Surveillance of Viral Hepatitis in Hong Kong

2019 Report

Viral Hepatitis Control Office
Department of Health
The Government of the Hong Kong Special Administrative Region

The information contained in this Report is up to year 2019 for the surveillance data, service statistics and published research findings.

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Comments and suggestions on this Report are most welcome.
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SURVEILLANCE OF VIRAL HEPATITIS IN HONG KONG 2019 REPORT

CONTENTS

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SURVEILLANCE 2019 AT A GLANCE

Number of reported cases of viral hepatitis

- Hepatitis A: 79
- Hepatitis B: 28
- Hepatitis C: 17
- Hepatitis E: 85

Prevalence of HBsAg

- New blood donors: 0.7%
- Antenatal women: 4.0%
- Newly recruited healthcare workers: 2.7%
- HIV/AIDS patients: 6.5%

Prevalence of anti-HCV

- New blood donors: 0.07%
- HIV/AIDS patients: 3.5%

Liver cancer statistics (2018)

- Number of new cases: 1742
- Number of deaths: 1487

Third-dose hepatitis B vaccination coverage

- Primary six students (2018-19): 98.2%
- Pre-school children born in 2012 - 2014: 99.7%

SURVEILLANCE MECHANISMS OF VIRAL HEPATITIS

1. Viral hepatitis is a statutory notifiable disease in Hong Kong. Voluntary reporting was started in 1966, and the disease has become notifiable since 1974. It was not until 1988 that the reported cases were classified by viral etiology, namely hepatitis A, hepatitis B, non-A non-B hepatitis and unclassified hepatitis. In 1996, non-A non-B hepatitis was further categorised into hepatitis C, hepatitis E and hepatitis (not elsewhere classified).

2. The extent of chronic viral hepatitis, notably hepatitis B and C, is determined by other mechanisms. This Report presents the latest findings from collation and analysis of viral hepatitis data obtained from the disease notification system, service statistics, seroprevalence studies and other research findings.

COMMENTARY

Epidemiology of Hepatitis A

3. Hong Kong was once of intermediate endemicity for hepatitis A virus (HAV) [1, 2]. After 1988 when viral hepatitis began to be reported according to etiologic agents, the largest epidemic of hepatitis A occurred in 1992, with over 3,500 cases reported to the Department of Health (DH) (Box 1). This represented a notification rate of 63 per 100,000 population (Box 8), and since then, a gradual declining trend in HAV incidence has been observed. This discernible decline in hepatitis A contributed to a parallel declining trend in overall reported viral hepatitis since 2002 (Box 4). The death rates from hepatitis A has been low, ranging between 0 and 0.15 per million population in the last two decades (Box 8).

4. From 2010 to 2019, the annual number of hepatitis A reported cases ranged from 43 to 138 (Box 1). In 2015, a review on 587 reported cases of hepatitis A from 2005 to 2014 was published by the Surveillance and Epidemiology Branch (SEB) of Centre for Health Protection (CHP), Department of Health. The male to female ratio was 1.2 to 1, with 75% aged below 40 years. The majority (70%) of cases required hospitalisation, and two fatal cases were recorded. Both fatalities had multiple comorbidities. The majority (76%) of the patients acquired the disease locally. Most (92%) were sporadic cases and 22 small clusters affecting two to four patients were identified. Of these, at least 60% were clusters affecting members of the same household [3].

5. An increase in the number of cases was noted in 2015 when a total of 138 cases were reported. The majority (75%) of the cases was reported from February to June. The male to female ratio was 1.2 to 1, with a median age of 33 years (range: 3 to 83 years). There was no fatality. Except two cases studying in the same school and two cases from the same family, no epidemiological link was found. No single identifiable source could explain the upsurge of cases [3].

6. In 2016, a total of 98 cases of hepatitis A were recorded, affecting 68 men and 30 women (male to female ratio: 2.26:1) aged from 3 to 86 years (median: 32 years).

Sixty-three cases (64.3%) acquired the infection locally, and 85.7% required hospitalisation.

7. In late 2016, an unusual upsurge of acute hepatitis A infection affecting men who have sex with men (MSM) with human immunodeficiency virus (HIV) infection was noticed. With retrospective investigations and prospective reporting, a total of 53 cases of laboratory-confirmed HAV infection with clinical symptoms among individuals identified as MSM were recorded between September 2015 and November 2017. The age range of the cases was 20 to 55 years (median: 33 years). Forty-five (84.9%) required hospitalisation and there were no fatalities. Thirty-seven cases (69.8%) were known to be HIV-positive attending one of the three designated public HIV clinics. The majority (96.2%) did not report history of hepatitis A vaccination. Eighteen (33.9%) reported travel history within the incubation period. Around one quarter of the cases had concurrent diagnosis of other sexually transmitted infections (STI) including syphilis, gonorrhoea and chlamydia infection. Among the cases with specimen available for laboratory analysis, forty-three (81.1%) had identical nucleotide sequences within the genotyping window. Apart from one cluster affecting two patients, who were sex partners residing together, no other epidemiological linkage could be found. No common food nor water source or social gathering was identified among these cases. Epidemiological investigations suggested that the outbreak was contributed by transmission by way of sexual contact between men, a high proportion of whom were HIV-infected. Hepatitis A outbreaks among MSM communities were reported during the same period in some other regions with low HAV endemicity, including Taiwan, Europe and both North and South America [4].

8. Over the years, there has been an increase in the proportion of reported cases over 35 years old. Although the majority were still below 44 years of age, the proportion of reported cases that were aged 45 and above had increased from less than 10% two decades ago to 14% - 41% since 2010 (Box 7).

Prevalence of anti-HAV

9. In a territory-wide seroprevalence study on viral hepatitis, involving 10 256 participants recruited between February 2015 and July 2016, the crude and adjusted prevalence of antibodies against hepatitis A virus (anti-HAV) in Hong Kong was 65.2% (95% confidence interval [CI]: 64.2% - 66.1%) and 52.2% (95% CI: 51.3% -

53.2%) respectively [5]. The prevalence of anti-HAV found in this study was significantly lower than that (71.0%) in the previous local seroprevalence study (P < 0.001), conducted back in 2001 via telephone household survey (Community Research Project for Viral Hepatitis 2001, CRPVH) [2].

10. Anti-HAV positivity was less common across all age groups among subjects aged 30 or above in the seroprevalence study in 2015-16 [5] than the subjects in the same age groups in CRPVH conducted in 2001 [2]. Similar phenomenon that a lower anti-HAV prevalence among the subjects of the same age groups in a more recent study was observed, while comparing the findings of CRPVH 2001 with those in another study conducted in late 1980s [6] or comparing the late 1980s findings with those of a late 1970s study on local HAV seroprevalence [7]. These observations signify an aging cohort effect with an overall decline in the prevalence of HAV infection. Together, these four studies suggest that age-specific prevalence of anti-HAV has right-shifted locally since 1980s. As of 2016, the prevalence of anti-HAV remained at low level (around 20%) among adults aged below 30 years old. However, an anti-HAV prevalence exceeding 80% could only be observed in people aged 60 years old or above in 2016, instead of those aged >=40 years in 2001, in the general Chinese population (Box 21).

11. Data from laboratory surveillance performed by Public Health Laboratory Services Branch (PHLSB) every five years also showed that the seroprevalence of anti-HAV remained below 40% among those younger than 30 years old in 2000, 2005 and 2010. The prevalence of HAV infection has been falling in Hong Kong, which has changed from a region with intermediate to very low endemicity in the past three decades (Box 24) [8].

12. Besides an increasing prevalence with higher age, people born outside Hong Kong were generally more likely to test positive for anti-HAV whereas the reverse was true for people of non-labour work [2]. In the seroprevalence study 2015-16, anti-HAV positivity was more likely among the participants born in the mainland China, while those having lower monthly household income were more likely to be anti-HAV-positive [5].

13. From the telephone interview part of the CRPVH 2001, some 11% of 4 564 subjects reported a history of HAV vaccination, about 80% of whom had completed

the course. The vaccination rate in the general population remained stable, as 5.9% of the participants in the seroprevalence study 2015-16 had received hepatitis A vaccination [5]. Both the low coverage of hepatitis A vaccination and the low circulating HAV in the community probably lead to a general decrease in anti-HAV prevalence over the years.

14. Cross-sectional surveys of anti-HAV at Kowloon Bay Integrated Treatment Centre (ITC), the HIV specialist clinic under Department of Health, have been started since 2007. The subjects consisted of all new HIV/AIDS patients who first attended ITC between July 2007 and 2019 and convenience samples of all active HIV/AIDS patients who first attended ITC before July 2007 (Box 22). The prevalence of anti-HAV increased with age of HIV/AIDS patients, and the overall positivity rate among these patients tested between 2007 and 2019 appeared to be comparable with that of the data obtained from serosurvey in the general population in 2001 and 2016. Confounding factors, such as different levels of past infection, immunodeficiency in HIV patients, history of hepatitis A vaccination and difference in years of testing, may have affected the results. Compared with patients acquiring HIV via other routes, those infected via homosexual or bisexual routes were at the highest risk of HAV infection, as reflected by the lowest level of anti-HAV prevalence in this group of patients (Box 23). Indeed, the increased susceptibility had manifested itself during the upsurge of hepatitis A infection among MSM occurring in 2015 to 2017 [4]. As a result, the Scientific Committee on AIDS and STI and Scientific Committee on Vaccine Preventable Diseases extended their recommendation for hepatitis A vaccine to MSM in June 2017 [9].

Epidemiology of Hepatitis E

15. The annual notification of hepatitis E infection increased from 11 in 1996 to a record high of 150 in 2012 (Box 1). In the past five years, the number of reported cases of hepatitis E ranged from 43 to 96. A seasonal pattern was observed with peak infections reported from February to April (Box 16), indicating that infection was more common during winter and spring seasons. Of 1399 cases reported, 916 (65.5%, Box 17) were male, giving male to female ratio of 1.9:1. The majority was adults, most of whom were aged between 35 and 74 (Box 18). Fatalities were more common with acute hepatitis E than with acute hepatitis A, and the death rate reached as high as 0.44 per million population in 2002 when three deaths attributable to acute hepatitis E infection occurred (Box 19).

16. The CHP reviewed all hepatitis E cases recorded between 2001 and 2010 [10]. Of the 524 cases, the commonest presentations were tea-coloured urine, jaundice, anorexia, fever, myalgia and nausea. 78.2% were hospitalised with a median stay of seven days. A total of 12 cases were fatal (9 males and 3 females), and age ranged from 53 to 82 (median age 67.5 years). The case fatality rate was 2.3%, which was comparable with reported figures from other countries. None of the fatal cases was pregnant. Most cases (99.4%) were sporadic infection and 87.4% acquired the disease locally. A small family cluster involving two males (aged 15 and 44 years) was identified. The two patients had shared multiple high-risk food items at home during the incubation period. It proved difficult to determine the exact source of infection of individual sporadic cases as hepatitis E has a long incubation period of 15 - 64 days. Nonetheless, epidemiological investigation did not identify any outbreak linked to a particular food premises.

17. The epidemiology of acute hepatitis E cases recorded by CHP was also reviewed in recent years [11, 12]. The latest review covering cases from 2013 to 30 September 2018 showed a total of 461 cases, with age ranging from 15 to 96 years (median: 56 years). More males were affected than females (62.5% vs. 37.5%). More cases were recorded from January to April. Most of the cases (81.8%) acquired the infection locally. Symptomatology was similar with the cases from 2001 to 2010. Three hundred and ninety-nine (86.6%) patients required hospitalisation with a median length of stay of seven days. Nine fatal cases were recorded, among whom eight had underlying illnesses, giving a case fatality rate of 2.0%. The age of the deceased patients ranged from 49 to 81 years (median: 74 years). A significant proportion of the patients recalled consuming pig liver (28.6%) and shellfish (28.9%) during the incubation period. Notably, one case recorded in August 2018 acquired the infection from organ transplant, involving a single deceased person whose organs had been donated to five recipients in February 2018. Subsequent laboratory investigations found that the other four recipients also had hepatitis E virus (HEV) infection [13].

18. The epidemiology and clinical features of sporadic hepatitis E cases were compared with those of another enterically transmitted hepatitis, namely hepatitis A. Of 105 acute hepatitis A and 24 hepatitis E patients seen at Princess Margaret Hospital (PMH) in 2002, patients having hepatitis A were significantly younger (median age: 27 years) and had recent history of shellfish consumption while

hepatitis E patients were older (median age: 53 year) and most had a recent travel history. Moreover, whereas hepatitis A was milder and recovery was uneventful, hepatitis E was more severe, associated with significant mortality and frequently complicated by protracted coagulopathy and cholestasis [14]. The higher disease severity for hepatitis E was also identified in a territory-wide cohort study, involving 1 068 cases of acute hepatitis A and 846 cases of acute hepatitis E from 2000 to 2016. As compared with hepatitis A patients, hepatitis E patients had more all-cause mortality (3.9% vs 0.6%; $P < 0.001$), liver-related mortality (2.0% vs 0.3%; $P < 0.001$) and hepatic events (2.8% vs 0.3%; $P < 0.001$) within 30 days from diagnosis [15].

19. A local study examined the genotype of 57 patients with acute hepatitis E infection who were admitted to Prince of Wales Hospital (PWH). Fifty-six patients (98%) were Chinese. All cases were sporadic. No fulminant hepatitis was recorded and all patients recovered. Phylogenetic analyses of the open reading frame ORF2 fragments from 46 patients and ORF1 fragments from 33 patients showed complete agreement, with most (n= 45 [98%]) belonging to genotype 4. The remaining isolate was genotype 3 obtained from a woman who had no history of travel. Most of the Hong Kong isolates clustered closely with a swine isolate reported from Guangxi Province, China [16].

20. Apart from pregnancy, coinfection with hepatitis B virus (HBV) might be associated with more fulminant clinical outcome in patients infected with HEV. Among three cases of serious HEV infection with acute liver failure reported to DH in the first two months of 2012, one required liver transplantation and two passed away. One of the deceased patients was tested positive for chronic hepatitis B infection [17]. Moreover, a 10-year retrospective study on acute hepatitis E in local hospitals showed that patients with chronic hepatitis B acutely infected with HEV had a higher rate of liver failure, liver-related mortality and all-cause mortality, though the association was not statistically significant [18]. In another territory-wide cohort study from 2000 and 2016, coexisting chronic hepatitis B was found to be an independent risk factor for liver-related mortality in patients with acute hepatitis E (adjusted hazard ratio = 3.34; $P = 0.02$), as compared with acute hepatitis A patients [15].

21. Given the evidence that suggests a zoonotic source of hepatitis E in overseas studies, the Centre for Food Safety conducted a risk assessment study titled “Hepatitis E Virus in Fresh Pig Livers” [19] to determine the HEV prevalence in fresh

pig liver samples obtained in local markets. One hundred fresh pig liver samples were collected from pigs slaughtered between mid-January and May 2009. Sixteen (31%) out of 51 roaster pig (around four months old) liver samples were positive for HEV, while none of the 49 porker pig (around six months old) liver samples tested positive. Partial sequences of some HEV isolates from roaster pigs were identical to those from 7 among 48 local human cases. The findings suggest the possibility of roaster pigs as one of the sources of local human hepatitis E infections.

22. The genetic association between human HEV infection and HEV-contaminated high-risk food in Hong Kong was examined in a molecular epidemiological study by comparing local virus strains obtained from sera from 24 hepatitis E patients with those surveyed from five types of high-risk food items (lamb, oyster, pig blood curd, pig large intestine and pig liver) between 2014 and 2016 [20]. HEV RNA was detected in pig liver, pig intestine and oyster samples with prevalence of 1.5%, 0.4% and 0.2% respectively. Phylogenetic analysis showed that all sequenced human and swine HEV strains belonged to genotype 4 with close genetic relatedness. Again, the findings suggested that swine could be an important foodborne source of autochthonous human HEV infections in Hong Kong. The study also echoed the evidence of a major epidemiological shift in hepatitis E in Southern China driven by genotype switch from HEV-1 to HEV-4 over the past two decades [21].

23. The usual HEV causing human infection belongs to *Orthohepevirus A* (HEV-A), while *Orthohepevirus* genus has three other species circulating in different hosts, namely *Orthohepevirus B* in chickens, *Orthohepevirus C* (HEV-C) in rats and ferrets and *Orthohepevirus D* in bats. Cases of human infection with HEV-C (also known as rat HEV) were first reported in Hong Kong in 2018, involving a 56-year-old man having immunosuppressant for anti-rejection prophylaxis after liver transplant in May 2017 [22] and a 70-year-old woman on immunosuppressant for treatment of underlying disease [23]. Epidemiological investigation of the first two cases conducted by CHP revealed that both cases resided in Wong Tai Sin District without travel history during the incubation period of usual HEV infection. The two patients could not recall having direct contact with rodents or their excreta, but one recalled having seen suspected rodent excreta in his residence. Based on the available epidemiological information, the source and the route of infection in these two immunocompromised patients could not be determined. The exact mode of transmission of rat HEV to humans is unknown at the moment.

24. To describe the epidemiological and clinical features of human HEV-C1 infection in Hong Kong, a territory-wide prospective study was conducted by screening blood samples from 2860 patients with abnormal liver function or immunosuppressive conditions between 1 January 2017 and 31 July 2019 [24]. Of the eight identified infections, three had acute hepatitis, four had persistent hepatitis and one had subclinical infection without hepatitis. HEV-C1 hepatitis was generally milder than HEV-A hepatitis. One HEV-C1 isolate obtained from a rat captured in Wong Tai Sin District, where half of the identified cases resided, was closely related to the major outbreak strain in Hong Kong.

Prevalence of HEV

25. In the CRPVH study conducted in 2001, 18.8% of adult subjects were found to have serologic evidence of HEV infection. People in the 40 - 49 years age group had the highest positivity rate of 24.1% (Box 25). Another local seroprevalence study on anti-HEV using 450 serum samples submitted for virological investigation in 2008 - 2009 in a local hospital found a higher rate of HEV IgG seropositivity at 28.7% [25]. The HEV IgG seropositivity rate increased from 8% among 1 - 10 years old to >56% among those aged over 80. The overall seropositivity rate was higher among male than female (32.9% vs 24.4%, p=0.048).

26. The overall anti-HEV seroprevalence had further risen in the past decade. A cross-sectional sero-epidemiological study conducted between February 2012 and May 2014 gave an overall anti-HEV seropositivity at 32.0% [26]. This community-based study involved a total of 1 539 participants sampled from different subpopulations, including healthy adults, pregnant women, patients with chronic liver disease, elderly people and frequent food handlers. Independent risk factors associated with anti-HEV seropositivity was older age (>35 years), no hand-washing practice after handling shellfish and lower education level. Prevalence of anti-HEV remained at a similar level at 33.3% (95% CI: 32.4% - 34.2%) in the territory-wide seroprevalence study on viral hepatitis in 2015-16 [5]. The study also found that hepatitis A and E shared similar risk factors, such as being born in mainland China and increasing age, and protective factor of higher family income. In both studies, male sex was associated with increased risk of acquiring HEV.

27. The HEV prevalence was also determined in Hong Kong blood donors [27]. Of 10 000 unlinked donation samples collected in March to May 2015, two were tested

positive for HEV RNA. Genotype 4, the dominant genotype in circulation in Hong Kong, was identified in one of the two RNA-positive samples, while genotyping was unsuccessful for another one. Both samples were also positive for IgG and IgM anti-HEV. Anti-HEV seroprevalence was estimated as 15.8% among all donors. IgG anti-HEV positivity rate was higher in males, and increased with age from 3.1% for age group 16 - 20 to 43.1% for age group 51 - 60. The HEV RNA positivity rate at 0.02% found in the study was within the reported range in developed countries (0.01% - 0.08%).

28. Following the documentation of bloodborne transmission of HEV in recent years, a matched cohort study was conducted to assess the effects of age, gender and addictive injection use on HEV serostatus and concentration [28]. HEV IgG seroprevalence was 46.2% among 91 people who inject drugs, who underwent HCV load testing between 1 January 2018 and 31 October 2019, as compared with 22.0% in 91 age- and sex-matched organ donors. Increasing age and addictive injection use were significantly associated with HEV IgG positivity. The study results suggested that people who inject drugs were at increased risk for hepatitis E and prone to repeated HEV exposure and reinfection, indicated by higher HEV IgG concentrations.

HEV Vaccine

29. An HEV vaccine licensed in China in December 2011 was considered a promising vaccine, which has shown a high degree of efficacy against HEV in 16 - 65-year old healthy subjects in China. However, data on its impact on the overall disease incidence and reduction of mortality in the general population where the infection is common are limited and it is not approved for use elsewhere. World Health Organization (WHO) has not made recommendation on its incorporation in national programmes [29].

Hepatitis B in Various Communities

30. The number of reported acute HBV infections has been decreasing over decades, from 137 cases reported in 2000 to 28 cases reported in 2019 (Box 1).

31. In an epidemiologic study of acute HBV infection conducted 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 tested

positive for hepatitis B surface antigen (HBsAg) for the first time and were then confirmed IgM anti-HBc positive were reported as having acute HBV infection. 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 infection determined despite undergoing a standardised 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 positive for HBsAg. Although these results could suggest a higher rate of HBV chronicity than what was previously reported in the literature, they have to be interpreted with caution owing to the relative small number of samples, incompleteness of data and potential biases from the subjects sampling and other study design.

32. Seroprevalence of HBsAg in different communities are monitored continuously and the various adult communities can be categorised into three groups according to the risk of contracting HBV:

(a) without apparent risk: blood donors, pre-marital/ pre-pregnancy service users, antenatal women, police officers, new health care workers (HCW)
(b) with undetermined risk: clients seeking post-exposure management and tuberculosis patients
(c) with apparent risk: drug users, HIV/AIDS patients and female sex workers

33. The latest territory-wide seroprevalence study gave a crude and age-and-sex-adjusted prevalence of HBsAg at 7.8% and 7.2% respectively in the general population [5]. Several features on the current pattern of HBV infection could generally be observed from the serologic investigations, namely

(a) chronic HBV infection is in a general declining trend in community groups without apparent risk of contracting HBV,
(b) HBV prevalence increases with increasing age, and
(c) chronic HBV infection is commoner in male than female.

34. A word of caution in the interpretation of data though, is that testing for HBV markers has been performed for a variety of reasons in different communities, with heterogeneous mix of population characteristics.

Seroprevalence of Adult Communities without Apparent Risks

35. The temporal decline of chronic HBV infection has been most obvious in new blood donors and police officers. For new blood donors, the HBsAg prevalence follows a continual falling trend since early 1990s, from 8% in 1990 to 0.7% in year 2019 (Box 27). The trend is even more obvious among the 16 - 19 years age group where the prevalence is as low as 0.3% in male and 0.2% in female (Box 28, Box 29). A similar trend was observed among police officers where the HBsAg prevalence fell from 7.9% in 1997 to 1.2% in 2019 (Box 37), with a prevalence of 0.8% among those aged 30 or less (Box 36). A falling trend was generally observed in other community groups without apparent HBV risk, albeit less prominent (Box 26, Box 34).

36. The HBsAg prevalence in antenatal mothers has been decreasing from over 10% in the early 1990s to 4.0% in 2019 (Box 30). As compared with other groups without apparent risk, the overall HBsAg prevalence in antenatal mothers is higher and confounded by the place of birth. A study of 2 480 pregnant women attending the Maternal and Child Health Centre (MCHC) of DH in 1996 found an HBsAg prevalence at 13.1% in those born in mainland China as compared to 8.4% in local mothers [30]. Data from Virus Unit, Department of Health also showed a higher prevalence of 12.5% and 13.8% in the subset of non-resident expectant mothers versus the overall positivity rate of 8.5% and 8.6% in 2004 and 2005 respectively. The prevalence in pre-marital/ pre-pregnancy package service users has dropped from 9.6% in 1990 to 3.6% in 2019 (Box 33). The prevalence of HBsAg among antenatal mothers also varied significantly by age (Box 31, Box 32). The HBsAg prevalence among antenatal mothers younger than 25 years has been dropping to a low level (less than 2%) in 2019, as compared with those aged 35 years or above (more than 6%). The age-specific prevalence is in line with the findings in a retrospective cohort study, involving 10,808 young pregnant women aged 25 years or below born in Hong Kong and managed at a single hospital between 1998 and 2011 [31]. The HBsAg prevalence in the study ranged between 2.3% and 8.4%, with a significantly lower prevalence among those being born in and after 1984 (Odds ratio [OR]: 0.68, 95% CI: 0.58 - 0.80), when hepatitis B vaccination was given to neonates born to HBsAg-positive mothers.

37. The prevalence in newly recruited health care workers as determined at pre-HBV vaccination screening also showed a decreasing trend from 6.1% in 2001 to 2.4% in 2019 among male (Box 38). Of note, the decreasing trend was less apparent among newly recruited female health care workers, whose HBsAg prevalence was 3.0% in 2019. Further investigation is required to determine whether there are confounders for the difference in HBsAg prevalence between male and female health care workers, such as age and place of birth.

Seroprevalence of Adult Communities with Undetermined Risk

38. Of 1091 tuberculosis patients attending Tuberculosis & Chest Clinics, DH between March and May in 2018, 103 (9.4%, Box 39) were detected HBsAg positive, with the highest prevalence rate in the middle age group (40 - 59 years old: 11.6%, Box 40) followed by the more elderly group (>= 60 years old: 10.1%, Box 40). The HBsAg positivity rate was higher in male clients (11.4%) than in female (6.4%, Box 39). Both the age (Box 40) and gender pattern (Box 39) were consistently observed over the last decade. Among clients attending for post-exposure management in 2018, HBsAg rate was low in both non-health care workers (1.2%) and health care workers (2.4%) (Box 42).

Seroprevalence of Adult Communities with Apparent Risk

39. The HBsAg prevalence in HIV/AIDS patients under care of DH was in the range of 5.6% to 11.3% in the past decade (Box 43). Due to underlying immunosuppression and shared routes of transmission, HIV/AIDS patients are more likely to be chronically infected with HBV [32]. The HBsAg prevalence in female sex workers attending the clinic of Action for REACH OUT tested between 2007 and 2011 ranged from 5.0% to 10.4% (Box 41). The data regarding prevalence of HBsAg in drug users was difficult to interpret because of the small number of subjects since 2006 (Box 45). Overall, the difference in HBsAg prevalence between groups with or without apparent risk of contracting HBV has not been prominent in the past few years.

Genotypes of Hepatitis B and Their Disease Course

40. Different HBV genotypes have been identified with distinct geographic distribution and association with different clinical outcomes. Local studies indicated that genotype C was the commonest genotype and genotype B was the second. 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 genotype B (252, 32.5%), with a majority of genotype B belonging to subgroup Ba [33]. Another study of 426 chronic HBV patients recruited consecutively from 1997 to mid-2000 at the Hepatitis Clinic of Prince of Wales Hospital (PWH) found a prevalence of 57% (242) and 42% (179) of genotypes C and B respectively [34].

41. A study of 49 HBV genotype C isolates from Chinese patients under the care of the PWH Hepatitis Clinic identified 2 distinct groups with different epidemiological distribution and virologic characteristics – 80% being genotype “Cs” (found mostly in Southeast Asia) and 20% “Ce” (predominated in Far East) [35]. In addition, subgenotype Cs appears to be more common in Hong Kong than other parts of China. In the recent analysis of a cohort of patients with HBeAg-negative chronic liver disease from three different parts of China (Beijing, Shanghai and Hong Kong), 69% of genotype C patients in Hong Kong belonged to subgenotype Cs whereas 97% of genotype C HBV in Shanghai and Beijing belonged to subgenotype Ce ($P< 0.0001$) [36].

42. Regarding HBV disease course, local studies suggested that patients infected with genotype C had a higher risk of cirrhosis and hepatocellular carcinoma (HCC) development [34, 37], as well as more severe histological fibrosis [38]. A recent meta-analysis concluded that genotype C hepatitis B virus was associated with a higher risk of HCC than other major hepatitis B virus genotypes [39]. Among HBV genotype C, subgenotype Cs appears to carry a worse prognosis than subgenotype Ce [36]. In a local study conducted by the Chinese University of Hong Kong, patients infected by subgenotype Cs had the lowest serum albumin and highest alanine aminotransferase levels compared with subgenotypes Ce and Ba. Moreover, patients infected by subgenotype Cs had more severe histological necroinflammation than subgenotype Ce [36]. However, the meta-analysis did not find significant difference in the risk of HCC between HBV-infected patients with subgenotype Ce and Cs [39].

43. Nevertheless, in a study of end-stage HBV-related liver disease patients requiring transplantation, those with genotype B had significantly more pre-transplant acute flare and worse liver function while genotype C patients had a greater risk and severity of recurrence due to lamivudine-resistant mutants [40].

44. 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 was mediated via the former [41]. A study of 5 080 chronic HBV patients focusing on familial HCC found 22 such families, giving a prevalence of 4.3 families/1000 HBV carriers [42]. Age of onset of HCC was significantly younger in familial HCC than sporadic cases, and it progressively decreased down the generations, suggesting an anticipation phenomenon.

Hepatitis B Vaccination

45. The universal vaccination programme for newborns, increased vaccination coverage in adults, practice of universal precaution in health care settings, screening of blood donors and promotion of safer sex all contributed to the reduced HBV incidence in Hong Kong [43].

46. A 16-year follow up study of 1 112 neonates born to HBsAg-positive mothers who received hepatitis B vaccine and hepatitis B immunoglobulin at different schedules demonstrated the long-term protective efficacy of immunisation [44]. Upon completion of the vaccination schedules, 92.6% developed antibody against surface antigen (anti-HBs) seroconversion. Thirty-nine (3.5%) babies were tested positive for HBsAg and had become chronic carriers, 35 of which (89.7%) occurred before one year of age. At the end of the 16th year, 610 subjects (54.9%) returned for blood test evaluation. Although the anti-HBs seroconversion rate dropped to 33.3% and a total of 96 (8.9%) vaccinees developed anti-HBc seroconversion, none was found to have breakthrough infection to become chronic HBV infection. At the 30th year of follow-up, 246 (22.1%) vaccinees returned for blood tests [45]. The anti-HBs seroconversion rate maintained at 37.4% at the 30th year. Although two and one subjects developed anti-HBc seroconversion at the 21st and 25th year respectively, there was no new development of HBsAg positivity detected. These findings demonstrated the long-term protective efficacy of neonatal hepatitis B immunisation among high-risk individuals up to at least 30 years. In another study comparing three different HBV vaccine regimens without boosters given to 318 HBV negative children recruited at age 3 months to 11 years and followed up annually, no subjects tested positive for HBsAg up to 22 years of follow up (55 subjects). Seventy-two subjects were noted to have at least one episode of anamnestic responses with significant increase in anti-HBs titres. Three subjects had benign breakthrough HBV infection with isolated anti-HBc seroconversion [46].

47. Universal neonatal hepatitis B vaccination programme has been in place in Hong Kong since 1988. The coverage rate for the birth dose of hepatitis B vaccine among infants born locally from 2010 to 2019 was consistently above 99% (unpublished DH data). There is generally a slight decline in the coverage rate for the second or the third dose. The drop may be related to two factors: some local-births had returned to the Mainland after delivery and did not attend MCHC for services, and some babies received the vaccine in the private sector instead of MCHC.

48. DH has been conducting immunisation coverage surveys (ICS) every two or three years starting from 2001 to determine the coverage rates of all vaccines under the Hong Kong Childhood Immunisation Programme, which includes hepatitis B vaccine. The surveys included children aged 2 to 5 years and attending pre-primary institutions including kindergartens and childcare centres. Results from ICS conducted in 2001, 2003, 2006, 2009, 2012 and 2015 confirmed high coverage rates of hepatitis B vaccination [47, 48, 49, 50, 51, 52]. In the latest round of ICS conducted in 2018 [53], 2830 children enrolled in 18 pre-school institutions participated in the survey, reaching an overall response rate of 76% (Box 48).

49. Apart from universal neonatal hepatitis B vaccination programme, supplementary Primary 6 vaccination programme was introduced in 1998. The coverage rate for three doses of hepatitis B vaccine had been consistently above 99% in the past decade but showed a slight decline in 2015/16 to 97.9% for the third dose. Of note, this coincided with a change of survey methodology in 2015 and an underestimation of the actual coverage was possible (Box 49). With a high coverage of the neonatal hepatitis B vaccination programme, the number of Primary 6 students eligible for hepatitis B vaccination continued to decrease in the past decade (from 15,479 in 2001/02 to 407 in 2018/19). The number of students who did not receive the third-dose vaccination remained stable at a few hundred per year.

