





## Chapter 8

# Analysing Public Policies and Communication Strategies in Zimbabwe's Eye Healthcare Industry

Vincent Tshuma  and Sibongile Mpfu 

Public health is defined as “the science and art of preventing disease, prolonging life and promoting, protecting and improving health through the organised efforts of society” (Acheson, 1988: 1). Its functions, among many, include developing policies and plans that support individual and community health efforts and also health promotion.

Eye health, specifically, is important because vision is the most valued of the five senses and plays a crucial role in every facet of human lives (WHO, 2019). Among the sighted, vision is integral to interpersonal and social interactions in face-to-face communication where information is conveyed through non-verbal cues such as gestures and facial expressions (WHO, 2019). It is for this reason that efforts by countries, organisations and communities to improve eye health contribute to the advancement of several United Nations' SDGs, including those not exclusively eye-health-related (Zhang et al., 2020). As such, Zhang et al. (2020) argue that eye health promotion is an essential part of improving universal access to improve livelihoods.

From this premise, communication policies and strategies towards eye healthcare promotion are therefore important processes in the attainment of the SDGs. This study therefore assesses how public health communication policies and strategies contribute towards public awareness of eye and vision health in a particular community. This is because

the wellbeing of an eye for an individual determines how one accesses education and employment, how they contribute to economic growth, and how they are affected by poverty (Zhang et al., 2020).

Similarly, Chen (2021) argues that eye health is essential for achieving the SDGs as poverty is both a cause and consequence of poor eye health. Statistics reveal that, globally, women and girls are 12% more likely to have vision loss and experience additional barriers to eye care services, thus contributing to gender inequality (Chen, 2021). Therefore, improved eye health can increase household income, which, in turn, reduces hunger and promotes inclusive economic growth, employment and improved living standards.

The IAPB further posits that, being driven by social, financial and political inequality, eye health promotion requires a holistic approach, and we argue that this should not be the preserve of governments alone, but of all stakeholders in the eye and vision healthcare industry. Therefore, this study critically assesses communication policies, activities and strategy frameworks by analysing the policy documents of eye health regulatory bodies in Zimbabwe, including the Pharmacists Council of Zimbabwe (PCZ), Health Professions Authority of Zimbabwe, Zimbabwe Optometric Association and Zimbabwe Ophthalmologists Association.

Further, strategy documents, social media activity, communications and stakeholder relationship and community engagement initiatives during the period January 2020 to July 2022 are analysed. The choice of the time frame, pre-COVID-19 and during the COVID-19 period, is relevant to identify health communication practices before and during the pandemic, including digital communication strategies in eye health promotion. The study is limited to optometry/optical practitioners, policymakers and strategy developers.

## **Overview of Public Health Communication in Zimbabwe**

Communication within the public health sector in Zimbabwe is governed overall by Chapter 15:17 of the Public Health Act of 2018. Section 3 of the Act stipulates that the Ministry of Health and Child Care (MoHCC) is responsible for informing, educating and empowering the population about health issues, and for taking measures to prevent, limit and suppress infectious, communicable and non-communicable diseases. Chapter 37 of this Act stipulates that the duty to disseminate information lies with the Health Services Board – which the Government of Zimbabwe later declared should work jointly with the Health Services Commission. The Health Services Board ensures that appropriate, adequate and comprehensive information is disseminated on health services.

The Public Health Act states who can be delegated to release such information. Generally, governments have used health marketing targeting whole communities, entire populations or segments of society to disseminate public health communication messages (Schiavo, 2014: 37). It is important to note that in Zimbabwe's public health system, the Health Services Board is the key regulatory authority for health matters and practice, but that there are numerous regulatory subsets in the form of healthcare professional regulatory bodies, outlined in Chapter 27: 19, Part II, Section 5 of the Health Professions Act, which also outlines the major responsibilities of the Health Professions Authority – to register and control health institutions and to regulate the services provided at, or from, them, as well as to conduct inspections in all health institutions throughout Zimbabwe. The authority is the coordinating umbrella body for the seven health professional councils that regulate health practitioners in Zimbabwe. Thus, the public health ecosystem in Zimbabwe is subject to heavy regulation and operational scrutiny.

