

Social Media Health Information Exposure and its influence on Self-Medication Practices among Adults in an Urban city of Nigeria

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Abstract

Background: Social media is an increasingly important source of health information, but exposure to health-related content may be associated with inappropriate self-medication. This study examined the association between social media health-information exposure and self-medication among young adults in Uyo, Nigeria.

Methods: A cross-sectional study was conducted among 384 respondents in Uyo, Akwa Ibom State, between April and May 2026. Data were collected using a structured questionnaire and analyzed using descriptive statistics and binary logistic regression at $p < 0.05$.

Results: High health-information exposure was reported by 218 (56.8%) respondents, while 235 (61.2%) practiced self-medication. Antimalarials (45.5%) and multivitamins/supplements (42.3%) were the most commonly used medications. After adjustment, health-information exposure was significantly associated with self-medication (AOR = 2.42, 95% CI: 1.16–5.03; $p = 0.018$). Marital status, social media use duration and income were also significantly associated with self-medication.

Conclusion: Social media health-information exposure was associated with self-medication. Digital health literacy and access to credible health information should be strengthened.

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1. Introduction

Social media refers to online platforms that allow people to interact, share and exchange information among online communities [1]. In recent years, social media has become a major source of health information due to its accessibility and interactivity [2]. The increase in the usage of these platforms such as Instagram, Facebook, TikTok, WhatsApp, X (formerly Twitter) and YouTube have promoted health education, self-management behaviors, peer support through social media online/community groups, health influencers, and digital health interventions [3].

Globally, as of April 2026, 6.12 billion people have access to the internet and 5.79 billion people use social media [4]. In Africa, social media use varies across regions with Northern Africa at 40.4%, Southern Africa at 41.6% and Central Africa at 10% [5]. In Nigeria, recent statistics indicate approximately 47.8 million active social media users [6]. These figures reflect the rapid growth and expansion of social media usage, particularly among young people. Young adults, who are the most active users of social media [7], frequently use these platforms to seek information on health

related issues such as physical activity and fitness, dietary behavior and nutrition, mental health and general wellbeing [8-10].

Although social media promotes digital health through campaign awareness it also poses a risk of health misinformation, increasing health disparities, unhealthy behaviors such as disordered eating, substance misuse or vaccine hesitancy [11-13]. These factors may contribute to inappropriate self-medication among users. Self-medication refers to the use of medication without prescription, medical or pharmaceutical advice and represents a significant public health concern [14].

In Nigeria, self-medication has remained highly prevalent with reported rates ranging from 60 to 90% despite the large number of doctors and healthcare practitioners [15]. This practice may result from various factors such as socioeconomic status, previous experience, over-the-counter, easy access to drugs, and increased availability of medicinal products [16-19]. More recently, media influence has been

identified as an additional driver of self-medication practice, with evidence suggesting that it accounts for up to 98% of symptom self-diagnoses [15]. Social media platforms such as Instagram, YouTube and Facebook have emerged as key sources for accessing information on self-medication [20].

While previous studies have shown that socio-demographic factors such as age, education, residence (urban/rural) can influence the likelihood of seeking health information online [15], individuals living in urban areas tend to have greater access to such resources than those in rural settings. However, there are limited studies on how this exposure to health information via social media platforms can influence the practice of self-medication particularly among the young adults who are heavy users of social media.

This study aims to examine how social media exposure to health information influences self-medication practice particularly among young adults in urban area (Uyo), Nigeria. The study further seeks to generate evidence to targeted interventions, strengthen public health policy and improve the health outcomes in an increasingly digital society.

2. Methods

Study Design and Study area

The study adopted a cross sectional design and was conducted in Uyo, Akwa Ibom state between April and May 2026. Uyo is one of the fast developing cities in Southern Nigeria and like most Nigerian cities; it faces urban growth which is driven by several environmental and socio-economic factors. Uyo is the administrative capital of Akwa Ibom State, an oil producing state in Nigeria. Uyo metropolis spans across about nine local government areas within the state and it is still expanding as more developmental strides occur. Geographically, it lies between Longitudes 07°45' E and 08°05' E and Latitudes 04°52'N and 05°07'N respectively [21].