50. In 2009, an HBsAg seroprevalence study was conducted among 1 913 children aged 12 to 15 years who were born after the implementation of universal neonatal hepatitis B vaccination programme [54]. The seroprevalence of HBsAg was 0.78% (95% CI: 0.39 - 1.16%, Box 47). This result showed that Hong Kong had already achieved a time-bound goal set by the Western Pacific Regional Office (WPRO) of the WHO, which referred to reducing chronic HBV infection rate to less than 2% among children at least 5 years of age by the year of 2012. In July 2011, Hong Kong

was verified by WPRO as having successfully achieved the goal of HBV control. Based on the same study, Hong Kong was also verified as of June 2013 as having met the goal of achieving a seroprevalence of less than 1%.

51. In the CRPVH 2001 study, about 16% of the telephone-interviewed subjects reported a history of hepatitis B 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 them or borne by their employers. In another local survey by face-to-face questionnaire interview on over 1900 adult Chinese, 58% (n=1151) of the subjects had been tested for HBV during adulthood. Among those tested negative for HBV infection, 58% (n=506) of them reported subsequent hepatitis B vaccination [55]. Age, occupation, having children and family monthly income were independent factors associated with vaccination in the study. In the recent territory-wide seroprevalence survey, a quarter of participants reported having received hepatitis B vaccination, which significantly reduced the chance of positive HBsAg by 85% (OR: 0.15, 95% CI: 0.11 - 0.21). The prevalence was 1.8% (13/706) in the participants who were born in Hong Kong after the commencement of the universal vaccination programme, compared to 8.3% (771/9 328, P< 0.0001) among those born before the universal vaccination programme [5].

Current Situation of Hepatitis C

52. From 2002 to 2019, a total of 178 cases of acute hepatitis C virus (HCV) infection were reported to DH under the statutory notification system (Box 1), with one to fourteen cases reported annually from 2006 to 2015 and a record high of 39 cases in 2016. A review conducted by the Centre for Health Protection [56] showed that among the 22 laboratory confirmed acute hepatitis C cases reported to DH from January 2008 to October 2011, there were 17 males and 5 females, most (86%) acquired the infection locally. The median age was 47.5 years. Majority (86%) was ethnic Chinese. Five (23%) of them reported history of injecting drug use while no particular risk factor was identified for the remaining cases.

53. Of the 39 cases in 2016, 31 were male (79%), with age ranged from 23 to 94 years (median: 42 years). Thirteen (33%) required hospitalisation and no fatalities were recorded. With regard to the potential risk exposures, one case reported having tattoo procedure, and two cases were identified as injecting drug users. Two cases reported having sex partners who were HCV carriers. Among the 31 male cases

reported, 23 (74%) were known MSM. There was also one case, who had history of repeated hospital admissions and had received multiple transfusions of blood product during the incubation period. Epidemiological investigation and contact tracing did not identify other acute hepatitis C cases and the source of infection in this case could not be determined. For the rest of the cases, no epidemiological linkage was identified and all cases were regarded as sporadic. There have been overseas reports of rising incidence of sexual transmission of HCV among MSM [57]. Further study and monitoring is required of the possibility that this is also the case for Hong Kong.

Prevalence of HCV

54. Although HCV shares similar transmission routes with hepatitis B, the epidemiology of two infections are different in Hong Kong. While HBV is prevalent in the general population in Hong Kong, HCV prevails only in specific populations.

55. Data from new blood donors who were mostly adolescents and young adults in the last decade suggested that HCV prevalence was around 0.1% locally, with the figure in 2019 being 0.07% (95% CI: 0.04% - 0.11%) (Box 50). Findings of the seroprevalence studies of the entire spectrum of adult age groups further supported the low prevalence of HCV infection among general population in Hong Kong; given the overall positivity rate for anti-HCV at 0.3% in 936 subjects in 2001 (95% CI: 0.07% - 0.94%) (Box 52) and 0.5% in 10 256 subjects in 2016 (95% CI: 0.3% - 0.6%) [5]. From 1999 to 2018, 10 of 2710 (0.4%) clients who attended the Therapeutic Prevention Clinic (TPC) at Integrated Treatment Centre of CHP, DH for post-exposure management were tested positive for anti-HCV. Nine (90%) cases were non-HCW and all cases were already HCV-infected at time of injury (Box 54).

56. From studies published in the early 1990s, it was shown that anti-HCV was more common in injecting drug users (IDU, 66.8%), haemophiliacs (56.0%) and haemodialysis patients (4.6%) requiring frequent blood/blood product transfusions but not persons at risk through sexual contact [58]. In an analysis of HCV-positive blood donors during the period from 2003 to 2010, of those with identifiable risk factors, history of blood transfusion (43.7%) was the most common risk factor, followed by intravenous drug use (34.9%) and tattoo (28.6%). The source of infection was unknown in more than half of the respondents in the study [59].

57. In a study conducted in 51 haemodialysis patients in 1990s, HCV RNA was found in 8 second-generation enzyme immunoassay-positive patients and in 1 patient negative for anti-HCV, giving an overall infection rate of 18% (9/51) [60]. This study also found a new infection rate of 4.9% per patient-year upon longitudinal follow up of 19 months.

58. A local survey in 2011 of haemophiliacs under public care found 100 of 222 patients (45%) tested positive for HCV antibody [61]. In another study, 14 (30%) HCV-infected blood donors recruited in 2014 - 2016 could be traced to a history of contaminated blood transfusion (n = 9) or injection drug use (n = 5). In donors without identifiable source of infection (n = 32, 70%), high-risk sexual behaviour, body piercing, intramuscular injection and vaccine inoculation abroad and having lived abroad for more than 3 months were associated with HCV infection [62].

59. Injecting drug use has been an important route of HCV acquisition. Results of testing non-random samples from drug users under treatment showed an HCV positive rate of 74% in 1988/1989 and 46% in 2000/2001 (Box 53). An HCV seroprevalence study in 2006 conducted in methadone clinics targeting IDU echoed the high prevalence rate of HCV in this community [63]. Of 567 IDU participants recruited in 2006, the prevalence of anti-HCV was 85% (95% CI: 82.5% - 88.3%). Two other studies in 2010s, involving IDU recruited at their gathering places, gave a similar figure of anti-HCV prevalence at 81.7% (95% CI: 78.6% - 84.7%) among 622 subjects in 2011 [64] and 76.4% (95% CI: 73.1% - 79.6%) among 664 subjects in 2014 [65] respectively. Injection duration, current or recent injection, ever sharing injecting equipment and concomitant use of other drugs, such as midazolam, were independent factors associated with HCV infection in these studies. In the recent New Life New Liver Project, which provided targeted HCV screening and education to ex-IDU in the community, 73% of 365 subjects screened were anti-HCV positive. The number needed to screen to detect one patient with positive anti-HCV was 1.4 (95% CI: 1.3 - 4.6) [66].

60. HIV/AIDS patients, with a proportion being IDU, is another group with consistent data showing a comparatively high HCV prevalence (Box 55, Box 56). From 2000 to 2019, HCV/HIV coinfection among new patients attending ITC ranged from 1.5% to 24.8%. The decreasing trend of anti-HCV seroprevalence was largely attributed to the decreasing proportion of new patients acquiring HIV via injecting drug use. The

prevalence rate appeared to be higher in male than female patients, likely related to the differential risk of parenteral and blood product exposure (Box 55). While HCV infection was present in 1.5 - 6.0% of HIV/AIDS patients infected due to sexual contact, HCV was nearly universal in patients infected through drug injection (Box 56). It should be noted that, among male patients who acquired HIV via heterosexual contact and tested anti-HCV positive, about three fifths (30 out of 51 subjects) had a past history of injecting drug use (Box 56). Among those heterosexual male HIV-positive patients without history of injecting drug use, the prevalence of anti-HCV was 2.5%.

61. There has been overseas data supporting sexual transmission of HCV among HIV-positive MSM [67]. The anti-HCV prevalence of subjects who contracted HIV via homosexual or bisexual contact in the ITC HIV/AIDS patient cohort has remained below 2% from screening since 2005. However, this figure has shown an increasing trend since 2012, with the cumulative number of individuals with HCV/HIV coinfection at the time of HIV diagnosis rising from 16 (1.3%) in 2013 to 62 (2.3%) in 2019 (Box 56).

62. From July to November 2013, ITC identified seven cases of recent HCV infection in Chinese HIV-positive MSM [68]. Five of the seven cases were also diagnosed to have recent syphilis infection during the period. None of them had history of injecting drug use. Phylogenetic analyses revealed that all cases belonged to the same genotype (genotype 3) although investigation showed no apparent linkage on their sexual exposure. An analysis on HIV-positive MSM attending ITC who had HCV seroconversion in the period 1999 - 2013 was subsequently performed [69]. Fourteen (1.1%) patients seroconverted, with an overall incidence rate of 0.22 per 100 patient-years. The incidence rate increased from 0.13 per 100 patient-years before 2002 to 0.19 per 100 patient years in 2002 - 2007 and 0.47 per 100 patient-years in 2008 - 2013. Genotype 3 was most commonly detected. Compared with the non-seroconverters, the seroconverters were of higher education level and had prior history of sexually transmitted infection. The overall higher HCV prevalence, and the increasing incidence of HCV infection among HIV-positive MSM, coupled with the hastened liver disease progression in patients with HIV infection [70], would demand further attention.

63. Since 2003, a surveillance project for HCV in Hong Kong had been in place to monitor the trend of anti-HCV among selected population groups, with the participation of the laboratories of HKRCBTS, Princess Margaret Hospital (PMH) and Prince of Wales Hospital (PWH, joined since 2005). Some 180 000 - 260 000 new and repeated blood donors of HKRCBTS were tested for anti-HCV each year, among which the prevalence was consistently low at less than 0.1% since 2003 (Box 57). Whereas among the selected hospital patients tested in the past eleven years, the overall anti-HCV prevalence was 2.0% (Box 58). Anti-HCV was most commonly found in drug users, of which 52.7% were found positive, followed by patients with history of blood transfusion at 8.9%. Overall, the male-to-female ratio of HCV positive subjects was about 2.3 to 1, with a mean age of 52.4 years old (Box 59).

Genotypes of Hepatitis C

64. 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 [71]. 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%) [72]. In another study of hospitalised patients with HCV testing for clinical indications, 1b was the commonest type found in patients with chronic liver diseases and chronic renal failure [73]. According to a local study of patients on renal replacement therapy, the predominant genotype was 1b, followed by 1a and 6a [74]. As reported in a recent territory-wide population-based study, the commonest HCV genotype was genotype 1 (48.8%), followed by genotype 6 (33.6%) and genotype 3 (10.8%) among 2699 patients who were tested positive for anti-HCV between January 2005 and March 2017 in public hospitals in Hong Kong [75].

65. The commonest genotype in intravenous drug users was genotype 6. A retrospective analysis of 106 intravenous drug users and 949 non-drug users with samples collected between December 1998 and May 2004 also confirmed the significant high prevalence of genotype 6a in drug users (58.5%) followed by 1b (33.0%), in contrast to 63.6% for 1b and 23.6% for 6a in non-drug users [76]. Besides intravenous drug use, age and sex were independent factors associated with HCV genotypes in this study. Further phylogenetic analyses revealed that HCV 6a strains from Vietnam might be ancestral to Hong Kong counterparts, suggesting an association between the high predominance of HCV 6a infections and Vietnamese immigration during 1987 - 1997 in Hong Kong [77]. In a methadone clinic-based study

published in 2011, out of 273 IDUs with different periods of initiating injection, 52% had genotype 6a and 38% had 1b. Both genotypes 1b and 6a were prevalent among older injectors, while subtype 3a was more common in young injectors and those initiating injection more recently during 1995 - 2006. Moreover, phylogenetic analysis revealed no specific clustering of any subtype or genotype, which did not suggest any outbreak of HCV among the study population. The extensive use of methadone, widely available since 1980s, may have protected Hong Kong from the emergence of HCV clusters among injection drug users [78].

66. For the HIV-positive MSM attending ITC who were diagnosed with acute HCV infection between 2009 to 2014, genotype 3a was the most prevalent (63.6%), followed by 1a (18.2%) and 6a (9.1%). The high prevalence of genotype 3a in MSM was in stark contrast to its rarity among HCV-infected IDU in Hong Kong. Phylogenetic analyses revealed a monophyletic HCV-3a cluster with members all diagnosed between 2013 and 2014, and a homologous pair with HCV-6a genotype. However, there was no temporal or genetic clustering of the corresponding HIV sequences [79]. Molecular analyses of HCV sequences from 58 HIV-positive patients from ITC between 2010 and 2016 also showed no international network of HCV among HIV-positive MSM in the three Asia-Pacific cities, namely Hong Kong, Taipei and Tokyo [80].

67. The natural history of 138 HCV genotype 1 patients (median age: 50 years) was compared with that of 78 HCV genotype 6 patients (median age: 46.5 years) in Queen Mary Hospital [81]. Both genotypes share a similar natural history based on liver biochemistry, HCV viral load, and probability of cirrhotic complications and mortality after a median follow-up period of over 5 years.

Liver Cancer – Major Morbidity and Mortality from Viral Hepatitis

68. Chronic HBV and HCV infection are important risk factors for cirrhosis and liver cancer. Globally 782 000 people died of liver cancer in 2018 [82], and HBV and HCV infection generally accounted for approximately 80% of liver cancer cases [83]. Local studies showed that 75 - 80% of hepatocellular cancers in Hong Kong were related to chronic HBV infection, and 3 - 6% of the cases were related to chronic HCV infection. HBV and HCV co-infection accounted for another 0.4 - 3% [84]. Among 76 liver transplants performed in Queen Mary Hospital due to cirrhosis from 1999 to 2000, 51 and 7 were related to hepatitis B and C respectively [85].

69. According to the data from the Hong Kong Cancer Registry [86], liver cancer, including neoplasm of liver and intrahepatic bile ducts, was the fourth commonest cancer in men and eleventh commonest cancer in women in 2018. There were 1 742 newly registered cases of liver cancer, with 1359 cases of males and 383 cases of females (male to female ratio was about 3.5 to 1) in 2018. There was a downward trend for the age-standardised incidence rate for both male and female in the past decade (Box 61). The figures were 21.1 for male and 5.0 for female per 100 000 standard population in 2018.

70. In 2018, liver cancer was the third leading cause of cancer deaths in Hong Kong. There were 1 487 registered mortality from liver cancer. There was a downward trend for the age-standardised mortality rate for both sexes in the past decade (Box 63). The figures were 16.1 for male and 4.5 for female per 100 000 standard population in 2017 [86].

SURVEILLANCE INFORMATION

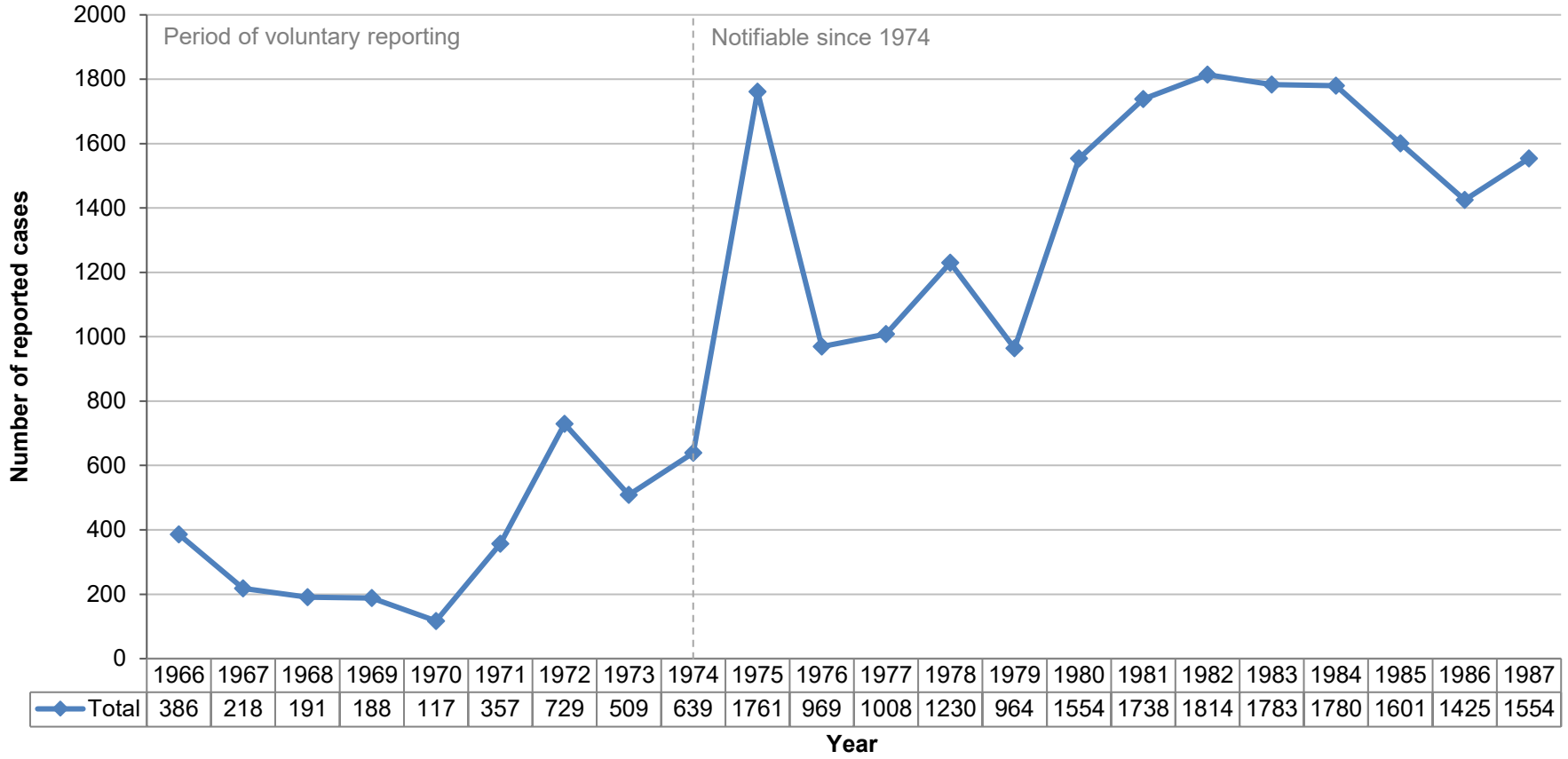
Acute viral hepatitis

(Data source: Centre for Health Protection, Department of Health)

Box 1. Number of cases of viral hepatitis reported to the Department of Health between 1988 and 2019 (Data source: CHP, DH)

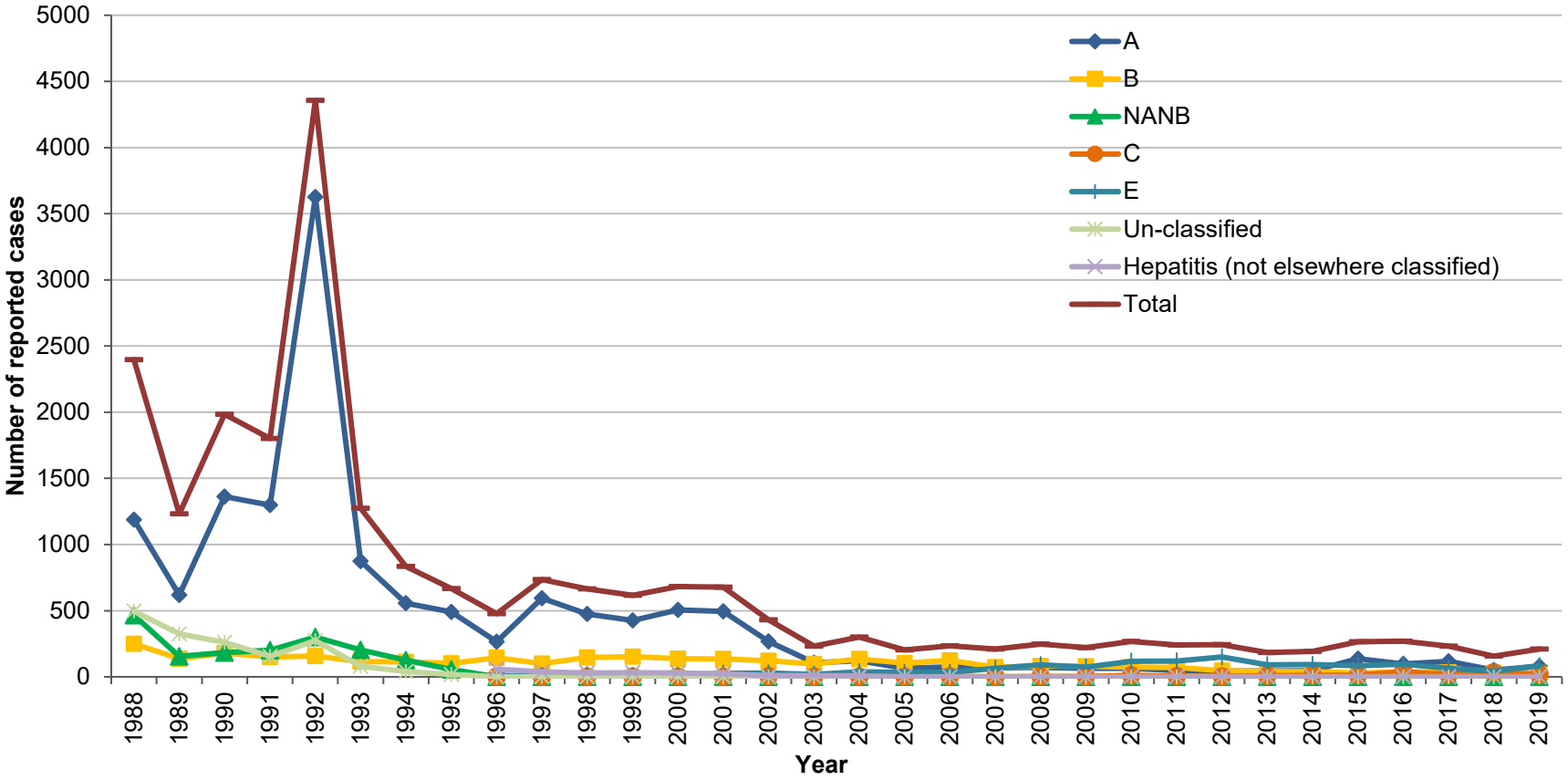
Year	A	B	NANB	C	E	Unclassified	Hepatitis (not elsewhere classified)	Total
1988	1187	250	465			496		2398
1989	618	136	154			324		1232
1990	1362	178	183			261		1984
1991	1297	150	200			154		1801
1992	3626	157	301			273		4357
1993	874	116	203			80		1273
1994	557	112	125			41		835
1995	491	102	55			18		666
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	121	134	-	1	38	-	6	300
2005	64	105	-	1	34	-	0	204
2006	76	123	-	2	34	-	0	235
2007	69	74	-	1	65	-	0	209
2008	71	83	-	3	90	-	-	247
2009	64	80	-	3	73	-	-	220
2010	65	73	-	11	118	-	-	267
2011	46	70	-	5	119	-	-	240
2012	43	47	-	3	150	-	-	243
2013	44	40	-	10	90	-	-	184
2014	46	41	-	12	93	-	-	192
2015	138	29	-	14	84	-	-	265
2016	98	37	-	39	96	-	-	270
2017	117	33	-	18	64	-	-	232
2018	50	29	-	34	43	-	-	156
2019	79	28	-	17	85	-	-	209

Box 2. Reported cases of viral hepatitis from 1966 to 1987 by syndromic surveillance (Data source: CHP, DH)

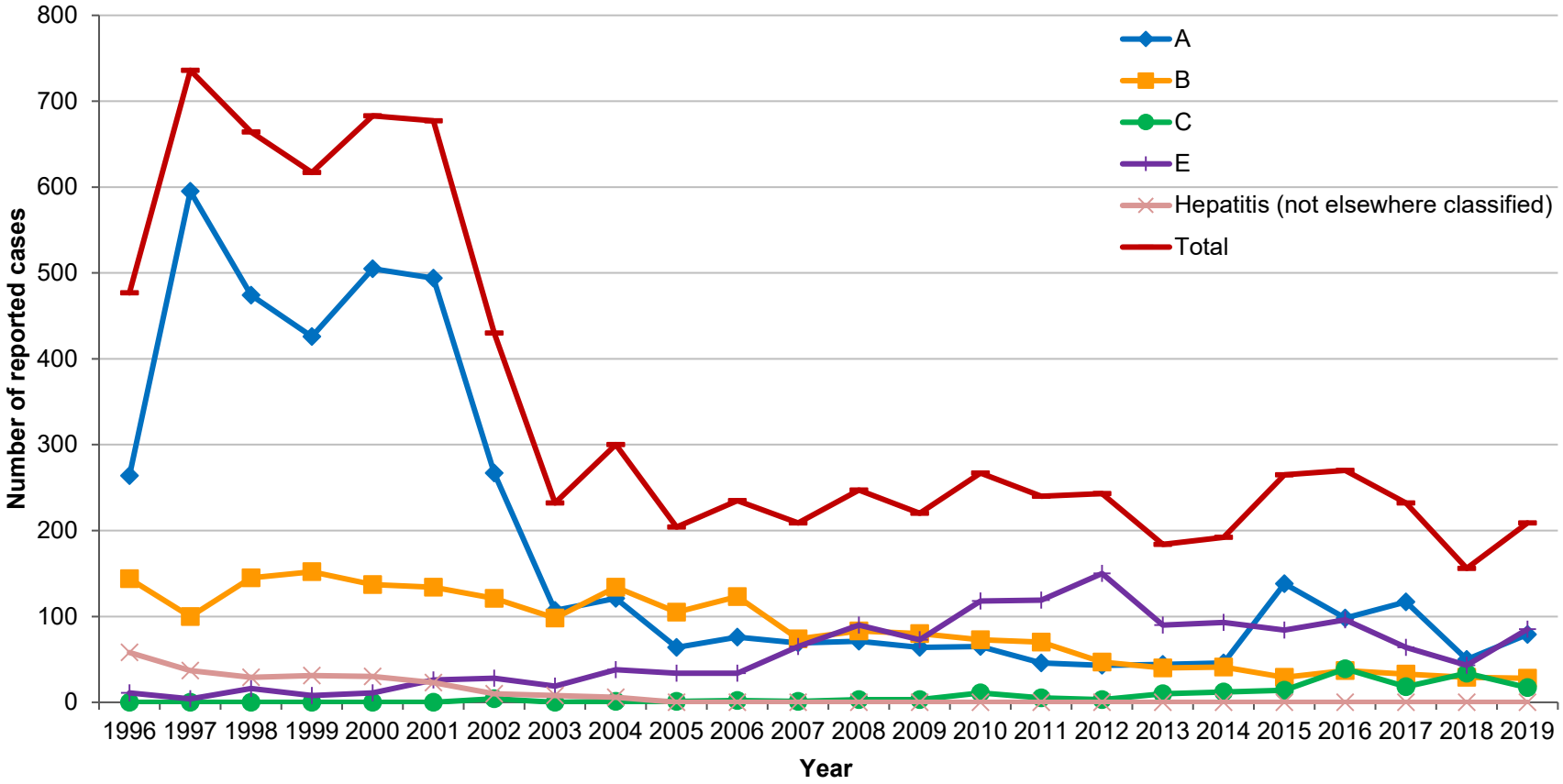


	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987
Total	386	218	191	188	117	357	729	509	639	1761	969	1008	1230	964	1554	1738	1814	1783	1780	1601	1425	1554

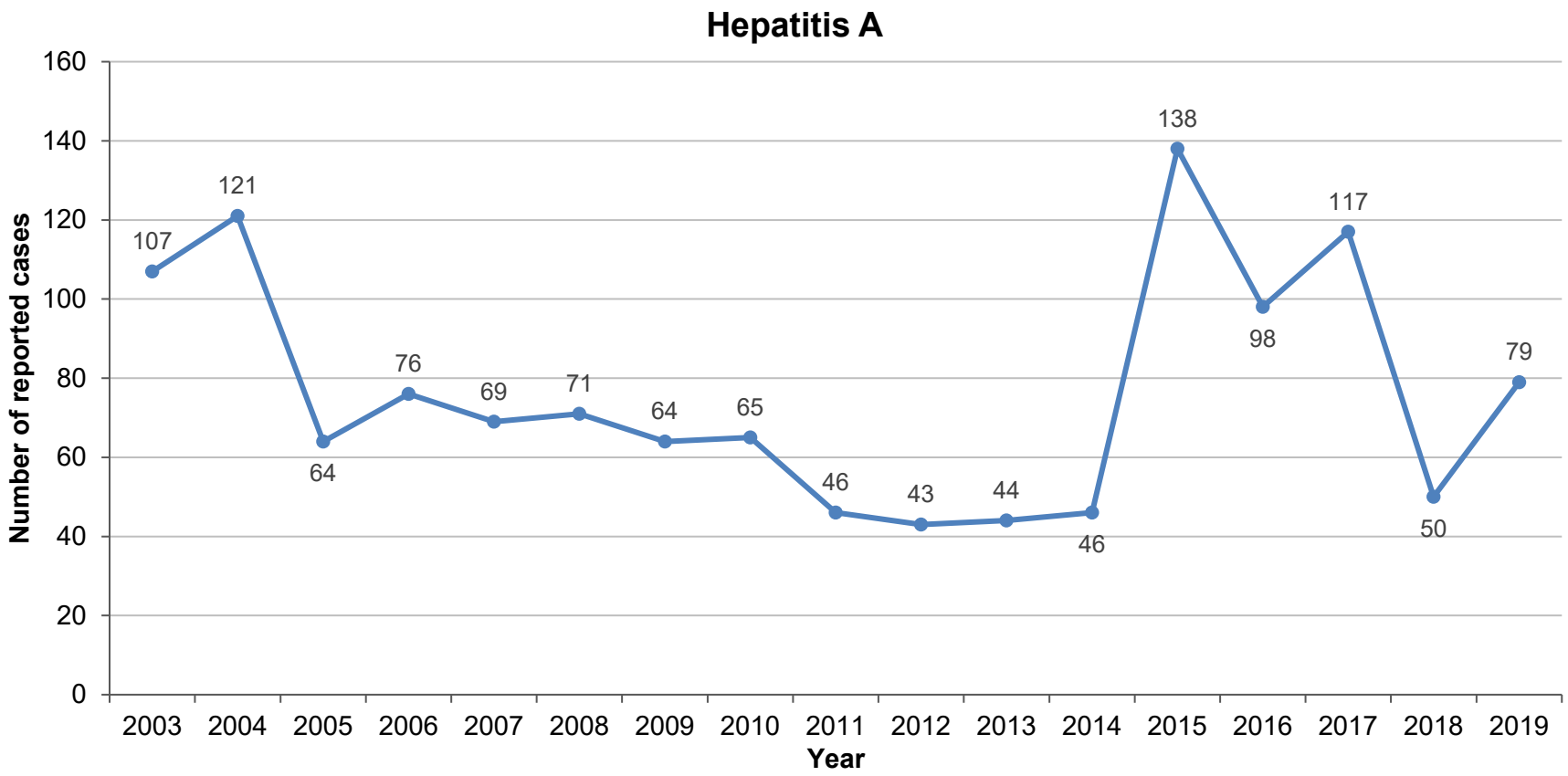
Box 3. Reported cases of viral hepatitis from 1988 to 2019 by viral etiology surveillance (Data source: CHP, DH)



