025.

Notifiable Diseases

Under Part 9 of the [Public Health Act 2016](#), medical and nurse practitioners attending to a patient with a notifiable infectious diseases have a legal obligation to notify the Department of Health. Similar obligations apply to pathology laboratories where test results indicate a notifiable disease. Data on individuals with notifiable diseases and related conditions are recorded in the Western Australian Notifiable Infectious Diseases Database (WANIDD). These data are crucial for informing disease surveillance, public health management, policy, and interventions. A list of notifiable infectious diseases and related conditions in WA is available [online](#).

Data Sources

Notification data

Notifiable disease data for Perth and WA were extracted from WANIDD on 19 March 2026 and are subject to revision. Data were retrieved using an **optimal date of onset of disease** from 1 January to 31 December 2025. Exceptions to this were diseases with a long delay between diagnosis and onset, namely, non-infectious syphilis, tuberculosis, leprosy, Creutzfeldt-Jakob disease, and unspecified hepatitis B and C. For these diseases, data were retrieved by the **date of receipt** of notification from 1 January to 31 December 2025. National notification rates were obtained from the National Notifiable Diseases Surveillance System data visualisation tool on 19 March 2026. Data related to mpox cases were extracted from the Public Health Operations COVID-19 Universal System on 27 May 2026. Data on sexually transmissible infection (STI) testing numbers in 2025 were provided by Communicable Disease Control Directorate.

Population data

Population data were obtained from the Australian Bureau of Statistics (ABS). The estimated resident population for Greater Perth on 30 June 2025 was 2,456,348¹ and for WA on 30 June 2025 was 3,044,382.² Population estimates for Health Service Provider catchment were derived from the ABS population by Local Government Area 2.

Immunisation data

The Australian Immunisation Register (AIR) provides quarterly reports of immunisation coverage for 3 age groups: 12 to <15 months, 24 to <27 months, and 60 to <63 months. Approval was provided by the AIR Data Steward for usage of these data from the quarterly reports for 2025 (see Appendix 3 for standard data suppression rules).

¹ Regional population, 2024-25 financial year | Australian Bureau of Statistics [Internet]. 2026 [cited 2026 Sep 4]. Available [online](#).

² National, state and territory population, December 2025 | Australian Bureau of Statistics [Internet]. 2026 [cited 2026 Sep 4]. Available [online](#).

Overview of notifiable diseases

In 2025, there were 81,157 infectious diseases notified in Perth. This was a 31.0% increase from 2024, largely attributable to influenza notifications more than doubling since the previous year. Furthermore, overall notifications remained above the 5-year average (31,810 per year between 2020 and 2024; up to 70,559 in 2025, excluding COVID-19 infections for comparability across years).

Figure 1 demonstrates the number of notifications by disease category in 2025. Notifications in every disease category exceeded the 5-year average, with the largest change in the vaccine preventable diseases category. Very few influenza notifications were received in 2020 and 2021 amid COVID-19 travel restrictions, which has lowered the 5-year average for this category, and created a substantial contrast with 2025, which saw the highest number of influenza notifications ever recorded in Perth.

The significant increase in the number of diseases notified in the ‘other diseases’ category is largely artefactual, with invasive group A streptococcal (iGAS) infection, mpox and respiratory syncytial virus (RSV) becoming newly notifiable diseases after the commencement of the 5-year average period.

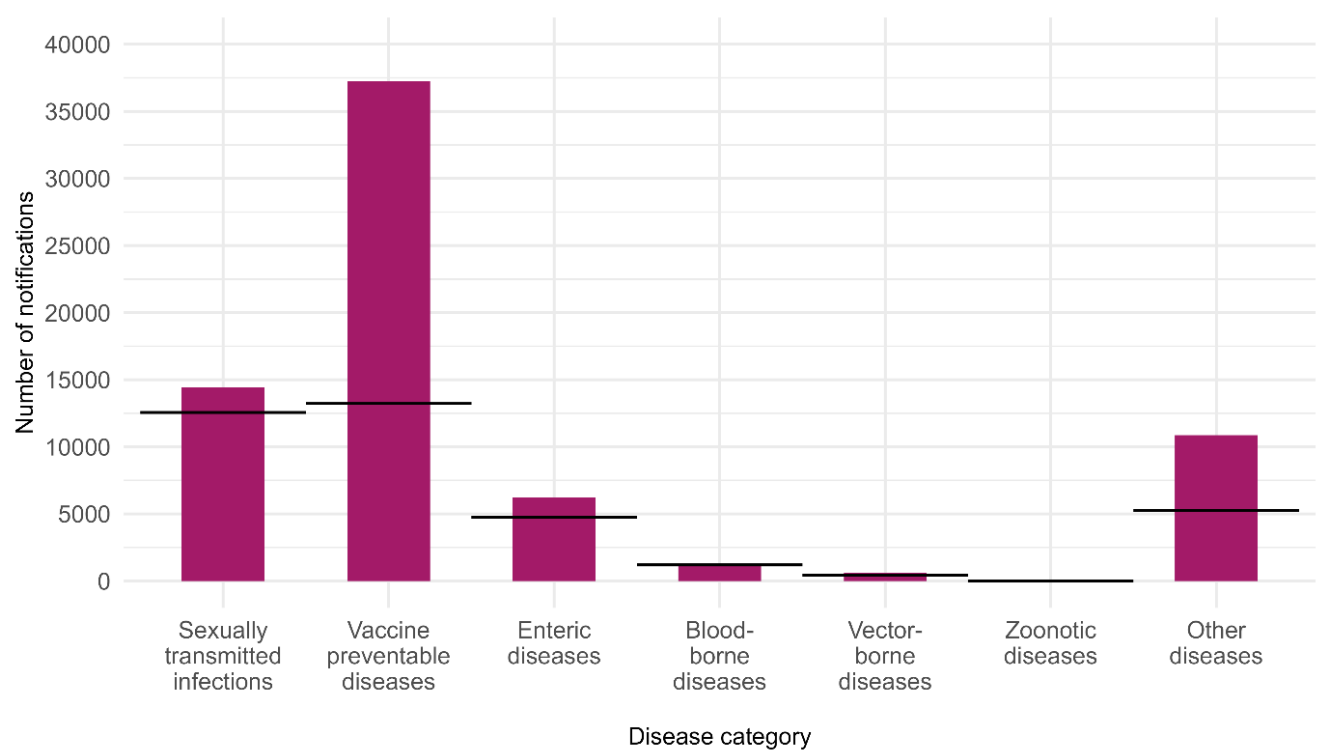


Figure 1: Number of notifications by disease category in 2025 (crimson) not including COVID-19. The black lines represent the average number of notifications across the previous 5 years (2020 to 2024) by disease category.

The number of notifications in metropolitan Perth for each disease is listed in Table 1 for the years 2021 to 2025. Crude notification rates for each disease in metropolitan Perth, WA and Australia are presented for 2025.



Table 1: Perth notifications 2021 – 2025, and notification rates for Perth, WA and Australia in 2025.

	Number of notifications per year					2025 notification rate per 100,000 population		
	2021	2022	2023	2024	2025	Perth	WA	Aus
Blood-borne viruses								
Hepatitis B (newly acquired)	7	5	15	13	15	0.6	0.6	0.3
Hepatitis B (unspecified)	404	308	406	450	452	18.4	17.5	21
Hepatitis C (newly acquired)	77	51	114	126	95	3.9	4.4	4.0
Hepatitis C (unspecified)	693	534	573	608	576	24	25	23
Hepatitis D	9	6	2	13	22	0.9	0.8	0.5
Enteric diseases								
Campylobacteriosis	2437	3128	3789	3758	3532	143.8	150.7	150
Cholera	0	0	0	0	1	<0.1	<0.1	<0.1
Cryptosporidiosis	53	194	135	651	1049	42.7	42.0	18
Hepatitis A	1	12	16	18	24	1	1	0.9
Hepatitis E	0	0	6	0	0	0	0	0.1
Listeriosis	4	8	5	7	5	0.2	0.2	0.2
Paratyphoid fever	0	1	14	6	7	0.3	0.3	0.4
Salmonellosis	639	693	1061	1256	1086	44.2	48.6	44
Shiga toxin-producing E. coli	83	123	119	95	77	3.1	6.5	4.0
Shigellosis	38	95	320	395	317	12.9	14.6	11
Typhoid fever	1	15	18	22	19	0.8	0.7	0.9
Vibrio parahaemolyticus	33	5	8	19	20	0.8	0.9	0.4
Yersiniosis	32	26	83	54	86	3.5	3.4	NN
Sexually transmitted infections								
Chlamydia	8715	8634	10195	10102	9724	395.9	411.7	355
Lymphogranuloma venereum	0	1	0	4	7	0.3	0.2	NN
Gonorrhoea	1871	2169	3451	3881	3862	157.2	176.5	160
Syphilis (infectious)	478	516	422	406	552	22.5	26.2	23
Syphilis (non-infectious)	158	135	155	171	257	10.5	11.4	11
Syphilis (congenital)*	1	1	4	0	1	4.1*	9.8*	4.8*
Vaccine-preventable diseases								
Diphtheria	0	1	2	0	1	<0.1	0.1	0.1
Haemophilus influenzae type B	0	0	0	0	0	0	0	<0.1
Influenza	22	10614	15880	12962	29717	1209.8	1230.1	1888
Measles	0	0	6	5	35	1.4	2.1	0.7
Meningococcal disease (invasive)	5	14	4	11	10	0.4	0.4	0.4
Mumps	0	0	2	9	1	0	0.2	0.6
Pertussis	40	21	56	616	1733	70.6	77.4	95
Pneumococcal disease (invasive)	108	125	165	151	189	7.7	9.1	10
Rotavirus	531	289	742	681	925	37.7	44.6	36
Rubella	2	1	4	1	2	0.1	0.1	<0.1
Tetanus	1	0	0	0	1	<0.1	<0.1	<0.1
Varicella	4149	4318	4717	4537	4630	188.5	189.7	195

	2021	2022	2023	2024	2025	Perth	WA	Aus
Vector-borne diseases								
Murray Valley encephalitis virus	0	0	1	2	0	0	0.1	<0.1
Japanese encephalitis virus	0	0	0	0	0	0	0	<0.1
Barmah Forest virus	4	6	8	12	6	0.2	0.6	1.0
Chikungunya virus	0	8	8	10	23	0.9	0.9	0.6
Dengue virus	0	61	160	450	302	12.3	12.1	7
Malaria	9	34	42	49	24	1	0.9	2
Rickettsial disease (typhus)	7	8	26	33	32	1.3	1.9	NN
Ross River Virus	375	285	150	85	256	10.4	14.7	7
Zika virus	0	1	0	0	1	<0.1	0.1	NN
Zoonotic diseases								
Leptospirosis	0	0	5	0	2	0.1	0.1	0.5
Q Fever	1	4	3	9	10	0.4	0.5	3
Brucellosis	0	0	0	1	0	0	0	<0.1
Other diseases								
Creutzfeldt-Jakob disease	6	6	6	4	3	0.1	0.2	NN
Haemolytic uraemic syndrome	2	1	2	0	0	0	<0.1	<0.1
Legionellosis	47	48	54	53	52	2.1	2.3	3
Leprosy	3	2	0	1	2	0.1	0.1	0.1
Melioidosis	3	1	3	1	2	0.1	0.1	NN
Tuberculosis	131	86	148	196	170	6.9	6.1	6
COVID-19	227	1038861	79739	12788	10598	431.5	407	698
Invasive Group A Streptococcus	12	129	166	144	117	4.8	6.1	7
Acute Post-Streptococcal Glomerulonephritis	4	3	2	11	7	0.3	0.7	NN
Respiratory Syncytial Virus	331	9385	8320	6836	10475	426.4	431.4	334
Mpox	0	7	2	21	26	1.1	0.9	0.4
Candida auris	NN	NN	0	5	2	0.1	0.1	NN

Data were retrieved from WANIDD; disease rows were excluded where no cases occurred locally, statewide and nationally in the past 5 years. Data for rheumatic heart disease, antibiotic resistant organisms and human immunodeficiency virus (HIV) are collected and managed separately. NN=not notifiable; <0.1 denotes a number less than 0.1 that would otherwise be rounded to zero. Varicella-Zoster includes chickenpox and shingles as well as those unspecified. From June 2021, iGAS and RSV were added as notifiable diseases. From January 2023, the case definition for hepatitis C (unspecified and newly acquired) were changed to account for reinfections, accounting for a small part of the increased case numbers. *Candida auris* was made notifiable in WA in December 2023. Comparability of COVID-19 notifications between years is limited by the temporary inclusion of positive Rapid Antigen Test (RAT) cases. Reporting of positive RAT results was compulsory between 8 February 2022 and 4 November 2022 and continued voluntarily until 9 October 2023. Between 1 January 2023 and 9 October 2023, RAT positive cases comprised 86% of notifications. Following 9 October 2023, only polymerase chain reaction (PCR)-positive results were notified. COVID-19 data from previous years has been revised to align with current methodologies for assigning case locations, including the redistribution of cases with unknown locations based on testing site data. Congenital syphilis rates are presented per 100,000 births (* denotes that numbers of births for Perth, WA and Australia are from 2024, the most recent data available).³

³ Births, Australia, 2024 | Australian Bureau of Statistics [Internet]. 2025 [cited 2026 Aug 10]. Available [online](#).

Biggest influenza season on record

More cases of influenza were recorded in Perth in 2025 ($n=29,718$) than any year since influenza became notifiable in 2001. Influenza notifications were unusually high in the inter-seasonal period between January and April, followed by a flu season with a protracted peak between July and September (Figure 2). These numbers occurred despite the increased availability of rapid antigen tests for influenza A and B, which might tend to reduce attendances for laboratory confirmation.⁴ Case numbers were highest among the 0-9- and 10-19-year age brackets.

Of note, newly emerged influenza A (H3N2) subclade K (dubbed 'Super-K') resulted in geographically widespread infection in Australia from August 2025. This strain of influenza is a consequence of antigenic drift and may have contributed to the prolonged peak of influenza notifications in 2025. Influenza A almost doubled in 2025 (to 21,624 cases) and influenza B increased more than 6-fold (to 7,903 cases) compared with 2024. Both influenza A and B peaked in September of 2025.

