

**ORIGINAL PAPER****A qualitative study on the Greek health professionals' role in smoking cessation during pregnancy**

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**ABSTRACT**

**Objective:** The aim of this study was to explore Greek health professionals' attitudes and perceptions regarding their role as health promoters in assisting pregnant smokers to quit smoking during their pregnancy.

**Methodology:** The sample consisted of 28 health care providers with a wide range of clinical experience in Greek primary health care. The data was gathered using semi-structured interviews. Some of the important topics discussed were the health professionals' awareness of sensitive and delicate issues; smoking during pregnancy, the Greek health care personnel's training on counselling and on approaching pregnant smokers, and reasons and barriers that health professionals cite for not offering advice to pregnant smokers.

**Results:** The study indicated that little is done in the area of health promotion and health education regarding smoking cessation during pregnancy. Various attempts by private or public services are isolated and mainly opportunistic, without offering anything important in the Greek community.

**Keywords:** Greek health professionals, role, smoking cessation, pregnancy.

**INTRODUCTION**

Smoking is a major cause of ill health and mortality. In industrial countries, 300.000 women die every year due to tobacco related diseases (World Health Organization 1992). That number will approximate one million women in the year 2020. Almost 20% will die of lung cancer (nearly the same percentage as chronic obstructive pulmonary disease), and 40% of cardiovascular diseases (Rieder 2002). Women display a greater reliance on smoking to help them deal with emotional conflicts, anxiety and stressful situations. Women who smoke during their pregnancy put both their

own health and the health of their child at significant risk for serious undesirable consequences. Research conducted by the W.H.O. in the European Union found that Greece has the biggest percentage of women smokers; this percentage was 29% in the year 2000 (Stauroulakis 2003).

Smoking involves a mixture of biological, psychological and social factors. Nicotine is considered to be more addictive for women than men, consequently women have a harder time quitting (Liebmann-Smith 2004). Symptoms such as irritability, snappiness, and lack of concentration discourage people and

reinforce the desire to carry on smoking (Bonas 2005).

Smoking prevalence during pregnancy is higher among women who present a combination of characteristics, such as very young age, single, unemployed, low socio-economic class, low educational level, and having parents who smoke (Health Education Authority 1999; Kerr 2002; Nicher et al. 2007).

Smoking remains the single most important modifiable cause of poor pregnancy outcome (Fang et al 2004). Pregnant women can be divided into two groups: those who believe the risk applies to them and those who do not (McLeine and McLeod 1991). Almost two-thirds of women cut-down or stop smoking during pregnancy, however, only a quarter actually quits (HEA 1999). The National Center for Chronic Disease Prevention and Health Promotion in the United States (2002) supports that a pregnant smoker is between 1.5 and 3.5 more likely to give birth to a low birth weight (LBW) baby, than a pregnant woman who does not smoke. In addition, Ward et al. (2007) present smoking as the main cause which leads to low birth weight babies.

Furthermore, maternal smoking during pregnancy is blamed for the presence of sudden infant deaths (SIDS) and high temperature during the first year of life (Chappell & Lilley, Tzenalis 2005; Anderson et al. 2005), damaging unborn babies' lungs which could lead to reduced lung capacity in later life (BBC News 2002), increasing the risk for drug abuse and conduct disorder as child matures (Varisco 2001), childhood obesity (Bloomberg 2002), (Moschonis et al. 2008), and recurrent wheezing (Lannero et al. 2006).

Health care professionals can play a very significant role in helping pregnant women to adopt healthy behaviours. The main reason for this is the fact that during pregnancy the regular contacts between health professional and pregnant woman enable the former to discuss on a frequent basis about adopting healthy behaviours and to provide care (Bakker, Mullen, Vries, & Breukelen 2003). Health care professionals who work with pregnant women, such as physicians, nurses, midwives and health visitors, are a potential source of health information for smoking cessation during pregnancy. Advice from health professional specialists may present a

very effective strategy for promoting cessation (Walsh & Redman 2003; Paisay 1996). However, even when health professionals recognize that smoking is an important issue for the health of the pregnant woman and her baby, they develop a number of reasons and barriers for not offering antismoking advice (HEA 1999).

