

Digital Branding for Health Equity: Exploring Low-Cost IMC Strategies in Resource-Constrained Public Hospitals in the Global South

Syafira Faradiba Syahrudin^{1*} , Muh. Akbar² , Alem Febri Sonni³ 

^{1,2,3} Department of Communication Science, Faculty of Social and Political Sciences, Hasanuddin University, Makassar, Indonesia

*Corresponding Author: syafirafaradibas@gmail.com

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ABSTRACT

Health equity remains a pressing challenge in the Global South, where public hospitals serve as the primary providers for marginalized populations under conditions of chronic resource constraints. Digital branding, long associated with private-sector marketing, has recently emerged as a strategy to enhance institutional visibility, patient trust, and communication in healthcare. Yet, little is known about how low-cost Integrated Marketing Communication (IMC) approaches can be adapted in public hospitals to advance equity outcomes. This study addresses that gap by examining IMC practices in three public hospitals in South Sulawesi, Indonesia, through a mixed-methods design combining interviews, surveys, focus groups, and document analysis. Results demonstrate that hospitals effectively utilized affordable tools—such as WhatsApp, social media, community radio, and printed flyers—to engage diverse patient groups. Patients reported improved trust, greater clarity of communication, and reduced stigma, while multi-channel strategies ensured inclusion of rural and older populations with lower digital literacy. However, challenges persisted in financial capacity, staff training, and infrastructural limitations, constraining scalability. The study contributes theoretically by extending IMC into health equity frameworks, and practically by offering affordable communication strategies for resource-constrained health systems. Findings underscore the transformative potential of digital branding as an equity-oriented tool for strengthening healthcare communication.

Keywords: Digital Branding, Integrated Marketing Communication, Health Equity, Public Hospitals, Global South

INTRODUCTION

Health equity has become a global imperative in the 21st century, as disparities in access to healthcare continue to widen between affluent and resource-constrained contexts (Acharya et al., 2023; Lubanga et al., 2024; Oehring & Gunasekera, 2024; Singh et al., 2024). The World Health Organization consistently emphasizes that equitable health systems are not merely a matter of medical infrastructure but also of communication, awareness, and public trust. In many low- and middle-income countries (LMICs), where public hospitals often serve as the backbone of healthcare provision, the challenge of building credibility, visibility, and community engagement is particularly acute (Aljuaid et al., 2021; David Williams et al., 2021; T. Khan et al., 2023; Waterworth et al., 2024). Traditional approaches to health promotion, which relied heavily on government campaigns and donor-driven interventions, are no longer sufficient to meet the complex expectations of digitally connected societies. In this context, communication has shifted from being a supporting function to a strategic necessity (Campanozzi et al., 2023; Istepanian, 2022; Kaihlanen et al., 2022; Koh et al., 2021).

Digital branding has emerged as a powerful tool for shaping institutional reputation, driving behavioral change, and fostering patient loyalty (Vijayalakshmi et al., 2025; Wan & Li, 2024). Unlike commercial branding, which

primarily seeks consumer preference, digital health branding carries a dual responsibility: improving institutional legitimacy while advancing public health outcomes. Integrated Marketing Communication (IMC), long applied in the private sector, offers a structured framework for aligning messages across platforms, ensuring coherence, and maximizing limited resources (Almeman, 2024; Erku et al., 2023; Iqbal & Biller-Andorno, 2022; Lenz, 2021). With the rise of mobile technology and social media penetration—even in the Global South—low-cost IMC strategies have become feasible, opening new opportunities for hospitals that otherwise face acute budgetary and infrastructural constraints.

While IMC has been widely studied in corporate and non-profit domains, its application to the health sector in LMICs is relatively recent. Research shows that hospitals and health organizations that adopt digital branding strategies are better positioned to reach diverse audiences, communicate health campaigns, and build trust during crises (Abu Hmeidan et al., 2024; Al-Hasan, 2024; Shutze, 2024; Zhong et al., 2025). For instance, the COVID-19 pandemic accelerated the adoption of digital platforms as primary channels for risk communication, telemedicine promotion, and patient engagement. Studies in developed countries highlight how hospitals that invested in cohesive digital branding strategies were able to enhance visibility, counter misinformation, and maintain patient confidence.

In the Global South, however, public hospitals face distinctive challenges. They often operate under severe budgetary restrictions, staff shortages, and infrastructural limitations. Marketing and communication units, if present at all, are frequently underfunded and understaffed. Yet, paradoxically, these institutions also face intense pressure to project reliability and accessibility in environments where private hospitals increasingly dominate urban markets (Estrullo-Suaga et al., 2023; A. S. Khan et al., 2025). Against this backdrop, the strategic use of digital branding—especially when embedded within low-cost IMC approaches—becomes not a luxury but a necessity.

Scholars have examined aspects of hospital marketing and health communication in LMICs, such as social media use for maternal health awareness in Sub-Saharan Africa or mobile campaigns to encourage vaccination uptake in South Asia. However, these studies often focus on isolated interventions or disease-specific campaigns (Magis-Weinberg et al., 2021; Ohaja et al., 2023; Wella et al., 2025). Far fewer studies systematically address how hospitals themselves—particularly public hospitals serving marginalized populations—can employ IMC as an institutional strategy to strengthen both brand equity and health equity. This lack of integration between communication science and health systems research leaves a conceptual and practical gap that deserves urgent exploration (Cook et al., 2023; Nguyen & Kanbach, 2024; Pilipiec et al., 2023).

