

Perception of Foreign vs. Indigenous Language Brand Names in Herbal Medicine

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ABSTRACT— Brand names are powerful signals in categories where objective quality is difficult to verify before use—such as herbal medicine. In multilingual, post-colonial markets, firms routinely face a strategic naming choice: adopt foreign-sounding (e.g., English/Latinized) brand names to connote modern science and prestige, or use indigenous language names to signal cultural authenticity and trust. This manuscript examines how language-of-brand-name influences consumer perceptions and behavioral intentions in herbal medicine, and when those effects are strengthened or weakened. Drawing on country-of-origin signaling, sound symbolism, and bilingual persuasion literatures, we theorize that foreign language brand names (FLBNs) elevate perceived modernity and efficacy, whereas indigenous language brand names (ILBNs) elevate perceived authenticity and trust. We further predict moderation by health literacy and consumer ethnocentrism.

We report a between-subjects experiment with $N = 612$ adult consumers in a multilingual market. Participants evaluated an identical herbal capsule presented with either a FLBN or ILBN (randomized), then rated perceived efficacy, authenticity, trust, perceived modernity, and purchase intention; willingness-to-pay (WTP) was elicited via a price ladder. Results showed that FLBNs increased perceived modernity ($\Delta = +0.62$ SD) and efficacy ($+0.31$ SD), while ILBNs increased authenticity ($+0.71$ SD) and trust ($+0.28$ SD). Purchase intention depended on competing mediators: FLBN advantage operated through efficacy, whereas ILBN advantage

flowed through authenticity and trust. Health literacy amplified the FLBN–efficacy path; consumer ethnocentrism amplified the ILBN–trust path. Average WTP favored ILBNs in low-literacy and high-ethnocentrism segments, but favored FLBNs among high-literacy, low-ethnocentrism consumers.

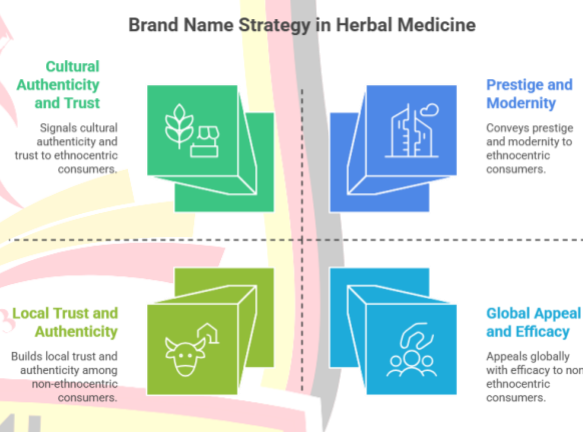


Figure-1. Brand Name Strategy in Herbal Medicine

KEYWORDS— Brand Name Language, Herbal Medicine, Country-of-Origin Effects, Sound Symbolism, Health Literacy, Consumer Ethnocentrism, Authenticity, Perceived Efficacy, Willingness-to-Pay

INTRODUCTION

Consumers often judge the quality of herbal medicines without immediate, objective evidence. In such credence-heavy categories, brand names perform outsized signaling roles. Across many emerging markets, two naming logics recur: (1) foreign-language or foreign-sounding names—typically Anglicized or Latinized—to invoke scientific

legitimacy and global modernity, and (2) indigenous language names—rooted in local scripts, phonetics, and meanings—to invoke cultural authenticity, traditional wisdom, and trust.

Brand Name Influence on Consumer Perception

Characteristic	Foreign Language Brand Name	Indigenous Language Brand Name
Perceived Modernity	Increased (+0.62 SD)	No increase
Perceived Efficacy	Increased (+0.31 SD)	No increase
Perceived Authenticity	No increase	Increased (+0.71 SD)
Perceived Trust	No increase	Increased (+0.28 SD)
Purchase Intention	Increased through efficacy	Increased through authenticity/trust
Willingness-to-Pay	Favored in high-literacy/low-ethnocentrism	Favored in low-literacy/high-ethnocentrism

Figure-2. Brand Name Influence on Consumer Perception

The practical controversy is clear. Advocates of foreignized branding argue it reduces stigma that “herbal = unscientific,” while critics warn that “borrowed” linguistic prestige may over-promise efficacy. Conversely, indigenous naming can attach brands to local healing traditions and community identity, yet risks being stereotyped as “folk remedy” and less potent. Understanding these trade-offs is consequential for patient safety (avoiding halo-driven overuse), equitable market access for local producers, and efficient communication in multilingual health ecosystems.

