Ανάλυση αντι-καπνιστικών πολιτικών: μια σύγκριση μεταξύ Αρμενίας, Ελλάδας και Νέας Ζηλανδίας

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ΠΕΡΙΛΗΨΗ

Εισαγωγή: Η παρούσα εργασία αναλύει τις αντικαπνιστικές πολιτικές σε Ελλάδα, Αρμενία και Νέα Ζηλανδία αναδεικνύοντας τις ιστορικές, πολιτισμικές και κοινωνικές διαφορές των χωρών αυτών. Σκοπός: ήταν η διερεύνηση και συγκριτική μελέτη των αντικαπνιστικών πολιτικών και πρακτικών σε χώρες με αντιδιαστημικά πολιτισμικά υπόβαθρα μέσω της συγκριτικής κριτικής ανάλυσης. Συζήτηση: Η Ελλάδα έχει αποκριθεί σχετικά αργά προς τις σύγχρονες αντικαπνιστικές πολιτικές. Η Νέα Ζηλανδία διατηρεί πάγιο δημόσιο ενδιαφέρον σχετικά με την αντικαπνιστική νομοθεσία. Η Αρμενία είναι μεταξύ των καρυφαίων πέντε χωρών παγκοσμίως καταναλωτών προϊόντων καπνού, με σχέδιο τρία τέταρτα του πληθυσμού να είναι ενεργοί καπνιστές. Είναι μια από τις τελευταίες χώρες που υιοθετήσει μια επίσημη αντικαπνιστική πολιτική η οποία απορρίφθηκε δύο φορές από το τοπικό Κοινοβούλιο και ακόμα δεν εφαρμόζεται πλήρως, αν και έχει γίνει επίσημος νόμος του κράτους από το 2005. Συμπεράσματα: Πολλοί Έλληνες πολίτες αντιλαμβάνονται τις αντι-καπνιστικές πολιτικές ως απειλή των ατομικών τους ελευθεριών. Είναι φανερό πως τα αντικαπνιστικά μοντέλα πρέπει να περιλαμβάνουν στο σχέδιασμά τους τις ανισότατες του ενηλίκου πληθυσμού στην αυτό-προοδευτική έννοια της ατομικής ελευθερίας και αυτοδιάθεσης. Αυτός ο παράγοντας σε συνδυασμό με τα υπόλοιπα επιχειρήματα αυτής της ανάλυσης δείχνει ότι τα νέα αντικαπνιστικά μοντέλα θα πρέπει να στοχεύουν στις νέες γενιές και στο γυναικείο πληθυσμό.

Λέξεις-κλειδιά: Αντικαπνιστικές πολιτικές, αντικαπνιστικά μοντέλα, κάπνισμα, αντι-καπνιστική νομοθεσία
Analysis on smoking policies: a comparison between Armenia, Greece and New Zealand

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ABSTRACT

Introduction: This paper discusses anti-smoking policies in Greece, Armenia and N. Zealand. A historical perspective showing different cultural and traditional differences is also provided. Aims: The aim was to examine smoking policies/practises in countries with polar opposite official and public attitudes towards smoking. A critical analysis approach was used. Discussion: Greece has responded slowly towards contemporary smoking policies. New Zealand is a country with a long standing public debate concerning tobacco legislation or self regulation and with strong anti-tobacco policies in situ. Armenia is among the top five tobacco consuming countries worldwide, with almost three quarters of the population smoking. It is also one of the latest countries to adopt a formal anti-smoking policy which was twice rejected by the local parliament and is still not fully implemented although it has become official law since 2005. Conclusions: Many Greeks perceive smoking legislation as an imposition on their rights in general. It is clear that anti-tobacco policies in Greece need to consider the resistance of the adult population to constraint on their perceived freedom. This factor and the many other reported in this paper clearly indicate that new policies should target the young especially those of junior school age.

Keywords: tobacco policy, tobacco policy models, smoking, anti-smoking and smoking legislation.

INTRODUCTION

Smoking is a major public health issue, and has been characterized as the cause of the largest number of preventable deaths worldwide (WHO, 2006). There is conclusive scientific evidence that smokers face significantly increased risks of earlier death from numerous causes - cancers (particularly lung cancer), heart disease, stroke, emphysema and many other fatal diseases. Breathing problems and other health issues more commonly affect the smoker. The emotional and financial costs of smoking in any society are enormous (Zhu et al. 2003; Gammon et al. 2004).

