**Supplementary table 1.** Free comments and responses thereof accrued during the feedback exercises.

| S. No. | Free comment | Relevant section in curriculum | Task force response |
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| | *Diagnosis* | | |
| | Demonstrate working knowledge to identify and promptly treat seizures related to toxins. | 1.2.2 | "Toxins" added to the list of main causes of seizures in adults and children. |
| | There should be a separate competency for obtaining a proper history for people presenting with seizures or epilepsy. There is a standard series of questions that should be asked to help differentiate seizures from non-epileptic events, questions to ascertain whether focal or generalized, and questions that inform about possible etiology (*e.g.*, birth and development, history of CNS insult, family history of seizures, history of cognitive impairment, infection, *etc*.). Since a diagnosis of seizures and epilepsy is made largely by history, this is the most important skill to have. | 1.4.1 | History taking in seizures and epilepsy is widely covered in the curriculum. For instance, the skill to obtain semiology from patient history. |
| | Recognize mimics for therapeutic importance. | 1.5.1 – 1.5.3 | Already covered (*see table 1; 1.5.1-1.5.3*). |
| | EEG basics to diagnose focal and generalized seizures. | | EEG interpretation skills are best left to the specialist; In many resource-limited settings, access to EEG is zero or limited. |
| | *Counselling* | | |
| | There is no mention of those with intellectual disabilities who typically experience severe epilepsies - the UN Convention on the Rights of Persons with Disabilities protects their right to receive services in the community. | 2.2.1 | This is covered under "counselling related to legal issues" (*see table 1; 2.2.1*). |
| | The use of self-empowerment is mentioned, but there is a whole body of literature on self-management, which includes daily epilepsy management, seizure plans, adherence, *etc*. Similarly, quality of life and adherence are not mentioned anywhere in the competencies. These are very important aspects of pediatric epilepsy management. For example, adherence also falls under pharmacological treatment. In some cases, non-adherence is the reason for breakthrough seizures and should be addressed before medications are adjusted. | 2.2.5; 2.2.2 | Both self-management and medication adherence is already covered (*see table 1; 2.2.5; 2.2.2*). |
| | Drug compliance and the relevant counselling skills on this issue; or the awareness to make referral for counselling regarding drug/treatment compliance. | 2.2.2 | Medication adherence is already covered (*see table 1; 2.2.2*). |
| | Emphasize need for MEDICATION compliance and long-term treatment during PATIENT COUNSELLING. | 2.2.2 | Medication adherence is already covered (*see table 1; 2.2.2*). |
| | The ability to make appropriate recommendations on lifestyle modifications that would contribute to seizure control, *e.g*. sleep, stress management, medication adherence, *etc*. | 2.2.2 | Both already covered (*see table 1; 2.2.2*). |

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| | Demonstrate knowledge of local or regional NGO epilepsy support services appropriate to patient needs, where continued non-medical support/advice/aftercare may be ongoing. | 2.2.5 | Added to curriculum (*see table 1; 2.2.5*). |
| | Awareness of organizations within the community in place to assist with all these tasks to lighten the load. Provide a pathway for patients to be referred to NGOs in the community available to patients. | | |
| | Referral to NGO agency for education and help. | | |
| | Epilepsy myths, the dos and don'ts (to dispel the misconceptions) *e.g.*, Keeping a metal object on hand for a patient with a convulsion, relationship with the lunar phases of the moon. | 2.3.1 | Already covered (*see table 1; 2.3.1*) |
| | Include a module on community education<br>How each healthcare professional has to impart this information to specify communities. | 2.3.3. | Added to *table 1; 2.3.3*: "Education of patients, their families and public…."; "public" added. |
| | A whole section on SUDEP is required. | | SUDEP can be dealt with using preventive counselling; this aspect is already covered in *table 1; 2.3.6.* |
| | *Pharmacological treatment* | | |
| | How to change antiseizure medications when the first one fails? | 3.6.1 to 3.6.3 | This is already covered in *table 1, 3.6.1 to 3.6.3*. |
| | How to manage patients after surgery including drug withdrawal and driving? | | Best dealt by a specialist. |
| | He/she should have some basic knowledge about workup for refractory epilepsy, and ability to counsel a patient according to procedures that would be required for presurgical evaluation of refractory epilepsy when the patient is referred to a more specialized center | | Best dealt with by a specialist. |
| | Common adverse effect of drugs. | 3.1.1 | This is already covered (*see table 1; 3.1.1*). |
| | Ability to be aware of and recognize early rare adverse events associated with antiseizure drugs. | | Best dealt with by a specialist |
| | Basic knowledge about therapeutic drug monitoring (esp. about the importance of trough levels and the role of TDM in control of adherence). | | Outside the scope of a primary health care provider; best dealt with by a specialist; moreover, drug levels are often not available in resource-limited settings. |
| | The curriculum should make explicit reference to an understanding of the role and limitations of antiseizure medicine blood levels / monitoring. This is recommended in many countries but associated with many pitfalls. | | Outside the scope of a primary health care provider; best dealt with by a specialist; moreover, drug levels are often not available in resource-limited settings. |
| | *Emergencies* | | |
| | Status epilepticus difficult to manage at our level. Need guidance to avoid complications until proper care is received. | 5.2.1 to 5.2.3 | Already covered (*see table 1; 5.2.1 to 5.2.3*). |
| | Management of status epilepticus. | | Already covered (*see table 1; 5.2.1 to 5.2.3*). |
| | How to handle a cluster of seizures at the primary care level. | 5.1.2 | Added to *table 5.1.2*. |
| | *Referral* | | |
| | Competency 4 lacks counselling related to academic problems. Many youths have learning disabilities and poor academic performance, which is not a "cognitive" problem such as intelligence or memory. | | Counselling for learning disabilities can be complex and is best done by a specialist after referral (*see table 1; 4.1.1*). |

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| | *Comorbidities* | | |
| | Demonstrate working knowledge regarding issues related to persons with intellectual disability and epilepsy. | | Counselling for intellectual disabilities can be complex and is best done by a specialist after referral (*see table 1; 4.1.1*). |
| | *Miscellaneous* | | |
| | Incorporate some history of epilepsy to maintain attentiveness / enthusiasm and a page on the people who have made a mark in their fields despite having epilepsy (*e.g.* sports, art, science, *etc*.). | | This is important but perhaps left out from the curriculum as the primary care provider has to deal with a multitude of health conditions; this might not be something that course-takers would like to be assessed on. |