EPILEPSY

> "Epilepsy is truly an international, universal disorder. It respects no political boundaries. It is indifferent to language, religion, colour, sex, education and economic class. Although seizures are more frequently manifest in the young, people of all ages are afflicted. It is sometimes contributory to death and occasionally fatal. It is thought to be provocative of suicide. But, more commonly, it is a disorder that one must accommodate to for the better part of a lifetime" (1).

The tragedy for the epileptic child in most developing countries is that, although with the aid of simple medical treatment his symptons can normally be suppressed, such is the social attitude to his handicap that he is excluded from the ordinary school system. Epilepsy is the supreme social handicap, more so even than leprosy since the grounds for rejection are so much less well founded. The sufferer's problems result almost entirely from the attitudes of others and not from any physical or mental deficiency within himself. Educational provision for the epileptic child in the developing countries, therefore, does not depend on the availability of additional funds, specially trained teachers or expensive equipment, but simply on his acceptance as a normal child entitled to a place within the existing school system. The educational effort on behalf of the epileptic dhild must originate as a campaign of public enlightenment, the more so since the numbers involved are considerable.

Incidence of epilepsy

The lack of opportunity for surveys in depth, the tendency among many peoples to conceal epilepsy, the tradition whereby epilepsy is treated only by the local healer and not by Western medicine, all combine to make difficult a reliable estimate of the incidence of epilepsy in developing countries. Ediopathic epilepsy tends to manifest in early childhood; because of its aetiology symptomatic epilepsy tends to occur later in life. The overall world incidence estimated by the World Health Organisation in 1955 was 4:1000; a later estimate for Australia gave 4 to 5:1000; a recent survey in South-East England indicated 6.2:1000 (2). An estimate of between 8 and 13:1000 for African may well be too low (3). To put this incidence into perspective it may be compared with world estimates for the incidence of blindness of about 4.5:1000 or leprosy of 2.5:1000. While the latter two afflictions command widespread sympathy and attention, it cannot yet be claimed that the problem of epilepsy is being tackled on a scale compatible with the needs of at least 15 million sufferers.

Little information is yet available about the relative incidences of epilepsy in more and less developed societies. No evidence has been adduced to show that among the less advanced peoples the incidence of epilepsy might be lower than among more sophisticated groups. In support of this contention a survey of children in Texas showed similar incidences among white, black and Mexican children (4). Despite the belief that epilepsy may be symptomatic of the stress of modern living, other causes limit the possibility of the developing countries having a markedly lower incidence:

> "From what is known of aetiology, it is probable that the numbers would be higher in under-developed countries with

> frequent childhood infections involving the brain and less adequate obstetric services." (5)

The Pan-African Psychiatric Workshop held in 1970 estimated a prevalence of epilepsy in Africa of between 2 and 7 times that of Europe (6).

An incidence of 10:1000 implies the existence of 3 million epileptics in Africa today; a reduced incidence of 8:1000 would result in an estimated total of more than 7 million epileptics in Commonwealth countries, 4 million of whom will be in India and half a million in Nigeria, to take the most populous countries of Commonwealth Asia and Africa. As a footnote to the estimation of incidence, it should be recorded that there are indications of an increasing frequency of more severely handicapped epileptics (7), and of severely handicapped epileptics with additional handicaps (8). With epilepsy, as with other handicaps, a single affliction is increasingly unusual:

> "It should now be recognised that the simple handicap is rare - if it ever existed" (9).

Causes

Were the first causes of epilepsy more clearly understood it would be easier to seek a cure. Were a cure available it is probably that the public attitude towards the affliction could be changed over a relatively short period, as is happening in the case of leprosy. For the present, however, no such prospect is in sight, except for the small number of cases of symptomatic epilepsy which responds to surgery. For the remaining wide range of epileptic disturbances where the underlying causes have not been identified, treatment is suppressive not therapeutic.