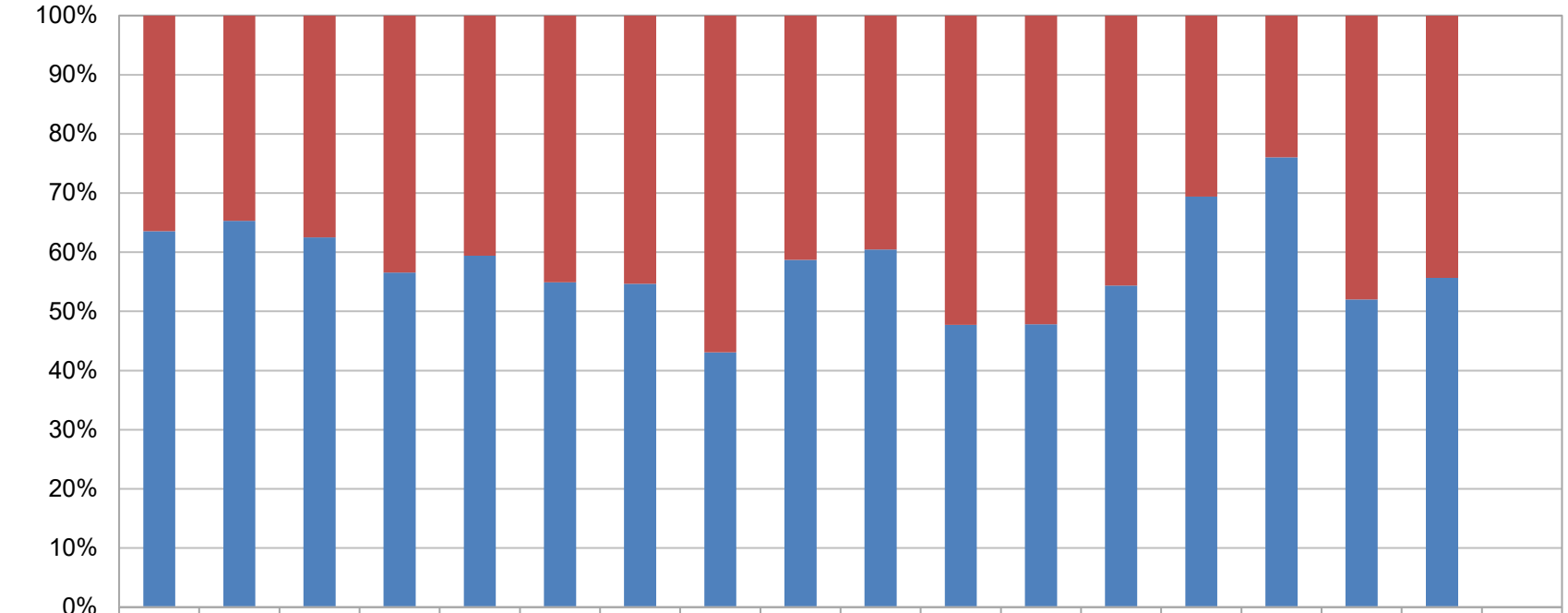
Box 4. Breakdown of viral hepatitis by etiology reported from 1996 to 2019 (Data source: CHP, DH)



Box 5. Number of hepatitis A cases reported from 2003 to 2019 (Data source: CHP, DH)



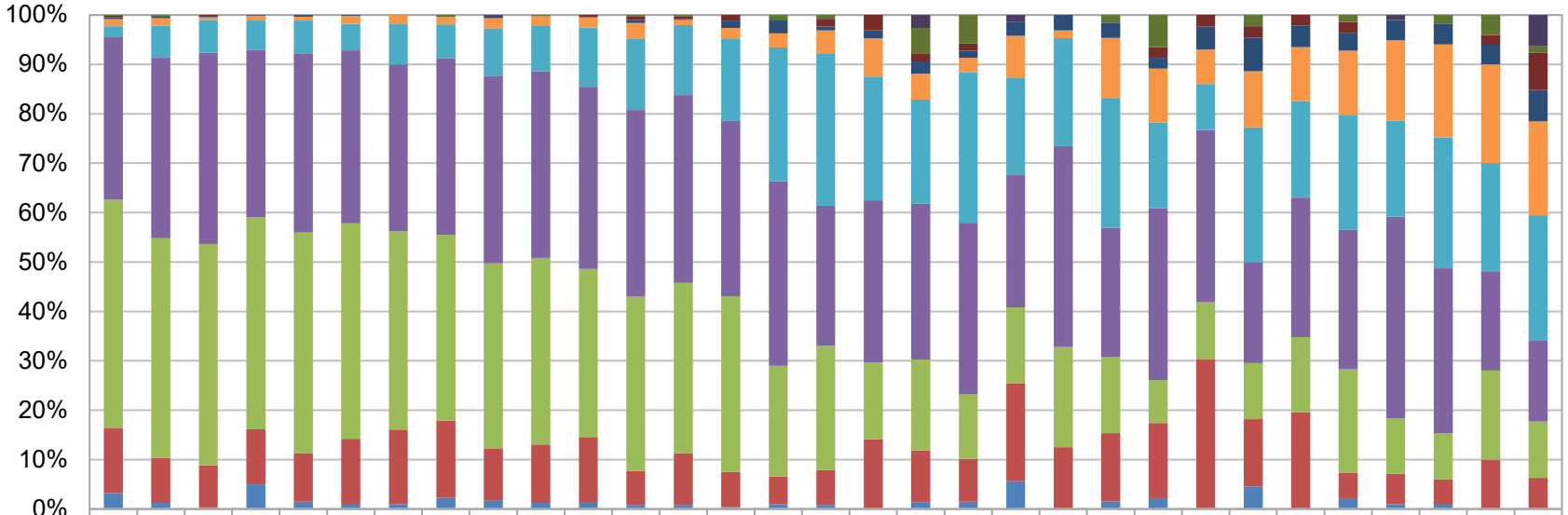
Box 6. Sex distribution of hepatitis A cases reported from 2003 to 2019 (Data source: CHP, DH)



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total
Female	39	42	24	33	28	32	29	37	19	17	23	24	63	30	28	24	35	527
Male	68	79	40	43	41	39	35	28	27	26	21	22	75	68	89	26	44	771
Total	107	121	64	76	69	71	64	65	46	43	44	46	138	98	117	50	79	1298

Year

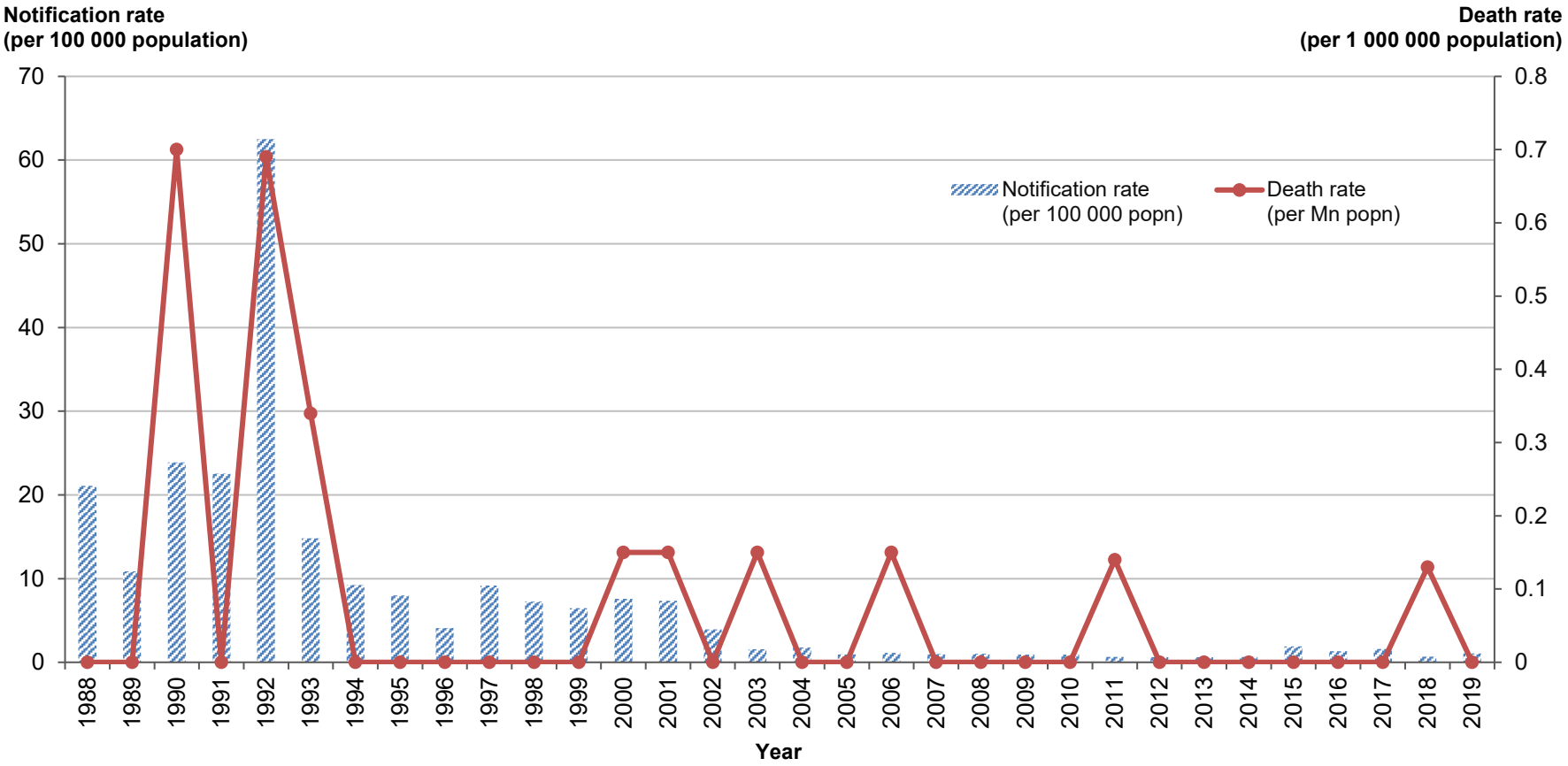
Box 7. Age distribution of hepatitis A cases reported from 1989 to 2019 (Data source: CHP, DH)



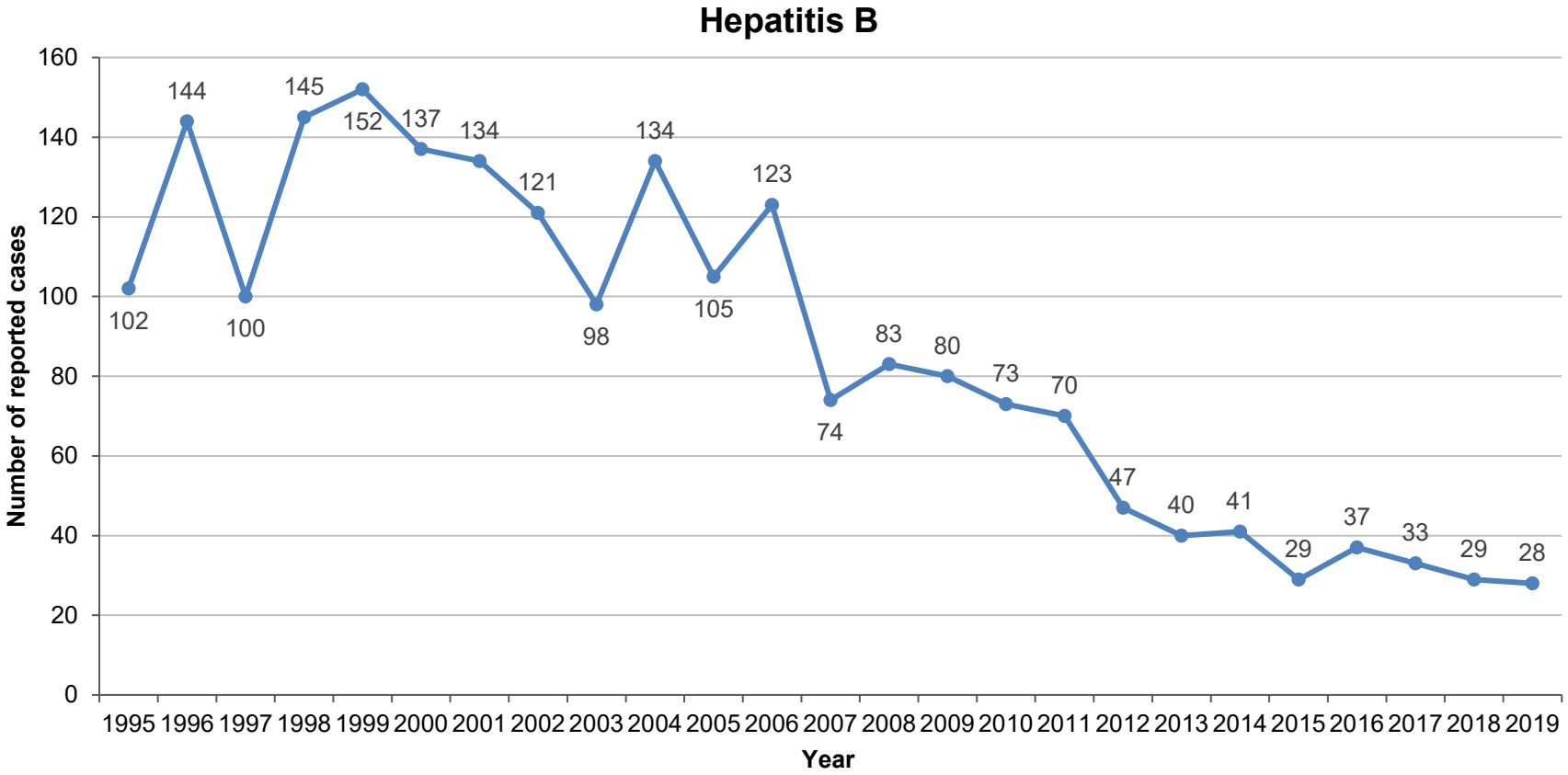
	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
> 84	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	3%	0%	1%	0%	0%	0%	0%	0%	0%	0%	1%	0%	0%	6%
75 - 84	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	1%	0%	5%	6%	0%	0%	2%	7%	0%	2%	0%	1%	0%	2%	4%	1%
65 - 74	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	1%	1%	0%	2%	3%	1%	1%	0%	0%	0%	2%	2%	2%	2%	2%	0%	0%	2%	8%
55 - 64	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	0%	1%	3%	1%	2%	3%	1%	3%	3%	3%	2%	5%	7%	4%	4%	4%	4%	4%	6%
45 - 54	1%	1%	1%	1%	1%	2%	2%	2%	2%	2%	2%	3%	1%	2%	3%	5%	8%	5%	3%	8%	2%	12%	11%	7%	11%	11%	13%	16%	19%	20%	19%
35 - 44	2%	7%	7%	6%	7%	5%	8%	7%	10%	9%	12%	14%	14%	16%	27%	31%	25%	21%	30%	20%	22%	26%	17%	9%	27%	20%	23%	19%	26%	22%	25%
25 - 34	33%	36%	39%	34%	36%	35%	34%	36%	38%	38%	37%	38%	38%	36%	37%	28%	33%	32%	35%	27%	41%	26%	35%	35%	20%	28%	28%	41%	33%	20%	16%
15 - 24	46%	44%	45%	43%	45%	44%	40%	38%	37%	38%	34%	35%	34%	36%	22%	25%	16%	18%	13%	15%	20%	15%	9%	12%	11%	15%	21%	11%	9%	18%	11%
5 - 14	13%	9%	9%	11%	10%	13%	15%	16%	11%	12%	13%	7%	11%	7%	6%	7%	14%	11%	9%	20%	13%	14%	15%	30%	14%	20%	5%	6%	5%	10%	6%
< 5	3%	1%	0%	5%	1%	1%	1%	2%	2%	1%	1%	1%	1%	0%	1%	1%	0%	1%	1%	6%	0%	2%	2%	0%	5%	0%	2%	1%	1%	0%	0%

Year

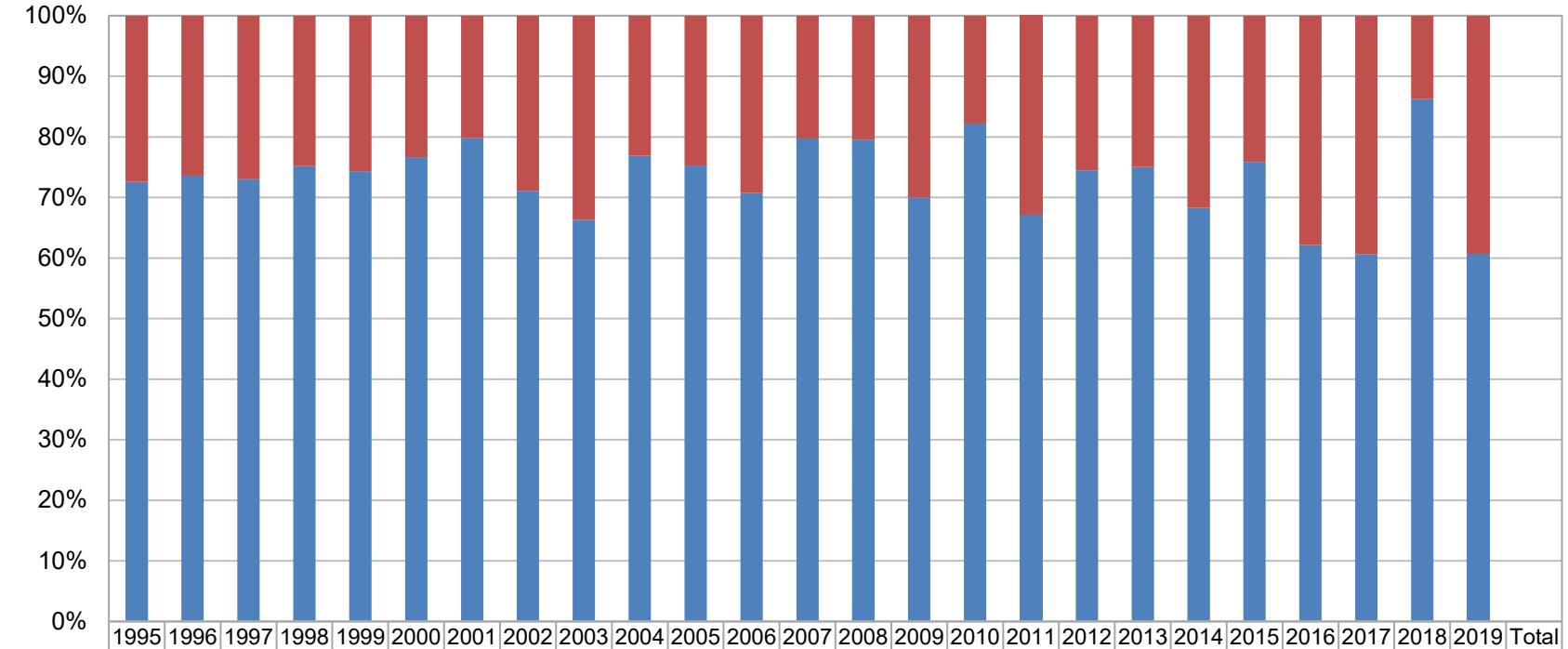
Box 8. Notification rates and death rates of hepatitis A, 1988 – 2019 (Data source: CHP, DH)



Box 9. Number of hepatitis B cases reported from 1995 to 2019 (Data source: CHP, DH)

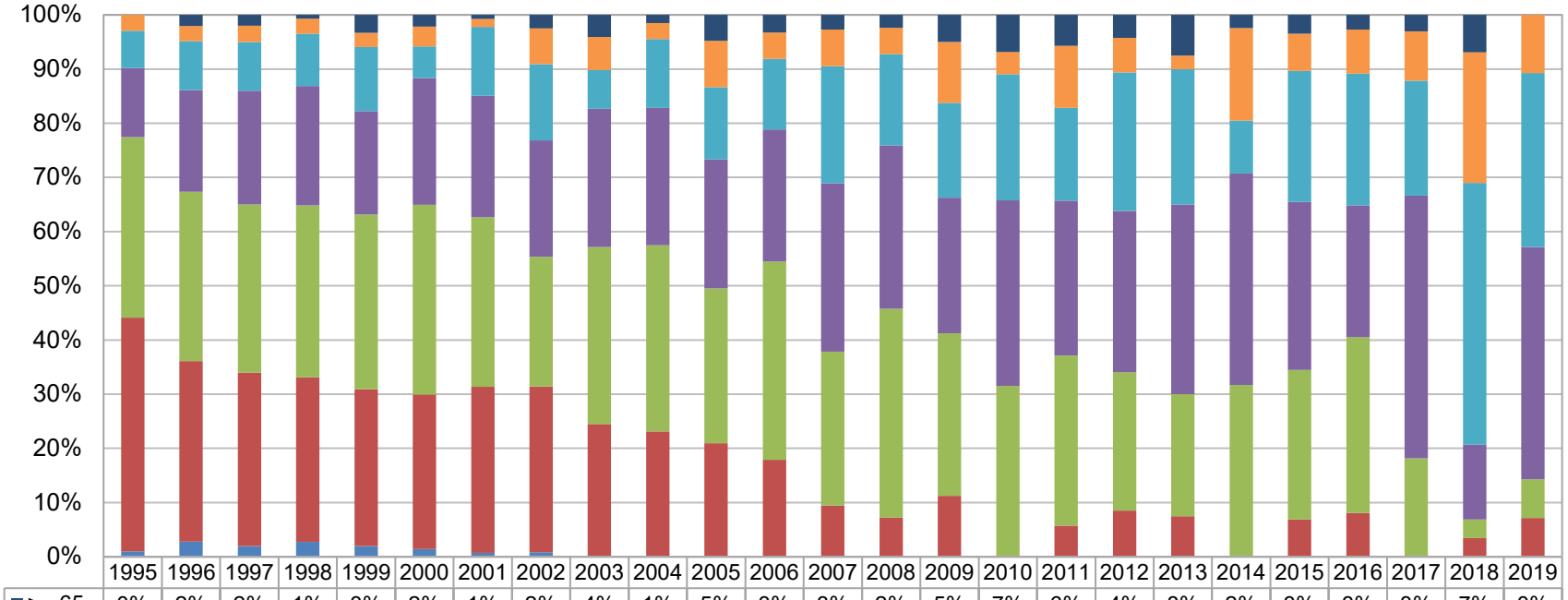


Box 10. Sex distribution of hepatitis B cases reported from 1995 to 2019 (Data source: CHP, DH)



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total
Female	28	38	27	36	39	32	27	35	33	31	26	36	15	17	24	13	23	12	10	13	7	14	13	4	11	564
Male	74	106	73	109	113	105	107	86	65	103	79	87	59	66	56	60	47	35	30	28	22	23	20	25	17	1595
Total	102	144	100	145	152	137	134	121	98	134	105	123	74	83	80	73	70	47	40	41	29	37	33	29	28	2159

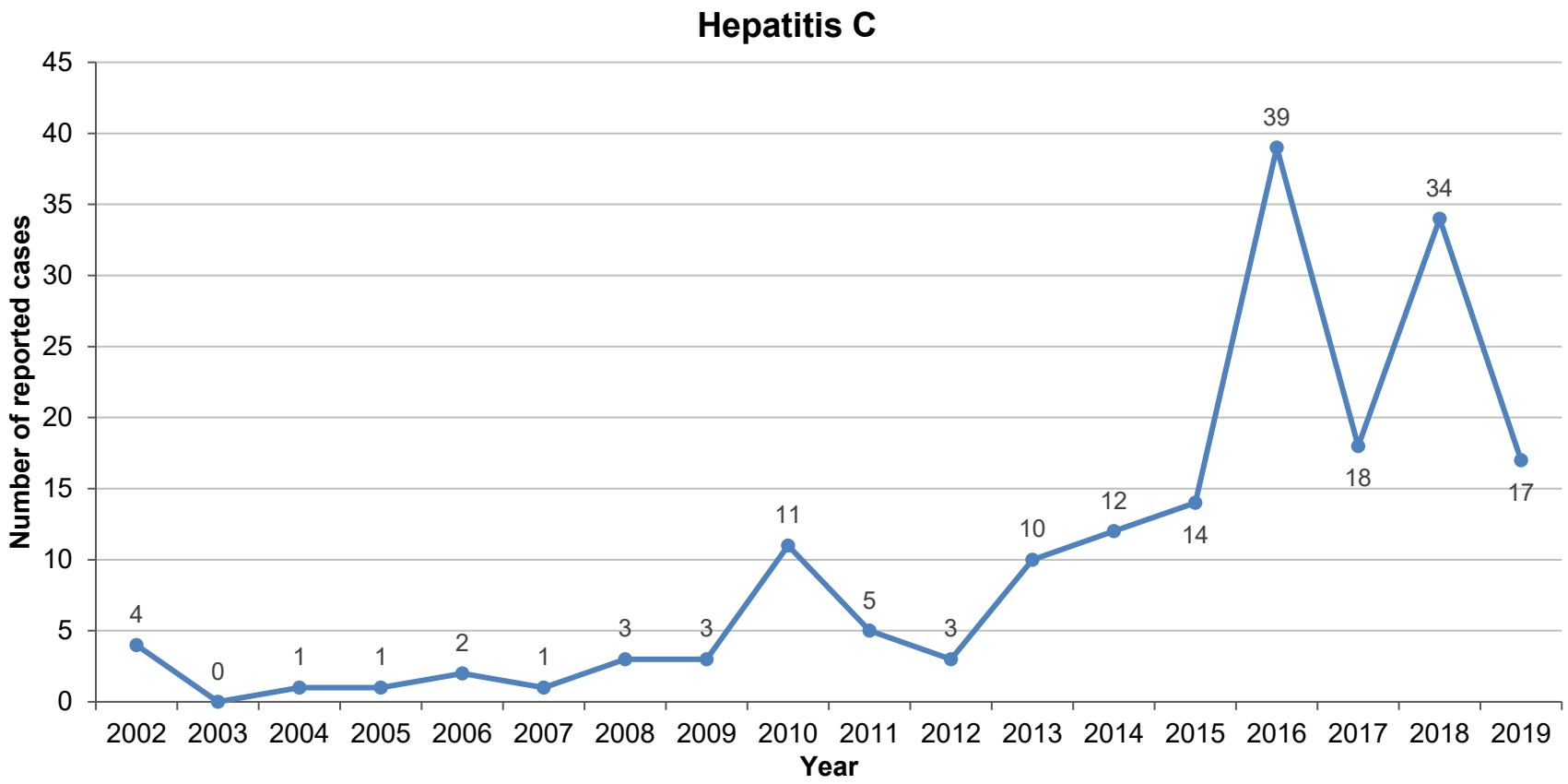
Box 11. Age distribution of hepatitis B cases reported from 1995 to 2019 (Data source: CHP, DH)



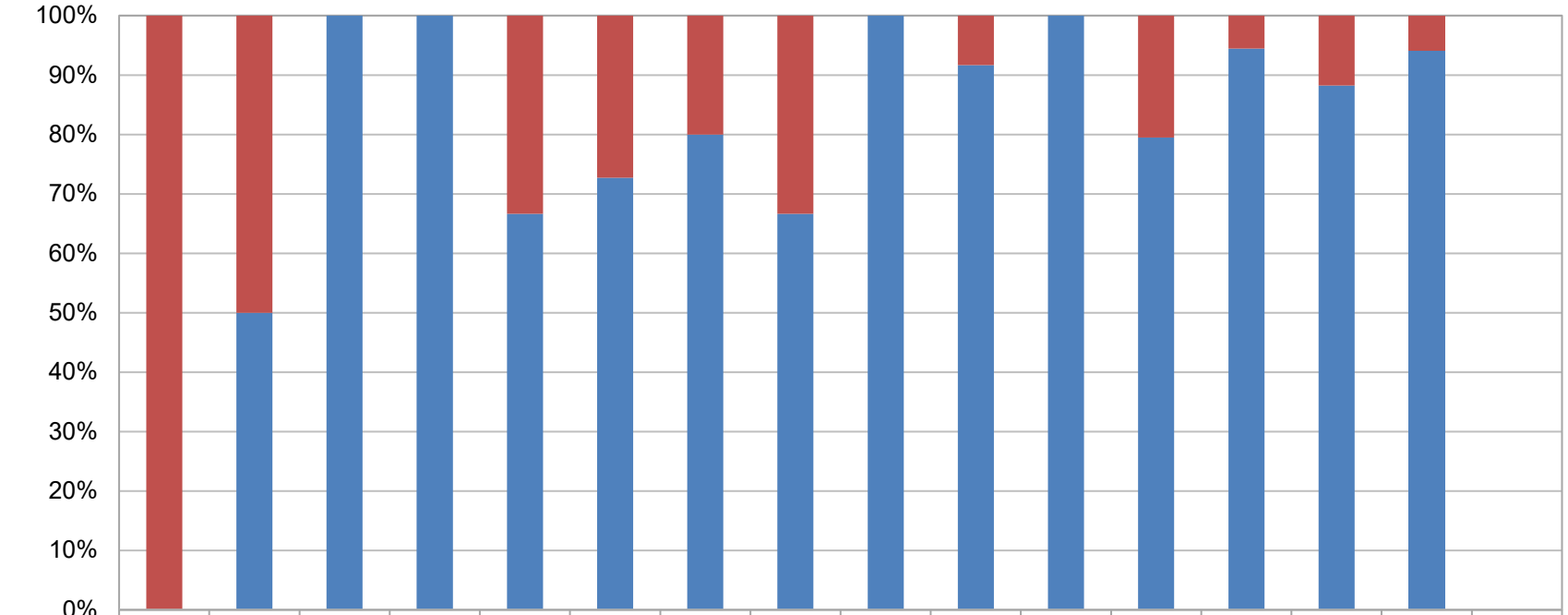
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
>= 65	0%	2%	2%	1%	3%	2%	1%	2%	4%	1%	5%	3%	3%	2%	5%	7%	6%	4%	8%	2%	3%	3%	3%	7%	0%
55 - 64	3%	3%	3%	3%	3%	4%	1%	7%	6%	3%	9%	5%	7%	5%	11%	4%	11%	6%	3%	17%	7%	8%	9%	24%	11%
45 - 54	7%	9%	9%	10%	12%	6%	13%	14%	7%	13%	13%	13%	22%	17%	18%	23%	17%	26%	25%	10%	24%	24%	21%	48%	32%
35 - 44	13%	19%	21%	22%	19%	23%	22%	21%	26%	25%	24%	24%	31%	30%	25%	34%	29%	30%	35%	39%	31%	24%	48%	14%	43%
25 - 34	33%	31%	31%	32%	32%	35%	31%	24%	33%	34%	29%	37%	28%	39%	30%	32%	31%	26%	23%	32%	28%	32%	18%	3%	7%
15 - 24	43%	33%	32%	30%	29%	28%	31%	31%	24%	23%	21%	18%	9%	7%	11%	0%	6%	9%	8%	0%	7%	8%	0%	3%	7%
<1 - 14	1%	3%	2%	3%	2%	1%	1%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Year

Box 12. Number of hepatitis C cases reported from 2002 to 2019 (Data source: CHP, DH)



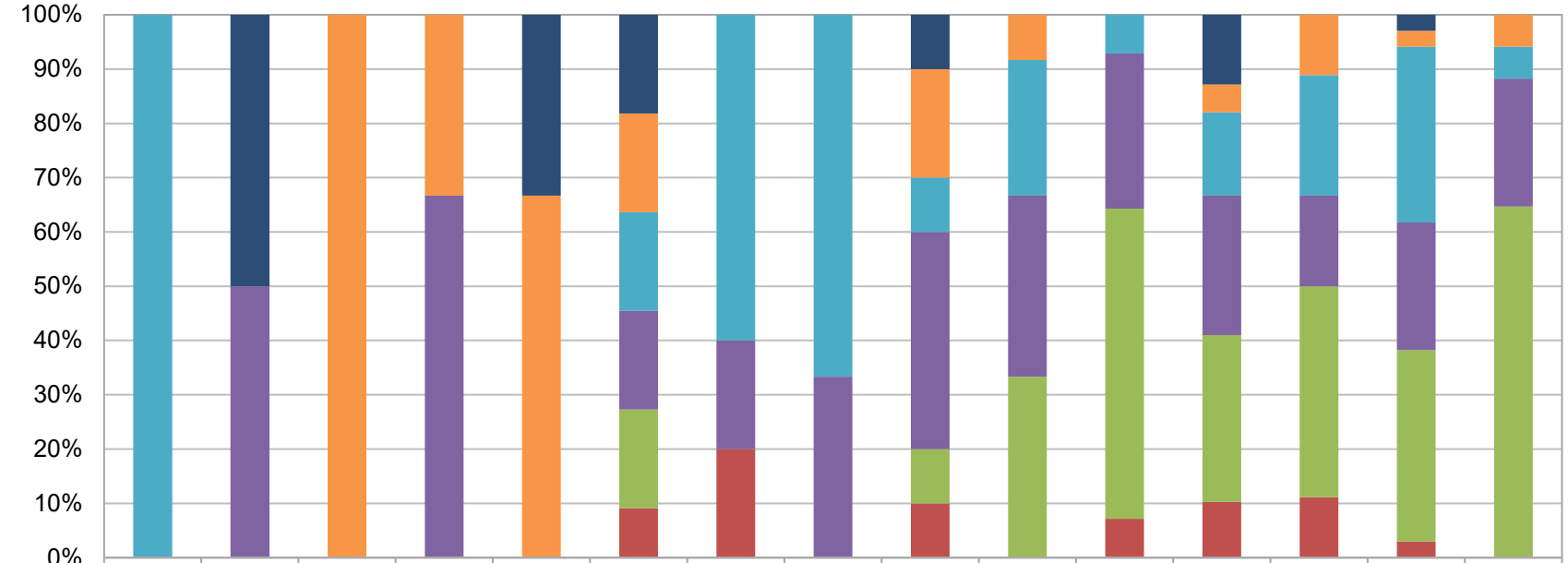
Box 13. Sex distribution of hepatitis C cases reported from 2005 to 2019 (Data source: CHP, DH)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total
Female	1	1	0	0	1	3	1	1	0	1	0	8	1	4	1	23
Male	0	1	1	3	2	8	4	2	10	11	14	31	17	30	16	150
Total	1	2	1	3	3	11	5	3	10	12	14	39	18	34	17	173

