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NOTIFIABLE DISEASES IN NEW ZEALAND ANNUAL REPORT 2025

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SUMMARY

This report provides a summary of the key trends in notifiable diseases for 2025.

In 2025, a total of 44,195 notifications were reported through New Zealand's notifiable disease database, EpiSurv, compared with 179,234 in 2024. COVID-19 accounted for 60.7% of notifications or 26,817 cases in 2025, compared with 91.3% of notifications in 2024. Excluding COVID-19, there were 17,378 notifications in 2025 and 15,516 in 2024.

Notifications of the following diseases increased significantly from 2024 to 2025: dengue fever, malaria, measles, mpox, pertussis and salmonellosis (Table 1). Notifications of COVID-19 and cryptosporidiosis decreased significantly.

VACCINE-PREVENTABLE DISEASES

There were significant increases in measles and pertussis from 2024 to 2025. There were 58 cases of measles notified in 2025, compared with one case in 2024. The majority (95%, 55 cases) were associated with three outbreaks resulting from separate importations. Notification rates were highest for those aged 10–14 years (2.9 per 100,000) and 15–19 years (2.5 per 100,000). Ten cases were fully immunised with two vaccine doses.

There were 2678 pertussis cases (50.3 per 100,000) notified in 2025, compared with 1745 cases (33.0 per 100,000) in 2024. Infants aged less than 1 year (426.5 per 100,000) had the highest notification rate and almost half (49%) of cases aged less than 1 year were hospitalised.

ENTERIC DISEASES

There was a significant increase from 2024 to 2025 for salmonellosis. There were 1104 cases (20.7 per 100,000) in 2025, compared with 844 (16.0 per 100,000) in 2024. The number of salmonellosis notifications in 2025 is similar to pre-COVID-19 pandemic levels. Infants aged less than 1 year (107.5 per 100,000) had the highest notification rate. Overseas travel and consumption of food from retail premises were the most common risk factors reported for salmonellosis.

There was a significant decrease in cryptosporidiosis. There were 870 cases (16.3 per 100,000) notified in 2025, compared with 1234 cases (23.3 per 100,000) in 2024. Contact with farm animals was the most common risk factor reported for cryptosporidiosis.

RESPIRATORY DISEASES

There was a significant decrease in COVID-19 notifications in 2025, with 26,817 cases (504 per 100,000) notified, compared with 163,758 cases (3096 per 100,000) in 2024. Adults aged 70 years and over had the highest notification rate (1062 per 100,000). Hospitalisations and deaths are no longer recorded in EpiSurv.

VECTOR-BORNE DISEASES

There were significant increases in dengue fever and malaria notifications in 2025. There were 432 cases (8.1 per 100,000) of dengue fever notified in 2025, compared with 124 cases (2.3 per 100,000) in 2024. The countries most commonly visited were Samoa (128 cases), the Cook Islands (108 cases) and Fiji (90 cases).

There were 48 cases (0.9 per 100,000) of malaria in 2025, compared with 29 cases (0.5 per 100,000) in 2024. The majority (66.7%, 32 cases) had been in the Solomon Islands.

OTHER DISEASES

There was a significant increase in mpox notifications in 2025 with 41 cases notified, compared with 23 cases in 2024. The majority (95%) were men who have sex with men and 85% of cases were acquired locally.

Table 1. Number of cases and rate per 100,000 population for selected notifiable diseases in New Zealand, 2024 and 2025

Disease	Number of notifications		Rate per 100,000		Change[a,b]
	2024	2025	2024	2025	
Campylobacteriosis	5800	5816	109.6	109.2	↓
COVID-19	163758	26817	3095.6	503.6	↓
Cryptosporidiosis	1234	870	23.3	16.3	↓
Dengue fever	124	432	2.3	8.1	↑
Gastroenteritis (acute)[c]	435	477	8.2	9.0	↑
Giardiasis	844	865	16.0	16.2	↑
Hepatitis A	68	65	1.3	1.2	↓
Hepatitis B	12	15	0.2	0.3	↑
Hepatitis C	20	18	0.4	0.3	↓
Invasive group A streptococcal infection[d]		645		12.1	NA
Invasive pneumococcal disease	718	720	13.6	13.5	↓
Legionellosis	181	168	3.4	3.2	↓
Leptospirosis	102	77	1.9	1.4	↓
Listeriosis	36	41	0.7	0.8	↑
Malaria	29	48	0.5	0.9	↑
Measles	1	58		1.1	↑
Meningococcal disease	43	41	0.8	0.8	NC
Mpox	23	41	0.4	0.8	↑
Mumps	19	19	0.4	0.4	NC
Paratyphoid fever	14	11	0.3	0.2	↓
Pertussis	1745	2678	33.0	50.3	↑
Rheumatic fever[e]	207	207	3.9	3.9	NC
Salmonellosis	844	1104	16.0	20.7	↑
Shigellosis	157	175	3.0	3.3	↑
STEC infection	1112	1191	21.0	22.4	↑
Tuberculosis disease	360	383	6.8	7.2	↑
Typhoid fever	62	50	1.2	0.9	↓
Yersiniosis	1140	1112	21.6	20.9	↓

[a] ↓↓= significant decrease, ↑ = significant increase, ↓ = non-significant decrease, ↑ = non-significant increase. NC=no change

[b] Fisher's exact tests were used to determine statistical significance. Results are considered statistically significant when $P \leq 0.05$.

[c] Cases of acute gastroenteritis from a common source or person in a high-risk category (eg food handler or childcare worker) or foodborne intoxication, eg, staphylococcal intoxication.

[d] Invasive group A streptococcal infection became notifiable on 1 October 2024.

[e] Includes rheumatic fever initial episodes and recurrent cases.

INTRODUCTION

The *Notifiable Diseases in New Zealand: Annual Report 2025* gives an overview of the state of notifiable diseases in New Zealand in 2025. The report includes diseases that are notifiable under the Health Act 1956.

The data presented is from surveillance systems operated by the New Zealand Institute for Public Health and Forensic Science (PHF Science) and from other organisations in New Zealand.

Surveillance is "the ongoing systematic collection, analysis and interpretation of outcome-specific data for use in the planning, implementation and evaluation of public health practice".[1] A surveillance system "includes the functional capacity for data collection and analysis, as well as the timely dissemination of information derived from these data to enable effective prevention and control activities".[2]

Surveillance provides *information for action*. Specific objectives for disease surveillance may include the following:[3]

- to identify cases of disease that require immediate public health control measures;
- to monitor disease incidence and distribution and alert health workers to changes in disease activity in their area;
- to identify outbreaks and support their effective management;
- to assess disease impact and help set priorities for prevention and control activities;
- to identify risk factors for disease to support development of effective prevention measures;
- to evaluate prevention and control activities;
- to identify and predict emerging hazards;
- to monitor changes in disease agents through laboratory testing;
- to generate and evaluate hypotheses about disease occurrence;
- to fulfil statutory and international reporting requirements.

Details about the individual surveillance systems are provided in the 'Surveillance Methods' section of this report.

The report focuses on diseases notified in 2025. The report presents each notifiable disease, or disease grouping, in alphabetical order.

National data and trends over time are shown in summary tables in the Appendix. Data is also presented for specific population groups including by health district, sex, age group and ethnic group.

Information on respiratory illness and sexually transmitted infections can be found in separate reports on the PHF Science website.

SURVEILLANCE METHODS

INTERPRETING DATA

Data in this report is presented by the date the case was reported to a public health service (PHS) and not by the date of the onset of illness. In general, cases are allocated to geographic location based on where a medical practitioner first diagnosed them.

Notifiable disease data in this report may differ from that published in other reports depending on:

- the date of data extraction from EpiSurv;
- the date used to aggregate data (eg, the date reported or date of onset of illness);
- whether laboratory-reported cases, notified cases or self-reported cases are used;
- whether the case has been confirmed by laboratory tests.

The information in this report shows disease trends by age group, sex, ethnic group and health district.

It should be noted that various factors influence disease notification and therefore the calculation of incidence rates. Where the illness is not severe, cases are less likely to consult a medical practitioner and, even if diagnosed, are less likely to be notified without laboratory confirmation.[4] Issues associated with the cost of and access to healthcare may also determine whether people visit healthcare providers for diagnosis.[5] Public awareness of the disease, case definitions and the resources and priorities of local healthcare services are other factors that affect disease notification rates.

This report presents the number of cases and population rates for different ethnic groups. However, caution should be exercised in the interpretation of these numbers as ethnicity information is not always provided, different ethnic groups have different patterns of access to healthcare, and the numbers may not accurately reflect the true burden of disease in the population.

For different ethnic groups, numbers and disease rates are based on a prioritised classification of ethnicity, with the Māori ethnic group prioritised first, followed by Pacific peoples, Asian, and European or Other (including New Zealander) ethnic groups. A disadvantage of using prioritised ethnicity is that people who identify with more than one ethnic group can be placed into a group they may not self-identify with. Furthermore, prioritisation undercounts non-Māori ethnic groups. This has been found to be most significant for Pacific peoples.[6] This undercount may generate an age-related bias, as the reporting of multiple ethnic groups is more common in younger age groups.[7].

The small New Zealand population and the low number of cases for some diseases mean that the disease rates calculated in this report may be highly variable from year to year. As such, it is necessary to interpret trends with caution. The ‘Analytical Methods’ section contains more information about the calculation of population rates for diseases.

DATA SOURCES

The key sources of data used in this report are described below.

EpiSurv – the national notifiable disease surveillance system

Under the Health Act 1956, health professionals are required to inform their local medical officer of health of any notifiable disease that they suspect or diagnose. Since December 2007, diagnostic laboratories have also been required to report notifiable diseases to medical officers of health. These notifications provide the basis for surveillance, and therefore control, of these diseases in New Zealand.

Notification data is entered by PHS staff via a secure web-based portal into a database (EpiSurv). PHF Science collates and analyses the near real-time data on behalf of the Ministry of Health. The data collected depends on the specific disease, but usually includes demography, outcome, basis of diagnosis, risk factors and some case and contact management information. Data in EpiSurv dates back to January 1997. For the current schedule of notifiable diseases see Schedule 1 Part 1 of the Health Act 1956.

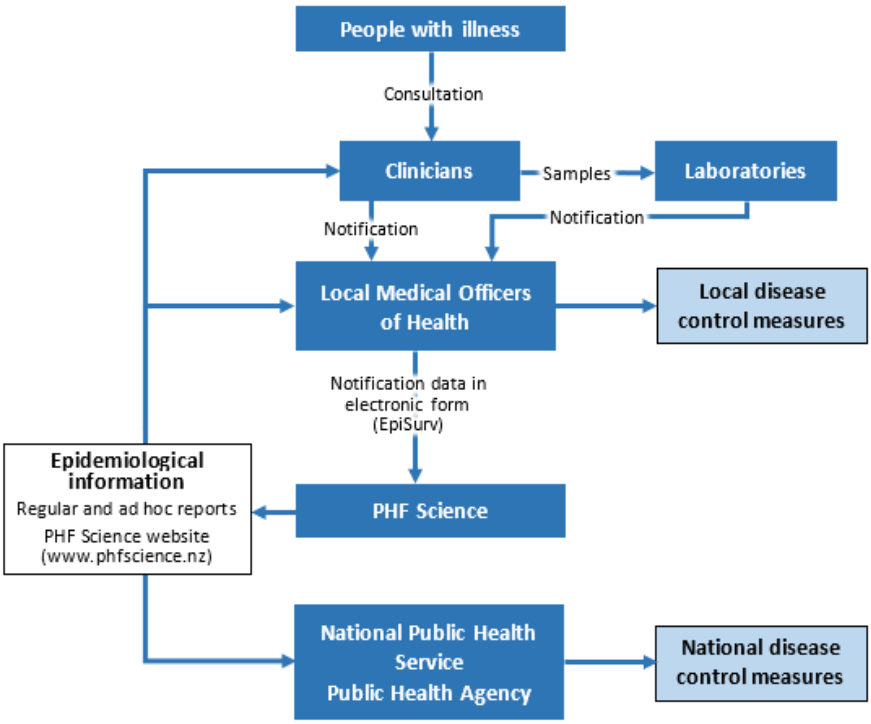
This report includes sections on diseases that are currently notifiable in New Zealand under the Health Act 1956, excluding AIDS, gonorrhoea, HIV, syphilis, lead absorption and poisoning arising from chemical contamination of the environment. Sexually transmitted infections are reported elsewhere, while Massey University's Centre for Public Health Research is responsible for the collection and reporting of surveillance data on lead absorption and poisoning arising from chemical contamination of the environment.

Case definitions (including laboratory and clinical criteria) for notification of diseases and/or conditions are in the latest version of the Communicable Disease Control Manual.[8]

Information on trigger points for notification of a laboratory test result is in Appendix 4 of the Communicable Disease Control Manual.[8]

Figure 1 illustrates the major components and information flow of the notifiable disease surveillance system. Since July 2022, provision of public health services has been the responsibility of Health New Zealand.

Figure 1. Notifiable disease surveillance system



Laboratory-based surveillance

Laboratory results for all organisms that meet the laboratory criteria for notification are reported directly to medical officers of health. After further testing at a reference laboratory, some reported cases may not meet the laboratory criteria of the surveillance case definition. Laboratory-reported cases may also not meet the clinical criteria of the case definition. For this reason, the number of laboratory-reported cases may not match the number of notified cases for some diseases.

Laboratory-based surveillance may be conducted to enhance data gathered by notifiable disease surveillance. Organisms under laboratory-based surveillance include *Legionella* spp., *Leptospira* spp, *Neisseria meningitidis*, *Salmonella* spp. and invasive *Streptococcus pneumoniae*. For these organisms, isolates are referred to a reference laboratory for confirmation and typing.

Statistics New Zealand

Statistics New Zealand provides the denominator data used to calculate the population rates of disease. Further details are provided in the 'Analytical Methods' section.

National Minimum Dataset

Health New Zealand collates national data on patients discharged from publicly funded hospitals. This data is stored as part of the National Minimum Dataset (NMDS) (see www.healthnz.govt.nz for more information). Upon discharge, patients are assigned disease codes using the 10th revision of the International Classification of Diseases (ICD10) coding system.[9] Information provided in this report uses the principal or primary diagnosis, which is the condition that was chiefly responsible for the hospital admission. This may be different from the diagnoses for the patient on admission, while in hospital, or from the final diagnosis after discharge.

Anonymised data for selected diseases was extracted from the NMDS and sent to PHF Science for analysis and comparison with data from other surveillance systems.

Hospital discharge data presented in this report includes multiple records for patients with chronic notifiable diseases (eg, tuberculosis), for diseases that have long-term health impacts (eg, meningococcal disease) and may include re-admissions for acute diseases (eg, pertussis). For some diseases, the criteria for notification (clinical and laboratory or epidemiological evidence) do not match those required for diagnostic coding. For these reasons, the NMDS and EpiSurv hospitalisation numbers may differ.

EpiSurv uses the same definition for hospitalisations as the NMDS: healthcare users who receive assessment and/or treatment for three hours or more (excluding time in a waiting room and triage), or who have a general anaesthetic.

New Zealand Creutzfeldt-Jakob Disease Registry

The New Zealand Creutzfeldt-Jakob disease (CJD) Registry (the Registry), at the University of Otago was established in 1996 to monitor sporadic, familial, iatrogenic and variant CJD. A medical practitioner must immediately report any suspected cases of CJD directly to the Registry as well as inform the local Medical Officer of Health. Any cases suspected of being iatrogenic or variant CJD are also notified to the Director of Public Health at the Ministry of Health.[8]

New Zealand Paediatric Surveillance Unit

The New Zealand Paediatric Surveillance Unit (NZPSU) [10] was established in 1997 to provide active surveillance of acute flaccid paralysis (AFP) to fulfil World Health Organization (WHO) requirements for the certification of polio eradication. Since then, other conditions have been added for surveillance by the NZPSU. Conditions currently under surveillance include acute hepatitis, congenital rubella syndrome (CRS), haemolytic uraemic syndrome (HUS), and perinatal exposure to syphilis and human immunodeficiency virus (HIV) (see https://www.otago.ac.nz/nzpsu for a complete list).

Every month, participating paediatricians and other specialists in paediatric practice are sent an email with a linked REDCap survey to report whether they have seen any children with the conditions under surveillance in the previous month. In 2024, there were between 262 and 289 clinicians participating in the surveillance programme with an average monthly response rate of 73%.[11] The NZPSU then collates and analyses the data. Information from the NZPSU is used in this report to enhance notification data on polio (AFP data) and rubella (CRS data).

ANALYTICAL METHODS

Key analytical methods are provided below.

Dates

The notification data contained in this report is based on information recorded on EpiSurv as at 20 February 2026. Changes made to EpiSurv data by PHS staff after this date are largely not reflected in this report. Consequently, future analyses of data may produce revised results. Notification data from previous years has been updated to reflect cases in EpiSurv as at 20 February 2026.

Disease numbers are reported according to the date of notification. Laboratory results are reported according to the date the specimen was received.

Geographic breakdown

This report provides rates for health districts. The health district populations used are shown in Table 2. These are from the Statistics New Zealand 2025 mid-year population estimates.

Table 2. Health district populations, 2025

Health district	Population
Northland	201100
Waitemata	683900
Auckland	506000
Counties Manukau	653200
Waikato	466900
Lakes	120700
Bay of Plenty	277500
Tairawhiti	52700
Taranaki	130400
Hawke’s Bay	179600
Whanganui	70000
MidCentral	192200
Capital, Coast and Hutt Valley	481600
Wairarapa	51400
Nelson Marlborough	165000
West Coast	34700
Canterbury	633400
South Canterbury	63400
Southern	360800
Total	**5324700**

Map classification scheme

On the maps provided in this report, the darkest colour represents the highest disease notification rates, and the lightest colour represents the lowest rates. The dark grey colour shows where there was insufficient data (fewer than five cases) to calculate a rate.

Case classification for notifications

All notifications recorded in EpiSurv that meet the case definitions [8], apart from cases classified as 'not a case', are included for analysis in this report. In some instances, the investigation of a case may not be complete, and the classification may be set to 'under investigation'. Cases that are under investigation are included in this report. Any changes to the final case classification will be reflected in future surveillance reports.

Population rate calculations for diseases

The denominator data used to determine disease rates (except the data used to determine disease rates for ethnic groups) has been derived from the 2025 mid-year population estimates published by Statistics New Zealand.

Denominator data used to determine disease rates for ethnic groups is based on the proportion of people in each ethnic group from the 2018 'estimated resident population' applied to the 2025 mid-year population estimates from Statistics New Zealand. Ethnicity is prioritised in the following order: Māori, Pacific peoples, Asian, European or Other (including New Zealander) ethnic groups.

Rates are not calculated where a category has fewer than five notified cases. Calculating population rates from fewer than five cases produces unstable rates.

Percentages

Percentages are calculated using the total number of cases for which the information was known as the denominator, unless specified otherwise. Cases with 'unknown' information are excluded from the denominator. These percentages are usually presented with numbers in brackets that show the numerator and denominator used, eg, 49.3% (523/1061).

Risk factors and sources of infection

For many diseases, an analysis of exposure to risk factors for the cases is reported. These risk factors are those included in the current EpiSurv case report forms. More than one risk factor is often reported for each case. The reporting of exposure to a risk factor does not mean that this was the source of the infection.

Vaccination data

Data on vaccinations is reported for a number of vaccine-preventable diseases. This represents the vaccination status of the case as reported in EpiSurv and has not been routinely validated against the Aotearoa Immunisation Register.

Statistical tests

Fisher's exact tests were used to determine statistical significance. Results are considered to be statistically significant where $P \leq 0.05$.

LIMITATIONS OF SURVEILLANCE DATA

Quality

Quality assurance in the collection and reporting of notifiable disease data in EpiSurv is supported by validation at the time of data entry (eg, field validation, allowable values), regular (weekly, monthly, quarterly, annual) data quality reports run by PHF Science on key reporting fields and liaison with PHSs.

Sensitivity

Sensitivity is a measure of our ability to identify the true burden of disease. More common and less severe diseases, such as acute gastroenteritis, are significantly less likely to be notified than severe diseases such as meningococcal disease.[12, 13]

The introduction of new diagnostic methods can alter our ability to detect notifiable diseases over time. For example, diagnostic tests for enteric disease can now screen for multiple disease agents at the same time and increase their detection. Changes in test sensitivity should be considered when interpreting disease trends.

Completeness

The completeness of data recorded in EpiSurv varies among diseases. Table 3 shows the percentage of notifications for which complete data was provided for selected demographic variables from 2016 to 2025.

The completeness of date of birth, age and sex has remained very high (99%) over the past 10 years. The completeness of ethnicity data in 2025 (98.9%) was higher than in the previous three years but not as high as in 2019–2021.

Table 3. Completeness for selected EpiSurv variables, 2016–2025

Report year	Completeness of data (%)				
	Date of birth	Age	Sex	Ethnicity	NHI
2016	99.9	100.0	100.0	96.3	98.5
2017	99.9	99.9	100.0	96.5	98.6
2018	99.9	99.9	100.0	93.6	99.0
2019	99.9	99.9	100.0	99.2	99.0
2020	99.7	99.8	100.0	99.7	99.4
2021	99.8	99.9	100.0	99.6	99.9
2022	99.8	99.8	100.0	97.7	99.6
2023	99.8	99.8	100.0	96.3	99.7
2024	99.7	99.7	100.0	98.1	99.7
2025	99.7	99.7	100.0	98.9	99.8

Timeliness

Timely receipt of information is essential for appropriate public health investigation and action.

Table 4 shows a summary of the timeliness of notifications by disease for 2025.

In 2025, 62.1% of disease notifications (excluding COVID-19) had an onset date recorded, compared with 63.0% in 2024. Of these, 48.6% were reported to a PHS within one week of the onset of symptoms and 77.0% were reported within two weeks of the onset of symptoms.

For some diseases, reporting delays are related to the nature of the symptoms, leading to late presentation eg, giardiasis, pertussis, rheumatic fever, tuberculosis disease. For other diseases there may be delays in confirmation of the diagnosis due to the particular laboratory test required eg, leptospirosis.

In 2025, 86.9% (86.0% in 2024) of notifications were entered into EpiSurv within a day of being reported to a PHS and over 99% were entered within one week.

