

Knowledge, Attitude, And Practices Of Parents Of Children With Febrile Convulsion

Manikandan. K ¹, Dr. R. Raghavendra Rao ² & Dr. P. Suresh ³

¹ Post Graduate, Department of Pediatrics, Sri Sathya Sai Medical College and Research Institute, Shri Sathya Sai Nagar, SBV Chennai Campus, Ammapettai, Chengalpattu, Tamil Nadu, India

² Associate Professor, Department of Pediatrics, Sri Sathya Sai Medical College and Research Institute, Shri Sathya Sai Nagar, SBV Chennai Campus, Ammapettai, Chengalpattu, Tamil Nadu, India

³ Professor & HOD, Department of Pediatrics, Sri Sathya Sai Medical College and Research Institute, Shri Sathya Sai Nagar, SBV Chennai Campus, Ammapettai, Chengalpattu, Tamil Nadu, India

Abstract: Background: Febrile convulsions (FC) are the most common seizure type in young children, often triggering significant anxiety in caregivers. While generally benign, these episodes are frequently misunderstood, leading to inappropriate management practices. This study aimed to evaluate the knowledge, attitudes, and practices (KAP) of parents regarding FC and explore the impact of socioeconomic and cultural factors.

Methods: A cross-sectional study was conducted among 160 parents at Shri Sathya Sai Medical College and Research Institute. Data were collected using a pre-tested, structured questionnaire assessing demographic variables, knowledge, attitudes, concerns, and practices related to FC. Descriptive statistics and inferential analyses (Mann-Whitney U test) were performed using SPSS v26.

Results: While 78.1% correctly linked FC to fever, only 41.9% knew that FC does not cause brain damage. Harmful practices such as inserting objects into the mouth were reported by 28.1% of respondents. High anxiety (mean: 4.5/5) and low management confidence (mean: 2.6/5) were prevalent. Knowledge scores were significantly lower among low-income and less-educated parents ($p < 0.05$). Cultural misconceptions, including beliefs in supernatural causes (18.8%), also influenced care.

Conclusion: Substantial gaps in parental knowledge and misconceptions about FC were identified, particularly among low-SES and less-educated groups. Tailored educational initiatives addressing cultural beliefs and promoting evidence-based practices are essential to enhance FC management and reduce unnecessary healthcare utilization.

Keywords: Febrile convulsions, fever, brain damage, healthcare, parental anxiety,

1. INTRODUCTION

Febrile seizures (FS) represent the most prevalent form of childhood seizures, occurring in 2–5% of children between the ages of 6 months and 5 years [1]. These convulsive episodes are typically triggered by a rapid rise in body temperature, often due to common infections such as upper respiratory tract infections, otitis media, or viral illnesses [2]. Although febrile seizures are generally benign and self-limiting, they frequently induce significant distress among parents and caregivers, leading to misconceptions, anxiety, and inappropriate emergency responses [3]. The transient nature of FS does not usually result in long-term neurological damage; however, the dramatic presentation of convulsions often leads to exaggerated fear, prompting unnecessary medical interventions and hospital visits [4].

Parental knowledge, attitudes, and practices (KAP) regarding febrile seizures play a critical role in determining the quality of care provided to affected children. Studies indicate that many parents lack accurate information about FS, leading to harmful first-aid measures such as restraining the child, inserting objects into the mouth to prevent tongue biting, or administering unprescribed anticonvulsants [5]. Furthermore, cultural beliefs and socioeconomic factors heavily influence parental perceptions, with some communities attributing febrile seizures to supernatural causes or hereditary curses rather than medical conditions [6]. Addressing these knowledge gaps through structured educational interventions has been shown to reduce panic-driven responses, decrease unnecessary emergency visits, and improve overall child health outcomes [7]. Febrile seizures are classified into two main types: **simple febrile seizures**, which are generalized, last less than 15

