
**“PREVALENCE OF SELF-MEDICATION
PRACTICES IN THE URBAN AREAS OF
BELAGAVI, KARNATAKA; A COMMUNITY
BASED STUDY ”**

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LIST OF ABBREVIATIONS USED

AMR	:	Antimicrobial Resistance
CF	:	Correction Factor
CHT	:	Chittagong Hill Tracts
COVID	:	Coronavirus Disease
CPI-IW	:	Consumer Price Index for Industrial Workers
CPM	:	Chlorpheniramine Maleate
JNMC	:	Jawaharlal Nehru Medical College
KPMG	:	Klynveld Peat Marwick Goerdeler International Limited
OTC	:	Over the Counter drugs
PRISMA	:	Preferred Reporting Items for Systematic Review and Meta Analysis
SM	:	Self Medication
SMA	:	Self Medication with Antibiotics
SPSS	:	Statistical Package for the Social Sciences
UHC	:	Urban Health Centre
WHO	:	World Health Organisation

ABSTRACT

“PREVALENCE OF SELF-MEDICATION PRACTICES IN THE URBAN AREAS OF BELAGAVI, KARNATAKA; A COMMUNITY BASED STUDY ”

Introduction

Self-medication, defined as the use of pharmaceuticals to treat self-diagnosed conditions without professional guidance, is a common practice worldwide. In India, the prevalence of self-medication is notably high due to factors such as the easy accessibility of over-the-counter (OTC) medications, financial constraints, and limited access to healthcare services. This widespread practice poses significant public health risks, including adverse drug reactions and the development of antimicrobial resistance. Understanding the prevalence and sociodemographic determinants of self-medication can aid in developing targeted public health interventions.

Objective

This study aims to evaluate the frequency of self-medication and identify the sociodemographic characteristics associated with self-medication practices among the urban population of Belagavi, Karnataka.

Method

A community-driven cross-sectional study was conducted for a duration of one year, from October 2022 to September 2023. The study had a total of 400 participants, who were systematically selected from the urban field practice areas of Rukmini Nagar UHC and Ashok Nagar UHC. The data were collected via face-to-face interviews using a self-designed questionnaire that had been previously verified

and tested. The questionnaire consisted of parts that focused on demographic information, self-medication trends, types of medicines used, sources of medicine, reasons for self-medication, and health insurance coverage. The collected data was analysed with SPSS version 25.0, employing descriptive statistics to succinctly characterize the data. Furthermore, a chi-square test was used to ascertain significant associations between sociodemographic factors and the practice of self-medication.

Results

The study found that 62.3% of participants had self-medicated within the past three months. The gender distribution was nearly equal, with females at 51.8% and males at 48.3%. The highest prevalence was among the 21-30 age group (24.0%). Most participants were married (80.5%) and graduates (26.5%). The largest occupational groups were employees (32.8%) and housewives (32.5%). Predominantly, participants belonged to Class II (47.5%) and Class III (45.5%) socioeconomic status. Key reasons for self-medication included saving time (54.5%), using old prescriptions (24.3%). Common symptoms were headache (79.5%) and fever (47.8%). Paracetamol had the highest use rate at 98%, while Diclofenac was utilized by 37.8% of individuals. Among those self-medicating with anti-infectives (58.2%), the main conditions were sore throat (80.7%) and cough (29.7%), with Azithromycin being the most frequently used (63.4%), followed by Amoxicillin (41.4%). The study highlights significant associations between self-medication practices and sociodemographic factors, including age, gender, marital status, educational attainment, employment, family size, and socioeconomic position.

Conclusion

The high prevalence of self-medication practices in urban areas of Belagavi, Karnataka, and its association with various sociodemographic characteristics emphasize the need for focused public health interventions. To effectively reduce the common practice of self-medication, it is crucial to improve the availability of healthcare, establish regulations for the selling of over-the-counter pharmaceuticals, and promote educated health-seeking behaviours. Public health initiatives should prioritize the dissemination of information to the general community on the possible hazards and encourage the responsible and efficient use of pharmaceuticals. To enhance health outcomes in the area and mitigate the adverse effects of self-medication, it is crucial to tackle these challenges.

Keywords:- Self-medication, Antimicrobial Resistance, Sociodemographic factors, Urban population, Public health interventions

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INTRODUCTION

Self-medication is a prominent global health concern, with differing incidence rates ranging from 11.7% to 92% in various locations.¹ The WHO has stressed the need to comprehensively examine and oversee self-medication activities.² There has been a substantial rise in concerns around self-medication among both the general public and experts, especially in developing nations during the last several decades. The characteristics and frequency of self-medication change based on cultural, social, and educational influences resulting in variations across different people.

The WHO has defined self-medication as “The 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 symptoms, or the use of medication recommended by lay sources or health workers not entitled to prescribe medicines”.³

Every day, people engage in self-medication practices as a form of self-care to manage minor health concerns or symptoms without seeking advice from healthcare professionals. In India, self-medication with “over the counter (OTC)” drugs are permitted under the country's drug laws, although there is no specific list of OTC medications outlined.⁴ Unlike other aspects of self-care, such as maintaining a balanced diet or engaging in physical activity, self-medication involves using medications that can have positive or negative effects. While it can alleviate common ailments and enhance overall well-being, misuse or overuse of drugs without proper medical guidance can result in adverse reactions, drug interactions, and various health

risks. Hence, practicing self-medication requires caution and awareness of potential dangers to ensure its efficacy and safety.

Self-medication rates vary across developing countries, ranging from 12.7% to 95%.⁵ It is reported at 59% in Nepal, while in Pakistan it is 51%.⁶ In Bangladesh, the rates are 81.3% among young individuals and 78.7% among the elderly.⁷ In India, studies conducted in Puducherry, Rajasthan, Tamil Nadu, and Delhi reported prevalence rates of 11.9%, 73.6%, 78.7%, and 92.8%, respectively.⁷

Self-medication is widely practiced in India because it offers an affordable option for those unable to afford costly clinical services. This practice serves as a low-cost alternative, particularly for individuals with financial limitations.⁸ Moreover, in numerous hilly and tribal regions across the country, where there is a substantial shortage of healthcare workers, patients often turn to self-medication to address minor symptoms. This reliance on self-medication stems from restricted access to healthcare facilities and a scarcity of healthcare professionals in these specific areas.

Engaging in self-medication is associated with risks such as the potential for misdiagnosis, delayed or insufficient medical guidance, inappropriate selection of treatment, drug interactions, failure to identify duplicate active substances sold under different brand names, adverse drug reactions, incorrect administration techniques, improper dosage, and the risk of developing dependence and abuse.⁹ Antimicrobial resistance (AMR) is a major risk factor linked to self-medication, and it is a growing worldwide problem, particularly in poor nations. Antimicrobial resistance (AMR) refers to the ability of bacteria, viruses, parasites, and fungi to survive the effects of antimicrobial treatments. The presence of this resistance complicates the treatment of infections and increases the probability of diseases spreading and worsening. Self-

medication practices, particularly with antibiotics, contribute to the development of antimicrobial resistance (AMR) in several ways:

Factor	Description
Inappropriate Use	Self-medication often involves incorrect or excessive use of antibiotics without proper medical supervision or guidance.
Incomplete Treatment	Individuals may not complete the full course of antibiotic treatment as prescribed, which can result in incomplete eradication of pathogens and the potential development of resistance.
Overuse	Availability of antibiotics without a prescription can lead to their overuse for minor infections or non-bacterial illnesses, contributing to the emergence of resistant bacteria.
Self-Diagnosis	Without proper medical assessment, individuals may misdiagnose their condition and use antibiotics unnecessarily, further fuelling the development of AMR.
Poor Quality or Counterfeit Drugs	Self-medication may involve the use of poor-quality or counterfeit antibiotics, which can be ineffective and promote AMR.

In developing countries, where healthcare services and antibiotic stewardship programs are often limited, the influence of self-medication on antimicrobial resistance (AMR) is especially significant.

Self-medication is a vital aspect of primary healthcare as it enables individuals to manage minor health issues independently, reducing the strain on healthcare systems, especially for non-serious conditions.¹⁰ Furthermore, self-medication can contribute to cost savings for both individuals and healthcare systems. By treating minor ailments at home with over-the-counter medications, individuals can avoid unnecessary visits to healthcare facilities, reducing healthcare costs and freeing up resources for more critical medical needs. Nevertheless, notwithstanding these advantages, there are other crucial concerns that want careful consideration before to advocating the merits of self-medication.

This study intends to address gaps found in previous research by focusing on areas such as access to healthcare, the involvement of pharmacies, the prevalence of antimicrobial usage, and the adverse reactions associated with self-medication. Additionally, there has been a limited amount of research conducted in this particular region of Karnataka. Hence, the current research aims to examine the frequency of self-medication and the variables linked to it in the urban regions of Belagavi, Karnataka.

STUDY OBJECTIVES

Primary Objective

To assess the prevalence of self-medication among the urban population of Belagavi, Karnataka.

Secondary Objective

To identify the factors associated with self-medication practices.

LITERATURE REVIEW

Self-medication practices, defined by the WHO as “The 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 symptoms, or the use of medication recommended by lay sources or health workers not entitled to prescribe medicines”.³

These practices include a broad spectrum of acts, ranging from the use of over-the-counter (OTC) drugs to the use of conventional therapies. They are impacted by variables such as the accessibility of healthcare services, economic circumstances, and cultural ideologies. Although self-medication may provide quick comfort and effective control of minor symptoms, it also raises issues surrounding the dangers of inaccurate self-diagnosis, drug interactions, and the possible abuse of prescription medications. Studies across various countries highlight a growing trend in the self-medication practices, underscoring the need for balanced policies that promote responsible self-medication while minimizing associated risks. Such practices underscore the dual need to educate the public on safe medication practices and to regulate the availability of potent drugs to prevent their misuse.

In 2023, Chaudhary et al. performed a systematic review and meta-analysis to examine the incidence of self-medication practices among pregnant women across India. The researchers sought to identify self-medication practices, the most often used types of medications, the specific conditions for which these prescriptions were used, and the underlying motivations behind such behaviours within this particular population. The study integrated data from several observational studies, according to

strict PRISMA requirements, and using a random-effects model to examine the data. The analysis revealed a notable incidence of self-medication behaviours among pregnant women in India. This extensive inquiry consolidated results from eight investigations including a combined sample size of 2208 pregnant women. The data showed that the combined prevalence of self-medication was 19.3%, suggesting that around 20% of pregnant women in India used self-medication. The ailments that individuals most regularly treated themselves for were colds, coughs, fevers, headaches, and stomach problems. The drugs most frequently used for self-treatment were antipyretics, analgesics, antihistamines, and antacids. The primary determinants of self-medication were the perception of mild illnesses the need for immediate relief, convenience, time effectiveness, and advice from family, friends, or media outlets. The results emphasized the crucial importance of community pharmacies and informal networks in delivering medicine and information.¹¹

In a community-based cross-sectional study conducted by Khushboo Juneja et al. in the year 2023 across urban and rural areas of Uttar Pradesh, India, a significant prevalence of self-medication was observed among the adult population. The research used a pretested, semi-structured questionnaire to collect data from a sample of 440 participants. The findings revealed that 66.4% of the participants used self-medication, mostly for common diseases such as fever, cough, and cold. The main therapeutic option chosen was allopathic, with paracetamol, cough syrups, and antihistamines being the most often used options. The main causes for self-medication were convenience and time limitations, with a notable 64.4% of respondents following the advice given by pharmacists. The data indicated that those residing in metropolitan areas, females, workers with specialized skills, those who had completed at least elementary school, and individuals with higher incomes exhibited an increased

inclination to practice self-medication. These findings highlight the need for targeted educational initiatives and stricter regulations to ensure safe medication practices, particularly given the influential role of pharmacists in these decisions.¹²

In a systematic review and meta-analysis conducted by Afaf Bouquoufi et al., in the year 2023, examined the prevalence of self-medication among pregnant women worldwide. The research collected data from many databases, including "PubMed, Science Direct, Web of Science, and Google Scholar". The assessment of the articles' quality was conducted using the Joanna Briggs Critical Appraisal Checklist for Analytical Cross-Sectional Research. The results indicated a worrisome occurrence of self-medication among pregnant women worldwide, with an overall prevalence of 44.50% and a confidence range spanning from 38.92% to 50.23%. The research also emphasized substantial variability and disparities in self-medication rates depending on geographical, economic, and study design variables.¹³

Uma Awasthi et al. conducted a study from March to August 2023 in Dhangadhi Sub-Metropolitan City, Nepal to examine the frequency and characteristics of self-medication among the inhabitants of the area. This research used a cross-sectional survey approach, including a sample size of 291 participants. Data was collected using a questionnaire that had been pretested and verified. The results revealed that a significant majority (77.7%) of the participants had engaged in self-medication during the last three months. The main medications used for self-administration were antibiotics, analgesics, and antipyretics, mostly for the management of illnesses such as the common cold, headaches, and fever. The main factors reported for engaging in self-medication were mild ailments (87.2% of instances), limited availability of time for doctor visits (40.7%), and expensive

medical costs (38.1%). The research emphasized the extensive prevalence of self-medication in Dhangadhi, urging for heightened state intervention to educate the community about the dangers linked to unsupervised medicine use and to enhance the control of prescription drug sales in pharmacies.¹⁴

Hossam Tharwat Ali et al. undertook a thorough study between February 7th and March 8th, 2023, to investigate the habits, knowledge, and attitudes of the general Egyptian community regarding self-medication (SM). The research used a self-administered questionnaire in Arabic, distributed via online and print forms. It gathered answers from 1630 people residing in seven regions in Egypt, with a median age of 25 years. The results revealed that 55.97% of the participants had a high level of understanding of SM, 48.28% displayed positive opinions towards it, and 62.8% engaged in SM activities in the previous three months. The most often self-administered pharmaceuticals were analgesics, antimicrobials, and antipyretics, typically based on the advice of pharmacists or by using expired medications found at home. Significantly, most instances of self-medication were motivated by the belief of experiencing mild symptoms. The multivariate regression study indicated that females and those in the medical profession had a greater understanding of SM. Additionally, females exhibited no notable disparity in their implementation of self-medication compared to males. Surprisingly, while a favourable attitude towards self-medication decreased the likelihood of its practice, increased knowledge did not significantly affect SM practices.¹⁵

In 2023, Shammari et al. conducted a study at King Saud Hospital in the Qassim province of Saudi Arabia. The aim of the research was to assess the comprehension and conduct of 427 parents about the administration of medicine to

their children. The cross-sectional study revealed that 62.1% of the participants were female, whilst 37.9% were male. The predominant age group seen included adults aged 31 to 35. Among the participants, 72.8% had a bachelor's degree, while 7.5% possessed a master's degree. A survey found that 78.7% of parents chose synthetic medications, while 21.3% preferred natural therapies. A majority of respondents (69.8%) have awareness of the potential negative effects and repercussions associated with drugs. The most often used self-administered remedies were antipyretics (81.5%), cough syrups (41.9%), and anti-allergy medications (23%). Parents cited familiarity with their children's symptoms (72.6%), long waiting times at clinics (61.8%), and high consultation fees (52%) as the primary reasons for self-medicating their children. Statistical analysis indicated significant associations between self-medication practices and factors such as parents' occupation and the number of children. Despite the acceptable level of knowledge and practice among most parents, there remains a need for better education on self-medication, highlighting its potential risks and the importance of professional healthcare guidance.¹⁶

A cross-sectional study was done in Gubre town, Gurage Zone, Southern Ethiopia by Tadesse Sahle Adeba et al. from Wolkite University in 2022. The study aimed to assess self-medication habits and the variables related with them among adult household members. The research, which included 398 participants from 399 houses, used a systematic random sample method and a pre-tested questionnaire to gather data. The results indicated that 28.4% of the participants practiced self-medication, whereas 61.05% reported having diseases during the two weeks before the study. Key determinants impacting self-medication were marital status, literacy level, personal endorsement of self-medication, peer influence, and availability of medical information. Individuals who were married, had the ability to read and write,

were affected by their peers, and had better access to medical knowledge were more inclined to engage in self-medication.¹⁷

In a cross-sectional study by Marina Darakhvelidze et al., at Ilia State University, Georgia in the year 2022, the prevalence and dynamics of self-medication with antibiotics were explored. Utilizing a random sampling approach and an internet-based survey conducted through Google Forms, the study captured responses from 742 adults. It found that 23.8% of participants had taken antibiotics without a prescription, and 12.7% administered antibiotics to minors based on personal judgment, cumulating in a total self-medication rate of 32.6%. The analysis highlighted significant correlations: young adults (18–24 years) and seniors (60+ years) were more likely to self-medicate based on personal experiences, while those with higher educational levels showed a greater distrust in medical practitioners. This prevalent reliance on pharmacies for obtaining antibiotics without prescription underscores the critical need for enhanced public awareness and stricter regulatory measures to mitigate the risks of self-medication in Georgia.¹⁸

Sharma D and Goel NK conducted a study in 2022 to examine the prevalence of self-medication behaviours among 1090 persons in a rural region near Chandigarh, India. The study revealed that 18.6% of the participants engaged in self-medication. The study findings indicated that fever was the predominant condition prompting individuals to engage in self-medication. The primary factors influencing this decision were past favourable experiences and guidance from family or friends. Significantly, the practice of self-medication was more widespread among adults aged 50 and above, as well as among individuals who were widowed. The research highlights the need of implementing public health measures to decrease self-medication, especially

targeting older and widowed individuals. It also recommends raising awareness about the dangers of self-medication and promoting consultations with healthcare professionals.¹⁹

In 2022, Abhishek Sharma et al. did a research in Haryana, India, to assess the reasons and obstacles related to the impact of self-medication perspective on para-medical science students. The research emphasized the prevalent habit of self-administering medicine for conditions such as fever, cold, cough, allergies, and headaches, with paracetamol being the most often used remedy. Despite the awareness of potential negative impacts, self-medication was prevalent among students, often driven by factors such as convenience, lack of healthcare services, and influence from advertisements and social media. The research revealed a substantial lack of understanding and disregard among students about the dangers linked to self-medication, including improper treatment, drug interactions, and the possibility of serious health complications. The results emphasized the need of implementing comprehensive teaching approaches to improve comprehension and appropriate conduct regarding self-administration of medicine among medical and para-medical students.²⁰

Liu et al. performed a research in 2021 to examine self-medication practices among Chinese teenagers aged 12-18 years. The study specifically looked at the elements that influenced their decision-making process about the effectiveness and safety of drugs. Using a multi-stage sampling procedure, the research was conducted across mainland China and revealed a very high self-medication rate of 96.61% among the participants. A significant proportion of these teenagers, namely 65.84%, regarded medication safety as very important, whereas 58.72% placed a higher

priority on therapeutic effectiveness. The research used logistic regression analysis to determine that teenagers who had access to superior healthcare and came from households with healthier lifestyles were more inclined to prioritize the importance of pharmacological effectiveness. Moreover, those residing in metropolitan regions, with extensive knowledge about preventive health measures and significant family health assets, exhibited a greater emphasis on the necessity of medication safety. In contrast, teenagers from homes with greater incomes and those who were the only child were less inclined to prioritize safety. The study emphasizes that several factors, such as demographic characteristics, social qualities, health literacy, and family health status, have a significant impact on how adolescents assess the effectiveness and safety of medications while practicing self-medication. This indicates the need for targeted educational programs to enhance safe medication habits among young individuals.²¹

In a population-based cross-sectional survey conducted from November to March 2021 in Basra, Southern Iraq, researchers Zainab Najim et al., evaluated the practice, attitudes, and perceptions of self-medication among the local population. The research collected data from 500 people, aged 12 to 80 years, using an online questionnaire. The respondents consisted of 24.40% females and 75.60% males. The results indicated that a considerable proportion of the population practiced self-medication, mostly obtaining medications such as pain relievers and fever reducers from pharmacies. The condition of headaches was reported as the most often treated by self-medication, as indicated by 74.9% of the participants. This was followed by fever and the common cold, which were reported by 51.90% of the respondents. The main drivers of self-medication behaviours were based on prior experience with drugs and belief that these conditions were not so severe. The research determined that self-medication is prevalent, but there is a pressing need for health experts and drug

authorities to provide public education on the hazards and advantages of this practice.²²

In a cross-sectional study conducted by Roy et al. on the prevalence and determinants of self-medication among Bangladeshi adults in 2021. And study surveyed 1320 participants, revealing that 41% engaged in self-medication, primarily for ailments like the common cold/flu, gastric problems, and headaches. Key motivations included perceived better care quality, absence of side effects, and time efficiency. The analysis identified higher educational attainment, smaller family sizes, business professions, active social group participation, and current ill-health as significant risk factors. In contrast, being under 30 years of age or practicing modern or herbal treatments showed a protective effect against self-medication. These findings underscore the need for increased awareness and stricter regulations to curb inappropriate self-medication practices in Bangladesh.²³

Mannan et al. undertook a study from January to July 2021 to examine the frequency and factors influencing self-medication with antibiotics (SMA) among indigenous inhabitants in the Chittagong Hill Tracts (CHT) areas of Bangladesh. The cross-sectional research, which included surveying 1336 indigenous individuals using a semi-structured questionnaire, revealed a substantial prevalence of SMA, especially among men who reported a higher incidence (60.54%) compared to females (51.57%). The research found that those with lower levels of education and wealth were more prone to engaging in self-medication. Azithromycin was the predominant antibiotic used for the treatment of cough, cold, and fever. The main factors that strongly predicted SMA were being male, having a lower family income, lacking sufficient understanding about antibiotic usage, and living in certain districts.

Specifically, those living in Rangamati had a decreased risk of SMA compared to those in Bandarban.²⁴

The multinational cross-sectional study conducted by Abdelwahed et al from August to late October 2021, focused on prevalence and factors influencing self-medication practices during pandemic of COVID-19 across ten Arab countries. The study, which included over 8,000 participants, revealed that nearly two-thirds (62.7%) engaged in self-medication, with Egypt showing the highest prevalence (72.1%) and Palestine the lowest (40.4%). Key factors influencing this practice were age, presence of chronic illness, and financial constraints regarding medical insurance and treatment costs. Commonly used medications were analgesics, antipyretics, vitamins, antitussives, and antibiotics, primarily for symptoms like headaches, flu, and common colds.²⁵

In 2021, Johnbasha and colleagues conducted a study on self-medication practices among an urban community of fishermen in Puducherry. The research was carried out between July and December 2021, including a total of 370 individuals. The participants were selected by the method of simple random selection. The study uncovered a significant occurrence of self-medication, as indicated by 67% of the participants, mostly impacted by socio-economic level and other contributing variables. A majority of participants engaged in self-medication to treat common ailments such as cough, cold, flu, headache, and myalgia. However, a notable proportion (12.1%) reported suffering adverse consequences as a result. Pharmacists were the main source of drug information, representing 55.8% of the assistance obtained. The research emphasized the need of improving public education on the

dangers of self-medication and implementing stricter regulations on pharmaceutical sales to prevent this behaviour.²⁶

Namboothiri et al conducted a study in Northern Kerala to explore self-medication behaviours among the local population. This community-based descriptive cross-sectional study, carried out from June to December 2021, included 212 participants over 18 years old, selected through convenient sampling. Namboothiri et al. discovered that 53.8% of participants engaged in self-medication, with significant influences including age, education level, and health system preferences. Notably, self-medication was more prevalent among individuals aged 41-60 and those with lower education levels. The primary reasons for self-medication were accessibility of over-the-counter drugs, cost considerations, and pharmacist recommendations. The findings underscored the necessity for public health interventions aimed at promoting responsible self-medication practices and enhancing access to healthcare to ensure safer and more effective use of medication.²⁷

In 2020, Marathe et al. examined the worldwide and Indian situations of over-the-counter (OTC) medications. The study explained how OTC drugs are legally sold without a prescription in many countries, offering quick and affordable access to treatment for minor ailments. However, India lacked specific regulations and a distinct category for OTC medicines, creating challenges in their management and usage. The study emphasized the importance of establishing clear guidelines for OTC drugs in India to improve health outcomes and prevent misuse. The research centered on patient education initiatives, as well as enhanced assistance from pharmacists and pharmaceutical firms, with the aim of maximizing the use of over-the-counter (OTC) drugs in India.²⁸

A study conducted by Akande-Sholabi et al. sought to investigate the prevalence, comprehension, and attitudes about self-medication activities among undergraduate healthcare students at a Nigerian university. This cross-sectional survey was performed between August and November 2019 and included 866 students specializing in medical, nursing, and pharmacy. The findings revealed that 54.6% of the individuals engaged in self-medication, mostly using analgesics, antimalarial medicines, and antibiotics. The primary factors contributing to self-medication are the desire to address minor symptoms and possessing sufficient medical expertise to self-administer treatment. The study highlighted that although a significant number of students possessed good knowledge and perceptions of self-medication, there was still a considerable group that could benefit from improved educational interventions.²⁹

Thoufiq et al. conducted a study to investigate the prevalence of self-medication practices in the urban areas of Kanchipuram district, Tamil Nadu. This study used a community-based cross-sectional descriptive design. Individuals residing in Anakaputhur, a designated urban area for field practice by Sree Balaji Medical College, were questioned individually using a pre-tested structured questionnaire. The study included individuals from both the teenage and adult groups, namely those who were 15 years of age or older. The study was carried out from June 2018 to May 2019. The results indicated a significant correlation between self-medication and many demographic variables, including age, employment, education, per capita income, and marital status. Nevertheless, no noteworthy correlations were detected between self-medication and the use of tobacco or alcohol. The research underscored the extensive prevalence of self-medication, which is fueled by reasons such as convenient availability of non-prescription pharmaceuticals and financial limitations.

