

“A pre-experimental study to evaluate the effectiveness of plan teaching programme (PTP) on knowledge regarding convulsion and its management among health care workers in selected rural areas of Kolhapur”

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ABSTRACT

Background of the study: Epilepsy is one of the first illnesses that humans have faced. Epilepsy has a lengthy history, and it was recognized by the Romans and Greeks even before the birth of Jesus Christ. According to the World Health Organization (WHO), there are over 50 million epileptic victims in the world today, 85 percent of them live in developing countries, and 2.4 million new cases of epilepsy are diagnosed each year. In Ayurveda, epilepsy is referred to as Apasmara. Treatment pauses are caused by a variety of factors, including administrative costs, a lack of case identification, and a failure to treat cases that have been discovered. People's views about the origins of epilepsy, the patterns of discomfort they experience, and their preferred methods of seeking care are all explored in cultural epidemiology of epilepsy. Epilepsy is linked to Patients and their families experience psychological and social anguish as a result of stigma in all countries. According to this research, Indians' perceptions of epilepsy are comparable to those in Western countries, but unfavorable opinions have a stronger impact on education, marriage, job, and other social activities. They also reveal that people frequently employ two or more healing systems, both allopathic and traditional, at the same time. More collaboration between neurologists and others working in the field of epilepsy and its causes is needed to raise public awareness and press for treatment and public health measures to prevent epilepsy. As a result, the researcher is interested in investigating the usefulness of PTP in the treatment of convulsions.

Material and Methods: One group was used as a control group in a pre-experimental study. A pre-test-post-test design was adopted, with a total of 60 samples chosen using a non-probability convenient sample procedure. Data on convulsion and its management among health care workers in selected rural regions of Kolhapur was obtained using Socio Demographic Variables and a Structured Knowledge Questionnaire.

Results: The results show that 58.66 % of health care workers has poor knowledge, 2.33 % had average knowledge, but none had good knowledge at the period of the pre-test. In a post-test after receiving the plan training programme, 35 (58.33 %) of health care workers had average knowledge, 25 (41.66 percent) had high knowledge, and none had bad knowledge. In the case of convulsion among health care workers, there was a highly significant difference in mean scores between pre-test and post-test. The tabulated't' value ($t_{tab} = 2.00$) is less than the computed't' value ($t_{cal} = 60.8$).As a result, H₁ is approved but H₀ is refused. At the 0.05 level, this implies that the plan teaching programme (PTP) is statistically significant. As a result, it was established that (PTP) was more effective in terms of improving health-care providers' awareness about convulsions and how to manage them. There is no significant relationship between pre-test knowledge scores and the socio-demographic variables that were chosen. All calculated values were lower than those in the table.Hence H₂ are rejected and H₀₂ is accepted.

Conclusion: The study found that the majority of health-care workers had knowledge deficit and that the plan teaching programme (PTP) was helpful in improving health-care workers' consciousness about convulsions and how to manage them.

Keywords: Evaluate: Effectiveness: Prepare a lesson plan: Convulsions and their Treatment: Workers

in the healthcare field: Primary health-care clinics.

INTRODUCTION:

“Epilepsy is what you have, not what you are.”

-Indian Epilepsy Association

Epilepsy is one of the oldest ailments that humans have encountered. Seizure has a long history and was recognised to the Romans and Greeks before the birth of Lord Jesus. According to the World Health Organization (WHO), there are over 50 million epileptics in the world today, 85% of who live in developing countries, and 2.4 million new cases of epilepsy are diagnosed each year.

Epilepsy is known as Apasmara in Ayurveda. The words "apa" and "smara" signify "loss" and "awareness," respectively. According to Sushuarta, 'apa' means destroy and 'smara' means memory, hence epilepsy occurs when a person's memory is lost. Epilepsy is derived from the Greek word "epilepsia," which literally means "attack." "Epilepsy" is derived from the terms epic-above and led-o-injury, which refers to damage to the top area of the skull.

