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Revised Family Communication Patterns Theory for Health Behaviour and Infodemic Management in Sub-Saharan Africa: An Afro-Centric Reconceptualisation

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ABSTRACT: Koerner and Fitzpatrick‟s Revised Family Communication Patterns (RFCP) addresses the impact of communication within a family setting on individual health behaviours; a critical concept within health communication. Nonetheless, the RFCP is shaped by a Western family normative bias. This limits its applicability to Sub-Saharan African settings, where family structures are anchored to extensive kinship. This paper critically evaluates the applicability of RFCP to African health contexts, reconceptualising conformity and conversation orientations and redefining the concepts of „parents‟ and „family‟ within these African settings. The paper proposes a health intervention framework that integrates the reconceptualised RFCP with the Integrative Model of Behavioural Prediction (IMBP). This integration demonstrates how family communication patterns shape attitudes, perceived norms, and self-efficacy in relation to health behaviours. With empirical evidence from Cameroon and Nigeria, establishing family networks as one of the most trusted sources of health information in Sub-Saharan Africa, the paper advances implications for intervention design, engaging with the family as a communicative unit. This approach to community engagement in health communication is informed by the Ubuntu philosophy. The paper also highlights the potential implications for infodemic management. This paper contributes to the decolonisation of health, challenges individual-level approaches to health communication, and positions the extended kinship network as the normative communicative unit for Sub-Saharan African health communication.

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INTRODUCTION

The concept of communication from a health perspective has since the 1960s gained significant centrality within social studies. The 1960s provided the critical theoretical lens for viewing health through a sociological prism, through Herbert Mead‟s *Mind, Self, and Society (1934)*, coined into Symbolic interactionism by Herbert Blumer in 1969. Within this same timeframe, McLeod and Chaffee (1973) introduced the Family Communication Pattern (FCP), providing a key empirical instrument for applying a sociological lens to the study of real-world health processes, proposing that family members develop shared understandings of their social world through communicative co-orientation. The result was a hybrid approach to health communication departing from traditional biomedical models, establishing social factors, labels, and roles as pivotal considerations in health studies. The FCP was operationalised by Ritchie and Fitzpatrick (1990) into the Revised Family Communication Patterns (RFCP) instrument, wherein the original dimensions of “socio-orientation” and “concept-orientation” were renamed conformity orientation and conversation orientation, with the former capturing the use of parental control to enforce agreement, and the latter capturing open, idea-focused discussion. Koerner and Fitzpatrick (2002) subsequently elaborated these dimensions into a full social-cognitive theory of family

communication, arguing that relatively stable family-level relational schemas are constructed through members‟ ongoing social interaction, a formulation later consolidated in their widely cited 2006 chapter.

Notwithstanding the significant influence of the RFCP theory, it remains heavily westerncentric, alienating African health systems. In agreement with Breshears & Rabe (2025), family communication as a field of study is almost non-existent from an African perspective, with most of the information coming from related disciplines such as Sociology, Anthropology, and Psychology. From a Sub-Saharan African health perspective, this justifies the growing need to provide a valuable framework that departs from Western-centric health communication models, to integrate the local realities of African communities. As argued out by Ambelem et al. (2025), such an approach permits the grounding of theoretical contribution, and offers practical insights for culturally sensitive interventions.

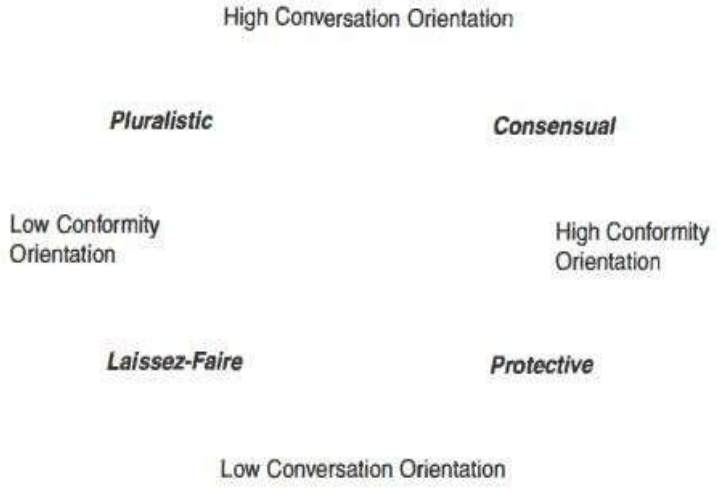
The present study aims at providing an Afro-centric discussion on the impacts of the FCP on individual health in terms of choice of health information providers and ensuing behaviours. It challenges the original conceptions of „family‟ and „parents‟ as presented in the FCP theory due its Western-centric family normative bias. What is argued out here is that FCP was built around a bounded nuclear-family unit; if Sub-Saharan African family health talk routinely pulls in aunts, grandparents, or community elders, the „family‟ that FCP was designed to measure may not be the same unit operating within African contexts, changing the dynamics of intervention. The present paper upholds that in non-nuclear family systems like those typical to sub-Saharan African societies, conformity and conversation orientations are impacted by cross-generational differences and have significant effects on African health systems that are not accounted for by FCP models.

