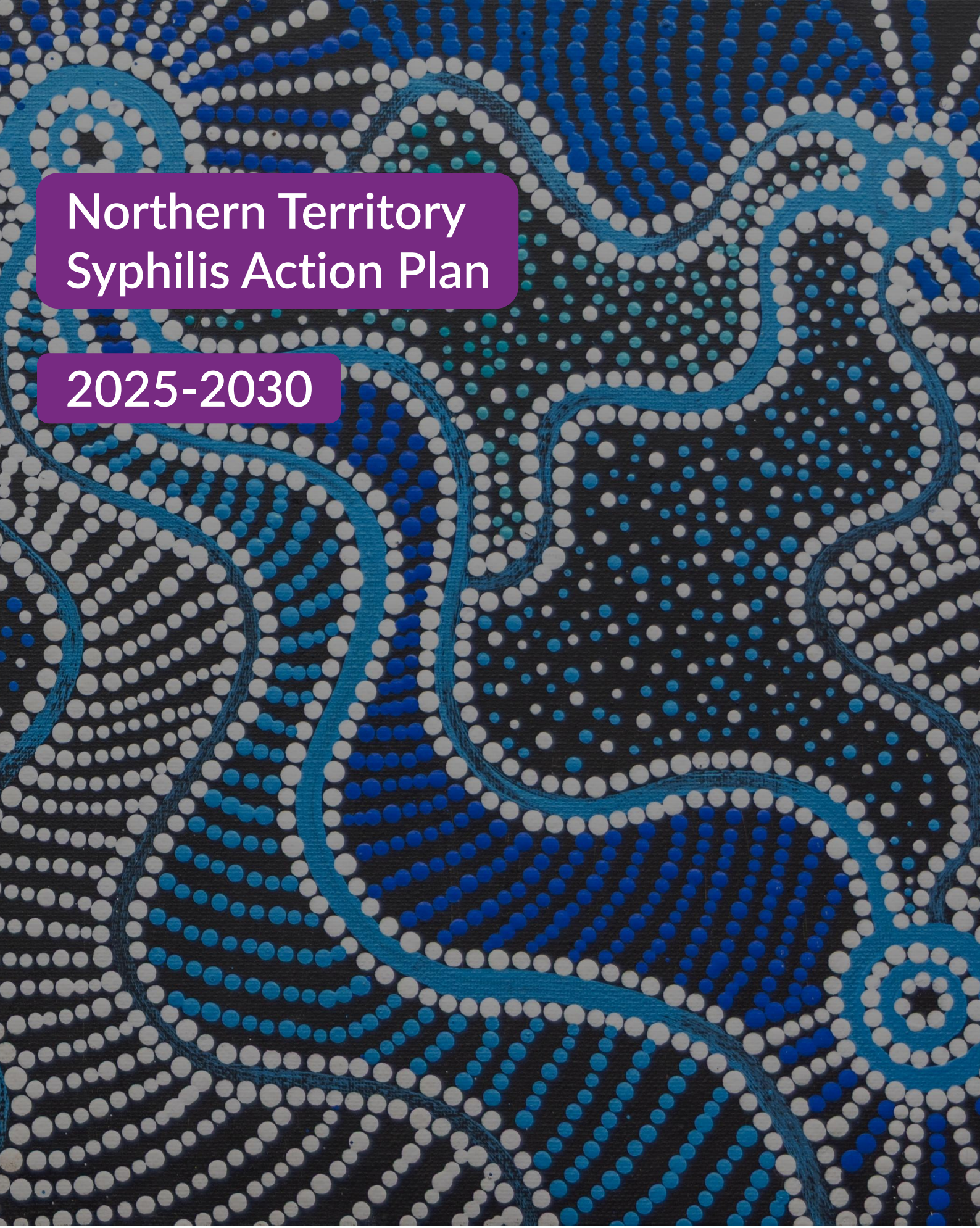


Northern Territory Syphilis Action Plan

2025-2030

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Term/Acronym	Full Form
ACCHS	Aboriginal Community Controlled Health Services
AEWD	Aboriginal Health, Engagement and Workforce Division, NT Health
AHP	Aboriginal Health Practitioner
AHPC	Australian Health Protection Committee
AMSANT	Aboriginal Medical Services Alliance Northern Territory
BBV	blood borne virus
BBVSS	Blood Borne Virus and Sexually Transmissible Infection Standing Committee
CDC	Centre for Disease Control, NT Health
CDNA	Communicable Diseases Network Australia
CDU	Charles Darwin University
CLEaRS	Clinical Learning Education & Research Service, NT Health
CSE	comprehensive sexuality education
ED	emergency department
GP	General Practitioner
HIV	human immunodeficiency virus
IMT	Incident Management Team
MBS	Medicare Benefits Schedule
MWI	Molly Wardaguga Institute
NACCHO	National Aboriginal Community Controlled Health Organisation
NGOs	non-government organisations
NNDSS	National Notifiable Diseases Surveillance System
NTAHF	NT Aboriginal Health Forum
NTG	Northern Territory Government
NT PHN	Northern Territory Primary Health Network
OCNMO	Office of the Chief Nursing and Midwifery Officer
PHC	primary health care
PoCT	point of care test/testing
SHAC	Sexual Health Advisory Committee, Northern Territory

SRH	sexual and reproductive health
STI	sexually transmissible infection
TAFE	Technical and Further Education
VET	vocational education and training
WHS	work health and safety

Acknowledgement of country

NT Health respectfully acknowledges the Traditional Custodians of the country on which we work and live throughout the Northern Territory (NT). We recognise the deep connection Aboriginal and Torres Strait Islander people have with their lands, waters and communities. We pay our respects to Elders past and present whose ancestral land we provide health services upon.

NT Health also acknowledges the vital role of Aboriginal Community Controlled Health Services (ACCHS), their boards, and community leaders in guiding health responses across the NT. We recognise that community leadership, sovereignty and self-determination are central to achieving equitable health outcomes. The ACCHS sector brings cultural authority, lived experience, and trusted relationships that are essential to preventing, diagnosing, and treating syphilis in remote, regional, and urban settings. This Action Plan commits to working in true partnership with ACCHS and respecting their governance structures as equal partners in decision-making and service delivery.

Throughout this document, the term Aboriginal should be taken to be inclusive of Torres Strait Islander people.



Acknowledgement of artist

The artwork in this action plan was created by artist, Glenda Napanangka Martin.

This painting represents Glenda's mother's dreaming, Soakage and Rain dreaming travelling to place to place.

Glenda Napanangka Martin. Yuendumu. Year of Birth. 1980.

Glenda describes the commissioned artwork for the Syphilis Action Plan 2025-2030 as Jintajarrimi-karnarlu meaning - We coming together.

Message from the NT Chief Health Officer

As Chief Health Officer for NT Health, I am proud to introduce the NT Syphilis Action Plan 2025–2030 – a coordinated, evidence-based roadmap to combat the ongoing syphilis outbreak and eliminate congenital syphilis in our communities.

Syphilis is a preventable and treatable infection, yet its impacts – particularly on unborn babies – can be devastating. Left untreated in pregnancy, syphilis can result in miscarriage, stillbirth, premature birth, and lifelong disability for babies who survive. Since 2013, the NT has recorded over 2,800 cases of infectious syphilis and 11 cases of congenital syphilis, including a stillbirth. These are not just statistics – they represent real people, real families, and real heartbreak.

What is most concerning is that this outbreak continues to disproportionately affect Aboriginal communities – communities that already face systemic barriers to accessing healthcare. The increase in congenital syphilis nationally, and the fact that we are no longer meeting World Health Organization elimination targets for Aboriginal babies, demands urgent and focused action.

This 5-year plan builds on the dedicated work already underway across NT Health, Aboriginal Community Controlled Health Services (ACCHS), and community partners. It aligns with the (Draft) Fifth National Sexually Transmissible Infections Strategy 2024–2030 and the National Syphilis Response Plan 2023–2030 and supports the response of the NT Syphilis Outbreak Incident Management Team.

To achieve the goals in this plan, we must deliver the maximum possible coverage of syphilis testing and treatment, particularly in antenatal care settings. We must also support better access to sexual health care for young people. This means working with our communities, investing in the workforce, enabling culturally safe care, and removing barriers that prevent people from accessing testing and treatment.

Some activities outlined in this plan are already in progress; others will require new investment and innovative approaches. This includes temporary measures appropriate for outbreak response, as well as longer-term system strengthening.

We have the tools, knowledge, and partnerships to stop syphilis in its tracks. But we must act now – and act together. This is a shared responsibility and a moral imperative.