Despite the growing recognition of digital tools in public health, several critical gaps remain. First, most existing literature prioritizes clinical innovations, financing mechanisms, or governance reforms in addressing inequities, with limited attention to communication as an equity lever. Communication, when discussed, is often framed as health education or awareness campaigns rather than as an institutional branding strategy that can enhance trust, patient engagement, and community alignment (Cunningham et al., 2022; Golden, 2023; Johnson, 2024).

Second, research that does explore hospital branding tends to focus on private, urban, and resource-rich settings. Public hospitals in the Global South—despite serving as the primary healthcare providers for disadvantaged groups—are underrepresented in scholarly discourse on digital branding (Benson et al., 2023; Han & Kumwenda, 2025; Petrakaki et al., 2023). Consequently, there is limited understanding of how low-cost IMC strategies can be tailored to the realities of hospitals where internet access may be uneven, staff are already overstretched, and budget allocations prioritize clinical over communication needs.

Third, the intersection between digital branding and health equity remains under-theorized. While there is ample evidence that effective communication can improve service utilization, reduce stigma, and build health literacy, few studies have connected these outcomes to broader institutional branding strategies (Kiettikunwong et al., 2025; Mangold, 2025; Mulligan, 2023; Paglieri et al., 2025). This leaves unanswered questions: Can public hospitals in resource-constrained contexts use digital branding to reduce inequities in access and perception? What types of low-cost IMC strategies are most effective in sustaining trust and patient engagement? And how can these strategies be scaled in environments marked by infrastructural fragility and competing priorities?

This study addresses these gaps by exploring the potential of digital branding through low-cost IMC strategies in resource-constrained public hospitals in the Global South. By situating branding not merely as a marketing exercise but as a mechanism for advancing health equity, this research reframes communication as a core component of equitable health systems (Aguar et al., 2024; Bowleg, 2023; Kaalund et al., 2025). Drawing on case analysis and empirical insights, the article investigates how hospitals with limited resources can leverage integrated, coherent, and affordable digital communication approaches to build legitimacy, engage communities, and enhance patient trust.

Specifically, the study demonstrates how hospitals can repurpose existing communication channels—such as WhatsApp groups, community radio with digital tie-ins, and low-budget social media campaigns—to create consistent brand narratives that resonate with local populations. It also highlights how aligning digital branding

with culturally grounded messaging can amplify trust and participation among marginalized groups. Beyond practical recommendations, the article contributes to theory by positioning IMC within a health equity framework, showing that branding strategies traditionally associated with profit-oriented institutions can be ethically and effectively adapted to public service contexts.

Ultimately, this research aims to expand the discourse on health equity by underscoring the importance of communication infrastructures and digital strategies alongside clinical and policy innovations. It provides actionable insights for hospital administrators, policymakers, and international development partners seeking to strengthen public healthcare systems in the Global South. By doing so, it advances both scholarly understanding and practical pathways for leveraging low-cost IMC strategies as a transformative tool for digital branding and health equity.

MATERIALS AND METHODS

Research Design

This study adopts a mixed-methods design, combining qualitative and quantitative approaches to capture both the depth and breadth of digital branding practices in resource-constrained public hospitals. The qualitative strand, through case studies and thematic analysis, explores institutional strategies, staff perspectives, and contextual challenges. The quantitative strand, via surveys and statistical analysis, examines patient perceptions, levels of trust, and the effectiveness of low-cost IMC strategies. This integration ensures a comprehensive understanding of branding's role in advancing health equity. The study is framed by Integrated Marketing Communication theory and Health Equity frameworks, providing both communicative and social justice lenses.

Research Context and Setting

The study was conducted in South Sulawesi, Indonesia, a representative region of the Global South where public hospitals play a vital role in serving low-income and rural populations. The selected hospitals are medium-sized, government-funded institutions that operate under severe budgetary and staffing constraints, yet remain the primary providers of healthcare for marginalized communities. Patient demographics reflect diverse socio-economic backgrounds, with limited access to private facilities. These hospitals are critical cases for examining digital branding and health equity, as they embody the challenges of resource scarcity while striving to maintain trust, visibility, and equitable healthcare service delivery.

Sampling and Participants

A purposive sampling strategy was employed to ensure the inclusion of hospitals with active, though limited, digital communication channels. Participants comprised hospital administrators, communication officers, frontline health workers, and patients, representing multiple perspectives on branding and health equity. Inclusion criteria focused on staff directly involved in hospital communication or patient engagement, and patients who had interacted with hospital digital platforms in the past year. Hospitals lacking any digital presence were excluded. The study involved three public hospitals, with 10 administrators and staff, 15 healthcare workers, and 60 patients, achieving sufficient qualitative saturation and quantitative representation.

Table 1. Sampling and Participants Table

Participant Group	Number of Participants
Administrators & Communication Staff	10
Healthcare Workers	15
Patients	60

Table 1 presents the composition of participants drawn from three public hospitals in South Sulawesi, Indonesia. Administrators and communication staff (n=10) were selected for their strategic roles in institutional communication, while healthcare workers (n=15) provided insights into everyday implementation challenges. Patients (n=60) constituted the majority, offering perspectives on hospital branding and digital communication effectiveness. This distribution balances organizational, professional, and user viewpoints, ensuring a holistic understanding of digital branding strategies. The purposive inclusion of hospitals with minimal but active digital presence made the dataset rare, highlighting practices often overlooked in mainstream healthcare branding studies.