This underscores the need for enhanced public health education and more stringent rules for pharmacies to address the related hazards.³⁰

Arpitha VS et al conducted a cross-sectional study in the urban field practice area of Dharwad to ascertain the prevalence and attributes of self-medication. The study, conducted from November 2018 to October 2019, had a sample of 335 adults aged 18 to 60. A research found that 46% of the participants engaged in self-medication, mostly to treat minor health problems and provide instant relief, via the use of over-the-counter drugs. The predominant symptoms addressed were elevated body temperature and cephalalgia. A substantial correlation was discovered between self-medication habits and characteristics such as religion, age, job level, and the presence of healthcare providers in the household. The research emphasizes the need for heightened awareness and more stringent rules to alleviate the dangers linked to self-medication, such as drug resistance and bad drug responses.³¹

In 2018, Desai et al. did a research in Bagalkot-North Karnataka to investigate the prevalence and patterns of self-medication in urban and rural areas. The study investigated the factors influencing people's decision to engage in self-medication, the prevalent health conditions for which it was used, and the level of understanding, attitudes, and associated with this practice. The study found that self-medication was strongly impacted by the availability of pharmacists, limited access to healthcare facilities, and financial limitations. Moreover, rural regions exhibited a greater inclination towards self-medication in comparison to metropolitan areas. The research highlighted the hazards associated with self-medication, such as inaccurate self-diagnosis and possible drug interactions, while proposing that pharmacists have a vital role in providing guidance for this practice. The need for enhanced regulation and

public education is emphasized to reduce the hazards connected with self-medication.³²

Veerakumar et al undertook a research to assess the self-medication habits among a rural community in Tamil Nadu, India. The study was conducted in a primary health center in Sirugambur from April to May 2016. It had 150 participants who were administered a pre-tested semi-structured questionnaire. The results revealed that 78.7% of the participants had engaged in self-medication, primarily purchasing medications directly from medical shops. Factors such as accessibility and familiarity influenced this behaviour. The most commonly used medications included paracetamol, antibiotics, and antihistamines, with pharmacists and friends being the predominant sources of drug information.³³

In 2015, a study conducted by Chari et al., researchers investigated self-medication practices among urban households in Belagavi, India. Conducted on 200 households and 593 individuals, the study found that 35.1% of the respondents engaged in self-medication. Paracetamol was the most commonly used drug, primarily for headaches and fever, while reasons for self-medicating included minor illnesses and convenience due to time constraints. Information sources for these medications were typically past prescriptions or local pharmacists. The study highlights that self-medication was more prevalent among women and people from higher socioeconomic backgrounds, suggesting a pattern influenced by accessibility to and knowledge of medicines. The findings emphasize the need for stricter regulations and public awareness on risk of self-medication.³⁴

Manish Jain et al. undertook a research to examine the frequency, trends, and variables related to self-medication in a city in Southern Rajasthan. The study, conducted between May and August 2015, had 440 individuals who were 18 years of age or older. A notable 73.6% of individuals engaged in self-medication in the last three months. The most commonly used medications were paracetamol and other analgesics, primarily for symptoms like fever and headache. The practice was more prevalent among younger individuals, males, and those with higher levels of education. Most respondents cited pharmacists as their primary information source for self-medication. The study highlights the need for enhanced informational and educational communications (IEC) to reduce self-medication practices, emphasizing the potential risks and promoting appropriate health-seeking behaviours.³⁵

Kalaivani Annadurai did a research to examine the self-medication practices among the rural people of Nellikuppam Village in Kancheepuram District, Tamil Nadu. The research was conducted as a descriptive cross-sectional survey between May and October 2014. The study included 335 adult households and used a pretested semi-structured questionnaire. The survey revealed that 53.43% of the individuals engaged in self-medication, with paracetamol being the most often used medicine. The primary factors revealed as predictors for self-medication were the opinion of the condition as being of little significance and the lack of access to medical professionals in the area. Approximately 47.49% of the individuals expressed their intention to persist in self-medication in the future.³⁶

Sushma Katkuri et al., undertook a study to examine how often and why people in urban slums in Hyderabad, India, engage in self-medication. This study was done in December 2014 and included 200 randomly selected persons who were at

least 18 years old. The research was community-based and cross-sectional in nature. The results revealed a notable prevalence of self-medication, with 73% of subjects partaking in this behaviour. Among the respondents, 84% expressed a preference for allopathic medications, while 67% said that they depended on pharmacists as their main source of information for self-medication. Typical ailments managed with self-administration of medicine include fever, common colds, coughs, and headaches. The main factors driving self-medication were the desire to save time and the notion of having a moderate disease. Notwithstanding the prevalent practice, around 53% of participants were uninformed of the possible adverse consequences. The research emphasizes the need of health education and more stringent laws to guarantee safe drug practices and diminish dependence on self-medication among susceptible groups.³⁷

Selvaraj et al. conducted a study to assess the frequency of self-medication practices and the factors associated with them in Urban Puducherry, India. The cross-sectional study was place from December 2012 to January 2013 in four urban health center districts, catering to a population of around 9000 persons. A sample size of 352 persons from 124 households was determined using a rigorous random selection procedure. The study identified a prevalence rate of 11.9% for self-medication. It also revealed strong correlations between self-medication and factors such as gender, age, and occupational activities. Self-medication was predominantly used for fever, headaches, and abdominal pain. The majority of these medications were procured by describing symptoms to pharmacists, and a significant number of users believed self-medication to be harmless, indicating a trend towards continued use and recommendation of self-medication practices.³⁸

Varun Kumar et al., conducted a study to investigate the occurrence and patterns of self-medication in a major urban area of Delhi, India. The cross-sectional study was carried out in March and April 2013, including personal interviews with 236 individuals using pretested questionnaires. The study revealed that self-medication was seen in 92.8% of the participants, particularly among younger adults, graduates, and postgraduates. The most prevalent conditions addressed by self-administration of medicine were the common cold (61.6%) and fever (51.8%), with paracetamol and cough syrups being the most frequently used remedies.³⁹

METHODOLOGY

SOURCE OF DATA

Belagavi is a district located in the north-western region of Karnataka. According to the 2011 Census statistics, the population of Belagavi city was 4,779,661. As per the 2022 data from the Aadhar Unique Identification Authority of India, the population of the district was estimated to be 5,444,990. In Belagavi, Rukmini Nagar had a population of 64,404 with 13,076 households, while Ashok Nagar had a population of 26,004 with 1,200 households. The data collection for the present study was done from the urban field practice areas of Rukmini Nagar UHC and Ashok Nagar UHC in the Belagavi district of Karnataka, India.

STUDY DESIGN

Cross-sectional study

STUDY PERIOD

The study was done for a duration of 12 months, namely from October 1, 2022, to September 30, 2023.

SAMPLE SIZE

The sample size for the current research was determined using the method,

$$n = \frac{Z^2 * p * q}{d^2}$$

Where,

n is the sample size

p is prevalence, taken as 35.1% (Based on the prevalence of reference study)³⁴

$$q = 100 - p = 64.9$$

d = Absolute Error, fixed as 5%

z score is the standard normal critical value for a given confidence interval

For 95 % confidence interval z value is 1.96.

$$n = \frac{1.96^2 \times 35.1 \times 64.9}{5^2}$$

$$n = 364.47$$

The sample size was rounded off to 400

SAMPLING METHOD

The systematic sampling method was used in the study, and it was conducted through a process called population proportionate sampling. The total population of the field practice areas, specifically Rukmini Nagar UHC and Ashok Nagar UHC, was first determined. For Rukmini Nagar, the population was 64,404 with 13,076 households, while Ashok Nagar had a population of 26,004 with 1,200 households.

Determining Sample Sizes for Each Area

The overall sample size needed was determined to be 400 based on the sample size calculation.

The proportion of the total sample to be drawn from each area was calculated based on the population of that area relative to the total population of both areas combined.

For Rukmini Nagar, the sample size was calculated as $\frac{64,404}{90,408} \times 400 = 285$.

For Ashok Nagar, the sample size was calculated as $\frac{26,004}{90,408} \times 400 = 115$

Systematic Sampling

A sampling interval was calculated for each area by dividing the number of households by the sample size needed from that area.

For Rukmini Nagar, the sampling interval K was $\frac{13076}{285} = 46$. This meant that every 46th house was selected for the survey.

For Ashok Nagar, the sampling interval K was $\frac{1200}{115} = 10$. This meant that every 10th house was selected for the survey.

A random starting point within the first interval was selected for each area to begin the sampling. For instance, if the starting point was the 9th house, then the subsequent houses would be 55th, 101st, etc., until the required sample size was reached.

Field Execution

Within the chosen residences, a door-to-door survey was carried out. Every chosen home was contacted, and the survey was carried out according to the eligibility and agreement of the participants. This methodology guaranteed that each demographic group in the specified regions had an equitable opportunity to be included in the research, hence reducing the potential for sampling bias.

INCLUSION CRITERIA

Participants had to have been residing in the urban field practice areas of Rukmini Nagar UHC and Ashok Nagar UHC for at least the last 12 months preceding the survey

EXCLUSION CRITERIA

Households that were locked after three consecutive visits were excluded from the study.

METHOD OF DATA COLLECTION

Each household within the systematically selected sample was visited, and the data collection was conducted by the primary investigator. From the selected households, after listing all the household members aged more than 18 years who were available at the time of the interview, the person to be interviewed was selected by the lottery method. Each eligible household member's name was entered into the lottery, and one name was randomly drawn to be the respondent for the survey. The data was collected through face-to-face interviews, using a pre-validated and pre-tested questionnaire covering demographic characteristics such as gender, date of birth, occupation, marital status, religion, highest qualification, and detailed self-medication habits, including types of medications used, sources of medication, and reasons for self-medicating, self-medication with anti-infectives and health insurance. It also assessed socio-economic status using the Modified B.G. Prasad classification. Written informed consent was obtained from all study participants. A pilot study was conducted in forty households, and necessary modifications were made to the questionnaire.

QUESTIONNAIRE DESIGN AND VALIDATION

A meticulously validated and specially crafted questionnaire was used for participant assessment. The questionnaire was partitioned into many discrete pieces. The first segment gathered socio-demographic data, including personal particulars such as age, gender, and employment, along with educational attainment, marital status, and religious association. This component also gathered information about the household's family size, monthly income, and socio-economic status, which was determined using the Modified B.G. Prasad scale.

The "Self-Medication Habits" section of the questionnaire provided a definition of self-medication, describing it as the use of medicinal products by individuals without a prescription from a healthcare provider. Participants were instructed to reflect on their self-medication practices over the past three months for the subsequent questions, unless a different time frame was specified. They were first asked whether they had engaged in self-medication during this period. If they had not, they were directed to skip to the health insurance questions. For those who had self-medicated, further questions probed into the reasons for this choice, such as distance to a doctor or clinic, time savings, or cost-related issues. The types of illnesses or symptoms treated through self-medication were then listed, with space provided for participants to specify the medicines used. Additional queries investigated the factors considered when selecting a medication, where the medications were obtained, whether prescribing information was consulted, and understanding of this information. Participants were also asked about any adverse events experienced from self-medication and the actions taken in response.

The section on "Self-Medication Habits with Anti-Infectives" queried participants on whether they had self-medicated with anti-infectives. Those who had were requested to list the infections treated and the medicines used. They also disclosed the most recent infection addressed through self-medication. Questions explored how individuals determined the dosage for anti-infectives, whether through professional advice or personal judgment, and if there were instances of dosage adjustments during self-treatment. Reasons for such adjustments, like health improvement or reduction of adverse events, were examined. The participants reported on the circumstances that led them to stop using anti-infectives, including the resolution of symptoms or completion of the medication, and where they acquired information on the duration of treatment for anti-infectives.

Finally, participants were asked to specify their type of health insurance, coverage, including options like no insurance, rural, government-sponsored, private, or other.

STATISTICAL ANALYSIS

The acquired data was encoded and inputted into a Microsoft Excel Worksheet. The data was analysed using the statistical program "SPSS version 25.0". Descriptive statistics were used to succinctly characterize the demographic features of the individuals and the prevalence rate of self-medication. Continuous variables were examined using statistical measures such as means and standard deviations, whereas categorical variables were analysed using frequencies and percentages. The chi-square test was used to analyse the correlation between categorical variables, specifically the connection between demographic parameters (such as age, gender, and socioeconomic position) and self-medication habits. The significance threshold was established at

$p < 0.05$ for all statistical tests, implying that any findings with a p-value below 0.05 were deemed statistically significant.

ETHICAL CLEARANCE

The document was acquired from the Institutional Ethics Committee for Human Subjects' Research of the Medical College on 27/09/2022, as stated in the letter with reference number MDC/JNMCIEC/72. Prior to data collection, all research participants provided written informed permission (ANNEXURE – II).

DEFINITION OF STUDY VARIABLES

1. Sociodemographic Variables

- **Gender**

Male / Female

- **Date of Birth/Age**

Age was recorded as told by the participant to the nearest completed years.

- **Occupation**

1. **Student:** Currently enrolled in an educational institution.
2. **Employee:** Engaged in employment and receiving a salary.
3. **Business:** Self-employed or managing a business.
4. **Housewife:** Engaged in managing the household and not employed for wages.
5. **Retired:** Not engaged in active employment due to retirement.
6. **Farmer:** Engaged in agricultural activities, either owning land or working on it.
7. **Other:** Any occupation not listed above; requires a specific explanation.

- **Marital Status**

1. **Single:** Persons who have never married.
2. **Married:** Individuals whose spouse of either the opposing or same sex is alive, unless the pair is separated or has legally divorced.
3. **Separated:** Individuals who are presently in a legal marriage but are no longer cohabiting with their spouse due to reasons other than sickness, employment, or education, and have not yet gotten a divorce.
4. **Divorced:** Individuals who have gotten a legally recognized divorce and have not entered into a subsequent marriage.
5. **Widow/ Widower:** Persons who have lost their legally-married spouse through death and have not remarried.

- **Religion**

Categorized into Hindus, Muslims, Christians, and 'Other' which includes Sikhs, Buddhists, and Jains.

- **Highest Qualification**

1. **Illiterate:** Those who cannot read or write with understanding in any language.
2. **Primary School:** Participant who had attended schooling between first and seventh standard
3. **High School:** Participant who had attended schooling between eighth and tenth standard
4. **College:** Participant who had studied between tenth to twelfth standard
5. **Diploma:** Participant who had specialized vocational education.
6. **Graduate:** Participant who had Bachelor's Degree

7. Post Graduate: Participant who had Master's Degree

- **Total Number of Family Members Staying with You in This House**

The total count of family members living in the same household.

- **Total House Income/Month**

The total earnings of the household per month.

- **Monthly Per Capita Income**

The average earnings per person in the household per month.

- **Socio-economic status – Modified B.G. Prasad Classification⁴⁰**

Socioeconomic status Data on the per capita income of the household (in rupees per month) was gathered, and the socio-economic status was determined using a modified version of B.G. Prasad's categorization for the research period of 2023.

“Monthly Per Capita Income = Total monthly income of family / Total number of family members”

Modification was done using the Correction Factor.

The Correction Factor (CF) was determined by the following process: The CPI-IW for October 2023 is at 138.4, according to the All-India Consumer Price Index for Industrial workers.⁴¹

CF = Current index value (138.4) x linkage factor between 1960 & 1982 (4.63)
x linkage factor between 1982 & 2001 (4.93) x linkage factor between 2001 &
2016 (2.88)

Base Index in 2016 (100)

“Modified B.G Prasad's Classification = Per capita family monthly income of
1961 (B.G Prasad) x CF”

Social Class	Original B.G. Prasad Classification 1961 (Rs./month)	Modified B.G. Prasad Classification for Oct 2023 (Rs./month)
I Upper class	100 and above	9098 and above
II Upper middle class	50 – 99	4549 - 9097
III Middle class	30 – 49	2729 – 4550
IV Lower middle class	15 – 29	1365 – 2728
V Lower class	Below 15	Below 1365

- **Health Insurance**

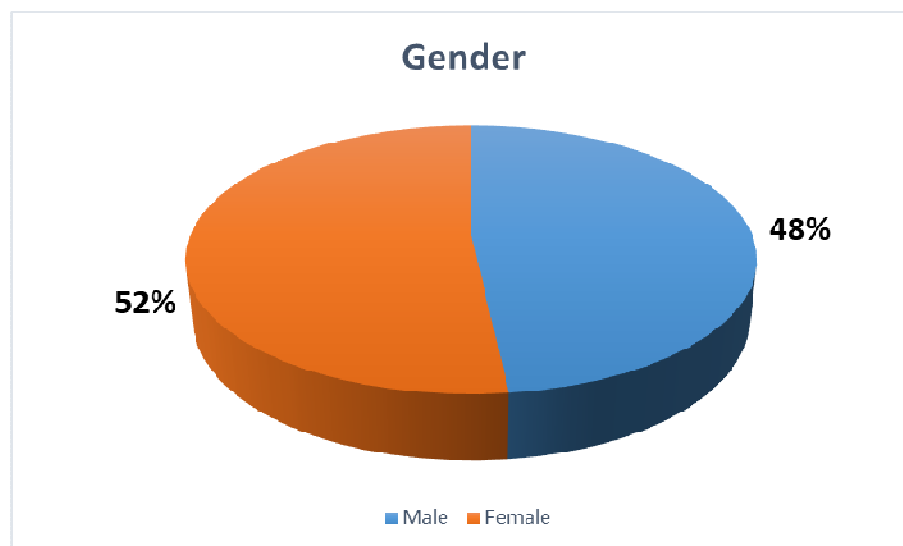
1. **No insurance:** The participant does not have any form of health insurance coverage.
2. **Government sponsored insurance:** The participant is covered by a health insurance scheme funded or provided by the government.
3. **Rural insurance:** The participant has insurance coverage designed specifically for individuals living in rural areas.
4. **Private medical insurance:** The participant's health insurance is provided by a private insurance company rather than a state-sponsored program.
5. **Other:** Any other type of health insurance coverage not listed. Participants are prompted to explain any alternative health insurance coverage they have.

RESULTS

Table 1:- Distribution of Study Participants According to Gender

Gender	Frequency (n)	Percent (%)
Male	193	48.2
Female	207	51.8
Total	400	100.0

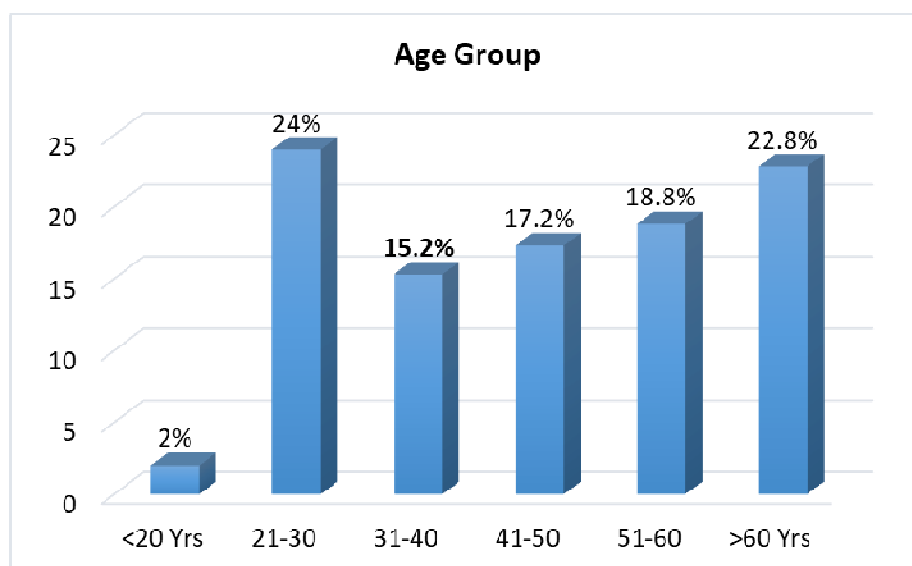
Figure 1:- Distribution of Study Participants According to Gender



In our study, out of a total of 400 participants, a majority of 48.2% were male and 51.8% were female. The results suggest a slightly higher proportion of females than males in this research.

Table 2:- Distribution of the Study Participants According to Age Group

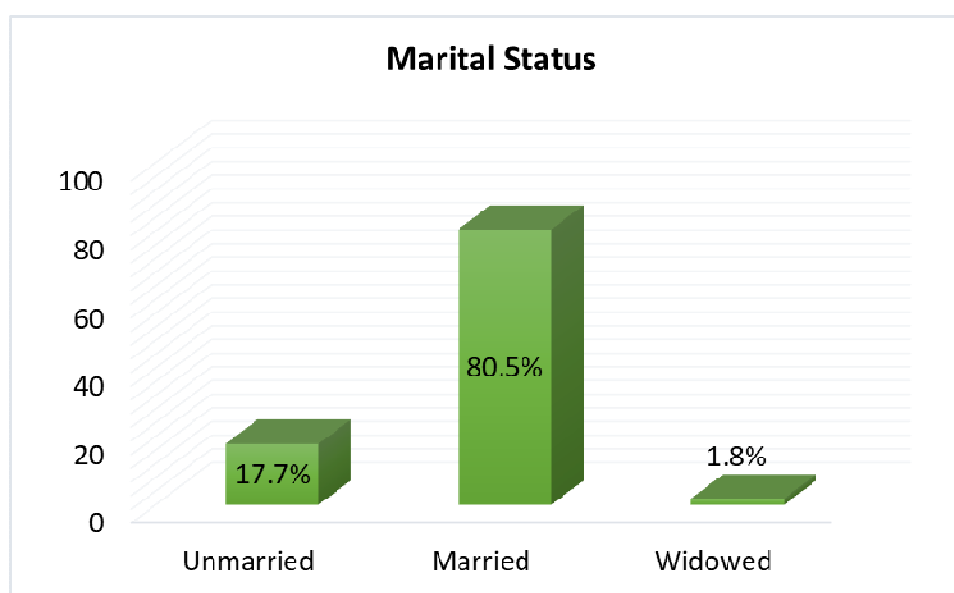
Age Group	Frequency (n)	Percent (%)
<20 Yrs	8	2.0
21-30	96	24.0
31-40	61	15.2
41-50	69	17.2
51-60	75	18.8
>60 Yrs	91	22.8
Total	400	100.0

Figure 2:- Distribution of the Study Participants According to Age Group

The age distribution of the 400 study participants is diverse, with the largest group being those aged 21-30 years, comprising 24.0% of the total participants. This is followed closely by participants older than 60 years, who make up 22.8%. Participants in the age group 51-60 years and 41-50 years account for 18.8% and 17.2% respectively. Those aged 31-40 years represent 15.2% of the participants, while the smallest group is those younger than 20 years, constituting only 2.0% of the total.

