White, W. (2016). Expanding prevention, treatment, and recovery support services in Kenya, Africa, and beyond: An interview with Dr. William Sinkele. Posted at www.williamwhitepapers.com.

Expanding Prevention, Treatment, and Recovery Support Services in Kenya, Africa, and Beyond
An Interview with Dr. William Sinkele

Introduction: The purpose of the Recovery around the World interview series is to inform addiction professionals and recovery advocates in the United States about innovative approaches around that globe that support addiction recovery. One such approaches I have closely followed for some time flows from the work of Dr. William Sinkele, founder and Director of Support for Addictions Prevention and Treatment in Africa (SAPTA). Dr. Sinkele also co-founded the Redhill Treatment Centre in Kenya and Joseph's House, an AIDS hospice for homeless men in Washington, DC. I recently (April 2016) had the opportunity to interview Dr. Sinkele about his life's work. Please join us in this engaging conversation.

Background

Bill White: Bill, it is a pleasure to finally get to interview you after an extended correspondence over the years. Could we begin by having you share some of your background and how you came to focus on the areas of the development of prevention, treatment, and recovery support services?

Dr. William Sinkele: I also come from a family background marked with alcoholism. I was a Dominican Catholic priest for many years stationed in various posts in Eastern USA. I was a daily drinker until I was 43 and also had been on a regular 20 mg of Valium due to a chronic medical condition I have. In my 40s I began a Doctorate in Ministry at Catholic University in Washington, D.C. A psychiatrist switched me from Valium to Xanax. So in my 40s I began to have substance-induced psychiatric episodes. One time I was walking down the street I thought I was able to see into buildings with x-ray vision and my heart seemed to be racing wildly. I thought it was cool. But when I got back to the seminary and a colleague of mine who was doing a doctorate in nursing took my pulse, it was normal. In another incident, I was waiting in a line for a movie and I thought I could see another self in front of me. So I went to a doctor who did a liver scan and it showed early liver damage from the years of drinking. I began going to AA meetings in 1968 in Washington once a week. But I heard from a fellow Dominican priest in recovery that you needed to give up all mind and mood changing substances. So I came off cold turkey from my Xanax and sleeping pills. Also at this time I joined the 7 a.m. AA meeting at the Westside Club in Georgetown. It was one of the best decisions I made.

Bill White: How did your work in Kenya begin?

Dr. William Sinkele: Even early in my childhood I said I want to go to Africa and work. The opportunity came in 1990 when the Dominicans were sending over 6 of us to start the Dominican Fathers and Brothers in Kenya and recruit vocations from Kenya, Uganda, and Tanzania. After

six months in Kiswahili language school in Tanzania I returned to Nairobi and was chosen to be the regional superior for East Africa. I was the Dominican regional superior for eight years. During this time I started to work with the regional bishops to develop a treatment center for priests. However, it did not work out. So with another American Catholic priest we will able to start Red Hill Treatment Centre (outside Nairobi) with the support of Archbishop Ndingi of Nairobi. It was open to Catholic priests from the region with alcohol problems as well as the ordinary lay people with alcohol and drug problems.

Bill White: Could you provide our readers an overview of the prevalence and patterns of alcohol and drug problems in Kenya?

Dr. William Sinkele: In 2012, NACADA (the government anti-drug agency) published a survey of alcohol and drug use and for the first time used the DSM-IV TR assessment to determine alcohol and drug abuse/dependency prevalence. About 5.8 percent of Kenyans were abusing alcohol while another 5.5 percent were dependent on alcohol use; [11.3 percent of 20,000,000 [15-64 years olds]: Abusers: 1,160,000; Dependent: 1,100,000. Total who needed counseling interventions: 2,260,000 Kenyans. 3.7 percent were abusing tobacco while 4.5 percent were dependent on tobacco use; Abusers: 740,000; Dependent: 900,000. 1.6 percent were abusing khat (a stimulant) while 1.5 percent were dependent on khat use and finally, Abusers: 320,000; Dependent: 300,000. 0.4 percent were abusing marijuana while another 0.4 percent were dependent on marijuana use: Abusers: 80,000; Dependent: 80,000.

A recent survey for the risks of Non Communicable Diseases in Kenya showed that 13 percent of the drinkers were binge drinkers: 23 percent were men and 3 percent women.

For those persons who inject drugs (PWID), it has been estimated that Kenya has 30,000 with probably four times that number smoking heroin. Fortunately, methamphetamine use here is still very low.

