Euroscip II

Executive Report

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Supporting organisation:

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Contents:

Executive Report

* to be placed on EURO-Scip homepage: www.bips.uni-bremen.de/euroscip

\# only reported to EU

& reported to EU, subject to future publication

National Reports

Annex

1. EURO-Scip I and EURO-Scip II: what are they about?

On September 15, 2002, the European Commission (EC) appropriated funds for the second part of the **Euro**pean Action on **S**moking **C**essation **i**n **P**regnancy (EURO-Scip II). The project had been launched in line with the First European Symposium on Smoking in Pregnancy realised in Bremen [Germany] in 1998 and the EURO-Scip I Project executed from 1999 to 2000. EURO-Scip I had helped to improve European efforts for smoking prevention in pregnant women by offering health professionals specific information and training.

For EURO-Scip II, Institutions from seven EU-Member States (Belgium, Germany, Greece, Ireland, Netherlands, Portugal, Sweden) and Bulgaria as a future-member of the EU gathered for the project. Portugal and Bulgaria had not taken part in EURO-Scip I, while the former partner in Sevilla (Spain) could not join for EURO-Scip II.

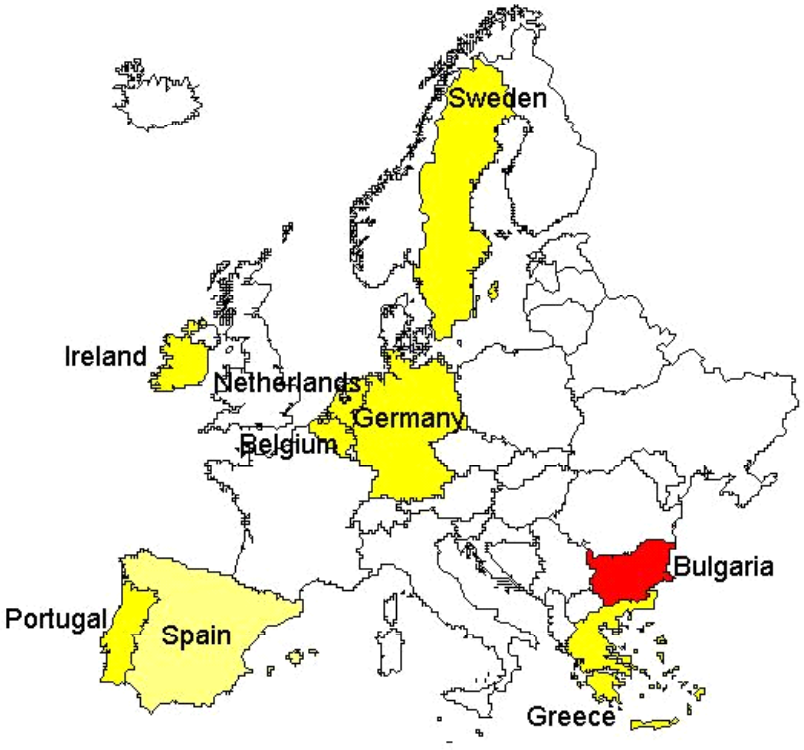
The aim of EURO-Scip II was to encourage the health professionals to take part in identifying intervention strategies to reduce smoking in pregnancy as well as to prevent relapse in the postpartum. Barriers and obstacles should be identified that hinder the implementation and effectiveness of counselling strategies.

Smoking during pregnancy

Smoking during pregnancy has considerable negative effects for the foetal development and the health status of new-borns. As a consequence, World Health Organization (WHO) ranks smoking as the most important modifiable risk factor for poor pregnancy outcome in the western World. Besides the health damaging consequences of prenatal exposure to nicotine, the burden of passive smoking is a relevant health risk for small children.

Many women who smoke quit smoking – often ‚spontaneously' – when realising being pregnant. However, the majority of those who consider to quit

will not succeed and a substantial proportion of mothers who quit smoking during pregnancy will take up smoking again in the postpartum.



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To promote the health and well-being of mother and child, supportive actions and counselling are needed in order to stabilise and improve interim successes and quit-smoking attempts. Studies have demonstrated an increased proportion of women who stop smoking during pregnancy and do not re-start cigarette consumption in the postpartum period if they are offered systematic and structured counselling. However, such structured and systematic counselling is hardly implemented in Europe as the *EURO-Scip I project – a needs assessment* - concluded in the year 2000.