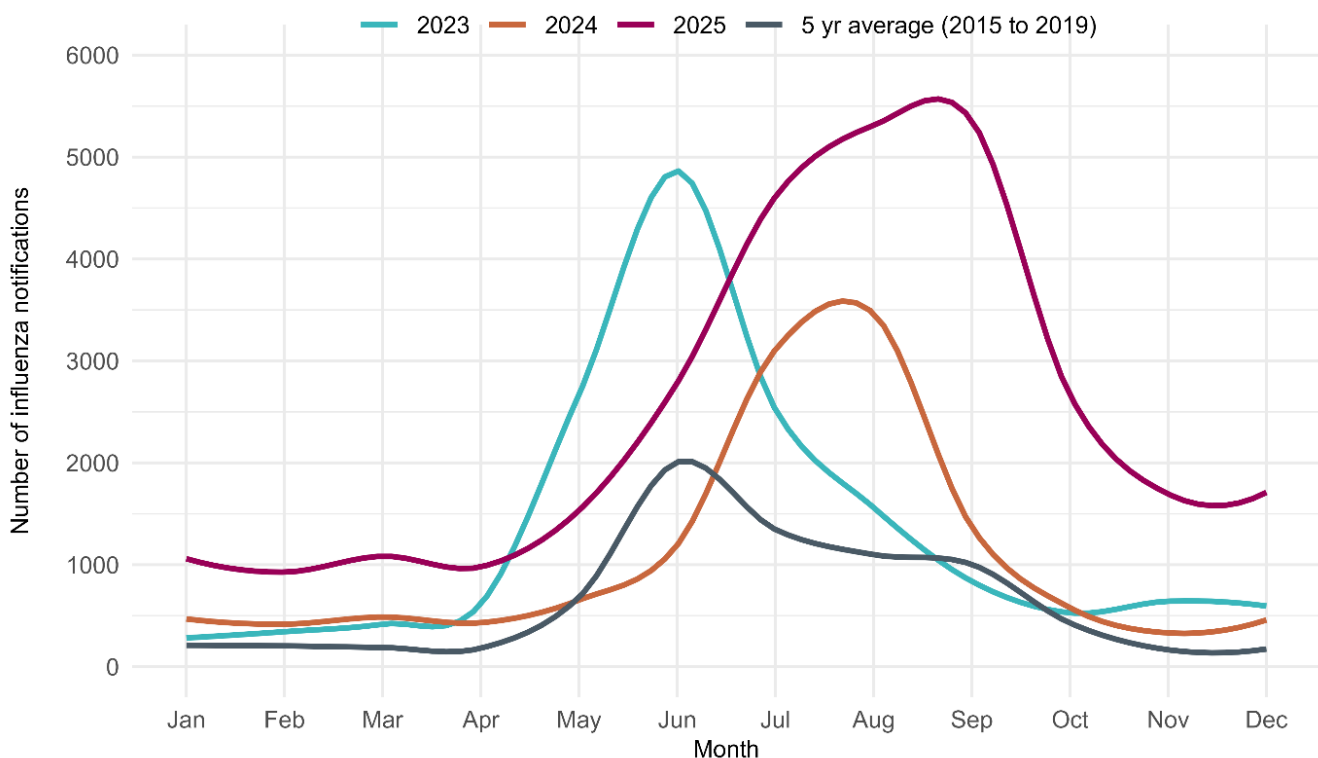


Figure 2: Number of influenza notifications per month for years 2023 to 2025, and the pre-COVID-19 5-year average (2015 to 2019, inclusive).

The influenza season placed considerable strain on the health system, with St John Ambulance reporting that ambulances spent an all-time record of 7,257 hours ramped outside hospitals in September 2025.⁵ There were 98 influenza outbreaks reported in residential aged care homes (RACH), surpassing the previous highest number of RACH flu outbreaks recorded in Perth in a single season (85 outbreaks reported in 2019).

⁴ Barr IG. Influenza in Australia before, during and after the COVID-19 pandemic. *Microbiol Aust.* 2024 Oct 28;45(4):188–92. doi:10.1071/MA24052

⁵ WA records worst-ever flu season amid poor vaccination rates. ABC News [Internet]. 2025 Oct 14 [cited 2026 Aug 10]. Available [online](#).

Measles – rise in cases, with two outbreaks managed

Thirty five cases of measles were notified in Perth in 2025, a significant rise from the previous 5-year average of 3 cases per year (2020-2024), reflecting escalating case numbers in many regions of the world. Two major outbreaks occurred in Perth in 2025: one linked to a prison (n=14 cases) and another involving fly-in-fly-out (FIFO) workers (n=10 cases). Beyond the outbreaks, there were 5 cases of overseas-acquired measles that resulted in local transmission, and a further 7 cases (6 overseas acquired and one interstate acquired) that did not result in onward local transmission.

Prison measles outbreak

Between March and April 2025, a case of measles diagnosed in a prison led to 14 measles cases being diagnosed across the Perth and Southwest regions (Figure 3). Upstream contact tracing for the first case did not reveal an obvious source of measles introduction to WA. Onward transmission occurred within multiple prison settings, hospitals, and a social setting. Cases within the prison environment led to substantial collaborative efforts between Boorloo PHU and the Department of Justice to quarantine close contacts and facilitate vaccination for inmates. Ultimately, 705 inmates and 85 prison staff received a Measles-Mumps-Rubella (MMR) immunisation after potential exposures, with high-risk sections of affected prisons achieving 80-100% coverage.

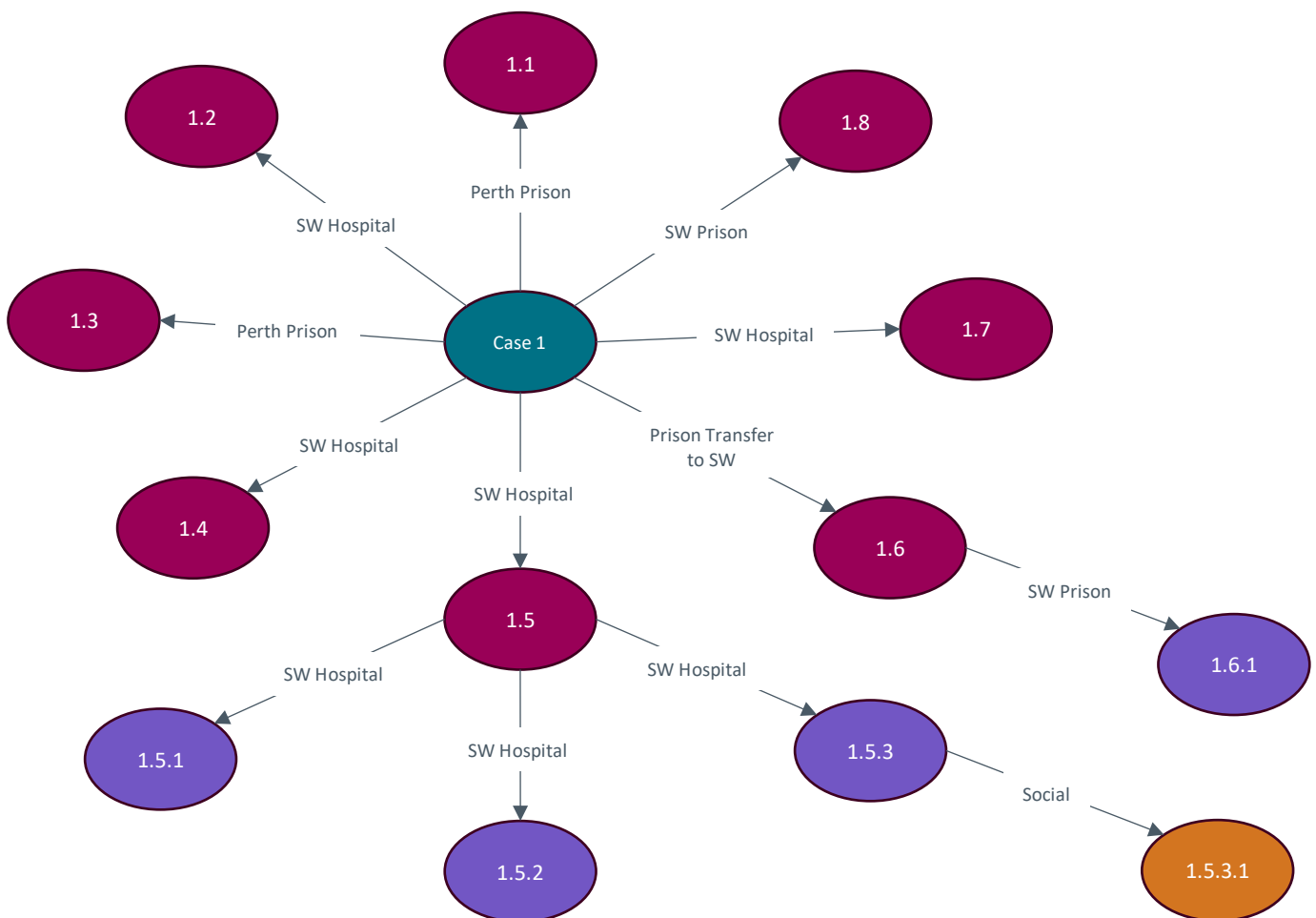


Figure 3: Transmission tree of the prison measles outbreak in Perth, 2025. SW = Southwest.

FIFO measles outbreak

Between June and August 2025, a case of measles likely acquired in Thailand led to local transmission among FIFO workers travelling to the Pilbara region, with onward spread on multiple flights, within households and a hospital emergency department (Figure 4).

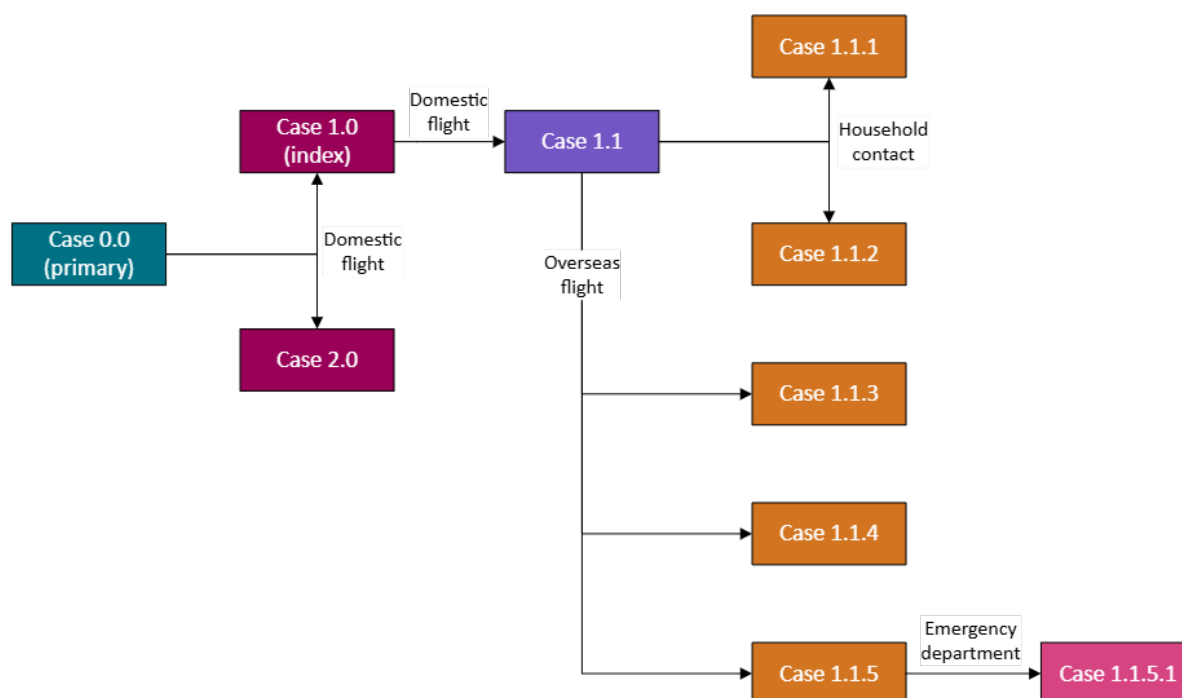


Figure 4: Transmission tree of the FIFO measles outbreak in Perth, 2025.

Syphilis – highest case numbers on record, especially among culturally diverse communities and men who have sex with men (MSM)

Syphilis outbreak reaches record high case numbers

There were 551 cases of infectious syphilis notified in 2025; the highest number since record keeping began in 1995 (Figure 5a). The syphilis outbreak in Perth was declared in June 2020, and a Syphilis Response Team (SRT) was established at Boorloo PHU in 2021 to coordinate the outbreak response and prevent cases of congenital syphilis in Perth.

After a modest reduction in case numbers in 2023 and 2024, numbers increased again in 2025. This most recent increase has been driven by cases among men, who made up 80.2% of cases in 2025, compared with only 68.7% of cases in 2024 (Figure 5b). Diagnoses of non-infectious syphilis were also higher than the previous year (257 in 2025 compared with 171 in 2024).

One case of congenital syphilis, overall fewer cases during pregnancy

In 2025, there were 94 notifications of syphilis among women of reproductive age (WRA), steady from the 91 cases reported in 2024. Boorloo PHU confirms adequate treatment and supports contact tracing of cases of infectious syphilis in Perth, which helps to avert transmission to people of childbearing potential.