Quitting smoking and providing smoke-free zones greatly reduces health risks and produces immediate and long-term community health benefits. As smoking is a global health issue, regarded by the World Health Organization (WHO) as an “epidemic” (along with obesity) all insights which reduce tobacco use need to be openly discussed with care to ensure that policies do not backfire enhancing increased consumption possibly by enticing more aggressive advertising by the tobacco industry. To reduce cigarette smoking in any society is one of the most essential preventive health measures of today (Moffatt et al. 2004; Eisner et al. 2005).

Historically, tobacco consumption has swung from one extreme to the other. Ever since Columbus introduced tobacco from the new to the old world, its use has been a matter of public concern and debate. These ranged from the initial joy of the trade potentials of this novel moneymaking product, to consumption related death penalties, swinging from medical advice ‘on smoking as a means of mouth sterilization’, to the contrast of the last half century’s scientific evidence and wider realization of the serious risks the product has on public health.

There have been eras throughout history when penalties for smoking were severe. The first recorded legislation prohibiting the use of tobacco dates back to 1575 in Mexico when the Roman Catholic Church forbade it in places of worship.
Smoking is ubiquitous in Greece ranking, at the end of last century, as Europe’s second heaviest smoking population (WHO, 1999). The prevalence of smoking remains high at 37%-40% and currently Greece has the highest smoking prevalence among member countries of the EU (Vardavas and Kafatos, 2006). The annual per capita consumption of cigarettes is also one of the highest in the EU. The legislation regarding tobacco use is inadequately enforced and in certain cases bluntly ignored by the population. In some areas in Greece the pro-tobacco culture has resulted in one in two adolescents being current smokers (Huisman et al. 2005; Vardavas and Kafatos 2007).

Current anti-tobacco policy interventions include product labelling as prescribed by the EU Directive 2001/37/EC. Written health warnings on tobacco advertisements have been in situ for the past 5 years, although their effectiveness is questionable. Although television and radio advertisements are banned, both small and giant bill board posters have been a successful advertising outlet for the tobacco industry.

One law, which is perceived to be correctly enforced, is the implementation of a smoking ban in health-care service centres such as public and private hospitals, health centres and pharmacies (Health Law 76017, 2002). According to the legislation (in force since August 2002) smoking is allowed only in designated areas, which should be provided with adequate air circulation for those who wish to smoke. The legislation also covers public services, educational institutions, public transport stations and public vehicles.

In contrast, a ban on smoking in the workplace, introduced in August 2003, was not strictly implemented. Designated areas in restaurants and cafeterias for smokers have also been ignored yet the government recently announced that there will be a total ban of smoking in these places by 2010 as part of an EU Directive. Reactions are already strongly against this.

Another policy which was introduced with little success was the banning of the sale of cigarettes to minors. Since Greece has a high percentage of current smokers, children are familiar with parental smoking and other sources of environmental tobacco smoke (ETS). Cigarette smoking permitted in the household can affect both the child’s perception of smoking and their daily exposure to ETS.

The case of Armenia

Armenia faces a serious smoking problem with more than 70% of the population smoking; ranking sixth in the world and number one in Eurasia. The WHO estimates that 63.7% of Armenian men smoke, which makes them the heaviest smokers in Europe (2005-2006). Armenia tops the list of the former eight Soviet Union republics in the prevalence of smoking among males. According to recent statistics smoking amongst women, and especially teenagers, has increased in recent years as has the production of, and importation of cigarettes into Armenia (Gilmore et al. 2004).
According to the National Survey on Drug and Smoking Prevalence among the general population of Armenia conducted by the United Nations Development Programme (2005) many tobacco users generally know that tobacco use is harmful, but surveys show that most of them are unaware of the true health hazards and that women and children face additional health risks from smoking. This is confounded by lax law-enforcement as those under 18 years of age are able to purchase cigarettes with impunity despite laws against such practices. Official figures show that around 1.7 billion cigarettes were imported into Armenia in 2004 and Armenians spent $25 million a year on cigarettes.