EURO-Scip I concluded:

- continued education for gynaecologists, midwives, and nurses is essential to further improve counselling for quit smoking;

- and identified a lack of counselling programmes that span the gestation as well as the postpartum period to increase the co-operation of health professionals involved during this time.

EURO-Scip II: project description

The present project, 'EURO-Scip II', built on this experience and

a.) Conducted (baseline) surveys to establish counselling standards: Parallel surveys in health care professionals providing medical care for pregnant women and new-borns were carried out in the co-operating countries (except in the Netherlands, where a larger National Survey was planned and could not be fit into the EURO-Scip II time frame). The intention of the Survey was to identify barriers and obstacles that hinder the implementation and effectiveness of counselling strategies. The results should lead to a better understanding of how to create or improve intervention approaches.

The national surveys were based on an identical survey instrument (see Annex 1). The goal was to obtain information from a net sample of about 200 health professionals per country.

b.) Developed counselling material and a plan to diffuse the method: Countries as the Netherlands and Sweden are establishing national intervention programmes. The Dutch and Swedish partners kindly made available to the EUROSCIP-group their Intervention-Manuals targeted at midwives.

c.) **Created and distributed two editions of a Newsletter** for health professionals providing medical care for pregnant women and new-borns: The newsletters provide health professionals with recent study results concerning smoking in pregnancy and the effects of passive smoking.

d.) **Updated National Status Reports:** National data and actions against smoking are summarized and updated in National Status Reports. Special emphasis was put on how the partner countries followed the European directive of smoking prevention.

All co-operating institutions had already gained experience for several years in the field of smoking prevention for pregnant women and parents of new-borns. Due to differences in health care systems, anti-smoking interventions had to focus on different target groups as intermediaries (gynaecologists, general practitioners, midwives, and nurses).

Data from the national surveys were merged for analysis and will be published shortly.

3. Changes that occurred during the course of the Project

In November 2002, the Irish partner from Dublin declared the withdrawal from the project. The person who was supposed to work on the project had left Ireland and was no longer available. The Project tried to compensate this loss by transferring resources to the other Irish Partner in the North-West of the country: Most tasks originally allocated to Dublin could be transferred to BALLINA, Co. Mayo, Ireland (Women North West, Ltd.)

The project acknowledges the willingness of BALLINA, Co. Mayo, Ireland to accept most of the obligations originally allocated to the partner in Dublin.

The Dutch partner decided not to take part in the Survey, as a larger Dutch Survey was planned and could not be fit into the EURO-Scip II time frame. The money saved from the Dutch Survey withdrawal could be re-allocated to a merged analysis of all other national surveys.

The update of the EURO-Scip **Website** (www.bips.uni-bremen.de/euroscip) was transferred from the Swedish to the German partner.

The intention was to publish two editions of the **Newsletter** per country. Most partners were able to comply with this arrangement. Due to delays in funding by the EU, the production of the second edition was delayed in Portugal and Greece. Portugal was not able to produce the second edition due to the limited time frame of the project after funds had arrived. Bulgaria was able to prepare the first edition of the Newsletter without being paid for it, which is greatly acknowledged.

4. Project Meetings

The **first meeting** took place November 22-24, 2002, in **Bremen** (Germany) to get together and allocate tasks of the project. All countries participated except Ireland due to late arrival of funds from the EU-Commission. During the meeting it was decided that the coordination of the **Motivational Interviewing (MI)** training should be done by the Swedish partner and that the centralised training session for MI-training should take place in Portugal, a location that could be reached cheaply by charter flights from every partner site. It was suggested to hire Jennifer Percival, London, manager of the Royal College of Nursing (UK) Tobacco Education Project, to be the trainer for MI, together with Yvonne Bergmark-Broske from Cancerfonden/Sweden.

In Bremen it was decided to share two international pages and to add two national pages to the four-page **Newsletters**. The co-ordination of the two international pages in newsletter was allocated to the Belgian partner.

The questionnaire for the **Survey** was discussed in Bremen and deadlines were fixed for the entire project.