Table 3:- Distribution of Study Participants According to Marital Status

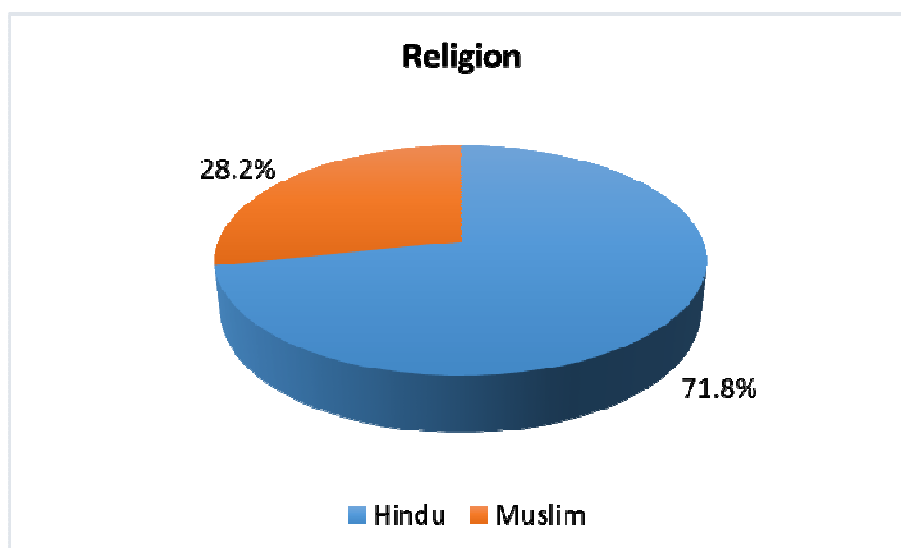
Marital Status	Frequency (n)	Percent (%)
Unmarried	71	17.75
Married	322	80.50
Widowed	7	1.75
Total	400	100.0

Figure 3:- Distribution of Study Participants According to Marital Status

Out of the 400 study participants, a significant majority of 80.5% were married. The unmarried individuals were 17.75%, while the smallest group consists of widowed participants, representing 1.8%.

Table 4:- Distribution of Study Participants According to Religion

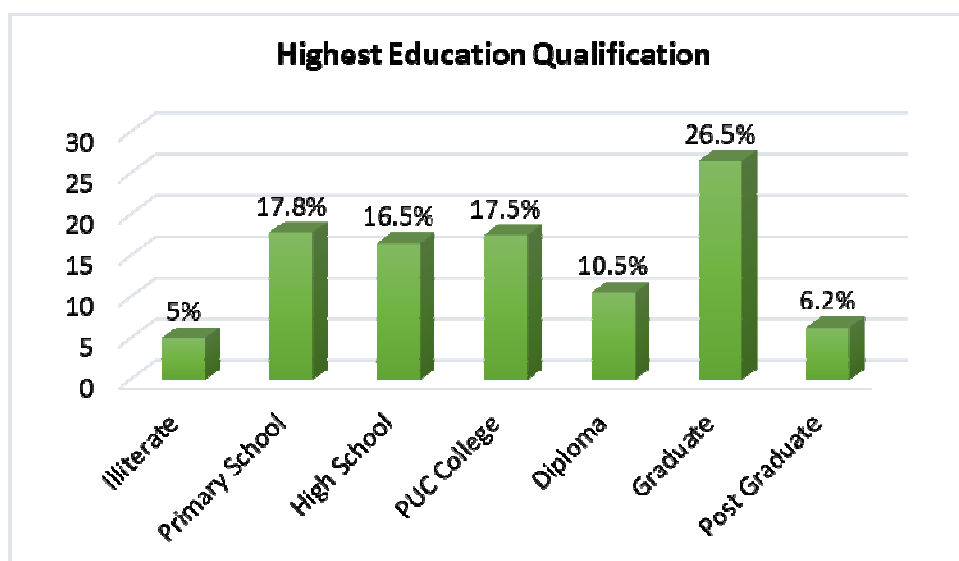
Religion	Frequency (n)	Percent (%)
Hindu	287	71.8
Muslim	113	28.2
Total	400	100.0

Figure 4:- Distribution of Study Participants According to Religion

Among the 400 study participants, the majority of the participants were Hindu 71.8%, while Muslim participants were 28.2%.

Table 5:- Distribution of Study Participants According to Qualification

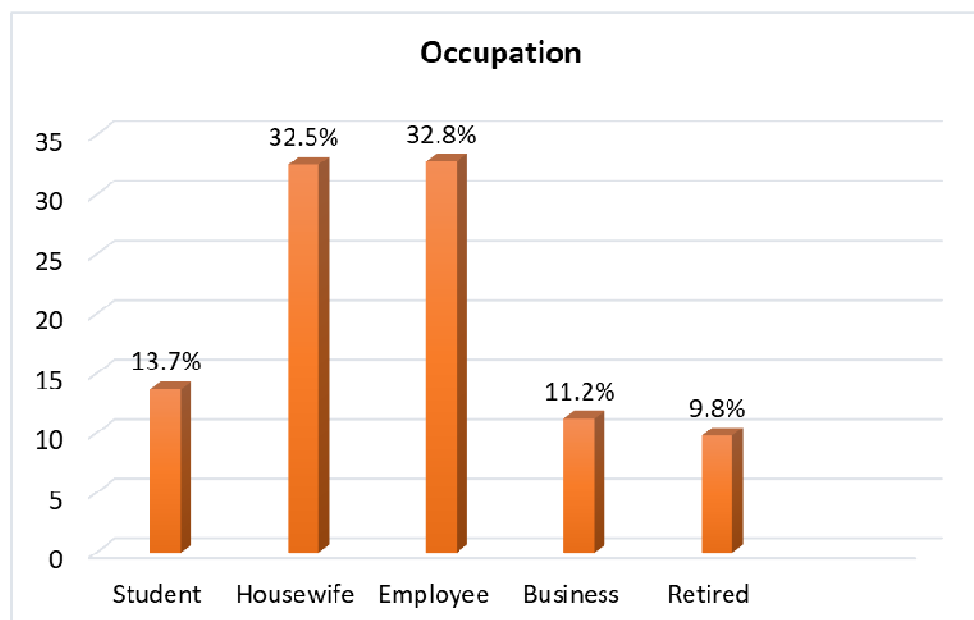
Qualification	Frequency (n)	Percent (%)
Illiterate	20	5.0
Primary School	71	17.8
High School	66	16.5
PUC College	70	17.5
Diploma	42	10.5
Graduate	106	26.5
Post Graduate	25	6.2
Total	400	100.0

Figure 5:- Distribution of Study Participants According to Qualification

In the present study, the majority of the participants were graduates 26.5%. A significant proportion have completed primary school 17.8% and PUC College 17.5%. High school graduates constitute 16.5% of the participants, while diploma holders were 10.5%. Postgraduates represent a smaller segment at 6.2%. Notably, 5% of the participants were illiterate.

Table 6:- Distribution of Study Participants According to Occupation

Occupation	Frequency (n)	Percent (%)
Student	55	13.7
Housewife	130	32.5
Employee	131	32.8
Business	45	11.2
Retired	39	9.8
Total	400	100.0

Figure 6:- Distribution of Study Participants According to Occupation

Among 400 study participants, the largest groups are employees, comprising 32.8%, and housewives were 32.5%. Students account for 13.8%, while business persons represent 11.3%. Retired individuals constitute 9.8%.

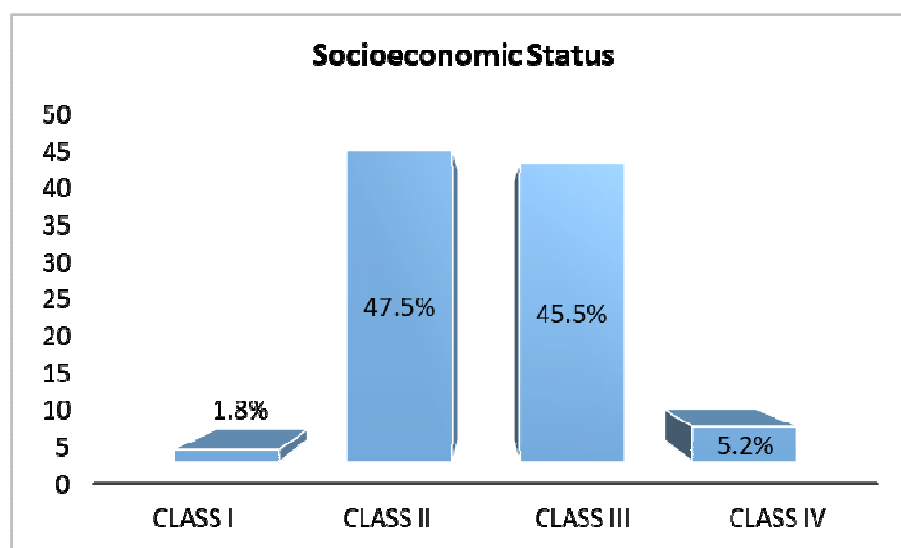
Table 7:- Distribution of Study Participants According to Number of Family Members

Total number of family members	Frequency (n)	Percent (%)
2	8	2.0
3	25	6.3
4	97	24.3
5	106	26.5
6	82	20.5
7	28	7.0
8	24	6.0
9	12	3.0
10	5	1.3
11	4	1.0
12	3	0.8
13	6	1.5
Total	400	100.0

Among the 400 study participants, the most common family size is five members, representing 26.5% of the total. This is closely followed by families with four members (24.3%) and six members (20.5%). Smaller family sizes of three members make up 6.3% and two members 2.0%. Larger families are less common, with 7.0% having seven members, 6.0% having eight members, and 3.0% having nine members. Families with ten or more members are rare, with the percentages progressively decreasing: ten members (1.3%), eleven members (1.0%), twelve members (0.8%), and thirteen members (1.5%).

Table 8:- Distribution of Study Participants According to Socioeconomic Status

Socio-economic status -MODIFIED B G PRASAD Classification	Frequency (n)	Percent (%)
CLASS I	7	1.8
CLASS II	190	47.5
CLASS III	182	45.5
CLASS IV	21	5.2
Total	400	100.0

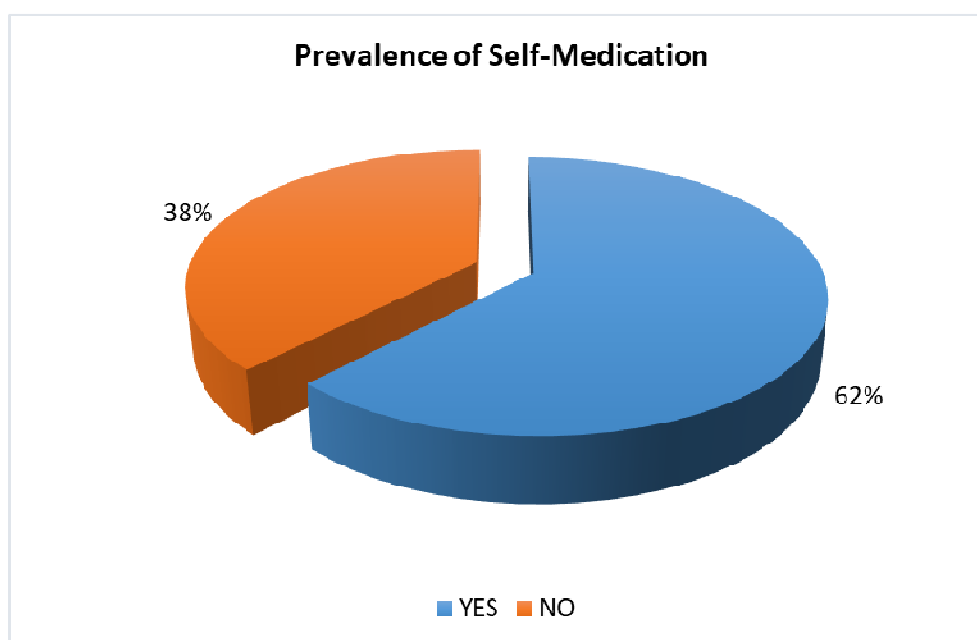
Figure 7:- Distribution of Study Participants According to Socioeconomic Status

Among the 400 study participants, based on the MODIFIED B G PRASAD Classification shows that the majority belong to Class II, representing 47.5% of the total. Class III participants follow closely at 45.5%. Class IV is less represented, making up 5.2% of the participants, while Class I constitutes the smallest group at 1.8%.

Table 9:- Distribution of Study Participants who Engaged in Self-medication During the Last Three Months

	Frequency (n)	Percent (%)
YES	249	62.2
NO	151	37.8
Total	400	100.0

Figure 8:- Distribution of Study Participants who Engaged in Self-medication During the Last Three Months

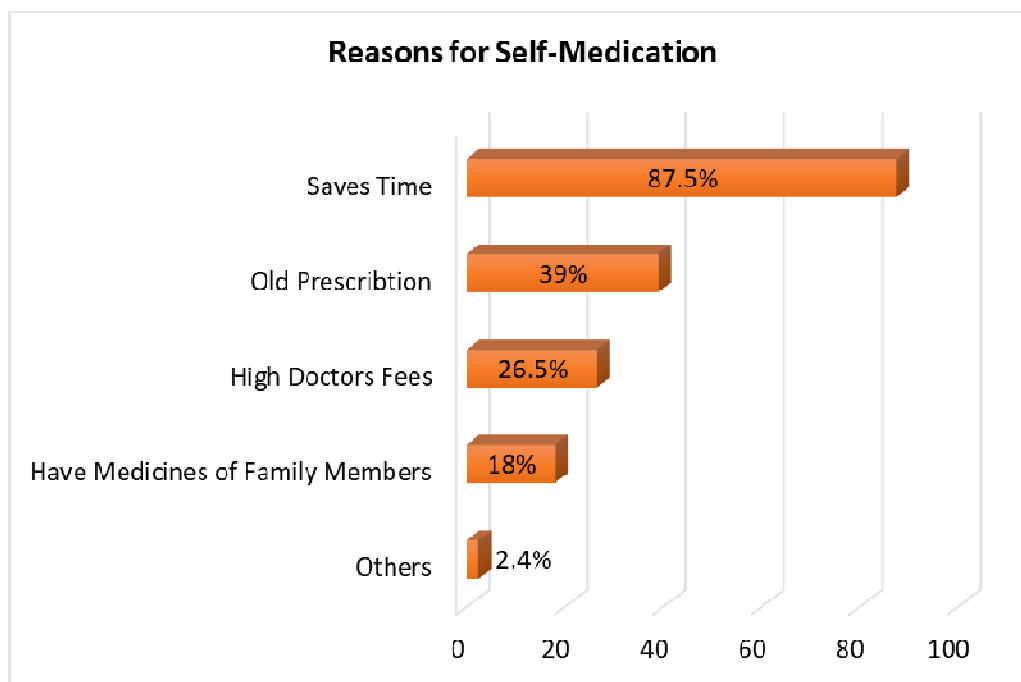


The prevalence of self-medication practices among study participants within last three months reveals that a significant majority, 62% have taken self-medication. In contrast, 38% of the participants have not engaged in self-medication.

Table 10:- Distribution of Study Participants According to Reasons for Self-Medication (n= 249)

	Frequency (n)	Percent (%)
Saves Time	218	87.5
High Doctors Fees	66	26.5
Old Prescription	97	39
Have Medicines of Family Members	45	18
Others	6	2.4

Figure 9:- Distribution of Study Participants According to Reasons for Self-Medication (n= 249)



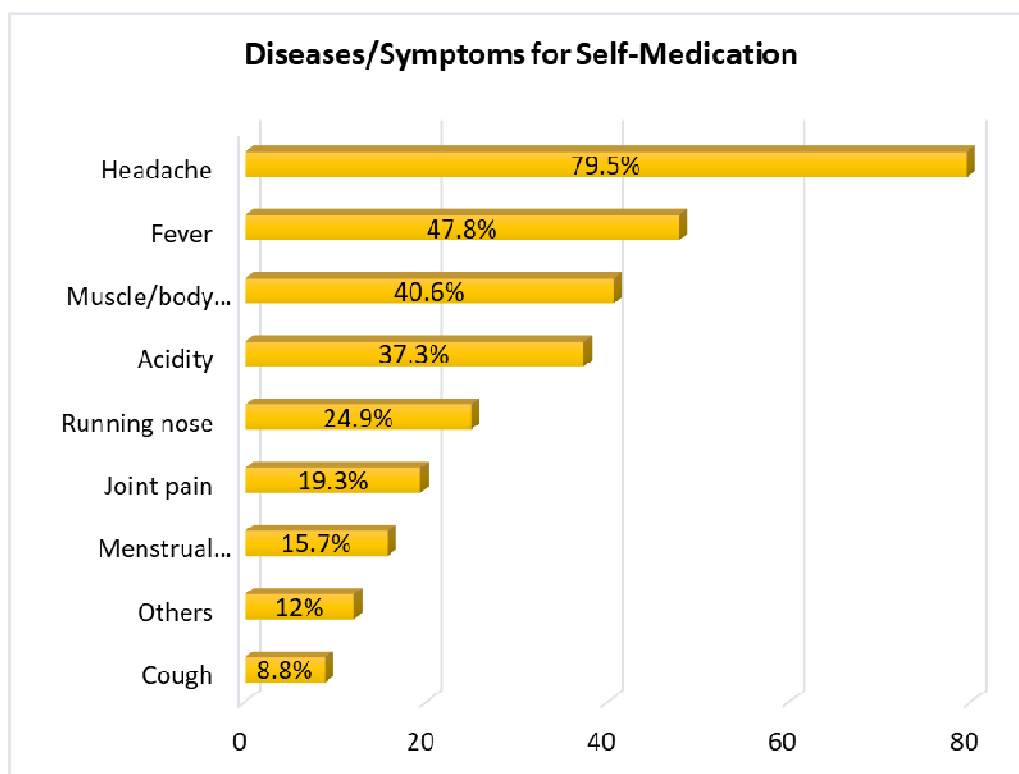
Note: *Multiple response

In the present study, the reasons for self-medication among the participants are varied. The most common reason, cited by 87.5% of those who self-medicated, is that it saves time. Another significant reason is the use of an old prescription, reported by 39% of participants. High doctors' fees motivated 26.5% of the participants to self-medicate, while 18% used medicines that belonged to family members. A small fraction, 2.4%, had other reasons such as Clinic far away, doctor busy with many patients.

Table 11:- Distribution of Study Participants According to Diseases/Symptoms for Which They Took Self-Medication in the Last Three Months (n= 249)

	Frequency (n)	Percent (%)
Fever	119	47.8
Headache	198	79.5
Running nose	62	24.9
Cough	22	8.8
Acidity	93	37.3
Muscle/body pain	101	40.6
Joint pain	48	19.3
Menstrual problems	39	15.7
Others	30	12

Figure 10:- Distribution of Study Participants According to Diseases/Symptoms for Which They Took Self-Medication in the Last Three Months (n= 249)

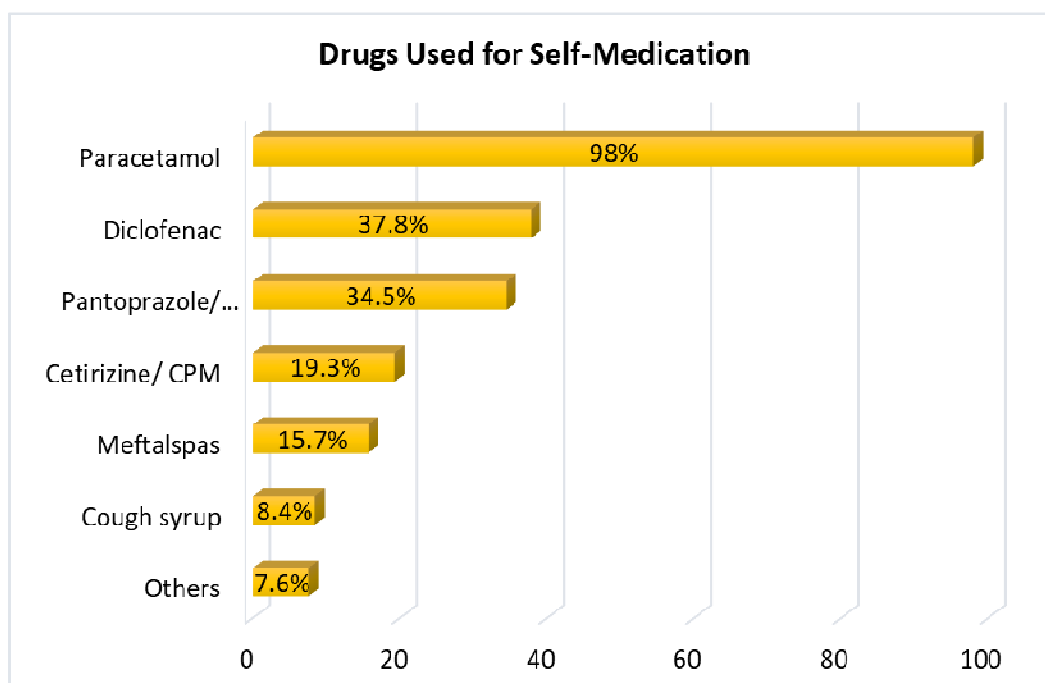


Note: *Multiple response

In our study, for the diseases or symptoms for which participants took self-medication in the last three months indicates that headache was the most common reason, reported by 79.5% of those who self-medicated. Muscle or body pain was another frequent issue, affecting 40.6% of the participants. Fever prompted 47.8% to self-medicate, while acidity was a reason for 37.3%. Running nose and joint pain were less common, reported by 24.9% and 19.3% of participants, respectively. Menstrual problems led 15.7% to self-medicate, and 12% cited other reasons which includes hair fall, skin diseases, rash, mouth ulcers, dental pain . Cough was the least common symptom, with 8.8% of participants self-medicating for it.

