Central European Journal of Nursing and Midwifery

Cent Eur J Nurs Midw 2023;14(4):1018–1025
doi: 10.15452/CEJNM.2023.14.0008

REVIEW

Beginning of community and public health care in the first Czechoslovak Republic, 1918–1938

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Received April 30, 2022; Accepted May 9, 2023.

Abstract

Aim: The period after the First World War was very challenging for countries across the whole of Europe. The health condition and health literacy of inhabitants in the First Czechoslovak Republic were poor. *Design:* Historical research. *Methods:* Direct, indirect, and progressive methods were chosen to describe community care and public health care. Archival sources were found in selected archives in the Czech and Slovak republics. *Results:* It is evident that many changes related to preventing infectious and non-infectious diseases. Ethnic and socioeconomic diversity was a factor that influenced the health condition and knowledge of the population, and the success of preventive measures. Therefore, the involvement of professional and voluntary organizations, and government institutions was essential. Public health care arose from the idea that a healthy population was the basis of the newly-formed republic. *Conclusion:* The literature and archival sources discovered show the importance of the health condition of the population to the newly-formed Czechoslovak state. To improve the health condition of the population, interventions were realized in cooperation with various organizations. Concurrently, there was an appreciable effort to enhance the health literacy of the population.

Keywords: community care, Czechoslovak Republic, First World War, health literacy, public health.

Introduction

The establishment of an independent Czechoslovakia in the autumn of 1918, following the First World War, was a significant moment in the history of Czechs and Slovaks. The nineteenth century brought with it a certain degree of loss of traditional fundamental certainties of life and a weakening in the pillars of conventional society. Perhaps as a result of this, health initiatives were developed which went hand in hand with town planning. In the period of the first Czechoslovak Republic (1918–1938), fundamental events occurred on Czechoslovak territory that shaped the course of its history. The establishment of Czechoslovakia was associated with rapid demographic growth, the development of trade and industry, a demographic shift to large cities, and an associated housing shortage. An essential determinant of the development was the ever-increasing tension between the Czech and German-speaking populations and between the Slovak and Hungarian minorities (Dostalík, 2015). The historical lands of the state – Bohemia, Moravia, and Silesia – were regarded as some of the most developed industrial regions in the western part of Central Europe.

In contrast, Slovakia and Carpathian Ruthenia were seen as more rural regions. Regarding population distribution, the German population was significantly more concentrated in areas along the borders with Germany and Austria, while the Czech population lived mainly in the interior regions; Poles were most numerous in Silesia. In Slovakia, the Hungarian population was concentrated on the southern border of Slovakia and Subcarpathian Ruthenia, bordered by Hungary and Romania; Ruthenians were concentrated mainly in eastern Slovakia and Carpathian Ruthenia. Jews formed a significant religious-cultural minority in the First Republic and lived throughout the territory of the newly-founded state.

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The newly-formed Czechoslovak state was a standard multi-ethnic state in the newly organized post-war Central-Eastern European region. The state-forming majority, made up of the Czechoslovak nation, was only about two-thirds of the total population. The other above-mentioned national groups accounted for about 35% of the total population, and most of these groups wished to be part of other states after World War I. Therefore, many national minorities viewed the newly-founded Czechoslovakia negatively. The Czechoslovak state was thus a typical multicultural Central European state in which several languages were spoken, and many inhabitants spoke more than one language. This demographic stratification may have contributed, to some extent, to manifestations of hostility between various ethnic groups (Fialová & Šprocha, 2018). Although the multi-ethnic composition of the state significantly affected virtually all areas of life in the Czechoslovak state, health care and population health were among the few areas not affected by ethnic conflict. It can be stated that members of all national groups had access to health care in their native language, and educational activities were also conducted in the languages of the various national groups. Thus, minorities fully participated in the state's national health care. Many health education publications were published not only in Czech and Slovak, i.e., in the languages of the majority of the Czechoslovak population, but also in German, Hungarian, Ruthenian, and Polish (Fialová & Šprocha, 2018; Zaoralová et al., 2015).