I am pleased to launch the NT Syphilis Action Plan 2025–2030, a shared commitment with our communities and partners to ensure every child has the best possible start to life, free from the impacts of congenital syphilis.

Adj Prof Paul Burgess
NT Chief Health Officer

Background

Syphilis is a sexually transmissible infection (STI) usually caused by having vaginal, oral or anal sex with a person who is infected. People of any sex or gender can be infected. It can also be passed on during pregnancy to the child.

Transmission to baby during pregnancy is more likely with untreated early syphilis but can also occur during late latent stage syphilis, during which time it is no longer sexually transmitted. While adverse foetal outcomes can occur with transmission at any stage of pregnancy the consequences of congenital syphilis acquired in the first trimester are often more severe.[1] Left untreated it can lead to miscarriage, low birth weight, prematurity, still birth, or death of a baby. If the baby survives, there can be a range of serious life-long health issues including organ, brain and nerve damage causing severe, permanent disability.

A multi-jurisdictional syphilis outbreak affecting Aboriginal people was first identified in January 2011, in northwest Queensland, followed by the NT in July 2013, and the Kimberley region of Western Australia in June 2014.

The 2024 Towards the Elimination of Congenital Syphilis in Australia Roundtable Report: Building Consensus for Priority Actions[2] highlights that, over the past 10 years, Australia has seen an alarming increase in cases of congenital syphilis. This increase has disproportionately affected Aboriginal communities, with congenital syphilis rates per 100,000 live births being on average 16 times that of non-Aboriginal infants.[3,4] Recent data indicates that for Aboriginal babies, Australia is no longer meeting World Health Organization triple elimination targets.[5]

To ensure health systems are supporting the elimination of both infectious syphilis and congenital syphilis, we must address inequity and make certain that policies are enabling, resources are targeted effectively, and existing systems[6] are strengthened to deliver culturally safe and effective services.

NT Health is committed to eliminating congenital syphilis and understands that to control the syphilis outbreak a response now needs to be delivered to achieve the maximum coverage of testing within the shortest possible time, in a range of settings including perinatal care to reduce the prevalence to pre-outbreak levels.[7,8,9,10]

This plan supports the activity of the NT Health 2025 Syphilis Outbreak Incident Management Team (NT Syphilis IMT) and the response of the wider health system and is designed to deliver on the (Draft) Fifth National Sexually Transmissible Infections Strategy 2024-2030[11] and National Syphilis Response Plan 2023- 2030.[12] At a local level, this plan also contributes to the achievement of the NT Health Aboriginal Health Plan 2021-2031[13] and the NT Health Strategic Plan 2023-2028.

This plan recognises NT Health's commitment to deliver the NT Health Aboriginal Cultural Security Framework 2016-2026 which aims to create system changes that promote the highest level of cultural competence in individuals, to ensure safe participation for Aboriginal staff and consumers.

Some actions in this plan build upon current relationships and existing work.[14] However, many activities in this plan will require new funding streams.

Whilst this is a 5-year plan, as with any outbreak, some of the new activity or approaches implemented may be temporary depending on the evolution of the outbreak and the achievement of the required health outcomes.

Epidemiological snapshot

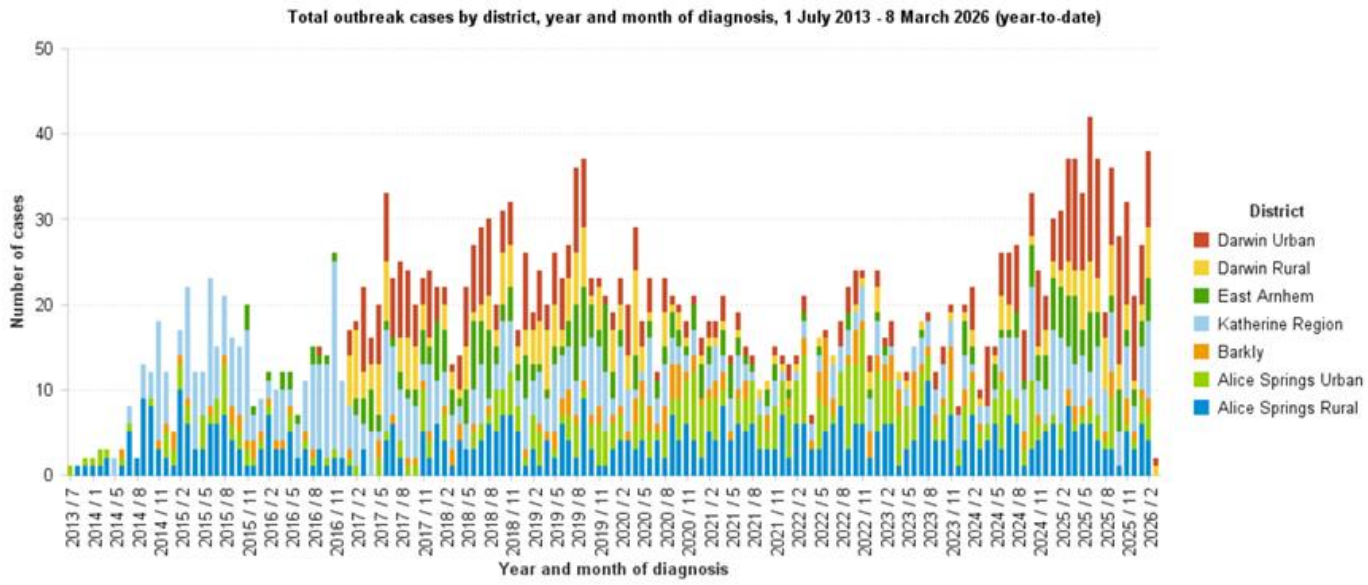
In Australia, the infectious syphilis notification rate more than tripled during 2012-2022.[i] This rise was initially characterised by outbreaks in urban areas among men who have sex with men and in Aboriginal people in remote areas, leading to the formation of a Multi-Jurisdictional Syphilis Outbreak Group by the Communicable Diseases Network Australia commencing in 2015.[15]

Since 2011 and as notifications of infectious syphilis in women of reproductive age have increased, so has the number of congenital syphilis cases.[16,17]

Since outbreak reporting began in 2013 in the NT, 2,802 cases (as of 8 March 2026) have been recorded and the outbreak now spans all 5 regions, both urban and rural. Since 2013, 53% of NT notifications have been female, with 11 babies born with congenital syphilis, one of these also being stillborn.

The figure below shows the alarming rise in the NT outbreak, and the proportion of cases by sex.[ii]

Figure 1: Total NT outbreak cases by health epidemiological district and year of diagnosis 1 July 2013 – 8 March 2026 (year-to-date). Source: NT Notifiable Diseases System



[i] National Notifiable Diseases Surveillance System (NNDSS).
[ii] At the time of writing, no notification data existed for people with innate variations in sex characteristics.

Priority populations and settings

Priority populations

A priority population is a group at higher risk, who may have historical or systemic disadvantage, structural barriers to accessing sexual health services, limitations to diagnostic services due to geographical and socioeconomic disadvantage, or where supporting this group is known to have an impact on the whole population. The priority populations for this plan are outlined below.

Aboriginal people

Across Australia, syphilis disproportionately affects Aboriginal people.[18] In the NT it is estimated that over 30% of NT's total population are Aboriginal.[19] The NT covers 1,349,129 square kilometres, with the majority of Aboriginal residents (72.5%) living in very remote areas.[20] Of the 72.5% living in very remote areas, 86% use Aboriginal languages at home, with only 10.4% using English only. The Aboriginal population is also younger than the non-Aboriginal population, with half of the Aboriginal people in the NT under the age of 24 years.

Women[iii] of reproductive age 15-44

While syphilis disproportionately affects all Aboriginal people it causes significant health risks for women who are pregnant and their babies.

Since 2013, 53% of syphilis notifications in the NT have been female and 47% male (as of July 2025). Across most age groups Aboriginal people recorded higher rates of infection compared with non-Aboriginal people.[21]

While there is not yet any syphilis data captured within the NT (or national) Perinatal Registry, in the NT in 2021 it was reported that Aboriginal women represented around 32% of all mothers (and their babies) and do experience poorer perinatal health outcomes.[22]

The NT Government Mothers and Babies Report 2021[22] stated that:

- Aboriginal mothers were more likely to reside in rural and remote areas (52%).
- Eighty seven percent of all mothers received their first antenatal visit during their first trimester of pregnancy (<14 weeks gestation), whilst 8% of all mothers at 32 weeks gestation or more, attended fewer than 5 antenatal visits.
- While there has been an increase in the proportion of mothers attending 5 or more antenatal visits for both Aboriginal and non-Aboriginal mothers (77% to 87% and 91% to 97%, respectively) during the reporting period 1989 – 2020, this means Aboriginal mothers are still more likely to receive fewer than 5 visits.