Convulsive seizures are divided into three categories: partial seizures, generalised seizures, and unclassified seizures. Partially convulsive seizures begin in one of the cerebral hemispheres and are classified according to whether or not the victim loses consciousness. Although a simple partial seizure does not result in loss of consciousness, it can result in motor, sensory, autonomic, or psychiatric symptoms. Over time, a simple partial seizure can develop into a difficult partial seizure. A loss of consciousness, as well as some behavioural automatisms, characterises complex partial seizures (unconscious repetitive motor actions). Simple partial seizures are supposed to involve only one hemisphere, whereas complex partial seizures are believed to involve both hemispheres. 2

The persistent rapid contraction and relaxation of muscles in the body is known as a convulsion. The length of convulsive seizures varies from person to person. Tonic-Clonic seizures begin with bodily rigidity and progress to generalised convulsions. When a person becomes unsteady or static, they get atonic seizures. These attacks

are often known as 'drop attacks,' because they might cause a person to fall to the ground unexpectedly. Myoclonic, tonic-clonic, tonic-clonic, and atonic seizures can last anywhere from a few seconds to several minutes in most cases. Seizures can last for hours or even days in rare cases. Status epilepticus is the medical term for this syndrome. 2

Adolescents greatly improve their cognitive ability in the years leading up to adulthood, although this may not have the same dramatic effect as a toddler taking their first steps or speaking for the first time. The overall volume of the brain continues to grow structurally until approximately the age of 14. According to a longitudinal magnetic resonance imaging (MRI) research, total white matter volume increases until the early 20s, frontal and parietal grey matter volume peaks around 14 years of age before falling, and grey matter in the occipital and temporal lobes increases until 20 years of age. 5 The loss of up to 30 000 synapses per second over the entire brain, with the frontal areas losing the most synapses, is believed to be the cause of the drop in frontal grey matter volume during this period, according to data from primate models. The "use it or lose it" argument says that the brain grows based on experience and relevant environmental needs, albeit the actual cause is unknown. Finally, during adolescence, there appears to be much more localised brain activity, with a large increase in the degree to which each hemisphere can process information separately, compared to early infancy.2

NEED OF STUDY

Epilepsy affects around 70 million people globally, with a prevalence rate of 5-9 people per 1,000. According to the GBD analysis for 2010, epilepsy accounted for 0.7 percent of the global burden, or over 17 million DALYs, with around 90% of these happening in low- and middle-income countries (LMICs). DALYs have ranged from 6.2 million in Africa to 1.6 million in Europe, with Southeast Asia accounting for 3.2 million DALYs, up 0.3 to 0.5 percent since 1990. In Southeast Asia, the prevalence of epilepsy ranged from 2 to 10 per 1,000

individuals, with more than half of the population affected. India contributed to the total number of epilepsy-related DALYs (as predicted by GBD 2010). This high burden is largely owing to India's large population, low income and education, societal prejudices, insufficient resources, competing infectious and non-communicable diseases, and epilepsy's public health elements being given low priority..
3

Several researches from India are provided, with variable prevalence rates at various eras and locations. When evaluating the results of previous research that consistently revealed lower prevalence rates, temporal trends and higher mortality rates must be taken into account, in addition to methodological difficulties. The prevalence rate of epilepsy among adults and the elderly ranged from 1.2 to 11.9 per 1,000 persons, with the exception of a study that revealed a prevalence rate of 22.2 per 1,000 people among children aged 8-12 years over a 5-year period. Some studies reported active epilepsy prevalence, which is defined as the number of people with epilepsy per thousand people in the community at the time the study was conducted, while others reported lifetime prevalence, which includes everyone who had epilepsy prior to the study. 3

The four indices used to represent mortality data are specific mortality rate (number of epilepsy deaths per 1,000 population), proportionate mortality rate (number of epilepsy deaths per 1,000 total deaths), case fatality rate (deaths from epilepsy per 100 cases), and standardised mortality ratio (SMR; ratio of number of deaths in those with epilepsy to the expected deaths in the people with epilepsy, if they experience the death rates of standard population). The mortality rate of epilepsy has been reported in western literature to range from 1 to 2 per 100,000 people, and death certificates are routinely changed. A number of hospital-based studies have been conducted in India. A case fatality rate of 29% was detected in 117 hospitalised SE patients, while another research found a death rate of 29.7% among SE patients with central nervous system infection. Higher mortality was linked to abnormalities on neurological examinations, older age group, refractoriness, and male sex, as well as socioeconomic status, time since diagnosis, higher seizure frequency, prolonged seizure

