CLINICAL GUIDELINES PROGRAM
NEW YORK STATE DEPARTMENT OF HEALTH AIDS INSTITUTE | HIV • HCV • STIs • SUBSTANCE USE • LGBTQ+ HEALTH

Prevention and Management of Hepatitis A Virus Infection in Adults With HIV

Updates, Authorship, and Related Resources

Date of current publication	June 11, 2026
Highlights of changes, additions, and updates in the June 11, 2026 edition	HAV Prevention section: Removed Twinrix as a recommended vaccine for individuals with HIV
Intended users	Clinicians in ambulatory settings who provide primary and HIV specialty care for adults who have or are at risk of acquiring hepatitis A virus infection
Lead author	Hector I. Ojeda-Martinez, MD
Writing group	Rona M. Vail, MD, AAHIVS; Sanjiv S. Shah, MD, MPH, AAHIVM, AAHIVS; Steven M. Fine, MD, PhD; Joseph P. McGowan, MD, FACP, FIDSA, AAHIVS; Samuel T. Merrick, MD, FIDSA; Asa E. Radix, MD, MPH, PhD, FACP, AAHIVS; Jessica Rodrigues, MPH, MS; Christopher J. Hoffmann, MD, MPH, MSc, FACP; Brianna L. Norton, DO, MPH; Charles J. Gonzalez, MD
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Committee	Medical Care Criteria Committee
Developer and funder	New York State Department of Health AIDS Institute (NYSDOH AI)
Development process	See Supplement: Guideline Development and Recommendation Ratings
Related NYSDOH AI resources	**Guideline** • Immunizations for Adults With HIV **Podcast** • Viremic—Cases in HIV

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Committee: Medical Care Criteria Committee

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All Recommendations

☑ RECOMMENDATIONS

Pre-Exposure Vaccination

- Clinicians should obtain an HAV IgG antibody measurement for all individuals with HIV [a] and should administer the HAV vaccine [b] to those who are HAV antibody-negative, regardless of CD4 count.
- Clinicians should administer the 2-dose anti-HAV vaccine series, with the initial dose followed 6 to 12 months later to ensure maximal antibody response [c]. (A1)
- Clinicians should obtain a post-vaccination HAV IgG antibody measurement at least 1 month after final dose in patients who are at increased risk of HAV-related morbidity and mortality. (B3)

Post-Exposure Immune Globulin

- Clinicians should administer a single dose of immune serum globulin (as a 0.1 mL/kg intramuscular injection) as HAV post-exposure prophylaxis to susceptible patients (no prior vaccine) with HIV within 2 weeks of an exposure to close personal contacts with serologically confirmed HAV infection (i.e., through a blood test), including:
  - Household and sexual contacts (A2)
  - Individuals who have shared illicit drugs with someone with HAV (A2)
- In patients for whom HAV vaccination is also indicated, clinicians should administer the HAV vaccine concurrently with immune serum globulin to protect against future infection. (A3)

Management of HAV/HIV Coinfection

- Whenever possible, ART should not be interrupted in patients with HIV/HAV coinfection; when interruption of ART is indicated for management of severe or fulminant liver disease, clinicians should consult with a care provider experienced in the treatment of hepatitis and HIV. (A3)

Abbreviations: ART, antiretroviral therapy; CDC, Centers for Disease Control and Prevention; HAV, hepatitis A virus; IgG, immunoglobulin G.

☑ RECOMMENDATIONS

Notes:

a. Citing the missed opportunity to vaccinate a patient when available and the possible prolonged risk of exposure to HAV, the CDC no longer recommends deferring HAV vaccination in patients with a CD4 count <200 cells/mm^3 [CDC 2024].
b. Currently available vaccines are Havrix and Vaqta. Twinrix, for prevention of HAV and HBV infection, is not recommended for individuals with HIV.
c. The HAV vaccine at the age-appropriate dose is preferred over immune serum globulin; however, for optimal protection, adults aged >40 years, immunocompromised people, and people with chronic liver disease or other chronic medical conditions planning to depart to an area with a high HAV transmission rate in <2 weeks should receive the initial dose of vaccine along with immune serum globulin (0.1 mL/kg) at a separate injection site. For additional information regarding HAV vaccination for travelers, see CDC Health Information for International Travel > Travel-Associated Infections and Diseases: Hepatitis A.

Purpose of This Guideline

This guideline on hepatitis A virus (HAV) and HIV coinfection was developed by the New York State Department of Health AIDS Institute (NYSDOH AI) to guide clinicians in New York State who provide medical care for adults (aged ≥18 years) with HIV who are at risk of acquiring HAV or have HAV coinfection.

