

The Influence of the BRIMHEALTH
Programme to Public Health
Development in Lithuania
A Descriptive-Qualitative Study

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– Essay –

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Abstract

The Nordic countries have been assisting the Baltic countries in their public health (PH) development from early nineties. The study describes PH development in Lithuania alongside with the BRIMHEALTH PH training programme. The study aimed at a qualitative assessment of the programme's implications in Lithuanian partner institutions. The grounded theory method was used in the analysis of the focus group interview and nine in-depth interviews. The subjective meaning attributed to the programme by its participants was summarized in the following five descriptive categories: *international postgraduate students feel welcome in BRIMHEALTH* (as the core category); *providing assistance*; *building partnerships*; *being an experimental programme*; *BRIMHEALTH as a model*. The core category focussed on the student, as the main actor. Each category is related to several subcategories. A constant comparative approach was applied to describe the thoughts and values of the participants. The concepts and categories were validated in the data. It was concluded that the study evaluates the impact of the BRIMHEALTH training programme, proving that PH training was connected to training abroad and international collaboration; the importance of the programme is assessed from a number of perspectives and can be helpful for further research.

Key words

grounded theory, interview, international, postgraduate

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INTRODUCTION

The BRIMHEALTH programme started in the Baltic countries in the nineties. Quite unexpectedly, it lasted for ten years. BRIM HEALTH'S main objective was to ensure the proper development of the public health function in the countries through support to national strategies for public health development, training programmes for public health professionals, programme managers and administrators (Baltic Rim Partnership for Public Health 1993).

It was a “path finder” programme - the organisers of BRIMHEALTH had to find their way to work with the new partners. Problem based learning did not exist in medical schools of Lithuania at that time. Only few students could speak English. The teachers at the Nordic School of Public Health had to be careful in order to avoid the so called culture shock teaching Baltic students. ”The main thing was not to shock the students”, so the teaching contents and lectures had to be adapted to the newly arrived programme participants. The programme experienced two critical moments during the long period of its existence when financing seemed to be cut. However, to a big astonishment of the leaders, it continued, and developed into a real partnership between the NHV, on the one hand and the ministries of health and medical universities in the Baltic countries, on the other. We are concentrating in this paper on the Lithuanian partner institutions only.

On 2nd June 2000 the Lithuanian Ministry of Health wrote a support letter to the Nordic Council of Ministers, expressing the Ministry's willingness to further benefit from the collaboration with the NHV. The letter said that “the BRIMHEALTH programme provided Lithuania with the possibility to use the expertise of the NHV and helped to start building a new cadre of public health leaders, managers and administrators which this country lacked after abandoning the old Soviet system of medical care. Our specialists benefited from the long and short-term training, also from the On the Job Training for future course administrators.” As agreed in the *Memorandum of Understanding*, Lithuania took up arranging training workshops for public health professionals. Preparing public health curricula, the Kaunas University of Medicine and the Medical Faculty of Vilnius University made use of the NHV public health training curricula. The first national textbook in public health was prepared in close collaboration and assistance of the BRIMHEALTH programme (Kalėdienė, et al. 1999a).

Public health in the 1990s: the start of changes

Having regained independence the Baltic countries were overwhelmed by the demand to adapt and cope with numerous challenges in economy, social life and

general development. Faced with a necessity to reform the health system, they also needed a new cadre of leaders. After decades of inertia, the country's political and managerial leaderships in the health sector had to address difficult transition issues of promoting a broad view of health (Barnard 1998a). The task itself was not easy. It is worth mentioning, that the first five-six years were marked by the general suspicion even of the word "planning" as it seemed to be a relic of the soviet system. (WHO 1996).

Decentralization of health care in the early 1990s

From 1990 to 1995 the role of local self-governments in administering outpatient care and most small and medium sized hospitals in Lithuania has increased (WHO 1996). In addition, medical universities became more autonomous. The prevalent ideology was that physicians, institutions and local self-governments should decide on the range and quality of health care services. More local self-governments became responsible for the provision of public health services. Coordination between self-governments was poor; patient choice to get secondary care was restricted to their place of residence; there was a lack of qualified managerial staff in local self-governments. In 1994-1995, when district administrations became responsible for planning and administration; the locus of administrative authority was shifted over from the Ministry of Health to the regional hospitals and public health institutions in the districts. Between 1991 and 1995, 40% of total public assets were privatised, mostly through the voucher system. Despite this, privatisation of the health sector has been restricted in Lithuania. There were tax exemptions for private health care providers, i.e. reduced profit tax and no value-added tax for health services (WHO 1996).

The Lithuanian National Health Concept and Lithuanian Health Programme

The progressively minded physicians, who had been strongly involved in the peaceful liberation movement of their countries, understood that the process of health system reform had to be initiated by changing the system of education and training of health professionals and managers. A group of physicians, led by Professor Grabauskas, former high WHO officer in Geneva, initiated the creation of the Lithuanian National Health Concept in 1989 that was adopted by the *Seimas* (parliament) in 1991 (Lithuanian 1993). The concept was based on the health for all vision born in the World Health Assembly in 1977 and launched at the International Alma-Ata Conference in 1978 (WHO 1999). Up to this day the Health Concept paper still constitutes the intellectual basis for decision making in the field. McKee (2001) says that researchers and the new emerging politicians in the early 1990s understood each other. They maintained personal and close two-way communication when they had one common goal – the independence of Lithuania from the Soviet

Union. At that time decision makers and researchers were working together and the political situation was favourable for new ideas.

However, since the Health Concept was not backed up with at least a medium-term implementation plan, very few of its targets have been achieved. The liberal approach to health care administration during these years favoured open-minded thinking in medical circles. At the same time, however, it led to increasing coordination problems between both decision-makers and institutions. It took seven years to create a national health programme based on long term planning (Lietuvos sveikatos programa 1998). The national health programme adopted in 1998 set *inter alia* an aim to prepare health managers and to continue the reform of public health sector.

Human resources for health

Target 18 "Developing human resources for health" of the WHO Health for All strategy (WHO, 1999) runs that "by the year 2010, all Member States should have ensured that health professionals and professionals in other sectors have acquired appropriate knowledge, attitudes and skills to protect and promote health". It is stressed that "public health workers" are a vital resource for health and states that they should receive values, education and information about experiences and issues, in order to be able contribute to the perception of health as a positive public message throughout society; they should play an important role in developing and carrying out multisectoral policies and programs for health improvement (Sveikata-21 2000).

From the start of the health care reform in Lithuania in 1991 the problem of human resources has not been adequately analysed. So far there exists no model outlining the planning, demand and geographical/professional distribution of human resources and short or long-term admission plans to health care studies (Bucioniene & Buis 1999). The number of physicians in Lithuania is 37.9/10000 of population, which is lower than the average of the European Union (38.7) but remains higher than the average of other countries of Central and Eastern Europe (24.9). Geographical, gender, regional and age distribution of human resources is very unequal; besides there exist favourable conditions for the work power flow to the European Union, the Nordic countries especially. The number of nurses during 1999-2000 in Lithuania has diminished by 30% and now is 75.8/10000. The number of medical students (dental, pharmacy and nursing included) is less than the EU average. There is a need to start preparing health care human resource planning specialists. A set of lectures and teaching modules on health human resources were prepared at the Kaunas Medical University and Vilnius Medical Faculty. The Open Society Fund Lithuania funded a project on human resources planning and development in 1990-2015 (Open Society Fund 2003). The project was run jointly with the Ministry of Health, WHO,

the National Health Board at the Parliament, medical universities and other Lithuanian institutions (Lietuvos 2002, Bartlingas et. al 2001).

A joint programme “Strategic health care and pharmacy human resource planning in Lithuania for 2003-2020” is being elaborated by a number of institutions in Lithuania in collaboration with Xavier University. The programme will embrace five working groups (physicians, dentists, pharmacists, nurses and midwives, as well as public health specialists planning) led by the programme management group (Open society Fund 2003).

Policy development and public health training

Prerogatives for public health training in Lithuania were numerous as WHO principles of health for all and the renewed strategy of HEALTH21 (WHO 1998) were finding their way to the Baltic region.

The Public Health Surveillance Service was established within the Ministry of Health in 1994, to replace the former sanitary-epidemiology service. It consists of 11 regional public health centres subordinate to the State Public Health Centre. Through a number of institutions, it is responsible for communicable disease control, AIDS, immunization, food control, environmental health and occupational health. It is implementing governmental policy in public health, health status monitoring and identifying priorities for the future.

The key events conducive to institutional development were:

- 1st National Health Policy Conference, 1993;
- 2nd National Health Policy Conference, 1996;
- The National Health Board established in 1998;
- 3rd National Health Policy Conference, September 2000 (new directions for public health reform set, mainly reorganisation of public health surveillance);
- Adoption of the Lithuanian Health Programme for 1997-2010 at the Parliament in 1998. The programme stated long and short term objectives (until 2005). One of the short term objectives is “to educate and re-qualify specialists in public health”.
- 4th National Health Policy Conference, 2004;
- 5th National Health Policy Conference, 2006 (mid-term review of the Lithuanian health Programme).

The 3rd National Health Policy Conference approved the need to complete and to implement the Public Health Strategy document which stated the importance of

developing a legal base for public health professionals training, continuous training and retraining.

There are two major institutions (partners with NHV) engaged in public health training: Kaunas University of Medicine (KUM) and the Medical Faculty of Vilnius University. KUM now has five faculties: Medicine, Dentistry, Pharmacy, Nursing and Public Health. The Faculty of Public Health was established in 1994 with an annual enrolment of 30 students. KUM integrates the public health training into the traditional training programme. The undergraduate training in public health was established already in 1994. This programme embraces four years of studies giving a Bachelor's degree (240 ECTS credits). 120 academic ECTS credits of additional training are needed for the Master's degree in three areas: ecology, educology and kinesiology. Several alternative MPH post graduate programmes are provided at the KUM, (among them BRIMHEALTH Diploma/MPH/MScPH degrees by the Nordic School of Public Health). The Faculty of Public Health (FPH) at Kaunas University of Medicine runs Master of Public Health (MPH) Programme since 1998. Faculty of Public Health is member of the Association of Schools of Public Health in the European region (ASPHER) and has rich experience in international teaching activities. Master programmes of PH have received recognition by the ASPHER PEER Review experts in 2003 and 2004 (Šumskas 2004a). International MPH program for foreign students started in 2004, coinciding with the start of Lithuania's membership in the European Union in May 2004 (Grabauskas 2004).

In Vilnius University (VU), the oldest university in the Eastern Europe, founded in 1579, started teaching hygiene as early as 1804. New public health teaching was started in 1995 at the Centre of Social Medicine, providing a four year degree of Bachelor of Hygiene; Master's degree takes two additional years. In 1993 the Centre of Social Medicine started teaching programme for health care administrators and managers in collaboration with the Nordic School of Public Health. In 2002 the Institute of Public Health was opened embracing the Department of Hygiene (founded in 1922), the Centre of Social Medicine (founded in 1991) and the Centre for Medical History and Information (founded in 1998). At present time there are three departments within the frame of the Institute of Public Health: Department of Environmental Health, Department of Social Medicine, Department of Medical History and Ethics with the Museum of History of Medicine (www.vu.lt)

Different training initiatives have been taken which underline the necessity to build up capacity in the public health care system to contribute to the reform process in the Lithuanian public health. Considerable efforts are being made by the academic society in Lithuania to stimulate the development of a new public health paradigm and to expand their training and research activities towards previously underdeveloped academic areas in the country such as public health management and health promotion. It is understood by the Lithuanian academic people that in order to improve public health education the curriculum should be structured around

competencies universally required of public health practitioners; and also that schools of public health should establish broad cooperative agreements with major local, regional and state agencies. Professional competencies and practical experience can best be achieved by training public health professionals in community-based settings where they can learn as part of a team (Nacionalinės sveikatos tarybos metinis pranešimas 2000).

