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Navigating Professional Paradigms: Transactional Sex, Behavior Change, and Structural Responses in Uganda

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Abstract

Professional paradigms within social work and related social service fields have been critiqued for being behaviorally focused, thereby obscuring and perhaps excusing structural determinants of health and well-being. Recent initiatives in international social work have aimed to align theory, practice, education, and research with sustainable development, reflecting the United Nations' Sustainable Development Goals, which aim to address structural determinants. Our qualitative research examined responses to transactional sex among Ugandan youth through in-depth interviews with 23 professionals working in social services with youth who were vulnerable to HIV. Through thematic content analysis, using deductive and inductive analysis, we examined the demographics and determinants of youth transactional sex, prominent models of response delivered by and observed by providers, and the critiques or observed limitations of current practice models. We found that behavioral strategies are pervasive, which is an apparent misalignment with the economic determinants identified by social service professionals. While interviewees described some structural economic interventions, they critiqued gaps and limitations in responses influenced by internal and external pressures shaping professional practice. Our study adds critical analyses regarding social work and social service paradigms to advance structural, social justice-informed responses that align with and advance sustainable development.

Keywords: *transactional sex, HIV, determinants of health, behavior change, structural intervention*

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Introduction

Transactional sex (TS) has received relatively little scholarly attention compared with other HIV and sexual health risk factors. Often conflated with commercial sex and age-disparate relationships, the defining features, demographics, and impacts of TS are contested (Ajayi & Somefun, 2019; Stoebenau et al., 2016; Choudhry et al., 2015). We defined TS as "non-commercial, non-marital sexual relationships motivated by the implicit assumption that sex is exchanged for material benefit or status" (STRIVE, 2019, p. 16; Kyegombe et al., 2020). Our study examined TS among Ugandan youth through in-depth interviews with 23 social work and social service professionals, focusing particularly on practitioner perceptions of the determinants of and responses to TS. In this qualitative research, we used thematic content analysis, combining deductive and inductive approaches, to examine the predominant paradigms and practice models employed to respond to this sexual health issue. Within social work and related social service fields, critical scholarship has identified the pervasive influence of a behavior paradigm in practice, which may obscure structural determinants of health and well-being, as a problem. However, recent efforts in international social work have aimed to align professional practices with sustainable development initiatives, such as the United Nations' Sustainable Development Goals (SDGs) that focus on addressing structural determinants.

Our research presents the observations and analysis of social work and social service professionals working in HIV social services with vulnerable youth, driven by four research questions: (1) How common is youth TS, and what are the demographics of those engaged? (2) What are the determinants of youth TS? (3) What are the predominant models providers are using and observing in the response to youth TS? (4) What are the limitations and/or critiques of available models of response?

Review of the Literature

The implicit nature of TS differentiates it from commercial sex and introduces important vulnerabilities for youth navigating agency and expectations in sexual relations (Stoebenau et al., 2016; Ranganathan et al., 2017; Fielding-Miller et al., 2017). Prior scholarship (e.g., Krisch et al., 2019; Bantebya et al., 2014; Osei-Yeboah et al., 2019) depicts disproportionate effects on adolescent girls and young women (AGYW) in low- and middle-income countries, particularly driven by gendered economic inequities, as well as the association of TS with HIV risk, in part due to AGYW's difficulties negotiating consent and condom use (e.g., Toska et al., 2017; Ranganathan et al., 2017; Fielding-Miller et al., 2017). Thus, differentials in social and economic power along gender lines play an important role in TS, representing important structural determinants of health and well-being.

Structural and Behavioral Paradigms

Critical scholarship has highlighted a long-standing tension in social work and related social service fields, particularly a tendency to overemphasize behavioral analyses and interventions at the expense of structural approaches. These critiques raise questions about professional paradigms (or accepted, often unquestioned, frameworks and conventions of practice [Kuhn, 1977]) that have trended toward behavioral strategies, often thereby obscuring, and perhaps even excusing, root causes.

As Ashcroft (2014) highlighted, public health social work evidences important historical and rhetorical commitments to structural or transformational change, but starting in the 20th century, deferred to therapeutic and individualized behavioral approaches (guided by behavior change theory and interventions). Lamenting the loss of a social justice orientation, Ashcroft (2014) argued, "the transformational view of social work strives for social change with the intention of fostering more egalitarian relationships in society so that the most disadvantaged can obtain power" (p. 607). Nikku and Rafique (2019) proposed political social work to redress how "social workers have abandoned their involvement in influencing societal macro-level changes and have undergone a process of de-politicization" in the neoliberal context (p. 878). Mathebane and Sekudu

(2017) considered how social work practice reflects coloniality through the dominance of Western epistemologies, including the proposition of a universalist international social work. They discuss how the Western paradigm centers values of individualism, materialism, and competition over the "collectivism, communalism, and cooperation" seen in African contexts (p. 1162) and reflected in the concept of ubuntu, an Africanist philosophy often summarized by the phrase, "I am because we are" (Onyebuchi Eze, 2011). Mathebane and Sekudu (2017) thus proposed a decolonized approach where Afrocentric social work perspectives can coexist nonhierarchically and discussed calls for social work "to return to its original domain of structural change and social justice" including "critical conscientisation, engagement with oppression and issues of power, a commitment to radical transformation, changes in epistemologies, and efforts to change material conditions" (p. 1164).

