Apr 20 – May 24 2025 WEEKS 17 – 21 VOL 21 ISSUE N° 5

Communicable Diseases WATCH

衞生防護中心 Centre for Health Protection 衞生署 Department of Health

FEATURE IN FOCUS

Immunisation Coverage of Vaccines under the Hong Kong Childhood Immunisation Programme - Findings of the 2024 Immunisation Survey on Preschool Children

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Introduction

Under the Hong Kong Childhood Immunisation Programme (HKCIP) recommended by the Scientific Committee on Vaccine Preventable Diseases (SCVPD) under the Centre for Health Protection of the Department of Health (DH), the Government provides 12 types of vaccines free-of-charge to eligible children in Hong Kong[1]. Pre-school children (aged 0 to five years) receive different types of vaccines and boosters at recommended ages of vaccination at the DH's Maternal and Child Health Centres (MCHCs). As for primary school children, vaccination is provided at schools by the DH's outreach School Immunisation Teams. The Student Health Service of the DH also provides free mop-up vaccination at Student Health Service Centres for secondary school students.

The DH follows up on cases where children have not been brought to MCHCs for vaccination at the recommended age. This includes contacting parents or caretakers by phone or other means to remind them to arrange timely vaccination for the babies/young children under their care according to the HKCIP.

The HKCIP has been highly effective in keeping the local incidence of relevant communicable diseases at a remarkably low level. Maintaining a high immunisation coverage is essential for the prevention of concerned vaccine-preventable diseases. The DH regularly conducts territory-wide cross-sectional immunisation surveys every three years to estimate the immunisation coverage among young children attending pre-primary institutions (PPI). Between 2001 and 2021, eight rounds of surveys were conducted, covering birth cohorts from 1995 to 2017. In 2024, a new round of immunisation coverage survey, adopting the same methodology as the previous round conducted in 2021[2], was carried out to assess the coverage and timeliness of vaccination for vaccines under the HKCIP among children aged three to five (born between 2018 and 2020) attending PPI in Hong Kong during the survey period. Key findings are presented below.

Survey results

A total of 24 local and international PPI (including kindergartens and kindergartens-cum-childcare centres) were recruited by stratified cluster sampling, covering 2.4% of the 984 PPI with enrolment in the 2023/24 school year. Among the 3 628 children enrolled in these 24 PPI, 2 556 (70.5%) responded to our survey. Excluding 120 (4.7%) ineligible children (not born between 2018 and 2020), 40 (1.6%) without vaccination records, two duplicated returns and two withdrawals, 2 392 (93.6%) of the 2 556 respondents were included in the immunisation coverage analysis. Amongst these 2 392 valid respondents, 67.2% and 32.8% attended kindergarten and kindergarten-cum-child care centre respectively, 94.2% were local children, and 52.9% were male (Table 1).

Table 1 – Descriptive characteristics of the survey participants (n = 2 392), Hong Kong Immunisation Coverage Survey 2024.

Characteristics		Number of participants	%
Year of birth	2018	807	33.7
	2019	863	36.1
	2020	722	30.2
Gender	Male	1 266	52.9
	Female	1 126	47.1
Birth & residential status*	Local	2 254	94.2
	Non-local	138	5.8
Preschool type	Kindergarten	1 607	67.2
	Kindergarten-cum-Child Care Centre	785	32.8

**Local children were defined as those who were born in Hong Kong, resided in Hong Kong before two years of age and lived in Hong Kong at the time of the survey. Children who did not fulfil all the aforesaid three criteria were defined as non-local children.*

For children born between 2018 and 2020, the immunisation coverage rates for all vaccines recommended under the HKCIP were above 97.0% (Table 2). Local children were more likely to have completed their vaccinations (98.9%) than non-local children (76.3%) (risk ratio = 1.30, 95% confidence interval [CI]: 1.15 – 1.39), excluding pneumococcal conjugate vaccine (PCV).