I. Revised Family Communication Patterns

The original model of „Family Communication Patterns‟ is traced back to the works of McLeod and Chaffee (1973) focusing on the nuclear family, and building on the concept of Co-orientation which was initially brought up by Heider (1946, 1958) and Newcomb (1953). Family communication within the works of McLeod and Chaffee is not discussed as a concept in itself, but rather, as a means through which social reality is expressed and consolidated through an analysis of three interdependent attributes of co-orientation; Agreement (the extent to which family members have similar perceptions), Accuracy (how correct each members‟ views are about the others), and Congruency (how well perceptions and actual communication behaviours align). The operationalisation of FCP by Ritchie and Fitzpatrick (1990) into the Revised Family Communication Patterns (RFCP), with the integration of the conformity orientation and conversation orientation, later on elaborated by Koerner and Fitzpatrick (2002), provides the empirical grounds from which the study attempts to integrate the RFCP into an African health context.

RFCP highlights two dimensions of communication within family setups; conversation orientation which emphasises liberal exchanges and values the act of communication itself, and conformity orientation which stresses the uniformity of ideas, values and principles, prioritising respect for parents. Ultimately, these two dimensions of communication are not treated as mutually exclusive within family communication but as overlapping to greater or lesser extents as the dimensions of communication could be high or low denoting four major types of families; consensual (high conversation, high conformity), pluralistic (high conversation, low conformity), protective (low conversation, high conformity), and laissezfaire (low conversation, low conformity) each with distinct communication specificities, as presented below.

Figure 4.1 Family Types determined by Conversation Orientation and Conformity Orientation



Source: Koerner, A. F., & Fitzpatrick, M. A. (2006). Family Communication Patterns Theory:

A Social Cognitive Approach.

From the foundational works of McLeod and Chaffee to the most recent formulations of Koerner and Fitzpatrick, RFCP retains two major characteristics: (1) its typological assumption of a nuclear family, and (2) the implicit actors involved in the communication process are the parents and the children. While this framework effectively captures the dynamics of western-centric family notions in terms of parent-child communication, delocalising its claims to Sub-Saharan African contexts, where the extended families constitute a source of social capital that significantly impacts decision-making within the health domain requires substantial context-sensitive adaptation.

II. Afro-centric reconceptualisation of conformity orientation and conversation orientation

The original formulation of the RFCP conformity orientation targets specifically the westerncentric nucleus family. This depicts the power dynamics between parents and children wherein the former exert control. However, typical African societies are characterised by extended family systems, implying conformity is systematically enforced through extended family networks: aunties, uncles, elders, and even grandparents, given these relations account for a form of social capital. This social reality implies a cultural transposition of the RFCP framework to an African healthcare setting without a reconceptualisation will fail to adequately inform healthcare systems about behavioural predispositions.

Afro-centric theorising of family communication is anchored to oral tradition, collectivism, and ancestral influence, all within a high-context communication norm, which does not always blend with the centrality of the nucleus family as depicted by the RFCP. Breshears & Rabe (2025), while not focusing on the health dimension of family communication as of interest to the present discussion, nonetheless discussed the uniqueness of South African families owing to family structures (racial categories), social challenges (high male incarceration rates), and cultural values (power dynamics and gender expectations). The argument is that these considerations have real implications for the conceptualisation and research targeting family communication attention, which should avert normative bias of western family research.