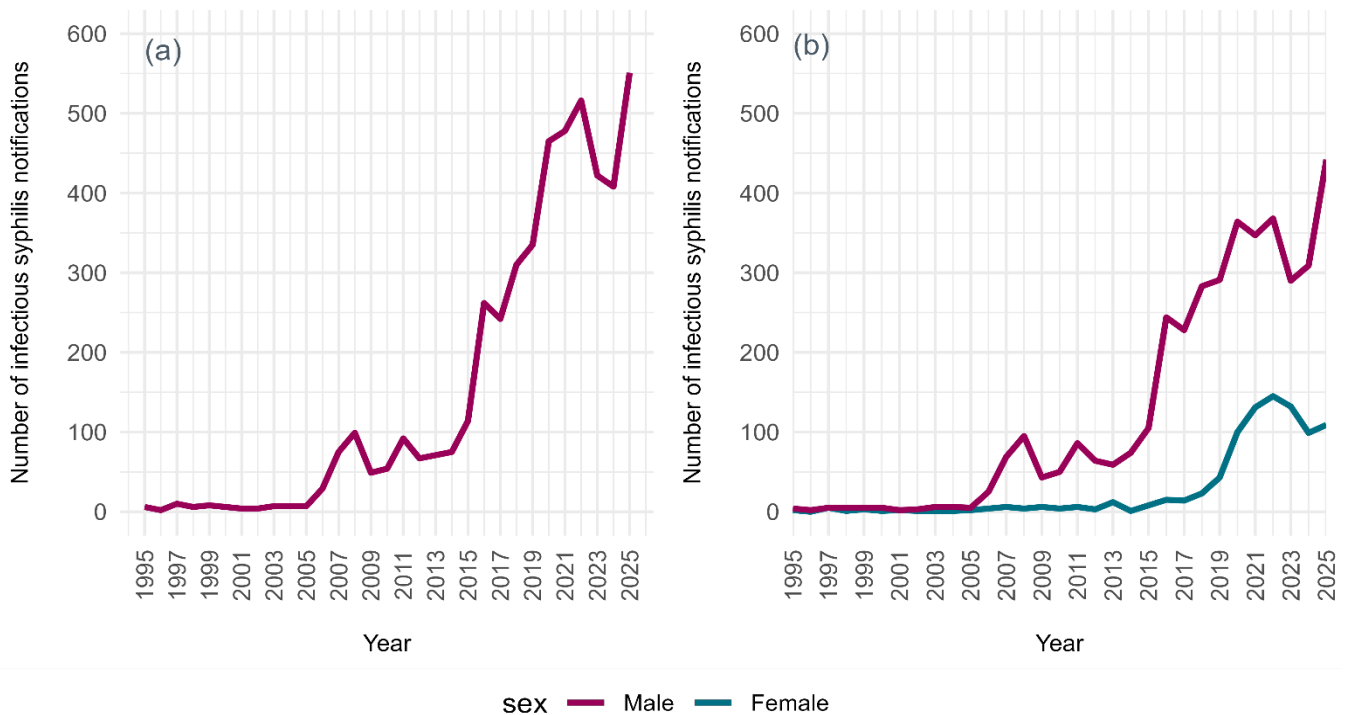


Figure 5: a) Number of infectious syphilis notifications per year from 1995 to 2025 in Perth. b) Number of infectious syphilis notifications among male and female per year from 1995 to 2025 in Perth.

There has been a steady reduction in the number of infectious syphilis notifications during pregnancy since the establishment of SRT, with notifications falling from a peak of 25 in 2020 to 14 in 2025. Significant public health efforts are directed at this population, in terms of regular testing, linkage with antenatal care, early treatment and comprehensive contact tracing. In addition to the 14 cases of infectious syphilis, SRT also managed 32 pregnant people with non-infectious syphilis, which may still pose a transmission risk to the infant.⁶ Of the total 46 pregnant cases, 45 were fully treated and one was partially treated for syphilis prior to birth.

One case of congenital syphilis was diagnosed in 2025, the first in Perth since 2023. Unfortunately, this mother was not tested for syphilis during pregnancy and was therefore not known to SRT prior to birth. Congenital syphilis is considered entirely preventable, and each case is reviewed in detail to identify potential system improvements. In this instance, recommendations related to promoting antenatal care options for culturally and linguistically diverse (CALD) and Medicare ineligible populations.

High syphilis case numbers among CALD populations, MSM and illicit drug users

Infectious syphilis notifications among CALD communities increased for the fourth consecutive year, reaching 63 notifications in 2025 (a 21% increase since 2024, Figure 6). These communities face significant barriers to effective healthcare, often coupled with social stigma related to sexual health.⁷ In response to this trend, Boorloo PHU have stepped up engagement with key governmental, educational and community stakeholders in 2025, to improve

⁶ Stoltey JE, Cohen SE. Syphilis transmission: a review of the current evidence. *Sex Health*. 2015 Apr;12(2):103–9. doi:10.1071/SH14174 PubMed PMID: 25702043; PubMed Central PMCID: PMC5973824.

⁷ Okeke SR, Horwitz R, Brener L, Vu HMK, Wu E, Jin D, et al. "The Culturally and Linguistically Diverse Community Is Not Just Minoritised But Ignored": Engaging Culturally and Linguistically Diverse Communities in Australia With Blood-Borne Viruses and Sexually Transmissible Infections Healthcare. *Health Expect*. 2025;28(5):e70416. doi:10.1111/hex.70416

awareness and encourage STI testing. Consumer resources have been reviewed to improve readability, and Boorloo PHU commenced hosting Master of Translation Studies students from the University of Western Australia on short placements where they assist with translation of resources. SRT have delivered education sessions for the Adult Migrant English Program, and organised sexual health training workshops for interpreters.

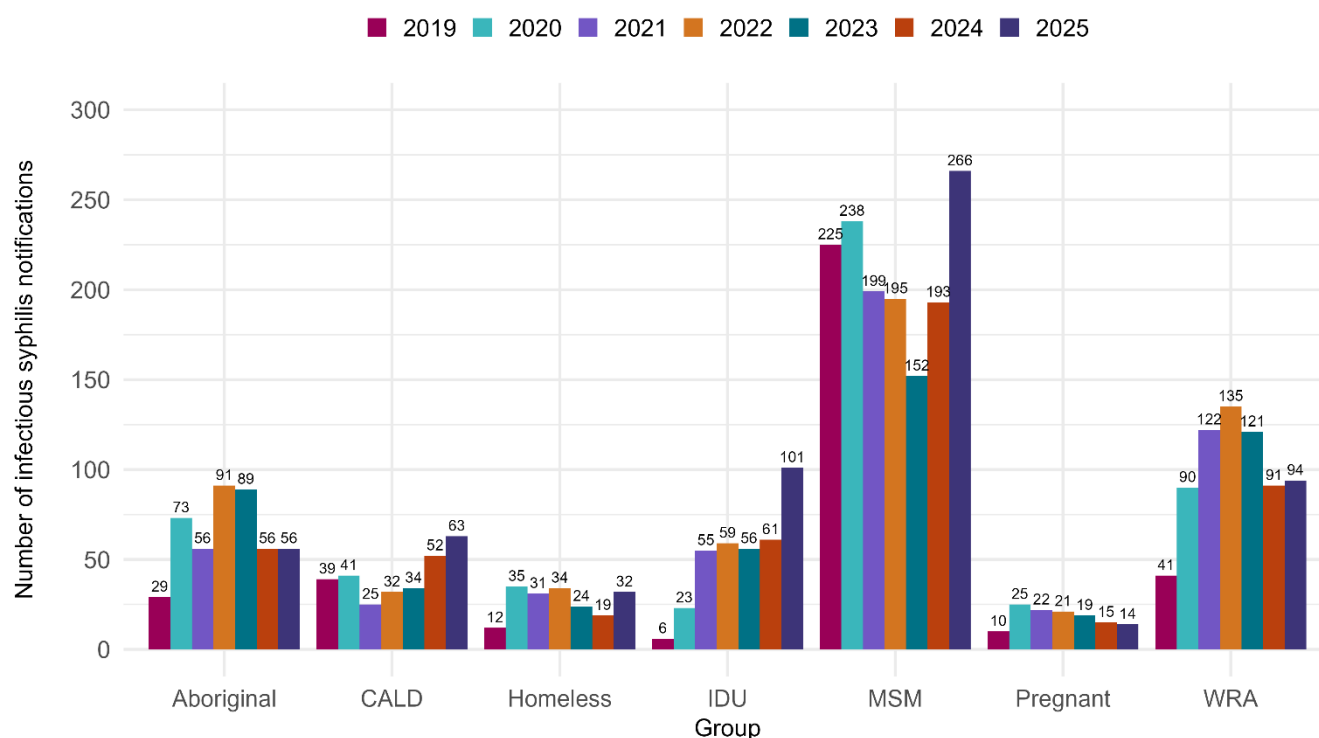


Figure 6: Number of infectious syphilis notifications by priority group per year, 2019 to 2025.

Notifications of infectious syphilis among MSM increased sharply in 2025 (to 266 cases, an increase of 38% from 2024, and the second consecutive year of increasing numbers). Initiatives such as a clinician forum and doxycycline post-exposure prophylaxis (doxyPEP) guidance have been led by WAAC to reduce disease burden in this group.

An increase in infectious syphilis notifications was also seen among people who engage in illicit drug use (IDU). This may be partially artefactual, as IDU definitions used by Boorloo PHU were broadened in mid-2024. SRT continues to provide additional support to people diagnosed with syphilis who have complex social circumstances (IDU, homeless, or other concerns), including running a regular multidisciplinary stakeholder meeting.

There were 40 people with syphilis experiencing homelessness in 2025, among whom 35 received full treatment and two received partial treatment. This 92.5% treatment rate is a great achievement for a population group often facing multiple barriers to care. Alongside regular stakeholder engagement, outreach services have been essential. In 2025, 116 home visits and 50 street outreach attendances were completed by the Boorloo PHU Aboriginal Health Team and SRT for people requiring additional support to access care.

Other STIs steady at high levels

Chlamydia cases remain high, sudden increase in LGV cases

The number of chlamydia cases in Perth has stabilised after peaking in 2023 (n=10,195 cases, now slightly decreased to 9,724 cases in 2025, Figure 7). This year also saw the highest number of cases among Aboriginal people ever recorded in Perth (now comprising 8.5% of total cases from 4.4% in 2015, with a steady increase over the years). The exponential increase in the notifications in the early 2000s is at least partially attributable to the rollout of nucleic acid amplification testing, which replaced less sensitive cell culture methods.⁸

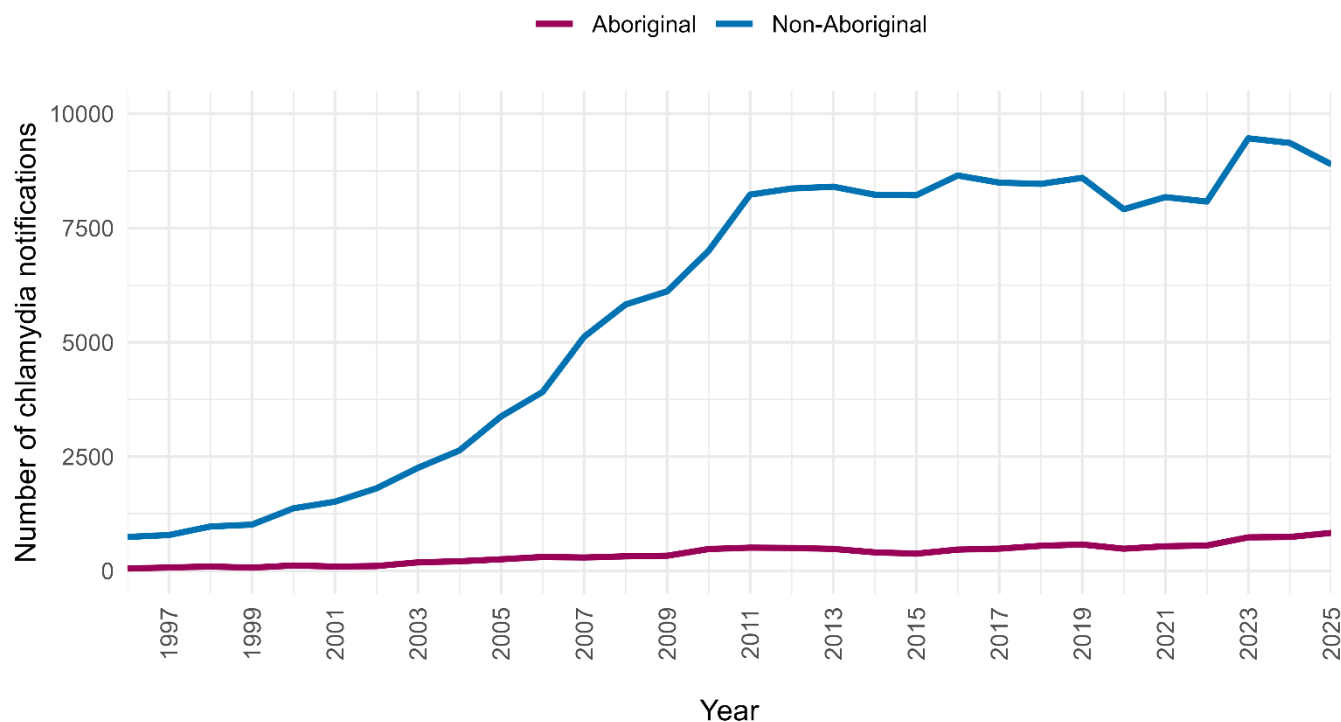


Figure 7: Number of chlamydia notifications in Aboriginal and non-Aboriginal populations per year from 1996 to 2025 in Perth.

Lymphogranuloma venereum (LGV) is caused by rare subtypes of chlamydia infection (serovars L1-L3); these subtypes are more infectious than other subtypes of chlamydia and can cause severe symptoms (proctitis, genital ulcers and inguinal buboes). LGV infections tend to be rare in Perth (0-4 cases per year). In 2025, there was a sudden increase to 7 cases, with further increases in 2026. All cases in 2025 were among men aged between 29 and 63 years (median 36 years). Boorloo PHU actively supports adequate treatment and contact tracing for each case of LGV to prevent onward transmission.

⁸ Jespersen DJ, Flatten KS, Jones MF, Smith TF. Prospective Comparison of Cell Cultures and Nucleic Acid Amplification Tests for Laboratory Diagnosis of Chlamydia trachomatis Infections. J Clin Microbiol. 2005 Oct;43(10):5324–6. doi:10.1128/JCM.43.10.5324-5326.2005 PubMed PMID: 16208009; PubMed Central PMCID: PMC1248517.

Gonorrhoea steady at high levels, ongoing introductions of drug-resistant isolates into WA

Like chlamydia, the number of gonorrhoea cases remained steady at high levels (from 3,881 cases in 2024 - the highest on record - down marginally to 3,862 cases in 2025, Figure 8). The number of cases who identify as Aboriginal has increased gradually in recent years (now comprising 13.2% of cases). There were 4 cases of gonorrhoea with antimicrobial resistance of public health significance in 2025, a decrease from 5 cases in 2024. One case had a multi-drug resistant (MDR) isolate, one had critical resistance to ceftriaxone, and two had critical resistance to azithromycin. Of these cases, 3 were in men and two were thought to be locally acquired.

