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Expanding Addiction Recovery Resources in East Africa: An Interview with Lonnetta Albright, Andre Johnson, Calvin Trent, PhD, and David Whitters, PhD

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Introduction

What began as a grassroots movement in the United States to forge new addiction recovery support institutions and related services has recently spread to other parts of the globe. In February 2013, I had the opportunity to interview four friends and colleagues, Lonnetta Albright, Calvin Trent, Andre Johnson, and David Whitters, who have been involved in an effort to expand recovery support services in The Republic of Tanzania (Zanzibar and the Mainland).



Zanzibar

What makes this initiative distinctive is the paucity of pre-existing addiction treatment and recovery support resources and an ongoing consultation process that brought a team of African Americans to East Africa for consultations with leaders concerned about growing addiction problems and the need to expand recovery support resources. The story of this process is by no means complete, but important lessons have already been discovered that will guide the continued process. Please join us in exploring these lessons.

Bill White: How did your work together in East Africa begin?

Lionnetta Albright: The story of how we got involved with this PEPFAR-funded “Twinning Project” is rooted in the Jane Addams College of Social Work at the University of Illinois at Chicago’s involvement in addressing the issue of HIV transmission and supporting people living with the virus in Tanzania and other parts of Africa. As you know, Bill, our ATTC has been a part of the Jane Addams College of Social Work at UIC since 1998. Our focus of course is on Substance Use Disorders, Addiction and Recovery. Because substance abuse and addiction play a critical role in the transmission of HIV, as well as adherence to treatment for people already living with the virus, the need to create a Tanzania Substance Abuse Twinning Partnership was initiated in 2008. The American International Health Alliance (AIHA) selected and awarded the Great Lakes Addiction Technology Transfer Center (Great Lakes ATTC) to be the new lead U.S. partner. The ultimate goal of this multi-partner twinning collaboration between Tanzania and the United States is to reduce HIV incidence and prevalence rates among substance abusers in Tanzania through a comprehensive, evidence-based approach with a

strong focus on a recovery-oriented system of care (ROSC) framework. We started on the island of Zanzibar where there were no addiction treatment resources.

As SAMHSA-CSAT's lead ATTC related to Recovery Management, ROSC and Peer-Based Recovery Support Services, it was natural for us to bring technical resources from the U.S. to work with our in-country partners in Zanzibar and then on the Mainland to help them develop a community approach for addressing the issues and impact of addiction. We believed that an adaptable model for use in these countries would benefit from what was developed by the Detroit Department of Health and Wellness Promotion and the Detroit Recovery Project. To help adapt this model within a predominately Muslim country in Africa, we also engaged Detroit Imam Abdullah El Amin to assist with the consultation. This project began in Zanzibar, in collaboration with key officials from Zanzibar's Department of Substance Abuse, Prevention and Rehabilitation (DSAPR) located within the Ministry of Health and Social Welfare, which was moved to The First Vice President's Office in 2010. The project was subsequently expanded to include key officials from Tanzania's mainland, and now includes collaborating partners from the mainland's Drug Control Commission (DCC), MOHSW- Non Communicable Diseases / Mental Health and Substance Abuse, MUHAS-TAPP, treatment and recovery organizations.



Dr. Trent and Lonna Albricht with Ahmed Salim

Dr. Calvin Trent: When Lonna first proposed getting involved in this project, we were of course very excited. We knew that the HIV/AIDS epidemic was ravaging African countries and their populations and as African Americans in a community facing very similar problems, we were fascinated by the prospects of sharing our experiences and learning from them how they were coping with the epidemic. We also were excited about the cultural relevance of being a team from one of the most heavily populated Black/Urban communities collaborating with members of Black/Urban communities in Africa on an issue of shared importance. We knew the goal of our project would be to reduce the spread of HIV/AIDS by improving substance abuse

interventions but how we were going to achieve that was left up to us. Although our team was going to be African Americans, we quickly realized that we knew very little about the island of Zanzibar or its country of Tanzania. We did some research on Zanzibar, Tanzania, and their problems with HIV and alcohol and drug abuse. We also learned that there was a community of Tanzanians living and working in Detroit who would prove to be wonderful allies in our project.

