# The Racial Profiling of Blindness: A Case of Colonial India

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## Abstract

Colonial dealing of disability in India was first started with the enumeration of the blind population. From 1881 to 1931, the colonial censuses included blindness as one of the categories of infirmity in the data collection. The enumerative and medical faculties on blindness in India associated blindness with other marker of differences such as race. While identifying, diagnosing, and recording blindness in Indian society, colonial agencies used a method called racial profiling. Race was understood as the reason for native blindness, and native blindness was understood as the reason for the degenerative aspect of the 'other.' In order to racially profile blindness in India, colonial agencies began to connect geography, climate, diet, living arrangements, and the social habits of India with the rising number of the blind population. This paper aims to draw out obvious connection between racial profiling and enumerative and medical narratives on blindness in Colonial India.

**Keywords**: Disability, Colonialism, Colonial India, Blindness, Race, Profiling, Census and Medicine.

## Introduction

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 a decreased ability to see to the point where it cannot be reversed by the use of means such as glasses and lenses (*Lehman, 2022*). In contrast to the numerous challenges encountered in identifying, diagnosing, and recording the insane, deaf-mute, and lepers, the enumerators found it easier to collect data on the visually impaired in India because they were easy to diagnose. Consequently, it bore less concealment in Indian society because it was palpable. Its physical characteristics allow it to be easily distinguished from other disabilities. The common estimate of the blindness was high throughout colonial census years regardless of the provinces.

While identifying, diagnosing, and recording blindness in Indian society, colonial agencies used a method called racial profiling. Race was understood as the reason for native blindness, and native blindness was understood as the reason for the degenerative aspect of the 'other.' In order to racially profile blindness in India, colonial agencies began to connect geography, climate, diet, living arrangements, and the social habits of India with the rising number of the blind population. Congenital visionary impairment was associated with climate and the specificity of diets in certain regions. The infectious nature of the blindness was connected to the living arrangements and social habits. There was a deliberate attempt at magnifying and misinterpreting facts that supported the argument that native blindness was closely related to the particularities of the race. Thus this paper investigates how blindness was placed as the fault of race in Colonial India by the colonial agencies.

## Defining Blindness

Sensory disabilities are those 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 a decreased

ability to see to the point where it cannot be reversed by the use of means such as glasses and lenses (*Lehman 385*). The main reason for blindness is cataracts. A cataract is a pathology that describes the greying or opacity of the crystalline lens, which is most commonly caused by intrauterine infections, metabolic disorders, and genetically transmitted syndromes (*Mathers and Wright 756*). 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. 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 (*Griff 9*).

## Demographic Distribution of Blindness in Colonial India: 1881-1931

The 1881 Census was the first synchronous census of Indians ever conducted, and it was 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 to the disabled, and the collectors were asked to enter particulars of the insane, deaf- mute, blind, and lepers (*1881 Census Report 256*). The 13th schedule was titled 'infirmities' (*1881 Census Report 256*). These disability classifications were the first official categorizations of disability in British India. These categories remained unchanged until the end of colonial rule.

In comparison to European statistics, the number of blind in India was high, owing to the fact that in Europe, only the completely blind are considered to be blind, whereas in India, even partially blind people are considered to be blind (*1881 Census Report 259*). 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 blind

people. In every province of India except Mysore, Coorg, Assam, and Cochin, the blind numbers were higher than England's total number of blind (*1881 Census Report 262*). There are noticeable variations in the figures between Punjab, Bombay, and Bengal. But still, the reasons for the high number of cases in some provinces and the 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, the Central Province, and Bombay (*1881 Census Report 262*). 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 the female blind population, and Punjab showed similar figures for men and women. 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, compared to 22 blind males for the same number (*1881 Census Report 262*). The largest age group among women who were affected by blindness was the older ones.

According to the 1901 Census General Report, 12 males and 12 females out of every 10,000 were blind, one for each sex. Assam had 25 blinds for every 100,000 people; Bengal had 3,594 blinds for every 100,000 people; Bombay had 2,038 blinds for every 100,000 people; Burma had 47 blinds for every 100,000 people; the Central Provinces had 607 blinds for every 100,000 people; Madras had 4,344 blinds for every 100,000 people; Punjab had 14,239 blinds for every 100,000 people; and the United Provinces had 43,361 blinds for every 100,000 people. The figure of the blind shrank since 1891 to 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 over the course of the previous ten years (*1901 Census Report*

*140*). The reduction in the high number of blind people in the United Provinces was primarily due to the extensive spread of medical relief and the restoration of sight through cataract surgeries. Geographically analyzed, the number of the blind in Punjab was higher than in other places (*1901 Census Report 141*). 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 people, 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 that 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" (*1901 Census Report 141*).