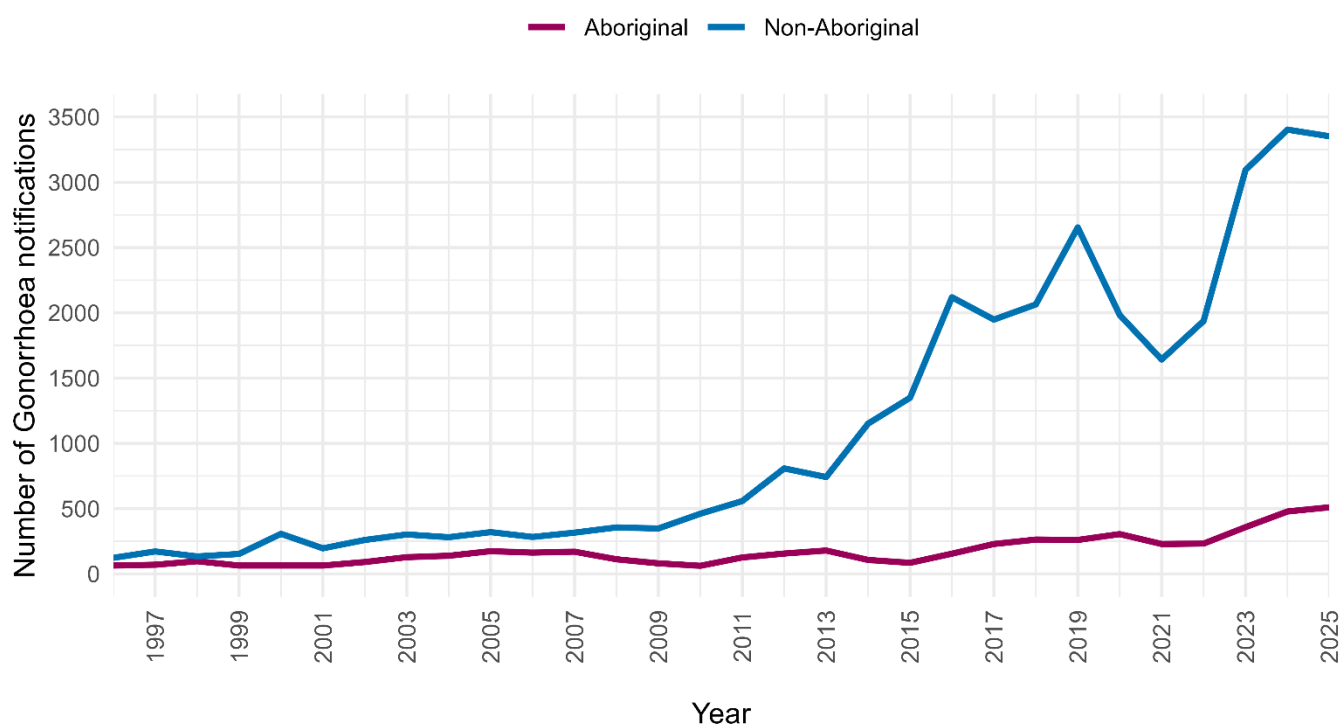


Figure 8: Number of gonorrhoea notifications in Aboriginal and non-Aboriginal populations per year from 1996 to 2025 in Perth.

STI co-infections remain common

There were 828 instances of STI co-infections notified to Boorloo PHU in 2025 (defined as two or more notifiable STIs (excluding HIV) at the same time (+/- 3 days)), among 816 unique individuals. Chlamydia and gonorrhoea remain the most common infections to be notified simultaneously (Figure 9) reflecting dual testing practices, though co-infections involving syphilis have steadily increased since 2023. Of individuals notified with co-infections in 2025, 61% were men. The age groups with the most co-infection notifications were adults aged 20-29 and 30-39 years.

Aboriginal people made up 21.4% of all STI co-infection cases, with especially high representation in the 10-29 and 20-29 year age groups. These findings highlight the importance of continuing to strengthen culturally safe, community-led sexual health education, testing, and treatment programs that support the health and wellbeing of Aboriginal young people and communities.

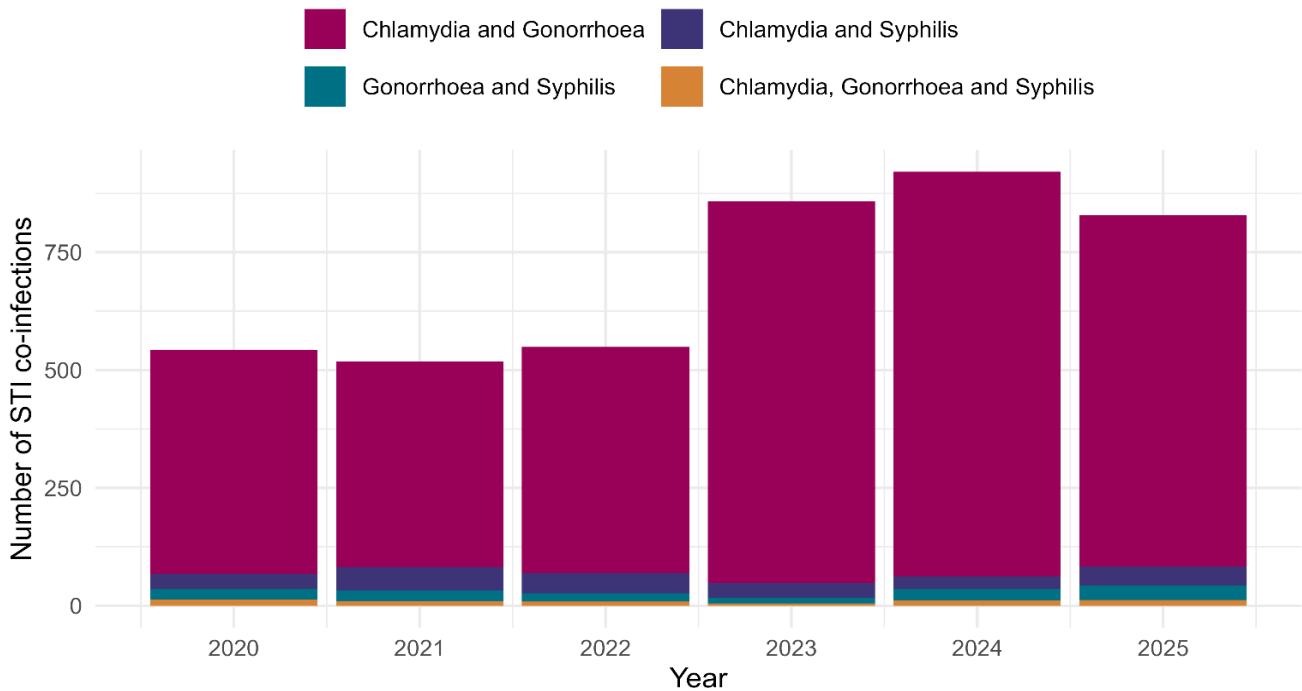


Figure 9: Number of STI co-infections notified by year and type.

Mpox – periodic community transmission in Perth

Twenty-six cases of mpox were notified in 2025, the greatest number notified per year to date. Cases were all among men between 21 and 56 years of age (Figure 10). Only two cases were acquired overseas, with the remainder (n=24) locally acquired. A large cluster of cases in January (n=9) arose from a continuation of local transmission at the end of 2024. This was followed by a cluster in May (n=5) and a trickle of cases throughout August to December. Of the samples successfully typed, all were found to be clade IIb consisting of 14 E.4 cases, four F.2 cases, three C.1.2 cases, and three of undetermined lineage. More than half of the cases diagnosed in 2025 were unvaccinated (n=15), while 8 were fully vaccinated and 3 were partially vaccinated against mpox. In 2025, there were total of 84 contacts identified (mean of 3 contacts per case). More than half of contacts were sexual partners who met via apps or at sex-on-premises venues.

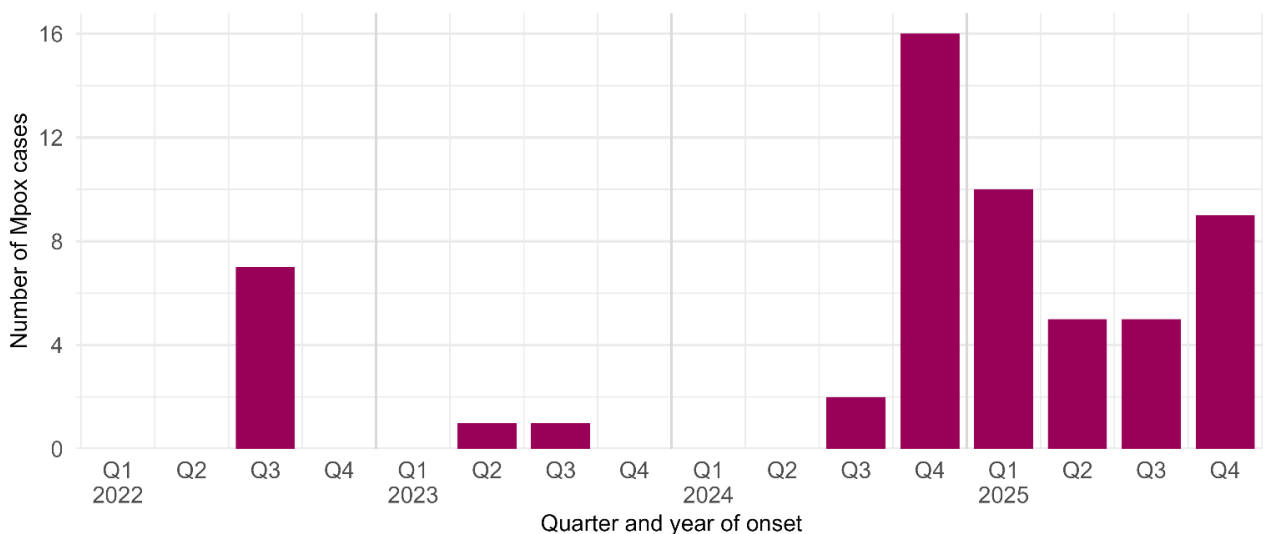


Figure 10: Number of Mpox cases notified in Perth, by quarter and year of onset.

Blood-borne viruses – mixed elimination progress

Hepatitis C – management targets for community on track, prisons lagging

The number of hepatitis C notifications has remained steady since 2023 (Figure 11), with 676 cases notified in 2025. Of these, 14.9% had evidence of acquisition in the past two years. The number of notifications has steadily decreased since the introduction of direct acting antivirals for hepatitis C in 2016; however, these gains have not been equitably shared. The number and proportion of cases who identify as Aboriginal has steadily increased in recent years, with 32.0% of cases now occurring among Aboriginal people. Similarly, more cases than ever before are being notified from prisons (36.8%).

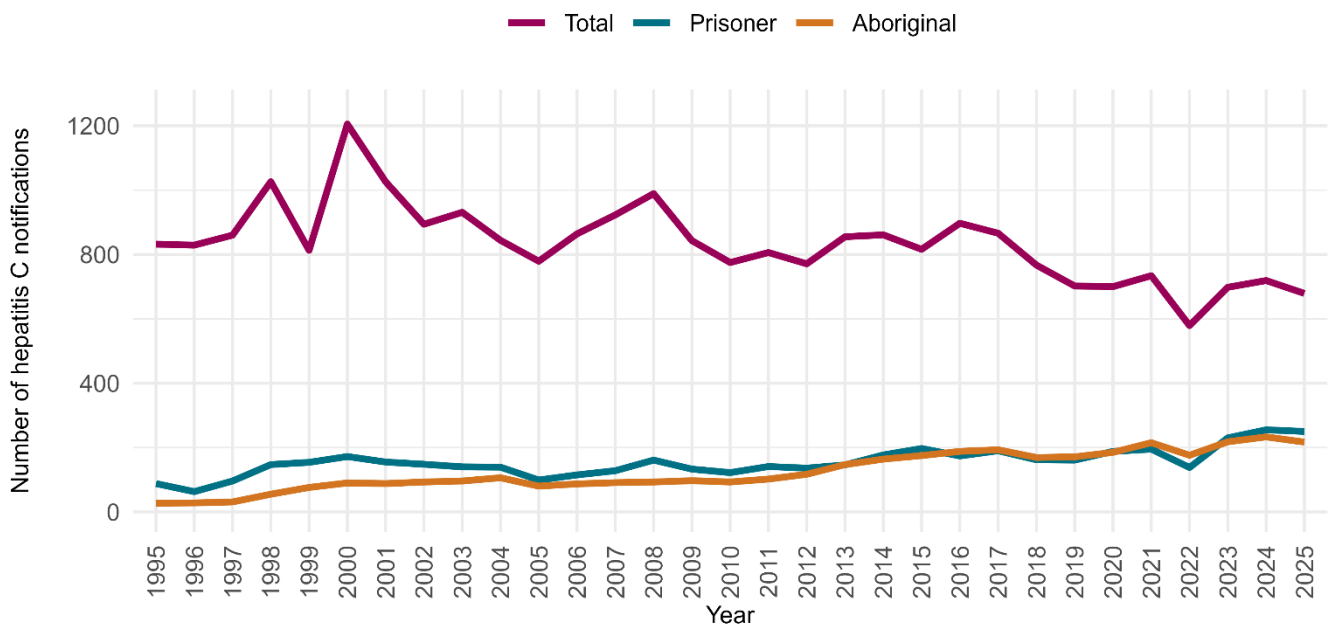


Figure 11: Number of hepatitis C notifications in Perth over time, 1995-2025, including number of cases among prisoners and Aboriginal people (categories are not mutually exclusive).

Boorloo PHU provides active follow-up of hepatitis C cases to support the elimination of hepatitis C as a public health threat by 2030. This includes collaborative efforts with laboratories to reflexively add RNA tests, as well as contacting clinicians and patients to encourage hepatitis C RNA testing and treatment. The Boorloo PHU Aboriginal Health Team actively assist Aboriginal people with hepatitis C to access care.