Similarly, Zimbabwe evidence upholds ubuntu-informed community practices serve as an informal system of parenting wherein the community as a whole becomes responsible for children upbringing. This challenges the traditional definition of the „family", demanding a recalibration of the notion of conformity when parent-child communication is to be investigated as a health indicator as within the present discussion. The work of Udah et al. (2025) gives insight into the Ubuntu philosophy highlighting the fact that within humanitarian social works, it enhances the participation of people in the decision-making process. What this implies within the current discussion is a strict depiction of the African family typology (be it conformity oriented or conversation oriented) will fail to adequately inform the health system of the targeted community given the two most important concepts lose their traditional definitions in an African context; „family" and „parents". As rightly pointed out by the RFCP, the two major dimensions of family typology are not mutually exclusive but rather overlapping to greater or lesser extents which justifies even more the need for a delocalised identarian approach to investigating communicational patterns, which could impact health behaviours from a Sub-Sahran African perspective born from the interrelated communal involvement.

Still within the same vein, Umennuihe & al. (2023) explored the relationship between family communication patterns and conflict management styles of adolescents within a local government area in Nigeria. While not focusing on health it was still able to ascertain a relationship between family communication patterns and behavioural predispositions in terms of conflict management, revealing 93.3% of respondents fell into the consensual RFCP type (high conversation, high conformity). The study also revealed the other three family types (pluralistic, protective, and laissez-faire) accounted for a joint total of 6.7%. Further to these findings, Oguntomisin & Oyewole (2023) applied the RFCP theory to the Yoruba community, in Nigeria, revealing conformity orientation to be the dominant dimension but with rather low conversation orientation. Even though the study essentially focused on the nuclear family, emphasising the *Baale* as the authority figure, this brings up an important finding for our present discussion; African families tend to be conformity-oriented, but they are not monolithic.

Similar evidence from Cameroon supports this claim. Its extraordinary linguistic diversity of over 250 ethnic groups speaking approximately 280 languages brings forth something the RFCP cannot account for. Consequently, what stems out from a cross-analysis of the African countries within which the RFCP or its main assumptions were used as an informative tool is the RFCP"s weak adaptability to the African context owing to its main strength; an extremely thorough depiction of the stable western-centric nuclear family. This echoes the main argument of the present write-up, which seeks to propose an Afro-centric application of the RFCP theory to inform health policy by fitting in the Integrative Model of Behavioural Prediction (IMBP) to permit an overview of the RFCP as a health moderator within African contexts. The IMBP model upholds that health behaviour is a function of attitudes, perceived norm, and self-efficacy, all of which offer a complementary lens through which the reconceptualised RFCP dimensions can be linked to specific health outcomes, as elaborated here below.

III. Linking the RFCP to the Integrative Model of Behavioural Prediction The discussion right up till this point establishes the RFCP framework, acknowledging its merits, while also highlighting the difficulties related to using such a framework within a SubSaharan African context without extensive reconceptualisation. The social configuration of African societies rooted in extended kinship structurally alters the operation of conformity and conversation orientations. Nonetheless, demonstrating that the

communication patterns vary across cultural contexts is only a first step. Making a meaningful contribution to health policy and practice will necessitate an articulation of how these specific communicative patterns translate into specific health behaviours. The Integrative Model of Behavioural Prediction (IMBP) opens to a complementary lens.

The Information-Motivation-Behavioural Skills (IMB) model was originally developed by Fisher and Fisher (1992) as a response to the urgent need for behaviour change during the HIV/AIDS epidemic. IMB is built on three major components: (1) Information (disease conditioning and available services), (2) Motivation (attitudes, beliefs, and values within a social setup), and (3) Behavioural skills (the ability to effectively perform a health-related behaviour); a structure that shares clear family resemblance with the model adopted here. The present study however draws on Fishbein and Yzer‟s (2003) Integrative Model of Behavioural Prediction (IMBP), which extends and consolidates the Theory of Reasoned Action and Theory of Planned Behaviour into three proximal determinants of intention: attitudes, perceived norms, and self-efficacy, while explicitly framing itself as a tool for designing health behaviour intentions in specific communities. IMBP is adopted here in preference to IMB for two reasons: it is the more recent and extensively validated of the two frameworks across diverse health behaviours, and its constructs, particularly perceived norm and selfefficacy, relate better to the conformity and conversation orientation dimensions of Family Communication Patterns central to this study.

A Previous attempt to merge the RFCP with the IMB in an operational health framework is evident in the work of Thomas & Hovick (2021). In a cross-sectional survey making use of 504 young adults, measuring conversation and conformity orientation besides descriptive and injunctive norms, they opine in a western context conversation orientation rather than conformity orientation influenced young adult‟s health self-disclosure to parents, with the effects mediated by descriptive norms and communication efficacy. The evidence above suggests the traditional African family tends to be more conformity oriented (without depicting the African society as a monolithic one), underscoring the necessity of the sociocultural adaptation of such a framework rather than supposing a universal applicability of it. It nonetheless provides empirical validation of the IMBP framework in the context of family communication and health behaviour.

