

Health content of Afghan media

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Abstract

Television has developed dramatically over the past six years in Afghanistan with a potential for providing extensive health information to its viewers, yet little is known about the coverage of health issues in the Afghan television.

Using the theories of agenda-setting and framing, and social norms approach this study explored what health-related topics were covered, how they were covered, and what sociocultural practices were broadcasted by the major Afghan private, national televisions.

The study used a sample of six constructed weeks in 2010 of two leading private, national television networks. Firstly, the study found that priority health problems such as maternal and child health, communicable disease and mental health received very less coverage. Secondly, however, individual-level and societal-level causes were blamed equally for the health problems; individual behaviour solutions were the favourite choice of the media, turning a blind eye to government weakness and organizational solutions. Thirdly, self-prescription, religious and traditional health seeking behaviour, and gender inequity were routine practices reflected on television.

As the first content analyses of the coverage of health-related issues in Afghanistan, the study provides public health professions, the Afghan media and policy makers a broad picture of health information available to the public on the leading Afghan television stations.

To my parents,

I love you both equally, but differently. Mom, you are the source of my love.

Dad, you are the strength of my life.

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Chapter One: Introduction

Researchers have found that the media, in particular television, have so far been a major source of health information for public, with the potential to influence audience's thinking, attitude, behavior, and decision-making process regarding health issues (AbuSabha, 1998; Mebane, 2003; Stuart & Achterberg, 1997). The finding is in the context of western society, where television existed since its invention, and the media has developed correspondingly with other social infrastructures such as public health.

This research aims to understand how the media of a war-torn state like Afghanistan deals with health issues of the country – a country that started to build its basic infrastructures including health and media from scratch in 2002 with the support of international community. This introductory chapter, first, discusses the public health condition and system in Afghanistan, the media development history in Afghanistan, and a brief theoretical connection between health and media. Later in the introduction the research question will be developed, followed by data sources and thesis structure.

Afghan public health context

Afghanistan is one of the poorest developing countries with over 28 million populations (USDS, 2010). This country has an infant mortality rate (IMR) of 129/1000 live birth, under 5 mortality rate (U5MR) of 191/1000 live births, and maternal mortality rate (MMR) of 1600/ 100,000 live births, the highest in the world except Sierra Leone (MoPH, 2009). Life expectancy at birth in this South Asian country is 47 years for men and 45 years for women, slightly more than half of life expectancy in Canada (CBC, 2010).

Major health concerns are maternal and child mortality followed by communicable diseases such as tuberculosis and malaria and non-communicable disease such as mental health (MoPH, 2009; WHO, 2009). Human Immunodeficiency Virus (HIV) is also emerging as a serious health problem due to increasing number of drug abusers (WHO, 2009). Other epidemics such as cholera, congo-crimea hemorrhagic fever, measles, meningitis and pertussis are also frequent (WHO, 2009). Moreover, there is a high level of acute and chronic malnutrition (WHO, 2009). With such extensive health problems, the country has 2 physicians and 5 midwives/nurses for each 10,000 people (WHO, 2010) compared to 19 physicians and 101 nurses/midwives per 10,000 people in Canada (WHO, 2007).

The health system of the country was rebuilt from scratch after the fall of the Taliban in 2001. Adopting a performance-based contracting health system Afghan government leads numerous national and international organizations to provide health services (MoPH, 2009). The national health program developed by the government is a part of the Afghan National Development Strategy (MoPH, 2009). The Afghan National Development Strategy is a five-year plan for Afghanistan to reach the Millennium Development Goals (MDG) of World Health Organization (MoPH, 2009). The structure of the health system is defined by the Afghan National Development program and the services are provided by non-governmental organizations, also known as contracting partners.

Afghan National Development (2008) defines Afghanistan's health structure as traditional because the primary health services are provided by non-health professionals

called community health workers. The entire system is categorized in the following structure based on its referral and supervision system.

Types and numbers of Health facilities used by the NHCS

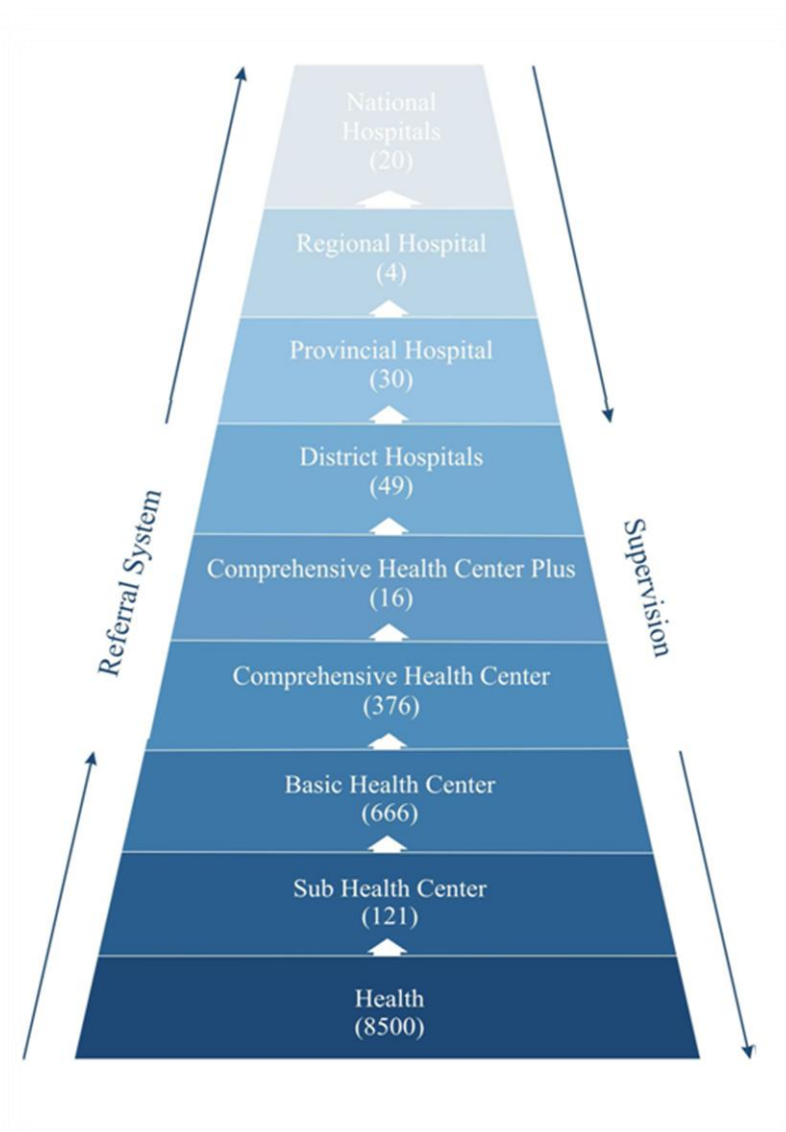


Figure 1 Types and Numbers of health facilities in Afghanistan (HMIS/MoPH, 2007)

Community health workers (CHWs), non-health professionals with some training, are at the very end of the health structure. A village house where one male and one female community health workers operate from is called a Health Post (HP), which targets around 1,000 to 1,900 individuals, equivalent of 100 to 150 families. A higher level unit of health structure is a Sub-Health Centers targeting 2,000 to 15,000 people and staffed with one male nurse and one community midwife (CMW). The sub-centers are also currently based in local houses because of lack of infrastructure. Followed by Sub-Health Centers are Basic Health Centers (BHCs) staffed with a nurse, a community midwife, and two vaccinators, targeting 15,000 to 30,000 depending on geography and population density of the area. Comprehensive Health Centers (CHCs) are small clinics with male and female doctors, midwives, a laboratory, and pharmacy technician, targeting up to 100,000 people. It also has limited space for inpatient care. Comprehensive Health Center Plus (CHC+) are similar to CHCs with the privilege of providing emergency obstetrics care with 10 beds. District Hospitals (DHs) staffed with doctors including female obstetricians/gynecologists, a surgeon, an anesthetist, and a pediatrician, midwives, lab and X-ray technicians, a pharmacist, and a dentist and dental technician covers an approximate population of up to 300,000 people. Provincial Hospitals (PHs) are health service facilities at provincial level and referral points to DHs. It provides additional special care for sophisticated health problems. Regional Hospitals (RgHs) are primarily a referral hospital with a number of specialties for assessing, diagnosing, stabilizing and treating, or referring back to a lower level hospital. The regional hospitals provide professional inpatient and emergency services at a higher level than services available at DHs and PHs. Finally, National Hospitals (NHs) or Specialty Hospitals (SHs) mainly based in the capital Kabul provide the

most sophisticated care in Afghanistan. One of its important tasks is educating and training health care workers.

The services provided in this structure are divided in two categories; Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS). BPHS is the service provided by primary structures such as HPs, Health Sub-centers, BHCs, and CHCs. Services offered by hospitals including district hospitals, provincial hospitals, regional hospitals, and national hospitals are considered EPHS.

In the Afghan context, the Ministry of Public Health sets the strategy of the national health system; international donors provide the fund; contracting non-governmental organizations provide the health services. The three main international donors are US Agency for International Development (USAID), World Bank, and European Commission (ANDS, 2008). Each has taken responsibility of specific number of the 34 provinces of Afghanistan: USAID funds 13 provinces, World Bank 11, and European Commission the remaining 10 provinces (USAID, 2010). The donors along with the health ministry contract out non-governmental organizations for providing health services in rural areas of Afghanistan.

At the very bottom level of the health system, national and international NGOs provide the basic services according to the priorities set by the Ministry of Public Health. NGOs are contracted based on their performance. According to the Ministry of Public Health, priority health problems are (1) maternal and newborn health, (2) child health, (3) communicable disease, (4) mental health, (5) other health problems. (Figure 12)

Maternal and newborn health includes maternal mortality, complication of pregnancy and delivery, neonatal mortality, newborn complications, and fertility. Child health includes, but is not limited to, infant and under 5 child mortality, acute respiratory disease and pneumonia, diarrhea and dysentery, vaccination of preventable disease, and malnutrition. Main communicable diseases are tuberculosis, malaria, sexually transmitted infections (STI), and acquired immune deficiency syndrome (AIDS). Most important non-communicable disease recognized as the fourth priority is mental health problem. Finally, other health problems as the fifth priority are mainly chronic problems such as disability and handicaps, substance abuse, cancers, diabetes, cardiovascular disease, and environmental health risks.

Considering the poor health situation, there are various challenges to develop an accessible, effective, and sustainable health care system in Afghanistan.

First, economic instability is widespread problem in Afghanistan directly and indirectly affecting health service to Afghans. Around 70% of the Afghans live in extreme poverty with a 32% unemployment rate (Acerra, Iskyan, Qureshi & Sharma, 2009). Poverty contributes to poor nutrition, sanitation and hygiene, and inability to access health care, and health education. It is also indirectly linked with sociocultural practices such as early marriage, high birth rate, patriarchal authoritarianism in families, illiteracy, violence against women, and other behaviors against improving standard of health.

Second, weak infrastructure is a big challenge. Lack of transportation infrastructure prevents a large number of the population in mountainous and isolated parts of the country from having access to health care. Only 30% of households outside of cities have access to

safe water, and only 6% of Afghans have access to reliable electricity sources (Acerra, Iskyan, Qureshi & Sharma, 2009).

Third, socioculture behaviors and beliefs have influenced health of Afghans extensively. Traditional beliefs about medicine, nutrition, and hygiene have led to mistakes or misinterpretations about what constitutes safe practice (Rand, 2004). For example, many Afghans believe that any moving water is clean and that liquids should be withheld from children with diarrhea (Rand, 2004). Turning to religious healers is still widespread practice in cities, let alone remote villages where professional health workers are scarce (Arnoldy, 2009). In addition, gender inequity has helped the high mortality rate of mothers and children. For instance, it is a widespread practice to marry girls as soon as they hit puberty. Having no idea of what family planning or protected sex is leads to pregnancy right after marriage. There is a reluctance to spend money on health care for daughters and wives (Rand, 2004). Women are secondary in the food chain in families; men and boys eat first, and women and girls eat the remaining (Rand, 2004). Families are hesitant to educate their daughters, and let them work if they are educated.

Most importantly, the first essential measure to achieve the top health priorities of Afghan Ministry of Health is health education (MoPH, 2008). Personal, community, and public health education, according to the Ministry of Public Health strategy, is the first vital measure to spread the idea of birth control, to reduce maternal mortality, to save lives of children under 5, to prevent communicable disease, to improve mental health problems, and to prevent from and care for chronic illnesses (MoPH, 2008). Despite health education being the top measure to better health, very few measures have been taken to educate the

public regarding health issues (USAID, 2010), opening the ground for the local media to fill the gap.

Media context

Historically, the first newspaper in Afghanistan *Shamsal-Nehar* (Sun of The Day) was published in 1873 (Rawan, 1992), which was mainly influenced by the ruling religious government (Ahang, 1970). In 1906, the father of journalism in Afghanistan Mahmud Tarzi published the first reformist and pro-independence newspaper, *Seradj-ul-Ahkbar* (Luminary of Chronicles), which was immediately banned by British authorities (Habibi, 1985). The newspaper continued publication in 1911 putting social change as the top agenda trying to combine traditional norms with modern ideas and concepts of its time ((Rawan, 1992; Vartan, 1967). Once Afghanistan got independence in 1919 the quantity and quality of Afghan mass media changed. For the first time in Afghanistan's history Article 11 of the 1923 Constitution provided the legal basis for the right of free speech for every Afghan citizen (Rawan, 2002). At the same time, a total of 23 state-owned and private newspapers and magazines appeared in Kabul and some provincial cities (Grevemeyer, 1987). Also among them was the first woman's magazine, *Erschad-al-Nasswan* (Instructions for the Women), published in Kabul by Queen Soraya in 1922 (Yussufi, 1977 as cited in Rawan, 2002). The press was trying to integrate modern European science, civilization, and culture with Afghan traditions (Rawan, 1992). The press was developing fairly well with the creation of the first news agency Bakhter in 1939 to exchange information locally between provinces and international among other news agencies (Rawan, 1992). At the end of the monarchy, Afghanistan had a total of 70

different dailies, weeklies, trade publications, and tabloids; 16 of these were daily newspapers (Rawan, 2002). The total volume of all publications was approximately 220,000 copies (Rawan, 2002). According to Ahang and Siddiq (1972) one copy of a given publication was shared by four different readers. Accordingly, it can be assumed that in 1970, out of a total of 13.5 million Afghans, 880,000 people read those publications (Rawan, 2002).

The first Radio was also set up by the King Amanullah Khan, which started broadcasting in 1928 (Rawan, 2002). From 1953 to 1963, when Daud Khan was the prime minister, radio communication has witnessed improvements in its technology and quality of programs (Rawan, 2002). Despite propagating government policies and development news, it has education programs for social change (Rawan, 1992). During the 80s and 90s, Afghan radio was used by various political regimes as means of ideological propaganda for communists, mujahidin, and the Taliban (Rawan, 2002). Instead, international radio channels mainly BBC Persian and Pashtu services provided credible information and education programs (Adam, 2005; Rawan, 2002).

Television technology and channels appeared in the 1970s when Prime Minister Daud Khan planned to set up the first Afghan television channel in a joint project with a Japanese company (Rawan, 2002). At the end of 1978, Afghan television started a daily one hour broadcast in Kabul (Khaydary, 1994, as cited in Rawan, 2002). At the beginning of the 1980s, Kabul television increased its broadcast time to 6 hours daily (Rawan, 2002). About 2 million people in and around the capital were able to receive these programs (Rawan, 2002). In 1982, with the support of the Soviets, a satellite station was installed

enabling Kabul television to exchange programs with countries abroad (Rawan, 2002). Moreover, the satellite station formed the basis for a 2-hour program by Kabul television broadcast to 11 provincial cities during the mid-1980s. Parts of the broadcast were also produced at these local stations (Rawan, 1992). After the fall of Najibullah's government in 1992, and once the mujahedin (religious fighters) took over the capital of Kabul, the broadcast of TV programs was anything but regular. And as soon as the Taliban conquered Kabul in 1996, they banned watching TV in accordance with their strict interpretation of Islamic law (Rawan, 2002).

After the fall of the Taliban, mass media development has been one of the main achievements of Afghanistan. The progress in the media sector includes television, radio, print, internet, and mobile services (Barker, 2008; Himelfarb, 2010). In a country where only a single radio (Radio Sharia) was the propaganda tool of the Taliban regime until 2001 (Rawan, 2002), there are dozens of television channels, more than 100 radio stations, and many hundreds of print outlets (Himelfarb, 2010). One third of the 28million population has registered for mobile phone services (Beam, 2010). A scholarly article records 10 million mobile phone subscribers (Beam, 2010), though the Ministry of Communication and Information Technology of Afghanistan has recorded 12,111,571 GSM (Global System for Mobile Communications) subscribers as of December 2009 (MCIT, 2009). In short, sources of information have dramatically increased since 2001 in Afghanistan.

Currently, Radio is the most accessible media for Afghan households with 82 per cent of the population having functioning radios in their households, according to a survey

carried out by the Asian Foundation (Tariq, Ayoubi & Haqbeen, 2010). International radio channels such as the BBC was the only source of information during wartimes in Afghanistan (Adam, 2005), while dozens of national and local radios operate currently across the country. Television follows radio with 44 per cent of Afghans watching TV, though the gap between rural (28%) and urban (88%) viewership is big (Tariq, Ayoubi & Haqbeen, 2010). The television viewership has started from scratch in 2002 after the fall of the Taliban, and grew rapidly in the past eight years. There are eight national television stations based in capital Kabul (Barker, 2008) with Tolo and Ariana private channels having the largest coverage all over the country (Tariq, Ayoubi & Haqbeen, 2010). National television has five players with Tolo (45%) and Ariana (19%) televisions capturing almost two third of the audience market (ALTAI, 2010).

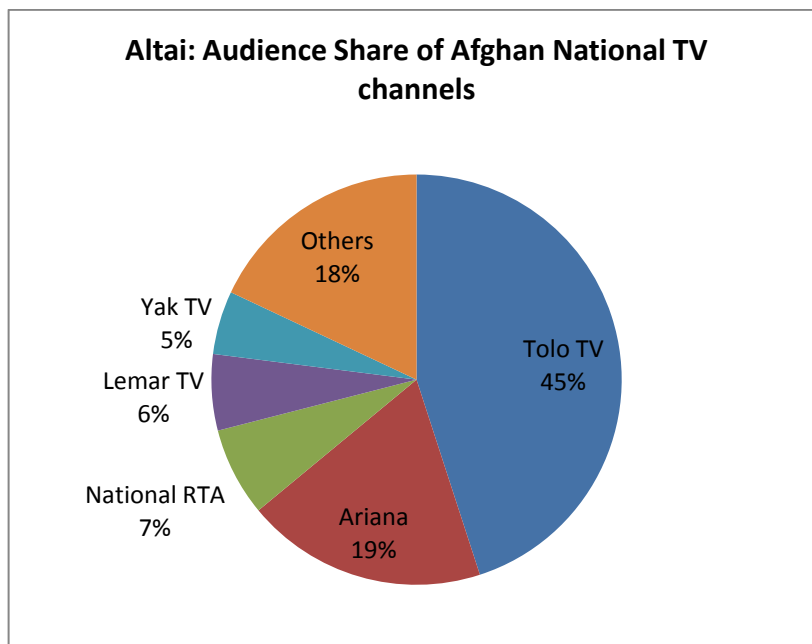


Figure 2: Audience share of Afghan national TV channels (Altai, 2010)

Tolo TV, the first private national channel starting operations in October 2004, is undoubtedly the most viewed and the most innovative Afghan channel (Altai, 2010; BBC, 2010). It belongs to the Moby Group with yearly revenue of \$20 million and growing rate of 50-70% annually (Altai, 2010). The company has 700 employees in the country and 40 in Dubai (Altai, 2010). The TV is one of the leading national entertaining channels broadcasting in over 14 cities in Afghanistan (BBC, 2010). Its audience share reaches a peak of over 60% during the evening news (1800-1700hour), and its total audience reaches 1.5-2 million Afghans on Sunday evenings (Altai, 2010).

According to Altai (2010) research group, Tolo has been a first mover in many fields, such as investigative journalism and entertainment. It continues to run ahead of other channels in terms of ideas, for instance in producing Afghan soap operas and Afghan star, a singing show similar to American Idol. As a result of this proactive approach, the channel has found itself several times at the center of controversies revolving around the freedom of media, Afghan culture, and government control. It is probably the most criticized and the most loved channel at the same time in Afghanistan, depending on the segment of society and on how particular programs are perceived.

