



Self-Medication Practices Among Non-Medical Healthcare Workers in Tertiary Care Hospital

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SUMMARY

Introduction: Self-medication is common in India and highly prevalent among healthcare professionals. It may be frequent among non-medical healthcare workers who have easy access to medicines but limited formal training in rational drug use.

Aim: To evaluate the prevalence, patterns, and determinants of self-medication among non-medical healthcare workers in a tertiary-care teaching hospital in South India.

Material and Method: A cross-sectional and non-interventional academic study was conducted among 260 non-medical healthcare employees (Group B, C, and D) at a tertiary-care teaching hospital in Mysore after obtaining approval of the Institutional Ethics Committee. Data were collected using a pre-validated questionnaire after obtaining written informed consent. Descriptive statistics were used to analyse the data, and chi-square test and independent t test were applied to explore associations between self-medication and socio-demographic or health-related factors, with $p < 0.05$ considered significant. Multivariable logistic regression analysis was used to find association between the various determinants and self medication.

Results: The mean age of participants was 40.1 years, the majority were female (68.1%), Group D employees (73.8%), urban residents (90%), and below the poverty line (69.2%). The prevalence of self-medication was 73.8% in non-medical healthcare workers. It was more common in younger workers, females, those with longer work experience, smokers, and those with a past history of disease. Common reasons included convenience, previous prescriptions, and perception of minor illness. Frequently used medicines were paracetamol, analgesics, and antacids. Most participants were somewhat aware of the ill effects of self-medication, and over 90% might or would definitely consider stopping after understanding the risks.

Conclusion: Self-medication is highly prevalent among non-medical healthcare workers for minor illnesses using easily available medicines, but many express willingness to modify this behavior. Workplace-based education and stricter control of non-prescription drug use may help promote safer medicine practices.

Keywords: Non-Medical Healthcare Workers, OTC Drugs, Prevalence, Self-Medication

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INTRODUCTION

World Health Organization [WHO] has defined self-medication (SM) as “use of pharmaceutical or medicinal products by the consumer to treat self-recognized disorders or symptoms, the intermittent or continued use of a medication previously prescribed by a physician for chronic or recurring disease or symptom, or the use of medication recommended by non-prescribing health staff” [1]. It involves obtaining medications without a prescription, taking medicines on the advice of pharmacists, relatives or friends without consulting a medical professional, sharing medicines with family members /friends or using leftover stored medications [2]. SM should be seen as the ability and desire of patients to play an independent and informed role, not only in terms of decision-making but also in the management of those diagnostic, therapeutic and preventive activities [3]. Among healthcare workers SM is usually practiced due to work stress, perceived familiarity with pharmacotherapy, and easy access to pharmacy. This can result in posing public health problems such as antimicrobial resistance and individual risk of misdiagnosis, adverse drug reactions, drug interactions, incorrect dosing, and masking of underlying disease leading to complications [4-6].

In India, prevalence of SM ranges from 11.9% to 92.8% across various populations which is driven by factors such as easy accessibility, over-the-counter availability, economic considerations, and cultural norms favoring pharmacy consultations for minor ailments [7-10]. The COVID-19 pandemic enhanced these practices in India, with studies reporting up to 47.8% prevalence among healthcare workers either for prevention or treatment due to fear of infection [11-12].

Despite high awareness levels, a persistent knowledge-attitude-practice gap exists, especially among non-medical healthcare workers who influence community behaviors. There are not many studies conducted to find out the factors influencing SM among non-medical healthcare workers in hospitals/institutions. This study was conducted to find out the factors influencing SM practices, and relationship between selected sociodemographic variables of the respondents and its practice amongst non-medical healthcare personnel working in the tertiary care hospital of South

India.

AIM

This study aims to evaluate the prevalence, patterns, and determinants of self-medication among non-medical healthcare workers in a tertiary-care teaching hospital in South India.