Table 4. Timeliness of disease reporting and data entry for selected notifiable diseases, 2025

Disease	Onset date recorded (%)	Reporting delay (%)[a]		Entry delay (%)[b]		
		≤1 week	≤2 weeks	≤1 day	≤1 week	≤2 weeks
Campylobacteriosis	40.1	59.5	88.8	84.8	99.1	99.9
Cryptosporidiosis	54.8	36.5	84.3	84.4	99.9	100.0
Dengue fever	91.4	55.4	86.8	94.0	100.0	100.0
Gastroenteritis (acute)[c]	81.6	61.7	88.2	89.1	99.0	99.2
Giardiasis	45.0	19.0	43.2	86.2	99.9	100.0
Hepatitis A	95.4	41.9	77.4	93.8	100.0	100.0
Invasive group A streptococcal infection	84.7	76.6	93.4	90.5	100.0	100.0
Invasive pneumococcal disease	79.7	68.6	89.9	89.0	99.7	99.9
Legionellosis	92.9	49.4	85.3	86.3	100.0	100.0
Leptospirosis	88.3	35.3	75.0	81.8	100.0	100.0
Measles	98.3	79.3	93.1	96.6	100.0	100.0
Meningococcal disease	78.0	93.8	93.8	95.1	100.0	100.0
Mpox	100.0	48.8	85.4	90.2	100.0	100.0
Pertussis	85.9	34.9	64.0	89.8	99.8	100.0
Rheumatic fever	87.4	20.4	47.0	91.3	96.6	98.6
Salmonellosis	80.5	62.0	88.1	87.1	100.0	100.0
Shigellosis	87.4	54.2	87.6	90.9	100.0	100.0
STEC infection	71.5	47.4	76.9	84.0	98.0	98.6
Tuberculosis disease	66.6	9.0	16.9	88.3	98.7	99.2
Typhoid fever	90.0	31.1	73.3	94.0	100.0	100.0
Yersiniosis	45.1	31.7	65.9	86.2	99.7	99.9
Other	52.7	46.8	72.8	85.7	93.7	95.0
Total	**62.1**	**48.6**	**77.0**	**86.9**	**99.3**	**99.7**

[a] Percentage of notifications reported (with onset date recorded) to a PHS within 1 week and 2 weeks of the onset of symptoms.
[b] Percentage of notifications entered into EpiSurv within 1 day, 1 week and 2 weeks of being reported to a PHS.
[c] Cases of acute gastroenteritis from a common source or person in a high-risk category (eg food handler or childcare worker) or foodborne intoxication, eg, staphylococcal intoxication.

NOTIFIABLE DISEASES

Anthrax

No cases of anthrax were notified in 2025. The last case was notified in 1940. New Zealand has been considered free of anthrax since the last recorded outbreak among domestic livestock in 1954.[14]

Arboviral diseases

This section includes arthropod-borne viral diseases with one or more cases notified since 1997 (when EpiSurv records begin). All notifications of arboviral infection to date have been in recent overseas travellers. Yellow fever is reported in a separate section later in the report.

Barmah Forest virus infection

No cases of Barmah Forest virus infection were notified in 2025. Six cases have been notified since 1997, most recently two cases in 2009, all with a history of travel to Australia.

Chikungunya fever

There were 16 cases of chikungunya fever notified in 2025, compared with seven cases in 2024.

The age groups with the highest number of cases were 40–49 years (5 cases) and 30–39 years (4 cases). Nine cases were female and seven were male. Eleven cases were of Asian ethnicity and five were European or Other.

Hospitalisation status was recorded for all 16 cases and five (31.3%) were hospitalised.

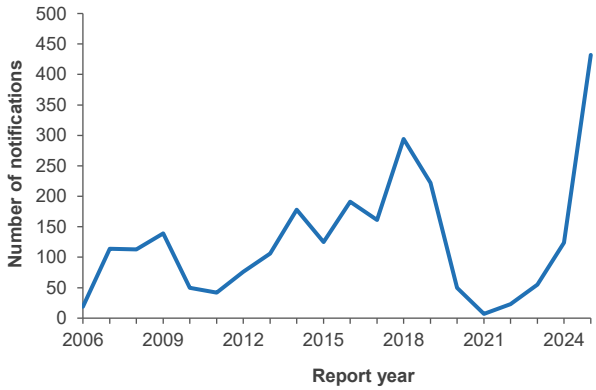
All 16 cases had travelled overseas during the incubation period. The countries most commonly visited were Sri Lanka (5 cases) and India (4 cases).

Dengue fever

In 2025, 432 cases of dengue fever were notified, compared with 124 cases in 2024. The 2025 notification rate (8.13 per 100,000) was significantly higher than the 2024 rate (2.3 per 100,000).

Figure 2 shows dengue fever notifications since 2006. Notifications peaked in 2018 when 294 cases were notified. There was a marked decrease in cases in 2020 and 2021 due to COVID-19 border restrictions.

Figure 2. Dengue fever notifications by year, 2006–2025



Adults aged 50–59 and 60–69 years had the highest notification rates (12.7 and 12.0 per 100,000 respectively), followed by young adults aged 15–19 years (9.9 per 100,000).

Males (8.8 per 100,000) had a higher rate than females (7.4 per 100,000).

Ethnicity was recorded for 430 (99.5%) cases. The ethnic group with the highest notification rate was Pacific peoples (34.6 per 100,000), followed by European or Other (7.2 per 100,000).

Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Hospitalisation status was recorded for 428 (99.1%) cases, of which 174 (40.7%) cases were hospitalised.

All 432 cases had travelled overseas during the incubation period. The countries most commonly visited were Samoa (128 cases), the Cook Islands (108 cases) and Fiji (90 cases).

Japanese encephalitis

No cases of Japanese encephalitis were notified in 2025. Since 1997, only one case of Japanese encephalitis has been notified (in 2004).

Ross River virus infection

One case of Ross River virus infection was notified in 2025, compared with no cases in 2024.

The case was a male, aged 50–59 years of European or Other ethnicity.

The case was hospitalised and had travelled to Australia during the incubation period.

Zika virus infection

Seven cases of Zika virus infection were notified in 2025, compared with eight cases in 2024.

The cases were aged, 50–59 years, 60–69 years (3 cases each), 20–29 years, 40–49 years and 70 years and over (1 case each). Four cases were male and three were female. All seven cases were European or Other ethnicity.

Hospitalisation status was recorded for all seven cases and four were hospitalised.

All seven cases had travelled overseas during the incubation period. The countries visited were Fiji (3 cases), Indonesia (2 cases), Malaysia and Thailand (1 case each).

Brucellosis

One case of brucellosis was notified in 2025. The case was a male, aged 30–39 years. The infection was due to *Brucella suis* which is associated with pigs. The case had consumed meat suspected to have been brought into New Zealand from Tonga.

Since 1997, 31 cases of brucellosis have been notified. There has been no evidence of locally acquired brucellosis in humans since New Zealand's declaration of freedom from bovine brucellosis in 1996.[15]

Campylobacteriosis

In 2025, 5816 cases of campylobacteriosis were notified, compared with 5800 cases in 2024. The 2025 rate of 109.2 per 100,000 was similar to the 2024 rate of 109.6 per 100,000. Since 2008, the annual number of campylobacteriosis cases reported has been much lower than in preceding years (Figure 3).

Figure 3. Campylobacteriosis notifications by year, 2006–2025

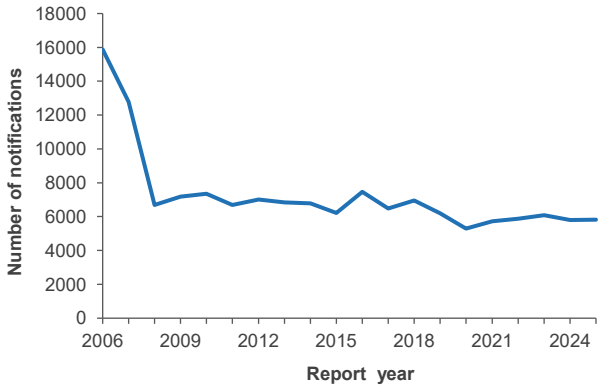
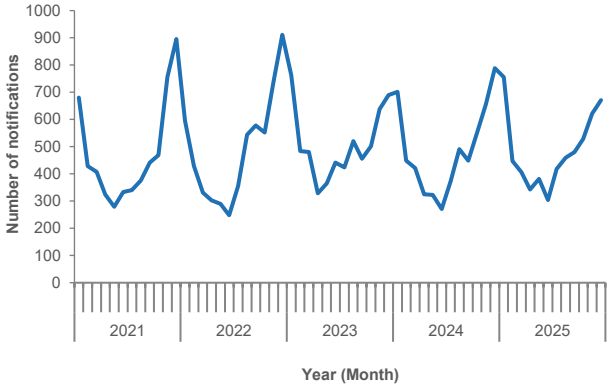


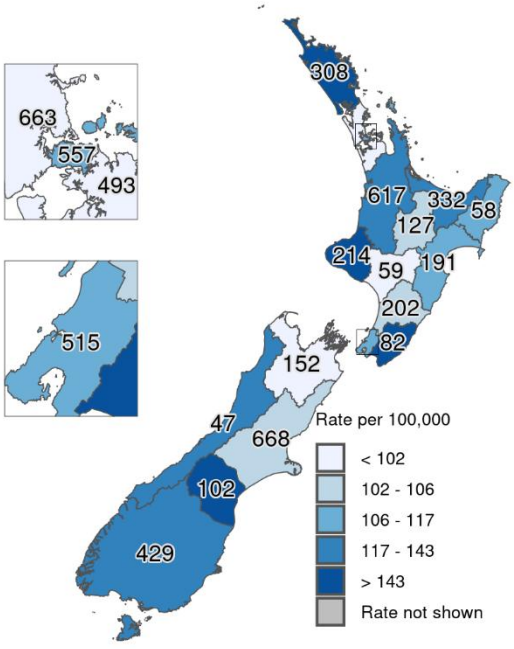
Figure 4 shows campylobacteriosis notifications by month since January 2021. There is a distinct seasonal pattern, with an early summer peak and a winter trough.

Figure 4. Campylobacteriosis notifications by month, January 2021–December 2025



The highest notification rates for campylobacteriosis were reported from Taranaki, South Canterbury, Wairarapa and Northland Districts (164.1, 160.9, 159.5 and 153.2 per 100,000 respectively) (Figure 5).

Figure 5. Campylobacteriosis notifications by district, 2025



Numbers represent notification count in district.
Where fewer than five cases rates are not shown.

Children aged 1–4 years (192.2 per 100,000), adults aged 70 years and over (163.6 per 100,000) and infants aged less than 1 year (157.8 per 100,000) had the highest notification rates.

Males (122.1 per 100,000) had a higher rate than females (96.4 per 100,000).

Ethnicity was recorded for 5714 (98.2%) cases. The ethnic group with the highest rate for campylobacteriosis was European or Other

(138.8 per 100,000), followed by Māori and Asian (68.0 and 66.4 per 100,000 respectively).

Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Hospitalisation status was recorded for 4720 (81.2%) cases, of which 734 (15.6%) cases were hospitalised.

Consumption of food from retail premises and contact with farm animals were the most common risk factors reported for campylobacteriosis (Table 5). Multiple risk factors are often reported for individual cases.

Seven outbreaks of campylobacteriosis were reported in 2025, involving 57 cases (Table 27)

Cholera

No cases of cholera were notified in 2025. Since 1997, 16 laboratory-confirmed cases of cholera have been notified. All 16 cases were overseas during the incubation period.

COVID-19

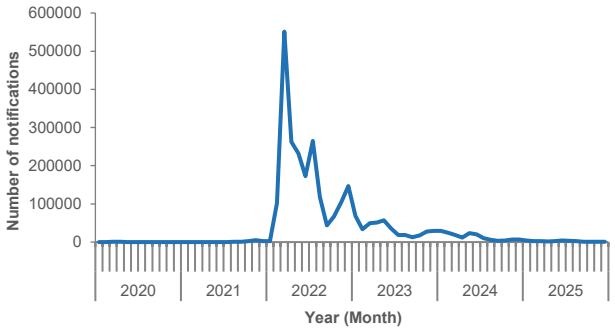
COVID-19 became a notifiable disease in New Zealand on 30 January 2020.[16] Public health measures were implemented to prevent the spread of the disease in March 2020.[17] The last of the COVID-19 specific restrictions were removed in August 2023.[18]

Since February 2022, COVID-19 notifications have been automatically generated from laboratory notifications and self-administered rapid antigen tests reported through the 'My Health Record' website or app. EpiSurv records contain demographic details only. Additional COVID-19 reporting is available on the Health New Zealand website.[19]

In 2025, 26,817 cases of COVID-19 were notified, compared with 163,758 cases in 2024. The 2025 notification rate (504 per 100,000) was a significant decrease from the 2024 rate (3096 per 100,000).

Figure 6 shows COVID-19 notifications by month since January 2020. Monthly cases reported in 2022 far exceeded those in 2020 and 2021. Cases peaked in March 2022, with 551,324 cases reported.

Figure 6. COVID-19 notifications by month, January 2020–December 2025



The highest notification rates were reported from Auckland, Capital, Coast and Hutt Valley, Southern, Nelson Marlborough and MidCentral Districts (842, 786, 633, 567 and 567 per 100,000 respectively (Figure 7).

Adults aged 70 years and over had the highest notification rate (1062 per 100,000), followed by those aged under 1 year (935 per 100,000).

Females (627 per 100,000) had a higher rate than males (377 per 100,000).

Ethnicity was recorded for 26,731 (99.7%) cases. The ethnic group with the highest rate of COVID-19 was European or Other (630 per 100,000), followed by Pacific peoples (389 per 100,000).

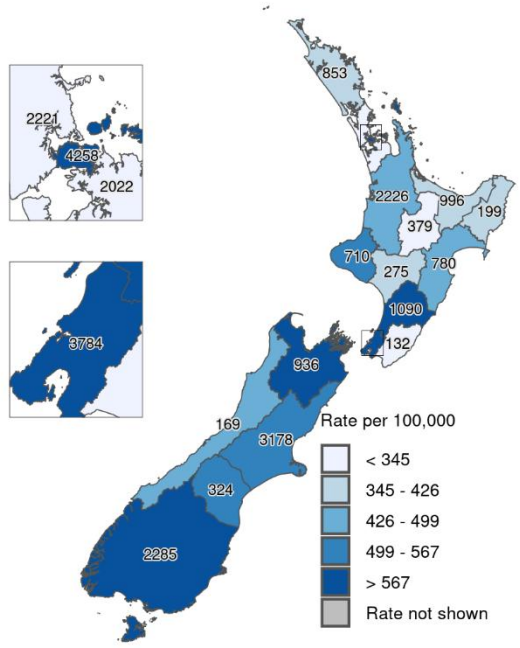
Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Table 5. Exposure to risk factors associated with campylobacteriosis, 2025

Risk factor	Yes	No	Unknown	Percentage (%)[a]
Consumed food from retail premises	771	794	4251	49.3
Contact with farm animals	725	961	4130	43.0
Consumed untreated water	320	1020	4476	23.9
Recreational water contact	313	1228	4275	20.3
Travelled overseas during the incubation period	376	1810	3630	17.2
Contact with other symptomatic people	197	1317	4302	13.0
Contact with faecal matter	187	1291	4338	12.7
Contact with sick animals	97	1369	4350	6.6

[a] Percentage refers to the number of cases that answered "yes" out of the total number of cases for which this information was known. Some cases had more than one risk factor recorded.

Figure 7. COVID-19 notifications by district, 2025



Numbers represent notification count in district.
Where fewer than five cases rates are not shown.

Hospitalisations and deaths are no longer recorded in EpiSurv.

In 2025, 40 outbreaks of COVID-19 were reported, involving 526 cases (Table 27).

Creutzfeldt-Jakob disease

The National Creutzfeldt-Jakob Disease (CJD) Registry is responsible for receiving notifications of suspected cases of CJD, undertaking a review of each notified case and providing advice and reporting on CJD in New Zealand. This section is based on the 29th annual report of the Registry (1 January 2025 to 31 December 2025).[20]

In 2025, 12 cases of CJD were confirmed by the New Zealand CJD Registry. The cases were classified as two definite and 10 probable cases.

The cases were aged 70 years and over (6 cases), 60–69 years (5 cases), and 50–59 years (1 case).

Seven cases were male and five were female.

Since 1997, the Registry has documented 158 cases of CJD, consisting of 64 definite and 94 probable cases.

No cases of variant CJD, the form linked with bovine spongiform encephalopathy, have been identified in New Zealand to date.

Cronobacter species invasive disease

Cronobacter species invasive disease (previously known as *Enterobacter sakazakii*) has been notifiable in New Zealand since mid-2005. In December 2017, the case definition for *Cronobacter* species invasive disease was restricted to infants aged less than 1 year.

No cases of *Cronobacter* species invasive disease were notified in 2025, and there have been no cases in infants or neonates since it became notifiable in mid-2005.

Cryptosporidiosis

In 2025, 870 cases of cryptosporidiosis were notified, compared with 1234 in 2024 (Figure 8). The 2025 notification rate (16.3 per 100,000) was a significant decrease from the 2024 rate (23.3 per 100,000).

Figure 8. Cryptosporidiosis notifications by year, 2006–2025

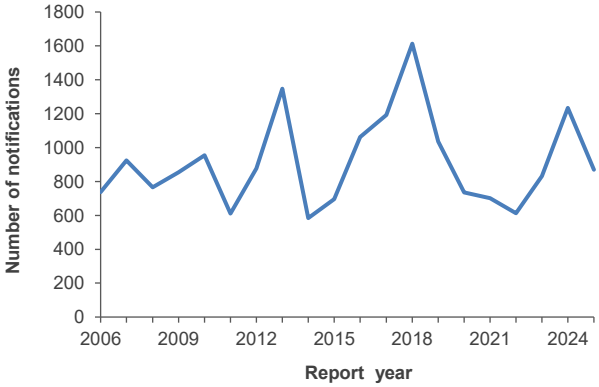
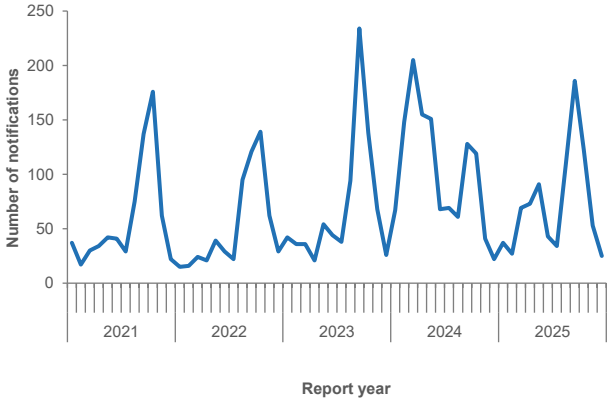


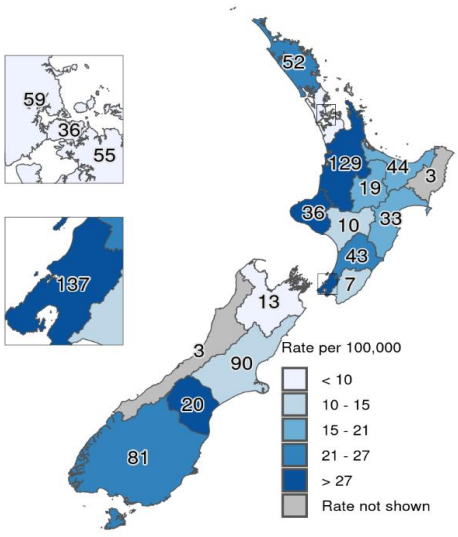
Figure 9 shows cryptosporidiosis cases by month since January 2021. There is a distinct seasonal pattern, with the highest number of notifications generally reported during spring each year. In 2024 and 2025 there were also earlier peaks in Autumn.

Figure 9. Cryptosporidiosis notifications by month, January 2021–December 2025



In 2025, the highest notification rate for cryptosporidiosis was reported from South Canterbury District (31.5 per 100,000) followed by Capital, Coast and Hutt Valley, Waikato and Taranaki Districts (28.4, 27.6 and 27.6 per 100,000 respectively) (Figure 10).

Figure 10. Cryptosporidiosis notifications by district, 2025



Numbers represent notification count in district.
Where fewer than five cases rates are not shown.

Children aged 1–4 years (64.6 per 100,000) had the highest notification rate, followed by children aged 5–9 years and infants aged less than 1 year (32.0 and 26.0 per 100,000 respectively).

Females (17.1 per 100,000) had a higher rate than males (15.5 per 100,000).

Ethnicity was recorded for 852 (97.9%) cases. The ethnic group with the highest notification rate for cryptosporidiosis was European or Other (20.8 per 100,000), followed by Māori (15.2 per 100,000).

Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Hospitalisation status was recorded for 764 (87.8%) cases, of which 80 (10.5%) cases were hospitalised.

Contact with farm animals and consumption of food from retail premises were the most common risk factors reported for cryptosporidiosis (Table 6).

Six outbreaks of cryptosporidiosis were reported in 2025, involving 158 cases (Table 27).

Cysticercosis

No cases of cysticercosis were notified in 2025. The last case was notified in 2018.

Decompression sickness

One case of decompression sickness was notified in 2025. The case was a female aged 30–39 years.

Health New Zealand hospital discharge data for 2025 included 20 cases where decompression sickness was the principal diagnosis (Table 37).

Over the last five years, the number of hospitalisations with decompression sickness as the principal diagnosis has ranged from 8 to 23 annually, compared with only seven notifications in EpiSurv during this time, indicating consistent under-notification of this condition.

Diphtheria

Diphtheria is caused by toxigenic strains of the bacterium *Corynebacterium diphtheriae* or, more rarely, toxigenic strains of *C. ulcerans* or *C. pseudotuberculosis.*

Four cases of cutaneous toxigenic diphtheria were notified in 2025. Three cases were male and one was female. The cases were aged 50–59 years (2 cases), 60–69 years and 70 years and over (1 case each).

Table 6. Exposure to risk factors associated with cryptosporidiosis, 2025

Risk factor	Yes	No	Unknown	Percentage (%)[a]
Contact with farm animals	261	177	432	59.6
Consumed food from retail premises	142	230	498	38.2
Contact with other symptomatic people	124	270	476	31.5
Contact with faecal matter	111	267	492	29.4
Recreational water contact	116	286	468	28.9
Consumed untreated water	93	251	526	27.0
Contact with sick animals	76	272	522	21.8
Travelled overseas during the incubation period	35	451	384	7.2

[a] Percentage refers to the number of cases that answered "yes" out of the total number of cases for which this information was known. Some cases have more than one risk factor recorded.