The eye health industry in Zimbabwe, with which this study is concerned, has been characterised by very low levels of communication, public relations, stakeholder engagement

and community engagement for more than a decade (MoHCC, 2014). International eye calendar events such as World Sight Day and World Optometry Day, among other international health commemorations, are barely recognised in Zimbabwe, while other conditions such as cancer, diabetes, HIV/AIDS, tuberculosis and other communicable diseases receive national attention from the Ministry of Health and Child Care and its stakeholders (MoHCC, 2014).

### **Literature and Theoretical Approach**

Health communication is an evolving and increasingly prominent field of public health and healthcare, both in the non-profit and private sectors (Schiavo, 2014). Schiavo further posits that when analysed, the various definitions of health communications:

“... point to the role that health communication play[s] in influencing, supporting, and empowering individuals, communities, healthcare professionals, policymakers, or special groups to adopt and sustain a behaviour, or a social, organisational, and policy change, that will ultimately improve individual, community, and public health outcomes.” (2014: 37)

This illustrates how communication, and health communication in particular, plays a pivotal role in shaping, directing and contesting narratives and behaviours in public health discourses, be it behaviour change, policymaking or increasing knowledge and awareness among societal groups. Therefore, health communication is a fundamental part of public health practice, whether in the context of clinical practice, community-based healthcare services or health behaviour change and awareness building (Schiavo, 2014: 37). It is of note that communication is a critical important component of healthcare and is worth investing in (Kreps, 1993; Pandit et al., 2017). Schiavo (2014) further adds that health communication creates the right organisational mindset and capacity that should lead to the successful use

of communication approaches to reach group, stakeholder and community-specific goals. From this premise, one can argue that health communication is vital not only for health practice, but also in contributing towards the promulgation of national health policies that empower, inform, engage and influence individuals and communities on matters regarding their health.

However, scholars such as Kreps (1993: 56) further lament the lack of attention to the dynamics of communication generally in public health research, especially as strategic communication directed at specific constituencies in communities can contribute to improved quality healthcare for the citizens of any country. He argues: "However, it [communication] is often taken for granted, its complexities and subtleties are overlooked, and it receives little attention in the literature on healthcare."

Much of the scholarly focus has been on interpersonal communication, especially the practitioner-to-patient communication, thus overlooking other communication dynamics and the influence of the environment. As Schiavo (2014) further observed, in contemporary society, health communication practice takes place in an open system environment, where the healthcare consumer (client) is in the centre of the system where he or she is surrounded by, and interacts with, service providers. In such instances, the client is usually the initiator of healthcare. Kreps and Thornton, (1992: 42–45) further concur that both clients and health professionals interact with the healthcare settings and external environment from where necessary and sometimes vital information is obtained. We therefore argue that it is critical for private healthcare professionals and policymakers to understand the key dynamics of how communication works outside the health institution. We further argue that there is a lack of appreciation and understanding that health communication, and communication in its raw form, exists at community, stakeholder and macro levels, which arguably contributes to high levels of ignorance, myths, misconceptions and misinformation on health matters, including eye care

across the world today. National Academies of Sciences, Engineering, and Medicine (2016) argue that eye and vision health remain absent as a priority in the overarching public health and healthcare systems globally, and thus is underrepresented in strategic plans that address the impact of chronic diseases in economies.

Further, critiques of health communication models, for example, Lupton (1994), have argued that communication in the health context is traditionally conceptualised as a top-down approach with communication flowing from centres to peripheral locations. Health communication is, therefore, according to Dutta-Bergman (2005: 106) a “political process marked by power relations that determine the relationship between the bourgeoisie and the subaltern classes”. Thus, health communication has the ability to shape social contexts (Wilkins & Mody, 2001: 198). From this premise, to achieve the intended health outcomes, there is a need for broader health communication strategies, tools and methods of communication – especially in view of new technologies – that take into account the social contexts and specific needs of communities. The social context in particular is critical: scholars such as Teutsch, Masur and Trepte (2018) remind us that the social, economic and health conditions of a country, community or society largely affect the outcome of eye health, hence the connection between eye health and economic, socio-cultural and health development. As such, one can argue that eye health is a catalyst to universal health equity for individuals and communities, hence contributing immensely to the achievement of the SDGs.