Funding problems were a big issue during the Bremen meeting as some centres did not have the potential to start their work prior to the arrival of the first EU-payment (EU-money arrived in Bremen in 2003).

The second Irish partner, Ireland NorthWest, had not been able to purchase a flight-ticket below the amount declared in the proposal and did not want to take the risk of paying for the surplus. Ireland NorthWest was thus excused for the meeting. All other partners had sent one delegate.

The **second meeting** took place May 09-11, 2003, in **Athens** (Greece). All partners were able to send one delegate. At the time of the meeting, most partners had already started their **Survey** and problems that had occurred as well as the methods for analysis were discussed.

The upcoming meeting in Portugal was prepared for the **training of the Motivational Interviewing.**

It was decided to **translate** the **Swedish Manual** on Motivational Interviewing for midwives from English into the other partners' language.

The **third meeting** took place August 01-03, 2003, in **Helsinki** (Finland).

The location of the meeting was changed from Stockholm - the original plan - to Helsinki, as most partners were attending the annual WCTOH-meeting in Helsinki and travel costs could be minimised that way.

Results of the Survey were discussed and decided, as well as a standardized layout for the Survey and the Reports.

The Dutch partner suggested translating their Manual from Dutch into English so it could be spread to a wider readership.

The Bulgarian partner had taken part in all activities, although they had not received any funding at all. The Bulgarian contribution was very valuable to the project and it was acknowledged by all partners that the Bulgarian staff had given a substantial input into the project at no pay at all.

5. Motivational Interviewing (MI): Training of the professionals

One of the aims of EURO-Scip II was to develop counselling material for health professionals and a plan to diffuse this method. Paulo Duarte Vitória co-ordinated the training meeting near Faro, Portugal, May 20-22, 2003. It was obvious that the training of national delegates within the times frame of the project was possible, while the evaluation of MI offered by these newly trained delegates by the EURO-scip -Survey was not feasible within the 14 months of the project time frame.

A three day "Train the Trainers" skills programme was devised and presented. The course was entitled "Behaviour change counselling in the context of smoking cessation" and was written and presented in the Algarve in May 2003 by Jennifer Percival, Manager of the Royal College of Nursing (UK) Tobacco Education Project. Yvonne Bergmark-Broske, the national trainer from Sweden, also presented her material to the participants.

Participants from Belgium, Germany, Holland, Sweden, Ireland, and Portugal attended the residential training course. At the beginning of the training the participants' specific needs for attending were established. The following issues were raised:

- How to ask about smoking?
- How to deal with "knowledge fight"?
- How to involve the smoker's partner?
- How not to destroy the relationship?

- How do you deal with the excuses people give to stay a smoker?
- How to do you make smokers think about the issue?
- What is effective and possible in 2 minutes?
- How do we change attitudes?
- What results can we expect?
- Cutting down – how effective is this?
- Pregnant women do not like being told what to do – how do we deal with this?

Jennifer Percival set out a programme which included demonstrating the UK-wide health professional one day programme entitled "One to one communication skills" which has been accredited by the RCN. This included a lecture on tobacco advertising, smoking in pregnancy, and the process of change, the use of NRT and how to teach cessation and communication skills to health professionals. Following the demonstration participants were invited to explore which aspects would be transferable to their own work. It was clear that the course had met everyone's practical needs.

On the second day, time was spent exploring further training needs. Yvonne Bergmark-Broske and Jennifer Percival worked together to provide specific training in motivational interviewing. This day involved experiential learning, individual / group work and exploration of case studies. Throughout the day there were opportunities for participants to ask questions and explore ways to adapt the material to their country's specific needs. The national Swedish training programme "Smoke Free Children" was explained and oral snuff use.

The third and final day of the training concentrated on putting the course into practice by enabling participants to create their own training package for use on their return to work. A selection of course handouts, work-

sheets and interactive participant materials were made available in addition to the RCN's full training programme.