Among people notified for hepatitis C in Perth in 2025, **98.5% had an RNA test completed** (i.e. only 10 out of 671 tests remain outstanding). Among cases notified from prisons, the RNA testing rate was 99.6% (reflexive RNA testing is routine), and for community notifications, the RNA testing rate was 97.8%, with Boorloo PHU interventions increasing this proportion by 30.2 percentage points.

Among the 206 cases in the Perth community with positive RNA results, **185 required treatment**, of whom **75.1% have now commenced treatment** (n=139). Boorloo PHU interventions boosted this proportion by 16.1 percentage points. Treatment data for cases in prison are unavailable, with many challenges to timely treatment initiation acknowledged in this setting. Since mid-2025, Boorloo PHU has also piloted PHU-led contact tracing for hepatitis C.

Hepatitis B – immunisation effective, but ongoing gaps in care evident

There were 467 notifications of hepatitis B in Perth in 2025, steady from 464 cases in the previous year. Of these, the vast majority (93.1%) were among people born overseas; a figure that has held steady since 2020. More cases were diagnosed in men (60%) than in women, with the most common age brackets at diagnosis being 30-39 years and 40-49 years.

Only 15 cases had evidence of acquisition within the previous two years. Notable risk factors included unprotected casual sex in 10 cases, intravenous drug use reported by 3 cases (only one case disclosing use within two years of diagnosis), and two cases reported potential percutaneous exposure through tattoos, body piercing or surgery. None of the cases notified in 2025 were among people born in Australia since 2000, the year hepatitis B vaccines were introduced to the infant immunisation schedule.

Australia has committed to the goal of eliminating hepatitis B as a public health threat by 2030.⁹ To contribute to these goals, Boorloo PHU commenced a new process in 2025 to minimise onward transmission for cases of hepatitis B with markers of high infectiousness (e antigen positive or viral load >2000IU/mL) at the time of notification. Clinicians are contacted to encourage household contacts and partners to check their hepatitis B immunity, provide the case with information on preventing transmission, and continue routine monitoring to determine whether hepatitis B treatment is needed.

WA has an estimated 24,786 people living with chronic hepatitis B (0.82% of the population). In 2024 (the most recent data), just over half (54.2%) had been diagnosed, only 24.8% were engaged in regular care, and only 8.5% were on treatment (Figure 12).¹⁰ All 3 measures were considerably lower than the national targets (90%, 80% and 27%, respectively).

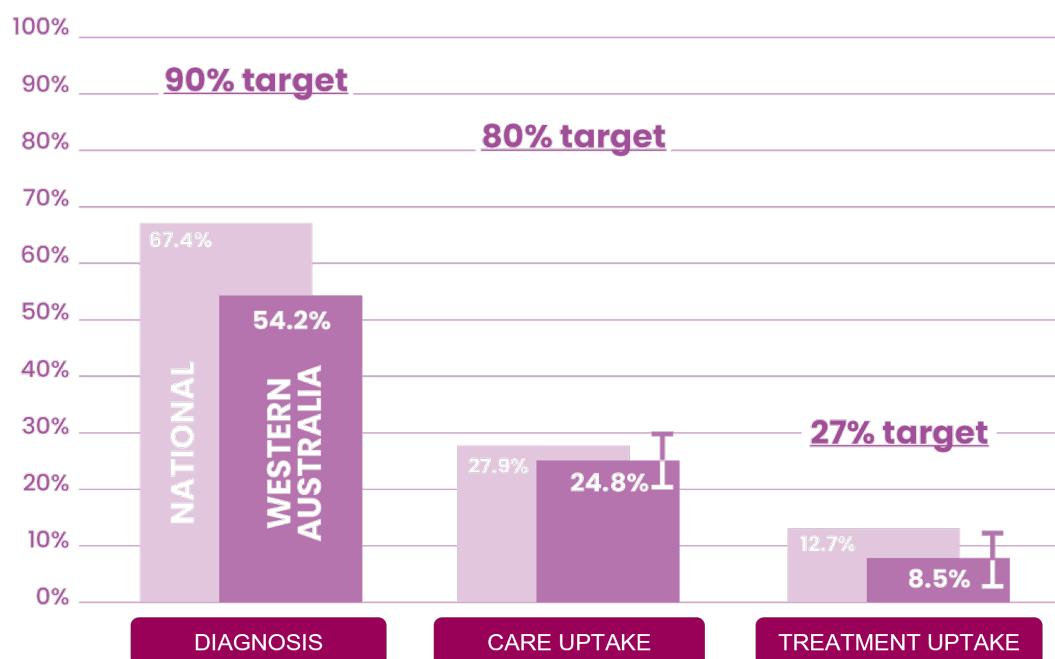


Figure 12: WA chronic hepatitis B cascade in 2024. Adapted from Doherty Institute.¹⁰ Ranges reflect variation in uptake according to Primary Health Network.

⁹ Australian Centre for Disease Control. New national strategies set path to eliminate hepatitis B and C [Internet]. Australian Centre for Disease Control; 2026 [cited 2026 Aug 10]. Available [online](#).

¹⁰ BBV STI surveillance and research programme: surveillance for hepatitis B indicators. Doherty Institute [Internet]. [cited 2026 Aug 10]. Available [online](#).

Meningococcal disease steady, pneumococcal disease reaches a record high

Invasive meningococcal disease – MenB dominates again

Ten cases of invasive meningococcal disease were notified in 2025 (Figure 13), down from 11 cases in 2024. Nine of the 10 cases were attributable to meningococcal B (MenB), and one case was attributable to meningococcal Y. All 10 cases were acquired in WA.

The marked decline in invasive meningococcal disease attributable to serogroups C, W135 and Y over time is associated with the rollout of Meningococcal C (MenC) vaccine in 2003 and the Meningococcal ACWY (MenACWY) vaccine in 2018. Some Australian jurisdictions have introduced MenB vaccines to their routine immunisation schedule; however, MenB vaccine is only funded for Aboriginal Australians and other high-risk groups in WA under the National Immunisation Program (NIP) infant schedule.¹¹

In addition to the 10 cases of invasive disease, there were 4 cases of meningococcal conjunctivitis in 2025, all non-typeable. These infections have a high chance of becoming invasive without prompt treatment, and receive the same public health management as confirmed invasive cases. The 4 conjunctival infections occurred among adolescents, young adults, and one child.

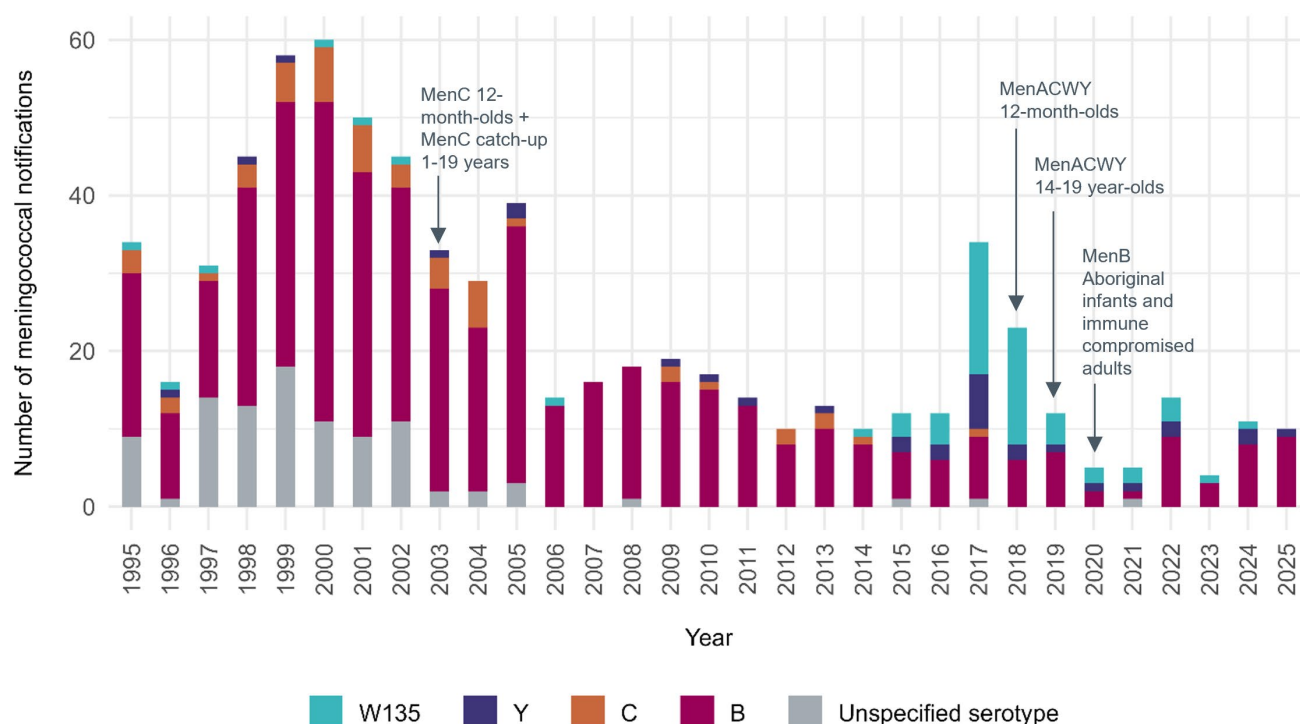


Figure 13: Number of meningococcal notifications per year from 1995 to 2025, by serotype.

¹¹ History of immunisation in Australia | NCIRS [Internet]. [cited 2026 Aug 10]. Available [online](#).

Invasive pneumococcal disease – more notifications, new vaccines

There were 189 notifications of Invasive Pneumococcal Disease (IPD) in 2025, the highest since recording began in 2001. The monthly trend was similar to other respiratory illnesses, with cases peaking from June to September and decreasing from October onwards (Figure 14a). In addition, Figure 14b displays a bimodal age distribution of IPD in Perth, with the highest number of cases in 2025 found among the 0-9 year age group (n=52 cases), followed by the 60-69 year age group (n=43 cases).

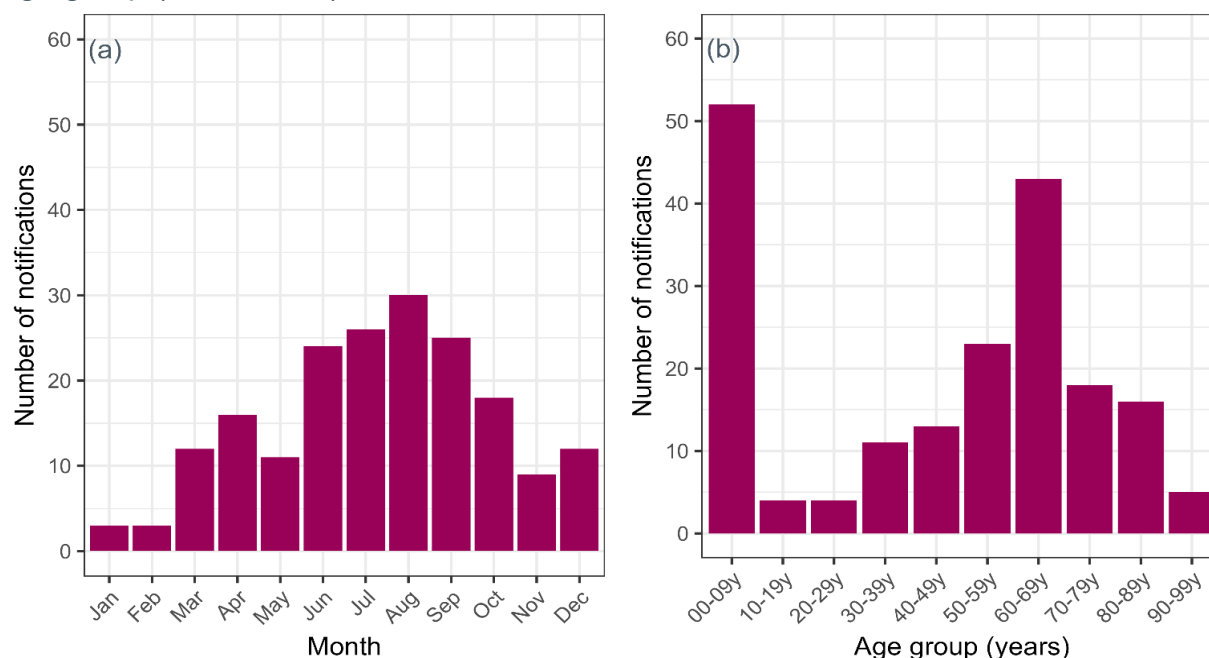


Figure 14: a) Number of IPD notifications in 2025 by month of onset. b) Number of IPD notifications in 2025 by age group.

From 1 September 2025, the new Prevenar 20 vaccine replaced both Prevenar 13 and Pneumovax 23^a on the NIP childhood schedule. Figure 15 displays the top 15 serotypes causing IPD among children aged 0–9 between 2023 and 2025, and compares serotype coverage between the new and previous pneumococcal immunisation recommendations. Prevenar 20 covers all the serotypes covered by Prevenar 13 and provides additional protection for 7 other serotypes.

For adults aged 18 years or older, Capvaxive (PCV21) was registered for use since February 2025,¹² and was added to the national immunisation schedule for adults in July 2026. Figure 16 shows the top 15 serotypes causing IPD among adults aged 60 years and over between 2023 and 2025, and compares serotype coverage between new and previous immunisation recommendations. For this age group, PCV21 covers 5 additional high frequency serotypes compared with Pneumovax 23 (Figure 16), though 19F is no longer covered. The new conjugated vaccine formulation is intended to provide stronger, more targeted and longer-lasting immunity against circulating serotypes than its predecessor.

^a Aboriginal children who never received Prevenar 13 by the age of 4 years received Pneumovax 23 prior to the change on 1 September 2025.

¹² History of immunisation in Australia | NCIRS [Internet]. [cited 2026 Aug 10]. Available [online](#).