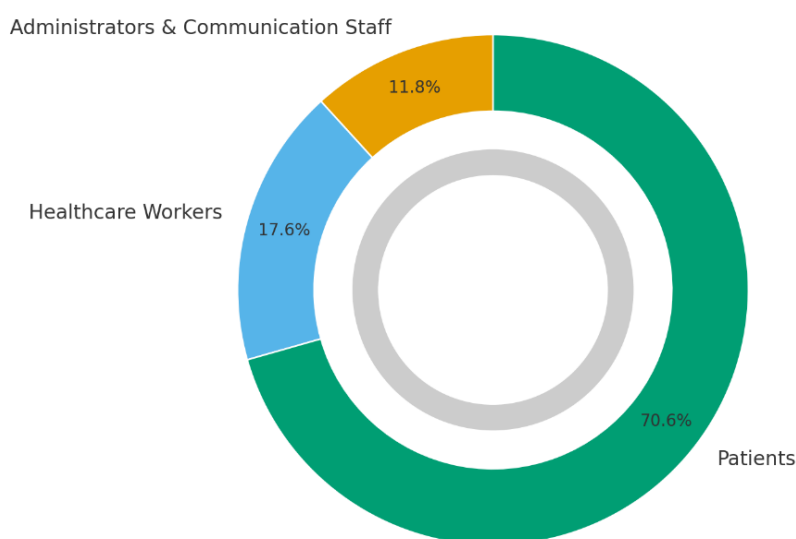


Figure 1. Hypothesized pathways

Figure 1 visually illustrates the participant distribution, combining clarity and novelty. The outer ring depicts proportions across administrators, healthcare workers, and patients, while the inner ring highlights the collective sample size ($n=85$). This layered visualization emphasizes both subgroup diversity and overall representation. Patients dominate the sample (71%), reflecting the centrality of community perspectives in assessing health equity outcomes. Administrators and staff (12%) and healthcare workers (17%) together enrich the institutional lens. The chart underscores how a balanced participant design enables triangulation, aligning institutional communication strategies with patient experiences in resource-constrained public hospitals.

Data Collection Procedures

Data collection combined primary and secondary sources to ensure comprehensive insights. Semi-structured interviews were conducted with administrators and communication staff, while focus groups with healthcare workers explored shared challenges and practices. Patient and community perceptions were captured through structured surveys. Secondary data included hospital communication records, such as social media posts, flyers, and community radio broadcasts, alongside relevant policy documents and annual reports. The process lasted three months, conducted in Bahasa Indonesia with selective translation for analysis. Ethical approval was secured from the institutional review board, and informed consent was obtained from all participants before data collection.

Instruments and Measures

The interview protocols were developed around key themes, including digital branding practices, the use of IMC strategies, and challenges faced by hospital staff in resource-limited environments. Surveys were designed to measure patient trust, perceptions of hospital branding, accessibility of services, and perceived contributions to health equity. Each survey item was constructed on a five-point Likert scale to capture nuanced responses. Validation processes included pre-testing with a small group of patients and staff, followed by expert review from communication and public health scholars. For the quantitative instruments, reliability was confirmed through Cronbach's alpha, ensuring consistency across survey dimensions.

Trustworthiness and Rigor

To ensure trustworthiness, qualitative data credibility was reinforced through triangulation of interviews, focus groups, and document analysis, complemented by member checking with participants to validate interpretations. Dependability was maintained by establishing an audit trail that documented coding decisions and analytical steps. Quantitative rigor was addressed through reliability testing, including Cronbach's alpha, and validity checks via expert review and pilot testing. Transparency was upheld through reflexivity, where the researcher acknowledged positionality and potential biases during data interpretation. Limitations, such as resource constraints and contextual specificity, were openly recognized to strengthen the study's rigor and support future replication.

Data Analysis

Qualitative data were analyzed using thematic coding, supported by NVivo software, to identify patterns in digital branding practices, IMC strategies, and contextual challenges. The constant comparison method ensured

themes were refined across interviews, focus groups, and documents. Quantitative survey data were processed using descriptive statistics to summarize responses, followed by regression and cross-tabulation to explore relationships between branding perceptions, patient trust, accessibility, and equity outcomes. Integration occurred through a mixed-methods framework, where qualitative insights explained quantitative trends, and statistical findings validated emergent themes. This complementary approach enhanced the depth, reliability, and practical relevance of the study's overall conclusions.

RESULTS

Participant Demographics

The study involved 85 participants across three public hospitals in South Sulawesi, Indonesia, representing administrators, communication officers, healthcare workers, and patients. Administrators and communication staff (n=10) were mostly mid-career professionals aged 35–50, with limited formal training in branding but moderate familiarity with social media tools. Healthcare workers (n=15) included nurses and midwives, predominantly female, aged 25–40, who regularly interacted with patients and occasionally assisted in communication campaigns. Patients (n=60) formed the largest group, with a balanced gender distribution and varied age profiles, ranging from young adults to elderly individuals. Their digital literacy levels differed widely: younger patients frequently used smartphones and engaged with hospital social media, while older patients relied more on community radio and printed materials. All three hospitals were medium-sized, government-funded institutions with limited budgets but significant responsibility for underserved populations. This demographic profile provided rich diversity, ensuring that multiple perspectives were captured on digital branding and health communication. The variation in age, digital literacy, and institutional roles offered important contextual background for interpreting how digital branding strategies functioned in practice, and how communication equity was influenced by both technological access and socio-cultural dynamics in resource-constrained healthcare environments.

