About STAR-E

Strengthening TB and AIDS Response – Eastern Region (STAR-E) is a six-year USAID-funded project being implemented by Management Sciences for Health (MSH) with Joint Clinical Research Centre (JCRC), Inter-Religious Council of Uganda (IRCU), Resources for Policy Exchange (RPX), and Liverpool Associates in Tropical Health (LATH).

STAR-E empowers the communities in Eastern Uganda to effectively respond to the challenges posed by the HIV & AIDS and Tuberculosis (TB) epidemics by:

- Preventing new infections of HIV and TB;
- Treating, caring, and supporting those infected and affected by HIV and TB; and
- Mitigating the health and social impacts of the HIV and TB epidemics.

Working closely with the Ministry of Health of Uganda and through District Health Management Teams, District Councils, health facilities, and communities, the project’s general objective is to increase access to, coverage of, and utilization of quality comprehensive HIV/TB prevention, care, and treatment services within district health facilities and their respective communities.

The project works in 12 districts (Busia, Butaleja, Budaka, Pallisa, Bududa, Kibuku, Bulambuli, Kween, Mbale, Kapchorwa, Bukwo, and Sironko) covering a population of just over 2.6 million.

STAR-E focuses on promoting use of the Lot Quality Assurance Sampling methodology at the national and district levels and among USAID-funded implementing partners supporting social services.

Working Toward an AIDS-Free Generation: STAR-E Implementation of Safe Male Circumcision Services

March, 2014

In recent years, there has been a shift in how the international community is addressing the HIV epidemic. As more people are receiving antiretroviral therapy, we are seeing the benefits of reduced viral load on a population level. Fewer babies are being born HIV positive and prevalence rates are dropping in most countries with the highest HIV burdens. With knowledge of how to prevent further spread of the epidemic and tools to keep those who are already infected alive, we are now working on “getting to zero”—zero new infections, zero discrimination, and zero AIDS-related deaths. We are working toward raising an AIDS-free generation, because for the first time, it is possible.

To reach this end, the global community is tackling the epidemic from all sides: improved access to treatment, improved treatment regimens, regimens for the elimination of mother-to-child transmission, and improved and better access to prevention strategies. One of these prevention strategies is safe male circumcision (SMC).

In 2007, data from three randomized controlled studies in Kenya, Uganda, and South Africa showed that circumcision reduces men’s risk of acquiring HIV through heterosexual intercourse by 60 percent. Subsequently, modeling studies have shown that reaching 80 percent of men aged 15 to 49 years with SMC in each of the 14 high prevalence priority countries would avert 3.4 million cases of HIV and save the world US$ 16.5 billion in care and treatment costs.¹

In the Mid Eastern region of Uganda where the USAID-funded Strengthening TB and AIDS Response – Eastern Region (STAR-E) project works, male circumcision is culturally familiar, often performed as a rite of passage into adulthood. The Uganda AIDS Indicator Survey 2011 found that up to 53 percent of males between the ages of 15 and 49 are circumcised in the Mid Eastern region. The national average is 26 percent.

Five out of twelve districts in the region do not practice traditional circumcision (Busia, Butaleja, Pallisa, Kibuku, and Budaka). The districts of Mbale, Bududa, Sironko, Bulambuli, Kween, Kapchorwa, and Bukwo perform traditional circumcisions only in even years.

Following the release of the Ugandan Ministry of Health’s Safe Male Circumcision Policy in 2010, which promotes SMC as part of a comprehensive HIV prevention strategy, STAR-E introduced SMC into four health centers. In that first year of implementation, STAR-E-supported sites performed just 75 SMC procedures. But four years later, the project has provided SMC services to over 146,000 men between the ages of 15 and 49.

¹ Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe
Introduction of Services

Training of Providers

In 2010, when STAR-E first introduced SMC into its portfolio of services, the project trained teams in four health centers. The next year they expanded to 11 and in the third year of implementation, STAR-E supported SMC in 22 facilities. But as time progressed, it became clear that even with multiple teams trained in each site, the health workers were stretched thin between scaling-up SMC services and their routine duties. In March 2013, STAR-E deployed five mobile dedicated teams trained in SMC, one into each of the traditionally non-circumcising districts.

The dedicated teams consist of ten personnel recruited from outside the public sector: four clinical officers who serve as surgeons, four nurses who work as assistant surgeons, and two counselors. The teams travel with all necessary supplies and equipment and set up temporary operations at lower level facilities that do not offer SMC services. They also set up camps in rural areas far from other SMC services.

One of two nationally-accredited provider institutions trained the teams over five days with both theoretical and practical content. STAR-E worked with the trainers to include a post-training mentorship visit, during which the teams set up their tent and established an actual SMC outreach service point that met the required standards.