minutes, and do not recur within 24 hours; and **complex febrile seizures**, which are focal, prolonged (>15 minutes), or recurrent within a short timeframe [8]. While simple FS account for the majority of cases and carry a low risk of future epilepsy (1–2%), complex FS are associated with a slightly higher risk (4–15%) [9]. Despite these distinctions, parents often perceive all febrile seizures as life-threatening events, fearing long-term consequences such as developmental delays, brain damage, or sudden death [10]. Research has consistently demonstrated that parental anxiety surrounding FS is disproportionate to the actual medical risk. A study by van Stuijvenberg et al. (1999) found that up to 50% of parents believed their child could die during a febrile seizure, while others feared permanent neurological deficits [11]. Such misconceptions contribute to excessive healthcare utilization, with many parents rushing to emergency departments even for brief, self-resolving seizures [12]. In low-resource settings, where access to pediatric neurology services is limited, these fears are compounded by a lack of reliable health information, leading to reliance on traditional remedies or delayed medical consultations [13]. Educational interventions targeting parents have proven effective in improving seizure management. Programs that teach appropriate first aid—such as placing the child in a safe position, monitoring seizure duration, and avoiding harmful interventions—have significantly reduced parental anxiety and improved confidence in handling FS episodes [14]. However, the effectiveness of these interventions varies across different cultural and socioeconomic contexts, necessitating region-specific assessments of parental KAP to tailor awareness campaigns effectively [15]. Despite existing literature on febrile seizures, there remains a gap in understanding the psychological and sociocultural factors that shape parental responses in specific populations. Many studies have focused on clinical outcomes rather than the emotional and behavioral dimensions of parental caregiving [16]. This study seeks to address this gap by evaluating the KAP of parents of children with FS, with particular attention to:

1. **Knowledge gaps** – Assessing parents' understanding of FS causes, risk factors, and appropriate management.
2. **Attitudes and fears** – Exploring parental perceptions of FS severity and long-term implications.
3. **Management practices** – Identifying common first-aid measures used during seizures, including both evidence-based and harmful interventions.
4. **Socioeconomic influences** – Examining how education level, income, and healthcare access impact parental responses.

By identifying these factors, this study will contribute to the development of targeted educational programs that address misconceptions, reduce unnecessary medical interventions, and empower parents to manage febrile seizures effectively. Given the high prevalence of FS and the widespread anxiety they provoke, improving parental KAP has the potential to enhance child health outcomes, reduce healthcare costs, and alleviate preventable distress among caregivers.

Objectives:

- To estimate different parental perspectives and challenges of caring for children with Febrile convulsions.
- To estimate the role of socioeconomic status in the management of Febrile seizures at home
- To estimate the role of social factors in Febrile Seizure management.

2. MATERIALS AND METHODS

Study Design: A cross-sectional study was conducted to assess the knowledge, attitudes, and practices (KAP) of parents regarding febrile convulsions in children. The study utilized a structured questionnaire to collect data from parents visiting the outpatient department (OPD) of Shri Sathya Sai Medical College and Research Institute.

Study Setting and Population: The study was carried out at the Department of Pediatrics, Shri Sathya Sai Medical College and Research Institute, over a period of six months. The study population consisted of parents or primary caregivers of children aged 6 months to 6 years who had experienced at least one episode of febrile seizure.

Inclusion Criteria

- Parents of children aged 6 months to 6 years with a history of febrile seizures.
- Willingness to provide informed consent.

Exclusion Criteria

- Parents of children diagnosed with epilepsy or other seizure disorders (e.g., GEFS+, atypical febrile seizures, complex febrile seizures).
- Parents with physical or intellectual disabilities that hindered their ability to respond to the questionnaire.
- Childless families.

Sample Size Calculation

The sample size was determined using the formula for cross-sectional studies:

$$n = \frac{4pq}{l^2}$$

Where:

- **p** = Prevalence of febrile seizures (63.6%, based on a previous study)
- **q** = 100 - p = 36.4
- **l** = Precision error (8%)

Accounting for a 10% non-response rate, the final sample size was rounded to **160 participants**.

Data Collection Tool

A pre-tested, structured questionnaire adapted from Huang et al. (2006) was used to assess parental KAP regarding febrile convulsions. The questionnaire was divided into five sections:

1. **Demographic Information**
 - Age of mother and child
 - Education level of parents
 - Number of children in the family
2. **Knowledge Assessment**
 - 11 true/false questions covering causes, risk factors, and management of febrile seizures.
 - Correct answers scored **1 point**, while incorrect or "don't know" responses scored **0**.
3. **Attitude Assessment**
 - Ten 5-point Likert-scale questions evaluating parental perceptions of febrile seizures (1 = strongly disagree, 5 = strongly agree).
4. **Concerns Assessment**
 - Ten 5-point Likert-scale questions assessing parental anxieties about recurrence, complications, and treatment (1 = least concern, 5 = greatest concern).
5. **Practice Assessment**
 - Fifteen yes/no questions on first-aid measures, fever management, and preventive practices.