duration, delay in starting treatment, poor Glasgow Coma Scale (GCS) score at admission, and poor drug compliance. Only two community-based studies on India's Parsi population have previously confirmed epilepsy-related mortality. The SMR for Mumbai's urban Parsi population was 0.76, While the SMR for Vasai's rural Parsi population was 7.8 for the 5-year follow-up and 3.9 for the 10-year follow-up in the research, it was 7.8 for the 5-year follow-up and 3.9 for the 10-year follow-up. In a 5-year follow-up among the general population in Kolkata, epilepsy had an annual death rate of 7.6 per 100,000 and an SMR of 2.58. Overall, rural epilepsy mortality is higher than urban epilepsy mortality, which is most likely owing to service accessibility and availability. 3

The treatment gap is caused by a number of factors, including the high expense of therapy, the failure to identify patients, and the incapacity to treat those who have been discovered. Cultural epidemiology of epilepsy investigates people's perspectives on the causes of epilepsy, the patterns of discomfort they experience, and their preferred methods of obtaining care. Epilepsy is stigmatised in every country, causing sufferers and their family's emotional and social distress. Several sociocultural studies on epilepsy have been undertaken in India. Epilepsy awareness in India is equivalent to that in Western countries, according to these research, but Negative attitudes affect schooling, marriage, job, and other social activities more than positive attitudes. They also show that people commonly use two or more techniques. At the same time, both allopathic and traditional healing approaches are applied. To promote public awareness and urge for treatment and public health measures to prevent epilepsy, more collaboration between neurologists and others working in the field of epilepsy and its causes is required. As a result, the researcher is curious about the effectiveness of a plan teaching programme (PTP) in the treatment of convulsions.4

RESEARCH METHODOLOGY:

The purpose of this research was to "determine the efficacy of a planned training programme on convulsion knowledge and management in selected rural areas of Kolhapur."

The intended research was carried out with the permission. The ethical committee of D.Y. Patil University's College of Nursing The medical officer at Shirol primary health centre Kolhapur offered his written approval, as well as the informed written consent of each respondent, before the data collection began. Throughout the study, the respondent's identity was kept anonymous.

The samples for this study were picked using a non-probability, easy selection strategy to assess a plan education programme on understanding of convulsions and their management among health care professional. This is a reliable instrument they developed a systematic knowledge questionnaire on convulsions and how to deal with them.

For the final data collection, a pre-test was performed in a primary health care centre. The data collection procedure and timings were explained to the medical officer. The investigator checked for health care workers in the respective settings and observed whether they were comfortable approaching them at that time; accordingly, the investigator proceeded with data collection, and the post-test was scheduled after the 7th day to avoid interfering with the health care workers' rest period.

First and foremost, the investigator presented him-self to the health-care personnel, followed by a briefing about the research project, its significance, and their moral duty to be honest in their replies. The investigator oriented them to the tool and the data gathering process to ensure reliability in data collection. The respondents were enlightened about their rights as 'the respondents' of the study and regarding the 'Data Protection Act'. The respondents were made aware that they can ask for any kind of clarifications from the investigator at any point in the interview. An informed consent was obtained from every respondent of the study at the start of the data collection. The investigator instructed each response personally, and the participants were thanked for their involvement at the conclusion of their instruction. If any of the respondents lacked information, the investigator used a PowerPoint presentation to explain what they needed to know about convulsions and how to handle them.

PLAN FOR DATA ANALYSIS

The researchers then continued with the data analysis and interpretation strategy after collecting the data according to the respondents' inclusive and exclusive criteria. For the statistical procedure, the data collected from respondents was put on an excel sheet. The demographic data and knowledge score were tallied and visually shown with frequency and percentage after being entered into an excel sheet.

Paired't' test was used to evaluate the effectiveness of plan teaching programe on convulsion and its management among health care workers.

Chi-square test was used to analyze the association between level of knowledge with their selected socio-demographic variables among health

All the variables included in the study were correlated with the disease modifying variables. The Karl Pearson's coefficient statistical r test was used to determine the correlation between for structured knowledge questionnaire on convulsion and its management.. The correlation coefficient matrix is presented in the separate tables with the correlation coefficient (r, p value) and p value presenting the significance of relationship SPSS package 22 version.

Paired't' test was used to evaluate the effectiveness of plan teaching programe on convulsion and its management among health care workers .