There was a general observation that blindness was common in tropical countries like India, particularly in Punjab, Baluchistan, the United Provinces, and Rajputana, where rainfall was low 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 (*1911 Census Report 352*). 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" (*1911 Census Report 354*). 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.

The statistics on blindness attested to some alterations in 1931 from 1921, when the numbers of male blind were higher, and they decreased in 1931. But in Travancore, the number of the blind among the age group of 14–18 was higher than any other age category, and

that too among the males (*1931 Census Report 255*). The Chief Census Enumerator from Travancore stated that the reason behind these phenomena was the higher educational opportunities in the state. 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 the 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 sectors progressed (*1931 Census Report 266*). 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.

## Blindness as the Fault of Geography in India? Colonial Justification for Profiling Race

The major reason for the higher rate of blindness in India throughout the censuses was examined by the enumerators and medical officers alike, and they concluded that the Indian environment played an important role in causing blindness (*1881 Census Report 263*). The reports stated that one of the primary causes was the extreme heat in the country (*1881 Census Report 264).* The summer in north India and the high temperatures in south India, reaching a maximum of 50 degrees Celsius at their peak in summer, led to vision-related difficulties. Out of twelve, for nine long months, India experienced summer, according to the officers, which led to constant pressure on the eyes. To prove their argument, they stated that every state in India except Mysore, Coorg, and Assam had higher figures for the blind (*1911 Census Report 354*). These are the places where the climate was moderate or cooler than other regions. But when we look at the census numbers given for blinds, it is important to see that the difference in the percentage of

blinds from hotter places in India and cooler places in India was very minimal. No large difference in percentage was recorded in the reports. It may be noted that in order to relate climate and disability in India, these geographical differences were magnified by the officials, both census enumerators and medical officers alike.

Additionally, colonial officials reported that 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" (*1901 Census Report 143*). It was noticed that as one approached the Equator, there was a tendency for blindness to increase in intensity due to the increase in temperature. It was equally understood that the prevalence of snow in a wide area may have an influence on sight in the extreme north. They argued that the glare from the white snow and dry wind caused strain on the eyes, which eventually resulted in vision loss. They also argued that when one considered the central Indian regions as a whole, the hot plain, and dry weather seemed more favourable to developing ophthalmic defects than the moist and warmer air of the coastal areas. Even if we exaggerate the association of blindness with a hot climate in India, census reports show that hotter and drier areas like Multan had less blindness in the records; in Malabar, where the climate was humid and green, there was a similar record to Multan, whereas there should have been much less (*1931 Census Report 267*). They amplified the high percentages of blinds in Bharatpur, Sirohi, and Bihar, which were arid regions and stressed the low number of blinds at Orrisa and Chota Nagpur, which were greener and more wooded (*1931 Census Report 267*). It is important to note that the difference in percentage between the above-stated arid and greener regions was minimal and should be attributed to population differences in reality. The critical omission of the high number of blinds in Malabar, which had a fair share of greenery, shows that colonial census reports cannot

be trusted when it comes to their application of geography to blindness. Colonial officials in India accepted and rejected facts and information that fit into their narrative.

According to the colonial 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 (*1881 Census Report 260*). The lower the immunity, the greater the spread of smallpox through the body. Smallpox not only infects the skin but can also grow on internal organs, tongues, and eyes. These blisters could spread into the veins and cornea, eventually causing blindness. The case of smallpox was connected to India's climate by the colonial reports. They argued that the heat of the country provided a comfort bed for the disease in India, which was 'unlikely' in the European countries owing to their colder climate. The 1881 report stated that

> "glare, heat, dirt, huts filled with pungent smoke, and the attacks of smallpox are all conditions that are injurious to the sight and prevail largely in these provinces, while many of them are absent in European countries due to a better climate" (*1881 Census Report 265*).