Two cases had recently travelled to Samoa and were due to *C. diphtheriae*. Two cases were due to *C. ulcerans,* including one case where the same strain was isolated from a pet dog. No source was identified for the other case.

The last case of toxigenic respiratory diphtheria was notified in 1998.[21]

In 2025, the Special Bacteriology Laboratory at PHF Science received 61 *Corynebacterium* isolates for toxin testing (56 *C. diphtheriae* and five *C. ulcerans* isolates). The majority (53/61 isolates, 86.9%) were from cutaneous sources, seven were from the throat and one was from blood. Isolates from four patients were toxigenic (all cutaneous).

Gastroenteritis (acute)

Not all cases of acute gastroenteritis are notifiable. Acute gastroenteritis is notifiable if there is a suspected common source, or it is in a person in a high-risk category (eg, food handler or early childhood service worker) or it is an infectious gastroenteritis of public health importance, or a single case of chemical or toxic food poisoning. Toxic shellfish poisoning (TSP) is reported in a separate section in this report. Diseases and conditions that are notifiable separately (eg, campylobacteriosis, giardiasis, STEC infection and salmonellosis) are reported in their own sections.

In 2025, 477 cases of acute gastroenteritis (other than TSP) were notified. The 2025 notification rate (9.0 per 100,000) was higher than the 2024 rate (8.2 per 100,000, 435 cases).

A causal agent was reported for 243 (50.9%) cases. The most common cause was enterotoxigenic *Escherichia coli* (30.6%, 146 cases). The distribution of acute gastroenteritis cases by cause is shown in Table 7.

Table 7. Acute gastroenteritis cases by cause, 2025

Cause[a]	Cases	Percentage (%)
Cause identified	**243**	**50.9**
Enterotoxigenic *Escherichia coli* (ETEC)	146	30.6
Norovirus	36	7.5
Vibrio parahaemolyticus	36	7.5
Ciguatera fish poisoning	5	1.0
Sapovirus	5	1.0
Vibrio fluvialis	5	1.0
Enteropathogenic *Escherichia coli* (EPEC)	4	0.8
Astrovirus	2	0.4
Bacillus cereus	1	0.2
Clostridium difficile	1	0.2
Histamine (scombroid) poisoning	1	0.2
Rotavirus infection	1	0.2
Cause not identified	**234**	**49.1**

[a] Does not include diseases that are notifiable separately.
Note: there may be more cases associated with specific causes through outbreak reporting, see Table 27.

The highest notification rates for acute gastroenteritis were reported from Lakes, Bay of Plenty and Waikato Districts (25.7, 25.2 and 22.5 per 100,000 respectively).

Children aged 1–4 years had the highest notification rate (20.0 per 100,000), followed by children aged less than 1 year (13.9 per 100,000).

Females (10.2 per 100,000) had a higher rate than males (7.6 per 100,000).

Ethnicity was known for 469 (98.3%) cases. The ethnic group with the highest notification rate was European or Other (10.3 per 100,000), followed by Māori (7.6 per 100,000).

Hospitalisation status was recorded for 451 (94.5%) cases, of which 63 cases (14.0%) were hospitalised.

Table 8. Exposure to risk factors associated with acute gastroenteritis, 2025

Risk factor	Yes	No	Unknown	Percentage (%)[a]
Consumed food from retail premises	208	114	155	64.6
Travelled overseas during the incubation period	126	249	102	33.6
Consumed water other than regular supply	76	208	193	26.8
Recreational water contact	76	233	168	24.6
Contact with other symptomatic people	73	244	160	23.0
Contact with human faecal matter	42	247	188	14.5
Contact with farm animals	45	269	163	14.3
Consumed untreated water	27	248	202	9.8

[a] Percentage refers to the number of cases that answered “yes” out of the total number of cases for which this information was known. Some cases had more than one risk factor recorded

The most common risk factor associated with acute gastroenteritis was consumption of food from retail premises (Table 8).

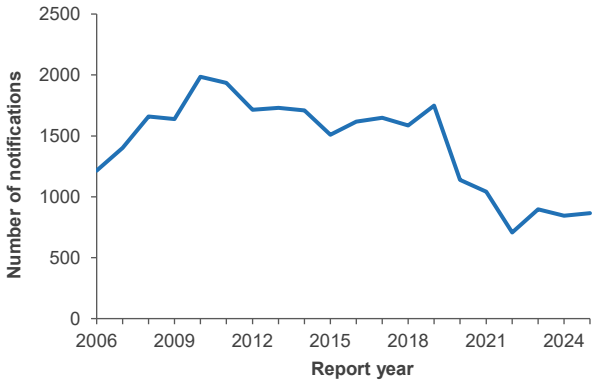
In 2025, 468 outbreaks of acute gastroenteritis were reported, involving 8478 cases (Table 27).

Giardiasis

In 2025, 865 cases of giardiasis were notified, compared with 844 in 2024. The 2025 notification rate (16.2 per 100,000) was similar to the 2024 rate (16.0 per 100,000).

Figure 11 shows giardiasis notifications by year from 2006 to 2025. Annual numbers have declined since 2019 when 1749 cases of giardiasis were notified.

Figure 11. Giardiasis notifications by year, 2006–2025

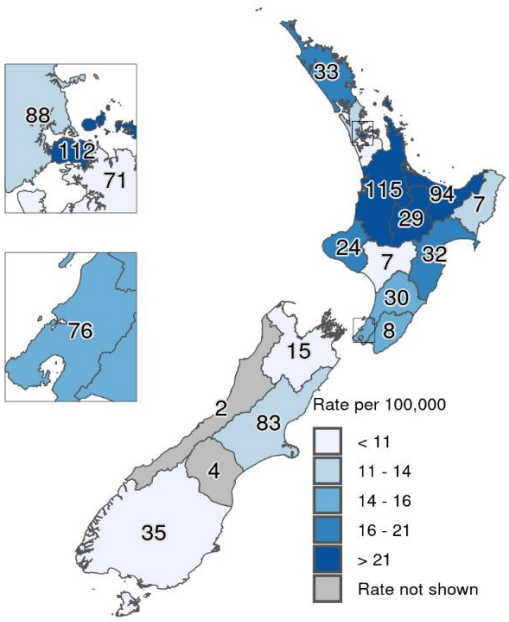


The highest notification rates for giardiasis were reported from Bay of Plenty, Waikato, Lakes and Auckland Districts (33.9, 24.6, 24.0 and 22.1 per 100,000 respectively) (Figure 12).

Children aged 1–4 years (32.5 per 100,000) had the highest notification rate, followed by adults aged 30–39 years (24.8 per 100,000).

Males (17.5 per 100,000) had a higher rate than females (15.0 per 100,000).

Figure 12. Giardiasis notifications by district, 2025



Numbers represent notification count in district.
Where fewer than five cases rates are not shown.

Ethnicity was recorded for 858 (99.2%) cases. The ethnic group with the highest notification rate for giardiasis was European or Other (20.8 per 100,000), followed by Māori (11.9 per 100,000).

Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Hospitalisation status was recorded for 722 (83.5%) cases, of which 38 (5.3%) cases were hospitalised.

Consumption of food from retail premises and recreational water contact were the most commonly reported risk factors for giardiasis (Table 9).

Two outbreaks of giardiasis were reported in 2025, involving four cases (Table 27).

Table 9. Exposure to risk factors associated with giardiasis, 2025

Risk factor	Yes	No	Unknown	Percentage (%)[a]
Consumed food from retail premises	118	164	583	41.8
Recreational water contact	95	216	554	30.5
Contact with faecal matter	88	212	565	29.3
Contact with farm animals	95	240	530	28.4
Contact with other symptomatic people	80	236	549	25.3
Travelled overseas during the incubation period	86	309	470	21.8
Consumed untreated water	53	205	607	20.5

[a] Percentage refers to the number of cases that answered "yes" out of the total number of cases for which this information was known. Some cases had more than one risk factor recorded.

Haemophilus influenzae serotype b disease

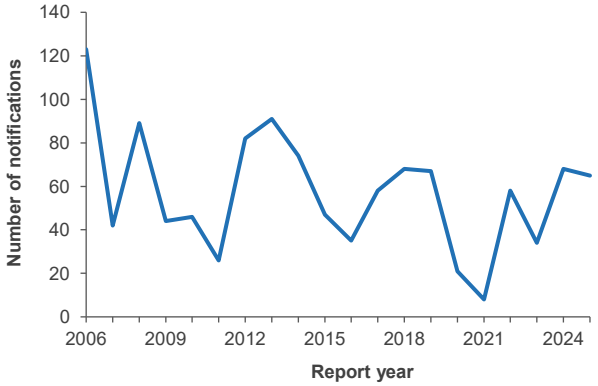
Haemophilus influenzae serotype b (Hib) vaccine was introduced in January 1994. The recommended vaccination schedule consists of a primary course of three doses of DTaP-IPV-HepB/Hib vaccine for infants at age 6 weeks, 3 months and 5 months and a booster of Hib vaccine at 15 months of age.[22]

One case of Hib disease was notified in 2025, the same number as in 2024. The case was a male, aged 20–29 years of Pacific ethnicity and not vaccinated. The case was hospitalised.

Hepatitis A

In 2025, 65 cases of hepatitis A were notified, compared with 68 cases in 2024. The 2025 notification rate (1.2 per 100,000) was similar to the 2024 rate (1.3 per 100,000). Since 2006, annual notifications have fluctuated, ranging from 8 to 123 cases (Figure 13).

Figure 13. Hepatitis A notifications by year, 2006–2025



The highest notification rates for hepatitis A were reported from Northland, Counties Manukau, Waikato, and Capital Coast and Hutt Valley Districts (2.5, 2.1, 1.9 and 1.7 per 100,000 respectively).

Adults aged 30–39 years (2.4 per 100,000), 20–29 years (1.9 per 100,000) and 40–49 years (1.8 per 100,000) had the highest notification rates.

Males (1.4 per 100,000) had a higher rate than females (1.0 per 100,000).

Ethnicity was recorded for 64 (98.5%) cases. The ethnic group with the highest notification rate for hepatitis A was Asian (3.2 per 100,000), followed by Pacific peoples (2.7 per 100,000).

Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Hospitalisation status was recorded for all 65 cases, and 45 (69.2%) were hospitalised

Travel information was recorded for all 65 cases, with 53 cases (81.5%) having travelled overseas during the incubation period. The most commonly visited countries were India (26 cases) and Fiji (16 cases).

Of the 12 cases that did not travel overseas, six were linked through genotyping to outbreaks that began in 2024 and likely originated from disease importations from Fiji and subsequent local transmission. Two further cases had contact with overseas visitors and one was linked to a case who had travelled to Fiji.

Two outbreaks of hepatitis A were reported in 2025, involving 16 cases (Table 27).

Hepatitis B

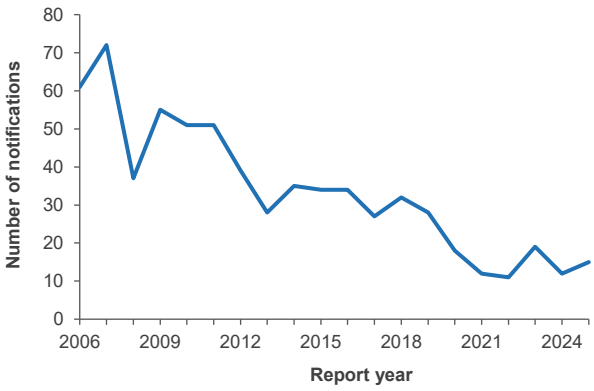
Hepatitis B vaccine was added to the national immunisation schedule in 1988. The current vaccination schedule consists of three doses of DTaP-IPV-HepB/Hib vaccine given to infants at age 6 weeks, 3 months and 5 months.[22]

Only acute hepatitis B is notifiable, so notification rates do not give an indication of the burden of chronic hepatitis B infection.

In 2025, 15 cases of hepatitis B were notified, compared with 12 cases in 2024. The 2025 notification rate (0.3 per 100,000) was similar to the 2024 rate (0.2 per 100,000).

There has been a steady decrease in the annual number of acute hepatitis B cases since 2007 when 72 cases were notified (Figure 14).

Figure 14. Acute hepatitis B notifications by year, 2006–2025



The highest number of cases was reported from Southern District (3 cases), followed by Waikato, Hawke's Bay and Nelson Marlborough Districts (2 cases each).

The age groups with the highest number of cases were 50–59 (5 cases) and 30–39 years (4 cases).

Twelve cases were male and three were female.

Ethnicity was recorded for all 15 cases. Five cases were Māori, four were Asian, four were European or Other ethnicity and two were Pacific peoples.

Hospitalisation status was recorded for all 15 cases and 10 (66.7%) were hospitalised.

The most commonly reported risk factors for acute hepatitis B were household contact with a confirmed case and sexual contact with a confirmed case (Table 10).

Hepatitis C

Only acute hepatitis C is notifiable, so notification rates do not give an indication of the burden of chronic hepatitis C infection.

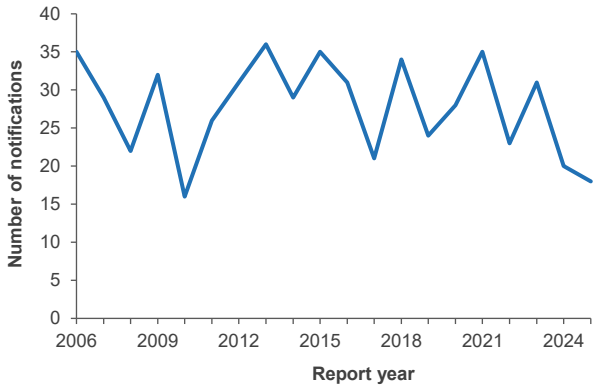
In 2025, 18 cases of hepatitis C were notified, compared with 20 cases in 2024. The 2025 notification rate (0.3 per 100,000) was similar to the 2024 rate (0.4 per 100,000).

Since 2006, the annual number of notifications has ranged from 16 to 36 cases (Figure 15).

The highest number of cases was reported from Waikato District (4 cases), followed by Auckland, Bay of Plenty, Taranaki, Hawke's Bay and Nelson Marlborough Districts (2 cases each).

The age groups with the highest number of cases were 30–39 and 40–49 years (5 cases each) and 60–69 years (3 cases).

Figure 15. Acute hepatitis C notifications by year, 2006–2025



Nine cases were male and nine were female.

Thirteen cases were European or Other ethnicity and five were Māori.

Hospitalisation status was recorded for 17 (94.4%) cases, of which three (17.6%) cases were hospitalised.

The most commonly reported risk factor for acute hepatitis C was a history of injecting drug use, followed by sexual contact with a confirmed case and body piercing or tattooing in the 12 months prior (Table 11).

Hepatitis (viral) not otherwise specified

In 2025, two cases of hepatitis (viral) not otherwise specified (NOS) were notified, compared with five cases in 2024. Both cases were hepatitis E.

Table 10. Exposure to risk factors associated with acute hepatitis B, 2025

Risk factor	Yes	No	Unknown	Percentage (%)[a]
Household contact with a confirmed case	4	6	5	40.0
Sexual contact with confirmed case	3	7	5	30.0
Travelled overseas during incubation period	4	10	1	28.6
Blood product or tissue recipient	3	10	2	23.1
Child of seropositive mother	1	9	5	10.0
Body piercing/tattooing in the last 12 months	1	11	3	8.3

[a] Percentage refers to the number of cases that answered "yes" out of the total number of cases for which this information was known. Some cases had more than one risk factor recorded.

Table 11. Exposure to risk factors associated with acute hepatitis C, 2025

Risk factor	Yes	No	Unknown	Percentage (%)[a]
History of injecting drug use	8	7	3	53.3
Sexual contact with confirmed case	4	6	8	40.0
Body piercing/ tattooing in last 12 months	5	8	5	38.5
Household contact with a confirmed case	3	8	7	27.3
Travelled overseas during incubation period	2	12	4	14.3

[a] Percentage refers to the number of cases that answered "yes" out of the total number of cases for which this information was known. Some cases had more than one risk factor recorded.

The cases were both aged 50–59 years. One was male, and one was female. One case was of Asian ethnicity, and one was European or Other.

Both cases were hospitalised.

One case had travelled overseas during the incubation period. No risk factors were identified for the other case.

Highly pathogenic avian influenza

Highly pathogenic avian influenza (HPAI) became a notifiable disease in New Zealand in February 2004. No human cases have been reported in New Zealand to date. An outbreak of HPAI in chickens due to H7N6 was reported in 2024. Prior to this event, New Zealand was free from HPAI.[23]

Hydatid disease

Five cases of hydatid disease (*Echinococcus granulosus*) were notified in 2025. Two cases were aged 70 years and over and one each were aged 15–19, 40–49 and 50–59 years. Three cases were female and two were male.

Two cases were overseas acquired, while three cases had no travel history and likely acquired their infection many years ago.

Since 1997, 85 cases of hydatid disease have been notified.

Echinococcus species are notifiable organisms under the Biosecurity Act 1993. All cases of hydatid disease are reported to the Ministry for Primary Industries for investigation of possible disease reservoirs in New Zealand animals. In September 2002, New Zealand was declared provisionally free of hydatids. [24] Given the natural history of the disease, it is expected that cases may occur for some years.

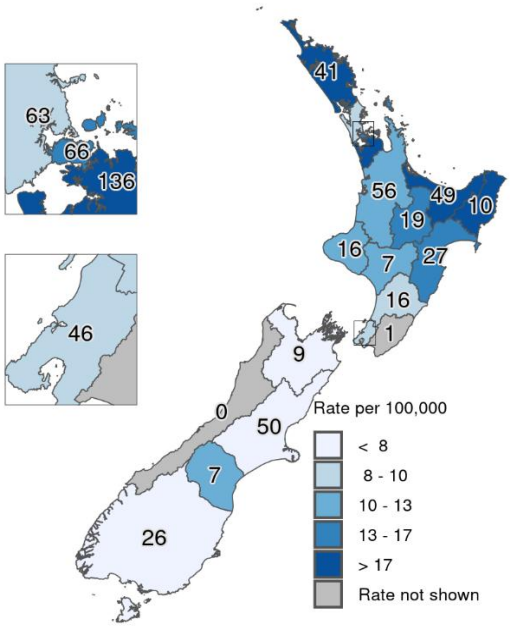
Invasive group A streptococcal infection

Invasive group A streptococcal (iGAS) infection became a notifiable disease on 1 October 2024.[25]

In 2025, 645 cases of iGAS infection were notified, giving a notification rate of 12.1 per 100,000.

The highest notification rates for iGAS infection were reported from Counties Manukau, Northland, Tairawhiti and Bay of Plenty Districts (20.8, 20.4, 19.0 and 17.7 per 100,000 respectively) (Figure 16).

Figure 16. Invasive group A streptococcal infection by district, 2025



Numbers represent notification count in district.
Where fewer than five cases rates are not shown.

Infants aged less than 1 year (32.9 per 100,000) had the highest rate of iGAS infection, followed by adults aged 70 years and over (29.2 per 100,000).

Males (12.4 per 100,000) had a higher rate than females (11.8 per 100,000).

Ethnicity was recorded for 640 (99.2%) cases. The ethnic group with the highest rate of iGAS infection was Pacific peoples (42.3 per 100,000), followed by Māori (21.8 per 100,000).

Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Hospitalisation status was recorded for 636 (98.6%) cases, of which 619 (97.3%) cases were hospitalised.

There were 27 deaths due to iGAS infection reported in 2025 (Table 36). Two deaths (7.4%) were in children aged less than 5 years, four (14.8%) were in adults aged 30–59 years and 21 (77.8%) were in adults aged 60 years and over.

Chronic comorbidities were the most frequently reported risk factors (130 cases), with the most common comorbidities being diabetes (75 cases), heart disease (30 cases), and obesity (27 cases) and kidney disease (24 cases). Other reported risk factors included being immune compromised or suppressed, skin conditions and wounds, and respiratory infections.

Four outbreaks of iGAS infection were reported in 2025, involving eight cases (Table 27).

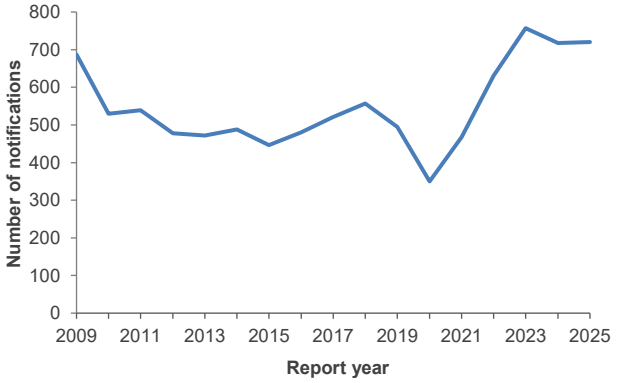
The Invasive Pathogens Laboratory at PHF Science received a viable group A *Streptococcus* isolate from a normally sterile site for *emm* typing for 622 (96.4%) notified cases in 2025. *emm*1 (85 cases, 13.7%) was the most common *emm* type, followed by *emm*44 (59 cases, 9.5%) and *emm*4 (41 cases, 6.6%).

Invasive pneumococcal disease

In 2025, 720 cases of invasive pneumococcal disease (IPD) were notified, compared with 718 cases in 2024. The 2025 notification rate (13.5 per 100,000) was similar to the 2024 rate (13.6 per 100,000).

Figure 17 shows the number of cases each year since 2009 (the first full year since IPD became a notifiable disease in October 2008). Annual notifications have increased in recent years from a low of 350 cases in 2020.

Figure 17. Invasive pneumococcal disease notifications by year, 2009–2025



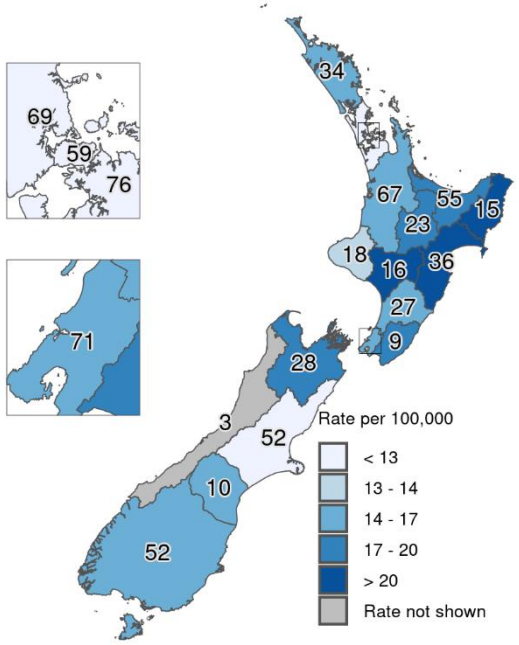
In 2025, the highest notification rate for IPD was reported from Tairawhiti District (28.5 per 100,000), followed by Whanganui and Hawke's Bay Districts (22.9 and 20.0 per 100,000 respectively) (Figure 18).