Calls for a shift in perspectives and practices transcend social service fields. Freedman (1995) examined the behavior paradigm's dominance in global public health, where women, often valued only instrumentally as mothers, are blamed for familial and societal issues like child malnutrition. While HIV policy and practice uncritically incorporate behavioral approaches, Freedman states, "It is also critical to recognize that the decision to focus on individual behavior to the exclusion of other social determinants of ill health is a *political choice*; it is not an inescapable answer compelled by an indisputable, 'scientifically correct' understanding of disease causation" (p. 322, italics original). Link and Phelan (1995) added to these critiques with their concept of "fundamental causes" that precede individual behaviors as root cause determinants. They implored that individual risks must be contextualized, arguing that "without an understanding of the context that leads to risk, the responsibility for reducing the risk is left with the individual, and nothing is done to alter the more fundamental factors that put people at risk of risks" (p. 85). Fundamental causes, like socioeconomic status and structural racism, are linked with multiple health outcomes and mediated by multiple pathways or mechanisms (Phelan et al., 2010; Phelan & Link, 2015). As such, addressing one pathway will often fail because it is "aimed at changing behaviors that are powerfully influenced by factors left untouched by the intervention" (Link & Phelan, 1995, p. 89). Echoing the calls of others, Phelan et al. (2010) advocated for structural approaches, including interventions that reduce resource inequalities to address the fundamental causes.

Sustainable Development

Recent initiatives in international social work have aimed to integrate theory, education, practice, and research with a focus on advancing sustainable development (i.e., Bromfield & Duarte, 2022; Ioakimidis & Sookraj, 2021). The United Nation's SDGs provide a framework for reducing poverty (goal 1), advancing good health and well-being (goal 3), and ensuring decent work and economic growth (goal 8). While there is a specific goal for advancing gender equality (goal 5), indicators of gender equity are infused across the SDG framework including within work; economic security and influence; health; and other social, economic, and political domains (United Nations, 2023). Lombard (2015) outlined how the SDGs align with the 2012 Global Agenda for Social Work and Social Development, as both focus on advancing a just society based on equality of opportunity. Both frameworks share a strategy of addressing structural determinants, including through political action. For instance, Lombard (2015) highlighted the common commitment to advancing social and economic equality as "economic power and political power are always interwoven; hence, redistributing economic and political power more fairly is often the first step towards breaking the cycle of inequality" (p. 484). As such, the SDGs provide a framework that aligns with professional calls to advance structural interventions as a core focus of social work practice, and they lend a rights-based approach to advancing health, including sexual health (Bromfield & Duarte, 2023; Ioakimidis & Sookraj, 2021; United Nations, 2023). This framework for sustainable development also reflected the ecological model of health, which considers multiple levels of health determinants, including structural determinants, and the interactive pathways through which these determinants shape health behaviors and outcomes (Gebbie et al., 2003; Tice et al., 2019).

Responses to Transactional Sex

Across existing TS literature, concluding recommendations also highlight the need to address structural determinants. Ajayi and Somefun (2019) examined TS among Nigerian university students and suggested free university housing as a structural intervention. Fielding-Miller et al. (2017) examined TS and HIV among pregnant women in Swaziland, concluding that interventions must address "structural drivers of gendered economic disparity that reduce women's agency within their sexual and romantic relationships" (p. 1). Wamoyi et al. (2018) studied age disparity and TS among AGYW and older men in Uganda and Tanzania and suggested a series of interventions, including cash transfers, financial literacy, female entrepreneurship, and gender transformative training for women and men. Ranganathan et al. (2017) examined TS among South African young women and suggested coupling HIV prevention education with income-generating programs.

Recommendations of structural interventions, including economic empowerment programming, are encouraging, although there are limited studies of TS describing such interventions or their outcomes. Sastry and Dutta (2013) also aptly critiqued the "neoliberal gendering" of global HIV policies that posit economic empowerment models as the answer while obscuring more complex global systemic determinants. They state that "the positioning of microcredit as a panacea to women's poverty serves neoliberal ideology by constructing empowerment within market logic, and simultaneously erasing the marginalization of women accomplished through the fundamentally patriarchal nature of neoliberal interventions" (p. 32).