Chi-square test was used to analyze the association between level of knowledge with their selected socio-demographic variables among health

RESULTS AND INTERPRETATION:

The gathered data was organized, tabulated, analysed with SPSS v25 and interpreted using descriptive and inferential statistics, on the basis of the following objectives and hypothesis of the study.

Section 1: Description and findings related to the socio demographic variables

Table no. 1a: Description of demographic data of samples**N = 60**

Socio demographic	Categories	Frequency	Percentage
Variable		(f)	(%)
Age in years	20-30 years		
	31-40 years	7	11.66
	41-50 years	22	36.66
	above 50 years	24	40
		7	11.66
Gender	Male Female	14	23.33
		46	76.66
Religion	Hindu	24	40
	Christian	11	18.33
	Muslim	9	15
	others	16	26.66
Habitat	Urban	13	21.66
	Semi urban	18	30
	Rural	29	48.33

Socio demographic		Frequency(f)	Percentage
Variable	Categories		(%)
Marital status	Single	9	15
	Married	43	71.66
	Divorced	5	8.33
	Widow	3	5
Type of family	Nuclear	25	41.66
	Joint	30	50
	Extended	5	8.83
Discipline	Nursing		
	Medical	7	11.66
	Pharmacists	4	6.66
	Lab technician	5	8.83
	Other	7	11.66
		37	61.66
Designation	Medical officer	1	11.66
	staff nurses		13.33
	Lab technician	8	10
	ASHA		36.66
	Anganwadi workers	6	15
	Others	22	23.33

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Table no. 1 Indicates That**Table 1: Indicates that,**

1. In terms of age group majority of subjects 7(11.66%) belonged to the age group Of 20-30 Years, 22(36.66%) belonged to the age group 31-40 years and 24(40%) belongs to age group of 41- 50 whereas 7 (11.66%) belongs to age group of above 50 years

2. In terms of gender, 46 (76.66 percent) of the participants were female, whereas 14 (23.33 percent) were male. The LTR was 9.7% (girls 9.3 percent, boys 10.1 percent, $P > 0.05$). The risk of febrile convulsion was 2.13 (95 percent confidence interval [CI]: 1.1-4.0) for children whose fathers' education level was equivalent to or less than elementary school, and 1.4 for children whose fathers were blue collar workers (95 percent CI: 1.0-1.8).

3. In term of religion the Majority of subjects 24 (40%) belonged to Hindu religion , whereas 11 (18.33%) belonged to Christian religion while 9(15%) belonged to Muslim religion , and 16(26.66%) belonged to Other religion.

4. In term of Habitat the Majority of subjects 13(21.66%) belonged to urban area , 18(30%) were belonged to Semi urban area and 29 (48.33%) belongs to rural area

5. In terms of marital status the majority of subjects 9(15%) were single medium 43(71.66%) were married medium while 5 (8.33%) were divorced and 3(5%) were widow .

6. In terms of type of family the majority of subject 25(41.66%) were belonged to Nuclear 30(50%) were belonged to Joint 05 (8.33%) were belonged to Extended

7. In terms Desicipline the majority of subjects 7(11.66%) were belonged to Nursing

4(6.66%) were belonged to Medical while 5(8.83%) were belonged to pharmacists and 7(11.66%) were belonged to lab technician , 37 (61.66%) belongs to other.

8. In terms of designation majority of subjects 1(.66%) were belonged to medical officer 8(13.33%) were belonged to staff nurses 6(10%) were belonged to lab technician while 22(36.66 %) were belonged to ASHA, 9 (15%) belongs to anganwadi workers while 14 (23.33%) belongs to others.

9. In terms of total year of experience the majority of subject 11(18.33%) were belonged to 0-1, 19(31.66%) were belonged to 1-5 , 19 (31.66%) were belonged to 8-10 where as 11 (18.33) belongs to above 10 years of experience.

10. In terms reason to work the majority of subjects 55(91.66%) were voluntary 5(8.33.%) were involuntary working as health care sector.

11. In terms of source of information majority of subjects 22(36.66%) were source of information was book 22(36.66%) were source of information was internet 7(11.66%) were source of information was educational course while 9 (15 %) were source of information was workshop and seminar.