Academic community through its knowledge and experience as well as international cooperation has considerably contributed to the health system reform process, medical education included, and in fact assured the continuity of the planned changes within the context of often changing governments in the country. Despite the existing problems and obstacles that Lithuania faces in the transition period both Lithuanian universities have innovatively used the opportunities and challenges in their medical education reform process. Now it is recognized that the Lithuanian model of medical education corresponds to the international requirements of medical education (Grabauskas 2001).

The content of the undergraduate public health curricula has been developing from strictly medically-hygienic oriented in both Kaunas and Vilnius Universities (the same applies to the Klaipėda University). Gradual changes were introduced to bring the curricula in line with the new public health concept as adopted by both institutions. Vilnius so far has kept the medically-hygiene concept of public health, which is also reflected in the curricula.

What were the constrains

The main problems in the public health service include bureaucratic and financial constrains, lack of intersectoral cooperation and staffing problems, particularly a very high staff turnover. In the reform plans are the harmonisation of legislative regulations in order to meet with the EU standards and the reorganization of these services. There still exists a large gap between public health services focussed on sanitary control functions and those arguing in terms of the broader sense of public health. Other points of the health sector that need more attention are weak administration (medical doctors acting as managers in many institutions); there exists no political will to make unpopular reforms, the empowerment of community members is in the bud and the citizens' voice is still very weak (TNO 2000).

The main obstacles of medical education reform in Lithuania were identified by Grabauskas (2001) as the following: a lack of dialogue among governmental bodies (Ministry of Health, Ministry of Education) on the one hand and institutions and medical community on the other; lack of expertise in some areas; a lack of financing; out-dated educational technologies and equipment; confusing messages from international experts and organizations and confusion between processes of

privatization and private medical practice.

Baltic-Nordic perspective

The Nordic countries followed closely the political changes taking place in the Baltics in the late eighties - early nineties. The authorities of the Nordic School of Public Health were discussing possibilities of expanding the activities to other countries. Among the staff of the NHV there were people involved in the work of the World Health Organisation and the Association of School of Public Health in Europe, who shared ideas of becoming more international and European thinking. In the discussions, the Baltic countries were targeted first, as having old traditions, fresh democracy and close geographically. The Nordic Council of Ministers had identified the series of initiatives that they wished to support to strengthen the democratic institutions in the newly independent countries inviting bids for grants. The idea of public health training in the Baltics was accepted, and in 1991 the East European Committee offered the Nordic School of Public Health to support the Baltic countries in academic and professional training in public health and building up a cadre of public health leaders. The first initiative was to arrange fact finding missions to the Baltic countries. The targets for the fact finding mission were the ministries either of health or education and training institutions. So that meant Tartu University in Estonia, Latvian Medical Academy in Riga, Vilnius University and Kaunas Medical Academy (now Kaunas University of Medicine) in Lithuania. The first mission consisted of Professor Lennart Kohler, Dean of the Nordic School of Public Health and Dr Keith Barnard, WHO/NHV consultant. The first fact finding mission lasted for two weeks. First the mission went to Tallinn; it was freezing cold, February 1992. They wore gloves and had their hats on when we slept in Estonia. There was no heating...

Professionally, however, the mission was very successful. It found that the level of development was quite different in the three Baltic countries. In Lithuania the mission met with the Minister of Health Dr Juozas Olekas, staff members Dr Robertas Petkevičius, Head Division of Health Strategy and Policy Strategic Planning Department and Dr Albertas Valavičius, Head of International Relations Division at the Ministry of Health, and Professor Gintautas Česnys, Dean of the Faculty of Medicine, Vilnius University. In Kaunas University of Medicine, the team of Rector Professor Vilius Grabauskas was closely collaborating with the WHO, so it was very easy to talk. Afterwards, in April 1992, the ministers were invited to Gothenburg for further negotiations, to establish a climate of a partnership and to identify public health and other training needs. In Gothenburg they met with Professor Edvardas Varnauskas, a famous cardiologist from Sahlgrenska Hospital, who had been providing much assistance to his native country; in 1992 Professor Varnauskas was nominated Honorary Doctor of Vilnius University. (http://www.vu.lt/en/welcome/facts_figures/honorary_doctors/).

In 1992 the BRIMHEALTH (Baltic Rim Partnership for Public Health) programme was launched (Rimpelä & Eklund 1996) in NHV. The Nordic School of Public Health was

concerned in promoting harmony around the Baltic rim, which explains the BRIM in the title. It was a collaborative programme, the main partners being higher academic medical and public health institutions in Estonia, Latvia, Lithuania, later in Poland and the St.Petersburg. During the history of BRIMHEALTH it was stressed that the area of St Petersburg and Poland had to be included into BRIMHEALTH. The collaboration between the Baltic training institutions and the Nordic School were to be built according to the same principles as between training institutions in the Nordic countries and in Europe in general (Baltic Rim partnership 1993, Köhler & Eklund 1999). The NHV wanted the target group to be multiprofessional and multisectoral.

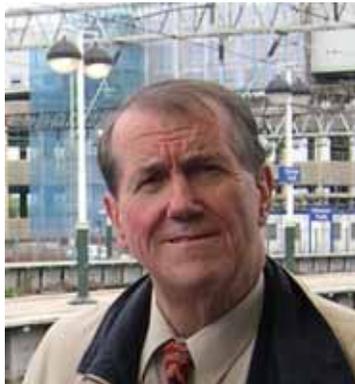
From the beginning of the programme the Nordic Council of Ministers had stressed the need to support the development of the public health in the Baltic countries. However, due to limited resources, the Nordic School was not able to offer Baltic students all courses they needed. It became part of the BRIMHEALTH strategy to organize courses as a joint venture with other schools of public health or corresponding institutions. Appropriate courses arranged by other schools of public health have been accepted as part of the MPH or Diploma programmes (Baltic Rim Partnership for Public Health 1999). The BRIMHEALTH programme aimed at two different time horizons: to achieve the long term strategy, through which a qualified and experienced group of experts (critical mass) could be created in each country; and the second was to implement a short term strategy to enhance students' knowledge and skills through shorter events and continuous education (Köhler & Eklund 1999). At the April 1992 meeting a Memorandum of Understanding was signed. This document was the basis for going to the Nordic Council of Ministers and asking for substantial funding to run the programme. The first funding was quite generous, 1.7 million Danish crowns for the first two years. However, the continuity of funding was important, not only from the planning point of view. Another problem was that although the school's board notionally accepted the importance of international collaboration, they were concerned that the budget was only used on Nordic activities, so that meant that BRIMHEALTH programme had to be entirely self funding. This situation changed in 1996-97 when the idea of student exchange was implemented. The initiative came from one of the Nordic students who wanted to be involved in the BRIMHEALTH programme in the Baltic countries. A plan how to do that in practice without exchanging money (changing credits and exchanging places) was made, the system was paying itself (Barnard 1998a, 1998b).

Each Baltic country was responsible for recruiting the students who had the greatest potential to influence the development both of health policy and health care in the country. BRIMHEALTH has by now existed over ten years and over 30 courses on different topics have been arranged in addition to other activities. In 1999, 160 students have been registered as BRIMHEALTH students and eight of them have finalized either their Diploma or MPH degree. Up to 2003 there were 92 Lithuanian students taking part in BRIMHEALTH. In 2004, 23 teachers and researchers in the Faculty of Public Health at the KUM had been BRIMHEALTH students (Šumskas 2004b). Students as well as ministries and universities (either orally or in the form of letters) have been highly satisfied with the

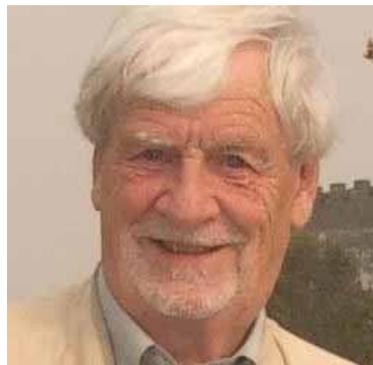
programme which has been seen both as career promoting and as supportive of health care reforms (Köhler & Eklund 1999). The Nordic public health family has gradually become the Nordic-Baltic family (BRIMHEALTH 2004).

In their support letter of 2nd June 2000 to the Nordic Council of Ministers the Lithuanian vice-minister of health expressed an idea that proper development of the public health function in Lithuania is closely related with the successful collaboration the BRIMHEALTH. The plan of transforming BRIMHEALTH partner network into a **Baltic International School of Public Health (BISPH)** was accepted at NHV in 2001 (Eklund, Berntsson 2001, Šumskas 2004b). The BISPH had to ensure the high quality of the curriculum fulfilling the requirements of NHV and ASPHER and corresponding to the standards of PH education in general in Europe.

BRIMHEALTH was started - In Sweden by...



Dr Keith Barnard



Professor Lennart Kohler



Professor Arja Rimpela ... Dr Leena Eklund

And in Lithuania by...



Professor Edvardas Varnauskas and
Professor Vilius Grabauskas



Dr Juozas Olekas



Dr Robertas Petkevičius

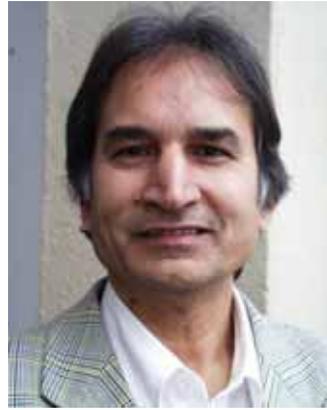


Professor Gintautas Česnys

BRIMHEALTH was developed in Sweden by:



Dr Gudjón Magnusson



Professor Vinod Diwan

In Lithuania by:



Professor Ramunė Kalėdienė



Associate Professor Linas Šumskas

AIM

The study aims at describing the general development of public health training in Lithuania, especially connecting it to the introduction of new public health notions and the start of the public health service reform and the health policy development. It is aimed at making a qualitative assessment of the implications of the BRIMHEALTH training programme on

public health training in Lithuania in the light of new public health and finding out how they interact. The study was not aimed at making statistical generalisations rather it was presumed that its findings would give a deeper understanding of the studied area and be helpful for further research in this area. Accordingly, the results of the present study might serve as a starting point for further research.

Another aim of this study is to develop a substantive theory to assess the influence and changes brought about by the BRIMHEALTH programme in the Lithuanian partner institutions and public health training situation in particular. It is a descriptive-qualitative study based on the findings from reading documents and analysing thoughts expressed by informants and through participatory research. The author participated in a BRIMHEALTH training programme for course administrators (six weeks) in 1994 when she started working for the WHO Liaison Office in Lithuania. Between 1995 and 1998 she took BRIMHEALTH courses in NHV, Lithuania (BRIM/NHV), Italy (ETC-PG), and Finland (BRIM/NHV). In 1999 she participated in MPH supervision seminar (BRIM/NHV) and in 2000 – the PH Foundations course (NHV/BRIM). In 2003 the researcher received the Diploma of Public Health at the Nordic School of Public Health. Being a participant of the programme she could observe the programme from the inside and thus be involved in participatory observation. This study concentrates on the effects of the programme in Lithuanian partner institutions only. There exists a lack of evidence about the effects of the BRIMHEALTH programme verified through research. This study will provide one aspect in the assessment of the programme.