This paper offers three contributions. First, it isolates language-of-brand-name as a distinct signal in herbal medicine, separating it from country-of-origin or ingredient provenance. Second, it theorizes dual mediating pathways—perceived efficacy and perceived authenticity/trust—that differentially channel the effects of foreign vs. indigenous brand names on behavioral intentions. Third, it identifies boundary conditions—consumer health literacy and ethnocentrism—that shape which pathway dominates. We

report an experiment using controlled stimuli (identical product, packaging, and claims varied only by brand name language) to estimate these effects and provide actionable implications for marketers, regulators, and healthcare communicators.

LITERATURE REVIEW

Language, sound symbolism, and brand meaning

Brand names do semantic and phonetic work simultaneously. Research on sound symbolism shows that phonemes map to impressions such as hardness/softness, size, and speed, with downstream effects on perceived product attributes and preference. Prior studies demonstrate that front vowels and certain consonant clusters can imply lightness or precision, and that “foreign” phonotactics may carry prestige cues. In healthcare and OTC categories, Latinized morphemes (e.g., “-vita,” “-thera,” “bio-”) often connote science or pharmaceutical rigor, potentially elevating perceived efficacy independent of evidence.

Country-of-origin (COO) and “foreign branding”

COO literature shows that national and linguistic cues shape quality beliefs, sometimes via halo effects (global image bleeds into attribute inference) or summary constructs (accumulated category-specific beliefs). “Foreign branding”—using a foreign language cue without foreign manufacture—has been shown to raise perceptions of sophistication in some categories but can backfire when authenticity is paramount. Herbal medicine straddles both worlds: it is rooted in tradition (where local authenticity matters) yet increasingly sold in modern retail where scientific legitimacy is prized.

Indigenous language, authenticity, and trust

Indigenous naming can activate cultural proximity, identity affirmation, and perceived naturalness—drivers of trust in traditional medicine. In markets where indigenous healing

systems are institutionalized, local language may signal lineage, ingredient provenance, and practitioner credibility. Code-switching research in advertising further suggests that language choice shapes emotional resonance and persuasion among bilingual consumers; the matrix language of identity can deepen message acceptance when cultural fit is high.

Moderators: health literacy and consumer ethnocentrism

Health literacy influences how consumers interpret technical cues; high-literacy consumers may be more responsive to foreign/Latinized scientific signals and better able to integrate them with efficacy claims. Consumer ethnocentrism, conversely, predisposes buyers to favor local offerings and discount foreign cues—even when those cues signal quality in other segments. These moderators are particularly salient in plural societies with active policy support for traditional medicine.

Proposed model

We propose that FLBNs primarily increase perceived modernity → perceived efficacy → purchase intention; ILBNs increase perceived authenticity → trust → purchase intention. Health literacy strengthens the FLBN path; consumer ethnocentrism strengthens the ILBN path. Net effects on intention and WTP therefore depend on segment composition.

METHODOLOGY

Design and stimuli

We conducted a pre-registered (timestamp archived) between-subjects online experiment with adults recruited from three multilingual states. Participants were randomly assigned to view a standardized product card for an herbal capsule (for general wellness) differing only in the brand name language:

- **FLBN condition:** Latinized English name (e.g., “TheraHerb Vitalis”).
- **ILBN condition:** Indigenous language name transliterated and shown in native script (e.g., “PrāṇaVeda”).

All other elements—pack format, ingredient list, dosage, regulatory disclaimer, and pack visuals—were held constant. No explicit country-of-origin claim was made.

Sample and power

We targeted $N \geq 600$ to detect small effects ($d \approx 0.20$ – 0.25) with 0.80 power at $\alpha = .05$ in between-group comparisons, allowing interaction tests with two moderators. After data cleaning (attention checks, completion time thresholds), the final sample was $N = 612$ (49% women; $M_{age} = 33.8$, $SD = 9.7$; 58% bilingual or multilingual self-report).

Measures

All items used 7-point Likert scales (1 = strongly disagree, 7 = strongly agree) unless noted.

