DISABILITY IN COLONIAL INDIA: A HISTORICAL PERSPECTIVE

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BY

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1. **'Medicine as a Key Agent: Enhancement of People with Disabilities in Colonial India,'** South Indian History Congress, Thirty Eight Annual Session Proceedings, Calicut, 2018, pp. 333–339.

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CONTENTS

ABBREVIATIONS USED IN THE MAIN TEXT AND BIBLIOGRAPHY

CABE: Central Advisory Board of Education

CEZMS: Church of England Zenana Missionary Society

CIDS: Congenital Iodine Deficiency Syndrome

CIP: Central Institute of Psychiatry

CMC: Christian Medical Commission

CMG: The Church Missionary Gleaner

CMS: Church Missionary Society

ECT: Electro Convulsive Therapy

EPW: Economic and Political Weekly

FMI: The Female Missionary Intelligencer

HF: The Harvest Field

HMSO: His Majesty's Stationary Office

IAMS: Indian Annals of Medical Science

IFE: The Indian Female Evangelist

IMG: Indian Medical Gazette

IMS: Indian Medical Service

IPC: Indian Penal Code

IW: India's Women

JMS: Journal of Mental Science

LCI: Leprosy Commission of India

MMS: Madras Medical Service

NAI: National Archives of India

NL: National Library

PWD: People with Disabilities

SMT: Slip Method of Tabulation

SPG: Gospel in Foreign Parts

WHO: World Health Organization

WMI: Welfare Ministry of India

Chapter One

INTRODUCTION

Disability history has recently become an important field to gain prominence in social research. The definition of the term disability, its social and economic implications, attitudes of the community and family towards disability, the legal status of disability, and the history of disability are some of the main foci studied in this sub-field. Currently, in India, vigorous efforts are on to bring recognition to disability studies.

People with disabilities are understood as a minority group who face stigma and discrimination in society. The historical positioning of disability in India in the ancient and medieval periods was not different from that of any other country. Disability was perceived as a curse and the result of sins. The disabled in India were marginalized and discriminated against in many ways. Indian society considered disability as a criterion similar to race, caste, and gender for defining the identity of a person. Evidence of historical oppression of the disabled is available in India's record of the past. To find out how disability was treated and understood in Colonial India, a clear understanding of factors like official categorization, development of legal rights, the role of missions, special education, institutionalization, and history of colonial medicine is needed. Thus my thesis aims to look at the discursive connection between the perspectives of colonial agencies and disability in India.

1.1. Introduction to Disability: Dichotomy Between Medical and Social Models

The models about disability emerged from a global-level discussion and debate. Disability models connect disability with the implications for body, society, culture, and subjectivity. The first model that emerged in the field of disability theory was the medical model. The medical model sees impairment as a consequence of 'deviation' from 'normal' body functioning, which has 'undesirable' consequences for the affected individual. The medical model considers impairment as a physical 'abnormality' and medical treatment is the only medium that can cure or limit 'abnormality' in the body. According to the medical model, disabilities are divided into three categories—mental disabilities, sensory disabilities, and orthopedic disabilities.

Today, ‘insanity’ as a category is divided into mental disability and mental illness.[1] Even though at times it is difficult to draw a line between the two, official categorizations are flexible and elastic. These distinctions are fixed by the assessment done by mental health professionals such as psychologists, psychiatrists, and clinical social workers using various tests such as psychometric tests, questioning, and observation.

Mental disabilities are those which permanently impact three factors of life—basic activities of daily life including self-care, interpersonal relationships including communication and making relationships and sustaining them, and occupational functioning which includes the ability to get employment and keep it. Mental disabilities are mostly related to cognitive functions of life and are congenital. The first category of mental disability is a developmental disability which is a diverse group of chronic conditions including down syndrome, fragile x syndrome, autism spectrum disorder, pervasive developmental disorder, and cerebral palsy.[2] The second category of mental disability includes disabilities affecting intellectual abilities wherein people have an IQ of less than 70, learning disabilities like dyslexia, and developmental coordination disorder.[3] This category also includes acquired permanent brain injuries and neurodegenerative disorders like Parkinson's and Alzheimer's.[4] The only mental diseases that are considered

[1] Mental disabilities and mental illnesses are different entities and are assessed in terms of the nature of the disorder. Mental disabilities are permanent and life-long conditions, whereas mental illnesses can be treated with medication and other support systems. The common types of mental illnesses are anxiety disorders, mood disorders, psychotic disorders, eating disorders, personality disorders, obsessive-compulsive disorders, and post-traumatic stress disorder. Gary L. Albrecht, *Encyclopedia of Disability* (Thousand Oaks: Sage Publications, 2005), 9.

[2] Down syndrome is a genetic disorder that occur when an individual has a full or partial extra copy of chromosome 21. This causes intellectual disability with an IQ of 50 and distant facial features.; Fragile x syndrome is a genetic condition that causes developmental problems and cognitive impairment.; FASD (Fetal alcohol spectrum disorder) is a behaviour and learning disorder that occurs in a person whose mother consumed alcohol during pregnancy.; Autism spectrum disorder is a congenital disorder that cause difficulty with emotion, speech delays, repetitive behaviours, hypersensitivity, and difficulty in social situations.; PDD (Pervasive developmental disorder) is a condition of delayed development of intellect.; CP (Cerebral palsy) is a disorder that affects muscle movement and coordination which also can affect the cognitive functions of a child. Ibid.

[3] Dyslexia is a learning disorder that involves difficulty reading due to the problem in identifying speech sounds and learning how they relate to letters and words (decoding). This condition is also called a reading disability.; DCD (Developmental coordination disorder) occurs when there is a delay in the development of motor skills, or difficulty coordinating movements result in a child being unable to perform common and everyday tasks. Ibid., 10.

[4] Parkinson's disease is a progressive nervous system disorder that affects movement. Tremors and stiffness of muscles are common with this condition which causes a reduction in mobility.; Alzheimer's is a type of dementia that causes problems with memory, thinking, and behaviour. Ibid., 14.

as part of mental disability are schizophrenia and bipolar disorder owing to their aggressive nature and permanent impact.

Sensory disabilities are those disabilities that affect the sensory information of the brain. They include blindness, deafness, and muteness. Visionary impairment or blindness is defined as an inability to see or decreased ability to see to the point where it cannot be reversed by the use of means such as glasses and lenses.[5] The main reason for blindness is cataracts. A cataract is a pathology that describes the graying or opacity of the crystalline lens which is most commonly caused by intrauterine infections, metabolic disorders, and genetically transmitted syndromes.[6] Glaucoma is another reason for blindness. It is the result of increased pressure in the eye. Child blindness can be caused by congenital rubella syndrome, retinopathy of prematurity, leprosy, and onchocerciasis.[7] It is also caused by trachoma and central corneal ulceration. Injuries also cause blindness, especially injuries to the eye socket itself and injuries to the occipital lobe that stop the brain from receiving and interpreting signals. Genetic defects like albinism, Leber's congenital amaurosis, and Bardet-Biedl syndrome may also result in blindness.[8]

Deafness is simply defined as the loss of hearing while mute is used to denote the inability to speak.[9] Hearing impairment is defined as partial or total inability to hear. It could occur in one ear or both. This may create problems during social interaction as well as while learning a language. Infection is the major reason for the loss of hearing in infants. This could be of two types—acute otitis media and chronic suppurative otitis media.[10] These two infections can cause inflammatory conditions in the middle ear.

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[5] S. S. Lehman, "Cortical Visual Impairment in Children: Identification, Evaluation, and Diagnosis," *Current Opinion in Ophthalmology* 23, no. 5 (2003): 384–387.

[6] M. Mathers and M. Wright, "A Review of the Evidence on the Effectiveness of Children's Vision Screening," *Child: Care, Health and Development* 36, no. 6 (2010): 756–780.

[7] CRS (Congenital rubella syndrome) can occur in a developing fetus of a pregnant woman who has contracted rubella, usually in the first trimester.; ROP (Retinopathy of prematurity) is a blinding disease caused by the abnormal development of retinal blood vessels in premature infants.; Onchocerciasis is an eye and skin disease caused by a worm (filaria) known scientifically as onchocerca volvulus. Ann Marie Griff, “Blindness,” *Journal of Healthline*, no. 3 (2019): 8–10.

[8] Ibid.

[9] Moore Matthew and Linda Levitan, *For Hearing People Only: Answers to Some of the Most Commonly Asked Questions About the Deaf Community, Its Culture, and the Deaf Reality* (New York: Deaf Life Press, 2003), 5.

[10] Ibid., 8.

Genetics can play a role in inheriting deafness as well.[11] Those who have inherited the same recessive genes and dominating genes of their parents tend to be born deaf. Genetic deafness can be of two types—syndromic and non-syndromic. Syndromic deafness occurs in a child along with syndromes such as usher syndrome, stickle syndrome, Waardenburg syndrome, and Alport-syndrome. Non-syndromic deafness occurs when a person is suffering only from hearing loss. Perinatal problems can also cause deafness. Fetal alcohol spectrum disorders cause hearing loss of infants born to alcoholic mothers.[12] Disorders like strokes, multiple sclerosis, and viral infections also cause damage to the ear nerve. Mumps, congenital rubella, meningitis, syphilis, and auto-immune diseases also can cause deafness in people.[13]

Muteness is defined as an inability to speak often caused by a congenital speech disorder or any physical trauma. To speak, the human body coordinates the movement of the esophagus, lungs, mouth, tongue, and most importantly vocal cords. Any trauma or disorder of these parts can cause muteness.[14] The variation in muteness starts with apraxia. This refers to a delay of learning or speaking abilities in an infant mainly owing to a general disorder of the muscles. Anarthria is another condition that causes muteness. It stems from damaged lungs and leads to aphasia, damage to the cerebral centre of the language.[15] At times, due to aphonia or conversion disorders, and in some cases, autism and down syndrome, some people will not be able to speak.[16]

Orthopedic disabilities are those disabilities that affect muscles, bones, and nerve system which eventually results in the loss of motor abilities.[17] Cerebral palsy is a neurological disability that affects body movements, muscle coordination, and orthopedic health. Damage to a specific part of the brain is the reason for this condition. Muscular dystrophy is another condition that weakens the muscle system. Arthrogryposis is another disability that causes tied joints and muscle bands which permanently reduce the mobility

[11] K. Stephens, "Deafness and Hereditary Hearing Loss," (2014). https://www.ncbi.nlm.nih.gov/pubmed/20301607.

[12] Ibid.

[13] Ibid.

[14] C. Rowland and P. Schweigert, "Tangible Symbol Systems: Symbolic Communication for Individuals with Multisensory Impairments," *Augmentative and Alternative Communication* 5, no. 6 (1989): 226–234.

[15] Ibid., 229.

[16] Ibid.

[17] Albrecht, *Encyclopedia of Disability*, 19.

of a person. Dwarfism, cured leprosy, club-foot, and acid-attack damage are also considered physical disabilities in India.[18]

Thus the medical model associates disability with a disorder that limits the 'ability' of a person. The medical model is useful as a guide for diagnosis, prognosis, and research when it comes to disability. But the model is problematic without the association of the social model. The medical model is criticized for its biological reductionism where it only gives importance to the physical state of human beings. It associates disability as an individual personal tragedy. This model did not associate disability with social contact or the social position of the disabled. The medical model was weak in conceptualizing multimorbidity. The model looks at disabled bodies as objects that require fixing instead of accepting differences. The medical model also associates disability with dependency and creates an image that a disability means disabled are unable to perform like 'abled.' This model also creates the image of a 'normal' body and behaviour. The medical model act against biological and intellectual differences and follow a process by which people are judged on their ability and inability to follow the accepted 'normality' of body function. This further results in creating a stigma around disability.

The history of disability cannot be written solely by using the medical model. It needs extensive support from the study of social pedagogy, education, psychology and psychoanalysis, community work, women's studies, and critical study of race. Goodley writes that disability history can provide awareness about the history of inequality and can produce new affirmative thinking about disability.[19] The other model, namely the social model considers disability as a socially created 'problem.' The solution to this problem according to this model is the full integration of the disabled into society. This model does not give importance to the individual. Instead, it analyzes the collective conditions of the social environment that cause and perpetuate disability. Just like medical agencies, social institutions also create an image of 'normal.' Such an image invalidates and eliminates those who don't fit the 'norm.' Thus based on this, society deals with disability in isolation which further intensifies exclusion.[20] The social model stands against such kind

[18] The Rights of Persons with Disabilities (RPWD) Act of 2016 (Delhi: Department of Empowerment of Persons with Disabilities, Ministry of Social Justice and Empowerment, Government of India), pp. 1–49.

[19] D. Goodley Hughes and L. Davis, *Disability and Social Theory: New Developments and Directions* (London: Palgrave Macmillan, 2012), 12.

[20] Ibid., 109.

of marginalization of the disabled and propounds equal opportunity and access to all people without discrimination. The model also believes that disabilities are constructed by the expectations of society and institutions. The social expectations of 'normality' create disability. The social construction of disability is similar to the social construction of race and gender.[21]

According to the social model, disability is constructed as the social response to a deviance from the 'norm.'[22] Along with it, the social model also talks about ableism as a by-product of society.[23] Disabled bodies become unsettling for the abled and create a situation where a disabled himself/herself is in denial of his/her 'vulnerabilities.' When an ableist community controls the narrative of the disabled community, it creates a distorted notion of disability known as ableism which is a complex of processes 'that exclude disabled people from the psychic habitus.'[24] The narrative of ableism produces the protocol for 'civilized living' according to the 'standard bodily and behaviour comportment.' Casual ableism proposes a solution to the 'problem' of the disabled in two ways—one related to removal and another related to the correction of the disabled person.

The process of elimination and correction ensure 'civility.' New binaries are created between the disabled and the abled, and segregation is enforced through new standards of normalcy.[25] Another problem is that standards and criteria of normalcy were created in the West. New rules of normalcy intensified the disgust of the abled community towards the disabled and the demand for the emotional and bodily redefinition grew stronger. Elias argues that this increased the intolerance and repugnance to the disabled

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[21] Both race and gender are not fixated on the biological differences but created by the social institutions to perpetuate biological differences. Similarly, the social model believes that disability is not created based on the biological capacity but created by society by making barriers in accessibility.

[22] Norbert Elias, *The Civilizing Process: Sociogenetic and Psychogenetic Investigations* (Oxford: Basil Blackwell, 2000), 78.

[23] Ableism is defined as discrimination and social prejudice against people with disabilities. It works on the idea that the disabled are inferior to the abled. Physical ableism is discrimination against the disabled based on physical differences. Mental ableism is discrimination based on cognitive differences. Medical ableism means hijacking the decision-making rights of the disabled. Structural ableism means structural inaccessibility in the society like barriers in mobility and education. Other models of ableism such as benevolent ableism, internalized ableism, and cultural ableism also exists in society. Simi Linton and Michael Berube, *Claiming Disability: Knowledge and Identity* (New York: New York University Press, 1998), 9.

[24] Elias, *The Civilizing Process*, 367.

[25] Nibert A. David, "The Political Economy of Developmental Disability," *Critical Sociology* 21, no. 1 (1995): 59–80.

bodies and the movement of segregation became the reality behind the process of 'civilization.'[26]

New stricter rules to create a standard set of emotional and physical behaviour reduced the gap between social classes, but created a marginalized section of 'outsiders' who were 'beyond the pale of polite communion.' This created a new model of citizenship which clarified who was eligible and who wasn't and 'what is fitting, to be fit and to be fit to do what is fitting.'[27] 'Appropriate' conduct and emotional control became an important part of daily life, and contempt was openly expressed for those who did not represent the 'embodiment of the civilized citizen.' This process pushed the disabled behind the doors and as a community, they remained a mystery to the general public which again resulted in the emergence of many superstitions and misconceptions regarding disability and the minds and bodies of the disabled.[28]

The social model posits that ableist society looks at disability as something to be tolerated or unacceptable. It always understands disability as a form of harm and danger to the authentic self and others and does not accept disability as part of diversity. This creates a norm of normalcy and rates independence as the higher value of individuality. Society values the economic contribution of the citizen and disabled bodies are considered as a burden, a drain from the system. Ableism creates a divide between 'what is normal' and 'what is not.' The criterion for 'normal' is placed on a person's ability to do expected daily life tasks. Those who cannot do the daily tasks without assistance are put into the 'abnormal' category. Ableism thinks disability always means suffering and a condition to 'overcome.' The social model also stands against this stigmatization of the disabled and disability. The social model and the medical model must interact with each other for better inclusion of the disabled in society because the medical model offers a scientific understanding of physical factors in disability and the social model offers an understanding of the impact of disease and its implication for society.

[26] Elias, *The Civilizing Process*, 21, 98, 103, 200, 414.

[27] Ibid., 23.

[28] Ibid., 203.

1.2. Disability and the Disabled in Indian History

Ancient Indian literature showcased disabled characters as persons who were filled with jealousy and treachery. The best example of this was Dhritarashtra, the blind king in the Mahabharata who was 'jealous' of his abled brother Pandu. The Mahabharata involves many instances which discuss the problems of the disabled. The text depicts the king's duty as 'cherishes thou like a father, the blind, the dumb, the lame, the deformed, the friendless, and ascetics that have no homes.'[29] The Sabha Parva advises king Yudhistathira that he should take care of the dumb, blind, and deaf. The Vana Parva includes a long section on Bhishma's death bed discussion which may be summarized as "the blind, the deaf, and they that are destitute of reason, are perfectly consoled for the loss of their senses."[30] The Shanti Parva referred to the disabled as *devairapihita-dwarah* which meant persons whose doors (senses) have been closed by the deities.[31]

The Ramayana has a similar character called Manthara who was demonized. Numerous ancient texts state that the orthopedically disabled Manthara was the real reason for the fourteen-year exile of Rama. She was publicly scrutinized and mocked for her behaviour. The sister of Ravana, Shoorpanaka described by Valmiki as a cross-eyed woman and this shows how physical deformities translated to meanness or wickedness. She met Rama when he was in exile and was smitten by him, but he rejected her proposal stating he already has a wife. Then she approached Lakshmana, the brother of Rama who also rejected her. To take vengeance she attacked Sita, the wife of Rama, and was eventually punished by face mutilation. Such texts also provided references to making people as disabled as part of the punishment. The Bhagavat Purana gives an account of a dwarf called Vamana. He was known for his treachery against Asura king Mahabali. The literal translation of Vamana is the 'little' man, and he was the incarnation of Vishnu. To restore the authority of Indra, Vishnu guided himself in the role of the Brahmin dwarf and met with Mahabali. The Vamana asked the king to offer three-foot land, and Vishnu used his powers and stepped on earth and heaven. To complete his promise, Mahabali asked the Vamana to step on his head. Even though the story of the Vamana does not depict him as evil but depicts him as cunning, and supernatural power is attached to him. Disabled

[29] Robert E. Hume, *The Thirteen Principals of Upanishads: Translated from the Sanskrit* (Oxford: Oxford University Press, 1931), 205.

[30] Ibid.

[31] Ibid.

goddess Manasa is another character described by the Puranas and Mahabharata as the most vengeful goddess. The first mention of the prosthesis can be seen in the Rigveda where one incident is cited. The text mentions Vishapala who lost her leg in the battle of Khela and people helped her to get an iron leg so that she could keep running.[32]

The Upanishads also give reference to disability. Chandogya denotes blindness as a metaphor for ignorance.[33] The Dharmasutras include the law codes of Apastamba, Gautama, Baudhayana, and Vasistha. They also help us to give information about the condition of the disabled in ancient India. These texts contain law codes for the bald, the blind, the childless, the deaf, the dumb, the insane, and the sick. Vasishtha opines that since a child is the blood of his/her mother and father, and if there is any impairment, the mother and the father are free to take care of the child, or sell, or abandon the child. The code of Vishnu or Vishnu Smriti had many references to disabled people. He advised men not to marry women with any 'deformity.' The law book believed that a sinner would be born again as a leper. The law of Manu says the sick and the disabled should be looked after well. The king should practice his duties of protecting the disabled who should be exempted from paying taxes. He also said disabled people should not get married, should not perform auspicious ceremonies, and should not become servants of the able-bodied. Chanakya wrote that it was the duty of the king to provide necessary help to the disabled. He suggested that a king should protect his country's women, children, and the disabled. Some jobs like weaving and wool-cutting were reserved for women and the disabled. Satatapa Shastra, another text, argued that people who did not repent their sins in the past life were born with disabilities, and it could not be altered and was the greatest sin of all. One of the medicinal texts, Charaka Samhita, written by Charaka also asserted that the disabilities were the result of *karma.*[34]

The Baudhayana Sutra says that a disabled person should not deal with legal activities such as owning property, transferring property, and witnessing any important legal or religious ceremony. The major discrimination of the disabled at this time was because of the lack of legal rights. The second reason why the discrimination prevailed was because of their lack of authority to perform religious duty.[35] It was believed that

[32] Ibid., 206.

[33] Ibid.

[34] Kane Pandurang, *History of Dharmasastra* (Poona: Bhandarkar Oriental Research Institute, 1962), 286.

[35] Danielo Alain, *Hindu Polytheism* (Madras: Bollingen Foundation, 1964), 22–28.

Chandragupta Maurya used to conduct rehabilitation workshops for the disabled.[36] Samudragupta used to appoint people with developmental disabilities to stay behind his throne.[37] But such tokenism never really improved the condition and stigmatization of disability.

Buddhist and Jain textual traditions dealt with the disabled in terms of care and protection but *karma* was also given importance. One Buddhist text gives an account of two women with disabilities. The first one is Khujjutara, a hunchbacked maid who played a major role as a famous teacher of Buddhism. The second is Vishaka, who walked slowly due to her orthopedic disability while her companions ran.[38] Jataka stories which are the collection of the stories of the previous life of Buddha also mentioned disability. Nangalisa-Jataka tells the story of a teacher using a special method to teach his slow learning student. In Muga-Pakkha-Jataka, Bodhisatta takes the form of a child prince who was a slow learner. Digha Nikaya passes comments on disability. Brahmajala Sutta considers mimicking deformities a gross sin.[39] Sama Sutta uses blindness as the metaphor for ignorance and lack of wisdom. These *Suttas* describes 32 symbols of the perfect body and disability was considered as 'imperfection.' No great teacher had any deformities, and if anyone was deaf, dumb, or mentally disabled, he/she was not considered appropriate for leading a holy life. Samyutta Nikaya listed out eleven weaknesses that can make a person not appropriate for leading the life of the monk, and one among them was physical disability. The story of Angulimala was another example of how the disabled were portrayed in Buddhist textbooks. Theragatha and the Angulimala Sutta in the Majjhima Nikaya describe Angulimala as a dark crippled man who became a serial killer and later changed his heart when he met the Buddha.

Majjhima Nikaya has direct discourse about mental disability. The text refers to mental retardation and the importance of mindfulness as a factor in leading a 'good' life. Culakamma Vibhanga mentions a discussion between a student and his teacher. The student Subha asked his teacher that how humans turn out inferior and superior, short-lived and long-lived, sickly and healthy, ugly and beautiful, and stupid and wise. The teacher answered that it was due to *karma*, and human "beings are owners of their

[36] Kerry Wynn, "Johanninne Healings and the Otherness of Disability," *Perspectives in Religious Studies* 32, no. 2 (2007): 61–75.

[37] Ibid.

[38] Dutt Nalinaksha, *Great Women in Buddhism* (Mumbai: Ashish Pub, 1993), 271.

[39] Ibid., 85.

actions and heirs of their actions."[40] The Buddhists believed in physical mutilation as the highest form of worship.[41] There are textual references to a Buddhist monk called Myoe who worked as an animal butcher. When he became a monk, he felt like an outcast in the Sangha due to his poor background. To become a recognizable monk, he mutilated his ears and cut out one part of his flesh.[42] He was known for his work among lepers. It is important to note that representing the disabled as dark, evil, and sinful was a trend that was also followed in the Buddhist texts.

The Jaina texts also provide us insights into disability in ancient India. Tattvartha Sutra, an important Jain text, states that people with disabilities are to be excluded from joining religious orders. The Akaranga Sutra which instructs a healthy life states, "With the deterioration of the perceptions of the ear, eye, organs of smelling, tasting, touching, a man becomes aware of the decline of life."[43] The text states that disabilities are the result of a previous sinful life.[44] The text also says when people meet the diseased and disabled, they should not use offensive language.[45] The religion "normally barred those who are physically or mentally incapacitated."[46] Many Jain texts refer to the purifying act with which a person entered the religious life was not be undertaken by anyone who had a physical disability.

While many Hindu scriptures state that a person with physical or mental deformities should not own property or hold religious duties, Buddhism and Jainism believe that it is the responsibility of society to take care of the disabled. But all the ancient Indian literature placed disability based on *karma*. In medieval India, differences of capacity were understood by scholars. Sadi's *Gulistan* contains a part on how to teach a slow-learning student.[47] Akbar was known for his charity programmes for the disabled. A

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[40] Hermann Jacobi, *Sutras Translated from Prakrit* (Oxford: Clarendon, 1884), 15.

[41] Ibid.

[42] Lynne M. Bejoian, "Nondualistic Paradigms in Disability Studies of Buddhism," *Disability Studies Quarterly* 26, no. 3 (2006): 18–27.

[43] Ibid., 18.

[44] Ibid.

[45] S. Padmanabh, *The Jaina Path of Purification* (Delhi: Motilal Banarsidass, 1979), 244.

[46] Usha Bhatt, *The Physically Handicapped in India: A Growing National Problem* (Bombay: Popular Book Depot, 1963), 36.

[47] Ibid., 37.

deaf-mute was appointed in the royal court to handle confidential papers.[48] But the stigma attached to disability was never reduced, and the disabled became a marginalized section of Indian society.

1.3. Review of Literature

To grasp the meaning and the scope of disability in the Colonial Indian context, the following texts are referred to. Anita Ghai, a leading disability rights activist is known as the pioneer of disability studies in India. Her book gives a detailed and complex overview of disability in India.[49] Ghai's vantage position at the interface between a research scholar on disability, a disability rights activist, and a disabled person makes her book interesting and demonstrative. Moving away from clinical, medical, and therapeutic perspectives on disability, her book explores disability in India as a social, cultural, and political phenomenon, arguing that this 'difference' should be accepted as a part of social diversity.

Anita Ghai placed disability as the primary identity of a person. Dan Goodley thinks that the overbearing importance that Ghai gave disability should be understood in terms of local and national context whereby disability is placed hierarchically lower.[50] For Ghai, placing disability as the prime identity of an individual became a protest against the oppression the disabled face in Indian society. Theoretically, along with individual identity, disability also should be used to identify and strengthen community feelings. The same is the problem with Colonial India where disability made the primary identity of a person and community ties were cut off which resulted in the late-blooming of disability-rights awareness. The development of community identity is important for the disabled. For example, missionary education of the blind in Colonial India was more advanced and widespread than the deaf-mute education because the blind as a community were in communication with one another while the deaf-mute education was scattered.

Anita Ghai also discusses how a disabled person in India was socially understood as an incomplete entity and debates that the slow speed of disability rights moments in India was mainly because of the reason how disabled were regarded as 'lacked' or

[48] Jayanti Narayan, "Persons with Disabilities in India: Personal Perspective," *Disability Studies Quarterly* 24, no. 2 (2005): 17–24.

[49] Anita Ghai, *Rethinking Disability in India* (London: Routledge, 2015), 3.

[50] Hughes and Davis, *Disability and Social Theory*, 3.

'flawed' in Indian society.[51] She draws out the history of the transmission from Colonial India's dealing of disability in terms of religion and charity to independent India's understanding of disability as a disease with social implications. Ghai also talks about how disability is associated with *karma* in India. She elaborates that disability is explained in terms of the sins of a person and this forces a person to accept the pain and suffering associated with their disease, which became a form of invisible oppression. She continues that this stress on disability as a 'curse' forces the families to have committed to their care. The colonial charity or medical model also made the government think that disability matters are the responsibility of the voluntary sector, Ghai argues.

Ghai is also engaged with the issues of disabled women in India.[52] Written from the epistemic location of an existential reality of physical disability, her goal is to locate disability within the feminist discourse. Ghai taking reference from Das and Agnihorti indicates that disability and gender are intersected.[53] They both argue that disabled Indian women are marginalized and society looks at the disability of a girl child as an additional burden. This double marginalization of the disabled women was further analyzed by Johri, Krishnaji, and Fine in their texts and associate marginalization with the low ritual importance of women in India.[54] It is interesting to note that how the colonial records associate disability with the low standing of women in India. Census reports and missionary records accused patriarchal social conditioning of women as the main cause for disability in India.

The idea of ableism and its influence drawn from colonialism has been discussed by Rosemarie Garland-Thomson.[55] She explains the idea of 'normate' in disability studies which is in use by society while it deals with disability and the disabled. She elaborates how colonial agencies created this by setting up a set of assumptions that encouraged

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[51] Anita Ghai, "Disability in the Indian Context: Post-colonial Perspectives," in *Disability and Postmodernity: Embodying Disability Theory*, eds. M. Corker and T. Shakespeare (London: Continuum, 2002), 62–75.

[52] Anita Ghai, *(Dis)embodied Form: Issues of Disabled Women* (Delhi: Har-Anand Publications, 2003), 15.

[53] D. Das and S. B. Agnihotri, "Physical Disability: Is there a Gender Dimension," *Economic and Political Weekly* (EPW from here on) 33, no. 52 (1999): 333–335.

[54] Rachana Johri, *Cultural Constructions of Maternal Attachment: The Case of a Girl Child* (PhD Thesis: University of Delhi, 1998), 12.; N. Krishnaji, "*Trends in Sex Ratio*," *EPW*, no. 13 (2000): 161–163.; Michele Fine and Adrienne Asch, *Women with Disabilities: Essays in Psychology, Culture, and Politics* (Philadelphia: Temple University Press, 1998), 10.

[55] Rosemaries Garland-Thomson, *Extraordinary Bodies: Figuring Physical Disability in American Culture and Literature* (New York: Columbia University Press, 1997), 75.

unequal treatment of people based on their body differences. This same idea was more elaborated by Fiona-Kumari Campbell.[56] She explains how ableism looks at the experience of the disabled through the lens of the able-bodied and how it hijacks the agency of the disabled by not giving them enough voice in the narrative. Hughes and Shakespeare also talk about how ableism is created, operated, and maintained by society and how it affects disability rights negatively.[57] They both call for an ontological reframing of disability studies. Bhattacharya also talks about how spontaneous, uncontrolled, and unnoticeable ableism is.[58] He also intersects disability with other social agencies of gender, class, and caste. The study of this bridge is important for the state to efficiently formulate policies of education and employment concerning disability. This understanding of the intersection of disability with other social agencies was missing in Colonial India which made colonial policies related to disability ineffective.

Bill Hughes associate ableism as a form of the civilizing process where disability is looked at as disgusting or something to be changed to 'better.'[59] He continues that 'white gaze' as the able-gaze looks at 'other bodies' as disabled bodies as something to be shaped into a different mould. Thus according to Arthur Frank, the 'other' becomes always colonized, dominated, and violated.[60] The idea of the disabled 'other' was also discussed by Nancy Mairs.[61] She discusses how disabled bodies are treated in terms of fear which creates a 'chasm of perceived difference.' She argues that it is this fear that creates hostility. Anita Ghai also argues that, on the other side of the coin, fear replaces inspiration if the 'other bodies' are changed according to the 'norm.'[62]

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[56] Fiona-Kumari Campbell, *Contours of Ableism: The Production of Disability and Abledness* (Hampshire: Palgrave Macmillian, 2009), 6.

[57] Corker and Shakespeare, *Disability and Postmodernity*, 62.

[58] Tanmoy Bhattacharya, *Returning to the Site of Degradation* (PhD Thesis: IIT Guwahati, 2016), 18.

[59] Bill Hughes, "Being Disabled: Towards a Critical Social Ontology for Disability Studies," *Disability and Society* 22, no. 7 (2007): 673–684.

[60] Arthur Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago: University of Chicago Press, 1995), 25.

[61] Nancy Mairs, *Waist-high in the World: A Life Among the Nondisabled* (London: Beacon Press, 1996), 37.

[62] Ghai, "Disability in the Indian Context," 68.

Anita Ghai also discusses the point that colonialism related disability to race.[63] She argues that disability was always secondary for the colonizer. Even though the colonizer's body was disabled, he remained the colonizer, whereas despite being able-bodied, the colonized remained colonized. By reading into the work of Albert Memmi, Ghai writes how colonialism created a narrative where the colonizer was everything that the colonized was not. The 'other' was always seen as 'lack,' lacking in the value and qualities of 'civilized' society. Memmi writes about the 'other' in terms of anonymous collectivity.[64] Ghai writes that this importance to 'anonymous collectivity' poses the colonized as mere bodies waiting on the edge to be transformed by the colonizer. Edward Said also argues that the colonized (read 'disabled') are fixed as a dependent, stigmatized, and underdeveloped ruled by a superior and developed overlord.[65]

Karen Soldric also examines the connection between colonialism and its impact on disability and the people with disabilities. He talks about the mapping, control, and subjugation of the human body and mind under colonial conquest. Sherry in his work opined that colonialism created the binary of non-disabled and disabled and this idea is flawed and limited because it constricts areas in-between or outside of these categories.[66] He calls for fluidity and contextuality while dealing with disabilities. Homi Bhabha also opposes binaries while analyzing colonialism.[67] He looks at binary as illusory and states that oppression created by colonialism in the form of displacement, distortion, and dislocation is more complex and this could be studied in relation to class, caste, gender, race, generation, institutional location, and geopolitical locale. Even though Bhabha did not write directly on disability, the implication for the disabled as 'hybrid,' displaced, and dislocated is evident in his work. Ghai argues that Bhabha viewed the disabled as 'hybrids' who were destroyed by the colonizers' culture, and by borrowing from the text of Mairian Corker, she argues that the idea of disability is unstable and hybridity does not always mean 'destruction.'[68] Ghai also places individuality as important because specific

[63] Ibid.

[64] Albert Memmi, *The Colonizer and the Colonized* (New York: The Orion Press, 1965), 19.

[65] Edward Said, *Orientalism* (New York: Pantheon Press, 1978), 42.

[66] Mark Sherry, "(Post)colonising Disability: Intersecting Gender and Disability Perspectives in Rethinking Post-colonial Identities," *Wagadu*, no. 4 (2007): 102–22.

[67] Homi K. Bhabha, "Foreword: Remembering Fanon: Self, Psyche, and the Colonial Condition," in *Black Skin and White Masks*, Frantz Fanon (London: Pluto, 1986), 73–86.

[68] Mairian Corker, "Sensing Disability," *Hypatia* 16, no. 4 (2001): 34–52.

realities and experiences of the disabled are lost when all is merged under community identity.

Schrimpf in her work writes that the disabled body is restricted in an anatomical sense. However, it also cut off the disabled from social, cultural, physical, and psychological environments.[69] She talks about disability in terms of a social construct rather than as pathology. Disability was understood as a problem that demanded help from colonizers in Colonial India. This image created by colonialism was criticized by many leading disability theorists like Gyan Prakash using post-colonial disability theories.[70] But many like Mark Phillip Bradley argue that the image of the disabled as a suffering human in the colonial period had a great influence on the evolution of disability rights and human rights.[71] Kudlick writes that the disabled were not passive as depicted under colonial rule.[72] She continues that they had a voice and some historical agency and when the system exploited them, they tried to hit the system back for their benefit.[73] Wagner talked about this interdependence where the cross-cultural encounter was common between the disabled and colonial agencies.[74] Galis writes that colonialism treated the disabled as dependent characters and a category who needed care.[75] This is why as states by Galis, colonial policies never got to the point of disability rights in current times.

Bickenbatch writes that disability is considered an 'issue' that affects the welfare, social security, and health laws of a state.[76] Yet, there is no text published that deals with the legislation and disability in Colonial India. Rumi Ahmed's book gives a background to the evolution of disability rights in India post-1947.[77] She has made an able attempt to

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[69] Alexa Schriempf, "(Re)fusing the Amputated Body: An Interactionist Bridge for Feminism and Disability," *Hypatia* 1, no. 16 (2001): 53–57.

[70] Gyan Prakash, *Bonded Histories* (Cambridge: Cambridge University Press, 2003), 17.

[71] M. P. Bradely, *The World Reimagined: Americans and Human Rights in the Twentieth Century* (Cambridge: Cambridge University Press, 2016), 10.

[72] Catherine J. Kudlick, "The Social History of Medicine and Disability History," in *Oxford Handbook of Disability History*, ed. Michael Rembis and Kim Nielsen (Oxford: Oxford University Press, 2018), 41–49.

[73] Catherine J. Kudlick, "Disability History: Why We Need Another Other," *The American Historical Review* 108, no. 3 (2003): 763–793.

[74] Mary Wagner, *The Academic Achievement and Functional Performance of Youth with Disabilities* (London: Olympia, 2006), 27.

[75] V. Galis, "Enacting Disability: How Can Science and Technology Studies Inform Disability Studies," *Disability and Society* 26, no.7 (2011): 825–838.

[76] Jerome E. Bickenbach, *Ethics, Law and Policy* (Oaks: Sage Publication, 2012), 60.

[77] Rumi Ahmed, *Rights of Persons with Disability in India* (Chandigarh: White Falcon, 2015), 35.

critically analyze the existing laws for persons with disabilities in India. She also covers the historical development of disability (legal) rights and policies and analyzes the legislative responses and the legal framework for disability rights in India. Renu Addlakha wrote about the disability rights movement in the areas of health, education, employment, barrier-free mobility, and social security.[78] Her book looks at the most recent work on disability studies from the country and engages with the concept of disability from a variety of disciplinary positions. G. N. Karna deals with a wide range of topics like understanding disability and disability public policy from a cross-cultural perspective and analyzes the influence of legislation in disability discourse.[79] Jayna Kothari also analyzes the theories regarding disability and equality.[80] Her text examines the theories on capabilities and the constitutional clause on equality and disability. But none of these books deals with disability in the colonial context.

To understand the importance of legislation and the theory of disability, the following work may be cited. Bickenbach categorizes four kinds of remedy that legislation provides to the disabled—anti-discrimination legislation, constitutional equality, entitlement programme, and human rights manifestos.[81] Joseph Raz argues that the rights of someone can protect the interest of the person in question as well as someone related, i.e., a disabled and his/her dependent or caregiver.[82] Joel Feinberg states that having access to the right is not sufficient, but the ability to use it is what makes it valuable.[83] Hart argues that a right is to protect individual choice which means standing in an advantageous position of bilateral choice.[84] To raise one's voice for rights, one must know the rights to which he/she is entitled. According to Wesley Hohfeld, the concept of rights has four elements—claim, liberty, immunity, and power.[85] Stoljar states that rights do not

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[78] Renu Addlakha, ed. *Disability Studies in India: A Global Discourse* (Delhi: Routledge, 2013), 13.

[79] G. N. Karna, *Disability Studies in India: Retrospect and Prospects* (Delhi: Gyan Publishing, 2002), 9.

[80] Jayna Kothari, *The Future of Disability Laws in India* (Delhi: University Press, 2012), 18.

[81] Jerome E. Bickenbach, "Disability Human Rights, Law and Policy," in *Hand Book of Disability Studies*, ed. Gary L. Albrecht, D. Katherine, D. Sleeman, and Michael Bury (London: Sage Publication, 2001), 568–573.

[82] Christopher Heath Wellman, "Liberalism, Communitarianism, and Group Rights," *Law and Philosophy*, no. 8 (1999): 16–20.

[83] Joel Feinberg, *Philosophy of Law* (London: Wadsworth Pub, 1944), 12.

[84] H. L. A. Hart, *The Concept of Law* (Oxford: Clarendon Press, 1961), 39.

[85] Wesley Newcomb Hohfeld, "Fundamentals of Legal Conceptions as Applied in Judicial Reasoning," *Yale Law Journal*, no. 26 (1917): 117–119.

always include X and Y and their correlative duty, but also includes some D which is the government that should ensure that the claim is filled.[86] Even though the above-mentioned works discuss disability in terms of legality, there is a lack of 'social' contextual study of disability. The material reality of the disabled and the barriers in accessing promised legal protection is hardly a subject matter of these works.

Many Indian and European historians obliquely mention disability and special education in India in their writings. But there is no detailed investigation in their writings about the emergence of special education and disability care in Colonial India. Writers like Roy, Amesur, Bhatt, Mukerji, Taylor and Taylor, Mohsini, Gandhi, Mani, and Ahuja tended to overemphasize the European involvement while dismissing the role of both the native agencies and the native disabled.[87] There is an overwhelming leaning towards colonizers and overshadowing of 'facts' in these works especially around the origin of disability care in Colonial India. For example, all of these writers talk about the role of Annie Sharp as the 'first' educator of the blind in Colonial India, whereas in reality, historic documents strongly testify that Miss Asho who was a blind herself was the first one who conducted formal study sessions for the blind by starting a school. This marginalization of the disabled and their work in the ableist narrative of history is a common practice in academia and Indian history narratives also are not free from this bias.

There is the problem of chronology in the works related to disability in Colonial India. For instance, Amal Shah argues that education of the blind in India only had a history of thirty years.[88] His work omitted the history of the emergence of the Lucas system of the script in Bengal Military Orphan Asylum around 1840 and the work of Mr. and Mrs. Leupolt in Banaras. He is dismissive of the missionary education of the disabled

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[86] Jennifer Nedelsky, "Preconceiving Rights and Constitutionalism," *Journal of Human Rights*, no. 7 (2008): 141.; Peter Jones, "Re-examining Rights," *British Journal of Political Science*, no. 7 (1989): 105–107.

[87] Suresh C. Ahuja, "Rehabilitation of Visually Handicapped Indians: The Problems and the Numbers," *Journal of Visual Impairment & Blindness*, no. 84 (1990): 270–273.; S. R. Mohsini and P. K. Gandhi, *The Physically Handicapped and the Government* (Delhi: Seema Publications, 1982).; Subodh Chandra Roy, *The Blind in India & Abroad* (University of Calcutta, 1944), 6.; C. A. Amesur "Welfare of the Physically Handicapped," in *History and Philosophy of Social Work in India*, ed. A. R. Wadia (Bombay: Allied Publishers, 1961), 330.; Bhatt, *The Physically Handicapped in India*, 25.; Rajendra T. Vyas, "The Blind–Other Aspects," *Encyclopaedia of Social Work in India*, no. 2 (1968): 59–63.; S. N. Mukerji, *Education in India Today and Tomorrow* (Baroda: Acharya Book Depot, 1964), 408.; Rama Mani, *The Physically Handicapped in India Policy and Programme* (New Delhi: Ashish Publishing House, 1988), 154.

[88] Amal Shah, *Problems of the Blind in India* (Calcutta: 1941), 21.

by calling it 'Bible study.' The autobiography of James Leupolt demonstrated that their educational endeavours went beyond the Bible.

It is hard to trace the genealogy and chronology of mission education of the disabled in Colonial India. Vohra in her text gives an extensive list of schools for educating the deaf.[89] She placed 1883 as the beginning year for the education of the deaf. Rikhye placed the year 1921 as the beginning year for the education of the mentally disabled, but Miles argued that the documentation of the year suggested that the programme was limited to literate inmates and memorization, and may not be taken as 'education.'[90] The celebrated work of Taylor and Taylor, published in 1970, is the first account concerning Indian disability services written using a historical perspective.[91] But Miles argued that the pre-1947 documentation of the Taylor and Taylor was poor to the point that they were dismissive of the limited data collected about the mentally disabled and their education in India.[92] Taylor and Taylor's account of disability in Colonial India lacked comprehensiveness and the history of special education up to 1934 is missing. Taylor and Taylor only talked about the establishment of the Central Nursing Home at Ranchi in 1934 and regarded it as a limited programme.

Many historians like Bhatt undervalued the role of the colonial government in dealing with the disabled in India.[93] Miles however argued that even though later activities were mainly taken up through voluntary effort, it was not possible to do without the help of the local government. Miles based on the documentation by Seth, Sargent, and Banerji, asserted that the government help in the form of a small budget, alms, institutionalization, and building was given for the benefit of the disabled.[94] The problem with these accounts is that instead of filling gaps in the chronology, they insist that any other attempt to educationally rehabilitate the disabled in Colonial India was small-scale and non-impactful.

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[89] Roopa Vohra, "Institutional Services for the Speech and Hearing-impaired Persons in India," *Disabilities and Impairments,* no. 2 (1988): 59–81.

[90] Doris Catherine Hall Rikhye, *Mentally Retarded Children in Delhi, India: A Study of Nine Schools* (Ann Arbor: University Microfilms, 1980), 36.

[91] Wallace W. Taylor and Isabelle Wagner Taylor, *Services for the Handicapped in India* (New York: International Society for Rehabilitation of the Disabled, 1970), 15.

[92] M. Miles, *Disability Care and Education in 19th Century India* (Birmingham: 1997), 8.

[93] Bhatt, *The Physically Handicapped in India,* 36.

[94] Dev Raj Seth, *A History of Western Education in India, 1854–1920* (PhD Thesis: University of Punjab, 1936).; John Sargent, *Society, Schools, and Progress in India* (Oxford: Pergamon, 1968).; S. N. Banerji, "Sixty Years with the Deaf in India," *The Deaf in India*, no. 1 (1949): 3–9.

To understand how Christianity and colonial missionaries dealt with the disabled population in India, it is imperative to refer to texts that talk about disability in Christianity. Christianity advocates that all are 'broken' in one way or another and all live a 'limited' life. To accept those limitations, Creamer states that it is important to create a theological 'normal' that includes the experience of disability.[95] Creamer further argues that the main problem with the theological model of disability is that Christian scriptures do not state or convey where the disabled belong. She suggests a 'model of limits' and argues that under this model, the disabled can determine their limit and their limit to creatively construct an image of God. Kathy Black argues that Christianity projected an image of an 'interconnected' God, an image of Jesus who interconnected with and influenced people.[96] Black in her text explains that theological efforts could improve the condition of the disabled but they could also strengthen oppressive structures. She continues that Christian dealing with the disabled was done under the hegemony of the able and thus the disabled were left voiceless in their matters. Brett Webb-Mitchel also argues that the church popularized an offensive 'inspirational sob' story through an ableist narrative while dealing with the disabled.[97]

Nancy Eiesland states that Christianity created an image of a disabled God.[98] Eiesland writes that Christ as a disabled God was understood to be the symbol of transformation and liberation in the life of the disabled. She argues that the church had been harmful in its relationship with the disabled because Christian traditions advocate a strange connection between God and the disabled and built on the idea that the disabled were either divinely blessed or darned. She writes that Christianity represented disability as the signs of saintliness to be admired, signs of the greater power of the God to be pondered, and suffering to be pitied. But both Eiesland and Black failed to theorize the impact of religion on disability under hierarchical power structures.

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[95] D. B. Creamer, *The Withered Hand of God: Disability and Theological Reflection* (PhD Thesis: University of Denver, 2004), 31.

[96] Kathy Black, *A Healing Homiletic* (London: Abingdon Press, 1997), 29.

[97] B. Webb-Mitchell, *Unexpected Guests at God's Banquet: Welcoming People with Disabilities into the Church* (New York: Crossroad, 1994), 8.

[98] N. L. Eiesland, *The Disabled God: Toward a Liberatory Theology of Disability* (Nashville: Abingdon Press, 1994), 22.

M. Miles is a prominent scholar who studied the body in the context of colonialism and colonial medicine. He traced back the history where segregation of the disabled bodies and colonial community-based care disrupted the traditional disability care in India.[99] Miles writes that there is an absence of terms about aspects of disabilities in the Indian context and he attributes this absence to 'proof of discrimination.' Even though he states that conceptualization of disability might be different in the Indian context, he seeks universal themes and categories in Indian 'legal, religious, medical, and folk lore' material. While doing so, he analyzes the life of the Indian disabled with a Eurocentric perspective and argues that the disabled were treated as monsters in India and places colonial medicine on a high pedestal. But he failed to contest how colonialism treated the disabled as 'faulty' and how it created a new 'normal.' He also failed to discuss the negative impacts of colonial rule on matters related to charity, care, and rehabilitation of the disabled community in India.

Medicine and disability had a strong connection with each other in Colonial India. Shilpa Anand in her text talks about how the colonial medical model in India created a distorted understanding of disability.[100] She argues that colonialism and its policies related to epidemics, religion, institutionalization, and medicine placed the disabled as 'abnormal.' She opines that such a medical model has a dehumanizing tendency while dealing with the disabling factor of disease. She continues that there is a lack of an explanation of how agencies worked with disability and how colonialism created the notion of 'ableness' which intensified segregation of the disabled and stigma around disability.

Bhargavi Davar in her work talks about the importance of disability discourse while dealing with the study of mental health.[101] But unfortunately, disability is hardly a subject matter of texts that deal with the development of mental health in India. The development of psychiatry and mental health care was seen as a Western endeavour by

[99] M. Miles, "Disability in an Eastern Religious Context: Historical Perspectives," *Disability and Society* 10, no. 1 (1995): 49–69.

[100] Shilpa Anand, "Historicizing Disability in India: Questions of Subject and Method," in *Disability Studies in India: A Global Discourse, Local Realities*, ed. Renu Addlkha (Delhi: Routledge, 2013), 23–38.

[101] Bhargavi Davar, "Legal Framework for and Against People with Psychosocial Disabilities," *EPW* 47, no. 29 (2012): 87–95.

historians like Erwin Ackerknecht, George Zilboorge, and Roy Porter.[102] According to them, science and medicine were coined by the West. The power structure in the practice of psychiatry and asylum care was discussed by historians such as Andrew Scull who found similarities between asylums and prisons. David Rothman looked at the negative impact of the institutional discipline of the insane.[103] Authors like Nancy Tomes and Anne Digby criticized the colonial institutionalization of the insane but their work remained Eurocentric.[104]

In the Indian context, Thomas Metcalf argued that after 1857, the colonial state was more intrusive which resulted in more legislation.[105] Bhattacharya writes that such intrusive nature of the state might be a reason for the passing of lunacy laws.[106] He goes on to say that it also resulted in more colonial involvement in science and medical institutionalization. J. Mouat also argues that criminalizing the 'other' was the main impact of colonial intrusive efforts.[107] The asylum care and its impact were further discussed by Frantz Fanon and Anand Yang.[108] Fanon called colonial asylum care 'systematized dehumanization.' Yang writes that asylum in India worked as a form of punishment. But these studies lack a disability-focused narration.

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[102] Erwin Ackerknecht, *A Short History of Psychiatry* (New York: Hafner, 1968).; Gregory Zilboorg, *A History of Medical Psychology* (New York: W. W. Norton, 1967).; Roy Porter, *A Social History of Madness: Stories of the Insane* (London: Phoenix Giants, 1996).

[103] Nancy Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840–1883* (Cambridge: Cambridge University Press, 1984).; Anne Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796–1914* (Cambridge: Cambridge University Press, 1985).

[104] Andrew Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth Century England* (London: St. Martin's Press, 1979).; David Rothman, *The Discovery of the Asylum: Social Order and Disorder in A New Republic* (Boston: Little Brown, 1971).

[105] Thomas Metcalf, *The Aftermath of Revolt: India, 1857–1870* (Princeton: Princeton University Press, 1964), 92.

[106] Anouska Bhattacharyya, *Indian Insanes: Lunacy in the 'Native' Asylums of Colonial India, 1858–1912* (PhD Thesis: Harvard University, 2013), 17.

[107] Ross Lawrenson, "Frederic John Mouat, 1816–1897," *Journal of Medical Biography*, no. 15 (2007): 201–211.

[108] Frantz Fanon, *The Wretched of the Earth* (New York: Grove Press, 1965), 42.; Anand A. Yang, "Disciplining 'Natives': Prisons and Prisoners in Early Nineteenth Century India," *South Asia* 10, no. 2 (1987): 31–42.

Jonathan Sadowsky writes that colonial medicine was mostly developed when there was a medical threat to the military or local workforce.[109] He also talks about how colonial psychiatry and medicine were used as a forensic tool to discipline the 'other.' Waltraud Ernst's account of insane asylums discusses how the asylum both in India and Britain worked on the same principle of 'control.' James Mills's account of the insane asylums in India considers the diagnostic and treatments regimes available.[110] He further elaborates on the development of the treatment regimes in the latter part of the nineteenth century when Indian students engaged with European psychiatry which resulted in the emergence of 'hybridity.' Megan Vaughan was an important historian who analyzed how colonialism made a distinction between sane and mad, impaired and unimpaired, and pathological and normal, based on racial division.[111]

Goffman, Rajpal, and Ernst talk about the segregation of the diseased and disabled.[112] They also talk about the medical treatment and the living condition of inmates in asylums. Erving Goffman writes that asylums became a place of residence and work where people were segregated. Rajpal argues that the colonial government did not bother about the therapeutic environment, comfort, and domesticity of the patients. Ernst talks about space in the context of colonialism and argues that colonizers practiced the geographical separation of asylums to bring distance between different races and classes. Most of these studies lack an understanding of the social reality of the disabled in India. The historicity of disability and the disabled is an area that is still not explored widely. The lack of study on the colonial agencies and their interaction with the disabled creates gaps in the field of disability studies.

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[109] Jonathan Sadowsky, "The Reality of Mental Illness and the Social World: Lessons from Colonial Psychiatry," *Harvard Review of Psychiatry* 11, no. 4 (2003): 91–112.

[110] James Mills, *Madness, Cannabis, and Colonialism: The 'Native Only' Lunatic Asylums of British India, 1857–1900* (New York: Macmillan, 2000), 185.

[111] Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford: Stanford University Press, 1991), 17.

[112] W. Ernst, *Mad Tales from the Raj: The European Insane in British India, 1800–1858* (New York: Anthem Press, 1991), 98, 142–147.; Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York: Anchor Books, 1961), 11.; S. Rajpal, "Psychiatrists and Psychiatry in Late Colonial India," *The Indian Economic & Social History Review* 55, no. 4 (2018): 515–548.

1.4. Chapter Overview

The main aim of my research is to examine how the disabled interacted with the colonial agencies in India. The project is also aimed at finding out how colonial agencies defined, categorized, and treated disabilities and people with disabilities and what model they used. The second chapter talks about the colonial census of India and the inclusion of disability in its clauses. The colonial government is credited with arranging for the first-time systematic enumeration of the disabled population in India. Official censuses from 1881 to 1931, under the term infirmity, categorized disability into four sections—the insane, the blind, the deaf-mute, and the lepers. The way colonial censuses defined disability was changed over the years. The chapter also talks about the errors in these enumerations in terms of the lack of clarity in the definition and categorization. Colonial census figures could not be taken as absolute as it has methodological flaws. Even so, the colonial census is the only source that can provide any numerical evidence about the disabled in Colonial India.

The colonial government is also credited with the passing of legal acts and clauses that deal with the problems of the disabled. The third chapter discusses mental disabilities stipulated under the colonial legislation and the legal remedies of colonial acts involving physical disability. The colonial legislation mentioned disability in their clauses directly and indirectly, and this was the result of the political changes in India and the legislative amendments in Britain. The Lunacy Act of 1858 (both Supreme Court and District Court Acts) and the Lunacy Act of 1912 defined insanity more in line with mental disabilities rather than mental diseases. The lunacy acts defined insane as a person who is not capable of managing his/her affairs. The ‘capacity’ under the act was analyzed in terms of one’s social usefulness examined by a committee including officials from the court and insane asylums who did not have expertise in psychiatry or psychology. The acts also provided provisions for the securing of the estate of the person in question, and a mentally disabled person was looked at as unfit to own or inherit a property irrespective of his/her ‘capacity.’ These acts established that disability is a legal liability to be protected.

It is under these lunacy acts that asylum care of the insane was established in Colonial India which eventually created a new segregated public place within society. These regulations emerged out of a colonial need to understand the Indian mind. The development of education and racial complexities also pushed the government to pass these laws. Mental illnesses and mental disabilities were also mentioned in the clauses of

the Indian Penal Code and Calcutta Police Act of 1866. Under these regulations, mental disability was criminalized in India and was associated with deviance and disturbance. Marriage, divorce, contract, property, will, ward, tax, and succession laws in Colonial India gave overwhelming importance to mental capacity, ability to consent, judgment elements, and reasoning ability of a person while neglecting the varying differences of different mental disabilities.

There are no such legislations that solely deal with physical disability in Colonial India, but the Leprosy Act in 1898 was passed to regulate the treatment of lepers. The act provided a segregated place for them to live. Motor Vehicle Act of 1930 also included clauses on the physically disabled. Workmen's Compensation Act of 1923 was the only act that talked about compensation given to those who got injured or met with disabling accidents in the workplace. The colonial anti-beggary laws criminalized physical disability. Even though colonial Indian legislations added clauses on disability, it strengthened segregation and failed to make sense of differences in capacity.

Missionary efforts of special education and Christian theological influences of the native disabled are the subjects of the fourth chapter. It was not the state but the missionaries that took the first step towards the education of the disabled. In other words, the conceptualization of the awareness about special care and education for the disabled in India started with the idea of charity by the missionaries. Special education in India began with the vocational training of the blind by the missionaries. They incorporated Moon and Lucas scripts in their schools in various parts of India. The curriculum developed in these schools was Christian, but the medium of instruction was a mix between English and Indian languages. The deaf-mute education in India was a collaborative effort of missionaries along with Indian educators. Missionaries with help of the native educators made language models of sign for the deaf-mute in India. Even though education of the mentally disabled was underdeveloped compared to the model of special education of the blind and the deaf-mute, missionaries with the help of behavioural therapy tried to educate the mentally disabled. Through the preaching of Christianity in these schools, missionaries constructed the idea of ‘divinity of brokenness’ to the disabled in India. They preached about the divinity of suffering and used education as a tool to integrate the disabled into Christianity. Christianity was appealed as a religion of ‘inclusion’ and this continuous mission work among the disabled population increased the popularity of Christianity in India.

Colonial medicine and its impacts on the disabled are the subject matter of the fifth chapter. Medicine was a principal-agent of social change in Colonial India. Colonial medicine played an important role in the development of the social, economic, and cultural conditions of the disabled. In the mid-nineteenth century, the colonial state established a few eye infirmaries and ophthalmic hospitals in Bombay, Madras, and Calcutta to treat eye infections and diseases like trachoma, cataract, and neo-natal blindness. In addition to serving as training sites to treat eye infections, local health training offices were also established. Vaccination policies against smallpox also reduced blindness drastically. Orthopedic disability is discussed in relation to polio, paralysis, and congenital disabilities. There was a great lack of information about this type of disability in Colonial India. Institutionalization of the disabled became a new norm and the first institution to be introduced was for the insane. New treatment regimens were introduced and the asylums became places of control and discipline. Treatment of insanity was affected by medicine, architecture, diet, and work, but there was no such clear distinction executed between mental illness and disability. Leprosy became a tool for political discourse and was discussed in relation to segregation and missionary medicine. The chapter also talks about how colonial medicine strengthened ableism in India.

My thesis has used evidence from primary sources. Primary sources have been collected in the form of archival data, digitalized manuscripts, medical records, missionary records, autobiography and biography and journals of the missionaries, records of the gazetteers, newspapers, census reports, and legal documents about the particular acts. These sources are collected from the digital websites of National Archives of India, New Delhi; South Asian Archives; National Library, Calcutta, and National Library of Scotland. Primary literature texts are majorly collected from the Digital Archives of India, the Internet Archive, and the Library of Congress. To collect census reports, the official website of the Census of India and Census Digital Library was referred to. To collect the original texts of the legal acts, official websites such as Legal Service in India and Kanoon India were referred to.

Chapter Two

THE COLONIAL CENSUS AND THE DEFINITION OF DISABILITY IN COLONIAL INDIA

The main contribution of the colonial investigation concerning 'disability' was the official categorization and inclusion of the disabled in the official censuses of Colonial India, conducted from 1881 to 1931. The colonial census from 1881 to 1931 had, for the first time, ascertained the disability status of India's disabled residents. Colonial census reports highlighted the disabled sections by documenting them under specific categories—the insane, the blind, the deaf-mute, and the lepers. Nevertheless, in the censuses, these four sub-groups were titled 'infirmities,' common terminology used in the nineteenth century, denoting physical and mental weaknesses. To grasp the different types of disabilities existed in Colonial India, it is imperative to look at the demographic distribution of these four disabilities. It is equally necessary to understand the thought process behind the census definitions and groupings of disability and whether there was any bearing on policymaking. It therefore would lead to an investigation of the history, the types, and the determinant factors of 'disability' in Colonial India. The history of disability statistics in Colonial India will enable us to make sense of the diagnosis and treatment for each type of disability.

2.1. Demographic Distribution of the Disabled Population, 1881 and 1891 Censuses

A population census is a process of collecting and analyzing demographic, social, economic, and cultural data of all persons in a country in ten years.[1] Conducting population censuses in India which is known for its diversity is a Herculean task. The information collected through the census about wealth, houses, amenities, socio-cultural features of the population make the Indian census a rich source of information to researchers, administrators, data users, and planners.[2] From 1881, disability statistics were included in the Census of India.

[1] United Nations, "Principles and Recommendations for Population and Housing Censuses," *Statistical Papers* 67, no. 2 (2008): 8.

[2] Pradeep Kumar, "Legal Aspects of Colonial Census Policy in India," *International Law Review* 12, no. 7 (2006): 13–18.

The 1881 Census was the first-ever synchronous census of Indians which was undertaken.[3] It was for the first time in 1881 that the census had included a scheduled question about disability in India. The 1881 Census memorandum stipulated that the last column of the census schedule was dedicated for the disabled and the collectors were asked to enter particulars of the insane, deaf-mute, blind, and lepers.[4] The 13th schedule was titled 'infirmities.'[5] These divisions of the disabilities were the first official categorization of disability in British India. These categories remained unchanged until the end of colonial rule.

The table under the section of infirmity was subtitled 'Total Number of Insane, Blind, Deaf-Mute, and Leper for India.' The table was again subdivided into different age groups and as per male-female ratio.[6] It is significant to note that the age categorization covered the life span of an average Indian. Even people whose age was not specified were covered though registration of birth and death was not popularly practiced in Colonial India. The total number of the male insane in India was recorded at 50,328; female insane at 30,776; blind males at 2,54,136; blind females at 2,72,326; deaf-mute males at 1,21,272; deaf-mute females at 75,943; leper males at 98,982 and leper females at 32,638.[7] It is noted that the number of blind females all over India was high. That may be related to the low standing of women in Colonial India. Half of the female blind population was under the age of sixty which illustrates that poor nutrition and low access to medical help were the reasons why blindness was high among the female population.[8]

The General Census Report of 1881 states that it is important to treat these statistics of insanity cautiously as "in more advanced countries than India, experience has shown how much omission has occurred even in recent years in the correct registration of the insane."[9] Moreover, the report adds that it is only in India that the violent mentally disabled are recorded as insane.[10] Insanity was associated with violent behaviour in

[3] The 1881 Census covered territories of Bengal, Madras, Bombay, Punjab, Assam, Berar, Coorg, Ajmer, Rajputana, Mysore, Baroda, Cochin, Central India, and Travancore.

[4] Report on the Census of British India:1881 (London: Eyre and Spottiswoode, 1883), 256. (1881 Census Report from here on).

[5] Ibid., 256.

[6] Ibid., 258.

[7] Ibid.

[8] Ibid., 259.

[9] Ibid., 256.

[10] Ibid.

Colonial India and there was a tendency to call people with a violent criminal background 'insane' without proper diagnosis. Meanwhile, in Europe, the recognition of criminal lunatics was done under a proper medical environment. It is interesting to learn that the number of insane in Europe was higher as compared to India. The census organizers believed that the number of female insane ought to be higher in India because of forced and early widowhood and insufficient nutrition.[11] The reason why the figures in India were low was that the condition of insanity in Europe was tested by medical practitioners, which was not done in India.[12] The report stipulated that "thus many persons who have suffered from harmless manifestations of mental disease or whose attacks are periodical have not been returned as insane, although they would have been so considered in Europe."[13] The report further states that 'idiocy' was omitted from the European censuses. Census enumerators from Europe believed that sensitive questions regarding mental disability like 'idiocy' would result in wilful concealment from the family side due to the social pressure of accepting mental disability.[14] The number of insane per 100,000 in Burma was high but low in the North-West Frontier Provinces.[15] Additionally, the data from other provinces was elucidated in the report.[16] There is great variation between the figures for Burma and Bengal, and the report states that it may be due to local reasons such as geography and climate.[17]

Compared to the statistics for Europe, the number of the blind in India was high mainly because, in Europe, only a complete blind is considered as blind, whereas in India, even a partially blind is considered as blind.[18] The statistics of the blind in India show that India had twice as many blind people as England. The area of Punjab registered the highest number of the blind. In every province of India except Mysore, Coorg, Assam, and Cochin, the blind numbers were higher than England's total number of blind.[19] There are noticeable variations in the figures between Punjab, Bombay, and Bengal. But still, the

[11] Ibid., 257.

[12] Ibid.

[13] Ibid.

[14] Instead of the term 'idiot,' from the 1901 Census, Britain added terms like 'feeble mind' and 'imbecile' to collect information on insanity.

[15] 1881 Census Report, 257.

[16] Ibid.

[17] Ibid.

[18] Ibid., 259.

[19] Ibid., 262.

reasons for the high number of cases in some provinces and low numbers in others could not be figured out. The Berar Census enumerator Mr. Kitts opined that whatever the cause of blindness, it was widely prevalent in Berar, Central Province, and Bombay.[20]

The 1881 Census provided a table to demonstrate the sex ratio of the blind enumerated in the survey. The collected data indicates that blindness is elevated in the female population on the whole, but the scenario varied between provinces. Assam, Coorg, Cochin, and Hyderabad showed lower numbers of female blind population and Punjab showed similar figures for men and women.[21] The Ajmer Census Report stated that more women suffered from blindness than men. Berar was similar to Ajmer. The Census General Report confirmed that there are 24 blind females for every 10,000 against 22 blind males for the same number.[22] The largest age group among women who were affected by blindness was the older women.

Bourdillon, Chief Census Enumerator from Bengal stated that blindness and muteness were fairly common conditions that prevailed in Bengal.[23] The number of females (144 for every 100,000) affected by blindness as compared to males (136 for every 100,000) was higher. The proportion of the blind in Bengal was below the average of the Indian standards but higher than certain European countries (Bengal: 138 for every 100,000; England: 95 for every 100,000; France: 84 for every 100,000; Italy: 105 for every 100,000; Germany: 88 for every 100,000). Similarly, Kitts, 1881 Census enumerator states that blindness was elevated in infants (153 for every 100,000).

Further, the number of deaf-mute given in the 1881 Census was higher than England's number (England: 51 for every 100,000, India: 86 for every 100,000). While the highest number of 123 deaf-mutes for every 100,000 belonged to Bengal, the lowest recorded figure of 32 for every 100,000 was in Cochin and Hyderabad.[24] The difference between the two sexes was noteworthy in that there were more men with the condition than women. The proportion projects that for every 1,00,000, there are 103 deaf-mute males and 67 females.[25] Along with Bengal, Punjab exhibited a very high number of

[20] Ibid.

[21] Ibid., 262.

[22] Ibid., 263.

[23] Ibid.

[24] Ibid., 264.

[25] Ibid.

deaf-mutes (114 for every 100,000). The 1881 Census Report stated that "it is probable that in the native states in each instance, the deafness of old age has been shown in a return which should embrace only congenital deaf-mute."[26]

The religious variations among the deaf-mute are also provided in the 1881 Census. The numbers from the Muslims were so high that this was practically the section of the population most liable to deaf-mute disability (98 for every 100,000). Christians had a lower proportion (46 for every 100,000) of the deaf-mute; among the sexes, Jews had 478 deaf-mute males to 100 deaf-mute females in every 100,000. The high number of the deaf-mute (222 male and 151 female deaf-mutes in every 100,000) were present in the older age group which showed that it was not only the congenital deaf-mutes who were included in the census.[27]

The representational table under the title of 'Total Population of Lepers' was included in the 1881 Census.[28] The table is divided by the ratio of sexes (male 16 percent for every 100,000; female 9.2 percent for every 100,000). From the table, one can note that Berar had the highest number of leprosy patients viz. 140 for every 100,000.

