

Meningococcal notifications in children (0–14 years)

This report presents statistics on meningococcal notifications for children aged 0–14 years in New Zealand. It is based on data provided to EHINZ by PHF Science in March 2026.

Key facts

- The number of meningococcal notifications declined from 21 (2.2 per 100,000) in 2023 to 18 (1.8 per 100,000) in 2024, primarily due to a decrease in notifications among the under-5 age group.
- Meningococcal B continues to be the most dominant strain in children aged 0–14 years.
- Infants (under 1-year-old) have had the highest rate of meningococcal disease since 2001. In 2022–24, the rate of meningococcal disease among infants (21.0 per 100,000) was 35 times higher than for children aged 10–14 years (0.6 per 100,000).
- Māori and Pacific children had four to six times the rate of meningococcal disease than European/Other children.
- Children living in the most deprived areas (NZDep 2018 quintile 5) had more than three times the rate of meningococcal disease (6.0 per 100,000) as children living in the least deprived areas (1.5 per 100,000) (quintile 1).

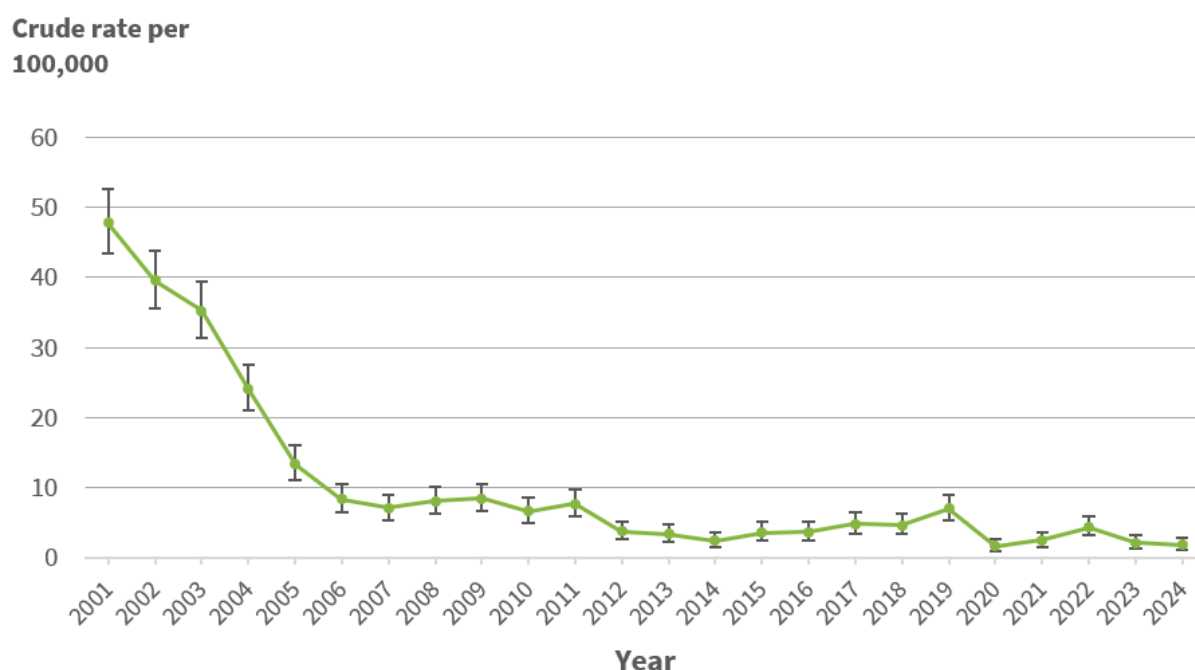
Household crowding and second-hand smoke exposure increase the risk of meningococcal disease

Meningococcal disease is a serious infection which can cause meningitis (an infection of membranes that covers the brain), septicaemia (blood poisoning), and even death. [Household crowding](#) increases the risk of meningococcal disease, particularly in those aged 0–16 years (Baker et al 2013). According to the 2023 Census data, over 100,000 households in New Zealand were overcrowded (Statistics NZ 2024). [Second-hand smoke exposure](#) is also associated with an increased risk of meningococcal disease in children (Lee et al 2010; Murray et al 2012).