A law restricting the sale, consumption and use of tobacco products was implemented in March 2005. It prohibited smoking in all public transport systems, and in all cultural, educational and health institutions. The bill also imposed a ban on tobacco advertising, the sales of tobacco products to underage persons, smoking in all public places, transparency in the tobacco industry as well as a gradual increase in price of tobacco products and in promoting health surveillance and healthy lifestyles. This law was twice rejected by politicians - some of whom were the biggest cigarette producers and importers in Armenia - before it came into force. The Armenian parliament also ratified the European Union’s Framework Convention on Tobacco control which includes warning labels on cigarette packs. In 2008, the latter part of the law became mandatory. In addition, cigarette advertising is to be outlawed by 2010. However, one should not overlook the fact that recent bans on smoking in public places were commonly flouted even after a widely publicised campaign. They continue to be disregarded as there are no effective penalties for violations and entrenched attitudes have not been addressed.

The importance of education as a preventative measure has been recognised in Armenia and a pragmatic privately sponsored Health Education and Lifestyle Program (HELP) has been initiated in the past decade. The programme emphasises risks of smoking, excessive drinking, substance and drug abuse, unhealthy diets as well as the benefits of healthy diets, exercise and a positive attitude in life. These have been taught to over 10,000 adolescent students in Armenia since 1998. At present the HELP course is being taught in 21 schools and HELP has openly sought assistance from the international anti-smoking arena to tackle Armenia’s entrenched smoking problems. The Armenian Ministry of Education and Science recently started to implement a health education and lifestyle programme in 16 schools since 2007. In the next academic year 125 schools will follow. The implementation and enhancement of this program will involve a publicity campaign utilizing the media together with public gatherings and publications in order to motivate the youth to say ‘no’ to smoking and to be aware of the health risks. A video to enhance public awareness of the risks of smoking has also been developed.

### The case of New Zealand

New Zealand has a long standing anti-tobacco platform which was enriched by the Smoke-free Environments Act 1990, with its subsequent amendments, and the Smoke-free Environments Regulations 1999. In December 2003, an amendment required that:

- Buildings and grounds of schools and early childhood centres be smoke free.
- Licensed premises (bars, restaurants, cafes, sports clubs, and casinos) be smoke-free indoors.
- Smoke free areas to include offices, factories, warehouses, work canteens and ‘smoko’ rooms (rest rooms).
- The display of tobacco products in retail outlets be restricted, and a ‘smoking kills’ sign to be erected near the display.
- Smoking bans included bans on herbal smoking products.

### Additional amendments:

- Further restricted access to those under 18 years of age to smoking products.
- Stipulated that all workplaces were to have an anti-smoking policy, annually reviewed.
- Regulated the marketing, advertising, and promotion of tobacco products and the sponsorship by tobacco companies of products, services and events.
- Placed a ban on the sale of tobacco products to people under the age of 18 years
- Demanded the control, disclosure and the contents of tobacco products.

The 1990 Act also established the Health Sponsorship Council with the primary function of encouraging healthy lifestyles through the provision of sponsorship and other means. Still, the burden of smoking in New Zealand remains heavy as it is claimed responsible for almost 5,000 deaths each year in a population of about 4 million. Yet many New Zealanders, especially Pacific Islanders, either underestimate or are unaware of the serious health consequences of smoking. Thus, the New Zealand government’s ongoing National Drug Policy 2007-2012 seeks to reduce the effects of tobacco use by restricting availability, limiting the use of tobacco, and reducing harm from existing tobacco use (Ministerial Committee on Drug Policy, March 2007). In February 2008, the government introduced a set of graphic pictorial warnings as part of new anti-tobacco regulations.

In January 2004, New Zealand ratified the World Health Organization’s Framework Convention on Tobacco Control (FCTC), which came into force on 27 February 2005 (WHO, 2004). The FCTC required New Zealand to meet health warning standards of at least 30 percent of the principal display area on tobacco packaging by 27 February 2008. The new graphic health warnings are the latest step to combat the tobacco epidemic and complement initiatives such as New Zealand’s...
comprehensive smoke free legislation as these health warnings provide a powerful confrontational message for smokers to quit and to discourage uptake or relapse.

Research on targeted graphic pictorial health warnings on cigarette packages is shown to be more effective, despite its "offensive" nature, than written warnings alone. Currently in New Zealand there are 14 different pictorial warnings in total but only seven of them were introduced in 2008. The remaining seven warnings are to be introduced in 2009 and will be rotated each year thereafter.