The second census conducted in 1891 followed the same pattern as the 1881 Census. In this census, Sikkim, Burma, and Kashmir were included to ensure more coverage. The census questionnaire contained 14 questions and the section on infirmities was continued. [29] In 1891, the rationales for the collection of the disability data in the census were noted. Firstly, it was the social dimension of disability and desirable state policy, and secondly, the medical dimension.[30] This census also followed the four divisions among the disabled; the unsound mind, deaf-mute by birth, complete blind, and the lepers. The key setback in this census was related to the language differences. People who dealt with data collection were confused about the colloquial terms of various disabilities. For example, the local term for the partially blind in Assam was identical to that for the fully blind in the Brahmaputra Valley.[31]

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[26] Ibid., 263.

[27] Ibid.

[28] Ibid., 267.

[29] Report on the Census of British India: 1891 (London: Eyre and Spottiswoode, 1893), 226. (1891 Census Report from here on).

[30] Ibid., 227.

[31] Ibid

According to the 1891 Census General Report, 4 insane males and 3 insane females; 10 deaf-mute males and 7 deaf-mute females; 22 blind males and 24 blind females; and 8 male lepers and 3 female lepers were found for 10,000 of each sex.[32] Nearly two-thirds of the insane in both sexes were over the age of 24, while the deaf-mute was nearly half in the same age group. In the case of the blind, there was more divergence between the two sexes and the affected males began to suffer from this affliction at an age considerably earlier than the females.[33] Twenty percent of the female lepers were under the age of 25 compared with 13 percent of the males affected in that age group.[34] It is significant to note that in the case of the deaf-mute, the count between the age of 5 and 10 was minimal, although there was a sudden rise after 20 years of age which elucidated that there was reluctance from the parents to admit that their child is a deaf-mute.

When it came to insanity, the highest collected incidence was witnessed in Sindh (107 for every 100,000) and the lowest figure was compiled for Berar (19 for every 100,000). The changes in the criteria of 'lunacy' produced some changes in the collected data. The 1881 Census defined insane as people with 'unsound mind,' but in 1891 it was further elaborated as 'people who could not take care of their affairs' owing to their state of 'unsound mind.' The congenital also became a criterion to identify insane which eventually reduced the total number of the insane. The Sindh and Burma forest tribes were mostly affected by Cretinism, a form of congenital mental disability that led to a rise in the figures.

The women of Burma were more prone to insanity than the men. In Assam, the elevated figures were essentially due to the return of the numbers of Cretinism.[35] To a smaller extent, the spread of hospitals and dispensaries in the rural parts of the country must have checked the growth of insanity, since the patient, who perhaps was only temporarily epileptic could be attended to by trained doctors before the disease was confirmed.[36]

[32] Ibid., 228.

[33] Ibid., 229.

[34] Ibid.

[35] Ibid., 230.

[36] Ibid., 231

In the case of blindness, females in the age group of 50-plus showed proneness to blindness. The numbers illustrated that over 40 percent were over 55.[37] Unlike female blindness, blind males preponderated in the age group of 30-plus. The blind over 55 was only about a third. The numbers of female lepers were low when compared to the males. It appears that grouping the four infirmities, the disabilities escalated among males after 30 and among females after 35.[38]

From 1881 to 1891, it is evident that the number of infirmities reduced due to the high mortality rate related to famine.[39] For example, the records addressed the fact that in Madras, after the famine, the congenital infirmities of the eye tracts were reduced on a major scale.[40] Poverty and food scarcity related to famine killed thousands of disabled under the deficient care of families. Rising economic status and better access to medical facilities might have reduced infirmities among some of the sections of the population. The data showed that Bengal, Bombay, and Central Provinces were in the front position of this change, especially in the reduction of infirmities in infants aged 0–10 years. Baroda Census Report exhibited that there was a sudden rise in the figures in the case of blindness.[41] Further, Ajmer also illustrated differences and a rise in figures given the alterations in the criteria of blindness. The 1891 Ajmer Census started to include partial and old-age blinds. Thus it should be noted that even though the general disabled population was decreased, the rise in numbers in some provinces was because of the changing nature of definitions.

Nilagiri in the Madras Presidency and the surrounding hilly regions registered the lowest number of the blind at 49 for every 100,000.[42] This progress was primarily based on two things—the spread of dispensaries across the plain bringing trained assistance within the reach of many groups; reduction in blindness caused by smallpox due to a

[37] Ibid., 229.

[38] Ibid., 228.

[39] From 1850 to 1899, Colonial India witnessed 24 major famines and it had a major impact on the population. Millions died due to poverty and the rest had to live with disabling conditions. In the late nineteenth century, from 1899 to 1900, India witnessed another major famine due to a failure of British economic policies and uneven rainfall. Naresh Chandra Subash, *Famines in the Late Nineteenth Century India* (Munich: Rachel Carson, 2015), 13.

[40] 1891 Census Report, 228.

[41] Ibid.

[42] Ibid., 231.

decrease in smallpox incidence.[43] The number of female blinds was higher in all places except Coorg, Assam, and Hyderabad. It appeared that blindness tended to be more prevalent in hot and dry plains away from the hills and the sea. In north India, social customs favored its spread among women. But blindness was generally on the decrease as vaccination controlled the spread of smallpox and also because better medical facilities became generally available.[44]

The 1891 Census General Report showed that the deaf-mute in Bengal (153 for every 100,000) and Punjab (141 for every 100,000) bore a similar number as in 1881. Following Bengal and Punjab was Assam with 96 for every 100,000, while Sindh noticed a rise in its figure of 75 for every 100,000. The General Report pointed out that the Himalayan climate and the diverse diets must have caused this variation in the numbers.[45] In the case of blindness, the report notified a decrease from 1881. The decline was general throughout the returning tracts, except for Mysore and Assam, where the ratio had risen to 77 for every 100,000 and 96 for every 100,000 respectively.

Finally, the records for leprosy in Berar were still showing the highest number. Sindh and Ajmer again occupied the last two positions, but with a considerable dwindle in the prevalence of the lepers. The numbers of lepers were still high in Punjab (29 for every 100,000), North-West Frontier Provinces (54 for every 100,000), Bengal (93 for every 100,000), and lower tracts of Burma (92 for every 100,000).[46]

2.2. Demographic Distribution of the Disabled Population, 1901 and 1911 Censuses

The 1901 Census additionally incorporated the populations of Baluchistan, Rajputana, Andaman Nicobar, Burma, Punjab, and rural Kashmir.[47] The targeted population was counted on a numeral basis wherever detailed surveys were not feasible. This census contained a sixteen question-schedule and the question about the house number was included.[48] The 1901 Census General Report mentioned the criteria of infirmities in the

[43] Ibid.

[44] Ibid.

[45] Ibid., 235.

[46] Ibid.

[47] Bhagat Ram, "Census and Caste Enumeration: British Legacy and Contemporary Practice in India," *Genus* 62, no. 2 (2006): 119–134.

[48] Report on the Census of British India: 1901 (London: Eyre and Spottiswoode, 1902), 130. (1901 Census Report from here on).

following manner—"If any person is blind in both eyes or deaf and dumb from birth or insane or suffering from corrosive leprosy enter the name of the infirmity."[49] The census regulations asked the enumerator not to record information about partial blindness, post-birth deaf-dumb conditions, and white leprosy-affliction.[50] White leprosy is known as leukoderma which mimics symptoms of discolored skin patches of leprosy but is a skin condition in reality. This census data eliminated the possibility of disease-induced disability from the records.

1901 Census recorded 81,182 insane; 1,97,216 deaf-mute; 6,25,748 blind; 1,31,908 lepers in India and in total 9,37,062 disabled population.[51] These figures illustrate that the number of people affected with infirmities was abridged from the previous census and the report remarked on the prosperity that India enjoyed under British rule. It should be noted that the methodology to conduct the census and the disability data acted as a tool for the justification of British rule in India. The 1901 General Report claimed that "with the spread of education, the greater attention paid to sanitation and above all the larger amount of medical relief afforded at the public hospitals and dispensaries, the number of which is constantly growing must have combined to bring about an improvement in the general health of the people and reduce the number of the afflicted."[52] Furthermore, another reason for the reduced figures was that people with disabilities died in greater numbers when famines occurred. The Chief Census Enumerator from Bombay recorded a swift dwindle in disabilities and attributed it essentially to the impact of famine.[53] The total number of the disabled was reduced to 10,827 for Rajputana and 2,635 for Hyderabad respectively. The numbers showed that in Punjab, three-quarters of the total disabled were blind. In Assam, lepers were in majority. In Burma, the insane were in majority.[54]

In terms of the collected data of the insane, the census eliminated the errors of the previously established census by employing the technique of the 'ridged criteria.' Additionally, merely 'weak-headed' and whose mental derangement was a temporary

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[49] Ibid., 231.

[50] Ibid., 131.

[51] Ibid., 132.

[52] Ibid.

[53] E. Enthoven, 1901 Census of India: Part 2, Vol. 7, Report and Table from Bombay (Bombay: Government Central, 1992), 161. (1901 Bombay Census Report from here on)

[54] 1901 Census Report, 133.

disposition were eliminated from counting.[55] The predicament with the data related to the insane referred to the non-unanimity of the criteria in individual provinces. On the one hand, in some provinces, the term 'unsound mind' was included for all 'mental affliction' cases, in other provinces, the data was collected in a combined form for the deaf-mute and the insane. It led to mistakes on the statistical level. Many a time, the deaf-mute was recorded as insane.[56] The number of the 'unsound mind' in the young age groups which was condensed drastically indicates that Cretinism was not largely recorded in data. It is also underlined that the total number of insane is less by nearly 11 percent from the last census.[57] The 1901 General Report notified that one province that did not follow this trend was the United Provinces, where in the last census, the number of the insane was low. A greater decrease was found in Bombay, where the decline was up to 50 percent of the preceding census record. The general ground for this reduction was the impact of famine rather than the positive interventions like medicine.[58] In Madras, this change was due to the treatment of diseases in hospitals, and in Assam, the high mortality rate was considered as the reason.[59] It is in this census that the relationship between climate, social practices, physical ailments, race, and disability was duly established. The close connection with insanity, Cretinism, and goiter became a part of the census enumerations.[60]

The 1901 Census General Report reported that 12 males and 12 females were blind out of every 10,000 out for each sex. Assam recorded 25 blind for every 100,000; Bengal 3,594 blind for every 100,000; Bombay 2,038 blind for every 100,000; Burma 47 blind for every 100,000; Central Provinces 607 blind for every 100,000; Madras 4,344 blind for every 100,000; Punjab 14,239 blind for every 100,000 and United Province 43,361 blind for every 100,000. The figure of the blind shrank since 1891 in a greater number than any other infirmity. Mr. Burn, the 1901 Census enumerator noticed that the number of cases of eye diseases relieved or cured in the United Provinces during the last ten years was nearly 73,000 compared to 47,000 in the course of the previous ten years.[61] The reduction in the

[55] Ibid., 131.

[56] Ibid., 133.

[57] Ibid., 134.

[58] Enthoven, 1901 Bombay Census Report, 163.

[59] 1901 Census Report, 134.

[60] Ibid., 135.

[61] Ibid., 140.

high number of the blind in the United Provinces was primarily due to the extensive spread of medical relief and restoration of sight through surgeries for cataracts. Geographically analyzed, the number of the blind in Punjab was higher than in other places.[62] Bengal, Bombay, Madras, Assam, and arid parts of Bihar stand out with high numbers of blind residents. The number of blind women was still high at 197 for every 100,000 compared to the previous census reports. The General Report states that "the proportion of the female blind is always high; it seems clear that there is something in the adverse condition that prevails which especially alters the sight of women. It may be that women are less able than men to bear the glare and dust, or else that they resort less freely to the hospitals where medical relief is afforded."[63]

The 1901 Census considered 'congenital deaf-mutism' as the criteria for deaf-mutism eliminating disease-induced deaf-mutism. However, the dilemma with this parameter was the data for the deaf-mute and 'dumb' (a term to denote people who could not speak) were collected together and the collectors mostly wrote only 'dumb' in the column.[64] This detailing systematically omitted the registering of the deaf. When the census counted the target population, the affected were regarded as absolute deaf-mutes. This kind of tabulation also omitted those people who lost their speech by accident or illness. The records showed that there were 6 males and 4 females who were deaf-mute for every 1000 persons of each sex.[65] Even though the number of deaf-mute were reduced drastically, the key basis for this condition was not the medical expansion, but most of the congenital deaf-mute was short-lived, especially children. The deaf-mutes' age groups were much higher within the range of 0 to 5 years. After 10 years, it steadily dropped off which confirms that the deaf-mute had a short life span in India especially among infants. Kashmir enjoyed the reputation of harbouring more deaf-mutes in proportion to its population.[66] The deaf-muteness was subsequently common in the provinces of the Himalayas except for the United Provinces.[67]

[62] Ibid., 141.

[63] Ibid.

[64] Ibid., 138.

[65] Ibid.

[66] Ibid., 139.

[67] Ibid., 138.

The 1901 Census revealed that there was a swift alteration in leprosy and the public attention was shifted specifically to the 10-year timeline from 1891 to 1901. Due to extensive medical rehabilitation, the number of lepers decreased in the census records. According to the 1901 Census, 48 male and 17 female lepers were reported for every 1,00,000 of the population of each sex.[68] The data discloses that Berar showed the largest population of lepers and Assam was next.[69] The number of women lepers was low and male lepers in the age group of 20–40 was high.

In the 1911 Census, territories administered by the British and native states were covered except few sparsely inhabited and un-administered tracts in Burma and Assam.[70] The census had 12 questions which were similar to the earlier census. But its scope was extended by adding the 'Age' category completed by the last birthday instead of 'Age.' The question of the 'Place of Birth' covered the districts and provinces.[71]

The 1911 Census also categorized disabilities into four categories notably, 'Unsound Mind,' 'Deaf-mute,' 'Blind from Birth,' and 'Leprosy.' The focal modification was that the category deaf-dumb from birth was positioned last to avoid confusion with deaf-mutism with other conditions.[72] The Slip Method of Tabulation (SMT) was altered because this technique resulted in the occasional failure to transcribe infirmities from the schedules to the slips. In the 1911 Census, to circumvent this inaccuracy, a separate slip for the infirmities was introduced with 16 questions with slight changes and it was prepared by a group of staff focusing on this single task.[73] The tabulation was classified into five sections elucidating the number of the distribution of infirmities by age per 10,000 of each sex, the number of persons afflicted per 1,00,000 of the population of each province, the number afflicted per 100,000 persons of certain selected castes, the number afflicted per 1,00,000 persons at each age phase, and the number of females afflicted per 1000 males and these divisions were appropriately tabulated.[74]

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[68] Ibid., 143.

[69] Ibid., 144.

[70] Shirras George Findlay, "The Census of India, 1931," *Geographical Review* 25, no. 3 (1935): 434–448.

[71] Ibid., 435.

[72] Report on the Census of British India: 1911 (Calcutta: Superintendent Government Printing, 1913), 343. (1911 Census Report from here on).

[73] Ibid.

[74] Ibid., 345.

It may be noticed that there was an unremitting collapse in the figure and proportion of the persons afflicted from 1881 to 1901. It is equally understood that "though the proportion is smaller the number of the insane and deaf-mutes was about the same as it was thirty years ago. The number of lepers and blind however is less by about a sixth than it then was."[75] This positive change was due to the accuracy of each fresh census, exclusion of the erroneous entries, and the improvements that occurred in sanitation and medical relief. When one compared 1891 and 1911 census records, there had been a trivial dwindle in the total afflicted persons, but the proportion per 1,00,000 of the population fell from 315 to 267.[76]

Furthermore, the number of the insane had not changed. However, there was a colossal diminution in all other infirmities especially leprosy. The Census of 1911 transformed the definition of the 'insane' as one who suffered from more active mental derangement.[77] It was complex to distinguish between the 'weak-minded' and 'insane.' Therefore, this census included the severe forms of 'insanity' and 'imbecility' which were usually considered as congenital defects. The total number of the insane exceeded the 1891 figures by 9 percent. Nevertheless, their proportion per 100,000 of the population had fallen from 27 to 20 percent.[78] Even if the decline was general, the chief exceptions were the United Provinces and the North-West Frontier Provinces. In the United Provinces, the number of the insane per 100,000 of the population rose from 12 to 18 percent.[79] Following the United Provinces, Baluchistan, Assam, Bengal, Kashmir, Bombay, Punjab, Mysore, and Hyderabad registered increases.[80] The General Report stated that it was tricky to draw connections between the physical environment and insanity. The only exception to this argument was that of the hilly regions where Cretinism recorded a higher number of insanity. With the wider availability of medicine by 1911, the understanding of disability was fairly scientific in Colonial India, whereby an average of 71 males and 53 females per 100,000 was deaf and dumb from birth. These numbers were much more similar to those obtained from the European countries. It was noted at the same time when heredity factors and their connections with disabilities were

[75] Ibid., 344.

[76] Ibid.

[77] Ibid., 345.

[78] Ibid., 346.

[79] Ibid., 146

[80] Ibid., 350

discussed in the medical field. It was in 1911 that the '*Toval Statistical Society Persona lderton Lame*' concluded that parents of the albinos, deaf-mutes, and the insane were relatively more often blood relatives and that if parents were so afflicted, the children were more likely to be similarly afflicted.[81] The deaf-mutism was most common in Sikkim where 25 persons per 100,000 suffered from it. It was equally common in Kashmir, North-West Frontier Provinces, Baluchistan, Madras, Assam, and Bihar. It was however less prevalent in Bombay and the United Provinces.

There was a general observation that blindness was common in tropical countries like India particularly in Punjab, Baluchistan, United Provinces, and Rajputana where rainfall was less and the climate was dusty. Even though these provinces witnessed a slight increase in blindness, the total number of the blind was fewer in 1911, by about 15,000 than it was in 1891.[82] Blindness was the only infirmity from which women suffered more than men. The recorded data displayed that "the total numbers of the deaf-mutes are slightly larger than 1891. This is because some of the tracts since included within the scope of the return contain an exceptionally large number of persons thus afflicted than in the area enumerated in 1891."[83] It was closely followed by the 1911 Census wherein 14 persons for every 10,000 of the population were blind, whereas it was only 9 per 10,000 in most European countries and the United States of America.

In India, according to the 1911 Census, 51 males and 18 females per 100,000 people of each sex were lepers. Assam suffered the most, followed by Burma, Bihar, Orissa, Central Provinces, Berar, Madras, Bengal, Bombay, and United Provinces in that order.[84] In Punjab and North-West Frontier Provinces, there were only 17 male and 8 female lepers for 100,000 of each sex.[85] In North Arakan, Nahan, Chamba, Almore, Jankura, Birbhum, and Burdwan districts of Bengal, leprosy was commonly prevalent and widely scattered.[86] While female lepers were quite low, many male lepers living as beggars were recorded. In the leper asylums in Bengal, Bihar, and Orissa, male lepers were twice in several females. The records on caste indexed that lower castes suffered

[81] Ibid., 354.

[82] The slight increase of blindness among individual provinces was attributed to the more coverage of rural areas. Ibid., 352.

[83] Ibid., 354.

[84] Ibid.

[85] Ibid.

[86] Ibid.

from leprosy in higher numbers in 1911. The proportion of Christians among lepers was also high, but the General Report stated that it was simply because most of the asylums were managed by the missionaries who made many converts among the inmates. The number of lepers dwindled from 126,000 in 1891 to 109,000 in 1911 even though the number of persons who suffered from the other infirmities remained almost stagnant.[87] The alteration in leprosy counts must have occurred because of the upgradation of sanitation and asylum works.

2.3. Demographic Distribution of the Disabled Population, 1921 and 1931 Censuses

The fifth census of British India was conducted in 1921. The census aimed at collecting data from Colonial India which as well included the regions controlled by the British directly and those administrated by the Indian chiefs or provisional areas under the care of the centre.[88] The census, although followed and maintained a schedule of 1911 Census, 'Christian' under the sub-section of religion was dropped, whilst data on caste, details regarding tribe, and race were collected irrespective of religion.[89]

It is interesting to note that the 1921 Census General Report on infirmities followed the same provisions as the previous censuses. The tabulation was divided into two parts—the total number of persons recorded as suffering from each infirmity and the distribution of these persons by age for main provinces. The main setback with this census report was that the procedure adopted in diverse provinces and states in dealing with persons suffering from more than one infirmity was not uniform.[90] Even if they were earmarked separately under each heading, they were counted only once. The group afflicted does not, therefore, correspond with the aggregate of the figures of the several infirmities. There were 8,57,537 persons affected by infirmities in 1921.[91] Among them, 3,81,972 were females and 4,75,565 were males. The tabulated data disclosed that Madras had the highest number of the disabled at 82,004, the Central Provinces had 60,822, Berar

[87] Ibid.

[88] J. Anon, "The Census of British India," *Journal of the Statistical Society of London* 39, no. 2 (1945): 411–416.

[89] Ibid.

[90] Report on the Census of British India: 1921 (Calcutta: Superintendent Government Printing, 1923), 140. (1921 Census Report from here on).

[91] Ibid.

had 60,783, Bihar had 60,408, and Orissa had 60,557.[92] Furthermore, Bengal had the highest number of 18,803 insane with 11,102 males and 7,791 females.[93] Among the Indian states, Hyderabad recorded 2,510 insane in which 1,462 were males and 1,057 were females.[94] Finally, the number of the deaf-mute, blind, and lepers did not present any drastic change from before.

Additionally, the number of persons suffering from multiple disabilities was compiled. The total number of the insane and the deaf-mute figured at 819 males and 534 females.[95] It also revealed that the 128 male blind and 118 female blind were also insane; 23 leper males and 19 leper females were also insane; 844 males were deaf-mute and blind and 270 females; deaf-mute and leper males were 71 and females at 25; insane deaf-mute and blind males were 7 and females were also 7.[96] Bengal had the highest number of insane and deaf-mute with a total number of 340 males and 187 females.[97] This new section of multiple disabilities was important in accommodating the disability data because persons with disabilities were prone to develop other disabilities too, principally when there was a connection between insanity and blindness as well as deaf-mutism and blindness, especially among infants.

The sixth census of British India was conducted in 1931. The 1931 Census General Report stated that the return of the figures on infirmities in the census was never going to be satisfactory given the dearth of a uniform definition of infirmity.[98] The tabulation given to the disabled, based on caste, was abandoned in this particular census. There was a drastic amendment in that year's enumeration in the number of people who had disabilities. The numbers were reduced mainly because of the rising accuracy of the data collected and the tools used. A total figure of 10,95,678 persons returned as afflicted in 1931.[99] They included 1,20,304 insane, 2,30,895 deaf-mute, 6,01,370 blind, and 1,47,911

[92] Ibid., 141.

[93] Ibid.

[94] Ibid.

[95] Ibid., 143.

[96] Ibid.

[97] Ibid.

[98] Ibid.

[99] Report on the Census of India: 1931 (Calcutta: Superintendent Government Printing, 1933), 257. (1931 Census Report from here on).

lepers.[100] It was noted that the distribution of the disabled by provinces increased since 1921 and the rise of this ratio was mainly due to the population rise. This increase was explained by the United Provinces Census Report as due to the increase in the economic condition of the families, reduced poverty, and the consequent dwindled mortality rate among the people with disabilities.

The total number of the mentally impaired in mental hospitals in 1931 was 11,147. The General Report showed a higher number of insane in Assam at 59 persons per 10,000.[101] While Ajmer had 39 insane, Madras presented 33 cases, Punjab showed 29, and Rajputana showed 23 cases.[102] As per the number of deaf-mute per 1,00,000, Burma acquired the highest position with 116, Assam had 75, Bengal highlighted 70, Berar presented 78, Madras had 71, and Baroda recorded 52. The sudden drop in the figures of Assam from 1921 to 1931 was essentially due to the hard-hit famine that killed thousands.[103] The statistics on blindness attested to some alterations in 1931 from 1921, when the numbers of male blind were higher and it reduced in 1931. But in Travancore, the number of the blind among the age group of 14–18 was higher than any other age category, that too among the males.[104] The Chief Census Enumerator from Travancore stated that the reason behind these phenomena was the higher educational opportunities in the state.[105] The government schools and colleges conducted periodical inspections on the students' eyesight and other age categories were omitted. With 386 in Ajmer, 329 in Baroda, 206 in Central Provinces, and 132 in Cochin, the overall ratio of blindness was reduced in 1931. In Assam, the ratio of blindness was reduced in 1931, precisely in those districts where the education and sanitation sector progressed.[106] The number of male lepers was still soaring and was at its highest in Madras which had 71 per 1,00,000 population.

Another notable census landmark during the data operation significant to this discussion is the Census of 1941, which started under the adverse condition of war. The government was unsure whether to conduct the census up to February 1940. Nonetheless,

[100] Ibid., 257.

[101] Ibid., 260.

[102] Ibid., 264.

[103] Ibid., 265.

[104] Ibid., 255.

[105] Ibid.

[106] Ibid., 266.

the enumerations were finally conducted directly in slips and sorted out into 5 or 6 tables. The question of infirmity was removed from the census. This decision was mainly taken due to a last-minute decision to conduct the census which did not provide sufficient time for enumerators to decide on the topic. The second reason why infirmities were not added to the census was due to inherent faults in the detection methods. The section of infirmity in the census was abandoned in Britain at the same time due to the proposed universal health care plans made these data redundant. It is worth mentioning that "independent reviewers were already aware of the need for reform in social and health care in India and the disinclination of the departing imperial government to be pro-active in this regard."[107] Whether the category was excluded for the methodological difficulties or as a cover-up for the glaring deficiencies in services for the disabled (existing and planned) is thus debatable.[108] Infirmities were not included again, even after 1947, in the census returns till 1981.

2.4. Categories, Causes, and Criteria of Disability in the Colonial Indian Censuses from 1881 to 1931

The 1881 Census Report of Bengal defined the criteria of 'infirmities' by stating that the survey "gives [sic] statics for all persons afflicted with four great infirmities which from their 'permanent' serious character seemed to require the compilation of special information."[109] Critically assessing the terminology 'permanent' which is the major character of disability, it is interesting to note that the colonial comprehension of 'infirmities' was close to the post-colonial understanding which looked at 'disability' as a 'permanent problem' needing a permanent 'solution.' Other than insanity, all of the other infirmities recorded in the colonial censuses were more permanent, since a lasting cure was yet to be prescribed for leprosy. Insanity was the first category of disabled included in the colonial census.[110]

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[107] Report on the Census of British India: 1941 (Calcutta: Superintendent Printing, 1943), 70.

[108] Ibid.

[109] 1881 Census Report, 256.

[110] During the eighteenth and the nineteenth centuries, terms like insanity and lunacy were used to address mental illness and mental disabilities alike. There was no clear distinction made between them. Terms such as 'insanity' and 'lunacy' are used in this thesis interchangeably denoting mental disabilities.

The 1881 Census General Report revealed that only the violent and riotous lunatics were registered under the insane category.[111] Psychiatry was an essential field of the eighteenth and nineteenth centuries where mental illness or disability was associated with 'violent' behaviour. It further revealed that alcoholism as a cause of insanity was not included in the censuses in India, while it was considered in Europe. This may be an important reason why the number of the insane in Europe exceeded their number in Colonial India. The number of male alcohol consumers who suffer from mental retardation was high in the case of Europe, and the 1881 Census General Report argued that this was due to the 'exposed' life Europeans pursued.[112] In this context, the census reports also claim that alcohol-induced mental retardation in India cannot be calculated because of the low consumption of alcohol by the population.[113] Reports suggest that there was a low alcohol consumption rate among Indians owing to the religious restrictions on the use of spirits, especially among high caste Hindus and Muslims.[114] Alcohol consumption among the native population increased in the early twentieth century after industrial and pharmaceutical companies used the opportunity of alcohol sale among native and British military in Colonial India.

The enumerators further suggested that one reason why insanity is high in Europe and low in India was mainly because of the differences in lifestyle. The 1881 Census General Report stated that the brain energy of the masses in India was not overtaxed by literary pursuits and busy town life.[115] The struggles of people in India concerned with toil on the soil and this less busy mind-related left a minimal strain on the psyche. It is interesting that even by the early nineteenth century, the relationship between busy urban life and stress or mental fatigue was established. Even though it had less to do with congenital mental impairments, certain lifestyles did indeed have a connection with mental health.[116] However, the underlying feeling of superiority of the 'white man' in drawing

[111] 1881 Census Report, 255.

[112] Ibid., 229.

[113] Despite stating the fact that alcohol-based insanity was not calculated in the censuses, the colonial authorities justified that the reason behind the minimal number of alcoholic-induced insane in India was directly related to the mode of life, which was exceptionally 'primitive' and the strain of mental work was comparatively unknown. Ibid., 255.

[114] Nandini Bhattacharya, "The Problem of Alcohol in Colonial India," *Sage Journals* 15, no. 6 (2017): 80–87.

[115] 1881 Census Report, 228.

[116] Ibid., 229.

this contrast may be noted. It implicitly indicated that people in India were not 'smart' enough to understand the competition and stress of 'tough' European ways of life.

The 1881 Census General Report further divided insanity into two categories—congenital and acquired.[117] The data reiterated that acquired insanity was more prevalent in the 'civilized' societies of Europe and less in 'backward' countries like India. Census enumerators believed that the mental health of the members of 'savage' cultures stayed superior as long as the daily necessities were met. The report added that in a fully 'civilized country,' the tension of the nerves impacted people more compared to 'primitive' people like in India.[118] The reports also noted that lower classes were more prone to insanity and stated that it is due to the stressed life they led to provide the basic necessities.[119]

Incidentally, the census reports likewise blamed anemia and other conditions like fevers as catalysts for brain damage. High fever and lack of blood supply seriously injure brain cells. It is worthy to note that the impact of high fevers on brain damage is accepted by contemporary medicine.[120] High fever was quite common in Colonial India; smallpox and other infectious diseases caused high fever among patients which shot up to 105 degrees Fahrenheit, which was not enough to cause brain damage. But fever in children which rose to 107 degrees Fahrenheit or low-grade fever related to meningitis caused juvenile delinquency. This may be the rationale behind why the colonial enumerators believed that having a high fever, as a result of an illness, could cause mental disorders. However, it is a proven fact that hyperthermia can cause trouble for those who are already dealing with mental illnesses.[121]

Besides, the reports held narcotic stimulants and ganja responsible for developing some brain diseases.[122] The Rajshahye and Dacca divisions in Colonial India, which were ganja producers on a large scale, revealed that the percentage (3 for every 10 insane) of the ganja addicted insane was soaring. Narcotic drugs cause hallucinations and mania. While the long-term abuse and usage of these substances even led to a reduction in brain

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[117] Ibid., 267.

[118] J. A. Bourdillion, 1881 Census of British India: Report and Tables from Bengal (Calcutta: Bengal Secretariat Press, 1993), 219. (1881 Bengal Census Report from here on).

[119] 1881 Census Report, 268.

[120] United States National Library of Medicine, "Fever," *Medical Encyclopedia*, no. 3 (2010): 1–3.

[121] Gary L. Albrecht, *Encyclopedia of Disability* (Thousand Oaks: Sage Publications, 2005), 9.

[122] Bourdillion, 1881 Bengal Census Report, 221.

functioning, the moderate exploitation of ganja may not bring any changes to the brain.[123] But the colonial perceptive was adamant as the colonialists firmly assumed that ganja could cause insanity. To prove their argument, they took the example of the Bengal Lunatic Asylum in 1891, where more than half of the registered cases of insanity were physical, and among them, the principal root was the habitual use of ganja.[124]

Furthermore, after the initial censuses, enumerators concluded that the usage of intoxicants like ganja and male insanity was not always related. The only way one begot any mental disability from the abuse of any intoxicant was when a pregnant woman consumes them.[125] Children with alcoholic or drug-addicted mothers were more prone to mental disabilities which eventually reduced their cognitive abilities. Enumerators argued that the female susceptibility to intoxicant addiction leading to insanity was alarming in India. Insanity among women in Colonial India was higher than among the women in Europe.[126] The census enumerators claimed that the key rationale for this disparity was the religious restrictions that were compelled on women, enforced widowhood for some from an early age, life of drudgery, and insufficient dietary nourishment in Colonial India. These factors act as the agency to stimulate depression and melancholia, but it is unlikely that they may also have caused any mental disability. Nevertheless, insufficient dietary nourishment during the time of pregnancy may have resulted in congenital deformities—mental or physical in children right from birth. Very often, the lack of sufficient intake of iron and other supplementary nutrients led to the underdevelopment of the brain of the fetus during pregnancy.[127] Iron deficiency during pregnancy puts the fetuses at high risk of mental disorders. The 1881 Census General Report stated that nervous instability in parents especially in mothers might result in congenital insanity among children.[128]

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[123] David McDowell, "Marijuana," in *Clinical Textbook of Addictive Disorders*, ed. Richard J. Frances (New York: Guilford Press, 2005), 169.

[124] 1881 Census Report, 236.

[125] Centre For Disease and Prevention, "Fetal Alcohol Spectrum Disorders," (2013). https://www.cdc.gov/ncbddd/fasd/alcohol-use.html.

[126] 1881 Census Report, 257.

[127] American Pregnancy Archives, "Dieting During Your Pregnancy," (2018). http://americanpregnancy.org/pregnancy-health/diet-during-pregnancy/.

[128] 1881 Census Report, 267.

Aligned with food deficiencies, the 1911 Census reported that harsh physical labour was associated with insanity in Colonial India, especially among women.[129] Enumerators argued that harsh physical labour results in the weakening of central nerves which then reduces mental ability. The stress from labour and harsh physical activities without accessibility to a healthy diet was looked at as a major reason for insanity. It may be observed that women and men in pre-independent Kerala worked together, whereas many of the women in central India tended to live in seclusion with less participation in labour. Those women who lived in the state of Cochin were mentioned as being highly prone to insanity and the reason claimed was physical labour.[130] The census detailed out that the Cochin families witnessed women as the heads of households which eventually exposed them to the 'realities of the harsh life.' The relationship between physical labour and mental disability in women is not established by modern psychiatry, even though women working in high-stress sectors tend to develop anxiety disorders. But harsh physical labour and elevated stress at the time of pregnancy are not advisable due to the higher likelihood of birth complications.

While motherhood and insanity formed an integral part of the colonial census, the relationship between widowhood and mental illness was equally backed by the collected figures at three widow insane among ten female insane. This was because it was among women of 50-plus age that the count of the insane was higher compared to other age categories. The hike in number was due to a higher mortality rate among men in Colonial India. Also, women in India used to get married early to men much older than them. These women became widows by the time they reached their 30s and lived the rest of life in widowhood due to the religious restrictions on remarriage. The widows in India lived in isolation and poor conditions; the census enumerators argued that this made them more susceptible to insanity.[131] It may be noted that widows in India appeared to be more prone to insanity than European widows, but the case of Britain appeared to tell a different story. The insane widows in Britain did not get easily 'cured,' were admitted to asylums, and frequently died there. But in India, due to religious restrictions on widowhood, widow insane were supported by family care before the popularization of institutionalization. The reason for the divergence in numbers is of course the difference in population, with India's population being much higher.

[129] 1911 Census Report, 345.

[130] Ibid., 342.

[131] Ibid., 343.

Moreover, the colonial enumerators firmly supposed that provincial and geographical factors had an important role to play in the incidence of insanity. The census reports linked insanity or mental degeneration with the environment. They postulated that there was a direct influence of the milieu on the psyche of the people. While it was argued that in Sindh, a large number of cases of insanity occurred due to the climate, water quality, and the frequent occurrence of drought. The high occurrence of insanity in Burma was attributed to the particularity of race.[132] Similarly, in the case of Punjab, it was argued that a high number of insane cases was due to its rivers "such as the Chenab in particular along which Cretinism is rife from the Himalayan valleys to the plains of Multan."[133]

As mentioned in the previous paragraph, the linkage between race and insanity was posited by an enumerator of the 1891 Census in Bengal. He argued that "the mongoloid strain in the eastern portion of the province together with the wider expansion of instruction and notoriously litigious temperament of the population in that tract make on the whole a more favorable seedbed for mental derangement than the solid plough-man of Bihar."[134] In linking race factors, the census records took into account the people who were affected by Cretinism, the congenital iodine deficiency syndrome (CIDS).[135] Cretinism is a form of congenital mental disability much prevalent among mountainous people and is associated with goiter. In this context, the records referred to Burma and Assam where Cretinism and associated 'degeneration' of mental ability was said to be elevated among the tribal people.[136] At the same time, the proceedings draw a stark comparison between goiter-affected areas in Bengal like Rangpur and the number of insane in the area.[137] Surprisingly, the data revealed that they share a similarly high percentage in the region. Further, according to the calculations, it is interesting to note that one locale stood out in numbers, namely Kashmir. More than 10 percent of the insane in

[132] 1891 Census Report, 230.

[133] Ibid., 236.

[134] Ibid., 236.

[135] Cretinism (Congenital Iodine Deficiency Syndrome) is a condition of severely stunted physical and mental growth owing to untreated congenital deficiency of thyroid hormone and iron in the blood. William C. Shiel, "Medical Definition of Cretinism," *Medicine Net* (2011). https://www.medicinenet.com/cretinism/definition.htm

[136] 1891 Census Report, 230.

[137] Bourdillion, 1881 Bengal Census Report, 223.

Kashmir were aged below ten.[138] It was argued that most of these kids would have suffered from congenital mental disability associated with Cretinism.

The colonial census records also draw a relationship between marriage and insanity. By taking the example of the Malabar Coast, the 1891 Census General Report stated that one in three insane people lived in a polyandrous domestic arrangement.[139] Reports stated that polyandrous arrangements put pressure on the family psyche which eventually resulted in insanity. The collectors believed that consanguineous marriages also increased congenital insanity.[140] They supported this argument by showing that among the communities that avoided marriages between close kin, the number of the insane was lower.[141] It concluded that the prevalence of insanity in line with marriage is superior among Muslims in India to other communities, mainly because of the existing system of parallel cousin marriage.

O. Malley, a census enumerator in 1901, referred to the popular belief that insanity was caused by sexual indulgence as well as sexual abstinence. By agreeing with this belief, he argued that sex as a human need could not be contained or indulged beyond a limit, and both extremes were practiced in India. Sexual abstinence was practiced among the Hindu *sanyasis*, which he argued caused strain to the psyche.[142] He drew attention to child marriage with sexual indulgence, whereby children consummated nuptials at an early age. A lack of proper knowledge about sex, and an early exploration of sexual behaviour caused insanity among young wives in Colonial India, he argued.[143]

In the colonial censuses, the enumerators omitted the tabulation of one particular group of people, the *adhpagal*—a vernacular term to address the 'half-witted.'[144] The censuses were completely directed towards insanity within a set of parameters that neglected the half-wits. Closely analyzed, just like half-wits, it is interesting to note that the enumerators excluded some of the members of the society like insane beggars as they

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[138] 1891 Census Report, 237

[139] Ibid., 236.

[140] Bourdillion, 1881 Bengal Census Report, 220.

[141] Ibid., 205.

[142] 1901 Census Report, 243.

[143] Ibid., 243.

[144] According to the census reports, a half-wit/dimwit is a person who has trouble communicating. But their mental capacity is more apparent compared to an idiot, imbecile, and moron. 1911 Census Report, 343.

did not possess any clear-cut parameters of categorization. Subsequently, one can notice that the colonial census authorities omitted those who suffered from harmless manifestations of mental diseases and whose attacks were periodical, mainly because there were no clear criteria to define insanity.[145] But such people were counted as insane in Europe showing a greater insane number there.

IQ definitions from the eighteenth and the early nineteenth century proved that the terms colonial census recorders in India used to collect and categorize the 'insane' served the purpose of collecting data on mental disability instead of mental illness. There are three main terminologies mentioned in the colonial census reports in association with insanity, namely idiot, imbecile, and moron. Firstly, 'idiot' referred to a fool from birth and someone unable to protect himself/herself from the common dangers with an IQ of less than 25, which today is considered a 'severe learning disability.'[146] Moreover, the term 'idiot,' which was not used in the European census records found a place in the Indian census records.[147] 'Idiot' as a term bears a key role as an indication of disability because they were defined as 'natural fools' from birth, which is a main feature of disability.[148]

Secondly, an 'imbecile' was mentioned as a person who was unable to take care of himself/herself and who possessed an IQ less than 50, translating into modern context as a 'moderate learning disabled.'[149] Unlike the 'idiots,' the colonial psychiatric records included the imbecile as it was stated that an imbecile was a person who had a good and sound memory.[150] Even though imbeciles have good memory and coordination, they faced trouble in understanding and following social cues and their condition was permanent.[151] This intellectual disability was added in the colonial censuses while counting the total number of insane.

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[145] 1881 Census Report, 257.

[146] Robert Sternberg, *Handbook of Intelligence* (Cambridge: Cambridge University Press, 2000), 12.; Patricia O. Sullivan, "Insanity Terminology in the 18th and early 19th Century," (2008). http://stfinanshospital.com/the-archives-of-st-finans-hospital/admission-trends-in-the-kerry-district-asylum-in-the-early-1900s.

[147] 1881 Census Report, 257.

[148] Ibid.

[149] Sullivan, "Insanity Terminology."; Sternberg, *Handbook of Intelligence*, 13.

[150] 1881 Census Report, 257.

[151] Sternberg, *Handbook of Intelligence*, 13.

Last, a feeble mind known as ‘moron’ pointed to people having an IQ less than 70, transcribed today as ‘mild learning disabled.’[152] This intellectual disability is permanent and bears a long-lasting impression on the daily life of a person. Following and understanding instructions will be difficult for them, though they can adapt well to the social scene through a special education system. Even though these three terms were popularized by the colonial censuses, contemporary psychology experts refrain from employing them because of their common usage in a society predominantly by way of insult. The inclusion of these three terms shows that statistical records on the disabled in the Indian census were more accurate in the case of ‘mental disability’ than ‘mental disease.’ But no separate categorization was given for them in the reports.

Lack of an official marker between sanity and insanity undeniably created setbacks for colonial enumerators. Many people whose conditions were periodic and whose lack of judgment and control, and hallucinations were not apparent, equally added to the predicaments as some enumerators considered them as ‘sane’ while others ‘insane.’ The census recorders were unable to draw the line due to the absence of earmarked criteria for both categories. Therefore, the lack of uniformity in the definition became a hindrance in the precise collection of information on insanity.

From 1881 to 1931, the colonial censuses included blindness as one of the categories of infirmity in the data collection. Visual impairment or blindness is defined as an inability to see or decreased ability to see to the point where it cannot be reversed by the use of means such as glasses and lens.[153] Contrasted to the multiple impediments faced in the identification, diagnosis, and recording of the insane and mental disabilities, the census enumerators found it easier to collect data on the visually impaired in India due to the established decisive factors to classify the blind. The common estimate of the blindness was high throughout colonial census years regardless of the provinces. ‘Blindness’ often defined as complete vision loss pointed out the one infirmity that was easy to diagnose. Consequently, it bore less concealment in the Indian society as it is palpable. Its physical bearings allow it to be easily discerned from other disabilities.

[152] Ibid., 14.

[153] S. S Lehman, “Cortical Visual Impairment in Children: Identification, Evaluation and Diagnosis,” *Current Opinion in Ophthalmology* 23, no. 5 (2002): 384–387.

The lack of uniformity among the census reporters regarding the criteria and standards for blindness caused confusion and commotion. The vernacular terms to denote a blind were diverse. Over time, changes in their meanings did not facilitate the defining process of blindness. The word used for 'partially blind' in the whole of upper India was restricted and understood in the Brahmaputra Valley as 'totally blind.' Even though the census reports tend to take account of the total blind due to the differences in these terms, at times partially blind people also found their place in the records. When compared, blindness in Europe was lower than in India.[154] The 1881 Census General Report classified people with complete blindness under the 'blind' section, whereas in Europe, the partially blind and the fully blind were both categorized as blind, and so, one may note that the Indian reports had no separate category for partial blindness. [155] Neglecting partial blindness in the census list turned the colonial census records partly reliable. Whilst some provinces considered the complete blind as the only people who should be counted in the censuses, other territories, especially Bengal enumerators, suggested that there should be a list to record the partially blind too. In Bengal, the blind section in the census included people who were unable to count the fingers of a handheld up at a one-yard distance.[156]

The major reason for the higher rate of blindness in India throughout censuses was examined by the enumerators and they concluded that the environment played an important role in causing blindness.[157] The reports stated that one of the primary causes was the extreme heat in the country.[158] The summer in north India and the high temperatures in south India, reaching a maximum of 50 degrees Celsius at its peak in summer, led to vision-related difficulties. Out of twelve, for nine long months, India experienced summer, according to the enumerators which led to constant pressure on the eyes. Every state except Mysore, Coorg, and Assam had higher figures for the blind.[159] These are the places where the climate was moderate or cooler than other regions. It may be noted that regional climate and blindness were interrelated, according to the understanding of the census collectors.

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[154] 1911 Census Report, 349.

[155] 1881 Census Report, 263.

[156] 1911 Census Report, 349.

[157] 1881 Census Report, 263.

[158] Ibid., 264.

[159] 1911 Census Report, 354.

Additionally, the world distribution of blindness revealed "an association with steep and rapidly drained valleys at comparative high elevations, and with Tarai country which is rapidly drained; its incidence is lower on the plateau and alluvial plains but seems to increase again here and there in deltaic land."[160] It was noticed that as one approached the Equator, there was a tendency for blindness to amplify in intensity due to the increase in temperature. It was equally understood that the prevalence of snow in a wide area may bear an influence on sight in the extreme North. When one considered the central Indian regions as a whole, the hot plain and dry weather seemed more favorable to develop ophthalmic defects than the moist and warmer air of the coastal areas. The census reports stated that it was complicated and to give full credit to the arid and hot milieu when it came to blindness was not correct because environment was not the only rationale behind sightlessness. It was disclosed that hotter and drier areas such as Multan, had less blind in the records; in Malabar, where the climate was humid and green had a similar record as Multan, whereas it should be much less compared to Multan.[161] The argument that drier and dustier climates caused blindness in India was challenged by stating that in the Western countries, 25 percent of blindness was caused by congenital anomalies, and the rest by ophthalmia neonatorum, syphilis, and injuries and damage to the optical nerve. This argument was opposed by the census reporters citing the examples of Bharatpur, Sirohi, and Bihar having the highest number of the blind than Orrisa and Chota Nagpur which were greener and more wooded.[162]

Furthermore, the reports disclosed that the unsanitary huts used by the people to live in were another cause of why eye infection was so common in India.[163] The small, cramped, dark, and pungent huts lacked the sanitary and hygienic parameters to ensure 'good' health. There was less aeration and light inside the huts due to inadequate ventilation. Under these unsanitary conditions, children, especially newborns were prone to develop eye infections. Cooking in these huts added to the already prominent issue especially during high temperatures and cold weather. The smoke inside the huts got trapped and caused eye irritation. It was a medically proven fact that living inside a dark room put a strain on vision as well as the toxic smoke from firewood also did. The census reporters' understanding of the relationship between blindness in Colonial India and the

[160] 1901 Census Report, 143.

[161] 1931 Census Report, 267.

[162] Ibid., 255.

[163] 1911 Census Report, 353.

surroundings was counteracted by many medical professionals. The argument about the prevalence of unsanitary huts and living conditions resulting in loss of sight was challenged by citing the fact that in 1931, blindness soared in Assam, precisely in those districts where sanitation and education made considerable progress.[164]

It was reported that the main reason for the blindness in Colonial India was pediatric cataract, which was a congenital and pediatric pathology that described the graying or reflection of the opacity of the crystalline lens which was most commonly caused by intrauterine infections, metabolic disorders, and genetically transmitted syndromes.[165] There were multiple grounds behind child blindness apart from cataracts. Child blindness was caused by infections such as congenital rubella syndrome, retinopathy of prematurity, leprosy, onchocerciasis, trachoma, and central corneal ulceration.[166]

Ophthalmia neonatorum, conjunctivitis, and trachoma which resulted from the neglect of simple eye infection were the main base for infant blindness in Colonial India.[167] The ophthalmic and cognate diseases were common among infants in India most of which was mainly due to congenital defects. But the majority of the blindness cases in Colonial India owe their origin to the infections. India depended on agriculture for livelihood whereby the domestic environs were nearer to the fields. It was therefore noted that the closer one was to the manure, the easier it was for the flies to carry the infection from the moisture to the eyes of the infants. The unhygienic conditions of the agricultural fields were breeding spaces for infant infection, not only eye contagion but other infections as well. Lack of proper toilet facilities forced people to relieve themselves in the open fields which in turn added to the unhygienic living conditions. People from the lower strata of Indian society were unable to access medical care once their children fell into eye infections. The delay in medical care also led to an increase in the number of cases of infant blindness in Colonial India.

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[164] 1931 Census Report, 257.

[165] M. Mathers, "A Review of the Evidence on the Effectiveness of Children's Vision Screening," *Child: Care, Health and Development* 36, no. 6 (2010): 756–780.

[166] Ibid.

[167] Richard D. Semba, *Handbook of Nutrition and Ophthalmology: Nutritional Blindness* (London: Nutrition and Health Book Series, 2009), 9.

According to a study by Dr. Deakin on North-West Frontier Provinces, it was found that famine was a major reason behind blindness.[168] Famine was quite familiar to Indians in the pre-independence period. Famine thrived on lack of nutrition to the body and vision was connected to the nutritious content intakes. For instance, deficiency of Vitamin A caused the loss of sight or low vision among people, especially children. Also, anything which depressed the nutrition of the body among the middle-aged induced degenerative changes in the crystalline lens of the eyes. The amplified degree of long periods of scarcity of proper living conditions and diets caused by famine increased the number of cataract-affected in Colonial India.[169]

Old age was one of the contributing agents to register a higher figure of 43 percent of the blind in Colonial India. The human tendency to face a reduction in their vision from the age of 40 was normal and inevitable. Nevertheless, in some cases, especially among those communities where nourishing food was rare and hit with incessant famine and poverty, the vision would start to reduce from the late 20s. However, reduction of vision was irregular among the male population where the number of the old blind and the blind in the 20s was high, but there was a decline in the male blind in the 30-plus age group. Even today, non-curable old age blindness is considered a disability regardless of the reason whether it was congenital or developmental.

Additionally, glaucoma was looked upon as another cause for blindness by the census reports, recorded as a result of increased pressure within the eye or intraocular pressure.[170] This caused visual field loss as well as severance of the optical nerve. The number of the blind in the age category of 55-plus was elevated and most of these people suffered from glaucoma, stated the reports.[171] Cataract and glaucoma were the listed causes of blindness that developed with increasing age in Colonial India.[172] Glaucoma was included in the Public Health Commissioner's list of the main causes for blindness in Colonial India.[173]

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[168] 1901 Census Report, 140.

[169] Ibid., 141.

[170] 1901 Census Report, 141.

[171] 1931 Census Report, 263.

[172] A cataract is the clouding of the normally clear lens of the eyes.; Glaucoma is a group of eye disorders that cause damage to the optic nerve that carries information from the eye to the brain. Semba, *Handbook of Nutrition and Ophthalmology*, 10.

[173] 1911 Census Report, 352.

According to the census reports, smallpox was one of the causes of blindness in India; it was medically understood that smallpox caused blindness especially among people who possessed low immunity.[174] The lower the immunity, the higher was the smallpox contagion through the body. Smallpox not only infected the skin but could as well grow on internal organs, tongues, and eyes. The blisters grew while pus and fluid collected in these, which could itch, hurt and swell.[175] Rubbing or poking them could lead to the breakage of these blisters; some blisters could heal, but others, especially those in the eyes got infected. These infections in the future could spread into the veins and cornea, which eventually resulted in the loss of sight. The smallpox deaths were not always recorded which doubled the number of the blind in records. The 1881 Census General Report stated that "glare, heat, dirt, huts filled with pungent smoke, and the attacks of smallpox are all conditions which are injurious to the sight and prevail largely in these provinces, while many of them are absent in European countries due to better climate and living conditions."[176]

The census reports discerned a correlation between blindness among women and the patriarchal condition of society.[177] Blindness among women was elevated in the upper regions of India—Sindh, Punjab, and Rajputana where the seclusion of women was prevalent. Coorg, Assam, Travancore, and Hyderabad registered a smaller percentage and the women enjoyed freedom in a 'limited' manner mainly because women were an integral part of the workforce. The seclusion was inevitable in the life of Indian women due to the patriarchal structure of Indian society. Consequently, this condition might lead to an indirect impact on the visionary health of Indian women. Women were secluded inside their poor-lighted houses for a majority of the time, which eventually strained their vision. This patriarchal seclusion also limited their opportunities to access timely medical care when 'abnormality' of sight was detected. Interestingly, the reports disclosed concealment of the problem in girls for blindness.[178] Despite registering an elevated number of the blind among women, there was a dearth of accurate data and information collected about girls suffering from low vision. The prevalent stigma around the predicament of girl-blindness related to scared parents, which eventually led to the

[174] Ibid., 353.; 1881 Census Report, 260.

[175] 1911 Census Report, 354.; 1891 Census Report, 231.

[176] 1881 Census Report, 265.

[177] 1911 Census Report, 266.

[178] 1901 Census Report, 141.

concealment of the disability. There were fewer female blind in the age category of 1–20 and after that, a steep hike, which meant that parents were hiding the fact that their girls were blind mainly due to the pressure of marriage.[179] It was hard for disabled women to find a suitor in Colonial India due to social and religious superstitions.

The shortage of proper nutrition played a significant role in the state of being blind.[180] When the enumerators compared the male-female ratio of blindness, they concluded that women suffered more as it was related to the lower status and lower nutrition intake of women in Indian society. It also denoted that the number of blind women from Buddhist and Muslim religions was also uniformly soaring. Owing to these observations, the census reports stated that women in Indian society were secluded and were positioned in the lower strata of the food chain.[181] Being part of patriarchal dominance, they were not likely to get enough nutrition or care. They were taken for granted and forced to eat after the men completed their meals, forced to stay inside the house even when they were sick, which made it difficult to get deserved medical care. The reports elaborated that a dearth of adequate sustenance at the time of pregnancy could lead to congenital visionary problems for the child.[182] The absence of healthy consumption had a direct impact on the fetus which depended on the mother for its growth.

Two factors introduced by the colonial government led to a cutback in the number of the blind in Colonial India. Firstly, the development and deployment of eye dispensaries all around India played a significant role. Secondly, increasing the accuracy of the death registration facilitated the decline. In later years, the diminution in the data of the blind in the records was noticeable.

Two of the disabilities which are registered around the world, including India, are the hearing impaired and the mute. On one hand, ‘deafness’ is plainly defined as the loss of hearing while ‘mute’ denotes the inability to speak.[183] Historically, the ‘deaf-mute’ terminology is applied to designate a person who is either deaf and uses sign language to

[179] 1911 Census Report, 352.

[180] 1901 Census Report, 143.

[181] Ibid., 144.

[182] Ibid., 145.

[183] J. E. Lieu, “Speech-Language and Educational Consequences of Unilateral Hearing Loss in Children,” *Otolaryngol Head Neck Journal* 130, no. 5 (2004): 524–530.

communicate or both deaf and unable to speak.[184] The term is now medically obsolete and has been withdrawn from its usage mainly because of the offensive connotation attached to it.[185]

It is only in the case of deaf-mutism that the colonial census surveys accepted inheritance factor as probable cause. Other infirmities like insanity, blindness, and leprosy were majorly considered as a result of external influence after the birth, in official definitions. The proportions of deaf-mutism in India and Britain were similar.[186] But in Britain, the congenital deaf were considered as the deaf-mute in records with no changes. However, in India, the record demonstrated a mix of the deaf-mute even from an earlier period. Subsequently, it is fair to assume that deaf-mutism was less in Colonial India when compared to the number of cases reported in Britain.

The census enumerators attempted to connect deaf-mutism to the environment. They argued that deaf-mutism in Colonial India was predominantly visible in the hilly tracks, where goiter-related Cretinism was highly prominent. Further, the areas surrounding the Chenab, Gandak, and Makhua rivers witnessed a reputation for producing deafness and mutism. The same surroundings proved to generate a higher rate of goiter deficiency Cretinism. In the case of Burma and Assam, the hill area showed a greater prevalence than plains.[187] Furthermore, the 'dumb' was also automatically considered as the congenital deaf-mute. The records of those who lost these abilities by the excessive growth of goiter and due to some illness sneaked into the census records.[188]

Geographically deployed, in the case of deaf-mutism, the areas of Sindh, Bengal, and Punjab were reported to have registered the highest numbers of casualties.[189] Assam came close to these regions in statistical terms where it registered 12 percent.[190] The enumerators stated that other than goiter-related Cretinism, deaf-mutism had a close affinity with diet. They recorded that the food of the citizens was quite different from the

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[184] This pessimistic connotation stems from an old Jewish law that considered deaf people as immoral agents as the Jews firmly believed that the deaf-dumb individuals should be kept away from the public eye, given that they were presented against the social 'normal.' Ibid., 525.

[185] 1891 Census Report, 234.

[186] Ibid., 234.

[187] Ibid., 235.

[188] Ibid., 258.

[189] Ibid.

[190] Ibid., 235.

staples favoured in the plains.[191] The enumerators connected famine to the quandary of congenital deaf-muteness as they followed a similar trend with blindness. For example, after the Madras Famine of 1876–78, in the 1880s, there was a perceptible birth rise of children with congenital defects that impacted their ability to speak and hear.[192] The census reports claimed that famine caused a shortage of proper diets was the main explanation for this trend.

Nevertheless, another setback arose in many provinces as the enumerators started to identify and add people with mental disabilities along with the deaf-mute, believing that the former faced troubles with hearing and speaking.[193] Medically scrutinized, such phenomena were referred to as multiplex disabilities were rare occurrences. However, in the colonial period, the data collectors started to automatically state that those who were deaf or mute were mentally disabled as well. Such kinds of errors did not only misread the data but rather, multiplied the number of casualties in the Indian context.

It was noted by the enumerators that similarly to insanity, deaf-mutism bears some connections with close-relative marriages.[194] This practice produced children with congenital disabilities mainly because if any gene mutation is the same in both parents, it could affect the well-being of the child to be born. In proportionate terms, this could have happened to fifty couples in over a hundred close-relative marriages. Marriages between blood relatives were frowned upon by the colonial enumerators believing that this led to the birth of a disabled child. Since heredity has a close correlation with deaf-muteness, it is reasonable to infer that marriages between blood relatives boosted the number of deaf-mute infants in Colonial India. Citing a high number of Cretinic deaf-mute in Assam, 1891 Census enumerators argued that "practice of consanguineous connection that is common amongst the tribes of those tracts had more to do with the spread of the infirmity."[195]

An increasing number of deaf-mute falling in the age group of 50-plus indicated that there was a possibility of adding old age deafness to the colonial record and there was an elimination of mutism. Yet, it should be noted that it was possible to turn deaf with

[191] 1881 Census Report, 257.

[192] 1901 Census Report, 257.

[193] Ibid., 134.

[194] 1881 Census Report, 257.

[195] 1891 Census Report, 234.

time. Nevertheless, the ability to speak is not a condition that people lose with old age. Further, it was a common trend to include those who lost their hearing due to old age in the records of deaf-mutism. But it was later strictly checked by the authorities and after 1891, such errors in the calculation were reduced. The loss of the ability to speak was either a result of the congenital defect or was due to certain infectious diseases or trauma that caused damage to the speech system. But a complete loss of the ability to speak in old age was very rare.

Moreover, if the congenital deaf-mute surveyed data alone had been collected, the 5–10 age group would have the largest percentage, and there would have been a gradual decrease owing to deaths in the natural course of life.[196] However, the statistical scenario is dissimilar in the case of both sexes when it registered a sudden rise in the 55-plus age group.[197] Therefore, it is evident that there were obvious parental objections to admitting that their child was deaf or mute, especially before the completion of marriageable age; and the same may account for some inconsistencies in the figures. Among the deaf-mute, only a small proportion of women in their early years were reported to have displayed congenital defects. This mainly owes to the fact that people usually hide the fact that their girl child cannot hear or speak. But had they made it known in the early years of the child's growth, he/she would have been counted as being affected by congenital deafness or muteness. It would have also led to the proper care and treatment of the affected children.

As the censuses' enumeration progressed, a sudden decrease in the number of the deaf-mute was visible in comparison to other infirmities after 1901. It is mainly due to the strict orders of the Census Commission to solely include those who are congenitally deaf or mute. In other words, the key reason for this decline is related to the short life span of the deaf-mute. Furthermore, the connections between deaf-mutism, goiter, and Cretinism have already been outlined. Census enumerators believed that these three conditions chiefly spread due to the injurious water properties of certain rivers, especially those originating from the Himalayas. The Bengal Census Report stated that deaf-mutism was highly prevalent on the banks of Burhi, Gandak, Dhanati, and Bagamati and that it rapidly decreased as the distance from these rivers increased.[198] The United Provinces Census

[196] Ibid., 236.

[197] Ibid., 258.

[198] 1911 Census Report, 350.

Report also stated that deaf-mutism was chiefly found on the new alluvium deposited by the Ghagra, Gandakand, and Rapti Rivers, as they formed the main source of water for the people staying nearby.[199]

When the colonial collection of information had come to the deaf-mute, colonial enumerators accepted that it was the congenital reasons that made people highly affected apart from the loss of senses that came with old age. They dismissed any alternative causes for the deaf-mutism. Colonial enumerators tried their best to include only congenital deaf-mute defects, but it is a fact that in many of the records the old age deafness crept into the record.[200] If one argues that only the congenital defects are part of census records, then one should expect highly-nominated figures in the middle-aged or below category. But in reality, the colonial census numbers are so high in the age category of 40-plus when it came to deaf-mutism.

The last infirmity to be included in the colonial census reports was leprosy, also known as Hansen's disease, caused by a bacterium called mycobacterium leprae.[201] It is quite cumbersome to diagnose this ailment as the infection spreads without any symptoms between three to five years. Gradually, inflammations affect the nerves, respiratory tracts, skin, and eyes. This results in the weakening of eyesight and in the lack of ability to feel pain. All these issues eventually lead to the loss of body parts due to repeated infections or unnoticed wounds.[202]

Leprosy in colonial census records was recorded in relevant statistical details. An investigation of the collected data demonstrates that the lepers in the age category of 40-plus were higher than any other infirmity in that age group. In the case of the latter, the female ratio is much less in the age category of 1–25.[203] Additionally, it was challenging

[199] Ibid.

[200] 1931 Census Report, 265.

[201] L. C. Rodrigues and D. N. Lockwood, "Leprosy Now: Epidemiology, Progress, Challenges, and Research Gaps," *The Lancet Infectious Diseases* 11, no. 6 (2011): 464–470.

[202] N. Ishii, "Current Status of Leprosy: Epidemiology, Basic Science and Clinical Perspectives," *The Journal of Dermatology* 39, no. 2 (2012): 121–129.

[203] 1901 Census Report, 144.

to diagnose leprosy in Colonial India, primarily due to the similarities between leprosy and leukoderma.[204] At times, leprosy was confused with the developed syphilitic sore by an unattended observer. These errors made the usage of the records of leprosy unreliable. The 1891 Census General Report states the disorientation between leukoderma and leprosy as the results of the "vernacular words assigned to it by the European professionals, for whilst in the mouth of the rustic, the two maladies are entirely distinct."[205] Also, census enumerators depended on the local police and village headman to collect the information on lepers. These non-medical persons were confused with the distinction between leprosy and leukoderma which led to many errors in statistics.[206]

The census reports noted that leprosy is significantly more prevalent in males than females. The disparities occurred mainly due to the concealment of the disease by parents. Contrasted to other infirmities, the covering up of leprosy among men is minimal because poor leper men earned a living by begging and exposing their sores in public. The pity factor associated with leprosy helped them positively in one sense. According to the reports, the country on the higher plateau is less affected than the districts below the ghats.[207] 'Heredity' parameters also play an important role in the spread of leprosy, stated the 1891 Census General Report. For example, among 38 total number of lepers, 7 were cases in which the disease has already occurred in the same family; in 4 cases, the father was a leper and in one case, the mother was a leper.

The enumerators clarified that there was no evidence of specific predisposition in one caste over another when it came to leprosy, but that prevalence was generally determined by locality. They explained the reason behind why the number within the higher caste-based lepers was less because the data collectors believed that the higher the status and higher the education, people tended to conceal their infirmities, particularly for a condition like leprosy.

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[204] Leukoderma is a skin disorder in which patches of skin tend to lose natural colour. Leukoderma is regarded as the de-pigmentation of the skin which is marked by the localization or complete destruction of melanocytes in the body. Vanessa Ngan, "Leukoderma," *Derma Net* (2021). https://dermnetnz.org/topics/leukoderma/

[205] 1891 Census Report, 234.

[206] Ibid., 235–236.

[207] Ibid., 237.

Geographically analyzed, the prevalence of leprosy varied greatly in diverse parts of the country. Berar registered the largest proportion of the lepers. When compared to the censuses, it was noted that the constantly high numbers of lepers were from the small districts of West Bengal. Berar figures were constant with some minimal variations amongst males and females. Lagging behind Berar, Sindh and Ajmer had always positioned themselves at the last two places; each with a decrease in the prevalence of their lepers, and it was noted that Assam closely followed. Enumerators were doubtful about how far the location related to the spread of leprosy. The data indicated that the percentage of leprosy was at its highest in the hill tracts of Punjab, North-West Frontier Provinces, and Bengal.[208] On the Burmese Toma tracts, it was highlighted that the hilly regions were favourable to its development, unlike the arid areas. Besides, leprosy had an affinity to coastal tracts, but the Malabar figures were inconclusive because those of South Kanara deviated from the pattern. It was apparent that leprosy found home in an ill-nourished population. When it came to leprosy in Colonial India, the rationales of local distribution were confusing and complex.[209]

By quoting the investigation carried out by Jonathan Hutchinson, an English surgeon in Colonial India, census enumerators believed that the bacillus enters through the stomach of a person, not through skin or breath. As per their understanding, eating raw fish and eating with a leper could cause the spread of leprosy.[210] Nevertheless, in Colonial India, leprosy was often found in regions at a distance from rivers or seas, and where comparatively little fish was consumed. These census conclusions were majorly opposed by medical professionals as no kind of bacillus was found in the fish body to prove these arguments.

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[208] Ibid.

[209] Ibid.

[210] The Census Report of 1901 further adds "There is little in the findings of the leprosy commission that will help us to explain the varying prevalence of the disease in this province. In East Bengal, the people are prosperous and well-nourished and so far as these factors affect the question, their relative freedom from leprosy is intelligible. But its diffusion is said to vary also with the degree of moisture in the atmosphere and East Bengal has a far more humid climate than these distracts and its population is on the whole less prosperous and yet it is comparatively free from the disease. … Orissa also stands high amongst the localities where leprosy is prevalent but East Bengal and North Bihar are the two parts of the province where that disease is least common…. Neither does the hypothesis that it is due to the use of badly cured fish find any corroboration in the excessive prevalence of the disease in Birbhum, Bankura, and Manbhum." 1901 Census Report, 246.

By the 1901 Census, The Leprosy Commission of India (LCI) was categorical about the causes of leprosy which was endorsed by the census enumerators. The report stated that the disease had no peculiar tendency to spread either by heredity transmission or by contagion. The commission also rejected any connection between race and leprosy but declared that the destitute were attacked much more frequently than the prosperous. They also rejected the rumour that eating fish could cause leprosy and advocated that "some kinds of food may render the system more ready to contact it."[211] The census reports stated that the poor were particularly susceptible as the shortage of nutritious food, sanitation, and medical care led to the spread of the disease. As a result, it was much more common in India as the living conditions were quite poor.

2.5. Disability Statistics: The Complicated Nature of Colonial Indian Census Returns on Disability

Census was the prime as well as the most appropriate tool to collect relevant information on persons with disabilities. The census took a broad approach while compiling types of disability. It considered not only disabilities but also the causes of disabilities.[212] The role of disability statistics in the form of the census played an important role in state policy. It is crucial to look into the protection and promotion policies for the disabled which should be monitored and assessed continuously. This assigned task cannot be done without proper and updated statistics of the conditions of the disabled in a locality.