Education and Advocacy

STAR-E works with District Health Educators, Village Health Team members, and local council leaders to raise awareness about the benefits of SMC among young men. The project also aired radio spots to educate men both about the health benefits of circumcision and also the availability of services at the STAR-E-supported facilities and through mobile teams. The messages were derived from national SMC policy and strategy documents. Educational materials, developed nationally, supplement the teams’ outreach efforts.

The mobile teams are successful as much because of the advocacy and education they do, as they are because of the services they bring. One week in advance of the full team’s arrival, the SMC team leader travels to the selected location and meets with local leaders to agree on the selection of Village Health Team members to do the mobilization. The Village Health Team members are provided with a megaphone and funds to fuel a local motor cycle rider to take them around the area. They also visit local congregations to inform them of when and where the mobile team will be located.

Provision of Services

When clients arrive for SMC services, they are registered and segregated into adults and children for group counseling. Topics covered during group counseling include: the risks and benefits of SMC; a description of the surgical procedure, including pain management; the limitation of SMC’s effectiveness in preventing HIV and the need to maintain other prevention measures; the need for a six-week abstinence period post-surgery to allow for wound healing; the limited benefit of SMC for those who are already HIV positive; and other reproductive health information, such as family planning and sexually transmitted infections.

After group counseling, clients are provided with individual HIV counseling and testing and a pre-op assessment before they provide informed consent. Once the surgical procedure has been performed, they are taken to a post-op area where providers assess their vital signs, provide wound care instructions, and advise on return dates and pain medication.

The national SMC protocol calls for clients to be seen 48 hours, 7 days, and 6 weeks after the procedure. In earlier phases of the project, STAR-E found that the rate of clients returning for follow up was far too low. Clients

![An SMC camp set up by a STAR-E team](image-url)

**Figure 1. HIV Prevalence by Region**

**Figure 2. Circumcision Prevalence by Region (Men Aged 15-49)**

Source: Uganda AIDS Indicator Survey 2011
rarely returned unless they encountered adverse events, the most common of which were wound hematomas and sepsis.

To remedy this, health workers began telling clients to “come back after 48 hours and we will change your bandage,” rather than the previous message which had simply been to return so that the health workers could check the wound. After outreach services, two team members are assigned to return and attend to clients returning for follow up.

At the pilot site where this intervention was first tested, a great improvement was seen within nine months. In March 2013 just 31 percent of clients returned after 48 hours. By December of the same year, the 48-hour follow-up rate had improved to 94 percent.

These simple measures had a big effect on improving outcomes for clients. Before these measures were introduced at the pilot site, 1 of 85 men experienced complications. However, once providers began telling clients to return for a bandage change and providing their phone numbers, that number dramatically dropped to only 1 in 454.

Early in implementation, the project struggled with stock outs of commodities necessary for the procedure. However, in September 2012, USAID took over centralized procurement of SMC kits, anesthetics, and other necessary supplies. This greatly facilitated the rapid scale-up of services, as both the mobile and facility-based teams had reliable stock.

**Results and Discussion**

To date, STAR-E has provided more than 146,000 men with SMC services and is on track to reach their target of 90,000 men in the sixth project year. According to mathematical models, by performing 146,000 circumcisions, STAR-E has already averted 7,684 new HIV infections. When we reach our target for the final project year, we will have averted 11,600 cases. That is nearly 12,000 men who will live to provide for their families, contribute to the workforce, and not pose a risk of transmitting HIV to their partners.

The last 50,000 men may be the hardest to reach. Some of the districts in which the project works are fast approaching the saturation point. As seen in Figure 3, STAR-E is meeting the need for SMC in Eastern Uganda and therefore, the number of men still in need of the service is decreasing. STAR-E is deploying our dedicated teams beyond their original assigned districts to help reach the remaining men. Lastly, during 2014 (an even year), there will be slightly more uptake of SMC in the seven traditionally circumcising districts.

One of the most rewarding aspects of providing SMC services is that public health impact is made through rapid scale-up of services, not through years of implementation. The men that STAR-E supported facilities and mobile teams have reached will have partial protection against acquiring HIV for the rest of their lives. And the providers trained by STAR-E will be able to continue to provide SMC to young men as they reach the traditional age of circumcision.

Male circumcision is an ancient practice, a simple procedure, yet its impact is immense. In the twelve districts served by STAR-E, there is the distinct possibility that 12,000 sons, brothers, husbands, and friends will remain healthy because they received SMC services. Twelve thousand lives will have been saved by the dedicated health workers trained and served by STAR-E.

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A safe male circumcision team ready for work!