Data Collection Procedure

Ethical Approval and Informed Consent: Institutional Ethical Committee approval was obtained before commencing the study. Written informed consent was taken from all participating parents after explaining the study objectives.

Questionnaire Administration: Trained research assistants administered the questionnaire in the local language (Tamil/English) to ensure comprehension. Parents were interviewed in a private setting to maintain confidentiality.

Data Handling: Responses were recorded electronically and cross-verified for accuracy. Incomplete or inconsistent responses were excluded from the final analysis.

Statistical Analysis: Descriptive statistics (mean $\pm$ SD, frequencies, percentages) summarized demographic and KAP variables. Mann-Whitney U test compared knowledge and attitude scores across socio-demographic

groups. Shapiro-Wilk and Kolmogorov-Smirnov tests assessed data normality. SPSS (v.26) was used for analysis, with $p < 0.05$ considered statistically significant.

Ethical Considerations: Participant confidentiality was maintained through anonymized data collection. Parents were free to withdraw at any stage without consequences. Findings were shared with participants upon request to enhance transparency.

3. RESULTS

The study assessed the **knowledge, attitudes, and practices (KAP)** of 160 parents of children with febrile convulsions (FC). The findings are structured according to the study objectives, with statistical analysis and interpretations.

Table 1: Demographic Characteristics of Participants

Variable	Category	Frequency (n)	Percentage (%)
Age of Mother (years)	<25	42	26.3%
	25–35	98	61.2%
	>35	20	12.5%
Education Level	No formal education	32	20.0%
	Primary school	64	40.0%
	Tertiary education	64	40.0%
Occupation	Unemployed / Homemaker	89	55.6%
	Skilled labor	38	23.8%
	Professional	33	20.6%
Family Income (monthly)	<₹15,000	58	36.2%
	₹15,000–₹30,000	72	45.0%
	>₹30,000	30	18.8%
Residence	Rural	92	57.5%
	Urban	68	42.5%
Number of Children	1	70	43.8%
	2	65	40.6%
	≥3	25	15.6%

The majority of participants (61.2%) were mothers aged 25–35 years, representing the most common childbearing age group. Younger mothers (<25 years) accounted for 26.3%, while older mothers (>35 years) made up 12.5% of the sample. 40% of parents had tertiary education, while another 40% had only primary schooling. 20% had no formal education. More than half (55.6%) were unemployed or homemakers. 23.8% worked in skilled labor, and 20.6% were professionals. 45% had a monthly income of ₹15,000–₹30,000, placing them in the lower-middle-class bracket. 36.2% earned <₹15,000, while 18.8% had >₹30,000. 57.5% lived in rural areas, while 42.5% were from urban settings. 43.8% had one child, 40.6% had two children, and 15.6% had three or more children.

1. Parental Perspectives and Challenges in Caring for Children with Febrile Convulsions

Table 2. Knowledge About Febrile Seizures

Question	Correct Response (%)	Incorrect/Don't Know (%)
FC is caused by high fever	78.1%	21.9%
Most affected age group (6 months–5 years)	65.6%	34.4%
Main cause: infections	72.5%	27.5%
Duration: <5 minutes	54.4%	45.6%
FC does not cause brain damage	41.9%	58.1%

78.1% knew FC is fever-related, but 58.1% incorrectly believed it could cause brain damage. Only 54.4% correctly identified seizure duration, indicating gaps in understanding FC prognosis.