Colonial enumerators' understanding of disability was comparatively one-sided. The white colonialists did not believe in the 'Theory of Karma' in the discourse of disability. Even though the colonial understanding was deeply rooted in Christian ideologies, they did not deem disability as a 'curse.' They incorporated a Christian-based 'moral model' within the 'medical model' which is not considered as an ideal model to use in the collection of disability data.[213] Today, the bio-psycho-social model is the

[211] Ibid.,144.

[212] World Health Organization (WHO from here on), "Disability Statistics: Why are they important," *Training Manual on Disability Statistics* (2010): 1–15. https://www.unescap.org/sites/default/files/Chapter1-Disability-Statistics-E.

[213] The moral model of disability associates physical and mental disability to spirituality and divinity. Religious principles and the morality of the person become central to the discourse of disability.; The medical model of disability looks at disability as a result of the disease. Anita Ghai, "Disability in the Indian Context: Post-colonial Perspective," in *Disability and Postmodernity: Embodying Disability Theory*, eds. M. Corker and T. Shakespeare (London: Continuum, 2002), 62–75.

accepted model employed to reformulate and define disability. The bio-psycho-social model follows a multidimensional approach that defines disability as the result of the interaction between a person's health conditions, environmental factors (social attitude/social structure), and personal factors like age, gender, social background, and education. The bio-psycho-social model understands disability as a phenomenon that bears on the medical and social dimensions, which is not the case when it comes to the colonial census. Colonial census looked at the medical and moral rehabilitation intervention and left out the social model of disability, which has a greater role in the development of the disabled as well in the development of body label aspects of disability.

While measuring disability, colonial censuses used a direct approach, namely the impairment approach. They approached disability as an 'abnormality' of the body structure and function that limited a person's physiological, psychological, and anatomical 'ability.' While doing so, they collected data related to the direct impact of the disease and disorder. It is important to note that the social impact of disability was rarely discussed in the colonial census. The functional data about the social and environmental settings where the disabled lived in Colonial India was absent from the census records.

The assessment of the functional data of the disability statistics helps the state to understand the social needs of the disabled.[214] These figures provide an insight into the requirement for different assistive technologies that are to be provided by the state policies in the field of employment and education.[215] The population disability data is essential for monitoring the quality and outcomes of policies for the disabled. In particular, these data assist to identify the set policy outcomes that maximize the participation of the disabled in all areas of social life. With the valid and complete disability statistics, state agencies will possess the assessment tools to scrutinize the cost-effectiveness of policies for the disabled, "which in turn can provide the evidence to persuade governments of their ultimate benefit for all citizens."[216]

[214] WHO, "Disability Statistics," 8.

[215] Welfare Ministry of India (WMI from here on), "Disabled World," (2017). https://www.disabled-world.com/news/asia/india.

[216] World Health Organization, "Disability Data," *Model Disability Survey* (2013). https://www.who.int/disabilities/data/en/.

The concept of disability, within its terminology and experience, is multidimensional. Disability as an idea cannot stand alone.[217] It is defined as an interaction between certain conditions of the disabled along with their physical and social barriers.[218] It is imperative to connect the medical, individual, social, and environmental influence with disability and the disabled. The listing of disability statistics in the census should be inclusive of various factors, namely the levels of functions which are the combination of body functions and structures, activities and participation, impairment and activity limitations, and participation restrictions.[219] The census includes an understanding of the functional levels of the disabled at the echelon of the body, person, society, and environment. This information provides an insight regarding the need for the availability of assistive devices, family and community support, supportive services, policies, attitudes of different people to the disabled, and their health conditions such as diseases, disorders, and injuries.[220]

When we look at the colonial census, the change in ideology or terminology in diverse censuses shows that the colonial understanding of the illnesses and disabilities evolved into a more medical one. For example, when the 1881 Census addressed the insane in a vague medical manner, the 1891 Census titled the particular section as persons with 'unsound mind' which included both insane and imbeciles.[221] But in the census reports, information about the individual, social, and environmental experiences of the disabled was left out from the analysis.

Colonial census questions regarding disability were vague and close-ended. There was no information available in the census reports about the severity of the disability and its impact on an individual level. Colonial census records failed to keep separate sections for mild, moderate, and severe disability. Keeping a record of the severity of the disability and its impact is important because many disabilities could be developmental. A mild disability could develop into a severe disability over time. No colonial census reports other than the 1921 Census Report talk about developmental disabilities.

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[217] Ibid.

[218] WMI, "Disabled World".

[219] Ibid.

[220] Global News, "Importance of Data in Disability," (2015). https://www.cbm.org/Importance-of-data-in-disability-497991.php.

[221] 1891 Census Report, 227.

The census must have a uniform definition and categorization of disability.[222] It is important to note that the major errors in the colonial census records were mainly due to the lack of uniform definition. The relative differences in the vernacular languages and disabilities related terms were a key challenge for colonial enumerators. The description of each infirmity was dissimilar in each province which created confusion among the enumerators. The definition of insanity was dissimilar in each province. The designed instruction given to the census enumerators was to survey and collect the number of persons with 'unsound mind' without further explanation. In some provinces, the 'unsound' minded were those who witnessed violent episodes of insanity. In some provinces, they included 'idiots' and 'imbeciles,' while in certain regions, the statistical records of the insane additionally included those persons whose attacks were periodical and temporary. A similar prevailing query was encountered in the case of blindness as well. In the case of blindness, some enumerators took complete blindness into account. In some provinces, one term was used alternatively to denote both complete and partial blindness. For deaf-mutism, there was no distinction done between these two conditions, which directed to inflation of numbers. For leprosy, enumerators were confused between 'white and 'black' leprosy.

There was a significant gap in the coverage of child disability in the colonial census. This gap was chiefly because of the complexity in identifying disability among the children. Colonial enumerators were hardly medically trained in identifying disabled children and failed to understand the characteristics of their conditions. The gap between the total number of the disabled in the colonial census also was because of the concealment of disability in India. The social prejudices compelled the people to conceal the disabilities of children and women which caused errors in the statistical denominators. While formulating questions, the colonial enumerators failed to appease the masses about the importance of the census process. Non-familiarity with India's customs also posed a challenge for the enumerators. The enumerators were not familiar with the methodology and understanding of both census and disability. This non-professionalism ushered in confusion when it came to the collection of the data. The wilful concealment of the disabilities from the public led to setbacks in delivering a concise and proper tabulation.

[222] Ibid.

The other dilemma presented in the colonial census data is that it failed to make an association between the medical aspect of disability and other demographic variables such as employment, income, and family. The working population among the disabled was not reflected in the colonial census. The labour force of the disabled in Colonial India was not huge but was rather heterogeneous. Instead of exploring the various possibilities of employment, the colonial census categorized the disabled under the traditional categorization of caste-related employment. The colonial census also counted the disabled based on the 'family' and 'household.' This failed to record the entries of the homeless disabled in Colonial India who were abandoned by their families and lived in streets and earned through begging.

Scientific and practical reasons behind infirmities were not discussed in the colonial census. Based on colonial speculation and assumption, while discussing the causes of disabilities, an over-emphasis was given to terrain, climate, and race. The role of heredity was not discussed fully while dealing with insanity and blindness. There was an overemphasis on the factors such as race, climate, and diet while discussing blindness. The disease factor of deaf-mutism was not explored thoroughly. The infirmity section was extended to only four infirmities which was yet another issue. Colonial census overlooked the account of orthopedic disabilities except for leprosy, which resulted in errors in the data. Colonial census failed to provide a piece of accurate information on the diversity of the disabled population in India.

The milieu and environment of the disabled always sought attention as a significant matter of concern which was never a worry for the colonial census. The disabled faced difficulties in their daily life due to their surroundings or impairments which eventually led to permanent disability.[223] Many of these conditions could be avoided if the census records included accurate information. On that basis, the government could plan and implement welfare programmes. The census could in addition identify the barriers faced by the disabled in the sectors of health, education, and transport. The census can also collect information about the livelihood of the disabled. Colonial census reports failed to take note of the barriers they faced in the sectors of health, education, and livelihood. Any practical information related to the challenges faced by disability health service, long-term support, disability accommodation, children's disability, disabled employees, school-to-work transition, health care reform initiatives, conditions of the

[223] Disability Research, "Disability Statistics and Demographics: Rehabilitation and Research," (2010). https://researchondisability.org/stats.

health care coverage for the disability and managed care, and various cost-containment measures were not focused by the colonial census. In this regard, the colonial census also failed to highlight the awareness of the fact that people with disabilities represented a significant proportion of India's population.[224]

Summing Up

From 1881 to 1931, the colonial censuses included infirmities in four sections—the insane, the deaf-mute, the blind, and the lepers. When one looks at these given statistics, it is evident that there was a reduction of people with infirmities in these four sections from 1881 to 1931. At times, these reductions were occurred due to famine and high mortality rates, but advances in medicines equally played an essential part. It in addition may be a result of developing clarity of the census methodologies. When it came to insanity, the census enumerators changed their definition of insanity from census to census. Only the aggressive insane were considered insane in 1881, and the same was modified with the inclusion of intellectual disabilities in 1931. Throughout all these censuses, the deaf-mute and blind were counted based on congenital. Old age and trauma-related blindness and deafness have also crept into the census records. The gradual reduction in the number of lepers is also evident in these tabulations. When it came to the sex ratio, it was different for all these infirmities. The number of men in the categories of the insanity, lepers, and the deaf-mute was surprisingly high. When it came to blindness, the number of women was high.

Some errors in the tabulation occurred mainly due to the altered criteria for infirmities. For example, there was no strict boundary between mental illness and mental disability. In sum, both wilful concealment and differences in definitions created errors in these statistical tabulations. Orthopedic disabilities, other than leprosy were never counted in the census. Moreover, colonial census data about disabilities were not faultless. Their methodologies and tabulations were not convincing. Their understanding of the disabilities was deficient and their perception of the causes behind these disabilities was often faulty. Even so, the colonial census is the only source that can provide numerical evidence about the disabled in Colonial India. A careful examination of the source can provide useful insights into the phenomenon of disability in Colonial India.

[224] Ibid.

Chapter Three

DISABILITY IN COLONIAL INDIAN LEGISLATION: ACTS AND LEGAL REMEDIES OF MENTAL AND PHYSICAL DISABILITIES

The term 'disability' bears manifold definitions and conceptualizations across cultures and societies. With time, the meaning and understanding of the term have undergone drastic changes. To deal with disabilities as a predicament, multiple approaches called 'models of disability' are suggested and implemented.[1] One of these stated approaches is the legal approach to disability which is simply described as a model to tackle the question of disability with the assistance of legislation. The colonial government was credited with introducing legal acts and clauses that deal with disability in India. This chapter discusses 1) mental disabilities stipulated under the colonial legislature and 2) legal remedies of colonial acts involving physical disability.[2] The chapter analyzes the colonial acts namely, the Indian Lunacy Acts of 1858; Calcutta Police Act of 1866; Indian Divorce Act of 1869; Anti-Vagrancy Act of 1869; Pension Act of 1871; Indian Evidence Act of 1872; Indian Contract Act of 1872; Military Lunatics Act of 1877; Vaccination Act of 1880; Code of Criminal Procedure of 1898; Lepers Act of 1898; Prisoner's Act of 1900; Design Act of 1911; Indian Lunacy Act of 1912; Court of Wards Act of 1920; Income Tax Act of 1922; Workmen's Compensation Act of 1923; Indian Succession Act of 1925; Motor Vehicle Act of 1930; Indian Medical Council Act of 1933; Central Services Extraordinary Pensions Rules of 1937; Bombay Medical Practice Act of 1939; Drugs and Cosmetics Act of 1940; Bombay Prevention of Begging Act of 1957, and the Indian Penal Code. The development of laws on mental disability in Colonial India was not a novel invention as it was the direct continuation of the established laws in Britain. Consequently, it is vital to look at the history and background of these legislations.

[1] Peter Issac, "Disability and the Education of Persons with Disabilities," in *Disability and Dilemmas of Education and Justice*, ed. Carol Christensen and Fazal Rizvi (Buckingham: Open University Press, 1996), 33.

[2] Legal remedies are the prescribed steps given in an act to access its legal protection. The main role of the legal remedy is to provide accessibility to the people.

3.1. Mental Disability and Lunacy Acts in Colonial India: The Indian Lunacy Acts of 1858 and 1912

The mentally disabled lived through exploitation and negligence in society; very often, their human rights got violated as they were deemed to be 'socially-unfit.' They were not only marginalized but easy and free access to a life in dignity, education, employment, and health care was denied to them. Mental health legislation redefines social integration with an aim to de-stigmatize and eliminates exploitation inflicted on the mentally disabled. Therefore, it was mandatory to stipulate mental health legislation to protect the rights of the mentally disabled. The implementation of legislation ensured the feasibility of quality medical treatment, education, employment, housing, and social security. Mental health laws provided guidelines for state health policies and medical care.[3]

As far as medical history in India is concerned, 1858 ushered in new features of legality to the medical-related discussions. In 1858, the first legislative document on the direct treatment of 'Indian insane' was passed. The Act of 36 of 1858 (The Indian Lunacy Supreme Court Act) and the Act of 35 of 1858 (The Indian Lunacy District Court Act) were passed in 1858 to deal with insanity among Indians.[4] Together known as Indian Lunacy Acts or Indian Lunatic Asylum Acts, these acts promised the medical rehabilitation of the insane in Colonial India. With the redefinition of the term of insanity, the realization of these acts in the public sphere was influenced by the construction and reorganization of other colonial institutions like insane asylums, prisons, universities, and hospitals.[5] Therefore, these acts unanimously defined an insane, which was substituted by terms such as 'lunatic' to define insanity. The word 'lunatic' was defined as "every person found by due course of law to be of unsound mind and incapable of managing his affairs."[6] But the acts were not clear enough in their statement to understand whether the term referred to the 'mentally ill' or 'mentally disabled' alone. It classified every person who could not take care of himself/herself as insane.

[3] Terms such as insanity, lunacy, and mental derangement are used in this chapter interchangeably. The terms are used to denote mental disabilities.

[4] Mentioned as Supreme Court Act and District Court Act in the chapter.

[5] Robin J. Moore, "Imperial India, 1858–1914," in *Oxford History of the British Empire: The Nineteenth Century*, ed. Andrew Porter (Oxford: Oxford University Press, 2001), 422–446.

[6] Jivan Krishna Ghosh, *Probate, Minority, Lunacy, and Certificate Acts Containing Minors* (Calcutta: J. Haldar & Co., 1890), 79.

Indian Lunacy Acts were the results of the changes in lunacy laws in Britain. Even before 1858, discussions on the mental health of the natives occurred and were heavily influenced by British discourse when lunatic and asylums acts were passed in England in 1845 and 1853.[7] The reason why new lunatic laws were enacted in Britain was the public anger about the inhuman practices forced upon the insane in the insane asylums.[8] It was further understood that the lunatic laws in India were the result of the colonial aspiration to control the natives through certain institutions. Subsequently, "this was a moment where the British government provided a different mode of sovereignty and an altered lens of authority, and Indian communities were also encouraged to engage with their new rules in a different light."[9]

After the Revolt of 1857, the colonial government re-imagined a new India already implemented in the education system, and politics through different policies and Indian intellectuals started to engage in discussions with the colonizers.[10] While the 1857 Revolt had destabilized the colonial arrogance, the colonial rule was transferred from Company to Crown. All these changes impacted the formulation of the new lunatic law. Formulating the lunatic law in India adapted from Britain was the colonial strategy to create a fake impression of including the Indian population under their rule of 'benevolence.' Thus lunacy laws were fuelled by the thought that if the colonial government had to continue ruling India, there was a need for understanding the native mind. The better running of the institutions like the prisons, army, universities, and hospitals needed a guidebook on native thought and mind.[11]

The two fundamentals which helped the new colonial government in understanding the native mind were the development of phrenology and the implementation of English education. "Theories about race were essential to the application of phrenology, especially in the subcontinent, which hoarded so many potential specimens with which to prove the feasibility of the phrenological theory. The

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[7] Bill Forsyth, "The New Poor Law and the County Pauper Lunatic Asylum–The Devon Experience, 1834–1884," *Social History of Medicine* 9, no. 3 (1996): 335–355.

[8] Ibid.

[9] Anouska Bhattacharyya, *Indian Insanes: Lunacy in the Native Asylums of Colonial India* (PhD Thesis: Harvard University, 2013), 45.

[10] Chris A. Bayly, *Rulers, Townsmen, and Bazaars: North Indian Society in the Age of British Expansion, 1770–1870* (Cambridge: Cambridge University Press, 1983), 263.; Thomas Metcalf, *The Aftermath of Revolt* (Princeton: University Press,1864), 39–43.

[11] Bhattacharyya, *Indian Insanes*, 55.

scientific examination of the Indian skull (in all its colonial variations) represented a way to transition from knowing the Indian body to knowing the Indian mind, and evidence uncovered from these examinations legitimized British colonial policies."[12] Borrowing ideas from phrenology, the colonial legal system categorized Indians into diverse criminal classifications such as 'hereditary thugs' and 'born criminals.'[13] This filing venture became a new colonial project to scientifically legitimate the natives as 'disabled,' 'criminals,' and 'inferior.' This new understanding of caste and crime also intensified the colonial desire to discipline the native mind with new legislations.

After the Revolt of 1857, the nature and scope of the colonial mission started to change. It was no longer about the physical control of the colonies rather extended beyond the material dominion. The spread of the evolutionary social theory that justified the colonial conquests provoked the colonial officers to study the native mind.[14] Consequently, in the mid-nineteenth century, Edwin Chadwick introduced his Poor Law, where he argued that "filth, not poverty, was the cause of moral decline, fever, and death."[15] By combining the moral economy of medicine with the political economy of an expanding industrial capitalist empire, "Chadwick was able, under the tutelage of Jeremy Bentham, to achieve some of the most far-reaching legislative reforms in this period. It is this vision to which the British in India was attracted; a vision that directed their desire for reform in India, and a vision that shaped the legislation they borrowed."[16]

Moreover, the need for implementing English education in India was another reason why the colonial authorities decided to study the Indian mind. Carla Yanni in her text, *Architecture of Madness* has argued that universities and asylums try to influence the mind in a similar but different way. Both educate, but the former educates the healthy and the latter educates the 'unhealthy.'[17] English education was one of the keys according to the British government that could distinguish between the 'healthy' and 'unhealthy' minds in India. The need for English education, therefore, was strongly advocated by Macaulay

[12] Ibid., 56.; Andrew Bank, "Of 'Native Skull' and 'Noble Caucasians': Phrenology in Colonial South Africa," *Journal of South African Studies* 22, no. 3 (1963): 387–403.

[13] Bhattacharyya, *Indian Insanes*, 56.

[14] Ibid., 57.

[15] Ibid.

[16] Ibid., 53.

[17] Carla Yanni, *The Architecture of Madness: Insane Asylums in the United States* (Minneapolis: University of Minnesota Press, 2007), 8.

who rejected any possible 'reason' in oriental education.[18] The medium of instruction was English and the pro-English team believed that 'to speak English was to be English.'[19] This was actualized in primary/secondary schools, residency universities, and the civil service examinations.

Furthermore, social reform was another motive that forced the colonizers to realize the urgent need to implement new legislation. The British could not employ military rule in India due to its large territorial size. The blow to the British army at the time of the Anglo-Sikh wars of 1848–49 and the Santal Rebellion was enough for the British to understand that they needed a change in strategy. Thus it was important to introduce social reform through the assistance of the local network to ensure the dominance of the British in India.[20] David Arnold argues that the grounds for new legislation were to punish the leaders of the revolt and most importantly, to take them into confinement.[21] He further adds that this action may prevent creating new idols for future rebellions.[22] However, it is interesting to note that the legislative proceedings on the drafting of the lunacy laws make no mention of the revolt.

Subsequently, the development of modern medicine and psychiatry and its cost-effectiveness also fuelled the expansion of the mental health legislation in India.[23] One of the main reasons for the introduction of the 1858 Indian Lunacy Acts in India was its relation to the company's burden in dealing with the maintenance cost. The soldiers who fell sick during their stay in India were sent to asylums for treatment, which became a burden on the government finances. Their treatment cost and other expenses were paid by the company as a loan to the patient. But the money was never repaid, and this trend

[18] T. B. Macauley, "Minute on Education," (1835). http://www.columbia.edu/itc/mealac/pritchett/00generallinks/macaulay/txt_minute_education_1835.html

[19] Tejaswini Niranjana, "Translation, Colonialism and the Rise of English," *Economic Political Weekly* (EPW from here on) 25, no. 12 (1990): 773–779.

[20] Chris A. Bayly, *Empire and Information: Intelligence Gathering and Social Communication in India, 1780–1870* (New York: Cambridge University Press, 2000), 2–9.

[21] David Arnold, *Police, Power and Colonial Rule: Madras, 1859–1947* (Delhi: Oxford University Press, 1986), 7.

[22] Bhattacharyya, *Indian Insanes*, 35.

[23] David Arnold, *Science Technology and Medicine in Colonial India* (Cambridge: Cambridge University Press, 2008), 42.

continued till 1818.[24] The Indian Lunacy Acts of 1858 were passed under these circumstances and it was the first pan-Indian legislation concerning mental disability in India. These acts were divided into two sections—the first one was implemented at the supreme court level and the second section operated at the district and local territorial level. These lunacy acts did not provoke uproar in the Indian society as the Europeans imagined. However, what these acts provided was the legal definition of who was 'insane.' The typical narrative of the 'colonial madness' portrayed in the majority of texts dealing with insanity in Colonial India underestimated this disability factor.[25] The acts provided a forum and defined framework to the question of what constituted 'insanity.'

The Indian Lunacy Supreme Court Act of 1858 stipulated that "the word 'lunatic,' as used in this act unless the contrary appears from the context, shall mean every person found by due course of law to be of unsound mind and incapable of managing his affairs."[26] 'Unsoundness of mind' taken by itself was not sufficient to bring a person within the meaning of the term 'lunatic' as used in the act, "unless it would incapacitate him from managing his affairs; nor on the other hand, will a person who is incapable of managing his affairs be a lunatic unless that incapacity is produced by unsoundness of

[24] The seventeenth and eighteenth centuries saw cut-throat competition between Europeans to gain power in India to control its resources and it resulted in more sick soldiers. Hence, the lunatic asylums in India started to shelter these European 'insane' soldiers. The earlier asylums were looked at as a temporary arrangement and their maintenance cost was higher when compared to the asylums in Britain. In the subsequent years, many private asylums were constructed especially in Bombay, Madras, and Calcutta to accommodate a greater number of mentally disturbed soldiers. But the inhuman conditions in these asylums forced the government to look for more legislation to enhance the services and treating milieux. Even after six months, if the condition of the patients did not improve, they were sent back to Britain. The transport cost and other expenses were paid by the company as a loan to the patient. But the money was never repaid and this trend continued till 1818. It was then the Lunatic Removal Act was passed in 1851. It was meant to generate the regulation regarding the transfer of the British lunatics in India back to home. This act was ceased in 1891 after the passing of the Indian Lunatic Asylum Amendment Act in 1886. Gauranga Banerjee, "The Law and Mental Health: An Indian Perspective," (2005). http://www.psyplexus.com/excl/lmhi.html.

[25] Many scholars like David Arnold, Christopher Alan, Homi K. Bhabha, and Nicholas Dirks failed to mention the factor of mental disability while discussing insanity in Colonial India. Arnold, *Police, Power and Colonial Rule.*; David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley: University of California Press, 1993).; Christopher Alan, *Indian Society and the Making of the British Empire* (Cambridge: Cambridge University Press, 1988).; Homi Bhabha, "Of Mimicry and Man: The Ambivalence of Colonial Discourse," in *Modern Literary Theory: A Reader*, ed. Philip Rice and Patricia Waugh (London: E. Arnold, 1992), 230–241.; Nicholas Dirks, *Castes of Mind: Colonialism and the Making of Modern India* (Princeton: Princeton University Press, 2001).

[26] The Indian Lunacy (Supreme Courts) Act, Act No. 36 of 1858 (London: Taylor and Francis), pp. 1–27. (Lunacy Supreme Court Act of 1858 from here on).

mind."[27] The act also offered provisions to look at the question of mental capacity of an insane. Therefore, the act states that "mere incapacity to manage his affairs is not enough unless it is shown that the said incapacity is due to unsoundness of mind."[28]

On examining this definition, it should be noted that for Colonial India, an 'insane' is not only a person with a mental disorder but also a person who cannot take care of his/her business.[29] Any person who could not prove his/her social 'usefulness' due to mental disability and illness falls into this category and the social 'usefulness' of the person would be decided by a committee after examining the mental capacity of the said person. There were instances where a person could be mentally ill and yet take care of his/her 'social role' just fine without any assistance. Some mental illnesses, especially those which are periodical or depressive would not completely take away the 'social ability' of a person.[30] But when it came to the severe mentally and intellectually disabled, based on a fixed or rigid social criterion it was difficult for a person to fulfil his/her 'social role' without the assistance of someone, state, or family. Care was vital to such persons. It is important to note that the definition of 'insane' under the act itself created the norm of what is normal. The normalcy of a person was embedded in his/her 'usefulness' to society and their ability to fulfil his/her expected social role grounded in fixed social criteria. The very definition itself is discriminatory to the mentally disabled. Today, a person who suffers from any mental disorders because of any illness or disability irrespective of his/her social 'usefulness' is treated equally before law. Law recognizes a person's individual or unique ability to take care of himself/herself and others.[31]

The Supreme Court Act also gave power to a committee to decide whether the person in question was of 'unsound mind' and whether his/her unsound mind caused 'incapacity' in his/her life for managing his/her own business.[32] Such inquiry can be requested through Advocate General by any blood relative of the alleged person or anyone who is married to him/her. If the case sounded urgent, under the act, the Advocate General can appoint an interim receiver of the estate of the 'alleged' insane.[33] The agency to prove

[27] Ibid., 2.

[28] Ibid.

[29] Ibid.

[30] Ibid., 3.

[31] Ibid.

[32] Ibid., 4.

[33] Ibid.

one's own 'usefulness' to the society and to prove the capacity to manage an expected way of life was denied to the individual and was given to a committee that acted as a social representative which set the social norm checklist to assess a person's ability to fulfil the social expectation. The involvement of a committee, a by-product of the society itself ruled out someone 'incapable' due to his/her inability to perform certain tasks in the same way expected from everyone and this could create negative setbacks to the future of the person in question.

The Supreme Court Act proclaimed that it was the responsibility of the government to take care of anyone who could not take care of oneself owing to their mental 'derangements.'[34] In other words, the government would take the position of the guardian to the mentally deranged person.[35] This clause still exists in the independent Indian legislation that the state has to take care of the person who is mentally unfit to take care of his/her needs. Considering the word 'mental derangement' in the act, it was not specified whether it included mental disability alone or not. 'Derangement,' therefore is defined as a state of a disturbance where one cannot think or act in a socially 'desired' way.[36] This condition applies to mental disabilities like autism, and to the severe forms of mental illnesses like bipolar disorder and schizophrenia which are today recognized as mental disabilities. In that sense, colonial laws included mental disabilities in their clauses.

The Supreme Court Act further states that the term 'unsound mind' in the section "included imbecility of any kind whether congenital or due to old age. It also includes mental aberration resulting from disease."[37] The act openly admitted that it included congenital mental disabilities too. No further explanation of whether it was meant for mental illnesses alone was needed because the term 'congenital' in the act considered all kinds of mental disabilities.[38] The act also included 'imbecility' and the extent of 'incapacity' caused due to imbecility, disease, age, or accident.[39] The act also mentioned 'intellectually disabled' whereby it stated that if the alleged person was in such a question

[34] Ibid.; Romani Doss, *The Law of Lunacy in British India* (Calcutta: S. Lahiri & Co., 1906), 123.

[35] Lunacy Supreme Courts Act of 1858, p. 5.

[36] Ibid.

[37] Ibid., 6.

[38] Ibid., 7.

[39] Ibid., 8.

where he/she could not understand what was going on, the court could appoint assistance in the hearing to help him/her.[40]

The Supreme Court Act mentioned two kinds of insane in its definition—the one who continued to be of 'unsound mind until the contrary is shown' and the other being 'those who assert it to prove that he/she was of unsound mind.'[41] The second one is probably used to identify the mentally and intellectually disabled. The first one should be used to identify the mentally ill because the clause of 'change' was also included in the section. But in the second statement, the assertion showed that this section took a note of the permanent nature of the mental disability.

Moreover, the Supreme Court Act also cited the procedures to examine the nature of a mental disorder.[42] A witness had to produce the evidence for the causes, progress, and treatment of the condition in court. After such an inquiry, it was the responsibility of the court to decide whether the person needed a personal examination to see whether he/she was mentally disabled or not. If the person in question was a woman, she did not have to appear before the court in public.[43] Private examinations were conducted in such cases by respecting the customs of Indian society and religion. For personal examinations, a judge could perform them by himself or could call for someone he thought was suited for the undertaking, and the examiner needed to submit a report to the court. During that time, judges who did not know about psychiatry examined people, and many times, asylum superintendents were called to assist them. However, the judges and asylum superintendents were not well-versed in medicine, thereby often creating issues in identifying a mentally disabled person. If the report of the judge was found to be faulty, the report was again sent back to the judge to make amendments. The court could also call for physicians and surgeons if the case was complicated.[44]

If the person was found to be mentally disabled and could not take care of himself/herself, his/her estate was transferred to his/her next kin. Strangers for the 'post' were entertained when there was a specific objection against the kin was presented in the

[40] Ibid.

[41] Ibid

[42] Ibid., 9.

[43] Ibid., 10.

[44] Ibid., 11.

court.[45] Furthermore, the court in addition checked the abuse of the property whereby the court decided whether the property was movable or not.[46] The person who had this power to handle the estate of the person could not sell or charge by way of mortgage for three years.[47] Sometimes, mentally disabled being the vulnerable category, the relatives held their land and abandoned them when they received the ownership of the estate. The court kept a record of the management of the estate of the mentally disabled. The court got notified if the kin tried to sell or mortgage the estate entirely or any part of it. The estate would remain as the immovable property for a maximum of three years. After the stipulated three years, if the kin wanted to sell the estate, then they could send a proposal to the court that would be discussed and decided later keeping the welfare of the mentally disabled in mind. The court also decided who should receive the money from the surplus of the estate. The Supreme Court Act states, "The court will not sanction the making of allowances out of the lunatic surplus income to his relatives or other persons."[48] It was only possible when the owner of the estate decided to do so, but "before his lunacy under some legal or moral obligation to contribute."[49] The manager appointed by the owner when he/she was in his/her sound mind could not be considered as the representative of his/her estate before the law, only the guardian of the estate could officially represent a mentally ill or disabled.[50]

It is significant to understand that the Supreme Court Act of 1858 denied any kind of property right to the mentally disabled. According to the act, a mentally disabled person was looked at as unfit to own or inherit a property irrespective of their 'mental capacity.' The main reason for this adverse state of affairs was the misunderstanding that all mentally disabled are not capable of understanding, judging, and communicating decisions. Furthermore, the Indian Contract Act of 1872 stated that any person who was of unsound mind was not fit to enter a contract.[51] Similarly, the Indian Succession Act of

[45] Ibid., 12.

[46] Ibid., 13.

[47] Ibid., 14.

[48] Ibid., 15.

[49] Ibid.

[50] Ibid., 16

[51] Indian Contract Act of 1872, pp. 1–30.

1925 decreed that probate cannot be granted to the mentally disabled.[52] But they could inherit property and the administrative rights of the property were given to a guardian. According to the Transfer of Property Act of 1882, a person of unsound mind could purchase property, but it could be challenged in court.[53] Nevertheless, in 2016 with the passing of the Rights of Persons with Disabilities Act, it became the responsibility of the state government to "ensure that persons with disabilities have right, equally with others, to own, or inherit property, both movable and immovable."[54]

The Indian Lunacy District Court Act of 1858 did not provide a detailed definition of the insane; it simply defined the 'insane' as "every person of unsound mind and every person being an idiot."[55] The District Court Act aimed to provide better care for the estate of the insane so that the burden of the Supreme Court of Judicature got reduced, and also to prescribe general rules concerning the state of mind of a person.[56]

The District Court Act was used when it was impossible to employ the Supreme Court Act of 1858. It was an obligation under this act to see and examine the property owned by the 'alleged lunatic.'[57] This examination was conducted by the district civil court where the person was residing. The civil court had to examine to see whether such a person was of an unsound mind or not and the level of his/her capacity to manage his/her own business. One amendment brought by this act was its power to appoint a manager to look after the estate of the insane even when the person was not living under the jurisdiction of the same court.[58] When the court called for applicants to be filled in the post of the manager, they were to be verified from the court's side. Verifying the application was a significant strategy of the court because the chances of misusing or exploiting the insane's estate were higher when strangers got involved in the affairs.

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[52] Amba Salelkar, "Property Rights of Persons with Disabilities," *Connect Special* (2019). https://www.patientsengage.com/news-and-views/property-rights-persons-disabilities

[53] Ibid.

[54] Rights of Persons with Disabilities Act of 2016 (Delhi: Department of Empowerment of Persons with Disabilities, Ministry of Social Justice and Empowerment, Government of India), pp. 1–49.

[55] The Indian Lunacy (District Courts) Act, Act No. 35 of 1858 (London: Taylor and Francis), pp. 1–21. (Lunacy District Court Act of 1858 from here on).

[56] Ibid., 1.

[57] The Gazetteer of India (Delhi: Government Printing, NAI, 1880), 676.; The Gazetteer of India (Delhi: Government Printing, NAI, 1881) 174.

[58] Lunacy District Courts Act of 1858, p. 2.

The District Court Act ensured that only the deserving candidates received the benefits after producing strong evidence to back their claim. Earlier an inquiry was made into every registered case. Many times, the allegations were made by greedy relatives to acquire property. This clause to provide evidence before the inquiry eliminated half of these kinds of fabricated cases because the person who filed a case could not support their allegations with strong evidence. Under the act, only the relative of the person or any public curator appointed could submit a request to an inquiry.[59] The appeal could furthermore be made by the collector of a district where the estate of the person in question was situated. Every application for such an inquiry was verified and proper notice was given to the person in question.

In case the person in question was not in the state of having an understanding of the content of the notice, the court would assist to help the situation.[60] Under these circumstances, the court had to send the notice to his/her relatives also. Instead of striking off a case because a person could not appear before the court, this provision helped the court to conduct an inquiry without any further confusion. This provision assisted many mentally disabled persons in Colonial India to appear before the court for their certification and seek legal protection. The right to conduct an inquiry was another effective clause in this act. According to the District Court Act, it was in the hands of the courts to directly examine a person.[61] Furthermore, the court could appoint a person who it might think could provide a medical report on the mental capacity of the person in question, whereas this authorizing power was non-existent during the earlier years. Formerly, personal examinations were made by people who were inexperienced in psychiatry. Later, the appointed person had to demonstrate a proven experience in the field of psychiatry. The Supreme Court Act also assisted a person in inquiry. But authorization was a novel idea introduced by the court later through the District Court Act. Personal examinations were conducted privately. The public court cross-examination was avoided in cases of insanity.[62] It was the responsibility of the court and related person to maintain great care and delicacy during examinations. Any situation which could cause pain or excitement to the person in question was discouraged. These guidelines facilitated the judiciary to deal with insanity with much transparency.

[59] Ibid., 3.

[60] Ibid., 4

[61] Ibid.

[62] Ibid., 5.

The results of the inquiry provided the base for the cost provision of the court inquiry.[63] If the person was found insane, the cost was to be catered for by the estate of the person. Under the District Court Act, three factors were taken into consideration to identify an insane—whether his/her mind was under-developed, whether he/she was unable to manage his/her estate, and whether he/she had a history of delusions.[64] If the person lived at a distance of fifty miles from the civil court, the court advised the subordinate court to conduct the inquiry on behalf of the district court.[65] The subordinate court sent its findings to the court along with its own opinion and assistant's opinion on the case. The inquiry and the final verdict must be announced by the judge and not by the subordinate court. This action eliminated the cases of familiar influences on the subordinate courts.

Under the regulation of the District Act, a manager of the estate was later appointed by the court.[66] The first preference was given to a relative of the lunatic; the second preference was directed towards a public curator, and if no such person was available, any suitable person was appointed by the court as seen fit to play the role.[67] Under the Supreme Court Act, a high court could not decide who should be appointed as a manager; only the district court should do that which eventually led to increased cases of property disputes in Colonial India.

Under the District Court Act, one such case of property dispute on the estate of a lunatic was registered in the Amritsar District Court against a person called Saabanse Sing by Juggesshur Koer.[68] Juggesshur Koer claimed that she should be appointed as the manager of her husband's property who was mentally disabled, which was sternly opposed by the nephew of her husband. Saabanse Singh, the nephew of the disabled was disqualified later on the grounds of misuse of the property. Koer advocated that the person who personally was taking care of the disabled should be held responsible for his/her estate so that he/she could enjoy its benefits. In this case, his close relative was his wife and she demanded to be held responsible for managing his affairs. But later, the nephew appealed that no manager could be appointed because the property was owned by both

[63] Ibid., 6.

[64] Ibid., 7.

[65] Ibid. 8.

[66] Ibid., 9.; The North-Western Provinces Land Revenue Act of 1873, pp. 1–12.

[67] Lunacy District Courts Act of 1858, p. 11.

[68] Lunacy District Courts Act of 1858, Registered Cases, Indian Kanoon.

him and his uncle, and "it was thereupon held that the nephew by claiming to be appointed manager could not object to the appointment on this ground."[69] But later both the wife and nephew were disqualified on the ground of misconduct. The court also ensured that only a judge will decide the person to be appointed without disclosing the details of estate property.[70] This would eliminate any conspiracy to acquire property by the wrong people. In another such case, Bhupendra Narayan Roy from Bengal submitted a petition in the Shahabad District Court to be appointed as the manager of his mentally disabled father-in-law's estate. Nevertheless, the court dismissed the case saying it was not strong enough and the motive of the petition was not the welfare of the person in question.[71] Later, he withdrew the case upon knowing that his father-in-law's estate was in debt.

In all cases, the manager of the estate was appointed with a formal order and certificate. Persons whose place of residence was near to the mentally disabled's house were taken into account. The frequency of visits and zeal for inspecting and managing the concerns were recorded by the court personnel. The sons-in-law of an insane would not be appointed as managers unless no other person could be found to take the role of a manager.[72] This clause showed that the colonial law thought of check provisions for the security of the mentally disabled's estate. The court appointed a 'fit' person to be the guardian of the disabled and also carried thorough checks on these kinds of situations with the above-mentioned clause.

The case of Kupulman Singh is a piece of relevant evidence to endorse the court with the power to exercise the inspection of the management of the estate of a mentally disabled. Kupulman Singh was a wealthy man from Calcutta. In 1862, Singh's younger son filed a case against his elder half-brother for acquiring the entire property. He charged that his father was a 'lunatic' and asked the court to declare him so. The mother of the younger son wanted to sell their land but the elder half-brother was unhappy about it. Under the District Court Act of 1858, the case was registered and the Calcutta High Court Committee announced the verdict stipulating that "the alleged lunatic had for many years now is in such a state of mind as to render it right to detain him at home…but that he was

[69] Ibid.

[70] Ibid.

[71] Ibid.

[72] Lunacy District Courts Act of 1858, p. 13.

of sound mind at the dates of the committee duly appointed."[73] Moreover, as the younger son's mother had mortgaged his estate without the prior sanction of the court, thus the "mortgage's suit for foreclosure was dismissed."[74] It was the concrete example of the court's examination capacity in Colonial India.

Even though the District Court Act provided provision for the legal protection to the property of the mentally disabled, it also established that disability is a legal liability to be protected. In doing so, it eradicated the human agency of the mentally disabled and posed the disabled body and mind as a 'thing' to be protected. The identity of the disabled was reduced to the protection of his/her property. The Indian Lunacy Acts of 1858, both Supreme Court and District Court Acts, failed to distinguish between physical dependency and social dependency. They mistook physical dependency for social dependency. Independent living situations including accessible environment, information, housing, education, employment, technical aid, and personal assistance were never given any importance under these acts, which barred giving autonomy and human agency to the disabled.

By this time, it was imperative to enquire who had jurisdiction over insanity in India. Medicine and law always mingled excessively in Colonial India. The border between colonial law and medicine, administrative branches of medicine and judiciary, and sanity and insanity kept changing over time. The dilemma in Colonial India was how the authorities managed insanity as a pure judicial or medical setback. This confusion over medicine and law regarding insanity was chiefly because of the lack of clarity in the British understanding of the purpose of the insane asylums. While vaccination, creation of dispensaries, and sanitation had clear agendas and aims of their own, the intention of insane asylums remained indistinct. This uncertainty was intensified when the Indian insanity was forcefully categorized into the already extant British models with the help of the Indian lunacy acts instead of making new and indigenous models. At the end of the nineteenth century, asylum superintendents and psychiatric experts started to speak about the importance of amendments to the existing lunacy laws related to insane asylums in

[73] Emile Henry Monnier, ed. *A Digest of Indian Law Cases: Containing High Court Reports, 1862–1900, and Privy Council Reports of Appeals from India, 1836–1900* (Calcutta: Superintendent of Government Printing, India, 1902), 38.

[74] Ibid.

Colonial India, which eventually resulted in the passing of the Indian Lunacy Act of 1912.[75]

There were three reasons why the demands for the scope of lunatic asylums rose by 1912. Firstly, psychiatry was considered as part of mainstream medicine by then. The psychiatric knowledge in Europe generated higher pay and respectable positions. This eventually increased the demand for psychiatry-trained manpower in Indian asylums. Secondly, the expanding medical education in India ushered in Western-educated doctors and staff. Medical education was significantly imperative for the Indians to climb the social ladder and the Indian Medical Service (IMS) provided educational opportunities. Finally, India was no longer a simple colony to the British; India was their trump card and prized possession. The days of military rule and territorial expansion were long gone and by now, careful administration, social reform, and judicial setup were considered as the important goals.[76]

Charles Hardinge, the Governor-General of India from 1910 to 1916, met with his council at Simla in September 1911, and introduced a new bill to amend the existing lunacy laws in India.[77] In January 1912, Guy Fleetwood Wilson, a British public servant, presided over the council, and the bill was taken up for consideration. Five of the fourteen members of the council who supported the bill were Indians—Syed Ali Imam, Syed Shamsul Huda, Dadabhoy, Babu Bhupendra Nath Basu, and Mudholkar.[78] Whereas in the case of the Indian Lunacy Acts of 1858, none in the council was Indian. The council ensured that the act should cover the whole of British India, including British Baluchistan, the Santhal Parganas, and the Pargana of Spiti.[79] Finally, the council submitted their report in February 1912 and in March, the Indian Lunacy Act of 1912 was passed.[80]

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[75] Bhattacharyya, *Indian Insanes*, 180.

[76] Ibid.

[77] O. Somasundaram, "The Indian Lunacy Act, 1912: A Historical Background," *Indian Journal of Psychiatry* 29, no. 1 (1987): 3–14.

[78] Ibid., 184.

[79] Ibid.; The Indian Lunacy Act, Act No. 4 of 1912 (Cranenburgh: Law Publishing Press), pp. 1–47. (The Act of 1912 from here on).

[80] Alexander W. and Overbeck Wright, *Mental Derangements in India* (Calcutta: Thacker, 1921), 10.

The Act of 1912 was intended to improve the situation of insane asylums in India.[81] The entire act contained rules related to the power of the high court to rule a person 'lunatic.' It also included clauses about the property of the lunatic and the appointment of the guardian and manager of his/her estate.[82] In these respects, the Act of 1912 was not much different from the Lunacy Acts of 1858. The word 'asylum' was defined by the act as an institution or mental hospital for lunatics, which was licensed by the state government or the central government.[83] The word 'mental hospital' in this context, showed positive attitudes of society towards tribulations of insanity. The growing significance of medical knowledge on the mind and psychiatry drove people to look at insanity as a setback that needed scientific exploration keeping aside their age-old prejudices about the outdated perspectives of 'madness.'

The Act of 1912 stated that "except with the special sanction of the provincial government, no one other than a registered practitioner shall be competent to hold any appointment as a physician, surgeon or other medical officers in any hospital, asylum, infirmary, dispensary or lying-in hospital."[84] It showed that the emphasis on the medically trained person's appointment in the respective institutions and court paved way for the rise of 'scientific' treatment of the insane in Colonial India. This was the reason why the asylum superintendents who had expertise in psychiatry were appointed to the asylums as well as in-court procedures. The act also talked about the provisions for the admission to and removal of an inmate at the insane asylum.

Under the Act of 1912, no person other than a criminal lunatic or a person who was found mentally disabled by inquiry could be taken into the asylum.[85] This provision brought a drastic change to the deprived conditions of the earlier asylums which sheltered the mentally ill, disabled, and poor from the street irrespective of their condition.[86] When one desired to submit himself/herself to the treatment, the superintendent of the asylum should collect the consent signature from the two visitors of the asylum.[87] If an individual, who got admitted to the asylum himself/herself desired to leave, the superintendent could

[81] The Act of 1912, p. 3.

[82] Ibid., 8.

[83] Ibid., 18.

[84] Ibid., 12.

[85] Ibid., 22.

[86] Ibid., 21.

[87] Ibid., 20.

not keep him/her in the asylum for more than 24 hours.[88] But his/her application of removal or admission should be accompanied by a statement from a local magistrate and supported by the certification of two medical officers.[89] The medical certificates were to be countersigned by any relative of the insane and the proof of their relationship also being attached with the application.[90] If the person had an inquiry from the court earlier, the report of the inquiry also had to be attached to the application which could be presented by the spouse of the insane. The petitioner had to specify why he/she was submitting the petition/application.[91] Once the petition got registered, the magistrate personally examined the person and checked the authentication of the attached certificates. The magistrate would keep the person in suitable custody till the conclusion of the inquiry. The petitioner, the alleged insane, and a person representing the insane should attend the inquiry in the magistrate's office.[92]

Under the power of the Act of 1912, a police officer could arrest persons from his station limit who were found to be wandering in the street and whom the officer had reason to believe to be a lunatic.[93] Those who were arrested in this way were to be presented in front of the magistrate and would be given a medical certificate by the medical officer, and eventually would put in the care of the asylum or would be put under the care of family or friends according to the situation.[94] It was the onus of the magistrate to find a suitable asylum for the person to get admitted and detained. If it appeared that a person was neglected, not under proper care, or treated cruelly by a relative, the magistrate would summon the relative and the 'alleged lunatic' to the court.[95] If the relative was

[88] Ibid., 19.

[89] Ibid., 23.

[90] After an inquiry, if the lunatic was 'unfit' to be at a larger asylum, he/she had to be moved to an asylum where the overseer was ready to take him/her and the petitioner had to pay the cost of his/her maintenance. A petitioner could not be replaced or substituted after the case had reached the magistrate for consideration. It was possible only when another person came forward willingly to take responsibility for the petition or when the petitioner was dead. Ibid., 24.

[91] Ibid., 16.

[92] Ibid., 17.

[93] Ibid., 28.

[94] Ibid., 29.

[95] Ibid., 30.

legally bound to take care of him/her and if he/she had not been taken care of wilfully, the relative would have to face a sentence for one month.[96]

The legal remedies of the Act of 1912 eliminated any kind of 'freedom of choice' from the mentally disabled and offered to a system of asylum staff and relatives. Today, the autonomy to decide whether to commit to treatment or not is entertained as a personal choice, but under the Act of 1912, it was given to a governmental institution. By awarding agency to an institution, the act imposed that people with mental disabilities were not capable of making a decision based on free will, and their ability to commit to responsibility was compromised. Gerben Meynen argues that law should look at the alternative possibilities of action and choice with relation to free will while dealing with mental disability.[97] The alternative possibilities in law promote 'supported' decision-making where the mentally disabled are included in decision-making with the help of a person chosen by him/her. The supporter has to provide advice, but the disabled make the final decision. The final decision will be concerning the wishes of the disabled. Meynen further suggests that "mental disorders may affect free will. Yet, the sense of free will that may be affected by the mental disorder in general and by specific disorders, in particular, remains to be elucidated."[98] But the Act of 1912 never included such alternative possibilities.

When a mentally disabled was admitted to an asylum, the cost of his/her maintenance was to be paid out of his/her estate or by his/her relatives. If the person did not have an adequate estate or relatives to fund his/her well-being, the court used to certify the same. If the certificate on whose basis the person admitted is found faulty, the person would get released with the consent of two visitors and a signature from a medical officer. At least, once a month, three officials used to visit the asylums.[99] One was a medical officer and the other two were the Inspectors General of Prisons. These three people

[96] Ibid., 31.

[97] Gerben Meynen, "Free Will and Mental Disorder," *Theoretical Medicine and Bio-Ethics* 31, no. 6 (2010): 429–443.

[98] Medical certificates signed under the Act of 1912 had to follow a prescribed form. It included the opinion of the medical officer and facts observed by him from the communication with the patient. The person who signed the certificate would examine the alleged person personally and would certificate that the reception order would be issued. If two medical certificates were needed, each person had to examine the person separately. The Act of 1912, p. 32.

[99] Ibid., 33.

together used to assess the condition of the asylums and check the certifications of the new admissions.[100]

Under this act, the provincial government licensed the asylums at places where it thought was appropriate. If any asylum failed in its provision for curative treatment, the provincial government cancelled its license. It was the responsibility of the asylum superintendent to provide these necessary amenities. But from 1857 to 1912, the condition of the asylums was not better than the earlier asylums. Even though lunacy acts provided many conditions to provide the welfare of the insane in the asylums, it was never implemented nor recorded nor examined properly. The inhuman treatment of the insane was common after 1912. Chaining, physical restraint, enclosure in closed cells, physical abuse, and sexual abuse were common in asylums in treating the insane.[101] Even though the Act of 1912 brought many positive outlooks such as the management of property, regulation and licensing of the asylum, and admission and discharge of the patient, it was not completely free of problems. The act transferred the power to the magistrate to decide on the insanity of a person. Even though medical officers were needed, at many times the magistrate's lack of knowledge in psychiatry created issues in verdicts. Subsequently, there were no provisions for emergency treatments.

The segregation of the insane and the provisions to take care of them in an asylum environment was entirely a new clause introduced by the British in India through the Act of 1912. By giving authority to asylums, the act dealt with the mentally disabled in three ways—first as a deficit, which reduced the status of a disabled from human to an object to be admitted, transferred, and removed without any power of protestation; second, the act never spoke about accessibility and positive rehabilitation; third, there was an excessive presence of corporeal power while dealing with the mentally disabled. With the help of asylums, the act implemented the 'deficit of credibility' using the elements of elimination through segregation and correction through rehabilitation. Bill Huges, a disability theorist, asserts that asylum treatments under the act were implemented as a colonial strategy to erase the problem of social difference represented by disability.[102]

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[100] Ibid.

[101] Bhattacharyya, *Indian Insanes*, 185.

[102] Bill Huges, *The Body, Culture, and Society: An Introduction* (Glasgow: Open University Press, 2000), 13.

In 1937, Professor Edwin Mapother, a British physician, was requested to write a report while visiting Ceylon about the suggestions to improve the conditions of the insane asylums in India.[103] The report made an extensive study on the scope of "post-graduate institutes for training of manpower, general hospital psychiatry units, easier access, reduction of legal procedures, setting up of visitors committees, and an urgent need to increase the number of beds."[104] But the medical board refused to publish his opinions for fear of public dissatisfaction. In 1946, the Bhore Committee, a health survey committee surveyed all hospitals and asylums in India. The committee advised the government to improve the pathetic condition of the insane asylums. After India's independence, the Indian Psychiatric Society was established in 1947 which considered the Act of 1912 as inappropriate for the treatment of the insane, and under the supervision of the Bhore Committee, a bill was formulated and submitted to the Government of India in 1950. The bill was passed in May 1987 and the Mental Health Care Act was passed in 2017 superseding the 1987 Act.[105] In 1995, finally, India passed the Disability Act under the title of Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act which provided mental disorders the status of disability. The act added clauses on the positive rehabilitation through employment and education and rights of the mentally disabled in India.

3.2. Mental Disability and Legal Status of Crime in Colonial India

It is recognized that when a person with a mental disability is arrested for an offence, the legislation has to treat them differently from the general population due to the vulnerable nature of the person in question concerning his/her disability. Today, the legislation concerning mental disability has referred to diverse diagnostic methods, different definitions of mental disability, and dissimilar degrees of mental disability.[106] It is essential to ask whether the colonial legislation which mentioned criminality and mental disability in India followed the same referring points. This part of the research deals with

[103] Report of Professor Edwin Mapother to Sir John Migaw: The President of Medical Board, India Office, NAI, 193.

[104] S. Jain, "Psychiatry and Confinement in India" in *The Confinement of the Insane, 1800–1965*, ed. Roy Porter and David Wright (Cambridge: Cambridge University Press, 2003), 273–298.

[105] J. K. Trivedi, "Mental Health Act," *Pub Indian Psychiatric Society* (2009). http://www.indianjpsychiatry.org/cpg/cpg2009/article7.pdf.

[106] J. Jones, "Persons with Intellectual Disabilities in the Criminal Justice System," *International Journal of Offender Therapy and Comparative Criminology* 51, no. 6 (2007): 721–723.

the Indian Penal Code of 1862, Calcutta Police Act of 1866, Indian Evidence Act of 1872, Code of Criminal Procedure, and the Prisoner's Act of 1900.

The Indian Lunacy Acts of 1858 and 1912 were the outcomes of colonial reorganization as well as the evolving nature of the discussions on 'madness' and mind. The other result of these interactions was the introduction of the Indian Penal Code (IPC) in 1862, in the context of lunacy being a setback, which needed attention from both the medical and judicial arenas.[107] Penal institutions like prisons functioned on the principles of discipline and authority. It is interesting to notice how lunatic asylums and prisons in Colonial India shared similarities and differences.

Responsibility in the law meant 'liability to punishment.'[108] The idea of responsibility was full-size when it came to the judiciary, crime, and criminal codes through IPC. A person was found liable for his/her crimes when he/she did it intentionally and with his/her free will. The motive of crime in law played a major part to the point that just committing a crime did not prove his/her crime. Laws were based on the concept of *actus non-facitreum nisi men's sit rea* that is, the physical act alone did not make a person guilty; the mental component was equally important.[109] The law required a person to be in sound mind to be held responsible for his/her crime "unless the contrary is proved to the satisfaction of the court."[110] A mentally disabled person could not be punished for his/her crime as he/she lacked free will, intelligence, and knowledge of the act.[111] To prove his/her unsoundness entirely is the responsibility of the defence. When it was proved that he/she is of unsound mind, the responsibility of crime weakened and the person was sent to care or treatment according to the verdict of the court. Moreover, the law suggested that the accused "need not be punished as punishment is already given to him by nature."[112]

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[107] Bhattacharyya, *Indian Insanes*, 151, 155.; David Skuy, "Macaulay and the Indian Penal Code of 1862: The Myth of the Inherent Superiority and Modernity of the English Legal System Compared to India's Legal System in the Nineteenth Century," *Modern Asian Studies* 32, no. 3 (1998): 513–557.; Thomas Macaulay, *Complete Works of Thomas Babington Macaulay* (London: Longmans, Green and Co., 1898), 579.; George Otto Trevelyan, *Life and Letters of Lord Macaulay* (Oxford: Oxford University Press, 1978), 86.

[108] A. Wahab, "The Concept of Criminal Responsibility," *Journal of Karnataka Medico-Legal Society* 11, no. 2 (2003): 30–32.

[109] F. E. Camps, *Legal Medicine* (Bristol: John Wright & Sons, 1976), 494.

[110] B. Knight, *Medical Jurisprudence and Toxicology* (Allahabad: The law Book Company, 1990), 516–519.

[111] B. V. Subrahmanyam, *Medical Jurisprudence* (New Delhi: Butterworths India, 1999), 663–669.

[112] S. N. Gaur, *Lyon's medical Jurisprudence' for India* (Allahabad: Law Publishers India, 1988), 489–492.

Michael Ignatieff, a social theorist by giving importance to the motive of the crime, has argued that the difficulty of the "insanity defence was its circularity; the horror of the act was proof of the insanity of the perpetrator. Similarly circular in the legal field, the only possible way of discovering a man intended to look at what he did."[113]

Section 84 in the IPC was formulated based on the details of 1843 McNaughten's court verdict. Daniel McNaughten killed Edmund Drummond, secretary to British Prime Minister, Robert Peel. McNaughten's defence was based on the plea of insanity. But at the time of the murder, there was no sign that he was insane. Thus to clarify such extraordinary confusion in the law, a 14-judge bench coded some rules regarding the criminal responsibility of the insane. According to the rule, at the act of crime one should be proved to be insane. Therefore, the terminology 'unsoundness of mind' in Section 84 of the IPC should be examined clearly to understand whether it included mental disabilities along with mental illnesses. The section defined 'unsoundness of mind' as a condition that affected the cognitive capacity of an individual, which was the feature of the mental disabilities along with some severe mental illnesses.[114] Not every person who is mentally ill is covered by Section 84—persons who had uncontrolled moods like anger, preservation, fear, and revenge could not be termed as being 'insane.' Nevertheless, the law only recognized those conditions which affect the cognitive faculties of the mind, which eventually impaired the person's understanding in knowing the nature of the act of crime.[115] The absence of motive in the criminal act was considered as one criterion for the unsound mind in law.[116] If the accused did not flee or hide after committing the crime, it also became another criterion of an 'unsound mind.'[117] If the accused was unaware of the nature of his/her act, he/she was not convicted.[118]

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[113] Michael Ignatieff, "An Introductory Essay," in *Wealth and Virtue: The Shaping of Political Economy in the Scottish Enlightenment*, ed. Istvan Hont and Michael Ignatieff (Cambridge: Cambridge University Press, 1983), 1–45.

[114] Mental illnesses like schizophrenia and bipolar disorders are posed as a reason for exemption from punishment. Subrahmanyam, *Medical Jurisprudence*, 664.

[115] Unfit to plead guilty on insanity is known as the insanity defence. This means a person cannot be held accountable for his/her crime due to his/her insanity.

[116] J. B. Mukherjee, *Forensic Medicine and Toxicology* (Calcutta: Academic Publishers, 2000), 164–167.

[117] Ibid.

[118] Ibid., 168.

The 'Law of Exemption' was well explained by the Calcutta High Court in the Kader Nasayer Shah case in 1923. Shah was mentally disabled and was arrested because he attacked one of his relatives in a delusion that he was breaking a jar. The high court report stated that "it is only unsoundness of mind which materially impaired the cognitive faculties of the mind that can form a ground of exemption from criminal responsibility, the nature and the extent of the unsoundness of mind required being such as would make the offender incapable of knowing the nature of the act, or that he was doing what was (1) wrong or (2) contrary to law" and in this regard, exception of insanity was used by colonial law. [119]

Section 84 of the IPC coined a more comprehensive and inclusive term—'unsoundness of mind' instead of 'insanity.'[120] The term widened the scope of the conditions inclusive of mental disabilities and disorders of emotions which normally did not come within the meaning of insanity.[121] The IPC sections referred to the term 'deviance' to elaborate on the clauses. When the term deviance was explained with insanity, the law formulated what normal behaviour was.[122] Underlying imagination was that any behaviour of a mentally disabled person was considered as deviance—an act which is not up to or different from the 'normal expected behaviour' from society.[123] 'Deviance' was further elaborated as a public nuisance, or creating injury or danger to people or property.[124] It was further explicated that "a person is guilty of a public nuisance who does any act or is guilty of an illegal omission which causes any common injury, danger or annoyance to the public or the people in general."[125]

It should be noted that the law associated mental disability with deviance and disturbance. 'Deviance' was understood to the deviance from 'social norms.' Society created and defined what normal behaviour was, and anyone who failed to behave

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[119] Mukherjee, *Forensic Medicine*, 31.

[120] Ibid.

[121] Shamsul Huda, *Principles of Law of Crimes in British India* (Calcutta: India Publisher, 1902), 271.

[122] The Indian Penal Code, Act No. 45 of 1860, Chapter 7: Of Offences against the Public Tranquillity, Section 153. (Indian Penal Code from here on).

[123] Ibid.

[124] After the Revolt of 1857, IPC related insanity to the concern of pubic disturbance. This strictness even criminalized public gatherings having the chance of a riot. Huda, *Principles of Law*, 273.

[125] Indian Penal Code, Chapter 14: Of Offences affecting the Public Health, Safety, Convenience, Decency and Morals, Section 268.

accordingly was relegated to crime based on insanity. The law gave recognition to one set of behavioural rules and any diversity within the set frame was condemned. The law also attributed mental disability to disturbance and stated that mental disability was pernicious to itself and society. It assumed that the mentally disabled were always capable of injury, danger, and annoyance to the public and could create social obstruction. The law itself here was discriminatory and prejudiced.

Section 84 and Chapter 2 in IPC regarding crime and mental disability pushed aside one set of people for scrutiny under the broad ideas of disability. [126] The plea on insanity deemed 'rationality' as the core of social and legal norms. Under the law of IPC, rationality was treated as a supreme human feature and assumed that any person with a mental disability was not capable of making rational choices. The law created a rigid criterion of rationality that overlooked past diversity which further intensified the stigmatization of the disabled. Such laws judged a person as not moral and equal to others because of their disability. Instead of justice, it provided highly patronizing restorative justice to the person where he/she would be trained or forced to think or act like the rest of the herd.[127] These laws also provided therapeutic jurisprudence which was criticized for its forced interventions. Instead of taking into account the person's rational ability when it came to mental disability, Tina Minkowitz argues that the subjective perception and beliefs of the person should be evaluated and "thus opens the door to accommodating the subjective realities of the disabled," but IPC asserted that disability was a prerequisite of crime. [128]

The Calcutta Police Act of 1866 which came into existence through the Bengal Act No. 4 of 1866, was an additional piece of legislation that mentioned mental disability in their legislative measures.[129] The main aim of the 1866 Act was to amend and consolidate the provisions of Act No. 13 of 1856, regulating the police of the cities of Calcutta, Madras, and Bombay.[130] Nevertheless, the act only applied to the town of Calcutta. Under the act, the administration of the town of Calcutta has vested in the hands of an officer

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[126] Ibid.

[127] Tina Minkowitz, "Rethinking Criminal Responsibility from a Critical Disability Perspective: The Abolition of Insanity/Incapacity Acquittals and Unfitness to Plead, and Beyond," *Griffith Law Review* 23, no. 3 (2014): 6–17.

[128] Calcutta Police Act, Act No. 2 of 1866, pp. 1–30.

[129] Ibid., 28.

[130] Ibid., 29.

titled the Commissioner of Police.[131] To assist the Commissioner, the provincial government appointed Joint Deputy or Assistant Commissioner of Police as additional personnel in the system.

Section 24 of the Calcutta Police Act of 1866 detailed a description of the duty and responsibility of the Town Police Officer. It is in this section that the cases of mental disabilities were mentioned. The act quoted that it was the prime responsibility of the Town Police Officer to "afford every assistance within his power to help the disabled or helpless persons in the streets and to take charge of intoxicated persons and lunatics at large who appear to be dangerous or to be incapable of taking care of themselves."[132] This was one of the acts in Colonial India whereby the terminology 'disabled' was utilized. It included everyone, from the blind to lepers, and from physically disabled beggars to 'lunatics.'[133] However, it is worth noting that the act did not provide a clear definition of the term 'disabled' which led to confusion on the nature of the 'disability' intended by the act. But the clauses stressed 'incapacity.'[134] The disabled and the mentally disabled were removed from the streets when it appeared that the alleged person could not take care of himself/herself.

The act defined an insane as someone who "is found incapable of taking care of himself/herself or is guilty of any riotous or indecent behaviour, in any public street or thoroughfare, or any place of public amusement or resort, shall be liable, on summary conviction before a magistrate, to a fine not exceeding twenty rupees, or to imprisonment, with or without hard labour, for a term not exceeding eight days."[135] It equally explains the 'do's' when a criminal lunatic was arrested by the police. Therefore, the Calcutta Police Act of 1866 also looked at how calmer and saner a criminal was to confess or defend and what his/her state of mind was before and at the time of the commission of the deed.[136]

[131] Ibid.

[132] Ibid., 30

[133] Ibid.

[134] Ibid., 27.

[135] Ibid.

[136] Ibid.

It should be noted that the initial identification and detention of the mentally disabled was done by the representatives of the penal institution who had no expertise in dealing with the mentally disabled. The act permitted a police officer to take a person off the street and detain him/her for 'disruptive' behaviour. Coercion was part of such processes. When a mentally disabled was detained by the police, the position of the offender became vulnerable because he/she might be prone to suggestions. There would be a poor understanding of the questions and implications of the answers. Similarly, a mentally disabled questioned by the police would not understand the standard questions. This might result in signing statements without any understanding of its contents and if the person faced problems with language and comprehension skills, it also posed difficulties. The initial identification of the mentally disabled was based on the personal opinion and prejudice of the police officer. The very right of the disabled in getting examined by a person with medical expertise was only possible after the trial which led to gross violation of basic rights.

The Evidence Act of 1872 was one of the legislations in Colonial India which mentioned 'mentally disabled' in its provisions. The act was implemented when a court had to take the assistance of special art or science to identify special skills like handwriting or finger impression.[137] When looking at such evidence, one expert had to keep in mind the unsoundness of the accused. The Indian Evidence Act of 1872, therefore, mentioned insanity in their clauses.[138] The act stated that "the question is, whether A, at the time of doing a certain act, was, because of unsoundness of mind, incapable of knowing the nature of the act, or that he was doing what was either wrong or contrary to law. The opinions of experts upon the question whether the symptoms exhibited by A show unsoundness of mind, and whether such unsoundness of mind usually rendered persons incapable of knowing the nature of the acts which they do, or of knowing that what they do is either wrong or contrary to law, are relevant."[139] The act was well placed when accused used insanity as a matter of defence, to bring circumstantial evidence of his/her insanity in front of the court was his/her responsibility.[140] If he/she failed to do so, the court would carry out the procedure similar in the way it did with a sound-minded person.

[137] The Indian Evidence Act of 1872, Section 45.

[138] Ibid.

[139] Ibid.

[140] Ibid.

It is noteworthy that if persons with mental disabilities were forced to testify in front of the court, his/her unsound mind would prevent him/her from understanding the questions asked or from giving 'rational' answers to the question.[141] Today, in such cases, the testimony of the person in question will not alone be taken into the account. His testimony will be corroborated with other witnesses and if there is no witness available, the jury will be advised that it is dangerous to convict unless there is 'corroborative evidence.' But the Indian Evidence Act of 1872 did not mention the need for any corroborative evidence.[142]

The Code of Criminal Procedure of 1898 dealt with insanity in Chapter 34.[143] The sections from 464 to 475 elucidated the regulations when a lunatic was found guilty of any crime or when an accused proved to be a lunatic.[144] When a magistrate believed that the accused was of unsound mind and could not deal with his/her defence, the magistrate would inquire about his/her unsoundness with the help of a civil surgeon of the district or any medical officer.[145] If it was found that he/she was of unsound mind, the case automatically got postponed. If any person sent to trial before the court of sessions or high court was a lunatic, the same provision mentioned above applied to him/her. The definition of lunacy in the code was changed from 'unsound mind' and 'incapacity' to deal with his/her affair to 'unsoundness' and 'incapacity' to defend themselves in court.[146] Even though some mental illnesses reduced the standard 'reasoning' capacity of a person, this unique trait was much more common in mental disabilities.[147] When an accused was found of having of unsound mind, he/she was released with sufficient security, even if bail was not granted. To take care of his/her affairs, one officer was appointed on his/her behalf. If the person was not given bail, then he/she was to be transferred into safe custody.[148]

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[141] Ibid., Section 103.

[142] Australian Human Rights Commission, "The Rights of People with Disabilities: Criminal Justice System," (2010). https://humanrights.gov.au/our-work/rights-people-disabilities-areas-need-increased-protection-chapter-5-criminal-justice#evidence

[143] Code of Criminal Procedure, Act No. 5 of 1898, pp. 164–167.

[144] Ibid., 164.

[145] Ibid.

[146] Ibid., 165.

[147] Ibid., 166.

[148] Ibid.

