

## Genesis of home care in Brazil at the start of the twentieth century

*Gênese da atenção domiciliária no Brasil no início do século XX*

*Génesis de la atención domiciliaria en Brasil al inicio del siglo XX*

Stefanie Griebeler Oliveira<sup>a</sup>  
Maria Henriqueta Luce Kruse<sup>b</sup>



### How to cite this article:

Oliveira SG, Kruse MHL. Genesis of home care in Brazil at the start of the twentieth century. Rev Gaúcha Enferm. 2016 jun;37(2):e58553. doi: <http://dx.doi.org/10.1590/1983-1447.2016.02.58553>.

DOI: <http://dx.doi.org/10.1590/1983-1447.2016.02.58553>

### ABSTRACT

**Objective:** to discuss the conditions that enabled home care at the beginning of the twentieth century.

**Method:** study of the genealogic inspiration on home care. The empirical material consisted of legal documents on the subject that were published in the Official Journal. The documents were studied using analytical tools, such as *Power, Discipline* and *Biopolitics*, which were inspired in Foucault.

**Results:** two analytical categories were established, “home inspection: visiting nurses and tuberculosis” and “records: political and economic apparatus”.

**Final considerations:** tuberculosis, the new profession of visiting nurses, inspection records and the detailed analysis of the cities grant home care a nature of surveillance, inspection and control to conduct the behaviour of individuals.

**Keywords:** Population surveillance. Home care services. Home nursing. Nursing.

### RESUMO

**Objetivo:** problematizar as condições de possibilidade para o aparecimento da atenção domiciliária no início do século XX no Brasil.

**Método:** estudo de inspiração genealógica sobre a atenção domiciliária. O material empírico foi constituído por dois documentos legais sobre o tema publicados no Diário Oficial. A análise documental utilizou as ferramentas analíticas *poder, poder disciplinar* e *biopolítica*, inspiradas em Foucault.

**Resultados:** foram elaboradas duas categorias: “Vigilância no domicílio: as enfermeiras visitadoras e a tuberculose” e “Registros: o aparelho político e econômico”.

**Considerações finais:** A tuberculose, a nova profissão das enfermeiras visitadoras, os registros produzidos pela vigilância e a análise minuciosa das cidades conferiram à atenção domiciliária um caráter de vigilância, inspeção e controle voltado a conduzir as condutas dos indivíduos.

**Palavras-chave:** Vigilância da população. Serviços de assistência domiciliar. Assistência domiciliar. Enfermagem.

### RESUMEN

**Objetivo:** problematizar las condiciones de posibilidad para el aparecimiento de la atención domiciliaria al inicio del siglo XX.

**Método:** se trata de un estudio de inspiración genealógica sobre atención domiciliaria. El material empírico fue constituido por documentos legales sobre el tema, publicados en el Diario Oficial. El análisis documental utilizó las herramientas analíticas *poder, poder disciplinar* y *biopolítica*, inspiradas en Foucault.

**Resultados:** fueron elaboradas dos categorías analíticas, “vigilancia en el domicilio: enfermeras visitadoras y la tuberculosis” y “registros: aparato político y económico”.

**Consideraciones finales:** la tuberculosis, la nueva profesión de las enfermeras visitadoras, los registros producidos por la vigilancia, y el análisis minucioso de las ciudades configuran la atención domiciliaria con carácter de vigilancia, inspección y control para mejor conducir las conductas de individuos.

**Palabras clave:** Vigilancia de la población. Servicios de atención de salud a domicilio. Atención domiciliaria de salud. Enfermería.

<sup>a</sup> Universidade Federal de Pelotas, Faculdade de Enfermagem. Pelotas, Rio Grande do Sul, Brasil.

<sup>b</sup> Universidade Federal do Rio Grande do Sul, Escola de Enfermagem. Porto Alegre, Rio Grande do Sul, Brasil.

## ■ INTRODUCTION

In Brazil, different expressions must be used to refer to the modality of health provided at home, according to the demands of different historical moments: home assistance, home visit, home hospitalisation, and home care. These expressions suggest an approximation or distancing, or similarity and difference, from their possible configurations and functions as variable criteria of inclusion or exclusion of different social groups depending on the historical or cultural period.