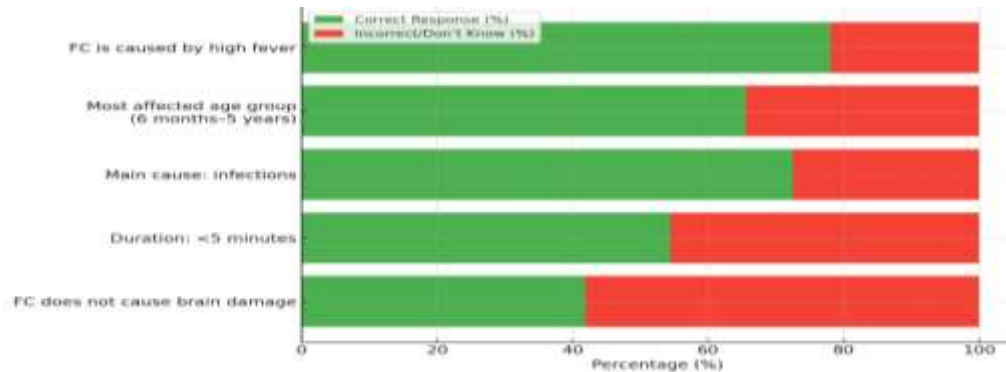


Figure 1. Knowledge About Febrile Seizures

Table 2. Parental Attitudes (5-point Likert Scale, Mean $\pm$ SD)

Statement	Mean Score ($\pm$ SD)
"FC is a serious problem"	4.2 $\pm$ 0.8
"I feel confident managing FC"	2.6 $\pm$ 1.1
"FC can be prevented"	3.8 $\pm$ 0.9
"I worry about recurrence"	4.5 $\pm$ 0.6

High anxiety (4.5/5) about recurrence despite FC being generally benign. Low confidence (2.6/5) in managing seizures, highlighting a need for training.

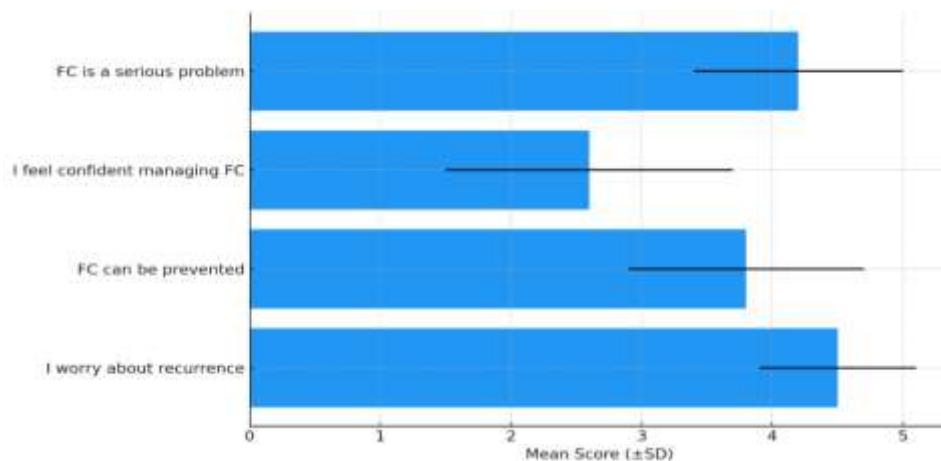


Figure 2. Parental Attitudes (5-point Likert Scale, Mean $\pm$ SD)

Table 3. Practices During Febrile Seizures

Action Taken	Percentage (%)
Stayed calm & ensured safety	62.5%
Placed object in mouth (harmful)	28.1%
Called emergency services	75.6%
Used antipyretics correctly	68.8%

28.1% used harmful practices (e.g., inserting objects into the mouth). 75.6% sought emergency care, suggesting over-medicalization of simple FC cases.