Section 2: Findings related to distribution of samples according to knowledge scores.**N = 60**

Table2a. Frequency and percentage distribution according to knowledge score

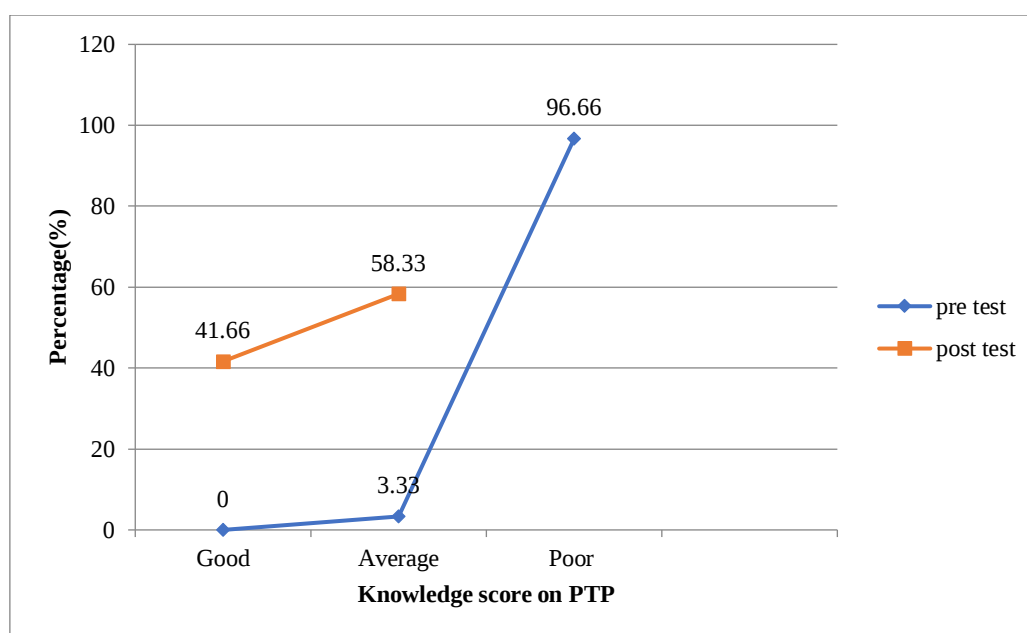
Knowledge Score	Pre test		Post test	
	Frequency (f)	Percentage (%)	Frequency (f)	Percentage (%)
Good (26-34)	0	0	25	41.66
Average (17-25)	2	3.33	35	58.33
Poor (Below 17)	58	96.66	0	0

Table 2 indicates that,

In pre-test 2(3.33%) of the health care worker were having average knowledge score, 0 (0%) of them were having good knowledge score, 58(96.66%) were having poor knowledge score.

In post-test after receiving the plan teaching

program, 35(58.33%) of the health care worker were having average, 25(41.66%) were having good knowledge score, 0 (0%) of them are having poor knowledge score regarding convulsion and its Management among health care workers

Figure 2b: Line diagram showing distribution of health care workers according to pre- test and post -test knowledge score on PTP

Section 3: Findings related to Mean, Median, Mode, Standard deviation and Range related to knowledge score **N = 60**

Table 3: Findings related to mean, median, modes, range and standard deviation related to knowledge score.