Studies of TS interventions are generally presented within broader HIV programming evaluations and offer various conclusions. Toska et al. (2017) presented a systematic review of research on HIV-positive youth in sub-Saharan Africa, with Uganda being the most represented country of study and where TS was one of eight risk factors. They identified just three studies demonstrating effective interventions to reduce sexual risk-taking, all involving behavior change strategies, where only one incorporated vocational training and livelihood support. Karamagi et al. (2018) examined strategies to prevent TS and HIV among AGYW in northern Uganda, sharing that "many interventions focus on changing individual-level behaviors rather than addressing the larger contextual and structural landscape" (p. 2). Nonetheless, the study largely focused on behavior change strategies to reduce sexual risk-taking, supported by parental and community-level resources and commodities. Cluver et al. (2013) studied the effects of child-focused state cash transfers on adolescent sexual risk in South Africa, finding that this structural intervention reduced "deprivation-driven behaviors," including TS. They stated that "although many prevention programmes prioritise educational and behavioural approaches, additional interventions that address structural drivers of the epidemic are needed" (p. 362).

Methods

Using qualitative methods, our study engaged providers working in social services with youth who were vulnerable to HIV. While most studies of TS examined affected populations, our study uniquely examined the perspectives of providers who are active in the response. We considered provider perceptions of the determinants of youth TS and then applied the concept of paradigm to consider the extent to which behavioral approaches infused practice, and whether structural interventions were utilized or encouraged.

Study Design

Our study was approved by the Simmons University IRB and The AIDS Support Organization's (TASO) Research and Ethics Committee of Uganda. Our semistructured interview guide consisted of open-ended questions inviting participants to share their professional perspectives based on their ongoing social service work with vulnerable youth. Providers were asked to describe (1) the extent of youth TS and the demographics of those engaged; (2) the drivers or determinants of youth TS; (3) their models of response and the predominant models they observe in practice; and (4) limitations in and critiques of service strategies and

provision. Interviews averaged 90 minutes (ranging from 1 to 2 hours) and were audio recorded. All interviews but one (where the interviewee selected Luganda) were completed in English.

Study Setting and Population

Our research took place in July, 2019 in Kampala, Uganda. This site was selected based on Uganda's internationally recognized success in responding to HIV/AIDS in the 1990s and 2000s (Vithalani & Herreros-Villanueva, 2018), recent increases in youth HIV prevalence, and estimates that one in four AGYW in Uganda engage in TS (UNICEF, 2019). We recruited professional social work and social service providers from a variety of health and human service agencies and nongovernmental organizations engaged in HIV prevention and care with at-risk and vulnerable youth. We used a purposive sampling approach to garner broad representation across organizations, programs, and professions. One of the authors (Dr. Kamya), a native Ugandan who has worked with local organizations for years, sent initial recruitment emails inviting participants and offering a $20 USD incentive. Interviews took place in a private setting of the participant's choosing, typically a workplace office, and participants completed the informed consent process at the start of the interview.

Participants

Twenty-three providers participated, including 13 who identified as women and 10 who identified as men, with a mean age of 37 years (range of 20–65 years old). Providers' professional experience ranged from 1 to 33 years, with a mean of 7.5 years in their present position and a mean of 10 years in the field of HIV services. Nearly half (48%) worked in direct service (22% counselors, 17% educators, and 9% medical providers) and the other half (52%) served in management positions (39% program management and 13% program operations). Twelve (52%) were academically trained in social work, counseling, and/or psychology; five (22%) were trained in medicine, nursing, and/or public health; and the remaining had varying degrees including secondary school diplomas and training in law, communications, management, and development. Interviewees worked for 12 different organizations in Kampala, of which five were focused nationally, four were focused internationally and nationally, and three provided local, city-wide services.

Data Analysis

Interviews were transcribed verbatim, and interviewee names were replaced with pseudonyms (including in this article). We used NVivo 12 software for data analysis, undertaking thematic content analysis that combined deductive and inductive approaches (Wamoyi et al., 2018; Flick; 2018). We created a coding framework guided by the four research questions on demographics of youth TS, determinants of youth TS, models of responses, and critiques or observed limitations of the response, which were further informed by iterative initial readings of interview transcripts. We began with thematic coding and proceeded to focused and axial coding (Padgett, 2017), with both of us completing line-by-line coding of each interview (Braun & Clark, 2006). Meeting regularly, we added to the coding frames inductively, through mutual agreement (Saunders et al., 2018).

Findings

We present our findings, first focusing on the extent of and demographics of youth TS and provider observations regarding determinants of TS. We then present our findings on providers' strategies and interventions and consider provider critiques of current practices.

Youth Demographics

Providers were asked to share their observations of how common TS was among youth and to discuss dynamics of gender, age-disparate relationships, and multiple partnerships. Eighteen of 23 providers described TS as "very common" among youth, although all discussed its presence as a youth issue. All providers noted that the youth tend to have multiple partners and that the relationships are age disparate:

> The partners tend to be actually older. In Uganda, we call them sugar daddies or sugar mommies. Ya, so the partners, they most tend to have a 20-year age gap between these teenagers and them. Or, if they are so young, there is a 15-year age gap between them. But most times they are older because also [the youth] have this view that these people will be able to provide for their needs so somebody of the same age group may not necessarily provide like they would want. (Grace, project manager with 2 years of experience; training in law)

All providers also described how both girls and boys participate in TS, although most emphasized that AGYW are more likely to be engaged.