But, when and how does home care occur in the home of patients? Since the Middle Ages, patients and medical professionals have been transported to and from places of treatment and cure of diseases<sup>(1-2)</sup>. During the studied period, hospitals already existed to provide health care to the poor and sick, who were considered a threat to society and should therefore be removed from collective circulation. The aim of these locations of exclusion was not to cure and care for the sick, but to save the souls of patients. Patients were considered dying beings and the hospital was seen as places of death. Medicine had an individual nature. It was practiced together with hospital practices and supported by the patient-doctor relationship, where the doctor observed in the body of patient the crisis of a disease<sup>(1)</sup>.

It is only in the late 18<sup>th</sup> and early 19<sup>th</sup> centuries that social medicine, of a more collective nature, was born. It was considered a way to leverage capitalism, since the body was now considered the object of production and labour force. For the formation of social medicine, Foucault identified three stages: urban medicine, state medicine and labour force medicine<sup>(2)</sup>. This paper will focus on two of these steps - urban medicine and state medicine - to address home care in Brazil since it was born as a strategy and tactic of biopower to control, analyse and observe people in their homes.

Urban medicine was born in France with the formation of cities and urbanisation, inspired by the model of urgency and used since the Middle Ages to control pests. In this model, the cities were divided into neighbourhoods (districts) under the responsibility of an overseeing authority. Inspectors were responsible for visiting the homes in their districts to verify the living and the dead and prevent the sick from leaving their dwellings. These authorities monitored the urban space in search of anything that could cause diseases, in addition to controlling movement and air and water quality, mainly the distribution and control of clean or serviced water. It is in this period that the concept of health emerged. This concept concerns the state of affairs and does not necessarily mean health, since hygiene

would be the material and social basis to ensure the best health for individuals. State medicine was born in Germany with the aim of providing a more systematised and observational inspection, organised in a hierarchical administration that defined the roles of doctors. It also standardised medical education. It should be noted that the key objective of urban medicine is the circulation of things to ensure salubrity. State medicine observed morbidity and birth and death records in France and England, and aimed to improve the living standards of the population<sup>(2)</sup>.

In Brazil, the urban model of medicine inspired the organisation of the national health and public assistance service of 1893 of the Board of Hygiene and Public Health. During this period, actions that should account for the inspection, the sanitation of localities and housing, and of food production organisation were formulated through health inspection officers, which could enter the homes to check the conditions of hygiene and recommend disinfection. In case of non-compliance with the notifications, the health inspection officers applied fines. The role of these officers was to advise people on ailments, catalogue diseases, aid victims in case of accidents and, when home care was not possible, transfer them to a hospital<sup>(3)</sup>. It can be assumed that these actions produced the first information on the home spaces and helped form this knowledge.

During this same period, yellow fever<sup>(4)</sup> was an important epidemic with a high death toll, like tuberculosis<sup>(5)</sup>. In a meeting with the national academy of medicine, the "easiness" of prophylactic actions was mentioned and recommended,

*"in exchange for repressive and violent measures, and which would be widely compensated by the resulting benefits. It is a pity that we must resort to these methods to obtain such results, but it must be this way insofar as the people do not possess the moral or intellectual education required to understand and value and importance of these measures [...]"<sup>(6, p.3023)</sup>.*

The techniques of inspection and behavioural surveillance of the population of that period reveal the introduction of a disciplinary power and the intertwining of medical and political knowledge related to civil society and the State, which organised the disease control actions and urban space, that would successfully eradicate yellow fever and other diseases<sup>(4)</sup>.

Urban medicine was a strategy that managed to meet certain needs by controlling the circulation of things and elements, isolating the sick in their homes, recording the living and the dead and creating a hierarchy for public health and hygiene services. This model

produced good results when the disease had already set in and was thus considered an emergency. Preventive measures were not observed in those days, probably due to lack of knowledge on the onset of diseases. This evidently made any form of protection of the population impossible. Although there was sufficient knowledge on the role of bacteria, the idea of promoting health and the relationship between health and living conditions as we understand them today were not observed. At that time, the circulation of elements, such as water and air, was considered sufficient to contain diseases.

Studies<sup>(4-5)</sup> show that by the end of the 19<sup>th</sup> century the medical-administrative movements aimed to eradicate the diseases that spread across the country and physically and economically affected the population. Water supply, sanitation and cleaning of the cities were the main focal points<sup>(4)</sup>. Urban agglomerations were believed to have caused the spreading of diseases and by the end of the 19<sup>th</sup> century, a relationship with the interior of homes was established. The relationship of inspectors with the homes and the sick occurred when the disease had set in or when there was suspicion of disease. Consequently, there was more disease notification and hygiene inspection and control than health care, and there was more inspection and punishment than risk tracking and prevention.

