Surveillance of Viral Hepatitis in Hong Kong - 2004 Update Report

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1. COMMENTARY

Surveillance Mechanisms of Viral Hepatitis in Hong Kong

1. Similar to many other places worldwide, viral hepatitis is a notifiable disease in Hong Kong. Locally, voluntary reporting was started in as early as 1966 and, since 1974, the disease has become notifiable. It was not until 1988 that the reported cases are classified by viral etiology, namely hepatitis A, hepatitis B, non-A non-B hepatitis and unclassified hepatitis. Since 1996, non-A non-B hepatitis is further categorized into hepatitis C, hepatitis E and hepatitis (not elsewhere classified). Under the current reporting system, hepatitis A and B are defined by the presence of IgM anti-HAV and IgM anti-HBc respectively, whereas hepatitis C and E are diagnosed by positive tests for anti-HCV and anti-HEV.

2. Expectedly, virtually all of the reported cases are acute viral hepatitis. While the figures captured under the local system could be a good reflection of the acute disease burden of viral hepatitis, the extent of chronic infections resulting from some hepatitis, notably hepatitis B and C, has to be determined by other mechanisms. Insight of the epidemiology of various forms of hepatitis in Hong Kong can be gained by an analytical interpretation of regular statistics collected by health care or other institutions, and the information generated from designated studies. This Report presents the latest findings from collation and analysis of viral hepatitis data obtained from the disease notification system, service statistics as well as seroprevalence studies. Much hopeful that the local viral hepatitis picture can be painted accurately and fully, this is certainly limited by the nature and availability of data. The presence of biases in data per se and their interpretation need to be acknowledged in reading this Report.

Changing Epidemiology of HAV and HEV

3. Hepatitis A virus (HAV) and hepatitis E virus (HEV) are both transmitted by faecal-oral route. Over the last decades, more data on hepatitis A relative to hepatitis E was available in Hong Kong. Hong Kong is of intermediate endemicity for HAV [1]. Since 1988 with the breakdown of reported hepatitis according to aetiologic agents, the largest epidemic of hepatitis A occurred in 1992, with over 3500 cases reported to the Department of Health (DH) (Box 1). This represents a notification rate of 63 per 100,000 population and since then, a gradual declining trend in incidence has been observed (Box 4). The number of 120 cases reported in 2004 is comparable to that of 107 in 2003. Overall, case fatality rates from hepatitis A had been low and ranged between 0 and 0.9% (Box 4). A seasonal pattern of occurrence of acute hepatitis A is present, with cases more commonly reported between January and May each year. Over the years, there is an overall increase in age, from a median of 23 years in 1989 to 29.5 years in 2004, with notable increase in the proportion of cases among the 30-39 years old. (Box 5).

4. An analysis was made by the Surveillance and Epidemiology Branch of Centre for Health Protection (CHP), DH on the 227 HAV cases notified between 2003 and 2004. The incidence rates were 1.57 in 100,000 in 2003 and 1.72 in 100,000 in 2004, which were lower than the rates in Mainland China (7.4 in 100,000 in 2003 and 6.9 in 100,000 in 2004). The male to female ratio was 1.83 to 1. There were five clusters of hepatitis A infection involving 2 persons in each cluster. No large single source outbreak was identified. During that period, 17 cases were classified as imported cases, with 8 from Mainland China, and the remaining from Asian and South-east Asian countries such as Indonesia, Pakistan and Thailand. One hundred and thirty-three (58.6%) required hospitalization. Patients were hospitalized for an average of 5.5 days, with a range of 1 to 25 days and a median of 5 days. Out of the 227 cases, 154 were in the working population. The majority of those affected were plant and machine operators and assemblers (34%) or were working in elementary occupations (26%). Sixty-three percent (142 cases) had history of consumption of marine products, of which 128 had eaten shellfish.

5. From the available data, prevalence of hepatitis A infection has been falling in Hong Kong, which echoes the finding of a higher median age in reported HAV cases that reflects the increased susceptibility of the adult population. The latest epidemiology of hepatitis A in the local general population can be estimated from a study conducted in 2001 [2]. In this household study (Community Research Project

for Viral Hepatitis 2001, CRPVH), anti-HAV positivity was less frequent (P<0.001) across all age groups among subjects >21 years [2], than subjects in the same age groups of another study conducted in late 1980s [3]. HAV prevalence has only increased insignificantly in every 10-year age groups of people aged 21-50 [2] when compared with their corresponding 10-year younger age groups [3], signifying an ageing cohort effect with no major infections in the last 10 years [2]. Similar conclusions can be drawn when comparing the late 1980s findings with those of a late 1970s study on local HAV seroprevalence [4]. Overall, these 3 studies suggest that age-specific prevalence of HAV has right-shifted locally in the last two decades. As of 2001, anti-HAV was present in about 20% of adults below 30 years old while it was over 80% in people aged >=40 in the general Chinese population (Box 7). Besides an increasing prevalence with higher age, people born outside Hong Kong were more likely to test positive for anti-HAV whereas the reverse was true for people of non-labour work [2]. From the telephone interview part of the CRPVH 2001, some 11% of 4564 subjects reported a history of HAV vaccination, with about 80% of which completed the course. More people less than 40 years old had received the vaccination. Over 98% had the cost paid by themselves or covered by their employers.

6. Serologic evidence of HEV infection was found in about 19% of adult subjects in the 2001 CRPVH study; people in the 40-49 years age group had the highest positivity rate of 24% (Box 8). Unlike HAV infection, a pattern of right shift in HEV seroprevalence was not as prominent when temporal change was analysed. Both the overall and age-specific HEV prevalence were lower in 2001 [1], when compared with the findings in a study done in late 1980s [5]. From 1996 to 2003, 4 to 28 HEV infections were notified each year. The number of cases reported in 2004 somewhat rose to 36. The time trend needs to be monitored.

Pattern of Hepatitis B in Various Communities and its Significance

7. The parenterally-transmitted viral hepatitis B is endemic in Hong Kong. After the drop in 2003, the number of hepatitis B virus (HBV) infections notified in 2004 increased back to 130. In an epidemiologic study of acute HBV by the Department of Health and Hong Kong Red Cross Blood Transfusion Service (HKRCBTS), 149 of 351 eligible subjects recruited from 2000 to 2003 participated in risk factor assessment with or without blood screening. Repeat blood donors who test positive

for HBsAg for the first time and are then confirmed IgM anti-HBc positive were reported as having acute HBV. There were 43 such clients, yielding an incidence rate of HBV seroconversion in repeat donors as 9.4/100,000 (n=148,366), 9.3/100,000 (n=150,420), 4.6/100,000 (n=151,410) and 3.5/100,000 (n=143,230) in 2000, 2001, 2002 and 2003 respectively. Nearly 70% of the study subjects were male; 99% were Chinese and the mean age was 31 years. Over half could not have risk factor of acute HBV determined despite undergoing a standardized questionnaire interview by nurses. Sexual contact was assessed to be the commonest risk (85%) in the rest. Of 124 subjects who had hepatitis B screening at 6 months post-IgM anti-HBc positivity, 50% developed anti-HBs while 9.7% were HBsAg positive. The results suggest a higher rate of HBV chronicity than what was previously reported in the literature. However, these findings have to be interpreted with extreme caution owing to the relatively small number of samples, incompleteness of data and potential biases from the subjects sampling and other study design.

8. Besides collection of acute HBV data, determining the seroprevalence of HBV sheds light on how common the infection is in different communities, as well as informing its chronic disease burden. The various adult communities can be categorized into 3 groups according to the risk of contracting HBV: those (a) without apparent risk, (b) with undetermined risk, and (c) with apparent risk. Groups without apparent risk for which data in 2004 was available include blood donors, university students/staff, pre-marital screening attendees, antenatal women, police officers and new health care workers. Clients coming forward for post-exposure management are those with undetermined risk. Drug users and HIV/AIDS patients are at apparent risk of getting HBV, as a result of risk behaviours and shared transmission routes between human immunodeficiency virus (HIV) and HBV.

9. A majority of the available seroprevalence data in different populations were limited to overall positivity rate of HBV markers. Still, temporal trend can be discerned as most have yearly data for the past decade or so. For groups with some demographic characteristics available, such as age and gender, further analyses have been made per the aggregate data. Several features on the current pattern of HBV could be observed from the serologic investigations, namely (a) chronic HBV infection is in a general declining trend, (b) HBV prevalence increases with increasing age, and (c) chronic HBV infection is commoner in male than female. A word of caution in the interpretation of data, though, is that HBV testings have been

performed for a variety of reasons in different communities, with heterogeneous mix of population characteristics.