Table 12:- Distribution of Study Participants Based on the Drug Used (n= 249)

	Frequency (n)	Percent (%)
Paracetamol	244	98
Diclofenac	132	37.8
Pantoprazole/ Rantac	82	34.5
Cetirizine/ CPM	46	19.3
Cough syrup	21	8.4
Meftalspas	39	15.7
Others	19	7.6

Figure 11:- Distribution of Study Participants Based on the Drug Used (n= 249)

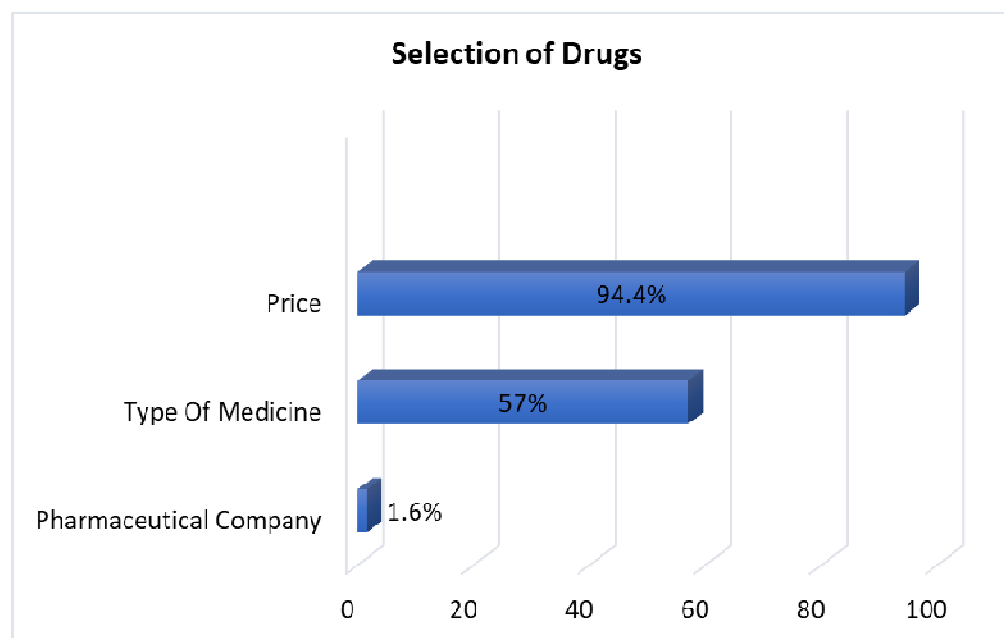
Note: *Multiple responses

The most commonly preferred drug for self-medication is Paracetamol which is used by 98% of participants. Diclofenac is the next most common, used by 37.8%, followed by Pantoprazole/Rantac at 34.5%. Cetrizine/CPM is used by 19.3% of participants, while Meftalspas is used by 15.7%. Cough syrup is used by 8.4%, and other drugs are used by 7.6% of participants.

Table 13:- Distribution of Study Participants Based on Factors Considered When Selecting Drugs for Self-Medication (n= 249)

	Frequency (n)	Percent (%)
Price	235	94.4
Pharmaceutical Company	4	1.6
Type Of Medicine	142	57

Figure 12:- Distribution of Study Participants Based on Factors Considered When Selecting Drugs for Self-Medication (n= 249)



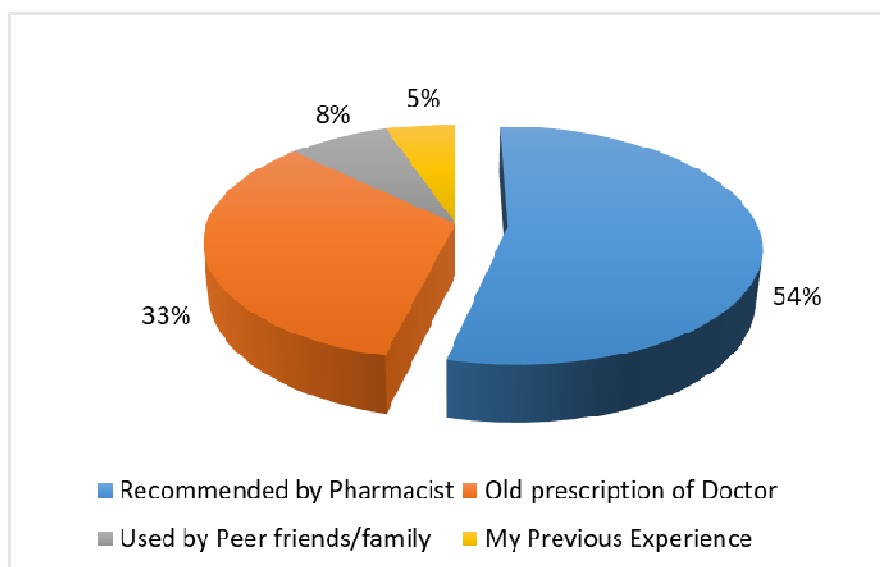
Note: *Multiple responses

When selecting a drug for self-medication, the majority of participants, 94.4%, consider the price as a primary factor. The type of medicine is also an important consideration for 57% of participants, in that all preferred Allopathy. In contrast, only 1.6% take the pharmaceutical company into account when choosing a drug.

Table 14:- Distribution of Study Participants Based on Factors Influencing the Selection of a Particular Brand for Self-Medication (n= 249)

	Frequency (n)	Percent (%)
Recommended by Pharmacist	134	53.8
Old prescription of Doctor	83	33.4
Used by Peer friends/family	19	7.6
My Previous Experience	13	5.2
Total	249	100.0

Figure 13:- Distribution of Study Participants Based on Factors Influencing the Selection of a Particular Brand for Self-Medication (n= 249)

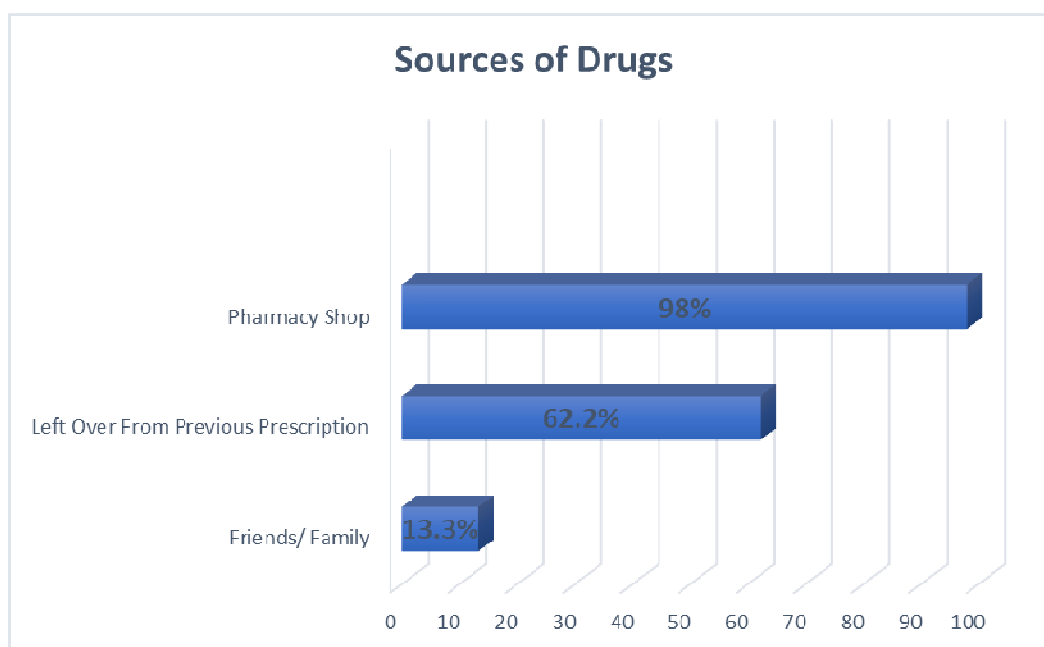


The selection of a particular brand for self-medication among the participants is influenced primarily by recommendations from pharmacists, accounting for 54%. An old prescription from a doctor is the second most common factor, guiding 33% of participants. The influence of peer friends or family is noted by 8% of participants, while 5% rely on their previous experience with the brand.

Table 15:- Distribution of Study Participants According to Sources for Obtaining Drugs for Self-Medication (n= 249)

	Frequency (n)	Percent (%)
Pharmacy Shop	244	98
Left Over From Previous Prescription	155	62.2
Friends/ Family	33	13.3

Figure 14:- Distribution of Study Participants According to Sources for Obtaining Drugs for Self-Medication (n= 249)



Note: *Multiple responses

The sources from which participants obtain their drugs for self-medication are primarily pharmacy shops, with 98% of participants obtaining their medications from these establishments. Additionally, 62.2% of participants use leftover drugs from previous prescriptions, while 13.3% obtain medications from friends or family.

Table 16:- Distribution of Study Participants based on Checking Prescribing Information for Self-Medication (n= 249)

	Frequency (n)	Percent (%)
Yes, sometimes	101	40.6
No, never	148	59.4
Total	249	100.0

In our study, majority 59.4% of the participants never checked the prescription information before self-medication, while 40.6% checks sometimes only.

Table 17:- Distribution of Study Participants based on the Understanding of Prescribing Information Prior to Self-Medication (n= 101)

	Frequency (n)	Percent (%)
Partially Understood	92	91
Not at all	9	9
Total	101	100.0

Among the 101 participants who checked prescribing information before self-medicating, 91% reported partially understanding the information. And 9% indicated that they did not understand the information at all.

Table 18:- Distribution of Study Participants Who Experienced Adverse Events with Self-Medication (n= 249)

	Frequency (n)	Percent (%)
YES, Excessive Sleep	8	3.2
YES, Rash	8	3.2
YES, Vomiting	11	4.4
NO	222	89.2
Total	249	100.0

In our study, out of 249 participants taking self-medication, majority 89% did not experience any adverse effects. While 11% have experienced adverse effects. Among those who have, 4.4% reported vomiting, while 3.2% each reported excessive sleep and rash.

Table 19:- Distribution of Study Participants According to Actions Taken for Adverse Events Experienced with Self-Medication (n= 27)

	Frequency (n)	Percent (%)
Go to Private Doctor	5	18.5
Go to PHC	1	3.7
Stop taking medication	21	77.8
Total	27	100.0

When participants experienced adverse events from self-medication, the majority, 77.8%, chose to stop taking the medication. A smaller portion, 18.5%, sought help from a private doctor, while 3.7% visited a Primary Health Center (PHC).

Table 20:- Distribution of Study Participants Taking Self-Medication for Chronic Diseases (n= 249)

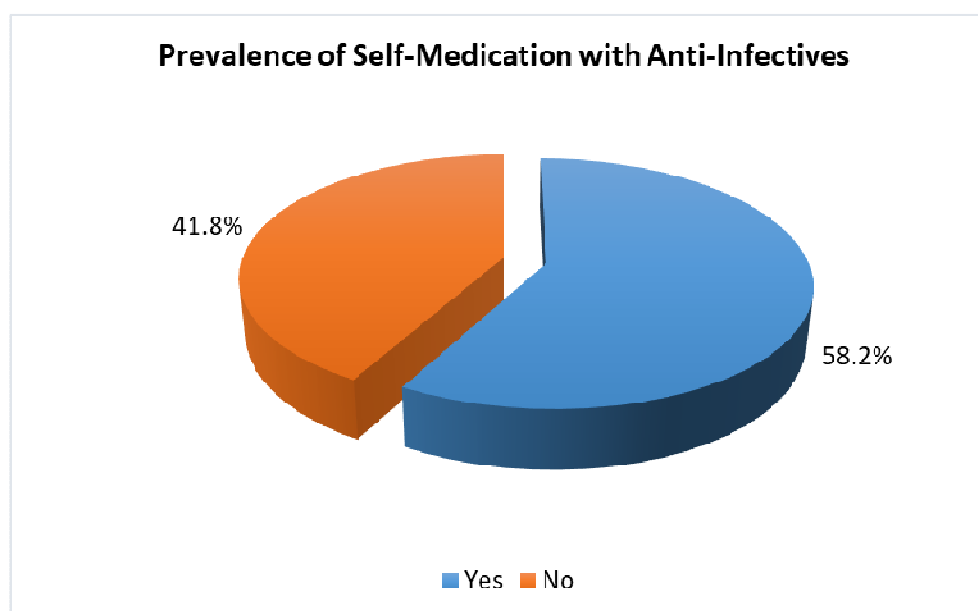
	Frequency (n)	Percent (%)
Yes	2	0.8
No	247	99.2
Total	249	100.0

In our study, self-medication for chronic diseases among participants shows that an overwhelming majority, 99.2%, do not use self-medication for chronic conditions. Only 0.8% reported using self-medication for a chronic disease, and they used for knee joint pain over a period of 3 months, specifically using Diclofenac.

Table 21:- Distribution of Study Participants Who Self-Medicated with Anti-Infectives (n= 249)

	Frequency (n)	Percent (%)
Yes	145	58.2
No	104	41.8
Total	249	100.0

Figure 15:- Distribution of Study Participants Who Self-Medicated with Anti-Infectives (n= 249)

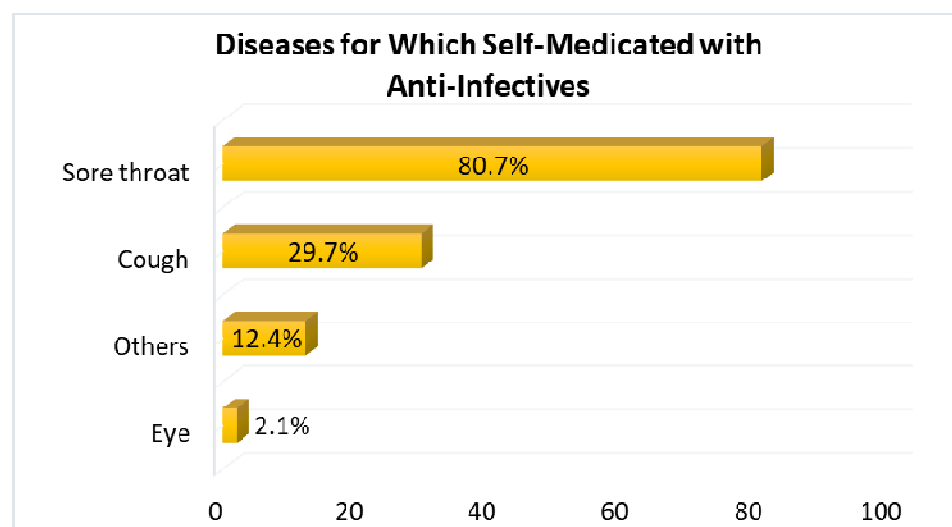


The prevalence of self-medication with anti-infectives among self-medicating 249 participants reveals that 58.2% have self-medicated with anti-infectives, while 41.8% have not.

Table 22:- Distribution of Study Participants According to Diseases for Which They Self-Medicated with Anti-Infectives (n= 145)

	Frequency (n)	Percent (%)
Sore throat	117	80.7
Cough	43	29.7
Eye	3	2.1
Others	18	12.4

Figure 16:- Distribution of Study Participants According to Diseases for Which They Self-Medicated with Anti-Infectives (n= 145)



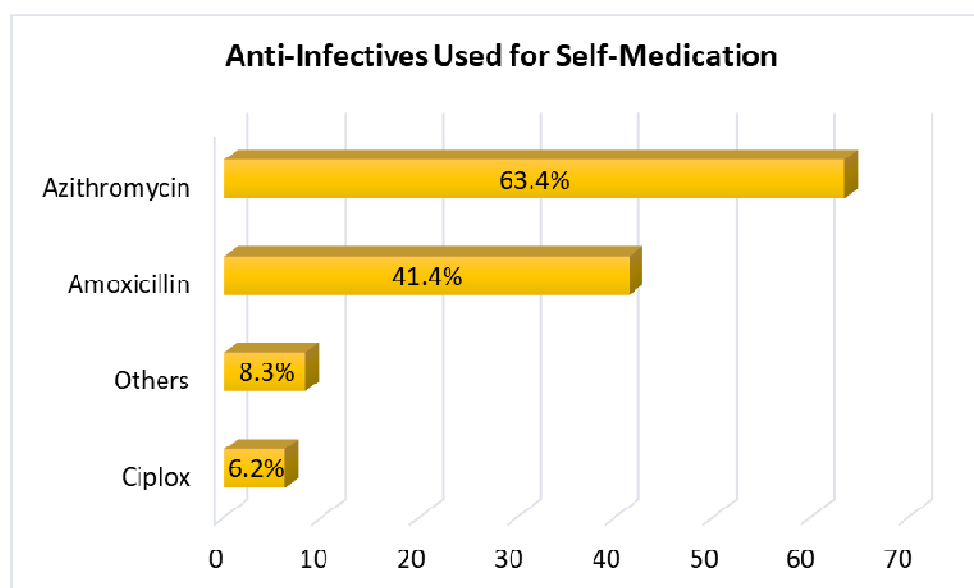
Note: *Multiple responses

The reasons for self-medicating with anti-infectives among participants show that the most common condition is a sore throat, reported by 80.7% of those who self-medicated. Cough was another frequent reason, cited by 29.7% of participants. Eye infections were a much less common reason, reported by 2.1% of participants. Additionally, 12.4% of participants used anti-infectives for other conditions including wounds and skin infections.

Table 23:- Distribution of Study Participants According to Anti-Infectives Used for Self-Medication (n= 145)

	Frequency (n)	Percent (%)
Azithromycin	92	63.4
Amoxicillin	60	41.4
Ciplox	9	6.2
Others	12	8.3

Figure 17:- Distribution of Study Participants According to Anti-Infectives Used for Self-Medication (n= 145)



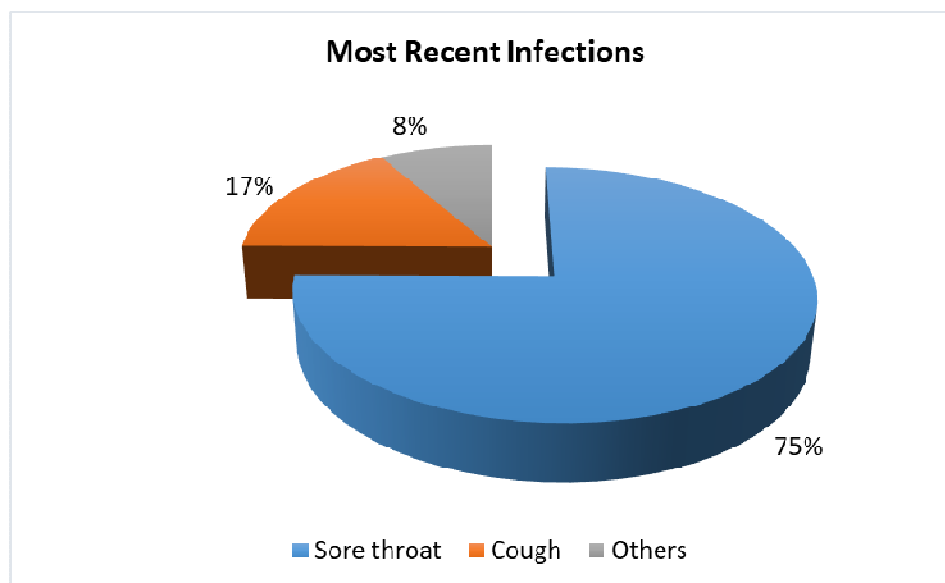
Note: *Multiple responses

Among participants self-medicating with anti-infectives, Azithromycin is the most frequently used, chosen by 63.4%. Amoxicillin used by 41.4%, followed by Ciplox is used by 6.2%, while other anti-infective drugs are used by 8.3% of participants.

Table 24:- Distribution of Study Participants According to the Most Recent Infections for Which they Self-Medicated with Anti-Infectives (n= 145)

	Frequency (n)	Percent (%)
Sore throat	109	75.1
Cough	24	16.6
Others	12	8.3
Total	145	100.0

Figure 18:- Distribution of Study Participants According to the Most Recent Infections for Which they Self-Medicated with Anti-Infectives (n= 145)

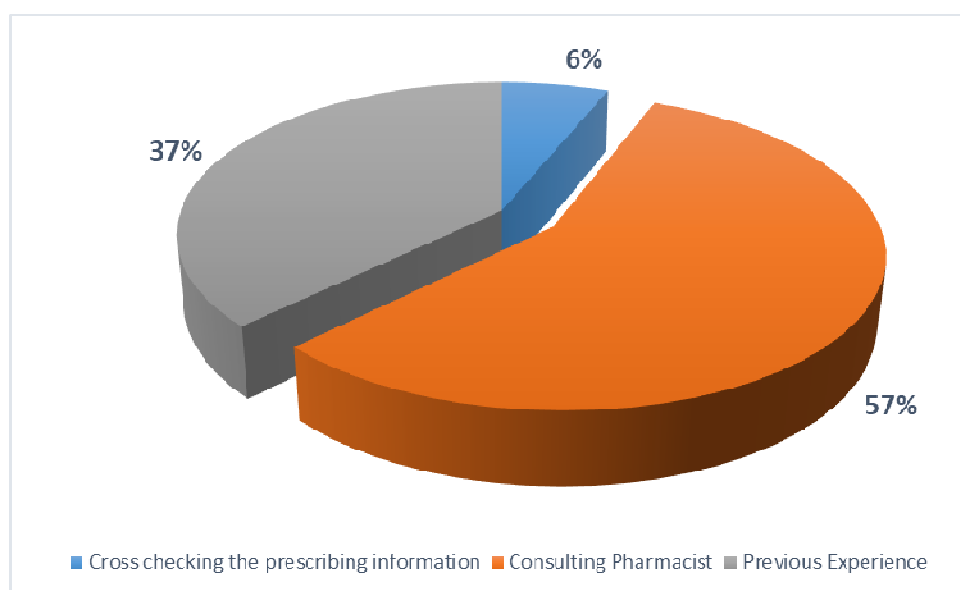


The most recent infections for which individuals self-medicated were predominantly sore throat, with 77.1% reporting this as their most recent ailment. Cough was the second most common infection for self-medication, with 14.3%. In addition, 8.6% stated that they self-medicated for various minor infections such as wound infections, skin infections, and urinary tract infections.

Table 25:- Distribution of Study Participants According to Methods Used to Determine Dosage of Anti-Infectives for Self-Medication (n= 145)

	Frequency (n)	Percent (%)
Cross checking the prescribing information	9	6.2
Consulting Pharmacist	82	56.6
Previous Experience	54	37.2
Total	145	100.0

Figure 19:- Distribution of Study Participants According to Methods Used to Determine Dosage of Anti-Infectives for Self-Medication (n= 145)



Among 145 participants, the dosage of anti-infectives they used for self-medication determined by consulting a pharmacist is 57%. Additionally, 37.2% relied on their previous experience with similar medications. Only 6.2% cross-checked the prescribing information to determine the dosage.

Table 26:- Distribution of Study Participants According to Dosage Changes of Anti-Infectives during Self-Medication (n= 145)

	Frequency (n)	Percent (%)
Yes, sometimes	22	15.7
No, never	123	84.3
Total	145	100.0

Out of 145 study participants, a significant majority of 84.3% stated that they never changed the dosage. While 15.7% reported changing the dosage of anti-infectives during the course of self-medication.

Table 27:- Distribution of Study Participants According to Dosage Changes of Anti-Infectives during Self-Medication (n= 145)

	Frequency (n)	Percent (%)
Health Improved	16	72.7
Disease Worsened	5	22.8
To reduce adverse events	1	4.5
Total	22	100.0

Out of the 22 individuals who reported modifying their dosage, the majority 72.7% did so because they felt their health had improved. While 22.8% changed the dosage because their disease worsened, and 4.5% adjusted the dosage to reduce adverse events.