Table 2 – Immunisation coverage& for vaccines included in the HKCIP, of children from the 2018 to 2020 birth cohorts, stratified by birth & residential status, Hong Kong Immunisation Coverage Survey 2024.

Type of vaccine	2018			2019			2020			2018-2020			Risk ratio
	Local (N=746)	Non-local (N=61)	Total (N=807)	Local (N=823)	Non-local (N=40)	Total (N=863)	Local (N=685)	Non-local (N=37)	Total (N=722)	Local (N=2254)	Non-local (N=138)	Total (N=2392)	Local vs Non-local (95% CI)
B.C.G.	100	100	100	100	100	100	99.8	100	99.9	100	100	100	1.00 (1.00-1.00)
Hepatitis B 1st dose	100	100	100	100	100	100	99.8	100	99.9	100	100	100	1.00 (1.00-1.00)
Hepatitis B 2nd dose	100	100	100	100	100	100	99.8	100	99.9	100	100	100	1.00 (1.00-1.00)
Hepatitis B 3rd dose	99.7	100	99.7	100	100	100	99.8	100	99.9	99.9	100	99.9	1.00 (1.00-1.00)
Polio 1st dose	99.7	100	99.7	100	97.2	99.9	99.8	100	99.9	99.9	99.2	99.8	1.01 (0.99-1.03)
Polio 2nd dose	99.7	98.2	99.6	100	97.2	99.9	99.8	100	99.9	99.9	98.4	99.8	1.01 (0.99-1.05)
Polio 3rd dose	99.7	98.2	99.6	100	97.2	99.9	99.8	100	99.9	99.9	98.4	99.8	1.01 (0.99-1.05)
Polio Booster	99.1	91.5	98.5	99.6	86.8	99.1	99.6	91.9	99.2	99.4	90.2	98.9	1.10 (1.04-1.16)
DTP 1st dose	99.7	100	99.7	100	97.2	99.9	99.8	100	99.9	99.9	99.2	99.8	1.01 (0.99-1.03)
DTP 2nd dose	99.7	98.2	99.6	100	97.2	99.9	99.8	100	99.9	99.9	98.4	99.8	1.01 (0.99-1.05)
DTP 3rd dose	99.7	98.2	99.6	100	97.2	99.9	99.8	100	99.9	99.9	98.4	99.8	1.01 (0.99-1.05)
DTP Booster	99.1	91.5	98.5	99.6	91.7	99.3	99.6	91.9	99.2	99.4	91.6	99	1.09 (1.03-1.14)
Measles 1st dose	99.7	95.6	99.4	100	100	100	99.8	96.9	99.7	99.9	97.2	99.7	1.03 (1.00-1.05)
Measles 2nd dose*	97.3	79.8	95.7	99.1	91.6	98.8	99.8	91.9	99.5	99.1	88	98.5	1.13 (1.01-1.22)
Mumps 1st dose	99.7	96.7	99.5	100	98.2	99.9	99.8	95	99.6	99.9	96.7	99.7	1.03 (1.00-1.06)
Mumps 2nd dose*	97.3	73.4	95.1	99.1	86.1	98.6	99.8	88.8	99.3	99.1	83	98.2	1.19 (1.08-1.29)
Rubella 1st dose	99.7	95.6	99.4	100	100	100	99.8	96.9	99.7	99.9	97.2	99.7	1.03 (1.00-1.05)
Rubella 2nd dose*	97.3	74.1	95.2	99.1	93.3	98.9	99.8	93.8	99.6	99.1	87.5	98.4	1.13 (1.01-1.25)
Varicella 1st dose	99.6	98.5	99.5	99.9	97.2	99.8	99.8	96.9	99.7	99.8	97.7	99.7	1.02 (1.00-1.05)
Varicella 2nd dose*	97.3	72.7	95.1	99	78.5	98.1	99.8	80	98.9	99	77.2	97.8	1.28 (1.15-1.48)
PCV 1st dose	99.9	94.7	99.5	100	91.7	99.6	99.8	100	99.9	99.9	95.2	99.6	1.05 (1.00-1.12)
PCV 2nd dose	99.6	74.4	97.7	99.9	78.3	98.9	99.8	86.4	99.2	99.8	78.6	98.6	1.27 (1.10-1.52)
PCV 3rd dose^	99.6	72.8	97.6	–	–	–	–	–	–	99.6	72.8	97.6	1.37 (1.18-1.69)
PCV Booster	98.9	68.1	96.6	99.9	59.4	98.1	99.8	77.6	98.8	99.6	68	97.8	1.46 (1.30-1.77)
PCV received at ≥12 months	99.9	91.5	99.2	100	89	99.5	99.8	93.8	99.6	99.9	91.4	99.4	1.09 (1.05-1.17)
Complete Immunisation#	98.3	78.9	96.9	98.9	72.3	97.7	99.6	76.1	98.5	98.9	76.3	97.7	1.30 (1.15-1.39)
Complete Immunisation+	98.3	73.6	96.5	98.9	72.3	97.7	99.6	76.1	98.5	98.9	73.9	97.5	1.34 (1.21-1.43)