Ariana, the second private channel starting operation in summer 2005, is one of the best established private television stations, with the widest coverage throughout Afghanistan, according to Altai (2010) research. The channel covers around 75% of districts in 33 out of 34 provinces. It employs almost 300 people including over 50 journalists; it airs programs in all three main languages of the country including Dari (45%), Pashto (35%), and Uzbek (15%). The channel is slightly pro-government. News

flashes focus on the Afghan president's speeches, trips and statements, and feature reports often underline efforts made by the local Afghan authorities in solving problems. It is owned by Engineer Ehsanullah Bayat, who also founded the Afghan Wireless Communication Company (AWCC) and the Bayat Foundation charity, whose activities are covered extensively on TV. The channel reaches a peak audience share of around 25% during the evening news at 2000 hours.

Mobile phone technology also had a remarkable development over the decade. According to a survey carried out by Asian Foundation, around 52% of population in rural areas and 86% in urban areas owned mobile phones (Tariq, Ayoubi & Haqbeen, 2010). Not only do they use mobile phone for voice conversation, but also for interacting with TV shows, voting for their favorite singers, transferring money to friends and families (Khoja, 2009), and browsing the Internet (AWCC, 2010). Interaction of mobile phone with TV has given the ability to the public to take part in producing content of TV shows and giving a voice to communities.

In spite of the progress in the media sector, the Afghan media have been constantly criticized for the quality of its educational programs, their dependence on foreign aids, the lack of professionalism and trustworthiness of the information (Himelfarb, 2010). For the sake of commercial success, various western and eastern soap operas dubbed into Afghan languages are provided for the audience. Afghan Ministry of Information has many times ordered the media not to show Western half-naked women or statues of Hindu deities. Independent media trying to educate the public fail to achieve commercial success and that leads to their dependence on foreign aid. The media, in general, lack professional

journalists due to low education level of the population and weak education system in the country.

Still, as the main source of information the media has great potential to inform and educate people on public issues in particular health. Studies in developing countries show that basic health information on increasing birth spacing, better nutrition, education on hygiene and safe water, and the warning signs of pregnancy and delivery could help reduce maternal death (Bartlett, Wawji, Whitehead, Crouse, Dalil, Lonete, & Salama, 2005).

Scientific Background

There is plenty of evidence that television has the potential to influence audience thinking, attitude, behavior, and decision-making process regarding health issues (AbuSabha, 1998; Mebane, 2003; Stuart & Achterberg, 1997). Dozens of media effect theories have been developed to explain how media affects the audience including but not limited to agenda-setting theory, social learning theory, cultivation theory, and social normative theory.

Out of many, agenda-setting theory elaborates the way the media prioritizes certain issues and downplays other topics for the public, through what issue to cover and how to cover the issue (McCombs, 1994). Agenda-setting theory argues that the media shapes the public's view of how important a given issue is by the amount of coverage it receives compared to other news items (McCombs & Shaw, 1972). Health literature also supports this finding. A recent study has found that mass-mediated information on breast cancer screening could affect the health agenda of middle-aged women (Ogata, Jones, Denham, &

Springston, 2006). Researchers have also found that by increasing the salience of health issues, the mass media may also stimulate people to search health information beyond their doctors (Dutta-Bergman, 2005; Pratt, Ha, & Pratt, 2002). For example, a time series analysis found that electronic bulletin board users would put health topics on their discussion agendas after being informed about the topics through traditional media outlets (Roberts, Wanta, & Dzwo, 2002).

Cultivation theory posits that exposure to health-related issues in the media, in long run, will shape how the audience think about those issues (Gerbner, 1969). The theory argues that repeated exposure to similar contents over time shape our view of the world (Gerbner, 1969). Our understanding of health issues and approach to health issues and behavior, when we are heavily exposed to the media, is a reflection of the information provided to us by the media.

Social learning theory explains that humans learn by observing the behavior of their fellows (Bandura, 1977). The learning process happens in four stages of (1) attention, (2) retention, (3) motor reproduction, and (4) motivation (Bandura, 1977). Speaking about direct behavioral effects, the theory posits that behaviors can be learned by observing others performing the behavior, either in face-to-face or mediated contexts (Bandura, 1977, 1986, 2001). Widely used in health communication research (e.g., Dilorio et al., 2000; Hawkins & Hane, 2000), the theory suggests that local television health stories can maximize the adoption of healthy behaviors by raising viewers' attention and recall of important health issues and by increasing viewers' confidence that they can, indeed, engage in healthy behaviors.

Social normative theory argues that there is a false consensus and a misconception about social norms in society (Perkins, 2003). As an example, when youths go home from parties and social gatherings, they remember and talk about the minority drunk or wasted peers rather than talking about the less interesting majority who remained sober in the party. Youths consider the one incident as a norm and the media reaffirm and amplify the story (Perkins, 2003). That's how a norm is misconceived and acted upon that leads to unhealthy risky behaviors. Therefore, Perkins' social normative theory argues that clarifying this misconception about the norm can lead to reduced risky behaviors. Mass communication channels can contribute to this process through characterization of risky health behaviors as public problem, and clarifying the ambiguities and misconceptions surrounding a norm (Yanovitzky and Stryker, 2001). Yanovitzky and Skryter sum up that norm-reinforcement approach of the mass communication channels can make a significant contribution to other social efforts to reduce risky behavior.

Research Question

The foundation of the new Afghan public health system is laid in 2002. The health system has developed gradually with major cooperation from international organizations such as United States Agency for International Development, World Bank, and the European Commission. Major health priorities of Afghan society are maternal and child health, communicable disease, and mental health. Based on the major health concerns, health literacy and education is a significant measure to better health. On the other hand, television media has developed dramatically over the past six years in Afghanistan with a

potential of providing extensive health information to its viewers. Yet little is known about the coverage of health issues in the Afghan television media. Thus:

1. Health education is a top measure in Afghanistan to improve health of people.
2. The media in Afghanistan has developed immensely since 2002.
3. Media has the potential to inform and educate the public.

The main concern of the researcher is whether the Afghan television media plays its significant role in providing health information for the public. A lot of research has been done on the role of the media in health largely in developed countries. Despite the progress in communication technology in Afghanistan, there is almost no or very rare scholarly researches about health content of its media. Thus, the main thesis question is *how the Afghan television media is dealing with health issues in Afghanistan*.

The research question will have the following sub-questions. First, *what health related stories do Afghan national private televisions broadcast?* Given that the media shapes the public opinion, the research aims to study the media health agenda in comparison to national health strategy of the Afghan government. Questions that the research attempts to respond are: do health stories in the broadcast media relate to major national health concerns? Do the media educate people on critical and widespread disease in Afghanistan? Do the media educate the public about preventive health care? Do the media provide information on epidemic disease? Do the media discuss or critique the national health strategy? And so on and so forth.

Second, *how do the Afghan private national televisions frame health stories?* Are the stories framed as an individual's health problem or a public health issue? Individualizing health stories limit the causes of and the cure to a problem to a particular individual, while public frames of health stories broadly assigns the responsibility of health conditions to government, businesses, and larger social forces (Lawrence, 2004).

Finally, *what health-related socio-cultural practices are televised through Afghan national, private televisions?* Studying the norms that the media communicate tells about the long-term potential effects of the media. Through a qualitative content analysis, the study will analyze how the broadcast media deals with health-related sociocultural practices of the Afghan society.

Data sources

The research focuses on the content of two major Afghan private television health shows. *Dabestan Bo Ali* (the school of Avicenna) is a weekly health program aired by Tolo TV. It broadcasts health-related stories of the week and educate the public on health issues. The second health show is *Darmelana* (treatment), a health-related show in which audience make direct phone calls to physicians in the studio and ask questions on weekly health topics. Ariana TV broadcasts *Darmelana* health show.

Thesis structure

The thesis has five chapters. The introductory chapter has provided a brief summary of the problem, the theoretical framework, and the research question. Chapter 2 gives an in-depth analysis of theories of media effects in particular agenda-setting theory

and the way it functions, and theories related to social norms. The chapter frames the theoretical boundaries of the study. Chapter 3 discusses the methodology of the study including sampling, data collection, transcribing, coding, and analyzing. The discussion in chapter 4 sets out the findings of the study and analyzes the findings of the research. Chapter 5 wraps up the thesis by answering the central research question, discussing the limitations, and proposing directions for future research.

Chapter Two: Theoretical Framework

This chapter discusses the concept of public health, and the media theories that deal with public health issues. In the beginning, health and public health concepts are defined and discussed, and later in this chapter, based on the research questions, the theories that lead the thesis are introduced. The theories are agenda-setting, framing, and social norm. Since the first part of the study analyzes health agenda of Afghan television media, the theory guiding the first part of the study is agenda-setting that deals with the role of the media that gives salience to particular topics (McCombs, 1972, 1982). As the second part of the analysis focuses on the content of the program to find how health stories are framed, framing theory is explained to understand how the stories are discussed in the media (Goffman, 1974). Another section of the thesis focuses on social norms related to health. The study aims to find health-related socio-cultural norms such as women not visiting male doctors, self-medication, home delivery due to religious beliefs, etc.

Public health

The word ‘health’ is used as early as 11th century (OED, 2010, health). Oxford English Dictionary defines health as the “soundness of body; in which its conditions are duly and efficiently discharged”. This definition undoubtedly is about the health of an individual and the functions of his/her body. World Health Organization defines health as “a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity” (WHO, 1948).¹ This definition of health is originally designed in

¹ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by

1946 and enforced as the international definition of health by UN in 1948. However, the definition of WHO is also designed to refer to the health of an individual; it includes the important element of social well-being. Health, therefore, is not only about soundness of individuals, but also the society in which they inhabit.

The importance of public level decisions and actions are highlighted in the very first definition of public health, which is described as “the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals” (Winslow, 1920).

Although the broad definition of public health by Winslow includes individual and community efforts; the focus of public health professionals, most of the time, has been individual behavior change and individual responsibility for societal health problems. Wallack and Lawrence (2005) say that however public health professionals believe in social determinants of health, yet they routinely rely on individual behavioral approaches to improving health.

Yet, Dan Beauchamp (1976), in his article entitled *Public Health as Social Justice*, alters the focus of public health from individual behavior change to social factors and determinants by recognizing the importance of collective action. By developing the concept of social justice within health, Beauchamp (1983) believes public health is fundamentally about community and about shared values of life, health, and security. To

the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

overcome the concepts of individualism and liberalism of the Western World in the health sphere, Beauchamp describes public health as “an alien ethic in a strange land”

(Beauchamp, 1976, p. 108).

The two different approaches, individual and public, are basically two sides of a coin. To take obesity as an example, an individual behavior approach would prescribe low-calorie diet and more physical activity. On the contrary, a public approach would blame corporations that produce inexpensive unhealthy food and policies that put high taxes on healthy food. The individual approach blames individual people for being lazy. The public approach blames the society for being organized in a way that facilitates high fat food consumption through advertisements, marketing, and the economic system.

Public health scholars identify both aspects of the issue and emphasize the balance

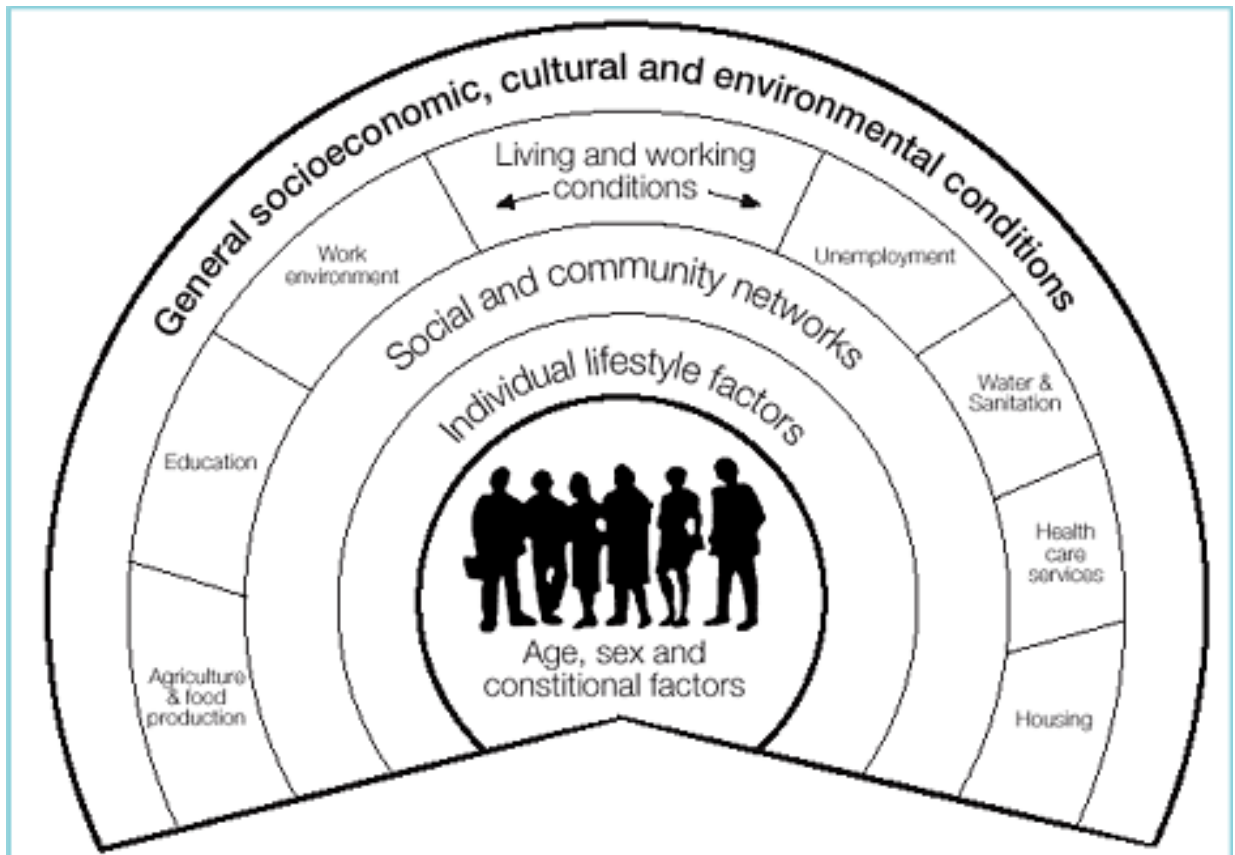


Figure 3 Dahlgren and Whitehead's (1991) public health model

between the two. Beauchamp (1983, p.83) says that “by insisting that individual responsibility coexists with collective rules to protect the common good, we can save tens of thousands of lives and limit disease”. In addition, Wallack and Lawrence (2005, p.6) sums up that “personal responsibility is undeniably a key to health, so are a range of social conditions that are shaped not just by our individual choices, but by our collective choices that manifest in public policy”.

The researcher agrees that both individual and public aspect of health should be taken into account equally in health education. Decisions taken by individuals to change personal behaviors are as important as those ones taken by policy makers to bring about social change. Therefore, the aim of public health promotions should be both individual-level behavior change and societal-level change.

Agenda Setting Theory

“The press might not be successful, most of the time, in telling people what to think, but it is stunningly successful in telling its readers what to think about” (Cohen, 1963, p.13).

Historically, it was columnist Walter Lippmann (1922) who first expressed his opinion over the power of the media in presenting certain images to the public. Later McCombs and Shaw (1972) worked on agenda-setting theory of the media. In a presidential campaign research of 1968, McCombs and Shaw (1972) focused on awareness and information elements of the campaign. The two investigated the relationship between voters’ choice of important issues and the important issues covered by the media during the campaign. They concluded that the content of the media coverage had significant influence

on the choice of voters as important issues of the campaign. Since then, agenda-setting has been about giving salience to a specific issue through the media (McCombs, 1972, 1982).

Framing and Agenda-setting

Two fundamental assumptions inspire research on the theory of agenda setting: (1) media focus on few topics make the public to consider those issues as more important than others; and (2) the press and the media do not reflect the reality, they filter and reshape it (Rogers & Dearing, 1988; Rogers, Hart, & Dearing, 1997). The latter assumption is also defined as framing. Framing is about how a story is told rather than traditional agenda-setting theory that is primarily about what story is told (Scheufele and Tewksbury, 2007). However the two media effects theories have strong correlation because both try to understand the effect of media, there are some distinctions. From a sociological perspective, framing is about making sense of information through classifying, organizing, and interpreting the information and connecting them to our life experience or environment (Goffman, 1974). Laying the sociological foundation of framing theory, Goffman (1974) argues that people use primary frameworks or interpretative schemas in order to classify information and interpret it meaningfully. To put it differently, framing is a process of persistent selection, emphasis, and exclusion which enables journalists to process a large of amount of information and relay it efficiently to their audiences (Gitlin, 1980). From a psychological perspective, framing is about how different presentation of an identical issue affects the decision-making process of individuals (Kahneman, 2003).

Journalists are at the center of frame making in the traditional media. They are bound by four main framing structures; syntactical structure, script structure, thematic

structure, and rhetoric structure (Pan and Kosicki, 1993). First, Syntactical structure is about arrangement of words and phrases into sentences and paragraphs such as the inverted pyramid structure² or the rules of attribution for journalists (Pan and Kosicki, 1993). Some other professional norms that have developed over time such as accuracy, impartiality or balance, and objectivity are considered as part of the syntactical structure (Pan and Kosicki, 1993). A news report in a script structure is a story that has a beginning, a climax, and an ending. Thus, questions such as what, who, when, where, why, and how should be answered in order to make sense of the information (Pan and Kosicki, 1993). Third, a theme is sometimes a news story, not just a specific incident or happening. For that, not just one incident but a couple of incidents stories will be gathered to give information about the theme (Pan and Kosicki, 1993). Finally, rhetoric structure is about what metaphors, examples, catchphrases, depictions, and/or visual images are used by a journalist to relay the information to its audience (Pan and Kosicki, 1993). The structures enable journalists to provide information from a specific perspective they have in mind.

The relationship between agenda-setting and framing can be studied at three level, news production, news processing, and news effects. At news production level, agenda-setting is about how an issue becomes an agenda item, while framing is about how social factors frame the issue that is, anyway, considered as an agenda item (Scheufele and Tewksbury, 2007). Both theories deal with message production at this level such as what message to produce and how to produce. Activities of civil societies, journalists, and policy makers influence both the ‘what’ and ‘how’ in the production level. At news processing level, it is more about the cognitive process of the recipient, in particular his amount of

² A journalism-style of writing in which most important information comes first and the least important last.

attention (Scheufele and Tewksbury, 2007). Agenda will be processed with the least attention to the news, while audiences need to pay more attention so that the framing concept is processed (Scheufele and Tewksbury, 2007). However information processing theories suggest that people attending to a message and engaging in some level of elaboration of it are most likely to recall information about it later (Eveland, 2004), but a mere exposure to message is enough for the effect of agenda, while framing effect takes place with more attention paid to the information. Finally, at the news effect level the issue will become an item of the agenda that receives more coverage (Price & Tewksbury, 1997). Thus, it is not information about the issue that has the effect; it is the fact that the issue has received a certain amount of processing time and attention that carries the effect. In contrast, the basic framing approach assumes that it is the way the locus of effect lies within the description of an issue or the label used in news coverage about the issue (Scheufele and Tewksbury, 2007). It is the underlying interpretive schemas that have been made applicable to the issue that are the central effect of a frame.

Many researchers, however, challenge the idea that agenda setting and priming, on the one hand, and framing, on the other hand, are based on the same theoretical premises and thus extensions of the larger agenda-setting construct (Price & Tewksbury, 1997; Scheufele, 2000). Price and Tewksbury (1997) writes that agenda setting looks on story selection as a determinant of public perceptions of issue importance, while framing focuses on the particular ways those issues are presented (p. 184).

McCombs (2004) argues that framing is simply a more refined version of agenda setting. Framing, from that perspective, means making aspects of an issue more salient

through different modes of presentation and therefore shifting people's attitudes. He labels this phenomenon as "second-level agenda setting." The concept of second level-agenda setting refines the original agenda-setting hypothesis, which has long been criticized for being somewhat simplistic in its focus on broad issues and for overestimating rank-order coefficients between these broad issue categories in media coverage and public-opinion surveys (Funkhouser, 1973a, 1973b). In fact, Kim, Scheufele, and Shanahan (2002) demonstrated that second-level or attribute agenda-setting can have important influences on people's perceptions of the relative importance of various aspects of an issue.