METHOD

Grounded theory

Grounded theory (GT), a qualitative method, was used in the present study. GT is aimed at generating concepts, a model or a theory. The method was presented in the classic book *Discovery of grounded theory: strategies for qualitative research* in 1967 and resulted from the fruitful collaboration between the two sociologists Glaser and Strauss who argued that the grounded theory method cuts across disciplines. The method has been widely adopted in education, evaluation research, nursing and organizational studies (Charmaz 1995). The constant comparative method for grounded theory, now labelled the classic grounded theory, stresses the emergence of theory from empirical data through analysing the basic social processes in the studied area. Glaser argues that categories and their properties emerge upon comparing data to data and category to category. According to Glaser, such a constant comparative approach, with a focus on process and without preconceived categories, is efficient and productive enough in analysing the data in a grounded theory study. Later Strauss and Corbin (1990) modified the method, i.e. they reformulated grounded theory, and “demystified” the classic version of grounded theory giving voice to the respondents as individuals and their views of reality. Charmaz (2000) proposed a

constructivist version of grounded theory. Constructivist grounded theory aims at gaining an interpretative understanding of subjects' meanings of their reality rather than seeking the "truth". In this perspective, the "discovered" reality is a product, or construction, of interactions between the researcher and data (Trulsson 2003). Charmaz' view of grounded theory, i.e. a more constructivist way of viewing the data, was used in this study especially the guidelines for open and focussed coding and an extensive memo writing in the analytical process. The guidelines for analysing the data in open, axial and selective coding processes, as described by Strauss and Corbin (1990), have also been helpful to the author because of their structured description of a complex coding process.

Qualitative and quantitative methods may be regarded as two different tools in the research process. The grounded theory method is particularly useful when there is few or no existing theory. The researcher begins with an area of study and allows the theory to emerge from the data (Glaser and Strauss, 1967). A grounded theory is a theory derived from empirical data, systematically gathered and analysed through the systematic analysis process. In this method, data collection, analysis, and the emerging results stand in close relationship to one another. In public health research this method is helpful in exploring different qualities of phenomena or getting a fresh view on issues studied earlier, what is difficult to convey with quantitative methods. Qualitative methods permit the evaluator to study selected issues in depth and detail. Approaching fieldwork without being constrained by predetermined categories of analysis contributes to the depth, openness, and detail of qualitative inquiry. Quantitative methods, on the other hand, require the use of standardized measures so that the varying perspectives and experiences of people can be fit into a limited number of predetermined response categories to which numbers are assigned.

The advantage of quantitative approach is that it is possible to measure the reactions of a great many of people to a limited set of questions, thus facilitating comparison and statistical aggregation of the data. By contrast, qualitative methods typically produce a wealth of detailed information about a much smaller number of people and cases. This increases understanding of the cases and situation studied but reduces generalizability.

In choosing grounded theory method for the present study, the author aimed at illuminating interactions within a complex issue where many actors, institutions, and cultures were involved. It was hoped that the qualitative method will make it possible to look at the BRIMHEALTH programme and its implications "from the inside and from the bottom up"; therefore it was obvious that quantitative methods would not be proper. Grounded theory has its theoretical roots in symbolic interactionism including that an individual's interpretation of his/her reality is constructed and changed within interactions between people (Trulsson 2003). Thus individuals themselves and individuals' perceptions of the world are changing by their interactions with it. These perceptions can hardly be grasped in standardised questionnaires; instead a qualitative method is more suitable. Grounded theory is based on theoretical sampling, constant comparisons, theoretical sensitivity and saturation.

Theoretical sampling is used to reach saturation and is guided from the categories that emerge from the data collected (Charmaz 2000). Saturation is reached when new interviews do not bring additional information into the emerging categories, i.e. when new data fit into the categories already devised. Theoretical sensitivity refers to the researcher's reflexive way of developing research questions and making analyses. Criteria for judging the validity of a grounded theory study include fit, work and relevance, modifiability, parsimony and scope (Glaser 1978). Fit means that a core category is developed which is related to the salient social problem under study. A core category fits when it is relevant and integrates all other categories indicating relations to major values, making the emerging theory dense, saturated and practically applicable. It is assumed that data in qualitative research are generated in the interaction between researcher and informant (Charmaz 2000). Therefore the relationship between the two subjects should be focussed on, i.e. to have reflexivity (Hall & Callery 2001) which contributes to the validity of the results. Validity in grounded theory means that identified concepts and categories emerge repeatedly and are saturated and validated in data. Reflexivity includes the idea that the researcher identifies and reflects on preconceptions brought into the study.

Study Group

A focus group interview (with three persons) was performed at the Nordic School of Public Health, in a quiet room. The focus group consisted of the Nordic representatives actively involved in the start of the BRIMHEALTH programme who participated in its implementation. Afterwards a study group of nine persons was selected on the basis of their involvement in the BRIMHEALTH programme either as students, staff or Advisory Group members. In-depth interviews were conducted using the interview guide prepared with the help of the focus group discussion (Kvale 1996, Alasuutari 1995). The author applied one of the basic principles of grounded theory – theoretical sampling which is crucial to data collection. Theoretical sampling means that the sampling procedure continues until the identified categories are saturated and no more new information emerges from new data. (Some authors, e.g. Dellve et al., 2002, however, notice that saturation is an “elastic” concept). Theoretical sampling demands that the researcher has completed the open sampling process and the work of comparing data with data and has developed a provisional set of relevant categories for explaining the data (Charmaz 1995). In the present study the sampling procedure involved taking two more additional interviews. The focus group interview and three open interviews were taken in English, while the rest – in Lithuanian. The English language was used with the Nordic and native English speakers. It was decided to use Lithuanian with the Lithuanian speakers. However, for the sake of convenience, coding was done in English. The essay and all other work were written in English. Verbal and written information concerning the aim and procedure of the study was provided to all the subjects.

Data collection - procedure

The fruit of qualitative inquiry are the findings, understandings and insights that emerge from fieldwork and subsequent analysis while the purpose of interviewing is to find out what is in and on someone's mind (Patton 1990). There is a scope of serendipity in qualitative interviews, i.e. making new pleasant unexpected discoveries. There exist three different types of interviews or three basic approaches for collecting qualitative data: the informal conversational interview, the general interview guide approach and the standardized open-ended interview. In order to find the main categories and to prepare the interview guide, a focus group discussion (Asbury 1995, Morgan 1998) with the staff members of the Nordic School of Public Health involved in the development of the BRIMHEALTH programme was performed. The focus group interview was conducted in a free conversational style and lasted for one hour and a half. The focus group interview was tape-recorded and transcribed by the interviewer. The author prepared an interview guide that helped her to collect data keeping within the themes such as Nordic-Baltic collaboration, culture shock, human resources for health, public health training, training of trainers, relationship among the partners, the age of students, long-term vs. short term training, obstacles and advantages, training of junior and senior staff, lessons learnt and future plans in relation to the BRIMHEALTH programme. The interview guide was used to conduct the interviews and covered the themes relevant to the topic in study. The interview guide presumes that there is common information that should be obtained from each person interviewed but there is no set of standardized questions written in advance. Afterwards seven in depth interviews each lasting for one hour were taken, tape-recorded and transcribed. In order to reach saturation and to elaborate categories, two more interviews were performed later to collect more information. Based on the themes, the interviewer asked follow-up questions. The informants had a possibility to ask questions in their turn. The author conducted the in-depth interviews in a conversational style with each respondent. In-depth interviews require an active and engaged involvement of both researcher and informant in clarifying the issues, getting responses and elaborating communication. During this process data are being created. The quality of data is influenced by the trusting relationship between researcher and informant (Trulsson 2003). Data collection analysis were conducted simultaneously (Glaser and Strauss 1967, Strauss and Corbin 1990, Charmaz 2000) and continued until new interviews did not provide additional information, i.e. saturation was reached.

Analysis of data

The material obtained was analysed using the grounded theory method. The aim is to generate substantive or formal theories, models or concepts from empirical data rather than to test existing hypothesis or theories. The present study concerned a limited area and aimed at developing a substantive theory. Raw data were coded as they were collected step-by-step and later re-coded in a more abstract level. The author recorded and transcribed all the interviews verbatim and analysed using hierarchical coding processes, i.e. open and

focussed (selective) coding. A code is meant to capture the meaning in the data. They are used as “handles” to find specific occurrences in the data that cannot be searched by simply applying text based research techniques. Codes are used as classification devices of a different level of abstraction to create sets of related information pieces for the purpose of their comparison. Glaser and Strauss (1967) as well as Charmaz ((2000) describe two coding processes (open and focused coding) whereas Strauss and Corbin (1990) describe three (open, axial and selective coding). Open coding of the interview transcripts included reading the transcripts line by line or segment by segment and putting questions to the data, “what is expressed here?” or “what does this mean?” Open coding implies that the researcher has identified and labels substantive codes/concepts representing the meaning in the data. The codes were labelled either using words of the informant (in vivo codes) or using the interviewer’s disciplinary concepts (in vitro codes). Emerging codes with similar content were grouped together into more abstract categories, which were labelled in a higher-order level. These categories were given more abstract labels than the substantive codes belonging to them. Accordingly, the process of open coding led to the clustering of substantive codes with similar content into summarizing categories. Axial coding is a systematic exploration of connections and links between categories and subcategories to develop a conceptual density. In the focussed (selective) coding process, categories and subcategories were saturated with additional information, assessed by new interviews or added by re-coding of the previously assessed data and the core category was identified (Glaser 1978, Strauss & Corbin, 1990, Miles & Huberman 1994). A core category is an essential aspect of a story; it depicts “what it is all about”. The categories and dimensions related to the core category were integrated and formed a conceptual framework. During the entire analysis process, constant comparisons were made between different parts of the data, between different subjects and between different categories, to secure that the emerging categories were grounded in the empirical data. The relationships between the categories were described and conceptual relationships were sought.

An important tool in the generation of a GT is the overview analysis, which makes use of field notes, theoretical memos and ideas. Through this memo writing analytical interpretations are linked with the empirical reality (Charmaz 2000). Memos contribute to the development of a hypothesis, relationship between categories and place the emerging theory in a broader context. During the entire process of analysis, ideas, preliminary assumptions and theoretical reflections were written down in notes or memos to keep track of the analysis. Memo writing helped the author to link the data of the empirical reality with analytical interpretations. The researcher made a vast use of memo writing in the analysis of data. Data collection and analysis occurred in alternating sequences. The first interview was followed by analysis that led to the next interview, which in its turn was followed by more analysis, and more interviews until saturation was reached and no more core categories were established by the researcher. Later in the analysis, memos were sorted with the purpose to find the core categories and how other categories relate to each other and to the core category.

Ethical aspects

Ethical issues were considered by the author. The design of the study involved obtaining the informed consent from the interviewees and securing confidentiality in data sampling, data protection and publishing and considering the possible consequences of the study for the subjects. According to the ethical rules regarding research in Lithuania and Sweden, the researcher is obliged to clearly inform about the study design and the aim of study, i.e. receiving an informed consent after informing the informants about the overall purpose of the study and further obtaining the voluntary participation of the informant with his/her right to withdraw from the study at any time (Kvale 1996). Smith (1995) points out that researchers are obligated to insure that participants in their studies are not harmed (physically or psychologically) by the research; the major issue to consider as a researcher using this technique is the potential of over disclosure by the participants, particularly if the research topic is sensitive. Confidentiality in research implies that private data identifying the subjects will not be reported. If information can be potentially recognizable to others, the informants' privacy is protected by changing names and identifying features. In our study, in order to protect informants from being identified, they were given codes. The informants had the right to withdraw from the study without any negative consequences. All informants were provided with oral and written information regarding the aim of the interview.