The focus of our project would be Zanzibar, and through our investigations, we found that they had been doing good research on their HIV/AIDS problem and the relationship of that issue with drug addiction. There were excellent papers published on the impact of drug usage on the risk factors for HIV/AIDS and the at-risk populations that were most affected. We also became aware that although Tanzania as a whole was about 80% Christian, the population of Zanzibar was over 95% Muslim. This would have to be a factor in the selection of team members for our project. We knew we needed to have a team with strong experience organizing treatment and prevention services and in developing and implementing recovery support services from a peer perspective. We also wanted to make sure that the project would be able to be successful working within a predominately Muslim culture. Fortunately, within our Detroit provider network, we had a strong relationship with the Muslim Center of Detroit and its Iman, Abdulla El Amin, who provided prevention and recovery services and was very interested in reaching out to African communities of faith. I had a lot to learn, as I had a lot of stereotypical ideas about the Muslim religion and knew very little about the cultures of East African countries. Our first team of myself, Andre, and El Amin brought strong credentials in addiction, prevention, treatment, recovery, and the role of faith in the recovery process. We were ready to go.



Early Community Meeting in Zanzibar



Dr. Trent Speaking at Community Meeting

Bill White: What was the first action you took beyond participating in the conference?

Dr. Calvin Trent: The first thing that we needed to do was meet with the African team members and get a more precise understanding of the community in general, the HIV/AIDS problem and how it was being addressed, and of course the drug issue with a focus on the local capacity to address it. We held meetings with the AIHA in country team, the PEPFAR team, and the representatives from the Zanzibar Department of Health. Most importantly, we met and formed a strong relationship with the Zanzibar Department of Substance Abuse Services. Through these meetings, we were able to better understand the depth of the problem that addiction, mostly Heroin IV drug use, was having on the HIV/AIDS epidemic but very importantly on the entire community and the families that were living with it. The behavior of addicts in the families was so culturally unusual that everyone in the community was seeking solutions and explanations for their abhorrent behavior.

I think our first big surprise was that there were absolutely no treatment services available in the country and no possibility of getting funding for formal treatment in the near future. And so we then began to think about alternatives to formal treatment and how to help facilitate recovery. Our first idea was, "Well, let's at least find some people here who are in recovery and begin to talk to them about their journey to recovery." In Detroit, when we first started our Recovery Oriented System of Care, Andre had set up a recovery committee, composed of peers in long-term recovery, for our city that guided our move towards a ROSC model and so that's where we began—finding people in recovery and mobilizing them to get involved in building systems of recovery support. Our in country team members there began helping us to identify people who were in recovery, and that's how the work began. A great deal of the first visit was getting our cultural bearings and exploring what we might have to offer. Finding people in recovery was the most important first step.



Recovery Celebration Event



Recovery Sports Team

Lionetta Albright: Dr. Trent makes an excellent point. When we started this in 2008, Bill, ROSC was not our focus. It was brilliant on Dr. Trent and Andre's part to start with the recovery community to launch the ROSC orientation to this work. We didn't start with the idea of developing a system of care when we first went to East Africa, but it grew there as it has grown

in the U.S. We were pleasantly surprised that the ROSC-building experience in Detroit seemed to be so applicable to the needs we found in Zanzibar and on the mainland.

Bill White: Andre, could you describe the early process there?

Andre Johnson: Yes, absolutely! The weather was amazing; the people were friendly, welcoming and receptive to hear from Dr. Trent and myself. It was nothing I could have imagined or dreamt up, the humbling spirits of the Tanzanian people. After the early introductory meeting, we tried to assess who in Zanzibar had long-term recovery and who could be mobilized as collaborators. That's when we met Zanzibar, Tanzania native Suleiman Mauly, who was bright and a recovery asset to Zanzibar. We also met Cathy, a Caucasian woman from the USA who lived in Zanzibar and had been in long-term recovery from alcoholism for over 20 years. We met Bukhari, who had been in long-term recovery for over a decade or so. There were approximately a dozen people we met who were in recovery. Many of them were introduced to recovery by Mewa rehab in Nairobi, Kenya.

I assisted in introducing the 12-step program Narcotics Anonymous to our brothers and sisters. They just took it all in. It was like a new revelation; they embraced the whole 12-step program concept. It was as if exposing them to such readings as "Who is an Addict?" and "What is the NA program" gave them something to live for and brought a sense of community. We also started meeting community health nurses, social workers, counselors, and people in recovery from Mombasa & Nairobi, Kenya. We started sharing the NA message with these people, and the next thing you know, NA meetings started cropping up on the island of Zanzibar. NA meetings started sprouting up in Dar es Salaam and we started sharing more information. We bought 12-step NA books, key tags, "Just for The Day" books, and shared it with them.

Dr. Calvin Trent: As I have mentioned, the team that we assembled to carry out this project proved to be key and probably the most important decision in the creation of the Detroit team was the inclusion of Imam Abdullah Bey El-Amin of Detroit's Muslim Center. The fact that El Amin was a member of the Muslim faith and was also an Imam (spiritual leader) created an immediate acceptance by the community. The influence of the religious leadership in Zanzibar is very strong, and Imam El Amin was welcomed and respected by the religious hierarchy. This cultural acceptance legitimized our project in a very culturally significant way. He helped explain addiction and the recovery process from a Muslim perspective and was successful in helping to ensure leadership that the recovery process fit with Muslim philosophy and was in no way a threat. We were also able to present a Muslim friendly version of the 12-step program. This product is called Millati Islami, and was created by a group of Muslim brothers in Baltimore.

