ADAPTING AND TAILORING OPIOID AGONIST TREATMENT SERVICES FOR FEMALE SEX WORKERS LIVING WITH HIV IN SOUTH AFRICA: AN IMPLEMENTATION PLANNING STUDY

Authors:
Rosen JG[1,2,3,4], Matenjwa N[5], Dladla N[5], Mcingana M[5], Steingo J[5], Singh C[5], Chen V[4], Payne M[4], Rucinski KB[4], Baral SD[4], Hausler H[5], Knox JR[6,7], Schwartz SR[4]

[1] Rhode Island Hospital, [2] Brown University Warren Alpert Medical School, [3] Brown University School of Public Health, [4] Johns Hopkins University Bloomberg School of Public Health, [5] TB HIV Care, [6] New York State Psychiatric Institute, [7] Columbia University Mailman School of Public Health

Background:
Despite the availability of opioid agonist treatment (OAT), specifically methadone, for people who inject drugs (PWID) in South Africa, there is limited study of optimal OAT delivery strategies for female sex workers (FSW)—many of whom smoke opioids. Thus, we characterized OAT implementation determinants and described necessary service adaptations to serve FSW in Durban (KwaZulu-Natal) and Mbombela (Mpumalanga), South Africa.

Methods:
We conducted 27 in-depth interviews with FSW reporting lifetime opioid use (*n*=17) and providers of OAT services (*n*=5) and FSW-focused HIV services (*n*=5), respectively. Using rapid qualitative analysis, we identified salient barriers and facilitators of PWID-centered OAT delivery, guided by the Consolidated Framework for Implementation Research; explored FSW's intentions and experiences with methadone initiation/maintenance, framed by the Transtheoretical Model; and articulated OAT service modifications to better engage FSW, structured using the Adaptome Model.

Results:
Participant narratives highlighted overlapping *structural* (i.e., opioid-injection prerequisites for OAT eligibility, regulations restricting methadone prescriptions to specialty physicians, law enforcement interference with service provision, suboxone cost/supply volatilities, stigma and "NIMBYism" towards OAT services) and *institutional* (i.e., OAT dispensing exclusively from static clinics, siloed workflows stymying OAT referral/initiation pathways, overburdened clinical and peer workforces) constraints to OAT implementation. FSW characterized daily, directly observed methadone dispensing as onerous and weighed the benefits of opioid cessation (i.e., income stability, repairing fractured relationships) against its consequences (i.e., withdrawal symptoms interfering with sex work productivity, dissolution of client relationships anchored in opioid use, child separation following methadone use disclosure, loss of coping strategies for stimulant overuse and post-traumatic stress). Participants suggested trauma-informed, peer-led programming; client mobilization via telephone messaging and social media platforms; and alternative delivery modalities (i.e., mobile dispensing, expanded clinic hours, suboxone availability) as requisite OAT service adaptations for FSW.

Conclusion:
FSW-responsive OAT service adaptations will likely require sustained financial commitments and methadone de-regulation in South Africa.

Disclosure of Interest Statement:
The authors have no conflicts of interest to disclose.