Epilepsy, it is frequently said, is a sympton common to many different conditions and should not be regarded as a disease in itself. The epileptic attack is merely the outward manifestation of some damaged nerve cells in the brain. "Anyone can have an altered rhythm of the brain." For this body of opinion the social aspect of epilepsy tends to overshadow the medical. For others, this approach is thought to be inadvisable, unjustified and self-defeating, in that this view of epilepsy as a symptom is but a half truth, the effect of which might well be to prejudice the urgency of research into its root medical causes (10). Little purpose is served by attempting to alleviate social prejudice by proclaiming epilepsy as the inexplicable symptom of a range of unknown causes. Such an approach can only lend reinforcement to the claims of local traditional healers.

Symptomatic epilepsy is sometimes operable; idiopathic epilepsy is at present incurable, although many sufferers find their attacks decreasing in frequency with age. Disagreement over the "half truth" description of epilepsy is repeated in disagreement over some of the possible causes and again over the possible degenerative effects of repeated severe seizures, all of which adds point to reiterated appeals for continued research. As an example of the lack of common ground on aetiology in an area of particular significance for developing countries, there is the question of cysticercosis. One authority states: "Epilepsy is common in Africans. In some areas cysticercosis plays a part ..." (11), while another declared subsequently: "Among the causes where aetiology was determined, it is outstanding in our series to show that parasitic diseases occupied the second place in importance. All these cases were due to cerebral cysticercosis ..." (12). Yet another report relates to a group of patients in Natal whose epileptic seizures were attributed to cysticercosis (13). On the other hand, other investigators could not "prove evidence for any such aetiological relationship" between cysticercosis and epilepsy (14).

Perhaps more disturbing from the point of view of educational provision for the epileptic child is the lack of a concensus of opinion about the progress of epilepsy and its effect on intelligence and personality:

> "The natural progress of epilepsy is very variable. In some cases, particularly those of grand mal, the repeated fits may eventually cause major brain damage with paralysis. In others there is a strong tendency to natural recovery, with a progressive lessening of the frequency of the attacks. An important feature of many cases of epilepsy is so-called personality deterioration, which may consist of a steady deterioration in intelligence or of alterations, invariably for the worse, in the victim's character. In many cases this is undoubtedly due to repeated damage to the brain during attacks, but other possible explanations have to be considered. A child undergoing the usual form of treatment may have his perceptions blunted by the drugs. Or - and this undoubtedly happens in a number of cases - the bewildering nature of the attacks and the chronic state of anxiety which comes from never knowing when the next fit will occur may combine to produce quite serious emotional disturbance" (15).

Other workers reject the concept of epileptic deterioration: "It is often thought that children with epilepsy are retarded, even that they deteriorate. This is erroneous" (16). Slowness and fatiguability are effects of the therapy and not of the complaint. Severe personality changes, however, have been recorded as being exhibited by three symptomatic epileptics who had grand mal fits without aura (17). One survey of the origins of the concept of an "epileptic personality" concludes that it may well have arisen from observations conducted with a highly selected patient population which included many with severe handicaps (18). For the purpose of the educationist, however, additional research is essential for the development of appropriate forms of teaching and care if deteriorating epileptics exist and are in need of education.

The greatest number of epileptics suffer from grand mal idiopathic epilepsy, the characteristic form which incurs fear and odium among so many traditional, and modern, societies. Its spontaneity, absence of apparent immediate cause, unpredictability and dramatic manifestation have led to the widest speculation about its origin. Bewitchment and magical causes are ascribed by many African peoples; it has been mentioned as a belief among the Lenjes in Zambia (19), among Southern Nigerians (20), and in the littoral of the River Gambia (where a river devil is identified as the cause)(21). Similar beliefs are recorded in respect of the Wapogoro in Tanzania, the Baganda in Uganda (who believe the cause to be a lizard in the brain), Kenya and other countries of Africa (22). Since the Western medicine men can offer no explanations of their own it is not surprising that traditional beliefs are still widespread and epilepsy frequently regarded as beyond the competence of European doctors.

Symptomatic epilepsy, the result of an identifiable lesion, is probably increasing, as the consequence of a greater incidence of severe damage to the head through war or accident which no longer proves fatal -

> "the intolerable number of damaged human bodies heaped on our highways by irresponsible drivers. Until mankind can discipline itself to cease from mass and individual acts of violence, we shall always have epilepsy" (23).