Study Population

The study included young adults from the age of 18 years-35 years who resided within Uyo and have actually used at least one social media platform and gave their consent for the study. Participant who withdrew consent during the study and submit incomplete or invalid questionnaire responses that could not be analyzed will be excluded from the study

Sample Size

The calculated sample size of 384 was estimated using the Cochran formula for cross-sectional studies at a 95% confidence level, a 5% error margin, and 50% estimated prevalence.

Method of Data Collection

Data was developed and collected using online Google form questionnaire and disseminated via social media platforms such as WhatsApp as well as in person. The questionnaire consisted of 3 sections: (a) socio-demographic information

(b) exposure on health information on social media platforms and (c) self-medication practices. To ensure and prevent duplicate entries responses were limited to one submission per device through Microsoft Forms. The questionnaire contained 22 items distributed across the three (3) sections (6 socio-demographic questions, 9 exposure-related questions, and 6 self-medication questions).

Validity and reliability of study instrument

The content validity of the questionnaire was evaluated by expert in the Department of Public Health. Each item was assessed for clarity, relevance, and alignment with the study objectives, and necessary corrections were made based on their recommendations. A pilot test will be conducted among 38 participants to assess the internal consistency of the instrument. Reliability analysis will be performed, and items were be revised as necessary based on the pilot results. A Cronbach's alpha coefficient of ≥ 0.70 was considered indicative of acceptable internal consistency reliability.

Method of Data Analysis

Data was analyzed using the Statistical package for the social science (SPSS) version 26.0. Data collected was analyzed using descriptive analysis such as frequencies, percentages, mean and standard deviations to summarize the socio-demographic variable and the main constructs of the study. A composite exposure score was generated from the Likert-scale items measuring the level of exposure to health information on social media, and respondents were categorized into low, moderate and high exposure levels based on the mean score. Similarly, self-medication practices were assessed using responses relevant to items and categorized appropriately. Inferential statistics was applied to examine associations between variables. The binary logistic regression was used to identify factors associated with self-medication practice with statistical significance set at $p < 0.05$.

Ethical Issues

A detailed explanation of the study objectives was provided to participants before administering the questionnaire. Anonymity and confidentiality were ensured throughout the study.

Results

Socio-demographic characteristics

A total of 384 young adults participated in the study. More than half of the respondents were aged 28–37 years, with 200 respondents (52.1%), while 130 respondents (33.9%) were aged 18–27 years. Females constituted a slightly higher proportion of the respondents, with 201 respondents (52.3%), compared with 183 males (47.7%). The majority of the respondents were unmarried, comprising 274 respondents (71.4%), while 110 respondents (28.6%) were married.

Nearly all the respondents had tertiary education, comprising 365 respondents (95.1%), while 19 respondents (4.9%) had

secondary education. Regarding employment status, more than half of the respondents were employed, with 224 respondents (58.3%), while 79 respondents (20.6%) were self-employed and 81 respondents (21.1%) were unemployed.

With respect to monthly income, 159 respondents (41.4%) earned below ₦100,000, while 110 respondents (28.6%) earned between ₦100,000 and ₦199,999. Respondents earning between ₦200,000 and ₦299,999 accounted for 54 respondents (14.1%), while 33 respondents (8.6%) earned between ₦300,000 and ₦499,999. Those earning ₦500,000 and above accounted for 28 respondents (7.3%) (Table 1).

Table 1. Socio-demographic characteristics of respondents

Variable	Frequency(n)	Percentage (%)
Age		
18-27	130	33.9
28-37	200	52.1
38-47	34	8.9
48-57	20	5.2
Gender		
Female	201	52.3
Male	183	47.7
Marital status		
Married	110	28.6
Not married	274	71.4
Education		
No formal education	0	0
Secondary	19	4.9
Tertiary	365	95.1
Occupation		
Employed	224	58.3
Self-employed	79	20.6
Unemployed	81	21.1
Income		
Below 100,00	159	41.4
100,000-199,999	110	28.6
200,000-299,999	54	14.1
300,000-499,999	33	8.6
Above 500,000	28	7.3

Social media use and health information sought

Figure 1 shows the social media platforms used by the respondents. WhatsApp was the most commonly used social media platform among respondents (21%), followed by YouTube (15.1%) and Instagram (12.0%). Twitter and TikTok accounted for 9.0% and 7.9%, respectively, while Snapchat was the least commonly used platform (3.0%). Regarding time spent on social media, 145 (37.8%) reported spending 1–2 hours daily, while 135 (35.2%) spent less than one hour. A further 64 (16.7%) spent 3–5 hours, 28 (7.3%) spent 6–10 hours and 12 (3.1%) spent 10 hours or more (Table 2).