Under the new regulations, 30% of the front and 90% of the back of cigarette packets will be covered in the new warnings, which include images of diseased lungs, gangrenous toes, rotting teeth and gums, mouth cancer and smoking-damaged hearts. These pictorials are to be enriched in 2009 with pictures of stroke victims, blocked arteries, lung damage and symbolic impotence. Back-up support is recognized as essential; cigarette packets will also carry a Quitline logo, freephone “helpline” number and other information about quitting smoking.

Policy Analysis of the three countries
Policy making is a complex process as it involves constraining power and resources in the ‘best interests’ of the people through the political dynamics of a community at any specific time. In the Health Care arena, policy making must satisfy the prime stakeholders, namely the ‘ill’, ‘poor’ and the ‘patient’. Yet, at the same time policy making should avoid conflict with relevant professional groups (e.g. health care teams) and economic partners (e.g. drug companies and health equipment manufacturers). In democracies, this delicate task is driven by the minimum-maximum principle i.e. cost control vs. positive outcomes, political loss vs. fulfilled objectives, political “invasion” through legislation vs. a democratic state of respect for individual rights and responsibilities (smokers and non-smokers, in the case of tobacco policy). Although scientific evidence and rigor underlines the whole effort of policy making from the initial stages of setting the agenda, to policy formulation, implementation and evaluation, other sources of evidence outside the scientific paradigm can influence policy making. The policies regarding tobacco use in Greece, Armenia and New Zealand are presented under Walt’s (1994) Policy Analysis Framework (PAF) as shown in table 1.

<table>
<thead>
<tr>
<th>Context</th>
<th>What is the problem?</th>
<th>What is the content?</th>
<th>Why is this an issue?</th>
<th>Which model to use? (rational or interactive?)</th>
<th>Actors who is involved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greece</td>
<td>The increasing smoking as a major global health seeks that national governments implement policies following its guidelines.</td>
<td>Armenia and Greece favour a top-bottom approach with much legislation but little implementation and lax enforcement.</td>
<td>New Zealand follows a bottom-up national approach where key stakeholders work closely together in order to tackle the problem.</td>
<td>In the case of tobacco, the whole population is involved as smokers affect non-smokers in tangible physical ways. On the other hand, non-smokers affect smokers when they demand their right for smoke – free environments.</td>
<td></td>
</tr>
<tr>
<td>Armenia</td>
<td>Tobacco related disease in Armenia and Greece and the need to further decrease the prevalence in New Zealand.</td>
<td>The WHO has ranked smoking as a major global health issue and seeks that national governments implement policies following its guidelines.</td>
<td>Armenia and Greece favour a top-bottom approach with much implementation and lax enforcement.</td>
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It is noteworthy that social scientists in New Zealand have formulated an integrated system for analyzing policy options for tobacco control. One of these models, using a simulation package (iThink) is able to simulate policy effects for 20-30 years into the future (Cavana and Tobias, 2008).

Advertising also has an impact on policy making. It is well recognized that cigarette advertising influences consumption levels thus tobacco policies must take this into account: the freedom of tobacco companies to advertise their products vs the right of citizens to know the truth about the dangers of the product. Furthermore, the global influence of tobacco promotion via movies, radio and TV can be particularly bold and aggressive. The depiction of national celebrities and pop stars on TV with cigarettes in their hands portrays power, success and glamour, linked to cigarette smoking. These deceitful images are readily imprinted in teenagers’ minds. Tobacco companies produce and promote specially designed (light-coloured, long, mentholated) cigarettes with “women-only” brands, using seductive images of emancipation, freedom, empowerment, sophistication, and slimness. Yet, most women are unaware of the harsh reality that smoking causes reproductive damage, cancer and premature death.

In countries of "transition", such as Armenia, where society is only just beginning to enjoy the pleasures of the market economy and consumerism, new forms of “consumer pleasures” are taking root and one of the main targets of advertising campaigns is the young generation. The tobacco market in Armenia is expanding because more young women and teenagers are either beginning to smoke or are increasing their daily cigarette volume. However, recent advertising laws restrict the promotion of tobacco goods in Armenia. In October 2006, the capital city of Yerevan was free of tobacco...
billboards. Nevertheless, there are many other direct and indirect pro-tobacco advertising venues in situ.