Adults aged 70 years and over (41.9 per 100,000) had the highest rate of IPD, followed by infants aged less than 1 year (36.4 per 100,000).

Males (14.0 per 100,000) had a higher rate than females (13.1 per 100,000).

Ethnicity was recorded for 717 (99.6%) cases. The ethnic groups with the highest rate of IPD were Pacific peoples and Māori (28.5 and 23.4 per 100,000 respectively).

Figure 18. Invasive pneumococcal disease notifications by district, 2025



Numbers represent notification count in district.
Where fewer than five cases rates are not shown.

Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Hospitalisation status was recorded for 715 (99.3%) cases, of which 695 (97.2%) cases were hospitalised.

There were 39 deaths due to IPD reported in 2025 (Table 36). Two deaths were in infants aged less than 1 year, one was in a young adult aged 15–19 years, and 36 deaths were in adults aged 50 years and over.

The most commonly reported risk factors for children aged less than 5 years were having a congenital or chromosomal abnormality or a chronic illness (Table 12). Having a chronic illness and being a current smoker (for cases aged 15 years and over) were the most common risk factors for cases aged 5 years and over (Table 13).

Pneumococcal conjugate vaccine (PCV) was added to the national immunisation schedule in June 2008. The recommended schedule is three PCV13 doses given at age 6 weeks, 5 months and 12 months. For defined groups of high-risk children and adults, the immunisation schedule also includes PCV13 and the 23-valent pneumococcal polysaccharide vaccine (23PPV).[22]

Table 12. Exposure to risk factors associated with invasive pneumococcal disease for cases aged less than 5 years, 2025

Risk factor	Yes	No	Unknown	Percentage (%)[a]
Congenital or chromosomal abnormality	4	50	4	7.4
Chronic illness	4	52	2	7.1
Premature (<37 weeks gestation)[b]	1	16	4	5.9
Immunocompromised	1	54	3	1.8

[a] Percentage refers to the percentage of cases that answered "yes" out of the total number of cases for which this information was known.
[b] Only cases aged less than 1 year are included for reporting of this risk factor.
Some cases had more than one risk factor recorded. No cases reported asplenia, cochlear implants or chronic lung disease as risk factors.

Table 13. Exposure to risk factors associated with invasive pneumococcal disease for cases aged 5 years and over, 2025

Risk factor	Yes	No	Unknown	Percentage (%)[a]
Chronic illness	370	255	37	59.2
Current smoker[b]	117	439	85	21.0
Chronic lung disease or cystic fibrosis	115	508	39	18.5
Immunocompromised	109	502	51	17.8
Resident in long-term or other chronic-care facility	44	580	38	7.1

[a] Percentage refers to the percentage of cases that answered "yes" out of the total number of cases for which this information was known.
[b] Only cases aged 15 years and over are included in the reporting of this risk factor.
Some cases had more than one risk factor recorded.

The Invasive Pathogens Laboratory at PHF Science received a viable *Streptococcus pneumoniae* isolate from a normally sterile site for serotyping for 694 (96.4%) notified cases in 2025. Serotype 8 (159 cases, 22.9%) was the most prevalent serotype followed by 19A (121 cases, 17.4%). Overall, 28.7% (199/694) of cases with a known serotype were due to a serotype covered by PCV13.

Legionellosis

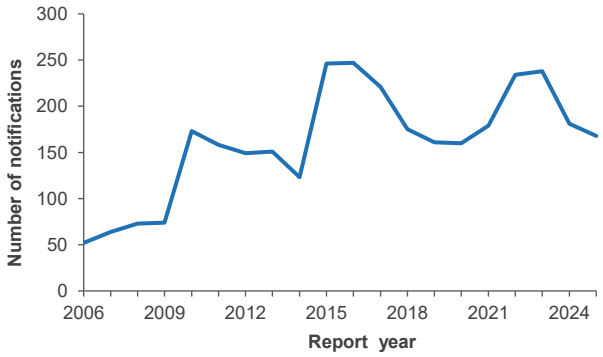
During 2025, 168 cases of legionellosis were notified, compared with 181 in 2024. The 2025 notification rate (3.2 per 100,000) was lower than the 2024 rate (3.4 per 100,000).

The annual number of notifications has increased since 2006 when 52 cases were notified (Figure 19). The increase in legionellosis cases in 2015 and 2016 is likely due to the LegiNZ study [26] which involved testing hospitalised patients with suspected pneumonia for *Legionella* spp. using PCR. The study ran from May 2015 to May 2016.

In 2025, the highest notification rate for legionellosis was reported from Canterbury District (6.5 per 100,000), followed by Bay of Plenty District (5.0 per 100,000).

Adults aged 70 years and over (13.5 per 100,000) and 60–69 years (7.6 per 100,000) had the highest notification rates for legionellosis.

Figure 19. Legionellosis notifications by year, 2006–2025



Males (4.2 per 100,000) had a higher rate than females (2.2 per 100,000).

Ethnicity was known for 165 (98.2%) cases. The ethnic group with the highest notification rate was European or Other (4.7 per 100,000), followed by Pacific peoples (2.4 per 100,000).

Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Hospitalisation status was recorded for 163 (97.0%) cases, of which 158 (96.9%) cases were hospitalised.

Four deaths due to legionellosis were reported in 2025 (Table 36). Three deaths were in adults aged 70 years and over and one was aged 40–49 years.

Table 14. Exposure to risk factors associated with legionellosis, 2025

Risk factor	Yes	No	Unknown	Percentage (%)[a]
Exposure to known environmental source	135	21	12	86.5
Pre-existing immunosuppressive or debilitating condition	55	84	29	39.6
Smokes cigarettes	18	128	22	12.3

[a] Percentage refers to the percentage of cases that answered "yes" out of the total number of cases for which this information was known. Some cases had more than one risk factor recorded.

Table 14 provides a summary of risk factors for which data was available. A total of 135 (86.5%) cases reported exposure to known environmental risk factors during the incubation period. Risk factors for *Legionella pneumophila* include water sources such as hot water systems, air conditioning cooling towers, decorative fountains, humidifiers, spa pools and respiratory medical devices, while risk factors for *L. longbeachae* include exposure to compost, potting mixes and soil.[27]

The species was identified in 162/168 (96.4%) legionellosis cases in 2025. As in previous years, the most common *Legionella* species identified were *L. longbeachae* (58.0%, 94 cases) and *L. pneumophila* (37.0%, 60 cases) (Table 15).

Table 15. *Legionella* strains for laboratory confirmed cases, 2025

Legionella species and serogroup	Cases	Percentage (%)
L. longbeachae	**94**	**58.0**
L. longbeachae sg 1	65	40.1
L. longbeachae sg 2	2	1.2
L. longbeachae sg 1 / *L. bozemanae* sg 1	1	0.6
L. longbeachae sg 1 / *L.* sp. D5382	1	0.6
L. longbeachae sg not determined	25	15.4
L. pneumophila	**57**	**37.0**
L. pneumophila sg 1	44	27.2
L. pneumophila sg 2	1	0.6
L. pneumophila sg 3	1	0.6
L. pneumophila sg 8	1	0.6
L. pneumophila sg 9	1	0.6
L. pneumophila sg 12	1	0.6
L. pneumophila sg 15	1	0.6
L. pneumophila sg 1 / *L. gormanii*	1	0.6
L. pneumophila sg not determined	9	5.6
Other *Legionella* species	**8**	**4.9**
L. micdadeii	5	3.1
L. bozemanae sg 1	2	1.2
L. bozemanae	1	0.6
Total	**162**	**100.0**

Leprosy

Four cases of leprosy were notified in 2025, compared with three cases in 2024.

Three cases were male and one was female. The cases were aged 30–39 years, 40–49 years, 60–69 years and 70 years and over. Two cases were Pacific peoples, one was Asian and one was European or Other.

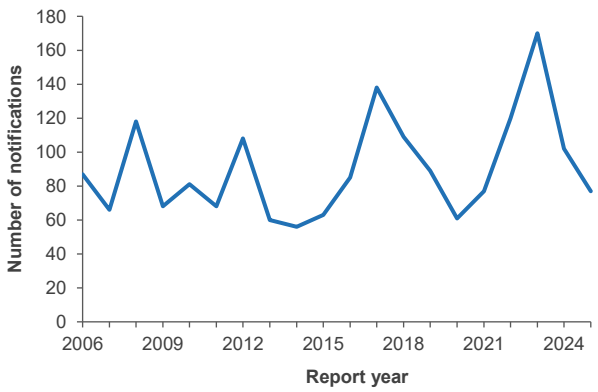
One case was a relapse. The cases had been in Samoa (2 cases), the Cook Islands, the Solomon Islands and South Africa (1 case each). One case had been in two countries.

Leptospirosis

In 2025, 77 cases of leptospirosis were notified, compared with 102 cases in 2024. The 2025 notification rate (1.4 per 100,000) was lower than the 2024 rate (1.9 per 100,000).

Figure 20 shows the number of notified cases of leptospirosis each year since 2006.

Figure 20. Leptospirosis notifications by year, 2006–2025



The highest notification rate for leptospirosis was reported from Bay of Plenty District (5.0 per 100,000), followed by Waikato and Hawke's Bay Districts (3.6 and 2.8 per 100,000 respectively).

Adults aged 30–39 years and young adults aged 15–19 years had the highest notification rates (2.1 and 2.0 per 100,000 respectively).

Males (2.1 per 100,000) had a higher rate than females (0.8 per 100,000).

Ethnicity was recorded for all 77 cases. European or Other (2.0 per 100,000) and Māori (1.3 per 100,000) and had the highest notification rates.

Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Hospitalisation status was recorded for 73 (94.8%) cases, of which 54 (74.0%) cases were hospitalised.

Occupation was recorded for 72 (93.5%) cases. Of these, 33 (45.8%) were engaged in occupations considered high risk for exposure to *Leptospira* spp. in New Zealand.[28] Of the 33 cases with a high-risk occupation, 30 (90.9%) were farmers, farm workers or those providing services to farms, two (6.1%) worked in the meat processing industry and one (3.0%) was a veterinarian. A further five cases worked in an occupation that involved contact with contaminated environments including arboriculture, horticulture, forestry and wastewater treatment. Other risk factors reported included exposure to farm or wild animals (56 cases) and exposure to lakes, rivers or streams (19 cases).

The Leptospira Reference Laboratory at PHF Science confirmed 28 cases of infection with *Leptospira* in 2025. The most common *Leptospira* serovars reported were *L. borgpetersenii* sv Hardjo (17.9%, 5 cases) and *L. borgpetersenii* sv Tarassovi (14.3%, 4 cases) (Table 16).

Table 16. *Leptospira* strain for specimens referred to PHF Science, 2025

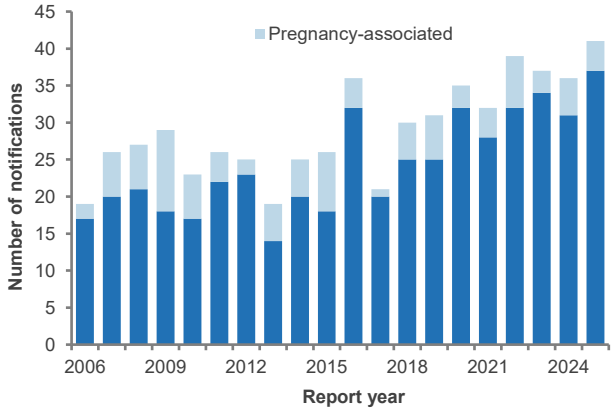
***Leptospira* species and serovar**	**Cases**	**Percentage (%)**
L. borgpetersenii	**12**	**42.9**
L. borgpetersenii sv Hardjo	5	17.9
L. borgpetersenii sv Tarassovi	4	14.3
L. borgpetersenii sv Ballum	3	10.7
L. interrogans	**6**	**21.4**
L. interrogans sv Canicola	3	10.7
L. interrogans sv Copenhageni	1	3.6
L. interrogans sv Grippotyphosa	1	3.6
L. interrogans sv Pomona	1	3.6
Serovar not identified	**10**	**35.7**
Total	**28**	**100.0**

Listeriosis

In 2025, 41 cases of listeriosis were notified (including four pregnancy-associated cases), compared with 36 cases (five pregnancy-associated) in 2024. The 2025 notification rate (0.8 per 100,000) was similar to the 2024 rate (0.7 per 100,000).

Figure 21 shows listeriosis notifications for each year since 2006.

Figure 21. Listeriosis notifications by year, 2006–2025



The Special Bacteriology Laboratory at PHF Science received 40 isolates of *Listeria monocytogenes* in 2025 for typing. Multilocus sequence type (MLST) replaced serotyping for listeriosis isolates in September 2025 and MLST results are available for all 40 isolates. Epidemiologically linked isolates that share the same sequence type undergo further analysis to identify genomic clusters. The most common sequence types identified were ST1 (7 isolates,17.5%), ST451 (4 isolates, 10.0%), ST4, ST7, ST9 and ST14 (3 isolates, 7.5% each).

Listeriosis not associated with pregnancy

Counties Manukau District report the highest number of listeriosis cases that were not associated with pregnancy (8 cases), followed by Auckland and Canterbury (4 cases each).

Adults aged 70 years and over (3.8 per 100,000) had the highest rate of listeriosis and accounted for almost two thirds (64.9%, 24/37 cases) of the cases.

Males and females had the same rates (0.7 per 100,000).

Ethnicity was recorded for all 37 cases. The ethnic group with the highest notification rate was European or Other (0.8 per 100,000, 23 cases), followed by Māori and Asian (0.6 per 100,000, 6 cases each).

All 37 cases were hospitalised for listeriosis and nine were also hospitalised for the treatment of another illness.

Four deaths from listeriosis were reported in 2025 (Table 36). All were in cases aged 70 years and over.

Information on underlying illness was recorded for 33 (89.2%) cases, of which 27 (81.8%) had an underlying illness such as cancer, renal failure, liver disease, diabetes, heart disease, or another chronic illness. Nine cases were reported to be receiving immunosuppressive drugs.

Pregnancy-associated listeriosis

Four cases of pregnancy-associated listeriosis were notified in 2025. The gestation of pregnancy for the cases ranged from 15 to 38 weeks.

Two cases were aged 40–49 years, one was 20–29 years and one was 30–39 years. Two cases were Asian, one was Pacific and one was European or Other.

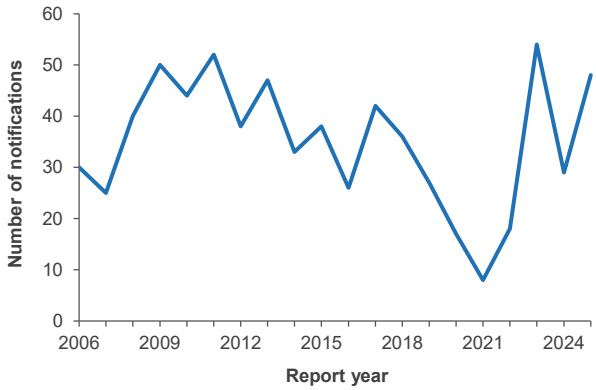
Two perinatal deaths from listeriosis occurred in 2025 (Table 36).

Malaria

In 2025, 48 cases of malaria were notified, compared with 29 cases in 2024. The 2025 notification rate (0.9 per 100,000) was significantly higher than the 2024 rate (0.5 per 100,000).

Figure 22 shows the number of notified cases of malaria each year since 2006. There was a large decrease in cases from 2020 to 2022 due to COVID-19 border restrictions.

Figure 22. Malaria notifications by year, 2006–2025



Adults aged 20–29 years had the highest notification rate (2.2 per 100,000), followed by those aged 30–39 and 40–49 years (1.6 and 1.5 per 100,000 respectively).

Males (1.5 per 100,000) had a higher rate than females (0.3 per 100,000).

Ethnicity was recorded for all 48 cases. The ethnic group with the highest notification rate was Pacific peoples (8.2 per 100,000).

Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Hospitalisation status was recorded for 47 (97.9%) cases, of which 35 (74.5%) cases were hospitalised.

Table 17 shows the region and country of overseas travel and the *Plasmodium* species identified for the 48 malaria cases. The species was identified in 47 (97.9%) cases: 38 were *Plasmodium vivax*, and nine were *P. falciparum.* The most commonly reported region was Oceania with 35 cases.

Table 17. Region and country of overseas travel and *Plasmodium* species for malaria notifications, 2025

Region	Country resided in or visited	*Plasmodium* species		
		P. falciparum	*P. vivax*	Indeterminate
North Africa and the Middle East	Sudan	1		
Sub-Saharan Africa	Côte d'Ivoire			1
	Eritrea		1	
	Nigeria	2		
	Sierra Leone	1		
	South Sudan	1		
Southern and Central Asia	Afghanistan		1	
	India	1	2	
	Pakistan		1	
South-East Asia	Indonesia		1	
Oceania	Papua New Guinea		2	
	Solomon Islands	3	29	
	Vanuatu		1	

Information on prophylaxis was available for 38 cases, of which 18 (47.4%) were offered prophylaxis. Fourteen (77.8%) cases were recorded as taking prophylaxis as prescribed.

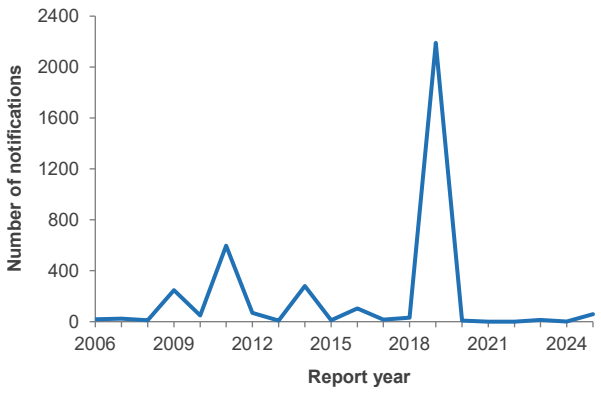
Measles

Measles vaccination was introduced in 1969 [22] and measles has been a notifiable disease since June 1996.[3] The recommended schedule for measles, mumps and rubella (MMR) vaccine is two doses given at 12 months and 15 months of age.[22] In October 2017, New Zealand was verified by the WHO as having eliminated endemic measles.[29]

In 2025, 58 cases of measles were notified, compared with one case in 2024. The 2025 notification rate (1.1 per 100,000) was significantly higher than the 2024 rate (0.02 per 100,000).

The number of measles cases notified since 2006 is shown in Figure 23. The most recent peak in notifications was in 2019 with 2190 cases.

Figure 23. Measles notifications by year, 2006–2025



The highest notification rates for measles were reported from Wairarapa and Northland Districts (13.6 and 6.5 per 100,000 respectively).

Notification rates were highest for those aged 10–14 years (2.9 per 100,000) and 15–19 years (2.5 per 100,000).

Females (1.2 per 100,000) had a higher rate than males (0.9 per 100,000).

The ethnic group with the highest notification rate was Māori (1.8 per 100,000), followed by European or Other (1.2 per 100,000).

Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Hospitalisation status was recorded for all 58 cases and 15 (25.9%) were hospitalised.

Vaccination status was known for 52 (89.7%) cases, of which 39 (75.0%) were not vaccinated. Of the 13 vaccinated cases, one had received one vaccine dose, 10 had received two doses and dose information was unknown for the remaining two cases (Table 18)

Eight cases were imported and 50 were import-related. The countries of importation were Canada (3 cases), Indonesia, Vietnam (2 cases each) and Australia (1 case).

Three outbreaks of measles were reported in 2025, involving 55 cases (Table 27). The index case in all three outbreaks had acquired their infection overseas.

Health New Zealand hospital discharge data for 2025 included 29 hospitalisations where measles was the principal diagnosis (Table 37).

Meningococcal disease

The meningococcal group B (MenB) vaccine was added to the national immunisation schedule on 1 March 2023. The recommended vaccination schedule for meningococcal group B disease is a primary course of MenB vaccine at ages 3 months and 5 months, followed by a booster dose at age 12 months. In addition, MenACWY and MenB vaccines are funded for high-risk groups, including those aged 13–25 years in their first year of close-living situations.[22]

Table 18. Age group and vaccination status of measles notifications, 2025

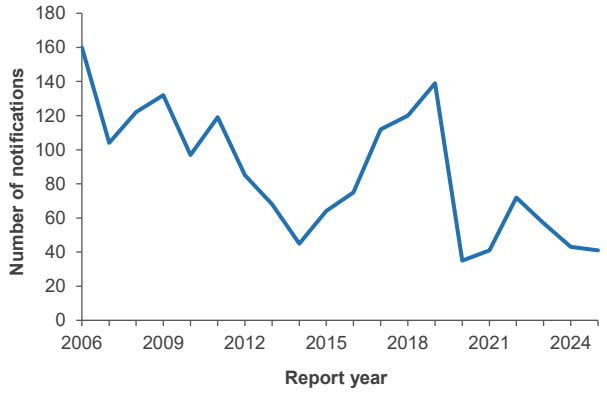
Age group	Total cases	One dose	Two doses	Vaccinated (no dose info)	Not vaccinated	Unknown
<1 year[a]	3	0	0	0	3	0
1–4 years	2	0	0	0	2	0
5–19 years	21	0	2	0	19	0
20+ years	32	1	8	2	15	6
Total	**58**	**1**	**10**	**2**	**39**	**6**

[a] Children aged less than 12 months are ineligible for vaccination.

In 2025, 41 cases of meningococcal disease were notified, compared with 43 cases in 2024. The 2025 notification rate is the same as the 2024 rate (0.8 per 100,000).

Figure 24 shows the number of meningococcal disease notifications from 2006 to 2025. During that time notifications decreased from 160 in 2006 to a low of 35 in 2020.

Figure 24. Meningococcal disease notifications by year, 2006–2025



Only four districts reported five cases or more. These were Counties Manukau (7 cases, 1.1 per 100,000), Auckland (6 cases, 1.2 per 100,000), Taranaki (5 cases, 3.8 per 100,000) and Waitemata (5 cases, 0.7 per 100,000) Districts.

Infants aged less than 1 year had the highest notification rate (13.9 per 100,000), followed by children aged 5–9 years (1.5 per 100,000) and adults aged 50–59 years (1.1 per 100,000).