The understanding of ethics is not just a study of theoretical knowledge, but includes an understanding of the applicability of ethics to real world situations. Varga (1978) defines ethics as a part of practical philosophy and seeks to study, rationally and systematically, the rightness or wrongness of human behaviour. As qualitative researchers, we must consider the rightness or wrongness of our actions in relation to the people whose lives we are studying, as well as the importance of these actions in relation to our colleagues or those who sponsor our work. (Miles and Huberman, 1994).

Another aspect while planning the study was the question of preconceptions. The researcher was a BRIMHEALTH student herself, thus taking part in interactive processes in the data collection and analysis. No one can be free from at least minimal theory about the studied object though Glaser and Strauss (1967) argue that the researcher in grounded theory should be free from any theory, as the emerging theory must be grounded in data. Thus it is necessary to take appropriate measures to minimize subjectivity in the analysis. Since the basic assumptions of grounded theory include the researcher's theoretical sensitivity, strategies are required that account for the effects of subjectivity (Dellve et al. 2002). One of such effects is postponing literature review. The researcher started analysis of the first interviews without making literature review, just being acquainted with the basic principles of GT and data coding. The researcher had no preconceived theory in mind (Strauss & Corbin 1998). Later, analysing and interpreting the results, more literature was added for review, new literature was selected depending on the emerging theory. The purpose of the GT study is discovery, and this requires creativity and insight. Dellve et al. (2002) make it clear that the researcher should be open-minded to the data, as the

researcher is an instrument in this theoretical sensitivity; the interpersonal interactions make the researcher a part of his/her observations which can be described in the terms of reflexivity and relationality. Reflexivity shows the interaction between the researcher and the data, as he/she is as part of the data, not separate from it. Relationality addresses power and trust in the relationship between the participant and the researcher. Hall & Callery (2001) suggest that memo writing can help to handle the effects of these two interactions and make the results more valid and reliable. The author of the study made an extensive use of memos. Memo writing helped the researcher to find out whether the conceptions belong to pre-understanding or empirical data.

RESULTS

In the data analysis there emerged five descriptive categories:

- **international postgraduate students feel welcome in BRIMHEALTH**
- **providing assistance**
- **building partnerships**
- **being an experimental programme**
- **BRIMHEALTH as a model.**

The category *international postgraduate students feel welcome in BRIMHEALTH* is the core category. It embraces both the Baltic (Lithuanian in our case) student at the NHV or BRIMHEALTH. Each of the four categories relates to this core category and adds to its description in its own way. The core category is central to the study as it embraces the multi-sided aspects of the qualitative assessment of the BRIMHEALTH programme implications in the Baltic partner institutions and shows their relationship inside the programme, the centre of which is the international BRIMHEALTH student.

The category *providing assistance* reflects the scope and the character of the support provided by the Nordic Council of Ministers and the NHV to the Baltic partner institutions to build up the resources in public health and in the development of public health training programmes. The category also defines Lithuania as a receiver of this support.

The category *building partnerships* depicts the Baltic-Nordic relationship built by the Nordic support and through the involvement of Baltic partners in the BRIMHEALTH and other international training programmes.

The category *being an experimental programme* describes the sub-categories related to the training programme rooted in the NHV and developed to many-sided BRIMHEALTH activities in the Baltic partner institutions.

To understand the process and the outcome of *BRIMHEALTH as a model*, an investigation of the sub-categories related to this category was performed.

The four descriptive categories are related to the core category as illustrated in Figure 1.

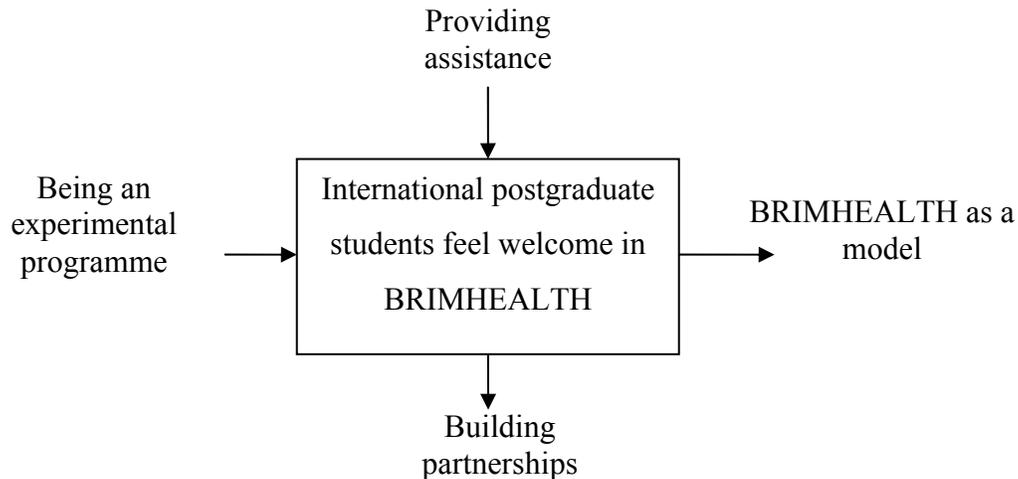


Figure 1. Model showing how the core category interacts with the four descriptive categories.

The core category *international postgraduate students feel welcome in BRIMHEALTH* emerged from the data analysis and describes the Baltic (Lithuanian, in our case) at the BRIMHEALTH courses. To some extent it also describes the Nordic student at BRIMHEALTH courses, at the later stages of the programme development. The core category *international postgraduate students feel welcome in BRIMHEALTH* embraces in itself a number of subcategories, such as:

- adapting to the new milieu
- acquiring new competences
- background and age
- criteria of selection.

Adapting to the new milieu: This subcategory denotes the necessity by the Baltic students to adapt to the new training environment, the difficulties experienced and their ability to cope

with the cultural differences. When the Baltic students first came to the Nordic School of Public Health, they needed more help than Nordic students to find their way and to adapt. The informants pointed out that the appearance of the Baltic students was very different from the Nordic ones when they first came to the courses in 1994 or 1995. Their clothes and the manner of behaviour witnessed that they come from a different world. This outward difference in the appearance disappeared after two or three years and later it was not possible to tell a Baltic student from a Nordic one. One can speak not only of learning public health but learning the way of life when coming to NHV. During the last years of the programme, the integration of students was easier than in the beginning. Informants mentioned that the School had found an emigrant Estonian teacher of English in Gothenburg who taught the Baltic students. At the same time she was introducing them to the basic concepts of public health as she borrowed material from the lecturers for her classes:

“...there was a nice teacher, lady from Estonia, she understood our limited knowledge of English and was teaching us with the help of songs, drills and everyday situations”.

The courses were arranged in other Baltic countries, in Poland, St Petersburg and Scandinavian countries. The informants pointed out to the international experience as “valuable in their future career”. The notion occurred very often in the informants responses.

The Baltic students characterised Nordic counterparts as working hard and not wasting their time. The Baltic informant thought that it was better for Nordic students to study in their usual environment, at Nya Varvet, where everything is so suited for learning.

Acquiring new competences: This subcategory relates to the satisfaction of the students to come to the Nordic School of Public Health on the one hand and the dissatisfaction of the Nordic trainers with the low speed and slow progress of the *BRIMHEALTH* students to finish their studies. The slow speed was explained by a shortage of time and the way students were putting priorities. In general, the enthusiasm shown by the students was not as expected by the NHV standards and the students did not prioritise studies at *BRIMHEALTH*, as the Nordic informant put it:

“Well, in general, it has been, the pace has been too slow. That means, I think, with the resources that we have, we might have done even more. With the enthusiasm that the Nordic School and also the collaborating institutions had, one could have achieved more. But the bottleneck has been the students who either did not prioritise this as the first priority or that if they did prioritise, they just didn’t have time because of their other work. So the progress in both attending the courses and finalising Master, PhD or Master of Science Programme has been slow. That I think is the weakness of the programme ... because I work with other programmes and I know...”

The Lithuanian informants thought that the students, younger and older ones, were thirsty for the new knowledge and ready to receive new ideas. The students needed new competences. They would use the smallest opportunities for training and would share the knowledge at home institutions. The knowledge level of the younger participants was similar to that in the Western countries, while the older staff working in public health admitted that they needed retraining in order to acquire new competences and to be able to work internationally. The students expressed the feeling of relief to come to the NHV. However, they pointed out to the shortage of time, stress and difficulties in obtaining employers' permission to come to the courses for two weeks or a month. In 2003 the NHV gave a special quota for Baltic students to finish their diplomas or Master's degree. There were 19 students left on the credit list during the time of the interview in 2003.

Background and age: The NHV informants pointed out that the first groups coming to courses were mostly composed of physicians.

“Only 27 doctors came to the first courses, no nurses, no social workers. It seemed hard to identify students with other background, not physicians; there was no junior staff...”

The students with medical background were satisfied with their education thinking it helped to see the problems and find the best solution involving community and preventive measures. The informants, all medical doctors, thought that public health specialists with a medical background had a better understanding of the basic human values and are not overshadowed by modern bio-statistics. They pointed out that all teachers of public health and supervisors of MPH programme at the Kaunas University of Medicine were former BRIMHEALTH students. The respondents noted that all students were higher school graduates and several had postgraduate degrees.

The problem of the proportion of younger and older students was defined as a very important issue. A group of respondents was stressing that a combination of younger and older students is most appropriate; pointing out that at least one quarter of the group should consist of young students. The advantage of younger students was that they have more time.

Criteria of selection: This subcategory relates to the criteria used to select students for the BRIMHEALTH courses. The informants thought that student selection criteria were very obscure. At first students were chosen depending of their knowledge of English. At first there were few such candidates. The School even hired a teacher of English for the newcomers.

Another problem as stated by the informants was the change of students which hindered building of a critical mass of personnel able to work in public health decision making. The respondents stressed the importance of the selection of the students depended on the country institutions.

“Participants to the programme were chosen in a very liberal way and their age varied. Later it proved beneficial because work in mixed age group showed that it is more interesting. People with different experience gather together and such groups are very creative, their discussions very fruitful. It was very important to share the experience and to hear how health reform is going on in other countries.”

The respondents expressed dissatisfaction with the method of student selection and poor information about the programme in the partner institutions.

Providing assistance

The notion of assistance itself is described as “help given to someone or help that allows something to be done” (Macmillan 2002). The subcategories of the category *providing assistance* are:

- *difficulties in administration*
- *Nordic support*
- *playing the parents’ role*
- *overcoming culture shock.*

The subcategory *providing assistance* reflects the willingness of the NHV to help the Baltic partner institutions to build up their capacities and to create the critical mass of leaders responsible for public health in the countries, to develop training programmes and to train the trainers.

Difficulties in administration: the NHV informants indicated that the task to establish contacts with the Baltic students demanded extra effort from the School’s administration. As pointed out by the informant, the Baltic students were not on the School’s register until 1998 and it meant a bigger workload for the BRIMHEALTH administrator. The staff of BRIMHEALTH often worked overtime and weekends.

‘...we started together with the course administrator, really to go through the list and she mailed almost every one of them (students) and asked where they were and what their plans were. ‘

Respondents from the NHV staff stressed that late cancellations occurred often and it posed a problem for the School. Despite certain difficulties, the informants at NHV expressed satisfaction with having Baltic students around.