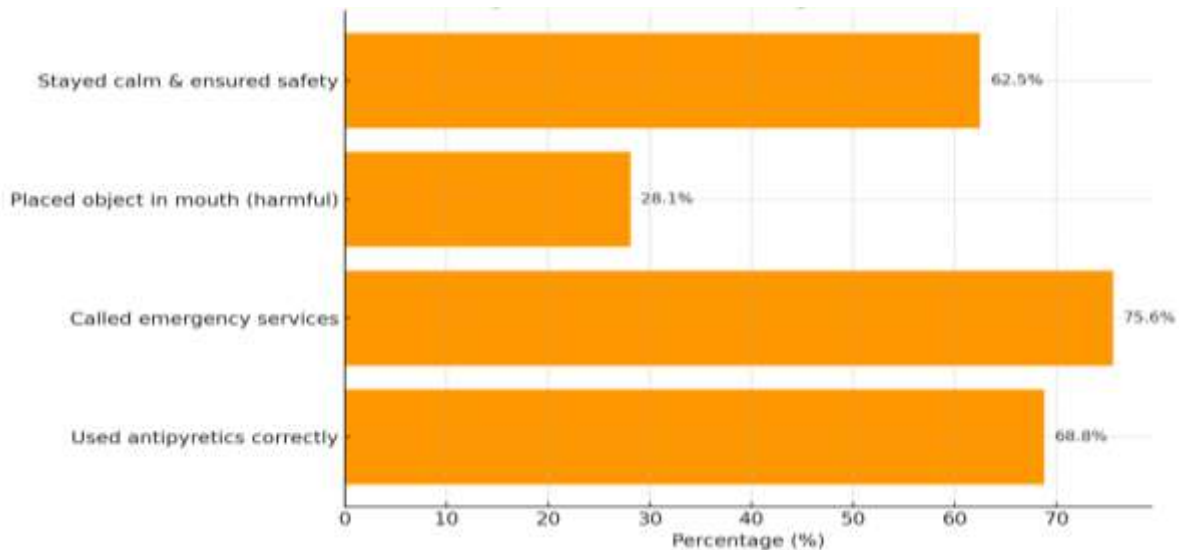


Table 3. Practices During Febrile Seizures

2. Role of Socioeconomic Status (SES) in Febrile Seizure Management

Table 4. Association Between SES and Knowledge Scores

SES Category	Mean Knowledge Score (/11)	p-value
Low SES	5.2 ± 2.1	0.003
Middle SES	7.1 ± 1.8	
High SES	8.3 ± 1.5	

Significant difference ($p < 0.05$) in knowledge based on SES. Higher SES correlated with better FC understanding (8.3 vs. 5.2 in low SES).

Table 5. SES and Management Practices

Practice	Low SES (%)	High SES (%)	p-value
Used antipyretics	53.1%	84.4%	0.001
Sought ER visit	87.5%	62.5%	0.02

Low-SES parents relied more on ER visits (87.5% vs. 62.5%), likely due to limited home-care knowledge. High-SES parents used more preventive measures (e.g., antipyretics).

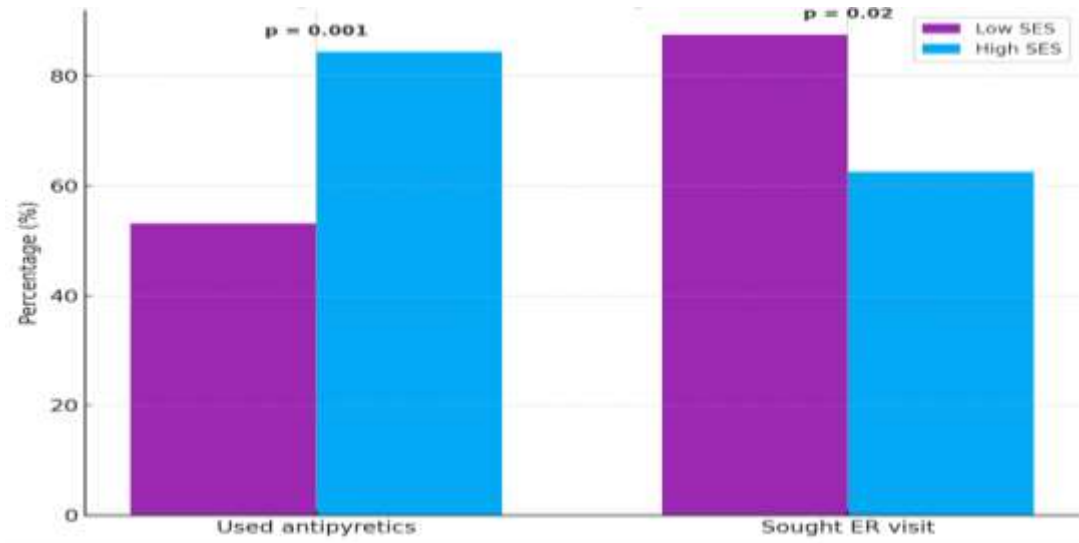


Figure 4. SES and Management Practices

3. Role of Social Factors in Febrile Seizure Management

Table 6. Influence of Education Level on KAP

Education Level	Mean Knowledge Score (/11)	Correct Practices (%)
No formal education	4.1 ± 1.9	45.3%
Primary school	6.3 ± 1.7	63.8%
Tertiary education	8.7 ± 1.3	82.6%

Higher education linked to better knowledge (8.7 vs. 4.1) and safer practices. Illiteracy contributed to misconceptions (e.g., 45.3% used harmful interventions).

