



# **Prophylaxis and exclusion: compulsory isolation of Hansen's disease patients in São Paulo**

*Profilaxia e exclusão:  
o isolamento compulsório dos  
hansenianos em  
São Paulo*

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This article aims to retrieve the history of Hansen's disease in Brazil, analyzing the medical thinking of the time and the shaping of health policies that permitted the implementation, in São Paulo, of a prophylactic policy of compulsory exclusion for all Hansen's disease patients. It also analyzes how the structuring and implementation of this policy led to a 'São Paulo model' that strongly influenced the rest of the country. It addresses the creation of the state's network of leper colonies, their characteristics and the emergence of a veritable 'parallel state' that endured until 1967, with complete disregard of all the changes taking place in both national and international prophylactic policymaking.

KEYWORDS: history of leprosy, Hansen's disease, exclusion, compulsory isolation, history of public health.

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*Este artigo busca resgatar a história da hanseníase no Brasil, analisando o pensamento médico e o direcionamento das políticas de saúde que possibilitaram a implantação, em São Paulo, de uma política profilática centrada na exclusão compulsória de todos os portadores de hanseníase. Analisa ainda como a estruturação e implantação dessa política resultou no 'modelo paulista', que exerceu forte influência no país. Estuda a formação da rede asilar, as suas características e o surgimento de um verdadeiro 'Estado paralelo', que subsistiu até 1967, à revelia das descobertas terapêuticas e das modificações havidas no direcionamento das formas de tratamento e prevenção nacional e internacional.*

*PALAVRAS-CHAVE: história da lepra, hanseníase, exclusão, isolamento compulsório, história da saúde pública.*

Hansen's disease has been present in Brazil since the dawn of colonization. Studies of the various health practices adopted over these past five hundred years illustrate that, even though alterations were made over time, by the end of the 20<sup>th</sup> century they all had one thing in common: social marginalization of the sick. The medieval image of leprosy and the leper, the latter being a carrier of an inexplicable evil and often considered to be evil incarnate, was firmly inserted into Brazilian culture, helping the government secure the support of the population for any prophylactic policy that promised to preserve the so-called healthy society, even if this meant harsh measures and the exclusion of the sick.

The disease became a target of concern for the authorities and measures started to be proposed in the 17<sup>th</sup> century<sup>1</sup>. The cities of Recife, Rio de Janeiro and Salvador built their first hospitals in the 18<sup>th</sup> century when the endemic spread, while this only occurred in São Paulo in 1802, in virtue of the characteristics of the state. In the 19<sup>th</sup> century, however, numerous small leper hospitals and colonies were built, particularly in inland São Paulo state, which can be explained by the growth of coffee farming in the region and the subsequent demand for immigrant and migrant labor. Isolation, however, was still not obligatory and leper colonies and hospitals allowed patients to come and go freely, largely due to the precariousness and lack of funding for these centers. The sick were often obliged to leave in order to make a living, which generally meant begging. As a result of this, the contingent of nomadic lepers that wandered the streets grew larger, prompting protests from the population and pressuring the government to take measures.<sup>2</sup>

The contagious character of Hansen's disease was only proven after the discovery of the *Mycobacterium leprae*, the causative agent of the disease, by Hansen in 1872.<sup>3</sup> This represented a breakthrough in the history of the disease, revolutionizing thinking and refuting the leading theories of the time that the leprosy was hereditary. It also gave rise to the so-called 'Norwegian model', based on the exclusion of the sick. The international leprosy conferences that followed Hansen's discovery — the first in Berlin in 1897 and the second in Bergen in 1909 — were the scene of important discussions between the advocates of hereditariness and those of the new contagion theory. It was only at the third conference — in Strasburg, 1923 — that members unanimously voted that the disease was contagious.<sup>4</sup> The policy of compulsory isolation was outlined at the Bergen conference and this practice was adopted by the majority of endemic countries. The policy included the isolation of the sick, the removal of their children, the medical examination of all the people who lived with the infected person and the encouragement of study and research. From here on, isolation was proposed to be the only way to prevent the propagation of Hansen's disease.

The ideas presented at these international congresses had a significant impact on policy in Brazil. The discourse and practice of compulsory isolation in Brazil may be divided into five main periods, each with

its own characteristics. From 1900 to 1920, the first prophylactic policies emerge; in the second period from 1921 to 1930, the National Public Health Department is founded and debates on forms of isolation intensify; the third period from 1931 to 1945 corresponds to the era of Getúlio Vargas: compulsory isolation is implemented, large leper colonies are built and sulfone treatment is discovered. The fourth period, from 1946 to 1967 is characterized by international leprosy congresses that advised against, or even criticized, isolationist measures. In 1962, compulsory isolation ends in Brazil, except in São Paulo. And, finally, in the fifth period, from 1967 onwards, compulsory isolation is replaced by outpatient treatment.

When studying Brazil's Hansen's disease health policies in the 20th century, we can see that they were strongly influenced by the isolationist approach adopted in São Paulo. What we now call the 'São Paulo model' served as a source of inspiration and, to a greater or lesser extent, determined prophylactic policy for the disease in several Brazilian states. The São Paulo model called for the exclusion of all Hansen's disease patients, regardless of the clinical form or stage of the disease, differing greatly from the methods adopted by doctors and authorities in other states. Even if patients had a non-contagious form of the disease, in São Paulo they would be forcefully interned shortly after the diagnosis (Monteiro, 1995, pp. 217-30).

In order to enforce these measures, it was extremely important to set up a network of leper colonies, whose planning and structure would influence the construction of similar institutions all over the country. São Paulo's leper colonies were often cited as examples in specialized literature and they were visited by researchers from several countries, transforming them into an obligatory reference for Brazilian and Latin American leprologists, notably up until the 1950s.

This model is important in the study of public health policies in Brazil at a crucial time in the country's history that is characterized by an extension of the power and interference of the State in the health matters. But it is more than just this: the São Paulo model forged the construction of a veritable 'parallel state', which had its golden age during the Getúlio Vargas government and endured until 1967, with complete disregard for all the changes taking place in both national and international prophylactic policymaking.

### **The São Paulo model and isolationist policy**

The stages of implementing compulsory isolation in São Paulo encompassed various prophylactic approaches that in some way reflect the concerns of the national and international scientific community and the methods adopted in other endemic countries. The preventative policy that would culminate in the São Paulo model was structured

gradually. While isolation was selective in some Brazilian states, in São Paulo it was compulsory for all people diagnosed with Hansen's disease and only in São Paulo was enough power and funding available to implement such a policy. The São Paulo model was also influenced by the eugenic thinking of the start of the century and its *modus operandi* was affected by both the 'Norwegian model' that preached the exclusion of the sick and by Brazil's own '*campanbista* model' that proposed strict, almost military-like strategies to combat diseases.