This leads the study to address the following questions:

1. Do the national policies guiding the eye health industry in Zimbabwe integrate communication for public awareness on eye health?
2. What strategies are utilised by service providers in the eye health industry to communicate with their various stakeholders?

3. Who are the key audiences for eye health communication messages, and what are the key messages?
4. How do these communication policies and strategies contribute to the attainment of SDGs in the Zimbabwean context, if at all?

This study utilises the critical theory, integrative strategic communication management and health communication theories as well the Precede-Proceed model to identify and analyse the communication policies and strategies within Zimbabwe's eye health industry.

### **Critical theory**

Critical theory is a normative approach that is based on the judgment that domination is a problem, and that a domination-free society is needed (Fuchs, 2016). According to Fuchs (2016), there are six dimensions of critical theory:

1. critical ethics;
2. critique of domination,
3. exploitation and alienation;
4. dialectical reason;
5. ideology critique; and
6. struggles and political praxis.

According to the critical theory of communication, communication is one of the crucial foundations of the economy (Habermas, 1987). Habermas (1987) further notes that in capitalism, communication – such as technology, the media, ideology or labour – is an instrument that is used by the dominant system to defend its rule. Critical theory is relevant for this study to effectively identify, analyse and interpret the hidden underpinnings of politics, domination and inequities inherent in the communication policies and strategies employed by regulatory bodies and service providers in the eye health industry in Zimbabwe.

The overall goal of using critical theory for this study is to assess whether the communication policies and strategies

encompass the needs of every Zimbabwean. In addition, through its diverse thematics of communication and power, critical theory allowed us as researchers to analyse the existing communications policies, strategies and activities in the eye healthcare industry, determine and decipher whom the policies favour, against whom they discriminate, and what eye health industry stakeholders are communicating to the public regarding eye health.

### **Integrative strategic communication management theory**

Strategic communication broadly explores the capacity of all organisations – not only corporations, but also for not-for-profit organisations (including advocacy and activist groups) and government – to engage in purposeful communication (Hallahan et al., 2007). Further, strategic communication emphasises the strategic application of communication and how an organisation functions as a social actor to advance its mission (Hallahan et al., 2007).

The integrative strategic communication management approach therefore emphasises a holistic, collaborative and intentional communication approach, where key stakeholders have an impact on the communication process (Steyn & De Beer, 2012). One of the key tenets of this integrative approach to strategic communication is that the value of communication is added at the strategic level, taking into account the changing environment, within a context – this to ensure sustainability and governance (Steyn & De Beer, 2012). Thus, health communication should be strategic and cognisant of the socio-cultural, economic and political environment for messages to have desired outcomes.

Another key characteristic relevant for this study is the differentiation between “strategic communication management” and “communication management” taking place on different levels in an organisation (De Beer, Steyn & Rensburg, 2013). While this paradigm was initially applied to corporate settings, it is relevant for government public affairs,

which serve a critical function of meeting public expectations and societal developmental goals. This paradigm is relevant as it will help identify the levels of decision-making and strategy-making within the eye health sector in Zimbabwe, and how these different structures and levels of regulation contribute, if at all, towards the communication strategy within the sector. The paradigm could also assist in assessing whether, in the formulation of eye health messages, there is integration among the relevant stakeholders in the eye health sector, such as private players, individuals, community and wider society.

### **Precede-Proceed model**

The Precede-Proceed model of Green and Kreuter (1999), posits that the approach to planning health communication should take into account the factors that contribute to behaviour change. The model further postulates that sustainable change is determined by the individual's motivation to become directly involved with the process of social change, and that individuals need to feel empowered to change their quality of life (National Cancer Institute cited in Schiavo, 2014). The model outlines three factors influencing behaviour change, two of which are relevant for this study: predisposing factors – i.e. individual knowledge, beliefs and values – and enabling factors – i.e. factors in the environment of an individual that enable or impede change (Schiavo, 2014: 53). This model helps us to assess health communication messages and especially the target audiences.