Year

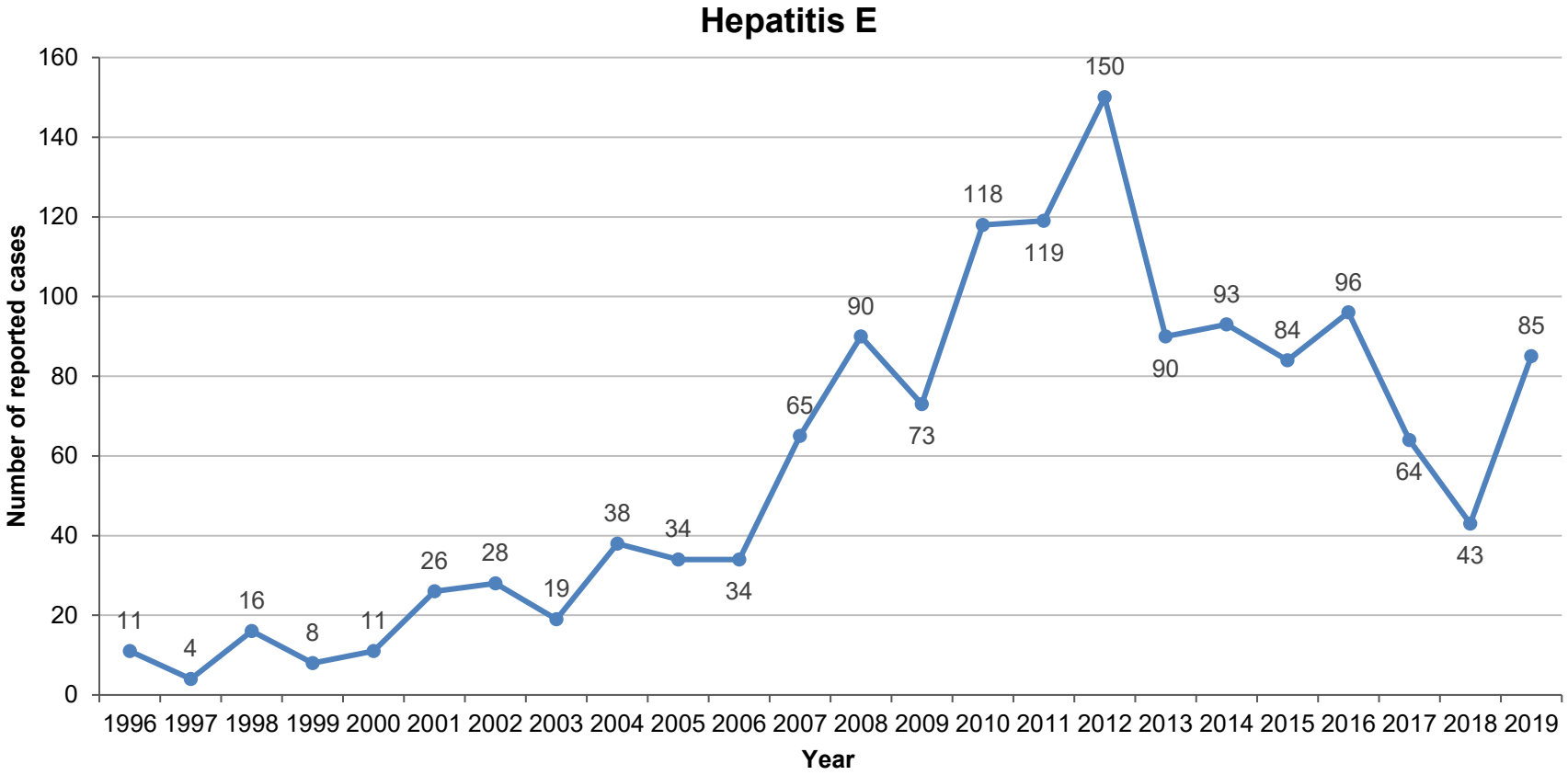
Box 14. Age distribution of hepatitis C cases reported from 2005 to 2019 (Data source: CHP, DH)



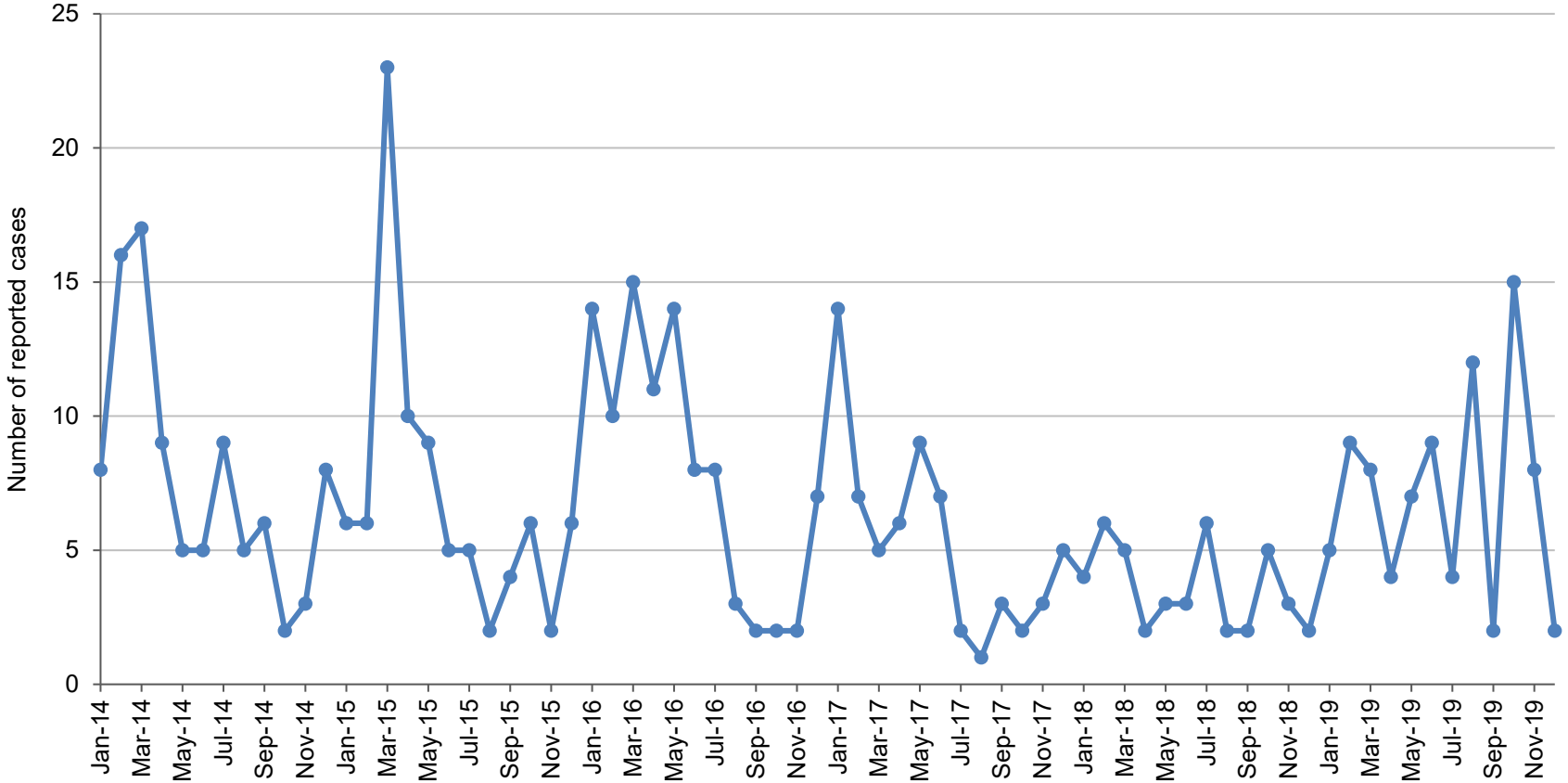
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
>= 65	0%	50%	0%	0%	33%	18%	0%	0%	10%	0%	0%	13%	0%	3%	0%
55 - 64	0%	0%	100%	33%	67%	18%	0%	0%	20%	8%	0%	5%	11%	3%	6%
45 - 54	100%	0%	0%	0%	0%	18%	60%	67%	10%	25%	7%	15%	22%	32%	6%
35 - 44	0%	50%	0%	67%	0%	18%	20%	33%	40%	33%	29%	26%	17%	24%	24%
25 - 34	0%	0%	0%	0%	0%	18%	0%	0%	10%	33%	57%	31%	39%	35%	65%
15 - 24	0%	0%	0%	0%	0%	9%	20%	0%	10%	0%	7%	10%	11%	3%	0%
<1 - 14	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Year

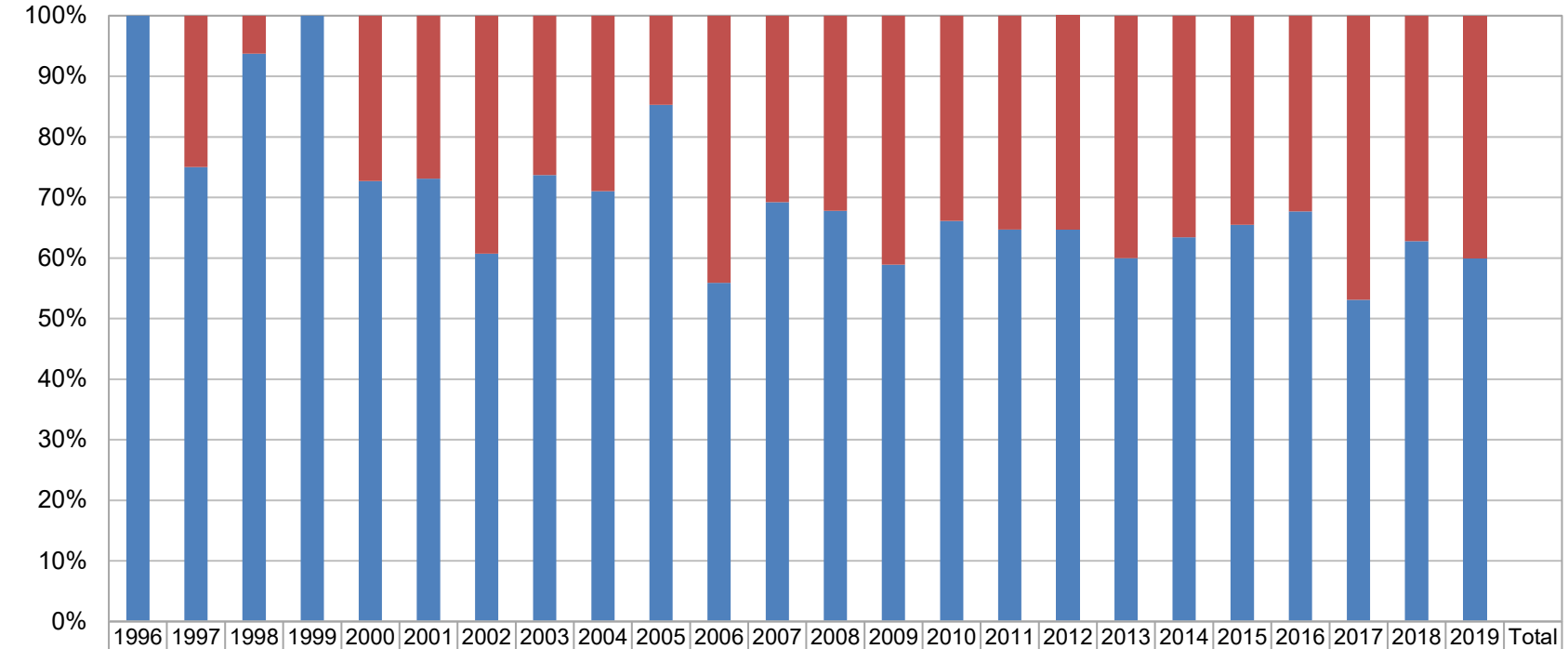
Box 15. Number of hepatitis E cases reported from 1996 to 2019 (Data source: CHP, DH)



Box 16. Distribution of reported cases of hepatitis E by month between 2014 and 2019 (Data source: CHP, DH)

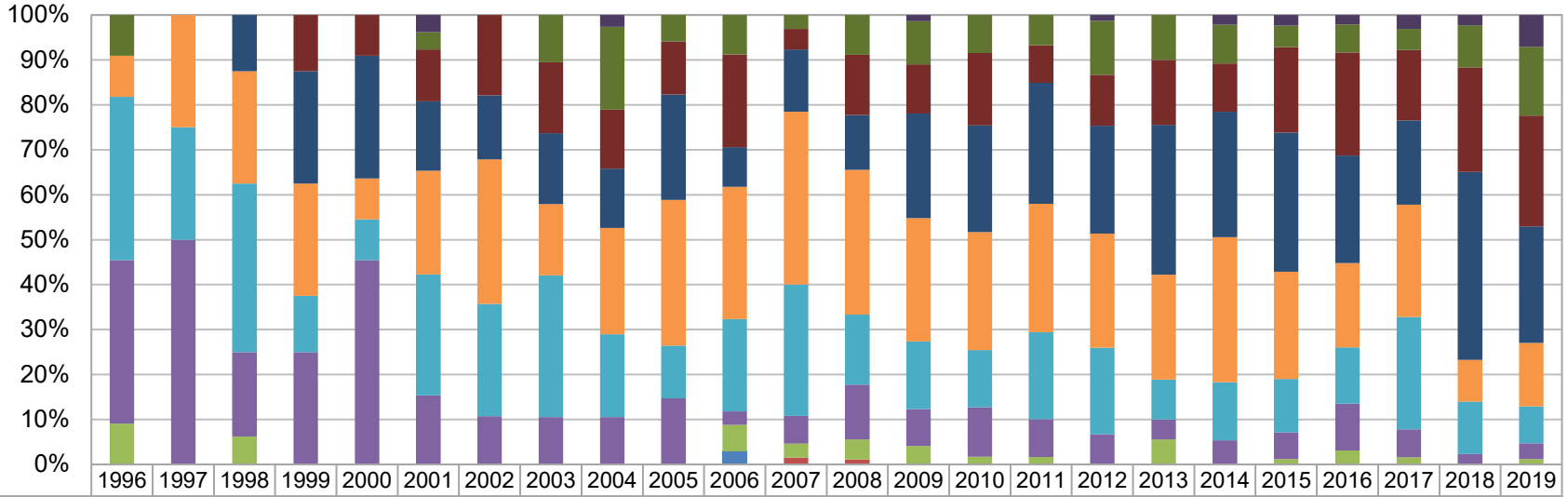


Box 17. Sex distribution of hepatitis E cases reported from 1996 to 2019 (Data source: CHP, DH)



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total
Female	0	1	1	0	3	7	11	5	11	5	15	20	29	30	40	42	53	36	34	29	31	30	16	34	483
Male	11	3	15	8	8	19	17	14	27	29	19	45	61	43	78	77	97	54	59	55	65	34	27	51	916
Total	11	4	16	8	11	26	28	19	38	34	34	65	90	73	118	119	150	90	93	84	96	64	43	85	1399

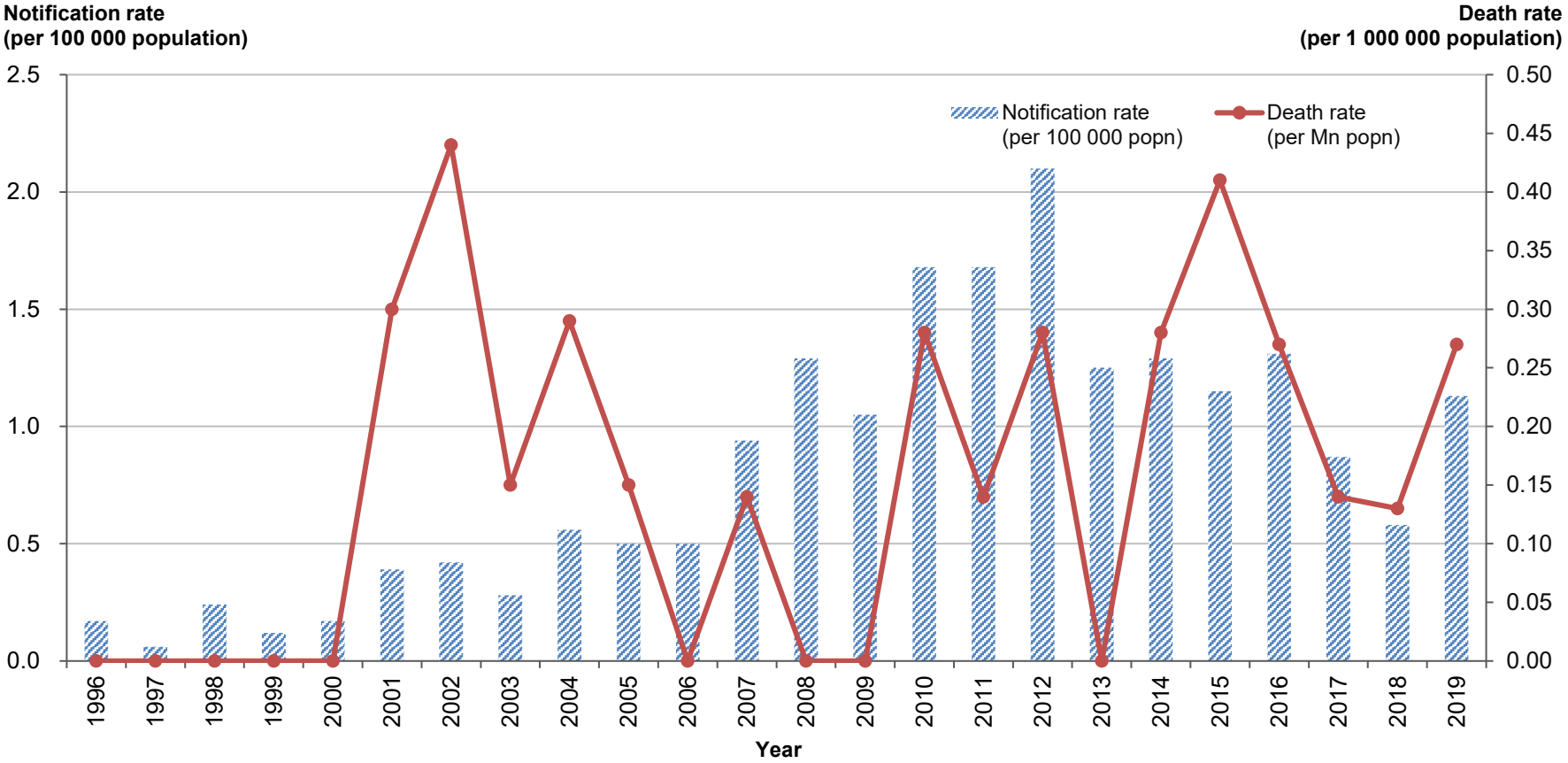
Box 18. Age distribution of hepatitis E cases reported from 1996 to 2019 (Data source: CHP, DH)



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
> 84	0%	0%	0%	0%	0%	4%	0%	0%	3%	0%	0%	0%	0%	1%	0%	0%	1%	0%	2%	2%	2%	3%	2%	7%
75 - 84	9%	0%	0%	0%	0%	4%	0%	11%	18%	6%	9%	3%	9%	10%	8%	7%	12%	10%	9%	5%	6%	5%	9%	15%
65 - 74	0%	0%	0%	13%	9%	12%	18%	16%	13%	12%	21%	5%	13%	11%	16%	8%	11%	14%	11%	19%	23%	16%	23%	25%
55 - 64	0%	0%	13%	25%	27%	15%	14%	16%	13%	24%	9%	14%	12%	23%	24%	27%	24%	33%	28%	31%	24%	19%	42%	26%
45 - 54	9%	25%	25%	25%	9%	23%	32%	16%	24%	32%	29%	38%	32%	27%	26%	29%	25%	23%	32%	24%	19%	25%	9%	14%
35 - 44	36%	25%	38%	13%	9%	27%	25%	32%	18%	12%	21%	29%	16%	15%	13%	19%	19%	9%	13%	12%	13%	25%	12%	8%
25 - 34	36%	50%	19%	25%	45%	15%	11%	11%	11%	15%	3%	6%	12%	8%	11%	8%	7%	4%	5%	6%	10%	6%	2%	4%
15 - 24	9%	0%	6%	0%	0%	0%	0%	0%	0%	0%	6%	3%	4%	4%	2%	2%	0%	6%	0%	1%	3%	2%	0%	1%
5 - 14	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	2%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
< 5	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	3%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Year

Box 19. Notification rates and death rates of hepatitis E, 1996 – 2019 (Data source: CHP, DH)



Seroprevalence of hepatitis A

Box 20. Prevalence of anti-HAV in studies/testing between 1978 and 2009 (Data sources: multiple sources)

Age groups	1978	1987	1989	1993^	1995	1996		1998	2000	2001	2001	2002	2003	2004	2005	2006	2007	2008	2009
0 – 20	12.9% (0 – 10) 44.8% (11 – 20)	5.3% (0 – 10) 17.1% (11 – 20)	6.8% (0 – 10) 11.2% (11 – 20)	59.4% (M) 53.3% (F)	8.3%	- 7.0%	(0 – 10) (11 – 20)	6.1%	5.4%	9.3%	4.58%	- 12.5%	(0 – 10) (11 – 20)	5.3%	10.3%	14.7%	15.4%	20.0%	14.3%	16.7%	25.0%
21 – 30	75.0%	53.8%	58.8%	59.4% (M) 53.3% (F)	11.3%	-		11.8%	7.6%	17.5%	13.2%	26.8%		12.6%	13.2%	21.0%	28.2%	25.8%	19.4%	26.3%	30.3%
31 – 40	82.9%	85.1%	83.5%	59.4% (M) 53.3% (F)	49.0%	-		37.7%	40.8%	35.0%	41.3%	53.2%		46.7%	52.4%	43.8%	35.7%	50.0%	37.5%	47.4%	36.4%
>40	91.1%	94.7%	91.1% (41 – 50) 93.9% (>50)	94.5% (M) 91.0% (F)	70.5%	-		58.6%	66.7%	60.0%	71.1%	88.3% (41 – 50) 97.7% (>50)		58.1%	100.0%	50.0%	72.7%	80.0%	62.5%	71.4%	26.7%
Data source	A	B	C	D	E	F		E	E	E	E	G		E	E	E	E	E	E	E	E

^Figure is the average of age 0 – 40

Data sources:

A. Study on left-over sera of 362 subjects, by Tsang et al of the University of Hong Kong [7]

B. Study on stored sera of 702 healthy subjects, by Chin et al of the University of Hong Kong [6]

C. Study on 1028 serum samples collected from individuals attending a health exhibition, by Lim et al of Department of Health. [87]

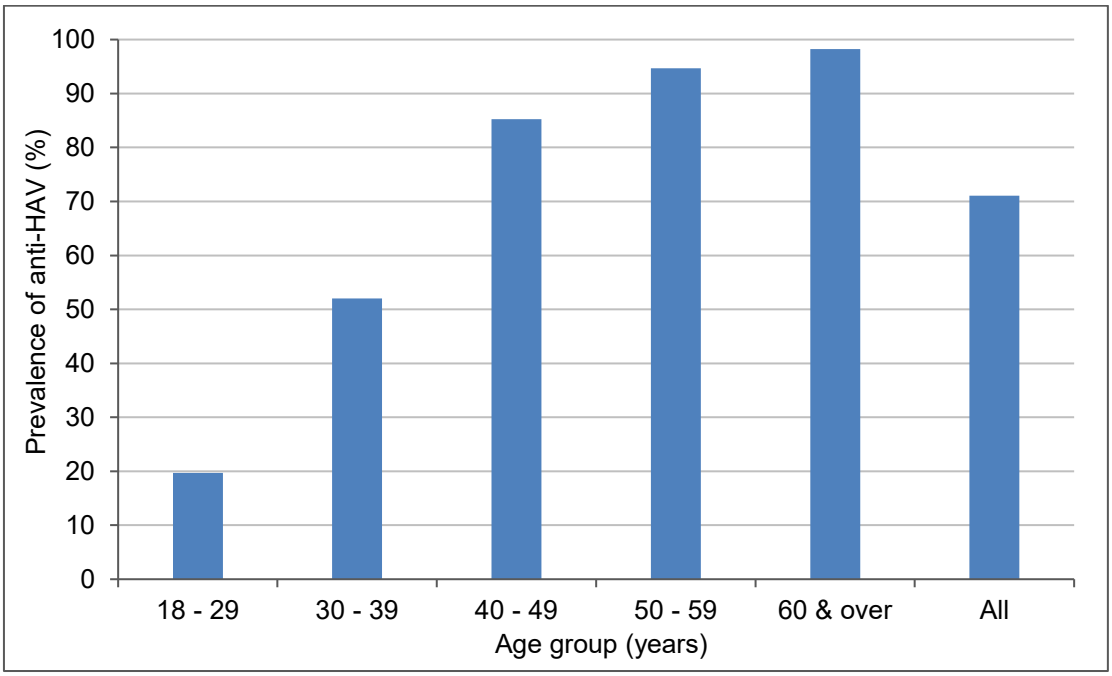
D. Seroprevalence results reported in the press by Lai et al of the University of Hong Kong. [88]

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), 77 (2005), 53 (2006), 54 (2007), 70(2008),63(2009) and students and staff of Lingnan University 125 (2003), 84 (2004). [Data from CHC-Group Medical Practice]

F. Seroprevalence study in school children by Lee et al of the Chinese University of Hong Kong. [89]

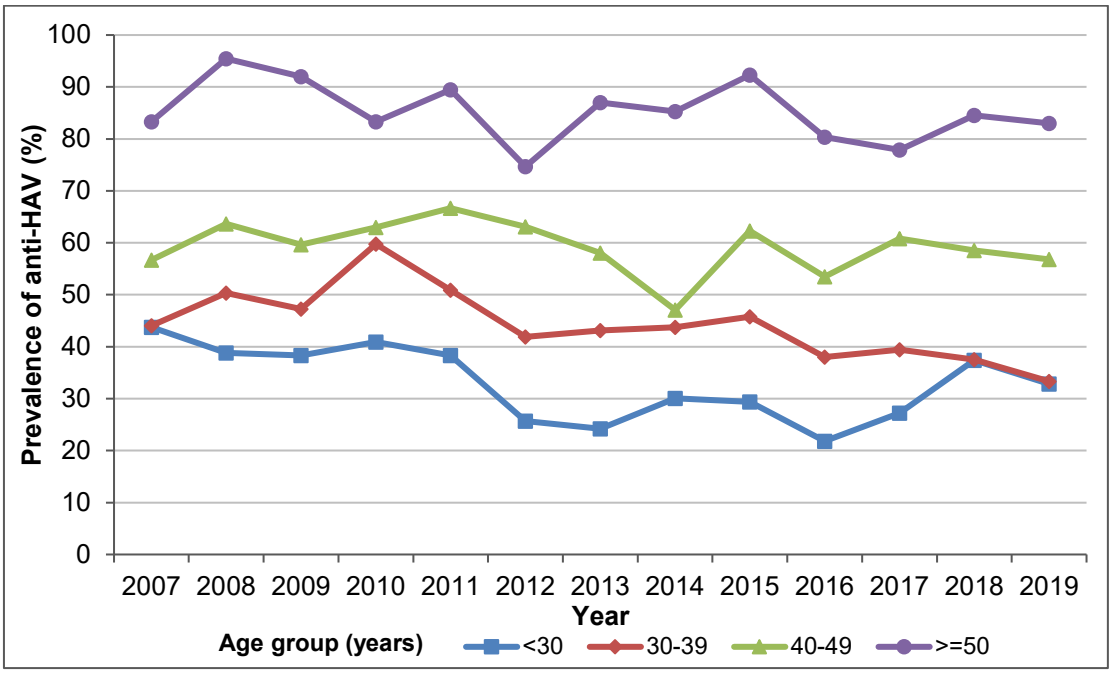
G. Community Research Project on Viral Hepatitis 2001. [2]

Box 21. Prevalence of anti-HAV in participants of Community Research Project for Viral Hepatitis in 2001 (Data source: DH)



Age group	No. Tested	Anti-HAV +ve (%)
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%)

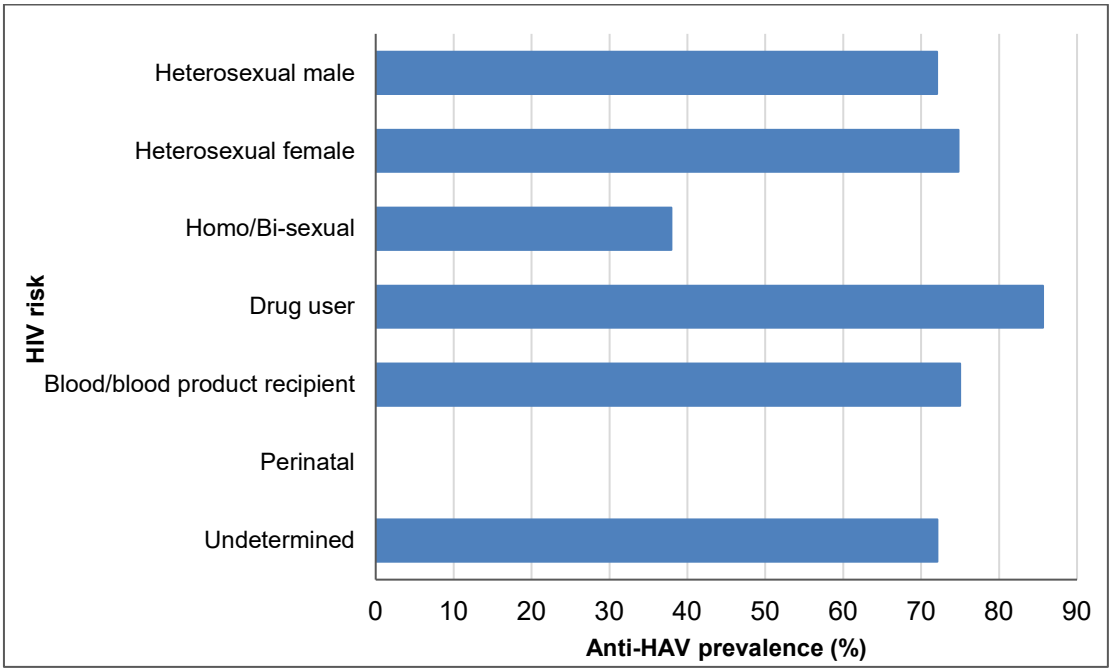
Box 22. Prevalence of anti-HAV at baseline screening of HIV/AIDS patients attending ITC from Jul 2007 to 2019 (Data source: ITC, CHP, DH)



Year (No. of patients)	Age	No. tested	Anti-HAV +ve (%)
2007 Jul-Dec (n=308)	<20	0	0 (0.0%)
	20-29	64	28 (43.8%)
	30-39	202	89 (44.1%)
	40-49	30	17 (56.7%)
	>=50	12	10 (83.3%)
2008 (n=506)	<20	2	1 (50.0%)
	20-29	101	39 (38.6%)
	30-39	282	142 (50.4%)
	40-49	77	49 (63.6%)
	>=50	44	42 (95.5%)
2009 (n=228)	<20	2	0 (0.0%)
	20-29	58	23 (39.7%)
	30-39	91	43 (47.3%)
	40-49	52	31 (59.6%)
	>=50	25	23 (92.0%)
2010 (n=222)	<20	3	0 (0.0%)
	20-29	41	18 (43.9%)
	30-39	82	49 (59.8%)
	40-49	54	34 (63.0%)
	>=50	42	35 (83.3%)
2011 (n=208)	<20	2	0 (0.0%)
	20-29	45	18 (40.0%)
	30-39	57	29 (50.9%)
	40-49	66	44 (66.7%)
	>=50	38	34 (89.5%)