But it is important to note that it was not the climate but the prevalence of vaccination and medical facilities that reduced the number of smallpox related blindness and deaths in Europe. In India, it is a true fact that smallpox caused a hike in the number of blind people, but it was ultimately the lack of medical facilities once a person fell ill from smallpox and the late introduction of smallpox vaccination that increased its prevalence.

The argument that drier and dustier climates and geography caused blindness in India was itself challenged by the census reports of Britain, which stated that in the Western countries, 25 percent of blindness was caused by congenital anomalies and the rest by ophthalmia neonatorum, syphilis, injuries, and damage to the optical nerve. The possibility of a geographical reason for disability was not considered

in the 'superior West.' Then one can ask why climate and geography were given this much importance in the Indian context. The answer would be that there was a deliberate attempt from the colonial side to link disability with Indian geography and its connection to the Oriental race. Taking the theory that a race is shaped by its experience with its environment, colonial reports firmly established the view that Indian disability is the fault of the Indian race.

Rosemarie Garland Thomson (*Thomson 75*) discusses the idea of 'normate' in disability studies. Normate is normal, and this is constructed by society based on the values of how people should look and behave accordingly. She elaborates on how colonial agencies, who were the dominators in their colonies, created this by setting up a set of assumptions that encouraged unequal treatment of people based on their body differences. Colonial agencies looked at Indians as "abnormal," and this abnormality was associated with disability, i.e., blindness. Thus, in order to justify their unequal treatment, they racially profiled blindness.

On a practical note, the reason why blindness in India was higher on paper compared to the reports from Britain was due to its changing definition. The British census considered the fully blind to be blind, just as half-blind people in India were considered blind without distinction in the initial censuses. Even though it was decided that only the completely blind would be included in the enumeration starting in 1901, there was no universal term for a completely blind person in India. The word used for 'partially blind' in the whole of upper India was restricted and understood in the Brahmaputra Valley as 'totally blind.' Due to the differences in these terms, partially blind people also found their place in the records. This was the reason why, when compared, blindness in Europe was lower than in India (*1911 Census Report 349*).

## Blindness as the Fault of Social and Customary Conditions in India? Colonial Justification for Profiling Race

The colonial officials also stated that the demographical distribution of blindness in India was complicated and that giving full credit to the

arid and hot milieu when it came to blindness was not logical because environment was not the only rationale behind sightlessness. So they added another factor to blindness that was close to the idea of race; the specificities of social and cultural aspects of living in the Indian subcontinent.

The colonial official reports attempted to connect blindness to the particularities of the "mongoloid strain in the hills" in India. They contended that blindness was most visible on the hilly trails, where goiter-related cretinism and congenital deafness were prevalent. Further, they stated that areas surrounding the Chenab, Gandak, and Makhua rivers had a reputation for producing blindness and deaf-mutism. They claimed that the same environment increased the incidence of goiter deficiency cretinism. In the case of Burma and Assam, the hill area also showed a greater prevalence than the plains (*1911 Census Report 235*). Geographically, reports suggested that in the case of blindness and deaf-mutism, the areas of Sindh, Bengal, and Punjab also had the highest number of casualties (*1911 Census Report 235*). Assam came close to these regions in statistical terms (*1911 Census Report 235*). The reports also stated that other than goiter-related cretinism, blindness and deaf- mutism had a close affinity with diet. They recorded that the food of the citizens was quite different from the staples favoured in the plains (*1881 Census Report 257*).

Colonial enumerators attacked Indian customs of marriage as one of the major reasons for the high number of blind children in Colonial India. The enumerators noted that, like insanity, blindness and deaf-mutism have some links with close-relative marriages (*1881 Census Report 257*). They argued that 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. Marriages between blood relatives were frowned upon by the colonial enumerators, who believed that this led to the birth of a disabled child. Citing a high number of cretinic blind and deaf-mute

people in Assam, enumerators in the 1891 report claimed that "the practice of consanguineous connection that is common amongst the tribes of those tracts had more to do with the spread of the infirmity" (*1891 Census Report 234*). By linking marriage practices with a specific race, colonial officials attacked Indian customs for producing the blind and disabled.