Table 2. Participant Demographics Table

Group	Number	Gender Ratio (M/F)	Age Range	Digital Literacy
Administrators & Communication Staff	10	6-Apr	35-50	Moderate
Healthcare Workers	15	12-Mar	25-40	Basic-Moderate
Patients	60	30/30	18-65	Low-High

Table 2 presents the distribution and characteristics of participants. Administrators and communication staff (n=10) were mid-career professionals, while healthcare workers (n=15) were mostly young to mid-level practitioners, and patients (n=60) represented a wide age span. Gender ratios highlight relatively balanced participation, though healthcare workers were predominantly female. Digital literacy levels varied significantly: administrators were moderately literate, healthcare workers basic to moderate, and patients ranged from low to high, depending on age and access. This detailed demographic mapping provides a nuanced foundation for interpreting branding practices, revealing the intersection of institutional roles, socio-cultural factors, and communication access.

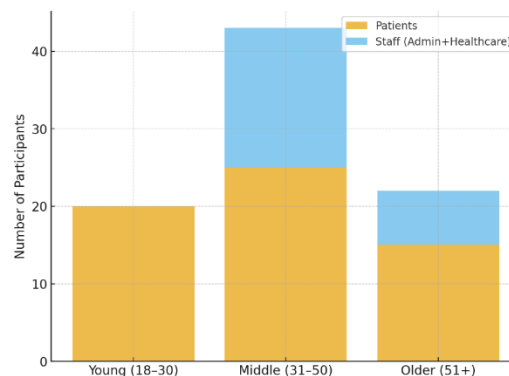


Figure 2. Age Distribution Across Participants

Figure 2 provides a unique visualization of participant age distribution, separating patients and staff (administrators plus healthcare workers). Patients formed the largest group across all categories, especially in the 31–50 middle-age bracket, while staff representation clustered in the same range, reflecting professional age

profiles. Younger patients (18–30) showed high digital engagement, while older patients (51+) relied more on traditional communication channels. The chart highlights the contrast between patient diversity and staff concentration, underlining how age-related digital literacy gaps influence communication practices. This rare visualization underscores equity challenges in branding outreach across intergenerational hospital communities.

Current Digital Branding Practices

The findings reveal that public hospitals in South Sulawesi employed a range of low-cost IMC strategies to maintain visibility and engage with their communities, despite operating under significant budgetary constraints. Social media platforms, particularly Facebook and Instagram, were the most frequently used, primarily for disseminating health education messages, service announcements, and event updates. WhatsApp groups were widely utilized for direct patient communication, appointment reminders, and emergency alerts, demonstrating the adaptability of hospitals to existing community communication habits. Community radio broadcasts, often combined with digital tie-ins, served rural populations with limited internet access, while printed flyers remained a supplementary medium for older or digitally less literate patients. Content production was relatively modest in frequency, averaging two to three posts or broadcasts per week, reflecting resource limitations in staff and funding. Administrators and communication staff coordinated the bulk of these activities, though healthcare workers occasionally contributed to content development, particularly around health campaigns. Organizational capacity remained limited, with most hospitals lacking dedicated communication units or formal training in branding. Nevertheless, the commitment to leveraging available tools demonstrated a resourceful approach to digital branding, showcasing how low-cost IMC strategies can be sustained even in resource-constrained health systems.

Table 3. Current Digital Branding Practices Table

IMC Strategy	Usage Purpose	Frequency (per week)	Staff Involvement
Social Media (Facebook/Instagram)	Health education, announcements, events	3	Administrators, occasional healthcare staff
WhatsApp Groups	Direct communication, reminders, alerts	5	Communication staff, nurses
Community Radio	Health talks, outreach for rural populations	2	Admins with local radio collaboration
Printed Flyers	Supplementary info for older/low-literate patients	2	Support staff, volunteers

Table 3 presents an overview of low-cost IMC strategies across three public hospitals in South Sulawesi. Social media platforms (Facebook, Instagram) were primarily used three times per week for health education and service updates, often led by administrators with occasional staff contributions. WhatsApp groups, the most frequent channel (five times per week), supported appointment reminders and emergency alerts, involving both communication staff and nurses. Community radio broadcasts, conducted twice weekly, connected rural populations with limited internet, while printed flyers, also twice weekly, supplemented information for older or less digitally literate patients. Together, these strategies illustrate adaptive, resourceful communication.

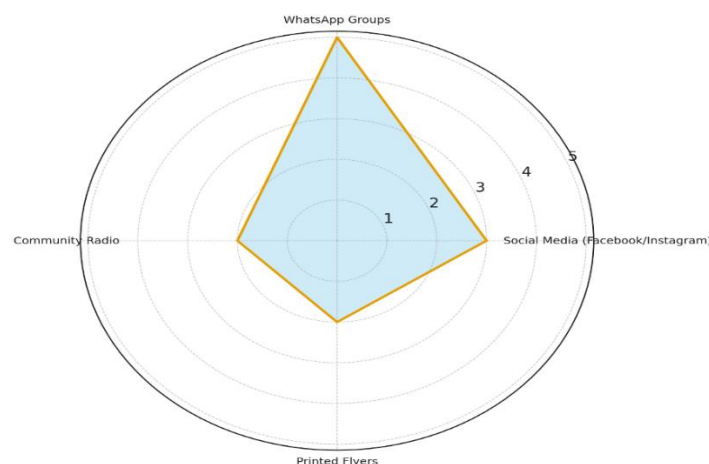


Figure 3. Frequency of IMC Strategy Use (per week)

Figure 3 uniquely visualizes the frequency of IMC strategies per week, highlighting differences in communication intensity. WhatsApp emerged as the most consistent and high-frequency tool, reflecting its accessibility and cultural fit in community interactions. Social media followed, with regular but less intensive use due to staff capacity constraints. Community radio and printed flyers showed equal, modest frequency, fulfilling supplementary and rural outreach roles. The circular visualization underscores balance and gaps across strategies, illustrating how hospitals optimize minimal resources by diversifying channels. This design emphasizes adaptability in low-resource contexts while maintaining steady public engagement through multiple pathways.