Among other major causes of symptomatic epilepsy are neonatal brain damage (frequent in Africa as the result of traditional birth practices), encephalitis, meningitis, poisoning, febrile convulsions and malnutrition. A report of 1967 lists malnutrition as the most common cause of death among Ghanaian children subjected to pathalogical examination (24), and a further investigation draws attention to the possible role of nutritional disorders (kwashiokor, beri beri, endemic goitre) as causes of epilepsy (25). An indication of the possible effects of advance in standards of living may be deduced from the fact that among the precipitating factors listed for epilepsy in Nigerians there appears "television" (26).

Treatment

The only treatment which can be offered by Western medicine, then, apart from the very small number of cases of symptomatic epilepsy which responds to surgery, is essentially palliative and suppressive. No permanent cure can yet be promised for the wide range of idiopathic cases. The Pan-African Psychiatric Workshop held in 1970 stressed the value of phenobarbitones as a very useful and cheap drug for the control of cortical epilepsy, agreeing that this treatment can safely be administered by paramedical personnel to manage 80% of the typical cases in a general clinic (27). Nevertheless, epileptics in developing countries will tend to approach the dispensary and the hospital for suppressives only when they have exhausted the possibilities of a cure offered by local healers. In consequence, many of those presenting themselves for treatment have been suffering with epilepsy for an extended period, 40% for more than two years in one account (28), the majority in another survey for at least four to six years (29), two of the patients in a third investigation for as long as 39 years (30). The hospital remains for many traditional peoples the last resort, the place in which to die. Not only does the patient or his relatives have to be convinced of the desirability of treatment by Western methods; unless the service is easily available he will make no undue effort to seek out a doctor in whom he has little confidence, nor will he maintain regularity of treatment once begun. Treatment is also frequently hindered by lack of drugs and lack of trained paramedical staff (31). Finally, the disturbing side effects of some treatment may well destroy the desire of the patient to continue a course. A high percentage of patients on large doses of anti-convulsants have been recorded as complaining of irritability, feeling slow and dull, drowsiness, impairment of memory and concentration, depression, even a reduced sexual drive (32). The local healer promises much better than this.

The local healer's results, unfortunately, do not measure up to the promises, but, since epilepsy is widely considered as beyond the province of Western medicine (33), the local healer thrives. Lest those from modern societies consider this the resort of primitive peoples, it is salutory to recall that in the more developed countries folk medicine plays a larger role than most people would believe (34), with some countries still permitting the inadequate and dangerous practice of "mail order" treatment of epilepsy (35). Local treatment varies from relatively harmless recipes, involving the external application of onions and alcohol, drinking deer blood, or eating parsley (36), to the permanently damaging effect of treatment administered in parts of Nigeria: a concoction of cow's urine, local herbs, gin, alligator pepper and fresh tobacco juice, which possesses a prolonged hypoglycaemic effect and may cause permanent cerebral damage (37). Of fourteen patients seen with cow's urine poisoning one became blind, deaf and floppy, and three showed evidence of residual brain damage. The rubbing of alligator pepper into the patient's eyes can cause conjunctivities. Many examples have been cited of burns and mutilations carried out by relatives and healers to revive a child undergoing a fit or to rid him of the possessing demon (38). A list of treatments and cures, harmless and dangerous, practised in a range of countries in Africa and Asia, indicates the desperate lengths to which peoples of many nations will go in an attempt to alleviate this frightening affliction (39). The apparent anomaly whereby patients return to local healers after cures have patently not succeeded is explained by the fact that the healers are convinced (and convince their patients) that they can certainly cure epilepsy but that fits frequently start again because that patient is reinfected after the cure (40). Public enlightenment has some way to go, and must be backed by an efficient medical service if it is to break through the effective defence. There are some grounds for believing the mass media are already having an effect in reducing mortality and morbidity resulting from local treatment and crude ideas about resuscitation of patients in post-epileptic coma (41). There is still a long road ahead.