10. The temporal decline of hepatitis B markers in most community groups without apparent risk was especially obvious in new blood donors. Its HBsAg prevalence follows a continual falling trend in the last 15 years, to a record low of 2.87% in year 2004 (Box 9). The drop in antenatal women is also persistent in the last 4 years (Box 13). The HBsAg prevalence in antenatal mothers is confounded by the place of birth. A study of 2480 pregnant women attending the Maternal and Child Health Centre of DH in 1996 found a 13.1% in those born in Mainland China as compared to 8.4% in locally mothers [6]. Recent data also showed a higher prevalence of 14.4% and 12.5% in the subset of non-resident expectant mothers versus the overall positivity rate of 8.8% and 8.5% in 2003 and 2004 respectively. After the slight rebound of HBsAg rates in university students/staff in 2003, the prevalence declined again in 2004. (Box 11). However, prevalence in pre-marital package service users had increased since 2002, to 7.4% in 2004 (Box 12). The prevalence in police officers and newly recruited health care workers as determined at pre-HBV vaccination screening showed a stable level in the last 3 years. Among clients attended for post exposure management, HBsAg rate was found to be consistently higher in non-health care workers than health care workers (Box 19).

11. Compared with aforementioned groups, a higher HBsAg prevalence with or without evidence of higher positivity rate of any HBV markers was consistently noted in drug users (Box 20) and HIV-infected patients (Box 21), underscoring their infection risk. Furthermore, due to the underlying immunosuppression, HIV/AIDS patients are more prone to becoming chronically infected with HBV after acute infection [7]. Up to 2004, HBsAg was present at some 10-17% in these two groups of clients for the last few years, which was substantially higher than the 2-9% in other clients (Box 23, 24). The increase in HBV prevalence among new male HIV/AIDS patients of the government HIV clinic in 2004 is related to more drug users diagnosed at methadone clinics from the new universal testing programme.

12. For some groups, evidence supported age as an important correlate of HBV infection, with a higher proportion of the older population having viral markers or being chronically infected. From the 1996 to 2004 data in police officers, the presence of HBV markers progressively increased with each 10-year age group, from 28.7% in officers <=20 years old to 57.7% in officers aged 51-60 years (Box 16). In

addition, there was a rise of HBsAg rate with increasing age in police officers, from 5.2% in <=20 years old to 9.3% in 51-60 years old subjects respectively (Box 16). HBsAg positivity appears to be lower in antenatal women aged <19 years but not too different among older subjects. Similar age pattern was, however, not observed in university students/staff. Also, no definite age pattern can be derived from the household study of adult general population conducted in 2001 (Box 17).

13. Male had a higher HBV prevalence than female, as observed in several groups. The overall HBsAg positivity rate was 3.5% in male blood donors and 2.3% in female in 2004 (Box 10). Male police officers had a 5.2% HBsAg rate while that was 2.7% in female officers in 2004 (Box 15). From 1996 through 2004, the overall HBsAg rate was 6.8% and 4.0% in male and female police officers respectively (Box 15). Data from the same 8-year period also showed that the presence of HBV markers (anti-HBs or HBsAg) was higher at 38.9% in male than the 34.0% in female officers. The overall HBsAg rate was also higher in male from the 2001 household study (Box 17).

14. Genotyping studies of HBV in Hong Kong became more common in the last years. A study of 776 chronic hepatitis B patients seen at the University of Hong Kong Liver clinic from 1999 to mid-2003 found that genotype C was the commonest (486, 62.6%), followed by B (252, 32.5%), with a majority of genotype B belonged to subgroup Ba [8]. Another study of 426 chronic HBV patients recruited consecutively from 1997 to mid 2000 at the Hepatitis clinic of Princess of Wales Hospital (PWH) found a prevalence of 57% (242) and 42% (179) of genotypes C and B respectively [9]. A specific study of 49 HBV genotype C patients identified 2 distinct groups with different epidemiological distribution and virologic characteristics – 80% being genotype “Cs” (found mostly in Southeast Asia) and 20% “Cs” (predominated in Far East) [10]. Several local studies have yielded controversial and inconclusive differences in the natural disease course and occurrence of complications between genotype B and C chronic hepatitis B patients. A study found a higher chance of and earlier HBeAg seroconversion in genotype B than C patients on longitudinal follow-up [8] but another study showed that the higher cumulative rate of HBeAg seroconversion became insignificant beyond 6 years of follow up [11]. This probably contributed to no significant reduction in the risk of development of cirrhosis and/or hepatocellular carcinoma (HCC) [11]. However, another local cohort study found that genotype C chronic HBV infection is an independent risk factor for HCC development in addition to liver cirrhosis [9]. In a case control study, it was concluded that HCC

patients had a significantly higher prevalence of core promoter mutations and genotype C but the association with HCC is mediated via the former [12]. A study of 5080 chronic HBV patients focusing on familiar HCC found 22 such families, giving a prevalence of 4.3 families/1000 HBV carriers [13]. Age of onset of HCC is significantly younger in familial HCC than sporadic cases, and it progressively decreased down the generations, suggesting an anticipation phenomenon.

15. Occurrence of new HBV infection is dependent on the interplay of multiple factors, including size of HBV pool, proportion of population being susceptible and chance of exposure to the virus. It is likely that the circulating pool of HBV has reduced over the years in Hong Kong, thereby lessening the risk of exposure which can lead to acute infection. The reduced HBV pool in the community might have resulted from the universal vaccination programme for newborns, increased vaccination coverage in adults, practice of universal precaution in health care settings, predonation blood screening and promotion of safer sex [14]. A 16-year follow up study of 1112 neonates of HBV carrier mothers who received HBV vaccine and hepatitis B immunoglobulin demonstrated the long term protective efficacy of immunization [15]. The study subjects were followed at 6 months and 1, 2, 3, 5, 7, 10, 13 and 16 years; 610 (54.9%) attended the 16 year visit. None of those who developed anti-HBs after completion of vaccination course seroconverted to become HBsAg positive. However, about 9% developed anti-HBc seroconversion [15]. In a screening of convenient samples of persons of different age who underwent virologic investigations in 2001, HBsAg was absent in those below 10 years old. Yet similarly, anti-HBc was present, at a rate of 1.3% in subjects 1-4 years of age and rose to 7% in those of 5-9 years old. In another study of 2/3-doses HBV vaccine regimen without boosters to 318 HBV negative children recruited at age 3 months to 11 years and followed up annually, no subjects became HBsAg up to 18 years of follow up (88 subjects). A total of 88 anamnestic responses with significant increase in anti-HBs titers were documented in 70 subjects; 3 subjects had benign breakthrough HBV infection with isolated anti-HBc seroconversion [16].

16. Universal neonatal HBV vaccination programme has been in place in Hong Kong since 1988, and a supplementary Primary 6 vaccination programme was introduced in 1998. From the statistics collected and maintained by Family Health Services, DH, the overall first dose of HBV vaccine coverage rate was consistently over 99% for newborns born between 2000 and 2004 in Hong Kong public and private hospitals. As of June 2005, completion of 3-dose vaccination course at Family Health Service was >85% for all babies locally born between 2000 and 2003 was

>85% but was 77% in 2004. Yet, these figures do not include second and third doses administration at private services. A survey on immunization coverage was conducted by DH in year 2001 for 4746 children aged 2 to 5 recruited from 16 kindergartens and 8 child care centres, 99.2% of locally born children (3669, 88.67% of all) versus 95.2% of Mainland China born children (273, 6.6%) received a full course of HBV vaccination. In the last 6 years, the first dose coverage of the Primary 6 mop-up programme was consistently over 99.5% while that for the third dose is >98% (Box 25). In the CRPVH 2001 study, about 16% of the telephone-interviewed subjects reported a history of HBV vaccination, with a higher frequency in persons below 50 years of age. Some 83% of them reported having completed the vaccination course. Over 99% had the cost paid by themselves or borne by their employers. Nonetheless, the still high HBsAg prevalence, though declining, means a significant disease burden in the years to come. Continued tracking of the trends of new infections and prevalent cases could inform more of the changing HBV situation in our locality.