The various theories for dealing with leprosy in Brazil at the start of the 20th century were reflected in both medical thinking and proposed public health policies. In São Paulo, the discussions were basically held between two main camps. In the first were the 'humanitarians': they championed a reform of the existing small leper colonies and the construction of others in the state to meet the demands of each region; they called for selective isolation, only for those with contagious forms of leprosy and with open lesions. In other words, only those patients who represented a contamination threat would be removed from society. It is worth pointing out here the existence of different clinical forms of Hansen's disease: indeterminate, tuberculoid, dimorphous and lepromatous; and only the latter two are contagious.<sup>5</sup> The advocates of the humanitarian approach also judged that patients who were unable to remain isolated at home should also be interned, with the remainder receiving outpatient treatment. This selective policy was at the time given the name 'humanitarian isolation' and one of its chief advocates was Emílio Ribas, a leading authority in the area of public health.<sup>6</sup>

In the other camp were the "isolationists", who proposed the following plan: construction of large isolation units in certain areas of the state, closure of the existing colonies, banning outpatient treatment, compulsory internment for all leprosy patients, regardless of socio-economic position, sex, age group or whether the clinical form of the disease was contagious. Among the defenders of this way of thinking was Francisco Sales Gomes, director of the São Paulo Leprosy Prophylaxis Service from 1930 to 1945 and, as such, responsible for the implementation of the São Paulo model. Within this second camp there was an even more radical group that proposed that Hansen's disease patients should be sequestered in areas of difficult geographical access, claiming this would make it easier to control the disease and harder for patients to escape. These radicals endorsed insular isolation or the creation of a municipality where the sick could be secluded. A key figure from this group, which did not manage to see its ideas put into effect, was the architect Abelardo Caiuby, designer of the projects to construct the Santo Ângelo leper colony, whose architectural conception influenced other colonies. The ideas put forward by Caiuby echo the positions defended by leading names in the Brazilian health system, such as Arthur Neiva, Heráclides

César de Souza Araújo and Belisário Pena.<sup>7</sup> It is worth emphasizing that there was no consensus on the type of isolation to be established in São Paulo until the end of the 1920s.



Leper camp alongside a highway.

Source: Iconographic file from the Health Memorial Research Center – Health Institute.<sup>8</sup>

Neither the conditions nor the space existed to house all the sick, in virtue of the growth of the Hansen's disease endemic in São Paulo and the precarious situation at the regional leper colonies. There were several small regional colonies inland in the state, while in São Paulo city there was only one, Guapira, which was set up and run by the Santa Casa da Misericórdia medical institution. Each colony was run differently, although one thing they all had in common was a lack of resources. Many offered no more than a place to live and did not have staff to care for the patients, nor medicines. Aside from these colonies, there also existed itinerant leper camps alongside highways. Although the legal means was available to intern lepers from these camps, it did not occur as a result of the inexistence of colonies in sufficient number and size to house so many people.

The controversy surrounding how best to address this situation involved the state, official medical services, scientific societies, charities, civil society groups and the press.<sup>9</sup> Several issues had to be analyzed and discussed: location and size of the colonies, the ideal number of people per colony and whether to intern all those infected or just those with contagious forms of the disease. The fear that the proximity of the colonies or the concentration of patients would contaminate surrounding areas prompted interminable discussions on the technical solutions to

adopt: wind direction, directional flow of water, means of supply, drainage, etc. These discussions, in general, involved not only leprologists and sanitary engineers, but also included the daily press at the time. The only consensus among these different groups was the removal of the sick from society.

This situation led municipal governments from inland São Paulo to convene the 'Municipalities Convention' to discuss the establishment of joint measures to choose the locations for regional leper colonies and the means of funding them. The official medical service<sup>10</sup> mediated the meetings and, by using a series of strategies, managed to extract from the hands of leprosy aid associations and municipal governments the management of the funding for the leper colonies and the construction that had already begun.

As a consequence, a network comprised of five establishments, four colonies and one sanatorium, was built within a short space of time, and it was run entirely by the State. Consequently, the isolation process was implemented in precisely the way the medical service wanted it done.

### **Structuring the prophylactic service**

At the end of the 19<sup>th</sup> century and during the first few decades of the 20<sup>th</sup> century, São Paulo witnessed a transformation resulting from the expansion of the coffee economy and the move towards industrialization. New demands arose both in the countryside and in the city, prompting a reform of the sanitary services in order to extend treatment to the countryside, in newly cultivated regions farther west and the old regions in decline, and to meet the new demands in the city resulting from industrialization. The state government was urged to adopt policy capable of promoting and protecting health, even if this required coercive measures. Due to this pressure, the state took steps improve sanitation in cities and the countryside and to combat endemics and epidemics. Many of these measures preceded those adopted by the federal government and by other states, as only São Paulo had resources enough to apply them.

Despite São Paulo's precedence, the development of its isolationist model was not entirely independent and it had to observe federal regulations, although disagreements between state and federal authorities at the time allowed Brazil's states to overlook some the stipulated rules and/or the legislation in force.

The transformations that occurred in Brazilian health services after 1920, particularly the founding of the National Health Department, had a direct impact on Hansen's disease policy, notably due to the creation of the Leprosy Prophylaxis Inspectorate and prophylaxis regulations.<sup>11</sup> The former was intended to oversee preventative programs on a nationwide level, although it was

prohibited from implementing the programs in virtue of the autonomy of the states. As a result of this, agreements were signed whereby state governments consented to respect federal sanitary legislation and ensure it was observed in their jurisdiction. All Brazil's states signed the agreements, with the exception of São Paulo.<sup>12</sup>

The state's independent position now enabled it to develop its own prophylactic policy. The growth of the endemic in São Paulo and the ensuing pressure prompted the Sanitary Services Department to create, in 1924, the Leprosy Prophylaxis Service, which was state-level, although very similar to the national service.<sup>13</sup> The following year, on July 19, 1925, the Service was remodeled and renamed as the Leprosy Prophylaxis Inspectorate (IPL)<sup>14</sup> and history illustrates its political clout in determining policy. Depending on the members of the board at any given time, the state's policy on isolation would vary. The Sanitary Service director and state governor also had a direct influence on the appointment or dismissal of the IPL's chief inspector and on the procedures for constructing the leper colonies.<sup>15</sup>