In Greece, as in many other countries, advertising agencies claim that women are easy to target if smoking is already prevalent amongst males (Hondroyiannis and Papapetrou, 1997). This was particularly relevant in the bill board poster campaigns targeting women in the late 1980’s and early 1990’s. These campaigns were evidence of the powerful subliminal force of bill board advertising for this product. Even today, throughout Greek cities, billboards at bus stops and road sides still promote glamorous portraits of young, slim and well-heeled healthy women holding cigarettes.

For global tobacco control, the WHO’s FCTC requests that individuals and organizations join the combat against tobacco and provides a framework for action against it. At the forefront of tobacco control initiatives are the national capacity-building programs (the ability to perform well, solve problems and achieve objectives) enhancing expertise and leadership, building data gathering and surveillance infrastructures. The general goals of tobacco control strengthening capacity in countries like Armenia and Greece is to analyze the national tobacco control scenario and to develop an action, sustain funding mechanisms, stimulate wide advocacy and publicity campaigns, develop activities for countering tobacco industry strategies and to establish new networks.

The key to more recent tobacco control in New Zealand involves explicit use of pictorial warnings. These are an important part of the World Health Organization’s six key strategies to fight the global tobacco epidemic. Currently, New Zealand’s six different text-only health warnings cover slightly less than 30 percent of each cigarette packet cover. New Zealand was one of the first countries to ratify the FCTC and there are now more than 150 countries around the world that have done so.

Research has shown that most smokers are only able to recall the more well-known illnesses caused by smoking and that they significantly underestimate the health risks from smoking. Studies have shown that large pictorial health warnings are the most effective way for tobacco packages to convey the range and severity of health risks associated with tobacco consumption, and to encourage positive behavioural changes.

Whereas New Zealand citizens might be ready to be exposed to vivid images of disease state on cigarette packages, recent research in Greece suggests that this would result in revulsion and denial (Rachiolis et al., 2008) possibly mixed with humour. In fact, smokers have come up with novel ideas for overcoming the impact of the printed warning on the package by inserting it in an outer packet which promotes their freedom to smoke by some humour-intending catch phrase.

Policy implementation
Globally, the most commonly cited factors contributing to smoking are: age, gender, ethnicity and acculturation, living arrangements, family size and structure, parental socioeconomic status, cash flow, employment status, and urban residence (Batra et al. 2003). Stress and associated distress or depression is also known to be important factors in the initiation and/or increase of cigarette smoking (Tyas and Pederson, 1998). Other factors that have been consistently associated with smoking are poor self-esteem and personal health concerns. Smoking among adolescents typically rises with increasing age and poor performance in school. Adolescents who begin smoking at a younger age are more likely to become regular smokers and less likely to quit smoking as adults. Individuals who adopt a healthy lifestyle and understand its implications tend to stay away from cigarette smoke, alcoholic beverages and other addictive substances (Schettler, 2001).

In Greece, and to some extent Armenia, the reasons for the lack of full implementation of anti-tobacco policies are multifactorial. Reinforcement agencies, mainly the police, are lax; smoking is widely accepted as a habit which promotes social interaction and is widely accepted in the home, unlike New Zealand where most smokers would use the veranda rather than lighting up indoors. However, in Greece where attitudes are entrenched little is done to alter the smokers’ viewpoint. With regards to teenagers, there is powerful peer pressure to start, and a relative degree of indifference by school teachers in secondary and tertiary education. Although research has also shown that smoking in childhood is associated with previous exposure to environmental tobacco smoke (ETS), cigarette smoke is widely tolerated by non-smokers. Contemporary Greek youths tend to defy authority and most policies are perceived as ‘policing’ measures rather than constructive directives for the citizens.

Although all countries under review have relatively similar anti-smoking policies (in line with the WHO guidelines or EU directives) it is clear that there is considerable variation in the way these policies are introduced, followed and enforced. There is also a strong cultural impact on whether people smoke or not. The permissive attitudes towards smoking in Greece and Armenia is reinforced by non-smokers who widely accept the habit, not necessarily due to amiability, but on the grounds of a long cultural tradition of letting others express their desire to act and being free to do so. In contrast, the Anglo-Saxon tradition dictates that the individual should oblige the demands of non-smokers who are not afraid to express their dislike of cigarette smoke. Furthermore, this culture is able to emphasise the notion of “personal space” which is not to be violated by the other person’s smoke. It should be recognized that such a concept is inconceivable to either the Greek or Armenian mentality which is based on the physical, emotional and psychic proximity of people.