Topics covered were:

- Smoking cessation – what skills are important?
- Group work skills for teaching doctors and nurses
- Developing a country specific training programme
- Advertising / recruitment to the participants' national programmes

A training support pack was produced to ensure participants had all the reference materials required to initiate this work. This pack contained:

Lesson plans broken down into individual sessions, training tips, a full set of factual handouts, published articles on smoking cessation, a full set of lecture notes and a PowerPoint copy of the main factual presentation. The Swedish "Smoke Free Children" video and book: Clearing the Air 2 – Smoking and tobacco control an updated guide for nurses: Self help to stop smoking book – for translation if required. Helping Smokers Change resource pack from WHO, the WHO Guidelines on helping smoker stop, NHS patient information leaflets and Anti-smoking – public information posters.

The evaluation at the end of the course indicated that the participants' expectations had been fully met. They commented that the experiential input of the English and Swedish models had made it easier for them to form their own training plans.

6. Newsletters

The Euro-SCIP partners agreed to create and distribute two editions of a Newsletter for health professionals such as gynaecologists, midwives, paediatricians, GPs, etc., providing medical care for pregnant women and newborns: By distributing the newsletter it was intended to provide health profes-

sionals with recent study results concerning smoking in pregnancy and the effects of passive smoking.

Every newsletter had four pages; two pages were identical internationally while the other two pages offered national topics about smoking cessation or risks regarding smoking. The mailing covered a minimum of 2,000 professionals/institutions per country.

The two international pages in the **first edition** of the newsletter gave a short description about the Euro-Scip-II-project. We thought this was important because of the gap between 2001 and 2003. In most of the participating countries, there were no newsletter between the first part of the project and the second part.

The newsletter also showed the results from the second European Symposium on smoking in Pregnancy and Passive smoking on children which took place at Djurönäset south of Stockholm on 27-29 May 2002. The organizer of this Symposium made clear that for some countries this conference had been the first step towards tobacco prevention work in the field of maternity and paediatric health care. For others, it has brought new knowledge and new opportunities for networking. The ongoing Euro-scip project has already benefited from contacts and experiences from the conference. Portugal has shown a great interest in hosting a third international conference on smoking during pregnancy and passive smoking and children by 2006 at the latest. As smoking is on the rise in women from southern Europe, Portugal will, for this reason, too, be an appropriate host country.

The second Newsletter also describes shortly the method of motivational interviewing and the visit from William R. Miller in Sweden (Professor of psychology and psychiatry at the University of New Mexico, USA), and deviser of this method.

Under the rubric "Actual Research Results" the problems between assisted fertilisation and smoking were discussed. And under the rubric "Do you already know?" it was pointed out

- that smoking during pregnancy can cause diabetes,
- how much money is necessary to treat smoking related diseases
- that a new study showed that the Swedish doctors have the lowest prevalence of smoking worldwide.

The international pages in the **second edition** of the newsletters described the "Motivational Interviewing train the trainer program" which was held in Portugal by Jennifer Percival and Yvonne Bergmark-Broske.

Under the heading "Do you already know?" it was shown that smoking can harm the fertility.

The second Newsletter also reported the results of the Dutch project "Minimal Intervention Strategy, Quit Smoking in Midwives Practice (V-MIS)".

This research had shown midwives who were trained in using the V-MIS were much more able to discuss the issue of smoking cessation.

This Newsletter described smoking habits of women before, during, and after pregnancy: many women who quit smoking during pregnancy resume smoking after they give birth (American Journal of Preventive Medicine, 2003; 24; Reuters Health, 24 January 2003).

7. Survey (Pooled analysis)

Parallel surveys were held in Belgium, Bulgaria, Germany, Greece, Ireland, Portugal and Sweden. The Netherlands did not take part in the Survey as the Dutch Partner *Stivoro* had collected similar data previously and was preparing a larger survey to be held in 2004 that should not interfere with the Euroscip-Survey. The time frame of the Euroscip-Project did not allow for an inclusion of the planned Dutch survey.

The intention for the Survey was to identify barriers and obstacles that hinder the implementation and effectiveness of counselling strategies. The survey

was planned without a specific hypothesis and each participating country was supposed to get answers from about 200 health professionals selected at random from those providers in the country who take care of pregnant women. The national results are reported by each country separately (see National Status Reports).