The most commonly sought health information on social media was information on symptoms of various health conditions (24.7%), followed by fitness and workout routines (21.6%) and nutrition tips (19.7%). Mental health information accounted for 11.2%, while safe sex practices and stress management accounted for 7.6% and 6.9%,

respectively. Information on patients' similar experiences (5.0%), substance use (2.5%) and general health knowledge (0.8%) were less frequently sought.

Health information exposure via social media

Exposure to health information through social media was generally high. The highest mean exposure score was recorded for seeing health professionals' content on social media (3.38 ± 0.52), followed by learning about new health developments (3.34 ± 0.58) and watching online health messages or videos (3.27 ± 0.49). Frequent encounters with health information had a mean score of 3.22 ± 0.59 , while exposure to health campaigns and perceived relevance of health information recorded mean scores of 3.16 ± 0.54 and 3.14 ± 0.51 , respectively (Table 3).

Overall, 218 (56.8%) respondents had a high level of health-information exposure through social media, while 166 (43.2%) had moderate exposure. No respondent fell within the low-exposure category (Table 4).

Self-medication practices among respondents

More than half of the respondents, 202 (52.6%), reported taking drugs without a doctor's prescription within the preceding six months, while 182 (47.4%) had not. One-third of the respondents, 127 (33.1%), reported giving their prescribed medication to another person without medical advice. Regarding pharmacy or chemist visits, 169 respondents (44.0%) had visited two to three times within the preceding six months, 129 (33.6%) had visited once, 67 (17.4%) had visited four to five times, while 19 (4.9%) had visited more than five times (Table 5).

Overall, 235 respondents (61.2%) were classified as having practised self-medication, while 149 (38.8%) did not practise self-medication. Among those who practised self-medication, 141 (60.0%) had low practice, while 94 (40.0%) had high practice (Table 6).

Among the medications taken without prescription, antimalarial drugs were the most commonly reported, with 172 respondents (45.5%), followed by multivitamins/supplements with 160 (42.3%) and antibiotics with 80 (21.2%). Analgesics were reported by 64 respondents

(16.9%), cough syrups by 48 (12.7%) and worm drugs by 39 (10.3%). Less frequently reported were antacids, herbal medicines and drugs for vomiting, with 33 (8.7%), 28 (7.4%) and 20 (5.3%) respondents, respectively.

The most commonly encountered medication-related content on social media concerned drugs for weight loss, reported by 146 respondents (38.0%), and drugs for sexual problems, reported by 145 (37.8%). This was followed by drugs for diabetes, reported by 102 respondents (26.6%), blood pressure by 100 (26.0%), hair problems by 90 (23.4%), weight gain by 77 (20.1%) and menstrual problems by 76 (19.8%). Drugs for arthritis were reported by 49 respondents (12.8%), while supplements and drugs for height gain were reported by 19 (4.9%) and 13 (3.4%), respectively.

The primary reason for self-medication was minor illness, reported by 242 respondents (63.0%), followed by confidence in knowledge of drugs, reported by 130 (33.9%). Other reasons included lack of time to visit the hospital, reported by 39 respondents (10.2%), influence from friends or family by 28 (7.3%), lower cost by 27 (7.0%), influence from social media platforms by 26 (6.8%) and long waiting time at health facilities by 20 (5.2%).