After the 1930 Revolution that gave rise to the Getúlio Vargas Era, the faction that advocated the compulsory isolation of Hansen's disease patients in São Paulo were now in a position to assume power, a process that can be illustrated by the number of new appointments, dismissals and exonerations during the years of the New State. In this political period, power over many health programs and services in São Paulo was centralized, which enabled exceptional measures to be taken, even in relation to diseases that were targeted for confinement and isolation — tuberculosis and Hansen's disease. The same thing occurred in the area of mental health. It is clear in these cases that authoritarian measures began to be accepted and, in some cases, even welcomed and were seen to be essential in the administration of prophylactic policy. This situation also made it possible to appoint medical professionals such as Francisco de Sales Gomes Júnior, a name that is closely associated with the Getúlio Vargas stage of combating leprosy.<sup>16</sup>

His administration clearly illustrates the authoritarianism that characterized São Paulo health policy in the 1930s and 1940s. Sales Gomes was a fierce opponent of outpatient treatment and defended compulsory isolation for all Hansen's disease patients. His rise to the head of the Leprosy Prophylaxis Service was purely political. The fact that he was a surgeon and had never before worked with the disease did not prevent him from being appointed and he remained in charge until the end of the Vargas Era. His administration was marked by authoritarianism and it was the time when the Leprosy Prophylaxis Service was at the peak of its power.

When he took over at the Leprosy Prophylaxis Inspectorate, as it was then called, Sales Gomes used the existing structure and some previously organized programs, while at the same time making certain

alterations to enable him to implement mass compulsory isolation, and, in very few years, he managed to establish the state's network of leper colonies. A structure was implemented that was deemed exemplary and was kept working by a regime of force that required, and received, generous political backing. The growing importance of the Leprosy Prophylaxis Inspectorate paved the way for its transformation, in 1935, into the Leprosy Prophylaxis Department (DPL). It had characteristics that differentiated it from all other health departments: a sizable budget, its own staff and its independence from the State Health Department. In fact, it took very little time for DPL decisions to cease being made within the sphere of the Health Department, instead being discussed directly with the state governor.

Sales Gomes implemented a system whereby all decisions were centralized into the hands of the director. Various strategies were adopted to remove from office members who opposed compulsory isolation of the sick. Courses and training began to be offered to medical students and young doctors to recruit only those who subscribed to the official prophylactic policy, which is how the consistency of medical thinking in the São Paulo Prophylaxis Service was achieved.

### **Implementation of the São Paulo model**

Beginning in the mid-1920s, a process takes shape that gave rise to the São Paulo prophylactic model, a process characterized by a modification of legislation, regulation of the isolation policy and a structuring of the official services according to new directives. While São Paulo advocated compulsory isolation of all Hansen's disease patients, other states opted for more 'lenient' prophylactic models that were more in line with what was being recommended by international congresses. Rio de Janeiro, for example, when it was still Brazil's capital city, only interned contagious cases, while patients with non-contagious forms and those cured by treatment were free to live in society and receive outpatient treatment.

From an operational point of view, São Paulo implemented a hierarchization and centralization of administrative functions with decision-making concentrated in the hands of the director of the Leprosy Prophylaxis Service. The headquarters was in the capital, but the director was able to intervene quickly in inland São Paulo state through his regional branches. These were assigned to implementing the measures to combat Hansen's disease within their jurisdictions and were authorized to administer punitive action whenever deemed necessary.<sup>17</sup>

For this model to consolidate, specific legislation permitting the use of the planned measures was essential. Law no. 2,416 of 12/31/1929, sanctioned by Governor Júlio Prestes, revoked existing legislation<sup>18</sup> and enabled the new policy to be implemented in the state. This legal text was of extreme importance, as it shaped the basis of the state's new



prophylactic practices. It was divided into two parts: the first, called 'Leprosy prophylaxis', fully regulated the lives of patients, from the moment of the diagnosis to their death, and it even regulated the lives of their 'associates'. The second part, 'Organization and staff', dealt with the internal organization of the Leprosy Prophylaxis Service, its operational structure, duties and jurisdiction. Over the years, the law suffered some minor alterations, making it even more stringent. Immediate notification of all cases became compulsory and only DPL doctors were authorized to treat leprosy patients. All other medical staff were expressly forbidden from treating their patients once the diagnosis had been made and they could be punished for doing so. This policy was designed to both centralize patient data into a single government institution and also to oblige the sick to seek their own internment in order to gain access to medicine.

The centralization of data on patients was essential to assume full control of the situation, which is why the registration of patients and their 'associates' was obligatory, storing information and background reports in a central file that was created in 1925. This file contained details of the evolution of the disease in each diagnosed patient and personal data, family information and current and former addresses. Over the years, the organization of the file was improved, speeding up access to the information. This provided the DPL with information on the location, forms of treatment, track record and data on the day-to-day life of every patient interned in any of São Paulo state's leper colonies.

The DPL collected data on the families and, sometimes, the close friends of patients for epidemiological reasons. Claiming that these people could easily have been infected, it labeled them as 'associates' and kept a file on them. These associates were obliged to present themselves for regular testing and their information was kept in a specific file. They were allowed to live in their homes, but they were kept under strict vigilance by the DPL.<sup>19</sup> This strategy enabled the swift location and capture of patients who managed to escape from the leper colonies or associates who failed to turn up for their tests. The existence of a thorough dossier on each of the interns together with information on their relatives allowed officials to monitor all those associated with the "world of Hansen's disease" and created a system of control and vigilance never before seen.

In short, the model set up in the name of prophylaxis called for immediate, compulsory removal of patients from society, deprived them of their most basic rights and segregated them in colonies where they were constantly watched, controlled and governed by specific laws. Once they entered this world, they were kept on file and given a number — their file number — that they would keep for the rest of their lives. The lives of their relatives, listed as associates, were also monitored by the Leprosy Prophylaxis Department.

The São Paulo model was based on the notorious trinity of leper colony, dispensary and prevention center. Each of these institutions had its own distinct, although complementary, roles. The colony was most important, as it insulated the sick. The job of the dispensary was to locate new patients and send them for isolation, document the cases and regularly test the associates while ensuring that they did not miss their appointments (a special vehicle used to go out in search of the associates, causing problems in their personal lives and at work). The role of the prevention center, meanwhile, was to provide shelter for the healthy children of patients and all the children born in the leper colonies and keep them under close observation.