Females (1.1 per 100,000) had a higher rate than males (0.5 per 100,000).

Ethnicity was recorded for all 41 cases. The ethnic group with the highest notification rate for meningococcal disease was Pacific peoples (2.7 per 100,000) followed by Māori (1.3 per 100,000).

Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Hospitalisation status was recorded for all 41 cases, and all were hospitalised.

Four deaths due to meningococcal disease were reported in 2025 (Table 36), giving a case fatality rate of 9.8%. Two deaths were due to group B, one was due to group Y, and the group was not identified for one death. The deaths were in cases aged less than 1 year, 15–19 years, 30–39 years and 70 years and over.

The group was determined for 35 cases. The majority (74.3%, 26 cases) were group B, six (17.1%) were group Y, two (5.7%) were group W and one (2.9%) was group C (Table 19). For children aged less than 5 years, all nine cases were confirmed and seven had a group determined: all were group B strains. Of the seven group B cases, six were unvaccinated and one was too young to be vaccinated.

Table 19. Meningococcal disease strain group distribution by year, 2021–2025

Strain group	2021	2022	2023	2024	2025
Group B	**29**	**46**	**33**	**26**	**26**
B:P1.7-12,14	12	14	11	10	11
B:P1.7-2,4	8	14	10	4	6
Other group B	9	18	12	12	9
Group Y	**1**	**8**	**6**	**5**	**6**
Group W	**6**	**3**	**2**	**4**	**2**
W:P1.5,2	6	3	2	3	2
Other group W	0	0	0	1	0
Group C	**0**	**0**	**2**	**0**	**1**
Total*	**36**	**57**	**43**	**35**	**35**

*Total number of laboratory-confirmed cases where the strain was determined.

The antimicrobial susceptibilities of 17 viable meningococcal isolates received by PHF Science from cases of invasive disease in 2025 were tested. All isolates were susceptible to ciprofloxacin, ceftriaxone and rifampicin. Two isolates were penicillin resistant (defined as minimum inhibitory concentration (MIC) ≥0.5 mg/L); one was group Y and one was group W. Twelve (70.6%) isolates had a penicillin MIC ≥0.12 mg/L, indicating reduced susceptibility to penicillin.

Middle East Respiratory Syndrome (MERS)

No cases of MERS have been notified in New Zealand since it became notifiable on 6 September 2013.

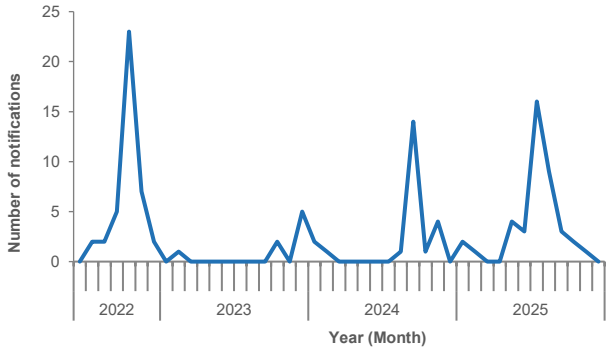
Mpox (Monkeypox)

Mpox became a notifiable disease in New Zealand on 9 June 2022 [30] after a global outbreak began in early May 2022.[31]

In 2025, 41 cases of mpox were notified, compared with 23 cases in 2024. The 2025 notification rate (0.8 per 100,000) was significantly higher than the 2024 rate (0.4 per 100,000).

Monthly notifications for mpox peaked in October 2022 when 23 cases were notified and again in September 2024 and July 2025 with 14 and 16 cases respectively (Figure 25).

Figure 25. Mpox notifications by month, June 2022–December 2025



Only three districts reported five or more cases. These were Auckland (13 cases, 2.6 per 100,000), Canterbury (10 cases, 1.6 per 100,000) and Waitemata (9 cases, 1.3 per 100,000) Districts.

Adults aged 30–39 years (2.1 per 100,000) had the highest rate of mpox, followed by those aged 20–29 years (1.3 per 100,000) and 40–49 years (1.2 per 100,000).

All 41 cases were male.

Ethnicity was recorded for all 41 cases. The ethnic group with the highest notification rate was Asian (1.2 per 100,000).

Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Hospitalisation status was recorded for all 41 cases and seven (17.1%) were hospitalised.

Vaccination status was known for 39 (95.1%) cases. Of these, 25 (64.1%) cases were not vaccinated, three (7.7%) had received one vaccine dose, nine (23.1%) had received two or more doses, and two were reported as being vaccinated but no dose information was available.

The majority of mpox cases (39/41, 95.1%) were men who have sex with men.

The source of infection was known for 39 (95.1%) cases, of which 33 (84.6%) acquired their infection locally and six (15.4%) acquired their infection overseas.

One outbreak of mpox was reported in 2025, involving three cases (Table 27).

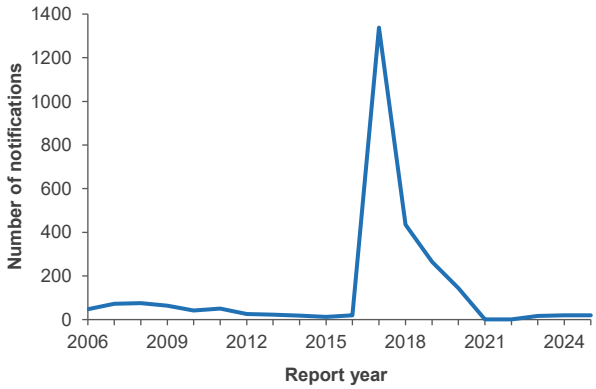
Mumps

Vaccination against mumps was introduced to the national immunisation schedule in 1990 as part of the MMR vaccine,[22] and mumps became notifiable in June 1996.[3] The recommended schedule for MMR vaccine is two doses given at 12 months and 15 months of age.[22]

In 2025, 19 cases of mumps were notified, the same number as in 2024. The 2025 and 2024 rates were both 0.4 per 100,000.

Figure 26 shows mumps notifications from 2006 to 2025. Prior to 2017, the last mumps epidemic occurred in 1994.[22]

Figure 26. Mumps notifications by year, 2006–2025



Auckland (7 cases) and Counties Manukau (5 cases) Districts reported the highest number of cases.

The age groups with the highest number of cases were 20–29 years (7 cases), 30-39 years and 40–49 years (4 cases each).

Fifteen cases were male and four were female.

Ethnicity was recorded for all 19 cases. Ten cases were Asian, seven were European or Other and two were Māori.

Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Hospitalisation status was recorded for all 19 cases and one (5.3%) was hospitalised.

Vaccination status was known for 10 (52.6%) cases (Table 20). Of these, five (50.0%) cases were not vaccinated, three (30.0%) had received one vaccine dose and two (20.0%) had received two doses.

Three outbreaks of mumps were reported in 2025, involving nine cases (Table 27).

Table 20. Age group and vaccination status of mumps notifications, 2025

Age group	Total cases	One dose	Two doses	Not vaccinated	Unknown
<1 year[a]	0	0	0	0	0
1–4 years	1	1	0	0	0
5–19 years	3	0	2	0	1
20+ years	15	2	0	5	8
Total	**19**	**3**	**2**	**5**	**9**

[a] Children aged less than 12 months are ineligible for vaccination.

Health New Zealand hospital discharge data for 2025 included 23 hospitalisations where mumps was the principal diagnosis (Table 37).

Non-seasonal influenza

Non-seasonal influenza became a notifiable and quarantinable disease in New Zealand in April 2009, with confirmed cases requiring evidence of influenza A(H1N1)pdm09 infection (the pandemic strain). This strain was re-classified as seasonal on 1 January 2011.

Non-seasonal influenza is currently inactive as a notifiable disease category. It will be activated in response to the emergence of a novel strain of influenza with pandemic potential.[8]

Paratyphoid fever

In 2025, 11 cases of paratyphoid fever were notified, compared with 14 cases in 2024. The 2025 notification rate (0.2 per 100,000) was similar to the 2024 notification rate (0.3 per 100,000).

Figure 27 shows the number of notifications of paratyphoid fever each year since 2006. The case definition for paratyphoid fever was changed in December 2017 to exclude cases of *S*. Paratyphi B var. Java.[8] A low of two cases was reported in 2021 when the New Zealand border was closed due to COVID-19 restrictions.

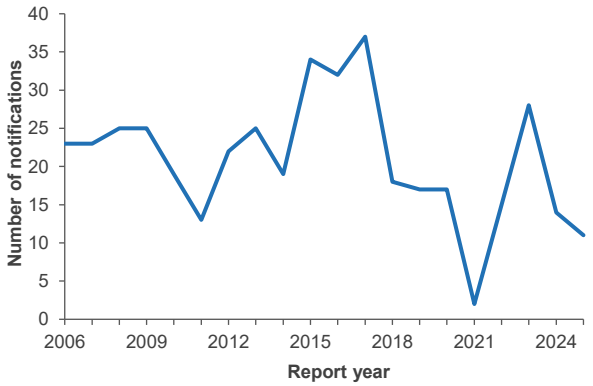
Adults aged 20–29 years (6 cases) and 30–39 years (4 cases) had the highest number of cases.

Eight cases were male and three were female.

Ethnicity was recorded for all 11 cases. Nine cases were Asian, and two were European or Other.

Hospitalisation status was recorded for all 11 cases and seven (63.6%) were hospitalised.

Figure 27. Paratyphoid fever notifications by year, 2006–2025



Note: Case definition changed in December 2017 to exclude cases due to *S*. Paratyphi B var. Java

All 11 cases had travelled to India during the incubation period.

The Enteric Reference Laboratory at PHF Science confirmed 10 isolates as *Salmonella* Paratyphi during 2025, all were *S*. Paratyphi A. The 7-gene MLST types identified were ST85 (6 isolates), ST129 and ST1938 (2 isolates each).

Pertussis

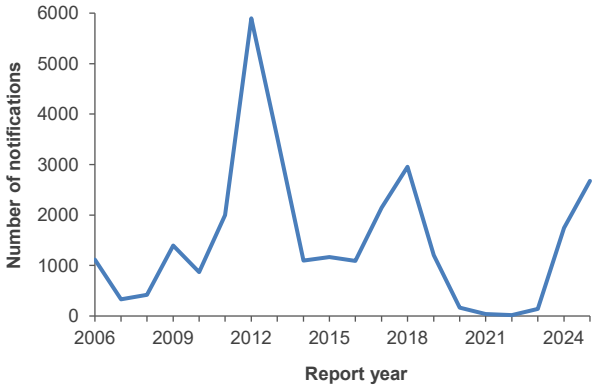
Pertussis is a vaccine-preventable disease caused by the bacterium *Bordetella pertussis*. Epidemics occur every 2–5 years, with a periodicity that is less affected by mass vaccination than other childhood vaccine-preventable diseases.[22] Pertussis vaccination has been included in the national immunisation schedule in New Zealand since 1960. Pertussis has been notifiable since June 1996.[3]

The recommended vaccination schedule for pertussis is a primary course of DTaP-IPV-HepB/Hib at ages 6 weeks, 3 months and 5 months, followed by booster doses at ages 4 years (DTaP-IPV) and 11 years (Tdap). Vaccination with Tdap is also recommended and funded for pregnant women from 16 weeks' gestation.[22]

In 2025, 2678 pertussis cases were notified, compared with 1745 cases in 2024. The 2025 notification rate (50.3 per 100,000) was significantly higher than the 2024 rate (33.0 per 100,000).

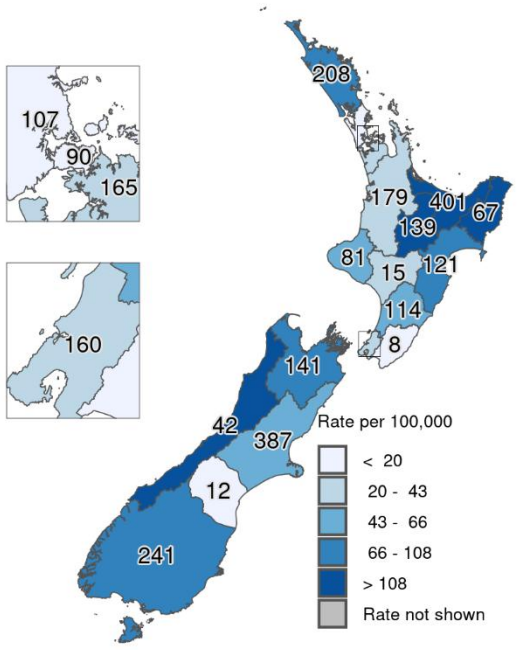
The current national outbreak of pertussis began in late 2024 and continued throughout 2025. The previous national outbreak occurred in 2017–2018 (Figure 28).

Figure 28. Pertussis notifications by year, 2006–2025



The highest notification rate for pertussis was reported from Bay of Plenty District (144.5 per 100,000), followed by Tairawhiti, West Coast and Lakes Districts (127.1, 121.0 and 115.2 per 100,000 respectively) (Figure 29).

Figure 29. Pertussis notifications by district, 2025



Numbers represent notification count in district.
Where fewer than five cases rates are not shown.

Infants aged less than 1 year (426.5 per 100,000) had the highest notification rate, followed by children aged 1–4 years (233.1 per 100,000) and 5–9 years (146.0 per 100,000).

Females (54.3 per 100,000) had a higher rate than males (46.0 per 100,000).

Ethnicity was recorded for 2667 (99.6%) cases. The ethnic group with the highest notification rate was Māori (99.7 per 100,000), followed by European or Other and Pacific peoples (47.7 and 47.6 per 100,000 respectively).

Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Hospitalisation status was recorded for 2652 (99.0%) cases, of which 252 (9.5%) cases were hospitalised. For Pacific peoples, 21.2% (38/179) of cases were hospitalised and for Māori 13.2% (122/926) of cases were hospitalised. Almost half (49.4%, 120/243) of cases aged less than 1 year were hospitalised.

Vaccination status was known for 2009 (75.0%) cases (Table 21). Of these, 748 (37.2%) cases were not vaccinated, including 26 infants aged less than 6 weeks who were too young to be vaccinated. One hundred and eight-five (9.2%) cases had received one dose of pertussis vaccine, 75 (3.7%) had received two doses and 850 (42.3%) had received three or more doses. A further 151 (7.5%) cases were reported as being vaccinated but no dose information was available. Information on maternal vaccination was not available for 2025.

There were 17 outbreaks of pertussis reported in 2025, involving 114 cases (Table 27).

Health New Zealand hospital discharge data for 2025 included 283 hospitalisations where pertussis was the principal diagnosis (Table 37).

Table 21. Age group and vaccination status of pertussis notifications, 2025

Age group	Total cases	One dose	Two doses	Three doses	Four doses	Five doses	Vaccinated (no dose info)	Not vaccinated	Unknown
0–5 weeks[a]	26	0	0	0	0	0	0	26	0
6 weeks–2 months	48	19	0	0	0	0	0	28	0
3–4 months	48	19	8	0	0	0	2	21	0
5 months–3 years	583	28	28	233	2	0	20	237	34
4–10 years	676	22	16	69	272	13	33	190	61
11+ years	1297	97	23	40	109	112	96	246	574
Total	**2678**	**185**	**75**	**342**	**383**	**125**	**151**	**748**	**669**

[a] Children aged less than six weeks are ineligible for vaccination.

Plague

The last case of plague (*Yersinia pestis*) in New Zealand was reported in 1911. From 1900 to 1911, 21 cases of plague were recorded in New Zealand, nine of which were fatal.[32]

Poliomyelitis (polio)

There were no polio notifications in 2025.

The NZPSU carries out active surveillance of acute flaccid paralysis (AFP) to demonstrate the absence of poliovirus. In 2025, 10 cases of AFP were notified to the NZPSU. All 10 cases were reviewed by the National Certification Committee for the Eradication of Poliomyelitis (NCCEP) and classified as non-polio.

Since the mass oral polio vaccine (OPV) immunisation campaigns in New Zealand in 1961 and 1962, six polio cases have been reported. All were either laboratory confirmed as vaccine associated (4 cases) or classified as probable vaccine-associated cases (2 cases).[22] The most recent vaccine-associated case occurred in 1999.[33]

No cases have been reported since the inactivated polio vaccine (IPV) replaced OPV in 2002.[22]

PHF Science introduced wastewater surveillance for polioviruses in January 2023. In 2025, Sabin-like poliovirus type 3 was detected on two occasions. There have been no detections of wild poliovirus or vaccine-derived polioviruses to date.

Primary amoebic meningoencephalitis

The last case of primary amoebic meningoencephalitis (*Naegleria fowleri)* in New Zealand was notified in 2000. There were five prior cases, four of which were part of the same outbreak in 1968. All six cases were fatal and were linked to swimming in geothermal pools in the central North Island.[34]

Q fever

One case of Q fever (*Coxiella burnetii*) was notified in 2025. The case was a male aged 50–59 years who had worked on a farm in Australia.

Six cases of Q fever were notified in New Zealand between 1997 and 2024. All six cases reported overseas travel during the incubation period.

Rabies and other lyssaviruses

No cases of rabies or other lyssavirus were notified in 2025. New Zealand is classified as a rabies-free country.[35] An imported case of rabies was notified in 2023.[36]

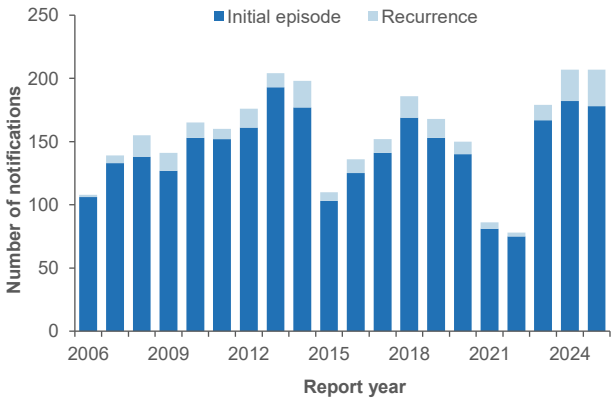
Rheumatic fever

In 2025, 207 cases of rheumatic fever were notified, which was the same number as in 2024. The notification rate was 3.9 per 100,000.

Of the 207 cases of rheumatic fever, 178 were initial episodes and 29 were recurrences.

Figure 30 shows the number of initial and recurrent episodes of rheumatic fever reported each year since 2006.

Figure 30. Rheumatic fever notifications by year, 2006–2025



Counties Manukau District (16.4 per 100,000) had the highest rate, followed by Tairawhiti (9.5 per 100,000), Hawke's Bay (5.0 per 100,000), Northland (4.5 per 100,000) and Auckland (4.2 per 100,000).

Children aged 10–14 years (19.2 per 100,000) had the highest rate, followed by those aged 5–9 years (9.8 per 100,000).

Females (4.0 per 100,000) had a higher rate than males (3.8 per 100,000).

Ethnicity was known for 206 (99.5%) cases. The ethnic group with the highest rate was Pacific peoples (30.3 per 100,000), followed by Māori (9.3 per 100,000). These two ethnic groups accounted for 97.6% of cases.

Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Hospitalisation status was recorded for 204 (98.6%) cases, of which 193 (94.6%) were hospitalised.

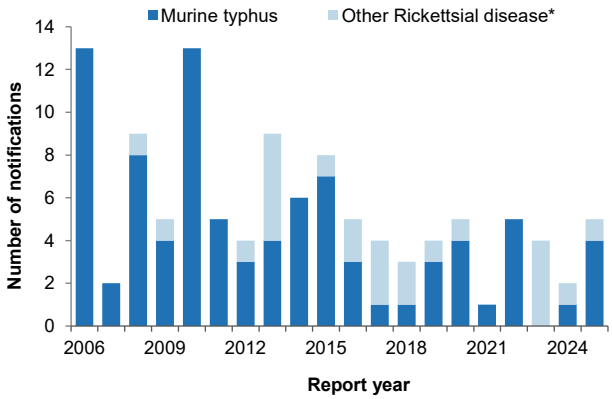
Health New Zealand hospital discharge data for 2025 included 266 hospitalisations where rheumatic fever was the principal diagnosis (Table 37).

Rickettsial disease

This section includes murine typhus (*Rickettsia typhi*), typhus (*Rickettsia prowazekii*) and other rickettsial diseases caused by organisms of the *Rickettsia* genus.

Five cases of rickettsial disease were notified in 2025, compared with two cases in 2024 (Figure 31).

Figure 31. Rickettsial disease notifications by year, 2006–2025



* Includes all other diseases caused by organisms of the *Rickettsia* genus, except typhus.

Murine typhus (*Rickettsia typhi*)

Four cases of murine typhus were notified in 2025. The cases were all reported from the Auckland area.

Two cases were male and two were female. Two cases were Māori and two were European or Other ethnicity. Two were aged 30–39 years and one each were 15–19 and 40–49 years.

All four cases were hospitalised.

Three cases lived rurally and the remaining case reported exposure to rats.

Typhus (Rickettsia prowazekii)

No cases of typhus have been reported from 1997 to 2025.

Other rickettsial diseases

A case of rickettsial disease due to *Orientia tsutsugamushi* (formerly *Rickettsia tsutsugamushi,* scrub typhus) was notified in 2025.

The case was a female, aged 60–69 years and was hospitalised. The case acquired their infection while travelling in Laos.

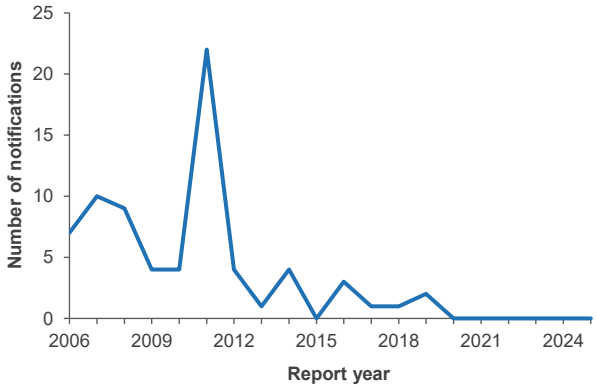
Rubella

Rubella vaccination was introduced in 1970 for all children at age 4 years. In 1979 it was limited to girls at age 11 years and then extended to all children again when MMR was introduced in 1990. The recommended schedule for MMR vaccine is two doses given at 12 months and 15 months of age.[22] Rubella has been a notifiable disease since June 1996.[3]

No cases of rubella were notified in 2025. The last case was notified in 2019.