Table 2. Social media use and health information-seeking behaviour of respondents

Variable	Frequency (n)	Percentage (%)
Time spent on Social media		
Less than an hour	135	35.2
1-2 hours	145	37.8
3-5 hours	64	16.7
6-10 hours	28	7.3
10 hours and above	12	3.1
Health information sought on social media		
Symptoms of various health information	196	24.7
Stress management	55	6.9
Safe sex practice	60	7.6
Fitness and workout routines	171	21.6
Nutrition tips	156	19.7
Mental health	89	11.2
Patient similar experience	40	5
Substance use	20	2.5
Others: General health knowledge	6	0.8

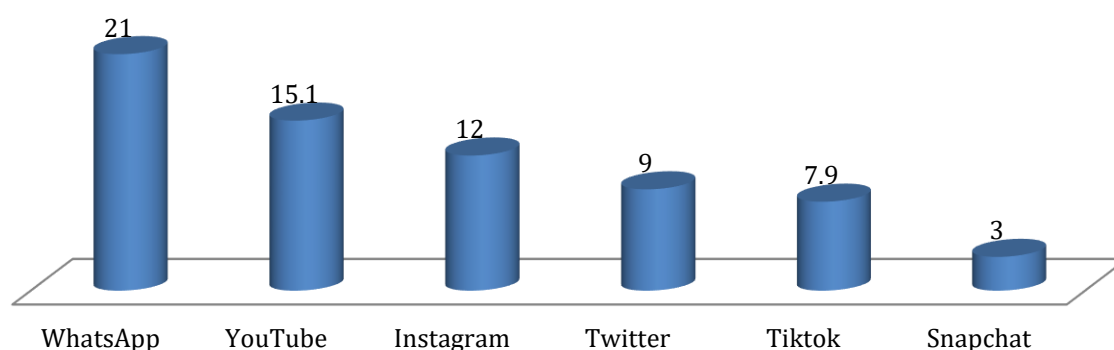


Figure 1. Social media usage among respondents

Table 3. Distribution of responses to health information exposure via social media platforms

Exposure item	Strongly disagree n(%)	Disagree n(%)	Agree n(%)	Strongly agree n(%)	Mean±SD
Comes across health campaigns on SM	0(0)	30 (7.8%)	262 (68.2%)	92 (24.0%)	3.16±0.54
Watched online health messages/videos	0(0)	7 (1.8%)	264 (68.8%)	113 (29.4%)	3.27±0.49
Frequently encounters health info on SM	0(0)	33 (8.6%)	233 (60.7%)	118 (30.7%)	3.22±0.59
Finds health info on SM relevant	0(0)	27 (7.0%)	278 (72.4%)	79 (20.6%)	3.14±0.51
Learns new health developments via SM	0(0)	21 (5.5%)	211 (54.9%)	152 (39.6%)	3.34±0.58
Sees health professionals' content on SM	0(0)	7 (1.8%)	225 (58.6%)	152 (39.6%)	3.38±0.52

Table 4. Level of health-information exposure via social media platforms

Level of exposure	Frequency (n)	Percentage (%)
Low	0	0
Moderate	166	43.2
High	218	56.8
Total	384	100.0

Table 5. Self-medication practices among respondents

Variable	Frequency (n)	Percentage (%)
Self-medication practice		
Taken drugs without a doctor's prescription in the last 6 months		
Yes	202	52.6
No	182	47.4
Shared prescription without medical advice		
Yes	127	33.1
No	257	66.9
Frequency of pharmacy/chemist visits in the last 6 months		
Once	129	33.6
2–3 times	169	44
4–5 times	67	17.4
More than 5 times	19	4.9

Table 6. Level of self-medication practice

Variable	Frequency (n)	Percentage (%)
Did not practice self-medication	149	38.8
Practiced self-medication	235	61.2
Low practice	141	60.0*
High practice	94	40.0*

Note: *Percentages for low and high practice are based on the 235 respondents who reported at least one self-medication behaviour.