Meningococcal disease notifications continue to decline in 2024

The number of meningococcal disease notifications among children aged 0–14 years continues to decline from 42 (4.4 per 100,000; 95%CI 3.1–5.9) in 2022 to 21 (2.2 per 100,000; 95%CI 1.3–3.3) in 2023 and 18 (1.8 per 100,000; 95%CI 1.1–2.9) in 2024 (Figure 1). This decrease has been driven by a drop in the number of notifications among children under five years old. The overall rate remains relatively low compared to the years immediately before the COVID-19 pandemic.

Figure 1: Meningococcal disease notification rate in children aged 0–14 years, 2001–2024 (crude rate per 100,000 population)



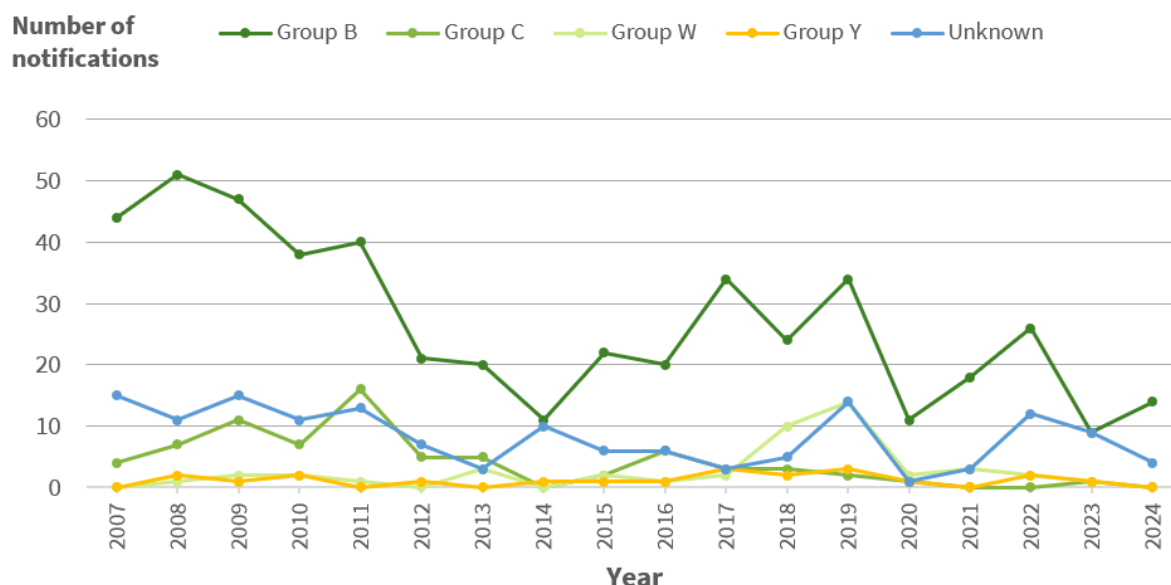
Note: 95% confidence intervals have been presented as vertical bars.

Source: EpiSurv, PHF Science 2026

Meningococcal Group B continues to be the most dominant strain in children

Meningococcal Group B notifications increased to 14 in 2024, up from 9 in 2023, but remain lower than the 26 reported in 2022. However, it has consistently accounted for the majority of notifications in children since 2007 (Figure 2). Case numbers for Groups C, W, and Y remained low in 2024.

