Key Themes and Concepts

Introduction

Three interlinked theoretical themes and concepts run throughout this book in its endeavor to understand the key influences and processes that have guided AIDS control in Uganda over the course of the epidemic. These are (i) the multilevel perspective; (ii) the construction, nature, and use of evidence; and (iii) the links between research, policy, and practice.

By presenting the relevant literature and debates, this chapter provides a conceptual foundation for the empirical material that follows. It will be helpful to bear in mind throughout the chapter that although the three topics can be taken as independent entities, they can also be seen as very closely related. Indeed, their power, both methodologically and analytically, is substantially increased when considered as interrelated phenomena—as they are throughout this book—rather than as three separate ones. For example, it is only really possible to understand the evolution of a national AIDS control policy within the context of a multilevel framework that also takes into account international and local influences. Equally, one needs a thorough conceptual understanding of evidence in its various guises in order to appreciate any attempt to produce Evidence-Based Policies (EBPs).

Another point to remember is that each of the three topics are phenomena that have evolved over time—none have remained as static entities since they first emerged in the literature, and doubtless they will continue to evolve conceptually in the future. They must therefore be seen as work in progress, and whatever understanding we may have of them today cannot be considered as final. As with the empirical material presented in the following chapters, the use of a historical approach may be the most effective means of placing the subject of investigation into its full context.
(i) The Multilevel Perspective

A multilevel perspective has been adopted by researchers from a number of different social science disciplines—both quantitative and qualitative—with the intention of guiding their work conceptually, methodologically, and/or analytically. Researchers who take on this approach do so for its capacity, one way or another, to act as a heuristic tool that can help identify determining factors and explanations for what is taking place within the parameters of a given study topic. But with researchers from many different disciplines using the multilevel perspective, there is also great diversity in its definition.

On the quantitative side, a multilevel perspective has been used to assist in a wide range of epidemiological, geographical, sociological, and public health research projects. It is usually taken within the context of a statistical analysis, and the levels may include, for example, individual and ecological (Jones et al., 1991); personal and community (Matteson, et al., 1998); “society, groups, individuals, organ systems, cells, and genes” (Diez-Roux, 2000:187); and “data that are nested within individuals, such as repeated measures and multiple responses” (Demers et al., 2002:417). Such a variety of different types of levels shows how malleable the concept can be to circumstance—with all the advantages and disadvantages implicit within that fact.

Relatively few qualitative social scientists have explicitly adopted a multilevel perspective in their work, but they too have tended to take the principle to suit the particular needs of their work. The rise of critical medical anthropology during the mid-1980s was in part facilitated by an early use of the multilevel perspective, with Baer et al. (1986) arguing that “any discussion of power relations in the delivery of health services needs to distinguish several levels in the systems of advanced capitalist and Third World nations” (ibid.:96). They suggested that these levels—each of which incorporated its own discourse, its own emic view of the world—would include the following:

1. The macro-social, defined primarily by the capitalist world system;
2. The intermediate-social, which could include a given health institution’s policies;
3. The micro-social, such as the physician-patient interaction; and
4. The individual, incorporating, for example, the patient’s experiential response to illness.

With just a single factor at the highest level—world capitalism—determining everything beneath it, this is a two-dimensional, purely