Determinants of Youth TS

When asked what factors drive TS among youth, 22 of 23 providers discussed economic disempowerment in at least one form (White & Kamya, 2021; Kamya & White, 2022). Most saliently, providers mentioned economic determinants such as food insecurity (19 providers) and needs for shelter (11 providers). They also discussed the pressures of unemployment and lack of viable economic opportunity (7 providers) and related cost pressures like feminine hygiene products (11 providers) and school fees (4 providers). These pressures sometimes led youth to take on more than one partner:

> Most of them, you know, the economy is getting tighter and tighter, people can't even, even after working so hard, all you can get is food… Most of these youth want a good life, so you find she is having someone to pay the rent, someone to buy her food, while she is working in a bar. (Lydia, social worker with 9 years' experience; training in social work and education)

In addition to these economic needs, 16 of 23 providers spoke about economically driven desires beyond subsistence, based in lifestyle or consumption aspirations (White & Kamya, 2021). These include things like furniture, fashion items, cell phones, entertainment, and other "luxury" items.

Providers also discussed gendered drivers of TS for AGYW (Kamya & White, 2022), including relationship violence (20 providers) and other forms of toxic masculinity and male dominance in women's lives (15 providers), such as marriage inequality (8 providers). Providers also spoke about a broader lack of value placed on women societally (12 providers). Seventeen of 23 providers discussed the role of gender socialization and the ways roles are reinforced across the lifespan:

> The girl child is more disadvantaged. But I think it is also coming from our cultural background, because we are dealing with a patriarchal society. We are looking at a man as the head of the household and they have each and every entitlement in society. They have every right when it comes to decision making; a woman is secondary … . So, it is kind of culturally connected, and maybe we need to do something about it which might take us a number of generations to change that. (Tinashe, counseling program manager with 8 years' experience; training in social work)

Current Models: Predominance of Behavioral Paradigm

When asked about models and approaches providers use to address youth TS, every provider discussed behavior change strategies. One of the primary approaches, described by 20 of 23 providers, was condom provision. Providers talked about the male condom being free and readily available, particularly through community dispensaries, and their comments normalized the method, affirming strong youth uptake. Six providers discussed female condoms, with two providers discussing the reluctance of women and/or men to use them.

Education and awareness strategies were commonly mentioned, with 17 providers discussing health education, outreach, and sensitizations. Providers discussed delivering such programs in schools, workplaces, and community settings. Some framed education as the limits of their influence:

> All we do is provide information. We provide you with the right information and then it's up to you to make the right decision. We give you the information, you are informed so that you know that, if I am doing this, it's either this is the right thing to do or not. If I am having sex with a sugar daddy, is it protected sex or not. We educate you, so it's up to you to make that decision because you can't force someone. (Isabel, peer educator with 2 years' experience; university student)

Eighteen providers discussed empowerment models, which they differentiated from education or outreach. These approaches center on life skills that promote assertiveness and self-value, ensuring that, beyond gaining knowledge, youth develop the capacity to act:

> It is not just about giving you information or services at one time … . Actually, we are moving away from sensitization to education. You have a series of repeated sessions … Awareness. But the empowerment makes you take responsibility, and [instills] the drive to take action. Sensitization—'We know there is HIV, we know there is condom, but what gives me conviction to know that I have to protect my life, I have to use a condom? What is that?' So, in the empowerment model, you trigger that in the young person… That has big power of change. (Andrew, national program manager with 10 years' experience; training in social sciences).

Providers discussed how women, in particular, learn how to navigate consent through these models:

> We would be talking about critical thinking, about creative thinking, and about negotiation … . Because life is all about these life skills. Because when you are faced with these very hard moments, it is you and that life moment. I may not be there, your parents may not be there, so how would you move out of this kind of moment without further harming yourself? (Tinashe, counseling program manager with 8 years' experience; training in social work)

With these models, providers discussed the importance of engaging community members as role models, rather than outside educators. In particular, 17 providers discussed peer educational models and how youth more readily open up to, and are influenced by, peers:

> They listen more to their age [peers], they understand their age mates and open up to them when they will not actually open up to you who is much older. So, when you have the youth, they tell you they got some problems and they also help pass the information through their age mates. They have helped us a lot. (Victoria, Clinical Officer with 9 years' experience; training in medicine and public health)

Providers also spoke of the power of youth voices in community advocacy, outreach, and social networking roles.

Considering community settings, nine providers talked about school-based programming, including a variety of models and curricula they use in these spaces. They described national models, and how the educational content is leveled according to age, development, and sometimes gender. Seven providers, two of whom worked for religious institutions, discussed the impacts of religious education, emphasizing positive influences such as moral guidance. As one shared, "Why do I say religion? I have met so many young people who choose to abstain because their religion says so. So, you can see that level of contribution" (Owilli, national coordinator with 15 years' experience; training in communications).