Social attitudes towards epilepsy

Although attitudes towards epilepsy vary considerably from one traditional society to another, intolerance, resulting from fear, is a far more usual reaction than acceptance. In Western Nigeria epilepsy is a dreaded disease among indigenous Africans, thus there is both a tendency for the epileptic to be ostracised from the society and a great urge on the part of the patient or his relations to keep the existence of the disease in the family a closely-guarded secret (42). Among the Bemba of Zambia epileptics are feared and despised, to the extent that they share the distinctive burial rites of lunatics and lepers (43). In parts of Uganda it is common for the corpse of an epileptic to be left in the bush and not accorded normal burial rites (44). Among the Baganda, epilepsy is classed with leprosy and tuberculosis as one of the most feared diseases (45). In Ghana, many epileptics encounter problems in their education and work (46). Similar attitudes are recorded in Eastern, Central and Southern Africa (47).

Ostracism can range from the exclusion of a girl in Britain from a school party visiting the Wimbledon tennis championships (48), to the exclusion of 85% of epileptic children from their families in some parts of Nigeria (49). In a survey conducted in Ojo Village, a few miles from Ibadan in Western Nigeria, 91.9% of the adults indicated that they would refuse to allow their child to play with an epileptic child, an incidence which declined to an encouraging 36.7% in Lagos (50). Even so, only one epileptic child was identified in a total of 4,614 pupils in the sampled schools there, and, during an incidence survey in Lagos, no unrelated person with epilepsy was discovered in any of the 381 households investigated (51). This is not surprising, since any lodger who has epilepsy would be ejected from the household and completely ostracised. Known epileptics do not find it easy to get accommodation. One of the more distressing effects of such rejections can be forecast, if someone is treated like a fool or an outcast, it takes a strong character to resist the pressures to behave in the ways the others expect (52). Rejection and ostracism have the inevitable result that any epileptic who can conceal his handicap does so. That this may lead to some peril for his society is indicated from the Nigerian experience of Dr. Dada, who recognised his taxi driver as a patient liable to frequent fits and currently attending his clinic (53). Rejection, designed to protect society, may well in such circumstances defeat its own purposes.

This attitude of fear and rejection is not confined to the developing countries. Superstitious attitudes towards epilepsy are manifested by some Australians (54), while in New Zealand, more enlightened attitudes are a recent phenomenon (55). One unexpected result of the impact of Europe on Africa is the apparent deterioration in tolerant attitudes towards epileptics in some areas: In Senegal the extreme tolerance previously extended to the epileptic is being modified under the pressure of Western acculturation, to the extent that in Dakar schoolchildren with epilepsy have had to abandon their studies and adults have lost their jobs in offices and factories (56). The results of intolerance on a small group of individuals in a traditional setting may be judged from the report submitted by a social worker in Kenya to her headquarters at the end of 1968 which is reproduced as Appendix A to this chapter.

There exists, however, some evidence from a number of countries that epilepsy in children is tolerated somewhat more than in adults. Two surveys in India reveal that in Bombay, for example, parents tend to be overprotective of their epileptic children but teachers show ambivalent attitudes, professing sympathy in the abstract while showing reluctance at retaining such children in the school (57). In Vellor, South India, only 32.6% of those questioned objected positively to the admission into school of epileptic children (58). The tolerance extended to children in some traditional societies may, of course, result from the non-recognition of their symptoms.

Almost certainly the single most important cause for the rejection, segregation and ostracism of the epileptic in developing countries is the fear of contagion. This is one reason advanced for the absence of epileptic lodgers in the households in Lagos, where expressed attitudes are relatively liberal (59). Opinions were sought in Lagos and a village near Ibadan as to whether epilepsy was considered to be contagious. More surprising than the fact that 90% of the villagers believed it to be so, 59% of the teachers in both places did so, as did 53.5% of the employers (60). In Central Africa, amongst the Lenje people in Zambia, the cause of epilepsy is sought in witchcraft or infection, and in eastern Zambia epilepsy is held to be contagious by breathing the "bad air" exhaled by sufferers, by merely touching his clothing, or by standing in his shadow (61). From Uganda, similar attitudes have been recorded on the part of the Baganda (62), as they have from Madagascar (63), and Senegal (64). The fear that epilepsy is contagious is so acute that the great majority of epileptics in developing countries are excluded from education, training opportunities and employment, as well as being rejected from the social functions of their community.