Despite its massive contribution to understanding health behaviours in terms of information, motivation, and behavioural skills, the original IMB model ultimately limits itself to the individual (which is argued out in the present write-up to alienate the Sub-Saharan African context). Consequently, a reconceptualisation of the RFCP dimensions coupled to an overlaying of the IMBP framework within the present discussion is believed to be able to provide a unique approach to understanding family communication as determinants of health behaviour within extended families south of the Sahara.

IV. Implications for Health Behaviour and Intervention design

An integrated framework combining the reconceptualised RFCP dimensions and IMBP has significant implications for health behaviour and intervention design in the sub-Saharan African context. The IMBP model posits that health behaviour is a function of attitude, perceived norm, and self-efficacy, all of which are shaped by family communication patterns. Two empirical studies underscore the relevance of this integration.

Omale et al. (2024), in a cross-sectional survey of 1,276 respondents (a study concerning health workers rather than the general population) in Ebonyi State, Nigeria, found that health workers were the most common individual source used (83.8%), followed by radio (67.9%), television (59.6%), and family/relatives/friends (57.9%). Similarly, in a mixed-methods study of 457 respondents across three Cameroonian towns: Dschang, Bamenda, and Douala, Ambelem (2026) examined the preferred sources of health information. Family, relatives, and friends were cited by an average of 36.52% of respondents, ranging from 42.74% in Dschang to 40.00% in Bamenda and 26.82% in Douala, ahead of healthcare professionals (22.12%), books and journals (15.65%), online sources (15.12%), and television or radio (10.42%). A separate measure produced a still starker figure: 92.1% of respondents reported that recommendations from family and friends were a major consideration in their choice of health-service provider. These realities independently corroborate that interpersonal sources, particularly family and kinship networks, are among the most trusted sources of health information in sub-Saharan African contexts. This redefines the implications of the joint RFCP and IMBP for African health communication along the three major axes of IMBP.

Firstly, with regard to attitude, the framework proposes a departure from the traditional individual-level approaches to engage with the family as a communicative unit. The understanding here is that, within African social setups, attitudes towards a health behaviour are a function of beliefs about its likely outcome. Consequently, a health communication that fails to consider family communication risks ineffectiveness because it overlooks social determinants that mediate health knowledge, motivation, the accuracy of the information circulating within kinship networks. Given that the IMBP attitude component is shaped by the accuracy and completeness of information that circulates within kinship networks, bypassing family structures risks excluding the very network that patients most often refer to in forming attitude-relevant beliefs.

Secondly, with regard to perceived norm, and in agreement with Ambelem (2026), the framework highlights the urgency of adopting culturally sensitive health messaging.

Perceived norm in IMBP terms comprises both injunctive beliefs (what important thing others think one should do), and descriptive belief (what important thing others actually do). The reconceptualised RFCP suggests that these norms are considerably stronger

and more binding in conformity-oriented houses like African households. As such, objective health communications that fail to consider subjective and injunctive norms, including contextual communication styles, family structure, and gender expectations, may encounter resistance. In high conformity orientation contexts, health communication that bypasses family authority or promotes unilateral decision-making may be perceived as disrespectful or threatening to family harmony. This is argued to weaken rather than strengthen perceived normative support for the recommended behaviour. By implication, within such a context, messaging that acknowledges family involvement in health decision-making is more likely to be accepted, given it aligns with, rather than works against, existing normative pressure.

Thirdly, with regard to self-efficacy, the argument here is that family communication typology shapes not only what a person believes and feels normatively pressured to do, but also their confidence in their own capacity to act on health information independently. In highconformity households, health decisions are typically made by the authority figure as evident in the work of Oguntomisin and Oyewole (2023), where the *Baale* hands down decisions, rather than negotiating with younger family members. This translates into relatively limited practical experience in independently sourcing, evaluating or acting on health information. Alternatively, in high-conversation households, this experience with decision-making is more likely to have been rehearsed through open family discussion, which IMBP identifies as a further determinant of whether intention translates into behaviour or not. Interventions that assume a uniform baseline of self-efficacy across a population may therefore need to account for this variation, which is exactly what this framework proposes.