DTP – Diphtheria, Tetanus and Pertussis vaccine, PCV –Pneumococcal conjugate vaccine

&Coverage for each vaccine as the proportion of children vaccinated divided by the total number of children with immunisation record submitted.

**The second dose of MMRV vaccine was advanced from Primary One to 18 months for children born on or after 1 July 2018. Only 1951 children (local (N=1840), non-local (N=111)) born between 1 July 2018 to 31 December 2020 were included in the analysis, while 441 children (local (N=414), non-local (N=27)) born on 30 June 2018 or before were excluded.*

^Two primary doses plus one booster (2P+1) schedule instead of a 3P+1 schedule for PCV was implemented for children born in and after 2019. Only 807 children (local (N=746), non-local (N=61)) who born in 2018 were included for the coverage of PCV 3rd dose.

#Excluding PCV

+Including PCV (with PCV catch-up)

For individual vaccines, non-local children were more likely to have incomplete vaccination than local children for the booster dose of polio vaccine and diphtheria, tetanus and pertussis (DTP) vaccine, the second dose of measles, mumps, rubella and varicella (MMRV) vaccine, and the second, third, and booster doses of PCV, with PCV having the highest difference (risk ratios ranged from 1.27 to 1.46). However, when a single 13-valent PCV dose given at 12 months or after (under the PCV13 catch-up vaccination schedule recommended by SCVPD) was considered up-to-date, the PCV coverage for non-local children rose to 91.4%, compared to 99.9% for local children (risk ratio = 1.09, 95% CI: 1.05 – 1.17).

Regarding the place of vaccination, 84.0% of doses received by local children were given at MCHCs, whilst 15.6% and 0.4% were received from private practitioners and in Mainland China/other places respectively. In contrast, only 43.2% of doses received by non-local children were given at MCHCs, whilst 38.7%, 12.8%, and 5.3% were received from Mainland China, other places, and the private sector respectively. (Figure 1).

Majority of local and non-local children received their vaccines at the recommended ages under the HKCIP, except that the second dose of MMRV vaccine (recommended at 18 months of age) among non-local children was delayed, with the second dose of measles, mumps, rubella and varicella received at an median age of 19.4, 21.5, 19.7, and 27.5 months respectively among non-local children.