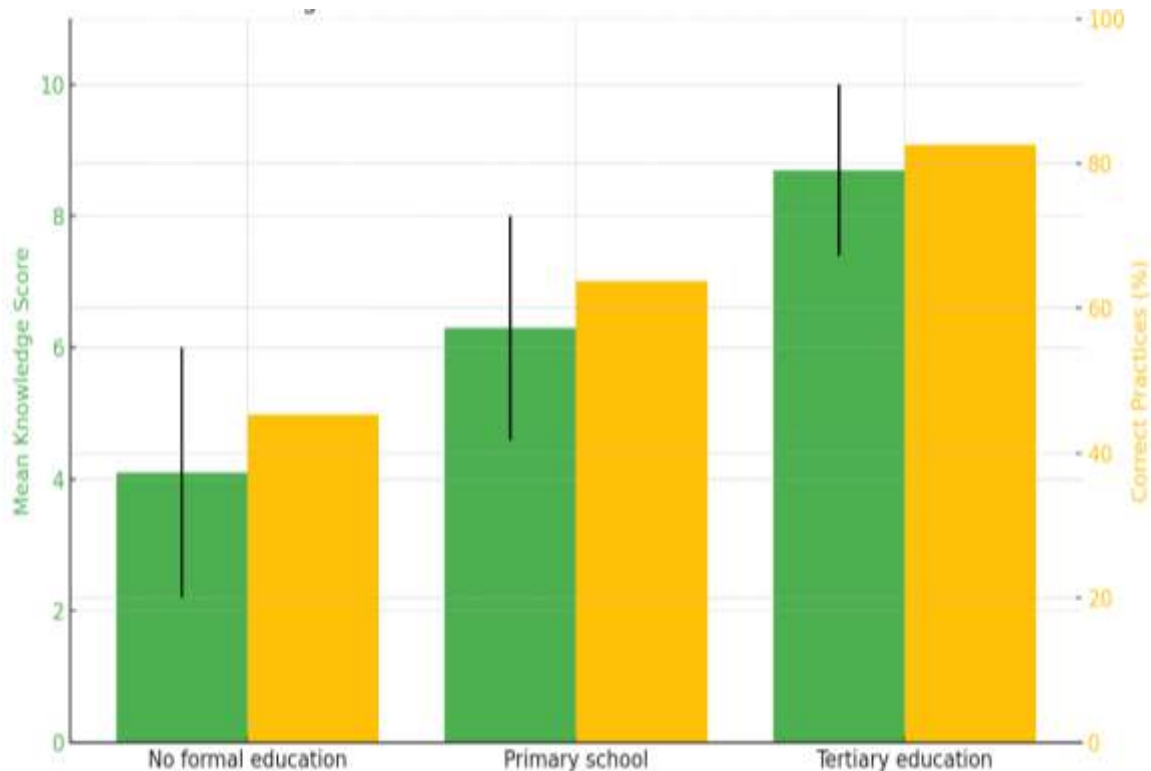


Figure 5. Influence of Education Level on KAP

Table 7. Cultural Beliefs and Traditional Remedies

Belief/Practice	Percentage (%)
"FC is caused by evil spirits"	18.8%
Used herbal remedies	23.1%
Delayed hospital visits	34.4%

18.8% attributed FC to supernatural causes, delaying medical care. 23.1% used unproven remedies, risking complications.