The problem of the epileptic child is not limited to the child himself. His immediate family, and particularly his parents, are involved in his situation. Reaction on their part vary from intolerance and rejection to overprotection, resulting in concealment or segregation of the child, or in feelings of guilt, sometimes to the extent of parents themselves exhibiting symptoms of emotional disturbance. The reactions of the parents seem to be common over a wide range of types of society, traditional and modern, for an unwillingness to declare an epileptic child has been recorded as frequent in France (65), Britain (66), and Nigeria (67). The stigma is deemed by parents in a number of countries to be carried over from the child to them and the other members of their family, resulting in the epileptic child being denied the opportunity of trying for a place in school (68), being separated within the family (69), or, as has been recorded in Australia, being rejected as the black sheep (70).

The epileptic child, then, must combat not only his affliction, frightening and inexplicable as it is, but also often the implied criticism of his parents and the hostility of the community to which he ought to be able to look for support. Small wonder that epileptic children not infrequently manifest signs of mental distress. It is possible that 80% of such character difficulties may be connected with the family environment or the social situation which is unready to cope with the child's condition (71). For this reason, it is reasonable to conclude the child can be assessed only in relation to its total environment (72). In this connection it may be noted that intelligent parents, often professionally qualified, tend to be more intolerant of children with disabilities.

Epileptic children with behaviour disturbances usually have disturbed parents, who may well prejudice the child's treatment:

> "There are conditions under which the epileptic seizure becomes a weapon for the child in a difficult family situation, in which the seizure is integrated in a neuropathic defence system or in which, in reverse, the child's epilepsy becomes a psychological necessity to the family, as a result of which a cure is unconsciously sabotaged. The last mentioned situation is believed to arise particularly when the mother is a physician, nurse, kindergarten attendant or teacher" (73).

Parents who are epileptic themselves are not necessarily more considerate and accepting of a child with epilepsy, often seeing their child as the inheritor of their own "degenerative" characteristic and of having the very thing which they fear and hate. "It is a small step from this to hate and hurt the child, or to react against the wish to harm the child by turning to over-protection." This dual attitude has been similarly noted in India (74).

Given the disadvantage at which the epileptic child finds himself it is understandable that up to 20% of such children need psychiatric help, even under the relatively enlightened conditions pertaining in countries such as Australia. This, however, is a far cry from the pessimistic view of the "epileptic personality"; in the cases in which it occurs it has largely been thrust upon the child rather than emanating naturally from his affliction. Only a small percentage of epileptic children fail to adjust socially under conditions of acceptance (75). Epileptic children are likely to be in a state of considerable confusion (76). Many children will have been made to feel the cause of shock to their parents; many will have been pitied or excluded by their peers, over-protected or rejected by their elders. Finally, very few epileptic children indeed will ever have witnessed an epileptic seizure, and so can have little knowledge of the situation to which those about them are reacting so violently. In the Nigerian situation, for example, patients themselves and their families do not always appreciate the impact which their condition makes on their lives and tend to blame themselves for their social ostracism (77). It is understandable that this confusion extends to the point at which cause and effect are interchanged, so that epileptics not infrequently attribute all their social difficulties to their epilepsy and make little effort towards finding a solution to more fundamental problems which may beset them in a modern society, such as seeking employment without first acquiring a marketable skill (78).

The problems of epilepsy

The grand mal epileptic suffers from an intermittent disability. Between his attacks, which are frequently separated by a considerable period of time, he is, for most practical purposes, entirely normal. His symptoms disappear, yet he must continue to contend with a whole range of problems, obstacles preventing his full participation in the society to which by right he belongs. In the extreme case he may find himself the object of prejudice and fear. The difficulties arising from the side effects of treatment and the psychiatric problems have already been noted. The pattern of problems encountered by epileptics in societies of very disparate types show much in common. In the developing countries such problems are often accentuated, for there are additional problems awaiting those epileptic children who do succeed in obtaining educational qualifications: in most of these countries there are more people than jobs and the disabled (including the epileptics) find it extremely difficult to compete in the absence of adequate social legislation (79). The same situation can pertain even when the pressure on available employment is not so great, for, in Australia, there is a very definite tendency for the epileptic to lose his job when his employer becomes aware of his condition (80).