Andre Johnson also played a very key role due to his personal persona—his time in recovery (20 years), his age (40ish), his likeability, and charisma. Andre quickly became something of a recovery hero to the people there. They had never seen a successful young Black man with his presence talk about recovery so openly and eloquently. Most of the people we worked with had rarely seen anyone with more than a year or two of recovery, and Andre's long-term recovery status was like an awakening to them. The majority of the addicts we were reaching out to were in their thirties; I don't think they really believed that anybody like them could recover from drug addiction until they met Andre and later on David Whitters.



Andre Johnson during First Consultation Visit



Andre Johnson during First Consultation Visit

Lionnetta Albright: I agree that acceptance from the community was the foundation for our subsequent work. El Amin helped us build the trust of the mosques there. The trust and acceptance of the leadership in the Muslim community that was built during our first visit and strengthened in subsequent visits were very important.



Muslim Recovery Coach Trainees

Dr. Calvin Trent: There was this deep hunger in the community and particularly in the families for trustworthy education about addiction. They were being traumatized by the consequences of addiction on their youth. The behaviors they were experiencing with these youth—stealing, lying, prostitution, and exposure to HIV/AIDS—was not culturally compatible and their only answer was that the youth were insane and lost. This growing drug problem was destroying their culture in ways they could not understand. This was a culture of close families where, before the problem of addiction, a child stealing from his or her mother would have been unthinkable. Addiction is a tragic and unfathomable problem today in many third world countries.

Bill White: David, let me invite you into the conversation to describe at what point you got involved in the project.

Dr. David Whitters: Thanks, Bill. I got involved in the project in year two. When Lonnetta initially invited me to be a part of this project, we thought my primary objective would be to go there and evaluate the efforts that were underway; however, this quickly morphed into simply recording as best I could the actual story that was taking place in East Africa, beginning first in Zanzibar and subsequently on the mainland of Tanzania. I traveled with Dr. Trent to East Africa and interviewed all of the key stakeholders and organizational leaders involved in developing this recovery-oriented system of care. What I saw in Tanzania was literally mind-blowing. I expected to see four or five individuals sitting in a circle having an NA meeting. What I did not expect to see was a host of what we call here in the states transitional housing programs and recovery homes. They were referred to in Tanzania and Zanzibar as “Sober Houses.”

Essentially, they are the same concept as the houses that are leased in the U.S. by recovering substance users that are used to house people in early recovery. They serve as safe, recovery supportive housing. When I arrived, there were ten houses, nine for men and one for women. Each house held its own individual Narcotics Anonymous meeting every night. Substance users would come from the streets to these houses and receive love and nourishing from members who were graduates of the housing program, many of whom had been trained previously by Dr. Trent and Andre as Recovery Coaches. Many of the Coaches within the Sober Houses received small stipends to provide as much recovery support as they possibly could.



Recovery Coach Trainees



Recovery Coach Trainees

Bill White: David, could you describe how NA World Services got involved with the work in East Africa?

Dr. David Whifers: When I saw how rapidly NA was growing in East Africa, I contacted Anthony Edmondson, who is an African American who has served as the Executive Director of Narcotics Anonymous World Services (NAWS) for several years now. Anthony as well as others at NAWS were very supportive and subsequently launched a project to translate four key NA Information Pamphlets (IP) from English to Swahili, the primary language spoken on the Mainland of

Tanzania and the island of Zanzibar (collectively referred to as the Republic of Tanzania or just the Republic). NAWs commissioned me to lead this process by facilitating several “literature translations workgroups” in the Republic with individuals who identified as members of Narcotics Anonymous. These members spent several hours on several days translating four IPs from English to Swahili. Once I completed facilitating five or six workgroups in the Republic of Tanzania, I then moved on to Mombasa, Kenya, to facilitate three days of identical workgroups. These workgroups included a select group of approximately 8 members from Tanzania in combination with NA members from Nairobi, Malinda, and Mombasa, Kenya. What was really exciting about this combined country workgroup effort is that it included NA members from Dodoma, the capital of Tanzania, and Tanga. Both cities include NA members who speak very little English and whose contribution to the translations ended up being invaluable. If you go to www.na.org and click on the link that says, “Publications,” you will find four very colorful information pamphlets that have been translated from English to Swahili.