Another major difference in the effectiveness of policies between the three countries is the degree of social obedience. As mentioned above, Greeks and Armenians to a certain extent, tend to see government policies as interference - or certainly perceive a health law as such - whereas New
Zealanders, especially within the health care sector, demand government action.

There is also much basic difference in the way educational interventions are planned, implemented and evaluated by governments and the way they are perceived by the public. In Armenia, there is a recent grass roots approach which, when it works, can be used as a model for government policies. The HELP programme in Armenia is a classical example of this down-up approach as it was initiated and implemented by a married couple concerned about smoking in their country. Yet, it took nearly a decade before officialdom could see the value of this educational tool and decided to adopt it in its entirety.

New Zealand and other Anglo-Saxon countries, hold a different attitude in policy-making, where bottom-top approaches are routinely favoured. Although private initiatives are also prevalent, the government takes anti-tobacco policies very seriously; in fact the electorate expects health policies of this nature. Greece, on the other hand, seems to follow neither of these two patterns; its current anti-tobacco policies are well designed but frequently jeopardised due to slack law enforcement.

In none of these three countries do smoking bans apply to households so parents have a powerful influence on the lifestyle of their children either positively or negatively by influencing their attitudes towards health and substance abuse. Unfortunately, parents, close friends and older siblings frequently encourage children to initiate smoking. Exposure to their parents’ smoking habits may lead adolescents to develop the perception that smoking is normal adult behaviour (Bandura, 1986). It has been found that paternal and maternal smoking status are strong predictors for the onset of child smoking as well as the transition from initiation to monthly, and then to daily, cigarette use (Darling and Cumsille 2003; Otten et al. 2007).

Parents that smoke not only act as negative role models for their children but also, unless precautions are taken, expose them to environmental tobacco smoke (ETS). Policy makers need to take care that overzealous policies do not drive smoking into the home. Children, due to their higher ventilation rates, inhale elevated levels of ETS for the same level of exposure and due to their smaller body mass, are affected more seriously than adults. Exposure to ETS affects children's health in many ways, by predisposing them to cancer, early cardiovascular disease, asthma, lower respiratory tract infections and neurological disorders. ETS has even been found to affect child cognitive abilities (Rapiti et al. 1999; Kosecik et al. 2005; Chan-Yeung and Dimich-Ward 2003; Yolton et al. 2005).

Age specific interventions need also to be considered when planning for national anti-tobacco policies. Many adolescents have a serious smoking problem and prevalence differs according to place of residence. Inner city 15 year-olds on the Greek mainland have a higher smoking prevalence (32%) than rural teenagers in Crete where only 10% smoke daily (Kokkevi et al. 2000; Linardakis et al. 2003). According to the findings of the Greek cohort of the Global Youth Tobacco Survey, among 13 to 15 year-olds throughout Greece, 32.2% had ‘ever smoked’ and approximately 1 in 4 of ‘ever-smokers’ had initiated smoking before the age of 10 (Kyresi et al. 2007).

Relevance for health care workers
Healthcare professionals, including nurses, frequently advise patients to improve their health by stopping smoking. Such advice may be brief, or part of more intensive interventions. A search in the Cochrane Tobacco Addiction Group specialized register and CINAHL revealed that nursing-delivered smoking cessation interventions are quite effective. The selection criteria included randomized trials of smoking cessation interventions delivered by nurses or health visitors with follow-up for at least six months. The main outcome measure was abstinence from smoking for at least this duration. Forty-two studies were identified which met the inclusion criteria. Thirty-one studies, comparing a nursing intervention to a control or to usual care, found the intervention to increase the likelihood of quitting significantly.

