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Prophylactic architecture:
Spatial configuration of Leper Colonies

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Abstract
This research discusses the Leper Colonies as part of the prophylactic policy of compulsory exclusion for all leper patients. The leper was identified as contagious in 1883, which triggered the discussion regarding the isolation of patients as the primary means for prevention of the disease. The discussions about the design of a Model Colony from which other Brazilian colonies could be built started in 1921. This represents the template for the prophylactic policy of leper in Brazil, being adjusted to the various regional circumstances, thus acquiring unique/particular configurations. In 1935, a National Plan to Combat Leprosy was established, resulting in construction of Leper Colonies throughout Brazil. The Mirueira Colony, built in Pernambuco from 1937 to 1940, was a part of that plan. It was conceived as a colony isolated from society, which should meet all the patients’ needs by including a hospital unit, as well as residences, leisure equipments and areas for the practice of agriculture and animal breeding. These were small towns where the patients would rebuild their lives ruled by the administrative staff. This episode represents the association between architecture and urbanism and the current medical and sanitary engineering precepts, where the purpose of the colony and its spatial configuration are closely linked. The colony is perceived as a prophylactic instrument, therefore, part of the medical apparatus. Thus, the aspects considered in the prophylaxis of the disease are based on assumptions of classification and inclusion of different social categories in a strict hierarchical system, expressed in the medical instructions and in architecture. Classification is a key to the spatial discourse. The organization of patients was based on several criteria: income level, gender and age, degree of disease. These classes appear in both discourse of leper prevention as in the spatial configuration of the colonies, defining how the patients were housed in these institutions. The different classes should be arranged in the colony with the meeting between them controlled so as to ensure order. In the case of the Mirueira Colony, there is a clear distinction between inhabitants and visitors. The classes are organized in a nondistributed system, with classes of equivalent status located at the same depth. The superior class - the healthy - appears in the shallower levels, while those related to the patients are located in the deepest levels. For the movement between spaces related to different classes, there is the obligatory passage through the space that has more control. Men and women, although side by side in the plan, meet only in scheduled activities, or on space under constant control. The study of spatial pattern of the leper colony shows that the space restricts and selects the users according to their functions and contributes to the prevention of leprosy, both by the patients’ isolation from society, but within the institution to ensure the order and the protection of the staff.

Keywords
Leper, leprosy prophylaxis, spatial configuration, categorical differentiation.
1. Introduction

The Mirueira Colony (Leprosário da Mirueira) was part of a National Plan to Combat Leprosy developed by the Brazilian Government in the first half of the 20th Century. Leprosy was identified as contagious in 1883, replacing the previous idea that it was a hereditary disease, which triggered the discussion regarding the isolation of the patients as the primary means for the disease's prophylaxis\(^1\) in order to protect them and society. The leper\(^2\) colonies were conceived for this purpose.

The patient isolation policy was based on international medical discussions from the First International Conference on Leprosy held in 1897 and on local discussions led by Oswaldo Cruz through the Public Health Reform of 1904. The argument was that isolation was necessary due to the disease's contagiousness, therefore considered a social threat, and due to its slow development, maintaining the patients productive for many years. Leper colonies were then conceived as small towns apart from society that should meet all patients' needs. Brazilian discussions were synthesized in 1918 at the project of a Model Leper Colony, a reference for the design of future leper colonies in the country.

This episode represents the association between architecture and urbanism and current medical and sanitary engineering precepts, where the purpose of the complex and its spatial configuration are closely related. The leper colony is understood as prophylaxis instrument, therefore, part of the medical apparatus. Thus, this research is based on a theory that investigates the relationship between space and society, since aspects considered in leprosy prophylaxis are based on classification of different social groups in a strict hierarchical system expressed in the medical instructions and, therefore, in architecture. Thus, architecture is not scenario but a supporting player of the institutional order. The supporting role is most evident when strict control over certain users' classes is necessary, as to the re-formation of patients (Markus, 1993). These institutions operate by the confinement of individuals and by imposing on them a secluded life, with their routine tightly controlled. Goffman (2005) calls them total institutions.