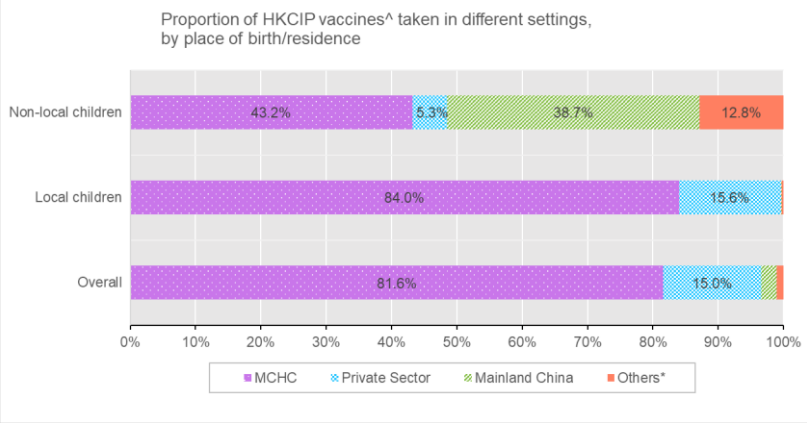

Figure 1 – Proportion of HKCIP vaccines received in different settings by place of birth & residential status, from the 2018 to 2020 birth cohorts, Hong Kong Immunisation Coverage Survey 2024.

**Others include those vaccinated at facilities under Macao SAR, other overseas places and unknown.*
^Only the HKCIP vaccines scheduled before two years of age were included, except BCG vaccine and the first dose of Hepatitis B vaccine which were given at birth.

Discussion

Overall, a high immunisation coverage of the HKCIP vaccines has been maintained in Hong Kong, showing further improvement compared to the Immunisation Survey 2021. As in previous survey rounds, local children continued to have higher immunisation coverages than non-local children for some vaccines under the HKCIP. On the other hand, coverages for polio and DTP booster doses among non-local children in this survey were found to be slightly lower than those in 2021.

Although the coverages of individual PCV doses among non-local children (ranged from 68.0% to 95.2%) remained lower than local children, they had improved compared to non-local children surveyed in 2021 (ranged from 53.1% to 84.7%)[2]. Besides, when PCV13 catch-up vaccination was considered as completing PCV vaccination, the proportion of non-local children in the current survey who completed PCV vaccination rose from 68.0% to 91.4%, indicating that many who missed the routine schedule had kept their PCV vaccination up-to-date through catch-up vaccination after one year of age.

This round's survey revealed that preschool children generally adhered to the HKCIP vaccination schedule and received their vaccines in a timely manner, except for a delay in receiving the second dose of MMRV vaccine among non-local children. This delay may be attributed to some parents or caregivers of non-local children being unware of the advancement of second dose of MMRV vaccine from Primary One to 18 months old under the HKCIP, which was implemented in 2019 for children born after June 30, 2018.

There are several limitations in the survey. Some parents might not have submitted all the immunisation records (i.e. potential incomplete documentation) such that the immunisation coverage contributed by the vaccines received in places other than MCHC (e.g. from private practitioners, Mainland China, or overseas countries) may have been underestimated. Secondly, as in previous rounds, a relatively low response rate (35.8 %) was found among international PPI, when compared to 73.4% among local PPI. However, as majority of the non-local children sampled (88.4%) attended local institutions, we believe the results are still representative for non-local children in Hong Kong. Lastly, since only children attending PPI were sampled, the findings from this survey may not be generalisable to children not attending PPI as early childhood education in PPI is not mandatory.

In conclusion, Hong Kong has maintained a high coverage rate for routine childhood vaccines over the years. Preschool children generally adhered to the updated HKCIP schedule. To protect the public from vaccine preventable diseases, medical practitioners and teachers are encouraged to take note of the survey findings and facilitate vaccination for eligible children, especially non-local ones, to maintain high immunisation coverage and achieve herd immunity in the community.

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Updated global and local situation of meningococcal infection

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Background

Meningococcal infection is caused by the bacterium *Neisseria meningitidis (N. meningitidis)*. It can manifest as non-invasive and invasive infections. Invasive meningococcal infection (IMD) includes meningitis and septicemia, which can be life-threatening, and could be complicated by arthritis, myocarditis, vitritis, or pneumonia.

The bacterium is transmitted through droplets or direct contact with respiratory secretions from infected individuals. Risk factors for meningococcal infection include close contact with infected patients (e.g. household members), immunodeficiency (e.g. HIV infection, complement component deficiencies and asplenia), cigarette smoking and travelling to areas with high prevalence or epidemic meningococcal disease[1]. Outbreaks are more likely to occur in settings that facilitate transmission of the infection, such as overcrowded living conditions and mass gatherings (e.g. religious pilgrimages like Hajj and Umrah)[2].