After the First World War, in addition to the problems related to ethnic groups, there were serious issues associated with the spread of epidemics. It was necessary to implement changes that could effectively reduce the number of sick and dying very quickly (Zaoralová et al., 2015). As Svobodný and Hlaváčková (2004) point out, despite the reform efforts of some physicians from 1918–1920, the state health administration primarily monitored compliance with laws and regulations. Legally, the organization and performance of health care was conducted according to the existing state of affairs from before 1918. An act of state from September 21, 1867 decided that health legislation was the responsibility of the Reich council. Another act to organize public health services was passed April 30, 1870 (Preininger, 1900).

We know that the new republic inherited various medical institutions and laws that were originally enforced separately for the Austrian and Hungarian parts of the former Austro-Hungarian Monarchy. It was not possible, despite repeated efforts, to unify medical legislation. Partial successes were achieved, but a unified health law was never adopted during the First Czechoslovak Republic.

Aim

This historical study aimed to describe the origins and state of community and public health care in the First Czechoslovak Republic from its foundation. We asked:

1) What form did community and public health care take in the First Czechoslovak Republic?
2) What factors influenced community and public health care at the beginning of the First Czechoslovak Republic?

Methods

Design

Historical research was conducted to describe this period's community and public health care, which allowed us to objectively study historical events in a particular time continuum (Ochrana, 2013; Zounek & Šimáně, 2014).

Data collection

Historical materials from the years 1918–1938 were found in state archives, state district archives in the Czech Republic (mainly in the State District Archive of the city of Ústí nad Labem, the State District Archive of the city of České Budějovice, the National Archives of the Czech Republic in Prague, and in the National Digital Library of the Czech Republic) and in Slovakia (the Slovakian state archive, Bratislava).

The aim and design (historical research) gave the research its strategy. Members of the research team sought out information of interest. We determined two essential areas for the study: the historical period (1918–1938) and the area of interest (First Czechoslovak Republic; community and public health care). Retrieval of information from archives continued from 2020 through 2022. Based on the analysis of relevant inventories, members of the research team analyzed selected files containing information of interest. Members of the research team photographed details of interest for further analysis with the agreement of archives. Since we were interested in factors that influenced the beginning of the community and healthcare system, we also analyzed materials from the years before 1918, provided they were related to the subject of interest.

In addition, we used the National Digital Library (Digital library Kramerius) to find other relevant information. We used the keywords: First

Czechoslovak Republic; community care; public health care; and health law to search. Given our topic, we analyzed sources from 1918–1938. Older sources were included if they were of interest to the area of study.

Data analysis

Timewise, the main focus of the study was the period 1918–1938, meaning from when the First Czechoslovak Republic originated to just before the start of the Second World War. The criteria for the defined time were the given period and historical events.

Direct, indirect, and progressive methods of historical research were chosen. Direct methods involved the study of events from historical documents containing information of interest (Zounek & Šimáně, 2014). It allowed us to identify factors that influenced progress of community and public health care in the First Czechoslovak Republic. Indirect methods allowed us to describe the context of the follow-up period. In this case, we studied historical materials based on analogous relationships. The information which was obtained using indirect methods was helpful to us in explaining changes in community and health care during the later period. Progressive techniques allowed us to describe events as they followed in time (Ochrana, 2013; Zounek & Šimáně, 2014).

Results

The beginnings of public health care during the First Czechoslovak Republic

In the post-war period, health was perceived as something that enabled people to achieve well-being, satisfaction, and happiness (Svozil, 1926). Weigner (1930) describes it as a factor that allows people to fill their lives with work, which will benefit them and all of society. Therefore, he saw efforts to raise health and healthcare awareness as one of the main components of education since "only healthy people can maintain their state." (Weigner, 1930). The Ministry of Public Health and Physical Education played an important role in this activity. In terms of public health, its competence was seen mainly in combating communicable, contagious diseases such as tuberculosis and venereal disease, and fighting alcoholism (Bébr & Chaloupka, 1937). Public health care had three main areas – preventive, medical, and care for the enfeebled and convalescent (Trnková, 1932).