In various spheres of human society, whether within public spaces or in environments for work or housing, architecture - the city or the building – consists and is constituted of socio-spatial relations, after all, according to Hillier and Hanson (1984), there is no non-social space and even less a non-spatial society. Buildings construction is preceded by expectations of society, represented by a series of social rules, such as those governing the social dynamics. These social assumptions, called the building's text by Markus (1987), described or prescribed in the language spoken or written, are not innocent, carrying meanings between the lines. According to Markus (1993), the main function of buildings is to order people in space, according to categories and interaction forms prescribed by society. In this sense, it acts as devices that control occurrence of some events, either to favour or restrict it. Architecture can be understood as a necessary interface to achieve the objectives of a reformer institution. Taking into consideration that space is the result of social requirements, Hillier and Hanson (1984) suggest that there is a mutual interference. Once built, it is the space that will interfere with human behaviour by the organization within it and especially by the relative position of each individual in relation to others.

This research observes the architecture of the leper colonies as an instrument for leprosy prophylaxis in the first half of the twentieth century in Brazil, when its prescriptive texts, derived from medical sciences, recommended the isolation of patients as prophylactic measure. This meant the permanent isolation of persons with leprosy from society, since the cure of the disease was unknown. The need to create appropriate conditions for the medical care of inmates is evident as well as to constitute socio-control mechanisms, based on the categorical differentiation between

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\(^1\) It means the measures designed to preserve health and prevent the spread of a disease (Prophylaxis, 1995).

\(^2\) The use of the term ‘leper’ is not recommended today because of its social stigma. We have chosen to use the terms ‘leprosy’ and ‘leper’ rather than Hansen’s Disease and its derivatives because those were the current denominations within the time frame of present research. A campaign led by The Leprosy Mission – England and Wales named ‘Don’t call me a leper’ advocate the use of the term ‘people affected by leprosy’ (The Leprosy Mission, n.d.). In Brazil, the word ‘lepra [leprosy]’ and its derivatives were abolished in 1976 (Alecrim, 2012).
managers and internal, as well as among the patients. The latter is classified according to medical diagnosis - health condition; gender; age, marital status and income level.

2. Leprosy prophylaxis in Brazilian cities

Since architecture is understood as an expression of social assumptions, the first step between language and building experience is the creation of a text on the object to be designed, expressing their goals and aspirations (Markus and Cameron, 2002). In the first decades of the twentieth century, the world witnessed discussions that defined the confinement of the patient as prophylactic measure for leprosy and how this should happen.

Until the late nineteenth century leprosy was treated in Lazar-houses, which spiritually supported the patient until his death, without changing the course of the disease (SNL, 1960). After the identification of the causative agent of leprosy in 1874 by Gerhard Armauer Hansen, the idea that it was a hereditary disease was questioned, leading to a theory based on its contagiousness, although the modes of transmission was unknown, as Oswaldo Cruz (1913, p.117) points out: ‘What is known is that the illness is transmitted. How, we do not know. But the leper is at least one virus deposit. This is proved. Thus there is the need to isolate them from community’. Hansen recommended, in the First International Conference on Leprosy in 1897, the compulsory isolation of patients and countries all over the world adopted this procedure. In Brazil, with the Public Health Reform led by Oswaldo Cruz in 1904, leprosy was considered a public health problem and the compulsory notification and isolation of the patients were determined. At that time, the isolation could be at home or at hospitals.