While 97% of all NT births occurred in hospital, and the remaining 3% occurred in other locations (including planned homebirths and births at health centres) 11% of Aboriginal women who gave birth lived in very remote areas.[23]

For Aboriginal women, the lack of engagement in mainstream antenatal care can stem from a lack of trust, given Australia's long history of forced child removals and cultural misunderstandings.[24]

[iii] The term 'women' is used throughout this plan. We acknowledge and affirm that trans men, non-binary people, and other gender diverse people may also experience pregnancy and require access to SRH care. References to 'women' in this document should be read as inclusive of these populations.

Given the importance of testing throughout pregnancy, the NT syphilis response requires a focus on reaching women, in remote areas, but also across NT who are less likely to present for early antenatal care and their sexual partners.

Across Australia it is estimated that around 40%[iv] of all pregnancies are unintended, which can also be associated with suboptimal pre-conception health behaviour and lack of engagement with reproductive health care and adverse maternal and neonatal outcomes.[25]

Therefore, this plan also requires a focus on how best to reach people before they become pregnant, or when seeking emergency contraception, planned contraception, pregnancy options counselling and/or abortion.

Young people aged 15-24

In the NT in 2024, the 15-24 year age group experienced the highest infectious syphilis rates (Table 1). The 15-24 year age group had the highest infectious syphilis rates in all health regions except Darwin urban and East Arnhem.[15]

Table 1: Infectious syphilis notification rate per 100,000 population by age group, NT, 2024. Source: NT Notifiable Diseases System

Age group	Rate per 100,000 population
<15	31
15-24	297
25-34	97
≥35	72

Gay, bisexual and other men who have sex with men

While less represented within the NT outbreak, gay, bisexual, and other men who have sex with men remain over-represented among syphilis diagnoses across Australia and globally. Recent research suggests[26] syphilis trends between gay and bisexual men and those prescribed pre-exposure prophylaxis for HIV have converged over the past 11 years.[18]

Sexual partners of people in priority populations

STIs don't affect individuals in isolation; they exist within networks of relationships. Sexual partners may be a source of reinfection. They may also share similar social or structural barriers – like limited access to healthcare or stigma – so supporting sexual partners helps break the chain of transmission.

In summary, the priority populations of highest focus in this plan are:

- Aboriginal people
- females of reproductive age, 15-44 years
- young people, aged 15-24 years
- gay, bisexual and other men who have sex with men
- sexual partners of people in priority populations.

While these groups above are our highest focus, individuals can have overlapping identities that compound risk or vulnerability. Other priority populations listed in the Draft National STI Strategy

[iv] At the time of writing, no data existed for Aboriginal and Torres Strait Islander people.

who will also be relevant to this plan include people who are trans and gender diverse, sex workers, people from culturally and linguistically diverse backgrounds, people who inject drugs, international students, travellers and migrant/Pacific Australia Labour Mobility (PALM) workers,[v] people experiencing housing insecurity, and people who have had an STI within the previous 12 months.

Priority settings

NT's highest priority settings for this plan are:

- **Rural, remote and very remote settings**: ACCHS, remote primary health clinics, very remote communities.
- **Primary health care**: ACCHS, NT Government/non ACCHS clinics, general practice, urgent care clinics, family planning services, urban areas, including Darwin and people experiencing homelessness, including those sleeping rough or living in the long grass
- **Community health care:** early pregnancy and pregnancy options services, alcohol and drug services, youth services, services that support birthing on country and women's health services, school nurses, ACCHS.
- **Tertiary and specialised healthcare: Public sexual health services (Clinic 34s),** emergency departments, maternal health care, mental health care.
- **Custodial settings**: adult and youth custodial settings, and other places of detention.
- **Other community settings**: youth programs, schools, sporting clubs and other non-school educational and support settings.

[v] Pacific Australia Labour Mobility scheme workers.

Primary goals

The primary goals of this plan are aligned with the goals of the national response[27] which are to:

1. Strengthen prevention strategies for syphilis in priority populations and settings.
2. Reduce incidence and ongoing transmission of syphilis across priority populations.
3. Reduce morbidity and mortality associated with syphilis.
4. Eliminate congenital syphilis (defined as sustained zero congenital syphilis cases).

New testing and treatment guidelines

The NT Chief Health Officer has issued updated testing and treatment guidance (Table 2) in response to further increases in syphilis case numbers in 2025 (Figure 1).

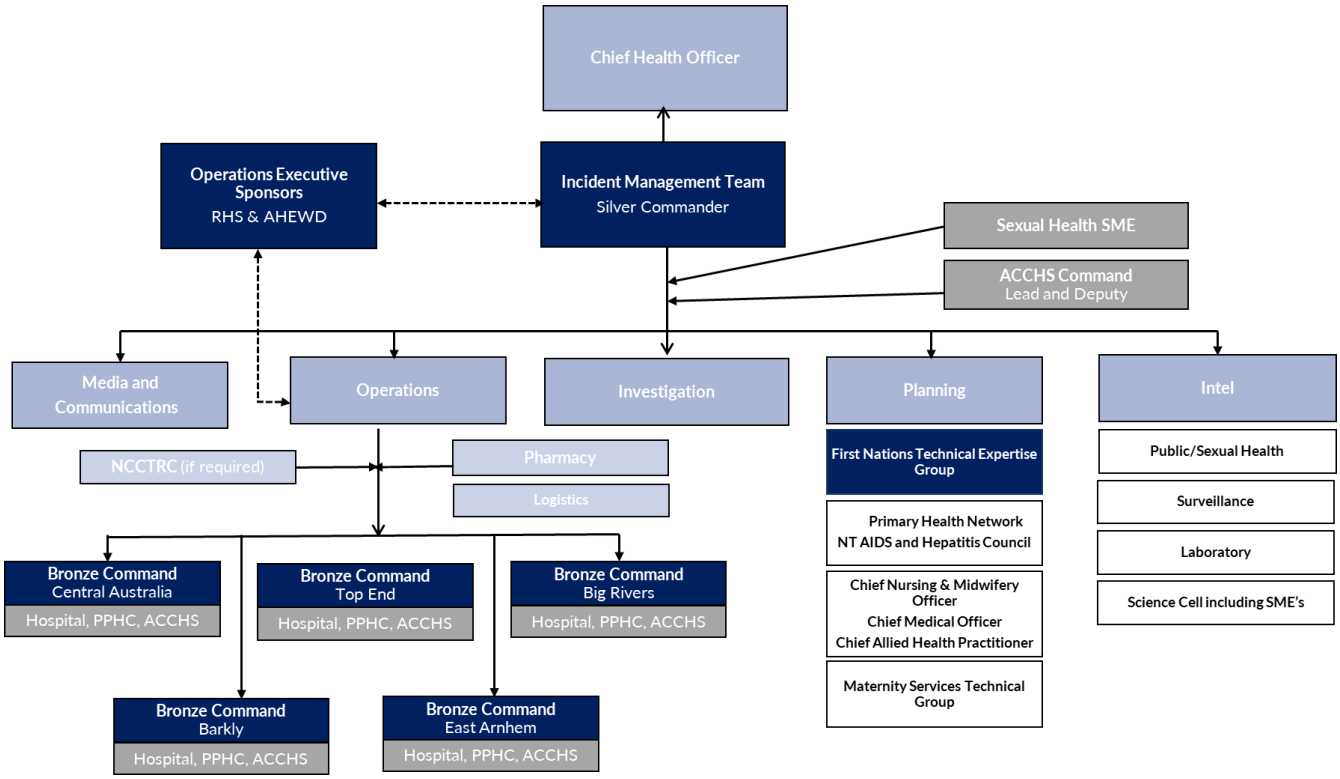
Table 2: NT summary testing and treatment guidance[28,29,30]

Summary of updated syphilis guidance for NT
For ALL pregnant women
Increase syphilis testing to 5 times (first visit, 28 weeks, 36 weeks, at birth, and at 6 weeks postnatal).
Treat symptomatic people immediately (i.e. chancre, genital ulcer, rash/fever/myalgia).
Test and treat all sexual partners of pregnant women, regardless of whether the pregnant woman returns a positive syphilis test.
For ALL people aged 15 years and over presenting to ANY health service, including NT primary health care, ACCHS, emergency departments, prison health, private GP practices.
Increase syphilis testing by actively offering syphilis, HIV and STI tests, especially young people.
Test all people diagnosed with an STI for syphilis, if it was not included in the original testing.
Treat symptomatic people immediately (i.e. chancre, genital ulcer, rash/fever/myalgia).
Test and treat all sexual partners of people positive for syphilis.
Offer opportunistic full STI screen to young people 11-14 years old if disclosing sexual activities or requesting contraception.