MATERIAL AND METHODS

A cross-sectional, observational academic study was conducted among non-medical healthcare personnel at a tertiary-care teaching hospital in Mysore, India. Approval was obtained from the Institutional Ethics Committee (MMCRI/ECR/134/RR-19) prior to study initiation. Written informed consent was obtained from all participants in their primary language (Kannada) before enrolment and was approved by two independent reviewers and administered in person during working hours after obtaining written informed consent in their native language. The questionnaire was administered face-to-face by the principal investigator who was not in direct supervisory line and confidential with an assurance that responses would not affect employment.

Assuming a total institutional population of 800 non-medical healthcare employees, a target sample size of 260 was calculated to achieve a 95% confidence level with a 5% margin of error, ensuring representation across all designated occupational strata.

Operational definition of non-medical health care workers (Group B, C, and D) based on the „WHO Classification of health workforce statistics” which defines the group as classified under healthcare management and support personnel, including non-health technicians and associates (bookkeeper, computer network technician, data entry supervisor, forensic science technician, health insurance claims officer, water treatment plant operator), clerical support workers (general office clerk, secretary, general receptionist, accounts clerk, data entry clerk, health insurance clerk, hospital admissions clerk, human resource assistant, medical appointments schedule clerk, payroll clerk), service and sales workers (building caretaker, cafeteria cook, hospital security guard), and elementary occupations (hospital garden laborer, kitchen helper, lavatory attendant, refuse collector, cleaner) [13]. Healthcare professionals with medical, paramedical, nurs-

ing, and pharmacy qualifications were excluded.

Data were entered using Microsoft Excel® (Version 2024, Microsoft Corp., Redmond, WA) and analyzed using IBM SPSS Statistics for Windows, Version 25.0 (IBM Corp., Armonk, NY). Continuous variables were presented as mean $\pm$ standard deviation (SD), and categorical variables were expressed as absolute frequencies and percentages (n, %).

The chi-square test and independent t-test were used to establish an association between SM practices and various factors with odds ratios (ORs) with 95% confidence intervals (CI). Variables with significant associations were intended for multivariable logistic regression to estimate adjusted odds ratio (aOR) and 95% CI. To account for multiple comparisons, Bonferroni correction was applied and adjusted threshold was set at $p < 0.05/m$, where m was the number of statisti-

cal tests performed.

RESULTS

This cross-sectional study was conducted at a tertiary care teaching hospital in South India over three months.

A total of 260 non-medical healthcare workers participated in this study. The overall mean age was 40.13 ± 10.07 years (range: 21-58 years), and females comprised the majority of the study population (n = 177, 68.1%).

Regarding occupational classification, most participants were Group D employees (n = 192, 73.8%), followed by secondary education attainment (n = 92, 35.4% high school education). Most respondents resided in urban areas (n = 234, 90.0%) and were classified below the poverty line (n = 180, 69.2%).

The mean BMI of the cohort was 24.19 ± 4.48 kg/m². The majority of partici-

Table 1. Sociodemographic characteristics of study participants (n=260) with result of chi-square test for association of self-medication practice with various factors. Statistical significance was interpreted using Bonferroni correction (adjusted threshold $p < 0.004$)

* - significant p value
- reference parameter for odds ratio calculation
OR - Odds ratio
CI - Confidence interval