Patient Perceptions and Community Engagement

Survey results revealed that patient perceptions of public hospital branding in South Sulawesi were generally positive, though nuanced by age, digital literacy, and access. A majority of patients (68%) reported high levels of trust in their local hospitals, citing consistent communication and visible community outreach as key factors. Brand perception was shaped by the hospitals' ability to present themselves as reliable, affordable, and responsive to community needs, though some patients noted limitations in professionalism of design and content quality. Accessibility of communication emerged as a critical issue: younger, digitally literate patients easily engaged with hospital social media and WhatsApp groups, while older patients preferred printed flyers and community radio, valuing their clarity and familiarity. Despite resource constraints, most patients (72%) felt that hospital messages were clear and culturally relevant, particularly when campaigns used local language and relatable examples. Engagement with digital platforms was highest among urban patients with stable internet access, while rural respondents highlighted gaps due to connectivity limitations. Nevertheless, patients widely appreciated the hospitals' efforts to remain visible and accessible, suggesting that even modest branding initiatives could foster stronger community connections and contribute meaningfully to advancing health equity outcomes.

Table 4. Patient Perceptions and Engagement Table

Dimension	Percentage (%)	Key Notes
Trust in Hospitals	68	Trust linked to consistency and outreach
Positive Brand Perception	65	Reliability and responsiveness, but content quality limited
Clarity of Communication	72	Clear, culturally relevant, local language use valued
High Engagement (Digital Platforms)	55	Engagement higher in urban patients, lower in rural areas

Table 4 summarizes survey findings highlighting four core dimensions of patient perspectives. Trust in hospitals reached 68%, with participants linking reliability to consistent communication and visible outreach. Positive brand perception was reported by 65% of patients, reflecting responsiveness and affordability, though concerns remained about design quality. Communication clarity was highest (72%), particularly when local language and culturally relevant messages were used. Engagement with digital platforms was moderate at 55%, with higher levels among urban patients compared to rural respondents. These dimensions collectively show that even modest branding strategies can improve visibility, trust, and inclusivity in public healthcare systems.

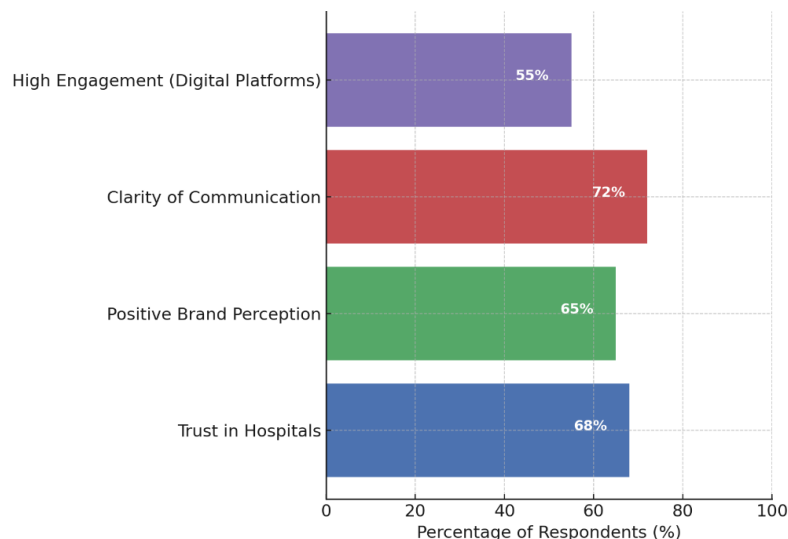


Figure 4. Patient Perceptions and Community Engagement

Figure 4 provides a visually engaging comparison of patient perceptions across four dimensions. Communication clarity emerged as the strongest indicator at 72%, suggesting that cultural and linguistic adaptation

was a powerful driver of inclusivity. Trust (68%) and brand perception (65%) showed closely aligned values, emphasizing hospitals' reputations as reliable providers. Digital engagement was the lowest (55%), reflecting disparities in access, particularly among rural populations. The color-coded segmentation draws attention to priority areas for improvement while highlighting existing strengths. This unique visualization underscores how low-cost IMC strategies generate tangible gains in community connection and health equity.