Current situation of hepatitis C

17. Although HCV shares similar transmission routes with hepatitis B, the two infections may not be of equal prevalence in a locality, as what epidemiological data points to in Hong Kong. While HBV is still prevalent in many populations in Hong Kong, HCV prevails only in isolated communities from available evidence. Conceivably related to the different epidemiology, HCV is of relatively less public health significance regarding chronic liver diseases when compared to HBV in Hong Kong. In a local study published in 1992, only 7% of HCC patients were found to be anti-HCV positive [17]; the figure included 3% from HBV-HCV coinfection and 4% with HCV infection alone. From 1996-2004, only 5 hepatitis C cases were reported to DH under the statutory notification system; four of which were reported in 2002 and one case in 2004. The 5 Chinese patients (2 males and 3 females) were aged between 7-62 years. While one patient had a history of injecting drug use, the route of transmission could not be established in the remaining four patients.

18. Data from new blood donors in the last decade suggested that HCV infection is below 0.1% in young adults locally, with the figure in 2004 being 0.089% (95% confidence interval, 0.063%-0.122%) (Box 26). This is much lower than the prevalence of HAV, HBV and to a lesser extent HEV. Findings of the household

study of the entire spectrum of adult age groups conducted in 2001 further supported the uncommon scene of HCV infection among general population in Hong Kong; the overall positive rate was 0.3% in 936 subjects (95% confidence interval, 0.07%-0.94%) (Box 28). From 2000 to 2003, 3 of 882 (0.34%) clients who attended the Therapeutic Prevention Clinic (TPC) at Integrated Treatment Centre (ITC) of CHP, DH for post-exposure management were tested positive for anti-HCV at 6 months. All three cases were already HCV infected at time of injury upon retrospect testing of baseline specimens.

19. Experience of clinicians and virologists has previously confirmed that HCV was common in injecting drug users (66.8%), haemophilia (56%), haemodialysis (4.6%) and other patients requiring frequent blood/blood product transfusions but not persons at risk through sexual contact [18]. Results of testing non-random samples from drug users under treatment suggested a decline in the rate of HCV infection from over 70% in 1988/1989 to below 50% in 2000/2001 (Box 29). HIV/AIDS patients, with a proportion being injecting drug users, is the only other group with data showing a comparatively high HCV prevalence (Box 30). From 2001 to 2004, about 8% to 18% annually of new patients attending ITC were HCV infected. The prevalence appears to be higher in male than female patients, likely related to the differential risk of parenteral and blood product exposure. While HCV infection is present in some 2% of HIV/AIDS patients infected due to sexual contact, HCV was universal in patients with HIV risk of drug use and blood transfusion (Box 31). The higher HCV prevalence, coupled with the hastened liver disease progression in HIV-infected patients [19], would no doubt result in a unique HCV/HIV coinfection that demands attention.

20. Limited genotypic studies in Hong Kong has identified that 1b and 6a were the prevalent HCV genotypes locally, a scenario different from that in western countries where 1a predominated [20]. In an early study of 212 blood donors tested anti-HCV positive from 1991 to 1994, the commonest genotype found was 1b (58.8%), followed by 6a (27.0%) [21]. A significantly greater number of donors infected with type 6a reported a history of drug abuse than those infected with type 1b. In a study of hospitalized patients with HCV testing for clinical indications, similar to the blood donors study, 1b was the commonest type in chronic liver diseases and chronic renal failure patients [22]. Yet, the commonest genotype in intravenous drug users was 6. A recent retrospective analysis of 1055 subjects with samples collected between December 1998 and May 2004 also confirmed the high prevalence of genotype 6a in

drug users (58.5%), in contrast to 63.6% of 1b in non-drug users (submitted for publication, Prince of Wales Hospital). Another local study of renal failure patients and non-renal failure controls also showed the predominance of genotype 1b, followed by 1a and 6a [23].

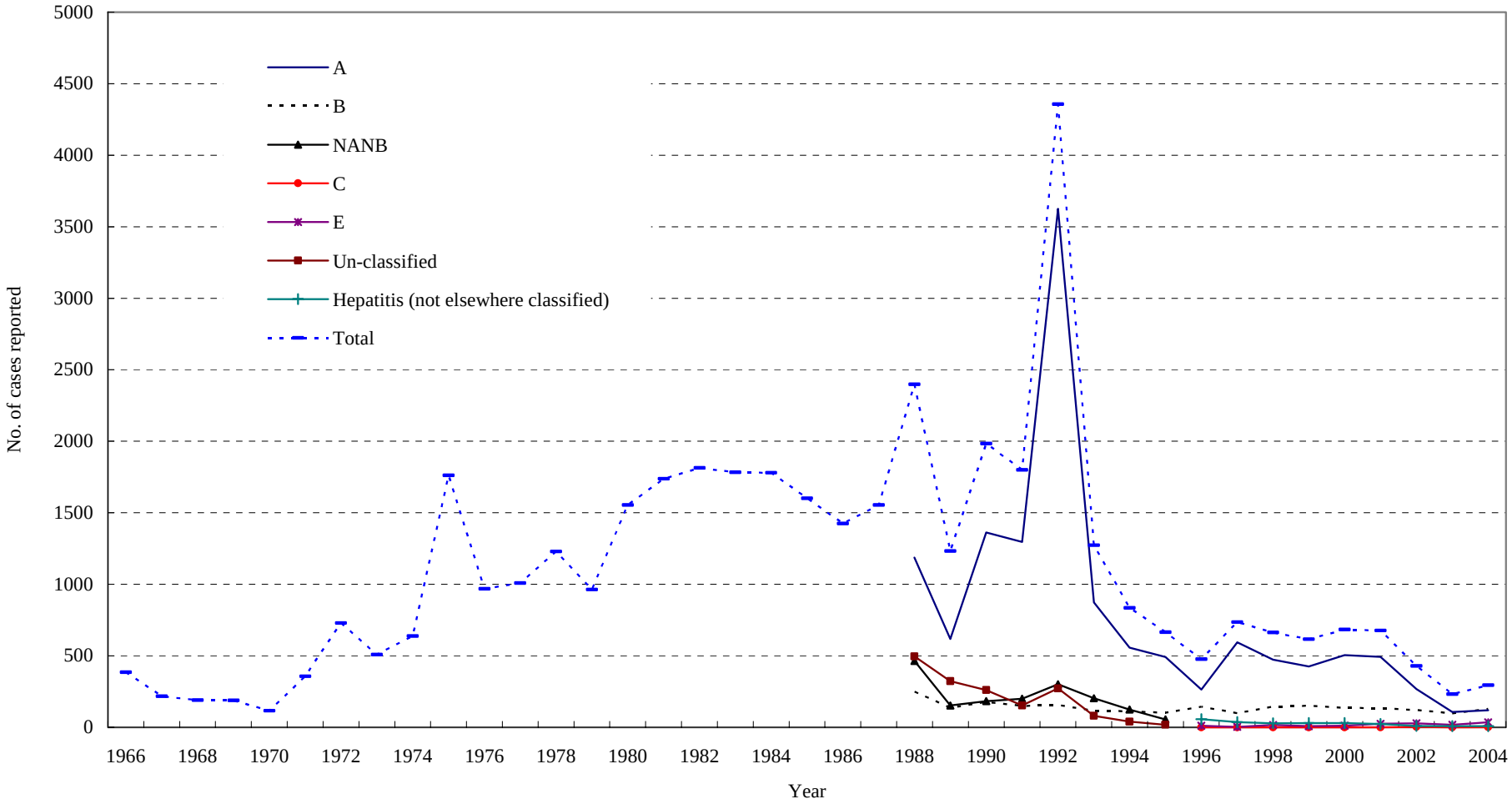
21. Since 2003, a surveillance project has been piloted to enhance understanding of the HCV situation in Hong Kong. Two laboratories, namely HKRCBTS and Department of Microbiology, Princess Margaret Hospital (PMH), had contributed HCV data in the last years. Some 180000-200000 new and repeat blood donors of HKRCBTS were tested for anti-HCV each year; the prevalence was consistent at 0.016% in 2003 and 0.021% in 2004. As for the PMH Laboratory, 1629 and 2288 subjects were tested for medical/clinical conditions or risk of infection in 2003 and 2004 respectively and the overall anti-HCV prevalence was 8.55% (Box 32). The highest anti-HCV rate was found in drug users, of which about half were positive. This was followed by patients with history of blood transfusion at about 11%, and patients done for clinical indication not falling under the standardised categorisation of screening. Of the total of 404 clients found positive in the two years, more than 80% were referred from PMH. Overall, the male-to-female ratio was about 2 to 1 (Box 33). The mean age was 43 years old (range, 11-86). Over half of the cases tested positive at PMH were drug users, followed by those with clinical indications (20%), other or unknown reasons (8.2%) and dialysis patients (4.5%).