The Nordic support: This subcategory defines the support received by the Baltic partner institutions as seen by the interviewed students. This subcategory was described by such selective codes as useful contacts, providing professional advice and expertise, mobilising

available resources. Talking about the support the informants often extrapolated and talked about the support to public health improvement received from the Scandinavian countries, not through the BRIMHEALTH programme only. The Nordic support was manifold and it was stressed that the Lithuanian partner institutions underestimated it as expressed:

Informant: The Swedish influence to Lithuania was big, strong enough, I am not able to say what impression they had of Lithuania, but I think that often they were forced to feel disappointed.

Interviewer: Why?

Informant: Simply because they were working to help and they were not valued enough by certain groups of people..."

In order to save funds, it was agreed that Baltic students would have 36 places in the courses arranged by the NHV and five Nordic students would be able to join BRIMHEALTH courses annually. A group of informants expressed an opinion that "...Lithuania should have approached the Nordic Council of Ministers for support..." and that "...new directions should be presented to the Swedish Government for providing support..." On the other hand, Lithuanian informants were critical of themselves saying that Lithuania showed not enough support for the BRIMHEALTH programme ("...too little effort from the Lithuanian side to support BRIMHEALTH was shown..."). The informants were blaming the local organisers for not making the programme more visible, for not highlighting it among the politicians and the society.

Playing the parents' role: This subcategory denotes that the NHV played the parents' role in the beginning (BRIMHEALTH 2004). The aim of assistance was to build the capacities of partner institutions. The provided assistance helped the students to cope with the differences in the learning environment and to adapt. The importance of learning different cultures was evident. According to the interviewers, the NHV staff showed eagerness to help the BRIMHEALTH students as they understood the initial difficulties of adaptation. The NHV respondents pointed out that they aimed at serving the students and fulfilling students' expectations.

"...We try to serve students... we serve the Baltic students much more than we do the Nordic students. As you know, there's a lot of student work with the tickets, the per diem, the taxi orders, which we don't do with the Nordic students."

Overcoming culture shock: The informants were not unanimous about the fact of a culture shock. The concept itself was not understood equally by the different nations. The Nordic informants were talking about cultural shock much more than the Lithuanian colleagues did. The Nordic informant said:

"The main idea was not to shock the students – to avoid failure it was practically necessary to do what the students were expecting... Problem based learning was not successful in the start and we made a decision to move to a more didactic way of introducing concepts"

...Baltics had no experience about finding facts themselves, they wanted to sit down and swallow... “

The Lithuanians either rejected the existence of a culture shock or tried to explain it in economical terms. The level of income and the economical situation was very different in the Baltic and Nordic countries, so they thought culture shock occurred due to the fact that the per diem received in Sweden was a considerable amount of money in the Baltic countries compared to the wages students received in their home countries while in Sweden it was not a big sum at all. An economic stimulus to come to Sweden existed as the programme organizers covered the travel and accommodation expenses.

Building partnerships

Partnership is a relationship between two or more people, groups or countries involved in an activity together (Macmillan 2002). This relationship was built through the assistance provided by the NHV to the Baltic institutions forming a Baltic-Nordic partnership. The category *building partnerships* is closely related to such subcategories as:

- *learning from each other*
- *equal partners*
- *psychological empowerment*
- *international collaboration*
- *shared functions.*

Learning from each other: This subcategory defines learning from the differences, either cultural or national, as was stressed by the informants. It was provoking discussion and assisting to find new solutions. From the start of the programme the respondents saw a large area of collaboration and a possibility to learn from each other. The informant said:

“...we, as neighbours, learn from each other...one can learn from negative experience also... I think we can learn very much from the situation which is in the Baltic countries, and also we can ask the people who attend the courses, Nordic students, they love to have Baltic students... in the courses, because that inducts the discussion in the course in a different way when for example when there is only one country...”

Equal partners: To be *equal partners* was stressed important by the informants, it was hoped that the recipients of assistance would become partners, *“taking over the started work and transforming the BRIMHEALTH to a new body”*. According the interviews, this Baltic-Nordic partnership was possible due to the long lasting support (11 years) provided by the Nordic Council of Ministers as one partner. Another partner was the NHV itself. The school gave quite a lot to BRIMHEALTH as stated by the informants. It never charged anything for the time the School’s teachers were spending. The third partner bearing the

costs were the national institutions that have provided “*more than people can realise*”, as stated in the interviews. The role of country institutions was stressed by the informants as one of the main factors conducive to a successful implementation of the programme. Despite the decrease in financing, the budgetary resources were used more efficiently thanks to moving the courses to the Baltic countries. The local teachers, participating in the BRIMHEALTH programme, felt they became *equal partners*.

One of the respondents said “*I always highlight BRIMHEALTH, it is a very good example of partnership ... it has a very high status at the School.*”

The informants pointed out that Nordic partners were collaborative, while the Lithuanian partners were not always supportive enough and forgetting their commitments. However, the first fact-finding mission “*found equal partners in the Kaunas Medical University*”.

A good instance of partnership was appointing local coordinators of the programme. In Lithuania, a local coordinator joined in 1996. Many respondents stressed the importance of the local coordinator institution as it often acted as a bridge between the NHV and the students of the partner institutions. Plans had to be changed and responsibilities with the partner institutions shared on a larger scale. A plan of student exchange without exchanging money was made and courses shifted to the Baltic countries. The informants stressed the importance of good administrative support to the BRIMHEALTH programme provided by the project manager and administrator.

Psychological empowerment: This subcategory is closely related to the previous subcategory *equal partners* and expresses the power felt and exercised by the national teachers working in the BRIMHEALTH courses. It was mentioned by a group of respondents that *psychological empowerment* was brought about by the partnership.

“We could use the term of psychological empowerment... that is when a person understands his potential, that he can be equal to specialists and teachers in Western countries... This is the highest attainment of cooperation... At the same time we understood that we are able to participate in the training market.... Just as we understand that institutions of the Nordic countries can create projects for the Baltic countries with no experience of training programmes, so we ourselves ... can assist the former Soviet countries to create such programmes”.

International collaboration: The informants spoke of possible intersectoral *international collaboration* around the Baltic Sea when the economic situation improved. According to the informants, the teachers from NHV started participating in the TEMPUS project, another public health training programme, run from 1996 to 1999 at the Kaunas University of Medicine; the scope of activities had increased. The partnership was reciprocally beneficial, as the KUM produced possibility for NHV teachers to participate in international programmes. There were also common projects with the UK institutions and participation in the activities of ASPHER.

“Our university, at a later stage, provided a possibility for the Nordic institutions to widen their international cooperation... to participate in projects of other EU countries, not only the projects of the Nordic countries, that was sort of a feedback...feedback link, we started being useful, one can say we became donors, not just like in the beginning when we were only recipients...”

Shared functions: This subcategory relates to a number of properties describing collaboration and sharing of functions through personal input brought about by individuals shaping the BRIMHEALTH programme. The partnership was built on human contacts and input. The informants named persons standing in the origin of the programme, authors of the sustainable strategy for the Baltic Rim Partnership in Public Health. The informants stressed the importance of the individual impact of the Advisory Group members, leaders of the Kaunas University of Medicine and the Medical Faculty of Vilnius University for creating favourable conditions for Lithuanian students to participate in the BRIMHEALTH and promoting them. The first national public health textbook presenting the basic concepts of public health in the Lithuanian language was written in collaboration with the teachers of NHV. Professor Ramune Kalediene became adjunct professor at the NHV.

“... so they are adjunct professors at the Nordic School of Public Health ... they are representing us. And that makes us feel very good that we can appoint people from other countries as adjunct professors to our school.”

Being an experimental programme

The category is related to the following subcategories:

- *path finding*
- *introducing new concepts*
- *survival strategies*
- *field visits*
- *experimental character.*

Path finding: During the focus group interview the main properties of the programme were described labelling it “*BRIMHEALTH was path finder*”. The Nordic informants said that the philosophy of the programme was based on the concern to promote harmony around the Baltic Sea and was aimed at building institutions. The NHV had little knowledge of the public health training needs at the Baltic institutions. The first fact finding missions witnessed a different level of development in the three countries and sensed a need for a radical change. The Baltic political events were a big concern to the Nordic countries:

“These political events that happened in the Baltic countries was not an ordinary business for the Nordic countries, obviously, it has been so close to us physically and emotionally,

politically... So we thought this was great what happened and we followed very closely on TV..."

The NHV promoted harmony around the Baltic rim, as explained by the acronym BRIM.

Introducing new concepts: This subcategory describes the necessity to introduce new problems and new concepts to the students. As problem based learning was not familiar to the Baltic students, teaching strategies had to be adjusted:

"There was a lack of people who understood new concepts of public health. No knowledge what is health system, health policy, what is public health care, prevention, health education, etc. I think that there were few people who knew these things, compared to the demand. And only several were admitted every year to public health residency programme in Kaunas University of Medicine..."

The informants pointed out that they received public health concepts through BRIMHEALTH courses.

Survival strategies: The subcategory relates to the properties such as uncertainty about the future, fight for funding, etc. as pointed by the respondents:

"In the beginning we did not know how long the programme would continue and whether we should have a possibility to finish a full course and to receive Master's degree. I can say that the organisers themselves did not have this goal in the beginning. The aim of the programme was to provide basic information and knowledge and to make an impact, maybe to create a critical mass of people who could teach modern public health. Our leaders were invited because it was planned to make the influence through the leaders. And only later the concept of training of trainers started to be developed as it was noticed as it was more efficient".

The programme underwent two critical phases when it seemed that no more financing would be secured. The staff had to be reduced (initially two staff members were the academic core, one project manager and one part time administrator), the workload was very big. The informants had to work weekends. The Nordic informants said *"the Nordic politicians did not understand the importance of the project, and we were not too strong to force the things through at the Nordic Council of Ministers."* Lithuanian respondents expressed it that *"Lithuania should have approached the Nordic Council of Ministers for support"*.

Field assignments: This subcategory relates to the field visits made by the students in Sweden. The respondents pointed out that field visits and *field assignments* were a peculiarity of the programme. *Field assignments* helped students to acquaint themselves with the Swedish healthcare system and other educational institutions. The descriptive

codes pertaining to field assignments were described by such properties as long term planning, openness to novelties, high level of computerisation, easy information retrieval.

Experimental character: The informants pointed that the programme was experimental (pilot). BRIMHEALTH helped to develop the public health curricula in Kaunas University of Medicine. There occurred changes in teacher-student relationship, bringing the medical schools of Vilnius and Kaunas closer, involving students in decision making, introducing new teaching methods. Nevertheless, the students pointed at their dissatisfaction of not being able to see the programme's aims and what they could gain in future. The informants expressed a negative attitude that "*the Nordic countries had a superficial understanding of the Baltic countries and that Baltic potential was underestimated*". It was stressed that there was lack or absence of previous knowledge of the Baltic countries in the NHV. Another negative trait was a lack of supervisors and qualified teachers. However, it was pointed out that participation even at a single course was very valuable to the general understanding of public health described as "*sowing a seed*" and the acquaintance with new teaching methods.

The Nordic students' reaction to BRIMHEALTH courses, as expressed in the focus group interview and by the BRIMHEALTH staff, was rather favourable. Sometimes the Nordic students complained about the accommodation conditions in the Baltic countries. There seem to have been no complaints about the contents of the lectures and the social programme. Nordics showed eagerness to join BRIMHEALTH courses, either at NHV or in the Baltic countries.