Bill White: Could you describe the history of addiction treatment services are available in Kenya?

Dr. William Sinkele: Addiction treatment in Kenya began in the 1980s in western Kenya when a Kenyan priest got sober and started a "Treatment" center. Actually it was having one or two AA meetings a day and that was treatment. But it was a beginning. Then in the early 1990s, with another American priest, we co-founded the Redhill Treatment Centre outside of Nairobi. It was for Catholic priests and the ordinary alcoholic but it was on the more expensive side. For the last 20 years private addiction treatment services (mostly AA-based) have sprung up over the country; many of them started by graduates of my addiction counselor institute. We have about 60+ treatment centers approved by NACADA. We have only 2 government facilities that offer addiction treatment but NACADA is supporting the establishing of ten new centers in the Kenyan countries. In the last year, with support from CDC, methadone centers have been established: two at the Coast and one in Nairobi.

Bill White: What recovery mutual aid fellowships are currently available in Kenya?

Dr. William Sinkele: AA started in Nairobi in the 1980s and has many meetings in Nairobi. For reasons I really do not understand it has not caught on too well outside of Nairobi. There are

plans to establish an AA central office in Nairobi and in Mombasa at the coast. One of the main challenges has been the lack of AA material. These two offices hope to help remedy this situation.

Bill White: Is there an organized recovery advocacy movement in Kenya?

Dr. William Sinkele: At the moment there is not an organized recovery advocacy movement in Kenya.

Bill White: Is there funding of prevention, treatment, and recovery support by the Kenyan Government?

Dr. William Sinkele: Funding for treatment has been limited. Up to fairly recent we only had two publically funded treatment centers: one in Nairobi at the largest mental illness hospital and another at the Coast in Mombasa. Most of the treatment centers in Kenya are privately owned.

Bill White: What were the circumstances that led to the founding of SAPTA?

Dr. William Sinkele: I left Kenya in 2000 and decided to leave the priesthood. I then worked in Washington, D.C. as the assistant director at a men's AIDS' hospice. But I could not adjust to living in America so I returned to Nairobi in 2004 without a job. I saw that in Kenya there was no diploma level training (entry level counselors) on addiction counseling. So with funding from Ford Foundation, I started SAPTA and we started a diploma in addiction counseling with a Kenyan lady with an MA in counseling but with no clinical experience in addiction counseling. [At that time there was not anyone.] Most of the addiction counselors in the treatment centers were men and women in recovery with good will but not addiction counseling training. A few counselors had BA or MA in counseling with little clinical experience or evidence-based addiction training.

Bill White: What is SAPTA's primary mission?

Dr. William Sinkele: SAPTA has a fivefold foci:

1) Alcohol and drug abuse evidence-based prevention science, especially for children, adolescents, and young adults.
2) Alcohol and drug abuse (AUD/SUD) treatment through outpatient services and alcohol and drug treatment programs especially focusing on the poor, those in slums, and those who are marginalized, e.g. injecting drug users, female sex workers, and LGBT.
3) Recovery programs: understanding SUD as chronic disease management.
4) Training on evidence-based addiction counseling and prevention science and continuing professional education courses for addiction professionals and others; preparation for addiction counselor certification exam (ICCE).
5) Research on alcohol/drugs/HIV/mental illnesses; advocacy for access to treatment.

Bill White: How is SAPTA organized and funded?

Dr. William Sinkele: SAPTA is a Kenyan registered nonprofit organization, or as they called it here, an NGO: nongovernmental organization. Presently we are funded through the fees we charge for addiction prevention and treatment training and through the Global Fund for our two centers in Nairobi which focuses on the WHO prescribed services to those who inject drugs. We have 2,700 People Who Inject Drugs in our program of which 380 are women who inject. SAPTA has almost 200 of its heroin using clients on methadone. I have to say that for many, the use of methadone has been life changing.

Bill White: What are the major service programs provided by SAPTA?

Dr. William Sinkele: SAPTA has been implementing evidence-based harm reduction interventions since 2011 funded by USAID and Global Fund in Nairobi. SAPTA is currently funded under Global Fund for two outpatient/outreach PWID programs in Nairobi. We have reached over 2,700 PWID of whom 300 are women who inject drugs. We have nearly 200 of our clients on methadone at the Mathare Hospital Methadone Clinic. We have seen dramatic improvements in the health of these clients and even improved hopefulness in their lives. Under the outreach model SAPTA has 60 peer educators, eight outreach workers, and five pathfinders who go to the dens to distribute clean needles and syringes and other commodities to the PWIDs. The delivery of services guided by the World Health Organization recommended interventions for PWIDs.