Table 7. Self-medication patterns and reasons for self-medication among respondents

Variable	Frequency (n)	Percentage (%)
Types of medication taken without prescription		
Antimalarial drugs	172	45.5
Multivitamins/supplements	160	42.3
Antibiotics	80	21.2
Analgesics	64	16.9
Cough syrups	48	12.7
Worm drugs	39	10.3
Antacids	33	8.7
Herbal medicines	28	7.4
Drugs for vomiting	20	5.3
Others: (None)	26	6.9
Types of drugs commonly seen on social media		
Drugs for weight loss	146	38.0
Drugs for sexual problems	145	37.8
Drugs for diabetes	102	26.6
Drugs for blood pressure	100	26.0
Drugs for hair problems	90	23.4
Drugs for weight gain	77	20.1
Drugs for menstrual problems	76	19.8
Drugs for arthritis	49	12.8
Supplements	19	4.9
Drugs for height gain	13	3.4
Reasons for self-medication		
Minor illness	242	63.0
Confidence in knowledge of drugs	130	33.9
No time to visit the hospital	39	10.2
Influence from friends/family	28	7.3
It is cheaper	27	7.0
Influence from social media platforms	26	6.8
Long waiting time at health facilities	20	5.2

Note: Percentages are based on percent of cases (n = 384) and may not sum to 100%, as respondents could select more than one option.

Factors associated with self-medication practice

In the crude analysis, marital status was significantly associated with self-medication practice, with married respondents having higher odds of self-medication than those who were not married (COR = 1.62, 95% CI: 1.01–2.59; $p = 0.045$). Time spent on social media and monthly income were also significantly associated with self-medication practice ($p < 0.001$ and $p = 0.001$, respectively). Gender ($p = 0.208$), occupation ($p = 0.304$) and health-information exposure score (COR = 0.68, 95% CI: 0.40–1.15; $p = 0.148$) were not significantly associated with self-medication practice in the crude analysis.

After adjustment for the variables included in the multivariable model, health-information exposure score was significantly associated with self-medication practice. Each one-unit increase in exposure score was associated with higher odds of self-medication (AOR = 2.42, 95% CI: 1.16–5.03; $p = 0.018$). Married respondents also had higher odds of self-medication compared with those who were not married (AOR = 2.30, 95% CI: 1.16–4.53; $p = 0.016$).

Time spent on social media remained significantly associated with self-medication practice overall ($p < 0.001$). Compared with respondents who spent less than one hour on social media, those in the 1–2-hour category had lower odds of self-medication (AOR = 0.11, 95% CI: 0.05–0.22; $p < 0.001$), as

did those in the 6–10-hour category (AOR = 0.26, 95% CI: 0.12–0.59; $p = 0.001$). The association for the 3–5-hour category was not statistically significant (AOR = 0.27, 95% CI: 0.07–1.03; $p = 0.055$), nor was that for 10 hours and above (AOR = 1.07, 95% CI: 0.34–3.40; $p = 0.911$).

Income was also significantly associated with self-medication in the adjusted model ($p = 0.001$). Compared with

respondents earning below ₦100,000, those earning ₦200,000–₦299,999 had lower odds of self-medication (AOR = 0.33, 95% CI: 0.13–0.80; $p = 0.015$). The other income categories were not statistically significant. Gender and occupation were not significantly associated with self-medication after adjustment ($p = 0.281$ and $p = 0.104$, respectively).

Table 7. Factors associated with self-medication practice among respondents

Variable	COR (95% CI)	p-value	AOR (95% CI)	p-value
Health-information exposure on social media platforms	0.68 (0.40–1.15)	0.148	2.42 (1.16–5.03)	0.018*
Gender				
Female	1		1	
Male	1.30 (0.86–1.97)		1.38 (0.77–2.48)	
Marital status		0.045*		0.016*
Not married	1		1	
Married	1.62 (1.01–2.59)		2.30 (1.16–4.53)	
Occupation		0.304		0.104
Employed	1		1	
Self-employed	1.18 (0.69–2.02)		1.26 (0.59–2.72)	
Unemployed	0.73 (0.44–1.22)		0.55 (0.26–1.14)	
Time spent on social media		<0.001*		<0.001*
Less than an hour	1		1	
1–2 hours	0.19 (0.11–0.32)		0.11 (0.05–0.22)	
3–5 hours	0.23 (0.07–0.76)		0.27 (0.07–1.03)	
6–10 hours	0.24 (0.13–0.47)		0.26 (0.12–0.59)	
10 hours and above	0.68 (0.26–1.78)		1.07 (0.34–3.40)	
Income		0.001*		0.001*
Below ₦100,000	1		1	
₦100,000–₦199,999	1.36 (0.81–2.30)		1.43 (0.68–3.00)	
₦200,000–₦299,999	0.33 (0.17–0.62)		0.33 (0.13–0.80)	
₦300,000– ₦499,999	0.98 (0.45–2.13)		2.28 (0.77–6.75)	
Above ₦500,000	0.56 (0.25–1.25)		0.41 (0.13–1.30)	