Parameter	Category	n (%)	Self-Medication		OR (95% CI)	p-value
			Yes=192 (%)	No=68 (%)		
Gender	Female [#]	177 (68.1)	141 (73.4)	36 (52.9)	2.45 (1.37-4.38)	0.003*
	Male	83 (31.9)	51 (26.5)	32 (47.1)		
Education Level	No formal education [#]	70 (26.9)	45 (23.4)	25 (36.8)	0.52 (0.28-0.96)	<0.001*
	Formal education (Primary, High School, Graduation)	190 (73.1)	147 (76.6)	43 (63.2)		
Work Strata	Group D [#]	192 (73.8)	156 (81.2)	37 (54.5)	3.63 (1.98-6.65)	<0.001*
	Group B & C	68 (26.2)	36 (18.8)	31 (45.5)		
Residence	Urban [#]	234 (90)	171 (89.1)	63 (92.7)	0.64 (0.23-1.8)	0.541
	Rural	26 (10)	21 (10.9)	5 (7.3)		
Socio economic Status	Below Poverty Line [#]	180 (69.2)	149 (77.6)	31 (45.6)	4.13 (2.28-7.47)	<0.001*
	Above Poverty Line	80 (30.8)	43 (22.4)	37 (54.4)		
Work Experience	>10 years [#]	97 (37.3)	65 (33.9)	32 (47.1)	0.52 (0.33-1.03)	0.037
	<10 years	163 (62.7)	125 (65.1)	36 (52.9)		
Smoking status	Yes [#]	22 (8.5)	6 (3.1)	16 (23.5)	0.1 (0.03-0.28)	<0.001*
	No	238 (91.5)	186 (96.8)	52 (76.5)		
Alcohol consumption	Yes [#]	21 (8.1)	16 (8.3)	5 (7.3)	1.14 (0.39-3.29)	1.000
	No	239 (91.9)	176 (91.6)	63 (92.7)		
Regular exercise	Yes [#]	53 (20.4)	33 (17.1)	20 (29.4)	0.49 (0.26-0.95)	<0.001*
	No	207 (79.6)	159 (82.8)	48 (70.6)		
Sleep status	Not disturbed [#]	153 (58.8)	110 (57.2)	43 (63.2)	0.77 (0.43-1.38)	0.476
	Disturbed	107 (41.2)	82 (42.7)	25 (36.8)		
Current disease	Yes [#]	58 (22.3)	33 (17.1)	25 (36.8)	0.35 (0.19-0.66)	0.002*
	No	202 (77.7)	159 (82.8)	43 (63.2)		
Past History of Disease	Yes [#]	31 (11.9)	10 (5.2)	21 (30.9)	0.12 (0.05-0.28)	<0.001*
	No	229 (88.1)	182 (94.8)	47 (69.1)		

Parameter	Adjusted OR	95% CI	p-value
Gender (female [#])	3.32	1.31 - 8.45	0.012*
Education Level (no formal education [#])	1.60	0.97 - 2.62	0.065
Work Strata (group D [#])	0.06	0.01 - 0.32	0.001*
Work Experience (> 10 years [#])	6.09	1.46 - 25.48	0.013*
Socio economic Status (below poverty line [#])	3.53	1.02 - 12.18	0.046*
Smoking status (Smokers [#])	3.14	0.68 - 14.44	0.142
Regular exercise [#]	0.48	0.14 - 1.61	0.235
Past History of Disease [#]	5.48	1.83 - 16.41	0.002*

Table 2. Multivariable logistic regression analysis of factors associated with self-medication practice

aOR - adjusted odds ratio
CI - confidence interval
- reference category
* - Statistically significant values (p < 0.05)

pants, 79.6% (n=207) did not perform regular exercise, and 41.2% (n=107) reported sleep disturbance.

The independent t-test was used to analyze the association of age with SM. Participants who practiced self-medication had a significantly lower mean age than those who did not practice self-medication (38.87 ± 9.95 years vs. 43.68 ± 9.63 years, respectively; $t = -3.51$, $p < 0.001$). Chi-square analysis was performed for categorical variables to assess the association between sociodemographic and lifestyle factors with practices. In bivariate analysis, gender, educational qualification, work strata, socioeconomic status, smoking habits, exercise, current and past history of disease were significantly associated with self-medication practice. Parameters showing significant association are depicted in Table 1.

To assess independent associations while controlling for confounding, multivariable logistic regression was performed. After adjusting for age, sex, education, job group,

work experience, socioeconomic status, smoking, and exercise, past history of disease remained independently associated with self-medication practice. Participants without a past history of disease had significantly higher odds of practising self-medication compared with those with a past history of disease (aOR = 5.48; 95% CI: 1.83–16.41; $p = 0.002$) (Table 2).

The majority reported positive health perception, with 51.5% (n=134) very satisfied and 28.8% (n=75) satisfied with their health status. The prevalence of SM was 73.8% (n=192) among non-medical healthcare workers, and most participants (69.6%) were not against SM. The majority had used drugs after self-diagnosis (63.5%, n=165). It was practiced often by 44.6% (n=86) of the participants, followed by 14.6% (n=29) of the participants who always practiced SM. It was practiced in the last month by 35.4% (n=68) of the participants. The various reasons for practicing SM are illustrated in Figure 1.