The Government of India Act of 1858 changed the functioning of the medical and judicial institutions in India. Under the act, three presidency medical boards were abolished and the director-general of the medical department was assigned.[149] It was under the home department that the asylum records were collected and preserved. In April 1896, the Indian Medical Service was created and the director-general remained under the aegis of the home department until 1918. By 1897, all of the matters related to the judicial system, crime, and punishment were taken care of by the home department.[150]

It was at the same time that a separate jail system for criminals and criminal lunatics also was introduced. Simultaneously colonial judiciary started to discuss the role of the medical experts in the case of criminal lunatics. Then the question which came up in front of the government was whether send criminal lunatics for treatment or whether they deserved punishment. Consequently, medical officers were appointed for the care of the criminal lunatics.[151] But the medical practitioners had to fit certain criteria. They had to have certification in medicine or surgery which was registered in Britain. The practitioner also was to be declared by the provincial government as a medical officer under special order. Thus it was interesting to note that asylum and jail reforms in Colonial India were initiated on a parallel basis.

In 1899, the two-year mandatory training of the surgeons and assistants in an official medical institution was introduced. When asylums were put under the medical department, the medically trained native doctors and British started to send their applications for participation in asylum care. It helped the asylums to acquire the status of the official medical institutions. Insanity became a medical predicament and the penal institutions lost their hold to define insanity. All of these developments resulted in the passing of the Prisoner's Act in 1900.

The Prisoner's Act of 1900 was another act that dealt with mental disability in Colonial India which provided the regulations for the running of prisons.[152] This act dealt with the detained persons in the custody of the prison and the discharge of the prisoners from the custody of the officer-in-charge of prisons.[153] Section 30 of this act detailed how

[149] Report of Medical Board Proceedings for January 25, 1858, Medicine, Indian Papers, National Library of Scotland (NLS from here on).

[150] N. Jayapalan, *Indian Administration* (New Delhi: Atlantic Publishers, 2001), 38.

[151] Ibid.

[152] The Prisoners Act, Act No. 3 of 1900, pp. 1–30.

[153] Ibid., 25.

the lunatic prisoners should be dealt with regarding their removal to the asylum.[154] If it came to the notice of the court that any provincial government detained any person with an unsound mind, the government should issue a warrant. The warrant should state that the alleged person had to be transferred from the prison to a lunatic asylum or any other place of safe custody. He/she had to be kept and treated there for the specified term for which he/she had been ordered to be detained. If that term expired and a medical officer certified him/her to be 'sane,' the person should be freed under the order of the provincial government. If it appeared to the provincial government that the criminal lunatic was no longer of unsound mind, before he/she completed his/her term, the provincial government had to issue a warrant stating the alleged person was going to be released from the asylum. The provincial government remanded him/her to prison from which he/she was removed or to another prison within the state.[155]

It should be noted that there is overwhelming importance given to 'rationality' in colonial legislation dealing with crime and mental disability. The emphasis on rationality in the classification and diagnosis of mental disability functions on the assumption that some levels of irrationality were sufficient for mental disorders. Rationality in psychiatry was attributed to the capacity of decision-making.[156] Understanding mental disorders were not based on clinical understanding but on the behavioural manifestation, which is subjective, and it should be realized that there is a possibility of variation in 'rationality.' From the 1970s, psychologists stated that irrationality is a feature of 'normal cognition' and is not only attributed to those who have mental disorders. People fail to 'test simple conditional statements' and these kinds of mistakes are 'widespread in everyday decision-making.'[157] Stein argues that 'rational' thought is well supported by evidence and there are enough thoughts that do not meet these standards.[158] Julian Craigie and Lisa Bortolotti also argue that "irrationality is not even necessary for mental disorder. There is no reason to suppose that mental disorder needs to manifest as a failure of epistemic rationality."[159]

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[154] Ibid., 26.

[155] Ibid., 27.

[156] Jillian Craigie and Lisa Bortolotti, "Rationality, Diagnosis, and Patient Autonomy in Psychiatry," *The Oxford Handbook of Psychiatric Ethics* 1, no. 8 (2014): 1–87.

[157] Ibid.

[158] E. Stein, *Without Good Reason* (New York: Oxford University Press, 1996), 3.

[159] Craigie and Bortolotti, "Rationality, Diagnosis and Patient," 63.

The colonial acts which mention mental disability and crime defined insanity as 'unsound mind' and no further definition on the classification and degrees of the disorders were given. It is important to note that symptoms do not 'straightforwardly map into mental disorders.' Different disorders share the same symptoms and the degree of each symptom will be different in each person. Some disorders are easily diagnosed and some are culturally bound to a particular geographical area. For example, if 'irrationality' becomes the diagnostic criteria for both schizophrenia and autism spectrum, if both of them are treated equally under the law, it will not be fair because both disorders are different. Autism damages one's ability for social communication, emotional reciprocity, non-verbal communication, and the understanding of a relationship. On the other side, schizophrenia causes distortion of thoughts but the intellectual capacity and consciousness of the person are usually maintained. Ignoring the differences in disorders and how they affect one's own ability to think and act is the main flaw of colonial law that dealt with mental disability. The United Nations Declaration on the Rights of Mentally Retarded in 1971 stated that if a mentally disabled is prosecuted for an offence, he/she has the right to protection from exploitation and abuse and will be treated in accordance to the degree of his/her mental responsibility.[160]

Another factor that was emphasized in colonial laws was mental incapacity which was defined as a person's inability to "understand, weight, and use relevant information, and to express their decision, grounds decisions about the right to self-determination."[161] Similar to 'rationality,' the diverse variations in mental capacity were not detailed in any of the colonial acts dealing with crime and mental disability. The United Nations Committee in the Rights of Persons with Disabilities, in 2014, condemned the usage of mental incapacity in legislation arguing that it violated a person's autonomy and dignity based on the medical model of disability which explained mental disability "solely concerning the individual's mental impairment."[162] The United Nations called for a social model of disability in legality which associated mental capacity with the "notion of decision-making ability and justifying the requirement of decision-making supports."[163]

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[160] The United Nations Declaration on the Rights of Mentally Retarded, 1971, pp. 1–20. https://www.ohchr.org/EN/ProfessionalInterest/Pages/RightsOfMentallyRetardedPersons.aspx

[161] Craigie and Bortolotti, "Rationality, Diagnosis and Patient," 64.

[162] Report of the United Nations Committee in the Rights of Persons with Disabilities, International Disability Alliance, 2014.

[163] Ibid.

3.3. Mental Disability and Marriage Acts in Colonial India

In 1869, the colonial government passed the Indian Divorce Act which was extended to India as a whole except for Jammu and Kashmir.[164] This act elucidated the clauses and the consequences related to the nullification of marriage between parties who resided in India. They also had to live in India at the time of the petition.[165] This act which mentioned insanity in one of their clauses, was amended in 2001. The new act demonstrated a slight difference from the original act to eventually achieve the title of the Indian Divorce Amendment Act of 2001. The Act of 1869 gave its power to a high court whether to nullify a marriage or not.[166] Section 10 of the act gave an account of the causes that could be used to nullify a marriage.[167] Any marriage that took place before or after the commencement of the Indian Divorce Act of 1869 or Indian Divorce Amendments Act of 2001 dissolved through a petition presented by a married couple. Insanity was one of the reasons to ask for a divorce.

One of the rationales mentioned in the Act of 1869 to nullify a marriage was insanity.[168] The act quoted that it was a ground for divorce if the person "has been incurable of unsound mind for a continuous period of not less than two years immediately preceding the presentation of the petition."[169] When a marriage was revoked on the grounds of insanity, the children the couple begotten before the final decree was entitled to succeed in the same manner as legitimate children to the estate of the parent.[170] The wife or husband going under trial based on insanity under this act was considered as still married and the property of the husband was transferred to the wife when the husband was dead, according to the property law.[171] After the final decree, both spouses were considered unmarried, and if the wife wanted, she could sue for alimony. When the husband or wife was a 'lunatic' or 'idiot,' any suit under the act should be brought by a committee or another person entitled to their custody.[172] Using the term 'idiot' in the act

[164] Indian Divorce Act, Act No. 4 of 1869, pp. 1–12.

[165] Ibid., 2.

[166] Ibid.

[167] Ibid., 3.

[168] Ibid.

[169] Ibid.

[170] Ibid.

[171] Ibid., 5.

[172] Ibid.

indicated that the clauses also included mental disability. The act does not apply to the suit for conjugal rights.[173] Any evidence in the form of a witness, especially on the foundation of insanity was examined orally and was subject to cross-examination and re-examination.[174]

Similarly, like earlier divorce acts, it was only in 1955, under the Hindu Marriage Act, that the conditions of marriage were finalized. It was decided that any party of the marriage petition should be capable of giving valid consent.[175] Even if they are capable of giving consent, one must not suffer from any mental disorders and one must not suffer from attacks of insanity in the form of arrested or incomplete development of the mind.[176] Under the Muslim Marriage Act of 1939, a person of unsound mind could be married by their legal guardian.[177] If the guardian of the person of unsound mind is ready to take the responsibility of the monetary obligations of the marriage and if the marriage is in the interest of the society, such marriages are considered valid. However, the Dissolution of Muslim Marriages Act of 1939 stated that a woman could divorce her husband if her husband had been insane for at least two years.[178] According to the Indian Divorce Act for Christians 1869, marriage was not valid if either of the party was insane or an 'idiot.'[179] The act did not recognize the consent of any mentally ill or disabled as valid. The act also stated that divorce could be obtained if the spouse had been of incurable of unsound mind for a continuous period of not less than two years. Under the Parsi Marriage and Divorce Act of 1936, divorce could be obtained if either of the spouses could not consummate the marriage on the ground of insanity.[180]

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[173] Ibid.

[174] Ibid., 6.

[175] Hindu Marriage Act of 1955, pp. 1–13.

[176] Siva Nambi, "Marriage, Mental Health, and the Indian legislation," *Indian Journal of Psychiatry* 47, no. 3 (2005): 14.; Siva Nambi and Siddharth Sarkar, "Mental Illness and Nullity of Marriage: Indian Perspective," *Indian Journal of Psychiatry Medicine* 37, no. 3 (2015): 366–369.

[177] Muslim Marriage Act, Act No. 8 of 1939, pp. 1–8.; White Swan Foundation "Law Relating to Marriage and Mental Illness." http://www.whiteswanfoundation.org/rights-and-responsibilities/faqs/legal-faqs-law-relating-tomarriage-and-mental-illness/

[178] The Dissolution of Muslim Marriages Act of 1939, Section 2 (6).

[179] The Indian Divorce Act for Christians of 1869, pp. 1–12.

[180] Parsi Marriage and Divorce Act of 1936, pp. 1–10.

The legal reason behind nullifying a marriage based on insanity was the assumption that a mentally disabled person may not be able to understand the obligations of a marital relationship, and his/her mental condition barred him/her from giving valid consent to the marriage which was a legal contract. But these acts failed to take into account the diagnostic label of each mental disorder. A person who was mentally unsound and his/her disease 'controlled' by medical care and supportive systems could not be equated with someone with a severe mental disorder who was 'not able to understand' the obligation of a marriage contract. These acts were unable to grasp the differences of the capacity of role functioning, consent and labelled all such cases under the title of 'insanity.'[181] None of these acts talk about the importance of a person with medical expertise to examine the capacity of the person in question in court.

3.4. Contract, Property, Will, Ward, Tax, Succession and Mental Disability in Colonial India

The capacity of the mind and civil law had a close relation contrary to the popular beliefs that mental capacity was only a concern for criminal legislation. Every civil aspect of law like contract, property, will, ward, tax, and succession had their physical and mental aspects attached to each. The mental capacity of a person may be impaired or varied due to mental disorders. According to the colonial civil legislations, the validity of any legal transaction or procedure depended on the 'soundness of the mind' of the concerned person; the higher the soundness of the mind, the higher the validity of his/her legal document. This part of the research deals with the civil legislation in Colonial India that includes mental disability in its clauses.

The Indian Contract Act of 1872 was the first civil act that included mental disability and its legal remedies. The act was implemented in 1872, according to which any person with a sound mind could make a legal contract.[182] Section 12 of the act which dealt with the unsoundness of mind stated that to make a contract, anyone in sound mind should be in a position to understand the purpose and consequences of the contract and be able to make a rational judgment that the contract is made upon his/her interest.[183] Any person who did not possess this 'rational' judgment could not make a contract.

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[181] Nambi, "Marriage and Mental Health," 15.

[182] The Indian Contract Act of 1872, pp. 1–15.

[183] Ibid., 6.

The general theory of contract refers to the fact that both parties should be of 'sound mind' and free to give consent to bind the contract. If there was any lack of rational consent from either of the parties, the contract is held to be void.[184] If at the time of signing the contract, either party was unable to give his/her consent due to insanity, the advantage of the contract was considered invalid.[185] Sometimes, the person who entered into a contract behaved in a 'normal' fashion, but could not make a formal 'rational judgment' about his/her activity.[186] In these cases, the test of the soundness of mind had to be conducted. It should be certified that the person who was making the contract was capable of understanding the business and the consequences of his/her contract. This kind of incapacity happened when a person had severe mental disabilities both congenital and acquired, like senile dementia. Under the act, "an idiot or a natural fool is a person that has no understanding from his infancy. Contracts entered into by an idiot other than those for necessaries are void."[187]

The Court of Wards Act of 1920 is the additional civil legislation that included insanity in the clauses.[188] Section 6 of the act mentioned the power of the Court of Wards about the property of the unsound mind.[189] When any landholder was a minor or of unsound mind and unable to manage his/her affairs, under the act, the Court of Wards issued an order assuming the superintendence of the property or the person.[190] Section 11 and Sub-Section 4 furthermore state how to manage the property of the insane.[191] If the owner of the property is alleged to be of unsound mind, "the Deputy Commissioner shall make application to a competent court in view to an inquiry being made by such court to ascertain whether such person was or was not of unsound mind and incapable of managing his affairs."[192]

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[184] Aishwarya Padmanabhan, "Unsoundness of Mind in Contract," (2006). http://www.manupatra.com/roundup/325/Articles/Unsoundness%20of%20Mind%20in%20Contract.pdf

[185] Prateek Rastogi, "Civil Responsibilities of Mentally ill," *Journal of Indian Law* 29, no. 3 (2007): 12–18.

[186] Ibid.

[187] Padmanabhan, "Unsoundness of Mind."

[188] The Court of Wards Act 1879, pp. 1–37.

[189] Ibid., 17.

[190] Ibid., 18.

[191] Ibid.

[192] Ibid., 19.

Section 35 of the Court of Wards Act of 1920 referred to the appointment, removal, and control of guardians and tutors of the insane.[193] This section stated that the Court of Wards from time to time appointed guardians for the care of persons under question.[194] This could be a minor, or of unsound mind, or someone suffering from any physical or mental defect or infirmity. Along with persons with disabilities, the section also included women and the unmarried. Together with the power of appointment, the Court of Wards as well had the power to control and terminate the guardianships.

The Income Tax Act of 1922 was passed to consolidate and amend the law relating to income tax and super-tax which mentioned insanity in the clauses.[195] Section 40 of the act dealt with the guardians, trustees, or agents of a minor or mentally disabled. According to this section, the income tax of the minor or mentally disabled should be paid by his/her trustee or guardian.[196] The amount should be the same as charged to any other person. In the case of the disabled, it would be the manager of his/her estate to pay the amount of the income tax.[197] The manager of his/her estate should take this money from the profit of the estate. The manager had to present an annual balance sheet of expenses and profits in the court in front of the magistrate, and it also included the payment of income tax. It was the duty of the manager to pay the taxes levied upon the estate of the insane and to produce the receipt of the same in the court at the time of the annual assessment. If the person was under the care of his/her friends or family under the Act of 1912, the amount should be paid by the relative or the family member.

The Indian Succession Act of 1925 explained a condition of testamentary capacity of will. This clause directly hinted at the mental capacity of a person whereby the testamentary capacity "is the legal status of being capable of executing a will, a legal declaration of the intention of a testator concerning his property, which he desires to be carried into effect after his death." [198] The act stated that any person who had a sound mind could make a will. A person who was of unsound mind intermittently could make a will, while in the phase of having a sound mind.[199] No person could make a will while he/she

[193] Ibid.

[194] Ibid.

[195] Income Tax Act of 1922, pp. 1–9.

[196] Ibid., 6.

[197] Ibid.

[198] Indian Succession Act of 1925, pp. 1–14.

[199] Ibid., 3.

was of unsound mind from illness or any other cause so that he/she was not conscious of his/her actions. To make a will, a person needed to be in his/her complete control of senses.[200]

The mental capacity of a person and his/her 'autonomy' were closely related to the civil law of Colonial India. The law assumed that the 'right of choice' was afforded to only those who did not suffer from any kind of mental 'incapacity.' Since the colonial law related mental capacity to autonomy, the decision of a person was respected on the grounds of the extent of his/her ability to make an autonomous decision.[201] Similarly, capacity and competence were understood as terms with similar meanings in colonial legislation. Both denoted a person's ability to perform certain tasks. But both had different meanings, where the first signified a person's choice to perform the task and the second meant a person's ability to complete the task 'well.' Capacity should be used in legality alone, and competence should be employed in a clinical setup. But according to the colonial legislation, the court took incapacity as incompetence. Competence and decision-making capacity were also understood similarly as in colonial legislation, whereas in reality, there was a degree of overlap between the two. The examination of both should be done by a professional, but according to colonial legislation, it was not guaranteed whether the court followed the professional assessment.

The degree of a mental disability was determined by a person's ability to fulfil, understand, and consent to or refuse certain tasks. If a person consented to or refused certain tasks, then it meant the person could take autonomous decisions. Colonial civil laws did not recognize a mentally disabled's ability to make autonomous decisions. They only emphasized the court's normative authority to waive rights. The court also de-emphasized a person's rights to make an informed decision and consent which violated autonomy.

The court treated the mentally disabled as property by limiting his/her rights of decision-making and consent. The court also provided provisions to release the rights back to the individual if they qualified the criteria of 'necessary abilities.' It is also important to

[200] The soundness of mind is important while signing a contract and will. It could confirm that the person understood what his/her contract is, what a will comprised of, to whom it could be given, and what consequences it entails. R. C. Jiloha, "Mental Capacity/Testamentary Capacity," in *Clinical Practice Guidelines on Forensic Psychiatry,* ed. Gautam S. Avasthi (Calcutta: Indian Psychiatric Society, 2009), 20–34.

[201] J. Pugh, *Autonomy, Rationality, and Contemporary Bioethics* (Oxford: Oxford University Press, 2020), 36.

understand how these criteria should be set. Colonial legislation set these criteria in an ideal context where authorization practices were scrutinized for valid consent. Using a crude tool such as mental capacity posed difficulties in Colonial India because "many of the abilities that society might plausibly agree are necessary for providing valid consent" were not always straightforward or amendable to external assessment.[202]

3.5. The Lepers Act of 1898 and Physical Disability in Colonial India

Physical disability is a condition that limits a person's mobility and ability to function.[203] Major physical disabilities are divided into mobility impairments that affect the upper or lower limbs and sensory impairments which affect the eyes, ears, and mouth. All of these physical disabilities impair and limit daily activities. These could be either congenital or acquired due to ill-health. One of the acquired physical disabilities extensively mentioned in the colonial legislation was leprosy-related. Unlike any other physically disabled, leprosy-impaired was the first section of the physically disabled who got attention from the colonial legislation. Leprosy demanded practical solutions in Colonial India because it threatened the well-being of both natives and the British citizens because of its widespread and contagious nature.

The first piece of legislation on leprosy was passed in 1898, and it clearly defined who was a leper whereby he/she was any person who was suffering from any variety of leprosy. [204] The condition of the 'ulceration of the skin' was deemed as a symptom of the disease.[205] The act was applicable for any person who publicly exposed or exhibited any sores, wounds, bodily ailment, or deformity with the aim of charity or getting alms.[206] The above statement makes it clear that it was not only the leper who was included in the regulations of the act but also included any person whose body was 'deformed' due to leprosy and the leprosy-cured amputees.[207] The fact that not only the diseased but also the disease-induced disabled got attention in the legislation proved that the leprosy regulations

[202] Ibid.

[203] California State University, "Physical Disabilities." https://web.archive.org/web/19990909103353/http://www.csun.edu/~sp20558/dis/physical.html

[204] The Lepers Act, Act No. 3 of 1989, pp. 1–31.

[205] Ibid., 3.

[206] Ibid.

[207] Ibid.

in Colonial India were advanced when it came to the inclusion of the disabled in the legislation.

Under the regulations of the Lepers Act of 1898, the government ordered the construction of the leper asylums.[208] It was the duty of the provincial government to find a site for the asylum and arrange for the necessary amenities for the edifice and maintenance of the asylum. The provincial government was given the authority to make decisions about the accommodation and medical treatment of the lepers in the jurisdiction.[209]

The Lepers Act besides instructed the police or any provincial government officer to arrest any wandering leper from the street without any warrant, and they would be taken to the nearest police station.[210] Every leper who was arrested under the provision of this section, without any delay, would be taken to the presence of the Inspector of Lepers. This was where he/she got examined, and if the examiner found that he/she was not a leper, they would be given a certificate stating the same and would be released. If the person was an actual leper, without delay, he/she would be presented in front of the magistrate.[211] When a person was presented in front of the magistrate and if found that he/she was indeed a leper, they would be sent to an asylum under the power of the police officer and would be forced to stay there under the completion of his/her treatment.[212] His/her release from the asylum would be decided by the order of the district magistrate. If the person denied his/her disease, the magistrate could again call up the examiner for the re-checking session. If his/her disease was in a state where it was not easy to determine whether it was leprosy or not, the person would be kept in a place suggested by the court for further observation. If the magistrate found out that the person was not a leper, he/she would be discharged.[213]

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[208] Ibid., 6.

[209] The act also gave the authority to the provisional government to appoint the chief of the asylum; any medical officer or other qualified medical people could be appointed to act as the chief of the asylum. Each asylum erected under the aegis of the government would be constantly checked by a three-member board committee where one would be a medical officer. The members of the board including the medical officer have to visit the asylum at least once in three months and examine the whereabouts of the asylum. This could include new admissions, the progress of the old admissions, discharged cases, and maintenance and amenities of the asylum. Ibid., 6.

[210] Ibid., 7.

[211] Ibid.

[212] Ibid.

[213] Ibid.

Section 9 of the Lepers Act related to the acts, by order, no leper could do.[214] Any disobedience to these regulations resulted in the punishment by fine up to twenty rupees. The following activities were banned—personally, prepare for sale or sell any article of food or drink or any drugs or clothing intended for human use; bathe, wash clothes or take water from any public well or tank debarred by any municipal or local bye-law for use by lepers; drive, conductor ride in any public carriage plying for hire other than a railway carriage; and exercise any trade or calling which may by such notification be prohibited to lepers.[215]

It is important to note that even though the Lepers Act included the physically disabled in its remedies, the overall aim was to remove the lepers from the streets. The clauses in the act amounted to gross human rights violations. Lepers or leper-amputees were banned from maintaining any kind of social contact and were forced to seclude themselves in the asylums. They were banned from doing daily activities such as working, driving, or using any public amenities. Any kind of social mobility or movement was restricted under the regulation of the act. The act does not talk about any rehabilitation measures for the lepers. The Lepers Act of 1898 included disability in its clauses, but it failed to look past the infectious factor of leprosy in Colonial India.

Even though the colonial regulations and legislations on leprosy were intended to provide a safer place for lepers, they criminalized leprosy. When a person is convicted under Section 9 of the act, the magistrate and the leper had to sign a bond ensuring that he/she would not enter any public places mentioned. If a person failed to adhere to the provisions of the bond, he/she would be arrested and sent to the asylum. A person employing a leper was considered as a violation of Section 9 rules and would be punished by a fine.[216] The alleged leper was then arrested and taken to the magistrate for examination and would be sent to the asylum if found to have the disease or disability.[217] If any person in a leper asylum left or escaped from the asylum without having a discharge report from the medical officer, he/she was arrested and taken back to the asylum for treatment.

[214] Ibid., 12.

[215] Ibid., 9.

[216] Ibid.

[217] Ibid.

The act was repealed in 2016 on the grounds of discrimination. The 1898 Act discriminated against and stigmatized people with leprosy and the people with cured-leprosy even after India's independence until 2016.[218] The New Leper's Amendment Act of 2016 was intended to go in the opposite direction of the 1898 Act by way of raising awareness about leprosy and increasing durability, providing access to education, employment, and benefits.[219] Under the regulation of the 1898 Act, lepers in Colonial India were subjected to forceful segregation in both state and missionary managed asylums. When the act supported the isolation of lepers, the state unknowingly endorsed that the disease was contagious. The act went against the report of the Leprosy Commission which did not agree to segregation. By enabling the act, the government gave in to the pressure of the Indian elites and colonizers for whom the ulcer-skinned people in the streets were not a pretty sight. In March 1895, the Government of India recorded that the act "has an administrative as well as a medical aspect and that the loathsomeness of the disease justified certain measures."[220] Moreover, "this argument underwrote the definition of leprosy which the act produced which had a political rather than a medical genealogy."[221]

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[218] Even after independence, lepers were discriminated against in India because of the disabling nature of leprosy. For example, Section 56 of the Indian Rail Act of 1990 states that a leprosy patient is not allowed to travel in trains owing to the infectious nature of the disease. The 1954 Special Marriage Act still declares leprosy as incurable and hence, a strong ground for divorce. Section 2 of the Hindu Marriage Act of 1955 states that any marriage registered under the act can be dissolved by the decree of the divorce on the ground that either party is suffering from incurable leprosy. According to Section 36 of the Chhattisgarh and Madhya Pradesh Panchayat Raj Act, no leper patient can become a member of the parliament. Section 16 of the Orissa Municipal Act of 1950 also stated that no person with leprosy can be qualified to stand for election. Section 25 (1) (e) of the Orissa Gram Panchayat Act, Section 19 (2) (B) of the Andhra Pradesh Panchayati Raj Act 1994, Section 26 (9) of the Rajasthan Municipality Act, Section 26 (1) (F) of the Karnataka Municipality Act 1976 also stated that any person with the unsound mind or deaf or dumb, or leper patient or leper amputees with chances of infection cannot stand for elections in Panchayat and municipality. Law Commission of India, Report No. 256: Eliminating Discrimination Against Affected by Leprosy (Delhi: Government Printing, 2015).

[219] Sajiv Kakar, "Leprosy in British India, 1860–1940: Colonial Politics and Missionary Medicine," *Medical History* 40, no. 3 (1999): 15–230.; The Leprosy Mission Trust of India, "Leprosy Mission." https://www.Leprosymission.org.uk/news-and-resources/news/indias-repeal-of-1898-lepers-act-is-positive-step/

[220] Kakar, "Leprosy in British India," 216.

[221] Ibid.

3.6. Workmen's Compensation Act of 1923 and the Motor Vehicle Act of 1930: Clauses on Physical Disability

The Workmen's Compensation Act which came into existence in 1923 is another act that included physical disability in Colonial India.[222] This act regulated rules related to the payment of compensation for injuries by accidents to certain classes of workers and came into force in July 1924.[223] The act stated that compensation should be given to the dependents of a person—widow, minor legitimate son, unmarried illegitimate daughter, and widowed mother.[224] The compensation also should be given to the wholly dependent person, defined by the act as minor or infant son and daughter.

The Act of 1923 defined 'disability' in terms of partial disablement, permanent partial disablement, and total disablement.[225] The act stated that any disablement which "reduces the earning capacity of a workman in any employment in which he was engaged at the time of the accident was a partial disablement."[226] The act affirmed that any condition which "reduces his earning capacity in every employment, which he was capable of undertaking at that time" was a permanent partial disablement.[227] According to the act, 'total disablement' meant complete loss of working ability which a worker was capable of. The disablement could be of temporary or permanent nature but had occurred due to an accident at the workplace.[228]

Section 3 and Part 2 of the Act of 1923 illustrated that if any worker was injured due to an accident at the workplace, his/her employer was liable to pay compensation.[229] If a person suffered from partial or total disablement exceeding three days or if the person died due to injury, the employer had to provide the compensation.[230] Furthermore, if a

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[222] Workmen's Compensation Act, Act No. 8 of 1923, pp. 1–17. (Act of 1923 from here on).

[223] Ibid., 5.

[224] Ibid.

[225] Ibid., 7.

[226] Ibid., 6.

[227] Ibid., 5.

[228] Total and permanent disablement remove the entire capacity of a person to earn. For example, in the case of Pratap Narain vs Srinivas Sabta, it was found that the worker's hand got cut off from the elbow in an accident at the workplace. The court took this as the loss of 100 percent capacity and as permanent total disablement. Workmen's Compensation Act of 1923, Registered Cases, Indian Kanoon, File No. AIR 1976 SC222.

[229] Act of 1923, p. 8.

[230] Ibid.

person had come into contact with any disease at the workplace resulting in a 'partial disablement,' the employer was liable to produce compensation provided that the person was working there for more than six months and contracted the disease at the workplace itself. This section referred to the diseases, namely smallpox and leprosy which resulted in 'partial disability.'

According to the Act of 1923, for 'permanent disablement,' the accidents within the work premises were compensated at 50 percent of the monthly wages.[231] The reason why compensation for the disabled was given was that the person was still alive and it took more money to take care of their expenditure in the context of the disability or the loss of his/her earning capacities. If there was more than one injury as the outcome of the accident, the money of the compensation would be increased based on the loss of earning capacity as assessed by a medical person.[232]

An employer was supposed to make a report to a labour commission within seven days of the occurrence of fatal accidents resulting in death or serious bodily injury in the workplace.[233] The employer should send the report to the commissioner stating the reasons.[234] The Act of 1923 defined a serious bodily injury as something "which involves or in all probability will involve the permanent loss of the use of or permanent injury to any limb or sight or hearing or the fracture of any limb."[235] Within three days of the accident, the employer had to complete the medical examination of the person by a medical practitioner free of cost. If the worker refused a medical examination, his/her rights for compensation got suspended. If the workman died within a short period, the commission could order compensation. If the person was under contract work, and he/she suffered disability due to an accident from the workplace, the compensation would be provided by the contractor.[236] If it appears that the employee had insurance and the disbursed insurance amount of the accident was used by him, the commissioner could order the insurance authority to stop the payment.

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[231] Ibid., 9.

[232] Ibid.

[233] It was the provincial government that appointed commissioners. If a commissioner wanted to appoint someone under him, he could do that by a special issue of order. Ibid., 11.

[234] Ibid., 12.

[235] Ibid.

[236] Ibid.

The purpose of the disability compensation was to provide adequate money for the benefit of the disabled to continue living in dignity. Disability compensation given under the Act of 1923 was a one-time sum to compensate for disability caused by employment. The money referred in the act was meagre and there was no continuation of the compensation even when disability was a non-reversible condition. Even though the act covered the medical expenses of the victim, it failed to measure the economic loss due to an injury. Under the act, it was also made difficult to sue the 'original' employer for compensation because it did not define who was an 'employer.' Instead, the immediate employer became the facilitator of compensation especially when an original employer lent his employee to an immediate or current employer. The act also failed to mention any legal aid to the benefit of the victim to take the case to the court.

The Motor Vehicle Act of 1930 was another piece of legislation in Colonial India that talked about persons with physical disabilities.[237] The act intended to regulate laws related to the use of motor vehicles. The act included many factors such as the registration of motor vehicles, processing of dealers, drivers, licenses, and the laws regarding carriage vehicles and heavy passenger motor vehicles.

Section 2 (9) of the Motor Vehicle Act refers to a kind of motor vehicle called 'invalid carriage.'[238] The act defined invalid carriage as a motor vehicle that did not exceed 300 kilograms, which was specially designed and 'not merely adapted' for the convenient use of a person who was suffering from any physical disability.[239] The vehicle in question should only be used by the disabled person. The possibility of a newly designed vehicle for use of a disabled person was quite progressive thought to note in 1939, especially when there was absolutely no discussion taking place on disability and mobility. The term disability was utilized in the clause and that also proves that by 1939, the discussion on disability as a condition that needed special attention was in existence. Section 25 (17) mentioned mobility assistance such as three wheeled-motorcycles.[240] The

[237] Motor Vehicle Act of 1939, pp. 1–15.

[238] Section 20 (13) of the act talks about a light motor vehicle which could be used by a physically disabled. The weight of the light motor vehicle needs to be under 3500 kilograms. A car weighs 4000 kilograms on average and it is concluded that the vehicles for the disabled under the category of lightweight do not include cars. Section 25 (17) mentions mobility assistance such as three-wheeled motorcycles. The act states that these kinds of motorcycles should not exceed 600 kilograms if they are with a detachable sidecar and an extra wheel. Ibid., 7.

[239] Ibid.

[240] Ibid.

act stated that those kinds of motorcycles should not exceed 600 kilograms if they were with a detachable sidecar and an extra wheel.

Section 7 of the Motor Vehicle Act laid out rules related to the grant of the driving license.[241] If the applicant of the license was disabled, his/her form would have to be backed up with a certificate from a medical practitioner.[242] If it appeared that his/her driving might cause danger to him/her, or the public, or to other passengers, the licensing authority could refuse to issue the license. He/she could be given a license if it appeared that his/her driving would be limited to the invalid carriage and he/she was fit to drive the same.[243] When a person is disabled but claimed to be subjected to "a test of his fitness or ability to drive a motor vehicle of a particular construction or design and if he passes such test to the satisfaction of the licensing authority and is not otherwise disqualified, the licensing authority shall grant him a driving license to drive such motor vehicle as the licensing authority may specify in the driving license."[244] No license could be given to the applicant if he/she did not pass the licensing authority's test of 'competence.'

A disabled person giving an application should specify the kind of vehicle they intended to drive. Whenever a driver of the transport and paid drivers make an application for the license, they had to produce medical certificates when they got the driving license.[245] The medical certificate should state that the person was mentally and physically fit to drive any vehicle. The Motor Vehicle Act further mentioned that this provision was included in the act with an intention of "reducing the risk of accidents owing to any disability from which the holder of the license may suffer."[246]

Section 12 of the Motor Vehicle Act dealt with the cancellation of the license on the grounds of disability.[247] At any time, an authority could revoke a license based on disability or disease. An authority could demand to furnish a new medical certificate for proof based on their discretion. If licensing authorities had adequate reason to believe that any license holder was disabled and unfit to drive a vehicle, the license could be

[241] Ibid., 9.

[242] Ibid.

[243] Ibid.

[244] Ibid., 10.

[245] Ibid.

[246] Ibid.

[247] Ibid.

revoked.[248] In 1956, this clause was amended, and a licensing authority could now revoke a license on the ground of disability only if the same license was issued by it. The act was amended in 1988 and a Second Schedule was added which mentioned the cases of accidents where the driver of the vehicle got a permanent disability.[249] The schedule further stated that the accidents resulting in permanent disability were compensated for a sum of money, that is, 5,00,000 rupees as per Schedule 1 of the Employee's Compensation Act of 1923.[250] But in an amendment in 2017, the amount was increased to 5,00,000 rupees in the case of deaths in accidents.[251] The compensation amount for permanent disablement and death was the same according to the act. By doing so the law was agreed to the perspective that being disabled is equal to the state of being dead.

3.7. Vaccination and Epidemic Diseases Acts in Colonial India: Clauses on Physical Disability

Vaccination was another area wherein the British provided legal support to the prevention of diseases that caused physical disability. Smallpox vaccination became the centre of vaccination legislation in Colonial India. Similar to leprosy, smallpox was one of those diseases which led to physical disabilities. Blindness was common among people who contracted smallpox in Colonial India. According to the 1901 Census Report, more than one-third of the cases of smallpox resulted in blindness.[252]

The low intake of vaccinations among the population and the fear of the spread of smallpox and other diseases among the army in the early nineteenth century forced the government to take the responsibility for vaccinations. The Indian Medical Service (IMS) tried its best to popularize vaccinations, but it was met with a lower intake from the people. Religious sentiments and the fear of the unknown was the main reason for this

[248] Ibid.

[249] Motor Vehicle Amendment Act of 1988, Schedule 2.

[250] Ibid.

[251] Ibid.

[252] J. N. Hays, *Epidemics and Pandemics: Their Impacts on Human History* (London: ABC-CLIO, 2005), 151–152.

lukewarm response.[253] By the mid-nineteenth century, the sanitary department took over the responsibility of the vaccination for smallpox. The introduction of the vaccination legislation in Britain has also impacted Indian legislation. In 1853, the Vaccination Act was passed in Britain which made vaccination against smallpox compulsory. All children born after August 1, 1853, needed to be vaccinated within the first three months. Any parents who failed to do were subjected to a fine.[254] By the 1860s, two-thirds of babies born were immune to smallpox, and this positive impact encouraged the colonial government to look at the possibility of other vaccination legislation in India.

The Vaccination Act of 1880 was passed mainly to implement two goals—to prohibit inoculation and to make the vaccination of children compulsory in certain municipalities.[255] The act was extended to the municipalities of the United Provinces, Punjab, Central Provinces, Assam, Delhi, Ajmer, and Coorg. The act was also extended to the military cantonments and places of a municipality chosen by the provincial governments.[256] The act prohibited inoculation and no inoculated person could enter without a certificate to a municipality. The act also states that "no person who has undergone inoculation shall enter such area before the lapse of forty days from the date of the operation, without a certificate from a medical practitioner, of such class as the state government may from time to time by written order authorize to grant such certificates, stating that such person is no longer likely to produce smallpox by contact or near approach."[257]

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[253] In 1802, smallpox vaccination was introduced in India. The initial incubation was tried in Madras, Pune, and Hyderabad. The Indian Medical Service tried its best to popularize vaccinations, but it was met with a lower intake from the people. This resistance was mainly because of the religious sentiments of Indian society. Smallpox outbreaks were understood as the wrath of goddess Kali and this misconception forced people not to participate in the vaccination process. A small fee was required to take for the vaccinations which equally irked the general public. There was a resistance from the *Tikadaars* (who were traditionally involved in vaccination processes) due to the fear of losing their job. By 1850, when the vaccination coverage increased, post-vaccination deaths and unsuccessful vaccines and its complications made the policies complex and brought a lower number of people to participate in the vaccine programme. The Hindu community was also against the vaccination on the pretext of the vaccine coming from a cow, which is considered a sacred animal. The low coverage of vaccines forced the government to pass an act in 1880 under the title The Vaccination Act. The reason why there was no legislation passed before 1880 was because the vaccination was mainly done under the initiatives of the trained vaccinator's tour. Hays, *Epidemics and Pandemics*, 151.

[254] Ibid.

[255] The Vaccination Act, Act No. 13 of 1880, pp. 1–19. (Vaccination Act of 1880 from here on).

[256] Ibid., 2.

[257] Ibid., 3.

Every municipality under the act was divided into vaccination circles to ease the vaccination process and the act generated the licensing system for private practitioners to perform vaccinations.[258] The respective states could cancel or suspend or grant a license to municipalities. Every infant under the age of six months compulsorily needed to be vaccinated and every child who was not vaccinated under the age of fourteen (boy) and eight (girl) needed to be vaccinated.[259] He/she was to be taken to the vaccinator by their parents or guardians. Every child under the above-mentioned age category was to be taken into the vaccinator for inspection and the vaccinator had to issue a certificate. If vaccination was not successful, the process of vaccination needed to be repeated.

The Vaccination Act provided power to the municipalities to make their own rules related to the division of the vaccination circle, place of vaccination, qualification of the public vaccinators, their appointments, suspension and dismissal, fee charged by private vaccinators, certification of successful vaccination, and keeping a record of the vaccinated and unvaccinated children.[260] This act ensured that every child was vaccinated for smallpox so that deaths due to smallpox and the permanent disability induced by the disease got lower with the help of vaccination. In 1892, the Compulsory Vaccination Act was passed and the provisions of the earlier act remained the same. The main aim of the new act was to ensure a higher coverage of smallpox vaccination and reduce the impact of the disease to a minimum.

During the 1890s, Bombay was shackled under the spread of bubonic plague. The Governor-General and his council came up with an act to control epidemic diseases. Thus the Epidemic Diseases Act was passed in 1897 to prevent smallpox, cholera, and plague.[261] This act used a defence mechanism instead of confrontation at approach. The act gave power to the provincial and central governments to formulate their own rules related to segregation and temporary hospital accommodation.[262]

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[258] Ibid.

[259] Ibid., 4.

[260] Indians were very hesitant about vaccinating their children due to fear. Vaccination-related deaths were very less but that it intensified the fear of vaccination. Hays, *Epidemics and Pandemics*, 151.

[261] P. S. Rakesh, "The Epidemic Diseases Act of 1897: Public Health Relevance in the Current Scenario," *Indian Journal of Medical Ethics* 3, no. 1 (2016): 156–158.

[262] Epidemic Diseases Act of 1897, pp. 1–12.

The Epidemic Diseases Act did not define what all involved in 'dangerous epidemic diseases.'[263] There is no clarity about the kinds of diseases which were included in the act and how the term 'dangerous' should be understood and what should be the central point, magnitude, and severity of the problem and its potential to spread rapidly.[264] The act requires a medical person to notify a public health authority about anyone with a communicable disease. It could be only assumed that smallpox was included in the act because it was both epidemic and communicable. The act invoked a vigorous case of inspection at homes and among travellers. Forcible segregation, disinfection and demolition of infected places, prevention of public meetings, and public examinations made it difficult for people to adjust to the act. David Arnold notes that the act was "one of the most draconian pieces of sanitary legislation ever adopted in Colonial India."[265] Even though smallpox vaccinations and sanitary legislations were successful in partially eradicating blindness caused by smallpox, compulsion in taking vaccinations and forced sanitary measures created huge dissatisfaction among the people in Colonial India. Enforcing such draconian measures to implement vaccination and sanitation without any awareness forced a deprived and 'illiterate' population to take a half-informed decision.

3.8. Anti-Beggary Acts and Physical Disability in Colonial India

Disability and begging had a vital connection in Colonial India. The south Asian philosophy of providing for the disabled by the able-bodied was only extended to the family. Those disabled who lived without a family or were abandoned in childhood had to earn money by begging. The disabled, mainly the blind, as a group often migrated to larger cities like Bombay, known as home to 'lame beggars.'[266] In Madras, beggars with mental and physical disabilities lived near Hindu, Muslim, and Christian worship places and made a living through charitable donations and this was a common practice. Blind beggars were higher in number because it was more physically visible than insanity, deafness, and muteness. Beggars with disabilities were frowned upon. They were considered a burden to society and were accused of faking disability to earn money to live

[263] David Arnold, *Science, Technology and Medicine in Colonial India* (London: Cambridge University Press, 2000), 143.; M. Echenberg, *Plague Ports: The Global Urban Impact of Bubonic Plague* (New York: New York University Press, 2007), 58.

[264] Vaccination Act of 1880, p. 13.

[265] Arnold, *Science, Technology and Medicine*, 144.

[266] L. J. Sedgwick, 1921 Census of India: Report and Tables from Bombay Presidency (Poona: Yervada Prison Press, 1922), 32.

a lazy life.[267] When the colonial authorities and missionaries were confronted with this quandary, ironically, instead of charitable and tolerant nature, colonial authorities' attitude towards beggary changed into disgust, suspicion, and condemnation. This disapproval paved the way for legislation aimed at controlling the practice of begging. The colonial authority believed that begging was an unworthy act and the disabled should earn in more 'dignified' ways.[268] The beggary laws did not only rule out beggary but prohibited a way of living based on asking for alms. It also prohibited vagrancy and wandering people were left without any ways of earning.[269]

In the late nineteenth century, Bombay was hard hit with many epidemics.[270] Malaria, plague, and famine increased the causalities, and the situation worsened by 1900. Bombay became an attractive place for refugees and it was up to colonial authorities to control the movement of refugees to stop the spread of disease. On August 25, 1877, the *Times of India* talked about the influx of people into the city because of famine. The newspaper report stated, "When we consider famine refugees, they are so thoroughly exhausted from travel and starvation that not more than from three to four percent can be

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[267] Ibid.

[268] Report on Public Instruction in Bombay for 1938–39 (Bombay: Education Department, Government of Bombay, 1939), 163.

[269] The anti-beggary laws of India go back to the colonial period when in 1869, the first Anti-Vagrancy Act was introduced by the colonial authorities. This was the first law that banned beggary in Colonial India. The act only covered the European citizens in India. The act defined 'vagrant' as a person who was of European heritage and found wandering asking for alms without any employment. After 1857, India needed an entire army of working class for enterprise work such as in railways. This sudden demand increased the number of European working class in Colonial India. Further, many English naval and ground forces were added to the royal forces or disbanded during 1859–1862 leaving hundreds of white men without any employment or pension. This also included people who lost their arms, legs, or sight in the war. When authorities realized that the native labour was cheaper than European, it increased unemployment. These Europeans were soon sided to extreme poverty and chose to beg in the streets. It was an embarrassment to the colonial government where they tried to 'civilize' the 'barbaric natives' and one group of them living the same life as natives. This was mentioned in the Minutes of W. R. Mansfield, the Commander in Chief of India, where he stated that "have long been keenly alive to the shame and inconvenience to which we are exposed by the destitution of some of our countrymen in India … This involves a serious stigma on the character of our government, which must suffer in native eyes accordingly, and that putting aside the question of charity, we lose in prestige as the dominant race in this country, by permitting such a state of things." The 'loss of prestige' forced the authorities to come out with legislation to ban begging. In August 1869, the bill on the prohibition of begging was presented in the Executive Council of Lord Mayo. It was finally passed in September 1869. Manas Raturi, "Raj and the Begging Brawl," (2018). https://theleaflet.in/raj-and-the-begging-brawl-the-colonial-roots-of-indias-anti-beggary-laws-echo-even-now/.; Aravind Ganachari "White Man's Embarrassment: European Vagrancy in 19th Century Bombay," *EPW* 37, no. 25 (2002): 247–248.

[270] Prashant Kidambi, *The Making of an Indian Metropolis: Colonial Governance and Public Culture in Bombay, 1890–1920* (Ashgate Publisher: Burlington, 2007), 83.

described as able-bodied."[271] In 1896, when the plague deaths were reported, panic rose high in the minds of the authorities and the urban elites. Even though the government tried to control these diseases by the implementation of the Epidemic Diseases Act in 1987, it was not adequate. The Bombay Commissioner looked at native beggars and refugees as 'extremely filthy in their habits' and 'afflicted with loathsome deformities,' and 'home of infectious diseases.'[272]

To tackle the begging issue in 1902, the City of Bombay Police Act was implemented. As mentioned earlier, the act provided clauses that allowed the police to monitor the movement of the beggars which included both mentally and physically disabled. Any disabled beggar asking for money on the roads and streets, in buildings, tents, circuses, theatres, and coffee houses was liable for punishment by imprisonment and a fine of 50 rupees.[273] But the act proved deficient in dealing with many other issues like rehabilitation. The Government of Bombay stated that "sustained police activity … can only touch the fringe of the problem … and until the district maintains its almshouses and Bombay city keeps up a clearinghouse into which beggars are put pending transfer to the district almshouses."[274] But no almshouses were established or maintained.

In 1920, the Bombay Commissioner appointed a commission to look into the problems related to the 1902 Act. The committee admitted that there was not ample space to deal with the beggars' rehabilitation. The committee suggested the framing of a new bill aimed at ensuring suitable housing and infirmaries for the detention of disabled beggars.[275] A new bill was passed in 1945, and was called the Bombay Beggars Act, and was implemented in 1946. After further amendments were made, legislation was passed in 1959 and was called as Bombay Prevention of Begging Act.[276]

Under the Bombay Prevention of Begging Act, any police officer could arrest any disabled person begging on the street without any warrant. If anyone got arrested under this act, he/she would be presented before the magistrate, and later would be sent to a

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[271] Ibid.

[272] Ibid., 84.

[273] City of Bombay Police Act of 1902 (Aundh Publicity Trust: Bombay, 1945).

[274] Annual Report of the Government of Bombay on the Work of the City Police for 1918, Commissioner of Police, Indian Papers, NAI.

[275] Bombay Prevention of Begging Act of 1957, pp. 1–20. (1957 Bombay Act from here on)

[276] This act was passed to set uniform and better rules for the detention, training, and employment of disabled beggars in Bombay. In 1960, the act was amended and extended to Delhi.

certified institution. If the disabled beggar's parents were alive, they were asked to contribute to his/her maintenance.[277] If it was found that the beggar had a child who completely depended on them, the child could be transferred to the same institution like that of the parent, irrespective of whether he/she was able-bodied or disabled. These certified institutions were examined by a chief inspector every three months. Section 26 of the act was about what to do when the arrested beggar was of unsound mind or leper.[278] The commissioner could transfer them to a mental hospital or leper asylum for their further treatment. He/she needed to stay there till the end of their detention and after its expiration, a medical officer could decide whether he/she needed to stay there for further treatment or could be released.

Any person exhibiting disease or disability in the streets to gain money was considered as committing a begging offence under the Bombay Prevention of Begging Act. The British wanted these diseased and disabled people off the streets. The act was implemented with the help of coercion by the police department which resulted in further exploitation. The act banned charity ceremonies and 'freak shows' that involved the disabled population.[279] It was an age-old practice to put the disabled on display in circuses and streets to gain money and it was more prevalent among families where a physically disabled was born. In earlier years, circuses were called 'freak shows,' and people with different disabilities were forced to participate or sometimes willingly performed and exhibited their disabilities to gain money. In a way, where no family was around a disabled to take care of them, the act ripped them of the one activity that helped them to earn money. Even though the act promised safe houses for the mentally and physically disabled, it was never fully materialized.

The Design Act of 1911 and the Evidence Act of 1872 which were already mentioned earlier in the context of mental disabilities, also focus on physical disabilities in Colonial India. Section 74 of the Design Act may be interpreted with the backdrop of physical disability.[280] Any person who looked after the property of a person who was incapable of making any oral or written statement was required under the act to be appointed by the court. According to the Indian Evidence Act, in the case of the disabled,

[277] 1957 Bombay Act, p. 4.

[278] Ibid., 6.

[279] Ibid.

[280] The Patent and Designs Act, Act No. 2 of 1911, pp. 1–21.

whatever was presented in the court was taken as being on behalf of that disabled person.[281] Section 118 of the Evidence Act talked about the provisions to be made when a person was presented before the court but was unable to understand or answer the questions due to any mental or physical disease or disability.[282] Sections 119 of the act gave provision for the making of the testimony of a person who could not talk.[283] The section stated that any person who could not speak may give their testimony in any manner they were comfortable—in writing or by signs.[284] Such writing would be signed in the open court and such pieces of evidence would be considered equivalent to oral evidence.

3.9. Pension and Medical Acts in Colonial India: Clauses on Physical Disability

Pension acts in Colonial India also talked about physical disabilities and the provisions to grant pensions. The first pension legislation in Colonial India was passed in 1871 under the title of the Pension Act, Act No. 23 of 1871.[285] Instead of regulating pensions to the disabled, Section 11 of the act stated that no pension would be granted or continued by the government through consideration of past services or infirmities.[286]

But in 1937, the central government published a set of rules called Central Services Extraordinary Pensions Rules.[287] The pensions under the rules covered any permanent disablement caused by any accident, injury, or disease during government service.[288] The rules also covered permanent partial disablement according to its degree as certified by the medical board.[289] A disabled person was entitled to pension either for a disability existing from before the entry into the government service, or for a disability incurred during government service. The pensions were only awarded when an injury or disablement was sustained for more than five years. Under the rules, any person who was disabled due to the government service would be given a pension following the percentage

[281] Indian Evidence Act of 1872, pp. 1–14.

[282] Ibid., 3.

[283] Ibid., 4.

[284] Ibid.

[285] Pension Act, Act No. 23 of 1871, pp. 1–30.

[286] Ibid., 15.

[287] Central Services Extraordinary Pensions Rules of 1937, Section 3–A.

[288] Ibid.

[289] Ibid.

of the disability as certified by a medical authority.[290] If an employee was not able to do the job after his/her disablement, then the percentage of his/her pension would be higher than the percentage of his/her disability. If the person was suffering from permanent disability and was not able to do their job, he/she would be given a pension equal to the pension admissible to a widow.[291] In 1972, this provision was amended concerning the years of service of the person till his/her disablement. The rules did not cover pensions for those who were disabled due to natural causes and accidents. The rules were again amended in 1997, and it covered all disabled, disabled from natural causes and also disabled due to accidents.

There was some legislation enacted in Colonial India in the medical field which helped the cases of the disabled directly or indirectly. The earliest of them was the Indian Medical Council Act of 1933.[292] The act was implemented to make a uniform Medical Council of India to provide higher quality in medicine. The council mainly aimed at improving the quality of surgery and obstetrics, both important to the prevention and treatment of disabilities, especially physical disabilities.[293] The council consisted of both members from each state as well as from each university that provided medical education. The main impact that the act made was on the granting of medical qualifications. The medical institutions were continuously examined, and grants of all medical qualifications were updated under the regulations of the act.[294] Medical degrees awarded by the universities of Allahabad, Bombay, Calcutta, Lucknow, Madras, Patna, Bihar, Poona, Gujarat, Nagpur, Andhra, Agra, and Delhi were regulated under this act.[295]

In 1939, the Bombay Medical Practice Act was implemented to regulate the quality of medicine in the Bombay Presidency. The act was amended in 1961 as the Maharashtra Medical Practitioners Act, which intended to regulate both modern and indigenous medicine. The 1939 Act talked about the need for licensing to any person who "shall be deemed to practice any system of medicine who holds himself out as being able to diagnose, treat, operate or prescribe medicine or other remedy or to give medicine for

[290] Ibid.

[291] Ibid.

[292] Indian Medical Council Act, Act No. 23 of 1933, pp. 1–17.

[293] Ibid., 6.

[294] Ibid., 13.

[295] Ibid.

any ailment, disease, injury, deformity or physical condition."[296] Licensing of any person who sold artificial eyes, limbs, lenses, or any other appliances, or a person who engaged in the examination of the eyes to create or adjust spectacles or lenses, or any person who practiced physiotherapy or any other therapy were also included under the act.[297] The license system helped people to differentiate between those who were properly skilled and professional from those who faked it. This was the only piece of legislation in Colonial India that talked about artificial assistance appliances or limbs.

Another act in which helped to provide treatment for the disabled in Colonial India was the Drugs and Cosmetics Act of 1940.[298] The act was amended in 2005. The act was implemented to provide high-quality medical drugs in the field. The act gave importance to the Drugs Technical Advisory Board, Central Drugs Laboratory, and Drugs Consultative Committee to deal with the issue of the quality of drugs used in the field.[299] The act also dealt with the issues of the standards of quality, misbranded drugs, altered drugs, spurious drugs, and the prohibition of certain drugs.[300]

In 1951, the All-India Special Disability Regulation Act included disability in its clauses that promised protection to the body and rights of the disabled in India. In 1961, the Income Tax Act included a clause stating that any person with permanent disability and unsound mind could claim reductions in their income tax.[301] In 1992, Income Tax Amendment Act added the percentage of disability to decide the reduction in the taxes. Along with these Acts, Schedule 7 (9.2) of the Indian Constitution talks about the problem of the disabled. The schedule states that relief should be given to the disabled and the unemployed. Part 3 in Fundamental Rights of the Indian Constitution talks about the importance of non-discrimination but does not talk about the problem of discrimination on the grounds of disability.[302] Article 326 of the Constitution states a person with an unsound mind cannot vote.[303] Article 41 of the Constitution says that states have to take the responsibility of securing the rights to work, education, and public assistance in case

[296] Bombay Medical Practice Act of 1939, pp. 1–14.

[297] Ibid., 8.

[298] Drugs and Cosmetics Act of 1940, pp. 1–32.

[299] Ibid., 2.

[300] Ibid., 8.

[301] Income Tax Amendment Act of 1921, pp. 1–8.

[302] Part III, Fundamental Rights, The Indian Constitution.

[303] Article 326, Voting Rights, The Indian Constitution.

of unemployment, sickness, and disablement.[304] Understanding that the entire population of the disabled should be taken care of, the Rehabilitation Council of India Act was passed in 1992.[305] The government passed the Persons with Disabilities (PWD) Act in 1995.[306] Instead of looking at disability as just a medical problem, the PWD Act states that disability should be understood concerning its legality and social practicality. The act was inclusive of blindness, low vision, leprosy-cured, hearing impairment, locomotor disability, mental retardation, and mental illness. The legality of disability in India was further expanded into a more inclusive one with the passing of the Multiple Disabilities Act in 1999 and the Rights of Persons with Disabilities Act in 2016.

Summing Up

The colonial laws on mental and physical disability criminalized disability and segregated the disabled from society and created a distinct space for them. These legal acts defined what is 'normal' and what is 'not normal' and treated disabled bodies as property to be owned, corrected, and managed. These acts associated disability with crime but also provided a first-time legal provision for the disabled to approach the court for their rights. Colonial acts intended to provide medical and institutional 'care' of the disabled. The acts intended to ensure that the disabled's property was managed in the interest of the person in question. However, colonial legislation was based on the principle of exclusion which is completely different from today wherein inclusion is the desirable yardstick.

[304] Article 41, The Indian Constitution.

[305] Rehabilitation Council of India Act of 1992, pp. 1–25.

[306] Persons with Disabilities Act (PWDs) of 1995, pp. 1–28.

Chapter Four

CHRISTIAN MISSIONARIES AND DISABILITY IN COLONIAL INDIA

The nineteenth century brought about multiple paradigmatic shifts around the world including the growth of new trends in special education, techniques, signs, and scripts. Being a new concept, special education was a designed instruction to meet the 'unique' needs and abilities of disabled students.[1] Tracing the history of special education, Tremblay says that people with disabilities were often placed in hospitals, asylums, or other institutions that provided little, if any, education.[2] The development of education for the disabled in Colonial India was significantly an outcome of the work of Christian missionaries.[3] The first part of this chapter attempts to trace the history of 150 years of mission care, work of special education, and informal efforts in Colonial India and its relationship with disabilities, families, religion, and education.[4]

The missionaries primarily used basic interpretations of the Bible to create an awareness of the care needs for the disabled among the local populations. They tried to spread the Christian ideology that everything under God's patronage was a created image of God and everyone held a high value. Most importantly, they maintained that all believers were created by God, and each has a mission to fulfil based on his/her destiny. For every evangelization, the missionaries quoted the Bible for more support and interpretations. The rooted dogma of having a life for a purpose was spread across to advocate the significance of the disabled in society. The missionaries indoctrinated the idea that 'in a healthy church, everybody belongs.'[5] Subsequently, this chapter also probes into the reason why Christianity was popular among the disabled community in India.

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[1] Phillipe Tremblay, *Special Needs Education Basis: Historical and Conceptual Approach* (Bruxelles: Université Libre, 2020), 3.

[2] Ibid.

[3] Hayden J. A. Bellenoit, "Missionary Education, Religion and Knowledge," *Modern Asian Studies* 41, no. 2 (2007): 121–130.

[4] Ibid.

[5] New-Church, *Everybody Belongs. Everybody Serves: A Handbook for Disability Advocates* (Michigan: Grand Rapids, 2009), 38.

4.1. Educating the Blind: The Role of Philanthropic Christian Mission

Christian mission-sponsored disability education came first and foremost in discussions about the policies of management of blindness. Blindness has been widely referred to in the Christian scriptures, and many cases are explained in the Bible where the blind had been consecrated in Christianity. The blind in India in the early 1800s were either looked after by the family or lived in the street earning through begging. They shared the resources available to the family and when shortages hit, they were the hardest affected.[6] The details of the blind population were registered in official records as those of the problems of begging in urban areas. The absence of official records in the rural population of the blind leaves us with the unanswered question of whether the blind depended on the family or were left alone to fend for themselves. But some district registers referred to how the blind was treated in rural areas. In Garo, northeast India, district officers recorded that "villages were said to have had a lame or blind person incapacitated from other work, who invokes the deities, and offers sacrifices for the recovery of a sick person."[7]

The Christian missions in India, especially in the 1800s, criticized the government's relaxed attitude towards the problem of blindness.[8] The British influence on the disabled, especially the blind in India always began with charity, donations, and ophthalmic surgeries.[9] Later, these works were extended to educate blind children in "ordinary schools, facilitated by the advent of reading materials using the embossed scripts of Lucas and Moon; with later on some residential asylum or orphanage schools and finally, the use of Braille."[10] Before the mission involvement in the blind education, the British aid fund to the blind was misdirected and the government did not have the authority to deal with the "problem created by the vast number of beggars and blinds in India, for whom poverty resulted from some physical disability."[11] But the missionaries

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[6] Rev. Claudius Buchanan, *Memoir of the Expediency of an Ecclesiastical Establishment for British India* (Cambridge: Cambridge University Press, 1811), 73.

[7] Adam White, *Memoir of the Late David Scott* (Calcutta, Calcutta Press,1832), 139.

[8] Buchanan, *Memoir of the Expediency*, 74.

[9] Peter Breton, "On the Native Mode of Couching," *Transactions of the Medical & Physical Society* 7, no. 2 (1826): 341–382.; H. E. Drake-Brockman, "The Indian Oculist, His Equipment and Methods," *Indian Medical Gazette* 3, no. 45 (1910): 207–210.

[10] M. Miles, *Blind and Sighted Pioneer Teachers in 19th Century China and India* (West Midlands: UK Press, 2011), 20.

[11] Kenneth Ingham, *Reformers in India, 1793–1833* (Cambridge: Cambridge University Press, 1956), 115–116.

were involved with the blind and beggars, through whom many became 'radical' protectors of the 'pious' evangelists after witnessing the horrors of the lives of these groups.[12] Although there was no genuine financial support from the government, weekly alms and donations for the blind continued and spread to many cities.

The first official attempt at dealing with the problem of blindness was launched by the Serampore Mission Trio. Missionaries like Joshua Marshman, William Ward, and William Carey made small weekly donations to the blind and the lepers in Serampore. They also demanded formal educational and medical services for the blind and the disabled from the British government. It all began with Carey's involvement in the construction of a hospital for lepers in 1818. To build the hospital, land and other donations were made by Raja Kali Shankar Ghosal, a rich businessman from Banaras involved in charity donations to match British efforts.[13] The same person organized a survey of blind beggars and their conditions that eventually led to the opening of a charitable asylum for the blind in Banaras in 1829.[14] Interested in funding an asylum for the disabled, Raja Kali Shankar informed the chaplain who was a good friend and wrote a letter to the government in 1824 asking for the provisions needed to materialize the plan.[15] Having a soft corner for Christianity, he wanted to establish a printing press in Banaras to spread Christian knowledge in the community. Kali Shankar and his family were tied to the Church Missionary Society (CMS) for years. His father Jai Narain Ghosal was related to the CMS through donations; Jai Narain used to donate a large sum of money for educational purposes and promised donation of his land to build an asylum. Kali Shankar was deeply influenced by the philanthropic activities of his father, and in 1821, after the death of Jai Narain, he donated and transferred the promised property to the care of CMS on his father's behalf on which the blind asylum was built to keep his father's promise. Kali Shankar also continued to pay the monthly allowances to the Christian missions in Banaras.[16]

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[12] Immanuel David, *Reformed Church in America Missionaries in South India, 1839–1938* (Bangalore: Asian Trading Corp., 1986), 160.

[13] K. P. Sen Gupta, *The Christian Missionaries in Bengal, 1793–1833* (Calcutta: Calcutta Press, 1971), 136–137.

[14] E. A. Reade, *The Asylum for the Blind and Destitute–Benares* (Agra: Contributions to the Benares Recorder, 1858), 4–11.

[15] Ibid.

[16] James Hough, *History of Christianity in India* (London: Thacker, 1860), 319.; Dirom G. Crawford, *History of the Indian Medical Service, 1600–1913* (London: Thacker, 1914), 84.

Before the foundation of Ghosal asylum, Raja Kali Shankar surveyed the blind in Banaras. It is probably the first-ever survey of persons with sensory disabilities in Colonial India. The survey report indicates that 225 blind individuals were interviewed and 100 were registered as congenitally blind. The record also shows that more than half of the population had family connections and did not enjoy living in an asylum. It is reported that the main reason blind people did not like being placed in an asylum was their strict no-begging policy.[17]

It was in 1824 that the magistrate of Banaras presented in the name of Raja Kali Shankar a grant for an asylum for the blind. The Raja proposed that he would invest 10,000 rupees to set up the construction infrastructure with a salary of 200 rupees per person for its management.[18] The magistrate expressed that he was much thrilled with the project. In the submitted proposal, he asked the government to put forth a new set of regulations about the management of the fund. In reply to this request, the government appointed a committee to evaluate and clarify further matters related to the foundation of the asylum, namely the feasibility of the institution and the number and the kind of residents.[19] The government feared that if all the blind flocked to Banaras, it would not be possible for the asylum to accept and accommodate them all. The committee suggested that, concerning the above-mentioned practical problems, it would be better if the plan for asylum was abandoned.[20] Instead, it would be preferable to set up an eye clinic that could provide the necessary medical treatment and provision of temporary stay for the blind. In addition to the eye infirmary, the committee also recommended establishing a leper asylum for those who had been cured of the disease but became disabled.[21] But after subsequent discussion, the committee concluded that an additional number of blind people at Banaras would not be a more serious issue and approved the asylum plan. The committee also suggested that Raja Kali Shankar should take care of the monthly expenditure of the asylum, as well as nutrition and clothing for patients. Later, in response

[17] Charles Lushington, *The History, Design, and Present State of the Religious, Benevolent and Charitable Institutions, Founded by the British in Calcutta and its Vicinity* (Calcutta: Hindostanee Press, 1824), 299.; Francis Buchanan, *An Account of the District of Pune in 1809–1810* (Patna: Bihar and Orissa Research Society,1928), 165.

[18] Kali Shankar Asylum Committee Report, India Office Library, Board Collections, Manuscript F/4/955, Section 1827–1828; Manuscript F/4/955, Section 27109–27118, quoted in Miles, *Blind and Sighted Pioneer Teachers*, 13.

[19] Miles, *Blind and Sighted Pioneer Teachers*, 14.

[20] Ibid.

[21] Ibid.

to the Raja's request, the institution was recognized as an asylum for the blind. Following the rules and settlement of the committee, the Raja paid 48,000 rupees to the Banaras Collector as a contribution to the fund.[22]

In 1826, even before the government's sanction, inmates were admitted to the asylum. The government delayed the sanction because it was concerned that the arrival of people with disabilities in the asylum would lead to a burden on charitable resources. A similar situation had happened in Calcutta after the establishment of the leper asylum. The influx of disabled people into Calcutta led to the predicament of begging in the streets. The government was acquiescent because it was natural for people with disabilities in India to earn by begging. Demonstrating their disability as a tool of pity, people with disabilities in India lived on at the mercy of the public. If they entered any asylum setting, their earnings would be forfeited. Therefore, the government and those in charge of the foundation of the asylum believed that people would not come to the asylum. But this fear was dispelled by those who pushed the foundation of the asylum for persons with disabilities. The main motive behind the creation of asylum was the desire to negate the typical Indian approach to coping with disability by eliciting pity. That response combined with anti-beggar colonial policies. The colonial elite wanted people with disabilities off from the streets because the disabled community became an eyesore to the 'welfare' they proudly claimed to have brought to the Indian society. Besides, the asylum foundation was a great example of colonial relations with the elite and wealthy sections of India. The asylum foundation was crucial as an example of friendship between the Indian elites and colonial government, especially at a time both private and public donors were hesitant to commit to an open-ended expense. In the end, the asylum was founded amid all the confusion and discussion. The Asylum Foundation Fund was run by the colonial officials themselves. In 1829, chief surgeon Thomas had a duty to administer the fund by regulating the expenses. But he committed suicide after it became public that he mismanaged the fund and siphoned off money for his personal purpose.[23]

In Banaras, missionaries namely Charles Leupolt and his wife Mrs. Leupolt also played an important role in the education of the blind in the Raja Kali Shankar Ghosal asylum. The asylum first invited students in 1826 and it was the first official asylum dedicated to the blind and education in Colonial India. Trained at Basel and the Christian

[22] Ibid.

[23] Crawford, *History of the Indian Medical Service*, 318.