The establishment of the São Paulo network of colonies, between 1928 and 1933, prompted mass internment. Prophylaxis Service teams scoured the whole state and the press reported on progress combating the disease as if it were an ongoing battle. The population was encouraged to participate by informing on suspicious cases. Both the capital and inland São Paulo were investigated by DPL employees who drove around the state in special vehicles taking into custody patient from their houses, camps and from old small colonies. These regional colonies were closed down, the camps destroyed and private houses burned to the ground. The sick were rounded up, taken to strategic points and, usually, placed in special train carriages and taken to the site of isolation.

The new large leper colonies soon filled up and, within a period of just ten years, the DPL had become an extremely powerful and organized outfit. It became one of the prides of São Paulo, supported by the government and praised by both the press and the majority of civil society.

The press reported on each act of the DPL as if it were another victory in the war against the 'plague of leprosy' and conduct that could otherwise have been considered to be an act of violence against the sick were presented as proof of the government's determination to 'do away with the insidious disease'. The fact that Brazil was living under the Getúlio Vargas dictatorship, whose Press and Propaganda Department harshly censured the press, made it easy to adopt authoritarian and repressive measures against its opponents.

In short, the 1930s are of special importance in the history of Hansen's disease in virtue of the implementation of a specific prophylactic model. The preventative services extended their sphere of influence, large leper colonies were built and mass internment was introduced. The measures in place at this point would steer São Paulo's policy for fighting the disease until the end of the 1960s.

### **The structuring of a world apart**

The introduction of the isolationist policy in São Paulo practically created a separate world, with the full backing of the government and blessing of most of society. If we look at the discourse and official documents of the time, we may observe that the chief justifications for this model were: a) preservation of society; the presence of patients in society was portrayed as a danger of contagion; b) epidemiological control; DPL leprologists believed that leprosy would be wiped out within a generation as long as all those infected were removed from society; c) well being of the patient; it claimed that, given the stigma associated with the disease, 'lepers' would feel more comfortable living among themselves, where they would not be the target of discrimination.

All the leper colonies in the network followed an architectural standard in order to make it easier to control the patients and, at the same time, monitor the life of each one. The colonies all had a strict division of space. Each one had three separate zones: the healthy, the intermediate and the sick zones, which were also referred to as clean, neutral and contagious. The healthy zone contained: the entrance, the power generator, water tanks, storehouses, garages, administration offices, management and other services necessary for the running of the colony. It also contained the houses of the director, the doctors and the administrative staff, the size and style depending on the importance of the profession. The intermediate zone was located between the healthy and sick zones. It contained the main 'pavilion', the site for checking visitors and the visiting room.<sup>20</sup> The sick zone, representing the colony itself, contained: the hospital, the clinical 'pavilion', the dormitories (Carvilles), houses for the married patients, psychiatric ward, prison, social club and church, in addition to the land for cultivating and keeping animals. The sick zone was rigorously separated from the healthy zone. At the Cocais leper colony, for example, a 300-meter buffer zone separated one section from another. The division of the two was clearly marked and there was even a gate and an entrance hall. Only very few people were authorized to cross the dividing line and only on very rare occasions were patients allowed to cross.

The style, size and internal distribution of the buildings clearly illustrate how the Prophylactic Service wanted the day-to-day life organized inside the colony; in other words, how the exclusion zone was organized. Over the years, buildings were reformed or new ones were constructed, although the structure of the sick zone always stayed the same.

Official documentation of the time provides important information on the construction of the colonies. One such publication from 1936 (*Revista Brasileira de Leprologia*, pp. 95-105), refers to the Pirapitingui leper colony and enables us to verify the types of installations, their sizes and their uses.

- a) Hospital complex comprised of: hospital with two wards with twenty beds each and another eight rooms for isolation; 'pavilions', a type of hospital/dormitory where incapacitated patients resided; five consultation rooms and a dental surgery; patients' kitchens for the hospital and the Carvilles, one for the men's pavilions and another for the women's.
- b) 54 groups of semi-detached houses, each one with two bedrooms, veranda, kitchen and bathroom, built along two avenues.
- c) Detached houses: three groups of detached houses for the chaplain, 'mayor' and teacher.
- d) Wooden houses: the colony's first constructions, before the brick houses, each with four bedrooms.
- e) Ten Carvilles (accommodations for unmarried patients), four for women and six for men; each Carville having 11 bedrooms.
- f) Social club: built with private money, it contained a cinema, classrooms, a reading room, a library, a games room, a billiard table, a bar and the office of the colony's charity fund (Caixa Beneficente).<sup>21</sup>
- g) One Catholic and one Protestant church.
- h) Restaurant built by the Caixa Beneficente, for the wealthier patients, that offered a wider variety of food.
- i) The psychiatric ward and the prison were located in the same building, the psychiatric ward on one side and the prison on the other.

As a result of the strict division of the healthy and sick zones, all tasks were carried out separately in each of the zones. The administrator of the former had his own staff working in the washroom, bakery, kitchen, butcher, conservation of buildings and vehicles, raising livestock, gardening and reforestation. These same tasks were carried out by different staff in the sick zone, under the control of the 'mayor',<sup>22</sup> who had his own staff to carry out these services.

As for the clinical services provided at the leper colonies, the DPL divided them into two sections, one healthy and another sick, both controlled by the director. The former was comprised basically of the medical staff, the latter by the nursing staff, who were all patients.<sup>23</sup> It is worth emphasizing here that until 1967 all nursing services were carried out only by patients, who rarely received courses or training to perform these services.<sup>24</sup>

Each leper colony was like a small town, with its own technical and bureaucratic structure that answered to the colony's director, who in turn answered to the director of the DPL. Just like in any town, the colonies had the power to police and punish residents who broke the rules. The 'police officer', a patient appointed by the director, controlled the so-called Sanitary Guard, also formed by patients, and the prison, where those who broke the internal rules of the colony were detained.

All disobedience of the rules was punishable and the most serious infringement was attempted escape.

Some of the colonies had their own prisons, which also held common criminals who had been legally condemned in the real world but who suffered from Hansen's disease and were therefore unable to be detained in federal penitentiaries. But the prisons were also used to punish patients who broke the rules of the colony. Psychiatric wards were also built at some colonies to house mental patients who had Hansen's disease.

The goal was to make each colony as self-sufficient as possible, which explained the presence of brickyards, repair shops, factories and agricultural activities. These activities were significantly important, as they kept the patients occupied and provided a small profit for the colony.

The leisure activities at the colonies were emphasized by the press at the time. Practically all the leisure activities — sports fields, the social club building that contained the library, games room, cinema and theater — were built from donations made by individuals, groups or associations.