As prenatal care is provided by different professional groups in the participating countries and at varying times during the course of a pregnancy, each country had to decide individually which professional group to approach for the Survey. As smoking has negative effects mainly during early pregnancy, the goal was to recruit providers that have access to pregnant women as early as possible during their pregnancies. midwives or doctors who see women for the first time during delivery and who thus do not have the chance to counsel at an appropriate time during pregnancy should not be included in the eligible persons for the Survey.

Originally it was planned to approach the target persons by telephone after a letter had been sent to the professionals.

For the Belgian Survey, all interviews were done by telephone.

In Bulgaria this approach was considered to be too expensive. In a first step, volunteers working for Euroscip contacted gynaecologists on the phone and paid two office visits: one for delivering and a second one for picking up the filled out questionnaire.

In Germany, most women see a gynaecologist for their first pregnancy visit. Midwives were asked whether they see women before the admission to the deliver clinic. Midwives were excluded from the sample when they reported to see women only at delivery. Most interviews were done by telephone, a written questionnaire was optional and doctors made frequent use of it (30/128).

In Greece and Ireland, physicians and midwives are both delivering prenatal care; all interviews were done by telephone.

In Portugal, the questionnaire was sent to all Portuguese Health Centres (primary care network).health centres were contacted and they decided on whom to answer the questionnaire: In most instances, doctors replied but some of them mentioned that the counselling was actually done by other staff in the health centres.

In Sweden, a list of about 300 randomly selected maternity health clinics was obtained from a registry. However, when calling the establishments, it was evident that many of these clinics had seized to exist or had no longer maternity services. Most interviews were done by telephone, a written questionnaire was optional.

Table 1: Target groups for the Euroscip-Survey: providers approached and survey instrument (mailed questionnaire or telephone interview)

Providers Country	Physicians		Midwives		Others		Total	Written questionnaire	Telephone
	N	%	n	%	N	%	n		
Belgium	**161	80.5	10	5.0	29	14.5	200	-	yes
Bulgaria	*99	100.0	-	-	-	-	99	yes	contact only
Germany	*128	63.4	74	36.6	-	-	202	Optional: 30 doctors 2 midwives	98 doctors 72 midwives
Greece	107	51.7	100	48.3	-	-	207	-	yes
Ireland	149	74.9	50	25.1	-	-	199	yes	-
Portugal	255	94.1	3	1.1	13	4.8	271	yes	-
Sweden	2	1.3	155	98.7	-	-	157	optional	yes
Total	1,001	75.0	292	21.9	42	3.2	1,335		

* =all gynaecologists/ obstetricians

**=Belgium: among them 134 gynaecologists

Table 2: Sources and methods for recruitment of study participants

Country	Physicians	Midwives / Others
Belgium	French-speaking Belgians only, at random: 134 gynaecologists (basis: 683) 27 general practitioners (basis: 8,825)	French-speaking Belgians only, at random: 10/61 midwives 29 TMS (community workers)
Bulgaria	at random: gynaecologists/obstetricians in Sofia City	-
Germany	at random: gynaecologists/obstetricians from listings provided by Kassenärztliche Vereinigung from of the Länder Baden-Württemberg, Niedersachsen, Mecklenburg-Vorpommern, Sachsen-Anhalt, and Bremen.	at random: from listings provided by Bund Deutscher Hebammen for the Länder Baden-Württemberg, Niedersachsen, Mecklenburg-Vorpommern, Sachsen-Anhalt, and Bremen.
Greece	at random: Yellow Pages Attica region (Athens included)	at random: Registry of the Hellenic midwives Association, Attica region (Athens included).
Ireland	Selection method not stated, Western Health Board region	Selection method not stated, Western Health Board region
Portugal	236 letters with 3 questionnaires inside were sent to the Health Centres.	-
Sweden	-	at random: from 300 maternity health clinics

Table 3: Response rates by country and provider

Country	Physicians	Midwives/others	Total
Belgium	-	-	79.7%
Bulgaria	-	-	not stated
Germany	60.4%	89.2 %	68.5%
Greece	-	-	not stated
Ireland	-	-	62.9%
Portugal	-	-	not stated
Sweden	-	62.5 %	62.5 %

The results of the international analysis are subject to a future publication in a peer reviewed journal.