Table 28:- Distribution of Study Participants According to Changes in Anti-Infectives Used by Them During Their Last Self-Medication (n= 145)

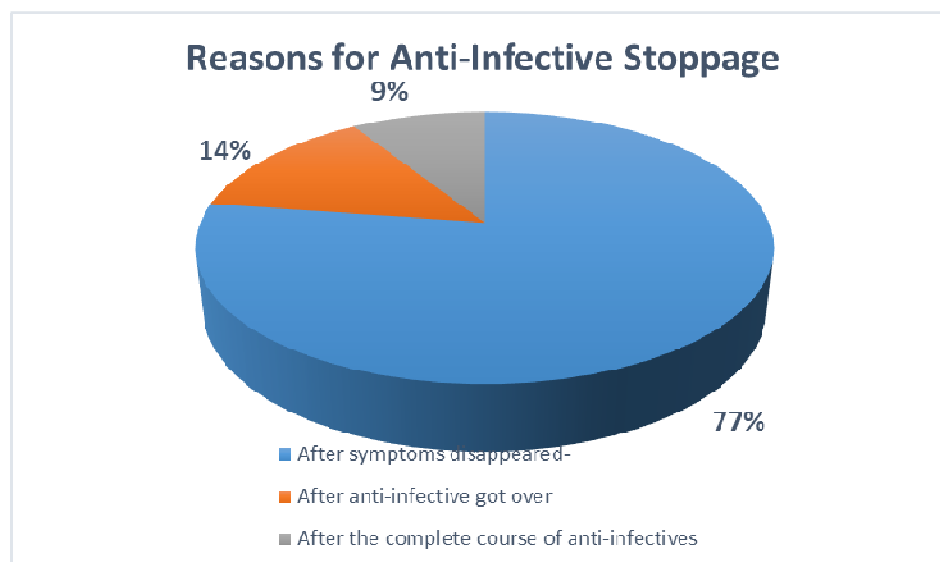
	Frequency (n)	Percent (%)
Yes, sometimes	3	2.1
No, never	142	97.9
Total	145	100.0

In our study, an overwhelming majority of 97.9% stated that they never changed their anti-infectives during self-medication. Only 2.1% admitted to sometimes changing their anti-infectives as the former anti-infective were not working.

Table 29:- Distribution of Study Participants According to Reasons for Anti-Infective Stoppage (n= 145)

	Frequency (n)	Percent (%)
After symptoms disappeared-	112	77.2
After anti-infective got over	20	13.8
After the complete course of anti-infectives	13	9.0
Total	145	100.0

Figure 20:- Distribution of Study Participants According to Reasons for Anti-Infective Stoppage (n= 145)



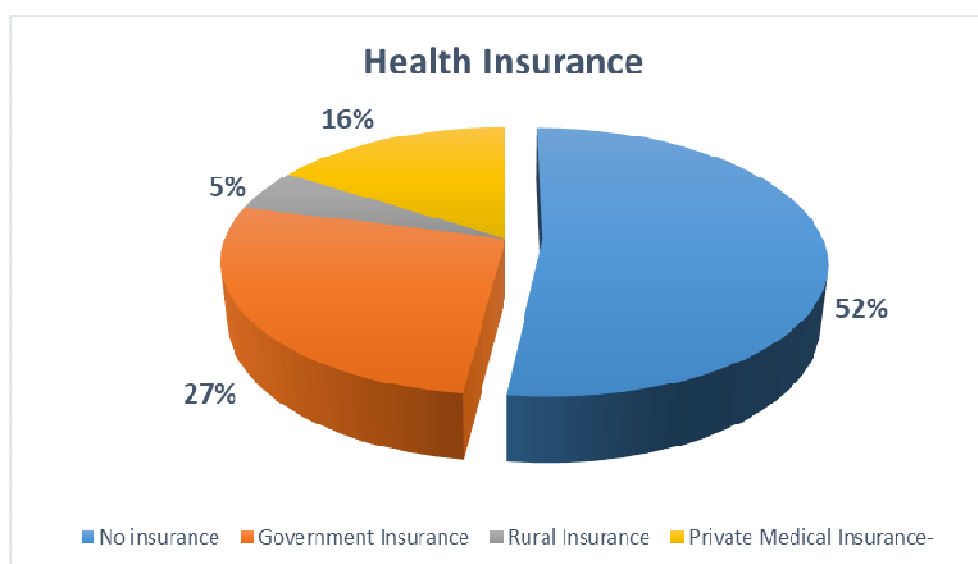
In our study, a majority of 77.2% reported stopping their medication after their symptoms disappeared. While 13.8% ceased taking the anti-infective once their supply ran out. A smaller group comprising 9%, completed the full course of their

prescribed anti-infectives and reported that they obtained their information about the course of anti-infective from a pharmacist.

Table 30:- Distribution of Study Participants According to Their Health Insurance (n= 400)

	Frequency (n)	Percent (%)
No insurance	209	52.25
Government Insurance	109	27.25
Rural Insurance	19	4.75
Private Medical Insurance-	63	15.75
Total	400	100.0

Figure 21:- Distribution of Study Participants According to Their Health Insurance (n= 400)



Out of 400 study Participants, a majority of 52% did not have any health insurance. Government insurance was held by 27%, while 16% have private medical insurance. Additionally, 5% of participants were covered by rural insurance.

Table 31:- Association Between Socio-demographic Factors and Self-Medication

		Have you taken self-medication in last three months?		Total	Pvalue
		YES	NO		
Gender	Male	113	80	193	0.140
	Female	136	71	207	
Total		249	151	400	
Age Group	<20 Yrs	8	0	8	<0.01
	21-30	61	35	96	
	31-40	33	28	61	
	41-50	55	14	69	
	51-60	54	21	75	
	>60 Yrs	38	53	91	
Total		249	151	400	
Marital Status	Unmarried	52	19	71	0.070
	Married	194	128	322	
	Widowed	3	4	7	
Total		249	151	400	
Religion	Hindu	183	104	287	0.320
	Muslim	66	47	113	
Total		249	151	400	
Highest Qualification	Illiterate	17	3	20	<0.01
	Primary School	47	24	71	
	High School	52	14	66	

	PUC College	42	28	70	
	Diploma	40	2	42	
	Graduate	44	62	106	
	Post Graduate	7	18	25	
Total		249	151	400	
Occupation	Student	44	11	55	<0.01
	Housewife	81	49	130	
	Employee	79	52	131	
	Business	40	5	45	
	Retired	5	34	39	
Total		249	151	400	
Total Number Of Family Members Staying With You In This House	2	0	8	8	<0.01
	3	17	8	25	
	4	63	34	97	
	5	56	50	106	
	6	65	17	82	
	7	12	16	28	
	8	8	16	24	
	9	12	0	12	
	10	5	0	5	
	11	4	0	4	
	12	1	2	3	
	13	6	0	6	
Total		249	151	400	
Socio-Economic Status -MODIFIED B G PRASAD Classification	CLASS I	0	7	7	<0.01
	CLASS II	90	100	190	
	CLASS III	148	34	182	
	CLASS IV	11	10	21	
Total		249	151	400	

This table explores various demographic factors influencing self-medication practices in the last three months among 400 respondents, categorized by gender, age

group, marital status, religion, highest qualification, occupation, family size, and socio-economic status.

- Age appears to be a significant factor ($p < 0.01$), with younger age groups (21-30 years) and middle-aged groups (31-50 years) more likely to self-medicate compared to older individuals. Marital status shows a marginal influence ($p = 0.070$), with married individuals being more prone to self-medication.
- Educational level is a significant factor ($p < 0.01$), where individuals with lower educational qualifications tend to self-medicate more than graduates and postgraduates.
- Occupation also significantly impacts self-medication ($p < 0.01$), with students, housewives, and employees more likely to self-medicate compared to retired individuals.
- Family size influences self-medication ($p < 0.01$), with those from larger families (4-6 members) more inclined to self-medicate.
- Socio-economic status significantly affects self-medication ($p < 0.01$), with individuals from Class III socio-economic status self-medicating the most, followed by Class II, and minimal self-medication observed in Class I and IV.
- There is no significant gender difference ($p = 0.140$) in self-medication, with males and females almost equally likely to engage in it.
- Religion does not significantly affect self-medication practices ($p = 0.320$).

Table 32:- Association Between Health Insurance and Self-Medication

Health Insurance	Self-Medication		Total	Pvalue
	YES	NO		
No insurance	161	48	209	<0.01
Government Insurance	48	61	109	
Rural Insurance	12	7	19	
Private Medical Insurance-	28	35	63	
Total	249	151	400	

This table examines the relationship between insurance status and self-medication practices over the last three months among 400 respondents. The data reveals a significant association ($p < 0.01$) between insurance type and the likelihood of self-medication.

- Among those without insurance, a substantial majority, 161 (77%) respondents reported self-medicating, compared to 48 (23%) respondents who did not.
- In contrast, individuals with government insurance were less likely to self-medicate, with 48 (44%) respondents self-medicating and 61 (56%) respondents not self-medicating.
- Among those with rural insurance, 12 (63%) respondents self-medicated while 7 (37%) respondents did not.
- Those 28 (44%) respondents with private medical insurance reported self-medicating, compared to 35 (56%) respondents who did not.

Table 33:- Association Between Gender and Reasons for Self-Medication.

		GENDER		Total	Pvalue
		Male	Female		
Saves Time	YES	98	120	218	0.719
	NO	15	16	31	
Total		113	136	249	
High Doctors Fees	YES	31	35	66	0.76
	NO	82	101	183	
Total		113	136	249	
Old Prescription	YES	31	66	97	<0.01
	NO	82	70	152	
Total		113	136	249	
Have Medicines of Family Members	YES	10	35	45	<0.01
	NO	103	101	204	
Total		113	136	249	
Others	YES	3	110	113	0.818
	NO	3	133	136	
Total		6	243	249	

This table explores the impact of gender on self-medication practices among 249 respondents, categorized as male and female.

- A significant gender differences emerged where, Females were more likely to use old prescriptions (66 females vs. 31 males, $p < 0.01$)
- Family members medicines (35 females vs. 10 males, $p < 0.01$) as reasons for self-medication.
- Time-saving is a common reason cited by both genders, with 98 males and 120 females indicating this motive, showing no significant gender difference ($p = 0.719$).
- High doctor's fees were a reason for self-medication for 31 males and 35 females, again showing no significant gender disparity ($p = 0.76$).
- For other unspecified reasons, there was no significant gender difference ($p = 0.818$).

Table 34:- Association Between Age Groups and Reasons for Self-Medication.

	AGE GROUP	<20 Years	21-30	31-40	41-50	51-60	>60 Years	Total	Pvalue
Saves Time	YES	8	58	27	44	53	28	218	0.001
	NO	0	3	6	11	1	10	31	
Total		8	61	33	55	54	38	249	
High Doctors Fees	YES	0	2	16	26	17	5	66	<0.01
	NO	8	59	17	29	37	33	183	
Total		8	61	33	55	54	38	249	
Old Prescription	YES	1	24	8	29	12	23	97	<0.01
	NO	7	37	25	26	42	15	152	
Total		8	61	33	55	54	38	249	
Have Medicines of Family Members	YES	5	0	0	7	12	21	45	<0.01
	NO	3	61	33	48	42	17	204	
Total		8	61	33	55	54	38	249	
Others	YES	0	3	0	3	0	0	6	0.214
	NO	8	58	33	52	54	38	243	
Total		8	61	33	55	54	38	249	

This table analyses the influence of age on the reasons for self-medication among 249 respondents, categorized into six age groups: under 20 years, 21-30, 31-40, 41-50, 51-60, and over 60 years.

- A significant association was found between age and the reason of saving time ($p = 0.001$), with younger respondents (21-30 years) being more likely to cite this reason compared to older groups.
- High doctor's fees as a reason for self-medication showed a significant age-related difference ($p < 0.01$), particularly affecting those in the 41-50 and 51-60 age groups.
- The use of old prescriptions was also significantly influenced by age ($p < 0.01$), with higher usage reported among those aged 41-50 and over 60 years.
- Having medicines of family members as a reason exhibited a significant age difference ($p < 0.01$), predominantly seen in respondents over 60 years.
- For other reasons no significant age difference was observed ($p = 0.214$).

Table 35:- Association Between Marital Status and Reasons for Self-Medication.

	MARITAL STATUS	Unmarried	Married	Widowed	Total	Pvalue
Saves Time	YES	49	166	3	218	0.196
	NO	3	28	0	31	
Total		52	194	3	249	
High Doctors Fees	YES	1	65	0	66	<0.01
	NO	51	129	3	183	
Total		52	194	3	249	
Old Prescription	YES	12	82	3	97	0.04
	NO	40	112	0	152	
Total		52	194	3	249	
Have Medicines of Family Members	YES	5	37	3	45	<0.01
	NO	47	157	0	204	
Total		52	194	3	249	
Others	YES	0	6	0	6	0.418
	NO	52	188	3	243	
Total		52	194	3	249	

This table explores the impact of marital status on self-medication practices among 249 respondents, categorized as unmarried, married, or widowed.

- High doctor's fees as a reason for self-medication significantly varies with marital status ($p < 0.01$), primarily affecting married individuals (65 respondents).
- The use of old prescriptions also shows a significant difference ($p = 0.04$), with married individuals being more likely to rely on them (82 respondents).
- Having medicines of family members as a reason demonstrates a significant marital status difference ($p < 0.01$), again mainly affecting married (37 respondents) and widowed individuals (3 respondents).
- The data shows that the reason of saving time does not significantly differ by marital status ($p = 0.196$), with 49 unmarried, 166 married, and 3 widowed respondents citing this reason.
- And other reasons for self-medication do not show significant variation with marital status ($p = 0.418$).

Table 36:- Association Between Influence of Religion and Reasons for Self-Medication.

		RELIGION		Total	Pvalue
		Hindu	Muslim		
Saves Time	YES	166	52	218	0.012
	NO	17	14	31	
Total		183	66	249	
High Doctors Fees	YES	52	14	66	0.256
	NO	131	52	183	
Total		183	66	249	
Old Prescription	YES	69	28	97	0.5
	NO	114	38	152	
Total		183	66	249	
Have Medicines of Family Members	YES	28	17	45	0.058
	NO	155	49	204	
Total		183	66	249	
Others	YES	0	6	6	<0.01
	NO	183	60	243	
Total		183	66	249	

This table analyses the impact of religion on self-medication practices among 249 respondents, categorized as Hindu or Muslim.

- A significant association between religion and the reason of saving time ($p = 0.012$), with 166 Hindus and 52 Muslims citing this motive.
- Having medicines of family members as a reason exhibits a marginal difference ($p = 0.058$), with 28 Hindus and 17 Muslims indicating this reason.
- High doctor's fees as a reason for self-medication does not significantly differ by religion ($p = 0.256$), with 52 Hindus and 14 Muslims reporting this issue.
- The use of old prescriptions also shows no significant difference between the two religion groups ($p = 0.5$), with 69 Hindus and 28 Muslims using old prescriptions.
- For other reasons, there is a significant difference ($p < 0.01$), with 6 Muslims and no Hindus citing this reason.

Table 37:- Association Between Occupation and Reasons for Self-Medication.

		OCCUPATION						Pvalue
		Student	Housewife	Employee	Business	Retired	Total	
Saves Time	YES	41	67	77	31	2	218	<0.01
	NO	3	14	2	9	3	31	
Total		44	81	79	40	5	249	
High Doctors Fees	YES	1	29	17	19	0	66	<0.01
	NO	43	52	62	21	5	183	
Total		44	81	79	40	5	249	
Old Prescription	YES	9	48	25	12	3	97	<0.01
	NO	35	33	54	28	2	152	
Total		44	81	79	40	5	249	
Have Medicines of Family Members	YES	5	27	5	5	3	45	<0.01
	NO	39	54	74	35	2	204	
Total		44	81	79	40	5	249	
Others	YES	0	3	0	3	0	6	0.086
	NO	44	78	79	37	5	243	
Total		44	81	79	40	5	249	

This table examines the reasons for self-medication among 249 respondents, categorized by their occupation: student, housewife, employee, businessperson, and retired.

- A significant association between occupation and the reason of saving time ($p < 0.01$), with the highest proportions seen among employees (77) and housewives (67). Students (41) and businesspersons (31) also frequently cited saving time, while it was least common among retired individuals (2).
- High doctor's fees as a reason for self-medication also significantly varies with occupation ($p < 0.01$), predominantly affecting housewives (29), businesspersons (19), and employees (17), with no retired individuals citing this reason.
- The use of old prescriptions shows a significant difference ($p < 0.01$), especially among housewives (48), employees (25), and students (9).
- Having medicines of family members as a reason is significantly influenced by occupation ($p < 0.01$), with housewives (27) being the most likely to cite this reason.
- Other reasons do not show significant variation with occupation ($p = 0.086$).

Table 38:- Association Between Socio-Economic Status and Reasons for Self-Medication.

		Socio-economic status -MODIFIED B G PRASAD Classification			Total	p value
		CLASS II	CLASS III	CLASS IV		
Saves Time	YES	83	126	9	218	0.232
	NO	7	22	2	31	
Total		90	148	11	249	
High Doctors Fees	YES	16	46	4	66	0.059
	NO	74	102	7	183	
Total		90	148	11	249	
Old Prescription	YES	37	55	5	97	0.75
	NO	53	93	6	152	
Total		90	148	11	249	
Have Medicines of Family Members	YES	14	29	2	45	0.735
	NO	76	119	9	204	
Total		90	148	11	249	
Others	YES	0	6	0	6	0.123
	NO	90	142	11	243	
Total		90	148	11	249	

This analyses the relationship between socio-economic status, based on the Modified B G Prasad Classification, and reasons for self-medication among 249 respondents, categorized into Class II, Class III, and Class IV.

- High doctor's fees as a reason for self-medication approaches significance ($p = 0.059$), with more respondents in Class III (46) and Class II (16) affected than in Class IV (4).
- No significant association between socio-economic status and the reason of saving time ($p = 0.232$), with the majority of respondents in Class III (126) and Class II (83) citing this reason, compared to 9 in Class IV.
- The use of old prescriptions shows no significant difference across socio-economic classes ($p = 0.75$), with Class III (55), Class II (37), and Class IV (5) similarly reporting this reason.
- Having medicines of family members also does not significantly vary by socio-economic status ($p = 0.735$), with Class III (29), Class II (14), and Class IV (2) indicating this reason.
- Other reasons show no significant variation with socio-economic status ($p = 0.123$).

DISCUSSION

I. SOCIODEMOGRAPHIC PROFILE OF STUDY PARTICIPANTS

Table 1:- Distribution of the Study Participants According to Gender

The research found that out of the 400 participants, 48.3% were men and 51.8% were females, suggesting a small majority of females in self-medication activities. The results align with a study carried out by Gupta and Chakraborty in an urban neighborhood in West Bengal. In this study, out of the 170 individuals who engaged in self-medication, 57.1% were females and 42.9% were men.⁴² In a research conducted by Mangal et al. in the urban slums of Southern Rajasthan, it was found that 52% of the participants were females. Among the participants, self-medication was more common among females (54%) compared to men (46%).⁴³

In contrast, a study from the Ernakulum District in Southern India by Paul et al. showed an almost equal gender distribution (50.5% males and 49.5% females) among the 539 participants, with no significant gender difference in self-medication rates.⁴⁴

These comparative findings highlight a common trend of higher self-medication practices among females, potentially due to their roles in managing household health and higher health-seeking behaviour.

Table 2:- Distribution of the Study Participants According to Age Groups

The current study observed that the largest group of self-medicating participants were aged 21-30 years (24.0%), followed closely by those older than 60

years (22.8%). This distribution is consistent with a study conducted by Gupta and Chakraborty where researchers reported a high prevalence of self-medication among participants aged 28-37 years (39.8%) in West Bengal.⁴² Similarly, Mangal et al. found that young adults aged 18-29 years constituted about 32% of self-medicators in Southern Rajasthan.⁴³ Phalke et al. in Maharashtra also found the highest prevalence among the 21-30 years age group (29%).⁴⁵ Choudhury T et al. in Delhi reported a higher prevalence among individuals aged 20-30 years (30%), followed by those aged 30-40 years (25%).⁴⁶ Sharma et al. noted that the age group 31-40 years had the highest prevalence (28%) in Haryana, indicating some regional differences, though the 21-30 age group was also significant (25%).²⁰

These findings collectively highlight a common trend of higher self-medication practices among younger adults, particularly those aged 21-30 years, suggesting that this demographic is more likely to self-medicate due to factors such as convenience and busy lifestyles. Understanding these age dynamics is crucial for designing targeted public health interventions to educate young adults about the risks of self-medication and promote safer health practices.

Table 3:- Distribution of Study Participants According to Marital Status

The current study found that 80.5% of the 400 participants were married, highlighting a significant prevalence of self-medication among married individuals. This finding is consistent with Gupta and Chakraborty in West Bengal, where 78.6% of the 170 self-medicating participants were married.⁴² Similarly, Mangal et al. in Southern Rajasthan reported that 70% of their 200 participants practicing self-medication were married.⁴³ In Haryana, Sharma et al. found that 65% of participants were married, supporting the trend despite a slightly lower proportion.²⁰ Choudhury T

et al. in urban Delhi observed that 75% of self-medicating participants were married, reinforcing the association between marital status and self-medication.⁴⁶ Phalke et al. in Maharashtra also reported a similar pattern, with 80% of their participants being married.⁴⁵

These comparative findings suggest that marital status is a significant factor influencing self-medication practices, potentially due to the increased health management responsibilities within families and the need for quick solutions to minor health issues.

Table 4:- Distribution of Study Participants According to Religion

The current study observed that among 400 participants, 71.8% were Hindu and 28.3% were Muslim. This distribution aligns with findings from Mangal et al. in Southern Rajasthan, where 78% of participants were Hindu, indicating a regional prevalence of Hindu participants in self-medication studies.⁴³ Similarly, Gupta and Chakraborty in West Bengal reported that 80% of their participants were Hindu, with higher self-medication rates among Hindus.⁴² However, in Paul et al. from Ernakulam, 85% of participants were Hindu but showed no significant differences in self-medication practices based on religion, suggesting other influencing factors.⁴⁴

Contrastingly, Saha et al. found that in Chattogram, Bangladesh, 85% of participants were Muslim, with self-medication more prevalent among Muslims, highlighting regional and cultural variations.⁴⁷

These comparisons suggest that while regional demographics heavily influence the religious composition of study participants, self-medication practices are

more strongly impacted by cultural, regional, and situational factors than by religion alone.

Table 5:- Distribution of Study Participants According to Qualification

The current study found that among 400 participants, the highest qualifications were diverse, with the majority being graduates (26.5%). A significant proportion had completed primary school (17.8%) and PUC College (17.5%), with high school graduates constituting 16.5%. Diploma holders made up 10.5%, postgraduates represented 6.3%, and 5.0% of participants were illiterate. This distribution of education levels in self-medication practices aligns with a study conducted by Saha et al. in Thimphu, Bhutan, and Chattogram, Bangladesh, it was found that participants with primary and secondary education levels were more prone to self-medication compared to those with higher education levels, indicating a similar trend where lower educational qualifications are associated with higher self-medication rates.⁴⁷ Another study by Mangal et al. in Southern Rajasthan observed that 24.3% of participants were graduates, and a significant number of self-medicators had only primary or secondary education, reflecting a pattern similar to the current study.⁴³

While the current study indicates that lower educational qualifications are associated with higher self-medication rates, consistent with findings in Bhutan and Rajasthan. This suggests that both lack of education and specific knowledge of medications can influence self-medication practices and public health interventions need to consider these facts when addressing self-medication practices across different educational backgrounds.

Table 6:- Distribution of Study Participants According to Occupation

The current study found that among the 400 participants, the largest occupational groups were employees (32.8%) and housewives (32.5%), followed by students (13.8%), businesspersons (11.3%), and retired individuals (9.8%). This distribution is comparable to several other studies on self-medication practices.

Saha et al. in Chattogram, Bangladesh, reported significant self-medication practices among employed individuals (45%) and students (22%), reflecting similar trends observed in the current study.⁴⁷ Mangal et al. in Southern Rajasthan found that self-medication was prevalent among housewives (58%) and unskilled workers (38.4%), consistent with the significant proportion of housewives in the current study.⁴³ Additionally, Paul et al. in Ernakulam, India, found that housewives (50%) and skilled workers (30%) were primary self-medicators, further supporting the current study's results.⁴⁴

Table 7:- Distribution of Study Participants According to Number of Family Members

The current study found that the most common family size among the 400 participants was five members (26.5%), followed closely by families with four members (24.3%) and six members (20.5%). Smaller family sizes of three members made up 6.3%, and two members constituted 2.0%. Larger families were less common, with seven-member families at 7.0%, eight-member families at 6.0%, and nine-member families at 3.0%. Families with ten or more members were rare, with progressively decreasing percentages for ten members (1.3%), eleven members (1.0%), twelve members (0.8%), and thirteen members (1.5%).