BRIMHEALTH as a model

This category is described by a number of subcategories, such as:

- *basis for new processes*
- *teaching methods*
- *things to be improved*
- *preconditions for BRIMHEALTH success in Lithuania.*

Basis for new processes: This subcategory embraces a number of codes, such as long term planning, future development, individual approach to student, etc. The informant pointed out at the importance of BRIMHEALTH in Lithuania saying:

"Cooperation in BRIMHEALTH training programme laid a foundation for many new processes taking place in Lithuanian public health development at present. The importance of long-term planning and other peculiarities were evident".

Moving the courses to the Baltic countries and training of trainers was a favourable development of the programme and helped to save funds. It was pointed out that the aim of training the trainers was not clearly stated in the programme at first. The idea became prominent only after the courses in the Baltics started and the first three courses of training

of trainers, i.e. of teachers, were organised in Poland. Later this idea, as progressive, got much support from the Open Society Fund. The Kaunas University of Medicine was considered to have made a large contribution to the development of the idea of training the trainers as it was among those partners who strove for the preparation of teachers.

The support letter written to the Nordic Council by the Ministry of Health showed how the country valued the programme. The letter was drafted by one of the BRIMHEALTH students. The Ministry of Health expressed its opinion about the necessity of developing the programme. A group of informants was talking about the future of BRIMHEALTH – the Baltic International School of Public Health, BISPH. This topic can be proposed for further research.

The informants thought that the qualitative evaluation method of the programme is appropriate and expressed an idea that the programme should not be assessed by figures only. When asked about criticism addressed to BRIMHEALTH that such a big project ended with only several MPH theses and only a few diplomas, the respondents did not agree with the subjective criticism as unfair. They expressed an opinion that the impact was enormous, even for those who came to NHV only once or twice. They saw how people communicate, what is modern public health, how it should function. The idea was expressed by one of the informants:

“...these things are difficult to measure using quantitative indices. I think that this work, being a qualitative one is very appropriate. Numbers do not show the real impact, but I think it was very big”.

Teaching methods: The subcategory reflects the characteristics of BRIMHEALTH teaching methods and the respondents’ attitude towards it. The informants noticed the individual approach to each of the students by the Nordic teachers and problem based teaching. The informants stressed that the idea of training the trainers was very successful though it was not easily introduced due to different teaching approaches and mentalities. Sharing and openness of mind brought new ideas of collaboration and development. How the students evaluated the new teaching methods may be described by this citation:

“We met with a slow presentation of learning material and long discussions, sometimes not very constructive ones ...this would even cause some frustration to us, because it is characteristic of our people to be in a hurry, to do things quickly... and here we had a slow process of material presentation ... which in the end really gave a much deeper understanding and better knowledge...”

The respondents thought that Nordic teachers make a better use of student’s individual capabilities and that their thoughts were more listened to. They were comparing Lithuanian and Nordic attitudes to various issues and thought that “*Swedes make a better use of good personal qualities*” and that they are more creative and tend to make “*informal solutions*”. Training is focussed at solving problems and is based on raising problems. The informants

stressed the importance of evidence based teaching and the importance of evidence based knowledge for making the right decisions.

Things to be improved: This subcategory embraces certain properties described by the codes expressing criticism of some negative characteristics or lack of something. The informants pointed out to negative aspects of the BRIMHEALTH programme defined as poor information about the training programme and its potential to public health development, low interest in the programme by high level officers and poor information provided to the politicians. There emerged descriptive codes reflecting such properties as lack of efforts to enlighten the society, not career promoting, no empowerment solutions, lack of interest by the high level officials. The informants pointed out that from the decision makers' point of view there were no efforts to enlighten the society and talk about the benefits of the programme. The informants thought that despite the high level of knowledge received during the training courses at BRIMHEALTH, it was not career promoting. Rather, the career was made through political parties and friends, especially in the state sector while the private sector makes a better use of good personal characteristics and education. The informants expressed a thought characterising the country's situation:

"We have the laws but they need to be implemented. The ability to implement laws is the nation's cultural feature... well... content wise we lag behind the Scandinavian countries, to my mind... certainly in some municipalities we have quite progressive programmes, better than in others, like trauma prevention, or disease prevention, or risk factors but on the national level, I think, there is still a long way to go..."

According to the informants, Lithuanian partners did not look for citizen empowerment solutions and provided too few opportunities to adopt the acquired knowledge. The programme taught how problems should be solved in a democratic way. However, in the beginning of the programme students in Lithuania had little information of BRIMHEALTH and its aims were not clear.

It was stressed that Lithuania (compared to Latvia and Estonia) gained maximum benefit from BRIMHEALTH: the greatest number of students, the students were most active, showed exceptional professionalism in collaboration and received the biggest number of diplomas and MPH degrees. However, if development plans were presented at the start, BRIMHEALTH would have been even more effective in Lithuania. The uncertainty of further financing hindered the clear vision of the programme's future.

There was an idea expressed by one informant that often decisions were made by a small group of people behind closed doors. This is related to the fear of competition among Lithuanians, and this leads to a closed society. Lithuanians stressed a low self esteem of their students and too high, sometimes groundless, expectations from the West.

The informant pointed out different methods of evaluation in Lithuania and in the West. It leads to some discrepancies and misunderstandings. The informant said:

“... *Westerners have their own criteria for evaluation which are not always clear to me...*”

Preconditions for BRIMHEALTH success in Lithuania: This subcategory embraces a number of descriptive codes shown in the Figure 2. The informants made it clear that the BRIMHEALTH programme would have not been possible if not the favourable political situation. Lithuania was facing the Independence movement in the early 90-ties; new progressive ideas were welcome and found support by the leadership of the Sajūdis (Movement). It was noteworthy that physicians and medical academic people were among the progressively minded intellectuals formulating new democratic ideas for the liberation Movement. The Sajūdis movement was mentioned by a number of respondents as many progressive thinkers and physicians took an active part in the Sajūdis. The main conditions for the BRIMHEALTH success in Lithuania can be partly explained by the citation “*Politics and science were close*” from the in-death interview with one of the respondents. The National Health Concept was adopted as early as 1989, created by democratically minded Lithuanian physicians in the light of the changes happening in the former Soviet Union in the late eighties and practically inspired by the WHO ideas. One more very important precondition for BRIMHEALTH success was that Kaunas University of Medicine was a WHO collaborating centre and the WHO Health for All database was widely applied there. The summary of the main conditions favourable to the implementation of the BRIMHEALTH programme is presented in Figure 2 describing the other causes conducive to BRIMHEALTH’s success.

Preconditions of BRIMHEALTH success in Lithuania: “Politics and science were close”

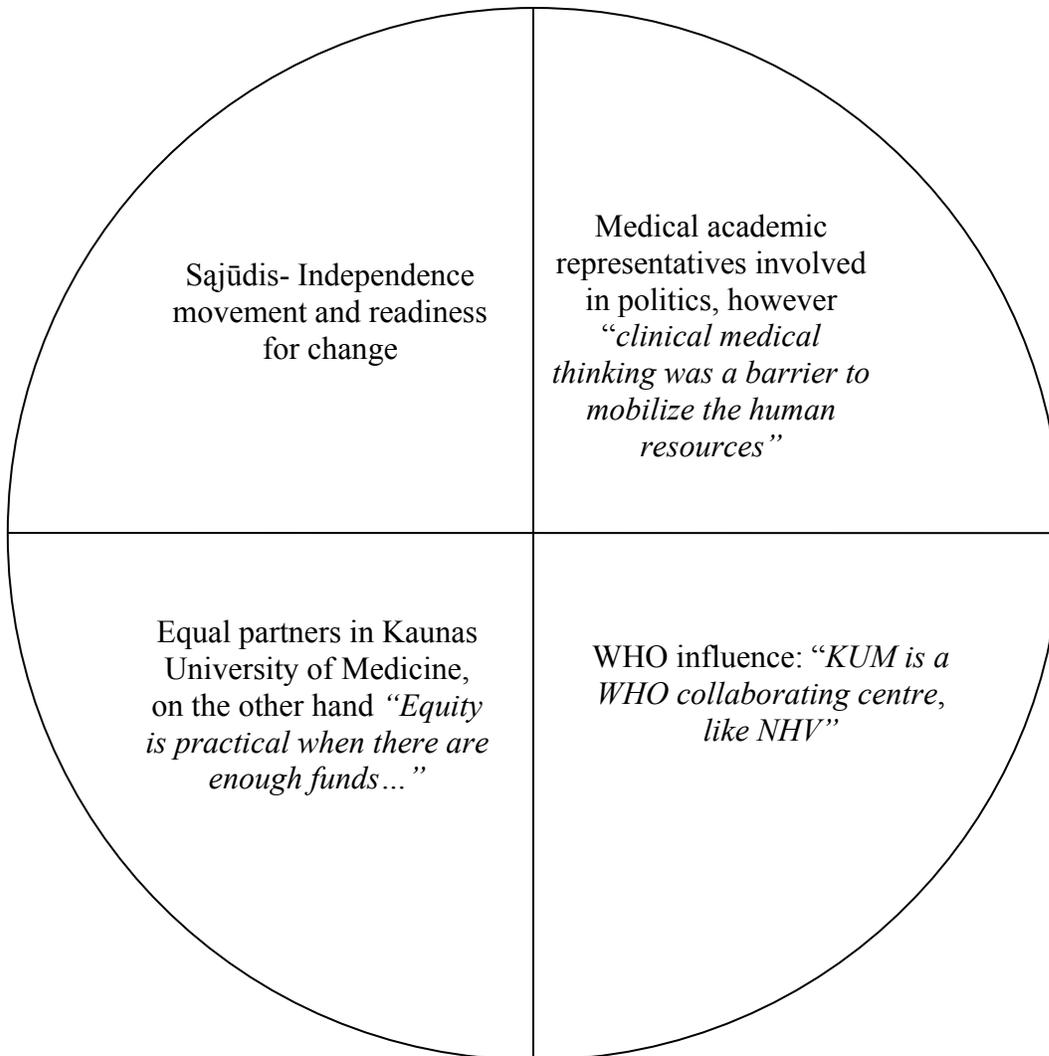


Figure 2. Model describing how BRIMHEALTH success was preconditioned in Lithuania based on the interviews with informants from Lithuanian partner institutions.

DISCUSSION

Methodological aspects

The choice of the qualitative research method for the study was dictated by the complexity of the topic and by the fact that the author was genuinely interested in the qualitative research methods. Allwood (2002) states that “the qualitative research approach has in the last decade become increasingly popular in the social sciences, including the health and health care sciences”.

For a number of successive years the author had been a passive participant observer as a student of the programme. The author’s role as a student makes a better understanding of the topic (Eklund 1999). In qualitative studies it is typical that the researcher is involved in actions and measures of the programmes or interventions they themselves later evaluate. It is argued in literature that the researcher, being engaged in the activities, sometimes personally, as a participant observer, is able to examine and judge their accomplishments and effectiveness better. The author spent about 8 months in total at the courses before she received the Diploma of Public Health and started her MPH thesis. In 1994 the author of the study participated in a BRIMHEALTH course for administrators (six weeks) and between 1995 and 2003 she took BRIMHEALTH-NHV courses in Gothenburg, Baltics, Finland and Italy (ETC-PG).