Home care can be considered one of the strategies of power over life, with the aim of supporting life through monitoring, inspection, control and analysis, and a strategy that helped improve the health levels of the population. This paper discusses the genesis of home care in Brazil in the early 20<sup>th</sup> century.

## ■ METHOD

A study of genealogical inspiration inserted in the post-structuralist Foucault approach and part of the thesis titled "*Melhor em casa? Uma história genealógica*"<sup>(7)</sup> that proposes to denaturalise and reveal truths that are part of a regime that is regarded as true. The intention of these studies is not to address the success or usefulness of the different theoretical positions, but entice a specific work from the thought that addresses the problem of something that is perceived as familiar<sup>(8)</sup>.

The empirical material comprised two legal documents related to home care and published in the Official Journal of the Brazilian Union (DOU). This material was obtained from the Jus Brasil website (<http://www.jusbrasil.com.br/diarios>) after a search in May 2013. The selected excerpts were transcribed to an Excel spreadsheet, containing the reference, excerpt, author and identification of the Fou-

cault tool used for analysis. The empirical categories were created according to the relationships established between the wording of the different historical periods. The reviewed documents were Decree 14189 of May 26, 1920<sup>(9)</sup>, Decree 16300 of December 31, 1923<sup>(10)</sup> and the bulletin of the Board of Rural Sanitation of 1928<sup>(11)</sup>. These documents were selected because of the detailed contents.

To guide document analysis and compose the study, we used the analytical categories proposed by Michel Foucault to discuss the circulating discourses regarding home care: power, particularly disciplinary power, and biopolitics.

The power governs the wording and the way it is organised to create a set of scientifically acceptable propositions. It is not a matter of knowing which power acts on the exterior, but rather which effects of power circulate in the wording and how and why it changes in certain moments as opposed to other moments. That which allows power to continue and to be accepted is not a force that says no, but a force that induces pleasure, forms knowledge and produces the discourse, thus constituting a productive network<sup>(12)</sup>. Disciplinary power includes a set of techniques that allows a thorough control of the body by constantly subjecting its forces and imposing a relationship of docility and utility, that is, a relationship that does not merely establish the maximisation of the forces of the body or further subjection, but a relationship that makes it more obedient and useful<sup>(13)</sup>.

Biopolitics deals with the population as a political problem and consists of a strategy to rationalise the problems of the governmental practice. It uses statistics, not to change anything in the individual, but to intervene in that which is determinant in the population, especially in processes such as birth, morbidity, and mortality, that is, in whatever can be adjusted in order to create a balance, ensure compensations and provide security<sup>(14)</sup>.

## ■ RESULTS AND DISCUSSION

Analysis enabled the construction of two analytical categories: "Home inspection: the visiting nurses and tuberculosis" and "records: the political and economic apparatus".

### Home inspection: the visiting nurses and tuberculosis

In 1920, monitoring patients at home started to be regulated by the National Department of Public Health, based on the rules of the Tuberculosis Prophylaxis Service, and chiefly performed by visiting nurses. The article reads as follows:

*Art. 558. The inspection of tuberculosis patients at home shall be especially performed by visiting nurses under the supervision of physicians of the Tuberculosis Prophylaxis Inspection Office. Sole paragraph. When the patient receives medical assistance, the visiting nurse shall seek to become the helper and shall do nothing without notifying the medical assistance, except in emergencies that involve the interests of patient health or public health. Art. 559. The visiting nurses shall: 1. Exercise the appropriate health inspection at the home of the tuberculosis patients under their responsibility, and shall visit them as often as necessary [...] IV. Provide the Tuberculosis Prophylaxis Inspection Office with all the necessary and convenient information about the patients, their treatment, their occupation, their resources, their home conditions and the active or pending prophylactic practices; V. Enable the correction of detected errors with determination, kindness, discretion and gentleness; [...] VII. Distribute and explain health and tuberculosis campaign information at the visited households<sup>(9, p. 9389)</sup>.*

Monitoring patients at home and the subsequent control of private spaces extended the government's power over the population. This organisation enabled the interlacing of urban medicine and state medicine and characterised a shift between these care models. This does not mean, however, that urban medicine disappeared; it simply lost its emphasis and gave way to state medicine.