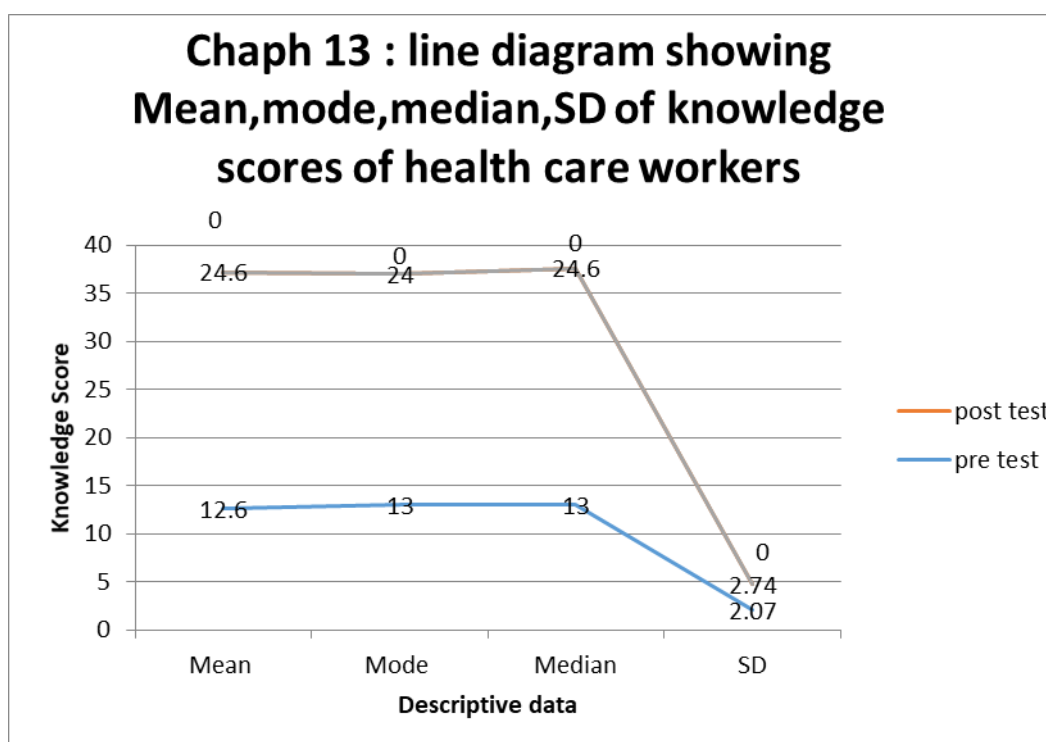
Area of analysis	Mean	Median	Mode	Standard deviation	Range
Pre test	12.6	13	13	2.07	9
Post test	24.6	24	24.6	2.74	10
Difference	12	11	11.6	0.67	01

Table 3: Indicates that

The mean pre-test and post-test knowledge score was 12.6 and 24.6 and the standard deviation in the pre-test and post-test was 2.07 and 2.74

respectively. The Mean difference was 12, median difference was 11, mode difference was 11.6 and standard deviation difference was 0.067

Figure 3: line diagram showing Mean, mode, median, SD of knowledge scores of health care workers



Section IV: Testing of hypotheses for effectiveness of plan teaching programme on knowledge regarding convulsion and its management among health care workers.

N = 60

1. **H₀₁:** There is no a significant difference

between pre-test & post - test knowledge scores regarding convulsion and its management among health care workers

2. **H₁:** There is a significant difference between pre-test and post-test knowledge scores regarding convulsion and its management of health care workers.

Table 4: Effectiveness of plan teaching programme on knowledge regarding convulsion and its management

Mean difference	Standard Error	Paired 't' test		Degree of freedom (df)
		Calculated value	Tabulated value	
12	0.19	60.8*	2.00	59

Note:* Indicates significance

Table 4: Reveals that the calculated 't' value (t_{cal.} = 60.8) is more than tabulated 't' value (t_{tab.} = 2.00). Hence H₁ is accepted and H₀ is rejected.

This indicates that plan teaching programme is statistically significant at p < 0.05 level. Therefore it was evidenced that plan teaching programme was more effective in terms of knowledge regarding convulsion and its management among the health care workers .

Section V: Testing of hypothesis for

association between the pre-test knowledge scores with their selected socio-demographic variables among health care workers

H₀₂: There is a no significant association between pre-test knowledge Scores with their selected Socio-demographic Variable Of health care workers

H₂: There is a significant association between pre-test knowledge scores with their selected socio-demographic variables among health care workers

Table 5: Association between pre-test knowledge score with their selected socio-demographic variables among health care workes

Socio demographic Variables	Pre- test level of depression			Chi square value	df
	Poor	Average	Good	Calculated	Tabulated

Age in years

a. 20-30	6	1	0			
b. 31-40	21	1	0	1.3	12.59	06
c. 41-50	23	1	0			
d. Above 50	7	0	0			

Gender

a. Male	13	1	0			
b. Female	44	2	0	0.15	5.99	02

Religion

a. Hindu	23	1	0			
b. Christian	11	0	0	1.96	12.59	06
c. Muslim	09	0	0			
d. Other	14	2	0			

Habitat

a. Urban	13	0	0			
b. Semi urban	16	2	0			
c. Rural	28	1	0	1.57	9.49	4

Marital status

a) Single	8	1	0			
b) Married	42	1	0	3.7	12.59	06
c) Divorced	4	1	0			
d) Widow	3	0	0			