2. Tabulated results of acute viral hepatitis under the disease notification system

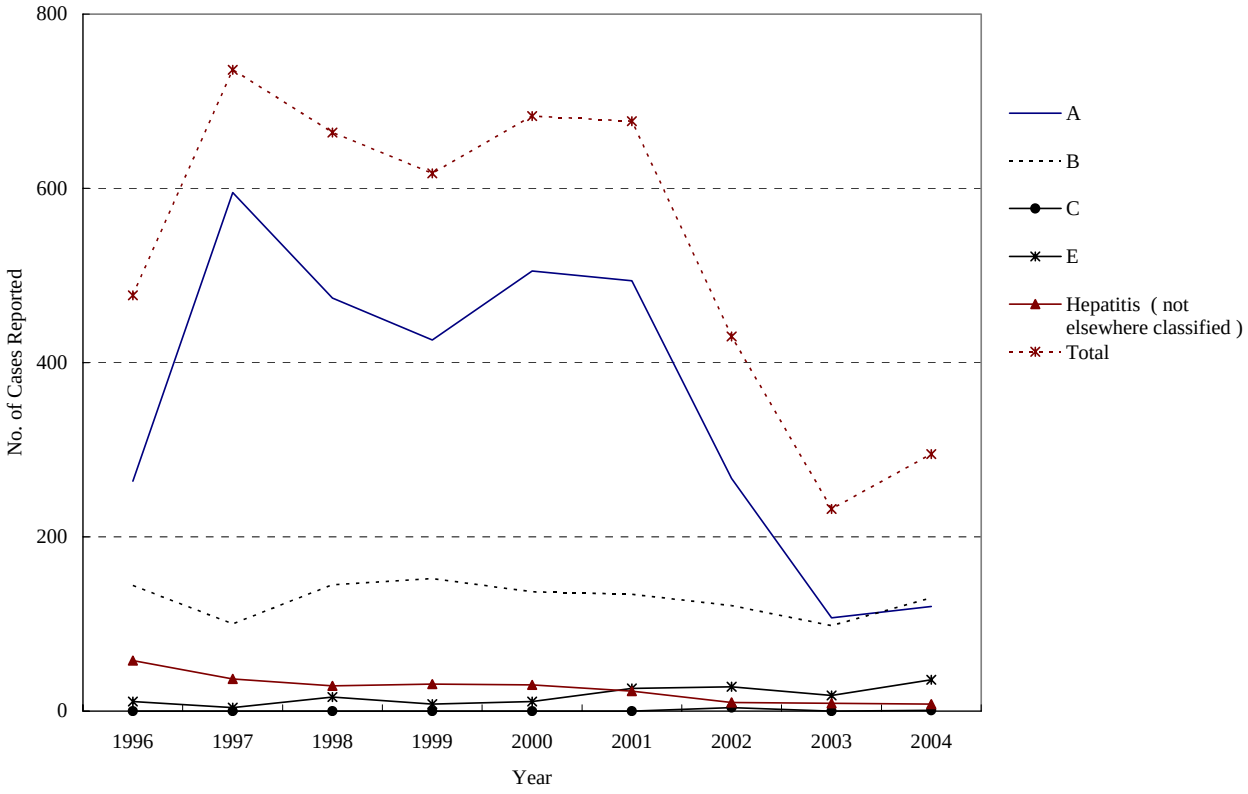
Box 1. Number of cases of viral hepatitis reported to the Department of Health between 1966 and 2004 (Data source: DH)

Year	A	B	NANB	C	E	Un-classified	Hepatitis (not elsewhere classified)	Total
1966		*voluntary reporting since 1966*						386
1967								218
1968								191
1969								188
1970								117
1971								357
1972								729
1973								509
1974		*notifiable since 1974*						639
1975								1761
1976								969
1977								1008
1978								1230
1979								964
1980								1554
1981								1738
1982								1814
1983								1783
1984								1780
1985								1601
1986								1425
1987								1554
1988	1187	250	465			496		2398
1989	618	136	154			324		1232
1990	1362	178	183			261		1984
1991	1297	150	200			154		1801
1992	3626	157	301			273		4357
1993	874	116	203			80		1273
1994	557	112	125			41		835
1995	491	102	55			18		666
1996	264	144	-	-	11	-	58	477
1997	595	100	-	-	4	-	37	736
1998	474	145	-	-	16	-	29	664
1999	426	152	-	-	8	-	31	617
2000	505	137	-	-	11	-	30	683
2001	494	134	-	-	26	-	23	677
2002	267	121	-	4	28	-	10	430
2003	107	98	-	-	19	-	8	232
2004	120	130	-	1	36	-	8	295

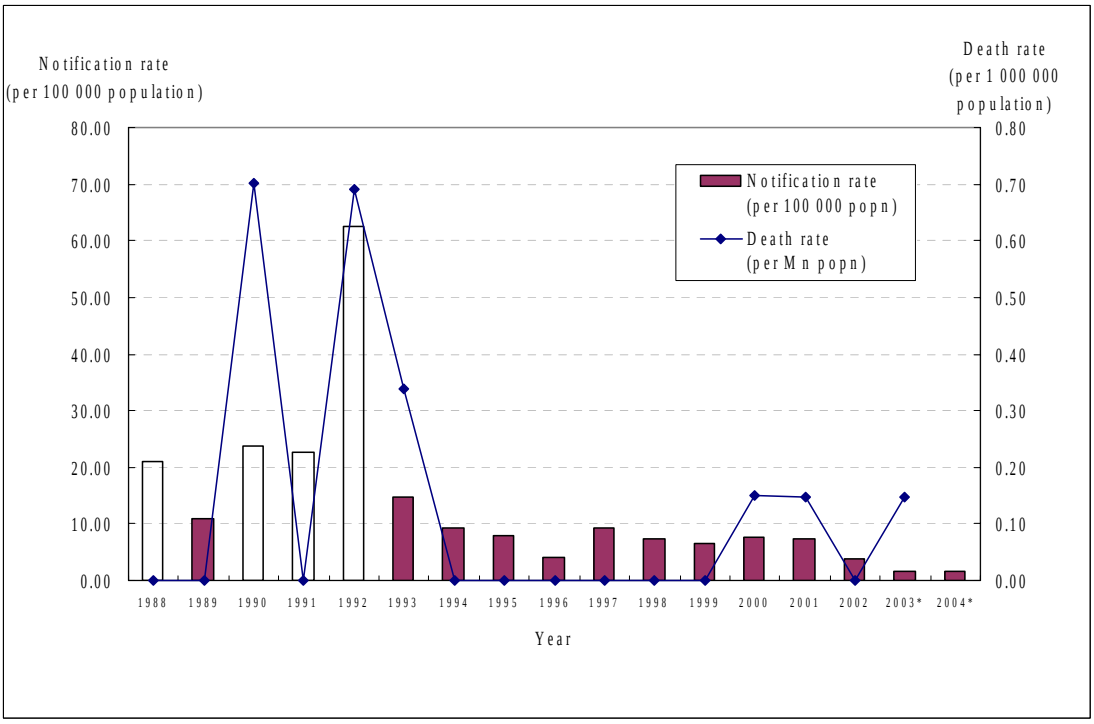
Box 2. Reported viral hepatitis from 1966 to 2004 (Data source: DH)