Finally, 18 of 23 providers discussed counseling in the form of group or one-on-one therapy. These approaches focused largely on changing values and belief systems and included social and behavior change communication, cognitive behavioral therapy, free association, psychoeducation, and goal setting. Eight providers discussed parent-child models, including support groups, clinic-based workshops, and home visits. They spoke about the importance of bridging communication gaps, some highlighting that parents are not readily dialoguing with their children about these issues. One provider explained:

> The other programming that we have introduced is the intergenerational programming, where we are also engaging the adults. Sometimes it's joint, where you have the youth and the adults in a dialogue or in sensitization sessions, or in a debate. But, also, sometimes we target the adults themselves. We are also doing a lot of mentorship on parenting, trying to strengthen the parenting because that is one of the major gaps. (Andrew, national program manager with 10 years' experience; training in social sciences)

Key Messaging and Modalities

Providers described the content of their messaging and various modalities used for service delivery. They emphasized youth-friendly approaches, with nine providers discussing social media, both its promise and complexity. Five providers discussed interactive games, music, skits, sports, video games, cartoons, and short films, describing how these approaches invite youth to learn through active play and engagement. Eight providers discussed popular campaigns delivered through billboards, posters, TV and radio ads, and the use of slogans. They described the effectiveness of campaigns like "books before babies," "it's cool to abstain," and "something for something love," the latter of which specifically addressed TS.

Providers also described the tone and content of messaging. Twelve spoke about the importance of creating relatable messaging, including offerings in multiple languages, in youth-friendly terms, and tailored to unique settings. One provider explained how this draws youth into an active exchange:

> How are we engaging them, what language are we using—how are they part of this whole thing we are talking about? … . So, if you are instructing, you are simply telling me, you are telling me, you are directing me what to do. If you inform me, you are just giving me information and I am just sitting there as a passive person listening to you. But if you are questioning, it means that we are balancing power in this conversation. You are an active participant; you are an active activist. You're not just someone who is listening to me, but you are actively and intimately engaging in the process. (Namuddu, program officer with 10 years' experience; training in social work and development)

However, there was division over whether negative or positive messaging is best. Twelve providers spoke of the use of scare tactics, some referencing the effectiveness of such messaging early in Uganda's epidemic:

> In the beginning of the epidemic, the reason why Uganda was credited is because we had scare messages. And, that was for a fact. As the epidemic grew … research comes out and says, scare messages don't work. We have tested it, we have proved it. But, in the beginning, why we got that from 30 to 6–7 [prevalence rates], and then to 6, was because people would see images of people who

> were dying of [AIDS]. (Owilli, national coordinator with 15 years' experience; training in communications)

Others spoke about uses of scare tactics with youth today:

> We take them through the challenges they can face. If you do this, if you continue this, this is what is going to happen, and when it happens, this will also, and when that happens, this will also … . So, from there they will understand and say, "oh, I get it." When they came back, and they told me that … . I have stopped." (Loraine, social worker and program manager with 11 years' experience; training in social work and community development)

In contrast, eight providers spoke of the importance of using positive messaging and embracing youth for who and where they are:

> Specifically, we use a benefits-based kind of language, so we are not just portraying a lot of negative… How do we frame the language in a way that someone will understand if I do [this], the benefits are these … ? How do we shine the light on the benefits rather than the negatives? (Namuddu, program officer with 10 years' experience; training in social work and development)

Another provider spoke about engaging LGBTQ+ youth, and how they aim to do so in a positive, relatable way, explaining, "Because every time you stigmatize me, you are pushing me away from services" (Tinashe, counseling program manager with 8 years' experience; training in social work).

Finally, in terms of models of sexual education that guide content, providers had a range of responses. Seven spoke about risk reduction and the importance of offering a full array of options:

> And then that is when you come in and critically assess—How do they engage? Why are they exposed to this kind of risk? And then, together, you walk through that kind of environment and see, what can you do to make life a little better or to improve? Because you have these risks here, you have these risks there, you have this here. But how do we—you may not totally eliminate them, but how do you live with them, without harming you? And maybe without you harming the society or community you are coming from. (Tinashe, counseling program manager with 8 years' experience; training in social work)

Six providers specifically spoke about the ABC model (Abstinence, Be Faithful, Condomize), a risk reduction model that was a part of Uganda's early success in the epidemic (Kirby, 2008). However, nine participants discussed the prominence of abstinence-only or abstinence-until-marriage models, particularly in schools, which we discuss further later in this article.

Available Structural Interventions

As illustrated previously, when asked about responses and approaches to addressing youth TS, providers focused on behavior change strategies. Only two providers volunteered that their work is guided by the ecological model, highlighting multilevel determinants of health:

> We use ecological model—I don't know if it is relevant. Ecological model looks at the young person directly and then looks at all the factors that influence the behaviors of this young person… We look at the young person, what is influencing the behavior, then we go to the family unit. Then we look at the environmental factors… Then we go to the school. How does the school influence the behavior of the young person? Then the cultural and community leaders. Then the political [factors]. How does all that influence the behavior of the young person? (Auma, logistics specialist with 7 years' experience; training in communications and development studies)

Within the interviews, after probing theories and models of response, we probed providers' thinking about structural determinants and interventions, asking about any models providers used or observed that address structural drivers.