Nurses comprise the single largest health professional group within a hospital setting and they spend the most time with the patient. It is also recognized that midwives, along with obstetricians, are well-placed to warn about the dangers of smoking and give advice and reading material to encourage mothers to quit smoking (Rosemary 1997). The health visitor has a significant health education role during the antenatal period, both in parent classes and in home visiting (Turton & Orr 1993).

The health professionals' role as health promoters in a delicate issue, such as smoking during pregnancy, is to start a process of enabling pregnant smokers to increase control over their unhealthy habit (Tobacco Information Campaign 2002; Ewles & Simnett 1995). Smoking cessation during pregnancy is not an easy task, mainly because smoking is often used as a coping strategy for stressful circumstances (Duncley 2000). Psychological pressure to a pregnant smoker can lead to undesirable consequences (Rafael-Leff 2001). For an expectant mother, failing to adhere to intensive advice is likely to induce feelings of guilt, stress and lack of self-esteem (Tobacco Information Campaign 2002). Lack of self-esteem has been shown to lead to problems with other key personal capacities and competences, such as unassertiveness, self criticism and a sense of powerlessness (Weare 2000).

The aim of this study is to examine which are the most popular forms of support and approaches that health professionals find appropriate to use in assisting pregnant smokers to give up their habit. The objectives of this study were:

1. To examine if the Greek health care personnel have any training in counseling and approaching women who smoke during their pregnancy
2. To investigate the reasons and barriers that Greek health professionals cite for not offering advice to pregnant smokers.

## METHODOLOGY

### Sample

The study took place in a Greek primary health care center, which is part of the D.N.H.S (District National Health Services) of the Regions of East Macedonia and Thrace. This institute is representative of many health centers in Greece. Apart from offering emergency medical care, these centers are specialized in promoting healthy behaviours and in informing the community about a variety of health topics. They employ health professionals of different levels and specialities.

The sample consisted of 28 health professionals with different training and educational background which were interviewed. Seven of the participants were physicians, four women and three men, who attend women during pregnancy. Seven were nurses, five women and two men, who are in daily contact with pregnant women. Seven participants were midwives, all women, whose training is based on pregnancy care. And finally, seven were health visitors, four men and three women, who visit pregnant women outside the hospital, in order to offer counselling. All the participants provided their consent to participate in the study. Table 1 presents the sample's characteristics.

**Table 1. Sample Characteristics**  
28

Health staff	Men	Women	Educational Level	Age
7 Physicians-Obstetricians	3	4	University	35-45
7 Nurses	2	5	Technological educational institute	30-45
7 Midwives	0	7	Technological educational institute	30-47
7 Health Visitors	4	3	Technological educational institute	29-44

### The instrument:

#### Semi-Structured interview

The interview is a process which enables interviewer and interviewee in a formal or informal conversation with the purpose to

extract specific information (Rubin 2005). Semi-structured interviews tend to be used when it is important to ask the same questions in the same sequence (Gribich 1999). The most important characteristic of this method is that even if the questions are fairly well-structured, unstructured responses are allowed (Amstrong, Calnam, & Grece 1990). This method allows consideration of non-verbal communication which is a key component for any interview. The interviewer can observe reactions, facial expressions, as well as body language.

### The interviews

The Director of the Primary Health Care Center granted written permission for the study. The interviews lasted between twenty-five to thirty-five minutes and took place in health professional's offices or an available office in the ward. The interviews were carried out within 26 days.

Prior to each interview the interviewer gave a brief explanation of the interview process and a second opportunity to the participant to address any concerns. Interviews were tape recorded, providing an exact record of what was said, and allowing the researcher to develop rapport with the participants and note any non verbal communication.

### The interview's structure

**QUESTION 1** - Do you believe that it is very important for women to give up smoking during their pregnancy? Yes or no, and could you please analyze the reasons behind your opinion?