Type of family

a) Nuclear	23	2	0			
b) Joint	29	1	0	0.25	9.49	04
c) Extended	05	0	0			

Discipline

a) nursing	7	0	0			
b) Medical	4	0	0			

c)	pharmacists	5	0	0	0.78	15.51	08
d)	lab technician	7	0	0			
e)	Others						
		34	3	0			

Designation

a)	Medical officer	1	0				
b)	Staff nurses	8	0	0			
c)	Lab technician	6	0	0	0.855	18.31	10
d)	ASHA	21	1	0			
e)	Anganwadi workers	8	1	0			
f)	Others	13	1	0			

Total years of experience

a) 0-1	10	1	0				
b) 1-5	18	1	0	0.581	12.59	6	
c) 8-10	18	1	0				
d) Above 10	11	0	0				

Reason to work

a)	Voluntary	52	3	0	0.0369	5.99	2
b)	Involuntary	5	0	0			

Source of information

a)	Books	21	1	0			
b)	Internet	21	1	0	1.31	12.59	6
c)	During education course	6	1	0			
d)	Workshop /seminar	9	0	0			

Note:**Indicates association****Table 5: Indicates that,**

There was no significant association between pretest knowledge Scores with there selected socio-demographic variables all the calculated chi-square value were lowest than tabulated value at 0.05 level of significance.

This indicate that there is no significant association between pre test knowledge score with all the selected socio-demographic variables Hence H_2 is rejected and H_{02} is accepted

DISCUSSION:

This chapter summarizes the study's main findings and compares them to similar studies conducted by other researchers. It sheds light on the study's findings in the perspective of current social problems and makes recommendations. 10

The purpose of this study was to assess the effectiveness of a plan training programme [PTP] on health care personnel' understanding of convulsions and how to manage them in a rural area of Kolhapur.

Objectives of the Study

1. To evaluate the effectiveness of plan Teaching programme [PTP] regarding convulsion and its management among health care workers
2. To determine the association between pre-test knowledge score regarding convulsion and its management among health care workers with their selected demographic variables.

Major findings of the Study

The discussion has presented under the following heading:

1. Findings related to distribution of selected socio-demographic variables of participants.

2. Findings related to distribution of subjects according to knowledge scores.

3. Findings related to mean, median, modes, range and standard deviation related to knowledge score.

4. Findings related to association between the level of knowledge with their selected socio-demographic variables.

5. Findings related to effectiveness of plan teaching programme [PTP] on convulsion and its management.

1. Findings related to distribution of selected socio-demographic variables of participants.

In terms of age group, 7 (11.66 percent) of the subjects were between the ages of 20 and 30, 22 (36.66 percent) were between the ages of 31 and 40, and 24 (40 percent) were between the ages of 41 and 50, while 7 (11.66 percent) were beyond 50.

A similar study was conducted by Abadi Kahsu Gebre, which shows that most of the participants 21 (52.5%) belonged to age group 21-31(15.23) In the present study, out of 60 majority of the age group 41-50 (23.8%) were females.

A similar study was conducted by Abadi Kahsu Gebre, which shows majority of the health care workers 25 (45.5%) were females and 17 (47.5%) were males.⁴³ In the present study, out of 60 elderly people majority of the participants 33 (56%) were Hindus and minor 16(23.6%) belonged to others category.

A similar study was conducted by Abadi Kahsu Gebre, which shows majority of the elderly 26(65.0%) were Hindus.⁴³ In the present study, out of 60 health care workers majority of the participants 31(50%) were widow/widower, whereas minor⁴(6.6%) were separated.

A similar study was conducted by Abadi Kahsu Gebre, which shows majority of the staff nurses working 21(52.5%). In the present study, out of 60 health care workers, majority of the 30(50%) came voluntarily whereas minor 10(16.6%) were brought by family members.

A contradictory study was conducted by Abadi Kahsu Gebre, which shows 20(50%) were health care workers for more than 5 years' experience.

2. Findings related to distribution of subjects according to knowledge scores.

In the pre-test, the majority of individuals had average knowledge, 0 % had good knowledge, and 58 (96.66%) had poor knowledge, however in the post-test, 35 (58.33%) had average knowledge, 25 (41.66%) had good knowledge, and 0 (0%) had poor knowledge.