Urban medicine had hygiene-based characteristics with the attribute of observing and recording living conditions and monitoring patients at their homes. The division of the city into districts allowed a detailed analysis of accumulation and ensured the circulation of elements such as air and water. Later, the organisation of the Tuberculosis Prophylaxis Inspection Office marked the emergence of state medicine<sup>(2)</sup> that aimed to increase the observational and systematised inspection in the form of a hierarchical administration that defined the roles of physicians. Prophylactic actions started to be carried out by visiting nurses in order to protect public health and prevent the proliferation of diseases, in this case, tuberculosis.

The power-knowledge relations between the professionals involved in home care were established by the Office, which was composed of physicians who received information from the visiting nurses that initiated their activities in Brazil. These visitors had to conduct their actions conveniently in order to be effective and accepted by the patients at their homes. This attitude also configured a power relationship since they could not make decisions without notifying the physician, whose activity depended on the knowledge obtained at the homes.

These power relations also involved the patients and their families because the works of visiting nurses depended on whether they were accepted at the homes and were able to conduct "convenient inspection" to extract the knowledge they needed from the bodies of their patients. Visiting nurses had the knowledge that granted them the right to say and do certain things. They depended on the supervision of inspectors and these depended on the activities they were carrying out in the households of patients to keep the "order". These relationships are a good example of the microphysical and capillary power that permeates the medical environment and the environments of the nurses, patients and their families.

Power is an action over actions. Those who submit to its action accept it and take it as something natural and necessary. In power, there are always several subjects participating in the same game. There is no antagonism, such as in violence, where the force acts on a body and results in a fight or flight reaction. Knowledge is the power driver element that produces a natural and necessary effect for its transmission, and requires the consent and active participation of everyone involved<sup>(10)</sup>.

The visiting nurses had to use their determination to correct the identified defects with gentleness, kindness and discretion for any solutions to have the desired effect. Two discourses intersected to constitute the visiting nurse: the feminine and the physician. Gentleness is part of the discourse related to being a woman, while determination, discretion and kindness are some of the requirements of medical knowledge. The success of state intervention depended on the articulation of these two discourses.

An investigation on the Brazilian medical hygienist mechanism in the 19<sup>th</sup> century found that the State used doctors to intervene in patriarchal families, where decisions came from the head of the family and where there was little room for interference among individuals. Consequently, the use of women to act as visiting nurses was probably a tactic to intervene in the lives of people and enter their homes. However, this intervention would have to be gentle, benevolent and discreet to enable the nurses to observe, evaluate and extract information, produce knowledge and correct any errors.

But who were these visiting nurses? The nursing service was organised by the National Department of Public Health (DNSP), which was created in 1920 by the health reform proposed by Carlos Chagas, to act as the primary federal health agency under the Ministry of Justice and Internal Affairs. The DNSP represented a reform in the structure of Brazilian public health because it allowed the government to broaden its scope in the capital and in the main sea and

river ports, especially regarding the diseases of the people in the interior. As there were no nurses qualified to practice in these specific health areas, short courses were offered to qualify visiting nurses:

*Art. 353. For the execution of health visitors or nurses qualified in public health, the city shall be divided into districts, where each nurse is responsible for the technical services in the various dependencies of the Department. [...] § Insofar as the school cannot provide enough qualified nurses for the provision of inspection services to ensure the good performance of these service, the general superintendent of the Nursing Service shall provide intensive courses for the practice and theoretical education of health visitors<sup>(10, p. 3230)</sup>.*

One of the characteristics of state medicine was to standardise teaching<sup>(2)</sup>, which also occurred in the case of the nurses. State medicine emerged with the organisation of state medical knowledge. Once medical education was standardised, medical education and requirements for the awarding of diplomas were established. Similarly, nursing knowledge was initially organised by the State since the practices were governed by the interests of the government and, in particular, of the National Department of Public Health. Nursing education in Brazil did already exist, but it did not meet the desired standards. The standardisation of nursing education was a tactic to strengthen the State when the health officers stopped intervening in households and physicians and visiting nurses started to occupy this space.

This educational trend was geared toward the needs of the health market, which was regulated by the State at that time<sup>(15)</sup>. The role of women was in accordance with the culture of the time and did not compete with the role of men since their duties were an extension of the activities carried out at home with the children, spouse and family. Health professionals believed that their presence in other people's homes was an advantage due to the skills of the women regarding their collective work within their families<sup>(16)</sup>.