The other major services are substance abuse prevention and treatment training, especially the diploma in addiction counseling. In the future we hope to offer a distance learning mode of diploma in addiction counseling to spread to areas outside Nairobi and also to the other sub-Saharan countries.

We also do outpatient treatment counseling at our main center in downtown Nairobi and do research with other major researchers (American and Kenyan institutions) on alcohol, drugs, HIV, and AIDS.

Bill White: Could you describe the peer education model used within SAPTA's Steps to Healthy Living Program?

Dr. William Sinkele: With funding from SAMHSA, colleagues, including Evans Oloo, head of training for SAPTA, and I created an evidence-informed alcohol/drugs/HIV risk reduction intervention. It is called, "Steps to Healthy Living," and consists of 12 psycho-educational lessons facilitated by trained peer educators. More recently, with further SAMHSA funding, it has been adapted for alcohol/drug abusing female sex workers and another edition for men who have sex with men/male sex workers. We are hoping these Key Population alcohol/drug/HIV risk reduction intervention could be up-scaled across sub-Saharan Africa through the Linkages/ FHI360 program.

Steps is 12 psycho-educational lessons of 1 ½ hours each intended to be delivered over a six-week period (that is, two lessons given per week). It incorporates evidence based substance abuse practices, namely, motivational interviewing, cognitive behavioral coping skills (e.g., drink refusal skills), introduction to Alcoholics Anonymous, and relapse prevention. It also contains lessons on alcohol and risky sexual behavior, and alcohol, and how to engage in a healthy living lifestyle.

Anyone who has a problem with alcohol or drugs can benefit from this program. The original format was designed for an adult heterosexual audience. The format is intended to be a group presentation with eight to ten people per group as the ideal number for a group presentation.

Peer educators who either do not have current problem with alcohol or drugs can facilitate the program. Also anyone in recovery from alcohol or drug abuse with six months of sobriety can also facilitate the program. Who also might benefit from the training? ART adherence counselors would find the training helpful to offer assistance to those are HIV+ and drinking. The peer educators are trained by SAPTA trainers in a five day training program. The first two days gives the participants the basic knowledge of the effects of alcohol and drugs, their relationship to risky sexual behavior and ART, an introduction to Alcoholics Anonymous and the first three steps, and the healthy living. In the last three days of the training the peer educators are taken through each of the lessons in order to know how to present them.

The Steps uses a manualized approach so that the peer educators can be guided to give an evidence-based presentation. They will have a manual to guide them.

Bill White: How is the Steps to Healthy Living Program disseminated within Kenya?

Dr. William Sinkele: As we find funding, most likely through PEPFAR and CDC HIV programming, we intend to spread the Steps program into the prison systems, the disciplined services, the female sex worker communities and LGBT communities, as well as the ordinary alcoholic. My intention is to get it into the slums and villages in Kenya and across sub-Saharan Africa.

Bill White: What do you feel are SAPTA's most important achievements to date?

Dr. William Sinkele: One major achievement is that we are the largest trainer of addiction counselors in Africa with over 300 who have graduated with the diploma in addiction counseling (entry level counselor). Most of our graduates are Kenyans but we also have graduates from Ethiopia, Somalia, Malawi, and Tanzania.

Another achievement is that we are one of the largest programs in Nairobi dealing with over 2,700 people who inject drugs. And we developed the Steps to Healthy Living program and adapted it for female sex workers and for those who have sex with men communities.

Bill White: What are your involvements with the government agencies to address prevention, treatment, and recovery in Kenya and beyond?

Dr. William Sinkele: I am a senior consultant to NACADA (the Kenyan government antidrug agency); on the Technical Working Group for Key Populations (people who inject drugs, female sex workers, men who have sex with men, prisoners) with NACC and NASCOP (Kenyan HIV government agencies) and am on the Kenyan government committee for regional drug experts for East African Community (Kenya, Uganda, Tanzania, and Rwanda) in preparation for UNGASS April 2016 (the meeting of world leaders to determine the new worldwide policy on drugs). I am the chairman of the Kenya prisons-probations-stakeholders psycho-social committee. Under the CDC HIV grant for prisons in March 2016 I trained the top prison's AIDS Control Unit management committee for AUD/SUD disorders and HIV management. I am a

consultant to the Ministry of Health on their proposed national alcohol risk reduction strategy as well as joining a new Ministry of Health technical working committee for national substance abuse management. I am a Global Master Trainer for Addiction Counseling and Addiction Prevention Science under the ICCE Colombo Plan which is supported by INL.