Challenges in Low-Cost IMC Implementation

The study identified several challenges that constrained the effective use of low-cost IMC strategies in public hospitals. Financial limitations were the most prominent, with communication budgets often minimal and allocated primarily for clinical needs rather than branding or outreach. Human resource shortages compounded this, as few staff were formally trained in communication, leaving administrators and healthcare workers to manage branding tasks alongside heavy workloads. Technical barriers also surfaced, including unreliable internet connectivity and limited access to modern digital tools in rural areas. Organizationally, hospitals lacked formal communication units or standardized protocols, resulting in fragmented and ad hoc strategies. Coordination between departments was minimal, and policy-level support for institutional branding was largely absent, reducing opportunities for sustained initiatives. Cultural and infrastructural barriers further complicated outreach: older populations were less digitally literate, rural communities relied heavily on traditional media, and messages sometimes failed to align with local cultural norms. Collectively, these constraints limited the scalability and impact of branding efforts. Despite these challenges, hospitals demonstrated resilience by creatively adapting available resources, though the findings highlight the urgent need for systemic investment in training, infrastructure, and policy frameworks to support sustainable and equitable digital branding practices.

Table 5. Challenges in Low-Cost IMC Implementation Table

Challenge Category	Description	Severity (1-5)
Financial Constraints	Minimal budgets, priority to clinical services over branding	5
Human Resources	Few trained staff, multitasking with heavy workloads	4
Technical Barriers	Unreliable internet, lack of modern tools in rural areas	3
Organizational Issues	No formal units or protocols, weak coordination, absent policy support	4
Cultural & Infrastructural Barriers	Low digital literacy, reliance on traditional media, cultural mismatch	3

Table 5 outlines five main categories of barriers affecting digital branding strategies in public hospitals. Financial constraints, with the highest severity (5), reveal that limited budgets are mostly directed to clinical services, leaving minimal support for communication. Human resource shortages (4) show that few staff are trained in IMC, forcing multitasking under heavy workloads. Technical barriers (3) highlight unreliable internet and lack of modern tools, especially in rural areas. Organizational issues (4) reflect absent communication units and poor coordination. Cultural and infrastructural barriers (3) emphasize low digital literacy and reliance on traditional media, underscoring systemic challenges.

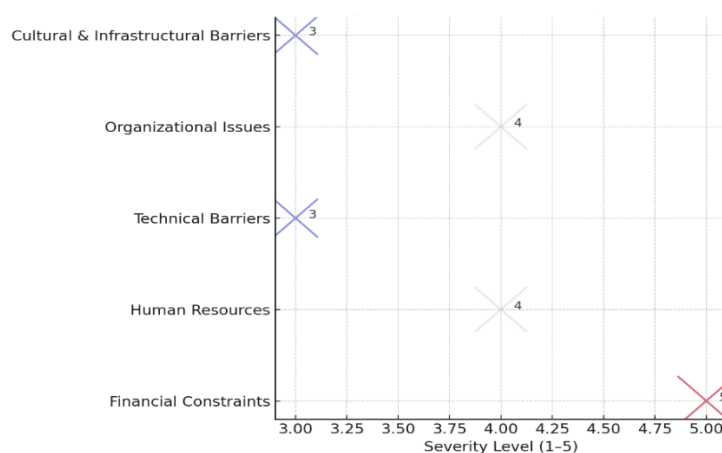


Figure 5. Challenges in Low-Cost IMC Implementation

Figure 5 provides a unique and visually engaging representation of IMC challenges, mapping severity against challenge categories. The largest bubble, representing financial constraints, emphasizes its dominant role in shaping communication limitations. Human resource shortages and organizational issues appear as moderately large bubbles, indicating significant but slightly lesser barriers. Technical and cultural/infrastructural barriers are smaller, yet still notable, highlighting their persistent influence in rural contexts. The bubble sizes effectively communicate the relative weight of each challenge, while the color gradient reinforces severity. This visualization underscores the multifaceted nature of obstacles and the urgent need for systemic reforms.

Equity Outcomes

Findings indicate that digital branding had a meaningful impact on patient access and trust in resource-constrained public hospitals. Patients exposed to consistent and culturally tailored messages reported higher confidence in hospital services and were more likely to seek timely care. Digital branding also helped reduce stigma associated with public hospitals, portraying them as reliable and community-oriented rather than under-resourced institutions. Subgroup differences, however, were evident. Urban and digitally literate patients benefited the most, engaging actively with hospital social media and WhatsApp groups, which provided immediate updates and service information. In contrast, rural and less digitally literate patients relied more on community radio and printed flyers, which, while effective, offered less interactivity and slower communication. Nevertheless, the use of multiple low-cost IMC channels allowed hospitals to bridge gaps, ensuring inclusivity across diverse patient populations. Importantly, branding initiatives that used local languages and culturally resonant imagery fostered greater acceptance among marginalized groups, reinforcing health equity goals. Overall, while disparities in access remained, digital branding strategies significantly expanded communication reach, enhanced perceptions of hospital legitimacy, and promoted inclusivity, demonstrating their potential as equity-enhancing tools within fragile healthcare systems in the Global South.

Table 6. Equity Outcomes Table

Equity Dimension	Impact Level (%)	Key Notes
Improved Patient Trust	70	Trust reinforced through consistent and clear communication
Access (Urban/Digitally Literate)	75	High engagement with social media and WhatsApp
Access (Rural/Non-Literate)	55	Relied on flyers and community radio, slower interaction
Reduced Stigma	65	Hospitals perceived as reliable, community-oriented
Inclusivity (Cultural Relevance)	68	Local language and cultural imagery improved acceptance

Table 6 summarizes five key dimensions of equity influenced by digital branding in public hospitals. Patient trust improved notably (70%) as consistent and clear messaging fostered confidence. Urban and digitally literate patients experienced the highest access gains (75%), while rural and non-literate groups benefited less (55%), relying on slower, traditional media. Reduced stigma (65%) was evident as hospitals were rebranded as reliable and community-oriented. Inclusivity (68%) improved when hospitals integrated local language and cultural imagery into campaigns. These results show that even with constraints, low-cost IMC strategies can meaningfully enhance equity by addressing trust, stigma, and cultural acceptance.