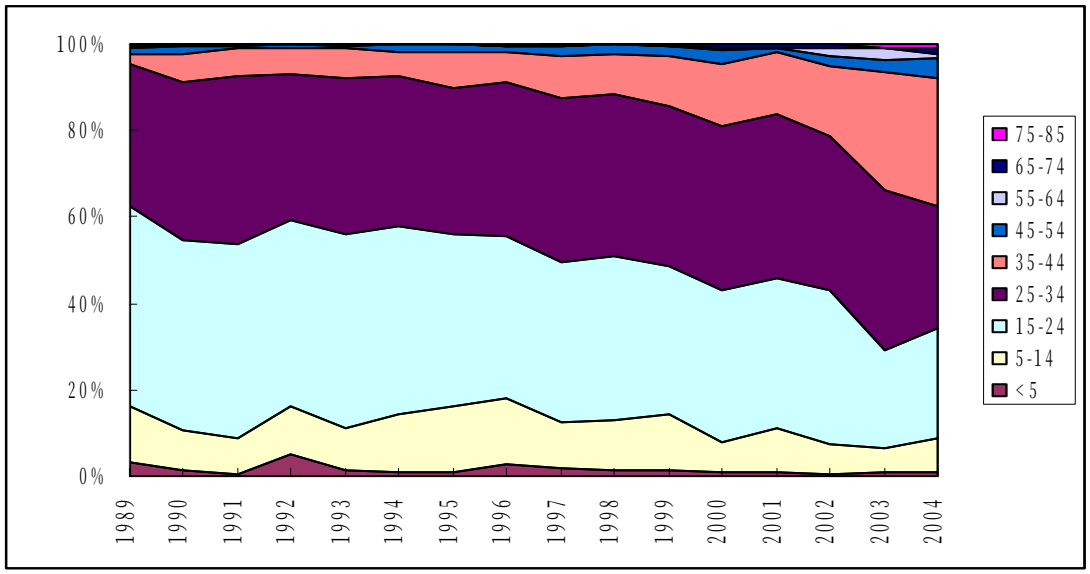
Box 3. Breakdown of different types of reported viral hepatitis from 1996 to 2004 (Data source: DH)



Box 4. Notification rates and death rates of viral hepatitis A, 1988 – 2004 (Data source: DH)



Box 5. Age distribution by proportion of total notifications of hepatitis A, 1989-2004 (Data source: DH)



Box 6. Sex distribution of hepatitis B cases notified from 1995 to 2004 (Data source: DH)

Year	Male	Female	Total
1995	74	28	102
1996	106	38	144
1997	73	27	100
1998	109	36	145
1999	113	39	152
2000	105	32	137
2001	107	27	134
2002	86	35	121
2003	64	34	98
2004	100	30	130
Total	937	326	1263

Box 7. Age distribution of hepatitis B cases notified from 1995 to 2004 (Data source: DH)

	Age group (years)							
Year	<1-14	15-24	25-34	35-44	45-54	55-64	>65	Total
1995	1	44	34	13	7	3	0	102
1996	4	48	45	27	13	4	3	144
1997	2	32	31	21	9	3	2	100
1998	4	44	46	32	14	4	1	145
1999	3	44	49	29	18	4	5	152
2000	2	39	48	32	8	5	3	137
2001	1	41	42	30	17	2	1	134
2002	1	37	29	26	17	8	3	121
2003	0	24	32	25	7	6	4	98
2004	1	28	45	33	17	4	2	130
Total	19	381	401	268	127	43	24	1263

3. Tabulated results of seroprevalence of hepatitis A and hepatitis E

Box 8. Prevalence of anti-HAV in a collection of studies/testings between 1978 and 2004 (Data sources: Multiple sources.)

Age groups	1978	1987	1989	1993	1995	1996		1998	2000	2001	2001	2002	2003	2004
0 – 10	12.9%	5.3%	6.8%	59.4% (M) 53.3% (F)	8.3%	-	6.1%	5.4%	9.3%	4.58%	-	5.3%	10.3%	14.7%
11 – 20	44.8%	17.1%	11.2%			7.0%					12.5%			
21 – 30	75.0%	53.8%	58.8%		11.3%	-	11.8%	7.6%	17.5%	13.2%	26.8%	12.6%	13.2%	21.0%
31 – 40	82.9%	85.1%	83.5%		49.0%	-	37.7%	40.8%	35.0%	41.3%	53.2%	46.7%	52.4%	43.8%
41 – 50	91.1%	94.7%	91.1%	94.5% (M) 91.0% (F)	70.5%	-	58.6%	66.7%	60.0%	71.1%	88.3%	58.1%	100.0%	50.0%
>50			93.9%			-					97.7%			
Data source	A	B	C	D	E	F	E	E	E	E	G	E	E	E

Data sources:

A. *Study on left-over sera of 362 subjects, by Tsang et al of the University of Hong Kong [4]*
B. *Study on stored sera of 702 healthy subjects, by Chin et al of the University of Hong Kong.[3]*
C. *Study on 1028 serum samples collected from individuals attending a health exhibition, by Lim et al of Department of Health. [24]*
D. *Seroprevalence results reported in the press by Lai et al of the University of Hong Kong. [25]*
E. *Pre-vaccination screening on students and staff of City University of Hong Kong: 553 (1995), 669 (1996), 608 (1998), 395 (2000), 592 (2001), 371 (2002), students and staff of Baptist University of Hong Kong 240 (2001), 259 (2002), 153 (2003), 55 (2004) and students and staff of Lingnan University 125 (2003), 84 (2004). [26]*
F. *Seroprevalence study in school children by Lee et al of the Chinese University of Hong Kong. [27]*
G. *Community Research Project on Viral Hepatitis 2001*

Box 9. Prevalence of anti-HAV in participants of Community Research Project on Viral Hepatitis (CRPVH) 2001 (Data source: DH)

Age group	No. Tested	Anti-HAV +ve	
		No.	%
18-29	137	27	19.7
30-39	223	116	52.0
40-49	291	248	85.2
50-59	170	161	94.7
60 & over	115	113	98.3
All	936	665	71.0

Box 10. Prevalence of anti-HEV in participants of Community Research Project on Viral Hepatitis (CRPVH) 2001 (Data source: DH)

Age group	No. Tested	HEV +ve	
		No.	**%**
18-29	137	11	8.0
30-39	222	32	14.4
40-49	290	70	24.1
50-59	170	39	22.9
60 & over	115	24	20.9
All	934	176	18.8

4. Tabulated results of seroprevalence of hepatitis B

Box 11. Prevalence of HBsAg in new blood donors from 1990 to 2004 (Data source: HKRCBTS)

Year	% HBsAg +ve
1990	7.97
1991	8.04
1992	7.38
1993	6.70
1994	5.87
1995	5.99
1996	5.62
1997	5.20
1998	4.89
1999	4.44
2000	4.15
2001	3.98
2002	3.64
2003	3.23
2004	2.87

Box 12. HBsAg prevalence and its gender and age breakdown in first time blood donors in 2004 (Data source: HKRCBTS)

	Male			Female		
Age Group	No. tested	HBsAg No. positive	%	No. tested	HBsAg No. positive	%
16-19	12253	329	2.7	12829	249	1.9
20-29	4631	213	4.6	4339	138	3.2
30-39	1747	80	4.6	2434	58	2.4
40-49	1040	62	6.0	1591	38	2.4
>49	344	17	4.9	470	11	2.3
Total	20015	701	3.5	21663	494	2.3

Box 13. HBsAg prevalence among university students/staff (Data source: City University Health Centre (till 2002), Baptist University Health Centre (since 2001) & Lingnan University Health Service (since 2003)

Year	Aged below 21			Aged 21 - 30			Aged <21 - 30		
	Total no. of cases	HBsAg+ve		Total no. of cases	HBsAg+ve		Total no. of cases	HBsAg+ve	
		No.	%		No.	%		No.	%
1994	305	7	2.3	830	29	3.5	1135	36	3.2
1995	324	10	3.1	768	33	4.3	1092	43	3.9
1996	348	4	1.1	762	30	3.9	1110	34	3.1
1998	371	5	1.3	608	21	3.5	979	26	2.7
2000	230	7	3	391	12	3.1	621	19	3.1
2001	508	13	2.6	814	28	3.4	1322	41	3.1
2002	266	10	3.8	483	13	2.7	749	23	3.1
2003	121	5	4.1	214	8	3.7	335	13	3.9
2004	114	3	2.6	217	4	1.8	331	7	2.1

Box 14. HBsAg prevalence from the Premarital Package Service (Data source: FPA)

Year	Total no. of cases	HBsAg +ve	
		No.	%
1990	17251	1659	9.6
1991	19142	1831	9.6
1992	18445	1708	9.3
1993	19193	1661	8.7
1994	16466	1210	7.3
1995	16798	1320	7.9
1996	19959	1575	7.9
1997	17109	1301	7.6
1998	13163	897	6.8
1999	12686	851	6.7
2000	15348	862	5.6
2001	16611	844	5.1
2002	15077	1033	6.9
2003	13489	957	7.1
2004	13773	1019	7.4