The publications of the time, particularly newspapers, gave broad coverage of the leisure activities in the colonies. The reports portrayed a view that was at the same time humanitarian and practical: seeing as compulsory isolation was established for the good of society, Hansen's disease patients ought to be compensated in some way for their forced exclusion from the social and family environment. But they also argued that there would be fewer escapes if patients felt more satisfied inside the colonies.

### **The role of private initiative**

Both individuals and organized groups from civil society mobilized behind the Hansen's disease cause, particularly during the 1920s and 1930s. This type of support was very important for the official medical service and it was encouraged in virtue of the funds that were raised. The funds paid for the construction of leper colonies such as Santo Ângelo and Cocais that, once completed, were incorporated into the State. It also enabled many improvements to be made at the colonies. Various projects and campaigns to raise funds were established, namely to improve the living conditions for the patients. Thanks to individual and group initiatives, many of the community lodgings for patients and houses for married patients were built. The newly-raised funds paid for the construction of new buildings and the renovation of the existing ones, such as the erection of workshops and facilities for leisure activities. The role of these organized groups was not limited to charity work or projects to assist the physical comfort of patients. They also concerned themselves with scientific research and the purchase of medicine. There

is a case in which the Society for the Assistance of the Leprous “sent away for chalmogra seeds from India and a ton of raw oil in order to set up its own factory to manufacture medicine for the treatment of those afflicted by leprosy”<sup>25</sup> (Tibiriçá, 1934, p. 31).

With the passage of time and the centralization of power, the DPL began to consider charitable contributions as “external interference” in the leper colonies. However, while it attempted to forestall the “benefactors” and/or the organized associations, the DPL did not want to dispense altogether with this type of collaboration, given its capacity to raise funds. A very delicate, at times conflicting, relationship therefore ensued between the private organizations and the Prophylactic Service, which was always on the lookout for sources of income but at the same time suspicious of any outside influence.

The way found to neutralize external interference was to set up intermediaries, or the *Caixas Beneficentes*. All donations would now have to be made to this institution, which would decide where and when to spend it. As a result, the Prophylactic Service ended up administering both the official budget and donated funds for the colonies.

### **The construction of the network of colonies**

The isolation network in São Paulo, comprised of four large leper colonies, one sanatorium and two prevention centers, was considered an example to be followed and was visited by leprologists from all over the world, particularly those from Latin America.

The engineers that planned the first colony were influenced by some of the architectural ideas from other countries, such as the communal pavilions for housing patients used in the Carville leper colony, in the United States. The original idea was to build four large leper colonies in inland São Paulo, each with the capacity to hold around seven hundred interns. Plans also included the construction of a sanatorium for patients with non-contagious forms of the disease. This would be located nearer the capital to facilitate study and research on the disease. However, the spread of the endemic, coupled with the obsession that drove the isolation policy, meant that the capacity of each colony had to be expanded and that overcrowding was a constant problem during the period of compulsory isolation.

The choice of the site of each colony took into account the number of infected people in the region and other pertinent factors about the land: salubrity, water supply and distance from urban areas. The authorities realized that the people to be interned would be a heterogeneous group, because Hansen’s disease affects people of all social classes, although more so the lower income population. For this

reason, the project had to anticipate communal living for long periods of time, possibly a whole lifetime, for very different people. Before constructing the colonies, therefore, the Sanitary Service held meetings with town councils from inland São Paulo and with organized groups from civil society.

The leper colonies were designed to become units of production and eventually self-sufficient. As a result, it was necessary to buy large rural properties far from urban centers.



Aerial view of the Santo Ângelo leper colony.

This stage presented some difficulties because, while society approved of the exclusion measures, residents and property owners from the chosen regions protested against the presence of a “leprosero” in the area. The population even threatened to burn the buildings that were being erected, forcing the official medical service to seek police protection for the patients.<sup>26</sup>

From 1931, when Salles Gomes took office, construction work to expand the network of colonies was accelerated. The urgency of the mass isolation policy was reflected in the speed of the building work. It was thought that once the isolation policy was in place, funding would be forthcoming to complete the projects. “All that will come later,” Salles Gomes said, “we will have the funding if enough patients are interned.”<sup>27</sup>

No two leper colonies had the same beginnings. The Santo Ângelo colony was planned and built by Santa Casa da Misericórdia, only to be taken over afterwards by the State. The installations of the Padre

Bento sanatorium already existed when the property was bought and they were reformed and adapted to the new requirements. The Pirapitingui, Aimorés and Cocais colonies were built by the 'Municipalities Commission' and the help of private initiative. Some of them, as we will later see, only started to be administered by the State after construction was completed. In addition to these establishments, a prevention center was also built in Jacaré that housed the healthy children of Hansen's disease patients (Monteiro, 1998, pp. 3-26).

The five colonies set up in different points in the state were, in theory, responsible for the internment of the sick from a predetermined region. Although each of the units was part of the same project, had the same objectives and answered to the same board, little by little and for varying reasons each one acquired its own character.

### **The Santo Ângelo colony**

The Santo Ângelo colony was built in the municipality of Mogi das Cruzes by the Santa Casa da Misericórdia, which managed to unite the efforts of various groups and associations, namely the Association for the Protection of Morpheans [Lepers], the Catholic Women's League, the Archdiocese of São Paulo and other religious groups. Supervising the construction of the project were the Sanitary Service director, Dr. Emílio Ribas, and the author of the National Sanitary Code, Dr. Artur Neiva (Ribas, 1917).

The architectural project idealized and approved by the Sanitary Service was organized in such a way that those sequestered in the colony could spend the rest of their lives there. This colony became a reference for the construction of other colonies in São Paulo and even in the rest of the country (Caiuby, 1918).

The buildings were planned to permit the separation of patients by sex, age and health condition. It was designed to become self-sufficient, containing land for cultivation and grazing livestock. The plans were so ambitious that it covered 348 'alqueires' [one alqueire in São Paulo is 24,200m<sup>2</sup>] and required a sizable budget.

An analysis of Santo Ângelo illustrates that the architecture played an important role in the organization of mechanisms to facilitate the identification, supervision and guarding of the interned patients. The divisions in the colony, its walls and buildings were planned in such a way to make it easier to control the behavior of patients. The planning and construction spread the vision of how an isolated world should be structured, in all its complexity, including relations of hierarchy, discipline, labor and morality. Shortly after its inauguration, the administration of Santo Ângelo was taken over by the Leprosy Prophylaxis Inspectorate and became part of the state's network of colonies.