The goals of this guideline are to:

- Provide evidence-based recommendations on screening for and vaccinating against HAV in adults with HIV.
- Provide evidence-based recommendations for post-exposure prophylaxis in adults with HIV who experience an HAV exposure.
- Advise clinicians on the clinical management of patients with HIV/HAV.

The modes of HAV transmission are well established: ingestion of contaminated water and food; oral-anal contact; person-to-person spread via fomites, such as shared utensils or bath towels; or, very rarely, blood or blood product transfusion. After the inclusion of an HAV vaccine in recommended pediatric immunizations in 1995, the total annual reported cases of HAV in the United States decreased to a low of 1,239 in 2014 [CDC 2024]. However, starting in 2015, the number of cases increased annually, reaching 18,846 in 2019. Outbreaks among people who use drugs, those who are unhoused, and men who have sex with men (MSM) contributed to the substantial increases in the reported cases of HAV [Foster, et al. 2022].

With ongoing prevention and control efforts, the total annual reported cases of HAV in the United States decreased 88% from 2019 to 2022 [CDC 2024]; in 2022, there were 2,265 new cases of HAV. Similar decreases have been observed in New York State and New York City [NYSDOH 2024; NYCDOHMH 2023b]. However, HAV outbreaks continue to occur among populations at risk, including MSM, and ongoing prevention efforts are needed (see NYC Health 2023 Health Alert #24: Increase in Hepatitis A Diagnoses Among Men Who Have Sex with Men).

Note on "experienced" HIV care providers: The NYSDOH AI Clinical Guidelines Program defines an "experienced HIV care provider" as a practitioner who has been accorded HIV Specialist status by the American Academy of HIV Medicine. Nurse practitioners (NPs) and licensed midwives who provide clinical care to individuals with HIV in collaboration with a physician may be considered experienced HIV care providers if all other practice agreements are met; NPs with more than 3,600 hours of qualifying experience do not require collaboration with a physician (8 NYCRR 79-5:1; 10 NYCRR 85.36; 8 NYCRR 139-6900). Physician assistants who provide clinical care to individuals with HIV under the supervision of an HIV Specialist physician may also be considered experienced HIV care providers (10 NYCRR 94.2).

HAV Prevention

☑ RECOMMENDATIONS

Pre-Exposure Vaccination

- Clinicians should obtain an HAV IgG antibody measurement for all individuals with HIV [a] and should administer the HAV vaccine [b] to those who are HAV antibody-negative, regardless of CD4 count.

☑ RECOMMENDATIONS

- Clinicians should administer the 2-dose anti-HAV vaccine series, with the initial dose followed 6 to 12 months later to ensure maximal antibody response [c]. (A1)
- Clinicians should obtain a post-vaccination HAV IgG antibody measurement at least 1 month after final dose in patients who are at increased risk of HAV-related morbidity and mortality. (B3)

Post-Exposure Immune Globulin

- Clinicians should administer a single dose of immune serum globulin (as a 0.1 mL/kg intramuscular injection) as HAV post-exposure prophylaxis to susceptible patients (no prior vaccine) with HIV within 2 weeks of an exposure to close personal contacts with serologically confirmed HAV infection (i.e., through a blood test), including:
  - Household and sexual contacts (A2)
  - Individuals who have shared illicit drugs with someone with HAV (A2)
- In patients for whom HAV vaccination is also indicated, clinicians should administer the HAV vaccine concurrently with immune serum globulin to protect against future infection. (A3)

Abbreviations: CDC, Centers for Disease Control and Prevention; HAV, hepatitis A virus; IgG, immunoglobulin G.

Notes:

a. Citing the missed opportunity to vaccinate a patient when available and the possible prolonged risk of exposure to HAV, the CDC no longer recommends deferring HAV vaccination in patients with a CD4 count <200 cells/mm^3 [CDC 2024].
b. Currently available vaccines are Havrix and Vaqta. Twinrix, for prevention of HAV and HBV infection, is not recommended for individuals with HIV.
c. The HAV vaccine at the age-appropriate dose is preferred over immune serum globulin; however, for optimal protection, adults aged >40 years, immunocompromised people, and people with chronic liver disease or other chronic medical conditions planning to depart to an area with a high HAV transmission rate in <2 weeks should receive the initial dose of vaccine along with immune serum globulin (0.1 mL/kg) at a separate injection site. For additional information regarding HAV vaccination for travelers, see CDC Health Information for International Travel > Travel-Associated Infections and Diseases: Hepatitis A.