Types of agenda setting

Scholars have identified three types of agenda-setting: media agenda-setting, public agenda-setting, and policy agenda setting (Dearing & Rogers, 1996). Media agenda setting concentrates on issues prioritized by the mass media (Cohen, 1963; Dearing & Rogers, 1996; McCombs & Shaw, 1972). Public agenda-setting focuses on the order of specific issues compared to others (Dearing & Rogers, 1996; Lippmann, 1922; McCombs & Shaw, 1972). Policy agenda-setting focuses on policy actions regarding a specific issue in response to media and public agenda (Cohen, 1963; Cobb & Elder, 1971; Dearing & Rogers, 1996). Along with three types of agenda setting, there should be three types of agenda: media agenda, public agenda, and policy agenda. They are defined as issues discussed in the media, issues discussed and personally related to the public, and issues that policy makers consider important (Dearing & Rogers, 1996). The three types of agenda are interrelated with each other. Media agenda has more potential to influence public agenda. Whether public agenda can in return affect the media agenda is still a

question. They both strive to influence policy agenda. In matters of health, it is hard for media and public agenda to influence policy agenda. In the meantime, for health promotion purposes it is more important to use interrelationships of media, public and policy agendas in order to make sure that health issues move to the forefront of policymakers' actions (Farmer & Kozel, 2005).

Health agenda-setting in the media

Kline (2006) says that the conflict between traditional news values and the values of medicine and public health is not a new issue to health communication scholars. News is a system of organized signifying elements that both advocate certain ideas and encourage certain kinds of audience processing of the news (Pan & Kosicki, 1993). The ideas advocated by news take into account financial and political issues, while the ideas advocated in public health take into account major health concerns. When it comes to public health news, it is the duty of communication scholars to understand economic, social, and political reasons behind competing health priorities in the media and still promote important health values. In the meantime, for health promotion purposes, it is even more important to use interrelationships of media, public and policy agendas in order to make sure that health issues move to the forefront of policymakers' actions (Farmer & Kozel, 2005). Kline (2006) suggests that health advocates and campaigners should tailor the information (i.e. press release) for different media outlets differently in order to promote their aims.

There is no doubt that media plays an important role in promoting public health with providing health information and education (Dambazau, 2004). Agenda-setting

theory, however first developed on political issues, is applied on health issues widely. Manganello and Blake (2010) have carried out a content analysis of health researches on the US media from 1985 to 2005. They have found that studies primarily examining magazines, television, and newspapers have focused on substance abuse, violence, sex, obesity, and body image. The study finds that 38 out of 441 studied articles (9%) have used agenda setting theory. More specifically, Wang and Gantz (2007) have applied agenda setting theory in their study of health topics in local television channels in the United States.

Taking into account policy, professional, and individual level of health issues, the media have the power to influence decision-makers, patients, and physicians (Benelli, 2003). It depends that what topic and how the topic is reported. If the story is directed to patient and physician, it will affect individuals to change behavior. If the story is directed at the society at large, it will influence policy makers to react to it.

In 1997, Professor Luigi Di Bella, a physiologist in the University of Modena, has proposed a treatment for cancer (Benelli, 2003). His claim of developing a viable and effective treatment for cancer was directed to policy makers to take action. The wide broadcast of the story by the media proposed a validation test for the Italian government (Benelli, 2003). Although the claim had its oppositions, but public protests and media campaigns forced Italian government to carry out a validation study on the treatment protocol (Benelli, 2003). The budget for the validation study, which was aimed to be carried out on few patients, was estimated 1.033million Euros. But Italian Supreme Court, under the public pressure, decided that patients excluded from the pilot study should not be

discriminated, and therefore should get the treatment free of charge until the end of the experimentation (Benelli, 2003). The cost rose to 25.8million Euros, and experiments showed that his treatment was ineffective (Benelli, 2003).

After the treatment protocol for cancer was provided invalid, Rodolfo Passalacqua et al. (1999) studied the influence of the media on patients seeking cancer therapy in Italy. They found that only 5 per cent of patients sought information about the Di Bella therapy from their physicians (Passalacqua et al., 1999). A majority of 85 per cent received information about the Di Bella therapy from the media (Passalacqua et al., 1999). Not only did they find that how important was the validity of health information on the media, but also that misinformation on health issue can create distrust in patient-physician communication.

Though providing information, educating, and warning on disease are positive aspects of media (Berry, Wharf-Higgins, &Naylor, 2007) while sensationalizing health issues and causing unnecessary fear (Signorielli, 1993) or expectation (Buntin, Jain, & Blumenthal, 2010) could cause negative impacts on the audience. Media health campaigns have been among the successful ones in decreasing, or preventing to increase disease such as AIDS, SARS, leprosy, and preventable children diseases as demonstrated in Uganda, Thailand, India, Nepal, Brazil, and Honduras (Dambazau, 2004). On the other hand, Signorielli (1993) claims the media is driven by what sells. In case of health, it is *health hype* that sells. He describes health hype as health news that exaggerates and entertains. Health hypes have the potential to misinform the public on health issues.

Fear-appealing messages on the media can be amplified quickly and widely. Scholars have proposed social amplification of risk model to understand how small risks are sometimes amplified (Kasperseon et al., 1988). Kasperseon et al. suggest amplification takes place at “two stages: in the transfer of information about risk, and in the response mechanism of society” (p. 177). Thus the media, as the main source of information transfer, play a role in risk amplification. The characteristics of information that can amplify the perception level of risks are “the volume of information, the degree to which information is disputed, the extent of dramatization, the information channel, and the symbolic connotations of the information” (Kasperseon et al., 1988, p. 184). Therefore, the media should be very careful about what health topics do they cover and how they construct health messages.

Social-norms approach

Scholars have established since decades now that social norms have direct influence on individual’s behavior (Schultz, Nolan, Cialdini, Goldstein, & Greskevicus, 2007). Norms are implicit codes of conduct understood within a social context (Fine, 1987). Descriptive norms refer to what behaviors are commonly practiced in a society, while injunctive norms refer to what behaviors are approved or disapproved. But there is always an ambiguity regarding what is the actual norm and what is perceived to be the norm. Yanovitzky and Stryker (2001) say there is always an ambiguity between socially acceptable and unacceptable behaviors. High levels of ambiguity may substantially reduce the prospects of behavior change because there is no clear norm to which individuals conform or deviate from (Merton, 1959). This is particularly true when formal social

conventions are at odds with informal ones (Glantz, 1996; Marlatt and Kilmer, 1998).

Thus, in order to reduce people's involvement in risky health behaviors, society must first remove much of the normative ambiguity that surrounds the norms. The ambiguity can be removed by clarifying and reinforcing social values and norms (Boraka, 1995; Williams, 1994). Clearing the ambiguity does not only help strengthen the acceptable norm but also refine the unacceptable ones (Schultz, Nolan, Cialdini, Goldstein, & Greskevicius, 2007).

Definition of social norms

There is no consensus between psychologists and sociologists about the definition of social norms. According to psychologists, norms refer to whatever most members of a given group do or think (Dubois, 2003). The entire reign of this definition remains within one's self. From this perspective, if someone chooses not to follow the norm, his penalty is a feeling of shame or guilt. Norms have merely descriptive meaning in the eyes of psychologists.

Sociologists, on the other hand, define it as a system of meaning (Fine, 1987), patterns for action, and statements that regulate behavior in a group of individuals (Horne, 2001). Fine (1987) brings in the issue of responsibility of individual towards the group. Sociologists argue that if someone violates the norm, they will be punished by the group, and the punishment will be imposition of certain sanctions by the group – i.e. exclusion from the group (Horne, 2001). That way the interest of the group will be taken into account. Therefore, norms have regulatory power in the eyes of sociologists. The research takes the sociological definition of norms into account. From this perspective, norms have four important features: sense of duty, sense of belonging, communication, and

implicitness (Horne, 2001). Scholars have also identified three significant elements of norms: social actors, social context, and social communication (Hechter and Opp, 2001).

The sense of duty, firstly, is a notion to be imposed from the inner conscience of the group member (Horne, 2001). Members should practice the norm so frequently until it is internalized and transformed into a value (Horne, 2001). There is a difference between mere acceptance and internalization of a norm (Hechter and Opp, 2001). To accept a norm is to have a positive attitude towards it (Hechter and Opp, 2001). In this case, one might not practice the norm or does not feel guilty or shameful. To internalize a norm means to practice it undoubtedly and to feel guilty or shameful if deviated from it (Hechter and Opp, 2001). Secondly, the sense of duty should be learned from other members of society by following them. Therefore, violating the norms should trigger sanctions on violators both from inside (feeling guilty) and from outside (social exclusion).

The second important feature of a norm is a sense of belonging to the group (Rimal and Real, 2003). It helps individuals to synchronize their personal value system with that of the group. There should be a sense of belonging to the group so that sanctions by other members affect the violator (Rimal and Real, 2003). Sanctions should give a feeling of internal loneliness, and deprive the violator from benefits of interaction with and being within the group. If an individual lacks a sense of belonging to the group, sanctions by the group would not mean anything for the violator, will not affect him internally, and won't influence his attitude and behavior.

Interaction with group members is important to develop a sense of duty and a sense of belonging. Communication among members of the group is the basics of both

understanding and applying the norms (Rimal and Real, 2003). Norms exist in a group, and emerge and spread in the process of interaction between individuals.

Finally, norms are different from laws (Rimal and Real, 2003). A Law is explicitly codified while a norm is an implicit code of conduct understood through social interaction (Rimal and Real, 2003).

Karl-Dieter Opp (2001) combines various features from different definitions of norms and introduces a minimal and a combined definition. The first feature is a sense of duty that exists in a minimal definition of norm. He extends the minimal definition to an extended one and adds the feature of sanction into it. In his combined definition of norms he includes all three features; existence of a behavioral regularity, imposing sanction if behavior is not performed, and shared expectation of individual or collective actors that behavior ought or ought not to be performed. Table 1 explains his definition of norms.

Table 1 Definitions of social norm

Criteria of the definition			Kind of definition	
Existence of a behavioral regularity	Sanction if behavior is not performed	Shared expectations of individual or collective actors that behavior ought or ought not to be performed		
--	--	Yes	Minimal	<i>Oughtness</i>
--	Yes	Yes	Extend	<i>definition</i>
Yes	Yes	--		Behavioral definition
Yes	Yes	Yes		Combined definition

Expecting a particular behavior from others and knowing that others expect us to behave in a particular way is what keeps the society going. Norms change through the

dynamic process of social evolution. It is important to understand how norms emerge, diffuse, and change over time in a particular social context.

Norm emergence

Opp (2001) suggests two propositions of norm emergence: private-good and public-good. Public-good instrumental proposition argues that norms emerge if they are instrumental for the goals of a collective of actors – a group. Some other scholars share the same view of instrumentality or functionality of norms. Williams (1968) argues that norms emerge in order to resolve recurrent problems of a group.

Since public is made up of individuals, private interest of individuals can also lead to a norm that will, in turn, benefit the public (Opp, 2001). It is called the private-good instrumental proposition of norm emergence. For example, a non-smoker does not want others to smoke close to him because of the negative impacts of smoking on his health. The individual non-smoker's negative reaction to a smoker can lead to non-smoking at particular places that can benefit the public.

Apart from these pure processes, many norms are the result of a combination of individual and collective processes of norm emergence (Opp, 2001). For example, the norm of non-smoking may first have developed spontaneously by individuals, and later put in place as explicit norms for the society. In any case, efficiency and functionality of behaviors have always been important for emergence of norms. According to classical functionalist instrumentality proposition of norm emergence, if the functional needs of a

social system are not met, and if a norm would have the effect that the system needs, the norm will emerge.

Norm diffusion

A behavior is not considered a norm, until it spreads within the group and is practiced for a period of time. For a behavior to become a norm, group members should accept and enforce it. The question is how a particular behavior is distributed among members of a group. Scholars point out that innovation diffuse from one actor to another actor across networks with both the social structure and the individual selection playing a role in it (Macy and Skvoretz, 1998). Defining an innovation as a practice, an idea, or an object, Rogers (2003) develop the theory of diffusion of innovation. He defines diffusion as a process in which an innovation is communicated in a social system through time. Four main features of diffusion are: An innovation is defined as an idea, a practice, or an object identified as new for its adopters: Communication is a process in which an innovation is passed on from one individual to another: A social system is defined as a set of interrelated units that are engaged in joint problem solving to accomplish a common goal; and the length of time needed for an innovation to get diffused among a social system is called innovation-decision period (Rogers, 2003).

For a healthy behavior to become a norm within a group, various elements of the diffusion of innovation process should be studied in details. Rogers (2003) identifies five stages of innovation adoption; knowledge, persuasion, decision, implementation, and confirmation. At knowledge level, individual is exposed to the innovation, a healthy practice in this case, and start seeking information about it. Persuasion is a stage when the

individual acquires enough information about the practice and starts forming an attitude towards it. Then, he decides whether to accept or reject the practice based on its advantages and disadvantages. Decision stage is a complete psychological stage. If the individual accepts the practice, he enforces it. The innovation process does not end here. The actor evaluates the behavior after implementation, and either confirms or rejects it. At all levels of norm development, individuals need to receive information about the behavior, its advantage and the way to practice it.

Norm modification

Ensminger and Knight (1997) say social norms are the product of individual human beings coping as best they can, formulating rules, following and breaking them. The process of social change is dynamic. For as long as the history is recorded, humans have lived in groups. They had ways of interaction, norms of behavior, and sets of beliefs. Norms have changed time and again in order to meet the needs of society.

Social efficiency and functionality are two factors in modification and emergence of new norms (Ensminger and Knight, 1997). The way competition in a free market leads to production of quality goods, competition of efficient and functional social interaction leads to emergence of new social norms. The already existed norms are negotiated and new norms are introduced and practiced. Actors negotiate patterns of behavior and recognize the efficient ones as norm. The negotiation process never stops. The role of social norm emergence/change is central to our understanding of how communities maintain and transmit dominant social practices (Ortner, 1984).

The norm change process could take place at various degrees. It could be a slight revision of the norm, i.e. alteration of three cheek-kissing to one cheek-kissing. Or it could be absolute, such as the practice of men attending delivery of their women compared to the times that men were not allowed to attend delivery of their women in the west.

There are various factors playing important roles in emergence, distribution, and modification of norms. Among others are culture and its social network (Hechter and Opp, 2001). Culture, defined as shared attitude, values, goals, and practices, influences all three main elements important in norm emergence; social actors, social setting, and social interaction (Hechter and Opp, 2001). Therefore, modification in any characteristics of social norms can lead to norm alteration. If individual's belief system changes, it affects the social norm. If the way society runs change, it affects the social norm. If interaction is changed from face-to-face to mediated-communication, it affects the social norm. Mass media directly and indirectly influences all three features and has great potential to change social norms.

Social norms change and mass media

Although individuals wish to take on healthy behaviors, many social norms, even not healthy, are widely practiced because of the perception that everyone else is doing it. Social normative theory posits that telling the public about the actual acceptable norms that are perceived wrongly will help reduce unacceptable norm, because people learn through social interaction with others about their expectation of their behavior, and then use the information to adopt behaviors that are accepted by others and avoid those that are not (Bandura, 1986).

In the process, the ability to provide information and characterize unacceptable behaviors puts the media in a central position to influence the process of change (Yanovitzky and Stryker, 2001; McComb, 2004). The media has the power to promote or demote social behaviors and norms. Scholars point to various theories of media influence on perceived social expectations and behavior change, such as cultivation theory and social learning theory.

According to cultivation theory, heavy exposure to health-related issues in the media in the long run shapes the way audiences think about health-related issues. Cultivation theorists believe that frequent coverage of same stories over time shape viewers' worldview (Gerbner, 1969). Based on the theory, audiences' understanding of health-related issues is a reflection of health information provided to them by the media. Some scholars have found that people who watch various amounts of television show develop different psychosocial health characteristics, including satisfaction with their weight and psychological depression (Dittmar, 1994; Hammermeister, Brock, Winterstein, & Page, 2005). Television viewing, on the one hand, might displace other physical activities and in turn affect the viewer's psychosocial characteristics. On the other hand, health information provided through television can cultivate the viewer's health knowledge and beliefs, and in turn shape the viewer's psychosocial characteristics (Wang and Gantz, 2007).

Social learning theory explains that humans learn by observing behavior of their fellows (Bandura, 1977). The learning process happens in four stages of (1) attention, (2) retention, (3) motor reproduction, and (4) motivation (Bandura, 1977). Speaking about

direct behavioral effects, the theory posits that behaviors can be learned by observing others performing the behavior, either in face-to-face or mediated communication (Bandura, 1977). Widely used in health communication research (Dilorio et al., 2000; Hawkins & Hane, 2000), the theory suggests that health stories conveyed through television can encourage the audience to adopt healthy behaviors by raising viewers' attention and recalling of important health issues, and by increasing viewers' confidence that they can, indeed, engage in healthy behaviors. Similar to the theory of Health Belief Model arguing that individuals will engage in healthy behaviors if they are exposed to severity of risky behaviors, know the benefits of taking action, and have the confidence of accomplishing the task (Dilorio et al., 2000). Thus, a strategy to heighten attention and information retention is to provide as much health stories to the viewers as possible. Beyond this health stories need to increase viewer self-efficacy and outcome expectancies. When a viewer feels more confident about adopting a health behavior or sees positive outcomes of the behavior, the viewer is more likely to adopt the behavior (Dilorio et al., 2000). That being said, a strategy television channels may employ is to include positive and encouraging health stories.

Yanovitzky and Stryker have found three possible paths by which the media can effect youth alcohol abuse; (1) a direct positive influence of alcohol-abuse-related media coverage on the perceived harmfulness of the behavior that in turn will be associated with a reduction in the prevalence of the behavior, (2) media representations of the issue will be associated with policy actions against alcohol abuse that can lead to reduced prevalence of the behavior, and (3) the plausibility of either a direct or indirect impact of news coverage

on perceived disapproval of alcohol abuse, which is expected to be associated with a reduction to this behavior.

Researches have applied normative theory on the actual norms that are perceived wrongly. Yanovitzky and Stryker (2001) have used social normative theory in order to correct misconceptions with regard to patterns of alcohol consumption by peers. They found that strategic focusing on peer influences and correcting misconceptions with regards to patterns of alcohol consumption by peers have proved to be useful in reducing youth alcohol abuse (Barnet et al., 1996; Perkins and Wechsler, 1996). The question is what if the actual norms (unhealthy ones) are not perceived wrong. For example, what if binge drinking is a norm among US college students, and all students already know it as a matter of fact. In developing countries, there are social norms that increase health risks, but they have cultural and traditional foundations such as self-care and self-treatment. People normally diagnose and treat their loved ones without any professional health knowledge. Would applying normative theory be still useful in these cases?

Summary

The current literature demonstrates a lack of research in developing countries, in particular Afghanistan – a country with a struggling public health system, promising communication technologies, and traditional, patriarchal social system. There is not a single study on the health information in the Afghan media.

The literature review explains, from a theoretical perspective, the public health, the reflection of public health through the media, and the reflection of socio-cultural practices related to health in the media.

The current research, partially, studies Afghan private televisions health agenda and compares it with the national health agenda set by the government of Afghanistan and its international partners and donors. The study further examines the content of the health message in order to make credible inferences to producers of the message and those who receive it. Agenda-setting theory explains the relation between public agenda and media agenda, while framing theory outlines theoretical structure for the way content of the media is communicated.

The second part of the research examines the role of the media in dealing with health-related socio-cultural practices. It identifies social norms, and examines the way they are reflected in the media.

Chapter Three: Methodology

This chapter briefly explains content analysis research method followed by a rationale for using this method for the research. It will then explain in details that how each step of the content analysis is applied.

Definition of Content analysis

Content analysis was created as a quantitative research method, but it has also developed as a qualitative one. Historically, Berelson (1952) defines content analysis as “a research technique for the objective, systematic and quantitative description of the manifest content of communication” (p. 488). According to the above definition, content analysis is about counting frequency of communication content which is represented in tables, charts, and graphs (Carney, 1972). A detailed explanation of the table, charts, or graphs is the interpretation of the data. Later, scholars have defined it as both a quantitative and qualitative method (Wright, 1986; Atheide, 1996; Carney, 1972), in which counting frequency and interpretation/description of communication content are simultaneous steps in the process. Wright (1986) says “content analysis is a research technique for the systematic classification and description of communication content... it may involve quantitative or qualitative analysis or both” (p. 125). While quantitative content analysis aims to verify a hypothesis, qualitative content analysis is used for discovery of a new knowledge, and/or verification of a hypothesis (Atheide, 1996). Scholars argue that quantitative factors such as size and frequency of media messages do not necessarily equate the impact of the message, and that it is not correct to assume that quantitative factors are the only or even the main determinants of media impact (Neuman, 1997;

Newbold, Boyd-Barrett, & Van Den Bulck, 2002). It is important to know that in what context, by whom and to whom a particular term, phrase, sentence, or paragraph is used.