Figure 2: Number of meningococcal disease notifications in children aged 0–14 years, by serotype, 2007–2024

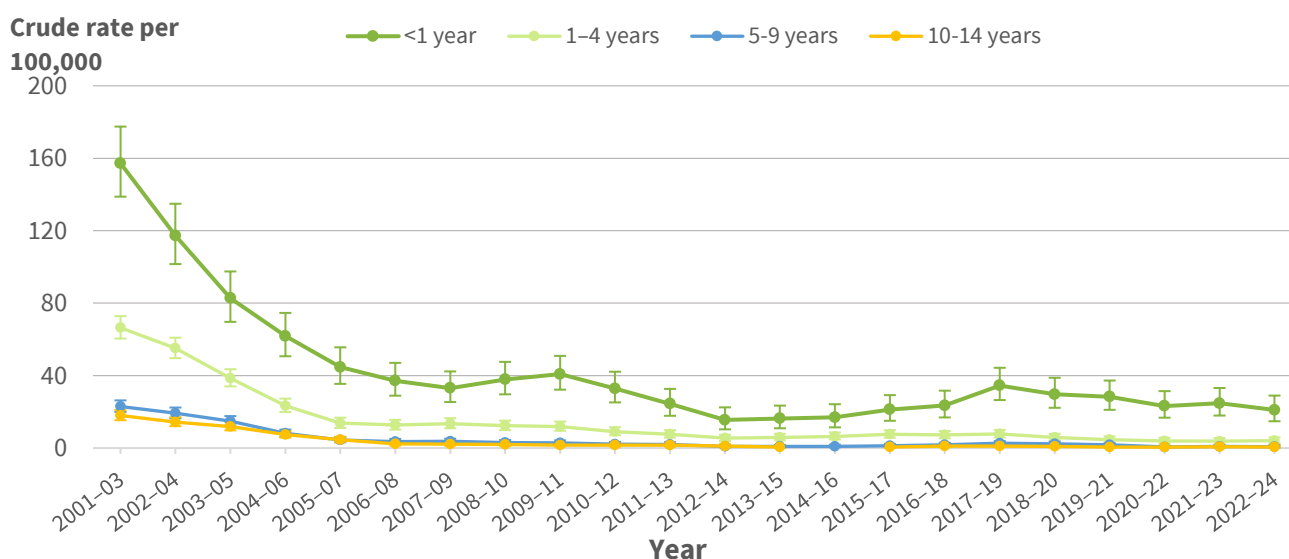


Note: Serotype data is only available from 2007 onwards. There was only one notification for Group E between 2007 and 2024.
Source: EpiSurv, PHF Science 2026

Infants continue to have the highest rate of meningococcal disease

From 2001 until 2024, infants (under 1-year-old) consistently had the highest notification rates of meningococcal disease compared to the older age groups (Figure 3). In 2022–24, the rate of meningococcal disease among infants (21.0 per 100,000; 95%CI 14.8–29.0) was 35 times higher than for children aged 10–14 years (0.6 per 100,000; 95%CI 0.2–1.3).

Figure 3: Meningococcal disease notification rate in children aged 0–14 years, by age group, three-year moving averages, 2001–2024 (crude rate per 100,000 population)