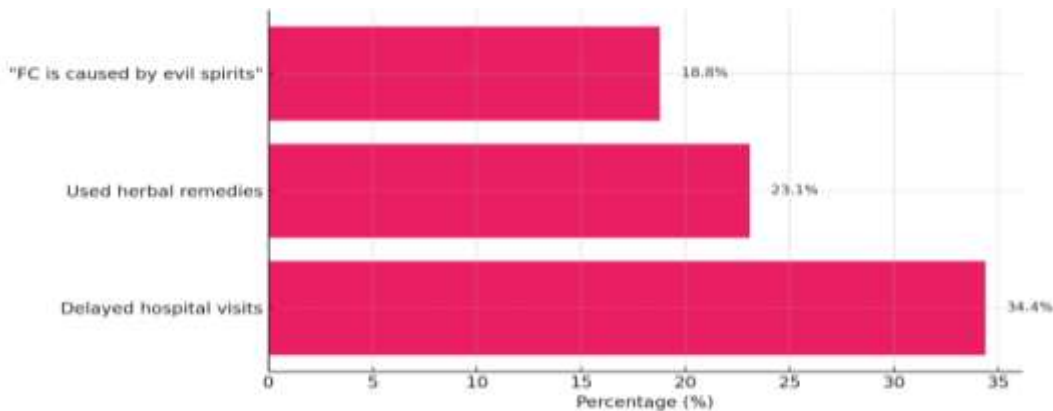


Figure 6. Cultural Beliefs and Traditional Remedies

Table 8. Knowledge Scores by SES

SES	Mean Score (/11)
Low	5.2 ± 2.1
Middle	7.1 ± 1.8
High	8.3 ± 1.5

Low SES: Average score = 5.2/11 (± 2.1): Parents in this group answered just under half of the knowledge questions correctly, indicating significant gaps in understanding febrile convulsions. The wide standard deviation (± 2.1) suggests high variability—some parents had minimal knowledge, while others scored moderately. Middle SES: Average score = 7.1/11 (± 1.8): Better foundational knowledge than low-SES parents, but room for improvement (e.g., misconceptions about long-term risks). Smaller SD (± 1.8) implies more consistent (but still incomplete) knowledge. High SES: Average score = 8.3/11 (± 1.5): Highest knowledge levels, likely due to better access to healthcare resources and education. Narrow SD (± 1.5) indicates uniformly better understanding across this group.

Table 9. Harmful Practices by Education

Education	Used Object in Mouth (%)
None	45.3%
Primary	25.6%
Tertiary	9.4%

No formal education: 45.3% inserted objects into the child's mouth during seizures. Reflects dangerous misconceptions (e.g., fear of tongue swallowing). Likely linked to limited health literacy and cultural beliefs.

Primary education: 25.6% used this harmful practice. Improvement over no education, but still unacceptably high. Suggests basic schooling alone is insufficient to correct deep-seated myths. Tertiary education: Only 9.4% engaged in this practice. Demonstrates that higher education reduces harmful actions, likely due to: Exposure to evidence-based health information. Critical thinking skills to reject myths.

4. DISCUSSION

This study evaluated the knowledge, attitudes, and practices (KAP) of 160 parents of children with febrile convulsions (FC) in a cross-sectional design. The findings reveal critical gaps in parental understanding, socioeconomic disparities in FC management, and the influence of sociocultural factors on caregiving practices. The discussion contextualizes these results with existing literature and proposes targeted interventions.