Medical College, London, Charles Benjamin Leupolt was a German missionary who worked under the aegis of the Church Missionary Society. After the 1857 Revolt, he critiqued the colonial government for its educational policy in producing 'atheists, materialists, and skeptics.'[24] His firm belief was that with 'truth,' Christianity can win over Hinduism. After 1857, he toured in north India, rallied support from the locals and he contacted other missionaries such as Sarah Tucker at Banaras and William Muir who worked in the special education field in Allahabad, to discuss various available methods of teaching and the scope of teaching the native blind and received words of affection and inspiration from them. Charles Leupolt strived for the improvements of the blind in India when he was posted in Banaras. Similar to the missionaries of his time, he was quite curious about India, its culture, and its geography. In his autobiography titled *Recollections of an Indian Missionary* published in 1884, he dedicated an entire chapter to describe the local culture and geography of the subcontinent. The main aim of the missionaries who worked for the disabled in India, according to Leupolt was to provide the English way of life which he described as the 'civilized' way of life, and to provide education and suitable employment.[25] Besides, Leupolt was worried about the religious 'well-being' of the Indian people.[26] Thus he strategized a four-way programme to spread the gospel through preaching, education, translating, and distributing scriptures and tracts.[27]

Charles Leupolt explained that Banaras where he was stationed was well-equipped in the missionary task of schooling and it remained an important branch for years. In the past, little attention was paid to the education of children with disabilities in Banaras. But Leupolt's schools which were largely comprised of day schools accommodated blind students. They were known as free schools, orphan schools, and orphan boys' and girls' schools in Sigra, which housed children with disabilities, especially the blind.[28] Many children with disabilities had been abandoned on the streets or in the orphanages due to disability and orphan schools educated them along with other children. Another large free school was run by Leupolt in Banaras known as Banaras Free School which was founded

[24] Charles B. Leupolt, *Recollections of an Indian Missionary* (London: Society for Promoting Christian Knowledge, 1884), 23.

[25] Ibid., 57.

[26] Ibid., 60.

[27] Ibid., 61.

[28] Ibid.

with the help of money donated by Raja Jai Narain, an elite native and the father of Raja Kali Shankar.[29] Raja Jai Narain donated money to build fixed property for the school and it was maintained by the monthly donations from the government.

The biblical teachings were one of the major subjects introduced by the Banaras Free School, and Leupolt recalled that parents approved it.[30] Parents believed that learning the Bible would inculcate obedience in children, but they never wished to be converted. Leupolt confirmed that missionary schools forced no one to become Christian.[31] The fourth report of the Banaras Church Missionary Association states that the "Bible, Political Economy, Indian History, Geography, Astronomy, Geometry, and Arithmetic" were the core subjects used in the school.[32] The history of the Bible and the reading of the Bible were the main subjects to be learned from first class to the third, and from fourth to fifth, other subjects were given importance. The Bible studies started with the explanation of doctrines followed by regular reading. Leupolt believed that reading the Bible should not be enforced on the students but they should consider themselves as 'privileged' to read the scripture.[33] Even though Leupolt rarely baptized anyone, he recollected his friends in the same field baptized children with disabilities who requested to be converted.

One of the first-ever pioneers of blind education in Colonial India was Jane Champers Jones Leupolt, also known as Mrs. Leupolt. Jane Leupolt was one of the first women missionaries sent to India by the Society for the Promotion of Female Education in the East. She was a trained infant educator and was stationed at Burdwan and later in Banaras.[34] Jane Leupolt was closely connected with William Moon, the founder of Moon script.[35] During her stay in India between 1857 and 1860, she collected study materials that were useful in teaching the blind.

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[29] Ibid., 150.

[30] Ibid., 151.

[31] Ibid.

[32] Ibid., 153.

[33] Ibid.,154.

[34] Ibid., 16.

[35] Moon script was a special writing system for the blind. The script used embossed symbols adopted from the Latin script. For practical use, the script was simplified and mostly helped people who already lost their sight as adults because they already know the shape of letters. William Moon, *Embossing Books for the Blind* (Brighton: William Moon, 1853), 9.

Initially, Jane Leupolt was given the responsibility of educating blind students in the orphan institutions at Sigra and Banaras.[36] She was supported and assisted by another missionary known as Mrs. Fuchs. Eventually, her educational programmes for 20 blind children were funded by the government in 1864. After years of trying, she created a system to print Hindi using the Moon script characters in 1867.[37] In 1870, the asylum committee of Kali Shankar Ghosal Asylums in Banaras reported that more than half of the visually impaired in the asylum were employed after Leupolt system of teaching was introduced in 1868.[38] Upon the retirement of Jane Leupolt, her works and books were given to Erhardt at Secundra Orphanage. Elizabeth Alexander, a missionary lady, also used Jane Leupolt's study materials to teach blind students. After Jane Leupolt's retirement, the education programmes for the blind in Banaras received a lukewarm response, and educating disabled children was looked at as a secondary effort. But women missionaries continued to educate the blind under the wraps.

There is little information available about the work of Jane Leupolt in the records of the Christian Medical Commission (CMC), but her work occupied a chapter in her husband Charles Leupolt's memoir.[39] When she worked in India, only a few missionaries were employed in the mission work, especially in education. The majority of the women missionaries were employed in medical missionary institutions as nurses while the primary aim of other women missionaries who worked was to provide shelter to the orphans rather than educating them. Education of the disabled, according to them, took more time and concentration with limited technology and it took away a significant share of their time when it could all be used to spread the 'word of God for which they had sent men out.'[40] Both Charles and Jane Leupolt faced problems related to funding especially due to a lack of interest from the government. Most institutions during their time were run with the money donated by Europeans and native elites. Educational work to benefit the disabled was considered worthy but was not understood as something with 'strategic importance.'[41]

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[36] Leupolt, *Recollections of an Indian Missionary*, 243–247.

[37] Ibid., 250.

[38] Ibid., 256.

[39] Ibid.

[40] Ibid., 270.

[41] Ibid., 169.

In 1836, missionaries under the direction of Jane Leupolt set up another institution—the Orphan School for Girls to disseminate education in Banaras and catered to the orphans and abandoned disabled, especially the blind. This school also had an integrated day school and a boarding school. One Mrs. Smith, the lady-in-charge of the school and boarding, remembered that the blind girls were taught reading, writing, arithmetic, geography, knitting, and some fancy work.[42] Simultaneously, Leupolt and his friends were worried about the condition of orphan boys in Banaras, and at the annual meeting of the Church Missionary Association, they proposed a need for new orphanages for boys. The proposal was accepted and another branch for boys was added under the care of Jane Leupolt. At the same time, C. Madden, another missionary who worked in Fatehpur, transferred 39 boys he rescued during a famine in 1839 to Banaras.[43]

1838, the year of the famine, was an eventful year for orphanages as in the same year more disabled children were admitted to these institutions. The famine affected the poor of India and killed thousands. The missionaries rescued people from the street in great distress especially providing for the orphaned disabled children. Leupolt was informed about the famine through his friend and he remembered that in one instance, one Rev. Moore wrote him a letter stating that disabled children were given away by their parents in return for goods, and such was the vulnerability of the disabled children during this period.[44] Leupolt recalled that when these children reached his orphanage, they were skin and bones due to iron deficiency, especially the small boys. Some were so weak and due to compromises in immunity, many had diseases or were disabled, and some could not even bear the travel and died midway.[45] Due to the harsh conditions of famine, many children contracted multiple diseases. Blindness among these children was common, and many were paralyzed.

In 1856, William Moon's school in Brighton was expanded and his script was developed into eighteen languages. There was a sudden surge in demand for these study materials and already translated scriptures. The Banaras Mission collected these study

[42] Ibid., 167.

[43] Ibid., 163.

[44] Ibid., 167.

[45] Mr. and Mrs. Leupolt recalled that they received 51 boys and 23 girls in the orphanage within 24 hours in 1838, and only one survived among the boys. Among 23 girls, many died and two survived with permanent disabling damage. Leupolt remembered that these kids were hard to handle and they ate table candles and soap instead of cooked food due to iron deficiency. Ibid., 171.

materials and transported them from Brighton to India.[46] Jane Leupolt got hold of these study materials and she trained blind students, especially girls to read in Moon script. Helped by her, one unidentified blind student of Leupolt became a teacher for the blind students. The blind teacher met blind native women and taught them whatever she learned.[47] Education of the blind in Banaras was not continuous, and it lacked regularity in instruction. But the girls' school in Banaras employed Mrs. Fuchs, a teacher who provided regular instruction related to the Bible to the blind students because of which many converted to Christianity.[48]

Meanwhile, the managers of the Ghosal asylum found it difficult to manage and communicate with its blind inmates. On the other side of Banaras, the orphan institution set up by Mr. Leupolt and Jane Leupolt made considerable progress in teaching the blind using Moon's gospel of St. John. Nonetheless, it was only available in the Moon's embossed adaptation in Urdu. Jane Leupolt tried to form an alphabet adapted to Hindi and in a few months, she printed the first Hindi reader for the blind. She then introduced this reader to the blind inmates of Raja Kali Shankar Ghosal Asylum. A few blind men and women in the asylum learned this script with no problem, and after the inspection of the Director of Public Instruction, the government paid the expenses of teaching at the asylum. Script learning by the blind was looked at as inspirational because beyond the expectations of the committee, people they thought 'helpless' were able to achieve such a skill. To continue with the efforts, the committee also suggested to the asylum to implement study courses related to industrial work. The success story of the blind teaching materials in the asylum made headlines and the script was introduced in many learning centres successfully. The Hindi script of Moon was exhibited at the Agra Exhibition of 1867 and it won a first-class special prize.[49]

In 1868, the popularity of blind education increased because it was a nice surprise for the native people to see the blind making progress in learning, but still, Jane Leupolt found it difficult to appoint teachers in her schools. Leupolt used to visit and meet the

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[46] W. Fison, *Darkness and Light; or Brief Memorials of Two Blind Deaf-Mutes: with facts relating to the origin of Moon's system of reading for the blind, and its success in answer to prayer* (London: Wertheim Macintosh & Hunt, 1859), 100.

[47] Fifth Report of the Society for Supplying Home Teachers and Books in Moon's Type to Enable the Blind to Read the Scriptures (London: Society for the Blind, 1861), 12–13.

[48] Mrs. Fuchs was the wife of S. Fuchs, a missionary and an ethnographer in Colonial India. S. Fuchs, *Anthropology for the Missions* (Allahabad: St. Paul Publication, 1979), 84.

[49] Ibid., 243.

students regularly and in late 1868, she saw how difficult it was for students to deal with their studies without the assistance of a teacher. She asked one Mr. Titus, a missionary and a trained instructor, to be the teacher for the blind and he started his job in March 1870.[50] Notwithstanding the above difficulties, six of the blind learned to read well and one was so advanced that he could give considerable assistance in teaching others.

In early 1870, Mr. Titus died—he was known as the first Indian teacher with formal training in special education. Another teacher was selected who taught raised-Moon script to the blind. The school hours were divided into two segments—the morning session was assigned to the blinds while the afternoon session was reserved for the 'lame and decrepit.'[51] The teacher used tales as the medium of instruction to coaching them in mental arithmetic. In 1872, twelve blind people joined Jane Leupolt's school, of which six left due to personal reasons. Of these twelve blind students, four remained under the instruction of the teachers and by 1872, they learned to read.[52] By 1876, five more students joined the school, and by 1877, two more children were added to the population of blind students.[53]

Amidst all these insecurities, both Mr. and Mrs. Leupolt worked hard with the same zeal and passion for the education and the sheltering of disabled children. Julius Richeter, in his text *A History of Missions in India* writes that the work of women missionaries "for the most part carried on in secret and little of it has found its way into missionary reports."[54] There are no valid sources available to examine how the blind thought about the process and their opinions were left unrecorded. But a few missionaries from Britain did not approve the tasks of mission education in India. For example, a British missionary, Van Landeghem was not supportive of the 'exile institutions,' where the disabled were receiving 'lasting advantages.'[55] Mr. Landeghem's anger was mainly because he believed there was no need to send money overseas from 'home' for the

[50] Ibid.

[51] Leupolt, *Recollections of an Indian Missionary*, 167.

[52] Report of Charitable Institutions in Allahabad for 1872, National Library of Scotland (NLS from here on), 38.

[53] Ibid., 26.

[54] J. Richter, *A History of Missions in India* (Edinburgh: Oliphant Anderson & Ferrier, 1908), 332.

[55] G. A. Philips, *The Blind in British Society: Charity, State, and Community, 1780–1930* (Aldershot: Ashgate, 2004), 148–152

advantage of the blind and for missionaries to conduct classes in their homes when thousands suffered under poverty and needed assistance.[56]

In 1839, the Madras Military Male Orphan Asylum, another establishment emerged in the limelight. This orphanage-cum-school was receptive to the new ways of teaching the blind. The mission treatment of the disabled in Madras differed from other parts of the country. By 1869, a fund in Madras was used to distribute alms every Monday morning to blind beggars outside in the streets.[57] In 1874, the alms were also provided by St. Mary Church Committee, and most of the disbursed fund was invested in the treatment of boatmen who turned disabled because of accidents.[58] This reference is one among the old regular funds given to the disabled in the country.

The founding executives of the Madras Military Male Orphan Asylum operated on the understanding that repetitive courses and vocational training could help disabled children in earning an income. The founders understood that the fund of the asylum was limited and the demand for the funding was high, and therefore, it was important to operate the asylum to the maximum potential possible. To maximize the optimal utility of the fund, they advocated that education given to the children should be career-oriented so that once they complete their education, children could earn a living. The executive committee of the orphanage ruled that the admission and rejection of any disabled children to the asylum should be based on their capacity to earn a living. Otherwise, the person probably might become permanently dependent on funds.[59] This stipulated rule of the asylum stirred criticism among many historians because the Indian disabled were ill-treated and humiliated by the asylum authorities based on European scaling of capacity. However, in reality, this decree was only limited to papers and the Madras Military Asylum sheltered many disabled children with 'limited capabilities' to be educated or employed.

Another institute committed to blind education in Madras was the Madras Orphan Asylum, which was a small branch of Madras Military Male Orphan Asylum. The Report of Andrew Bell, Superintendent of the Madras Orphanage from 1753 to 1832, recorded

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[56] Ibid.

[57] Frank Penny, *The Church in Madras* (London: Smith Elder & Co, 1904), 385.

[58] Ibid.

[59] John Murray, *Military Male Orphan Asylum at Madras: A New Edition* (London: Missionary Press, 1812), 84.

the case of a blind boy admitted with intellectual disabilities and taken care of for long years.[60] He reported that his classmates used to tease and mock him continuously.[61] Bell tried many methods to train the boy but witnessed no changes in his behaviour. He tried to use the techniques advocated by Jean Itard, a French physician in 1801, who supported 'assiduous training' where persistence is the key to teach a person with low capacity.[62] However, it did not help Bell in training the 'boy' in question. Later, he borrowed the Indian *pathashala* method to teach his blind students whereby the teacher taught the older students first. Then the trained older students taught the younger learners. It was understood that repetition and this teaching process could provide clarity of the 'topic.'[63] It would also save money or salary that had to be dispensed to multiple teachers. This method of repetition or rote learning established in Madras Asylum led to vigorous promotions, demotions, and competitions which pushed the disabled child to the bottom of performing students in their class, and no special methods customized based on the needs of each blind student were adopted for their advancement.[64] Bell's pity on the blind boy was mostly for his helpless state and the abuse he had to bear in the asylum. Instead of provisioning special education, Bell wanted to protect the boy from the abuses.[65] Later, Bell placed the boy under the care of another older student which impacted the behaviour of the disabled boy for the better. He used the method of integration, where the disabled are placed in a 'normal' environment.[66]

In Madras Orphan Asylum, William Cruickshanks, a blind teacher received much limelight during the 1830s. [67] He was born in Vellore and he lived in Madras Orphan Asylum where his eyesight weakened. By the time he turned 12 years old, his eyesight

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[60] Andrew Bell, *An Analysis of the Experiment in Education in Madras* (London: 1807), 89.

[61] Ibid.

[62] Jean Marc Gaspard Itard, *An Historical Account of the Discovery and Education of a Savage Man, Or of the First Developments, Physical and Moral, of the Young Savage Caught in the Woods Near Aveyron, in the Year 1798* (London: Richard Phillips, 1802), 67.

[63] Bell, *An Analysis of the Experiment in Education,* 17.

[64] Ibid., 15.

[65] Ibid.

[66] Ibid., 74–75.

[67] Cruickshanks, before he lost his eyesight received little formal education. He chose teaching as his career and worked as a tutor for private families. After years of service, he was requested to join a native English school known as Anglo Vernacular School in Palamcotta where he taught for 26 long years. Anonymous, "The Blind Schoolmaster of Palamcotta," *Church Missionary Gleaner* 6 (1879):40–78.

reduced tremendously to the point of blindness. When he completed his studies from the asylum in 1838, he was given the responsibility of 100 students and was appointed as the headmaster of the Native Education Society's School of Madras. Later in 1841, he was appointed as the head of Madras Military Male Orphan Asylum. [68]

Cruickshanks was a keen Christian evangelist, which was reflected in his designed curriculum based on the Bible and the oral method of teaching the blind.[69] He also included music in his curriculum. He was a performer himself and used to play flute and violin.[70] He retired from teaching at the age of 70, nevertheless, used to tutor at the University of Madras. He wanted to open a school for the blind but did not live to see the fructification of his work, and died in 1876.[71] His success in life was influenced by external factors such as his early years of sight and his mixed-race background. He had the advantage of sight till the age of 12 years and that helped him to learn letters and frames fast. His father was an Irish citizen and his race helped him to get recognition because mixed-race or European descendent disabled children in India were given special attention from the missionaries. There is no evidence available to prove whether he learned to read or write using Moon and Lucas scripts.

Similar to Cruickshank, another disabled person who received much appreciation for his success in the Madras Orphanage Asylum was Virijananda Saraswathi. He was blinded by smallpox and orphaned at 11 years of age. He was helped by Dayananda Saraswati, an Indian philosopher, and his reformation society Arya Samaj, and later taught blind adults in Punjab.[72] Both Cruickshank and Virijananda used the technique of memorization and oral repetition as their tools and means of educating the students.[73] The reason these two succeeded in their field of expertise was due to their hard work and persistence.

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[68] Ibid., 42.

[69] William Cruickshanks took no objection from his Hindu students when he tried to teach them Christian ideologies. Even though he could use visual signals, he could not teach other blind students with his oral methods. This resulted in dissatisfaction among the students and many used to leave his classes taking advantage of his blindness. Ibid., 65, 76.

[70] Ibid., 77.

[71] Paul Rajaiah, *Chosen Vessels: Lives of Ten Indian Christian Pastors of the 18th and 19th Centuries* (Madras: Christian Literature Society, 1961), 195–201.

[72] Lajpat Rai, *A History of the Arya Samaj* (Bombay: Orient Longmans, 1967), 21–25.

[73] Anonymous, "The Blind Schoolmaster of Palamcotta," 77.

Throughout the nineteenth century, children like Cruickshanks and Virijananda Saraswati integrated themselves with the sighted by using their memory. Blind students were committed to oral repetition and considered it as an important teaching tool. Priscilla Chapman recalled a blind girl who learned the Bible by heart by hearing from her friends.[74] The lack of any special system of education was evident during those times. This scenario made missionaries uncomfortable, especially at the Bengal Military Male Orphan Asylum in 1838. To solve this condescending condition, they sought assistance from the London Society for Teaching the Blind. The orphanage requested the London Society for study materials that could be practically helpful in India. The London Society provided the asylum with reading materials printed in the Lucas system in 1841.[75] The society established by Thomas Lucas in 1838 was a London-based charity institution that aimed at helping and improving the condition of the blind.[76] With the initial aim of assisting the blind through education and employment opportunities, it ran on private funds raised by Mrs. Lydia Johnson and her Ladies Committee.[77] It was here that Thomas Lucas introduced and implemented his Lucas script for the blind.[78] By 1840, the asylum taught the blind using the Lucas system provided by the London Society. The society in 1841 reported that the board received reports from the Bengal Orphan Asylum saying that many blind students were learning well through the Lucas system.[79] In 1844, more study materials were dispatched from the Society for the Education of the Blind to Madras and Calcutta. With the help of newly arrived study materials, the Bengal Military Orphan Asylum in Calcutta became the first-ever blind institution in South Asia to function with a formal special education system.

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[74] Priscilla Chapman, *Hindoo Female Education* (London: Seeley & Burnside, 1839), 91, 137.

[75] Ibid., 138.

[76] Royal Society for Blind Children, "About Us." https://www.rsbc.org.uk/about/about-us

[77] Ibid.

[78] Thomas Lucas developed a form of embossed text using a stenographic shorthand with arbitrary symbols. The script was complicated and confusing compare to the Moon script and was not widely used. The script was first used for experimental purposes in a small school for the blind in Bristol before it was popularized by the London Society. T. M. Lucas, *Instructions for Teaching the Blind to Read with the Britannic or Universal Alphabet, and Embossing their Lessons* (Bristol: Philip Rose and Son, 1837), 12.

[79] Third Report of London Society for the Blind for 1841, 11, quoted in Miles, *Disability Care & Education*, 24.

Since then, the Bengal Military Orphan Asylum in Calcutta became known for its positive appraisal of the Lucas system and many blind readers benefited.[80] Report of the London Society stated that they received a letter from the manager of the orphanage mentioning that the students from there were "learning to read Lucas system and their joy and satisfaction were great at acquiring such an important source of instruction."[81] In 1844, the orphanage received more embossed books for the blind.[82]

From 1850 onwards, women missionaries worked in Punjab and west India, especially in the education field, and used whatever materials were available to teach the blind. Mrs. Fitzpatrick, a missionary at Amritsar, and Mrs. Strawbridge, a missionary and special education instructor in Punjab practiced training the blind in reading and writing English.[83] These two worked independently and looked at teaching the blind as work ordained by God.[84] Many blind people who worked and learned under them later converted to Christianity. Women missionaries who worked for the disabled in India were influenced by the Judeo-Christian scriptures notion that God chose the poor, weak, and despised persons to 'confound the mighty.'[85] When their husbands spent time teaching and private tutoring elite Hindu children, women missionaries wanted to spend their time 'usefully' in teaching the blind 'ignorant' orphans. For them, other people in India had 'less value' than blind girls.[86] When these blind girls acquired skills and chose Christian beliefs, missionaries looked at them as a success greater than the conversion of the 'able-bodied.'[87]

[80] Annual Report of the London Society for Teaching the Blind to Read for 1839 (London: London Society, 1840), 11.

[81] Annual Report of the London Society for Teaching the Blind to Read for 1844 (London: London Society, 1845), 19.

[82] Annual Report of the London Society for Teaching the Blind to Read for 1845 (London: London Society, 1846),12.

[83] Miles, *Disability Care & Education*, 22.

[84] Ibid.

[85] Ibid., 23.

[86] Ibid., 26.

[87] Ibid., 27.

In Amritsar, as early as 1861, a blind lady named Sarah came into the limelight in missionary circles as the new hope of the blind in India. She was living in an orphanage under the care of Mrs. Fitzpatrick.[88] In 1861, Sarah learned the Moon system in English and received a chapter of the Bible in Moon Urdu in 1873. The Moon's Bible portions were published and added to the "Gospel of St. Matthew in the Urdu language, for the use of blinds in India."[89] In 1883, Hindustani, Bengali, Tamil, and Malayalam Bible sections were added to the gospel. These systems of scripts were used by the missionaries collectively or individually. But the efforts of these times did not materialize to a point where they made an immense impact. Blind children were taught separately, and by that time, these efforts were forgotten. Moon argued that to make a significant impact through the education of the blind, they should be schooled with the sighted children.[90] But it never materialized on a large scale until the late 1880s. Another missionary, Mrs. Strawbridge, taught Sarah to read the Christian scriptures. She was trained in English and later in Urdu, by another missionary named Rev. John Matlock Brown who called her 'the first Indian blind reader.'[91]

During the 1880s, women missionaries and blind education instructors like Sarah Tucker, Sarah Hewlett, Francis Sharp, Annie Sharp, and Miss Asho dominated the field of blind education in Amritsar. It was Miss Hewlett, who started the education of the blind in Amritsar which was later taken up by Francis Sharp and Annie Sharp, two other missionary instructors.[92] Sarah Tucker established a Female Converts Home which housed and taught blind women in Amritsar.[93] The women were taught knitting and Moon-scripted Bible. Miss Smith taught raised-Moon script which was easy to feel and memorize for the students than the regular Moon scripts provided to the young learners. Tucker recalled that many blind converts did a splendid job in knitting which earned them

[88] Robert Clark, *The Missions of the Church Missionary Society and the Church of England Zenana Missionary Society in the Punjab and Sindh* (London: Church Missionary Society, 1904), 73–74, 218.

[89] Ibid., 79.

[90] Ibid.

[91] Eight Report and Speeches at the Annual Meeting of the London Society for Supplying Home Teachers and Books in Moon's Type to Enable the Blind to Read the Scriptures (London: London Society, 1864), 9–10.

[92] Clark, *The Missions of the Church*, 58.

[93] Charlotte M. Tucker, *A Lady of England, The Converts' Industrial Home* (London: Society for the Blind, 1881), 89–90.

a livelihood and improved their living conditions.[94] In parallel, Miss Asho was sent from Lahore to Tucker's institution and was stationed there for three months and received daily Bible classes, and learned to read the Moon script.[95] Asho, when she reached Tucker's institution, was partially blind but was losing her remaining sight rapidly. The main reason she was sent for further studies was that Asho was exceptionally intelligent and she would be more useful as a blind teacher.[96] After three months, Asho returned to Lahore and converted to Christianity.

Sarah Hewlett and Francis Sharp found it difficult to manage the small school by themselves in Amritsar. On seeking assistance from her fellow missionaries, Hewlett writes, "As the years went by, it was frequently a cause of sadness to us that we had to send away unrelieved so many cases of blindness; and the idea began to take shape in our minds, and to find a large place in our prayers, that we might open a school for the blind."[97] Hewlett was quite affected emotionally and psychologically by the precarious condition of the institution. They invited Annie Sharp, the sister of Francis Sharp who was working in London before she reached Amritsar to work with the blind. In her letter written to G. Martin Tait, member of Committee for Home Teaching of the Blind, Annie Sharp mentioned that she wanted to work to benefit the blind people and that might sound foolish because she did not possess the professional skills and expertise to help and teach the blind. She requested him to send two or three teachers to assist her.[98] Finally, in 1886, under the care of Hewlett, a small knitting class was established and three blind women joined them. But her classes did not create the impact she expected. People were hesitant about joining the classes because the incentive given to them was little when compared to the money they earned through begging.[99] In 1886, Annie Sharp joined St. Catherine Hospital and associated herself with activities that helped the blind. But Asho's plans were not making enough impact and the missionaries faced hurdles in finding markets for products like knitted mats and bamboo baskets produced by the blind. Annie Sharp took the matter into her hands and introduced the programme of basket-making among the

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[94] Margaret Smith, "Report from Amritsar," *Indian Women* (IW from here on), no. 1 (1881): 169-73.

[95] Emily Wauton, "Report on the Converts' Home," *IW*, no. 2 (1882): 217.

[96] Ibid.

[97] Sarah Secunda Hewlett, *They Shall See His Face: Stories of God's Grace in Work Among the Blind and Others in India* (Oxford: Alden, 1898), 48.

[98] Annie Sharp, "Letter, Dated October 7, 1889, to G. Martin Tait," *IW*, no. 10 (1890): 221–222.

[99] Hewlett, *They Shall See His Face*, 48.

missionary teachers and the blind, and demonstrated a rise in the demand for these products.[100] The blind under her care were keenly interested in joining these vocational programmes because it earned them a small but steady income.

In Lahore, work for the education of the blind was carried out by Miss Fuller, another missionary, since 1867. Before getting into blind education, she worked with the Indian Female Education Mission as a teacher in Punjab. The Fuller sisters, Mary Fuller and Miss Emma Fuller worked together in Punjab from 1868 and conducted teaching classes. Miss Mary Fuller worked in education until she died in 1898, according to the records of Hewlett.[101] Even though Mary Fuller was not familiar with special education and instruction for the blind, she still instructed Asho. She taught the blind students whatever she knew. Miss Fuller's knowledge of geography was exceptional but no formal curriculum was drafted by her.[102] All her classes were about general topics such as religion, manners, knitting, and vocational training. She was able to induce interest in the students with her enthusiasm. She asked the students to practice rote-learning and taught biblical stories and hymns.[103]

In Lahore, Asho became well-known for her stocking and knitting techniques and classes. But her mentor from Lahore had other plans for her. Mary Fuller, the mentor of Asho, believed that knitting was not the only skill blind people were capable of. She taught Asho to make mats from a string produced in India from an indigenous rush, a 'stout useful door-mat.'[104] Upon seeing Asho capable of making these mats entire single-handedly, Hewlett also adopted these crafting methods at her school.[105] When Asho went back to Lahore, she visited families and *zenanas* to preach Christianity.[106] She was assisted by Mrs. Morrison, a missionary from Firozpur. Asho was welcomed in family circles of the disabled and this gave new hope to the families of blind children. The death of Mrs. Morrison and Miss Fuller took a toll on Asho's missionary activities. But

[100] Ibid., 58.; Sharp, "Letter," 221.

[101] Hewlett, *They Shall See His Face*, 59.

[102] Ibid.

[103] Emma Fuller, "Lahore, Miss Fuller's Report," *Indian Female Evangelist* (IFE from here on), no. 5 (1880): 121–125.

[104] Hewlett, *They Shall See His Face*, 49.

[105] Ibid., 50.

[106] Ibid.

colleagues of Asho suggested to her to go to Amritsar's St. Catherine's Hospital. It was from there she launched coarse-mat making on a large scale.[107]

St. Catherine hospital in 1898 received several boys and girls orphaned and many were also blind.[108] During the 1890s, this hospital was the only blind institution that combined a Christian orphan home, industrial school, Bible-reading club, and direct missionary work.[109] Dennis, a commentator argued that under the care of Hewlett, the school in Amritsar had collected 27 blind students, and all of them converted to Christianity.[110] When the school in Amritsar under Miss Annie Sharp received fair popularity among missionaries and Indians, the same blind asylum and school under Hewlett were struggling to find a strong footing. Finally, in expanding the school, the institute was moved to Rajpur in the United Provinces in 1903. Clark, another commentator stated that during its sixteen years of functioning, the institute cared for 90 blind inmates.[111] Francis Sharp headed the new institute in Rajpur and remained connected to the Church of England Zenana Missionary Society (CEZMS).[112] Asho stayed back in Amritsar and continued to work in the CEZMS Mission Hospital as a Bible teacher.[113] Even before the change of location for the school, Miss Asho already received a job promotion at the school.

Asho was a determined lady and when her mentors died, other missionaries in Lahore found it difficult to collaborate with her plans.[114] Finally, she reached out to Annie Sharp and under her management, the North India Industrial Home for the Blind was established in 1886.[115] Initially, some Muslim women and some children joined. Later, the

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[107] Ibid., 52.

[108] Ibid.

[109] Ibid., 1–2.

[110] James S. Dennis, *Christian Missions and Social Progress: A Sociological Study of Foreign Missions* (Edinburgh Press: Edinburgh, 1899), 385.

[111] Clark, *The Missions of the Church,* 60.

[112] Anonymous, *Until the Shadows Flee Away: The Story of CEZMS Work in India and Ceylon* (London: Marshall Bros, 1912), 78.

[113] Sharp, "Letter," 220.

[114] Ibid.

[115] Ibid.

home was expanded into a residential place for Christian students, but the school was closed due to lack of funds.[116]

One of the good deeds the school did was to popularize *zenana* visiting. Missionaries like Miss Barlett and Annie Sharp visited many houses which had children with disabilities, especially blind children. They advocated the parents to take the children to school to teach them reading and industry work. These women missionaries opened the closed doors of Indian families for medical intervention. Clark says these women missionary educators, made it easy for the medical missionaries to reach the families where medical attention was needed urgently.[117] Due to the increased *zenana* visiting, Muslim girls, women, and widows joined the school. This effort resulted in the growing importance of the blind Christian teachers "in evangelic Christian idiom and this would refer to spiritual maturity, rather than physique."[118] The school classes were divided into two sessions—a morning session for knitting and basket-making and an evening session for Bible lessons. The script they used was Moon script adapted to Roman Urdu. Nevertheless, men in the families of these women were unhappy about their study endeavours, and asked the women missionaries to escort the students from home to school and from school back to home. By 1889, Annie Sharp was planning to expand the school to a new building with more facilities, but due to a lack of financial means, she moved the school into a large balcony.[119] Sharp's blind school was not as successful as she expected.[120] Lack of funds, absence of infrastructure like buildings, and unpopularity of the missionaries among Muslim communities created a large obstacle to Sharp's dream of having a blind school. But one outstanding endeavour achieved by her was that she completed 1000 non-medical *zenana* visits in 1892.[121]

The success of Annie Sharp's visits popularized Christian blind education programmes among missionaries. Blind institutions were looked at as separate branches of mission that needed more support and call.[122] Annie Sharp died in 1903, while Hewlett

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[116] R. Nathan, *Progress of Education in India, 1897–1898 to 1901–1902: Fourth Quinquennial Review* (London: His Majesty's Stationary Office, 1904), 396.

[117] Clark, *The Missions of the Church,* 58.

[118] Sharp, "Letter," 221.

[119] Ibid., 221.

[120] Ibid.

[121] Clark, *The Missions of the Church*, 58.

[122] Ibid., 60.

and Miss Capes, other women missionaries returned to India to find new opportunities in blind education. It was at this time that special attention was given to the rearrangement of the Moon Urdu alphabet. The intention behind the plan to rearrange was to expand the utility of the script into most Indic languages.[123] In 1888, Mrs. Shirreff, a woman missionary, specialized in blind education in Lahore, invented the 'Shirreff' script. Her husband Rev. F. A. P Shirreff was a student at Punjab University. She combined Hindi, Telugu, Hindustani, and Braille and came up with a new script.[124] Her contribution did not end with Shirreff script as in 1891, she adapted Braille to Urdu. Her script was regarded as the best practical script by the British and other-country blind associations.[125]

In Secundra (also known as Secunderabad), John James Erhardt was the first one to initiate the education of the blind. He was a German missionary who recapitulated the memories of famines and explained that most of the children were only skin and bones as all were malnourished and some even went blind due to the harsh conditions.[126] He also recalled that 330 children affected by famine in Agra became blind because of the eye diseases caused by low immunity and overcrowding, due to which, the orphan institution was relocated to Secundra.[127] It was noted that limited reports were available about the blind institution at Secundra.[128] Therefore, it is hard to recover the statistical relevance of the blind orphans who lived at the foundation as well as to understand the kinds of skills they acquired and the means developed to cope with blindness.

After Erhardt, Mrs. Dauble, a women missionary, took charge of blind education in Secundra. She also deserves special mention for her role in the special education of blind girls. Notes of Mrs. Dauble listed 69 orphan girls in her asylum, of whom four were blind, four had no sight in one eye, and four others suffered from some form of visual impairment. She also mentioned two other blind girls who used to help in teaching. She noted down every blind girl in her asylum—Anna, the half-blind with one eye; Bertha, the half-blind and can read Barth's Bible stories fluently; Elvelyn, the 12-year-old with weak

[123] Ibid.

[124] Henry J. Wagg and Mary G, *A Chronological Survey of Work for the Blind* (London: Pitman, 1932), 66–67.

[125] Clark, *The Missions of the Church*, 60.

[126] Ibid.

[127] Ibid., 61.; John James Erhardt, "The Story of Secundra," *Church Missionary Gleaner*, no. 3 (1876): 75–76.

[128] Erhardt, "The Story of Secundra," 76.

eyes; Grace, the one helping Ellwanger to teach other blinds; Mary, blind and who learned to read the Bible from Ellwanger; Phoebe and Regina, little ones with one eye; Victoria and Beata, complete blinds; Gertrude, the knitting master; Adelaide, the blind who helps others in reading the Bible and Maria, Augusta, and Balance who can read and knit.[129]

There is no record available to examine what kinds of scripts and methods were used by Mrs. Dauble to teach girls to read the Bible. But according to the notes, most of the blind girls in her custody were partially blind or had a little sight left in their eyes, which may have helped them to learn reading. She mentioned that it was quite difficult to manage the complete blind and it was hard for them to learn reading.[130] It may be assumed that her teaching method to read was heavily based on memory. Under her patronage, girls were taught reading, writing, knitting, sewing, and kitchen work.[131] The institution at Secundra under Mrs. Dauble's stewardship worked in duality as a school with a clear schedule, and knitting was a major activity. Every day in the evening, Mrs. Dauble's assistant, Miss Ellwanger, who was affectionately called *Babaji* by the kids, taught small kids to sew their own and boy's clothes. Some older girls also used to teach the younger ones about the Bible and Christian history.[132] Among them, a blind girl named Sarah was in the records like the one who used to teach younger children about the Bible, history, and hymns.

Along with Mrs. Dauble, in 1847, the Orphan Boys Institution at Secundra also cared for blind boys. C. T. Hoernle, a missionary and the person-in-charge of the institution remembered one blind boy in the orphanage.[133] He recalled that the boy was well-behaved and was blind, but was an asset in the baking room. He further added that the boy used to attend Urdu classes with his friends in school; he used to listen to what his friends were reading during the classes in the New Testament. Hoernle recollected that the boy had a sharp memory and memorized the whole gospel of Matthew and parts of other gospels too; upon asking, he could read out any chapter. In this instance, there was no separation of the blind in educational institutions. There was no additional facility provided for them to learn any specific skills or any different scripts.

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[129] C. G. Dauble, "Our Orphans at Secundra, Agra, North India," *FMI*, no. 8 (1866): 37–40.

[130] Ibid., 38.

[131] Ibid.

[132] Ibid.

[133] Seventh Report of the Agra Church Missionary Society & Orphan Institution Committee (London: Church Missionary Archives, 1847), 85.

In Palamcotta (also known as palayamkottai), Madras, an Indian-born blind named Marial, was educated in the Bible and Christian scriptures in a missionary home when she was young. She was known for conducting a lot of blind education activities by herself. Passionate about Christianity, she persuaded her parents to convert to Christianity and took refuge in a Christian missionary's house. She helped missionaries in their house chores but wanted to do more, and so went out to teach the Bible along with other missionaries. She was well-received by the local population, remarked Miss Askwith, her mentor, and a missionary.[134] She further wrote, "She is an active intelligent and independent woman, a happy exception to the generally helpless, ignorant, and incapable blind people of this country."[135] After witnessing the success story of Marial, Miss Askwith started a small class consisting of 6–7 blind students in her house. She started by teaching the methods of weaving and gardening. She was credited with inventing the Tamil Braille and translated the Bible and the prayer book into Tamil.[136] In the early 1890s, Miss Askwith recorded that her students enjoyed reading raised-Moon script and ball-frames for counting.[137] By 1901, the Palamcotta School connected with the Sarah Tucker Institution for easy functioning by sharing study materials, amenities, and resources.

The curriculum in Miss Askwith's school was inclusive of reading and arithmetic. The school was examined by the government inspector just like any other school. Many students from the school converted to Christianity when they completed their studies and worked as teachers. Examinations such as the primary board examinations were conducted annually. When they completed education, Miss Askwith provided them with study materials in Moon script, certificates, and clothes facilitating their employability. She wrote that she tried her best to employ as many students as possible, and by 1901, she already employed 12 students in mission schools. Many blind girl students from Palamcotta received a job as teachers at Tuckers' institution and they lived with their students in the same institution.[138] She also wrote that blind boys in the institution also

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[134] Anne J. Askwith, "The Blind Children of Palamcotta," *Church Missionary Gleaner*, no. 28 (1901): 124–125.

[135] Ibid.

[136] K. Nora Brockway, *A Larger Way for Women. Aspects of Christian Education for Girls in South India, 1712–1948* (Oxford: Oxford University Press, 1849), 105.

[137] Anne J Askwith, "Sarah Tucker Institution' and Branch Schools; or, the Girls of Tinnevelly, 1890," *CEZMS Reports,* no. 10 (1905): 307–310.

[138] Askwith, "The Blind Children of Palamcotta," 125.

learned needlework and knitting, and other sighted students learned these industrial skills from them.[139] Miss Askwith's students were examined for the first time in 1891 and 10 girls passed. She stated that blind girls did things nobody expected them to do. This was a surprising experience for the examiner.[140]

In 1893, Chota Nagpur missionaries started a small class to educate the disabled, especially the blind. The objective of the class was to assist Christians and natives "to do something towards supporting themselves and to read for their edification."[141] Mrs. O'Connor, a missionary and an educator reached Ranchi in 1892. She worked as a nurse before she reached Ranchi and was overwhelmed to see the condition of the blind. She met Rev. J. C. Whitely, Bishop of Chota Nagpur, and was determined to do something about the condition of the blind. Initially, she found people who would learn Braille and some industrial work.[142] Therefore, under the supervision of Mrs. O'Connor, a small class of blind students was formed, which was later expanded to a school in 1895. More than half of the students were adults and they were taught the Bible and industrial work. Most learned to write in Braille and read Moon script as well as to make Bamboo baskets and chairs. The women were advised to learn knitting from Mrs. Whitely, another missionary and educator in Chota Nagpur. An increasing number of students were finally required in erecting a separate building in 1899.[143] Just like Chota Nagpur, Travancore also in 1893 witnessed many educational policies introduced by Mr. L. Garthwaite, Government Inspector of Schools, and Rev. Joshua Knowles, a missionary of London Missionary Society for the Blind.[144] The main problem they faced was to find Braille alphabets that could be adapted to the vernacular language of the area.[145]

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[139] Ibid.

[140] Irene H. Barnes, *Behind the Pardah: The Story of CEZMS Work in India* (London: Marshall Bros, 1899), 156.

[141] Ibid.

[142] Eyre Chatterton, *The Story of Fifty Years' Mission Work in Chota Nagpur* (London: Society for Promotion of Christian Knowledge, 1901), 124, 137.

[143] C. F. Pascoe, *Two Hundred Years of the SPG: An Historical Account of the Society for the Propagation of the Gospel in Foreign Parts, 1701–1900* (London: SPG, 1901), 500.

[144] Dennis, *Christian Missions and Social Progress*, 385.

[145] Ibid., 225.

Another residential school for poor students comprising of 40 boys and girls aged from 5 to 15 was set up and headed by Miss Elizabeth R. Alexander in Agra.[146] A handful of students from the school were blind, and Miss Elizabeth used raised-Moon script to teach them to read. At this same time, Miss Erhardt opened an industrial department so they could print the Bible in blind scripts. She mentioned that most of her blind students knew how to read scriptures and this newly printed Bible could help them in attaining greater accuracy.[147] She also trained teachers only for teaching blind students mentioning that three of the blind students who could read stayed in the school to teach other students—Victoria and Julia were students who became completely blind after they joined, and Rosemont with weak sight became a master in needlework.[148]

In Allahabad, the teaching of the disabled was started as early as 1826, but in a limited way. In 1826, Europeans residing in Allahabad collected some funds and transferred the amount to a local missionary called Mackintosh.[149] Using this money, he gathered about 250 of the mentally disabled, blind, and aged for the Bible study.[150] The remaining funds were distributed as alms to those who attended study sessions. By the 1880s, Rev. Francis Heyl took charge of the educational plans of the missionaries in Allahabad. He was an American Presbyterian missionary and was given charge of a blind asylum and an educational establishment in Allahabad. Together, the blind asylum and the school came to be known as the 'School and Homes for the Blind and Deaf-Mutes.'[151] In both institutions, evangelistic instruction was given.

In 1900, a home for the blind was established in Kedgaon, Poona, which shared an association with Mukti Mission, funded by Ramabai which hosted 25 inmates.[152] Miss Abrams was a missionary, who was the head of this institution. Ramabai wrote about a girl who was rescued from the famine that had gone blind. Miss Abrams taught her scripts, scriptures, tables, and arithmetic. The girl also taught other students in her spare time. In

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[146] Editorial India, Vol. 10, October 1, 1870, quoted in Miles, *Disability Care & Education*, 10.

[147] Ibid.

[148] Mrs. Erhardt, "Schools in Secundra," *FMI*, no. 12 (1880): 24–26.

[149] Daniel E. Potts, *British Baptist Missionaries in India, 1793–1837: The History of Serampore and Its Missions* (Cambridge: Cambridge University Press, 1967), 104.

[150] Ibid.

[151] James S. Dennis, *Centennial Survey of Foreign Missions* (London: Ferrier, 1902), 220.

[152] J. Inglis, *Protestant Missionary Directory, 1920–1921* (Ajmer: Scottish Mission Industries, 1921), 191.

1938, two schools were established in the provinces of Lucknow and Allahabad, and classes for the blind, deaf, and mentally disabled were conducted. Both schools were run by private and charity missions.[153]

In Bombay, the educational instruction for the blind started as early as 1820. Provisions were applied in the colonial Missionary Schools of Bombay where slow learners, especially the blind were well taken care of. The school produced books for free and no reading lessons were required. Therefore, "there were no classes, no marks and no examinations to pass and no hurdles of standards to get over. Each went ahead according to his own pace and could leave school as and when he liked."[154] Those who were not progressed in learning were given a choice to complete their education in six years. Following in the footsteps of Missionary School of Bombay, in 1900, Mission School for the Blind was established in Bombay soon followed by the opening of a school called Victoria Memorial School for the Blind in 1902. These two schools were mostly known for their industrial classes related to knitting, sewing, mat-making, and basket-making.

Colonial education of the disabled children, especially the blind, took place in private institutions and residential asylums. The colonial government was keen to conduct a data collection survey on people with disabilities and their formal institutionalization but never officially took up the education of the disabled students. Colonial missionaries took care of the responsibilities of fulfilling the educational needs of the disabled. This was the main reason Lord Carmichael, Governor of Bengal mentioned in 1912 that it was very difficult to get the number of special educational institutions existing in India because such data gathering was recent.[155] The same opinion was expressed by A. K. Shah who opined that the education of the blind in Colonial India was recent, and most of these institutions were handled and cared for by the missionaries.[156] He further added that all these started from the residential asylums and homes established by the missionaries and "the only attempt at education was to teach them to read the Bible in Moon."[157]

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[153] Annual Report of the Working of Charitable Institutions in Ranchi, 1937, NLS, 8.

[154] R.V. Parulekar, *Survey of Indigenous Education in the Province of Bombay, 1820–1830* (Bombay: Asia Publishing House, 1945), 15.

[155] Amal Shah, *Problems of the Blind in India* (Calcutta: Calcutta Press, 1941), 8.

[156] A. K. Shah, *The Work for the Blind in India: Report of the International Conference on the Blind and Exhibition of the Arts and Industries of the Blind, Held at the Church House, Westminster, June 18th to 24th,1914* (Bradbury: Agnew, 1914), 83.

[157] Ibid.

But Miles argues that Shah was not aware of the work that had been done in Calcutta Military Orphan Asylum by using Lucas's script in 1840.[158] He further argued that Mrs. Leupolt's teaching in Banaras had gone beyond the Bible teaching. In his defence, he argued the curriculum was about the Bible because no other materials translated in Lucas or Moon scripts were available. He argued that mission education was based on personal interests because it would never be enough to pay their salary and with the limited means received, running an institution would be difficult.[159] Taylor and Taylor's account of disability in Colonial India in 1970 gives us a different picture. They dismissed the importance of educational institutions in pre-1947.[160] They also argued that from the side of the colonial government, no action for the disabled was taken except for the work done by missionaries.[161] Miles confronted this statement and opined that even though there was no nationwide plan, many colonial records proved they helped missionaries in fulfilling their cause.[162]

The education of the disabled, especially of the blind and the mentally disabled was related to the colonial agenda of 'civilizing mission.'[163] The missionaries introduced behavioural therapy into the curriculum for the blind and the mentally disabled. They were taught not only to read and write but also to dress, eat and sleep. Teaching Western ways of life in these orphanages and educational institutions showed that the missionaries felt superior to the children they received because the civilizing mission was based on the assumption that one race was superior to the other. British believed that intellectually Indian minds were 'dull' and 'inferior.'[164] The narratives of 'wolf boys' and mission accounts of 'dirty, sick, and rude' children in blind and insane asylums strengthen the argument that the mission looked at these children as people to be 'civilized.'[165] Charles Leupolt in his memoir described the blind children in their orphanage as 'uncultured' and

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[158] Miles, *Disability Care & Education*, 4.

[159] Ibid., 5.

[160] Ibid., 6.

[161] Taylor Wallace and Isabelle Wagner Taylor, *Services for the Handicapped in India* (New York: International Society for Rehabilitation of the Disabled, 1970), 279.

[162] Miles, *Disability Care & Education*, 5.

[163] Gauri Viswanathan, *Masks of Conquest: Literary Study and British Rule in India* (Columbia: Columbia University Press, 2015), 8.

[164] Ibid., 9.

[165] Ibid.

he believed that their habits had something to do with their lack of education.[166] Many missionaries who worked for the education of the blind in Colonial India, vouched that the habits of the orphans they received lacked 'proper' mannerisms, that they did not clean themselves, that they did not know how to talk to others with respect, or that they did not know how to be polite, and most importantly they lacked faith in any religion.[167] This resulted in including behavioural therapies in their curriculum, which included classes on how to eat, dress, and follow etiquette 'properly.' Missionaries regarded Western-oriented behaviour as 'right' and looked down upon any native behaviour as 'poor in taste.' Behaviour was scaled using Western standards and little oriental habits left among the disabled children were changed into Western ways.[168]

It was already known to the natives and European teachers in India of the eighteenth century about the differences in 'capacity' among children. Missionaries were aware of the fact that they would not be able to survive if the orthodox Western style of education was taught. Instead, they were forced to find a common ground and connection with the indigenous methods.[169] Missionaries tried to make a connection between Christian theological education and the indigenous Gurukul system of repetition and memorization.[170] Even though the topics in special education were westernized, the main reason why missionary education of the disabled was popular among the natives was that it gave them a sense of familiarity when it came to the style and mode of education.

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[166] Leupolt, *Memories of an Indian Missionary*, 128.

[167] Ibid.

[168] Ibid.

[169] Michal Mann, "Self Esteem in a Broad-Spectrum Approach," *Journal of Academic* 19, no. 4 (2004): 357–372.

[170] It is known that special techniques enforced in the colonial period to teach disabled children were already known in India, but were never widely practiced. The capacity differences in children were widely noted and discussed in many Indian scriptures. To increase their capacities, 'handling and playing with children and activation and motivation' played a significant role in child education in ancient India. Nagasena advised the teachers to use the techniques of motivation in the learning process. The Nangalisa Jataka proposed using the activity-based method to teach a slow learning student. Muga Pakkha Jataka talked about 'audiological assessment and different stages of knowledge development among children.' Panchatantra discussed the special education curriculum for a slow learning student. There was an increasing and prominent trend of memorization in ancient and medieval India and these techniques and their practicality were already in discussion by the Christian missionaries. Proceedings of the Church Missionary Society for 1892, NAI, 78.

Gail P. Kelly and Phillip G. Altbach state that the Christian missionary special education of the blind attempted to assist the consolidation of the colonial rule in India.[171] Even though the educational policy of the missions was to partially legitimize the colonial rule through control of the content of the education, the effects and efforts of the missions should be acknowledged. One feature that differentiated the state policy on education from the mission policy on education was the medium of education. While the colonial government wanted to make English the medium of instruction, missionaries tried to use scripts in vernacular languages.[172] The force-feeding of English in government schools was the greatest symbol of British power where English acted as a cultural and political instrument.[173] However, in the education of the disabled by missions, this was not the case. The basic letters of English were taught, but study materials for the blind to read and write were translated into Moon, Lucas, and Braille scripts in Hindi, Hindustani, Bengali, Tamil, and so forth.

This fluidity of missionary education invited elements of oriental religions for discussion and comparison and blind education became a mixture of Indian moral supplements supported by Christian principles. The high moral tone in the advertisement of mission-based education was welcomed by the people.[174] Bellenoit argued that the readiness of the missionary to conduct dialogues about the 'disagreements' related to religion and morality invited the educated Indian elite who cheered the "indigenization of existing curriculum."[175] When government education policy did not change the nature of de-emphasizing primary education post-1858, missionaries took their own time to change the curriculum to make it more job-oriented. It must be mainly because the missionary education was primarily to enable the disabled to be employed so their dependency level can be reduced. Similarly, the nature of the study materials also needed to be tailored to fit the agendas of missionary education of the blind.

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[171] Philip G. Altbach and Gail P. Kelly, *Education and Colonialism* (New York, London: Longman, 1978), 12.

[172] Ibid.

[173] Ibid., 13.

[174] Ibid.

[175] Bellenoit, "Missionary Education," 13.

It is an indisputable fact that the missionary curriculum used in the education of the blind was Christian in scope and nature. Viswanathan argues that Christian missionaries served as a tool for pedagogical imperialism.[176] Bellenoit argues that instead of blindly going with the criticism, this topic should be analyzed about the reception of curriculum and practicality of imparting it.[177] He argued that missionaries who worked in India rejected the claim that the introduction of English education was the reason for the moral advancement of India. However, Viswanathan further argues that assimilation was the main strategy of 'special' education, the process where the colonized was forced to follow the culture and way of life of the colonizer was important with colonial missionary education. The missions tried to internalize the Western ways through cultural appropriation, which was an invisible process.[178] Viswanathan points out that assimilation worked better if a political action was involved. Cultural appropriation and cultural domination happened with consent and were often followed by 'conquest by force.'[179] Assimilation became stronger when the colonizer nullified 'all' indigenous ways of education. This is partially untrue about the missionary education of the blind. Colonial missionary educators did bring a pinch of indigenous ways into the education of the disabled, especially of rote learning and older students teaching the younger students.[180]

The primary repercussion of this colonially infused missionary education of the blind was that it created a dissociation of students from their heritage and past.[181] Many young educated blind students later became teachers in the schools where they were educated. They followed a strict Christian educational framework, just like their teachers.[182] Miss Asho and her educational service is a prime testimonial to this approach. These students had a limited sense of their past as the history of India was understood poorly by colonial missionaries. Educated children adopted hybridity whereby their identities became a mixture of local cultural elements and the culture of the colonizers.[183] This created a blurred and thin line between the imposed ideas and the already prevalent

[176] Viswanathan, *Masks of Conquest*, 45.

[177] Bellenoit, "Missionary Education," 14.

[178] Viswanathan, *Masks of Conquest*, 80.

[179] Ibid.

[180] Frantz Fanon, *A Dying Colonialism* (New York: Grove Press, 1959), 11.

[181] Ibid.

[182] Ibid., 13.

[183] Ibid.

indigenous ideas of disability. This situation created a sense of inferiority amongst the educated, and this was the reason many mission-oriented educated disabled children refused to let go of the colonial elements of identity. The sense of inferiority imposed the idea that native disability was something to be ashamed of and something that should be overpowered through Christian education. Cruickshank was the main embodiment of this trend, whereby he carried out Bible studies in his class even though his ideas were not popularly supported by his students.

The over-emphasis on Christianity and the Bible in the curriculum was comparable for both missionary schools for the disabled and the able-bodied. Missionary education was not always for charity, and religiously inclined agendas were also present.[184] Missionaries' attitude towards the religions of India was rather aggressive as they considered Indian religions as 'evil' and preached that the 'true religion' was Christianity. This bias is visible in the memoir of Charles Leupolt. He believed that Indian minds were evil due to their 'false faith.'[185] Bellenoit argued that missionaries used education as a tool against Indian religions by blurring the thin lines between the ideas of the civilizing mission, Christianity, and the 'moral improvement' of the disabled.[186] After the 1857 Revolt, when the government and the company allies were in a cash crunch, Bellenoit advocated that missionaries used this situation and looked at it as an opportunity to push Western pedagogy to propagate their faith through education of the disabled.[187]

It may be concluded that missionary schools—mainstream and blind schools were Christian in nature. Bellenoit stated that missionaries believed that the world's religions would evolve to perfection through an embrace of Christianity.[188] The relationship between a disabled student and the teacher was looked at as a spiritual journey.[189] The reason why missionary education of the disabled was more Christian than that of the abled was that religion always crept into the discourse of disability, especially when medical definitions failed to provide complete answers.

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[184] Viswanathan, *Masks of Conquest*, 34.

[185] Bellenoit, "Missionary Education," 9.

[186] Ibid.

[187] Ibid.

[188] J. N. Farquhar, *The Crown of Hinduism* (London: Hesperides Press, 1913), 86.

[189] Ibid.

Missionaries who worked for the education of the blind and other disabled were careful about the question of conversion. Even though Indian families were welcoming the moral education of their children, conversions were an outright 'no.' Missionaries were conscious of the fact that one conversion could disrupt an entire school system. Thus conversions of the students were lengthily discussed and scrutinized. Missionaries were not ready to risk their careers for the conversion of one student. Edward Oakley, the headmaster of the Ramsay College, Almora, stated that "he was in doubt about conversion plans after a rebellion started in the college regarding the conversion of a Hindu student."[190] Mary Fuller mentioned a blind girl who wished to become a Christian. Mary Fuller writes, "If we take in the girl and support her, it will be of course said that she was bribed to become a Christian."[191] This shows that on one hand, the missionaries were hesitant about converting the blind and other disabled students, and on other hand, more than half of the students who acquired education in missionary schools had converted to Christianity.

The success of missionary schools made headlines in the community of elite Indians. The educated, wealthy, and elite Indians wanted to contribute to the education of the disabled. Many schools and institutions were constructed with the help of Indian funding and missionary manpower. In Bahraich, United Provinces, 18, 21, and 32 blind were taken care of in 1877, 1880, and 1882 in an institute not listed under the recognized charitable organizations.[192] The 'Bhinga Raj Anthalya' was another institution that sheltered the blind in Bahraich which received funds from elite Indians. By 1825, the blind asylum of the 'Bhinga Raj' hosted 130 inmates sharing a building.[193] One small house was dedicated for the convenience of the 'blind maimed and indigent' inside the asylum.[194] In Bareilly, institutions for the blind were founded in 1865, through the efforts of Hakim Inayat Hussain, a rich native.[195] It is noted that some learning activities were always run by these institutes.

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[190] Annual Report of the London Missionary Society (LMS) for 1890, 1891, NLS, 68.

[191] Ibid.

[192] Report on the Dispensaries and Charitable Institutions of the North-Western Provinces for 1871, 1872, 1873, 1875 and 1876, NLS.

[193] Dev Raj Seth, *History of Western Education in India, 1854–1920* (PhD Thesis: University of London, 1936), 80, 338.

[194] Ibid., 81.

[195] Ibid., 36.

In 1889, the Report of the British Royal Commission on Education forwarded a proposal for the education of the 'blind, deaf, and dumb' to the colonial government in response to the pressure from the missionaries for official government intervention. But during discussions, it was concluded that the proposal was not suitable to implement in India especially in a situation where even schools for able children had not materialized.[196] After careful consideration and deliberation, the Central Advisory Board of Education of India advised the provisional governments not to delay the schooling programme for disabled children.[197] The then Education Advisor to the central government, Mr. Sargent included a section for the education of the disabled in the Central Advisory Board of Education Report (CABE) in 1938.[198] He mentioned that after the war, "the first official attempt to analyze the problem of educating handicapped children, estimate its extent and suggest ways of dealing with it."[199]

4.2. Educating the Deaf-Mute: Collaboration Between Christian Missionaries and Indian instructors

It should also be noted that the most successful and long-run school programmes for the disabled in Colonial India were established, handled, and managed by missionaries—especially the education of the blind. But the education of the deaf-mute was also an important concern for them. In 1882, D. De Hearne, a missionary wrote a letter to Lord Ripon, Viceroy of India, seeking his help to establish a deaf school in Calcutta. Ripon asked him to seek assistance from the church as it was the church that was involved in educational activities of the disabled. De Hearne then wrote to the Archbishop of Calcutta

[196] The Report of British Royal Commission on Education for the year of 1889, 1890, NAI, 255-256.

[197] Ibid.

[198] Report of the Central Advisory Board of Education, Chapter 9, NAI, 76–82.

[199] Ibid. After India's independence, according to the provisions of Section 32 of the Persons with Disabilities Act of 1995, it was established that each disabled child would be provided free education until the age of 18. Under the schemes of Sarva Sikhsha Abhiyan and NCERT, the integration of blind children into the school was supported. Organizations like the National Association of the Blind, National Blind Youth Association, and Score Foundation have been working for blind education in India, and they are the lead providers of Braille kits, tailor frames for Mathematics, and special laptops. Under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), provisions of the learning of Braille and alternative scripts, different means of communication, mentor, and peer support are provided in India. But sadly, even in 2021, blind students are still at the margins of the education system in India due to the deficiency of special teaching material and trained teachers. Persons with Disabilities Act of 1995, Section 32.; Baston Staff, "Inclusive Education of the Visually Impaired in India,'' *The Bastions* (2019).; United Nations Convention on the Rights of Persons with Disabilities 2006, Article 24.

and Bishop Meurin of Bombay as they were directly involved in the relief programmes for the disabled. Bishop John Gabriel Leon Meurin, Vicar Apostolic of Bombay was also known for the establishment of St. John of Beverley's Institution of Deaf-Mutes and St. Isabel Association for Ladies which intended to take care of the poor, deaf, and disabled women.[200] In 1884, before the establishment of the deaf-mute institution, Meurin visited many blind, deaf and dumb children of Roman Catholic Christians to understand their issues. Upon seeing their 'helpless' condition, he was heartbroken and conducted training school for the affected. The first school comprised of classes in his house but later, these classes were transferred to a new building on Grant-Road in Bombay.[201]

The Calcutta Bishop cited an 'absence of proper personnel,' nonetheless, De Hearne received a positive reply from Bombay.[202] Based on these correspondences in 1882, T. A. Walsh, a missionary and deaf education instructor, was sent to Bombay to teach the deaf.[203] Before coming to India, T. A. Walsh was working as a teacher for the deaf-mute in Ireland and Belgium for twenty years. He arrived in Bombay in October 1884. He was trained in the manual style of teaching, but he adopted the oral model of instruction when he reached India.[204] The first principal of the institution was Rev. Father Goldsmith. From its foundation, the school was managed by the brothers of the Society of St. Vincent de Paul.[205]

The founding fund for the school was put together based on donations by many Europeans and famous and rich natives.[206] The government also provided a subsidy of 1200 rupees annually. By 1885, the working condition of the school improved and the teachers implemented an elaborate system of teaching which used verbal technique "namely to enable them to understand what is said by watching the lips of the speaker, and even to learn how to talk themselves by imitating the lip-movements of their teacher—

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[200] P. A. Colaco, *A Biographical Sketch: Select Writings of the Most Reverend Dr. Leo Meurin* (Bombay: Examiner Press, 1891), 11.

[201] Seth, *History of Western Education in India*, 284.

[202] Ibid.

[203] S. D. Mishra, "Sixty Years with the Deaf in India,'' *The Deaf in India* 1, no. 3 (1950): 26–27.

[204] Manual teaching of the deaf is known for its use of sign language and hand gesture communication. Oralism is based on lip-reading, speech, and mimicking the mouth shapes and breathing patterns. J. Crossett, "Account of a visit: School Items. Bombay Institution," *American Annals of the Deaf* 32, no. 2 (1887): 124–25.

[205] Wellesley Bailey, *A Glimpse at the Indian Mission-Field and Leper Asylums In 1886–1887* (London: John Shaw, 1888), 52.

[206] Ibid.

sometimes touching his throat, then their own, to know what the sound feels like."[207] Consequently, the first school for the deaf was established in 1882 by Bishop Meurin, which came to be known as the Bombay Institute for Deaf-Mutes. By 1884, the school worked in full swing helped by the Catholics of Bombay and with T. A. Walsh as the teacher.[208]

In Calcutta, education of the deaf-mute was first undertaken by the school of Mrs. Wilson, a Christian missionary in 1826. She trained native girls to read and a few among them were blind and some total deaf-mutes. Chapman wrote in 1826 that one deaf-mute girl was admitted to the school and was keenly interested in studies. She used to read the lips of other students while reading the Bible and memorized many passages from the gospel.[209] However, no special help related to the deaf sign was provided. In 1839, another deaf and dumb girl Gunga was admitted to the school and lived there for years. She was taught by her friends to communicate with two fingers and everything that she knit was sent to England for admiration.[210] Due to a lack of special programmes related to signs, Mrs. Wilson's classes were limited and only focused on vocational training.

In 1891, a government school for the deaf was established in Calcutta and Sahib Garindranath Bose, a rich native, helped them to raise funds for the school.[211] Bose had four deaf-mute children and he wanted to educate them. Since he was wealthy, he tried to use his connections in England to find a teacher to educate his children. However, he could not find a suitable person and he settled for a native teacher for the job. It was then that he met Srinath Sinha, a native educator. Sinha had a deaf brother and he agreed to work with the children of Bose. Bose provided the required materials he collected from London on deaf-mute education to Sinha. Eventually, Sinha and Banerji, the son of Jamini Nath Banerji, founder of Calcutta School, agreed to conduct classes for the deaf children.[212]

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[207] Ernest R. Hull, *Bombay Mission History with a Special Study of the Padroado Question, 1858–1890* (Bombay: Examiner Press, 1913), 309.

[208] A. Farrar, *Arnold on the Education of the Deaf: A Manual for Teachers* (London: Simpkin Marshall, 1901), 84.

[209] Chapman, *Hindoo Female Education*, 91.

[210] Ibid.

[211] Anonymous, "School Items," *American Annals of the Deaf,* no. 36 (1891): 21–48.

[212] S. N. Banerji, "Sixty Years with the Deaf in India," *The Deaf in India,* no. 1 (1949): 13–19.

In 1892, Ramachandra Banerji, editor for a journal produced by *Dasashram*, which was an important Calcutta residential home that housed a considerable number of the disabled, devised Bengali Braille.[213] He received study materials from the blind schools of Amritsar and Palamcotta. After he designed Bengali Braille, L. B. Shah, a native teacher also contributed by trying to mate Bengali and Braille to form a new script.[214] Finally, in 1893, under the guidance of Sinha and Banerjee, the Calcutta Deaf and Dumb School was established and it earned a name as an important educational institution for the disabled in Calcutta within a short period of time. The teaching staff consisted of Srinath Sinha, Jamini Nath Banerji, and Mohini Mazumdar. It was recognized as the first deaf-mute school in Calcutta managed by native people instead of missionaries. The school took in deaf children from both the native and European populations.[215] In 1895, Banerji was sent to England to study the systems available for the deaf, which helped the young deaf learners in their educational apprenticeship. He received his training from the Van Praagh's Training School for the Deaf. From his understanding, he stated that the numerous methods used by London-based schools were related to how to 'breathe' the words properly.[216] He wanted to implement this method for the deaf students in the Calcutta school.[217]

In Cawnpore (Kanpur), as early as 1818, Mrs. Sherwood, a missionary established an orphanage, where she worked among the deaf-mute and their families. She also wanted to create a good impression of the disabled in society. She noted that many children with disabilities in Indian society were abandoned in the streets or given away to the care of asylums. She wrote about a child, Maria Clarke, a child of seven years, who was deaf and put in asylum care.[218] She added that the death of the child "may account a desirable circumstance for herself, but she had suffered hugely in her constitution by her

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[213] Ibid., 18.

[214] Subodh Chandra Roy, *The Blind in India & Abroad* (Calcutta: University of Calcutta, 1944), 234–237.

[215] Anonymous, "The Deaf-Mutes in India," *The Indian Magazine and Review*, no. 7 (1895): 436.; Ernest J. D. Abraham, "The British Deaf-Mute and the Deaf and Dumb," *The Indian Magazine and Review*, no. 2 (1896):107–109.

[216] K. S. Macdonald, "Instruction of Deaf-Mutes," *The Indian Evangelical Review*, no. 6 (1897): 56–65.

[217] International Report of Schools for the Deaf made to the Volta Bureau (Washington: DC House 1896), 6–7.

[218] Ibid.

deformity."[219] Later, the missionary ladies of Cawnpore established a native orphan asylum in 1834. Within a year, 64 children with disabilities were admitted, and among them, 27 were deaf or mute.[220] Cawnpore missionaries recalled that the orphanage received many children who were disabled due to the physical abuse from families and disabled children who were abused by families because of their disability. There was a deaf boy whose nose had been cut off and another paralyzed girl who was abandoned by her family.[221] Mrs. Perkins, a missionary who worked with deaf people in the orphanage, remembered a blind girl named Bessy who was quite enthusiastic about studies.[222] Alongside accommodating the disabled, some learning activities related to vocational training always took place in the orphanage.