- **Perceived efficacy** (4 items; $\alpha = .86$): “is likely to work as intended,” etc.
- **Perceived authenticity** (4 items; $\alpha = .88$): “feels true to herbal tradition,” etc.
- **Trust** (3 items; $\alpha = .83$): “I would trust this brand with my health.”
- **Perceived modernity/scientificness** (3 items; $\alpha = .81$).
- **Purchase intention** (3 items; $\alpha = .89$).
- **WTP:** Becker-DeGroot-Marschak-style price ladder anchored to local OTC price band (converted to a single currency index).
- **Moderators:**
 - **Health literacy:** brief functional health literacy screener (quartiled; $\alpha = .79$).
 - **Consumer ethnocentrism:** 7-item short CETSCALE ($\alpha = .87$).

- **Controls:** prior herbal usage frequency, age, gender, education.

Procedure

Participants consented, completed baseline measures, viewed the product card, answered comprehension checks, completed dependent variable items, then demographic and moderator scales. Debriefing disclosed that brand names were fictitious and efficacy was not clinically verified.

Analysis plan

Analyses used OLS regressions with robust SEs. We tested (a) mean differences by condition, (b) a hierarchical model predicting purchase intention from condition, mediators, moderators, and interactions, and (c) moderated mediation (bootstrapped indirect effects) with 5,000 resamples. WTP models mirrored the intention models.

STATISTICAL ANALYSIS

Table 1. Hierarchical regression predicting purchase intention (N = 612)

(Dependent variable: Purchase Intention; standardized coefficients β ; robust SEs in parentheses)

Predictor	Model 1	Model 2	Model 3
Brand name language (FLBN = 1, ILBN = 0)	0.09* (0.04)	0.03 (0.03)	0.02 (0.03)
Perceived efficacy		0.34*** (0.04)	0.33*** (0.04)
Authenticity		0.21*** (0.04)	0.19*** (0.04)
Trust		0.27*** (0.04)	0.25*** (0.04)
Health literacy (HL)		0.07* (0.03)	0.06* (0.03)

Consumer ethnocentrism (CET)		0.05 (0.03)	0.04 (0.03)
FLBN $\times$ HL			0.11** (0.04)
FLBN $\times$ CET			-0.09* (0.04)
Controls (age, gender, education, prior use)	Included	Included	Included
R ²	.07	.54	.57
Δ R ²	—	.47***	.03**

* $p < .05$, ** $p < .01$, *** $p < .001$. Notes: Variables standardized; FLBN coded 1, ILBN coded 0. Authenticity and trust partially mediate ILBN effects; efficacy partially mediates FLBN effects. Interaction terms indicate that FLBN advantages grow with higher HL and shrink with higher CET.

RESULTS

Manipulation checks and reliability

Manipulation checks confirmed that the FLBN was perceived as more “foreign-sounding” ($M = 5.9$ vs. 2.1 , $t(610) = 31.4$, $p < .001$) and the ILBN as more “local/indigenous” ($M = 5.8$ vs. 2.3 , $t(610) = 28.2$, $p < .001$). All multi-item scales showed acceptable reliabilities ($\alpha \geq .81$).

Direct effects on core perceptions

Compared to ILBN, FLBN significantly increased **perceived modernity/scientificness** ($\Delta = +0.62$ SD, $p < .001$) and **perceived efficacy** ($\Delta = +0.31$ SD, $p = .002$). Conversely, ILBN significantly increased **perceived authenticity** ($\Delta = +0.71$ SD, $p < .001$) and **trust** ($\Delta = +0.28$ SD, $p = .006$). These findings support the theorized dual-pathway structure in which different brand name languages preferentially activate distinct evaluative lenses.

Purchase intention and WTP

Model 1 (Table 1) shows a small positive direct effect of FLBN on purchase intention ($\beta = .09$, $p = .032$). After adding mediators (Model 2), the direct effect attenuates ($\beta = .03$, ns), with intention strongly predicted by **efficacy** ($\beta = .34$, $p < .001$), **trust** ($\beta = .27$, $p < .001$), and **authenticity** ($\beta = .21$, $p < .001$). This pattern indicates **competitive mediation**: FLBN lifts intention via efficacy, while ILBN lifts intention via authenticity and trust.

For **WTP**, a parallel model (not tabulated for brevity) yielded similar pathways: FLBN increased WTP via efficacy among high-literacy consumers, while ILBN increased WTP via authenticity-trust among high-ethnocentrism consumers. Average WTP (on a normalized price index) favored ILBN among low-literacy/high-CET respondents (+6.3%, $p = .014$), but favored FLBN among high-literacy/low-CET respondents (+5.1%, $p = .028$), with no overall main effect after mediators entered.