In the study, the author made use of a number of qualitative research methods: study of documents, passive and, later, participant observation, focus group and in-depth interviews as listed by Greenhalgh (1997). The question of avoiding bias had been raised during the approval procedure of the MPH plan by one of the committee members, arguing that the author may have a bracketed understanding of the topic. However, the author had never occupied an executive or a leading position in the BRIMHEALTH programme herself, rather observing it as a participant. When gathering data through participant observation the author learned about the environment of the object in study as suggested by Allwood (2002) talking about naturalistic ((not laboratory based)) interpretive approach. Through the in-depth interviews the author understood that a semi-structured interview guide would help not to lose the main objective of the research; during the interviewing process the interview guide was adjusted. The method of participant observation used by the author in the fieldwork made it possible to grasp many interesting phenomena, especially prominent in different cultural surroundings. As argued by Alasuutari 1995, participant observation does not always have to mean either the traditional fieldwork based on ethnographic participant observation or in-depth interviews of a relatively small number of individuals.

The study starts with a vast description. As argued by Guba and Lincoln (1981) the purpose of the description is to take the reader into the setting. Pure description and quotations are raw data of qualitative inquiry. Patton (1990) says that the fruit of qualitative inquiry are the findings, understandings and insights that emerge from fieldwork and subsequent

analysis. Interviewing techniques were thought of by the author in connection with the particular case in mind, using a semi-structured interview guide. In order to avoid preconceptions, the author made use of memos in which ideas were jotted down during the coding process.

It is argued in literature that the qualitative research approach may also produce quantitative results and the distinction between the two approaches is often fuzzy, they often overlap; any phenomenon researched has both, qualitative and quantitative aspects (a degree of much-ness) (Allwood 2002, Guba and Lincoln 1998). It is argued that qualitative methods are widely used as exploratory methods, when the results of qualitative analysis are used to design quantitative research. The strength of the qualitative research is that it generates theories aiming at a better understand of the sample studied rather than generalising from the sample to population. Allwood 2002 argues that the goals of qualitative research are understanding, description, discovery, hypothesis generation, producing holistic, possible to develop results, while quantitative research aims at prediction, description, control, proofs and hypothesis testing that lead to precise, detailed, reductionistic results. However, the results of qualitative research can be applied to other settings – as long as the reader of the research understands the limitations.

The author summarized the data in as few categories as possible, without missing too many nuances in the data in agreement with the findings of Glaser and Strauss (1967). It is of great importance that the generated categories really fit, i.e., are grounded in the data. The five categories of the study were identified using the basic principles of grounded theory: theoretical sampling (until theoretical saturation is reached), constant comparisons (studying differences and similarities in the codes and categories), and theoretical sensitivity (when the investigator reflects on the data using personal and professional experience) as discussed by Trulsson *et al* (2002).

Results

This study intends to shed some light on the BRIMHEALTH training programme as perceived by the participants of the programme, its staff and the author. The subjective meaning attributed to the programme by its participants is summarized in the following dimensions: international postgraduate students feel welcome in BRIMHEALTH (the core category), providing assistance, being an experimental programme, building partnerships, and BRIMHEALTH as a model.

International postgraduate students feel welcome in BRIMHEALTH

The courses of the BRIMHEALTH programme were incorporated into the curricula of a number of public health training institutions in Lithuania, Latvia, Estonia, St.Petersburg and NHV. The variability of the incorporation changed from one institution to another,

however, a common characteristic to all of them was that BRIMHEALTH was an international postgraduate public health training programme. The peculiarity of the programme was that it was created abroad and “imported” into the partner institutions. The “import” was unique as it provided students not only with solid knowledge and skills based in real life, i.e. the Nordic School of Public Health, but also introduced them to the new concepts and understandings of public health (BRIMHEALTH 2004). The BRIMHEALTH students came back to the partner institutions being clearly aware of a different pattern of learning they had been exposed to. They were distinguished from the rest by this new way of thinking they had witnessed. As shown in the results of the study, the students were aware that they became a source of information for their colleagues.

We can talk of a new virtual institution, the international BRIMHEALTH postgraduate student institution. It is not a big closed institution and it is not located in any particular partner institution. However, it has common features. K. Polluste, one of BRIMHEALTH coordinators, claims in her report that during the ten years BRIMHEALTH has grown up as a small society, with its traditions, rules, understandings, even rumours and something else what you can feel, but not explain or describe (Polluste K 2004). Its students are distinguished by the knowledge of new public health, by the ties with their communities and a pre-history of former higher education. They are educated in national schools, as well as internationally. Some scholars argue that, regardless of whether one system is considered better or worse than another, experiencing a different way of education can often be considered to be the most important, enriching element of an international learning experience (Dubois et al. 2006). Beaglehole and Bonita (1997) think that if medical schools embrace public health and establish close links with their communities, public health is flourishing. We argue that the BRIMHEALTH students understand the importance of public health training in their native schools and the necessity to have ties with the community they work for.

However, finding oneself in a different cultural context a person has to adapt to the new milieu. Here the question of retaining one’s identity arises. It is argued that the continuing movement towards internationalisation will certainly make it more and more difficult to retain one’s faith in naively self-evident meanings, interpretations and identities. (Alasuutari 1995). This movement is not simple. Today the spread of globalisation shows that in order to adapt to the new milieu, countries and individuals have to develop new competences. We argue that the UN Millennium Development Goals (2005), the updated version of the WHO Health for All strategy (WHO 1999) or other joint strategies to reach global goals require new competences and knowledge, public health and management including. Raskin et al. (2002) pointed out that “a global system is taking shape with fundamental differences from previous phases of history”, therefore, as the global change is accelerating, new ways of thinking, acting and being are urgently needed. Raskin et al. (2002) claim those critical developments between 1980 and the present are seen in: the global environment, technology, geo-politics, economic integration and institutions (where internationally connected civil society becomes prominent).

We raised ourselves a question: what is a Lithuanian international student? The Lithuanian participants of the emerging international BRIMHEALTH postgraduate student institution are highly educated persons, the age of whom varies from young (26-35 years) to matured (50-55 years), and the background is mostly medical doctors (11 of 13 respondents). In Lithuania public health care leaders were traditionally medical doctors with poor management skills. Public health management knowledge demand and needs for continuous education were stressed by some authors in the late 90-ties (Kalėdienė 1999b, Bucioniene & Buis 1999). The workforce distribution analysis showed that many persons with a physician's diploma also work in educational institutions or in administration or business companies (Bartlingas et al. 2001). This was reflected in the BRIMHEALTH training programme: the majority of Lithuanian participants (out of 92 persons during 1993-2003) were teachers and researchers (making 31.5% of the Lithuanian students), public health managers and administrators (44.6%), postgraduate students (PhD or MPH in national programmes) – 13%; while 10.9% were medical doctors and nurses (Šumskas 2004b). It needs to be mentioned that two public health schools were established in collaboration with the BRIMHEALTH: Latvian School of Public Health and the Public Health Faculty at the KMU in Lithuania (BRIMHEALTH 2004).

However, the results showed that Lithuanian students have a low self esteem and lack of confidence especially when exposed to international surroundings. We attribute this to the perceived low socio-economic status, lack of self identity, increased psychosocial strain, bad coping, and weak sense of coherence as shown by Kristenson et al. (1998) and to other causes. For example, the findings of Kristenson et al. (1998) point out to marked differences in psychosocial risk factors between Lithuanian and Swedish men. The authors have found out that coronary heart disease (CHD) mortality is four times higher in 50-year-old Lithuanian men than in 50-year-old Swedish men. Petkevicius (1982) investigated risk factors conducive to ischemic heart disease and atherosclerosis among children in Kaunas, Lithuania. His findings show that health education in childhood and other preventive measures can reduce the level and frequency of risk factors in the population and play a crucial role in lowering the morbidity of CHD in adulthood. However, today four times higher mortality from CHD among Lithuanian men than among Swedish men is reported. It is not our aim to explain the reasons for the differences; we can only point out to the different political and ideological situation in the two countries and the unfavourable social environment in the soviet Lithuania (as well as other soviet republics).

The author of the study investigated what were BRIMHEALTH student selection criteria. Leyva Lopez (2005) claims that it is a complex decision making process, a ranking problem, in which multiple selection criteria often need to be considered and where subjectiveness and imprecision are usually present, resulting in the use of imprecise data. On the contrary, the results of our study showed that the criteria for student selection were not clearly defined nor the selection process elaborated.

Providing assistance

Lithuania, like countries of the CEE region, has a recent history of highly formalized, state-centred system, with only a limited presence of civil society and participation in social and public life. Individual participation in the running of the health system was virtually nonexistent. Many countries in transition have sought to address this issue; however, it has often been difficult to overcome resource constraints, cultural blocks and professional resistance in linking either with the individual or with the community (Figueras 2004). After regaining their independence, the Baltic countries were offered assistance from the Western more affluent societies. Raskin et al. (2002) point out that with the wave of national independence there came an international initiative to assist poor countries that aspired to the development standards of the wealthy nations. They argue that the concern for the well-being of the earth itself emerged in the 1970s, initially focused on natural resources and the human environment, and later extended to the complex systems that support life on earth (Raskin et al. 2002). Our findings show that overcoming constraints and resistance created difficulties not only to administer the assistance but to receive it as well. We point out to the necessity for the poor countries to aspire to higher standards, only then can assistance be provided and made use of.

The findings of our study show that Lithuanian partner institutions were capable of formulating far reaching goals and their aspirations were clearly articulated. However, due to the lack of managerial capacities and a rigid administrative system in the Baltics, the Nordic institutions met with difficulties. However, we think that the Nordic countries were in a good position to provide assistance as the life standard in the Scandinavian countries appealed to the Baltic States for many reasons, historically, geographically, and culturally. Our findings show that treating their Baltic counterparts in a paternalistic way (as described by the code of this study “playing the parents’ role”) was favourable to the development of institutions and individuals in these countries. This finding is supported by Ovretveit (1993) claiming that in some situations it is necessary to take responsibility for people, and to take decisions on their behalf. The point of doing so is to take the pressure off them to enable a healing or development process to take place which would not otherwise occur, and through which they can regain control over their lives. Enabling people to take decisions and exercise responsibility and choice strengthens them for the future, supports a ‘healing process’, and is integral to many ‘treatments’ (Ovretveit 1993). On the other hand, the result of our study show that the Lithuanian counterparts felt underestimated and not valued enough by the way the Nordic assistance was offered as the scientific potential accumulated in these institutions was not properly valued and assessed.

We found numerous references of Nordic assistance to the Baltic countries, e.g. Archer 1990, or Baltic Development Forum in 2005). The assistance was usually aimed at building institutional capacities of the target countries, usually starting as training programmes. It was characteristic that the Nordic support was often combined with the support from the European Union, the World Bank or international organisations. Providing assistance

always implies making visits in order to get acquainted with the specificity of the country and to define its needs in the particular sphere, followed by study visits to the Nordic countries. Another example of such assistance is a collaboration between the Nordic Medico-Statistical Committee (NOMESCO) and the Baltic countries which started in 1994 as part of EU/EUROSTAT's statistical training programme in the field of health statistics for the Baltic countries and was initially financed by both the PHARE Fund and the Nordic Council of Ministers; the extensive courses and seminars led to a mutual understanding how health systems are organised in the Nordic and Baltic countries (Nordic/Baltic 2002).

Some authors (Jankauskienė and Huttunen 2001) have stressed the role of the WHO Regional Office for Europe in assisting Lithuania in the formulation and implementation of the National Health Concept (1991), the Lithuanian Health Programme (1998) and the HFA (1999) policy. Since 1992, Lithuania has been part of the Regions for Health Network, the aim of which has been to work together and strengthen the focus at regional level on achieving the HFA targets. Lithuanian drug policy has been developed with technical and economical support from the WHO, the European Union and the World Bank.