Bill White: Can you tell us about your research efforts?

Dr. William Sinkele: I call myself "an in-the-trenches interventionist" who is attempting to create evidence-informed (confirming they are evidence-based practices that will need grants for research) addiction treatment interventions that are culturally relevant to our African situation and that are economically affordable, scalable, and sustainable. Working with FHI360 and the International Centre for Reproductive Health in Mombasa several years ago, we ran a randomized control study of an alcohol-risk reduction intervention I had designed for six personal counseling sessions with female sex workers who were drinking hazardously/harmfully but not addictively. This intervention was so successful that even a year later they had still reduced their drinking to safer levels and they had less gender-based violence from their clients than the control group. There are now 4 scientific journal articles on this RCT.

SAPTA will sign a MOU with KEMRI (the Kenyan government research agency) to develop alcohol/drug related proposals. We are currently working on writing a proposal for a study of TB among PWID. SAPTA with Dr. Carey Farquhar, Professor, Department of Medicine, Division of Allergy and Infectious Diseases, Departments of Epidemiology and Global Health, Director, International AIDS Research and Training Program, are also writing proposals on PWID, HIV, and Hepatitis C. Dr. Alicia Monroe-Wise of the University of Washington won a small grant from Fogarty for study of Hepatitis C among PWID at SAPTA' centers. SAPTA has on its board 4 principal investigators in the substance abuse/mental health and HIV and AIDS fields.

Bill White: Can you tell our readers about the ICCE UTC and UPC programs and how they intend to build the addiction prevention and treatment program in Africa.

Dr. William Sinkele: Two years ago, eight of us from Africa and eight from Asian countries were chosen by the International Centre for the Certification and Training of Addiction Professionals (ICCE through the Colombo Plan: http://colombo-plan.org/icce) to be the first Global Master Trainers on a new Universal Prevention Curriculum (UPC). UPC was designed by a team of American prevention science specialists led by Dr. Zili Sloboda, former director of NIDA's Division of Epidemiology and Prevention Research. It was funded by the USA State Department's International Narcotics and Law Enforcement Bureau (INL). INL had several years before also funded ICCE for the Universal Treatment Curriculum (UTC). [I was also trained as a Global Master trainer on UTC.] Through these two curricula ICCE with INL support is building up the capacity building in both prevention science and addiction counseling in 43 countries in the world. They also have a two-week training on women and substance abuse treatment ("Grow") and another two week training on recovery. SAPTA is the first training institute in Africa to sign an MOU with ICCE to offer in Kenya the UTC and UPC training as well as prepare Kenyans to take the ICCE sponsored addiction counselor certification exam. A year ago in Bangkok, Thailand with several other worldwide addiction organizations they launched the International Society of Substance Use Prevention and Treatment Professionals,

ISSUP (http://issup.net/en/) which intends to become the prime professional organization representing addiction prevention and treatment specialist worldwide. We will be launching soon ISSUP-Kenya to represent the substance abuse professionals of Kenya.

Bill White: Are there ways that our readers could help support the work of SAPTA in Kenya?

Dr. William Sinkele: Depending on grants is necessary but there always is the in-between period for grants when you are really financially struggling. So we need to find ways for financially sustainable programs. I would appreciate anyone who is willing to support us financially or who could connect us to possible American donors.

A few readers may consider coming to Nairobi to volunteer to work with us for periods up to 6 months. I can't pay anyone. For $50 one can get at the airport a three-month visa which can be renewed for 3 more months. English is spoken in Nairobi. All of the training is in English. Volunteers could work with our trainers. Also Nairobi and environs has some of the best wild life parks which could be visited while here.

Areas we could use technical training on include relapse prevention, adolescent treatment, women treatment, clinical supervision, family therapy, sex addiction treatment, mindfulness-based relapse prevention, and trauma/PTSD treatment. We need advice on telehealth solutions for SUD prevention, treatment, and recovery APPs. Also we are looking for treatment programs: evidence-based treatment planning; psycho-educational material and software for treatment planning, and any addiction books for our library.

Another possibility is real-time training from the States via Skype or Vsee: 8 a.m. Eastern Standard; 4 p.m. Nairobi, Kenya. If any organization has training videos they can send them to me via: Dropbox or Google Share.