### The Pirapitingui colony

Pirapitingui emerged from an agreement between 48 municipalities from the central and southern part of the state to house the sick from their area. These municipalities met for the first time in 1929 and agreed to free up 5% of their income for the construction of the colony. To these funds were added private donations.

The Pirapitingui colony was built along the Sorocaba-Itu highway, 22 kilometers from Sorocaba and 14 kilometers from Itu. Access was via the Sorocabana railroad, and the Pirapitingui station was five kilometers from the colony. A property with 136-alqueires was purchased in order to build the colony and, little by little, the surrounding land was also bought, increasing its size to around six hundred alqueires.

Due to the mass internment policy introduced in the state, this colony was inaugurated in 1931, when it was still being completed and had just sixty wooden lodgings, enough to house 456 patients (Maurano, 1939, v. \_\_, p. 177). The other installations were completed when the colony was already functioning.

The rapid rate of construction can be verified by the growing number of interns. In 1934, two and a half years after its inauguration, the colony had 178 houses for married patients, ten pavilions for unmarried patients, two infirmaries with eighty beds each and a prison. In the same year, it has 1,243 interns: 754 men, 427 women, 32 boys and thirty girls. Five years later, in 1939, two more pavilions were erected with the capacity for another eighty beds each and five more houses (*Diário Carioca*, 1939). A pavilion was also built for Hansen's disease patients with tuberculosis with funds from the Ministry of Education and Health (*Diário da Noite*, 1939).



Site of the Pirapitingui colony

Pirapitingui, just like the other colonies, was like a small town, with several types of workshops, minor industries and agricultural activities. It also contained services and installations that were not found in all colonies, such as a cemetery, prison and psychiatric ward. The social club building had a dance hall, library and a cinema big enough to hold six hundred people (*Folha da Noite*, 1934).

The religious requirements were the object of attention right from the start. A catholic church similar in size to one of the cathedrals from an average inland state town was built in 1936 by Caixa Beneficente with donated money. Later in the same year, a protestant church was also built.

Pirapitingui stood out from the other colonies in virtue of its size and the number of interns. According to interviews we conducted, patients from other colonies dreaded being transferred to Pirapitingui because of the inferior conditions.

### **The Cocais colony**

This colony had a similar outset to Pirapitingui. It was built to house patients from 36 municipalities. The first meeting was held in 1927 and each one agreed to reserve 10% of their annual revenues to build the project. With this money and private donations, an area of three hundred alqueires was purchased in the municipality of Casa Branca, where the colony was built (*Folha da Noite*, 1937).

The men's and women's pavilions, called Carvilles, and 46 houses for married patients were the first structures to be built, almost entirely from donations from individuals and charities. The colony was inaugurated in April 1932, when the first patients started to arrive.



Entrance to Cocais colony.

The Cocais leper colony was considered to be the worst place to be interned. This was due to a series of factors, such as the distance from the capital, the large number of interns and the small number of medical staff. The Official Service medical staff came to refer to the colony as ‘Siberia’, because it operated almost like a place of exile, where patients and staff alike were sent to be ‘punished’. Of all the state’s colonies, Cocais was the one with the highest rate of escape attempts.

### **The Aimorés colony**

This colony was planned to intern patients from 64 municipalities that, in 1927, agreed to spend 10% of their annual revenues to finance the construction. Work began in early 1930 on a rural property of four hundred alqueires and it was inaugurated on April 13, 1933, with 317 patients. It was initially planned to have one thousand beds, but this soon proved to be insufficient as only four years after it opened, it already had 1,435 patients, or 60% overcrowding. Extension work was done, to increase capacity to two thousands beds.<sup>28</sup>

Just like the other colonies, Aimorés obtained its own sports facilities, on May 1, 1943. The DPL considered Aimorés a “model colony” and it was visited by leading figures, notably politicians and leprologists passing through São Paulo. For this reason, the DPL went to greater lengths to maintain order and good presentation at the colony.



Aerial view of the Aimorés colony.

In 1944, a propaganda film was made on São Paulo’s Hansen’s disease treatment and prevention policy, which would be “distributed to the four corners of Brazil” (*Correio Noroeste*, 1944). The colony

is presented as a type of “prophylactic paradise”, with images specially selected to serve the propaganda requirements of the DPL. Internationally, experts were already starting to question the merit of segregation, and this film was made to justify the São Paulo model.

### **The Padre Bento sanatorium**

It was located only 20km from the city of São Paulo, in Guarulhos. To house the sanatorium, the government purchased an old psychiatric hospital that was located with easy access to both the highway and the railroad.

The sanatorium was inaugurated on June 5, 1931, with 83 patients. It started functioning with only the existing installations — a building for hospital patients and another for administration, but within a space of few years, it too was transformed into a small town. The arrangement of its buildings observed the same architectural and urbanistic planning as the leper colonies, although on a smaller scale than the other facilities: just 23 alqueires.

Only patients with non-contagious clinical forms of leprosy and those who were not in the advanced stages of the disease were interned in Padre Bento, while its patients whose condition deteriorated were transferred to one of the four colonies in inland São Paulo. From our research, however, we have observed that these rules of internment could be bent in accordance with external interests, via letters of recommendation or requests from politicians, that were usually accepted by the DPL board. This meant that Padre Bento became a privileged location compared to the other colonies.

The campaigns to obtain funding for the Padre Bento center involved the elite of São Paulo society and they were often sponsored by associations such as the Rotary Club. It was with these funds that new hospital wards, a dental surgery, pavilion for doctors, social club, theater, church, leisure park, sports stadium and even a small zoo were built. Much of the money was spent on furnishing the buildings earmarked for leisure activities. Photographs from the time illustrate the care taken with the decoration and the luxury of the interiors. However, not all patients interned in the center were given access to these privileges.

The proximity of the sanatorium to the capital was, from the start, the main reason to use it as a research center and for training doctors in leprology. The medical team at Padre Bento was comprised of class of ‘elite doctors’ that was not changed for decades. “Padre Bento is one of the largest therapeutic and clinical research centers of any country in the world...” (*Diário da Noite*, 1941). Phrases like this one, reported by the press, illustrate the vision of this isolation center in its time.

The interest of its director, Lauro de Souza Lima, in pediatric leprosy meant a large number of children were sent there and the particular research being carried out at any given time determined

the method of selecting patients for the facility and as a result, these methods varied. In virtue of this, many children — even those with parents interned at other facilities or those with contagious forms of the disease — ended up being housed in Padre Bento. It became a type of showcase, where distinguished visitors such as politicians, scientists and journalists were taken. Generally, they only visited the healthy zone without adventuring into the area set aside for the sick.