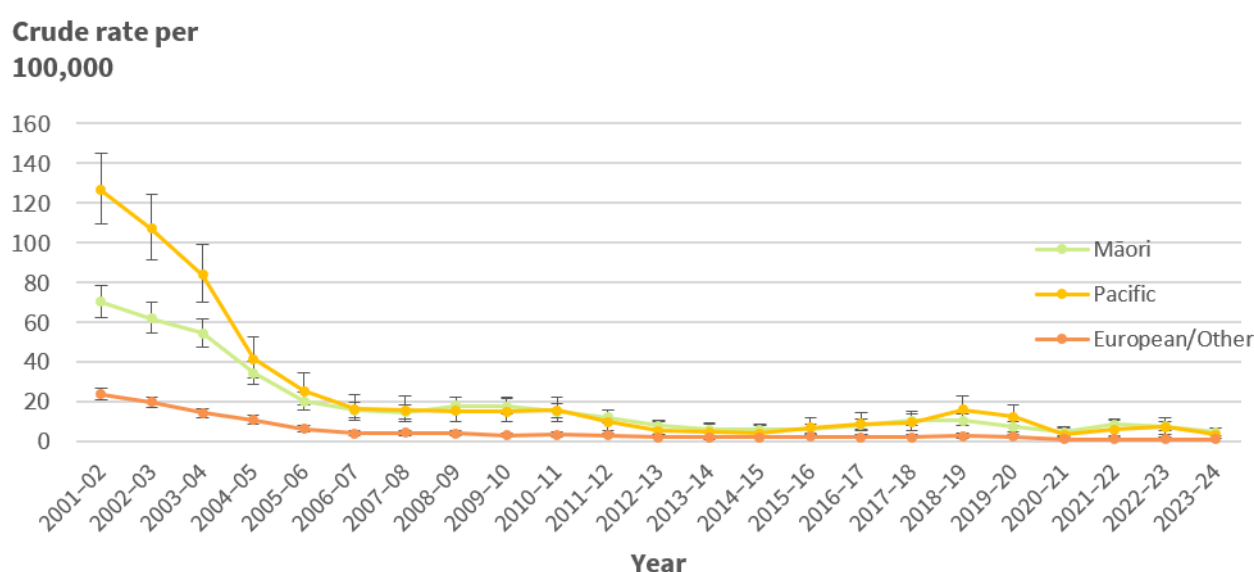


Note: 95% confidence intervals have been presented as vertical bars.
Source: EpiSurv, PHF Science 2026

Pacific and Māori children were disproportionately affected by meningococcal disease

Since 2001, Pacific and Māori children have had the highest rates of meningococcal disease (Figure 4). In 2023–24, the meningococcal rate was nearly six times higher in Māori (4.7 per 100,000; 95%CI 3.0–6.9) than in European/Other children (0.8 per 100,000; 95%CI 0.3–1.7). Additionally, the rate in Pacific children (3.2 per 100,000; 95%CI 1.2–6.9) was nearly four times higher than that observed in European/Other children.

Figure 4: Meningococcal disease notification rate in children aged 0–14 years, by ethnic group (prioritised), two-year moving averages, 2001–2024 (crude rate per 100,000 population)



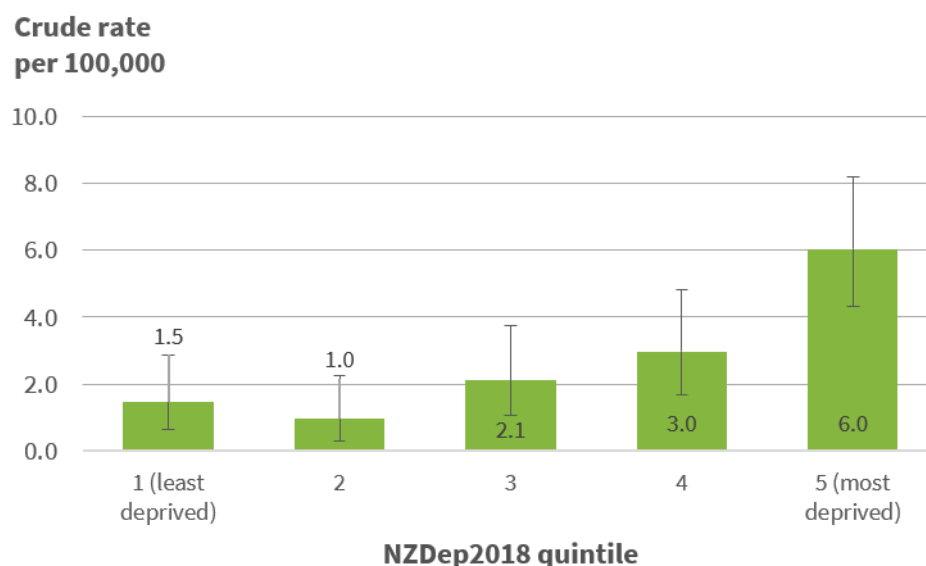
Note: 95% confidence intervals have been presented as vertical bars. The rate is suppressed for Asian children due to an unreliable estimate with small numbers.