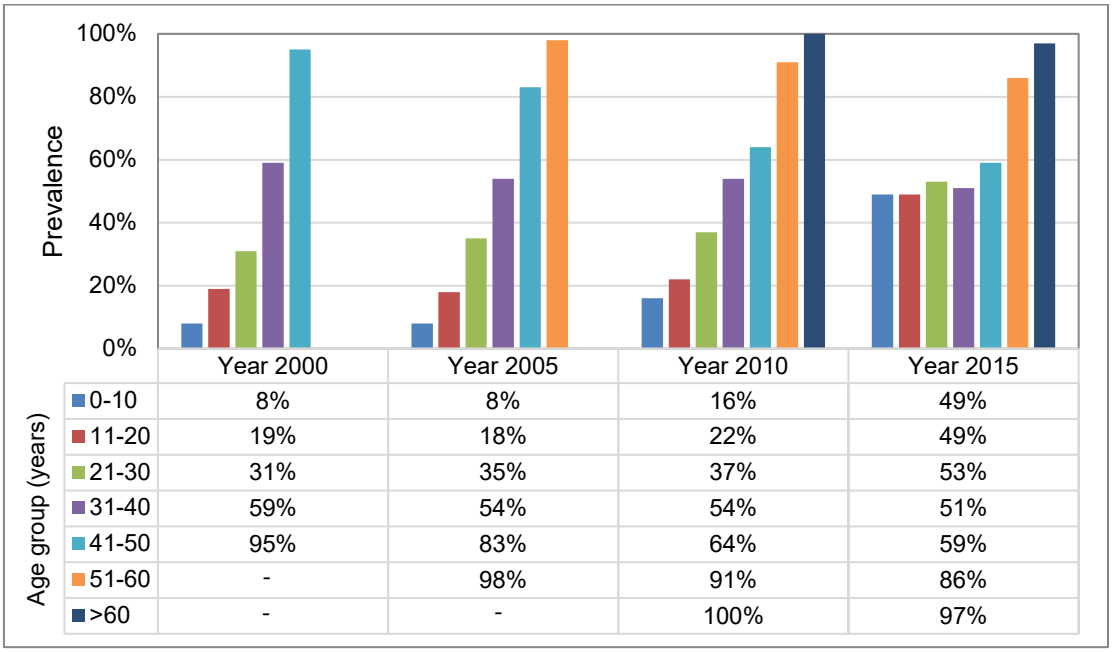
Year (No. of patients)	Age	No. tested	Anti-HAV +ve (%)
2012 (n=361)	<20	6	0 (0.0%)
	20-29	64	18 (28.1%)
	30-39	105	44 (41.9%)
	40-49	111	70 (63.1%)
	>=50	75	56 (74.7%)
2013 (n=432)	<20	5	2 (40.0%)
	20-29	90	21 (23.3%)
	30-39	102	44 (43.1%)
	40-49	112	65 (58.0%)
	>=50	123	107 (87.0%)
2014 (n=375)	<20	8	1 (12.5%)
	20-29	135	42 (31.1%)
	30-39	96	42 (43.8%)
	40-49	68	32 (47.1%)
	>=50	68	58 (85.3%)
2015 (n=378)	<20	13	6 (46.2%)
	20-29	113	31 (27.4%)
	30-39	118	54 (45.8%)
	40-49	69	43 (62.3%)
	>=50	65	60 (92.3%)
2016 (n=345)	<20	4	0 (0.0%)
	20-29	106	24 (22.6%)
	30-39	121	46 (38.0%)
	40-49	58	31 (53.4%)
	>=50	56	45 (80.4%)
2017 (n=394)	<20	10	4 (40.0%)
	20-29	115	30 (26.1%)
	30-39	109	43 (39.4%)
	40-49	74	45 (60.8%)
	>=50	86	67 (77.9%)
2018 (n=301)	<20	2	1 (50.0%)
	20-29	97	36 (37.1%)
	30-39	64	24 (37.5%)
	40-49	41	24 (58.5%)
	>=50	97	82 (84.5%)
2019 (n=236)	<20	3	1 (33.3%)
	20-29	67	22 (32.8%)
	30-39	69	23 (33.3%)
	40-49	44	25 (56.8%)
	>=50	53	44 (83.0%)

Box 23. Prevalence of anti-HAV per HIV risk at baseline screening of HIV/AIDS patients attending ITC from Jul 2007 to 2019 (Data source: ITC, CHP, DH)



HIV risk	No. tested	Anti-HAV +ve (%)
Heterosexual male	801	577 (72.0%)
Heterosexual female	516	386 (74.8%)
Homo/Bi-sexual	2695	1023 (38.0%)
Drug user	202	173 (85.6%)
Blood/blood product recipient	28	21 (75.0%)
Perinatal	9	0 (0.0%)
Undetermined	43	31 (72.1%)
Total	4294	2211 (51.5%)

Box 24. Prevalence of anti-HAV in individuals with blood collected for serological diagnosis of conditions unrelated to hepatitis (Data source: PHLSB, CHP, DH)

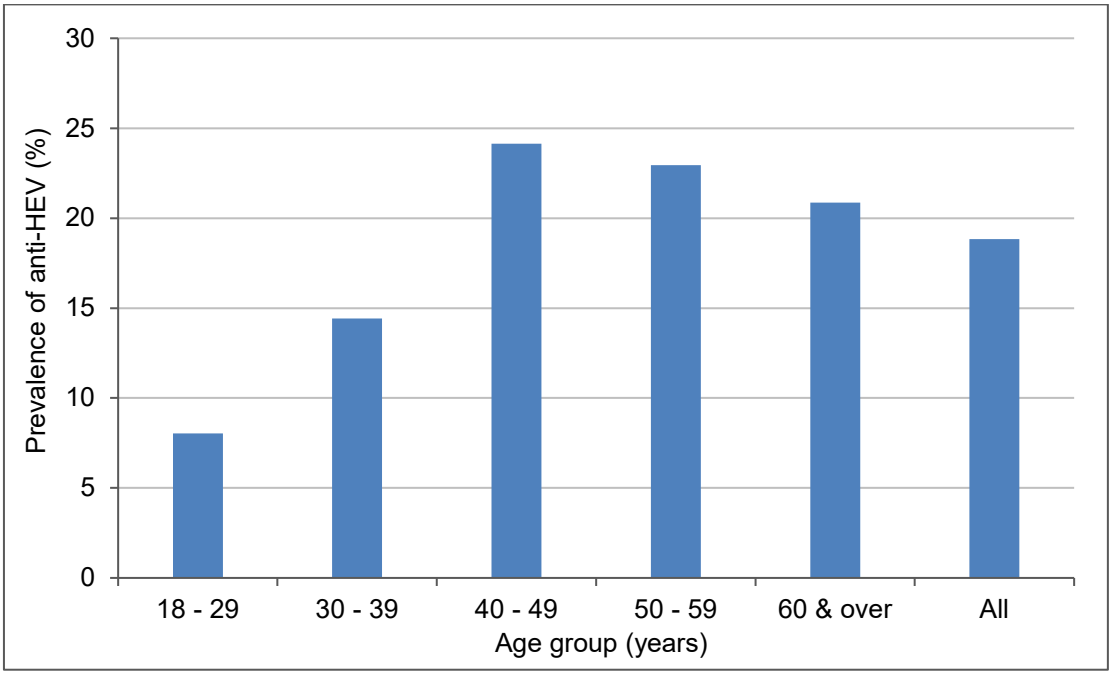


Age group (years)	Year 2000	Year 2005	Year 2010	Year 2015
0-10	8%	8%	16%	49%
11-20	19%	18%	22%	49%
21-30	31%	35%	37%	53%
31-40	59%	54%	54%	51%
41-50	95%	83%	64%	59%
51-60	-	98%	91%	86%
>60	-	-	100%	97%

	Age group (years)													
	0-10		11-20		21-30		31-40		41-50		51-60		>60	
Year	No. tested	%	No. tested	%	No. tested	%	No. tested	%	No. tested	%	No. tested	%	No. tested	%
2000	420	8	190	19	200	31	190	59	100	95	-	-	-	-
2005	200	8	181	18	187	35	200	54	100	83	100	98	-	-
2010	96	16	100	22	100	37	95	54	100	64	100	91	100	100
2015	160	49	162	49	122	53	127	51	99	59	70	86	58	97

Seroprevalence of hepatitis E

Box 25. Prevalence of anti-HEV in participants of Community Research Project for Viral Hepatitis in 2001 (Data source: DH)

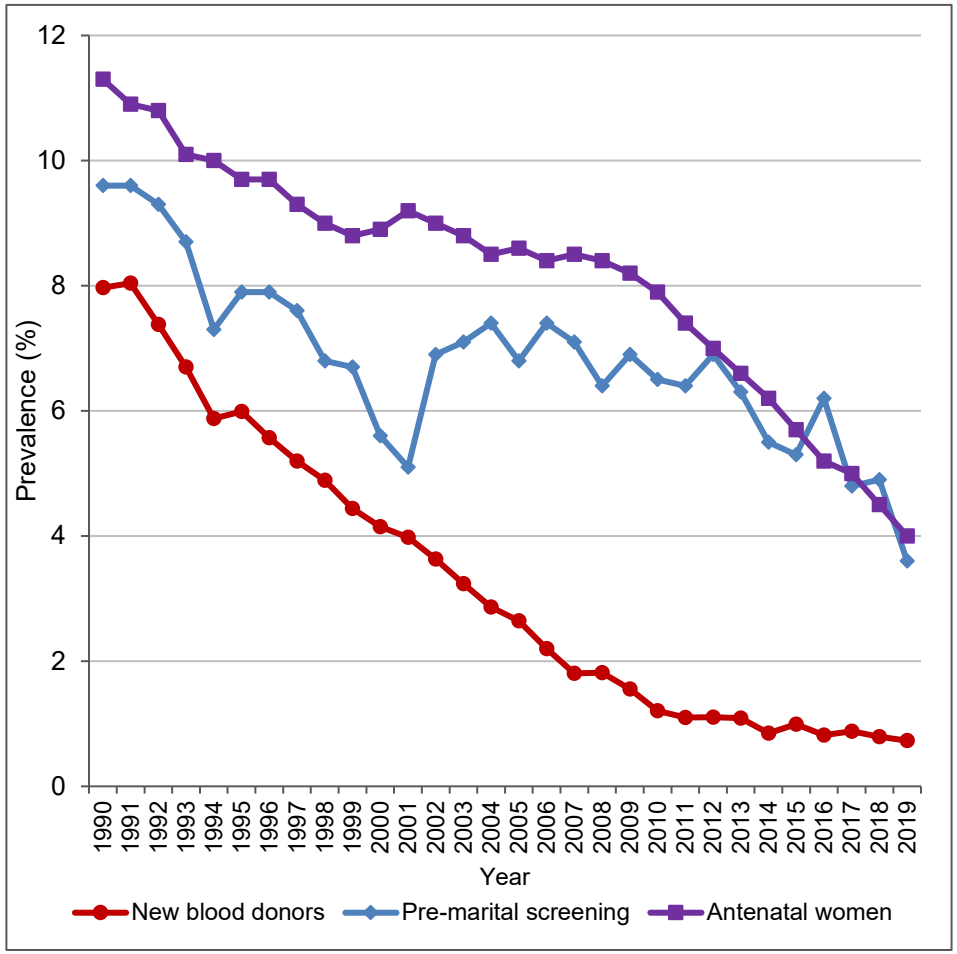


Age group	No. Tested	Anti-HEV +ve (%)
18-29	137	11 (8.0%)
30-39	222	32 (14.4%)
40-49	290	70 (24.1%)
50-59	170	39 (22.9%)
60 & over	115	24 (20.9%)
All	934	176 (18.8%)

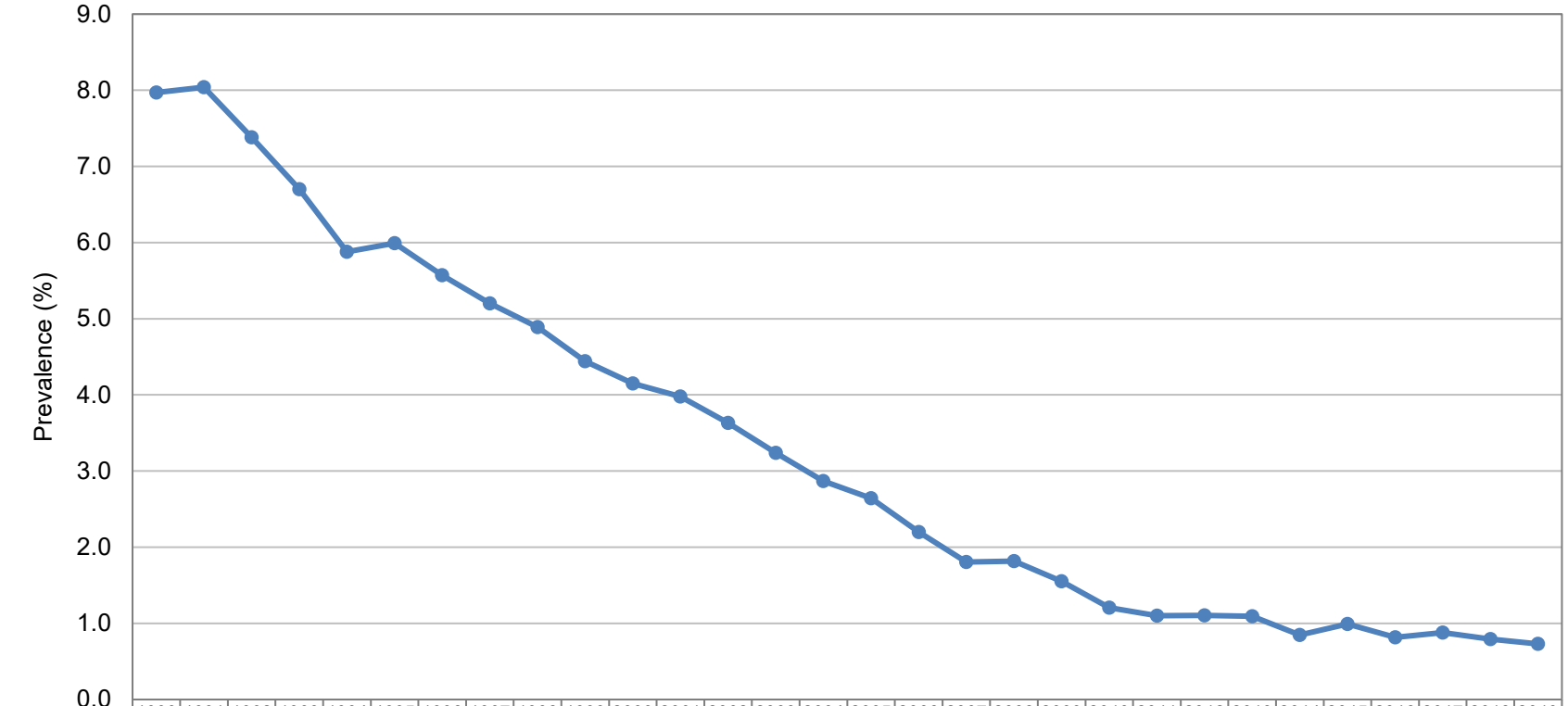
Seroprevalence of hepatitis B

Box 26. HBsAg prevalence in new blood donors, pre-marital screening and antenatal women from 1990 to 2019 (Data source: multiple sources)

Year	New blood donors	Pre-marital screening	Antenatal women
1990	8.0	9.6	11.3
1991	8.0	9.6	10.9
1992	7.4	9.3	10.8
1993	6.7	8.7	10.1
1994	5.9	7.3	10.0
1995	6.0	7.9	9.7
1996	5.6	7.9	9.7
1997	5.2	7.6	9.3
1998	4.9	6.8	9.0
1999	4.4	6.7	8.8
2000	4.2	5.6	8.9
2001	4.0	5.1	9.2
2002	3.6	6.9	9.0
2003	3.2	7.1	8.8
2004	2.9	7.4	8.5
2005	2.6	6.8	8.6
2006	2.2	7.4	8.4
2007	1.8	7.1	8.5
2008	1.8	6.4	8.4
2009	1.6	6.9	8.2
2010	1.2	6.5	7.9
2011	1.1	6.4	7.4
2012	1.1	6.9	7.0
2013	1.1	6.3	6.6
2014	0.8	5.5	6.2
2015	1.0	5.3	5.7
2016	0.8	6.2	5.2
2017	0.9	4.8	5.0
2018	0.8	4.9	4.5
2019	0.7	3.6	4.0



Box 27. HBsAg prevalence in new blood donors from 1990 to 2019 (Data source: HKRCBTS)

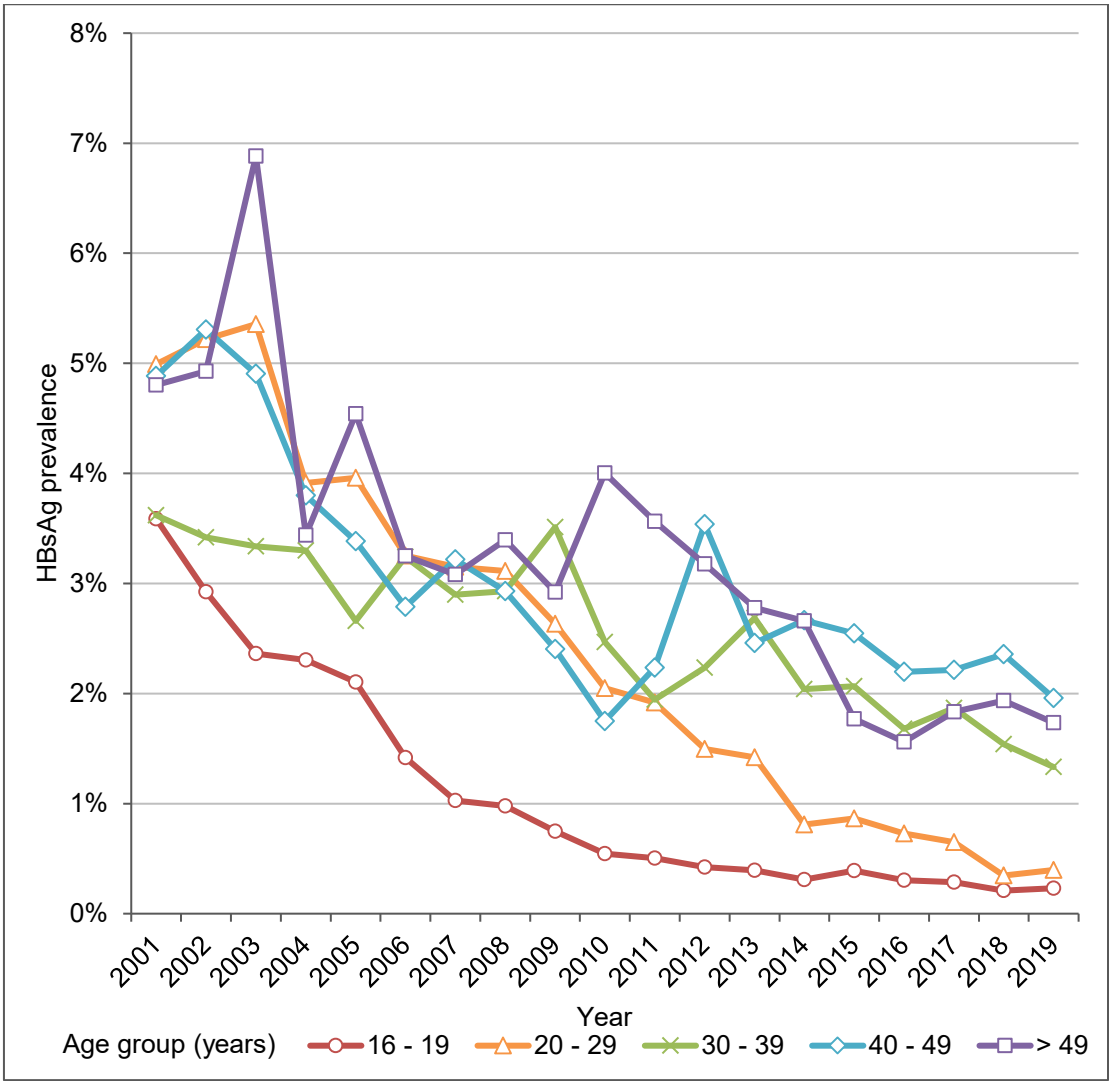


	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
% HBsAg +ve	8.0	8.0	7.4	6.7	5.9	6.0	5.6	5.2	4.9	4.4	4.2	4.0	3.6	3.2	2.9	2.6	2.2	1.8	1.8	1.6	1.2	1.1	1.1	1.1	0.8	1.0	0.8	0.9	0.8	0.7

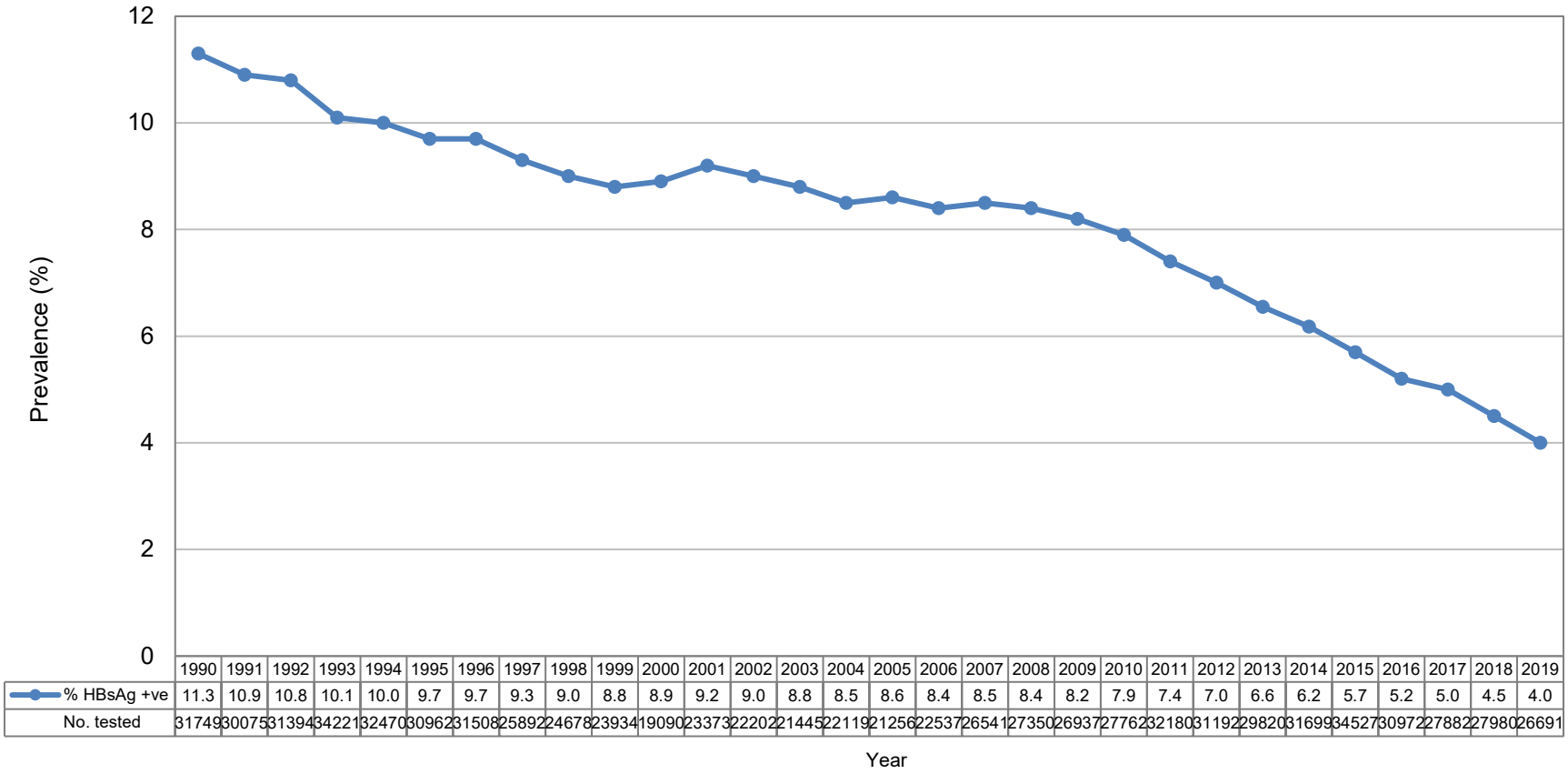
Box 28. HBsAg prevalence and its sex and age breakdown in new blood donors in 2019 (Data source: HKRCBTS)

	Male		Female		Total	
Age Group	No. tested	HBsAg +ve (%)	No. tested	HBsAg +ve (%)	No. tested	HBsAg +ve (%)
16-19	5137	16 (0.3%)	7044	12 (0.2%)	12181	28 (0.2%)
20-29	3476	14 (0.4%)	4060	16 (0.4%)	7536	30 (0.4%)
30-39	1815	34 (1.9%)	2615	25 (1.0%)	4430	59 (1.3%)
40-49	1075	33 (3.1%)	2091	29 (1.4%)	3166	62 (2.0%)
>49	695	18 (2.6%)	1324	17 (1.3%)	2019	35 (1.7%)
Total	12198	115 (0.9%)	17134	99 (0.6%)	29332	214 (0.7%)

Box 29. HBsAg prevalence among new blood donors by age, from 2001 to 2019 (Data source: HKRCBTS)



Box 30. HBsAg prevalence in antenatal women from 1990 to 2019 (Data source: FHS and PHLSB, CHP, DH)



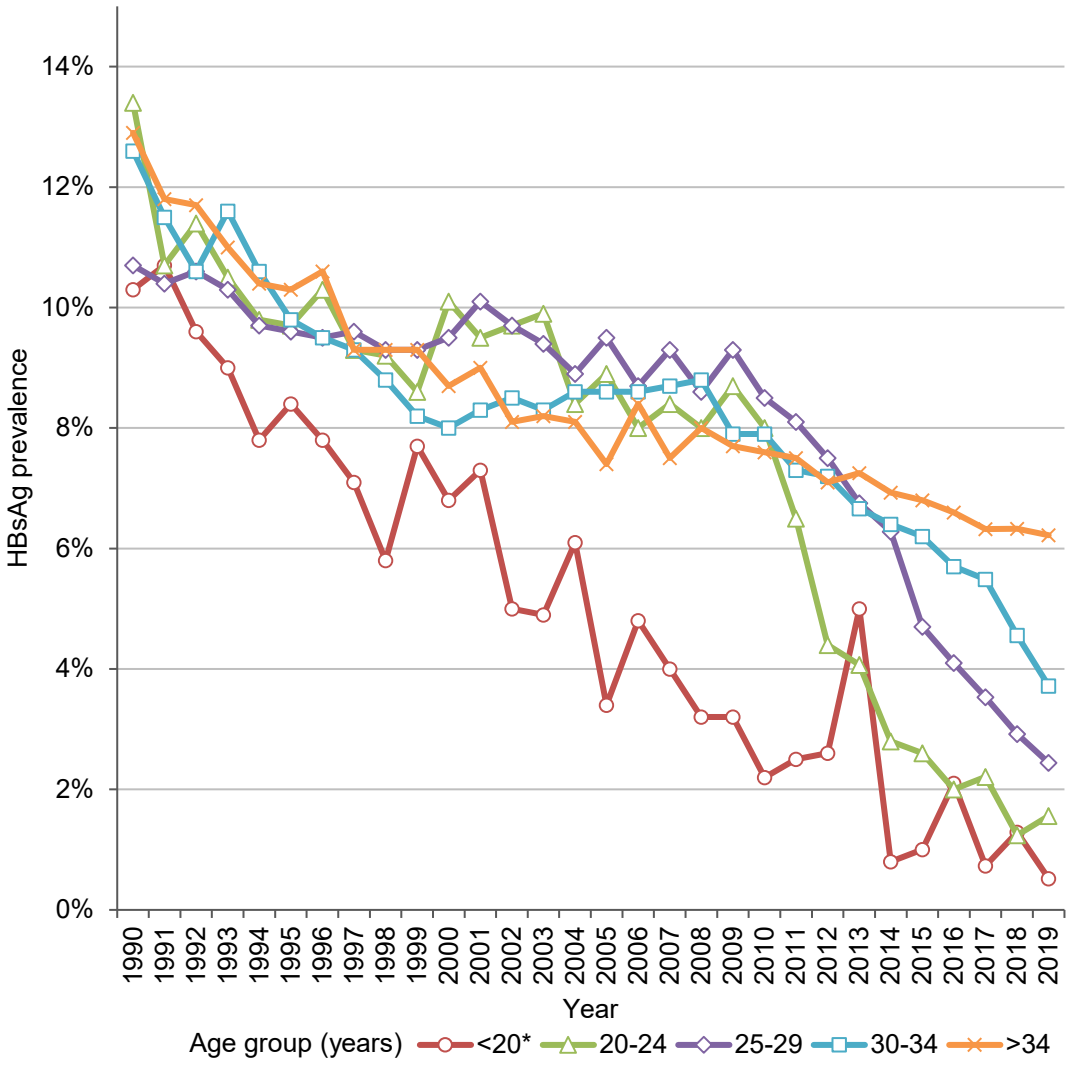
	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
% HBsAg +ve	11.3	10.9	10.8	10.1	10.0	9.7	9.7	9.3	9.0	8.8	8.9	9.2	9.0	8.8	8.5	8.6	8.4	8.5	8.4	8.2	7.9	7.4	7.0	6.6	6.2	5.7	5.2	5.0	4.5	4.0
No. tested	31749	30075	31394	34221	32470	30962	31508	25892	24678	23934	19090	23373	22202	21445	22119	21256	22537	26541	27350	26937	27762	32180	31192	29820	31699	34527	30972	27882	27980	26691

Box 31. HBsAg prevalence and age breakdown of antenatal mothers from 1990 to 2019 (Data source: FHS, DH)

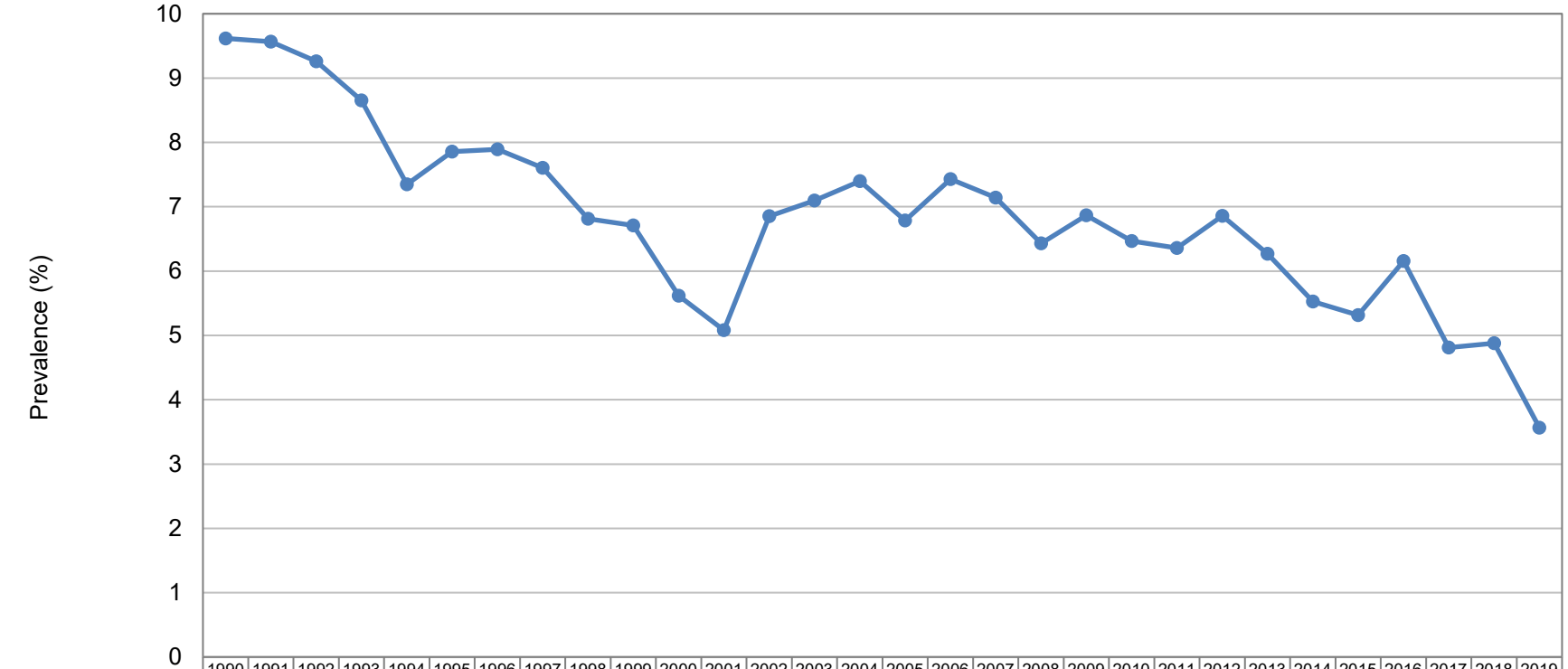
	No. tested (% HBsAg +ve) according to age group of antenatal mothers				
Year	<20*	20-24	25-29	30-34	>34
1990	1044 (10.3%)	4671 (13.4%)	15228 (10.7%)	7639 (12.6%)	2780 (12.9%)
1991	987 (10.7%)	4620 (10.7%)	13151 (10.4%)	8168 (11.5%)	3063 (11.8%)
1992	928 (9.6%)	5065 (11.4%)	13093 (10.6%)	8788 (10.6%)	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%)
2005	445 (3.4%)	2753 (8.9%)	6063 (9.5%)	7869 (8.6%)	4114 (7.4%)
2006	516 (4.8%)	2590 (8.0%)	6271 (8.7%)	8637 (8.6%)	4514 (8.4%)
2007	520 (4.0%)	2929 (8.4%)	7301 (9.3%)	10232 (8.7%)	5551 (7.5%)
2008	533 (3.2%)	2968 (8.0%)	7652 (8.6%)	10354 (8.8%)	5838 (8.0%)
2009	434 (3.2%)	2830 (8.7%)	7444 (9.3%)	10156 (7.9%)	6071 (7.7%)
2010	446 (2.2%)	2903 (8.0%)	7817 (8.5%)	10211 (7.9%)	6385 (7.6%)
2011	447 (2.5%)	2898 (6.5%)	9010 (8.1%)	12273 (7.3%)	7552 (7.5%)
2012	463 (2.6%)	2467 (4.4%)	8161 (7.5%)	12664 (7.2%)	7437 (7.1%)
2013	423 (5.0%)	2237 (4.1%)	7526 (6.8%)	12466 (6.7%)	7168 (7.3%)
2014	366 (0.8%)	2252 (2.8%)	7901 (6.3%)	13488 (6.4%)	7692 (6.9%)
2015	409 (1.0%)	2439 (2.6%)	8589 (4.7%)	14434 (6.2%)	8656 (6.8%)
2016	328 (2.1%)	2123 (2.0%)	7580 (4.1%)	13018 (5.7%)	7923 (6.6%)
2017	274 (0.7%)	1897 (2.2%)	6624 (3.5%)	11476 (5.5%)	7611 (6.3%)
2018	233 (1.3%)	1698 (1.2%)	6376 (2.9%)	11647 (4.6%)	8026 (6.3%)
2019	193 (0.5%)	1474 (1.6%)	5948 (2.4%)	11333 (3.7%)	7743 (6.2%)