Governance

Syphilis is a nationally notifiable infection. This plan was developed, implemented and will be monitored by an NT Syphilis IMT stood up in 2025 and the NT Public Health Division. Progress reports will be provided based on the NT Syphilis Action Plan Monitoring Framework to the NT Sexual Health Advisory Committee (SHAC) who will provide updates to the NT Aboriginal Health Forum (NTAHF) through the NT Health Senior Executive Group. Figure 2 below describes the NT Syphilis IMT structure.[vi]

Figure 2: NT Syphilis Outbreak Incident Management Team Structure



The NT Syphilis IMT may be time limited, at which stage the governance structure will be updated. NT Health also provides reports and engage with the Commonwealth Government including via the:

- Communicable Diseases Network Australia (CDNA)
- National Blood Borne Virus and Sexually Transmissible Infections Surveillance Subcommittee (of CDNA)
- National Aboriginal and Torres Strait Islander Health Protection Subcommittee (of the Australian Health Protection Committee (AHPC))
- Blood Borne Virus and Sexually Transmissible Infections Standing Committee (BBVSS), subcommittee of AHPC, which has a Ministerial advisory role.

[vi] Membership of the SHAC and the governance structure itself, may need to vary from time to time, depending on the areas of focus at different stages of the response. Reporting lines may vary should other bodies receiving reports on the Action Plan, such as NTAHF refine their functions.

Guiding principles

This plan supports the guiding principles articulated in the Draft National STI Strategy 2024-2030 which form the basis for our approach to the achievement of this plan which are:

- person-centred response
- partnership
- human rights
- health equity
- health promotion and prevention
- access and quality services
- harm reduction
- shared responsibility
- commitment to evidence-informed, enabling policies and programs
- multi-sectoral partnership and collaboration.

In addition to these guiding principles, NT Health recognises that the entrenched inequities in perinatal outcomes in the NT are inextricably linked with the congenital syphilis and infectious syphilis profiles of the NT. As a partner in a Multi-Institution Agreement called 'Birthing on Country: RISE SAFELY in rural, remote and very remote Australia' NT Health is committed to utilising the RISE framework to co-design culturally and clinically acceptable maternity models of care.

NT Health will be guided by the RISE[31] Framework in any system or service reform, acknowledging the right to birth on country. The RISE Framework has 4 pillars to drive important reform:

- redesign the health service
- invest in the workforce
- strengthen families; and
- embed Aboriginal community governance and control.

The application of the RISE Framework to any work that seeks to make changes in maternal health and birthing is likely to result in short and long-term health gains for Aboriginal families.

This plan is also being guided by the NACCHO's Core Services and Outcomes Framework: The Model of Aboriginal and Torres Strait Islander Community Controlled Comprehensive Primary Health Care.[32] This places Aboriginal community control, cultural safety, and leadership at the centre of health system design. The framework highlights the need to address social determinants such as racism and discrimination, and to ensure care is holistic and community led.

In the context of syphilis, this means embedding cultural safety and anti-racism across all services, prioritising health literacy equity through resources that are plain language, highly visual, and available in Aboriginal languages, and supporting community-led health promotion driven by Aboriginal leaders, boards and health workers. These approaches ensure that prevention, testing, and treatment strategies are not only clinically effective, but trusted, culturally relevant and accessible in remote, regional and urban Aboriginal communities.

Together these principles underpin our approach and our collaborative relationships as we work across the sector to design, implement and monitor the actions in this plan.

Priority areas for action

In accordance with the (Draft) National STI Strategy 2024-2030 and the 2024 Towards the Elimination of Congenital Syphilis in Australia Roundtable Report, this plan aims to meet the goals of the National Syphilis Response and achieve elimination of congenital syphilis in NT. In addressing these aims, 6 priority areas for action that align with the Draft National STI Strategy 2024–2030 these have been contextualised for NT and are outlined below:

Priority area for action 1: Integrated primary care

- Working in partnership with the ACCHS and NT Primary Health Network (NT PHN) to optimise connections and opportunities within general practices, emergency departments, hospitals, and community services.
- Highlighting the important role of antenatal services and the birthing on country movement in the syphilis response.

Priority area for action 2: Workforce development

- Ensuring NT has a capable, adaptable workforce, to support greater mobilisation.
- Addressing NT's more challenging sexual health workforce issues, with a focus on the Aboriginal health workforce, who are the key to expanding access in hard-to-reach communities.

Priority area for action 3: Education and awareness

- Increased community awareness and education in the wider health and community services system.
- Ensuring age appropriate STI education in schools, in the context of comprehensive relationships and sexuality education.

Priority area for action 4: Prevention, testing and treatment

- Expanding access to and use of condoms and Doxy-PEP.
- Ensuring a 'no wrong door approach' encouraging expansion and diversification of testing points, including point of care testing, and timely treatment.

Priority area for action 5: Equity and access

- Improving cultural competency as we deliver services.
- Continuing to improve the policy and legal pathways to progress.

Priority area for action 6: Data surveillance, research and evaluation

- Strengthening capacity for surveillance, contact tracing, sexual partner notification and complex case management.
- Re-design (including re-platforming) the syphilis register to enable timely access to information and reporting while maintaining the highest standards of privacy and cultural safety.
- Advocating for the inclusion of syphilis testing data in the Perinatal National Minimum Data Set.

Action tables

Priority area for action 1: Integrated primary care

Actions	Outputs	Outcomes	Indicators	Partners	
1.1. Work in partnership with services providing perinatal care to develop and implement strategies to reach women, particularly those who are more likely to present late in pregnancy, and their sexual partners. *Note: For those found to have new infection, ensure no one is left untreated.*	NT Health Response to the Congenital Syphilis Aggregate Review 2025.	All women receiving syphilis testing in pregnancy.	Number of congenital syphilis cases per year. Proportion of women engaged in antenatal care, by trimester. Proportion of people who gave birth who received all 5 syphilis tests during pregnancy and postnatally by sector e.g. NTG, ACCHS, general practice. % of pregnant women who have a new infection are treated.	NT Health (including Office of the Chief Nursing and Midwifery Officer (OCNMO), Perinatal Data Registry, Communicable Disease Control (CDC), ACCHS, NT PHN, non-government organisations (NGOs), Molly Wardaguga Institute (MWI).	Short term
1.2 Work in partnership with the NT PHN to identify opportunities to integrate or expand syphilis testing and treatment within urban primary care settings in the context of comprehensive sexual and reproductive health care.	NT PHN programs and supports for primary care in targeting testing and treatment.	Testing and treatment are integrated into more primary care and sexual and reproductive health care settings.	Number of tests performed in primary care. Number of patients treated in primary care.	NT Health, AMSANT, ACCHS, NT PHN, NGOs.	Short term
1.3 Work in partnership with the NT PHN and AMSANT to improve geographical coverage of testing in primary care.	Review of Sexual and Reproductive Health Services and funding in NT.	Increased testing and treatment in priority populations.	Number of testing and treatment points outside the urban area.	NT Health, AMSANT, ACCHS, NT PHN, NGOs.	Medium term

Actions	Outputs	Outcomes	Indicators	Partners	
1.4 Work in partnership with the NT PHN to improve access to free, confidential and anonymous testing and treatment.	Review of sexual and reproductive health services in NT.	Increased access to free and anonymous testing.	Number of free tests performed. Number of anonymous tests performed.	NT Health, ACCHS, NT PHN, NGOs.	Long term
1.5 Provide support and guidance for embedding sexual health into primary health care systems. *Note: includes advice on embedding routine STI/syphilis testing in 715 checks, antenatal care, and opportunistic consultations.*	Development of a Sexual Health Integration Guideline for NTG, ACCHS, and general practice. Training package. Clinical tools (recall systems, decision support prompts in Communicare) developed.	Guideline published NT Health PHC and ACCHS staff trained. Clinical tools developed.	% of 715 health checks that include syphilis/STI testing.	NT Health, NGOs, ACCHS, NT PHN, MWI.	Medium term