Beyond IMBP‟s three core determinants, the framework highlights the major role of community engagement in health interventions. The Western normative bias in family and health communication fails to account for contexts where the Ubuntu philosophy informs community practices. Implicitly, this may manifest through social scarring (shaming, stigma) or identity threat, where non-compliance with community health norms carries a reputational risk, justifying different attitudes towards people infected or affected by various health conditions. Explicitly, this is evident through leveraging existing community health structures like village health committees and other forms of social associations. Health interventions that utilise these existing structures can tap into communal decision-making processes that define health behaviours in extended family systems like those typical to Sub-Saharan African communities.

The integration of the reconceptualised RFCP with the IMBP model thus provides a more holistic framework, one that includes the African relational and communicative context, while offering a behavioural mechanism that informs health policy globally. Having established this integrated framework, the present discussion now turns to how family communication patterns shape trust in information sources. This is particularly relevant in a contemporary digital landscape wherein health communication creates complex social identities from a health perspective.

V. Health-Related Behaviours (HRB) and Infodemic Management

We understand health-related behaviours to involve any action an individual takes, capable of impacting his/her health. This implies that health information embedded within African extended kinship networks represent a potential source of infodemics. The argument here is that communication patterns observed within Sub-Saharan African societies function at two levels: (1) in shaping health-related behaviours, and (2) in the management of infodemics.

An infodemic is best described as an abundance of information, including false or misleading information, within digital and physical environments during a disease outbreak. While the presence of information in itself does not constitute a threat to health, an unverified access to inaccurate information can magnify the undesirable outcomes out a disease outbreak. This is exemplified with the Cameroonian approach to HIV/AIDS communication in the late 1980s and early 1990s, during which the initial government response, heavily reliant on donor funding rather than community involvement, was ineffective and, as Tsala Tsala (2005) observed, inadvertently reinforced suicidal and transmissive behaviour. Denial, misinformation, and extreme social exclusion, born from fear-based communication failed to achieve their objectives, as such, deepening stigma. Similarly, Napakol and Dralega (2022) discuss several communication shortcomings: political interference, failed community engagement, inaccurate information, threats to journalist safety, in times of disease outbreak across several African countries, including Nigeria, Ghana, Zimbabwe, and especially South Africa.

The on-going analysis, based on such evidence, agrees with the opinion that the future of behaviour change is in listening, not telling (International Federation of Red Cross and Red

Crescent Societies, 2026). The baseline argument here is that real change happens only when we understand why people behave the way they do and identify practical ways to support and influence those behaviours in a systematic and meaningful way, and real change starts from within. This underscores the relevance of the present framework.

Having established a relationship between communication patterns and health-related behaviours in a Sub-Saharan African context, the present discussion now turns to defining what infodemic management should therefore imply for Sub-Saharan African communities. Eysenbach (2020) identifies four major pillars of infodemic management: (1) Facilitate Accurate Knowledge Translation, (2) Knowledge Refinement, Filtering, and Fact-Checking, (3) Build eHealth Literacy, and (4) Monitoring, Infodemiology, Infoveillance, and Social Listening. In line with this, Ishizumi and Yau (2023), drawing on the definition of World

Health Organisation (WHO), describe infodemic management as the systematic use of risk and evidence-based analysis and approaches to manage the infodemic and reduce its impact on health behaviours during health emergencies. However, applying this conception of infodemic management will be particularly challenging, especially when considering the third and fourth pillars, which assume a certain familiarity with eHealth and the internet as frequently used sources of health information. Building eHealth literacy for infodemic management within Sub-Saharan African contexts should therefore develop health literacy that matches the cultural and technological realities of the target communities. This is achievable through community engagement and the understanding of the digital health identities that reflect the cultural, economic, and infrastructural realities of the target communities.

CONCLUSION

This paper argues that the decontextualized application of Western-centric family communication models to Sub-Saharan African contexts risks producing ineffective health interventions that fail to account for the distributed, multi-generational nature of Sub-Saharan African family systems. It advocates a socio-culturally communicative framework that reconceptualises the RFCP dimensions, integrates the IMBP, thus, providing a holistic lens for examining how family communication patterns shape health-related behaviours and enhance infodemic management. Beyond theoretical refinement, the significance of this framework resides in its practical interventions for health policy and intervention design. This framework challenges health communicators to move beyond individual-level approaches and engage with the communal structures that define health behaviours in Sub-Saharan African communities.

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