Comparing these findings to other studies, Saha et al. in Chattogram, Bangladesh, observed that self-medication practices were prevalent in both nuclear and extended families, with larger families showing higher tendencies towards self-medication due to shared health practices and limited access to healthcare.⁴⁷ Mangal et al. in Southern Rajasthan reported that families with five to six members were the most common, consistent with the current study's findings of higher self-medication rates in similar family sizes.⁴³

Paul et al. in Ernakulam, India, also noted that nuclear families had higher self-medication rates, which could be due to less collective health decision-making and more individual autonomy in medication use.⁴⁴

These comparisons suggest that family size and structure significantly influence self-medication practices. Larger families may share medications and rely on collective knowledge, while nuclear families may engage more in self-medication due to individual health autonomy.

Table 8:- Distribution of Study Participants According to Socioeconomic Status

The current study found that the majority of the 400 participants belonged to Class II (47.5%) and Class III (45.5%) socioeconomic status, based on the Modified B G Prasad Classification. Class IV was less represented (5.3%), and Class I constituted the smallest group (1.8%).

This distribution is comparable to findings from other studies on self-medication practices. Saha et al. in Chattogram, Bangladesh, and Thimphu, Bhutan, reported that self-medication was prevalent among participants from lower-middle and middle socioeconomic classes.⁴⁷ They found that participants from the lower

socioeconomic classes were more likely to self-medicate due to economic constraints and limited access to healthcare. Similarly, Gupta and Chakraborty in West Bengal observed that 46.9% of self-medicating participants belonged to Class III and IV, highlighting that lower socioeconomic status groups have a higher tendency to self-medicate.⁴²

Paul et al. in Ernakulam District, Southern India, found that the prevalence of self-medication was higher among participants from lower socioeconomic classes (Class III and IV) and emphasized that economic constraints often lead individuals to self-medicate instead of seeking professional healthcare.⁴⁴ Additionally, a study by Selvaraj et al. (2014) in Urban Puducherry, India, noted that self-medication was significantly associated with lower socioeconomic status, as individuals from these groups tend to rely more on over-the-counter medications due to cost concerns and limited access to medical facilities.³⁸

These comparisons indicate a consistent trend across various regions where individuals from lower socioeconomic classes are more likely to engage in self-medication. This behaviour is driven by factors such as economic constraints, limited access to healthcare, and the need for cost-effective treatment options.

II. Prevalence of Self-Medication

Table 9:- Distribution of Study Participants Who Took Self-Medication in the Last Three Months

The current study found that 62.3% of the 400 participants had taken self-medication in the last three months. This high prevalence aligns with several other studies. Saha et al. in Chattogram, Bangladesh, observed a higher prevalence of

61.8% in Thimphu, Bhutan, and 41.5% in Chattogram, reflecting increased self-medication.⁴⁷ Another study by Pranav et al. in urban slums of Karnataka reported a prevalence of 47.0%, while Gupta et al. found a prevalence of 55.9% in Mumbai, and Varghese SS et al. reported 68.0% in Maharashtra.^{48,42,49} These figures are closer to the findings of the current study, indicating that self-medication is a common practice across various regions, especially in urban areas and during healthcare access constraints. Additionally, a study in West Bengal by Gupta and Chakraborty found that 57.7% of participants practiced self-medication, which is similar to the current study's findings.⁴²

A study conducted by Paul et al. in Ernakulam District, Southern India, reported that 21.5% of participants had practiced self-medication within the last three months, which is significantly lower compared to the current study.⁴⁴

These comparisons indicate a consistent pattern of high self-medication prevalence across various regions, influenced by factors such as healthcare accessibility, economic constraints, and the need for immediate relief from health issues.

III. Patterns of Self-Medication

Table 10:- Distribution of Study Participants According to Reasons for Self-Medication

The current study found that the primary reason for self-medication among participants was saving time, cited by 54.5% of those who self-medicated. Other significant reasons included the use of an old prescription (24.3%), high doctors' fees (16.5%), using medicines belonging to family members (11.3%) and a small fraction

(1.5%) had other reasons. This pattern is consistent with findings from several other studies.

In a study by Paul et al. in Ernakulam, India, 32.4% of participants reported self-medication due to lack of time to visit a doctor, and 27.8% cited the triviality of their illness.⁴⁴ Similarly, Saha et al. in Chattogram, Bangladesh, and Thimphu, Bhutan, found that 32.4% of participants engaged in self-medication for treating minor ailments, with 22.5% doing so because of their medical knowledge from previous prescriptions.⁴⁷ In another study conducted in urban slums of Karnataka by Pranav et al., the primary reasons for self-medication were economic benefits (24.1%), quick relief (64.4%), and ease of availability (54.4%).⁴⁸ Gupta et al. in Mumbai reported that 40.5% of participants self-medicated to save time, which is consistent with the current study's findings.⁴² Moreover, Mahanta R et al. in Assam found that the main reasons for self-medication were monetary benefits (60%) and previous good experiences with certain medications (46.5%).⁵⁰

These studies collectively highlight that time-saving, economic benefits, and prior knowledge or experience with medications are common motivators for self-medication across different regions and contexts.

Table 11:- Distribution of Study Participants According to Diseases/Symptoms for Which They Took Self-Medication in the Last Three Months

The current study found that 79.5% of participants self-medicated for headache, making it the most common symptom. Muscle or body pain was another frequent reason for self-medication, reported by 40.6% of participants, followed by fever (47.8%), acidity (37.3%), running nose (24.9%), and joint pain (19.3%). Less

common reasons included menstrual problems (15.7%) and cough (8.8%). This distribution is consistent with findings from several other studies.

Pranav et al conducted a research in Karnataka and found that headaches (40%), colds (33.3%), fever (20.3%), and coughs (14.7%) were most common health issues for which people self-medicated.⁴⁸ Similarly, Saha et al. conducted a study in Chattogram, Bangladesh, and Thimphu, Bhutan, where they discovered that self-medication was often seen for mild diseases such as headaches (32.4%), cough and cold (17.22%), and bodily discomfort (11.11%).⁴⁷ According to a study conducted by Paul et al. in Ernakulam, the primary reasons for self-medication were physical discomfort (28.9%), elevated body temperature (22.8%), and long-term illnesses (13.7%).⁴⁴ In West Bengal, Gupta and Chakraborty found fever (27.6%) and cough-cold (24.5%) as prevalent causes for self-medication.⁴² These studies highlight that headache, fever, and body pain are common symptoms leading to self-medication across different regions and demographics.

Table 12:- Distribution of Study Participants According to Drug Used

The current study found that Paracetamol was the overwhelmingly preferred choice for self-medication, used by 98% of participants. Diclofenac was the next most common drug, used by 37.8%, followed by Pantoprazole/Rantac at 34.5%, Cetirizine/CPM at 19.3%, Meftalspas at 15.7%, cough syrup at 8.4%, and other unspecified drugs at 7.6%. This pattern is consistent with findings from several other studies.

A research done by Paul et al. in Ernakulam, India revealed that pain suppressors and antibiotics were the predominant drugs used for self-medication,

accounting for 46.9% and 43.9% respectively.⁴⁴ Similarly, Saha et al. found that in Chattogram, Bangladesh, and Thimphu, Bhutan, people often used antipyretics and antihistamines for self-medication.⁴⁷ The use of antipyretics was almost twice as high in Thimphu compared to Chattogram, with a rate of 54.2% against 27.8%.

Pranav et al. reported that Paracetamol and pain medications were the most often used pharmaceuticals for self-medication in the urban slums of Karnataka, which aligns with the findings of the present research.⁴⁸ In West Bengal, Gupta et al. discovered that 46.9% of the individuals used pain suppressors, a finding that aligns with the prevalent usage of Paracetamol in the present research.⁴²

Another study by Jain et al. in Southern Rajasthan reported that antibiotics and painkillers were commonly used, with 43.9% of participants using antibiotics for self-medication.⁵¹ Varghese et al. in Maharashtra also found that Paracetamol and antibiotics were frequently used, with 55.9% of participants reporting the use of pain relievers.⁵² In Assam, Borah et al. noted that the use of painkillers and antibiotics was prevalent among urban slum dwellers, with 79.1% using Paracetamol for self-medication.⁵³ Similarly, Keche et al. in Pune, Maharashtra, found that painkillers were the most common drugs used for self-medication, consistent with findings of the current study.⁵⁴

These comparisons indicate that Paracetamol and pain relievers are the most commonly used drugs for self-medication across various regions, reflecting their widespread availability and effectiveness in treating common ailments.

Table 13:- Distribution of Study Participants Based on Factors Considered When Selecting Drugs for Self-Medication

The present research revealed that a significant majority of participants (94.4%) prioritize price as the key determinant when choosing a medicine for self-medication. In addition, 57% of individuals consider the specific kind of drug, whilst just 1.6% take into consideration the pharmaceutical business. This focus on pricing corresponds with conclusions drawn from previous research investigations. A study conducted by Samuel et al. in Erode, India, revealed that the main factors driving self-medication were price and convenience.⁵⁵ A considerable proportion of participants emphasized the importance of cost in their decision-making process. Similarly, Balamurugan and Ganesh in South India reported that 71% of participants considered cost an essential factor in their decision to self-medicate.⁵⁶ In another study by Banerjee and Bhadury in West Bengal, 60% of participants indicated that the cost of medications was a primary consideration.⁵⁷

Rajendran et al. in Kerala and Parimi et al. in Trinidad and Tobago both found that affordability was a key determinant in the choice of self-medication, aligning with the findings of the current study.⁵⁸

And in the current study found that among participants who consider the type of medicine when selecting drugs for self-medication, all preferred allopathy. In a study by Biswas et al. in Bangladesh found that 64.5% of participants used allopathic medicines for self-medication, reflecting a strong preference for conventional medicine over alternative treatments.⁵⁹ In another study conducted by Ahmad et al. in Uttar Pradesh, India, 58% of participants reported a preference for allopathic medicines due to their perceived effectiveness and quick relief.⁶⁰

Arrais et al. in Brazil also noted that 72.3% of participants opted for allopathic medicines, indicating a global trend towards the use of conventional pharmaceuticals for self-medication.⁶¹ Paudel and Aryal in Nepal found that 60% of participants chose allopathic medicines for self-medication, highlighting their trust in conventional treatments for common ailments.⁶²

These comparisons highlight that while price is a predominant factor in selecting drugs for self-medication across various regions, other considerations such as the type of medicine and the need for quick relief also play significant roles. And these studies collectively indicate a significant preference for allopathic medicines in self-medication practices across various regions and populations.

Table 14:- Distribution of Study Participants According to Factors Influencing the Selection of a Particular Brand for Self-Medication

The current study found that the selection of a particular brand for self-medication among participants is influenced primarily by recommendations from pharmacists, accounting for 53.8%. An old prescription from a doctor guided 33.3% of participants, the influence of peer friends or family was noted by 7.6%, and 5.2% relied on their previous experience with the brand.

In a study by Samuel et al. in Erode, India, 42% of participants indicated that their choice of medication was based on pharmacist recommendations.⁵⁵ Similarly, a study conducted by Banerjee and Bhadury in West Bengal found that 40% of participants selected medications based on previous doctor prescriptions, highlighting the influence of past medical advice.⁵⁷ Balamurugan and Ganesh in South India reported that 45% of participants relied on pharmacists for brand selection, while 35%

depended on old prescriptions.⁵⁶ Sharma et al. in Jammu city found 38% of participants were influenced by pharmacists, and 25% by previous prescriptions, showing a similar pattern of reliance on professional advice for self-medication.⁶³

Wijesinghe et al. in Sri Lanka noted that 50% of respondents chose drugs based on pharmacist advice, reflecting a strong influence of pharmacists in brand selection.⁶⁴ A study by Abdi et al. in Iran highlighted that 44% of health sciences students selected medications based on pharmacists' recommendations, showing the global relevance of these findings.⁶⁵

These studies collectively indicate that pharmacists play a crucial role in influencing the selection of medication brands in self-medication practices across various regions, with old prescriptions also being a significant factor.

Table 15:- Distribution of Study Participants According to Sources for Obtaining Drugs for Self-Medication

The current study found that the primary source for obtaining drugs for self-medication was pharmacy shops, with 98% of participants obtaining their medications from these establishments. Additionally, 62.2% of participants used leftover drugs from previous prescriptions, while 13.3% obtained medications from friends or family. In a study by Samuel et al. in Erode, India, it was found that 64.3% of participants obtained their self-medicated drugs from pharmacies, and 34.7% used expired prescriptions.⁵⁵

Mathias et al. in South Karnataka reported that pharmacies were the primary source of drugs for 76.5% of participants, and 34.7% used old prescriptions to obtain their medications.⁶⁶ A study conducted by Paul et al. in Ernakulam District, Southern

India, revealed that 76.3% of participants sourced their medications from community pharmacies, and a smaller percentage (19.3%) used leftovers from previous prescriptions.⁴⁴ Another study by Jain et al. in Southern Rajasthan found that 72.6% of participants obtained their drugs from pharmacies, reflecting a similar pattern to the current study.⁶⁷ Borgohain et al. in Assam reported that 83.8% of urban slum dwellers obtained their medications from pharmacies, while 24.4% used drugs left over from previous prescriptions.⁶⁸ In the study by Gupta et al. (2011) in Mumbai, 80.5% of participants obtained their medications from pharmacies, and 25.4% used old prescriptions.⁴² In a study by Kaushal et al. in Northern India, 74% of participants obtained their self-medicated drugs from pharmacies, while 30% used leftover medications from previous prescriptions.⁶⁹

These consistent findings across various regions highlight the predominant role of pharmacies as the primary source for obtaining self-medicated drugs, with a substantial proportion of individuals also relying on leftover medications from previous prescriptions.

Table 16:- Distribution of Study Participants Checking Prescribing Information for Self-Medication

The current study found that 40.6% of participants sometimes check the prescribing information before self-medicating, while a majority of 59.4% never check the prescribing information. This trend is observed in several other studies across different regions, indicating a widespread issue of inadequate engagement with prescribing information.

In a study by Gras et al. among French university students, it was reported that only 35% of participants regularly checked the prescribing information before taking medication, while 65% either never or only occasionally checked the information.⁷⁰ Similarly, in a study by Afolabi et al. in Ondo State, Nigeria, 42% reported checking prescribing information sometimes, and a larger portion, 58%, rarely or never did so.⁷¹

Saha et al. in Chattogram, Bangladesh, and Thimphu, Bhutan, it was observed that 48% of participants sometimes checked the prescribing information before self-medicating, while 52% never did so, aligning closely with the current study's findings.⁴⁷ Additionally, a study by Paudel and Aryal in Pokhara Valley, Nepal, reported that 50% of participants sometimes engaged with prescribing information, whereas the remaining 50% did not bother checking.⁷²

These studies collectively highlight a common issue across different populations: a significant portion of individuals engaging in self-medication do not adequately check prescribing information. This behaviour can lead to improper use of medications, increased risk of adverse effects, and drug resistance.

Table 17,18,19:- Distribution of Study Participants Understanding of Prescribing Information Prior to Self-Medication/ Who Experienced Adverse Events with Self-Medication

The current study found that among participants who sometimes or always check prescribing information before self-medicating, 91% partially understood the instructions, while 9% did not understand them at all. Additionally, 89% of participants reported not experiencing any adverse events with self-medication.

Among those who did experience adverse events, vomiting was reported by 4.4%, and both excessive sleep and rash were reported by 3.2% of participants.

Similarly, in a study conducted by Saha et al. in Chattogram, Bangladesh, and Thimphu, Bhutan, it was observed that a significant portion of participants had limited understanding of prescribing information, which influenced their self-medication practices. In a study by Samuel et al. in Erode, India, reported that a majority of participants only partially understood the prescribing information, which often led to misuse and adverse effects.⁴⁷ Additionally, a study by Afolabi et al. in Ondo State, Nigeria, highlighted that misunderstanding or ignorance of prescribing information was a significant factor contributing to adverse effects in self-medication practices.⁷¹ The study revealed that many participants experienced similar adverse events such as vomiting and skin reactions due to improper self-medication.

Table 20:- Distribution of Study Participants Taking Self-Medication for Chronic Diseases

The findings of this study reveal a low prevalence of self-medication for chronic diseases, with only 0.8% of participants engaging in such practices, specifically using Diclofenac for knee joint pain over a three-month period.

This contrasts sharply with a study conducted by Abay and Amelo in Ethiopia, which reported a 38.6%, and Alam et al. in Saudi Arabia, where 26.2% of adults self-medicated for chronic conditions.^{73,74} These differences may reflect variations in healthcare access and cultural attitudes towards self-medication.

These findings indicate a cautious approach to self-medication for chronic diseases but a more prevalent tendency to self-medicate for chronic diseases among adult populations in the other regions.

IV. Patterns of Self-Medication with Anti-Infectives

Table 21-29:- Distribution of Study Participants Who Self-Medicated with Anti-Infectives: Diseases Treated, Medications Used, and Influencing Factors"

The current study reveals significant insights into self-medication practices with anti-infectives among participants. Notably, 58.2% of participants have self-medicated with anti-infectives, with Azithromycin being the most frequently used (63.4%), followed by Amoxicillin (41.4%). The most common infections for which participants self-medicated was sore throat (75.2%) and cough (16.6%). This high prevalence of self-medication with anti-infectives aligns with some regional trends but also stands out compared to global patterns, indicating specific local behaviours and healthcare access issues.

When comparing these findings globally, the current study's prevalence of self-medication with anti-infectives (58.2%) is notably higher than the 3% to 48% range reported by Grigoryan et al. in Europe.⁷⁵ Similarly, Auta et al. found a global prevalence of 43.0% for self-medication with antibiotics, which is lower than the current study's results.⁷⁶ These differences may be attributed to variations in healthcare access, cultural attitudes towards self-medication, and the availability of medications without prescriptions.

In contrast, the prevalence reported by Bachhav and Kshirsagar in India (53%) closely aligns with the current findings, suggesting similar self-medication behaviours in the region.⁷⁷ Similarly, the study by Zafar et al. in Pakistan found that 51% of the urban population self-medicated with antibiotics, which is close to the current findings, indicating similar trends in urban settings, and Shehadeh et al. in Jordan found that 42.5% of university students self-medicated with antibiotics, which is lower than the current study's findings.^{78,79} This might reflect differences in population demographics, with the current study possibly including a broader or different demographic.

The current findings indicate a relatively high prevalence of self-medication with anti-infectives compared to many other regions. The frequent use of Azithromycin and Amoxicillin is consistent with common choices in other regions. The practice of consulting pharmacists for dosage information and the high adherence to prescribed dosages in the current study underscores a reliance on professional advice even when self-medicating.

V. Health Insurance

Table 30:- Distribution of Study Participants According to Their Health Insurance

The current study provides a detailed overview of health insurance coverage among respondents, revealing that 52.3% do not have any health insurance, 27.3% have government insurance, 15.8% have private medical insurance, and 4.8% are covered by rural insurance. The KPMG (2020) reported that approximately 60% of the Indian population did not have any health insurance, which is slightly higher than

the 52.3% observed in the current study.⁸⁰ This similarity suggests that both contexts face substantial challenges in extending health insurance coverage. However, the penetration of government schemes is better in the current study, with 27.3% compared to around 20% in India.⁸¹

When comparing these findings globally, the dominance of government insurance schemes in Europe, ensuring almost universal coverage, highlights the disparities in healthcare systems and the effectiveness of public health policies compared to the 27.3% government insurance coverage in the current study.⁸²

The significant lack of insurance coverage among more than half of the participants highlights a crucial gap in healthcare accessibility and financial protection. Without health insurance, individuals are more likely to face substantial barriers when seeking proper medical care.

VI. Factors Associated with Self-Medication

Table 31-38:- Associations of Socio-Demographic Factors and Health Insurance with Self-Medication Practices

The current study explores various demographic factors influencing self-medication practices over the last three months among 400 respondents.

The analysis reveals no significant gender difference ($p = 0.140$) in self-medication, indicating that both males and females are equally likely to engage in this behaviour. This finding is consistent with global studies such as the one by Fadare et al. in Nigeria, which also reported no significant gender differences in self-medication practices.⁸³

However, age appears to be a significant factor ($p < 0.01$), with younger (21-30 years) and middle-aged groups (31-50 years) more likely to self-medicate than older individuals. Similar trends have been observed, such as in the study by Gupta and Chakraborty where researchers reported a high prevalence of self-medication among participants aged 28-37 years in West Bengal and Auta et al. in Ethiopia, found younger age groups were more inclined to self-medicate due to greater health awareness and access to information.^{42,76}

Marital status shows a marginal influence ($p = 0.070$) on self-medication, with married individuals being more prone to self-medicate. This aligns with findings from a study by Sontakke et al. in India, where married individuals were more likely to self-medicate, possibly due to the need to manage household responsibilities quickly.⁸⁴

Religion does not significantly affect self-medication practices ($p = 0.320$), a result that is supported by studies like that of Mangal et al. in Southern Rajasthan, Paul et al. from Kerala and Sarahroodi et al. in Iran, where religious beliefs did not significantly influence self-medication behaviours.^{43,44,85}

Educational level is a significant factor ($p < 0.01$), with individuals with lower educational qualifications tending to self-medicate more than graduates and postgraduates. This finding is echoed in studies by Mangal et al. in Southern Rajasthan, Abay and Amel in Ethiopia, which reported higher self-medication rates among less educated individuals due to limited health literacy.^{43,86}

Occupation also significantly impacts self-medication ($p < 0.01$), with students, housewives, and employees more likely to self-medicate compared to retired

individuals. This is similar to findings by Mangal et al. in Southern Rajasthan, Paul et al. from Kerala and Ruiz et al. in Spain, where occupation influenced self-medication behaviours, particularly among working individuals and students.^{43,44,87}

Family size influences self-medication ($p < 0.01$), with those from larger families (4-6 members) more inclined to self-medicate. This trend is also observed in the study by Alghanim in Saudi Arabia, where larger family sizes were associated with higher self-medication rates due to economic constraints.⁸⁸

Socio-economic status significantly affects self-medication ($p < 0.01$), with individuals from Class III socio-economic status self-medicating the most. This pattern is consistent with findings from a study by Abula et al in Ethiopia, which reported higher self-medication rates among lower socio-economic classes due to limited access to healthcare services.

The study also examines the relationship between insurance status and self-medication practices. There is a significant association ($p < 0.01$) between insurance type and the likelihood of self-medication. Among those without insurance, 77.0% reported self-medicating, compared to lower rates among those with government (44.0%), rural (63.2%), and private medical insurance (44.4%). This aligns with findings by Bawazir in Saudi Arabia, where uninsured individuals were more likely to self-medicate due to high healthcare costs and limited access to medical services.⁹⁰

Time-saving is a common reason cited by both genders for self-medication, showing no significant gender difference ($p = 0.719$). This finding is consistent with study like the one by Banerjee and Bhadury in India, where both genders equally cited convenience as a reason for self-medication.⁹¹ However, significant gender

differences emerged in other areas, such as the use of old prescriptions and family members' medicines, which were more common among females. This aligns with findings by Klemenc-Ketis et al. in Slovenia, where women were more likely to use previously prescribed medications for self-treatment.⁹²

Age significantly influences the reasons for self-medication, with younger respondents more likely to cite time-saving and older respondents more likely to use old prescriptions and family members' medicines. This is consistent with findings by Lukovic et al. in Serbia, where younger individuals cited convenience and older individuals relied on previous prescriptions.⁸

Marital status also affects self-medication reasons, with married individuals more likely to cite high doctor's fees and the use of old prescriptions, similar to findings by Mehta et al. in Nepal.⁶²

The impact of religion on self-medication practices shows significant differences for reasons such as time-saving and other reasons. This contrasts with findings by Sarahroodi et al. in Iran, where religion did not significantly influence self-medication reasons, highlighting regional variations in how religious beliefs impact health behaviours.⁸⁵

These findings highlight important demographic influences on self-medication practices, underscoring the need for targeted interventions to address these behaviours. Interventions should prioritize health literacy, affordable healthcare access and treatments, considering factors like convenience and financial constraints.