Sanatoriums also contributed to the development of inhabitants' health literacy. Their role was not only therapeutic but also educational. Patients were encouraged to take responsibility for their health and to be aware of particular aspects such as clean air and compliance with medical regimens to prevent relapses (Procházka, 1925). Occupying the lowest tiers of the public health system were official municipal and district physicians, who, according to the Act on the State Health Police of 1920 (respectively 1922), were in the service of the state when the Act came into force. They were employed and paid by the municipalities (Svobodný & Hlaváčková, 2004).

The system of health care was inspired by acts passed in the period before 1918. The act of September 21, 1867, established, in paragraph 11, that: "the remit of the Reich Council includes: … f) health legislation … epidemics and animal plagues." Another significant piece of legislation was the act of April 30, 1870, which focused on the organization of public health services. Paragraph two gave attention to the roles of the state administration. This implied mostly: keeping health records of inhabitants, supervising medical and social facilities, and supervising pharmacies etc. (Obentraut, 1876; Preininger, 1900). Close cooperation in the goal of public health was realized through collaboration with the police (the so-called "health police") (Bébr & Chaloupka, 1937). The aims of the health police were: to supervise the fulfilment of health and police regulations, to oversee the care of socially disadvantaged groups (such as foundlings, the deaf and hard of hearing, and those with psychological conditions), and to supervise the fulfilment of acts in cases of infectious diseases etc. (Bébr & Chaloupka, 1937; Collection of laws and regulations of the Czechoslovak state, 1923). Health policy also involved close cooperation with "imperial district physicians". The Act passed 24 November, 1876 also mentions the role of "medical assistant". Medical assistants formed a health service auxiliary (act of 24 November, 1876). We can find the inspiration for the setting up of an evidence-based system in the "Report on Conditions and Health Facilities in the Kingdom of the Czech Republic over the Years ..." (1894). In this report, we find detailed statistics about disadvantaged people (i.e., those with psychological conditions, the deaf and mute, the blind, foundlings etc.) who were not treated in health or social institutions.

The beginnings of community care during the First Czechoslovak Republic and the significance of voluntary organizations

Caring for a relative is as old as humankind itself. Throughout the history and evolution of humanity,

the term "care" has been given different dimensions and meanings. In addition to the care recipient, the caregiver remains the central figure in this process (Jarošová, 2007). Samaritan philosophy viewed community care mainly in terms of protection (prophylaxis), general protection of health, and the prevention of communicable diseases and abuse of alcohol etc. (Welz, 1921).

The first direct community-oriented nursing care in Czechoslovak territory was provided by Czechoslovak Red Cross nurses (ČSČK) (Jarošová, 2007), an organisation founded in 1919 (Filľarská, 2017). Given the health conditions of the population at that time, its activities were mainly directed towards children, the poor, the sick, the elderly, and the disabled. Care was mainly implemented within the primary care framework, i.e., provision of hygiene, food, and clothing (Jarošová, 2007; Ministry of Social Welfare, 1925). Also important were activities focusing on fund-raising by means of public collections (Bishop's Archive of České Budějovice – Bishop's Consistory of České Budějovice 1785–1945 [1949]; humanitarian institutions, file 1683, in Třeboň 15. 11. 2021).