It would be extremely careless of me to leave out of this discussion a very important natural born and charismatic leader from Zanzibar, Kassim N. Kassim, a mentee of Suleiman’s. Kassim, before NAWs had even dreamed about translating any of NA literature from English to Swahili, had already begun this process on his own. This young man sat down with pen and paper and initiated the translation of the Serenity Prayer, the NA 3rd step prayer, the NA Just for Today daily meditation, and had started trying to translate word for word the NA basic text. He, like so many others, played a very important role in the Swahili literature translations.

Bill White: What has been the community response to the growth of NA?

Dr. David Whitters: On the island of Zanzibar where the heroin epidemic is rapidly destroying large sections of this great community, NA has become the saving grace for many substance users. Bill, when we started our efforts there about five (5) years ago, Suleiman and a few others were the only “former drug users” we identified who seemed to believe that there was hope for suffering substance users on this island; however, none of them had ever heard of Narcotics Anonymous. When we shared the concept of substance users sitting in a circle sharing with one another their experiences and efforts for remaining drug free, we might as well have been talking Japanese. They did not get it. And the fact that there are now more than 300 NA members on the island of Zanzibar today and greater than 100 on the Mainland of Tanzania is proof that God is doing for us what we were not able to do for ourselves.

In Dodoma, the police commander had two nephews, his sister’s sons, die from heroin overdoses. He is as pro-NA as anybody I have ever met. He literally took pictures holding several pieces of our NA literature. I use this photo in several presentations I conduct worldwide depicting how influential NA has become in this great East African country. In addition, he has converted part of his precinct into a meeting hall used exclusively for ongoing daily NA meetings. He charged his police staff with the responsibility of picking substance users off the streets and bringing them to the meetings as opposed to taking them to jail. For those of us who believe in God, all this stuff had a spiritual component to it, Bill. The way things just started to fall out and happen. I don’t know the words to describe it. The local politicians in Dodoma have concluded that they do not have the money to develop treatment programs or medication-assisted treatment programs such as methadone or buprenorphine and had basically concluded that they would never be able to adequately address the heroin epidemic crippling their community; however, because of the insurgence of Narcotics Anonymous, they now feel hopeful where they once felt hopeless. They believe that NA is a godsend and the answer to their addiction problem.



Dr. David Whitters with Dodoma Police Commander

By the time of my second trip to Zanzibar in February-March 2012, NA had become the most common method for addiction recovery. On the mainland, Narcotics Anonymous was picking up slower than it was in Zanzibar but still growing nonetheless. A new development on the mainland is the recent introduction of medication-assisted treatment (methadone). There are very articulate NA members who object to this approach on the grounds that their perception leads them to believe that methadone maintenance is just going from one drug dependence to another. In spite of this controversy, methadone as another pathway to recovery is gaining momentum and could very well surpass NA as the most prominent method of recovery in Dar es Salaam. I don't believe this would ever be the case in Zanzibar, Dodoma or Tanga, though one can never be so certain.

Bill White: Did you feel any tension introducing this idea of multiple pathways of recovery into this unique cultural context?

Dr. David Whitters: I did experience a lot of personal dilemmas in this process. First of all, I knew that Dr. Trent was expecting me to give attention to various pathways to recovery, including Millati Islami—an Islamic-focused adaptation of the 12-Step program. We did see, witness, and visit a variety of recovery programs. We saw NA meetings taking place every day on the island of Zanzibar and in Dodoma and several times per week in Dar es Salaam and Tanga. Inside a few of the Zanzibar-based mosques were support groups consisting of a mixture of 12-step recovery and the Islamic approach. There was a Christian-based approach to recovery that Dr. Trent and I visited that was several miles inside the Mainland. They focused on Christian conversion as a pathway to recovery. The tension was how to work within the cultures and traditions of these various approaches. Coming from a 12-step background for my own personal recovery, I was also challenged by that little voice in the back of my mind attached to the faces of all my friends in 12-step recovery who subscribe to a belief that any recovery approach other than a 12-step recovery is an “approach predestined for failure.” Though I haven't believed this for several years, I must be honest, there was a side of me that only wanted to promote 12-step

recovery, and more specifically, NA, as the best of all the approaches. But because of my recent training on the value of multiple pathways to addiction recovery, I did not succumb to this desire.

Bill White: This would be a good time to discuss the other partners who were part of this consultation process on ROSC development in East Africa.