Further, because the model considers the individual as part of the social environment, it allows for the analysis and integration of Zimbabwe's socio-cultural, economic and political environment into understanding the importance of eye and vision health. The model further supports the notion of individual empowerment and capacity building at both the individual and community levels (Schiavo, 2014: 53). Thus, the model is applicable in the identification and analysis of

the communication strategies used in the eye health sector in Zimbabwe.

### **Methodology**

This study utilises a qualitative research approach, enabling a deeper exploration of the social phenomenon of interpretation and sense construction (Corbin & Strauss, 2007). Within the context of the COVID-19 pandemic, in-depth interviews were conducted utilising online technologies/platforms, in particular Zoom and Skype, as well as email. Informed consent was sought from the participants and the organisations concerned, and the interviews were recorded with the participants' consent. Ten eye healthcare practitioners participated in the study. Observations were used to monitor social media pages of at least 10 optometry/optical organisations/practices and the online activity of ophthalmologic practitioners was monitored as well to assess the characteristics of this activity on the sites concerned.

Document analysis was utilised to analyse Chapters 27:19 and 15:17 of the Health Professions Act, as well as the Optometrists and Dispensing Opticians Professional Conduct Regulations of 2010. Document analysis was conducted to analyse power dynamics in eye health governance especially the power structures, hidden meanings and intended meanings in the communications policies and strategies implemented by eyecare service providers in Zimbabwe.

### **Discussion**

#### **National and organisational policies guiding communication in the eye health industry in Zimbabwe**

Our findings demonstrate that the policies governing the eye health industry are not drafted by the country's eye healthcare service providers, but are developed, enforced and enacted by the Pharmacists Council of Zimbabwe and Health Professions Authority of Zimbabwe. Furthermore, Chapter 27:19 of the Health Professions Act is the primary reference point for all

regulations drawn up by industry regulators who craft policies to govern professions such as optometry, ophthalmology, opticianry, pharmacies and other health professions. With regards to communication, Section 4, subsection (1) of the Optometrists and Dispensing Opticians Professional Conduct regulations (PCZ, 2010), limits promotional communication and states that:

“... no optometrist or dispensing optician shall advertise or give publicity to his/her practice or business ...”

Furthermore, subsection (2) of the regulation states that:

“Any advertising undertaken by optometrist or dispensing optician, and which is permitted under these regulations, shall be of a dignified and restrained character, and free from any reference to the efficiency of him/her, or the facilities offered by other optometrists or dispensing opticians.”

The clause is in line with section 145 of the Health Professions Act, Chapter 27:19.

Therefore advertising, which is defined on page 3 of the policy document as “including any advertisement contained in a print media publication or as a production in the electronic media or by loudspeaker or public address system”, is disallowed by law. In addition, the policy document further adds that the term “publication” includes:

“(a) any newspaper, book periodical, pamphlet, poster, playing card, calendar or other printed matter; or (b) any writing or typescript which has in any manner been duplicated or exhibited or made available to the public or any section of the public”.

Thus, within this industry, there are considerable restrictions on communication as a whole imposed on private eye health providers by the government's health professions authority function. This conforms to other findings by Lupton (1994) and

Dutta-Bergman (2005) that health communication is largely top-down from the centre to peripheral locations, and marked by relations of power between the elite and subaltern classes.

Another finding reveals that there are legislative restrictions on stakeholder communications and public relations activities by eye healthcare practitioners/service providers. Section 6, subsection 2 of the regulations enacted by the PCZ on eye health service providers/eye health industry stipulate that:

“An optometrist or a dispensing optician may take part, in relation to his practice or business, in—

(a) trade shows or exhibitions which are **not open to the general public and are wholly or mainly related to the display of optical appliances and parts thereof, or of fittings, appliances, apparatus and instruments intended for use or sale by opticians or medical practitioners;** [bold is for emphasis by the authors]

(b) other shows or exhibitions with **the consent of the local association and subject to any conditions which the association may impose.**”