* *Figures before year 2010 refer to age group 15-19;*
figures in year 2010 and thereafter refer to age group <20

Box 32. HBsAg prevalence among antenatal mothers by age, from 1990 to 2019 (Date source: FHS, DH)



Box 33. HBsAg prevalence from the FPAHK's clinical services (Data source: FPA)



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
% HBsAg +ve	9.6	9.6	9.3	8.7	7.3	7.9	7.9	7.6	6.8	6.7	5.6	5.1	6.9	7.1	7.4	6.8	7.4	7.1	6.4	6.9	6.5	6.4	6.9	6.3	5.5	5.3	6.2	4.8	4.9	3.6
Total no. of cases	17251	19142	18445	19193	16466	16798	19959	17109	13163	12686	15348	16611	15077	13489	13773	11772	11831	9787	10669	9553	14137	13163	12191	13850	13117	11325	11091	10101	10315	8776

Note: 1990-2010 only contain pre-marital check up
Start from 2011 contain both pre-marital and pre-pregnancy check up

Box 34. HBsAg prevalence in other selected populations from 1990 to 2019 (Data sources: multiple sources)

Year	University students/staff (aged 21-30)	Police officers	Health care workers
1990	-	-	-
1991	-	-	6.2
1992	-	-	-
1993	-	-	4.4
1994	3.5	-	-
1995	4.3	-	7.0
1996	3.9	6.1	4.2
1997	-	7.9	-
1998	3.5	7.4	-
1999	-	6.4	2.2
2000	3.1	5.6	5.4
2001	3.4	5.9	6.0
2002	2.7	5.3	5.0
2003	3.7	4.6	5.2
2004	1.8	4.9	5.3
2005	-	4.2	5.4
2006	1.0	4.6	4.9
2007	1.2	-	3.9
2008	1.2	-	3.8
2009	0.0	-	5.1
2010	-	-	4.6
2011	-	-	2.5
2012	-	3.0*	4.3
2013	-	2.8	3.9
2014	-	2.6	2.5
2015	-	2.8	3.2
2016	-	1.9	3.5
2017	-	1.4	3.1
2018	-	2.3	3.5
2019	-	1.2	2.7

** For a period between Mar-Dec 2012*

Box 35. HBsAg prevalence among university students/staff (Data source: City University Health Centre (till 2002), Baptist University Health Centre (2001 to 2009) & Lingnan University Health Service (2003 and 2004)

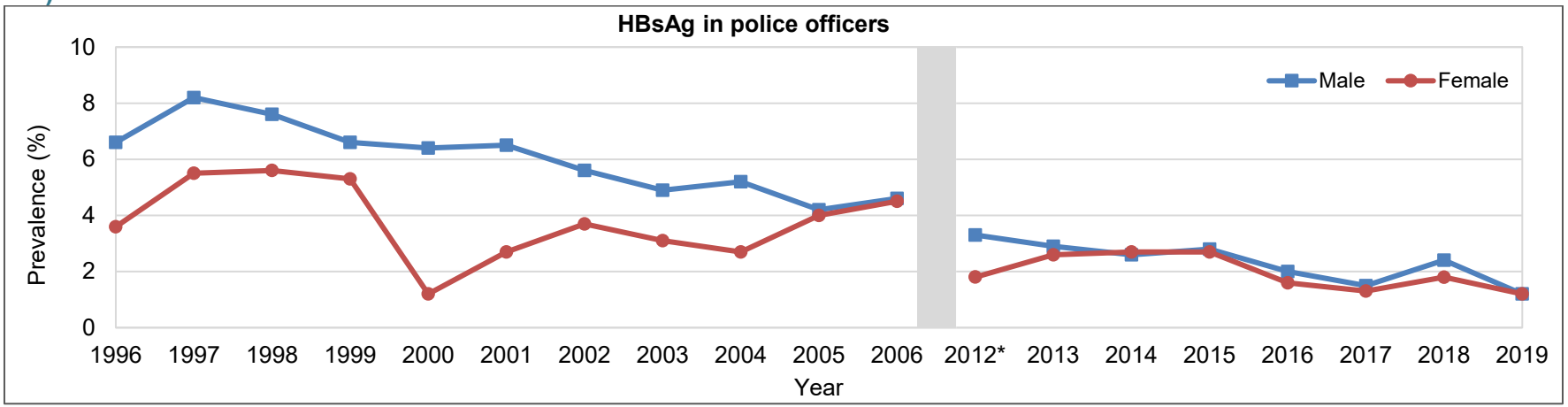
	Aged below 21		Aged 21 – 30		Aged < 30	
Year	Total no. of cases	HBsAg +ve (%)	Total no. of cases	HBsAg +ve (%)	Total no. of cases	HBsAg +ve (%)
1994	305	7 (2.3%)	830	29 (3.5%)	1135	36 (3.2%)
1995	324	10 (3.1%)	768	33 (4.3%)	1092	43 (3.9%)
1996	348	4 (1.1%)	762	30 (3.9%)	1110	34 (3.1%)
1998	371	5 (1.3%)	608	21 (3.5%)	979	26 (2.7%)
2000	230	7 (3.0%)	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%)
2005	57	1 (1.8%)	115	0 (0.0%)	172	1 (0.6%)
2006	26	3 (11.5%)	104	1 (1.0%)	130	4 (3.1%)
2007	16	0 (0.0%)	82	1 (1.2%)	98	1 (1.0%)
2008	18	0 (0.0%)	82	1 (1.2%)	100	1 (1.0%)
2009	8	0 (0.0%)	56	0 (0.0%)	64	0 (0.0%)

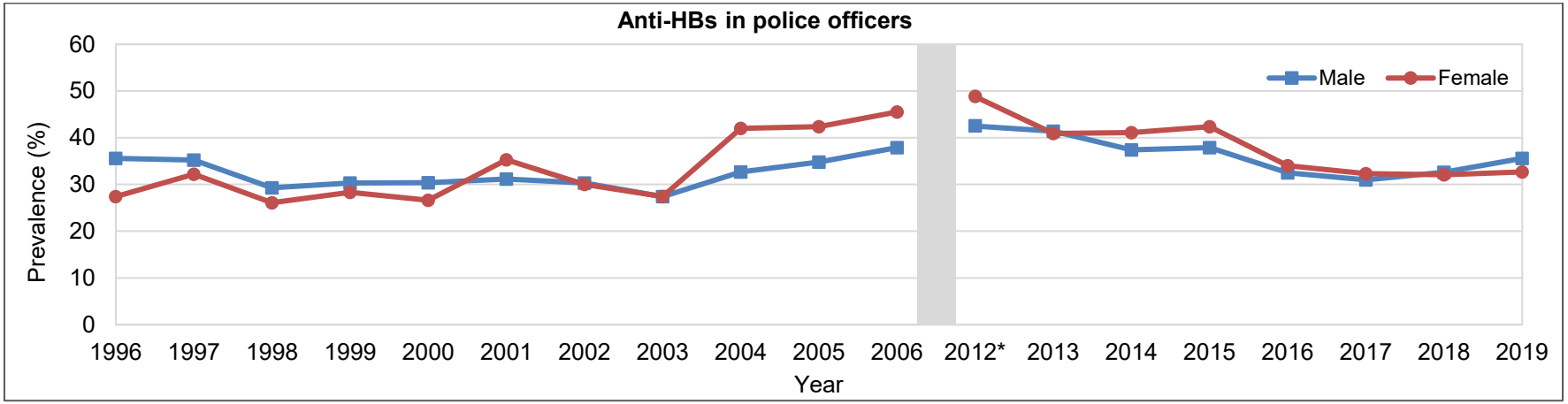
Box 36. Prevalence of hepatitis B markers in police officers, by age from 1996 to 2006 and 2012 to 2019 (Data source: DH)

	Age group														
	≤20			21-30			31-40			41-50			>50		
Year	No. tested	HBsAg +ve (%)	Anti-HBs +ve (%)	No. tested	HBsAg +ve (%)	Anti-HBs +ve (%)	No. tested	HBsAg +ve (%)	Anti-HBs +ve (%)	No. tested	HBsAg +ve (%)	Anti-HBs +ve (%)	No. tested	HBsAg +ve (%)	Anti-HBs +ve (%)
1996	17	0.0	35.3	733	4.8	24.4	1155	6.8	32.9	544	5.9	49.6	44	18.2	40.9
1997	15	6.7	46.7	1494	6.1	25.4	2081	7.3	35.0	999	11.4	46.6	110	13.6	55.5
1998	387	5.9	20.7	969	5.5	25.0	828	8.3	30.8	356	12.4	40.4	60	6.7	51.7
1999	270	4.4	24.1	799	6.1	27.5	428	6.8	31.8	202	8.9	42.1	22	9.1	40.9
2000	72	4.2	22.2	746	6.4	24.3	460	4.3	31.3	242	5.8	44.6	24	4.2	45.8
2001	68	4.4	30.9	602	5.8	28.4	339	5.6	30.7	225	6.2	40.0	45	8.9	48.9
2002	145	4.8	29.7	697	4.9	25.3	443	3.6	29.6	307	9.1	37.5	52	3.8	61.5
2003	72	1.4	16.7	702	4.8	22.9	505	4.6	26.5	357	5.0	38.1	38	2.6	42.1
2004	8	0.0	37.5	466	5.2	35.6	441	3.4	28.6	321	5.9	39.6	57	8.8	31.6
2005	80	1.3	52.5	791	3.8	32.7	533	4.3	31.0	427	4.2	43.3	105	8.6	45.7
2006	0	-	-	39	0.0	51.3	86	5.8	36.0	90	4.4	36.7	24	8.3	41.7
2012*	267	0.7	20.2	1169	2.1	47.3	122	6.6	53.3	203	5.9	47.8	71	11.3	43.7
2013	393	0.0	24.4	1635	2.7	43.8	95	4.2	57.9	133	11.3	46.6	62	3.2	46.8
2014	456	0.7	24.8	1789	1.9	37.8	188	6.4	48.9	280	6.4	51.1	114	6.1	46.5
2015	455	0.9	24.8	2077	2.4	38.9	221	5.4	50.7	309	5.5	46.9	122	4.1	47.5
2016	428	0.5	17.3	2250	1.6	33.2	154	5.2	53.2	125	7.2	49.6	54	3.7	42.6
2017	391	0.5	21.2	2594	1.3	31.7	182	2.2	46.7	13	38.5	30.8	3	0.0	66.7
2018	332	2.1	27.7	1908	1.9	31.1	176	6.3	53.4	7	0.0	85.7	1	0.0	100.0
2019	274	0.7	33.2	1475	0.8	32.5	217	4.6	49.8	32	0.0	59.4	3	0.0	100.0

Note: Data were not available from 2007-Feb 2012
** For a period between Mar-Dec 2012*

Box 37. Prevalence of hepatitis B markers in police officers, by sex from 1996 to 2006 and 2012 to 2019 (Data source: DH)





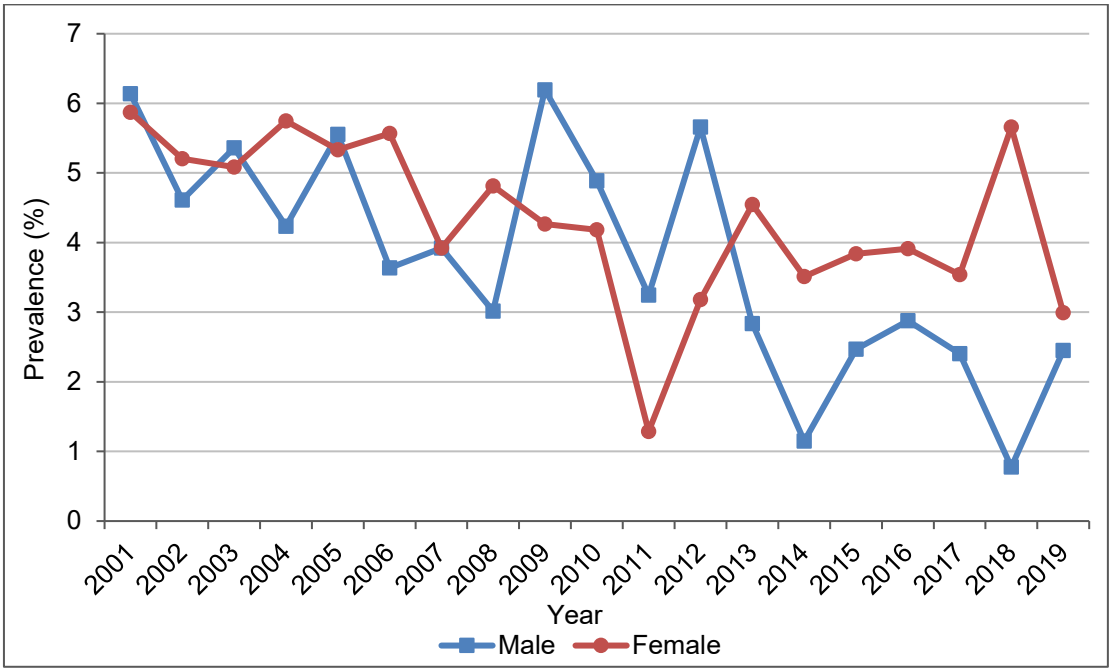
Note: Data were not available from 2007-Feb 2012
** For a period between Mar-Dec 2012*

	Male			Female			All		
Year	No. tested	HBsAg +ve (%)	Anti-HBs +ve (%)	No. tested	HBsAg +ve (%)	Anti-HBs +ve (%)	No. tested	HBsAg +ve (%)	Anti-HBs +ve (%)
1996	2080	138 (6.6%)	740 (35.6%)	413	15 (3.6%)	113 (27.4%)	2493	153 (6.1%)	853 (34.2%)
1997	4227	346 (8.2%)	1489 (35.2%)	472	26 (5.5%)	152 (32.2%)	4699	372 (7.9%)	1641 (34.9%)
1998	2316	177 (7.6%)	678 (29.3%)	284	16 (5.6%)	74 (26.1%)	2600	193 (7.4%)	752 (28.9%)
1999	1399	93 (6.6%)	424 (30.3%)	322	17 (5.3%)	91 (28.3%)	1721	110 (6.4%)	515 (29.9%)
2000	1300	83 (6.4%)	395 (30.4%)	244	3 (1.2%)	65 (26.6%)	1544	86 (5.6%)	460 (29.8%)
2001	1058	69 (6.5%)	330 (31.2%)	221	6 (2.7%)	78 (35.3%)	1279	75 (5.9%)	408 (31.9%)
2002	1374	77 (5.6%)	416 (30.3%)	270	10 (3.7%)	81 (30.0%)	1644	87 (5.3%)	497 (30.2%)
2003	1415	69 (4.9%)	388 (27.4%)	259	8 (3.1%)	71 (27.4%)	1674	77 (4.6%)	459 (27.4%)
2004	1105	58 (5.2%)	361 (32.7%)	188	5 (2.7%)	79 (42.0%)	1293	63 (4.9%)	440 (34.0%)
2005	1613	68 (4.2%)	562 (34.8%)	323	13 (4.0%)	137 (42.4%)	1936	81 (4.2%)	699 (36.1%)
2006	195	9 (4.6%)	74 (37.9%)	44	2 (4.5%)	20 (45.5%)	239	11 (4.6%)	94 (39.3%)
2012*	1494	49 (3.3%)	635 (42.5%)	338	6 (1.8%)	165 (48.8%)	1832	55 (3.0%)	800 (43.7%)
2013	1812	52 (2.9%)	751 (41.4%)	506	13 (2.6%)	207 (40.9%)	2318	65 (2.8%)	958 (41.3%)
2014	2267	59 (2.6%)	847 (37.4%)	560	15 (2.7%)	230 (41.1%)	2827	74 (2.6%)	1077 (38.1%)
2015	2563	71 (2.8%)	972 (37.9 %)	621	17 (2.7%)	263 (42.4%)	3184	88 (2.8%)	1235 (38.8%)
2016	2450	49 (2.0%)	796 (32.5%)	561	9 (1.6%)	191 (34.0%)	3011	58 (1.9%)	987 (32.8%)
2017	2477	36 (1.5%)	768 (31.0%)	706	9 (1.3%)	228 (32.3%)	3183	45 (1.4%)	996 (31.3%)
2018	1913	46 (2.4%)	623 (32.6%)	511	9 (1.8%)	164 (32.1%)	2424	55 (2.3%)	787 (32.5%)
2019	1582	19 (1.2%)	563 (35.6%)	419	5 (1.2%)	137 (32.7%)	2001	24 (1.2%)	700 (35.0%)

Note: Data were not available from 2007-Feb 2012

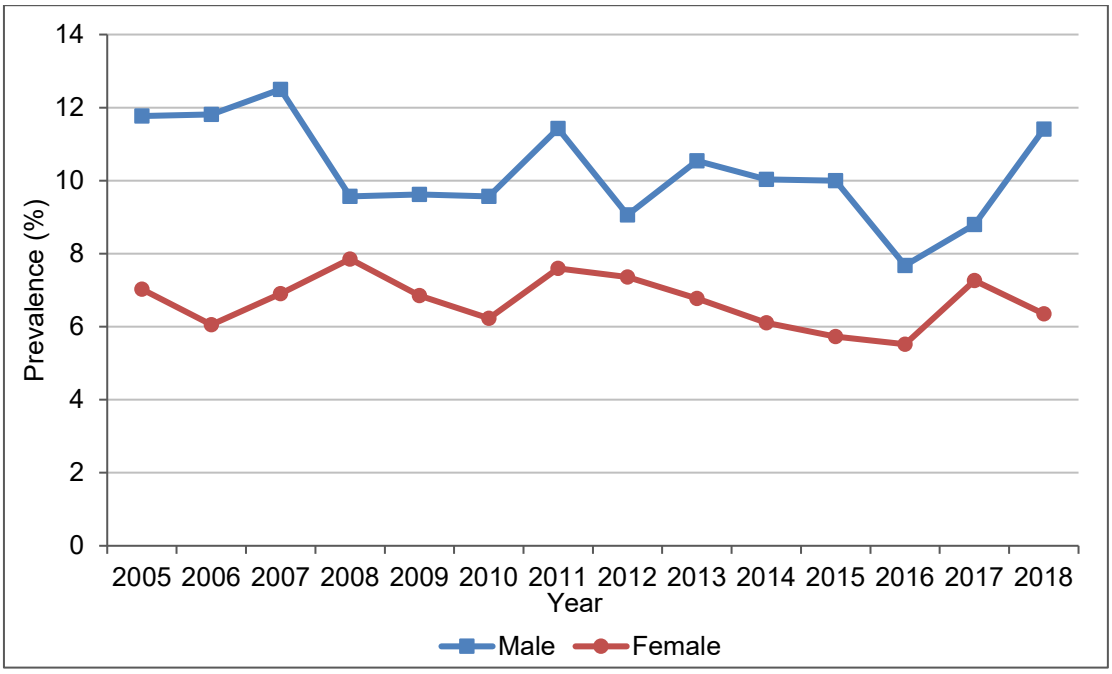
** For a period between Mar-Dec 2012*

Box 38. HBsAg prevalence in newly recruited health care workers of DH from 2001 to 2019 (Data source: DH)



	Male		Female	
Year	No. tested	HBsAg +ve (%)	No. tested	HBsAg +ve (%)
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%)
2005	396	22 (5.6%)	956	51 (5.3%)
2006	220	8 (3.6%)	449	25 (5.6%)
2007	204	8 (3.9%)	102	4 (3.9%)
2008	232	7 (3.0%)	187	9 (4.8%)
2009	226	14 (6.2%)	328	14 (4.3%)
2010	307	15 (4.9%)	239	10 (4.2%)
2011	370	12 (3.2%)	233	3 (1.3%)
2012	318	18 (5.7%)	377	12 (3.2%)
2013	282	8 (2.8%)	418	19 (4.5%)
2014	261	3 (1.1%)	370	13 (3.5%)
2015	324	8 (2.5%)	391	15 (3.8%)
2016	278	8 (2.9%)	409	16 (3.9%)
2017	291	7 (2.4%)	452	16 (3.5%)
2018	258	2 (0.8%)	318	18 (5.7%)
2019	245	6 (2.4%)	234	7 (3.0%)

Box 39. HBsAg prevalence in tuberculosis patients treated at chest clinics, by sex from 2005 to 2018 (March to May) (Data source: Tuberculosis and Chest Service, CHP, DH)



	Male		Female		Total	
Year	No. tested	HBsAg +ve (%)	No. tested	HBsAg +ve (%)	No. tested	HBsAg +ve (%)
2005	442	52 (11.8%)	242	17 (7.0%)	684	69 (10.1%)
2006	821	97 (11.8%)	446	27 (6.1%)	1267	124 (9.8%)
2007	768	96 (12.5%)	420	29 (6.9%)	1188	125 (10.5%)
2008	648	62 (9.6%)	382	30 (7.9%)	1030	92 (8.9%)
2009	759	73 (9.6%)	438	30 (6.8%)	1197	103 (8.6%)
2010	669	64 (9.6%)	353	22 (6.2%)	1022	86 (8.4%)
2011	674	77 (11.4%)	382	29 (7.6%)	1056	106 (10.0%)
2012	651	59 (9.1%)	367	27 (7.4%)	1018	86 (8.4%)
2013	664	70 (10.5%)	369	25 (6.8%)	1033	95 (9.2%)
2014	598	60 (10.0%)	393	24 (6.1%)	991	84 (8.5%)
2015	560	56 (10.0%)	314	18 (5.7%)	874	74 (8.5%)
2016	534	41 (7.7%)	308	17 (5.5%)	842	58 (6.9%)
2017	500	44 (8.8%)	303	22 (7.3%)	803	66 (8.2%)
2018	666	76 (11.4%)	425	27 (6.4%)	1091	103 (9.4%)

Box 40. HBsAg prevalence in tuberculosis patients treated at chest clinics, by age from 2005 to 2018 (March to May) (Data source: Tuberculosis and Chest Service, CHP, DH)

	Age group									
	0-19		20-39		40-59		≥60		Total	
Year	No. tested	HBsAg +ve (%)	No. tested	HBsAg +ve (%)	No. tested	HBsAg +ve (%)	No. tested	HBsAg +ve (%)	No. tested	HBsAg +ve (%)
2005	31	1 (3.2%)	168	11 (6.5%)	204	34 (16.7%)	281	23 (8.2%)	684	69 (10.1%)
2006	47	2 (4.3%)	314	21 (6.7%)	402	57 (14.2%)	504	44 (8.7%)	1267	124 (9.8%)
2007	57	1 (1.8%)	287	20 (7.0%)	374	60 (16.0%)	470	44 (9.4%)	1188	125 (10.5%)
2008	26	1 (3.8%)	256	14 (5.5%)	316	42 (13.3%)	432	35 (8.1%)	1030	92 (8.9%)
2009	45	0 (0.0%)	275	22 (8.0%)	370	56 (15.1%)	507	25 (4.9%)	1197	103 (8.6%)
2010	34	0 (0.0%)	224	15 (6.7%)	315	39 (12.4%)	449	32 (7.1%)	1022	86 (8.4%)
2011	35	0 (0.0%)	259	18 (6.9%)	303	45 (14.9%)	459	43 (9.4%)	1056	106 (10.0%)
2012	32	0 (0.0%)	261	21 (8.0%)	315	32 (10.2%)	410	33 (8.0%)	1018	86 (8.4%)
2013	54	1 (1.9%)	228	13 (5.7%)	320	41 (12.8%)	431	40 (9.3%)	1033	95 (9.2%)
2014	34	1 (2.9%)	211	8 (3.8%)	313	36 (11.5%)	433	39 (9.0%)	991	84 (8.5%)
2015	30	0 (0.0%)	187	13 (7.0%)	260	26 (10.0%)	397	35 (8.8%)	874	74 (8.5%)
2016	25	0 (0.0%)	180	6 (3.3%)	222	19 (8.6%)	415	33 (8.0%)	842	58 (6.9%)
2017	35	0 (0.0%)	153	6 (3.9%)	237	28 (11.8%)	378	32 (8.5%)	803	66 (8.2%)
2018	36	1 (2.8%)	197	11 (5.6%)	311	36 (11.6%)	547	55 (10.1%)	1091	103 (9.4%)

Box 41. HBsAg prevalence in persons attending ITC, drug users and sex workers from 1990 to 2019 (Data sources: multiple sources)

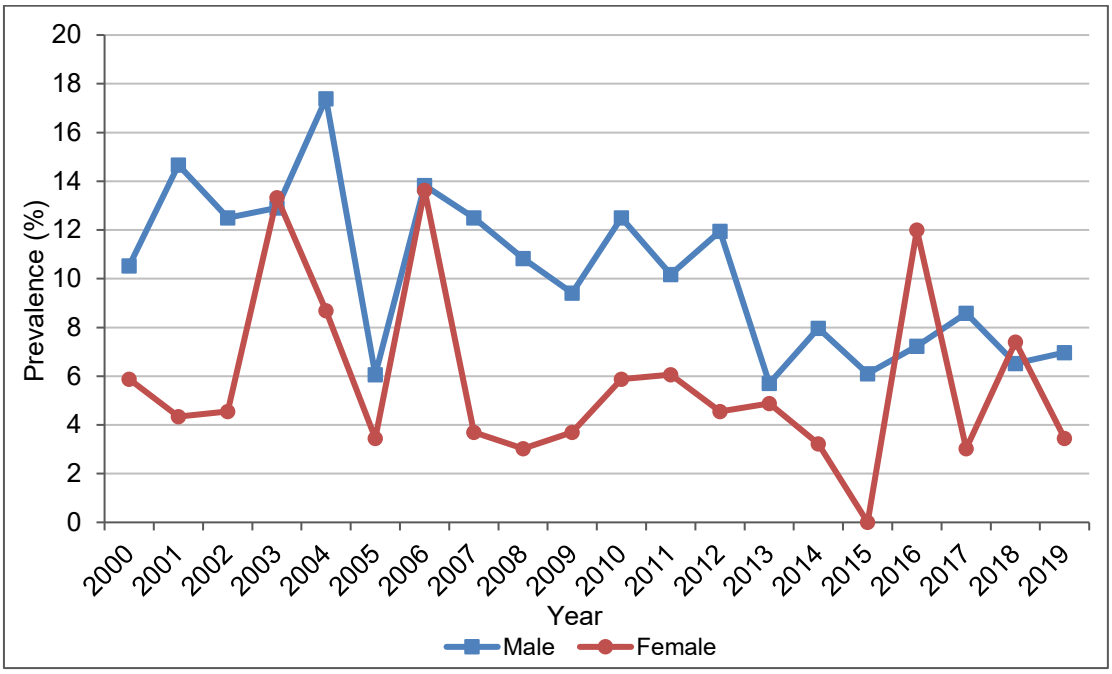
Year	Drug users	Female sex workers	HIV/AIDS patients	TPC patients
1990	13.4	-	-	-
1991	14.4	-	-	-
1992	13.9	-	-	-
1993	14.4	-	-	-
1994	12.9	-	-	-
1995	10.5	6.8^	-	-
1996	8.7	6.8^	-	-
1997	6.6	6.8^	-	-
1998	10.0	6.8^	-	-
1999	11.2	-	-	13.6*
2000	11.4	-	9.5	8.5
2001	11.6	-	12.2	5.3
2002	12.7	-	11.2	8.8
2003	10.1	-	13	10.1
2004	-	-	15.9	7.7
2005	-	-	5.6	6.3
2006	-	-	13.8	6.1
2007	-	10.4**	11.5	6.7
2008	-	9.0	9.7	7.6
2009	-	6.5	8.6	6.5
2010	-	5.0	11.3	3.8
2011	-	7.2***	9.5	4.0
2012	-	-	10.7	4.7
2013	-	-	5.6	4.1
2014	-	-	7.5	2.9
2015	-	-	5.6	2.8
2016	-	-	7.6	3.0
2017	-	-	8.1	0.7
2018	-	-	6.6	1.4
2019	-	-	6.5	-

For a period between Jul-Dec 1999; **For a period between Aug-Dec 2007; * For a period between Jan-Jul 2011; ^Figure is the average of 1995-1998*

Box 42. Prevalence of hepatitis B markers in persons attending Therapeutic Prevention Clinic of ITC for post-exposure management, from July 1999 to 2018 (Data source: ITC, CHP, DH)