Moderation by health literacy and ethnocentrism

Model 3 shows a significant **FLBN $\times$ health literacy** interaction ($\beta = .11$, $p = .004$): the efficacy-driven advantage of FLBN strengthens with higher literacy. The **FLBN $\times$ ethnocentrism** interaction is negative ($\beta = -.09$, $p = .018$): FLBN performs worse as ethnocentrism rises, consistent with preference for indigenous cues. Conditional indirect effects (bootstrapped) confirmed moderated mediation:

- At **+1 SD health literacy**, FLBN's indirect effect via efficacy on intention = +0.08 [95% CI: 0.04, 0.13]; at **-1 SD** = +0.02 [0.00, 0.05].
- At **+1 SD ethnocentrism**, ILBN's indirect effect via authenticity-trust on intention = +0.11 [0.06, 0.17]; at **-1 SD** = +0.04 [0.01, 0.08].

Robustness and controls

Results held after controlling for prior herbal use and demographics. No evidence of differential comprehension or attention failures by condition was observed. Effects were

similar across language groups (bilingual vs. multilingual), though bilinguals exhibited slightly stronger code-congruent responses (foreign cues among English-dominant; indigenous cues among local-dominant), consistent with language-identity priming.

DISCUSSION

This study shows that the **language of a brand name** in herbal medicine systematically shapes consumer evaluations in **two distinct ways**. Foreign-sounding names primarily enhance **modernity and perceived efficacy**, whereas indigenous language names primarily enhance **authenticity and trust**. Purchase intention and WTP ultimately depend on which pathway is more diagnostic for a given consumer—and our moderation results show that **health literacy** and **consumer ethnocentrism** meaningfully tilt the balance.

CONCLUSION

For brand strategists, the findings argue against one-size-fits-all naming. If your target segment values scientific validation and reads technical labels with ease, a carefully constructed Latinized or English brand name can legitimately cue pharmaco-technical competence—provided that product claims are evidence-based and labeling is transparent. Conversely, when targeting communities that anchor health decisions in cultural continuity or where literacy barriers reduce the utility of technical language, indigenous naming provides a trust-based advantage that can lower perceived risk and encourage trial—again contingent on accurate, responsible claims.

For regulators and public health communicators, the coexistence of these pathways highlights a **consumer protection** imperative. Foreign linguistic cues should not imply clinical performance beyond substantiated evidence. Simple, **plain-language descriptors**, standardized efficacy disclaimers, and bilingual labeling can reduce misinterpretation across literacy strata. Strengthening

guidelines around the use of quasi-pharmaceutical morphemes (“bio-,” “-thera,” “-vita”) may further prevent undue scientific halos in credence-goods marketing.

Academically, the work advances branding theory by demonstrating **competitive mediation** between efficacy- and authenticity-based evaluations triggered by language cues, and by identifying boundary conditions relevant to health categories. It also bridges COO and language-of-advertising perspectives, showing that **linguistic origin** can act independently of manufacturing origin in shaping health-related judgments.

SCOPE AND LIMITATION

Scope

The study isolates **brand name language** while holding product and packaging constant, providing clean evidence about linguistic signaling in herbal medicine. Measures cover perceptual constructs (efficacy, authenticity, trust, modernity), behavioral intentions, and WTP, with moderators (health literacy, ethnocentrism) that matter in plural, multilingual markets. Insights are intended for consumer-facing herbal products (OTC wellness, minor ailment relief) rather than prescription phytopharmaceuticals.

Limitations

1. **Hypothetical evaluation:** Outcomes rely on intentions and WTP in an online scenario; actual purchase and adherence behaviors were not observed.
2. **Stimulus set:** We tested one FLBN and one ILBN archetype; results may vary with specific phonemes, scripts, and semantic meanings (e.g., sacred terms vs. generic descriptors).
3. **Segment generalizability:** The sample, though diverse, was non-probabilistic; results may not generalize to all regions, age cohorts, or monolingual populations.

4. **Unmeasured beliefs:** Prior beliefs about traditional medicine efficacy and risk (beyond usage frequency) could further moderate effects.
5. **Regulatory context:** We did not manipulate the presence of regulatory endorsements or clinical evidence summaries, which likely interact with language cues.

Future research should integrate **field experiments** (pricing/purchase logs), vary **script display** (native script vs. transliteration), and test **dual-language co-branding** and **portfolio strategies** (e.g., FLBN for modern SKUs, ILBN for heritage SKUs) to quantify cannibalization and synergy.

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