The analysis of writings about tuberculosis prophylaxis services revealed the offshoot of this theme: the detailed examination of bodies and the spaces they occupied.

*§ 1.0 Isolation of the tuberculosis patient shall be at home or in hospitals, sanatoriums or appropriate public or private nursing homes. --§ 2.0 Isolation of the tuberculosis patient shall consider the comfort and most favourable conditions for healing. Art. 448. Tuberculosis patients who are negligent or purposely rebel against the precepts of*

*prophylaxis, and those who cannot implement these principles due to poverty will be isolated in hospitals and sanatoria. Art. 449. Tuberculosis patients at home shall receive regular visits [...] of health inspectors or nurses and visiting nurses of the Tuberculosis Prophylaxis Inspection Office, who shall teach and recommend the precepts of anti-tuberculosis hygiene; verify the application of these precepts; check whether the patient receives appropriate treatment and resolve, within their professional scope, any observed errors; report the hygiene conditions of the household, the working conditions of patients and their needs; and, in general, collect and provide all information for the prophylaxis of tuberculosis and the cure of the sick<sup>(9, p. 9388)</sup>.*

Authorised by the State, the National Department of Public Health regulated the Tuberculosis Prophylaxis Service and established that isolation would observe the comfort of patients and the most favourable conditions for curing the disease. These conditions were monitored by health inspectors and visiting nurses, who had permission to provide knowledge of the disease, perform hygienic prophylaxis and teach methods of protection and cure of the disease. Such professionals used their knowledge to conduct and transmit the relationship of power that they sought to establish. If all went "well", that is, if the patients agreed with the recommendations, the relationship of power was established. If the patients resisted, another tactic of power was used to observe and penalise patients. In summary, when patients rebelled or resisted prophylaxis or when their social and financial conditions were too precarious to follow the guidelines of the authorised professionals (visiting nurses and health inspectors), the relationship of power could not be established. Thus, the patients were penalised and removed from their homes, where inspection was regular, and taken to institutions, such as hospitals, nursing homes or sanatoria. These places enabled a more direct and prolonged inspection and monitoring of patients.

In our societies, the punitive systems work with a certain "political economy" of the body, since the body does not suffer violent or bloody punishments. Even when subtle methods of enforcement or correction are used, they always observe the body and its strengths, the usefulness and docility of these strengths, and of its distribution and submission<sup>(13)</sup>. Thus, the disciplinary authority operates within these relationships.

It also became necessary to classify patients who followed the teachings of the nurses and inspectors from those who did not due to poverty or rebelliousness. The classification allowed the action of power in each individual body. This separation enabled the sending of rebellious

patients to institutions to remove the “danger” that they represented to healthy subjects and other patients in treatment, since their “bad” conduct could interfere with the good conduct of the more docile patients.

Although it may seem that comfort and environmental conditions determined the place of isolation, it was actually the behaviour of the patients and the docility of their bodies that mattered the most. Once docile, their bodies became the target of the biopolitical interventions<sup>(14)</sup> of the State and policies and programmes that established conducts to enhance the productivity of operations and control of the population.

The urgency of state medicine should be noted, considering that the interventions carried out on the bodies of individuals with or without tuberculosis sought to maximise the forces of the Brazilian population, that is, of the Brazilian State. The interventions did not merely occur on the bodies that worked, but on the bodies of the individuals that constituted the State. Medicine was not only expected to perfect and develop the labour force, it must also be expected to enhance the state force and its economic and political conflicts with neighbouring states<sup>(2)</sup>. During that period, Brazil sought to strengthen the State because it had recently detached itself from a slave economy and was formally entering the Republican order. And it was through science, medical practice and improving the health of the population that Brazil attempted to become a nation<sup>(17)</sup>.

At that time, home care, or monitoring patients at home, was associated with tuberculosis and the “new” profession of visiting nurses. And it is through the power-knowledge relations established according to disciplinary mechanisms concerning tuberculosis that the processes and struggles affected and constituted doctors and nurses and determined home care.