8. Manual

One of the key-concepts of successful direct counselling is the Motivational Interviewing (MI) approach developed by Miller & Rollnick. Countries as the Netherlands and Sweden have already established national intervention programmes based on MI. As the Swedish Cancer Society (Cancerfonden) generously provided the copyright of their Manual, it was decided to translate it into French, Bulgarian, German, Greek, and Portuguese and to make it available to the midwives and physicians in the mentioned countries.

The Dutch manual was translated into English so it may be shared by a larger readership. Copies of the English translation of the Swedish Manual may be obtained from Cancerfonden / Stockholm (see "12. Partners involved in EURO-scip II).

9. Website: www.bips.uni-bremen.de/euroscip.

The already existing website has been updated and all materials are accessible to the public, such as

1. Newsletters
2. National Status Reports, including the Survey reports
3. Cover sheets of all Manuals for training in Motivational Interviewing

Links were produced and updated for international references on smoking prevention and national links by country.

10. Recent trends in smoking prevalence in participating countries: a synopsis

Table 4: Smoking prevalence and recent trends in participating countries

↓ recent trend downwards ↑ recent trend upwards
+- recent trend stable n.a. figures not available

Country	total	male	female	Trend
Belgium	29 % +-	33 % ↓	25 % ↑	From 1982 to 1993, the percentage of daily smokers dropped from 40 to 25%. Since 1991, it fluctuated between 25% and 30%. There is a decrease in smoking behaviour in men and a slight upward trend among women (especially in young women).
Bulgaria	n.a.	n.a.	n.a.	n.a.
Ger-many	25 % +-	35 % ↓	22 % ↑	Since 1992 the smoking prevalence of female smokers has slightly increased, whereas in males it has decreased.
Greece	38 % ↑	47 % ↓	29 % ↑	Increased of smoking prevalence 1984 to 1998 from 34.8% to 37.6% (general population, age 12-64). Increase to increase in females (19.5% to 29%). Smoking in men decreased from 54% in 1984 to 47% in 1998
Ireland	27 % n.a.	28 % ↑	26 % ↓	There was an increase in smoking in males in the 18 to 34 year category who have completed secondary education from 37% to 41% from 1998 to 2002, while the same category in women saw a 2% drop to 38% from 1998 to 2002
Portu-gal	n.a.	29 % ↓	8 % ↑	smokers' prevalence among men is decreasing, among women increasing. Regarding smoking prevalence in women at different age levels, the percentage of smokers is close to zero among women older than 55 years, in contrast with a very high percentage in women aged 15-34 (15% in 1995 and 17.8% in 1998).
Sweden	19 % ↓	17 % ↓	21 % ↓	Smoking of tobacco in Sweden has fallen drastically over the last two decades 19 % of Swedes aged between 16 and 84 smoked every day in 2001. Men smoke less than women. 17 % of men and 21 % of women smoked every day. In 1980, 36 % of men and 29 % women smoked.
The Nether-lands	31 % ↓	34 % ↓	28 % ↓	since 1958, there is a decrease in males' smoking prevalence. In women, it increase until 1970. More recently, it fell again in women

- Greece has thus highest smoking prevalence (38%)and Sweden the lowest.

- Smoking prevalence is higher among males in all participating countries, except in Sweden!
- In most participating countries, smoking prevalence is declining in males except in: Ireland.
- In some countries, smoking prevalence is still increasing in women, especially in young women (Belgium, Germany, Greece, Portugal)

11. Prevalence of smoking during pregnancy: a synopsis

While gender- and age-specific data on smoking prevalence are available from most participating countries, data on prevalence during pregnancy are more difficult to obtain: Sweden, Belgium, Portugal and the Netherlands provide these figures on a national basis and with regular updates, while others present these figures on a sporadic basis.

One issue that should be observed comparing these data is at what time during pregnancy the data has been collected: As a substantial fraction of pregnant smokers give up their habit as soon as they find out about pregnancy, cross-sectional data will give higher prevalence figures at the beginning of pregnancy than at the time of delivery. From the public health point of view, smoking should be quit as early as possible during pregnancy as the harmful effects of toxins are more pronounced during the first trimester.

American data on smoking prevalence during pregnancy are collected on birth certificates (Martin et al. 2003). In Germany, these figures are derived from women reporting at the time of delivery to a perinatal survey. Sweden collects this data at several points in time during pregnancy.