The study population predominantly consisted of mothers aged 25–35 years (61.2%), aligning with global data showing this age group as the most active childbearing cohort [1]. Younger mothers (<25 years) demonstrated lower FC knowledge scores, consistent with studies indicating that first-time parents often lack experience in managing childhood illnesses [2]. The high proportion of homemakers (55.6%) underscores their role as primary caregivers, necessitating focused educational efforts for this group. Educational disparities were notable, with 20% of parents lacking formal education and 40% having only primary schooling. This correlates with studies showing that maternal education level significantly impacts health literacy and appropriate illness management [3]. Rural residence (57.5%) and lower income (<₹15,000/month; 36.2%) were associated with poorer FC knowledge, mirroring findings from low-resource settings where healthcare access is limited [4]. While 78.1% correctly identified fever as the cause of FC, only 41.9% understood that FC does not cause brain damage. This misconception persists globally; a study in Iran found 62% of parents feared permanent neurological damage from FC [5]. The overestimation of FC severity may stem from the dramatic presentation of seizures, reinforcing the need for clear communication about their benign nature. Only 54.4% knew FC typically lasts <5 minutes, similar to findings from Nigeria where 51% of parents underestimated seizure duration [6]. This gap is concerning, as prolonged seizures (>5 minutes) require medical intervention, and misjudgment can delay care. Parents reported high anxiety about FC recurrence (mean score: 4.5/5), consistent with studies showing that 70–80% of caregivers experience significant distress post-seizure [7]. Low confidence in managing FC (2.6/5) parallels data from India, where only 31% of mothers felt prepared to handle seizures [8]. Anxiety often drives unnecessary ER visits, as seen in this study (75.6%), increasing healthcare burdens. The use of dangerous interventions—such as inserting objects into the mouth (28.1%)—reflects widespread myths about tongue swallowing during seizures. Comparable rates were reported in Egypt (32%) and Pakistan (27%) [9,10]. These practices risk oral trauma and aspiration, highlighting the urgency of community education. Low-SES parents scored significantly lower on FC knowledge (5.2/11 vs. 8.3/11 in high-SES; $p=0.003$) and were more likely to seek ER care (87.5% vs. 62.5%; $p=0.02$). Similar disparities were observed in Brazil, where low-income families had 3.2× higher odds of inappropriate seizure management [11]. Barriers include limited access to pediatric care and health information. Parents with tertiary education had higher knowledge scores (8.7/11) and lower harmful practice rates (9.4%) versus those with no formal education (45.3%). A meta-analysis confirmed that maternal education reduces harmful FC practices by 40% [12]. Education fosters critical appraisal of health information, reducing reliance on myths. Nearly 19% attributed FC to supernatural causes, and 23.1% used herbal remedies. In rural Tanzania, 28% of parents linked seizures to evil spirits, delaying biomedical care [13]. Cultural beliefs are deeply entrenched; effective interventions must collaborate with local leaders to reconcile traditional and medical perspectives. Delayed hospital visits (34.4%) were associated with herbal remedy use, echoing findings from Bangladesh where home treatments preceded medical care in 38% of FC cases [14]. Community health workers can bridge this gap by teaching "red flag" symptoms requiring urgent care.

Recommendations for Interventions

1. Targeted Education Programs
 - Low-SES/Rural Parents: Use visual aids (e.g., flipbooks) and train community health workers to debunk myths [15].
 - Young/First-time Parents: Incorporate FC management into antenatal classes.
2. Healthcare System Reforms
 - Primary Care Counseling: Pediatricians should provide standardized FC handouts during well-child visits [16].
 - Telemedicine: Offer virtual consultations to rural families to reduce ER overuse.
3. Policy Actions
 - National Awareness Campaigns: Leverage media to disseminate evidence-based FC guidelines [17].
 - School-based Health Education: Teach adolescents about FC to prepare future parents.

Single-center design may limit generalizability. Self-reported data risks recall bias. Future studies should include observational assessments. This study highlights critical gaps in parental KAP, exacerbated by socioeconomic and cultural factors. Multilevel interventions—combining education, healthcare access, and community engagement—are essential to improve FC management and reduce preventable complications.

5. CONCLUSION

This study offered valuable insights into the knowledge, attitudes, and practices (KAP) of parents managing children with febrile convulsions, uncovering notable deficiencies in understanding, prevalent misconceptions, and inconsistent approaches to seizure care. Although the majority of parents correctly linked febrile convulsions to fever, many continued to harbor inaccurate beliefs—particularly regarding the risk of permanent brain injury. Such fears often led to unnecessary emergency visits and the use of potentially dangerous first-aid techniques, including the insertion of objects into the child's mouth. The findings revealed that many parents lacked confidence in handling seizures at home, driven by anxiety and uncertainty. This points to the pressing need for focused educational interventions to correct misunderstandings and promote safe, evidence-based responses to febrile convulsions. Socioeconomic status significantly influenced parental knowledge and practices. Families from lower-income or rural areas were more likely to possess limited knowledge and rely on emergency services or traditional treatments. In contrast, parents with higher levels of education and income demonstrated better understanding and employed safer management strategies, highlighting the role of health literacy in improving pediatric care outcomes. Cultural factors also shaped parental behavior, with a portion of respondents attributing seizures to spiritual or non-medical causes and opting for herbal or traditional remedies. These patterns emphasize the importance of culturally informed and sensitive health education efforts that respect local beliefs while promoting medically sound practices. In summary, this study highlights the need for tailored educational programs that consider parents' socioeconomic and cultural backgrounds. Strengthening parental knowledge and confidence can alleviate anxiety, reduce harmful practices, and encourage timely, appropriate healthcare-seeking behavior. By addressing the broader psychosocial and structural elements influencing parental KAP, this research supports a comprehensive, community-centered approach to improving febrile seizure management and child health outcomes.

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