Communication's main components are source, message, channel, and receiver. However, content analysis is about studying the message; it is also about the other components of communications; the source, the channel, and the receiver. Some scholars consider it as a tool not just for content analysis but for observation of communication content. Budd, Thorp, and Donohew (1967) say content analysis "is a tool for observing and analyzing the overt communication behavior of selection communicators" (p. 2). They argue that content analysis, on the one hand, can make predictions about the source, the channel, and the receiver. On the other hand, more knowledge about the other elements of communication helps to better analyze the message.

Berelson (1952) suggests various purposes of content analysis; (1) To describe substance characteristics of message content; (2) To describe form characteristics of message content; (3) To make inferences about producers of content; (4) To make inferences about the audience; (5) To predict the potential effects of the content on the audience.

There are various stages of analyzing communication data; developing research questions, collecting sample and defining categories, coding, scaling the codes, comparison, and interpretation (Budd, Thorp & Donohew, 1967). However, analysis of television content, after sampling and collecting the data, can also be organized by the following list: (1) unitizing the content, (2) transcription, (3) developing categories, (4) verbal analysis, (5) vocal and expressive analysis, (6) scene composition analysis, (7)

describing interplay of components, and (8) explanation (Fields, 1988). The 8 stages are not necessarily chronological, since the data can be transcribed first and then categorized into units of analysis. Vocal analysis could be done before verbal analysis, or there might be just verbal analysis without vocal or scene composition analysis. Units in broadcast media could be an entire broadcast, a story within a broadcast, combination of speech and/or dialogue, vocalization, and visual images within a segment (Fields, 1988, p. 184).

Data analysis in this method entails procedures to identify patterns in the communication content (Riffe et al., 2005). The patterns could be explained from various approaches, Neuendorf (2002) categorizes approaches to analysis of communication data into descriptive, inferential, psychometric, and predictive. Psychometric approach is more psychoanalytical use of content analysis (Neuendorf, 2002), which is not related to the current study. Other approaches like **descriptive, inferential, and predictive** ones are a part of the content analysis method used in this study. Descriptive approach describes the characteristics of the content of communication; inferential approach makes credible inferences about the producer of the message, channel of communication, and the receiver of the message; and predictive approach predicts the potential effect of the content of communication on its audience.

Rational behind using content analysis

The reason why this study applies media content analysis is because it is the most suitable method to answer the research questions. The research questions are about the main substance of the message (health topics), the form of the message (frames), and particular themes in the message (socio-cultural beliefs and practices). It allows the

researcher to make valid predictions about the producers, the channels and the receivers of the message after analyzing the content itself.

It has other advantages too. The data is the content of broadcast media that is available for the public. Atheide (1996) says that easy and inexpensive accessibility of data in content analysis is one of its strengths. Moreover, content analysis is a mixed method of analysis which is necessary for health related researches. Though, the researcher needs to count specific health-related variables in the communication content; description and interpretation of the health-related variables is an entirely qualitative process that is necessary for the study.

Applying content analysis

Sampling

After developing the research questions regarding the health topics, message frames, and sociocultural beliefs and practices, a systematic sampling method was used. To narrow down the population of the data, the criteria for sampling of Afghan broadcast media (television channels) were; (1) privately-owned channel, (2) nation-wide broadcast, (3) most-highly viewed, and (4) containing health-specific shows.

Two national private televisions, Tolo TV and Ariana Television Network, met the criteria. They were the most-viewed TV channels nationwide in Afghanistan at the time of data collection, and both were privately-owned, although Tolo television received funds from USAID at the beginning of its operation (Barker, 2008). Each television channel had one health-only show broadcasted every week. Tolo TV had one health-only show called

Dabestan-e Bo Ali (School of Avicenna). *Dabestan Bo Ali* was a recorded program broadcasted every week for half an hour. It covered health stories of the week and was considered to be informative and educational. Ariana Television Network had one health show called *Darmelana* (Cure). *Darmelana* was a live health show broadcasted every week for fifty minutes. It had a health professional in the studio who would talk about a particular health topic, and the audiences call the health professional by telephone and asked questions or commented on the health topic.

Transcription

The initial plan was to record six consecutive weeks of each show. But due to technical problems of recording, unreliable electricity in Afghanistan, not broadcasting of the show due to political turmoil during parliamentary elections in 2010, six weeks of each program were recorded from the months of July, September, and October 2010.

Once the recording was finished, the whole data was transcribed and simultaneously translated from Dari and Pashto (two official languages of the country) into English.

Unitizing and coding

The data was classified in different units of coding according to the themes of the research.

Health topics

To look for the health agenda of the media, the researcher used the primary categories determining the health priorities of the Ministry of Public Health and World Health Organization in Afghanistan; (1) Maternal and newborn health, (2) Child health, (3) communicable disease, (4) mental health, (5) other health problems. Later, the health topics were refined, new categories were added based on the data content, such as oral and dental health and food and environment safety. The category of ‘other health problems’ that mainly included diabetes, cardiac disease, hypertension, cancer, disability, and substance abuse according to Afghan Ministry of Health was expanded to any health related issues discussed in the data sample.

To identify health topics, each health story in *Dabestan Bo Ali* health show was considered as a coding unit. Since a health story fit into various categories, the researcher used a multi-coding technique to cross code one health story into two or many categories. For example, a story on hepatitis with a focus on children is coded under communicable disease and child health.

On the other hand, in case of *Darmelana*, a live health show, the whole show was designed to be about one health topic. Therefore, the whole show was considered a single unit with possibility of cross coding into various categories. Some shows were coded to different categories. For example, health story on bad breath in children was coded under oral and dental health and child health.

Health frames

To identify the frame of each story, both shows were unitized differently. In *Dabestan Bo Ali*, each change of speaker or a segment of health story was considered as a unit of analysis. In some cases, the on-screen presenter's word was considered a part of the unit of its following speaker, because he either introduced the speaker or provided an introduction to the speakers words. Otherwise, presenters who spoke independently were coded as single units.

For example, below are two units from a story on bad breath broadcasted by *Dabestan Bo Ali* health show on July 15, 2010.

Transcription of *Dabestan Bo Ali* health show on Tolo TV 1730 local time, 15 July, 2010

Topic: Bad breath

A unit of analysis

Frame: Info on health topic

<i>Visuals</i>	<i>Script</i>	<i>Speaker</i>
<i>Images of an big open mouth with little woman running away, a man's bad breath,</i>	<i>Where does bad mouth smell come from? Dr. Bashir Ahmad Faizi, a stomatologist, gives information</i>	<i>Anchor</i>
<i>CPD. Dr. Faizi wearing light blue professional gown sitting in his office,</i>	<i>Bad breath or bad mouth smell is an awful smell that comes out of a patient's mouth while breathing and his surroundings can feel it.</i>	<i>Dr. Bashir Ahmad Faizi</i>

A unit of analysis

Frame: 1- Cause of health problem (Individual-level)

<i>Images of mouth cavity cleaned with brushing</i>	<i>There are different factors. First, those who have one or many dental caries and do not treat it on time will have bad breath. In the meantime, a cavity will be formed in those teeth and will be a good place for food to gather there. The cavity will provide the ground for the growth of bacteria, which in turn creates bad mouth smell. Other factor is defective refilling of teeth caries or cavities, which will be a good place for growth of bacteria.</i>	<i>Dr. Bashir</i>
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In *Darmelana*, it was an interaction between the presenter and the physician, or among an audience, the presenter, and the physician as a coding unit.

For example, below is a unit of analysis from *Darmelana* health show.

Transcription of *Darmelana* health show on Ariana TV 1730 local time, 17 July 2010

Topic: Infant care

A unit of analysis

Frame: Info on health topic

<i>Presenter</i>	<i>How long is the neonate period, or until when is a baby called newborn?</i>	<i>Dr. Sediqi</i>
<i>Professional guest, images of baby inside a womb, outside a womb captioned neonate, babies lying in bed with cloths on, eyes open, and eyes closed.</i>	<i>Good question. The neonate period is very crucial because a baby changes atmosphere from inside a womb to the outside world. In the first 28th days of birth, the baby is called newborn. The period has early stage and late stage. Seven first days are called the early stage and the rest is considered late stage of neonate period.</i>	<i>Dr. Nasiry</i>

A unit of analysis (Socio-cultural practices)

Frame: Cause of health problem (individual-level)

<i>First caller on the phone</i>	<i>I have a newborn baby, who is just born yesterday, and he has fever and is crying a lot.</i>	
<i>Presenter</i>	<i>Is the baby born at home or hospital</i>	<i>Dr. Sediqi</i>

<i>First caller</i>	<i>At home</i>	
<i>Presenter</i>	<i>Can it feed?</i>	<i>Dr. Sediqi</i>
<i>First caller</i>	<i>Yes, it does get little mom's milk and some other stuff</i>	
<i>Presenter</i>	<i>Any delivery problem? Normal delivery?</i>	<i>Dr. Sediqi</i>
<i>First caller</i>	<i>There was no problem, and it was a normal delivery, yeah normal.</i>	
<i>Presenter</i>	<i>How you knew the baby had fever?</i>	<i>Dr. Sediqi</i>
<i>First caller</i>	<i>When we touch his neck, it's very hot.</i>	
<i>Presenter</i>	<i>Have you consulted any physician?</i>	<i>Dr. Sediqi</i>
<i>First caller</i>	<i>No, yesterday we got a drop for him, and the fever drops once he gets it, but he gets hot before the period of the drop is over.</i>	
<i>Presenter</i>	<i>Dear brother, I have an advice for you not to take any medicine without a doctor's consultation, in particular for a newborn baby, it might increase the problems, and the doctor [the guest] will have more advices.</i>	<i>Dr. Sediqi</i>
<i>Guest physician</i>	<i>Since the baby is feeding, it is a good sign of health. The reasons behind baby crying are many. Hunger could be a reason. Being too warm can cause baby crying. Wet cottons [pampers] can cause baby crying. Thirst, for example, can cause discomfort and crying. If our brother sees any of these signs or symptoms like if the baby cannot suck mother's milk well, he should take the baby to a close medical center, and his problem will be solved.</i>	<i>Dr. Nasiry</i>

The whole data was coded twice for two different classifications of frames.

First, the researcher coded the data for the following frames:

General information on health problems: It included definition of disease, general information about health situations, signs and symptoms of health problems, and prognosis of the health problem if nothing is done about it.

Causes of health problems: This frame covered medical causes, behavioral causes, social risk factors, and organizational inactions and weaknesses helping the health problem.

Solutions to health problems: This frame included medical solutions, behavioral solutions, preventive measures, social changes, and organizational solutions.

Then, the causes of and solutions to health problems were coded again as individual-level or societal level. At this point the researcher aimed to find if the causes and solutions of health conditions were framed as individual problems with no mention of social determinants of health, or as social problems with a need for public and institutional level decisions and actions. Lawrence (2004) argues individual frames limit the causes of and solutions to problems to particular individuals, often those who are afflicted with the problem, while societal frames “broaden the focus, assigning responsibility to government and non-government organizations, businesses, and larger social factors” (p. 57).

In this study, individual level frames for causes and solutions to health problems were defined as those that relate causes and solutions of health problems to individuals. Societal-level frames for causes and solutions to health problems were defined as those that relate the causes and the solutions of health problems to an institution, a business, or larger social factors. Examples of individual level and societal level causes and solutions to health problems are as follows:

Individual-level cause

“Factors that can cause sleeplessness in children can be ear pain or discomfort, hunger, caffeine drinks, respiratory infection, diarrhea, room temperature, putting on many cloths,

parents late night conversation, television or crowd noise, in appropriate sleeping positions, urinary infections, or any other illness or discomfort” (Dabestan, July 15, 2010).

Individual-level solution

“Any pregnant woman having headache, belly pain, unexpected edema, bleeding, discharge, burning pee, frequency, big belly which could be because of a twin or diabetes, history of caesarean section, or history of abortion should 100% visit a doctor. Others can seek help from midwives and see doctors in case of accessibility” (Darmelana, Oct 30, 2010)

Societal-level cause

“Well, I have a comment... I know the doctor [on TV] recommended monthly and biweekly visit to doctors, while people in the rural areas do not have access to doctors. And people are poor, they hardly make a living, and when you visit a doctor, each time they will ask you to do the television exam [ultrasound] ...” (Darmelana, Oct 30, 2010).

Societal-level solution

“We are planning to inaugurate the hospital as soon as possible. Jamhoriati hospital is a special national hospital in the country. We are planning to make a model hospital for the country. It took three years to build the construction of the hospital with the support of Chinese government. In the past three months, strategy and policy of national hospitals are finalized in the ministry and we are working on an article to allow the ministry to get fees from customers. Our main problem is limited budget of the government for hospitals. However, we have talked with the ministry of finance and international community donors to help us open this hospital” (Dabestan Bo Ali, July 22, 2010).

Socio-cultural beliefs and practices

To identify socio-cultural practices in the content of the data, an open coding technique was applied. First, social norms such as going to a religious leader and buying medicine from pharmacy without doctor’s consultation and etc. were identified. Then they were classified in categories. Categories were defined and all the codes were once again matched with the categories to make sure the codes met the categories.

Coding

The entire coding and classification process was carried out using NVivo 9.0 software. NVivo is qualitative analysis software that helped the researcher bring together all the data, code and classify them, and create charts, tables, and graphs.

Analysis

The findings of the study are explained in details in the analysis part. Health agenda of the media are compared with the priorities of Afghan Ministry of Public Health; Content of health messages was evaluated against public health concepts; Socio-cultural practices identified on the media were explained in details.

The descriptive approach helped the researcher to give more clarity to health messages provided by the two different programs. The inferential and predictive approaches allowed the researcher to elaborate on the potential influence of the health content on the audience based on the health communication theories. Based on the findings, a number of assumptions were made regarding producers, channels, and receivers of the message.

Afghan national strategy on health, which includes the health priorities, is retrieved from the website of the Ministry of Public Health of Afghanistan. Since the Afghan health ministry works closely with the World Health Organization to reach the millennium health goal for Afghanistan, the website of World Health Organization for Afghanistan was also consulted for collection of documents on health situation of Afghanistan. The main international donors for health services in Afghanistan are the United States Agency for

International Development (USAID), the World Bank, and the European Commission.

Their websites were consulted to collect documents on the public health situation of

Afghanistan.

Chapter Four: Findings and discussion

Findings

Health topics

The research studied 12 health programs from two different television channels in Afghanistan. In total 23 health stories were coded, with some of them as many as three times. The topic that received the most frequent coverage was Food and Environment Safety (7 stories) followed by Maternal Health (6 stories), oral and dental health (5 stories), child health (3 stories), mental health (2 stories), and communicable disease (1 story). The programs also carried single stories on health infrastructure, kidney stones, stomach cancer, and appendicitis.

Table 2 Health topics broadcasted by major Afghan televisions

Health topics covered by two national television channels over six weeks of 2010.	
Health Agenda	Number of matching nodes
Food and environment safety	7
Maternal and newborn health	6
Oral and Dental Care	5
Child health	3
Mental health	2
Communicable Disease	1
Other	4

Food and environment safety

The health programs broadcasted 7 stories (25% of health topics) only on food and environment safety in twelve health programs. Most of the stories on food and

environment safety came from a particular serial story called 'Kabul city through the camera of *Dabestan Bo Ali*' on Tolo TV. The program covered stories on city cleansing, food maintenance in warehouses, food production houses, and food hygiene in the local market.

Maternal health

The second most frequent topic is maternal and newborn health (21%), one of the biggest killers in the country. One woman dies every half-an-hour in Afghanistan due to maternal causes (MoPH, 2009). Each television carried only one health story entirely related to maternal care over the six weeks. A number of other stories were indirectly related to maternal health. Some stories were about newborn care, which had partial correlation with maternal health.

Oral and dental health

Interestingly, the third frequent topic discussed in the two health programs was oral and dental health (18%). The two television channels carried stories on bad breath, mouth sores, tonsillitis, and gingivitis. They say mouth is the mirror of body, but the fact does not fit the reality of the health situation in Afghanistan.

Child Health

Stories related directly and indirectly related to child held accounted for 11% of the health topics. Child health is the second priority of Afghanistan's Health Ministry. The country has the third highest infant mortality ratio and children under 5 mortality ratio in

the world (MoPH, 2010). The top killers are malnutrition, acute respiratory infections, pneumonia, diarrhea, dysentery, malaria, and lack of vaccinations (MoPH, 2009). None of the topics received any coverage over the six week period of television health shows. There was merely one story entirely related to child health and that too about children's sleeplessness. Two other stories including tonsillitis and hepatitis partially had association with the diseases in children.

Communicable disease and mental health

The two most important public health priorities including communicable disease such as tuberculosis, malaria, STI, HIV/AIDS, and cholera, and mental disease such as depression, anxiety, and post-traumatic disorders have received the least amount of coverage. The television covered hepatitis (4%) which is not a major communicable health problem compared to tuberculosis that killed 9000 people in 2009 in Afghanistan (MoPH, 2011). Other major communicable health priorities in Afghanistan are malaria and sexually transmitted infections.

Recent epidemiological studies of mental health in communities affected by the war in Afghanistan found high prevalence of symptoms of depression, anxiety and PTSD (Cardozo et al. 2004, Scholte et al. 2004). Only 7% of the health topics had some association with mental health. There has not been a single story entirely related to mental health issue. One story partially related to mental health was a story on hypnosis and its usage to treat depression. Another story was a neurosurgery operation, one of its kinds in Afghanistan.

Other disease

Other stories that did not match the above categories accounted for 14% of the health stories covered on the two televisions. The stories were appendicitis, kidney stones, hospital reconstruction, and a health conference. It is worth mentioning that infectious disease got frequent coverage too. Due to weak sanitation and hygiene in Afghanistan, infectious disease is a widespread problem.

Comparing televisions coverage of health

Seventeen stories were the share of Tolo TV's recorded health program, *Dabestan Bo Ali*. This program carried 3 health stories each week on various topics. One serial story entitled 'Kabul city through the camera of *Dabestan Bo Ali*' was basically about food and environment in Kabul city. In other stories, a health professional would speak about a particular health topic throughout the story. Comparatively, only 6 health stories came from the live television program, *Darmelana*, broadcasted by Ariana Television Network. The entire program was interactions between presenter and one health professional in the studio speaking about a single health topic. The audience made telephone calls directly to the studio and asked questions on the topic. Because of the style and the content of the program, each weekly program was considered as single story.

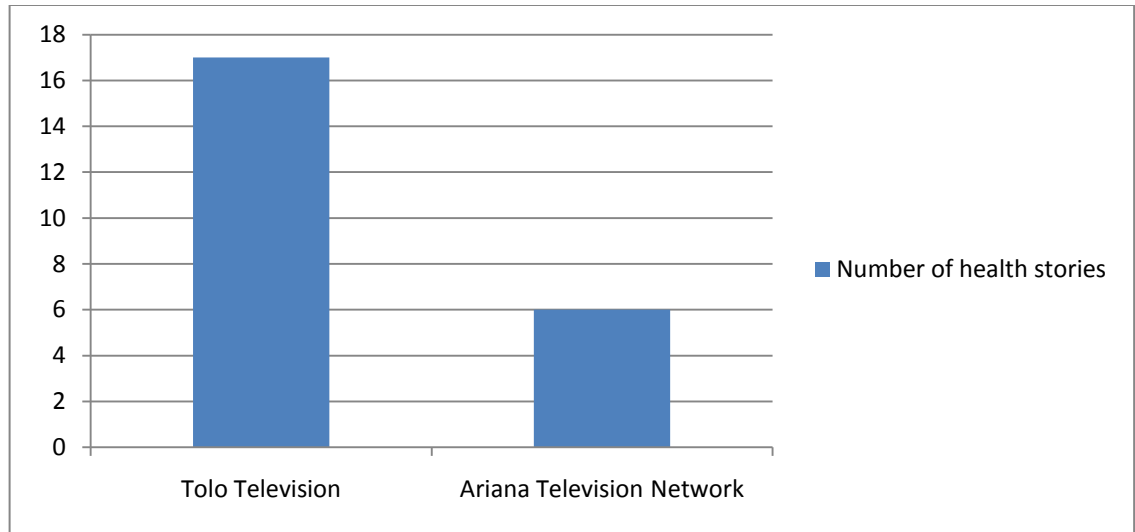


Figure 4 Number of health stories by television channels

On the other hand, the total duration of six *Darmelana* health show (3hr: 57mins) was twice longer than the total duration of six *Dabestan Bo Ali* health programs (1hr: 55mins). In the meantime, *Darmelana* health program attracted audience from all over the country. Audiences called from southern Helmand and northern Mazar-e Sharif provinces. Women asked questions about pregnancy-related issues and men questioned poor health delivery of the government, to mention a few. Five (18%) out of 28 callers on *Darmelana* health show were female inquiring about their health problems.