Dr. Calvin Trent: By far, the most important partnership in our project has been that with the recovery community. The men and women who have committed to the journey of recovery and who are dedicated to giving back to others have become the heart and soul of this project. This group, led by Suleiman Mauly, but including so many others, has been able to demonstrate to their community that recovery does work and that it is possible. They have built a series of organizations that are actively bringing addicts into care and guiding their recovery. They are doing this with only the resources that they generate and are becoming a model for other countries to emulate in their fight against addiction. The government was an important partner—the Department of Substance Abuse Prevention and Rehabilitation, which was under their Ministry of Health and Social Development. Ahmed Salim, Mussa and Fatuma were our most important early government contacts. The team at the Zanzibar substance abuse department had done fantastic work on producing studies describing the epidemic in Zanzibar and had laid the foundation for our work by producing a national strategic plan for addressing the epidemic with a focus on substance abuse. This was tremendously important since PEPFAR and the funders of projects to address HIV/AIDS did not view substance abuse as a central issue for their interventions to address. The work of the Zanzibar group has been a voice of change and has called for help in this area and has been heard. I think that their courage to press this issue has been critical in beginning to open the door to more attention on reducing drug addiction as an HIV reduction strategy.



Fatma Mussa and Mahmoud Ibrahim Mussa

Our other partners were the religious community. We worked through their existing interfaith council with Abdul El Amin working with the council and becoming very close with the religious leaders of the Zanzibar community. Through them, the Mosques have become even more involved in the struggle against addiction. They are providing sub-acute detox services, providing a venue for NA and AA meetings and opening the school system to substance abuse prevention activities. Of course, the dedicated work of AIHA and in particular the in-country team was tremendous. Having Sally and Rebecca and their team providing support and encouragement meant everything to us. Having this leadership from Tanzanian/Americans and those committed to the country support our work let us know the true importance of the project.



Dr. Trent with Interfaith Committee

Bill White: How did this consultation evolve over time?

Lionetta Albright: As we've mentioned throughout this interview, we started on the island of Zanzibar and then extended our work to the mainland of Tanzania by year three. We developed the model on the island for two years before expanding it to the mainland. For the past four years, Great Lakes ATTC and its U.S. Subject Matter Experts (SME) have built long-standing partnerships, mobilized the recovery community, and trained over 100 participants (peers, professionals, government officials, faith-based leaders, providers and researchers) in East Africa.

This collaborative project prepared more than 50 recovering IDU as peers (providers of services to current IDU), expanded the membership of local 12-step recovery fellowships, initiated methadone recovery support services, and established 11 recovery houses (referred to there as sober houses), including one specific to women, that provide safe living environments for high risk HIV populations. This collaboration has led to an expansion in addiction treatment services and partnerships with faith- and non-governmental agencies, leading to an expansion in "recovery pathways" (methods by which IDU recover from addiction), ultimately reducing high risk HIV and HCV behaviors among IDU and their sex and drug sharing partners.



Lonnetta Albright Discussing Recovery Support Services

We have also built a sustainable system approach for transforming communities using Training of Trainer programs, “How To” Manuals for facilitating and leading transformation and education on evidence-based practices. Our accomplishments include building and expanding the capacity of the Tanzania partners and key stakeholders related to system transformation and developing ROSCs within East African communities. Six individuals now represent indigenous subject matter experts in East Africa who are able to lead, train and assist other African countries. We also developed and trained peers from the recovery community who now serve in leadership roles and also as trainers. We have already seen a significant reduction of HIV and HCV among East African injection drug users, alcohol dependent residents, and their sex and drug sharing partners. PEPFAR considers this a “South to South” capacity building approach. When the U.S. is the expert, it’s considered a “North to North” approach. The “South to South” approach is a genuine demonstration of empowerment and sustainability.

It is also noteworthy that this local coalition received an award from the Tourism Bureau in Zanzibar. This award went to Suleiman and the recovery community acknowledging that their work and mobilization of people in recovery had a direct impact on reducing crime in Zanzibar. Put simply, there is today a culture of recovery in Zanzibar and on the Mainland that is evident in the transformed lives of individuals and families and the entire community.

Dr. Calvin Trent: Our first trip was one that was exciting, but it was also sobering in that we began to realize the financial limitations we were facing. The project budget was pretty bare bones and only covered our travel and related expenses. There was a great need for treatment services, but there was no possibility for the dollars to start a treatment program. Our first visit’s objective was to become familiar with the problem and to develop a year plan to address it. We had found that we had supportive religious and governmental entities to work with. There was a treatment program in the neighboring country of Kenya, and we found that there were several individuals that had found sobriety there and were continuing their recovery back home in Zanzibar. Our initial strategy then became twofold: one, to recruit a cadre of individuals in active recovery to join our project and two, to create a drop-in center in the offices of the Bureau of

substance abuse services to house the recovery community volunteers. These were the two major outcomes of the first trip. So that's how we got started. In the time between the first trip and the second trip, the volunteers from the Zanzibar recovery community began identifying other people in recovery in the community and inviting them to join in organizational meetings. The government also joined in and began refurbishing a section of their building into the drop-in center.