The aim of this particular question was to introduce the participants to the topic and to explore the importance of the subject according to their views.

**QUESTION 2** - Is it part of your routine to enquire about pregnant women's smoking habits? In other words, do you ask them on a regular basis or you don't take the subject into account?

According to the Health Education Authority's tracking survey in 1999, 61% of the expectant mothers who smoke said that they had not received any advice on smoking.

**QUESTION 3** - Do you offer advice to pregnant smokers? If yes, can you describe to

me which forms of support you offer and why? For example: Immediate verbal advice, leaflets, referral to a counselor, nicotine substitute, something else, or a combination of the above?

This particular question is important because it is linked to the aim of this study, that is trying to explore which interventions - forms of support are considered by health professionals as the most appropriate in order to advise pregnant women against smoking.

**QUESTION 4** – Did you have any training or guidance during your studies, or later as a health professional, on counseling pregnant smokers? If yes, what forms of training/guidance, and if no, would you embrace the offering of such training no matter the personal cost?

Special training on counseling is a crucial element for such a sensitive issue. Question four is linked to the first objective of this study, which is to examine if the health care staff has any particular training on the topic.

**QUESTION 5** - According to the European literature, health professionals give the following reasons for not offering advice to pregnant smokers:

- Fear of damaging their relationship with the pregnant woman
- Lack of time
- Concern that their own smoking cessation knowledge and skills are insufficient
- Lack of good resources to back up the counseling
- Assumption that a colleague has already dealt with the issue
- They are themselves smokers

Could we please comment on those barriers one by one?

Health Education Authority's Pack (1999) about action on smoking and pregnancy, exhibits the above six reasons as potential barriers for health professionals not offering counseling to pregnant smokers. Using that question the researcher wanted to compare whether those barriers compose a problem for health professionals in Greece as well, and whether they apply to their attitudes about not offering advice to pregnant smokers. This question has a direct link with the second objective of the study.

**QUESTION 6** - Simple advice, backed up with clear information, delivered in a non-

judgmental way, will achieve the best results. How would you comment on this statement?

Question six aims to examine the health care professionals' awareness of the delicate issues and their perceptions on the sensitive elements of maternal smoking during pregnancy. The statement which was asked to be commented upon is focused on the non-judgmental way of approaching pregnant smokers.

### Validity

The researcher tried to insure the validity of the interviews for interviewers and interviewees. Taking into account his own perceptions, the author tried to avoid seeking answers that supported his ideas and personal perspectives.

With respect to the respondents' validity, the researcher recognized that various factors could affect the study, especially the issue of confidentiality. Therefore, he reassured participants about the confidentiality of the study. The researcher received each respondent's consent for tape-recording the interview. In order to encourage respondents to give their honest answer/opinion, the interviewer introduced his nursing professional background, so that they would see him as one of them. In this way, the participants felt comfortable, because the interviewer was a colleague/health professional and not a formal researcher who would judge them.

### Data analysis

The ideal analysis of audio-taped interviews starts with transcribing them in order to provide a record of what was said (Pope & Mays 2000). However, according to Couchman & Dawson (1999), transcribing takes three times as long as the original interview. Therefore transcription is a time-consuming process, especially when the amount of interviews is large and they have to be translated from a different language. In this study, since the researcher had limited time and the whole number (28) of interviews should be translated from Greek into English, he decided to use an alternative to transcription (Weare, Prosser, Bryant & Swann 1995).

The researcher first listened once to each recorded interview without making any notes,

in order to have a general understanding of what was said. He did not perform any analysis directly after listening each interview, considering the possibility of missing important information. The next step was to listen to each interview very slowly, stopping the tape whenever necessary, making notes to summarize what was said by the respondents. Moreover, he left enough space to add any further important notes later. Simultaneously, the researcher made some notes of any particular interesting quote that could be used to support the findings. During the next stage the author listened to each interview again to verify the accuracy of what was written in his notes, and to add any detail which could be a key element. Finally, notes from all interviews were re-examined, to determine main themes and place individual quotes or sections from each interview into the corresponding themes. The researcher focused on staying as close as possible to the meaning of the original data, in order to extract the true meaning of the interviews (Tarling, Crofts & Kitson 2002).