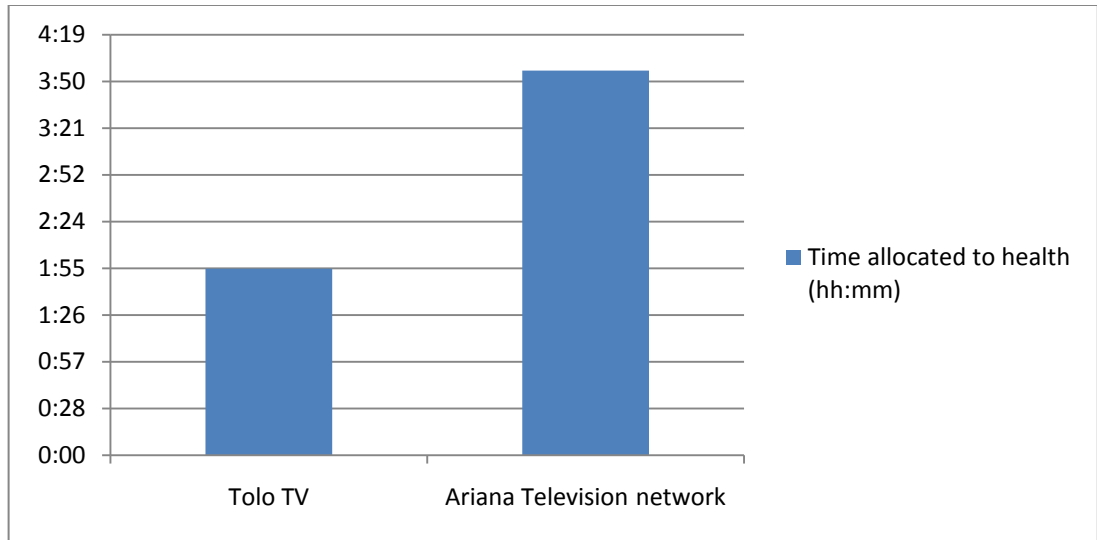


Figure 5 Amount of Time allocated to health programs by television channels

Health message frames

The 23 health stories from both television channels produced 172 coding units. A demographic analysis of the units

indicates that men provided 74% of the information with women only accounting for 26 per cent. All the units coded for three categories. The first category (general information on health problems) included definition of disease, general information about health situations, signs and symptoms of health problems, and prognosis of health issues if nothing was

done about it. Examples of coding units for general information are as follows.

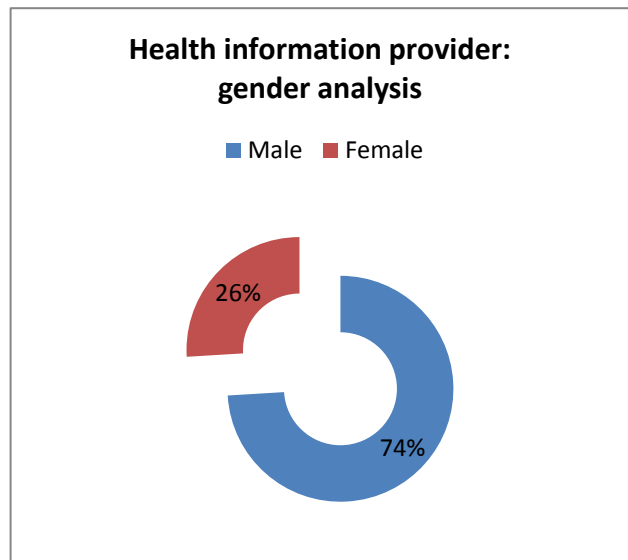


Figure 6 Women's participation in Afghan health shows

Example 1

“This patient is a 68 years old female who is suffering from chronic headache that does not respond to any medicine, she also suffers from general weakness, low mobility of arms and legs, and even speech difficulties. She was admitted to the hospital in a semi comatose condition. After diagnosing the brain tumour, she was prepared for the operation”. (Dabestan Bo Ali, 29 July 2010)

Example 2

“There are types of sleeplessness, one that child cannot go to sleep, and the other that child sleeps in small cycles.” (Dabestan Bo Ali, 15 July 2010)

The second category (causes of health problems) covered medical causes, behavioral causes, social risk factors, and organizational inactions and weaknesses.

Examples are as follows:

Example 1

“Bad mouth smell is an awful smell that comes out of a patient while breathing, and his surroundings will feel it. It could originate from teeth or disease of the mouth cavity. It is an illness. It not only bothers the people around the patient, but also causes psychologic problems to the patient”. (Dabestan Bo Ali, 15 July 2010)

Example 2

We have not only had problems in city cleansing, but also food sanitation today. We can see what food stuff are sold for our fellow countrymen. I, as an Afghan and the head of Sanitation Department of Kabul advice all our countrymen, never to use these materials, not to buy such poisonous materials. If you want to eat chutneys, you can buy standard produced chutneys. These [chutneys] are microbes and poison, and very harmful for our countrymen. We will shut this house, and provide transport to garbage these harmful and infectious ingredients outside the city of Kabul. (Dabestan Bo Ali, 15 July 2010)

The third category (solutions to health problems) included medical solutions, behavioral solutions, preventive measures, social changes, and organizational measures.

Examples are as follows:

Example 1

“However we are talking about neonates, we can still give advice. [In Pashto addressing the audience] You should consider cleanliness measures, children should be feed well, and children should learn cleanliness measures. Provide them clean water. If you have access to electricity, you can use fans or air conditioners. (Darmelana, 17 July 2010)

Example 2

“Well, parent should not worry about sore throat, because more than 90 percent of them are viral and medication can’t help. My main message to parents and children is to wash their hands. Clean hands prevent from many diseases such as diarrhoea, sore throat, and so on, and even it is said that helps 30 percent reduction in mortality. Second, eating stuff from street such as lollipop and chocolates are other main causes of sore throat in children. Finally, parents shouldn’t insist in tonsillectomy and follow what the doctor advises.” (Darmelana, 23 Oct 2010)

Out of 173 units, solution to health problems accounted for 69 units (40%)

followed by general information on health problems with 62 units (36%). Causes of health

information accounted for only 42 units (24%).

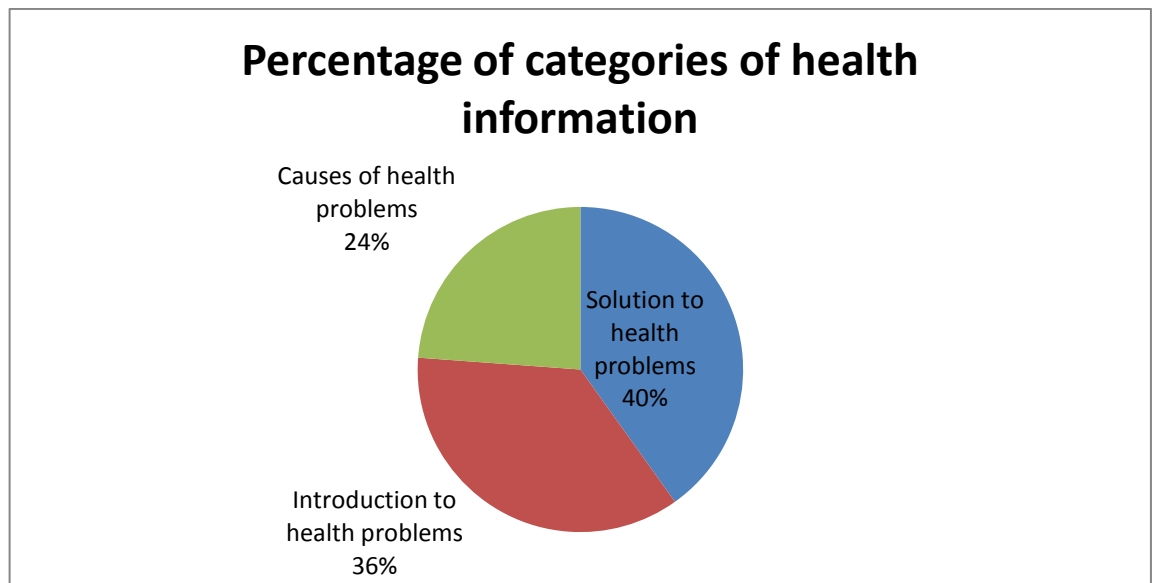


Figure 7 Categories of health information

The units for causes and solutions were then categorized as individual-level and societal level. Out of 42 units, 25 (52%) individual-level causes of health problems and 23

(48%) societal-level causes of health problems were identified. A number of causes were cross coded as both individual-level and societal-level. Out of 69 units, 60 (87%) individual-level solutions and 9 (13%) societal-level solutions were identified. Figure 9 indicates individual-level and societal-level causes and solutions comparatively.

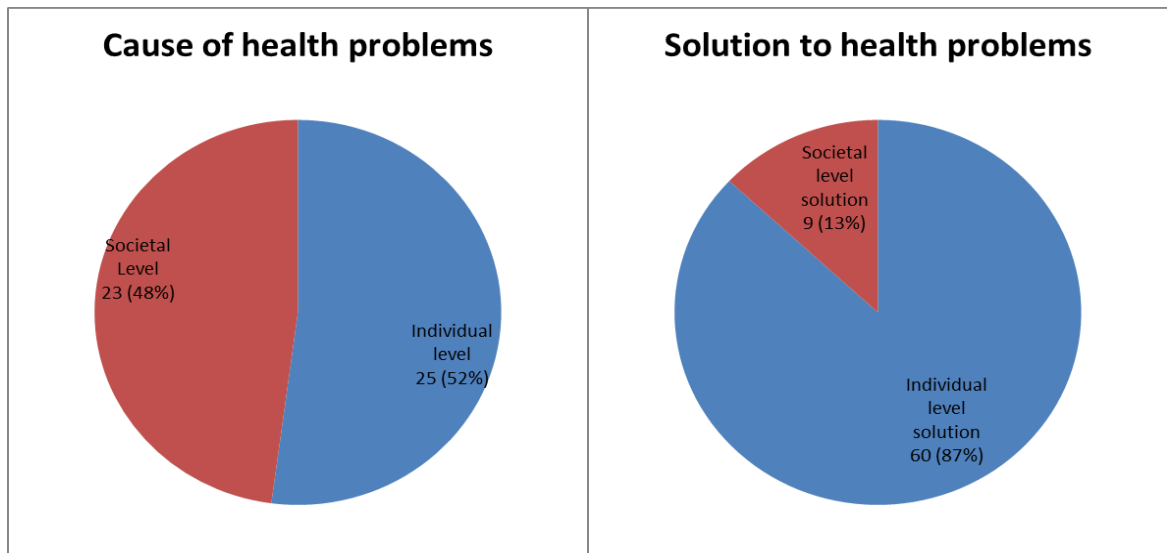


Figure 8 Comparison of causes of and solutions to health problems

The diagram indicates that both individual factors and social factors were almost equally blamed for causing health problems. However, individual behavior was largely prescribed as the solution of the health problems.

Socio-cultural beliefs and practices related to health

A thematic study of the two television programs finds the following themes of sociocultural beliefs and practices: (1) health seeking norms, and (2) Health-related gender norms. The norms are either explicitly mentioned on the programs or implicitly referred to.

Health seeking norms

Healthcare seeking norms include self-prescription, parents administering medicine to their children without physician consultation, and seeking religious treatment for health.

Below are examples of health seeking norms broadcasting in the two television shows: Ex. 1

<i>Physician wearing a white gown, sitting, and speaking to camera</i>	<i>... When children have illnesses and do not go to sleep, some parents give opium, or Phenobarbital, diazepam or peritol, to their children. It has bad consequences.</i>	<i>Dr. Rodwal</i>
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(Dabestan Bo Ali, July 15, 2010)

Ex. 2

<i>0000 Presenter</i>	<i>Have you consulted any physician?</i>	<i>Dr. Sediqi</i>
<i>0000 First caller</i>	<i>No, yesterday we got a drop for him, and the fever drops once he gets it, but he gets hot before the period of the drop is over.</i>	

(Darmelana, July 17, 2010)

Ex. 3

<i>0737 Female Dentist</i>	<i>... About medication, it depends on the diagnosis, but unfortunately, our people love to prescribe drugs themselves which is wrong and a big problem.</i>	<i>Dr. Alokzai</i>
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(Darmelana, Oct 16, 2010)

Ex. 4

<i>0312 Hypnotist sitting in front of the camera wearing striped shirt and necktie</i>	<i>Hypnotism ...doesn't relate in any way to magic or wizard or divine ability, it is a practice which is used in most countries. We hear that people say they walked by a river late in the evening or night and were influenced by ghosts ... People who have headache, stomach-ache, backache, and pain on other parts of body, they relate it to evil. Those people go to 'holy' people and it is described as if they are being influenced by evil. Such patients can come out of that condition with one hypnosis therapy, and if the patient is told again that he or she has come under evil power, he will not buy it. However hypnotism doesn't have to do</i>	<i>Dr. Muslem Jamal</i>
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anything with evil or djinns. That's true that we believe in existence of djinns but we don't believe that it harms us.

(Dabestan, Sep 16, 2010)

One of the common advices of medical doctors to the audience on the shows was to seek professional care and stop taking medicines without doctor's consultation. The issue of self-prescription appeared from the television to be a general fact.

The first example comes from *Dabestan Bo Ali* health show in which a physician talks about child's sleeplessness. It indicates how parents carelessly administer opium or addictive drugs to their children as a social practice. In the second example, an audience, who asks question about his newborn baby, casually admits that he gave a drop to his newborn baby to control his fever. In the third example, which comes from another interactive show between audience and physician, a female dentist criticizes the widespread practice. The fourth example points how the public go to 'holy people' to treat "headache, stomach-ache, backache, and pain on other parts of body". The physician, however, cannot reject people's belief in evil or djinns straightforward and thus stop them from going to traditional healers; he vigilantly attempts to provide a scientific alternative – hypnosis therapy.

Gender related norms

Health-related gender norms include husbands not allowing wives to seek healthcare, home delivery and its accessories (unhygienic delivery, unhealthy management of umbilical cord after delivery, and unhealthy ways of caring newborns) , and women being secondary in family food chain.

Below are four examples of gender-related social norms that affect health:

Ex. 1 Husband's now allowing wives to see doctors

<i>1445 Presenter</i>	<i>And, any message for those husbands who do not allow their wives to go to clinics or see doctors? It is seen that husbands have not let their wives, although being in a critical condition, to see doctors?</i>
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<i>1515 Female doc</i>	<i>Well, I don't think it is time to restrict your women so badly in homes. If your wife is suffering life-taking dangers and if your baby is suffering, you will also not be happy. All mothers have either one to come, or already many more children to take care of. Husbands should take it into account. If your wife has a problem, you should take them to hospital immediately.</i>
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(Darmelana, Oct 30, 2010)

Ex. 2 Home deliver

<i>First caller on the phone</i>	<i>I have a newborn baby, who is just born yesterday, and he has fever and is crying a lot.</i>
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<i>Presenter</i>	<i>Is the baby born at home or hospital</i>	<i>Dr. Sediqi</i>
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<i>First caller over the phone</i>	<i>At home</i>
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(Darmelana, July 17, 2010)

Ex. 3 Burning umbilical cord

<i>Presenter</i>	<i>It is seen that family members prescribe medicine or do things themselves such as burning the umbilical cord or doing other things to newborn babies.</i>	<i>Dr. Sediqi</i>
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<i>Professional guest</i>	<i>I know there are families who burn the umbilical cord once the baby is born; there are families who give medicine to their babies without doctor's consultation. These things are against today's medical practice.</i>	<i>Dr. Nasiry</i>
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(Darmelana, July 17, 2010)

In the first example, the presenter puts forward the norm that husbands do not allow wives to visit doctors. The second one in which a man talking about his newborn baby admits that the baby is born at home affirms the type of norm that women suffer from. The

third example talking about burning umbilical cord, of course at home, further verifies the suffering of women from traditional practices.

Discussion

The core of agenda-setting theory is that the media has the power to tell the audience what to think about. Regarding health issues in Afghanistan, the Ministry of Public Health (MoPH) has five health priorities for the country: (1) Maternal and newborn health, (2) Child health, (3) Communicable disease, (4) Mental health, (5) Other health problems.

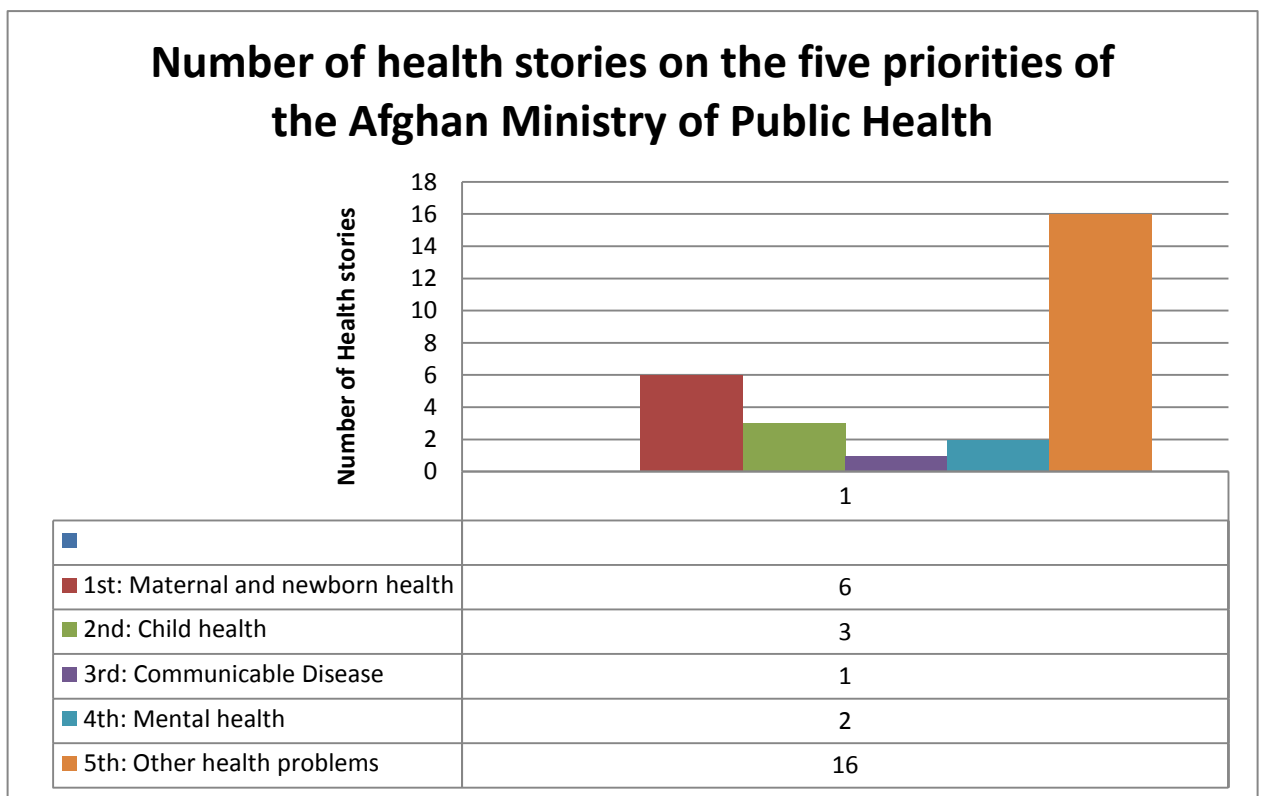


Figure 9 Number of health stories based on MoPH priorities

The priorities were the initial category in the coding process to look for health topics in the media. The study of two health shows of Afghan national, private television

channels indicated that the fifth health priority (other health problems) with 16 stories (57%) received more frequent coverage than the first four priorities (maternal and newborn health, child health, communicable disease, and mental health) all together with 12 stories (43%).