Update on global situation

Meningococcal infection occurs globally and six serogroups of *N. meningitidis* (A, B, C, W, X, and Y) account for the majority of disease and epidemics[2]. The highest meningococcal disease burden occurs in sub-Saharan Africa extending from Senegal to Ethiopia (the meningitis belt), where outbreaks and recurring epidemics are typically recorded during epidemic seasons (November to June).

During the period from 2011 to 2023, average annual incidences of 31.3 suspected cases and 7.5 confirmed cases per 100 000 population were recorded, with more than 160 epidemic districts in the meningitis belt[3]. Following the introduction of a meningococcal A conjugate vaccine for mass vaccination campaigns and routine immunisation programmes since 2010, serogroup A which used to be the major cause of epidemics in the meningitis belt, has been disappearing, with the last case of serogroup A disease confirmed in 2017. Yet, other meningococcal serogroups (such as W, X and C) still cause epidemics in the meningitis belt albeit with lower frequency and smaller in size[4].

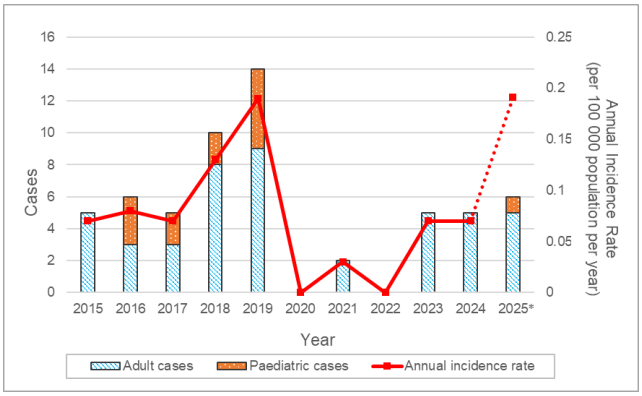
In the Kingdom of Saudi Arabia (KSA), the health authorities identify meningococcal disease as a significant public health threat during mass gatherings and require quadrivalent meningococcal vaccination (MenACWY) prior to traveling to KSA for Hajj and Umrah. However, the vaccination compliance declined in the past two years. It was estimated by KSA health authorities that only 54% of international Umrah pilgrims have complied with the meningococcal vaccination requirements. In 2024, 12 cases of meningococcal disease associated with Umrah and/or pilgrimage to KSA (nine unvaccinated, three with unknown vaccination status) were reported from the United States of America (US), the United Kingdom (UK), and France. According to the World Health Organization (WHO), there were 17 IMD cases (with at least 13 caused by serogroup W135) involving unvaccinated individuals who had performed Umrah in KSA in the first quarter of 2025[5].

In addition, an increase in IMD cases was observed in some overseas countries, subsequent to a fall in cases during the COVID-19 pandemic. The US, UK, Australia and France recorded an increase in cases that either approached or exceeded pre-COVID-19 pandemic level[6]. Notably, France reported 616 IMD cases (with 69 fatalities) in 2024, which is the highest annual total in the past decade (2015-2024). Easing social and physical restrictions was suggested as one prominent factor underlying the increase in IMD cases after the drop during the COVID-19 pandemic. Serogroup B was the most prevalent serogroup causing IMD cases reported in the UK, Australia and France, whilst serogroup Y had dominated meningococcal disease incidence in the US since 2022.

Update on local situation

In Hong Kong, the number of reported IMD cases ranged from zero to 14 per year in the past decade (2015 to 2024), translating to an annual incidence rate of zero to 0.19 per 100 000 population (Figure 1). The number of reported IMD cases increased from five cases in 2015 to 14 cases in 2019, but declined significantly to zero to two cases during 2020 to 2022 when social distancing measures were implemented during the COVID-19 pandemic, then slightly increased to five cases each in 2023 and 2024 after lifting of the social distancing measures.