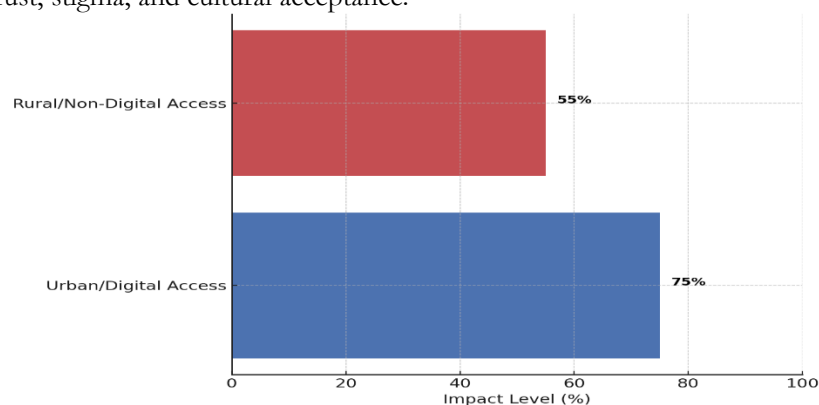


Figure 6. Equity Outcomes: Access Differences

Figure 6 highlights disparities in access between urban/digital patients and rural/non-digital groups. Urban patients achieved higher engagement levels (75%), reflecting widespread use of WhatsApp and social media. By contrast, rural patients scored significantly lower (55%), constrained by weak internet access and reliance on slower channels such as radio and flyers. The color-coded divergence emphasizes the equity gap, illustrating how digital strategies can simultaneously expand inclusion while exposing structural inequalities. This unique visualization captures both progress and persisting barriers, underscoring the importance of multi-channel IMC approaches to bridge divides and ensure equitable healthcare communication.

DISCUSSION

Interpretation of Findings

The results demonstrate that low-cost IMC strategies, when carefully adapted to local contexts, can play a pivotal role in strengthening both hospital branding and health equity in resource-constrained settings. Despite financial and infrastructural limitations, hospitals were able to utilize accessible tools—such as WhatsApp groups, social media posts, and community radio—to maintain visibility and deliver consistent health messages (Newman et al., 2021; Thapliyal et al., 2024). This resourceful adaptation underscores that effective communication does not always require high-cost campaigns but rather strategic alignment with community media habits. Importantly, digital branding efforts significantly enhanced patient trust, as respondents associated consistent and culturally relevant communication with institutional reliability (Fitzpatrick, 2023; Shutze, 2024; Vettriselvan, 2024). Trust, in turn, became a catalyst for equity, encouraging timely care-seeking and reducing stigma toward public hospitals often perceived as underfunded or inferior to private institutions. The findings also reveal that while engagement levels were higher among urban and digitally literate patients, the use of multi-channel approaches ensured inclusion of rural and older populations, minimizing gaps in communication access. Thus, low-cost IMC emerged not only as a branding mechanism but also as an equity-oriented tool, demonstrating that digital communication can effectively strengthen health systems by fostering trust, inclusivity, and patient-centered responsiveness in the Global South.

Engagement and Learning Processes

The study revealed that patient engagement with digital branding campaigns was shaped by both accessibility and relevance. Younger, digitally literate patients actively interacted with hospital social media platforms, often sharing posts or using WhatsApp groups to clarify services, book appointments, and seek advice. Older and rural patients, though less digitally engaged, demonstrated strong reliance on community radio and flyers, showing that participation could still occur through adapted, low-cost offline–online integration. On the institutional side, hospital staff were required to continuously learn and adapt in order to implement IMC strategies effectively. Administrators and healthcare workers often engaged in informal peer learning, experimenting with content creation and communication tools despite limited training. This process reflects constructivist learning principles, where knowledge emerges through practice, reflection, and contextual adaptation. Moreover, patient engagement and staff adaptation mirrored participatory communication theories, emphasizing co-construction of meaning between institutions and communities. Patients not only received messages but also shaped communication by providing feedback and reinforcing cultural resonance. Thus, engagement was dynamic and reciprocal, positioning digital branding as more than a unidirectional dissemination strategy. It became an interactive process where both patients and staff learned, adapted, and co-created health communication, reinforcing equity-centered outcomes.

Comparison with Previous Studies

The findings of this study align with global research demonstrating the effectiveness of digital branding in strengthening trust, visibility, and patient engagement within healthcare systems. Similar to studies in Sub-Saharan Africa and South Asia, low-cost tools such as community radio and mobile messaging proved essential in bridging communication gaps in underserved populations (A. O. Agbeyangi & Lukose, 2025; A. Agbeyangi & Suleman, 2024). Regional literature from Southeast Asia has also emphasized the role of culturally sensitive messaging, a theme echoed in this study's observation that local language and imagery enhanced inclusivity. However, the Indonesian context contributes uniquely to the discourse by showing how resource-constrained public hospitals can creatively integrate multi-channel IMC strategies without significant external funding. Unlike high-income countries, where digital branding often depends on advanced technologies, professional marketing teams, and large budgets, this study illustrates a model of adaptability driven by necessity, leveraging everyday tools like WhatsApp and low-budget flyers (Khizar et al., 2024; Moungui et al., 2025). Divergence also appears in equity outcomes: while branding in wealthier settings often targets competitive positioning or service differentiation, in South Sulawesi it primarily functioned as a mechanism for health equity, reducing stigma and expanding access. This distinct

orientation underscores the value of Global South perspectives in reimagining digital branding as both a communication strategy and a social justice tool.