Box 15. HBsAg prevalence in antenatal women from 1990 to 2004 (Data source: FHS, DH and Virus Unit, CHP, DH)

Year	No. tested	HBsAg +ve	
		No.	%
1990	31749	3574	11.3
1991	30075	3278	10.9
1992	31394	3391	10.8
1993	34221	3456	10.1
1994	32470	3247	10.0
1995	30962	3016	9.7
1996	31508	3072	9.7
1997	25892	2417	9.3
1998	24678	2223	9.0
1999	23934	2114	8.8
2000	19090	1701	8.9
2001	23373	2142	9.2
2002	22202	2005	9.0
2003	21445	1890	8.8
2004	22119	1883	8.5

Box 16. HBsAg prevalence and age breakdown of antenatal mothers (Data source: FHS, DH)

Year	No. tested (% positive HBsAg) according to age group				
	15-19	20-24	25-29	30-34	>34
1990	1044 (10.3)	4671 (13.4)	15228 (10.7)	7639 (12.6)	2780 (12.9)
1991	987 (10.7)	4620 (10.7)	13151(10.4)	8168 (11.5)	3063 (11.8)
1992	928 (9.6)	5065 (11.4)	13093 (10.6)	8788 (10.6)	3470 (11.7)
1993	984 (9.0)	5589 (10.5)	12345 (10.3)	9395 (11.6)	3798 (11.0)
1994	951 (7.8)	5723 (9.8)	11590 (9.7)	10158 (10.6)	3998 (10.4)
1995	922 (8.4)	4979 (9.7)	10619 (9.6)	10112 (9.8)	4283 (10.3)
1996	842 (7.8)	4765 (10.3)	10137(9.5)	9759 (9.5)	5908 (10.6)
1997	902 (7.1)	4207 (9.3)	8895 (9.6)	7982 (9.3)	3897 (9.3)
1998	911 (5.8)	3887 (9.2)	8507(9.3)	7418 (8.8)	3851 (9.3)
1999	794 (7.7)	3777 (8.6)	8068 (9.3)	7196 (8.2)	3975 (9.3)
2000	618 (6.8)	2974 (10.1)	6466 (9.5)	5818 (8.0)	3192 (8.7)
2001	659 (7.3)	3516 (9.5)	8330 (10.1)	6936 (8.3)	3915 (9.0)
2002	484 (5.0)	2829 (9.7)	9120 (9.7)	6351 (8.5)	3414 (8.1)
2003	548 (4.9)	2880 (9.9)	7614 (9.4)	6789 (8.3)	3602 (8.2)
2004	510 (6.1)	2854 (8.4)	7161 (8.9)	7732 (8.6)	3856 (8.1)

Box 17. Prevalence of hepatitis B markers in police officers, by sex from 1996 to 2004 (Data source: DH)

Year	Male					Female					All				
	No. tested	+ve for HBV markers		+ve for HBsAg markers		No. tested	+ve for HBV markers		+ve for HBsAg markers		No. tested	+ve for HBV markers		+ve for HBsAg markers	
		No.	%	No.	%		No.	%	No.	%		No.	%	No.	%
1996	2080	878	42.2	138	6.6	413	128	31.0	15	3.6	2493	1006	40.4	153	6.1
1997	4227	1836	43.4	346	8.2	472	178	37.7		5.5	4699	2014	42.9	372	7.9
1998	2316	855	36.9	177	7.6	284	90	31.7	16	5.6	2600	945	36.3	193	7.4
1999	1399	517	37.0	93	6.6	322	108	33.5	17	5.3	1721	625	36.3	110	6.4
2000	1300	478	36.8	83	6.4	244	68	27.9		1.2	1544	546	35.4	86	5.6
2001	1058	399	37.7	69	6.5	221	84	38.0		2.7	1279	483	37.8	75	5.9
2002	1374	493	35.9	77	5.6	270	91	33.7	10	3.7	1644	584	35.5	87	5.3
2003	1415	458	32.4	69	4.9	259	79	30.5		3.1	1674	537	32.1	77	4.6
2004	1105	419	37.9	58	5.2	188	84	44.7	5	2.7	1293	503	38.9	63	4.9
1996-2004	16274	6333	38.9	1110	6.8	2673	910	34.0	106	4.0	18947	7243	38.2	1216	6.4

Box 18. Prevalence of hepatitis B markers in police officers, by age from 1996 to 2004 (Data source: DH)

Year	Age group														
	≤20			21-30			31-40			41-50			51-60		
	No. tested	% +ve for HBV markers	% +ve for HBsAg markers	No. tested	% +ve for HBV markers	% +ve for HBsAg markers	No. tested	% +ve for HBV markers	% +ve for HBsAg markers	No. tested	% +ve for HBV markers	% +ve for HBsAg markers	No. tested	% +ve for HBV markers	% +ve for HBsAg markers
1996	9	33.3	0.0	741	29.3	4.7	1155	39.7	6.8	544	55.5	5.9	44	59.1	18.2
1997	9	55.6	11.1	1500	31.5	6.1	2081	42.2	7.3	999	58.2	11.4	110	69.1	13.6
1998	225	24.9	5.8	1131	30.2	5.6	828	39.1	8.3	356	52.8	12.4	60	58.3	6.7
1999	149	30.9	5.4	920	32.6	5.8	428	38.6	6.8	202	51.0	8.9	22	50.0	9.1
2000	29	31.0	6.9	789	30.3	6.2	460	35.7	4.3	242	50.4	5.8	24	50.0	4.2
2001	31	35.5	6.5	639	34.3	5.6	339	36.3	5.6	225	46.2	6.2	45	57.8	8.9
2002	63	39.7	6.3	779	30.2	4.7	443	33.2	3.6	307	46.6	9.1	52	65.4	3.8
2003	72	18.1	1.4	702	27.8	4.8	505	31.1	4.6	357	43.1	5.0	38	47.4	2.6
2004	8	37.5	0.0	466	40.8	5.2	441	32.0	3.4	321	45.5	5.9	57	40.4	8.8
1996-2004	595	28.7	5.2	7667	31.4	5.5	6680	38.3	6.3	3553	51.9	8.5	452	57.7	9.3

Box 19. Prevalence of HBsAg from the Community Research Project on Viral Hepatitis (CRPVH) 2001 (Data source: DH)

Age Group	Male			Female			Total		
	No. tested	HBsAg +ve		No. tested	HBsAg +ve		No. tested	HBsAg +ve	
		No.	%		No.	%		No.	%
18-30	72	6	8.3	87	6	6.9	159	12	7.5
31-40	93	5	5.4	144	20	13.9	237	25	10.5
41-50	100	20	20.0	183	10	5.5	283	30	10.6
51 & Over	111	8	7.2	146	7	4.8	257	15	5.8
Total	376	39	10.4	560	43	7.7	936	82	8.8

Box 20. Prevalence of hepatitis B markers in newly recruited health care workers from 2001 to 2004 (Data source: DH)

Year	Male			Female		
	No. tested	+ve for HBsAg No.	%	No. tested	+ve for HBsAg No.	%
2001	440	27	6.1	613	36	5.9
2002	499	23	4.6	730	38	5.2
2003	373	20	5.4	531	27	5.1
2004	307	13	4.2	644	37	5.7

Box 21. Prevalence of hepatitis B markers in persons attending Therapeutic Prevention Clinic of Integrated Treatment Centre (ITC) for post-exposure management, from July 1999 to 2003 (Data source: ITC, CHP, DH)

	Health care workers					Non- Health care workers					Total				
	No. tested	+ve for HBsAg		+ve for anti-HBs		No. tested	+ve for HBsAg		+ve for anti-HBs		No. tested	+ve for HBsAg		+ve for anti-HBs	
		No.	%	No.	%		No.	%	No.	%		No.	%	No.	%
Jul-Dec 1999	23	2	8.7		47.8	87	13	14.9	41	47.1	110	15	13.6	52	47.3
2000	77	5	6.5	11	72.7	217	20	9.2		41.9	294	25	8.5	147	50.0
2001	102	2	2.0	77	75.5	313	20	6.4	143	45.7	415	22	5.3	220	53.0
2002	99	9	9.1	62	62.6	250	21	8.4	132	52.8	349	30	8.6	194	55.6
2003	96	6	6.3		68.8	199	23	11.6	81	40.7	295	29	9.8	147	49.8
Total	397	24	6.0		68.5	1066	97	9.1		45.8	1463	121	8.3	760	51.9