Leprosy has a slow development and lasts for many years. During this time, it causes several modifications on the structure and functioning of the body. Initially the deformities and disabilities are mild and reversible, and with time it becomes serious and permanent. That is why regarding the isolation of patients at hospitals, doctors advocated the creation of Leper Colonies:

‘The essentially chronic character of leprosy prevents the isolation measures at generic isolation hospitals. The leper might, for many years, devote himself to work; so their sequestration of society must be made, not in a hospital but in suitable institutions, 'leper colonies', where, besides the essential treatment, the leper will find necessary elements for the realization of activities, still very usable’ (Cruz, 1913, p.116).

Although this discussion began in the early twentieth century, it was only in 1935, with the National Plan to Combat Leprosy, that the leper colonies’ construction program was established. With this plan, eighteen leper colonies were built in the country from 1937 to 1941, including Mirueira Colony in Pernambuco, concluded in 1941 (Alecrim, 2012). Besides offering medical treatment and researches for the disease’s greater understanding, those institutions were designed as small towns, isolated from society, as recommended. They were designed to meet all patients’ needs, including a hospital, residences, workshops, areas for agriculture and livestock and leisure facilities. The medical and social expectations for those colonies pointed towards two apparently contradictory goals. On one hand, its main function was to isolate the patient from society. This should be achieved without any aspect of hospital or prison, so without walls ‘for the bad effect it causes on internns spirit, to whom should be avoided any impression of forced confinement’ (Ponde, 1948, p.289). The contention of the patients within leper colonies should then be achieved through other means, ‘especially those derived from a good surveillance, in addiction to those moral elements that should be managed in a way to make the hospital a more attractive place’ (Ponde, 1948, p.289). On the other hand, the humanitarian approach recommended the creation of an environment where patients could enjoy apparent freedom. At those colonies, the patients would create a parallel society:
‘A shelter of kindness and faith in better days appeared, where at least the sense of society, conviviality, placidity, peace of mind and finally its own intimate haven, may be created, giving them the ultimate and fortunate illusion that the world no longer repels them and that the right to life was found again’ (Neiva, 1919, p.245).

Thus, in a scientific and humanitarian point of view, these colonies should protect the community from contamination danger and offer the patient treatment in a decent environment, similar to a life in society. From the strict scientific point of view, isolating the patient meant the isolation of its causative agent. Thus, it was not enough to just remove from society the bacillus carriers, but also insert them in an environment regulated by rigorous hygienic precepts and required their subordination to treatment. At leper colonies, social control instruments were associated with therapeutic tools.

Once arrived at the colonies, suspected cases should be kept in observation pavilions until diagnose was conclusive. Those diagnosed with leprosy were intended for confinement. Once they were admitted, they would be deprived of all their possessions. This procedure reflects the practices of total institutions where the inmates suffer the ‘mortification process of self’ (Goffman, 2005). Without any possessions, patients begin to lose their identity and are labelled as lepers, forming a large class of individuals that the colony intended to re-form (Markus, 1993). Hence, it marks the first and most obvious categorical distinction between users of the complex: the sick and the healthy. Patients were initially classified into valid and invalid, according to the disease’s degree, and the last one would be hospitalized at an infirmary. Married couples or families could cohabitate in specific departments of the colony. Singles and children would live in collective pavilions, separated by age and gender. Wealthy patients could rent houses built for this purpose or even construct their own dwellings. Patients should then be organized at the colony so that ‘is respected hierarchy featured to all human societies’ (Continentino, 1933, p.834).

Figure 1: Diagram of classes in leper colonies

Therefore, the leper colony can be understood as a total institution, ordered accordingly to a prescriptive text that classifies subjects and activities. It can be seen as the materialization of these concepts and as a tool to achieve efficient leprosy prophylaxis through the re-formation of patients.