Pre-Exposure Vaccination

All adults with HIV should be offered an HAV IgG test, and those who are antibody-negative should be vaccinated against HAV [Nelson, et al. 2020]. Patients who are antibody-positive have immunity to HAV from vaccination or prior infection.

Infection with HAV can be prevented by active immunization before exposure with either of the 2 currently licensed vaccines, which are considered equivalent in efficacy. HAV vaccines are highly immunogenic in immunocompetent adults, with >95% seroconversion. However, the seroconversion rates and the geometric mean serum antibodies in individuals with HIV are lower than in those without HIV, with response rates from 50% to 95% [Mena, et al. 2013; Shire, et al. 2006; Weissman, et al. 2006; Rimland and Guest 2005; Wallace, et al. 2004; Kemper, et al. 2003]. HAV vaccine appears to have no effect on the course of HIV infection or on plasma HIV viral load.

Administration of HAV vaccine is recommended for all adults with HIV regardless of CD4 count. An effective antibody response may not occur in up to 15% of immunocompromised patients [Mena, et al. 2013; Wallace, et al. 2004]. This committee recommends follow-up HAV antibody testing for patients who are at increased risk of HAV-related morbidity and mortality to verify vaccine efficacy and to identify those who should be counseled to avoid infection because of continued susceptibility. A single booster vaccination has been shown to generate sufficient immune response in individuals with HIV [Nelson, et al. 2020; Chen, et al. 2018].

Post-Exposure Immune Globulin

Immune serum globulin is the recommended HAV post-exposure prophylaxis for patients with HIV and should be given to individuals who are susceptible to HAV infection within 2 weeks after an exposure to an HAV-infected household contact, sex partner, or needle-sharing partner [CDC 2024; ACIP 2007]. Consideration should also be given to patients with HIV who are providing other types of ongoing, close personal contact with someone with HAV (e.g., a regular babysitter or caretaker) [CDC 2024; ACIP 2007]. A single dose of 0.1 mL/kg intramuscularly is effective in preventing infection or attenuating HAV infection that might result from such an exposure [Nelson 2017]. Concurrent administration of HAV vaccine with immune serum globulin is indicated for individuals at risk of future infection.

Management of HAV/HIV Coinfection

☑ RECOMMENDATION

Management of HAV/HIV Coinfection

- Whenever possible, ART should not be interrupted in patients with HIV/HAV coinfection; when interruption of ART is indicated for management of severe or fulminant liver disease, clinicians should consult with a care provider experienced in the treatment of hepatitis and HIV. (A3)

Abbreviations: ART, antiretroviral therapy; HAV, hepatitis A virus.

Acute HAV infection: The incubation period of HAV infection averages 28 days (range, 15 to 50 days). Clinical symptoms may include abnormal liver enzymes, fatigue or malaise, and jaundice, and diagnosis is based on a positive HAV immunoglobulin M (IgM) antibody test. Suspected or confirmed HAV infection must be reported to the health department (see Box below). Although HAV does not cause chronic hepatitis, it is not a benign disease; the morbidity in adults is substantial. Young children tend to have asymptomatic or minimally symptomatic disease, whereas older children and adults have more severe illness, with jaundice occurring in approximately 70% of cases [Cuthbert 2001]. In 2022, 80% of adult patients with HAV in New York City were hospitalized [NYCDOHMH 2023a].

HIV/HAV coinfection: HAV does not cause more severe clinical illness in people with HIV than in people without. Patients with HIV may have significantly higher HAV viral load levels and significantly prolonged durations of HAV viremia than people who do not have HIV [Gallego, et al. 2011], which may result in a prolonged duration of risk of HAV transmission to others.

Maintain ART: Patients with HIV and acute HAV infection rarely require even temporary interruption of ART. Cessation of ART should be avoided whenever possible because of the potential increased risk of cardiovascular events [Siedner 2016] and loss of virological control [El-Sadr, et al. 2008]. In the rare instances when interruption of ART is indicated for management of fulminant liver disease, clinicians should consult with a care provider experienced in the treatment of hepatitis and HIV.

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- Clinicians must report all suspected or confirmed HAV infections to the local health department of the area where the individual resides according to NYSDOH Communicable Disease Reporting Requirements.
  - Infections that occur among food handlers or in other settings that pose a high risk of transmission are immediately reportable by telephone to the local health department.