With the identification of 35 peers in recovery in Zanzibar and the completion of the drop-in center, we were ready for our second visit. The intent of the second visit was to introduce the 12-step program to the peers and train them to run groups and be advocates for recovery through the drop-in center. Our Detroit team was able to train on NA and AA, but we also wanted to train the participants on the Muslim version, Millati Islami. We were fortunate to be able to enlist the help of David and Margie Lewis to provide the Millati training. David Lewis was Muslim and had previously visited Tanzania; he was also an outspoken person in long-term recovery himself. His wife Margie was also in recovery. This training was pivotal to all the future successes because these people we initially trained became the backbone of everything that followed. After the training, the recovery peers brought us a problem that they needed a solution for. They let us know that addicts had been coming to the drop-in center for information and help but that since it was just a drop-in center, they had to turn the addicts back out into the streets. They felt that they would be more successful recruiting addicts to recovery if they had a place where they could provide shelter and not just send them back out. Margie Lewis was a driving force behind convincing our team members to assist with this idea and we agreed. Consequently, we contributed enough money to rent a house and provide some mattresses for addicts seeking help. This became the first "Sober House" and laid the foundation for the establishment of over 10 Sober Houses that now exist. These houses provide a place where addicts can not only detox but also learn about recovery.

The Peers that we trained are now the leaders of the recovery movement in Eastern Africa and are shining examples that recovery is possible. Hundreds of addicts have found recovery through these houses, and the community has taken notice. On subsequent trips, we were able to meet and train the medical staff personnel in all the regional health clinics on what addiction is and how to help people presenting with addiction problems to get to the Sober House programs. Political winds also helped us. After we had worked there a couple of years, elections were held and it ended up that the party that won has aligned themselves with the recovery community and in particular with Suleiman Mauuly, the movement's leading peer. The new political leadership decided to move the Substance Abuse Department out of the Ministry of Health and make it a part of the first vice president's office, which is where it is at present. Because of this change, the government has begun to include some support of this activity in their national budget. There have been challenges, but the recovery movement continues to make strides and gain the attention of policymakers. The national government in Tanzania has decided to reach out for more help with drug addiction and was successful in getting the first methadone program in East Africa and has decided to build a national treatment center in the capital of Dodoma.

Lonnetta Albright: One of the unique aspects of this project was bringing together public health leaders, religious leaders, and people in recovery.

Dr. Calvin Trent: And on that religious side, they have one sober house and it's strictly founded on Millati Islami, but the other nine sober houses are more NA-oriented, which is more spiritual than explicitly religious. I would say 90% of the participants are Muslim, but NA does not seem to be a religious threat to Islam. I have great hope for their growing NA connection. The first NA Convention in East Africa is going to be quite a milestone in the history of recovery in Zanzibar and Tanzania. It is amazing to watch these formerly addicted young people taking on

other responsibilities in the community. They are becoming heroes because of their recovery and their subsequent service to the community.

Andre Johnson: There is now a cadre of people who are in long-term recovery in Zanzibar and Dar Es Salaam (Dar). The Tanzanian people have an established recovery connection both on the mainland in Dar and the island of Zanzibar in addition to Kenya. They have fully adopted recovery and have gone from meetings with people days clean to meetings with people with one and then multiple years clean. They now have drivers' licenses, automobiles, and jobs. People once alienated from their families are now an integral part of their families again. They've reintegrated back into their traditional cultures—back to the mosque. This is a direct result of finding recovery.

Lionnetta Albright: There were several critical pieces to this collaborative work. The first two years focused on Dr. Trent and Andre's mobilization of the recovery community and the development of peer-run recovery support services. The other piece I think that worked beautifully here was the focus on the whole community. I'm always reminded of Don Coyhis' discussion of the need for a healing community and the recovery of the entire community, not just the wounded individuals. This is a community that is recovering without one person going through treatment. That's what ROSC means within a culture where there are no resources to provide treatment as we know it in the U.S. We were certainly a catalyst; however, this very quickly became a grassroots movement involving the most significant people in the community. We didn't have to shift from an acute-care approach to a ROSC because they had no acute care.

Dr. Calvin Trent: Bill, I'm a big fan of yours and the books that you've written that put us on this trajectory, and our work in Africa affirmed the power of community that you write about. And I'm always in awe of this twelve-step philosophy and the contagious way it helps people transform regardless of whether they are Muslim, Hindu, Christian, or a person of no faith. The incredible dedication and determination of the recovery peers to make a way for others to find recovery has been nothing less than a miracle and points to the possibility of this model being made available to other communities that have limited financial resources for treatment. After a while, we just sat back and watched the peers take this thing, make it their own, and blend it into their culture.

Bill White: We've described quite a bit about the process. What are the important achievements you've witnessed to date?