Miss Swainson, one missionary in Ceylon read about the special training needed for the deaf and blind instruction, and in 1908, she contacted M. F. Chapman, a missionary and an instructor, and she took charge of the school of Palamcotta in Madras. She started her educational work for the disabled near Dehiwala, Colombo in 1913. Statistically, the 1911 Census claimed that 3000 blind inhabited the island. The school was, nevertheless, opened also to the deaf-mute. It is noted that people from the island themselves took a real interest in the educational activities because it helped the deaf-mute in starting communication with their families.[223] Behavioural therapy was one method used by her while dealing with the deaf-mute. Behavioural therapy is effective for children with severe disabilities because it taught the students to cope with their disability. The main purpose of the therapy was to teach disabled children in picking up social cues. One set of therapy is not acceptable to all disabled children because each one of their needs and capacities would be different. Behavioural therapy is only effective when it is custom-tailored with the need and capacities of the child it deals with. But missionary understanding of the therapy was limited and used colonial standards. Since there was no customization available, instead of teaching social cues, it imposed a mould in which a child should behave. Western behaviour became the standard and criteria of such moulding processes. The therapy was applied to all and limited to teaching students how

[219] Sophia Kelley, *Mary Martha Sherwood: The Life of Mrs. Sherwood* (London: Darton, 1884), 443.

[220] Ibid.

[221] Anonymous, *The Story of the Cawnpore Mission* (London: SPG, 1923), 19.

[222] Joseph Mullins, *A Brief Sketch of the Present Position of Christian Missions in Northern India and of Their Progress During the Year 1847* (Calcutta: Baptist Mission Press, 1848), 86.

[223] M. Saumarez Smith, *CEZMS Work Among the Deaf in India & Ceylon* (London: Church of England Zenana Missionary Society, 1915), 13.

to handle their daily life activities like eating, bathing, and keeping things tidy and clean. Even though this provided positive results to certain students who already had the capacity of 'understanding,' this also resulted in writing off many students as 'hopeless.'

In 1881, in Hoshangabad, central India, Rachel Metcalf, the first missionary of Friends Foreign Missionary Association was in charge of the education for the disabled. She arrived in India in 1866, and started her missionary work in education in 1881.[224] She mentioned that many disabled children were under her care and she used behavioural therapy to deal with them.[225] She worked with Jane Leupolt and moved to Hoshangabad later. She was disabled later in life and used a wheelchair to move around. She especially wrote about two deaf children—Topsy and Guliya and her struggles in dealing with them. Rachel noted that she received Topsy in 1881 and she was mentally disabled; her habits were more like those of an 'animal.'[226] Her 'violent' tendencies were reduced later in life, and she turned into a quiet and 'steady' girl. She experienced problems with her speech and was blind in one eye and her learning capacity was impaired. Guliya also behaved in a similar way to Topsy, but later, with much effort, learned simple things like cleaning herself and cooking.[227]

By 1896, in connection to the Sarah Tucker Institution, a small class for the deaf-mute was started in Palamcotta, the responsibility of which was given to Miss Swainson, a missionary and a nurse from the Church of England.[228] She received many cases of the same kind throughout the year. She argued that Indian society regarded deafness and blindness as equated to having no skills. Swainson wrote that in 1897, a little deaf-dumb girl was brought to the Sarah Tucker School by her father. The father pleaded with her to take the girl under her care because the people in his village looked at her as a 'devil.' Swainson concluded that the supposed 'devil' was deafness and because of her

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[224] Rachel Metcalf, *Sketch of the Orphan Home in Hoshangabad* (Indore: Canadian Mission Press, 1888), 4.

[225] Ibid.

[226] Ibid.,16.

[226] Pumphrey Caroline, *Samuel Baker of Hoshangabad: A Sketch of Friends' Missions in India* (London: Headley Bros. 1900), 65–71.

[226] Metcalf, *Sketch of the Orphan Home,* 32.

[227] Ibid.

[228] Sarah Askwith, "Report from Sarah Tucker Institution," *IW*, no. 4 (1886): 289–293.

disability, she was forced to leave home. Under Swainson's care, the girl learned to sew and earn an income.[229]

Similarly, another deaf girl was also sent to Swainson by her fellow missionary and she asked the students about their deaf relatives. Initially, classes were conducted together with other able children, and one day, she noticed that during Bible Studies, one deaf girl was concentrating on the lips of the teacher. She stated this was the exact time when she thought about the possibility of teaching them lip-reading and not just handiworks and knitting.[230] Banerji writes about the class of Swainson that "in their own homes, these poor children are regarded as having no intelligence and are sadly neglected, and yet it is wonderful how their minds and hearts opened during the short time since the class was formed."[231]

Swainson opened a small school for the deaf in Palamcotta and invited applicants from deaf children to the orphanages.[232] The first head of the school was an Indian lady called Devanesam Ammal, whom Swainson called a blessing.[233] When Ammal took charge of the school, there were only six students whom she taught orally. She wrote about the hardships she faced while teaching deaf students in the school.[234] She stated that she had to go through the scripture lesson over and over using signs, but students were not able to understand.[235] Soon, Swainson faced trouble in running her schools. There was no time for her to stay in India, and she learned late about the formal oral method used to teach the deaf. Thus she traveled to England for funds and returned with money from

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[229] Florence Swainson, *Work for Christ Amongst the Deaf and Dumb Children of India* (London: Church Society, 1915), 2.

[230] Ibid.

[231] Banerji, "Sixty Years with the Deaf in India," 38.

[232] Swainson, *Work for Christ*, 3.

[233] Ibid., 12

[234] Ammal wrote "I shall never forget my first week's adventures in teaching the deaf. The whole week we used to teach them one scripture lesson, going over and over it, and Miss Swainson examined it on Sundays. I tried to teach about the creation in the first week. Had we understood the children as we do now, we should never have taken that lesson first. I tried my best to explain it to them in signs. On Sunday, when they came before Miss Swainson, they were not able to say anything, and I was so ashamed and discouraged, and thought I should never be able to teach them, but God has wonderfully made me fit for my work. The children were so naughty and tiresome; they would not look at us, but shut their eyes if we talked to them. Imagine how we could deal with them, if they would not look when they could not hear! We could not punish them, for they would run away for any little thing, and we had to run after them. Now we see a great change in them". Ibid., 13.

[235] Smith, *CEZMS Work Among the Deaf*, 5.

many charities. She adapted Tamil letters to finger alphabets. She tried to teach students assisted by signs and pictures familiar to the Indian people. She also agreed that the method she adopted was unorthodox, but added that it was the only thing she could do.[236] By using the Tamil alphabet, she taught nine girls and two were proficient in reading, writing, arithmetic, and sign.[237]

By 1900, the school hosted 19 boys and 21 girls, inclusive of Christians and Hindus. The oral teaching methods used in the school were customized by Swainson. The Zenana School Report in 1900 criticized her assertion that no attempt was made to teach kids to read lips.[238] By 1902, the school's work was recognized and was admired by examiners. Everything was considered good, but reading still posed a problem for the students.[239] Schools had different departments for both the deaf and mute students. Seven teachers worked in the departments and they all were Indians.[240] A teacher who taught deaf students in Palamcotta writes that the systems followed in India and England were different. She added that the school functioned in similar modes for the hearing students. The teachers spoke naturally to the students and the lip-reading skills of the deaf and mute were excellent. The speech of the deaf students was poor but she continued that "their language, history, geography and nature-study (which is better than any I have ever seen in an English school) simply surprised me. The lessons were conducted mainly by lip-reading and writing, but what surprised me was the result."[241] Swainson's school's instruction was purely based on lip-reading and the positive results shocked many special education instructors. With the assistance of limited technology, the success story of her educational efforts inspired missionaries to continue their work.

In 1904, Swainson invited two teachers from London trained in oral education of the deaf. Miss Hart, a specialist in deaf education, and Miss Allen, a deaf lady who had experience in teaching deaf, worked with Swainson. However, due to the harsh conditions in India, Miss Hart died and Allen returned to England. Heartbroken, Swainson sought

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[236] Ibid., 45.

[237] Barnes, *Behind the Pardah,* 155–156

[238] The Zenana School Report for 1900, quoted in Smith, *CEZMS Work Among the Deaf*, 6.

[239] Ibid.

[240] E. Mary Campbell, "First Impressions of the Deaf and Dumb School, Palamcottah, India," *The British Deaf Monthly*, no.11 (1902): 123–336.

[241] S. E. Hull, "A Few Words on the Extension of Our Work," *Journal National Teachers of the Deaf*, no. 6 (1920): 21.

help with the practice and implementation of oral methods in India from the Glasgow School of Deaf. She gradually made progress in teaching reading, and classes were held in both Tamil and English and industrial works were conducted every day after lunch. This enhanced the quality of the education, stated Swainson.[242] She offered more classes for the elder girls of whom 50 used to speak, but she gave commendable importance to the sign.[243] She mentioned a girl named Pyari, a deaf-blind girl who joined the school in 1907, who responded well to the educational methods and learned to speak and read. Swainson called her 'another Hellen Keller.'[244] Pyari exemplified a success story among the other students who made considerable efforts.

Miss McDowell, another missionary and special educator, joined Swainson in 1912 and she conducted most classes in oral style. It was however impossible to impose oral technique in all the classes because many students took admission in the school late and it was quite impossible to ensure its implementation for them to learn speech. She stated that classes succeeded if "our children can now follow the lips of people and can speak fairly well to the surprise of visitors who can hardly believe the children are deaf."[245] By 1912, the school registered 130 children.

Developing 'signs' in missionary educational efforts was initiated by Mrs. Wilson's school in Calcutta in the 1830s. She received many children with speech impairment and deafness who she and other missionaries described as 'feral children.'[246] Mrs. Wilson developed the early form of sign for deaf students using mime and gestures.[247] She was surprised to note the response she received from the children. The main reason why there was a lack of 'uniform sign' was that the deaf-mute population was scattered all over India and there was little contact between the educators about the development of different teaching methods.[248] The official effort for the deaf sign came from Miss Swainson's school in Palamcotta, which has been already mentioned above.

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[242] Florence Swainson, *Report of the Deaf and Dumb and Industrial School in connection with the Church of England Zenana Mission, Palamcottah, South India, for 1905* (Palamcotta: Church Mission Press, 1906), 3.

[243] Ibid., 12

[244] Smith, *CEZMS Work Among the Deaf*, 12.

[245] Swainson, *Report of the Deaf and Dumb*, 6–7.

[246] Ibid.

[247] Ibid., 8.

[248] Ibid., 9.

The teachers in Palamcotta successfully introduced unique signs to the children. In 1898, Miss Carr, a school examiner, wrote in her report that she was surprised to find how easy it was to examine children.[249] She added that children were sharp in counting and writing digits and they mastered the signs for many things.[250] Assisted by pictures and signs, Miss Swainson taught children well, wrote Miss Carr.[251] After a few years, the Palamcotta model of the sign was used in public functions like church services for the deaf in Palamcotta. Deaf schools in Bombay and Calcutta opened in 1884 and 1893, where instruction was given orally. T. A. Walsh, a missionary and mentioned already in this chapter, with expertise in the Palamcotta sign also switched to the oral model of teaching in 1884. Sign model of teaching was used till 1894, until Jamini Nath Banerji vehemently supported oral teaching for the deaf.[252] Special education instructors gave overwhelming importance to 'lip-reading' while teaching the deaf-mute in India. The 'sign' was looked at as something 'primitive,' and unesthetic and was associated with the elements of the 'degenerative race.'[253] The native educators who received training from Europe also internalized this colonial view which resulted in the implementation of the oral method in their deaf-mute schools. Only a handful of women missionaries understood the practical use of signs and they were criticized for their teaching methods by the Christian associations in India and London.

Missionary education of the blind and deaf-mute resulted in a phenomenon called 'selective exhibition.' These schools served as a space where focused anxieties of the differences of both the white and 'other race' and the abled and disabled intertwined. This created awe among the spectators about the disabled body doing their normal things and made disability a 'visual for display.' The records of the blind and the deaf-mute reading, writing, and understanding of the Bible were looked at as interesting and astonishing, and

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[249] Ibid.

[250] Ibid.

[251] Report on Public Instruction in the Madras Presiding for 1897–98, 118–119, quoted in Florence Swainson, "The Education of the Deaf in India," *Volta Review*, no. 16 (1914): 173–177.

[252] Ibid., 174. After India's independence, similar to blindness, deaf-muteness was also given special attention in the education system. The implementation of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in India ensured facilitating of sign languages in educational institutions. The same convention ensured the promotion of the linguistic identity of the deaf community in India. Indian Sign Language (ISL) is established in India to form a universal deaf-mute language, based on which in 2018, the Indian Sign Language Dictionary was launched. Vaibhav Kothari, "India Must Empower Millions with Hearing Disability," (2020).

[253] D. Goodley Hughes and L. Davis, *Disability and Social Theory: New Developments and Directions* (London: Palgrave Macmillan, 2012), 12.

their works were sent to Britain for admiration. These selective exhibitions were used to objectify and visualize 'civilization' as the achievement of colonial missions in India. This popularized the notion that disability was something to be overpowered by fitting into the features of Western 'normal.'

4.3. Educating the Mentally Disabled: Role of Christian Missionaries

Teaching mentally disabled children in Colonial India was handled by the missionaries privately who admitted a small number to the asylums. British narratives indicated some mentally disabled children were raised by wolves.[254] These narratives could be found from Sleeman and he mostly connected these children to the wolves even though there was no evidence to support such a claim.[255] These children were given to the care of missionaries such as Mr. James Erhardt and Henry Lewis stationed at Secundra.[256] One of such children was Dina Sanichar who was admitted to the Secundra orphanage and his biography was narrated by Zingg, a psychologist in 1940.[257] Before his accounts, Ireland and Prideux, two anthropologists wrote to Erhardt, person-in-charge of the orphanage about wolf children, and Ball in 1880 visited Secundra to see the boy.[258] According to the admission note received by the Zingg in 1940, the boy was admitted to the asylum in 1872 when he was about six years old. When he joined the institution, he could neither talk nor communicate with others in any way. Erhardt wrote that the boy could not do anything without assistance and that he taught the boy was to behave like a 'normal' child. He remembered that upon training for months, he could drink a cup of water by himself.[259] Lewis in his letter wrote that this boy did not talk and was undoubtedly an 'imbecile or idiotic.'[260]

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[254] W. H. Sleeman, *A Journey Through the Kingdom of Oude in 1849–1850* (London: Richard Bentley, 1858), 67.; W. H. Sleeman, *Rambles and Recollections of an Indian Official* (London: Constable, 1893), 13.

[255] Sleeman, *Rambles and Recollections*, 14.

[256] William Ireland, "An Inquiry into Some Accounts of Children Being Fostered by Wild Beasts," *Journal of Mental Science*, no. 20 (1874): 185–200.

[257] R. M. Zingg, "Feral Man and Extreme Cases of Isolation," *American Journal Psychology*, no. 53 (1940): 487–517.

[258] W. F. Prideaux, "Wolf boys," *Notes and Queries* 29, no. 12 (1885): 178.; Valentine Ball, *Jungle Life in India* (London: de la Rue, 1880), 10.

[259] Ball, *Jungle Life*, 11.

[260] H. Lewis, Reports and Letters from Secundra Orphanage, 1885, quoted in Prideaux, "Wolf boys," 178.

Kuresong School is the first school in Colonial India to take the responsibility of mentally disabled children. According to the revised list of the recognized government institutions, aided and unaided European schools in Bengal for 1918, Kuresong School was known as the school for the 'defective' children.[261] Missionaries who worked for the education of the mentally disabled looked at them as 'defective' and someone who deviated from the 'norm.' For them, education meant bringing 'defective' children closer to 'normal.' In that sense, education of the disabled, especially of the mentally disabled, acted as a correctional and coercive tool. The school was managed privately and educated both boys and girls. Four teachers were employed by the school.[262] Miss Silvia De Laplace, a missionary and instructor, was credited with the establishment of Kuresong School in association with the Children's House of Kuresong in Bengal. The school aimed at educating mentally and physically disabled children, who could not benefit from the education of regular schools. By this time, it was already established that disabled children "can be educated chiefly by special apparatus, exercise, and discipline."[263]

Kuresong School used special methods of sense training and the institution was recognized by the government for its educational efforts. The school received a sum of 100 rupees per year from the government. By 1921, Kuresong School had nine students on the rolls. Along with teachers in Kuresong School, Miss Place, who worked as headmistress for St. Thomas School also educated 37 mentally disabled children at the elementary level. However, her school did not make a huge impact. Lack of proper knowledge on how to teach mentally disabled children and lack of study materials made instruction difficult.

Near Dinapore, in Patna, the responsibility of shelter and education of the mentally disabled was looked after by E. Baumann. Throughout his life, he had been a caretaker for three deaf girls and several mentally disabled children. Bauman was not highly experienced in the schooling of these children, but he tried behavioural therapy. He tried to teach them to clean and to take care of themselves. He stated that it was however difficult for him to "teach any accepted behaviour to mentally disabled children."[264] He

[261] Alfred Mercer, Annual Report on European Education in Bengal for 1917–18 (Calcutta: Bengal Secretariat Book Depot, 1918), 32.

[262] Ibid.

[263] Ibid., 5.

[264] E. Baumann, "Deaf and Dumb Ellen, and How She Became a Christian," *IFE*, no. 8 (1886): 241–248.

described a deaf and mentally disabled child, Ellen, stating that since there was no provision of 'communicating through fingers' (sign), she had to use gestures.[265] He wrote that Ellen was eight or nine years old and she behaved like a 'caged animal,' She had problems keeping still and trashed around his house. He called her a *jungli* (wild) creature and commented that after nine long months of training she was 'clean' in her habits and became much quieter.[266] Describing the mentally disabled as 'wild,' animal-like, and 'primitive' was a common practice among missionaries in India who cared for the disabled population. Missionaries believed that this 'wildness' was because of their indigenous influences, and the habits of these children were looked at as unclean and dirty.

Accounts of women missionaries in the 1870s poke a hole to the romantic notion that every mission in Colonial India was a success story. While dealing with mental disability in Colonial India by the missionaries, the 'other' was often racialized and identified in terms of disability.[267] It was believed that the 'dumbness' of the 'natives' was the evidence of 'piteous incapacity.'[268] The missionaries considered educational rehabilitation of the mentally disabled as habituating the 'primitive, uncivilized, and the disembodied' into the Christian was their mission.[269] As the colonial government, missionaries also looked at disabled children as 'savage' entities to be mended to a 'civilized' way of life. Miss Thornley, a missionary who worked in an Indian orphanage explained that kids at her orphanage were not intelligent like others, but repulsive and ignorant.[270] She said receiving mentally disabled children after famine was 'quite a job' to

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[265] Ibid., 243.

[266] Baumann wrote "Her age might be nine or ten—we are never sure, and have to guess by growth and intelligence. Her hair stood out like a bush all around her head, her eyes were bright and restless, and reminded one of a caged animal. But as poor Ellen had lived a life little better than that of a wild animal, I found it no easy task to teach her to sit still; as soon as my back was turned on the schoolroom, off darted Ellen to the kitchen or bedrooms until I brought her back. She used to recklessly tear and burn, and stain her clothes, break plates and dishes on purpose and fight with the junior girls, and many a time was she punished for her manifold offences. But at last, we all began to see a great change working in Ellen, and after nine months she could not have been recognized as the same *jangli* creature she had been on arrival. She now took a real pride in keeping her person and clothes tidy and clean, she sewed nicely and sometimes helped to cook. She would sit quietly in the school during school hours, and tried her best to write neat copies, though she never excelled in writing." Ibid.

[267] V. V. Kamat, *Measuring Intelligence of Indian Children* (Oxford: Oxford University Press, 1951), 84–85.

[268] Ibid., 85.

[269] Ibid.

[270] E. J. Whately, "Leaves from the History of a Missionary Auxiliary," *Church Missionary Gleaner*, no. 5 (1878): 28–29.

handle.[271] Just like her, Baumann, who worked for bettering the blind and the mentally disabled described that when he received another 'jungle child' to care, he had to accept the offer with a 'heavy heart.'[272] Personally and privately, putting mentally disabled children under the care of missionaries was a common practice.

Under the care of the Directory of Institution for the Mentally Handicapped Persons in India, the Central Institute of Psychiatry was established in Ranchi in 1918, and took in some mentally disabled children up to the age of fourteen. The institution worked as a daycare centre rather than a formal school.[273] They were taught using some basic behavioural therapy. This teaching was not comparable with what a regular school taught. Many criticized the institute for sheltering mentally disabled children along with the mentally ill persons and demanded a separate institution for the children.[274]

The mental hospital in Calicut in 1921 turned into a learning centre for the mentally disabled. The learning classes were conducted to help the intellectually disabled communicate better and this was mentioned in the reports of the Madras Lunatic Asylum.[275] The first one who reported this was Rikhye and he believed it was the first-ever recorded incident of teaching the intellectually disabled.[276] But later, reports of the asylum proved that the learning process was limited to memorization only and no fruitful efforts were made to make them learn anything beyond.[277] Only 48 among the 1,287 patients admitted to the hospital were affected by congenital mental disabilities and were given training classes. But it is hard to imagine that any full-fledged classes could take place in the asylum.[278]

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[271] E. Baumann, "Lucknow: Miss Baumann's Report," *Indian Female Evangelist*, no. 6 (1882): 270–275.

[272] Baumann, "Deaf and Dumb Ellen," 241.

[273] S. H. K. Reddy, *Institutions for the Mentally Handicapped Persons in India* (Secunderabad: National Institute for the Mentally Handicapped, 1988), 24.

[274] J. E Dhunjibhoy, Annual Report on the Working of the Ranchi Indian Mental Hospital for 1936 (Patna:1938) 48.

[275] Annual Reports of the Three Lunatic Asylums in the Madras Presidency, 1921–23 (Madras: Government Printing, 1924), NLS, 2.

[276] Doris C. Rikhye, *Mentally Retarded Children in Delhi, India: A Study of Nine School* (PhD Thesis: Columbia University Teachers College, 1980), 50.

[277] Ibid.

[278] Triennial Report on the working of the Lunatic Asylum in the Madras Presidency, 1921, NLS, 3.; Annual Report on the Working of the Lunatic Asylums in the Madras Presidency, 1922, NLS, 14–19.

Till 1921, only a few experimental missionary endeavours for the education of mentally disabled children were conducted in Colonial India. Rev. E. L. King of Narsinghpur, in Indore, and Rev. D. S. Herrick of Bangalore, two missionaries deserve a special mention for their efforts to educate the mentally disabled. The central advisory board meeting of the Board Education of Madras, held in October 1921, advised the missionaries that mental intelligence and practical tests should be framed, to be conducted in normal schools on large scale to identify mentally disabled children at an early stage. To make it practical, Binet Simon Test, revised from the Stanford curriculum, was sent to the principals of different colleges.[279] The reports of the experiments were sent back to the board by many missionary teachers that included special education instructors like Miss Gordon of Saidapet, Mr. Spencer of Jubbulpore, Mr. West from Dacca, and Mr. Wyatt of Lahore.[280] The reviews of some experiments in mental testing in India reported that these reports were sent to the educationists in India and London.[281]

Early mental disability education was not developed in full swing because of the way mental disability was treated in Colonial India. It was found that parents with children with mental disabilities understood the condition of their children quite late; they were ignorant about the many visible symptoms associated with mental disability. Upon discovering the 'abnormality,' instead of seeking 'professional' help, they sought the service of native healers and some even admitted them to schools with able children, but their children could not keep up with the learning process. This created a sense of disappointment among parents and it was understood these children were beyond healing. The major mistake they committed was admitting them to the 'normal' schools. It was imperative to admit the mentally disabled children in special schools where the curriculum is drafted per the needs and capacities of students. It is also important for special schools to provide opportunities for interaction between mentally disabled children and regular school children for better growth. But in Colonial India, children who were admitted to the special schools also were taken out by their parents because they could see no significant

[279] Binet intelligence test was originally introduced by Alfred Binet in France. It was further standardized by Lewis Termon, and later came to know as Stanford-Binet Test where IQ score was calculated by dividing the test taker's mental age by his/her chronological age and then multiplying this number by 100. Kendra Cherry, "Alfred Binet and the History of IQ Testing," *Very-well Mind*, no. 19 (2020): 139–145.

[280] J. A. Richey, *Provisional Series of Mental Intelligence Tests for Indian Scholars* (Calcutta: Bureau of Education, 1924), 15.

[281] A. S. Woodburne, *Psychological Tests of Mental Abilities* (Madras: University of Madras, 1924), 199, 201.

changes or improvements. It was not understood that teaching mentally disabled children could take a long time and patience; every simple detail they would learn was to be treated like a milestone.

The main advances in the education of the mentally disabled were realized in 1927 when the first intelligence test in English, Hindi, and Urdu was published in Bombay. In 1929, Rice's Hindustani Binet IQ test was published, and later Dr. V. V. Kamat's Marathi and Kannada versions were revised in 1936.[282] Many efforts were put in to retrieve an accurate count of the number of mentally disabled children in India. One survey was conducted by Dr. Kamat, a native psychologist, in 1929 to understand the percentage of mentally disabled children admitted in the schools. While revising his 'Binet system' for Kannada speakers, he found that from 1,074 children in Dharwar (Mysore), only 4 percent of the mentally disabled children were enrolled in a school. Dr. Kamat certified that most children with mental disabilities were not sent to schools by their parents. Hence, calculating the number of disabled children, by merely looking at those attending school, did not seem to be a correct strategy. According to his survey, three children with mental disabilities were in secondary classes and 30 in primary classes.[283] In 1926, a Deficiency Committee in Bengal looked at the problem of the disabled, and conducted a survey and found that among 105,000 disabled children aged between 7 to 16, 77 percent were enrolled in ordinary schools.[284]

In 1933, a school for the mentally disabled was established in Jhargram, Bengal, by Bodhan Samity with the help of Rev. H. Parker, which hosted eight students and the cost of maintenance of the school was solely sourced from private firms or connections.[285] Founded under the care of Mr. Girija Prasanna Mukherji, an advocate of the high court, the school was known as Bodhana Niketan and he donated a considerable amount of money for the establishment of the institution. The school was later shifted to Belghoria, Calcutta, and educated 15 students by 1936.[286]

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[282] Rice revised the Binet Test incorporating the Army Beta Test where pictures also were used instead of only writing. The test was presented in Urdu. C. Herbert Rice, *Examiners' Manual-Hindustani Binet Performance Point Scale* (Bombay: Oxford University Press, 1929), 19.

[283] Kamat, *Measuring Intelligence*, 85.

[284] John Gabby and Webster Charles, "Changing Educational Provision for the Mentally Handicapped: from the 1890s to the 1980s," *Oxford Review of Education*, no. 9 (1983): 169–175.

[285] Report of Public Schools in Bengal, 1933, 34, quoted in Miles, *Disability Care & Education,* 5.

[286] Ninth Year Quinguennial Report of Bengal, 1932, 130, quoted in Miles, *Disability Care & Education*, 18.

In 1934, 'Central Nursing Home for the Mentally Invalid' was established at Ranchi which was run privately and admitted children above the age of five.[287] The institute authorities believed that nothing has been done for educating the mentally disabled. The establishment was set up to educate people with mental disabilities rather than segregating them to isolated places. The school decided to use practical education which meant methods adopted helped by 'modern' psychology. There was a tendency of declaring an educable mentally disabled into non-educable disabled.[288] To avoid this trend, the school examined the mental capacity of its inmates in 1934.[289] Miles dismissed the importance of this institution which created a school kind of a setup for six mentally disabled children calling it a 'limited programme.'[290]

In Madras Mental Hospital, assisted by its superintendent H. S. Hensman, a missionary psychologist, started a learning programme for the mentally disabled which benefitted young patients from the hospital.[291] A trained and educated teacher was recruited in the hospital to cater to and care for the students.[292] The report for the training of the mentally disabled children stated that "a suitable programme of practical object demonstration, storytelling, picture cutting, drawing, sense attention, habit training etc., was adopted in the Madras Mental Hospital. Physical drills, play of various types, singing and dancing were also practiced. Swings, see-saw, and a cycle added to their enjoyment. Training in handicrafts such as mat and rope making carpentry and spinning was given."[293] This kind of active model of participation teaching methodology benefited greatly to the inmates of the hospital. They actively participated in the programmes and this increased their social communication skills over time.

By the 1940s, two more significant schools were established—the Home for Mentally Deficient Children in Man Khud, Bombay, and the School for Children in Need of Special Care in Bombay. The former was established in 1941 and only took in mentally

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[287] Roopa Vohra, "Institutional Services for the Mental Retardates," *Disabilities and Impairments*, no. 1 (1987): 91–117, 114.

[288] Miles, *Disability Care & Education*, 4.

[289] S. Sinha, "Learning Curve of a Mentally Deficient child," *Indian Journal of Psychology*, no. 13 (1936): 223–35.

[290] Miles, *Disability Care & Education*, 4.

[291] Ibid.

[292] Annual Report of the Working of Mental Hospitals in Madras for 1936, NLS, 4.

[293] Annual Report of the Working of Mental Hospitals in Madras for 1937, NLS, 8.

disabled children who were put in foster care by the court. The second school was established in 1944 by Shrimati Vakil, facilitated by some local missionaries.[294] In 1944, Brindaban School of Champaran in Bihar admitted two students with mental disabilities. The school provided a suitable environment and special attention to the mentally disabled, and the two children surprised their teachers with their improvement in habits and behaviour.[295] In the 1940s, India witnessed a debate on how mentally disabled children should be educated in school. Many missionaries argued against segregation and opined that it was not good to segregate children in a school based on their mental abilities.[296] Since children had to live among the people who were not disabled, the children needed to be accommodated within society. A report in 1944 reflected that "the mentally handicapped children who are educable should, therefore, remain within the general educational system, though special provisions will have to be made for their particular requirements."[297] Post-1944, schools in the United Provinces of Agra and Oudh implemented a test among 1,419 children using Hindustani verbal intelligence tests from class six. It was decided that only children with an IQ of 70 would be promoted.[298] Simultaneously, in 1944, Kuresong Children's Home and School was closed due to the lack of funds. It was still known as the only institution which took care of Anglo-Indian, European and native mentally disabled children under one roof.

By 1944, only three institutions were operating in India for the care of mentally disabled children; the Ranchi-based Nursing Home and the two institutions of Bombay. The Ranchi Nursing Home changed into a custodial home for the mentally disabled children and it sheltered children directed by the juvenile court for custodial purposes. From 1950 to 1960, 11 more institutions became functional, and from 1960 to 1966, the number increased to 35 institutions. In 1949, using the Gujarati model of Binet Simon Test, 250 Parsi children were tested to evaluate their mental capacities. Out of 250, 20

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[294] A Report on the Review of Education in Bombay State, 1855–1955 (Poona: Government of Bombay, 1958), 455.

[295] N. C. Chatterjee, "Education of the Mentally Defective," *The Indian Journal of Educational Research*, no. 3 (1953): 35–37.

[296] Ibid.

[297] Miles, *Disability Care & Education*, 77.

[298] Sohan Lal, "Distribution of Intelligence in U.P., India," *British Journal of Educational Psychology*, no.14 (1946): 95–98.

children were found to have an IQ of 50 to 60 percent, and 2.8 percentage were included in the category of mentally disabled.[299]

The nature of missionary education in Colonial India is a hot topic for contestation. Bellenoit argued that missionary education in India was not highly Christian. He commented that religious influence was absent on a large scale due to the high pressure imposed by the education department to 'secularize' the entire process of education.[300] He continued that missionaries also depended on Hindus and Muslims to run their institutions and Christianizing them would be 'bad for businesses.'[301] This is one way to look at missionary education in India, but the case is different for the education of the disabled. Special education was conducted privately and the education department had little say about the nature, curriculum, and medium of instruction. This was the main reason why reports of the education department were not inclusive of special education institutions because it was performed on a small scale. The reason special education was 'Christian' should be looked at with its context.[302] Missionaries largely depended on study materials transported from London and technological and technique-based limitations forced them to adopt whatever was available in Britain. Even though missionary special education was Christian, it lacked the means to make a huge impact in society. But it is important to note that while looking at the individual impact, the education of the disabled was highly influenced by Christianity. Thus the next part of the chapter looks at how Christianity turned into an attraction and fascination for the disabled community in Colonial India.

[299] B. M. Batelwalla, "Results of Mental Testing of 250 Parsi School Going Children of Lower Middle-Class Families between the Ages of 8–11 Years," *Indian Journal of Psychology*, no. 24 (1949): 52–61.; In independent India, just like other disabilities, mental disability is also included in the constitution which promises free and inclusive education. The constitution also promises the assurance that no child will be denied admission to school based on his or her disability. The Persons with Disabilities Act in 1995 also talks about the inclusion of the mentally disabled child in the educational system. Unlike other disabled such as blinds and deaf-mutes, education of the mentally disabled in India is done separately.

[300] Bellenoit, "Missionary Education," 19.

[301] Ibid.

[302] Miles, *Disability Care & Education*, 20.

4.4. Disability and Christian Theology in Colonial India

To understand how the colonial mission functioned in its totality in India vis-a-vis disabilities, it is imperative to look at the role of Christian inclusivity and interdependency in India. Religion and disability have an inescapable relation to each other. Religious perception of disability includes the way the disabled are treated in a religious community, definitions given to disabilities, and the way disabilities and the disabled are pictured in religious principles and texts. Religion always provides an intimation of divinity to the disabled and disabilities. We shall see how Christianity and Christian missionary theories functioned and meaningfully interpreted the concept and framework of disability.

There are two extreme ways in which religion deals with disability—first, disability as the result of sins committed in one's lifetime, and second, the curative possibility for disability through sufficient faith in religion.[303] Hindu, Buddhist, and Jain scriptures dealt with disability in the light of '*karma*' and sin. Christianity dealt with disability through healing and divine suffering. There are marked differences in interpretation, internalization, and preaching of disability-related matters between Christianity and other religions.

According to the Christian scriptures, people should reflect on God in a personal way. One way in which God's reflection is fulfilled was through 'brokenness'—the brokenness of body and mind, i.e., disability.[304] It is believed that brokenness brings a person closer to God. Christianity glorifies 'brokenness' and talks about the additional benefits and abilities associated with disability. Christianity advocates not the body but the soul matters and 'we' as a society always rehabilitate our bodies while ignoring the demands of the soul.[305] Christian scriptures promote that people should not blame their souls for the condition of their bodies.[306] Therefore, the concept of disability goes beyond the physical and mental defects of human beings; the body goes back to dust as prescribed in the biblical preaching while the soul is permanent. In simple words, the soul is pure and abled despite any visible disability in the human body.

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[303] Kerry Wynn, "Johanninne Healings and the Otherness of Disability," *Perspectives in Religious Studies*, no. 32 (2003): 21–75.

[304] Glenn Kreider, *Disability and Theology* (PhD Thesis: London University, 2001), 22.

[305] Ibid., 23.

[306] Ibid.

Missionaries who worked for the disabled urged Indians not to look at the limitations of the body, but to see and actualize the possibilities of the soul.[307] They preached that people may not obsess over 'abnormalities' of the body. Missionaries advocated that a body is whole, whether weak or strong they work together, and 'abnormalities of the body' should not be ridiculed. Missionaries preached that those body parts which are weaker should be treated with special honour. They delivered the message that it is imperative to treat a person with dignity and acknowledge the bodily variations. According to the Christian faith, it was not correct to associate a person's bodily features with a person's abilities.[308]

Missionaries in Colonial India particularly exploited a specific episode from gospel where a man asked Jesus about a blind person. The questioner's inquisitiveness about blindness as an enigmatic phenomenon of the human body encouraged him to question further as to whether it was due to his sins or due to the sins of his parents.[309] Jesus answered that the man becoming blind had nothing to do with his/his parent's sin, but "this happened so that the works of God might be displayed in him."[310] Jesus's response was clear enough to dispel doubts and establish the 'divine plan' enacted through disability. Christianity's non-association with sins and *karma* was the prime reason why disability was received in a positive light among the families of the disabled because they were tired of the discrimination that they faced. This non-association of disability with *karma* is the principal difference between Christianity and the other native religions.

Missionaries who worked in Colonial India asked the families of the disabled to see the virtue in disability so that the disabled could be integrated into the community. They preached that the disabled should not be subjected to mockery, abandonment, discrimination, and marginalization. Missionaries in Colonial India advocated that disability was a "spiritual gift, the kind of spiritual gift that brings a person closer to God," and preached that the 'gift of disability' also teaches a person the good side of dependence and help.[311] Providing help to the disabled was looked at as an act of good faith.

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[307] Leupolt, *Recollections*, 14.

[308] Sharifa Stevens, "Christianity and Disability: Thinking Theologically About Brokenness," (2013). https://voice.dts.edu/article/christianity-disability-thinking-theologically-about-brokenness/

[309] Book of John 9, 1: 3.

[310] Ibid.

[311] Swainson, *Work for Christ*, 9.

Colonial missionaries preached the idea of 'healing' among the disabled community. They defined disability in terms of a defect that could be healed in the 'kingdom of God.' They used biblical promises such as "in the reign of the Christ the blind will recover sight."[312] The kingdom of God was proven and raised by Jesus by curing the blind, the sick, and the 'lame.'[313] The Bible also accentuated the healing power of the faith. This gave hope to many Indian families with disabled children which ultimately resulted in conversions. Unlike Indian religions which preached that disability was the result of sins they or their forefathers had committed, Christianity preached that disability was a sign of weaker faith and as faith grew, healing chances brightened.

Healing is the miracle that is attributed in Christianity as the panacea for disability. Missionaries talked about a leper who was healed by Jesus.[314] Missionaries also quoted the story of a paraplegic man who was healed by Jesus.[315] They narrated the story of a man who was physically disabled and was a part of a preacher's group.[316] He talked to Jesus and was thankful to Jesus for not despising him. They also mentioned an incident in the book of Mark, where a deaf and mute man was brought in front of Jesus. Jesus took the man away from the crowd, put his fingers inside his mouth and ears, and cured him.[317] All these stories of healing had a favourable reception with the disabled population in India. By quoting such stories from the Bible, missionaries advocated that the disabled should look at Jesus as a friend who "whenever we struggle in life, (God) sits beside us and helps us cry," and this portrayal of Jesus as a 'compassionate God' increased the popularity of Christianity among the disabled in India.[318]

[312] Book of Luke, 4, 16: 21.

[313] Ibid.

[314] Book of Mark, 1, 40: 45.

[315] Book of Matthew, 8: 5–13.

[316] Book of Galatians, 4: 13–15.

[317] Book of Mark, 7: 32–16.

[318] K. Black, *A Healing Homiletic: Preaching and Disability* (Nashville: Abingdon Press,1996), 37–38.

Missionaries preached that the reason why the disabled were looked upon with contempt in India was because of the absence of a Christian understanding.[319] They advocated that accepting Christianity would increase awareness about loving the poor and the disabled. Many families with native or converted disabled in India were ostracized by their communities. They were seen as bringing shame to the family honour, and the conversion was regarded as an act of treachery to the native religions. For example, the blind teacher Asho, already discussed in an earlier part of the chapter, was converted against the wishes of her family. She was humiliated and insulted by her family because of her conversion.

The first step adopted by the missionaries was the implementation of the integration of the disabled into the conventional space of worship—the church. Missionaries advocated that the body of Jesus was comprised of both the church and people.[320] They preached that the church and people should reflect the image of an 'inclusive' world how Jesus wanted the world to be. Therefore, excluding people from places of worship basis on their disabilities means 'sinning against the order of Christianity.'[321] However, it is unclear whether these spaces of worship were physically accessible for the disabled or not. Many records show that the disabled were integrated into churches, or special provisions for the sermons were arranged. Some instances will be mentioned here. In 1839, in Banaras, William Smith, a missionary preached in a local town church to a crowd including several blind and lame; he also gave out alms and food to the disabled after the prayers.[322] Similarly, in 1857, in Ratnagiri, Bombay, De Crespigny stated that the 'blind, lame, and the deformed' received help from the local European community through charitable contributions. In the 1890s, in Agra, Dr. Colin Valentine arranged religious services and the distribution of money and food to the poorest in the area. He attracted thousand attendees 'of whom nearly three hundred are

[319] Missionaries talked about a part in Luke 6: 6–11, Matthew 2: 9–14, and Mark 3: 1–6. Jesus saw a man having trouble with his daily life due to his paralyzed hands. When he was healed by Jesus, the first response from the crowd was awe, then fear. Upon witnessing the miracle of healing, the crowd wanted to kill the man accusing him of witchcraft. The New Testament mentions that it happened because the idea of Christianity was not familiar to people. Leupolt, *Memories*, 5.

[320] Book of Corinthians, 1: 12.

[321] Ibid.

[322] Penny Frank, *The Church in Madras: being the history of the ecclesiastical and missionary action of the East India Company in the Presidency of Madras in the seventeenth and eighteenth centuries* (London: Smith, Elder & Co, 1904), 216, 313.

blind.'[323] In 1826, in Allahabad, Mr. Mackintosh used to read the Bible to 250 blind and 'lame.' He regularly distributed alms to them collected from the local Europeans. St. Mary Church used to conduct sabbaths for boatmen who were injured or disabled because of the accidents. A fine was taken from the owners who forced their boatmen to work on the day of the sabbath and that money was used to fund the treatment of the disabled or injured.[324] Many disabled who lived in the streets attended the sermons regularly, not only to hear about the Christian scriptures but also to receive alms, food, and other necessary items because they were unable to make ends meet by begging alone.

Missionaries like Mrs. Sherwood used to write children's stories explaining the need for a compassionate and inclusive approach to the disabled.[325] Through her stories, Mrs. Sherwood introduced the idea of the disabled as 'children of God' in India.[326] This approach offered the disabled a newfound feeling of 'positive spirituality.'[327] According to missionaries, if there is any impairment, people would remember God, and in that suffering, it was the responsibility of each Christian to provide aid and a place for them in the institute of worship so that they could heal. In her narration, Mrs. Sherwood emphasized the charitable nature of Christianity which accommodated and valued everyone irrespective of the disability. This idea of the need for charity in Colonial India attracted rich elite educated Indians to donate funds to missionary endeavours.

By quoting instances from the Bible where Jesus embraced the blind, the deaf-mute, lepers, and people with bodily differences, missionaries in Colonial India presented Christianity as a religion that accepts everyone.[328] Missionaries like Miss Hewlett, Miss Swainson, and Mrs. Sherwood met with disabled people and introduced Jesus as an 'accessible God' and Christianity as a religion that 'saved, secured, and

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[323] Ibid., 217.

[324] Ibid., 216.

[325] Mrs. Sherwood, *Stories Explanatory of the Church Catechism* (Baltimore: Published Under the Direction of the Rt. Rev. Dr. Kemp, by the Protestant Episcopal Female Tract Society of Baltimore,1823), 12.

[326] Christianity holds the idea that Christ was disabled. Nancy Eiesland's argues that after the resurrection, Jesus was disabled. She advocated that the "Imago Dei''–the image of Christ with pierced arms and legs on the cross is an embodiment of disability. This illustration was employed as a strategy to legitimize the argument that the disabled were undeniably 'special' to God as his 'son' was himself reborn in a scarred and disabled body after his crucifixion. N. F. Eiesland, *The Disabled God: Toward a Liberatory Theology of Disability* (Nashville: Abingdon Press, 1994), 12.

[327] Ibid.

[328] J. W. Block, *Copious Hosting: A Theology of Access for People with Disabilities* (New York: Continuum, 2002), 11.

protected the disabled and poor.'[329] They popularized a 'God' who was committed to 'inclusion' and claimed that inclusivity was biblically based because "people of all races, nationalities, gender, and physical conditions were included in Jesus's ministry."[330]

The role of women missionaries in popularizing Christianity among the disabled population in India was massive. They traveled through villages, visited homes of the disabled, and tried to get to know the local customs related to disability in India. Women missionaries like Mrs. Sherwood had in various instances, stated that there was a prevailing habit of killing disabled children because they were considered a burden on the family.[331] Many missionary narrations about 'wolf boys' and '*jungli*' children' were all references to children who were abandoned by their parents due to their disabilities.[332] Blind and the physically disabled were valued based on their ability to make money from the streets through begging. These disabilities were deemed as sources of revenue where the disabled were exploited and commercialized. However, children with mental disabilities were abandoned by their families.[333] The mentally disabled were considered 'useless' whose dependence sought more attention and was troublesome to the families. Women missionaries used to pick them from streets and residential places to house them in orphanages.

Just like abandonment and forced begging, infanticide of a disabled girl child was a common trend. Miss Hewlett who worked among the blind, wrote in her account that she witnessed such an incident where a blind girl child was abandoned by her family in a street to die. The villagers were not ready to help the child because they thought the child's disability would bring them bad luck. The child was rescued by missionaries after two days but sadly died due to starvation and exposure.[334] Realizing this trend among the native families, women missionaries in their *zenana* missions used to preach about the value of life, especially of the disabled.[335]

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[329] Ibid., 80.

[330] Ibid., 120.

[331] Baumann, "Deaf and Dumb Ellen," 52.

[332] Ibid.

[333] Ibid.

[334] Hewlett, *They Shall See His Face*, 30.

[335] Sharp, "Letter," 16.

Miss Hewlett also talked about Wiran in her journals, a paraplegic Christian converted disabled and the aunt of a young educated man named Pratab, whom Hewlett met in a train journey.[336] Wiran was disabled when she was just an infant by falling from the roof. She was fondly loved by her nephew and through him, she learned to read. Hewlett wrote that reading the Bible was the only pleasure in her life then. Hewlett used the term 'invalid' to denote Wiran, to explain her physical disability, and wrote that through her conversion, her existence became 'valid.' Colonial missionaries like Hewlett looked at the disabled as 'invalid people' who needed saving from their 'horrible' state of life. The only way they could be saved was through learning the Christian way of life. [337]

Missionaries like Hewlett advocated the idea of 'divine suffering.' Wiran's story is the best example of how missionaries incorporated her suffering into her 'supposed divinity.' They preached about bodies, whether disabled or abled in terms of 'failing' and 'broken,' and associated life with suffering. They also preached that those who suffer hardship in life are loved by God, and added that God chooses weak people to love because their minds and faith are strong enough to hold the 'burden of the disability.'[338] They also advocated that God never gave humans anything more than they can bear and people with disabilities were special to live through the sufferings and trials. This attempt to associate pain and suffering with divinity attracted many disabled people to Christianity.

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[336] Sarah Secunda Hewlett, *None of Self and All of Thee: A Tale of Indian Life* (London: R. Carter, 1888), 2.

[337] Wiran used to question life and its purpose and was in deep thought about her disability. Hewlett wrote, Wiran's disability was 'darkness' and she would come to light when she converts to Christianity. Just like Wiran, Pratab also was growing dissatisfied with his religious ways of treating the disabled and slowly turned to Christian scriptures. With the help of Pratab, Wiran received the Bible from the missionaries. Hewlett stated that the reason why Wiran was attracted to Christianity was due to her disability, and the Bible answered her questions about sin, life, death, grace, and blessing. Pratab attributed her sharpness to her disability and looked at her intellect as something given by God to compensate her physical condition. This was another idea propounded by missionaries in Colonial India, where disability was attributed to special intelligence, and that intelligence is related to the grace of God. Wiran's Bible in possession was confiscated by her brother and the entire family asked Pratab to leave the family for covering her 'wrongdoing.' Later Missionaries found Wiran in a deprived condition, denied of the basic necessities, avoided and neglected in her own house. After a long legal battle, Wiran was removed from her house with the help of missionaries and lady doctors. She converted to Christianity later and died due to her illness. Ibid.

[338] Book of Corinthians, 2: 10.

To teach and preach Christianity to the disabled, colonial missionaries sought the assistance and support of technological inventions like signs and scripts. They translated the Bible into blind scripts like Moon, Lucas, and Braille. Missionaries translated the Moon scripted Bible of St. Matthew in Urdu from London in 1873 to teach blind students in the mission orphanages.[339] Later, the Bible was translated into Moon scripts of Hindustani, Malayalam, Tamil, and three portions of Bengali, and Dr. Moon adapted Moon characters into Sanskrit, Telugu, and Panjabi.[340] All of which were used by the colonial missionaries printed extensively and distributed among families of the disabled or communities to teach about how Christianity dealt with disability.

Missionaries in Colonial India carefully talked about the process of conversion of the disabled who learned about Christian Scriptures. Missionaries like C. T. Hoernle, who taught the New Testament to the blind was supportive of conversion. Under his instruction, a blind boy who learned chapters from the New Testament and the whole gospel of Matthew using only his memory was converted to Christianity.[341] Sarah, the blind student under the care of Mrs. Dauble also converted after reading the Bible.[342] Mrs. Dauble used to teach her blind students Christian stories from the Bible in hope of more voluntary conversions and was quite proud of her girls being able to read them efficiently. She mentioned a blind girl Mary who read the gospel of St. John and converted to Christianity.[343]

Similar to Mrs. Dauble, Miss Annie Sharp also believed in converting the disabled to Christianity. It was under her mentorship that Miss Asho was converted. Miss Sharp stated that she was happy with the growth of Asho in terms of her faith. Asho became the missionary 'poster girl' for the 'newfound Christian hope' for the disabled. Under the care of Miss Sharp, along with Asho, many blind students from the Amritsar institution were converted to Christianity.[344] Many young children like Ellen, a deaf-mute girl under the care of Mr. Baumann was baptized on the false belief that converting to Christianity could cure their disability. Miss Marial, another blind woman whose parents treated her badly due to her disability was converted to Christianity under the mentorship of Mrs.

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[339] Shrap, "Letter," 29.

[340] R. Meldrum, *Light on Dark Paths: A Handbook* (Edinburgh: Menzies, 1883), 112.

[341] Ibid., 113.

[342] Dauble, "Our Orphans at Secundra," 38.

[343] Dennis, *Christian Mission*, 225.

[344] Clark, *The Missions of the Church*, 60.

Askwith.[345] These inspirational stories of the disabled finding Christian faith and 'getting better' increased the popularity of Christian missions in India.

Disabled individuals who converted to Christianity faced harsh treatment from their families and neighborhood; it led to their marginalization, dehumanization, and exclusion by and within their family and social surroundings. At times, families of the disabled along with other children were converted. It was not only the popularity of Christianity that attracted the disabled and their families, the social acceptance of the disabled among Christian communities was higher when compared to other religious communities. Along with it, many were able to access education, medicine, and better living standards provided by the missionaries. For the disabled who were abandoned, a conversion meant having access to stable shelter to live.

However, many missionaries were hesitant to convert the disabled to Christianity due to the fear of local resistance. Miss Fuller, in 1880, recorded about an 18-year-old blind girl who wished to convert to Christianity. Miss Fuller stated that if the girl converted, the locals would accuse the missionaries of bribing her. Miss Fuller and other missionaries discussed the need for a home for the native women who converted and lost their homes, families, and friends. Accordingly, missionaries worked carefully on the question of conversion so that government, as well as local communities, did not hamper their larger agendas.

Summing Up

Christian missionaries in Colonial India were known for their efforts in educating the disabled population. The first group of disabled who benefited from missionary education was blind. They worked for the education of the blind in India in separate as well as integrated schools in orphanages of Banaras, Calcutta, Madras, Secundra, Palamcotta, and Amritsar. With the help of missionaries from London, these missionaries collected study materials in Moon, Lucas, and Braille scripts and distributed them among the blind in India. The style and the medium of instruction were a mixture of Indian and Western, but the curriculum was heavily influenced by Christianity.

The deaf-mute education in India was developed due to a collaborative attempt by Indian instructors and missionary efforts. The deaf-mute schools were established in Bombay and Calcutta through the involvement of missionaries. Missionaries were

[345] Askwith, "Report from Sarah Tucker," 24.

collaborated with native educators in making an Indian language model of signs to be used in missionary established deaf-mute schools. Women missionaries also worked for the education of the deaf-mute in the different parts of India. Colonial missionaries were also credited with introducing educational institutions for the mentally disabled, although it was not widespread like blind and deaf-mute education. Missionaries used education as a tool for correction for the disability through imposing behavioural therapy in these institutions.

Missionaries attributed ‘brokenness’ to disability and preached that faith could heal disability which attracted the disabled population to Christianity in Colonial India. They popularized the idea of charity concerning disability and tried to integrate the disabled into conventional places of worship. They also advocated the idea of divine suffering, and sought the help of signs and scripts to spread Christian ideas. Even though the conversion of the disabled population was a common practice, missionaries were careful about it.

Chapter Five

MEDICINE AND DISABILITY: INSTITUTIONALIZATION, TREATMENT REGIMES AND MEDICAL MISSIONS IN COLONIAL INDIA

The idea of disability in Colonial India is usually discussed along with the context of health and disease, effects of plague and smallpox, and other such infectious diseases. However, colonial disability and disease management and the institutionalization of the disabled are some important areas yet to be studied. Modern medicine and the scientific knowledge on disability eliminated superstition about disability that it was a curse. The colonial attempt to study the Indian forms of bodily and mental 'deviance' led to a partly systematic approach to the study of disability and its causes. This chapter aims at looking into the connection between colonial medicine and the institutionalization of people with disabilities. The first part deals with the treatment regime which was available to treat blindness. The second part traces the history of orthopedic disabilities and the institutionalization of the mentally disabled, and the third part looks at the institutionalization of leprosy patients and the role of medical missions.

5.1. Medical Interventions and Blindness

Colonial records extend from the official and the legal to the missionary and all of them discuss the magnitude of blindness in India. They discuss how uniquely India was vulnerable to blindness, and in the 1940s, it was stated that 2.2 million blind lived in India.[1] The history of blindness in Colonial India was mentioned in historical works for its relationship with colonial medicine.[2] However, there is a paucity of studies that talk about the magnitude of the problem, namely the type of blindness common in India, the development of eye hospitals, treatments available, and the rehabilitation of the blind in Colonial India. Blindness was never analyzed for its infectious character, its focus on

[1] Y. B. Yeats, *Census of India* (Delhi: Government Printing, 1943), 5.; A. K. Shah, *Six Hundred Thousand* (Calcutta: Calcutta Blind School, 1942), 3.

[2] Linker Beth, "On the Borderland of Medical and Disability History: A Survey of the Fields," *Bulletin of the History of Medicine* 87, no. 4 (2013): 499–535.

public health programmes, and maternal and child policies.[3] The works of Chander and Miles focus on blind education and do not talk about the medical experiences of the blind.[4]

The first step to include blindness as a concern for colonial medicine was its enumeration in the official censuses. The definition gave to the term 'blindness' changed from census to census; in the initial census, it only took complete blindness as the criterion, but the later censuses included both complete-blind and half-blinds.[5] The returns of the numbers of the blind were more accurate when compared with the information on other infirmities, mainly because blindness was not and could not be easily concealed.

The census reports also talk about the reasons for blindness listed by the ophthalmologists who worked in India.[6] They often linked the arid region and hot climate in India to blindness, especially in the regions of Rajputana and Sind.[7] According to census reports, extreme heat put a strain on the eyes, other factors like dust and 'excoriating' winds, and sandy plains contributed to eye infections which led to blindness.[8] Just like hot climate, extremely cold climate also caused blindness, stated the records. People who lived in Ladakh, where the glare of the sun was extra over the white snow, were prone to develop blindness. When people from these regions lived inside small huts, the non-ventilated and cramped space along with smoke from cooking fires also put a strain on the eyes.[9]

The medical narratives in the census reports also talked about gender discrimination and poverty as one of the reasons for the high number of the blind. Women and the poor were less likely to have access to medical care and proper diet and spent their

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[3] Nandini Bhattacharya, *Contagion and Enclaves: Tropical Medicine in Colonial India* (Liverpool: Liverpool University Press, 2012), 30.; Narin Hassan, *Diagnosing Empire: Women, Medical Knowledge, and Colonial Mobility* (London: Ashgate, 2011), 12.

[4] M. Miles, *Disability Care and Education in 19th Century India* (Birmingham: 1997), 13.

[5] Farrell Gabriel, *The Story of Blindness* (Cambridge: Cambridge University Press, 1956), 208–209.

[6] Yeats, *Census of India,* 4.; M. Hogeweg, "Cataract: The Main Cause of Blindness in Leprosy," *Leprosy Review* 72, no. 2 (2011): 139–142.; Report of the Fifty-Sixth Year's Work in India of the Mission to Lepers, 1929–1930 (Mysore: Wesley Press and Publishing House, 1930), 23.

[7] S. E. Maunsell, *Notes on Medical Experiences in India Principally with Reference to Diseases of the Eye* (London: H. K. Lewis, 1885), 21–22.

[8] Gajanan Krishnan Bhatawadekar, 1881 Census of India: Vol. 3, Report from Baroda (Vadodara: Education Society's Press, 1883), 260.

[9] Matin-Uz-Zaman Khan, 1911 Census of India: Vol. 20, Report from Kashmir (Lucknow: Newul Kishore Press, 1912), 189.

days inside huts, stated many reports.[10] Lack of quality diet made the rural population prone to diseases like blindness and leprosy.[11] Insanitary conditions, flies, wet mud walls, and housing near the farmland were thought to have caused many eye infections.[12] Colonial physicians also blamed local practices of healing. According to common healing practices, eye diseases were treated by applying tobacco juice and hot coals and such practices aggravated blindness.[13]

The development of eye care in Britain was chequered and Indian eye care depended on its progress. Before eye surgeries became common, eye care was dominated by 'quacks, mountebanks and itinerants,' wrote William Laurence in his treatise on the diseases of the eye.[14] During the early nineteenth century, the specialization of eye care developed as an important branch of medicine with the treatment of an eye disease called trachoma. In trying to provide successful treatment for the epidemic of trachoma (also called Egyptian ophthalmic) which struck the English and French soldiers, ophthalmology developed as a field of research.[15] Trachoma was understood as a major threat to the health of the English army and this increased government involvement in ophthalmology research. Physicians believed that the condition of trachoma was caused by environmental factors, but John Vetch, a British physician, opined that the condition was contagious and his research on prevention became a cornerstone in the development of ophthalmology. Many hospitals were established and a royal infirmary for the diseases of the eye was established at Cork Street, Dublin, in 1804, which was the first institution entirely dedicated to eye care.[16] In 1804, John Cunningham Saunders established a London dispensary for curing diseases of the eye and the ear.[17] King George III supported the first

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[10] H. H. Risley, 1901 Census of India: Vol. 1, Part 2: Table (Delhi: Office of the Registrar General of India, 1903), 142

[11] Ibid.

[12] Ibid., 143.

[13] R.V. Russell, 1901 Census of India: Vol. 13, Central Provinces (Nagpur: Secretariat Press, 1902), 47.

[14] William Lawrence, "Lectures on the Anatomy, Physiology, and Diseases of the Eye," *The Lancet* 5, no. 22 (1825): 145–151.

[15] Mary Wilson Carpenter, "A Cultural History of Ophthalmology in Nineteenth-Century Britain," *Extension of Romanticism and Victorianism on the Net* (2010). http://www.branchcollective.org/?ps_articles=mary-wilson-carpenter-a-cultural-history-of-ophthalmology-in-nineteenth-century-britain

[16] Nick Black, *Walking London's Medical History* (London: Royal Society of Medicine Ltd, 2006), 57.

[17] Ibid., 58.

eye hospital from 1815 to 1835, and many hospitals were started in London, Dublin, and Edinburgh.[18] Luke Davidson wrote that the reason why the British government supported eye treatment was also that it was concerned about the economic complications of a lot of young people losing sight along with the older population.[19]

Trachoma was a common eye infection that turned people blind in Colonial India. The infectious nature of the disease and the permanent damages it could cause scared the British in India, especially about the health of its soldiers.[20] Trachoma is a bacterial infection that causes a granulation of the conjunctiva. The bacteria which causes this infection is known as chlamydia trachomatis, and the infection may result in permanent complete or partial loss of sight in patients. Trachoma-related blindness received special attention from the Indian medical community because of its infectious nature. Trachoma was believed to have a relationship with hot climate, and it was known locally as *kheel* and *khupri*. [21]

The treatment available to help trachoma patients in India was recorded by Lt. Colonel Lane who was a spokesman of the Indian Medical Service (IMS). He recorded that in Ambala, more than 90 percent of blindness was caused by trachoma. He also mentioned that doctors used to treat trachoma with the help of chloroform. Along with this, mercury perchlorate and mercury cyanide washes were also prescribed. Surgeries were conducted to scrap off the granulation caused by trachoma.[22]

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[18] Luke Davidson, "'Identities Ascertained: British Ophthalmology in the First Half of the Nineteenth Century," *Social History of Medicine* 9, no. 3 (1996): 313–333.

[19] Medical literature produced during this time, especially from ophthalmologists started to romanticize the importance of the eye as the primary sensory organ in the body and asserted that blindness was the most pitiful condition anyone could ever have to go through. Ophthalmologists like John Stevenson considered the treatment of blindness as a moral enterprise and believed that vision is the precious ornament of the body and this created a sense that loss of vision should be dreaded. L. S. Jacyna, *Lawrence, Sir William: first baronet, 1783–1867* (Oxford: Oxford University Press, 2004), 8.

[19] Davidson, "Identities Ascertained," 326.

[20] Amrita Bazar Patrika, 19, 09, 1916, National Archives of India (NAI from here), 8.

[21] H. J. M. Desai, "Article on the Prevention of Blindness," *Memorandum of the First All India Conference for the Blind,* no. 14 (1952): 56.

[22] The Tribune, 26, 04, 1914, NAI, 7.

Along with trachoma, cataract was seen as another major cause of blindness in Colonial India. [23] Two kinds of cataract surgeries were available in Britain and its colonies. Eye surgeons used to 'couch' the cataract, by inserting a needle into a lens clouded by the cataract. By using the needle, the surgeon simply 'pushed the lens down or backward into the vitreous-filled cavity' of the eye. This procedure allowed light to enter the eye through the pupil and reach the retina so that the patient could see. Before the surgery, belladonna, a kind of numbing medicine was applied to the eye twice and this was also used to expand the pupil.[24] The surgery took place for 15 minutes and the patients experienced burning but tolerable pain. The couching method of cataracts was familiar in India even before colonization. Monks and barbers performed these surgeries.[25] However, by the 1820s, surgeons started to use advanced methods like extracting the lens entirely. This method involved making a small incision at the corneal flap and lifting it and removing the lens entirely. The procedure required greater knowledge in eye anatomy and surgery and needed special instruments. The main problem with this method was that to hold the lens in a required position, patients were asked to stay inside a dark room without any movement because eye stitches were not widely practiced. [26]

Ophthalmologists in Colonial India tackled eye diseases with the help of a special instrument known as the ophthalmoscope. In 1850, Herman Von Helmholtz invented the ophthalmoscope which provided great help to the later surgeries related to glaucoma and opened a door to the anatomy of the eye.[27] The instrument was commonly used in the eye hospitals of India and it helped doctors to detect diseases in the eye as well as diseases related to hypertension, brain tumours, and heart diseases. The instrument also helped in prescribing power lenses for the people according to their needs, instead of the earlier practice of prescribing glasses based on age. The use of the instrument in India also helped

[23] J. H. Hutton, 1931 Census of India: Vol. 2 Tables (Delhi: Manager of Publications, 1933) 260–261.

[24] Carpenter, "A Cultural History of Ophthalmology."

[25] Couching practiced by monks and barbers were criticized for the use of non-sterilized instruments which further spread eye infections. The biggest challenge that came with the couching method was that the temporary folded lens came back to its normal position and the cataract returned to normal. This could happen anytime, after days, months or years and the people were forced to undergo couching now and then. Hutton, 1931 Census of India, 128.

[26] Ibid.

[27] Daniel M. Albert, "The Development of Ophthalmic Pathology," in *The History of Ophthalmology*, ed. Daniel Albert and Diane D. Edwards (Cambridge: Blackwell Science, 1996), 65–106.

in performing a surgical procedure called 'iridectomy' which was introduced by Von Graefe.[28]

Another common reason for blindness in Colonial India was neo-natal eye infections which were persistent among infants.[29] This infection occurred during delivery through the birth canal. Local midwives who were called *dhai*s were accused of spreading eye disease among infants.[30] Practitioners of Western medicine criticized them for their unsanitary practices during childbirth.[31] Native doctors were also criticized for their practice of pouring fresh blood from a calf on the eyes of the infected infant.[32] In 1881, German obstetrician Karl Siegmund Franz Crede found out that putting a single drop of 2 percent solution of silver nitrate in the eye of a newborn could eradicate ophthalmia neonatorum, and this was adopted by British surgeon Simon Snell, and he reported that 40 percent of infants in the Sheffield Institute for the Blind were helped by the use of this solution. Initial careful cleansing of the infant's eye with clean water was enough to eradicate chances of blindness among children, and this practice was common in the Indian mission hospitals where midwives were asked to watch out for cases of infection among infants.[33] This precautionary measure reduced the cases of ophthalmia neonatorum drastically in Colonial India.

Medical training of the local midwives (*dhai*s) heavily reduced infant blindness in Colonial India. *Dhai*s belonged to the lower strata of the society and were friendly to the village flock, old, experienced, and most kept clean habits to their occupation.[34] They also were given the duty of taking care of the mother and child. Colonial missionaries like William Ward believed that *dhai*'s method of childbirth was unscientific and she played a huge role in increasing the number of child mortality and child blindness in Colonial

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[28] Iridectomy was a surgical procedure where a part of the iris was removed to enhance drainage of excess fluid from the eye which reduces the eye pressure and infection related to acute glaucoma. Ibid., 67.

[29] Hutton, 1931 Census of India, 154.

[30] Ibid.

[31] Sean Lang, "Drop the Demon Dai: Maternal Mortality and the State in Colonial Madras, 1840–1875," *Social History of Medicine* 18, no. 3 (2005): 357–378.

[32] M. E. Hume Griffith, *Dust of Gold: An Account of the Work of the CEZMS Among the Blind and Deaf of India, China, and the East* (London: Church of England Zenana Missionary Society, 1927), 5.

[33] Carpenter, "A Cultural History of Ophthalmology."

[34] Julius Jolly, *Indian Medicine* (Delhi: Munshiram Press, 1994), 69.; William Ward, *A View of the History* (Serampore, Mission Press, 1818), 222.

India.[35] James Wise, the civil surgeon of Dhaka in 1871, wrote that infants in India were prone to infections due to the pollutant nature of childbirth, especially in a household where the smallest and darkest room was given to the new mother and infant.[36] Records suggest that Indians *dhai* used dirty rags to clean babies and mothers.[37] Elizabeth Beilby, a missionary physician, wrote that she did not think that all *dhai*s were bad but their lack of knowledge in practicing safe medicine was the biggest problem.[38]

The maternity hospital in Calcutta was established in 1814, under the care of Loudon and Moira who started to train local *dhai*s. In 1840, a 100-bed capacity hospital was established under the care of the Christian Medical Commission (CMC) and trained *dhai*s were appointed to care for the difficult deliveries. In 1852, another hospital was opened in Calcutta and the hospital was specially designed to train both *dhai*s and native nurses to care for both women and children. In the subsequent years, hospitals like Medical College Hospital, Mayo Hospital, Campbell Hospital, Municipal Police Hospital, and North Suburban Hospital were worked along with *dhai*s which increased the practice of safe birth and reduced the number of infant eye infections in Colonial India.

By the mid-nineteenth century, the colonial government established a few eye infirmaries in the main cities of Bombay, Madras, and Calcutta to treat the more serious eye infections among soldiers deployed there.[39] With the help of Parsis and other local communities, an eye hospital was opened in Bombay for the public.[40] These eye infirmaries acted as places where people were prescribed glasses to correct their vision. These hospitals also functioned as treatment centres as well as training sites for the native

[35] Ward, *A View of the History*, 223.

[36] Hannah Catherine, *Women Writing in India* (New York: Feminist Press, 1991), 205.

[37] Margaret Balfor and Ruth Young, *The Work of Medical Women in India* (London: Oxford University Press), 126–127.

[38] E. Beilby, "Medical Women for India," *Journal of the National Indian Association*, no. 76 (1885): 357–65.