Fourteen of 23 providers acknowledged that responses were not targeted to address structural determinants, an important finding related to our interest in professional paradigms. Nine interviewees spoke about how providers and programs are not adequately tackling gender dynamics and inequalities. Several acknowledged the limitations of behavioral approaches directly: "That is why it has to be multifactorial, a multifaceted approach, because, apart from behavior change, we have to talk about addressing the economic frailties in women. We have to address them" (Joseph, medical officer with 33 years' experience; training in medicine).

In terms of available structural interventions, 14 providers discussed vocational training and income-generating activities. These included financial literacy courses, skills-based courses, and sometimes seed money or start-up inputs. Providers described various trades, typically promoted along gender lines (e.g., carpentry and electrical for boys, hairdressing and soapmaking for girls), and several emphasized how girls gain economic independence and confidence:

> When they have dropped out of school, we often, every girl must get … vocational skills. We train them in tailoring, cabinet making, bead making, and in that way, they can acquire a skill which will be [useful] for a lifetime. So, when they leave this place they will learn not to depend on a man to give them money but to have a skill working with their hands for life where they can earn a living if they fail to go back to school. (Hilda, program founder and director with 15 years' experience; training in nursing and counseling psychology)

Another interviewee echoed this sentiment, stating, "If you get them involved in a productive activity then they will build that confidence in themselves, they learn to earn a living, they are less likely to seek for a sugar daddy and get into transactional sex" (John, community psychologist with 24 years' experience; training in social psychology and community medicine). Overall, interviewees discussed the strong positive impacts of this programming.

Six interviewees identified other structural approaches, including bursary or scholarship programs, direct food distribution, village savings and loans programs, provision of sanitary pads, and working with religious and cultural leaders to change or address cultural practices. Included in this, four providers discussed the importance of gender transformative training with girls and boys. These six providers also discussed their policy advocacy work, or their support of youth advocacy, focused on improving HIV and public health capacity, and developing laws for the protection of women, marriage equality, and preventing youth sexual exploitation.

Critiques of the Response

As we invited discussions about structural responses, our questions often prompted a turning point in the conversation, where providers began identifying issues or inadequacies in current practices. Toward the conclusion of our interviews, we also asked providers to speak about what is missing in the response to the challenges of youth TS. Here, and otherwise throughout the dialogue, interviewees shared their critiques of services and models of responses, some highlighting structural or political barriers.

One of the most common critiques focused on the influence of religious institutions. Eighteen discussed negative influences on the response to TS and seven providers also shared positive aspects, discussed previously. Providers focused primarily on Christian (particularly Catholic) institutions, though some also critiqued Muslim and other institutions. They described how these institutions shape sexual education (to the

detriment of the ABC model), influence policy, and perpetuate myths among congregants. Several highlighted how religious leaders' silence, or stoking of stigma surrounding HIV and sexuality, causes damage:

> I am forced to start with, that, I think it is a sleeping giant, this is the religious bodies have got all the power to change the lifestyles of their people, of their followers. But they have been dormant, they have not come up to speak up, to talk about it on their pulpit. They have forgotten that there is AIDS still eating up their society and the people in the church, or mosques, or whatever. So, they … it is like they haven't woken up to say how do we go about it? They have not. (Hilda, program founder and director with 15 years' experience; training in nursing and counseling psychology)

In terms of policy, most participants discussed the national sexuality framework and the influence of religious pushback:

> Again, in terms of any policy that will be passed even at the parliamentary level, for example, of recent, they were objecting [to] the sexuality education framework that was passed by the government for young people and the basis was that it is immoral and promotes immorality in the schools and the discussions are still going on. (Kigongo, program evaluation specialist with 4 years' experience; training in social sciences and management)

Participants framed religious institutions as formidable players in influencing available models of response and their effectiveness. Some shared that, as such, organizations must try to engage religious leaders:

> If I am spending 2 hours with the young person, I should spend 2 hours on the priest. Because I can do so much here, and the priest comes up on one Sunday and undoes everything I have done … . Then, even at the government level, when the church comes up and says something, all the technocrats that you've been working with begin to pull off." (Kennedy, program manager with 12 years' experience; training in psychology)

Condom barriers were another limitation noted by 17 providers. Much of the critique focused on the inability, per national policy, to provide condoms in schools to youth through age 18. Providers discussed myths about condoms, their functions, or success rates, sometimes stoked by religious or political figures. Some related the discussion to cost barriers, as people may resist free condoms while struggling to pay for commercial ones, due to misperceptions about quality differences. Also, some noted that condom dispensaries, while essential, sometimes run empty, or stoke stigma and youth avoidance:

> The condom dispenser is here. So, he rides by and parks way over there. [He] comes back, and first goes somewhere else, comes through there, then comes to the dispenser, looks around, like this, picks the condoms, puts it in his pocket, then he walks back around, then he goes back to his bike. (Owilli, national coordinator with 15 years' experience; training in communications)