Public Health Significance

The findings of the current study underscore the pervasive nature of self-medication practices among various demographic groups. With 62.3% of participants reporting self-medication in the past three months, the study highlights significant public health concerns.

The high prevalence of self-medication, particularly with anti-infectives, poses risks of antibiotic resistance, adverse drug reactions, and potential misuse of medications. The frequent use of medications such as Azithromycin and Amoxicillin without proper medical guidance could contribute to the growing global threat of antimicrobial resistance. Public health campaigns should prioritize educating the population about dangers of self-medication and necessity of consulting healthcare professionals.

The significant influence of socio-economic status on self-medication practices indicates a need for improved healthcare access and affordability. Individuals from lower socio-economic classes are more likely to self-medicate due to economic constraints and limited access to healthcare services. This finding suggests that public health policies should aim to enhance healthcare accessibility and affordability, particularly for vulnerable populations. Additionally, the high reliance on pharmacists for dosage information and medication recommendations emphasizes the need for better regulation and training of pharmacists to ensure they provide accurate and safe guidance.

CONCLUSION

The study conducted on the urban population of Belagavi, Karnataka, provides comprehensive insights into self-medication practices and their public health significance. 62.3% of participants reported self-medication within last three months and it highlights a substantial public health challenge that warrants immediate attention. The gender distribution of the study reveals a slightly higher prevalence of self-medication among females (51.8%) compared to males (48.3%). This gender disparity is critical for public health planning as it suggests that females, potentially due to their roles in household health management, are more inclined towards self-medication. This tendency could lead to the misuse of medications and higher exposure to potential adverse drug reactions among females, necessitating targeted educational campaigns to address their specific health needs and behaviours.

Age distribution data indicate that younger adults (21-30 years) and older adults (>60 years) are the most significant groups practicing self-medication. Younger adults might resort to self-medication due to busy lifestyles and the need for quick relief from minor ailments, while older adults might self-medicate due to chronic conditions and familiarity with certain medications. Public health initiatives should focus on educating these age groups about the risks of self-medication and promoting safer alternatives, such as regular health check-ups and consultations with healthcare professionals. Marital status plays a significant role, with married individuals (80.5%) showing a higher prevalence of self-medication. Married individuals often manage the health of multiple family members, which might drive them to opt for quick solutions like self-medication. This highlights the need for public health policies that support

families in accessing affordable healthcare services, thereby reducing the reliance on self-medication.

Educational levels among the participants varied, but a notable observation was that graduates constituted the largest group (26.5%). Despite higher educational qualifications, self-medication practices were prevalent, indicating that education alone does not mitigate the practice. This suggests a gap in healthcare literacy, emphasizing the importance of integrating comprehensive health education into curriculums to foster a better understanding of risks associated with self-medication behaviours and importance in a professional medical advice. Occupation-wise, employees (32.8%) and housewives (32.5%) were the largest groups practicing self-medication. This trend indicates that both working individuals and homemakers seek convenient solutions to health issues. Public health strategies should include workplace wellness programs and community health initiatives that provide accessible healthcare services and information, reducing the inclination towards self-medication.

Family size also influenced self-medication practices, with families of five members (26.5%) showing the highest prevalence. Larger families might share medications and rely on collective knowledge for treating ailments, which can lead to inappropriate use of drugs. Public health interventions should aim to educate larger families about the risks of sharing medications and encourage them to seek professional healthcare advice. Socioeconomic status significantly impacted self-medication, with the majority of participants belonging to Class II (47.5%) and Class III (45.5%). Economic constraints often drive individuals to opt for over-the-counter drugs as a cost-saving measure. Public health policies should focus on improving the

accessibility and affordability of healthcare services for lower socioeconomic groups, thereby reducing their reliance on self-medication.

The primary reasons for self-medication included saving time (54.5%), using old prescriptions (24.3%), and high doctors' fees (16.5%). These reasons reflect broader systemic issues such as inadequate healthcare access and high medical costs. Addressing these systemic issues through policy reforms and investments in healthcare infrastructure can significantly reduce the prevalence of self-medication. In terms of medication types, Paracetamol was the most commonly used drug (98%), followed by Diclofenac (37.8%) and Pantoprazole/Rantac (34.5%). The widespread use of these medications underscores the need for stricter regulations on the sale of over-the-counter drugs and enhanced public awareness campaigns about the risks of unsupervised drug use.

The high prevalence of self-medication in the urban population of Belagavi, influenced by various sociodemographic factors, underscores the need for comprehensive public health interventions. Strategies should focus on improving healthcare accessibility, regulating over-the-counter drug sales, and enhancing public awareness about the risks of self-medication.

By addressing these factors, public health initiatives can improve health outcomes and mitigate the risks associated with self-medication, ultimately ensuring safer health practices among the population.

RECOMMENDATIONS

The study opens several avenues for future research. Longitudinal studies could provide deeper insights into the long-term effects of self-medication practices on individual health outcomes and the broader healthcare system. Understanding how self-medication trends evolve over time and their impact on healthcare costs and antibiotic resistance could inform more effective public health interventions.

There is a need for qualitative research to explore the underlying reasons behind self-medication behaviours. Understanding the motivations, attitudes, and beliefs that drive self-medication can help design targeted educational campaigns and interventions. For example, exploring why certain demographics, such as younger adults and married individuals, are more prone to self-medicate could provide valuable insights.

Comparative studies across different regions and cultural contexts could help identify unique factors influencing self-medication practices. Such research can guide the development of region-specific public health strategies and policies.

Additionally, investigating the role of digital health tools and mobile health applications in managing self-medication practices could offer innovative solutions for monitoring and guiding self-medication behaviours.

STRENGTHS OF THE STUDY

Community-based studies are often more relevant to policymakers and public health practitioners. In the present study, by focusing on the urban areas of Belagavi helped in capturing specific health behaviours and self-medication practices unique to this community. This localized approach ensures that the findings are relevant and can directly inform local public health initiatives and policies.

This study's objective to identify both prevalence of self-medication practices and associated factors provides a comprehensive overview of the issue. This dual focus not only identifies how widespread the practice is but also uncovers the underlying reasons and contributing factors. This approach allows for a more in-depth analysis and understanding, facilitating the development of multifaceted cost-effective strategies and targeted interventions.

The study's findings can guide the formulation of more effective regulations and guidelines for the sale and use of medications, potentially leading to stricter control measures. Prevention strategies can be more proactive, targeting the root causes and risk factors identified in the study.

This study adds to knowledge on self-medication practices, especially from an urban Indian context, which is often underrepresented in global research. This contribution helps fill existing knowledge gaps and provides a basis for comparative studies.

This study provides baseline data that can be used for future research and longitudinal studies. This foundation allows for tracking changes in self-medication practices over time and assessing the impact of interventions.

LIMITATIONS

There are some limitations in the research that should be taken into account. The cross-sectional methodology of the study limits the capacity to show a causal association between demographic characteristics and self-medication habits. This emphasizes the need of conducting longitudinal research to get a better understanding of these interactions over time.

Moreover, the dependence on self-reported data might lead to bias, as individuals may intentionally provide inaccurate information about their self-medication habits owing to memory or the need to conform to societal norms. Incorporating objective metrics, such as pharmacy records or electronic health data, in future study might be advantageous for validating self-reported information.

Additionally, the study's focus on a specific geographic region may limit generalizability of this findings to any other regions or communities with a different healthcare systems and cultural contexts. Comparative studies in diverse settings are necessary to confirm these findings and understand regional variations.

Also, the study did not investigate the clinical outcomes of self-medication practices, such as adverse drug reactions or treatment failures, which are crucial for comprehending the full health implications of self-medication. Addressing these limitations in future research can enhance our understanding and inform more effective public health strategies.

SUMMARY

Self-medication is a significant worldwide health issue, with varying incidence rates seen in various locations. Self-medication, as defined by the WHO refers to the practice of people using pharmaceutical goods to cure diseases or symptoms, they have identified themselves, continuing to use pharmaceuticals previously given to them, or using medicines based on advice from non-professional sources. Self-medication using over-the-counter (OTC) medications is prevalent in India owing to variables such as cost-effectiveness, convenience, and restricted healthcare accessibility. The objective of this research is to examine the frequency and determinants of self-medication in urban regions of Belagavi, Karnataka.

The study was structured as a community-based cross-sectional study carried out for a duration of 12 months. 400 participants were chosen using systematic selection from the urban field practice regions of Rukmini Nagar UHC and Ashok Nagar UHC. The sample size was determined using the prevalence of self-medication reported in prior research, and the sampling technique guaranteed that each location was represented proportionally. The data was gathered by conducting door-to-door surveys using a pre-validated questionnaire that included demographic information, self-medication behaviours, and health insurance details. The statistical analysis was conducted using SPSS version 25.0. Descriptive statistics and chi-square analysis were used to discover any significant relationships.

The study found that 62.3% of the participants had engaged in self-medication in the past three months. Gender-wise, 51.8% of the participants were females, indicating a slight predominance in self-medication practices among females. Age-

wise, the highest prevalence was observed among participants aged 21-30 years, followed by those over 60 years. Marital status showed that a significant majority (80.5%) of the participants were married, aligning with other studies that suggest higher self-medication rates among married individuals due to increased health management responsibilities. The highest educational qualification of participants varied, with graduates constituting the largest group (26.5%). Occupation-wise, the largest groups were employees (32.8%) and housewives (32.5%). Family size analysis revealed that most participants came from families with five members, followed by families with four and six members. Socioeconomic status analysis indicated that the majority belonged to Class II (47.5%) and Class III (45.5%) according to the Modified B.G. Prasad Classification. Comparative analysis with other studies showed consistent findings, particularly regarding the reasons for self-medication. The primary reason cited by participants was saving time (54.5%), followed by using old prescriptions, high doctors' fees, and using medicines belonging to family members. Common symptoms leading to self-medication included headache (79.5%), muscle or body pain (40.6%), and fever (47.8%). Paracetamol was the most commonly used drug for self-medication, followed by Diclofenac and Pantoprazole/Rantac.

Among the 249 self-medicating participants, 58.2% used anti-infectives. Common reasons for self-medication included sore throat (80.7%), cough (29.7%), and Azithromycin was the most frequently used anti-infective (63.4%), followed by Amoxicillin (41.4%). For their most recent infections, 77.1% self-medicated for sore throat and the dosage of anti-infective determined consulting a pharmacist (57%), previous experience (37.2%), and cross-checking prescribing information (6.2%).

This study revealed significant associations between socio-demographic factors and self-medication behaviour. Younger (21-30 years) and middle-aged (31-50 years) individuals were more likely to self-medicate compared to older individuals ($p < 0.01$). Lower educational levels were linked to higher self-medication rates ($p < 0.01$), as were occupations such as students, housewives, and employees compared to retired individuals ($p < 0.01$). Larger family sizes (4-6 members) also showed a higher propensity for self-medication ($p < 0.01$). Socio-economic status significantly influenced self-medication, with Class III individuals self-medicating the most, followed by Class II, and minimal self-medication in Classes I and IV ($p < 0.01$). Marital status had a marginal influence, with married individuals more prone to self-medicate ($p = 0.070$). However, gender ($p = 0.140$) and religion ($p = 0.320$) did not significantly impact self-medication practices.

The study concludes that self-medication is a prevalent practice in the urban areas of Belagavi, Karnataka, influenced by factors such as age, gender, marital status, educational level, occupation, family size, and socioeconomic status. The significant occurrence of self-medication emphasizes the need for specific public health initiatives aimed at educating the population about the dangers and advocating for safer health practices. Implementing regulatory measures and improving access to healthcare services are crucial in order to reduce the hazards connected with self-medication and safeguard the overall health of the community.

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ANNEXURES**ANNEXURE - I****INFORMED CONSENT FORM****KAHERs JNMC****BELAGAVI****“PREVALENCE OF SELF-MEDICATION PRACTICES IN THE URBAN AREAS OF BELAGAVI, KARNATAKA; A COMMUNITY BASED STUDY”****Name of Student/Principal Investigator:****Name of Guide/Co Investigators:**

Objective: You are being invited to participate in the study to assess the prevalence of self-medication and to identify the factors associated with self-medication practices. The study will be carried out in the urban field practice areas of Rukmini Nagar and Ashok Nagar at Belagavi.

Introduction: Self-medication is one of the major health concerns worldwide and World Health Organization (WHO) has laid emphasis on correctly investigating and controlling it. This is a one-year study is to assess the prevalence of self-medication practices in the urban field practice areas of Rukmini Nagar and Ashok Nagar, Belagavi.

Explanation of procedure: In this study you will have to answer a few predesigned questions about your socio- demography details and about your self-medication practices. The entire procedure may take 20-30 minutes. If you agree to participate, the required information will be collected.

Withdrawal from participation in the study: Participation in this study is voluntary. You will be free to decide whether to participate in this study or continue participation

once enrolled. In case you decide to withdraw your participation, you are free to do so. However, please convey the decision to the principal investigator.

Possible benefits from participating in the study: You will/will not have nor get any benefits by participating in this study. The data gathered will help the population at large.

Possible risks from participating in the study: There are no risks involved in participating in this study.

Privacy and confidentiality: The information collected from you will be coded, to prevent any person from identifying you. Your identity will never be revealed. The data collected from you will be kept confidential and only processed or aggregated data will be used for publication.

Financial incentives: You will not receive any payment for participating in this study.

Authorization for publication of aggregated data: Results obtained after processing of the aggregated data will be published for scientific purposes and or presented to scientific groups. However, your identity will never be revealed.

Questions: In case of any questions with regard to this study, you are free to contact. If you have any question or complaints with regard to your right as study participant you may contact Dr Harsha Hegde, Chairperson, Ethical committee of JNMC, 0831-2473777 Extension 4052.

Legal rights: By signing this consent form, we are not waving off any of your legal rights.

CONSENT STATEMENT

I am making a voluntary decision to participate in the study “**PREVALENCE OF SELF-MEDICATION PRACTICES IN THE URBAN AREAS OF BELAGAVI, KARNATAKA; A COMMUNITY BASED STUDY**”. My signature below indicates that I have decided to participate and I have read the information provided above or the information provided above has been read to me in the language that I understand best. I was given the opportunity to ask questions and that they have been answered to my satisfaction.

Name of the participant:

Signature or left thumb impression of the participant:

Name of the witness:

Signature or left thumb impression of the witness:

Name of the investigator:

Signature of the investigator:

Date:

Place:

ಸಮ್ಮತಿ ನಮೂನೆಯ ಸ್ವರೂಪ

KAHERs JNMC

ಬೆಳಗಾವಿ

ಮಾಹಿತಿ ನೀಡಿದ ಒಪ್ಪಿಗೆ ನಮೂನೆ

“ಕರ್ನಾಟಕದ ಬೆಳಗಾವಿಯ ನಗರ ಪ್ರದೇಶಗಳಲ್ಲಿ ಸ್ವ-ಔಷಧಿ ಪದ್ಧತಿಗಳ ವ್ಯಾಪಕತೆ;
ಸಮುದಾಯ ಆಧಾರಿತ ಅಧ್ಯಯನ”

ವಿದ್ಯಾರ್ಥಿ/ಪ್ರಧಾನ ತನಿಖಾಧಿಕಾರಿಯ ಹೆಸರು:

ಮಾರ್ಗದರ್ಶಿ/ಸಹ ತನಿಖಾಧಿಕಾರಿಗಳ ಹೆಸರು:

ಉದ್ದೇಶ: ಸ್ವಯಂ-ಔಷಧಿಗಳ ವ್ಯಾಪಕತೆಯನ್ನು ನಿರ್ಣಯಿಸಲು ಮತ್ತು ಸ್ವಯಂ-ಔಷಧಿ ಅಭ್ಯಾಸಗಳಿಗೆ ಸಂಬಂಧಿಸಿದ ಅಂಶಗಳನ್ನು ಗುರುತಿಸಲು ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ನಿಮ್ಮನ್ನು ಆಹ್ವಾನಿಸಲಾಗುತ್ತಿದೆ. ಬೆಳಗಾವಿಯ ರುಕ್ಮಿಣಿ ನಗರ ಮತ್ತು ಅಶೋಕನಗರದ ನಗರ ಕ್ಷೇತ್ರ ಅಭ್ಯಾಸ ಪ್ರದೇಶಗಳಲ್ಲಿ ಅಧ್ಯಯನವನ್ನು ಕೈಗೊಳ್ಳಲಾಗುವುದು.

ಪರಿಚಯ: ಸ್ವಯಂ-ಔಷಧಿ ಪ್ರಪಂಚದಾದ್ಯಂತದ ಪ್ರಮುಖ ಆರೋಗ್ಯ ಕಾಳಜಿಗಳಲ್ಲಿ ಒಂದಾಗಿದೆ ಮತ್ತು ವಿಶ್ವ ಆರೋಗ್ಯ ಸಂಸ್ಥೆ (WHO) ಅದನ್ನು ಸರಿಯಾಗಿ ತನಿಖೆ ಮಾಡಲು ಮತ್ತು ನಿಯಂತ್ರಿಸಲು ಒತ್ತು ನೀಡಿದೆ. ಬೆಳಗಾವಿಯ ರುಕ್ಮಿಣಿ ನಗರ ಮತ್ತು ಅಶೋಕನಗರದ ನಗರ ಕ್ಷೇತ್ರ ಅಭ್ಯಾಸ ಪ್ರದೇಶಗಳಲ್ಲಿ ಸ್ವಯಂ-ಔಷಧಿ ಅಭ್ಯಾಸಗಳ ವ್ಯಾಪಕತೆಯನ್ನು ನಿರ್ಣಯಿಸಲು ಇದು ಒಂದು ವರ್ಷದ ಅಧ್ಯಯನವಾಗಿದೆ.

ಕಾರ್ಯವಿಧಾನದ ವಿವರಣೆ: ಈ ಅಧ್ಯಯನದಲ್ಲಿ ನಿಮ್ಮ ಸಾಮಾಜಿಕ-ಜನಸಂಖ್ಯಾಶಾಸ್ತ್ರದ ವಿವರಗಳು ಮತ್ತು ನಿಮ್ಮ ಸ್ವಯಂ-ಔಷಧಿ ಅಭ್ಯಾಸಗಳ ಕುರಿತು ಕೆಲವು ಪೂರ್ವನಿರ್ಧಾರಿತ ಪ್ರಶ್ನೆಗಳಿಗೆ ನೀವು ಉತ್ತರಿಸಬೇಕಾಗುತ್ತದೆ. ಸಂಪೂರ್ಣ ಕಾರ್ಯವಿಧಾನವು 20-30 ನಿಮಿಷಗಳನ್ನು ತೆಗೆದುಕೊಳ್ಳಬಹುದು. ನೀವು ಭಾಗವಹಿಸಲು ಒಪ್ಪಿದರೆ, ಅಗತ್ಯವಿರುವ ಮಾಹಿತಿಯನ್ನು ಸಂಗ್ರಹಿಸಲಾಗುತ್ತದೆ.

ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸುವಿಕೆಯಿಂದ ಹಿಂತೆಗೆದುಕೊಳ್ಳುವಿಕೆ: ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸುವಿಕೆಯು ಸ್ವಯಂಪ್ರೇರಿತವಾಗಿದೆ. ಒಮ್ಮೆ ದಾಖಲಾದ ನಂತರ ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಬೇಕೆ ಅಥವಾ ಭಾಗವಹಿಸುವಿಕೆಯನ್ನು ಮುಂದುವರಿಸಬೇಕೆ ಎಂದು ನಿರ್ಧರಿಸಲು ನೀವು ಸ್ವತಂತ್ರರಾಗಿರುತ್ತೀರಿ. ನಿಮ್ಮ

ಭಾಗವಹಿಸುವಿಕೆಯನ್ನು ಹಿಂತೆಗೆದುಕೊಳ್ಳಲು ನೀವು ನಿರ್ಧರಿಸಿದರೆ, ನೀವು ಹಾಗೆ ಮಾಡಲು ಮುಕ್ತರಾಗಿದ್ದೀರಿ. ಆದಾಗ್ಯೂ, ದಯವಿಟ್ಟು ನಿರ್ಧಾರವನ್ನು ಪ್ರಧಾನ ತನಿಖಾಧಿಕಾರಿಗೆ ತಿಳಿಸಿ.

ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸುವುದರಿಂದ ಸಂಭವನೀಯ ಪ್ರಯೋಜನಗಳು: ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸುವ ಮೂಲಕ ನೀವು ಯಾವುದೇ ಪ್ರಯೋಜನಗಳನ್ನು ಪಡೆಯುವುದಿಲ್ಲ/ಪಡೆಯುವುದಿಲ್ಲ. ಸಂಗ್ರಹಿಸಿದ ಮಾಹಿತಿಯು ಜನಸಂಖ್ಯೆಗೆ ದೊಡ್ಡ ಪ್ರಮಾಣದಲ್ಲಿ ಸಹಾಯ ಮಾಡುತ್ತದೆ.

ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸುವುದರಿಂದ ಸಂಭವನೀಯ ಅಪಾಯಗಳು: ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸುವುದರಿಂದ ಯಾವುದೇ ಅಪಾಯಗಳಿಲ್ಲ.

ಗೌಪ್ಯತೆ ಮತ್ತು ಗೌಪ್ಯತೆ: ಯಾವುದೇ ವ್ಯಕ್ತಿ ನಿಮ್ಮನ್ನು ಗುರುತಿಸದಂತೆ ತಡೆಯಲು ನಿಮ್ಮಿಂದ ಸಂಗ್ರಹಿಸಿದ ಮಾಹಿತಿಯನ್ನು ಕೋಡ್ ಮಾಡಲಾಗುತ್ತದೆ. ನಿಮ್ಮ ಗುರುತನ್ನು ಎಂದಿಗೂ ಬಹಿರಂಗಪಡಿಸಲಾಗುವುದಿಲ್ಲ. ನಿಮ್ಮಿಂದ ಸಂಗ್ರಹಿಸಿದ ಡೇಟಾವನ್ನು ಗೌಪ್ಯವಾಗಿ ಇರಿಸಲಾಗುತ್ತದೆ ಮತ್ತು ಪ್ರಕ್ರಿಯೆಗೊಳಿಸಿದ ಅಥವಾ ಒಟ್ಟುಗೂಡಿದ ಡೇಟಾವನ್ನು ಮಾತ್ರ ಪ್ರಕಟಣೆಗಾಗಿ ಬಳಸಲಾಗುತ್ತದೆ.

ಹಣಕಾಸಿನ ಪ್ರೋತ್ಸಾಹಗಳು: ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ನೀವು ಯಾವುದೇ ಪಾವತಿಯನ್ನು ಸ್ವೀಕರಿಸುವುದಿಲ್ಲ.

ಒಟ್ಟುಗೂಡಿದ ದತ್ತಾಂಶದ ಪ್ರಕಟಣೆಗೆ ಅಧಿಕಾರ: ಒಟ್ಟು ದತ್ತಾಂಶವನ್ನು ಸಂಸ್ಕರಿಸಿದ ನಂತರ ಪಡೆದ ಫಲಿತಾಂಶಗಳನ್ನು ವೈಜ್ಞಾನಿಕ ಉದ್ದೇಶಗಳಿಗಾಗಿ ಪ್ರಕಟಿಸಲಾಗುತ್ತದೆ ಅಥವಾ ವೈಜ್ಞಾನಿಕ ಗುಂಪುಗಳಿಗೆ ಪ್ರಸ್ತುತಪಡಿಸಲಾಗುತ್ತದೆ. ಆದಾಗ್ಯೂ, ನಿಮ್ಮ ಗುರುತನ್ನು ಎಂದಿಗೂ ಬಹಿರಂಗಪಡಿಸಲಾಗುವುದಿಲ್ಲ.