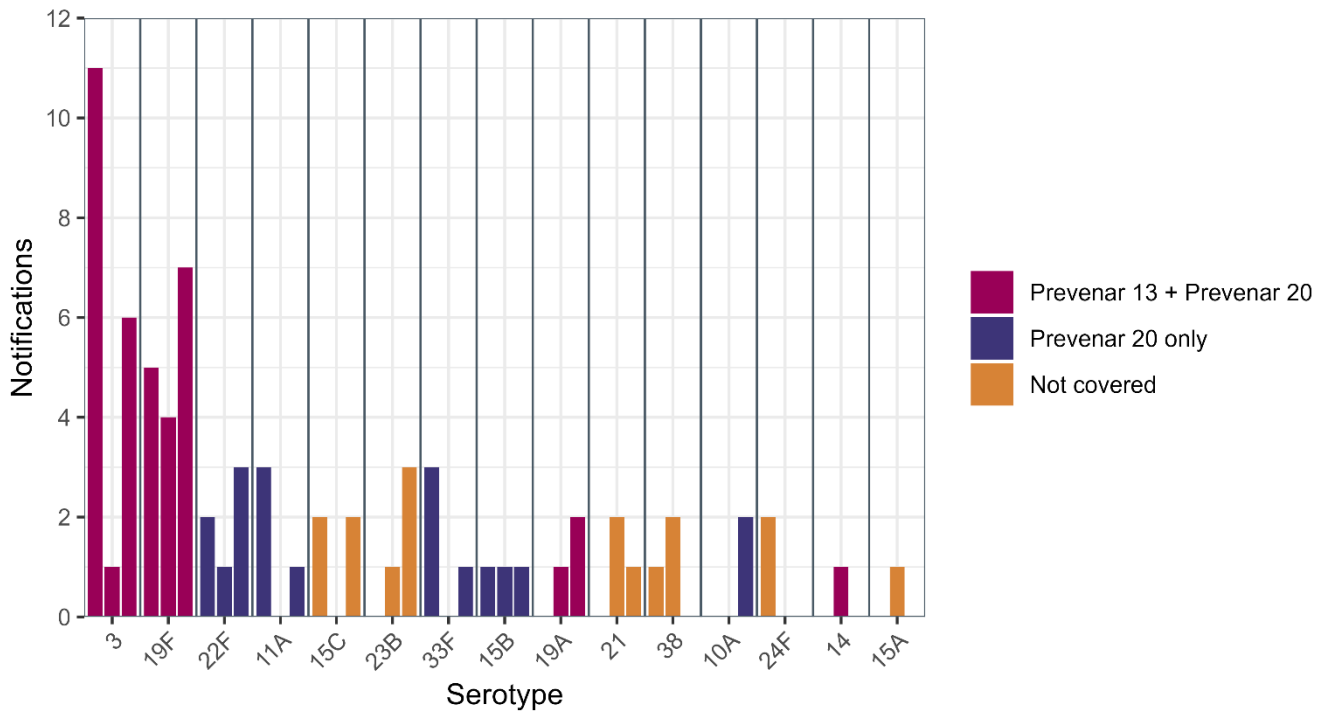


Figure 15: Number of IPD notifications by serogroup in 0-9 year old children and serotypes covered by current and previous vaccination, 2023-2025. For each serotype, bars are ordered by the year of notification.

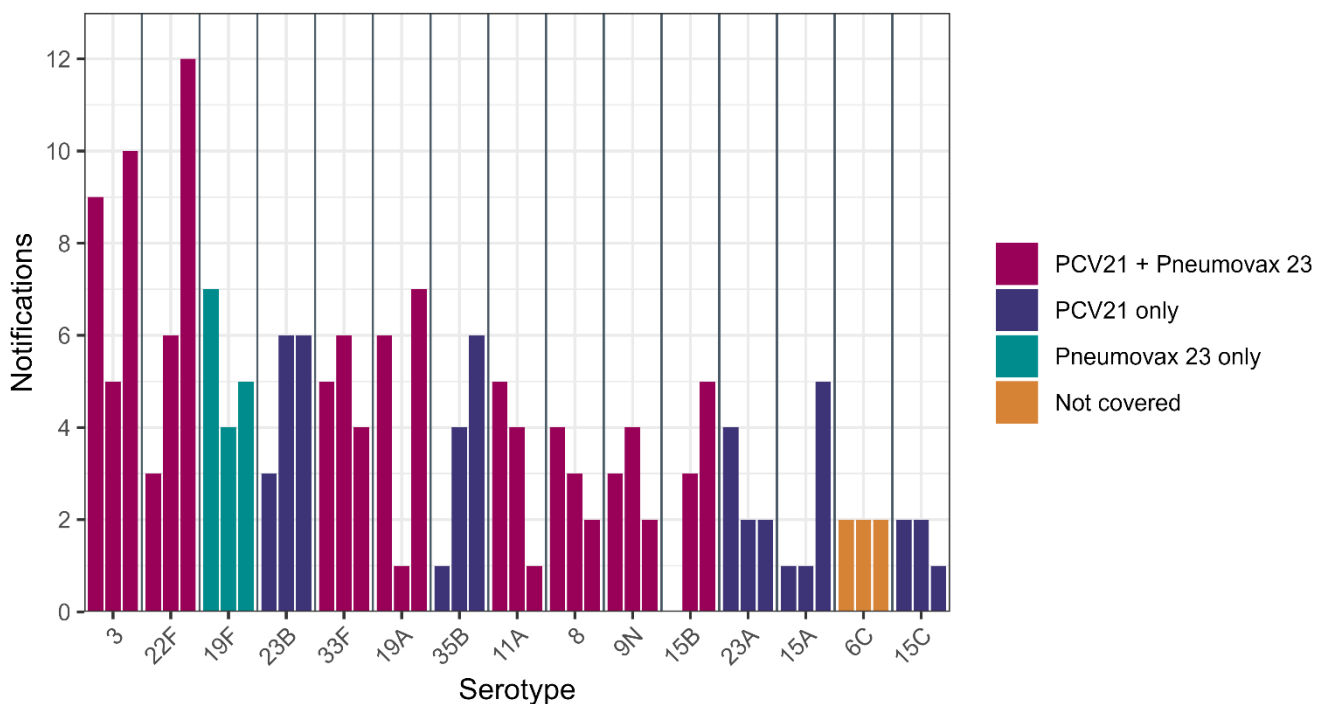


Figure 16: Number of IPD notifications by serogroup in 60 or above age group and serotypes covered by current and previous vaccination, 2023-2025. For each serotype, bars are ordered by the year of notification.

High numbers of vaccine-preventable respiratory pathogens

Pertussis outbreak continued through all of 2025, not yet declining

Pertussis is endemic in Perth and exhibits a pattern of cyclical outbreaks every 3-7 years. The anticipated outbreak that commenced in the latter half of 2024 continued throughout 2025, with 1,733 cases notified in total, and an average of 144 notifications per month (range 85 to 214). Notifications per month were still increasing at the end of 2025.

Public health management of pertussis centres on prevention of disease in infants under the age of 6 months who are too young to be fully vaccinated and have a case fatality rate of up to one in 125.¹³ This is achieved through identifying cases who are at highest risk of transmitting disease to infants and implementing preventative measures. In 2025, there were 20 notifications of pertussis in infants aged less than 6 months. Five of these cases had received two doses of pertussis containing vaccines (and therefore considered fully vaccinated for age); 7 cases had received one dose (partially vaccinated); 7 cases were unvaccinated; and one infant was too young to be immunised with pertussis containing vaccine. Maternal vaccination during pregnancy was recorded for 10 of these cases.

Placental transfer of maternal antibodies can aid early protection, therefore maternal pertussis vaccination during pregnancy is recommended. Across WA, 75.1% of mothers were known to be vaccinated for pertussis during their pregnancy in 2025, an increase from 71% in 2024.¹⁴

High RSV numbers amid first season of maternal immunisation program

Since RSV became notifiable in 2022, a consistent seasonal pattern has been observed. Notifications have generally increased around May, with a peak between July and August, then a gradual decline to inter-seasonal levels. Notifications were higher in 2025 (n=10,475) than in recent years (n=9,385 in 2022, n=8,320 in 2023 and n=6,836 in 2024). The 0-4 year age group were over-represented among RSV notifications, comprising 40.7% of all cases.

In April 2024, WA became the first Australian state to fund an infant RSV immunisation program, which was associated with reduced hospitalisations among infants under one year of age.¹⁵ In February 2025, the maternal RSV vaccine Abrysvo was funded under the NIP. Uptake was about 62.8%^b in the first 15 months of the maternal program. The effectiveness of this program in reducing infant hospitalisations in WA is yet to be presented, but national data for the combined maternal and infant program is promising.¹⁶

¹³ Pertussis (whooping cough) | The Australian Immunisation Handbook [Internet]. 2026 [cited 2026 Aug 10]. Available [online](#).

¹⁴ Department of Health WA. Pertussis vaccination [Internet]. Cited 2026 Aug 10]. Available [online](#).

¹⁵ Bloomfield LE, Pingault NV, Foong RE, French S, Morgan JA, Wadia U, et al. Nirsevimab immunisation of infants and respiratory syncytial virus (RSV)-associated hospitalisations, Western Australia, 2024: a population-based analysis. *Med J Aust*. 2025;222(11):568–70. doi:10.5694/mja2.52655

^b Approximately 41,285 women gave birth in WA between 1 February 2025 and 31 May 2026 (pro-rata based on [quarterly statistics](#), and 25,929 [Abrysvo vaccines administered](#) to eligible women in WA in the same period.

¹⁶ Wadia U, Richmond PC, Britton PN, Carr J, Clark JE, Crawford NW, et al. Impact and effectiveness of Australia's 2025 hybrid RSV immunisation program: results from the PAEDS-FluCAN Network. *Lancet Reg Health - West Pac*. 2026 Aug 1;73:101938. doi:10.1016/j.lanwpc.2026.101938

Outbreaks of respiratory illness in residential aged care

A total of 440 COVID-19, influenza and RSV outbreaks were notified in RACH in Perth in 2025. In keeping with the record influenza season, 98 of these outbreaks were due to influenza infections. A further 282 were due to COVID-19 outbreaks; a significant reduction compared with the 500 outbreaks reported in 2024.

The median outbreak duration was 13 days (range 5 to 42 days) for influenza outbreaks and 15 days (range 5 to 61 days) for COVID-19 outbreaks. The median number of resident cases reported was 7 for both influenza and COVID-19 outbreaks. A total of 7 hospitalisations and 42 deaths resulted from influenza outbreaks, compared with 66 hospitalisations and 34 deaths from COVID-19 outbreaks. COVID-19 outbreak activity and community wastewater concentrations peaked in June 2025, but unlike the two previous years, no second peak over the summer months was observed.

Enteric diseases

Cryptosporidiosis from local aquatic centres

After a record high number of cryptosporidiosis notifications in 2024 (n=651), case numbers escalated further to reach a new record in 2025 (n=1049, Figure 17). Cases in 2025 showed a typical bimodal age distribution with 41.8% of cases occurring in children aged less than 10 years, and 23.8% of cases occurring in adults aged between 30 and 40 years, likely representing transmission between children and parents. OzFoodNet is responsible for the investigation and management of locally acquired cryptosporidiosis outbreaks in Australia. Fifteen aquatic centres in Perth were identified as probable places of cryptosporidium acquisition in 2025.

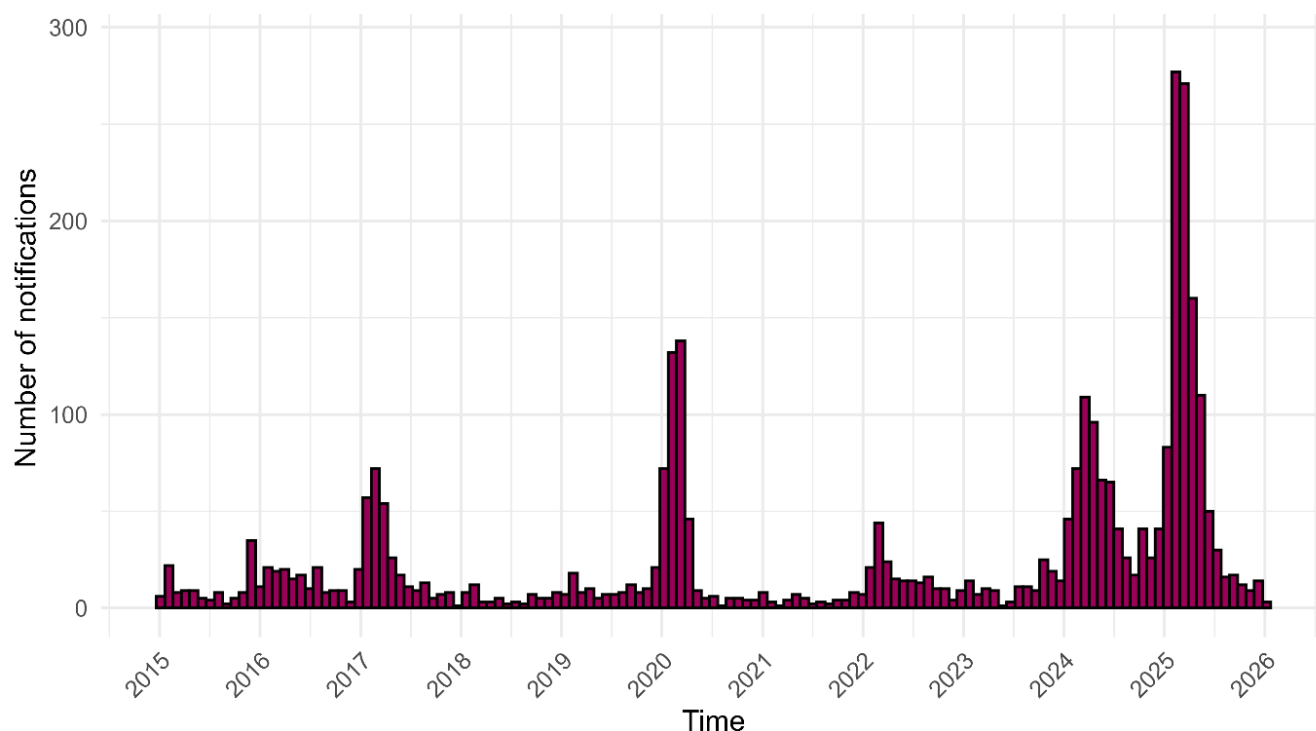


Figure 17: Number of cryptosporidiosis notifications per month from January 2015 to January 2026.