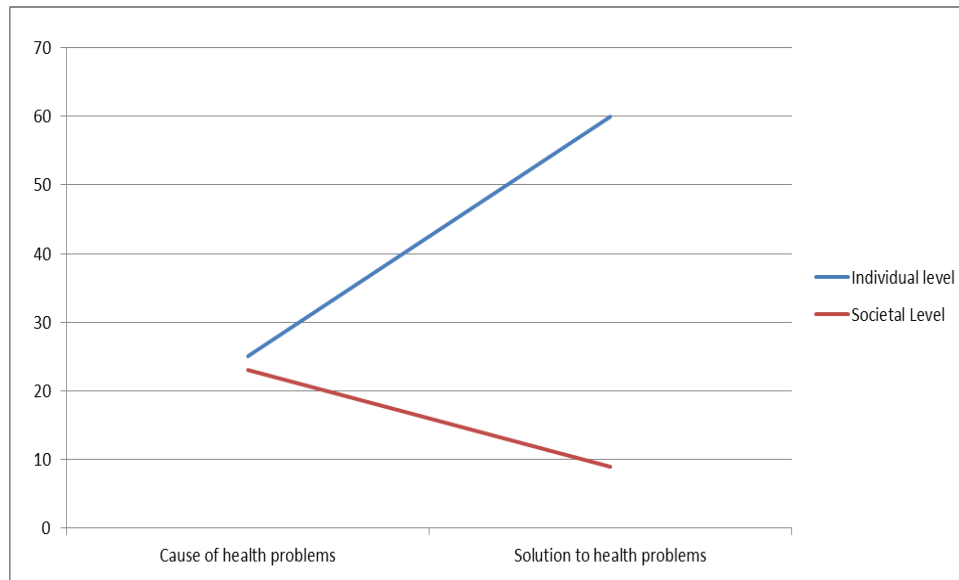


Figure 10 Framing of health problems and solutions

Other health problems according to MoPH included disability, cancers, diabetes, drug abuse, cardiovascular disease, disaster response, environmental risks, and health infrastructure. To make the category more inclusive, other health problems in this research added all other health topics such as kidney stones, appendicitis, and health news. The core of McComb's agenda-setting theory is that the media have the power to tell the public what to think *about*. Based on the theory, Afghan national private channels focus the attention of the audience on the health topics that are least important for public health.

Moreover, Beauchamp (1983) explained that combination of individual responsibility and collective rules in health education could save thousands of lives. But the way stories received coverage in regard to causes and solutions of health problems

indicates a much unparalleled linear graph. Figure 10 indicates that the health programs spoke almost equally about individual-level (52%) and societal-level (48%) causes of health problems, but they failed to provide equal individual-level and societal-level solutions to the problems. The programs provide high amount of information in regards to individual-level solutions to health problems (87%). On the contrary, they have very little to say about societal-level solutions to the health problems (13%).

The two above-mentioned findings and some other observations of the media content point to some issues regarding the Afghan media and its public health system. Poor journalism skills, lack of knowledge in public health, poor participation of women in the media, patriarchal society, and poverty is blamed for what and how health information is provided to the public. However, new communication technology such as mobile phone and the television has provided the ground to challenge health-related social problems and to publicize the problems as issues of concern.

Lack of journalism skills

Professional journalism is about being truthful, objective, impartial, independent, and balanced (Herrscher, 2009). Every story for a journalist has at least two sides, like a coin. It is possible that a story might have more than two sides. Health stories cannot be excluded from the rules. There are doctors, patients, pharmaceutical companies, government health departments, individual health, public health, etc. Health journalists need to consider all aspects of a story.

Most health stories broadcasted by Afghan televisions were informative and educative stories that appeared to be neutral. For example, stories on tonsillitis, appendicitis, hepatitis, kidney stones, and gingivitis provided medical information on the diseases. One or two medical doctors spoke about the topic and in one program the audience would ask questions regarding the topic. The topics generally involved doctors and patients.

However, stories on food and environment safety included food businesses, government departments, non-government organizations, international security forces, individual health, and public health. Balancing such health stories needed journalism skills, something that the TV journalists lacked. Most stories on food and environment safety were less of journalistic values and more of promotion for government departments. The television crew accompanied government food inspection officers who inspected food safety of the local businesses. In most stories the camera would merely follow government delegate during inspection and at the end of the camera tour, the presenter would talk to a government official who would explain government policies and actions blaming the local business for breaking the rules. For example:

<i>0713 Presenter holding microphone faces camera, official in the background</i>	<i>Dear audience, you have seen the condition of the factory, and now we will have some words from the head of Environment Health Department.</i>
<i>0722 Official speaking to the presenter</i>	<i>In the name of God. As we have witnessed, the factory is located in a residential area operating against the rules of environment safety. On the other hand, the factory does not have any work permit either from the municipality of Kabul or the ministry of public health. It is operating against food safety of the ministry. Neither raw nor cooked material of the factory is examined prior to its operation.</i>

Workers do not wear clean cloths and hygiene regulations are not taken into account. It has also bothered the locals. It is a residential area. One of the locals has informed us about this factory and how it has bothered them. We will inform related departments to stop such illegal factories.

(Dabestan Bo Ali, Sep 24, 2010)

The way the stories on food and environment safety got coverage indicated an obvious favor for the government. In journalism, when a dog bites a man it is not a news story because that’s so usual and routine. Government officials were supposed to inspect food productions as part of their routine. Covering their routine as health stories appears to be more of an advertisement for government departments rather than journalistic stories on the real situation of food and environment safety in Afghanistan.

The inspection process, undoubtedly, would not go smoothly. For example, in another story, a business owner barely being focused by the camera argues with a government delegate saying, “Date should be kept in cold stores, where is the cold store of the government, tell me if the government has any, other countries’ governments, like Iran, have freezer warehouses” (Dabestan Bo Ali, July 22, 2010). The government officials have no answer to the business owner. The whole confrontation was broadcasted as part of the story. Confrontation of business owner and workers with government official created a nice drama instead of a firm health message. For example:

<i>Visual</i>	<i>Script</i>
<i>0314 A man wearing a long beard and local cloth, confronts the officials [owner]</i>	<i>Government is obliged to give us land, and permit so that we work, it doesn't work other way. Shouldn't we earn bread? Shouldn't we eat? There are 30 people working here. The government, or the minister, or whoever has the authority, just tell us not to eat anything, then we will stop working.</i>
<i>0334 Another man</i>	<i>Isn't the government bothering you all the time?</i>

<i>wearing long beard, half-sleeve shirt argues with the officials [worker]</i>	<i>Just tell me, Isn't there explosion in front of your house every day? What's the government doing about it?</i>
<i>0341 Owner</i>	<i>There you go. The entire factory is yours. Do whatever you want. You want to confiscate the materials, close the factory? Do it.</i>
<i>0347 toffees being weighed and packed in plastic bags; Finger pointing to expiry dates of plastic packs from 2010 to 2013; unclean floors and baskets messed around; electricity generator and its wires;</i>	
<i>0440 Official</i>	<i>On what basis do you put the expiry date of the toffees from 2010 to 2013?</i>
<i>0447 Owner</i>	<i>It is a general period, from two to three years.</i>
<i>0447 Official</i>	<i>Do you know that foodstuff in particular diaries go bad quickly? And material mixed with milk can't be safe for more than one year. How do you put three years?</i>
<i>0503 Owner</i>	<i>Wait, the plastic we order from abroad takes six months to a year to get here. We don't have any production factory for it here. The plastic bag might get filled six months later or a year later. If you want, I will show my visa last time I went abroad.</i>

(Dabestan Bo Ali, Sep 24, 2010)

The confrontation clearly indicated the business owner cared less for government officials or their actions. He says “you want to confiscate the materials, close the factory? Do it” (Dabestan Bo Ali, Sep 24, 2010). This kind of conversation broadcasted by the media as a health message could frustrate the audience. It provides a vague and confusing health message that leaves the audience in the middle of nowhere. On the one hand, the audiences learn about the poor sanitation of the food they consume every day. On the other hand, they find the government weak enough to control the food production, and the

audience, as individuals, have no choice but to consume it anyway. Above all, such coverage is clear indication of poor journalism skill of the health reporter.

Lack of journalism skills can be blamed for both covering food inspection process as health stories and the way it was covered. Dozens of other stories worth covering such as performance of government in providing basic health services, pharmaceutical companies importing illegal medicine, businesses importing low quality fuel polluting the air, and so on and so forth. Weakness of journalists in selecting the topic and the way of covering has affected a large part of the health information on the television.

Lack of knowledge of public health and highly medical language

In addition to poor journalism skills, lack of knowledge on the issue of public health can also explain the topic and style of coverage. Fifty seven percent of stories covered by the two televisions were not among the first four health priorities of the country. It is because both the society in general and the media in particular lack public health professionals. There is literally no public health school in Afghanistan. All public health practitioners are primarily trained as medical doctors in four medical schools in the capital Kabul, western Herat, eastern Jalalabad, and northern Mazar-e Sharif cities (MoPH, 2010). The producers of health programs of the television media were all medical doctors. The presenter of *Darmelana* live health show was Dr. Ahmad Jawed Sediqi (Wearing medical white gown) and so were all the guest speakers. The health journalist of *Dabestan Bo Ali* was also medical doctor, Dr. Mohammad Yasin Babrak, and so were most of the information providers.

Taking the fact that most information providers on televisions were medical doctors, their education and knowledge of health influenced the message production in general.

For example:

<i>0140 Presenter</i>	<i>Maybe we can start with some information about appendix, its form, and its function, and then we will move on to the disease.</i>
<i>0208 Guest speaker</i>	<i>Appendix means something extra or an adjacent. It is a part of digestion system of the body located inside abdomen, at the end of the small intestine and the beginning of the large one. To locate it on the belly, it is located below bellybutton on the right. Or if we divide belly with a vertical and horizontal line crossing the bellybutton into four quadrants, appendix is located on the right-lower quadrant. It is 7 – 10cms long. In the past, it was thought that it doesn't have any function. Today, research has found that it plays role in immune system and has some other functions too.</i>
<i>0419 Presenter</i>	<i>Thanks, let's move on to its disease. When can we say that a person has appendicitis? I have heard patients saying that they had appendix. Maybe you can differentiate appendix and appendicitis.</i>
<i>0447 Guest speaker</i> <i>0544 Images of bloody appendix, and a necrotic one, surgeon's hand opening appendix area of the abdomen, bring out appendix with surgery clippers</i>	<i>I have seen health professionals too making mistake about it. Appendix is the organ itself, and when it is infected, it is called appendicitis. Or simply infection of appendix is called appendicitis. The disease is a very common acute abdominal surgery case, which needs emergency surgery and care. It is very common in teenagers.</i>

First, the style of the story on appendicitis started with the definition, form and functions of appendix, and continued with the causes of disease, its signs and symptoms, its diagnosis, its differential diagnosis, its treatment, and its post-operative care. That's how appendicitis is taught for medical students. Secondly, since both the presenter and the

guest speaker were medical doctors, their conversation had lots of such medical terms as ‘*appendix*’, ‘*appendicitis*’, ‘*intestine*’, ‘*digestive system*’, ‘*immune system*’, ‘*acute*’, etc. that were unheard of for a local Afghan audience. A number of scholars studying health message in the American media said that a 10th grade education was required to understand the verbal component of the health news stories (Wang & Gantz, 2007). If the health message in the States need a 10th grade American education to understand them, there is no doubt that the highly illiterate Afghan audience won’t understand the language of medical doctors at all.

Moreover, in one of the live health shows, an audience called from southern Helmand Province, which is considered to be the worst-hit part of the country by the war on terror. Both the presenter and the physician were surprised knowing that they had an audience from the other end of the country – a remote area in the south.

<i>0000 Audience</i>	<i>We are living in Helmand where the weather is very hot. We have a lot of children. How to take care of our children in such places?</i>
<i>0000 Professional guest [speaking in Pashto]</i>	<i>However we are talking about neonates, we can still give advice. [Speaking in Pashto] You should consider cleanliness measures, your children should be fed well, and children should learn cleanliness measures. Provide them clean water. If you have access to electricity, you can use fan or air conditioner.</i>

(Darmelana, Jul 17, 2010)

The response by professional guest indicated lack of knowledge about Helmand province. He didn’t demonstrate any knowledge about the pathology of the area, any major epidemic in the southern provinces, or its social situation such as access to electricity power. He shouldn’t have known too, because he was a medical doctor, not a public health

professional. It proves that there is a lack of public health professionals to know of major public health issues and to convey the right message to the right people through the media.

Low professional health care, low coverage in the media

Medical doctors' knowledge of major public health concerns comes from their medical education and day to day clinical experiences. This in turn could affect low coverage of major public health concerns in the media. For example, in developing countries, patients with acute and severe symptoms seek professional care, while those with chronic or latent ones go to traditional healers (Cordazo et al., 2004). According to Afghan medical doctors speaking on television shows, gingivitis manifests with bloody and edematous gingivae; appendicitis demonstrates intolerable abdominal pain, vomit, and nausea; tonsillitis demonstrates sore throat, painful swallowing, and difficulty in breathing; kidney stones, once blocked the ureter or urethra, manifest with severe pain. Patients with those types of symptoms seek professional care in Afghanistan, and professional doctors working in the media industry cover them as public health problems in the media. Disease that manifested acute signs and symptoms accounted for around 20% of health topics. On the contrary, mental health problems such as depression and post-traumatic stress disorders are easily overlooked in the media, because mental patients seek traditional or supernatural healing. Cordazo et al (2004) argues that most people suffering from mental health disorders in developing countries do not seek treatment in health facilities at any level, and instead resort to traditional healers and rituals. Mental patients in the outskirts of eastern city of Jalalabad in Afghanistan are tied to a tree, deprived of food, and given a diet of black pepper for 40 days to get better (Arnoldy, 2009). Mental patients are considered

cursed in that traditional society and thus need supernatural healing. The stigma attached to mental health reduces the chance of professional health seeking in religious societies such as Afghanistan. Afghan televisions had one story on hypnosis and one on neurosurgery. In total 7% of the health topics were about mental problems. Considering that mental health is the fourth significant health priority in the war-ravaged Afghanistan, it is quite low.

Lack of women's participation in the media

One of the reasons that could explain low coverage of maternal health issues in the media is low participation of women in the health programs. This research finds that male dominated health programs on the two television channels with 74% coverage. However, the acting health minister, who was a woman, was covered at two different stories; most health information providers were men.

Women's participation in the media has been a problem for decades either due to social or cultural factors. In the early 1990s, the civil war was the reason of low education and employment both for men and women. After the war, education and employment of women were banned by the Taliban in the late 90s. When they were ousted in 2001, most women were deprived of education and employment for more than a decade making them unqualified to work.

Culturally, women are considered as second-class citizens, deprived of their basic rights (Emadi, 2005). Their activities are traditionally restricted to domestic works inside the house such as cooking, cleaning, and pleasing her husband as and when her husband wishes (Emadi, 2005). Due to gender segregation women visit only female doctors. It is

particularly difficult for men to even talk about women issues. Women's appearance in public, however promoted by communist regimes and reformist monarchies in the 60s, was stigmatized by the fundamentalist regimes during the civil war and the rule of the Taliban (Emadi, 2005). Though the regimes left, the social norms they promoted stayed. In 2005, a female journalist was brutally killed in her home in Kabul city because of appearing on television as an anchor (Rawa, 2007). In 2007, two female journalists were killed for the same reason in major cities of Herat and Parwan (Rawa, 2007). The Taliban still set fire to girls' school, kill women workers, and threaten working women to death to quit working. The government, on the other hand, is too weak to provide security for the citizens.

Therefore, considering that the local culture prevents men to intervene in women's issues and that women cannot work or appear in the media, maternal health issues receive low coverage on the television media.

Financial reasons behind self-care

This study found that self-prescription was slammed by medical doctors in the media relentlessly. Most health shows advised the audience not to take medication without physician's advice. Self-prescription, defined as the purchase and use of restricted medications by an individual without medical advice (Drug Utilization Research Group, 1997), is a common practice in developing countries. People can purchase any kind of medications without prescription in Afghanistan (Paterson & Karimi, 2005). Pharmacy attendants, who are mostly not chemists, help people with giving them medicine for particular symptoms in developing countries (Pylypa, 2001).

One of the reason people rely on self-prescription could be the high cost of professional care for the poor nations that lives with a dollar a day. Self-prescription saves patients the doctor's fee and numerous medications that a professional doctor would be prescribing. There is a tendency among doctors to over-prescribe medicines generally and antibiotics in particular without due consideration of possible side effects (Paterson and Karimi, 2005). Recently, modern medical technologies such as Ultrasonography, Computed Tomography Scan, and Magnetic Resonance Imaging have also entered the market that has increased the financial burden for the majority poor Afghans to seek professional health care. An audience speaking on the phone to a medical doctor on one of the television shows comments on why people don't go to medical doctors.

“Well, I have a comment... I know the doctor [on TV] recommended monthly and biweekly visit to doctors, while people in the rural areas do not have access to doctors. And people are poor, they hardly make a living, and when you visit a doctor, each time they will ask you to do the television exam [ultrasound], and we have heard, we don't really know, that ultrasound harms pregnant woman...” (Darmelana, Oct 30, 2010).

Not only the audience of the health shows are unhappy with the poor government healthcare system, but also the financial burden of modern technology like ultrasound, Computed Tomography scanning (CT-scan), or Magnetic Resonance Imaging (MRI). The financial burden associated with seeking care from of health professionals is a reason for the frequency of the inexpensive practice of self-prescription with the help of pharmacy attendants (Paterson and Karimi, 2005). Helman (2001) argues that patients, in most cases in developing countries, seek self-treatment when they fell ill. If self-care is ineffective or if the illness becomes acute, patients have no other choice but to seek professional care as the final resort.

The financial burden coming with the low quality medication and substandard professional care feeds the social norm that resists modern technologies as harmful. Poor patients who finally seek professional care receive numerous low quality medicines overprescribed by physicians and provided by medicine smuggler (Paterson and Karimi, 2005). Eighty per cent of Afghans pharmaceutical markets are filled with cheap bad quality medicines from Pakistan, Iran, and China (Paterson and Karimi, 2005). This is the main reason why patients, their family and their community do not have recourse to health professionals. It is true in the traditional, collectivist society of Afghanistan that ‘if you fail one patient, you fail the entire community’ (Fadiman, 1997, p. 153).

Patriarchal system and women

Financial issues are not the only or even the strongest factor feeding unhealthy social norms; it is the entire social structure of Afghanistan – patriarchal society. Family structure in Afghanistan is primarily based on the patriarchal system in which the authority of the family is in the hands of the father or the eldest son (Emadi, 2005). Women are treated as second-class citizen, deprived of her basic rights, and restricted to domestic activities inside the house such as cooking, cleaning, pleasing her husband as and when her husband wishes (Emadi, 2005). In some tribal communities woman is even less valued than an animal (Emadi, 2005). Some Turkmen, for example, attach more value to their horses than to their wives (Emadi, 2005). In such culture, there is great respect for older people, married men and women, and mothers, which gives incentive for girls to marry at a young age and bear a child as soon as they can (Emadi, 2005). Women are not allowed to leave their homes without a legitimate reason, and without securing permission from their

husbands or other male members of the family (Emadi, 2005). The practice is even extended to women's healthcare seeking. A wife must secure permission from her husband even for health problems.

<i>1445 Presenter</i>	<i>And, any message for those husbands who do not allow their wives to go to clinics or see doctors? It is seen that [some] husbands haven't let their wives, even when their wives were in critical conditions, to see doctors?</i>
<i>1515 Female doc</i>	<i>Well, I don't think it is the time to confine your women so badly in homes. If your wife is suffering life-taking dangers, and if your baby is suffering, you will also not be happy. All mothers have either one to come, or already many children to take care of. Husbands should take it into account. If your wife has a problem, you should take them to hospital immediately.</i>

(Darmelana, Oct 30, 2010)

Emadi (2005) says most women do not care about their own self-interests, but their husbands'. Joan Tronto (1987) says that preventing individuals from opportunities to pursue their own self-interest may encourage them "to live through others, using caring as a substitute for more selfish gratification" (pp. 647 and 650). That's what Afghan women do, living the dreams of others (in this case, a husband or a father).

The take of the media on norm issues that have social basis without any strong traditional value is strict. For instance, the consultation regarding self-prescription is 'don't take medicine without doctor's consultation'. However, issues with strong religious or traditional value in the patriarchal society of Afghanistan such as going to religious healers and gender segregation are dealt with caution. For example, the presenter, who is female, does not or cannot tell women directly that it is the women's basic universal rights to have access to health care. Instead, she asks men to allow her to have access to health care or take her to a health center in case she falls sick. It is a vigilant approach in order not to

anger the conservative husband. The example implies that Afghan society is a strong, traditional patriarchal society and decisions regarding healthcare of women are taken by men. If one aims to improve the health condition of women, they have to go through their husband. Whereas a fairer argument is that access to health care is the basic rights of individuals, it does not have to do anything with husband or father or brother. Women themselves should be empowered to gain their rights. An Afghan proverb says ‘rights are to be taken, they cannot be given’. It appears that in a patriarchal system, everything is about men. Even the proverbs do not apply to women.