ಪ್ರಶ್ನೆಗಳು: ಈ ಅಧ್ಯಯನಕ್ಕೆ ಸಂಬಂಧಿಸಿದಂತೆ ಯಾವುದೇ ಪ್ರಶ್ನೆಗಳಿದ್ದಲ್ಲಿ, ನೀವು ಸಂಪರ್ಕಿಸಲು ಮುಕ್ತರಾಗಿರುತ್ತೀರಿ. ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸುವ ನಿಮ್ಮ ಹಕ್ಕಿನ ಕುರಿತು ನೀವು ಯಾವುದೇ ಪ್ರಶ್ನೆಗಳನ್ನು ಅಥವಾ ದೂರುಗಳನ್ನು ಹೊಂದಿದ್ದರೆ ನೀವು JNMC ನ ನೈತಿಕ ಸಮಿತಿಯ ಅಧ್ಯಕ್ಷರಾದ ಡಾ ಹರ್ಷ ಹೆಗ್ಡೆ, 0831-2473777 ವಿಸ್ತರಣೆ 4052 ಅನ್ನು ಸಂಪರ್ಕಿಸಬಹುದು.

ಕಾನೂನು ಹಕ್ಕುಗಳು: ಈ ಸಮ್ಮಿತಿಯ ನಮೂನೆಗೆ ಸಹಿ ಹಾಕುವ ಮೂಲಕ, ನಾವು ನಿಮ್ಮ ಯಾವುದೇ ಕಾನೂನು ಹಕ್ಕುಗಳಿಗೆ ಕೈ ಹಾಕುತ್ತಿಲ್ಲ.

ಸಮ್ಮತಿ ಹೇಳಿಕೆ

ನಾನು ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ಸ್ವಯಂಪ್ರೇರಿತ ನಿರ್ಧಾರವನ್ನು ಮಾಡುತ್ತಿದ್ದೇನೆ “ಕರ್ನಾಟಕದ ಬೆಳಗಾವಿಯ ನಗರ ಪ್ರದೇಶಗಳಲ್ಲಿ ಸ್ವ-ಔಷಧಿಗಳ ಪ್ರಾಕ್ಟೀಸ್; ಸಮುದಾಯ ಆಧಾರಿತ ಅಧ್ಯಯನ”. ಕೆಳಗಿನ ನನ್ನ ಸಹಿ ನಾನು ಭಾಗವಹಿಸಲು ನಿರ್ಧರಿಸಿದ್ದೇನೆ ಮತ್ತು ನಾನು ಮೇಲೆ ಒದಗಿಸಿದ ಮಾಹಿತಿಯನ್ನು ಓದಿದ್ದೇನೆ ಅಥವಾ ಮೇಲೆ ಒದಗಿಸಿದ ಮಾಹಿತಿಯನ್ನು ನನಗೆ ಚೆನ್ನಾಗಿ ಅರ್ಥವಾಗುವ ಭಾಷೆಯಲ್ಲಿ ಓದಲಾಗಿದೆ ಎಂದು ಸೂಚಿಸುತ್ತದೆ. ಪ್ರಶ್ನೆಗಳನ್ನು ಕೇಳಲು ನನಗೆ ಅವಕಾಶವನ್ನು ನೀಡಲಾಯಿತು ಮತ್ತು ಅವುಗಳಿಗೆ ನನ್ನ ತೃಪ್ತಿಗೆ ಉತ್ತರಿಸಲಾಗಿದೆ.

ಭಾಗವಹಿಸುವವರ ಹೆಸರು:

ಭಾಗವಹಿಸುವವರ ಸಹಿ ಅಥವಾ ಎಡ ಹೆಬ್ಬರಳಿನ ಗುರುತು:

ಸಾಕ್ಷಿಯ ಹೆಸರು:

ಸಾಕ್ಷಿಯ ಸಹಿ ಅಥವಾ ಎಡ ಹೆಬ್ಬರಳಿನ ಗುರುತು:

ತನಿಖಾಧಿಕಾರಿಯ ಹೆಸರು:

ತನಿಖಾಧಿಕಾರಿಯ ಸಹಿ:

ದಿನಾಂಕ:

ಸ್ಥಳ:

सहमतिप्रपत्र प्रारूप
कहेर जेएनएमसी
बेलगावी
सूचति सहमतिप्रपत्र

"प्रचलन की स्व-दवा प्रथाओं में शहरी क्षेत्रों की बेलगावी, करनाटक; एक समुदाय आधारित अध्ययन "

छात्र/प्रधान अन्वेषक का नाम:

गाइड / सह अन्वेषकों का नाम:

उद्देश्य: आपको एक अध्ययन में भाग लेने के लिए आमंत्रित किया जाता है जो स्व-दवा की व्यापकता और स्व-दवा प्रथाओं से जुड़े संबंधित कारकों का आकलन करता है। अध्ययन रुक्मिणी नगर और अशोक नगर बेलगावी में आयोजित किया जाएगा।

परिचय: स्व-दवा दुनिया भर में प्रमुख स्वास्थ्य चिंताओं में से एक है और विश्व स्वास्थ्य संगठन (डब्ल्यूएचओ) ने इसकी उचित जांच और नियंत्रण पर जोर दिया है। रुक्मिणी नगर और अशोक नगर, बेलगावी में शहरी क्षेत्र अभ्यास क्षेत्रों में स्व-दवा प्रथाओं के प्रसार का आकलन करने के लिए यह एक साल का अध्ययन है।

स्पष्टीकरण की प्रक्रिया: इस अध्ययन में आपको अपनी सामाजिक-जनसांख्यिकी और आपकी स्व-दवा पद्धतियों के बारे में कुछ पूर्वनिर्धारित प्रश्नों का उत्तर देना होगा। पूरी प्रक्रिया में 20-30 मिनट लग सकते हैं। यदि आप भाग लेने के लिए सहमत हैं, तो आवश्यक जानकारी एकत्र की जाएगी।

नकिसी से भागीदारी के अध्ययन में भागीदारी: स्वैच्छिक। आप यह तय करने के लिए स्वतंत्र होंगे कि इस अध्ययन में भाग लेना है या नहीं या नामांकित होने के बाद भागीदारी जारी रखना है। यदि आप वापस लेने का निर्णय लेते हैं, तो आप ऐसा करने के लिए स्वतंत्र हैं। हालांकि, कृपया मुख्य जांचकर्ता को निर्णय से अवगत कराएं।

यह अध्ययन लाभों में भाग लेने के बारे में है: डेटा बड़े पैमाने पर आबादी की मदद करेगा।

संभावित जोखिमों में भाग लेने का अध्ययन: इस अध्ययन में कोई जोखिम शामिल नहीं है।

गोपनीयता और गोपनीयता: किसी भी व्यक्ति को आपकी पहचान करने से रोकने के लिए आपसे मांगी गई जानकारी को कोडित किया जाएगा। आपकी पहचान कभी नहीं होगी। आपसे एकत्र किया गया डेटा गोपनीय होगा और प्रकाशन के लिए केवल संसाधित या एकत्रित डेटा का उपयोग किया जाएगा।

वर्तितीय प्रोत्साहन: यह अध्ययन किसी भी भुगतान में भाग लेने के बारे में है।

प्राधिकरण के लिए एकत्रित डेटा: परिणाम प्राप्त करने के बाद, समेकित डेटा वैज्ञानिक उद्देश्यों के लिए प्रकाशित किया जाएगा और वैज्ञानिक समूहों को प्रस्तुत किया जाएगा। हालाँकि, आपकी पहचान कभी नहीं जानी जाएगी।

इस मामले में, आप संपर्क करने के लिए स्वतंत्र हैं। यदि आपके कोई प्रश्न या शिकायत हैं, तो कृपया डॉ. हरष हेगडे, अध्यक्ष, जेएनएमसी की नैतिकता समिति, 0831-2473777 एक्सटेंशन 4052 से संपर्क करें।

कानूनी अधिकार: इस सहमत फॉर्म पर हस्ताक्षर करके, हम आपके किसी भी कानूनी अधिकार का उल्लंघन नहीं कर रहे हैं।

सहमत विक्त्व

मैं अध्ययन में भाग लेने के लिए एक स्वैच्छिक निर्णय ले रहा हूँ "बेलागवी, कर्नाटक के शहरी क्षेत्रों में प्रसार की आत्म-चकित्सा अभ्यास; एक समुदाय आधारित अध्ययन"। नीचे मेरा हस्ताक्षर है कि मैंने भाग लेने का फैसला किया है और मैंने ऊपर दी गई जानकारी या उपरोक्त भाषा में दी गई जानकारी को पढ़ लिया है। मुझे प्रश्न पूछने का अवसर दिया गया और उन्होंने मेरी संतुष्टि का उत्तर दिया।

प्रतभागी का नाम:

हस्ताक्षर या बाएं अंगूठे के निशान का भागीदार:

गवाह का नाम:

बाएं अंगूठे के निशान के हस्ताक्षर या गवाह:

अन्वेषक का नाम:

अन्वेषक के हस्ताक्षर:

दिनांक:

स्थान:

संमती फॉर्मचे स्वरूप
KAHERs JNMC
बेलागावी
सूचति संमती फॉर्म

“सेल्फ-मेडिकेशन प्रॅक्टिस ऑफ प्राव्हलैन्स, कर्नाटकमधील शहरी भागातील
बेलागावी; समुदाय आधारित अभ्यास ”

वदियार्थ्याचे/मुख्याध्यापकाचे नाव:

मार्गदर्शक / सह अन्वेषकांचे नाव:

उद्दष्टि: स्वयं-औषधांचा प्रसार आणि स्वयं-औषध पद्धतीशी संबंधित संबंधित घटकांचे मूल्यांकन करणार्या अभ्यासात सहभागी होण्यासाठी तुम्हाला आमंत्रित केले आहे. बेळगावी येथील रुक्मिणी नगर आणि अशोक नगरमध्ये हा अभ्यास केला जाणार आहे.

परिचय: स्व-औषध ही जगभरातील प्रमुख आरोग्य चिंतेची एक आहे आणि जागतिक आरोग्य संघटनेने (WHO) त्याची योग्य तपासणी आणि नियंत्रण करण्यावर भर दिला आहे. रुक्मिणी नगर आणि अशोक नगर, बेळगावी मधील शहरी क्षेत्र सराव क्षेत्रात स्वयं-औषध पद्धतीच्या प्रचलिततेचे मूल्यांकन करण्यासाठी हा एक वर्षाचा अभ्यास आहे.

स्पष्टीकरणाची प्रक्रिया: या अभ्यासात तुम्हाला तुमच्या सामाजिक-लोकसंख्याशास्त्र आणि तुमच्या स्वयं-औषध पद्धतीबद्दल काही पूर्वनिर्धारित प्रश्नांची उत्तरे द्यावी लागतील. संपूर्ण प्रक्रियेस 20-30 मिनिटे लागू शकतात. तुम्ही सहभागी होण्यास सहमत असाल तर आवश्यक माहिती गोळा केली जाईल.

पैसे काढण्यापासून सहभागाच्या अभ्यासात सहभाग: ऐच्छिक. या अभ्यासात भाग घ्यायचा की नाही हे ठरवण्यासाठी तुम्ही मोकळे असाल क्वि एकदा नावनोंदणी झाल्यावर सहभाग सुरू ठेवाल. तुम्ही माघार घेण्याचा निर्णय घेतल्यास, तुम्ही तसे करण्यास मोकळे आहात. तथापि, कृपया मुख्य अन्वेषकांना निर्णय कळवा.

हा अभ्यास लाभांमध्ये सहभागी होण्याबद्दल आहे: डेटा मोठ्या प्रमाणात लोकसंख्येला मदत करेल.

संभाव्य जोखमीमध्ये भाग घेण्याचा अभ्यास: या अभ्यासात कोणतेही धोके नाहीत.

गोपनीयता आणि गोपनीयता: कोणत्याही व्यक्तीला तुमची ओळख पटवण्यापासून रोखण्यासाठी तुमच्याकडून मागितलेली माहिती कोड केली जाईल. तुमची ओळख कधीच होणार नाही. तुमच्याकडून गोळा केलेला डेटा गोपनीय असेल आणि केवळ प्रक्रिया केलेला क्वि एकत्रित केलेला डेटा प्रकाशनासाठी वापरला जाईल.

आर्थिक प्रोत्साहन: हा अभ्यास कोणत्याही पेमेंटमध्ये सहभागी होण्याबद्दल आहे.

अधिकृततेसाठी एकत्रित डेटा: परिणाम प्राप्त केल्यानंतर, एकत्रित डेटा वैज्ञानिक हेतूसाठी प्रकाशित केला जाईल आणि वैज्ञानिक गटांना सादर केला जाईल. मात्र, तुमची ओळख कधीच कळणार नाही.

या प्रकरणात, आपण संपर्क करण्यास मोकळे आहात. तुम्हाला काही प्रश्न कवि तक्रारी असल्यास कृपया डॉ. हर्षा हेगडे, अध्यक्ष, JNMC च्या नीतिशास्त्र समिती, 0831-2473777 वसितार 4052 यांच्याशी संपर्क साधा.

कायदेशीर अधिकार: या समिती फॉर्मवर स्वाक्षरी करून, आम्ही तुमचे कोणतेही कायदेशीर अधिकार गमावत नाही.

संमती वधिन

मी “बेलागावी, कर्नाटकाच्या शहरी भागात प्रसाराच्या स्वयं-औषध पद्धती या अभ्यासात सहभागी होण्याचा ऐच्छिक निर्णय घेत आहे; समुदाय आधारित अभ्यास”. खाली माझी स्वाक्षरी आहे की मी सहभागी होण्याचा निर्णय घेतला आहे आणि मी वर दिलेली माहिती कवि वरील भाषेत दिलेली माहिती वाचली आहे. मला प्रश्न विचारण्याची संधी देण्यात आली आणि त्यांनी माझे समाधानकारक उत्तर दिले.

सहभागीचे नाव:

स्वाक्षरीचा सहभागी कवि डाव्या अंगठ्याचा ठसा:

साक्षीदाराचे नाव:

स्वाक्षरी कवि डाव्या अंगठ्याचा साक्षीदार:

तपासकर्त्याचे नाव:

अन्वेषकाची स्वाक्षरी:

तारीख:

ठिकाण:

ANNEXURE-II
KAHERs JNMC
BELAGAVI
QUESTIONNAIRE

**“PREVALENCE OF SELF-MEDICATION PRACTICES IN THE URBAN
AREAS OF BELAGAVI, KARNATAKA; A COMMUNITY BASED STUDY”**

Investigator:

PG Guide:

SOCIO-DEMOGRAPHIC

1. Name:

Date of visit: ____/____/____

(D D / M M / Y Y Y Y)

2. Gender: ☐ Male ☐ Female3. Date of Birth/Age: ____/____/____
(D D / M M / Y Y Y Y)

4. Occupation:

☐ Student	☐ Employee	☐ Business
☐ Housewife	☐ Retired	☐ Farmer
☐ Other. Explain		

5. Marital status:

☐ Unmarried	☐ Married	☐ Divorced
☐ Widowed	☐ Separated	

6. Religion:

☐ Hindu	☐ Muslim	☐ Sikh
☐ Christian	☐ Other. Explain	

7. Highest Qualification:

☐ Illiterate	☐ Primary school	☐ High School
☐ College	☐ Diploma	☐ Graduate degree
☐ Post graduate degree	☐ PhD	☐ Other. Explain

8. Total number of family members staying with you in this house. _____

Total House income / month: _____

Monthly per capita income: _____

9. Socio-economic status – Modified B.G. Prasad classification

- | | | |
|-------------|-------------|--------------|
| 1. Class I | 2. Class II | 3. Class III |
| 4. Class IV | 5. Class V | |

SELF-MEDICATION HABITS

Now let me define what is self-medication?

- ***Self-medication is the use of medicinal products by the consumer which is not prescribed by the physician.***

From now on to the next questions, your answers should be based on last 3 months experience, unless I specify the different time period.

10. Have you taken self-medication in last three months?

Select only 1 choice by crossing (×) the appropriate box below.

☐ No

If your answer is no, then go to health insurance question number 31.

☐ Yes

If your answer is yes, then continue with the rest of the questions.

11. What was your reason for self-medication?

(Self-medication is the use of medicinal products by the consumer which is not prescribed by the physician.)

You can select multiple choices by crossing (×) the appropriate boxes below.

☐ Doctor / clinic far from home	☐ Saves time
☐ High fees of doctor	☐ I have old prescription
☐ Doctor is busy with many patients	☐ I have medicines of family members
☐ No trust in doctor	☐ Pharmacist advice
☐ Other. Explain	

12. For which disease/symptom you have taken self-medication in last 3 months?

You can select multiple choices by crossing (×) the appropriate boxes below.

DISEASE/SYMPTOM	MEDICINE USED
☐ Headache	
☐ Dandruff	
☐ Hair fall	
☐ Faints	
☐ Epilepsy	
☐ Migraine	
☐ Eye Infection	
☐ Running Nose	
☐ Ear Pain	
☐ Mouth Ulcer	
☐ Dental Pain	
☐ Cough	
☐ Difficulty in swallowing	
☐ Acidity	
☐ Vomiting	
☐ Nausea	
☐ Fever	
☐ Asthma	
☐ Diarrhea	
☐ Dysentery	
☐ Muscle Pain	
☐ Body Pain, Specify	
☐ Pain in joints	
☐ Arthritis n	
☐ Varicose veins	
☐ Genital infection	
☐ Sexually transmitted disease	
☐ Urination problems	
☐ Menstrual problems	
☐ Impotency	
☐ Birth control	

☐ Rash	
☐ Skin disease in covered areas	
☐ Skin disease in open areas	
☐ Wounds	
☐ Diabetes	
☐ Hypertension	
☐ Other. Specify	

13. What do you consider while selecting the drug for self-medication?

You can select multiple choices by crossing (×) the appropriate boxes below.

☐ Price
☐ Pharmaceutical Company
☐ Type of medicine Which type of medicine you select? ☐ Ayurvedic ☐ Allopathic ☐ Homeopathic
☐ Brand. If you select any specific brand, then answer question 14, or else go to question 15.
☐ Other. Explain

14. Your selection of particular brand depends on which of the following choices?

You can select multiple choices by crossing (×) the appropriate boxes below.

☐ Recommended by pharmacist	☐ Old prescription of doctor
☐ Used by peers – friends / family	☐ Advertisement
☐ My previous experience	☐ Other. Explain

15. Where do you obtain your drugs for self-medication?

You can select multiple choices by crossing (×) the appropriate boxes below.

☐ Pharmacy shop	☐ Online shopping
☐ Primary health care center	☐ Left over from Previous Prescription
☐ Friends / family	☐ Other. Explain

16. Do you check the prescribing information before self-medicating?

Select only 1 choice by crossing (×) the appropriate box below.

☐ Yes, always	☐ No, never	☐ Yes, sometimes
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If your answer to question 16 is Yes, always or Yes, sometimes then answer 17. If not go to question 18.

17. How much did you understand from the instructions of prescribing information?

Select only 1 choice by crossing (×) the appropriate box below.

☐ Fully understood	☐ Partially understood	☐ Not at all
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18. Have you ever experienced adverse events with self-medication?

☐ No	☐ Yes. Explain _____

If your answer to question 18 is yes, then solve question 19. If not, then go to question 20.

19. What did you do for the adverse event you experienced?

You can select multiple choices by crossing (×) the appropriate boxes below.

☐ Go to private doctor	☐ Go to pharmacist
☐ Go to primary health care center	☐ Stop taking medication
☐ Others, Explain _____	

20. Are you taking self-medication for any chronic disease?

(Chronic disease in this study is defined as a disease lasting three months or longer.)

☐ No	☐ Yes
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If your answer to question 20 is yes, then solve question 21. If not, then go to the next section of questionnaire on anti-infectives (question 22).

21. How long you have been taking self-medication for any chronic disease?

Name of disease	Time period in months

**SELF-MEDICATION HABITS
WITH ANTI-INFECTIVES**

22. Have you ever self-medicated yourself with anti-infectives?

☐ No

☐ Yes

If your answer to question 22 is yes, then go to question 23 or else go to the next section on Healthinsurance that is question 31.

23. For which of the following diseases did you self-medicate with anti-infectives?

You can select multiple choices by crossing (×) the appropriate boxes below.

Infection	Medicine name	Infection	Medicine name
☐ Eye infection		☐ Skin disease on open areas	
☐ Running nose		☐ Skin disease in covered areas	
☐ Ear pain		☐ Genital infection	
☐ Cough		☐ Sexually transmitted disease STD	
☐ Sore throat		☐ Urinary problems	
☐ Dental pain		☐ Menstrual problems	
☐ Vomiting		☐ Diarrhea	
☐ Fever		☐ Other. Explain	
☐ Wounds			

24. From the above which was the most recent infection for which you self-medicated?

25. How did you know the dosage of anti-infectives?

You can select multiple choices by crossing (×) the appropriate boxes below.

☐ By checking the prescribing information	☐ Consulting pharmacist	☐ Internet
☐ Consulting peers – friends / family	☐ Guessing the dosage by myself	☐ Previous experience
☐ Consulting primary health care center	☐ Advertisements	
☐ Other. Explain _____		

26. Did you ever change the dosage of anti-infectives during the course of self-medication?

Select only 1 choice by crossing (×) the appropriate box below.

☐ Yes, always	☐ Yes, sometime	☐ No, never	☐ Do not know
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If your answer to question 26 is Yes, always or Yes, sometime then go to question 27. If answer is No, Never or Do not know, then go to question 28.

27. Why did you change the dosage of anti-infectives during the course of self-medication?

You can select multiple choices by crossing (×) the appropriate boxes below.

☐ Health improved	☐ To reduce adverse events	Other. Explain _____
☐ Disease worsened	☐ Drug insufficient for self-medication	

28. Last time when you used anti-infective, did you change that anti-infective/s during self-medication?

Select only 1 choice by crossing (×) the appropriate box below.

☐ Yes, always	☐ Yes, sometime	☐ No, never	☐ Do not know
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If your answer to question 28 is Yes, always or Yes, sometime then go to question 29. If your answer is No, Never or Do not know, then go to question 30.

29. Why did you change anti-infectives during self-medication?

You can select multiple choices by crossing (×) the appropriate boxes below.

☐ The former anti-infective did not work	☐ The latter one was cheaper	☐ Pharmacy ran out of former anti-infective
☐ The former anti-infective got over	☐ To reduce adverse events	☐ Other. Explain _____

30. When did you stop taking anti-infectives?

You can select multiple choices by crossing (×) the appropriate boxes below.

☐ After a few days regardless of the outcome	☐ After symptoms disappeared	☐ After anti-infective got over
☐ After complete course of anti-infective If you select this choice then where did you get the knowledge about course of anti-infectives? You can select multiple choices by crossing (×) the appropriate boxes below.		
☐ Prescribing information ☐ Pharmacist ☐ Primary health care center ☐ Doctor ☐ Peers- family / friends		
☐ Other. Explain		

Health insurance

31. What kind of health insurance do you have this year?

You can select multiple choices by crossing (×) the appropriate boxes below.

☐ No insurance	☐ Government sponsored insurance
☐ Rural insurance	☐ Private medical insurance
☐ Other. Explain	

ANNEXURE – III KEY TO MASTER CHART

[illegible]

[illegible]

[illegible]

[illegible]