Source: EpiSurv, PHF Science 2026

Higher meningococcal disease notification rates in more socioeconomically deprived areas

In 2022–24, the meningococcal disease notification rate for children living in the most socioeconomically deprived (NZDep 2018 quintile 5) areas (6.0 per 100,000; 95% CI 4.3–8.2) was higher than for those living in the least deprived areas (quintile 1) (1.5 per 100,000; 95%CI 0.6–2.9) (Figure 5). Children living in the most deprived areas had more than three times the rate of meningococcal disease as children living in the least deprived areas (rate ratio=3.67; 95%CI 1.7–7.9).

Figure 5: Meningococcal disease notification rate in children aged 0–14 years, by NZDep2018 quintiles, 2022–24 (crude rate per 100,000 population)



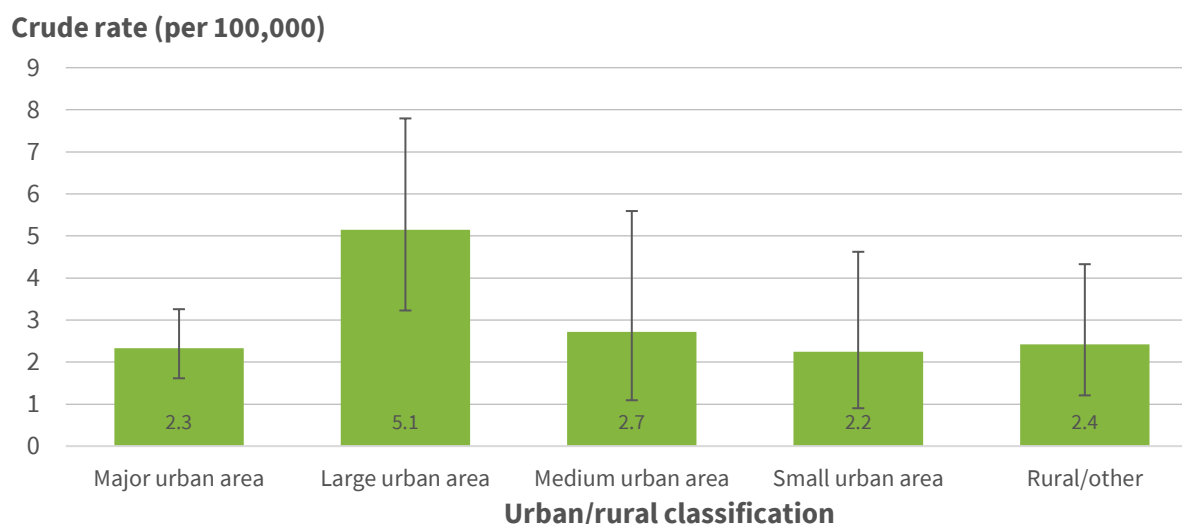
Note: 95% confidence intervals have been presented as vertical bars.

Source: EpiSurv, PHF Science 2026

Meningococcal disease notification rates were high in the large urban area

In 2022–24, the rates of meningococcal disease were high in the large urban area (5.1 per 100,000; 95% CI 3.2–7.8). There were no statistically significant differences in the notification rates among children by urban/rural classification (Figure 6).

Figure 6: Meningococcal disease notification rate in children aged 0–14 years, by urban/rural classification, 2022–24 (crude rate per 100,000 population)



Note 1: 95% confidence intervals have been presented as vertical bars.