Then they criticised India's social living conditions for contributing to the high number of blind people. 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 (*1911 Census Report 353*). The 'small, cramped, dark, and pungent' huts lacked the 'sanitary and hygienic' parameters to ensure 'good' health, according to the colonialists. They argued that there was less aeration and light inside the huts due to inadequate ventilation. Under these 'unsanitary' conditions, children, especially newborns, were prone to developing eye infections, and cooking in these huts added to the already prominent issue, especially during high temperatures and cold weather. They explained that the smoke inside the huts got trapped and caused eye irritation. The census reporters' understanding of the relationship between blindness in Colonial India and its surroundings was contradicted by many medical reports. 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 (*1931 Census Report 257*). So linking living situations and the prevalence of the blindness in India was a part of large scale agenda of blame game by the colonists in India.

Colonial reports associated the origin of blindness in India with infection. Ophthalmia neonatorum, conjunctivitis, and trachoma, which resulted from the neglect of eye infections, were the main causes of infant blindness in Colonial India (*Semba 9*). Ophthalmic and cognate diseases were common among infants in India, most of which were due

to congenital defects. However, the colonists investigated the majority of blindness cases in Colonial India for their link to infections. The infectious nature of blindness in India again made the colonial officials link it with living conditions. They argued that the rural and agricultural nature of India is the culprit behind these developments. They stated that living plots in India were closer to the manure, which made it easier for the flies to carry the infection from the moisture to the eyes of the infants. They also stated that lack of proper toilet facilities forced people to relieve themselves in the open fields, which in turn added to the 'unhygienic' living conditions. They also blamed the lower strata of Indian society for blindness because of their reluctance to seek medical attention when their children became ill with eye infections. It should be noted that the term 'unsanitary' was associated with Indian living conditions, and colonial officials mercilessly trolled the Indian rural living setup for its 'said' ability to produce more eye-related infection. They pictured rural India as the breeding house of infection. According to the census reports from Britain, it was proved that the blindness owing to infection and a lack of proper living conditions was on the same lines as India, but 'unhygienic' was only mentioned in India's reports. This clear hypocrisy was visible when it came to the examination of blindness in Colonial India. The Indian subcontinent was portrayed as filthy, and its living conditions and social habits were blamed for the rising number of people suffering from vision problems.

Bill Hughes (*Hughes 684*) associates colonial ableism as a form of the civilising process where disability is looked at as disgusting or something to be changed to 'better.' He continues that 'white gaze' as the able-gaze looks at 'other bodies' as in disabled bodies, sees them as the product of unhygienic environments or habits and as something to be shaped into a different mould. Here, according to the colonial reports, native blindness was the product of an unhygienic environment and living conditions. It separated the colonisers from the colonized, and this created the idea of 'other'. Arthur Frank (*Frank 25*) says that

the 'other' is always colonized, dominated, and violated. The other, i.e., the disabled body, is then treated in terms of fear or disgust, which further intensify differences, and it is this fear that creates hostility, states Nancy Mairs (*Mairs 37*). Anita Ghai (*Ghai 89*) also argues that, on the other side of the coin, fear replaces inspiration if the 'other bodies' are changed according to the 'norm.' She also discusses the fact that the disability was always secondary to the colonizer. Even though the colonizer's body was disabled, he remained the colonizer, whereas the colonised remained colonised despite being able-bodied. Colonialism shaped a narrative in which the coloniser represented everything that the colonised did not. The 'other' was always seen as "lacking,' lacking in the values and qualities of 'civilized' society. This might be the reason why, despite owing a fair share of blindness to infection, census reports of the British never mentioned the word "unhygienic."

Similarly, to living arrangements, colonial reports suggested a link between women's blindness and religious and patriarchal segregation of women in Indian society (*1911 Census Report 266*). They argued that blindness among women was elevated in the upper regions of India—Sindh, Punjab, and Rajputana—where seclusion of women was prevalent. They stated that seclusion was inevitable in the lives of Indian women due to the patriarchal structure of Indian society, and this led to an indirect impact on the visionary health of Indian women. According to them, women were 'secluded' inside their poorly lit houses for the majority of the time due to religious reasons, which eventually strained their vision. Colonial reports observed that this seclusion related blindness was visible in the areas where the Muslim population was higher. It is true that the patriarchal setting increases the likelihood of women developing disabilities, but not because of seclusion, as colonial reports suggested, but because of unequal access to timely medical care and nutritional value. A patriarchal society such as India limited women's opportunities to access timely medical care when 'abnormality' of sight was first detected. Surprisingly, the