To achieve its aims, the maximum separation between the categories was necessary, complemented by the absolute control of patients, according to several criteria: disease’s development degree, income level, marital status, gender and age. These classes are present both in the prescriptive text and in the colony’s spatial configuration (Figure 01).
In addition to residences for patients, other activities were provided in the colony. Surveillance and control equipment contributed to maintaining the order on the institution, such as guardhouses, police stations and prison. Some activities consisted of services for the colonies’ maintenance, as bakery, power station, water collection systems, sewage treatment, laundry and incinerator. As pointed out previously, the objective of the institution from a medical point of view was treatment and research. For treatment, it was necessary encounters between doctor and patient, so medical services pavilions were conceived. As leprosy patients could develop other diseases, or suffer temporary worsening of their conditions, they should be housed in specific locations for medical treatment, such as intercurrent disease pavilions and infirmary, the latter also designed to house those invalid patients. If, however, patients presented other contagious diseases apart from leprosy, it would be necessary to separate them at isolation pavilions.

In order to contribute to the medical treatment, researches were encouraged. To this end, buildings such as pharmacy and laboratory were designed for the development of drugs, and morgue, for autopsies. Buildings were designed to enable the implementation of what would be a life in society, as school, shops, amusement pavilion, refectory and Catholic Church, among others. A key component of the patients’ treatment was the consent of visits, either to contribute to a voluntary hospitalization or to enhance a general welfare at the institution. Visits would take place at the conversation pavilion, designed to assure the main points of the leper colonies’ text: the strict separation between sick and healthy.

In sum, for each category of person or activity defined by the institution text, a place in the complex should be assigned (Markus and Cameron, 2002). Hence, two premises should guide the functioning of leper colonies: distinction between categories of occupants and activities and absolute control of the relations between them. To achieve both goals, it is expected that space perform its function.

Figure 2: Model Leper Colony Plan. (Souza-Araújo, 1948, print 13 / edited by authors)

An intercurrent disease occurs during and modifies the course of another disease (‘Intercurrent’, 1995).
3. From text to model Leper Colony

In 1918, at 8th Brazilian Congress of Medicine and 1st South American Congress of Dermatology and Syphilology, doctor Emilio Ribas presented the project of Model Leper Colony at Santo Ângelo Fields, \(^4\) (Figure 02) from which other Brazilian Leper Colonies should be built. The colony, designed by the engineer-architect Adelardo Soares Caiuby, would occupy a site with 2000 hectares to house 1,000 people, including patients and staff (Ribas, 1921).

The Model Leper Colony was organized into two main sectors, one intended for healthy and another one for sick, connected through an inspection and control sector, as shown in its sector’s graph, \(^5\) (Amorim, 1997; 1999) (Figure 03). The sick sector, in turn, is divided into several subsectors connected by a mediator, representative of a sequence of streets in the justified graph. The subsector’s graph shows that subsectors are organized symmetrically in relation to this mediator. The administration subsector is in a central position and connected directly to four housing subsectors. The mediator is the obligatory passage to various subsectors. An alternative route through is provided through the administration subsector, under the domain of the staff. Hence, it is possible to identify the presence of strong and well-defined subsectors. The access street to sick sector is strongly connected. All the sector distribution is made from it as well as the three links with the supervision and control sector. This space is configured as a cut-vertex (Steadman, 1983); a connection that, if deleted, would make the system fall into two disconnected complexes. This type of access to the sick sector features the control exercised to it.

Observing the organization of the entire colony, including its buildings and street systems, accessibility within it is asymmetric and predominantly non-distributive. On the other hand, the organization within subsectors has, in most cases, several rings and therefore various alternatives of movement. Thus, relations between sectors and subsectors are intensely controlled and probably operated according to rigid rules. On the other hand, within the sector, the distributive organization operates to hold meetings in more informal activities.

It is interesting to note that more movement alternative to access is provided to male subsectors in relation to other subsectors if compared to women. Although it is important to note that the male subsector is exclusively composed of residence units, whereas the female one had several support equipment. Thus, men would have to leave their subsector to perform other activities, such as entertainment or to go to the research subsector, since the male patients would be the main research volunteers (Caiuby, 1919). These three subsectors - men, amusement and research have smoother edges since there are several connections between them.