From the forementioned, we argue that such policies restrict stakeholder communications as exhibitions are typically a platform where multiple stakeholders are addressed simultaneously. What can be inferred is that the policies in the eye healthcare industry are not conscious of the need for strategic public relations practices in promoting eye healthcare services and information to the public. Because of the limitations imposed by the government, they thus create a gap in public knowledge about eye and vision health, which, arguably, negatively affects the pace at which SDGs are being achieved in Zimbabwe. This argument is supported by the World Health Organization (2017), which argues that communication is an integral part of promoting and achieving the SDGs for every community as it bridges the gaps in knowledge, information and education about healthcare, economic, political and socio-cultural narratives of members

of society. The findings from the document analysis previously mentioned correspond with those from the interviews, in which the health practitioners confirmed the consequences of the restrictions imposed by the public sector on their eye health promotion activities.

Furthermore, section 7 of the Professional Conduct regulations (2010) restricts tools of communication within the industry to trade or professional periodicals, and not mass media. The regulation policy document states that:

“An optometrist or dispensing optician may publish advertisements, or other matter relating to his practice or business, in periodicals circulating wholly or mainly among optometrists, medical practitioners, ophthalmologists, pharmaceutical chemists or members of ancillary professions to medicine, or to manufacturers of or dealers in optical appliances and employees of optometrists or dispensing opticians”.

From this premise, one can argue that there is a dearth of knowledge on eye health education and awareness among the public communities in Zimbabwe, owing largely to restrictive regulations. It is for this reason that we argue that there is a de-prioritisation of public eye health education and awareness in Zimbabwe and this, according to the Precede-Proceed model (Green & Kreuter, 1999), disempowers individuals and communities. Since advertisements and exhibitions are forms of communication, we argue their restriction is a direct impediment to the practice of public health communication in Zimbabwe, specifically in relation to the furthering and promotion of eye health communication and education information. The effect of this is lower prioritisation of eye and vision health in the country. Further, the restriction of mass media tools in communicating eye health is indicative of the lack of an integrative strategic communication management approach proposed by Hallahan et al. (2007) and Steyn and De Beer (2012). We therefore argue that by communicating through trade and professional periodicals, such eye health communication negates wider society, as these trade shows

are prevalently done in urban setups and neglect the wider population living in peri-urban and rural areas. Thus, such policies can also be argued to be largely discriminatory as far as promoting access to health communication and knowledge are concerned.

The country's eye healthcare policy as stipulated by the Zimbabwe Optometric Association (2021) also states how practitioners in the industry should communicate with their existing clients/patients, stating that such communication should be in the form of print communication material such as pamphlets and flyers. Zhang (2020) argues that health communication campaigns can play a central or supportive role in health education and social marketing; hence, as the findings of this study attest, advertising and marketing efforts aimed at increasing awareness and access to eye healthcare services could promote positive eye healthcare choices, attitudes and behaviours in Zimbabwe. Section 10 (1) of the Professional Conduct regulations (2010: 7) states that:

“An optometrist or dispensing optician may send to a person who has had an eye examination or been supplied with optical appliances in the course of his practice or business, a notice informing them of –

a change of address or telephone number of the premises where their eyes were examined or where they were supplied with optical appliances, or of closing those premises, or the changes in hours of opening or closing of the premises, or of the name under which the practice or business is carried on at those premises ...

And that:

An optometrist or a dispensing optician may send circular letters, booklets, leaflets or pamphlets, relating to optical appliances and of an informative nature, by—

making them available at his premises;

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sending them to persons who have had their eyes examined or have been supplied with optical appliances in the course of his practice or business,

sending them to any person who has specifically requested that they should be sent to him.”

What we deduce from the forementioned is that there are also restrictions on what should be contained in the printed communication material such as pamphlets and circulars. The findings therefore highlight that the policies regulating the industry only allow specific communication to a particular type of stakeholder – i.e. only a client who has accessed eye healthcare services, and not the general public, who may need such information. As such, there is no consideration for the prospective or potential client/patient out in the community or workplace and the general community member who is not aware of eye health or the importance of eye healthcare, and hence this also contradicts one of the core principles guiding public health in Zimbabwe. Specifically, Chapter 15:17, Part III, Section 31(d) of the Public Health Act stipulates that public health plays/should play a role in the promotion of health and of access to the social determinants of health. Therefore, the lack of consideration given to the sharing and dissemination of eye health communication with people who are not existing patients of an eye health facility affects the extent to which public health information and awareness fundamentals are attained in Zimbabwe. A representative of the Pharmacists Council of Zimbabwe stated:

“Practitioners are allowed only to advise the public of their practice’s location and trading hours.”