During 2015-2024, a total of 52 sporadic IMD cases were recorded, including six deaths (all were adults, with two elderly aged ≥ 65 years),



**Annualised incidence rate of IMD, as of May 22, 2025*

Figure 1 – Number of IMD cases and annual incidence rate in Hong Kong, 2015 to 2025 (as of May 22).

amounting to a case-fatality rate of 11.5%. Most of the cases (30 cases; 58%) clinically presented with septicemia, followed by meningitis (16 cases; 31%), mixed presentation with both meningitis and septicemia (five cases, 10%), and septic arthritis (1 case, 2%). The patients' ages ranged from one month to 97 years, with about two-thirds being male. The 19 to 64 age group accounted for over half of IMD cases (29 cases; 56%), followed by pediatric patients ≤ 18 years (12 cases; 23%) and the ≥ 65 age group (11 cases; 21%). Serogroup B was the dominating serogroup (23 cases; 44%), followed by Y (nine cases; 17%), C (7 cases; 14%), W (four cases; 8%) and X (one case; 2%) (Figure 2).

In 2025 (as of 22 May), six local cases of IMD (age range seven to 73-year-old) have been reported. Clinical manifestations included meningitis (three cases), septicemia (two cases), and septic arthritis (one case). There was one fatal case affecting a 73 year-old male. Two male cases (aged 34 and 69 year-old) were epidemiologically linked to a construction site at a public hospital, which is the first cluster recorded in the past decade. Five cases were serogroup B and one case was serogroup Y. This is consistent with the pre-dominance of serogroup B over the past decade.

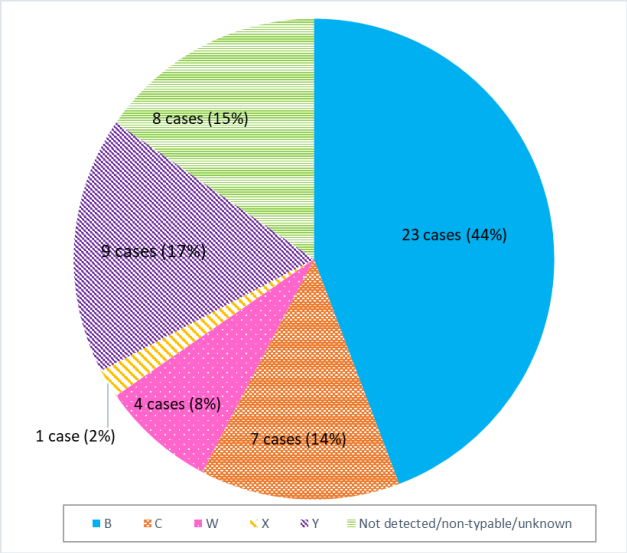


Figure 2 – Serogroup distribution of IMD cases in Hong Kong, 2015-2024.

Prevention of IMD

Meningococcal infection can be effectively prevented through a multifold approach: adequate hand hygiene; droplet precaution during sneezing and coughing; healthy lifestyle; and optimal environmental hygiene. Chemoprophylaxis can effectively reduce the risk of infection among close contacts of patients with meningococcal disease.

Meningococcal vaccination is recommended for travellers to areas where the disease has a high prevalence (e.g. sub-Saharan regions of mid Africa and KSA during Hajj and Umrah). In Hong Kong, the Scientific Committee on Vaccine Preventable Diseases under the Centre for Health Protection of the Department of Health (DH) recommends the following travellers to receive meningococcal vaccines:

- ✧ Travellers to Mecca in Saudi Arabia during the Hajj pilgrimage (quadrivalent A,C,Y, W-135 vaccine);
- ✧ Travellers to sub-Saharan regions of mid Africa during dry seasons, i.e. December to June (bivalent A & C vaccine or quadrivalent A,C, Y, W-135 vaccine) according to the risk of exposure and local epidemic situations; and
- ✧ Travellers to areas, apart from the above, that are known to experience epidemic meningococcal disease.