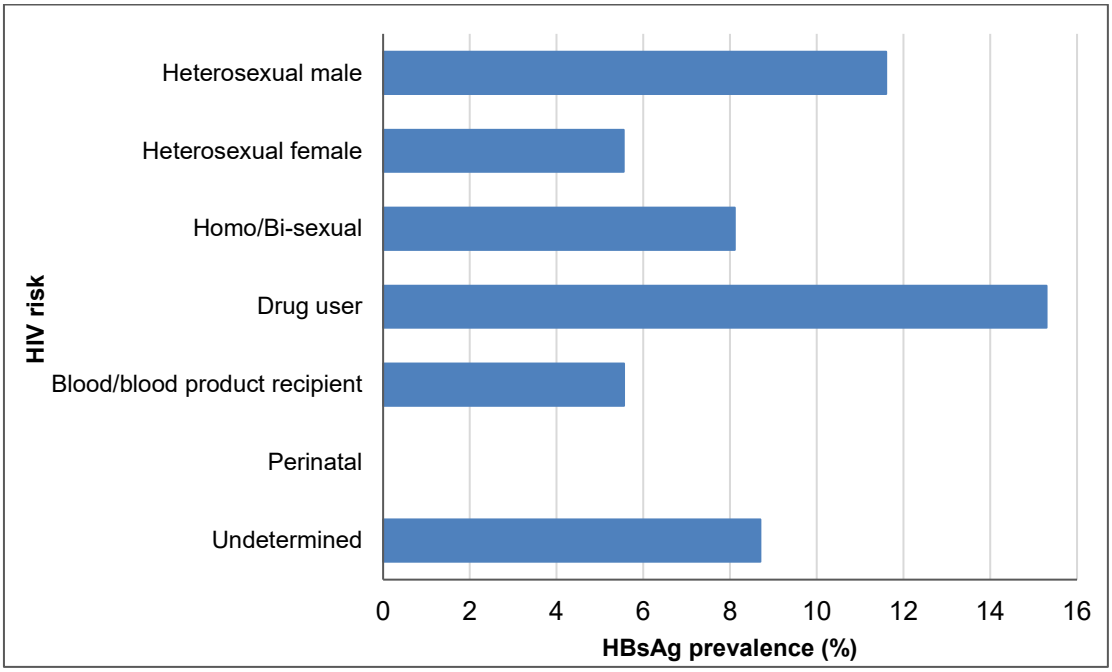
	Health care workers			Non- Health care workers			Total		
Year	No. tested	HBsAg +ve (%)	Anti-HBs +ve (%)	No. tested	HBsAg +ve (%)	Anti-HBs +ve (%)	No. tested	HBsAg +ve (%)	Anti-HBs +ve (%)
Jul-Dec 1999	23	2 (8.7%)	11 (47.8%)	87	13 (14.9%)	41 (47.1%)	110	15 (13.6%)	52 (47.3%)
2000	77	5 (6.5%)	56 (72.7%)	217	20 (9.2%)	91 (41.9%)	294	25 (8.5%)	147 (50.0%)
2001	103	2 (1.9%)	78 (75.7%)	313	20 (6.4%)	143 (45.7%)	416	22 (5.3%)	221 (53.1%)
2002	99	9 (9.1%)	62 (62.6%)	252	22 (8.7%)	133 (52.8%)	351	31 (8.8%)	195 (55.6%)
2003	96	6 (6.3%)	66 (68.8%)	201	24 (11.9%)	81 (40.3%)	297	30 (10.1%)	147 (49.5%)
2004	66	4 (6.1%)	41 (62.1%)	182	15 (8.2%)	97 (53.3%)	248	19 (7.7%)	138 (55.6%)
2005	49	3 (6.1%)	31 (63.3%)	206	13 (6.3%)	99 (48.1%)	255	16 (6.3%)	130 (51.0%)
2006	54	6 (11.1%)	33 (61.1%)	289	15 (5.2%)	151 (52.2%)	343	21 (6.1%)	184 (53.6%)
2007	54	1 (1.9%)	45 (83.3%)	228	18 (7.9%)	88 (38.6%)	282	19 (6.7%)	133 (47.2%)
2008	54	2 (3.7%)	39 (72.2%)	235	20 (8.5%)	111 (47.2%)	289	22 (7.6%)	150 (51.9%)
2009	56	1 (1.8%)	41 (73.2%)	297	22 (7.4%)	138 (46.5%)	353	23 (6.5%)	179 (50.7%)
2010	47	1 (2.1%)	33 (70.2%)	245	10 (4.1%)	137 (55.9%)	292	11 (3.8%)	170 (58.2%)
2011	54	1 (1.9%)	35 (64.8%)	270	12 (4.4%)	159 (58.9%)	324	13 (4.0%)	194 (59.9%)
2012	70	2 (2.9%)	54 (77.1%)	311	16 (5.1%)	173 (55.6%)	381	18 (4.7%)	227 (59.6%)
2013	82	1 (1.2%)	64 (78.0%)	313	15 (4.8%)	149 (47.6%)	395	16 (4.1%)	213 (53.9%)
2014	79	3 (3.8%)	58 (73.4%)	330	9 (2.7%)	180 (54.5%)	409	12 (2.9%)	238 (58.2%)
2015	85	1 (1.2%)	66 (77.6%)	311	10 (3.2%)	172 (55.3%)	396	11 (2.8%)	238 (60.1%)
2016	118	2 (1.7%)	82 (69.5%)	343	12 (3.5%)	155 (45.2%)	461	14 (3.0%)	237 (51.4%)
2017	83	1 (1.2%)	56 (67.5%)	350	2 (0.6%)	186 (53.1%)	433	3 (0.7%)	242 (55.9%)
2018	82	2 (2.4%)	53 (64.6%)	347	4 (1.2%)	165 (47.6%)	429	6 (1.4%)	218 (50.8%)
Total	1431	55 (3.8%)	1004 (70.2%)	5327	292 (5.5%)	2649 (49.7%)	6758	347 (5.1%)	3653 (54.1%)

Box 43. Prevalence of HBsAg at baseline screening of HIV/AIDS patients attending ITC from 2000 to 2019 (Data source: ITC, CHP, DH)



	Male		Female		Total	
Year	No. tested	HBsAg +ve (%)	No. tested	HBsAg +ve (%)	No. tested	HBsAg +ve (%)
2000	57	6 (10.5%)	17	1 (5.9%)	74	7 (9.5%)
2001	75	11 (14.7%)	23	1 (4.3%)	98	12 (12.2%)
2002	112	14 (12.5%)	22	1 (4.5%)	134	15 (11.2%)
2003	93	12 (12.9%)	15	2 (13.3%)	108	14 (13.0%)
2004	115	20 (17.4%)	23	2 (8.7%)	138	22 (15.9%)
2005	132	8 (6.1%)	29	1 (3.4%)	161	9 (5.6%)
2006	188	26 (13.8%)	22	3 (13.6%)	210	29 (13.8%)
2007	216	27 (12.5%)	27	1 (3.7%)	243	28 (11.5%)
2008	203	22 (10.8%)	33	1 (3.0%)	236	23 (9.7%)
2009	170	16 (9.4%)	27	1 (3.7%)	197	17 (8.6%)
2010	160	20 (12.5%)	34	2 (5.9%)	194	22 (11.3%)
2011	167	17 (10.2%)	33	2 (6.1%)	200	19 (9.5%)
2012	226	27 (11.9%)	44	2 (4.5%)	270	29 (10.7%)
2013	263	15 (5.7%)	41	2 (4.9%)	304	17 (5.6%)
2014	301	24 (8.0%)	31	1 (3.2%)	332	25 (7.5%)
2015	328	20 (6.1%)	26	0 (0.0%)	354	20 (5.6%)
2016	304	22 (7.2%)	25	3 (12.0%)	329	25 (7.6%)
2017	326	28 (8.6%)	33	1 (3.0%)	359	29 (8.1%)
2018	230	15 (6.5%)	27	2 (7.4%)	257	17 (6.6%)
2019	201	14 (7.0%)	29	1 (3.4%)	230	15 (6.5%)

Box 44. Prevalence of HBV infection per HIV risk at baseline screening of HIV/AIDS patients attending ITC from 2000 to 2019 (Data source: ITC, CHP, DH)



HIV risk	No. tested	HBsAg +ve (%)	Anti-HBs +ve (%)
Heterosexual male	862	100 (11.6%)	401 (46.5%)
Heterosexual female	523	29 (5.5%)	221 (42.3%)
Homo/Bi-sexual	2702	219 (8.1%)	1461 (54.1%)
Drug user	268	41 (15.3%)	128 (47.8%)
Blood/blood product recipient	18	1 (5.6%)	6 (33.3%)
Perinatal	9	0 (0%)	2 (22.2%)
Undetermined	46	4 (8.7%)	23 (50.0%)
Total	4428	394 (8.9%)	2242 (50.6%)

Box 45. Prevalence of hepatitis B markers in drug users from 1990 to 2010 (Data source: PHLSB, CHP, DH)

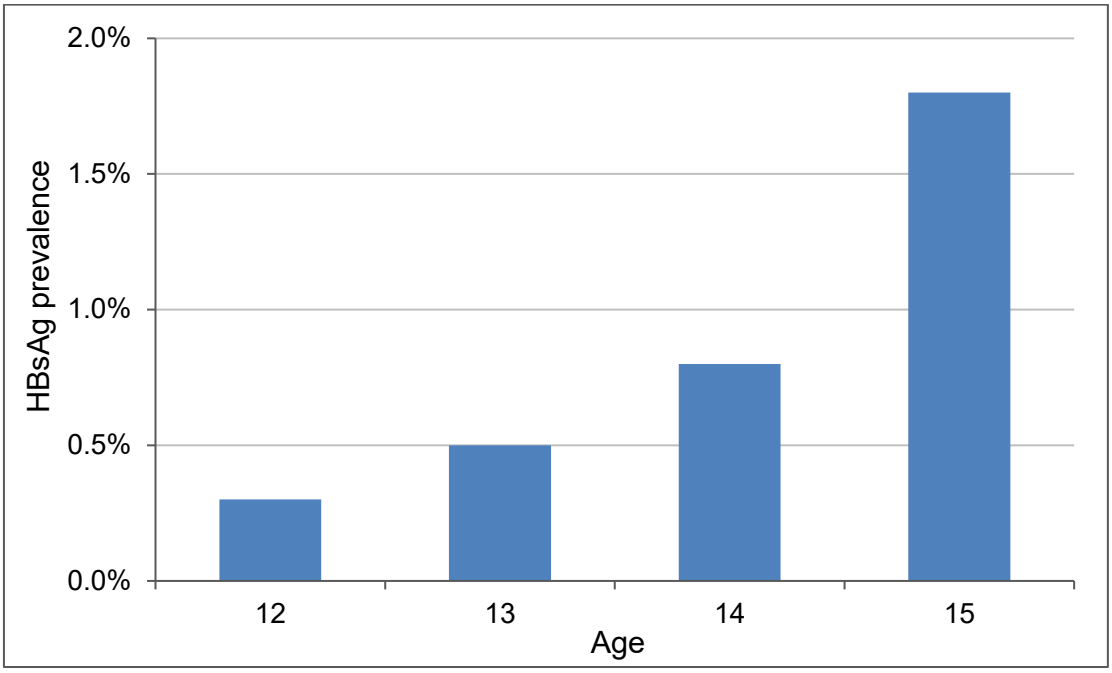
Year	No. tested	HBsAg (%+ve)	Anti-HBs (%+ve)	Anti-HBc* (%+ve)	Any marker (%+ve)
1990	1067	13.4	59.0	15.7	90.8
1991	1517	14.4	54.4	20.5	89.3
1992	832	13.9	49.0	21.4	84.4
1993	744	14.4	43.4	16.4	69.2
1994	607	12.9	38.1	13.5	64.1
1995	190	10.5	36.8	12.1	58.9
1996	358	8.7	43.0	12.6	62.8
1997	290	6.6	36.2	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
2005	26	11.5	46.2	11.5	69.2
2006	6	33.3	50.0	16.7	100.0
2007	11	0.0	81.8	9.1	90.9
2008	7	28.6	28.6	14.3	71.4
2009	11	9.1	72.7	9.1	100.0
2010	12	8.3	58.3	8.3	100.0

**Anti-HBc was not tested in specimens that were HBsAg positive*

Box 46. Prevalence of HBsAg in participants of Community Research Project on Viral Hepatitis in 2001 (Data source: DH)

	Male		Female		Total	
Age Group	No. tested	HBsAg +ve (%)	No. tested	HBsAg +ve (%)	No. tested	HBsAg +ve (%)
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 47. HBsAg prevalence by age among children aged 12 to 15 years in 2009 (Data source: unpublished data of DH)



Vaccination coverage of hepatitis B

Box 48. Hepatitis B immunisation coverage rates among children aged 2 to 5 by year of birth (Data source: ref 47 - 53 & unpublished DH data)

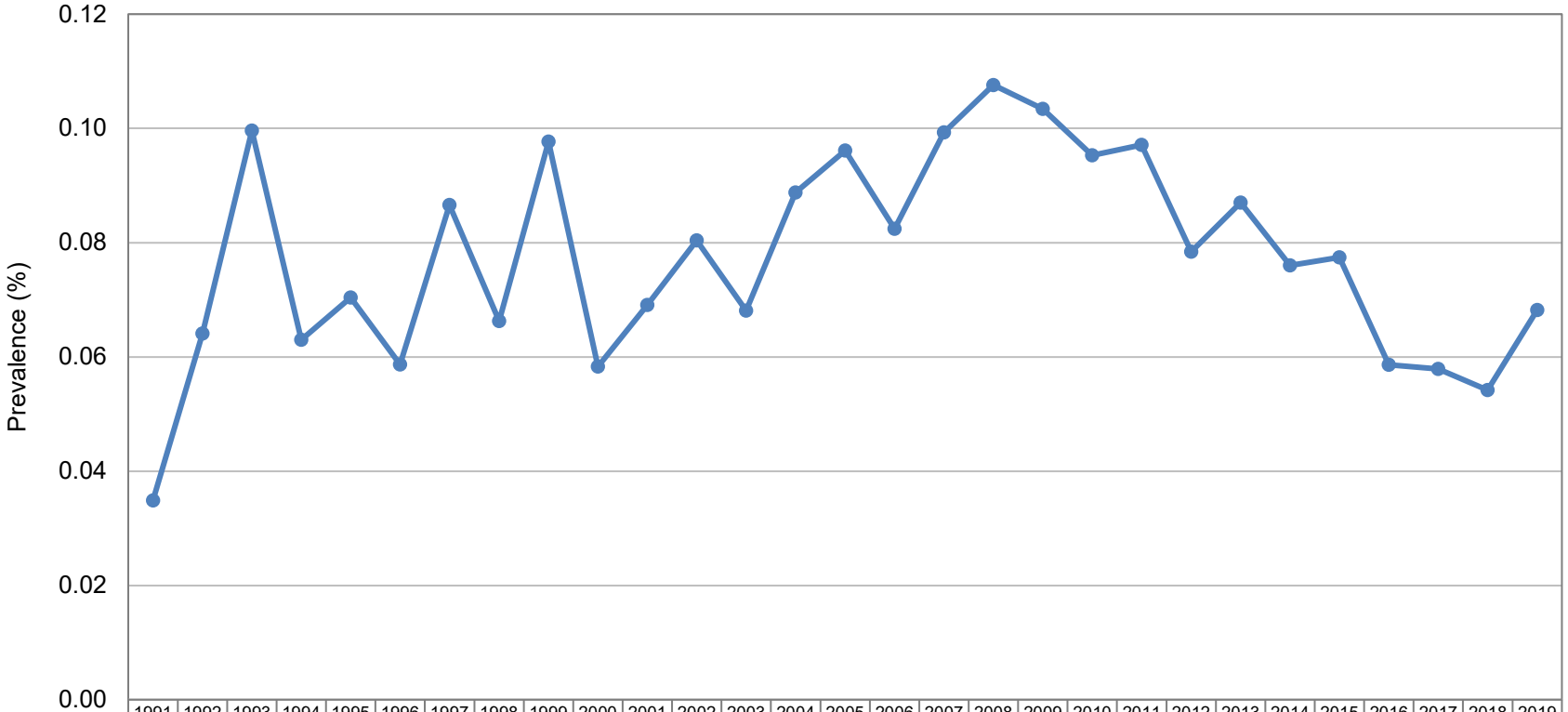
Year of Survey	Year of Birth	First dose (%)	Second dose (%)	Third dose (%)
2001	1995	99.5	99.5	99.1
	1996	99.1	99.0	98.6
2003	1997	99.5	99.3	99.1
	1998	99.9	99.9	99.6
	1999	100	100	99.7
2006	2000	99.9	99.8	99.6
	2001	99.9	99.9	99.6
	2002	99.9	99.8	99.5
2009	2003	99.9	99.8	99.5
	2004	99.9	99.9	99.8
	2005	99.7	99.7	99.5
	2006	100	100	99.7
2012	2006	99.6	99.5	99.0
	2007	99.8	99.8	99.3
	2008	99.8	99.8	99.3
	2009	100	100	98.8
2015	2009	99.7	99.6	99.2
	2010	99.6	99.6	99.2
	2011	99.6	99.5	99.2
	2012	100	100	99.2
2018	2012	100	100	99.8
	2013	100	99.9	99.5
	2014	99.9	99.8	99.7

Box 49. Cumulative statistics of the supplementary hepatitis B vaccination programme for Primary 6 students from the school years 2001 to 2019 (Data source: DH)

	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019
Cumulative no. of Primary 6 students	86052	86515	86208	83974	83164	81818	77273	73757	67310	63332	63394	57487	54845	52013	51009	52848	55660	59481
First Dose																		
Cumulative no. eligible for vaccination	15479	14245	10625	8433	6648	6351	6204	5165	4698	3736	2509	2376	1992	1797	982	710	483	407
Cumulative no. administered	15333	14084	10519	8313	6591	6262	6095	5043	4520	3563	2318	2237	1810	1606	729	588	346	218
Acceptance rate (at the present campaign)	99.1%	98.9%	99.0%	98.6%	99.1%	98.6%	98.2%	97.6%	96.2%	95.4%	92.4%	94.1%	90.9%	89.4%	74.2%	82.8%	71.6%	53.6%
Coverage rate (for the whole Primary 6 population)	99.8%	99.8%	99.9%	99.8%	99.9%	99.9%	99.9%	99.8%	99.7%	99.7%	99.7%	99.8%	99.7%	99.6%	98.4%	98.6%	98.5%	98.5%
Second Dose																		
Cumulative no. eligible for vaccination	15485	14250	10626	8545	6710	6392	6243	5165	4698	3787	2573	2432	2033	1825	1025	753	540	443
Cumulative no. administered	15206	13800	10341	8185	6573	6278	6068	4969	4398	3516	2286	2203	1718	1578	675	589	384	224
Acceptance rate (at the present campaign)	98.2%	96.8%	97.3%	95.8%	98.0%	98.2%	97.2%	96.2%	93.6%	92.8%	88.8%	90.6%	84.5%	86.5%	65.9%	78.2%	71.1%	50.6%
Coverage rate (for the whole Primary 6 population)	99.7%	99.5%	99.7%	99.6%	99.8%	99.8%	99.8%	99.7%	99.5%	99.6%	99.5%	99.6%	99.4%	99.5%	98.2%	98.6%	98.5%	98.5%
Third Dose																		
Cumulative no. eligible for vaccination	16119	14918	11222	9300	7397	6986	6741	5575	5032	4104	2825	2692	2283	2096	1307	1071	965	938
Cumulative no. administered	14947	13999	10069	8478	6965	6607	6273	4817	4409	3526	2344	2232	1777	1708	835	839	734	579
Acceptance rate (at the present campaign)	92.7%	93.8%	89.7%	91.2%	94.2%	94.6%	93.1%	86.4%	87.6%	85.9%	83.0%	82.9%	77.8%	81.5%	63.9%	78.3%	76.1%	61.7%
Coverage rate (for the whole Primary 6 population)	98.6%	98.9%	98.7%	99.0%	99.5%	99.5%	99.4%	99.0%	99.1%	99.1%	99.2%	99.2%	99.1%	99.3%	97.9%	98.4%	98.3%	98.2%

Seroprevalence of hepatitis C

Box 50. Anti-HCV prevalence in new blood donors from 1991 to 2019 (Data source: HKRCBTS)



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
% Anti-HCV +ve	0.03	0.06	0.10	0.06	0.07	0.06	0.09	0.07	0.10	0.06	0.07	0.08	0.07	0.09	0.10	0.08	0.10	0.11	0.10	0.10	0.10	0.08	0.09	0.08	0.08	0.06	0.06	0.05	0.07

Box 51. Anti-HCV prevalence and its sex and age breakdown in new blood donors in 2019 (Data source: HKRCBTS)

	Male		Female		Total	
Age Group	No. tested	Anti-HCV +ve (%)	No. tested	Anti-HCV +ve (%)	No. tested	Anti-HCV +ve (%)
16-19	5137	1 (0.02%)	7044	1 (0.01%)	12181	2 (0.02%)
20-29	3476	4 (0.12%)	4060	1 (0.02%)	7536	5 (0.07%)
30-39	1815	2 (0.11%)	2615	1 (0.04%)	4430	3 (0.07%)
40-49	1075	4 (0.37%)	2091	3 (0.14%)	3166	7 (0.22%)
>49	695	1 (0.14%)	1324	2 (0.15%)	2019	3 (0.15%)
Total	12198	12 (0.10%)	17134	8 (0.05%)	29332	20 (0.07%)

Box 52. Prevalence of anti-HCV in participants of Community Research Project on Viral Hepatitis in 2001 (Data source: DH)

Age group	No. Tested	Anti-HCV +ve (%)
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%)

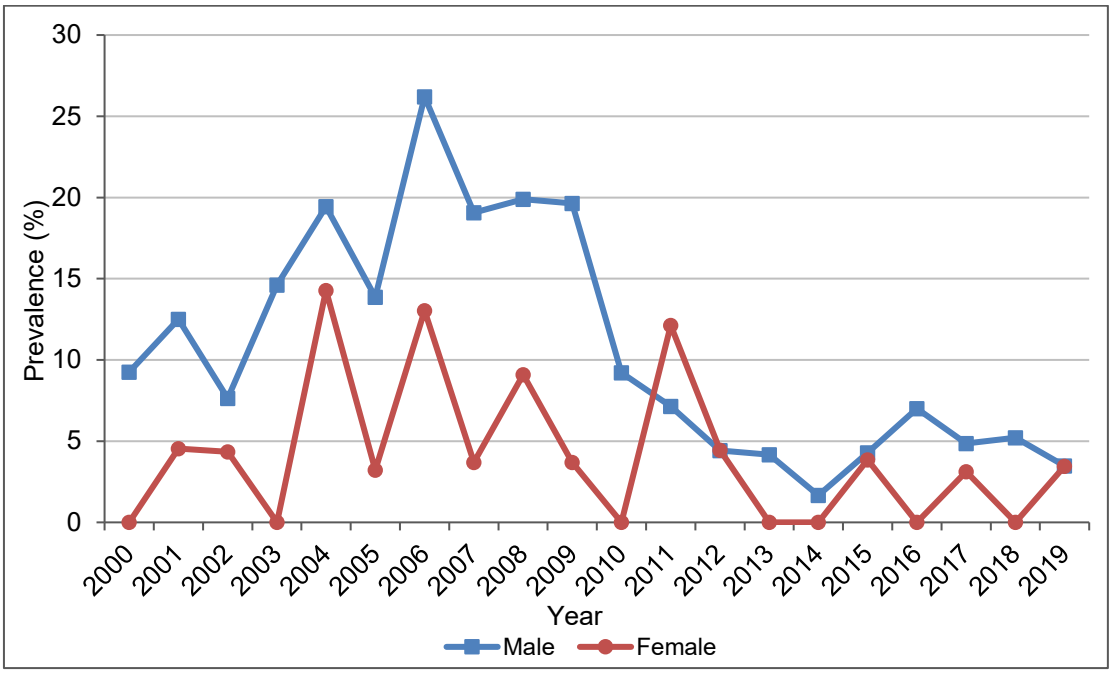
Box 53. Prevalence of anti-HCV in drug users on rehabilitation (Data source: PHLSB, CHP, DH)

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

Box 54. Prevalence of anti-HCV in persons attending Therapeutic Prevention Clinic of ITC for post-exposure management, from July 1999 to 2018 (Data source: ITC, CHP, DH)

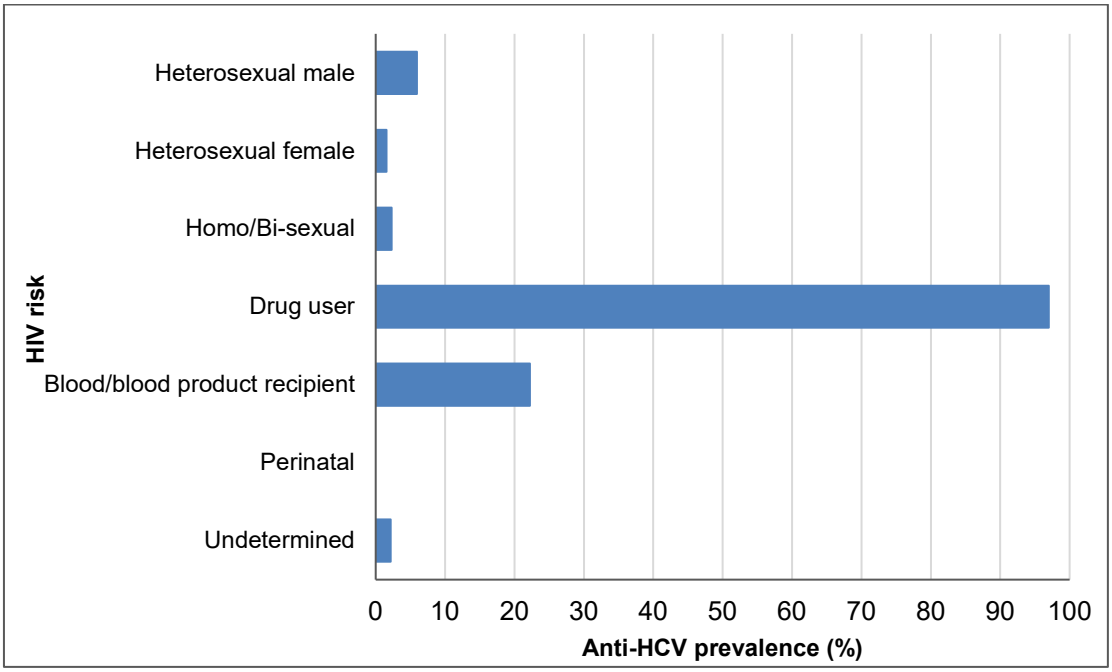
	Health care workers		Non- Health care workers		Total	
Year	No. tested	Anti-HCV +ve (%)	No. tested	Anti-HCV +ve (%)	No. tested	Anti-HCV +ve (%)
Jul-Dec 1999	2	0 (0.0%)	3	0 (0.0%)	5	0 (0.0%)
2000	15	0 (0.0%)	20	1 (5.0%)	35	1 (2.9%)
2001	22	0 (0.0%)	50	1 (2.0%)	72	1 (1.4%)
2002	27	0 (0.0%)	50	1 (2.0%)	77	1 (1.3%)
2003	18	0 (0.0%)	43	0 (0.0%)	61	0 (0.0%)
2004	17	0 (0.0%)	40	0 (0.0%)	57	0 (0.0%)
2005	10	0 (0.0%)	57	0 (0.0%)	67	0 (0.0%)
2006	33	0 (0.0%)	139	0 (0.0%)	172	0 (0.0%)
2007	36	0 (0.0%)	118	0 (0.0%)	154	0 (0.0%)
2008	23	0 (0.0%)	126	3 (2.4%)	149	3 (2.0%)
2009	25	0 (0.0%)	161	1 (0.6%)	186	1 (0.5%)
2010	25	0 (0.0%)	131	0 (0.0%)	156	0 (0.0%)
2011	17	0 (0.0%)	145	0 (0.0%)	162	0 (0.0%)
2012	37	0 (0.0%)	154	0 (0.0%)	191	0 (0.0%)
2013	26	0 (0.0%)	162	1 (0.6%)	188	1 (0.5%)
2014	29	0 (0.0%)	157	0 (0.0%)	186	0 (0.0%)
2015	34	0 (0.0%)	150	0 (0.0%)	184	0 (0.0%)
2016	47	1 (2.1%)	145	1 (0.7%)	192	2 (1.0%)
2017	38	0 (0.0%)	165	0 (0.0%)	203	0 (0.0%)
2018	41	0 (0.0%)	172	0 (0.0%)	213	0 (0.0%)
Total	522	1 (0.2%)	2188	9 (0.4%)	2710	10 (0.4%)

Box 55. Prevalence of anti-HCV at baseline screening of HIV/AIDS patients attending ITC from 2000 to 2019 (Data source: ITC, CHP, DH)



	Male		Female		Total	
Year	No. tested	Anti-HCV +ve (%)	No. tested	Anti-HCV +ve (%)	No. tested	Anti-HCV +ve (%)
2000	54	5 (9.3%)	15	0 (0.0%)	69	5 (7.2%)
2001	72	9 (12.5%)	22	1 (4.5%)	94	10 (10.6%)
2002	118	9 (7.6%)	23	1 (4.3%)	141	10 (7.1%)
2003	89	13 (14.6%)	14	0 (0.0%)	103	13 (12.6%)
2004	108	21 (19.4%)	21	3 (14.3%)	129	24 (18.6%)
2005	137	19 (13.9%)	31	1 (3.2%)	168	20 (11.9%)
2006	187	49 (26.2%)	23	3 (13.0%)	210	52 (24.8%)
2007	215	41 (19.1%)	27	1 (3.7%)	242	42 (17.4%)
2008	201	40 (19.9%)	33	3 (9.1%)	234	43 (18.4%)
2009	168	33 (19.6%)	27	1 (3.7%)	195	34 (17.4%)
2010	163	15 (9.2%)	33	0 (0.0%)	196	15 (7.7%)
2011	168	12 (7.1%)	33	4 (12.1%)	201	16 (8.0%)
2012	226	10 (4.4%)	45	2 (4.4%)	271	12 (4.4%)
2013	264	11 (4.2%)	40	0 (0.0%)	304	11 (3.6%)
2014	301	5 (1.7%)	31	0 (0.0%)	332	5 (1.5%)
2015	327	14 (4.3%)	26	1 (3.8%)	353	15 (4.2%)
2016	300	21 (7.0%)	25	0 (0.0%)	325	21 (6.5%)
2017	330	16 (4.8%)	32	1 (3.1%)	362	17 (4.7%)
2018	230	12 (5.2%)	27	0 (0.0%)	257	12 (4.7%)
2019	201	7 (3.5%)	29	1 (3.4%)	230	8 (3.5%)

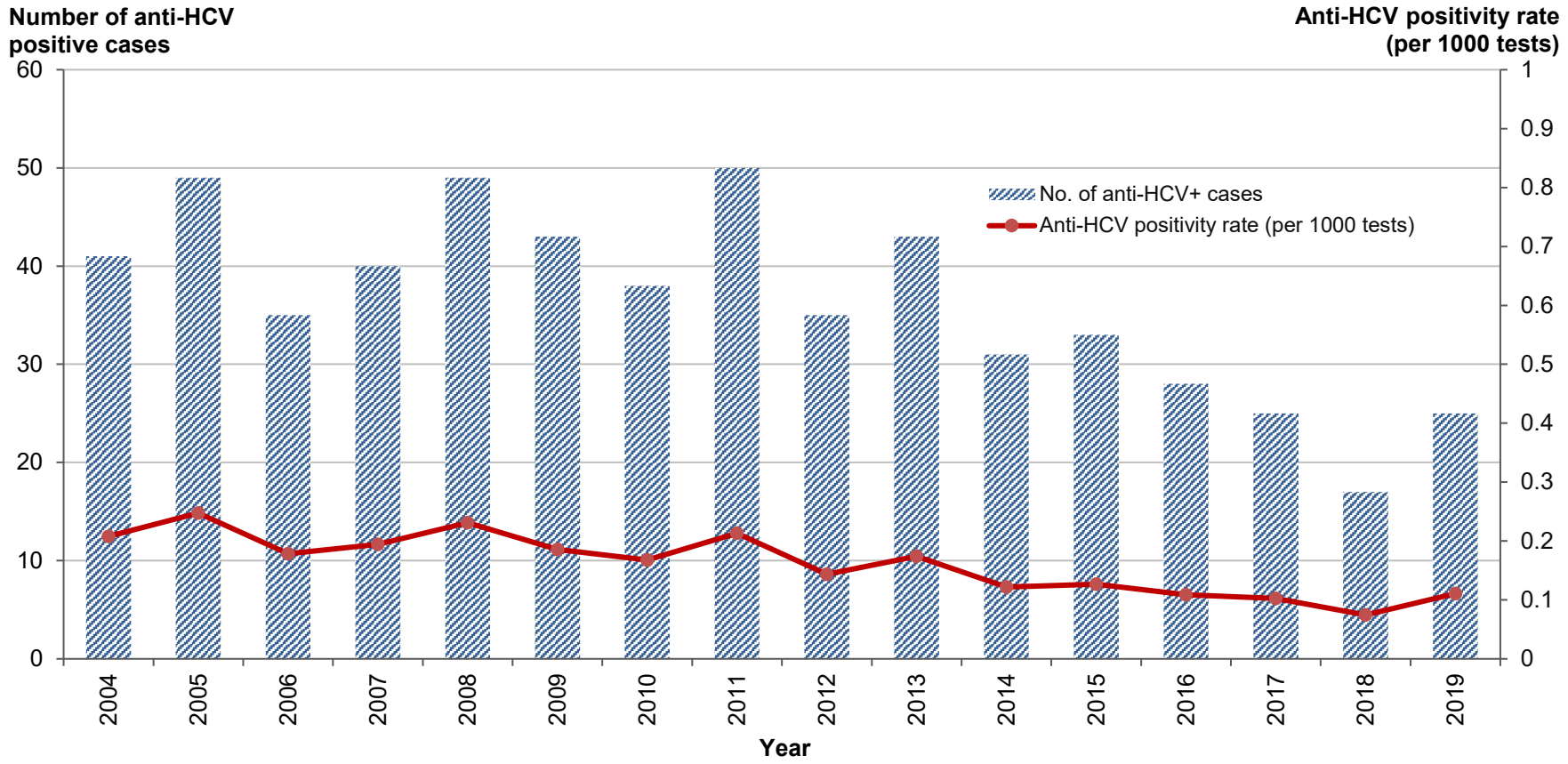
Box 56. Prevalence of anti-HCV per HIV risk at baseline screening of HIV/AIDS patients attending ITC from 2000 to 2019 (Data source: ITC, CHP, DH)