And that:

“The profession has noted that advertising of professional services has to continue to be regulated to ensure that the public is not misinformed and there is no unhealthy competition which will end up harming the public” (Practitioner 1, 2022).

Thus, we argue there is no strategic intention to create public awareness on eye healthcare through public policy. The major weakness of the policy is that it is not sustainable as far as promoting eye healthcare and services to individuals in the community is concerned. This is because these policies specifically do not allow an eyecare service provider to inform other members of society who have not received eye health services and products either about the importance of eye health or on various issues to do with eye health, as also argued by Lederman, Kreps and Roberto (2017). Thus, one can argue that the policies on eye health in Zimbabwe do not favour the advancement of the SDGs as they do not extend their reach to communities and individuals in much need of eye health education and services. Therefore, we posit that eye health communication does not take into context the specific needs of communities in Zimbabwe. As Teutsch et al (2016) remind us, there is a connection between eye health and socio-cultural as well as overall health development. Not taking cognisance of the specific needs of societies regarding eye health may arguably be detrimental to the attainment of SDGs, not only for healthcare but for the entire betterment of society socially, economically and physically (WHO, 2019).

In addition, the restrictive policies in the eye health industry arguably present an obstacle to eye and vision health as little information filters through to individuals and communities on the importance of eye health. Eye health is an integral part of individual healthcare and can affect large parts of the population if neglected (Teutsch et al., 2016: 4; Burton, Faal & Ramke, 2019). Therefore, the restrictions imposed upon eye health practitioners in Zimbabwe make the promotion of public health messages in the context of promoting eye health very difficult, negatively affecting the overall extent to which public health as a national health thematic is achieved and adequately promoted.

Interview respondents concurred with the findings from the analysis of policy documents and made the point that these policies need to be updated to reflect the evolving nature of health communication – advertising included – and

its community orientation rather than a focus on profit. One of the respondents – an optometrist with more than 20 years of optical practise in Zimbabwe – gave the following remarks when asked to mention the key challenges in implementing communication, marketing or public relations activities as a practitioner/organisation:

“Outdated legislation is a huge challenge for my practice’s marketing and communication activities. The laws that are governing eyecare practitioners are 10+ years ago and they need urgent updating. It is difficult to spread awareness and educate communities since the existing laws do not allow us to market or practice communication/public relations activities. Our industry legislation needs to be updated.”  
(Practitioner 2, 2022)

An optometrist with an optical practice in Bulawayo also added:

“The current laws governing the eye healthcare [industry] are very outdated. They no longer make sense towards our efforts to spread awareness on eye health and educate communities on the importance of eyecare. Unfortunately, our industry regulators do not seem to be aware of the gap their laws are creating in terms of access to eyecare services in the country.” (Practitioner 3, 2022)

What is inferred, therefore, is that policies governing the eye health industry in Zimbabwe are outdated and in need of review and amendment in line with the current needs of the modern health communication ecosystem, which is aimed at using communication to improve health outcomes through encouraging behaviour modification and social change (Schiavo, 2014: 45).

From the perspective of the health communication theoretical approach, the findings mentioned previously highlight communication as a fundamental element of policy change and promoting health behaviours for all stakeholders in society and/or communities (Schiavo, 2014: 37). Thus, in the

context of this study, the data presented on policies governing communication in the eye health industry reveal that the existing policies do not favour the creation of new policies and the promotion of eye healthcare to individuals and society. Furthermore, the data indicate that health communication as a practice is not understood, and its implications appreciated in the eye healthcare industry.