Hepatitis A – notifications mainly driven by overseas acquisition with rare local transmission from frozen coconut

Hepatitis A is not endemic in WA and is usually diagnosed among returned overseas travellers. In 2025, there were 20 overseas acquired hepatitis A cases, an increase from 16 overseas acquired cases in 2024. Following a substantial decline in notifications at the height of COVID-19 international travel restrictions (only one case reported in 2021), hepatitis A notifications have since returned to pre-pandemic levels.

WA observed 4 locally acquired hepatitis A cases in 2025; two in Perth and two in regional areas. None of the 4 reported travel or contact with sick travellers. After an in-depth investigation, they were ultimately thought to have acquired hepatitis A from contaminated frozen coconut products, which led to a recall of these products by Food Standards Australia New Zealand.

Gastroenteritis outbreaks in childcare, schools and residential aged care

In 2025, Boorloo PHU was notified of 185 possible gastroenteritis outbreaks in childcare facilities, schools and RACH. This represents a 45% increase in notifications compared to 2024, predominantly driven by an almost two-fold increase in outbreak notifications from childcare centres. Of these notifications, 160 were confirmed outbreaks of gastroenteritis (defined as two or more people in the same facility becoming unwell with vomiting and/or diarrhoea within a 24-hour period, not explained by other medical causes). RACH were the site of 63 notified gastroenteritis outbreaks, while 112 came from childcare centres and 9 from schools. The causative pathogen was unknown in 79.5% of outbreaks, with norovirus detected as the causative agent in 17.8% of notifications, and 4 outbreaks being attributed to a foodborne pathogen. There were 28 hospitalisations related to gastroenteritis outbreaks (22 in RACH, 6 in childcare) and 5 RACH deaths attributable to these outbreaks.

Rare communicable diseases

Chikungunya cases more than doubled in 2025 (n=23 cases) compared with 2024 (n=10) and reached the highest number of annual cases for a decade. The most common locations of acquisition for this mosquito-borne virus in 2025 were Indonesia (6 cases), Sri Lanka (5 cases), Mauritius and Réunion Island (3 cases each).

There was one case of **Zika Virus** in 2025, in a returned traveller from Indonesia.

Ten people were notified for **Q Fever** in 2025, the highest number on record for a single year since 1993. These infections were thought to be acquired in private farms (n=4) and abattoirs (n=1). Five cases had an unclear source of exposure.

In 2025 there were 7 cases of **acute post-streptococcal glomerulonephritis** (APSGN), aged between 3 and 13 years. APSGN is a significant, immune-mediated renal injury occurring typically after skin or pharyngeal Group A streptococcal infection. Outbreaks of APSGN can occur and Aboriginal communities are disproportionately affected, reflecting ongoing inequities in the social and environmental determinants of health, and access to healthcare. Of the 7 cases in 2025, two identified as Aboriginal and occurred in the same household. The remaining cases were sporadic with no onward transmission identified.

Immunisation

Annual immunisation data summary – increased coverage among Aboriginal 12- and 24-month-olds, reduced coverage elsewhere

Annual immunisation coverage for children at ages 12, 24 and 60 months was calculated as the number of children documented as ‘fully immunised’ according to AIR (Appendix 1), divided by the number of children enrolled with Medicare (as reported by AIR), annualised based on quarterly AIR coverage reports.

In 2025, **immunisation coverage** rate in Perth was higher than the overall immunisation rate of WA for all age categories except for the 60-month-old Aboriginal population, but remained lower than the national rate in all age categories (Figure 18). In Perth, the rates were 90.3% at 12 months of age, 88.2% at 24 months of age, and 92.1% at 60 months of age. These rates have fallen from 2024 figures, with absolute reductions of 1.3%, 0.8% and 0.4%, respectively. This is the fourth year of consecutive declines in coverage for all age groups, which is similar to the national trend (Figure 18), and reflects a global decline in coverage that was aggravated by the COVID-19 pandemic.^{17,18}



Figure 18: Perth metropolitan and National immunisation coverage by age cohort and year. The dotted line represents the national target of 95% immunisation coverage.

¹⁷ Haeuser E, Byrne S, Nguyen J, Raggi C, McLaughlin SA, Bisignano C, et al. Global, regional, and national trends in routine childhood vaccination coverage from 1980 to 2023 with forecasts to 2030: a systematic analysis for the Global Burden of Disease Study 2023. *The Lancet*. 2025 Jul 19;406(10500):235–60. doi:10.1016/S0140-6736(25)01037-2

¹⁸ Australian Government Department of Health D and A. Immunisation dashboards [Internet]. Australian Government Department of Health, Disability and Ageing; 2026 [cited 2026 Aug 31]. Available [online](#).

For **Aboriginal children** in Perth, immunisation coverage was 86.5% at 12 months of age, 83.3% at 24 months of age, and 92.1% at 60 months of age. Compared with 2024, this represents a 0.7% and 2.1% absolute increase in immunisation coverage among those 12 and 24 months of age, respectively, and a 0.2% absolute decrease in immunisation coverage among Aboriginal children at 60 months of age (Figure 19). In comparison to declining immunisation coverage among Aboriginal children nationally, the increases in coverage among Aboriginal 12- and 24-month-olds reflect considerable efforts from Boorloo PHU and others.

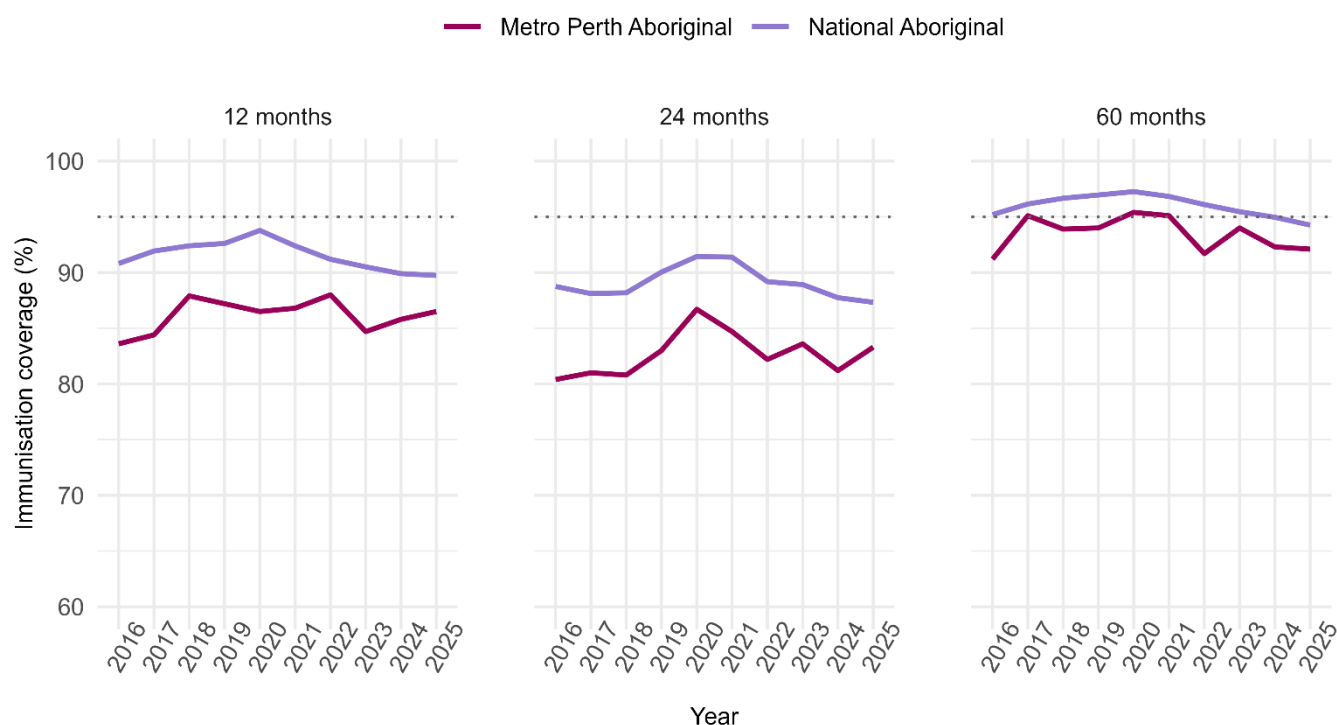


Figure 19: Perth metropolitan and National immunisation coverage in Aboriginal population by age cohort and year. The dotted line represents the national target of 95% immunisation coverage.

Supporting immunisation of Aboriginal children in Perth

Gains in Aboriginal immunisation coverage across Perth in recent years are the culmination of considerable ongoing efforts to improve immunisation access for Aboriginal families.

The **Moorditj Start** program offers telephone support to the families of every Aboriginal child in Perth, including assistance from Aboriginal Health Liaison Officers with service navigation and appointment booking, and reminders via SMS or phone call before immunisation doses become due. If children become overdue for immunisations, further support is offered via phone as well as a culturally safe home visiting immunisation service for families unable to access a clinic.

In 2025, more than 1200 Aboriginal infants and young children were followed up under the Moorditj programs with successful contact rates exceeding 90%. Among those who were successfully contacted, the first dose of diphtheria-tetanus-pertussis-containing vaccine was on time for 92%, compared with only 78% among those who were not reached. The home visiting model was well utilised, with 290 visits booked, and 223 additional household members immunised opportunistically during these visits.

Moort Vax Waangkiny was a dedicated research project to gather evidence on the barriers and facilitators to vaccine uptake among Aboriginal children in Perth, led by Telethon Kids Institute in collaboration with Boorloo PHU. The project found that illness in the child (48%) and lack of reminders about immunisation due dates (28%) were the main reason for delays in vaccine uptake.¹⁹ Most caregivers (88.4%) who participated in the research specified that receiving reminders would be helpful before vaccines were due. The study findings reinforce the value of Moorditj Start program and align with its strategies to facilitate vaccine uptake.

Demand for immunisation catch-up plans continues to increase, multiple efficiency and automation measures implemented

Individuals who have not received appropriate immunisation for age as per the WA immunisation schedule are recommended to commence a vaccination catch-up plan with their immunisation provider. Catch-up plans can be complex, negotiating vaccine spacing to ensure the schedule is safe, effective and delivered in the shortest possible timeframe. Boorloo PHU helps immunisation providers to prepare immunisation catch up plans upon request.

In 2025, Boorloo PHU completed **1841 catch-up plans**, a 21.8% increase from 2024, and an 86.1% increase from the preceding 5-year average, reflecting very high demand for this service (Figure 20). Boorloo PHU has made several major improvements to procedures for handling and responding to these requests, including the use of CARL, a novel catch-up plan automation tool developed by the Medical Director of Boorloo PHU. In 2025, the median time to complete requests was 3 days (down from 15 days in 2024) despite the high volume of requests. However, on review, creating catch-up plans faster did not translate into adherence to the provided plan. Further work is underway to streamline the catch-up plan service.

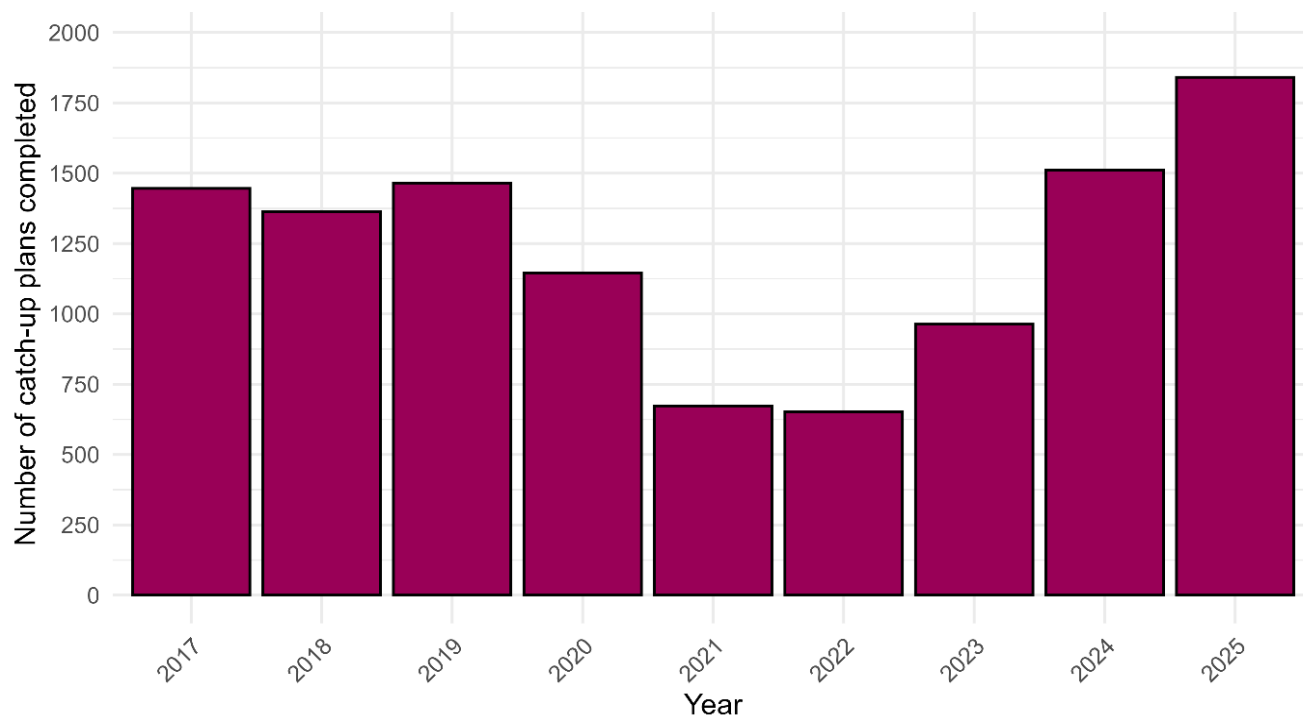


Figure 20: Number of immunisation catch-up plans completed by Boorloo PHU per year, 2017 to 2025.

¹⁹ Puca C, Carlson SJ, Conway LA, Phillips A, Nelson N, Swift V, et al. A cross-sectional survey confirming the barriers and facilitators to vaccine uptake and timeliness among Aboriginal children in Perth, Western Australia. Aust J Prim Health. 2026 Aug 17;32(4):PY26057. doi:10.1071/PY26057 PubMed PMID: 42486652.