Interestingly, some noted that youth feel judged or surveilled by healthcare providers themselves, which raises a concern beyond general societal stigmatization:

> They will look for [condoms] from informal sector, through their peers. But for formal [channels], that young person cannot go to the hospital [saying] that they need a condom. Some of the health workers will say that they are going to report you to your parents. (Andrew, national program manager with 10 years' experience; training in social sciences)

More broadly, eight providers said fellow service professionals use judgmental language and frameworks that alienate youth. These discussions often stemmed from providers' insistence on using positive language to meet youth on their terms:

> You are a young person, where do you go? You are a young person, and you are sick—is there a hospital you can go to where you will not be judged, and you get the service you want to, and go back to doing your things? The young people, when you sit with them and they open up, they have this itching on them, but where do they go? If they go to that hospital, they will be judged, "it means you have started having sex now." So, most of them are suffering. (Andrew, national program manager with 10 years' experience; training in social sciences)

Providers said professionals need to stop the "blame game," particularly of young women. As we coded interviews, we noted providers' framing of youth, in terms of how they portrayed their behaviors, attitudes, or responsibility. We found that 10 of 23 providers framed youth as deviant, describing their sexual activities as "misbehaving," "doing funny things," "problematic," and evidencing "bad behavior." Thus, while some providers identified negative judgment as problematic, the framings presented by some interviewees suggest that providers themselves may see youth through an individualistic, behavioral lens. For instance, one provider placed responsibility firmly on her clients: "We have done talking! We have done the education! I think we have tried to address these issues. I feel like it's now down to the person. Someone should be willing to change their mindset" (Isabel, peer educator with 2 years' experience; university student).

Providers also discussed holistic gaps in programming. Seven spoke about the lack of programming to address TS specifically, and another seven discussed resource barriers:

> There is no one who funds strategies to prevent transactional sex. Just thinking about how this can be dealt with, because it is a main driver of HIV … . Yes, it is an area that has been neglected a lot and it is really a major driver for HIV. (Auma, logistics specialist with 7 years' experience; training in communications and development studies)

A few providers lamented the discontinuation of the something for something love campaign, mentioned previously, which historically addressed age-disparate relationships and TS. Others discussed the loss or recent defunding of vocational programs, school scholarships, and other key programs addressing structural determinants.

Finally, nine providers discussed silos among providers affecting the response and the need to take a multisectoral, collaborative approach. However, some highlighted the difficulty in alignment that can arise in coalition building, where not all share a commitment to tackling structural determinants:

> The issue is about how, then, do we fill the capacity of all these people we work with to look at this issue with the same lens. Because I think that is where the issue has been. Everyone may be able to bring something to the table, but with what lens? What is their interest in this? (Namuddu, program officer with 10 years' experience; training in social work and development)

This interviewee discussed the importance of engaging holistic, structural, and intersectional approaches, lamenting that these are not priorities for all providers.

Discussion

Our research highlights paradigmatic tensions that are critiqued within the literature on HIV policy and practice, social work, and related social services. Our interviews revealed some misalignment in the ways that providers discussed the determinants in comparison with the theories and models of response to TS. While providers pointed to economic and gendered determinants as important drivers of TS, they highlighted a predominance of individualized behavior change strategies. The implications could be considerable, as sustained impact may be compromised. The concept of fundamental causes (Link & Phelan, 1995; Phelan &

Link, 2015; Phelan et al., 2010) is salient here, as providers' efforts to address just one mechanism or pathway may leave root cause determinants unaddressed.

Ashcroft and Katwyk (2016) discuss three fundamental "views" of social work. The behavioral strategies described by providers in our research fall into the first two, the "therapeutic view" (focused on well-being through self-fulfillment) and the "social order view" (focused on maintenance supports). However, as the Ashcroft and Katwyk (2016) critique points out, both of these views are flawed as they blame individuals, "encourage[ing them] to thrive despite structural inequalities, with a support system that only just meets immediate needs" (p. 141). Providers debated the merits of various messaging approaches to influence youth, and while some critiqued "blaming" frames, our finding that nearly half of the providers themselves framed youth as deviant raises concern. Providers' characterizations of youth's "misbehavior" reveal perceptions that individual responsibility prevails in the face of structural drivers.

At the same time, more than half of the providers discussed the availability, if limited and waning, of economic interventions. Although these were individualized vocational and income-generating approaches that perhaps reflect a false panacea (Sastry & Dutta, 2013), they represented salient attempts to address economic drivers or fundamental causes (Link & Phelan, 1995; Phelan & Link, 2015; Phelan et al., 2010). These approaches begin to suggest the third view of public health social work. Ashcroft and Katwyk (2016) describe the "transformational view," which is guided by social justice principles and demands redress of societal power differentials. Such approaches could be seeds toward nurturing the critical views and engagement with systems of oppression that Mathebane and Sekudu (2017) advocate. As Morgan et al. (2017) argued, based on their work on maternal health in Uganda, these kinds of economic interventions could have a sustained impact if combined with the gender transformative approaches that a few providers discussed. That these strategies were not as pervasive as behavioral strategies, nevertheless, seems to represent a challenge of professional paradigm, consistent with prior critical analyses. These findings, thus, may have important implications for the potential success or sustainability of HIV prevention and sexual health services.