From the point of view of integrated strategic communication management theory (Steyn & De Beer, 2012), the findings indicate a lack of awareness among regulators about why eye health should be integrated into key strategic communication plans within the overall healthcare system. This finding concurs with National Academies of Sciences, Engineering, and Medicine (2016) that globally eye health remains underrepresented in national strategic plans. Additionally, regulators need to be made aware of the need for strategic communication within the eye and vision health sector, in particular the need for strategic dissemination of key messages to the general public in order to improve population health (Gupta, Narain & Yadav, 2021).

### **Communication strategies utilised by service providers in Zimbabwe**

To a great extent, eye health industry service providers in Zimbabwe use outreach programmes as their key communication strategy in an attempt to navigate around the communication restrictions imposed and enacted by the PCZ.

Our findings show that health campaigns, including outreach programmes and activities, are one of the most effective means that service providers use to communicate with their various stakeholders. The findings of our study reveal that optometrists/optometry practices, ophthalmologists, eye health NGOs and industry bodies all utilise outreach activities as their fundamental communication strategy to promote eye healthcare among communities in Zimbabwe. Stakeholder relationship and partnership events are also widely used communication strategies in the eye health industry as service

providers classify them as outreach programmes. One of the practitioners interviewed in the study stated that:

“Other stakeholders must be made aware of the need for eye health. Without advertisement and communication programme activities, eyecare services will not reach out to the deprived communities. So, the only way we are currently trying to bypass these restrictions is through outreach activities in partnership with stakeholders in other industries such as medical insurance and corporates.” (Practitioner 5, 2022)

Therefore, one could argue that outreach programmes access and positively impact wider audiences for eye health communication as they may reach other family members and communities rather than existing eyecare patients only.

The study found that few eye healthcare service providers in Zimbabwe have active social media pages, websites or other online platforms, likely due to the restrictions imposed and enacted by PCZ under the Health Professions Act, Chapter 27:19. This is despite the fact that ICTs have been shown to serve as support structure for all 17 SDGs, including equity in health (ADEC, 2017). One of the representatives interviewed – a National Programmes Manager for the Zimbabwe Council for the Blind – said:

“Our organisation has outsourced a communication specialist to help us manage our social media pages – our posts, content and updates.”

“Organisations in Zimbabwe should be free to share their content and communicate their strategies and also market their services online, as these platforms are now the most preferred by the majority of the population.” (Practitioner 4, 2022)

This explains why relatively few eye healthcare service providers are active online. Social media communications for public health promotion are underutilised by eye health

practitioners in Zimbabwe as they fear penalties could be imposed and practice certificates/licences be revoked by industry regulators.

Also noteworthy is that few service providers in the eye health industry have strategies for communicating with their stakeholders. Except for individuals who have already received eye health services and are contacted for follow-up examination, there is a lack of communication at the functional level between service providers in the eye health industry and their various stakeholders, especially members of the community. This was confirmed during the interviews carried out in this study, the following being an example:

“We are only allowed to engage stakeholders such as medical aid societies and other corporate institutions on non-optical concerns and processes. Communicating eye healthcare messages to other people outside our practice databases is not possible given the strict laws on how we should communicate.” (Practitioner 9, 2022)

For this reason, one could argue that there is a dearth of stakeholder communication in the eye health industry in Zimbabwe, which leads to the conclusion that, because current communication policies do not encourage service providers to share knowledge with the wider communication, health communication is not prioritised in the eye health industry. From a critical theory perspective, this study is able to unearth the inequities that are inherent in eye health communication, and in particular the fact that eye health communication favours those in power.

The study further highlights the importance of strategic communication in the eye health sector in order for communities to benefit from purposeful eye health messages. Key to note is that community involvement in healthcare decisions, actions and issues is also one of the principles of public health and practice stipulated in Chapter 15:17, Part III, Section 31(i) of the Public Health Act. Emphasis is placed on community participation as an integral role in

decision-making and actions affecting their health; again, this shows unfriendly legal communication policies in the eye healthcare sector negatively influences public health in Zimbabwe broadly.