## RESULTS

The most accepted view among the health professionals was that smoking during pregnancy should stop. The reasons they gave are all related to the fetus' and infant's health. Table 2 summarizes the reasons mentioned during the interviews.

**Table 2. Reasons for quitting smoking during pregnancy**

**Health professionals believe that smoking during pregnancy should stop because it is related to the child's:**

Low Birth Weight  
 Later cardiovascular diseases  
 Brain problems  
 Down syndrome  
 Lung damage  
 Asthma  
 Miscarriages  
 SIDS  
 Bronchitis  
 Early addiction

A female nurse pointed out that:

"Smoking is one of the worst things a woman can do during her pregnancy and must be stopped. However, from my experience when I was pregnant, I know that the body

alone feels the need to stop it, even if it is very difficult indeed."

A physician said that:

"Smoking is a very aggravating factor, especially during the first three months of pregnancy, because those months are the most important for the development of the baby's brain and vital organs."

The majority of the health care professionals ask pregnant women about their smoking habits on a regular basis whenever they meet them.

A physician mentioned that:

"This is a standard question and I think that any conscious health professional should ask the expectant mother about her smoking habits and advise her simultaneously. Those advices could be given anywhere in any setting."

Those settings, according to participants' responses, could be: the Primary Health Care Center where they work, other health care centers where they work part-time, their family environment, their friends - acquaintances, or the wider community. The above findings are shown in Table 3.

**Table 3. Counseling settings**

Primary health care center  
 Other health centers  
 Family environment  
 Acquaintances - Friends  
 Wider community

A summary of the forms of advice provided to pregnant smokers and the frequency of use are given in Table 4. This particular question is important because it is linked to the aim of this study which is trying to explore which interventions - forms of support are considered to be most appropriate by health professionals in order to advise pregnant women against smoking.

One nurse said:

"I offer immediate verbal advice because in my opinion personal contact, face to face counseling, is the best. Besides, sometimes a leaflet is useless. They just look at it and then they throw it away."

A health visitor suggested:

"As long as you are present and you speak to her it is useful. But in addition, when you go

away she will take a glance at the leaflets that you left on her table. It is all about her and her baby and she will definitely look at it.”

**Table 4. Advice against smoking**

Forms of advice to pregnant smokers	Frequency of use
Immediate verbal advice	28 out of 28 (100%)
Leaflets	21 out of 28 (75%)
Referral to counselor	11 out of 28 (40%)
Nicotine substitute	Irresolution
Combination of the above elements	22 out of 28 (80%)

According to most participants' responses there is no sufficient training in counseling pregnant smokers. However, the group of health visitors is an exception, mostly due to the nature of their job which is based on counseling.

Surprisingly, the findings show the participants' willingness for further education on the topic. Table 5 illustrates the results.

**Table 5. Health professionals training in supporting pregnant smokers**

**Reason for insufficient training:**

The health professionals education is based on pathological & medical health consequences of smoking during pregnancy

**Willingness to receive further education:**

There is willingness apart from the cost of personal time, fatigue, financial expands

**Health visitors are the exception:**

They have good training based on counselling methods

A health visitor said:

“I remember that we had a similar course on that topic in our Department. It was interesting. But during the years you forget many things. You need to refresh your knowledge and that is why I would be interested in further education programmes.”

One physician said:

“I remember that we had a very tough course in gynecology, but smoking during pregnancy is a very specific topic.”

A nurse gave a similar answer indicating that:

“Counseling pregnant women is a very sensitive and detailed issue, but we never

touched it at School. Our training was based on the medical and pathological effects of smoking during pregnancy in general.”

Table 6 presents the health professionals' barriers for not offering advice to pregnant smokers.