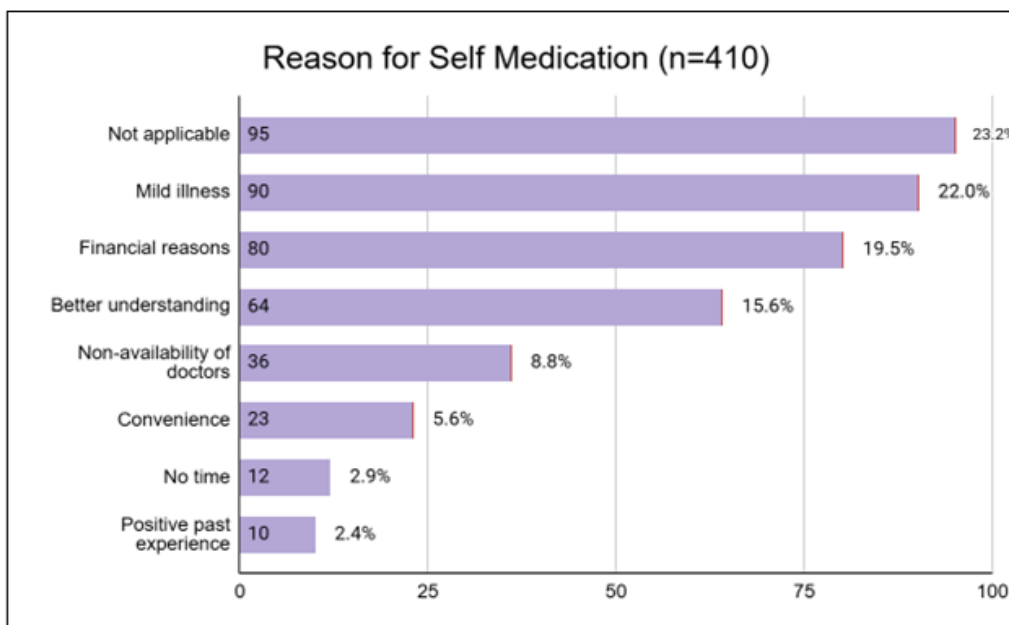
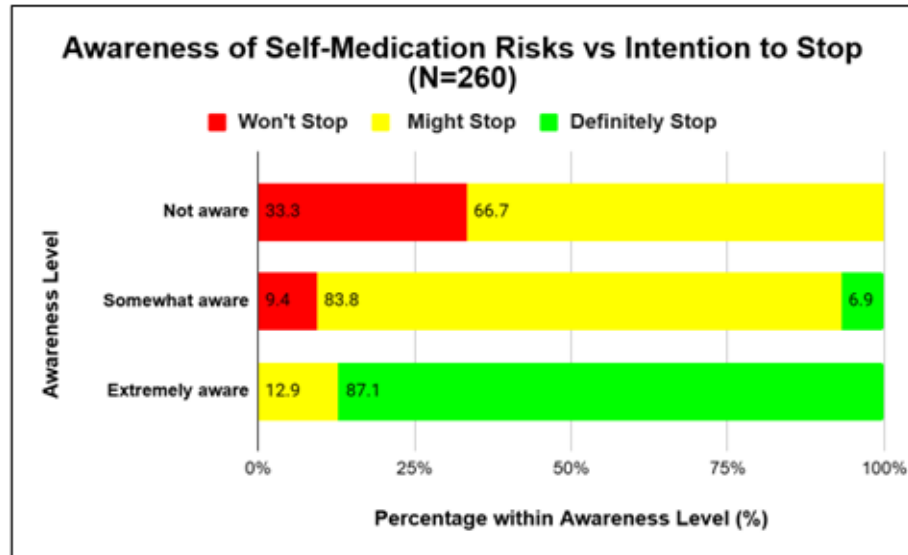


Figure 1. Various reasons for self-medication practice by non-medical healthcare workers. (n=410 as few participants had more than one reason)

Figure 2. Awareness of self-medication ill effects and intention to stop by awareness level, n=260



Previous prescriptions were the predominant procurement method (36.2%, n= 69) and allopathic medicines were usually sought for treatment by 96.5% (n=185) of medication users. SM was most commonly practiced for oneself (35%, n= 67) rather than for family members or friends.