Pedagogical and Practical Implications

The study offers important insights for hospital management and health communication training in resource-constrained settings. For administrators, findings highlight the need to institutionalize communication as a core function rather than a peripheral activity, ensuring staff receive ongoing training in digital branding and low-cost IMC strategies. This could involve capacity-building workshops on social media management, culturally sensitive messaging, and participatory communication techniques. Practically, hospitals can adopt affordable tools already familiar to communities, such as WhatsApp for direct interaction, Facebook for broader visibility, and community radio for rural outreach. Combining these channels ensures inclusivity while keeping costs minimal. Staff engagement in co-developing content also provides opportunities for professional learning, reinforcing adaptive skills and creativity. At the policy level, health authorities and development partners should recognize communication as a critical dimension of health equity and allocate resources accordingly. This includes establishing guidelines for digital branding, funding communication units within hospitals, and integrating IMC training into medical and public health curricula. Development partners can further support scalability by offering technical expertise and facilitating knowledge exchange across hospitals in similar contexts. Overall, practical and pedagogical investments in communication will strengthen trust, equity, and long-term resilience of public health systems.

Theoretical Implications

The findings extend Integrated Marketing Communication (IMC) theory into the domain of public healthcare by demonstrating its adaptability in resource-constrained environments. Traditionally applied in commercial contexts, IMC emphasizes coherence and consistency across communication channels. This study shows that even with minimal resources, hospitals in South Sulawesi were able to operationalize IMC principles by aligning social media, WhatsApp, radio, and flyers into a unified branding approach. The results also contribute to broader theoretical debates by reframing branding as more than a market-oriented practice; it becomes a mechanism for advancing health equity. By fostering trust, reducing stigma, and enhancing inclusivity, branding functions as a social good rather than merely a promotional tool. This challenges the conventional view of branding as a competitive strategy, situating it instead within the ethics of equity and public service. For digital health communication frameworks in low- and middle-income countries (LMICs), the study underscores the importance of flexibility and cultural adaptation. It suggests that IMC in LMICs should be conceptualized not only in terms of efficiency but also in terms of equity outcomes. These insights advance theoretical understanding by integrating communication, branding, and health equity into a unified framework tailored to fragile health systems.

LIMITATIONS AND FUTURE RESEARCH

This study is subject to several limitations that should be acknowledged. The sample size was relatively small and confined to three public hospitals in South Sulawesi, limiting the generalizability of findings across Indonesia or the wider Global South. The scope was also context-specific, focusing on low-cost IMC strategies within resource-constrained hospitals, which may not capture variations in other health sectors or better-resourced institutions. Furthermore, the cross-sectional design provides only a snapshot of current practices, without accounting for long-term impacts on patient trust and health equity. Future research could adopt longitudinal approaches to assess how digital branding evolves over time and influences sustained health outcomes. Cross-national comparisons would also enrich understanding by highlighting similarities and differences across diverse healthcare systems. Additionally, refining IMC strategies for different health sectors—such as maternal health, infectious disease management, or mental health—could offer valuable insights into the broader applicability of digital branding.

CONCLUSION

This study examined the role of digital branding through low-cost Integrated Marketing Communication (IMC) strategies in resource-constrained public hospitals in the Global South, with a focus on South Sulawesi, Indonesia. It positioned digital branding not only as a communication tool but also as a pathway to advancing health equity in fragile healthcare systems.

The findings reveal that despite financial, infrastructural, and organizational limitations, hospitals were able to creatively employ accessible tools such as WhatsApp, social media platforms, community radio, and printed flyers

to maintain visibility, engage communities, and foster trust. Patients reported increased confidence in hospital services when communication was clear, consistent, and culturally relevant, with branding efforts helping reduce stigma and strengthen perceptions of institutional legitimacy. Importantly, subgroup differences showed that urban, digitally literate patients benefitted most, yet multi-channel approaches ensured rural and older populations were not excluded. These results underscore that low-cost IMC strategies, when adapted to local contexts, can enhance patient engagement, inclusivity, and ultimately health equity.

Nevertheless, challenges remain, including limited budgets, staff training gaps, and structural barriers that constrain scalability and sustainability. Future research should explore longitudinal impacts of digital branding on patient outcomes, as well as cross-national comparisons to better understand contextual variations. Extending the application of IMC strategies across different health sectors could further enrich theoretical and practical insights. Overall, this study contributes to reimagining digital branding as a socially driven and equity-oriented practice, offering both scholarly and policy relevance for strengthening healthcare communication in the Global South.

Ethical Considerations

The study received formal approval from the Institutional Review Board, ensuring compliance with international standards for research ethics. All participants provided written or oral informed consent after being briefed about the study's purpose, procedures, and voluntary nature. To safeguard confidentiality, hospitals and individual respondents were anonymized, with identifying details removed during transcription and reporting. Data were securely stored with restricted access to the research team. Special attention was given to power dynamics between hospital staff and patients, ensuring patient voices were respected and not overshadowed by institutional authority. This ethical rigor strengthened the study's credibility and integrity.

Conflict of Interest

The authors declare that they have no conflicts of interest.

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