Dance hall and side room, The Padre Bento Sanatorium.

While São Paulo introduced “mass internment” in the 1930s with a hefty investment and unlimited government support, internment in other states in the country occurred more slowly. This is clearly illustrated when comparing the number of leper colonies and the number of internments in each of the Brazilian states.

These data do not necessarily mean that regions with higher numbers of internments also had higher prevalence of the disease. We know that Hansen’s disease in São Paulo state was highly endemic since colonial times and the problem was compounded at the end of the 19<sup>th</sup> century and during the 20<sup>th</sup> century when economic growth attracted immigrant labor (both foreigners and Brazilians), which had a direct impact in the epidemiological situation. Irrespectively, we believe the percentage of internments in São Paulo, which in 1942 was so much higher than in the rest of the country, was due more to the prophylactic policy adopted in the state than the endemic proportions of the disease.

**Leproseries in Brazil**  
**Number of interned patients per state in the 1<sup>st</sup> quarter of 1942**

State	N <sup>o</sup> of isolation centers*	N <sup>o</sup> of internments	%
São Paulo	5	8697	52.00
Minas Gerais	6	2202	13.17
Pará	3	999	5.97
Federal District	2	641	3.83
Paraná	1	630	3.77
Amazonas	2	555	3.32
Rio Grande do Sul	1	466	2.79
Espírito Santo	1	358	2.14
Santa Catarina	1	341	2.04
Ceará	2	314	1.88
Rio de Janeiro	1	247	1.48
Pernambuco	1	213	1.27
Mato Grosso	2	206	1.23
Goiás	4	200	1.20
Maranhão	1	184	1.10
Others	8	473	2.83
<b>TOTAL</b>	<b>41</b>	<b>16726</b>	<b>100.00</b>

\* These figures include leper colonies, hospitals and sanatoriums (Source: *Revista Brasileira de Leprologia*, vol. X, June 1942).

## Conclusion

The isolationist model adopted in São Paulo at the start of the 1930s was accepted by some countries as the ideal method of combating Hansen's disease, given the lack of an appropriate treatment and in view of the expectations to wipe out the disease in a short space of time.

Isolationism was a "direct" prophylactic policy. It was designed to eliminate the endemic of Hansen's disease by removing the focuses of infection — the sick — and thereby not making "indirect" prophylactic policy a primary concern. An analysis of the discourse and actions accompanying the São Paulo model reveal the lack of concern for the need to improve housing, nutrition, labor conditions etc., even in infected areas. The plan was to end the endemic nature of the disease by controlling the infected individual, a practice that was also adopted to combat other endemic diseases.

Once sulfone treatment was discovered, the prophylactic policy recommendations made by the international scientific community underwent important modifications. Leprosy congresses began to question the need for isolating patients and to recommend only selective isolation, such was the case in the Madrid Congress in 1953 and the Rome Congress in 1956. In the final resolutions of the 1958 Tokyo Congress, isolation was considered outdated. However, irrespective

of scientific progress and international recommendations, the São Paulo Leprosy Prophylaxis Department continued its policy of compulsory isolation for Hansen's disease patients.

But the impact of these international congresses in Brazil did occur on a federal level, beginning in the 1950s. The National Leprosy Service subscribed to the view that compulsory isolation was outdated and its staff helped alter federal legislation, passing federal decree nº 68 of 5/7/62 that abolished isolation. However, the fact that São Paulo's DPL had its own budget and enjoyed relative autonomy from federal funds, enabled it to defy the new national and international rules that countered its working method. The São Paulo DPL ignored the federal decree and maintained its isolationist policy in the state until 1967.

The prophylactic policy of compulsory isolation came to a close in São Paulo after a decree was passed by governor Abreu Sodré.<sup>29</sup> The DPL was restructured and stripped of its authority. The restructuring took place on 7/6/1967 and it was later transformed into the Hansen's Disease and Sanitary Dermatology Division when the Health Institute was created in 7/16/1969.

It is interesting to observe that during the 1960s, a decade of intense struggles for freedom and human rights, there is no record of any movement opposing this harsh policy in São Paulo among civil society organizations. The abolishment of compulsory isolation in São Paulo was not achieved by any social movement or the efforts of legal or human rights organizations, but instead by the initiative of the state government.

## NOTES

<sup>1</sup> Martin de Sá proposed the idea of founding a leprosy hospital in the city of Rio de Janeiro (Varnhagen, 1927, v. 2, p. 252).

<sup>2</sup> The camps and the nomadic bands of the sick were commonplace and, although not all of them had Hansen's disease, the population considered them all to be lepers.

<sup>3</sup> G. H. Armauer Hansen discovered the causative agent of leprosy in 1872, mentioned it in a report in 1873 and published his discovery in 1874. For more information, see Leger (1927) and Monteiro (1995, p. 121).

<sup>4</sup> Even after Hansen's discovery, some still insisted that the disease was hereditary and it was decades before the theory that it was contagious was fully accepted. Among the advocates of hereditariness are the key figures: Danielssen, Boeck, Hebra, Hardy, Bague, Godart, Alibert, Brassac, Virchow etc. In São Paulo, one of the followers of this theory was José Lourenço de Magalhães, director of the Guapira hospital, run by the Santa Casa da Misericórdia to treat Hansen's disease patients in the capital.

<sup>5</sup> This classification of Hansen's disease, proposed at the Havana Congress in 1948 and again at the International Leprosy Congress in 1953, is still in place today and enables the detection of four basic forms: indeterminate or early form: initial stage of the disease; tuberculoid: non contagious 'pole', normally stable; lepromatous: contagious 'pole' with large number of bacilli; dimorphous: very unstable, with positive or negative bacilli. Hansen's disease is classified according to its tendency to shift to one of the 'poles': lepromatous or tuberculoid.

<sup>6</sup> Emílio Ribas is associated with the start of experimental science in São Paulo, having worked in several areas. He was a leading figure in the combat of tuberculosis, bubonic plague, yellow fever and also for his role with leprosy. During his time as director of the São Paulo Sanitary Service, he oversaw the construction of the Campos do Jordão sanatorium and the founding of the Butantã Institute.

<sup>7</sup> Artur Neiva was author of the 1918 Sanitary Code and São Paulo state health secretary; Heráclides Cezar de Souza-Araújo was director of the National Leprosy Service in 1926; and Belisário Pena was director of the National Health Department in 1930.