Given the recent occurrence of IMD cases linked to Umrah in KSA, all individuals aged one year or above planning to visit KSA for Hajj and Umrah are strongly advised to receive the quadrivalent (serogroups A, C, Y and W135) meningococcal vaccine at least 10 days prior to travel as recommended by the WHO[7]. The Travel Health Service of DH provides meningococcal vaccination to travellers. Information on overseas communicable disease outbreaks is also available on its website (https://www.travelhealth.gov.hk/english/index.html). If travellers become ill after returning from other areas, they should promptly seek medical advice and inform their doctor of their travel history.

Sporadic cases of IMD are known to occur in some countries in schools, colleges, travel resorts, military barracks, and other places with significant congregation of adolescents and young adults. Travellers and students planning to study in overseas countries should seek professional advice from doctors for vaccination with respect to their age and health condition, as well as details of their journeys such as place(s) of destination, duration and nature of travel[8].

Given the low incidence of IMD in Hong Kong and the effective use of chemoprophylaxis for prevention of secondary cases, introduction of meningococcal vaccination under the Hong Kong Childhood Immunisation Programme is not warranted from the public health perspective. Parents are advised to seek professional advice from their family doctors on the benefits and risks of receiving meningococcal vaccines. Based on the doctor's assessment of the health and medical history of their children, parents can make informed decision as to whether their children should receive such vaccines for personal protection.

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NEWS IN BRIEF

Hand Hygiene Day 2025: Clean Properly—Every Surface, Every Time

Hand Hygiene Day (HHD), a global campaign promulgated by the World Health Organization, is held annually on May 5. In support of this initiative, the Infection Control Branch (ICB) of the Centre for Health Protection (CHP) launched the 2025 HHD campaign in May, featuring the tagline "Clean Properly—Every Surface, Every Time". This year's focus was on the techniques of hand hygiene, as the 2024 Personal Protective Equipment Audit conducted by the ICB and another local study identified areas for improvement among both healthcare workers and the general public.

Hand hygiene is a seemingly small but powerful act to prevent the spread of infections. Approximately 80% of infectious diseases are transmitted by inadequately cleaned hands after touching contaminated surfaces, and a single bacterium can multiply into 16 million bacteria in just six hours. Hand-washing can prevent approximately 30% of diarrhoea-related illnesses and about 20% of respiratory infections.

The ICB has ramped up publicity efforts this year by employing diverse channels to promote proper hand hygiene practices. Key activities include displaying new instructional posters and stickers at handwashing facilities, animated e-banners on websites and mobile apps, posts on social media and distributing gimmicks like zipper bags, folders and cutlery sets. Outreach has expanded to new locations such as public toilets, Care Teams of the Home Affairs Department, and specialist outpatient clinics under the Hospital Authority. In addition, the ICB set up booths to further raise awareness among healthcare professionals through games and hand hygiene training machines.

Photo 1 – The ICB set up a booth at the CHP Building on 2 May to kick off HHD 2025.

Photo 2 and 3 – Posters showing proper hand hygiene techniques are displayed at public toilets (left), and training machine to demonstrate the surface(s) of the hands missed during hand hygiene (right).

Photo 4 – Promotional materials for HHD 2025.

Photo 5 – Promoting proper hand hygiene techniques at the Hospital Authority convention 2025.

A probable case of sporadic Creutzfeldt-Jakob disease

On April 24, 2025, the Centre for Health Protection (CHP) of the Department of Health recorded a probable case of sporadic Creutzfeldt-Jakob disease (CJD) affecting a 67-year-old male with underlying diseases residing in Tai Po. He presented with visual disturbances, progressive dementia, myoclonus, and akinetic mutism beginning in early January 2025. He was admitted to a public hospital on February 11, 2025. Findings of MRI and electroencephalogram were compatible with CJD. His condition deteriorated and he passed away on May 12 due to pneumonia. He had no known family history of CJD. No risk factors for iatrogenic or variant CJD were identified.