main reason for this inaccessibility was not religious seclusion, but the widespread stigma associated with disability, social pressure from the inevitability of marriage, and fearful parents, all of which eventually led to the concealment of the disability and, in most cases, the disabled themselves (*1901 Census Report 141*). There was 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 (*1911 Census Report 143*). The religious seclusion in the case of blindness did not make sense, as the reporters themselves recorded that Coorg, Assam, Malabar, Travancore, and Hyderabad registered a smaller percentage of blind women even though they had a considerable Muslim population. But the reports suggested that women here enjoyed freedom in a 'limited' manner because women were an integral part of the workforce. Adding the logistic of religion to fund irrelevant facts and denying when contradictions arise is a classical colonial characteristic, and this was evidently used in the enumeration of the blind population in Colonial India, which was ableistic in character. Fiona-Kumari Campbell (*Campbell 6*) explains how ableist normality 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. Here, neither the women, nor the blind women were given an assessment of seclusion as the reason for their distress or disability. Instead, the colonisers assumed seclusion as the reason instead of looking at the practicality of that reason.

Intriguingly, one factor of women's blindness and patriarchal Indian society was correctly assessed by the colonial reports; the lack of nutritional value. The lack of proper nutrition contributed significantly to the state of being blind (*1901 Census Report 143*). 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. Owing to these observations, the census reports stated that women in Indian society

were positioned in the lower strata of the food chain (*1901 Census Report 143*). Being under 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. The reports elaborated that a dearth of adequate sustenance at the time of pregnancy could lead to congenital vision problems for the child.

The colonial understanding of child blindness in India was evidently mainly concentrated on infection, social habits, seclusion, and living situations. But unlike census reports, the health and sanitation department states that the main reason for the blindness in Colonial India was pediatric cataract, which is a congenital and pediatric pathology that describes the greying or reflection of the opacity of the crystalline lens and is most commonly caused by intrauterine infections, metabolic disorders, and genetically transmitted syndromes (*Mathers 756*). Pediatric cataract had nothing to do with the 'unhygienic' and "secluded" living arrangements in Colonial India. But it all had to do with something that colonial reports swept under the rug: the man-made famines that were the result of colonial greed that haunted the health of the generation that witnessed it and future generations.

Famine was quite familiar to Indians in the pre-independence period. Famine thrived on a lack of nutrition for the body, and vision was linked to nutrient intake. For instance, a deficiency of Vitamin A causes the loss of sight or low vision among people, especially children. Furthermore, anything that reduced body nutrition in the middle-aged caused degenerative changes in the crystalline lens of the eyes. The amplified degree of long periods of scarcity of proper diets caused by famine increased the number of cataract-affected people in Colonial India (*1931 Census Report 141*). According to a study by Dr. Deakin on the North-West Frontier Provinces, he found that famine was a major reason behind the rising number of the blind. Famines in India increased blindness among women, as they were already vulnerable due to patriarchal social conditioning. Along with this, congenital blindness

was also on the rise due to a lack of nutrition during pregnancy. The absence of healthy consumption had a direct impact on the fetus, which depended on the mother for its growth.

Old age was one of the factors contributing to the higher figure of 43 percent of the blind in Colonial India. The human tendency to lose vision after the age of 40 is normal and unavoidable. Nonetheless, in some cases, particularly in communities where nourishing food was scarce and there was constant famine and poverty, the vision would begin to fade by the late 20s. But instead of equating old age blindness with famine in India, colonial reports cite glaucoma and cataracts as the leading causes of old age blindness. It is safe to infer that the inadequate mention of famine related congenital and acquired blindness in the colonial reports proves their ultimate motive to associate Indian blindness with race, geography, and social conditions. There were multiple grounds behind blindness apart from cataracts. Blindness was caused by infections such as congenital rubella syndrome, retinopathy of prematurity, leprosy, onchocerciasis, and central corneal ulceration, none of which were mentioned in the colonial reports.

## Conclusion

Colonial demographical survey of blindness in India showcases a trend, the trend to show an image that an 'active' and 'Western' colonial state provided help to the 'passive' and 'oriental victims' of blindness. Under colonial rule, blindness as disability and 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 records on blindness interestingly used an interplay between colonialism, disability and race in terms of evolution and degeneration. Colonial anxieties were expressed when they encountered differences or disability, ie., blindness. The 'sightlessness' of the people was looked at as 'piteous incapacity.' The 'white' population was regarded as in an 'advanced stage of civilization,' and the 'blind other'

was discussed in terms of being 'degenerative.'