### Records: the political and economic apparatus

Hierarchical inspection, which is a characteristic of state medicine, produced many records on the information of tuberculosis patients from nurses, inspectors or doctors. These records were taken to the superiors, who analysed the records to provide an overview of the health situation of the population. For inspection to be effective, the production of sanitary and hygiene information did not suffice; the support of other organs or institutions was also included to obtain and produce more knowledge. To control tuberculosis, the National Department of Public Health included the civil registry offices and required them to issue periodic information about births to the Tuberculosis Prophylaxis Office.

*Art. 562 The officials of the civil registry are required to submit weekly to the Tuberculosis Prophylaxis Office a list of births registered at their registries, with name, gender, parentage, exact residence and date of birth of all newborns. Art. 563. The families of newborns will be visited by doctors or nurses of the Tuberculosis Prophylaxis Office for the special purpose of transmitting the precepts of tuberculosis prophylaxis among lactating women, when tuberculosis infection is detected in the family, and prophylactic measures within the purview of the Tuberculosis Prophylaxis Office* <sup>(9, p. 9389)</sup>.

Thus, the civil registry office was also included in the prevention and control of tuberculosis. They were necessary to obtain individual and collective information on the lives of people for the purpose of good government. The recording and quantification of newborns was important, but intervention was also required. Information on the sex, date of birth and place of residence was essential to access and intervene with the population.

Civil registry provided not only population figures, it also provided locations. This is biopower<sup>(12)</sup> operating in each and every member of society. As the civil registry offices sent the information of births to the Tuberculosis Prophylaxis Office, the nurses or doctors had the power, through the application of their knowledge, to enter the homes and teach tuberculosis prophylaxis. This intervention placed doctors and nurses in the position of educators and allowed the monitoring of new tuberculosis cases and the extraction of previously accumulated knowledge to produce an archive of knowledge about the disease. Moreover, this strategy helped health professionals to conduct the habits of the individuals of this population.

The records became necessary as population control technology and produced numerical, spatial or chronological variables and variables of longevity and health for theoretical purposes and for inspection, analysis, interventions, and transforming operations, etc.<sup>(14)</sup>. A good medical “discipline” includes the processes of writing that allows the integration of information in cumulative systems without losing individual data. These processes must also enable access to individual data from a general registry and the use of personal data to make collective calculations<sup>(13)</sup>.

Doctors and nurses assumed the role of educators and appropriated the knowledge that was being created from the logic of hygiene and prophylaxis. At that time, interventions on the health of people through education was more subtle than the repressive techniques used and recommended at the end of the 19<sup>th</sup> century. These techniques were used because the population was still “deprived” of

the education required to understand the benefits of health interventions. In 1920, the proposed home intervention through education was only possible with the engendering of docile bodies initiated in the late 19<sup>th</sup> century.

Many studies<sup>(15, 18 -19)</sup> show how health professionals additionally assumed the role of health educators during that period. An investigation<sup>(18)</sup> that analysed the medical discourses of hygiene at a school in Paraná in 1920-1937 found that physicians received a new function, that of educators, in order to sanitise, provide care and civilise. Another study<sup>(19)</sup> on the images of visiting nurses that circulated in *Revista da Semana* (1929), showed the role of nurses as educators who are responsible for providing information to the families to improve living conditions. These images also sought to spark the interest of other women and encourage them to exercise the profession of visiting nurses.

A report on the district of Santa Cruz, in Rio de Janeiro, presents detailed information on interventions to contain an outbreak of malaria. This district had ten watersheds and a flood period that started in November and ended in March. The peak of the outbreak would be in May, hence the need for an emergency campaign.

*A full topographic survey was made of the district, and while the marshes were being drained and the ditches were checked, the officers in charge of anopheline larvae sites and of capturing adults carefully tended to the "honifica umana" and took quinine and plasmoguinine to the homes for the quickest and most radical cure of the infected. The full spread of the disease was measured through specific testing and blood tests [...] Active anti-larvae actions was organised and especially directed against Cellii ocolp. itarsis, which is largely responsible for spreading local malaria, while simultaneously and intensively distributing free doses of quinine at the homes of the sick and convalescent. During this emergency phase that lasted until June, around 1600 breeding sites of anopheline were destroyed. The care and actions of those involved in the work were noteworthy, leading to the absence of this feared epidemic and the unprecedented reduction of morbidity rates, from June 1927 to date. With the reduction of cases, we can now tend to the definite work plan<sup>(11, p. 6404)</sup>.*

This record provides information on how the activities were carried out, with numerical results. Similarly, records of previous years on malaria, type of larva, number of cases and flood periods enabled comparisons for morbidity control. The adopted strategies and tactics appear to have been effective, even if organised in a short period of time. The feared epidemic did not occur, the number of cases

was reduced considerably compared to the previous year, and there was a definite plan of work.