Underreporting is another issue that should be considered as smoking during pregnancy is becoming more and more stigmatised leading to artifactual downward trends (CDC 2002, Kharrazi et al. 1999, Wong et al. 2001).

Efforts to reduce can be quite successful. The Swedish figures reported in our project are encouraging. In the United States, similar trends can be observed: cigarette smoking during pregnancy dropped to 11.4 percent of all mothers in 2002 in the USA, a decline of 42 percent from 1989. Smoking rates

declined for all age groups and most race and Hispanic origin groups in 2002 (Martin et al. 2003).

Sweden and Portugal report a similar prevalence (12-13 % during pregnancy): while Sweden is coming down from higher levels, Portugal may be found at a stage where more women in general pick up the habit and smoking during pregnancy may not yet have reached its maximum.

Table 5: Smoking prevalence during pregnancy in participating countries

Country	Smoking prevalence during pregnancy	Time Trends
Belgium	37 %	Increase 1993 -1998, thereafter there is a decrease . 15.3% of pregnant women in 2001 smoked between one and ten cigarettes a day.
Bulgaria	No national data	No national data
Germany	No national data. Estimates: 30 % at the beginning of pregnancy, about 15-20 % at the end of pregnancy	No national data. In Bremen and Niedersachsen decreasing recently.
Greece	No national data Survey in one clinic: 23.6%	No national data
Ireland	No national data	No national data
Portugal	12.2 %	decreasing trend 12.7% in 1995 and 12.2% in 1998 stronger decreasing trend for women that maintained smoking behaviour when pregnant: 62% in 1995 and 56% in 1998
Sweden	12.8 %	decreasing trend
The Netherlands	21 – 25 %, depending on survey	Since 1982 a decreasing trend

All other participating countries reported much higher prevalences during pregnancy.

Self-help does not look too successful to cut down on smoking during pregnancy, as a recent study from Britain has confirmed again in a randomised trial (Moore et al, 2002). The self help intervention was acceptable but ineffective when implemented during routine antenatal care. The authors of

the study concluded that more intensive and complex interventions, appropriately targeted and tailored, need to be developed and evaluated. Validated smoking cessation rates among pregnant women are substantially lower than the self reported rates on which current smoking policy is based.

EUROscip has shown the way how this target group should be approached more successfully: Midwives and attending physicians should be trained in Motivational Interviewing, they should devote more time to the issue of smoking during pregnancy and the information on harmful effects of smoking should be communicated better.

The EUROscip-Survey has shown that midwives and attending physicians are willing to answer questions on smoking related issues and that they want more and better information to give more efficient care to pregnant women.

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12. Summary and recommendations

- In general, more men in the participating countries are smokers than women (except in Sweden)
- In most participating countries, the prevalence of smoking is still increasing in women, especially in young women.
- Data on smoking in pregnant women is not easily accessible, national data are often missing.
- For comparisons it is important to watch the point in time during pregnancy measuring smoking prevalence (at the time a woman finds out to be pregnant or at the time of delivery)
- The Swedish example of a registry recording the prevalence of smoking in pregnant women should be followed by other countries. The registry serves as an efficient tool to measure intervention effects and time trends.
- Data on smoking cessation should be validated, numerators and denominators are not always clear for calculating quit rates (who is considered to be a smoker, how successful cessation is defined)
- European tobacco legislation has led to a more uniform pattern in terms of access to tobacco, labelling of tobacco packages with warning signs, restriction of smoking in public buildings, restaurants, and at the worksite, and advertising. However, there remain still large discrepancies to be handled in the future.
- Prevention campaigns on the European and on the national level should find more support. Motivational Interviewing as a counselling method seems to be especially promising and should be spread further. EuroSCIP II has made a special contribution by providing teaching material (MI-manual)
- The EuroSCIP-Survey has been a successful pilot Survey and should be repeated on a larger scale with larger samples allowing statically stable inferences.
- Future steps should put more emphasis on Motivational Interviewing as a counselling method, the effects on smoking prevalence could be measured in a randomised trial. The method should be spread by other media than just print media: The video tape from Sweden should be adapted to other European languages and settings.

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