However, in patriarchal societies, women do the women work. It is very interesting that in one of the programs where a female physician talked about pregnancy related issues, four female audiences called, talked about their health problems, and asked for medical advices. In such a patriarchal society, women are comfortable talking to women, however on television and through a cell phone. This means that the presence of woman in mass media encourages other women to take part in the program and share their stories.

Technology comes handy

To see the presence of women in the media from a different angle, in patriarchal culture where gender segregation is widely practiced, technology comes handy. In Afghanistan, according to local culture men do not tell the name of their wives, sisters, and mothers to others, let alone allowing women to socialize with strangers (Emadi, 2005). However, using cell-phone technology, women interact with men on television programs and tell their personal problems.

0553 Fifth caller [F]	<i>My name is ... and I am calling from I am in my fifth month. I have visited doctors a couple of times, now I have shortness of breath.</i>
0623 Presenter [M]	<i>Do you feel it while walking?</i>
0627 Fifth caller [F]	<i>Yeah, I feel shortness of breath and feel like I might stop breathing any moment.</i>
0635 Female doc [F]	<i>Which baby is this for you?</i>
0637 Fifth caller [F]	<i>It is my fifth baby. I took pills for two years, I don't know if it is because of that. I take medications, but it doesn't help.</i>
0654 Presenter [M]	<i>Have you seen any doctor?</i>
0657 Fifth caller [F]	<i>Yeah, many times.</i>
0700 Presenter [M]	<i>And you took medicine too?</i>
0701 Fifth caller [F]	<i>Yeah,</i>
0702 Presenter [M]	<i>Do you feel it when doing any physical work?</i>
0704 Fifth caller [F]	<i>It is there all the time, while I am working or resting, staying home or going for invitations, happy or sad, it is with me all the time. I feel like this for ten, fifteen days now.</i>
0720 Presenter [M]	<i>Did you have this problem in your previous babies?</i>
0722 Fifth caller [F]	<i>No, I didn't have this problem in my previous babies.</i>

(Darmelana, Oct 30, 2010)

Five (18%) out of 28 callers on *Darmelana* health show were female viewers inquiring about their health problems. Some of them told their names and places, while others did not. However, it should be mentioned that the professional guest in the program was a female physician. That could have encouraged female audience to call.

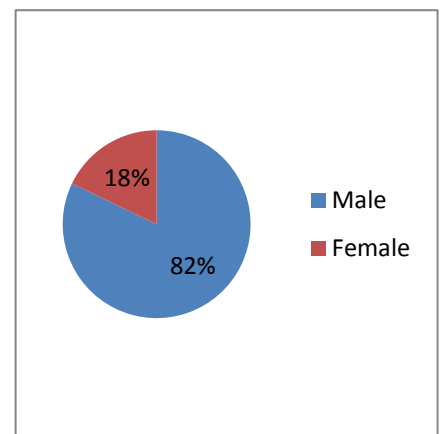


Figure 11 Percentage of callers by gender

Those women who called the health show obviously had access to cell-phone, and most probably they either had permission from their husbands or they didn't need permission to call a television show, a new type of

communication. Since interaction has always taken place face to face in the traditional society, cell-phone has introduced a new type of communication for the society. The traditional society has not yet developed any particular norms for it. The advantage of mediated-communication is that it can hide the identity of participants and allow them to communicate with people from opposite sex, and talk on issues that they normally don't.

Most female callers did not mention their names or places, nor did the male presenter dared to ask her name, something he normally did with other callers.

<i>0018 Fourth caller [F]</i>	<i>I am almost finishing my eight month, and entering the ninth one. I have stomach-ache and headache, and had burning pee before. I have seen a doctor who gave me some medication, but still my kidneys are painful and my stomach burns and aches.</i>
<i>0047 Presenter [M]</i>	<i>Have you finished your medication?</i>
<i>0050 Fourth caller [F]</i>	<i>I have taken lots of medicine, but none was so effective.</i>
<i>0058 Presenter [M]</i>	<i>Do you still take medication for your stomach-ache?</i>
<i>0103 Fourth caller [F]</i>	<i>That is over. I also had nausea until the fourth month.</i>
<i>0116 Female doc [M]</i>	<i>Have you seen any doctor recently and what have you taken?</i>
<i>0123 Fourth caller [F]</i>	<i>Well, currently I have some medication for anemia, syrup for burning and painful stomach, and I had burning pee until two weeks ago. I also had fever.</i>

(Darmelana, Oct 30, 2010)

In other interactions, the presenter would ask the name of the caller and the place he would call from. For example:

<i>1017 First Caller</i>	<i>Hello, salaam</i>
<i>1018 Presenter</i>	<i>Walikum Salam brother, what is your name and where are you calling from?</i>
<i>1023 First Caller</i>	<i>My name is Wahab and I am calling from Pol-e</i>

Sorkh intersection [Kabul city]. I have a patient who is almost 12. Four months ago, he had a severe abdominal pain and we took him to a doctor, the doctor asked to do an ultrasound. The exam test was normal but the doctor said it was appendix [disconnected].

(Darmelana, Oct 30, 2010)

Technology paves the ground for a new type of communication that traditional society of Afghanistan is not familiar with. It can help end gender segregation and raise topics of discussion between different genders that they normally don't discuss.

Summary of discussion

The study finds that top Afghan private television channels starting from scratch almost six years ago have developed to provide some health information to the public. However, the health topics and the way health messages are framed have a lot of room to get better. The main findings are as follow.

- The health topics broadcasted by television media are somewhat related to national health concerns, but does not accord with the national health priorities.
- The health information in the television media has a tendency towards individualization of solutions to health problems, whereas it equally includes individual reasons and societal factors as the causes of health problems
- The health programs point out some sociocultural practices and beliefs that affect public health.

Various reasons could be blamed for the media's inattention to national health priorities and the way health messages are framed for the public. A number of them observed by the researcher in this study are (1) lack of journalism skills, (2) lack of public health knowledge, (3) patriarchal social system, and (4) low women's participation in

health and media industry. The findings also suggest that communication technologies such as the television and mobile phone can help decrease gender segregation and increase media attention to the women's health.

Chapter Five: Conclusion

“All of us who professionally use the mass media are the shapers of society. We can vulgarize that society. We can brutalize it. Or we can help lift it onto a higher level”, William Bernach.

Significance and further research

There is a significant lack of research in Afghanistan. Thus it is impossible to make decisions based on evidence or scholarly researches. This study is a step, however minor, towards scholarly documentation of health information in the Afghan television media that can be useful for health media professionals, public health professionals dealing with media, and health communication scholars focusing on Afghanistan.

There are a number of possibilities for future research. First, this research studies television media in a national level, which opens the ground for studying local televisions. Second, the period of this study was six weeks within four months. A larger sample can provide a broader perspective about health information in the television media. Third, radio is the most widespread mass media tool in Afghanistan which can be the focus of a future study. Finally, newspapers can also be the focus of another study in urban space. Because illiteracy is widespread in the country, print media is not very popular in the country.

Contribution to the theories

The study uses the communication theories as frameworks. The only contribution to the theories, at the time being, would be the application of them in a war-ravaged country. In order to be able to comment on agenda-setting and framing theories, there is a need to study what health topics the audiences consider as important and how they perceive the causes and solutions of health problems – something out of the structure of this research.

Regarding normative theory, which is basically about clearing ambiguities and misconceptions regarding prevalence of a norm, the theory is mostly applied on the norms that are perceived wrong. For example, college teenagers perceive binge drinking as a norm, while it is not. Since this research finds undesirable social norms from the data, the question that could be raised is how to apply normative theory on the actual norms that are not only perceived wrong, but are actually wrong and prevalent such as self-prescription and avoiding health care for women. The researcher thinks if it would be possible to apply normative theory in traditional and collective societies where actually harmful norms have traditional or cultural values attached to it.

Main results

The current study was designed to detect three issues in the Afghan television media: (1) what health topics were broadcasted, (2) how the health topics were discussed, and (3) what health-related socio-cultural practices were publicized. The main theoretical frameworks guided the thesis were agenda-setting theory, framing theory, and social

normative theory. The study carried out a content analysis of two health programs from two national television channels in Afghanistan.

The study found that Afghan television media broadcasted health stories on food and environment safety (25%), maternal and infant health (21%), oral and dental health (18%), child health (11%), mental health (7%), communicable disease (4%), and other health issues (14%). Regarding the frames, the media equally held responsible individual and societal factors for the health problems, while individual behavior change was frequently mentioned as the solution rather than societal change. The media also conveyed health-seeking norms and gender-related norms. The media have been brave enough to raise some sensitive harmful cultural norms. Talking about women's issue and implicit disapproval, if not explicit slamming, of traditional/religious healing were taboos just a decade ago. But the way the media dealt with socio-cultural practices were very primitive.

Though the media carried one story on health infrastructure in which the health minister spoke about health policy, there was no mention of health policy, health infrastructure, public health performance, quality or quantity of public health services, or other larger public health issues. Major public health concerns in Afghanistan, according to its Ministry of Public Health, were maternal and infant care, child care, communicable disease, and mental health. The media agenda did not follow major public concerns in Afghanistan. Instead of the major concerns, food and environment safety topped the frequency of coverage with oral and dental care in the third place. On the contrary, communicable diseases, which are easily preventable through the promotion of healthier behaviors with simple information, received the poorest coverage; that too not about any

major communicable diseases such as tuberculosis, malaria, HIV, or sexually transmitted disease. In addition, mental health that affects the war-ravaged people was the second lowest in the media health agenda.

Interestingly, there was no mention of statistics or epidemic of disease over the entire six week of coverage in any television media, except one health news on a conference regarding gynecology and obstetrics in which the health minister spoke of huge maternal death. This means the media has not been successful in giving awareness to the public regarding widespread diseases that affect the population the most. For instance, child health is the second important priority in the country, and the most critical disease that kill children under five are acute respiratory disease, pneumonia, diarrhea, dysentery, malaria, and lack of vaccination (MoPH, 2010). They are all easily preventable with a little knowledge about better child care. Comparatively, the media had one story over the six weeks on newborn care and another on child's sleeplessness. This lack of awareness of major public health issues was indicative of the poor relation between the media and public health professionals.

This poor relation was the result of weakness from both sides: the media and the public health professionals. Both fields were dominated by medical professionals. In the media, the medical doctors lacked journalism skills. In the public health industry, they lacked public health knowledge. Government journalism schools are remnants of communist-regimes to whom journalism meant a vehicle of communism ideology propaganda and nothing else. Regarding public health, there is not a single public health

school in the country. All public health professionals are trained as medical doctors who then follow a career in public health.

The dominance of the health communication field by medical doctors not only influenced the topics covered in the media but also the way they were covered. The result of the frame studies of the media content indicated that very little information was provided regarding societal-level (public health) solutions to health problems. The frame studies indicated that the media blamed individuals' behavior and societal factors equally for the health problems, while regarding the solutions to health problems individuals' behavior change was the media's favorite compared to societal-level change. For what medical doctors care is individual's health, and whatever is good for the society at large is the duty of public health professional to tackle.

A number of factors that can help provision of better health information in the media are better training for journalists in the field of health, increasing female participation in the health media, taking advantage of modern communication technology such as mobile phone and internet, and better coordinating with public health professionals regarding public health issues. The research also suggests a dire need for public health school in the country.

Reference:

AbuSabha, R. (1998). *Effective Nutrition Education for Behaviour Change*. Clarksville, MD: Wolf Rinke Associates.

Acerra, J. R., Iskyan, K, Qureshi, Z. A., & Sharma, R. K. (2009). Rebuilding the health care system in Afghanistan: an overview of primary care and emergency services. *International Journal of Emergency Medicine*, 2, 77 – 82.

Adam, G. (2005). Radio in Afghanistan: socially useful communications in wartime. In O. Hemer & T. Tufte (eds). *Media & Glocal Change: Rethinking Communication for Development* (pp. 349 - 65). Goteborg, Sweden: Nordicom. Retrieved January 20, 2011, available from <http://bibliotecavirtual.clacso.org.ar/ar/libros/edicion/media/29Chapter22.pdf>

Afghan National Development Strategy (ANDS). (2008). *Health and Nutrition Section Strategy 2008 – 2013*. Retrieved November 1, 2010, available from http://www.MoPH.gov.af/en/downloads/Strategy_2007_2008_2012_2013.pdf

Afghan Wireless Communication Company. (2010, April 1). Retrieved June 10, 2010, available from AWCC's website: http://www.afghan-wireless.com/index.php?page=en_homepage_readmore

Ahang, M. K. (1970). *Short History of Journalism in Afghanistan* (Dari). Kabul: Government Press.

Altai. (2010). *Afghan media in 2010*. Retrieved December 20, 2010, available from

<http://www.alticonsulting.com/docs/media/>

Arnoldy, B. (2009). Afghanistan mental health treatment caught between ancient and modern worlds. *Christian Science Monitor*. Retrieved March 14, 2011, available from [http://www.csmonitor.com/World/2009/1215/Afghanistan-mental-health-](http://www.csmonitor.com/World/2009/1215/Afghanistan-mental-health-Treatment-caught-between-ancient-and-modern-worlds)

[Treatment-caught-between-ancient-and-modern-worlds](http://www.csmonitor.com/World/2009/1215/Afghanistan-mental-health-Treatment-caught-between-ancient-and-modern-worlds)

Atheide, D.L. (1996). *Qualitative Media Analysis*. Thousand Oaks: Sage.

Baer, J.S., Stacy, A & Larimer, M. (1991). Biases in the perception of drinking norms among college students. *Journal of Studies on Alcohol*, 52(6), 580-586.

Bandura, A. (1977). *Social Learning Theory*. New York: General Learning Press.

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice Hall.

Bandura, A. (2001). Social cognitive theory of mass communication. *Media Psychology*, 3, 265–299

Barker, M. J., (2008). Democracy or polyarchy? US-funded media developments in Afghansitan and Iraq post 9/11. *Media, Culture & Society*, 30(1), 109 – 130.

Barnett, L.A., Far, J.M., Maus, A.L. & Miller, J.A. (1996). Changing perceptions of peer norms as a drinking reduction program for college students. *Journal of Alcohol and Drug Education*, 41(2), 39-61.

- Barokas, J. (1995). *Lessons learned from public health campaigns and applied to anti-DWI norms development* (DOT HS 808 273). Washington, DC: U.S. Department of Transportation, National Highway Traffic Safety Administration.
- Bartlett, L. A., Wawji, S., Whitehead, S., Crouse, C., Dalil, S., Lonete, D., & Salama, P. (2005). Where giving birth is a forecast of death: maternal mortality in four districts of Afghanistan, 1999-2002. *Lancet*, 365, 864-870.
- Beam, C. (2010, February 12). Does Afghanistan have phone books? Telecommunications after the Taliban. *Slate*, Retrieved September 15, 2010, available from <http://www.slate.com/id/2244440/?from=rss>
- Beauchamp, D. E. (1976). Public health as social justice. *Inquiry*, 13, 1- 14.
- Beauchamp, D. E. (1983). What is public about public health? *Health Affairs*, 2(4), 76 – 87.
- Benelli, E. (2003). The role of the media in steering public opinion on health care issues. *Public Policy*, 63, 179 – 186.
- Berelson, B. R. (1952). *Content Analysis in Communication Research*. Free Press.
- Berkowitz, AD (1997). From Reactive to Proactive Prevention: Promoting an Ecology of Health on Campus. In P.C. Rivers and E. Shore (Eds.): *A Handbook on Substance Abuse for College and University Personnel*. Westport, CT: Greenwood Press.

- Berkowitz, AD (2003). Applications of Social Norms Theory to Other Health and Social Justice Issues. In H.W. Perkins (Ed). *The Social Norms Approach to Preventing School and College Age Substance Abuse: A Handbook for Educators, Counsellors, Clinicians*. San Francisco, Jossey-Bass
- Berry, T. R., Wharf-Higgins, J., & Naylor, P. J. (2007). SARS wars: An examination of the quantity and construction of health information in the news media. *Health Communication*, 21(1), 35 – 44.
- British Broadcasting Corporation. (2010). *Country profile: Afghanistan*. Retrieved August 25, 2010, available from http://news.bbc.co.uk/2/hi/south_asia/country_profiles/1162668.stm#media
- Budd, R. W., Thorp, R. K., & Donohew, L. (1967). *Content Analysis of Communications*. New York: Macmillan.
- Buntin, M. B., Jain, S. H., & Blumenthal, D. (2010). Health information Technology: Laying the infrastructure for national health reform. *Health affairs*, 29(6), 1214 – 1219.
- Canadian Broadcasting Corporation. (Feb, 2010). *Life expectancy in Canada nears 81*. Retrieved July 20, 2010, available from <http://www.cbc.ca/health/story/2010/02/23/life-expectancy-canada.html>
- Cardozo, Barbara Lopes, Oleg O. Bilukha, Carol A. Gotway Crawford, Irshad Shaikh, Mitchell I. Wolfe, Michael L. Gerber and Mark Anderson. (2004). Mental health,

social functioning, and disability in postwar Afghanistan. *Journal of the American Medical Association*, 292(5), 575-584.

Carney, T. F. (1972). *Content Analysis: A technique for systematic inference from communications*. Manitoba: University of Manitoba.

Cobb, R. W., & Elder, C. D. (1971). The politics of agenda-building: An alternative perspective for modern democratic theory. *Journal of Politics*, 33(4), 893-915.

Cohen, B. C. (1963). *The Press and Foreign Policy*. Princeton, NJ: Princeton University Press.

Cooter, Robert. 1994. Structural Adjudication and the New Law Merchant: A Model of Decentralized Law. *International Review of Law and Economics*, 14, 215-231.

Dahlgren, G. & Whitehead, M. (1991). *Policies and Strategies to Promote Social Equity in Health*. Stockholm: Institute of Futures Studies.

Dambazau, A. (2004). *The role of media in national development*. Retrieved July 25, 2010, available from http://ndc.viburnix.com/uploads/editor_files/pdf/43-abdul.pdf.

Dearing, J. W., & Rogers, E. M. (1996). *Agenda-setting*. Thousand Oaks, CA: Sage Publications.

Dilorio, C., Resnicow, K. Dudley, W. N., Thomas, S., Wang, D. T., Van Marter, D. F. (2000). Social cognitive factors associated with mother–adolescent communication about sex. *Journal of Health Communication*, 5, 41–52.

- Dittmar, M. L. (1994). Relationship between depression, gender, and television viewing of college students. *Journal of Social Behavior and Personality*, 9, 317–328.
- Dubois, N. (2003). Introduction: the concept of norm. In N. Dubois (Ed). *A Sociocognitive Approach to Social Norms* (pp. 1 – 16). London: Routledge.
- Dutta-Bergman, M. J. (2005). Developing a profile of consumer intention to seek out additional information beyond a doctor: The role of communicative and motivation variables. *Health Communication*, 17, 1–16.
- Emadi, H. (2005). *Culture and Customs of Afghanistan*. London: Greenwood Press
- Ensminger, J. and Knight, J. (1997). Changing social norms: Common property, bridewealth, and clan exogamy. *Current Anthropology*, 38 (1), 1 – 24.
- Eveland, W. P. (2004). The effects of political discussion in producing informed citizens: The roles of information, motivation, and elaboration. *Political Communication*, 21(2), 177–193.
- Fadiman, A. (1997). *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*. New York: Farrar, Straus & Giroux.
- Farmer, J., & Kozel, C. (2005). Agenda-setting and the Albuquerque clean indoor air ordinance. *Journal of Health Education*, 36(5), 313-315.

Fields, E. E. (1988). Qualitative content analysis of television news: systematic techniques. *Qualitative Sociology*, 11(3), 183 – 193.

Fine, G. A. (1987). *With the Boy: Little League Baseball and Preadolescent Culture*. Chicago: University of Chicago Press.

Funkhouser, G. R. (1973a). The issues of the sixties: An exploratory study in the dynamics of public opinion. *Public Opinion Quarterly*, 37(1), 62–75.

Funkhouser, G. R. (1973b). Trends in media coverage of the issues of the sixties. *Journalism Quarterly*, 50, 533–538.

Gerbner, G. (1969). Toward “cultural indicators”: The analysis of mass mediated message systems. *Communication Review*, 17, 137–148.