The number of rubella cases since 2006 is shown in Figure 32. The most recent peak in notifications was in 2011 with 22 cases. The last national rubella outbreak occurred in 1995.[22]

Figure 32. Rubella notifications by year, 2006–2025



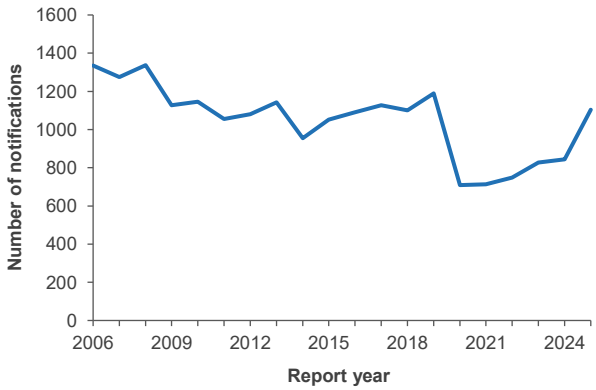
Congenital rubella

No cases of congenital rubella were reported to the NZPSU in 2025. There have been no reported cases of congenital rubella in New Zealand since 1998.

Salmonellosis

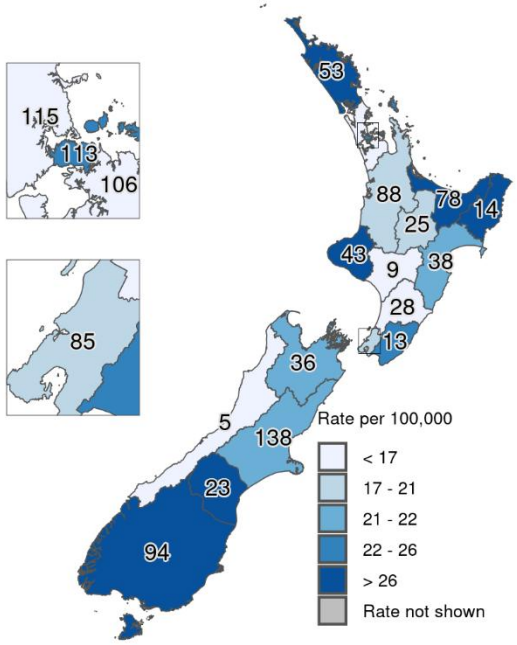
In 2025, 1104 cases of salmonellosis were notified, compared with 844 in 2024. The 2025 notification rate (20.7 per 100,000) was significantly higher than the 2024 rate (16.0 per 100,000). The number of salmonellosis notifications in 2025 is similar to pre-COVID-19 pandemic levels (Figure 33).

Figure 33. Salmonellosis notifications by year, 2006–2025



The highest rate of salmonellosis was reported from South Canterbury District (36.3 per 100,000), followed by Taranaki, Bay of Plenty, and Tairawhiti Districts (33.0, 28.1 and 26.6 per 100,000 respectively) (Figure 34).

Figure 34. Salmonellosis notifications by district, 2025



Numbers represent notification count in district.
Where fewer than five cases rates are not shown.

Infants aged less than 1 year (107.5 per 100,000) had the highest notification rate, followed by children aged 1–4 years (53.8 per 100,000).

Males (21.2 per 100,000) had a higher rate than females (20.0 per 100,000).

Ethnicity was recorded for 1099 (99.5%) cases. The ethnic group with the highest notification rate was European or Other (23.5 per 100,000), followed by Asian (18.0 per 100,000).

Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Hospitalisation status was recorded for 1063 (96.3%) cases, of which 383 (36.0%) cases were hospitalised.

The most common risk factors reported for salmonellosis in 2025 were overseas travel and consumption of food from retail premises (Table 22).

Nine outbreaks of salmonellosis were reported in 2025, involving 74 cases (Table 27).

The Enteric Reference Laboratory at PHF Science confirmed the identity of *Salmonella* isolated from 1041 cases of salmonellosis in 2025. The most common serotypes identified were *S.* Typhimurium (433 cases) and *S.* Enteritidis (11 cases). Whole genome sequence analysis was used to confirm 7-gene sequence types and genomic clusters. The most common *S.* Typhimurium sequence types were ST19 (205 isolates) and ST568 (90 isolates).

Severe acute respiratory syndrome (SARS)

No cases of SARS have been diagnosed in New Zealand since SARS emerged in Southern China in 2003.[8]

Shiga toxin-producing *Escherichia coli* infection (STEC)

Shiga toxin-producing *Escherichia coli* (STEC) may also be referred to as Verocytotoxin-producing *E. coli* (VTEC) or enterohaemorrhagic *E. coli* (EHEC). STEC is now the preferred term.

In 2025, 1191 cases of STEC infection were notified, compared with 1112 cases in 2024. The 2025 notification rate (22.4 per 100,000) was higher than the 2024 rate (21.0 per 100,000).

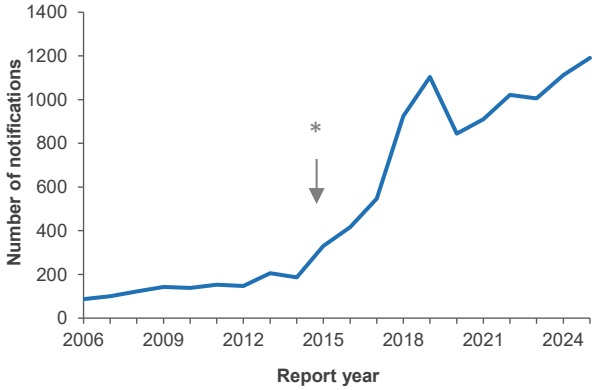
Table 22. Exposure to risk factors associated with salmonellosis, 2025

Risk factor	Yes	No	Unknown	Percentage (%) [a]
Travelled overseas during the incubation period	340	608	156	35.9
Consumed food from retail premises	255	540	309	32.1
Contact with farm animals	166	584	354	22.1
Recreational water contact	162	585	357	21.7
Consumed untreated water	103	530	471	16.3
Contact with other symptomatic people	108	662	334	14.0
Contact with faecal matter	62	648	394	8.7
Contact with sick animals	38	665	401	5.4

[a] Percentage refers to the number of cases that answered "yes" out of the total number of cases for which this information was known. Some cases had more than one risk factor recorded.

The introduction of culture independent diagnostic testing (CIDT), which is particularly sensitive to detecting non-O157 serotypes, is the main contributor to the increase in STEC infection notifications since mid-2015 (Figure 35).

Figure 35. STEC infection notifications by year, 2006–2025



*Screening of faecal specimens using PCR begins in some laboratories.

The highest rate of STEC infection notifications was from South Canterbury District (61.5 per 100,000), followed by Taranaki, Northland and Southern Districts (45.2, 44.3 and 39.9 per 100,000 respectively) (Figure 36).

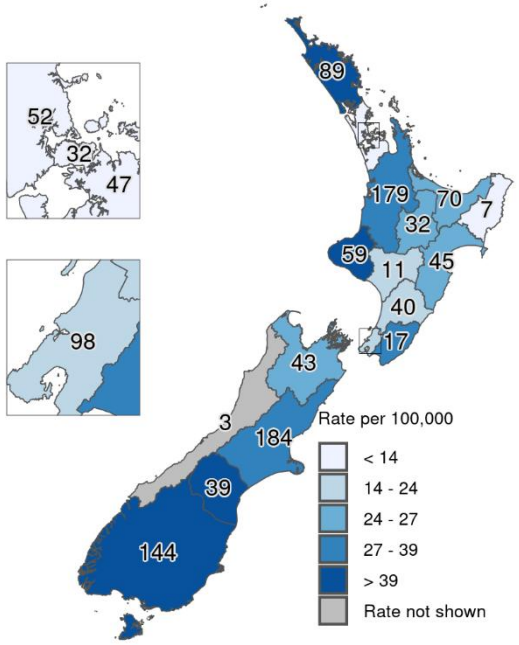
Infants aged less than 1 year (83.2 per 100,000) had the highest notification rate, followed by children aged 1–4 years (61.3 per 100,000).

Females (23.8 per 100,000) had a higher rate than males (20.9 per 100,000).

Ethnicity was recorded for 1179 (99.0%) cases. The ethnic group with the highest notification rate was European or Other (28.8 per 100,000), followed by Māori (20.6 per 100,000).

Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Figure 36. STEC infection notifications by district, 2025



Numbers represent notification count in district.
Where fewer than five cases rates are not shown.

Hospitalisation status was recorded for 1119 (94.0%) cases, of which 294 (26.3%) cases were hospitalised. Of the 185 (62.9%) hospitalised cases that were serotyped, 63 (34.1%) were due to *E. coli* O157:H7 and 60 (32.4%) were due to *E. coli* O26:H11. Haemolytic uraemic syndrome (HUS) was reported for 29 hospitalised cases, and a serotype was determined in 26 of these: 17 were due to *E. coli* O26:H11 and nine were due to *E. coli* O157:H7.

The most common risk factors reported for STEC infection cases in 2025 were contact with pets, farm animals and animal manure (Table 23).

Table 23. Exposure to risk factors associated with STEC infection, 2025

Risk factor	Yes	No	Unknown	Percentage (%)[a]
Contact with pets	442	45	704	90.8
Contact with farm animals	226	213	752	51.5
Contact with animal manure	128	222	841	36.6
Contact with recreational water	191	608	392	23.9
Contact with other animals	57	287	847	16.6
Contact with a person with similar symptoms	115	706	370	14.0
Contact with children in nappies	94	690	407	12.0
Travelled overseas during the incubation period	98	834	259	10.5

[a] Percentage refers to the number of cases that answered "yes" out of the total number of cases for which this information was known. Some cases had more than one risk factor recorded.

Table 24. Foods consumed by STEC infection cases, 2025

Foods consumed	Yes	No	Unknown	Percentage (%)[a]
Chicken or poultry products	553	124	514	81.7
Dairy products	521	134	536	79.5
Raw fruit or vegetables	541	143	507	79.1
Beef or beef products	499	185	507	73.0
Fruit or vegetable juice	278	327	586	46.0
Processed meat	286	378	527	43.1
Lamb or hogget or mutton	217	435	539	33.3
Home kill meat	175	521	495	25.1
Pink or undercooked meat	99	552	540	15.2

[a] Percentage refers to the number of cases that answered "yes" out of the total number of cases for which this information was known.

The most commonly consumed foods among STEC infection cases were chicken or poultry products, dairy products, raw fruit or vegetables, and beef or beef products (Table 24).

Four outbreaks of STEC infection were reported in 2025, involving 91 cases (Table 27).

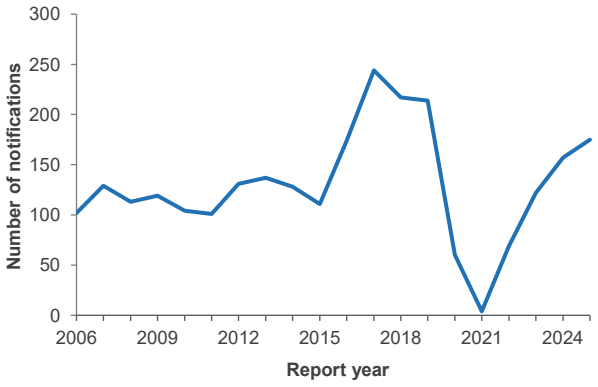
The Enteric Reference Laboratory at PHF Science typed 742 isolates of STEC in 2025. The most common serotypes identified were *E. coli* O157:H7 (21.6%, 160 isolates), *E. coli* O26:H11 (19.9%, 148 isolates) and *E. coli* O128:H2 (11.6%, 86 isolates).

Shigellosis

In 2025, 175 cases of shigellosis were notified, compared with 157 cases in 2024. The 2025 notification rate (3.3 per 100,000) was similar to the 2024 rate (2.0 per 100,000).

Figure 37 shows shigellosis notifications by year from 2006 to 2025. There was a decrease in 2020 and 2021 due to COVID-19 border restrictions.

Figure 37. Shigellosis notifications by year, 2006–2025



South Canterbury, Auckland, Waitemata and Counties Manukau Districts had the highest notification rates for shigellosis (11.0, 9.3, 4.7 and 4.0 per 100,000 respectively).

Children aged 1–4 years (5.8 per 100,000) had the highest notification rate, followed by adults aged 30–39 years (4.9 per 100,000) and 60–69 years (4.5 per 100,000).

Males (4.8 per 100,000) had a higher rate than females (1.8 per 100,000).

Ethnicity was recorded for 173 (98.9%) cases. The ethnic group with the highest notification rate was Pacific peoples (4.8 per 100,000), followed by Asian and European or Other (both 3.2 per 100,000).

Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Hospitalisation status was recorded for 172 (98.3%) cases, of which 55 (32.0%) cases were hospitalised.

The most commonly reported risk factors for shigellosis were MSM sexual behaviour and overseas travel (Table 25). For the 70 cases who travelled overseas during the incubation period, the countries most commonly visited were India (22 cases), Indonesia (11 cases) and Australia (7 cases). Some cases reported travel to more than one country.

Three outbreaks of shigellosis were reported in 2025, involving 11 cases (Table 27).

The Enteric Reference Laboratory at PHF Science confirmed 165 isolates as *Shigella* in 2025. The most common species identified were *S. sonnei* (89 isolates, 53.9%) and *S. flexneri* (70 isolates, 42.4%). The majority (88 isolates, 98.9%) of the *S. sonnei* isolates were sequence type 152. The most common *S. flexneri* sequence type was ST245 (56 isolates, 80%).

Table 25. Exposure to risk factors associated with shigellosis, 2025

Risk factor	Yes	No	Unknown	Percentage (%)[a]
Men who have sex with men[b]	49	21	43	70.0
Travelled overseas during the incubation period	70	86	19	44.9
Contact with other symptomatic people	30	105	40	22.2
Consumed food from retail premises	24	109	42	18.0
Consumed water other than regular supply	17	93	65	15.5
Recreational water contact	17	108	50	13.6
Contact with faecal matter	15	106	54	12.4

[a] Percentage refers to the number of cases that answered "yes" out of the total number of cases for which this information was known.
[b] Only cases in males aged 15 years and over are included for reporting of this risk factor.
Some cases had more than one risk factor recorded.

Taeniasis

Two cases of taeniasis were notified in 2025. The cases were aged 20–29 years and 30–39 years. Both cases were male and were of European or Other ethnicity.

One case had lived in Ethiopia and had consumed raw beef while there. The other case had travelled extensively, including to Ethiopia and Europe, and had consumed raw beef entrails.

A total of 76 cases of taeniasis have been notified since 1997, of which 75 (98.7%) reported a history of overseas travel. One case had an unknown travel history.

Tetanus

No cases of tetanus were notified in 2025.

Between 1997 and 2024, a total of 38 tetanus cases were notified. Of these, four were children aged less than 10 years. Four deaths due to tetanus were reported, all in cases aged 70 years and over

Health New Zealand hospital discharge data for 2025 included two cases where tetanus was the principal diagnosis (Table 37). Over the last five years, there have been 20 hospitalisations with tetanus as the principal diagnosis, compared with only four notifications in EpiSurv during this time, indicating substantial under-notification of tetanus.

Toxic shellfish poisoning

Toxic shellfish poisoning is notifiable under the category of acute gastroenteritis. There are four main types of shellfish poisoning in New Zealand: paralytic shellfish poisoning, neurotoxic shellfish poisoning, amnesic shellfish poisoning and diarrhetic shellfish poisoning.[37]

One case of toxic shellfish poisoning was notified in 2025. The case was classified as suspected paralytic shellfish poisoning based on symptoms.

The case was a female aged 30–39 years and had eaten commercially produced oysters.

Trichinellosis

No cases of trichinellosis were notified in 2025.

Trichinellosis was added to the notifiable diseases schedule in 1988. Since then four cases have been reported, including two cases reported in 2001.[38]

Tuberculosis disease

In 2025, 383 cases of tuberculosis were notified, compared with 360 cases in 2024. The 2025 notification rate (7.2 per 100,000) was higher than the 2024 rate (6.8 per 100,000). There were 371 (96.9%) new cases and 12 (3.1%) reactivations.

Laboratory information was available for 376 (98.2%) tuberculosis cases. Of these, 327 (87.0%) cases were reported as laboratory confirmed.

Figure 38 shows the total number of new and reactivation tuberculosis cases reported since 2006. The number of cases notified in 2025 is the highest total during that time.

The highest notification rates for tuberculosis were reported from Counties Manukau (12.7 per 100,000) and South Canterbury (11.0 per 100,000) Districts, followed by Auckland, Lakes and Waikato (9.9, 9.9 and 9.6 per 100,000 respectively) (Figure 39).

Adults aged 30–39 years had the highest notification rate (13.7 per 100,000), followed by those aged 20–29 years and 40–49 years (10.3 and 9.8 per 100,000 respectively).

Figure 38. Tuberculosis notifications by year, 2006–2025

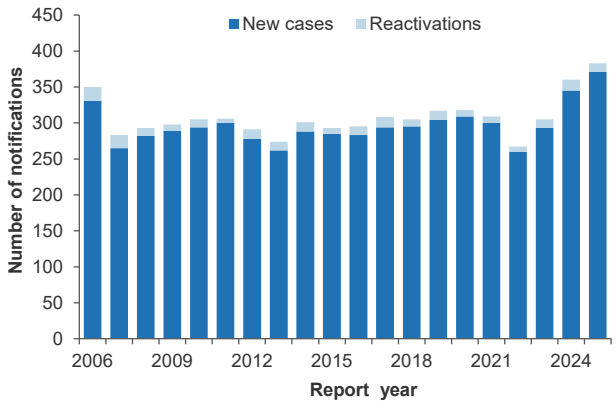
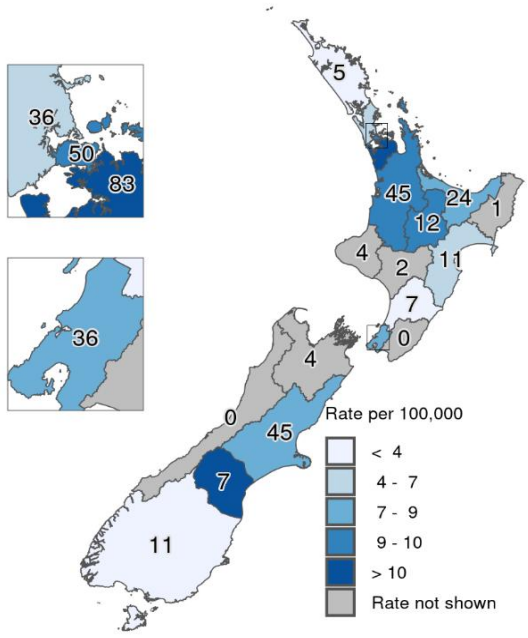


Figure 39. Tuberculosis notifications by district, 2025



Numbers represent notification count in district.
Where fewer than five cases rates are not shown.

Ethnicity was recorded for 377 (98.4%) cases. The ethnic group with the highest notification rate was Asian (29.9 per 100,000), followed by Pacific peoples (9.3 per 100,000).

Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Hospitalisation status was recorded for 379 (99.0%) cases, of which 199 (52.2%) were hospitalised.

Five deaths were reported among tuberculosis cases, two were aged 70 years and over, two were aged 50–59 years and one was aged 30–39 years.

There were five cases aged less than 5 years. Two had not received the BCG vaccine, one of which had miliary tuberculosis. Two cases had received the BCG vaccine as infants and the BCG vaccination status was unknown for the remaining case.

The majority (338/383, 88.3%) of tuberculosis cases were born overseas. Of the cases born in New Zealand, 16.3% (7/43) had been, or were presently, living with a person born outside New Zealand. Māori accounted for half (51.1%, 23/45) of the New Zealand born cases.

Nine of the 12 (75.0%) reactivation cases were born overseas. Six were diagnosed with previous tuberculosis disease overseas and five were diagnosed in New Zealand. The place of diagnosis was unknown for one case. Treatment status was recorded for nine reactivation cases, and eight (88.9%) had previously been treated for the disease.

A quarter (56/219, 25.6%) of cases reported contact with a confirmed case of tuberculosis.

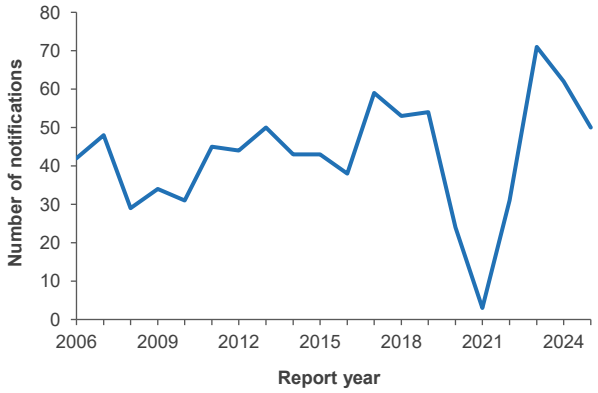
Health New Zealand hospital discharge data for 2025 included 266 hospitalisations where tuberculosis was the principal diagnosis (Table 37).

Typhoid fever

In 2025, 50 cases of typhoid fever were notified compared with 62 cases in 2024. The 2025 notification rate (0.9 per 100,000) was lower than the 2024 rate (1.2 per 100,000).

Figure 40 shows the number of notifications of typhoid fever each year since 2006. A low of three cases was reported in 2021 when the New Zealand border was closed due to COVID-19.

Figure 40. Typhoid fever notifications by year, 2006–2025



The highest notification rates for typhoid fever were reported from Counties Manukau, Waikato and Auckland Districts (2.8, 1.7 and 1.2 per 100,000 respectively).

Notification rates were highest for children aged 1–4 and 5–9 years (both 2.5 per 100,000).

Males and females had similar rates (1.0 and 0.9 per 100,000 respectively).

The ethnic group with the highest notification rate was Asian (4.0 per 100,000), followed by Pacific peoples (2.7 per 100,000).

Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Hospitalisation status was recorded for all 50 cases and 41 (82.0%) were hospitalised.

Of the 50 cases, 42 (84.0%) had travelled overseas during the incubation period. The majority of cases (35 cases, 83.3%) had visited India. One case had travelled overseas outside the incubation period.

Of the seven cases that did not travel overseas, three had contact with another case, and one consumed food prepared by an infected food handler. No source was identified for three cases.

One outbreak of typhoid fever was reported in 2025, involving two cases (Table 27).

The Enteric Reference Laboratory at PHF Science confirmed 54 isolates as *Salmonella* Typhi during 2025. The 7-gene MLST types identified were *S*. Typhi ST1 (31 isolates, 57.4%), ST2 (22 isolates, 40.7%) and ST102 (1 isolate, 1.9%).