<sup>8</sup> All the illustrations shown here are from the Iconographic File of the Health Memorial Research Center, of the Health Institute.

<sup>9</sup> In São Paulo, leprosy was frequently discussed in newspapers, which contributed to raising the interest of the public in the disease. In the early decades of the 20<sup>th</sup> century, various organized groups and institutions were set up to address the problem or get involved with the treatment. The leading organizations were the Association for the Protection of Morpheans [Lepers], the Society for the Assistance of the Leprous and Defense Against Leprosy. The latter served as a reference for similar organizations founded both in São Paulo and in the rest of Brazil.

<sup>10</sup> In 1924, the São Paulo Leprosy Prophylaxis Service was created and transformed the following year into the São Paulo Prophylaxis Inspectorate. In 1935, this was replaced by the powerful Leprosy Prophylaxis Department — DPL. In virtue of the continuity of these services in leprosy prophylactic policy, I have opted to use simply the acronym DPL and/or “official medical service” or “prophylaxis service”, which were the terms used at the time.

<sup>11</sup> The regulations would later be reformed by decree nº 16,300 of 12/31/1923.

<sup>12</sup> Where leprosy was concerned, São Paulo disregarded the agreement although it later observed the regulation through the 1925 decree (Valle, 1928, p. 67).

<sup>13</sup> São Paulo leprologists had already requested an official government department with its own budget, staff and special legislation for Hansen's disease prophylactic programs, as can be seen in a proposition submitted to the São Paulo Medicine and Surgery Society by Dr. Aguiar Pupo. See *Anaes Paulista de Medicina e Cirurgia* (1924, p. 262).

<sup>14</sup> The IPL continued to answer to the Sanitary Services' Infectious Disease Division, which in turn was answerable to the Department of the Interior. In São Paulo, the State Education and Public Health Department was not created until 3/3/1931.

<sup>15</sup> An example of this can be seen during the Júlio Prestes government, in 1927, when José Maria Gomes was replaced by Aguiar Pupo, professor at the Dermatology and Syphilography Clinic from the São Paulo Faculty of Medicine. The former opposed the policy of isolation and, during his tenure, dispensaries were set up to treat patients with non-contagious forms of the disease, thus avoiding their internment and allowing them to live in society. The latter was an advocate of isolationism. For more information, see Belda (1974, p. 274) and Pupo (1955).

<sup>16</sup> On taking power, Getúlio Vargas appointed Colonel João Alberto Lins de Barros as federal intervener in São Paulo. “Determined to resolve the problem of leprosy practically,” he fired the head of the IPL, Dr. Aguiar Pupo, and appointed in his place Dr. Heráclides Cesar de Souza Araújo. As the latter was in Europe at the time, the position was filled temporarily by the surgeon Francisco de Sales Gomes Júnior, who ended up taking the job permanently. See ‘A campanha contra a lepra em São Paulo: o programa organizado pelo dr. Souza Araújo’ (the campaign against leprosy in São Paulo: a program organized by Dr. Souza Araújo), *Mundo Médico*, 5/28/1931.

<sup>17</sup> The regional branches were located in the offices of the Regional Health Delegateships, which were situated in six strategic locations in the state: Campinas, Santos, Ribeirão Preto, São Carlos, Botucatu and Guaratinguetá.

<sup>18</sup> The following was revoked: state decree nº 3,876, of 1921, which had been inspired by federal legislation, and law nº 2,121, of 12/20/1925, replaced by law nº 2,416, of 12/31/1929.

<sup>19</sup> “Associates” were all people who had been in contact with the patient. In general, when a Hansen's disease patient was put on file, his whole family was listed and they automatically became “associates”.

<sup>20</sup> The visiting room was the place where patients received visitors. There was always a screen separating them from the visitors, either a wall or a single or double barrier, depending on the colony.

<sup>21</sup> The Caixa Beneficente was a way the DPL found to neutralize any possible influence from private donors on the internal structure of the colony. The Caixa management was always appointed and controlled by the director of the colony and all donations were centralized in the Caixa Beneficente, which decided where and how to spend the money.

<sup>22</sup> Each colony had a ‘mayor’ who was selected from among the patients by the director. Even though the article was written about the Pirapitingui leper colony, the structure and the characteristics mentioned were similar to those of São Paulo's other colonies. For more on the topic, see *Brasileira de Leprologia* magazine, 1936 pages, 95-105.

<sup>23</sup> At the Pirapitingui colony, the staff was comprised of eight employees: two resident doctors, two dermatologists, one surgeon, one ophthalmologist, one trainee general practitioner, one dentist and one pharmacist. The trainees had to care for more than one thousand patients. The nursing staff was made up of 45 patients: one head nurse, 23 nurses and 21 assistant nurses.



<sup>24</sup> Data collected from interviews conducted by the project currently underway 'Nursing practices in leper colonies in the state of São Paulo', a project coordinated by Professors Yara N. Monteiro, Ph.D, and Maria Lúcia de Barros Mott, Ph.D.

<sup>25</sup> Chaulmoogra oil was widely used in the East as a medicine for leprosy. It was introduced in Brazil at the end of the 19<sup>th</sup> century and became the principal medicine against the disease, used until the discovery of sulfone treatment in the 1940s. It was administered both internally and externally, producing strong reactions among the patients. Despite its widespread use, there is no proof that it ever had any effect against the disease

<sup>26</sup> This occurred in 1931 at the Padre Bento sanatorium, 15km from the town of Guarulhos, not far from the city of São Paulo. See *Estado de São Paulo*, 6/17/1931.

<sup>27</sup> Statement made by DPL director Francisco Sales Gomes, mentioned by Francisco de Palma Travassos, a member of the Leper Colony Planning and Construction Commission who had been taught by Souza Araújo (Travassos, 1945, p. 87).

<sup>28</sup> The number of interns and the need to expand the colonies was frequently reported in the newspapers, both in the capital and in inland São Paulo. They published data supplied by the DPL and made comparisons between the different colonies in the state. For examples, see *A Tribuna de Franca* (1937).

<sup>29</sup> There was a change of government in São Paulo in 1967: the governor elect, Abreu Sodré, appointed Walter Leser as Health Secretary, who in turn appointed Dr. Abraão Rotberg, who had already retired from the official service, to the board of the DPL. This appointment represented a radical shift in policy. However, the abolishment of compulsory isolation in São Paulo was not a easy process, not even for the new director. Special measures were required that affected, internally, the DPL itself and, externally, the government and society.

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