Municipal and district doctors conducted professional supervision over their municipalities' sanitary conditions; regarding medical care, they treated the poor free of charge and provided first aid and vaccinations. In the field of health, social, and humanitarian care, they cooperated with counselling centers for mothers and infants and social welfare institutes and carried out health education. However, some of their disease prevention tasks were gradually taken over by counselling centers founded by voluntary organizations (Svobodný & Hlaváčková, 2004; Kříž, 2009). One such counselling center provided health counselling for young people. The reasons for the establishment of this counselling center were: to give advice to people with infectious diseases; to provide materials and care for patients (funded by health insurance companies, a treatment fund or another financial source); to increase awareness of sexually transmitted diseases; to raise awareness of the choosing part from the abolition law (which made certain types of prostitution illegal), forced treatment and of punishments for the transmission of disease (Czechoslovak Red Cross, 1928).

In Slovakia, the activities of the Czechoslovak Red Cross were directed towards fighting epidemic diseases and tuberculosis, and on training Red Cross nurses and Samaritans to provide initial pre-medical aid (Filľarská, 2017). In the Sokol Bulletin (Czechoslovak Sokol Community, 1924), the Czechoslovak Sokol Community emphasized the importance of the Czechoslovak Red Cross in food and clothing distribution and in fighting epidemics. It underlined the importance of founding health centers in which sanitary conditions were adequate and, where necessary, provision of health education services and direct health care. Films anminid publications were used to promote prevention and to improve the health literacy of the population. The topic of hygiene and health care also entered into civics lessons within the education system, with a particular focus on disinfection, vaccination, and quarantine (Traub, 1921). The effort to raise healthcare awareness was also evident in other editions of the Sokol Bulletin (Czechoslovak Sokol Community, 1933). People were urged to attend to personal hygiene regularly and not only at sports facilities (i.e., Sokol gyms and related facilities), according to the quote, "Always cleanliness, in everything and everywhere." (Czechoslovak Sokol Community, 1933). The importance of the quality of hygienic facilities and food was also emphasized by Procházka (1925), who stated: "It doesn't do any good to work in a hygienic factory if you live and sleep in unhealthy conditions."

The Sokol community played a significant role in the population's health care not only through its educational activities but also through the active organization of physical education events, promoting healthy lifestyles based on dynamic movement. The Czechoslovak Sokol community was one of Europe's most progressive mass physical education organizations at that time. One of the most famous and well-known events of the Czechoslovak Sokol Community was the regular nationwide All Sokol Festival (General Congress of the Sokols), which took the form of mass public exercise events. For these purposes, the largest stadium in the world was built in Prague, where up to 14,500 practitioners could perform at the same time during the All-Sokol Gatherings. A comprehensive national network of regional Sokol organizations participated in the organization of this event. At the time of the second Czechoslovak All-Sokol Festival in 1926, the Czechoslovak Sokol community consisted of 3,134 essential organizations with 335,000 members, 92,000 of whom were women. However, with the inclusion of youth and children, this mass physical education organization involved up to 548,000 people in physical education activities (Hrdlička, 1927).

The objective of improving population health can also be seen in the activities of the Center of Voluntary Social and Social Health Associations in Smíchov, which brought together the Czechoslovak

Red Cross, Masaryk League against Tuberculosis, Czechoslovak Society Combating Venereal Diseases, Czechoslovak Total Abstinence Union, the Czechoslovak Society for the Protection of Mothers and Children, the Czech Provincial Commission for Youth Care in Bohemia, the Czech Provincial Youth Care in Brno, the Provincial Association for the Education and Treatment of Disabled Children in Bohemia, and the "Záchrana" association. These organizations operated throughout the country and focused on voluntary social and healthcare issues (Ministry of Social Welfare, 1925). Under the jurisdiction of the Ministry of Health and Physical Education, a synergy between various sectors was ordered in health and medical issues. The question of determining the boundary between health care and social care was also discussed (Tůma, 1925), which in many cases was very difficult to determine (e.g., in the case of tuberculosis) (Procházka, 1925). Similarly, recommendations were made for treating patients during hospitalization or as outpatients in their homes (Procházka, 1925). In this regard, nurses in outpatient clinics had the competence to educate individuals. The physician was then obliged to support the nurse in this activity, especially if she met with resistance from the target group (Bébr & Chaloupka, 1937).