The most commonly used drugs for SM were paracetamol, analgesics (diclofenac, nimesulide), antihistamines (cough-cold preparations), and antacids for conditions such as fever, headache, and gastritis, accounting for 55.2% (n=106), 31.7% (n=61), 26.5% (n=51), and 20.8% (n=40) respectively.

Healthcare knowledge was perceived to help SM practices (54.2%, n=104) and healthcare workers were the predominant source of information (67.3%, n=129). Media endorsement influenced around 6.2% (n=12) of SM users. The majority were aware of the ill effects of SM, with 61.5% (n=118) being somewhat aware and 32.7% (n=63) extremely aware. Most participants would consider stopping SM (59.6%, n=114 might consider it, 32.7% n=63 definitely consider it) (Figure 2).

DISCUSSION

Self-medication among non-medical healthcare workers represents a critical occupational health and drug safety issue. Easy workplace access to hospital dispensaries, combined with time constraints, often promotes rationalized yet unsafe pharmaceutical self-administration.

In the present study, the prevalence of self-medication among non-medical healthcare workers was 73.8%, which aligns with

findings of Kumar V et al., of 92.8%, while Panda A et al., reported 18.7%. This shows highly variable rates across diverse healthcare worker populations despite differences in professional exposures [14-15]. Among respondents, 35.4% had used within the past one month, while the overall SM measure was based on self-reported practice without a uniform recall window.

SM is widely followed by women due to their greater health-seeking behavior, societal pressures, as they prioritise family work over their own health. This explains the higher drug use among female non-medical healthcare workers. However, previous studies reveal that females are inclined towards procuring drugs from pharmacies and inform the doctors during consultation and do not share their medicines with others [16]. High recent practice rates of SM observed in our study can be a result of occupational health demands like continuous shift timings, prolonged working hours and excessive workload [17].

In previous studies, workers with a history of disease were more likely to self-medicate than those without comorbidities. This practice is attributable to the increased awareness about their health condition or an extra care to take no chance to worsen the pre-existing illness [18]. Also, workers with experience of more than 10 years were more likely to self-medicate when compared to freshers, which is consistent with an earlier study. This association can be explained by familiarity of the medicines, advancing age, presence of comorbid disease and easy access due to hierarchical position [19].

In this study, for minor acute condi-

tions such as fever, headache, and gastritis, workers self-medicated using over-the-counter (OTC) drugs such as antipyretics, analgesics, and antacids. In a study on health professional students, it was observed that analgesics (81.2%) and antipyretics (67.6%) were most frequently used for complaints such as fever with chills (62.5%) and headache (40%). However, the use of antimicrobial as SM was not encountered in this study. The participants feel that medical knowledge obtained through observation and experience over the years and ease of access allows them to manage minor ailments without formal consultation [20].

Multivariable logistic regression identified female sex, lower educational attainment, Group D employment, >10 years of work experience, low socioeconomic status, and a personal history of medical illness as independent determinants of self-medication. These findings indicate that these factors independently influence the practice of SM among non-medical healthcare personnel [21].

Studies have observed that mild disease, time constraints, accessibility, lower expense, previous experience, mild illness, quick relief, and economic considerations are the most sought reasons for SM. Across various settings and populations including healthcare workers and the general population, who rationalize the use of self-medication due to above reasons [22-23].

Lolla and Kotakala noted that 81.5% of medical staff continued self-medication despite acknowledging its hazards. Similarly, Easwaran et al. reported that 85.6% of healthcare students had adequate knowledge and 84.8% had a positive attitude towards the risks of SM, yet only 15.9% were willing to stop. In contrast, 59.6% of non-medical healthcare workers in our study might consider stopping after understanding its ill effects. This suggests that targeted educational interventions in this group may more readily translate into behavior change than in healthcare populations [24-26].