Andre Johnson: Well, let's start with the fact that there are now daily twelve-step NA meetings on the mainland and on the island where before no such resources existed. We have a higher number of people who are now in recovery, which means we have less people who are using drugs, particularly injecting drugs. Key leaders we worked with now see ROSC as a critical strategy in reducing rates of HIV infection. Their attitude was, "Here's something we can embrace and we can implement on our own. All we need is to be taught. All we need is to be educated. All we need is to be trained." And that was our primary role. And once we had done that, they just ran with it. So now they have a large network of recovering people. We have the first East Africa NA Conference that's scheduled for May of 2013. And we have people who have taken on this whole recovery model. They're talking ROSC in the mosques and the churches and in the HIV prevention programs and other nongovernmental organizations. They have adapted this whole model of recovery-oriented systems of care. It makes me smile just to hear how they pronounce it with such enthusiasm. You know what I mean? When they pronounce, "ROSC," they pronounce it like this is the best thing since sliced pie.

Bill White: And I understand some of the leaders have visited the U.S. to further study the ROSC model.

Lionnetta Albright: We have had delegations come to the U.S. twice. These U.S. Exchange visits to the U.S. were very important.

In December 2012, we met in D.C. with several federal agencies including SAMHSA, HRSA, the DEA, ONDCP and the Office of Global Affairs. El Amin was also able to get meetings with two congressional members who also happen to be Muslim. Our Tanzanian colleagues were able to highlight some of their major accomplishments—the ten sober houses in Zanzibar, the training of more than 70 recovery peers, new family therapy resources, and the work of the Inter-Faith Council on the mainland. This opportunity for them to tell their story as opposed to us reporting their story had tremendous impact and really helped to raise awareness about how successful the ROSC framework is for assisting an entire community or in this case a Country. We should mention that they also met with the Tanzania Embassy and the D.C. historic Mosque, Masjid Muhammad. Their Imam Sharif hosted a reception that raised over \$500 by purchasing artwork developed by the peers in Zanzibar as part of their recovery industries.

In 2009, we hosted a fundraiser during their first visit to Detroit that raised more than \$7,000 to help support their growing services, including their Drug-Free Zanzibar website. When they saw the Detroit Recovery Project during their first visit, they could see what a drop-in center looked like and how it operated. They could see what a sober house could look like and that it could be run by people in recovery. They spent time in Detroit witnessing what was possible.

The time in Washington D.C. was important and we hopefully created enough support to continue this project. I think the trip was successful from a political standpoint in terms of continued funding to help us support this type of work in other African countries.



Tanzania Team Meeting with Dr. Clark of SAMHSA and Project Officer Aazamina Rangwala of AIHA during Washington D.C. Visit



Tanzania Team Members Visit to Detroit

Bill White: Has there been any efforts to integrate peer recovery supports with the medication in the mainland methadone program?

Lonnetta Albright: We've talked about recovery-oriented methadone maintenance, and we've seen a shift in views about methadone by the peers we have trained.

Dr. David Whitters: That's correct, Lonnetta. There was some reluctance on the part of those who were in abstinence-based recovery to inviting those who were peers in the methadone program to the training. At first, they did not think they belonged there. But let me tell you, those four guys who are on methadone and serving as peers were absolutely awesome. They were smart, they understood outreach and they understood the value of sharing their recovery stories with others as a strategy for attracting more people to recovery. What they struggled with—what they all struggled with—was the idea of attracting people to multiple pathways to recovery because their job was to only attract people to their particular pathway to recovery.

Bill White: I think one of the amazing things about this story you've all shared is how much you've been able to do with so little substantial funding to support it.

Lonnetta Albright: We've been able to do that because of our U.S. partners. It's been heartwarming. Dr. Trent, Andre, David Lewis, and his wife: they took money out of their pockets to fund the first sober house that was opened in Zanzibar. And there are no salaries being paid to any of us for this work. PEPFAR expects that everything is done voluntarily, and we have done this on a shoestring budget. I think Dr. Trent continues to fund a teacher in one of the

communities there. When the women's sober house needed money, we just pulled money out of our pockets and sent what was needed and did the same thing to get the sober houses started on the mainland. Our "seed funds" helped to launch and then the community (families, government and others) keep the sober houses going. We've done fundraisers here to support the ongoing work in East Africa. And David was able to engage NA World Services, which will certainly go a long way in sustaining this work and continuing to increase the number of people who achieve health, wellness, and resilience.

Bill White: David, I'm wondering with your contact with other African countries if you have some perspective on how adaptable this process would be in other African countries.