Priority area for action 2: Workforce development

Actions	Outputs	Outcomes	Indicators	Partners	
2.1. Support and develop culturally safe and appropriate, syphilis specific workforce education program for orientation and periodic professional development/updates for all relevant workforces and settings, delivered in a manner that responds to the reality of high workforce turnover. Workforces could include • NT Health and NGO services: doctors, nurses, midwives, Aboriginal Health Practitioners, Aboriginal maternal support workers, health educators. • GPs, practice nurses, rural and remote nurses. • Other: fly-in-fly-out (FIFO), and agency health workers coming in from outside NT. WHS and staff health services in mining, resources and other sectors with high numbers of FIFO workers. *Note: online training material to be available for non NTG partners such as ACCHS to be able to tailor to their region*	Updated testing guidelines. Syphilis health workforce orientation training and update packages. Training calendar. Summary report of training participant completion, learning change and feedback results. *Note: training topics could include:* • *integrating syphilis testing into primary care and annual health checks* • *engaging and educating patients on sexual and reproductive health* • *offering comprehensive STI screening* • *syphilis diagnosis, management (including dealing with needle phobia and needle pain)* • *contact tracing and sexual partner notification* • *clinical and electronic notification tools* • *optimising use of Medicare*	Updated guidelines accessible to all health workers. All NT Health (estimated 5,600 staff)[vii] to receive syphilis education. All NT Health staff (estimated 500 -1,000 per year) are receiving syphilis education at orientation and ongoing education on syphilis management. All non-NT Health staff targeted are receiving syphilis education at orientation.	Evidence of knowledge shift from pre and post training. Number of participants by profession and service.	NT Health (including Clinical Learning Education & Research Service (CLEaRS), Remote Sexual Health Team, CDC, Acute Care) and non-government clinicians.	Short term

[vii] Australian Government Department of Health, Disability and Ageing Website: Summary Statistics, Allied Health, State

Actions	Outputs	Outcomes	Indicators	Partners	
and health service. May include existing resources.	• *delivering sexual and reproductive health to young people.* • *cultural safety and the impacts of racism on SRH services (and how to contribute to creating respectful, inclusive, safe environments)* • *sexual health promotion in Aboriginal communities* • *working with Aboriginal Health Practitioners to support their full scope of practice.*				
2.2. Ensure regularly updated syphilis education is incorporated into VET and undergraduate curricula for all relevant health workers.	List of relevant courses. Updated course materials.	All graduates educated on syphilis prevention, testing and management.	Evidence of knowledge shift from pre to post training, by course.	NT Health, Charles Darwin University, Flinders University (NT), Batchelor Institute of Indigenous Tertiary Education.	Medium term
2.3. Develop, in partnership with CLEaRS and the ACCHS sector, a comprehensive Sexual Health Workforce Plan to recruit, train, support and retain Aboriginal sexual and reproductive health and maternal health workforce, health promotion workers and the other health	Sexual Health Workforce Plan.	Greater engagement of Aboriginal people in the sexual and reproductive health and maternal health workforce, at all levels, in all settings. Particularly rural and remote areas.	Number of Aboriginal people, and other professions, in the sexual and reproductive health workforce, and	NT Health (including Aboriginal Health, Engagement and Workforce Division (AEWD),	Short term

Actions	Outputs	Outcomes	Indicators	Partners	
professionals working around them (doctors, nurses, midwives etc). *Note: to be informed by the NT Aboriginal Employment and Career Development Strategy key focus areas: targets, attraction, retention, leadership, workplace culture, remote.*		Greater support from non-Aboriginal workforce to enable Aboriginal Health Practitioners to work to their full professional and individual scope of practice.	health promotion workforce. Support for full scope of practice.	OCNMO, Public Health Division, CLEaRS) ACCHS, NT PHN, AMSANT.	

Priority area for action 3: Education and awareness

Actions	Outputs	Outcomes	Indicators	Partners	
3.1. Use co-designed and developed (or licence and adapt existing) health promotion multi-media campaigns and information resources tailored to syphilis priority populations, regions and communities. *Note: key messaging might include free STI testing and treatment availability, condoms and lube, syphilis information. To create resources in languages spoken at home by Aboriginal people.*[33] *Consideration to be given to the impact of Australia's new age limits on young people's social media access.*	NT Health Communications Plan with culturally appropriate campaign key messaging, creative and information. Campaign reports. Translated and plain English information resources. *Note: campaign communication channels may include other key stakeholders/sector partners.* *Other partners may also lead their own communication strategies and campaigns.*	Increased community awareness of free testing and treatment, access to condoms and syphilis information.	Campaign reach, views, engagement, targeting, landing page results.	NT Health, Strategic Media, Marketing and Communications, NGOs, Department of Education and Training.	Short term
3.2. Use co-designed and developed (or licence and adapt existing) sexual health community education tailored to syphilis priority populations, regions and communities. *Note: key messaging might include free STI testing, condoms and lube, syphilis information.*	Community Education Packages. *Note: to include culturally appropriate information, educational resources and guidance on their use with their clients are integrated into training packages. Examples of this are the Mooditj program, Young Deadly Free and 'condom tree making' for men.*	Increased community awareness of free testing, access to condoms and syphilis information.	Community education packages delivered to clinical and non-clinical workforces	NT Health (including, Strategic Media, Marketing and Communications), NGOs.	Short term

Actions	Outputs	Outcomes	Indicators	Partners	
3.3. Review STI education in the context of existing comprehensive relationships and sexuality education (CSE)[viii] for school age children and young people in schools and other settings where young people congregate.	Review of STI Education for School Age Young People. Work in partnership with Department of Education, church and independent schools to ensure all NT children and young people have access to evidence-based CSE.	Ensure accurate syphilis education in schools. Ensure accurate syphilis education in other settings where young people congregate.	Teacher, Aboriginal Education Worker, community worker and/or student feedback.	NT Health, Department of Education, NGOs.	Medium term
3.4 Build the capacity of the education workforce to facilitate knowledge and awareness of STI by embedding education that is age-appropriate, inclusive and stigma-free within pre-service training for educators and teacher development processes at the primary, secondary and tertiary levels (such as university, TAFE and international colleges).	Work in partnership with Department of Education, church and independent schools to ensure all NT children and young people have access to evidence-based CSE. Develop pre-service and professional development STI education for school-based educators.	Ensure accurate syphilis education in schools.	Teacher, Aboriginal Education Worker, community worker and/or student feedback.	NT Health, Department of Education, NGOs. CDU	Long term

[viii] Defined within the UNESCO technical guidance on sexuality education: An evidence-informed approach, 2019.

Actions	Outputs	Outcomes	Indicators	Partners	
3.5. Promote the delivery of culturally appropriate, comprehensive relationships and sexuality education for school-age children and young people in urban, regional and remote areas, including those not engaged in school. *Note: this may be done through utilising existing programs or through co-design of new and/or peer to peer programs.*	Co-designed education strategy.	Ensure evidence-based, clinically accurate CSE for school age children and young people.	Number of schools engaged in programs by location.	NT Health, Aboriginal community leaders, Elders, young people and service providers. Department of Education.	Long term

Priority area for action 4: Prevention, testing and treatment

Actions	Outputs	Outcomes	Indicators	Partners	
4.1. Work in partnership to secure increased funding to increase the distribution of condoms across NT.	Condom access point and volumes audit. Proposed list of access points and volumes. NT Health updated web page. NT Health communications on social media. *Note: this might be achieved through community-led condom distribution initiatives delivered through ACCHS, youth services, and remote stores; and relate to earlier actions on health promotion and workforce education.*	Greater access to condoms.	Number of access points. Number of condoms distributed.	NT Health, NGOs, ACCHS.	Short term
4.2. Work in partnership to offer access to Doxy-PEP informed by the 2023 Consensus Statement.	List of Doxy-PEP access points NT Health updated web page.	Greater access to Doxy-PEP for gay, bisexual and other men who have sex with men.	Number of syphilis cases in gay, bisexual and other men who have sex with men who use Doxy-PEP.	NT Health, NGOs, ACCHS.	Medium term
4.3 Encourage guideline-based STI testing in all priority populations including in pregnancy.	Updated guidelines. Testing audits. Update electronic health record systems care plans.	All priority populations are receiving syphilis testing including in pregnancy.	Number of congenital syphilis cases per year.	NT Health, (including CDC, CLEaRS, OCNMO) MWI, AMSANT, antenatal services.	Short term