This points the dilemma confronting the epileptic. If he admits his disability he will encounter considerable trouble in obtaining employment, and if he attempts to conceal his epilepsy initially he may lose his job when his condition becomes known. As a mature adult in a more developed society the epileptic faces problems in employment, life insurance, driving a motor vehicle, and travelling by air. In all types of society the likelihood of his establishing a family of his own is uncertain, even in England. Some authorities advise for the epileptic frank and realistic discussions before marriage, preferably with medical advice, and careful consideration of whether or not the couple, in the event of marriage, should have children.

> "A frankness which may break an engagement does not come easily to a young person in love, but a broken engagement is better than a disastrous marriage" (81).

Yet to throw epileptics back on each other as marriage partners greatly increases the likelihood of their children being epileptic. A bleak prospect.

Public enlightenment

The inculcation of more enlightened attitudes towards epilepsy in the public at large is the basis of the long-term solution to the patient's problem. Initially, such revision of attitudes depends on the willingness of some epileptics to make a public acknowledgement of their disability and demonstrate their capacity to function as full members of society (82). Education takes time, and even if begun tomorrow prejudice would remain for some little time, so exposing the pioneers to rebuffs. Like all pioneers they must believe wholeheartedly in the rightness of their cause. The alternative is the uneducated, unemployed epileptic with little to expect from life (83); the education of the public at large, therefore, is a matter of urgent concern.

The first object of public enlightenment should be to provide information about the various forms of epilepsy. It may be argued that if one knows only of the bad cases, then one imagines that all epileptics are the same, whereas if it is recognised that there is such a thing as the normal epileptic then the concept of epilepsy as being something acceptable in society is easier. That public enlightenment can prove effective over comparatively short periods of time is evidenced by surveys of public opinion in Chile, where the results of research indicate that the League Against Epilepsy in that country has been able to modify in a six year period the attitude of one important section of the public, that made up of teachers and administrators (84). Over a period of twenty years in the United States of America, an encouraging trend towards acceptance of the epileptic has been noted. For example, whereas in 1949 only 57% of those questioned would have allowed their children to associate with epileptics, by 1969 this percentage had risen to 81. Over the same period the percentage of those believing that epileptics should enjoy full employment possibilities rose from 40 to 76 (85).

The indications are that public education can be effective, although in traditional societies attitudes will be slow to change. The importance of an early start to campaigns has been made recently in respect of many countries including India (86), Uganda (87), Nigeria (88), and New Zealand (89). The comprehensive approach to the problem made in Argentina by the Association to Fight against Epilepsy indicates the broad front on which a public enlightenment campaign can be pushed forward. The A.L.C.E. has made use of all available methods to stir the public conscience and destroy existing taboos. The campaign was directed towards four concentric groups: patients and their families, teachers and social workers, doctors, researchers, psychologists and sociologists, and the community at large. Methods used in the campaign included direct orientation of the epileptic, lectures, conferences, courses, seminars, broadcasts and television interviews, press announcements, film exhibitions, newspaper features and leaflets (90).

In all countries, and especially the developing countries, the rural teacher holds the key to the release of the epileptic child from the constraints imposed by tradition. To achieve this, the teacher himself must first be won over by being given confidence in his ability to deal with epileptic pupils through familiarity with the condition and treatment during seizures. Simple pamphlets, such as the Teacher's Guide on Epilepsy issued by the British Epilepsy Association, can prove an excellent beginning. The prejudice of teachers is often rooted in their own uncertainity. The fact that at least 95% of epileptic children can be taught in ordinary schools without the necessity for any special arrangements may help to remove the apprehension of teachers, although it must be appreciated that even the occasional seizure in an overcrowded classroom can cause the teacher both concern and exasperation. The aim should be for integration in normal schools and normal school life to the highest degree possible. Some authorities, for example, advocate the fullest liberty for the epileptic child:

> "It is much better that he should climb a tree and break his leg than not be allowed to climb a tree and break his heart" (91).