The health of children and young people was considered a priority when it came to educating the nation on physical and moral fitness. With this goal in mind, Weigner (1930) described the function of the school physician, whom he regarded as a school health officer, responsible for monitoring the classroom, the health of children, and the prevention of contagious diseases. He also characterized him as a "health leader" at school who mentored pupils and teachers. The state administration was aware of the importance of the health of the younger generation, as evidenced by material from the archives in Ústí nad Labem (Soka Ústí nad Labem, Ústí nad Labem District Office, 1850–1938, file 152, Supplements to the regulation of medical service in national schools, November 23, 1923) (State District Archive of the city of Ústí nad Labem, 1923). When specifying individual competencies, the role of the social nurse is listed, who should, in cooperation with the doctor, carry out investigations to comprehensively assess the factors affecting the health status of children. Among the interventions that should be implemented in an investigation, Weigner (1930) includes anthropometric measurements (including chest circumference and respiratory width), assessment of general physical condition (including dentition, vision, and hearing), checks for physical and mental deviations or disorders, the taking of a medical history with a focus on genetic issues, and the assessment of external living conditions (i.e., family, housing, nutrition, social circumstances, etc.) (Weigner, 1930).

Czechoslovak health laws, with the relevant implementation regulations (Bébr & Chaloupka, 1937) and those concerning the care of young people, mention the cooperation of school doctors and school nurses. There was a clear obligation for the district school physician to examine any child whose health was reasonably suspected of being impaired in any way. The child was to be be referred to such examinations by the district school physician, teacher, school nurse, or authority. The school nurse was also assigned the role of educator. Included among other interventions by school nurses (also referred to as a "confidant"), was the monitoring of prescribed treatments in the child's home. In addition to these roles, she was also obliged to develop professional nursing knowledge and skills through internships abroad (Bébr & Chaloupka, 1937).

Another critical area of public health care was occupational injury hygiene, which included, among other things, the prevention of occupational diseases and accidents (Bébr & Chaloupka, 1937).

Care for the disabled (formerly referred to as "crippled") consisted of three levels: preventive, institutional, and social care. In practice, efforts were directed towards preventive activities to avoid disabiliy, the building of institutions for this target group, and the issues of social care and assistance. To provide timely treatment, the role of general counselling centers, professionally instructed school doctors, midwives and various health and social institutions in locating orthopedically ill children was emphasized (Report on the activities of the Provincial Association for the Treatment and Education of Crippled Children in Moravia, 1930).

Interestingly, obesity in women (deemed the possession of a big belly) was considered a result of poor posture, improper breathing, lack of exercise, or moderation (Svozil, 1926).

The social and health significance of marriage was described in terms of offspring fitness; therefore, marriage required special health considerations. The status of married and illegitimate children was also mentioned, as well as the basics of prenatal care and the need to eliminate risk factors that could contribute to impaired child development (Růžička, 1923).

Increasing inhabitant's health literacy, and community care during the First Czechoslovak Republic

The Ministry of Health and Physical Education was also active in health protection and awareness-raising activities, organizing various exhibitions to fight against tuberculosis and alcoholism, and promoting child care and personal hygiene. These events took place, for example, at trade fairs (Brno, Prague) or exhibitions on social hygiene in Pilsen. The Ministry of Health also supported lectures or initiated the publication of many health brochures; for example, 25,000 copies of a document on cancer were published. Various social and educational institutions, such as the Czechoslovak Red Cross, the League Against Tuberculosis, among others, were involved in health education (Hrdlička, 1927).

The state also supported the promotion of healthy lifestyles by establishing the National Institute of Physical Culture. The Institute organized regular, multidisciplinary physical education courses for school staff in various disciplines to strengthen the role of schools and physical education in instructing young people about a healthy lifestyle. Approximately 8,000 school staff attended these courses annually (Hrdlička, 1927).