Actions	Outputs	Outcomes	Indicators	Partners	
4.4 Encourage expansion and diversification of syphilis testing through community screening in all health services, using any opportunity. *Note: examples might include annual testing drives, outreach testing, event-based testing. May need to support resourcing for follow-up.*	Regular Incident Management Team meetings to support progress. Updated List of Syphilis Test Access Points (on a public facing website)	Greater access to testing.	Number of testing points. Number of tests performed. Number of page visits.	NT Health, NGOs, ACCHS. NT PHN, AMSANT	Short term
4.5 As with the primary health care system, support the acute care system (including emergency departments) by undertaking follow up of patients with positive serology.	Aboriginal Health Practitioner Liaison role or Public Health Liaison Nurse (all priority populations). Working relationships with other Aboriginal Health Practitioners and ACCHS.	The capacity to case-find in emergency departments and manage people as recommended in guidelines.	Number and % of ED cases lost to follow up. Time between testing and treatment.	NT Health, NGOs, ACCHS.	Medium term
4.6. Where relevant, utilise HealthPathways, GP practice software, linkage with NT PHN system. *Note: other services may use other systems or methods.*	Updated HealthPathways and/or other decision support tools.	Use of existing decision support tools by clinicians and ACCHS to increase STI testing.	Number of STI tests, including syphilis performed in primary care.	NT Health, NT PHN, ACCHS.	Ongoing
4.7 Scale up the NT coordinated syphilis response in the key priority areas for action.	Maintain and enhance a coordinated public health response to enable a full package of testing, workforce, clinical and surveillance activities.	Action plan activities supported and monitored.	Overall achievement of the action plan.	NT Health.	Short term

Actions	Outputs	Outcomes	Indicators	Partners	
4.8 Strengthen timely treatment of all index cases and partner notification to ensure sexual contacts are traced, tested, and treated, to break transmission cycles and prevent reinfection.	Workforce training delivered on treatment protocols, Point of Care Testing (PoCT), and culturally safe partner notification. Dedicated resources (e.g., AHPs, liaison officers, community workers) allocated for contact tracing in remote communities as well as urban centres Innovative contact tracing methods developed.	Increased proportion of index cases treated within recommended timeframes. Increased proportion of identified contacts tested and treated.	% of index cases treated within 7 days of diagnosis. % of identified contacts tested and treated within 14 days	NT Health, NT PHN, ACCHS, NGOs.	Medium term
4.9 Increase access to PoCT and ensure timely treatment for syphilis, including same-day treatment where possible.	Expanded availability of PoCT across NTG services, ACCHS, and general practices. Staff trained and accredited to deliver PoCT and same-day treatment. Clinical protocols and standing orders updated to support immediate treatment following reactive PoCT after discussions with syphilis register	Reduced time between testing and treatment initiation. Increased number of people receiving same-day treatment for syphilis. Reduced loss to follow-up in remote and mobile populations.	Number of health services (NT government, ACCHS, general practice) offering PoCT. Median time from testing to treatment initiation (measured via surveillance data).	NT Health, NT PHN, ACCHS, NGOs.	Medium term

Priority area for action 5: Equity and access

Actions	Outputs	Outcomes	Indicators	Partners	
5.1 Improve access to non-judgemental care by strengthened cultural competency in the SRH, and maternal health workforces. *Note: this action links back to 2.3 with the development of a Sexual Health Workforce Plan.*	Cultural safety training package.	Improved quality of care and removal of cultural barriers to access. Implementing cultural practices and protocols.	Evidence of knowledge shift from pre to post training. Number of training participants.	NT Health, CLEaRS, ACCHS, NT PHN, AMSANT.	Medium term
5.2 Syphilis response actions are tailored and co-designed in partnership with priority populations.	Co-design Policy for Building SRH Health Services for Aboriginal people.	Co-design carried out on key elements throughout this plan.	Feedback from sector partners.	NT Health, ACCHS, AMSANT, NGOs.	Ongoing
5.3 Support the enhancement of culturally safe birthing services Note: NT Health supports the application of the RISE Framework in any system or service reform, acknowledging the right to birth on country.	Collaborative work with antenatal services supporting Aboriginal women.	Increased engagement of Aboriginal women into syphilis testing.	Number of congenital syphilis cases per year.	NT Health (including CDC, NT Syphilis Register, Perinatal Data Registry, OCNMO), ACCHS, MWI.	Ongoing
5.4. Promote free STI testing (including syphilis testing) through Clinic 34, including for people who are ineligible for Medicare rebates.	Engagement with multicultural NGOs, NT PHN and ACCHS. Free STI testing.	Greater access for people who are ineligible for Medicare.	Number of tests provided for people who are ineligible for Medicare.	NT Health, NGOs including multi-cultural NGOs.	Short term

Actions	Outputs	Outcomes	Indicators	Partners	🕘
5.5 In partnership with community/peer led advocacy organisations, continue to identify and progress improved policy and legal reform in the areas of: geographic and financial access, cultural and structural barriers, stigma and discrimination. *Note: this might include supporting affirmative consent laws, furthering sex worker rights, and challenging spitting legislation. May also include workforce issues such as standing medication orders, pathology or imaging requests, MBS item numbers and scope of practice for non-medical practitioners.*	NT SRH Services Review (including policy and legal barriers).	Remove policy and legal barriers to eliminating the outbreak.	Progress report by topic.	NT Health, NGOs.	Ongoing

Priority area for action 6: Data surveillance, research and evaluation

Actions	Outputs	Outcomes	Indicators	Partners	
6.1. In partnership with ACCHS, and other primary health services to consider all options to strengthen capacity (training, systems and human resources) for surveillance, complex case management and contact tracing (including sexual partner notification) to reduce time from diagnosis to effective treatment. *Note: to include strategies to overcome confidentiality concerns in smaller rural and remote communities.*	Contact tracing and sexual partner notification training. Aboriginal Health Practitioners incorporated into partner notification.	Expanded contact tracing in partnership with ACCHS, primary health services. Enhanced syphilis register capacity.	Time to testing for sexual partners. Time between testing and treatment for sexual partners. Proportion of syphilis outbreak cases (<2 years infectious syphilis & Aboriginal person) who have named ≥1 contact/s.	NT Health, ACCHS, GPs, NT PHN, AMSANT.	Ongoing
6.2. Work with ACCHS and pathology providers to improve the ability to report positivity data in community including antenatal care.	Enhanced reporting from pathology providers. Advocate for the inclusion of syphilis testing on the national perinatal data collection	More timely and complete data available for public health decision making.	Completeness of NT Syphilis Action Plan indicator reporting.	NT Health, ACCHS, MWI, Pathology Services.	Short term
6.3. Implement the recommendations of the NT Aggregate Review of Congenital Syphilis 2013-2023.	Public health reviews. Updates to relevant clinical and public health guidelines (as required). Syphilis Register operators alerting Sexual Health Coordinators, so they are all aware of cases across the regions. Sexual Health Coordinators meeting regularly across the region. Routine dissemination of findings by CDC at the health centre level.	Awareness of findings at the health centre level.	Number of congenital syphilis cases.	NT Health (including CDC), ACCHS, GPs, NT PHN, AMSANT, SHAC.	Short term

Actions	Outputs	Outcomes	Indicators	Partners	
6.4 Re-design the syphilis register.	Develop a business case to update the syphilis register to enable real-time treatment and reporting.	Syphilis surveillance system is strengthened to support clinicians, coordinators and public health policy makers. Better access to timely information to support treatment and clinical decision making. Enhanced reporting from the syphilis register.	Real-time or close to real-time reporting of cases, treatment, testing and contact tracing. Time between testing and treatment for all cases.	NT Health.	Short term
6.5 Strengthen syphilis register functions and cross-border coordination/communication.	Additional 1 FTE Syphilis Register clinical nurse specialist.	Better support for planning and surveillance functions.	Achievement of plan.	NT Health.	Short term
6.6 Ensure timely monitoring and evaluation of this plan.	NT Syphilis Action Plan Monitoring Framework. Regular NT Syphilis Action Plan progress reporting. Regular NT Action Plan updates to key partners in the achievement of the plan.	Improved co-design, and continuous improvement of the NT response.	Achievement of plan.	NT Health.	Short term and ongoing