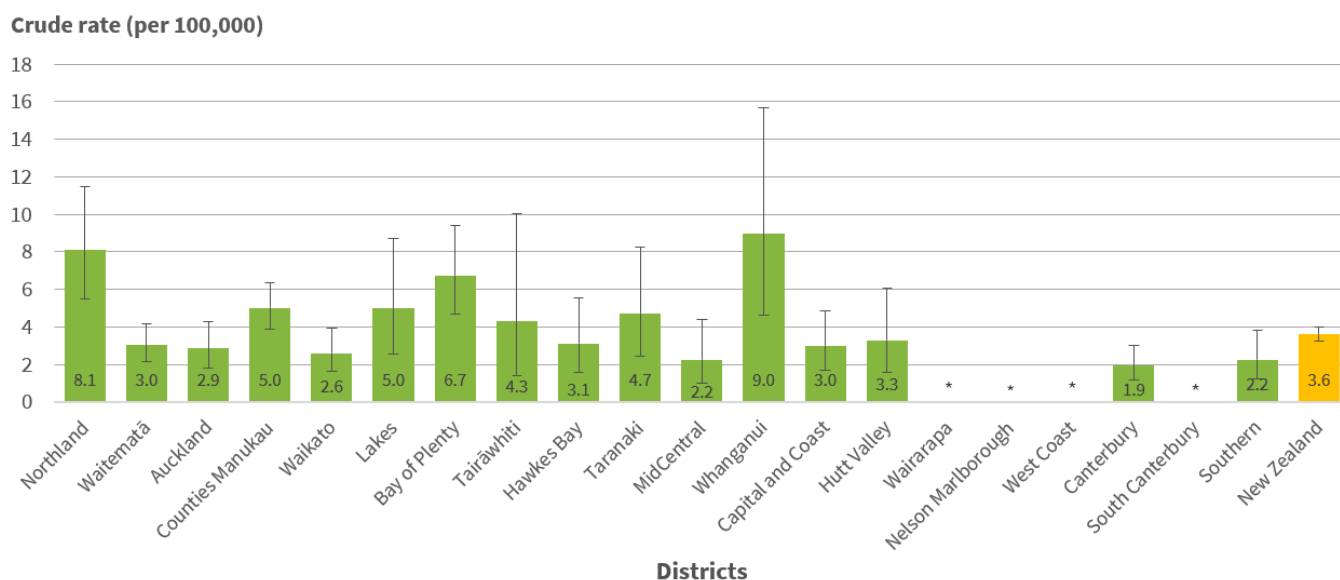
Note 2: The Statistics New Zealand urban-rural classification for 2018 has been used. Major urban areas are major towns and cities with a population of 100,000 or more. Large urban areas are larger towns and cities with a population of 30,000–99,999 people. Medium urban areas are towns with a population of 10,000–29,999 people. Small urban areas are smaller towns with a population of 1,000–9,999. Rural areas include rural centres (less than 1,000 residents) and rural areas outside of these.

Source: EpiSurv, PHF Science 2026

High meningococcal disease rates in the Whanganui and Northland districts

In the ten years 2015–24, children living in the Northland and Whanganui districts had high meningococcal disease rates (Figure 7).

Figure 7: Meningococcal disease notification rate in children aged 0–14 years, by district, 2015–24 (crude rate per 100,000 population)



Note: Districts refer to areas formerly known as District Health Boards (DHBs). 95% confidence intervals have been presented as vertical bars.

*The rate is suppressed for Wairarapa, West Coast, and South Canterbury districts due to counts less than five.

Source: EpiSurv, PHF Science 2026

Data for this indicator

This indicator is an analysis of the most recent data available from the EpiSurv notifications surveillance database, provided to EHINZ by the Public Health and Forensic Science (PHF Science – formerly ESR) in March 2026. The Institute for Environmental Science and Research (ESR) changed its name to the New Zealand Institute for Public Health and Forensic Science (PHF Science) on July 1 2025.

Notifications only cover those people who visited a GP or received hospital treatment, and therefore may underestimate the true rate of disease in the population.

For additional information, see the [Metadata](#) sheet.

References

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