Gitlin, T (1980). *The whole world is watching: Mass media in the making and unmaking of the New Left*. Berkeley, CA: University of California Press.

Glantz, S. A. (1996). Editorial: Preventing tobacco use—the use access trap. *American Journal of Public Health*, 86(2), 156-158.

Goffman, E. (1974). *Frame analysis: An essay on the organization of experience*. New York: Harper & Row.

Grevermeyer, J.-H. (1987). *Afghanistan: Social change and state in the 20th century*. Berlin: Express Edition.

- Habibi, A. H. (1985). *The Constitutional Movement in Afghanistan* (Dari). Kabul: Government Press.
- Hammermeister, J., Brock, B., Winterstein, D., & Page, R. (2005). Life without TV? Cultivation theory and psychosocial health characteristics of television-free individuals and their television-viewing counterparts. *Health Communication, 17*, 253–264.
- Hawkins, K., & Hane, A. C. (2000). Adolescents' perceptions of print cigarette advertising: A case for counter-advertising. *Journal of Health Communication, 5*, 83–96.
- Hechter, M. & Opp K-D. (Eds.) (2001). *Social Norms*. New York: Russell Sage Foundation.
- Helman C. (2001). *Culture, health and illness* (4th ed). London: Butterworth Heinemann.
- Herrscher, R. (2009). A universal code of journalism ethics: Problems, limitations, and proposals. *Journal of Mass Media Ethics, 17*(4), 277 – 289.
- Himelfarb, S. (2010). Media and peacebuilding in Afghanistan. *United States Institute of Peace, Peacebrief, 15*. Retrieved November 20, 2010, available from <http://www.usip.org/files/resources/PB15%20Media%20and%20Peacebuilding%20in%20Afghanistan.pdf>

- Horne, C. (2001). Sociological perspectives on the emergence of social norms. In M. Hechter, & K-D. Opp (Eds.) *Social Norms* (pp. 3 – 34). New York: Russell Sage Foundation.
- Kahneman, D. (2003). Maps of bounded rationality: A perspective on intuitive judgment and choice. In T. Frangmyr (Ed.), *Les Prix Nobel: The Nobel Prizes 2002* (pp. 449–489). Stockholm: Nobel Foundation.
- Kasperseon, R. E., Renn, O., Slovic, P., Brown, H. S., Emel, J., Goble, R., Kasperson, J. X., & Ratick, S. (1988). The social amplification of risk: A conceptual framework. *Risk Analysis*, 8(2), 177 – 187.
- Khaydary, R. S. (1994). The introduction of new communication technology into developing countries. Unpublished doctoral dissertation, University of Leipzig, Germany.
- Khoja, K. (2009). Connecting a nation: Roshan brings communications services to Afghanistan. *Innovations: technology, governance, globalization*, 4(1), 33-50.
- Kim, S. H., Scheufele, D. A., & Shanahan, J. (2002). Think about it this way: Attribute agenda-setting function of the press and the public's evaluation of a local issue. *Journalism & Mass Communication Quarterly*, 79(1), 7–25.
- Kline, K. N. (2003). Popular media and health: Images, effects, and institutions. In T. L. Thompson, A. Dorsey, K. I. Miller, & R. Parrott (Eds.), *Handbook of Health Communication* (pp. 557–582). Mahwah, NJ: Lawrence Erlbaum Association.

- Krippendorff, K. (2004). *Content Analysis: An Introduction to its Methodology*. Thousand Oaks: Sage
- Lindbeck, A. (1997). Incentives and social norms in household behavior. *The American Economic Review*, 87(2), pp. 370 – 377.
- Lippmann, W. (1922). *Public Opinion*. New York: Macmillan
- Macy, M. W. and Skvoretz, J. (1998). The evolution of trust and cooperation between strangers: A computational model. *American Sociological Review*, 63(5), pp. 638 – 660.
- Manganello, J., & Blake, N. (2010). A Study of Quantitative Content Analysis of Health Messages in U.S. Media From 1985 to 2005. *Health Communication*, 25(5), 387-396.
- Marlatt, G. A., & Kilmer, J. R. (1998). Consumer choice: Implications of behavioral economics for drug use and treatment. *Behavior Therapy*, 29(4), 567-576.
- McCombs, M. E. (2004). *Setting the Agenda: The Mass Media and Public Opinion*. Malden, MA: Blackwell.
- McCombs, M.E. (1972). Mass communication in political campaigns: Information, gratification and persuasion. In: Kline, F. & Tichenor, Ph.J. (Eds.) *Current Perspectives in Mass Communication Research* (pp. 169 – 177). Beverly Hills, CA: Sage.

- McCombs, M.E. (1982). The agenda-setting approach. In Nimmo, D. & Sanders, K. (Eds.) *Handbook of Political Communication* (pp. 121 – 135). Beverly Hills, CA: Sage.
- McCombs, M.E., & Shaw, D.L. (1972). The agenda-setting function of mass media. *Public Opinion Quarterly*, 36 (Summer), 176-187.
- Mebane, F. (2003). Examining the content of health care reporting: Neither the health care system or policies creating it receive coverage they deserve. *Nieman Reports*, 57(1). Retrieved January 15, 2011, available from <http://www.nieman.harvard.edu/reports/article/101183/Examining-the-Content-of-Health-Care-Reporting.aspx>
- Merton, R. K. (1959). Social conformity, deviation, and opportunity structure. *American Sociological Review*, 24, 177-189.
- Ministry of Communication and Information Technology (MCIT). (2009, December). Telecom statistics 2009. Retrieved March 18, 2010, available from <http://www.mcit.gov.af/>
- Ministry of Public Health. (2008). Afghanistan Comprehensive Health Information System Strategic Plan 2009 – 2013. Retrieved November 1, 2010, available from <http://www.MoPH.gov.af/en/downloads/Afghanistan-CHISSP-v5.pdf>
- Ministry Of Public Health (MoPH). (2009). Annual Report 2009. Retrieved January 22, 2010, available from <http://www.moph.gov.af/en/reports/HNSS-Report-ENG-v4-1.pdf>

MoPH. (2011). *9000 Afghans died of TB last year*. Retrieved April 5, 2011, available from <http://moph.gov.af/en/News/902>

Neuendorf, K. (2002). *The Content Analysis Guidebook*, Thousand Oaks, CA: Sage

Neuman, W. (1997). *Social research methods: qualitative and quantitative approaches*.
Needham Heights, MA: Allyn & Bacon.

Newbold, C., Boyd-Barrett, O. & Van Den Bulck, H. (2002). *The media book*. London:
Arnold

Ogata Jones, K., Denham, B. E., & Springston, J. K. (2006). Effects of mass and
interpersonal communication on breast cancer screening: Advancing agenda-setting
theory in health contexts. *Journal of Applied Communication Research*, 34, 94–
113.

Opp, K. (2001). How do norms emerge? An outline of a theory. *Mind and society*, 3(2),
101 – 128.

Ortner, S. B. (1984). Theory in anthropology since the sixties. *Comparative Studies in
Society and History*, 26(1), 126 –66.

Health. (2011). Oxford English Dictionary, available from
<http://www.oed.com/view/Entry/85020?rskey=cZ9uSr&result=1&isAdvanced=false#>

Pan, Z., & Kosicki, G. M. (1993). Framing analysis: An approach to news discourse.

Political Communication, 10(1), 55–75.

Passalacqua, R., Campione, F., Caminiti, C., Salvagni, S., Barilli, A., Bella, M., Barni, S.,

Barsanti, G., Caffo, O., Carlini, P., Cinquemani, P., Di Costanzo, F., Giustini, L.,

Labianca, R., Mazzei, A., Olmeo, N., Paccagnella, A., Toscano, L., and Cocconi,

G. (1999). Patients' opinions, feelings, and attitudes after a campaign to promote the Di Bella therapy. *Lancet*, 353, 1310 – 4.

Paterson, A. & Karimi, A. (2005). Understanding markets in Afghanistan: A study of the market for pharmaceuticals. *Afghanistan Research and Evaluation Unit*. Retrieved December 22, 2010, available from

<http://www.areu.org.af/Uploads/EditionPdfs/532E-Market%20for%20Pharmaceuticals-CS-web.pdf>

Perkins, H. W. & Wechsler, H. (1996). Variation in perceived college drinking norms and its impact on alcohol abuse: A nationwide study. *Journal of Drug Issues*, 26, 961–974

Perkins, HW (2002). Social Norms and the Prevention of Alcohol Misuse in Collegiate Contexts. *Journal of Studies on Alcohol*, 14 (Supplement), 164-172.

Perkins, H.W. (2003). The emergence and evolution of the social norms approach to substance abuse prevention. In H.W. Perkins (Ed). *The Social Norms Approach to Preventing School and College Age Substance Abuse: A Handbook for Educators, Counselors, Clinicians* (pp. 3 – 19). San Francisco: Jossey-Bass.

- Pratt, C. B., Ha, L., & Pratt, C. A. (2002). Setting the public health agenda on major diseases in sub-Saharan Africa: African popular magazines and medical journals, 1981–1997. *Journal of Communication*, 8, 889–904.
- Price, V., & Tewksbury, D. (1997). News values and public opinion: A theoretical account of media priming and framing. In G. A. Barrett & F. J. Boster (Eds.) *Progress in Communication Sciences: Advances in Persuasion* (pp. 173–212). Greenwich, CT: Ablex.
- Pylpa, J. (2001). Self-medication practices in two California Mexican communities. *Journal of Immigration Health*, 3(2), 59–67.
- Rawa (2007). Women attacked or killed in Afghanistan. Retrieved March 22, 2010, available from <http://www.rawa.org/temp/runews/2007/06/26/women-attacked-or-killed-in-afghanistan.html>
- Rawan, S. M. (1992). Foundational aspects of the emergence and development of journalism in Afghanistan. Unpublished doctoral dissertation, University of Leipzig, Germany.
- Rawan, S. M. (2002). Modern mass media and traditional communication in Afghanistan. *Political Communication* 19, 155 – 170.
- Riffe, D., Lacy, S., & Fico, F.G. (2005). *Analyzing Media Messages*. (2nd Ed). New Jersey: Lawrence Erlbaum.

- Rimal, R.M. & Real, K. (2003) Understanding the Influence of Perceived Norms on Behaviours, *Communication Theory*, 13 (2): 184-203.
- Roberts, M., Wanta, W., & Dzwo, T. (2002). Agenda setting and issue salience online. *Communication Research*, 29, 452–465.
- Rogers, E. M. (2003). *Diffusion of Innovation*. New York: Free Press.
- Rogers, E.M., & Dearing, J.W. (1988). Agenda-setting research: Where has it been? Where is it going? In: Anderson, J.A. (Ed.). *Communication yearbook, 11* (pp. 555-594). Newbury Park, CA: Sage.
- Rogers, E.M., Hart, W. B., & Dearing, J.W. (1997). A paradigmatic history of agenda-setting research. In Iyengar, S. & Reeves, R. (Eds.) *Do the media govern? Politicians, voters, and reporters in America* (pp. 225-236). Thousand Oak, CA: Sage.
- Scheufele, D. A. (2000). Agenda-setting, priming, and framing revisited: Another look at cognitive effects of political communication. *Mass Communication & Society*, 3, 297–316.
- Scheufele, D. A. and Tewksbury, D. (2007). Framing, agenda setting, and priming: The evolution of three media effects models. *Journal of Communication*, 57, 9 – 20.
- Schultz, P. W., Nolan, J. M., Cialdini, R. B., Goldstein, N. J., & Greskevicius, V. (2007). The constructive, destructive, and reconstructive power of social norms. *Psychological science*, 18(5), 429 – 434.

Signorielli, N. (1993). *Mass media images and impact on health: A sourcebook*. Westport, CT: Greenwood.

Stuart, T. H., & Achterberg, C. (1997). Education and communication strategies for different groups and settings. *FAO Food and Nutrition Paper*, 62, 71–107.

Tariq, M. O., Ayoubi, N., & Haqbeen, F. R. (2010) Afghanistan in 2010: A survey of the Afghan people. *The Asia Foundation*.

Tolo Television. (2010). About us. Retrieved July 2, 2010, available from http://tolo.tv/index.php?option=com_content&task=blogcategory&id=21&Itemid=39

Tronto, J. (1987). Beyond gender differences to a theory of care. *Sign*, 12, 644 -663

United Nations Children Fund. (2010). Afghanistan: statistics. Retrieved July 21, 2010, available from http://www.unicef.org/infobycountry/afghanistan_statistics.html

United States Agency for International Development (USAID). (2010). Afghanistan: Health. Retrieved September 21, 2010, available from <http://afghanistan.usaid.gov/en/programs/health#Tab=Description>

United States Department of States. (2010). Background note: Afghanistan. Retrieved October 10, 2010, available from <http://www.state.gov/r/pa/ei/bgn/5380.htm>

Vartan, G. (1967). Mahmud Tarzi and Seradj-al-Akhbar: Ideology of nationalism and modernisation in Afghanistan. *Middle East Journal*, 21, 345–368.

Wallack, L. & Lawrence, R. (2005). Talking about public health: developing America's "Second Language". *American Journal of Public Health*, 95(4), 567 – 570.

Wang, Z., & Gantz, W. (2007). Health content in local television news. *Health Communication*, 21(3), 213 – 221.

Williams, A. F. (1994). The contribution of education and public information to reducing alcohol-impaired driving. *Alcohol, Drugs & Driving*, 10(3-4), 197-205.

Winslow, C. A. (1920). The untilled fields of public health. *Science*, New Series, 51 (1306), 23-33.

World Health Organization. (2006). Country Cooperation Strategy for WHO and Afghanistan 2006–2009. Retrieved August 22, 2010, available from http://www.who.int/countryfocus/cooperation_strategy/ccs_afg_en.pdf

World Health Organization. (2007). Country profile: Canada. Retrieved September 21, 2010, available from <http://www.who.int/gho/countries/can.pdf>

World Health Organization. (2009). Country cooperation strategy at a glance. Retrieved September 21, 2010, available from http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_afg_en.pdf

Wright, C. R. (1986). *Mass Communication: A Sociological Perspective* (3rd ed.). New York: Random House.

Yanovitzky, I & Stryker, J. (2001) Mass Media, Social Norms and Health Promotion Efforts. *Communication Research*, 28 (2), 208-239.

Yussufi, N. (1977). Journalism in developing countries. Unpublished doctoral dissertation, University of Berlin, Germany.

Annex

Priority Health Problems

Afghanistan Comprehensive Health Information System Strategic Plan 2009-13

Annex C: Priority Health Problems and Related Essential Health Services in Afghanistan

Priority Health Problems	Related Essential Health Services	Indicator
Maternal and Newborn Health		
Maternal Mortality	Health Education, Antenatal Care (Fe/FA, multi-micronutrients, TT vacc, IPT, Malaria Rx, Diagnosis and Rx of UTI, STI, Rx of complications), skilled delivery attendance and care, Transfer and Rx of complications (EOC), Postpartum Care (Vit A, detect & Rx anemia, puerperal infection, FP & BF counseling)	Maternal Mortality Ratio CEOC coverage - # provinces with at least one facility providing Emerg Ob Care
Complications of pregnancy, delivery and postpartum period		% births attended by skilled birth attend. % women with at least one ANC
Neonatal Mortality	PNC, PPC	NNMR Rate of postpartum visits within 7 days
Newborn complications	Care of the newborn (PNC) incl education, early & exclusive BF, resuscitation, BCG/HepB, manage infection	% of pregnant women with 2 TT
Fertility	Family Planning education and services	Total Fertility Rate % married women using modern contraceptive methods (CPR) Proportion of women's need for FP met
Child Health		
Infant Mortality		IMR
Under-five Child Mortality	IMCI	U5MR No. health centers implementing IMCI
ARI and pneumonia	Diagnosis and community Rx (antibiotics), referral and Rx	% <5 Pneumonia cases receiving antibiotics
Diarrhea and Dysentery	Diarrhea Treatment (ORT + Zinc), referral	% <5 diarrhea cases treated with ORS
Ear infection	Referral and treatment	
Fever UO, Malaria	Promotion, distribution and monitoring of use of LLITNs, Malaria diagnosis and Treatment	% <5 children with fever treated with appropriate anti-malaria drugs
Vaccine Preventable Diseases (Tetanus, Pertussis, Diphtheria, Hepatitis B, HIB, measles, polio)	IEC, vaccine management, Childhood Immunization (BCG, DPT, HepB, HIB, measles, OPV)	% <1 receiving DPT 3 immunization % <1 immunized against measles
Malnutrition and Anemia	BF promotion (early intro., exclusive for 6 mos), Comp feeding, Growth monitoring, Vit A Supplementation, de-worming, therapeutic feeding De-worming	Under-weight prevalence under five % Mothers who start breastfeeding within 1 hour of birth % aged 0-6 months exclusively breastfed % 6-59 m receiving vit A every 6 months % 2-59 m receiving mebendazole every 6 months Proportion of under-5s hospitalized for malnut'n that were discharged successfully
Iodine deficiency	Iodized Salt	% Households consuming Iodized Salt
Maternal Nutritional Deficiency	Antenatal Care, Post Natal Care	% pregnant women rec'g 60 Iron/folate tabs during 1 st and 30 during 2 nd consultation % Pregnant & all Women 15-49 with iron deficien. anemia % postpartum mothers rec'g 42 Iron/folate % postpartum women who received 1 Vit A capsule within 8 weeks of delivery
Communicable Diseases		
Tuberculosis	Community Education, BCG vacc., Case detection (sputum exam), Community DOTS, MDR control & DOTS-plus, preventive Rx for contacts, in-patient care for severe cases	Prevalence rates associated with tuberculosis (per 100.000 population) Death rates associated with tuberculosis (per 100.000 people) (%) Proportion of TB cases detected (%) Tuberculosis treatment success under DOTS (%)
Malaria	Community education, promotion and use of LLITNs, Case detection (clinical and blood exam, RDTs), treatment with ACT, refer and treat complicated cases	Prevalence/incidence rates associated with malaria (% of the population) % <5 y children who slept under an ITN last night Proportion of population in malaria risk areas using effective prevention Proportion of population in malaria risk areas using effective Rx No.ITNs distributed in the last complete year

Annex C: Priority Health Problems and Related Essential Health Services in Afghanistan

Priority Health Problems	Related Essential Health Services	Indicator
STI	Education on STI prevention, Case detection and treatment	Prevalence among blood donors % of population aged 15-49 with comprehensive and correct knowledge of HIV/AIDS
HIV/AIDS	IEC, referral for VCCT, PMTCT, ART, Blood donation screening and transfusion services	Condom use as a proportion of CPR
		Contraceptive prevalence rate (national)
		Contraceptive prevalence rate (rural)
		Contraceptive prevalence rate (urban)
		Proportion of blood samples screened for HIV/AIDS and STIs
		Proportion of women's unmet needs for family planning met
		Proportion of IV drug users are in treatment by 2015
		HIV prevalence 15-24 years
		# VCCT Proportion of the population with advanced HIV infection with access to ART
Cholera	Community education, water supply, sanitation, food safety, case notification, investigation and treatment, outbreak control	
<i>All the above categories</i>	<i>Provision of essential drugs</i>	
Non-Communicable Diseases and Conditions		
Mental Health Problems	Education, case detection, classification, community care	
All above categories of service		
	Contacts with the health system	# of consultations per person per year in BPHS facilities
	Treatment	Proportion of the population with access to affordable essential drugs
	BPHS coverage	% population residing in districts with arrangements to provide the BPHS No. of health facilities, district, provincial and regional hospitals equipped with standard package of defined clinical and diagnostic services Hospital beds per 10,000 population Increased access to PHCSs within two hours walking distance
Other Health Problems/ Interventions		
Injuries and Accidents	Emergency transport, trauma management, blood transfusion services, treatment, rehabilitation	
Disability and Handicaps	Education, referral, assessment, treatment, prostheses,	
Substance Abuse	Health education, identification and support	
Cancers	Anti-smoking legislation and promotion, screening	
Diabetes	Education, screening, case management	
CVD	Health education (diet), hypertension monitoring and control; Anti-smoking education	
Disaster Response	Disaster preparedness	
Environmental health risks	Access to safe water, food safety	% pop with access to safe water
	Improve sanitation	% pop with access to improved sanitation
Others (cross-cutting)		
Health Care Financing	Implementation of Health care Financing Strategy	Out-of-Pocket Spending on Health (OOPS) as % of Private Expenditure on Health Public Expenditure on Health (PHE) as % of Total Expenditure on Health
Human Resources	PRR/RIMU implementation	% of central and provincial MoPH technical staff who have PRR status

Figure 12 Priority Health Problems in Afghanistan