As mentioned, the sick sector’s subsectors are connected to the administration subsector - where are also located the refectory pavilion, the church and conversation pavilions. This subsector is directly connected to the access road from these last two devices. The graph on Figure 03 presents all permeability possibilities in the open spaces of the complex. The relation of them with buildings is shown as an interface, which may or may not also provide permeability through the building when it has multiple accesses. When the permeability exists, this can still be changed by social measures - behavioural rules, coercive signs or even by closing doors, ceasing the permeability to specific classes at limited time. Those buildings are devices conceived to allow co-awareness and co-presence without compromising the prophylactic precepts. They functioned as mediators of sectors within the complex and its occupants. At them, the space is a mediator for the encounter of distinct categories of the complex, supported by precise and complex rules, representing a long model (Hillier and Penn, 1991).

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\(^4\) This colony has never been built.

\(^5\) The sector graph derives from the subsector graph that, in turn, derives from the justified graph. Each spatial unit was identified with a category or was assigned as mediator when connected different categories. When an aggregation of continuous spaces of same category was identified, these spaces sequences were represented by a single node, corresponding to a subsector (Amorim, 1999). The sector graph resulted by grouping all subsectors in sick sector.
Figure 3: Model Leper Colony – interface map, justified graph, sector’s graph, sub-sector’s graph.

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The refectory did not provide the meeting of distinct categories, but enabled the performance of the same activity for distinct classes at the same time. Permeability between the wings, and therefore among the subsectors in fact exists but it occur in staff domain area. Hence, this permeability is not presented to the patient. The church, on the other hand, was conceived as a device to provide a certain type of encounter between sick and healthy. The building is divided into three wards for the public (healthy, men and women) and one for the altar and the dependencies of the religious. Finally, the Conversation Pavilion provided the encounter of interns with strangers to the complex. But to allow the encounter between patients and the healthy could undermine the main objective of the institution: to isolate the patient. So, the Conversation Pavilion was designed to provide the meeting through the adjacency of spaces intended for different categories and the installation of a transparent material, the glass, between them. Co-science would be possible thus the contact was impossible (Figure 04).

Figure 4: Model Leper Colony - Conversation Pavilion, Refectory Pavilion and Church (Caiuby, 1919, p.63, 71, 92.).

Thus, the Model Leper Colony selects and orders its users at various levels, from their overall organization to the buildings that promote the encounter of different classes. The non-distributive structure between sectors and between subsectors associated with the distributiveness within the subsector is probably related to aspects of a free life presented in the medical and social discourse (Caiuby, 1919; Ribas, 1921) associated with the necessary control to maintain order in the institution. The permeability between subsectors occurs under strong programs, since it is a regulated and controlled activity.

4. Mirueira Colony

The Mirueira Colony (Figures 05 and 06) was part of the National Plan to Combat Leprosy and it was built in a small valley surrounded by hills, near a virgin forest, fourteen kilometres away from Recife, capital of the State of Pernambuco.

The first and most obvious categorical distinction is between the interior and the exterior of the colony. In order to ensure separation between the institution and the outside world, the physical structure for insulation is a fundamental element in a total institution (Goffman, 2005), but the social expectations indicated that any forced seclusion aspect should be avoided. The recommendation of installing the colony in lands with just one access point (Continentino, 1933) allows for a deep spatial structure without the need for building walls.
Figure 5: Mirueira Colony Plan (Arquivo Público Estadual Jordão Emereciano (Divisão de Iconografias, Planta: 215/3) / Edited by authors).

Figure 6: Mirueira Colony - Panorama from marrieds’ subsector (CPDOC – Arquivo Gustavo Capanema, Ref. GC foto 529).
The colony was divided into three sectors as recommended by the medical discourse: healthy, sick and neutral (Figure 07). The healthy sector is located at the higher levels close to the colony’s entrance and contained houses for administration employees, doctors and directors. This healthy sectors’ elevated position allowed the surveillance of neutral and sick sectors. The only access to the colony is through the healthy sector. The interface between the medical and administrative staff’s residences and the road access resulted in a potential surveillance by the healthy all the time, which reinforced the control of the colony’s only access.