50 91

66

272 488

Box 22. Prevalence of hepatitis B markers in drug users from 1990 to 2004 (Data source: Virus Unit, CHP, DH)

Year	No. tested	% +ve			
		HBsAg	Anti-HBs	Anti-HBc*	Any marker
1990	1067	13.4	59.0	15.7	90.8
1991	1517	14.4	54.4	20.5	89.3
1992	832	13.9	49.0	21.4	84.4
1993	744	14.4	43.4	16.4	69.2
1994	607	12.9	38.1	13.5	64.1
1995	190	10.5	36.8	12.1	58.9
1996	358	8.7	43.0	12.6	62.8
1997	290	6.6	36.2	15.9	53.4
1998	290	10.0	43.4	7.9	59.3
1999	725	11.2	44.8	13.8	67.2
2000	892	11.4	42.5	15.8	67.8
2001	654	11.6	41.3	17.3	70.2
2002	553	12.7	43.0	16.6	72.3
2003	198	10.1	42.4	12.6	65.2
2004	45	11.1	57.8	4.4	73.3

** Specimens positive for HBsAg were not tested for anti-HBc*

Box 23. HBsAg prevalence in new HIV/AIDS patients from 2000 to 2004. (Data source: ITC, CHP, DH)

Year	Male		Female		Total	
	No. tested	No. HBsAg + (%)	No. tested	No. HBsAg + (%)	No. tested	No. HBsAg + (%)
2000	63	7 (11.1)	17	1 (5.9)	80	8 (10.0)
2001	71	10 (14.1)	24	1 (4.2)	95	11 (11.6)
2002	119	14 (11.8)	23	1 (4.3)	142	15 (10.6)
2003	90	13 (14.4)	13	2 (15.4)	103	15 (14.6)
2004	111	20 (18.0)	23	2 (8.7)	134	22 (16.4)

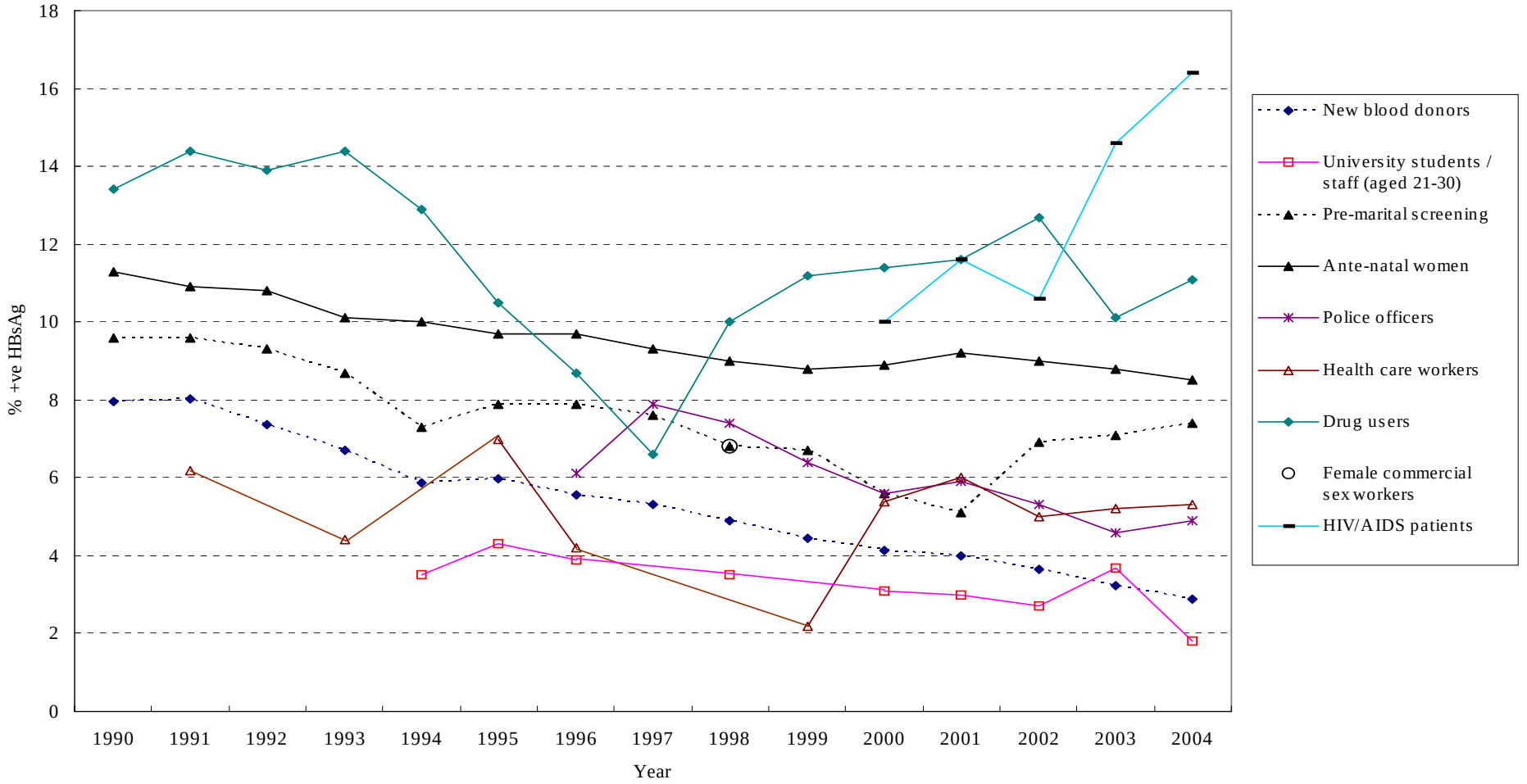
Box 24. Prevalence of HBV infection per HIV risk in cumulative ever-tested HIV/AIDS patients as of 2004 (Data source: ITC, CHP, DH)

HIV risk	No. tested	HBsAg/anti-HBs			
		+/		-/+	
		No.	%	No.	%
Heterosexual	625	72	11.5	270	43.2
Homo/Bi-sexual	320	37	11.6	153	47.8
Drug user	63	14	22.2	25	39.7
Blood/blood product recipient	18	2	11.1	12	66.7
Undetermined	3	1	33.3	2	66.7
Total	1029	126	12.2	462	44.9

Box 25. HBsAg prevalence in different population groups from 1990 to 2004 (Data source: multiple sources)

Year	% HBsAg+								
	New blood donors	University students/staff (aged 21-30)	Pre-marital screening	Ante-natal women	Police officers	Health care workers	Drug users	Female commercial sex workers	HIV/AIDS patients
1990	7.97	-	9.6	11.3	-	-	13.4	-	-
1991	8.04	-	9.6	10.9	-	6.2	14.4	-	-
1992	7.38	-	9.3	10.8	-	-	13.9	-	-
1993	6.70	-	8.7	10.1	-	4.4	14.4	-	-
1994	5.87	3.5	7.3	10.0	-	-	12.9	-	-
1995	5.99	4.3	7.9	9.7	-	7	10.5	6.8	-
1996	5.62	3.9	7.9	9.7	6.1	4.2	8.7		-
1997	5.20	-	7.6	9.3	7.9	-	6.6		-
1998	4.89	3.5	6.8	9.0	7.4	-	10.0		-
1999	4.44	-	6.7	8.8	6.4	2.2	11.2	-	-
2000	4.15	3.1	5.6	8.9	5.6	5.4	11.4	-	10.0
2001	3.98	3.4	5.1	9.2	5.9	6.0	11.6	-	11.6
2002	3.64	2.7	6.9	9.0	5.3	5.0	12.7	-	10.6
2003	3.23	3.7	7.1	8.8	4.6	5.2	10.1	-	14.6
2004	2.87	1.8	7.4	8.5	4.9	5.3	11.1	-	16.4

Box 26. Trends of HBsAg in selected population groups from 1990 to 2004 (Data source: multiple sources)



Box 27. Cumulative statistics (as of September) of the supplementary Hepatitis B Vaccination Programme for Primary 6 Students from the school years 1998 to 2004 (Data source: DH)