[39] Hutton, 1931 Census of India, 155.

[40] Ibid

oculists in Western medicine.[41] These small eye infirmaries also collaborated with the local *dai*s and paid them a sum to report any new cases of eye disability but it was limited to cities.

C. G. Henderson was a British physician who worked in India especially with the blind population. He argued that more than half of the cases of blindness in India were 'preventable' by controlling infectious diseases like smallpox.[42] Blindness in Colonial India was undoubtedly strongly related to smallpox.[43] It was found that smallpox caused blindness among those who had low immunity. The introduction of vaccination to curb smallpox reduced the number of the blind in Colonial India. Many Indians falsely understood the incidence of smallpox in religious terms. The colonial government criticized this and attempted to persuade Indians to take the vaccination. Many Indian parents did not approve of vaccinating their children, which increased the case of child blindness. This hesitation from the parent's side resulted in the passing of the vaccination acts in Colonial India. Along with compulsory vaccination acts, widespread vaccination programmes in India reduced blindness associated with smallpox.[44]

In 1774, Benjamin Jesty in England experimented with cowpox matter and found out that those who were exposed to the virus showed minimal symptoms of smallpox. He created the smallpox vaccine in 1798, and it reached India in 1802.[45] The first dose of the smallpox vaccine in India was given to Anna Dusthall, a child from Bombay, and from then, through the help of local officers, the vaccine was sent to Madras, Poona,

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[41] First-ever glass to help near sight and the far sight was introduced in 1730 and it was with C shaped bridge. This lens had a range of optical power. By 1730, optical glasses were introduced. In 1760, opticians in London created split lenses and these glasses were bifocals which allowed a single glass to be used for both distance vision and reading. By 1850, steel appeared for the making of glasses. From then, the shape and materials used to make glasses changed, but lenses were similar until the end of the nineteenth century. The College of Optometrists, "Eighteenth Century Spectacles." https://www.college-optometrists.org/the-college/museum/online-exhibitions/virtual-spectacles-gallery/eighteenth-century-spectacles.html

[42] Hopkins Donald, *The Greatest Killer: Smallpox in History* (Chicago: University of Chicago Press, 2002), 53.

[43] B. L. Henderson, *Blindness in India and the Possibility of Its Diminution* (St Leonard: King Bros and Potts, 1917), 7.; J. Banthia and Dyson Tim, "Smallpox in Nineteenth Century India," *Population and Development Review* 25, no. 4 (1999): 649–680.

[44] C. Lahariya, "A Brief History of Vaccines and Vaccination in India," *Indian Journal of Medicine* 139, no. 4 (2014): 491–511.

[45] The College of Physicians of Philadelphia, "The History of Vaccines." http://www.historyofvaccines.org

Hyderabad, and Surat.[46] The vaccination was not received positively from the people due to a small fee needed to pay and also because of the opposition from *Tikadaars* who were traditionally associated with the smallpox treatment.[47] By the second half of the nineteenth century, the fee was banned which increased the number of people who were ready to be vaccinated.[48] Later, the sanitary department and urban dispensaries took the responsibility of vaccination, and from 1880, vaccines were locally produced in Bombay.[49] Consequently, the vaccination programme drastically reduced the number of smallpox-affected blinds in Colonial India.

5.2. Medical Interventions and Orthopedic Disability

Orthopedic disabilities are those kinds that limit a person's physical movements or impair any voluntary and non-voluntary mobility in partiality or totality. The common causes for orthopedic disability in Colonial India are classified as congenital and developmental.

When it came to orthopedic disabilities, colonial records—both administrative and medical, omitted from counting this group of the disabled population in India. However, some district records talk about an orthopedic disability known as *kungja*. Weakness and irregular motions of the muscles in the knee were the characteristics of this disease. The knees of those who had the condition were bent with irregular motion and tremors. It was noted that the disease was not congenital but due to a virus. The virus attack left a patient with a confirmed and permanent bend in the knee. The symptoms were worsened without treatment and resulted in paraplegia and uncontrollable muscle tremors.[50] Sleeman in 1833 wrote that the condition affected the poor population. Many people within days became paralyzed and the improvement of the condition varied from person to person. According

[46] S. Bhattacharya, M. Harrison, and M. Worboys, *Smallpox, Public Health and Vaccination Policy in British India, 1800–1947* (Hyderabad: Orient Longman, 2006), 68.

[47] D. Wujastyk, "A Pious Fraud: The Indian claims for pre-Jennerian smallpox vaccination" in *Studies on Indian Medical History*, ed. Jan Meulenbeld and D. Wujastyk (Delhi: Motilal Banarsidass Publishers, 2001), 121–54.

[48] A. Kumar, *Medicine and the Raj: British Medical Policy in India, 1835–1911* (New Delhi: Sage Publications, 1998), 89.

[49] Bhattacharya et.al., *Smallpox, Public Health*, 69.

[50] Francis Buchanan, *An Account of the District of Purnea in 1809–10* (Patna: Bihar and Orissa Research Society, 1928), 18.; D. Scott, "Letter from the late David Scott, to Mr. C. A. Fenwick, Register to the Local Record Committee, Sylhet, Dacca, 7th March, 1827" in *Memoir of the late David Scott–agent to the Governor-General on the North-East, Commissioner of Revenue and Circuit in Assam,* ed. Adam White (Calcutta: Archibald Watson, 1832), 138–139.

to him, between 1833 and 1834, many lost the use of their lower limbs completely due to this condition.[51]

Poliomyelitis was the main reason for orthopedic disability in Colonial India. Poliomyelitis, often called polio or infantile paralysis is an acute viral infectious disease that spreads primarily via the fecal-oral route. It can cause muscle rigidity, paralytic body, weakness of the muscles, neck, abdomen, and trunk diaphragm, weakness in motor function, damage to cranial nerves, spinal injuries, and tremors. Many people who were affected with locomotor disabilities in Colonial India suffered from polio.[52]

A local dispensary in Baluchistan used to treat two kinds of orthopedic disabilities. One related to polio fever, wherein a child was brought to the hospital for care if he/she had a fever and was unable to move his/her limbs. The first job of the doctor was to control the fever by using a warm bed and by controlling his/her diet. The second kind of disability was induced by complicated childbirth and careless pregnancy. Women and infants who were paralyzed or disabled due to complicated childbirth were brought and treated here.[53] Baschurchu, a surgeon from a hospital in Bombay, recorded that one entire ward was opened in the Baluchistan dispensary for people with birth-related orthopedic disabilities and the charge was given to a surgeon who had experience in working with a European orthopedic centre.[54]

Establishing hospitals specialized in women and child care and training of the *dhai* and native nurses also reduced the number of birth-related orthopedic disabilities in India. Traditionally, to speed up the process of childbirth, perineal massages were practiced by *dhai*s in India.[55] Perineal massages and force pulling of the child from the vaginal canal could harm the fragile body and nerve tissue of infants, which caused trauma-related orthopedic disability in many children.

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[51] W. H. Sleeman, *A Journey through the Kingdom of Oude in 1849–1850* (London: Richard Bentley, 1858), 32.

[52] The polio vaccine was discovered by Jonas Sulk in 1955 and with the help of the vaccine, polio was eradicated in India since 2014.

[53] Denys Bray, *The Life History of a Brahui* (London: Royal Asiatic Society, 1913), 89.

[54] A. Baschurch, "An Orthopaedic Nurse in Nepal," *The Cripples' Journal* 3, no. 12 (1927): 349–351.

[55] Geraldine Forbes, "In search of Pure Heathen: Missionary Women in Nineteenth Century India," *Economic and Political Weekly* (EPW from here) 21, no. 17 (1986): 2–8.

To reduce such kind of unfortunate disabling conditions, Sarah Hewlett, a medical missionary in Punjab worked in association with the Church of England Zenana Missionary Society (CEZMS) and started taking classes for 100 local midwives in the 1880s. It was she who founded the St. Catherine hospital in 1884 at Amritsar with six beds dedicated to women. Rose Greenfield, a nurse, in 1881 set up a one-room dispensary known as Charlotte Hospital in Ludhiana. She with Dr. Edith Brown, a medical missionary, established Women Christian Medical College in Ludhiana. Mrs. Priscillia Sandys opened a dispensary for women where she gave instructions related to general health and childbirth.[56] Mrs. Winter at the same place ran a group called White Ladies Association, and by 1868, she started to train local women in Delhi in obstetrics.[57] Under the care of Miss Engelman, a small dispensary in collaboration with White Ladies Association evolved into a hospital specialized in midwifery. She with Cambridge Brothers established St. Stephens Women Hospital in 1881.[58] Baby welfare clinics were established along with this hospital in 1933, and they employed European doctors and Indian doctors in 1939, which helped early detection of disabilities such as club-foot.[59] These clinics also increased the awareness about the need for nutritious supplements during pregnancy which is important for the muscle and bone development of the fetus. These schools and hospitals medically trained native nurses and midwives and urged the people to practice safe methods of childbirth. Doctors asked local midwives to call them to assist during childbirth and taught them simple anatomy and obstetrics.[60] *Dhai*s and nurses were asked to carry sterilizers, surgical instruments, anesthetics, and apt lightings whenever they out to a private home to attend a difficult case.[61] This practice reduced birth complicated orthopedic disability in Colonial India.

Colonial medical records also talk about amputation, surgery, and paralysis in the context of orthopedic disability. Honigberger, in 1830 wrote that he met with the Military General of Wazirabad in Delhi, who sprained his ankle to the point that the leg inflamed, got infected, and needed amputation. It was found that the general took help from the

[56] Ibid.

[57] Anonymous, *Western, Early History of the Cambridge Mission to Delhi in Connection with SPG* (London: 1902), 102.

[58] Ruth Roseveare, *Delhi Community of St. Stephen's 1886–1986* (Delhi: 1986), 35.

[59] Ibid.

[60] Ruth Dibble, *Voice of a Stranger: Missionary Endeavour in India* (Ludhiana: Fellowship, 1975), 23.

[61] Annual Report of the Society for the Propagation of Gospel in South Punjab for 1939, NAI, 12.

native surgeons and barbers who applied irritants on the leg which worsened the condition. Honigeberger added that under his treatment the leg was saved from amputation.[62] But due to complications from the inflammation, he developed a limp while walking. In 1856, a charitable dispensary in Allahabad provided free consultation and treatment for the 'crippled' from the nearby villages. It was found that a surgeon, Irving, treated many paraplegics through surgery.[63]

One such case of paraplegia was reported from the Mesmeric Hospital in Calcutta. In 1847, Munnoojohan, a peasant woman was admitted to the hospital with partial paralysis. She was aged 40 and had a condition that caused her leg muscles to go weak and eventually lost movement under the waist. She was not able to walk unassisted by a family member. The lady was treated in the Mesmeric Hospital in 1847 and eventually cured of her disabling condition. Her post-operative care was provided by the hospital and after initial trouble with fever, she was discharged with functioning limps in less than two months.[64] The hospital was founded by Dr. James Esdaile in 1846. He experimented with mesmerism and performed many surgeries and amputations for similar patients. He was given a special ward for surgery in the Calcutta Native Hospital.

Shortt in 1858 reported that he used to treat deformities produced by cicatrices (the scar of a healed wound) from burns. He added that it was impossible to count the number of people who suffered this and came to him for treatment. He continued that a majority of the surgeries he conducted were trifling operations that largely removed the effects of the condition.[65] In 1856, an asylum under the name David Sasson Infirm Asylum was established in Saharanpur in Allahabad. The asylum provided shelter and medical care for the people with orthopedic disabilities and burn victims and no other institution was entirely dedicated to the 'crippled' children and adults. The asylum was associated with a

[62] John Martin Honigberger, *Thirty-Five Years in the East: Adventures, Discoveries, Experiments, and Historical Sketches Relating to the Punjab and Cashmere, etc* (London: Bail Press, 1856), 78.

[63] James Irving, "Notice of a Form of Paralysis of the Lower Extremities," *Indian Annals of Medical Science* 6 (IAMS from here on), no. 11 (1859): 424–134.; James Irving, "Report on a species of palsy prevalent in Pergunnah-Khyraghur, in Zillah, Allahabad," *IAMS* 7, no. 13 (1860): 127–143.

[64] W. Ridsdale, *Records of Cases in Mesmeric Hospital in 1847* (Calcutta: Military Orphan Press, 1848), 27.

[65] John Short, "Medical Topography of Modern Orissa," *IAMS* 5, no 10 (1858): 489–518, 507.

local dispensary, housed children with polio, and treated 31 cases of functional paralysis by 1870.[66]

The civil surgeon of Mussoorie in Uttarakhand was interested in the malformation of hands and feet. He stated that these were irremediable. He further added that this condition caused little inconvenience to the life of people, and it was evident that this orthopedic disability was not seen as a condition that needed urgent medical care. This lenient attitude from the people about orthopedic disability resulted in the discontinuity of the treatment. He stated that out of the nine cases he attended, only three resumed the treatment. In 1880, another asylum dedicated for the orthopedic disabled was established in North-West Frontier Province which was known as Mejah Cripple Asylum. It housed the poor, lepers, and people who were suffering from lathyrism.[67] Along with orthopedic disability, cleft palate as a physical disability was mentioned by Hendley in 1895. He wrote that the condition was rare in Europe, and he corrected many cases of girls and boys in India and some cases of adults too. Cleft palate was locally known as *Ravana Kanda* because of the mutilated look it posed.[68]

Grant in 1898 wrote that he encountered many physical disabilities in India. He stated that locomotor ataxia was common and spinal cord-related and other disabilities like infantile paralysis, pseudo hyperopic paralysis, muscular atrophy, dystrophies, and sclerosis were common.[69] Mr. J. Norman and his wife established a hospital to treat the conditions related to spinal code in Calcutta in 1899. The hospital specialized in children's care. Harnett wrote that in 1927, a Calcutta hospital provided the necessary care to modify walking caliper and splints as a therapy to help patients afflicted with club-foot.[70] A polio clinic and physiotherapy functioned in Ahmadabad in 1943.[71] It is important to note that when compared to other disabilities, information on the type and treatment of orthopedic disabilities in Colonial India lacks details.

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[66] A Gardon, "Malformations of the Hands and Feet," *Indian Medical Gazetteer* 13 (IMG from here on), no. 10 (1875): 121–123.

[67] Ibid.

[68] T. Holbein Hendely, *A Medico Topographical Account of Jeypore* (Calcutta: Central Press, 1898), 57.

[69] R. L. Braddom, *Physical Medicine and Rehabilitation* (Philadelphia: W. B. Saunders, 1996), 135.; A. E. Grant, "Remarks Upon Certain Diseases in India," *IMG*, no. 33 (1898): 47–48.

[70] W. L. Harnett, "The Walking Caliper Splint and Its Uses," *IMG*, no. 62 (1927): 616–618.

[71] Usha Bhatt, *The Physically Handicapped in India*: *A Growing National Problem* (Bombay: Popular Book Depot, 1963), 129.

5.3. Mental Disability and the Origin of Asylum Care

The disease factor of insanity in Colonial India has been extensively researched based on its association with the emergence of modern medicine and institutionalization. It was Ernst who tried to make a connection between psychiatry and colonialism in India. He opined that reading the colonial psychiatry through the prism of medicine ignored other dimensions. Ernst also writes that insane asylums in Colonial India were a 'less conspicuous form of social control.'[72] S. Rajpal, another researcher, argued that colonial psychiatry did not always point to the hegemonic nature of colonialism.[73] S. Sharma argued that the main role of institutions of rehabilitation for the insane was custodial and not curative.[74] David Arnold considers colonial medicine and its treatment of insanity as a powerful tool, a colonizing agent, and an imperial tool for penetration.[75] But the above-stated research underplays the condition of the mentally disabled in these institutions. The main reason for this undertone was that while looking at the insane asylum records, there was no clear and uniform distinction done between the mentally ill and the mentally disabled.[76]

Growing urbanization and the advantages of a growing medical community forced the official and nonofficial realms in Colonial India to take action to medically institutionalize the mentally disabled and ill.[77] The British established insane asylums all over India along with the establishment of hospitals, orphanages, schools, and

[72] W. Ernst, "The Rise of the European Lunatic Asylum in Colonial India," *Bulletin of Indian Medical History*, no. 17 (1987): 94–107.

[73] S. Rajpal, "Psychiatrists and Psychiatry in Late Colonial India," *The Indian Economic & Social History Review* 55, no. 4 (2018): 515–548.

[74] S. Sharma, *Mental Hospitals in India* (New Delhi: Directorate General of Health Services of India, 1990), 9.

[75] David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley, Los Angeles: University of California Press, 1993), 11.

[76] This part of the chapter is an attempt to recreate the history of the mentally disabled in the insane asylums in Colonial India. It was done by reading the insane asylum reports. Even though there were no special provisions available to the treatment of the mentally disabled, general factors related to daily life inside the asylum and treatment programmes were distributed equally among the inmates without having any distinction done based on the nature of their condition.

[77] At the same time in Britain, discussions were taking place about the establishment of a central and unified, publicly controlled, and locally administered 'mad-house system.' Ernst, "Rise of the European Lunatic Asylum," 95.

dispensaries.[78] The first institution for the insane in Colonial India was established in Bombay in 1745 and the second in Calcutta in 1787.[79] Madras Mental Hospital was the first mental hospital established in south India under the care of Surgeon Vallentine Conolly.[80] After the implementation of the Lunacy Act in 1858, new asylums were established in Dacca, Patna, Calcutta, Colaba, Poona, Berhampur, Banaras, Agra, Bareilly, Lahore, Dharwad, Ahmedabad, Sindh, and Ratnagiri. Insane asylums in these cities argued for the segregation of the patients from the mainstream society and supervision and treatment of them with the help of medicine and trained professionals. The Western conceptualization of segregation and medical treatment was advised to implement in dealing with native 'madness.'

This period contributed very little to the development of psychiatry because the above-mentioned plan was only for the sheltering of the 'insane' and no treatment plan was envisaged. Ernst writes that the small institutions established during this period acted as places of 'refuges or temporary receptacles' and nothing more.[81] The first proper insane asylum was established in Lucknow in 1859, and it took two years to find a building for the house inmates. Sixteen asylums out of the total 26 in Colonial India had their origin during the 1860s and the 1870s, and the rest were constructed after the 1870s like the Dacca Lunatic Asylum.[82]

After the Revolt of 1857, the expansion of the medical, military, and legal systems in India contributed greatly to the development of institutional care for the disabled.[83] By using psychiatry and institutional networks, the colonial power in India excised direct control of the population.[84] Between 1858 and 1880, the number of people detained in insane asylums increased, and to meet the demand for more housing facilities, new asylums were built. The population of the insane in asylums was fast increasing. For

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[78] Annual Reports of the Lunatic Asylum in Punjab, Oudh, United Provinces, North-West Frontier Provinces, Central Provinces, Madras, Berar, Assam, Bengal, Patna, Bihar, Orrisa, Rangoon and Burma. All retrieved from Indian Papers, Mental Health in National Library of Scotland (NLS from here).; D. G. Crawford, *A History of the Indian Medical Service* (London: Thacker, 1914), 400, 415, 429.

[79] L. P. Varma, "History of Psychiatry in India and Pakistan," *Indian Journal of Neurol Psychiatry*, no. 4 (1953): 26–53.

[80] Sharma, *Mental Hospitals in India*, 89.

[81] Ernst, "The Rise of the European Lunatic Asylum," 166.

[82] Ibid.

[83] B. Stein, *A History of India* (Oxford: Blackwell, 1998), 242.

[84] T. Metcalf, *Ideologies of the Raj* (Cambridge: Cambridge University Press, 1995), 90.

example, in the Bombay Presidency, asylums in 1864 housed 353 inmates, it increased to 568 by 1865 and to 646 by 1875.[85] In the Madras Lunatic Asylum, the numbers of inmates were 140 in 1867, and it increased to 330 in 1880. By 1885, the number increased and reached 600. The numbers started to fall at the beginning of the nineteenth century and decreased to 559.[86]

The Bengal Presidency had the highest number of asylums in Colonial India and housed the largest number of inmates. The Bengal Lunatic Asylum housed 627 inmates in 1865, and the number increased to 1147 in 1875. The beginning of the nineteenth century saw a reduction in inmates and fell to 955 persons.[87] The number of inmates in the Bombay Lunatic Hospital was 795 in 1900, and increased to 1153 by 1914.[88] The Madras Presidency Lunatic Asylum housed 559 insane in 1900, which increased to 921 in 1914.[89]

Asylum care in India became active after the passage of lunacy acts. The Lunacy Acts of 1858, became a cornerstone for the establishment of formal care for the insane in Colonial India.[90] With the arrival of the lunacy acts, insane asylums proved to be centres for medical, formal, and personal care. Rajpal argues that lunacy laws in India were arbitrary at one level and paternalistic at another.[91]

Just like lunacy laws, another factor that helped the growth of asylum care for the insane in India was James Clark Inquiry. In 1868, Sir James Clark inquired about the existence of mental disorders and asylums in India. In 1868, Sir Stafford Northcore, then the Secretary of State for India ordered James Clark to formulate a survey about mental

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[85] Asylums in the Bombay Presidency for 1864–1865, NLS, 20.

[86] Asylums in the Madras Presidency for 1879–1880, NLS, 18.; Asylums in the Madras Presidency for 1890, NLS, 10.

[87] Asylums in Bengal for 1875, NLS, 28.

[88] Asylums in the Bombay Presidency for 1914, NLS, 9.; Asylums in the Bombay Presidency for 1900, NLS, 11.

[89] Asylums in the Madras Presidency for 1901, NLS, 30.

[90] The Indian lunacy laws also provided a definition for the term 'lunatic.' However, owing to the paucity of research in the field, only a vague definition was possible. The term was defined to mean a person with the unsound mind and incapable of managing his affair and an 'idiot.' Under the acts, the primary care of an insane was given to the family and his/her properties were managed by a curator. Lunacy acts gave power to the government to establish an asylum or to grant license to an asylum. The government had the power to interfere in the matters of maintenance, admission, and discharge of patients and staff in the asylum. All asylums were asked to maintain an average status and were examined by the 'visitors.' S. Rajpal, "Colonial Psychiatry in Mid-nineteenth Century India," *South Asia Research* 35, no. 1 (2015): 61–80.

[91] Ibid., 62.

health in India.[92] Dr. Clark planned to house all those who were considered insane by the British in institutions. He stated that even those who were being taken care of by families and friends should also be admitted to the asylum.[93] Other medical officers like O. Kinealy were concerned about the overcrowding of the asylums and believed that the asylums should provide answers to the problem of pauperism in India.[94] This resulted in strict monitoring of asylum-related matters like expenditure per patient, diet management, and profitable management. Every penny spent on asylum care was audited and all asylum reports dedicated an entire chapter to finances. Due to the budget crunch, many asylums like Midnapur Lunatic Asylum in Bengal and Hazaribagh Lunatic Asylum in Jharkhand were closed in 1877 and 1879. Even though the government was enthusiastic about their role in asylum care, the deficit in funding resulted in slower growth of asylum progress. Miles wrote that another reason why asylum growth was a burden on the government was the flooding of asylums by patients with chronic mental illnesses and disabilities or patients with 'little or no hope' of improvement.[95] Till 1914, insane asylums in Colonial India housed people from poor sections, and their dependence on care in the long term was a burden on the institutions.[96]

5.4. Categorizing Insanity: Locating the Mentally Disabled in Asylum Records

In the nineteenth century, colonial psychiatry believed that there were three causes for insanity—physical, moral, and congenital. The physical causes of mental disorders were mentioned as opium, *charus,* and hemp usage. Spirits, epilepsy, paralysis, and masturbation were also seen as the physical reasons for insanity. As for moral insanity, grief, loss of property, and exaltation were observed to be the main types in this category.

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[92] Ibid.

[93] Ibid., 27.

[94] Asylums in Bengal for 1862, NLS, 13.

[95] M. Miles, *Disability & Education,* 13.

[96] Rather than serving to be a medical institution, asylums in India became a place to house the poor. All asylum annual reports record the background of inmates, and the majority were beggars or ones who did menial work. Most of them belonged to the lower caste. For example, more than half of the inmates from Lucknow Lunatic Asylum turned out to be beggars, labours, and cultivators. Indian Medical Gazette in 1877 reported that it was not fair that the whole responsibility of social relief be entrusted on the shoulders of medical officers. Thus the early nineteenth century saw the rise of two sections, one who believed that it was the duty of the government to provide necessary facilities for the improvement of people with mental disorders, and the second believed that long term asylum care could put a strain on the finance and the government's ability to function. Report of the Asylums, Vaccination, and Dispensaries in Bengal for 1868–1873, NLS, 13.

Congenital was also explained as the main cause for insanity in asylum records. Instead of categorizing people under the category of mania and melancholia, asylum records further divided insanity based on moods, as mental derangements, one featured by visible excitement and the other by depression. The category which featured visible excitement was also applicable to mental disabilities. To compartmentalize further, asylum records also talked about depression which involved some painful sentiment, with a propensity to suicide or homicidal impulse. Colonial psychiatrists argued that conditions characterized by delusions should be treated as a separate section, and idiocy needed to be made a separate category, and epileptic mania should be placed under chronic mania.

According to the Lahore Lunatic Asylum Report in 1868, the first group of people who were admitted to the institutions was tagged under the title of moral insanity.[97] It included both the nature of lascivious, which was defined as addiction to sex and intoxicating substances.[98] Contemporary psychiatry stated that addictions should never be treated along with mental illness or disability, and needed specially designed de-addiction centres for the purpose. Dacca Lunatic Asylum Report stated that it had housed a few inmates whose mental capacities were reduced due to the consumption of opium.[99] The asylum superintendent believed that the ingredients in alcohol caused insanity among the Indian population. Lahore Lunatic Asylum superintendent wrote that either directly or indirectly used as a toxin, alcohol abuse was worrying. He noted that alcohol abuse was causing 'degenerate, vicious and idiotic children.'[100] Asylum records also linked insanity

[97] Annual Report of the Lahore Lunatic Asylum for 1868, NLS, 9.

[98] The first discussion around whether intoxicating substances produced insanity or not started in Colonial India with the news that European and native soldiers were exploiting ganja. The Indian Hemp Commission in 1871 contacted doctors, civil officers, and soldiers for information on the impact of ganja in producing dangerous effects. The main purpose of the inquiry was to restrict the cultivation and sale of the product. In 1873, it was concluded that there was no evidence obtained to prove that there was some relation between the dug and its incentive to crime and the number of crimes in relation to ganja was relatively small. In the end, the colonial government legalized its production and consumption to earn profit. It was added that if the production of ganja was stopped altogether, it could produce an adverse effect where people may start to look for alternatives like alcohol, and the crimes related to alcohol were higher than the ganja. Rajpal, "Psychiatrists and Psychiatry," 15–16.

[99] James Clark, *Sir James Clark's Enquiry as to the Care and the Treatment of Lunatics* (Delhi: Home Department, 1868), 60.

[100] G. F. W. Ewens, *Insanity in India: Its Symptoms and Diagnosis, with Reference to the Relation of Crime and Insanity* (Calcutta: Thacker, Spink & Co., 1908), 21.

with excessive sexual behaviour. Rajpal argues that "excessive sexual intercourse and masturbation were often linked to the degenerate civilization of India."[101]

The second section of insanity included monomania, which was seen as a condition of obsessive behaviour. However, nineteenth century psychiatry understood monomania as partial insanity "conceived as a single pathological preoccupation in an otherwise sound mind."[102] It was characterized by strong emotions like an obsession or love for an object, domination of an idea, irresistible urges to start a fire or steal, depression, and narcissism.

The next groups who were admitted to the insane asylums were maniacs and melomaniacs. Asylum records divided melomaniacs into groups based on the identification of their symptoms like fighting propensity, religious exaltation, and exaltation of position. They further divided melomaniacs into persons with melancholia, chronic melancholia and epilepsy—periodical and hereditary. The last group consisted of inmates with amentia, which was defined as moderate to severe mental disability. This section was further divided into inmates with dementia, imbecility, and hereditary and this was where the mentally disabled occupied a space. Even though there was a blurred division between the categories of mental disability and illness in the asylum reports, the main problem with the asylum was that there were no physical separate sections for the mentally ill and disabled, except for criminal lunatics.[103] The Lahore Lunatic Asylum Report in 1870 showed a new category of inmates added to the mentally disabled. Older divisions and categories were changed. Mania, melancholia, and dementia were now divided into acute and chronic. The last two sections were titled idiocy congenital and imbecility congenital.[104]

The Delhi Lunatic Asylum in 1870 admitted 'a few patients with chronic incurable congenital' mental disabilities and the asylum superintendent reported that this long-term commitment increased the budget and burden on the asylum. The Delhi Lunatic Asylum Report, unlike Lahore Lunatic Asylum Report, gave grave importance to congenital as the main physical reason for insanity. In the year 1870, four persons were newly admitted

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[101] Rajpal, "Psychiatrists and Psychiatry," 8.

[102] German E. Berrios, *The History of Mental Symptoms: Descriptive Psychopathology Since the Nineteenth Century* (Cambridge: Cambridge University Press, 1996), 38.

[103] Annual Return of Patients Under Confinement in the Insane Asylum at Lahore, Under the Charge of the Civil Surgeon for 1868, 1869, NLS, 9.

[104] Annual Report of the Lahore Lunatic Asylum for 1870, NLS, 4.

with congenital mental disabilities. Along with this, intoxications, old age, injury, and epilepsy also were recognized as the physical reasons for insanity. The moral causes explained by the report included anger, religion, fright, and jealousy. According to modern psychology, extreme fright can trigger phobia-related behaviour among people, but the above-mentioned emotions are symptoms of many disorders and not their cause. In 1871, two young people with congenital mental disabilities were admitted to the Lahore Lunatic Asylum.

In the late nineteenth century, colonial insane asylums categorized patients into different categories—curable and incurable, violent and harmless, epileptic and idiots. Classifications were kept for the easy management of the asylums and kept on changing every year. The curable insane were characterized by a person's ability to perform assigned work.[105] The definition of 'sane' was changed and fitted into the expectation of colonial psychiatry. Rajpal argues that "the idea of curability meant a change in the patient's attitudes to fit the doctor's or white man's expectations."[106] The incurable patients were mentally disabled, and people whose ability to do things was 'limited.' The criminal lunatics were put in the category of violent and they were confined to different cells inside the wards of other patients. The epileptic and idiotic were congenital mentally disabled and put in one part of the asylum for 'special' care they needed but no segregation of physical space was provided.

Classification of insanity in Colonial India and asylum records was influenced by the classifications prevalent in England. Ernst argues that these categories were 'refashioned' to fit the needs of colonial context and to justify their 'peculiar' social and racial prejudices.[107] Rajpal also argues that "both language and culture proved to be crucial entry points into what constituted madness in the asylum's records."[108] Annual returns of the Indian asylum records show that primary categorization was carried out based on the nature of insanity. The first section was divided into curable, incurable, and

[105] Constance McGovern, "The Myth of Social Control and Custodial Oppression: Patterns of Psychiatric Medicine in Late Nineteenth-century Institutions," *Journal of Social History* 20, no. 1 (1986): 3–23.

[106] S. Rajpal, *Curing Madness: A Social and Cultural History of Insanity in Colonial North India* (Oxford: Oxford University Press, 2020), 8.

[107] W. Ernst, "Racial, Social and Cultural Factors in the Development of a Colonial Institution: The Bombay Lunatic Asylum, 1670–1858," *International Asian Forum,* no. 22 (1991): 61–80.

[108] Rajpal, *Curing Madness,* 18.

congenital. This clear, easy, and flexible categorization was very popular among asylum records because of its great practicability and helped asylums in managing their inmates.

Secondary level patients were divided into acquired or non-acquired forms of insanity. Many mental disorders were a part of the acquired form and in the other section, idiocy and epilepsy were included. Mills wrote that throughout the Victorian period, idiocy was categorized based on its manifestations.[109] The nineteenth century psychiatrists understood that insanity was not congenital, not acquired by birth, and 'idiocy' was seen as 'insane by birth' and having 'no mind at all.'[110] It was believed that their state of mind was the result of a malformed skull. In Britain, separate asylums were provided for the congenital mental disabled. Asylum superintendents or the staff in India were trained in surgery or family medicine, not in psychology or psychiatry. Thus providing separate asylums for 'imbecile' or 'idiotic' were not practiced in India.

Paralytic dementia was another type of insanity affecting patients admitted to the asylums in India. The condition was caused by end-stage syphilis and many patients suffered from dramatic euphoria, delusions, hallucinations, and brain fog which usually led to the loss of mental abilities permanently. Mercury paste was applied to the sore to reduce the brain impact but this caused nausea and pain. They were provided with waterbeds for comfort and conventional treatments never worked until the use of penicillin in 1940.

The vast majority of research dealing with insanity and insane asylums in India does not talk about the admission of the mentally disabled to these institutions. Locating the mentally disabled while combing through the asylum records poses a difficult task but is important for understanding how colonial medicine treated the mentally disabled. Rikhye wrote that the mental hospital in Calicut provided special medical and personal care for persons with mental disabilities.[111] Madras Lunatic Asylum Report in 1921 mentions the existence of the mentally disabled and the role of the asylums in teaching

[109] J. Mills, "The History of Modern Psychiatry in India, 1858–1947," *History of Psychiatry* 12. no. 48 (2001): 431–458

[110] David Wright, *Mental Disability in Victorian England: The Earlswood Asylum, 1847–1901* (Oxford: Oxford University Press, 2001), 107.

[111] Doris Catherine Hall Rikhye, *Mentally Retarded Children in Delhi, India: a study of nine schools* (Ann Arbor: University Microfilms, 1980), 7.

idiots 'proper social behaviour.'[112] In 1922, the asylum had housed a total of 1287 inmates and among them, 48 were mentally disabled.[113]

Few doctors in Colonial India were against the housing of the mentally disabled along with the mentally ill. In many asylum records, visitors of the asylum transferred the mentally disabled from the care of asylum to hospitals. For example, the Amaravati Andhra Lunatic Asylum Report talks about a boy who was transferred to the care of the Amaravati Charitable Dispensary in 1882. He was mentally disabled and the visitors considered him as a case with no chance of improvement. The visitors wrote that he should be removed from the asylum because there was no treatment for his condition. They went on to say he should be placed in almshouses if such entities existed and failing these, "the producers of such monstrosities must be content to bear the burden."[114] This callous remark occurs during a lengthier, more humane argument about the balance of duty between public and private resources for the treatment of the mentally disabled. The writer believed that the insane could be treated and discharged, whereas the mentally disabled could not, so the asylum should not progressively become filled with the latter, to the detriment of the former. Variations of this argument recur in other asylum reports.[115]

The Delhi Lunatic Asylum in 1870 admitted 13 inmates who had some kind of mental disability. They had a violent past, an excited state, and a problem with communication. Among them, one boy was taken from the street who had congenital 'idiocy.' In 1870, the Delhi Lunatic Asylum witnessed the death of Sundual Khan, an old-age mentally disabled. The report said that they could not do much to help him as his disorder 'was of his brain.'[116]

In 1838, in Dacca Lunatic Asylum, one boy was admitted. The boy was 14 years of age and had an unknown family origin. He was found in a nearby jungle at the age of 10 and was brought to Guwahati at first. After his admission to the asylum, he was able to do what he was asked to do, but never really showed any kind of 'intellect' regarding communication or social skills. He used to bite his fellow mates and did not eat, walk or

[112] Annual Report of the Madras Lunatic Asylum for 1936, NLS, 3.

[113] Progress Report of the Lunatic Asylums in the Madras Presidency for 1922, NLS, 14–15.

[114] Report of the Amraoti Lunatic Asylum in the Hyderabad for 1881, NLS, 5.

[115] Ibid.

[116] Annual Report of the Delhi Lunatic Asylum for 1870, NLS, 22.

sleep. The boy died in 1852 after he became ill.[117] Punjab Lunatic Asylum housed a girl of 8 years of age. She was found wandering by a man and was termed a 'wolf child.' She was put on behavioural therapy and was able to understand simple commands but never attempted to speak. She was transferred to an orphanage in Agra and she found happiness in playing, but her intellect never really improved.[118]

Many instances of 'harmless idiots' who were most likely suffering from cognitive disabilities were transported to other places due to the overcrowding of the asylums. From 1841 to 1867, the mentally disabled were taken from Madras Lunatic Asylum to Monegar Choultry in Chennai. This institution was used as a famine asylum in 1782 by the Native Poor Fund Committee and later was used as a charitable home housing people with disabilities.[119] By 1853, the asylum housed 49 mentally disabled inmates, out of which 25 of them were employed in light occupations daily for a few hours by sweeping, cooking, and collecting water.[120]

In 1856, Madras Lunatic Asylum had a native infirmary, which housed the mentally disabled before they were admitted into the asylum. The asylum had a total of 163 insane kept inside the infirmary during 1856, of whom 29 were mentally disabled. The patients were kept in the infirmary for a few days for observation where their nature of insanity was examined. If the patient did not improve or turn violent, they were referred to insane asylums.[121]

Cretinic 'idiots' were also part of the asylum system in Colonial India. One Cretin girl was admitted to Oudh Lunatic Asylum in 1910. Her name was Radho and was 30 years old and had two siblings with a normal growth rate. She was born normal size but grew slower than the other children and stopped growing at the age of sixteen. Genetically, her family was clean from any history of dwarfism and disability. She had a weaker intellect and could not understand or utter words. She made sounds that only her mother could interpret. She was given thyroid extract in the asylum and the superintendent

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[117] W. A. Green, "Contributions Towards the Pathology of Insanity in India," *IAMS*, no. 4 (1857): 374–435.

[118] Progress Report of the Lunatic Asylums in Punjab for 1876, NLS, 18.

[119] Frank Penny, *The Church in Madras: being the history of the ecclesiastical and missionary action of the East India Company in the Presidency of Madras in the seventeenth and eighteenth centuries* (London: Smith, Elder & Co., 1904), 430.

[120] Annual Report of the Madras Asylum for 1855, NLS, 8.

[121] Selections from the Madras Asylum for 1857, 1858, NLS, 10–11.

reported that her condition improved slowly.[122] The only group of mentally disabled who was absent in the official record was that of the people with down syndrome. Chand in 1932 wrote that even though medical officers and pioneers in education conducted surveys about the number of mentally disabled children in Colonial India, they could not find a person with down syndrome.[123] Thus he concluded that the condition was rare in Colonial India.

The Central Nursing Home for the Mentally Invalid was established in 1934 in Ranchi. The institution was run privately and provided both medical and educational care to the mentally disabled. Sinha wrote that the number of children with mental disabilities in India was greater and nothing significant was done for their benefit.[124] The Madras Mental Hospital was another institution that admitted children with disabilities. The hospital was established in 1937 and admitted children of the 5–17 age group in a special children's department.[125] It was H. S. Hensmen, the superintendent of the hospital, who formulated a training programme for the children with trained attendees. They used treatments that gave importance to interaction and communication through storytelling, picture cutting, physical drill, play, music, and dance. They were also taught rope-making and carpentry.[126]

There were lone voices about the need for separate asylums for the mentally ill and disabled. Madras Public Department in 1859 demanded a new asylum to reduce the problem of overcrowding.[127] In 1863, W. J. Van Someren wrote that it should be noted that some inmates in the insane asylum were mentally disabled, and instead of keeping them among the mentally ill, there should be new places found for young and imbecile children.[128] Surgeon S. Mason wrote that referring the mentally disabled to separate

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[122] C. H. Ames, "Three Varieties of Dwarfs," *IMG*, no. 45 (1910): 443–446.

[123] The feature of the face of a child with down syndrome is similar to the physical feature of the Mongolian race. Thus they were also known as Mongols in Colonial India. Amir Chand, "A Case of Mongolism in India," *British Journal on Children's Diseases,* no. 29 (1932): 201–205.

[124] S. Sinha, "Learning Curve of a Mentally Deficient Child," *Indian Journal of Psychology*, no. 11 (1936): 223–235.

[125] R. Vohara, "Roopa Institutional Services for the Mental Retardates," *Disabilities and Impairments*, no. 1 (1987): 91–117.

[126] Annual Report of the Madras Lunatic Asylum for 1859, NLS, 4.

[127] Selections from the Madras Lunatic Asylum for 1858, NLS, 10.

[128] Annual Report of the Madras Lunatic Asylum for 1861, NLS, 9.

asylums was constrained by a large number of applications, and fewer homes dedicated only to the disabled.[129]

Indigenous institutional care of the mentally disabled was not unheard of in India and associated with the treatment of microcephaly.[130] The early records of medical treatment of patients with microcephaly were related to the traditional healing practiced in Colonial India in 1857.[131] It was recorded that people with microcephaly were brought and left for care in Chuas of Shah Daulah in Gujarat. Jadunath Sarkar opined that the shrine was mentioned in 1695 CE and people with microcephaly might have been involved with the place long before 1857.[132] From 1857 to 1866, records show that 14 boys and three girls were brought to the shrine for care.[133] Ewens wrote that 'microcelpaths' were different from other mentally disabled with less violent reactions. They were capable of practicing smaller and simpler jobs. Children who were left there were taken care of at the shrine until their death. After 1857, these children were attached to *faqirs* who took them to the streets for begging. Some corrupt employees leased these children to the *faqirs* to be used as objects of the display as it fetched more money out of begging. These men carried them all around Punjab subjecting the children to ill-treatment. However, the condition of children inside the shrine was fairly good.[134]

People with microcephaly were also admitted to insane asylums in India. In 1883, Lahore Lunatic Asylum housed a girl of 16 with microcephaly. The report said that even though her senses were perfect, her intelligence was low and her understanding was equal to a one-year-old. She recognized different people, but could not articulate anything. She swayed her body back and forth and was constantly violent with other patients.[135]

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[129] Selections from the Madras Lunatic Asylum for 1864, NLS, 67–70.

[130] S. G. Chuckerbutty, "The Present State of the Medical Profession in Bengal," *British Medical Journal* 2, no 23 (1864): 86–88.

[131] Ibid.

[132] Jadunath Sarkar, *The India of Aurangzib: With extracts from the Khulasatu-t-Tawarikh and the Chahar Gulshan translated and annotated* (Calcutta: Bose Print, 1980), 99–100.

[133] Mirza Azam, "Vernacular Settlement Report of Gujarat, Abstracted by Wo Fanshawe: An account of Shah Dawla's Chuhas," *The Indian Antiquary*, no. 6 (1897): 176–177.

[134] George Ewens, *Francis William: An Account of a Race of Idiots Found in Punjab* (Lahore: 1903), 330–334.

[135] Annual Report of the Lunatic Asylum in Punjab for 1883, NLS, 3–4.

Another indigenous institution that performed 'healing treatment' to the mentally disabled was Mira Datar *Dargha* in Hyderabad.[136] The *Dargha* was famous for providing healing for people who were epileptic and autistic. This place was listed by William Hunter as an institution visited by many mentally disabled.[137] Autistic and epileptic in Colonial India were looked at possessed by Ghosts and were abandoned in the *Dargha*. Native healing treatment for the mentally disabled in India was associated with religious practices and mostly resulted in the abuse of patients.

5.5. Types and Ways of Treating Insanity

In the nineteenth century, psychologists believed that the non-restraint of the patient could create better chances of healing. This Victorian concept gave importance to a curative environment in British insane asylums. John Connolly, one of the leading researchers of the time on mental health, asserted that asylums completely should avoid physical restraints. He argued that the insane should be treated with kindness and observation should be a major part of their treatment. He and his supporters believed that the moral superiority of the doctor and therapeutic environment could force an inmate to control or change their behaviour. They argued that asylum should work in such a way that the superintendent would behave like a father, inmates as children, and asylum as a home 'for those whose minds had gone astray.'[138] From this, it is evident that, by creating a benevolent ableist treatment atmosphere at the asylums, the mentally disabled in Colonial India were subjected to infantilization. Any treatment, which included bloodletting, was not advised in Britain, especially after Philippe Pinel discarded it.[139] The practice however was common in Colonial India, especially in the treatment that uses leeches. Patna Lunatic Asylum's superintendent wrote in the annual report that he resorted to "topical depletion, applying as needs be, three to twelve leeches to each temple."[140]

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[136] Chuckerbutty, "The Present State of the Medical Profession," 88.

[137] William W. Hunter, *The Imperial Gazetteer of India*, Vol. 13 (London: Turner & Co., 1881), 18.

[138] Rajpal, *Curing Madness*, 18.

[139] Ibid., 19.

[140] Benjamin Rush in the nineteenth century believed that insanity was caused by unbalanced body fluids, especially blood. His theory of balanced body fluid resulted in inventing treatment plan where he forced blisters, vomiting, and bleeding on patients to cure their insanity. This resulted in the death of many patients due to excessive blood loss. Thus to reduce this risk, doctors invented a method of bloodletting by using leeches who believed to suck out toxins from the blood. Mary de Young, *Madness: An American History of Mental illness and its Treatments* (New York: McFarland Press, 2014), 16.; Clark, *Sir James Clark's Enquiry*, 48.

Even though physical restraints were frowned upon in Britain, they became an important part of medical treatment in India. To restrain patients, asylum staff used straitjackets, manacles, waistcoats, and leather wristlets. Use of restraint could go for minutes to hours based on the prescription of the doctors. They believed that restraints kept patients 'safe,' especially in an overcrowded asylum. The major restraints used in the nineteenth India were mittens and straitjackets. Patients were asked to wear mittens to prevent scratching, especially the staff, during the examination.[141] Straitjackets were specially designed jackets that could help an inmate's arms be held tightly across his/her chest.

Conolly's role in making asylums in Britain restraint-free was important and he contributed to the formulation of non-restraint moral management treatment of the insane.[142] Clark's report on Indian asylums also talked about the non-restraint of patients, but Rajpal states that the record did not provide information if any steps were indeed taken to abolish abuse. Throughout the eighteenth and the nineteenth centuries, restraints were used in one or the other form, and especially mechanical restraints. Lucknow Lunatic Asylum reported that civil surgeons approved using only one kind of restraint—straitjackets. Midnapur Lunatic Asylum superintendent wrote that handcuffs and mittens were used for restraint, though was not kept in the asylum and borrowed from the jail whenever needed.[143] In nineteenth century Britain, wooden pens were used to confine criminal or violent inmates, but they were not used in India, and instead, small solitary confinement rooms were used to keep violent or criminal patients.

Many in India supported the non-use of physical restraints and supported the idea of the humane and enlightened curative system.[144] However, not all of them supported non-restraint like Surgeon-Major of Bengal, Payne. He stated that restraints looked like medieval barbarism and non-restraint was a modern and ethical treatment. He added that "but personal restraint is good for the individual subjected to it."[145] He asserted that personal restraint reduced damages to self and others when it came to the mentally disabled.

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[141] Mittens are specially designed gloves with two sections, one for the thumb and the other for all four fingers. Clark, *Sir James Clark Enquiry,* Ibid.

[142] Ibid., 7.

[143] Ibid., 76.

[144] Asylums in the Madras Presidency for 1877, NLS, 12.

[145] Asylums in Bengal for 1868, NLS, 3.

Temporary solitary confinement was also treated as a way of treatment. According to the insane asylum reports, cells seemed to have a great advantage, especially when a patient of 'unstable' mind came for admission. Definitions were given in the annual reports for the word 'unstable' matched with the symptoms of mental disability. Annual reports stated that an unstable person was violent or unruly, or was not able to control his/her gestures, or was noisy, or was 'dangerous' or who could not communicate with other inmates or hospital staff.[146] Lack of communicative ability or lack of an understanding of 'socially accepted' behaviour was understood as the major symptom associated with severe mental disability. At the Dacca Lunatic Asylum, Dr. Wise wrote that he put patients in solitary cells for a few hours. He also sought other treatment methods like daily curtailment of tobacco and giving productive punishments for disobedience and mischief.[147] Rajpal writes that chastisement of insanity was practiced and it could be said that the depiction of an 'ideal' asylum and 'kind and humane treatment of the insane was imaginary as the conditions remained grim.'[148]

Medicines such as hydrocyanic acid, opium, digitalis, tartar emetic, and bromide of potassium were used to treat patients. Patna Lunatic Asylum's superintendent used to prescribe narcotics for those patients who were restless and could not sleep. He also prescribed tartar emetic to subdue excitements in patients.[149] Hydrocyanic acid was used to calm excited inmates. Bareilly Lunatic Asylum superintendent found bromide of potassium to be useful for sleepless inmates.[150] Colonial psychiatrists failed to implement advanced ways of treatments that were already available in Britain, argues Bhattacharya.[151] There is very little information on the treatment of the congenital mentally disabled. Britain was experimenting with new ways of liberal diet, occupational therapy, and amusement, and these all together became an integral part of the treatment

[146] Lahore Lunatic Asylum Report for 1868, 9.

[147] Ibid., 53.

[148] Rajpal, *Curing Madness*, 19.

[149] Clark, *Sir James Clark's Enquiry*, 48

[150] Ibid., 20

[151] Anouska Bhattarcharya, *Indian Insanes: Lunacy in the 'Native' Asylums of Colonial India, 1858–1912* (PhD Thesis: Harvard University, 2013), 143.

plan. However, in the Indian asylums, the diet was too "meagre as adapted to the person in good bodily health."[152]

Bath of surprise, also known as waterboarding, was another method used by the attendees to calm a patient down. If any patient was violent and refused to be cleaned, they were restrained and their head was dunked in a cold-water tub. Asylum staff believed that doing this could bring them back to 'reality.' Some inmates were asked to sit in warm water while cold water was poured over their heads. Other treatments like mesmerism, a kind of hypnotism, alcohol therapy to soothe patients on their deathbeds, and cannabis to produce pleasant feelings among patients were also used in the Indian asylums.

It was in the mid-1800s that the use of drugs to treat mental disorders started to get popular in India. The main purpose of the early drug administration was to sedate patients, especially in overcrowded asylums so that the staff could manage them. Chemical restraints replaced some of the physical restraints used in the early days. Asylum doctors used to prescribe sedative drugs like opium and morphine. Both came with the risk of addiction in patients. Toxic mercury was given to patients to cure the difficulties with mania, and barbiturates were used to put patients in deep sleep to help with the problem of hallucination and excited behaviour. More than treating the patients, available drugs were intended to control their behaviour through sedation. Hydrate chloral was used to treat insomnia associated with mental illness, and morphine was used to control excitement.[153] Alcohol was used to induce sleep and this was common in the Madras Lunatic Asylum. The superintendent of the Madras Lunatic Asylum wrote that he used to give wine to the patients before sleep but he detested the use of opioids. Some superintendents used experimental cocktails to induce sedation. They experimented with a cocktail of drugs like bromide potassium, hydrate of chloral, and morphine.[154]

During the 1930s, another method of treatment that was introduced in the insane asylums of England and the United States was shock therapy. The method was rarely used in India and only a few asylum records mentioned shock therapy. Shock therapy was done by injecting high levels of insulin into the bloodstream until the patient went into convulsion and coma. After several hours, the patient revived from the coma and was

[152] W. Ernst, "The Establishment of Native Lunatic Asylums in Early Nineteenth-century British India," in *Studies in Indian Medical History*, ed. G. Jan Meulenbeld and Dominik Wujastyk (Delhi: Motilal Banarsidass, 2001), 161.

[153] Asylums in Bengal for 1863, NLS, 66.

[154] Asylums in the Madras Presidency for 1879, NLS, 6, 78.

believed to have been cured of 'madness.' The treatment was repeated daily for several months and each patient might undergo up to 50 or 60 sessions. This posed more health risks like amnesia. Another popular shock therapy was metrazol therapy which caused epilepsy-like seizures in patients. The method posed a high risk of bone fractures because of the powerful seizures caused by metrazol. Shock therapies were barred from being used in the asylum because of their high risks, and Electro Convulsive Therapy (ECT) was introduced. ECT was introduced in 1938, and was less dangerous when compared to metrazol therapy because of the use of anesthetics during the process. Surgeon General Whitewell's article in the Indian Medical Gazette stated that ECT was used in the Colonial Indian asylums.[155]

Hydrotherapy was used as a method to cure insanity and idiocy in Europe, America, and India. [156] It was known that the nineteenth century psychiatry associated mental disorders with temperature. They, therefore, tried experimenting with methods that reduced agitation by connecting it to temperature. Doctors felt that using warm-and-cold water techniques could reduce agitation in 'maniacs' and the mentally disabled. Doctors kept patients in either freezing water or hot water for a fixed duration. Hydrotherapy was used as a restraint method to calm down agitated patients and coercive elements were part of it.

Epileptic patients were also housed in the Indian insane asylums. In 1857, the effect of potassium bromide as medicine for epilepsy was discovered and the drug had properties of anti-convulsion and sedation. The same was used to treat many nervous disorders. Many asylum doctors treated epilepsy with arsenic, tonics, leeches, and cold-water therapy. Cupping was also tried to reduce the impact of many mental disorders. Cupping was another conventional method that was believed to draw out noxious toxins from the body.

Until 1914, the diagnostic practices adopted by the British medical officers in India varied from place to place. Terms like 'impulsiveness' and 'obsessive insanity' were used widely in the Bombay asylums. Terms like 'circular insanity' were used in the Madras

[155] R. Whitwell, "Notes on the Treatment and Management of Lunatics in Jails," *IMG*, no. 12 (1894): 28.

[156] Use of hydrotherapy in Europe and American insane asylums was common. Nellie Bly who visited Blackwell Insane Asylum of New York in 1887, wrote that patients were forcefully wrapped in a cloth before they were dunked in cold or hot water. John R. F. Burt and Kathryn Burtinshaw, *Lunatics, Imbeciles and Idiots: A History of Insanity in the Nineteenth Britain and Ireland* (London: Pen and Sword, 2017), 37.

asylums and 'hashish insanity' in Bengal.[157] The treatment plans included classification of the insane, regulation of their social life, recreation, education, cure, and employment. The moral management models entailed that the asylum officers tried to keep the patients in a steady mood, avoid any noise, and control aggression. They should lend an ear to their ramblings and complaints and this would help the patients to calm down. Colonial doctors believed that sufficient cleanliness, a liberal diet, affordable recreation, occupation, and medical care could uplift the insane and reduce the effects of insanity in their life.[158]

Mills wrote that even though many treatments available in Europe were tried in India, they did not work.[159] This was mainly because the superintendents of the medical institutions or asylums in India had no formal training in psychiatric therapy or treatment. Entering the Indian medical field for a European never required any evidence of training or experience, whereas, in the West, those who worked in an insane asylum needed certification in surgery or medicine or anatomy or physiology. Mills also argued that asylum superintendents were amateur psychiatrists and spent limited time in an asylum because asylum care was only one of their many responsibilities.[160]

The development of post-Independence psychiatry and rehabilitation of both mentally ill and disabled can be traced back to innovative service programmes in the 1920s. The Central Institute of Psychiatry (CPI) introduced an occupational therapy unit in 1922 and hydrotherapy in 1923. The institution also conducted programmes on mental hygiene and preventive psychiatry.[161] They also introduced another programme called habit formation chart.[162] In 1922, two institutions collaborated with innovative ideas in mental health, those were Indian Association for Mental Hygiene in Ranchi and the Psychoanalytical Association which was established in 1922 by Girindra Shekhar in Calcutta.[163] CPI collaborated with centres inside and outside Europe and adopted seizure

[157] Progress Report of the Bombay Presidency Asylums for 1914, NLS, 20.

[158] Annual Report of the Lunatic Asylums in Punjab for 1871, NLS, 5.

[159] Mills, "The History of Modern Psychiatry," 440.

[160] Ibid.

[161] S. H. Nizamie, A. R. Davis, and S. Sharma, *Contribution of Ranchi to Psychiatry in India* (Vizag: 36th Annual National Conference of Indian Psychiatric Society, 1985), 30.

[162] O. Berkeley Hill and C. Hartnack, "Freud on Garuda's Wings: Psychoanalysis in Colonial India," *Journal of Mental Science*, no. 89 (1929): 298–301.

[163] D. Bhugra, "Psychiatry in Ancient Indian Texts: A Review," *History of Psychiatry*, no. 3 (1992): 167–186.

treatment in 1938 and ECT in 1943. Drugs like santina, serpasil, meralfen extracted from rauwolfia were used from 1940.

5.6. Occupational Therapy and Its Therapeutic Role in Care

In Britain, the mentally disabled were put through some 'harsh' treatments. People in England were fascinated with 'madness' and 'mad houses.' They paid a certain sum of money to visit the asylums in the same way they visited a zoo. Private madhouses took money from families for admission of their ill or disabled family members. Insane people were harshly treated and kept hidden from the public eye. Some inmates were deliberately killed so that it enables studies about the causes of insanity and the specifics of their anatomy. Edward Wakefield, a member of parliament, visited an asylum in 1815, was shocked to see the condition of the inmates.[164] He ordered an inquiry with a select committee and that marked the beginning of new regulations in the care of the insane in England.

The major change the regulations brought about was the implementation of occupational therapy. Through moral therapy, patients were encouraged to participate in work—both asylum work and production work. It was first implemented in Dundee Lunatic Asylum which asked its inmates to gather potatoes from the farm. More sports activities were later introduced. Leisure activities like dancing were actively conducted, and many doctors vouched that positive mood enhancers like dance and music had a huge role in recovery and rehabilitation.[165] Moral therapy or occupational therapy was adapted in Indian asylums as well.

Occupational therapy gained momentum in the later phase of colonial rule. Occupational therapy was looked at as labour as well as an activity that had therapeutic effects. The insane were made to put in the hard work that was required for maintaining asylums. Dacca Lunatic Asylum's inmates were put in hard labour. The superintendent recorded that inmates were asked to manufacture almirah, chairs, tables and did other jobs related to mending the floor and doors, and oil mill.[166] Labour became an important part of reforming the insane. Ernst indicated that "employment of patients in agricultural and horticultural activities which would guarantee self-reliance in material subsistence was

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[164] Monrose Royal Asylum Progress Report for 1868, NLS, 40.

[165] Ibid., 41.

[166] Clark, *Sir James Clark's Enquiry*, 54.

envisaged."[167] Pot-making, weaving, and gardening were the favourites modes of therapy in the Bengal Lunatic Asylum, and medical doctors were aware of the financial as well as therapeutic benefits of the physical engagements.[168]

Inmates inside asylums helped other staff in running the asylum. The asylum used the manual power of the inmates to continue with some labour inside the walls. Special care was taken to make labour less tiring and physical activities were encouraged. Rewards were given in the form of sweets or tobacco. In 1869, Lahore Lunatic Asylum Report stated that this special training in employment and ordered life made inmates more organized and quieter. The visitors could not believe that these people were put in the institutions for treatment.[169]

Insane asylum annual reports provided a list of occupations inmates used to undertake. Cloth weaving, moonj string-making, and oil-pressing were the main tasks that were assigned to the inmates. Cloth weaving provided the biggest profit as compared to others. The entire asylum work population was divided into cooks, vegetable garden maintainers, bullock keepers, dispensary coolies, sweepers, water carriers, cleaners of wards, floors, and cells, tailors, road menders, and lunatic keepers and hospital attendees.

The free movements of the inmates were restricted unless they were actively participating in labour inside or outside the asylum. Delhi Asylum superintendent Dr. Fairweather wrote that one insane named Ashraff Khan was gradually introduced to the outer world through labour.[170] He was free to roam outside and was working as an assistant keeper before he was discharged. Insane workers completed menial jobs that were given to them and were hardly paid.

5.7. Growth of Therapeutic Architecture in Colonial India

The right environment was considered to play an important role in treating the insane by eighteenth and nineteenth century psychiatrists. While discussing Victorian psychiatry, Showalter wrote that the largest, modern, and most costly asylum Colney Hatch in England was made considering the external environment effect, if any, might have on the

[167] Ernst, "Racial, Social and Cultural Factors," 77.

[168] Progress Reports of the Lunatic Asylums at Bareilly and Benares for 1867, NLS, 57.

[169] Ibid.

[170] Progress Reports of the Lunatic Asylums at Delhi for 1890, NLS, 68.

inmates.[171] The building plan included wards, corridors, chapel, staple, farm, and cemetery.[172] Rajpal writes colonial psychiatry was the surrogate child of Victorian psychiatry and the idea of moral architecture.[173]

Discussions of moral architecture were in full swing in India, but the reality of the asylums remained in a deplorable condition. Asylum conditions in India never improved beyond the 'level of rhetoric' with broken buildings packed inmates like military barracks. Colonial asylum buildings originally acted as places of prison, hospitals, and other such institutions. Only half of the entire building complexes were built new for housing the insane and, the other half of old and empty buildings were reshaped into asylums.

Forced segregation of the insane was very common all over India and Europe mainly because of the stigma attached to mental illness and disability. The fear of the patients becoming a threat to themselves and the general public resulted in the emergence of segregated asylum care. Jeffrey Lieberman wrote that the main purpose of the insane asylum was to enforce separation of insane from society and the reason why such segregation took place was that mentally disabled were considered as 'social deviants or moral misfits.'[174] Gender segregation was common in all Indian asylums whereby women and men were kept separate in different cells. Both had different solitary confinement cells and airing spaces. Jabalpur Lunatic Asylum superintendent wrote that between male and female wards, the mode of communication was only through one door that was locked and the key was kept in the custody of a resident native doctor.[175]

Colonial asylum architecture was designed for internal segregation and it was modeled to segregate males from females, curable insane from the incurable. Even though the gender separation was implemented in toto, the second segregation was not done effectively. This created confusion and problems among the patients. Indian asylum architecture segregated the occupation of inmates also, where different work sheds were provided for males and females. Insane asylum reports claim that asylums especially took care of the recreational needs of the inmates and they were aware of their impact on the

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[171] Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830–1980* (New York: Virago Press, 1987), 23–24.

[172] Ibid., 24.

[173] Rajpal, *Curing Madness*, 19.

[174] Jeffrey Lieberman, *Shrinks: The Untold Story of Psychiatry* (London: Back Bay Books, 2016), 67.

[175] Clark, *Sir James Clark's Inquiry*, 7.

mental health of the admitted persons. Buildings were carefully designed including compartments and seated arrangements so that inmates could have a place for communication. But in reality, the asylums failed to provide any kind of space for amusement and entertainment.

According to the annual reports of the asylums, in-patient wards were divided into two sections—one for the women, and the other for the men. For all wards, three solitary cells were built to accommodate 'dangerous' or criminal patients.[176] Instead of building a separate wing to accommodate the mentally disabled, many were put into these cells inside the respective wards. The Lucknow Lunatic Asylum Report talks about two individual beggars taken from the street, presumably mentally disabled, and put into these cells for being 'dangerous inmates.' The first one was Allee Jaima, a beggar of 40 years of age admitted to the asylum in 1862. It seemed that he was abandoned and lived in extreme poverty and appeared to be weak in intellect.[177] He could not communicate with the asylum staff and died soon. Another patient Subnee, 25 years of age was admitted to the asylum in 1862 under the label of 'dangerously insane.'[178] The report wrote that she was 'wild' and excited and attacked people occasionally. She was abandoned in the street and no inquiries were ever made about her by anyone. The report stated that she spun around all the time, the kind of motion associated with autism. It shows that both of the inmates were mentally disabled but never understood to the such, but labeled 'dangerous.'

Another building section was provided to the criminal lunatic in the asylums. The separate building section had strong partition, and the walls were double the height of the usual walls. But in many asylums because of fund crunch, they were put in a different ward with a small partition or in the cells of the common ward. In Lahore Lunatic Asylum in 1868, only one criminal lunatic was admitted who had a congenital mental disability. His name was Jowahir and was admitted to the asylum in 1869, after being accused of theft.[179] He was kept inside the separate cell of the common ward.

The non-division of the mentally disabled and mentally ill in asylums created many problems for the asylum administrators. Easily manipulated and overly excited mentally disabled inmates created troubles for the caretakers. Lahore Lunatic Asylum's

[176] Report of the Lahore Lunatic Asylum for 1868, 10.

[177] Progress Report of Lucknow Lunatic Asylum for 1862, NLS, 30.

[178] Ibid., 32.

[179] Progress Report of the Lahore Lunatic Asylum for 1869, NLS, 12.

officer narrated one such story that happened in 1868. Keetapai, one of the asylum inmates who was mentally ill, was fond of dogs. He was identified as having paranoia and believed that he was a local deity. The dog and its litter became a nuisance to the other inmates and were relocated. Keetapai was angered by this and attacked the caretakers, and killed one guard. Before the attack, he acquired the bamboo stick he used for attack from the construction site of the asylum. This manipulation and his ability to plan an attack clearly show that he was mentally unwell but not mentally disabled. However, during this fight, Phummon, another inmate who was mentally disabled also joined him. The report stated that Phummon joined Keetapai in a state of excitement and was not aware of the consequences of his action. Together, they killed three people and injured Mr. Wilson, the deputy superintendent of the asylum. They were captured and Phummon received a special omission in the court on the ground of insanity.[180] This is a fine example of how no segregation between the mentally ill and disabled in the asylums posed problems in India.

Medical categorization of the mentally disabled in Colonial India was ignorant about the differences and independent abilities of the mentally disabled in the spectrum based on their severity, course, and duration. No categorization of the mentally disabled in a building can have far-reaching consequences that can restrict both their personal and social roles. Such institutionalization of the mentally disabled results in a phenomenon called secondary disability. Keeping people in a large facility without any specific division can result in a limitation of medical care given. For example, if a mild-autistic child is kept among nonverbal mentally disabled, over time this accommodation setup can limit the verbal development of the child with mild-autism. This is known as secondary socio-genic disability and this can cause greater damages to the person rather than his/her initial disability. Institutional care in Colonial India caused secondary disability to its inmates because no strict architectural categorization was practiced, and these institutions concentrated more on what an inmate expected to do rather than what he/she could do. Such institutionalization also caused withdrawn behaviour and social breakdown syndrome among inmates in India.[181]

[180] Ibid., 5.

[181] Withdrawn behaviour is featured by self-neglect, lack of responsiveness, and avoidance of work or recreation.; Social breakdown syndrome is a condition where an individual is unable to perform daily activities due to his/her mental health.

Inside Indian insane asylums, people were crammed. The reason why overcrowding was common was because of the lack of a correct definition of who was insane. Many people who wandered in the streets, who looked insane and homeless, were taken into the asylum for care, thus leading to overcrowding. Confinement of people who roamed freely in the streets 'who looked lunatic and who can be dangerous to themselves and others' was supported by the British officials and identifying them was a responsibility of the local police or *darogha,* and dealing with their official paperwork became the responsibility of the magistrate.

The individual space dedicated for an inmate was undecided throughout the eighteenth and nineteenth centuries. Dacca Lunatic Asylum superintendent wrote that a criminal lunatic's space was decided to be 54 feet, and for an insane, it was 99 feet, but the spaces were not demarcated since the total space of the asylum was very limited and small. The Calcutta Lunatic Asylum marked 47 feet as the personal space for the insane.[182] Despite the renovation of asylums, it was always damp and dark inside. Any ventilation ports that were present were closed by wooden or metal pipes to eliminate escapes. Asylums became small, hot, closed, damp, and dark places inside the big walls. Finnane argued that colonial government built such institutions and what happened in India was the 'architecture of isolation,' where the buildings were built or reshaped with isolation being the sole purpose.[183] When one looks at the insane asylums situated in Lahore, Madras, and Calcutta, they were isolated, at a geographical distance from the city or the centres of importance. The Delhi Lunatic Asylum was built outside the city wall. This isolated architecture emerged from the shame that was tied to the 'insanity' like a disease and disability.[184]

[182] According to colonial psychiatry, temperature and ventilation had the power to reduce and increase insanity. Doctors believed that asylum should not be kept low and damp. Thus British asylums were made wide with adequate air and light passage. But in Colonial India, all of romantic notions of big, clean, and airy buildings merely remained in the paper. Ernst, "Racial, Social and Cultural Factors," 64–67.

[183] Mark Finnane, "The Ruly and Unruly: Isolation and Inclusion in the Management of the Insane," in *Isolation: Places and Practices of Exclusion,* eds. Carolyn Strange and Alison Bashford (London: Routledge, 2003), 89–103.

[184] Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (London: Tavistock, 1965), 65.