**Table 6. Health professionals' barriers for not offering advice to pregnant smokers**  
**Barrier 1: Fear of damaging the relationship with between pregnant woman and health professional**

For	Against
It happens in the private sector & by new doctors for financial reasons	Unconscious-dangerous health professionals

**Barrier 2: Lack of time for counselling**

For	Against
Because of the N.H.S. structure	There is always time in primary health for counselling

**Barrier 3: Insufficient knowledge and skills about the topic**

For	Against
Especially in health professions who are graduates of Technological Education Institutes	All health professionals have enough knowledge to provide counselling

**Barrier 4 : Lack of resources to back up counselling**

For	Against
New resources go to doctors only	Great availability of resources for all health professionals (internet/ universities/ libraries/ hospitals)

**Barrier 5 : Assumption that another colleague has dealt with the issue**

For	Against
It is popular among health professionals	They don't do that

**Barrier 6 : They themselves smoke**

For	Against
Health professionals' smoking is irrelative to the topic	Health professional's smoking is a barrier to offering advise

A physician said :

“In many occasions and for many reasons people change their doctor. If the doctor oppresses you, then you’ll just go to someone else. I have heard many experiences from other colleagues who lost some clients because they were strict with them.”

A nurse said:

“We run all day to help as many patients as possible. Pregnant women come, but we are not enough, so we don’t have time for special contact and approach.”

Another nurse mentioned:

“I don’t agree that there is lack of resources. Medical and nursing journals mention the subject of smoking during pregnancy all the time. But you need to search for those studies because nothing can come to your hands without putting some effort into finding it.”

A physician said:

“Especially if they know that I am a smoker, I feel very uncomfortable. What can I say? Am I something different? I am just trying to focus on her baby, but I don’t think it is appropriate.”

Is there any awareness among the health care personnel of the delicate issues and their perceptions on the sensitive elements on maternal smoking during pregnancy? This question gives the opportunity to health professionals to reveal their views through the discussion on their approaching and counseling pregnant smokers in a very open-ended way. The statement which was asked to be commented by the participants is focused on the non-judgmental way of approaching pregnant smokers.

A nurse said:

“A woman’s emotional world is so strange and imbalanced during pregnancy. And here comes our role to support her, to help her, and not to impose rules and orders, do’s and don’ts.”

A health visitor said:

“I am chatting with her, I am speaking about her problem, I am smiling and before I leave, I am giving her a book about smoking during pregnancy. What is the best way to offer support other than offering trust and knowledge?”

A physician argued:

“It depends on the pregnant woman’s personality. If she is educated or she has planned her pregnancy, then it is easier for me to advise her without using extreme methods.

Even her age plays a role; the older the pregnant woman the more mature the mind.”

Table 7 shows the division of the health professionals’ approaches on supporting pregnant smokers.

**Table 7. Division of the health professionals’ approach in supporting pregnant smokers**

**The best way to approach pregnant smokers is:**

<b>Non-judgmental Way</b>	<b>Judgmental Way Because a pregnant woman:</b>	<b>Sometimes depends on the woman’s:</b>
Friendly environment	is an adult	age
Gentle advice	is responsible	social class
Courage & support	has to change	educational level
Offering knowledge	must know	financial status
Sufficient information	ought to be ready	pregnancy planning
Emotional support	must be aware of the consequences	mature personality
Freedom of choices		
Smile		

## **DISCUSSION**

### **Health professionals’ perceptions on the importance of the topic**

All health professionals who participated in the study were strongly opposed to maternal smoking during pregnancy, which is not a surprising finding, if someone considers that the health care personnel are the key people who are supposed to know well the undesirable consequences of smoking during pregnancy. The existing literature and the health professionals’ responses are identical with respect to the health problems that smoking causes on foetus and infant’s health. This finding supports that they have sufficient knowledge of the pathological and medical factors related to the topic.