A sporadic case of human myiasis

On May 3, 2025, the CHP recorded a case of human myiasis affecting a 90-year-old resident of an elderly home in Tsuen Wan. She was chairbound with multiple chronic diseases including a chronic facial wound. On May 1, maggots were found in the facial wound and she was admitted to a public hospital for treatment on the same day. The maggots were confirmed to belong to the family *Sarcophagidae,* which is the main fly family attracted to open wounds, ulcers and lesions for depositing larvae. Her condition remained stable after treatment and she was discharged on May 2. Advice on personal care and environmental hygiene was given to the elderly home. The Agriculture, Fisheries and Conservation Department (AFCD) and Food and Environmental Hygiene Department (FEHD) were informed to follow up. The Social Welfare Department was informed to monitor care standard in the elderly home concerned.

A sporadic case of necrotising fasciitis due to *Vibrio vulnificus* infection

On May 5, 2025, the CHP recorded a sporadic case of necrotising fasciitis caused by *Vibrio vulnificus*. The case involved a 68-year-old female with underlying disease residing in Kwai Tsing. She presented with left forearm redness, pain and swelling on May 2 and was admitted to a public hospital on May 3. She had several wounds on left forearm and was clinically diagnosed to have necrotising fasciitis. Her condition improved after antibiotic treatment. She reported having worked part-time in a fish stall on May 1 and 2 before symptom onset, but she did not recall any injury at work. There was no history of recent travel.

A confirmed local case of leptospirosis

On May 6, 2025, the CHP recorded a local sporadic case of leptospirosis involving a 55-year-old male with underlying disease residing in the Southern district. He developed symptoms including cough, fever, malaise, jaundice, and low urine output since April 7. He was hospitalised on April 10 due to acute kidney injury and impaired liver function, and his condition improved with antibiotic treatment. He was discharged on April 28. Laboratory tests showed a four-fold increase in antibody titers against *Leptospira* from paired serum samples taken on April 15 and April 25. The patient worked as a sailor. He occasionally walked barefoot on a ship, but reported no sightings of any rats or other animals. He had not travelled outside Hong Kong during the incubation period. His family members remained asymptomatic.

A local sporadic case of listeriosis

The CHP recorded a local sporadic case of listeriosis on May 9, 2025. The case involved an 82-year-old retired man with underlying diseases residing in Kowloon City. He presented with fever, chills, cough with sputum since May 3, and was admitted to a private hospital on May 6. A blood specimen collected on May 6 grew *Listeria monocytogenes*. His condition improved with antibiotic treatment. According to his relatives, he had no recent travel but had consumed high-risk food items during the incubation period. His household contacts remained asymptomatic.

A local case of severe community-associated Methicillin-resistant *Staphylococcus aureus* (CA-MRSA) infection

The CHP recorded a local case of severe CA-MRSA on May 13, 2025 affecting a 34-year-old man with good past health residing in Sham Shui Po. He presented with fever and cough with sputum since April 22, and was admitted to the intensive care unit of a public hospital on April 24. The clinical diagnosis was severe pneumonia with respiratory failure. He required intubation and extracorporeal membrane oxygenation. Respiratory specimens collected on April 25 were cultured positive for CA-MRSA. His condition deteriorated despite appropriate antibiotic treatment, and he passed away on April 29, 2025. He lived alone and had no recent travel.

A sporadic case of psittacosis

On May 19, 2025, the CHP recorded a case of psittacosis involving an 89-year-old woman with underlying disease residing in Kwun Tong. She presented with cough and chills on May 10. She developed fever, and shortness of breath on May 14, and was admitted to a public hospital on May 16. Chest X-ray showed bilateral lung consolidation and her sputum specimen tested positive for Chlamydia psittaci DNA. Her condition was stable, and she was treated with antibiotics. She had no travel history during the incubation period. She did not keep any birds at home, but reported encountering pigeons near her residence. The case was referred to the AFCD and FEHD for follow-up. Her home contacts remained asymptomatic.