5.8. Daily Life Inside Insane Asylum

Unlike what was claimed in the asylum records, the daily life of the insane in the asylum was difficult due to the lack of necessary amenities. Necessary items provided for the inmates were received by contract and the superintendent could request more items, which needed to be permitted by the visitors. The annual reports of the asylums vividly explained life in an asylum to create an image of an ideal asylum.[185] However, the reality was far from that picture. There was larger neglect, inadequacy, and indifference when it came to asylum care of the inmates. Patients were forced to sleep on a canvas spread on a positioned floor, under which water flushed all year. Patients who could not keep up the required cleanliness or patients who could not clean themselves were left naked in secluded places with no clothes or blankets. Many of these patients were mentally disabled. These patients were given a bath once a week with the help of staff, and at other times, they were left to lie on their waste. Many patients were under-clothed and suffered from extreme cold or heat.

In many reports, superintendents justified the lack of proper necessities stating that Indians were not accustomed to European habits. J. C. Whishaw, Lucknow Lunatic Asylum's civil surgeon, wrote that native patients dined out in the open and when it rained, they dined in covered sheds and there was no provision for a recreational hall.[186] Other superintendents wrote that they used work-shed for a variety of purposes and they let inmates dine on the floor of the work-shed. Asylum rooms were paved with bricks or mud and always were damp with water and urine. Water availability on the premises was rare and had to be fetched from a well, situated inside the asylum or outside of it.

The main problem insane asylums faced was the lack of essentials like bedding, food items, and clothing.[187] According to the records, clothing and necessary bedding were provided to the inmates, considering the weather. Annual reports inform that extra sick, infirm, and congenital 'insanes' were given extra blankets to keep them warm, and their beddings and clothes were organized and cleaned with the help of assistants.[188] But in reality, bedding items were quite insufficient in the Delhi Lunatic Asylum where harsh

[185] Susan Piddock, "The Ideal Asylum and the Nineteenth Century Lunatic Asylums," in '*Madness' in Australia: Histories, Heritage and the Asylum*, eds. Catherine Colborne and Dolly MacKinnon (St. Lucia: University of Queensland Press, 2003), 37–48.

[186] Clark, *Sir James Clark Inquiry*, 23.

[187] Ibid.

[188] Annual Report of the Lahore Lunatic Asylum for 1866, NLS, 3.

weather was a common phenomenon throughout the year. J. C. Penny, the superintendent of the asylum wrote that due to lack of sufficient bedding, during winter, inmates slept on beds of straw and canvas, and in the summer, they were forced to sleep on a canvass spread on a raised platform. He assigned special dormitories for patients who could not take care of themselves and who dirtied the place.[189] Patna Lunatic Asylum's superintendent wrote that Indians were accustomed to sleeping on the floor, thus finding justification for the lack of bedding materials.[190]

A strict diet was a type of treatment in insane asylums. Diet control was looked at as something that possessed healing properties in both traditional and colonial medicine. The annual reports provided a huge list of food items supplied in each asylum. The Indian asylum records stated that the food and diet of the patients were given special care and meals were prepared round the clock. According to the diet chart provided by the annual reports, Indian food was provided in the asylums and the diet mainly consists of food items made of *atta*, *dal*, *ghee*, rice, and vegetables. In reality, however, just like the bedding, food was insufficient for distribution among the inmates.[191] Dairy products were very rare and were only given to people with low immunity and non-vegetarian food items were served only once in a blue moon. This accounted for an insufficient vitamin intake and also made them prone to disease. In Delhi Lunatic Asylum, to make up for the insufficiency of food, women were given less food. Dr. Taylor, the superintendent of the Delhi Asylum wrote that the reason why women inmates were prone to disease and died early was because of insufficient diet.[192]

Many of the inmates could not complain about the lack of proper diet, and it was impossible for the mentally disabled to ask for the food they deserved. They ate what they were provided and did not complain. One criminal lunatic Ashraff Khan protested against the rationing of food items and asked to meet the superintendent. Upon the visit, he asked him to measure the weight of the food that he was served the previous day which he kept

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[189] Annual Report of the Delhi Lunatic Asylum for 1919, NLS, 83.

[190] He wrote that "native custom is entirely at variance with European practice. In nine out of ten cases among the lower classes man, woman and children fall asleep on the bare bosom of the mother earth; in fact, his embraces are more greedily sought after than the more elaborate contrivances of cots." Annual Report of the Patna Lunatic Asylum for 1868, NLS, 48.

[191] W. Ernst, "The Establishment of Native Lunatic Asylums," 161.

[192] W. Ernst, "Idioms of Madness and Colonial Boundaries: The Case of the European and "Native" Mentally Ill in Early Nineteenth-century British India," *Comparative Studies in Society and History* 39, no.1 (1997): 153–181.

untouched. The food weighed more than what was prescribed for him and therefore the matter ended on a good note. Dissent among the inmates about the deplorable condition of the asylums was rare, but inmates often resisted the deplorable condition in many ways.[193]

5.9. Role of the Native Doctor and His Staff

Besides the role of the magistrate, superintendent, and the visitors, no laws did not specify the duties of other asylum staff. Mills argued that the work of Indians had a great role in the asylum's daily life and in taking care of the mentally disabled.[194] Khalid wrote that Indian labour was the backbone of colonial administration including asylum work.[195] However, the annual reports have to say little about the training and appointment of the Indian workers.

Some native doctors used to work in the asylums. In 1869, Lahore Lunatic Asylum employed Mirza Koodrut Ali, a native doctor.[196] Another native doctor who made it to the official records, whose name was Mohendra Nath Roy from Berhampur Lunatic Asylum.[197] Even though the native doctor's presence was not properly acknowledged, he still played an important role in managing the asylum. He was the link between patients and authorities. It was easy for him to work among the natives because he was familiar with the local custom. Ernst argued that the white superior was just a nominal head and he had to work closely with the native doctor.[198] He further added this dual management was intended to increase discipline and social hierarchy inside the asylum setup.[199] The native doctor was housed inside the asylum and was in charge of daily activities in the absence of the superintendent. He was educated and had some medical training without any power of command. Rajpal asserts that the "organization of the asylum was in his hands and he had considerable resources at his disposal."[200]

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[193] Rajpal, "Psychiatrists and Psychiatry,"10.

[194] Mills, "The History of Modern Psychiatry," 163.

[195] Amna Khaldi, "Indigenous Staff, the Colonial State, and Public Health," in *The Social History of Health and Medicine in Colonial India*, eds. Biswamoy Pati and Mark Harrison (London: Routledge, 2009), 46.

[196] Ibid.

[197] List of Asylums in Bengal for 1878, NLS, 23.

[198] W. Ernst, "The Establishment of Native Lunatic Asylums," 139.

[199] Rajpal, *Curing Madness*, 20.

[200] Ibid., 14.

Staff and attendees were an integral part of asylum life. Permanent staff in the asylum were mostly Indians and it was not clear whether they received any formal training. Madras Lunatic Asylum records show that the asylum used to send their male and female warders for training.[201] The number of attendees was small, given the number of patients they had to take care of. In Dullunda Lunatic Asylum in Bengal, 71 staff worked for the care of 215 patients in 1880. In Delhi, 25 staff took care of 73 patients.[202] Many attendees received praise for their dedication like Luchman Singh who became a first-class hospital assistant, and many received harsh criticism for their carelessness and harsh treatment meted out to the patients.[203]

The asylums employed several attendants to handle patients. For every asylum, there were head keepers and one keeper for eight inmates. Asylum employed sweepers, cooks, water carriers when inmates could not do their assigned job themselves.[204] The number of attendants was less than the number that was needed. Male attendants attended male patients and female attendants attended female patients. These attendants were not trained properly and were poorly paid. There was a lack of security and many annual reports mention inmates attacking attendants. Just like the insane, society also discriminated against those who worked in the asylum. The same stigma that was attached to mental disability and illness was attached to anyone who was associated with the institution of the insane.[205]

5.10. Popularization of the Institutional Care of the Insane

Traditionally, India followed a system of family care while dealing with the disabled before institutionalization became popular. Mentally disabled children were depended on their parents and siblings and were provided with both physical, financial, and medical care. They were looked at as a burden on the family due to their 'inability' to earn. Due to this many families abandoned children with mental disabilities in the street because they could not take care of them properly and because of the shame attached to the disorders. Children who were abandoned in the streets lived by begging and were picked up by the police. They were transferred to asylum care and most of the families did not want to do

[201] Annual Report of the Three Lunatic Asylums in the Madras Presidency for 1873–1874, NLS 13.

[202] List of Asylums in Bengal for 1880, NLS, 36, 82.

[203] List of Asylums in Punjab for 1875, NLS, 3.

[204] Moydnapore Asylum Report for 1898, NLS, 76

[205] Ernst, "The Establishment of Native Lunatic Asylums," 106.

anything with them. This kind of admission was known as community admission in Colonial India.

In the nineteenth century, people started to warm up to the idea of asylum care and began to admit their family members. The number of family admissions and community admission were increased. In 1865, Mooloowa, a 22-year-old boy was admitted to the Lucknow Lunatic Asylum with suspected mania.[206] The report suggested that his uncle had no other means to keep him under control. He lacked the intellect and clear communication skills and was very violent and abusive. His uncle stated that he was like this from his childhood and more than mania, it appears that he was suffering from a type of congenital mental disorder. His condition never improved and he was handed over to his mother as per the order of one of the visitors in 1866.[207] Through the community admission, 40-year-old Bhugia was admitted and abandoned in Lucknow Lunatic Asylum in 1863 by her husband accusing her of mania. She was never visited by her family members and her condition never improved. She died in the asylum in 1870.[208] Mills argued that the reason why the number of admissions in the asylum increased was that more Indians realized that there was an opportunity given by these institutions to pass the cost involved "in providing for non-productive members of their families."[209]

The number of self-admissions in Colonial India were very few. The self-admitting people were from the street who looked at the asylum as a refuge from their harsh life. Bhagooie was 45 and lived in Lucknow as a beggar.[210] She admitted herself to the Lucknow Lunatic Asylum and the records state that, when she reached, she was draped in dirty clothes and it appeared that she was a person with weak intellect. She was admitted in 1861 and discharged in 1862 with 'improvements' in health and habits. The asylum record states that even though her intellect was weak she was 'sane' enough to ask for help and understand her situation.

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[206] Annual Report of the Lucknow Asylum for 1865, Case Book II, Patient no. 222 (Lucknow: Government Printing, 1866), 86.

[207] Ibid.

[208] Annual Report of the Lucknow Asylum for 1870, Case Book II, Patient no. 3 (Lucknow: Government Printing, 1871), 302.

[209] Mills, "The History of Modern Psychiatry," 8.

[210] Annual Report of Lucknow Asylum for 1862 (Lucknow: Government Printing, 1863), 33.

After 1914, asylums in Colonial India received sudden popularity. Mills asserted that one reason for this was the universal demand for the institutionalization of psychiatry care, and the second was that greater awareness among Indians about the alternatives to family care. The rising popularity for psychiatric institutions emerged after the First World War when Indian soldiers employed in the war for the benefit of Britain returned home with 'broken minds' and Post-Traumatic Stress Disorder (PTSD).[211] Due to the high demand, asylums were reshaped and integrated into bigger structures gradually, so that they could house a larger number of patients.[212] One such example was from Ranchi where a new hospital for the care of the insane was opened.[213]

The second change of the period was the rising number of patients admitted to the asylum by their families or communities. The main reason for this increased number was the low-cost care provided by the insane asylums. Family care was not possible to be offered for the mentally disabled by all families. The story of Katijibai was an example of this phenomenon. She was admitted by her father and the nature of her insanity is absent in the records. Even though asylums asked the families to pay the very little sum, the richer the family, the more they were expected to pay for the asylum. Upon knowing that he had to pay above the amount he expected, the father of Katijibai discharged her and put her on family care again.[214] Thus it is evident that the admission of some patients in an asylum by their families was purely based on financial considerations.

At the same time, Indians also started to interact with the institution of colonial psychiatry. For example, Sir Jehangir Boman Behram donated a sum of 50,000 rupees to build a new ward at Yervada Hospital in Poona.[215] Staffing at local asylums also started to show some significant changes in this period. Before 1914, the lower grade staff positions

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[211] Mills, "The History of Modern Psychiatry," 53.

[212] Ibid.

[213] Mills argue that even though it may appear that the expansion was rapid in Ranchi, the fight to build a new hospital date back to 1905 when it was decided that Ranchi had the best climate suitable for a hospital, especially for the treatment of insanity. The money proposed for the hospital however had to be spent on the establishment of a new asylum in Berhampur. In 1906, the Ranchi plan was again making rounds in discussions with newly added clauses arranged by C. J. Robertson Milne, a specialist in asylum architecture. The plan was then presented in the conference of officials of the imperial and local government. However, the plan was delayed until 1918 because of the government's hesitation in spending a huge sum of money on grand architecture just for a 'mad house,' especially during the war crunch. Progress Report of the Asylums in Bengal for 1903–1905, NLS, 11.

[214] Ibid.

[215] Ibid.

were given to Indians and all significant posts were reserved for Europeans. However, after 1914, many senior positions were given to the natives. From 1905, European recruitment to the Indian Medical Service (IMS) was limited in order to encourage Indians to enter medicine. Even then, only a few from India reached the posts of colonel and lieutenant colonel. After 1914, the number of native people in IMS increased.[216] War was the main reason for this change whereby European doctors or medical persons who served in India were sent to accompany active units in the war. Thus the native asylums were left to the complete care of Indian medical trainees.

For example, the Thane Hospital and its associated asylum were cared by Rao Bahadur Modi and Dr. K. R. Masani, and for the first time, native doctors exercised some power.[217] From 1859 to 1880, local governments remained content with the facilities and occasionally granted permission to build newer buildings but nothing exclusive for the mentally disabled. Many old asylum buildings were refurnished and replaced. All this brought changes to the future of the mentally ill in India but no changes to the condition and treatment of the mentally disabled.

5.11. The Curious Case of Leprosy and Role of the Medical Mission

Leprosy is a bacterial infection caused by mycobacterium leprae, which is known as a chronic disease in the medical world because it tends to attack superficial tissues, skin, and peripheral nerves. Leprosy causes physical disabilities due to muscular weakness and ulceration. The entire colonial state's policy on leprosy was based on two objectives—to regulate the disease and stop its spread, and to maintain the social distinction between European and Indian upper classes on the one hand, and leprous and disabled beggars on the other hand through institutionalization. In two of these instances, medicine and institutionalization were used as an active tool of segregation by elite Indians and colonial missionaries.

Following are some of the asylums and institutions that provided medical and rehabilitative care for lepers in Colonial India with the help of missionaries and elite natives. In 1831, in Lucknow, Nawab Naseerood-deen Hyder established a poor house in Oudh, which was supervised by Dr. Logan. The institution employed ten surgeons and

[216] M. Harrison, *Public Health in British India: Anglo-Indian Preventive Medicine, 1859–1914* (Cambridge: Cambridge University Press, 1994), 31–34.

[217] Ibid.

invested a huge sum of money in medical care. The house was open to all disabled but gave special preference to lepers, orthopedically disabled, and the old. By 1831, it housed 148 inmates.[218] In Farrukhabad, in 1872, with the help of missionaries, a poor house was built for the care of 63 poor lepers. In Meerut, a poor house was established in 1864 for the care of lepers and poor beggars. The charitable institutions report in Allahabad in 1872 stated that the Meerut house was purchased later by a European where conventional asylum work started.[219] Saharanpur Poor House was established in 1864 which also provided accommodation to lepers. The building had a separate ward for the lepers and the disabled lepers.[220] These institutions were maintained by the authority of the municipality and the main aim of these houses was to eradicate begging in the street.[221]

At Serampore, Mrs. Ann Grant founded an institution that housed 13 lepers who were disabled and were given a place to stay and two pence a week.[222] In 1872, a small house for lepers at Allahabad was founded with the help of missionaries from Oudh.[223] In Almora, a missionary leper house provided shelter to 72 lepers in 1870.[224] In Bahraich, Bhinga Raj Anthalya Asylum for the lepers provided medical care and housed 21 lepers in 1879, 32 in 1880, and 21 in 1882.[225] Raja Kali Shankar Asylum also provided medical care and shelter to the lepers.[226] Bishop John Gabriel Leon Meurin of Bombay established a leper's home at Trombay in 1885, known as Eduljee Framjee Albless Leper's Home.[227] In 1861, in Palliport (Pallippuram), a town near Cochin also had a leper asylum managed

[218] C. Wellesley Bailey, *A Glimpse at the Indian Mission-Field and Leper Asylums in 1886–1887* (London: John Shaw, 1888), 140.

[219] Report of the Charitable Institutions in Allahabad for 1872, NLS, 39.

[220] Ibid., 33.

[221] Ibid.

[222] Sen Gupta and Kanti Prasanna, *The Christian Missionaries in Bengal, 1793–1833* (Calcutta: Firma K. L. Mukhopadhyay, 1971), 136.

[223] A. Walker, Report of Dispensaries and Charitable Institutions of the North-Western Provinces for 1871 (Allahabad: Government Print, 1872), 33–36.

[224] Report of Charitable Institutions in Allahabad for 1875, NLS, 30.

[225] District Gazetteers of the United Provinces of Agra and Oudh (Allahabad: Government Print, 1990), 181.

[226] Dev Raj Seth, *A History of Western Education in India, 1854–1920* (London: Library of School of Oriental & African Studies, 1936), 184.

[227] P. A. Colaco, *A Biographical Sketch: Select Writings of the Most Reverend Dr. Leo Meurin* (Bombay: 'The Examiner' Press, 1891), 179.

by surgeon Father Day.[228] In Poona, another asylum known as Sasson was established in 1865, and by 1883 it housed 26 lepers.[229]

How Colonial India dealt with any disability and disease was never a matter of medicine alone. The case of leprosy was no different and it became a matter of concern when the colonial interests were at stake. Radhika Ramasubban writes that the colonial state's policies on leprosy emerged from a background where the state was concerned about the health of the army, the health of the European population, and its mercantile interests. The health of the indigenous population was a matter of concern when the vital interests were in danger. Jane Buckingham argues that the reason why government policy in Colonial India on leprosy was not efficient was that medicine lacked legal sanction and financial support 'to become an effective tool of empire' and was always subjected to negotiations due to the inconsistency of the state.[230] Many historians, who looked at the history of leprosy, believed that studying the history of leprosy in Colonial India could open windows to the study of social tensions and political trends. This trend is very evident in the works of David Arnold, Ira Klein, and Ian Catanach who tried to establish a connection between colonialism, disease, and resistance. The social and medical impact of leprosy, institutionalization of lepers, the role of missionaries, and the disabling factors of leprosy are some of the important dimensions in need of investigation.

The natives sought the help of local healers at first to cure leprosy. Even though there was a high demand for Western medicine, it was seen as a last resort. This delay in necessary treatment worsened many cases and when they reached the asylums, patients were already disabled. Many who joined the institutions voluntarily could be more hopeful of the medical treatment because they were aware of effective remedies.

To treat leprosy and leprosy-induced disability in Colonial India, the British used both Western and indigenous treatment methods. External methods of treatment were common which included massage sessions of the sores with neem leaves. Internal treatments related to drugs included mercury and arsenic. Fumigation therapy was also used with a cocktail made out of zinc, copper, and cobra meat powder, and carbolic acid. The doctors who worked in the leper asylums came up with new therapeutic plans to help

[228] Selections from the Madras Lunatic Asylum for 1862, NLS, 66–67.

[229] District Gazetteer of the Bombay Presidency, Vol. 18, Part 3 (Bombay: Government Print, 1885), 342–343.

[230] Jane Buckingham, *Leprosy in Colonial South India* (Basingstoke: Palgrave, 2001), 5.

the patients. They used *gurjon* oil (plant-based oil), which was developed by surgeon Dougall from Madras Medical Service (MMS) in 1870.[231] He started to use the oil after hearing about its healing properties. The oil yielded positive results for the affected people in Venezuela. Doctors in Venezuela used cashew nut oil mixed with *gurjon* oil to treat tissue-scarring caused by leprosy. In India, especially in the leper asylums of Madras, *gurjon* oil was taken from a particular type of wood and was prescribed to rub on the skin. The use of *gurjon* oil which was first practiced by a doctor from Port Blair was part of indigenous therapies to cure leprosy. Initially, the oil was used to treat gonorrhea, and later doctors adopted it for the treatment regime of leprosy.

After 1870, *chaulmoogra* oil (Hydnocarpus seed oil) was commonly used and from then onwards the doctors started to decrease their borrowing from the indigenous traditions.[232] *Chaulmoogra* oil was used commonly in Europe and Britain by patients until the introduction of sulphone drugs in 1940. *Chaulmoogra* oil was used widely because it acted as a moisturizer and made skin softer. But it was expensive and the oil was very difficult to obtain.[233] Jane Buckingham argued that the oil was part of Ayurvedic treatment to remove skin infections, but the British promoted it as a specific treatment for leprosy. Along with oil therapy, diet and hygiene were also associated with treatment plans.[234] Since the treatment heavily depended on the amount of care the patient had to take, many found it difficult to follow the treatment plan. Many patients who did not use the oil therapy on regular basis suffered disabling scars and their condition worsened. Many left the asylum and had no means to get the oil outside in the market. Many left asylum care believing in the traditional healing and spiritual practices to cure the disorder. Even though by the end of the nineteenth century *chaulmoogra* oil was used all over India, there was no evidence to suggest the effectiveness of the therapy. The oil was used extensively not because of its therapeutic effects but because concerns about leprosy became acute.

By 1870, leprosy researches and treatment plans received global attention which led to the discovery of bacillus by Hansen. This discovery sparked another debate about whether the condition was contagious and the effects of segregation as a therapy. Amid these debates, the colonial government started to give special attention to leprosy-related

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[231] Ibid.

[232] Ibid., 10.

[233] Wyndham Cottle, "Chaulmoogra Oil in Leprosy," *British Medical Journal*, no. 1 (1879): 968–969.

[234] Buckingham, *Leprosy in Colonial South India*, 86.

researches like H. V. Carter's investigation of leprosy in the Indian Medical Service. He was highly influenced by the researches of Hansen and by the isolation therapy in Norway. However, his work which supported isolation was treated with skepticism by the officers from the sanitary department of India.

At first, the British government did not look at leprosy as a grave danger and was hesitant about public interventions. The disease however received visibility in the second half of the nineteenth century. One reason why it was seen as a concern was because of the international rumour that the West Indies was hit hard with a leprosy epidemic. When the Crown took over the rule of Colonial India, the government ordered a survey of the lepers in India and found the number to be 99,073.[235] This 1862 survey and enumeration led to an investigation about the causes of leprosy in India by the Royal College of Physicians. The British government asked the researchers to find out whether segregation was necessary in Colonial India.

In 1867, the Royal College submitted a report claiming that leprosy was hereditary and no confinement was needed. The report drew considerable criticism because of their overreliance on the research of Danielssen and Boeck, two Norway researchers whose work was looked at as the cornerstone in the scientific study of leprosy.[236] Even in their researches, the nature of transmission of the disease was not finalized, until Hansen discovered the bacillus with the help of germ theory in 1873.[237] Hansen advocated confinement and rejected the hereditary theory, and his suggestions formed the basis of legislation in Norway in 1885, which supported compulsory confinement of lepers.[238] Hansen however was not sure how the transmission of leprosy occurred and he believed that it must be through inoculation and from a leper to a healthy person. Hansen was criticized by those who believed leprosy was hereditary and was also related to the climate.

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[235] Phineas S. Abraham, "Leprosy: An Interplay of Research and Public Health Work," *International Journal Review*, no. 2 (1973): 189–198.

[236] D. C. Danielssen and William Boeck, *Traite de la spedalskhedou elephantiasis des grecs*, tran. J. B. Bailliere (Paris: 1848), 58.

[237] Lorentz M. Irgens, "Leprosy in Norway: An Interplay of Research and Public Health Work," International Journal of Leprosy, no. 41 (1973): 189–194.

[238] Anonymous, *Leprosy in India, 1890–1891* (Calcutta: Government Print, 1892), 417–418.

In 1887, Royal College again conducted another investigation due to the pressure from the government after the Hawaiian leprosy epidemic in 1889.[239] Since the cause of leprosy was identified in 1873, that discovery changed how leprosy was looked at in Colonial India. Medical opinion on leprosy as a contagious disease started to gain momentum in 1889, after the death of Father Damien due to leprosy. Father Damien de Vestuer died due to leprosy after spending time with lepers on a closed island. This reminded the researchers that leprosy might be contagious which increased the call for isolation by the research community in the West. After the death of Damien, a national leprosy fund was established under the power of the Prince of Wales whose job was to appoint a Leprosy Commission in India.[240] In England, there were wide discussions on the cases of leprosy. A. Kanthack wrote that the stories of leprosy were received with too much credulity.[241]

Human touch was understood to be a primary reason for leprosy's spread and the colonial government in India feared that leprosy could spread the infection to Britain and other European countries. Compulsory confinement was vigorously demanded but the government was not sure about how it would affect their image in India. Finally, Leprosy Commission submitted its report stating that the disease was not hereditary but also viewed that among the human groupings, the amount of contagion was insignificant. The report also suggested that segregation was not necessary and this brought criticism from medical and non-medical fields alike. The conclusion on segregation was asked to be reviewed under the power of a special executive committee. The committee declared that the government should take necessary action to segregate patients with leprosy while some members of the committee argued that the possible contagious nature of leprosy was not enough to justify segregation.[242] Kakar writes that the government verdict on leprosy was to appease pressure groups and occasional medical enquires were conducted to justify

[239] Zachary Gussow, *Leprosy, Racism and Public Health: social policy in chronic disease control* (London: Westview Press, 1989), 90.

[240] Ibid.

[241] A. A. Kanthack, "Notes on Leprosy in India," *The Practitioner*, no. 50 (1893): 463–472.

[242] The revised commission report supported isolation rather than environmentalist orientation. The members of the commission reported that the disease was contagious to a point and argued that laws that ensure hygiene should be enforced and there should be a control put on begging and on certain occupations. They were very lenient in their recommendations and moderate to those who supported 'heavy-handed intervention.' Ibid.

political decisions.[243] By 1882, the state washed its hands off quoting public expenses and only voluntary initiatives were allowed.

In 1889, the central government drafted a bill on segregation and asked the opinions of officials, medical men, native chiefs, and researchers. All unanimously suggested that partial segregation was not a solution to the problem and with the support of the Indian elites, the Lepers Act was enabled in 1898. The act enabled forcible segregation of pauper lepers and limited to asylum care of those who were halfway through the disease.[244] Even though the colonial government supported the Leprosy Commission on segregation, there was pressure from the urban elite in dealing with the problem of leper beggars. The act was a political solution to disease and undermined the importance of the disabling medical perspective.

The isolation policy suggested by Hansen in the first Leprosy Conference in Berlin posed two practical problems for the colonial government in India. Firstly, the already strained relationship between a foreign government and natives in Colonial India would get even worse; secondly, the cost of implementation of a widespread policy of isolation would put more strain on the finances of the colonial government.[245] It was during this turmoil that the missionaries stepped forward towards the end of the nineteenth century.

One of the important reasons why leprosy received such attention from missionaries in Colonial India was its association with biblical connotations, and service of the lepers looked at as a Christian and civilizing duty. The increased interest in leprosy was also because the British looked at India as a place of infection and feared the 'racial decline.' By the nineteenth century, leprosy was rare in Europe outside of Norway. Another reason why missionaries took interest in the work related to leprosy was that the contact Europeans had with the places where leprosy was endemic created panic that it might "eat into the nerve tissues of England's people."[246]

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[243] Sanjiv Kakar, "Leprosy in British India, 1860–1940, Colonial Politics and Missionary Medicine," *Medical History Journal*, no. 40 (1996): 215–230.

[244] Report on Papers Relating to the Treatment of Leprosy in India, from 1887–95: Selections from the Records of the Government of India (Calcutta: Government Print, 1896), 304.

[245] Henry Press Wright, *Leprosy and Segregation* (London: Parker and company, 1885), 106

[246] Ibid.

The nineteenth century saw the rise of the biblical discussions on leprosy and the leper-disabled. Missionaries in Europe interpreted passages from the New Testament that related to the healing of lepers at the hands of Christ.[247] Missionaries believed that work related to leprosy was an emulation of Jesus. Missionaries who worked for lepers in Colonial India unapologetically and explicitly wrote that their work was 'biblically prescribed.'[248] Missionaries who worked for lepers continued to be outspoken about the spiritual origin of their work.[249]

Wellesly Cosby Bailey was the first popular missionary who worked for the medical and social care of lepers and the leper-disabled in India.[250] While staying in India, Bailey along with his mentor Mr. Teuther, a German missionary, visited leper asylums connected to the Morrison Mission. Monthly allowance was provided by the municipality and the British officers and civilians gave private donations alike. Bailey wrote in his account that he wanted to give these 'sick and poor' people something to look forward to in life and offered comfort in times of suffering.[251]

The moment Bailey started to work for lepers, he faced a grave scarcity of resources. From 1871, he worked along with his wife, Alice Grahme Bailey, under the direction of Morrison Mission in Ambala. In 1873, he returned to England to raise money for lepers. He was invited to give a speech about the terrible condition of Indian lepers in Monkstown. He distributed hundreds of pamphlets under the title of 'Lepers in India' in the hope of raising funds. Bailey returned to India in 1875 with the support of the missions of the Church of Scotland, was posted in Chamba, and established the first formal missionary asylum dedicated for lepers. By 1878, with the money collected from England, more asylums were established in Ambala, Chamba, Sabathu, and Almora by him. 'Mission for Lepers in India and the East' was formed to distribute the funds equally.

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[247] Many passages in the New Testament speaks about the healing of leprosy, especially in Mark 1:40-42 where a man asked Christ to 'clean' him and Jesus healed him from his disease and in Mathew 10:1,7-8 where Christ asked his 12 disciples to go out and heal all those who suffer from leprosy.

[248] Wellesley Bailey, *The Lepers of Our Indian Empire: A visit to them in 1890–1891* (Edinburgh: Darien Press, 1899), 112.

[249] The Mission to Lepers Report for 1932, Vol. 1, 1933, NLS, 7.

[250] Bailey reached India as an officer in the British army at Faizabad and worked under Rev. Teuther. He also worked as a teacher at a mission school in Ambala. He decided to become a missionary because it gave him social mobility and security. Donald A. Miller, *An Inn Called Welcome: The Story of the Mission to Lepers, 1874–1917* (London: The Mission to Lepers, 1965), 8.

[251] Bailey, *The Lepers of Our Indian Empire*, 113.

From 1886 to 1917, he served as the secretary of the mission and raised a considerable amount of money. By the end of 1917, the mission had helped 15,000 people with leprosy, funded 87 asylums in 12 countries, and worked in cooperation with 37 missionary societies.[252]

In 1874, the Mission Charter was drawn up to provide both spiritual and medical instruction to lepers and children in Colonial India. The main aim of the charter was the eradication of leprosy. By 1910, under the service of the charter, 4500 missionaries were working in India for leper care and 130 missionary societies were associated. 'Mission for Lepers in India and the East' did not directly engage in the mission work in India after the departure of Bailey. Instead, it provided funds to missionaries and mission institutions to work among the lepers. By 1910, it provided help to 19 British, 16 American, and 3 Protestant missionary societies. As the asylums grew in number, the mission employed medical staff and workers from other missionary societies. Those missionaries who were associated with moral and evangelical goals received immense help from the mission.

Under the missionary care, asylums provided segregated wards for both men and women. The children of the inmates admitted to the asylum were removed and placed in another institution to learn the Christian principles. The missions preferred European staff in the asylum rather than Indian natives. All asylum administrators asked the inmates to contribute to the asylum operations as much as they could. The missions believed that asking inmates to participate could teach them a sense of discipline and the ethics of Christian work and service.

Leprosy missions in Colonial India continued the relationship between medicine and Christianity. Even though missions for lepers did not require lepers to convert to Christianity for medical care, it was made clear that receptivity to Christianity was a 'pre-requisite to care.' Dr. Hutchinson, the superintendent of the Sialkot Leper Asylum wrote that he always started his day in the asylum with a small talk about Christianity. When he visited the villages, he also preached along with the distribution of medicine.[253] Rogers wrote that proselytization was easy for the missionaries because lepers were helpless and the staff extended the stay of patients with the promise of medicine and food. The reason why *chaulmoogra* oil was rare was that the missionaries controlled its supply. They envisaged that lepers would return to the asylum if they did not get the medicine in

[252] John Goodwin Bailey, *Wellesley Cosby* (Nashville: Abingdon Press, 1849), 49–50.

[253] Bailey, *The Lepers of Our Indian Empire*, 33.

the market and this gave missionaries the time needed for persuasion.[254] Bailey wrote that if it was the same hand that gave medicine and also provided the meaning of life, patients would choose both without question.

The missionaries supported the government in implementing the 1898 Lepers Act that required the lepers to be put in isolation if necessary. After the enforcement of the act, missionaries were dissatisfied with the government because they could not access resources to fully enforce the act. Missions also had problems with the definition of 'leper' given in the act. The act stated that any person who had ulceration was a leper but the missionaries wanted to include all variations of leprosy. The asylum superintendent meeting report in 1908 and 1913 advised the government to further amend the act. Due to the non-clarity of the definition of the term leprosy, only 10,000 persons were put in the asylums from among 1,50,000 lepers in Colonial India by 1910.[255]

Around this time, the Roman Catholic Church also started to actively participate in the care for lepers in Colonial India. Bailey and his Protestant team lost a huge number of lepers who were dissatisfied due to the lack of funds. They were converted to Christianity by the Roman church. Another reason why people found a liking for the Roman church was the way leprosy was interpreted by the Protestants by using the story of Lazarus. While the Roman church preached that the leper Lazarus went to heaven owing to his leprosy, and the Protestant missions identified Lazarus as a living corpse which description put people off.

John Jackson was a successful London businessman who joined the Mission for Lepers in 1898. In his book, he detailed his travel to India during 1900 and 1901, and included personal observations and descriptions of lepers who lived in Colonial India.[256] Just like Jackson, Bailey also familiarized the life of Indian lepers to the English reading public in England.[257] It served as a descriptive narrative of what a leper's life looked like in Colonial India. The idea of leprosy before these writings was based on imagination and myth. The vivid explanations and attached pictures from the books gave a picture to the Europeans about leprosy. Bailey wrote that "the description of limbless lepers who must

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[254] Leonard Rogers, *The Treatment of Leprosy: In report of a cogenerate of leper asylums in India* (Cuttack: Orrisa Mission Press, 1920), 23, 38.

[255] Ibid., 26.

[256] John Jackson, *In Lepers Land: A record of 7000 miles among Indian lepers with a glimpse of Hawaii, Japan, and China* (London: Society for Lepers, 1902), 208.

[257] Bailey, *The Lepers of Our Indian Empire*, 18.

be carried to receive communion, who lacked hands to receive the communion of water and who lacked lips to receive the communion of wine appealed to all emotional and spiritual sensibilities of their readers."[258] Such literature produced an image of Indians as sick, ill, disabled, and looked at as undesirable, deviant, and pathological. Colonizers used this image to justify their rule in India posing as the rescuers of people in distress. The main aim of such literature was to create sympathy and compassion to raise enough funds for lepers in Colonial India. Missionaries that worked in India used to distribute photographs to their friends whenever they visited their home country. The photographs were captioned with long lines explaining how the lepers in India lived in misery and needed help from Christian brothers. Photographs gave a small glimpse of reality to the European audience.

Bailey wrote about the condition of lepers in Colonial India, and how they became disabled at the end. Lepers were usually cast away from their family and friends and left in the streets to beg or die. Bailey explained that the arms and legs of the people who contracted the disease dropped bit by bit, joint by joint until they had nothing but stumps left. The sores left permanent scarring on the body of the patient.[259] Missionaries like Bailey presented the most horrifying description of Indian lepers in England and it left an image to the English audience that lepers in Colonial India were living in poor and pathetic conditions. Thus the most abnormal portrayal of leprosy became a common description of Indian lepers. This image stayed as the evidence of the 'inferiority' of the Indian race, and for missionaries it provided a practical solution to the problem of fundraising.

Mission publications and asylum annual reports include a description of the inmates housed, their treatment and progress, and importantly the number of the converts and the baptized under the title of 'happy lepers.' Allahabad Leper Asylum's superintendent stated in his reports that people were astonished to see the inmates so happy and that happiness he believed came from the love and service of Jesus.[260] Bailey in his biography quoted the superintendent and concluded that the Christians in the asylums were happy in temperament and they forget the sorrow of their disease before God's love. According to Peter Williams, pathology remained secondary, and the doctors appointed in

[258] Ibid.

[259] Ibid.

[260] Ibid., 19.

the mission's leper-asylums were taught about how spiritual work remained primary.[261] Missionaries who worked for lepers saw conversion as an act of civilization. Sanjay Kakar writes that it is very difficult to divorce the sentiments of religion from the political and social objectives of the imperial interests.[262]

Lepers in the nineteenth century experienced colonial authority through forced public health laws to control epidemics and the establishment of asylums on the model of prisons.[263] Confinement in an asylum for a leper with family support was like a hospital stay to better their condition, and confinement for a person who had no system of support, asylum care was like prison. Mission interventions in the field of leprosy were a mix of medicine, medieval practices, and religious observation. The mission regiment plan was not fixed—it was at times open to modification with the opinions of the inmates.

Leper asylums in India were created somewhat like a monastery with an architecture that supported seclusion and segregation. It did not look like a medical institution.[264] Ambala Leper Asylum was created as separate huts placed in a long row under trees. The diagnosis was the job done by laypersons and this led to many misdiagnoses for leukoderma and syphilis.[265] Inside the walls of these asylums, people were segregated based on their type of disease and sex. Those who believed leprosy was hereditary separated sexes in their asylum which was supposed to break the chain of infection.

Soon, this type of segregation was seen as bad, and D. D. Cunningham stated that government should look at the social dislocatory and economic aspects of segregation. By 1880, segregation increased and sanitary conditions were given less importance.[266]

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[261] C. Peter Williams, "Healing and Evangelism: Place of Medicine in Later Victorian Protestant Missionary thinking," in *The church and healing*, ed. W. J. Sheils (Oxford: Published for the Ecclesiastical History Society by Basil Blackwell, 1982), 280.

[262] Ibid

[263] Buckingham, *Leprosy in Colonial South India*, 98.

[264] Ibid.

[265] In the middle of the nineteenth century, Vandyke Carter visited Norway's leper asylums and found that patients were put under the care of an experienced surgeon who practiced safe methods of surgery and bandaging. This forced the colonial government to recognize Indian asylums as a place for medical practices. Henry Vandyke Carter, *Leprosy and Leper-asylums in Norway: with references to India* (London, Eyre and Spottiswoode, 1874), 13.

[266] Report of a Conference of Leper Asylum Superintendents held at Purulia, Bengal, from 18th to 21st February 1908: Under the Auspices of the Mission to Lepers in India and the East (Edinburgh: Daren Press, 1908), 29.

Begging lepers were placed in asylums and many asylums were removed outside of the town.[267] All this increased the dissatisfaction of the patients. They started to leave the asylum for begging and pilgrimages. Lepers in Colonial India had great mobility and the Rawalpindi Leper Asylum officer wrote that his asylum housed temporary patients from Calicut, Tibet, Bombay, Calcutta, and Madras.[268] The forced teaching of Christian principles also proved to be another reason for the native lepers to leave the asylum. Many mission records denied the force-feeding of religious principles but the alienness of the new religion posed a problem for the native lepers.[269]

Even though there was no evidence to prove that leprosy spread sexually, all mission asylums segregated sexes. Cunningham opined that segregation of the sexes was adopted by the missionaries from the practices of leper asylums in medieval Europe. Children born to lepers were also segregated as a precaution.[270] Missionaries enforced all kinds of segregation vigorously because the donating public in England expected segregation to be enforced.[271] In 1929, Calcutta Conference for Leprosy Asylums reported that sex segregation was practiced to prevent births in the asylum. The superintendent of the Naini Leper Asylum, A. G. Noehren in 1937, enforced segregation notwithstanding resistance from the inmates.[272] This segregation was hugely resisted by lepers because the many who were admitted to the asylum were with their non-infected spouses. Those who violated were punished with excommunication, which implied that religious sentiments prevailed over medical considerations. Many people left the asylums and escaped to other asylums where segregation was not practiced. Naini Asylum in Allahabad provided shelter to such inmates.

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[267] For example, the location for Albert Victor Leper Asylum was settled to be in Gobra, instead of Bengal which was rejected by the sanitary commission. Ibid.

[268] Ibid., 30.

[269] For example, Rev. J. Uffman argued that he never forced lepers to convert in his asylum in Purulia and each inmate was allowed to continue being a part of their religion. However, Gonesh Dutta Sigh, the local self-government minister of Orissa and Bihar wrote that many were converted and were compelled to adopt because the asylum keepers kept the atmosphere largely Christian. Ibid., 31.

[270] T. R. Lewis and D. D. Cunningham, *Leprosy in India: A Report* (Calcutta: Government Print, 1877), 63.

[271] Bailey, *The Lepers of Our Indian Empire,* 10.

[272] Kakar, "Leprosy in British India," 230.

[272] Ibid.

Surgical facilities were also provided in some rare cases. For example, Ernes F. Neve conducted nerve-stretching in the asylum in Kashmir in 1889, where he conducted 270 operations altogether. Even though eye complications were common with leprosy, there was no provision for eye surgery arranged inside the asylum.[273] Europeans founded to find a cure for leprosy, and this obsession with a cure undermined many other treatments like bandaging and ulcer care in the Indian asylums.

Even though asylums were places of medical treatment, no medicines for other diseases were provided until the 1920s when Calcutta Tropical Medicine Institute claimed to have found a cure, which increased the medical presence in asylums. Almora Leper Asylum had no medical facilities until 1929, and the superintendent E. M. Moffatt wrote that necessary actions like operations, bandaging, and pain relief methods were never practiced.[274] There was no dressing system practiced in Purulia Leper Asylum and medical care was limited to experimenting with cures until 1921. In 1927, anti-septic dressings were used and dressing near drainage was eliminated.[275] It is a known fact that disabled bodies in these asylums became an object of medical experiments based on the changing nature of colonial interests.

In 1920, many factors contributed to the betterment of the leper asylums. Medical analysis of leprosy started to be considered as important. Microscopic investigations and laboratory experiments found out that those who were in the first stage of leprosy posed a threat of infection when compared to the later stages. New medicines were introduced and under the care of Calcutta School of Topological Medicine, both medicine and knowledge were disseminated. Leonard Rogers, in 1915, discovered an injection that had active agents of *chaulmoogra* oil.[276] It was difficult for the asylums to accept new treatment regimens when they were specifically dedicated to segregation, diagnosis of ulceration, and religious understanding. This dilemma between medicine and religion, medical care, and religious sanctuaries is explained by J. N. Hollister from Almora. He wrote that the new medicine should serve as many as possible and those who could not return to society due to their mutilation and disability should be kept in the asylum for the sake of shelter.

[273] Lancet, "A Case of Cataract in a Leper: Extraction of Lens, Recovery in Seven Days," *IMG*, no. 1 (1876): 102.

[274] Report from E. M. Moffatt to Mission to Lepers for 1927, quoted in Kakar, "Leprosy in British India," 235.

[275] E. B. Sharpe, *Purulia Leper Colony, 1888–1931*, quoted in Kakar, Ibid., 237.

[276] Leonard Rogers, *Happy Toil: fifty-five years of tropical medicine* (London, Frederick Muller, 1950), 190–194.

W. H. P. Andreson, the secretary of Mission for Lepers, argued that irrespective of whether new medical interventions helped or not, asylums would stand as centres for service and love of Christ.[277]

Summing Up

It is believed that colonial medicine played a major role as an agent of social change rather than that of a scientific agency. The implication of colonial medicine was part of the British agenda of civilizing the orient or civilizing the oriental body. First, they created the 'other' racially, culturally, bodily, and spiritually. But after constructing the 'other,' the colonizer had to manage and subjugate them to discipline and civilize them, as a moral duty and obligation and using all means necessary. The implementation of medicine for the body perpetuated the same racial and other ideologies of difference, and bodies became the medium through which these differences were inscribed. The native's disabled body was considered malicious, unruly and something to be controlled and civilized. Enforcing medical treatment on the disabled body also enforced that all able bodies should look like the prescribed 'normal' and compulsorily 'able-bodies' became an integral part of the medical discourse. Disabled people were often subjugated and confined in this normalizing process, as missionaries and Western medical professionals imported charity and other European institutions into India. Colonial medical understanding of disability in India was framed in terms of the debates in pathology, spiritual depravity, charity, weakness, and infection. The missionary used medicine as a tool to heal the soul by healing the body. These ideas isolated the disabled and broke the traditional family care system.

[277] The responsibility to distribute new medicine was given to Dr. E. Muir, a native doctor. Asylums adopted the treatment after Muir started to make personal visits. Travancore Asylum in 1920, Champa Asylum in 1921, and Subathu Asylum in 1913 adopted the new treatment regime. Travancore Asylum adopted hypodermic treatment in 1920. Purulia Asylum provided outpatient care and provided treatment to 1000 patients in 1931 but still confined inmates. Mission hospitals such as Manicktolla Hospital provided 11036 injections in 1931. The story of segregation continued, but inmates acted favorably towards the new medicine. Ibid., 236.

[277] Ibid., 227.

Chapter Six

Conclusion

Examining disability and its theories concerning colonialism is important. There is not much attention given to the history of disability in India, especially in the colonial period. Colonial state and its instruments such as government, law, religious policy, education, and medicine depicted the disabled population as passive, sad, and suffering group. Disability care in Colonial India was based on the model of charity and it entailed an image that an 'active' and 'Western' colonial state provided help to the 'passive' and 'oriental victims.' Under colonial rule, disability as a marker of difference had acquired some similarity with race as a marker of difference. Such associations were problematic and posed danger to the disabled community. This perception led to ways of categorizing and subjugating the 'other.'

Colonial census records interestingly used an interplay between colonialism and disability in terms of evolution and degeneration. Colonial anxieties were expressed when they encountered a difference in 'disability.' The 'dumbness' of the people was looked at as 'piteous incapacity.' The 'white' population was regarded as in an 'advanced stage of civilization,' and the 'other' was discussed in terms of being 'degenerative.' When Britain expanded its political, economic, and cultural hegemony in India, bodily differences began to be popularly articulated. The growing impact of colonialism emphasized hereditary and bodily differences as the justification for subjugation. Census records highlight the 'paternalistic' and 'charity' policies of the colonial government and argue that those were used to 'civilize' the 'non-civilized disabled natives.'

It is important to note that the disabled were treated as 'other' in the colonial census records. The records associated race as the major cause for native disability and it created an image where disability was conceptually placed in the orient. Colonial census and medical narratives of disability and disease also gave importance to geographical factors which also intensified the framing of 'otherness.' The Indian subcontinent was pictured as hot and sickly, both morally and epidemiologically. The emphasis on climate as the reason for disability intensified the idea that geography was eminently related to disability. Colonial census records treated the disabled in terms of fantasies based on views of extraordinary, disturbing, and disruptive against a Western imagined 'social norm.'

Colonial law associated disability in three ways—first as a deficit which reduced the status of a disabled from human to an object; second, legislations were subjected to the bodily differences and were not about its social impact and the need for social inclusion; third, there was an excessive presence of corporeal power while dealing with disabilities. Colonial legislation also associated 'reason' to an individual who had a particular kind of body, one that is 'stable,' 'perfect' and having the neutral instrument of the individual will. 'Perfect' was defined in the sense of physical and intellectual capacities of the abled, which were 'absent' or 'limited' in a disabled. A clear distinction of the abled and disabled bodies was elaborated in the colonial legislative discourse.

The definition of the term disability created by the colonial discourse was flawed. There was a lack of attempt to understand the meaning of the term in association with the local political, social, and cultural conditions, especially when the meaning of the term varies from community to community. Instead of looking at how disability was shaped, lived, and experienced, colonial legislation followed a method of comparison of the local to the European notion of 'normality.' This process ignored the role of difference in personhood and bodily interaction in association with disability and the fact that they are fluid and ever-changing. Colonial legislation could not make a distinction between physical dependency and social dependency. They mistook physical dependency for social dependency. Independent living conditions including accessible environment, information, housing, education, employment, technical aid, and personal assistance were not given any importance. This tendency curtailed autonomy and human agency to the disabled and treated the disabled as passive recipients. There was also a lack of involvement of disabled people in the decision-making process.

The education of the disabled, especially of the blind and the mentally disabled, was related to the colonial agenda of 'civilizing mission.' The charity-based special education of the disabled was begun with the talk of the suffering body of the 'colonial other' and with the European belief that 'degraded people need Christian benevolence.' The growing hold of the British empire, development of 'pseudo-scientific racism,' and the proliferating missionary travelogues about India carried the image of racial 'other' to the British public. The 'other' was increasingly associated with bodily differences and they were described as 'savage,' 'wild,' and 'primitive.' At the same time, missionaries also popularized sympathetic narratives of the suffering disabled body in the orient. Disabled bodies were written off as suffering beings who needed rescue. Colonial

missionaries described disabled children as ill-adapted, ignorant, having a propensity for evil, troublesome, and burdensome.

Colonial economic strategies resulted in the increase of poverty, wage gap, inequality, unemployment, and conflict. This impact hit hard on the disabled communities which also negatively influenced small-scale employment opportunities and shattered traditional family support. Colonialism also encouraged violence and war which created more disabled. To justify the harrowing experience of colonialism, civilizing intervention became an important mission that was implemented through special education.

Missionary discovery of disabled people in the orient resulted in the innovation of special education. Missionaries believed that disabled bodies needed rescue from families and they were subjected to moral and physical neglect in the oriental world. Missionary narratives positioned educating the disabled as 'help' and charity to the helpless 'other.' Disabled children were educated in orphanages, asylums, and schools that implemented segregation. Many schools functioned separately from the schools for abled children. Religious socialization was the main agenda of educational institutions. The civilizing mission of the disabled bodies also taught how to eat, dress 'decently,' how to read and write and undergo moral reform. There was an attempt to moralize and 'normalize' the disabled in these institutions. Both the segregation and behavioural therapy models adopted by the missionaries imparted the idea that disabled are 'invalid' and there is a need to be 'corrected.' These special education institutions introduced new manners and style of life which was mainly based in the Western social conduct.

The civilizing model of disability used by the colonial missionaries in India looked at disabled bodies as an error in evolution. Disability was understood as grotesque and non-civilized and this increased 'able gaze.' Disability was looked at with an emotion of disgust with a curious enticement and an object of display. This able gaze evaluated disabled bodies as an object, inferior to the able-bodied. This also divided the people into two sections, one being the 'civilized spectator' and another being a person is in need of 'civilization.'

The missionary narrative of disability was always based on 'overcoming' stories and they transcended the disabled body and its pain into extraordinary or divine which created a religious perceptive of disability. Church in India promoted an image of the divinity of suffering and the miracle of healing among the disabled communities. When native religions placed disembodied and decontextualized knowledge of disability based

on the idea that disability is the result of the sins of previous life, the colonizer introduced a religion that promised heaven to the sufferer. Christianity was appealed to as a religion committed to inclusion. Both the special education programmes and the charity work among the disabled were heavily adopted and implemented Christian values and the understanding of disability. Missionaries treated the 'other' disabled as something to be discovered, conquered, and as exotic curiosities.

Colonial medicine played a huge role in the study of Indian forms of mental and physical disability and its causes. British ophthalmologists who worked in India linked the Indian arid region, hot climate, extreme heat and cold, 'excoriating' winds, sandy plains, small and non-ventilated cramped living spaces, and lack of hygiene as the main reason for Indian blindness. Surgery to help pediatric and old age cataract, early detection of trachoma, and vaccination policy to reduce smallpox blindness was practiced in the eye hospitals where training was also given to native doctors. Orthopedic disabilities were less discussed in colonial records about treatment but some varieties of limb alignments and paralysis were treated by medicine and surgery. Mentally disabled and ill was one group who were institutionalized hugely. Congenital and acquired mental disorders were treated under one institution without any distinction. Criminal lunatics were also committed to treatment along with the mentally ill and disabled. They were treated with physical restraints, temporary solitary confinement, tranquilizers, water therapy, occupational therapy, and modifications in diet and architecture. Lack of necessary facilities and abuse of the patients was a common story in these asylums and these places became a place of control rather than medical institutions. It also destroyed the traditional family care of the disabled in India. Leprosy policy and the segregation of the leper disabled became a matter of governmental strategy based on the changing nature of colonialism and Christian mission in India.

Colonial medicine closely worked with disabled bodies in India through asylum care. The disability care was implemented in two ways, through institutional rehabilitation and correction. Both of them were made real through a process of invalidation of the social reality of the disabled by giving importance to pathology. Invalidation under colonial medicine involved confinement of the mentally and physically disabled based on 'incapacity.' Incapacity was understood as the 'incapacity' to follow European standards of body function. Segregation was practiced through the process of 'correction' in the asylums and rehabilitation centres. Instead of acting as a place of reformative and creative alternatives, medical asylums in Colonial India worked as a place of colonial power where

a system of disciplinary power was imposed. Biological differences of both disability and race intersected in Colonial Indian medicine. Disabled bodies were associated with otherness and races were explained using ideas of medical and psychological 'deformity.' Disability was treated as racial degeneration, and on another side, racial degeneration was treated as the cause for disability. This racial understanding of disability was influenced the medical care of the disabled in India.

Today, disability experiences and disability theories are studied through the eye of inclusion and accessibility. Disability policies are framed to create an equal place for the disabled in society. This approach gives a new outlook to the problem of the disabled as a human rights issue. It is understood that for better implementation of the policies, it is crucial that the disabled people need to interrogate their cultural-psycho-social locations. In contrast, colonial agencies picture the disabled as 'passive sufferers.' They were analyzed in terms of people who were marginalized by Indian customs, and suffered silently, and had no agency. Colonial agencies in India strengthened the othering of the disabled population. The fear of the 'other' forced them to implement exclusion instead of inclusion. This also created an idea of 'normal' based on European fantasy. Disabled people were pushed to a side only dedicated to them being separated from mainstream society. The disabled community in India has been recorded as a group that received benefits from colonial policies, extensive medical researchers, and religious care.

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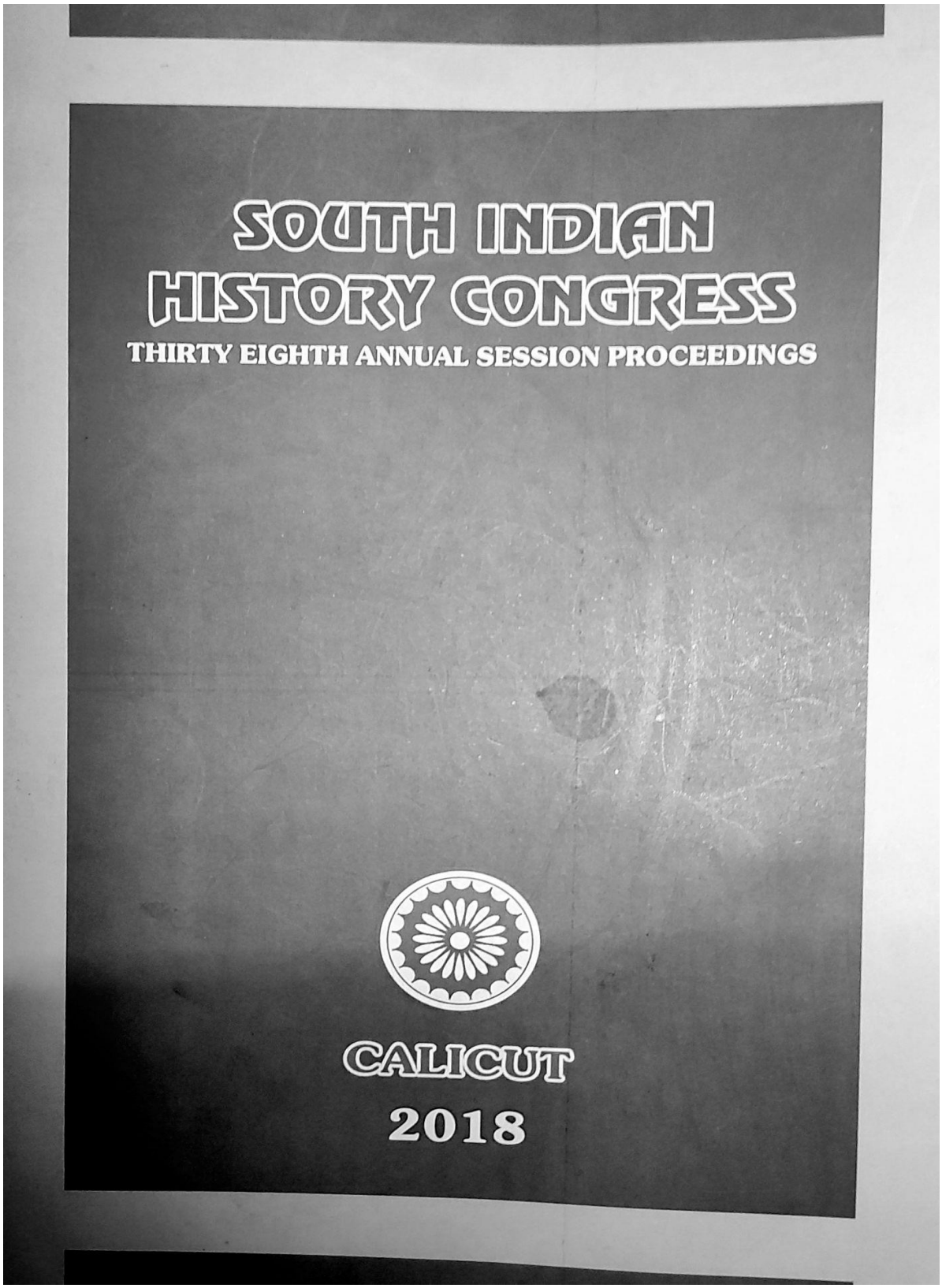
ANNEXURES

Annexure 1. A



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into their daily life and many of them are 'bilinguals' (French and Tamil). The Nationality status helps them to get employment under the French and become an affluent section in the society of Pondicherry through French pensions. Pondicherry has become a 'French Pensioner's Paradise' and they become 'wealthiest' in Pondicherry. The term soldat has become the common term for all the Franco-Pondicherrians and synonymous with affluent or wealthy person. Pondicherry stands as an icon of French culture and the growth of Franco-Pondicherrian population is the legacy of the French culture.

This tiny community of Franco-Indians is the biggest French community located in the East of the Suez Canal. Between India and France, baptisms and marriages are an opportunity to gather dispersed families. The Franco-Indian community is the remaining French aroma of Pondicherry. This intriguing mixing of cultures contributes to the uniqueness and beauty of Pondicherry. Thus, the French colonial rule has brought some social and economic changes in the Indian (Pondicherry) society and led to the formation of a class of people called the Franco-Pondicherrians as the legacy of their culture.

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6. V. Raji Sugumar, op.cit., pp. 154-158.
7. Interview with some Franco-Pondicherrian families.
8. Treaty of Cession provides this clause.
9. My-self attended one of the functions and witnessed.
10. Members of this community revealed in the interview with them.
11. Elected member for Franco-Pondicherrians to represent the French Parliament.
12. Revealed from the interview.
13. Gazetteer of Pondicherry, vol. I, pp. 362-364.
14. Information collected from the Municipal Commissioner's Office.
15. Elicited information through discussion with the Franco-Pondicherrians.
16. Gazetteer of Pondicherry, vol. I, pp. 328-346.
17. V. Raji Sugumar, op.cit., pp. 247-256.
18. S.A. Rahman, op.cit., pp. 252-253.
19. Ibid., p. 262.
20. Observed from the Franco-Pondicherrians.
21. P. Raja, A Concise History of Pondicherry, Pondicherry, 2003, pp. 106-109.
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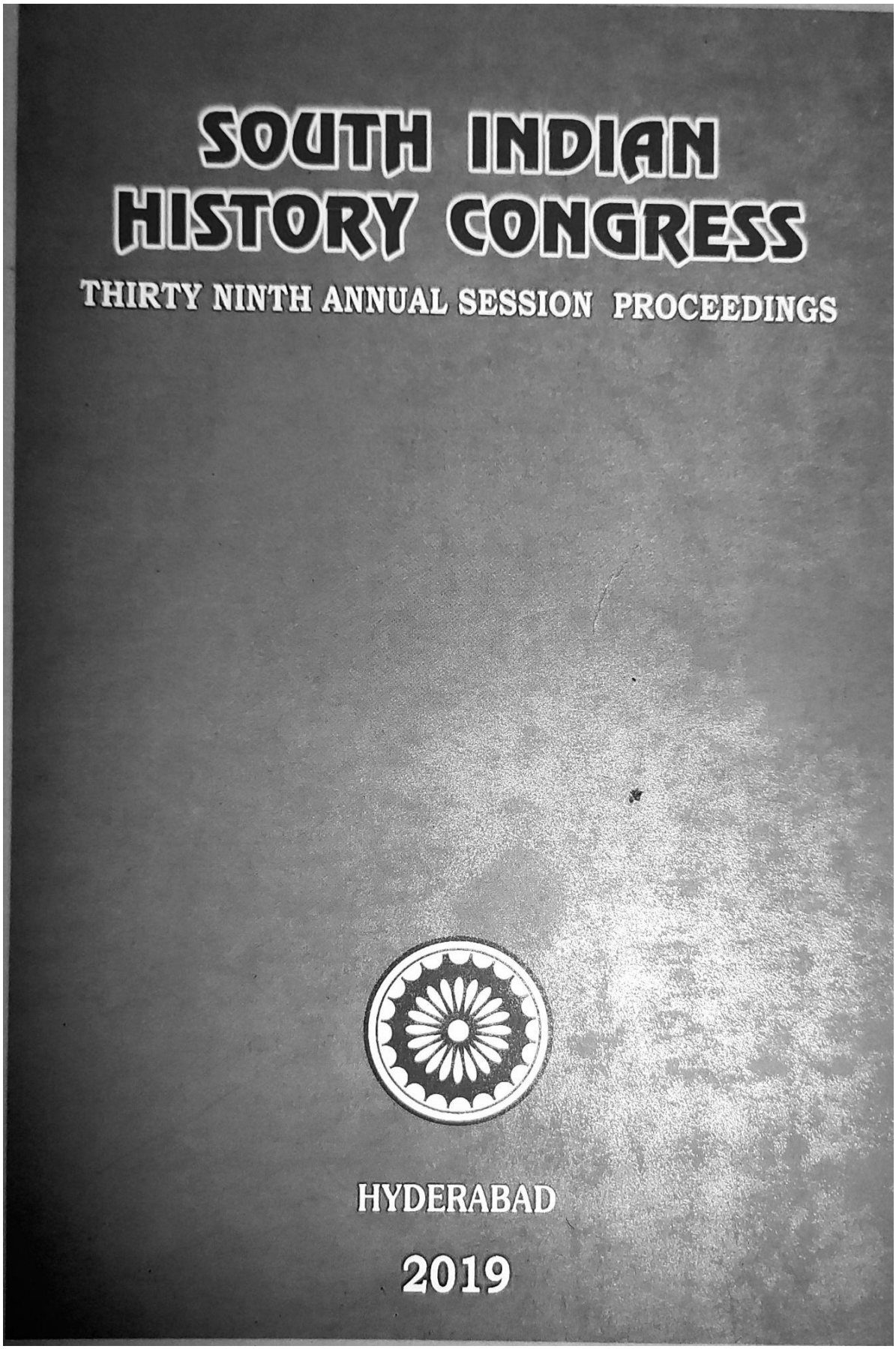
23. V. Raji Sugumar, op.cit., pp. 135-137.
24. The minimum pension received by a French soldier after completing service of fifteen years is around 7000 francs, (now paid in Euros) when converted to Indian money he becomes very rich. By way of pensions, the Reserve Bank of India is getting nearly 150 million rupees as foreign exchange every month.

MEDICINE AS A KEY AGENT: ENHANCEMNET OF PEOPLE WITH DISABILITIES IN THE COLONIAL INDIA

N.V. Baby Rizwana

The idea of disability in colonial India was usually with the colonial context of the health and disease, effects of plague and smallpox and collaboration of Indian medical system with the colonial medical system. However, colonial management, idealization, and institutionalization of the disabled are some of the important areas which are yet to be studied. The modern medicine and the scientific knowledge on physically and mentally disabled people and their treatment did eliminate a certain amount of superstition about disability as monstrous and cursed. The colonial attempt within medicine and psychiatry to study about Indian forms of bodily and mental deviance led to the scientific approach to the study of disability and its causes. This paper aims at looking in to the connection between colonial medicine and its implication and the enhancement of the people with disabilities in colonial India.

Annexure 1. B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necessary for the erection of the building within the fort. A memorandum by Chief Engineer Coimbatore Circle dated 30th January, 1928, that the proposed building to be treated as a tiffin shed for the use of the members of several offices located in the fort, to be auctioned every year. Therefore the sanction of the Government would not be necessary provided the cost does not exceed the powers of the Collector. The Superintending Engineer was required to arrange for the preparation of plans and estimate after obtaining the approval of Superintendent, Archaeological Department and forward it to Collector. An estimate of Rs 2700/ was forwarded and in the proposed construction two stalls, one for Hindus and other for Christians and Mohammedans was detailed.[14] The fort was put to number of uses. School building, offices, prisons, even a tiffin stall was also opened. In the tea stall opened we find separate rooms for the Hindus, Christians as well as Mohammedans.[15] In the beginning, the authorities had plans to demolish it but later changed their decisions. Thus the fort and the surrounding areas always posed a strong symbol of dominance and power of the British rule in India. It is still maintained in good condition by the Archaeological Survey of India.

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1. The treaty of Seringapatam was signed between Tipu Sultan and English and allies, the Nizam of Hyderabad and Peshwas of Marathas, the allies stood to gain on all accounts, acquired many territories in Malabar Tamil nadu, and Karnataka.
2. Proceedings of the Board of Revenue, dt. 31st Jan. 1867, G.A. Ballard, Collector of Malabar to the Secretary of the state to the Board of Revenue dated . 23rd Jan. 1865 , Calicut , RAK
3. Correspondence files relating to Jails, 1878 Palghat Fort, Cantonment from 19th Sept - July 1888, RAK
4. Acting secretary is C.A. Galton
5. IG of Jails is Tennant.
6. File No.235, Correspondence relating to Jails, Palghat Fort, Cantonment from 19th September,to July 1888,RAK
7. File No. 235, Correspondence relating to Jails, Palghat fort, cantonment from 19th Sept. 1878 to July 1888. Regional archives Kozhikode.
8. Pise is a building material of stiff clay or earth, forced between boards which are removed as it hardens.
9. Mr. Tyrrell, permanent keeper, succeeded G.D. Grimes as superintendent of jails in Palghat in Feb. 1879.
10. Letter dated 14th May 1881.
11. Madras correspondence Vol. 4, Sl.No. 1547, Vol. 7876. The date of correspondence is on 14th May, 1857, Palakattucherry
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13. PW&L(1930) Department MS Series, GO NO.3162—W dt.8.11.1930, RAK
14. Department of Revenue , D.Dis File,9021-27 ,DT.2.2.29, RAK
15. Reference to the map attached in which clearly it was shown the space meant for each sections. An indicator to the existence of caste system in the society.

THE CRUCIAL ROLE OF DISABILITY STATISTICS: A CRITIQUE ON COLONIAL CENSUS IN INDIA

N.V. Baby Rizwana

Introduction

Traditionally, Disability Statistics is the information which counts the blinds, the deaf and the loco motor disabled into different groups to decide who deserves several kinds of disability benefits of the existing policies[1]. This categorization and statistical - numerical strategy has got only a limited purpose. Because, this strategy convinces society that disabled fits neatly into certain categories with clear boundaries. But the new studies suggest that this categorization of the Disability Statistics has a lot to provide for the disability welfare plan of the state[2]. A deep understanding of the Disability Statistics provides an important role in the welfare policy making of the state. This set of information can be an asset from the very stage of planning and implementation, in checking the objectives, monitoring the impacts and analyzing cost effectiveness of the policy. Disability welfare policies are incomplete without valid data. The effectiveness of these

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