### **Forms of support**

The participants were asked to describe which methods of support they offer to pregnant smokers among: immediate verbal advice, leaflets, referral to a counsellor, nicotine replacement, or any other form that they prefer. The most common answer was the

offer of immediate verbal advice. That is reasonable because oral advice is the easiest and quickest way to counsel people. Besides, verbal advice on how to stop smoking is much more likely to be part of routine antenatal care (Kenen, McLeish & May 1998).

However, an important part of the sample prefers to combine immediate verbal advice with the use of leaflets. All health professionals, whatever their educational background, presented a high irresolution and ignorance of the nicotine substitute as form of support in assisting pregnant women to stop smoking.

### **Training in counselling**

Training or guidance in counselling during the participants' studies or later in their career as health care providers was very uncommon for most of the participants. Especially the physicians', nurses' and midwives' answers indicate that their studies were limited to the medical consequences of smoking during pregnancy, without expanding on the women's sensitive psychology and their need for appropriate counselling.

### **Barriers in counselling**

The most common barrier that emerged from the answers is lack of time; this is a very common excuse for missing many health care providers' duties. About half of the participants mentioned that lack of sufficient time is a crucial preventive factor in offering support to pregnant smokers, blaming the Greek N.H.S. structure. Ambiguously, the other half supported that time is always available for counselling and prevention, especially in a primary health care center, where health care personnel have a commitment to promote people's health. The structure of the country's N.H.S. is much more based on treatment than prevention. Time constraints mean that health professionals in many cases feel that they do not have sufficient time to consider smoking cessation for pregnant women (Bishop, Panjari, Astbury & Bell 1998; HEA 1999).

Another important barrier is the fear of damaging their professional relationship with the pregnant woman. Health professionals fear losing their clients; the pressure to quit smoking could lead the clients to changing obstetrician, midwife, family doctor or other professionals. Thus, financial reasons prevent

health care providers, especially in the private sector, from raising the issue of maternal smoking during pregnancy. That is what really motivates the participants to leave initiation of the discussion of the topic to the pregnant woman.

However, several studies regarding health professional-patient communication indicate that the relationship between them depends on many factors such as how much information is conveyed by the professional, how many questions are asked and in what way they are asked (by both the health professional and the client), and finally how much information is recalled by the later (Hall, Horgan, Stein & Roster 2002).

### **Health professionals themselves smoke**

Almost all health professionals who participated in this study were regular smokers. They supported that their personal smoking habits did not compose a barrier to counselling pregnant smokers because it is something irrelative that has nothing to do with the topic. Using the argument that they are adults and have freedom of their choices whatever their professionals' status, the participants tried to persuade the researcher that their smoking habits should not concern other people. However, health care providers have a responsibility to act as role models in the community.

### **Awareness of the sensitive issues**

The participants responses are divided into two opposing philosophies. About half strongly opposed to the idea that the best way to approach and support pregnant smokers is to be non-judgemental. The other half believed that the unconcerned pregnant smoker should be alarmed about the undesirable consequences, and she should change her unhealthy habit, even if her emotional world becomes disturbed, since it is better for her to feel guilty and stop smoking, than to give birth to and unhealthy child.

Therefore, the researcher divided the participants into two groups: Those health professionals who make use of the empowerment model in their smoking cessation approach, and those who utilize the health belief model.

Health promotion is not sufficiently developed in Greece and health professionals are not always familiarized with the process of

helping people change their unhealthy behaviours. Change is something that does not happen in an accidental way. Change comes through planning and interventions. Smoking cessation interventions implement intensive multi-compact programs (Rovina et al. 2007). However, Greek health care personnel do not seem to have sufficient training in health promotion, and interventions in promoting health behaviours among pregnant smokers depend on the staff's personal idiosyncrasy and previous experience on the topic.