Viral haemorrhagic fevers

No cases of viral haemorrhagic fever (including Ebola) have ever been reported in New Zealand.[8]

Yellow fever

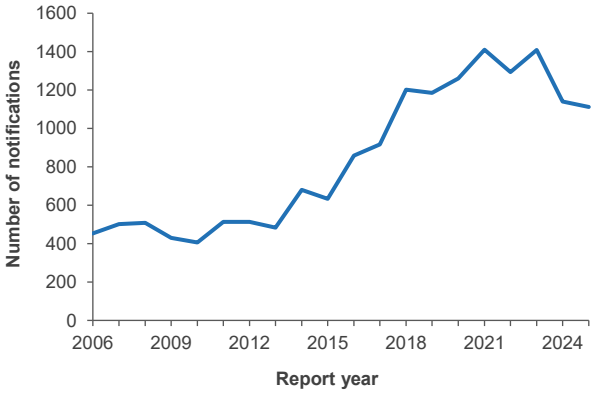
No cases of yellow fever have been notified in New Zealand since at least 1996.

Yersiniosis

In 2025, 1112 cases of yersiniosis were notified, compared with 1140 cases in 2024. The 2025 notification rate (20.9 per 100,000) was a decrease from the 2024 rate (21.6 per 100,000).

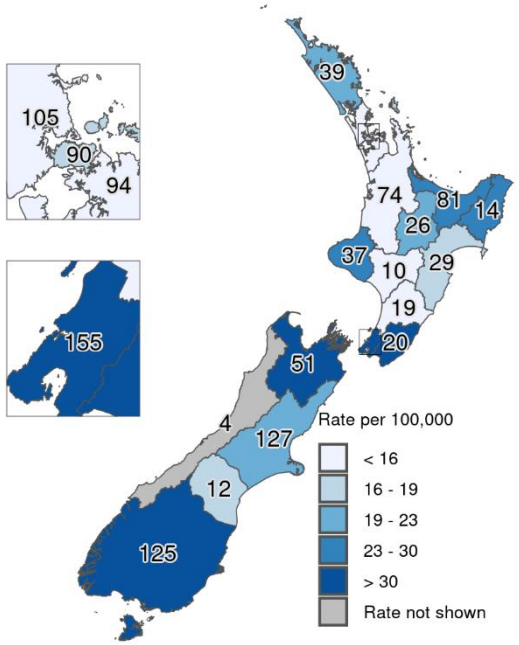
There was a steady increase in the number of yersiniosis notifications from 2013 to 2021 (Figure 41). The introduction of culture independent diagnostic testing methods for *Yersinia* in 2017 has had no significant impact on yersiniosis notifications.[39]

Figure 41. Yersiniosis notifications by year, 2006–2025



Wairarapa, Southern, Capital, Coast and Hutt Valley, and Nelson Marlborough Districts had the highest notification rates for yersiniosis (38.9, 34.6, 32.2 and 30.9 per 100,000 respectively) (Figure 42).

Figure 42. Yersiniosis notifications by district, 2025



Numbers represent notification count in district.
Where fewer than five cases rates are not shown.

Infants aged less than 1 year had the highest notification rate (119.6 per 100,000), followed by children aged 1–4 years (50.9 per 100,000) and adults aged 70 years and over (32.0 per 100,000).

Females (22.7 per 100,000) had a higher rate than males (19.0 per 100,000).

Ethnicity was recorded for 1099 (98.8%) cases. The ethnic group with the highest notification rate was Asian (28.5 per 100,000), followed by European or Other (20.5 per 100,000).

Further information by district, age, sex and ethnic group is in Table 32 to Table 35 in the Appendix.

Hospitalisation status was recorded for 967 (87.0%) cases, of which 163 (16.9%) cases were hospitalised.

Consumption of food from retail premises and contact with farm animals were the most commonly reported risk factors for yersiniosis (Table 26).

Two outbreaks of yersiniosis were reported in 2025, involving 47 cases (Table 27).

The Enteric Reference Laboratory at PHF Science confirmed 748 isolates as *Yersinia enterocolitica* and seven as *Y. pseudotuberculosis* during 2025. The most common *Y. enterocolitica* sequence types identified were ST12 (483 isolates, 64.6%), and ST18 (89 isolates, 11.9%). Diagnostic laboratories in the upper half of the North Island no longer test for *Y. pseudotuberculosis* in faecal specimens, so this species is likely to be under detected.

Table 26. Exposure to risk factors associated with yersiniosis, 2025

Risk factor	Yes	No	Unknown	Percentage (%) [a]
Consumed food from retail premises	183	261	668	41.2
Contact with farm animals	122	354	636	25.6
Recreational water contact	72	395	645	15.4
Consumed untreated water	61	363	688	14.4
Contact with faecal matter	51	388	673	11.6
Contact with other symptomatic people	50	391	671	11.3
Travelled overseas during the incubation period	33	511	568	6.1

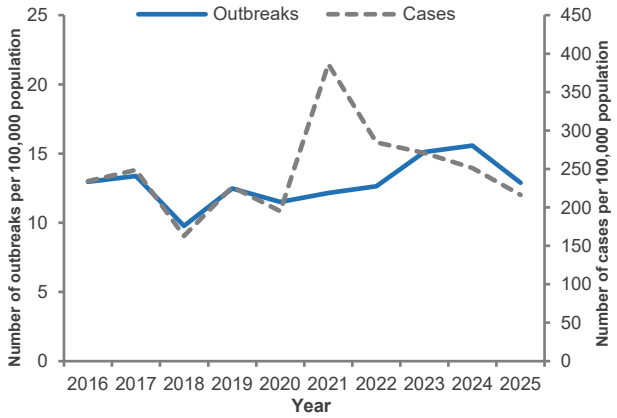
[a] Percentage refers to the number of cases that answered “yes” out of the total number of cases for which this information was known. Some cases had more than one risk factor recorded.

OUTBREAKS

This section summarises outbreaks that were recorded in EpiSurv in 2025. There were 687 reported outbreaks in 2025, a decrease from the 824 reported in 2024. A total of 11,507 cases were associated with outbreaks in 2025, compared with 13,298 cases in 2024.

The outbreak rate in 2025 (12.9 per 100,000) was lower than the rate reported in 2024 (15.6 per 100,000) (Figure 43). The 2025 case rate (216.1 per 100,000) was also lower than the 2024 case rate (251.4 cases per 100,000).

Figure 43. Outbreak rate and outbreak case rate by year, 2016–2025



Causal agents

A causal agent or condition was identified in 53.4% (367/687) of outbreaks, involving 57.8% (6653/11,507) of all outbreak-associated cases (Table 27). No specific pathogen was identified in 320 outbreaks, which were recorded as gastroenteritis (286 outbreaks), influenza-like illness (15 outbreaks) and acute respiratory infection (19 outbreaks).

Enteric agents were implicated in the majority of outbreaks (72.9%, 501/687) and associated cases (77.0%, 8859/11,507) (Table 27). Norovirus was the most common causal agent implicated in outbreaks in 2025 (22.6%, 155/687) and accounted for 32.3% of outbreak cases.

Non-enteric agents accounted for 27.1% (186/687) of outbreaks and 23.0% (2648/11,507) of outbreak cases.

Outbreak settings

Most outbreaks (89.7%, 616/687) were set in institutions, with childcare centres (43.8%, 301/687) and long-term care facilities (37.7%, 259/687) accounting for over three-quarters of the reported outbreaks and associated cases (Table 28).

Modes of transmission

The most commonly reported mode of transmission in 2025 was person-to-person (92.6%, 636/687 outbreaks) (Table 29). Person-to-person transmission also accounted for the highest percentage of associated cases (93.6%, 10,776/11,507).

Table 27. Outbreaks and associated cases by pathogen, 2025

Pathogen or condition	Outbreaks[1]			Cases[1]	
	Total	% of outbreaks (n=687)	Median cases per outbreak	Total	% of cases (n=11,507)
Enteric	**501**	**72.9**	**14**	**8859**	**77.0**
Norovirus	155	22.6	20	3713	32.3
Rotavirus	9	1.3	13	135	1.2
Salmonella[2]	9	1.3	2	74	0.6
Sapovirus	7	1.0	23	149	1.3
Adenovirus	7	1.0	7	79	0.7
Campylobacter	7	1.0	3	57	0.5
Cryptosporidium	6	0.9	30.5	158	1.4
Astrovirus	5	0.7	9	44	0.4
Shiga toxin-producing *E. coli* (STEC)	4	0.6	20.5	91	0.8
Clostridium perfringens	3	0.4	32	135	1.2
Enteropathogenic *E. coli* (EPEC)	3	0.4	7	112	1.0
Shigella	3	0.4	2	11	0.1
Yersinia	2	0.3	23.5	47	0.4
Hepatitis A	2	0.3	8	16	0.1
Giardia	2	0.3	2	4	0.0
Clostridium difficile	1	0.1	24	24	0.2
Histamine (scombroid) fish poisoning	1	0.1	5	5	0.0
Vibrio parahaemolyticus	1	0.1	5	5	0.0
Typhoid fever	1	0.1	2	2	0.0
Pathogen not identified	286	41.6	12	4303	37.4
Non-enteric	**186**	**27.1**	**12**	**2648**	**23.0**
Influenza[3]	130	18.9	14	2361	20.5
SARS-CoV-2	40	5.8	8	526	4.6
Bordetella pertussis[4]	17	2.5	5	114	1.0
Mycobacterium tuberculosis	5	0.7	3	15	0.1
Invasive group A streptococcal infection	4	0.6	2	8	0.1
Measles virus	3	0.4	9	55	0.5
Mumps virus	3	0.4	3	9	0.1
Hepatitis A	1	0.1	3	3	0.0
Mpox	1	0.1	3	3	0.0
Invasive pneumococcal disease	1	0.1	2	2	0.0
Neisseria meningitidis	1	0.1	2	2	0.0

[1] More than one agent was reported in 31 outbreaks, therefore the numbers don't add up to the group totals.
[2] Non-typhoidal *Salmonella* species only.
[3] Includes outbreaks of influenza A (49 outbreaks, 897 cases), respiratory syncytial virus (RSV) (23 outbreaks, 402 cases), acute respiratory infection (19 outbreaks, 304 cases), influenza-like illness (15 outbreaks, 247 cases), influenza B (12 outbreaks, 371 cases), rhinovirus (5 outbreaks, 54 cases), enterovirus (3 outbreaks, 32 cases), human metapneumovirus (HMPV) (2 outbreaks, 31 cases), influenza NOS (1 outbreak, 14 cases), and coronavirus HKU1 (1 outbreak, 9 cases).
[4] Includes four household outbreaks. Household outbreaks of pertussis were not required to be reported in 2025.

Table 28. Outbreaks and associated cases by setting of exposure, 2025

Outbreak setting	Outbreaks[1]		Cases[1]	
	Total	% of outbreaks (n=687)	Total	% of cases (n=11,507)
Institution	**616**	**89.7**	**10905**	**94.8**
Childcare centre	301	43.8	5007	43.5
Long term care facility	259	37.7	4854	42.2
Hospital (acute care)	23	3.3	267	2.3
School	17	2.5	567	4.9
Camp	7	1.0	112	1.0
Marae	1	0.1	33	0.3
Hotel/motel	1	0.1	23	0.2
Hostel / boarding house	1	0.1	3	0.0
Other institution	7	1.0	63	0.5
Commercial food operators	**30**	**4.4**	**319**	**2.8**
Restaurant / café / bakery	20	2.9	149	1.3
Caterers	3	0.4	140	1.2
Takeaway	3	0.4	11	0.1
Fast food restaurant	1	0.1	3	0.0
Supermarket / delicatessen	1	0.1	3	0.0
Other food outlet	3	0.4	16	0.1
Workplace / Community / Other	**46**	**6.7**	**364**	**3.2**
Home	28	4.1	115	1.0
Community, church, sports gathering	3	0.4	49	0.4
Cruise ship, airline, tour bus, train	3	0.4	20	0.2
Farm	2	0.3	7	0.1
Workplace	2	0.3	5	0.0
Other setting	**9**	**1.3**	**171**	**1.5**
Unknown setting	**4**	**0.6**	**30**	**0.3**

[1] More than one setting was recorded in 8 outbreaks, therefore the numbers don't add up to the group totals.

Table 29. Outbreaks and associated cases by mode of transmission, 2025

Mode of transmission	Outbreaks				Cases	
	Primary mode	Secondary mode	Total	Percentage of outbreaks (n=687)[1]	Total	Percentage of cases (n=11,507)[1]
Person-to-person	569	67	636	92.6	10776	93.6
Environmental	10	111	121	17.6	2581	22.4
Foodborne	30	0	30	4.4	344	3.0
Waterborne	4	1	5	0.7	70	0.6
Zoonotic	1	3	4	0.6	64	0.6
Sexual contact	1	3	4	0.6	13	0.1
Other mode	0	3	3	0.4	53	0.5
Parenteral	1	0	1	0.1	3	0.0
Unknown	0	0	15	2.2	212	1.8

[1] More than one mode of transmission was recorded for 125 outbreaks, therefore the totals add up to more than 100%.
No outbreaks with vector borne or parenteral transmission were reported in 2025.

APPENDIX: NATIONAL DATA AND TRENDS

Table 30. Number of cases of notifiable diseases by year, 2016–2025

Disease	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Campylobacteriosis	7457	6482	6957	6203	5293	5729	5878	6092	5800	5816
Chikungunya fever	28	8	11	11	4	0	5	9	7	16
COVID-19[a]					2176	12033	2069115	418761	163758	26817
Creutzfeldt-Jakob disease[b]	4	13	4	6	5	9	5	7	7	12
Cryptosporidiosis	1062	1192	1613	1035	735	702	612	831	1234	870
Dengue fever	191	161	294	222	50	7	23	55	124	432
Gastroenteritis (acute)[c]	510	319	228	485	353	240	329	462	435	477
Giardiasis	1616	1648	1585	1749	1139	1041	707	898	844	865
Hepatitis A	35	58	68	67	21	8	58	34	68	65
Hepatitis B	34	27	32	28	18	12	11	19	12	15
Hepatitis C	31	21	34	24	28	35	23	31	20	18
Hepatitis NOS	8	10	7	9	11	8	2	8	5	2
Invasive group A streptococcal infection[d]									145	645
Invasive pneumococcal disease	480	521	557	495	350	468	631	757	718	720
Legionellosis	247	221	175	161	160	179	234	238	181	168
Leptospirosis	85	138	109	89	61	77	120	170	102	77
Listeriosis	36	21	30	31	35	32	39	37	36	41
Malaria	26	42	36	27	17	8	18	54	29	48
Measles	103	15	30	2190	9	0	0	14	1	58
Meningococcal disease	75	112	120	139	35	41	72	57	43	41
Mpox[e]							41	8	23	41
Mumps	20	1338	435	264	144	1	1	16	19	19
Paratyphoid fever	32	37	18	17	17	2	15	28	14	11
Pertussis	1093	2142	2955	1206	169	41	18	141	1745	2678
Rheumatic fever[f]	136	152	186	168	150	86	78	179	207	207
Salmonellosis	1091	1127	1100	1190	709	714	749	827	844	1104
Shigellosis	174	244	217	214	60	4	69	122	157	175
STEC infection	417	547	925	1103	845	911	1022	1005	1112	1191
Tuberculosis disease	295	308	305	317	318	309	267	305	360	383
Typhoid fever	38	59	53	54	24	3	31	71	62	50
Yersiniosis	858	917	1201	1185	1260	1410	1294	1408	1140	1112
Zika virus	100	11	2	7	0	0	0	4	8	7

[a] COVID-19 become notifiable on 30 January 2020.
[b] Creutzfeldt-Jakob disease (CJD) data is provided by the National CJD Registry, University of Otago [20]
[c] Cases of acute gastroenteritis from a common source or person in a high-risk category (e.g. food handler or childcare worker) or foodborne intoxication, e.g., staphylococcal intoxication.
[d] Invasive group A streptococcal infection became notifiable on 1 October 2024.
[e] Mpox became notifiable on 9 June 2022.
[f] Includes rheumatic fever initial episodes and recurrent cases.

Table 31. Number of cases of rare notifiable diseases by year, 2016–2025

Disease[a]	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Botulism	0	0	0	0	4	1	0	0	1	0
Brucellosis	0	1	3	2	2	1	1	4	1	1
Cholera	0	0	1	0	0	0	1	1	1	0
Cysticercosis	0	0	1	0	0	0	0	0	0	0
Decompression sickness	0	0	1	3	2	2	2	0	2	1
Diphtheria	1	1	0	1	0	0	2	3	2	4
Haemophilus influenzae type b	2	4	3	2	3	3	0	4	1	1
Hydatid disease	2	1	0	1	0	1	3	2	2	5
Leprosy	0	3	3	6	3	5	3	4	3	4
Q fever	0	0	0	1	0	0	0	0	2	1
Rabies	0	0	0	0	0	0	0	1	0	0
Rickettsial disease	5	4	3	4	5	1	5	4	2	5
Ross River virus infection	4	7	1	5	3	1	0	0	0	1
Rubella	3	1	1	2	0	0	0	0	0	0
Taeniasis	4	4	4	5	3	1	3	0	2	2
Tetanus	1	0	0	0	0	1	1	1	2	0
Toxic shellfish poisoning	3	5	3	1	0	3	2	0	1	1

[a] No cases of the following notifiable diseases were reported in the past 10 years: anthrax, Barmah Forest virus infection, Cronobacter species invasive disease, highly pathogenic avian influenza, Japanese encephalitis, Middle East respiratory syndrome (MERS), non-seasonal influenza, plague, poliomyelitis, primary amoebic meningoencephalitis, severe acute respiratory syndrome (SARS), trichinellosis, viral haemorrhagic fever and yellow fever.

Table 32. Number of cases and rate per 100,000 population of notifiable diseases by Health District, 2025

Disease	Health District																			
	Northland		Waitemata		Auckland		Counties Manukau		Waikato		Lakes		Bay of Plenty		Tairawhiti		Taranaki		Hawke's Bay	
	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
Campylobacteriosis	308	153.2	663	96.9	557	110.1	493	75.5	617	132.1	127	105.2	332	119.6	58	110.1	214	164.1	191	106.3
COVID-19	853	424.2	2221	324.8	4258	841.5	2022	309.6	2226	476.8	379	314.0	996	358.9	199	377.6	710	544.5	780	434.3
Cryptosporidiosis	52	25.9	59	8.6	36	7.1	55	8.4	129	27.6	19	15.7	44	15.9	3		36	27.6	33	18.4
Dengue fever	16	8.0	54	7.9	81	16.0	83	12.7	26	5.6	4		24	8.6	2		7	5.4	10	5.6
Gastroenteritis (acute)[a]	21	10.4	12	1.8	12	2.4	12	1.8	105	22.5	31	25.7	70	25.2	1		3		3	
Giardiasis	33	16.4	88	12.9	112	22.1	71	10.9	115	24.6	29	24.0	94	33.9	7	13.3	24	18.4	32	17.8
Hepatitis A	5	2.5	5	0.7	6	1.2	14	2.1	9	1.9	1		4		0		0		0	
Hepatitis B	0		0		1		1		2		0		1		0		1		2	
Hepatitis C	0		0		2		0		4		0		2		0		2		2	
iGAS infection	41	20.4	63	9.2	66	13.0	136	20.8	56	12.0	19	15.7	49	17.7	10	19.0	16	12.3	27	15.0
Invasive pneumococcal disease	34	16.9	69	10.1	59	11.7	76	11.6	67	14.3	23	19.1	55	19.8	15	28.5	18	13.8	36	20.0
Legionellosis	5	2.5	17	2.5	9	1.8	27	4.1	20	4.3	5	4.1	14	5.0	0		4		4	
Leptospirosis	5	2.5	6	0.9	1		4		17	3.6	3		14	5.0	3		3		5	2.8
Listeriosis	1		5	0.7	4		8	1.2	1		2		2		0		2		1	
Malaria	1		3		1		2		3		1		8	2.9	2		1		12	6.7
Measles	13	6.5	1		10	2.0	4		1		0		0		0		1		0	
Meningococcal disease	0		5	0.7	6	1.2	7	1.1	2		0		2		0		5	3.8	1	
Mpox	1		9	1.3	13	2.6	2		0		0		1		0		0		0	
Mumps	0		2		7	1.4	5	0.8	2		0		0		0		0		0	
Paratyphoid fever	0		1		2		1		0		0		2		0		0		0	
Pertussis	208	103.4	107	15.6	90	17.8	165	25.3	179	38.3	139	115.2	401	144.5	67	127.1	81	62.1	121	67.4
Rheumatic fever[b]	9	4.5	18	2.6	21	4.2	107	16.4	8	1.7	4		8	2.9	5	9.5	3		9	5.0
Salmonellosis	53	26.4	115	16.8	113	22.3	106	16.2	88	18.8	25	20.7	78	28.1	14	26.6	43	33.0	38	21.2
Shigellosis	4		32	4.7	47	9.3	26	4.0	8	1.7	1		4		1		2		1	
STEC infection	89	44.3	52	7.6	32	6.3	47	7.2	179	38.3	32	26.5	70	25.2	7	13.3	59	45.2	45	25.1
Tuberculosis disease	5	2.5	36	5.3	50	9.9	83	12.7	45	9.6	12	9.9	24	8.6	1		4		11	6.1
Typhoid fever	0		3		6	1.2	18	2.8	8	1.7	1		1		0		0		2	
Yersiniosis	39	19.4	105	15.4	90	17.8	94	14.4	74	15.8	26	21.5	81	29.2	14	26.6	37	28.4	29	16.1

[a] Cases of acute gastroenteritis from a common source or person in a high-risk category (eg, food handler or childcare worker) or foodborne intoxication, eg, staphylococcal intoxication.

[b] Includes rheumatic fever initial episodes and recurrent cases.

Note: Where fewer than five cases have been notified a rate has not been calculated and the cell has been left blank.