While I am in the States for the ATTC NFAR Technology conference at the beginning of August 2016, I would appreciate anyone who could organize fundraising for our work. If my expenses were paid I could travel and give talks. From 21st-23rd September I will be at the TOT LGBT substance abuse training in Minneapolis. If anyone knows of a donor who might be interested in our work, you can introduce us.

One of my dreams is to buy land for two farms, one near Nairobi and another at the coast that we would have greenhouses both to raise food for our PWIDs and their children and to have financial support for them for income-generating activities. Eventually we would open also a rehabilitation center for those needing longer term treatment.

I know this seems a long list of things I am looking for but our needs are many and our resources limited so we would appreciate any support to increase the effectiveness of our training, treatment, and research programs.

Career Reflections

Bill White: What have been the greatest personal challenges you have faced in this work?

Dr. William Sinkele: Work in this field has not been financially rewarding to me. I am poorer now than I ever was as a priest with a vow of "poverty." Just keeping SAPTA alive over the last few years has been a major challenge. But we have had several "miracles" that have kept us going. I have been blessed with a dedicated staff who have stayed in the fight despite financial challenges and offered excellent services to our students and our clients.

Bill White: What has sustained your involvement for all of these years?

Dr. William Sinkele: My own faith in a loving God has sustained. I say there are two absolutes in Africa: 1) God's love for all people at all times; and 2) whatever you planned will change. My own involvement with AA has helped sustain me and keep me sober. The Dominican Order when I was a priest also was supportive as was my Kenyan wife when I was married. My wife died a couple of years after we were married so now I am a single parent to nine children (six stepchildren of my wife's first marriage and three young men from Rwanda I "unofficially" adopted after they came to Kenya after the genocide). My kids have supported my work. Over the last couple of years I have begun to practice mindfulness and compassion meditation practices, part of it to recapture my early career contemplative orientation and also to ground me in the middle of the many activities I am involved in.

Bill White: What are some of the most important lessons you have learned that would be of potential benefit to others seeking to expand treatment and recovery support services in Africa?

Dr. William Sinkele: While I do believe that inpatient treatment is important and necessary, in Africa it will always cater to a relatively small number of people. I believe that we need task shifting to more community-based evidence-informed prevention, treatment and recovery. We need a massive scale-up of manualized-guided peer educators supported by a digital-based mentoring system and distance learning platform.

A new and exciting area is e-health/e-counseling/e-digital solutions to prevention, treatment, and recovery. Our adolescents and young adults are very digital. The female sex workers and men who have sex with men, even when they are drunk, are more likely to hold onto their phones in order to be in contact with their clients and friends.

I think we are facing a possible public health epidemic across sub-Saharan Africa if we do not systemically face the issue of people who are HIV-positive and drinking. The negative consequences are many leading to a greater progression of morbidity and mortality. One of the things I really fear is the development of ART resistance through drinking, missing dosages, and developing ART resistance and then, through unprotected sex, passing on both the HIV infection and the ART resistance.

Another issue is our adolescents and young adults. Kenyans are the most Westernized of the East African countries. There are good points and bad to this. I believe that many of our younger generations are facing major challenges of alcohol, drugs, mental illness, and process addictions, specifically pornography. We need to intervene early and often with them. We need to set up an adolescent addiction treatment program. I am advocating with the Ministry of Health that we set up a national task force of psychiatrists, psychologists, pediatricians, addiction specialists, educationists, and church and mosque leaders to address the critical substance abuse-mental health challenges of our children, adolescents, and young adults.

I have been advocating for 7 years that SAMHSA fund an ATTC for Africa from several points in Africa: East, West, and Southern Africa. The population of sub-Saharan Africa in 2015 was 962,286,000: more than three times the size of the USA. If there are ten ATTC regional centers in the USA, surely we need several regional ATTCs in Africa.

Bill White: Dr. Sinkele, thank you for taking this time to share your experience, strength, and hope with our readers.

Dr. William Sinkele: Bill, thank you for this opportunity. I have admired your writing for many years and was happy that we had the chance to personally meet at a NAADAC conference years ago. I can be contacted at: williamsinkele@yahoo.com also I am willing to Skype with anyone: bill.sinkele. Additional information is available at www.sapta.or.ke

Acknowledgement: Support for this interview series is provided by the Great Lakes Addiction Technology Transfer Center (ATTC) through a cooperative agreement from the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT). The opinions expressed herein are the view of the authors and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA, or CSAT.