![Diagram illustrating the layout of the colony](image)

**Figure 7**: Mirueira Colony – interface map, justified graph, sector’s graph, subsector’s graph.

This same road led to the neutral and the sick sector, both located in lower area and surrounded by hills. Only one alternative connection is provided directly between the two sectors, through the road where the infirmary is. Aside from this, the entire relation between them occurs through the main road that begins in the healthy sector. However, relations with this route at the neutral and sick sectors are so fluid and with so many points of contact that they can be understood as a unique sector. It is only in the relation between the healthy and neutral sectors that there is a cut-vertex (Steadman, 1983).

An observation pavilion, the administration building, a pharmacy with laboratory and the house of the nuns composed the neutral sector. There was also a house for the nurses and a purge pavilion with a dressing room where the staff eliminated the dangers of contamination after contact with patients. The boundary between the neutral and sick sectors was marked by the facilities in which it was necessary the encounter of sick and healthy: the Conversation Pavilion, the Medical Services Pavilion, intended for medical appointments; and the Infirmary with an operating room. These
buildings’ design received special attention in order to distinguish spaces for sick and healthy. In the Medical Services Pavilion (Figure 08), their meeting only occurred at the consulting room, with independent circulations for each category. As for the Conversation Pavilion, Oliveira (2007) describes it as the designed for the Model Leper Colony. As in Model Leper Colony, the referred buildings are devices conceived to allow co-awareness and co-presence of distinct categories without compromising the prophylactic precepts and so represent a long model (Hillier and Penn, 1991).

Figure 08: Mirueira Colony – Medical Services Pavilion

Source: CPDOC – Arquivo Gustavo Capanema, Ref. GC foto 529

In sick sector were exclusive facilities to patients - housing, leisure and services. The residential subsectors have defined boundaries - men, women, married and taxpayers occupy different places in the complex, with only one or two accesses to the mediator street. The categorical distinction is very clear in Mirueira between the patients and obeys two axes in the plan. A horizontal axe, in which there is a distinction among patients by gender, and other vertical, with the distinction by social class, even more restrictive than the first one. It would be the government’s way to establish the social rules, ‘in a way that peculiar hierarchy of all human societies is respected’, as pointed out by Continentino (1933). In this plan, the central area, marked by the area for sports and leisure and the amusement pavilion, while it unites all people, since it is equidistant from all residence subsectors, is the separator element between taxpayers and indigent. Thus, relations between sectors and subsectors of each sector are intensely controlled and probably operated by rigid rules, in a structured derived from a long model.

5. Prophylactic Architecture

The study of spatial pattern of leper colonies offers the opportunity to analyse the relationship between the requirements of leprosy prophylaxis and form and space principles. Architecture and urban planning were understood as result of requirements to meet the aim of certain institutions. Therefore, these requirements structures spaces in which people move and act, providing the material preconditions for the movement and encounter patterns which are material achievements of social relations (Hillier and Hanson, 1984; Markus, 1993).

The primary function of the leper colony was isolating the patient from society. But the isolation principle was not enough to ensure the proper functioning of this institution. It was also necessary the division of space accordingly to the occupant’s classes and the distribution of individuals in it, with defined position of each one in the series and the distance that separates him from the other (Foucault, 2004), thus establishing presences and absences and establishing communications and interrupting others, in a way to enable the surveillance and analysis of each individual’s behaviour.