Table 32. Number of cases and rate per 100,000 population of notifiable diseases by Health District, 2025 (continued)

Disease	Health District																	
	Whanganui		MidCentral		Capital, Coast and Hutt Valley		Wairarapa		Nelson Marlborough		West Coast		Canterbury		South Canterbury		Southern	
	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
Campylobacteriosis	59	84.3	202	105.1	515	106.9	82	159.5	152	92.1	47	135.4	668	105.5	102	160.9	429	118.9
COVID-19	275	392.9	1090	567.1	3784	785.7	132	256.8	936	567.3	169	487.0	3178	501.7	324	511.0	2285	633.3
Cryptosporidiosis	10	14.3	43	22.4	137	28.4	7	13.6	13	7.9	3		90	14.2	20	31.5	81	22.5
Dengue fever	6	8.6	18	9.4	17	3.5	1		12	7.3	3		51	8.1	2		15	4.2
Gastroenteritis (acute)[a]	0		0		57	11.8	1		13	7.9	0		97	15.3	6	9.5	33	9.1
Giardiasis	7	10.0	30	15.6	76	15.8	8	15.6	15	9.1	2		83	13.1	4		35	9.7
Hepatitis A	0		1		8	1.7	1		0		0		9	1.4	0		2	
Hepatitis B	0		0		1		0		2		0		1		0		3	
Hepatitis C	0		0		1		0		2		0		1		1		1	
iGAS infection	7	10.0	16	8.3	46	9.6	1		9	5.5	0		50	7.9	7	11.0	26	7.2
Invasive pneumococcal disease	16	22.9	27	14.0	71	14.7	9	17.5	28	17.0	3		52	8.2	10	15.8	52	14.4
Legionellosis	0		2		3		0		7	4.2	1		41	6.5	2		7	1.9
Leptospirosis	2		2		0		2		0		0		4		2		4	
Listeriosis	0		0		5	1.0	1		1		0		4		2		2	
Malaria	0		1		6	1.2	1		2		1		3		0		0	
Measles	0		4		9	1.9	7	13.6	4		0		0		0		4	
Meningococcal disease	1		3		4		0		1		0		4		0		0	
Mpox	0		1		2		0		0		0		10	1.6	1		1	
Mumps	0		0		1		0		0		0		2		0		0	
Paratyphoid fever	0		0		3		0		1		0		0		0		1	
Pertussis	15	21.4	114	59.3	160	33.2	8	15.6	141	85.5	42	121.0	387	61.1	12	18.9	241	66.8
Rheumatic fever[b]	0		4		7	1.5	0		0		0		1		1		2	
Salmonellosis	9	12.9	28	14.6	85	17.6	13	25.3	36	21.8	5	14.4	138	21.8	23	36.3	94	26.1
Shigellosis	4		5	2.6	8	1.7	0		2		0		19	3.0	7	11.0	4	
STEC infection	11	15.7	40	20.8	98	20.3	17	33.1	43	26.1	3		184	29.0	39	61.5	144	39.9
Tuberculosis disease	2		7	3.6	36	7.5	0		4		0		45	7.1	7	11.0	11	3.0
Typhoid fever	0		0		4		2		0		0		4		0		1	
Yersiniosis	10	14.3	19	9.9	155	32.2	20	38.9	51	30.9	4		127	20.1	12	18.9	125	34.6

[a] Cases of acute gastroenteritis from a common source or person in a high-risk category (eg, food handler or childcare worker) or foodborne intoxication, eg, staphylococcal intoxication.

[b] Includes rheumatic fever initial episodes and recurrent cases.

Note: Where fewer than five cases have been notified a rate has not been calculated and the cell has been left blank.

Table 33. Number of cases and rate per 100,000 population of notifiable diseases by age group, 2025

Disease	Age group											
	<1 year		1–4 years		5–9 years		10–14 years		15–19 years		20–29 years	
	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
Campylobacteriosis	91	157.8	461	192.2	211	64.8	187	53.7	289	81.6	755	112.4
COVID-19	539	934.5	460	191.8	370	113.7	505	145.0	610	172.1	2382	354.5
Cryptosporidiosis	15	26.0	155	64.6	104	32.0	32	9.2	69	19.5	130	19.3
Dengue fever	0		0		7	2.2	19	5.5	35	9.9	43	6.4
Gastroenteritis (acute)[b]	8	13.9	48	20.0	12	3.7	12	3.4	15	4.2	55	8.2
Giardiasis	7	12.1	78	32.5	48	14.7	12	3.4	17	4.8	116	17.3
Hepatitis A	0		2		3		5	1.4	3		13	1.9
Hepatitis B	1		0		0		0		0		2	
Hepatitis C	0		0		0		0		0		2	
iGAS infection	19	32.9	26	10.8	17	5.2	17	4.9	23	6.5	61	9.1
Invasive pneumococcal disease	21	36.4	37	15.4	13	4.0	8	2.3	19	5.4	30	4.5
Legionellosis	0		0		0		0		0		0	
Leptospirosis	0		0		0		1		7	2.0	12	1.8
Listeriosis	0		0		0		0		0		2	
Malaria	0		1		1		1		1		15	2.2
Measles	3		2		2		10	2.9	9	2.5	11	1.6
Meningococcal disease	8	13.9	1		5	1.5	4		4		4	
Mpox	0		0		0		0		0		9	1.3
Mumps	0		1		0		0		3		7	1.0
Paratyphoid fever	0		0		1		0		0		6	0.9
Pertussis	246	426.5	559	233.1	475	146.0	331	95.0	179	50.5	189	28.1
Rheumatic fever[c]	0		0		32	9.8	67	19.2	26	7.3	44	6.5
Salmonellosis	62	107.5	129	53.8	65	20.0	38	10.9	40	11.3	117	17.4
Shigellosis	1		14	5.8	10	3.1	3		3		21	3.1
STEC infection	48	83.2	147	61.3	94	28.9	86	24.7	41	11.6	122	18.2
Tuberculosis disease	1		4		2		10	2.9	9	2.5	69	10.3
Typhoid fever	0		6	2.5	8	2.5	6	1.7	2		8	1.2
Yersiniosis	69	119.6	122	50.9	34	10.4	42	12.1	36	10.2	112	16.7

[a] Total includes cases where age was unknown.

[b] Cases of acute gastroenteritis from a common source or person in a high-risk category (eg, food handler or childcare worker) or foodborne intoxication, eg, staphylococcal intoxication.

[c] Includes rheumatic fever initial episodes and recurrent cases.

Note: Where fewer than five cases have been notified a rate has not been calculated and the cell has been left blank.

Table 33. Number of cases and rate per 100,000 population of notifiable diseases by age group, 2025 (continued)

Disease	Age group											
	30–39 years		40–49 years		50–59 years		60–69 years		70+ years		Total[a]	
	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
Campylobacteriosis	631	78.6	649	96.3	711	111.1	803	137.9	1027	163.6	5816	109.2
COVID-19	3594	447.5	3683	546.2	4144	647.6	3866	663.8	6664	1061.8	26817	503.6
Cryptosporidiosis	167	20.8	80	11.9	47	7.3	39	6.7	32	5.1	870	16.3
Dengue fever	70	8.7	63	9.3	81	12.7	70	12.0	44	7.0	432	8.1
Gastroenteritis (acute)[b]	75	9.3	57	8.5	71	11.1	51	8.8	66	10.5	477	9.0
Giardiasis	199	24.8	96	14.2	109	17.0	116	19.9	67	10.7	865	16.2
Hepatitis A	19	2.4	12	1.8	3		1		4		65	1.2
Hepatitis B	4		2		5	0.8	0		1		15	0.3
Hepatitis C	5	0.6	5	0.7	2		3		1		18	0.3
iGAS infection	68	8.5	67	9.9	69	10.8	95	16.3	183	29.2	645	12.1
Invasive pneumococcal disease	50	6.2	54	8.0	105	16.4	120	20.6	263	41.9	720	13.5
Legionellosis	4		12	1.8	23	3.6	44	7.6	85	13.5	168	3.2
Leptospirosis	17	2.1	12	1.8	10	1.6	10	1.7	8	1.3	77	1.4
Listeriosis	1		5	0.7	2		7	1.2	24	3.8	41	0.8
Malaria	13	1.6	10	1.5	1		4		1		48	0.9
Measles	15	1.9	2		3		1		0		58	1.1
Meningococcal disease	3		1		7	1.1	3		1		41	0.8
Mpox	17	2.1	8	1.2	4		3		0		41	0.8
Mumps	4		4		0		0		0		19	0.4
Paratyphoid fever	4		0		0		0		0		11	0.2
Pertussis	183	22.8	204	30.3	149	23.3	92	15.8	70	11.2	2678	50.3
Rheumatic fever[c]	31	3.9	6	0.9	1		0		0		207	3.9
Salmonellosis	107	13.3	116	17.2	135	21.1	154	26.4	139	22.1	1104	20.7
Shigellosis	39	4.9	25	3.7	22	3.4	26	4.5	11	1.8	175	3.3
STEC infection	83	10.3	84	12.5	107	16.7	155	26.6	224	35.7	1191	22.4
Tuberculosis disease	110	13.7	66	9.8	35	5.5	30	5.2	47	7.5	383	7.2
Typhoid fever	14	1.7	2		3		1		0		50	0.9
Yersiniosis	139	17.3	124	18.4	111	17.3	122	20.9	201	32.0	1112	20.9

[a] Total includes cases where age was unknown.
[b] Cases of acute gastroenteritis from a common source or person in a high-risk category (eg, food handler or childcare worker) or foodborne intoxication, eg, staphylococcal intoxication.
[c] Includes rheumatic fever initial episodes and recurrent cases.
Note: Where fewer than five cases have been notified a rate has not been calculated and the cell has been left blank.

Table 34. Number of cases and rate per 100,000 population of notifiable diseases by sex, 2025

Disease	Sex					
	Male		Female		Total [a]	
	Cases	Rate	Cases	Rate	Cases	Rate
Campylobacteriosis	3232	122.1	2582	96.4	5816	109.2
COVID-19	9980	377.1	16789	626.8	26817	503.6
Cryptosporidiosis	411	15.5	459	17.1	870	16.3
Dengue fever	232	8.8	199	7.4	432	8.1
Gastroenteritis (acute)[b]	202	7.6	274	10.2	477	9.0
Giardiasis	462	17.5	403	15.0	865	16.2
Hepatitis A	38	1.4	27	1.0	65	1.2
Hepatitis B	12	0.5	3		15	0.3
Hepatitis C	9	0.3	9	0.3	18	0.3
Invasive group A streptococcal infection	328	12.4	317	11.8	645	12.1
Invasive pneumococcal disease	370	14.0	350	13.1	720	13.5
Legionellosis	110	4.2	58	2.2	168	3.2
Leptospirosis	56	2.1	21	0.8	77	1.4
Listeriosis	18	0.7	23	0.9	41	0.8
Malaria	39	1.5	9	0.3	48	0.9
Measles	25	0.9	33	1.2	58	1.1
Meningococcal disease	12	0.5	29	1.1	41	0.8
Mpox	41	1.5	0		41	0.8
Mumps	15	0.6	4		19	0.4
Paratyphoid fever	8	0.3	3		11	0.2
Pertussis	1218	46.0	1454	54.3	2678	50.3
Rheumatic fever[c]	100	3.8	107	4.0	207	3.9
Salmonellosis	561	21.2	542	20.2	1104	20.7
Shigellosis	126	4.8	49	1.8	175	3.3
STEC infection	554	20.9	637	23.8	1191	22.4
Tuberculosis disease	195	7.4	188	7.0	383	7.2
Typhoid fever	26	1.0	24	0.9	50	0.9
Yersiniosis	503	19.0	608	22.7	1112	20.9

[a] Total includes cases where sex was unknown.
[b] Cases of acute gastroenteritis from a common source or person in a high-risk category (eg, food handler or childcare worker) or foodborne intoxication, eg, staphylococcal intoxication.
[c] Includes rheumatic fever initial episodes and recurrent cases.
Note: Where fewer than five cases have been notified a rate has not been calculated and the cell has been left blank.

Table 35. Number of cases and rate per 100,000 population of notifiable diseases by ethnic group, 2025

Disease	Ethnic group									
	Māori		Pacific peoples		Asian		European or Other		Total[a]	
	Cases	Rate	Cases	Rates	Cases	Rate	Cases	Rate	Cases	Rate
Campylobacteriosis	635	68.0	204	54.3	640	66.4	4235	138.8	5816	109.2
COVID-19	3133	335.7	1461	388.8	2907	301.4	19230	630.2	26817	503.6
Cryptosporidiosis	142	15.2	22	5.9	52	5.4	636	20.8	870	16.3
Dengue fever	48	5.1	130	34.6	33	3.4	219	7.2	432	8.1
Gastroenteritis (acute)[b]	71	7.6	25	6.7	60	6.2	313	10.3	477	9.0
Giardiasis	111	11.9	19	5.1	92	9.5	636	20.8	865	16.2
Hepatitis A	10	1.1	10	2.7	31	3.2	13	0.4	65	1.2
Hepatitis B	5	0.5	2		4		4		15	0.3
Hepatitis C	5	0.5	0		0		13	0.4	18	0.3
Invasive group A streptococcal infection	203	21.8	159	42.3	37	3.8	241	7.9	645	12.1
Invasive pneumococcal disease	218	23.4	107	28.5	44	4.6	348	11.4	720	13.5
Legionellosis	5	0.5	9	2.4	8	0.8	143	4.7	168	3.2
Leptospirosis	12	1.3	2		3		60	2.0	77	1.4
Listeriosis	6	0.6	3		8	0.8	24	0.8	41	0.8
Malaria	0		31	8.2	4		13	0.4	48	0.9
Measles	17	1.8	1		3		37	1.2	58	1.1
Meningococcal disease	12	1.3	10	2.7	2		17	0.6	41	0.8
Mpox	5	0.5	0		12	1.2	24	0.8	41	0.8
Mumps	2		0		10	1.0	7	0.2	19	0.4
Paratyphoid fever	0		0		9	0.9	2		11	0.2
Pertussis	930	99.7	179	47.6	104	10.8	1454	47.7	2678	50.3
Rheumatic fever[c]	87	9.3	114	30.3	3		2		207	3.9
Salmonellosis	148	15.9	61	16.2	174	18.0	716	23.5	1104	20.7
Shigellosis	26	2.8	18	4.8	31	3.2	98	3.2	175	3.3
STEC infection	192	20.6	30	8.0	78	8.1	879	28.8	1191	22.4
Tuberculosis disease	23	2.5	35	9.3	288	29.9	31	1.0	383	7.2
Typhoid fever	0		10	2.7	39	4.0	1		50	0.9
Yersiniosis	158	16.9	42	11.2	275	28.5	624	20.5	1112	20.9

[a] Total includes cases where ethnicity was unknown.
[b] Cases of acute gastroenteritis from a common source or person in a high-risk category (eg, food handler or childcare worker) or foodborne intoxication, eg, staphylococcal intoxication.
[c] Includes rheumatic fever initial episodes and recurrent cases.
Note: Denominator data used to determine disease rates for ethnic groups are based on the proportion of people in each ethnic group from the estimated resident 2023 census population applied to the

2025 mid-year population estimates from Statistics New Zealand. Ethnicity is prioritised in the following order: Māori, Pacific peoples, Asian and European or Other ethnic groups. Where fewer than five cases have been notified a rate has not been calculated and the cell has been left blank.

Table 36. Deaths due to notifiable diseases, as recorded in EpiSurv, 2006–2025

Disease	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Campylobacteriosis	1	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Gastroenteritis (acute)[a]	0	0	0	0	0	0	0	0	2	0	1	0	0	0	0	0	0	0	0	0
Haemophilus influenzae type b	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Hepatitis B	0	1	0	0	0	0	1	0	1	1	0	0	1	0	0	0	0	0	0	0
Invasive group A streptococcal infection[b]																			7	27
Invasive pneumococcal disease[c]			7	33	25	30	29	18	23	27	22	27	25	12	11	27	26	25	25	39
Legionellosis	2	1	4	2	5	4	6	3	1	4	1	5	3	2	2	4	5	4	1	4
Leptospirosis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Listeriosis - non-pregnancy associated	0	2	3	2	3	1	4	2	3	1	0	0	2	0	1	3	4	5	0	4
Listeriosis - pregnancy associated[d]	1	2	2	2	4	0	2	3	2	3	2	0	0	4	1	1	2	2	1	2
Malaria	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Meningococcal disease	7	6	8	5	6	13	6	4	3	4	2	9	10	10	3	3	3	1	2	4
Non seasonal influenza A (H1N1)[e]				36	17	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pertussis	0	0	0	0	0	1	2	1	0	0	0	0	0	0	1	0	0	3	1	0
Rabies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Salmonellosis	1	1	1	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Shigellosis	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
STEC infection	0	0	0	1	0	0	0	0	1	0	0	0	2	1	0	0	1	0	0	0
Tetanus	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0
Tuberculosis disease	6	3	4	4	9	3	4	3	5	6	5	1	4	3	5	6	3	3	6	5
Typhoid fever	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0

[a] Cases of acute gastroenteritis from a common source or person in a high-risk category (eg, food handler or childcare worker) or foodborne intoxication, eg, staphylococcal intoxication.
[b] Invasive group A streptococcal infection became notifiable on 1 October 2024.
[c] Invasive pneumococcal disease became notifiable on 17 October 2008.
[d] The pregnancy-associated listeriosis deaths reported here are foetal deaths.
[e] Non-seasonal influenza became notifiable on 26 April 2009. Deaths recorded in 2009 and 2010 were due to influenza A(H1N1)pdm09.
Note: The numbers in this table are those recorded in EpiSurv where the notifiable disease was the primary cause of death. Information on a death is most likely to be reported when it occurs close to the time of notification and investigation.

Table 37. Hospital admissions for selected notifiable diseases, 2023–2025

Disease	ICD 10 codes	2023		2024		2025	
		Prin [a]	Oth [b]	Prin [a]	Oth [b]	Prin [a]	Oth [b]
Arboviral diseases	A83, A84, A85.2, A92, A93, A94, B33.1	1	1	4	1	8	2
Brucellosis	A23	2	2	2	1	3	1
Campylobacteriosis	A04.5	823	215	928	203	904	196
Cholera	A00	0	1	3	5	3	1
Creutzfeldt-Jakob disease	A81.0	7	3	6	3	16	7
Cryptosporidiosis	A07.2	58	11	71	36	47	21
Cysticercosis	B69	1	4	3	4	0	3
Decompression sickness	T70.3	8	1	10	3	20	5
Dengue fever	A90, A91	19	0	50	1	188	14
Diphtheria	A36	1	4	1	1	0	0
Giardiasis	A07.1	21	23	31	25	33	26
Hepatitis A	B15	36	29	53	35	50	35
Hepatitis B	B16	16	11	9	12	14	9
Hepatitis C	B17.1	2	10	2	12	1	11
Hydatid disease	B67.0-B67.4	3	0	0	0	0	0
Legionellosis	A48.1	199	47	161	37	138	25
Invasive group A streptococcal infection	A40.0, B95.0	159	3040	171	3125	150	3066
Invasive pneumococcal disease	A40.3, A49.1, B95.3, G001, J13	895	489	830	468	939	485
Leprosy	A30	1	0	2	1	2	1
Leptospirosis	A27	134	41	88	19	72	19
Listeriosis	A32	26	25	19	24	28	22
Malaria	B50-B54	49	2	22	2	48	1
Measles	B05	12	1	4	0	29	2
Meningococcal disease	A39	52	21	39	18	34	18
Mpox	B04	1	1	1	1	2	1
Mumps	B26	11	3	12	5	23	3
Paratyphoid	A01.1-A01.4	4	1	13	0	5	0
Pertussis	A37	49	34	184	42	283	71
Poliomyelitis	A80	0	0	0	0	0	0
Q fever	A78	0	0	1	0	3	0
Rheumatic fever	I00, I01, I02	234	32	298	45	253	42
Rickettsial diseases	A75, A77, A79	2	3	3	3	3	1
Rubella	B06	0	0	0	0	1	1
Salmonellosis	A02	201	100	213	74	314	103
Shigellosis	A03	42	37	55	57	66	45
STEC infection	A04.3	25	23	39	31	60	48
Taeniasis	B68	0	0	0	0	0	0
Tetanus	A33-A35	3	1	4	2	2	2
Tuberculosis	A15-A19, P37.0	202	132	265	175	266	167
Typhoid	A01.0	66	4	56	5	46	1
Viral haemorrhagic fevers	A96, A98, A99	0	0	0	0	0	0
Yersiniosis	A04.6	124	94	89	102	103	85

[a] Principal diagnosis.
[b] Other relevant diagnosis.
Note: Hospital admission data may include multiple admissions (to the same or different hospitals) for the same case, and admissions may relate to cases first diagnosed in previous years.

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ACRONYMS AND ABBREVIATIONS

Acronym/Abbreviation	Description
AFP	Acute flaccid paralysis
BCG	Bacillus Calmette-Guérin
CIDT	Culture independent diagnostic testing
CJD	Creutzfeldt-Jakob disease
CRS	Congenital rubella syndrome
COVID-19	Coronavirus disease
DTaP-IPV	Diphtheria, tetanus, acellular pertussis, inactivated polio vaccine
DTaP-IPV-HepB/Hib	Diphtheria, tetanus, acellular pertussis, inactivated polio, hepatitis B and *Haemophilus influenzae* type b vaccine
EHEC	Enterohaemorrhagic *Escherichia coli*
Hib	*Haemophilus influenzae* serotype b
HIV	Human immunodeficiency virus
HPAI	Highly pathogenic avian influenza
HUS	Haemolytic uraemic syndrome
ICD-10	International Classification of Diseases 10th revision
iGAS	Invasive group A *streptococcus*
IPD	Invasive pneumococcal disease
IPV	Inactivated polio vaccine
MenACWY	Meningococcal quadrivalent conjugate vaccine
MenB	Meningococcal group B
MERS	Middle East Respiratory Syndrome
MIC	Minimum inhibitory concentration
MLST	Multilocus sequence typing
MMR	Measles, mumps and rubella
MSM	Men who have sex with men
NCCEP	National Certification Committee for the Eradication of Polio
NHI	National Health Index
NMDS	National Minimum Dataset
NOS	Not otherwise specified
OPV	Oral polio vaccine
NZPSU	New Zealand Paediatric Surveillance Unit
PCR	Polymerase chain reaction
PCV	Pneumococcal conjugate vaccine
PCV13	13-valent pneumococcal conjugate vaccine
PHS	Public health service
RSV	Respiratory syncytial virus
SARS	Severe acute respiratory syndrome
ST	Sequence type
STEC	Shiga toxin-producing *Escherichia coli*
sv	Serovar
Tdap	Tetanus, diphtheria and acellular pertussis vaccine
VTEC	Verocytotoxin-producing *Escherichia coli*
WHO	World Health Organization
23PPV	23-valent pneumococcal polysaccharide vaccine



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