It is important to note that the blinds were treated as 'other' in the colonial census and medical records. The records associated race as the major cause of native blindness and it created an image where it was conceptually placed in the Orient. Colonial census narratives of blindness 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 blindness intensified the idea that geography was eminently related to disability. Colonial census records treated the blinds in terms of fantasies based on views of extraordinary, disturbing, and disruptive against a Western imagined 'social norm.'

## Bibliography

Bhatawadekar, Gajanan K. *1881 Census of India: Report from Baroda*. Education Society's P, 1883.

Bhattacharya, Nandini. *Contagion and Enclaves: Tropical Medicine in Colonial India*. Liverpool UP, 2012.

Black, Nick. *Walking London's Medical History*. Royal Society of Medicine Ltd, 2006.

Bourdillion, J. A. *1881 Census of India: Report and Tables from Bengal*. Bengal Secretariat, P, 1993.

Campbell, Fiona-Kumari. *Contours of Ableism: The Production of Disability and Abledness*. Palgrave Macmillian, 2009.

Carpenter, Wilson Mary. *Branch Collective*, 15 Jan. 2010, www.branchcollective.org/?ps_articles=mary-wilson-carpenter-a-cultural-history-of- ophthalmology-in-nineteenth-century-britain

Frank, Arthur. *The Wounded Storyteller: Body, Illness, and Ethics*. Chicago UP, 1995.Gabriel, Farell. *The Story of Blindness*. Cambridge UP, 1956.

Ghai, Anita. "Disability in the Indian Context: Post-Colonial Perspectives." *Disability and Postmodernity: Embodying disability theory*, edited by M. Corker and T, Continuum, 2022,pp. 88-100.

Griff, Ann Marie. "Blindness." *Journal of Healthline*, vol. 2, no. 3, 2019, pp. 8–10.

Hassan, Narin. *Diagnosing Empire: Women, Medical Knowledge, and Colonial Mobility*. Ashgate, 2011.

Hogeweg, M. "Cataract: The Main Cause of Blindness in Leprosy." *Leprosy Review*, vol. 7, no. 2, 2011, pp. 139–142.

Hughes, Bill. "Being Disabled: Towards a Critical Social Ontology for Disability Studies." *Disability and Society*, vol. 2, no. 7, 2007, pp. 673–684.

Hutton, J. H. *1921 Census of India*. Vol. 2, *Tables*. Delhi Manager of Publications, 1933.

Khan, Matin-Uz-Zaman. (1912). *1911 Census of India. Report from Kashmir*. NewulKishore, 1912.

Lawrence, William. "Lectures on the Anatomy, Physiology, and Diseases of the Eye," *The Lancet*, vol. 5, no. 22, 1825, pp. 145–151.

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

Mairs, Nancy. *Waist-high in the World: A Life Among the Nondisabled*. Beacon P, 1996.

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

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

Maunsell, S. E. *Notes on Medical Experiences in India Principally with Reference toDiseases of the Eye*. H. K. Lewis, 1885.

Miles, M. *Disability Care and Education in 19th Century India*. Birmingham P, 1997.

*Report on the Census of British India: 1881*. Eyre and Spottiswoode, 1883.*Report on the Census of British India: 1891*. Eyre and Spottiswoode, 1893.*Report on the Census of British India: 1901*. Eyre and Spottiswoode, 1903

*Report on the Census of British India: 1911*. Superintendent Government Printing, 1913.

*Report on the Census of British India: 1921*. Superintendent Government Printing, 1923.

*Report on the Census of British India: 1931*. Superintendent Government Printing, 1931.

*Report on the Census of British India: 1941*. Calcutta: Superintendent Government Printing, 1943.

Risley, H. H. *1901 Census of India: Vol. 1, Part 2, Tables*. Office of the Registrar General of India, 1903.

Russell, R. V. *1901 Census of India: Vol. 13, Central Provinces*. Secretariat Press, 1902.

Sedgwick, L. J. *1921 Census of India: Report and Tables from Bombay*. Yervada Prison P,1922.

Semba, Richard D. *Handbook of Nutrition and Opthalmology: Nutritional Blindness*. Nutrition and Health Book Series, 2009.

Thomson, Rosemaries-Garland. *Extraordinary Bodies: Figuring Physical Disability in American Culture and Literature*. Columbia UP, 1997.

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