Appendices

Appendix 1: Stakeholders list

Name	Role and Organisation
Aayushma Wagle	Health Services Coordinator, Melaleuca Refugee Centre
Amanda Holt	Teaching and Learning Advisor, Respectful Relationships Education, Department of Education and Training
Amy McGregor	Family Support Worker, Danila Dilba Health Service
Anna Lewin	Anglicare, NT
Anthony Beven	Acting CEO, AMSANT
Barbara Molanus	Sexual Health Coordinator, Aboriginal Medical Services Alliance NT
Belinda Hengel	Research Fellow, Surveillance, Evaluation & Research Program, Kirby Institute, UNSW
Chelsea Jennings	STIBBV Capacity Builder, Danila Dilba Health Service
Claire Boardman	Executive Manager, Health Workforce & Primary Care Support, NT PHN
Craig Castillion	Principal Policy Officer, Aboriginal Health, Engagement and Workforce Division, NT Health
Daniel Williams	Health Coordinator, Tennant Creek, NT Health
Dr Danielle Martorana	Public Health Registrar, Aboriginal Medical Services Alliance NT
Darren Braun	Aboriginal Health Practitioner/Senior Project Officer, Aboriginal Health, Engagement and Workforce Division, NT Health
Dawn Casey	Director Communicable Diseases, National Aboriginal Community Controlled Health Organisation, ACT
Dean Neishner	Senior Aboriginal Health Practitioner, Bagot Community Clinic, NT
Demian Coates	CEO, Central Australian Aboriginal Alcohol Programmes Unit
Denise Durston	Senior Advisor, Operational Policy and Strategic Programs, Student Wellbeing and Inclusion Programs and Services, Department of Education and Training
Donna Ah Chee	CEO, Central Australian Aboriginal Congress
Elizabeth Coombes	Specialist Aboriginal Health Practitioner, NT Health
Erin Lew Fatt	CEO, Red Lily Health Board
Erin O'Connor	Principal Policy Officer, Sexual Health and Blood Borne Viruses Policy and Strategy, Public Health Division, NT Health
Genevieve Dally	Executive Director, Northern Territory AIDS and Hepatitis Council
Glenda Abraham	CEO Laynhapuy Homelands Aboriginal Corporation
Dr Hayley Dyke	Head of Surveillance and Response, NT Health
Prof James Ward	Director, Poche Centre for Indigenous Health, University of Queensland

Prof Jane Davies	Co-Director and Specialist of Infectious Diseases, NT Health, and Menzies School of Health Research
Janelle Collins	CEO, Anyinginyi Health Aboriginal Corporation
Jerry Chen	Epidemiologist and Surveillance Officer, NT Health
Jess Jarrett-Wright	Syphilis Outbreak Incident Management Team Planning Lead, Public Health Division, NT Health
Jo-ann Adams	Senior Aboriginal Health Promotion Officer, Healthy Families Team
Johanna Waide	Communications Manager, NT Health
John Ah Mat	Director, Aboriginal Health Policy, Aboriginal Health, Engagement and Workforce Division, NT Health
Dr John Boffa	Chief Medical Officer Public Health, Central Australian Aboriginal Congress
John Kaldor	Senior Principal Research Fellow, Kirby Institute, UNSW
Julie Cook	Aboriginal Health Promotion Officer, Katherine Outreach Team
Karly Ahfat	Sexual Health Coordinator, Sunrise Health Service
Kat Byron	Health Promotion Manager, Sexual Health and Blood Borne Virus Unit, NT Health
Kay Simes	Community Engagement, Remote Sexual Health, CDC, NT Health
Kaye Shipard	District Manager, Prison Health, Central Australia Health Service
Assoc Prof Kayli Wild	Medical Anthropologist & Health Systems Researcher, Molly Wardaguga Institute for First Nations Birth Rights
Dr Kelly Hosking	Director, Sexual Health and Blood Borne Viruses Policy and Strategy, Public Health Division, NT Health
Kim Nicole Gorey	Emergency Department Aboriginal Care Coordinator, Aboriginal Support Services
Lauren Pike	Director, Strategic Media, Marketing & Communications, NT Health
Leander Menezes	CEO, Pintupi Homelands Health Service
Assoc Prof Lisa Vermeulen	Director of Nursing & Midwifery, Population & Primary Health Care, Top End Region, NT Health
Dr Liz Moore	Public Health Medical Officer, Aboriginal Medical Services Alliance NT
Mandy Charlton	Director, STI Section, Communicable Diseases Branch, Australian Centre for Disease Control
Dr Manoji Gunathilake	Head of Sexual Health and Blood Borne Viruses Unit & Senior Staff Specialist – Sexual Health Medicine, NT Health
Mary-Clare Arkoll	Regional Executive Director, East Arnhem Region, NT Health
Megan Campbell	Medical Advisor, National Aboriginal Community Controlled Health Organisation
Megan Munckton	Aboriginal Health Practitioner, Urban and Outreach, Barkly Region, NT Health
Melissa Hinson	CEO, Urapuntja Health Service
Michelle Nuske	Pathways to Community Control Manager, Aboriginal Health, Engagement and Workforce Division, NT Health
Michelle Stacey	CEO, Ampilatwatja Health Centre Aboriginal Corporation
Morris Gitonga Ndwiga	Clinical Nurse Specialist, Remote Sexual Health Program, NT Health

Natasha Tatipata	Aboriginal Health Practitioner, Sexual Health and Blood Borne Viruses Unit, Centre for Disease Control, NT Health
Nathan Rosas	Acting CEO, Wurli Wurlinjang Health Service
Nerida Grant	Nurse Management Coordinator, Central Australia Remote Sexual Health, NT Health
Nicola Fabok	Operations Manager, Sexual Health and Blood Borne Virus Unit, Centre for Disease Control, NT Health
Nicola Hunter	Director of Emergency Management, Office of Emergency Management, NT Health
Nicole Carter	Chief Medical Officer, Danila Dilba Health Service
Nicole Kim	Assistant Director, Corporate Strategy, Australian Department of Health, Disability and Ageing
Nicole Stephens	Chief Executive Officer, Family Planning Welfare Association NT
Adj Prof Paul Burgess	Chief Health Officer, NT Health
Paul Van Polanen	Sexual Health Coordinator, Miwatj Health Aboriginal Corporation
Peter Solly	CEO, Marthakal Homelands Resource Centre
Priscilla Moore	General Manager, Palmerston Regional Hospital, NT Health
Raenae Reeves	Aboriginal Health Practitioner Coordinator, Katherine Outreach Team, NT Health
Dr Rajendra Pillay	Regional Director of Medical Services, Gove District Hospital, NT Health
Ray Matthews	CEO, Mala'la Health Service Aboriginal Corporation
Raymond Da Costa	Aboriginal Trainee, Batchelor Primary Health Care Centre, NT Health
Rebecca Bond	CEO, Sunrise Health Service Aboriginal Corporation
Rebecca Cooney	Senior Prevention and Population Health Advisor, Katherine West Health Board.
Rebecca Piper	Nurse Management Coordinator, Barkly Centre for Disease Control, NT Health
Rob McPhee	Chief Executive Officer, Danila Dilba Health Service
Roisin Steward	Sexual Health Coordinator, Central Australian Aboriginal Congress
Roy Farmer	Student Aboriginal Health Practitioner, NT Health
Rus Nasir	Principal Policy Officer, NT Health
Samara Hanley	Executive Director, Aboriginal Health, Engagement and Workforce Division, NT Health
Sarah Betts	Senior Policy Officer, Sexual Health and Blood Borne Viruses Policy and Strategy, Public Health Division, NT Health
Sarsha Sheriff	Syphilis Outbreak IMT Support Officer, Sexual Health and Blood Borne Viruses Policy and Strategy, NT Health
Scott McKeen	CEO, Council for Aboriginal Alcohol Program Services
Sharni Braun	Aboriginal Health Practitioner, Anyinginyi Health Aboriginal Corporation
Shiraline Wurrawilya	Aboriginal Health Practitioner, Top End Region Primary and Preventative Health Care, NT Health
Simone Grimmond	CEO, Warnumamalya Health Services Aboriginal Corporation

Sinon Cooney	CEO, Katherine West Health Board
Steve Rossingh	CEO, Miwatj Health Aboriginal Corporation
Susannah O'Brien	Principal Policy Officer, Sexual Health and Blood Borne Viruses Policy and Strategy, Public Health Division, NT Health
Tawhio McKay	Specialist Aboriginal Health Practitioner, Anyinginyi Health Aboriginal Corporation
Teio Tapera	Aboriginal Student Cadet, NT Health
Teresa De Santis	Aboriginal Health Practitioner, Population and Primary Care, NT Health
Dr Vicki Krause	Executive Director, Communicable Diseases, NT Health
Walbira Murray	Cultural Liaison and Development Manager
Prof Yu Gao	Professor of Health Service Redesign, Deputy Director of Data and Integrity, Molly Wardaguga Institute for First Nations Birth Rights, Charles Darwin University
Prof Yvette Roe	Co-Director, Molly Wardaguga Institute for First Nations Birth Rights, Charles Darwin University