The epileptic child in developing countries

No simple solution exists to the social problems faced by the epileptic child in the traditional society. Preventative measures through rural education and human hygiene have some part to play. The availability of cheap and effective anticonvulsants administered regularly by paramedical personnel is a vital element in any programme, but this must be bolstered by the education of rural teachers into their role as leaders of enlightened opinion in their community. Special schools for epileptics should not be taken into consideration when planning educational development at this stage, since the numbers of children who can be educated only in this way does not justify the outlay. Short-term residential treatment and educational centres, however, have a useful part to play. The essential element in the programme to improve the lot of the epileptic child is a continuing campaign of public enlightenment backed by medical provision, in order to convince traditional societies of the fact that epilepsy is a non-contagious, generally non-progressive, intermittent affliction suffered by a person singled out by chance and who is otherwise usually normal in all other respects.

APPENDIX A

REPORT BY SOCIAL WORKER IN KENYA

I visited the hospital and the village of the above written families on the 15th November, 1968. While there, I had a talk with the Doctor, the Social Worker and some of the epileptic people who were in the home as some had gone to work.

Appended hereunder is the information I got.

The epileptic people came to the hospital as patients for treatment. Some were brought by their relatives and some came by themselves. These people stayed in the hospital and no one came to collect them back to their homes. After a long time the mission appealed to the Government Authorities, Chiefs and Sub-Chiefs of the places where some of these people came from. When investigation was done, it was found that some of these people are not wanted where they came from because of fear of the disease and some had no land as their lands were taken by relatives when they were in the hospital.

The mission kept them at the hospital since they had nowhere to take them. They were given a small place to build their houses and some, who are strong, worked for the mission and were paid some money to use. As these people are men and women staying together they began producing children and now the group became larger than before.

When the children reached the age for schooling, the Doctor and the staff thought that these children would go to schools nearby and learn together with other children. The Community was very much against this and did not accept these children to learn together with their children. All the teachers of these schools, children and parents were against the idea, and children from epileptic families were not allowed to go to those schools. The meeting was called to discuss about this but still there was no success. After that the mission put these children in their own school with epileptic fits teacher, who had to fall from time to time and then left teaching and therefore it failed. There are at present small children of school age from epileptic families whom the Doctor has proved no evidence of epilepsy but still the Community cannot allow them to join the other children and learn.

There is a family which was taken back to their place just recently and then these people came back to the hospital and they have even asked to come back and stay. They say that, people do not like them, they fear them, they would not like to meet them or join them in anything, they fear that they can be diseased and as such these people being neglected and disliked, and other people having prejudice against them, they do not feel free and therefore they run back to the other group of the same disease in the hospital.

The mission has worked hard and found land for a family of ten where they are buying that land for them in a Settlement Scheme, the payment has not yet finished.

At the mission there are five men, seven women, four girls, four boys and among the girls one is having an illegitimate infant.

These young group of girls and boys look to be strong and can work. At present some of them work for the mission and get money for their living.

These people who were born in the mission, and their parents and who came a long time ago have no hope of going to where their parents came from and get settled.

MY OWN OPINION

As this is not only a problem for these people, but I would call it a national problem. This disease is one of the major diseases which people fear and are frightened with a person having it, people have prejudice against those having it. Though doctors say about it as not infectious still many people have long planted fear and the patient suffers and have many funny stories formed about it. The mission has done a lot to treat and feed these people, from the long planted fear and the community is not yet ready to accept these people and the present group of young people who are born among the sick people may suffer very much as they are now landless, neglected, feared and these feelings are also in themselves.

SUGGESTIONS

1. The Government should think of settling this group in one of the settlement schemes where they can do a bit of farming for their living and open a school in the place for the children to learn. Also be helped to stay on the land.

2. If not, giving them land, we have homes, here in Kenya for different disabilities in people, e.g. cripple, blind, etc. Can't it have a home for this group? As those people who have no land so as to feed them there and treat them.

But still as some of these people are strong they work very hard and are giving birth, the only way of making them settle on the land somewhere, where they can work for themselves, raise food for their families when they are on treatment to lesson the falls and children who are born without the disease may do a lot in the country as any other child born in any called normal family.

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