Half of the participants consider the pregnant smoker's psychology a priority. The issues of habit, physical addiction to nicotine, stress, depression and body image are only some of the crucial reasons for an expectant mother to smoke (Lancaster et al. 2006). Many smokers spend the whole of their pregnancy in a state of guilt and feelings of inadequacy. It is very difficult to predict what the effects of such chronic stress and anxiety might be on the pregnancy progress and labour, or even on the ultimate relationship with the child. Half of the respondents take into consideration those sensitive elements and try to approach the pregnant smokers in a friendly, informative and gentle way, giving them advice and offering courage and support. Their intentions are to provide them with enough and sufficient knowledge in order to increase each woman's individual ability to choose and to influence her environment, and not to oppress them to change.

Working for the pregnant smoker's self-empowerment, the health care providers seek to increase her self-esteem by the feeling of taking active control over her unhealthy habit. Making a positive choice about her health can be a self-empowering process (Ewles & Simmet 1995). The empowerment approach assists pregnant smokers to quit smoking and it is the one that helps them give the appropriate information to identify their own concerns and gain the skills and confidence to act upon them (Roske et al. 2008).

On the other hand, the other half of the health care professionals who make use of the judgmental approach on counselling pregnant smokers, act according to the orders of the health belief model. Knowledge, individual woman's responsibility and baby's disease avoidance are the elements that compose those health professionals' perceptions on counselling pregnant smokers. The former aim

to provide pregnant smokers with freedom from every medically defined disease and disability that could arise from smoking habit in their baby's health. Thus, they try to make pregnant smokers feel threatened by their current behaviour and think that their change would be beneficial for them and their baby. Health professionals using the health belief model claim that women are more likely to comply with professional medical advice if they believe that themselves are at risk from the harmful effects so they change in order to gain benefits (MacLaine & MacLeod 1991).

Pregnant smoker's age, socio-economical class, personal characteristics and their educational level are those variables which are decisive to make health care workers decide how they will counsel and support pregnant woman. For health professionals who wish to help pregnant smokers stop smoking, it is important to understand the stresses that pregnant women experience (Duncley 2002).

#### **CONCLUSIONS AND RECOMMENDATIONS**

There is very little official involvement in the area of health promotion regarding the potential role of health professionals in assisting pregnant smokers to quit smoking. The various State attempts in promoting health behaviours among pregnant smokers are isolated and mainly opportunistic. Health professionals and others who comprise the primary health care team are the core people in Greece who undertake health promotion without official guidance and strategy, working according to their own beliefs and perceptions towards their role in counselling pregnant smokers. That have a very negative impact on the health care providers' activity, because even if the staff is well motivated, they hesitate to undertake smoking cessation work, when they feel that there is no clear strategy at an organisational and national level. Clear guidelines for the health staff are required. A policy in which women would be asked about their smoking habits and about the appropriate way in which health professionals could offer advice.

Apart from educational training during the health professionals' studies, further education should be provided later on during their career in order to fill the gaps of knowledge. The use of multiple communication vehicles could improve the knowledge of health care

providers (Lumley et al. 2008). Health professionals themselves should take into account their responsibility in the subject and support the general population strategies towards a progressive reduction of cigarette smoking not only among pregnant women, but also in the general population. Health care providers should fight to increase cigarette excise taxes, to ban all forms of tobacco advertising, to make all public areas non-smoking and to develop non-smoking policies for institutions and workplaces. In other words, their aim should be to make the healthy choices easy choices (Enkin, Keirse, Neilson, Hodnett, & Hofmeyer 2000).

The Greek State should take into consideration all the above and build and strengthen public and private partnerships with health professionals working in the topic. National and professional organisational work could encourage and motivate more physicians, nurses, midwives and health visitors to counsel new and expectant mothers about the risks of smoking and to support their efforts to give up their unhealthy habit.

Health professionals should try to identify pregnant smokers in all community settings, encourage and support them in providing follow-up. However, this should be undertaken systematically, not instinctively and opportunistically, because pregnant women benefit more when health professionals offer intensive and methodological counselling. By learning how to approach this subject and by offering the appropriate sufficient support, health professionals are able to see their efforts rewarded by helping women to stop smoking, while also maintaining the ideal relationship with them.

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