Appendix 2: Monitoring framework

Indicators	Target by 2030	Baseline 2024	Data source/comments
Priority area for action 1: Integrated primary care			
Number of congenital syphilis cases	Zero	11 since 2013	See testing indicators below
Number of tests performed in primary care	n/a	n/a	See testing indicators below
Number of patients treated in primary care	n/a	n/a	See testing indicators below
Number of testing and treatment points in all areas (including urban outreach)	n/a	n/a	See testing indicators below
Number of free tests performed	n/a	n/a	See testing indicators below
Number of anonymous tests performed	n/a	n/a	See testing indicators below
Priority area for action 2: Workforce development			
Total number of training participants (all professions)	5,600	n/a	New data – Relating to Syphilis Training Package
Characteristics of training participants (profession, service, course)	n/a	n/a	New data – Relating to Syphilis Training Package
Sample of participant pre and post test results (profession, service, course)	10%	n/a	New data – Relating to Syphilis Training Package
Sample of free text participant feedback (where available)	n/a	n/a	New data – Relating to Syphilis Training Package
Number of Aboriginal people in the SRH (including health promotion) workforce	n/a	n/a	New data – related to a NT Sexual Health Workforce Plan.
Supported professional and individual scope of practice of AHP by non-Aboriginal workforce	n/a	n/a	New data - related to a NT Sexual Health Workforce Plan. (narrative brief)
Priority area for action 3: Education and awareness			
Campaign and promotion metrics (reach, views, engagement, targeting, landing page results)	n/a	n/a	New data – relating to any NT Health communications.
Community Education reach and engagement	n/a	n/a	New data – to be developed.
Improving syphilis education in schools	n/a	n/a	New data – relating to Review of CSE in NT.
Number of schools engaging in CSE programs by location	n/a	n/a	New data – relating to Education Strategy
Priority area for action 4: Prevention, testing and treatment			
Prevention			
Number of free condom access points promoted	n/a	86	NT Health website nt.gov.au/wellbeing/sexual-health/free-condoms

Indicators	Target by 2030	Baseline 2024	Data source/comments
Number of free condoms distributed	n/a	Estimated 140,000	New data – NT government procurement reporting.
Co-design principles followed	n/a	n/a	New data (brief narrative, comparing against the Lowitja Institute Critical Review, Co-design vs Faux Design, principles informed by NGOs and AHF)
Testing and treatment			
Total number of syphilis tests performed in NT	80% of all people in NT	n/a	NT Health working with pathology providers to obtain data. Modelling suggests at least 60% coverage required to meet pre-outbreak notification levels.
Characteristics of people testing for syphilis (sex, region, age ranges 0-10, 11-15, 16-25, 26-35, 36-45, 46-55, 56+)	n/a	n/a	NT Health working with pathology providers to obtain data. Future consideration to be given to additional characteristics including pregnancy status, Aboriginal person, men who have sex with men, health care setting (e.g. primary care, acute care, antenatal care)
Ongoing, yearly full STI screen to targeted groups; 6 monthly best practice for 15-24 year olds	80% of 15-24 year olds (twice yearly) 80% 25-35 year olds (yearly)	n/a	NT Health considering ways to access this data
Characteristics of people testing for full STI screen (sex, region, age ranges 0-10, 11-15, 16-25, 26-35, 36-45, 46-55, 56+).	n/a	n/a	NT Health considering ways to access this data. Future consideration to be given to additional characteristics including Aboriginal people, men who have sex with men, pregnancy status
Number of testing points promoted in NT	n/a	16	NT Health website nt.gov.au/wellbeing/sexual-health/find-sexual-health-services
Number of testing and treatment points outside the urban area	n/a	13	NT Health website nt.gov.au/wellbeing/sexual-health/find-sexual-health-services
Number of free tests performed (including for people who are Medicare ineligible)	n/a	n/a	New data – subject to collaboration with primary health care sector
Number of anonymous tests performed including for people who are Medicare ineligible)	n/a	n/a	New data – subject to collaboration with primary health care sector
% of 715 health checks that include syphilis/STI testing.	n/a	n/a	New data – subject to collaboration with the primary health care sector
Syphilis testing and management in pregnancy			
Proportion of pregnant women who received all 5 syphilis tests by sector. *	100%	n/a	NT Health working with pathology providers to obtain data. Future consideration to be given to additional characteristics including pregnancy

Indicators	Target by 2030	Baseline 2024	Data source/comments
**noting some people may experience pregnancy loss or premature birth*			status, Aboriginal person, men who have sex with men, health care setting (e.g. primary care, acute care, antenatal care)
Proportion of sexual partners of people tested for syphilis in pregnancy	100%	n/a	See Syphilis testing and management in pregnancy indicators above.
Total number of cases of syphilis in pregnancy	n/a	186	New data subject to NT Health Syphilis Register enhancements
Total number of congenital syphilis cases	Zero	11	NT Syphilis Register
Total number of cases of syphilis in pregnancy managed and followed up within 48 hours	n/a	n/a	New data subject to NT Health Syphilis Register enhancements
Total number of cases of syphilis treated and preventing congenital syphilis	100%	95%	NT Syphilis Register - yet to be published.
% of cases of syphilis in pregnancy managed and followed up within 48 hours	100%	n/a	New data subject to NT Health Syphilis Register enhancements
% of sexual partners of pregnant women tested and treated	100%	n/a	New data
Syphilis treatment			
Number of infectious cases treated within 14 days of a positive result	100%	n/a	New data - subject to NT Health Syphilis Register enhancements
Number of symptomatic people treated immediately	100%	n/a	New data - subject to NT Health Syphilis Register enhancements
Time between testing and treatment for all cases	n/a	n/a	New data - subject to NT Health Syphilis Register enhancements
Proportion of women engaged in antenatal care, by trimester	n/a	n/a	Existing data - NT Perinatal Register
Priority area for action 5: Equity and access			
Total number of training participants (all professions)	n/a	n/a	New data – Relating to Cultural Safety Training Package
Characteristics of training participants (profession, service, course)	n/a	n/a	New data – Relating to Cultural Safety Training Package
Sample of participant pre and post test results (profession, service, course)	n/a	n/a	New data – Relating to Cultural Safety Training Package
Sample of free text participant feedback (where available)	n/a	n/a	New data – Relating to Cultural Safety Training Package
Improving policy and legal pathways to progress	n/a	n/a	New data (narrative progress brief informed by NGOs)
Priority area for action 6: Data surveillance, research and evaluation			
Notifications			

Indicators	Target by 2030	Baseline 2024	Data source/comments
Total number of syphilis notifications in NT per annum	<10	249	Existing data - from the NT Notifiable Diseases System.
Characteristics of notifications for syphilis (sex, region, Aboriginal, pregnancy status, age ranges 0-10, 11-15, 16-25, 26-35, 36-45, 46-55, 56+)	n/a	n/a	Existing data - from the NT Notifiable Diseases System. Future consideration to be given to additional characteristics such as men who have sex with men.
Proportion of syphilis outbreak cases < 2 years infectious syphilis and Aboriginal person, who have named ≥1 contact.	n/a	n/a	New data - subject to NT Health Syphilis Register enhancements
Real-time or close to real-time reporting	n/a	n/a	New data subject to NT Health Syphilis Register enhancements (narrative brief)
Contact tracing			
Total named contacts	n/a	n/a	New data - subject to NT Health Syphilis Register enhancements
Total named contacts tested at their first visit	n/a	n/a	New data - subject to NT Health Syphilis Register enhancements
Total named contacts treated at their first visit	n/a	n/a	New data - subject to NT Health Syphilis Register enhancements
% of named contacts tested at their first visit	100%	n/a	New data - subject to NT Health Syphilis Register enhancements
% of named contacts treated immediately	100%	n/a	New data - subject to NT Health Syphilis Register enhancements
Number of ED cases lost to follow-up	n/a	n/a	New data - Subject to the establishment of additional syphilis liaison roles in ED
Evaluation			
Summary of achievements	n/a	n/a	NT Syphilis Action Plan Evaluation Report. This would be a summary of regular Progress Reporting to the NT Sexual Health Advisory Committee plus a short narrative on learnings with recommendations. National and comparative data may be considered as part of this report include sources such as: • Australian Survey of Secondary Students and Sexual Health 2024 (iterative every 5 years) • Kirby Institute Annual Surveillance Reports • Current research.

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