A similar study was done by R C Parmar , The findings suggest that when it comes to the knowledge, attitude, and practises of parents of children with febrile convulsions, 83 parents (59.3%) couldn't recognise the convulsion. 90.7 percent (127) of parents did not intervene before taking their child to the hospital.

3. Findings related to mean, median, modes, range and standard deviation related to knowledge score.

The tabulated value was bigger than the calculated paired t value (tcal. 60.8). (ttab. 2.00) As a result, the findings demonstrated that the plan education programme has an impact on health care personnel' knowledge of convulsions and how to handle them, so H1 is accepted and H01 is refused.

4. Findings related to association between the level of knowledge with their selected socio- demographic variables health care workers.

At the 0.05 level of significance, there was no significant relationship between pretest knowledge scores and the specified socio-demographic characteristics. All calculated chi-square values were lower than tabulated values. This implies that there is no significant relationship between pre-test knowledge score and any of the socio-demographic variables studied. As a result, H2 is rejected but H02 is approved.

LIMITATION AND IMPLICATIONS OF THE STUDY

- No broad generalization could be made up to the small sample size and it was limited only to health care workers in selected rural area of Kolhapur.

IMPLICATIONS

The findings of the study have several implications in different areas which are discussed in following area,

1. Nursing Practice
2. Nursing Education
3. Nursing Administration
4. Nursing Research.

NURSING PRACTICE

1. Develop a teaching programme on convulsions and their management as part of a health education programme that should be implemented in hospitals and the community.
2. Educating parents and family members on how to offer a safe and emotionally healthy environment for their children with epilepsy (convulsions) and raising awareness.
3. This research will assist them in avoiding convulsions.
4. It will assist nursing workers in providing health education to people in the health-care sector or in any community setting, thereby strengthening the community.

NURSING EDUCATION

1. The nursing curriculum is in charge of teaching future nurses and other paramedical personnel to focus on curative, preventative, and promotive health practises in relation to convulsions and their management.
2. Nursing students should be well-versed in PTP, which can be included into nursing care and the care of convulsion patients.
3. Health workers' awareness of

convulsions and how to manage them can be improved by in-service education.

NURSING ADMINISTRATION

1. Adequate information materials on convulsions and how they effect academic achievement, made available to all health care workers, families, and community members.

2. Nurse administrators can create the protocols and policies needed to promote PTP in the primary health care setting as well as in the community.

3. Nurse administrators must develop Continuing Nursing Education programmes for nurses working in hospitals and the community so that they can stay current on convulsions and their treatment.

NURSING RESEARCH

1. The pre-experimental study serves as a baseline for subsequent research.

2. The study will inspire aspiring researchers to perform large-scale investigations of their own.

3. The investigator's current study can be used as a source of literature review for others who are conducting studies on convulsion in health care workers.

4. Evidence-based practise increases quality of life, and this study focuses on preventing convulsions and improving treatment quality.

CONCLUSION:

The following conclusions were formed based on the study's findings:

The effectiveness of a plan education programme on convulsions and their management among health care personnel was evaluated in a pre-experimental investigation.

The study found that the calculated paired 't' value ($t_{tab.} = 2.00$) was greater than the calculated paired 't' value ($t_{cal.} = 60.88$), indicating that the plan teaching programme was statistically significant at the $p0.05$ level. As a result, H1 is approved but H0 is refused.

There was no significant relationship between pre-test convulsion and its management score and socio-demographic characteristics in this

study. All calculated values were lower than those in the table. As a result, H2 is rejected but H02 is approved.

Recommendations

The following recommendations were made based on the study's findings:

1. A larger study with more samples conducted over a longer period of time would be more relevant in reaching broad generalisations.

2. A pre-experimental study can be conducted in two groups: a single group to assess the effectiveness of the plan teaching programme [PTP] knowledge score of health care workers, and a second group to assess the effectiveness of the plan teaching programme [PTP] knowledge score of health care workers.

3. A comparative study on the efficiency of a plan teaching programme on convulsion knowledge and management might be undertaken.

4. A comparable study can be carried out in a variety of settings.

5. A qualitative technique can be used to perform a phenomenological research on health care professionals in a health care centre.

6. In a similar research, experiments can be used. There is an experimental group and a control group in this study.

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