Classification is a key for the spatial discourse. As seen, a total of eight classes should be arranged in the device. The classes were organized in a non-distributive way and classes with equivalent status were usually at the same depth. The hierarchically superior class - the healthy - is always in the role of access controller to the system, while those related to patients – with no categorical distinction between them - are located within the same depth regarding this access.
The Model Leper Colony was designed as the precise reification of prophylactic principles, in particular those related to the distinctions between the various classes of patients. Sociability in such a complex could be established, and indeed the distributive structure within subsectors would provide encounters, but this would always be between individuals of the same class. Men and women would never meet in Model Leper Colony. But patient voluntary internment desired by prophylactic campaign would hardly be achieved if possibilities of interaction between men and women were not offered, since this is an important aspect of social life. That is probably why in Mirueira Colony, as in other colonies built in Brazil (Alecrim, 2012), the categorical distinction between men and women are not as strict as those found in Model Leper Colony, at least not in its spatial structure. Nevertheless, the encounter of men and women and permission to dating and marriages within the colonies shows it was essential to achieve an essential point of social life’s reproduction – even if it is a controlled event. At Mirueira Colony, for example, social rules defined that unmarried couples could only meet in the presence of a married couple or a nun (Oliveira, 2007).

To balance the encounter potential provided by the spatial structure, social control’s mechanisms were conceived to curb disobedience to regulations. At Mirueira Colony, as in most colonies in Brazil (Alecrim, 2012), the administration is located at neutral or even healthy sector in opposition of what is proposed in the Model Leper Colony, that it is located in a central position at sick sector. At those colonies there was a surveillance pyramid on interns that had on its base some of the patients themselves operating in maintaining order: there was a mayor, a sheriff and policemen. With the existence of such jurisdiction, subordinated to general direction of the colony, it was unnecessary the presence of a healthy administration among the patients – which reinforces the aspect of a normal life. The exception in the segregation of classes occurred at institutional ceremonies that aimed a greater approach between those classes. The aim of such institutional celebrations was the temporary release of the papers as a way to ease tensions and mounting frustrations, allowing further integration between the intern and the staff (Goffman, 2005). At the colonies, those are represented by celebration of festive dates, such as Carnival or Christmas, when everyone celebrated together.

Testimonies of life at Mirueira and other colonies (Serres, 2004; Braga, 2006; Oliveira, 2007; Câmara, 2009) suggest that the sociability at those places was the result of the institution’s own organization to provide a social reorganization for the interns (Goffman, 2005). Meetings between the different classes were programmed and monitored, guided by a strong program (Hillier et. al, 1984; Hillier and Penn, 1991).

The study of the spatial pattern of the Model Leper Colony and Mirueira Colony shows that the architectural space restricts and selects users of the complex accordingly to their functions and contributes to the leprosy prophylaxis structured in the first decades of the twentieth century, both by isolating the sick from society as to ensure the operation of the order, and by the protection of the healthy working there. As pointed out by Markus (1993, p.97) on re-formation buildings

‘order is based on stable categories of people, objects and activities, together with a set of rules – much stronger and more explicit than in other buildings – which govern their interactions […] They define the location of persons and things, they control the paths of movement and the degree of choice as well as the visual paths, they define programmed encounters and place limits on those occurring by chance. Time and space are joined in rules, which govern the opening times of specific spaces. In short the building and its management determine who does what, where, with whom, when and observed by whom’

Associated with segregation determined by the colonies’ space pattern, patients were subjected to strict internal regulations based on the instructions of the Leprosy National Service in order to control the routine and prevent escapes or indiscipline. Despite this, the colonies were also sociable environments. Oliveira (2007, p.107) studied the everyday life in Mirueira and draws attention to the
resistance tactics of the interns that ‘did not build a history of life based on pain and suffering. [...] Within the space imposed on them, they reshaped their lives, forged new relationships, new pacts of familiarity and solidarity [...] they turned that space into a real city’. This sociability can be both subversion of the system or, more likely, a result of concession of programmed encounters. A deeper study of its social life could answer this point. But, regarding to its spatial pattern, Mirueira Colony attend the expectations expressed in its text and contributes for leprosy prophylaxis.

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