	School Year					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
Cumulative no. of Primary 6 students	79641	86481	85612	86052	86515	86208
First Dose						
Cumulative no. eligible for vaccination	26624	25873	17172	15504	14245	10625
Cumulative no. administered	26248	25505	16986	15351	14079	10519
Acceptance rate (at the present campaign)	98.59%	98.58%	98.92%	99.01%	98.83%	99.00%
Coverage rate (for the whole Primary 6 population)	99.53%	99.57%	99.78%	99.82%	99.81%	99.88%
Second Dose						
Cumulative no. eligible for vaccination	26626	25889	17183	15510	14250	10626
Cumulative no. administered	26096	25334	16889	15215	13800	10338
Acceptance rate (at the present campaign)	98.01%	97.86%	98.29%	98.10%	96.84%	97.29%
Coverage rate (for the whole Primary 6 population)	99.33%	99.36%	99.66%	99.66%	99.48%	99.67%
Third Dose						
Cumulative no. eligible for vaccination	26647	25905	17772	16144	14918	11222
Cumulative no. administered	25420	24205	16664	14719	13912	10036
Acceptance rate (at the present campaign)	95.40%	93.44%	93.77%	91.17%	93.26%	89.43%
Coverage rate (for the whole Primary 6 population)	98.46%	98.03%	98.71%	98.34%	98.84%	98.62%

5. Tabulated results of seroprevalence of hepatitis C

Box 28. Anti-HCV prevalence in new blood donors, 1991 to 2004 (Data source: HKRCBTS)

Year	No. of new donors	Anti-HCV+	
		No.	%
1991	48769	17	0.035
1992	43674	28	0.064
1993	36146	36	0.100
1994	38077	24	0.063
1995	39778	28	0.070
1996	40875	24	0.059
1997	40419	35	0.087
1998	43756	29	0.066
1999	40960	40	0.098
2000	41166	24	0.058
2001	43415	30	0.069
2002	42292	34	0.080
2003	36732	25	0.068
2004	41679	37	0.089

Box 29. Anti-HCV prevalence and its gender and age breakdown in new blood donors in 2004 (Data source: HKRCBTS)

	Male			Female		
Age Group	No. tested	Anti-HCV No. Positive	%	No. tested	Anti-HCV No. Positive	%
16-19	12253	2	0.02	12829	1	0.01
20-29	4631	7	0.15	4339	6	0.14
30-39	1747	5	0.29	2434	5	0.21
40-49	1040	1	0.10	1591	3	0.19
>49	344	2	0.58	470	3	0.64
Total	20015	17	0.08	21663	18	0.08

Box 30. Prevalence of anti-HCV in participants of Community Research Project on Viral Hepatitis (CRPVH) 2001 (Data source: DH)

Age group	No. Tested	Anti-HCV +ve	
		No.	**%**
18-29	137	0	0.0
30-39	223	1	0.4
40-49	291	0	0.0
50-59	170	2	1.2
60 & over	115	0	0.0
All	936	3	0.3

Box 31. Anti-HCV prevalence in drug users on rehabilitation (Data source: Virus Unit, CHP, DH)

Year	No. tested	Anti-HCV+	
		No.	%
1988/1989	134	99	73.9
2000/2001	210	97	46.2

Box 32. Anti-HCV prevalence in new HIV/AIDS patients from 2001 to 2004 (Data source: ITC, CHP, DH)

Year	Male		Female		Total	
	No. tested	Anti-HCV + (%)	No. tested	Anti-HCV + (%)	No. tested	Anti-HCV + (%)
2001	71	7 (9.9%)	23	1 (4.3%)	94	8 (8.5%)
2002	118	10 (8.5%)	22	1 (4.5%)	140	11 (7.9%)
2003	87	14 (16.1%)	13	0 (0.0%)	100	14 (14.0%)
2004	107	20 (18.7%)	21	3 (14.3%)	128	23 (18.0%)

Box 33. Prevalence of HCV infection per HIV risk in cumulative ever-tested HIV/AIDS patients as of 2004 (Data source: ITC, CHP, DH)

HIV risk	Anti-HCV		
	No. tested	+	
		No.	%
Heterosexual	601	12	2.0
Homo/Bi-sexual	313	8	2.6
Drug user	61	60	98.4
Blood/blood product recipient	18	18	100.0
Undetermined	3	0	0.0
Total	996	98	9.8

Box 34. Prevalence of hepatitis C from screening of blood donors and clinical testing of patients in a cluster hospital from 2003 to 2004 (Data source: HKRCBTS, PMH Microbiology Laboratory)

Category		2003			2004			Overall		
		No. tested	HCV +ve		No. tested	HCV +ve		No. tested	HCV +ve	
			No.	%		No.	%		No.	%
1. BLOOD DONATION		178188	28	0.016	197426	42	0.021	375614	70	0.019
2. SCREENING	Pre-transplant	7	0	0.00	20	0	0.00	27	0	0.00
	Drug users	167	87	52.10	202	100	49.50	369	187	50.68
	Needlestick injuries	90	1	1.11	130	1	0.77	220	2	0.91
	Haemodialysis/ peritoneal dialysis	508	5	0.98	463	13	2.81	971	18	1.85
	Post-renal transplant	36	2	5.56	48	0	0.00	84	2	2.38
	Haematology (pre-chemotherapy)	36	1	2.78	43	0	0.00	79	1	1.27
	Rheumatology (pre-methotrexate)	55	0	0.00	56	1	1.79	111	1	0.90
	History of blood transfusion	35	2	5.71	46	7	15.22	81	9	11.11
	Pre-vaccination	1	0	0.00	0	0	-	1	0	0.00
	TOTAL (2)	935	98	10.48	1008	122	12.10	1943	220	11.32
3. *CLINICAL INDICATION		501	30	5.99	710	51	7.18	1211	81	6.69
4. OTHERS OR UNKNOWN		193	10	5.18	567	23	4.06	760	33	4.34
TOTAL (2+3+4)		1629	138	8.47	2285	196	8.58	3914	334	8.53

**includes suspected hepatitis, work up for liver function derangement and others*

Box 35. Characteristics of anti-HCV positive patients from HKRCBTS and PMH Laboratory in 2003 and 2004 (Data source: HKRCBTS, PMH Microbiology Laboratory)

		2003 (n=166)		2004 (n=238)		Overall (n=404)	
		No.	(%)	No.	(%)	No.	(%)
Lab	HKRCBTS	28	(16.9)	41	(17.2)	69	(17.1)
	PMH	138	(83.1)	197	(82.8)	335	(82.9)
Sex	Male	115	(69.3)	157	(66.0)	272	(67.3)
	Female	51	(30.7)	81	(34.0)	132	(32.7)
Age at diagnosis	Mean	41.6		44.0		43.0	
	S.D.	14.6		14.7		14.7	
	Range	17 - 83		11 - 86		11 - 86	
Category	Blood donation	28	(16.9)	42	(17.6)	70	(17.3)
	Drug users	87	(52.4)	100	(42.0)	187	(46.3)
	Needlestick injuries	1	(0.6)	1	(0.4)	2	(0.5)
	Pre-haemodialysis/ peritoneal dialysis	5	(3.0)	13	(5.5)	18	(4.5)
	Post-renal transplant	2	(1.2)	0	(0.0)	2	(0.5)
	Haematology	1	(0.6)	0	(0.0)	1	(0.2)
	Pre-methotrexate	0	(0.0)	1	(0.4)	1	(0.2)
	History of blood transfusion	2	(1.2)	7	(2.9)	9	(2.2)
	Clinical Indication	30	(18.1)	51	(21.4)	81	(20.0)
	Others or unknown	10	(6.0)	23	(9.7)	33	(8.2)

ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
Anti-HAV	Antibody against hepatitis A virus
Anti-HBc	Antibody against hepatitis B core antigen
Anti-HBs	Antibody against hepatitis B surface antigen
Anti-HCV	Antibody against hepatitis C virus
Anti-HEV	Antibody against hepatitis E virus
BUHC	Baptist University Health Centre
CHP	Centre for Health Protection
CRPVH	Community Research Project on Viral Hepatitis
CUHC	City University Health Centre
DH	Department of Health
FHS	Family Health Service
FPA	Family Planning Association
HBsAg	Hepatitis B surface antigen
HAV	Hepatitis A virus
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HEV	Hepatitis E virus
HIV	Human immunodeficiency virus
HKRCBTS	Hong Kong Red Cross Blood Transfusion Service
IgM	Immunoglobulin M
IDU	Injecting drug users
ITC	Integrated Treatment Centre
LUHC	Lingnan University Health Centre
PMH	Princess Margaret Hospital
TPC	Therapeutic Prevention Clinic

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