Assistance puts the basis for collaboration and helps to overcome cultural differences. One of the manifestations of cultural differences is seen in the so-called culture shock; the term coined by anthropologist Kalervo Oberg in 1954 (Oberg 1954). It means the anxiety felt by a person moving to a completely new environment. Culture shock can be described as physical and emotional discomfort one suffers, sometimes it can give a feeling of profound disorientation. The feeling of culture shock generally sets in after the first few weeks of coming to a new place. The issue of culture shock and cultural competency is tackled by many authors. In addition, Agar (2005) talks of a language shock and points out that using a foreign language involves background knowledge and local information. Our findings show that Baltic students coming to Sweden did experience the language shock. Despite the fact that they had some knowledge of English, they lacked knowledge of the local background. Culture is also claimed to be one of the most widely (mis)used concepts in the contemporary vocabulary (Agar 2005).

Building partnerships

Partnerships need understanding of the problem and an insight into the phenomenon. Our findings show that this understanding was reached through the long term Nordic assistance which created high-volume open information sharing based on mutual dependency. We claim that the situation in public health training in Lithuania was to a greater or less degree connected to training abroad. The ideas of new public health were finding their way mostly through international collaboration. However, as pointed out by Childress (2002), partnership solutions are closely connected with issues of ethics. Building partnerships in public health involves public health ethics.

Public health activities also include community collaborations and partnerships for health and the identification of priorities for public health action.

Partnership for health have crossed country borders and started bearing fruit. Especially well it is reflected in developing educational programmes, such as BRIMHEALTH and others. The Ministry of Health of Estonia acknowledging the Nordic-Baltic cooperation stressed the role of the Nordic Council of Ministers as coordinating cooperation projects in the educational, cultural, social, as well as in economic fields. Due to the increased co-financing of joint projects and the development of joint planning, the assistance programs are being transformed into co-operation programs (website of the Estonian Ministry of Health, 2006 at www.vm.ee)

The financing of joint projects was gradually increased by the participating countries developing into a number of networks. In 2000, the Council of the Baltic Sea States (or CBSS, established on the initiative of Denmark and Germany in 1992) launched the Task Force on Communicable Disease Control in the Baltic Sea Region. In the Task Force's focus was tuberculosis, HIV and sexually transmitted infections, antibiotic resistance and hospital infection control, surveillance of communicable diseases and vaccine-preventable diseases, and primary health care, establishing an additional expert group on prison health in 2003. The activities carried out under the Task Force are continued under the Northern Dimension. The Declaration concerning the Establishment of a Northern Dimension in Public Health and Social Wellbeing was signed in Oslo in 2003. The process of establishment of the partnerships is extensively described by Honneland and Rowe (2004). One more instance of partnership is the Baltic Euroregional Network (BEN) launched in 2005 for cross-border cooperation in the Baltic Sea region between the Baltic States, Russia and Belarus, coordinated by the Nordic Council of Ministers.

In addition to intergovernmental co-operation there develops cooperation between different Nordic and Baltic institutions such as membership of Estonia, Latvia and Lithuania of the Nordic Investment Bank (NIB) in 2005 by which the countries share the responsibility of ensuring the economic growth of the region. The Baltic-Nordic partnerships have developed, the formerly narrow spheres of interest expanded (BRIMHEALTH 2004). The process has been noticed and called the Enhanced Partnership in Northern Europe, or e-PINE by the government of the United States (US Department of State 2006). It was stressed that building on existing assistance programmes in the Nordic Baltic region, democratic institutions and civil society will be strengthened. The Baltic countries have useful lessons to convey on how to make the transition to a more open society, while the Nordic nations have long histories of supporting democracy and human rights beyond their borders.

Additionally, our findings also prove that the codes "becoming equal partners" and "learning from each" reflect indispensable processes in building partnerships. Citizen empowerment and community participation is stressed by many authors as important elements in modern health and development strategy. Indeed, a broad range of partnerships

started as community participation and developed into public-private partnerships (Kickbusch 2004). It is repeatedly stressed in the WHO European Regional health policy framework, HEALTH21, that health cannot be resolved through the health sector alone but needs to be approached as a joint societal effort: “health is everybody’s business.” (WHO 1998). However, Kickbusch (2004) points out that to avoid the failure of well-meaning efforts, the traditions within a country should be understood, as well as the role of citizens and organizations, particularly in relation to the state.

Being an experimental programme

Our findings show, that the transitional period from “the socialist system of health care” to the western approach was connected with the necessity to look for new forms in collaboration and educational programmes. Many donors, according to the United Nations Development Programme (UNDP) analysis (2002), have failed to understand the complexity and painfulness of the transition. The changes experienced by Central and Eastern European societies is described as “the most comprehensive natural experiment in population-wide stress available, short of war or mass starvation” and a detailed analysis is still outstanding as to what social coping mechanisms have been developed (Kickbusch 2004). The small BRIMHEALTH programme had to find its ways and methods as well, “it was a path finding programme” through the turmoil and upheaval. A large body of research now shows the strong positive connections between social integration and health as well as the feeling of empowerment and health. Our results point out that the students of the training programme experienced the feelings of empowerment. The democratic character of the programme made it possible for the students and the partner institutions to feel “psychologically empowered” and to learn through field visits and through the new teaching methods. Also, as seen in the results, distance learning in the programme was introduced in 1996; however, it took several years to introduce distance learning in other courses at the Nordic School of Public Health (BRIMHEALTH 2004). So here again we provide evidence that it was a path finding programme.

Another aspect proving an experimental character of the BRIMHEALTH training programme was application of problem based learning (PBL). Arndt K (2002) in her essay on PBL says that it has roots in medical education, rising from the conviction that lecture-based instruction encourages a passive approach to learning, which results in a narrow understanding of subjects. Students learn what they are taught during lectures, and many times they fail to develop the skills needed to acquire deeper knowledge through independent learning and discovery. Traditional teaching methods (lectures specifically) are particularly risky when used to present information about cultures because they often utilize and perpetuate the kind of oversimplification that leads to the formation of stereotypes. For example, the University of Missouri-Columbia, School of Medicine, has trained physicians using PBL since 1993. Our findings show that the problem based learning (PBL) in BRIMHEALTH started about the same time and was rooted in practical situations. However, as already discussed, taken into account that Baltic students faced a culture

shock, the practical situations, as they were seen by the Nordic teachers, and looked not so practical to the Baltic students. We claim that this was one of the reasons why problem based learning was not easy in the beginning.

Our findings show that the BRIMHEALTH programme had to find its own “survival strategies” as the financing was often at stake. We claim that the fact of the necessity to find survival strategies proves that BRIMHEALTH was an experimental programme causing a lack of the future perspective at its start. The students felt certain difficulties in connecting their education plans with the programme. If one compares the implications of survival strategies for a human life, as found by Kickbusch (2004) in the analysis of Bulgaria where almost every second citizen over 18 relies on a survival strategy, we see that this does not leave room for forward-looking organized civil engagement and/or plans for future.

BRIMHEALTH as a model

The category characterizes the BRIMHEALTH programme as perceived by the partner institutions. To our mind, it also describes the level on which the possibilities provided by the programme were adapted in the public health development in Lithuania. The BRIMHEALTH programme in this respect could be treated as a model, an example, with the use of which the public health training situation or even the development of public health in Lithuania at large can be reflected or described. The programme, from the viewpoint of its participants, becomes a pattern of international collaboration or an international training programme. We argue that in the complicated transitional situation, the Lithuanian participants developed trustful relationships with each other and with the teachers. Our results show that the programme was characterized as putting the basis for new processes in institution and capacity building and new understanding of public health. In the notion of public health defined by Childress (2002) the multidimensional nature of the determinants of health is stressed with a focus on the complex interactions of many factors – biological, behavioral, social, and environmental, while another definition developed by the Institute of Medicine in 1988 sounds like this: "Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy."

The BRIMHEALTH example illustrates lessons learned from the collaboration with the Baltic countries. Our findings show that through the training of trainers' sessions the BRIMHEALTH programme was teaching how to organize public health programmes and prepare lecturers capable of advocacy and lobbying. “Advocacy for health is a combination of individual and social actions designed to gain political commitment, policy support, social acceptance and system support for a particular health goal or programme” (Gaining Health 2006). On the other hand, it is claimed by Kickbusch (2004) that CEE government officials are wary of advocacy groups, they want cheaper ways of getting some things done quickly rather than investing in longer-term organizational and administrative change. This claim is enforced by our results, showing that students felt their advocacy skills were not

taken into consideration and important public health related decisions were made behind closed doors. The function of advocacy is closely connected with the public health ethics, while as Varga (1978) pointed out the foundations of morality and ethics are residing in human nature.

Public health is one of the few professions that have, in many matters, legal power - in particular, the police power of the state - behind it. In public health there is an opening for the teaching of ethics. As a profession, public health should develop continuing education requirements and make ethics prominent among them. This type of initiative could start at the governmental level with periodic programs designed to educate practitioners on ethical issues they face. University graduate schools of public health should do more to reach out to the practice community and support the development of in-service ethics programs. (Rogers 2004, Callahan & Jennings 2002).

This study supports the claim that politics is a necessary part of public health. Political controversy is often treated as some kind of disaster for calm reflection and rationality. However, Callahan and Jennings argue that given the governmental role of public health and its use of coercion for many purposes, politics is unavoidable and necessary. Politics is a necessary component of public health, moreover, precisely in order to achieve public health policies and practices.

Another function of BRIMHEALTH was strengthening institutions and capacity building. It prepared public health leaders capable to manage change and organize training courses. Such governmental institutions in Lithuania like the State Patient Fund, the Health Committee of the Parliament, the former Health Reform Management Bureau SARB at the Ministry of Health, Kaunas University of Medicine, Vilnius University, a private Centre of Medical Diagnostics, medical libraries of the universities and others received support from the NHV. We claim that our findings show that this contribution was considerably connected with the BRIMHEALTH programme.

As stated by Grabauskas (2001), Lithuania appreciated and looked forward to strengthening collaboration and partnership with the Nordic School of Public Health, European universities and those beyond Europe. A large part of training of the WHO Country Office staff in Lithuania also took place in the NHV.

One more lesson learned from collaboration with the NHV was the understanding of a need to integrate research, education and public health. Continuing education programmes are an important guideline for this integration which started in 1992-1993 through PH training components introduced into educational curricula at the KUM. It is not accidental, that the postgraduate school of public health is being established at the Kaunas University of Medicine (Grabauskas 2004). The continuation of BRIMHEALTH – the Baltic International School of Public Health, BISP - this topic can be proposed for further research.

Concluding remarks

- The results show that the situation in public health training in Lithuania was to a greater or less degree connected to training abroad. The ideas of new public health were finding their way mostly through international collaboration.
- The experiences of the study group in the present thesis regarding BRIMHEALTH programme vary depending on the specific relationship of the study group members to the programme and their place in public health training. According the informants, the importance of BRIMHEALTH programme can be evaluated from a number of perspectives.
- We conclude that this qualitative study provides evidence on the evaluation of the impact of the BRIMHEALTH training programme on the Lithuanian public health training partner institutions. It is possible to expand the MPH level study assess the influence and outcomes of the programme in other Baltic countries and St. Petersburg area, looking into the outcomes from the students' perspective.
- The results of the findings gave a deeper understanding of the studied area and can be helpful for further research in the area serving as a starting point for further research. We conclude that the topic of the Baltic International School of Public Health, continuing BRIMHEALTH can be proposed for further research.

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