Population health was also mentioned in a document from the Central Union of Czechoslovak Physicians (1926), which emphasized the undeniable importance of the Ministry of Public Health in achieving this goal. Among other things, this institution was intended to prevent the premature death of citizens from inadequate health education and unsuitable hygienic conditions. In Czechoslovak Health Laws, with the relevant regulations for their implementation, we encounter terms such as urban (municipal) health, sanitation (i.e., water supply, sewage disposal, etc.), building hygiene, issues concerning medical establishments, etc.; and from the perspective of the organization of public health services, transport hygiene, and maritime and ship hygiene (Bébr & Chaloupka, 1937). In the archival materials, we sometimes encounter notifications of infectious disease outbreaks. The need to educate the population about diseases such as typhoid fever, and the punishability of concealing the presence of illness are often mentioned (AM České Budějovice 1929–1945, Carton 85, IX, 1d., No. 16/227/San., Typhus in České Budějovice, July 17, 1933).

Discussion

The situation in the newly-formed Czechoslovak state was complicated. The impact of World War I was extensive. It was necessary to develop infrastructure, fight against the spread of epidemics, and improve the legal system (Svobodný & Hlaváčková, 2004; Zaoralová et al., 2015). Community and family care were familiar concepts even in the period before the formation of the First Czechoslovak Republic. This care did not focus only on those with physical conditions but also on those with psychological disorders. The development of community and family care was necessary given the lack of capacity for beds in health and social institutions (Kafka & Procházka, 1930). Environmental health checks were also necessary in buildings and flats. The increase in the number of city inhabitants who migrated for work contributed to poor housing conditions. The rapidly growing housing developments were often of poor quality (e.g., with mould and a musty smell in the rooms) (National archive, 1923).

For the development of inhabitants' health literacy, it was necessary to involve different organizations (for example, ČSČK, Czechoslovak Sokol Community etc.) and quality-trained health workers (Filľarská, 2017); National archive, 1925; Traub, 1921).

From the sources discovered, it is evident that the beginning of community and public health care in the First Czechoslovak Republic was a challenge. The structure of the population was very diverse. There were different nationalities and land areas with differing socioeconomic conditions and political and national attitudes (Dostalík, 2015; Fialová & Šprocha, 2018). The need to improve inhabitants' health condition was evident. Different organizations participated in this aim – inadequate health literacy and the prevalence of infectious diseases led to the development of community and public healthcare systems. Professor Dr Hamza pointed out the importance of activities focusing on increasing inhabitants' health literacy in 1925. He stressed that all means and ways must be used to carry out health education (including radio broadcasts). He realized very well that for success in health and social care, it was necessary to ensure the participation and health education of all inhabitants (National Archive, 1925).

Conclusion

Care for the health of the population was a fundamental issue in the past. Literature and archival sources indicate that various interventions and cooperation with different organizations were used to ensure the population's health. Although our results represent information from historical materials, we can track the starting points and historical context associated with the organization of community and public health care in the Czech

Republic. Knowledge of the history of the community and public healthcare system in the First Czechoslovakian Republic can give us knowledge valuable even today.

Ethical aspects and conflict of interest

This article contains no ethical conflicts or conflicts of interests.

Funding

This paper is a partial result of scientific project registration number 20-09470S: "Health system of the first Czechoslovak Republic in the context of its national and social composition – center vs. periphery" supported by the Grant Agency of the Czech Republic

Author contributions

Conceptualization (VH, VT, AT), data curation (VH, VT, AT, IK, MČ, LN), funding acquisition (AT, VT), investigation (VH, VT, AT, IK, MČ, LN), methodology (VH, VT, AT), project administration (AT, VT), writing – original draft (VH), writing – review & editing (VH, VT, AT, IK, MČ, LN).

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