HIV risk	No. tested	Anti-HCV +ve (%)
Heterosexual male	857	51* (6.0%)
Heterosexual female	519	8 (1.5%)
Homo/Bi-sexual	2700	62 (2.3%)
Drug user	267	259 (97.0%)
Blood/blood product recipient	18	4 (22.2%)
Perinatal	9	0 (0.0%)
Undetermined	46	1 (2.2%)
Total	4416	385 (8.7%)

**30 out of 51 had a history of injecting drug use*

Box 57. Prevalence of anti-HCV from screening of blood donors from 2004 to 2019 (Data source: HKRCBTS)



Box 58. Prevalence of anti-HCV from clinical testing of patients in 2 hospital clusters under Hospital Authority from 2009 to 2019 (Data source: PMH Microbiology Laboratory and PWH Microbiology Laboratory)

	2009		2010		2011		2012		2013		2014		2015		2016		2017		2018		2019		Overall	
Category	No. tested	Anti-HCV +ve (%)	No. tested	Anti-HCV +ve (%)	No. tested	Anti-HCV +ve (%)	No. tested	Anti-HCV +ve (%)	No. tested	Anti-HCV +ve (%)	No. tested	Anti-HCV +ve (%)	No. tested	Anti-HCV +ve (%)	No. tested	Anti-HCV +ve (%)	No. tested	Anti-HCV +ve (%)	No. tested	Anti-HCV +ve (%)	No. tested	Anti-HCV +ve (%)	No. tested	Anti-HCV +ve (%)
1. SCREENING																								
Pre-transplant	48	1 (2.1%)	68	2 (2.9%)	80	0 (0.0%)	96	0 (0.0%)	82	0 (0.0%)	111	1 (0.9%)	118	0 (0.0%)	108	0 (0.0%)	128	0 (0.0%)	90	0 (0.0%)	75	1 (1.3%)	1004	5 (0.5%)
Drug users	154	93 (60.4%)	116	75 (64.7%)	84	61 (72.6%)	103	53 (51.5%)	112	63 (56.3%)	114	66 (57.9%)	124	51 (41.1%)	81	41 (50.6%)	87	38 (43.7%)	103	40 (38.8%)	90	35 (38.9%)	1168	616 (52.7%)
Needlestick injuries	574	5 (0.9%)	550	5 (0.9%)	559	4 (0.7%)	592	6 (1.0%)	610	4 (0.7%)	537	6 (1.1%)	494	3 (0.6%)	516	5 (1.0%)	667	9 (1.3%)	614	2 (0.3%)	678	7 (1.0%)	6391	56 (0.9%)
Haemodialysis/ peritoneal dialysis	1936	34 (1.8%)	2016	36 (1.8%)	2251	34 (1.5%)	2452	34 (1.4%)	2449	37 (1.5%)	2569	34 (1.3%)	2535	48 (1.9%)	2613	34 (1.3%)	3557	60 (1.7%)	3021	44 (1.5%)	2713	33 (1.2%)	28112	428 (1.5%)
Post-renal transplant	650	19 (2.9%)	680	25 (3.7%)	722	18 (2.5%)	737	17 (2.3%)	718	16 (2.2%)	692	15 (2.2%)	863	18 (2.1%)	541	6 (1.1%)	708	9 (1.3%)	611	6 (1.0%)	636	5 (0.8%)	7558	154 (2.0%)
Haematology (pre-chemotherapy)	262	2 (0.8%)	344	6 (1.7%)	399	1 (0.3%)	415	4 (1.0%)	444	2 (0.5%)	472	2 (0.4%)	489	4 (0.8%)	533	2 (0.4%)	687	6 (0.9%)	622	2 (0.3%)	615	2 (0.3%)	5282	33 (0.6%)
Rheumatology (pre-methotrexate)	396	5 (1.3%)	430	1 (0.2%)	464	2 (0.4%)	449	2 (0.4%)	471	4 (0.8%)	580	3 (0.5%)	689	5 (0.7%)	730	5 (0.7%)	1285	3 (0.2%)	1310	8 (0.6%)	1501	6 (0.4%)	8305	44 (0.5%)
History of blood transfusion	263	32 (12.2%)	239	21 (8.8%)	168	19 (11.3%)	197	17 (8.6%)	275	28 (10.2%)	224	22 (9.8%)	222	15 (6.8%)	166	14 (8.4%)	292	16 (5.5%)	222	18 (8.1%)	211	18 (8.5%)	2479	220 (8.9%)
Pre-vaccination	5	0 (0.0%)	0	0 (0.0%)	0	0 (0.0%)	0	0 (0.0%)	0	0 (0.0%)	0	0 (0.0%)	0	0 (0.0%)	0	0 (0.0%)	0	0 (0.0%)	0	0 (0.0%)	0	0 (0.0%)	5	0 (0.0%)
TOTAL (1)	4288	191 (4.5%)	4443	171 (3.8%)	4727	139 (2.9%)	5041	133 (2.6%)	5161	154 (3.0%)	5299	149 (2.8%)	5534	144 (2.6%)	5288	107 (2.0%)	7411	141 (1.9%)	6593	120 (1.8%)	6519	107 (1.6%)	60304	1556 (2.6%)
2. *CLINICAL INDICATION	7971	216 (2.7%)	8661	262 (3.0%)	8196	293 (3.6%)	9815	308 (3.1%)	10911	323 (3.0%)	11229	316 (2.8%)	12360	351 (2.8%)	15472	383 (2.5%)	15889	329 (2.1%)	15208	338 (2.2%)	16028	302 (1.9%)	131740	3421 (2.6%)
3. OTHERS OR UNKNOWN	7472	131 (1.8%)	8269	102 (1.2%)	8835	132 (1.5%)	9026	131 (1.5%)	9615	136 (1.4%)	11213	150 (1.3%)	10836	107 (1.0%)	10701	125 (1.2%)	15527	171 (1.1%)	18844	179 (0.9%)	19100	182 (1.0%)	129438	1546 (1.2%)
TOTAL (1+2+3)	19731	538 (2.7%)	21373	535 (2.5%)	21758	564 (2.6%)	23882	572 (2.4%)	25687	613 (2.4%)	27741	615 (2.2%)	28730	602 (2.1%)	31461	615 (2.0%)	38827	641 (1.7%)	40645	637 (1.6%)	41647	591 (1.4%)	321482	6523 (2.0%)

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

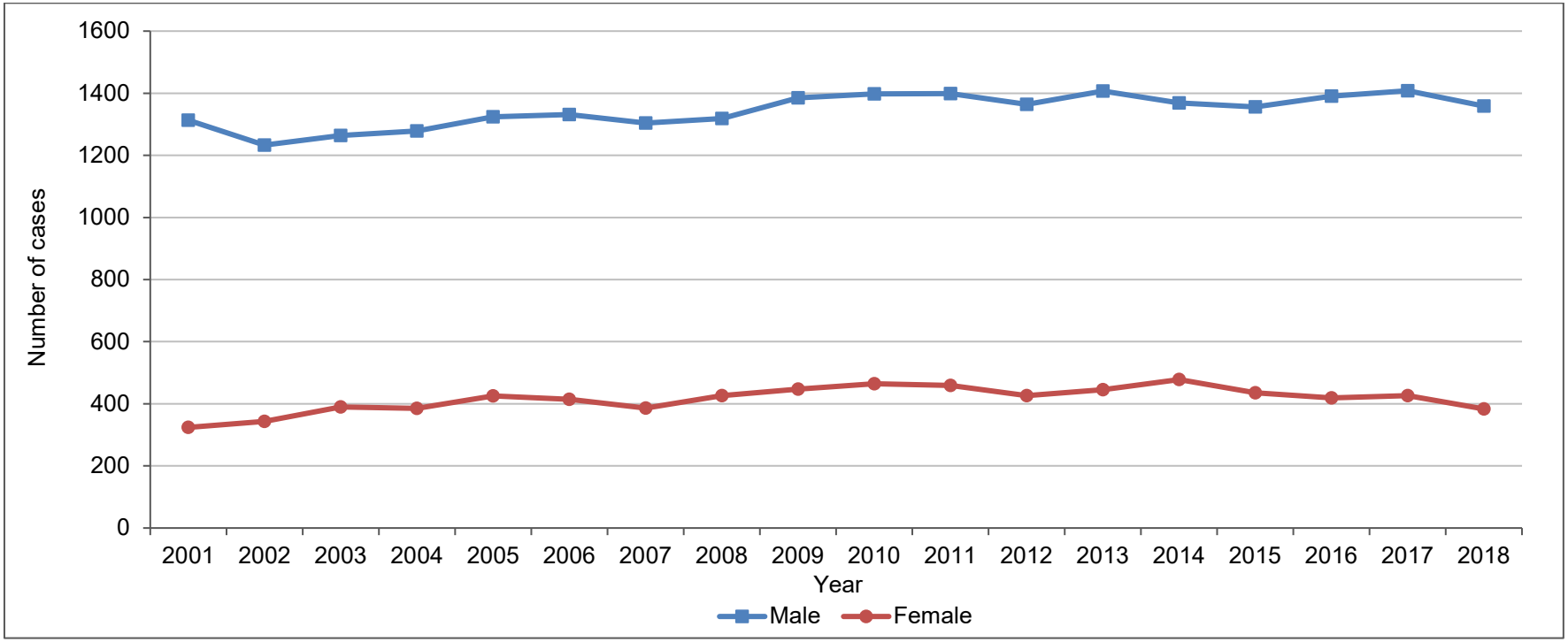
Box 59. Characteristics of anti-HCV positive subjects detected at HKRCBTS and 2 hospital clusters under Hospital Authority from 2006 to 2019 (Data source: HKRCBTS, PMH Microbiology Laboratory, PWH Microbiology Laboratory)

		2006 (n=542)	2007 (n=555)	2008 (n=543)	2009 (n=585)	2010 (n=575)	2011 (n=615)	2012 (n=609)	2013 (n=659)	2014 (n=646)	2015 (n=635)	2016 (n=643)	2017 (n=666)	2018 (n=655)	2019 (n=617)	Overall (n=8545)
		No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
Lab	HKRCBTS	35 (6.5%)	40 (7.2%)	49 (9.0%)	43 (7.4%)	38 (6.6%)	50 (6.6%)	35 (5.7%)	43 (6.5%)	31 (4.8%)	33 (5.2%)	28 (4.4%)	25 (3.8%)	17 (2.6%)	25 (4.1%)	492 (5.8%)
	PMH	142 (26.2%)	89 (16.0%)	208 (38.3%)	273 (46.7%)	271 (47.1%)	280 (47.1%)	298 (48.9%)	279 (42.3%)	297 (46.0%)	354 (55.7%)	372 (57.9%)	340 (51.1%)	363 (55.4%)	312 (50.6%)	3878 (45.4%)
	PWH	365 (67.3%)	426 (76.8%)	286 (52.7%)	269 (46.0%)	266 (46.3%)	285 (46.3%)	276 (45.3%)	337 (51.1%)	318 (49.2%)	248 (39.1%)	243 (37.8%)	301 (45.2%)	275 (42.0%)	280 (45.4%)	4175 (48.9%)
Sex	Male	390 (72.0%)	377 (67.9%)	378 (69.6%)	415 (70.9%)	405 (70.4%)	434 (70.4%)	438 (71.9%)	464 (70.4%)	440 (68.1%)	434 (68.3%)	453 (70.5%)	454 (68.2%)	471 (71.9%)	434 (70.3%)	5987 (70.1%)
	Female	152 (28.0%)	178 (32.1%)	165 (30.4%)	170 (29.1%)	170 (29.6%)	181 (29.6%)	171 (28.1%)	195 (29.6%)	206 (31.9%)	201 (31.7%)	190 (29.5%)	211 (31.7%)	183 (27.9%)	183 (29.7%)	2556 (29.9%)
	Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.2%)	1 (0.2%)	0 (0.0%)	2 (<0.1%)
Age at diagnosis	Mean	47.4	50.3	49.8	52.9	51.2	50.8	51.1	51.0	52.0	54.0	54.6	55.7	55.6	55.7	52.4
	S.D.	16.6	16.3	17.9	16.9	17	16.5	16.3	16.6	16.2	15.5	15.5	15.1	15.4	14.9	16.5
	Range	0 – 101	0 – 94	0 – 88	1 – 102	0 – 90	0 – 90	0 – 99	0 – 113	0 – 95	1 – 95	0 – 97	0 – 94	0 – 99	0 – 96	0 – 113
Category	Blood donation	35 (6.5%)	42 (7.6%)	52 (9.6%)	47 (8.0%)	40 (7.0%)	51 (8.3%)	37 (6.1%)	46 (7.0%)	31 (4.8%)	33 (5.2%)	28 (4.4%)	25 (3.8%)	18 (2.7%)	26 (4.2%)	511 (6.0%)
	Pre-transplant	0 (0.0%)	1 (0.2%)	0 (0.0%)	1 (0.2%)	2 (0.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.2%)	6 (0.1%)
	Drug users	59 (10.9%)	29 (5.2%)	66 (12.2%)	93 (15.9%)	75 (13.0%)	61 (9.9%)	53 (8.7%)	63 (9.6%)	66 (10.2%)	51 (8.0%)	41 (6.4%)	38 (5.7%)	40 (6.1%)	35 (5.7%)	770 (9.0%)
	Needlestick injuries	7 (1.3%)	6 (1.1%)	6 (1.1%)	5 (0.9%)	5 (0.9%)	4 (0.7%)	6 (1.0%)	4 (0.6%)	6 (0.9%)	3 (0.5%)	5 (0.8%)	9 (1.4%)	2 (0.3%)	7 (1.1%)	75 (0.9%)
	Pre-haemodialysis/ peritoneal dialysis	35 (6.5%)	37 (6.7%)	31 (5.7%)	34 (5.8%)	36 (6.3%)	34 (5.5%)	34 (5.6%)	37 (5.6%)	34 (5.3%)	48 (7.6%)	34 (5.3%)	60 (9.0%)	44 (6.7%)	33 (5.3%)	531 (6.2%)
	Post-renal transplant	18 (3.3%)	19 (3.4%)	21 (3.9%)	19 (3.2%)	25 (4.3%)	18 (2.9%)	17 (2.8%)	16 (2.4%)	15 (2.3%)	18 (2.8%)	6 (0.9%)	9 (1.4%)	6 (0.9%)	5 (0.8%)	212 (2.5%)
	Haematology	1 (0.2%)	0 (0.0%)	5 (0.9%)	2 (0.3%)	6 (1.0%)	1 (0.2%)	4 (0.7%)	2 (0.3%)	2 (0.3%)	4 (0.6%)	2 (0.3%)	6 (0.9%)	2 (0.3%)	2 (0.3%)	39 (0.5%)
	Pre-methotrexate	1 (0.2%)	1 (0.2%)	1 (0.2%)	5 (0.9%)	1 (0.2%)	2 (0.3%)	2 (0.3%)	4 (0.6%)	3 (0.5%)	5 (0.8%)	5 (0.8%)	3 (0.5%)	8 (1.2%)	6 (1.0%)	47 (0.6%)
	History of blood transfusion	11 (2.0%)	12 (2.2%)	18 (3.3%)	32 (5.5%)	21 (3.7%)	19 (3.1%)	17 (2.8%)	28 (4.2%)	22 (3.4%)	15 (2.4%)	14 (2.2%)	16 (2.4%)	18 (2.7%)	18 (2.9%)	261 (3.1%)
	Clinical Indication	170 (31.4%)	179 (32.3%)	215 (39.6%)	216 (36.9%)	262 (45.6%)	293 (47.6%)	308 (50.6%)	323 (49.0%)	316 (48.9%)	351 (55.3%)	383 (59.6%)	329 (49.4%)	338 (51.6%)	302 (48.9%)	3985 (46.6%)
	Others or unknown	205 (37.8%)	229 (41.3%)	128 (23.6%)	131 (22.4%)	102 (17.7%)	132 (21.5%)	131 (21.5%)	136 (20.6%)	150 (23.2%)	107 (16.9%)	125 (19.4%)	171 (25.7%)	179 (27.3%)	182 (29.5%)	2108 (24.7%)

Liver cancers

(Data source: Hong Kong Cancer Registry, Hospital Authority)

Box 60. Hong Kong liver cancer statistics, number of new cases by gender from 2001 – 2018 (Data source: Hong Kong Cancer Registry, Hospital Authority)



Year	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Female	324	343	390	385	425	414	386	426	447	465	459	426	445	478	435	419	426	383
Male	1313	1233	1264	1278	1324	1331	1304	1319	1385	1398	1399	1364	1407	1369	1356	1391	1408	1359
Total	1637	1576	1654	1663	1749	1745	1690	1745	1832	1863	1858	1790	1852	1847	1791	1810	1834	1742

Box 61. Hong Kong liver cancer statistics, number of new cases and incidence rate by age and gender, from 2001 – 2018 (Data source: Hong Kong Cancer Registry, Hospital Authority)

	0-19						20-44						45-64						65+						Crude rate			ASR		
	Male		Female		Total		Male		Female		Total		Male		Female		Total		Male		Female		Total		Male	Female	Total	Male	Female	Total
Year	N	I	N	I	N	I	N	I	N	I	N	I	N	I	N	I	N	I	N	I	N	I	N	I	CR	CR	CR	ASR	ASR	ASR
2001	4	0.5	1	0.1	5	0.3	130	9.5	26	1.7	156	5.3	590	76.9	86	12.1	676	45.7	589	169.3	211	52.0	800	106.2	40.0	9.4	24.4	32.8	7.4	20.1
2002	4	0.5	2	0.3	6	0.4	130	9.7	17	1.1	147	5.1	534	67.1	79	10.5	613	39.5	565	157.6	245	58.5	810	104.2	37.6	9.9	23.4	30.0	7.4	18.6
2003	6	0.8	2	0.3	8	0.5	110	8.4	25	1.6	135	4.7	581	70.5	100	12.6	681	42.1	567	154.5	263	61.4	830	104.4	38.8	11.2	24.6	30.3	8.2	19.1
2004	2	0.3	1	0.1	3	0.2	121	9.4	18	1.2	139	4.9	554	64.6	91	10.9	645	38.1	601	159.2	275	62.3	876	107.0	39.1	10.9	24.5	29.6	7.8	18.5
2005	2	0.3	0	0.0	2	0.1	110	8.7	21	1.4	131	4.7	605	67.5	110	12.4	715	40.1	607	157.8	294	65.3	901	107.9	40.6	12.0	25.7	29.9	8.3	18.9
2006	6	0.8	1	0.1	7	0.5	88	7.1	21	1.4	109	3.9	637	68.5	109	11.8	746	40.2	600	152.6	283	61.7	883	103.6	40.7	11.5	25.4	29.3	8.0	18.4
2007	2	0.3	1	0.2	3	0.2	83	6.8	13	0.8	96	3.5	621	64.7	95	9.8	716	37.1	598	148.3	277	59.1	875	100.3	39.7	10.6	24.4	27.9	7.1	17.2
2008	1	0.1	1	0.2	2	0.1	90	7.5	24	1.6	114	4.2	636	64.0	135	13.2	771	38.3	592	144.6	266	56.2	858	97.2	40.1	11.6	25.1	27.4	7.6	17.2
2009	2	0.3	2	0.3	4	0.3	87	7.4	20	1.3	107	4.0	695	68.0	131	12.3	826	39.6	601	143.8	294	61.1	895	99.6	42.2	12.1	26.3	27.9	7.7	17.5
2010	0	0.0	4	0.7	4	0.3	78	6.7	23	1.5	101	3.8	711	67.9	140	12.6	851	39.5	609	142.4	298	60.7	907	98.7	42.4	12.5	26.5	27.2	8.1	17.3
2011	6	0.9	3	0.5	9	0.7	85	7.4	22	1.5	107	4.0	694	65.0	122	10.7	816	36.9	614	140.1	312	62.0	926	98.4	42.4	12.2	26.3	26.8	7.5	16.8
2012	2	0.3	1	0.2	3	0.2	69	6.0	25	1.6	94	3.5	654	60.6	108	9.2	762	33.9	639	140.1	292	55.7	931	95.0	41.0	11.1	25.0	25.1	6.6	15.5
2013	6	1.0	2	0.3	8	0.7	64	5.6	19	1.2	83	3.1	698	64.3	126	10.6	824	36.2	639	134.5	298	54.7	937	91.9	42.3	11.6	25.8	25.4	6.9	15.8
2014	3	0.5	1	0.2	4	0.3	69	6.0	17	1.1	86	3.2	644	59.2	130	10.8	774	33.7	653	131.7	330	58.1	983	92.4	40.9	12.3	25.5	23.9	6.9	15.0
2015	1	0.2	2	0.3	3	0.3	51	4.4	14	0.9	65	2.4	621	57.2	107	8.7	728	31.5	683	131.3	312	52.5	995	89.3	40.3	11.1	24.6	22.7	6.2	14.1
2016	1	0.2	2	0.4	3	0.3	64	5.6	9	0.6	73	2.7	679	62.6	118	9.5	797	34.2	647	119.2	290	46.8	937	80.6	41.2	10.6	24.7	23.0	5.7	13.9
2017	3	0.5	3	0.5	6	0.5	71	6.2	17	1.1	88	3.3	618	57.0	111	8.8	729	31.1	716	126.3	295	45.5	1,011	83.2	41.5	10.7	24.8	22.9	5.6	13.7
2018	1	0.2	2	0.4	3	0.3	48	4.2	15	1.0	63	2.4	587	54.0	91	7.1	678	28.6	723	122.5	275	40.7	998	78.8	39.8	9.5	23.4	21.1	5.0	12.6
Average	3	0.4	2	0.3	5	0.4	86	7.1	19	1.3	105	3.8	631	64.0	111	10.6	742	36.5	625	141.0	284	55.6	909	95.3	40.6	11.2	25.0	26.5	7.0	16.4

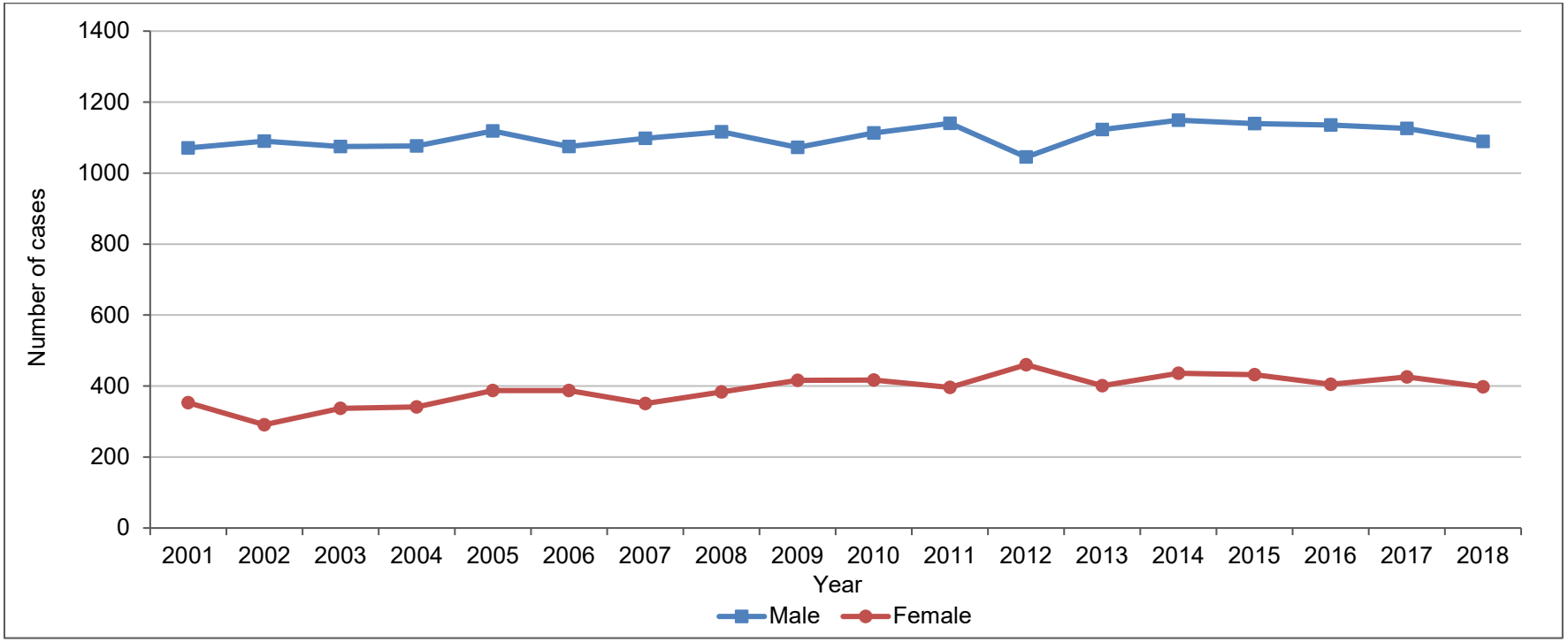
Notes:

I: Incidence rate per 100,000 population *N: Number of new cases by selected age groups*

ASR: Age-standardised rate (per 100,000 population) is calculated based on the reference standard population used

CR: Crude rate per 100,000 population

Box 62. Hong Kong liver cancer mortality statistics by gender from 2001 – 2018 (Data source: Hong Kong Cancer Registry, Hospital Authority)



Year	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Female	353	291	337	341	387	387	351	383	416	417	396	460	401	436	432	405	426	398
Male	1071	1090	1075	1076	1119	1075	1098	1116	1072	1113	1140	1045	1123	1149	1139	1135	1126	1089
Total	1424	1381	1412	1417	1506	1462	1449	1499	1488	1530	1536	1505	1524	1585	1571	1540	1552	1487

Box 63. Hong Kong liver cancer mortality statistics, by age and gender, from 2001 – 2018 (Data source: Hong Kong Cancer Registry, Hospital Authority)

	0-19						20-44						45-64						65+						Crude rate			ASR		
	Male		Female		Total		Male		Female		Total		Male		Female		Total		Male		Female		Total		Male	Female	Total	Male	Female	Total
Year	N	I	N	I	N	I	N	I	N	I	N	I	N	I	N	I	N	I	N	I	N	I	N	I	CR	CR	CR	ASR	ASR	ASR
2001	3	0.4	2	0.3	5	0.3	101	7.4	16	1.0	117	4.0	434	56.6	74	10.4	508	34.3	533	153.2	261	64.4	794	105.4	32.6	10.3	21.2	26.8	7.8	17.2
2002	3	0.4	1	0.1	4	0.3	98	7.3	15	1.0	113	3.9	425	53.4	51	6.7	476	30.7	564	157.3	224	53.5	788	101.4	33.2	8.4	20.5	26.5	5.9	16.1
2003	2	0.3	0	0.0	2	0.1	80	6.1	15	1.0	95	3.3	436	52.9	69	8.7	505	31.2	557	151.8	253	59.0	810	101.8	33.0	9.7	21.0	25.6	6.8	15.9
2004	2	0.3	0	0.0	2	0.1	66	5.1	15	1.0	81	2.9	428	49.9	69	8.2	497	29.3	580	153.6	257	58.2	837	102.2	32.9	9.7	20.9	24.7	6.6	15.4
2005	0	0.0	1	0.1	1	0.1	93	7.4	17	1.1	110	3.9	432	48.2	75	8.5	507	28.5	594	154.4	294	65.3	888	106.4	34.3	10.9	22.1	24.8	7.2	15.8
2006	2	0.3	0	0.0	2	0.1	49	3.9	12	0.8	61	2.2	420	45.2	64	6.9	484	26.1	604	153.6	311	67.8	915	107.4	32.9	10.8	21.3	23.4	6.8	14.8
2007	3	0.4	0	0.0	3	0.2	57	4.7	7	0.5	64	2.3	470	49.0	62	6.4	532	27.6	568	140.8	282	60.1	850	97.5	33.4	9.7	21.0	23.1	5.9	14.2
2008	1	0.1	0	0.0	1	0.1	68	5.7	17	1.1	85	3.1	480	48.3	82	8.0	562	27.9	567	138.5	284	60.0	851	96.4	33.9	10.4	21.5	22.9	6.3	14.3
2009	2	0.3	0	0.0	2	0.2	43	3.7	10	0.7	53	2.0	442	43.3	95	8.9	537	25.7	585	140.0	311	64.7	896	99.7	32.6	11.3	21.3	21.2	6.7	13.7
2010	0	0.0	0	0.0	0	0.0	35	3.0	15	1.0	50	1.9	474	45.3	89	8.0	563	26.1	604	141.2	313	63.8	917	99.8	33.8	11.2	21.8	21.2	6.5	13.6
2011	1	0.2	1	0.2	2	0.2	52	4.5	8	0.5	60	2.2	462	43.3	72	6.3	534	24.1	625	142.6	315	62.6	940	99.9	34.5	10.5	21.7	21.3	5.9	13.2
2012	0	0.0	1	0.2	1	0.1	50	4.3	10	0.7	60	2.2	431	39.9	95	8.1	526	23.4	564	123.7	354	67.6	918	93.7	31.4	12.0	21.0	18.9	6.5	12.4
2013	3	0.5	1	0.2	4	0.3	38	3.3	13	0.8	51	1.9	437	40.3	82	6.9	519	22.8	645	135.8	305	56.0	950	93.1	33.7	10.4	21.2	19.4	5.6	12.1
2014	2	0.3	0	0.0	2	0.2	48	4.2	11	0.7	59	2.2	469	43.1	71	5.9	540	23.5	629	126.8	354	62.3	983	92.4	34.4	11.2	21.9	19.5	5.7	12.2
2015	1	0.2	1	0.2	2	0.2	37	3.2	6	0.4	43	1.6	427	39.4	76	6.2	503	21.8	674	129.6	349	58.7	1,023	91.8	33.8	11.0	21.5	18.5	5.4	11.6
2016	1	0.2	1	0.2	2	0.2	39	3.4	7	0.5	46	1.7	445	41.1	75	6.0	520	22.3	650	119.7	322	51.9	972	83.6	33.6	10.2	21.0	18.0	4.9	11.0
2017	3	0.5	0	0.0	3	0.3	32	2.8	8	0.5	40	1.5	409	37.7	70	5.6	479	20.4	682	120.3	348	53.7	1,030	84.8	33.2	10.7	21.0	17.3	4.9	10.7
2018	0	0.0	1	0.2	1	0.1	39	3.4	11	0.7	50	1.9	351	32.3	62	4.8	413	17.4	699	118.4	324	47.9	1,023	80.8	31.9	9.8	20.0	16.1	4.5	9.9
Average	2	0.2	<1	0.1	2	0.2	57	4.7	12	0.8	69	2.5	437	44.3	74	7.1	511	25.2	607	137.0	303	59.4	910	95.4	33.3	10.5	21.2	21.3	6.0	13.3

Notes:
I: Mortality rate per 100,000 population *N: Number of death cases by selected age groups*
ASR: Age-standardised rate (per 100,000 population) is calculated based on the reference standard population used
CR: Crude rate per 100,000 population

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
CHP	Centre for Health Protection
CI	Confidence interval
CRPVH	Community Research Project on Viral Hepatitis
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
HCC	Hepatocellular carcinoma
HCV	Hepatitis C virus
HCW	Health care worker
HEV	Hepatitis E virus
HIV	Human immunodeficiency virus
HKRCBTS	Hong Kong Red Cross Blood Transfusion Service
ICS	Immunisation coverage survey
IgG	Immunoglobulin G
IgM	Immunoglobulin M
IDU	Injecting drug users
ITC	Integrated Treatment Centre
MCHC	Maternal and Child Health Centre
MSM	Men who have sex with men
OR	Odds ratio
PHLSB	Public Health Laboratory Services Branch
PMH	Princess Margaret Hospital
PWH	Prince of Wales Hospital
RNA	Ribonucleic acid
SEB	Surveillance and Epidemiology Branch
STI	Sexually transmitted infections
TPC	Therapeutic Prevention Clinic
WHO	World Health Organization
WPRO	Western Pacific Regional Office

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