Cold-chain management and provider support

A cold chain breach is defined as the occurrence of vaccine storage temperatures outside the recommended range of 2 to 8°C. Perth immunisation providers are required to notify Boorloo PHU of cold chain breaches affecting government-funded vaccines. Boorloo PHU provides advice on whether vaccines should be discarded and, when affected vaccines have been used, if repeat administration is required. Boorloo PHU managed a total of **803 cold chain breaches in 2025**, of which 6 required revaccination advice. This represents an increase in activity of 3.5% compared to the 776 cold chain breaches managed in 2024, and equates to a 30.4% increase compared with the 5-year average for 2020-2024.

Vaccine wastage in the Perth metropolitan area due to cold chain breaches cost WA Health \$531,000 in 2025. To minimise the risk of cold chain breaches, immunisation providers are required to perform a vaccine cold chain management self-audit at least once every 12 months. Boorloo PHU collaborates closely with more than 1,000 metropolitan immunisation providers to assist with this process. Following completion of the survey, providers receive tailored feedback from the Boorloo PHU Immunisation Team, including targeted education where needed. In 2025, 1,097 providers completed annual audits which is a 96.3% response rate. Additionally, 42 practice visits were carried out to deliver education and quality improvement support, including several evening events which were held in collaboration with WA Primary Health Alliance (WAPHA) across the Perth metropolitan area.

Other efforts to improve immunisation coverage in Perth

Safe Start is a targeted reminder program for 8-month-olds and 4.5-year-olds, supporting families whose children are overdue for vaccination. Tailored text messages and/or emails were sent to all children in the age cohort who were identified as overdue for immunisations. The response rate was 14.5%, with more than one third of respondents requesting further contact from Boorloo PHU nurse to obtain personalised support.

Families are also supported at the time of school enrolment. The *No Jab No Play* legislation requires that childcare centres and schools report children overdue for immunisations at enrolment. Boorloo PHU nurses followed up 392 children to support carers to discuss immunisations and access clinics. In addition, schools submitted 123 requests for assistance related to immunisation information.

Several automation projects, under the project name **ImmsonTIME**, were developed in 2025 with academic, health service and consumer partners, to support children at risk of undervaccination. In addition, a collaborative project with Perth Children's Hospital will provide catch-up immunisation plans to children visiting hospital, to enable opportunistic vaccination.

Rabies and Australian Bat Lyssavirus – increase in animal exposures during travel

Boorloo PHU provides advice to clinicians regarding post-exposure prophylaxis (PEP) for rabies and lyssavirus, and authorises the use of WA Department of Health-funded immunoglobulin and vaccine supplies according to national guidelines. In 2025, Boorloo PHU received 408 requests for PEP advice, a marked 87% increase from the 218 requests in 2023 and 41% increase from the 289 requests received in 2024, respectively. Of the 408 requests assessed, Boorloo PHU

facilitated the provision of Rabies Immunoglobulin (RIG) to 112 potentially exposed people and rabies vaccine to 373 potentially exposed people.

Consistent with recent years, the highest number of PEP requests were for travellers returning from Indonesia (n=180), followed by travellers from Thailand (n=62). Dogs were the most common animal causing rabies-prone exposures (n=196, 48.0%), followed by cats and monkeys. There were 10 exposures to bats in Australia in 2025.

Among all rabies-prone exposures reported to Boorloo PHU in 2025, 296 would have met World Health Organization criteria to receive RIG (category II or III bat exposures, and category III terrestrial animal exposures, with no pre-exposure immunisation history). Less than a third (n=87, 29.4%) received RIG overseas; a further 112 (37.8%) received RIG upon return to Perth; and 97 (32.8%) did not receive any RIG. For the latter category of RIG-eligible patients, all 97 did not receive RIG because they presented to a Perth health clinic more than 7 days after the first rabies vaccine was given, after which time RIG should not be administered.

The tragic death of an Australian man from Australian Bat Lyssavirus (ABLV) infection in northern New South Wales in 2025 has reinforced the serious consequences of ABLV and rabies infections and the importance of immediate treatment including PEP.²⁰ This incident has prompted a review of post-exposure management, and changes to recommendations are expected.

²⁰ A rare case of rabies-like Australian bat lyssavirus infection - The Lancet Infectious Diseases [Internet]. [cited 2026 Aug 31]. Available [online](#).



Appendices

Appendix 1: Communicable disease notification rate by geographic health service area

	2025 notification rate per 100,000 population					
	North	East	South	Perth	WA	Aus
Blood-borne viruses						
Hepatitis B (newly acquired)	1	0.7	0.1	0.6	0.6	0.3
Hepatitis B (unspecified)	11.9	27.3	16.4	18.4	17.5	21
Hepatitis C (newly acquired)	0.8	5	6.1	3.9	4.4	4
Hepatitis C (unspecified)	13.1	29.1	31.6	24	25	23
Hepatitis D	0.7	1.6	0.4	0.9	0.8	0.5
Enteric diseases						
Campylobacteriosis	136.9	149.2	143.8	143.8	150.7	150
Cholera	0.1	0	0	<0.1	<0.1	<0.1
Cryptosporidiosis	56.5	35.8	36.3	42.7	42	18
Hepatitis A	0.7	1.8	0.4	1	1	0.9
Hepatitis E	0	0	0	0	0	0.1
Listeriosis	0.5	0	0.1	0.2	0.2	0.2
Paratyphoid fever	0.1	0.7	0	0.3	0.3	0.4
Salmonellosis	46.8	43.3	42.9	44.2	48.6	44
Shiga toxin-producing E. coli	2.6	3.3	3.5	3.1	6.5	4
Shigellosis	13.6	13.2	11.5	12.9	14.6	11
Typhoid fever	0.5	1.2	0.7	0.8	0.7	0.9
Vibrio parahaemolyticus	0.8	1	0.4	0.8	0.9	0.4
Yersiniosis	3.6	2.8	4.1	3.5	3.4	NN
Sexually transmitted infections						
Chlamydia	351	452.5	384.4	395.9	411.7	355
Lymphogranuloma venereum	0.4	0.4	0.1	0.3	0.2	NN
Gonorrhoea	114.2	209.6	146.5	157.2	176.5	160
Syphilis (infectious)	15.2	33	19.8	22.5	26.2	23
Syphilis (non-infectious)	6.9	16.8	7.9	10.5	11.4	11
Syphilis (congenital)	0	0	0.1	4.1*	9.8*	4.8*
Vaccine-preventable diseases						
Diphtheria	0	0	0	<0.1	0.1	0.1
Haemophilus influenzae type B	0	0	0	0	0	<0.1
Influenza	1329.6	1264.3	1022.9	1209.8	1230.1	1888
Measles	1	1.2	1.9	1.4	2.1	0.7
Meningococcal disease (invasive)	0.6	0.5	0.1	0.4	0.4	0.4
Mumps	0.1	0	0	0	0.2	0.6
Pertussis	87.5	66.4	58.7	70.6	77.4	95
Pneumococcal disease (invasive)	7.7	8.1	7.4	7.7	9.1	10
Rotavirus	37.7	35.4	37.4	37.7	44.6	36
Rubella	0.1	0.1	0	0.1	0.1	<0.1

	North	East	South	Perth	WA	Aus
Tetanus	0.1	0	0	<0.1	<0.1	<0.1
Varicella	188.5	200.6	173.9	188.5	189.7	195
Vector-borne diseases						
Murray Valley encephalitis virus	0	0	0	0	0.1	<0.1
Japanese encephalitis virus	0	0	0	0	0	<0.1
Barmah Forest virus	0.2	0	0.5	0.2	0.6	1
Chikungunya virus	1	1.2	0.5	0.9	0.9	0.6
Dengue virus	12.9	11.6	12.8	12.3	12.1	7
Malaria	1	1.5	0.5	1	0.9	2
Rickettsial disease (typhus)	1.1	1.3	1.1	1.3	1.9	NN
Ross River Virus	5.2	10.9	14.8	10.4	14.7	7
Zika	0	0	0.1	<0.1	0.1	NN
Zoonotic diseases						
Leptospirosis	0.2	0	0	0.1	0.1	0.5
Q Fever	0.5	0.4	0.4	0.4	0.5	3
Brucellosis	0	0	0	0	0	<0.1
Other diseases						
Creutzfeldt-Jakob disease	0	0.2	0.1	0.1	0.2	NN
Haemolytic uraemic syndrome	0	0	0	0	<0.1	<0.1
Legionellosis	2.5	1.6	2	2.1	2.3	3
Leprosy	0	0.2	0	0.1	0.1	0.1
Melioidosis	0	0.2	0	0.1	0.1	NN
Tuberculosis	5.9	10.9	3.3	6.9	6.1	6
COVID-19	459.4	453.0	377.65	431.5	407	698
Invasive Group A Streptococcus	3.5	4.7	6.2	4.8	6.1	7
Acute Post-Streptococcal Glomerulonephritis	0.2	0.6	0	0.3	0.7	NN
Respiratory Syncytial Virus	458.9	463	353.7	426.4	431.4	334
Mpox	1	1.8	0.7	1.1	0.9	0.4
Candida auris	0.2	0	0	0.1	0.1	NN

Data were retrieved from WANIDD; disease rows were excluded where no cases occurred locally, statewide and nationally in the past 5 years. Data for rheumatic heart disease, antibiotic resistant organisms and HIV are collected and managed separately. NN=not notifiable; <0.1 denotes a number less than 0.1 that would otherwise be rounded to zero. Varicella-Zoster includes chickenpox and shingles as well as those unspecified. From June 2021, iGAS and RSV were added as notifiable diseases. From January 2023, the case definition for hepatitis C (unspecified and newly acquired) were changed to account for reinfections, accounting for a small part of the increased case numbers. Candida auris was made notifiable in WA in December 2023. Comparability of COVID-19 notifications between years is limited by the temporary inclusion of positive Rapid Antigen Test (RAT) cases. Reporting of positive RAT results was compulsory between 8 February 2022 and 4 November 2022 and continued voluntarily until 9 October 2023. Between 1 January 2023 and 9 October 2023, RAT positive cases comprised 86% of notifications. Following 9 October 2023, only PCR-positive results were notified. COVID-19 data from previous years has been revised to align with current methodologies for assigning case locations, including the redistribution of cases with unknown locations based on testing site data. Congenital syphilis rates are presented per 100,000 births (* denotes that numbers of births for Perth, WA and Australia are from 2024, the most recent data available).

Appendix 2: Immunisation coverage by Local Government Area in 2024

Local Government Area	Age Group	Immunisation coverage for all children (%)
Armadale	12 months	90.99
	24 months	88.21
	60 months	93.22
Bassendean	12 months	93.33
	24 months	88.69
	60 months	92.23
Bayswater	12 months	91.72
	24 months	90.21
	60 months	91.79
Belmont	12 months	90.00
	24 months	85.42
	60 months	90.49
Cambridge	12 months	92.61
	24 months	90.70
	60 months	93.68
Canning	12 months	92.38
	24 months	89.67
	60 months	92.01
Claremont	12 months	87.34
	24 months	90.32
	60 months	92.73
Cockburn	12 months	90.22
	24 months	88.93
	60 months	91.99
Cottesloe	12 months	86.44
	24 months	87.76
	60 months	94.52
East Fremantle	12 months	≥95.00*
	24 months	91.67
	60 months	92.11
Fremantle	12 months	90.78
	24 months	89.35
	60 months	93.51
Gosnells	12 months	88.41
	24 months	87.84
	60 months	91.97
Joondalup	12 months	90.73
	24 months	87.88
	60 months	91.63
Kalamunda	12 months	89.61
	24 months	87.02
	60 months	93.41

Kwinana	12 months	90.51
	24 months	88.51
	60 months	93.23
Mandurah	12 months	87.43
	24 months	85.60
	60 months	90.82
Melville	12 months	91.68
	24 months	89.19
	60 months	95.01
Mosman Park	12 months	94.94
	24 months	91.36
	60 months	93.62
Mundaring	12 months	87.47
	24 months	80.00
	60 months	89.24
Murray	12 months	84.64
	24 months	84.66
	60 months	89.61
Nedlands	12 months	94.78
	24 months	88.61
	60 months	91.26
Peppermint Grove	12 months	NP
	24 months	NP
	60 months	NP
Perth	12 months	85.82
	24 months	87.02
	60 months	86.71
Rockingham	12 months	88.29
	24 months	85.77
	60 months	91.37
Serpentine-Jarrahdale	12 months	88.34
	24 months	87.07
	60 months	90.82
South Perth	12 months	92.51
	24 months	89.04
	60 months	92.03
Stirling	12 months	92.09
	24 months	90.38
	60 months	92.95
Subiaco	12 months	90.12
	24 months	92.00
	60 months	94.14
Swan	12 months	91.04
	24 months	88.55
	60 months	91.85



Victoria Park	12 months	93.46
	24 months	89.46
	60 months	92.62
Vincent	12 months	92.44
	24 months	89.58
	60 months	93.96
Wanneroo	12 months	89.99
	24 months	87.86
	60 months	91.83
Warroona	12 months	80.00
	24 months	80.00
	60 months	79.55

*The following data suppression rules have been applied to protect the privacy of individuals as per the requirements of AIR data publication:

1. Not Published (NP) indicates the number of individuals for that row is less than 25.
2. ≥ 95.00 indicates that the number of individuals for that row is between 25 and 100, and the coverage rate for that population is equal to or greater than 95%.
3. ≥ 99.00 indicates that the number of individuals for that row is greater than 100, and the coverage rate for that population is equal to or greater than 99%.

Appendix 3: AIR criteria for determining whether a child is classified as fully immunised

To be considered fully immunised:

A 12 to <15-month-old child requires 3 doses of diphtheria, tetanus and pertussis vaccine, polio, and hepatitis B vaccines; two or 3 doses of Haemophilus influenzae type b; and two doses of pneumococcal vaccine.

A 24 to <27-month-old child requires 4 doses of diphtheria, tetanus and pertussis vaccine; 3 doses of polio, hepatitis B, and pneumococcal vaccines; 3 or 4 doses of Haemophilus influenzae type b; two doses of MMR; and one dose of meningococcal C and varicella vaccines.

A 60 to <63-month-old child requires a record on the AIR of dose 4 or 5 of a diphtheria, tetanus and pertussis containing vaccine; and dose 4 of a polio containing vaccine.

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