### **Targeted audiences and key messages**

Ideally, health communication and eye health in particular should target entire communities in any context (Ruben, 2016). However, owing to the centralised nature of communication and restrictions on what eye service providers may and may not say, we find that, in the Zimbabwean context, eye health information has very limited reach among stakeholders. Our findings reveal that:

- there is more service provider–client communication;
- there is more peer–peer communication among eye health professionals themselves; and
- there are pockets of stakeholders who are reached through a few events such as outreach or wellness programmes.

Large communication gaps still exist in Zimbabwe for eye health awareness and there is virtually no mass targeting for eye and vision health messages. The key target audiences are people who have already accessed specialist eye care or visit the optometrist regularly to avoid or reduce the risk of severe eye problems.

In terms of key messages being communicated by eye health service providers in Zimbabwe, these are insignificant as service providers are practising little to no communication in the eye health industry. Similarly, mass communication messages on eye and vision health in Zimbabwe are partially evident only during the annual commemorations such as World Sight Day, where eye health practitioners encourage communities to take care of their eyes by following eye health standards, being aware of symptoms of eye complications and regularly visiting their optometrists.

While some service providers do use outreach activities and stakeholder partnership events to disseminate eye health

information, the prevalent communication restrictions in the eye health industry deter them from promoting access to and knowledge on eye health in the country. Fuchs (2016: 11) argues that “communication is a tool or instrument that is used by those in power to retain their power and maintain it”. As such, one could argue that the industry largely serves the literate and elite few who have an appreciation of the need for eye healthcare but neglect ordinary and marginalised citizens who lack information on eye and vision health and why this is important for their general wellbeing and development. Thus, the restrictions on communication practice in the eyecare industry indicate a deliberate intention to control perceptions and control narratives on access to healthcare thereby negatively affecting the entire population’s appreciation, knowledge and information on eye health.

### **Implications for the attainment of SDGs in the Zimbabwean context**

As mentioned, the study has found that the eye healthcare industry in Zimbabwe has a specific policy that prohibits the practice of strategic communication management to inform, educate and communicate to the public about eye health matters. As such, one could argue that this has a negative impact on the attainment of the SDGs because of the low level of awareness on basic eye healthcare among members of the public and society. As one of the optometrists interviewed commented:

“Due to the restrictions on marketing and other communication practices in the eye healthcare industry, eyecare services and information are not reaching underserved and remote communities, especially in rural areas. Hence there is need for improvement in the industry’s marketing and advertising policies.” (Practitioner 10, 2022)

In addition, the study found that exhibitions and trade fairs hosted and facilitated by stakeholders in the eye healthcare

sector are not open to the general public, preventing education and information from reaching the most affected stakeholder in the eye health industry – the community. There are also low levels of awareness on the SDGs in the eye healthcare sector, and the majority of eye healthcare practitioners interviewed could not explain or describe how communication in the eye healthcare industry contributes to the attainment of the SDGs in Zimbabwe. In line with the Precede-Proceed model (Green & Kreutner, 1999), with low levels of awareness, it becomes difficult for individuals to embrace behaviour change regarding eye and vision health.

## **Conclusion**

This study concludes that communication practices and strategies in the eye health industry in Zimbabwe are heavily restricted, with limited cooperation between the public and private sector. The relevant communication policies are set at the highest level of decision-making, namely the PCZ as the industry regulator, with support from the MoHCC. These policies, drafted and enforced by the industry regulator, restrict who eye practitioners should communicate with; how they should communicate; what they communicate, when they should communicate and for what purpose.

We conclude that the policies are the largest contributor to the dearth of knowledge on eye health education and awareness for communities in Zimbabwe. According to these policies, eye health service providers are not allowed to use any print or electronic communication methods to promote eye health to the general public, nor to market and advertise any eye-healthcare-related products or information. The fact that such information only targets individuals who have received eye services, leads us to conclude that the rest of the Zimbabwean population have remained unaware of the importance of eye health to their wellbeing.

Our analysis further revealed the absence of knowledge, understanding and appreciation of the SDGs in the eye health industry, leading us to conclude that the eye health policies

found in Zimbabwe do not contribute to the attainment of the SDGs. Overall, we conclude that there is an absence of integrated strategic communication management with regards to eye and vision health and subsequently, a de-prioritisation of public eye health education and awareness in Zimbabwe.

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