acetate in a single dose (30 mg) available by prescription, levonorgestrel in a single dose (1.5 mg) available over the counter or by prescription, or a combined estrogen and progestin pill regimen. Insertion of a copper-containing IUD ≤5 days after unprotected sex can reduce pregnancy risk from a sex act by approximately 99% (*60*). ECPs are most efficacious when initiated as soon as possible after unprotected sex. Ulipristal acetate is effective ≤5 days after unprotected sex, and levonorgestrel is most effective ≤3 days after unprotected sex but has some efficacy at ≤5 days. ECPs are ineffective (but not harmful) if the woman is already pregnant (*61*). A 2019 Cochrane review summarized the efficacy, safety, and convenience of different emergency contraception methods (*61*).

More information about emergency contraception is available in *Contraceptive Technology, 21st Edition* (*31*), in the 2016 U.S. Selected Practice Recommendations (U.S. SPR) for Contraceptive Use (emergency contraception) available at https://www.cdc.gov/reproductivehealth/contraception/mmwr/spr/emergency.html, and in the 2016 U.S. Medical Eligibility Criteria (U.S. MEC) for Contraceptive Use (copper IUDs for emergency contraception) available at https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/appendixj.html.

Providers should educate males and females about emergency contraception, especially if other methods of contraception were used incorrectly or not at all and pregnancy is not desired (*62*). An advance supply of ECPs can be provided or prescribed so that ECPs will be available when needed (*59*).

Male Circumcision

Male circumcision reduces the risk for HIV infection and certain STIs among heterosexual men. Three randomized, controlled trials performed in regions of sub-Saharan Africa, where generalized HIV epidemics involving predominantly heterosexual transmission were occurring, demonstrated that male circumcision reduces the risk for HIV acquisition among men by 50%–60% (*63*–*65*). In those trials, circumcision also was protective against other STIs, including high-risk genital HPV infection and genital herpes (*66*–*68*). Follow-up studies have demonstrated sustained benefit of circumcision for HIV prevention (*69*) and that the effect is not mediated solely through a reduction in HSV-2 infection or genital ulcer disease (GUD) (*70*).

The World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) recommend that male circumcision efforts be scaled up as an effective intervention for preventing heterosexually acquired HIV infection (*71*) in countries with hyperendemic and generalized HIV epidemics within the context of ensuring universal access to comprehensive HIV prevention, treatment, care, and support (https://www.afro.who.int/publications/voluntary-medical-male-circumcision-hiv-prevention). In the United States, the American Academy of Pediatrics (AAP) recommends that newborn male circumcision be available to families that desire it because the benefits of the procedure, including prevention of penile cancers, urinary tract infections, GUD, and HIV infection, outweigh the risks. ACOG has also endorsed AAP's policy statement. In light of these benefits, the American Urological Association states that male circumcision should be considered an option for risk reduction, among other strategies (*72*). Additional information for providers counseling male patients and parents regarding male circumcision for preventing HIV, STIs, and other adverse health outcomes is available at https://www.cdc.gov/hiv/risk/male-circumcision.html.

No definitive data exist to determine whether male circumcision reduces HIV acquisition among MSM, although one meta-analysis of 62 observational studies reported that circumcision was protective against HIV acquisition in low- to middle-income countries but not in high-income countries (*73*). Further studies are needed to confirm any potential benefit of male circumcision for this population.

Pre-Exposure Prophylaxis for HIV

Daily oral antiretroviral PrEP with a fixed-dose combination of emtricitabine (FTC) and either tenofovir disoproxil fumarate (TDF) or tenofovir alafenamide (TAF) have demonstrated safety (*74*) and a substantial reduction in the rate of HIV acquisition for MSM (*75*). TDF/FTC has demonstrated safety and efficacy for mixed-status heterosexual couples (*76*) and heterosexual men and women recruited individually (*77*); however, no evidence is yet available regarding TAF/FTC among heterosexually active women. In addition, one clinical trial involving persons who inject drugs (*78*) and one involving heterosexual mixed-status couples (*76*) demonstrated substantial efficacy and safety of daily oral PrEP with TDF alone. High adherence to oral PrEP was strongly associated with protection from HIV infection. Studies conducted with MSM have demonstrated that taking PrEP at specific times before and after sexual intercourse was effective in preventing HIV; however, less experience exits with this regimen, it is not FDA cleared, and it has not been studied among other populations (*79*).

Comprehensive clinical practice guidelines are available for providers in prescribing PrEP to reduce the risk for HIV infection (*80*). Among HIV-negative sexually active men and women, bacterial STIs are key indicators of risk for HIV acquisition. Studies have documented the risk for HIV acquisition among MSM within 1 year after infection with rectal gonorrhea or chlamydia (one in 15 men), primary or secondary syphilis (one in 18), and among men with no