Since this was a single-center study conducted in a tertiary care hospital the findings may not be fully generalizable to non-medical personnel in primary care facilities or other geographic regions. There is a chance of recall bias as self-medication practice was assessed using a self-reported questionnaire without a uniform recall window. Also we did not verify medicines with prescriptions for the

exact drugs, doses, and duration of use. As this was a cross-sectional study, we could only show the existence of associations and could not establish causal relationships.

CONCLUSION

Self-medication was highly prevalent among non-medical healthcare workers. Convenience, perceived mild symptoms, and workload were the common reasons to self-medicate. However, a substantial proportion expressed willingness to stop or reduce self-medication, highlighting the importance of targeted education and interventions, which can curb this irrational practice. Strengthening the regulation of over the counter drug sales and providing workplace-based awareness programs may help promote safer medicine use among non-medical healthcare personnel.

CONFLICT OF INTEREST

All authors declare no conflict of interest.

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Praksa samolečenja među nemedicinskim zdravstvenim radnicima u tercijarnoj zdravstvenoj ustanovi

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KRATAK SADRŽAJ

Uvod: Samolečenje je česta pojava u Indiji i veoma je rasprostranjeno među zdravstvenim radnicima. Može biti naročito učestalo među nemedicinskim zdravstvenim radnicima koji imaju lak pristup lekovima, ali ograničeno formalno obrazovanje o racionalnoj primeni lekova.

Cilj: Ispitati prevalenciju, obrasce i determinante samolečenja među nemedicinskim zdravstvenim radnicima u tercijarnoj nastavnoj bolnici u južnoj Indiji.

Materijal i metode: Sprovedena je studija preseka, neintervenciona akademska studija faze IV, među 260 nemedicinskih zdravstvenih radnika (grupe B, C i D) u tercijarnoj bolnici u Majsuru, nakon odobrenja Institucionalnog etičkog odbora. Podaci su prikupljeni pomoću prethodno validiranog upitnika nakon pribavljanja pisanog informisanog pristanka učesnika. Za analizu podataka korišćena je deskriptivna statistika, dok su hi-kvadrat test i nezavisni t-test primenjeni za ispitivanje povezanosti između samolečenja i sociodemografskih, odnosno zdravstvenih faktora, pri čemu je vrednost $p < 0,05$ smatrana statistički značajnom. Multivarijabilna logistička regresiona analiza korišćena je za ispitivanje povezanosti između različitih determinanti i samolečenja.

Rezultati: Prosečna starost ispitanika iznosila je 40,1 godinu. Većinu su činile žene (68,1%), radnici grupe D (73,8%), stanovnici urbanih sredina (90%) i osobe koje žive ispod granice siromaštva (69,2%). Prevalencija samolečenja među nemedicinskim zdravstvenim radnicima iznosila je 73,8%. Samolečenje je bilo češće među mlađim zaposlenima, ženama, osobama sa dužim radnim stažom, pušačima i ispitanicima sa prethodnom istorijom bolesti. Najčešći razlozi za samolečenje bili su praktičnost, prethodno dobijeni lekarski recepti i uverenje da se radi o blagim zdravstvenim tegobama. Najčešće korišćeni lekovi bili su paracetamol, analgetici i antacidi. Većina ispitanika bila je donekle upoznata sa štetnim posledicama samolečenja, a više od 90% je navelo da bi verovatno ili sigurno odustalo od ove prakse nakon upoznavanja sa mogućim rizicima.

Zaključak: Samolečenje je veoma rasprostranjeno među nemedicinskim zdravstvenim radnicima i najčešće se primenjuje kod blagih zdravstvenih tegoba uz upotrebu lako dostupnih lekova. Ipak, veliki broj ispitanika iskazao je spremnost da promeni ovakvo ponašanje. Edukacija na radnom mestu i stroža kontrola upotrebe lekova koji se izdaju bez recepta mogli bi doprineti unapređenju bezbedne primene lekova.

Ključne reči: nemedicinski zdravstveni radnici, lekovi koji se izdaju bez recepta (OTC), prevalencija, samolečenje

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