Observation and inspection records in the different districts and regions of the city were evidently important. And what is the inspection technique, if not the technique of observation? Previously undertaken by health officers, they were not confronted with the medical discourse. This technique is used to date for physical examinations and health inspection at family health units, called the Family Health Strategy. That which is seen and observed becomes true through the records that can be read by other team members.

The control and the inspection carried out by the professionals in the district, which included the home as a space to distribute medication, in addition to the monitoring of patients and convalescents, led to a certain economic productivity and, to some extent, to a political productivity. It can be said that the relationships with patients established the disciplinary power, especially for tests and medication.

Consequently, patient inspection at home or home care, which previously functioned as an instrument of inspection and control used by health officers to extract information from the living, sick and dead, gradually became medicalised. With the organisation of the National Department of Public Health and the establishment of state medicine, the emphasis of control interventions at home shifted and became medicalised through the performance of doctors and nurses.

In addition, the use of statistics, also characteristic of state medicine, was included in the guidelines of the National Department of Public Health. Numbers, measurements and indexes gained increasing political and economic importance for government action, and enabled the generation of standards, strategies and actions in the form of programmes and campaigns to guide individual and collective conduct<sup>(20)</sup>.

The results of activities also had to be recorded by the health units.

*At the units of the Federal District, 2307 people were registered for 45255 consultations [...] Home inspection visits totalled 30975<sup>(11, p. 6404)</sup>.*

The sole purpose of recording the number of procedures was to demonstrate the State's concern with the health of the population. On the other hand, it is through these records that we can discuss the writings, since the number of procedures already established a certain control over the population.

The interrelation between numbers and statistics is used to establish truths and to guide the conduct of the subjects. The records aimed to propose, monitor and assess interventions carried out on the population in order to quantify aspects of interest to the government and create knowledge provided by the different institutions and experts, based on the collected data, that could support administrative decisions to maintain and optimise desirable characteristics of the population<sup>(20)</sup>.

These records produce the effects of truth and form knowledge that was used to control and intervene in the population, which includes the health professionals. In addition to monitoring the population, the records ensure that health professionals are constantly monitored through the number of procedures they perform.

## ■ FINAL CONSIDERATIONS

This study sought to show how home care was configured in Brazil in the early 20<sup>th</sup> century. To this end, it sought to address how the interventions used for surveillance, inspection and control drifted progressively from the model of urban medicine and drew closer to state medicine, and how the relationships of power-knowledge were established by disciplinary mechanisms.

According to the studied documents, home care started to take shape with the establishment of the Tuberculosis Prophylaxis Service in 1920. The knowledge invested in the creation of this service was found in the tuberculosis case records during the early 1900s that were provided by the visiting nurses, and in the records of the health reform proposed by Carlos Chagas in the 1920s. Health inspection at the homes of patients from the onset of tuberculosis was based on the creation of the “new” profession of visiting nurses.

The records and reports produced and published in the Official Journal of the Union allowed the Brazilian State to establish guidelines to govern individuals and the population with regard to the diseases. This hierarchical supervision, as well as the use of statistics, produced knowledge about the epidemic and configured home care as a service of control and inspection rather than as a service of care.

Whereas disciplinary power is established from technologies such as surveillance, hierarchy inspections and report writing, it can be affirmed that the genesis of home care lay in the disciplinary power of that period. The intersection of knowledge related to tuberculosis, the new profession of visiting nurses, the health inspection records, and the thorough analysis of cities, organised within the logic of the state medicine, endowed home care with a na-

ture of surveillance, inspection and control, which helped guide the conduct of individuals so that they could protect themselves from existing diseases. In summary, there was more inspection and control than care. This inspection and control helped guide the conduct of people and prevented the agglomerations that should promote the transmission of infectious and contagious diseases.

This is one of the possible analyses on the genesis of home care in Brazil. Post-structuralist research does not include the neutrality of the researcher, who becomes intertwined with the object and constructs it in an artisanal manner, while minimising some aspects and maximising others. In the case of nursing, studies that address the problem of historical objects, such as home care, are essential to reflect on our current practices, considering that nurses were fundamental for the configuration of home care at that time and continue to configure this modality of care today.