Dr. David Whitters: I was hoping we could discuss this. We recently submitted a proposal to CSAT/SAMHSA that expands the peer component of our ROSC to Ethiopia, Kenya, and in Durban, South Africa. There's a plan to begin a ROSC replication in a medical college in the capital of Ethiopia, March 11-23. We will also expand our training for recovery coaches and peers in Tanzania in May during the same time that the NA Convention's taking place. That expansion then goes to Mombasa, Kenya, which will include peers from Nairobi, Malinda and Mombasa. We will end this trip in Durban, South Africa, where we will build on the peer development work that GLATTC and TASC co-held last year in there. So there are at least three countries—Ethiopia, Kenya, and South Africa—where we hope to replicate the work that's taken place in Tanzania.

Bill White: What are your visions of the future of this work in the Republic of Tanzania as well as in other parts of Africa and other countries?

Calvin Trent: My vision is that people like the ones in Tanzania who have been exposed to the devastation that addiction can cause can also be exposed to the reality that recovery is possible and that it is possible in their families and communities and that they do not always have to have huge amounts of funding to support a recovery movement that will pay many dividends. So many third world communities around the world feel that addiction is a death sentence for their members and that help is out of their reach, but a program like this demonstrates that they can have an answer that they can do themselves. I think that program with a minimum level of effort can be replicated even in the poorest of countries because it actually comes from the community and not from some national funding initiative.

Andre Johnson: I think long-term we will see more viable recovery communities expanding across the entire African continent. I think we've planted a seed. The fact that we have a first NA Convention in May speaks volumes. I mean we already have the energy of people in recovery in Detroit committed to helping support NA development and growth in Africa. I think that the momentum we have started will continue to grow, and it will eventually infuse throughout the continent.

Dr. David Whitters: Bill, I think we've learned among the four of us that it may not be possible to implement all the components of a ROSC in some of these African countries, but there appears to be one component of a ROSC that appears to be fairly easy to develop and implement and that's the peer component. And the key to this spreading and sustaining itself is that you have to have folks who buy in to this and take over leadership. That's the fundamental principle of our peer component of our ROSC. We don't go there and tell folks what to do. We

locate and mobilize opinion leaders who can take ownership, buy into the concept, and lead this movement.

Bill White: Lonnetta, I give the final word to you.

Lonnetta Albright: David is right. Our key strategy from the ATTC perspective is one of capacity-building. We've started that process, and I think our next steps involve getting more of the process on paper and helping people now measure outcomes as these new systems of support continue to evolve. We've got two manuals that are close to finished to help countries develop a ROSC framework beginning with planning and hosting an initial ROSC summit. We're trying to write things in a way that people can take and tailor for what they need and within the context of their unique cultures. There is a buzz about what has started in Tanzania. For example, when we were in DC, we met with a couple from Ghana who was visiting ONDCP. They heard about the work in Tanzania and wanted to talk to them to hear about and understand how they were being so successful. So getting what we have done to date disseminated—even doing this interview—is an important next step for us.



ROSC Summit. Dar es Salaam, Tanzania (the mainland), 2012

My professional assessment of this project is that it is the partners, especially our Tanzania colleagues, who deserve tremendous credit in the success of this effort. The sheer volume of people that they were able to engage across the Republic of Tanzania has been amazing to witness. The development and creation of Sober Houses, with little or no funding support, in my opinion has been miraculous. Their ability to leverage resources and partnerships, including the government, was accomplished in a short period of time. The U.S. partners that were selected came to the project with tremendous expertise in the area of Recovery and Addictions; HIV/AIDS; law enforcement (criminal justice); training and technical assistance; collaboration and partnership building; evidence-based practices; system change and capacity building; how to develop networks and organizations; advocacy; and more. Then

coupling the expertise and skills of U.S. partners with their commitment and dedication to helping individuals, families, and communities recover created a critical mass for this “North to South” effort.

The fact that U.S. partners were all from the African American community as well as our Muslim U.S. partner opened many doors very quickly and helped us to understand and adapt to the cultures (ethnic, religious, law enforcement, etc.) that exist within and across Tanzania. And the support of our University and College, our ATTC’s sponsor, SAMHSA and leadership at their Center for Substance Abuse Treatment (Dr. H. Westley Clark) are not to be overlooked. Our partners at AIHA also deserve much credit as our PEPFAR sponsor. AIHA staff went far beyond the role of project officers and participated in the learning, training, and all activities as well as providing logistical support for trips, conference calls, and addressing any challenges that came up. They were also critical in making connections and brokering relationships for us in the U.S. and Africa.

And let me conclude by emphasizing that what we are doing is not just helping countries create a treatment resource. It is a much broader process of community-organizing. Your doing this interview will help tell the story of how we have done that in East Africa. I’m hoping that such organizing efforts will extend beyond anything we can now imagine.



Lonnetta Albright with Zanzibar Children

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