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Supplement: Guideline Development and Recommendation Ratings

Table S1: Guideline Development: New York State Department of Health AIDS Institute Clinical Guidelines Program	
Developer	New York State Department of Health AIDS Institute (NYSDOH AI) Clinical Guidelines Program
Funding source	NYSDOH AI
Program manager	Clinical Guidelines Program, Johns Hopkins University School of Medicine, Division of Infectious Diseases. See Program Leadership and Staff.
Mission	To produce and disseminate evidence-based, state-of-the-art clinical practice guidelines that establish uniform standards of care for practitioners who provide prevention or treatment of HIV, viral hepatitis, other sexually transmitted infections, and substance use disorders for adults throughout New York State in the wide array of settings in which those services are delivered.
Expert committees	The NYSDOH AI Medical Director invites and appoints committees of clinical and public health experts from throughout New York State to ensure that the guidelines are practical, immediately applicable, and meet the needs of care providers and stakeholders in all major regions of New York State, all relevant clinical practice settings, key New York State agencies, and community service organizations.
Committee structure	• Leadership: AI-appointed chair, vice chair(s), chair emeritus, clinical specialist(s), JHU Guidelines Program Director, AI Medical Director, AI Clinical Consultant, AVAC community advisor • Contributing members • Guideline writing groups: Lead author, coauthors if applicable, and all committee leaders
Disclosure and management of conflicts of interest	• Annual disclosure of financial relationships with commercial entities for the 12 months prior and upcoming is required of all individuals who work with the guidelines program, and includes disclosure for partners or spouses and primary professional affiliation. • The NYSDOH AI assesses all reported financial relationships to determine the potential for undue influence on guideline recommendations and, when indicated, denies participation in the program or formulates a plan to manage potential conflicts. Disclosures are listed for each committee member.
Evidence collection and review	• Literature search and review strategy is defined by the guideline lead author based on the defined scope of a new guideline or update. • A comprehensive literature search and review is conducted for a new guideline or an extensive update using PubMed, other pertinent databases of peer-reviewed literature, and relevant conference abstracts to establish the evidence base for guideline recommendations. • A targeted search and review to identify recently published evidence is conducted for guidelines published within the previous 3 years. • Title, abstract, and article reviews are performed by the lead author. The JHU editorial team collates evidence and creates and maintains an evidence table for each guideline.
Recommendation development	• The lead author drafts recommendations to address the defined scope of the guideline based on available published data. • Writing group members review the draft recommendations and evidence and deliberate to revise, refine, and reach consensus on all recommendations. • When published data are not available, support for a recommendation may be based on the committee's expert opinion. • The writing group assigns a 2-part rating to each recommendation to indicate the strength of the recommendation and quality of the supporting evidence. The group reviews the evidence, deliberates, and may revise recommendations when required to reach consensus.

Table S1: Guideline Development: New York State Department of Health AIDS Institute Clinical Guidelines Program	
Review and approval process	• Following writing group approval, draft guidelines are reviewed by all contributors, program liaisons, and a volunteer reviewer from the AI Community Advisory Committee. • Recommendations must be approved by two-thirds of the full committee. If necessary to achieve consensus, the full committee is invited to deliberate, review the evidence, and revise recommendations. • Final approval by the committee chair and the NYSDOH AI Medical Director is required for publication.
External reviews	• External review of each guideline is invited at the developer's discretion. • External reviewers recognized for their experience and expertise review guidelines for accuracy, balance, clarity, and practicality and provide feedback.
Update process	• JHU editorial staff ensure that each guideline is reviewed and determined to be current upon the 3-year anniversary of publication; guidelines that provide clinical recommendations in rapidly changing areas of practice may be reviewed annually. Published literature is surveilled to identify new evidence that may prompt changes to existing recommendations or development of new recommendations. • If changes in the standard of care, newly published studies, new drug approval, new drug-related warning, or a public health emergency indicate the need for immediate change to published guidelines, committee leadership will make recommendations and immediate updates and will invite full committee review as indicated.

Table S2: Recommendation Ratings and Definitions		
Strength	**Quality of Evidence**	
A: Strong B: Moderate C: Optional	1	Based on published results of at least 1 randomized clinical trial with clinical outcomes or validated laboratory endpoints.
	*	Based on either a self-evident conclusion; conclusive, published, in vitro data; or well-established practice that cannot be tested because ethics would preclude a clinical trial.
	2	Based on published results of at least 1 well-designed, nonrandomized clinical trial or observational cohort study with long-term clinical outcomes.
	2†	Extrapolated from published results of well-designed studies (including nonrandomized clinical trials) conducted in populations other than those specifically addressed by a recommendation. The source(s) of the extrapolated evidence and the rationale for the extrapolation are provided in the guideline text. One example would be results of studies conducted predominantly in a subpopulation (e.g., one gender) that the committee determines to be generalizable to the population under consideration in the guideline.
	3	Based on committee expert opinion, with rationale provided in the guideline text.