However, nurse based interventions of hospitalized patients, and especially those with cardiovascular disease when compared to inpatients with other conditions, showed limited indirect evidence that they were more effective. Accordingly, interventions of non-hospitalized patients also showed evidence of benefit. Nursing interventions which were merely part of either a screening health check or part of a multifactorial secondary prevention in general practice were found to be less effective (Rice and Stead, 2008). Tobacco use by Health professionals is of genuine concern; it is evident that where smoking is prevalent among HCPs anti-tobacco policies are jeopardised. A positive image of the health professional is central in promoting tobacco-free lifestyles and cultures via this route. Health care professionals and the medical profession in particular have a primary role to advice and guide patients and the wider public on health issues. Thus, they are often perceived as role models and exemplars for health. Yet, many continue to smoke, even in the presence of patients. In countries where there are lax or no smoke-free policies in hospitals, the rate of smoking among physicians remains high. The prevalence of smoking among physicians in Armenia was still high (above 40%) in 2005 while in New Zealand, studies in the 1990s had revealed their smoking prevalence to be around 5% (Young and Ward 1997; Roche et al. 1995, 1996). A Greek study by Polyzos at al. (1995) reported that the highest smoking prevalence rate was in Greece where roughly half of all physicians (49%) were reported to be current smokers, despite hospitals being smoke-free zones. They also stressed that international policy makers who were attempting to tackle the tobacco problem on a global scale, such as the WHO, would need to consider that health care professionals may not always be the best role models from where sound policy can originate.
Conclusions and recommendations
In contrast to Armenia and Greece, the use and exposure to environmental tobacco smoke in New Zealand is declining mainly due to a bottom-up approach to the problem. Key stake-holders work closely with the government to tackle the problems so there is greater success in tobacco control. The government also takes greater responsibility to use solid scientific tools not only in planning their policies but also in projecting their short and long term efficacy. Greek policy makers would be wise to observe closely the strategies followed to this country. Of special interest is the new policy in New Zealand requiring all cigarette packets to carry a helpline for quitting along with graphic depictions of smoking related diseases. If evaluation of this helpline scheme has a positive outcome, its implementation in Greece could be considered.

This paper has highlighted that many Greeks perceive smoking legislation as an imposition on their rights in general. It is clear that anti-tobacco policies in Greece need to consider the resistance of the adult population to constraint on their perceived freedom. This factor and the many other reported in this paper clearly indicate that new policies should target the young especially those of junior school age.

It is recommended that the broader consequences of smoking be spelled out clearly to this age group by enshrining the facts in the forthcoming editions of junior school textbooks. Greece’s centralized education system makes this measure relatively straightforward to implement and evaluate. The information should be inserted in textbooks over a 3-4 year period so the debate stays active during the junior school years. Textbooks should not only concentrate on the effects of smoking in health, but also on misconceived perceptions that individual rights are being threatened by health promoting policies. Greater social awareness and personal responsibility could thus be instilled in this age group. Reinforcement in senior schools should also be made. Follow-up studies should consider whether this approach potentially creates tomorrow’s concerned citizens for a bottom-up approach to anti-smoking and other health related policies.

Another reason why policies should aim at targeting the young is that if smoking does not start during adolescence, it is less likely ever to occur. It is also known that the probability of cessation among adults is inversely related to age of initiation. Even infrequent experimental smoking in adolescence significantly increases the risk of adult smoking. Once smoking has begun, cessation is difficult and smoking is likely to be a long-term addiction. This complicates policies concerning quitting. As the duration of smoking is 16 - 20 years for 50% of smokers, prevention on the onset of adolescent smoking is an essential component in reducing cigarette consumption and its attendant morbidity and early mortality.

The Greek government, as in all tobacco producing countries, faces a dilemma – on the one hand it wants to protect its citizens via effective anti-tobacco policies and on the other to sustain or increase the financial revenues from tobacco production and taxation. This can often result in weak law enforcement. Nevertheless, recent efforts to reduce tobacco production are encouraging.

There is a need to examine the psycho-cultural fabric of societies before following anti-tobacco policies which have succeeded in other countries. If there is deep-seated distrust of authority or a fierce sense of individual freedom of choice, policies can backfire should they try to superimpose those of another country without cultural adjustment and modifications. Greeks hold a cultural characteristic of confronting each other on many aspects of daily living; the majority does not wish to confront a smoker because this act is seen as a symbol of his freedom and self respect, highly appreciated values within Greek culture. Supporting groups which challenge these attitudes prior to policy making might enhance greater compliance

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