## ■ REFERENCES

1. Foucault M. O nascimento do hospital. In: Foucault M. *Microfísica do poder*. 25. ed. Rio de Janeiro: Graal; 2012. p. 171-89.
2. Foucault M. O nascimento da medicina social. In: Foucault M. *Microfísica do poder*. 25. ed. Rio de Janeiro: Graal; 2012. p. 143-70.
3. Estados Unidos do Brazil. Actos do Poder Executivo. Conselho Municipal. Título I: das repartições da saúde. Diário Oficial [da] República Federativa do Brasil. 1893 jun 23;Seção I: 2797-2803.
4. Gurgel CBFM, Silvestre MB, Teixeira DF, Romão M. Fragmentos da história da higiene e saúde públicas: a febre amarela em Campinas-SP no século XIX. *Rev Patol Trop*. 2014;43(2):111-20.
5. Maciel MS, Mendes PD, Gomes AP, Siqueira-Batista R. A história da tuberculose no Brasil: os muitos tons (de cinza) da miséria. *Rev Soc Bras Clín Méd*. 2012;10(3):226-30.
6. Estados Unidos do Brazil. Academia Nacional de Medicina. Sessão Ordinária, em 9 de julho de 1892. Diário Oficial [da] República Federativa do Brasil. 1892 jul 19;Seção 1: 3023-3025.
7. Oliveira SG. *Melhor em casa? uma história genealógica [tese]*. Porto Alegre: Escola de Enfermagem, Universidade Federal do Rio Grande do Sul; 2014.
8. Barbosa RLF. Foucault e a ética: algumas considerações. *Rev Aulas*. 2006-2007;(3):1-15. Dossiê Foucault.
9. Estados Unidos do Brazil. Departamento Nacional de Saúde Pública. Decreto no 14.189, de 26 de maio de 1920. Dá regulamento para a execução do decreto legislativo n. 3.957, de 2 de janeiro de 1920, que criou o Departamento Nacional de Saúde Pública. Regulamento dos serviços a cargo do Departamento Nacional de Saúde Pública. Diário Oficial [da] República Federativa do Brasil. 1920 jun 03;(Seção 1):9386-90.
10. Estados Unidos do Brazil. Atos do Poder executivo. Decreto no 16.300 de 31 de dezembro de 1923 aprova o regulamento do Departamento Nacional de Saúde Pública. 1924 fev 01;(Seção 1):3199-314.
11. Estados Unidos do Brazil. Directoria de Saneamento Rural. Diário Oficial [da] República Federativa do Brasil. 06 mar. 1928. (Seção 1):6404.



12. Foucault M. História da sexualidade I: a vontade de saber. 19. ed. Rio de Janeiro: Graal; 2009.
13. Foucault M. Vigiar e punir: nascimento da prisão. 41. ed. Petrópolis: Vozes; 2013.
14. Foucault M. Em defesa da sociedade: curso dado no Collège de France (1975-1976). São Paulo: Martins Fontes; 2005.
15. Santos FBO, Marques RC. Egressas da Escola de Enfermagem Carlos Chagas: campos de atuação, 1936-1948. Esc Anna Nery. 2015;19(2):363-8.
16. Ayres LF, Amorim WM, Piva TCC, Porto FR. As estratégias de luta simbólica para a formação da enfermeira visitadora no início do século XX. Hist Cienc Saúde-Manguinhos. 2012;19(3):861-81.
17. Romero M. Ciência, construção da nação e exclusão social, São Paulo-Brasil (1889- 1930). Amérique Latine Histoire et Mémoire. Les Cahiers ALHIM. 2015;(29).
18. Costa MCL. Influências do discurso médico e do higienismo no ordenamento urbano. Rev ANPEGE. 2013;9(11):63-73.
19. Deslandes AKM, Aguiar S, Neto M, Porto FR. A imagem do cuidado prestado pelas enfermeiras de saúde pública veiculada na Revista da Semana (1929). Rev Latin-Am Enferm. 2013;21(1):412-8.
20. Santaiana R. Educação integral: do uso das estatísticas à produção de sujeitos aprendentes. Textura. 2012jan/jun;(25):22-33.

■ **Corresponding author:**

Stefanie Griebeler Oliveira

E-mail: stefaniegriebeleroliveira@gmail.com

Received: 22.11.2015

Approved: 21.03.2016