*significant at $p < 0.05$

Discussion

This study examined the influence of social media health-information exposure on self-medication practices among young adults in Uyo, Nigeria. The findings showed a generally high level of exposure to health information through social media, with respondents frequently encountering health campaigns, online health messages, information on new health developments, and content from health professionals. This finding suggests that social media has become an important channel through which young adults access health-related information. The high exposure may be explained by the accessibility and convenience of social media, which allows health information to be encountered repeatedly during routine online activities. The finding is consistent with [20], who reported that young adults use various social media platforms to obtain health information. For example, heavy social media engagement was similarly

linked to increased likelihood of self-medicating with weight-loss products [22]. However, the availability of health information online does not necessarily guarantee its accuracy or appropriateness. Previous studies [23, 24] have reported concerns regarding misinformation and the quality of health information available on social media. These concerns underscore the importance of strengthening digital health literacy and promoting access to credible health information. YouTube and Facebook have specifically been identified as key channels through which young adults now encounter health content that can substitute for professional consultation [20], a pattern reflected in the present study where YouTube and Instagram were among the most-used platforms

Self-medication was also common among the respondents. Among those who practiced self-medication more than half showed a high level of practice. This is close to the 61.9%

found among household members in Hosanna town, Ethiopia [25], and consistent with the broadly high self-medication rates documented in Nigeria [15]. The rate reported in this study is also comparable to global estimates, given that self-medication prevalence has been reported to range widely across countries and populations depending on measurement approach and setting [14]. This consistency across geographically distinct African populations suggests that similar structural drivers limited primary healthcare access, high out-of-pocket costs, and pharmacy-based drug availability operate across the region rather than being unique to any one city.

The pattern of medication use showed a high use of antimalarial medicines, followed by supplements and antibiotics consistent with Nigeria's high malaria burden and the routine over-the-counter availability of both drug classes [26] while minor illness and confidence in knowledge of medicines were the leading reasons for self-medication. This may reflect the tendency of young adults to manage familiar or perceived minor illnesses without professional consultation. The presence of medication-related content on social media, particularly information concerning weight management, sexual health and chronic conditions, further suggests that social media may contribute to awareness and perceptions surrounding medicine use [27]. Nevertheless, exposure to such content may also encourage individuals to believe that medicines can be selected and used independently without adequate professional assessment.

After adjustment, health-information exposure, marital status, time spent on social media and income were significantly associated with self-medication. The association with health-information exposure agrees with findings among Nigerian undergraduates, where social media was an important source of health information and health-related misinformation was associated with self-medication [28-29]. Similarly, students at Makerere University commonly used digital platforms to guide medication decisions (Namukasa et al., 2025).

Time spent on social media was significantly associated with self-medication. However, the association did not follow a simple pattern in which self-medication increased progressively with longer duration of use, suggesting that the nature, purpose and content of engagement may be more relevant than duration alone. This contrasts with a study from Norway, where no statistically significant relationship was found between social media use and consumption of prescription-free medicines among university students, despite a positive trend [30]. The differences may reflect variations in study populations, cultural contexts, types of medicines assessed and patterns of social media use. Thus, students may spend substantial time online without seeking health information, whereas shorter but purposeful searches for information about specific health conditions or medicines may be more relevant to self-medication.

Marital status was also independently associated with self-medication, although previous Nigerian studies have reported inconsistent findings. This finding is consistent with [31], which reported an association between marital status and self-medication, but contrasts with [32] and [33], which found no significant association. The present finding may reflect differences in household responsibilities, healthcare decision-making and previous experience with managing common illnesses.

Income was also associated with self-medication, consistent with evidence linking socioeconomic circumstances, financial barriers and access to medicines with self-medication [19]. Similar associations have been reported among previous findings and Nigerian adults [15][34], although the non-linear pattern observed in this study across income groups may explain differences between studies.

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