With this said, it is important to acknowledge that paradigms are shaped by both internal and external pressures (Freidson, 1994). All of the professionals we interviewed worked within institutions and were influenced by national frameworks, funding constraints, grant requirements, and other external pressures. As they discussed the limitations of current responses, providers highlighted both internal dynamics (judgmental views of providers, unnecessary professional silos) and external dynamics (policy influences, funding limitations, and pressures from religious institutions) (White & Kamya, 2021). Social service professionals exist, by nature, within "dependent" professions that do not enjoy great autonomy (Freidson, 1994). Babb (2001) explored how institutional isomorphism within professions derives from both coercive forces (e.g., the influence of resource-granting entities) and normative influences (e.g., pressures exerted within the profession by internal "experts"). Thus, as we add to the critique of professional paradigms, we hope to invite consideration of the multilevel forces that shape the available, accepted, and sanctioned frameworks of response.

Implications for Practice

We hope that our research will challenge social work and social service professionals, academics, and policy makers to consider how paradigms might be shifted to realize the potential of transformative, structurally responsive social services. While behavior change strategies are central to the response to sexual risk factors, including TS, important limitations of the behavior paradigm have been highlighted in critical scholarship. At the same time, calls for structural responses do not seem to be pervasively reflected in practice, perhaps due to internal and external pressures on service professionals and organizations. Social service professionals in micro- and mezzo-level practice might engage in a reflective analytical assessment to examine assumptions

and limitations embedded in their practice models, applying concepts like fundamental causes (Link & Phelan, 1995; Phelan & Link, 2015; Phelan et al., 2010) and the ecological model of health (Gebbie et al., 2003; Tice et al., 2019) to contextualize understandings of and interventions related to health behavior. Such models likewise encourage practitioners to organize efforts to address economic and social inequities shaping health outcomes, which may include economic interventions like state-sponsored cash transfers (Cluver et al., 2013), free university housing (Ajayi & Somefun, 2019), and gender transformative training and policies (Wamoyi et al., 2018). The potential of these and other structural interventions speaks to the importance of macro-level social work and social service practice, and the engagement of micro- and mezzo-level professionals in policy advocacy (Tice et al., 2019). Ultimately, the efforts of social work and social service professionals at all levels are needed to address powerful structural determinants situated in economic, social, and political realms. As Nikku and Rafique (2019) highlighted, this would require reckoning with social work's depoliticization and formulating a practice of political social work.

In support of such shifts, social work and social service professions will need to continue to recognize and challenge pervasive paradigms. For instance, professionals engaged in mezzo-level community organizing and macro social work at policy levels should challenge funding streams and other institutional pressures that favor individualized responses while overlooking powerful economic and gendered determinants of sexual health. Academics, through research and teaching, should challenge the predominance of behavioral strategies, preparing practitioners with new, more structurally focused models of response. This likely requires the engagement of national and international professional frameworks to overcome faculty reticence to teach skills of political advocacy as central to the practice of health and social services (Everhart et al., 2015)—and some of these frameworks already exist (Ioakimidis & Sookraj, 2021).

The United Nations' SDG framework offers one opportunity to align social work and social service practices to address underlying structural determinants (Lombard, 2015), such as gendered economic disadvantage, that contribute to youth TS in Uganda and beyond. While it is a universalist international framework that may be importantly critiqued (Mathebane & Sekudu, 2017), the framework centers global efforts on advancing material conditions through redressing socioeconomic inequalities, particularly toward gender equity (United Nations, 2023). As such, the SDGs create a platform for social work and social service professionals to engage in macro-level, policy-oriented political advocacy. Professionals could advocate for national policies that incorporate economic interventions as development strategy, which would likewise advance gender equity in health. For instance, policies to expand economic opportunity for AGYW in school, work, marriage, and in other social and political realms would go a long way toward redressing the economic drivers of youth TS observed by the interviewees in our study. Their enactment would also represent the transformational view of social work that Ashcroft and Katwyk (2016) and others have advocated, which is informed by social justice, human rights, and the redress of power differentials.

The limitation of our study was its small sample size of 23 interviewees. Although we recruited to maximize variance and garnered a variety of professional viewpoints, the research did not focus on one type of social service provider, nor was the sample large enough to consider subcategories of professionals (e.g., social workers versus medical providers, etc.). Our analysis also did not directly account for the types of funding received by organizations or individual providers, thus limiting our ability to consider such direct influences over practice paradigms. Interviews with service professionals worked well for our research questions, although we acknowledge that participants could not provide firsthand perspectives regarding experiences of TS, its determinants, and/or recipient dynamics in social services. We hope that this study lays groundwork for larger studies and strategies examining models of response to TS and related sexual health issues, analyzing professional paradigms, and considering avenues to advance practice and policy change for sustained community health improvement.

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